CAA – What is it and how will it affect my business?

Speakers:

CD Chris Deacon – founder of VerSan Consulting

JT Jeffrey Toewe – co-founder of Medxoom

JT Hi, I'm Jeff, the founder of Medxoom. This is the first in our podcast series where we're speaking to thought leaders in the healthcare benefits ecosystem that have created demonstrated success and cost containment for their clients. Today's guest is Chris Deacon with VerSan Consulting. She had previously been with the state of New Jersey, and helped overhaul their health care plan administration and created great measurable results. And perhaps this should be considered a case study as to what larger entities can do when it comes to creating measurable results and positive outcomes for their health benefits

strategy. Without further ado, let's get on to the session. We hope you enjoy. Thanks. Hi, welcome to the Medxoom Podcast. I'm Jeff. And I'm here with my first guest of this series, Chris Deacon. And we're here today to talk about effective measures in cost containment in healthcare. Chris, I'd like you to introduce yourself and tell us what you do.

CD

Sure. Thanks for having me. I'm excited to be the first guest. I'm currently a principal and founder of VerSan Consulting, where I help large employers, Taft Hartley groups and public sector health plans, as you said, optimize their health plans, seeking out high quality, low cost solutions for their health plan. I actually am an attorney by training. So I practiced law for several years before joining the public sector in the state of New Jersey, versus a deputy attorney general. And then as assistant counsel to the governor's office, where I oversaw a department of banking and insurance, and Department of Treasury, which was really sort of my first real foray into healthcare, as the Treasury Department oversees the state health plan. After the administration ended, I was asked to stay on and run the state health benefits and school employee health benefits program for the state of New Jersey. We represented not only state employees, early retirees and retirees, but also institutes of higher education, local governments and school districts that opted to join the plan.

> **At the time, we had about 720,000 lives across all of our populations. And at the time of my departure in September of 2021, we had about 820,000 and that delta was as a result of sort of the structure of the plan.**

Fast forward, as I said, I'm now back in the private sector, but very much hoping to, through my services, benefit public private sector, and large employer groups, as I feel that employers are really, they're paying the bill, and they're ultimately going to be the catalyst for change in controlling this thing we call healthcare.

JT

So for folks that are unfamiliar, I'm one of the founders of Medxoom. We license a white label platform to our clients -- TPAs, also known as benefits administrators and health plans. And we enable them to create a more usable, more cost effective health plan. We are essentially unifying the member benefits and healthcare payments experience. And we'll get into a little more detail afterwards. But I want to put a focus lens today on what your experience is, and the challenges and the practical things that you've done. And, of course, most importantly, the results of your efforts for the New Jersey plan, for example. So today, we're going to talk about the Consolidated Appropriations Act. This is a recent act that really creates what we believe are effective measures to have teeth for legislators to ensure that fiduciaries and other entities managing and designing health plans, really put in a genuine effort and have measurable results in creating cost containment solutions. Because as most folks know, in the US, we spend more than twice than any other developed nation on our healthcare and we're not getting the results we need. There's a lot of inefficiency. There are massive cost spreads in the system. And there have been some other executive mandates to publish data related to negotiated prices, first at the

hospital level and July 1 today - the payors, meaning the insurance companies themselves are required to publish their negotiated rates across different services with different providers. And we'll maybe touch on how effective we think those things will be. But let's dive into the Consolidated Appropriations Act. Chris, you're a subject matter expert in this area. Can you help lay out sort of a playbook for the administrators of plans, and the folks, the fiduciaries, and people who use our system and sponsored plans as to what it means to them, and what the practical efforts that they can take to first comply with this and then more importantly, get measurable results related to health care cost containment?

CD I think first, it's important to note that while the CAA, which is really just as another name for the budget, the federal budget, is a 2000-page document the provisions regarding health plan administration are sort of buried on page 1800 something. But, you know, long before the Consolidated Appropriations Act of 2020, and 2021, were enacted, the fiduciary responsibilities of health plan administrators have been sort of been there all along, right. And what the CAA has done in recent years, is really laid out a little bit more meat on the bones of "what does that mean?" So yes, I understand I'm a health plan administrator, I have a fiduciary duty to be a prudent purchaser. But what does that mean, right? And what the CAA tells us, now two primary areas.

> **One is in disclosure of fees and compensation of third party service providers. So your brokers and consultants, all direct and indirect renumeration that they receive.**

And fees that you pay to them have to be disclosed to you and you have an affirmative duty to ask for that information. And if they don't give it to you, you can't do business with them, or you're sort of in breach of your fiduciary duty. The other important piece is your obligation to have access to your data. So in previous times, I think every health plan administrator out there has heard, you know, if you want access to your data, you might get a response that it's proprietary, or it's subject to HIPAA, and we can't give it to you, or we're only going to give you these fields, well no more. Now you have a legal obligation that set forth in law that says you cannot sign a contract as a health plan administrator, that limits your access to your data. This, I think is probably the most important piece. Because with data and with sort of your right to data, and legal obligation to have the data, your claims data and quality data. Now that your head has sort of been forced out of the sand, as a health plan administrator, you have to look at the data. And the data is going to tell you where you've been spending your money, how the money has been misspent over the years, and really enable you to get a handle on your health plan spend.

JT We have a prospective client that we're speaking to and it is a teachers association, out west. And they signed a contract with a BUCAH, not to be named specifically what state or organization or network and they do have audit rights already in their contract. Yet they've been unable to access any of that data. There's discussions, bait and switch, we don't, we can't give this to you. The clause says that you have audit rights, however, it's only forensic. Now we're only allowed to see this data and I read the clause and it says we're only allowed to discuss audit topics after the network's negotiated rate has already been paid.

> **When it's too late, to move the needle whatsoever or determine whether or not that's an appropriate rate.**

What about this Consolidated Appropriations Act gives teeth to being able to get the data because the contracts already say that - what's the recourse?

CD Even without the CAA the fact that somebody's entered into a contract that essentially limits their audit rights, to your point, right? Sure you have a forensic audit rights, but I probably I guarantee it's too late. It's not only late because the money has left the door, but the recoupment of those funds are going to be subject to their approval, the recoupment of those funds, if any, is going to be subject to their discretion. So really, I think it's problematic that that agreement, and agreements like that, because this district is not unique, right? That that's even been part of the ecosystem. It's been problematic since day one. But recognizing that that's where we are, and those contracts are in place. I think what the CAA does, if I'm that school district, or that employer, I'm going back to my BUCAH, my BUCAH partner, and I'm saying, I need an amendment right to our contract, because the law says I have to do these three things. One of them is have access. I cannot be party to an agreement that limits my right to my data and my access to my data. So we can do this one of two ways we can agree to an amendment that recognizes the state of the law, or I'm going to guess, and this is where I sort of put my attorney hat on, most contracts are going to have a clause somewhere towards the end with all the clauses that nobody really reads. It's called a savings clause, essentially, it says, you know, should anything in here become invalid pursuant to a statute ruling, whatever. We don't want to throw away the baby with the bathwater, we just strike that clause, sort of, it's self executing. So you could even exercise that provision and say the law trumps, and the the contract recognizes that the law trumps so I would caution though, that these like this discussion, this hypothetical discussion that I'm having, as the district with the carrier, it only happens if you're willing to like stand up and have the conversation because trust me, they'll continue to throw out, you know, no HIPAA, or no, you don't have audit rights, or no, get I need a stronger business justification or there's information is proprietary and confidential. It's on the employer, as the entity with ultimately what the legal obligation and legal exposure here, it's on the employer or the district or the joint Insurance Fund, whomever it is the trustees to demand that their carriers and their partners deliver on these things. And in the absence of that to take their business elsewhere. That's really the power that they hold.

JT Let's play through the concept of breach of fiduciary duty, and what are the real impacts? And what what is the exposure to a fiduciary? If they are not demonstrating, you know, effective progress towards finding obtaining the data working with folks to demonstrate cost containment, what happens to them and who enforces their breach?

CD Yeah. So it's interesting, there was a case filed just recently, May 27, 2022. So very recently, and this was filed by Department of Labor itself against a TPA for a breach of fiduciary duty. That particular lawsuit is in regards to a sort of a carrier TPA entity, commingling self insured plan funds with other self insured plan funds, as well as the entity's funds itself, right. So all of the money from self insured employers and individual you know, individuals who bought this product on an exchange are being aggregated commingled and then not act accurately accounted for.

JT So that's an ERISA violation for segregating different entities

CD Right, not holding funds in trust. Another example, another case, recent case, that was actually dismissed, but it's still very instructive, is a Blue Cross Blue Shield of Massachusetts Labor's case so a labor union brought a foot breach of fiduciary duty case against Blue Cross Blue Shield of Massachusetts, alleging that that carrier and that TPA, paid claims and air play duplicate claims paid according to wrong incorrect fee schedules and harming the plan. The case was dismissed for lack of or failure to state a claim which essentially means that like the court said, we accept everything you say is true. Even if Blue Cross BlueShield paid claims in error, paid inflated claims knowingly, you don't get to state you're not stating a claim, because they don't owe you a fiduciary obligation. You're the people running your plan, your health benefits administrator, they're the fiduciary, right? The only relationship between Blue Cross Blue Shield and the laborers union was contractual in nature.

JT Interesting. So it really reflects a mirror back on whomever the fiduciary is for that group. And the administrator that they're working with who is dispensing these dollars, and essentially, if you were to revise a claim or make a more specific claim, it's back. It's not against the plan. It's against it's against the TPA. And the fiduciary, well, what happens when the TPA is owned by the plan, aren't we in court with that particular carrier at the moment? What's the next step, essentially? Because that problem still needs to be rectified. Right?

CD Yeah. And so this is sort of I think the push and pull that's happening right now in the courts is who's bringing the case against whom? Who's the named plaintiff, who's the named defendant, who holds the fiduciary obligation? And what I see playing out and what I predict, and I'm not alone here is we have the playbook and the playbook has been written. And it was written in the 401k context over the last several years. And that is that classes of employees, right. And unions, and organized employee classes are going to file lawsuits against their employer. And as the health plan administrator, right, as the ERISA is an employer sponsored health plan for breach of fiduciary duty for failure to

be a good steward of their health care dollars, right. They're contributing to their health plan, whether that's through premium contributions, lost wages, etc. They're paying into this fund for health benefits, and is the health plan administrator, ie the employer health plan administrator, doing so prudently? When they contract with a BUCAH and sign away all audit rights or rights to their data? Are they are they being prudent purchasers of healthcare? Probably not? Right, that is the playbook. And as I said, in the 401k realm, which by the way, the health plan dollars at stake here, dwarf the 401k dollars and investment fees, to absolutely, absolutely, this is much bigger. But in those cases over the last few years, we're talking 10s, hundreds of millions, if not billions of dollars, at stake and liability because the employer failed to adequately monitor investment fees, right, and failed to adequately monitor, to see whether investment vehicles that they were putting in front of their members were prudent. And then they've paid out huge financial costs for it. And I think it's going to be even bigger with health plan liability.

JT

How is this going to manifest itself in folks that are looking for guidance and legal defense? How does how does a fiduciary demonstrate that they are taking the right measures? And are their benchmarks or criterion or how do they prove that they are now complying with their fiduciary responsibilities? And are there certain benchmarks or criterion as to how to prove that they're doing that?

CD

No, that's a great question. And I think the sort of legal term of art you're looking for here is like, what is the safe harbor? Right? What can an employer do to put themselves in a safe harbor that essentially says, if I did these 10 things, you can't sue me, because I've shown good faith efforts at trying to comply with my fiduciary obligation. And those safe harbor elements have been sort of set and codified on the 401k side, if you do these five things, you will not you know, that's a defense to a potential lawsuit. We don't yet have the codified Safe Harbor on the health on the health plan side, because it is so new. But that being said, I think there are some very sort of clear things that an employer can do to very, you know, very safely put themselves into what I'll call the Safe Harbor. And that first, it starts with getting access to your data, right and not taking no for an answer, even when the carrier says yeah, but our legal folks say you're not entitled to it. If you know, there's a reason they're fighting you. But there's a reason why it was written into the CAA and it was to give you the tool to get it. So have access to your data, all of your financial, you know, your claims data. And I would even argue any sort of quality metrics that you are able to obtain. And if your partner is not willing to share the data, then you find a new partner. That's step number one out of the gate. So on to step number two, right. Now, once you have this, what do you do with it? Right? And the answer can't be nothing. And so this is where I think the other tool in our toolbox through the CAA, which is disclosure and being really transparent with our vendors, and knowing where their income is being derived from, right, is finding trusted partners to make sense of the data. To your point is somebody benchmarking what I'm paying, right. So if I'm paying a hospital 1000 times CMS, you know, the CMS rate is that really reasonable, which, you know, paying reasonable prices is one of my fiduciary obligations. So who can help ensure that I'm paying only fair and reasonable prices, knowing who you're working with, where they're deriving their income, you mentioned some of the big name consulting houses, if a majority of their income is coming from the BUCAH Industry, and the big PBMs, I'm going to think twice about trusting any advice or counsel that they're giving me regarding staying

with that vendor or not? Or challenging a price or not? Because now I know, through these disclosures, you know, where they might be conflicted?

JT Right? Have you seen any of them start to change your pricing models or rethink how they go about business as opposed to receiving their revenues off the back end and having different motivations as to what's in their best interest? Or challenging a price or not? Because now I know, through these disclosures, you know, where they might be conflicted?

CD Right. And I think, you know, the first step is knowing the answer to that question, because until we know the answer that question, we can't truly challenge it. And, you know, what, if I now know, that, you know, big consulting firm is deriving 50% of its income from my carrier, right? Am I going to put that consultant in charge of my RFP process? Absolutely not. Right, they're not getting that business. And, and I might find another trusted partner that's willing to be transparent. So to me, I'm not, I don't necessarily know that I am going to boil the ocean in terms of changing the all of the economics and financing behind healthcare.

> **But what transparency does is it allows me as a purchaser to make prudent, you know, informed decisions.**

And I now know, going back to that Blue Cross Blue Shield of Massachusetts case, if I now know that what is between myself and Blue Cross Blue Shield is only contractual in nature. And you know, sort of they can do whatever bad deeds in terms of overpayment of claims and inflated fee schedules, and my only recourse is going to be contractual in nature, I'm managing that contract entirely differently than its then if I had sort of assumed that they were acting on my behalf as a fiduciary. So I think again, the first step absolutely, is full disclosure, and then we can really go toe to toe.

JT Okay, Chris, I have a related question. What do you think, are proper measures to do? Have you ever thought about how TPAs and plan administrators can change plan design, in a manner that that puts the member in control of discovery of prices and discovery of quality providers? You know, above and beyond what the in-network search tools have done beforehand? What is it about plan design, after they have the data? What are the most effective steps?

CD I think this is an area where it's really it is dependent upon your population, and we shouldn't sort of sit in an ivory tower and guess what our members, right? So if I'm working with like, a white shoe law firm, or, you know, a big consulting firm, right, and everybody's fairly high income, salaried, what moves them, right might be very different from a plan design perspective might be very different than my hourly workers at an Amazon plant or, you know, organized labor, blue collar.

JT Yeah, we see same. We see for the, for the middle wage earners, that designing a plan that offers them an incentive to choose a particular provider for a service. And there's zero out of pocket that is works incredibly well. I see that as a strong motivator of all. What did New Jersey do? What did you do for New Jersey?

CD So, New Jersey is interesting, because the plan design structure, it was negotiated, right. So it wasn't in terms of cost saving opportunities, we have to get really creative and primarily drove, you know, the billions of dollars in cost savings through things like procurement methodologies, financial guarantees, oversight and accountability, and less through strategic plan design, because that was really struck at the bargaining table between the administration and the labor unions. There were over 35 labor unions that we worked with. That being said, there were some opportunities that, for example, we had a direct primary care medical home pilot, where we incentivized members to utilize primary care, which again, are really high value service that is under-utilized and under invested in, in today's fee for service world dominated by hospital systems. So we wanted people to go there, so waiving all cost share for members to utilize Primary Care. I think that, you know, some other creative programs that were sort of on the roadmap, included using centers of excellence, right. So and not an off the shelf one from one of the BUCAHs, but an actual curated Center of Excellence program, where we, we did the due diligence on the quality metrics, and the efficiency, and getting members to use high value care at providers, you know, at a surgeon who maybe did, you know, 300 knee replacement surgeries a year as opposed to 3. And there's a lot of opportunity there, I think, to do sort of a value based insurance design and plan design. But it's difficult when you have the level of benefit and cost sharing limit and cost sharing, you have to get a little more creative with incentives. And I think you should always lead with quality and efficiency first.

JT What still needs work in the Jersey situation?

CD Um, well, where to begin. I mean, I think it's, you know, the healthcare system is somewhat of a whack-a-mole, right? We move folks out of the hospital systems and more to like outpatient settings that are supposed to be more affordable. But now we see that hospitals are owning the logos and all the buildings, right. And so we've seen this spiraling and utilization on urgent care centers, and a dwindling engagement with primary care. So again, it's a bit of whack-a-mole. So it's staying ahead of that. But I think more strategically, and so broadly speaking, it's about maintaining the financial alignment and knowing where the misalignments are in the system, and always being on guard for that. So whether it's oncology drugs delivered at the hospitals and the markups that we're paying, or, you know, neutral site of service payment models. There are there are a ton of opportunities out there, it's prioritizing what's right for your population. And certainly the state's population is very varied. But, you know, bringing, for us, I think bringing labor together to again, lead with sort of a quality first mindset and high value, right? Because nobody wants to fork over a bunch of money to a hospital Corp, that's funneling it off to a for profit venture arm, but maybe they don't know that. So it's a lot of education, but also a lot of opportunity. And just getting it done. I mean, what's the saying? Vision without execution is just hallucination. We have a lot of vision in this industry, it's really hard to execute.

JT What was the net effect for the New Jersey effort? How long did it take? And what are the measurable results pre/post?

CD So I mean, I think when you say measurable results. I think that to my earlier point, it's ongoing and it's going -- there's not some finish line that any health plan is going to get to and cross because there's a $2 million drug in the pipeline. And we're going to have to figure out how to deal with that. And it's only going to increase, right. So over the course of those three years, really, you know, we're talking north of $3 billion in savings to the state, which emanated from doing a reverse auction for our PBM services, which I know has been sort of like touted as sort of it was certainly one of the first of its kind at the time. For a large public sector, I think more states are interested and doing reverse auctions for PBM services. And that generated a tremendous amount of savings to the state over what we were currently and how we were currently purchasing PBM services. And our TPA contract, which was issued in 2019, with an award for 2020 was also very revolutionary, in the sense that we moved away from a discount model and move towards a unit cost guarantee model. And it was credited with saving over $200 million in the first year with dividends to pay off and years to follow. From not sort of pegging what our TPA was required to produce from a discount, because I don't care about a 90% discount off a number I don't know, I care about a unit cost on a service in a region, not going up over a percentage point over time. And that's how we procured and evaluated the vendors. And I think it was successful. There are some challenges and learning opportunities with navigation and advocacy services that I think the state is addressing or trying to address. I hope but you know, like I said it's an evolution, and they're just needs to be constant innovation, and revisiting to stay ahead of the curve. Because to your point, right, like, if you want to shrink that $4.1 trillion pie, it's not going to happen because the hospitals are carriers, your premiums or drug manufacturers want it to happen. Right. And in fact, the opposite, it's going to take a constant addressing to get there.

JT That's a lot of money you helped save New Jersey. Thanks, my family still lives there and helping to contain the cost. So this is an ongoing battle, right. We've seen different mandates come into play. And then the Empire sort of reinvents itself and finds new ways, new separate service visits and stuff to you know, maintain their revenue. And also, I certainly appreciate you as a thought leader in this space. And I hope we can be speaking more. It's great to see you again. Thanks for tuning in today. We hope you enjoyed the session and see you on the next one.