Building Service 32BJ Health Fund
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Cora Opsahl Oral Testimony
Senate Committee on Aging
July 11, 2024

Good morning. Thank you Chairman Casey, Ranking Member Braun, and the rest of the Committee on Aging for inviting me to speak this morning.

My name is Cora Opsahl, and I am the Director of the 32BJ Health Fund. The 32BJ Health Fund is a self-insured, Taft-Hartley benefit fund that provides health benefits to over 200,000 union members and their families. Our members are essential workers who work in the real estate industry, security officers, school workers, and airport workers. We are based primarily in the New York/New Jersey area, but we have families up and down the East Coast including Pennsylvania and Massachusetts. The Fund is jointly governed by a board of trustees appointed by the Union and the Employers, and we provide high-quality health benefits with no premium sharing, $0 in-network deductibles, and low in-network copays. We believe the fund has an important role in tackling the problem of healthcare affordability, and we have spent over a decade doing just that by leveraging our data, challenging the status quo, and finding innovative ways to manage our benefit.

Having access to our claims data is foundational to our work. For almost 20 years, we have been fortunate to have access to our medical, pharmacy, and ancillary claims data. We use this data to understand our healthcare spend, make benefit decisions, and ensure we are a good steward of the Fund's resources. Because of our data, we know the following:

- In 2023, we spent $1.4 billion in healthcare.

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- Of the $1.4B we spend in healthcare, 55% is spent on inpatient and outpatient care
- In 2021, we paid 271% over Medicare prices for the same care, which is up from 219% of Medicare in 2016
- And, in the past 10 years, healthcare has risen from 17% of total compensation to 37% of total compensation; wages have gone up 54% but healthcare costs have increased 230%; and to put that into a dollar amount, our members could have had $5,000 more in annual wages had healthcare spend risen at the same rate of inflation

While having your data and being able to see how your benefit is being spent is important, as a plan we know this is only the first step. The next step is taking action on this data.

In 2018, after spending over 10 years looking at our claims data, it became abundantly clear to us that we needed to address the prices we were paying. The data showed we were paying wildly different prices for the same procedures, depending on what hospitals our members went to. For example, we were paying approximately $10,000 for a colonoscopy at NY Presbyterian system versus approximately $4,000 at Mount Sinai Hospital system. The same pattern was true at other high-priced hospitals. Based on our data, we tiered our network on price beginning in 2019. Members could still access the higher priced hospitals, but they would have to pay higher copays to do so.

While we had won the right to tier our plan in 2019, in 2021, NY Presbyterian and our carrier, Anthem, were up for their network renewal. During that renewal, NY Presbyterian told Anthem they would have to be preferred in all networks, leveraging a clause in their contract. Eventually, NY Presbyterian granted the Fund permission to remove them from our network only in 2022. This

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change has saved the plan approximately $30M every year by members receiving care from lower priced facilities and providers. Additionally, in the most recent contract negotiations, the union and employers leveraged the savings in our benefits to give union members a one-time bonus, the largest wage increase in contract history, a pension increase, and limit employer premium contribution increases to no more than 3% every year through 2027.

While these benefit changes showcased our ability to leverage our data, both changes also illuminated the contract terms between providers and carriers that obstruct, hinder, and limit the ability for us or any employers to take action on their data.

Recently, the Health Fund led a procurement for a medical and hospital benefit third party administer, or carrier. We were adversely affected by anti-competitive contract provisions between providers and carriers. The provider contracts included items such as requirements to be in network, anti-steering and anti-tiering provisions, limitations in how claims are allowed to be paid, and even limitation in access to claims data. For us, the network inclusion and other contracting demands of hospitals limited participation of TPA bidders in our procurement process. Every TPA bidder, except one, was unable to meet our network requirements, including that NY Presbyterian remain out of network. Other network provider contract provisions routinely demanded by hospitals include restrictions on retroactive claim reviews, exclusion of “lesser-of” provisions, and limitations on overpayment recoupment. None of those contract provisions are beneficial for employer sponsored plans or their membership. This is just one example of how difficult it is for employers and self-funded plans, even of our size, to have a highly competitive bid process.

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While our bidding process faced limitations by the anti-competitive contracting provisions in provider and carrier contracts, we would not be where we are without access to our data, allowing the Union and Employers to give raises and limit premium increases – ensuing our members can continue to have access to high quality and affordable care. Employers having access to their claims data and the terms in which their benefits are being managed are essential for them to be able to do the same thing. That's why we need the Braun Sanders bill, and section 7 in particular.

Thank you for having me.