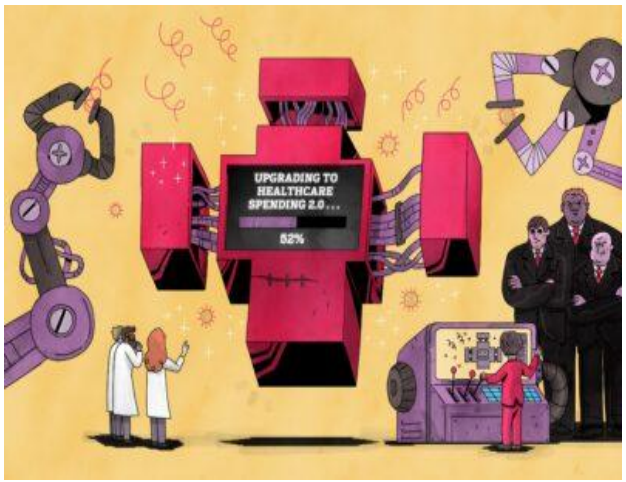
In Montana, a Tough Negotiator Proved Employers Don't Have to Pay so Much For Healthcare

TRUSTED BENEFIT ADVISORS

With its employee health plan in financial crisis, Montana hired a former insurance insider who pushed back against industry players with vested interests in keeping costs high. She proved, essentially, that bargaining down health care prices works.



Marilyn Bartlett took a deep breath, drew herself up to her full 5 feet and a smidge, and told the handful of Montana officials that she had a radical strategy to bail out the state's foundering benefit plan for its 30,000 employees and their families.

The officials were listening. Their health plan was going broke, with losses that could top $50 million in just a few years. It needed a savior, but none of the applicants to be its new administrator had wowed them.

Now here was a self-described pushy 64-year-old grandmother interviewing for the job.

Bartlett came with some unique qualifications. She'd just spent 13 years on the insurance industry side, first as a controller for a Blue Cross Blue Shield plan, then as the chief financial officer for a company that administered benefits. She was a potent combination of irreverent and nerdy, a certified public accountant whose Smart car's license plate reads "DR CR," the Latin abbreviations for "debit" and "credit."

Most importantly, Bartlett understood something the state officials didn't: the side deals, kickbacks and lucrative clauses that industry players secretly build into medical costs. Everyone, she'd observed, was profiting except the employers and workers paying the tab.

Now, in the twilight of her career, Bartlett wanted to switch teams. In her view, employers should be pushing back against the industry and demanding that it justify its costs. They should ask for itemized bills to determine how prices are set. And they should read the fine print in their contracts to weed out secret deals that work against them.

The way health care works in America, most employers cede control of health care costs to their health insurers, to the hospitals that treat their employees and to the companies they pay to manage their benefits. The costs are a dense thicket that few employers feel equipped to hack through. So, they don't.

> This failure helps explain why Americans pay the highest health care costs in the world — and why the tab continues to increase, year after year. Employers fund these costs through employee compensation packages, so the math is typically bad news for workers: Rising health costs mean

fewer wage increases and less take-home pay. Montana was no different.

And so Bartlett pitched a bold strategy. Step one: Tell the state's hospitals what the plan would pay. Take it or leave it. Step two: Demand a full accounting from the company managing drug costs. If it wouldn't reveal any side deals it had with drugmakers, replace it.

Bartlett's strategy would expose a culture in which participants fail to question escalating costs and the role each part of the health care industry plays in them. ProPublica and NPR are investigating these little-seen aspects of the health insurance industry and the way Americans pay for medical care. Previous stories have examined how health insurers profit from big medical bills and how the industry is teaming up with data brokers to rate how much patients cost based on their lifestyles.

As Bartlett laid out her plan that day in July 2014 in a conference room in Helena, Sheila Hogan, then the director of the state's Department of Administration, liked what she was hearing. They needed something radical. To her knowledge, no one had ever tried anything like this.

Bartlett would be taking on some of the state's power players: hospitals and health insurers — and their politically connected lobbyists. If her plan didn't work, the state and its employees were in trouble. If it did, it could create a blueprint for employers everywhere.

Bartlett knew employers have negotiating power that few of them use. The health care system depends on the revenue produced by the surgeries, mammograms, lab tests and other services it provides, and it can ill afford to lose it. Bartlett got the job. She would call the industry's bluff.

Ballooning Medical Costs

Employer-sponsored health benefits are almost as old as America itself. In 1798, John Adams, the second U.S. president, signed a law that took 20 cents per month from the paychecks of U.S. seamen to fund their medical care. After the Civil War, lumber, mining and railroad companies in the American West withheld money from employee paychecks to pay for doctors and hospitals.

After World War II, such plans became mainstream. Today, about 150 million Americans get their health benefits through their employers. The industry is dominated by what some call the "BUCAH" plans — Blue Cross Blue Shield, UnitedHealth Group, Cigna, Aetna and Humana. Half a dozen health insurers currently sit near the top of the Fortune 500, with combined annual revenue of about half a trillion dollars.

Despite the money at stake, many employers have, wittingly or not, deferred to the industry. Decisions about health benefit plans are usually made by midlevel human resources managers, who may not understand the forces in the medical industry operating against them. They're often advised

by insurance brokers, who are traditionally funded by the industry. And they're trying to keep the peace for employees — who demand convenient access to the care they need. It's a recipe for inertia.

The conventional wisdom is that insurance companies want to reduce health care spending. In reality, insurers' business plans hinge on keeping hospitals and other providers happy — and in their networks — often at the expense of employers and patients.

Employers often feel caught between rising costs and concern that changes they make will be bad for their employees, says Michael Thompson, president of the National Alliance of Healthcare Purchaser Coalitions, which represents groups of employers who provide benefits to more than 45 million Americans. And, he says, they rely on the advice of industry experts instead of digging into the details.

"We have got to get control of this thing or it's going to bring down the economy, our personal bankrolls and our wages," he says. "It'll cost jobs in the United States and it'll bring down our public programs. This is not a small issue. It's a huge issue."

But Bartlett soon discovered that it was easier to talk about pushing back than to do it.

A Showdown With Montana's Hospitals

Bartlett arrived in Helena, the state capital, in the fall of 2014 as an outsider navigating a minefield of established relationships. From the start, she knew she'd have to tackle the staggering bills from the state's hospitals, which made up the largest chunk of the plan's expenses. It wouldn't be popular because they also made up a significant chunk of hospitals' profits

Montana, like many large employers, self-funds its plan. That means it pays the bills and hires an insurance company or other firm to process the claims. More than half of American workers are covered by self-funded plans. As the boss in this arrangement, Bartlett assumed she'd have access to detailed information about how much the plan, which was managed by Cigna, paid for procedures at each hospital. But when she asked Cigna for its pricing terms with the hospitals, Cigna refused to provide them.

Its contracts with hospitals were secret, Cigna representatives told her. That didn't sit well with Bartlett, she recalls. "The payer cannot see the contract," she says, "but we agree to pay whatever the contract says we will pay."

A cumbersome querying process set up by Cigna allowed her to get individual claims and other limited information. But the company would only give her aggregate data, with

things lumped together, to show what she paid each hospital. It was like telling a family trying to reduce its grocery spending that it could only see what it spent in a year, not a breakdown of what bread and fruit and other items cost at each market.

When Bartlett continued to demand information, Cigna balked; it needed to balance what she wanted with keeping the hospitals happy. "I don't see the need for a balance," she recalls telling them. "I am representing the payer."

Cigna declined to answer questions about its relationship with Montana's plan, but it said in a statement that it had prioritized the plan's preferences and needs.

Bartlett ultimately settled on a radical solution: The plan would set its own prices for the hospitals.

In the illusory world of hospital billing, the hospitals typically charge a high price for a procedure, then give insurers in-network discounts. These charges and discounts might be different for each procedure at each hospital, depending on who has more leverage during negotiations.

The discounts, however, are meaningless if the underlying charges aren't capped. When Bartlett looked at a common knee replacement, with no complications and a one-night hospital stay, she saw that one hospital had charged the plan $25,000, then applied a 7 percent discount. So, the plan paid $23,250.

A different hospital gave a better discount, 10 percent, but on a sticker price of $115,000. So, the plan got billed $103,500 — more than four times the amount it paid the other hospital for the same operation. Bartlett recalled wondering why anyone would think this was okay.

Under Bartlett's proposed new strategy, the plan would use the prices set by Medicare as a reference point. Medicare, the federal government's insurance for the disabled and patients over 65, is a good benchmark because it makes its prices public and adjusts them for hospitals based on geography and other factors. Montana's plan would pay hospitals a set percentage above the Medicare amount, a method known as "reference-based pricing," making it impossible for the hospitals to arbitrarily raise their prices.

Fed up, Bartlett ended the plan's relationship with Cigna. Her battle to upend the status quo riled some employees of her own office, who complained that she was demanding too many changes. Some quit. Bartlett didn't let up.

> That Christmas, the Cigna representative sent each employee in Bartlett's office a small gift, a snow globe. Bartlett didn't get one.

But her ideas were exciting to Ron Dewsnup, the president of Allegiance Benefit Plan Management, a Montana-based subsidiary of, ironically, Cigna. Allegiance had been studying variation in hospital prices for years and had twice sent reports to Montana hospitals showing how their prices for the same procedures differed significantly. The company had also considered a reference-based pricing model, but it "didn't have any employers that were serious about taking a stand," Dewsnup says.

Allegiance got the state contract and began by comparing what the plan paid the 11 biggest hospitals in the state to the Medicare rates. The cheaper ones averaged about twice the Medicare rates, the most expensive one about five times the Medicare rates.

No one wanted to stiff the hospitals, but this was ridiculous, Bartlett recalls thinking. She determined the new rate for all hospitals would be a little more than twice the Medicare rate — still a lucrative deal, but a good starting point to get prices under control. The contracts would also prohibit a practice called "balance billing," where hospitals bill patients for whatever charges a health plan refuses to pay.

It would mean a boost for some lower-cost hospitals. Now, she had to persuade the more expensive hospitals to take less.

"You're In or You're Out"

Kirk Bodlovic, the chief financial officer of Providence St. Patrick Hospital in Missoula, remembers the day an entourage from the state health plan, including Bartlett and Hogan, arrived at his hospital.

Bodlovic knew from Allegiance's reports that St. Patrick's prices were on the high side. But he wasn't prepared for the ultimatum: If St. Patrick's wanted to treat state employees, the hospital would have to accept lower rates. If it didn't, the state would pay for its employees to travel to other hospitals.

"You're in or you're out, basically," Bodlovic says.

The state's demand set off a series of meetings within the Providence chain, which also operates in California, Alaska and the Northwest. It didn't have a lot of leverage because Missoula is a two-hospital town. Its competitor, one of the lower-priced facilities, had already agreed to the deal.

St. Patrick's considered rejecting the deal. Bodlovic says that thought gives him heartburn to think about now, envisioning the wrath of doctors if some 3,000 state plan members had ended up at a rival hospital. And the hospital would have lost about $4 million in annual revenue. "That's a good chunk of business," he says.

In their final analysis, he says, St. Patrick's officials decided it was the "lesser pain" to accept the new contract than to be left out of the deal.

While the state worked to get hospitals to sign new contracts, their CEOs and lobbyists plotted end runs, scheduling meetings with the governor's office to propose alternative solutions. When they arrived for the meetings, they found that Bartlett had also been invited. She effectively blocked their ideas.

Still, Bartlett had to get all the hospitals on board — or else. The new pricing was set to go live on July 1, 2016, and, with a month to go, six of the major hospitals were holding out. "I started to panic," Bartlett recalls. During sleepless nights, Bartlett imagined thousands of state employees being forced to zigzag across the state for medical care or running up massive bills at non-contracted hospitals. She put together communication plans for members describing how they would need to travel to avoid certain hospitals.

Bartlett thinks employers should be pushing back against the medical industry and demanding that it justify its costs. (Mike Albans for NPR)

With her stomach in knots, she went on the offensive. She took a graph showing the variation in hospital prices to state legislators. Then she threatened to go public. She couldn't name names because of contract restrictions, but she could tell the media that some hospitals' prices were three times as high as others and let reporters figure out which ones were which.

Five of the holdouts surrendered and signed the contract. "The hospitals didn't want that out there," she says.

Only Benefis Health System in Great Falls, one of the higher-priced hospitals, refused. The hospital's CEO told the local newspaper that "it was business for them and it was business for us."

The new plan went into place July 1, without Benefis as a contracted hospital. Bartlett ratcheted up the pressure one more time, calling in the Montana Federation of Public Employees. The union has hundreds of members in the Great Falls area, including Keith Leathers, who works as an investigator with the state's child support enforcement division. Leathers has a young daughter with scoliosis, and he didn't want to drive long distances to get her the care she needs. He readily engaged in the fight.

> "We have a regional medical facility here that's supposed to be able to handle almost any medical problem, period," he recalled thinking. "And I got to go out of town to get care because they want to charge more than anyone else?"

Union leaders launched a campaign against the hospital. Leathers says he sent a postcard and made a phone call every day to the hospital CEO, the board members — anyone he could find in leadership. He urged them to accept the new rates. Hundreds of other employees from across the state did the same.

Within a month, Benefis agreed to join the health plan. The hospital declined to comment for this story.

Leathers says employers and workers should be protesting health care costs "over and over again" all over the country. "Are we going to wait until the health care system just crashes?" he says.

When Bartlett took over the state health plan, it spent about $200 million a year. Bartlett's team estimated that the new hospital pricing schedule saved the plan more than $17 million in the second half of 2016 and all of 2017 — almost $1 million a month. By 2017, a plan that state officials had predicted would go broke had turned itself around. And it's projected to save an additional $15 million in 2018 without cutting benefits to employees or raising their rates.

Exposing Hidden Drug Deals

But Bartlett had one more target in her sights: prescription drug costs. Health plans contract with separate companies, middlemen entities known as pharmacy benefit managers, to get members their medication. And everyone assured Bartlett the state's pharmacy benefits deal was "state of the art." But just like with Cigna, she insisted on examining it herself. That wasn't easy because the pharmacy benefits were run through a cooperative arrangement with other health plans, including those of universities, school trusts and counties. The state plan anchored the co-op, and the other partners were happy with the arrangement.

Bartlett knew that pharmacy benefit managers are notorious for including deals that boost their profits at the expense of employers. One of the common tricks is called the "spread." A pharmacy benefit manager, for example, will tell an employer it cost $100 to fill a prescription that actually cost $60, allowing the pharmacy benefit manager to pocket the extra $40. The fine print in the contracts often allows it.

The spread is widespread. A recent report by the Ohio state auditor noted that the spread on generic drugs had cost that state's Medicaid plan $208 million in a single year — 31 percent of what it spent.
Sure enough, when she got the contract, Bartlett found that the state plan had fallen victim to the spread.

Pharmacy benefit managers also rake in dollars through rebates paid by pharmaceutical companies. Most health plans would assume that since they're paying for the drugs, they should get any rebates. But pharmacy benefit managers often don't disclose the size of the rebate, which allows them to keep some or most of it for themselves. When Bartlett pressed, she discovered the state wasn't getting the full amount of its rebates.

Montana was getting taken, but it put Bartlett in a touchy political situation. The co-op needed the state as a partner or it wouldn't survive. Bartlett decided her allegiance was to the plan's bottom line. She pulled out of the deal.

"She wasn't afraid of ruining her career or making people angry," says Scott McClave, a consultant with Alliant Insurance Services who helped analyze the pharmacy benefit contract.

Bartlett says it helped that she was near the end of her career and didn't need to please people. "I'm 67, so I could give a shit," she says. "What are they going to do, fire me? I'm packin' a Medicare card."

Bartlett found a pharmacy benefit manager, Navitus Health Solutions, that would not take any spread and would pass along all rebates in full. The next year, the plan saved an average of almost $16 per prescription. It purchased a similar mix and volume of drugs in 2016 and 2017. But it saved $2 million on the spread. And its revenue from rebates jumped from $3.5 million to $7 million, Bartlett said. The savings continue to this day.

In July of this year, her mission accomplished, Bartlett left her position as administrator of the state employee health plan. She now works for the Office of the Montana Insurance Commissioner, which is taking on pharmacy benefit managers in a bigger way.

But Bartlett also has a side gig as a guru to other employers around the country seeking to pay less for their health benefits. Her advice boils down to pushing back. "You've got to get in there and do it," she says.

So how are Montana's hospitals after the price cut? Just fine, it appears.

Bob Olsen, vice president of the Montana Hospital Association, says he has not heard hospital leaders say they are struggling under the new state contract. They have had "reasonable financial performance," he says.

But Bartlett's legacy may be even greater. With the state's model in mind, St. Patrick's Bodlovic said Blue Cross Blue Shield of Montana, the state's largest insurer, recently came calling. Now it wants a similar pricing arrangement.