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# SB 770 Public Input Meeting

## Introduction

- **Context of today's meeting:**
  - Building on the work of the Healthy California For All Commission, which concluded and issued its final report in 2022.
  - Senate Bill 770 (Chapter 412, Statues of 2023) requires the California Health & Human Services Agency (CalHHS), to develop a federal waiver framework for and submit a report on, unified health care financing system in California, in consultation with stakeholders.
- **CalHHS contracted with the UCLA Center for Health Policy Research to conduct research and draft an Interim Report.**



## Moderator

**Garen Corbett, MS**

**Director, California Health Benefits Review Program**

The California Health Benefits Review Program (CHBRP) is an impartial organization housed at the University of California tasked with evaluating the impacts of proposed legislation related to health insurance benefits. It provides rigorous evidence-based analyses directly to California's State Legislature, so that it can make informed decisions.



## Report Team

- **Nadereh Pourat**
- **Gerald Kominski**
- **Mark Peterson**
- **Dylan Roby**
- **Petra Rasmussen**
- **Srikanth Kadiyala**
- **Tom Rice**

## Agenda

- **Introduction by California Health and Human Services Agency**
- **Report Approach**
- **Issues Examined**
  - Role and Value of Health Plans
  - Outpatient Provider Payment
  - Institutional Payment
  - Promoting Equity through Provider Payment
  - Administrative Costs of Providers and Health Plans
- **Next Step: Additional Key Design Considerations and Final Report**
- **Comments and Q&A**



## Approach

- **Tasks**
  - Provide information on how access and quality are impacted by specific aspects of health care financing currently
  - Discuss options on how to promote access and quality under unified financing
  - Identify key design considerations
- **Methodology**
  - Review of available academic literature and reports and studies from reliable sources
  - Expert interviews

# The Role and Value of Health Plans



## Current Role of Health Plans

- **Health plans predominately act as third-party administrators or fully insured plans**

| Health plan role | Key responsibilities | Market segments |
|---|---|---|
| Third-party administrator | - Administrative tasks | - Self-insured employers<br>- Fee-for-service Medicare & Medicaid |
| Fully insured health plan | - Administrative tasks<br>- Financial risk for the covered population | - Medicare Advantage<br>- Medicaid managed care<br>- Individually-purchased<br>- Fully insured employers |

  - Additional responsibilities: care coordination, population health management, and data collection
- **Exception: Fully insured plans that integrate with providers as a single entity (e.g., Kaiser Permanente)**



## Key Administrative Functions of Health Plans

**Health plans do the following:**

- Design benefits
- Establish enrollment systems & manage enrollment
- Set premium and cost-sharing amounts, collect premiums, & track enrollee cost-sharing contributions
- Utilization management including prior authorization & denials
- Create and manage provider networks
- Process provider claims and payments



## Plan Type Impact on Access and Quality

- **Mixed and inconclusive evidence on impact of Medicare Advantage versus fee-for-service Medicare on access and quality**
  - In addition to providing mixed results, existing evidence is subject to variations in methodologies used and key differences between Medicare Advantage and fee-for-service Medicare data

    *Interpreting and extrapolating comparisons of the two market segments must be done cautiously*
- **State variation in how Medicaid managed care networks and organizations are organized, staffed, and funded make comparisons challenging**



## Provider Networks Impact on Access and Quality

- **Mixed evidence on impact of narrow and tiered provider networks**
  - Few adverse impacts on utilization and adequacy measures
  - Adverse impact on some access measures such as time to appointment and provider availability
  - Most analyses showed no effect on quality of care; some showed worse quality; fewer showed better quality
  - Positive or no effect of tiered networks on patients switching providers and market share of providers in the network's top tier



## VBID Impact on Access and Quality

- **Limited and mixed early evidence on the impact of value-based insurance design (VBID)**
  - Positive association between VBID and improved medication adherence and increases in Medicare Advantage health plan star ratings
  - Inconsistent findings of VBID's impact on clinical outcomes (such as inpatient utilization and reaching blood pressure, cholesterol, and HbA1C targets) and spending

## Administrative Burden Impact on Access and Quality

- **Administrative burden on providers may reduce time spent on patient care**
  - Evidence to date indicates that physicians spent an average of 3 hours per week interacting with health plans
  - Physicians lose 2.4-18% of revenue to billing problems; highest estimate of lost revenue occurring for Medicaid billing



## Health Plans Internationally and in States Pursuing Universal Health Systems

- **Few other high-income countries use health plans in the same way as the United States**
  - In other countries: primary role is to pay claims; most insurers are non-profit entities; provider networks are very uncommon
  - Voluntary health insurance is offered in some countries
- **Oregon and Washington state have passed legislation to establish a universal health care system**
  - Oregon Joint Task Force recommended a more limited role for health plans; support some forms of voluntary insurance
  - Washington is exploring three models, two of which include a role for health plans



## Options for Role of Health Plans

- **Scenario 1: Retaining the role of health plans as fully insured plans that operate similarly to how they do today**
  - Similar to status quo
  - Requires more extensive regulations to align with provisions of SB 770
- **Scenario 2: Reducing the role of health plans to third-party administrators in all market segments**
  - Requires greater adjustments to current system and adequate transition time
  - Allows for greater control in implementing provisions of SB 770
- **Scenario 3: Restricting the role of health plans to the provision of voluntary insurance only**
  - Requires most adjustments to current system and adequate transition time
  - Allows greatest control in implementing provisions of SB 770

Note: Under Scenarios 1 and 2 health plans could offer voluntary insurance in addition totheir role in the publicly financed system



# Outpatient Provider Payment



## Outpatient Services

**Refers to a broad range of services**
- Primary care
- Specialist care
- Behavioral health care
- Dental care
- Vision care
- Ancillary services (e.g., imaging, laboratory, durable medical equipment)

**Focused Analysis**
- Primary care
- Specialist care



## Current Provider Payment Methods

- **Common payment methods**
  - Fee for Service (FFS)— promotes more visits and therefore may promotes access
  - Capitation—promotes use of preventive and primary care, but may reduce access due to incentives to avoid complex and high-need patients
  - Salary—removes financial considerations from physician-patient relationship, but may reduce access due to incentives to avoid complex and high-need patients
- **Payment methods differ for primary care physicians and specialists**
  - Primary care physicians are more often paid through capitation and salary
  - Specialists are frequently paid through FFS
- **Limited robust research evidence base on the impact of these methods on quality of care and outcomes**

## Current Provider Payment Amounts

- **Differential payment amounts**
  - Higher payment is associated with better access
    - Private Insurance—highest (143% of Medicare for physician services overall, 119% of Medicare for physician office visits)- greater physician participation
    - Medicaid—73% of Medicare for all services, 76% of Medicare for primary care- lower physician participation
  - Across types of care
    - Specialists highest paid—because of more procedures that are compensate at higher rates
    - Primary care lowest paid— because of more time on consultation that is compensated at lower rates
- **Other forms of compensation**
  - Contractual agreements frequently include rewards (e.g., profit sharing) and disincentives (e.g., over utilization of services) — may reduce access
- **Alternative payment models (APMs)**
  - Pay-for-performance most common—promotes access and quality for targeted services



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## Factors Modifying Payment Impact on Access

- **Consolidation of outpatient medical practice may restrict access**
  - Nationally, share of physicians in solo practices is down to 13%, 69% are in single-specialty or multi-specialty group practices—solo/small practices important for access in rural areas
  - Mergers have led to larger practices with acquisitions of practices by hospitals, corporations, and private equity, leading to higher prices
  - Only 44% of physicians are owners of their practices, 50% are employees of the practices and governed by the practice's operating rules and financial priorities
  - Research on impact of consolidation on the quality of patient care is limited and the reported effects are mixed or unclear



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## Factors Modifying Payment Impact on Access

- **Selective contracting by health plans in provider networks restrict access**
  - Traditional Medicare and Medi-Cal FFS do not have networks
  - Networks restrict access to in-network physicians and in some areas few physicians are available or plan directories are inaccurate
  - Impact on access varies by plan types including HMOs and PPOs
- **Physician participation in integrated models of care may restrict access**
  - Vertical integration of physicians in Accountable Care Organizations (ACOs)
  - Research shows impact on access



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## International Approaches

- **High-income countries pay the same amount for the same service regardless of the source of coverage**
- **Canada**
  - No provider networks or clinical practice restrictions
  - Largely FFS
  - In Ontario: primary care is paid through a blended capitation and FFS
  - Long wait times for some procedures
- **Germany**
  - Largely FFS
- **The Netherlands**
  - Capitation for primary care providers
  - Bundled payments
  - Pay-for-performance incentives



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## Outpatient Payment Option Considerations

- **Options for payment methods to promote access and quality**
  - For primary care — a blend of capitation and fee for service may be needed to comport with major evaluation and management role and procedures
    - Additional benchmark investments in primary care to ensure adequate infrastructure and access
  - For specialty care — a range of payment approaches may be needed to fit with the particular types of patients and procedures associated with each specialty
- **Options for payment amounts to promote access and quality**
  - Identifying payment amounts that promote access for all patients regardless of complexity
  - Identifying a fee schedule that reduces payment gap between procedures and patient consultation and management services
  - Identifying a fee schedule that pays for the time providing care and equalizes compensation across procedures



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# Institutional Provider Payment



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## Current Methods of Payment

- **Prospective payments to facilities**
  - Represent a bundle of services related to the inpatient admission (DRG) or outpatient visits/procedures (APC) in hospital-based clinics
  - Similar volume-based incentives as "fee-for-service"
    - While it does reward "higher volumes" the evidence suggests that hospital admissions have decreased over time and much of spending has shifted to outpatient
  - Excludes professional fees for physicians providing care during these admissions or visits



## Current Approaches to Payment Reform

- **Federal efforts**
  - Alternative payment models (e.g., ACOs, episode-based bundles)
  - Hospital Value-Based Purchasing
  - Hospital Readmission Reduction Programs
  - CMS AHEAD Model
- **Other states' efforts**
  - Global budget programs in a handful of states among select providers
  - Maryland's Global Budget waivers are the best example for potential routes and limitations of the approach



## Global Budgeting Models

- **Global Budgets can be implemented in several ways:**
  - There are international examples of the "system" using a global budget for all health care spending, with an agreed upon inflation rate based on regional or national benchmarks
    - In these cases, payment to providers might vary from fee-for-service for physicians to DRG-based facility payments for hospitals
    - Could exist in a single-payer or multi-payer context
  - There are also international provider-based global budgets, similar to Maryland
- **The Maryland model is a valuable example due to the U.S. context and the ability of the state to leverage federal funds**
  - However, it still exists in the multi-payer environment where there are differences in insurance coverage, premiums, and sources



## Maryland Global Budgeting Models

- **All-Payer Rate Setting (1977-2013)**
  - Multi-payer, set hospital (inpatient/outpatient) prospective rates
- **Global Budget (2014-2018)**
  - Hospital-related care only, based on prior utilization and rates
  - 3.58% growth rate
- **Total Cost of Care (2019-present)**
  - Hospital Global Budget
  - Separate requirements for Medicare services (including physicians)
  - Growth still capped at 3.58% in both components



## Unified Financing Approach / Rate Setting

- **Maryland still has multi-payer system**
  - Hospital payments still paid by respective insurers based on DRG, APC, or other claim types
  - Aggregated hospital payments count toward the budget target
  - Smaller program to provide stability to rural hospitals
- **Rate Setting Authority: Health Services Cost Review Commission**
  - HSCRC has contract with each system, monitors performance
  - Hospitals do monthly reporting, and have capacity to change rates slightly or request larger changes each year
  - Rates vary by hospital and within hospital (by payer) – use case mix and other factors for risk adjustment



## Waiver Authority, Implementation, and Oversight

- **Initially authorized under Medicare and Medicaid waivers in 1977**
  - In 1980, explicit authority for rate setting in both Medicare and Medicaid made "permanent" through federal legislation/regulation conditional on a "waiver test."
  - Subsequent changes occurred and approved by CMS
- **CMS AHEAD Demonstration**
  - Opportunity for other states to engage in global budgeting through CMMI (which has Medicare waiver authority)
- **Ongoing Section 1115 Medicaid Demonstration Waivers**

## Mechanisms to Promote Access and Quality

- **Quality reporting required**
  - Includes some population level measures focused on surrounding community rather than patients of facilities
- **Maryland Primary Care Program (MD PCP) is part of TCOC waiver, but not linked to global budgeting**
  - Program to improve social needs screening and improve ability for PCPs to coordinate care and address patient needs
    - Relies on Health Information Exchange and Clinical Transformation Organization supports
- **Care Redesign Program**
  - Hospitals use surplus funds to invest in local providers and community



## Option Considerations for Institutional Global Budgeting

- **Could remain multi-payer (e.g., Maryland) or become single-payer**
- **Facilitate the flow of federal supplemental payments**
- **Global budget could be based on historical utilization and linked to DRG and APC use in the past**
  - Risk adjustment approach that address underlying community and equity issues (e.g., geography, social needs)
  - Budget could be partially based on DRG use, while also allowing for other factors to drive budget (Ontario, Canada)
- **To address entrenched drivers of inequity, other support via grants for capital planning, modernization, and/or planning could be issued to health systems to assist in transition**



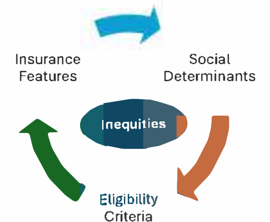
# Equity in Provider Payment



## Factors Perpetuating Inequities in Access & Quality

**Root causes of inequities include:**

- Structural factors Related to Insurance or Health Care Delivery
  - Who is eligible for what type of insurance
  - What are the features of health insurance
  - Structural racism and discrimination
- Social determinants of health (SDOH)
  - Poverty level, housing, etc.




**Unified financing system as envisioned by SB 770 is likely to change eligibility criteria and insurance features**



## Current Evidence of Inequities in Access & Quality

**Among Marginalized Populations**

- Poverty level
- Race/ethnicity
- English proficiency
- Sexual orientation and Gender Identity
- Disability status
- Rural and inner-city residence

**By Insurance Market**

- Medicaid
- Medicare
- Private insurance



## Current Strategies to Address Inequities

- **Federal**
  - Establishment of a health equity office at US HHS Agency
  - A position statement to incorporate a culture of equity in all policies and programs
  - Example: CMS's strategic plan and framework for achieving health equity
- **California**
  - Performance-based financial incentives to Medi-Cal MCPs to develop value-based payment (VBP) strategies for provider payment
  - MCPs to collect data by race/ethnicity
  - MCPs to include health equity improvement metrics in provider payments
  - VBP to public hospitals under the Quality Incentive Pool program
    - Success in reporting by and inconsistent success in improving metrics by race/ethnicity
  - VBP incorporated in payment for Enhanced Care Management and Community Supports

## Issues to Consider under SB 770

- **SB 770 provider payment strategies are yet to be determined**
- **If adopted, uniform rate setting is likely to:**
  - Reduce/remove variation in provider payment amounts by insurance market segment
  - Promote access and quality for population overall
- **Overall improvements do not necessarily promote equity**
  - Marginalized populations are more complex and have a higher burden of disadvantage
  - Providers may continue to prefer less complex patients and those with higher SES
  - The rate amounts still matter in provider participation



## Option Considerations to Promote Equity through Provider Payment

- **Higher payment amounts can be targeted to:**
  - Those with complex health profiles
  - Those with higher burden of disadvantage from SDOH such as SES, housing, area of residence, etc.
- **Higher payment amounts can be paired with incentive payments such as pay-for-performance with specific features:**
  - Adjusted for risk or case-mix
  - Pay for metrics that target disparity reduction
  - Show progress in outcomes vs. just achieving target values



# Administrative Costs & Employment



## Defining Administrative Costs

- **Billing and insurance related activities (BIR)**
  - Providers efforts for claims submission and resubmission and obtaining coinsurance from patients
  - Roughly 60% of estimated total administrative costs
- **Non-BIR activities**
  - Medical record-keeping
  - Initiatives that monitor and improve care quality
  - Programs to combat fraud and abuse



## Existing Estimates of Provider BIR Costs

| Kahn et al. (2005) | | Jiwani et al. (2014) | | Tseng et al. (2018) | |
|---|---|---|---|---|---|
| **Physicians** | | | | | |
| Multi-Specialty | 13.9% | Single and Multi Specialty | 13% | Single and Multi Specialty | 14.5% |
| Single-Specialty Primary Care | 14.5% | | | | |
| Single-Specialty Surgical | 12.4% | | | | |
| **Hospitals** | | | | | |
| Inpatient Stay | 6.6%, 10.8% | Inpatient Stay | 8.5% | Inpatient Stay | 8.0% |
| | | | | Inpatient Surgery | 3.1% |
| | | | | Emergency Department Visit | 25.2% |



## Existing Estimates of Health Plan BIR Costs

| Kahn et al. (2005) | | Jiwani et al. (2014) | |
|---|---|---|---|
| Commercial | 8.4% | Commercial | 18% |
| Medicaid | 9.4% | Public Insurers | 3.1% |
| Medicare | 4.5% | | |

## Existing Estimates of Reduced Expenditures Following Administrative Simplification

| Study | Category Measured | Summary Results |
|---|---|---|
| Cutler and Pozen (2010) | Physician and Hospital Spending | 40% of difference between U.S. and Canada due to administrative costs |
| Kahn (2010) | Provider Costs | 50% of provider costs will be reduced by unified financing |
| | Private Insurance Costs | 66% of private insurer costs will be reduced by unified financing |
| Jiwani et al. (2014) | Provider Costs | 73% higher administrative costs in U.S. due to more complex BIR requirements, when compared to simplified systems |



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## Calculated Reduction in Costs of Administrative Simplification for Provider BIR

| California Health Expenditures (Clinical + Admin.) (millions) | Estimated Provider Admin. Cost Reduction (millions) | Estimated Health Plan Admin. Cost Reduction (millions) | Total Cost Reduction (millions) | Percentage Decrease in California Expenditures |
|---|---|---|---|---|
| $454,086 | $17,626 | $24,514 | $42,140 | 9.28% |

Preliminary Estimates. Please do not cite without permission



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## Potential Effects on Employment

- **Employment loss may occur due to administrative simplification**
  - Fewer jobs at health plans
  - Fewer jobs at provider settings
- **Employment loss may be mitigated by employment gains**
  - An estimated 2.5 million California residents will be newly insured
  - Administrative support needed to provide benefits to the newly insured
  - An increased supply of health care workers will likely be needed due to newly insured's increased access to health care
  - Administrative support will be needed for the currently insured under a unified financing system.



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# Next Steps: Key Design Considerations



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## Key Design Considerations

- **Unified financing models**
- **Role and functions of health plans**
- **Eligibility and enrollment**
- **Essential and new benefits**
- **Premiums and cost sharing**
- **Provider payment models**
- **Effectiveness, efficiency, and equity**
- **Overall impact on access and quality**



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## Next Steps

- **What to expect after today:**
  - Consideration of public comments - We will be taking the feedback today and in the public comment email box as a whole for the UCLA team to consider as they draft the report
  - Public comment email box - no hard deadline but next two weeks most helpful for UCLA team
  - Second Convening forthcoming for UCLA to present findings of report
- **5-minute break prior to the start of the comment and questions session**



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## Break

- **Convening will restart in 5 minutes (*to add time here*)**





## Comments

- **Slides are available at the link in Save the Date email (https://www.chhs.ca.gov/sb770meeting/)**
- **Comments should be less than 1 minute**
- **Comments should be on the presentation, not other comments**
- **Two ways to provide comment:**
  - Send written comment or feedback to SB770publiccomment@chhs.ca.gov
  - To provide verbal comments or feedback, please use the raise your hand function





## Break

- **Convening will restart in 5 minutes (*to add time here*)**