

HB19-1233: INVESTMENTS IN PRIMARY CARE TO REDUCE HEALTH COSTS

Concerning payment system reforms to reduce health care costs by increasing utilization of primary care.

Details

Bill Sponsors:	House – <i>Froelich (D) and Caraveo (D)</i> Senate – <i>Ginal (D) and Moreno (D)</i>
Committee:	House Health & Insurance
Bill History:	3/8/2019 – Introduced
Next Action:	3/26/2019 – Hearing in House Health & Insurance
Fiscal Note:	<u>3/19/2019 Version</u>

Bill Summary

The bill creates a primary care payment reform collaborative in the Division of Insurance (DOI). The Commissioner of Insurance is required to set affordability standards for premiums, including adding targets for insurance carrier investment in primary care. Also, the bill requires the Department of Health Care Policy and Financing (HCPF) and insurance carriers who offer health plans to state employees to set targets for investment into primary care.

Issue Summary

Primary Care

Currently, the U.S. spends 4 to 7 percent of total health care dollars on primary care.¹ Receiving primary care has been associated with significantly more high-value care and a better care experience.² Also, areas with higher ratios of primary care physicians to population had much lower total health care costs than other areas.³ Studies have demonstrated that primary care providers utilize fewer resources, such as diagnostic tests and procedures, than specialists, while incurring equal or lower costs of care.⁴ Patients with a usual source of care have greater satisfaction, lower rates of non-urgent emergency department use, and are more likely to receive recommended preventive services.

Fewer new clinicians are entering primary care fields and only about 35 percent of all clinicians (including nurse practitioners and physician assistants) provide primary care.⁵ A 2014 survey found that 68 percent of

¹ Stream, G. & Tuggy, M. (Aug. 6, 2018). Delivering value in healthcare starts with increased primary care investment. *Medical Economics*. Retrieved from <https://www.medicaleconomics.com/article/delivering-value-healthcare-starts-increased-primary-care-investment>

² Levine DM, Landon BE, Linder JA. Quality and Experience of Outpatient Care in the United States for Adults With or Without Primary Care. *JAMA Intern Med.* 2019;179(3):363–372. doi:10.1001/jamainternmed.2018.6716

³ Starfield, B., Shi, L., and Macinko, J. (2005). Contribution of primary care to health systems and health. *Milbank Q.* 83(3): 457-502. doi: 10.1111/j.1468-0009.2005.00409.x

⁴ Friedberg, M.W., Hussey, P.S., and Schneider, E.C. (May 2010). Primary Care: A critical Review of the Evidence on Quality and Costs of Health Care. *Health Affairs* 29(5). Retrieved from <https://www.healthaffairs.org/doi/10.1377/hlthaff.2010.0025>

⁵ Lazris, A., Roth, A., and Brownlee, S. (Nov. 20, 2018). No More Lip Service; It's Time We Fixed Primary Care. *Health Affairs Blog*. Retrieved from <https://www.healthaffairs.org/doi/10.1377/hblog20181115.750150/full/>

family physicians would not choose the same specialty and would start their careers anew.⁶ An underlying reason may include burnout, as 46 percent of physicians experience symptoms.⁷

Patient centered medical homes (PCMH) are being widely implemented throughout the country. There are five central aspects and functions of PCMHs, they provide comprehensive care, are patient-centered, coordinate care, deliver accessible services, and commit to quality and safety. A PCMH is not a location but rather describes the coordinated approach to patient care that is led by the primary care provider. For example, among patients with diabetes, studies have associated the PCMH with increased primary care visits, decreased emergency department use, and improved diabetes care process measures.⁸

Value-Based Payments and Fee-for-Service Reimbursement

Fee-for-service (FFS) is a system of health payments where a provider or facility is paid a fee for each service rendered. Many assert that this system rewards providers for volume and quantity of services, no matter the patient outcome. On the other hand, value-based health models provide payment to providers based on the health outcomes of the patient. The value aspect of this model comes from measuring health outcomes against the cost of delivering those outcomes.⁹

Affordability Standards in Rhode Island

In 2010, Rhode Island's Office of the Health Insurance Commissioner implemented affordability standards that imposed price controls on contracts between private insurers and hospitals while requiring the insurers to increase spending on primary care and care coordination services. There were two goals in implementing these affordability standards.¹⁰ The first was to improve primary care through requiring insurer investment in primary care and encouraging practices to transform into PCMHs. The second goal was to reduce costs through payment reform strategies. The Office claims that primary care spending in the state increased by more than a third since 2008 and the rate of increase of hospital costs slowed.

A study of these standards was recently published in *Health Affairs*.¹¹ The study compared spending of 38,001 commercially insured Rhode Island adults and the same number of matched adults in other states in a period lasting from 2007 to 2016. After the implementation of the standards, quarterly FFS spending among the Rhode Island group decreased by \$76 per enrollee, a decline of 8.1 percent from 2009 spending, relative to the control group. Primary care coordination spending increased by \$21 per enrollee. The decline in growth was driven by lower prices, not decreased utilization of services. However, the results suggest that that the increased care coordination spending did not drive the reduction in spending growth. The study concludes that this experience may indicate that states can slow total commercial health spending growth through price controls while maintaining quality.

Legislative History

A similar bill, HB19-1365, that intended to create a primary care payment reform collaborative was introduced during the 2018 session.¹² The bill was postponed indefinitely by Legislative Council in April 2018.

⁶ Kane, L. & Peckham, C. (Apr. 2014). *Medscape Physician Compensation Report*. Retrieved from <https://www.medscape.com/features/slideshow/compensation/2014/public/overview#24>

⁷ Bodenheimer, T. & Sinsky, C. (Nov 2014). From Triple to Quadruple Aim: Care of the Patient Requires Care of the Provider. *Annals of Family Medicine*. 12(6). Retrieved from <http://www.annfam.org/content/12/6/573.full#ref-6>

⁸ National Institute of Diabetes and Digestive and Kidney Disease (n.d.). *The Patient Centered Medical Home (PCMH)*. Retrieved from <https://www.niddk.nih.gov/health-information/communication-programs/ndep/health-professionals/practice-transformation-physicians-health-care-teams/team-based-care/patient-centered-medical-home>

⁹ NEJM Catalyst (Jan. 1, 2017). *What is Value-Based Healthcare?* Retrieved from <https://catalyst.nejm.org/what-is-value-based-healthcare/>

¹⁰ Rhode Island Office of the Health Insurance Commissioner (2019). *Reform and Policy – Affordability Standards*. Retrieved from <http://www.ohic.ri.gov/ohic-reformandpolicy-affordability.php>

¹¹ Baum, A., et al. (Feb. 2019). Health Care Spending Slowed After Rhode Island Applied Affordability Standards to Commercial Insurers. *Health Affairs* 38(2). doi: <https://doi.org/10.1377/hlthaff.2018.05164>

¹² HB19-1365: Primary Care Infrastructure Creation. Retrieved from <http://leg.colorado.gov/bills/hb18-1365>

This Legislation

The Commissioner of Insurance is to convene a primary care payment reform collaborative with an outlined purpose. The collaborative is to:

- Consult with the Department of Personnel, HCPF, and the Center for Improving Value in Health Care (CIVHC)¹³
- Advise in the development of affordability standards and targets for insurer investments in primary care
- Analyze the percentage of medical expenses allocated to primary care, in coordination with CIVHC, by health insurers, Medicaid, and Child Health Plan Plus (CHP+)
- Develop a recommendation to the Commissioner on the definition of primary care
- Report on current insurer practices and methods of reimbursement that direct greater health resources and investments toward innovation and care improvement in primary care
- Identify barriers to the adoption of alternative payment models by insurers and providers, and develop recommendations to address barriers
- Develop recommendations to increase the use of alternative payment models that are not paid on a fee-for-service or per-claim basis in order to increase investment in primary care, align primary care reimbursement by all consumers, and direct investment toward higher value care with aim of reducing health disparities
- Consider how to increase investment in advanced primary care without increasing consumer costs or total cost of health care
- Develop and share best practices and technical assistance to insurers and consumers, including:
 - Aligning quality metrics, as developed in state innovation model (SIM)
 - Facilitating the integration of behavioral and physical health care
 - Practice transformation
 - Delivery of advanced primary care that facilitates appropriate utilization of services in appropriate settings

The Commissioner is to invite representatives to participate in the collaborative. These individuals shall represent the following individuals, industries and entities: health providers, primary care providers, consumers, employers, insurers, insurers that contract with HCPF as managed care entities, Centers for Medicare and Medicaid Services (CMS), Primary Care Office within the Department of Public Health and Environment (CDPHE), HCPF, and experts in health insurance actuarial analysis. The collaborative is to be convened by July 15, 2019. By October 15, 2019, and by each October 15 thereafter, the collaborative is to publish primary care payment reform recommendations, which is to be informed by the primary care spending report.¹⁴ The payment reform report is to be posted publicly online. The DOI can seek, accept, and expend gifts, grants, or donations to implement the collaborative. The collaborative is scheduled to sunset on September 1, 2025, with the General Assembly to review the sunset before it occurs.

An additional duty is added to the Commissioner's responsibilities. The Commissioner is to encourage the fair treatment of health providers, including primary care providers. Additionally they are to encourage policies, including increased investment into primary care, that decrease disparities and improve quality, affordability, and efficiency of services and outcomes. Finally, the Commissioner is to view the health system as a comprehensive entity as well as encourage and direct insurers toward policies that advance public welfare of the public through overall efficiency, affordability, improved quality, and appropriate access.

During annual rate filing, in determining whether those rates are excessive, the Commissioner can currently only consider the expected filed rates in relation to the actual rates charged. The bill adds that the

¹³ The current administrator of the All-Payer Claims Database

¹⁴ Contents of the primary care spending report are detailed in Section 6 of the bill.

Commissioner can consider whether the carrier's products are affordable and whether the carrier has implemented effective strategies to enhance affordability of its products. The Commissioner is to promulgate rules that establish affordability standards for premiums. The standards must include appropriate targets for primary care investments by carriers. While developing the standards, the Commissioner is to consider recommendations from the Collaborative. In alignment with the affordability standards, a carrier is to adopt appropriate primary care investment targets to support value-based health care delivery.

By August 31, 2019, and every August 1 thereafter, CIVHC to provide a primary care spending, for the carriers and programs that report claims to the All-Payer Claims Database, report to the Commissioner for use by the Collaborative. The report is to include the percentage of medical expenses allocated to primary care, share of payments made through alternative payment models, and the share of payments that are not paid on a fee-for-service or per-claim basis.

HCPF is to adopt appropriate targets for investments in primary care for the health programs that they administer (Medicaid and Child Health Plan Plus [CHP+]) to support value-based health delivery in alignment with the affordability standards adopted by the Commissioner.

The bill is effective upon passage and the Governor's signature.

Reasons to Support

Proponents assert that the bill will guide Colorado to achieve better health outcomes and health care cost savings. Greater investments in primary care may enable practices to offer services like extended hours, telehealth services, integrated behavioral health, and social workers to coordinate care for complex patients. The combination of the affordability standards and requiring increased investment in primary care may lead to a redistribution of spending toward primary care without losses to payers. Without investment in primary care practices, implementation of initiatives like care coordination and PCMH can have mixed results both on cost containment (since more services are being provided) and on sustainability, with providers often experiencing burnout in trying to keep up with the added demands and little or no additional resources provided. Transitioning from a FFS system may decrease administrative requirements, which may increase the time primary care teams can spend with patients and decrease professional burnout. The primary care spending report prepared by CIVHC can inform future policies or initiatives regarding the cost and utilization of care.

Supporters

- American Academy of Pediatrics- Colorado Chapter
- American College of Physicians- Colorado Chapter
- Colorado Academy of Family Physicians
- Children's Hospital Colorado
- Colorado Community Health Network
- Colorado Medical Society

Reasons to Oppose

The bill does not include details on how the affordability standards are to be enacted. This could lead to a variety of methods being utilized to achieve this aim. This uncertainty may lead to concerns for potentially affected insurers and providers and how these entities may react to these changes is unknown. Further, the affordability standards translate into increased government interference and control in the health care market. Some may assert that this is not an appropriate role for the state government to play.

Opponents

- Any opposition has not been made public at this time.

Other Considerations

Neither the number of members nor the exact makeup of the collaborative are dictated in the bill, rather these details are left up to the Commissioner of the Insurance. The timeline for the collaborative to convene and generate a report in 2019 is short, as the members are to be gathered by July 15 and have the report ready by October 15. The recommendations from the collaborative and the affordability standards can only apply to plans that are under the regulatory purview of the DOI, including the individual, small group, and portions of the large group market.

About this Analysis

This analysis was prepared by Health District of Northern Larimer County staff to assist the Health District Board of Directors in determining whether to take an official stand on various health-related issues. The Health District is a special district of the northern two-thirds of Larimer County, Colorado, supported by local property tax dollars and governed by a publicly elected five-member board. The Health District provides medical, mental health, dental, preventive and health planning services to the communities it serves. This analysis is accurate to staff knowledge as of date printed. For more information about this summary or the Health District, please contact Alyson Williams, Policy Coordinator, at (970) 224-5209, or e-mail at awilliams@healthdistrict.org.