The Primary Care Trust is an essential aspect of the Primary Care for You legislation (S.750). This Trust will collect money from commercial payers as well as from other entities in the Commonwealth that will be contributing to an increased investment in Primary Care. The Trust will distribute funds to Primary Care practices based on the Primary Care for You payment model as determined by the Primary Care Council and the Health Policy Commission. The Trust will have the capability of paying for efforts to support and train smaller practices engaging in Primary Care transformation. The Trust will also have the capability of paying for efforts to evaluate the savings in total medical expense in the Commonwealth that are generated by this legislation.

There are seven specific things that the Trust achieves:

1. Primary Care payments NOT bound to price differences in the fee schedule (market power)
The amount of financial help that primary care practices receive should not be based on existing differences in market power, whereby larger provider organizations command higher prices than smaller organizations. To avoid being bound by these differences in market power, financial help should be allocated separate from the negotiated fees between insurers and providers. The trust could accomplish this goal while commercial payers are bound by the forces of market power and could not accomplish this goal, even if they wanted to do so.

2. Primary Care payments for self-insured lives, which state law cannot touch (ERISA) without the Trust
Allocating financial help to primary care practices through the trust would enable Massachusetts to support primary care for all of its residents, including self-insured lives. Close to 60% of the commercial market in Massachusetts are self-insured lives. Due to ERISA, without the use of the Primary Care Trust, the S.750 legislation could not apply to that large segment of the population.

3. Primary Care payments to disadvantaged lives who are NOT enrolled with commercial payers
Allocating financial help to primary care practices through the trust would enable Massachusetts to directly assist disadvantaged lives, particularly those who are NOT enrolled in commercial insurance. Targeting help towards those who need it most would address racial, ethnic, and socioeconomic disparities in health care access. Thus, the trust is a powerful tool for health equity.

4. Single administration (low admin costs) vs. each payer doing their own disbursement
State government has extensive expertise in collecting funds and disbursing funds. Indeed, that is a core function. Allocating help to primary care practices through a public body, rather than private actors, reduces the administrative costs of this function. Asking many payers to separately allocate such help in their own ways to primary care practice increases administrative burden to Primary Care practices and increases wasteful total medical expense that does not help patients.

5. Public sector control of the money (transparency) and accountability for it
Allocating financial help to primary care practices through the public sector assures its transparency and assists in its accountability. The Commonwealth will have an unprecedented opportunity, through the Trust, to measure both the amount of money being spent on Primary Care, as well as the amount of money being saved due to the increased investment in Primary Care. The trust will have the ability to support long-term rigorous scientific evaluation of the financial, health, and equity effects of S.750.

6. The ability to collect money from other sources
The Trust will be able to collect money from other entities in the Commonwealth (besides the payers) that are being required to contribute toward the increased Primary Care investment: large health system reserves, for-profit health systems, commercial insurance surplus, pharma/PBMs

7. The Trust can deliver Primary Care transformation support for smaller practices
Primary Care transformation is more challenging for smaller practices. The Trust can offer financial support and can also establish regional collaborations that help create more efficient economies of scale.

The current U.S. healthcare system relies upon a fragmented system of payers, which introduces immense administrative complexity. This administrative burden is extremely costly, as demonstrated by the fact that one third to one quarter of all healthcare spend is sunk into administrative costs (Cutler 2020; Altarum 2018). One estimate suggests the total cost of administrative expenses in 2018 in the US was $765 billion (Cutler, 2020). Public payers in the U.S. (e.g. Medicare) spends approximately 1.8% of total spending on admin, while private insurers spend 12.3% of total spend on admin (Altarum, 2018). This shows how a public entity can dramatically decrease cost and administrative burden.

A large portion of administrative spend can be considered billing and insurance related (BIR), which is made up of tasks such as billing and claims management as well as prior authorization. In multi-payer systems, prices for services and medications are negotiated in individual contracts, which requires administrative oversight to ensure claims are billed accurately. This means managing claims is work-intensive, and therefore cost intensive. For private insurers, BIR is estimated to comprise 85% of all admin expenses (Altarum 2018). In 2018, private insurers were estimated to spend $108 billion in BIR admin (Cutler, 2020). Therefore, a fragmented fee-for-service (FFS) system increases costs by requiring more money to cover work-intensive administration. The PC4You model tackles both administrative complexity from a claims management perspective by eliminating FFS specifically for primary care, and by using a single Primary Care trust to more efficiently deliver payments.

Perhaps the most demonstrative of the consequences of excess BIR admin spend is the example of prior authorization. One may question whether the investment in prior authorization programs is worth it for private insurers. Do these programs help commercial payers turn a larger profit? The fact that commercial payers continue with prior authorization requirements is evidence that they believe the investment is worth it, however, the head of a major commercial payer in the commonwealth reported to us that the cost of administering prior authorizations was almost as much as their savings. While there was a net positive, the gains were extremely narrow. Meanwhile, studies have shown that prior authorization programs have not been shown to reduce overall healthcare spending, and, in fact, can increase spend on alternative treatments in some cases (Altarum, 2019).

Most saliently, prior authorization is a nightmare for doctors and patients–delaying care, causing administrative headaches, increasing confusion for treatment plans, and harming patient trust in the system. Patients with cancer have been forced to delay treatment while prior authorization cases are being drawn out over CT imaging. When the program does not reduce overall healthcare spend and does not make a significant dent in commercial payers profit, it becomes a wasteful machinery without any winners. This example of prior authorization, a large component of BIR and therefore total administrative spend, demonstrates how a simplified healthcare payment system such as with Primary Care for You and the Primary Care Trust stands to save taxpayers and patients immense sums of money, with an added benefit of overall better patient care and much less frustration.

Employers who are major purchasers of healthcare want their employees to have access to high quality Primary Care. Access to Primary Care means employers can avoid being out of work due to illness and unnecessary spending associated with worsening of chronic disease, unnecessary trips to the Emergency Department, unnecessary hospitalizations, etc. Investment in high quality Primary Care through PC4You generates happy employees (Grundy et al. 2010). Employers will be pleased with the unfettered access to primary care that PC4You offers their employees (no cost sharing: no copays, no deductibles).

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