Better Data for Better Results: AB 1122's Super User Pilot Project and Other 2019 Bills That Improve Health Care Transparency

As California continues its implementation of an all-payer claims database, we take a look at other bills the Legislature introduced to further the aim of better understanding the factors and activities that drive health care costs and quality. SB 343 subjects the Kaiser Permanente system to the same reporting requirements as other plans and hospitals. SB 612 and AB 929 mandate public disclosure of cost reduction and quality improvement activities. Additionally, AB 1122 proposes a pilot project that utilizes existing data sets to identify a new data set: high health care users. If passed, these bills could provide a clearer picture of how to reduce costs and improve quality in health care.

Eliminating Alternative Reporting for Kaiser Health System

SB 343 would, in a nutshell, remove multiple exemptions and alternate reporting methodologies for Kaiser Permanente. Previously, Kaiser only had to report revenue and expenses in the aggregate, unlike other hospital systems, which reported each of its hospitals' income and expenses separately. Kaiser also reported only the amount of its actual medical trend experience, whereas other plans had to report both overall annual medical trend factor assumptions and the amount of the projected trend attributable to the use of services, price inflation, or fees and risk for annual plan contract trends.

Because Kaiser is one of the largest, if not the largest, insurer and hospital system in California, its alternative reporting method skews and hampers full interpretation of the healthcare system. By eliminating Kaiser's alternative reporting schemes to require Kaiser "to report the same data as its competitors, regulators can make

"apple to apple" comparisons of health care pricing."[1] This change would result in more specific data as Kaiser would provide separate data for each of its hospitals. Additionally, revealing assumptions for rates and expenses would provide more insight into what drives costs at Kaiser hospitals.

Public Reporting of Cost Reduction and Quality Improvement Activities

To gain a more comprehensive picture of California's reform efforts, SB 612 would require a health care service plan, a health insurer, or a medical group to report participation in health care delivery and management collaboratives and activities to the Office of Statewide Health Planning and Development (OSHPD).[2] Examples of these collaboratives include delivery reform involving medical homes, accountable care organizations (ACOs), transitional care, telehealth, incentive payments, and integrated healthcare. [3] The data for these collaboratives and activities would include a detailed description of the specific activity, performance measures, and the outcome of these initiatives. Subsequently, OSHPD would compile and publish the aggregate information received pursuant to this section, organized by health care service plan, health insurer, and medical group, on its internet website.

By having all the data reported to the same entity and released to the public, policymakers, purchasers, and the public will be made aware of what cost reduction and quality improvement efforts are being done and how each of these efforts fared. Understanding this information will allow policymakers and purchasers to choose and incentivize activities that would enhance patient health and improve efficiency.

Similarly, AB 929 would allow Covered California to contractually require its plans to report the plans' cost reduction efforts, quality improvements, or disparity reductions and make public such a report. The goal of this bill is to "monitor immediate health system problems and underlying social determinants of health."[4] With this bill, Covered California, as a health plan purchaser for about 1.4 million consumers, can deliver substantial amount of *disaggregated* (i.e. individualized plans) health care data. That kind of data can help governments, consumer groups, and other stakeholders identify the shortfalls in healthcare cost reduction and quality improvement.

With these two bills, policymakers will have a greater understanding of how plans and insurers use different activities and collaboratives to improve quality and decrease costs.

Identifying and Predicting Heavy Users of Health Care Services Through Existing Data

One bill seeks to promote data utilization to decrease costs. AB 1122 would create a Super User Pilot Project in Ventura County. *Super users* or *super utilizers* are a small subset of the population that contributes to a disproportionate amount of spending in a health system.[5] Atul Gawande's 2011 *New Yorker* article, The Hot Spotters, first presented this problem, noting that "one percent of a hundred thousand people . . . accounted for thirty per cent of [Camden's medical facilities'] costs."[6] This happens when such patients utilize costly emergency rooms for conditions that could have been resolved with inexpensive options like primary care or early interventions.[7] Gawande hypothesized that "the creation of intensive outpatient care to target hot spots [would] . . . reduce overall health-care costs."[8] AB 1122 aims to do just that.

If passed, AB 1122 would provide Ventura County the following four data sets: Medi-Cal claims data, employment and unemployment data, county resident incarceration and release data, and CalWORKs and CalFresh user data. Using these data, the county would create a "prospective model" to predict which Medi-Cal beneficiaries will be super users. Theoretically, the model would identify "hot spot" super users and ensure that the county intervenes and helps these users early on. By targeting super users and their high health care utilization, healthcare costs should decrease over time.

Conclusion

Overall, these four bills seek to offer new data sets, whether it be Kaiser's, survey of cost and quality improvement activities, or the identity of super users. What's

important is that more data allows policymakers to make better and more precise legislation that will reduce costs while improving quality. Readers may note one omission here: AB 731, which aims to expand large group rate disclosures and remove confidentiality protections for contracted rates. However, the scale and history behind it requires its own post, which we'll cover next month. Stay tuned!

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[1] Sen. Com. on Health, Analysis of Sen. Bill No. 343, 2019-2020 Reg. Sess. as amended Feb. 19, 2019, p. 3 (Cal. Apr. 3, 2019).

[2] Notably and as the America's Physician Groups (APG) points out, the bill does not include Federally Qualified Health Centers (FQHC) and public hospitals, which may also be involved in these collaboratives and activities.

[3] The list is dizzying. The bill language lists at least 9 specific programs and multiple other initiatives such as the federal Centers for Medicare and Medicaid Services (CMS) Innovation Center Transforming Clinical Practice Initiative or a payment reform program sponsored by the Integrated Healthcare Association or CMS Innovation Center.

[4] *See* Assem. Com. on Health, Analysis of Assem. Bill No. 929, 2019-2020 Reg. Sess. as amended Feb. 20, 2019, p. 2 (Cal. Mar. 26, 2019).

[5] *See* Atul Gawande, *The Hot Spotters*, The New Yorker (Jan. 16, 2011); Karen Weintraub and Rachel Zimmerman, *Fixing the 5 Percent*, The Atlantic (Jun. 29, 2017).

[6] Gawande, *supra* note 5.

[7] *See* Assem. Com. on Health, Analysis of Assem. Bill No. 1122, 2019-2020 Reg. Sess. as amended Mar. 21, 2019, p. 3 (Cal. Apr. 23, 2019).

[8] Gawande, *supra* note 5.