



March 2024

Capitated Payment for Primary Care in Self-Funded Health Insurance Arrangements in California

An Exploration

Background

Accessible primary care is the foundation of high-performing health care systems, yet the share of health care spending in the United States devoted to primary care is small and declining.¹ In addition to the level of primary care spending, the structure of primary care payments also influences health outcomes. A 2021 report from the National Academies of Sciences, Engineering, and Medicine (NASEM) recommends that health care purchasers and payers “pay for primary care teams to care for people, not doctors to deliver services” and encourages purchasers and payers – including self-insured employers – to adopt a hybrid payment model that combines fee-for-service and capitation.² Prior efforts have gathered input from stakeholders to build a case for aligned hybrid primary care payment in California.³

In order to strengthen and simplify the financial signals received by primary care practices and to reduce the administrative burden associated with proliferating payment models, the California Quality Collaborative, a quality improvement program of the Purchaser Business on Health, and the Integrated Healthcare Association, launched the [California Advanced Primary Care Initiative](#), a voluntary effort focused on multi-payer alignment in measuring, reporting, paying for and rewarding performance on primary care. In 2022, six health plans (Aetna, Anthem, Blue Shield, Health Net, Oscar and United Healthcare) and one provider organization (Aledade) signed a memorandum of understanding that outlines shared commitment in multiple areas, including moving toward a hybrid payment approach – one that incorporates capitation alongside some fee-for-service (FFS) payments – for primary care.⁴ Although capitated payments are used widely in fully insured HMO products in California, FFS payments for primary care and other outpatient services are thought to be the dominant payment structure within PPO products, including self-funded PPOs.⁵

As efforts toward aligned, hybrid primary care payments expand, some key decision-makers have questioned the feasibility of adopting capitation as a payment mechanism among self-funded and flex-funded health coverage arrangements. Several health plans participating in the California Advanced Primary Care Initiative, including Aetna, Anthem,

Blue Shield and United, have a substantial line of business providing “Administrative Services Only” (ASO) to self-funded clients that bear their own insurance risk. The administrative and infrastructure costs of shifting to a hybrid payment model for primary care are substantial, and health plans are more likely to make those investments if they can adopt a single payment mechanism across both fully-insured and ASO lines of business. Capitation within insured arrangements is widespread and California’s health plan regulatory framework is designed to address that reality. However, within private sector health plans that self-insure, capitation and other payment arrangements not tied directly to the delivery of services are less common. The federal Employee Retirement Income Security Act of 1974 (ERISA) exempts these plans from direct state oversight; nevertheless, it is unclear how state and federal law would apply if private self-insured plans adopted capitated payment for primary care more widely. This technical memo, based on a review of publicly available documents and key informant interviews conducted between August 2023 and January 2024, explores how state and federal regulatory oversight of health coverage affects opportunities for hybrid primary care payment.

Two important limitations constrained the scope of the exploration. First, determining how a regulatory framework will apply within a complex and evolving market and policy landscape is often open to interpretation and may unfold over time only as changes are made and tested through regulatory and legal channels. Second, our ability to engage key informants was limited. Despite repeated overtures, some major plans and some self-insured payers declined to participate. The memo that follows offers context, identifies areas of clarity and ambiguity and suggests implications related to the expansion of hybrid primary care payments in self-funded products in California. It is by no means the last word on these topics, but is instead intended to spark further discussion among interested individuals and organizations.

Primary Care Payment Alignment and the Role of Capitation

Primary care provides value to consumers in several ways, including addressing immediate health concerns, guiding people through a complex health care system, engaging patients and their families in decision-making about care and supporting early detection and preventive care.^{6,7} Accumulated evidence shows that delivering core primary care functions through a usual source of care and orienting the health system as a whole toward primary care is associated with improved population health outcomes.⁸ Among commercially-insured Californians, populations served by provider organizations that spend more on primary care have better outcomes in the areas of clinical quality, patient experience, utilization and cost.⁹

Strategies to increase primary care spending, in the aggregate and as a share of total health expenditures, are being pursued through many efforts in California¹⁰ and in the U.S.¹¹ and are not the subject of this paper. Instead, this project was motivated by a desire to decrease reliance on FFS primary care payment linked to one-on-one clinician interactions and increase pre-payment arrangements with the potential to reward population health management and team-based care.

Despite efforts to shift compensation toward arrangements that reward value rather than volume, a 2022 study reviewing physician compensation arrangements in four states, including California, found that primary care physicians (PCPs) saw increased volume as the top action by which they could increase compensation.¹² The same study found that only about one-third of physician organizations included capitation among their PCP payment arrangements, finding that among PCPs receiving some capitation, those payments accounted for about one-third of total compensation.¹³

Among this project's key informants, primary care providers and researchers consider FFS payment for primary care problematic for several reasons. They note that FFS payment offers limited flexibility to invest in staff and support that could improve clinical quality and the patient experience. Citing experience with the COVID-19 pandemic, they observe that FFS payments do not adapt quickly to shifts in the channels through which people prefer to access care. FFS payments do not lend themselves to investments, such as case management, with the potential to improve health or clinical outcomes across a panel of patients. Finally, FFS payments are cited as a major contributor to physician and clinician burnout, offering incentives to maximize the quantity of patient visits rather than the quality, in terms of clinical outcomes or patient experience, of those visits.

From the provider perspective, the rationale for a move toward greater reliance on capitation and better-aligned payment incentives across multiple payers is straightforward to understand if challenging to implement. Primary care practices have ethical and operational imperatives to deliver the same standard of care for all patients regardless of employer or payer characteristics.¹⁴ At the point of service, clinicians typically do not have visibility into a given patient's payment mechanisms. Despite this opacity, the distinction between fully-insured and self-insured payers has a meaningful impact on provider revenue streams and financial incentives because fully-insured health plans in California rely extensively on capitated payments, whereas self-insured plans rely largely on FFS payments. Given the pervasiveness of self-insurance among employer-sponsored coverage arrangements, a sizable shift toward capitation in self-insured arrangements will be needed to achieve payment alignment sufficient to support widespread transformation of primary care delivery. One study used microsimulation techniques to estimate that capitation payments would need to make up 63% of annual revenues in order for primary care practices to switch from a visit-based to a team- and non-visit-based approach while maintaining financial viability.¹⁵



Regulatory Context Pertaining to Primary Care Payment in California

A complex patchwork of regulatory oversight for health insurance has evolved over time in service of several goals (e.g., consumer protection, manageable administrative burden for employer purchasers, predictability for health plans and third-party administrators and financial stability within the care delivery system), some of which can be at odds with one another. It is therefore unsurprising that potential changes in provider payment arrangements and financial incentives

yield questions and confusion about whether and how federal or state authorities might intervene.

As shown in Table 1, regulatory oversight for health coverage is contingent on the characteristics of the purchaser or sponsor as well as whether the coverage is fully-insured (i.e., a health plan or insurance carrier bears the financial risk associated with providing benefits) or self-insured (the employer or purchaser bears the financial risk).

Table 1: Sponsors, Funding Arrangements and Regulators of Commercial Health Coverage in California

Sponsor/ Purchaser	Funding Arrangement	Regulatory Framework/ Regulator		
		Knox-Keene Act/ DMHC*	ERISA/Federal Department of Labor	Other
Private employers	Fully-insured	●		
	Flex-funded	●		
	Self-insured		●	
Public sector employers	Fully-insured	●		
	Flex-funded	●		
	Self-insured			● ¹⁶
Taft-Hartley multi-employer trusts	Fully-insured	●		
	Self-insured		●	

*A small share of fully-insured lives in products that do not rely on capitated payments are regulated by California's Department of Insurance (CDI) rather than the Department of Managed Health Care (DMHC); see text for more information.

Broadly speaking, health insurance oversight is divided between state which regulate the business of health insurance and the federal government which administers ERISA to “make sure plan sponsors follow through on promises to provide pensions and other benefits, including health coverage, while facilitating the voluntary provision of employee benefits.”¹⁷ ERISA exempts health benefit plans established by private sector employers from direct state regulatory oversight; thus, self-insured health plans are subject only to the relatively modest fiduciary and dispute resolution requirements included in federal law. Regulation of the business of health insurance in California is further bifurcated between DMHC which oversees all HMOs and some PPO products and the Department of Insurance which regulates a small and declining share of the fully-insured market.¹⁸ Within this regulatory landscape, reporting about capitation and other non-FFS payment arrangements varies enormously.

The impact of ERISA on many state policy initiatives is unclear because ERISA’s provisions to preempt state law “always depend on the precise language of the state law in question,” per the National Academy of State Health Policy (NASHP).¹⁹ State authority is unclear in domains related to the “regulation of non-traditional insurers such as provider-sponsored organizations accepting risk from ERISA plans.”²⁰ The U.S. Department of Labor, which enforces ERISA, does not appear to monitor or directly regulate how providers are paid by self-funded ERISA plans. Instead, “ERISA establishes a relatively hands-off approach” to private sector health benefits plans.²¹ Within that context, informants for this project speculated that a self-insured ERISA plan which engaged extensively in direct contracting and delegation of financial risk to providers might be challenged on the basis that it had abdicated its fiduciary responsibilities as a plan sponsor. That is, if the employer sponsor transferred all or substantial risk to a provider group or groups without financial scrutiny or assessment of the capacity of the providers to carry out those responsibilities, it could be seen as abandoning its obligation to act on behalf of plan enrollees.

The Knox Keene Act (KKA) of 1975, and a substantial body of related legislation enacted over subsequent decades, provides a robust framework for the oversight and regulation of managed care in California. Prepaid health care, which eventually evolved into HMO insurance products, emerged in California in the early 20th century and grew rapidly following World War II.²² Under the KKA, California’s DMHC provides oversight of health plans, including the health plans’ financial stability and their provision of health care services. The DMHC also registers and oversees the financial stability of “risk-bearing organizations,” professional medical corporations or similar entities that deliver health care services and pay claims for health care services delivered by “downstream” providers. The DMHC also enforces an extensive set of consumer protections intended to ensure managed care plans keep their promise to deliver – as opposed to simply pay for – care.²³ The DMHC’s mission is to protect consumers’ health care rights and ensure a stable health care delivery system. The DMHC scrutinizes health plans that transfer risk and responsibility to medical groups and medical providers because these actions have implications both for consumer protection and for delivery system financial stability.

Although the KKA explicitly exempts self-insured health plans “operated by any city, county, city and county, public entity, political subdivision, or public joint labor management trust” from its oversight, that exemption is tempered by the requirement that such plans meet certain criteria. To qualify for exemption under the KKA, such self-insured plans must reimburse “all providers... solely on a fee-for-service basis, so that providers are not at risk in contracting arrangements” and must not expend “an excessive amount” for administrative costs. If plans contract directly with providers for health care services and do not pay for those services, consumers may not be held liable for payments owed by plans to providers. Finally, the KKA requires such plans to submit annual audited financial statements and notes that the director of the DMHC has the authority to terminate exemptions.²⁴

Table 2 compares areas of regulatory domains and requirements imposed by DMHC under KKA to those overseen by the federal Department of Labor under ERISA.

Table 2: Summary Regulatory Requirements: California’s DMHC and Federal Department of Labor (DOL)²⁵

	DMHC (KKA)	DOL (ERISA)
Consumer protections	Reviews plan internal grievance processes, maintains consumer help center, monitors plan compliance with continuity of care requirements and provides for independent medical review	Offers limited consumer assistance but does not review grievance processes nor conduct independent medical review
Access to care	Requires plans to receive prior approval of networks and meet timely access requirements	No direct oversight
Financial oversight	Requires plans to meet minimum tangible net equity requirements	Assigns plan sponsors broad fiduciary responsibilities to act in the interest of plan participants and beneficiaries. Does not directly monitor plan solvency.
Provider networks and relationships	Reviews provider contracts (but generally not rates of payment) and health plan policies and procedures to prevent providers from assuming excessive risk. Sets standards and requires reporting for risk-bearing provider organizations (RBOs).	No direct oversight

The DMHC does not typically offer opinions about oversight of care delivery or payment arrangements that have not been implemented. An exception relevant to this paper’s topic was a 2009 DMHC response to an outside inquiry regarding concierge medical practice (see next page for further discussion of direct payment and concierge approaches which, like hybrid primary care payment approaches, are accompanied by regulatory ambiguity). The premise of the inquiry was that “up to 200 patients [would be] charged a basic monthly fee in exchange for certain pre-defined health care services... such as 24-hour physician access, next-day appointments, nutrition and wellness counseling... and other services typically not covered by Medicare or private-sector health insurance plans.” In a letter explicitly marked “Not an Interpretative Opinion,” the DMHC wrote that the proposed program constitutes a

health care service plan under the KKA and must obtain a license to operate as such. The supporting reasoning noted that the program offers enrollees physician services and preventive services in exchange for a fee and “arranges” for provision of health care services. The letter also noted that the director of the DMHC has discretionary authority to exempt such an entity from the act if, among other considerations, the director finds that exemption would serve the public interest. Per the DMHC letter, the originating inquiry did not provide sufficient evidence to support the exemption.²⁶ One key informant for the present exploratory project cited this letter 14 years after it was written to highlight risks and uncertainties around hybrid primary care payment, testimony to the seriousness with which potential DMHC oversight is taken by California health plans and medical groups.



Direct Contracting Between Purchasers and Providers: Experimentation, Potential and Limitations⁴¹

In an effort to improve health care access and quality and to manage spending, some self-insured private employers contract directly with provider organizations for the delivery of primary care, eliminating or substantially restructuring their reliance on third-party administrators to identify networks and negotiate payments. If direct contracting involves FFS payment, as when employers make direct payments for onsite clinics that deliver preventive and primary care,²⁷ these arrangements are not subject to DMHC oversight. Other direct contracting approaches, such as concierge-style wrap-around services purchased by employers on behalf of their employees²⁸ or directly-contracted Accountable Care Organization (ACO)-like arrangements,²⁹ may involve some capitation and provider risk-bearing, although it is unclear how widely risk is transferred in these arrangements.³⁰

When asked to review an earlier draft of this memo, representatives of the DMHC indicated that they are aware of a variety of direct contracting arrangements in California and that their regulatory response depends, in part, on the scope of those arrangements. When a direct contracting arrangement is constrained by location, involves a well-

defined and limited set of services and results in limited financial risk being assumed by the provider, the DMHC will generally not require the provider to obtain a KKA license. The DMHC considers each arrangement on a case-by-case basis.

With or without capitation, direct contracting tends to be limited to large employers whose employees are geographically concentrated and is thus unlikely to offer a comprehensive alternative to aligned payment structures imposed through self-insured employers or third-party administrators.³¹

California legislation from 2020, AB 1124, allowed a limited pilot to experiment with direct contracting using capitated payments, authorizing DMHC to permit two pilot programs (one in Southern California and one in Northern California) that allow health care providers to undertake risk-bearing arrangements without the involvement of a fully state-licensed health plan, with a voluntary employees' beneficiary association (VEBA) and a multi-employer plan.³² The Southern California pilot through California Schools VEBA is slated to launch in early 2024.³³

In California, several health plans offer DMHC-regulated flex-funded products which some large public sector employers (for example, CalPERS, the University of California and the City and County of San Francisco) make available to their enrollees. Private sector employers may use flex-funding as well, although details of their funding arrangements are typically not publicly available. In flex-funded arrangements, employers contract with health insurance carriers to pay for a portion of health care services via capitation while the employers make direct FFS payments for remaining covered services. The categories paid via capitation may include physician-delivered services only or a broader set of services extending to those delivered at health care facilities. Key informants indicate that the share of primary care paid via capitation in flex-funded arrangements varies based on the carrier, the geographic area, and other market conditions. Services paid via capitation must be specified within contracts that the DMHC reviews. Flex-funded

arrangements overseen by the DMHC offer one path by which the benefits to employers of self-insurance (lower corporate taxes, greater control of cash flow) and the benefits of health plan contracting (network design, payment alignment) can be combined.

In sum, neither the DOL through its administration of ERISA nor the DMHC through its oversight of KKA imposes a regulatory framework that systematically scrutinizes all payment arrangements between purchasers, plans or TPAs and health care providers. Because it is concerned whenever parties engage in the “promise to deliver” care under specific risk transfer conditions, the DMHC requires reporting and conducts oversight to prevent provider insolvency. However, when considered in the context of gradually increasing reliance on capitated primary care payments, the exact conditions under which such oversight would be exercised are not well-defined.



Motivations and Tradeoffs Affecting Primary Care Payment Structure

This exploratory project was initiated with the view that the benefits of greater capitation and prepayment for primary care were compelling and widely accepted, implying that regulatory barriers were the most salient obstacle to the broad uptake of non-FFS payment arrangements. However, key informants offered a wide and nuanced set of considerations and tradeoffs that contribute, along with the regulatory context, to the continued acceptance of status quo payment arrangements and reluctance to broadly embrace hybrid primary care payments. These considerations are described below, organized from the perspective of the different parties to payment negotiations.

Self-Funded Employers

In key informant interviews, the following considerations were offered by or attributed to self-funded employers:

- Some employers may feel that the benefits in improved quality and value associated with changes in primary care payment structure are not sufficient to justify the attention and effort required to effect those changes.
- Employers that cover a transitory workforce may be reluctant to structure payments to encourage team-based care out of concern that employees will not remain in their plans long enough to reap the benefits of such care.
- Employers may be uncertain about the levels of primary care capitation payment required to achieve goals related to quality, equity and care coordination. For example, they may debate whether to vary payment rates by age or health status.
- Employers may be concerned about member communication and transition issues, particularly if their workforce includes employees unaccustomed to having a usual source of primary care who would be newly required to select a primary care provider.

Third-Party Administrators

Key informants offered the following observations about the market factors that influence how health plans serving as third-party administrators (TPAs) engage with provider networks in order to serve self-insured employers:

- Some TPAs view a movement to alternative payment models, and the construction of networks that maximize value-based payment such as capitation, to be a positive market differentiator. These TPAs welcome the prospect of greater reliance on hybrid payments aligned across market segments.
- Other TPAs differentiate themselves by assembling broad provider networks that serve a variety of markets, geographies and payer needs. They tend to associate little upside with fine-tuning the structure of provider payments.
- Some TPAs are compensated based on a percentage of billed charges and/or service fees. Those that rely heavily on an incentive structure based on a share of billed charges tend to be less motivated to constrain spending or to use network design and payment structure to influence quality outcomes.



Primary Care Providers

Key informants observed that opportunities to change payment structures play out differently across diverse primary care practitioner and medical group circumstances:

- Primary care providers who rely entirely or almost entirely on FFS reimbursement would need to make significant shifts in operations, data systems and financial management to support capitation. The risk and uncertainty that would accompany such a transition may be especially challenging for providers in smaller practice settings.
- Primary care providers serving primarily commercially-insured patients may be uncertain about how changing their practice models and investing in non-clinical resources would affect cost and quality for the particular population they serve.³⁴
- In some market settings, medical groups may maintain FFS payment structures because they wish to be differentiated from closed panel, capitated care delivery structures.³⁵

Consumer Advocacy Perspectives

Consumer advocates are concerned that enrollee cost-sharing requirements and the uneven distribution of primary care providers compromise access to primary care and negatively affect health care outcomes. They welcome efforts to increase access to affordable primary care but note that these efforts should not come at the expense of the extensive consumer and solvency protections provided under the KKA. Key informants offered observations about how consumer interests or perceptions might intersect with the spread of capitation for primary care:

- Consumer advocate informants did not express strong views about the pros and cons of expanding capitated primary care payment within self-insured plans that are not subject to state oversight. However, they were wary of steps that might make it easier for California employers to arrange for coverage that reduces consumer protections and skirts oversight. From this perspective, issuing expansive permissions to self-insured plans to pay capitation for primary care or other services could encourage an undesirable migration away from insured arrangements under a regulatory framework that emphasizes consumer protection.
- Despite ample evidence of the benefits of maintaining a usual source of primary care,³⁶ and the adoption by Covered California and CalPERS of assigned primary care providers within PPO arrangements, informants noted that a subset of consumers may not value PCP assignment, perhaps reflecting concerns about timely access to both primary care and specialists and the desire to keep provider choice options open. Informants encouraged transparency regarding primary care payment structure and methods for attributing services to providers so that incentives are clear and there is adequate oversight of that care.



Primary Care Capitation in Self-Insured Plans: Allowable Conditions, Remaining Uncertainty

This exploration was initiated by the following key question: Under the current DMHC regulatory framework, may self-funded plans pay primary care providers capitation (rather than FFS)? A unitary, definitive answer to that question did not emerge from this analysis, but more was learned about the circumstances under which primary care capitation in California is or is not allowable:

- If employers participate in flex-funded arrangements, they may pay capitation for primary care under the insured portion of the funding arrangement. To qualify for flex funding, they must engage in contracts that document the services subject to capitation.
- If self-funded ERISA plans pay capitation for primary care, the specific circumstances surrounding the primary care providers that receive those capitated payments will determine which DMHC regulations apply:
 - If medical groups accept both institutional and professional risk, they are required by DMHC to file as a restricted licensee.³⁷
 - If medical groups use primary care capitation payments to pay other “downstream” providers on a capitated basis, they must register with the DMHC as RBOs.³⁸
 - With a few exceptions,³⁹ a group or practice that receives primary care capitation from self-insured employers or other payers would be acting as an unlicensed health plan under the rubric of Knox-Keene because it is undertaking “to arrange for the provision of health care service to subscribers or enrollees... in return for a prepaid or periodic charge paid by or on behalf of the subscribers or enrollees.”⁴⁰

Potential Next Steps

This project was an initial exploration of the multi-layered regulatory landscape and complex market forces that surround employer payment for primary care in insured and self-insured arrangements in California. Based on the interviews conducted for this project, virtually all stakeholders would benefit from more clarity about the ways that greater reliance on primary care capitation within self-funded benefit arrangements would affect their interests. There appears to be an opportunity for greater discourse about ways in which the goals of key decision-makers – purchasers, providers, consumers – overlap or diverge. By convening leaders representing these interests, a clearer vision of the conditions under which capitation for primary care is feasible and desirable is likely to emerge. Such a process might identify potential shifts in the regulatory context to allow capitated, hybrid or other primary care payment arrangements under specified conditions that advance health care quality and equity, protect consumer interests and take into account implications for system financial stability.



Appendix

Key Informants

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Blue Shield of California

Endnotes

- 1 NASEM, [Implementing High-Quality Primary Care: Rebuilding the Foundation of Health Care](#), May 2021.
- 2 Ibid., pages 7-8.
- 3 Stowe, Edith Coakley, et al, [Supporting the Future of Primary Care in California Through Aligned Hybrid Payment Models: A Call to Action](#), Blue Shield of California, November 2021.
- 4 California Advanced Primary Care Initiative, [Memorandum of Understanding Among California Payers in Support of Multi-Payer Partnership](#), California Quality Collaborative and Integrated Healthcare Association, 2023.
- 5 As discussed later in this paper, a lack of uniform and universal data reporting from plans and third-party administrators, along with “tremendous variation and complexity in contractual relationships and payment arrangements,” makes it difficult to assess the prevalence of capitation versus FFS payments in primary care settings. See Yegian, Jill and Marta Green, [California’s Physician Practice Landscape: A Rapidly Changing Market with Limited Data](#), CHCF, March 2022.
- 6 Institute of Medicine (US) Committee on the Future of Primary Care; Donaldson MS, Yordy KD, Lohr KN, et al., editors: [Primary Care: America’s Health in a New Era Chapter 3, “The Value of Primary Care”](#). Washington (DC): National Academies Press (US); 1996.
- 7 Primary care does not occur in a vacuum. Health care quality and health outcomes are affected not only by primary care but also by many other health care services including those delivered in inpatient settings and those offered by specialists. The structure of payments to all of these health care providers, as well as network and benefit design, influence the extent to which care is accessible, integrated, and readily navigated by consumers.
- 8 Starfield, B., et al, [Contribution of Primary Care to Health Systems and Health](#), *Milbank Quarterly*, Vol. 83, No. 3, 2005 (pp. 457–502); Friedberg, Mark W., et al. [Primary Care: A Critical Review of the Evidence on Quality and Costs of Health Care](#), *Health Affairs* 29, No. 5, 2010 (766-772).
- 9 Yanagihara, Dolores and Ann Hwang, MD, [Investing in Primary Care: Why It Matters for Californians with Commercial Coverage](#), California Health Care Foundation: April, 2022.
- 10 In order to strengthen primary care in California, the California Health Care Foundation (CHCF) has brought together public and private health care purchasers, policymakers, consumer advocacy organizations, improvement specialists and funders on primary care investment strategies in the [Primary Care Investment Coordinating Group of California \(PICG\)](#). CHCF has invested in many research, analytic and learning efforts around primary care. Another major effort with the potential to expand primary care spending as a share of total health spending is housed at the California Department of Health Care Access and Information’s [Office of Health Care Affordability \(OHCA\)](#), established via 2022 legislation to slow health care spending growth, promote high value system performance and assess market consolidation. OHCA will set benchmarks for primary care and behavioral health spending and alternative payment model adoption, and measure progress against the benchmarks.
- 11 American Academy of Family Physicians, AAFP Primary Care Investment Toolkit, 2023; Milbank Memorial Fund, [The Health of US Primary Care: A Baseline Scorecard Tracking Support for High-Quality Primary Care](#), February 2023; Andrews, Michelle, [Compensation is Key to Fixing Primary Care Shortage](#), KFF Health News, November 16, 2023.

- 12 Reid, Rachel O., et al., [Physician Compensation Arrangements and Financial Performance Incentives in US Health Systems](#), JAMA Health Forum 2022:3(1):e214634, January 28, 2022.
- 13 Ibid.
- 14 Nationwide in 2023, per [KFF](#), 65% of covered workers were enrolled in a self-funded health plan. In California, long-standing reliance on managed care and capitated payment arrangements have resulted in less reliance on self-funding but recent employer survey data indicate that nearly half (48%) of covered workers are in self-funded health insurance arrangements. [California Employer Health Benefits: Cost Burden on Workers Varies – 2023 Edition](#), California Health Care Foundation, April 2023 (Slide 11).
- 15 Basu, Sanjay et al., [High Levels of Capitation Payments Needed to Shift Primary Care Toward Proactive Team and Nonvisit Care](#), Health Affairs 36, No. 9 (2017): 1599-1605.
- 16 For example, CalPERS, which purchases health benefits for state employees and their dependents, as well as many local public agencies, is exempt from ERISA and is subject to the Public Employees' Medical & Hospital Care Act (PEMHCA). PEMHCA requirements (e.g., benefits, contribution requirements and consumer protections) are generally more comprehensive and more prescriptive than those of ERISA. Many other public sector employers participate in Joint Powers Authorities (JPAs) or Jointly Managed Trusts (JMTs) to administer self-insured health benefits. As public employers they are exempt from ERISA and, because they have not opted into CalPERS participation, are not subject to PEMHCA. An analysis of the legal context for JPA and JMT health benefits oversight is beyond the scope of this paper.
- 17 Butler, Patricia and Karl Polzer, [Regulation of ERISA Plans: The Interplay of ERISA and California Law](#), California Health Care Foundation, June 2002.
- 18 [California Health Insurers, Enrollment: Quick Reference Guide](#), California Health Care Foundation Almanac, October 2023. In 2022, 1.1 million Californians were enrolled in fully insured health plans regulated by CDI, while 29.1 million Californians were in plans regulated by DMHC.
- 19 NASHP, [ERISA Preemption Primer](#), 2009, p 5
- 20 NASHP, [ERISA Preemption Primer](#), p 6
- 21 Monahan, Christine, [ERISA 101: The United States' Hands-Off Approach to Regulating Employer Health Plans](#), Georgetown University Center on Health Insurance Reforms, CHIRBlog, January 24, 2023.
- 22 Roth, Debra and Deborah Reidy Kelch, [Making Sense of Managed Care Regulation in California](#), California Health Care Foundation, November 2001.
- 23 Roth and Kelch, [Making Sense of Managed Care Regulation in California](#).
- 24 [California Knox Keene Health Care Service Plan Act and Regulations](#), 2021 edition, accessed through Department of Managed Health Care website. See §1349 and particularly §1349.2(a)(3) for language excerpted in the text. DMHC's attention to the implications of capitated payment is grounded in one of the KKA's goals: "Helping to ensure the best possible health care for the public at the lowest possible cost by transferring the financial risk of health care from patients to providers," as stated at §1342(d).
- 25 Roth and Kelch, [Making Sense of Managed Care Regulation in California](#), Appendix B; Kelch, Deborah, [Ready for Reform?: Health Insurance Regulation in California under the ACA](#), California Health Care Foundation, June 2011; Monahan, [ERISA 101: The United States' Hands-Off Approach to Regulating Employer Health Plans](#); Butler, Patricia and Karl Polzer, [Regulation of ERISA Plans: The Interplay of ERISA and California Law](#), California Health Care Foundation, June 2002.

- 26 Bae, David, Staff Counsel, Office of Legal Services, Department of Managed Health Care, Letter dated May 15, 2009.
- 27 McCarthy, Douglas, Case Study: [QuadMed – Transforming Employer-Sponsored Health Care Through Workplace Primary Care and Wellness Programs](#), Commonwealth Fund, c. 2010.
- 28 Shyrock, Todd, [Amazon’s One Medical Forges Strategic Partnership with Major Employers for Employer-Based Primary Care](#), Medical Economics, November 16, 2023.
- 29 DelBanco, Suzanne and David Lansky, [Creating an ACO: Advice for Employers and Purchasers](#), AJMC, September 24, 2014;
- 30 One direct contracting example that garnered considerable commentary several years ago involved Boeing contracting directly with Memorial Care in Southern California to provide primary care as well as other services for about 37,000 enrollees beginning in 2017. Lendner, Paul, [With Direct Contracting Boeing Cuts Out the Middleman](#), ManagedCareMag.com, December 8, 2023; Terhune, Chad, [Boeing Contracts Directly with Southern California Medical System for Employee Benefits](#), KFF Health News, June 21, 2016.
- 31 Gaal, Mike and Cory Gusland, [Is Direct-to-Provider Contracting a Potential Silver Bullet for Achieving Value-Based Care for Employer-Sponsored Plans?](#), Milliman, July 19 2019.
- 32 California Schools VEBA Resource Center, [California Governor Passes Assembly Bill No. 1124](#), September 29, 2020; California Association of Health Plans, CAHP Legislative Information AB 1124 (Maienschein), November 2020.
- 33 San Diego Business Journal, [The 2023 San Diego](#), profile of Laura Josh, General Manager, California Schools VEBA, page 38.
- 34 The benefits of capitation for team-based primary care have been inferred from experience with advanced primary care approaches via risk-based Medicare and Medicaid managed care arrangements, in which a “high touch, capital-intensive” model serves “panels of high-risk patients.” Some providers question how readily transferable these findings are to a commercially insured population with lower health care needs and utilization patterns. See, for example, Sharp, JP, et al, [Realizing the Vision of Advanced Primary Care: Confronting Financial Barriers to Expanding the Model Nationwide](#), Health Affairs Forefront, March 30, 2020.
- 35 An anecdotal example: “In Northern California, for example, for Stanford’s managed competition model, we found few medical groups motivated to try to compete with Kaiser Permanente on value for money; they do not need to when most of the market is self-insured and, therefore, most patients can be served with open-ended FFS.” Enthoven, Alain C., [Employer Self-Funded Health Insurance is Taking Us in the Wrong Direction](#), Health Affairs Forefront, August 13, 2021.
- 36 Huffstetler, Alison N., et al., [Relationships Matter: Primary Care Physicians and Usual Sources of Care](#), Am Family Physician 2023;107(4):356-357.
- 37 Yegian and Green, [California’s Physician Practice Landscape: A Rapidly Changing Market with Limited Data](#), Table 3.
- 38 Department of Managed Health Care website, [Risk-Bearing Organization Frequently Asked Questions](#), accessed 12/29/23.
- 39 For example, DMHC has issued an exception in the case of Memorial Care, previously mentioned at Footnote 29.
- 40 Health & Saf. Code section 1345(f).
- 41 The sidebar focuses on direct employer contracting for primary care and/or other broad health care services over an extended period of time. Self-insured employers also contract directly with providers in more limited contexts, for example to use bundled payments for specific episodes of care such as hip and knee replacements. See, for example, Whaley, Christopher, et al, [An Employer-Provided Direct Payment Program is Associated with Lower Episode Costs](#), Health Affairs March 2021.

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Acknowledgements

The Primary Care Investment Coordinating Group of California, with funding from the California Health Care Foundation, commissioned the background research and interviews summarized within this technical memo.

The author gratefully acknowledges comments on an earlier draft from DMHC Chief Counsel Sarah Ream and Deputy Director Pritika Dutt. Their comments do not imply DMHC endorsement of this memo's findings.

About the California Quality Collaborative (CQC)

California Quality Collaborative (CQC), a program of the Purchaser Business Group on Health, is health care improvement program dedicated to helping care teams gain the expertise, infrastructure and tools they need to advance care quality, be patient-centered, improve efficiency and thrive in today's rapidly changing environment.

CQC is committed to advancing the quality and efficiency of the health care delivery system across all payers, and its multiple initiatives bring together providers, health plans, the state and purchasers to align goals and take action to improve the value of health care for Californians.

About the Integrated Healthcare Association (IHA)

At Integrated Healthcare Association (IHA), we bring the health care community together to solve industry-wide challenges that stand in the way of high-value, equitable care. As a non-profit industry association, we use objective data, our decades of expertise, and our unique role as a trusted facilitator to make the health care system work better for everyone.

We provide insights that help the health care system continuously improve. We build new tools that simplify how the industry works together. And we provide a forum for cross-industry leaders—through our board and our programs—to have honest conversations that guide the future of health care.

Because we envision a future where people get the best possible care at an affordable price. Where providers can focus on delivering care, health plans can focus on serving their customers, and purchasers feel confident they're getting value for their money. A future where the health care system works.

