

# The Greater Philadelphia Business Coalition on Health

**2023 Annual Conference**

May 24, 2023

**Independence** 

# What do we mean by “value” in health care?

## Triple Aim 2007

1. Improved Patient Experience
2. Better Outcomes
3. Lower Costs

## Quadruple Aim 2014

4. Clinician Well-being

## Quintuple Aim 2021

5. Health Equity



**Better Health**



**Improved Economy**

# Who can be responsible for value?



# Employers are accountable for value in self-funded arrangements- but they can't do it alone

Accountability for value



**Employee**



**Employer/  
Fund**

## Strengths

- Hold total cost risk in self-funded
- Accountable to employees who expect benefits that give them coordinated access to high quality care
- Close relationship with employees and their families

## Limitations

- Less content/specialized expertise in healthcare and health policy
- Sub-scale to influence providers – small share of panel
- Sub-scale to develop and own population health tools and analytics

# Health plans are in a position to deliver comprehensive value to employers and their covered population

Accountability for value



**Employee**



**Employer/  
Fund**



**Health Plan**

## Strengths

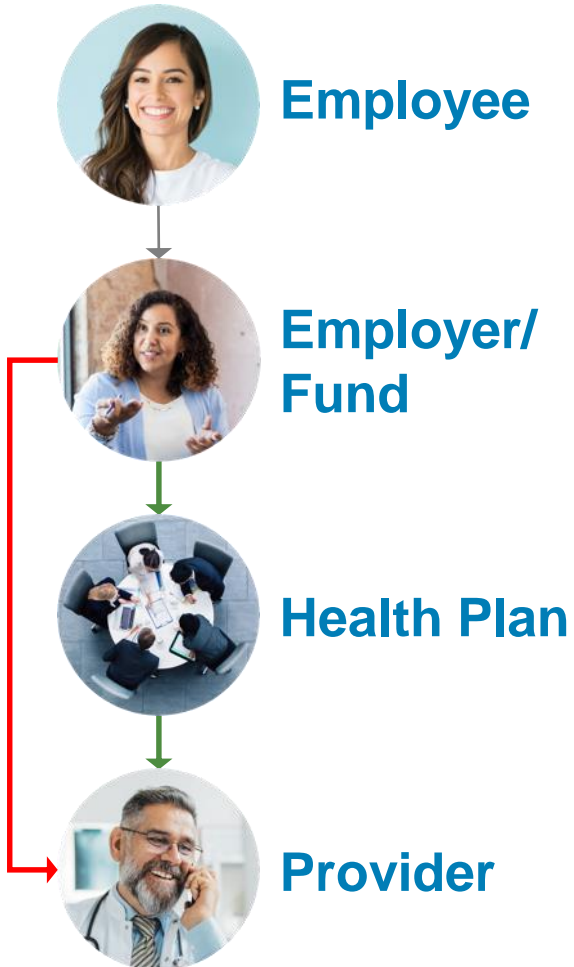
- Able to take on accountability for all of cost quality and experience tied to each member at all sites of care
- Data and analytics for targeting/prioritizing
- Expertise in health care and health care policy
- May be able to have sufficient local density (share of panel) to be an effective partner to providers

## Limitations

- Rarely providing direct care for patients
- Not always paid for outcomes in self funded
- May not move as quickly as smaller actors

# Providers need value-based payment at scale to change care approaches

Accountability for value



## Strengths

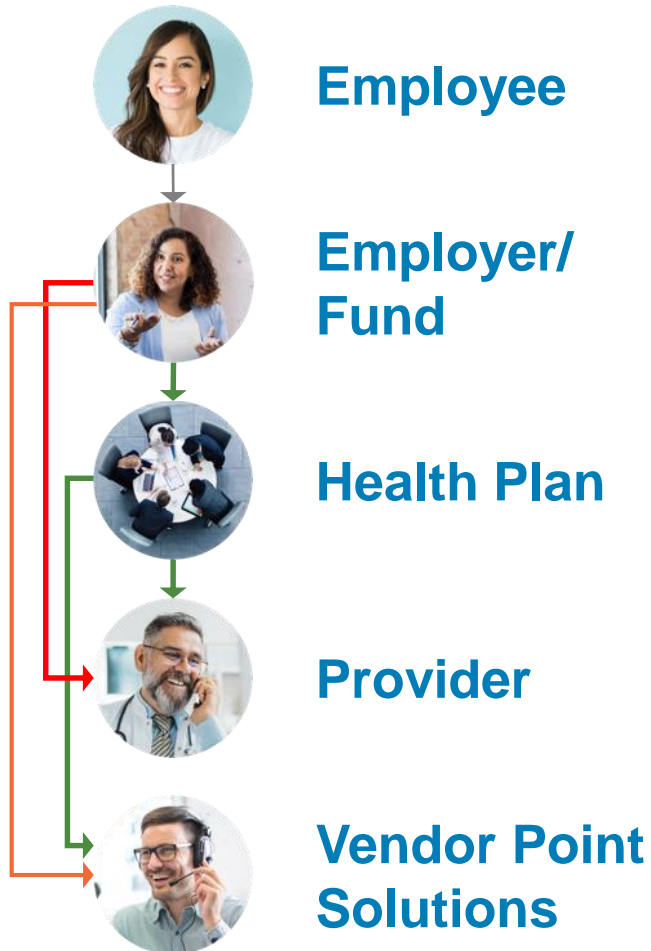
- Delivers care, most direct mediator of total cost, quality, and experience for their patients
- Analytics capabilities (variable)
- Expertise

## Limitations

- “Productivity” mindset from fee-for-service– unless paid for value at scale to influence strategy
- Smaller “network” – often insufficient to be an easy comprehensive solution for a population and allow choice

# Point solutions can play a targeted role in filling existing gaps when a part of a comprehensive value strategy

Accountability for value



## Strengths

- Agile, able to build from ground up without having to account for existing infrastructure
- Draw upon new talent and venture investments
- Can be very responsive to customer needs, including developing new products/geographies

## Limitations

- Point solutions often lay claim to overlapping value/ accountability (e.g., primary care, diabetes, heart disease, kidney disease, MSK- especially when one individual can be overweight, with diabetes, vascular disease, CKD, and back pain)
- Limited experience and evidence of consistent value delivery with ability to make quantitative causal inference
- Focus on their own area – limited ability to advise on prioritizing among various potential focus areas
- Often add to complexity and fragmentation of healthcare

# Health plans should take on responsibility for value from employers, and make it easy

## Payment linked to performance:

- Total cost of care
- Quality of care
- Member experience of care
- Health equity
- Provider experience



# Health plans have the tools to maximize value for other healthcare actors

## Employee



Network selection and guidance for members



## Provider



Pay for outcomes to providers



Co-invest in outcomes

JVC

Invest in interventions

Population health

Data



## Vendor Point Solutions



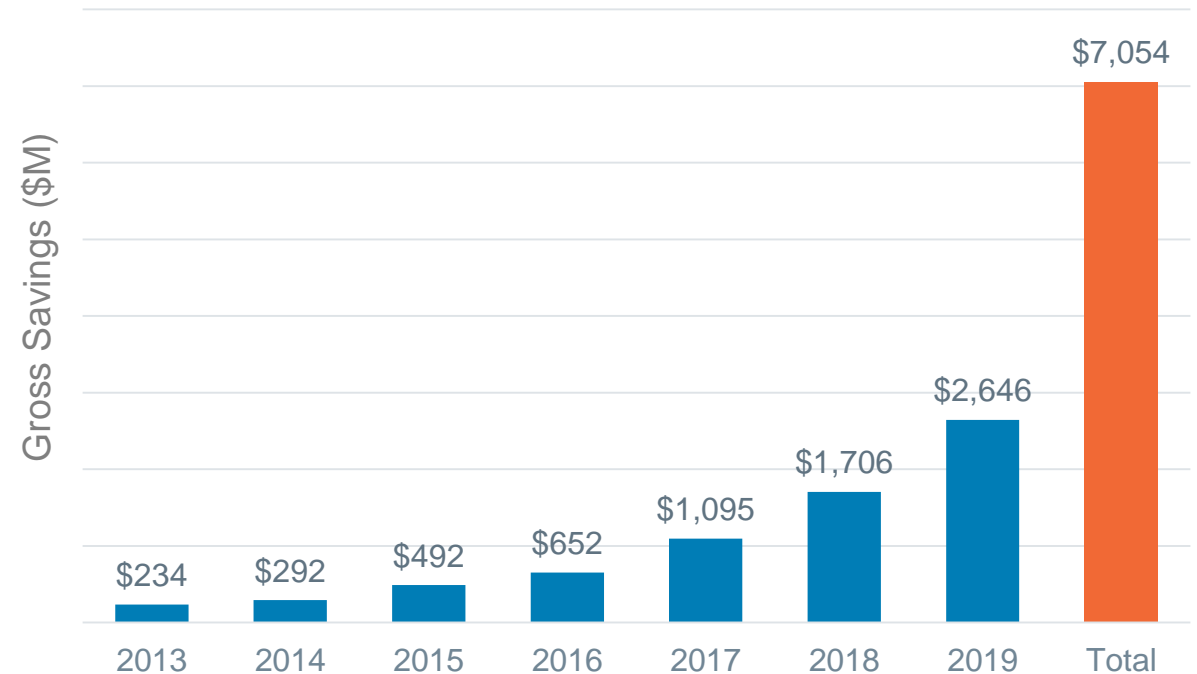
Bring point solution judiciously where necessary to address gaps in the system and minimize fragmentation



# Committed health plans at local scale can follow CMS example and deliver savings

- CMMI/MA Stars programs have been successful in driving value – by leveraging incentives at scale
- Nationals aren't influential with most providers (local density, presence) – though they can purchase some providers
- Blues are local everywhere and at scale- but can do better on transparency and coordination

**Gross federal savings from the Medicare Shared Savings Program**



# Appendix

# Our Role in Driving Value-Based Care with Providers



## Engage

Drive financial & organizational alignment



## Enable

Transform provider behavior with actionable data & programs



## Empower

Practice specific support

# Blue Plans are Best Positioned to Drive Valued-Based Care

**73M+**  
**MEMBERS**

with access to  
value-based care  
programs

**634K**  
**PROVIDERS**

in BCBS value-based  
care arrangements

**3X**  
**MORE PROVIDERS**

than our closest  
competitor

**100**  
**TOP MSAs**

**48%**  
**OF CLAIMS SPEND**  
tied to value-based care



Collaboration  
with doctors



Blues' local  
density



Lowest total  
cost of care



The best quality  
care and member  
experience

# Independence Value-Based Care Programs

## Total Value of Care (TVOC)

Shared savings/deficit program measuring provider quality & total costs incurred by each member of the practice

## Quality Incentive Payment System (QIPS)

Incentivizes PCPs to perform or exceed national benchmarks in care quality, cost, and efficiencies. (i.e. low utilization of ER visits)

## Episodes of Care (EOC)

Places accountability on providers to manage the patients' entire episode of care



## Collaboration

- Joint Value Committees with large health systems to discuss programs, progress and opportunities for improvement on a continuous basis
- Onsite population health specialists and care management support
- Investments in innovation to improve cost savings and clinical care

# Savings & Quality Driven from Value-Based Care Arrangements

**\$250M+** total net savings to our customers over the last 4 years\*

**2021**

**\$11 PMPM**

savings for Medicare

**\$8 PMPM**

savings for Fully Insured

**\$11 PMPM**

savings for Self-funded

**Medicare Advantage received ★★★★★ rating 2 years in a row**

\*Savings does not include QIPS

**Overall Value Independence is  
Driving to Our Customers**

**Value-Based Care**

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**Utilization Management**

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**Condition Management**

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**Return on Recoveries**

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**13%** Total Cost of  
Care Advantage



# Challenges and the Implications

## Challenges



Telling a consistent, national story among all Blue Plans



Quantifying results from value-based care arrangements for self-funded

## Implications



Out-marketed by vendors & other national carriers



We're not financially incented to drive better outcomes & self-funded margins are slim

# Imagine a World Where...

**We take on accountability (performance risk) for cost, quality, and experience for both home and hosted members.**

- **Transparent and consistent data** across Blue Plans on at-risk outcomes
- **Financial upside and downside** in contracts – analogue to provider value-based payment
- **Network access fees reflect performance on outcomes** for hosted members where outcomes-based contracts exist

**What would it take?**



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# How it Would Work

## Home vs. Host Plan Members



**TJX** Distribution Center Employee

 Health coverage  
MASSACHUSETTS

 Penn Medicine Patient

**\$13.36 PMPM savings** to **TJX**

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**25% less likely**  
to be readmitted



 Mass General Brigham

 COMCAST Technician

**Independence**  Health coverage

 Mass General Brigham Patient

**\$12-\$40 PMPM savings** to  COMCAST

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**7% increase** in quality of  
chronic disease management

# Let's Discuss

## Key Considerations



What would Home/Host Plans need to take on financial risk?

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What would it take to put the right resources in place?

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What would customers need to get their buy-in?

## Perspectives from Internal Key Stakeholders

- Underwriting
- Actuary
- Sales/Marketing
- Clinical team
- Consultants
- Customers