THE PURSUIT OF GREATER VALUE

Explore the role of value-based care and evolving network models in your healthcare benefits strategy.

THIS IS HOW℠

BlueAdvantage Administrators of Arkansas

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WELCOME

As leaders in healthcare, Blue Cross Blue Shield companies take their role to influence improvement in the healthcare payment and delivery system seriously. Because of our work with thousands of large employers nationwide, we have a unique view into what is working to improve health outcomes and address the concerning cost trend. Sophisticated data modeling is driving identification of opportunities and evaluation of potential solutions. The results can be seen in new and innovative provider relationships and contracts based on outcomes, not volume.

It should not surprise you that all types of employers are concerned with controlling costs and improving care quality for their employees and their families. What might surprise you is just how advanced health benefits and plan design are becoming. Plan sponsors can choose from a variety of network options, and some are blending solutions to maximize value from their investment.

This eBook highlights the important shift happening in healthcare payment and delivery to create a higher-performing system. It also explores key areas to consider when evaluating your optimal network design. We hope you find this resource useful and welcome the opportunity to discuss your unique healthcare challenges and opportunities.

Sincerely,

Bryan Dorathy

Lead Executive, Group Sales
BlueAdvantage Administrators of Arkansas

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ANSWERING THE CALL FOR HIGH-VALUE HEALTHCARE

Employers today face extreme pressures when it comes to offering and supporting healthcare benefits for employees and managing the significant financial responsibility that comes with it. A compounding cost trend further challenges business leaders' and human resource administrators' ability to balance their company's fiscal health with employee benefits and healthcare needs.

As they search for solutions, many business leaders are demanding better performance and accountability in the healthcare system.

In healthcare, value creation starts at the moment of care. Where care is delivered and how it's paid for directly impacts care quality, health outcomes and financial sustainability. How individuals choose a care provider is also vital, and new network solutions are emerging to help employers guide employees to higher-performing providers.

These developments bring important considerations to light as employers look to drive value through optimal network arrangements and plan design. By partnering with a health plan that uses a data-driven process, companies can create healthcare benefit solutions that work better for their employees.

Today more than ever, employers, consultants and health plans are collectively pursuing better solutions that will improve employee health and healthcare outcomes while minimizing total cost.

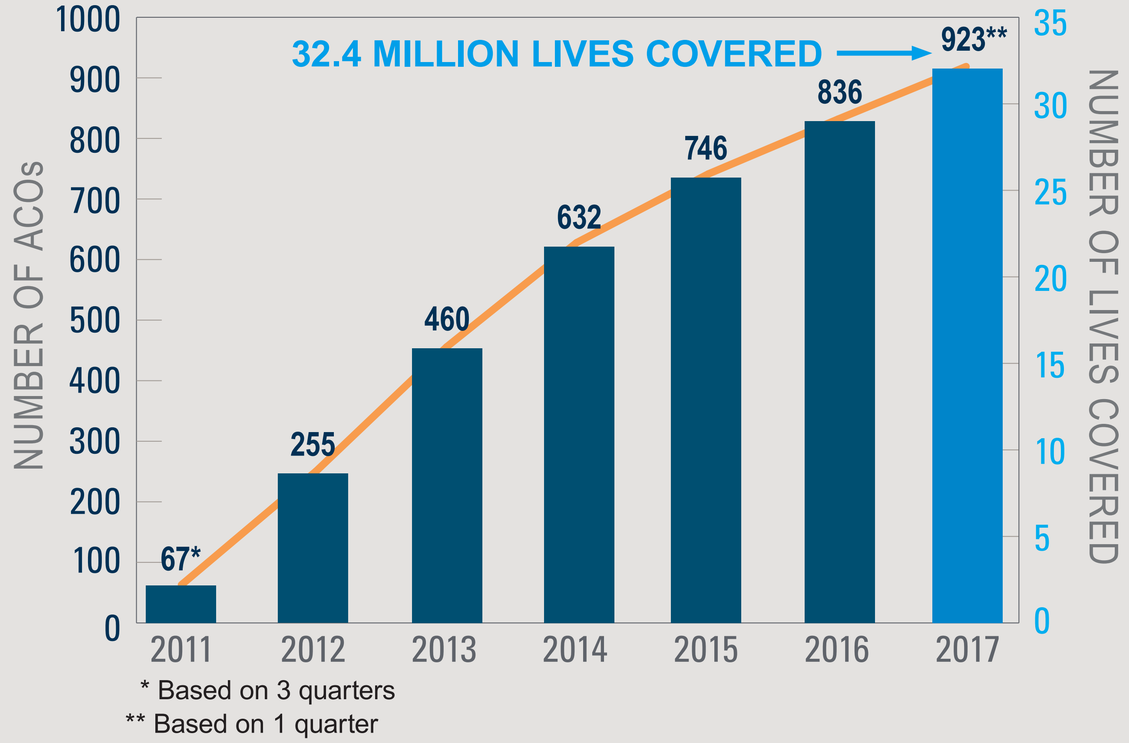
THE TRANSITION TO VALUE-BASED CARE

SHIFTING REIMBURSEMENT MODELS ARE CHANGING HEALTHCARE FOR THE BETTER.

Health plans and healthcare providers have been partnering for decades to improve care delivery and health outcomes. As the ability to harness and analyze data has evolved, so too has the ability for health plans to share data and performance insights with doctors. Enhanced reporting and collaboration enable doctors to identify areas to improve patient satisfaction and health and reduce unnecessary care. As a result, contracts are moving away from traditional “fee-for-service” agreements through which providers are paid based on the quantity of services they provide. A healthy shift toward value-based payment arrangements is occurring in its place. This transition is evolving and gaining sophistication, momentum and acceptance.

THE STEADY GROWTH OF VALUE-BASED CARE

ACOs and Covered Lives, 2011–2017



* Based on 3 quarters

** Based on 1 quarter

Source: Muhlestein, David, et al. “Growth Of ACOs And Alternative Payment Models In 2017,” Health Affairs, 28 June 2017 (authors’ analysis of Leavitt Partners ACO Database)

CREATING HIGHER-QUALITY CARE THAT COSTS LESS.

At its core, value-based care is simply a different way of compensating providers, and it can exist within a variety of emerging network models. In value-based contracting, providers manage a defined population of patients and agree to reimbursement that's based on the health outcomes of that population and better containment of total cost. In other words, they're paid for value (results of care provided) rather than volume (quantity of services provided).

Value-based payments are tied more directly to providers' ability to help their patients get healthy and stay healthy.

In many cases, shared rewards or shared risk is adopted to create alignment and accountability. This means providers share in the savings produced when care is delivered more efficiently and effectively, and may receive lower compensation otherwise. Patients benefit from better care, improved outcomes and lower healthcare costs. Employers can benefit from lower total healthcare costs and increased employee time at work.

VALUE-BASED CARE HAS SHOWN PROMISING IMPROVEMENTS IN QUALITY AND TOTAL COST OF CARE.

THE TREND IS TOWARD BETTER SITE OF CARE DECISIONS...

A 10% DECLINE | **275K FEWER** emergency department visits

A 2% DECLINE | **17.5K FEWER** inpatient hospitalizations

...AS WELL AS BETTER PREVENTION AND CHRONIC CARE MANAGEMENT.

7% INCREASE in routine blood glucose testing for diabetes patients

5% BETTER adherence to medications for patients with cardiovascular disease

THESE IMPROVEMENTS AND OTHER EFFICIENCIES ARE DRIVING A 35% DECREASE in aggregate cost trend in some cases (as compared with national averages)

SOURCE: Blue Cross and Blue Shield (BCBS) companies' analysis, Blue Distinction® Total Care (Total Care) Evaluation 3.0 – National Aggregate Results, January 2018; performance denotes Total Care designated providers versus non-Total Care providers, calendar year 2016, includes data from 6.25 million BCBS members attributed to Total Care providers.

WHEN CONSIDERING VALUE-BASED CARE, YOU SHOULD ASK YOUR HEALTH PLAN PARTNER:

- What's available where you have employees? Is there ample coverage both across and within communities to offer and promote the use of value-based providers and programs to all your employees?
- How long has the program been in place? In many cases, more established programs have been shown to drive quality improvements and provide a clear path to cost trend mitigation.
- How do the health plan and provider practice(s) collaborate to understand local dynamics? Does the contractual agreement align with market and provider dynamics so that behavior change and progress along the risk continuum are sustainable? Is there sufficient local support from the health plan to help the practice and improve the program?
- How extensive is the plan's total local member base and value-based provider network? The larger the health plan's presence, the greater its ability to share meaningful data and influence care delivery practices based on demonstrated outcomes.

INCREASING PERFORMANCE THROUGH NETWORK DESIGN AND SELECTION.

In addition to the evolution of value-based payment models, networks are evolving and new solutions are emerging to advance benefit program performance. While the various network types share common goals of increasing quality and/or controlling cost, differences exist in how quality and savings are measured and achieved. Some are designed to increase performance by carving out high-cost or low-performing providers, some by designating providers who meet rigorous quality and cost containment standards, and others by incentivizing members to choose higher-performing providers in exchange for lower out-of-pocket expenses. Regardless of the type of network, the most efficient models rely heavily on data (episodic cost, utilization, provider, quality of care, health outcomes, hospital readmissions and patient experience, to name a few).

Each network type serves a particular purpose in furthering cost control and/or quality of care, with some more focused on specific goals. It's important to understand the purpose of each and how it aligns to your employee health benefits and business objectives, as a one-size-fits-all approach may not necessarily apply.

KNOW YOUR PRIORITIES.

Common objectives that may be prioritized differently by employers include: lower **cost** and/or better cost control, increased **access** to care, better health **outcomes** and improved **patient experience.** Striking the right balance requires prioritization and network selection that aligns to your business objectives.

EVOLVING NETWORK SOLUTIONS: AN EASY REFERENCE GUIDE*

	What does it do?	Current market usage	Purpose	Key considerations
Centers of Excellence (COEs)	Informs employees as to which providers perform best in high-cost/high-complexity procedures.	88% of large employers in 2018, up from 79% in 2016[1]	Reduce total cost of care and improve quality and outcomes for employees needing complex and high-cost specialty care procedures.	How mature is historical performance data? What quality standards are applied? How significant are the cost differences within a center of excellence?
Tiered Networks	Groups providers into tiers based on performance, with top-tier providers having been shown to deliver better quality outcomes at a lower cost.	23% of firms with 1,000 to 4,999 employees 31% of firms with 5,000+ employees[2]	Reduce total cost of care and maintain quality while enabling employees to select from a broader provider network. Benefits used as incentives to encourage the selection of top-tier providers.	Are both cost and quality standards consistently applied? What utilization assumptions were used to project savings? Are the tiers overly restrictive? Are incentives strong enough to encourage selection of top-tier providers?
Narrow Networks	Limits the network to providers who've agreed to lower fees in return for patient volume, and/or who have been shown to deliver care at a lower cost.	8% of firms with 1,000 to 4,999 employees 19% of firms with 5,000+ employees[2]	Generate savings through contracting a lower unit cost and limiting in-network access to select providers.	Is quality of care appropriately emphasized? How many employees will be impacted by reducing in-network providers? Are you prepared to handle employee feedback and/or dissatisfaction in these cases?
High-Performance Networks	Limits and/or promotes in-network providers who have been shown to deliver care at a lower cost AND achieve better quality outcomes compared with other like providers.	15% of employers[3]	Ensure employees are accessing high-quality providers while also reducing total cost of care. May or may not include limitations to in-network access.	Are there well-defined and rigorous quality standards, using sufficient data, applied across all providers? Are you offering side-by-side with a PPO which may negate effectiveness due to self-selection?

Where does value-based care come in?

Value-based payment arrangements can be tied to many types of networks, including those listed above.

* For illustrative purposes only. Not intended to reflect any specific network. Network features and purpose will vary.

1. National Business Group on Health, NBGH 2018 Large Employers' Healthcare Strategy and Plan Design Survey
2. Kaiser Family Foundation, 2017 Employer Practices and Health Plan Networks
3. Kaiser Family Foundation Employer Health Benefits 2017 Annual Survey

CASE STUDY

AN UNPRECEDENTED COLLABORATION

YIELDS A UNIQUE HIGH-PERFORMANCE PLAN.

What do you do when local health disparities lead to an annual per member premium in one market that is $3,000 higher than your other key markets?

For one Fortune 500 company in America's southwest, partnering with a Blue Cross and Blue Shield (BCBS) company provided the answer. BCBS led a collaborative effort that brought consultants, providers and point solution vendors all to the table. By combining strengths and expertise, they created a locally tailored, best-in-class solution.

The unique solution blends an accountable care organization (ACO) with a centers of excellence specialty network. However, unlike a traditional ACO that requires members to choose a physician at enrollment, members select one of three primary care practices comprising 2,500 physicians in their area. This allows members broader access and choice while also letting the practices know for whom they're responsible.

"The key to making this work is the data we and our partners are offering providers. With it, they can better assess whether a back surgery, for instance, is necessary and if it is, ensure the patient sees a specialist who achieves outstanding results," noted the BCBS team leader.

The solution that resulted from this truly collaborative effort is conservatively projected to achieve 15% savings. Tailoring at this level often requires additional coordination. But more than ever, leading employers are willing to invest the extra time needed to create a best-in-class solution for key markets, because the results in quality improvement and cost savings more than justify the effort.

DEEPER DATA AND STRONGER INSIGHTS ARE ESSENTIAL PIECES OF THE VALUE EQUATION.

As you think about your network options and the care your employees will receive, it's helpful to understand how data is used to inform and influence network design and care delivery within those networks. Today's healthcare system generates a wealth of information—but how is data used to affect care delivery practices? Value-based care, for example, puts the patient and their health outcomes in the center of healthcare informatics. While data drives payments based on health outcomes, it also provides the transparency required for providers to deliver coordinated patient-centered care.

Putting the data to work for you.

Make sure you understand the data and tools your health plan partner will use to design and optimize the right network for your organization and employees. The analysis is only as good as the underlying data—the more robust the data, the better the analysis and the more likely you are to design the ideal solution for your business.

In considering plan alternatives, here are important data questions you should ask to ensure analysis is relevant and valid:

Provider Performance
Are the provider case populations and resulting data sufficient to accurately measure provider performance?

Provider Categorization
Are providers grouped and/or categorized for performance analysis? Is analysis conducted at the individual physician and/or facility level? Does it analyze the organizational entity within which the providers are delivering care (e.g., practice group, ACO, multi-hospital system)? Will this influence tiering and utilization?

The Member Population
What is the size of the data sample in regard to population and claims experience? Are projected outcomes tailored to your employee population?

Market-Level Analysis
Can your plan partner provide deep, reliable data that adjusts for health disparities and variables in healthcare cost and quality within and across geographic markets where you have employees?

Benefit Differentials
As you think about guiding employees to higher-performing providers, can your plan partner help analyze employee utilization patterns and projected changes in utilization and cost based on various benefit designs?

KEY FACTORS IN BUILDING YOUR NETWORK AND HEALTH BENEFITS.

As you explore network designs and look to build a healthcare benefit program unique to your company, there are additional factors that can influence performance and the value ultimately realized.

1 Blended Modeling: Network and Benefit Differentials.

Historically, self-insured employers have factored in benefit design after a network type was selected. With changing care delivery practices and payment models (e.g., value-based care, ACOs) and new network options (e.g., narrow, tiered), it's important to take a holistic approach in modeling the impact of network type and benefit differentials at the same time. A more comprehensive model is more effective in predicting total cost savings. When this integrated approach is applied locally using claims and utilization data at the market level, you can develop specific solutions for areas where you have large employee populations. This approach enables you to target and align benefit and network solutions to the needs of your employees where they live and work.

2 Provider access in all geographic markets.

Your employees may be spread over a few key cities or all across the United States. It's important to understand the geographic variability among network options. For example:

- **How many hospitals/physicians are available in-network in each geographic area covered?**
- **How many of your employees will the network reach?**
- **How does each network option under consideration impact employees' ability to be seen by a provider of their choice?**
- **What is the provider/employee ratio by specialty?**

Ease of getting to an in-network doctor and the ability to maintain a long-term provider relationship will drive employee satisfaction with their benefits.

3 Flexibility to support local needs.

For large companies with multiple locations and/or a variety of employee demographics and cost drivers (e.g., factory workers' healthcare needs may differ greatly from those of a sales force), you may need to choose networks and benefits that can flex and support local variations with localized solutions. While this can help to maximize total performance, it brings with it important considerations. How does benefits consistency matter across your organization? How does a lack of consistency affect both employees and your administrative workload (e.g., employee education requirements and communication complexity)? The results can support a healthier, more productive workforce, but the decisions and support need to be carefully planned.

4 Total cost of care projections.

As this eBook notes, network solutions are designed to lower healthcare cost in a variety of ways. It's essential to understand the resulting total cost of care when finalizing network strategy and selecting a health plan partner. Total cost projections from brokers, consultants and health plans are based on a variety of critical assumptions—be sure to ask for specific details on the assumptions used to calculate their estimates.

FIND THE VALUE YOU'VE BEEN LOOKING FOR.

BlueAdvantage is deeply committed to creating smarter, better healthcare for employers and their employees. As part of that commitment, we're continually innovating and evolving our network capabilities and partnering with employers and providers to deliver high-quality healthcare that's financially sustainable.

If you would like to learn more on how a data-driven approach can enhance value in your health plan investment, please visit us at bcbs.com/smarterbetterhealthcare.

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