The Cigna Group | 2023

Accelerating the transition to value-based care

THE CIGNA GROUP

Table of contents

Employer health care costs expected to increase by up to 7%

Introduction

The U.S. health care system has long grappled with fragmented care, inconsistent quality, variable outcomes, and rising costs. In recent years there's been a renewed push for value-based care (VBC) as a promising alternative or addition to the traditional volume-based, fee-for-service (FFS) model, and with inflation on the rise and employer health care costs expected to increase by up to 7%, VBC is getting even more attention.

While the VBC landscape includes many variations, VBC broadly incentivizes coordination of care, quality outcomes, and cost efficiency. It holds tremendous potential for improving health while reducing unnecessary costs – and advancing a more sustainable health care system. According to McKinsey, VBC could lead to $1 trillion in systemic value, positively impacting consumers, employers and other payers, industry shareholders, and other stakeholders. As primary payers of health care in the U.S., employers can use their scale and influence to accelerate a systemwide transition.

Timeline of key moments in value-based care

2021

CMS sets 100% alternative payment model (APM) objective

The Center for Medicare and Medicaid Services (CMS) established a new objective to enroll 100% of Medicare beneficiaries and most Medicaid beneficiaries in value-based payment models by 2030.

2018

CMS introduces primary care initiatives

CMS introduced the Primary Cares Initiative, introducing new payment models that prioritize high-quality, patient-centered primary care.

2015

MACRA establishes Quality Payment Program

The Medicare Access and CHIP Reauthorization Act (MACRA) introduced the Quality Payment Program (QPP) that incentivizes providers to prioritize quality and value through the Merit-Based Incentive Payment System (MIPS) and Alternative Payment Models (APMs).

2010

Affordable Care Act includes VBC reforms

The ACA introduced comprehensive reforms aiming to improve access to value-based care, establishing accountable care organizations (ACOs), bundled payments, the Hospital Readmissions Reduction Program, and health insurance exchanges

Recognizing private sector employers as key drivers of change

U.S. employers provide health insurance for 159 million people, including 59% of those younger than 65 – more people than all other forms of coverage combined. The majority of these employers are in self-insured arrangements, which means they pay for all health care costs, and the insurance provider is the administrator. They feel the rising costs of health care every day and are increasingly looking for innovative approaches to advance the health and well-being of employees and their families, enhance the care experience, optimize productivity, and ultimately reduce costs. Health plan interest in and readiness for VBC is considered the top facilitator of adoption and government influence is second, according to the Health Care Payment Learning & Action Network (HCP-LAN).

U.S. employers provide health insurance for 159 million people

VBC has been shown to enhance health outcomes, improve cost efficiency, and promote overall health care quality. CMS announced more than $1.8 billion in 2022 savings for Medicare through its value-based Shared Savings Program, marking six consecutive years of savings. VBC has also been shown to reduce hospital admissions and readmissions, improve patient satisfaction, and strengthen management of chronic conditions. In a survey of more than 100 health care industry executives, 24% reported seeing improvements both in outcomes and reduced costs in an incentive-based VBC approach that rewards performance in a fee-for-service (FFS) model, while 35% experienced improved outcomes alone, and 20% didn't experience either. Different models have different approaches with the intent to help align incentives among health care providers by promoting care coordination and interdisciplinary collaboration, which encourages prevention and results in early intervention and lower health care costs overall.

Despite progress made to advance VBC by government and private sector payers, systemic transformation is difficult. Government programs are moving more quickly, and CMS plans to have 100% of Medicare beneficiaries and most Medicaid beneficiaries in some form of value-based payment model by 2030. Conversely, commercial data representing more than 60% of the national market in 2021 shows that nearly 54% of private sector commercial health care spend remains strictly FFS with no link to quality and value.

Value-based care is more than an alternative payment model (APM)

It is important to differentiate between the framework of value-based care (VBC) and the payment models underpinning VBC. There are three critical components of VBC:

1. Financial: Fee-for-service through APMs such as upside only, downside or shared risk, bundled payments, and partial/full capitation.
2. Clinical Model: How a physician or provider cares for a patient.
3. Information: Outlining what data is needed to deliver care.

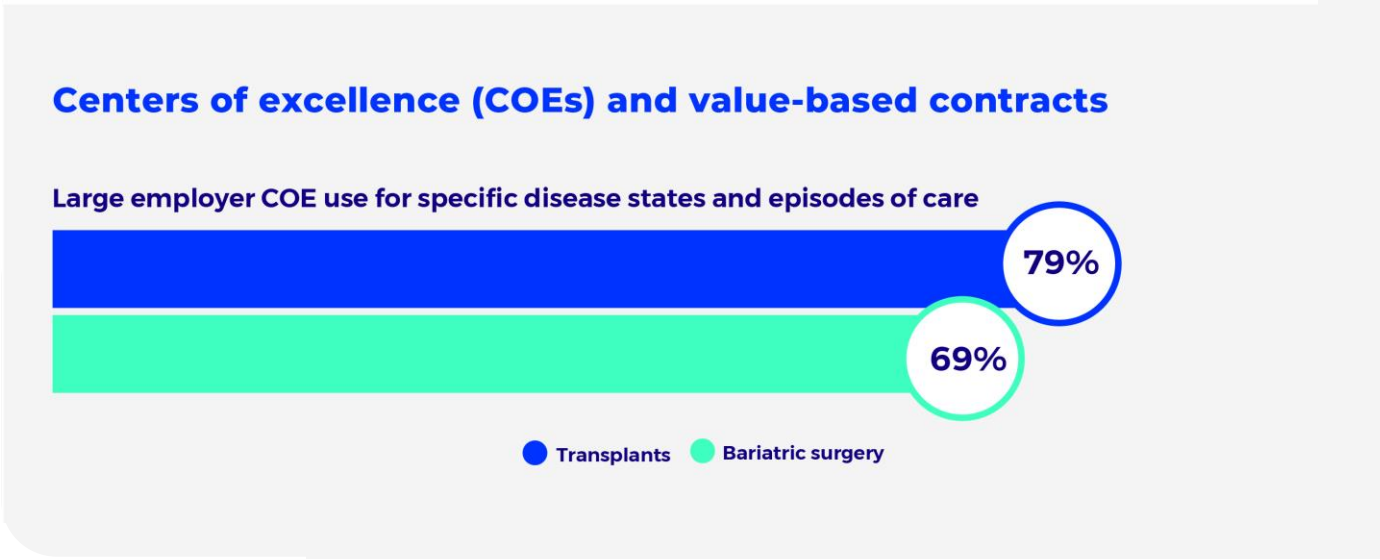
In fee-for-service (FFS) or lower category alternative payment model (APM) tiers, the clinical care and information models are driven by reimbursement. With this approach, which depends upon the provider documenting all services in order to be paid, the financial model still dominates care. In higher tier APMs such as downside or shared risk and capitation (category 3B and higher in the Health Care Payment Learning & Action Network framework), the clinical model reigns over the financial model, generating the clinical care margin and outlining how patient information is used. Advanced APMs include episode-based payments for specific procedures and population-based payments such as per member, per month, or premium-based payments. Because advanced APMs require that clinicians share in both the risks and potential benefits for patients, they will accelerate the progression toward the true aims of VBC: quality health care that is delivered affordably and in collaboration with the patient.

Employers have a vested interest in a healthy and productive workforce and already invest in the safety, health, and well-being of employees in numerous ways. They have an opportunity to change the trajectory of health care. Doing so, however, will require changing how employees engage in their health care by changing how employers pay for it. In particular, employers that take on full financial risk for their employees' health insurance can engage more holistically in VBC by purchasing innovative solutions to drive market changes, offer incentives to members for healthy behaviors, and impact provider behavior.

Guiding employees to quality providers

Through health insurance and benefits design, as well as employee engagement levers, employers have a track record of influencing health and wellness behaviors. They can encourage the use of preventive care and high-value services from quality health care providers and discourage use of low-value care and services. Most employers collaborate with health services and insurance providers to design a benefits structure that meets the needs of their unique employee population and their families. Some employers with larger populations and other employers that negotiate collectively may contract directly with provider organizations, hospitals, and health systems.

Guiding employees toward value-based arrangements can help ensure an enhanced health care experience, reduce duplication and error in services, and improve quality and continuity of care. A 2022 survey found that 96% of payers agree VBC will result in better quality of care and improved care coordination, and 82% agree it will result in more affordable care. In fact, McKinsey estimates that savings from VBC models could range from 3% to 20%, depending on the incentive model. This can occur through quality provider networks, centers of excellence (COEs), and value-based contracts for specific disease states (e.g., cancer) and episodes of care (e.g., heart attack). According to the Business Group on Health, 79% of large employers use COEs for transplants, 69% use them for bariatric surgery, and a majority expect to implement COEs for other conditions.



Additionally, 43% offer high-performance networks and 30% offer accountable care organizations to their employees. These types of VBC arrangements are opportunities to drive improved results and demonstrate the value of VBC.

The benefits of value-based care

The significance of value-based care is its potential to transform the health care system to one that focuses on keeping people healthy

The essence of value-based care lies in a collaborative approach between health care providers and patients as well as payers and health services partners, where emphasis is placed on achieving positive health outcomes. VBC promotes early disease detection, evidence-based decision making, reduced variations in practice patterns among health care providers, reduced errors, and a reduction in errors or unnecessary care and services. In VBC models, health care providers have access to better patient data and the time to focus on patient care. Providers benefit financially from positive health outcomes and quality of service, and in competitive markets, demonstrating a commitment to providing high-value care can result in preferred status with payers, increasing volume and revenue. In the future, as VBC continues to take hold, the need for utilization management tools such as prior authorization will decrease, offering efficiencies and reducing administrative burdens for providers.

Incorporating a person-centered approach, VBC prioritizes patient engagement, experience, and satisfaction and has been shown to improve shared decision-making between providers and patients. Actively involving individuals in health care decisions builds the knowledge, skills, and confidence they need to feel more in control of their health. That sense of autonomy and ability to engage helps drive improved health and higher satisfaction.

VBC's emphasis on preventive care enables providers to identify potential health risks earlier and intervene to help people maintain and improve their health before long-term issues occur. In addition, health care consumers can avoid unnecessary expenses that result from illness and disease, such as transportation costs to receive care and out-of-pocket costs for care, services, and medications, as well as time away from work and family. This model also helps keep people safe from unnecessary care, such as unneeded radiology studies like CT scans, which may increase risk of cancer over a patient's lifetime, and the overuse of antibiotics, which may impact effectiveness.

VBC Alternative payment models (APMs) incentivize providers to improve quality and reduce costs

Pay for performance

Value-based bonus payments
(CMS Category 1/2)

Payments atop a FFS chassis, awarded based on adherence to specific quality and/or efficiency metrics

Bundled payments

Episode-specific fixed payments
(CMS Category 3)

Retrospective or prospective fixed payments ("bundles") for services linked to a particular episode (e.g., surgery) or condition

Shared savings

Upside-only and two-sided (downside) risk
(CMS Category: 3a upside, 3b downside)

Payments made when medical costs are managed below a given benchmark, with no penalty to providers for costs above the benchmark in upsidenly

Global payments

Partial or full capitation
(CMS Category 4)

Fixed payments to manage all or a portion of costs for a given population. In global cap, providers assume full risk

Total cost of care savings

1-2% of TCC → **20+%** of TCC

Advanced risk models (bundles, downside risk, global capitation) dramatically increase the value capture opportunity

For employers, the benefits of a healthy workforce extend beyond decreased health care costs. Higher productivity, increased employee engagement, greater commitment to the company, and higher retention all contribute positively to business impact. In a 2021 Economy Impact study of health executives, a majority agreed investment in employee health and well-being has a direct influence on a company's financial performance. Talent attraction and retention is also an increasingly key consideration.

Ultimately, the significance of VBC is its potential to transform the health care system to one that focuses on keeping people healthy through personalized, equitable, quality care and services. By emphasizing proactive preventive care, early intervention, and effective management of chronic conditions, VBC aims to reduce the prevalence of illness, disease, and complications that result in costly hospitalizations and emergency department visits. Furthermore, while VBC initially focused on primary care physicians, models are evolving to include downstream care, specialist intervention, and management of chronic conditions. This approach not only reduces the financial burden on patients but also decreases health care expenditures for payers, including health insurance providers, employers, and the government.

Headwinds

Employee & operational resistance

Employee turnover

Provider readiness

Stakeholder resistance

Technology & interoperability

Legal & regulatory policies

Challenges on the path to value-based care: Headwinds of change

Despite the numerous benefits when employers approach health care differently, the status quo largely persists. This is due to many reasons, including the complexities of the health care ecosystem, employee and operational resistance, and employee turnover. Systemic change requires a longer-term perspective of health care as well as organizational effort and commitment, but the current system – in which employers often make changes to the health benefits they offer annually and employees may be able to change their health benefit selections each year – rewards short-term thinking.

Historically, some VBC approaches, such as bundled payments for episodes of care, may have cost more up front and focused on a narrow scope of claims and coverage, but newer models are being developed to meet both the short- and long-term needs of employers and are expected to provide sustained savings over time via holistic care models and even prevention-based bundles.

Value-based care requires a connected health ecosystem

When switching to these newer models, employers should be prepared to see improved experiences and outcomes before they see cost savings. The potential for improving population health that results in meaningful cost savings may take time as care becomes more connected and people experience improved health outcomes. The alternative is the status quo, which is increasingly unsustainable.

Provider readiness is also a concern. It takes a lot of time, effort, and resources to succeed in VBC. It requires a connected ecosystem of technology, data and analytics, care coordination, incentive structures, patient engagement, and more. Without providers who are ready and able to practice within a VBC model, it will be challenging to take hold. Additionally, the lack of rate standardization in commercial VBC, in contrast to Medicare, poses a major challenge to providers in predicting and thus controlling costs. This is particularly difficult with respect to downstream specialist referrals. The creation of commercial "networks within networks" may help solve for this.

Several other stakeholders with a vested interest in the status quo also play a role in health care. Engaging employees to change their behavior can be challenging on any issue, and their health and well-being is no exception. Employees may perceive these actions as a means of cost-cutting only, rather than purposeful with positive intent. Employee support requires trust, which takes time and effort to build. With multiple competing priorities for employer decision-makers, the status quo is often the path of least resistance – and the path taken.

The broker and consultant community also face disruption with the adoption of VBC, but they have proven time and again that they can adapt. They will likely begin to think differently about how they assign value in the coming years as health services companies and payers shift how they deliver value and patients begin to engage with their health in new ways.

First, the collection and analysis of vast amounts of data is the foundation of coordinated care across providers, systems, and sites of care. Equally important is the ability to assess health outcomes, measure value, and optimize payment. The lack of standard, universally accepted measures and variations in systems may make it difficult to reliably compare and assess the value provided by different providers. Achieving interoperability and integrating data from different sources is a complex, time-consuming, and costly process, especially in a fragmented health care system, and the ability to do so will continue to be a prerequisite to change. Likewise, expanding access to digital tools will allow providers focusing on VBC to manage patient care more effectively.

Existing legal and regulatory frameworks also present obstacles to implementing VBC initiatives. Antitrust laws, privacy regulations, and reimbursement models designed around fee-for-service require adaptations to support the transition to VBC and create a supportive environment for employers.

Tailwinds

Unsustainable costs

Innovation

Social determinants

Consumers

Government programs

Environmental factors demanding action: Tailwinds of change

The cost of health care is increasingly untenable for consumers, employers, and others in the ecosystem – and there is no indication of abatement. Annual U.S. health expenditures now exceed $4 trillion, of which 90% can be attributed to people with chronic and mental health conditions. The prevalence of chronic conditions, including diabetes, heart disease, and obesity, continues to increase and will drive significant health and economic costs for the foreseeable future.

> **"The prevalence of chronic conditions will drive significant and increasing health and economic costs for the foreseeable future."**
>
> -Dr. David Brailer, EVP, chief health officer, The Cigna Group

U.S. health expenditures now exceed $4 trillion

For employers, this means costs are expected to continue to rise, with average costs increasing 8.5%, to more than $15,000 per employee in 2024, assuming the employer does not implement employee cost-sharing increases. This is almost twice the 4.5% increase to health care budgets that employers experienced from 2022 to 2023. Employees feel the impact of rising costs as well. The average premium for employer-sponsored health coverage for a family increased 20% over five years (2017-2022) and 43% over 10 years. Additionally, indirect costs such as absenteeism, disengagement and reduced work output, and disability add to the employer imperative to drive change. Productivity losses related to personal and family health problems alone are estimated to cost U.S. employers more than $225 billion annually or $1,685 per employee per year.

Adding to the significant pressure for change is the dynamic pharmaceutical development and pricing landscape, including high-cost specialty medications, cell and gene therapies (CGT), and increasing prices of existing drugs. Although specialty medications are used by only 2% of the U.S. population, they currently account for half of total drug spending, and the number of specialty drugs and the conditions they are designed to treat continues to expand. The CGT environment will expand as well to address more common diseases (e.g., diabetes, arthritis), accelerating a shift in clinical focus away from chronic condition management toward disease intervention and prevention. The payment, delivery, and reimbursement system will need to accommodate potential one-time curative and preventive treatments and enable long-term value assessments. Further fueling paying for value, pharmaceutical innovation is a tailwind for health care transformation.

Research demonstrates that social determinants have a greater influence on health than genetic factors or access to health care services. The impact of social determinants of health became more evident during the COVID-19 pandemic and calls for more equitable care became louder. Gaps in the current system will continue to add pressure to address health disparities historically associated with inequitable outcomes (e.g., race, ethnicity, gender identity, sexual identity, rurality). When outcomes are the priority, the factors that impact individual health – social determinants, engagement, and experience – all matter.

As people become more engaged and as technology facilitates transparency and engagement, they will increasingly demand personalization, convenience, and affordability from their employer-sponsored health benefits and insurance.

The government is paving the way for VBC with providers. The Affordable Care Act introduced reforms to improve access to VBC in 2010 and CMS set targets to ensure all Medicare and most Medicaid beneficiaries will be in value-based payment models by 2030, which means any provider who receives reimbursement from government programs will know how a VBC model works by the end of the decade. Employers will be able to learn from these programs and will have a smoother road to implementing VBC.

The commitment to transformation

As the movement toward VBC grows ever more necessary, the role of employers cannot be overstated. Their influence as drivers of economic growth, as health care payers, and as stewards of workforce health are profound, and they are uniquely positioned to drive change. Incremental progress requires a systemwide goal of employers committing to value-based care. Systemic transformation requires a paradigm shift – business leaders must feel a sense of collective responsibility to ensure an overall healthy American workforce that will fuel a sustainable, strong, and vibrant economy.

While challenges remain, evidence suggests the benefits of value-based care, including improved quality, health equity, cost-effectiveness, and health outcomes, are worth striving to attain. By embracing their role in the health care system and working collaboratively over time, employers can advance systemic transformation. The ripple effect of value creation will extend beyond healthier, more productive individuals and families, workplaces, and communities to a stronger economy and thriving society.

Explore more ways to unlock the full potential of value-based care at: Evernorth.com/value-based-care