An Association of Independent
Blue Cross and Blue Shield Plans

Building Tomorrow's Healthcare System

The Pathway to High-Quality, Affordable Care in America

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Executive Summary

Executive Summary

The Blue Cross and Blue Shield Association and its 39 independent, locally based companies envision a transformed healthcare system that provides people with the best, most affordable care possible. To build tomorrow's healthcare system, we must take comprehensive action to reward quality and safety and tackle rising healthcare costs.

Healthcare spending in the United States exceeds $2.5 trillion annually and strains the budgets of America's families, businesses and governments. Too much of this money is not well spent. One study estimates that at least 30 cents of every healthcare dollar goes to care that is ineffective or redundant (Fisher and Wennberg, 2003).

At the same time, patients have only a 50-percent chance of getting the most advisable care, with "dangerous gaps" between known best practices and the care that Americans actually receive (Schuster, 1998 and Robert Wood Johnson Foundation, 2010). Hundreds of thousands of patients continue to experience medical errors each year, costing billions of dollars in avoidable healthcare spending.

Rising healthcare costs affect us all. We must act now to improve quality and rein in unsustainable costs — to begin Building Tomorrow's Healthcare System . . . today.

Tomorrow's healthcare system should deliver safe, high-quality care; eliminate inefficient spending; and encourage and reward actions individuals can take to improve their health. We must address key components of care delivery rather than continue to simply shift costs across the system. For example, when public programs underpay providers, it impacts healthcare costs for everyone. One study found that the rates paid to providers by private payers can increase by 15 percent due to low Medicare and Medicaid provider payments. This in turn increases premiums for consumers and employers (Milliman, 2008).

The Blue Cross and Blue Shield System is working locally across the country to help people stay well and ensure that, when they do get sick, healthcare is safe, coordinated, evidence-based and affordable. To achieve these goals on a larger scale, we propose a comprehensive, interconnected action plan with specific recommendations that the government should take to:

1. **Reward Safety:** National and local leadership along with new provider incentives are needed to eliminate preventable medical errors, infections and complications that cause tens of thousands of people to die each year.

2. **Do What Works**: The incentives in our system must be changed to advance the best possible care and reward quality outcomes, instead of paying for more services that are ineffective or redundant and add unnecessary costs to the system.

3. **Reinforce Front-Line Care:** A higher value must be placed on primary care and on ensuring there is an adequate workforce of professionals to deliver necessary, timely and coordinated care that results in better outcomes and lower costs.

4. **Inspire Healthy Living:** With 75 percent of today's healthcare dollar spent on the treatment of chronic illnesses — many of which are preventable — consumers must be empowered and encouraged to make better choices, live healthier lives and better manage their health.

This document provides representative examples, but is not exhaustive of what the 39 independent Blue Cross and Blue Shield companies are doing to help transform the U.S. healthcare system. As leaders in the healthcare community for more than 80 years, serving all 50 states and federal territories and offering coverage in every market and every ZIP code, we are committed to collaborating with all stakeholders — consumers, hospitals, physicians, payers and policymakers — to build tomorrow's healthcare system today.

Overview

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Reward Safety

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Do What Works

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Reinforce Front-Line Care

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Inspire Healthy Living

WHAT THE BLUES ARE DOING

WHAT THE GOVERNMENT SHOULD DO

What the Blues are doing:

- Designing incentive programs to ensure safety
- Preventing harm to patients
- Harnessing technology to drive safety
- Managing pharmacy benefits to protect patients

What the government should do:

- Provide sustained leadership
- Incorporate incentives in Medicare and Medicaid to promote safety
- Use technology to drive safer, better care
- Promote medication safety

What the Blues are doing:

- Rewarding quality care
- Building high-quality networks
- Putting research and analytics into practice
- Reducing medication costs while ensuring safety and efficacy
- Preventing and fighting healthcare fraud

What the government should do:

- Expand value-based payment in Medicare
- Make care coordination available to all Medicare beneficiaries
- Encourage Medicare beneficiaries to use high-quality providers
- Support the use of evidence-based medicine
- Enact malpractice reform
- Increase use of generics
- Attack healthcare fraud and abuse

What the Blues are doing:

- Coordinating care to better manage chronic illness
- Enhancing the practice and delivery of primary care
- Investing in the primary care workforce

What the government should do:

- Ensure government payment policies recognize the value of primary care
- Align federal delivery system reform initiatives with private sector best practices to promote primary care
- Improve care for "dual eligibles" and others by promoting managed care
- Use federal dollars wisely to leverage the full primary care workforce
- Evaluate the impact of provider consolidation on access to high-quality primary care

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What the Blues are doing:

- Identifying and addressing gaps in care
- Prioritizing healthy lifestyles
- Combating obesity by encouraging healthy eating
- Advocating healthy pregnancies and safe deliveries

What the government should do:

- Expand government initiatives to reduce healthcare disparities
- Support physical activity and wellness in schools, the workplace and the community
- Stress the importance of healthy eating and support good nutrition through federal initiatives
- Promote safe deliveries and improve maternal health

1 Reward Safety

More than a decade has passed since the Institute of Medicine's landmark report, *To Err is Human*, estimated that 98,000 people die each year from preventable medical errors. With hundreds of thousands of patients being harmed while seeking treatment, much work remains to be done. In the Medicare program alone, preventable adverse events have been estimated to cost hundreds of millions of dollars annually.

Infections acquired during healthcare treatments are among the leading causes of preventable complications. Many times, these infections could be avoided through simple strategies such as proper handwashing or posting safety checklists.

Keeping patients out of harm's way will not only save lives and prevent injuries, it will save billions of dollars.

WHAT THE BLUES ARE DOING

- Designing incentive programs to ensure safety
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WHAT THE GOVERNMENT SHOULD DO

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WHAT THE BLUES ARE DOING

Designing incentive programs to ensure safety

Highmark Blue Cross Blue Shield's QualityBLUE hospital pay-for-performance program aligns reimbursement with high-quality care and improved outcomes for patients. Through a partnership with 81 hospitals and about two-thirds of the primary care physicians in Highmark's network, QualityBLUE addresses key healthcare quality issues such as reducing healthcare-associated infections. Based on both clinical and performance measures, Highmark conservatively estimates that reductions in healthcare-associated infections such as methicillin-resistant Staphylococcus aureus (MRSA) and central-line infections for the most recent four years, and the reduction of surgical site infections, deep vein thrombosis and pulmonary embolism in 2011, resulted in at least $48 million in savings. Hospitals participating in QualityBLUE prevented 2,796 adverse events, saving at least 384 lives through initiatives to improve healthcare quality and patient safety.

Anthem Blue Cross and Blue Shield's initiative, Quality-In-Sights®: Hospital Incentive Program (Q-HIP®), financially rewards hospitals for practicing evidence-based medicine and implementing industry-recognized practices in the areas of patient safety, health outcomes and member satisfaction. The program drives improvements in health outcomes for patients in approximately 530 hospitals across the 14 states involved. For example, angioplasty complications decreased

by 47 percent among participating hospitals. In addition, a new component of Q-HIP will require that hospitals renewing their contracts with Anthem Blue Cross and Blue Shield report quality benchmarks to qualify for a rate increase. This change is anticipated to reduce growth in the amount spent on inpatient care by three to five percentage points annually.

Horizon Blue Cross and Blue Shield of New Jersey, Inc. incorporates healthcare-associated infection (HAI)-related measures into its Horizon Hospital Recognition Program. Horizon also covered a large portion of the costs for hospitals to acquire technology that empowers healthcare providers with actionable data and tools to educate staff and change procedures, resulting in fewer HAIs and saved lives. From 2005-2010, more than 10,000 HAIs have been avoided at the 23 participating hospitals, representing an estimated overall healthcare savings of nearly $36 million.

Preventing harm to patients

Blue Cross Blue Shield of Michigan is a key partner and funding source for the Michigan Health & Hospital Association's Keystone: ICU Program, which has dramatically reduced central line-associated bloodstream infection (CLABSI) rates and ventilator-assisted pneumonia rates in ICU patients. The program is now used as a model for national CLABSI initiatives. More than 70 Michigan hospitals participate in this program, representing the most successful regional partnership of ICUs assembled for a single patient safety initiative. In six years, the initiative saved more than $300 million and 1,830 lives, eliminating an estimated 140,700 avoidable hospital days for patients.

Preventing Readmissions through Effective Partnerships (PREP) is a landmark quality collaborative between **Blue Cross and Blue Shield of Illinois** and the Illinois Hospital Association (IHA) to significantly reduce Illinois hospital readmissions by 2014 through redesigning hospital discharge processes. According to the Commonwealth Fund, Illinois ranks 44th in the nation with a 20.3 percent Medicare 30-day hospital readmission rate, well above the nationwide median. As part of this collaboration, more than 200 Illinois hospitals have pledged to reduce readmissions, with a goal of raising the state's performance from the bottom quartile to the second quartile nationally.

Blue Cross and Blue Shield companies are working with hospitals to encourage them to adopt the **Blue Surgical Safety Checklist℠**, a one-page tool that itemizes essential safety steps that surgical teams should perform at three key stages of surgery. In addition to sharing this checklist with hospitals and physicians, Blue companies are sharing it with their members to review and discuss with their healthcare team prior to surgery. Research published in the *The New England Journal of Medicine* found that hospitals that implemented the World Health Organization's Checklist, the foundation for the **Blue Surgical Safety Checklist**, showed a 36-percent decrease in complications and mortality rates arising from errors in the operating room.

Harnessing technology to drive safety

Blue Cross and Blue Shield of Alabama works with the Alabama Hospital Association and more than 60 hospitals statewide through the Alabama Hospital Quality Initiative by providing tools and technology to eliminate healthcare-associated infections (HAIs). The company has underwritten most of the costs for hospitals to acquire technology that reduces HAIs by equipping clinicians with real-time, hospital-wide information that pinpoints actionable opportunities to prevent infection. Hospitals also convene quarterly to share best practices in infection prevention. The statewide initiative is estimated to have saved 316 lives and $7.8 million in 2010 by preventing HAIs in 1,520 patients and avoiding 12,152 hospital days.

The "Virtual Intensive Care Unit" is a partnership program spearheaded by **CareFirst BlueCross BlueShield** and Maryland eCare LLC to address a shortage of intensivists, specially trained critical care physicians, to monitor and provide care for 7,000 patients in six intensive care units (ICUs) within five hospitals throughout rural Maryland. The virtual care concept utilizes a central ICU to remotely monitor patients and coordinate care through nurses working at their respective hospitals. Early results of the program demonstrate significantly decreased patient mortality rates, length of stay and turnover of ICU staff. All participating hospitals are consistently meeting or exceeding the program goals to improve care and quality outcomes for rural Maryland residents.

Blue Cross & Blue Shield of Rhode Island's Quality Counts program, which began in November 2005, is designed to incent primary care physicians (PCPs) to implement multifunctional electronic health record (EHR) systems in their offices. Through the initiative, the company partially funds physician practices' EHR adoption and provides bonus payments based on mutually agreed-upon quality measures. To date, 80 PCPs have fully implemented EHRs in their practices; those that have been using EHRs for one year or more are required to write e-prescriptions for certain medications at least 60 percent of the time. Quality metrics were selected to reflect providers' attainment or improvement in immunizations, blood pressure control, cholesterol control and preventive screening exams and are demonstrating positive results to date. For all these measures, Family Medicine and Pediatrics experienced a 44-percent improvement; Women's Care experienced a 35-percent improvement; and Internal Medicine achieved a 24-percent improvement.

Managing pharmacy benefits to protect patients

Capital BlueCross in Pennsylvania implemented a Medication Reconciliation Outreach Referral program that focuses on patient transition from hospital to home. This program incorporates a collaborative approach between the member, a pharmacist, an outreach nurse and the company's clinical management programs. Ninety-one percent of members surveyed felt this program helped them better understand their hospital discharge instructions, and 88 percent felt participation improved understanding of their medications. Based on the outcomes of the pilot, a comprehensive transition of care program is in place to screen 100 percent of members discharged from hospital to home for potential medication, resource or coordination of care issues.

The **Blue Cross and Blue Shield Association** and **Blue Cross and Blue Shield companies** in 24 states supported and promoted the **Drug Enforcement Agency's (DEA) National Drug Take-Back Day** in 2011. The Blue System is leading efforts to increase patient safety through proper handling and disposal of unused medication. The DEA reported that the 5,361 Drug Take-Back Day sites collected 376,593 pounds of medication. That amounts to almost 500 milligrams per person in the U.S., and represents an almost 50-percent increase from the first Drug Take-Back Day in 2010.

WHAT THE GOVERNMENT SHOULD DO

Provide sustained leadership

The Department of Health and Human Services (HHS), along with public and private partners, has focused on eliminating the medical errors, infections and complications that cause harm to hundreds of thousands of patients each year, but more can be done. HHS should convene public and private stakeholders to continue defining the source of the problem and identify effective solutions. This must be among the highest priorities for HHS and related institutions.

- As the Partnership for Patients — a new public-private partnership to help improve healthcare quality and safety for all Americans — progresses, the government could show further leadership and help bolster local progress by issuing reports that highlight common problems; quantify the scope of the problem; propose pathways for improvement; share results in fixing problems; and showcase best practices.
- Congress should reinforce the importance of patient safety at federal agencies such as the Centers for Medicare and Medicaid Services (CMS) and the Food and Drug Administration (FDA). Congress should provide additional resources to support safety-related activities such as scientifically rigorous reviews and surveillance of drugs and medical devices.

Incorporate incentives in Medicare and Medicaid to promote safety

Medicare and Medicaid have taken meaningful steps to address safety, but additional actions must be taken to stop avoidable errors such as drug-to-drug interactions and other preventable complications that can occur in a healthcare setting.

- The government should expand current initiatives by refining or incorporating new patient safety measures in pay-for-quality programs.
- It can take several years to incorporate a new measure into Medicare's Hospital Value-Based Purchasing (VBP) Program. CMS should develop a fast-track process for incorporating new, high-priority safety measures in hospital VBP and in Medicaid fee-for-service.

Use technology to drive safer, better care

Technology has the power to transform healthcare delivery by improving the safety and overall quality of each patient encounter. To encourage better use of technology, the government should:

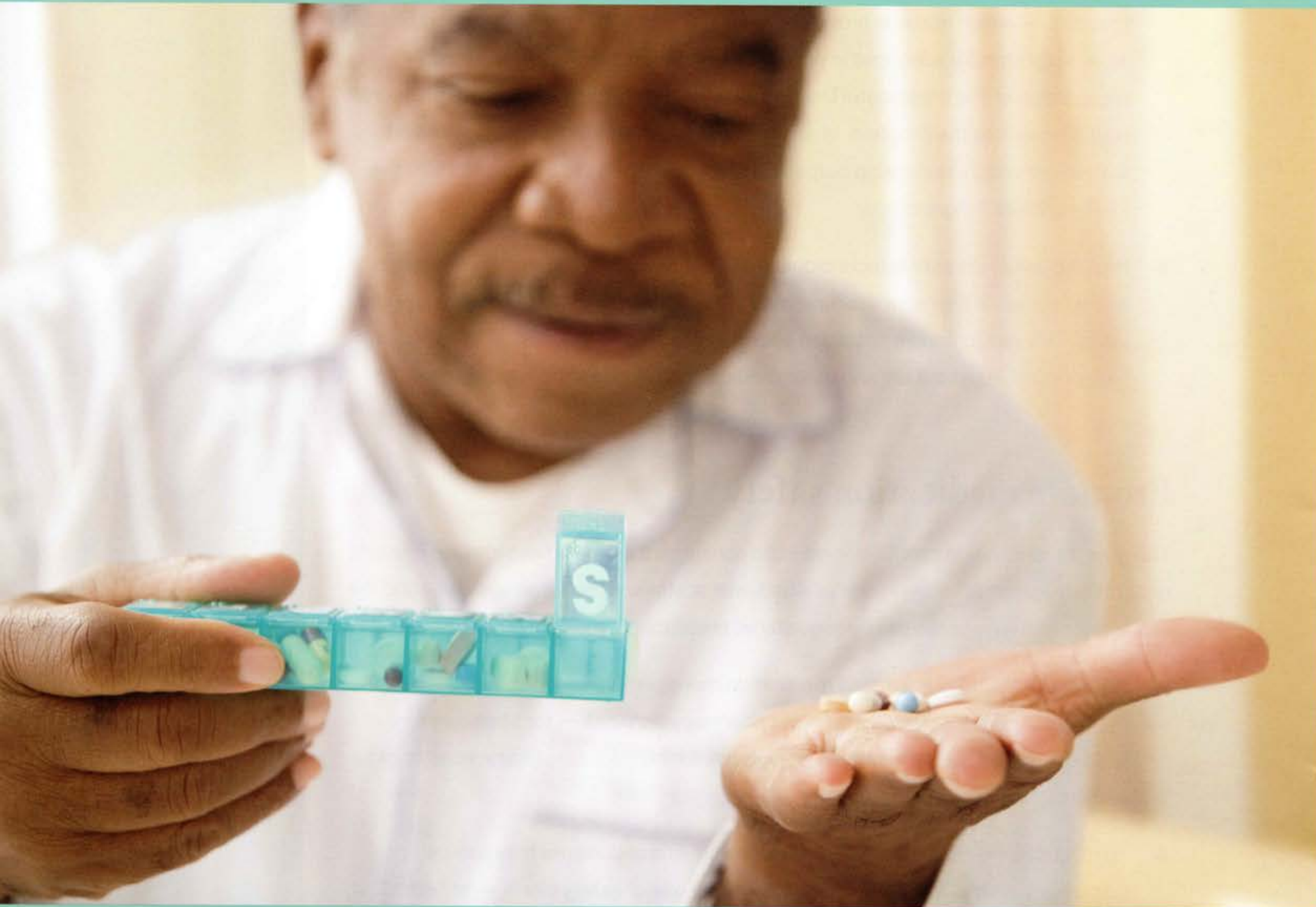
- Use the Medicare and Medicaid Electronic Health Record (EHR) Incentive Program — which rewards providers for the "Meaningful Use" of certified EHRs — as a platform for advances in patient safety. Safety should be made a core expectation of the Meaningful Use Program, with safety-related quality measures built directly into the program. In addition, the federal government should work with stakeholders to develop outpatient safety measures to incorporate into the EHR Incentive Program.
- Pilot the use of innovative technologies, such as the virtual ICU, to improve safety and outcomes in intensive care units and other critical care settings in underserved areas. This would enable physician specialists to be available "virtually" to treat patients and assist nurses and other medical staff in providing the best care.

Promote medication safety

The government should continue to educate consumers on the adverse health impacts of certain drug interactions — such as accidental acetaminophen overdosing — and the importance of taking prescriptions regularly as prescribed ("medication adherence").

- HHS should employ enhanced medication management techniques —reminder mailings or phone calls and mail order pharmacy services — for Medicare and Medicaid beneficiaries identified as high risk for harmful drug interactions or gaps in medication adherence.
- To minimize the risks of negative drug interactions and assure they can be addressed rapidly, HHS should encourage the use of safety alerts — or "edits" — at the time a physician writes a prescription. This would be in addition to edits already in place at the pharmacy counter.
- The government should continue to educate consumers about the importance of safe drug disposal to prevent misuse and abuse, including leveraging and expanding the Drug Enforcement Administration's successful Drug Take-Back initiative.

2 Do What Works



Evidence clearly shows that more care does not necessarily mean better care. An estimated 30 percent of healthcare spending goes toward ineffective or redundant care (Fisher and Wennberg, 2003). In real terms, this means as much as $750 billion of America's $2.5 trillion annual healthcare spending may not be well spent. We need to change incentives to promote higher quality, evidence-based care for all patients.

Today, providers generally are paid based on the number of services they deliver, regardless of effectiveness. This is due partly to medical professionals not having ready access to information about which treatments and services work best. Studies have shown long delays — perhaps as much as 17 years — before scientific findings about what works best get incorporated into everyday practice (Institute of Medicine, 2001).

By identifying best practices and putting them to use more quickly, the government and private sector can improve quality, help control rising costs and reduce inefficiency in our healthcare system.

WHAT THE BLUES ARE DOING

- Rewarding quality care
- Building high-quality networks
- Putting research and analytics into practice
- Reducing medication costs while ensuring safety and efficacy
- Preventing and fighting healthcare fraud

WHAT THE GOVERNMENT SHOULD DO

- Expand value-based payment in Medicare
- Make care coordination available to all Medicare beneficiaries
- Encourage Medicare beneficiaries to use high-quality providers
- Support the use of evidence-based medicine
- Enact malpractice reform
- Increase use of generics
- Attack healthcare fraud and abuse

WHAT THE BLUES ARE DOING

Rewarding quality care

Blue Cross and Blue Shield of Massachusetts' Alternative Quality Contract (AQC), launched in January 2009, replaces the typical fee-for-service model with a modified global payment model, designed to encourage cost-effective, patient-centered care by paying participating physicians and hospitals for the quality, not the quantity, of the care they deliver. The new model combines a per-patient global budget with performance incentives based on nationally endorsed measures tied to quality, health outcomes and patient experience. Physicians and hospitals provide the care they believe is needed to improve the health of their patients, giving them the flexibility to directly contact patients (e-visits), offer group visits for patients who share a common chronic illness, or provide follow-up home visits for patients after hospitalizations. This program already has positively affected major healthcare cost drivers. For example, while AQC groups reduced their readmission rates, avoiding $1.8 million in related costs, the rates for the rest (non-AQC) of the network increased.

WHAT THE BLUES ARE DOING

Blue Cross and Blue Shield of Minnesota is partnering with the largest healthcare systems in the state on an Aligned Incentive Contracting model that is designed to achieve accountable care. This multi-year contract between the provider and insurer, ties provider payment increases to their ability to improve quality and lower costs during a three-year term. While the program is still in its infancy, these efforts are already showing promise. Findings indicate that the cost trend is below the national average while quality has remained high. Through collaboration, Blue Cross and Blue Shield of Minnesota and providers in the state were able to re-engineer the payment structure to make it possible for patients to get high-quality healthcare at a lower cost.

Blue Cross Blue Shield of North Dakota has collaborated with the state's healthcare providers to launch the Sustainable Health Initiative, an action plan designed to reduce the medical inflation trend by 1.5 percent, a potential savings of $30 million, during the next three years. Designed to ensure a sustainable and affordable healthcare system in the state, the initiative is focused on developing local solutions to the issues of cost, quality and access to care. Though in its first year of implementation, many of the innovative programs included will impact quality and efficiency of care.

Since 2006, **Wellmark Blue Cross and Blue Shield** partnered with an industry-leading radiology benefit management company to ensure appropriate outpatient diagnostic imaging utilization, the use of evidence-based clinical criteria and appropriate exchange of member information. Appropriate management of diagnostic imaging services helps patients receive appropriate, quality radiology services while minimizing unnecessary costs and exposure to radiation. Diagnostic imaging is one of the fastest-growing medical expenditures in the U.S. for public and private payers. While much of this growth can be attributed to the improved diagnostic capabilities of new technologies and to the rapidly aging population, it is estimated that as much as one-third of all outpatient imaging is clinically unnecessary. The program has consistently demonstrated an annual return of at least 3-to-1 and realized a gross return on investment of over 10-to-1 in its first two years.

Building high-quality networks

Blue Cross and Blue Shield companies and the **Blue Cross and Blue Shield Association** developed **Blue Distinction®**, a national quality and value-based designation program designed in close collaboration with the medical community, to recognize medical facilities demonstrating expertise in delivering high-quality specialty care efficiently. Consumers and employers expect their health insurers to continuously identify solutions that improve the quality and value of care. While the Blue Distinction program began as a designation based purely on quality (e.g., 21-percent lower readmission rate for cardiac bypass procedures for Blue Distinction Center (BDC) vs. non-BDC), it is evolving to become a designation awarded to facilities that not only meet stringent quality measures focused on patient safety and outcomes but also meet clear cost measures. BDCs today help identify programs with better overall patient results and value in the areas of bariatric surgery, cardiac care, complex and rare cancers, knee and hip replacement, spine surgery and transplants. These categories address medical services that comprise more than 30 percent of today's total inpatient hospital expenditures.

Anthem Blue Cross and Blue Shield developed the Care Comparison tool that serves as the foundation for a nationwide cost-based shopping tool designed to help Blue members make informed healthcare decisions when choosing a healthcare provider. By year-end 2011, the tool will contain nationwide cost data for more than 100 of the most commonly billed elective inpatient, outpatient, diagnostic and office-visit procedures. It is designed to help members understand the typical costs associated with all aspects of a medical procedure and is made available to members in the majority of markets nationwide. Blue members can compare the differences in costs among hospitals as well as get information about how frequently facilities perform each procedure, which can assist members in making more informed decisions.

BlueCross BlueShield of Tennessee's Quality and Cost Transparency Program provides members access to clinical quality and cost-of-care information for physicians and hospital facilities via a secure, Web-based provider directory. Using nationally recognized quality indicators, a statewide physician advisory panel helped select a set of measures used to evaluate the performance of physicians. Included with the quality measures are cost ratings based on claims data. The performance results for physicians and hospitals are available online to showcase high-quality healthcare providers. This online directory along with telephonic support from care coordinators allows members to research their best options for chronic care services.

Putting research and analytics into practice

Excellus BlueCross BlueShield worked with local cardiologists to understand, measure and address gaps between clinical practice and evidence-based guidelines regarding variation in practice patterns for non-invasive and invasive cardiac diagnostic testing. As a result of this collaborative approach, trends in testing from 2007 to 2010 revealed a 35-percent decrease in nuclear stress tests and a 6.3-percent decrease in cardiac angiography. This effort with the cardiology community clearly reduced Excellus members' unnecessary exposure to radiation and related risks.

Founded in 1985, the Blue Cross and Blue Shield Association's **Technology Evaluation Center** pioneered the development of scientific criteria for assessing the effectiveness of medical devices, procedures and biological products through comprehensive reviews of clinical evidence. As one of 14 Evidence-based Practice Centers (EPCs) for the U.S. Agency for Healthcare Research and Quality, TEC assessments are based on objective clinical and scientific evidence used to evaluate whether a technology improves key health outcomes. TEC most recently has taken a national leadership role in the evaluation and analysis of evidence in the rapidly proliferating area of genetic testing and pharmacogenomics (i.e., how a person's genetic make-up interacts with a drug's effectiveness). TEC produces evidence-based healthcare technology assessments that are publicly available at www.bcbs.com.

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Blue Health Intelligence (BHI®) leverages Blue data representing the healthcare experience of more than 110 million individuals nationwide to improve the delivery of care. BHI's advanced analytics and applied research studies produce findings that improve medical cost and network management, increase operational efficiency and support consumer engagement. BHI analytics quantify variation in quality, utilization and cost, for example, by measuring the impact of specific co-morbidities in knee replacement patients. Blue companies have identified leading providers and instituted pre-surgical programs that minimize complications.

BHI's sophisticated predictive models include the identification of individuals at greatest risk of hospitalization due to diabetes-related complications. By focusing on modifiable risk factors, health plans design patient and provider programs targeted to meet unique patient needs. BHI is a leader in delivering the next generation of data-driven information about healthcare trends and best practices resulting in healthier lives and affordable access to safe and effective care.

Reducing medication costs while ensuring safety and efficacy

Premera Blue Cross of Washington's Polypharmacy Program has been touted by Harvard Medical School researchers as "... a simple yet effective example of what we can do to improve safety and reduce medical errors and healthcare costs." The program helps engage members in understanding how medications work by identifying members older than 19 years of age who are taking five or more medications. These members, more than 166,000 to date, are sent proactive communications educating them about the increased risks for medication-related problems and the importance of reviewing all medications with their healthcare providers. An observational study showed decreased emergency room and hospital utilization rates in members the year after they were sent the educational materials, as compared with the year before. Member research also showed that since the program's inception in June 2001, there has been a measurable decrease in inappropriate treatment or dosage: 29 percent reported medication changes, 64 percent reported dosage changes and 57 percent reported that a medication was stopped.

Blue Cross of Idaho Health Service implemented a pharmacy program that used coupons as an incentive to move members from prescription drugs to appropriate over-the-counter (OTC) alternatives that offered similar quality and greater value for members using non-sedating antihistamines. The program decreased the company's drug and prescription processing costs overall and achieved $1.9 million in savings, nearly double the initial target.

Preventing and fighting healthcare fraud

Blue Cross and Blue Shield companies actively work to combat healthcare fraud and abuse. Anti-fraud efforts protect consumers' health and lives, and help save consumers' healthcare dollars. Blue companies' investigators work alongside federal, state and local enforcement authorities and other anti-fraud organizations to investigate and prosecute healthcare fraud. Blue companies' anti-fraud investigations have resulted in an annual average of $326 million in savings and recoveries for the past five years, totaling more than $1.6 billion.

Anthem Blue Cross and Blue Shield (Georgia) detected suspicious billing practices by a provider. In-depth data analysis revealed excessive provider billing, namely surrounding protracted treatment times. Undercover activities by the company's internal Fraud and Abuse team revealed evidence, including intent to defraud and kickback arrangements. The investigation was referred to the Federal Bureau of Investigation and the U.S. Office of Personnel Management. This investigation resulted in the indictment and conviction of three providers, with restitution of $6.6 million ordered by the court and the closing of clinics offering fraudulent services.

Expand value-based payment in Medicare

The fee-for-service (FFS) Medicare program effectively rewards providers when they deliver more services, regardless of quality or value. While the Affordable Care Act includes a number of pilots and demonstrations to expand the use of value-based payment in federal programs, the government must move more aggressively to implement fundamental payment reforms to shape a higher quality healthcare system. It is important to assure adequate overall payments to providers under these revised systems to avoid merely shifting costs from one program or payer to another.

- The government should link a portion of payment to quality for all Medicare provider types. Although a phased approach may be necessary while quality measures are under development, Medicare must move away from the disconnected FFS payment models, shifting to quality-based bundled payments and more patient-centered models like "medical homes" and Accountable Care Organizations, where primary care providers and patients engage to comprehensively coordinate the patient's healthcare needs.
- The government must continue to encourage collaborative development and widespread adoption of consensus-based quality measures for all provider types. Measures used for purposes of payment should be widely agreed upon and focus on health outcomes as well as processes of care.

Make care coordination available to all Medicare beneficiaries

The Medicare Advantage (MA) program offers seamless access to traditional Medicare benefits and prescription drugs with a focus on care coordination. Reports have shown improvements in healthcare outcomes for MA enrollees.

- The government should assure continued access to a wide range of MA options for Medicare beneficiaries, with payment rates sufficient to sustain valuable features like comprehensive care coordination and disease management.
- The government should explore new initiatives to encourage coordination of care for Medicare beneficiaries in the FFS program. To ensure appropriate, high-quality, coordinated care, beneficiaries should be encouraged to seek support, such as one-on-one nurse health coaching and hospital pre-admission or post-discharge counseling. Additional outreach should be directed at beneficiaries with chronic conditions to assist them in better managing their health to decrease the use of emergency rooms and inpatient services.

Encourage Medicare beneficiaries to use high-quality providers

Federal programs should make it easier for consumers and their loved ones to identify high-quality providers.

- Consumers should have access to cost information for common procedures available to them on Medicare's "Compare" websites for hospitals and physicians in addition to the currently available quality scores. For example, prior to scheduling an operation, beneficiaries and their family members should be able to analyze facilities' typical costs from admission to discharge or for an entire outpatient stay. Information regarding the "price" of high volume or routine physician procedures should be displayed to show the beneficiary's likely out-of-pocket costs and the amount Medicare would pay. Cost information by service area also should be included for a particular service or procedure.
- Medicare should test the impact of financial incentives, such as a modified fee-for-service cost-sharing structure, to encourage beneficiaries and others to seek care from providers who score well on key quality measures, as reported on Medicare's "Compare" websites.
- In the Medicare Advantage program, the government should allow differential networks and tiered cost-sharing for medical benefits to give beneficiaries options to seek higher quality care at lower costs.

Support the use of evidence-based medicine

The government must bolster the use of evidence-based medicine by developing research on what works, sharing best practices and actively managing services and technologies at high risk for misuse in federal programs.

- The government should continue to prioritize funding for the evaluation of clinical effectiveness of different procedures, drugs, devices and biologics, including the Food and Drug Administration, the Agency for Healthcare Research and Quality and the Patient-Centered Outcomes Research Institute (PCORI).
- The government should work with PCORI and others to analyze best practices for disseminating comparative effectiveness research (CER). Federal agencies should make CER findings widely available in varying formats and channels to reach as many populations as possible.
- The government should play a leadership role by using the federal Meaningful Use Program to accelerate the adoption of clinical decision support tools that help increase provider awareness and usage of evidence-based guidelines.
- Medicare should actively manage potentially harmful and costly technologies with a high risk of overuse or misuse, such as advanced imaging services. Prior authorization and beneficiary education relating to safety concerns and alternative diagnostic options should be considered. Private Radiology Benefit Managers have demonstrated success in the private sector and could make a substantial impact in public healthcare programs as well.

Enact malpractice reform

Rising malpractice premiums fuel "defensive medicine," which increases utilization of unnecessary and potentially harmful healthcare services. This raises costs for everyone. The federal government should follow the example set by many states and enact comprehensive medical liability reform legislation to not only address rising costs, but also help assure access to necessary services. As a further incentive for adoption of evidence-based practice guidelines, providers who reasonably rely on such guidelines should be given safe harbors for noneconomic (e.g., pain and suffering) and punitive damages. Similar protections should apply to insurers in adjudicating claims.

WHAT THE GOVERNMENT SHOULD DO

Increase use of generics

Taking medications regularly is one key to getting and staying healthy. The government should encourage wider use of safe, effective and affordable medications by consumers — both inside and outside of federal programs — by:

- Adopting quality measures that evaluate generic prescribing practices.
- Looking at the implications of drug assistance programs that promote brand-name drugs rather than the lower-cost generics.
- Shortening the exclusivity period brand-name manufacturers have for biological products to seven years so generic biologics can be brought to market quicker.
- Providing specific funding for the FDA to enhance the timely approval of generics.
- Reviewing and encouraging changes to state laws that limit consumers' ability to receive lower-cost, clinically effective generics.

Attack healthcare fraud and abuse

The government should continue to bolster healthcare fraud prevention and recovery efforts by:

- Upgrading federal data systems to assure fraud trends can be monitored across provider types and geographic regions.
- Collaborating with private sector anti-fraud programs, through greater information-sharing and by reinstituting local multi-payer fraud task forces.
- Taking an active role in ensuring all providers are ready to convert to ICD-10 on time and are fully prepared to utilize the new system accurately to help support fraud detection efforts.

3 Reinforce Front-Line Care

Too often, our healthcare delivery system does little to encourage coordinated care, which produces better health outcomes and saves money (Institute of Medicine, 2006). In Medicare fee-for-service, for example, the average patient sees seven different physicians in four different practices each year, with little or no coordination (Pham, 2007). Also, millions of fee-for-service Medicare and Medicaid patients undergo numerous and sometimes redundant or even harmful procedures each year, with little or no coordination among their physicians.

A strong primary care workforce is key to increasing care coordination and reducing overall healthcare costs, but experts agree there is a significant and growing shortage. Just 37 percent of physicians practice primary care medicine, and only 8 percent of the nation's medical-school graduates enter family medicine (Health Resources and Services Administration, 2008).

To deliver optimal results — improved quality and lower costs — care coordination must be integral to healthcare delivery. Primary care must be prioritized so people can get the care they need, when they need it, with greater efficiency, less redundancy and fewer return trips to the hospital or doctor's office.

WHAT THE BLUES ARE DOING

- Coordinating care to better manage chronic illness
- Enhancing the practice and delivery of primary care
- Investing in the primary care workforce

WHAT THE GOVERNMENT SHOULD DO

- Ensure government payment policies recognize the value of primary care
- Align federal delivery system reform initiatives with private sector best practices to promote primary care
- Improve care for "dual eligibles" and others by promoting managed care
- Use federal dollars wisely to leverage the full primary care workforce
- Evaluate the impact of provider consolidation on access to high-quality primary care

WHAT THE BLUES ARE DOING

Coordinating care to better manage chronic illness

Regence Blue Shield developed a Patient-Centered Medical Home (PCMH) pilot, the Intensive Outpatient Care Program (IOCP), in partnership with a major account, for "highest-risk" employees — those representing 65 percent of the company's healthcare costs. By delivering highly personalized, coordinated care, the program aimed to improve health and employee productivity, increase patient and provider satisfaction and reduce overall costs. Employees in the program received 24/7 access to a care team and a personal registered nurse that worked with the member to develop an integrated care plan. Regence provided patient claims history back to providers to help identify gaps in care and target interventions. In addition to high reported patient and provider satisfaction scores, the pilot resulted in a 14.8-percent increase in patient-reported physical function and a 16.1-percent increase in mental function. The average number of patient-reported workdays missed in the last six months of the pilot decreased by 65.5 percent. Healthcare costs of pilot participants were 20 percent less than the control group, primarily due to reduced emergency room use, hospital admissions and inpatient days.

WHAT THE BLUES ARE DOING

Horizon Blue Cross and Blue Shield of New Jersey, Inc. pays for what are traditionally non-covered care coordination activities such as telephonic consultations and reaching out to patients who may need additional assistance with taking their medications or keeping doctor's appointments. The company uses claims' data to identify and alert providers when patients need routine tests and screenings. In one program covering 7,000 State Health Benefit members with diabetes, patients' compliance with tests rose substantially, and overall healthcare costs decreased by nearly 10 percent in one year.

Blue Cross of Idaho Health Service provides one-on-one nurse health coaching and outreach to members who visit the ER or receive inpatient services due to congestive heart failure. By using a team-based and patient-centered approach, the program helps ensure that members take the correct medications and receive the necessary screenings and follow-up care. Biometric monitoring equipment is shared with high-risk members with congestive heart failure, enabling them to report their conditions from home. The program collectively achieved more than $1 million in medical claims cost savings in a single year, and a recent in-depth medical cost savings analysis revealed an average return on investment of 4-to-1 for members who participate in disease management programs. Blue Cross of Idaho offers disease management programs for members with diabetes, chronic obstructive pulmonary disease, coronary artery disease, asthma and depression.

Enhancing the practice and delivery of primary care

The Blues are working in collaboration with national and local healthcare industry stakeholders to enhance the practice and delivery of primary care. The **Patient-Centered Medical Home** (PCMH) places the patient and primary care practice at the center of care, creating a partnership between the patient and their personal physician. The goal of the PCMH is to provide comprehensive and coordinated care delivery by a primary care team focused on continuous care across all aspects of the healthcare system. **Blue Cross and Blue Shield companies** have launched PCMH programs across 39 states, the District of Columbia and Puerto Rico, encouraging increased use of health information technology and greater patient involvement and interaction with primary care providers.

WHAT THE BLUES ARE DOING

Since 2007, **Independence Blue Cross** has demonstrated a commitment to better primary care through its participation in Pennsylvania's Chronic Care Initiative, a groundbreaking patient-centered medical home model. Pennsylvania is one of only eight states to be part of a new federal medical home demonstration pilot that will explore better ways of raising quality of care while lowering costs. The early results of Pennsylvania's Chronic Care Initiative demonstrate that chronically ill participants took more responsibility for their care and showed marked improvement in health outcomes. Diabetic patients showed positive results in key factors important to preventing complications: significant increases in controlling blood sugar, blood pressure and cholesterol; getting preventive eye and foot exams; and taking medications proven to delay and prevent kidney disease. Of the participants in the program, 50 percent more had well-controlled diabetes, 70 percent more had well-controlled cholesterol, and 38 percent more had well-controlled blood pressure.

Blue Shield of California created an Accountable Care Organization (ACO) pilot to improve quality of care for the 41,500 CalPERS members it serves in Sacramento. Launched in January 2010, the CalPERs ACO brought together leaders from physician groups, hospitals and Blue Shield of California to develop strategies to improve quality and lower costs. Care delivery improvements, including shared systems that allow the ACO to communicate seamlessly with members, have led to a 15-percent decrease in hospital readmissions; a 15-percent decrease in inpatient hospital stays; a 50-percent decrease in inpatient stays of 20 days or more; a half-day reduction in the average patient length of stay; and an estimated $15.5 million in overall healthcare cost savings. Leveraging the lessons learned and success of the Sacramento pilot, the company has replicated the ACO model in San Francisco, Modesto and Orange County.

Blue Cross Blue Shield of Arizona, in partnership with Arizona hospitals, launched a pilot program in January 2011 to lower readmission rates for its members. The program aims to lower hospital readmission rates by ensuring members have their prescriptions filled and keep follow-up appointments with their physicians after discharge. Compliance with these two key measures can decrease readmission rates and avoid an estimated $1 million in costs. Of the 456 members in the program, 66.2 percent had their prescriptions filled within five days of discharge; 63 percent saw their doctor within 14 days of discharge; and fewer than 20 percent were readmitted within 30 days of discharge. In contrast, members who did not participate in the program had lower medication refill rates and fewer follow-up physician visits, resulting in a 10 percent higher hospital readmission rate than program participants. By simply focusing interventions on these two important evidence-based measures, the company and state hospitals can collectively improve patient outcomes and reduce healthcare costs.

WHAT THE BLUES ARE DOING

Investing in the primary care workforce

Blue Cross Blue Shield of Michigan's Physician Group Incentive Program (PGIP) connects physician organizations from across the state to encourage information sharing and collaboration among primary care physicians and specialists, with the goal of improving the state's healthcare system. Each initiative offers incentives based on clearly defined metrics to measure performance improvement and program participation. PGIP includes more than 30 initiatives that reward physician organizations for their efforts to improve quality of care and affordability by implementing capabilities such as e-prescribing, registries and care coordination. By end of 2011, PGIP will include 40 contracted physician organizations with membership totaling more than 11,000 primary care physicians and specialists who provide care for approximately 1.7 million members. Sixty percent of members in participating practices have 24/7 access to care, as compared to 25 percent in non-participating practices. Practice units that have met program criteria have 17 percent fewer inpatient admissions for ambulatory-care sensitive conditions, a 6-percent lower 30-day readmission rate and a 4.5-percent lower emergency room visit rate.

Blue Cross and Blue Shield of North Carolina Foundation awarded a grant to the North Carolina Academy of Family Physicians (NCAFP) Foundation to develop a mentoring program to help address the state's shortage of family physicians. The $1.18 million grant supports the establishment of the Family Medicine Interest and Scholars Program, an effort to help increase the number of North Carolina-trained medical students who elect family medicine residency programs and go on to practice in the state. Physician mentors will work with students for three consecutive years to strengthen skills, offer guidance and help fast-track their healthcare leadership training and experience. North Carolina currently has approximately 2,700 family physicians, with projections indicating the state will need 2,000 more by 2020 to address the state's healthcare needs. The program aims to increase the percentage of medical students who commit to a residency in family medicine by approximately 30 percent and increase the percentage of those who elect to stay in the state for their residency training from 56 percent to at least 66 percent during the length of the program.

Blue Cross and Blue Shield of Texas launched a Pre-Admission / Post-Discharge Outreach Program in January 2008 with the goal of reducing hospital readmission rates. Blue Care Advisors initiate telephone calls to identify members to reinforce pre- and post-operative instructions, review medication management and discuss self-management techniques. In 2009, members who received the call experienced a 23 percent lower readmission rate versus those who did not, resulting in estimated potential cost savings of $1.2 million.

Ensure government payment policies recognize the value of primary care

The existing fee-for-service payment systems must be changed to place greater value and emphasis on primary care, including care coordination. As policymakers consider options for overhauling the current Medicare physician payment formula, primary care services must be protected from payment reductions resulting from increased utilization of specialty care services. Payments must be sufficient to ensure continued access to physicians and other providers as the Medicare population grows, and to prevent cost-shifting from one program or payer to another.

Align federal delivery system reform initiatives with private sector best practices to promote primary care

The government should review and leverage private sector efforts that place a high value on primary care and care coordination, which improve the patient experience and healthcare outcomes.

As accountable care organizations and patient-centered medical homes continue to evolve in Medicare, the government should maintain critical design elements — such as quality measures that are largely outcomes-based and closely aligned with private sector best practices — to assure that quality improvement and system-wide savings can be achieved and maintained. In time, beneficiaries enrolled in these programs should be encouraged to consult with primary care practitioners before seeking specialty care. The government should use incentives to manage overall care, which in turn will drive greater accountability and improvement.

Improve care for "dual eligibles" and others by promoting managed care

Millions of new individuals are expected to enroll in Medicaid within the next five years, underscoring the importance of building greater value into this state-federal partnership. Medicaid managed care applies private sector innovations to foster better health outcomes for beneficiaries through improved access to primary care, preventive services and care coordination.

WHAT THE GOVERNMENT SHOULD DO

The federal government and states should continue to focus on improving healthcare outcomes, reducing unnecessary utilization, improving access to services and achieving greater continuity of care by expanding Medicaid managed care. Particularly for "dual eligibles" enrolled in both Medicare and Medicaid and for the Aged, Blind and Disabled (ABD) Medicaid population, there is substantial opportunity to improve quality and reduce costs by better managing healthcare services. While a majority of Medicaid beneficiaries currently are served through managed care, these two cohorts largely remain in fee-for-service programs.

Use federal dollars wisely to leverage the full primary care workforce

More focus should be placed on incentives to support and increase the primary care workforce. The government should redirect training resources from hospital-based specialty programs to those geared toward primary care, including non-physician practitioners and allied health professionals. In an effort to assist beneficiaries in managing their healthcare needs, registered nurse care management consultants should be available to beneficiaries through the 1-800-MEDICARE call line. Medicare should analyze program data to identify populations and communities at high risk for gaps in care and should test the impact of targeted care management services and higher reimbursement for primary care physicians working to close these gaps.

Evaluate the impact of provider consolidation on access to high-quality primary care

To assure a robust, high-quality primary care marketplace, the government should remain vigilant of the impacts of provider consolidation. Ongoing analysis should assess and monitor the relationship between provider consolidation and healthcare access, quality and pricing.

4 Inspire Healthy Living

One of the greatest challenges facing our healthcare system is the growing number of people with chronic illnesses. Empowering patients with information and tools to support healthier lifestyles is crucial to curbing healthcare cost growth.

More than 133 million Americans — one of every two adults — have at least one chronic condition (Centers for Disease Control and Prevention, 2010). In addition, more than a quarter of all Americans — including two in three older Americans — have multiple chronic conditions (Medical Expenditure Panel Survey, 2006).

Initiatives to curb the growth of chronic illness are sound investments. A Milken Institute study estimates the impact of chronic illness on the economy at $1 trillion annually, much of which is avoidable (DeVol, 2007). Rising obesity rates and other unhealthy lifestyle choices, such as smoking, contribute to the growing number of people with chronic illnesses. Obesity alone has been estimated to cost $147 billion a year (CDC, 2009).

Encouraging healthy lifestyles, including good nutrition, regular physical activity and smoking cessation, can lower the risk of developing chronic conditions that add significant costs to the healthcare system. To do this, we must have a dual strategy — keep people healthy to prevent the onset of disease and effectively coordinate care for those with chronic conditions.

WHAT THE BLUES ARE DOING

- Identifying and addressing gaps in care
- Prioritizing healthy lifestyles
- Combating obesity by encouraging healthy eating
- Advocating healthy pregnancies and safe deliveries

WHAT THE GOVERNMENT SHOULD DO

- Expand government initiatives to reduce healthcare disparities
- Support physical activity and wellness in schools, the workplace and the community
- Stress the importance of healthy eating and support good nutrition through federal initiatives
- Promote safe deliveries and improve maternal health

WHAT THE BLUES ARE DOING

Identifying and addressing gaps in care

Blue Cross and Blue Shield of Hawaii supports self-monitoring of blood glucose (SMBG) to help address gaps in diabetes care. As part of a comprehensive diabetes care improvement initiative, more than 1,800 members on insulin therapy without persistent SMBG, along with their prescribing physicians, were included in an educational intervention program to promote regular monitoring. This targeted intervention was associated with a nearly 14-percent increase in the proportion of members on insulin therapy who perform SMBG. The intervention resulted in increased SMBG compliance from 50.5 percent to 65.7 percent among Medicaid members; 58.1 percent to 67.8 percent among Medicare members; and 67.5 percent to 75.6 percent among commercial members.

Blue Cross and Blue Shield of Florida launched an initiative that focuses on African-American and Hispanic members with type 2 diabetes who had at least two identified gaps in care, such as a retinal eye exam and Hemoglobin A1c testing. If they were missing at least two recommended screenings, they were targeted for further interventions using a three-pronged approach: physician notification, member outreach with information on care gaps and follow-up calls by nurse educators.

Prioritizing healthy lifestyles

Louisiana 2 Step is **Blue Cross and Blue Shield of Louisiana's** flagship free health and wellness program available to both members and non-members. The program was developed to address one of the state's main health challenges – obesity – which is not only linked to a variety of other diseases, but also is directly tied to lifestyle choices. At the program's core is teaching Louisianans how two small steps, eating right and moving more, can greatly impact their health. More than 17,700 Louisianans across the state already have taken the first step by becoming registered members of the program. Registered members have access to an interactive website featuring healthy food recommendations, activity and walking logs, weight tracker, calorie counter and personal virtual coach. In 2011 alone, the site received more than 2.3 million visits.

Blue Cross and Blue Shield of Illinois, **Blue Cross and Blue Shield of New Mexico**, **Blue Cross and Blue Shield of Oklahoma**, as well as **Blue Cross and Blue Shield of Texas** (under the operation of Health Care Service Corporation) are partnering and investing with local nonprofit organizations to develop sustainable, measurable programs that will build healthier communities for children and their families. Healthy Kids, Healthy Families is a three-year initiative designed to improve the health status of at least 1 million children by focusing on four areas: nutrition education, promoting physical activity, preventing and managing disease and supporting safe environments. The initiative will focus on engaging children and their families to help them understand the importance of nutritious food, raise their level of physical activity, encourage safe play and increase immunizations. In 2011, Healthy Kids, Healthy Families expects to provide more than 150,000 immunizations through a unique mobile van program, encourage children to exercise by building safe places to play, and offer entertaining nutrition education to the schools and kitchen tables of 125,000 students.

Blue Cross and Blue Shield of Kansas City's A Healthier You represents workplace wellness programs that engage employees in positive behavior change to improve their health status and avoid the impact of chronic disease. A Healthier You is a comprehensive, customizable and turnkey program for employers, including a workplace wellness audit and an employee health event, consisting of biometric screenings, a Health Risk Assessment (HRA) and nurse consultation. To support continual behavioral change, incentive programs, lifestyle coaching, and webinar and onsite health education classes are offered. With this program, the medical trend was reduced by more than 30 percent compared with the national trend.

At **Blue Cross of Northeastern Pennsylvania** (BCNEPA), Blue Health Solutions^{SM} is an individualized health management and wellness program designed to help members improve their health or maintain an already healthy lifestyle. The program provides a full spectrum of offerings from health coaching, lifestyle management and health management programs for chronic conditions, to life-balance resources, a 24/7 nurse line, portals for online coaching and health risk assessments and discounts on health products and services.

From 2006 through 2010, Blue Health Solutions has had a positive impact on the health status of the company's membership and associated medical care costs. Over that period, total hospital admissions decreased from 75 per 1,000 members to 51 per 1,000 members for an average annual trend of negative 9 percent, and total ER visits decreased from 3.53 per 1,000 members to 3.26 per 1,000 members for an average annual trend of negative 2 percent.

Blue Cross and Blue Shield companies established the **National Walk@Lunch Day** to help people incorporate physical activity into their day by encouraging them to walk at lunch. National Walk@Lunch Day is a component of WalkingWorks®, a Blue company program developed in 2002 with the President's Council on Physical Fitness and Sports. Nationwide in 2011, hundreds of companies, schools, organizations, state and local governments hosted or participated in the fifth annual National Walk@Lunch Day events.

Combating obesity by encouraging healthy eating

Blue Cross Blue Shield of Delaware is an active participant in Delaware Partners to Promote Healthy Eating and Active Living (HEAL), that is working to prevent obesity through promoting healthy eating and increasing physical activity. This statewide coalition of 70 organizations and 200 individuals focuses on policy, environmental and systems changes to impact the issue. Delaware was listed in a 2011 Gallup Poll as the second heaviest state in the U.S. Research indicates that healthy diet and physical activity are important behaviors in controlling chronic diseases that are the leading causes of death in Delaware: heart disease, diabetes and select types of cancer.

The **Blue Cross and Blue Shield Association** has rolled out a national Pediatric Obesity and Diabetes Prevention Program to help reduce childhood obesity and prevent future cases of diabetes. In collaboration with the American Diabetes Association and the American Academy of Pediatrics, as well as five Blue companies, the Good Health Club Physician Toolkit was developed to provide educational and behavior-changing tools to share with patients and parents. The toolkits have been distributed to more than 15,000 pediatric and family physician practices across the country, and are available on BCBS.com in English and Spanish. A survey of physicians showed that since receiving the Good Health Club toolkit, 72 percent of respondents discuss this issue with patients more often, and 77 percent found the physician materials effective. Additionally, as part of overall efforts to reduce childhood obesity, BCBSA and several Blue Cross and Blue Shield companies are involved in ongoing discussions with the Partnership for a Healthier America, the private sector counterpart to first lady Michelle Obama's "Let's Move!" campaign.

Advocating healthy pregnancies and safe deliveries

Anthem Blue Cross and Blue Shield partners with the Commonwealth of Virginia for a benefit-based incentive program to encourage pregnant women to enroll in maternity management. Current research demonstrates that pregnancy complications are increasing. To reverse this trend, Anthem Blue Cross and Blue Shield collaborated with the Commonwealth of Virginia to conduct a year-long pilot of a maternity management program to support prenatal and postpartum care with Virginia state employees. A financial incentive offered to employees resulted in increased enrollment in the maternity management program. There is substantial evidence that optimal prenatal care offers maternal and infant health benefits by supporting optimal pregnancy health, mitigating high-risk behaviors, providing entry into the healthcare system for both mother and infant and monitoring appropriate resources.

Expand government initiatives to reduce healthcare disparities

The government should focus on large-scale health and wellness initiatives known to be effective in populations and communities affected by healthcare disparities. Initiatives should have a substantial impact on overall community health with particular focus on prevention and chronic illness care.

Support physical activity and wellness in schools, the workplace and the community

The government should increase resources to promote health for school-aged children, such as new federal funding to support:

- Physical education five days per week in all grades.
- Health education on diet, nutrition and tobacco use prevention.
- Body mass index screening programs.
- School-based programs to ensure all children receive recommended vaccinations.

Federal policies should empower employers to offer wellness incentives to individual workers and allow for inclusion with other tax-deferred healthcare benefits. In particular, the government should ensure employer contributions towards employee health and wellness activities, including smoking cessation, are excludable from employees' incomes and should ensure that employees can use tax-free dollars to pay their share of health and wellness activities.

Stress the importance of healthy eating and support good nutrition through federal initiatives

Healthy eating can help reverse or prevent many health concerns associated with obesity, such as type 2 diabetes, heart disease and arthritis. The government should support improved nutrition throughout its programs, including:

- Tying federal funding for school meal and snack programs to improved nutritional quality.
- Offering nutrition, meal-planning and preparation education to Supplemental Nutrition Assistance Program (SNAP) enrollees and provide incentives to use SNAP for healthy foods.
- Establishing tax and other incentives for grocery stores to locate in underserved neighborhoods.
- Assuring robust funding for obesity programs and community infrastructure to encourage healthy lifestyles.

Promote safe deliveries and improve maternal health

State and federal governments should work together to establish local public-private partnerships to improve prenatal care and utilize innovative, technology-driven approaches, such as toolkits and mobile apps. Medicaid should collaborate with medical societies and private payers to prioritize prenatal care and postnatal health through education campaigns and payment policies that discourage elective induction prior to 39 weeks gestation, which can be harmful to the mother and child unless medically indicated.

Moving Forward

Blue Cross and Blue Shield companies have been leaders in healthcare coverage since the 1930s. Developed from a grassroots approach to financing hospital and physician services, Blue Cross and Blue Shield companies continue to provide local leadership and solutions to promote safe, high-quality and affordable care. We are committed to comprehensive action to transform our nation's healthcare system. Working together, America can build a better healthcare system by addressing four interconnected areas:

- **REWARD SAFETY:** Change incentives and provide leadership to achieve better care.
- **DO WHAT WORKS:** Put what works into practice and empower consumers and providers with knowledge to make informed, evidence-based decisions.
- **REINFORCE FRONT-LINE CARE:** Assure access to well-coordinated, high-quality care by placing a higher value on primary care.
- **INSPIRE HEALTHY LIVING:** Promote and encourage health and wellness to reduce the incidence of chronic illness and help people live healthier lives.

With Blue Cross and Blue Shield companies in all 50 states and federal territories offering coverage in every market and every ZIP code, we are committed to collaborating with all stakeholders — consumers, hospitals, physicians, payers and policymakers — to build tomorrow's healthcare system.

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