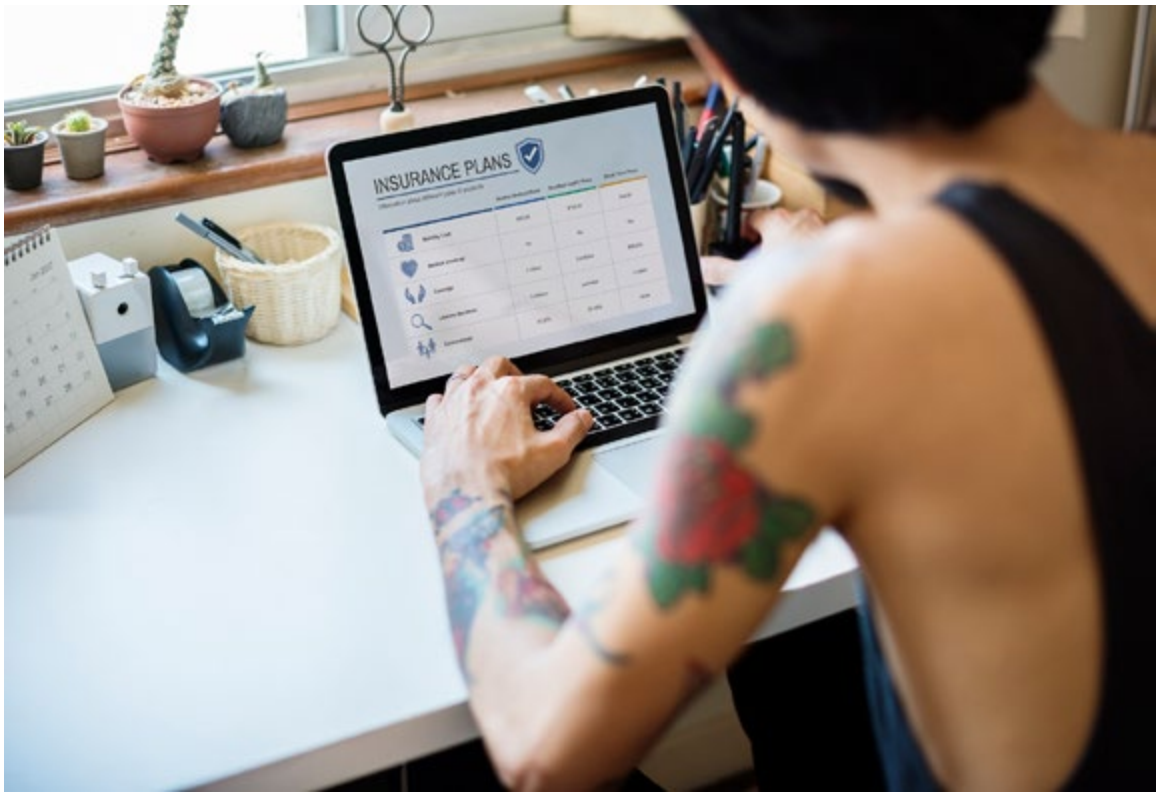

WRITTEN BY GENEVIEVE CARUNCHO-SIMPSON

BREAKING NEW GROUND THROUGH JOINT VENTURE MODELS

Enrollment season is upon us and people are determining what style health plan would meet and exceed their needs from a member and employer perspective. The ideal plan provides members with the highest level of personalized care while protecting cost efficiencies for employers through a seamless, comprehensive workflow. In terms of a traditional Accountable Care Organization (ACO) product options, the benefits can be considered a bit restrictive and siloed, which can leave members and employers in a position seeking more from their health care plan.

The ACO model, which does not address the lack of strong financial and operational alignment between health plan and provider entity, is not for everyone. Through the voluntary platform, ACO plans lack a level of personalization and coordination that other plans offer.

More recently, joint venture health plans have made their mark in the health care industry by breaking new grounds and setting the bar at a higher level for members,

brokers and employers through high-touch, integrated solutions. Additionally, the combined resources provide even more opportunities for member care and reduction of costly care options.

For some plans, the focus stays on the cost effectiveness without providing many alternatives. In the joint venture health plan model, the efforts are united to decrease the total cost of care of the member through utilization of personalizing patient needs on a holistic level, saving time and money for the employer while providing custom health alternatives to the member.

The goal is to keep it easier for the member, leaving the complexities of managing accurate and timely customized treatments and health maintenance options to the professionals on the back end.

Additionally, combined with a high-performance provider network, this structure offers an extended footprint for members while integrating the highest quality resources and maintaining the costs for members and employers, drawing in new business and increasing the number of members. These efforts aim to connect the members with a long-term, highly engaged primary care provider and reduce the overall cost incurred each year caused by a lack of early detection and treatment and effective chronic care and disease management.

Integration of resources is the backbone of a joint venture. It's through the utilization of shared resources to serve all parties that makes this style of a health plan stand out. In addition to increased resource options, the joint venture health care model makes services and programs that are easier to access and more effective by connecting key components of the system – from benefit design to post-hospital discharge care coordination.

By taking a 'no-wrong-door' approach to the care experience –allowing for quick, convenient, and integrated access points via text, call, video chat, or in person—it ensures members are getting the timely support and guidance they need and don't miss vital primary care visits.


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For health plans offering joint venture resources like a locally-based care team, the benefits include a dedicated medical director, nurses, pharmacists, diabetes educators, social workers, and behavioral specialists who support the members and their families with their complex needs, often face-to-face. These personalized clinical care coordination teams are equipped with resources to cater to the 5% highest risk patients that typically drive as much as 50% of overall costs.

This holistic approach includes a community-based focus that seeks to address a broad range of social, economic and environmental factors that shape an individual's engagement in health behaviors. It's an all-in-one plan that focuses on educating and caring for the members while maintaining costs for employers. The more hands-on, local support the member and their families receive, particularly if they have a complex, high-cost condition, the less likely they are to struggling navigating an often-complex health system that decreases member engagement and increases overall cost and dissatisfaction.

Researchers have found that in 1 out of every 7 visits[1], important data is missing. Situations like these have can adversely impact patients and the quality of care they receive. Through personalized care and the utilization of patient data analytics solutions, physicians are provided a seamless workflow, avoiding gaps in care coordination and compromised care.

Patient data combined with claims data that are regularly analyzed provide proactive, comprehensive insights tailored to the patient across various sites of care. Utilization of this data within aligned hospital and providers ensure that coordination of care occurs, regardless of the hospital or medical group that the patient sees.

This directly reduces significant resource waste, saving both employer and member costs for what's important. Partners in the joint venture sector are continuously working to improve the data sharing platforms to maximize member satisfaction, decrease employer costs and maintain the health and happiness of all participants.

Additionally, duplication of efforts are no longer an issue within the business model. Resources in the joint venture structure provide seamless, coordinated, precise information down to the prescription level through cost transparency. The goal of this is to equip providers with information and options to prescribe medications that fit the members both clinically and health plan benefits-wise through effective updates and communication within the member's health plan.

Joint venture partners aim to reduce member and employer costs by linking up with forward-thinking primary care physicians and securing value-based arrangements that reward them for high-quality, efficient care for all members without the disadvantage of driving up costs that impacts all parties. This also provides them with tools and resources that help physicians simplify their practices and focus on delivering great care to our members, offering timely appointments, often with same-day / next-day availabilities; enhanced data to ensure members' care is efficiently coordinated especially after an ER or inpatient visit; with no referral requirements to in-network specialists.

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This healthcare model extrapolates data from a health plan and health system partner and supports all sides by catching data that might fall through the cracks, creating new, novel solutions and risk analysis. Real savings are created and quality improvement is enhanced. Instead of avoiding complex health care needs, this structure aims to solve them through personalized, local, integrated initiatives. It's a comprehensive snapshot of health care from the provider side that leads to a high-touch, accurate process and connection to member and employer needs from the insurance side. ■

Genevieve Caruncho-Simpson is the chief operating officer of Texas Health Aetna. Leveraging the strengths of two leading organizations, Texas Health Aetna is blurring the lines of traditional health care plans and health systems to create a truly integrated solution that's simple to navigate and puts the member's experience first. The local health plan is committed to providing affordable, high-quality health care services and delivering customized care to members throughout the Dallas-Fort Worth metroplex. For more information about Texas Health Aetna, visit www.texashealthaetna.com.

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