

Commercial Value-Based Care Has Quietly Turned Into a Real Messy, Multi-Payer Operating Layer Wedged Between Employer Cost Pressure, Payer Network Strategy, Specialty Economics & Provider Margin Reality

APR 26, 2026 • PAID



Table of Contents

The setup, in plain English

Medicare wrote the manual, then forgot to translate it

Contract heterogeneity, or why one provider's "VBC contract" is actually fifteen

Quality measure overload and the normalization problem

Risk adjustment vs. MA, different sport, same jersey

Specialty is where the money actually lives

Employers turned into active buyers, not passive bag-holders

Where the tooling gap turns into a real business

The bigger pattern, and why this is finally investable

Abstract

Core thesis: Commercial value-based care has crossed the line from theoretical to operational, but the infrastructure required to run it at scale is roughly a decade

behind Medicare. Primary sources from the largest commercial payers now show actual scale, real dollars, and explicit specialty expansion, which means the next generation of healthcare infrastructure companies will be built to operate inside fragmentation, not around it.

Key data anchors used throughout:

- Cigna Collaborative Care: 230+ primary care arrangements across 32 states, 2.6 commercial customers, 144,000+ contracted physicians (81K PCPs, 63K specialists)
- Cigna's stated specialty focus: cardiology, GI, OB-GYN, oncology, orthopedics, representing 57% of medical spend
- Elevance: value-based arrangements >60% of medical expense (2021 reporting)
- Blue Shield of California: 56% of cost-of-care spend in pay-for-value, \$31M net ACO savings, 7.4% cost reduction in Primary Care Reimagined, 7.4% savings in orthopedic episodes
- Blue Cross NC: Episodic Bundle Payment Plan live as of Jan 1, 2025 for knee, hip and shoulder replacements with a single member copay
- Highmark behavioral health: 24.7% PMPM cost reduction commercial, 45.9% FFS Medicare, in a value-based collaboration with Value Network IPA
- BCBSMA: pay-for-equity layered onto the Alternative Quality Contract
- Highmark + Stellar Health: VBC enablement spanning Commercial and MA lines

Categories of opportunity examined:

- Multi-payer contract intelligence and management
- Quality measure normalization
- Specialty bundle administration (orthopedics, oncology, cardiology, OB, GI, behavioral)

- Attribution and patient-panel engines for commercial books
- Risk and stop-loss hybrids
- Case-rate billing infrastructure
- Performance analytics for independent specialty groups

The setup, in plain English

For roughly fifteen years, the entire conversation about value-based care in this country has effectively been a Medicare conversation dressed up in different outfits: ACOs, MSSP, Pioneer, Next Gen, Direct Contracting, ACO REACH, Medicare Advantage capitation, the various bundled payment demos out of CMMI: all government, all anchored in CMS rulemaking, all measured against a Medicare fee schedule that everyone in the industry treats as the gravitational center of payment design. The commercial side, by contrast, has spent most of that time being characterized as a slow follower, a payer-by-payer mishmash of pay-for-performance bonuses and half-hearted ACO knockoffs that nobody on a board deck took particularly seriously. That framing is now obsolete. The published material from the largest commercial insurers in the country tells a different story, and it is worth taking that story at face value rather than continuing to describe commercial VBC as a Medicare spillover.

Run through the receipts and the picture changes pretty fast. UnitedHealth Group's October 2025 white paper on advancing value-based care explicitly extends the program logic to commercial health plans and employers and frames an all-payer alternative payment model context. Cigna has more than 230 Collaborative Care arrangements with primary care groups across 32 states, covering more than 2.6 million commercial customers and contracts with over 144,000 doctors, including roughly 63,000 specialists. Elevance has stated that value-based arrangements represented more than 60% of medical expense in 2021. Blue Shield of California publicly stated that 56% of its cost-of-care spend now flows through pay-for-value models, with a stated ambition to push that number to 90%. Blue Cross NC went

January 1, 2025 with the Episodic Bundle Payment Plan for knee, hip, and shoulder replacements at a single member copay. BCBSMA has layered equity-linked incentive payments on top of its Alternative Quality Contract. Highmark's behavioral health value-based arrangement with Value Network IPA has produced a 24.7% PMPM reduction for commercial members and a 45.9% PMPM reduction for Medicare. of this is a press release fantasy. These are operational programs with attribution engines, contract clauses, settlement timelines, and dollar flows attached to them.

So commercial VBC is real. The interesting question is no longer whether it is real but what kind of market structure it actually creates. And the short version of the answer is that it creates a fundamentally different beast from Medicare, one that is much messier, much more fragmented, much harder to operate inside, and therefore much more interesting for anyone trying to build infrastructure businesses on top of it.

Medicare wrote the manual, then forgot to translate it



Continue reading this post for free, courtesy of Special Interest Media.

[Claim my free post](#)

[Or purchase a paid subscription.](#)

[← Previous](#)

