



eValue8 Employer Report

2009 Health Plan

Diabetes Care Performance



**THE NATIONAL BUSINESS COALITION ON HEALTH
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EXECUTIVE SUMMARY

In the past decade diabetes has emerged as a crucial health care cost driver for many employers, one that hand in hand with obesity is on the rise. Employers are increasingly seeing that it is a bottom line issue to prevent diabetes, identify it early, and treat it “to goal” in their employee population. This imperative must be carried out in partnership with health plans and other health vendors to control the personal and financial costs of diabetes exacerbations and complications. In this third Annual eValue8 Employer Report we examine data from leading health plans that report to business coalitions on their health management activity. Coalitions and their employer members use the eValue8 standardized Request for Information to assess health plan performance and expect plans to adopt innovations and evidence based practices to stem the health care quality crisis in diabetes.

This report outlines important treatment goals for diabetes, and then discusses the approaches plans are using to prevent the disease and improve its care. Some of the eValue8 results from 72 verified results from health plans are*:

- Overall diabetes quality indicators continue to improve slowly. Health plans report that 80% of diabetics have at least an annual hemoglobin A1C test, an important indicator, and an annual cholesterol screening. Still, one third of patients have uncontrolled blood sugar. [Figure 2]
- Virtually all health plans offer a personal health assessment (PHA also called health risk assessment or HRA) as one means to identify people with or at risk for diabetes, and some proactively search for members with diabetes using claims and other data sources. But PHA use and uptake is far from universal by members of employers; only 3% of members respond to the PHA, and not all employers offer it. To increase employer use, 67% of plans “bundle” the PHA in their administrative fee to self insured employers; for the remaining employers the PHA is a “buy up.” To fully engage employers, plans could more routinely offer the PHA as a bundled service.

- Plans continue to work with physicians to help them overcome shortcoming in physician information management systems and identify gaps in care. 95% of health plans have capability to report back to physicians on gaps in care and 70% of plans can now show physicians how they compare with their peers. 35% of plans offer financial rewards or incentives to physicians to adopt electronic health systems. [Figures 4 and 5]
- Plans have a way to go in helping members identify the best doctors and those with the best infrastructure to provide diabetes care. Physicians that deliver high quality care are often designated “Recognized” by the National Committee for Quality Assurance. 61% of plans use recognition as a tool to report high quality doctors to patients, but only 16% have web features that allow patients to search for Recognized physicians. Less than 20% of plans guide members to more “wired” physicians, e.g. by letting them know which physicians offer web visits, emails, or e-prescribing. [Figure 6 and text]
- Plans use diverse systems to reward physicians: 57% use clinical results, 39% use patient experience surveys to decide which physicians get rewards, and 57% can reward physicians for adopting modern office infrastructures [Figure 7 and 8].
- Plans are also making progress in helping member identify and select the better quality physicians, but this capability is still low. Less than 20% offer a lower copay, deductible or premium to members who choose a high quality primary care doctor [Figure 8], and less than half have any financial rewards to patients for selecting higher quality specialty physicians, where the health stakes are even higher. [Figure 9]
- Disease management continues to be a core service of health plans. 90% of health plans responding to eValue8 offer it to all customers; just 10% include it as an employer option to purchase disease management. Approximately 90% of plans deliver disease management through phone calls to members along with online web based interaction. [Figure 13]

* It is important to note that these eValue8 results show the capabilities of health plans. It is up to employers to ask for these leading edge services and to use eValue8 or other accountability approaches to ensure that health plans execute them effectively.

- Disease management is an opportunity for plans to identify gaps in diabetes care quality, address medication adherence, and assess the member for co-morbidities that need to be treated by the physician. For members with diabetes, 89% of plans monitor medication use through pharmacy claims; more plans are developing capability to take action on gaps in adherence by alerting the member's practitioner (92%), reminding the member directly (92%), or asking a pharmacist to assess the member's situation (64%).
- Value-based insurance design continues to gain traction as a means to encourage members to use essential medications and treatments for chronic disease. In 2008 48% plans had capability to waive copays for first time prescriptions and equipment for diabetes. For maintenance medications in 2009 57% of plans could alter the copay as an incentive. 73% of plans have capability to reward members for using the PHA to identify and control risk factors.

In 2009 several trends began to gain serious footholds – for example, use of the patient-centered medical homes

and value-based insurance design. In 2009 61% of plans were involved in pilot testing or implementing patient-centered medical homes. Other innovations to engage provider and members – for example, tiering and use of variable payments that reflect the efficiency and quality of physicians – continue to inch forward slowly. NBCH has seen avid interest among employers in promoting initiatives that will improve the quality of diabetes care, get members involved in choosing high quality physicians, and incentivizing members to manage their diabetes more effectively. These member centered programs complement efforts under way for years to measure physician quality and raise the bar for diabetes quality care.

In 2009 health plans reported to NBCH that they are moving forward on the diabetes quality efforts, but there have been no major transformations in approaches or outcomes. With health care reform on the horizon and the inexorable movement towards electronic health information systems, coalitions and employers hope to see an acceleration of activities that stem the tide of new diabetes and prevent the devastation of improperly managed disease.

SECTION I: THE DIABETES LANDSCAPE FOR EMPLOYERS

Introduction

Diabetes, a serious chronic health condition, is on the rise in the United States. Diabetes causes high blood sugar in the body, which in turn damages other organs. This triggers a series of health problems impacting the eyes, kidneys, heart and limbs. The nation's employers are seeing more diabetes in the working population, and are paying the costs of health care services needed to treat diabetes and its complications. Some employers say that diabetes is one of the most important health care cost drivers in their covered population. Diabetes can be frustrating to employers because it is often preventable. For people who do have diabetes, complications can be prevented or reduced through aggressive treatment and careful self management.

Most employers are not health care providers. Increasingly, though, employers have taken the reins to help ensure that health care providers, and the health care plans that administer health benefits, are working to prevent and carefully manage diabetes. This report examines results of one tool used by employers to examine health plan activities to address diabetes. The eValue8 Request for Information (RFI), is administered by the National Business Coalition on Health (NBCH) as a standardized approach to collecting information from health plans. Local coalitions of business leaders invite health plans in their areas to respond annually to eValue8. The information provided by health plans is used in comparisons of health plan performance and purchasing decisions.

eValue8 is an important element of a proactive health purchasing strategy, designed to add value to employer purchasing decisions. eValue8 incorporates questions addressing how well health plans have adopted the most recent evidenced based treatment patterns and innovations around care delivery. In fact, eValue8 questions are actually "expectations." eValue8 expects that plans will develop programs and policies that enable them to report on robust activities in each of the eValue8 program areas. Health plans are scored by trained reviewers on behalf of local coalitions. The final eValue8 score shows how well health plans perform in specific categories and overall.

Coalitions share eValue8 results with local employers and plans to support employer discussions with plans and purchasing decisions.

Specific to diabetes, eValue8 asks plans to report on how they help to identify people with diabetes, how they support physicians in offering the most effective treatments, and how they work directly with patients to help them improve their own management of diabetes. Plans are asked to report standardized measures of their performance in diabetes care. In addition, eValue8 asks questions about health care innovations that indirectly impact diabetes. For example, eValue8 drills down with questions about how health plans reward physicians who offer better care, and what plans are doing to support medical homes, an approach used to improve coordinated primary care services for patients.

About the 2009 eValue8: Themes and Priorities

The 2009 eValue8 tool included a series of questions about how health plans are "engaging" members. Member engagement is a term used to describe how individuals are encouraged to become involved in their own care. For diabetes, the results of engagement are that the member has taken steps towards improving nutrition, controlling weight, exercising regularly, and taking medications essential for treating diabetes. Engagement is assessed by looking at how plans interact with members through various modalities - the web, phone calls, reminders - and how effectively. It is also measured by patients' willingness to take on responsibility for their own health. This report looks at 2009 health plan performance focusing particularly on the area of member engagement.

This report includes 2009 data from 72 health plans in regions represented by NBCH member coalitions. Local coalitions reviewed the data and "verified" the information reported by the health plans. Only verified data from health plans are used for the figures in this report. 63 verified health plans reported both in 2008 and 2009, and their results are used in the trend reports. In all, 89 health plans reported data to eValue8. The scoring, verification

and feedback process is an important quality improvement component of eValue8. Data from health plans not verified because they are not in regions represented by eValue8 coalitions are not included in this report. NBCH commends all of the participating plans for stepping up to the scrutiny and self improvement process of eValue8.

Important note: It is important for employers to recognize that the answers provided by the health plans reflect their *capabilities*. In other words, the plan has the programs, services, and infrastructure needed to deliver the service. They may not deliver this service to all customers or all beneficiaries. Particularly in self insured markets, plans deliver the services chosen by their customers, the employers. Employers have an essential role in selecting benefits and directing plans to carry out evidence based and innovative benefit designs. It is also important to recognize that the respondents to eValue8 are a *self selected* group. Their performance may not be representative of other health plans. Most likely the performance of eValue8 responding plans is better than average performance, since lower performing plans might not report.

More details about eValue8, including a list of participating plans, can be found in the NBCH report, *eValue8 2009: Measuring Progress Toward Value-Based Purchasing*, available on the NBCH web site.

About NBCH and Coalitions

The National Business Coalition on Health (NBCH) is a national, non-profit, membership organization of nearly 60 employer-based health care coalitions, representing over 7,000 employers and approximately 25 million employees and their dependents across the United States. NBCH and its members are dedicated to value-based purchasing of health care services through the collective action of public and private purchasers. NBCH member coalitions are composed of mostly mid- and large-sized employers in both the private and public sectors in a particular city, county, or region.

NBCH members are local health care coalitions that represent local employer needs and priorities around health care purchasing. The dramatic escalation of health care costs, and steady or declining health care quality, generated a demand for greater value in health care purchasing. NBCH and its members strive to identify promising programs and practices that add value to the health care system. These strategies promote better outcomes for health care dollars spent and prevent onset or exacerbation of health care conditions that drive costs. For additional information visit: <http://www.nbch.org/>.

SECTION II: WHY DIABETES

Importance

The importance of diabetes as a health care cost driver to employers is widely known. Health and productivity experts have repeatedly urged employers to recognize that “good health is good business” and are refining methods to capture the impact of chronic disease on work productivity.^{1,2} Some of the essential facts are:

- **Prevalence:** The federal Centers for Disease Control and Prevention (CDC) says that almost 9% of the population over the age of 20 has diabetes. 1.3 million new cases are diagnosed each year. Racial and ethnic minority populations are even more likely to have diabetes than the general population.³
- **Health Care Cost:** A 2008 study estimated the total cost of Type 1 or Type 2 diabetes at \$218 billion. The study estimates the additional costs of diabetes on people who haven’t been diagnosed yet (\$18 billion), women who develop diabetes temporarily during pregnancy (\$636 million) and those on track to develop diabetes, an increasingly common condition called pre-diabetes (\$25 billion).⁴ Costs are \$174 billion for just diagnosed diabetics.
- **Productivity cost:** The American Diabetes Association (ADA) estimates that indirect costs, including lost productivity, make up 1/3 of the total cost of diabetes. The ADA reports that people with diabetes have over two time higher medical costs than people without.⁵

Diabetes is not just a disease of old age. It has an impact on the working age population as well. Figure 1 shows data from the Managed Care Digest Series showing that over half of commercial claims for Type 2 diabetes are incurred by individuals in the 18-64 age range.⁶

The working years are typically the period when diabetes begins, and when employees can take action to reverse diabetes or prevent diabetes complications. There is reason to believe the diabetes epidemic could get worse in the working age population: an increase in the rate of obesity among children and working age people should trigger alarm bells in employers about the future high costs of diabetes. Obesity is strongly linked to diabetes, and only one state (Colorado) has less than 20% obesity in the general

population. In many states, over 30% of the population is obese.⁷ This suggests that the toll of diabetes will rise unless vigorous multi-stakeholder interventions are implemented.

Figure 1: Diabetes Demographics by Age and Gender in 2008

Age/ Gender	0-17	18-35	36-64	65-79	80+	male	female
Percent of Diabetics	0.4	3.2	48.4	34.7	13.4	45.2	54.8

Source: Managed Care Digest % are representative of the universe of Type 2 diabetes patients on whom claims data have been collected in a given year (e.g. diabetics who have received care, not all diabetics)

Quality Care and Treatment

What is particularly frustrating to employers is that prevention and treatment strategies for Type 2 diabetes are well known. For prevention these strategies are:

- Maintaining normal weight or weight loss for overweight people
- Exercise
- Healthy nutrition

And the best practice treatment protocols are also well known. Important goals of diabetes treatment are to help the patient maintain normal “blood glucose” and to prevent heart disease.⁸ Clinical goals are these:

- Maintaining fasting blood sugar at or below 120
- Maintaining an indicator of blood sugar control, called the hemoglobin A1C at around 7
- Keeping blood cholesterol in the normal range
- Keeping blood pressure in the normal range
- Never smoking or smoking cessation
- Preventing complications affecting eyes, feet, and kidney function

Diabetes is always a challenging condition to treat. Its complications are largely due to changes in blood sugar that damage the small blood vessels of the body. Complications cause heart disease, kidney disease, blindness and foot amputations. Diabetes is considered a progressive disease. Preventing complications requires careful monitoring the patient and frequent adjustments to a treatment regimen.⁹ The American Diabetes Association says that a key goal of treatment is to keep blood sugar as close to normal

WHY DIABETES

as possible through regular treatment and treatment intensification as needed.¹⁰

To achieve the goals of diabetes treatments, basic treatments for diabetes generally entail:

- Controlling blood sugar through medications or injected insulin
- Controlling blood pressure
- Preventing complications or catching them early through regular examinations of eyes, feet, and kidney function
- Improving the impact of treatments by exercising regularly and eating right

The success of these preventive and treatment approaches depends on a successful partnership between the patient and the physician. If patients are not treated properly by physicians, or they don't comply with treatment recommendations, they are far more likely to experience complications of diabetes. Control of blood sugar has a very important impact on heart disease risk for people with diabetes.¹¹ In fact, people who have diabetes have 2-4 times the risk of heart disease.¹² Although diabetes is a leading cause of death, many people with diabetes die of the more serious heart disease complications that would not have developed if the diabetes had been well managed, or could have been prevented if the heart disease were also aggressively treated.

The physician's responsibility is to correctly diagnose and treat diabetes and its potential complications. Physicians must also support and advance patient efforts to improve health, adhere to treatments, and make lifestyle changes. Since diabetes is a progressive disease, the physician's role is to closely monitor the patient and to update treatments regularly. The patient is responsible for "self management." Self management includes checking blood sugars as prescribed, making lifestyle changes, and following medication treatments. A partnership that includes proper physician treatment and proper member self management is the most effective way to reduce the health and cost effects of diabetes. Lack of effective diabetes care can result from either patient or physician factors^{13,14} and is one reason that employers and plans are positioned to engage both constituencies.

According to the National Diabetes Education Program good treatment is worth it both from the member and the employer perspective.¹⁵

- Regular eye exams and timely treatment could prevent up to 90% of diabetes-related blindness
- Foot care programs that include regular examinations and patient education could prevent up to 85% of diabetes-related amputations
- Treatment to better control blood pressure can reduce heart disease and stroke by 33%–50% and diabetes-related kidney failure by 33%
- Diet and exercise that achieves a 5- to 7% weight loss can reduce diabetes incidence by 58%.

What Good Care Means To Employers

Good diabetes care is complex. It takes high quality providers and involved patients to prevent diabetes or reduce its toll on health. Employers look to health plans to have the expertise and programs to tackle the complexities of diabetes. The role of employers is to leverage their purchasing power to examine the data on what plans are doing to prevent and manage diabetes, and to continually raise the performance bar. eValue8 shows employers details of plan capability to address diabetes through patient and provider interactions. Through eValue8 employers can monitor, interact, and leverage plan activities to continually improve plan performance in promoting good diabetes care.

Larry Boress, President and CEO of the Midwest Business Group on Health put it like this: "Employers want to know if the programs they pay for are doing any good. They want to understand the value of the programs they are already investing in. Then they want to know how the programs are reaching people: are people engaged and participating? They don't want the plan just to touch people, but also to engage them."

The next section of this report examines some of the performance results from health plans. Employers are encouraged to drill down further at the local level. If the employer is in a region supported by an NBCH member coalition, that coalition may be able to reproduce many of the national statistics reported here in a subset of health plans offering services in a particular region. Also, employers can access specific market level health care cost and diabetes data through the Managed Care Digest Series. Employers interested in reviewing local data and statistics should contact their local health care coalition to ask about availability of local diabetes data and a drill down on local eValue8 health plan performance.

2009 eValue8 Expectations

The eValue8 RFI survey tool is updated annually to address national and employer priorities. In 2009 eValue8 asked for information in six modules, each of which has implications for better diabetes care:

- **Plan Profile (Operations and Organization).**

Plans report on how they organize services and on their accreditation status by an external organization. Plans report on health information technology systems to manage and report information that improves quality. Plans also discuss their programs to remove barriers to care and reduce disparities in health care for racial or ethnic minority populations. Plans report on oversight programs for contracting and claims management processes. For people with diabetes these issues are important because health plans may need to do additional outreach for racial and ethnic minority populations and need effective information systems to identify individuals with diabetes.

- **Consumer Engagement and Support.** Plans report on their programs to support members in choosing the best doctors, hospitals, and treatment alternatives as well as decision support services to assist consumers in comparing costs of selecting certain medications or services. Plans also report on their programs to offer personal health records that enable consumers to keep their own health information in a portable, electronic format. For people with diabetes these engagement and support services are essential for helping them manage the disease and prevent complications.

- **Provider Measurement.** Plans report what they do to track, benchmark, and provide performance feedback to physicians and hospitals. Health plans also report their activities designed to promote and reward doctors and hospitals for superior performance, including clinical outcomes. Provider measurement activities are important for people with diabetes because some physicians are more effective than others at coordinating all the services needed from a variety of providers and assuring better health outcomes.

- **Pharmaceutical Management.** Plans report on their relationships with pharmacy benefit management firms, how they manage costs through the use of generic equivalent medications, whether they have specialty pharmacy programs, and what steps they have taken to improve safe and appropriate use of medications. Plans report on their activities to

reduce inappropriate prescribing of antibiotics and reduce errors in physician prescribing. eValue8 asks plans to report on activities to promote electronic prescribing to reduce errors and improve efficiency. Pharmacy programs are important to people with diabetes because appropriate and consistent use of medications are essential to controlling blood sugar and the complications of diabetes, and many people benefit from programs to increase their adherence to medication.

- **Prevention and Health Promotion.** Plans report on programming and performance in cancer screening, immunizations, tobacco use, weight management, worksite health promotion, and risk factor education. In particular, eValue8 encourages plans to use personal health assessment (PHA) (also called “health risk assessment”) tools to identify members who have or are at risk for chronic disease. Plans are scored on their programs to support members in making health improvements, for example, by offering reminders, counseling, or internet programs to support healthy lifestyles. Health promotion is an important part of reducing risk of diabetes and preventing the onset of diabetes where risk factors are present. For individuals with diabetes, health promotion activities reduce the rate and severity of diabetes complications.

- **Chronic Disease Management.** Plans report on programs they use to help their members with cardiovascular disease and diabetes manage their conditions. Plans are asked to report on what they do to help people with diabetes reduce complications, diabetes care process and outcomes as measured through HEDIS data, and other indicators of impact on health and productivity. Diabetes disease management has been shown to improve satisfaction and reduce complications of diabetes for participants in the program.

- **Behavioral Health.** Plans report on efforts to increase effective care for members with depression or alcohol problems. They are asked how they track patients and ensure that their care is coordinated between behavioral health specialists and the patients’ usual physicians. Plans report performance results in behavioral health and the support offered to patients and physicians. Behavioral health programs are important for people with diabetes because many diabetics have depression or other risk factors that can be treated to improve health outcomes.

CASE STUDY

Nevada Health Care Coalition Jump Start a Healthy Life with Diabetes Worksite Wellness Program

The Nevada Health Care Coalition (NHCC) is a partnership of 19 Nevada employers formed to provide improved quality and more cost-effective health care to their employees and families. The NHCC used NBCH Diabetes Seed Grant funding to develop a pilot project that brings 12 one-hour weekly group education sessions to the worksite for those employee participants who have elevated Hemoglobin A1C levels. NHCC sought to reduce participants' risk factors (e.g., A1C levels, blood pressure, waist circumference) for diabetes complications and comorbidities. The overall goal was to develop a program that could be easily replicated and offered at the worksite to other coalition employer members.

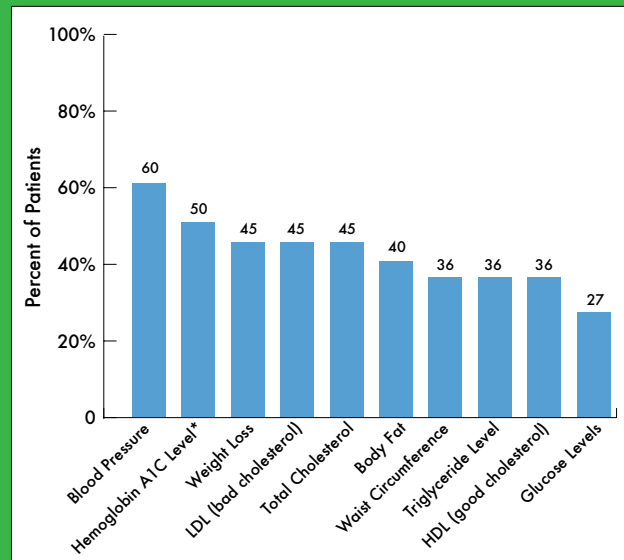
The NHCC selected the City of Reno as the employer to pilot the program. The program was developed so that all classes would be once-per-week and during lunch time. The program was designed to cover a specific topic each week (the topics are shown below). In some cases, employer leadership had to allow additional time off for class participation. Class binders were created for all participants that included educational materials and other items supplied by various program partners. NHCC identified 37 eligible employees. "Jump Start" program invitations were sent to all 37 employees of whom 12 enrolled in the class. The program had only 1 employee drop out of the program and this was due to a hospitalization. To establish a baseline, A1C levels were drawn one week prior to the start of classes.

There was an 87% participant attendance rate over the course of 12 weeks. The general results are shown in the accompanying graphic. Of those participants with an A1C level above 7.0% at baseline, 50% showed a decrease after the program. While 60% of participants showed an overall improvement in their blood pressure after the entire 12-week program, 90% has experienced improvement at the 6 week check. In terms of other risk factors, 45% of all participants experienced weight loss, 36% experienced a decrease in waist circumference, and 45% had a decrease in LDL cholesterol levels.

The NHCC has faced some challenges to launching a worksite diabetes wellness program. Identifying program participants who would benefit from such a program was challenging. The NHCC ultimately relied heavily on employees who had enrolled in a prior existing program.

Scheduling employees also proved to be challenging. Convincing employers to allow time off for class participation and finding a time for the classes to be held that was convenient for all participants were both noted barriers by the NHCC. NHCC would encourage other coalition employers to replicate the program, but notes that additional funding is needed for each employer launch.

Percentage of Patients Showing Improvement by Diabetes Risk Factor



12 Week Diabetes Program Curriculum

Week	Topic
1	Introduction and Baseline Assessments
2	Coronary Risk Profile and Wellness Vision
3	Nutrition 101 (Registered Dietitian)
4	Glucose Management 101
5	Nutrition 202 (Registered Dietitian)
6	Diabetes: Long Term Complications
7	Diabetes and Fitness
8	Pharmacy Overview (Pharmacist)
9	Grocery Store Tour/Reading Labels
10	Diabetes and Stress Management
11	Physician Overview (Endocrinologist)
12	Wrap Up and Re-Evaluation

SECTION III: eVALUE8 HEALTH PLAN PERFORMANCE TRENDS

Overall Diabetes Care Performance

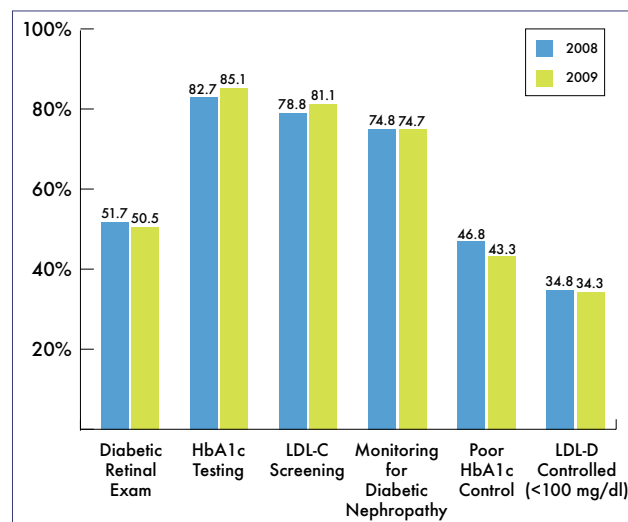
This section reports on the capability of health plans to deliver effective programs for people with diabetes. According to Michael Ginder, Executive Director of the Nevada Health Care Coalition in Reno, Nevada, “Employers think of diabetes as a high cost health priority. For many it’s the number one. Many see it as originating with lifestyle – weight and exercise. They recognize that for people with disease, the issue is to self manage and to improve medication adherence.” The Nevada Coalition is working directly with employers in a worksite diabetes quality improvement initiative called, “Jump Start Healthy Life with Diabetes.” That initiative was initially funded through an NBCH Diabetes Seed Grant and is now being replicated in a large public employer, largely because employers urgently see the need to address diabetes. A profile of the Reno initiative is included in a sidebar of this report.

In many ways, all of the efforts of a health plan to address diabetes care are reflected in a set of standardized measures of performance. The majority of the health plans who responded to eValue8 are accredited by an independent national organization called the National Committee for Quality Assurance (NCQA). NCQA sets standards for health plans and carries out audits to ensure health plans are complying with national standards. NCQA also requires health plans to report on their actual performance using a standardized measurement approach called HEDIS – the Healthcare Effectiveness Data and Information Set.*

HEDIS includes a performance measure that examines many of the essential aspects of clinical care for people with diabetes. The measure looks at the percentage of patients with diagnosed diabetes who received a specific diabetes related service – an eye exam, blood testing, cholesterol (LDL-C) testing, cholesterol control, and kidney monitoring within the prior year. It also shows how well plans are doing in controlling things that should not happen – e.g. poor A1C control. Many of the activities health plans take on are designed to improve their performance in these metrics. This, in turn, will mean better care and better outcomes for patients with diabetes.

Figure 2 shows 2008 and 2009 data on plan diabetes performance. In most categories health plans have improved slightly from 2008 to 2009, although both improvements and declines have been relatively small. In some areas plans are doing well. For example, over 80% ensure that patients have at least an annual A1C test and cholesterol screening. In other areas, there is much room for improvement: only about half of all patients have had an annual eye exam, and a third of patients do not have their blood sugar controlled as measured by A1C control.

Figure 2*: Diabetes HEDIS Results: 2008 to 2009



*Note: This table shows health plan HEDIS data reported to NBCH. The set of plans reporting to NBCH is slightly different than the set that report to NCQA, thus NBCH’s HEDIS findings may vary slightly from those reported to NCQA.

The remaining figures of eValue8 data illustrate plan performance in some of the tactical strategies to engage and activate patients and providers in ways that will improve diabetes performance measures and more importantly improve the quality of diabetes care.

Health Plan Health Promotion

Employers value health plan efforts to use health promotion interventions to engage members in healthier lifestyles. According to Nevada’s Ginder, “Nevada ranks

* NCQA allows health plans to collect and report HEDIS data even when they are not accredited, as long as the plans follow the standardized protocols established by NCQA.

very low in terms of healthy lifestyle – we’re 47th overall and dead last in the area of prevention and treatment.* There are a lot of risk takers in the population, and a 24 hour lifestyle. Several employers in the group have gyms and onsite wellness coordinators at the company level. But that’s not enough in this economy. We have a 13% unemployment rate and the gaming properties have seen a major downturn. Employers see diabetes as a cost issue and a huge cost driver. They see that we need to do more in prevention, and the employees are motivated to do something because they see the future of their jobs tied in with their employers’ financial viability.”

All plans reporting eValue8 data offer health promotion services that include personal health assessments (also called HRAs), health promotion programs, worksite wellness, and smoking cessation programs. The majority – shown in Figure 3 – bundle the services in administrative fees or include it in the premium, meaning that employers automatically receive that service. The remainder of the plans offer the services as a “buy up” that the employer can select. Bundled services or those offered in fully insured products are those the plan considers essential. The services range from offering a PHA to identify health risk – including diabetes risk – to health promotion services, smoking cessation programs, and worksite wellness offerings.

Figure 3: Health Promotion Services Offered Under a Self-Insured and Fully-Insured Basis

	Bundled in Standard ASO Fee	Included in Fully Insured Premium
Personal Health Assessment (Health Risk Assessment)	67%	87%
Health Promotion and Wellness	70%	86%
Worksite Wellness	20%	37%
Smoking Cessation Support Program	41%	61%

Wellness programs are dependent on employer uptake. Plans are clearly responding to less than optimal employer demand, as evidenced by lower rates of “bundled” health promotion offerings in the self insured market than in fully insured products. In fully insured plans, 87% offer a PHA; fewer, 67% bundle the PHA in the self insured fee.

Provider Engagement and Assistance

eValue8 addresses a number of health plan capabilities to engage physicians. Engagement tactics include:

- Measuring physician performance
- Reporting back to physicians on gaps in care or overall performance
- Promoting more effective physician practice by encouraging adoption of electronic systems and coordinated care processes such as patient-centered medical homes
- Rewarding physicians for better practice through financing or increased patient referrals

Health care is delivered by physicians and other health care providers, not health plans. Health plans contract with providers and pay the bills. Through these activities they access data about physician practice patterns and gain some leverage over physician behavior. Over the past decade plans have increasingly used their leverage as the bill-payers to encourage physicians to deliver recommended diabetes care and to provide the needed support to encourage patient engagement and self management. (Health plans also offer “wrap around” services such as disease management, web based education and other programs to augment physician care; these services are discussed later in this report.)

Plans are looking for ways to collaborate with physicians and use “carrots” to help them improve diabetes performance. The Midwest Business Group on Health’s Larry Boress says, “A lot of the plans are carrying out work around pay for performance and physician quality. As an employer group we are trying to understand how to get physicians to understand employer programs around value and quality. We are doing a survey now on physician perspectives on incentives, disease management, and health plan engagement strategies. We want to understand barriers and triggers to help us work together with physicians.”

Plans are often better positioned than physicians to get the big picture of how physicians are delivering care. Using claims data plans can estimate which patients with diabetes have received needed services and can notify the physician of gaps in care. Of course this is recognized as a problem in health care. For one thing, there is a long lag time in claims analysis, which makes gap notification rather untimely. Also, it illustrates the weakness in current information management practices in physician offices.

Physicians should be able to easily identify diabetics in their practices and determine which ones need services. This type of capability is available in health care registries and some electronic health records, both of which are being heavily promoted to improve physician practice capability.

A recent report by the Center for Studying Health System Change underscored the need for plans to support physicians in developing information management capability. That report found that use of “care management tools,” e.g. registries, reminders and group visits, are highly variable among physicians who care for patients with chronic conditions. Physicians who practice in organized settings or larger groups generally do better at having systematic ways to track and manage chronically ill patients. For example, only 10% of smaller physician practices reported having registries to track patients, while 70% of physicians practicing in group model HMOs had such capability. Practice size was the greatest predictor of use of care management tools. Sadly, there was no greater use of technology reported by physicians who also report having more chronically ill patients in their practices.¹⁶

Figure 4: Provider Performance Feedback Approaches: 2008 to 2009

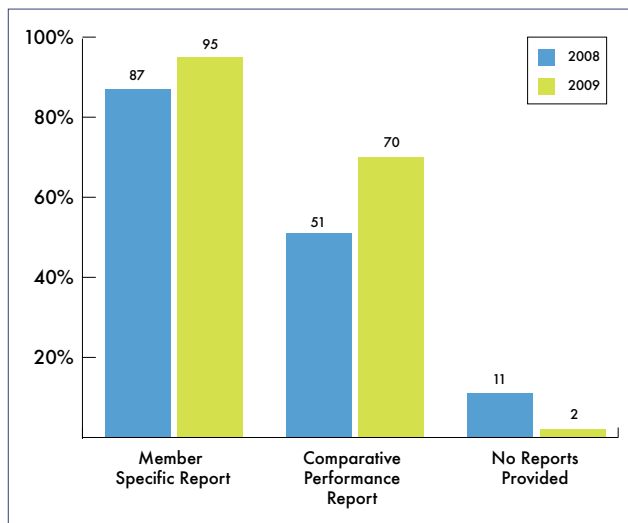
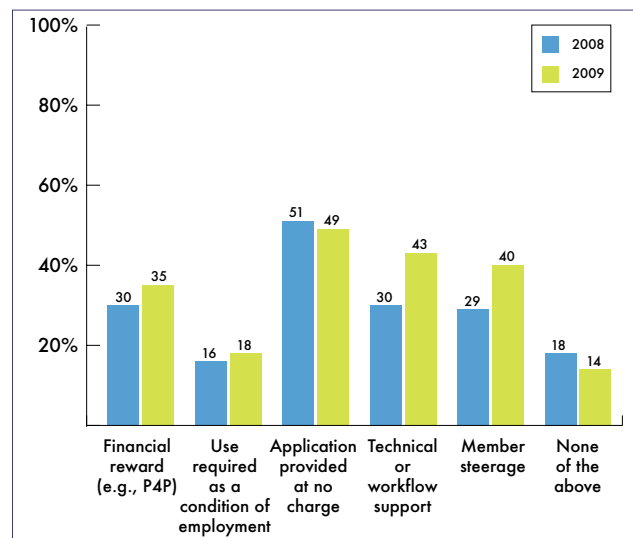


Figure 4 shows what types of reports plans are reporting to the physicians. 95% of health plans have capability to report back to physicians on gaps in care or quality of care for individual patients. This reflects an increase from 87% in 2008. In addition, 70% of plans can now show physicians how they compare with their peers. This comparative

reporting helps physicians to recognize what is possible, and often motivates them to make changes that improve delivery processes.

Specifically related to diabetes, 84% of plans report to physicians on overall A1C management in their practice, 59% report to physicians on how well their patients are controlling A1C, 81% report on physician performance tracking needed eye exams, and 76% report on cholesterol screening. Only 24% report on how well the physician is doing in helping to control blood pressure, and 52% report on cholesterol control. The goal of this type of feedback is to help physicians understand where their tracking and quality management processes need additional improvement. A new research study in 2009 showed that plan feedback may be less effective at promoting improvement than physician self assessment (such as through the NCQA Recognition process) and point of care decision support, so future trends may show increased emphasis in these areas.^{17,18}

Figure 5: Physician Support to Promote Electronic Tools to Support Clinical Decision Making: 2008 to 2009



As Figure 5 shows, plans are slowly but surely increasing their activities to promote technology uses in physician offices. Use of technologies such as electronic health records and registries is linked to higher quality care: physicians who use electronic systems can better identify the patients in need of care or generate reminders to themselves to deliver essential diabetes services. A minority of plans (18%) require electronic decision support tools

as a condition of employment or contracting, but more plans (35%) now offer financial rewards or incentives to physicians to adopt electronic health systems. Plans also offer technical assistance to physicians, with 49% offering electronic programs at no charge to providers, and 43% offering support to workflows.

Identifying and Promoting High Performance Physicians and Networks

An adjunct to health plan activities to help physicians and other providers deliver better care are plan activities to help patients identify and select high quality providers. Virtually all health plans publish an on line or hard copy “directory” of physicians and other practitioners. Members use the directory to identify “in network” physicians and other providers. These directories routinely publish physician name and specialty, along with location of the office and languages spoken.

Still in its infancy are health plan efforts to help guide patients to higher quality providers. For example, NCQA’s Diabetes Physician Recognition Program enables physicians to audit medical records of their patients for quality indicators. Physicians who achieve target rates for diabetes care are given a seal of approval for high quality by NCQA. Currently 61% of plans include information on Recognition status of physicians, but only 16% of plans include a web based search feature that allows patients to search for the high quality diabetes care providers who have been “Recognized” by the NCQA. Figure 6 illustrates how plans are using NCQA Diabetes Physician Recognition.

Figure 6: Use of NCQA Individual Physician Recognition Information by Plans

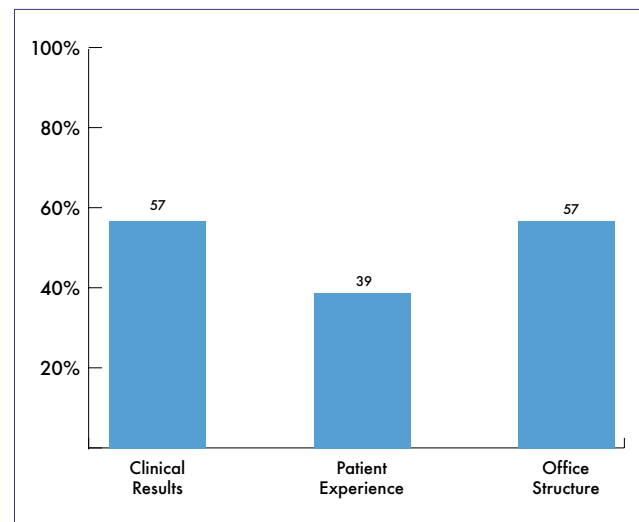
Monitored internally	54%
Used for performance feedback	36%
Used for comparative feedback reports	19%
Used for consumer reporting	61%
Used for payment rewards	13%

Although not necessarily searchable, often information on physician quality is available to members. eValue8 shows that 14% of plans include in their searchable directories data on mortality or complication rates (relevant to surgeons). 13% have searchable databases for physicians rated favorably by patients in the CAHPS “Experience of

Care” survey or other patient surveys. 60% of health plans have capability to show which providers participate in a “high performance network” – meaning that they have high ratings for quality or efficiency. These networks are discussed further below.

Starting to emerge are indicators of physician office function that are important to today’s wired patients: 14% offer information on which physicians offer web visits, 13% show which providers use email, and 16% show which physicians use e-prescribing (electronically communicating directly with the pharmacy) or use electronic medical records. Health care experts place a very high priority on use of electronic records as a strategy to improve care and improve health care efficiency. Recent “recovery funds” from the government have provided grants to physicians to improve use of technology. It is hoped that these incentive funds will increase adoption of electronic management systems that will improve care – and that health plans will soon be able to promote more wired practices through their directories.

Figure 7: Basis for Physician Financial Incentives



eValue8 also examines how health plans reward physicians for high performance in clinical quality, patient satisfaction, or efficiency. Figure 7 shows 57% of health plans use clinical results to determine financial incentives they paid to physicians, 39% based financial incentives to physicians on patient experience, and 57% paid financial rewards to physicians based on their office structure, such as electronic health record systems. For several of the responses there are

sharp distinctions between strategies that national plans use compared with those of regional plans. In this case, the results show that regional plans are more likely to use clinical, patient experience, and office structure indicators as a factor in determining financial rewards.

Employer interest in “high performance networks” is steadily gaining ground. These networks are created by plans from a subset of available providers. The concept is based on the premise that the quality and cost of care are highly variable across providers. By contracting with efficient or high quality providers, plans believe they can get better value for health care dollars. It is complex for plans to develop and market higher performance networks. Plans first need to determine the measurements used to evaluate the providers. Once the measures are in place, the plan does the analytics and creates a network of high quality or high performing providers. Most plans that offer performance networks have developed a combination of metrics based on the physician’s profile of utilization, cost, and quality, benchmarked by specialty and region.*

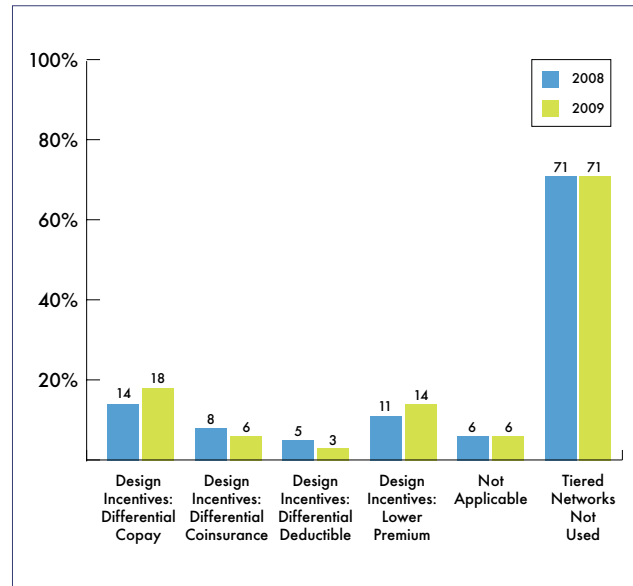
Member Engagement

eValue8 also expects plans to recognize the importance of both physician and patient roles in improving diabetes outcomes by engaging members. Engagement efforts can be through information, incentives, and benefit design. Some member engagement approaches addressed by eValue8 include:

- Offering high value physician networks or physician information to members
- Using incentives to increase member uptake
- Offering health information both passively, e.g. On a web site, and interactively, e.g. through a PHA
- Offering effective health promotion and disease management programming for members at varying points on the health continuum
- Promoting member action on health by encouraging members to use the PHA and to engage with the disease management program

It is very challenging to change member behavior either related to self management or provider selection. Members tend to select physicians based on geography and recommendations of friends and families and are reluctant to move simply because a plan offers a high value network.

Figure 8: Member Incentives for Tiered Primary Care Networks or Providers: 2008 to 2009

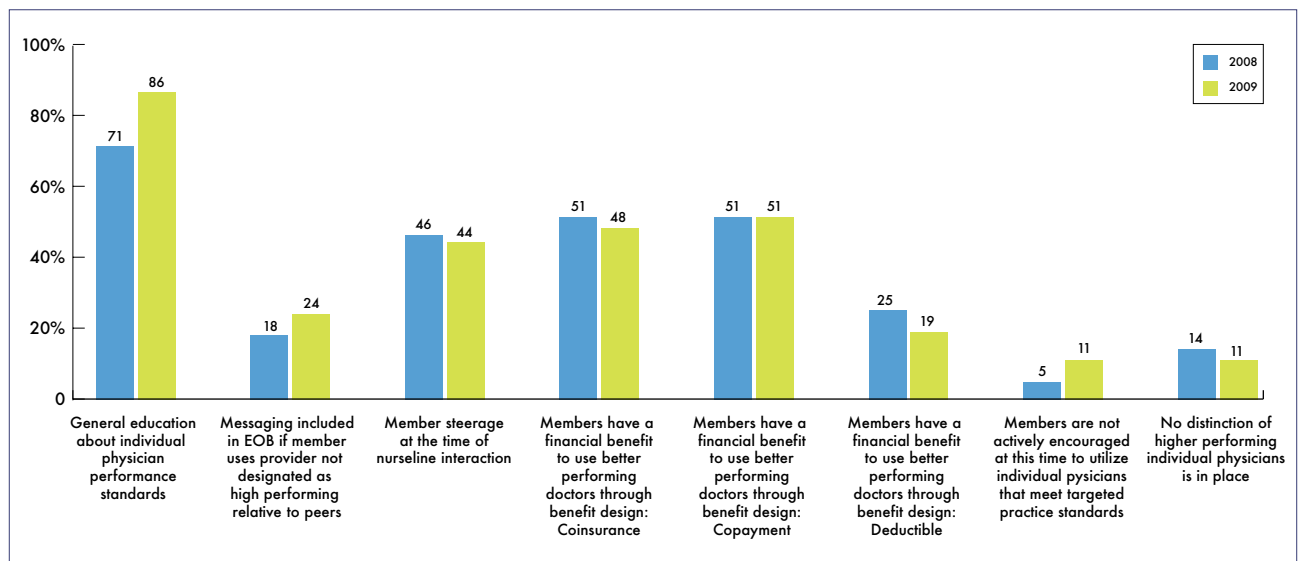


To achieve any market shift, a health plan has to market the value of a performance network to employers and directly to consumers. To this end, some plans now administer benefit designs that have incentives patients to select better performing physicians. These designs, and member use of selected networks, are still rare. For example, Figure 8 shows that less than 20% of plans report having benefit design differentials to reward members for choosing a higher performing *primary* care provider in the network. Slight increases were seen in 2009 of plans that offer a differential co-pay (from 14% to 18% or a lower premium 11% to 14%). More plans use these incentives to encourage members to select higher quality *specialty* physicians. The reported use of incentives to help direct members to higher quality physicians including specialty physicians is shown in Figure 9, found on the next page.

Figure 9 looks at the strategies used by plans specifically to encourage members to use higher performing providers of any type. Plan performance has not changed substantially in most categories since 2008. The exception is that more plans are offering member education about physician performance measurement, increasing from 71% in 2008 to 86% in 2009. The increase may reflect the fact that physician performance measurement is becoming more mature and plans are ramping up means to educate members about comparative selection of their physicians.

* The use of cost and quality measures at the physician level is controversial and has been the subject of lawsuits by physicians against health plans. Many plans abide by national standards for measuring physician level quality adopted by NCQA and URAC.

Figure 9: Incentives and Education for Members to Select Better Performing Physicians: 2008 to 2009



Plans often carry out programs to direct members to higher quality physicians in combination with other techniques such as benefit design, disease management and other approaches to try to get the most at risk patients – such as those with diabetes – to more intensive management and to the providers who are most qualified to treat them. As shown in Figure 9, 86% of plans conduct general member education activities about standards of care. 60% provide information on which specific providers meet practice standards (not shown). Plans also are developing capability to interact with and engage members who have identified care needs: 21% can include a message with benefit information mailed to the member, and 41% can use nurse advice lines to help direct the member to a qualified provider.

Plans have found that any type of member engagement requires extensive communications. Plans can use general enrollment information to communicate with members, but also communicate with members via web sites, newsletters, and most recently, through voluntary electronic communications such as secure email, podcasts and Twitter.

Says MBGH’s Boress, “If you do have a program that functions well and has the right features, you need to communicate it well to reach people and help people understand what to do and take action. There has to be something in it for the member, and they need to understand that. Our program ‘Taking Control of Your Health’ is for

employees that want to have a different kind of diabetes program and really learn something about how to manage their condition. We also have waived or reduced copays so there’s a financial incentive. We set high expectations for the type of care people get and we make sure all of the key players – employers, plans, physicians, members and a local partner – in this case, a pharmacist – are involved.” A profile of the MBGH program is included in this report.

Diabetes Care Management – Member Identification

Figure 10, seen on the next page, shows that there is real variability in how diabetes is distributed across the U.S. and that diabetes prevalence is steadily increasing. As such, plans in every region should consistently be able to identify which members have risk factors or have been told they have diabetes. There is still a wide range in the effectiveness of health plan diabetes detection activities: the number of diabetics identified as eligible for disease management reported by plans ranged widely. This shows that plans (and employers) use varying definitions for disease management eligibility and have varying methods to identify members. This leaves open the potential to miss engaging members with diabetes who are in need of services and support.

Earlier statistics presented in this report show that a large percentage of people with diabetes do not know they have it. Identifying patients who have not been diagnosed, and identifying patients who have been told they have diabetes

Midwest Business Group on Health Taking Control of Your Health (HealthMapRx)

The Midwest Business Group on Health (MBGH) is a coalition of 104 public and private employers representing over 2 million covered lives. The MBGH used NBCH Diabetes Seed Grant funding to expand their HealthMapRx program, Taking Control of Your Health (TCYH), by increasing the number of participating employers, pharmacists, and employees. Funding was also used to support an evaluation of the program’s impact on patient clinical outcomes.

The MBGH hosted employer-only luncheons and convened meetings with 20 employers in 2008 to increase awareness and market the program. The MBGH Learning Network served as a platform to demonstrate participating employer successes to non-participating members. From early 2008 to March of 2009 the MBGH had 5 employers participate in the TCYH program. A total of 179 employees with diabetes enrolled in the program. In their initial goal-setting the MBGH aimed to train an additional 50 new pharmacists for the TCYH program. Since that time, 100 new pharmacists have been diabetes certified bringing the total participating pharmacists to 200.

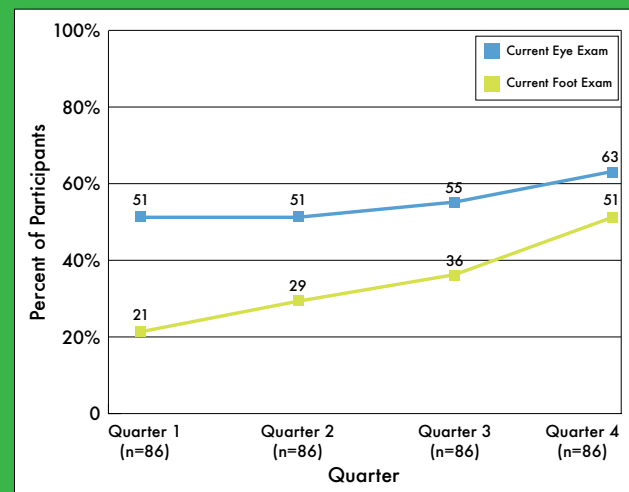
The MBGH was able to report on clinical, satisfaction, and economic outcomes data on employees during the one year period ending June 30, 2008. Participant behavior change is reflected in the lower A1c values, lower blood pressure, lower cholesterol, and weight loss. The average hemoglobin A1c value dropped from a mean average 7.52 at baseline to 6.95 during Quarter 4, as shown in the accompanying Table. The percentage of participants with an A1c value of 6.5 or less grew from 33% at baseline to 48% at one-year. The percentage of patients with a current foot and eye exam increased by 144% and 23%, respectively as shown in the attached figure. Participant satisfaction with overall diabetes care improved and satisfaction with pharmacist care was very high. Economics data indicated a year 1 return on investment when compared to actual, with an average saving per participant in the evaluation group (n=86) of \$1,467.

Internal communication about the program by employers to their members is essential to the success of a value-based purchasing initiative such as this. Employer agreement to participate is not enough to ensure employee enrollment – there has to be comprehensive and ongoing communication with employees to support the program.

The MBGH faced some barriers in trying to expand an existing HealthMapRx program but the coalition believes that overall the program was a success. The coalition continues to expand the TCYH program. Issues to overcome with each expansion include obtaining buy-in from senior management and justifying front-end investment for the increase in pharmacy costs and payment to pharmacists. This is especially challenging in the current economy. Coalitions also wrestle with obtaining claims data from employers and/or their vendors.

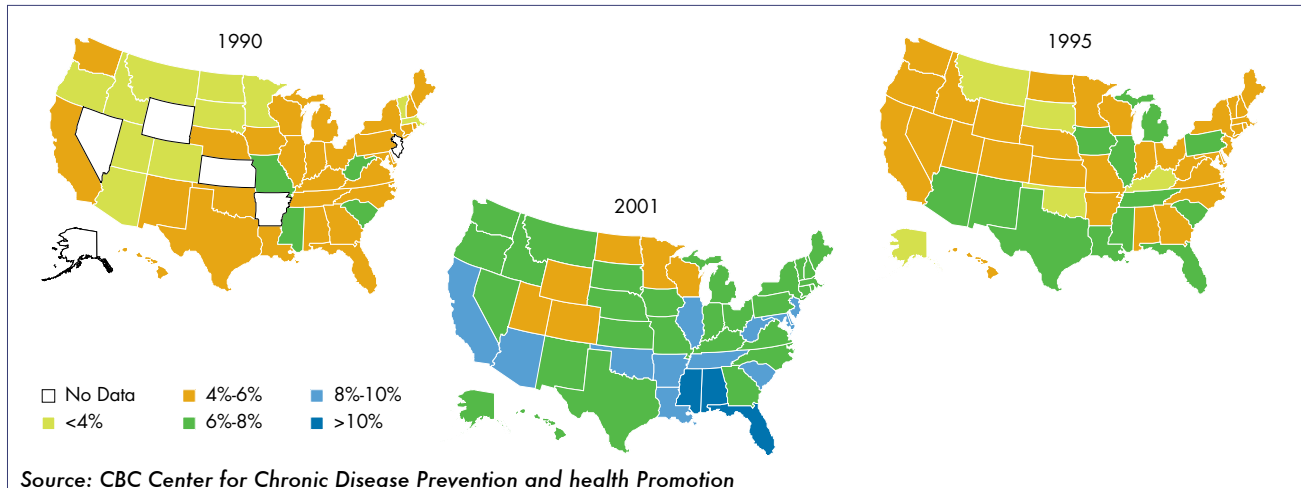
For up to date results visit www.mbg.org.

Eye and Foot Exams



Quarterly Results					
Hemoglobin A1c Metric	Baseline (n=24)	Quarter 1 (n=46)	Quarter 2 (n=37)	Quarter 3 (n=40)	Quarter 4 (n=42)
Average A1c Value	7.52	7.23	6.98	6.85	6.953
6.5 or Less	33%	46%	35%	43%	48%
6.6 to 6.9	21%	13%	22%	13%	7%
7.0 to 9.0	33%	30%	38%	45%	36%
9.1 or greater	13%	11%	5%	-	10%

Figure 10: Diabetes and Gestational Diabetes Trends Among Adults in the United States, Behavioral Risk Factor Surveillance System, 1990, 1995 and 2001



but are not aggressively treating it, is a high priority for health plans. Plans undertake a variety of approaches to identify diabetics. Outside of using claims to identify people who have already been diagnosed with diabetes, one of the most common strategies to identify members at risk is to use a Personal Health Assessment (PHA).

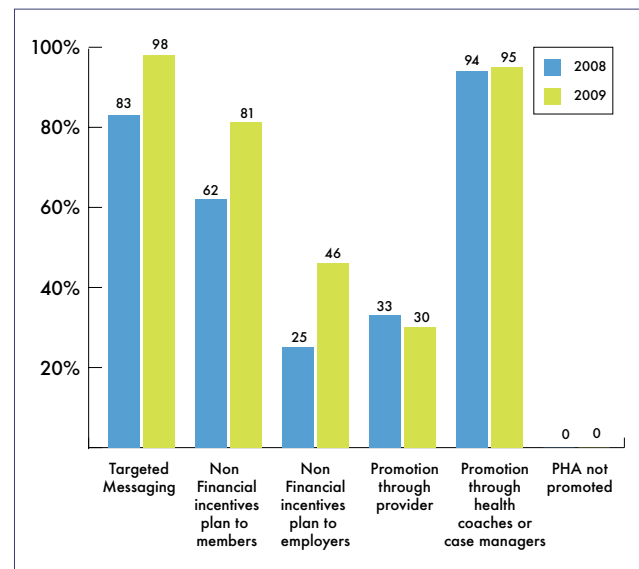
PHAs are an important tool for identifying patients and engaging them in treatment follow up. PHAs are paper based or online tools that are completed by patients. Patients respond to a series of questions about family history, weight, exercise habits, nutrition patterns and other topics related to health.* Most PHAs generate a report directly to the patient that explains their health risks identified during the screening with recommendations on issues they should discuss with their physicians. Some PHAs are also linked to the health plan's health management division. (Patients give permission for the plan to do this when they sign on to the PHA). Through the PHA the plan can flag patients who either have risk factors for developing diabetes, or who have diabetes and may not be getting all the follow up they need.

Although all health plans responding to eValue8 offer a PHA, most of them show a very low response rate by enrollees. On average, 2.7% of eligible enrollees complete a PHA each year. There is great variability in the percentage of people who respond for any particular plan, with half of all plans reporting that less than 1% of people respond to the PHA.

Many employers have a direct role in offering and incentivizing PHAs at the worksite. Employers believe that it is important

for their contracted plans to know who is responding to the PHA so that plans can work to improve response rates. In 2009 98% of plans could track the percentage of enrollees from a given employer that had responded. While plans must take vigorous precautions to maintain HIPAA-mandated privacy protections for enrollees, this tracking means that they can take action to reach out to members to encourage them to get engaged in the risk assessment process and from there, engage them in diabetes risk reduction.

Figure 11: Methods for Targeted Messaging for PHA completion



* The use of PHAs is currently in flux. Recent regulatory activity defining legislation, the Genetic Information Non-Discrimination Act (GINA) appears to prohibit plans from asking information about family history as a means to protect a member from genetic discrimination. This would prevent plans from asking about a key factor in predicting patient health risks. See Federal Register October 7, 2009 or article at: http://mcgrawhrentworth.com/Special_Alert/2009/Special_Alert_Issue_8.pdf

eValue8 includes a series of questions on how plans work to increase use of PHAs. Plans typically use general announcements / reminders using their web sites and member newsletters, often coupled with benefit design incentives. In 2009 38% include general messages at least 1-2 times per year, and 44% have more than six of these general reminders. In addition, most plans have capability to deliver more focused reminders. As Figure 11 shows, almost 100% of plans have “targeted” messaging – that means for enrollees the plan has identified at high risk (often through a disease management program or because of an emergency visit), they can do outreach to get the member involved. Over 90% of plans also promote the PHA when they have direct interaction with members, for example through health coaches or case managers. Almost half of plans have capability to use non-financial incentives such as gift certificates to encourage members to respond to PHAs.

Increasingly plans are using member communications, along with incentives, to get members involved. Plans are using a calculated strategy that it is worthwhile to employ incentives and focused outreach to get members involved in the risk assessment (with its potential for follow up care), in order to start the process of better self management and improved health. In some instances it is the employer who directly offers the PHA or who provides the incentive for member use of a PHA. Figure 12 shows the capability of plans to meet their self insured customer’s goals for administration of incentives.

Diabetes Disease Management

Members who have serious diabetes (beyond just risk factors) are often offered more intensive outreach services to ensure that they are provided necessary treatments and services. Through disease management patients receive support to improve self management for a chronic condition such as diabetes. Virtually all health plans offer disease management. 90% of health plans responding to eValue8 offer it to all customers; just 10% include it as an employer option to purchase disease management.

Most health plan disease management programs use the best practice approach of assuming that patients want to be involved unless the patient actively “opts out.” 84% of plans use the “opt out” model, while just 16% require patients to declare their desire to be in the program, or “opt in.” National accreditation organizations have developed standards addressing just how disease management programs should operate to ensure quality and protect patients; 64% of plans have a disease management program that is accredited either by NCQA or another accrediting organization, URAC, or by both organizations.

Many patients report challenges in making the many lifestyle changes required for diabetes, including compliance with diet, exercise and treatment follow up.¹⁹ Figure 13, seen on the next page, shows how plans make a continuum of services available to patients to help them manage diabetes. Disease management offers personalized support and helps the member to identify specific strategies and

Figure 12: Plan Support for Administration of Employer-Sponsored Incentives

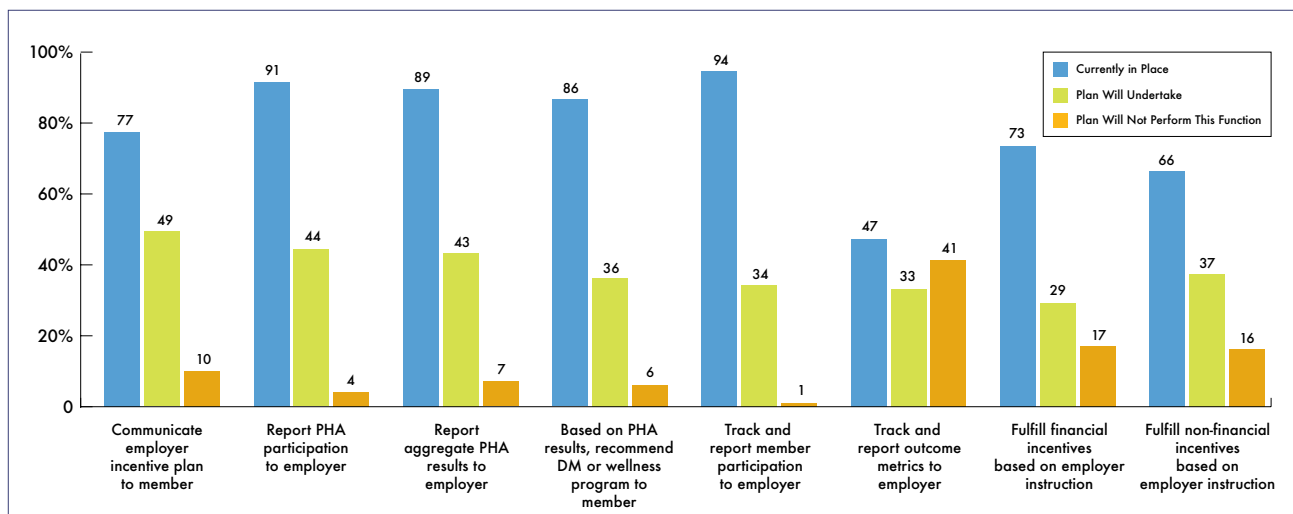
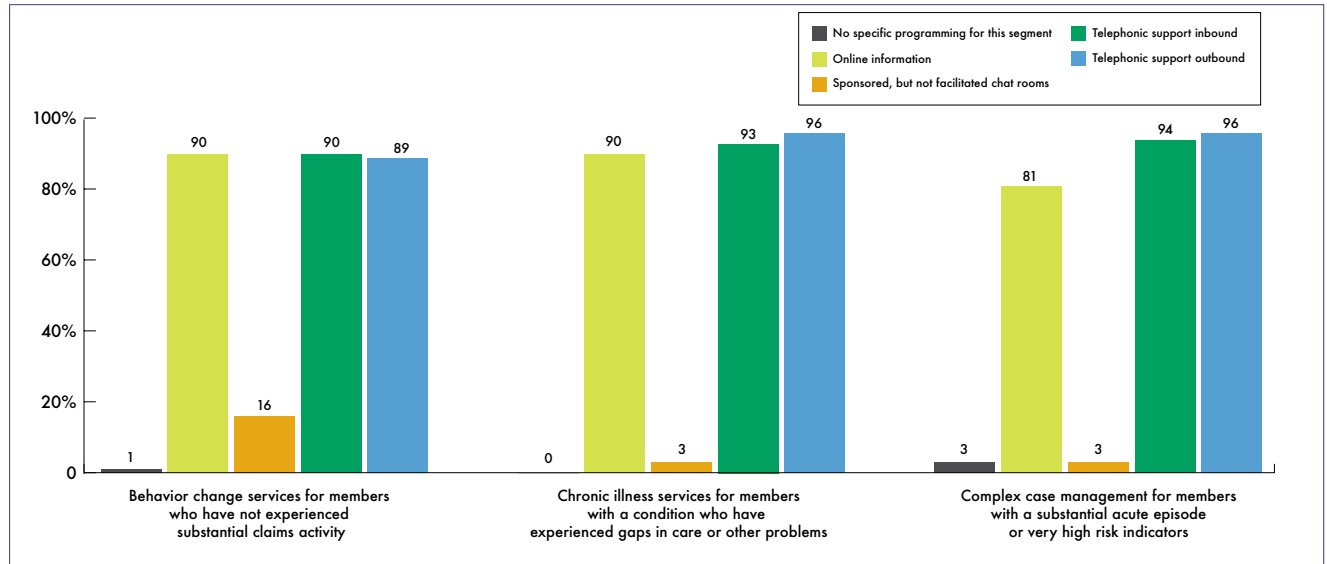


Figure 13: Plan Services to Meet the Needs of Members at Risk for Diabetes



opportunities for health improvement. 90% offer coaching or other services to enrollees who are identified through a health risk assessment.

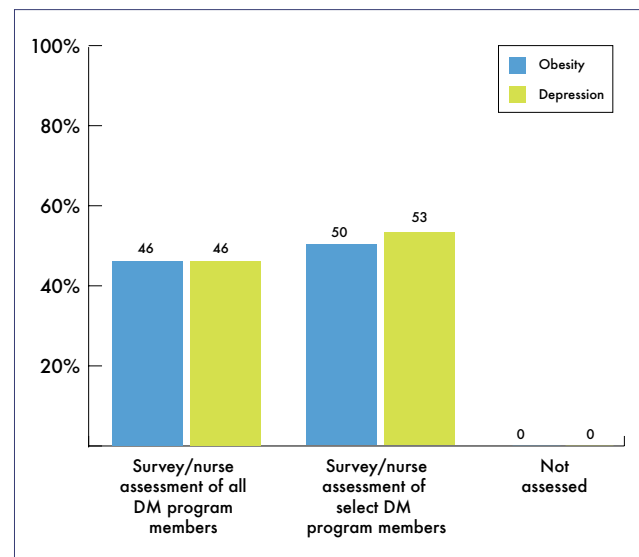
Disease management is most frequently a phone based program in which nurses or other professionals reach out to patients with diabetes. The nurses are trained to work with patients to evaluate whether the care being provided is consistent with best practices. These professionals encourage patients who are not receiving ideal diabetes treatment to ask their physicians about additional tests, medications, or services needed to most effectively manage diabetes. Disease management professionals usually also work with patients to set self management and behavior change goals. For example, such goals might include adding an exercise program or helping to improve nutritional intake. The majority of plans do outreach to members through phone calls, called outbound telephone support. Health plans also commonly have robust web sites that contain online information on health conditions and self management tools. Figure 13 also shows that over 80% of plans use their web sites to reach members with a continuum of health needs from coaching to complex case management.

Medication Support

Physicians know, and the research shows, that taking essential diabetes medications such as insulin and other “hypoglycemics” (medications to reduce blood sugar) is

crucial to keeping diabetes in control. But for many reasons patients often do not take medication as prescribed or do not continue with medications over time. Non-adherence increases the risk of complications and hospitalization for the member and costs money for preventable treatments.²⁰ This is one reason employers ask health plans to take special measures to use member support strategies to help improve member adherence to medications.

Figure 14: Health Plan Interventions for Screening Diabetic Members for Co-morbid Conditions



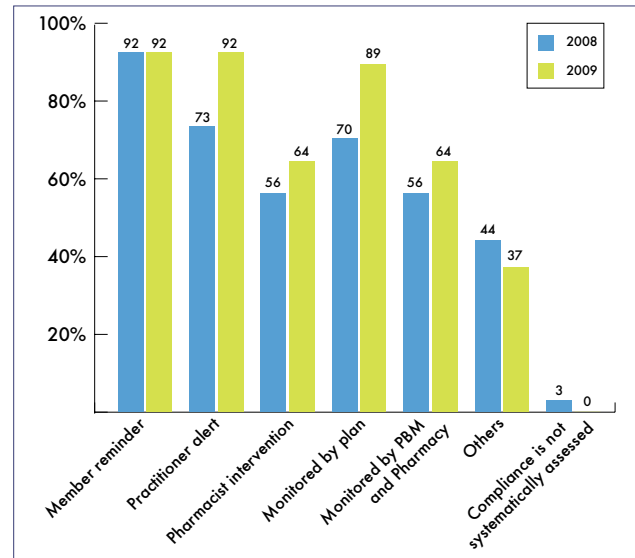
The majority of commercial health plans have access to both claims and pharmacy data. As noted earlier, this data allows plans to identify members with diabetes. It also enables them to track which individuals with diabetes also have a claim for a diabetes related medication. When the plan does not see regular claims for medication refills, it can surmise that there is a gap in patient “persistence” in taking the essential medications. Measures of member “adherence” that is, taking the medication as prescribed, and “persistence” - taking the medication regularly for the duration prescribed, are important indicators of member engagement in diabetes self care.

Increasingly employers expect plans to monitor patient adherence and persistence and to take action when there are gaps in care. Figure 15 shows some of the approaches used by plans to address a gap in prescription drug use. 89% of plans monitor medication use through pharmacy claims. This can be either directly, or as shown in Figure 15, 64% use a pharmacy or pharmacy benefits manager. That Figure also shows increases or holding steady in the percent of plans who take action on gaps in adherence by alerting the member’s practitioner (92%), reminding the member directly (92%), or asking a pharmacist to assess the member’s situation (64%).

In mail order pharmacy programs (often used by patients who take medications for chronic conditions due to lower costs) 63% of plans offer a “live” outbound reminder call program, 69% have an automated call program, 24% offer

web based reminders, and 69% will mail a reminder letter to the member. This type of monitoring and interaction with patients can have an important impact on patient engagement in their own care.

Figure 15: Health Plan Monitoring and Actions for Medication Compliance



Plans also recognize that members increasingly want medication information and comparative purchasing information. Figure 16 shows that web educational information made available to members about pharmaceuticals is universal. Plans are adding capabilities to help members

Figure 16: Pharmacy Data and Tools Available on the Web

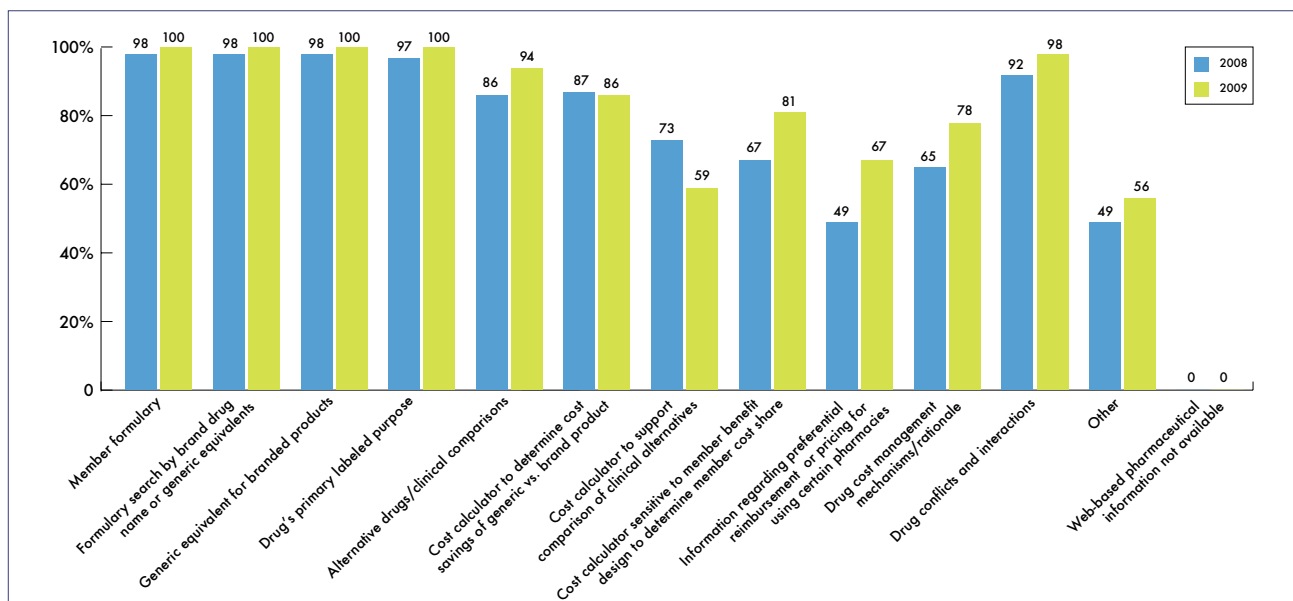
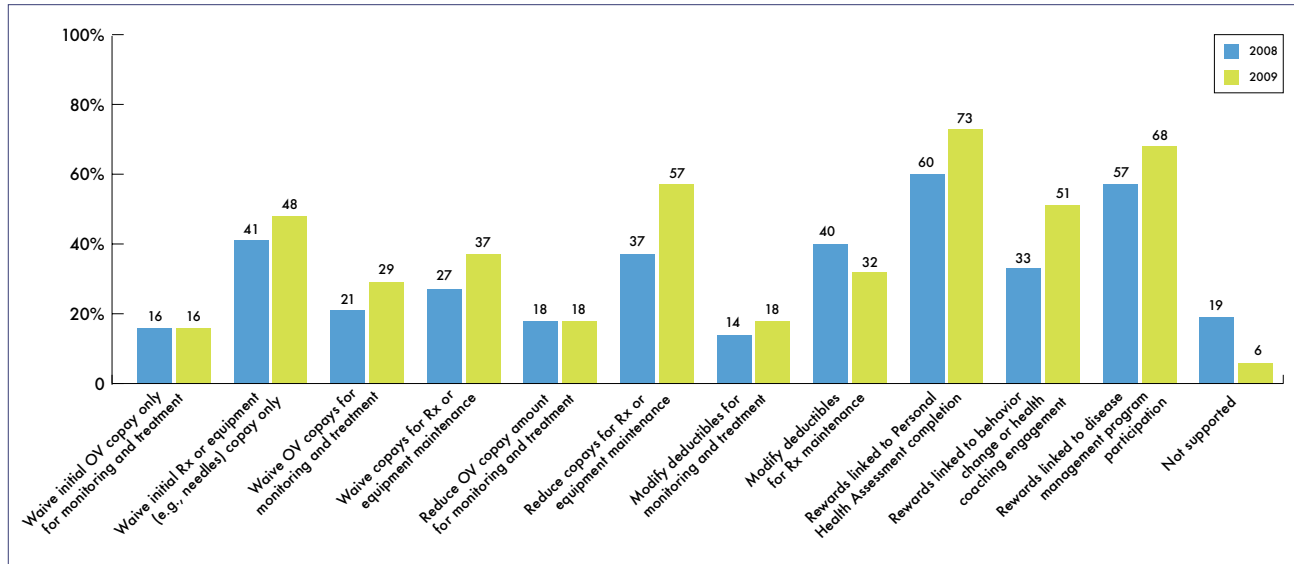


Figure 17: Value-Based Benefit Design: 2008 to 2009



make comparative purchasing decisions for their medications with 81% of plans allowing consumers to compare medication costs based on their benefit offerings, up for 67% in 2008. This capability is an important complement to the value-based benefit design strategies discussed in the next section.

Benefit Design

For several years NBCH has promoted the concept that employers' benefit design should help direct members to higher value health actions. For example, NBCH believes that differential co-payments or deductibles can be used to promote adherence to visit schedules, testing, and treatment for chronic disease. The logic for "value-based insurance design" is that it is worthwhile for employers to lower the cost of compliance for selected high value services, because it is highly likely to have a payoff in lower overall treatment costs. In diabetes care, for example, a value-based insurance design would reduce or eliminate member costs for insulin or other diabetes medications, as well as potentially for hemoglobin A1C testing and diabetes related follow up visits. By reducing the financial barrier to compliance, the goal is to reduce the development of diabetes complications with resulting preventable emergency and hospital costs.

One of the health plans responding to eValue8 has taken the concept of value-based purchasing for diabetes to a higher level. UnitedHealthcare was recognized with an eValue8

award in 2009 for its innovative "Diabetes Health Plan." The Diabetes Health Plan (profiled briefly in the following pages) layers onto United's health plan offerings. Employers who sign up for it get a higher level of monitoring and activities to engage members. Members are encouraged to closely monitor and manage diabetes indicators (in partnership with physicians) and are offered incentives for monitoring. Employers are looking carefully at this plan innovation to determine if the results in health improvement and cost avoidance merit further investments in this approach.

Figure 17 shows a number of the value-based strategies adopted by plans. Most categories have shown a slight uptick in 2009. For example, in 2008 41% of plans had capability to waive copays for first time prescriptions and equipment for diabetes, while in 2009 48% had capability to do so. For maintenance medications – essential to effective chronic disease management – the numbers jumped from 37% of plans with capability to reduce copays in 2008 to 57% in 2009. Many plans also consider initial patient engagement to be a value-based strategy; the earlier members can be identified with chronic disease or disease risk factors, the sooner the member and his/her physician can start working to head off serious problems. 73% of plans now have capability to reward members to participate in a PHA, an increase from 60% in 2008. 68% of plans in 2009 link rewards to participating in a disease management program (for those who need it.)

Another element of value-based purchasing is using incentives to direct members to higher quality providers. This is particularly important for members with chronic diseases, and for whom assuring evidence based care is directly related to improved outcomes. The earlier section of this report addressing high value network discussed some health plan strategies for identifying and creating incentives around high quality providers. Many plans are also pilot testing the concept of patient-centered medical homes (PCMH).

eValue8 plans are participating in PCMH pilot tests by contributing data or personnel or by experimenting with innovative financing arrangements. Many are also using claims data to evaluate the impact of enhanced chronic care services delivered through a PCMH. Because most physicians contract with multiple plans, a number of multi-insurer PCMH pilot tests are under way. In 2009 57% of eValue8 plans reported participating in a single-insurer pilot in their market. An additional 4% of plans reported participating in a multi-insurer pilot, for a total of 61% of plans participating in a pilot.

According to the model, a PCMH fosters relationships between patients and providers, improves access, and increases quality and consistency of care. PCMH incorporates re-created office processes and payment systems to reward an ongoing physician patient relationship and high quality, coordinated care. The PCMH requires an

investment in financing either through up front payments or redesigned reimbursement, to help providers implement and sustain the model. Through better information management, use of guidelines, and coordinated care, the PCMH theoretically may contribute to better quality, which in turn drives cost reductions in avoided hospitalizations and emergency department visits.

Of the 43 health plans that reported participating in pilot tests, enhanced care management and reducing gaps in care was an important priority. In 72% of these plans the PCMH looks for member-specific gaps in preventive and chronic care services at the time of a visit so that these needs can be proactively addressed. Plans report that 67% of PCMHs have an “outbound mechanism” such as automated phone calls, a personal call from a care manager, or an email, to contact a patient who has not scheduled a needed visit to remind them to visit the physician. Physician offices have also staffed up to meet the additional care management and coordination requirements of a PCMH. 91% of plans report that the PCMH has a nurse or other clinical personnel dedicated to care management and 37% have additional non-clinical resources as the primary personnel dedicated to care management. Some of the plans report that practices share personnel for care management, and 77% of the reporting plans indicate that they provide care management personnel to physician practices as part of the PCMH pilot test.

CASE STUDY

Case Example: UnitedHealthcare's Diabetes Health Plan Designed to Help Employers Improve Health, Control Costs

In November, 2009 NBCH gave an award to UnitedHealthcare for a plan design innovation specifically targeting quality of care improvements for diabetes. UnitedHealthcare submitted the Diabetes Health Plan as part of its eValue8 response. According to UnitedHealthcare, employers are signing up for a first-of-its-kind health plan by UnitedHealthcare designed to help control the escalating costs of insuring diabetic and pre-diabetic employees and their families while improving their health.

The Diabetes Health Plan has been piloted in 2009 with three employers - General Electric, Hewlett-Packard and Affinia Group. All three have either renewed or expanded their participation in the program for 2010. Employers such as the City of New Orleans and the American Postal Workers Union Health Plan will offer the plan to diabetic and pre-diabetic employees for the first time beginning Jan. 1, 2010.

The Diabetes Health Plan goes further than traditional diabetes wellness programs by providing patients with financial rewards for adhering to certain routine preventive care compliance requirements such as having regular blood sugar checks, routine exams and preventive screenings, which can result in better self-management of their care. In addition to helping people live healthier lives, the preventive steps under the Diabetes Health Plan can help significantly lower a diabetic employee's total health care costs.

Participation in the Diabetes Health Plan is voluntary. Based on historical claims analysis and biometric screening, UnitedHealthcare plan participants whose employers offer the plan and who are identified with diabetes or pre-diabetes are invited to enroll. The Diabetes Health Plan is available to self-insured commercial health plan customers and their family members with diabetes or pre-diabetes. Plan benefits,

which can include some free diabetes supplies and diabetes-related prescription drugs, as well as lower co-payments for related doctor visits, could save individuals up to \$500 a year in addition to their regular health care benefits.

Participants can receive access to online monitoring and education tools at no charge, in addition to self-monitoring training and certain diabetes-related services and drugs (i.e. insulin, oral hypoglycemics, ARB and ACE, anti-depressants and statins). To remain in the program, participants must comply with the plan's requirements that are based on diabetes and preventive care evidence-based guidelines tailored to meet the needs of each individual. Employees enrolled in the Diabetes Health Plan who lose their employer-based coverage are still eligible for the plan under COBRA, provided their employer offers it and they continue to follow the plan's compliance requirements.

Employers can tailor plan benefits to provide incentives to participants for following plan guidelines, such as cash rewards for enrollment or every quarter of compliance, lower deductibles, free or low-cost prescription medications, test meters or other diabetic supplies, and lower co-pays for related doctor visits and diabetes-specific treatments. Plan benefits vary by employer.

** adapted from the UnitedHealthcare web site, http://www.uhc.com/news_room/2009_news_release_archive/more_employers_turning_to_unitedhealthcare_diabetes_health_plan.htm*

SECTION IV: WHAT THE FUTURE MIGHT HOLD FOR EMPLOYERS

The Search for Value

Employers are urgently seeking value in their health care purchasing decisions. Many have recognized that more expensive health care does not necessarily translate into higher quality health care. eValue8 has served for almost a decade to help employers examine the detailed strategies underlying their health plan offerings and to point plans in the direction of evidence based innovations. This year, eValue8 asked plans to discuss in details the methods they use to identify members in need of services or at risk for chronic disease, and how they get these members into a coordinated, patient-centered program.

In the coming year we are likely to see ongoing efforts to develop “value” programs. Employers will continue to experiment with patient-centered medical homes as a way to encourage physicians to deliver comprehensive, coordinated care supported by modern information technology.

One of the stumbling blocks to adoption of PCMH tools by physicians has been lack of a payment method that promotes physicians’ capitol investments in technology to support coordinated care (e.g. systems to track lab results, specialty referrals and results, or patients’ clinical needs). The financing system also discourages qualitative health care visits often needed for chronic disease management. The lack of reimbursement has been a particular problem for primary care physicians. Physicians have typically been rewarded at much higher dollar rates for interventions and procedures than for sitting down to educate a patient about caring for diabetes. Plans, including Aetna and CIGNA are partnering with physicians to develop clear expectations for what services will be delivered in a medical home and then reward physicians financially for delivering those higher value services.

NBCH has developed two publications specifically examining health plan and employer approaches to improving access to patient-centered medical homes. In the *Purchaser Guide to the Medical Home*,²¹ NBCH partnered with the Patient-centered Primary Care Collaborative to examine three questions:

- What is the patient-centered medical home?
- Why should employers/purchasers support it?
- What strategies and action steps should employers/purchasers consider now?

The second publication, to be released in first quarter, 2010, is an in depth look at how plans and purchasers have consciously used either value-based purchasing strategies or the patient-centered medical home to improve the value of health care, and how the two approaches could be used synergistically. NBCH staff and expert co-authors advocate maximizing the potential of the PCMH by using value-based incentives and rewards to encourage members to use recognized PCMH for their chronic condition needs. The Purchaser Guide is available free on the internet at the location cited, and the PCMH-VBID analysis will be available on the NBCH web site.

Community Initiatives

Employers also see the future in community based initiatives to “rise the tide” of health throughout the community. Nevada Health Care Coalition’s Mike Ginder says, “As a coalition director one of my roles is to bring together partners in the community for education and intervention campaigns. We need to tackle diabetes with a clear focus that can include helping each individual employer make individual changes in their workplace. It also means we need to get the whole community to address health, rather than just throwing darts. Employers have their own role working on individual benefit design elements – for example, our school district provides testing supplies at no cost for employees with diabetes – but we also see employers working in partnership with public health and other community organizations.”

This type of population based health initiative is likely to increase as employers recognize that community factors impact the health of their current and future workers. Investments in community health promotion may well yield lower long term chronic care costs. Employers are also asking plans to participate at the table, participating

WHAT THE FUTURE MIGHT HOLD FOR EMPLOYERS

both in health promotion for members and in community level activities. In 2010 NBCH will be working with coalitions and their employer members to test out a variety of collaborative approaches to improve population health at the community level.

Health Care Reform

At the time of this report writing, the Nation had taken important steps towards health care reform. These actions will influence management and prevention of diabetes for decades to come. It is likely that in 2010 employers will be responding to reform in some shape or another.

NBCH believes that the current health system is built on a toxic financing approach that encourages overuse and high intensity services at the expense of coordinated, patient-centered care that encourages member engagement and self management. NBCH has communicated with the President and legislators with specific recommendations to reinforce the importance of establishing a health care system built on value, with a clear return for every dollar spent. NBCH notes in its letter that the path to health care delivery reform and cost containment is value-based purchasing. The eValue8 tool embodies the functionality that must be disseminated throughout the health care system: the need to measure, publicly report, and, most importantly, reward — through payment and selection — high performance and value in health care services and delivery.

As we move forward to implementing reforms in whatever shape they emerge, NBCH encourages employers to consider advocating for these value-based purchasing pillars:

- Standardizing performance measurement
- Reporting performance measurement results publicly
- Reforming the health care delivery payment system
- Engaging consumers in informed decision making

NBCH recognizes that many employers are ready to share in the fiscal responsibility for extending coverage to all Americans but only if real cost containment through value-based purchasing is a core element of reform legislation.

Conclusion

eValue8 is a tool used by the nation's employers — working in partnership with local health coalitions — to assess health care quality and nudge health plans towards innovations and improvements. This year's report focuses on strategies to engage members in self management. Increasingly, plans are using incentives and rewards to engage members. Employers believe that these incentives must be coupled with a more effective delivery system. The progress towards adoption of patient-centered medical homes is heartening, but is only a first step. Health care providers, plans, and employers must keep promoting improvements in the system — for example, through technology, adoption of best practices, and new strategies for engagement — that will transform our trajectory. We must move away from the path towards obesity, diabetes, and the cost of chronic illness. To do this we must forge new partnerships, new financial incentives, and most importantly, embrace modern technology in the care management system.

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