



AAPPO Innovations in Value-Based Approaches to Diabetes Care Issue Brief

Innovations in Plan Design to Improve Diabetes Care

This Issue Brief, *Innovations in Plan Design to Improve Diabetes Care* is part of a series **Innovations in Value-Based Approaches to Diabetes Care** by the American Association of Preferred Provider Organizations (AAPPO). This Issue Brief examines a new product offering – the United Diabetes Health Plan, which incorporates value-based insurance design (VBID) features to improve diabetes care. VBID strategies are rapidly emerging in the healthcare industry and have been adopted as part of health care reform. Preferred provider organizations (PPOs) including PPO networks and third party administrators (TPAs) are encouraged to examine VBID as a strategy to add value for customers and drive improvements in health outcomes for patients.

For more information on diabetes and VBID, visit AAPPO's Accountability and Value web site. Other Issue Briefs from the series are available on the site, along with presentations, toolkits and resources on VBID and diabetes. The resources are designed to assist PPOs in working with payers, providers and patients to identify value-added strategies that improve diabetes care.

About AAPPO

AAPPO is the leading national association of preferred provider organizations (PPOs) and affiliate organizations. More than 193 million individuals are enrolled in a PPO program, which means 69% of Americans with health care coverage receive their health care services through a PPO delivery system. A PPO network of providers may be an embedded part of a traditional insurance program or it may be contracted as an element of a self-insured program that includes a third party administrator of claims and care management programs. PPOs also provide network services to newer types of insurance products such as consumer directed health plans.

Introduction

It is difficult not to be impressed by the growing prevalence and staggering impact of diabetes on patients, employers and health care providers. Type 2 diabetes, in which the body does not produce enough insulin or the cells ignore the insulin, is the most common type.¹ Type 2 diabetes is strongly influenced by obesity and a sedentary lifestyle. Diabetes affects all demographic groups and has a price tag of about \$174 billion in direct and indirect costs. The numbers have steadily escalated and in 2010 about 24 million, or almost 8 % of the population, was diagnosed with diabetes. Even more troubling, another 57 million people (or double those with diagnosed diabetes) have pre-diabetes - blood glucose levels that are higher than normal but not high enough to be classified as diabetes. Pre-diabetes puts people at increased risk for developing diabetes and its associated complications.²

Diabetes is the sixth leading cause of death in the U.S. and it has debilitating and disabling complications such as blindness, decreased circulation that can lead to amputations, hypertension and other conditions that can severely

affect patient’s quality of life.³ Diabetes is frequently the underlying cause of heart disease, and individuals with diabetes are very likely to suffer cardiac co-morbidities. Diabetes is also associated with another highly prevalent and costly diagnosis: depression. Evidence suggests that diabetes increases the risk for depression and vice versa,⁴ and depression may reduce the capacity of patients to manage the medication and behavioral treatments for diabetes. A full discussion of diabetes impact, treatment, and VBID levers is available in AAPPO’s Issue Brief # 1.

Value-Based Insurance Design (VBID) and Diabetes

Value-Based Insurance Design (VBID) essentially uses the principles of behavioral economics applied to health plan design and patient decision-making. The value, in value-based insurance design, is that it applies dollars and incentives to increase actions most likely to influence good outcomes in health care. VBID is a consumer-centered approach that varies the benefit level by offering incentives to drive evidence-based interventions that result in better health and productivity outcomes.

Why VBID Matters to PPOs

PPOs need to recognize diabetes as a major cost driver for payer and employer clients. Risk bearing PPOs can develop and offer VBID products that offer cost management and care improvement solutions for customers. Network PPOs can contract with high value providers and offer expert advice to clients on VBID opportunities that improve care and lower costs.

Successful VBID programs use the levers of information and incentives to motivate patient behavior changes such as better eating or getting more exercise, improving adherence such as taking essential medications regularly, or making better provider choices, such as choosing a high performing physician. VBID strategies include variable co-pays or deductibles, contributions to the patients’ premium share, or cash/gift incentives designed to improve uptake of the services most likely to improve patient health.

The common thread across diverse VBID strategies is use of evidence to determine high value services and use of a “carrot” or stick (incorporating disincentives for use of services that are not evidence-based) to promote higher value services. Through reductions in adverse events such as hospitalizations and benefit design changes, VBID can be a cost neutral program. The obvious upside for plan sponsors is that they are paying for higher value care for their members. In addition to improving quality, this should result in an ultimate cost savings to the plan.

VBID has been demonstrated to have an impact in improving diabetes management. Despite the alarming news cited earlier about the growing prevalence of diabetes and its impact, improved member engagement coupled with evidence-based care can have a positive influence. For example, individuals with pre-diabetes can reduce the rate of onset of Type 2 diabetes by 58% by adopting lifestyle changes including weight loss and increasing physical activity.⁵ United Health Plan, discussed later in this paper, has seized on this finding and is collaborating with the YMCA to enroll pre-diabetic patients in an evidence-based, structured lifestyle program, an initiative they believe will add value by reversing diabetes in program participants.

VBID has been shown to improve medication adherence, particularly when non-adherence is related to medication expense. Adherence to a prescribed medication regime is something that intuitively makes sense. Yet patients routinely fail to take even essential medications as prescribed, a leading source of concern among healthcare providers and plans. A recent study from the New England Health Care Institute cites that “poor medication adherence in all its manifestations costs the U.S. upwards of \$290 billion per year in unnecessary health care spending.”⁶ Or put more simply by the former US Surgeon General C. Everett Koop, MD., “Drugs don’t work in patients who don’t take them.”

The table below shows changes medication adherence attributed a VBID intervention: reduction in the patient’s drug acquisition cost. In this case the program “reduced copayments 50% for brand names and completely eliminated copayments for generic diabetes medications,”⁷ and positively impacted medication adherence.

Employers and plans are experimenting with diverse VBID approaches that try to increase adherence. These include incentivizing simplified medication regimens such as once a day dosing or prefilled pen syringes or moving diabetes medications and testing supplies into preferred tiers. The VBID expectation is that increased drug costs will be offset by reduced costs of complications.

Table 1: Impact of Copayment Reductions on Diabetes Medication Adherence

	Baseline Compliance (MPR*)	Percentage (%) Point Increase in MPR	Increase in Compliance	Decrease in Non-Adherence
Diabetes medications	69.5%	4.02 (p<0.001)	5.8%	-13.2%

*MPR=Medication Possession Ratio; the % of days in the quarter that the patient possessed the prescribed medication. MPR, particularly when measuring refills, has been shown to be a fairly good way to approximate adherence. Source: Adapted from NIHCM Foundation. Value-based Insurance Design: Maintaining a Focus on Health in an Era of Cost Containment. June 2009

VBID Spotlight: United’s Diabetes Health Plan

United Healthcare (United) launched a Diabetes Health Plan in 2009 designed specifically around VBID concepts of incentives and member engagement.⁸ United had observed that 40% of an average plan sponsor’s total expenses were related to diabetes. The Diabetes Health Plan, available to administrative services only (ASO) clients, was created to address the problem of increasing diabetes prevalence and cost trends. The Diabetes Health Plan product enrolls members with diabetes and prediabetes from the overall health plan, and engages them with incentives for them to seek and adhere to evidence-based diabetes care.

The Diabetes Health Plan is based on the following VBID concepts:

- Value-based Plans are specific benefit plans that support evidence based medicine in an effort to drive the best clinical and financial outcomes.
- Diabetes Health Plan (DHP) is a Value-based Plan Design that creates financial incentives for members who are in compliance with specific health actions related to diabetes and pre-diabetes.
- Financial incentives are designed to removed financial barriers. Incentives are linked to point of service reductions such as waived or reduced office visit and pharmacy copays. Incentives can also be provided through account based means, deductibles and limited point of service copays for consumer directed health plans.
- The key opportunity is to increase compliance in the diabetic population and impact behavior and lifestyle in the pre-diabetic population. These actions delay the progression in diabetes and can prevent the conversion to diabetes for the pre-diabetic member.
- Cost, prevalence, external compliance indices and a modifiable condition are among the prominent factors that make diabetes the ideal condition for a Value-based Plan Design.

The Diabetes Health Plan focuses on early identification and customized member incentives to prevent diabetes progression and/or complications. Without intervention, United data shows that diabetes progresses from about \$3700 per member per year with pre-diabetes, to about \$17,000 per member per year for a non-compliant member with diabetes plus complications. One key goal is to reduce that progression and cost trend.

Essential Components of the Diabetes Health Plan:

1. Diabetes and Pre-Diabetes Screening
2. Compliance Requirements for Members
3. Diabetes Specific Benefits (reduced co-pays for visits, monitoring and selected medications)
4. United “Premium” designated Physicians and Facilities that Meet Quality and Efficiency Standards

Execution of the plan entails:

1. Historical claims review – to identify diagnosed diabetics and prediabetics;
2. Campaigns and referrals – to encourage enrollment in the Diabetes Health Plans
3. Biometric screenings – to identify members with risk factors but not diagnosed
4. Employee enrollment – opt in or opt out approaches can be used
5. Individual health assessment and referral
6. Member compliance – specific diabetes care and preventive services tracked, along with provider and medication utilization
7. Member benefits –reduced out of pocket costs for pharmacy and treatment services
8. Employer benefits – reduced long term expenses, reduced productivity loss, increased employee satisfaction

United’s design innovations include reducing or eliminating co-payments for diabetic related medications, supplies and office visits and offering access to supportive services such as nutrition and weight loss programs. As a trade-off for reduced costs, diabetic and pre-diabetic members must follow certain evidence-based clinical guidelines. For example, diabetic enrollees must obtain labs tests for hemoglobin A1c, low density lipoprotein (LDL) cholesterol and microalbuminuria/creatinine every six months, among other requirements.⁹ The Diabetes Health Plan also offers personalized member reporting and services tracking.

In addition to the lowered copayments, United offers member education programs for important issues such as nutrition, exercise and lifestyle changes. United forged a partnership with the YMCA to offer a weight loss and exercise program modeled on the evidence based “diabetes prevention program. (DPP).” The YMCA program will be offered to pre-diabetic members with the expectation that relatively minor weight loss can promote major improvements in pre-diabetes indicators.¹¹ (Some Diabetes Health Plan programs are currently offered at select geographic locations but are expected to roll out nationally over the next two years.¹⁰)

The United Diabetes Health Plan’s initial six month results showed positive results. Data showed a 22.5 % higher compliance for members enrolled in the plan, with improvements in all discrete quality measurement areas for diabetics and pre-diabetics. Over time, United expects to see moderating costs due to earlier identification of pre-diabetics with a lowered rate of conversion to full diabetes, earlier identification of previously undiagnosed diabetics resulting in fewer developing complications, and increased compliance for diabetics resulting in fewer complications. United expects a positive return on investment for the Diabetes Health Plan at 5% diabetes prevalence for populations of 4000+, assuming voluntary participation in the program. Future evaluation measures will focus on actual clinical outcomes and comparative effectiveness of various treatments, such as medications.

Satisfaction results are also positive. According to United, there has been a positive reaction from members and providers about the Diabetes Health Plan. Members appreciate rewards and support for adopting or sustaining healthy behaviors. This can be especially important to members who are already following healthy habits since historically those members who are unhealthy or non-compliant have received most of the positive incentives. The program has also had success with a population that has been historically difficult to engage, the pre-diabetic, especially those who are not taking medications. United has found that the lifestyle and weight loss components of the Diabetes Health Plan are important factors for connecting with this latter group.

The Diabetes Health Plan provides opportunities for improved provider relations and communications. For instance, those providers who are following evidence-based guidelines for screening and office visits now have more influence to get their less compliant patients into the office and more closely monitor their care. They may also gain patient volume by participating as designated high quality diabetes care providers. For providers not following recommended evidence-based guidelines, United can use this as an additional opportunity for focused provider outreach and education.

United initially offered the Diabetes Health Plan to their administrative services only (ASO) product segment; however, the company intends to next expand to one of their fully insured plans. United was recently awarded a \$15 million grant from the CDC to conduct a longitudinal study the impact of the Diabetes VBID design over a five year period. Along with the research and program expansion, United intends to explore new ways to fully engage members in their healthcare.

Other Stakeholders and VBID

Along with employers and health plans, other healthcare stakeholders are incorporating VBID opportunities into their business offerings. All of the major health insurers offer some VBID programs, and many are developing VBID-specific products. Recognizing the increased market share of VBID programs, health care vendors are developing products to support and administer patient-centered VBID programs.

For example, in 2010, TriZetto, a comprehensive technology solution provider, integrated the value-based insurance design for diabetics and pre-diabetics into their core administrative and claims adjudication systems.¹² The TriZetto program is designed to help manage the complexity introduced by VBID programs, which vary eligibility for benefits and payments based on the members' behavior and prior claims.

Pharmacies and pharmacy benefit management companies are also offering programs that support the aims of the diabetes value-based insurance design. CVS Caremark, a pharmacy healthcare provider, conducted research to evaluate the impact of VBID and patient adherence for insulin and oral diabetes medications and found positive results from lowered co-payments. CVS Caremark plans to use these findings to develop programs such as direct patient counseling for first face-to-face prescription fills, automated refill reminders with interactive voice responses, web reminders and other methods to improve patient medication adherence.¹³

Consulting firms are actively promoting VBID strategies. In response to growing employer demand for VBID, the consulting firm of Hewitt Associates launched an initiative known as DIAGNOSIS: DIABETES to help organizations assess their diabetes management. Given the role of consultants and actuaries in recommending Plan design changes and predicting financial impact to employers, PPOs can anticipate seeing more adoption of VBID plans and initiatives in the coming years.

Conclusions: Considerations for PPOs

Interest and acceptance of VBID plans appears to be escalating throughout the country, although it is still not a ubiquitous benefit design. PPOs report an increase in clients exploring VBID opportunities and the impact. Given the support for VBID found in health reform legislation [See AAPPO's Issue Brief #1], other employers and state purchasers are likely to be looking for VBID type incentives in future product offerings. PPO leaders should to anticipate and prepare for VBID changes to their business delivery model and demands of customers.

At first glance it may appear that VBID will have little bearing on traditional (or non-health plan owned) PPOs. The primary business impetus of a PPO is to offer a cost-effective network where members are financially motivated through lowered co-payments to seek care within the network. But in fact, the VBID model, in which the copayments are either further lowered or eliminated for patients, can be layered on to the PPO model. PPOs must respond to the VBID paradigm shift by designing networks and developing capability to administer variable benefits that drive better diabetes outcomes.

Demand for VBID strategies by payers and employers may impact both network and full risk PPOs. For example:

- PPOs may be asked to identify "high value" providers in the network, e.g. ones that have been shown to deliver better diabetes care. PPOs may be able to meet this demand by identifying "medical home" providers or those with Diabetes Physician Recognition status from NCQA.
- PPOs may need to add and credential new provider types in network development. Increased demand for chronic disease prevention and improved management will drive a need for service providers such as diabetes educators, nutritional counselors and fitness programs.
- PPOs may need to offer blended chronic care management programs with wellness / prevention initiatives. New offering may include evidence-based prevention services such as the YMCA Diabetes Prevention Program.

- PPOs may need more effective consumer interface such as web based health management tools, and cost and care trackers that enable members to manage VBID benefits.
- From a provider relations perspective, the PPO may need to expand communication and education regarding VBID benefit changes so that providers can in turn better engage members and deliver evidenced based care.
- PPO senior staff can provide expert guidance to customers on VBID strategies most likely to work in the covered population. PPO leadership can recommend the incentives for medication adherence, behavior change or treatment adherence most likely to be effective in the customer's population.
- PPOs may need to implement or have access to outcomes based reporting in order to evaluate provider adherence to clinical guidelines and use the information for member steering, credentialing and provider feedback.
- PPOs may also need more sophisticated tools to track member engagement and report it to physicians and purchasers. PPOs may need to integrate claims, laboratory and pharmacy information to track adherence, and develop capability to share appropriate information with patients and providers.

PPO leaders need to understand VBID as a competitive market strategy. Diabetes is a huge health care cost driver for payers. PPOs need to come to the table with innovations that help to improve care and reduce complications that drive cost. For some PPOs, the next step may be exploring pilot tests or product offerings with discrete diabetes related VBID incentives to change patient behavior or improve treatment adherence. For other PPOs, the response to the VBID market trend may be to look at how the PPO network can be segmented to offer up additional value through better diabetes care. And for other businesses, engagement with VBID may be through understanding how it operates and helping employers, TPAs, and insurer clients to develop their own programs.

Simply having the VBID plan design could be viewed as "necessary but insufficient" to realize the outcomes demanded by employers. Successful implementation, execution and measurement of outcomes is also needed to demonstrate the value of VBID to employers and payers.¹⁴ PPO leadership can ensure that the infrastructure, culture and environment exist to support the VBID strategy and deliver the optimal benefit for customers and patients.

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Information about companies referenced in this report was taken from public presentations and sources, and has not been approved by any company other than AAPPO. All conclusions are those of the authors.

For more information and additional resource material visit www.aappo.org

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