Leveraging Disease Management to Support Value-Based Insurance Design

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Disease Management is a Systematic Approach to the Management of Chronic Illness

- Population identification processes
- Evidence-based practice guidelines
- Collaborative practice models
- Patient self-management education
- Process and outcomes measurement, evaluation and management
- Routine reporting/feedback loop

www.dmaa.org (12/7/05)
DM Programs Employ a Population-based Approach

- Identification of all individuals in a covered population that have the condition
- Stratification of individuals in groups with varying needs
  - Sickest, less sick, not so sick
  - Costliest, less costly, inexpensive
- Intensity and type of intervention is tied to stratification level
- Ultimately, although interventions are customized to the level of the stratification group, they are applied at the individual level
Stratification and Customization

- The more homogeneous the stratification group is, the more the interventions are perceived as being customized to the individual.
- The ultimate in customization is stratification groups of one
  - Requires sophisticated IT and management processes (e.g., Active Health Management)
DM Programs Attempt to MEASURABLY Improve:

- **Health processes**
  - Compliance with testing, medications, diet, exercise, etc.

- **Health outcomes**
  - Better test results, fewer complications

- **Use of resources, including financial resources**
  - Eliminate waste, invest in proven services

- **Patient satisfaction with services provided**
  - Patient engagement, self-management support
DM Program Results

Meta-analysis of DM literature:

- Many DM programs are associated with improvements in quality of patient care
  - Varies by program, condition
  - Greatest improvements in patient satisfaction, adherence, disease control, and provider adherence
- Relatively few studies evaluated health care utilization or costs
  - Findings were often modest and inconsistent
  - Program development and implementation costs often not considered

Ofman et al, AJM, August 1, 2004
DM Program Results

Meta-analysis of DM literature:

- Weak to moderate evidence of economic effectiveness of disease management programs
- Programs are more economically effective with severely ill enrollees
  - But studies were mostly short term (12 months)
- Most of the direct economic outcomes measures were related to hospitalizations and emergency room visits; few analyzed total medical costs

Krause, Disease Management, April 2005
Single Disease DM vs “Whole Patient” Approaches

- DM programs initially targeted a single common, costly chronic disease
  - Diabetes
  - Asthma
  - CHF
- The list of conditions managed has expanded and now included “rare” diseases (e.g., MS) and other “impact” conditions (e.g., GERD)
- Some programs claim to manage the “whole patient” including multiple conditions, co-morbidities
DM Programs Have Experienced Dramatic Growth in Recent Years

- Nearly 70% of large employers are using disease management programs through their health plans this year, compared with 49% last year, according to the 10th Annual National Business Group on Health/Watson Wyatt Survey Report.

- Another 28% of the 555 large employers participating in this year's survey are adopting disease management programs through an outside vendor, up from just 11% in 2004.

www.businessinsurance.com, posted 3/17/05
Investment in DM Programs is Substantial...

- DM revenue is estimated to be $1.2 billion in 2005 up from $346 million in 2000 and $78 million in 1997

Personal communication, Al Lewis, Disease Management Purchasing Consortium, 12/10/05
DM Industry Revenue Growth

Revenue Growth in $Millions

Personal communication, Al Lewis, Disease Management Purchasing Consortium, 12/10/05
...and Has Resulted in a Robust DM Infrastructure

- Sophisticated population identification software
  - Complex algorithms to identify members with disease
  - Complex algorithms to identify “care opportunities”
  - Predictive modeling
- Disease registries
- Automated reminders (patients & providers)
Robust DM Infrastructure (cont.)

- Educational materials (patients and providers)
- Call centers
- Multidisciplinary health “coaches”
- Infrastructure to measure results
  - Data collection, analysis and reporting tools
  - Measurement teams
- Evaluation infrastructure
  - Experts in evaluating financial ROI for population-based programs
- Administrative infrastructure
- Accreditation infrastructure
DM Programs Continue to Innovate

Use of incentives:

◆ Provider incentives
  ◆ Pay-for-Performance programs tied to DM

◆ Patient incentives
  ◆ Earn rewards for participation, compliance or outcomes
    ◆ American Healthways & MyHealth IQ
  ◆ Eliminate or reduce disincentives
    ◆ Reduce co-pays for conditions related drugs if participate in a DM program
Patient Incentives: American Healthways “MyHealth IQ”

- MHIQ is a corporate health risk management program that gives financial rewards based on quantifiable, improved biometrics.
- Employees receive a monthly health insurance premium discount for participation (health and lifestyle history and blood samples).
  - > 80% participation rates.
Patient Incentives: American Healthways “MyHealth IQ”

- If the employee raises his/her score in the span of 12 months, they receive additional rewards in year two
  - Greater premium reduction
  - Contribution to a health savings account for use towards co-pays and deductibles
Patient Incentives: American Healthways “MyHealth IQ”

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<th>Baseline At Risk %</th>
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</tbody>
</table>

Personal Communication, Mark McConnell, American Healthways, 12/8/05
Insurance Plans are Also Population-based Programs

- The population is the coverage (or employer) group
- Usually no attempt to stratify and/or customize
  - Everyone in the group gets the same benefit package regardless of need
  - May promote over-use, under-use and misuse
  - Benefit designs may not support and may conflict with goals of disease management programs
Example of Insurance Benefit Designs That Do Not Support DM Programs

- Aggressive management of blood glucose is the cornerstone of diabetes disease management programs
  - Expensive insulin sensitizer drugs, such as Actos and Avandia, are placed in third tier
  - They also have a prior authorization requirement discouraging busy physicians from prescribing them
Copay Distributions for Preferred Brand Name Drugs by DM Enrollment Status in a Single Large Health Plan

Chernew, Rosen, Fendrick, unpublished data, 2005
Failing to Adjust Co-Payments for Individuals in DM Programs Creates Waste

- Employers, plans and individuals “invest” in DM in an effort to drive treatment plan adherence and better outcomes.
- Copays are in place that discourage adherence.
- More DM resources must be utilized to “overcome” the disincentive.
Value-based Insurance Can Be Designed to Support Disease Management Programs and Goals

- Co-pays are reduced for diabetes medications and waived when diabetes patients actively participate in a diabetes disease management program.
- Individuals with pre-diabetes and/or metabolic syndrome "earn" lower out-of-pocket by participating in a risk reduction program.
Value-based Insurance Designs Should Leverage, *not* Disincent DM

- The infrastructure is in place to effectively manage populations with chronic illness
- Cost-sharing reduces utilization, including appropriate utilization
- Customization of benefits, via Value-based Insurance Designs, offer the opportunity to apply benefits in a way that optimizes their value
Questions?