Leveraging Disease Management to Support Value-Based Insurance Design

Patricia R. Salber, MD, MBA
Chief Medical Officer
Center for Practical Health Reform
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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

DMAA
Disease Management Association of America

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:

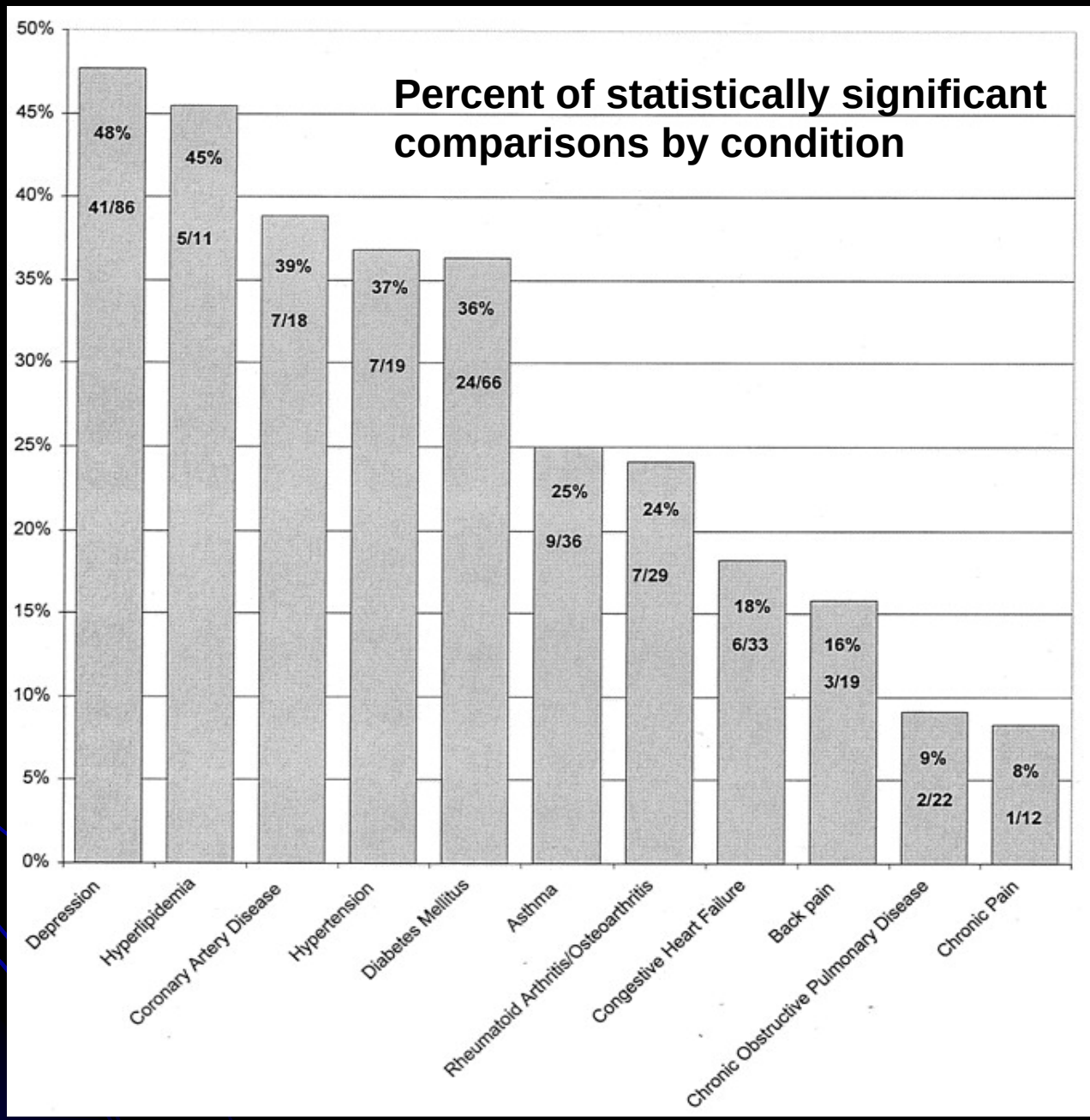
- Health processes
  - Compliance with testing, medications, diet, exercise, etc.
- Health outcomes
  - Better test results, fewer complications
- Use of resources, including financial resources
  - Eliminate waste, invest in proven services
- Patient satisfaction with services provided
  - Patient engagement, 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



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

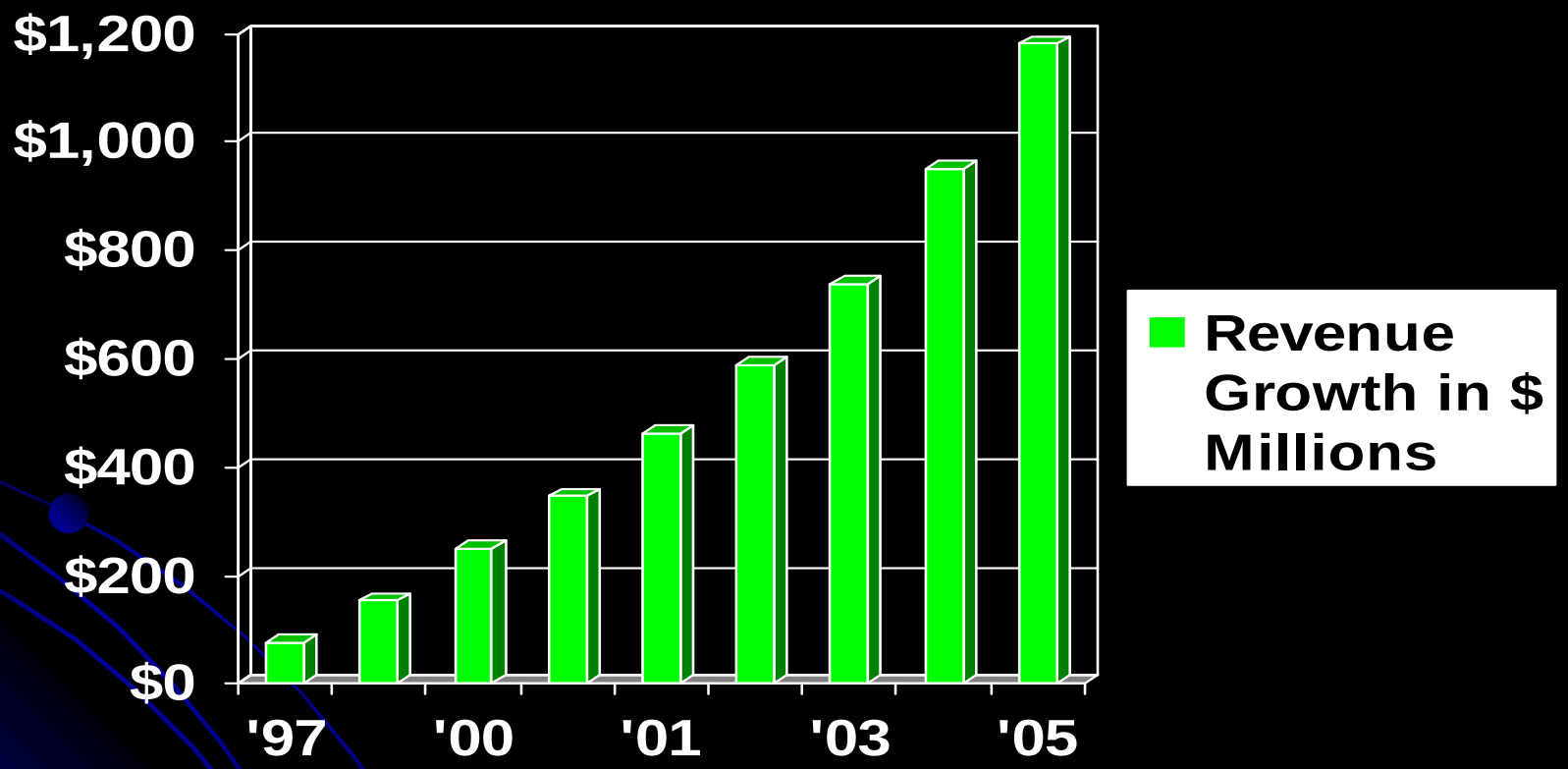
Investment in DM Programs is Substantial…

- 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

DMPC
Disease Management
Purchasing Consortium International, Inc.

DM Industry Revenue Growth



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

AMERICAN HEALTHWAYS

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"

1500+participants, 6-8 employers	Baseline No Risk %	Baseline At Risk %	End yr 1 No Risk %	End yr 1
Total Cholesterol*	68.4	31.6	75.4	24.6
HDL	51.1	48.9	47.2	52.8
LDL*	25.2	74.8	31.5	68.5
Total Chol/HDL	27.8	72.2	31.0	69.0
Body Mass Index	29.3	70.7	29.9	70.1
Systolic BP*	41.7	58.3	55.2	44.8
Diastolic BP*	65.2	34.8	76.2	23.8
Triglycerides	60.9	39.1	63.8	36.2
Glucose	76.5	23.5	77.8	22.2

Personal Communication, Mark McConnell, American Healthways, 12/8/05

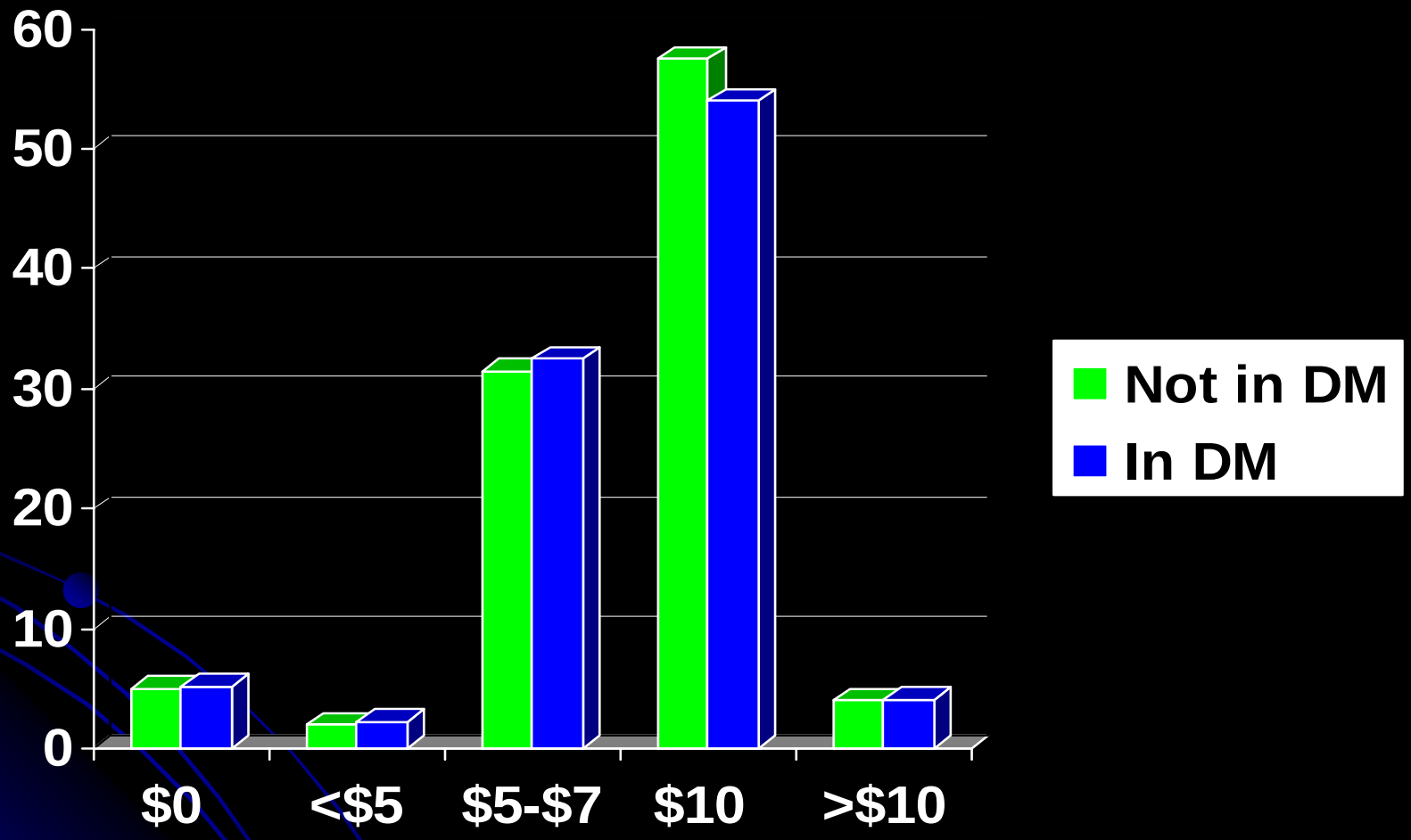
Insurance Plans are Also Population-based Programs

- 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?