



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

Health Care Reform, Value-Based Insurance Design, and Implications for Diabetes Care

This is the first *Innovations in Value-Based Approaches to Diabetes Care Issue Brief*, a series by the American Association of Preferred Provider Organizations (AAPPO). This Issue Brief examines how 2010 health care reform legislation incorporated the current benefit trend of Value-Based Insurance Design (VBID), and the potential for VBID approaches to improve care of one of the Nation's leading chronic diseases, diabetes. VBID strategies are rapidly emerging in the healthcare industry and have been adopted by many commercial payers and plans. Health care reform legislation marked the first federal government recognition of VBID, an approach that places financial and other incentives on evidence-based "high value" treatments.

Through this Issue Brief and other AAPPO resources, preferred provider organizations (PPOs) including PPO networks and third party administrators are encouraged to examine VBID 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 website. The site includes downloadable Issue Briefs along with presentations, toolkits and resources to assist PPOs in working with payers, providers and patients to identify value-added strategies to 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 – HEALTH REFORM LEGISLATION

The Patient Protection and Affordable Care Act (PPACA), enacted in March, 2010, is changing the way the U.S. health care system delivers and finances health care. In addition to making coverage, tax and access changes to the health system, the PPACA included a number of very specific elements designed to encourage delivery of more effective health care. Regardless of the ultimate fate of the PPACA, there will be ongoing pressure on PPOs and health plans to innovate reimbursement and the delivery system to bring about higher quality, lower cost care.

The PPACA took a concept that has slowly been gaining momentum in the commercial sector, "value-based insurance design," and embedded it firmly in the principals of reform. The PPACA also created pilot tests and demonstrations for delivery system changes designed to bring higher value health care to the American public.

By authorizing expansions of VBID, expanding access to preventive services, and creating “accountable care organizations,” and “patient-centered medical homes,” the PPACA made a strong statement of its goal to change payment and care delivery to promote high value care over high volume care.

Undoubtedly, AAPPO members are preparing for changes under the PPACA and are considering whether to compete in new markets such as health insurance exchanges. PPOs are also watching development of new delivery models such as patient-centered medical homes (PCMHs), accountable care organizations (ACOs) and determining how these models factor into care management and reimbursement strategies. This Issue Brief highlights these as a few but important changes likely to impact PPO management of chronic diseases such as diabetes.

THE IMPACT OF DIABETES ON HEALTH AND THE HEALTH CARE SYSTEM

There are 17.9 million people diagnosed with diabetes in the United States, comprising 7.8 percent of the total population. Another 5.7 million remain undiagnosed. By 2011, 22 million Americans are projected to have type 2 diabetes, potentially growing to 32 million by 2031— an increase of 46 percent. People diagnosed with diabetes have 2.3 times more medical expenditures than those without the condition.¹ Commensurate with the growth in prevalence, the portion of health care expenditures to treat those with type 2 diabetes is expected to increase from 10 percent in 2011 to 15 percent in 2031— pushing health care costs for these patients from \$340 billion in 2011 to \$1.6 trillion in 2031 in non-deflated dollars.²

Diabetes is a complex medical condition to manage, yet effective management is crucial to preventing or delaying complications. These complications – heart disease, retinal disease, and kidney problems – are serious health conditions themselves and are detrimental to the patients’ quality of life. Effective treatment requires coordination of services by diverse medical and ancillary professionals along with specialists. Important goals of diabetes treatment are to:³

- Maintain daily blood glucose at target range through diet, oral medications or insulin to aggressively control blood glucose
- Maintain long term blood glucose control as evidenced by hemoglobin A1c levels (HbA1c) of approximately 7. (This goal must be individualized based on the patient’s individual clinical situation.)
- Maintain blood pressure and cholesterol at normal levels through medication and behavioral interventions to control cardiovascular complications
- Maintain or reduce to normal body weight
- Promotion of a wholesome diet/sound nutrition and regular physical activity
- Never smoke or quit smoking
- Prevent diabetic and cardiovascular complications by adhering to medications
- Prevent, screen for, and intervene early in eye, kidney and peripheral vascular complications
- Obtain other screening and preventive services: annual influenza vaccine; depression assessment; annual foot exam, regular oral health assessment.

Adherence to treatment is a major challenge for patients. Patients have difficulty making and sustaining the behavioral changes necessary, and the high cost of managing diabetes places an economic burden on patients and their families. Economic factors are enough to cause poor adherence to vital medications, one of the considerations underlying VBID approaches. Twenty-five percent of households with a family member suffering from diabetes spend 10 percent or more of their income on health care, while 8 percent have costs exceeding 20 percent of family income.⁴ Patients who do not take their medications as prescribed by their doctors cost the U.S. health care system an estimated \$290 billion a year, or 13% of total health care expenditure in avoidable medical spending.⁵

ABOUT VBID

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 evidence-based incentives to drive 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.

According to Dr. Mark Fendrick, M.D. co-director of the Center for Value-Based Insurance Design at the University of Michigan and one of the leading researchers on VBID, “Up until recently, emphasis has been on the supply side of payment reform—how providers are reimbursed—rather than the demand side, payment from the perspective of the patient. If we are trying to successfully address the regulations of PPACA, it is necessary for the benefit design to be aligned with patients so that they can accomplish what’s in their best interest in managing their health. Reducing barriers to certain health care services cannot be based entirely on price. By definition, VBID includes a clinical component and an economic component.” For example, a program that reduces or eliminates cost-sharing for *all* generic drugs—regardless of the clinical benefit provided—fails to capture the value that could be achieved by incentivizing *essential* medications for the specific patient.

VBID adjusts out-of-pocket costs based on an assessment of clinical benefit value—not simply cost—to a specific patient population. Thus, the more clinically beneficial the service is for a patient, the lower the patient cost-share. Successful VBID programs use the levers of information and incentives to motivate patients and encourage patient behavior changes.⁶ Frequently targeted behaviors include better eating or more exercise, improving adherence such as taking essential medications regularly, and making informed choices of physicians. VBID strategies may 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 National Business Coalition on Health has developed a “Purchaser Guide” that describes a number of employer case studies and outlines approaches to offsetting increased VBID expenses through cost reductions in other benefit design areas.⁷ Through tailoring benefit design and reductions in adverse events such as hospitalizations VBID has potential to be cost saving or cost neutral. The common thread across diverse VBID strategies is use of evidence to determine high value services and use of a “carrot” to promote higher value services. Under the VBID premise, incentives both encourage use of high-value services and discourage use of low-value services to maximize effectiveness of health investments.⁸

VALUE-BASED INSURANCE DESIGN (VBID) AND DIABETES

Diabetes is a condition crying out for improvements in care coordination and management. VBID for diabetes incentivizes patients to adopt behaviors that evidence shows will improve overall health outcomes.

For example, Centers for Disease Control and Prevention (CDC), Diabetes Prevention Program has shown that individuals with pre-diabetes can reduce the rate of onset of type 2 diabetes (the most common form in which the body does not produce enough insulin or the cells ignore the insulin⁹) by 58% by adopting lifestyle changes including weight loss and increasing physical activity.¹⁰ A VBID approach may focus on identifying members with pre-diabetes or at risk by incentivizing use of a health risk assessment, and may go further by providing incentives to members that actively participate in a structured weight loss and exercise program. In another example, CDC

notes that “detecting and treating diabetic eye disease with laser therapy can reduce the development of severe vision loss by an estimated 50% to 60%.”¹¹ Thus a VBID plan design might eliminate or reduce co-payments to remove the financial barrier and provide an incentive for diabetic patients to obtain an annual retinal eye exam.

The upside of using VBID for plan sponsors is that they are paying for higher value care for their members at highest risk. By actively encouraging high risk members to participate in evidence based programs, payers drive cost savings to the payor or plan along with driving quality improvements to the member. Table 1 shows other examples of VBID interventions that could be applied to prevent and reverse pre-diabetes, and manage Type 2 diabetes.

Table 1: Treatment Recommendations for Diabetes and Pre-Diabetes, with VBID-Type Approaches

Treatment Goal	Incentives For...
Weight loss for overweight individuals	<ul style="list-style-type: none"> • Participation in an interactive health risk assessment to identify needs for behavior change and health intervention • Participation in a structured exercise and weight loss program such as YMCA • Demonstrated weight loss
Regular exercise	<ul style="list-style-type: none"> • Structured evaluation for exercise needs • Documented regular participation in a fitness program • Achieving fitness goals as evidenced by tests
Dietary management	<ul style="list-style-type: none"> • Delivery of medical nutrition therapy (MNT) • Delivery of diabetes self-management training (DSMT)
Blood Glucose control	<ul style="list-style-type: none"> • Weight loss, exercise and dietary management strategies • Reduced copays or deductibles for diabetes medications • Reduced copays or deductibles for hemoglobin A1c testing • Reduced copays or deductibles for hemoglobin A1c results within normal limits
Improve medication adherence	<ul style="list-style-type: none"> • Pharmacy benefits include coverage of medication modalities most likely to result in adherence (insulin pumps and pens, monitors and strips) • Reduced copays or deductibles for hemoglobin A1c results within normal limit
Smoking cessation	<ul style="list-style-type: none"> • Behavior modification programs and therapies for smoking cessation (multiple attempt coverage) • Offering support services through Quitlines • Incentives for cessation participation or successful cessation
Prevent cardiac complications	<ul style="list-style-type: none"> • Behavioral programs such as MNT and DSMT that promote healthy diet and exercise • Strategies to improve adherence to medications for cholesterol management, hypertension control and other cardiac medications
Prevent eye, foot and kidney complications	<ul style="list-style-type: none"> • Reduce or eliminate copays for specialty visits for eye and kidney screening of diabetics • Provide cash incentive or reward to patients who partake of all recommended primary and specialty screenings

VBID APPROACHES IN THE PPACA

The PPACA included reforms intended to drive improvements in health care quality, particularly for chronic disease. Improvements in insurance coverage, definition of essential benefits, and coverage of preventive care services will all positively impact care of chronic disease. But, the legislation also aimed to identify high value strategies for improving care. Elements of the PPACA that will add value to diabetes care management include:

- Language specifically authorizing VBID for plans participating in exchanges
- Improved coverage of evidence based preventive services for all Americans
- Development of patient centered medical homes (which by definition have demonstrated capability to deliver more effective, coordinated chronic care services at the primary care level)
- Development of accountable care organizations (which by definition improve coordination of care across levels of the health care systems such as specialty, inpatient, and outpatient care).

These VBID approaches are discussed further in the following sections.

VBID Specific Language

The PPACA authorizes VBID as a tool for aligning out-of-pocket costs with the value of medical services. In section 2713 discussing the coverage of preventive health services, the law says: “The Secretary may develop guidelines to permit a group health plan and a health insurance issuer offering group or individual insurance coverage to utilize value-based insurance designs.” On July 19, 2010, the Departments of Health and Human Services (HHS), Labor and Treasury jointly released, “Interim Final Rules for Group Health Plans and Health Insurance Issuers Relating to Coverage of Preventive Services under the Patient Protection and Affordable Care Act.”

The Interim Final Rule defines VBID as including “the provision of information and incentives for consumers that promote access to and use of higher value providers.” The rule also recognizes the importance of PPO networks in delivering cost effective services. The Interim Final Rule permits plans and insurers to implement designs that foster better quality and efficiency by allowing cost-sharing for recommended preventive health services delivered out-of-network while eliminating cost-sharing for services provided in-network.

A subsequent Request for Information was published in a December, 2010 Federal Register requesting additional input on how plans implement VBID to drive cost and quality improvements.¹² That notice reconfirmed that plans may continue to use networks to achieve cost efficient care management, and that plans can define the frequency and intensity of mandated preventive services through their evidence based medical policy.

Preventive services included in the PPACA are:

- Evidence-based items or services that have an A or B rating in the current recommendations of the U.S. Preventive Services Task Force (USPSTF), except for its recommendations on breast cancer screening, mammography and prevention issued in 2009.¹³
- Routine immunizations for children, adolescents and adults recommended by the Centers for Disease Control and Prevention.
- Evidence-informed preventive care and screenings for infants, children and adolescents provided for in the comprehensive guidelines supported by the Health Resources and Services Administration (HRSA).
- Evidence-informed preventive care and screening for women provided for in comprehensive guidelines supported by HRSA, which are expected to be issued no later than August 1, 2011.¹⁴

“The law recognizes that properly structured, clinically nuanced VBID programs provide more clinically effective health care, prevent chronic disease and promote better health,” says Dr. Fendrick,¹⁵ “PPOs will have to adapt to the elimination of cost-sharing for preventive services and devise strategies to accommodate the transformation required by health care reform by putting pressure on the demand side of the equation,” he says.

Accountable Care Organizations/New Reimbursement Alternatives

While not specifically described as a VBID intervention, the PPACA provides for the establishment of accountable care organizations (ACOs). ACOs will be groups of providers formed to work together under a legal arrangement to manage and coordinate overall care for Medicare fee-for-service beneficiaries. ACOs are expected to provide higher value health care services. PPACA gives HHS the authority to develop a five-year, national voluntary pilot program starting in 2013 to test and evaluate alternative payment methodologies for ACOs.

ACOs' key elements are:

- Local accountability for the quality and costs of patients participating in an ACO
- Ability to prospectively establish the organization's budget and resource needs
- Ability to measure performance and use the results to drive improvement
- Capability to provide or manage patient care across a continuum of settings
- Willingness to implement payment incentives that reward health care quality improvement, efficiency, effectiveness and timeliness.¹⁶

ACOs have potential to drive improvements in diabetes care by coordinating and integrating the complex primary and specialty services required to manage diabetes. The PPACA program offers providers incentives through bundled payments to coordinate patient care across the continuum of care and accept responsibility for an entire episode-of-care centered around hospitalization. The gain-sharing program established for ACOs sets the precedence for a new provider payment structure based on achieving clinical improvement goals rather than on the volume of services provided. If actual per capita expenditures of assigned ACO beneficiaries fall below a specified benchmark, then an ACO will be eligible to share in the savings.

ACOs are relevant to PPOs in the commercial sector as well as those serving Medicare populations. Medicare innovations and policies generally spread quickly to the commercial side of health care insurance, as do Medicare payment methodologies. Once the infrastructure of ACOs has been established, it is likely that ACOs will market services in the commercial sector. Many experts believe that ACOs, if they reach their potential to improve quality while managing costs, fit well within a PPO delivery model. In fact Humana is one of five organizations participating in a collaboration facilitated by the Brookings Institute and Dartmouth University.¹⁷ Humana transformed its ACO pilot in Kentucky into a full-fledged program in July 2010.

"Our ACO is predicated on total management for cost, quality and patient experience," says Thomas James, M.D., medical director, national network operations for Humana. The Humana ACO has partnered with Norton Healthcare, a Louisville-based hospital system, and targets Humana and Norton employees. Dr. James says that in his ACO, providers earn 2 percent of projected costs as an acknowledgement of "good faith," and its gain-sharing arrangement is 60/40, payers and providers, respectively. Quality is measured through achieving targets using National Committee for Quality Assurance's (NCQA) Healthcare Effectiveness Data and Information Set (HEDIS®) diabetes measures. These indicators include hemoglobin A1c and lipid screenings and management control, eye and foot examinations and blood pressure management, along with patient satisfaction through the Consumer Assessment of Healthcare Providers and Systems (CAHPS) Hospital Survey.

"The ability to do both population health and individual care coordination comes from the structure and philosophy of the ACO," Dr. James says. "While medical care is built upon the relationship between the patient and the provider (doctor or mid-level practitioner), there are others behind the scenes making sure that the individual patient is receiving the appropriate preventive services or coordinating care. This is a new way of delivering medicine in the PPO environment, and will promote more coordination between plans and providers."

To be successful, the ACO must design care around each individual instead of patients fitting into a provider structure. Dr. James considers the ACO process a "clinical reengineering." "How can we make sure that a diabetic patient gets to see the eye doctor for a retinal examination?" he asks. "We have to have integrated data management systems that flag the patient and use an electronic medical record with reminders for the provider. In addition, we need outreach capability by nurses and social support staff to help the patient deal with the barriers that might otherwise prevent getting the necessary specialty care."

PCMH: Potential for Improved Care

Another innovative delivery model authorized in the PPACA may have a payoff in diabetes care improvement and drive value. Section 3502 of the PPACA creates authority for HHS to support development of “patient-centered medical homes.” The PPACA authorizes community-based interdisciplinary, inter-professional teams to support primary care providers in creating medical homes. HHS grants will provide capitated payments to physicians and their teams for practice transformation and care coordination. The PCMH is expected to strengthen the infrastructure of primary care, while ACOs build on a primary care foundation to improve quality and value of specialty and inpatient care.

The definition of a medical home provided in the new legislation mirrors the components recommended by a joint working group of physician organizations.¹⁸ These “Joint Principles” define a medical home as having a personal care physician, whole-person orientation, coordination of care, adoption of health information technology, enhanced communications, shared savings for physicians and incentives for achieving measurable and continuous quality improvement.¹⁹

Many initial PCMH programs focus on creating coordinated care programs for diabetes and evaluate effectiveness of the PCMH based on improved diabetes care metrics such as HbA1c control. Mark Fendrick argues that the PCMH is a VBID strategy because the coordinated care offered in a PCMH is a high value service. Fendrick says it will be worth it for employers to offer patient incentives such as reduced co-payments to seek care from PCMH practices, because patients will have better diabetes outcomes and lower overall costs if they do.²⁰

Many health plans and PPOs have already begun developing PCMH’s in commercial programs, and the PPACA is expected to spur further development. For example in April 2009, Blue Cross Blue Shield of South Carolina and BlueChoice Health Plan partnered with Palmetto Primary Care Physicians, which has 22 sites and more than 55 providers, to form a medical home targeting diabetes. The plans developed a blended reimbursement strategy for their provider group for enhanced services. The combination includes:

- Fee-for-service payments, including services such as electronic visits
- Per member per month (pmpm) coordination fee
- Pay-for-performance reimbursement based on 10 pre-negotiated measures, including percent of participants who have an HbA1c test, blood pressure test, LDL cholesterol or body mass index (BMI) measurements and the percent who achieve an HbA1c reading of less than 8 percent, blood pressure controlled at less than 130/80, LDL cholesterol levels less than 100 and an improved BMI.

Palmetto, which was eligible for up to a 20 percent increase in the monthly pmpm if its providers improved on the 10 measures after the first year, earned an 8 percent increase by achieving target levels on four of the measures—blood pressure, LDL cholesterol and BMI measurements and blood pressure control 130/80. Palmetto also improved on utilization measures and showed a 6.5 percent decrease in total medical and pharmacy costs. This focus on measuring the effectiveness of the PCMH by assessing diabetes quality is common. Other medical home initiatives cited in the literature also focus on improving delivery of essential diabetes care indicators and tie their reimbursement to hitting quality targets.

THE NEXT GENERATION OF VBID

Demand for VBID as a cost management / quality improvement strategy continues to grow. For example, 19% of employers of all sizes offered reduced pharmacy copays or coinsurance for those with chronic conditions in 2010, up from 17% in 2009 and 12% in 2008, according to the recent National Business Group on Health/Towers Watson survey [Raising the Bar on Health Care: Moving Beyond Incremental Change](#).²¹ In addition, 64% of National Business Group on Health large employer members said they are considering implementing VBID and more than half said it will help them manage their pharmacy plan over the next 3-5 years, according to a 2009 survey on pharmaceutical benefit strategies.²²

The PPACA makes important strides in allowing for flexible benefit design and improved delivery systems that will improve care for diabetes. Some experts feel that there is still room for improvement in the VBID approach, however. For example, Dr. Fendrick points out that PPACA only allows for zero cost sharing on primary preventive services, not “secondary” prevention needed to prevent the complications of diabetes.

“Prevention as defined by the new law is too narrow, focusing on primary prevention services for individuals without a specific disease,” Dr. Fendrick says. The Center for VBID recommends a provision allowing the identification of high-value, secondary prevention services, such as eye examinations for diabetes patients, be made available without patient cost-sharing, the arrangement prescribed for primary prevention services.

VBID leaders also believe that the next generation of VBID products will go beyond using incentives for specific services, and will incentivize members to use entire high value care delivery systems. Future VBID approaches will direct patients to systems with demonstrated efficient and good outcomes, including ACOs and PCMHs that have documented better outcomes for diabetes.

CONSIDERATIONS FOR PPOS

PPOs along with their customers have long been struggling to contain the cost and care consequences of the diabetes epidemic. Risk bearing PPOs pay the cost of poorly managed diabetes, while network PPOs face increased scrutiny and displeasure of employers and payers if network providers do not effectively manage care for individuals with diabetes. Many PPOs have encountered VBID outside of reform as one of the many tactics adopted by employers to try to align incentives to promote better care.

The PPACA presents numerous business and regulatory challenges for PPOs, but also incorporates innovations that have potential to add leverage to PPO diabetes care management strategies. Many PPOs will want to take a leadership role in adopting high value strategies that will drive more effective care and attract customers. Examples of VBID strategies available to PPOs include:

- Offering and incentivizing use of programs and tools to improve patient and payer decision-making about health and wellness
- Developing data management capability to support VBID strategies and identify members in need of services
- Incentivizing or rewarding patient adherence to medication and behavior change that improve outcomes
- Identifying key high value services – including tests, medications, specialty visits and other interventions - and applying incentives to get behavior change results
- Contracting with PCMH and ACO organizations and demanding clinical accountability through measurement along with cost management
- Offering up a high value physician network by measuring quality of care directly or using proxies of quality such as NCQA’s recognition programs
- Identifying and encouraging use of technology – including medication and testing technology and social networking applications – that improve patient adherence
- Designing network, pharmacy and care management programs to increase member adherence to high value diabetes medications, tests and treatments
- Working with customers to design pharmacy benefits to improve diabetes management
- Providing expert guidance to payers on best practice incentive strategies to improve outcomes

Conclusion

As this Issue Brief illustrates, PPACA introduces a number of initiatives that will change the way PPOs deliver and finance care. While these strategies—VBID, ACOs, PCMHs and reengineered reimbursement systems—present many challenges to PPOs, they hold promise for improving the quality of care, reducing inappropriate utilization of services and generating savings, while aligning incentives among stakeholders. Pilot projects for ACOs and PCMHs are beginning to show results in managing chronic conditions such as diabetes. VBID, created by employers and insurers, already has a track record and has shown potential for reining in costs and providing better, more affordable care. The challenge for PPO leaders is to mix and match effective strategies that improve diabetes care outcomes, control costs, and help Americans lead healthier lives.

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