



eValue8 Employer Report

Health Plan Diabetes Care Performance



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EXECUTIVE SUMMARY

Employers increasingly recognize the impact of diabetes on the health and productivity of the workforce. Evidence is growing that effective management of diabetes reduces complications, reduces health care costs, and protects employee productivity. Both employers and their contracted health plans have responsibilities for helping employees manage diabetes. Employers determine benefits available to workers, while health plans have clinical expertise and the means to promote and create incentives to patients and physicians that result in better quality care.

Through its “eValue8 Request for Information” (eValue8), the National Business Coalition on Health (NBCH) conducts an assessment of health plan activities on behalf of employers. This report is a national snapshot of eValue8 Request for Information (RFI) data on health plan strategies to address diabetes. This report uses data and information from 98 plans with data verified by NBCH member coalition scoring staff. It illustrates how employers can leverage health plan services to help their diabetic employees while both improving care and controlling costs.

eValue8 Expectations and Findings

- *Purchasers expect plans to work with them to develop worksite programs, identify patients and risk, and reach out to high risk patients:* 87 percent of health plans offer health risk assessments (HRAs) online and in print. Unfortunately, of plans that offer a health risk assessment, only two percent of members complete one per year. Forty percent of health plans offer members the opportunity to send their HRA results to their personal physicians.
- *Purchasers expect health plans to engage patients in self-management and preventive health behaviors:* 82 percent of plans offered general reminders, 71 percent offered members specific reminders based on missed services, and 85 percent offered live outbound telephone management programs as standard options; 37 percent of reporting plans are using the internet for online medical consultation, a strategy that may improve access to health care and reduce costs.

- *Purchasers expect plans to provide disease management programs or other organized approaches for adult diabetes care:* All plans offer disease management approaches, and 96 percent use an opt-out approach, which enables more patients to be contacted by the program.
- *Purchasers expect plans to screen diabetic patients for co-morbidities and complications:* Almost all health plans screen diabetic members for both depression (99 percent) and tobacco use (98 percent).
- *Purchasers expect services for patients with multiple conditions to be coordinated by the plan:* 37 percent of health plans coordinate co-morbid conditions with a centralized case manager. Almost half (49 percent) of plans coordinate behavioral health and chronic care services separately.
- *Purchasers expect plans to provide actionable information to physicians to help them identify and manage diabetic patients effectively:* 87 percent of responding health plans offered practitioners member-specific reports and 63 percent provided comparative performance reports.
- *Purchasers encourage plans to reduce barriers to essential medications such as those for diabetes:* More than 38 percent of responding health plans reduced co-pays for selected medications, tests or services for diabetic members, and 28 percent reduced deductibles.
- *Purchasers expect plans to help patients understand their medications and take them appropriately:* 77 percent of health plans responding use member reminders to support prescription compliance. Sixty percent alert the member's practitioner if the patient does not refill a medication, and 39 percent seek intervention through the pharmacist.

This national snapshot report offers a glimpse of health plan activities to improve diabetes care. Through ongoing improvements, health plans are applying data, information and expertise to support physicians and patients in effectively managing diabetes and reducing the complications of disease. Employers are encouraged to work with local coalitions for plan-specific eValue8 information that can be used to assess activities of health plan vendors and maximize the value of health benefits.

I. DIABETES LANDSCAPE

Introduction

Employers increasingly recognize the impact of diabetes on the health and productivity of the workforce. More workers are being impacted by diabetes, pre-diabetes, or undiagnosed diabetes. Evidence is growing that effective management of diabetes reduces complications, reduces health care costs, and protects employee productivity. Both employers and their contracted health plans have responsibilities for helping employees manage diabetes. Employers determine benefits available to workers, while health plans have clinical expertise and the means to promote and create incentives to patients and physicians that result in better quality care.

Through its annual “eValue8 Request for Information” (eValue8), the National Business Coalition on Health (NBCH) conducts an assessment of health plan activities on behalf of employers. NBCH member coalitions, and the employer-members of coalitions, use eValue8 results to assess health plan performance, establish expectations, and drive continuous improvements in care quality. Employers in eValue8 markets can receive detailed reports on plan activities, and with the coalition, meet with plan leadership to discuss results and future performance expectations. eValue8 is the leading evidence-based evaluation tool used to help employers and other health plan purchasers make sound decisions about health plan value and performance.

This report offers the first national snapshot of eValue8 data on health plan strategies to address diabetes. Diabetes is one of the most costly chronic diseases to employers in economic terms, and to patients in terms of quality of life; this report illustrates how employers are in a unique position to leverage health plan services to help their diabetic employees while improving care and controlling costs.

NBCH's eValue8 offers employers critical information to make decisions about how they will support employees living with diabetes. Employers increasingly use eValue8 as a management tool to assess how health plans respond to and potentially mitigate the downstream cost and productivity impact of diabetes. By using eValue8 to set expectations in multiple areas of diabetes care and monitor how health plans measure up (both individually and collectively), employers help ensure that their workforce remains successful and productive. NBCH and its member coalitions encourage employers to use eValue8 information to improve health plan management, oversight and delivery of health care services.

The 2007 eValue8 RFI Respondents

For more than five years NBCH has offered its member coalitions access to standardized results analyzing health plan performance. Through coalitions, employers have access to health plan-specific performance and operational information. For health plans operating in market areas with a participating NBCH member organization, the health plan scores are verified by a trained staff member. This adds consistency to the information analyzed by NBCH.

eValue8 data in this report represent a wide range of health plans covering millions of lives. Sixty percent of the verified 2007 respondents were health maintenance organizations (HMO) and the other 40 percent were provider preferred organizations (PPO). Most responding health plans, HMO or PPO, were for-profit organizations (67 percent). According to the health plan reports, almost five percent of adult and 0.5 percent of pediatric plan members have been identified as having diabetes.

About NBCH

The National Business Coalition on Health (NBCH) has a membership of over 60 employer-led coalitions across the United States, representing over 10,000 employers and approximately 34 million employees and their dependents. These business 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 member coalitions are committed to Community Health Reform, including an improvement in the value of health care provided through employer-sponsored health plans and to the entire community. Employers who wish to utilize the RFI results for information on health plans in their area can work directly with NBCH member coalitions. Visit www.nbch.org for information on local business coalitions.

The eValue8 RFI survey tool is updated each year to examine health plan activities that address national or employer priorities. In 2007 eValue8 asked for information in the following modules; this report examines health plan activities to improve diabetes care in each of these areas.

- **Plan Profile.** Plans report on how they organize services and on their accreditation status by an external organization. This section also examines plan use of “consumer directed” benefit offerings such as Health Savings Accounts, and the use of “value based” benefits to reduce consumer expenses for highly effective services. Plans report on health information technology systems to manage and report information that improves quality.
- **Consumer Engagement and Support.** Plans report on their programs to support members in choosing the best doctors, hospitals, and treatment alternatives as well as support services such as advice lines or health coaching, automated e-mail services based on member disease or condition, and online enrollment in disease management programs.
- **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.

- **Pharmacy 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.
- **Illness 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.
- **Chronic Disease Management.** Plans report on accreditation status, performance results and support offered to physicians and members that help their members with cardiovascular disease and/or diabetes manage their conditions.
- **Behavioral Health Screening and Management.** Plans report on use of clinical guidelines and screening tools for plans’ members who are depressed and/or use alcohol. The plans report performance results in behavioral health and the support offered to patients and physicians.

The data presented in this report are from 98 plans with verified responses to 2007 eValue8. The number of responses to each question varies. Tables may show a blank column or cell if data for a question was not available due to lack of response or a change in the question wording from year to year.

About eValue8

eValue8 is the leading evidence-based Request for Information (RFI) Tool and is a key initiative of NBCH. eValue8 is the nation’s leading standardized RFI tool that employers and coalitions use to gather health care data from health plans and health insurers. Over 100 million Americans, or one in every three Americans, are members of health plans that respond to the eValue8 RFI. It is widely used by business health coalitions, their purchaser members, and national employers to assess and manage the quality of health care vendors. eValue8 raises the bar for health care performance and moves the market to deliver greater value for the purchaser’s health care dollar. For more information, visit www.evalue8.org.

About Diabetes

Increased Prevalence and Impact

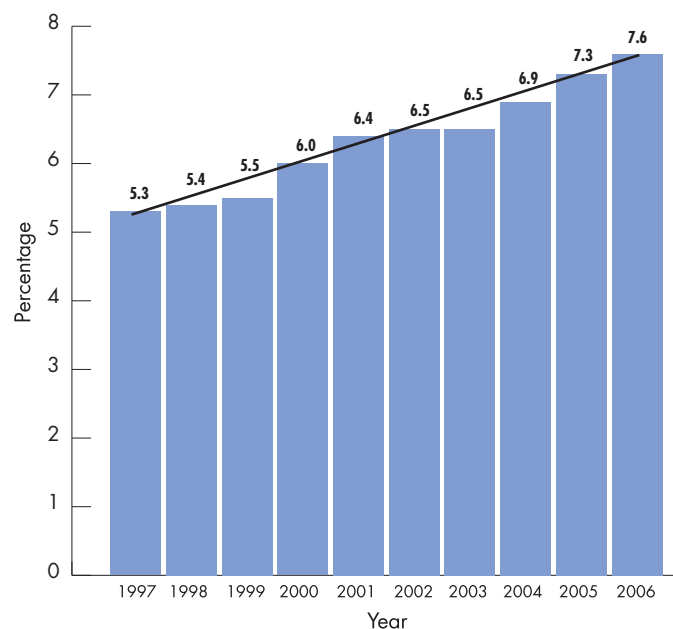
More than 20.8 million people in the U.S. have diagnosed or undiagnosed diabetes. Another 54 million people have prediabetes, a treatable medical condition marked by higher than normal blood glucose levels. More than 1.5 million new cases are diagnosed per year and more than 9 percent of people aged 20 years and older are currently living with the disease. Since the 1980s the prevalence of diabetes in the U.S. has more than doubled and is expected to reach 39 million by 2050.*

**Citations for diabetes-related statistics mentioned in this report are available from NBCH. Please contact NBCH for more information. Many data points on diabetes are available from www.cdc.gov.*

As Figure 1 illustrates, the prevalence of diagnosed diabetes is increasing. Between 1980 and 2005 the incidence of diagnosed diabetes among people aged 18 years and over tripled from 493,000 to 1.4 million people. Additionally, the number of people living with undiagnosed diabetes increased from 5.2 million to 6.2 million between 2002 and 2005. Much of the increase in prevalence is in the working population.

The increase in diabetes prevalence and the under-diagnosis of the disease are problematic to employers. Diabetes has a significant impact on health care costs and work place productivity. As this report illustrates, careful management of the disease is crucial to avoiding complications and onset of other health problems. Employers can encourage their health vendors to identify diabetes risks, encourage individuals to be tested, and to promote effective care management strategies. This is a business imperative.

Figure 1: Prevalence Rate of Adult Diabetes: 1997-2006



Source: The Centers for Disease Control and Prevention, National Health Interview Survey. Age-adjusted data presented include adults aged 18 years and older and do not include undiagnosed diabetes.

Types of Diabetes

Diabetes is a disease in which the body does not produce or properly use insulin, leaving the body unable to convert sugar, starches and other food into energy. There are two major types of diabetes:

- Type I diabetes is a condition where the pancreas no longer makes insulin. Accounting for 5-10 percent of all cases, Type I diabetes is most likely caused by an immune deficiency or other genetic response.

eValue8 Expectations: Diabetes Prevention & Screening

Plans are expected to provide a comprehensive set of prevention and health promotion services and to provide mechanisms of support to consumers and practitioners. Partnership with employers for health promotion at the worksite is a valuable way to reach members. Health plans are expected to partner with employers to provide health risk assessments for diabetes risk factor screening, and to offer meaningful risk reduction information to members.

Prediabetes Defined

Before people develop Type II diabetes they typically have a condition called prediabetes. People with prediabetes can prevent or delay the onset of Type II diabetes by establishing healthy lifestyles or making progressive changes in their diets and activity levels. For instance, a loss of 10-15 pounds may be enough to return a prediabetic blood glucose level back to normal. The purpose of many employer or health plan-led health risk assessments is to identify risk factors for diabetes and to work with them on lifestyle changes that can reverse prediabetes.

- Type II diabetes is a condition that allows the pancreas to make insulin, just not enough. Type II diabetes accounts for 90-95 percent of all cases and is most often associated with older age, obesity, physical inactivity, family history of diabetes, and race/ethnicity. These traits are called risk factors, and help plans and physicians identify patients who may develop diabetes in the future.

Complications of Diabetes

People with diabetes are more at risk for other serious health complications than other members. It is vital that employers seek out quality diabetes management programs and preventive care services from health plans, and that these programs address both diabetes and related conditions.

Co-morbidities are diseases or conditions that exist with diabetes and may be partially caused by diabetes. Co-morbidities and complications of diabetes are more likely to occur if blood sugar is not controlled. Standards of care for diabetes call for early treatment and for using medications and other means necessary to prevent high blood sugar. Co-morbidities and complications are serious medical conditions that put a person at risk for death or severe illness. Common diabetic co-morbidities include:

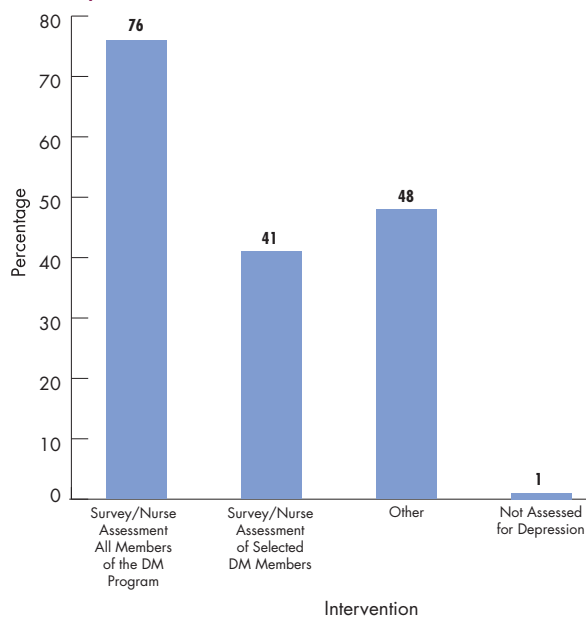
- **Heart disease and stroke:** Heart disease and stroke account for about 65 percent of deaths in people with diabetes. This is 2 to 4 times higher than the rate in non-diabetic populations. Similar to the overall diabetes prevalence, diabetes-related deaths due to heart disease are also on the rise.
- **High blood pressure and cholesterol:** 73 percent of adults with diabetes have hypertension and nearly all have cholesterol problems. By controlling blood pressure, however, people with diabetes can reduce their risk for heart disease and stroke by 33-50 percent and reduce their risk for eye, kidney, and nerve diseases by about 33 percent. Likewise, improved control of cholesterol levels can reduce heart disease complications by 20-50 percent.
- **Eye Complications and Blindness:** Diabetes is the leading cause of blindness among adults aged 20-74 years old. In 2005, 3.2 million adults with diabetes aged 18 years or older (or roughly 22 percent) reported some form of visual impairment.
- **Kidney disease:** In 2002, diabetes caused 44 percent of all new cases of kidney failure. This number is on the rise.
- **Lower extremity conditions and amputations** have a costly and disabling effect on the quality of life for people with diabetes. In 2003, there were 873,000 discharges with a LED as either the first-listed or secondary diagnosis.

- **Depression and Inappropriate Alcohol Use:** Depression and alcohol use can also have a tremendous effect on the health of people with diabetes. An estimated 35 percent of people with diabetes reported bouts with depression in 2004. Alcohol can make diabetic problems worse by increasing nerve damage and eye complications.

Insufficient management of diabetes can be costly to purchasers. On average, patients with controlled blood sugar cost employers only \$24 per month compared with the \$115 per month estimate for people who do not have controlled blood sugar.

eValue8 solicits information on health plan strategies for identifying and managing co-morbid conditions. For example, eValue8 asks how health plans address depression and tobacco use of members being managed for diabetes. As Figure 2 illustrates, most health plans responding to the 2007 eValue8 RFI provide depression screening via survey or nurse for all members of their diabetes disease management programs (76 percent). A very small percentage (1 percent) do not screen diabetes disease management members for depression.

Figure 2: Health Plan Interventions for Ensuring that Diabetic Members are Screened and Treated for Depression: 2007 eValue8 RFI Results



Source: 2007 eValue8 RFI Data note: plans may use more than one approach

eValue8 Expectations: Obesity

The eValue8 RFI tool sets expectations for health plan performance in prevention, screening and management of obesity and obesity risk factors. Employers that purchase health benefits expect plans to educate overweight members on the health risks of obesity, identify and target members who can benefit from treatment, and track successful program efforts. Health plan purchasers also expect plans to have a robust primary prevention program that educates members about the risk factors for obesity and its relationship to other chronic diseases.

Obesity & Overweight Defined

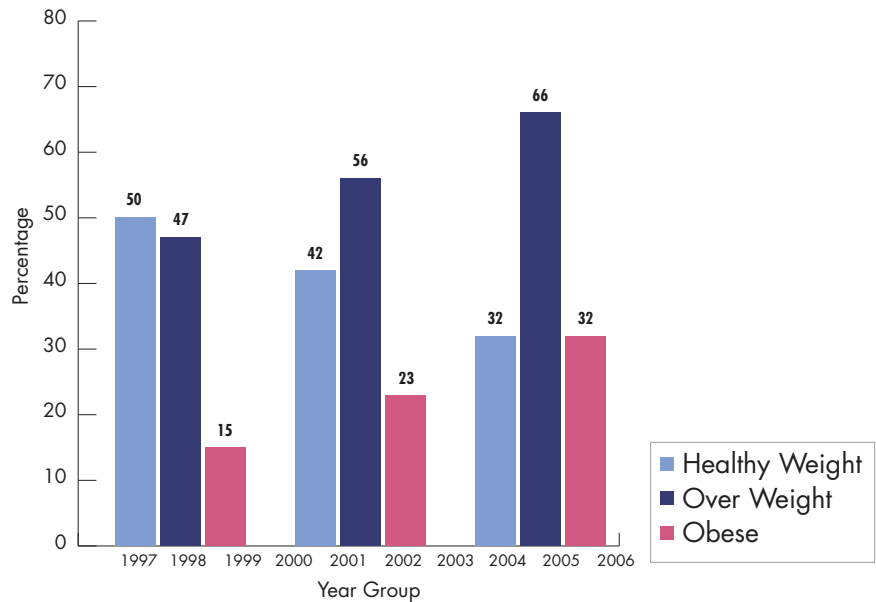
Medical and health professionals use the terms overweight or obese to describe a person's range of body fat if their weight is in excess to what is considered healthy for their height. Body mass index (BMI) is the crude but quick standard method that many people use to initially gauge weight status. Overweight is the label given someone who registers a BMI of 25-29.9. A BMI of 30 or higher is considered obese. The BMI table in Appendix 1 was reprinted from the National Institutes of Health at: http://www.nhlbi.nih.gov/guidelines/obesity/bmi_tbl.pdf

The Link Between Obesity and Diabetes

Obesity is a significant risk factor for diabetes. As Figure 3 shows, in the past 30 years, the prevalence of obesity has more than doubled. According to the Centers for Disease Control and Prevention (CDC), over 60 million adults or roughly 30 percent of the U.S. population aged 20 years and older are obese. Much of the rise in obesity is attributed to overeating and physical inactivity.

People who are obese are over seven times more likely to be diagnosed with diabetes. They are also at increased risk for heart disease, high blood pressure, arthritis-related disabilities, and some cancers. Compared to people with healthy weights, those with a Body Mass Index (BMI) of 40 or higher have an almost doubled risk of developing high cholesterol and are six times more likely to be diagnosed with high blood pressure. These factors suggest an urgent need for employers to work with health plans to identify individuals with or at risk for obesity, and to develop interventions that promote improved nutrition, physical activity, and other lifestyle interventions.

Figure 3: Prevalence Rate of Healthy Weight, Overweight, and Obesity Among Adults: 1976-1980 through 2001-2004



Source: Health, United States, 2006. Data notes: Age-adjusted data presented include adults aged 20 years and older. Underweight not shown; obese are shown in both overweight and obese columns. Numbers do not add up to 100%.

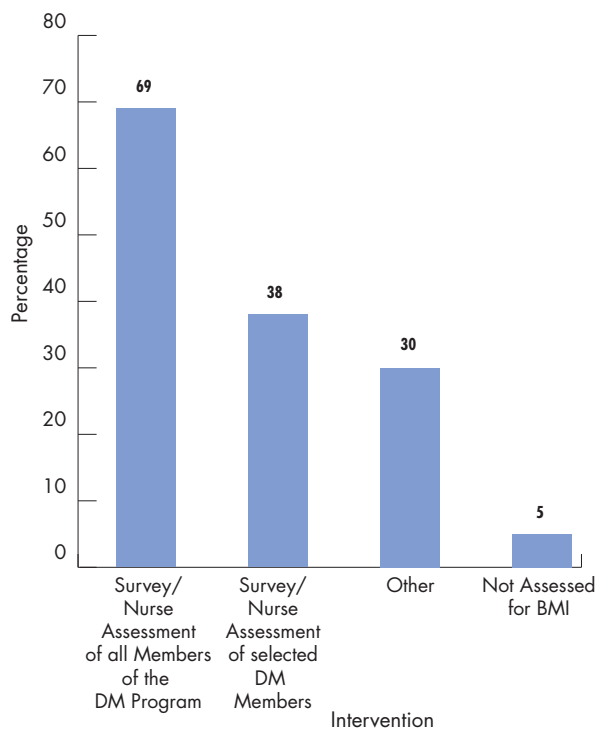
On the critical issue of weight management, almost all health plans (99 percent) provide educational materials online and in print. Ninety seven percent offer self management support tools such as pedometers and BMI calculators. Among health plans offering specific weight loss strategies:

- 62 percent provide benefit coverage of FDA-approved weight loss drugs
- 48 percent provide family counseling
- 74 percent offer in-person nutritional or weight management counseling

- 48 percent distribute BMI calculators to doctors
- 68 percent distribute treatment guidelines to physicians
- 36 percent report data on overweight or obese members to physicians
- 30 percent provide comparative performance reports to physicians.

Patients enrolled in disease management programs have already been diagnosed with a disease, and are thus a high priority group for risk factor management. As Figure 4 shows, almost 70 percent of health plans that responded to the 2007 eValue8 RFI reported that all diabetes disease management program members were screened and/or treated for overweight/obesity. Only five percent of responding health plans did not assess this group of members for weight problems.

Figure 4: Health Plan Interventions for Ensuring that Members are Screened and Treated for Overweight/Obesity (BMI): 2007 eValue8 RFI Results



Source: 2007 eValue8 RFI; respondents may choose multiple responses thus numbers do not add up to 100%

Health and Productivity Costs of Diabetes

The upward trend in diabetes prevalence has a profound impact on the U.S. economy. In the last decade, per-capita annual costs of healthcare for people with diabetes have increased by more than 30 percent. Diabetes accounts for 11 percent of the total U.S. health care expenditure. On average, the medical expenditure for a person with diabetes is \$13,243, 5.2 times greater than the cost for a person without the disease. In 2002, the estimated cost of diabetes reached \$132 billion. Approximately \$92 billion of that was attributable to direct medical costs and another \$40.8 billion to indirect costs such as disability, work loss and premature death.

Diabetes accounted for more than 88 million lost disability days in 2002 and 176,000 permanent disability cases costing more than \$7 billion. On average, people with diabetes take 8.3 sick days off from work per year, while people without diabetes or other chronic illness take only 1.7 days off from work.

Ensuring quality diabetes care is a cost effective strategy for employers. For example, according to CDC:

- By bringing blood pressure under control, health care costs for people with Type II diabetes are cut by more than \$900 over a lifetime.
- Within five years, a foot care program for a person with foot ulcers can save \$500 and prevent costly amputations.
- Patient education on self-managing diabetes prevents hospitalizations. For every \$1 spent on these programs, health care spending is cut by \$8.76.
- Simple improvements in blood sugar control can make a positive impact on employee quality of life and job productivity. Workers with diabetes who control their blood sugar are more productive at work and able to stay employed longer than people who do not control their blood sugar levels. Also, blood sugar control lowers the rate of absenteeism by one percentage point, while poor blood sugar control increases absenteeism by eight percent.

eValue8 encourages employers to consider both the medical costs and the lost productivity costs of individuals with diabetes. eValue8 points employers to innovations that can improve health and productivity, including benefit design to promote quality care and self management, value based purchasing, and implementation of strategies to promote employee health.

Guidelines and Clinical Goals

Clinical practice guidelines for diabetes are the foundation of performance expectations established for health plans and physicians. Researchers have developed extensive information on the most effective ways to care for diabetes. This evidence of effectiveness is reviewed by doctors and other experts and captured in guidelines for care. Clinical practice guidelines, as they are known, reflect the current standards of care for diabetes. Guidelines are updated frequently to incorporate new information on best practices for diabetes care.

The NBCH eValue8 tool reflects national clinical practice guidelines on the care of diabetes. While NBCH does not endorse a specific guideline, the expectations it sets for health plans are consistent with national guidelines such as those of the American Diabetes Association (ADA).

eValue8 asks health plans to report on their activities to manage key aspects of diabetes care as outlined in national guidelines. For example, the ADA Standards of Medical Care for Diabetes include the following recommendations:

- Screening for diabetes in at-risk people, including those who are overweight or have a family history of diabetes;
- Preventing/delaying diabetes through weight loss and exercise;
- Treating diabetes by using medications, exercise, monitoring and diet to achieve “glycemic control.” This is measured by monitoring a key indicator, “hemoglobin A1c,” and keeping it at or below 7, a level slightly above normal;
- Managing commonly occurring co-morbid conditions, including obesity, heart disease, hypertension, and high blood lipid levels.

Experts are increasingly recommending early and “tight” management of diabetes, to help patients maintain close-to-normal blood sugar. While these goals are difficult for patients and providers to achieve, better management dramatically reduces complications and improves patient health outcomes. The goals for diabetes care established in guidelines are addressed in eValue8, which asks health plans to report on how they are working to achieve diabetes standards of care.

II. HEALTH PLAN ACTIVITIES TO PROMOTE EVIDENCE-BASED DIABETES CARE

Plan Profile

This section of the report identifies purchaser expectations for health plans, and describes current health plan performance.

Health Plan Performance Measurement Trends

Several organizations have developed protocols for standardized measures of health plan and physician clinical performance. Rather than duplicate these national efforts, eValue8 collects data on measures developed and endorsed for health plans by the National Committee for Quality Assurance (NCQA) and for physicians by the AQA (formerly known as the Ambulatory Quality Alliance), a broad-based coalition made up of 125 organizations. eValue8 captures NCQA HEDIS and AQA measures for diabetes and related co-morbidities.

HEDIS performance measures currently include seven measures that assess health plan ability to offer effective and complete management of diabetes. One of the measures reflects undesirable practices, so a lower number is better (poorly controlled hemoglobin A1c); while the others reflect standards of care and should be high (e.g., annual hemoglobinA1c testing). Other measures reflect goals and are clinically hard to achieve but are a best practice in clinical care, for example, LDL-C (cholesterol) less than 100.

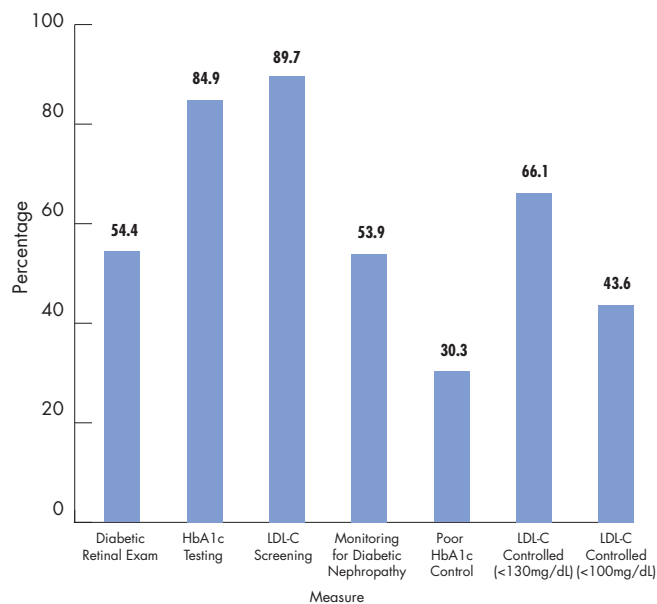
2007 diabetes-related HEDIS indicators reported in eValue8 include the HEDIS Eye Examination rate, Cholesterol Screening rate, HbA1c Screening rate, Nephropathy Monitoring, LDL Control and HbA1c Poorly Controlled (>9.0 percent). HEDIS measures reflect the percentage of health plan members between the ages of 18-75 years with diabetes who received certain screening tests, or were able to achieve improved testing results. Figure 5 shows mean HEDIS scores reported by plans responding to eValue8 in 2007.

eValue8 Expectations: HEDIS Measures

Performance measures such as NCQA HEDIS measures and AQA measures reflect clinical goals established through major evidence-based clinical practice guidelines. Given the maturity of diabetes programs and the significance of available diabetes HEDIS measures, purchasers place great emphasis on the degree to which plans perform well in the HEDIS measures. Purchasers also expect plans to evaluate and adjust their member and practitioner interventions to improve performance. eValue8 asks health plans to go beyond the HEDIS measures by tracking additional measures that are important to health plan purchasers. Additional measures of interest to purchasers include functional status and presenteeism (productivity).

HEALTH PLAN ACTIVITIES TO PROMOTE EVIDENCE-BASED DIABETES CARE

Figure 5: HEDIS Performance Measures (Mean Scores): 2007 eValue8 RFI Results



Source: The 2007 eValue8 RFI 2007

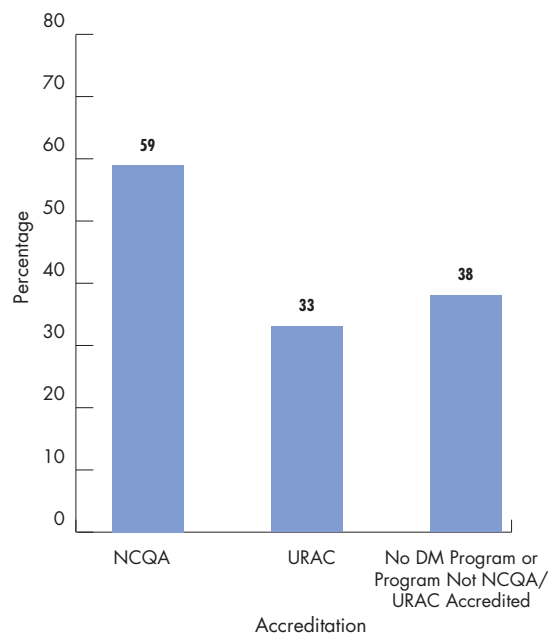
Please note: LDL-C screening and monitoring for diabetic nephropathy performance measures underwent major specification changes in 2007.

Accreditation

In addition to health plan performance measures, external organizations have also developed standards for health plan organization and structure. NCQA and URAC both review health plan operations to ensure that they are consistent with standards of care. Health plans can seek outside review and certification either for their entire operations, or specifically for their diabetes care management programs.

Figure 6 shows that 62 percent of diabetes disease management programs are accredited by either NCQA or URAC or both. Almost 60 percent of responding health plans operating diabetes programs have received patient and practitioner accreditation from the NCQA. Plans that receive this NCQA accreditation employ various means to encourage members to self-manage healthy behaviors and work with practitioners through supplemental programming or within integrated delivery systems.

Figure 6: Diabetes Management Program Accreditation Status: 2007 eValue8 RFI Results



Source: 2007 eValue8 RFI Data note: Plans may be accredited by both organizations; numbers do not equal 100%

Benefit Design

Employers play an important role in designing health care benefits. Many employers have asked health plans to implement strategies to create financial incentives to promote patient adherence to selected high priority medications. More than 38 percent of 2007 responding health plans reduced co-pays for selected medications, tests or services for diabetic members; and more than 28 percent reduced deductibles. However, 35 percent of health plans do not yet support benefit designs that reduce barriers to essential services for members with diabetes.

eValue8 findings are consistent with those of the Kaiser Family Foundation in the annual survey of employee benefits. Kaiser Family Foundation showed an increased use of stratified tiers of cost sharing for medical prescriptions and supplies in health benefit plans. In “tiered” plans there are varying levels of co-payment for drugs of different classes. Often the lowest co-payment is for generic and essential medications, while members pay more for branded drugs and discretionary medications. According to Kaiser Family Foundation, since 2000 the percentage of employees enrolled in health plans with three or more tiers for prescription drug cost sharing increased from 27 percent to 74 percent.

Member and Provider Engagement

Plan Member Identification

eValue8 incorporates the premise that health plans should have multiple mechanisms to identify patients with diabetes. The plan cannot begin to improve the quality of care and interact with patients until it knows who they are. Member identification is key to enrolling patients in disease management programs. Most often health plans identify diabetic members through claims analysis, HRAs, predictive modeling, and referrals from doctors, case managers and others.

HRAs are viewed as an important strategy to identify patients at risk for diabetes and as a tool to engage patients early in prevention and health promotion activities. eValue8 asks health plans if they make HRAs available to members either online or in print. The data show that 87 percent of health plans offer HRAs both online and in print. However, results also suggest that on average, only two percent of plan members completed an HRA in the last year.

An important performance indicator is how health plans collect HRA results and make it available to the patients and their doctors. HRA results are most valuable if they can be used by patients and their physicians to identify risks and promote behavior change. An emerging best practice is for HRA results to be transmitted electronically and to be linked to other important patient information. The results also show that only 40 percent of health plans offer members the opportunity to send their HRA results to their personal physicians. With the development of improved health information technology, improved information collection and sharing (with appropriate privacy protections), is an area of expected improvement for plans.

Once a member has entered information into an HRA, it is important for that information to be available to the member and health care providers they select. Figure 7 shows how health plans incorporate information from HRAs and other sources into the patient's personal health record.

eValue8 Expectations: Diabetic Member Identification

eValue8 expects health plans to employ mechanisms to identify, recruit and retain members who may benefit from diabetes care and interventions. The number of members identified is expected to be in proportion to the prevalence found in the general population for specific age cohorts. Purchasers expect that plans have a mechanism for identifying and sorting diabetic members according to intensity of needs (e.g. predictive model, clinical criteria). Plans are expected to provide a health risk assessment (HRA) that is available to all members, comprehensive, automated, able to produce multiple reports, and that demonstrates strategies to maximize completion rates. eValue8 requires information on worksite-based communications with employees about health and risk management, use of HRAs, and use of HRA data to engage patient in disease management, case management, or education.

Figure 7: Methods Available from Health Plans for HRA Data Entry

	Entered by Member	Electronically Populated by Plan	Electronically Populated by Physician	Electronically Populated from Vendor	No Provision
Personal Health History	67%	20%	8%	1%	22%
Family Health History	66%	1%	4%	1%	25%
Health Risk Assessment	75%	4%	2%	1%	22%
Physician Visit Notes	31%	5%	9%	0%	46%
Physician Orders	30%	18%	9%	1%	54%
Lists of Visits, Tests, etc.	49%	40%	9%	0%	25%
Lab Test Results	49%	42%	8%	0%	24%
X Ray Results	29%	19%	3%	0%	44%
Pharmaceutical Fills	49%	34%	3%	5%	29%
OTC Drugs Used	62%	0%	1%	0%	32%

Source: 2007 eValue8 RFI

HEALTH PLAN ACTIVITIES TO PROMOTE EVIDENCE-BASED DIABETES CARE

eValue8 Expectations: Provider Performance Measurement

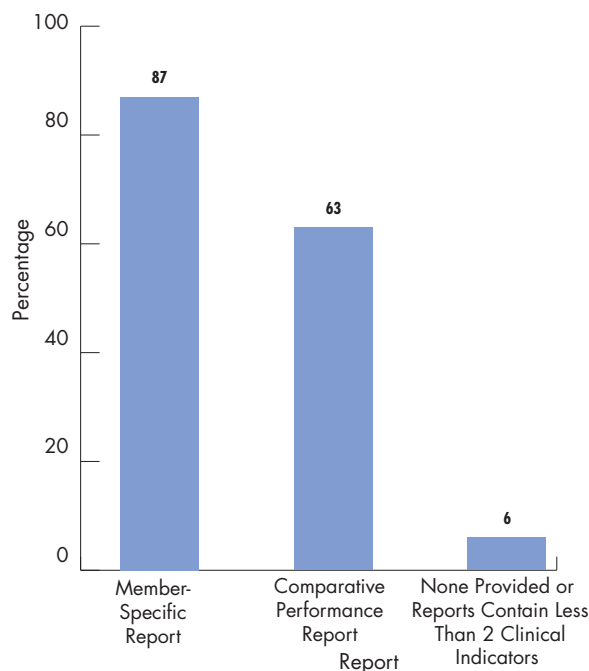
Purchasers expect plans to evaluate the quality of the provider network, and where feasible, implement steps to improve the overall quality of the provider network. This may include activities such as promoting use of electronic medical records, working with clinical centers of excellence, or offering high performing networks as a benefit option. eValue8 establishes the expectation that plans monitor member-specific compliance and practitioner compliance with clinical guidelines. Monitoring can occur at the plan or practitioner group level depending upon the model of the plan. The goal of such monitoring is to make clinical data available to practitioners to promote improved practice. The plan is also expected to proactively engage practitioners in the disease management program.

Provider Performance Measurement and Engagement

Employers can use eValue8 data to identify health plans that track physician performance through proven quality diabetes performance measures. While HEDIS indicators reflect the performance of the health plan as a whole, AQA measures address physician performance. Increasingly, plans are encouraged to provide information back to physicians and hospitals that will improve their performance in treating diabetes. Plans are also expected to communicate information about physician and hospital performance to patients to help the patients make choices about high quality providers.

Figure 8 shows the percentage of health plans that give physicians specific information about which of their patients are in need of services. Some plans also use performance reports that compare providers to each other. Eighty-seven percent of responding health plans offered practitioners member-specific reports and 63 percent provided comparative performance reports. Only small percentages of health plans did not offer any reports.

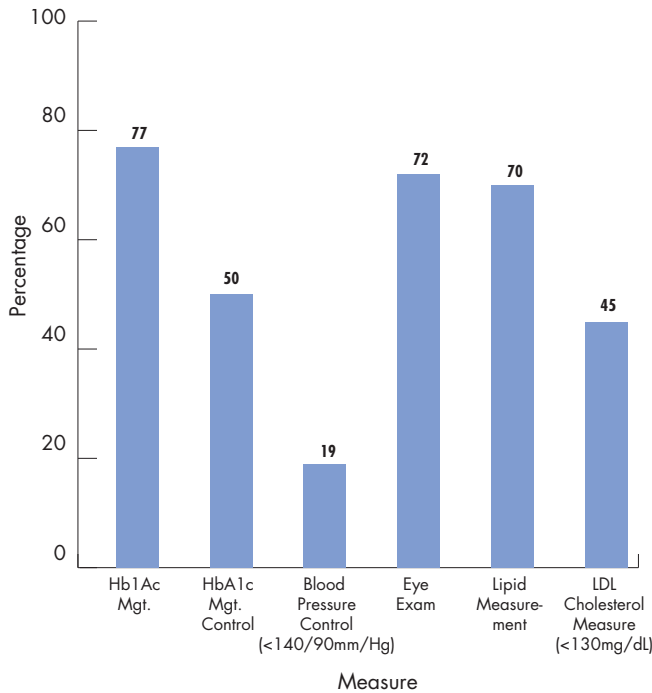
Figure 8: Type of Reports Available to Practitioners: 2007 eValue8 RFI Results



Source: 2007 eValue8 RFI plans may offer multiple reports

One goal of eValue8 is to encourage plans to use the data they have in hand to effectively manage care and educate patients and providers. As noted above, eValue8 asks plans to report their results of AQA performance measures – measures developed by a national organization to assess effectiveness of diabetes care offered by physicians. Figure 9 illustrates the specific diabetes quality indicators plans report to physicians.

Figure 9: Provider Feedback and Benchmarking for AQA Diabetes Measures: 2007 eValue8 RFI Results



Source: 2007 eValue8 RFI

eValue8 Expectations: Patient Engagement

Employers expect health plans to provide multiple interventions designed to engage patients in self-management and preventive health behaviors, including lifestyle changes. Purchasers expect plans to provide their members and primary care physicians with information and other types of support (e.g., counseling, web-based programs, etc) that facilitate member engagement in their health. Purchasers expect that plans will educate members about their disease and support them in their efforts to self-manage and navigate the health care system. Plans are expected to provide actionable member-specific reminders or demonstrate that all network practitioners are tracking compliance.

Member Communications

Employers increasingly are asking health plans to involve patients in making decisions about their own care. eValue8 asks for information about strategies used by plans to educate and involve patients. Plans frequently use personal phone calls and letters to reach out to patients, educate them about diabetes, and alert them to the need for follow-up care. Health plans also assign a disease manager or case manager, a nurse, or other clinician who calls the patients to discuss diabetes care, medications, and other lifestyle changes.

Results from the 2007 eValue8 RFI showed that health plans used a variety of interventions to communicate with diabetic patients. For instance, Figure 10 shows that 82 percent of plans offer general reminders, 71 percent offer member-specific reminders based on missed services, and 85 percent offer live outbound telephone management programs as standard options. Fewer plans offer one-on-one counseling.

Figure 10: Health Plan Communications with Members Enrolled in Standard Option Plans

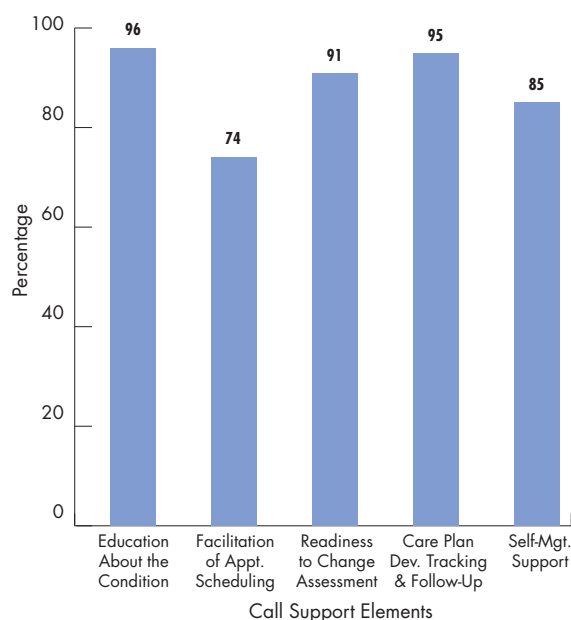
eValue8 RFI Results: Standard Option Interventions for Patients with Diabetes:	2007
Live outbound telephone management program	85%
General reminders	82%
Member-specific reminders based on missed services	71%
Member self-management support/education in a group setting	46%
Interactive, disease specific electronic support	45%
Individual one-on-one counseling	39%
In-home assessment	29%

Source: 2007 eValue8 RFI

HEALTH PLAN ACTIVITIES TO PROMOTE EVIDENCE-BASED DIABETES CARE

Within disease management programs, health plans use personalized phone calls to educate members about diabetes (almost 96 percent). As shown in Figure 11, health plans use personalized phone calls for a variety of purposes. In 2007 74 percent of responding health plans offer member appointment setting through live outbound call programs, and almost all (96 percent) provide members with education about diabetes.

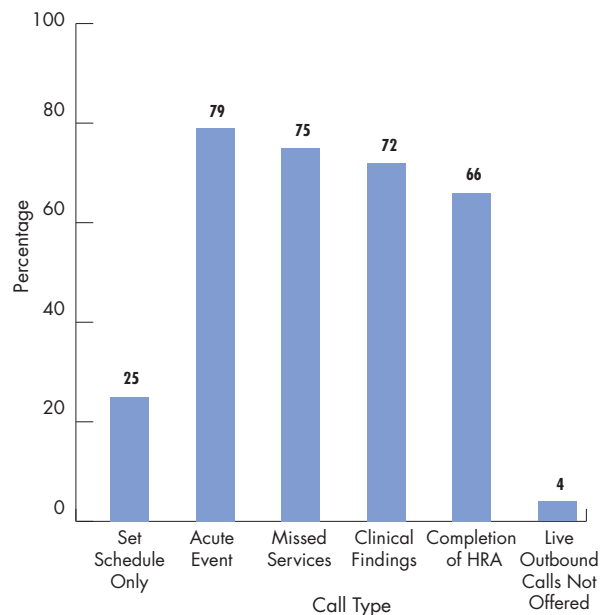
Figure 11: Health Plan Member Support Elements Used for Live Outbound Calls to Members with Diabetes: 2007 eValue8 RFI Results



Source: 2007 eValue8 RFI

Acute events such as emergency rooms visits or inpatient hospital stays may be a trigger for plans to call members. As seen in Figure 12, missing a service and acute events were common reasons for health plans to contact members outside of regularly scheduled calls.

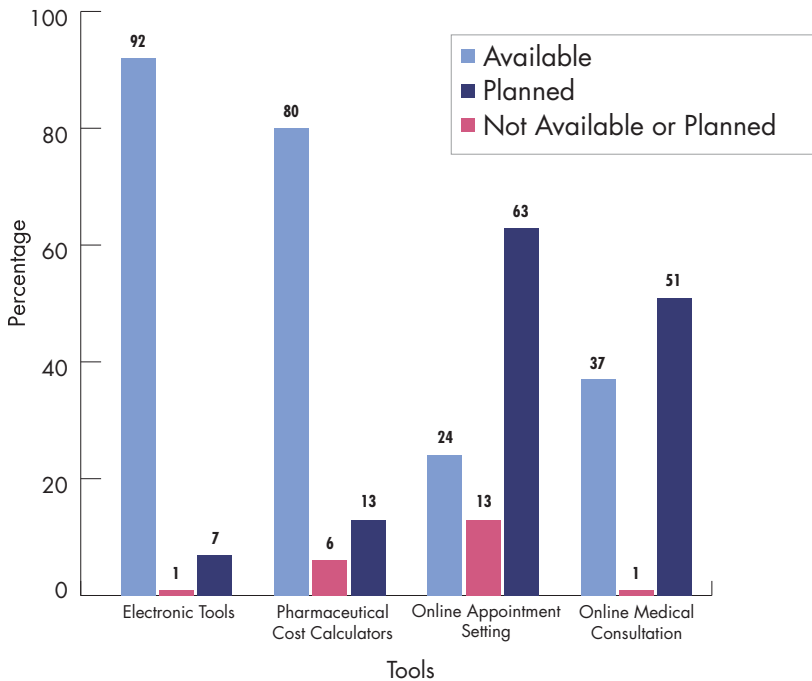
Figure 12: Health Plan Live Call Prompts to Contact Members Outside of Normal Schedule: 2007 eValue8 RFI Results



Source: 2007 eValue8 RFI

In addition to phone calls, eValue8 encourages health plans to use tools that interact with patients to help them make decisions based on cost and quality information. Figure 13 shows how plans are using or considering web-based approaches. For example, 37 percent of reporting plans are using the internet for online medical consultation, a strategy that may improve access to health care and reduce costs. Eighty percent are making pharmaceutical cost calculators available to patients, a feature that may help members to better manage costs within their health savings account plans. Many health plans are contracting with specialized companies to offer treatment support and performance information to members that will enable patients to choose among treatments and providers more effectively.

Figure 13: Select Tools Used by Health Plans to Improve Quality and Engage Patients: 2007 eValue8 RFI Results



Source: 2007 eValue8 RFI

Diabetes Disease Management

Disease management is a comprehensive, proactive approach to treating chronic diseases. Plans that recommend disease management for patients are offering a more intensive, customized program for diabetes care. Most disease management programs establish goals with patients and work closely with them by phone and internet to help them achieve control of their diabetes.

The Centers for Disease Control and Prevention and others have concluded that there is sufficient research evidence showing that diabetes disease management is effective. These programs focus on prevention, patient education, and outpatient care to keep people from needing inpatient and acute care services. Disease management is based on the premise that informed, coordinated care helps to prevent recurring symptoms and maintains quality of life while reducing health care costs.

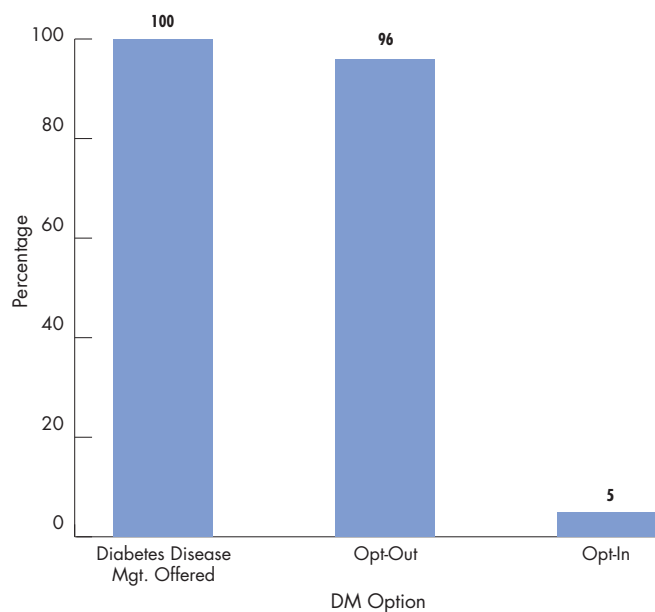
eValue8 Expectations: Disease Management

Purchasers expect plans to provide disease management programs or other organized approaches to improve care of members with chronic conditions, and proactively offer these programs to all appropriate members. Increasingly, eValue8 expectations will evolve to encourage plans to not only offer programs, but to implement strategies (incentives or other) to actively engage patients and providers and to document the impact of those programs. Purchasers expect that plans will employ mechanisms to identify, recruit and retain members who may benefit from disease management interventions. The number of members identified should be in proportion to the prevalence found in the general population for specific age cohorts. Purchasers expect that plans will have a mechanism for identifying and stratifying members according to intensity of needs (e.g. predictive model, clinical criteria). Member support should include tailored education and interventions that reflect the severity of the condition, and should include coordination of care for members with co-morbid conditions.

HEALTH PLAN ACTIVITIES TO PROMOTE EVIDENCE-BASED DIABETES CARE

As shown in Figure 14, the majority of health plans that offered disease management do so through opt-out programs. Opt-out automatically enroll members into disease management unless they request not to be enrolled, while opt-in disease management programs require that plan members or practitioners request enrollment.

Figure 14: Health Plan Adult Diabetes Disease Management Options Available (Opt-In Vs. Opt-Out): 2007 eValue8 RFI Results



Source: 2007 eValue8 RFI Data note: Plans may structure their diabetes disease management program as both "opt-in" and "opt-out". Thus, percentages for these two categories do not add up to one hundred percent.

Coordination of Care

Purchasers increasingly recognize that it is not effective to manage a single disease for patients with multiple and inter-related illnesses such as diabetes and heart disease. Multiple risk factors place patients at a higher risk. This group is often a high priority for health plans, and receives special services such as disease and case management. Purchasers are working to promote coordination across health plan services for co-morbid conditions, with a particular emphasis on coordination of care for patients with a chronic illness such as diabetes and a behavioral health problem such as depression.

Results from the 2007 eValue8 RFI reveal that only 37 percent of health plans coordinate co-morbid conditions with a centralized case manager. Most separate physical and mental health issues, while others may outsource management of other medical conditions to an outside vendor. Figure 15 shows some of the methods used by health plans to coordinate care for patients with several disease conditions, including those with behavioral health concerns such as depression.

Figure 15: Case Management Approaches for Members with Multiple Conditions

eValue8 RFI Results How is case management handled across comorbid conditions?	2007
One case manager addresses medical conditions and another addresses behavioral conditions	49%
Single case manager is assigned to address all conditions (medical and behavioral)	37%
One case manager addresses all conditions managed by the plan and another (vendor) case manager addresses conditions outsourced to a vendor	19%
Separate case managers for each chronic condition	10%
Condition is not addressed through case management	1%

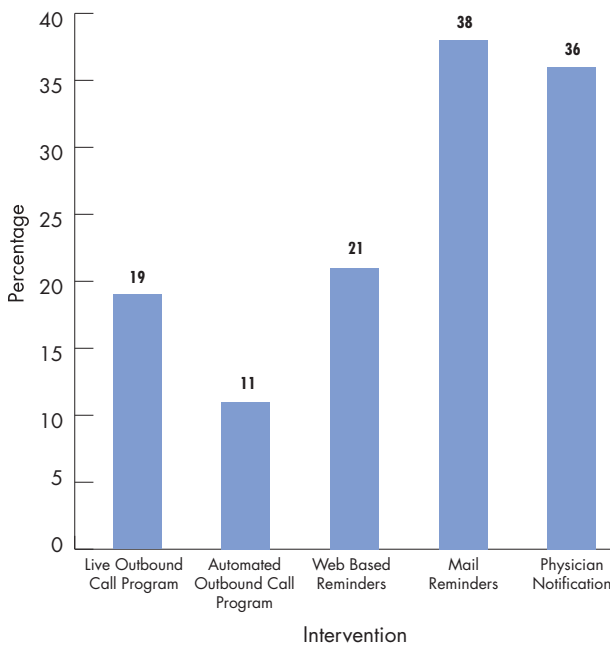
Source: 2007 eValue8 RFI Data note: health plans may offer more than one approach in different product lines. Does not equal 100%

Pharmacy Management

Support for Medication Compliance

Medication compliance is an essential aspect of controlling diabetes. Employers want to know how health plans identify, monitor and support members with poor medication compliance. Figure 16 shows a number of strategies employed by health plans to encourage members to continue taking essential diabetes medications. Health plans use a variety of interventions to identify and alert members about their prescriptions, including live and automated calling programs, web based and mail reminders, and physician notifications.

Figure 16: Health Plan Interventions to Increase Medication Compliance (All Retail): 2007 eValue8 RFI Results



Source: 2007 eValue8 RFI

Pharmacy Program Design

As Figure 17 illustrates, most health plans that responded to the 2007 eValue8 RFI reported that pharmacy experts were consulted in the design of diabetes disease management program interventions (93 percent). Likewise, many of the responding health plans (58 percent) used pharmacy experts to conduct assessments of member medication regimens and intervene with members or their practitioners to optimize diabetes treatment.

Figure 17: Use of Pharmacy Experts in Disease Management Programs

eValue8 RFI Results: How does the plan ensure that pharmacy management is integrated into diabetes management?	2007
Pharmacy expert consulted in the design of disease management program interventions	93%
Pharmacy expert conducts assessment of individual member medication regimens and intervenes with member or practitioner to optimize treatment	58%
Pharmacy expert performs academic detailing with practitioners	45%
Formulary adjusted to cover key maintenance medications at lowest (or no) cost tier	34%

Source: 2007 eValue8 RFI

eValue8 Expectations: Pharmacy Management

eValue8 expects that health plans involve pharmacy expert resources in program design and interventions. Plans are also expected to identify individuals with poor medication compliance through routine monitoring of refill activity. Through eValue8, purchasers expect that health plan formularies—the list of drugs health plans cover—are readily available to members. Purchasers also expect health plans to provide comprehensive information about each covered drug, including purpose, alternatives, side effects, risks, and contraindications.

III. FUTURE DIRECTIONS FOR EMPLOYERS

Promising Initiatives

Employer expectations for health plan management of diabetes continue to evolve. Employers have a vested interest in ensuring that members are provided with high quality care; this care should help to mitigate unnecessary costs, and maximize employee wellbeing and productivity. Many employers are utilizing newer practices, like value-based health care, and purchasing health plans that offer enhanced patient engagement as further ways to ensure the health of employees with diabetes and other chronic conditions.

Value-Based Benefit Design (VBBD)

There is a growing evidence base that VBBD is an effective approach to allocating resources to control cost and improve outcomes. Under this model, plans/sponsors identify incentives to increase use of essential tests, treatments and pharmaceuticals, while maintaining cost sharing or other approaches to manage utilization. NBCH is developing eValue8 content in the area of VBBD. In the future, eValue8 will address the extent to which plans maximize their clinical strategies and benefit offerings through incentives for patient and provider engagement and the results of these initiatives.

Transparency

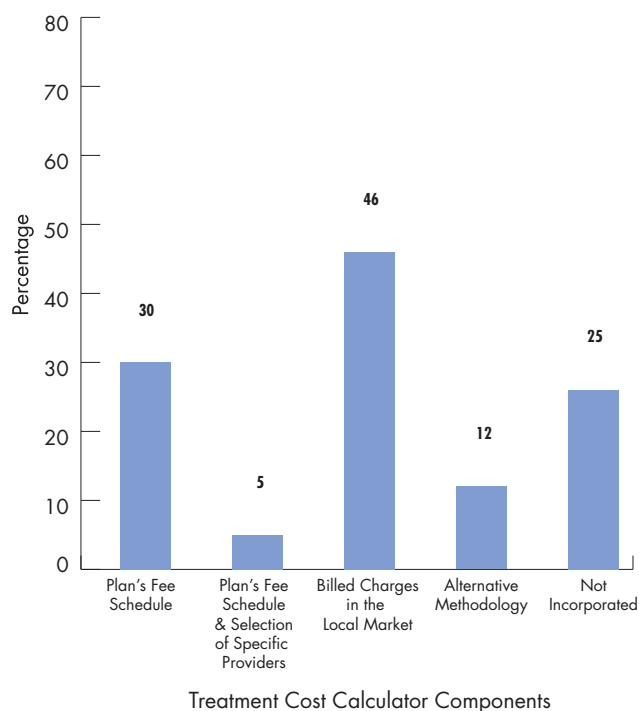
Recent federal support (Executive Order 13410, Promoting Quality and Efficient Health Care in Federal Government Administered or Sponsored Health Care Programs) energized value-driven health care by identifying Four Cornerstones of value-driven care. The Cornerstones are centered on the concept of making information available about health care cost and quality (transparency), strategies for making crucial information available where needed, and incentives to promote best practices. The Four Cornerstones are:

1. Transparency of quality
2. Transparency of price
3. Incentives for high-value health care
4. Interoperable health information technology.

Patient engagement can be especially enhanced by implementing transparency. Figure 19 shows many plans are beginning to provide tools to patients that offer price transparency. These tools are particularly needed for plans offering Health Savings Account benefit plans, in which patients are encouraged to compare services to purchase on the basis of cost and quality.

eValue8 itself is a source of transparency of information, as are programs that measure quality of care performance and make this information available to consumers, purchasers, and providers. Transparency of quality information allows consumers and employers to have ready-access to the most valuable information available—how health plans treat their enrollees and how they identify and engage patients in making informed health care decisions.

Figure 18: Price Transparency: Health Plan Use of Treatment Cost Calculators to Incorporate Cost Information into Vendor Supplied Products: 2007 eValue8 RFI Results



Community Initiatives

Many employers are working collaboratively with health plans to implement community initiatives such as the Asheville Project (now called HealthMapRx) and the Diabetes Care Link (DCL) through Bridges to Excellence (BTE). These programs use incentives to pharmacists and physicians, respectively, to increase member access to diabetes information and education. HealthMapRx adds the incentive of reduced costs for diabetes medications for patients who remain in a pharmacist-lead counseling program.

These community programs have shown cost and quality results: for employees enrolled in the HealthMap RX program, average annual medical claims per employee decreased by more than \$2,000 per year. Employers report that annual sick leave for employees with diabetes was reduced by more than 50 percent. This created annual savings for the employer, ranging from \$1,622 to \$3,356 per participating employee. The Asheville project also resulted in fewer emergency room visits and decreased hospitalizations. The Bridges to Excellence Diabetes Care Link program has provided incentives to physicians to improve quality care, resulting in overall savings in the BTE DCL program of \$1,059 per patient.

Conclusion

NBCH and its member business coalitions believe employers should have access to detailed quality information from their health plan suppliers. This is particularly important as employers gear up to help employees manage the growing problem of diabetes. By investing in prevention, as well as quality diabetes health care management programs, employers can help employees manage risks, prevent complications, and improve overall health and productivity.

Employers should ensure that the health plan they purchase includes features and benefit designs that enable quality care through member identification, patient and provider engagement, and thorough pharmaceutical management. As this report illustrates, health plans are working hard to meet employer expectations. The eValue8 tool helps to set expectations for plans, and helps employers plan and purchase health care packages that incorporate best practice features. Through information that drives the evolution of health care services, employers and their partner health plans and coalitions can move towards better quality diabetes care – and better health and productivity for employees with diabetes.



IV. RESOURCES

Diabetes Related Web sites

American Diabetes Association Guideline

The American Diabetes Association “Standards of medical care in diabetes” offers a clear overview of necessary elements of diabetes care, based on expert review of research.

http://www.guideline.gov/summary/summary.aspx?doc_id=10400&nbr=005446&string=diabetes

ADA’s Diabetes in the Workplace site offers valuable information to employers.

<http://www.diabetes.org/communityprograms-and-localevents/diabetes-in-the-workplace.jsp>

Centers for Disease Control and Prevention (CDC) Resources

CDC offers a wealth of information on diabetes statistics, community initiatives, and evidence-based information for purchasers.

<http://www.cdc.gov/diabetes/>

In particular, the CDC / National Business Group on Health publication, “A Purchaser’s Guide to Clinical Preventive Services: Moving Science into Coverage” is a valuable resource for improving benefit design based on evidence of what works.

Recommendations for employer activities in worksite health promotion are available at:

<http://www.thecommunityguide.org/worksite/default.htm>.

Diabetes at Work is a national program of the CDC and other partners that offers a complete package of interventions that can be implemented at the worksite.

<http://www.diabetesatwork.org/diabetesatwork/>

Center for Value-Based Insurance Design

The University of Michigan Center for Value-Based Insurance Design offers literature and cutting edge information on innovations in benefit design, including pharmacy benefits, that can promote better care for patients.

<http://www.spb.umich.edu/vbidcenter/KaiserFamilyFoundationSurveyofHealthBenefits>

This annual survey of employers provides a detailed look at trends in employer-sponsored health coverage, including changes in premiums, employee contributions, cost-sharing provisions, and other relevant information.

<http://www.kff.org/insurance/7672/>

National Diabetes Education Program

This CDC and NIH joint initiative offers a menu of approaches to improving diabetes care that can be implemented by employers, plans, or communities.

<http://ndep.nih.gov/>

National Institutes of Health Body Mass Index Table

Body Mass Index Table																																																						
	Normal								Overweight					Obese							Extreme Obesity																																	
BMI	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	50	51	52	53	54																		
Height (inches)	Body Weight (pounds)																																																					
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Source: Adapted from Clinical Guidelines on the Identification, Evaluation, and Treatment of Overweight and Obesity in Adults: The Evidence Report.

http://www.nhlbi.nih.gov/guidelines/obesity/bmi_tbl.pdf



National Business Coalition on Health

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