new & news in diabetes policy

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Alejandro has type 1 diabetes

In This Issue:

- Diabetes detection increases in states with expanded Medicaid
- Implications of high cost sharing for patients who gain health insurance coverage
- Newly confirmed surgeon general to focus on chronic disease

Diabetes detection increases in states that have expanded Medicaid

Research published in *Diabetes Care* examined the impact of Medicaid expansion on the number of cases of newly diagnosed diabetes among Medicaid beneficiaries. The study found that a significantly greater number of new cases of diabetes were identified in states that expanded Medicaid, compared to states that have not yet expanded.[1]

Under the Patient Protection and Affordable Care Act (ACA), states can choose to expand Medicaid eligibility to all non-elderly adults with incomes up to 138% of the federal poverty level, which is approximately an annual income of $16,000 for a single adult. The federal government incentivized states to expand eligibility pursuant to the ACA by offering increased federal matching dollars for the Medicaid expansion population. As of January 2014, the time of this study, 26 states and the District of Columbia had expanded their Medicaid programs.[1]

The researchers in this study used clinical laboratory data from Quest Diagnostics for over 400,000 patients from all 50 states. A case of newly diagnosed diabetes was defined as having a corresponding ICD-9 code or a hemoglobin A1C of greater than 6.4% during the study period.

"It is likely that changes in access to health care for patients with Medicaid contributed to testing for diabetes at an earlier state of disease."[1]

All patients included in the study were Medicaid enrollees at the time of their diabetes diagnoses. For the analysis, the patient group was divided between Medicaid expansion states and non-expansion states to examine the differences in diabetes detection.

The results indicate that in states that expanded Medicaid eligibility, there was a 23% increase in cases of newly identified diabetes from 2013 (pre-expansion) to 2014 (post-expansion). In the remaining 24 states that did not expand Medicaid, there was only a 0.4% increase in cases of newly identified diabetes.

These findings suggest that expanded coverage and access to care through Medicaid has resulted in greater diabetes detection.[1] Once the disease is detected, patients can begin appropriate treatment to mitigate risk for future complications.

You can access the full study here.

Diabetes Advocacy Alliance™

Analysis of life years lost and lifetime health care spending for patients with diabetes

Calculations of the lifetime health care expenditures and life years lost due to diabetes show the impact of the disease. A study published in *Diabetes Care* earlier this year found a 3.3- to 18.7- year decrease in life expectancy and a $8,946 to $159,380 increase in lifetime health care expenditures among individuals with diabetes.[2]

The researchers used data from the National Health Interview Survey (NHIS), the NHIS Linked Mortality Public-Use Files, and the Medical Expenditure Panel Survey (MEPS), and were able to link the individuals between the different data sources. NHIS and MEPS data from 1997 to 2000 were used, in addition to 2006 follow-up data from the NHIS Public-Use File.

P.J. PIMPINELLI
P.J. has type 1 diabetes

The researchers developed a Markov model, which was used to compute life years lost and medical expenditures by age, race, sex, and BMI classifications.

The results highlight the immense population health burden of diabetes, both in terms of length of life and health care costs. Depending on age, sex, race, and BMI, diabetes can reduce life expectancy by up to 18.7 years and can increase lifetime health care spending by up to $159,380.[2]

You can access the full study here.

Type 2 diabetes patients with multiple chronic comorbidities have poorer outcomes

People with type 2 diabetes who also have other chronic conditions have poorer health outcomes, according to research published in the *American Journal of Managed Care*.[3] The analysis examined the presence of multiple chronic comorbidities (MCCs) with diabetes in order to identify MCC clusters that are associated with poor outcomes among patients with type 2 diabetes. The leading MCC cluster was hypertension-dyslipidemia-obesity, accounting for 19%.


CYNTHIA TALLEY
Cynthia has type 1 diabetes

The researchers utilized electronic health record data from Humedica data sets, spanning 2008 through 2012. A total of 161,174 patients were included in the final data set.

The researchers used a list of comorbidities established by the American Diabetes Association to identify 14 diabetes-related comorbidities: hyperlipidemia, hypertension, obesity, depression, chronic obstructive pulmonary disease (COPD)/asthma, coronary artery disease (CAD), chronic kidney disease (CKD), arthritis, cancers, neuropathy, heart failure, fractures, peripheral arterial disease, and retinopathy. The patient outcome measures included having a face-to-face diabetes-related visit at least every 6 months and meeting the goal of A1C <8%.

The researchers found that 88% of patients with diabetes had at least one of the examined comorbidities, and more than half of patients had three or more of the comorbidities.[4] The most common MCC cluster was hypertension, hyperlipidemia, and obesity, as nearly one in five diabetes patients exhibited this cluster.[3] Patients with no documented comorbidities (54%) or obesity, only (60%) were less likely to meet their A1C goal and most likely to have emergency department visits (22% and 20%, respectively). Obesity was more common as a comorbidity among younger patients.[3]

You can access the full article here.

"Our findings suggest that diabetes guidelines should explicitly address the co-occurrence of multiple concordant comorbidities and the co-occurrence of concordant and discordant/dominant conditions. Explicit consideration of MCC clusters is important because appropriate management of individual diseases in isolation may not be optimal for patients with MCCs."[4]

Implications of high cost sharing for patients who gain health insurance coverage

A recent issue brief released by the Kaiser Family Foundation examined the relationship between patient cost-sharing responsibility and consumer decision making in health care. The recent slow growth in health care costs is thought to be at least partially due to increased consumer cost responsibility, such as higher deductibles in health insurance plans. The authors of this issue brief sought to understand what this high cost-sharing responsibility means for people with limited financial resources who may therefore not have the same consumer choices.

"Particularly as we extend private coverage to more families with lower incomes and limited resources, we need to be cognizant of their financial capacity to use the coverage that they are being asked to buy."[4]

The brief's authors used data from the 2013 Survey of Consumer Finances, which is a nationally representative household survey of household finances conducted every 3 years by the Federal Reserve Board. The authors used liquid financial assets (those most easily converted to cash) and net financial assets (broader measure of a household's total resources) as measures of resources that households use to afford health insurance cost sharing. Only non-elderly individuals with incomes above the federal poverty level were included in the analysis.

From these data, the authors found that the median amount of liquid financial assets was $4,560 and the median total of net financial assets was $2,564. Cost sharing annual limits were established, consistent with the ACA for 2015, at $6,600 for an individual and $13,200 for family coverage.[4]

The authors concluded that only 63% of households (non-elderly and above the federal poverty level) have enough liquid financial assets to afford a typical deductible of $1,200 for an individual or $2,400 for a family. Just about half of households are able to afford a deductible of $2,500, which is the average combined medical and drug deductible sold through the federal health insurance exchange, Healthcare.gov.[4]

The authors conclude that as we continue to promote health insurance coverage through the ACA, we must also focus on ensuring individuals and households can afford their cost sharing once they are enrolled in the plan. The high cost-sharing requirements in plans can compromise access and adherence.[4]

You can view the full issue brief here.

"Cost sharing that seriously stresses family budgets may act as an impediment to seeking needed care, frustrating a primary reason people seek to be insured in the first place."[4]

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Newly confirmed surgeon general to focus on chronic disease

In April 2015, Dr. Vivek Murthy was sworn in as the 19th surgeon general of the United States. Dr. Murthy is a physician at Boston's Brigham and Women's Hospital and a professor at Harvard Medical School. He was confirmed in December by a 51-42 Senate vote.

Dr. Murthy, in his new role as the "nation's doctor," has announced that he plans to focus the nation's attention and effort on preventing chronic disease. Specifically, Dr. Murthy hopes to reduce chronic diseases such as obesity, diabetes, and heart disease, and to promote physical activity.[5]

Dr. Murthy's efforts to prevent chronic disease will include working to make communities more safe and walkable, and to make healthy food more accessible.

Quoted in *USA Today*, he said, "The shift we have to make as a country is from one that is predominantly focused on treatment to one that is focused much more on prevention."[5]

You can view the *USA Today* article here.

Annals of Internal Medicine publishes editorial and evidence review supporting draft USPSTF screening guideline

"A national policy to screen all persons at high risk for diabetes (closer to the American Diabetes Association policy) would help identify those with undetected diabetes and prediabetes,"[6] argues an editorial in *Annals of Internal Medicine* accompanying a systematic review of the evidence for diabetes screening conducted for the U.S. Preventive Services Task Force (USPSTF).

In their commentary, "Screening for Hyperglycemia (high blood glucose): The Gateway to Diabetes Prevention and Management for All Americans," K.M. Venkat Narayan, MD, and Mary Beth Weber, PhD, both of the Emory Global Diabetes Research Center and the Rollins School of Public Health at Emory University, contend that, "Without screening, 90% of prediabetes cases will remain undetected, and we will continue to miss the opportunity to aggressively implement strategies to prevent diabetes and remain unable to slow the growing costs of managing diabetes and its complications."[6]

They point out that with better screening for diabetes and identification of people with prediabetes, there is a need to scale up medically proven interventions that can help prevent or delay diabetes. According to the commentary, "The strong evidence backing diabetes prevention unequivocally calls for aggressive implementation, and adequate integration of community and clinic resources and infrastructure for delivery of effective lifestyle interventions are imperatively needed."[6]

You can view the editorial here[6] and the systematic review here.[7]

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New county-level data from the CDC show an increase in diabetes prevalence in nearly all US counties


DENISE TROUTMAN
Denise has type 2 diabetes

The Centers for Disease Control and Prevention (CDC) recently released data on county-level diabetes prevalence. The data indicated that diabetes prevalence increased in 2,992 US counties from 2004 to 2012, while prevalence remained the same in only 5 counties and decreased in 10 counties.[8]

Among all states, Colorado has the most counties with low diabetes prevalence. In fact, many Colorado counties have populations with 4% or less diagnosed with diabetes.[8] This contrasts with South Dakota, Alabama, Mississippi, Montana, West Virginia, North Carolina, and South Carolina, which are the states with the most counties with high diabetes prevalence. South Dakota, North Carolina, and Mississippi all have multiple counties where 14% or more of the population is diagnosed with diabetes.[8]

CDC also provides an interactive map that shows the numbers and rankings for each county.

To view the data and interactive map on the CDC website, visit here.

Digital programs now meet CDC standards for preventing diabetes

The CDC recently recognized digital diabetes prevention programs offered by Omada Health, Noom Health, and DPS Health under the National Diabetes Prevention Program (National DPP).[9] These programs are faithful to the intervention used in the National Institutes of Health's Diabetes Prevention Program clinical trial and meet the CDC's evidence-based criteria.

To learn more about the National DPP Recognition program, click here.

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