Alliance of Community Health Plans

Report on Affordability in Health Care, 2023

November 2023

achp.org

Overview

When health plans are aligned with their provider partners to keep patients healthy and out of the hospital, costs go down, outcomes improve and consumers maintain their coverage.

Alliance of Community Health Plans (ACHP) member companies have long leveraged their close ties to the community, to caregivers and to the chronically ill to tailor care that results in healthier patients, fewer hospital visits and significantly lower health care spending.

This personalized approach is the foundation of efforts to tackle the interconnected challenges of unfilled prescriptions and medications not taken as directed. In the U.S., one out of every five prescriptions goes unfilled. Among those who do fill their prescriptions, only about half take them as directed by their prescriber.[1] The cost is twofold. First, otherwise manageable chronic illnesses become more severe, resulting in sicker patients and more hospitalizations. And secondly, as a result, roughly $300 billion gets added to the nation's overall health care bill each year.[2]

New analysis for ACHP by Wakely Consulting Group, LLC, finds that medication adherence programs focused on diabetes, hypertension and high-cholesterol medications save tens of millions of dollars each year by keeping patients healthier and out of the hospital. People who stay with their health plans for a year or more also tend to be healthier, resulting in lower overall spending by the individual, employer and taxpayer.

ACHP's third annual Report on Affordability in Health Care highlights the benefits to consumers, employers and taxpayers when individuals adhere to prescribed medications and remain with their health plan year after year. These benefits are a testament to the value and impact of coordinated care and coverage that is unique in the ACHP model of payer-provider alignment.

Table of Contents

MEDICATION MANAGEMENT:
ADHERENCE PROGRAMS DRIVE DOWN EMERGENCY ROOM UTILIZATION, RESULT IN FEWER HOSPITALIZATIONS AND INCREASED SAVINGS

Even small improvements to medication adherence can lower health care spending. ACHP member companies save $1,040 a year on health care costs for each diabetic consumer who follows their medication regimen.[6] Likewise, ACHP member companies' consumers who stick with their hypertension and cholesterol medications reduce health care spending about $3,025 and $2,000, respectively a year.[7]

Diabetics who follow their medication protocols correctly are

30%

less likely to end up in the ER and

24%

less likely to be admitted to the hospital.[3]

Hypertensive patients who follow their medication protocols correctly are

42%

less likely to end up in the ER and

54%

less likely to be admitted to the hospital.[4]

Patients with high cholesterol who follow their medication protocols correctly are

35%

less likely to end up in the ER and

38%

less likely to be admitted to the hospital.[5]

ucare℠

12 percent increase in adherence to prescribed medication regimens amongst participants in the coaching program.

UPMC Health Plan

92%

of enrollees currently take their statin medications as prescribed.

Health Alliance™

More than

75%

of members being treated for a combination of all three conditions are following their prescribed regimens.

SecurityHealth Plan℠

75%

of Security Health Plan's diabetic Medicare members take their medications as prescribed.

fallonhealth

Of the

8,900

Medicare enrollees with hypertension,

90%

were taking their medications properly.

Full case studies available in Appendix A

ACHP
ALLIANCE OF COMMUNITY HEALTH PLANS

READMISSION RATES DECREASE WHEN PATIENTS TAKE THEIR MEDICATION

Preventable readmissions have been a longstanding and unnecessary challenge. But successful interventions exist. When consumers closely follow their hypertension and cholesterol medication regimens, **hospital readmissions are reduced by 23 percent and 20 percent, respectively.**[8]

While this report focuses on patients treated for diabetes, hypertension or cholesterol, across-the-board readmission rates are typically lower when people have access to information about their medications and are equipped with tools to help them stick with their regimens.

At Albany, NY-based Capital District Physicians' Health Plan, for example, a nurse or care manager meets members at their bedside as part of the **Hospital to Home** program to discuss discharge plans and follow-up appointments as well as secure transportation, medication delivery and adherence plans. The program has resulted in a **14 percent lower hospital readmission rate** for patients who participate compared to patients who do not.

THE POWER OF STAYING PUT: PLAN LOYALTY IS COST-EFFECTIVE

ACHP member companies are rooted in the communities they serve – many for decades. This commitment is recognized by consumers who stay with their community health plan year after year.

The evidence shows that continuing coverage with the same health plan year over year has measurable advantages. Health plans spend 26 percent less treating Medicare beneficiaries with diabetes, hypertension or high cholesterol if those seniors stay with their plans for more than one year.[9] Chronic disease management takes time, so the longer a patient is with a health plan, the more time the provider partners have to get to know the patient, understand their motivations and hesitations and address care delivery concerns.

CASE STUDY

Priority Health

Priority Health's PriorityMOM Program was initially implemented to solve the challenge of post-delivery readmissions related to hypertension. Participating mothers receive emails at specific times throughout their pregnancy with targeted messages to keep them on track with ideal care. Expectant mothers, for instance, are provided at-home blood pressure cuffs and are trained in how to use them. Since launching, over 640 moms have enrolled, and nearly 90 percent would recommend the program.

Nearly

90%

of the

640

patients enrolled in PriorityMom would recommend the program.

FOR SENIORS:
SEEING STARS—AND IMPROVED HEALTH

Now covering a majority of eligible beneficiaries, Medicare Advantage (MA) is the only government health care program that measures and rewards high-quality, efficient, coordinated coverage and care. Community health plans are uniquely positioned to offer this level of care to consumers. In addition to leading on overall scores in the CMS Star Rating system, ACHP member companies excelled in key metrics in the 2024 MA Stars—both in clinical measures and consumer experience. On average, ACHP member plans outscored non-ACHP plans on 35 out of 42 measures, including preventive health care measures, member experience, drug safety and pricing accuracy.[10] When it comes to consumers taking their prescribed medications to treat diabetes, hypertension or cholesterol, ACHP members significantly outperformed the rest of the industry.[11]

ACHP members **outperform the industry** by

17.5%

on members who take their **diabetes** medications.

ACHP members **outperform the industry** by

28.9%

on members who take their **hypertension** medications.

ACHP members **outperform the industry** by

24.5%

on members who take their **cholesterol** medications.

Conclusion

The connection between successful health care strategies and affordability is clear: patients properly following medication regimens are healthier, leading to fewer dollars spent throughout the health care system. Medication adherence for diabetes and hypertension is especially valuable, reducing risks of expensive complications such as amputations, kidney failure and heart disease. Considering that a quarter of all health expenses in the U.S. go toward treating complications from diabetes, any successful strategy could result in billions of dollars saved.

Provider-aligned health plans manage care and keep people out of the hospital in part by forging close ties to their communities, clinicians and consumers. ACHP member companies, in particular, are industry leaders in member retention, leading to even greater patient health outcomes and reduced costs.

.

While there's no guarantee a patient will always follow medication protocols, individuals covered by ACHP's nonprofit regional plans have higher success rates, creating a virtuous cycle of better health outcomes and lower costs. Investing in medication adherence is delivering value for the premium dollar, and that's good news for everyone.

ACHP Members

Monterey, California

Canton, Ohio

Temple, Texas

Albany, New York

Tulsa, Oklahoma

Madison, Wisconsin

Worcester, Massachusetts

Danville, Pennsylvania

Madison, Wisconsin

Champaign, Illinois

Detroit, Michigan

Springfield, Massachusetts

Minneapolis, Minnesota

Buffalo, New York

Oakland, California

Portland, Maine

New Orleans, Louisiana

Springfield, Oregon

Albuquerque, New Mexico

Grand Rapids, Michigan

Sioux Falls, South Dakota

Marshfield, Wisconsin

Salt Lake City, Utah

Minneapolis, Minnesota

Pittsburgh, Pennsylvania

Appendix A: Case Studies

CASE STUDY

ACHP member UCare has expanded its ***Diabetes Health Coaching Program*** to address barriers to care, such as transportation or appointment availability, faced by some members. In 2022, the Minnesota-based company started offering over-the-phone health coaching and virtual visits with endocrinologists. The program has since expanded to include a phone app complete with educational materials, care management tools and other resources, such as scheduled reminders to take medications on time.

Additionally, health coaches use motivational interviewing and behavior change techniques to help members achieve their health goals. Coaches also look for gaps in care that could result in missed doses of medication and implement any needed changes to ensure compliance. UCare has seen a 12 percent increase in adherence to prescribed medication regimens amongst participants in the coaching program.

***12 percent increase in adherence** to prescribed medication regimens **amongst participants** in the coaching program.*

CASE STUDY

SecurityHealth Plan℠

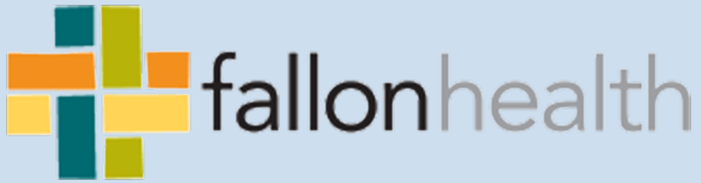
As part of its commitment to ACHP's Chronic Disease Pledge, Wisconsin-based Security Health Plan partners with virtual-care providers to reduce the rate of diabetes among its members. Health plan members receive personalized support to help them live healthier lives. Under the program, members are provided advice, tips and encouragement on how to stay healthy. For eligible members, Security will even cover the costs.

If patients advance into more serious levels of diabetes, Security Health Plan partners with clinical pharmacists to conduct personal outreach phone calls to provide additional support and boost medication adherence. With these strategies and more, *73 percent of Security Health Plan's diabetic Medicare members take their medications as prescribed*.

73%

of Security Health Plan's diabetic Medicare members take their medications as prescribed.

CASE STUDY



ACHP member Fallon Health, based in Worcester, MA, developed the ***Pharmacy Medication Adherence*** program to help members stay current with their prescriptions. Under the program, patients receive personalized attention, including in-home pharmacist visits for members who may benefit more from face-to-face interactions. During these visits, Fallon Health members learn more about the medications that they are prescribed, including potential benefits and adverse effects. Social factors, including housing instability, food insecurity and communication barriers, are also assessed to determine if additional types of interventions are needed.

Fallon Health pharmacists partner with local provider groups to assist in improving medication adherence and aid in improving chronic disease outcomes. Providers are supplied with notifications regarding non-adherent patients, opportunities for conversion to a 90-day supply and low refill notifications to avoid interruptions in therapy.

The pharmacy team alone has reached out to 340 members and 60 percent have engaged with the program. Preliminary data shows that more than half of those who participated have shown improvement in taking their medications properly. In 2021, Fallon Health's hypertension adherence greatly contributed to its high overall Medicare Advantage star ratings. *Of the 8,900 Medicare enrollees with hypertension, 90 percent were taking their medications properly.*

***More than half** of those who participated **have shown improvement** in taking their medications properly*

Of the

8,900

Medicare enrollees with hypertension,

90%

were taking their medications properly.

CASE STUDY

UPMC Health Plan

UPMC Health Plan has implemented a pilot program for its Medicaid population that targets increases in statin prescribing and adherence through the Pennsylvania Pharmacy Care Network, a subset of over 160 independent pharmacies. These pharmacies can more closely target members with diabetes who may benefit from statin therapies and provide necessary education.

UPMC is also measuring increased statin prescriptions among patients who are at risk of heart disease or diabetes. They use predictive analytics to determine the potential for medication noncompliance, and offer digital tools such as integrated voice response, text messaging and blogs to promote better medication management. UPMC's statin adherence rate has steadily increased every year since 2015, with *92 percent of enrollees currently taking their statin medications as prescribed.*

92%

of enrollees currently take their statin medications as prescribed.

CASE STUDY

Champaign, Ill.-based Health Alliance's commitment to quality and community led to the development of the Population Health Program, which integrates pharmacists into three different clinics across central Illinois. The program fosters collaboration among pharmacists who work with providers to improve adherence measures and address gaps in care. In addition, Health Alliance's Electronic Medical Record system now features a "gap in care" notification alert, which sparks conversations with providers about ways to achieve better outcomes. Amongst nearly 10,000 Health Alliance members being treated for diabetes, hypertension, high cholesterol or some combination of all three, more than 75 percent are compliant with following their prescribed treatment regimens.

More than

75%

of the nearly

10,000

members being treated for diabetes, hypertension, high cholesterol or some combination of all three are compliant with following their prescribed treatment regimens.

CASE STUDY

Priority Health

Priority Health's PriorityMOM Program was initially implemented to solve the challenge of post-delivery readmissions related to hypertension. Participating mothers receive emails at specific times throughout their pregnancy with targeted messages to keep them on track with ideal care. Expectant mothers, for instance, are provided at-home blood pressure cuffs and are trained in how to use them. Since launching, over 640 moms have enrolled, and nearly 90 percent would recommend the program.

Nearly

90%

of the

640

patients enrolled in PriorityMom would recommend the program.

Appendix B: Citations

Citations

1 Source: Neiman, A.B., Ruppar, T., Ho, M., et al. (Nov. 17, 2017). “CDC Grand Rounds: Improving Medication Adherence for Chronic Disease Management—Innovations and Opportunities.” MMWR Morb Mortal Wkly Rep. https://www.cdc.gov/mmwr/volumes/66/wr/mm6645a2.htm#:~:text=In%20the%20United%20States%2C%203.8,%2C%20and%20duration%20(4).
2 IBID
3 Source: ACHP commissioned analysis by Wakely Consulting Group, LLC, an HMA Company (Wakely) to analyze the relationships between various quality measures and certain utilization and cost metrics (September 2023).
4 IBID
5 IBID
6 IBID
7 IBID
8 IBID
9 IBID
10 IBID
11 IBID