

Improving Chronic Disease Prevention and Management

EVIDENCE-INFORMED PRACTICES, POLICY, AND PARTNERSHIPS



Executive Summary

More than 3 in 4 American adults live with at least one chronic disease,¹ impacting individual and community health, reducing productivity, straining the health care system and raising health care costs for everyone. Addressing the drivers of preventable chronic disease requires behavior changes, tailored interventions, collaboration, and policy changes. Health plans have a broad view of the challenges and opportunities given their engagement with patients, providers, employers, states, community-based organizations and policymakers. In collaboration with their provider partners, health plans are well positioned to play a key role in reducing the burden of chronic disease and improving health.

At the direction of our Board of Directors, AHIP convened a Task Force of Chief Medical Officers and Public Policy leaders from more than 30 health plans covering approximately 200 million Americans. The Task Force identified a range of voluntary actions health plans could choose to pursue and recommendations for government entities that could help achieve the aspirational goal of reducing the current levels of chronic disease prevalence by at least 10 percent by 2035.

Prevalence and Impact of Chronic Disease

The U.S. Centers for Disease Control and Prevention (CDC) estimate 76% of American adults have at least one chronic disease and over half of American adults have more than one chronic disease.² Recent studies also demonstrate adolescents were 15-20% more likely to have chronic disease in 2023 than in 2011.³

Such high levels of disease—many of which can be preventable—create significant challenges.

- **Diminished quality of life:** Chronic conditions lead to reduced physical functioning and worse mental health (e.g., people with diabetes are 2-3 times more likely to develop depression).⁴
- **Lost productivity:** Poor health costs U.S. employers \$575 billion and 1.5 billion days of lost productivity per year.⁵
- **Health care system strain:** Chronic disease exacerbates health care workforce shortages that are expected to worsen, compromising care for all Americans.⁶

Health Plan Voluntary Actions

- Build on existing efforts to promote healthy behaviors, early intervention and care management
- Increase behavioral health prevention, screening and integration with primary and specialty care
- Improve uptake of prevention and screening for diabetes, cardiovascular disease and cancer

Government Policy Recommendations

- Modernize regulatory policies to encourage healthy behaviors, including by making healthy foods available and affordable
- Use regulations to enable quality and payment models that emphasize chronic disease prevention
- Provide regulatory flexibility that supports efforts to promote chronic disease prevention and management through benefit design
- Ensure regulatory framework supports efforts to leverage technology and data interoperability
- Use regulations to optimize care delivery models and workforce capacity

- **Increased health care spending:** 90%⁷ of the \$5.3 trillion annual health care expenditures⁸ are attributed to managing and treating chronic disease.
- **Reduced life expectancy:** 5 of the top 10 leading causes of death are associated with or caused by potentially preventable and treatable chronic diseases.⁹

Drivers of Preventable Chronic Disease

There are many drivers of preventable chronic disease. Some risk factors and ongoing barriers include:

- **Unhealthy eating:** Consuming unhealthy food contributes to chronic disease. 75% of Americans do not eat enough fruits/vegetables, 63% exceed the limit for added sugars, 77% exceed the limit for saturated fat, and 90% exceed recommended limits for sodium.¹⁰
- **Insufficient physical activity:** Only 1 in 4 U.S. adults gets recommended levels of physical activity.¹¹

- **Substance use (e.g., tobacco, excessive alcohol use, illicit drugs):** Almost 50 million Americans, or 17%, had a substance use disorder in the last year.¹² Almost 30 million Americans, or 12%, smoke cigarettes.¹³
- **Underinvestment in preventive care:** Overall spending in the U.S. on preventive care is much lower (\$589 per capita) than all other spending categories (inpatient & outpatient care \$7,500 per capita; prescription drugs and medical goods \$1,635 per capita; long-term care \$924 per capita).¹⁴
- **Low uptake of recommended preventive screening:** Only 8% of adults receive all their high-priority recommended preventive screenings and services.¹⁵
- **Medication non-adherence:** Approximately half of Americans prescribed medication are not taking the medication as prescribed.¹⁶ Non-adherence can account for up to 50% of treatment failures and up to 25% of hospitalizations.¹⁷
- **Not enough focus on improving health over the lifespan, especially among children:** An estimated 25 million children and young adults aged 5 to 25 live with a chronic condition or functional limitation (30% increase over 25 years).¹⁸
- **Health care workforce shortages:** Health care workforce shortages are most severe in rural and underserved areas and are expected to worsen over time, challenging access to care.¹⁹
- **Limited health literacy:** The most recent comprehensive survey of health literacy indicated 9 out of 10 Americans are limited in their ability to “obtain, process and understand basic health information and services needed to make appropriate health decisions.”²⁰

Goal: Reduce Chronic Disease Prevalence 10% by 2035

In recognition of the burdens of chronic disease and the importance of strong emphasis on prevention and care management, AHIP and our health plan members will work toward the aspirational goal of reducing the current chronic disease prevalence rate by at least 10 percent by 2035. Health plans cannot achieve this goal alone. Progress in this direction will require a broad, coordinated, collaborative approach across many stakeholders.

Moving Prevention Upstream

Reversing the chronic disease trends in the U.S. will require meaningful changes that address the key drivers noted above—promoting healthy eating and physical activity, increasing uptake of recommended preventive screening and improving medication adherence, greater emphasis on the health of children, reducing substance use including smoking, augmenting the workforce, and improving health care literacy.

Early intervention and the power of information: Earlier interventions can prevent the progression of disease and reduce complications, potentially at lower costs than interventions for patients already suffering from chronic diseases. Information and education can be a particularly impactful early intervention that can empower patients to optimize their health. Providing information at the right time arms healthy people with resources to help keep them healthy and helps those at-risk or already with chronic conditions understand how to manage their risk factors and conditions effectively and prevent future progression of the condition.

Moving Prevention Upstream

HEALTH PLANS

- Screening/health risk assessments
- Benefit design to promote prevention, lifestyle changes
- Connecting members to providers and community resources

COMMUNITY BASED ORGANIZATIONS

- Support social needs (e.g., transportation, food)
- Collaborate with providers, payers, government

MATERNAL-CHILD HEALTH (PROVIDERS, PLANS, OTHERS CAN SUPPORT)

- Perinatal support
- Instill healthy behaviors early (nutrition, physical activity)
- Mental health

PROVIDERS

- Preventive screening
- Patient referrals to address behavioral health, obesity

GOVERNMENT

- Promote healthy eating
- Encourage physical activity

SCHOOLS

- Healthy food
- Physical activity
- Health screenings
- School nurses

EMPLOYERS

- Wellness programs



GOALS

- Improve health
- Emphasize prevention
- Lower chronic disease rates
- Address behavioral health

Encouraging healthy behaviors early in life: It is important for families to embrace and instill healthy behaviors in children as early as possible. Starting with maternal-child health sets the foundation to promote strong health and healthy behaviors for children and families. Families who consistently eat healthy, nutritious foods such as protein, fruits and vegetables, whole grains, less processed foods and added sugar, and enjoy physical activity, build lifelong habits that promote health and reduce chronic disease for years to come. Similarly, schools can help foster healthy eating and physical activity and can facilitate access to health screenings and other services through school nurses and virtual care.

Emphasizing screening and providing practical tools and resources: Many health care providers and health plans can screen people for chronic disease risks and help people engage in their health by giving them practical tools and resources. For example, health plans can increase screening of their members

during enrollment and connect members to resources including health coaching, digital tools, and referrals to providers and community resources that address social needs that can exacerbate risk factors. Providers can similarly screen patients and offer referrals to clinicians who address other clinical needs such as obesity or behavioral health. Employers can also positively influence employee health through incentives for healthy behaviors and other types of wellness programs, which can increase productivity and lower health care costs. Governments operating public health insurance programs can simplify enrollment for beneficiaries eligible for available programs addressing social needs that can contribute to chronic disease. Community-based organizations can serve as a critical resource to help people access food, housing, employment support and other resources that help promote health and avoid or slow the progression of chronic disease.

Voluntary Health Plan Actions to Improve Health

Health insurance coverage enables patients to access preventive care, care management, and the right care at the right time and place. Studies consistently show that individuals with health insurance use recommended preventive services at much higher rates than those without coverage.²¹

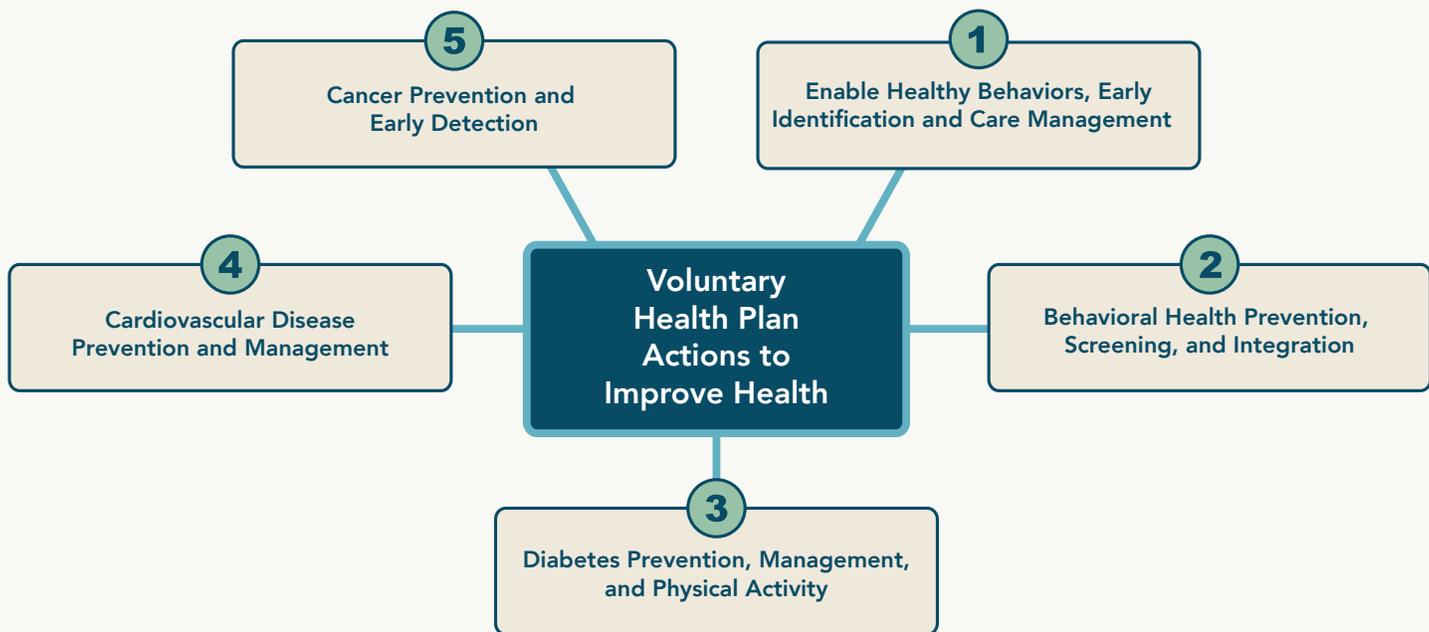
Health plans connect 2 in 3 of Americans with their health care.²² This gives health plans, working closely with providers, a unique and comprehensive view to improve individual and population health. Health plans directly engage with patients, providers, employers, states and community-based organizations that together can reduce the prevalence of chronic conditions.

To make progress towards the aspirational goal of reducing chronic disease prevalence from current levels by 10 percent by 2035, health plans will build on their longstanding efforts in prevention and care management, including through the voluntary use of any of the approaches described below. Plans may decide to use approaches from several focus areas depending on their individual priorities and the needs of the populations they serve. Many of these actions are tied to the Healthcare Effectiveness Data and Information Set (HEDIS) measures related to specific or multiple chronic diseases, and a holistic approach to care.

Enable Healthy Behaviors, Early Identification and Care Management

Health plans work directly with their members to improve health using tools such as health assessments, health coaching, and care management. To help combat chronic disease, health plans may voluntarily use approaches from any of the following areas.

- **Increasing uptake of health plan programs that support healthy lifestyle choices:** By increasing member uptake of health plan programs intended to encourage physical activity, healthy eating and other lifestyle choices, plans can help their members prevent the onset of chronic conditions and stop or slow progression of existing chronic conditions. These programs may include gym memberships, health coaching, fitness tracking, and other digital tools that help prevent obesity and related chronic conditions.
- **Increasing screening for chronic conditions and social needs:** When plans increase touchpoints with members and employer groups to screen for chronic conditions, health risk factors, and social risk factors, they can help enable early interventions that are proven to prevent chronic disease and reduce its progression. Touchpoints include at the time of enrollment and can help address gaps in patient care that can help prevent chronic conditions.



- **Increasing enrollment in case management to address gaps and support complex patients:** Increasing member enrollment in health plans' case management programs that help address whole-person health can be particularly helpful for members with multiple chronic conditions. Case management programs can include personalized care plans for members with complex health issues, care coordination across multiple providers, and care transition services for members following a hospital visit.
- **Improving health literacy:** Expanding and increasing member use of health plan digital tools, for instance, can help members better understand their health insurance and health care options. These tools include phone apps and web-based tools designed to help members navigate the health care system and get connected with the right providers, helping to prevent and address chronic conditions.

child-maternal health that can help prevent the onset of chronic disease.

- **Depression screening:** Increasing the percentage of members who are screened for clinical depression using a standardized instrument (measured as part of the HEDIS data set) can help mitigate depression, which is a contributing factor to developing and exacerbating chronic disease.
- **Behavioral health integration with primary and specialty care:** Expanding the number of health care practices offering integrated behavioral health can help address behavioral health issues in a more seamless and effective way, reducing a key chronic disease risk factor. Supporting opportunities to integrate behavioral health (BH) into specialty practices in addition to primary care practices will help address the co-morbidity associated with behavioral health and many chronic physical conditions.

Behavioral Health Prevention, Screening, and Integration

In partnership with providers, health plans may voluntarily use any of the following specific approaches to improving behavioral health.

- **Postpartum depression screening and follow-up:** Increasing the percentage of deliveries where women are screened for postpartum depression and receive follow-up care within 30 days (measured as part of the HEDIS data set) can help make sure there is a strong foundation for

Diabetes Prevention, Management, and Physical Activity

In partnership with providers, health plans may voluntarily use any of the following specific approaches to improving diabetes prevention and physical activity promotion.

- **Prediabetes awareness:** Reducing the proportion of adults who do not know they have pre-diabetes (tracked as part of the National Health and Nutrition Exam Survey) can help stop the onset of diabetes and enable interventions.

- **Adolescent weight control counseling:** Increasing the percentage of members aged 3-17 years who had an outpatient visit with a primary care physician or OB/GYN and who had BMI assessment, nutrition counseling and/or physical activity counseling (measured as part of the HEDIS data set) can help encourage healthy behaviors proven to stop the onset of diabetes and other chronic conditions, both during adolescence and later in life.
- **Older adult physical activity:** Increasing the percentage of Medicare members who had a visit with a physician in the past 12 months and discussed physical activity and/or received advice to start, increase, or maintain physical activity (measured as part of the HEDIS data set) can help encourage physical activity, a proven way to help avoid the onset of diabetes as well as other chronic conditions.
- **Blood pressure control for people with diabetes:** Increasing the percentage of members aged 18-75 years with diabetes whose blood pressure is adequately controlled (measured as part of the HEDIS data set) is an effective way to mitigate the number of people with diabetes experiencing disease progression and additional negative health outcomes.

Cardiovascular Disease Prevention and Management

In partnership with providers, health plans may voluntarily use any of the following approaches to improve cardiovascular disease prevention.

- **Blood pressure control:** Increasing the proportion of members with diagnosed hypertension whose blood pressure was adequately controlled (measured as part of the HEDIS data set) helps reduce or reverse disease progression and improves health for those members.
- **Tobacco cessation:** Increasing the proportion of members screened for tobacco use and the proportion of members who use tobacco who received cessation counseling (measured as part of the HEDIS data set) can help reduce a major risk factor that contributes to—or worsens—cardiovascular disease.
- **Statin therapy:** Increasing the proportion of members with cardiovascular disease who receive statin therapy and exceed 80% medication adherence (measured as part of the HEDIS data set) helps reduce or reverse disease progression and improve health for those members.

Cancer Prevention and Early Detection

In partnership with providers, health plans may voluntarily use any of the following approaches to improving cancer prevention and early detection.

- **Colorectal cancer screening:** Increasing the percentage of members aged 45-75 years who had appropriate screening for colorectal cancer (measured as part of the HEDIS data set) enables earlier detection of cancer, which allows for more effective treatment and increased survival rates.
- **Breast cancer screening:** Increasing the percentage of members aged 40-74 years who were recommended for routine breast cancer screening and had a mammogram (measured as part of the HEDIS data set) enables earlier detection of cancer, which allows for more effective treatment and increased survival rates.
- **Cervical cancer screening:** Increasing percentage of members 21+ who were recommended for cervical cancer screening and were screened using one of three recommended approaches based upon age segment (measured as part of the HEDIS data set) enables earlier detection of cancer, which allows for more effective treatment and increased survival rates.

Public Policy Recommendations to Improve Health

While voluntary actions by health plans can help prevent and manage chronic disease, changes to government regulations are also needed. Health plans support targeted public policy changes to help meet the goal to reduce chronic disease prevalence from current levels by at least 10 percent by 2035.

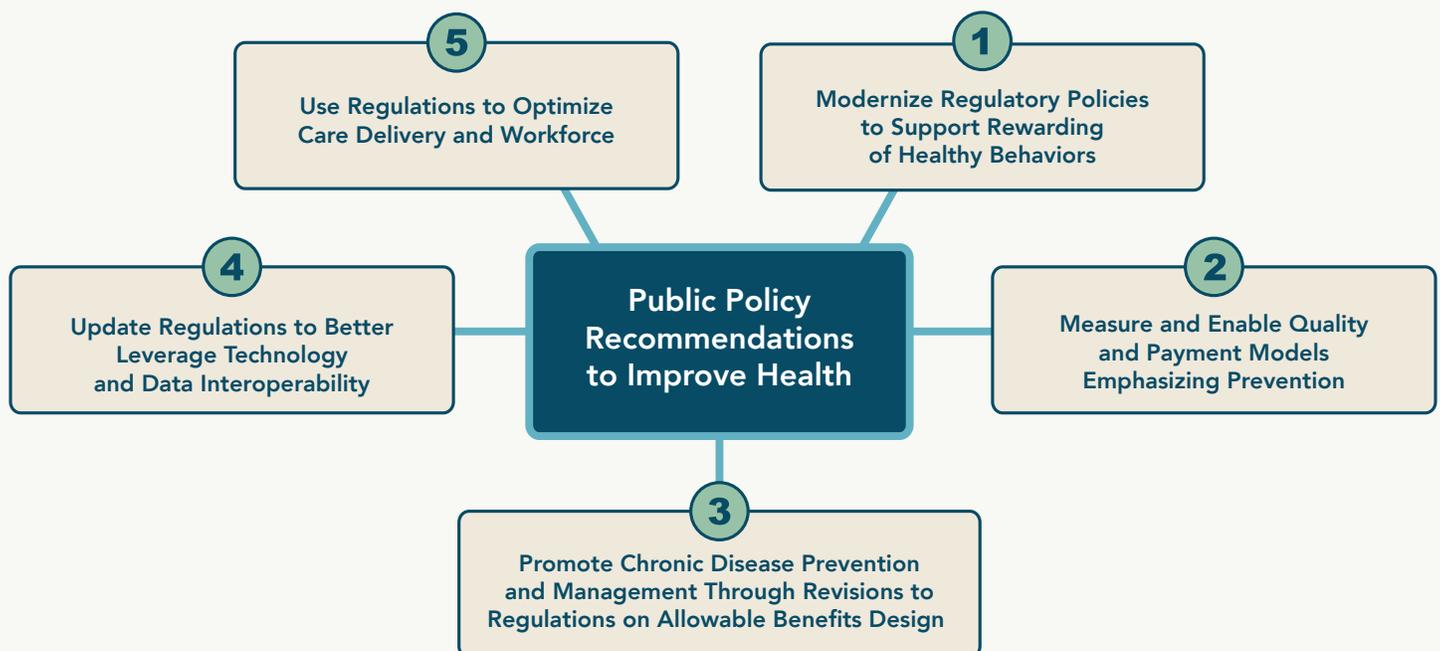
Modernize Regulatory Policies to Support Rewarding of Healthy Behaviors

Providing consumers with a premium discount for participating in a wellness program or specified health activities can be an effective tool for preventing chronic disease. Under current law and regulation, employers partner with their health plan administrators to offer premium discounts up to 30%. But federal regulatory changes are needed to fully realize the potential of such programs.

- **Modernize and improve regulations governing employer wellness programs:** Under existing regulations, employer wellness programs can be challenging to operate due to outdated requirements and inconsistencies between regulations from the Equal Employment Opportunity Commission (EEOC) and the Departments of Health and Human Services (HHS), Labor, and Treasury (Tri-Agencies). The EEOC proposed regulatory changes in 2021 intended to provide updates and clarifications (e.g., modifications to incentive limits, clarifications on family participation)

but the changes were not finalized. We recommend that the Administration, working collaboratively with employers, make regulations consistent across agencies, with additional flexibility and sufficient clarity to minimize the disincentives that come from the threat of costly litigation. The Administration should also exempt rewards from personal income tax to avoid diluting the rewards. These changes would increase the availability of wellness programs and their impact on preventing chronic disease.

- **Ease states' ability to incorporate wellness programs in the individual market:** Under existing law, HHS is permitted to allow up to 10 states to propose waivers that would extend wellness program premium discounts in the individual market. While HHS issued guidance in late 2019 allowing states to submit such waiver requests, no states submitted requests, due to overly stringent requirements in the guidance. We recommend CMS update the guidance with streamlined requirements to increase states' ability to expand wellness programs, increasing the number of people who have financial incentives for healthy behaviors.



Measure and Enable Quality and Payment Models Emphasizing Prevention

Encouraging quantitative measures related to chronic disease prevention can be an effective way to expand efforts to improve health and prevent chronic disease. We support the following public policy changes to help achieve that goal.

- **Ensure Medical Loss Ratio (MLR) definitions incentivize prevention strategies:** Under existing regulation that limits health plan administrative costs, health plans can include some administrative costs relating to improving quality as a benefit expense, but some efforts that would help prevent chronic disease continue to be discouraged by the regulation. We recommend HHS expand the definition of allowable costs in the numerator of the MLR calculation to incentivize proven strategies to prevent and reduce chronic disease (e.g., community partnerships, food programs, and workforce programs that help enable better health).
- **Support quality measures focused on prevention:** Health plans support an increased government focus on the use of chronic disease prevention-focused quality measures, including government support for measures in the Core Quality Measures Collaborative core measure sets. The adoption of prevention-focused measures will further increase the health system's focus on preventing chronic disease.
- **Support federal value-based contracting (VBC) programs' inclusion of chronic disease prevention measures:** The Centers for Medicare and Medicaid Innovation (CMMI) can continue to help encourage the use of chronic disease prevention measures and models that provide financial rewards for reducing chronic disease burden. We support continued CMMI implementation of voluntary multi-payer value-based programs that incorporate chronic disease prevention-focused quality measures and models that will help reduce chronic disease.

Promote Chronic Disease Prevention and Management Through Revisions to Regulations on Allowable Benefits Design

What benefits are allowed to be covered under a health plan can help enable prevention and address chronic disease risk factors. Health plans support the following legislative and regulatory changes to help achieve that goal.

- **Increase flexibility for Health Savings Accounts (HSAs) and qualifying high-deductible health plans to align with proven chronic disease treatment and prevention strategies:** Under existing law and regulation, qualifying

high-deductible health plans that are paired with HSAs cannot cover many proven services that help treat chronic disease without the member first reaching their deductible (first-dollar coverage is limited to services considered to be preventive). Health plans support federal adjustment to the HSA law to enable first-dollar coverage for chronic disease treatments under high-deductible health plans. This change would help encourage strategies to lower the out-of-pocket cost for chronic disease treatments for members in health plans that are paired with an HSA. Health plans also support expanding allowable preventive expenses under HSAs to include items proven to prevent chronic disease, such as gym memberships, without a letter of medical necessity from a physician.

- **Expand flexibility for Medicare supplemental benefits:** Under current MA and Part D regulations, health plans are prohibited from covering and/or offering lower cost sharing for some supplemental benefits that are proven to prevent chronic disease and related risk factors. Health plans recommend CMS add flexibility for Medicare supplemental benefit offerings through regulations to permit plans to offer targeted benefits and lower cost-sharing based on chronic conditions or other risk factors (e.g., low-income, duals status, disability), including incorporating benefits for plan years 2027 and beyond that have been available through the Value-Based Insurance Design (VBID) model that ended in 2025, such as Part D flexibility. These changes would help encourage the use of services proven to prevent chronic disease.
- **Increase cap for Medicaid In Lieu of Services (ILOS) to promote prevention strategies:** Under existing Medicaid regulation, health plans are prohibited from dedicating more than 5% of state coverage payments (capitation rates) to "in-lieu-of-services" that are proven to prevent chronic disease. Health plans recommend CMS increase the cap to enable additional benefits that reduce chronic disease in the Medicaid population, such as nutritious meals, housing transition services, and asthma remediation in the home.
- **Disseminate best practices for Medicaid food benefits:** Given the foundational role nutritious food has in preventing chronic disease, health plans encourage CMS to work with states to disseminate best practices for food interventions. This would help ensure states have information on what food interventions are most successful in reducing the prevalence of chronic disease.
- **Create a nutrition program safe harbor:** Under existing anti-kickback laws and regulations, health care providers may face a legal risk for offering a nutrition program to patients. Health plans support CMS establishing clear safe

harbors from patient inducement laws to ensure that it is permissible for providers to offer nutrition programs. This would help providers offer healthy food interventions to their patients to reduce chronic disease.

Update Regulations to Better Leverage Technology and Data Interoperability

With advances in data systems, telehealth and federal data interoperability regulations, there are significant opportunities to increase coordination of efforts to prevent chronic disease, close gaps in care, and enable information sharing between health plans, providers, employers, community-based organizations and schools. Health plans support the following federal actions to help prevent chronic disease and close care gaps.

- **Expand data interoperability and infrastructure:** Health plans support federal action to establish a national network that enables data interoperability, digital measurement and connections to public health data such as immunization registries. These changes would improve the electronic exchange of patient records to inform providers as they care for patients to prevent and/or manage their chronic disease.
- **Use regulations to support increased information exchange between health systems and payers:** Health plans encourage federal regulation to increase the capacity for data to be exchanged between health systems and payers, which will improve care coordination, reduce friction between entities, and will enable improvements to patient care and outcomes, including provider information exchange.
- **Make permanent remaining temporary telehealth flexibility:** Under existing law, certain telehealth flexibilities established during the COVID-19 Public Health Emergency in Medicare remain temporary. Health plans support Congress making remaining temporary flexibilities permanent. This change would help increase access to care in ways that can prevent chronic disease and close gaps in care.

Use Regulations to Optimize Care Delivery and Workforce

A sufficient and coordinated health care workforce with providers working at the top of the scope of their license is critical to maximize efforts to reduce chronic disease. Health plans support the following regulatory changes to help optimize the health care workforce.

- **Support Community Health Workers (CHWs):** Given the critical role CHWs can play to reduce chronic disease, health plans support the promotion by government regulation of standardized training programs and common credentialing/certification and core competency standards for CHWs. These standards would help expand the workforce and encourage use of CHWs, who can act as a trusted support for preventing and reducing chronic disease.
- **Encourage multi-state licensing:** Under existing state laws and regulations, some barriers exist to health care professionals serving geographies where care gaps exist. Health plans support state efforts to expand participation in multi-state licensure compacts for various types of health care professionals to increase availability of telehealth and help mitigate geographic workforce shortages. This change would help increase access to care in ways that can prevent chronic disease and improve care for those with chronic disease.
- **Support Behavioral Health (BH) integration:** BH integration is an evidence-based practice that has been proven to increase access and improve patient outcomes. Health plans support (1) adoption of BH collaborative care codes in state Medicaid programs where not currently covered; (2) additional federal funding for start-up costs and technical assistance for primary and specialty care practices to integrate BH care into their practices for management of co-morbid BH and chronic physical conditions; and (3) additional federal efforts to promote BH integration, such as through reduced administrative burden (e.g., reduced CoCM/BHI documentation requirements for optional add-on codes to Advanced Primary Care Management services) as included in the 2026 Physician Fee Schedule Final Rule and support through federal regulation for more comprehensive value-based models that integrate BH. These changes would help address BH needs that often co-exist with and contribute to the prevalence of chronic conditions.

Conclusion and Next Steps

Health plans are committed to improving chronic disease prevention and management as described in this report. The recommended public policy changes are critical to making meaningful progress toward the goal of reducing chronic disease prevalence in the coming years.

Additionally, partnerships and collaborations across different parts of the health care system are essential to help break through systemic barriers, improve patient outcomes, and address gaps in care. For example, data sharing and the use of interoperable digital tools that link care teams and support the

care coordination necessary to prevent and manage chronic disease. Similarly, addressing social needs often requires strong coordination at the local level between health plans, government entities, and community organizations.

AHIP and its health plan members will continue to collaborate with providers, patient and consumer groups, employers, states, policymakers and others to make progress towards the goal of reducing chronic disease prevalence by 10 percent by 2035.

Improving Chronic Disease Prevention and Management

More than 3 in 4 American adults live with at least one chronic disease, affecting individual and community health, reducing productivity, straining the health care system, and driving up costs. Addressing the drivers of preventable chronic disease requires behavior changes, tailored interventions, collaboration, and supportive policy reforms.

The following health plan examples highlight current work underway to promote healthy behaviors, enable early interventions, strengthen care management, and improve the lives of those affected. These case studies feature innovative health plan approaches to health care delivery, financing, and community engagement, demonstrating the leadership of health plans in advancing high-quality, affordable, accessible care for all Americans.

AMERIHEALTH CARITAS: Food as Medicine Programs to Improve Chronic Care and Reduce Readmissions

AmeriHealth Caritas District of Columbia has contracted with Mom's Meals to provide medically tailored meals (MTM) and personalized nutrition support for members and their families. These programs are designed to meet the needs of people managing chronic conditions, maternal health challenges, and recovery after hospital discharge. By making healthy food part of care, the plan is helping members improve their health while easing the burden on the health system.

The results of the collaboration have been substantial. The total cost of care for AmeriHealth Caritas District of Columbia attributed to enrollees participating in the post-discharge program between January 2017 and August 2022 declined by approximately \$10 million, and a 20% reduction in readmissions, based upon a pre- versus post-intervention claims analysis.

Similarly, between January 2017 and August 2022, the total cost of care for AmeriHealth Caritas District of Columbia enrollees participating in the hypertension and congestive heart failure program decreased by approximately \$4 million. During the same period, participant readmissions dropped by about 65%, based upon a pre- versus post-intervention claims analysis. The maternal health program helped ensure healthier pregnancies and postpartum recovery, demonstrating a pre- versus post-intervention cost reduction of approximately \$186,000 for participants in this program between January 2017 and August 2022.

The diabetes MTM program revealed especially impactful results, based upon a comparison of the participant group to a matched control group with like demographic and health condition characteristics. Participants in the diabetes MTM program experienced a 19% reduction in total annual costs versus a 99% increase for the control group.

Program participants also saw major comparative reductions in EMS (ambulance) utilization (62%) versus increases in the control group (20%) and reductions in preventable hospital admissions (63%) versus increases for the control group (42%). By extending meal benefits to family members, AmeriHealth Caritas District of Columbia takes a whole-family approach that not only improves health outcomes but also strengthens support at home, demonstrating how food can be a powerful tool for better health and lower costs. While none of the above results can be considered causal in nature, they demonstrate that there is statistically significant correlation between the use of medically tailored meals and the positive outcomes experienced by the program participants.

AETNA/CVS: Compassionate Care Management at End-of-Life

Aetna/CVS's Compassionate CareSM program fills a critical gap in a patient's health care experience by offering members and their families the resources and support to plan for end-of-life care on their own terms. The program relies on a proprietary algorithm and predictive model to identify members across all lines of business who could benefit from the program.

Aetna/CVS's nurse case managers reach out to members, their families, and their caregivers to provide support and assistance on a wide range of issues including facilitating advanced directives, addressing pain and other symptom control, and discussing options for palliative and end-of-life care.

The program provides customized care management outreach support to meet members where they are based on their needs. This customization allows for flexibility to evaluate the patient's needs and preferences as they evolve and modify the plan of care to ensure the right care at the right place at the right time – all while honoring the patient's dignity and quality of life.

CAMBIA: Closing Care Gaps and Promoting Early Identification for Populations At-Risk for Developing Chronic Conditions

Cambia identifies at-risk members across a range of chronic conditions including diabetes, hypertension, behavioral health, oncology, cardiometabolic, musculoskeletal, and kidney disease. They use specific diagnostic codes and claims experience to identify at-risk members that could benefit from targeted outreach.

Once at-risk members have been identified, Cambia addresses gaps in care by promoting services such as preventive screenings for cancer, diabetes, and behavioral health, as well as addressing any needed immunizations and assessments for healthy behaviors, like exercise, and social determinants of health. This approach supports early diagnosis of members with emergent chronic conditions, helps overcome medical, psychological, and social barriers to care, and directly contributes to the improved health of Cambia members with these chronic conditions.

In addition, Cambia provides targeted member education and support to ensure that members receive applicable preventive screenings, with the expectation that enhanced screening will result in early and more treatable stages of diagnosis.

CIGNA: Deploying Digital Tools, Remote Monitoring to Proactively Address Maternal Health Risks

Cigna partners with digital health platforms to deliver virtual maternity care for members, with a focus on chronic disease prevention during pregnancy. The program serves pregnant individuals, particularly those with risk factors for gestational diabetes, preeclampsia, or other complications, who benefit from home monitoring and remote engagement.

Members receive connected devices to track blood pressure and blood glucose, educational materials tailored to pregnancy stage, and secure communication channels with their care team. Remote monitoring tools allow for early detection of potentially concerning trends and rapid escalation to clinical care, reducing reliance on in-person visits without compromising safety.

Initial program results indicated strong patient engagement with monitoring tools and a reduction in care gaps. Cigna's partnership with Babyscripts, for example, found that participating members had a 40 percent reduction in in-person visits without adverse outcomes, showing the model's potential to enhance access, maintain quality, and prevent pregnancy-related complications (Babyscripts Outcomes Report, 2022).

ELEVANCE HEALTH: Medicare Advantage Supplemental Food Benefits – Chronic Disease

Management Impact

Elevance Health conducted an analysis of food and transportation supports its affiliated plans under the Medicare Advantage (MA) Value-Based Insurance Design (VBID) model. The analysis focused on MA members with chronic conditions, including diabetes and cardiovascular disease, who may also face socioeconomic barriers to improving health. By providing benefits such as monthly food packages or grocery cards, the benefits aim to address health-related social needs that impact chronic disease management and access to preventive care.

The study found that members who used food benefits showed significantly higher Healthcare Effectiveness Data and Information Set (HEDIS) quality scores for diabetes and cardiovascular disease management compared to non-users. For example, food benefit users, relative to non-users, had 35% greater odds of blood pressure control among those with cardiovascular disease, and 45% greater odds of HbA1c control for those with diabetes. Use of these benefits was also linked to better statin adherence.

Transportation benefit use was also associated with quality improvements, though the effects were smaller than for food benefits. The findings underscore that addressing nutrition insecurity, along with other social needs, through supplemental benefits can lead to measurable improvements in chronic disease outcomes. As the VBID model is set to conclude at the end of 2025, Elevance Health's analysis suggests that preserving flexibility for non-medical benefits is critical to supporting members with complex health and social needs (Elevance Health Public Policy Institute, 2025).

FLORIDA BLUE: Breaking Down Barriers to Care for At-Risk Populations with Chronic Conditions

Florida Blue promotes access to preventive care and care for chronic conditions that includes a special emphasis on at-risk populations. For example, patient groups that Florida Blue is focusing its efforts on include subsets of Medicare members and Commercial members with diabetes, including those with severe mental illness, who receive a low-income subsidy, or who are disabled. Another focus of Florida Blue's efforts includes maternal health and those at risk of hypertensive disorders of pregnancy or gestational diabetes.

Identification of at-risk members for diabetes relies on a combination of data driven insights leveraging a repeatable reporting framework and support from providers in value-based arrangements as well as identification through care management based on acuity, co-morbidities, severe mental illness, zip code, and other social vulnerability risk factors. Maternal populations at risk are identified through diagnosis of

obesity, diabetes, chronic kidney disease, hypertension, HIV, or substance use disorder, as well as zip code, and other maternal vulnerability risk factors.

These programs are critical to closing care gaps where disparities have been identified to improve health outcomes, prevent progression of chronic conditions, and mitigate the overall burden of chronic disease. Florida Blue is continuing to evaluate the impact of these programs and has already found that members engaged with maternal health support have experienced better outcomes for postpartum visits and are receiving critical access to care services including establishing primary care. Next steps include assessing severe maternal morbidity rates and infant outcomes via the pregnancy and infant outcomes dashboard data.

HCSC: A Precision Approach to Chronic Care Management

HCSC uses a comprehensive approach that includes risk stratification, segmentation, and predictive modeling to identify members with chronic or complex conditions for clinician outreach and management. Individuals with chronic conditions often have multiple co-morbidities, and HCSC offers support to individuals across the chronically ill spectrum, not just to the most chronically ill members. Lower risk members have access to self-directed journeys focusing on the next best action, integrating with the plan's services offered through business partnerships. And at any point, if a member responds to a questionnaire that indicates rising risk, the member will be routed to a care manager for a clinician-led journey.

Members at risk for acute, chronic, and complex conditions are prioritized for clinical outreach and access to social services, pharmacy, and specialty nurses and advocates – such as diabetes educators and oncology certified clinicians – to help manage their chronic conditions. The navigation offered by the specialty nurses and advocates helps guide members and provides education, resources, and support.

To supplement these services, HCSC has implemented an authorization extension program for certain services to provide continuity of care to members with chronic conditions to ensure access to medically necessary care without care interruption. In addition, the plan is implementing at-home programs for members with chronic conditions through specific targeted pilot programs.

INDEPENDENT HEALTH: Improving Outcomes for Members with Chronic Kidney Disease

In addition to providing case management services and end of life care across a range of conditions that includes congestive heart failure, COPD, and diabetes, Independent Health created

a new PRECISION model that analyzes member data and predicts rising risk for members with chronic kidney disease. Partnership with a large, local kidney center in this care delivery model helps inform and educate primary care providers and nephrologists caring for members with chronic kidney disease.

The model focuses on identifying the stage of a members' chronic kidney disease, those members at risk of advancing to the next stage, whether there has been stage-appropriate engagement with a nephrologist, and members who are at the highest risk of experiencing an imminent hospital dialysis emergency.

Independent Health evaluates the success of the model through feedback from case management staff, increased member and provider engagement, decreased in-hospital dialysis emergencies, and increased member connections with nephrologists at the appropriate stage of their condition, among other factors. Closing gaps in kidney care through partnerships and shared decision making will result in better outcomes for members with chronic kidney disease.

KAISER PERMANENTE: RN-Led Cervical Cancer Screening Program Closes Gaps, Improves Access

In response to pent up demand for care delayed during the COVID-19 pandemic, Kaiser Permanente created a Registered Nurse (RN) Cervical Cancer Screening program to improve cervical cancer screening rates, create more access to appointments, address health disparities, and enable nurses to work at the top of their scope of practice.

The program was implemented in multiple ob-gyn locations in the Pacific Northwest following a multidisciplinary and hands-on approach that included a range of key stakeholders in developing the program's goals, targets, and training plan. For example, training involved support from physicians, midwives, nurse practitioners, and physician assistants working side by side with the nurses to train and validate their cervical cancer screening skills to achieve the same high quality as clinician-performed screening.

Kaiser Permanente's evaluation of the program found that the increase in the cervical cancer screening rate exceeded the program's goals and improved performance for cervical cancer screening, resulting in the Kaiser Permanente Northwest region achieving the HEDIS National 90th percentile benchmark. In addition, the program addressed at-risk members by improving screening rates within populations with historically low rates and has increased access to ob-gyn clinicians by reducing the wait time for appointments.

KAISER PERMANENTE: Cardiometabolic Management Through Pharmacy-Based Protocols

In Kaiser Permanente's cardiometabolic management program, primary care providers identify members of target populations, including members with hypertension, diabetes, hyperlipidemia, and obesity. Pharmacists who specialize in direct patient care and are cross-trained to manage this cluster of conditions are leveraged as key members of care delivery teams and help expand the focus beyond specific conditions to broader management of complex and multi-condition care.

In addition to this expanded focus, involvement of pharmacists in this team-based approach equips them to manage non-symptom-based chronic care and, as an added benefit, frees up primary care access for symptom-based care.

Kaiser Permanente's evaluation of the program has shown a positive impact, particularly on hypertension control with averages well above the national average. Additionally, the program has been effective at narrowing disparities between populations and creating efficiencies that come with managing a cluster of related conditions rather than each condition individually.

UPMC HEALTH PLAN: Personalized Health Coaching to Improve Chronic Disease Management

UPMC Health Plan offers health coaching delivered by phone or video and incorporate text messages and chat channels to make it easy and convenient for members with chronic conditions to connect with support. Members can self-schedule or be referred through providers or care managers to participate. Beginning with a Personal Health Review to match the member with the right program, members will enroll and meet with their coach on a regular, but flexible, cadence. The coaching programs cover lifestyle health (which includes nutrition, activity, stress, sleep, tobacco cessation, diabetes prevention), emotional health coaching for anxiety and depression, and wellness coaching, which focuses on lifestyle and behavioral changes to improve chronic conditions. UPMC also offers coaching for family wellness, a program tailored to families to promote healthier habits among children and caregivers to reduce the risk of future chronic conditions.

Evaluations of the program show measurable improvements in overall health. Among participants in the coaching programs, 72% reported increased physical activity, 64% reported improved nutrition, and 58% achieved weight loss goals. Members in emotional health programs showed an average 3-to-5-point improvement on standardized screening tools such as PHQ-9 and GAD-7. For those managing chronic conditions like diabetes and hypertension, participants demonstrated improved adherence to care plans and reductions in avoidable emergency department utilization. Member feedback reflects consistently high satisfaction, with over 90% reporting that coaching helped them achieve meaningful health goals.

Endnotes

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