

United Against Diabetes and Cardiovascular Disease

**UAD/CVD**

**and**

**Prevention, Wellness and Health Promotion  
In the Health Care Act**

Supported by Pfizer, Inc

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# *United Against Diabetes and Cardiovascular Disease (UAD/CVD)*

*An initiative Of  
National Coordinating Committee For  
Multiemployer Plans*

*and  
CPWR: Center for Construction Research and Training  
Duke University  
University of Maryland*

Co-chairs:

Edward C. Sullivan

Robert A. Pearlman

# UAD/CVD Mission

Only organization dedicated to:

- Reducing prevalence of chronic diseases *in working families*
- Developing and testing strategies for prevention, early detection and aggressive management of diabetes/CVD *in multiemployer health plans*
- Helping multiemployer plans adopt *evidence-based* programs

# UAD/CVD Organization

**UAD/CVD**  
Steering  
Committee

Funds Advisory  
Committee

Science Advisory  
Committee

# Steering Committee

- Randy DeFrehn, NCCMP, Chair
- Pete Stafford, CPWR
- Robert A. Pearlman, DRIF
- Dr. John Dement, Duke University
- Dr. Laura Welch, Medical Director
- Richard Hopp, Legal Counsel
- Dr. Knut Ringen, Consultant
- James Buckley, Consultant

# Funds Advisory Committee

Tells us what can be done

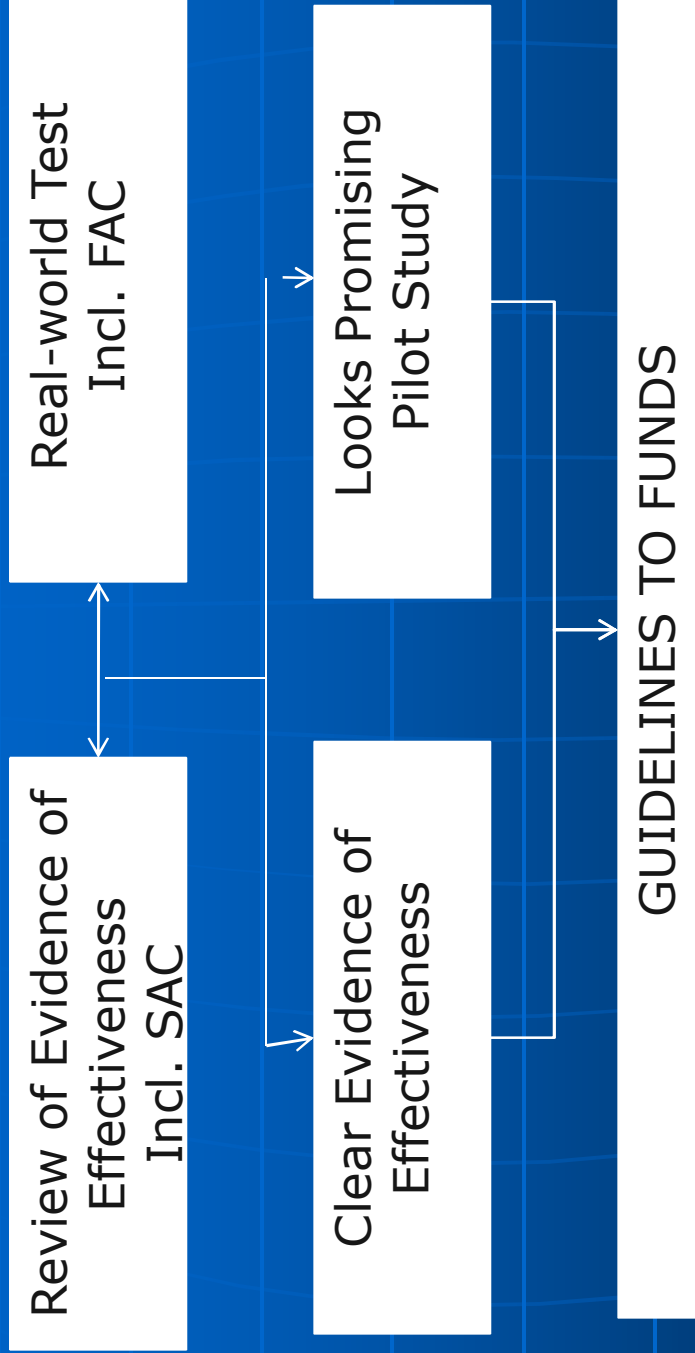
- Michael Jacobson, National Sprinklerfitters Industry Funds
- John McNerney, Elevator Constructors National Benefit Funds
- Larry McNutt, Northwest Carpenters Trust Funds
- William Schaeffer, Teamsters Central States
- Dr. Celia Shmukler, 1199 National Benefit Funds
- Alan Skolnick, IAM National Funds

# Science Advisory Committee

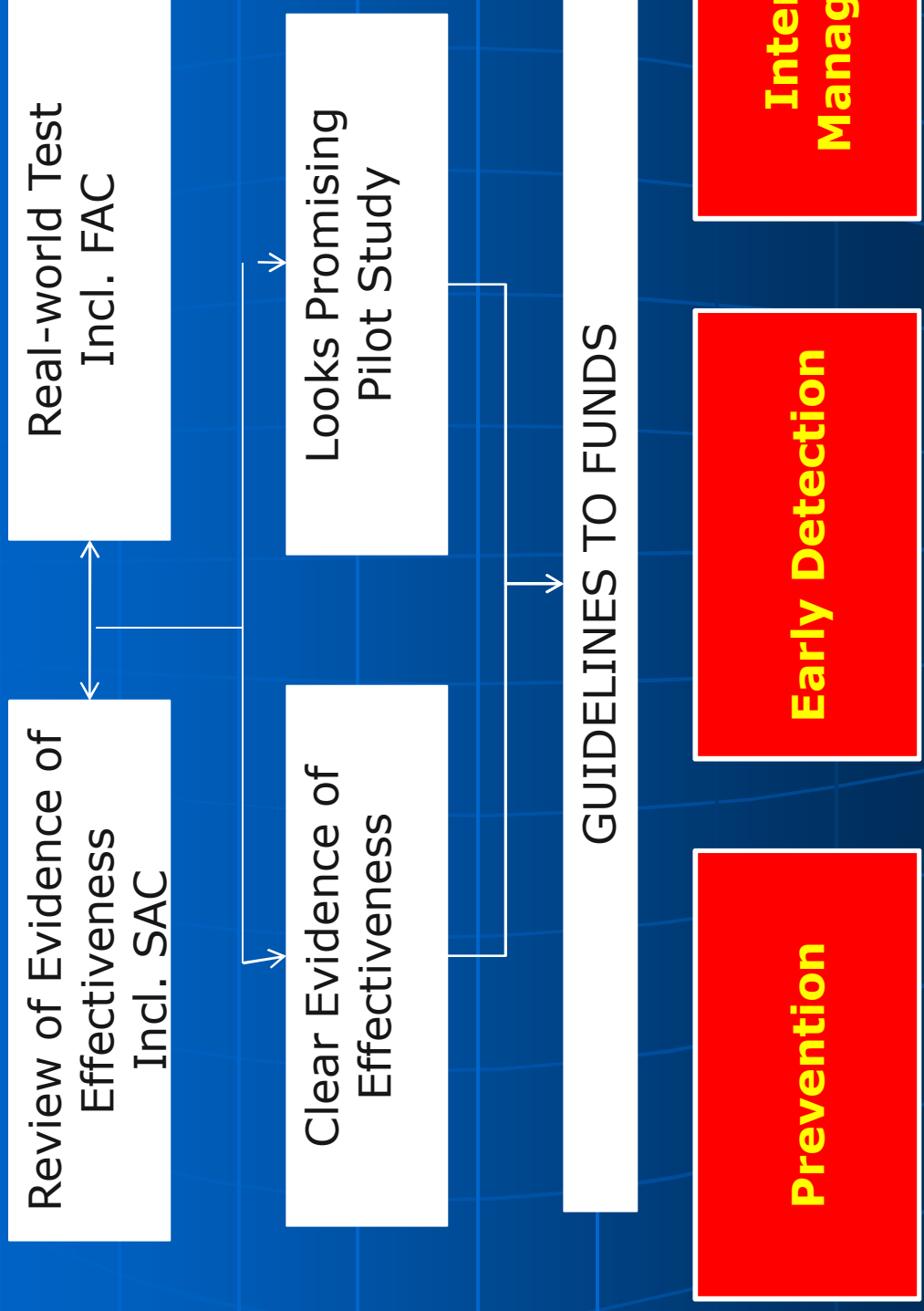
Tells us what **should be** done

- Dr. Ronald Goldberg, DRI, University of Miami
- Dr. Luigi Meneghini, DRI, University of Miami
- Dr. James Merchant, University of Iowa
- Dr. Robert Ratner, Medstar/George Washington University
- Dr. Celia Shmukler, 1199 NBF
- Dr. Greg Wagner, Harvard University

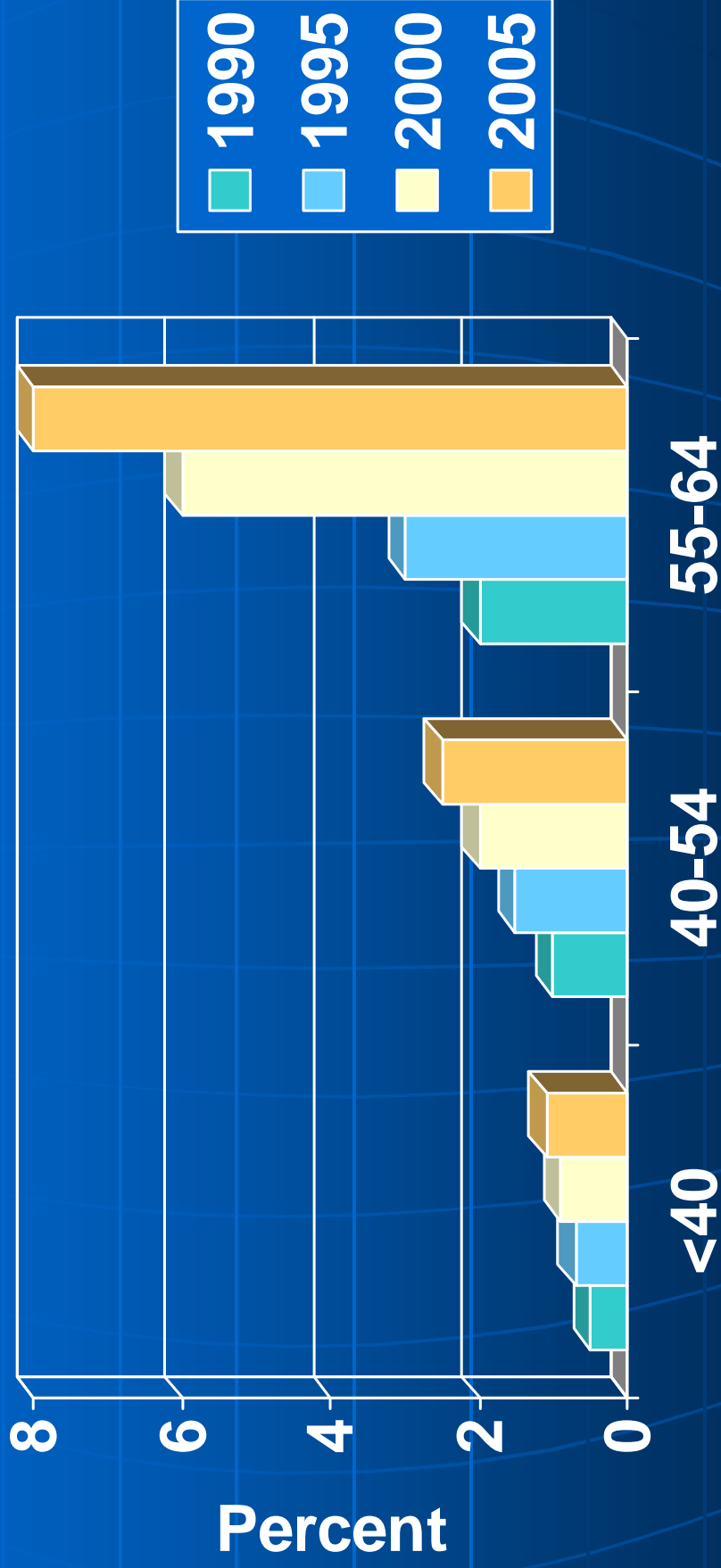
# How We Function



# How We Function



# Prevalence of Diagnosed Diabetes, Construction Trades Members



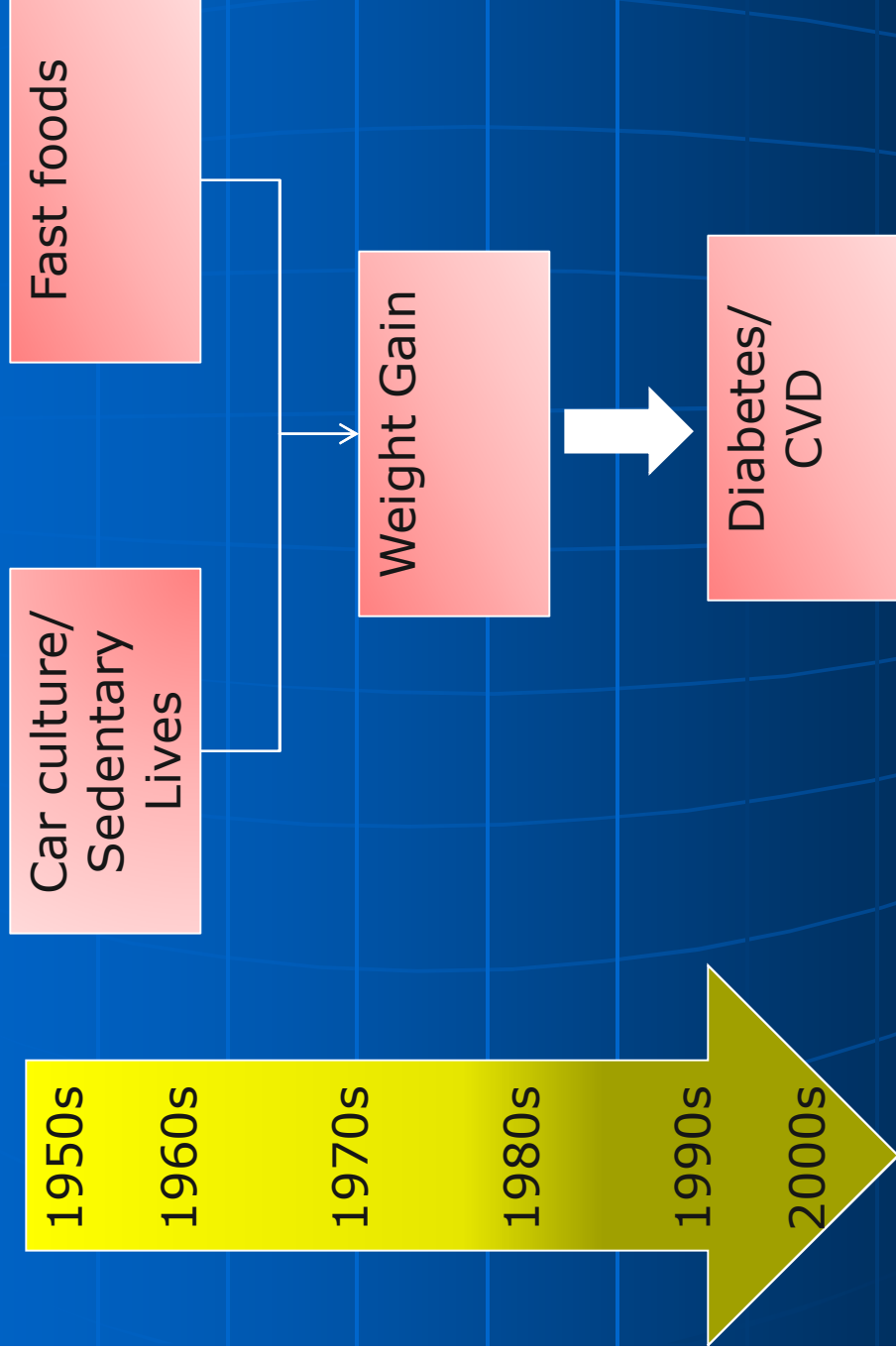
# MAKING THE LINK

## Diabetes and CVD

- 68% of patients with diabetes don't think CVD is a serious complication
  - 60% don't even think they are at risk
- Even though**
- 2 out of 3 patients with diabetes die prematurely from CVD

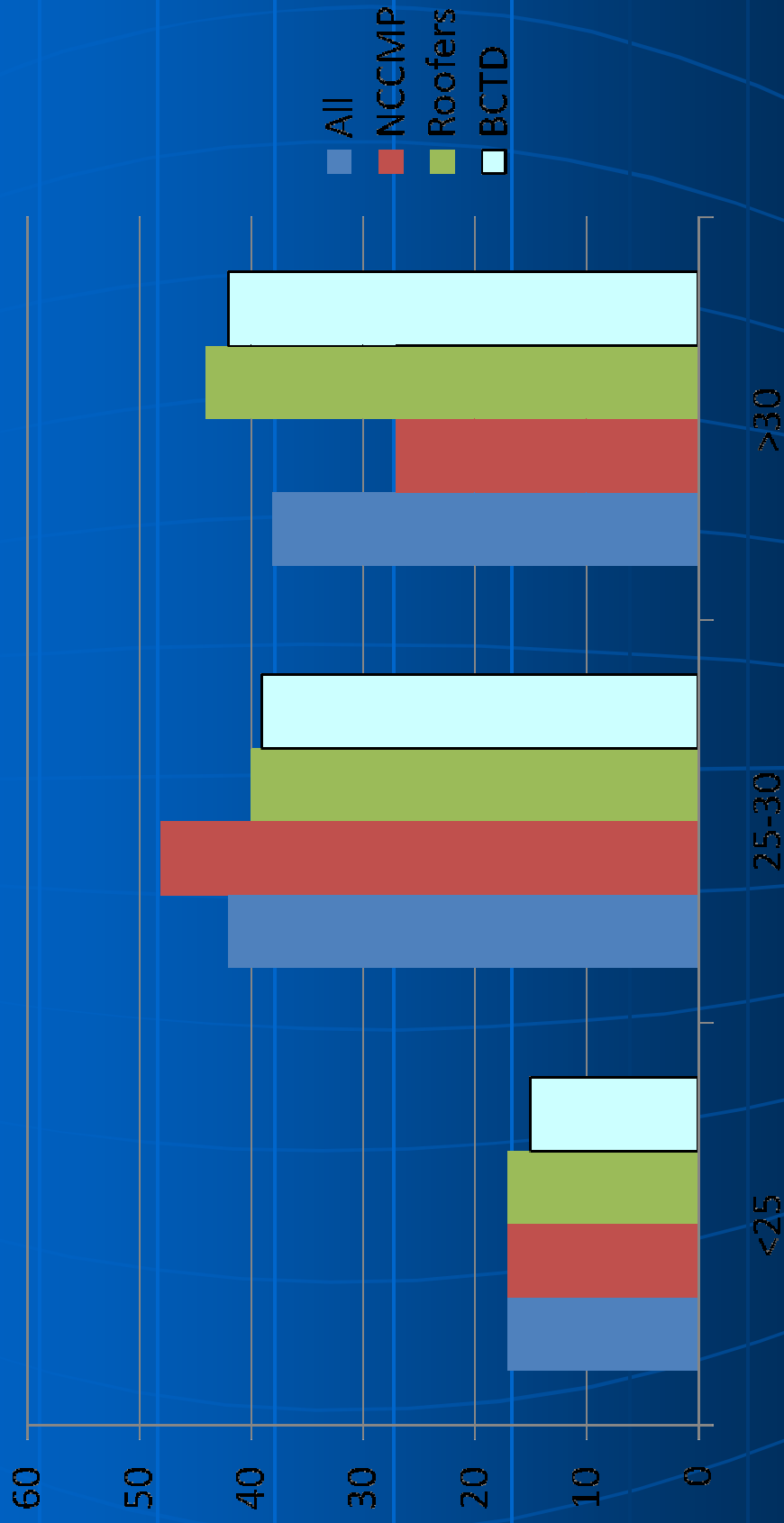
**Making the Link** is an ADA/AHA joint initiative

# How Did We Get To This?

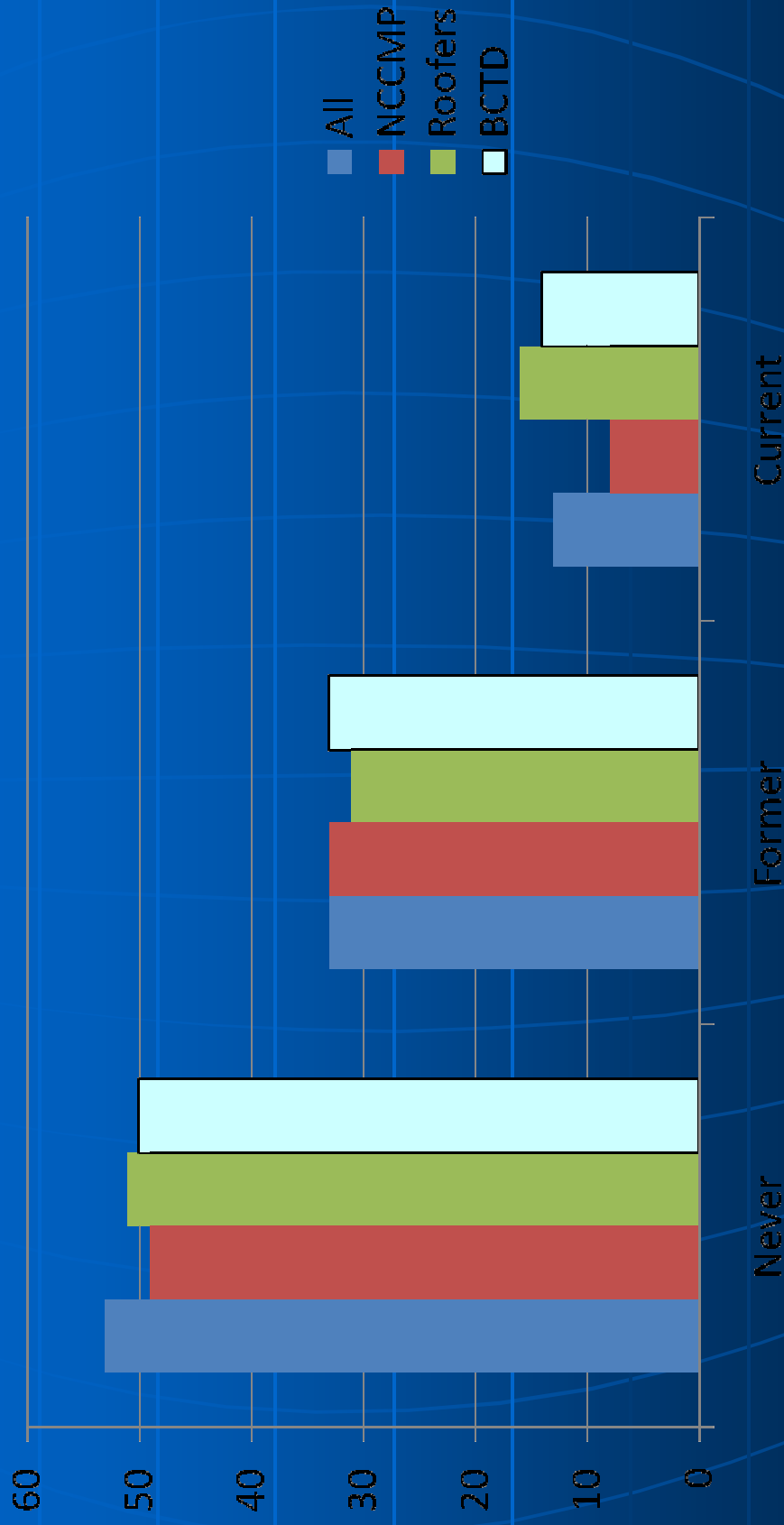


# Findings to Date

# Results from Pilot Screening Programs: Body Mass Index (n=264)

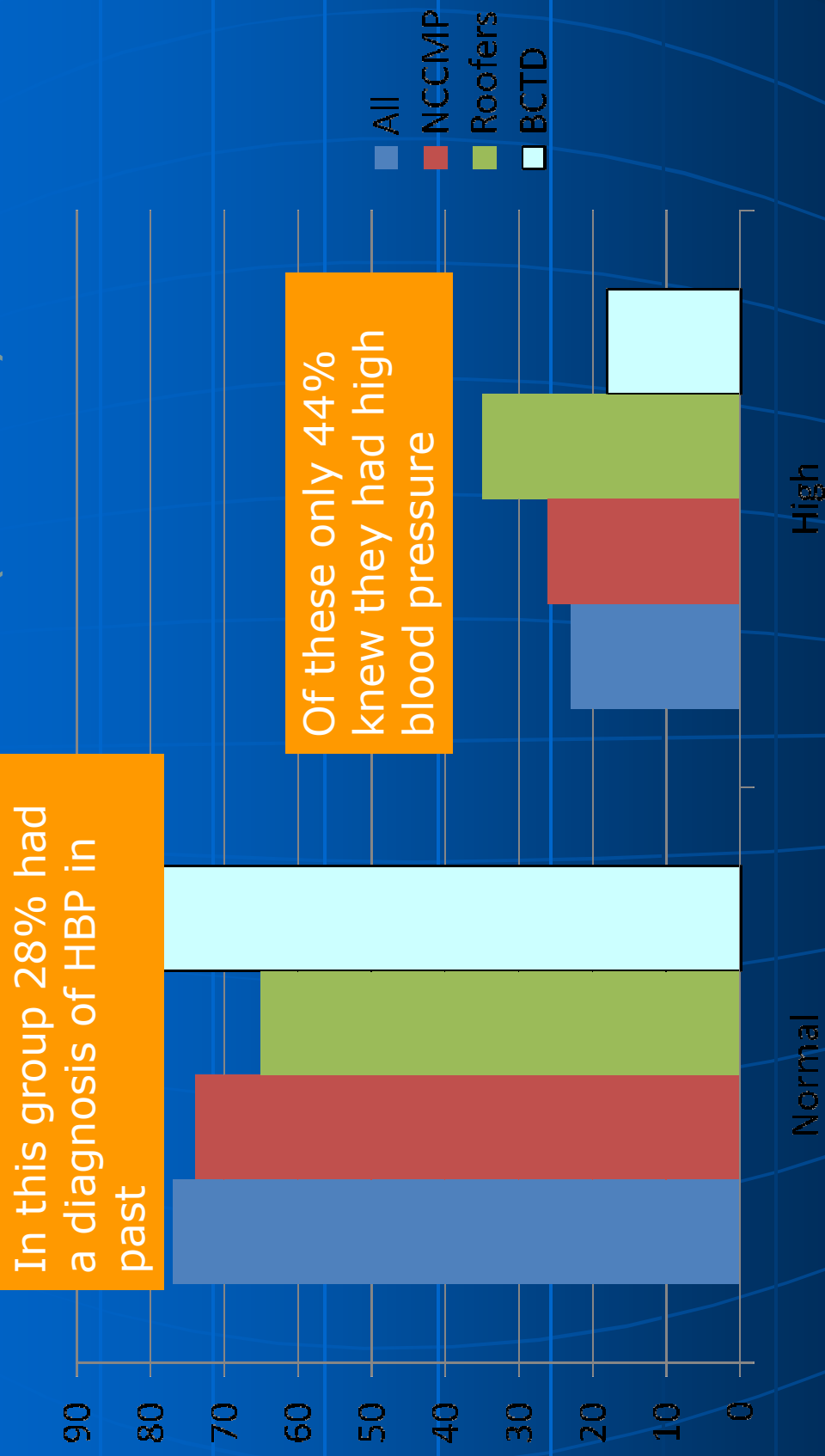


# Results from Pilot Screening Programs: Smoking History (n=259)



# Results from Pilot Screening Programs:

## Blood Pressure (n=264)



# The Costs of Doing Nothing

- **By 2015**
  - **25%** of adult population will have diabetes
  - They will consume **25-30%** of all health and welfare costs
- **By 2020**
  - **30-40%** of adult population will have diabetes
  - They will consume **30+%** of all health and welfare costs

# **Prevalence and Health Care Costs for Diabetes and Hypertension among in One Fund**

**Report Prepared by:**

**Douglas Myers, Ph.D. <sup>1</sup>**

**John M. Dement, Ph.D. <sup>1</sup>**

**Knut Ringen Dr. P.H. <sup>2</sup>**

**Laura Welch, M.D<sup>3</sup>**

**<sup>1</sup>Division of Occupational and Environmental  
Medicine, Duke University Medical Center**

**<sup>2</sup>Stoneturn Consultants**

**<sup>3</sup>The Center for Construction Research and  
Training**

# HEDIS 2008 Comprehensive Diabetes Care

## Annual Quality Measures

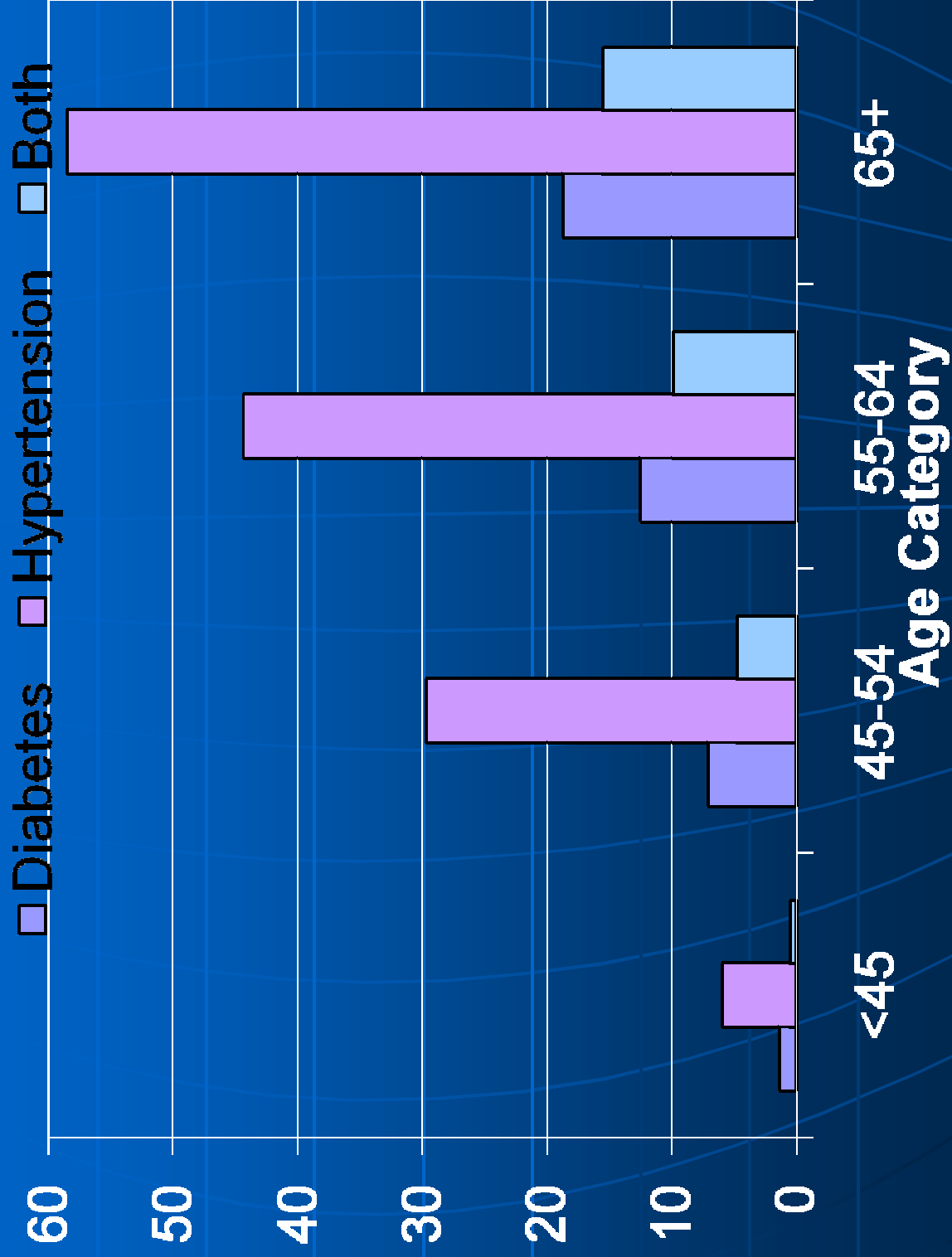
- HbA1c Performed\*
- HbA1c Good Control (<7.0%)
- HbA1c Poor Control (>9.0%)
- Retinal Eye Exam Performed\*
- LDL-C Screening\*
- LDL-C Controlled (<100 mg/dL)
- Medical Attention to Diabetic Nephropathy\*

\* Measures using claims data

# Health Plan Data 2007-2008

- Claims (raw data):
    - 2.2 million line item health claims
    - 1.1 million line item pharmaceutical claims
      - **Scripts per eligible life/year = 10.25**
  - Total Plan Paid Costs: \$400.6 million
    - \$312 million in health claims
    - \$88.5 million in pharmaceutical claims
      - **Average Rx spend per eligible life/year = \$825**
- Rx spend 22% of total \$

# Diabetes and Hypertension Prevalence Boilermakers and Dependents



# Diabetes and Hypertension Annual Costs Boilermakers Only – No Dependents, No Retirees

Diabetes	Hypertension	Cost Rate \$/Year
No	No	\$2671
Yes	No	\$6866
No	Yes	\$6562
Yes	Yes	\$10479

# HEDIS Compliance Compared with 2008 NCQA

## Data

HEDIS Measure	Member	Spouse	2008 Commercial HMOs (Mean %)	2008 Commercial PPOs (Mean %)
HbA1c Test	60.3%	54.2%	88.1%	75.4%
LDL-C Screening	54.7%	46.0%	83.9%	72.4%
Eye Exam	90.8%	93.3%	55.0%	33.0%
Medical Attention to Diabetic Nephropathy	60.6%	56.4%	80.6%	63.0%

# Pilot Studies

# Evidence of impact

Name	Lives	Actions
Fund A	56,000	Has completed data analysis; has decided to adopt UAD disease mgt guideline, is soliciting for vendor
Fund B	25,000	Has adopted a number of guidelines
Fund C	40,000	Has requested data analysis
Fund D	55,000	Serves on FAC
Fund E	350,000	Is reviewing its operations based on UAD recommendations
Fund F	8,000	Has adopted disease mgt guideline and has hired vendor. Has requested UAD analyze impact on claims data.
Fund G	40,000	Is serving as case study. Adopted screening (with incentives) smoking cessation, disease management
Fund H	500,000	Is serving as case study to examine role of depression in diabetes mgt
Coalition	>1 Mill	Promoting UAD Guidelines
Fund I	67,000	Has adopted screening, disease mgt, smoking cessation etc. May serve as pilot for "centers of excellence" approach

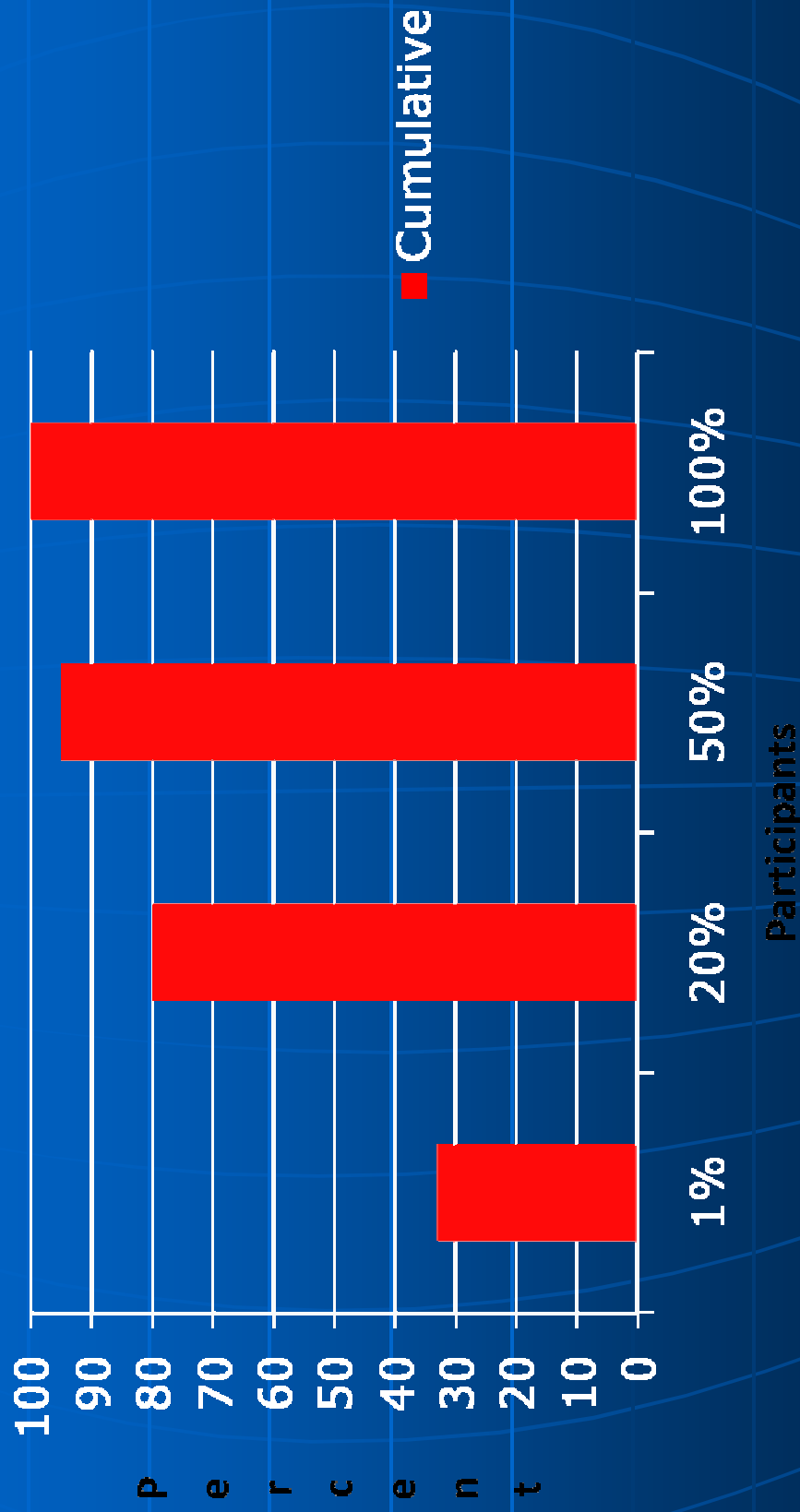
# Current Pilot Studies

- Communication to Fund Participants
- Screening
- Use of Incentives
- Centers of Excellence/Medical Homes

# What we Have Learned

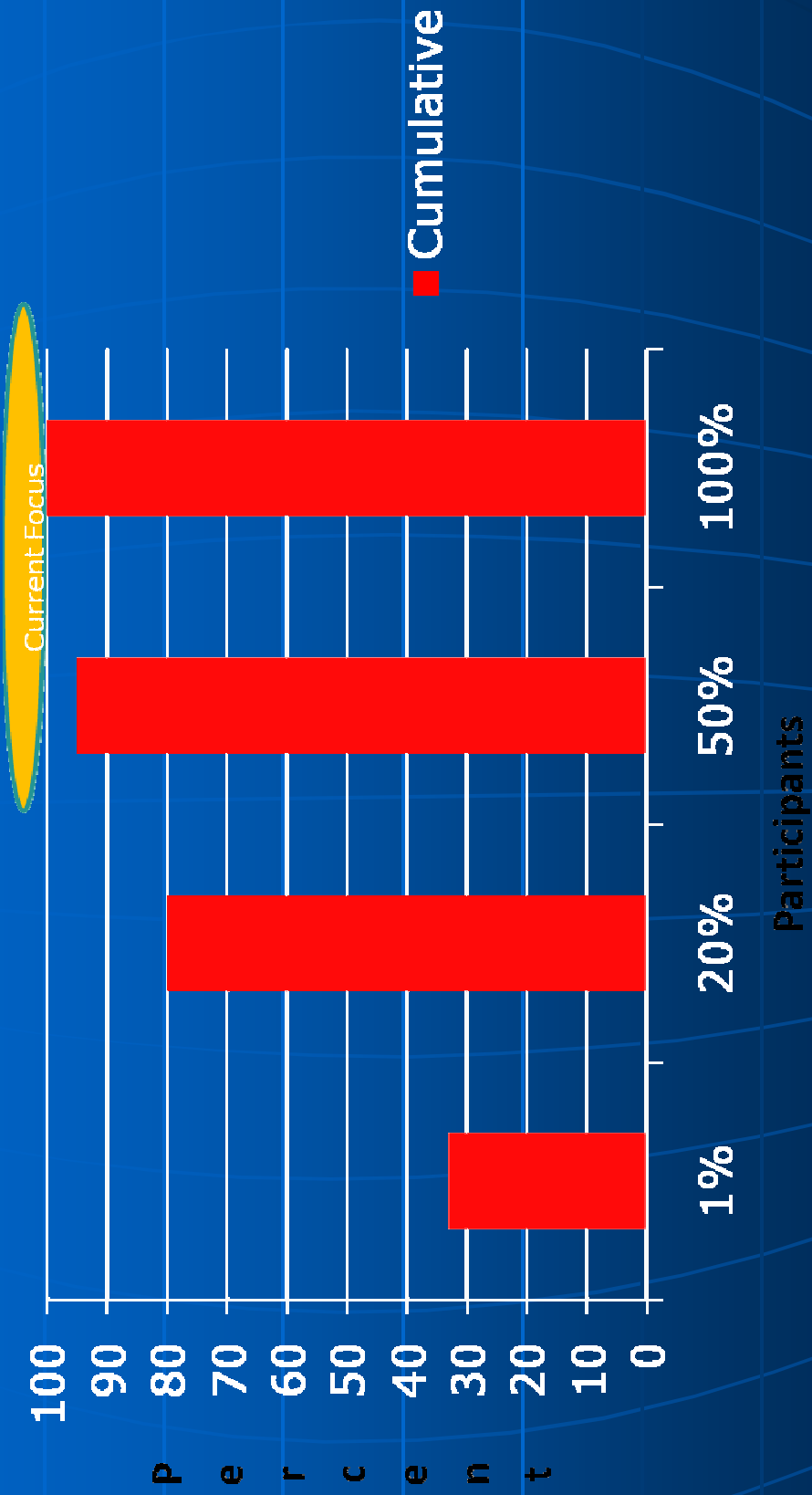
# WHERE TO PLACE OUR FOCUS

National Distribution of Health Care Costs



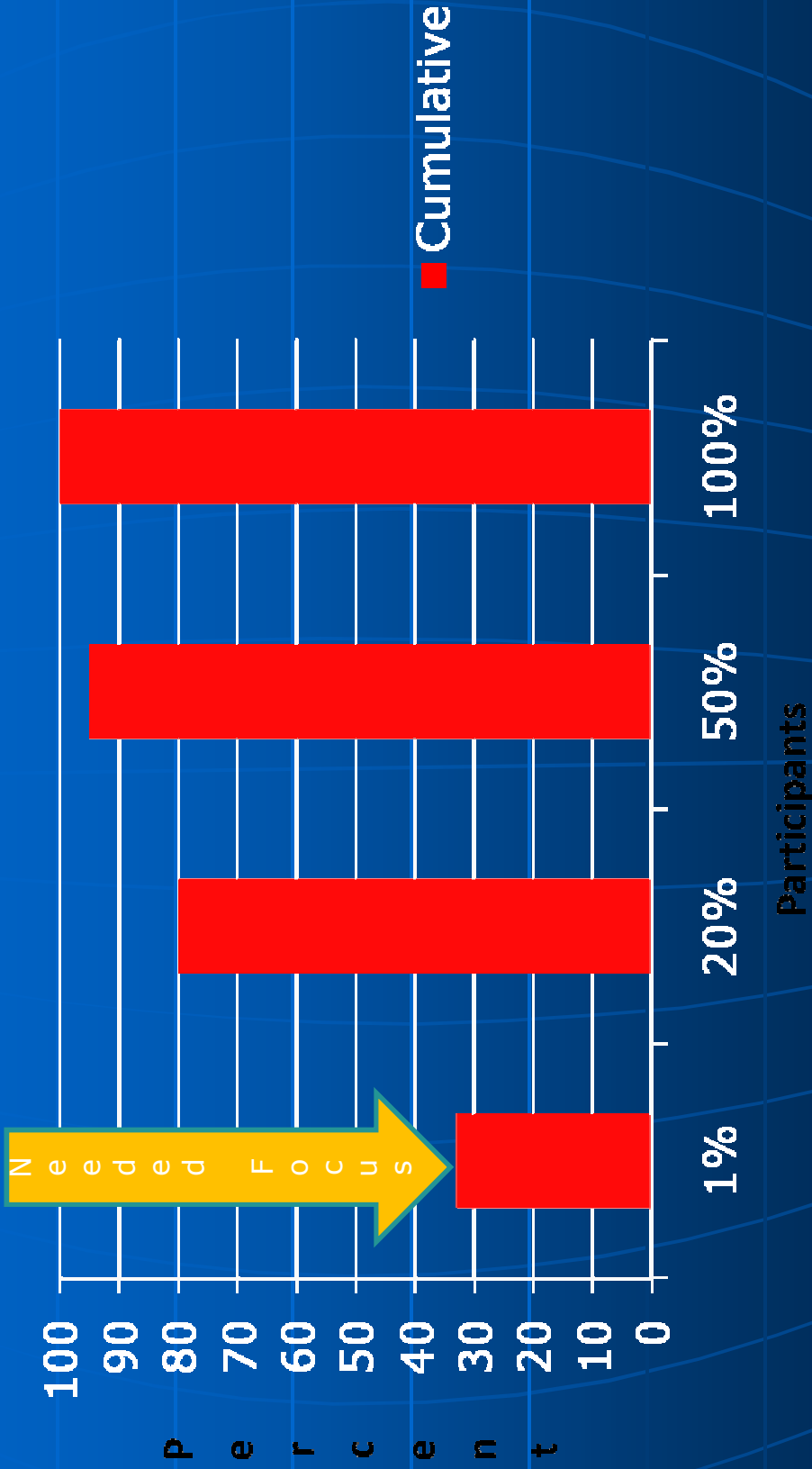
# WHERE TO PLACE OUR FOCUS

National Distribution of Health Care Costs



# WHERE TO PLACE OUR FOCUS

National Distribution of Health Care Costs



# Where we Are Focused

- Too much focus on acute health conditions
  - Cancer
  - Maternity
  - Orthopedics
  - etc

# The Top Cost Illnesses

Diabetes

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Diabetes

Patients with diabetes account for  
20% of total medical costs

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Patients with diabetes account for  
20% of total medical costs

Patients with diabetes account for  
one-third of Medicare costs

# The Top Cost Illnesses

## Diabetes

Patients with diabetes account for 20% of total medical costs

Patients with diabetes account for one-third of Medicare costs

Diabetes treatment costs account for half of these costs

# The Top Cost Illnesses

Diabetes

Congestive  
heart failure

# The Top Cost Illnesses

Diabetes

Congestive  
heart failure

Coronary  
Artery  
Disease

# The Top Cost Illnesses

Diabetes

Congestive  
heart failure

Coronary  
Artery  
Disease

Hyper  
tension

# The Top Cost Illnesses

Diabetes

Congestive  
heart failure

Coronary  
Artery  
Disease

Hyper  
tension

Asthma

# The Top Cost Illnesses

Diabetes

Congestive  
heart failure

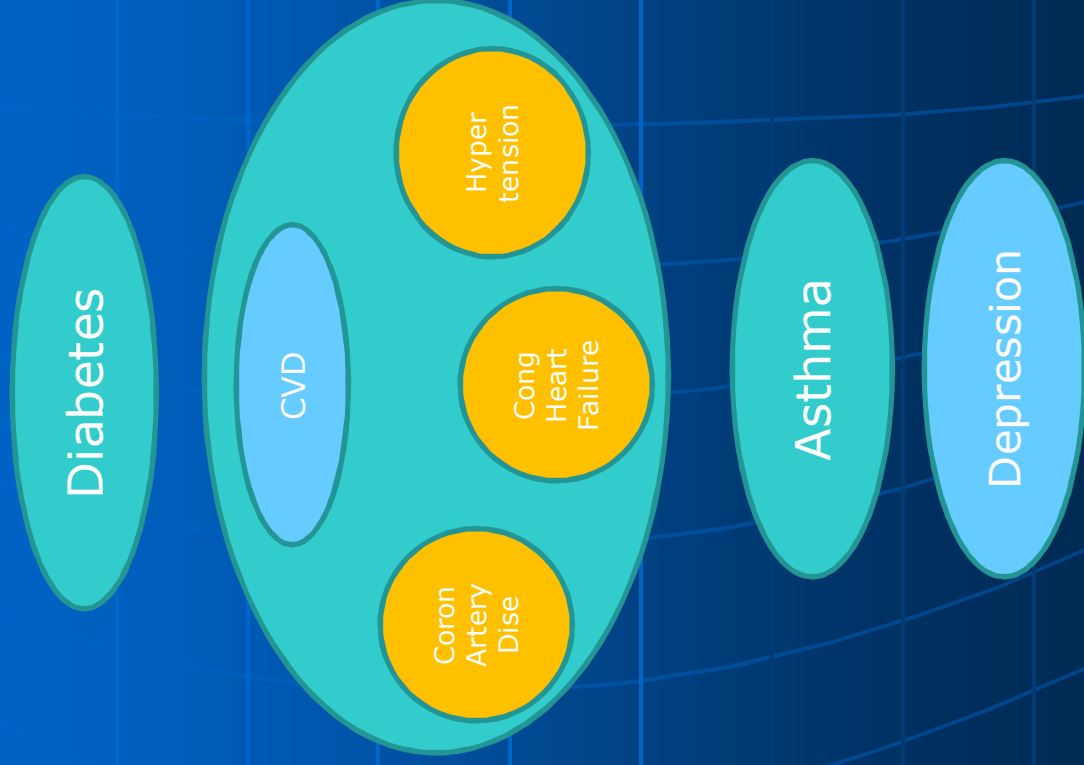
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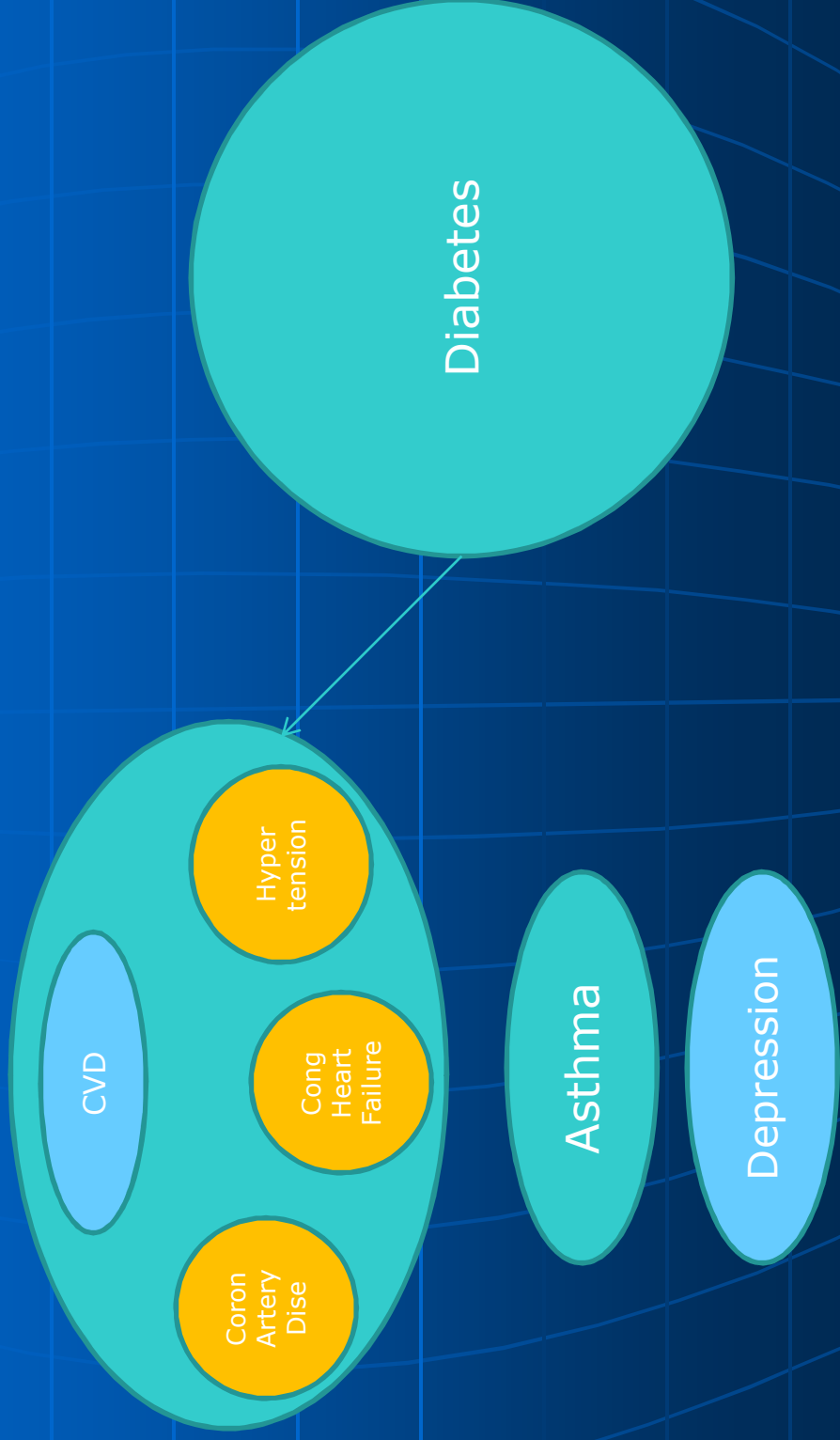
Asthma

Depression

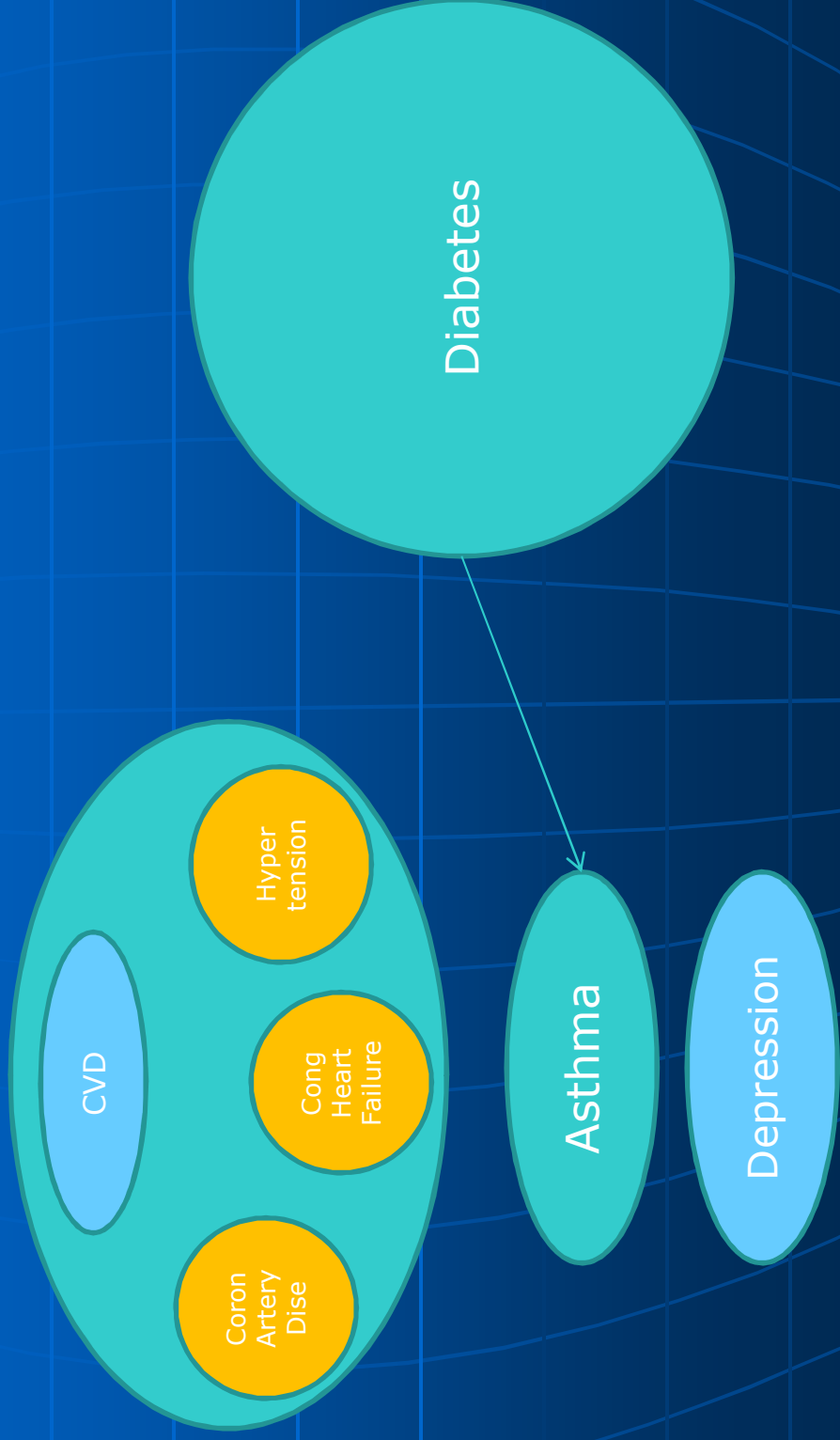
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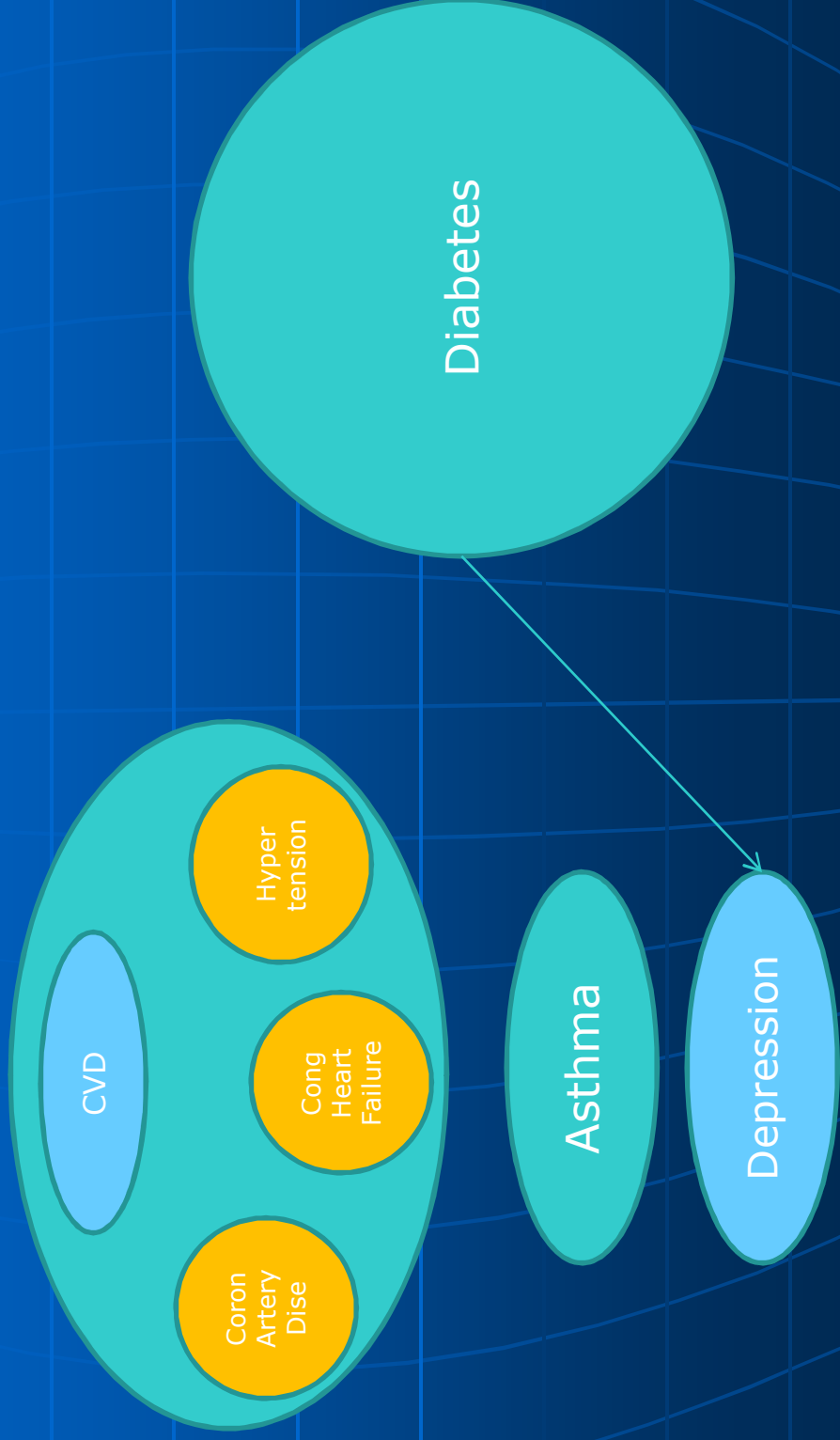
# The Top Cost Driver



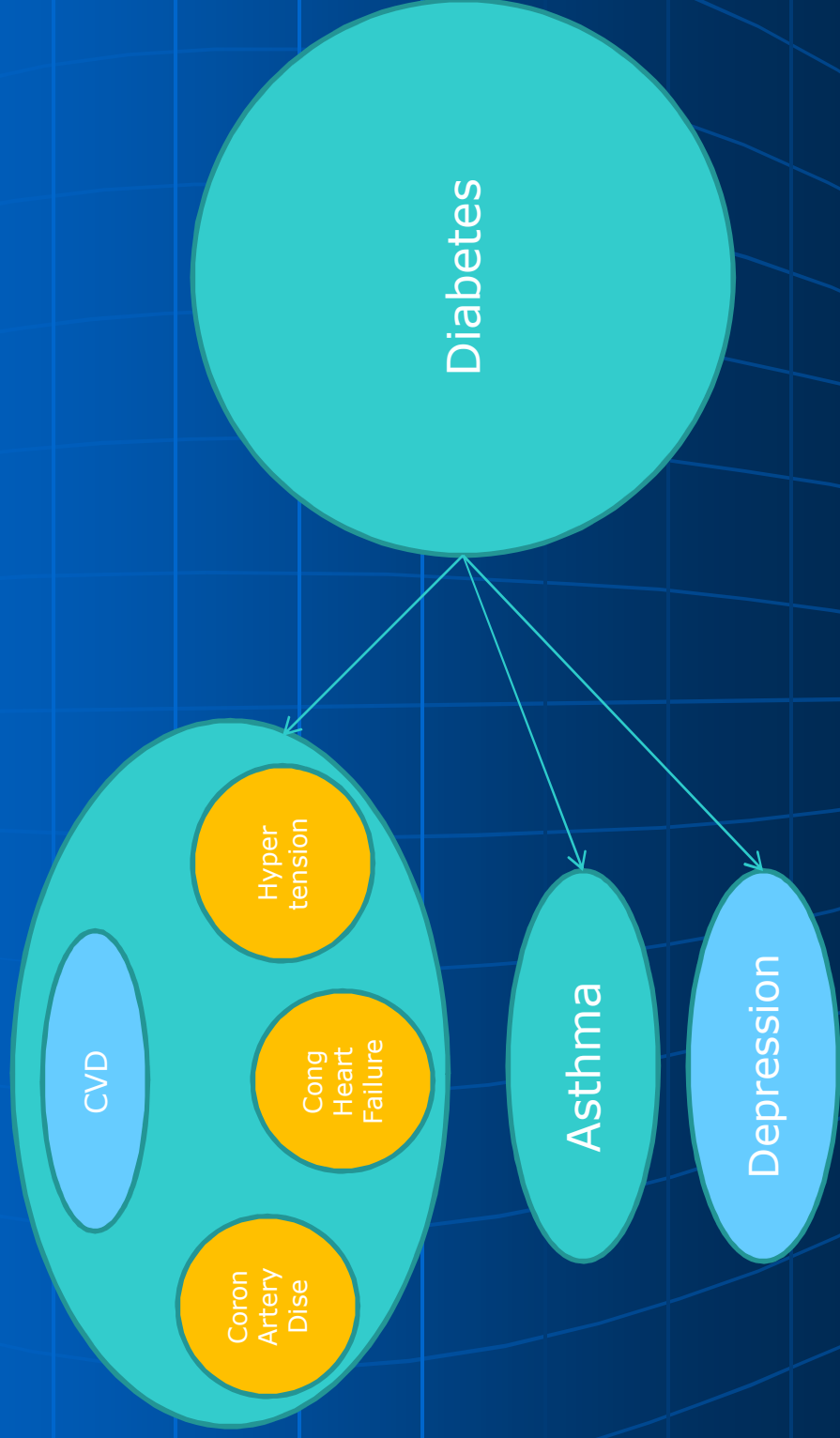
# The Top Cost Driver



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# The Top Cost Driver



# Where we Need to Focus

- Participants with chronic diseases

# Disconnected Health Care

- A patient with chronic disease may have 5-10 different care givers

And/But

- No coordination

And

- Indemnity payors are hands-off

# Quality is Highly Variable

- Among top 10% providers, quality measures vary by up to 50%
- We pay regardless of the quality

# Our Data are Deficient

- We track charges and payments
- We don't track health

# How do we Build on our Strengths

- Stable populations
- A very high degree of trust

# A New Approach to Disease Management

- Disease management is more about relationships than science
- Improving health care is not rocket science:
  - Surgical check lists reduce complications

# Assuring Performance

- Holding providers responsible
- Holding participants responsible

# Assuring Performance

- Communicating expectations
- Offering assistance
- Monitoring care

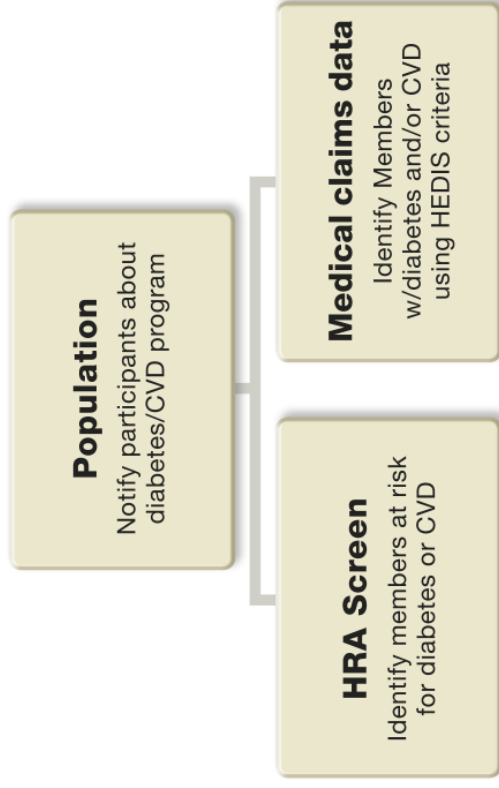
# Guidelines

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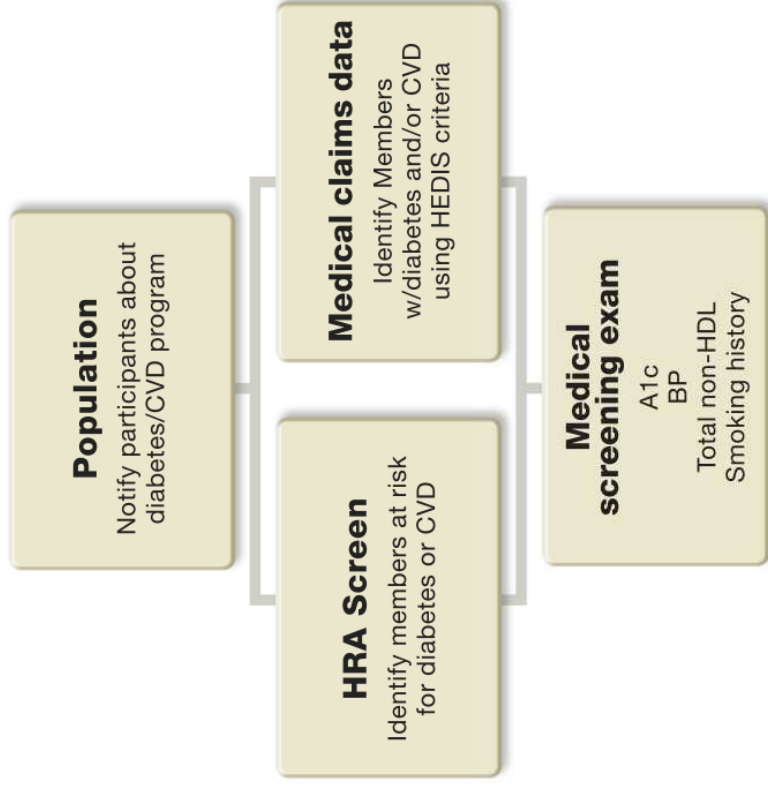
# Recommendations to Funds

1	Optimizing prevention and control of diabetes/cvd
2	Appointing a lead person for diabetes/CVD on H&W Fund staff
3	Informing participants about diabetes/CVD program
4	Using claims data to identify participants with diabetes/cvd
5	Using HRA to identify participants at risk for diabetes/CVD
6	Screening participants for diabetes/cvd
7	Providing the <i>UAD/CVD Disease Self-Management Guide</i>
8	Providing information on diet, exercise and stress management
9	Providing smoking cessation benefits
10	Recommending use of daily 80 mg aspirin
11	Dealing with depression
12	Managing diabetes in pregnancy
13	Monitoring program impact

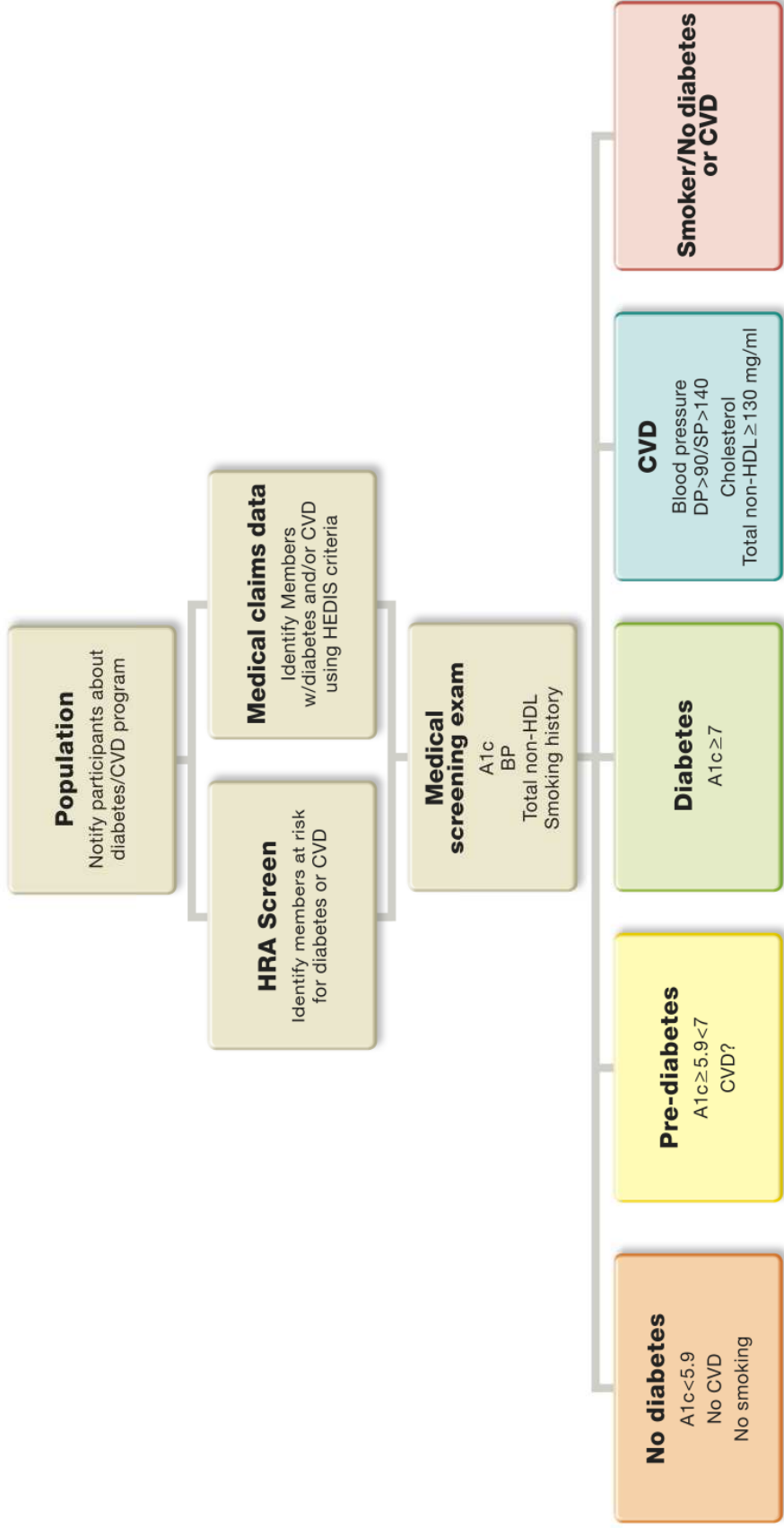
# UAD/CVD Program Algorithm



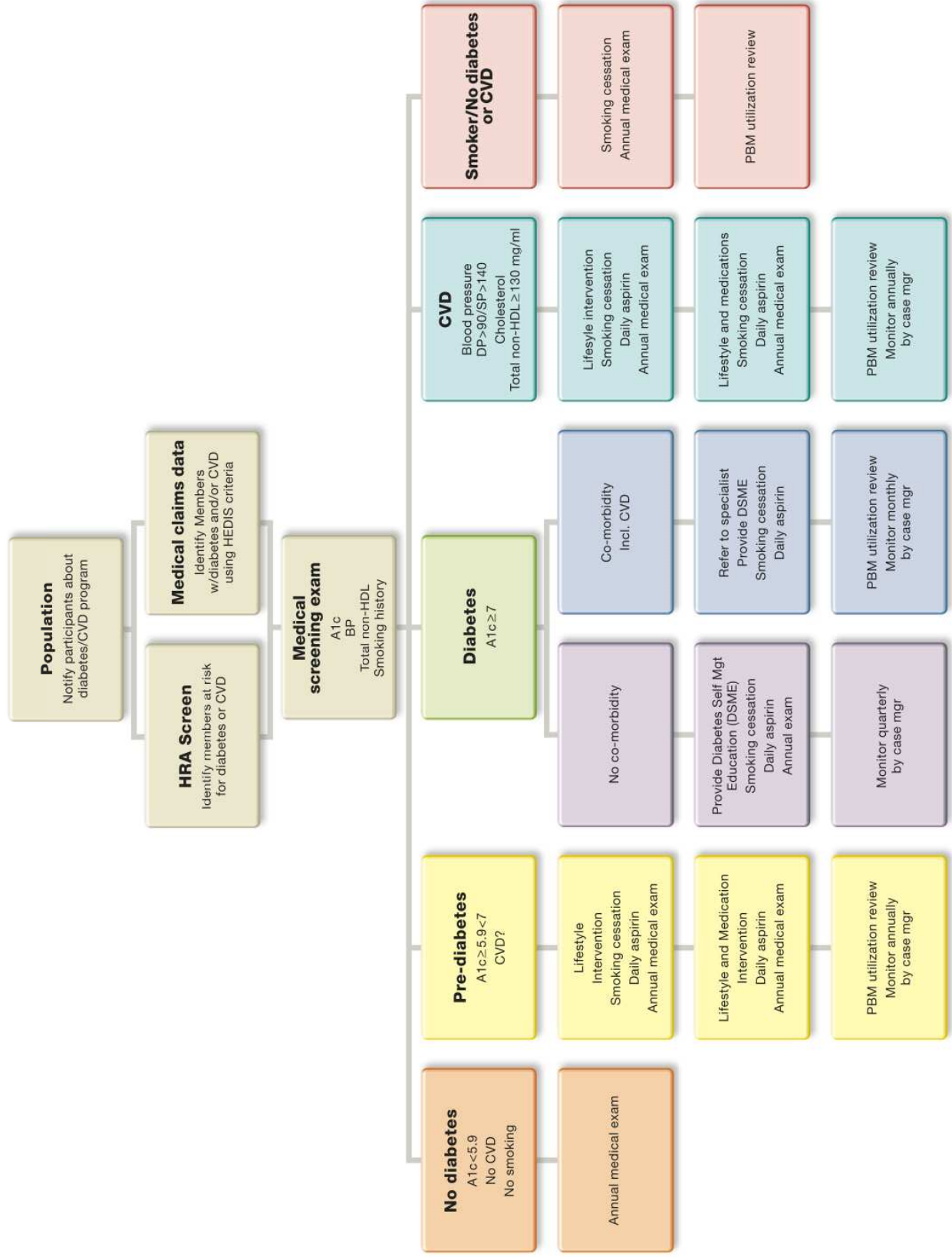
# UAD/CVD Program Algorithm



# UAD/CVD Program Algorithm



# UAD/CVD Program Algorithm



# What Does Participation in UAD/CVD Mean?

# What Does Membership Mean?

- Participating funds agree to adopt UAD/CVD recommendations *in some form suitable to their environment*
- Participating funds agree to participate in one or more *pilot* or *case studies* and provide data to UAD/CVD

# What UAD will Provide to Funds

- A preliminary analysis of historical claims data by Duke University to identify immediate potential savings from better management of participants with diagnosed diabetes/CVD
- Diabetes/CVD self management guide
- Access for fund office staff to training in appropriate methodologies for communication of disease specific awareness programs, prevention, early detection and treatment of diabetes and cardiovascular disease
- Access to UAD/CVD website

# Pilot Program Areas

- Program 1 – Communications
- Program 2 – Screenings
- Program 3 – Incentives
- Program 4 – Centers of Excellence

# How a Pilot Would Work

UAD Performs Baseline Data  
Evaluation

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Duke and Fund establish  
Data use Agreement

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UAD Performs Baseline Data  
Evaluation

Duke and Fund establish  
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Fund sends Duke data file  
with two years of claims data

# How a Pilot Would Work

UAD Performs Baseline Data Evaluation

Duke and Fund establish Data use Agreement

Fund sends Duke data file with two years of claims data

Duke performs analysis and submits draft report to Fund

# How a Pilot Would Work

UAD Performs Baseline Data  
Evaluation

UAD and Fund Work Together  
to Design Intervention

# How a Pilot Would Work

UAD Performs Baseline Data  
Evaluation

UAD and Fund Work Together  
to Design Intervention

Fund Implements  
Intervention

# How a Pilot Would Work

UAD Performs Baseline Data  
Evaluation

UAD and Fund Work Together  
to Design Intervention

Fund Implements  
Intervention

UAD Evaluates Impact

# Outcomes (Communications Program)

- Increase in the number of participants participating in health risk assessments and screenings

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- Increase in the number of participants participating in health risk assessments and screenings
- Increase in the number of participants diagnosed as having diabetes using HEDIS measures

# Relevant HEDIS Measures

- Minimum of two face-to-face encounters with a diagnosis based on ICD-9-CM diagnosis codes of diabetes (ICD 250) or hypertension (ICD 401) on different dates of service in an outpatient setting or non-acute inpatient, **or**
- One face-to-face encounter in an acute inpatient or emergency department setting with a diagnosis based on ICD-9-CM diagnosis codes of diabetes (ICD 250) or hypertension (ICD 401), **or**
- Receipt of any HEDIS diabetes prescription medications, such as insulin, oral hypoglycemics, or antihyperglycemics

# Outcomes (Communications Program)

- Increase in the number of participants participating in health risk assessments and screenings
- Increase in the number of participants diagnosed as having diabetes using HEDIS measures
- **Increase in the utilization of diabetes treatments among participants with a diagnosis of diabetes**

# Measures for Increased use of Treatment

- Medical claims data (CPT Codes)
  - Hemoglobin A1c (HbA1c) test,
  - Retinal eye exam,
  - LDL-C screening using CPT codes
  - Medical attention for diabetic nephropathy including a nephropathy screening test or evidence of nephropathy,
- Rx Data
  - Continuous dispensing of any HEDIS diabetes prescription medications, such as insulin, oral hypoglycemics, or antihyperglycemics

# Outcomes (Communications Program)

- Increase in the number of participants participating in health risk assessments and screenings
- Increase in the number of participants diagnosed as having diabetes using HEDIS measures
- Increase in the utilization of diabetes treatments among participants with a diagnosis of diabetes
- **Decrease in adverse events for participants with a diagnosis of diabetes**

# Measures for Adverse Events

- Frequency of emergency room visits
- Rates of in-patient admission
- Costs of treatment for those who are in adherence with HEDIS measures compared to those who are not in adherence

# Our Promise to You

## UAD/CVD

- Will be evidence-based in terms of medicine
- Will be compliant in terms of HIPAA, ADA and other laws

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# Patient Protection and Affordable Care Act

P.L. 111-148, March 23, 2010

**Prevention, Wellness and Health Promotion  
Requirements**

# Coverage of Preventive Services

## Section 1001

# SEC. 1001. Amends Public Health Service Act (42 U.S.C. 300gg et seq.)

**by inserting**

**SEC. 2713: Coverage of Preventive Health Services**

**SEC. 2717: Ensuring Wellness & Quality of Care**

# SEC. 2713 COVERAGE OF PREVENTIVE HEALTH SERVICES

**On the first anniversary date following Sept 23, 2010, all new health plans must cover without cost sharing:**

## **a) Preventive services**

- i. U.S. Preventive Services Task Force rated “A” or “B”
- ii. HRSA Comprehensive Guidelines
  - i. Infants, children, and adolescents,
  - ii. Women.

**Note: Existing Health Plans have a “Grandfather” Exemption**

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  - i. Infants, children, and adolescents,
  - ii. Women.

## b) Immunizations

- i. CDC Advisory Committee on Immunization Practices

# US Preventive Services Task Force Recommendations Rated A or B

Services	Men	Women	Pregnant Women	Child
Abdominal Aortic Aneurysm, Screening	✓			
Alcohol Misuse Screening and Counseling	✓	✓	✓	
Daily Aspirin	✓	✓		
Asymptomatic Bacteriuria Screening			✓	
Breast Cancer Screening		✓		
Breast Ovarian Cancer Genetic Risk Assessment		✓		
Breastfeeding promotion/counseling		✓	✓	
Cervical Cancer Screening		✓		
Chlamydial Infection Screening		✓	✓	
Colorectal Cancer Screening	✓	✓		
Congenital Hypothyroidism Screening				✓
Dental Caries in Preschool Children Prevention				✓
Depression Screening	✓	✓		
Gonorrhea Screening		✓	✓	85
Gonorrhea Prophylactic Medication				

# US Preventive Services Task Force Recommendations Rated A or B

Services	Men	Women	Pregnant Women	Child
Hearing Loss in Newborns Screening				✓
Hepatitis B Virus Infection Screening			✓	
High Blood Pressure Screening	✓	✓		
HIV Screening	✓	✓	✓	✓
Iron Deficiency Anemia Prevention				✓
Iron Deficiency Anemia Screening			✓	
Lipid Disorders in Adults Screening	✓	✓	✓	
Major Depressive Disorder in Children and Adolescents Screening				✓
Obesity in Adults Screening	✓	✓		
Osteoporosis in Postmenopausal Women Screening		✓		
Phenyketonuria Screening				✓
Rh (D) Incompatibility Screening			✓	86
Sexually Transmitted Infections Counseling	✓	✓		

# US Preventive Services Task Force Recommendations Rated A or B

Services	Men	Women	Pregnant Women	Child
Tobacco Use and Tobacco-Caused Disease Counseling	✓	✓	✓	
Type 2 Diabetes Mellitus in Adults Screening	✓	✓	✓	
Visual Impairment in Children Younger than Age 5 Years Screening				✓

# SEC. 2717

## Ensuring Quality of Care

By March 23, 2012, **new** health plans must report to **DHHS** on their activities to:

- (A) Improve health outcomes:** quality reporting, case management, care coordination, disease management, medication & care compliance, medical homes model
- (B) Prevent hospital readmissions:** hospital discharge planning including post discharge reinforcement by an appropriate health care professional;
- (C) Improve patient safety and reduce medical errors:** use of best clinical practices, evidence based medicine, and health information technology

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- (C) Improve patient safety and reduce medical errors:** use of best clinical practices, evidence based medicine, and health information technology
- (D) Cover wellness and health promotion**

# Implement Wellness and Health Promotion Activities

**SEC. 2717(a)(1)(D) & 2717(b)**  
**Effective Date March 23 2012**

*Wellness and health promotion activities may include personalized wellness and prevention services, which are coordinated, maintained or delivered by a health care provider, a wellness and prevention plan manager, or a health, wellness or prevention services organization that conducts health risk assessments or offers ongoing face-to-face, telephonic or web-based intervention efforts for each of the program's participants*

# Examples of Wellness Benefits

- (1) Smoking cessation.*
- (2) Weight management.*
- (3) Stress management.*
- (4) Physical fitness.*
- (5) Nutrition.*
- (6) Heart disease prevention.*
- (7) Healthy lifestyle support.*
- (8) Diabetes prevention.*

# Employer-Provided Wellness Programs

## Section 4303

# SEC. 4303 Amends Public Health Service Act (42 U.S.C. 241 et seq., Section 4102)

by inserting

**SEC. 399MM. TECHNICAL ASSISTANCE  
FOR EMPLOYER-BASED WELLNESS PROGRAMS**

“In order to expand the utilization of evidence-based prevention and health promotion approaches in the workplace, the Director [of CDC] shall-”

- Provide employers with tech assistance, consultation, tools, etc.
- Build evaluation capacity to enable employers to measure impact of wellness programs

**This provision is not mandatory on any employer**

# High Risk Professions

## Section 9001

# SEC. 4303 Amends Public Health Service Act (42 U.S.C. 241 et seq., Section 4102)

by inserting

**SEC. 399MM. TECHNICAL ASSISTANCE  
FOR EMPLOYER-BASED WELLNESS PROGRAMS**

# SEC. 4303

Amends Chapter 43 of the Internal Revenue Code of 1986, as amended by section 1513

by inserting

**SEC. 4980I. EXCISE TAX ON HIGH COST  
EMPLOYER-SPONSORED HEALTH COVERAGE**

# Designation of High Risk Professions

- SUBSECTION (b)(3)(C)(ii) EXCEPTION FOR CERTAIN INDIVIDUALS.—In the case of an individual who is a qualified retiree or who participates in a plan sponsored by an employer the majority of whose employees are engaged in **a high-risk profession** or employed to repair or install electrical or telecommunications lines
  
- SUBSECTION (f)(3) EMPLOYEES ENGAGED IN HIGH-RISK PROFESSION.—
  - Police
  - Firefighters
  - Emergency medical personnel
  - Construction
  - Mining
  - Agriculture (not food processing)
  - Fisheries
  - Longshore workers (added in section 10901)

# Research and Demonstration Funding

## SEC. 4002. PREVENTION AND PUBLIC HEALTH FUND

- to provide for expanded and sustained national investment in prevention and public health programs to improve health and help restrain the rate of growth in private and public sector health care costs.
  - FY 2010 - \$500 Mill
  - FY 2011 - \$750 Mill
  - FY 2012 - \$1.0 Bill
  - FY 2013 - \$1.25 Bill
  - FY 2014 - \$1.5 Bill
  - FY 2015 and each year thereafter - \$2.0 Bill

# Comparative Effectiveness Research

- Title XI of the Social Security Act (42 U.S.C. 1301 et seq.) is amended by adding at the end the following new part B
  - **Establishes Patient-Centered Outcomes Research Institute**
- Part D of title XI of the Social Security Act, as added by subsection (a) and amended by subsection (c), is amended by adding Section 1183
  - **Establishes the Patient-Centered Outcomes Research Trust Fund.**
- Chapter 34 of the Internal Revenue Code of 1986 is amended to add Sec 4375
  - **Requires all health plans including self-insured to pay**
    - **FY 2012: \$1 per covered life**
    - **FY 2013: \$2 per covered life**
    - **FY 2014-2019: \$2 per covered life adjusted for inflation**

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## **What this means for Multiemployer funds:**

- **Approx \$26 Mill in 2012**
- **Approx \$52+ Mill/year thereafter**

# The NCCMP Plan

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# NCCMP Strategy I

- Revamp UAD/CVD to meet requirements of Act
- Get recognition for
  - the lack of prior effectiveness research and demonstration in multi-employer environment
  - special emphasis on “high risk occupations” and these pops are likely to be covered by multiemployer funds
- Get funding proportionate to the size of the multi-employer population

# NCCMP Strategy II

- Conduct R&D on the cost-effectiveness of evidence base prevention and wellness interventions in multi-employer funds
- Provide technical assistance and support to optimize prevention and wellness investments
  - To multi-employer funds in the adoption
  - To employers and unions that are signatory to multi-employer funds

# The Funding Goal

- **Prevention and Public Health Fund**
  - Proportional to Size of Population x 50%
    - Multiemployer population = 26 mill, or 8.5% of US population
      - FY 2011, \$32 Mill; FY 2012, \$42 Mill; FY 2013, \$53, Mill; FY 2014, 64 Mill
      - FY 2015 and thereafter: \$84 mill/year
- **Comparative Effectiveness Research Fund**
  - Equal to total contributions x 50%
    - FY 2012: \$13 Mill
    - FY 2013 and thereafter: \$26 Mill/yr

# How to get it done

- NCCMP and signatories to Multi-employer Funds should get monies directed to this purpose:
  - By appropriations committees as authorized under Section 4002(d) of the Act
  - By getting White House support to direct DHHS and DOL.

# Preventive Services Timeline

2010

Cover Required Preventive Services as Defined in the Act with no Cost Sharing by 9/23

Prevention & Public Health Fund

2011

National Prevention, Health Promotion and Public Health Council to Establish Additional Prevention & Wellness Services and periodically thereafter [at least every 5 years]

Wellness assistance to small employers

Comparative Effectiveness Fund

2012

Must Cover additional services without cost sharing  
Must start reporting on quality

2014

May provide rewards to employees who meet certain wellness/prevention criteria, to be defined

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It's a brave new world  
but the UAD/CVD work puts  
us in a good position to begin  
to respond to these new  
requirements