

State of Arkansas – Employee Benefits Division

Diabetes Study – Consolidated Report

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Diabetes Study Review

1. As we saw in the series of these presentations, prevalence and costs of diabetes are high in the Plan and need to be addressed.
2. Comorbidities of diabetes present a higher burden of illness, such as:
 - Hypertension
 - Hyperlipidemia
 - Cardiovascular Disease
 - Obesity
3. Mental health as a comorbidity of diabetes remains very high as well.
4. Costs of newer diabetes medications such as GLP-1s are very high and needs to be managed
5. Members living in health deprived areas (as measured by Area Deprivation Index) need more help in diabetes management in terms of health education, coaching, access, and affordability

Why Diabetes Management is Important

Early diabetes management is important because it can prevent many other serious illnesses in the future

- Early action to prevent or delay type 2 diabetes can have numerous long-term benefits.
- Effective blood sugar management can reduce the risk of eye disease, kidney disease, and nerve disease by 40%.
- Improve mood and energy

Some ways to manage diabetes

- Making healthy eating and physical activity part of your daily routine
- Maintaining a healthy weight
- Monitoring your blood sugar
- Following your health care provider's instructions for managing your blood sugar level
- Taking your medications as directed by your health care provide

Effective Diabetes Management

All of components of effective diabetes management need:



Some or more of the above may not be available in deprived areas as we saw in earlier analysis.

Let's Recap...

Area Deprivation Index Analysis

What is ADI

About the Area Deprivation Index (ADI)

The Area Deprivation Index (ADI) is based on a measure created by the Health Resources & Services Administration (HRSA) over three decades ago, and has since been refined, adapted, and validated to the Census Block Group neighborhood level by Amy Kind, MD, PhD and her research team at the University of Wisconsin-Madison. It allows for rankings of **neighborhoods by socioeconomic disadvantage** in a region of interest (e.g. at the state or national level). It includes factors for the theoretical domains of **income, education, employment, and housing quality**. It can be used to inform health delivery and policy, especially for the most disadvantaged neighborhood groups.

<https://www.neighborhoodatlas.medicine.wisc.edu/>

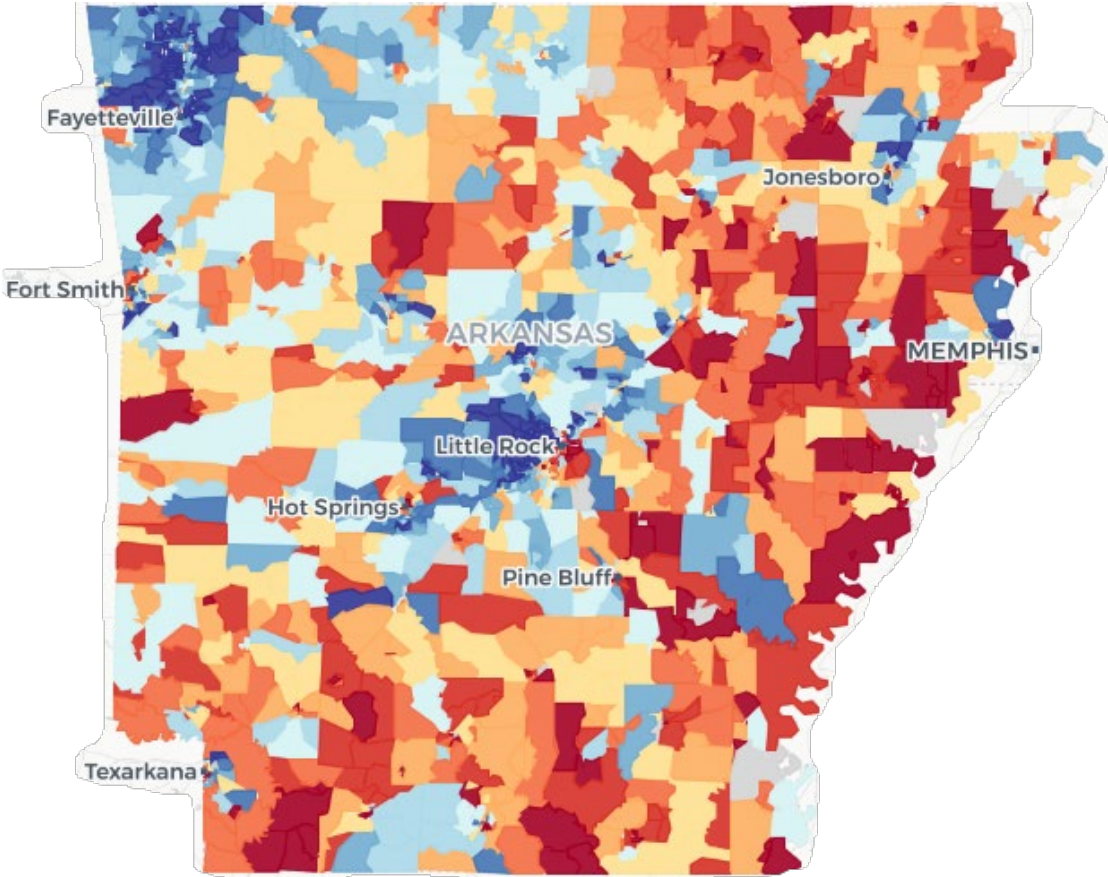
What do the ADI values mean?

The ADIs on this website are provided in national percentile rankings at the block group level from 1 to 100. The percentiles are constructed by ranking the ADI from low to high for the nation and grouping the block groups/neighborhoods into bins corresponding to each 1% range of the ADI. Group 1 is the lowest ADI and group 100 is the highest ADI. A block group with a ranking of 1 indicates the lowest level of "disadvantage" within the nation and an ADI with a ranking of 100 indicates the highest level of "disadvantage".

Similarly, ADIs are also available in deciles from 1 to 10 for each individual state. The state deciles are constructed by ranking the ADI from low to high for each state alone without consideration of national ADIs. Again, group 1 is the lowest ADI (least disadvantaged) and 10 is the highest ADI (most disadvantaged).

Area Deprivation Index (ADI)

Map of Area Deprivation Index



Arkansas

State-Only Deciles

National Percentiles

ADI scores from within this state alone are ranked from lowest to highest, then divided into deciles (1–10).

least disadvantaged block groups – most disadvantaged block groups

1 2 3 4 5 6 7 8 9 10

Members and Claims by ADI

Active and Non-Medicare Retiree

Further Data Analysis of ADI showed:

- Most diabetics, 58%, reside in moderately disadvantaged areas. However, the most disadvantaged areas have the highest diabetes prevalence for the Plan at **10.4%**
- Obesity prevalence is also the highest in the most disadvantaged areas, at **21.7%**
- The breakdown of key utilization metrics showed that **high-cost treatment** settings, e.g. hospital inpatient and emergency room, is the **highest for the most disadvantaged members** (ADI 8-10).
- On the other hand, low-cost treatment settings, e.g. urgent care and telehealth, are the lowest for most disadvantaged members.
- **Preventive visits** were also the **lowest for the most disadvantaged group**.

Nutrition and Lifestyle Management

Medical Nutrition Therapy (MNT)

Cost Effectiveness and Reduction in Risk Factors

Medical Nutrition Therapy (MNT) proves to be cost effective by providing alternatives to more costly therapies. Studies show only one in ten adults meet the recommendations of the U.S. Dietary Guidelines for Americans (DGA) for fruits and vegetables while fewer than 10 percent met the guidelines for whole grains.



MNT provides the following interventions:

Reduces risk of chronic diseases, delays disease progression, and enhances efficacy of medical/surgical treatment

Reduces medication use and improves patient outcomes including quality of life

Continuous usage of MNT services positively impacts weight, blood pressure, blood lipids, and blood sugar control, which are some of the leading risk factors for cardiovascular disease and stroke

American Heart Association conducted a systematic review on the cost-effectiveness and economic savings of MNT in dyslipidemia reported improved quality-adjusted life years (+0.75 to +0.78) and reduced medication use for a cost saving of an additional \$818 per patient per year

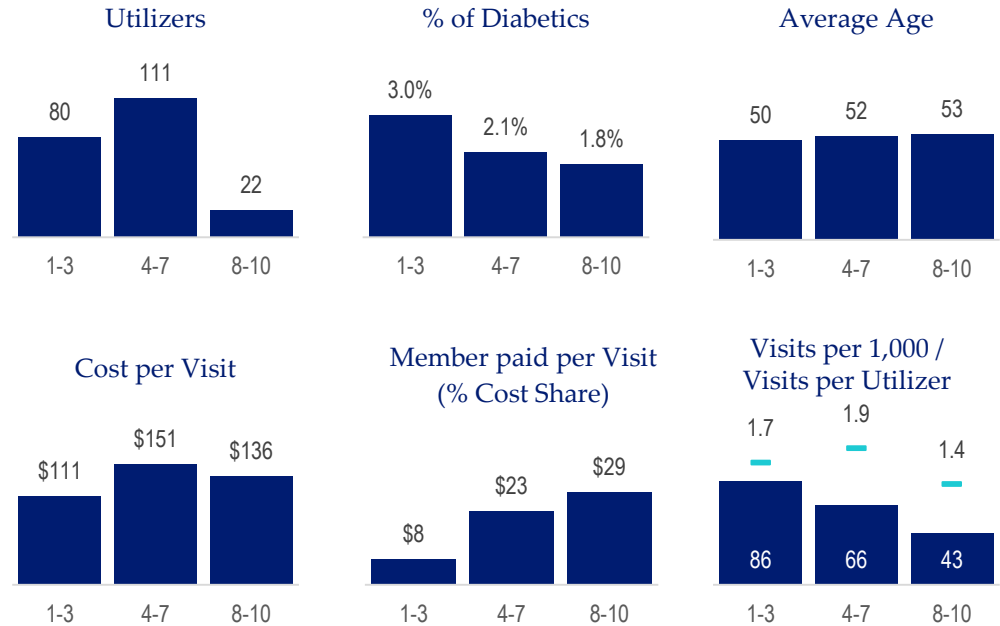
Reduction in hospital readmissions

Medical Nutrition Therapy

Active and Non-Medicare Retiree

Area Deprivation Index (ADI) Levels¹

| Categories | Least Disadvantaged (1-3) | Moderately Disadvantaged (4-7) | Most Disadvantaged (8-10) |
|-----------------------|---------------------------|--------------------------------|---------------------------|
| Utilizers | 140 | 201 | 36 |
| Average Age | 51 | 52 | 54 |
| % of Diabetics | 5.3% | 3.8% | 3.0% |
| Cost per Visit | \$126 | \$145 | \$119 |
| Member Paid per Visit | \$10 | \$21 | \$25 |
| % Cost Share | 7.8% | 14.3% | 21.4% |
| Visits per Utilizer | 1.6 | 1.7 | 1.4 |



Observations

- In CY 2022, 4.1% of diabetics had at least one medical nutrition therapy visits. The cost per visit was about \$136, of which \$17, or 13%, was paid by the member.
- Diabetics in the most disadvantaged areas are the least utilizer of medical nutrition therapy services.

¹ Refer to page 5 and 6 on Area Deprivation Index (ADI)

² Reflects adults only with valid BMI value (92% of Utilizers). Excludes adolescents (age < 18) and members with no BMI value

Obesity

Obesity

Active and Non-Medicare Retiree

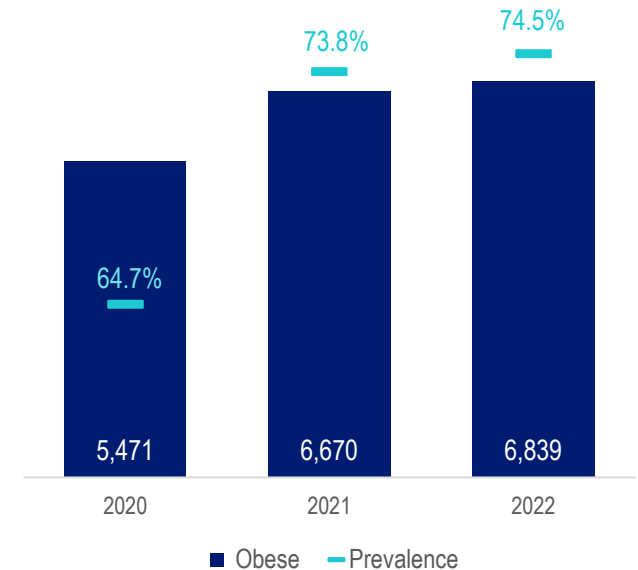
Obese Diabetics

| Calendar Year | Members | % of Diabetics | % MNT ¹ Utilizers | Medical & Rx PMPM | Relative Cost ² | Medical Cost | Rx Cost | Rx Cost (AOM ³ Only) |
|---------------|---------|----------------|------------------------------|-------------------|----------------------------|--------------|--------------|---------------------------------|
| 2020 | 5,471 | 64.7% | 6.7% | \$989 | 2.5x | \$44,296,876 | \$20,081,374 | \$0 |
| 2021 | 6,670 | 73.8% | 5.2% | \$950 | 2.2x | \$48,216,820 | \$27,001,206 | \$0 |
| 2022 | 6,839 | 74.5% | 4.6% | \$990 | 2.4x | \$44,606,394 | \$35,843,590 | \$0 |

CY 2021: Obese Diabetics

| Obesity Class ⁴ | Members | % of Total | Medical & Rx PMPM | Relative Cost ⁵ |
|----------------------------|--------------|------------|-------------------|----------------------------|
| Class 1 | 2,174 | 31.8% | \$976 | 1.0x |
| Class 2 | 1,966 | 28.7% | \$935 | 0.9x |
| Class 3 | 2,527 | 36.9% | \$940 | 0.9x |
| Unknown | 3 | 0.0% | \$220 | 0.2x |
| Total | 6,670 | | \$950 | |

Historical Obesity Prevalence



Observations

- In CY 2022, 74.5% of diabetics were also classified as obese. 4.6% of obese diabetics had at least one medical nutrition therapy during the same time period.
- The prevalence of obesity within the diabetic population has increased over the past 3 year.
- The bottom table breaks down the CY 2021 diabetics by class. While class 3, the morbidly obese class, had the highest percentage of obese diabetics (about 37%), the cost comparison – on a PMPM basis – was almost identical for all classes.

¹ MNT means medical nutrition therapy.

² Relative cost compares the PMPM of obese diabetic to the PMPM of the overall population.

³ AOM: anti-obesity medication

⁴ Class 1: BMI 30-34, Class 2: BMI 35-39, Class 3: BMI 40+.

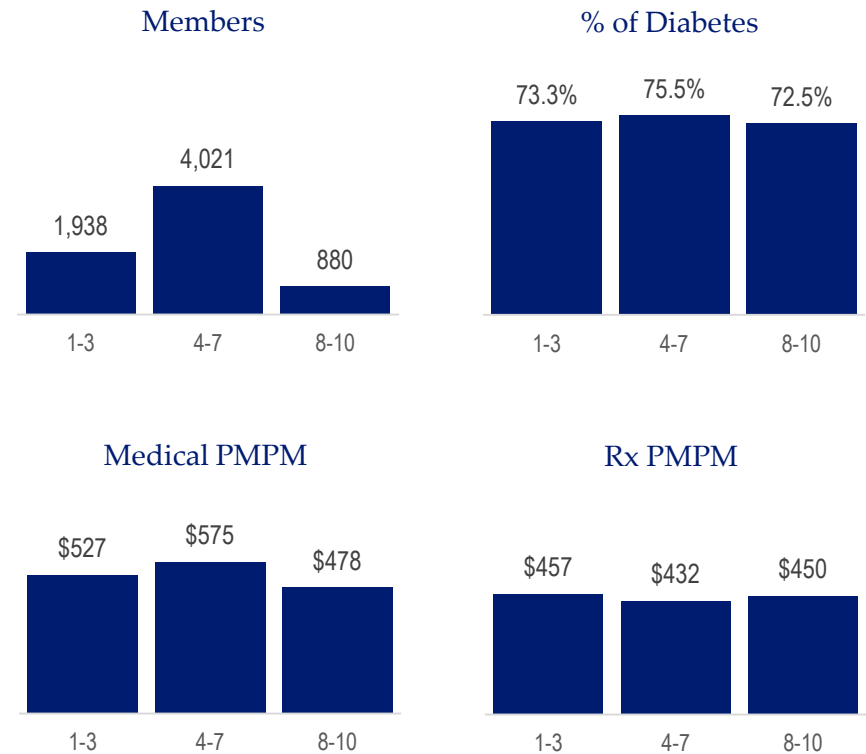
⁵ Relative cost compares the PMPM of specified class to the PMPM of obese diabetics in CY 2022.

Obesity

Active and Non-Medicare Retiree

CY 2022: Area Deprivation Index (ADI) Level¹

| Categories | Least Disadvantaged (1-3) | Moderately Disadvantaged (4-7) | Most Disadvantaged (8-10) |
|-------------------------|---------------------------|--------------------------------|---------------------------|
| Membership | | | |
| Members | 1,938 | 4,021 | 880 |
| % of Total | 28% | 59% | 13% |
| % of Diabetics | 73.3% | 75.5% | 72.5% |
| Claim Experience | | | |
| Medical PMPM | \$527 | \$575 | \$478 |
| Rx PMPM | \$457 | \$432 | \$450 |
| Total PMPM | \$985 | \$1,007 | \$928 |



Observations

- Most obese diabetics, 59%, reside in moderately disadvantaged areas, they also have the highest obesity prevalence for the Plan diabetics at 75.5%.
- Medical and Rx cost, on a PMPM basis, are comparable between ADI groups.

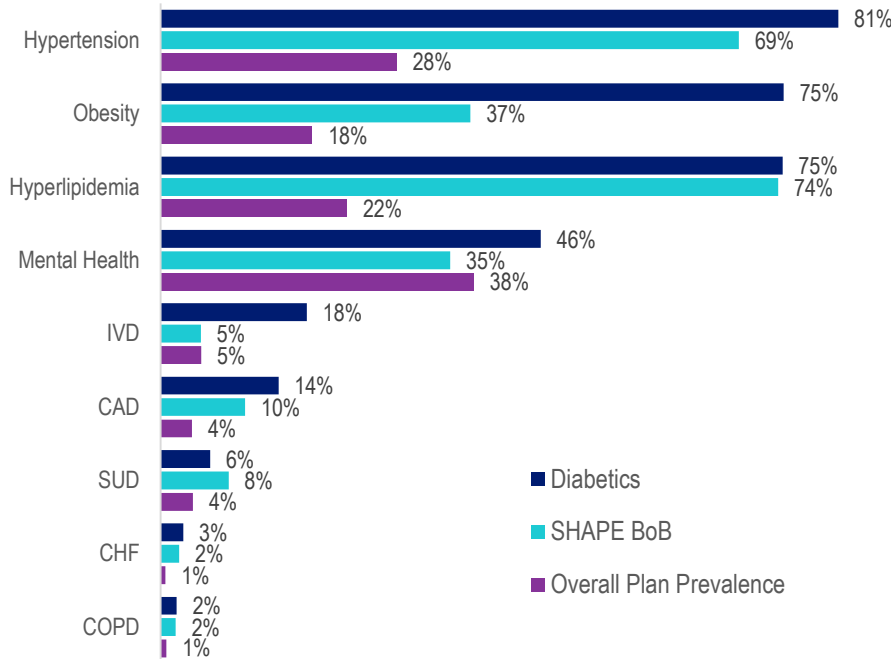
¹ Refer to pages 5-6 for more details on Area Deprivation Index (ADI).

Comorbidities

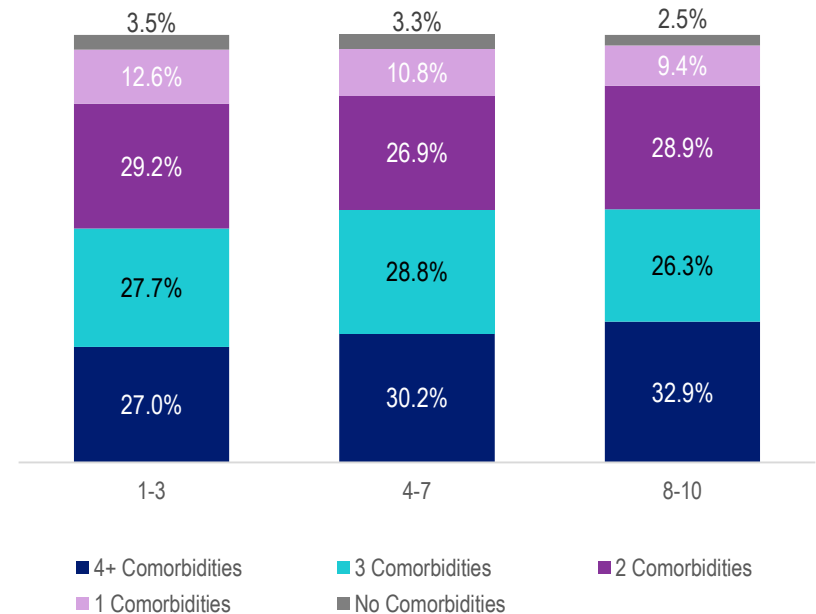
Comorbidities

Active and Non-Medicare Retiree

Diabetic Comorbidities



Diabetic Comorbidity Distribution (by ADI³)



Observations

- The top left chart reflects the prevalence of comorbid conditions of diabetics¹, compared to the SHAPE² BoB and overall Plan prevalence.
- At 81%, hypertension was the top diabetes comorbid condition, followed by hyperlipidemia at 75%. Obesity was the third highest comorbid condition at 74%. Note: SHAPE BoB comorbid prevalence of obesity is significantly lower due to lack of proper coding of BMI diagnosis.
- The top right chart illustrates the distribution of comorbidity by ADI. 27% of diabetics had 4 or more comorbidities in the 1-3 ADI band, compared to about 33% in the 8-10 ADI Band.

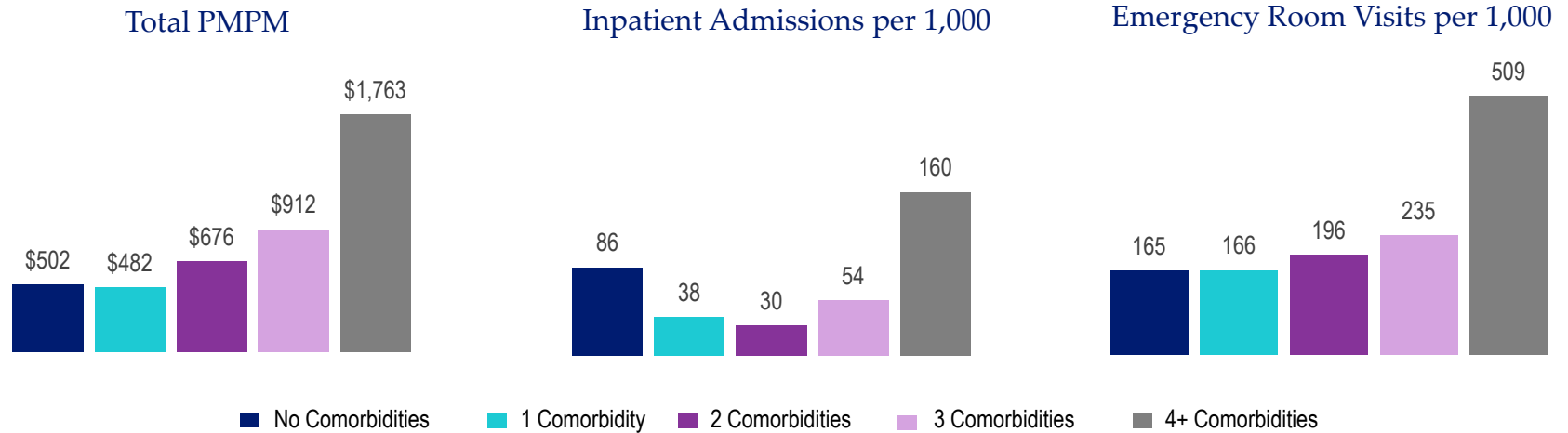
1. Type I diabetics are excluded from this analysis. Reflects CY 2022 claims experience.

2. SHAPE is Segal's internal data warehouse. Benchmarks are based on calendar year 2021 claims experience for 2.3M lives.

3. Area Deprivation Index (ADI). Refer to pages 5-6 for more details.

Cost and Utilization by Comorbidities¹

Active and Non-Medicare Retiree



Observations

- The above charts breakdown total PMPM, inpatient admissions, and emergency room (“ER”) visits by the number of comorbidities.
- Diabetics with 4 or more comorbidities have the highest PMPM, mainly driven by higher inpatient and ER utilization.
- The middle chart shows that diabetics with no comorbidity have the second highest rate of inpatient admissions, however they seem to be of lower severity since the overall PMPM for that cohort is still the lowest of all other cohorts.
- The next page looks at specific comorbidities of diabetics and compares cost, utilization, and compliance rates.

¹ Comorbidities reflect conditions listed in the top left chart on page 2.
Note: Type I diabetics are excluded from this analysis. Reflects CY 2022 claims experience.

Mental Health

Mental Health

Active and Non-Medicare Retiree

| CY 2022 | | | Medical | | Pharmacy | | Total | |
|---|-----------------------|---------------------------|--------------|-------------------------------|--------------|-------------------------------|--------------|-------------------------------|
| Diabetic ¹ Cohort | % of All Diabetics | % of All Non-Diabetics | PMPM Cost | Relative Cost ² | PMPM Cost | Relative Cost ² | PMPM Cost | Relative Cost ² |
| No mental health condition | 53.2% | 61.5% | \$544 | 0.9 | \$381 | 0.9 | \$925 | 0.9 |
| Any mental health condition | 46.8% | 38.5% | \$710 | 1.1 | \$466 | 1.1 | \$1,176 | 1.1 |
| Sleep | 24.3% | 8.6% | \$878 | 1.4 | \$577 | 1.4 | \$1,454 | 1.4 |
| Anxiety | 12.4% | 14.1% | \$741 | 1.2 | \$396 | 0.9 | \$1,137 | 1.1 |
| Depression | 10.4% | 8.7% | \$730 | 1.2 | \$477 | 1.1 | \$1,207 | 1.2 |
| Psychotic disorders | 0.3% | 0.2% | \$2,265 | 3.6 | \$661 | 1.6 | \$2,926 | 2.8 |
| Any substance use disorder ³ | 0.6% | 0.5% | \$893 | 1.4 | \$632 | 1.5 | \$1,525 | 1.5 |
| Alcohol use disorder | 0.3% | 0.3% | \$623 | 1.0 | \$355 | 0.8 | \$978 | 0.9 |
| Opioid use disorder | 0.3% | 0.2% | \$1,133 | 1.8 | \$879 | 2.1 | \$2,012 | 1.9 |

Observations

- In CY 2022, 53.2% of diabetics had no mental health condition, while 46.8% had at least one mental health condition. This compared to 61.5% and 38.5% for the non-diabetic members, respectively.
- Sleep disorder is the most prevalent mental health condition for diabetics, followed by anxiety. Diabetics with sleep disorders are 1.4 times costlier, on a PMPM basis, than the average PMPM of all diabetics.

¹ Type I diabetics are excluded from this analysis. Reflects CY 2022 claims experience

² Relative cost compares the PMPM of specified cohort to the PMPM of all diabetics in CY 2022

³ Excludes members with tobacco use disorders

Mental Health and Pre-Diabetes

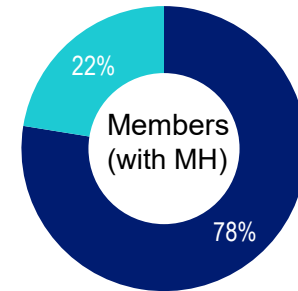
Active and Non-Medicare Retiree

| CY 2022 | Neither Pre-Diabetics, Nor Diabetics | Pre-Diabetics | Diabetics ¹ |
|--------------------------------|--|---------------|------------------------|
| Members | 112,109 | 3,753 | 9,177 |
| % of Members | 90% | 3% | 7% |
| Medical Allowed PMPM | \$283 | \$494 | \$622 |
| Rx Allowed PMPM | \$94 | \$176 | \$421 |
| Total PMPM | \$378 | \$670 | \$1,043 |
| Relative Cost ² | 0.8 | 1.5 | 2.3 |
| Inpatient Admissions Per 1,000 | 53 | 59 | 78 |
| ER Visits Per 1,000 | 207 | 316 | 297 |

Observations

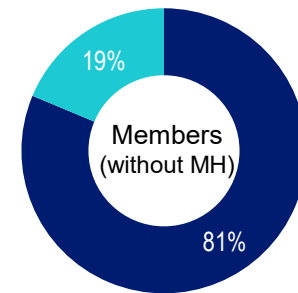
- 3% of Plan participants were identified as pre-diabetics. The top right chart shows that 22% of pre-diabetics with mental health (“MH”) as a comorbidity become diabetics. On the other hand, 19% of pre-diabetics become diabetics with the absence of MH comorbidity.
- Pre-diabetics, on a PMPM basis, are 1.5 times costlier when compared to the PMPM of all Plan participants; diabetics are 2.3 times costlier.

Historical Pre-Diabetes Progression



■ % Remain Pre-Diabetic ■ % Become Diabetic

Historical Pre-Diabetes Progression



■ % Remain Pre-Diabetic ■ % Become Diabetic

¹ Type I diabetics are excluded from this analysis. Reflects CY 2022 claims experience

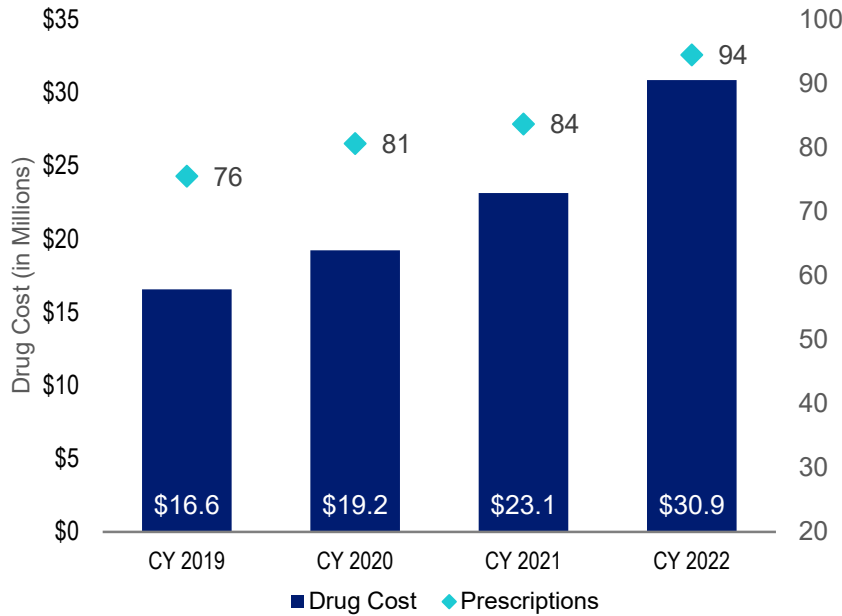
² Relative cost compares the PMPM of specified cohort to the Plan PMPM in CY 2022

Diabetes Medications

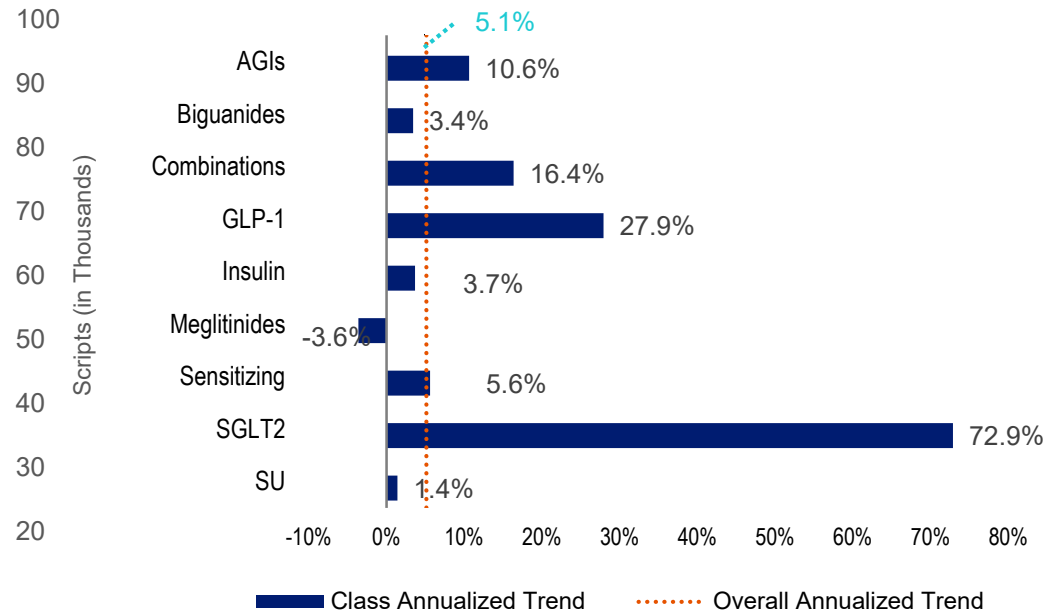
Diabetes Medications

Actives and Non-Medicare Retirees

Drug Cost and Utilization



4-Year Trend of Utilizers by Diabetes Class

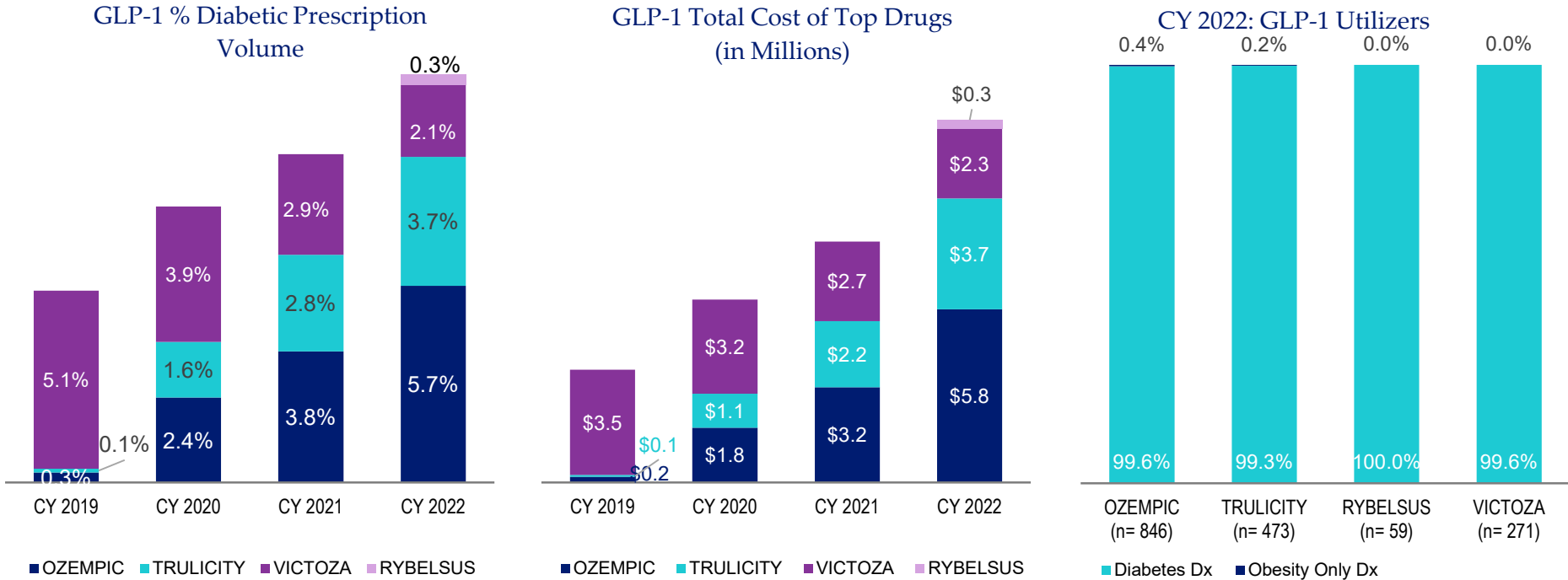


Observations

- Diabetic medication spend, on a PMPM basis, has increased at an annual rate of 21.5% from CY 2019 to CY 2022, while dispensed medications, on a per 1,000 basis, increased at a rate of 6.4% during the same period.
 - The rate of increase in pharmacy total spend, scripts per 1,000, and pharmacy PMPM for diabetic medications have all increased year-over-year during this time
- Biguanides (metformin), traditionally considered first-line therapy, have increased at a rate of 3.4% over the 4-year period, below the overall rate of 5.1%, while SGLT2 and GLP-1 products have increased at an annual rate of 72.9% and 27.9% respectively. Refer to appendix for definitions of the diabetes classes.

Diabetes Medications (GLP-1)

Actives and Non-Medicare Retirees



Observations

- Ozempic, Trulicity, Victoza, and Rybelsus comprise the list of drugs dispensed within the GLP-1 class (additional medications in the class were added to the formulary effective 10/1/2023).
- Ozempic has seen the highest change in dispensed volume share, increasing from 0.3% of all diabetic medications dispensed 4 years ago to 5.7% in CY 2022.
- The top right chart outlines historical medical diagnoses of current period utilizers for these medications – as with SGLT2s, there is little concern of off-label utilization
 - 843 (or 99.6%) of the 846 Ozempic utilizers in the CY 2022 had a history of diabetes. Only 3 utilizers had a history of obesity in absence of a diabetes diagnosis.

Diabetes Dx means that utilizer had history of diabetes medical diagnosis
 Obesity Only means that utilizer had history of obesity medical diagnosis and no history of a diabetes diagnosis
 NA means that there was no adequate history to assess historical diagnosis. This would include new members joining the Fund.

State of AR Current Vendors

Blue Cross Program Components

| | |
|--|---|
| <p>Identification and Stratification</p> | <p>Program utilizes AI driven cohorts to predict members who are in the top 10% emerging high cost and complex chronic conditions</p> <p>For complex chronic condition management, cohort identification consists of members who are in the top 20% driven by cost, members with > 4 high-cost claims, polypharmacy >6 prescriptions filled monthly, and the use of more than one pharmacy</p> |
| <p>Outreach</p> | <p>Outreach methods through phone, digital (ArkBlueConnect) APP and in written form (email and regular mail)</p> |
| <p>Gaps in Care</p> | <p>Identify and close gaps including preventive care gaps such as mammogram and colonoscopy gaps</p> <p>Gaps manages thirty conditions and focuses on the six chronic conditions of congestive heart failure, chronic obstructive pulmonary disease, coronary artery disease, asthma, diabetes, and renal</p> <p>Address medication adherence and perform medication reconciliations</p> <p>Contact with members is telephonic, digital, and written (email and regular mail)</p> |
| <p>Education</p> | <p>Self-education topics include understanding diabetes and diabetes treatment, healthy eating, medication adherence, checking their blood sugars, risk reduction for other health problems, and coping with stress, depression, and other concerns</p> |
| <p>Goals</p> | <p>Diabetic self-management to lower A1C levels, prevent or reduce complications of diabetes, improve quality of life, and lower medical expenses</p> |
| <p>Team</p> | <p>Multidisciplinary team of Registered Nurses, a Certified Diabetic Educator, a Registered Dietician, Licensed Clinical Social Workers, Behavioral Health case managers, Medical Directors, Pharmacy Benefit Managers, and internal pharmacists.</p> |
| <p>Partnerships</p> | <p>Onduo</p> <p>Virta Health</p> <p>Strive Health</p> |

Navitus Program Components

Pharma Coadherence Program

- Identifies and measures outcomes for nonadherent members with diabetes
- Targets members with a Proportion of Days Covered (PDC) for diabetes medical (excludes insulin) of less than 0.80
- Mails intervention letters to members and their prescribers

Concurrent Drug UR

- Point of sale alerts based on clinical severity
- Checks members prescriptions against active and historical medications for potential conflicts
- Diabetes-focused drug-drug interactions
 - Combinations with increased risk of low or high blood sugar
 - Combinations with increased or decreased adverse effects
- Interactions that cause liver, heart or kidney damage
- Therapeutic duplication of diabetes medication
 - Identify claims for medications in the same drug class
 - Duplication of diabetes medication can increase risk of low blood sugar and adverse effects

Retrospective Drug UR

Duplicate Therapy Intervention

- Identifies members using multiple drugs in the same therapeutic class consistently during the last four months
- Duplicate therapy has the potential for additive toxicity or adverse effects, and may cause therapeutic redundancy without increased benefit to the patient
- Simplifying the member's drug regimen to one drug may save the member money and lead to better adherence
- GLP-1 receptor antagonists and DPP-4 inhibitors
 - Drug classes used to treat Type 2 diabetes
 - Both work the same way in the body

Reporting

- Identifies members with newly prescribed diabetes medication and who are filling a diabetes medication for the first time
- Enables clinical staff to perform outreach and case management for identified members

Partnerships

Virta Health

Recommendations and Next Steps

Obesity Causes and Risks

Causes/Triggers of Severe Obesity

Psychological

Social

Emotional

Metabolic (Syndrome)

Genetics (New information,
and we keep learning more)

High Risks of:

Hypertension

Diabetes

Infertility

Joint stress

Sleep apnea

Gallstones

Coronary Artery
Disease (CAD)

Infertility

Varicose veins

Gout

Deep vein thrombosis
(DVT)

Degenerative arthritis/
osteoarthritis

Inventory of Options

Wellness programs

- Diet/Nutrition/healthy eating
- Exercise/physical activity/fitness
- Behavior change
(through counseling/support groups)
- Lifestyle coaching programs
- Lifestyle electronic devices
to monitor health
- Alternative medicine/therapies

Disease management programs

- Self-care coaching for obesity
- Pre-diabetic and diabetes
DM programs
- Digital therapeutics

Step therapy approach to combat Obesity

Prescription weight-loss meds

Vagal Nerve Blockade - Avoid

Bariatric surgery coverage

Multi-faceted Management of Diabetes

DECISION CYCLE FOR PATIENT-CENTERED GLYCEMIC MANAGEMENT IN TYPE 2 DIABETES



Top Point Solutions in Diabetes and Weight Loss

Diabetes Prevention Program Options

[Virta](#)

[Livongo](#) (also Hypertension)

[Omada](#)

[Lark](#) (also Hypertension and Behavioral)

[Solera](#) (also Behavioral)

Diabetes Options

[Virta](#)

[Livongo](#)

[Omada](#)

[TrestleTree](#)

[Onduo](#)

[Vida](#)

Weight Loss Options

[Wondr Health \(formerly Naturally Slim\)](#)
(Behavioral/Eating Skills)

[Burnalong](#) (Fitness/Physical Activity)

[TrestleTree](#) (Health Coaching Focus, AR based)

[Habitnu](#) (Community/Weight Coach)

[Noom](#) (Diet & Chronic Cond. Coaching)

[Burner](#) (Community/Point for Activities)

[Wellable](#) (Challenges/Healthy Activities)

[Vida](#) (Mental/Condition/Lifestyle Health)

[Strive](#) (Community/Fitness/Activities)

[WW](#) (formerly WeightWatchers) (Diet/Coaching)

This is not a complete list.
There are many more point solutions in Diabetes and Weight Loss.

More on Point Solutions

- All of them are actively engaged in managing the GLP-1 class of drugs and include a variety of interventions, such as: 1:1 health coaching, physician lead management, educational resources, nutrition counseling, behavioral counseling, connected devices (weight scale, glucometer, etc.), 24x7 monitoring and support
- All Point Solutions charge as PPM: Per Participant Per Month, so the State only pays for those engaged.
- All have provided Performance Guarantees (PGs)
- Vendor reported ROI approx. 2 : 1
- Some vendor reported outcomes:

| | |
|-----------------------|---|
| Diabetes | 69% of at-risk individuals reduced their HbA1c from 8.8% to 7.2% |
| Blood Pressure | 74% of at-risk participants lowered blood pressure from an average of 149/92 mmHg to 128/78 mmHg |
| Cholesterol | 78% of at-risk participants reduced cholesterol from an average of 272 mg/dl to 210 mg/dl |
| Tobacco | 53% 6-month quit rate and 41% 12-month quit rate using the Intent-to-Treat methodology, with an average weight loss of 0.9 lbs. per participant |
| Weight* | 58% of participants with a BMI \geq 30 lost an average of 13.4 pounds |

* Weight loss outcomes for all participants \geq 30 BMI without Anti-Obesity Medication

Next Steps

1. Segal recommends the Plan implement a diabetic program that includes:
 - Mental health and other comorbidity monitoring and treatment integrated within the diabetic treatment module
 - Claims integration to facilitate identification of high-risk individuals for proactive outreach
 - Control over GLP-1 drug costs
 - Performance guarantees that address proactive outreach process measures in addition to outcomes measures for mental health and other comorbidities
2. Conduct a competitive bid (Request for Proposal)
3. Compare vendor fees; consider whether the vendor offers credits or allowances to offset its cost. Negotiate competitive vendor contracts that include performance guarantees.
4. Compliance considerations: MHPAEA, HSA/HDHPs, wellness rules, ERISA, etc.
5. Manage rollout and member engagement communications, which are important because the learning curve can be steep as participants adjust to the new user experience.
6. Measure the actuarial-driven ROI periodically.



Appendix

Abbreviations for Diabetic Classes

| Medication Class | Abbreviation | Typical Medication Use Case | Examples |
|--|--------------|---|--|
| Alpha-Glucosidase Inhibitors | AGIs | Inhibit the absorption of carbohydrates from the small intestine | Acarbose (Precose), Miglitol (Glyset) |
| Antidiabetic - Amylin Analogs | Amylin | Injected medicine for people with type 1 and type 2 diabetes that helps control blood sugar levels after eating | Pramlintide (Symlin) |
| Antidiabetic Combinations | Combinations | Medicines with two or more classes of antidiabetic agents (with different mechanisms of action) in one pill or dose | Sitagliptin/Metformin (Janumet), Insulin glargine/Lixisenatide (Soliqua) |
| Biguanides | Biguanides | Oral diabetes medication that helps lower blood sugar levels for people with Type 2 diabetes | Metformin |
| Diabetic Other | Other | Other diabetic medication such as glucose tablets. | Glucose tablets |
| Diabetic Supplies | Supplies | Supplies such as needles and test strips. | Needles, lancets |
| Dipeptidyl Peptidase-4 (DPP-4) Inhibitors | DPP-4 | Used with diet and exercise to control high blood sugar in adults with type 2 diabetes | Linagliptin (Tradjenta), Sitagliptin (Januvia) |
| Dopamine Receptor Agonists - Antidiabetic | Dopamine | Used with diet and exercise to improve glycemic control in adults with type 2 diabetes | Bromocriptine (Cycloset) |
| Incretin Mimetic Agents (GLP-1 Receptor Agonists) | GLP-1 | Used to treat type 2 diabetes mellitus and, in some cases, obesity | Dulaglutide (Trulicity), Semaglutide (Ozempic) |
| Insulin Sensitizing Agents | Sensitizing | Work to lower blood sugar by increasing the muscle, fat and liver's sensitivity to insulin | Pioglitazone (Actos) |
| Insulin | Insulin | Controls blood glucose levels | Inulin aspart (Novolog), Insulin glargine (Lantus) |
| Meglitinide Analogues | Meglitinides | Increases insulin secretion; in particular, during the early phase of insulin release | Nateglinide (Starlix), Repaglinide (Prandin) |
| Sodium-Glucose Co-Transporter 2 (SGLT2) Inhibitors | SGLT2 | Used to lower blood sugar in adults with type 2 diabetes | Canagliflozin (Invokana), Empagliflozin (Jardiance) |
| Sulfonylureas | SU | Older class of oral antidiabetic medication that is rarely used nowadays | Glimepiride, Glyburide |

A word about privacy

- Data presented has been “de-identified”, which means it does not contain names or SSNs, etc.
- Specific medical conditions are identified.
- If the plan administrator knows the identity of individuals with a specific condition, that information is considered PHI.
- PHI is subject to the HIPAA Privacy Rule’s protections, which means it must be kept confidential and cannot be used for any reason other than health plan administration (e.g., using it for employment purposes, or by other benefit plans, is prohibited).