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How Significantly Can Health Care Costs Really Be Impacted with Today's Approaches to Disease Management?

by John E. Ragan

Recently I have been reviewing programs related to the treatment of health plan members with various illnesses or diseases. Examples include Disease Management (DM) programs for handling members with diabetes, chronic obstructive pulmonary disease, coronary artery disease, end-stage renal disease, cancer and congestive heart failure, to name a few. Other programs are also being reviewed to handle services instead of particular illnesses. They include services such as for emergency room, radiology, prescription drug and mental health.

All of these programs attempt to reduce the payout that would otherwise result if they were not initiated. If the program works well, then it can very well control the costs of a particular member or service. Some of the major problems, however, revolve around the fact that even if it does work, there are issues related to overlap or co-morbidity. Overlap occurs when more than one program applies to a member with a given disease, and co-morbidity becomes an issue when a member has more than one disease for which there is a DM program.

Overlap would occur, for example, if you develop a provider contracting initiative and a prescription drug initiative to reduce facility and drug costs, while at the same time cover diabetics under a specific DM initiative where an outside vendor was hired to manage the diabetic member's total claims costs. If the total risk pool of diabetic members had a claim PMPM that was reduced 10% in a year's time, one would have to be careful not to credit the vendor with the full savings. This is because some of the PMPM reduction directly resulted from reduced unit costs for facility and drug claims of those members. Co-morbidity would be an issue when you have a member covered under a coronary artery disease program who is also a diabetic (and therefore eligible for the diabetic program also). As a result of this overlap and co-morbidity, projected savings of the DM programs are often double-counted and their true effectiveness is overstated. This makes it even more difficult in determining whether or not the DM program makes sense on a financial basis.

There are also issues related to incorporating these programs into a healthcare environment where health coverage is predominantly provided by employer groups and where providers are used to treating patients without oversight of an outside vendor. Many employer groups are not willing to pay for these programs unless they are guaranteed significant savings from them. Some expect this to be part of the normal course of providing managed care benefits to employees. It is easier to justify paying for treatment provided to an employee than it is to pay a vendor's fee with the hopes of avoiding the utilization of care. On the provider side, some physicians resent another party recommending how to handle their patients. Plus, often the patient gets confused as to who is managing their health: the doctor, the insurer or the vendor.

Even if the above situations can be worked out so as to not over- or under-credit a particular program as to what its impact was on claims cost of a member or service, there is a more significant problem we must address. It is related to the fact that more people are overweight, lack proper exercise and are exposed to significant levels of stress. A recent study by the American Medical Association stated that in the last 10 years, Americans went from 1 out of every 8 persons being obese to roughly 3 out of every 8. Also, we are encountering more cases related to mental illnesses, whether this is because of increased stress, lack of a family support group or just having better methods to appropriately diagnose mental illness. Thus, we would be foolish in thinking that health care costs and trend rates will be lower in the near or even distant future.

In the future, we will be forced to deal with a much higher incidence rate of the more severe types of illnesses, which have a high price tag associated with them. New forms of treatment and technology also contribute to higher claim trends. The problem is that we are "mopping up the messes" instead of stopping the incident in the first place. We offer few programs that attempts to do this. The Dr. Dean Ornish program, which focuses on members with coronary problems, is one type of program that may help reduce the incidence rates of some major heart-related illnesses.

This program incorporates proper diet, exercise and mental wellness into one program. It only makes sense that these types of preventative measures would help reduce future claim costs as compared to an existing disease management program that handles a member after they had a major episode of care.

In contrast to an after-the-fact DM program, preventive measures such as the Dr. Ornish program can significantly reduce or eliminate the impact of a major illness. Often a DM program reduces claim cost temporarily only to see even higher claims incurred a year or two later, especially if an unhealthy person is kept alive from year to year. They are bound to incur significant health care costs as time goes on.

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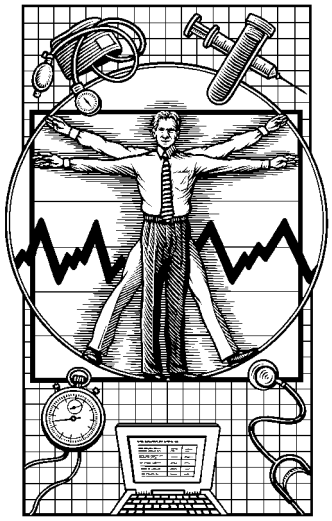
Consider this example of taking care of an automobile. If you wash and wax it and change the oil, filters, and spark plugs, you are likely to get more trouble-free years out of it as compared to if you neglect these items. Once a car gets rust spots, they always come back no matter how well you think they were touched up. Also, the engine won't last as long if the oil and filters are not changed. Of course, there are always exceptions to any case.

A similar philosophy should be used with health care. Although, that is easier said than done because of today's short-term needs of insurers, employers and members. An insurer cares more about its claims costs today and is less inclined to pay for preventive measures when a member may be under a competing insurer's product in the future. A good example is that many insurers will not cover a $10 flu shot, but will pay for a $45 office visit and $30 for prescriptions once a member does get sick. Many employers won't offer the flu shot as part of their benefit package but must deal with the costs associated with time off from work of an employee who gets sick from the flu.

Another problem is many members feel they can do whatever they want to their bodies now but they better not be denied top-notch health care if they need it in the future. It would take tremendous changes in the health care environment to alter this type of thinking on the member, employer and insurer's part. It would also be difficult from a provider standpoint because they receive higher income the



more people become ill. Plus, hospitals have the incentive to fill their beds and would have a hard time covering their expenses if they saw fewer patients coming through their doors because of the incidence rate of a major disease being cut in half.

Unless members take more responsibility for their own health, especially through their lifestyle choices, and unless insurers, HMOs, and healthcare providers focus more on long-term outcomes, disease management programs will be ineffective at lowering overall healthcare costs or trend rates. Instead, these programs will be needed just to control trend rates from going even higher.

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