

Complex Chronic Illness: An Essential Target in Health Cost Management

Corporate America continues its battle with rising medical costs. In 2008, the average annual cost for family medical coverage in the United States surpassed an astonishing \$12,500. Between 2002 and 2007, plan sponsors experienced a 78-percent increase in cumulative health-insurance premiums while inflation and wages grew by 17 percent and 19 percent, respectively (Kaiser Family Foundation/HRET and KPMG 2008). The rapid growth in health-care costs has caused many plan sponsors to respond on two fronts: to pass steep premium contribution increases on to employees and to revise plan designs to shift more out-of-pocket costs to patients.

THE HEALTH-CARE LANDSCAPE AND CHRONIC ILLNESS

While cost shifting to employees has moderated medical trends for employers in the short term, it is not a permanent — or sustainable — solution to the challenge of increasing costs. Employees rebel at increases in medical plan contributions that may negate wage increases. At the same time, the difficult economic times make it impossible for employers to have an open checkbook for medical expenses.



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The only effective long-term solution for plan sponsors is to address the root causes of medical cost increases. While much attention is devoted to identifying at-risk populations and promoting wellness, most health-care experts concur that achieving the goal of quantifiable wellness solutions — both in terms of financial results and employee health outcomes — is a long-term journey. As that reality becomes even clearer, the focus has turned to chronic illness — conditions that continue indefinitely, have no known cure and require long-term treatment and monitoring such as diabetes, congestive heart failure and asthma. By addressing chronic conditions, employers can manage costs in the short and long-term, improve the overall quality of life for individuals and reduce potential incidences of chronic conditions in the employee population in the future.

Focusing on Chronic Illness

These statistics underscore the size and scope of the problem:

- On average, health-care expenditures for someone with a chronic condition are four times greater than for someone without a chronic condition.
- Nearly 50 percent of Americans have a chronic medical condition.
- Approximately half of all people with a chronic condition have *multiple chronic conditions*.
- Annual medical plan spending, on average, is 15 times greater for someone with five or more chronic conditions than for someone without chronic illness (Anderson 2007).

Chronic Illness Increasing at Alarming Rates

The prevalence of chronic illness among the workforce has grown at an alarming speed. Poor health habits and the resultant spike in chronic illness account for more than 50 percent of national health-care expenditures during the past 15 years (Thorpe 2005).

In addition, the prevalence of multiple chronic conditions increases with age. Figure 1 shows that among 45- to 64-year-old workers, 68 percent have at least one chronic condition and 42 percent have two or more. This multiple condition cohort is responsible for most medical expenditures and should be an important target for employer cost-management activities.

Financial Impact of Chronic Illness

Sixty-five percent of private health insurance spending in 2004 was consumed by individuals with two or more chronic conditions. Expenditures for someone with a chronic condition are four times greater than for someone without a chronic condition, and spending is 15 times greater for someone with five or more chronic conditions (Anderson 2007). *Thus, to have an impact on medical costs, employers must address chronic illness among their employee populations.*

■ **The hidden costs of chronic illness.**

Extensive studies demonstrate the link between employee health status and worker productivity: Employers can rely on the intuitive axiom that better health leads to enhanced productivity, while poor health degrades productivity. In fact, studies have shown that the indirect costs of absence, disability and “presenteeism” can be three times that of overall medical plan costs (Loeppke, et al. 2007). We define presenteeism as reduced productivity on the job due to illness or an underlying acute or chronic medical condition. Presenteeism can manifest itself in poor time management, lack of concentration, lower quality work (defects) and poor teamwork. Fundamentally, it results in lower output per hour worked. Chronic medical conditions can significantly diminish worker productivity. Conditions such as heart disease, diabetes, depression and gastrointestinal disorders can account for 40 percent to 60 percent of annual medical and pharmacy costs. But with many employees taking these illnesses to work every day, the toll on worker productivity will exceed the direct costs.

■ **Patient safety considerations.** The complex medical system in the United States too frequently leads to poorly coordinated and disjointed medical treatment. Those with multiple chronic conditions are at the greatest risk for poor quality care as they have exceptional treatment needs and they interact with multiple medical providers. In fact, a 2002 Gallup survey found that more than 50 percent of those with serious chronic illness used three or more physicians (See Figure 2).

FIGURE 1 Older Adults Have More Chronic Conditions (Medical Expenditure Panel Survey [2004])

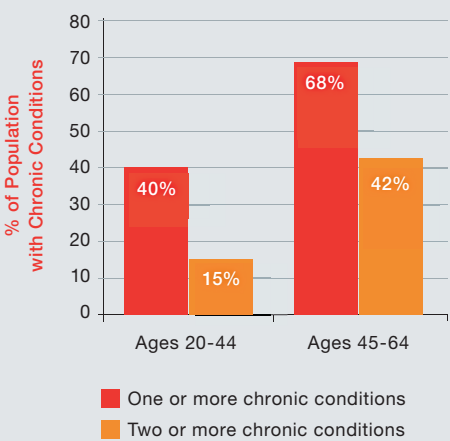
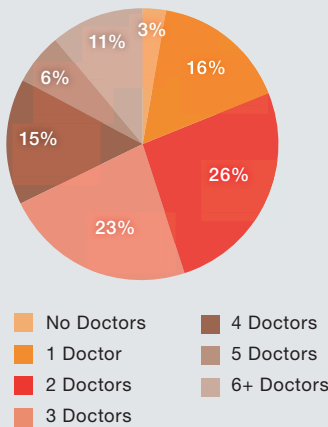


FIGURE 2 Number of Different Physicians Seen by People with Serious Chronic Conditions (Gallup 2002).



Individuals with serious chronic conditions who use multiple physicians have a greater likelihood of medical treatment complications due to inadequate coordination. Poor coordination generally leads to less effective and more costly care, and more importantly, can result in potential errors, misdiagnoses and expensive complications, as well as increased mortality and morbidity rates.

EMPLOYERS CAN JOIN THE BATTLE AGAINST CHRONIC ILLNESS

Much chronic illness can be avoided or slowed by adopting a healthy lifestyle including maintaining a healthy weight, practicing proper nutrition, avoiding smoking, exercising regularly, controlling stress and adhering to prescribed medication. Some chronic conditions, such as diabetes, may not disable an individual in the short term, but may lead to severe disabling effects if not treated early and effectively.

It costs less to maintain health, especially for those with complex chronic illness, than it does to restore health when a condition worsens (Edington 2009). Comprehensive and convenient support services provided to individuals with complex chronic illness, such as coronary heart disease, advanced diabetes, COPD and heart failure, will avoid expensive emergency room visits, hospitalizations and extensive absences during long recovery periods for unmanaged complications. This focused, proactive, patient-centered care creates a “win-win” for all participants — the patient, plan sponsor and medical provider.

Incentives

As a result of heightened awareness about the role of unhealthy lifestyles in driving increased chronic illness and medical costs, employers have shown intense interest in finding novel ways to motivate workers and dependents to be more accountable and responsible for their health-related actions. We find the majority of employers are actively investigating, offering or expanding wellness program efforts. They understand that the success of these programs is closely linked to featuring incentives to motivate individual change. Many employers now use incentives to motivate health-behavior change.

Opinions vary on the effectiveness of incentives to drive sustained health behavior change. However, evidence indicates that some incentives motivate discrete health-behavior change, such as medication compliance, completing a health assessment, or participating in weight loss, smoking cessation, or other specific programs.

Incentives come in many forms such as cash, contributions to a health reimbursement account, flex credits, lower monthly contributions, prizes, lottery drawings and wellness credits. Experience has shown that different populations are motivated by different types of incentives.

Aon Consulting interviewed strategists and product management staff at leading health-management programs and health plans to discover the latest industry thinking about incentives. Highlights of major findings include:

- Employers should target incentives for condition management to the subgroup of chronically ill with the proper risk profiles.
- For risk-averse employers with self-funded medical plans, it may be best to let their health-plan partners design condition-management incentives to minimize exposure to possible discrimination (see “Examples of Condition Management Incentives” below).
- Incentives for condition management remain relatively uncommon today as most employers limit incentives to wellness (healthy behavior) programs.
- Value-based benefits design is the most common approach being explored by employers for condition-management engagement. For example, one national health plan’s financial incentive for diabetic condition management waives deductibles and co-payments for diabetic medications and essential screenings for those who enroll in health coaching.
- Increasingly, employers use a tiered approach for incentives with a defined financial amount earned for enrollment in a condition-management program and another financial amount received upon “graduation” from the program.
- Some employers extend incentives across all health management activities affecting healthy behavior and chronic condition management.
- Health plans and health management vendors encourage the use of “point systems” enabling individuals to amass points for complying with health-management activities; the points can then be traded for various awards.
- Increasing numbers of employers with consumer-driven health plans deposit financial awards in reimbursement accounts that may be used for current-year medical services or rolled into the next year.

A small minority of employers have implemented punitive (also known as stick) incentives, and a considerable number of employers are considering punitive incentives. Some observers view these incentives as a desperate reaction by frustrated employers who face high medical premium increases despite efforts to control costs. Some examples include increasing premiums in the following year for individuals with chronic illness who opt out of condition management support in the current year, and denying medical plan enrollment rights to adult members who fail to complete a health risk assessment.

Examples of Condition Management Incentives

Aon Consulting has advised several clients on a new approach to incentives that is predicated on the proposition that a comprehensive, low-cost health plan should not be viewed by employees as an entitlement. Rather, employees would earn the right to enroll in a health plan with lower contributions by completing a health risk assessment, enrolling in health-behavior change programs where needed and participating in condition management to address chronic illness. The lower-value plan forced on those who are not compliant with the wellness message might have higher contributions, a large deductible and/or may lack

coverage for certain services. Employees might need to earn specific amounts of “wellness credits” to qualify for the preferred plan. Following are some examples of using incentives to encourage participation in and compliance with condition management programs.

- **Risk assessment for diabetes/cardiac issues/hypertension.** An employer offered a \$25 gift card incentive to employees and spouses who participated in a risk assessment. Between 60 percent and 70 percent of eligible participants completed the risk assessment.
- **Drug co-pays waived when diabetic member joins health-care system’s diabetes management program.** An employer offers a diabetes-management program, in which members who are covered by the health plan can receive free counseling and ongoing management for their diabetes. As a result of their participation, employers waive all co-payments for drugs and supplies related to diabetes (see “Value-based Benefit Design” below).
- **Incentives for actively engaging in condition management.** Members receive a \$20 deposit in their flexible spending account (FSA) to return the initial call from the condition management supplier and answer questions for an initial assessment. Compliant members receive a \$100 deposit into their FSAs every six months. Members also receive a \$120 deposit every six months into their FSAs if they adhere to their medication.

Value-Based Benefit Design

Shifting more financial responsibility to patients for medical and prescription drug plans at point of care has meant increasing plan deductibles or co-payments to discourage unnecessary care. A famous RAND experiment revealed that higher out-of-pocket costs do reduce medical care utilization (Newhouse 1993). However, unintended consequences of cost shifting can include a decreased use of lifesaving health-care services leading to a worsening of health outcomes, especially to those with complex chronic illness.

Value-based benefit design (VBBD) is based on the understanding that employers will reap the highest value for health dollars spent if the benefit design encourages members to use scientifically proven, high-value services and supplies. Under VBBD, the traditional “one-size-fits-all” plan design is discouraged, and patients are encouraged to use services when the clinical benefits exceed the costs. In other words, VBBD tailors co-payments to the evidence-based value of specific services for targeted groups of patients. Currently, cost sharing is usually based on the expense of the service or medicine and rarely is related to its potential benefit to a patient. However, under VBBD, the patient pays less for proven, high-value treatment and is responsible for more out-of-pocket expenses for unproven or lower-value services. For example, a diabetic would have lower out of pocket costs for high value glycemic (glucose lowering) agents and medications to regulate hypertension and cholesterol, while all plan

members pay more out-of-pocket for low value services, such as routine whole body CT scans.

Experience to date with value-based benefit design shows improved patient compliance with prescribed services and medications. Patients, empowered through instructed self-management of chronic illness, have experienced lower medical costs, higher productivity and more satisfaction with the medical system.

COMMUNICATION AND EDUCATION: THE CRITICAL LINKS

For health initiatives to succeed, employees must be engaged and willingly participate in the initiative and in any resulting health-care activity. Unfortunately, merely offering an incentive will not make employees do something they otherwise would not (Hunnicuttt 2008).

Communication and education are the critical components that foster employee engagement and link program design with employee action. Research into employer-based programs that create employee health behavior change consistently identifies communication as a vital factor behind program success (National Business Group on Health 2004). Additionally, Aon research reports that 75 percent of employers indicate that communication has a very significant or significant impact on employee participation and appreciation of benefits.

The most effective communication programs draw upon best practices in information delivery and incorporate social marketing practices. Social marketing recognizes that changing behavior involves changing perceptions. For example, successful marketers understand that for consumers to purchase their product in place of a competitor's, consumers must perceive the new product as better, stronger, faster — or perceive that it will make the consumer better, stronger, faster or more appealing. Changing perception is hard and changing behavior is even harder.

Reaching Employees

It is essential, and challenging, to cut through the clutter of advertising messages and other “background noise” in the employee’s life. That noise includes 5,000 advertising messages every day, up 300 percent since the 1970s (Shaller 2005).

INFORMATION DELIVERY PRINCIPLES

Effectively delivering information to a target audience entails:

- Reaching employees
- Being understood by employees
- Having relevance to employees and creating engagement
- Clearly explaining any desired action steps and mitigating barriers
- Managing expectations around what will happen when an action is taken
- Making messages clear, honest and direct.

RESOURCES PLUS

For more information related to this paper:

www.worldatwork.org

Type in any or all of the following keywords or phrases on the search line:

- Wellness incentives
- “Condition management” incentives
- Health care cost containment.

www.worldatwork.org/bookstore

- *Managing Employee Health Care Costs: A Collection of Articles from WorldatWork*
- *Developing a Strategic Benefits Program: How-to Series for the HR Professional*
- *Benefits Compliance: An Overview for the HR Professional.*

www.worldatwork.org/education

- Health and Welfare Plans — Plan Types and Administration, Certification Course: B3
- Health and Welfare Plans — Strategic Planning and Design, Certification Course: B3A
- Benefits Outsourcing — Selecting, Contracting and Managing Service Partners, Certification Course: B12
- Strategic Communication in Total Rewards, Certification Course: T4.

Being Understood by Employees

Today’s workforce includes employees at many educational levels, some of whom may not speak the employer’s primary language as their first language. Reaching employees in a language and vocabulary they truly understand is critical. Employees must be able to understand and follow direction for plan design and incentives to be effective.

Having Relevance to Employees and Creating Engagement

Creating relevance and engagement involves building trust, letting employees know they are cared for (and not simply the means to an employer’s money-saving end) and clearly conveying the benefit a given action or decision provides to the employee (Hunnicuttt 2008).

Clearly Explaining Desired Action Steps and Mitigating Barriers

Once employees are engaged,

they must clearly understand the action(s) they are being asked to take. Barriers that make it difficult or impossible for employees to complete the action must be anticipated and addressed.

Managing Expectations Around What Will Happen When An Action Is Taken

To lay the groundwork for positive health-related interactions, communication must build trust, mitigate fear and help employees understand what to expect from a specific interaction.

Making Messages Clear, Honest and Direct

Depending on an organization’s culture, employees may be skeptical of employer motives regarding promoting wellness and managing chronic illness. That is why it is critical to develop messages that are consistent with the organization’s culture.

Each communication is an interaction with employees. With each interaction occurring repeatedly and in different combinations, each touch point is an opportunity to apply the communication principles, build and/or strengthen

the relationship with employees and support appropriate health behaviors and improved outcomes. Whether printed material (letters, newsletters, posters), electronic communication (e-mail, Web, podcasts, video), or face-to-face channels work best depends on the specific needs of the organization and the desired outcome, message being delivered, and worksite communication practices.

For example, face-to-face communication is often best suited to delivering personal and/or sensitive health information, given the importance of building trust, the emotional impact of the content and the focus on confidentiality.

Additionally, personalizing communication (where appropriate and feasible) consistently increases the impact of communication by drawing employees in, enhancing awareness and encouraging action.

CONCLUSION

The fundamental key to controlling health-care costs in the long run lies with improving the health status of workers, especially those with chronic illnesses. To make a real difference in the health of employees, senior management must be committed to improving the overall health of the employee population. An organization's leadership must be involved, in appropriate ways, in that process and held accountable for process outcomes. This is the "acid test" of how well the organization "walks the talk" of its vision and values.

The commitment, both financial and in program content and function, must be driven from, and supported by, the top of an organization for employees to truly understand the importance of managing chronic conditions. The reward is an organization that takes a fiscally responsible approach to actively manage health-care costs, and one that addresses the overarching and complex issue of presenteeism, and, ultimately, improves each person's quality of life. ■

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