It’s no secret that as a nation, the United States is becoming increasingly unhealthy. The growing incidence of chronic diseases such as obesity, diabetes, coronary artery disease (CAD) and chronic obstructive pulmonary disease (COPD) results in higher costs throughout the health care system. This makes it more challenging than ever for employers and TPAs to deliver high quality, cost-effective solutions to their member groups.

Chronic Disease: A Public Health Crisis

The Centers for Disease Control and Prevention (CDC) has called chronic disease “the public health challenge of the 21st century.” In 2005, 133 million Americans — almost 1 out of every 2 adults — had at least one chronic illness. For every 10 deaths among Americans each year, 7 of them are due to chronic diseases. That’s 70 percent.

Chronic conditions rarely occur in isolation. More often than not, one disease serves as a risk factor or pre-condition for another. Obesity, for example, has been linked to increased risk for heart disease, high blood pressure and type 2 diabetes. Diabetes, in turn, is the leading cause of kidney failure, and a major risk factor for heart disease and stroke. Treating chronic conditions individually without addressing the larger context in which they exist is ineffective from both a cost and patient outcome perspective.

Higher disease incidence drives higher costs

The United States has one of the fastest growing health care expenditures in the world; expenditures have more than tripled since 1990. Health care spend in the U.S. was $2.6 trillion in 2010, $3 trillion in 2011 and is projected to be $4.4 trillion in 2018. More than 75% of this expenditure is spent on people with chronic conditions.

Incidence trends by chronic disease are alarming:

- Heart disease and COPD remain the first and third leading causes of death, accounting for more than 40% of all mortality.
- Nearly 24 million Americans have diabetes, and if current trends continue, 1 in 3 people born in 2000 will develop diabetes in their lifetime.
- Stroke is the fourth leading cause of death in the U.S.
- 1 in 3 adults is obese, and more than 15 million Americans are morbidly obese.

Obesity-related health spending was $147 billion in 2008 and is projected to reach $344 billion per year by 2018.
Integrated Care Solutions and Strategic Intervention Can Be the Key to Successful Chronic Disease Management

While chronic conditions are among the most costly to manage, they also offer the most opportunity in terms of cost savings through prevention, education and clinical intervention. According to the World Health Organization (WHO), if the major risk factors for chronic disease were eliminated, at least 80% of all heart disease, stroke and type 2 diabetes would be prevented.11

Despite a wealth of evidence that supports the power of prevention, our health care system has historically focused on finding treatments and cures for diseases instead of addressing the factors and behaviors that cause them. To effectively mitigate rising health care costs, the focus must shift to prevention.

The CDC cites three key components to successful chronic disease prevention:

• Health promotion activities
• Early detection efforts
• Strategies for appropriate management of existing diseases and related complications

Health care solutions that focus on these three components can lead to better outcomes for members and lower costs for TPAs and employers.

Employers and TPAs Struggle to Identify and Manage At-Risk Members

Health care solutions that proactively identify at-risk members and encourage them to take an active role in their health and well-being can ultimately drive improved outcomes. Disease management and case management solutions deliver results by helping to better manage the chronic disease risk factors that lead to costly medical claims. For TPAs and employer groups that rely solely on utilization review and general case management, achieving better results is difficult due to the complexities of chronic disease and a lack of focus on the nurse/member relationship.

Often, there are multiple vendors involved that each offer a different medical management component. This can result in fragmented services and information, making it difficult to assess member populations for the presence of co-morbidities and other risk factors. Valuable patient information is often missing from the equation—information that could trigger the need to educate patients who could be managing their situations more optimally in accordance with their doctor’s plan of care.

Lack of complex condition management expertise is another obstacle. Because chronic diseases are closely tied to other conditions, they require a specialized approach with nurses and case managers who are trained in behavior-change techniques and can help members set actionable health goals that support their doctor’s care plan.

The administrative costs and requirements associated with multiple care management vendors can also be burdensome, especially for smaller employers and the TPAs that support them. Smaller groups often have difficulty locating vendors that will provide service at an affordable price, forcing them to source solutions from more than one provider and sacrifice cost efficiencies.
A Comprehensive Care Management Solution Can Help Mitigate Chronic Disease Cost Burden

While care management offerings can be assembled using individual components from multiple vendors, TPAs and employer groups can realize the greatest value through a single, comprehensive, end-to-end solution. This approach may offer:

• **Bottom line savings** through competitive program pricing, one-time setup costs and streamlined administration versus duplicative costs and administrative requirements for individual care management services.

• **Better member outcomes** with an integrated solution that coordinates care across physicians, providers and care management programs, offering a complete picture of an individual’s total health.

• **A seamless member experience** through a single solution that gives members one place to go for information related to their health conditions, saving them time and making their care more convenient.

Employers Increasingly Pursue Value-Based Benefit Designs

In an effort to control health care spend, employers are pursuing more cost-effective, value-based benefit plans designed to promote better health outcomes for dollars spent. Guided by the premise that sickness costs more than wellness, value-based initiatives focus on prevention, risk assessment and clinical interactions.

A key part of value-based programs is the use of rewards and incentives for members who participate in health management programs and activities. In a survey conducted by Towers Watson, 56% of employers currently use financial incentives for individuals who complete a health risk appraisal or participate in health management activities, and 32% plan to implement incentives such as these between 2012 and 2014.\(^{12}\)

As employer groups begin to see returns on their value-based investment, the need for these types of solutions that deliver proof of performance will only grow.

Criteria to Consider When Evaluating a Health Care Solution

• **Scalability** – Consider a vendor with the resources and experience to easily meet your needs as your customer and member population grows.

• **Flexibility** – Consider partnering with a vendor that can tailor their care management offering to meet the needs of your customers and members; a rigid, one-size-fits-all approach is not usually effective due to the unique requirements of each population.

• **Coordinated care programs** – Consider partnering with a vendor that can easily augment their care management offering with additional services to meet the needs of your customers or members; this will help you streamline your administrative burden and achieve greater cost efficiencies.

• **Member focus** – Consider a provider with a member-centric approach focused on engagement and education, to drive cost savings and help members effect lasting lifestyle changes.

• **Proof of quality** – Consider a vendor partner that has designed their program to be accredited by trusted industry organizations, such as the Utilization Review Accreditation Commission (URAC), or to meet national accreditation standards, and demonstrates a focus on quality and best practices.

38% of employers are actively pursuing more value-based health management strategies for 2013 or 2014.\(^{12}\)
Care Flex from Optum® Offers an Integrated, Value-Based Solution

Care Flex is a comprehensive care management offering that can help TPAs, employer groups and their members get more value for their health care dollars, through interactions and management strategies that reduce chronic disease risk factors—which over time helps lower costs.

The Care Flex program encompasses four key solutions, all supported by value-added services.

Four Key Health Management Solutions

- **Disease Management**
- **Case Management**
- **Maternity Management**
- **Health & Wellness**

Care Flex helps mitigate rising health care costs through:

- **Proactive member engagement strategies** – Industry-leading technology helps decrease the risk factors that drive medical claims costs.

- **Economies of scale** – One-time setup costs, streamlined administration and simplified billing by partnering with a single vendor.

- **Competitive program pricing** – Offers better value through integration.

**Supported by the experience and resources of Optum**

The Care Flex program is backed by a knowledgeable team of experts who understand the complexities of care management. For more information on how Care Flex can help you more cost effectively meet the needs of member populations, contact Optum at 1-866-427-6845 or engage@optum.com.
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