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 to deliver high quality, cost-effective solutions.

**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.¹ 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 1990.² 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 2018.³ More than 75% of this expenditure is spent on people with chronic conditions.⁴

**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 organizations.

**Health care organizations 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 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 groups. These 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, health care organizations 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.

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.10
Organizations increasingly pursue value-based benefit designs

In an effort to control health care spend, organizations 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 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** – The resources and experience to easily meet your needs as your customer and member population grows.

- **Flexibility** – Tailoring your 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** – Easily augment the 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** – Member-centric approach focused on engagement and education, to drive cost savings and help members effect lasting lifestyle changes.

- **Proof of quality** – Accreditation by trusted industry organizations, such as the Utilization Review Accreditation Commission (URAC), or meets 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 2013-2014.12
Sources


3. Department of Health and Human Services, 2009

4. Centers for Disease Control and Prevention, 2009


9. American Society for Metabolic and Bariatric Surgery

10. Risk & Insurance, October 1, 2011


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