Exploring Global Health Care Cost Drivers:
South Africa and the United States

Sponsored by the International Actuarial Association Health Section (IAAHS) and the Academy’s Health Practice International Task Force (HPITF)

May 13, 2015
Presenters

- Emile Stipp, BBusSc, LLB, FIA, Chairperson, International Actuarial Association Health Committee (South Africa)
- Tom Wildsmith, MAAA, FSA, President-Elect, American Academy of Actuaries (United States)
- Moderator: April Choi, MAAA, FSA, Chairperson, International Actuarial Association Health Section (United States)
All nations face difficult challenges in providing health care to their people.
A series of webcasts that highlight the health care models of various countries in 2015

- February 18 (Israel & Netherlands)
- May 13 (South Africa & US)
- September 3 (Australia & Singapore)
- November (Canada & Chile)

We are holding a conversation that will explore the following:

- General characteristics
- Financing system
- Cost drivers
- Methods of coping with the cost drivers
- Measurement metrics
- Insights, successes, hurdles
- Future trends
Exploring Global Health Care Cost Drivers - South Africa

Emile Stipp
Chairman, International Actuarial Association Health Committee

May 13, 2015
Healthcare in South Africa
Overview of Healthcare in South Africa

R121 bn (4.1 percent GDP)

Funded by taxes

~42m

Public sector

R122 bn (4.1 percent GDP)

Funded by contributions

~8.7m

Private sector

Source: Statistics South Africa
## Imbalance of Resources Between Public and Private Sectors

<table>
<thead>
<tr>
<th>Category</th>
<th>Public</th>
<th>Private</th>
</tr>
</thead>
<tbody>
<tr>
<td>Population</td>
<td>9 million</td>
<td>42 million</td>
</tr>
<tr>
<td>Spend</td>
<td>R122bn</td>
<td>R121bn</td>
</tr>
<tr>
<td>Per capita spend</td>
<td>R13,444</td>
<td>R2,905</td>
</tr>
<tr>
<td>Beds</td>
<td>33,000</td>
<td>100,000</td>
</tr>
<tr>
<td>Per 1,000 lives</td>
<td>3.7</td>
<td>2.4</td>
</tr>
<tr>
<td>Doctors</td>
<td>11,500</td>
<td>10,000</td>
</tr>
<tr>
<td>Per 1,000 lives</td>
<td>1.3</td>
<td>0.2</td>
</tr>
</tbody>
</table>

Source: Discovery Health Medical Scheme internal data
The Private Healthcare Sector in South Africa

Sets healthcare policy

Regulator of medical schemes

- Funding mechanism
- Not for profit organisation governed by Board of Trustees

Department of Health (DOH)

Council for Medical Schemes (CMS)

Board of Trustees

Medical Schemes (DHMS)

- Premiums
- Benefits

Members & employers

Medical services

Doctors & hospitals

Medical Scheme Administrator / Managed Care Organisation (DH)

Administration fees

Administration & managed care services

Claims

Reimbursements

Source: Medical Schemes Act

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## Regulations Governing Medical Schemes in South Africa

<table>
<thead>
<tr>
<th>Open enrolment; Guaranteed acceptance; limited underwriting</th>
<th>Community rating</th>
<th>Strict solvency regulations</th>
<th>Prescribed Minimum Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anyone can apply and must be accepted. Max waiting periods of 3-12 months on pre-existing conditions</td>
<td>Everyone pays the same premium – no adjustment for age and health status</td>
<td>Schemes must retain 25 percent of total annual contributions as a solvency margin</td>
<td>&gt;300 specified conditions must be covered; Prescribed Minimum Benefits account for 50-60 percent of total claims</td>
</tr>
</tbody>
</table>

Source: Medical Schemes Act
Medical Inflation in the Private Sector
Inflation in Medical Schemes

Five year average annualised claims inflation rates (2009-2013)

[Diagram showing inflation rates]

Demand-side drivers:
- Increased disease burden
- Adverse selection
- Ageing

Supply-side drivers:
- Fee for service system
- Fragmentation of care
- New technology & procedures
- New hospitals

Tariffs
- Hospital tariffs
- Doctor tariffs

Inflation is also affected by:
- Non-healthcare expenses
- Financing requirements

Source: Discovery Health Medical Scheme internal data

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Claims Inflation

CPI between 2008 and 2013:

- 2008-2009: 13.1%
- 2009-2010: 6.1%
- 2010-2011: 3.2%
- 2011-2012: 5.7%
- 2012-2013: 5.5%
- Average '08-'13: 6.7%

Source: Statistics South Africa
Components of claim increases between 2008 and 2013:

- **2008-2009**: 13.1%
- **2009-2010**: 6.1%
- **2010-2011**: 7.9%
- **2011-2012**: 3.2%
- **2012-2013**: 5.7%
- **Average '08-'13**: 6.7%

Tariffs are not a significant driver of claims inflation.

**Source:** Discovery Health Medical Scheme internal data
Claims inflation (cont.)

Components of claim increases between 2008 and 2013:

- **Average '08-'13**: 2.9%
- **2012-2013**: 2.9%
- **2011-2012**: 2.7%
- **2010-2011**: 3.2%
- **2009-2010**: 7.9%
- **2008-2009**: 13.1%

**Tariff Increase**: Demand side impact = CPI at Sep of prior year

Source: Discovery Health Medical Scheme internal data
Components of claim increases between 2008 and 2013:

- **2008-2009**: 15.0%
- **2009-2010**: 11.4%
- **2010-2011**: 6.1%
- **2011-2012**: 9.7%
- **2012-2013**: 11.1%
- **Average '08-'13**: 11.3%

**Source:** Discovery Health Medical Scheme internal data
Demand Side Inflation
Claims Per Life Per Month (PLPM) by Age

Source: Discovery Health Medical Scheme internal data
Discover Health Medical Scheme (DHMS)
Age Proportions
Change From 2002 to 2013

Source: Discovery Health Medical Scheme internal data

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Industry Chronic Prevalence

Prevalence of Top 10 diagnosed conditions per 1,000 lives

Source: Prevalence of chronic diseases in the population covered by medical schemes in South Africa January 2015 – Council for Medical Schemes

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DHMS Proportion of Chronic Lives by Age Change from 2002 to 2013

Source: Discovery Health Medical Scheme internal data
Adverse Selection by Age

1. Young people opt out of medical schemes
2. Medical schemes have higher proportions of older people

Source: StatsSA and Discovery Health Medical Scheme internal data
Adverse Selection by Gender

Source: Discovery Health Medical Scheme internal data
Duration on scheme before first maternity admission (2008 to June 2013)

- 45 percent of all maternity events are for members who have been on the scheme for <= 12 months.

1-year withdrawal rate of lives who joined <12 months before maternity admission

- 26 percent of these leave the scheme within 12 months of the maternity event.

Source: Discovery Health Medical Scheme internal data
Adverse Selection by Biologics Claimants

**Duration on Scheme – Musculoskeletal conditions**

14 percent who claimed biologics for musculoskeletal conditions had been on the Scheme for less than 1 year.

**Duration on Scheme – Multiple Sclerosis (MS)**

17 percent who claimed interferon had been on the Scheme for less than 1 year.

Source: Discovery Health Medical Scheme internal data
In summary, there is a trade-off:

- Guaranteed acceptance to a medical scheme vs Anti-selection associated with voluntary membership

- Cost of demand side inflation of 2.9 percent per year
- Represents 70 percent of excess inflation
Supply Side Inflation
Supply Side Inflation

This is the year on year inflation that is not associated with the clinical need for healthcare services

- Supply side inflation is estimated at 1.3 percent
- Represents 30 percent of excess claims inflation

Attributable to the decisions and actions of health professionals, which are in turn influenced by changes in the supply of other factors such as hospital beds or the entry of new medical technologies

Main drivers of supply side are:
- New medical technologies
- Increased radiology and pathology investigations
- Health professional billing and coding optimization

Source: Discovery Health Medical Scheme internal data
High Cost Technologies

Increasing use of ICU and High Care wards

10 percent increase in use of high intensity care in the hospital

Source: Discovery Health Medical Scheme internal data
New Medical Technologies
High Cost Drugs

Source: Discovery Health Medical Scheme internal data

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Increased Use of Radiology and Pathology

Pathology visit rate per 1,000 lives

Source: Discovery Health Medical Scheme internal data
The NHE component of medical schemes costs comprises the following main elements:

- Administration and managed healthcare fees
- Broker fees
- Other expenses such as trustee remuneration, and scheme office fees

Sources: StatsSA and internal data
Components of premium increases between 2008 and 2013 in Rands PLPM

- **Premium inflation**: R454.21
  - **CPI**: R273.84 (60%)
  - **Excess inflation**: R180.37 (40%)
    - **Claims**: R192.70 (107%)
    - **Solvency requirements**: R2.35 (1%)
    - **NHE**: -R14.68 (-8%)

*Source: Discovery Health Medical Scheme internal data*
Managed Care and Other Interventions
Strategic Approach to Population Risk Management

% Spend

21%
Complex Condition

27%
Significant chronic condition

52%
Well but at risk

70%
Healthy

Initiatives

- Care coordination programme for members with highest clinical needs
- HIV
- Renal failure
- Diabetes
- Cardiac failure
- Oncology
- Elder care
- Preventative Screening
- Corporate wellness

Source: Discovery Health Medical Scheme internal data
Exploring Global Health Care Cost Drivers: United States

Tom Wildsmith, MAAA, FSA
President-Elect, American Academy of Actuaries

May 13, 2015
Agenda

- Structure of U.S. health care system
- U.S. health care reform
- U.S. health care spending
- Initiatives to address cost growth
U.S. Health Care System

Public Programs

Medicare
Seniors (65+) and Disabled

Medicaid
Low income
LTC

CHIP
Low income children
not eligible for Medicaid
## Medicare Spending

Table 1: Total Medicare Expenditures as a Percent of GDP  
Sources: 2014 Medicare Trustees’ Report, CMS Office of the Actuary

<table>
<thead>
<tr>
<th>Calendar Year</th>
<th>2014 Report (projected baseline)</th>
<th>2014 Alternative Projection</th>
</tr>
</thead>
<tbody>
<tr>
<td>2013</td>
<td>3.5</td>
<td>3.5</td>
</tr>
<tr>
<td>2020</td>
<td>3.7</td>
<td>3.7</td>
</tr>
<tr>
<td>2030</td>
<td>4.9</td>
<td>5.1</td>
</tr>
<tr>
<td>2040</td>
<td>5.6</td>
<td>6.0</td>
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<tr>
<td>2050</td>
<td>5.9</td>
<td>6.5</td>
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<tr>
<td>2060</td>
<td>6.2</td>
<td>7.0</td>
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<tr>
<td>2070</td>
<td>6.6</td>
<td>7.6</td>
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<tr>
<td>2080</td>
<td>6.8</td>
<td>8.1</td>
</tr>
<tr>
<td>2085</td>
<td>6.8</td>
<td>8.3</td>
</tr>
</tbody>
</table>
U.S. Health Care System

Private Market

- Individual
- Small Group
- Large Group
Pre-Reform U.S. Health Care System

Coverage of Non-Elderly Americans in 2010

Sources of Coverage
- Private: 20%
- Public: 18%
- Uninsured: 62%

Private Coverage by Type
- Job-based: 89%
- Individually Purchased: 11%

Why Were People Uninsured?

<table>
<thead>
<tr>
<th>Family Income as % of Federal Poverty Level</th>
<th>Uninsured Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 – 99 %</td>
<td>33.4%</td>
</tr>
<tr>
<td>100 – 149%</td>
<td>32.6%</td>
</tr>
<tr>
<td>150 – 199%</td>
<td>28.6%</td>
</tr>
<tr>
<td>200 – 299%</td>
<td>20.7%</td>
</tr>
<tr>
<td>300% or more</td>
<td>8.5%</td>
</tr>
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</table>

Why Were People Uninsured?

<table>
<thead>
<tr>
<th>Work Status of Family Head</th>
<th>Uninsured Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Full-time, Full Year Worker</td>
<td>13.9%</td>
</tr>
<tr>
<td>Full-time, Part Year Worker</td>
<td>30.7%</td>
</tr>
<tr>
<td>Part-time, Full Year Worker</td>
<td>28.0%</td>
</tr>
<tr>
<td>Part-time, Part Year Worker</td>
<td>24.6%</td>
</tr>
<tr>
<td>Non-Worker</td>
<td>28.8%</td>
</tr>
</tbody>
</table>

Why Were People Uninsured?

### Uninsured Rate by Age
Non-elderly Americans in 2010

<table>
<thead>
<tr>
<th>Age</th>
<th>Uninsured Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 18</td>
<td>9.8%</td>
</tr>
<tr>
<td>18 to 24</td>
<td>27.2%</td>
</tr>
<tr>
<td>25 to 34</td>
<td>28.4%</td>
</tr>
<tr>
<td>35 to 44</td>
<td>21.8%</td>
</tr>
<tr>
<td>45 to 64</td>
<td>16.2%</td>
</tr>
<tr>
<td>65 and older</td>
<td>2.0%</td>
</tr>
</tbody>
</table>

Did the Uninsured Get Care?

All Non-Elderly

Projected 2008 Spending

Full-Year Insured $4,463
Part-Year Insured $2,983
Uninsured $1,686

(includes uncompensated care)

Source: Covering the Uninsured in 2008: A Detailed Examination of Current Costs and Sources of Payment, and Incremental Costs of Expanding Coverage, Kaiser Family Foundation, August 2008
Pre-Reform Individual Market Premiums by Age

U.S. Health Care Reform
Health Care Reform

- The Patient Protection and Affordable Care Act (PPACA) was signed into law on March 23, 2010.

- Focused *primarily* on expanding coverage:
  - Expanding Medicaid for low-income
  - Subsidizing private coverage for the lower middle income

- The most significant market reforms became effective in 2014.
Key Elements of Reform

- Individual and employer mandates to buy coverage
- Medicaid expansion
- Individual and small group market reform
- Public exchanges to simplify purchase of insurance
- Premium and cost-sharing subsidies for individuals
  - Premium subsidies available between 133% and 400% of federal poverty level (FPL)
  - Cost-sharing subsidies available up to 250% of FPL
Insurance Market Reforms

- Individual and small group market reforms
  - Guaranteed issue; modified community rating (age, tobacco, family size, and geography)
  - Elimination of lifetime limits
  - First dollar coverage of preventive services
  - Risk-sharing mechanisms (risk adjustment, reinsurance, and risk corridors)
  - New rate review requirements
Cost Control and Quality Initiatives

- Select provisions aimed at addressing health care cost growth and improving quality
  - Promote wellness and prevention
  - New payment and delivery system initiatives
  - Facilitate comparative effectiveness research and best practices
  - Improve workforce training and development

- Although several provisions aimed to increase the quality and cost effectiveness of care (with a goal of reducing cost growth), more work in this area is needed
U.S. Health Care Spending
## Overview of Health Care Spending Growth

### National Health Expenditure Estimates
**Calendar Years 2007-2023**

<table>
<thead>
<tr>
<th>Year</th>
<th>Total</th>
<th>Out-of-Pocket Payments</th>
<th>Private Health Insurance</th>
<th>Medicare</th>
<th>Medicaid</th>
<th>Other Programs</th>
<th>Other Third Party Payers</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Historical</strong></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>2007</td>
<td>$2,302.9</td>
<td>$293.6</td>
<td>$1,611.8</td>
<td>$777.7</td>
<td>$432.8</td>
<td>$326.2</td>
<td>$75.1</td>
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<tr>
<td>2008</td>
<td>$2,411.7</td>
<td>300.7</td>
<td>$1,703.2</td>
<td>807.8</td>
<td>467.9</td>
<td>344.9</td>
<td>82.6</td>
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<tr>
<td>2009</td>
<td>$2,504.2</td>
<td>300.7</td>
<td>$1,798.5</td>
<td>833.1</td>
<td>499.9</td>
<td>375.4</td>
<td>90.2</td>
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<tr>
<td>2010</td>
<td>$2,599.0</td>
<td>305.6</td>
<td>$1,873.9</td>
<td>859.6</td>
<td>520.2</td>
<td>398.1</td>
<td>96.0</td>
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<td>2011</td>
<td>$2,692.8</td>
<td>316.1</td>
<td>$1,943.4</td>
<td>888.8</td>
<td>546.2</td>
<td>407.7</td>
<td>100.7</td>
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<td>2012</td>
<td>$2,793.4</td>
<td>328.2</td>
<td>$2,014.4</td>
<td>917.0</td>
<td>572.5</td>
<td>421.2</td>
<td>103.8</td>
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<tr>
<td><strong>Projected</strong></td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
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<tr>
<td>2013</td>
<td>$2,894.7</td>
<td>338.6</td>
<td>$2,094.1</td>
<td>947.5</td>
<td>591.2</td>
<td>449.5</td>
<td>105.9</td>
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<td>2014</td>
<td>$3,056.6</td>
<td>338.1</td>
<td>$2,246.1</td>
<td>1,012.2</td>
<td>615.9</td>
<td>507.2</td>
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<td>$3,207.3</td>
<td>345.7</td>
<td>$2,372.5</td>
<td>1,082.4</td>
<td>632.7</td>
<td>541.1</td>
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<td>$3,386.2</td>
<td>356.0</td>
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<td>1,136.9</td>
<td>669.2</td>
<td>587.5</td>
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<td>2017</td>
<td>$3,579.0</td>
<td>372.1</td>
<td>$2,662.2</td>
<td>1,191.3</td>
<td>714.1</td>
<td>626.5</td>
<td>130.2</td>
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<td>2018</td>
<td>$3,797.5</td>
<td>391.2</td>
<td>$2,827.8</td>
<td>1,252.9</td>
<td>769.5</td>
<td>666.7</td>
<td>138.8</td>
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<td>2019</td>
<td>$4,042.5</td>
<td>413.5</td>
<td>$3,015.2</td>
<td>1,330.4</td>
<td>825.3</td>
<td>711.3</td>
<td>148.2</td>
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<tr>
<td>2020</td>
<td>$4,307.4</td>
<td>437.5</td>
<td>$3,219.1</td>
<td>1,410.0</td>
<td>890.3</td>
<td>760.4</td>
<td>158.4</td>
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<tr>
<td>2021</td>
<td>$4,577.8</td>
<td>461.1</td>
<td>$3,427.5</td>
<td>1,489.3</td>
<td>958.9</td>
<td>810.3</td>
<td>169.1</td>
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<tr>
<td>2022</td>
<td>$4,861.9</td>
<td>486.1</td>
<td>$3,646.7</td>
<td>1,569.5</td>
<td>1,033.1</td>
<td>863.0</td>
<td>181.2</td>
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<tr>
<td>2023</td>
<td>$5,158.8</td>
<td>512.2</td>
<td>$3,875.9</td>
<td>1,653.2</td>
<td>1,111.3</td>
<td>918.8</td>
<td>192.6</td>
</tr>
</tbody>
</table>

1Includes Private Health Insurance (Employer Sponsored Insurance and other private insurance, which includes Marketplace plans), Medicare, Medicaid, Children's Health Insurance Program (Titles XIX and XXI), Department of Defense, and Department of Veterans' Affairs.

2Includes worksite health care, other private revenues, Indian Health Service, workers' compensation, general assistance, maternal and child health, vocational rehabilitation, other federal programs, Substance Abuse and Mental Health Services Administration, other state and local programs, and school health.

3SOURCE: Centers for Medicare & Medicaid Services, Office of the Actuary.

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3SOURCE: Centers for Medicare & Medicaid Services, Office of the Actuary.
Two Components of Health Spending

- The number of services purchased
- The prices paid for those services
Drivers of Health Care Costs

- Drivers that increase the use of services
  - Payment structures that reward volume, not value
  - Medical technology advances
  - Lifestyle choices
  - Increased coverage levels
  - Lower out-of-pocket costs

- Drivers that increase the price paid for services
  - Broader versus narrow provider networks
  - Primary care shortages
  - Provider consolidation
  - Cost shifting from system to system (Medicare/Medicaid to private insurance)
Geographic Variations in Cost

Chart 1: Medicare Spending per Beneficiary, by Hospital Referral Region, 2006

National Average = $8,304

< $7,000

$7,000 – $7,500

$7,500 – $8,000

$8,000 – $9,000

> $9,000

Not populated


Note: Data adjusted for age, race, and sex but not price. Category definitions as in source document.
Initiatives to Address Cost Growth
How Do You Reduce Spending?

- Reduce the number of services
- Reduce the prices paid for services
- Shift to more cost-effective services
What Has Been Done?

- Provider networks with negotiated prices
- Increased use of “consumer driven” plans
- Significant advances in health information technology
Approaches to Address Cost Growth

- Delivery system reforms (e.g., Accountable Care Organizations (ACOs))
- Payment system reforms (e.g., bundled payments)
- Focus on disease management and wellness initiatives
Accountable Care Organizations (ACOs)

- ACOs are groups of health care providers – physicians and hospitals – that work together to manage and coordinate care for patients.

- PPACA established the Medicare Shared Savings Program (MSSP)
  - Led to creation of Pioneer ACO program (for more established ACOs, offering higher shared savings potential but more downside risk as well).
Accountable Care Organizations (ACOs) (cont.)

- MSSP
  - Currently 404 programs participating; 7.3 million assigned beneficiaries
  - Of the 114 that started in 2012, 54 had lower expenditures than expected in the first year. Of those 29 had shared savings of $126 million

- Pioneer ACO
  - Currently 19 participating organizations; launched in 2012 with 32 participating organizations
  - 10 of the original 32 participating organizations experienced significant savings in both performance years

- Advance Payment ACO
  - Currently 35 programs participating; mostly physician-based, rural providers
  - Advance monthly payments for those organizations that don’t have the initial capital to invest in a coordinated care structure
Bundled Payments

- Bundled payments
  - Single, predetermined lump sum payment for all health care services related to a specific course of treatment or condition over a set period of time.

- Bundled Payment for Care Improvement (BCPI)
  - Three-year initiative established by PPACA
  - 232 acute care hospitals, skilled nursing homes, physician group practices, long-term care hospitals, and home health agencies are participating in at least one of the four BCPI initiatives.

- BCPI Models
  - BCPI Model 1 – Retrospective Acute Care Hospital Stay
  - BCPI Model 2 – Retrospective Acute & Post Acute Care Episode
  - BCPI Model 3 – Retrospective Post Acute Care
  - BCPI Model 4 – Prospective Acute Care Hospital Stay
Wellness/Prevention

- Private market
  - National Prevention Council (created by PPACA) set seven priority issues: tobacco free living, substance abuse prevention, healthy eating, active living, injury and violence free living, reproductive and sexual health, and mental well being
  - PPACA allows employers to offer employees incentives or surcharges (up to 30% of the cost of coverage) to employees participating in wellness programs
  - U.S. Preventive Services Task Force studies, ranks, and recommends which preventive services are to be covered by insurers under PPACA
  - Most employers providing health benefits offer some form of wellness program

- Public market
  - Some state Medicaid programs have implemented pay for performance incentives for managed care plans that increase participation in prevention/wellness programs
Disease Management

- Disease management programs are typically designed to improve care and support for individuals with specific conditions (e.g., diabetes management).
- Disease management programs are predominantly implemented by managed health care plans.
- In the early 2000s, 15 demonstration programs were conducted of Medicare beneficiaries with chronic conditions.
  - Results showed limited evidence of significant reductions in spending
  - Results showed more promise in improving quality of care
  - Similar results in Medicaid disease management programs
Considerations

- Many of these initiatives are in the early stages and there is not enough evidence to definitively conclude whether and how much savings to expect going forward as well as the degree of quality improvement.

- Most of the initiatives discussed here are pilot programs/initiatives for Medicare/Medicaid populations. Many organizations/issuers in the private market have their own initiatives that may have experienced varying degrees of success.
Concluding Thoughts

- The U.S. is enjoying a slow-down in health costs
- History suggests rising costs are tenacious
- An aging population will put upward pressure on costs
- Information technology is making more sophisticated provider collaboration practical
- Health reform has increased coverage levels
- It’s too soon to know how reform will affect cost trends