FEATURE

Counting Comorbidities

With chronic conditions driving claims, what can be done to better manage patients with multiple health issues?

Written By Bruce Shutan

Chronic illnesses are obviously top of mind at a time when two-thirds of the U.S. population is overweight, and the nation's obesity epidemic has triggered hypertension, diabetes and heart disease. But that's just the tip of a much larger iceberg for self-insured employers.

Over the past four years, for example, 81% of Sun Life claims of $2 million or higher involved comorbidities and 55% of claimants had more than one comorbidity. With the exception of 2020 when pandemic lockdowns restricted access to medical care beyond treating COVID-19, those claims have steadily increased. The carrier's most commonly reported condition was respiratory disease, while others included congenital anomalies, newborn, cardiovascular and neurological diseases, malignant neoplasm, gastrointestinal abdominal disorder, leukemia, lymphoma, multiple myeloma and transplants.

"All high-cost claimants are going to have some kind of comorbidity," according to Kimberlee Langford, vice president of clinical services and director of business development for Specialty Care Management.

Kimberlee Langford

Citing diabetes as a key culprit that affects 80% to 90% of her cases, she explains that it drives high blood pressure, high cholesterol, atherosclerosis, coronary artery disease, cancer and fatty liver. It also destroys the liver, eyes, nerves and kidneys, she adds.

While there's a fair share of high-cost claims linked to premature births and hemophilia that are single episodes or illnesses, the vast majority of U.S. adult patients have some sort of comorbidity and typically more than one when they're either in the hospital or undergoing some high-dollar treatment. So says Stacy Borans, M.D., founder and chief medical officer of Advanced Medical Strategies.

Usual suspects include obesity, which she says can predispose people to multiple chronic illnesses, diabetes, hypertension, high blood pressure, high cholesterol, hyperlipidemia, asthma and arthritis, which is occurring in younger people. Tobacco smoking also needs to be considered as a comorbid condition, she argues, since it can trigger chronic obstructive pulmonary disease, asthma and bronchitis and is a huge risk factor for heart disease.

The underlining challenge of comorbid claims is that there may be issues that are hidden from view. Chronic kidney disease (CKD) is a great example of how there's a lot more underneath a high-cost claim. "It's actually our No. 3, and it's our biggest laser, too," Collier reports. "It's an issue that the entire industry struggles with… Most individuals with kidney disease don't know they haven't until very late stage and often end up in the ER as part of an acute event." The goal is to manage all of the comorbidities such as hypertension, food choices and weight gain, medication, etc., as part of a very targeted or methodical approach. That will keep patients who are juggling multiple conditions out of the hospital and delay or avoid dialysis which, if it's deemed necessary, she suggests should be done at home for better outcomes at a lower cost.

Stacy Borans, M.D.

The fact is that serious health problems can have a cascading effect in today's chronically ill environment. "Having rheumatoid arthritis doesn't preclude you from, say, having hypertension, nor does it preclude you from getting a stroke or cancer," explains David A. Galardi, Pharm.D., chief commercial officer for Paydhealth, LLC, which is why so many working Americans are treated for multiple conditions.

Describing diabetes cases that spring into CKD, hypertension and atherosclerotic disease, among others, as "the worst from a financial perspective," he notes that 10 disease groups drive comorbid conditions. Many of them are circulatory in nature, such as stroke, heart disease and CKD, as well as cancer, varying types of diabetes, respiratory illnesses that include asthma, bronchitis and COPD, cirrhosis of the liver and neurologic conditions.

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With so many of these conditions swirling around, self-insured health plans are often faced with polypharmacy challenges. Someone with comorbidities typically is on between five and eight prescription drugs, Galardi notes, "and then if you add the fact that they may be treated for a specialty condition, they may be on multiple specialty drugs which, depending on the reference point, they are easily going to exceed, $50,000 to $60,000 a year on the low end of costs."

Health plan members who fit this description "will have exceedingly high out-of-pocket costs, even with insurance," says Galardi, whose firm helps them reduce their spend through patient-assistance programs and other resources. The trouble with traditional fee-for-service medicine, he says, is that the higher the costs, the less inclined patients will be to pursue medical treatment or adhere to their drug regimen.

Jen Collier

One overlooked category is behavioral health. Jennifer Collier, president of health and risk solutions for Sun Life, says individuals who have both medical and mental health issues cost two to three times those who just have a medical issue, which makes treatment more complex and lengthens care paths.

David Galardi

The stigma associated with mental health can also seep into physical problems. Amid efforts to turn around diabetes, Langford laments all the body shaming that goes on. "We tend to think, 'well, that person has no self-control, they have no willpower.' Willpower is only going to carry you so far… When you look at especially these kinds of disease states, it's not so much that they're genetic where folks say,

'well, my mamma had diabetes. My grandmother had diabetes.' It's not a family thing. It's a table thing" – as in kitchen table. But it's also "a burden thing."

She explains further: Most people in the U.S. start out by grabbing a cup of coffee, muffin or bagel – huffing and puffing their way through a frantic work day until they're out of energy. Exhausted, they often reach for another cup of coffee or soda and maybe something out of the vending machine because all they had was carbs in the morning. Then at lunchtime, they may pick up fast food that's cheap and easy. By 5 p.m., their fuel tank must be refilled with more food and beverages to help motivate them for shopping, running errands, cooking, going to the gym, bathing and helping kids with homework. But they also may be tempted to microwave a Lean Cuisine or Stouffer's frozen dinner rather than eat fresh.

FOCUSING ON BEHAVIORAL MODIFICATION

"At the end of the day," Galardi believes, "it comes down to really one thing – and that is behavioral modification… In order to change behaviors, you actually have to understand the psyche of the individual. Programs that are generally out there today are, for the most part, fairly poor at changing behavior. They're very good at getting people treated, but that doesn't necessarily mitigate costs."

What contributes to the most expensive claims

If we narrow the focus even further to the most expensive claims, those that reach $3M or more, several risk factors are often contributing to the high cost. In 2022, we had 18 members with claims over $3M. Of these 18 members, 16 of them had a comorbidity; the only two without comorbidities were those with a primary diagnosis of Orthopedic/musculoskeletal disorders.

Below you will see the combination of factors that contributed to the cost for each individual. The individuals are categorized based on their primary diagnosis.

Newborn/Infant Care and Congenital Anomaly

Total spend	Hospital stays	Comorbidities	High-cost drugs	Complicated surgeries
$6.5M	•	•	•	
$3.5M	•	•		•
$3.5M	•	•		•
$3.4M	•	•		•
$3.1M	•	•		•

Cardiovascular

Total spend	Hospital stays	Comorbidities	High-cost drugs	Complicated surgeries
$4.3M	•	•	•	•
$4.2M	•	•		•
$3.7M	•	•		•
$3.2M	•	•		•

Malignant Neoplasm

Total spend	Hospital stays	Comorbidities	High-cost drugs	Complicated surgeries
$4.0M	•	•	•	

Orthopedics/Musculoskeletal

Total spend	Hospital stays	Comorbidities	High-cost drugs	Complicated surgeries
$4.5M			•	
$3.3M	•		•	

Other conditions (**diseases of the blood, respiratory, physician treatment, burns, fluid disorder**)

Total spend	Hospital stays	Comorbidities	High-cost drugs	Complicated surgeries
$4.6M	•	•	•	
$4.2M	•	•	•	
$3.8M	•	•	•	
$3.6M	•	•	•	
$3.6M	•	•		•
$3.5M	•	•	•	

Behavior change is predicated upon guiding health plan members on the many choices they face, Langford observes. "We have members all the time who are reversing diabetes, getting off of meds, losing weight, quitting drinking, quitting smoking," she reports. "It's not because we get them to do anything. It's because we turn on a light to help them see where they are. Most people are walking around blindfolded, and they're walking straight off a cliff. And the problem is they can't see it. But once we can open their eyes, and they see how close they are to the cliff, chances are they're going to figure out how to turn it around."

Several dramatic cases come to mind for Langford. One involved a member with "weeping" legs, which produce fluid from swelling or a wound. She had become overweight, as well as developed congestive heart failure and diabetes for which two different injectables and two different medications were needed. After drawing a metabolic panel, which not all internists keep a close enough watch on, her kidney function was found to be functioning at just 17%. So, a nephrologist was brought in and the patient started routinely tracking her blood sugar in relation to meals and working with a physical therapist to develop a safe exercise program. Her kidney function jumped to 34%.

"We have several members now getting off of their meds, and they're reversing diabetes and stages of kidney disease in two or three months," she reports.

Another member who had gone in for a total hip replacement pre-op appointment raised a red flag when her blood pressure was 220 over 180. Fearing she was symptomatic of a stroke, an extra blood pressure pill was prescribed, which lowered her blood pressure and avoided a stroke. A follow-up visit revealed that she had an undiagnosed kidney disease. But after a very impactful intervention, the member became highly engaged and was on the road to better health.

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In addition, a third member's planned total knee replacement surgery had to be cancelled when it was discovered that his prostate was blocking the flow of urine, which was destroying his kidneys. The grim diagnosis: he was close to renal failure with stage-five kidney disease. Dialysis seemed inevitable. But after working on his blood pressure and prostate issues, including self-catheterization, his kidney function had improved within months, and about eight years later he had not progressed to dialysis. "His words to me were, 'I thought my life was over. And I can't believe this. I'm going to see my grandkids graduate now,'" she recalls.

Another point Galardi makes is that network environments must be conducive to treating the whole person. If someone has colorectal cancer, he notes, as many as 10 to 15 types of physicians will be involved in their care, which should be set up as episodic so that the payment is actually a case rate based on the disease and normal course of that condition. His suggestion is that more risk share needs to be placed in the hands of providers and patients, with the latter doing a better job of following the former's instructions, which also need to be more thoughtful.

"We're excellent at high-dollar treatment for the disease once it occurs, and what we're really terrible at is putting dollars into prevention," Borans says, calling the investment "miniscule." Paying for routine screenings and physicals, wellness programs, behavioral health support, close follow-up visits and case-management strategies is much less expensive than the resulting diseases that arise from comorbid conditions, she adds. In short, they help avoid heart attacks, end-stage renal disease, cirrhosis of the liver and other major health problems that become high-cost claims.

Softer financial incentives such as tying wellness program participation to a reduced monthly premium are proving more effective at helping change behavior than direct incentives involving cash, she explains. There also are social factors to consider. For example, a single working mother who is diabetic, hypertensive or overweight may need to line up childcare so she can get to the gym. Also, an alcoholic may not be able to attend an AA meeting if there's not one in their neighborhood and they don't have any transportation lined up.

TOP 10 COMORBIDITIES FOR SUN LIFE CLAIMANTS

1	Respiratory Disease/Disorder
2	Physician treatment/not elsewhere categorized
3	Congenital Anomaly-structural
4	Newborn/infant/care disease disorder
5	Cardiovascular Disease/Disorder
6	Neurological Disease/Disorder
7	Malignant neoplasm
8	Gastrointestinal Abdominal
9	Leukemia, Lymphoma, Multiple Myeloma
10	Transplant

Between 2018-2022, and specific to $2M+ claimants: 81% (189 of 233) had comorbidities

Benefit Year	2 million + Claimants (1+ Comorbidities)	2 million + Claimants (total)
2018	27	30
2019	37	44
2020	32	40
2021	39	49
2022	53	70

Source: Sun Life

A SICKENING TREND

Looking ahead, Langford is concerned about a significant uptick in younger people developing completely preventable kidney disease and going on dialysis largely because of what has become known as "diabesity," which as the name suggests is driven by diabetes and obesity. "We're seeing it because of the comorbid conditions," she explains, adding that dialysis now accounts for 1% of the nation's health care budget and is a huge burden for the U.S. economy.

The scariest trend of all to her is the younger population having heart attacks, as well as developing fatty liver disease and liver failure. "They're working on a form of dialysis for liver disease that's going to be an expensive little procedure" she says. "Diabetes is a huge driver of cirrhosis of the liver and a huge comorbid condition. You see it with the same things that drive kidney disease."

Comorbidity factors will continue to mount along with the cost burden, Galardi says. As a result, more therapies are coming to market – not just drug, gene and cell, but also surgical interventions that are available. While the medical home model has been chased for decades, he says the reality is that that will work in some markets but not others. "If we can incentivize local contracted networks and local interventions for the sickest of our populations, whether they're an advocate like us, doctor, nurse, pharmacist, etc., that's taking care of them, then that's actually what's going to lower costs," he notes. ■

Bruce Shutan is a Portland, Oregon-based freelance writer who has closely covered the employee benefits industry for more than 35 years.

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