

Minnesota Physician-Patient Alliance
Policy Statement on Disease Management by Insurers
December 4, 2003

Summary

HMOs, managed care organizations and other health insurers are increasingly providing “disease management” services. Having these services provided by the insurer, rather than physicians and hospitals, is bad health care policy, may violate patient privacy and is not cost-effective. The Minnesota Physician-Patient Alliance believes insurers and managed care organizations should not provide disease management. Rather, doctors, hospitals and health care organizations should be reimbursed for providing clinical care including what managed care organizations refer to as disease management.

Current Practice of Disease Management by Insurers

Disease management by insurers evolved from services formerly provided by physicians and hospitals. In the 1970’s and 80’s, providers across the country used disease management protocols to coordinate care, improve quality and reduce health care costs. Disease management techniques meld health education, social services and care management in order to help patients with chronic disease and achieve optimal health outcomes. Also, patients recovering from acute care episodes benefit from coordination and continuity of care at the appropriate level of service.

During the 1990’s, two trends combined to move disease management out of doctor offices and hospitals and under the purview of health insurers and their contractors. The first: insurers reduced reimbursement to doctors and hospitals and stopped paying for disease management services. The second: insurers began using funds diverted from providers to pay for, among other things, their own “disease management” services. Estimates are that insurers expenditures for disease management exceeded \$1 billion in 1999.^{1,2}

In Minnesota, the three insurers that cover approximately 90% of Minnesotan’s commercially insured population each have extensive and growing disease management programs. Meanwhile, hospitals and doctors in Minnesota have seen steady declines in their reimbursement levels and are rarely reimbursed for providing disease management and case management services. For example, reimbursement to physicians for care of patients requiring counseling to manage a complex of multiple diseases (including telephone calls) is usually not reimbursed by Minnesota health plans. Meanwhile, telephone calls from a ‘disease management’ person employed or contracted directly by the health plan and ignorant of the intimate details of a patient’s complex multiple

¹ Joe V. Selby et al., "Determining the value of disease management programs," Joint Commission Journal on Quality and Safety, September 2003, 29:491-499, 491

² S. R. Weingarten et al, "Interventions used in disease management programmes for patients with chronic illness: Which ones work? Metanalysis of published reports," BMJ 325:925-932

problems, are reimbursed by these very same insurers with the justification of improving quality of care.

The widening role of insurer disease management is exemplified by Blue Cross Blue Shield of Minnesota's "Blueprint for Health". In December 2001, BCBSM signed a 10-year contract valued in the hundreds of millions of dollars for disease management services with American Healthways, Inc., a publicly traded company (NASDAQ ticker "AMHC") based in Nashville, Tennessee³. Using data from enrollment forms and insurance claims, BCBSM identifies people who apparently have chronic health conditions and, without consent from these people, gives their names and phone numbers to American Healthways. American Healthways then contacts these BCBSM enrollees and attempts to enlist them in their "disease management" program. Blueprint for Health has expanded from an initial focus on three conditions (diabetes, coronary artery disease, and high risk pregnancies) to cover, as of June 2003, 18 different medical diagnoses.

Disease management as practiced by HealthPartners, another of the three big Minnesota health plans, is similar to the BCBSM approach. Rather than contract externally, however, HealthPartners has established an internal department called the "Center for Health Promotion" charged by HealthPartners with accomplishing "total population management (TPM)... focusing on an entire population and managing all levels of severity of a particular disease."⁴ In the year 2000, HealthPartners set goals for its "population" within five years. To accomplish these goals, HealthPartners "assesses the risk status of its population through claims data, chart audits and Internet-based risk assessments, and stratifies them along a risk continuum."⁵ Specific techniques used by HealthPartners include "patient and provider education materials, health education courses, phone-based counseling, work site health promotion programs, and community health promotions."⁶

MPPA Policy Statement on Disease Management by Insurers

Minnesota Physician-Patient Alliance believes that disease management by insurance companies rather than health care providers reduces the quality of health care and violates patients' privacy rights. To date, disease management by insurers has not proven effective; researchers have concluded that disease management by insurance companies has only a limited ability to control costs or improve quality.⁷

MPPA has the following objections to disease management by insurance companies:

³ "Job Should Be A Cinch For Chief in Waiting", Investor's Business Daily, June 13, 2003.

⁴ "Total Population Management Reduces Future Treatment Costs", Managed Healthcare Executive, November 2002, pp. 46-48.

⁵ Ibid, p. 47

⁶ Ibid, p. 47

⁷ "Disease Management: A Leap of Faith to Lower-Cost, Higher-Quality Health Care," by Ashley Short, Glen Mays and Jessica Mittler, Issue Brief No. 69 by the Center for Studying Health System Change, October 2003.

1. **There is a fundamental conflict of interest between caring for patients and managing the cost of their insurance.** Insurers primary business function is to insure payment for health care. An insurer's interest in managing the cost of care often conflicts with the interests of a caregiver to do what is in the best interests of the patient. Therefore, when an insurer's disease management employee or contractor gives medical advice to enrollees, patients have no assurance that this advice is in their best interests or in keeping with that of their physician.
2. **Patients' rights to privacy are violated by insurance companies' disease management programs.** Insurance companies should have explicit consent for permission to share information about their enrollee's health status with disease management contractors.
3. **Patients' recourse against bad medical advice is unfairly limited by insurance companies' disease management programs.** Individuals have limited rights to sue insurance companies. This is unfair to patients and increases the risk that insurance companies may favor their own interests, or the interests of a "population", over the interests of an individual enrollee or patient.
4. **Insurers usurpation of the disease management function adversely affects health care costs.** When doctors and hospitals were adequately paid to coordinate their own patients' care, there was not the need to incur additional expenses to "assess the risk status of populations"; this was done on an individual basis each time a patient was seen by a physician. Now, with funds diverted from providers by insurance companies so that the insurance companies can provide their own disease management functions, care is more fragmented. Fragmentation of care increases administrative costs, increases the risk of medical error, and, in the hands of a stranger on a telephone, depersonalizes the care that patients need and deserve.
5. **Insurers providing disease management diminish health care's continuity, timeliness, accessibility, and personal compassion.** When insurers supplant providers' ability to perform disease management by directly delivering these services to their enrollees, physicians and hospitals lose in their ability to manage the continuity and timeliness of care. Patients' relationships with their caregivers are fragmented. As a patient's relationship with his or her doctor is diminished, so too is the quality of their care. While there is some evidence that disease management by insurers enhances quality in comparison to no disease management at all⁸, evidence that disease management by insurers is superior to physician or hospital care is non-existent (and counter-intuitive).

For these reasons, the Minnesota Physician-Patient Alliance recommends that insurance companies should be prohibited from running disease management programs independent of physicians' care and encourages reimbursement for disease management and care coordination services to doctors and hospitals.

⁸ "Can a disease self-management program reduce health care costs?" by John Wheeler, Medical Care, (2003; 41(6): 706-715)