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Population Health NEWS

Obesity: the Latest Time Bomb to Threaten Provider Sustainability

by Joy Stephenson-Laws

In today's rapidly changing and uncertain healthcare economy, providers need to navigate a complex minefield of challenges to their financial well-being and for many, even to their financial viability. At the top of the list, of course, are payer-denied reimbursement claims and uncompensated provider services. Combined, these two account for billions of dollars of potentially lost revenue annually.

The former includes such well-known justifications for denials as insufficient medical necessity, experimental treatment, lack of precertification or authorization and uncovered charges. Uncompensated provider services are usually attributable to a provider's charity services and uncollectable debts.

Reimbursement denial rates for all payers generally hover between 5 and 10% nationally, with certain parts of the country exceeding 10%.[1] Considering that healthcare spend in the United States is more than $3.2 trillion,[2] even a fraction of a percent change in denied reimbursement rates or uncompensated care levels can spell financial disaster for any healthcare provider. This is not even factoring in the cost and time involved in appealing and litigating the denied reimbursement claims, which can further undermine financial sustainability.

If this were not enough for providers to manage, they now also need to be concerned about, and be prepared for, another reason that could increase a provider's level of uncompensated services—patient obesity.

True Cost of Obesity to Providers

Recent studies have clearly shown that obesity increases the overall cost of treating patients for conditions other than obesity itself. One study compared hospital stay and surgical costs for obese patients to non-obese patients. To control for medical complexity, each obese patient was matched one-to-one with a non-obese patient using age, sex, race and 28 comorbid defined elements to ensure an accurate side-by-side comparison.

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In This Issue

Patient Interactive Education, Engagement Generate Successful Outcomes

by Richard Bootes and Susie Sonnier

Patient engagement, outcomes, patient-centered care and patient experience are some of the latest buzzwords driving hospitals and healthcare to meet standards of care, regulatory requirements and fiscal mandates. Hospitals are rapidly shifting patient care models from volume-based to value-based care with an intense focus on quality, safety and outcomes.

With value-based purchasing and patient-centered care in the industry spotlight in 2017, patient engagement continues to be a primary focus for hospitals and caregivers. Patient education is an important element for improving health and patient outcomes and increasing patient satisfaction.

Yet a conventional practice to engage patients in their care—video-based, patient education—is being neglected by too many hospitals despite demonstrated success over decades. Today, technology systems for patient engagement deliver interactive video for patient education, as well as integration with electronic medical records and other systems that provide entertainment and access to a broad range of hospital services. Something as simple as televisions in patient rooms are an ideal platform for engagement.

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The results show that total hospital costs incurred from obese patients was some 3.7% higher than for non-obese patients undergoing the same procedure. Looking at the components of hospital costs, length-of-stay was higher for obese patients as was the cost per day for diagnostic and therapeutic procedures needed after the surgical procedure. This study estimates that annual hospital expenditures for the largest volume of surgical procedures is about $160 million higher for obese patients compared to their non-obese counterparts.[3] The question for providers is, "Who is covering this additional cost?" If not managed well, they could end up footing the bill.

Obesity also increases the probability of complications when patients are being treated for other conditions, thereby increasing treatment risk and potential financial loss. These conditions include stroke, cardiac failure, hypertension, diabetes, osteoarthritis and breathing problems. In addition to the risks these pose to any patient, they also increase the costs of treating them. One study has shown that each additional chronic disease contributes an estimated $177 per year to the healthcare costs of an obese individual.

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Overall, studies indicate that obese persons have more hospitalizations (one study indicates that obese persons have a 3.85 greater risk of hospitalization), use more prescription drugs and make more outpatient visits than do normal-weight persons. It's not surprising that total healthcare costs for obese persons were higher than for the non-obese. Studies have shown that BMI is a good indicator of the cost increase with an estimate of an increase of 2.3% in healthcare costs for every BMI unit increase. And these costs may go directly to a provider's bottom line.

The real threat to the financial viability of healthcare providers when treating obese patients is whether these obesity-related, increased costs will be approved for Medicare and Medicaid reimbursement. If they are not, then providers will need to absorb these costs. When it comes to private or commercial payers, many of these obesity-related complication costs may not be reimbursed because they were not factored in per diem rates, case rates or stop-loss calculations. In those instances where there is no contract between a healthcare provider and a payer, the applicable reasonable and customary rates may be far less than the actual cost because they are generally based on what is a reasonable and customary payment for normal-weight patients and not obese patients.

While obesity is not new, the United States continues to see skyrocketing rates of obesity. Currently, more than one-third of adults are considered obese.[4] Some studies even project that by 2020, 75% percent of the population will be obese. Other estimates vary between 42% and 60%.[5] Whatever the projection, obesity is no longer the exception or outlier; it is fast becoming the norm. And very soon, the typical patient will be obese, and the outlier will be patients of normal weight.

What Providers Can Do Now

A reimbursement system that uses the costs associated with normal- weight patients as the primary basis for provider payment will not appropriately compensate providers for services rendered with this rapid increase of obese patients.

But this does not appear to be at the forefront of the ongoing discussion about provider financial economics and viability. Given the obesity epidemic and its impact on overall patient health, providers need to adequately address the threat obesity poses to their financial health.

The current obesity epidemic shows no signs of abating despite government and private sector efforts. This trend, coupled with the general uncertainty and flux in healthcare economics, compels healthcare providers to properly take obesity into account when doing reviews of their administrative and financial management policies and procedures. Healthcare pricing structures should accurately account for the increased costs caused by the shift in the obesity population.

Providers should consider negotiating reimbursement rates that will result in more reasonable compensation for medically necessary services. At the same time, they should evaluate their current spend and investment in community programs that address obesity as a threat to their financial health. Lack of education leads to bad decisions that can lead to obesity.

These programs should be designed to focus on useful education and making sure people have the tools they need to effectively manage their weight before it gets out of control. For example, people should not only know what they need to eat but also be able to objectively assess their health status throughout their lives to identify dietary or lifestyle changes they might need to make.

Obesity is not only a threat to national welfare and health but also to those who provide care for those with the condition.

[1] Claxton G, Cox C, Damico A, et al. "Underwriting in the Individual Insurance Market Prior to the ACA." The Kaiser Family Foundation. Dec. 12, 2016.
[2] "National Health Expenditure Data, Historical." CMS.gov. Accessed July 3, 2017.
[3] Mason RJ, Moroney JR, Berne TV. "The Cost of Obesity for Non-bariatric Inpatient Operative Procedures in the United States: National Cost Estimates Obese Versus Non-obese Patients." *Annals of Surgery*. October 2103;258(4):541-551.
[4] Parks JC, Alston JM, Okrent AM. "The Marginal External Cost of Obesity in the United States." Robert Mondavi Institute Center for Wine Economics. May 2012.
[5] "Overweight & Obesity." Centers for Disease Control and Prevention. Sept. 1, 2016.

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