MBGH
Midwest Business Group on Health

Burden of Inflammatory Bowel Disease (IBD):

How Crohn's Disease & Ulcerative Colitis Impact Workforce Health, Productivity and Total Cost of Care

Is it Inflammatory Bowel Disease (IBD) or Irritable Bowel Syndrome (IBS)?

IBD and IBS are two distinct gastrointestinal disorders, though the differences between the two can be confusing for many people. While they have some similar symptoms, IBS and IBD are not the same condition, and they require very different treatments[1].

IBD is classified as a disease. It can cause destructive inflammation and permanent harm to the intestines. The disease can be seen during diagnostic imaging. There is an increased risk for colon cancer.

IBS is classified as a syndrome and defined as a group of symptoms. It does not cause inflammation; and rarely requires hospitalization or surgery. There is no sign of disease or abnormality during an exam of the colon, nor is there an increased risk for colon cancer or IBD.

Inflammatory diseases are lifelong medical conditions in which a dysregulated, overactive immune system mistakenly attacks healthy cells, organs, and tissues[2]. These include conditions such as rheumatoid arthritis, psoriasis[3], Crohn's disease, and ulcerative colitis – the latter two are collectively classified as inflammatory bowel disease[4]. These conditions are chronic, relapsing, and associated with persistent health challenges, increased long-term healthcare costs[5], and reduced workforce productivity[6].

This Employer Action Brief outlines the IBD landscape, highlighting barriers to timely diagnosis, appropriate treatment, and sustained disease control, along with evidence-informed strategies to improve outcomes – particularly for those with moderate-to-severe disease.

Drawing on employer insights and real-world experience, it identifies key challenges and actionable solutions, and reinforces the employer role in optimizing care delivery, benefit design, and vendor accountability to improve workforce health, productivity, and total cost of care.

IBD can be effectively managed with early intervention, appropriate use of advanced therapies, and proactive care coordination. The gap lies in translating clinical evidence into benefit structures and care pathways that ensure timely access, reduce low-value care (e.g., prolonged steroid use), and address variation in practice and adherence.

Employers that invest in data visibility, aligned incentives, and condition-specific management are better positioned to reduce avoidable complications, prevent high-cost events, and support employees living with IBD.

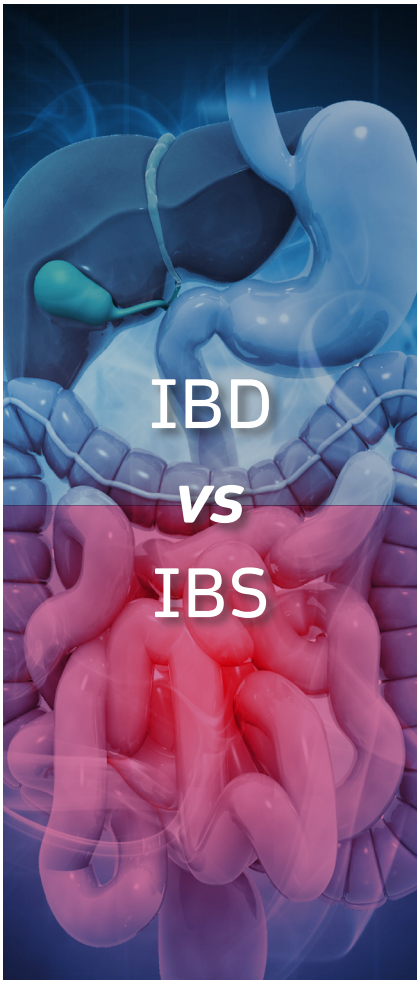
Quick Links

Employer Action Steps

Vendor Partners Checklist

IBD vs IBS – Key Differences

	IBD (Inflammatory Bowel Disease)	IBS (Irritable Bowel Syndrome)
What it is	Chronic **inflammatory disease** of the GI tract	**Functional disorder** (no visible damage)
Examples	Crohn's disease, ulcerative colitis	IBS-D, IBS-C, IBS-M
Inflammation	✅ Yes (objective, measurable)	❌ No
Tissue damage	✅ Can cause ulcers, strictures, damage	❌ None
Symptoms	Diarrhea, abdominal pain, **blood in stool**, weight loss, fatigue	Abdominal pain, bloating, diarrhea/constipation
Disease course	Progressive if untreated	Chronic but **non-progressive**
Complications	Fistulas, hospitalization, surgery	None (does not damage bowel)
Diagnosis	Endoscopy, imaging, biomarkers	Symptom-based (rule out other disease)
Treatment	Immunosuppressants, biologics, steroids	Diet, stress mgmt, symptom control
Seriousness	**Serious, can be life-altering**	Not life-threatening



Inflammatory Bowel Disease (IBD)

Characterized by inflammation and destruction of the GI tract, IBD is a chronic autoimmune disease. It occurs in men and women equally and may have an early onset, resulting in a lifetime of necessary care. It is most often diagnosed in adolescents and adults in their 20s and 30s. As a result, there may be significant impact on an employee's early-to-peak earning years in the workforce. Symptoms include diarrhea, abdominal pain, fatigue, anemia, malnutrition, nausea and weight loss. Both diseases follow a relapsing-remitting course with flares and periods of remission, which can range from mild to severe. IBD often presents in an inconsistent manner with nonspecific symptoms, making accurate diagnosis challenging[7].

Crohn's disease can affect any part of the digestive tract – from the mouth to the anus – and primarily affects the colon where it controls exit of stool from the body, and the rectum where it temporary stores feces before defecation[8].

Ulcerative colitis affects the inner lining of the large intestine and rectum, with additional symptoms including bowel urgency and nocturnal defecations[9].

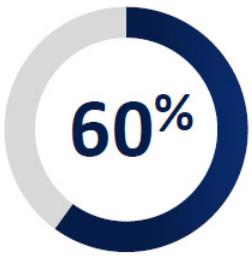
IBD Quick Facts

- About 3.1 million U.S. adults have been diagnosed with IBD, and prevalence is expected to rise exponentially over the next decade[10].
- Direct costs, including ambulatory visits, hospitalizations, and medications average $9,000 to $12,000 per person per year and indirect costs, including loss in productivity, absenteeism, presenteeism, early retirement, premature death, and delayed workforce increase the total costs[11].
- Patients with IBD incur about 3 times as much in direct costs of care compared to those who do not live with the disease – employers pay most of these costs[12].

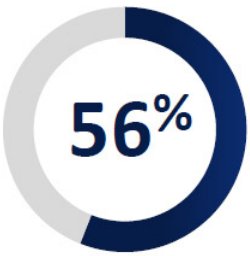
Magnitude of Work Impairment and Productivity Loss in IBD

Patients with IBD may experience reduced productivity at work[1]

EFCCA Patient Survey (N=4,670)



of patients with IBD felt **stressed or pressured** about taking sick leave from work



of patients felt IBD **negatively impacts** their career path

- According to US data from the Medical Expenditure Panel Survey, 1996–2012:[2]
  - **18%** of the CD vs 10% of the non-CD population were **unemployed** during the year due to illness
  - **57%** of the CD vs 67% of the non-CD population were **unemployed** at least part of the year

EFCCA=European Federation of Crohn's and Ulcerative Colitis Associations.

References: 1. Ghosh S, Louis E, Beaugerie L, et al. Development of the IBD Disk: a visual self-administered tool for assessing disability in inflammatory bowel diseases. *Inflamm Bowel Dis*. 2017;23(3):333-340. 2. Ganz ML, Sugarman R, Wang R, et al. The economic and health-related impact of Crohn's disease in the United States: evidence from a nationally representative survey. *Inflamm Bowel Dis*. 2016:22:1032-1041.

A Deeper Understanding of Inflammatory Bowel Disease (IBD) as a Lifelong Disease

Burden of IBD and Its Impact on Employers and the Workforce

For most employers, IBD is not a top prevalence condition, but it can be a high-burden condition and may lead to high-cost claims if not appropriately managed. The burden manifests in biologic drug spending, infusion logistics, emergency care, surgery, missed work, reduced on-the-job performance, and family disruption when the disease is not well controlled.

In addition to significant gastrointestinal symptoms, individuals may experience extraintestinal manifestations that contribute to broader functional impairment. These can include musculoskeletal, dermatologic, ocular, and hepatobiliary complications (e.g., from minor infections to serious issues like liver failure), alongside systemic effects such as nausea, weight loss, and sleep disruption during disease flares. 25% to 40% of patients experience these manifestations, with as many as 30% experiencing arthritis and approximately 1 in 3 experiencing anemia[13].

There is an enormous burden on IBD patients, as it is unpredictable and patients can have active flares followed by little to no symptoms. This increases anxiety and depression, so it also impacts behavioral health.

The highest-value employer strategies are timely, evidence-based therapy; steroid stewardship; objective monitoring; biosimilar and site-of-care optimization, where appropriate; and workplace support that reduces avoidable disruption for employees and caregivers.

To understand the burden within your member population, including use of the ED for care, review your annual utilization data, including codes for IBD conditions – see section below on ***Tracking the Prevalence of IBD***. In addition, benefit leaders should:

1. Consult with their healthcare plan advisors to strategize how best to improve care
2. Review their provider network and prior authorization process to ensure members have timely access to an IBD treating specialist
3. Improve both the member experience and plan performance by offering:
   - Fast access to evidence-based therapy
   - Biosimilar and site-of-care discipline
   - Steroid and monitoring controls
   - Practical workplace support that keeps employees and caregivers engaged in care and in work

Direct & Indirect Costs

Both direct and indirect costs for IBD are expected to rise with increased prevalence, wider biologic use, and earlier diagnosis. Key drivers include:

1. Hospitalizations, ED visits and surgeries – severe flares, complications
2. Outpatient physician and specialist visits
3. Diagnostic/testing procedures
4. Biologic therapies – high cost, long-term use
5. Medical supplies and out-of-pocket patient costs
6. Work impairment
   - Absenteeism – missed workdays due to flares, medical visits, or hospitalization
   - Presenteeism – reduced productivity while at work
7. Disability/early retirement – chronic disease burden may lead to long-term workforce exit
8. Comorbidities – anemia, infections, colorectal cancer risk

Direct Costs

Hard-dollar costs show up in medical and pharmacy claims. In the U.S. this cost is approximately $8.5 billion annually. Prescribed medications represent the largest cost component at 71% followed by inpatient, office-based, and emergency visits[14].

The Crohn's & Colitis Foundation cost initiative estimated total direct paid claims of $22,987 per member per year for people with IBD versus $6,956 for members without IBD. This included a mean first-year post-diagnosis cost of $26,555 and ongoing costs that remain around $20,000 or higher over time[12].

Condition-specific employer datasets show the same pattern. In a U.S. privately insured population. Crohn's disease was associated with $24,500 in direct healthcare costs per patient per year versus $7,037 in those without IBD, plus $5,490 in work-loss costs versus $3,322 in those without IBD[15]. For ulcerative colitis, direct costs were $18,198 versus $7,170, and work-loss costs were $5,307 versus $3,165[16].

Indirect Costs

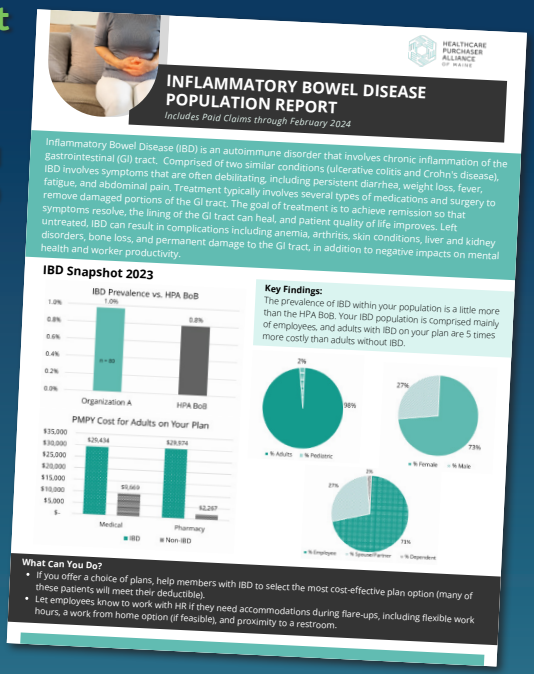
Soft-dollar costs are broader and can include workforce productivity, such as absenteeism and presenteeism. Other economic losses included outside the healthcare system – chiefly work loss, reduced productivity, presenteeism, disability, early retirement, and caregiver time. Some analysts suggest indirect costs can equal or exceed direct medical costs, particularly in younger, working-age populations. In addition, workers experience unscheduled restroom breaks, reduced concentration, low energy, disrupted travel, missed advancement, caregiver work loss, and the friction created when infusion appointments, colonoscopy preparation, or flares collide with shift-based work or client-facing roles.

We are starting to look at data outside of the medical plan, because IBD impacts absenteeism and being able to be on the job and be present.

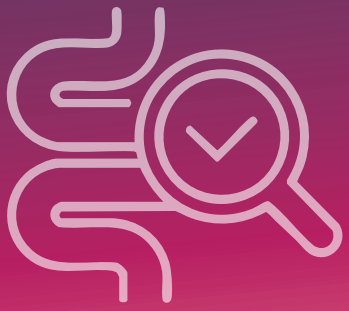
Productivity cost estimates for patients show losses of ~$5,131 per patient per year for Crohn's[17] and ~$6,583 annually for ulcerative colitis[18] (international review including U.S. data).

IBD Population Report

MBGH's sibling coalition, the Healthcare Purchaser Alliance of Maine, produced a report benchmarking IBD prevalence, spending, and quality of care indicators against their book of business. The report offers practical guidance on how to better support members with IBD while managing medical and pharmacy costs more effectively. For more information, click here.



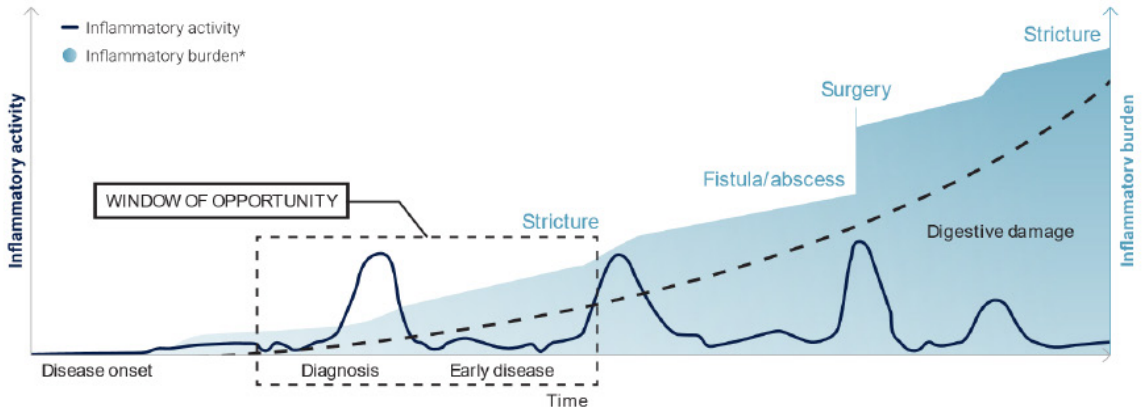
For employers, the practical issue is not only which therapy is clinically appropriate, but how fast an employee can get to the right therapy and whether the plan avoids paying for unnecessary step therapy, chronic steroids, poorly coordinated infusions, or preventable hospital care.



The Importance of Early Intervention and Management in IBD

Lifelong, progressive, and inflammatory states of the bowel occur in a relapsing and remitting pattern

Cumulative Bowel Damage Due to Inflammation[1-3]
in a theoretical patient with CD



Disease activity is a cross-sectional snapshot of one moment in time. Inflammatory burden includes longitudinal and historical factors of disease severity, providing a more complete picture of disease course.[2]

Diagnostic delay and **prolonged use of ineffective treatment** for patients with IBD is associated with an increase in:[4]

- Surgery rate
- Bowel stenosis (narrowing of the intestine)
- Perianal disease
- Overall complications

Long diagnostic delay has also been associated with shorter time to surgery.

References: 1. Pariente B, Cosnes J, Danese S, et al. Development of the Crohn's disease digestive damage score, the Lémann score. *Inflamm Bowel Dis*. 2011;17(6):1415-1422. 2. Siegel CA, Witman C, Spiegel B, et al. Development of an index to define overall disease severity in IBD. *Gut*. 2018;67(2):244-254. 3. Danese S, Fiorino G, Fernandes C, Peyrin-Biroulet L. Catching the therapeutic window of opportunity in early Crohn's disease. *Curr Drug Targets*. 2014;15(11):1056-1063. 4. Nguyen VQ, Jiang D, Hoffman SN, et al. Impact of diagnostic delay and associated factors on clinical outcomes in a U.S. inflammatory bowel disease cohort. *Inflamm Bowel Dis*. 2017;23(10):1825-1831.[10]

When it comes to IBD, it's not enough to simply manage symptoms—we need to treat the underlying disease to truly change outcomes. Time matters as well. These are progressive conditions, and delays in diagnosis or treatment can lead to more serious complications over time. Access is also a key issue; significant unmet needs remain, and patients require broad, timely access to the full range of therapies to receive the care that works best for them.

Treatment Options and Cost Profile

IBD treatment typically includes anti-inflammatory medication, corticosteroids for short-term flare control, medications that suppress the immune system, biologics, newer small molecules, and surgery when complications emerge or when IBD does not respond adequately to the standard treatments. The National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK) notes that 30% to 55% of people with Crohn's disease require surgery within 10 years after diagnosis[20], while ulcerative colitis surgery is used for cancer risk, life-threatening complications, or failure of medical therapy[21]. Early effective treatment can result in better outcomes and could change the progression of the disease, reverse damage, and reduce surgeries and hospitalizations.

Traditional and Current Guidelines for Treating IBD[22]

The medical treatment for IBD has three main goals:

1. Achieving remission (the absence of symptoms)
2. Maintaining remission (prevention of symptoms or flare-ups)
3. Improving quality of life

To accomplish these goals, treatment is aimed at controlling the ongoing inflammation in the intestine – the cause of IBD symptoms. There is no standard approach to managing all people with IBD. The symptoms, severity of disease, and how the disease may impact a person down the road vary considerably.

Traditional Treatments

This step-up approach aims to reduce or eliminate symptoms such as diarrhea, abdominal pain and fatigue. This approach relied heavily on patient-reported outcomes and short-term improvement. However, it had a critical limitation – symptoms do not reliably correlate with underlying inflammation. Patients could feel better while mucosal inflammation persisted. Although it can offer lower upfront costs, it is primarily appropriate for individuals with mild disease, and there may be limitations:

- Delayed disease control which can result in ongoing inflammation
- Increased risk of complications – e.g., strictures, fistulas in Crohn's
- Heavy reliance on steroids – not intended for long-term use
- Missing the "window of opportunity" to alter disease course

Treat-to-Target Treatments

This step-down approach emphasizes disease control within a broader treat-to-target framework, following current guidelines that prioritize endoscopic healing, with therapy adjusted until predefined objective biological targets are achieved, rather than symptom relief alone. It is associated with:

- Reduced relapse rates
- Fewer hospitalizations and surgeries
- Lower corticosteroid dependence
- Improved long-term disease modification

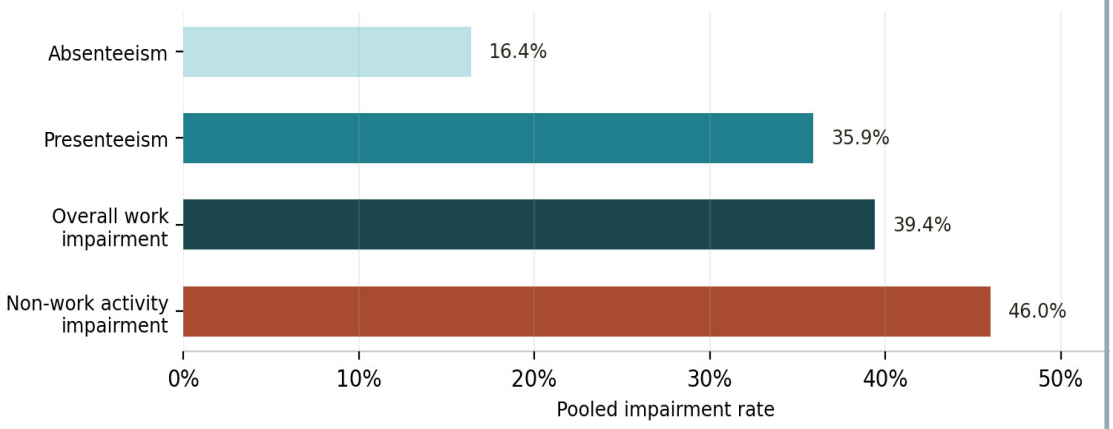
Endoscopic healing measures intestinal inflammation and has been associated with reduced hospitalizations, colectomy and bowel resection rates, reliance on corticosteroids, and the risk of colorectal cancer[23].

Advanced Therapies

Selecting the right medication for individuals with IBD often requires time and ongoing adjustment[21]. Effective management depends on consistent adherence to therapy and continuous collaboration with the healthcare team to achieve and sustain remission.

While treatment categories span options for mild, moderate, and severe disease, patients with moderately to severely active IBD typically require advanced therapies, including biologics and small molecules.

IBD Work Loss is Driven More by Reduced Productivity than Absence



Pooled work and activity impairment in adults with IBD from a 2024 systematic review and meta-analysis. [17]

Treating patients more aggressively upfront aligns with clinical evidence that early intervention can prevent irreversible bowel damage. Yet, many plans still require patients to step through conventional therapies before accessing advanced treatments. We need top-down approaches that enable earlier use of advanced therapies without step requirements.

It's important to understand how complicated the path to an IBD diagnosis can be. A lot of people feel embarrassed talking about their symptoms which can delay even getting started. Once they do, there are a lot of steps and friction points along the way.

How IBD Affects Employees and Families

IBD affects work through both absenteeism and presenteeism – A 2024 meta-analysis reported rates of 16.4% absenteeism, 35.9% presenteeism, and 39.4% overall work impairment, with an average of 23.9 sick days per year across studies[17].

Disease control matters – In U.S. working adults with Crohn's disease, annual indirect costs due to total work impairment rose from $7,169 in remission to $29,524 in moderate-to-severe disease; in ulcerative colitis, the same range was $4,348 to $24,283[18].

Day-to-day impacts of IBD are often intuitive to employers – Fatigue is the most frequently reported cause of absenteeism and presenteeism, but abdominal pain, frequent toilet visits, hospital visits, adverse drug effects, and travel difficulties also contribute[6].

Employment consequences can last longer than the single flare – The same 2024 meta-analysis found that only 65.6% of patients were employed, 21.3% reported work disability due to IBD, 12.3% received disability pensions, and 29.6% had lost jobs due to the disease[17].

Family impact is significant – In one study, 39% of caregivers experienced caregiver burden. Employed caregivers averaged about 12 hours of caregiving per week, and those with high burden were much more likely to report absenteeism and presenteeism than caregivers without burden[24].

Indirect Employer Cost Rises Sharply When Disease is Not Controlled

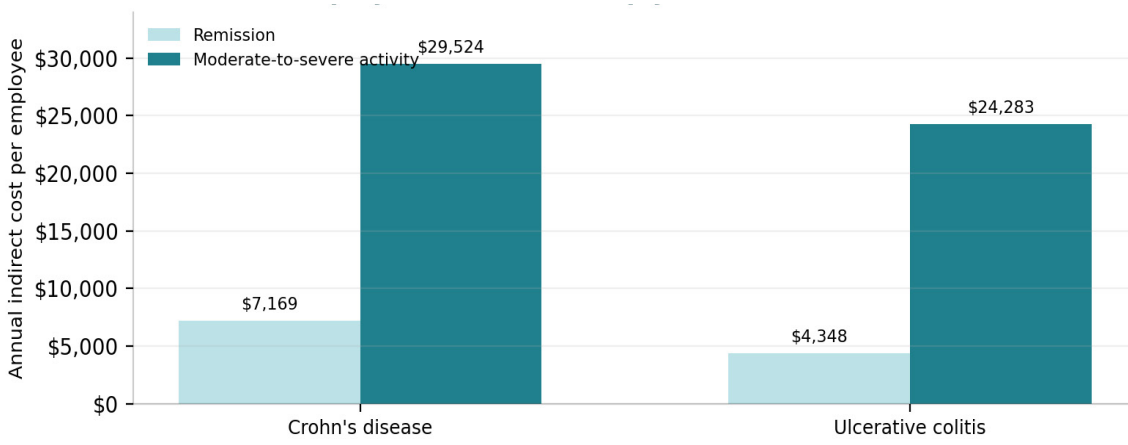


Figure 2. Annual indirect cost due to work impairment by disease activity in U.S. workers with IBD[18].

Employer Action Steps

For employers, inflammatory bowel disease is not a niche condition – it is a high-cost, high-variability, and operationally disruptive disease that directly affects medical spend, productivity, and workforce stability.

It can have significant implications for employers because it concentrates on cost, disrupts productivity, and is clinically manageable when benefits are aligned with evidence-based care. Employers that actively manage IBD – through data, benefit design, and vendor accountability – can materially improve both financial performance and workforce outcomes.

We need to give employees the tools they can take with them to feel confident in advocating for either themselves or a loved one. It's important they know how to negotiate with their doctor and be their own advocate – this is where we will see earlier intervention.

Use these important action steps to help guide you in supporting employees and members to maintain disease control.

1. Align access policy to disease severity, not rigid step therapy

- AGA guidelines for both ulcerative colitis and Crohn's disease support early use of advanced therapy in moderate-to-severe disease rather than forcing prolonged failure of lower-value therapy that doesn't stop the progression of IBD.
- Benefit designs should allow rapid access for patients with moderate-to-severe disease; ensuring providers have access to multiple treatment options helps prevent care delays and can support better member outcomes.

2. Build steroid stewardship and monitoring into utilization management

- Corticosteroids remain appropriate for initial treatment, but not for maintenance.
- If a member requires repeated steroid bursts or stays on them too long, your vendors should review and consider escalating treatment; steroids are only appropriate for short-term use.
- Repeated steroid bursts (i.e., short courses of systemic corticosteroids used to rapidly control disease flares, occurring > 2 in 12 months) or ongoing steroid dependence (remaining beyond 8-12 weeks) should trigger GI review, therapy escalation, and case management because they often signal under-treated disease and avoidable downstream cost.
- This approach reduces complications, infections, and downstream costs driven by under-treated disease.

3. Work with your vendor partners (e.g., carriers, PBMs) to allow members with documented moderate-to-severe disease to start advanced therapy right away, instead of requiring them to fail multiple lower-value, ineffective drugs first

- Your vendors should use objective criteria such as endoscopy, biomarkers, imaging, and steroid dependence to determine severity.
- When the criteria are met, they should approve advanced therapy without step therapy and should avoid requiring prolonged trials for therapies that guidelines no longer recommend.
- This approach both aligns with guidelines and reduces avoidable ED visits, hospitalizations, and steroid or opioid complications.

4. Require vendors to use regular, objective monitoring and treat-to-target standards

- Guidelines recommend:
  - 3 months: symptom assessment
  - 3 to 6 months: biochemical monitoring (CRP, fecal calprotectin)
  - 6 to 12 months: endoscopic monitoring
- Encourage appropriate monitoring through benefit design, case management, and GI quality programs – the results should be used to guide early therapy adjustments and to prevent flares, steroid and/or opioid dependence, and high-cost care.
- The intended outcome should be members staying on track toward remission – not just symptom control.

5. Adopt a clinically disciplined biosimilar strategy

- Consider biosimilar strategies for brands with available biosimilars. Guidelines state that biosimilars of infliximab, adalimumab, and ustekinumab can be considered equivalent to their originators (Remicade, Humira and Stelara, respectively) for therapy selection.
- Employers should combine preferred biosimilars with patient education, transition support, and minimal administrative disruption to capture savings without harming adherence.
- Non-medical switching, the transitioning of stable patients from branded drugs to non-equivalent biosimilars, is not recommended as it may delay/disrupt therapy, impact disease control and lead to an increase in total cost of care.
- Restrictive autoimmune formularies with forced substitutions for stable patients may have unintended clinical and economic consequences.

Carefully consider the impact of Rx Carve-Out vendors given the potential for non-medical drug switching and member disruption.[25]

See Milliman's report on Considerations for Commercial Plan Sponsors Evaluating Specialty Drug Carve-out Programs

6. Optimize the site of care and formulation where clinically appropriate

- Subcutaneous infliximab and vedolizumab have shown efficacy comparable to intravenous maintenance therapy.
- Employers should evaluate home, ambulatory, office, and self-administered options for clinically stable patients while preserving gastroenterologist discretion.

7. For clinically stable members, allow lower-cost, convenient infusion or self-administered options, while keeping the gastroenterologist in the driver's seat

- Recognize that subcutaneous treatments have maintenance-phase efficacy comparable to IV therapy.
- For appropriate, stable patients, your vendors should evaluate:
  - Home infusion
  - Ambulatory infusion centers
  - Office-based infusion
  - Self-administered subcutaneous formulations
- Build benefit pathways that:
  - Encourage lower-cost sites of care
  - Avoid unnecessary hospital outpatient infusions
- Preserve GI discretion to determine when IV therapy or higher-acuity settings are clinically necessary.
- This approach reduces avoidable spend while maintaining continuity and safety.

8. Close non-drug care gaps that drive avoidable costs

- Treat IBD as a whole-person condition – not a pharmacy-only issue – by integrating medical, behavioral, and supportive care into a single, coordinated pathway. This includes embedding specialty pharmacy, behavioral health, nutrition, anemia management, and pre-biologic screening into standard workflows, alongside routine infection screening and prevention (e.g., vaccinations).
- Address common comorbidities and care gaps—such as anemia, bone loss, arthritis, mental health conditions, fatigue, and missed vaccination or infection screening—which reduces complications and helps control total cost of care.

9. Support work and caregiver accommodations as a cost-management tool[26]

- Flexible scheduling for infusions and colonoscopy preparation, restroom access, remote or hybrid work where feasible and leave policies that recognize caregiver burden can reduce productivity loss and prevent avoidable turnover.
- This is especially relevant because caregiver burden is common and materially affects absenteeism and presenteeism.
- By supporting practical work and caregiver accommodations, employers can meaningfully reduce avoidable productivity loss and the downstream costs of preventable attrition.
- When able, use on-site or near-site clinics to support symptom management.

Work with your third-party vendors to design benefit plans so that they do not come between the patient and their healthcare team when it comes to their treatments.

Fewer Than Half of Newly Treated U.S. IBD Patients Received Colonoscopy Within 15 Months

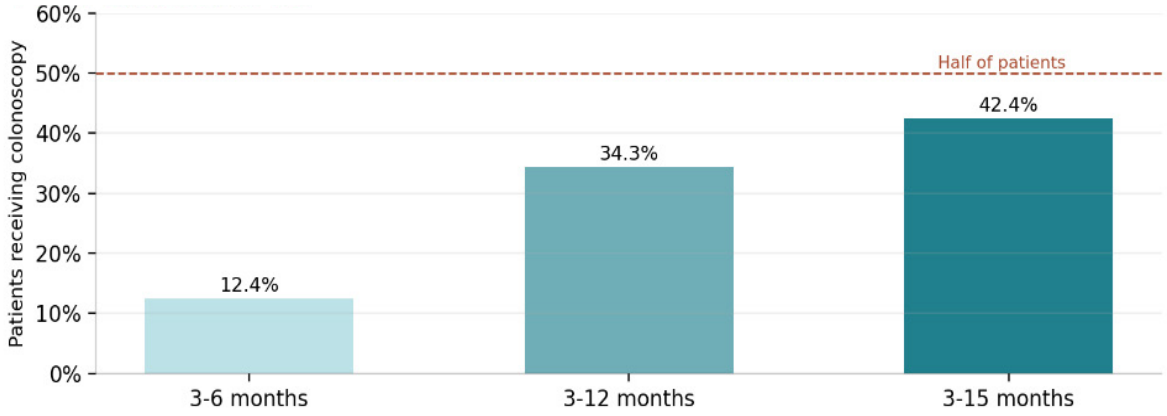


Figure 3. Endoscopic monitoring gap after IBD treatment initiation in a U.S. commercially insured cohort.[27]

Vendor Partners Checklist

A practical way to implement an IBD strategy is to align pharmacy, medical management, specialty care, and workplace policy around a short list of measurable controls.

Therapy selection should be individualized based on disease severity, comorbidities, prior treatment history, and patient preferences. Ensuring timely access to advanced therapies-when clinically appropriate-can reduce healthcare resource use and generate measurable savings.

Use the checklist below to identify important actions you can use to support your efforts working with vendor partners:

1. Action:

- ☐ Create an IBD prior authorization pathway tied to severity
- ☐ Ensure early and broad access to advanced therapies for patients with moderate-to-severe disease

Why it matters:

- Reduces low-value delay for moderate-to-severe disease while preserving control of inappropriate use

What to monitor:

- Approval turnaround time, appeals, and steroid use before biologic approval

2. Action:

- ☐ Direct vendor partners to use objective severity criteria when applying utilization management policies (e.g., Prior Authorization and Step Therapy)
  - Objective severity criteria include endoscopy, biomarkers, imaging, and steroid and/or opioid dependence
- ☐ Require that advanced therapies are approved without step therapy when the objective evidence shows existence of moderate-to-severe disease
- ☐ Do not allow prolonged trials of therapies no longer recommended for moderate-to-severe disease
- ☐ The rules need to be applied consistently across all reviewers, policies, and delegated entities

What vendor partners need to monitor:

- Approval turnaround time
- Appeal approval rates – High approval rates may indicate unnecessary delays caused by the review process
- Steroid use before biologic approval – Continued use of opioids

Why it matters:

- Reduces delays caused by low-value therapies

3. Action:

- ☐ Direct carriers, PBMs, and specialty pharmacy partners to automatically flag members with repeated steroid or opioid use and route them for GI review, because these patterns often signal uncontrolled disease and rising avoidable cost
- ☐ Report back on members flagged, steroid or opioid utilization trends, and ED utilization tied to uncontrolled disease
- ☐ Use these reports to confirm that vendor partners are catching under-treated disease before it escalates into hospitalizations or high-cost complications

What vendor partners need to monitor:

- Members who show signs of poor control, including:
  - Two or more steroid bursts within 12 months
  - High or rising steroid days supplied
  - Any opioid use related to IBD symptoms
  - ED visits for abdominal pain, dehydration, or suspected flare
- When these patterns appear, it should trigger GI outreach, case management contact, or care-coordination review

Why it matters:

- Repeated bursts often signal poor control and rising avoidable costs

4. Action:

- ☐ Instruct carriers, PBMs, and specialty pharmacy partners to steer members to preferred biosimilars (for brands that have available, equivalent biosimilars) and ensure that every switch is paired with clear education and structured transition support so that savings are realized without compromising adherence or disease control

Require vendor partners to:

- Treat equivalent biosimilars as clinical options for therapies that have brands with available, equivalent biosimilars
- Implement preferred formulary placement to support biosimilar uptake
- Avoid non-medical switching (i.e. changing a patient's medication for reasons unrelated to clinical need, typically driven by formulary design, rebate strategies, or cost management by a payor or PBM) to ensure vendors do not move stable patients from branded drugs to non-equivalent biosimilars
- Ensure providers have access to multiple treatment options to help prevent care delays and better support patient outcomes
- Ensure seamless transitions with:
  - Clear, consistent patient education on equivalence, safety, and expectations
  - Coordinated pharmacy outreach and support during the switch

- Minimal administrative disruption (e.g., avoiding unnecessary reauthorization or treatment restarts)

Why it matters:

- Captures category savings while preserving adherence and continuity of care
- Reduces the risk of avoidable discontinuation or disease destabilization during switches

What to monitor:

- Originator-to-biosimilar conversion rates
- Discontinuation or lapses in adherence after switching
- Net cost trend across the therapeutic category

5. Action:

☐ Direct carriers, PBMs, and specialty infusion partners to evaluate whether members on maintenance therapy can safely transition from high-cost hospital outpatient infusions to lower-cost home, office, ambulatory, or self-administered options—without overriding gastroenterologist discretion

Require vendor partner:

- Assess whether members can use lower cost infusion options when clinically appropriate
- Avoid defaulting to hospital outpatient department unless medically necessary
- Coordinate transitions with the treating GI to maintain continuity and safety

Require vendor partner monitors and report back on:

- Hospital outpatient infusion rates
- Home/office infusion penetration (% delivered in home/office)
- Adverse event rate to ensure safety is preserved while costs decline

Why it matters:

- Higher penetration of these settings means more members are receiving therapy in lower-cost, equally effective environments, which directly reduces total cost of care without compromising safety

6. Action:

☐ Recommend that GI care-management partners report whether members receive the recommended follow-up labs or endoscopic reassessment within the expected 6–12-month window, since treat-to-target only works when monitoring actually happens

What to monitor:

- Members who start an advanced therapy and whether they receive:
  - Biomarker follow-up (CRP or fecal calprotectin) within 3–6 months
  - Colonoscopy or endoscopic reassessment within 6–12 months
- Flag members who miss these milestones so case management or GI outreach can close the gap.

What to monitor and report back on:

- Rates of biomarker follow-up
- Rates of colonoscopy/endoscopic reassessment
- Members overdue for monitoring, since these gaps often signal rising risk and avoidable cost

Why it matters:

- Treat-to-target depends on labs and endoscopic reassessment

7. Action:

☐ Instruct carriers, PBMs, behavioral health vendors, and case-management partners to proactively identify members with fatigue, anemia, or caregiver strain and route them to the right supports, because these issues drive major productivity loss even when disease activity appears controlled

What employers should require from vendor partners

- Flag members showing signs of fatigue, anemia, or caregiver burden through claims, labs, case-management notes, or leave patterns

Connect flagged members to appropriate services, including:

- Case management for care coordination
- Behavioral health support for depression, anxiety, or burnout
- Nutrition or anemia management programs
- Caregiver support resources and flexible leave navigation

Require vendor partners monitor and report back on:

- Case-management referrals
- Behavioral health utilization
- Leave patterns
- Caregiver-leave activity, since these indicators reflect both risk and opportunity to prevent productivity loss

Why it matters:

- These issues materially affect productivity even outside major flares

Tracking the Prevalence of IBD

Diving into our IBD data was interesting, and the prevalence was more than we expected. We can see how much of an impact it's having on our population. We need to look at how we can better educate our employees and there needs to be a campaign to help de-stigmatize these issues in the future.

Employers can track the prevalence of IBD in their covered population by building a claims-based identification and measurement framework. The goal is to move from passive reporting to auditable, longitudinal prevalence tracking. This is most accurate when medical claims, plus pharmacy claims, plus continuous enrollment rules are combined into a validated cohort definition, rather than relying on diagnosis codes alone.

1) Define a Claims-Based Identification Algorithm

The most validated approach is to use medical claims (ICD-10 diagnostic codes). Click here for a breakdown of all ICD-10 codes for IBD.

- K50-All Crohn's disease ICD-10 codes begin with these 3 characters
- K51-All ulcerative colitis ICD-10 codes begin with these 3 characters

Common inclusion rules include:

- ≥2 outpatient claims with IBD diagnosis on different dates, or
- ≥1 inpatient claim with IBD diagnosis, or
- 1 diagnosis + confirmatory treatment (see pharmacy signals in #2 below)

A validated approach is to use administrative claims algorithms to improve accuracy when requiring multiple encounters rather than a single diagnosis code.

2) Incorporate Pharmacy Data to Increase Specificity

Use prescription or infusion claims to confirm the active disease:

- Biologics
- Immunomodulators – not recommended for moderate to severe IBD
- Steroid dependency patterns as severity proxy
- Opioid claims may be used as a way to identify patients with active/uncontrolled disease; opioids should not be used in the IBD population

For a list of IBD therapies, click here.

Gather evidence by combining diagnosis codes with IBD-specific therapies to improve positive predictive value for case identification.

3) Apply Continuous Enrollment Criteria

To ensure complete capture, require 6–12 months of continuous medical and pharmacy eligibility, and avoid partial-year enrollment distortion.

How to Cross-Check NDC Codes With ICD-10 Codes for IBD

1. Check the ICD-10 codes submitted with the claim. Click here for a breakdown of all ICD-10 codes for IBD.
2. Pull the 11-digit NDC from the pharmacy or medical claim. This tells you what drug was dispensed or administered.

Optional for finding mismatches:

3. Confirm that the NDC's FDA indication includes IBD. Some drugs used in IBD also have other indications (e.g., psoriasis, rheumatoid arthritis). You must verify that the NDC corresponds to a product FDA-approved for Crohn's or UC, not just used in other autoimmune conditions.
4. Match the NDC to the ICD-10 code(s). A claim should show:
   - An IBD-relevant NDC, and
   - An IBD-relevant ICD-10 code (K50 or K51)

If both appear together, the claim is highly likely to be for Crohn's or UC treatment.

5. Flag mismatches for review If you see:
   - An IBD drug NDC without an IBD ICD-10 code, or
   - An IBD ICD-10 code with a non-IBD drug NDC

   …then the claim may be miscoded, off-label, or incorrectly routed.

4) Calculate the Prevalence

Once the cohort is defined, use this formula and report the number per 1,000 members.

$$\text{IBD prevalence} = \frac{\text{number of members meeting case definition}}{\text{total covered lives}} \times 1{,}000$$

- Stratify by employee vs dependent, age band, and severity proxy (biologic use, hospitalizations)

5) Validate with Utilization Benchmarks

Employers should cross-check prevalence against:

- GI specialist visits
- Endoscopy utilization
- Specialty pharmacy spend
- Hospital admissions for GI flares

References

1. Crohn's & Colitis Foundation. (n.d.). *IBS vs IBD*. https://www.crohnscolitisfoundation.org/patientsandcaregivers/what-is-ibd/ibs-vs-ibd

2. Cleveland Clinic. (2024, October 22). *Autoimmune diseases: Types, symptoms & treatments*. https://my.clevelandclinic.org/health/diseases/21624-autoimmune-diseases

3. National Institute of Arthritis and Musculoskeletal and Skin Diseases. (2023, March). *Autoimmune diseases: Overview and types*. U.S. Department of Health & Human Services. https://www.niams.nih.gov/health-topics/autoimmune-diseases (niams.nih.gov in Bing)

4. Im, M. E., & Lee, J. L. (2024). *Molecular foundations of inflammatory diseases: Insights into inflammation and inflammasomes*. National Library of Medicine, National Center for Biotechnology Information. https://pmc.ncbi.nlm.nih.gov/articles/PMC10813887/

5. Broder, M. (2023, September 28). *Does IBD influence financial burden, distress, and toxicity?* MedPage Today. https://www.medpagetoday.com/resource-centers/autoimmune-inflammatory-diseases/does-ibd-influence-financial-burden-distress-and-toxicity/4765

6. van Gennep, S., Evers, S. W., Rietdijk, S. T., Gielen, M. E., de Boer, N. K. H., Gecse, K. B., Ponsioen, C. I. J., Duijvestein, M., D'Haens, G. R., de Boer, A. G. E. M., & Löwenberg, M. (2020). *High disease burden drives indirect costs in employed inflammatory bowel disease patients: The WORK-IBD study*. National Library of Medicine, National Center for Biotechnology Information. https://pmc.ncbi.nlm.nih.gov/articles/PMC7885332/

7. Yale Medicine. (n.d.). *Inflammatory bowel disease*. https://www.yalemedicine.org/conditions/inflammatory-bowel-disease

8. Taylor, M. (2024, June 3). *How does Crohn's disease affect the digestive system?* HealthCentral. https://www.healthcentral.com/condition/crohns-disease/crohns-disease-digestive-tract

9. Centers for Disease Control and Prevention. (2024, June 21). *Ulcerative colitis basics*. https://www.cdc.gov/inflammatory-bowel-disease/about/ulcerative-colitis-uc-basics.html

10. Xu, F., Dahlhamer, J. M., Zammitti, E. P., Wheaton, A. G., & Croft, J. B. (2018). *Health-risk behaviors and chronic conditions among adults with inflammatory bowel disease — United States, 2015 and 2016*. MMWR. Morbidity and Mortality Weekly Report, 67(6), 190–195. https://www.cdc.gov/mmwr/volumes/67/wr/mm6706a4.htm

11. Xu, F., Dahlhamer, J. M., Zammitti, E. P., Wheaton, A. G., & Croft, J. B. (2018). *Health-risk behaviors and chronic conditions among adults with inflammatory bowel disease — United States, 2015 and 2016*. MMWR. Morbidity and Mortality Weekly Report, 67(6), 190–195. https://www.cdc.gov/mmwr/volumes/67/wr/mm6706a4.htm

12. Park, K. T., Ehrlich, O. G., Allen, J. I., Meadows, P., Szigethy, E. M., Henrichsen, K., Kim, S. C., Lawton, R. C., Murphy, S. M., Regueiro, M., Rubin, D. T., Engel-Nitz, N. M., & Heller, C. A. (2020). *The cost of inflammatory bowel disease: An initiative from the Crohn's & Colitis Foundation.* Inflammatory Bowel Diseases, 26(1), 1–10. https://doi.org/10.1093/ibd/izz104

13. Crohn's & Colitis Foundation. (n.d.). *Extraintestinal complications of IBD*. https://www.crohnscolitisfoundation.org/what-is-ibd/extraintestinal-complications-ibd

14. Centers for Disease Control and Prevention. (2024, June 21). *Inflammatory bowel disease (IBD): IBD facts and stats*. https://www.cdc.gov/inflammatory-bowel-disease/php/facts-stats/index.html

15. Manceur, A. M., Ding, Z., Muser, E., Obando, C., Voelker, J., Pilon, D., Kinkead, F., Lafeuille, M.-H., & Lefebvre, P. (2020). *Burden of Crohn's disease in the United States: Long-term healthcare and work-loss related costs*. Journal of Medical Economics, 23(7), 699–708, https://www.tandfonline.com/doi/full/10.1080/13696998.2020.1789649#abstract

16. Pilon, D., Ding, Z., Muser, E., Obando, C., Voelker, J., & Manceur, A. M. (2020). *Long-term direct and indirect costs of ulcerative colitis in a privately-insured United States population*. Current Medical Research and Opinion, 36(8), 1285–1294. https://doi.org/10.1080/03007995.2020.1776263

17. Youssef, M., Hossein-Javaheri, N., Hoxha, T., Mallouk, C., & Tandon, P. (2024). *Work productivity impairment in persons with inflammatory bowel diseases: A systematic review and meta-analysis.* Journal of Crohn's & Colitis, 18(9), 1486–1500. https://doi.org/10.1093/ecco-jcc/jjae057

18. Ding, Z., Muser, E., Izanec, J., Lukanova, R., Kershaw, J., & Roughley, A. (2022). *Work-related productivity loss and associated indirect costs in patients with Crohn's disease or ulcerative colitis in the United States.* Crohn's & Colitis 360, 4(3), otac023. https://pmc.ncbi.nlm.nih.gov/articles/PMC9802455/

19. American Medical Journal. (2018, August 28). *Individualised care for Crohn's disease: Evolving approaches for a progressive disease.* https://www.emjreviews.com/en-us/amj/gastroenterology/symposium/individualised-care-for-crohns-disease-evolving-approaches-for-a-progressive-disease/

20. National Institute of Diabetes and Digestive and Kidney Diseases. (2024, July). *Treatment for Crohn's disease: How do doctors treat Crohn's disease?* https://www.niddk.nih.gov/health-information/digestive-diseases/crohns-disease/treatment

21. National Institute of Diabetes and Digestive and Kidney Diseases. (2020, September). *Treatment for ulcerative colitis: How do doctors treat ulcerative colitis?* https://www.niddk.nih.gov/health-information/digestive-diseases/ulcerative-colitis/treatment

22. Crohn's & Colitis Foundation. (n.d.). *Medications.* https://www.crohnscolitisfoundation.org/medications

23. Buchner, A. M., Farraye, F. A., & Iacucci, M. (2024). *AGA clinical practice update on endoscopic scoring systems in inflammatory bowel disease: Commentary.* Clinical Gastroenterology and Hepatology. https://www.cghjournal.org/article/S1542-3565(24)00718-3/fulltext

24. Zand, A., Kim, B. J., van Deen, W. K., Stokes, Z., Platt, A., O'Hara, S., Khong, H., & Hommes, D. W. (2020). *The effects of inflammatory bowel disease on caregivers: Significant burden and loss of productivity.* Crohn's & Colitis 360. https://pmc.ncbi.nlm.nih.gov/articles/PMC7302133/

25. Julia Shelton, Kristin Niakan (2026). Milliman Report on Considerations for Commercial Plan Sponsors Evaluating Specialty Drug Carve-out Programs. https://www.milliman.com/en/insight/commercial-plan-sponsors-specialty-drug-carve-out

26. Crohn's & Colitis Foundation, Patient & Caregivers. https://www.crohnscolitisfoundation.org/patientsandcaregivers/ibd

27. Yang, J. Y., Lund, J. L., Pate, V., & Kappelman, M. D. (2022). *Utilization of colonoscopy following treatment initiation in U.S. commercially insured patients with inflammatory bowel disease, 2013–2019.* Crohn's & Colitis 360. https://pmc.ncbi.nlm.nih.gov/articles/PMC10152285/

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Midwest Business Group on Health

About MBGH

Midwest Business Group on Health (MBGH) is a 501c3 non-profit supporting employers seeking solutions to better manage the high cost of health care and the health and productivity of their covered populations. Founded in 1980, MBGH offers members leading educational programs, employer-directed research projects, purchasing opportunities and community-based activities that increase the value of health care services and the health benefits they offer to members. MBGH serves over 180 companies who provide benefits to over 4 million lives, with employer members spending more than $15 billion on health care each year.

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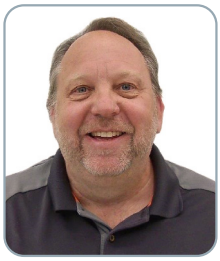

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The information provided in this resource is based on the author's and contributors' experiences working in the health benefits and health care industry. For more information on any aspect of this report, please contact info@mbgh.org.