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HR Strategy and Employee Benefits

Analysis of Health Claims Data Drives Appropriate Plan Design and Targeted Wellness

After shopping for shoes online last week (I really hate going to the mall!), I noticed that all of the sudden I had a lot of suggestions for shoe companies showing up in my Facebook feed and as advertisements in my Yahoo mail account. While a bit creepy, it's a sign of an increasing trend across industries. Today, the analysis of data drives advances in commerce more than nearly anything else. The power of Amazon is less in the products sells and more in the algorithms that determine what you might buy next, and the ability to address that need.

The same is true in health care claims data. Data drives the ability for employers and insurers to address trends in claims data via plan design, plan election steerage, incentives and disincentives for use and participation, and targeted wellness programs.

Self-funding (aka self-insurance, partial self-funding, etc.) has traditionally provided the greatest ability for employers to have access to and analyze their employee, dependent, and spouse claims data. Unfortunately, this has historically been limited to employers with approximately 100 or more covered employees. However, the self-funding trend is beginning to move to smaller employers now as well, and that creates a significant opportunity for employers of all sizes to review their claims data.

What Kind of Data Should Employers Seek?

The analysis of claims data focuses on a wide variety of factors, and looks for trends from year-to-year, as well as deviations from benchmarking norms.

Examples of the types of trends an employer might find include:

- Very high emergency room utilization.
- High incidents of diabetes diagnosis, and correspondingly low utilization of testing strips, H1AC tests, prescription drug utilization, and other supplies.
- Low claims numbers for annual preventive checkups.
- Low generic drug utilization.
- Higher than average cholesterol medication usage.

In a vacuum, many of these numbers don't provide much guidance on what steps to take to address them. However, in the context of year-to-year data and benchmarking norms, you can begin to formulate a plan to lower the

number of incidents and costs specific to that employer.

What Can be Done with the Data?

The results provided from the analysis of claims utilization data has two primary purposes – health/prescription drug plan design and wellness program design. Let's use our earlier examples to provide some examples of plan design and/or wellness design changes.

- Very high emergency room utilization.
  - Increase emergency room copays or separate deductibles.
  - Educate employees on a) how to find a primary physician b) the appropriate use of the emergency room and urgent care centers and c) the location of urgent care centers or other non-emergency facilities, hours, and phone numbers.
- High incidents of diabetes diagnosis, and correspondingly low utilization of testing strips, and other supplies.
  - Remove the copay barriers on checkups, and testing strips and other supplies.
  - Utilize wellness program to provide seminars on proper diet and exercise, the long term dangers of diabetes, and incentives for regular checkups.
  - Provide incentives to taking positive action towards managing the disease and/or results towards improved health.
- Low claims numbers for annual preventive checkups.
  - Provide wellness incentives for employees and family members who attend their annual preventive checkups.
  - Communicate the importance of annual checkups, and low cost for the visit.
- Low generic drug utilization.
  - Educate employees on the chemical equivalency of generic and brand name drugs.
  - Increase copay differential between generic and brand name drugs.
  - Implement coinsurance (versus copay) design to encourage consumerism.
  - Share programs at local pharmacies that provide low or no cost generic or certain classes of drugs (such as antibiotics).

- Higher than average cholesterol brand name medication usage.
    - Incorporate programs that drive generic utilization.
    - Utilize wellness program to provide seminars on proper diet and exercise, the long term dangers of high cholesterol, and incentives for regular checkups and maintenance drugs.

HIPAA Privacy Compliance

The analysis of claims data and the design of wellness programs also necessitate legal compliance as well. Protecting the privacy of the individuals covered under the health plan is paramount, and HIPAA provides the legal guidelines within which employers and Business Associates must act.

HIPAA Incentive Compliance

In addition, with regard to wellness incentives, HIPAA also regulates the incentives allowed for wellness activities and/or achieve certain outcomes (see our previous article).

Summary

The analysis of claims data provides the greatest ability for an employer to have an impact on health care costs and employee health. Altruism and short-term cost savings are important, but the largest ROI is the impact on avoiding future high dollar claims (i.e. strokes, cancer, heart attacks, etc.).

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