# Views How ‘thinking medically’ can better manage healthcare costs

By Steve Laczynski
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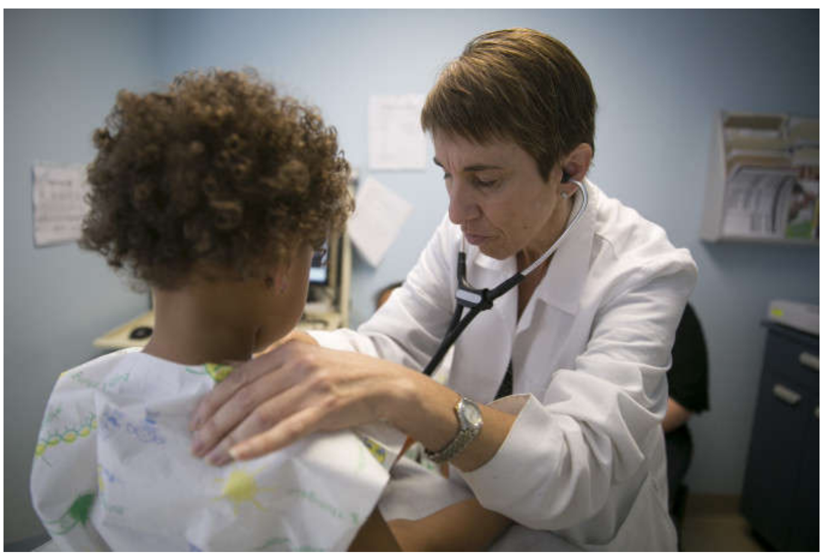
By the second week of January, athletic clubs report a doubled increase in volume, based on a flood of New Year's resolutions to “get in shape.” But as good intentions fall by the wayside, an estimated 80% of those would-be fitness enthusiasts stop showing up by the second week of February — about the same percentage as those who abandon use of wearables within two weeks.

Similarly, companies launch employee wellbeing programs with high expectations about achieving improved employee health and healthcare cost savings by heading off chronic disease. But in some cases, those expectations are dashed when employees either fail to participate or participate only through the assessment phase, without following through on the steps needed to improve health. In both cases, savings fail to materialize.

In addition to the missed health opportunity from limited or non-engagement in wellbeing initiatives, both employees and employers incur financial repercussions. The average self-insured employer experiences a 5-6% increase in healthcare costs every year — a financially unsustainable proposition for any business. Many employers have passed on those costs to employees through cost-shifting. Based on a Quest Diagnostics analysis, we found employees in employer-sponsored wellness programs had 30% lower claim costs than non-participants ($6,300 versus $9,142 per employee, per year), were 50% less likely to have an in-patient hospital visit, and visited the emergency room 33% less often.



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Given these trends of healthcare costs, the best way to keep healthcare costs flat for both employers and employees is to use tools that results in savings. But one-size-fits-all, blanket approaches to employee health and wellbeing generally fail to deliver on their promise, doing little to rein in costs.

As one of the nation's largest providers of employer health and wellbeing programs, we encourage employers and their third-party administrators to “think medically” — using their programs to proactively target the right people at the right time with the right interventions. By prioritizing not just engagement but action and monitoring, companies can maximize their investment and increase the chance of actions that both improve health and flatten costs.

**Engagement must serve as a conduit to care**

First, just as it does little good to identify a banking error without actually having it rectified by the bank, employers must ensure that engagement doesn't start and end with an initial assessment.

Most individuals are highly motivated, for example, when test results are first provided — their "aha" moment. But when faced with "going it alone," without guidance or support, many employees fail to take action in a way that will actually change the trajectory of their health.

To encourage maximum engagement, screening programs should be actionable. They should aim to provide not only privacy-protected result values but also custom messaging about resources available to employees and/or opportunities for digital or in-person care management. When the employee are encouraged to access the right care at the right time — for example, when pre-diabetes is identified –they are more likely to pursue strategies that not only benefit their health, but also prevent costly complications of advanced disease onset.

**Data integration for cost-saving intervention**

According to the American Health Policy Institute, high-cost claimants — individuals with high utilization of services such as inpatient hospital costs, disproportionate pharmacy benefit use, specialist care and ambulatory services — represent 1.2% of the member population, but 31% of total healthcare spend.

Many third-party administrators understand that these claimants drive the majority of spend for employers and recognize that costs (and conditions) need to be controlled, but lack the expertise to "think medically" about solutions. To reduce costs, programs must leverage claims data and cognitive computing for a deeper, individualized analysis, and provide predictive insights about the "path" these high cost claimants and future high cost claimants are on.

These health analytics can examine de-identified claims data to help determine whether utilization is out of the ordinary, so high utilization subpopulations can be offered supportive and acceptable alternatives that are less costly. For example, groups of employees who repeatedly seek emergency care may be offered regular consultations with telehealth professionals.

Successfully managing healthcare costs requires a clear understanding of the health of the population that is being managed. There are two data elements that are critical insights that should drive a cost management strategy, the first foundational component is biometric screenings; when screening programs provide testing that is insightful, meaningful, and connected to care it enables early identification of disease and enables employers to understand key population level trends in aggregate and adjust health management strategies and programs. The second component is to closely monitor de-identified claims data and work in conjunction with third party administrators to adjust plan design accordingly.

**Proof of "thinking medically" is in the savings**

According to a 2016 Kaiser Family Foundation study, deductibles for employees in employer-sponsored plans are 50% higher than they were five years ago, and workers are paying a higher percentage of the premiums, an average of $5,277 annually. This is similarly unsustainable.

By going beyond basic engagement and thinking medically, employers may reach two ultimate goals on the return on their investment in health and wellbeing initiatives: long-term cost-savings and a happier, healthier workforce that, in turn, delivers for the company.

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