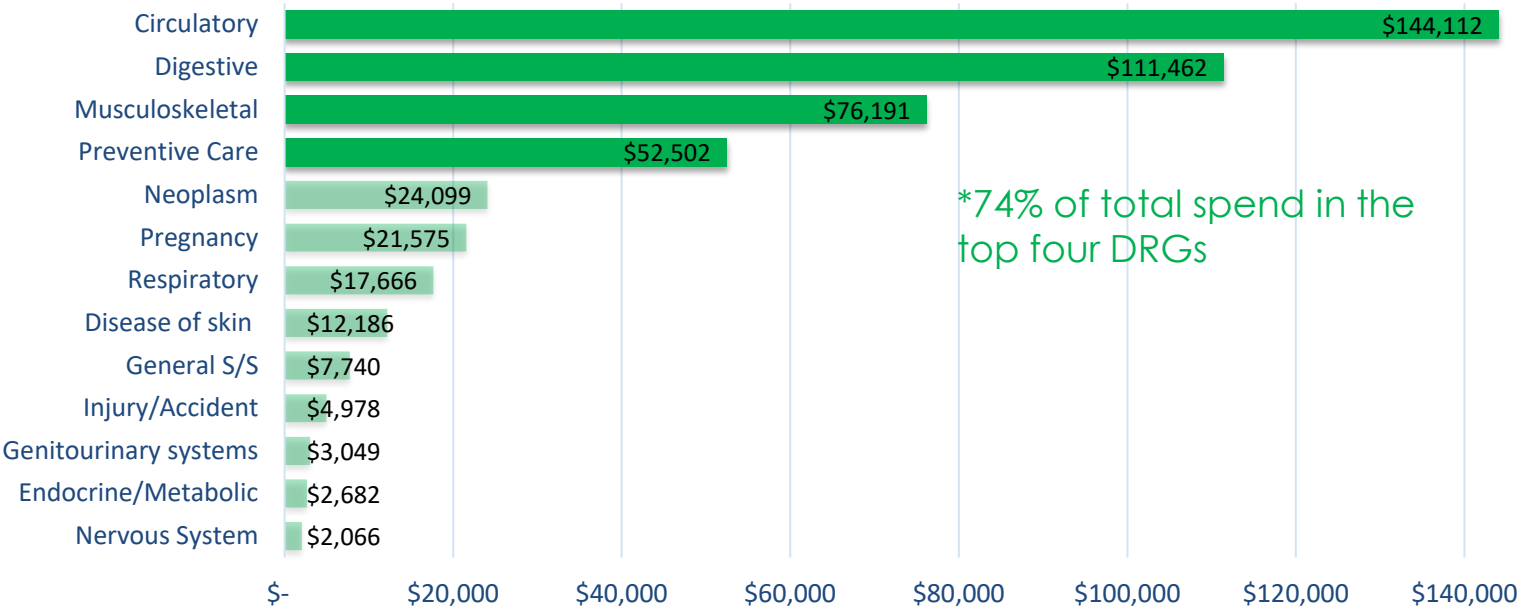
# Merit Distributors Health Plan Analysis

Prepared for Giltch Benefits Group
by Connect Healthcare Collaboration

## Top Diagnosis Groups by Spend




*74% of total spend in the top four DRGs

## Weaknesses

- No Specialty Drug Program
- Expensive Care Management Program
- Predominately older male population (two expensive members over age 69; nine over age 65)
- Lower income population

## Threats

- Lower than expected Diabetes spend
- High malignant findings
- High circulatory spend
- High preventive care spend, but still unhealthy population
- High hypertension diagnosis
- 10% avoidable ER visits

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# Recommendations

## We Recommend…

- Validated Centers of Excellence program
- Specialty Drug management program
- Nurse advocate outreach
- Fair Market Pricing Model
- Musculoskeletal Risk Mitigation

- **74% of total** employer spend is in **top 4 areas:** Circulatory, Digestive, Musculoskeletal and Contact with Health Services. Circulatory (heart attacks) and digestive issues are where the most plan dollars are spent, followed by musculoskeletal issues. We recommend a combination of a Centers of Excellence program and a possible risk mitigation plan for reducing musculoskeletal claims by 35%.

- There have been **some malignant** findings, **yet cancer costs remain low**. This is a future cost that could be on the horizon. However, it is worth noting 30% of all cancers are misdiagnosed in the US. Again, we recommend a Centers of Excellence program that has been validated, along with a potential return to work plan for cancer survivors.

- **Specialty drugs** are carved out (100%-member responsibility), so adherence is unknown (and most likely low based on the unhealthily population.) If left in place**, this could amount to more expensive** medical diagnosis/costs in the future. Our suggestion is to add a specialty drug management program, with a higher specialty drug deductible to help mitigate future medical costs and current admin costs to employer. Step one would include a complete drug spend audit at no cost to employer or advisor.

- **Care Management** is an add on at $135/hr. How is it being received and used? There are several markers in the plan that could **indicate a missed opportunity** for early engagement. Generally, these could be addressed through a similar program:
  - Diabetes spend is low – could be underdiagnosed. Are people not going to the doctor? This would be something to watch for, given the population.
  - COPD is a high spend that should be addressed through care management.
  - Sleep stands out as a high spend – is this a high anxiety population?

  In place of Care Management, we suggest adding a nurse advocate who has specific outreach plans based upon the factors above. A cost savings from an hourly fee, but with a roadmap in place to support the execution of a high performing health plan.

- It appears the plan is **running incredibly well** when it comes to **using preventive care services**. If each preventive care service counts for one unique user – then 82% of adults had a preventive care visit so far this year. However, the population is still unhealthily – what is being missed?

- This is a **predominately older, male population** located in the southeast. How have they responded to the change toward RBP? A Fair Market Pricing model might be a less disruptive option with a similar expected cost savings realized.

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