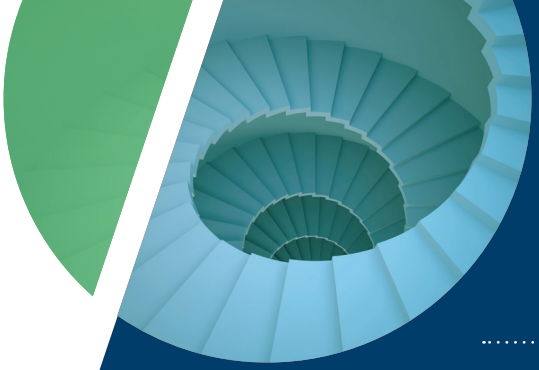


February 2022

viewpoint

# Is the private medical claims data gap costing you?

In many markets around the world, healthcare services are delivered through a mix of public and private healthcare. These sectors operate in two very separate spheres and, while governments and policymakers have excellent insights into public healthcare usage and visibility, there's often inadequate information available about the private sector.[1]

We're sure you're aware of the importance of analysing your own private medical claims data to make proactive changes and keep your people healthy, but did you know the lack of visibility of private medical claims data for policymakers and governments might be costing you too?

If policymakers don't have the full picture of the health landscape in their country, how can they effectively implement change to tackle the biggest healthcare problems affecting their populations? You don't want to be left to pick up the slack and pay the price because public health systems don't know the full picture.

When policymakers do have full visibility of the healthcare landscape – by looking at both public and private healthcare data – they can make proactive changes that can benefit all patients. And, ultimately, this benefits employers. If people are healthier, it can lead to increased productivity, greater individual, team and organisational resilience, reduced absenteeism rates, increased engagement and morale, and lower healthcare costs.

## The global private healthcare landscape – a story told by MAXIS claims data

The good news is, there are some things that can be done to help close the data gap. At MAXIS, we collect anonymised medical claims data from our local insurance partners so we can inform our multinational clients about their biggest cost drivers.

This means we are looking at a missing piece of the puzzle – private medical data that is often unseen in the public space. While this isn't a silver bullet to close the data gap, and we are just a small portion of the world's private claims data, we do have an opportunity to do our part and share some of our insights.

For the first time ever, we've taken our findings from the standardised and anonymised data and created a report on the private medical landscape in all our markets around the world. It's called **"The global private healthcare landscape – a story told by MAXIS claims data"** and will be released very soon.

But closing the data gap isn't our only goal. By sharing an in-depth look at private medical claims data, we hope that multinationals like you can gain insights into the biggest cost-drivers in each region, and understand the underlying trends that play a role in those drivers, so you can plan accordingly. This could be done in a variety of ways from putting in place wellness and preventative programmes, making adjustments to plan design and reimbursement processes, to network changes and other new innovative healthcare cost reducing methodologies.

## Tackling outpatient claims

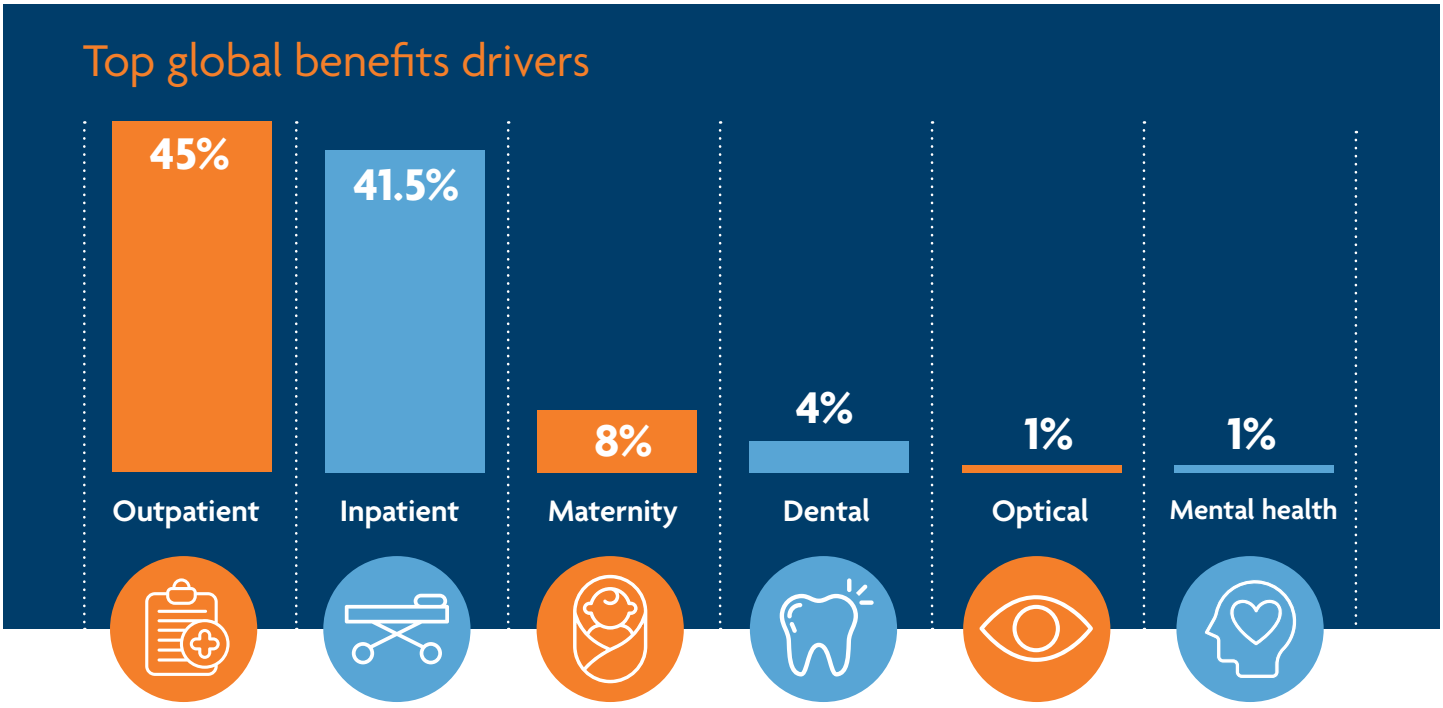
"What kind of insights will you be sharing", we hear you ask?

To give you a teaser of what to expect from the report, we thought we should talk you through one of the more surprising findings – multinationals in our healthcare markets are spending more on outpatient claims than any other benefit type.

In fact, outpatient care makes up 45% of paid claims, surpassing inpatient claims (41%). This is surprising for three main reasons.

1. **Some of our medical markets are predominantly in-patient-only** – the only outpatient costs in these markets (such as Mexico) come when inpatient cases need follow-up treatment on an outpatient basis.
2. **Outpatient services are typically not offered by private insurance carriers** – in many countries, particularly in many emerging markets, outpatient treatments are covered by a country's national healthcare system.
3. **Inpatient services are normally considerably more expensive than outpatient.**

Deductibles, co-payments and other required employee contributions haven't increased in line with general inflation and medical trend for several years, some for over decades. Naturally with this progression, employers will be left carrying the extra costs.



## Given all of this, why are outpatient claims more costly?

The first trend we observed in the data that plays a role in driving up claims is self-referral to specialists due to under-developed primary care infrastructures. In many markets, there's no standard primary care physician or general practitioner (GP) system or no requirement to see either before seeing a specialist, leading to inappropriate use of specialist care. Patients are often able to see several specialists without the centralised co-ordination of primary care, running up often unnecessary costs from repetition of diagnostic tests and treatments.

Another factor that is contributing towards increased outpatient costs is the lack of follow-up care when the primary care model isn't used. While there's no doubt that excellent specialist care is necessary to streamline a diagnosis and correctly manage illness, when there's no central care coordination, the percentage of patients doing the recommended follow-up care is low.

There are also a number of ways an insurance plan is designed that can cause a rise in outpatient costs. One such factor is that employee contributions are not rising in line with inflation. In some of our emerging markets, we see that deductibles, co-payments and other required employee contributions haven't increased in line with general inflation and medical trend for several years, some for over decades. Naturally with this progression, you could be left carrying the extra costs.

It's also worth discussing the reimbursement of pharmacy costs. Our claims data shows that, up until fairly recently, certain markets in EMEA and Central America were more generous in their reimbursement approaches to branded than generic drugs, leading to an imbalance in the prescription and dispensation of branded drugs versus their generic alternative.

In the Middle East, our data reflected this market practice for an extensive period but slowly we see perceptions changing in this area. In many markets in this region, however, we still see that over the counter (OTC) drugs are reimbursed in full when prescribed by the physician, unlike in more sophisticated markets where OTC drugs are not covered under the healthcare plan. To put things in perspective, we consistently see branded medications account for a far greater percentage under pharmacy costs than generic drugs. In 2020, 59% of medication spend was for branded medications and over the counter drugs was 24%. With generic drugs on average costing 80-85% less than their branded counterparts, it's easy to see why this area can be a quick win for multinationals looking to control their healthcare premiums.

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### Consultation factors driving outpatient costs

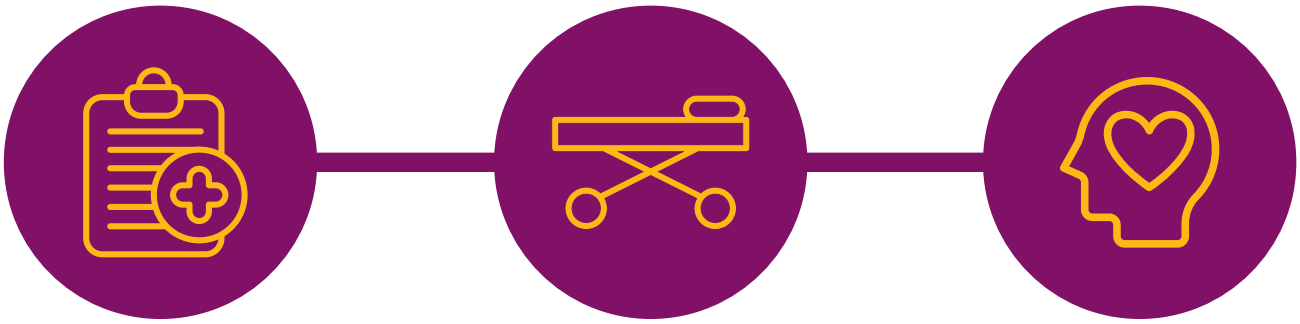
- Self-referral to specialists
- Under-developed primary care infrastructure
- Lack of appreciation of the value of primary care
- Other factors including sick leave certifications etc

### Plan design factors leading to increased outpatient costs

- Patient contributions not rising in line with inflation in less mature markets
- Reimbursement of brand and over the counter drugs

We think it's hard to deny the value of analysing private medical claims data. Not only can this help multinationals like you make proactive changes to improve employee health and stay ahead of the claims curve, but it can help to close the public and private healthcare data gap.

This is a fascinating subject and we can't wait to share the full findings of our report with you. Keep an eye on our LinkedIn page and website in the coming days!



1 Various, World Health Organization https://www.who.int/docs/default-source/health-system-governance/private-sector-landscape-in-mixed-health-systemsc23a2a3a-dc7a-4ef2-8c11-09d74fdb606e.pdf?sfvrsn=b1b58b15_1&download=true (sourced December 2021)21)