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Self-Funding MasterClass

MasterClass Series

Turn Claims Data into a Strategic Lever in Hard Markets

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Welcome

Thank you for investing your time in the Self-Funding MasterClass.

Interpreting **claims data** correctly gives you **control** of the narrative.

Let's **rise** to understand.

So, you have data.
Now what?

Today, we answer what data & how to leverage it in two ways:

Plan Design & Point Solutions

What Makes Up a **Complete** Data Set?

Four required inputs for plan design and point solution decisions

01 Claims Data

Medical and Rx claims at the line-item level — paid, allowed, service dates, diagnosis, procedure, place of service, and member identifiers.

Enables cost, utilization, and driver analysis.

02 Plan Design Data

SPD, SBC, deductibles, copays, coinsurance, OOP max, networks, exclusions, and tier structures by plan option.

Contextualizes utilization and member behavior.

03 Premiums & Funding

Equivalent rates, employer/employee contributions, enrollment by tier, fixed costs, admin fees, and funding arrangement.

Anchors true cost and projected savings.

04 Stop Loss Contract

Specific and aggregate deductibles, contract basis (12/12, 12/15, paid), lasers, reimbursement terms, and disclosure requirements.

Defines catastrophic risk exposure.

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Lag Risk & How Runout *Distorts* Consultant Recommendations

% of Incurred Claims Paid by Month of Runout

30 days = 20%

90 days = 60%

365 days = 85%

Why This Matters

- **Immature data** — paid-basis runs at 3-6 months capture only 60-85% of incurred claims.
- **Understates trend** — driving false "savings" claims and soft renewal recommendations.
- **Hides large claims** — high-dollar inpatient & specialty Rx claims lag the longest.
- **Fix:** evaluate on ***incurred-with-IBNR***, require 12+ months runout before locking strategy.

High Prevalence vs. *Acute*
Claim Drivers Consultants Must Distinguish

MANY MEMBERS · MODERATE COST

High Prevalence

- **Chronic & lifestyle conditions** — diabetes, hypertension, MSK, obesity, behavioral health
- **Predictable, actuarially stable** — consistent year over year
- **Point-solution addressable** — CCM, GLP-1 oversight, MSK, behavioral vendors
- **Plan-design levers** — value-based benefits, steerage, preventive incentives

Strategy: engage & manage *with scaled vendor solutions.*

FEW MEMBERS · CATASTROPHIC COST

Acute / Catastrophic

- **High-severity events** — cancer, transplant, NICU, cell & gene therapy, trauma
- **Volatile & unpredictable** — can swing loss ratio 20+ points
- **Stop-loss driven** — SSL deductible, laser risk, disclosure integrity
- **Case-mgmt levers** — COE, specialty Rx oversight, Rx carve-out

Strategy: protect & finance *through stop loss and clinical oversight.*

Different populations. Different tools. Mixing the two is how consultants misprice renewals.

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Why ICD-Level Reporting *Misleads* Renewal Strategy

Codes alone will not put the whole story together

ICD CODE ALONE

C50.911

Malignant neoplasm, right female breast

- ✕ Stage, grade, biomarkers
- ✕ Treatment trajectory
- ✕ Specialty Rx regimen & cost
- ✕ Site of care / unit cost
- ✕ Comorbidities & risk score
- ✕ Ongoing vs. resolved status

WHAT RENEWAL STRATEGY ACTUALLY NEEDS

- ✓ **Episode-level roll-up** — group related claims across dates, settings, Rx
- ✓ **Risk scoring** — HCC / clinical risk adjustment on top of codes
- ✓ **Rx + medical integration** — specialty drugs often exceed the medical claim
- ✓ **Trajectory view** — ongoing, resolving, or escalating in next 12 months
- ✓ **Stop-loss alignment** — which claimants approach SSL and lasering risk
- ✓ **Actionable cohort** — who is reachable, where, and with which intervention

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Predictive Analytics: Translating Claims Insight into Proactive Action

Predictions aren't guarantees — they're probabilities you can act on

1. IDENTIFY

WHAT CAN BE IDENTIFIED

- Members likely to develop a chronic condition in 12 months
- Gaps in care (labs, screenings, med adherence)
- Rising-risk members trending toward high-cost status
- Specialty Rx / therapy launches (cell & gene, GLP-1)
- Emerging stop-loss exposures

2. PRIORITIZE

HOW TO PRIORITIZE

- Rank by **probability × impact**, not raw claim dollars
- Filter to members reachable by an existing benefit or vendor
- Separate **preventable** from **inevitable** cost
- Match cohort size to vendor minimums and ROI thresholds
- Validate against model confidence & backtest

3. ACT

HOW TO TAKE ACTION

- Deploy targeted outreach and case/condition management
- Tune plan design: steerage, COE, site-of-care, formulary
- Disclose emerging claimants to stop-loss carrier proactively
- Re-run predictions each quarter and measure lift
- Track ***avoided cost***, not just PMPM

Use predictions to shape the next 12 months — not to promise a specific claim outcome.

Three Big Takeaways

1. Get access
2. Prioritize
3. Take action!

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Thank you.

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