MANAGING HEALTH RISK IN THE POST REFROM ERA

Presented by Christian Moreno, Lockton Companies

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L O C K T O N C O M P A N I E S

OVERVIEW

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ASSUMPTION OF RISK – PLAN SPONSORS

The Real Employer Mandate

Brief History – Risk Management

The Current Picture

RISK MITIGATION – EMERGING STRATEGIES

Evaluating New Strategies

Rx, Obesity Surgery & Contingent Wellness

Benefit Designs and Economic Impact

HEALTH CARE REFORM & EMPLOYERS

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REDUCE OVERALL COSTS

{ INCREASE **ACCESS** }

IMPROVE HEALTH

PPACA & PAYER REFORM

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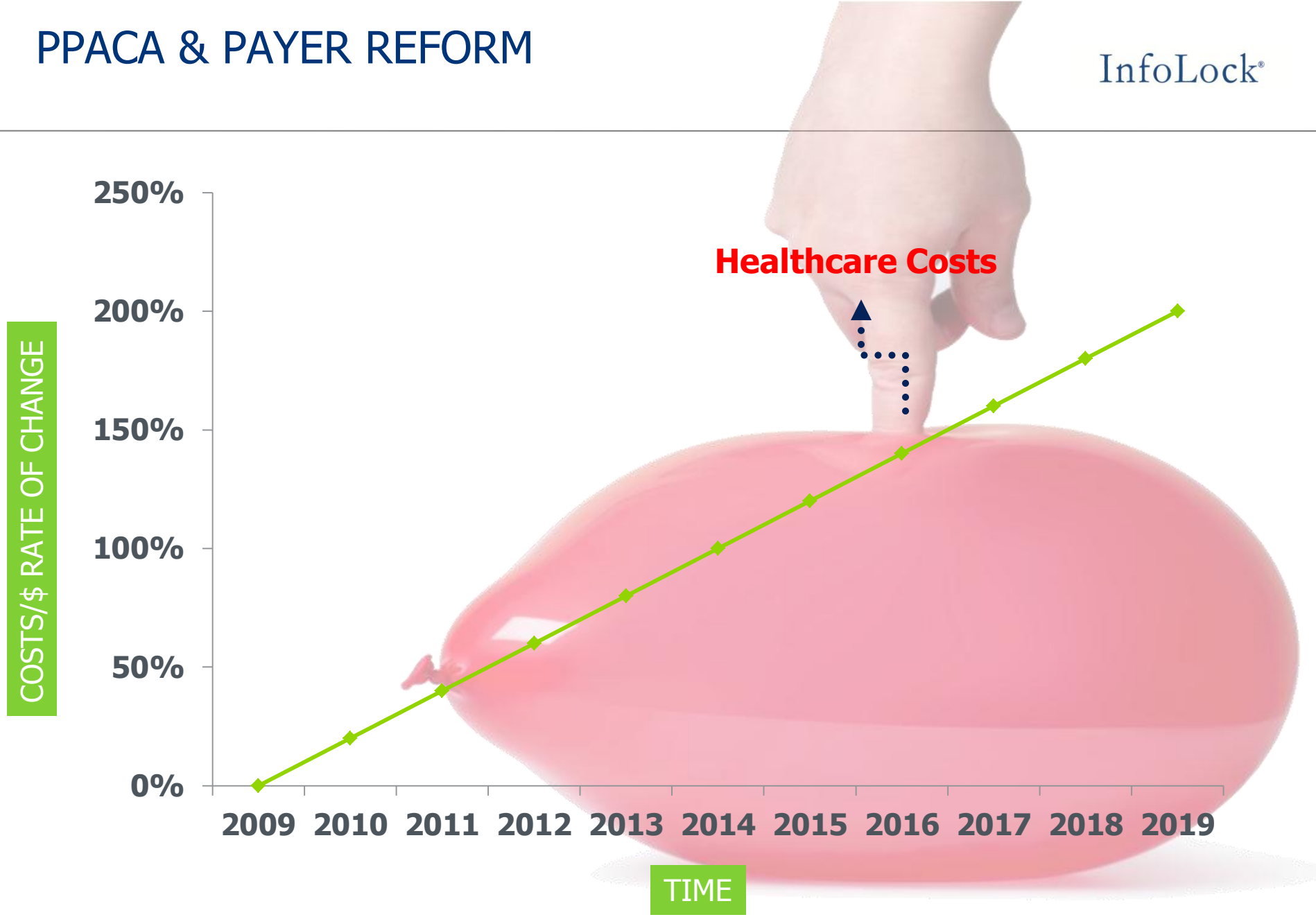

PPACA & PAYER REFORM

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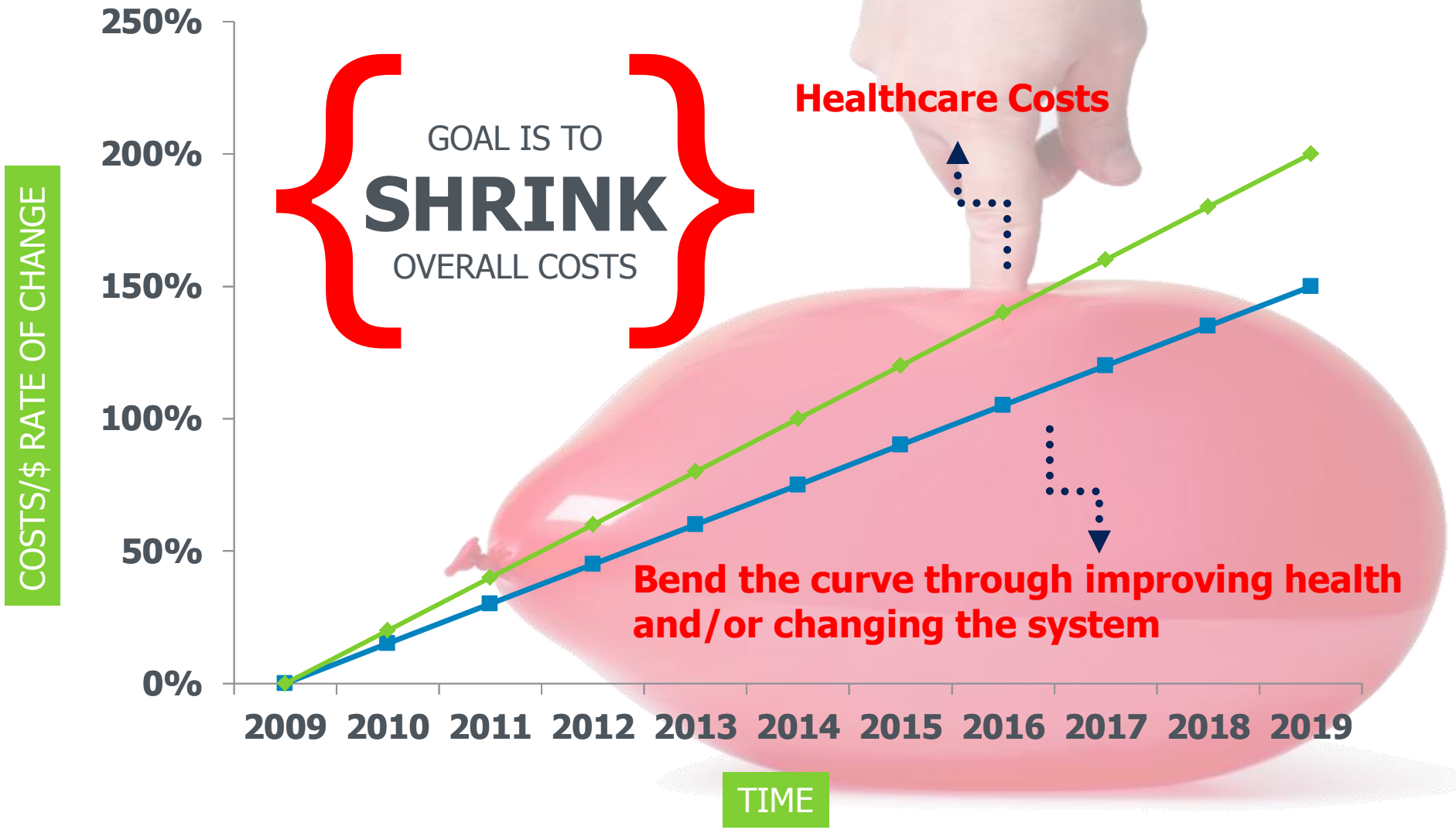

EMPLOYER RISK RETENTION

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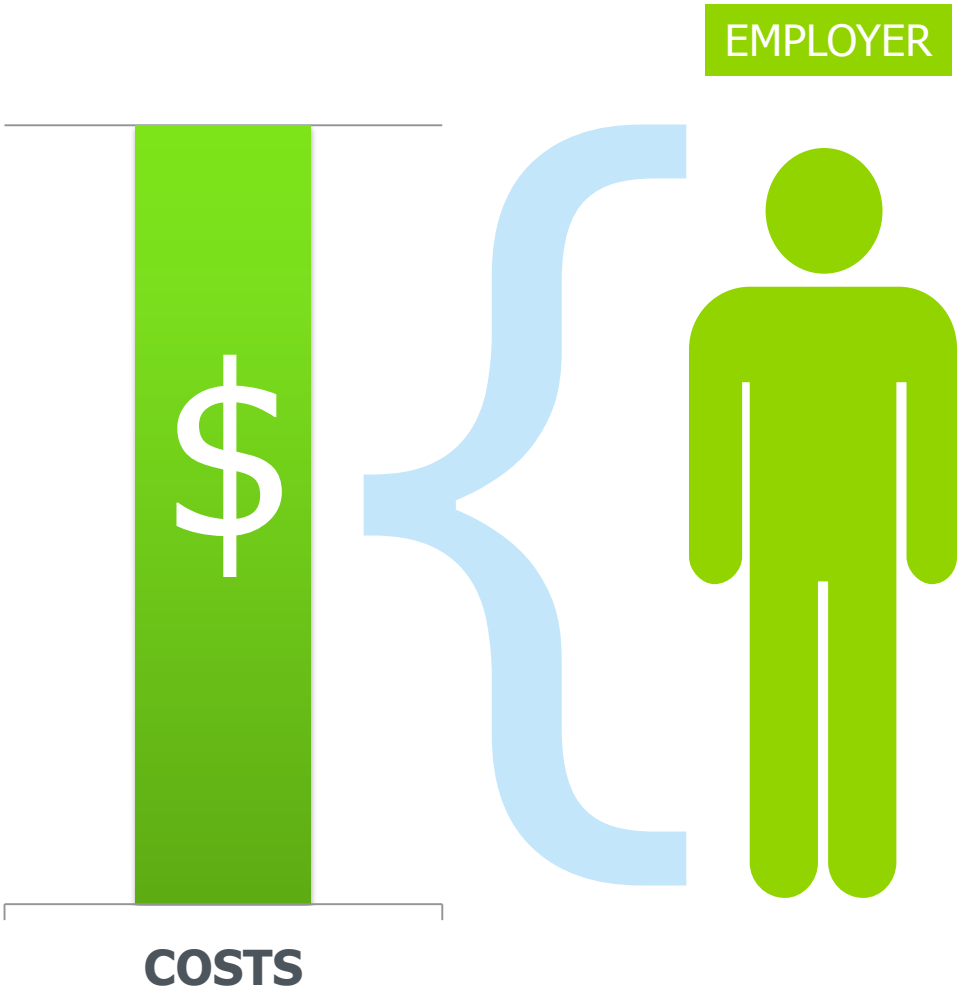

Employers bear the risk (costs) of health care plans

EMPLOYER RISK TRANSFER

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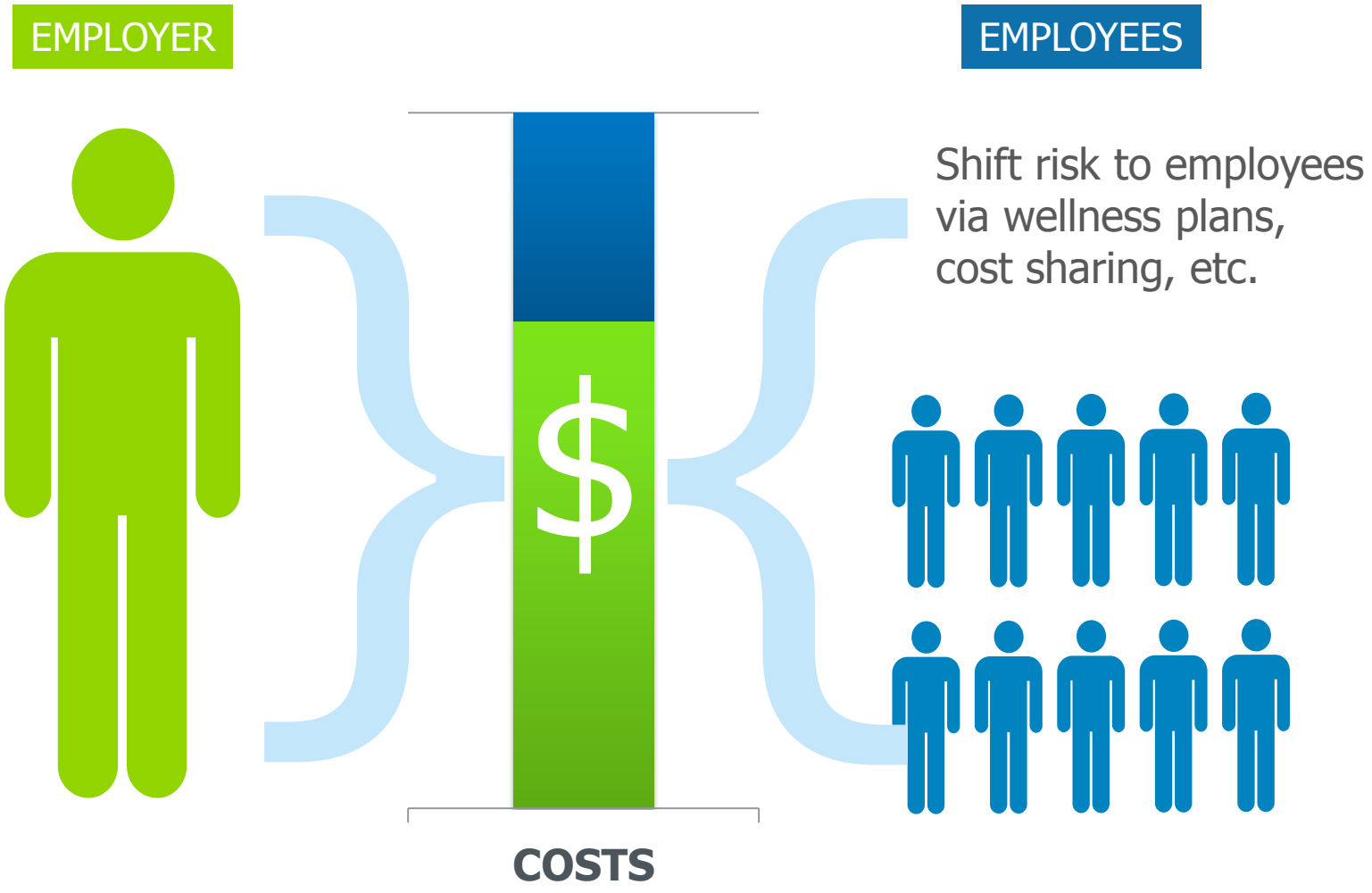

EMPLOYER RISK MANAGEMENT

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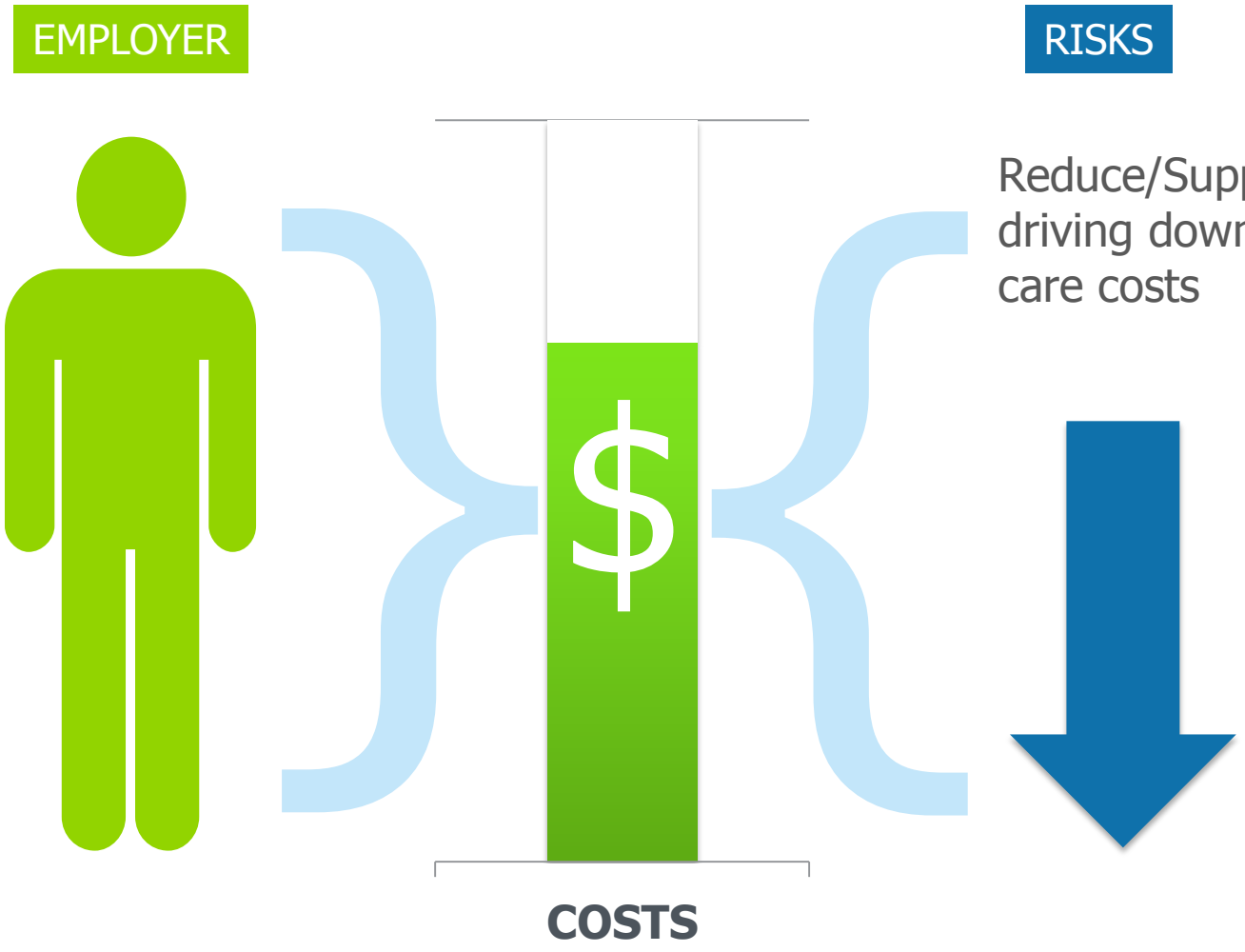

PLAN SPONSOR'S RISK MANAGEMENT PARADIGM

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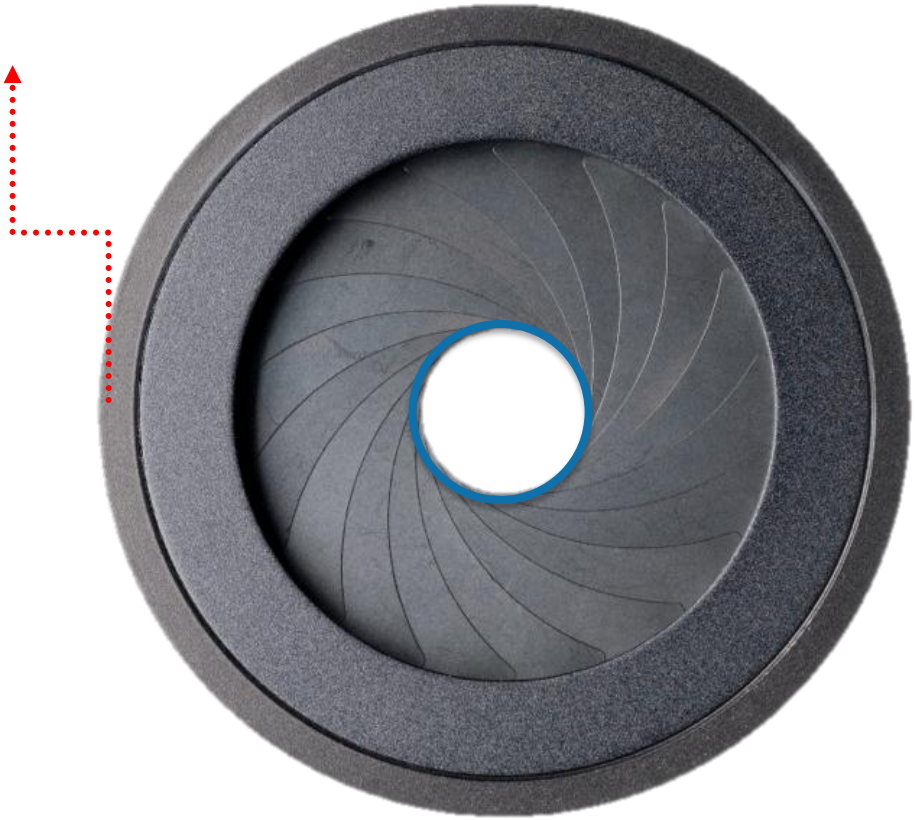
APERTURE – FINANCIAL/BENEFIT DEMONSTRATION

Widening & Narrowing

- Driven by population relevance, costs and relevance/need
- Benefit design = pass through rate at center
- Ebb and flow of plan coverage occurs slowly – i.e. Bariatric and certain Rx
- New entrant/innovation is difficult to evaluate – in particular those that address pre-disease state co-morbidities



COMPLEX PROBLEM

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OBESITY & THE BRAIN: A COMPLEX RELATIONSHIP

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MUST HAVE FOOD ASAP

OBESITY COMPLICATIONS

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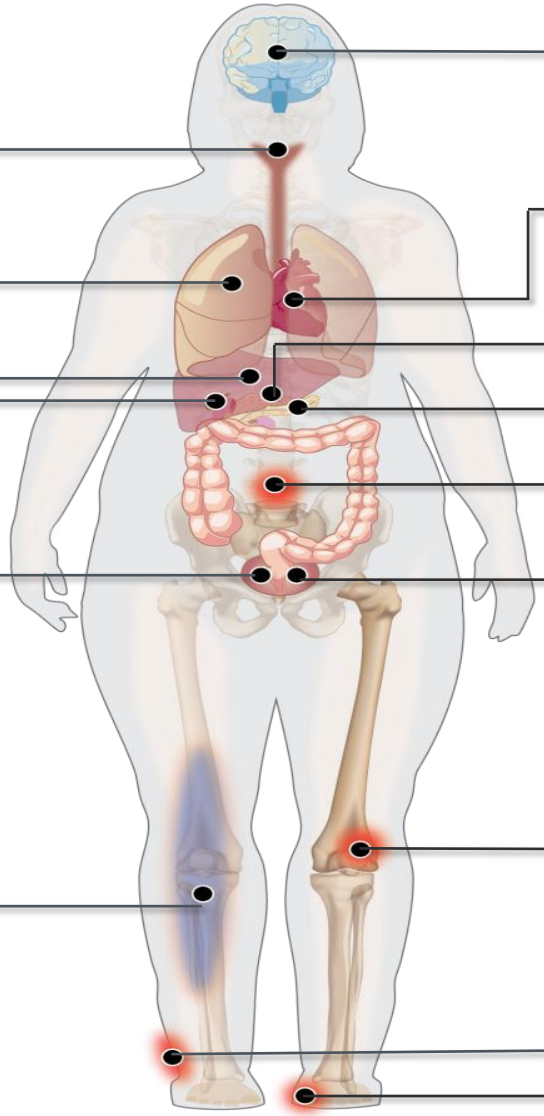

Stroke

Sleep apnea

Lung disease
Asthma
Pulmonary blood clots

Heart disease
Abnormal lipid profiles
High blood pressure

Diabetes

Liver disease
Fatty liver
Cirrhosis

Pancreatitis

Gallstones

Chronic back pain

Urinary incontinence

Infertility
Polycystic Ovarian Syndrome

Cancer
Breast, uterus, cervix, colon, esophagus, pancreas, kidney, prostate

Arthritis

Venous insufficiency

Inflamed veins,
often with blood clots

Peripheral edema

Gout

COMPLEX PROBLEM ECONOMICALY

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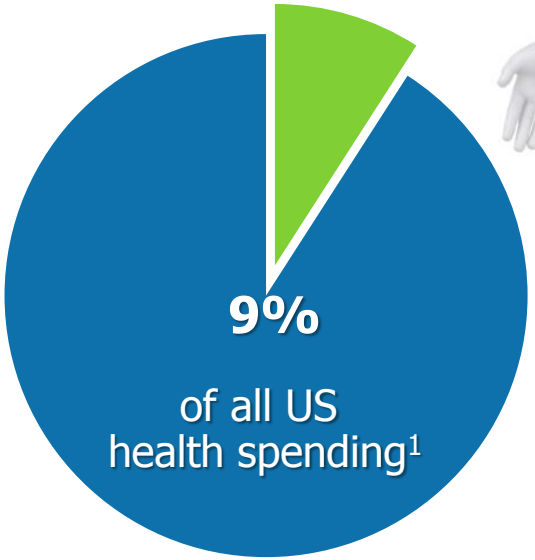
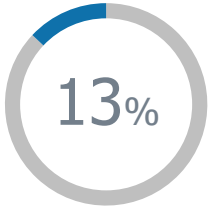
$166 BILLION*[1]

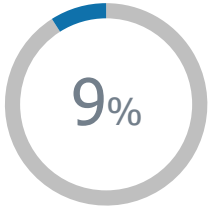
Equivalent to



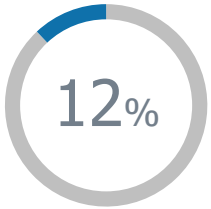
% OF ALL PAYER SPENDING ATTRIBUTABLE TO OBESITY[1]



Commercial



Medicare



Medicaid

*Inflated to 2012 dollars (from $147 billion in 2008) using the medical care component of the consumer price index (CPI)[2]

1. Finkelstein EA, et al. *Health Aff.* 2009;28:w822-w831. 2. Bureau of Labor Statistics. CPI (All Urban Consumers), medical care component. Available at: http://data.bls.gov/pdq/SurveyOutputServlet. Accessed November 8, 2012.

HISTORICAL FOCUS – "EFFECT"

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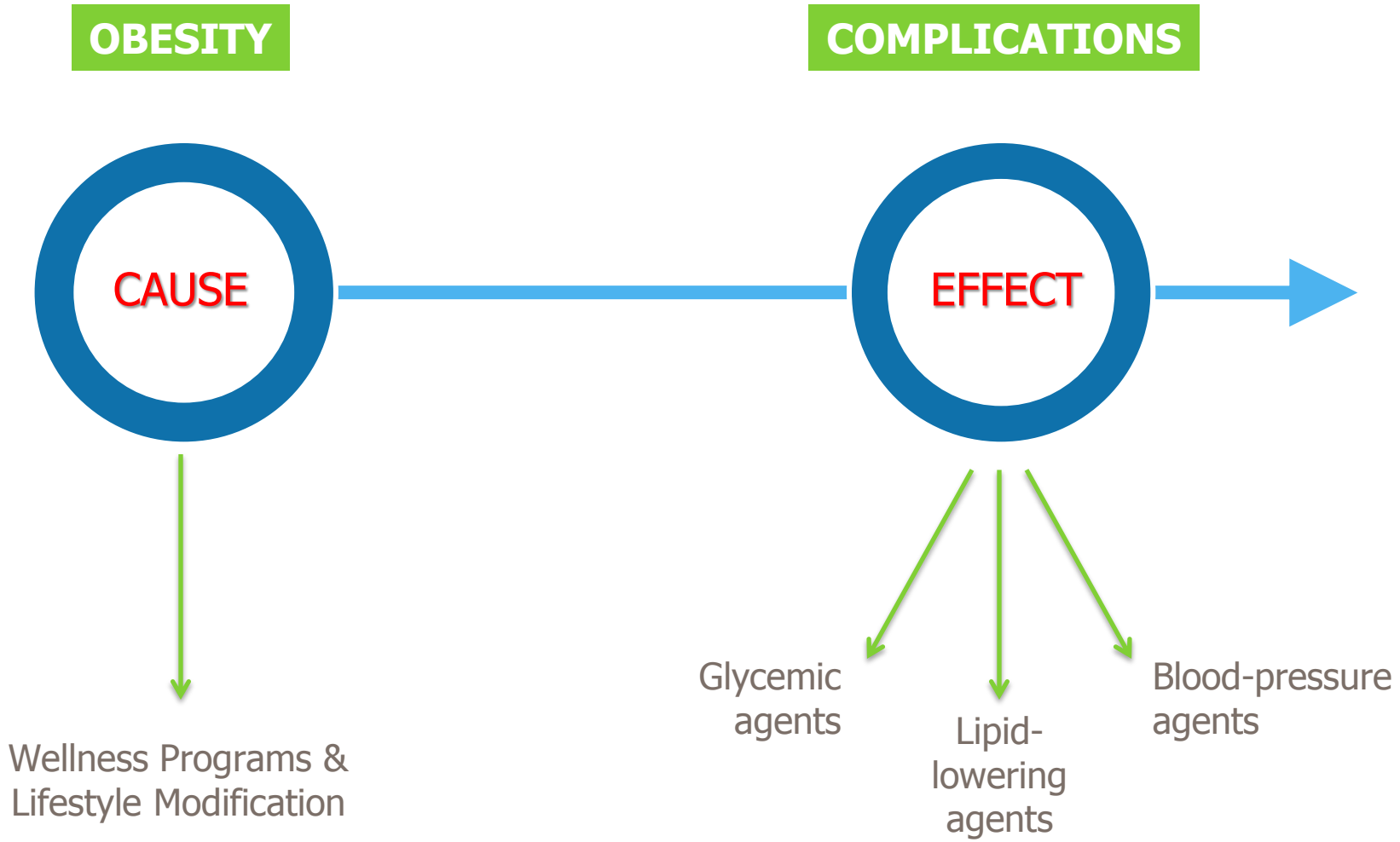

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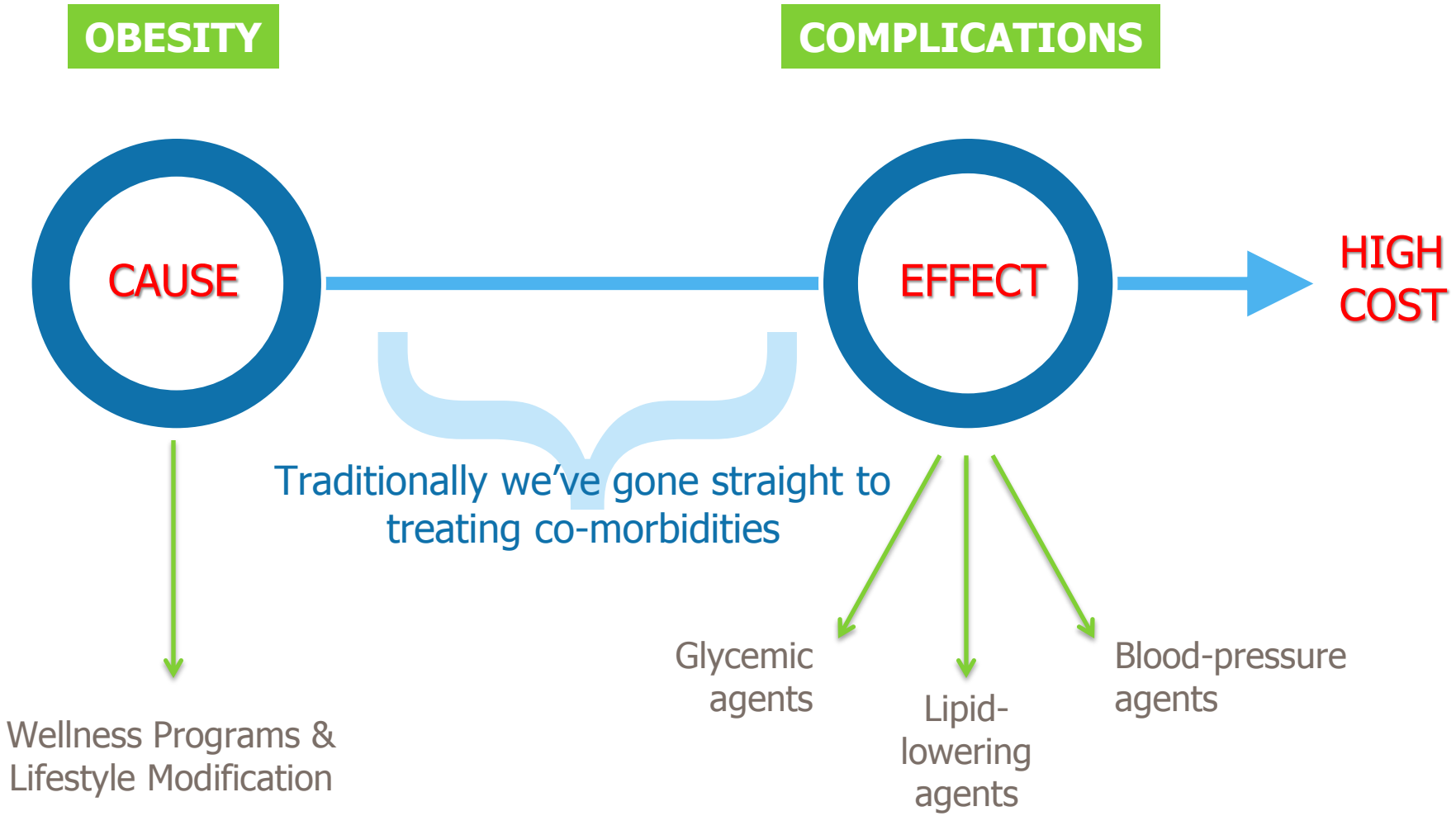

HISTORICAL RISK MANAGEMENT

VICTORIES AND FAILURES

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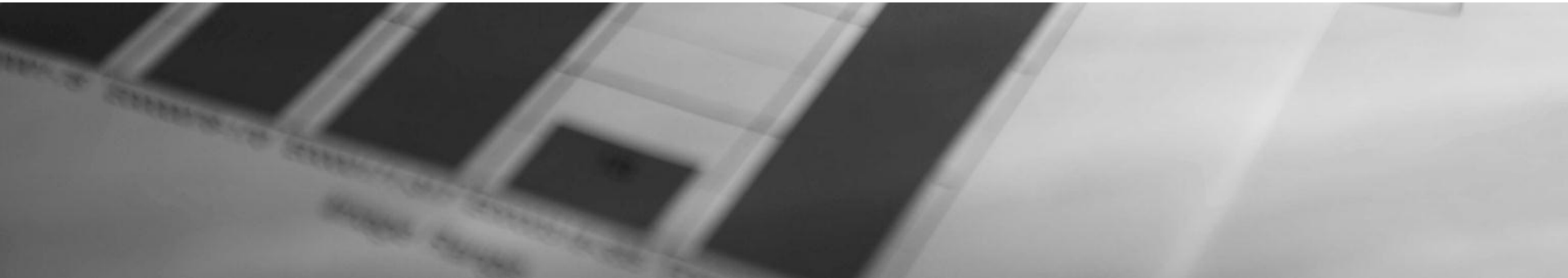

THE EVOLUTION OF RISK MANAGEMENT

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1970's

How we worked changed – dramatically

20 – 40% reduction in occupational caloric burn in this decade

THE EVOLUTION OF RISK MANAGEMENT

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1970's **1980's**

Early adopters

largely telephonic and information based

THE EVOLUTION OF RISK MANAGEMENT

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Disease Management, Telephonic coaching and wellness adaptation

THE EVOLUTION OF RISK MANAGEMENT

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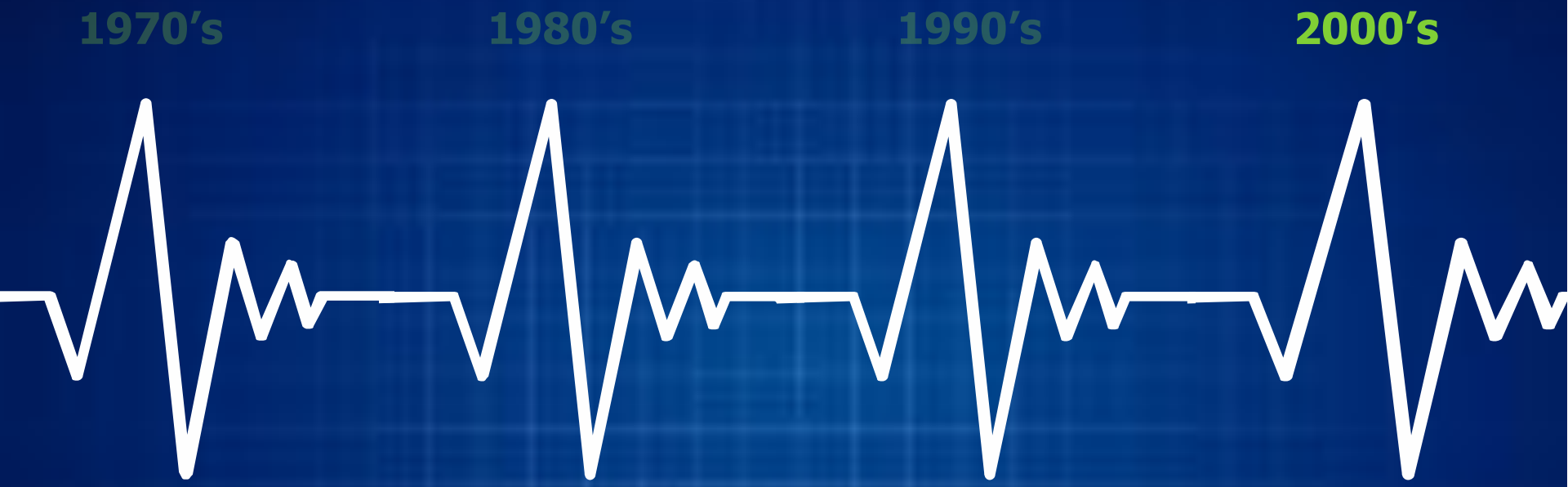

Wellness vendors program proliferation and legislative clarification
outcomes programs emerge

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PPCA & PAYER REFORM

Driving the aperture smaller in wellness programs

- Health outcomes programs
- Hospitals may own risk
- "Participation" wellness model under attack

THE LANDSCAPE TODAY

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AND YET… HERE WE ARE

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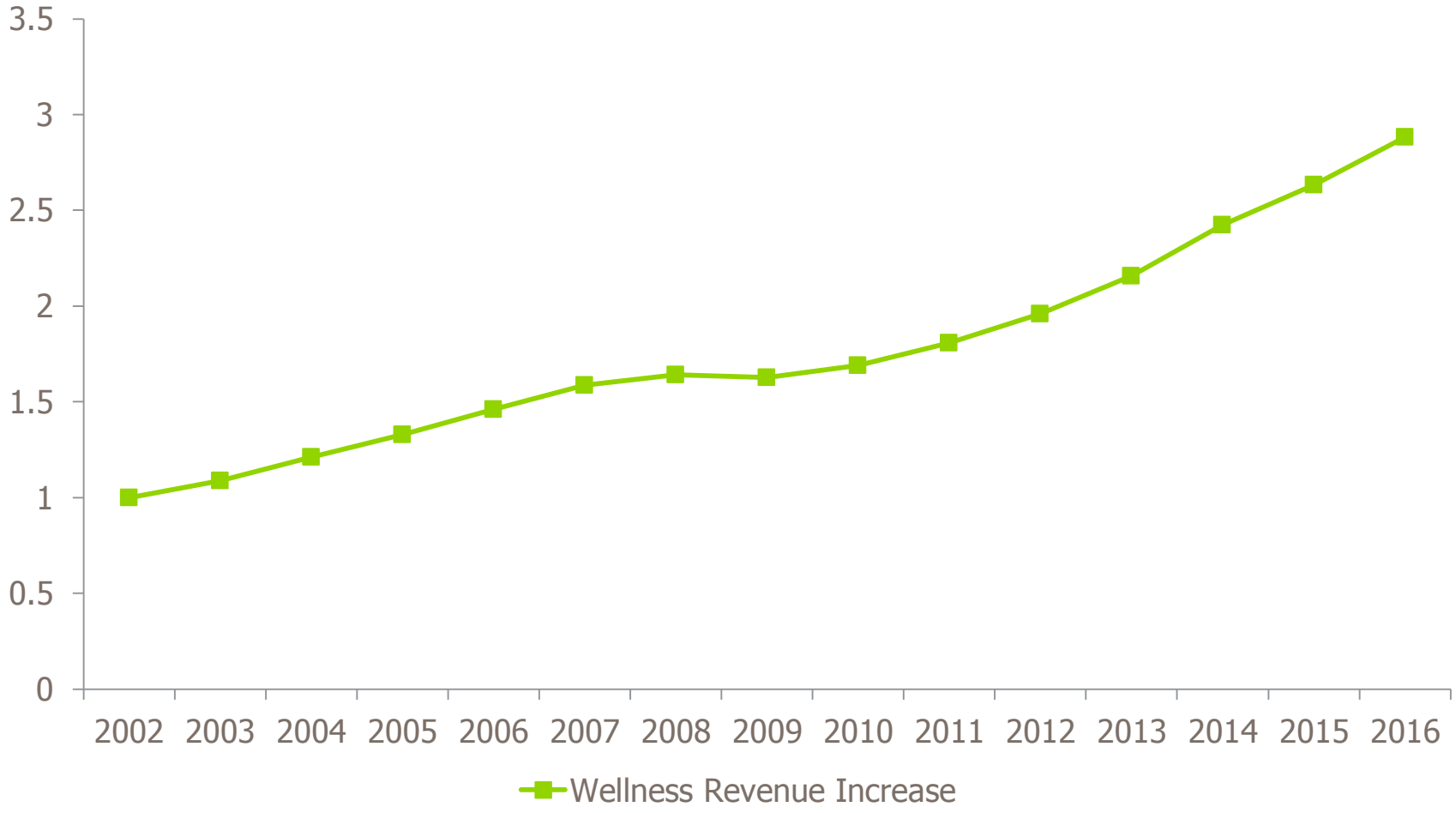

AND YET… HERE WE ARE

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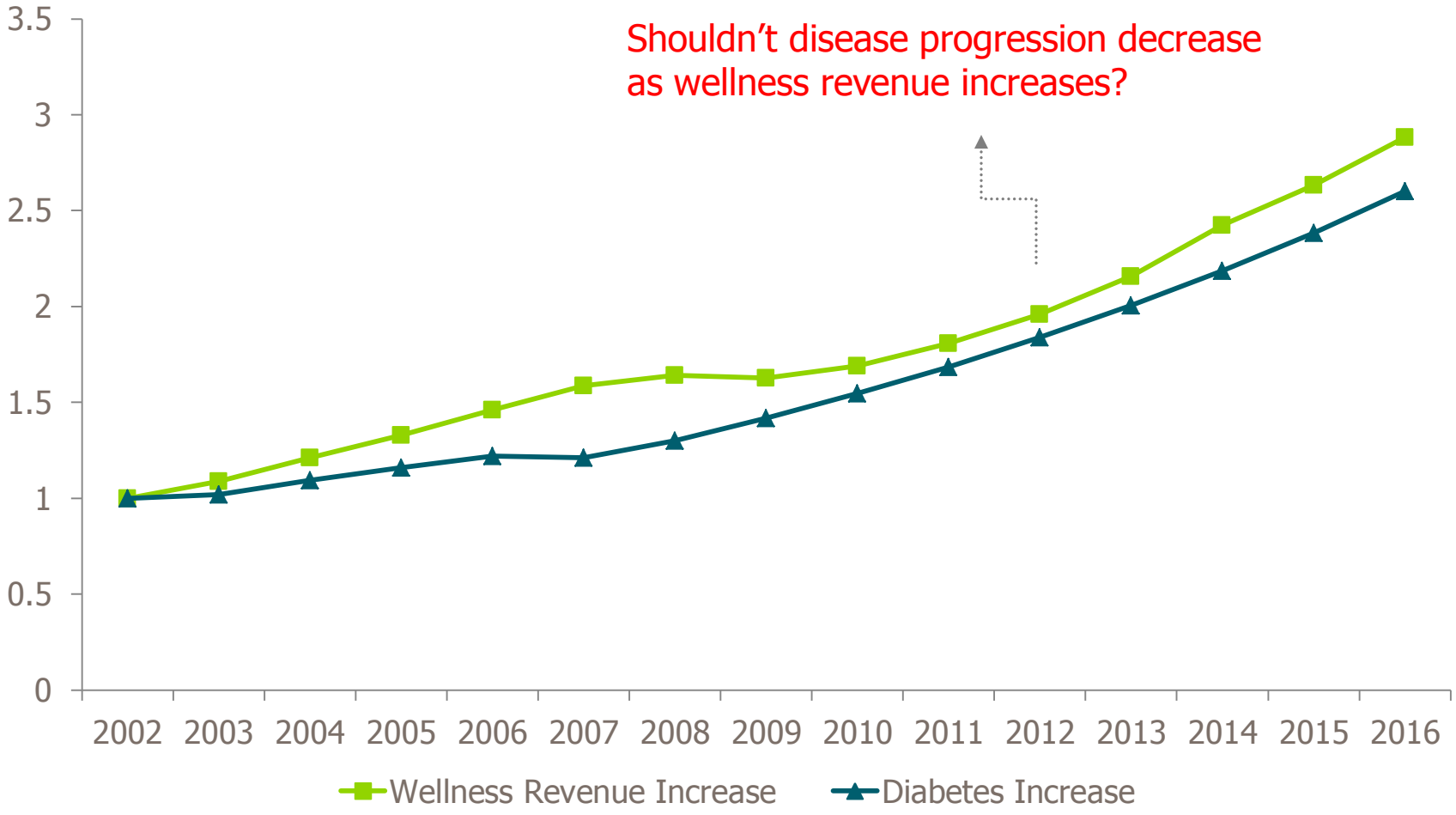

EMERGING STRATEGIES

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EMERGING STRATEGIES

What risk management/mitigation entrants must employers consider?

RISK MITIGATION – EMERGING STRATEGIES

What are the measures for performance – and for what employers are measures appropriate?

BENEFIT DESIGN

What benefit designs are evolving to include with new strategies?


BARIATRIC SURGERY PROLIFERATION
HEALTH CONTINGENT WELLNESS
OBESITY PHARMACOTHERAPY
what is the
IMPACT
to employers?

EVALUATE THE FINANCIAL EFFICACY

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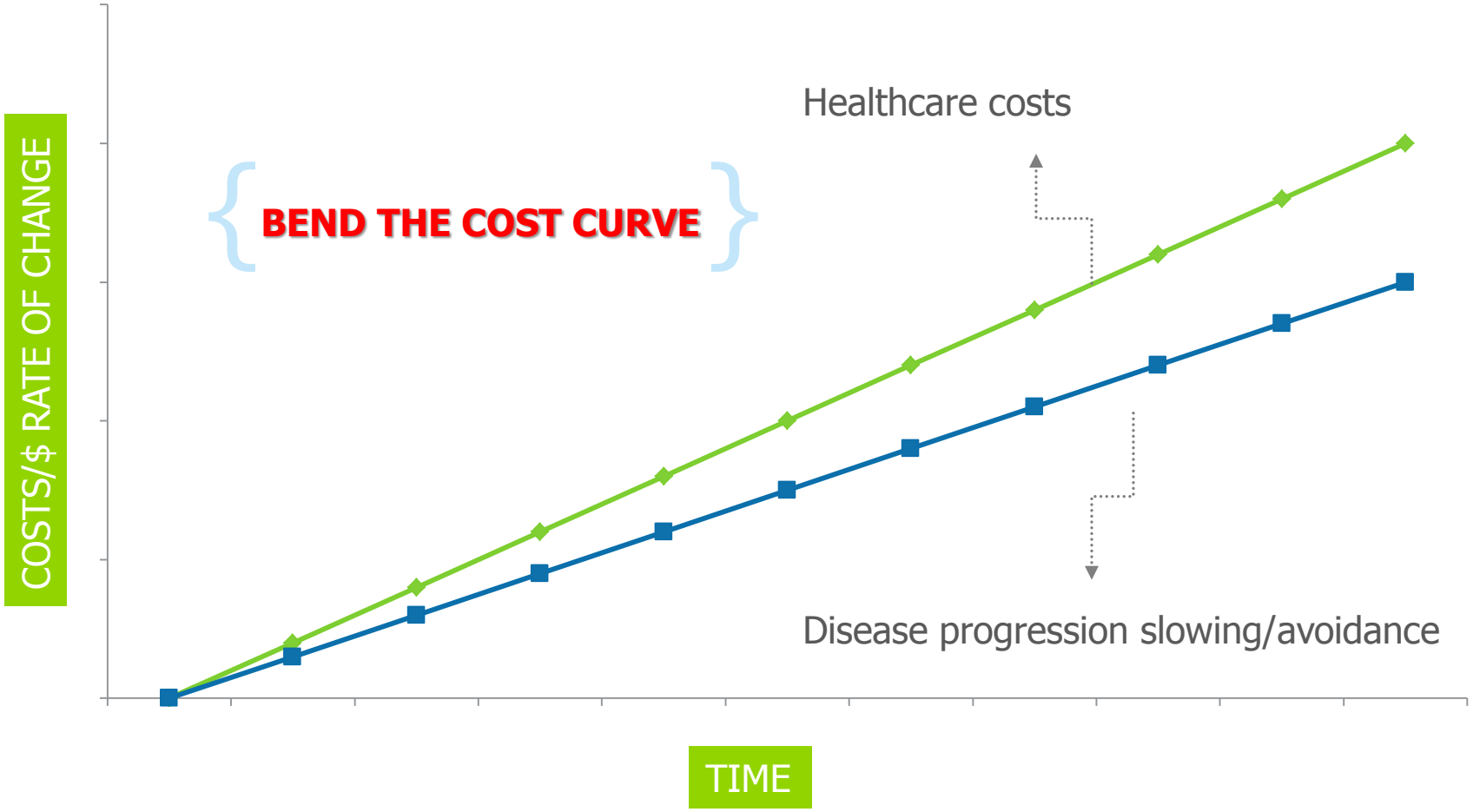

THE RELEVANT RISKS

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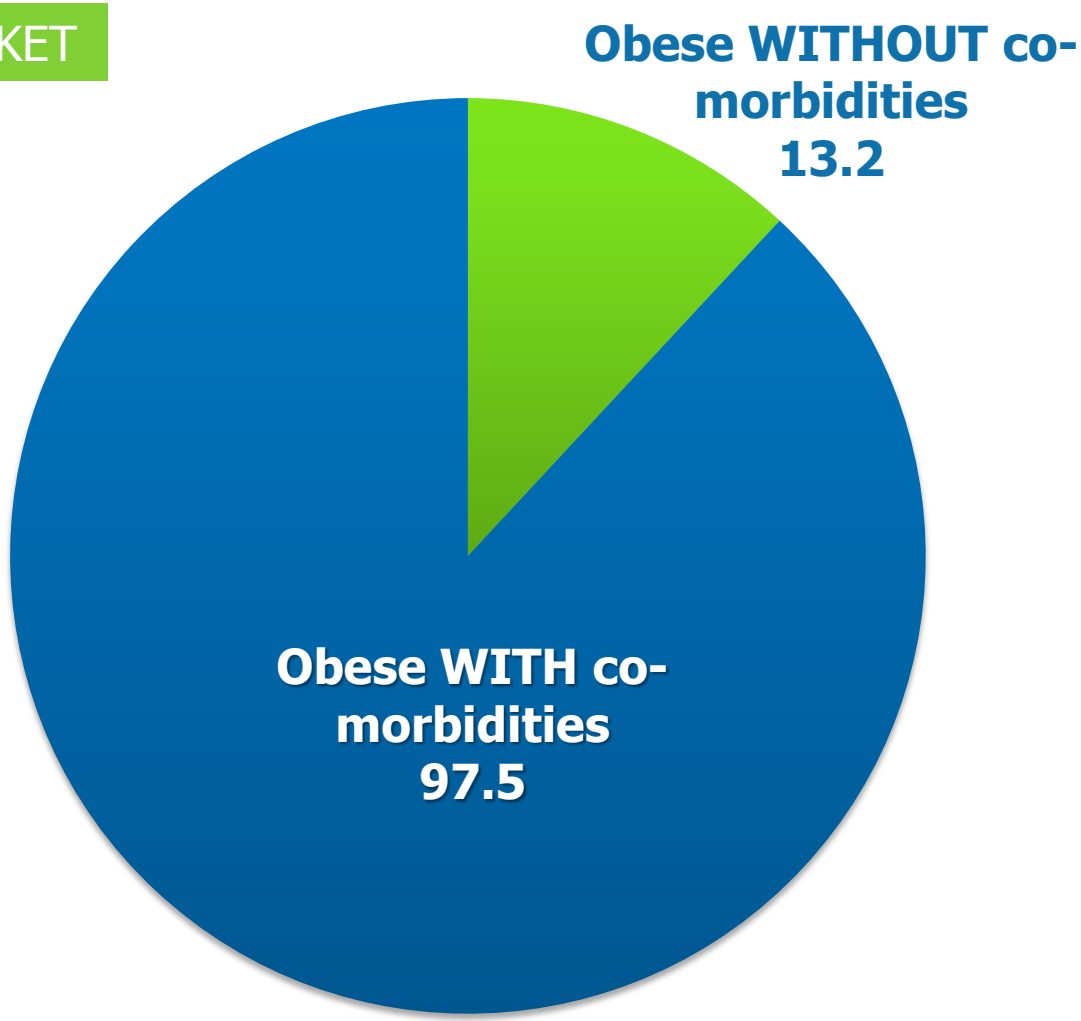
TOTAL TARGET MARKET

110.7 M
OVERWEIGHT
& OBESE ADULTS



THE RELEVANT RISKS

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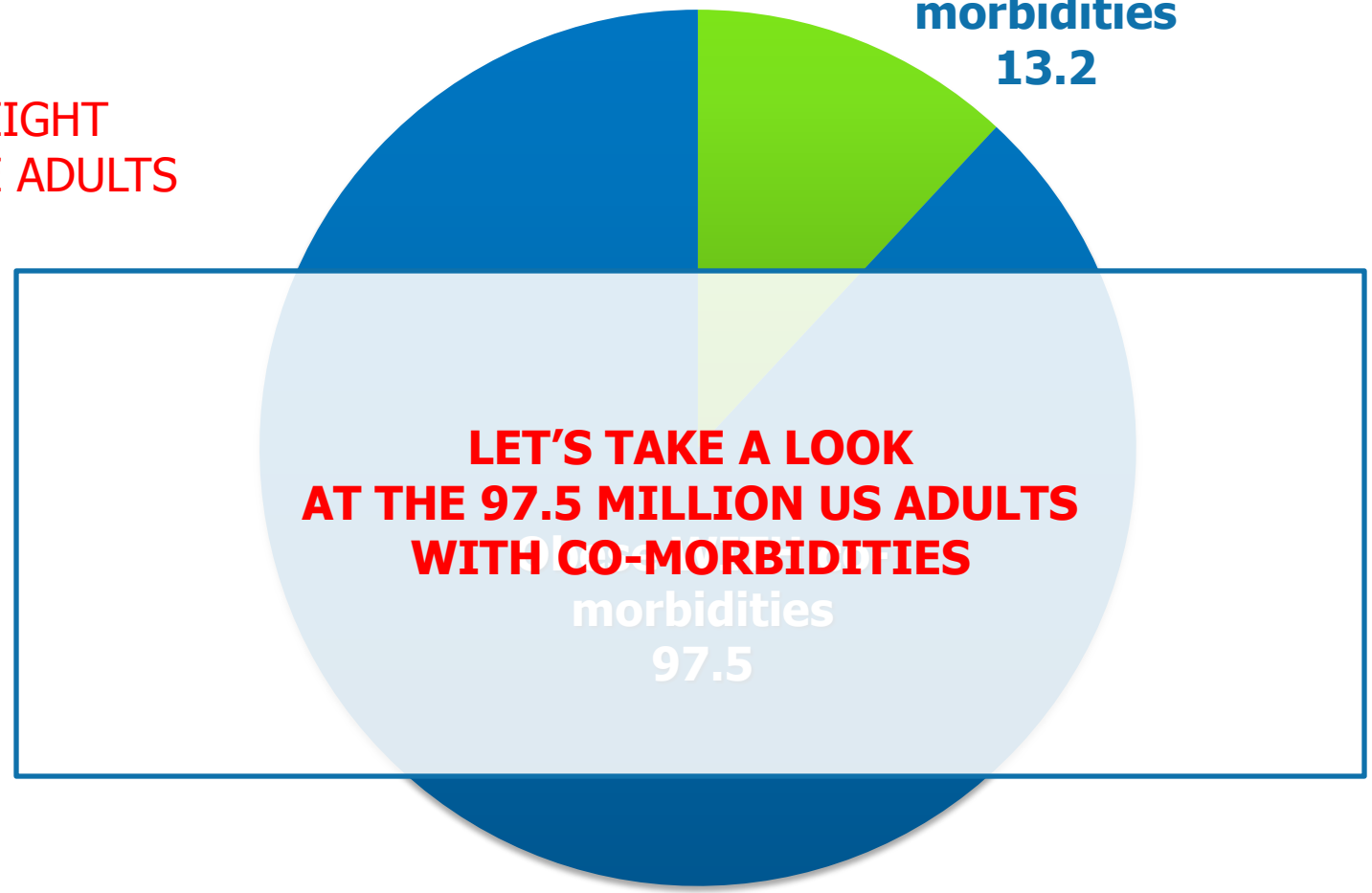

THE RELEVANT RISKS

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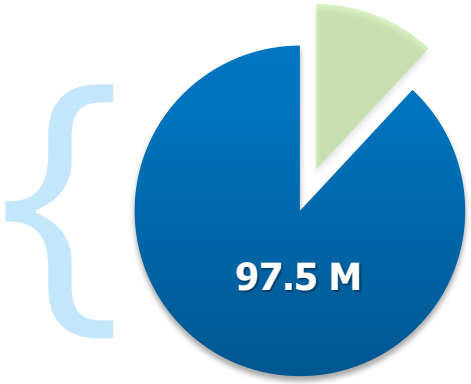
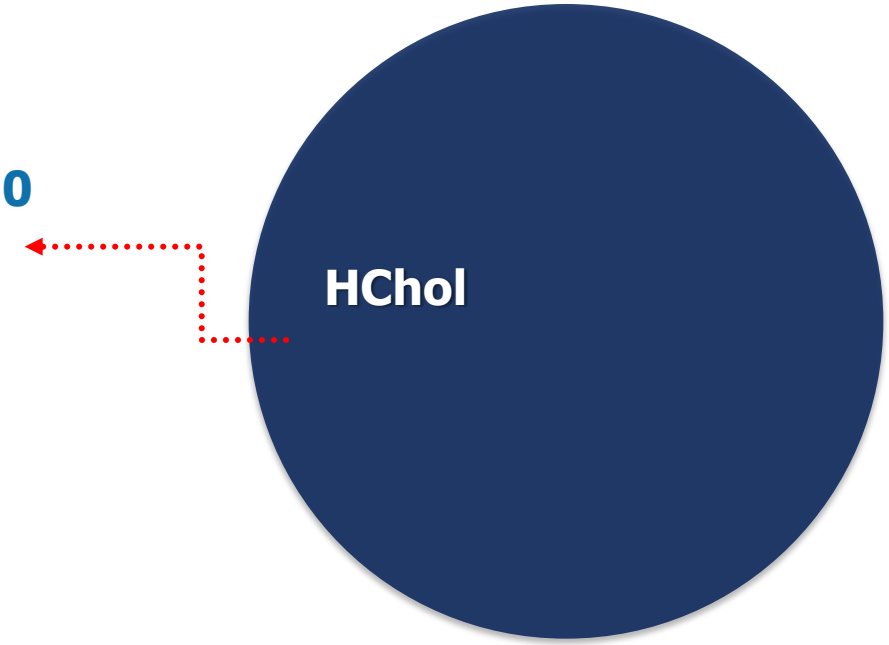


HChol: **35.0**



THE RELEVANT RISKS

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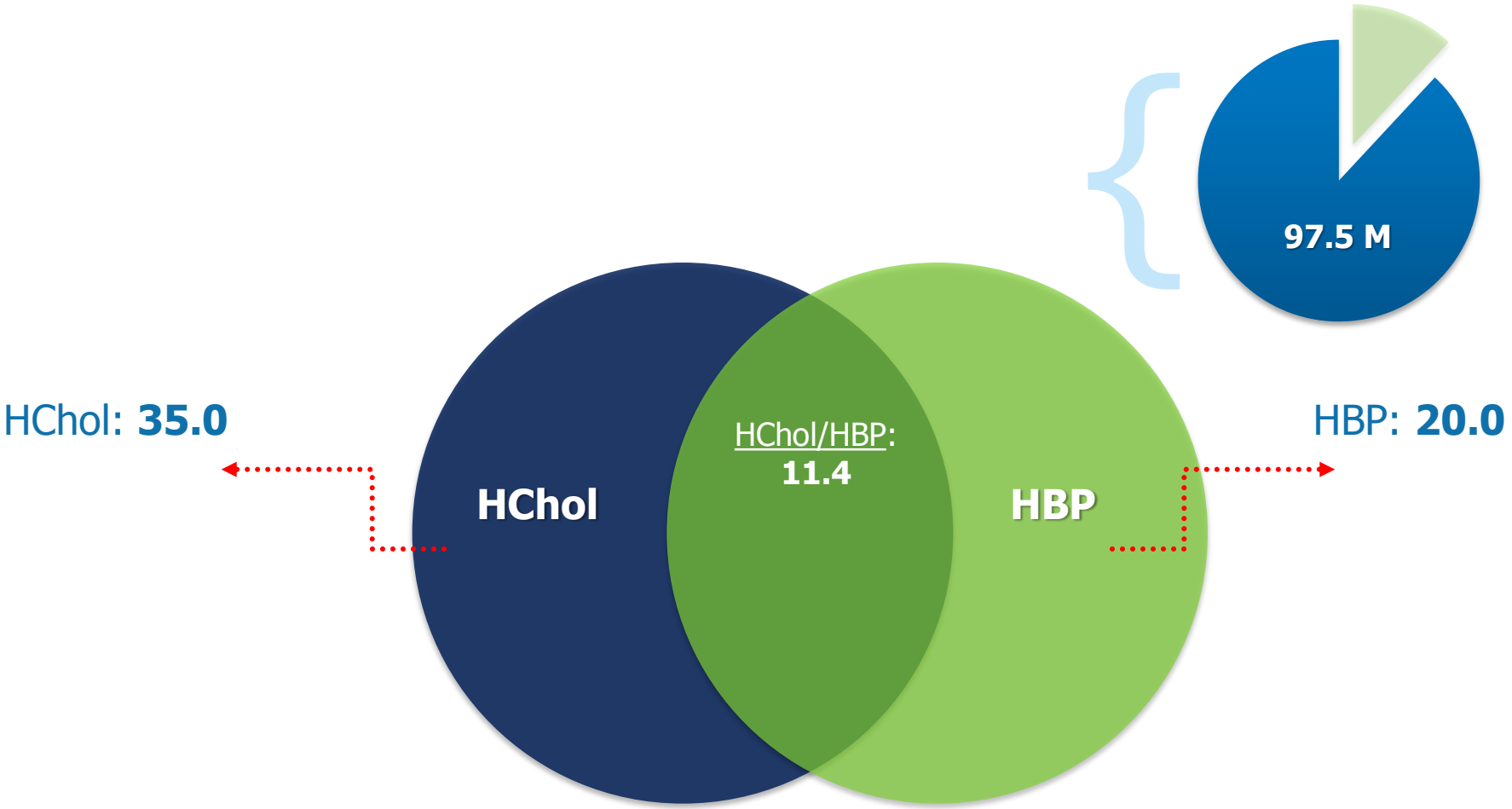

THE RELEVANT RISKS

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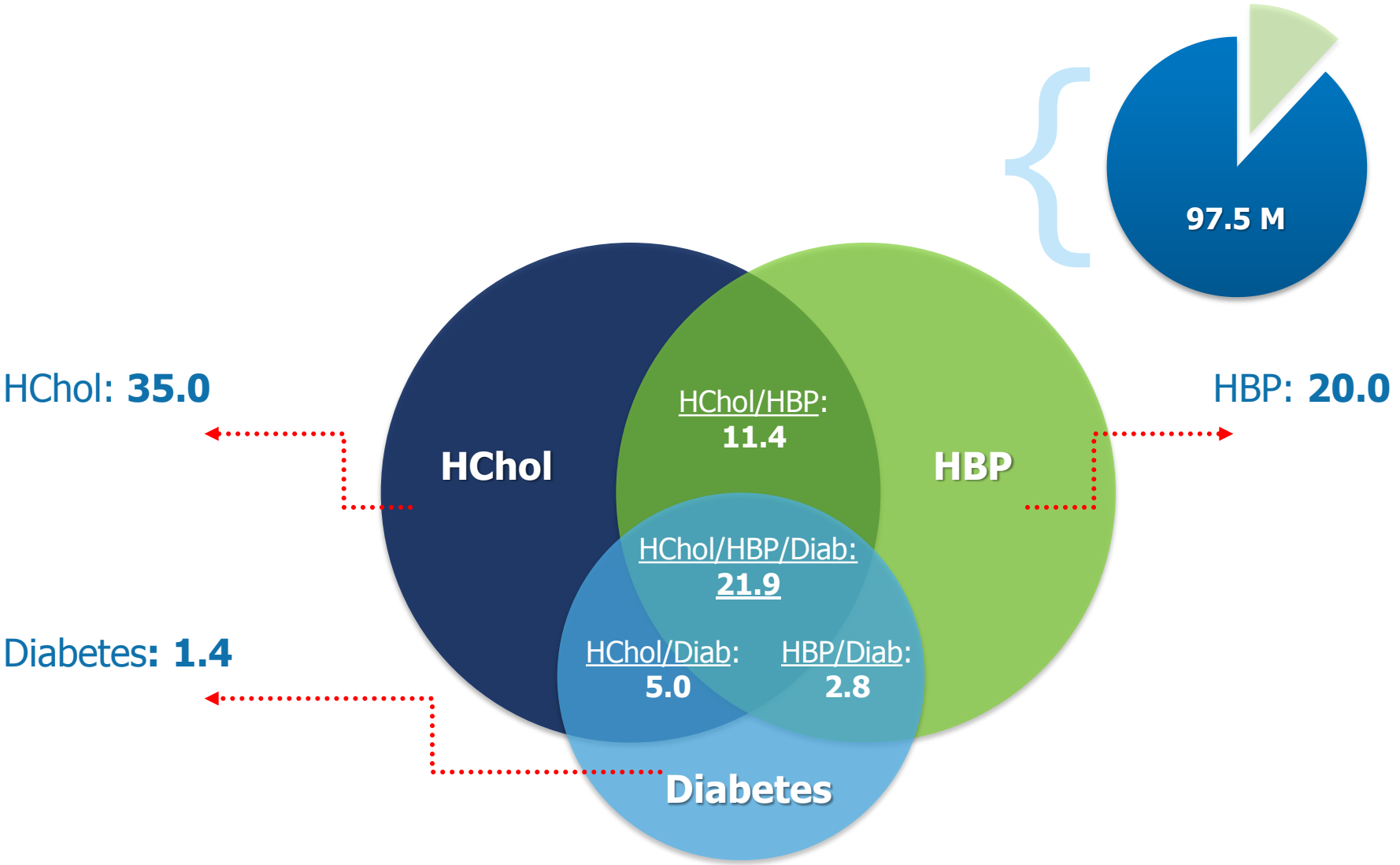


BARIATRIC SURGERY

STUDY 1: BARIATRIC AND GASTRIC BANDING

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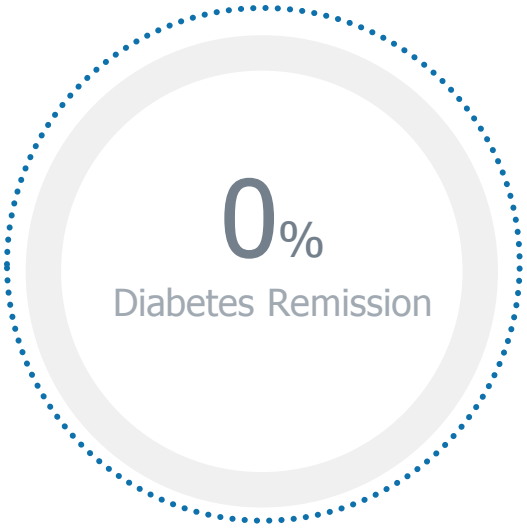
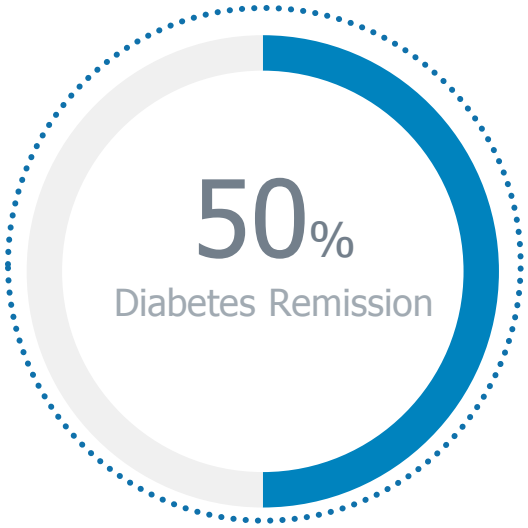
61 OBESE PATIENTS RANDOMLY ASSIGNED SURGERY

Diabetes Remission 1-Year Post Surgery

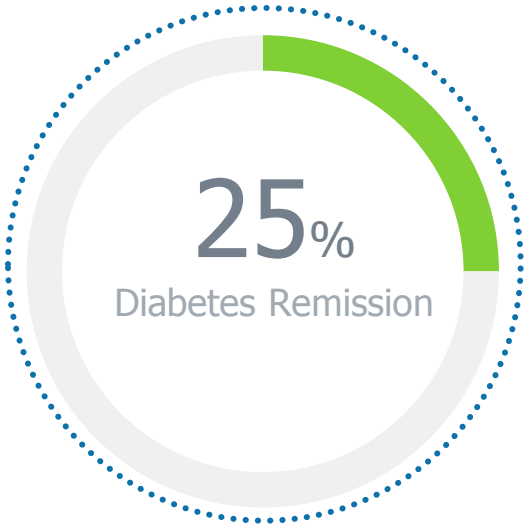
PLACEBO



BYPASS



BANDING



Dr. Anita Courcoulas – University of Pittsburg Medical Center - JAMA June 2014.

STUDY 2: BARIATRIC AND GASTRIC BANDING

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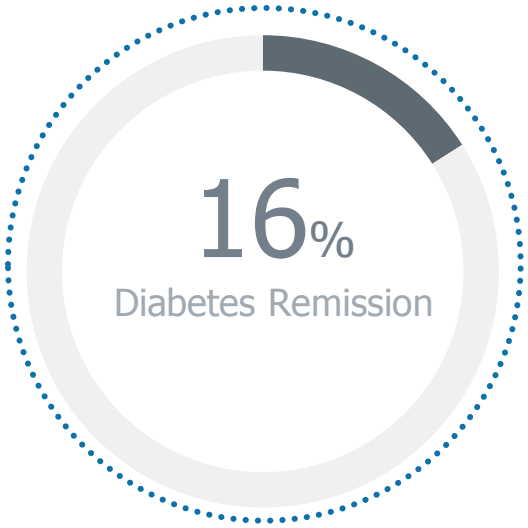
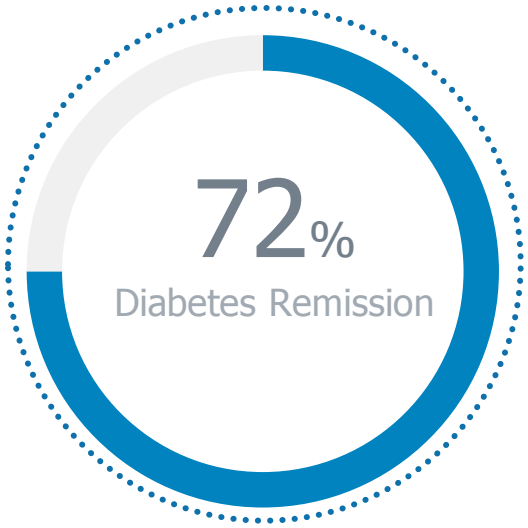
343 OBESE PATIENTS WITH DIABETES ELECTED SURGERY & 260 WAIVED SURGERY

Diabetes Remission 2-Year Post Surgery

NON-SURGICAL



GASTRIC BYPASS



***30% remission at 15 years*

HEALTH CONTINGENT WELLNESS

what is the
IMPACT
to employers?

WELLNESS PROGRAM TYPES: DEFINED BY REGULATIONS

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Participatory Programs

Require completion of an activity that is not contingent on a health factor to earn a reward

- Screening
- HRA
- Health Education or Health Coaching

Health-Contingent Programs

Require an individual to satisfy a requirement related to a health factor in order to earn a reward.

Activity-Based Wellness Programs

- Walking or Diet Program
  - Alternative program

and/or

  - Medical waivers/affidavits are allowed

Outcome-Based Wellness Programs

- Screening/test - standard criteria
  - Alternative program (participatory, activity or outcome-based) available for all who do not meet standard criteria. If the alternative program is outcome-based, plan must follow two "special rules."

QUEST BOOK OF BUSINESS OUTCOME-BASED DESIGNS

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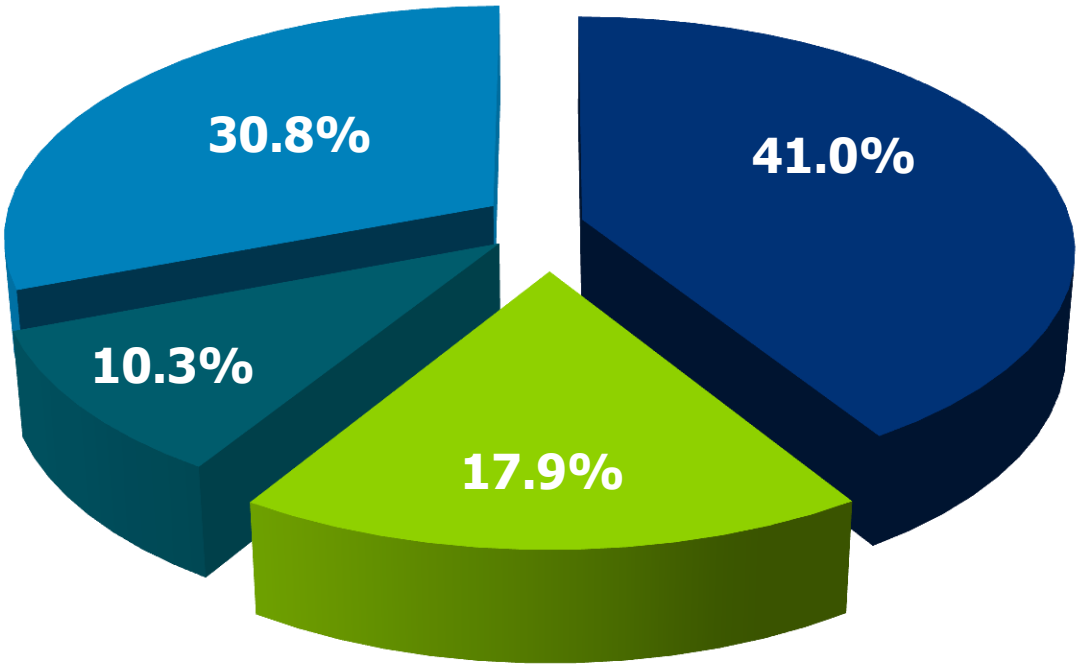

- **14%** of Quest Blueprint for Wellness clients use Rewards for Outcomes scoring
- **50-60%** of clients provide participation incentives at a minimum

OUTCOME-BASED INCENTIVE ADOPTION

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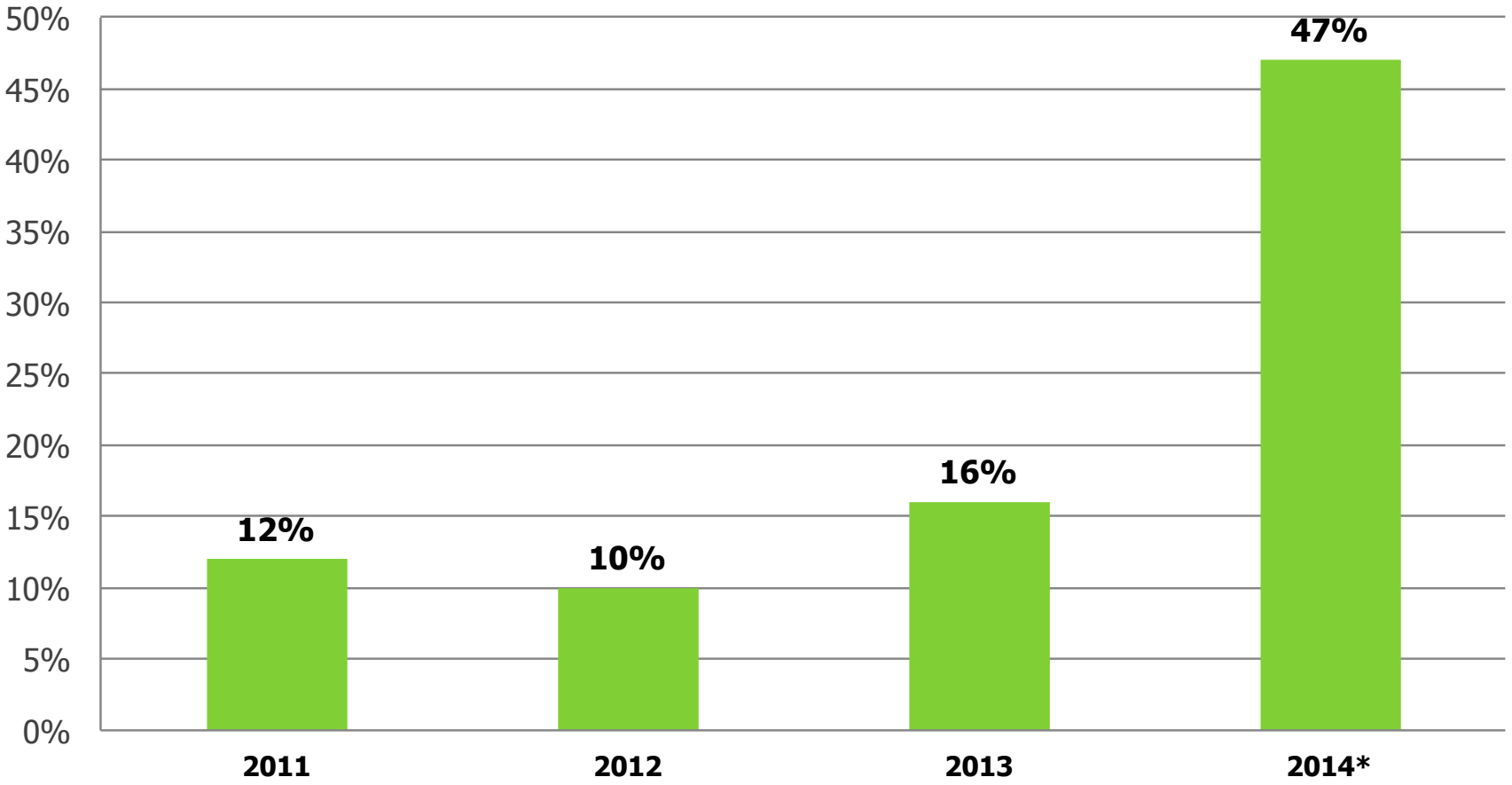
Employers planning to reward or penalize based on biometric outcomes other than smoker, tobacco-use status

(Towers Watson/National Business Group on Health Annual Survey Annual Survey 2013)



RISK MIGRATION COMPARISON: OUTCOMES EMPLOYER VS. QUEST

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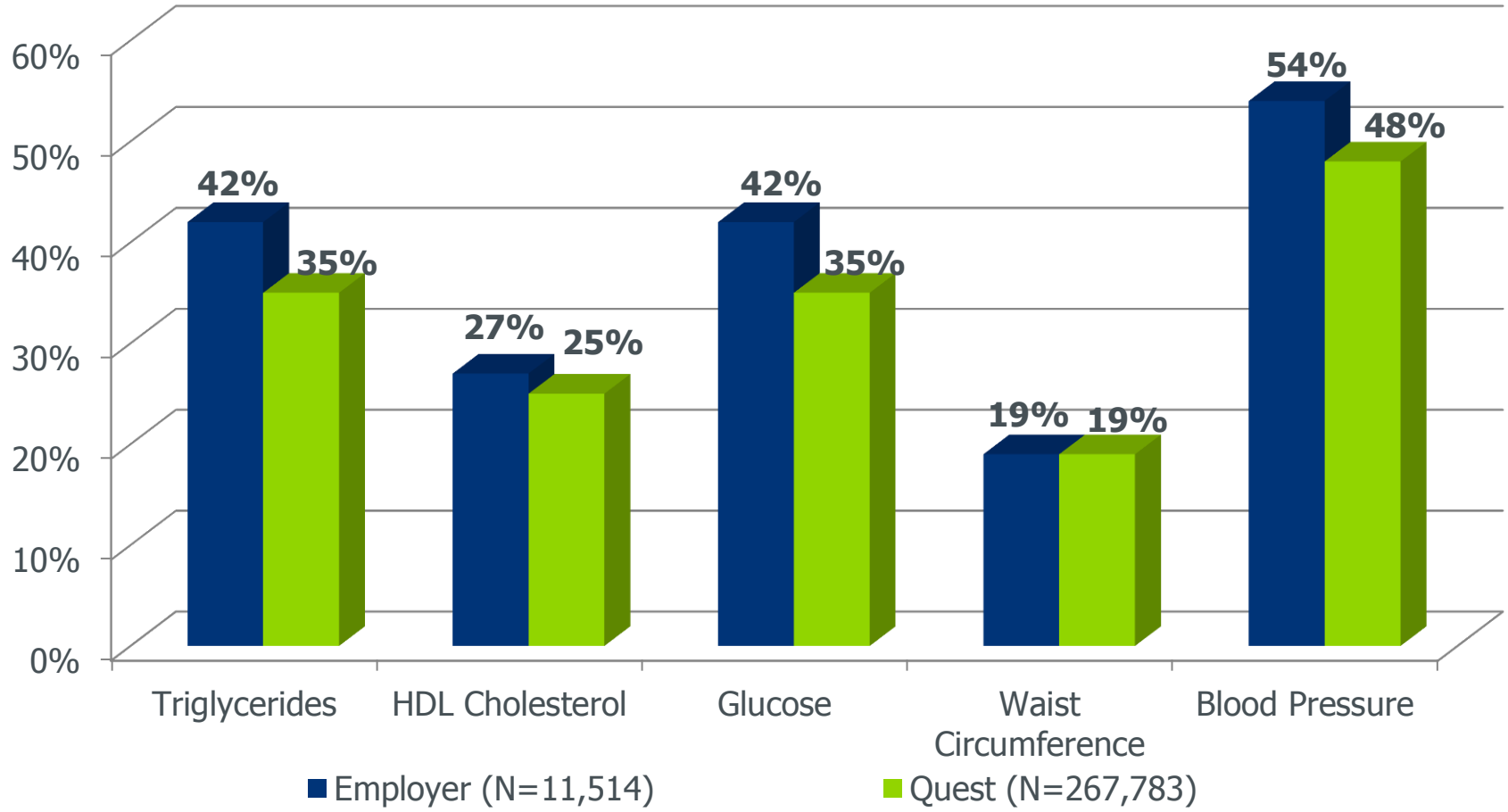
The percent of participants that migrate from a high risk status to a low risk status is higher for employer's outcomes-based program when compared to the Quest cohort database.



MEDICAL & RX TREND COHORT COMPARISON: 2010 TO 2012

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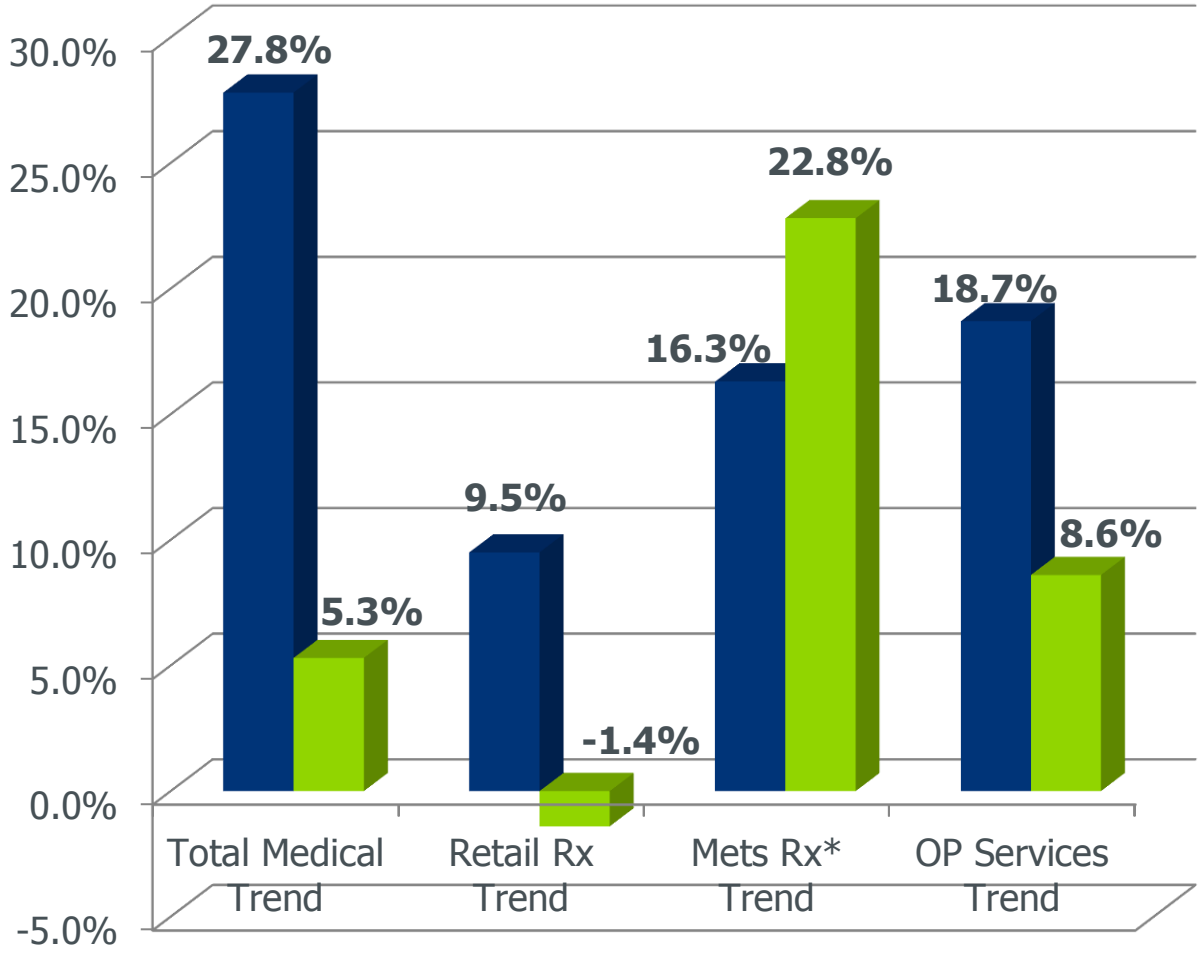

Those who remain at high risk for Metabolic Syndrome spend **5 times more** on total medical costs compared to those who moved to a low risk status.

*Metabolic syndrome related pharmacy includes the following drug classes: Antidiabetics , Antihypertensives, Beta Blockers, Calcium Channel Blockers, Diuretics, Antianginal Agents and Antihyperlipidemics

CASE STUDY: HRS TIMELINE

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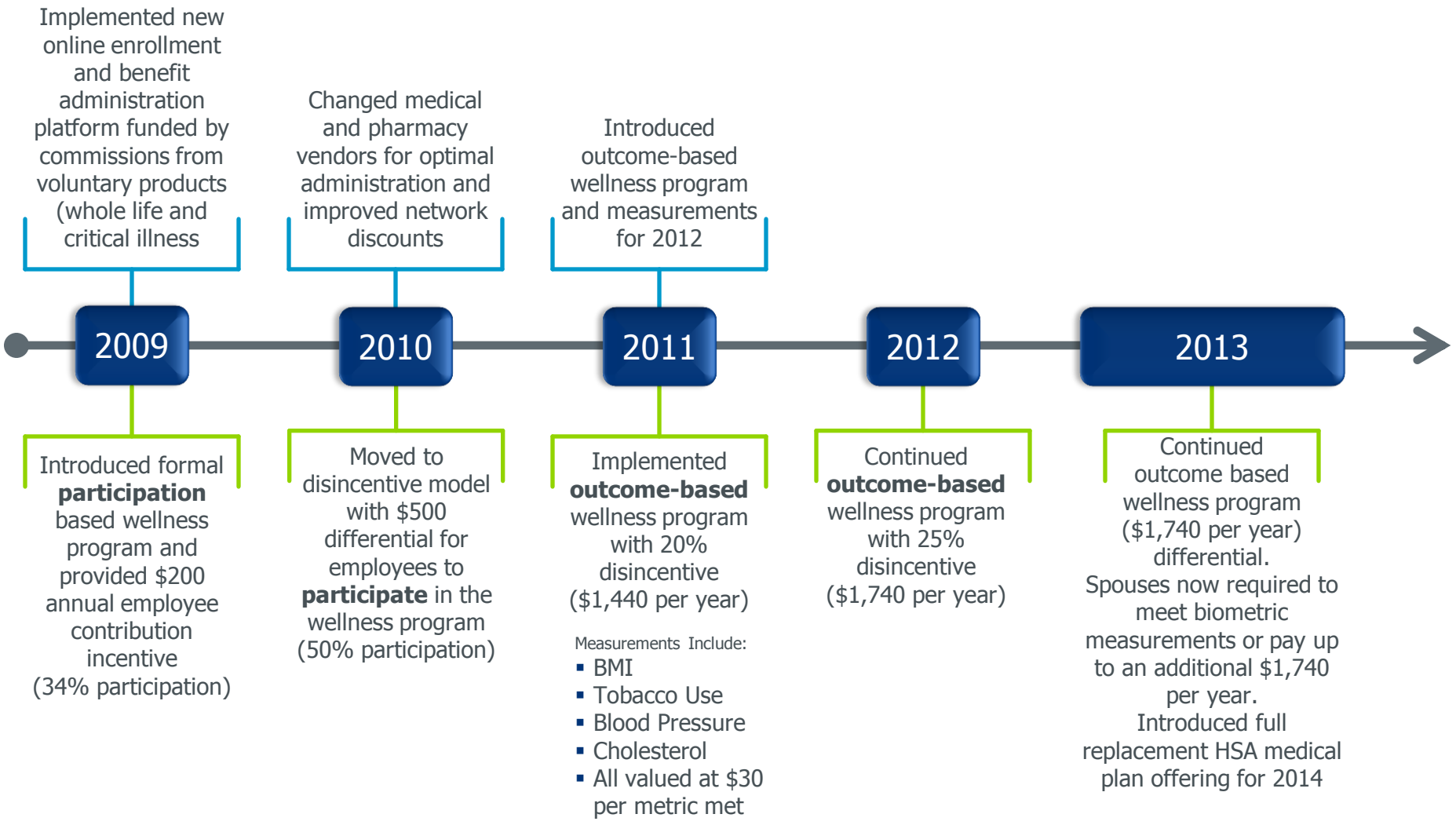

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IMPACT OF METABOLIC SYNDROME ON CHRONIC CONDITIONS

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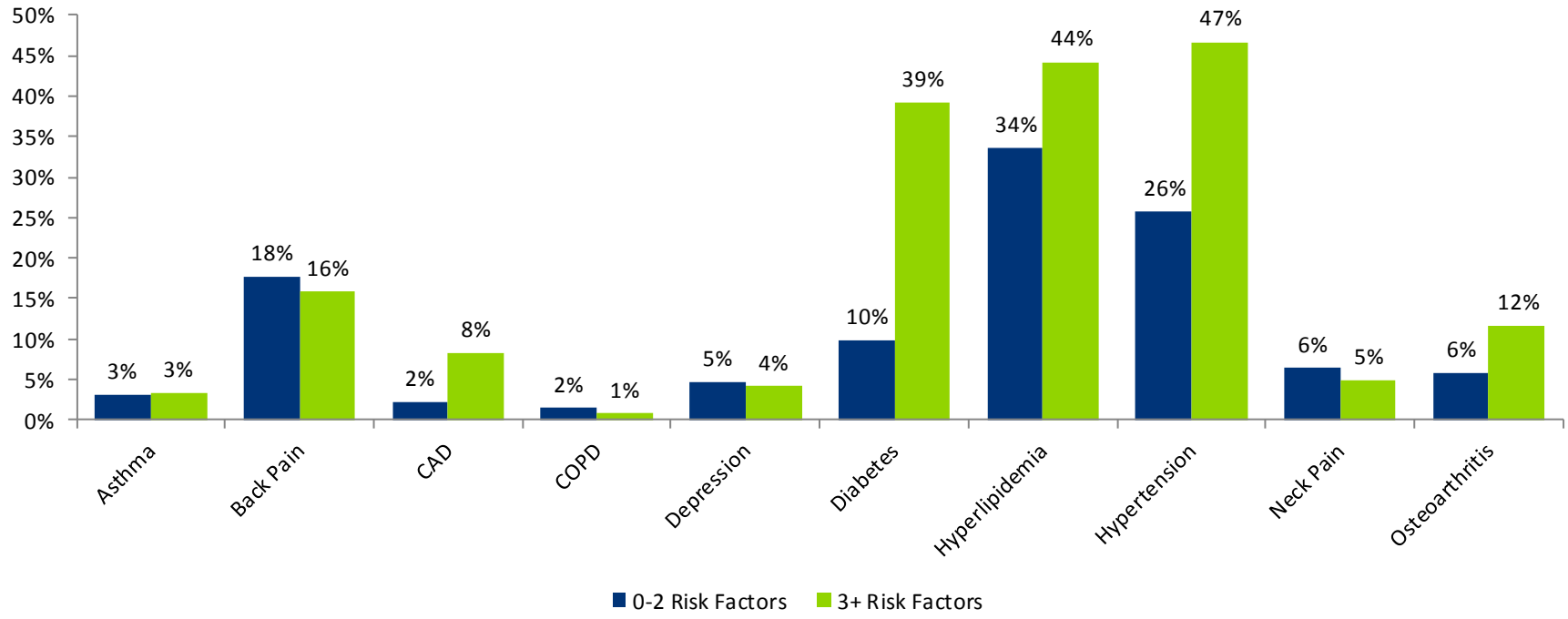

Participants with Metabolic Syndrome are more likely to develop the following chronic conditions:

Prevalence vs. Non Metabolic Participants

1. Diabetes: **290%**
2. Hyperlipidemia: **30%**
3. Hypertension: **81%**
4. Osteoarthritis: **100%**
5. CAD: **300%**

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BIOMETRIC ANALYSIS: RISK CLUSTERS COHORT ANALYSIS 2010 VS. 2013

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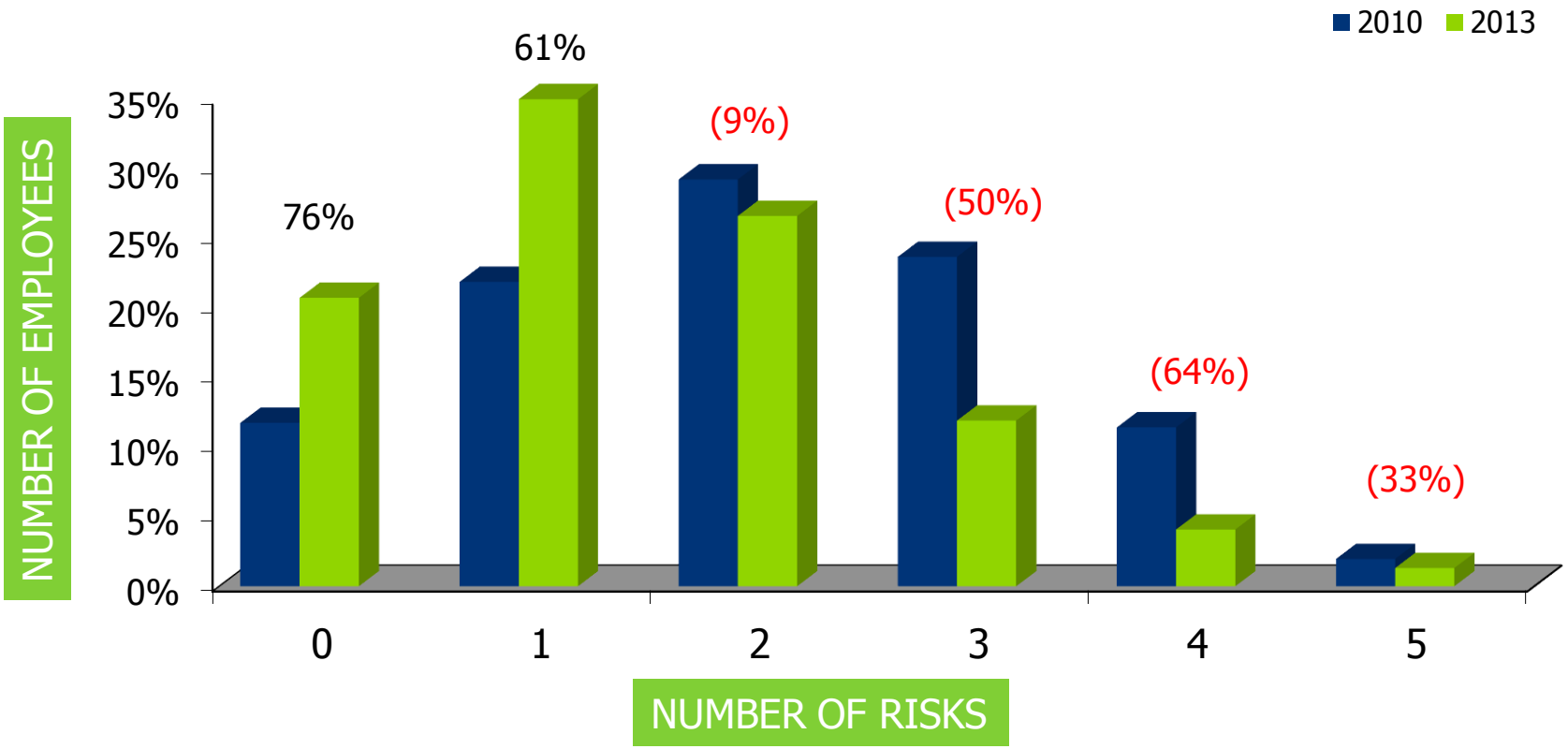
2010-2013 Cohort Population Risk Factor Distribution with Percent Change



- In 2010, approximately **37%** of cohort group had **3 or more risk factors**
- In 2013, approximately **17%** of cohort group had **3 or more risk factors**

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OBESITY PHARMACOTHERAPY

what is the
IMPACT
to employers?

ANTI-OBESITY MEDICATIONS

DRUG APPROVALS SINCE 2012

Qsymia®

(phentermine/topiramate extended-release)

BELVIQ®

(lorcaserin HCl)

1 YEAR STUDY WITH OBESITY PHARMACOTHERAPY

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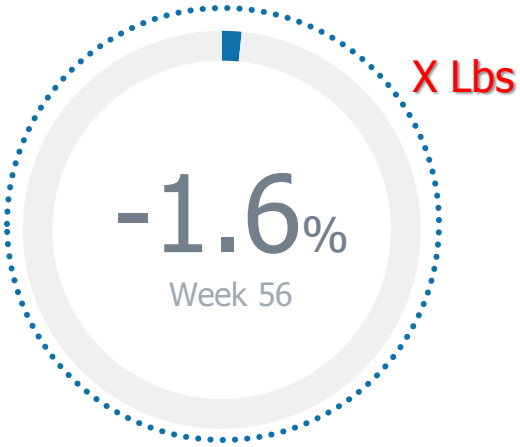
COMPLETERS ON "DRUG A "

% of weight loss

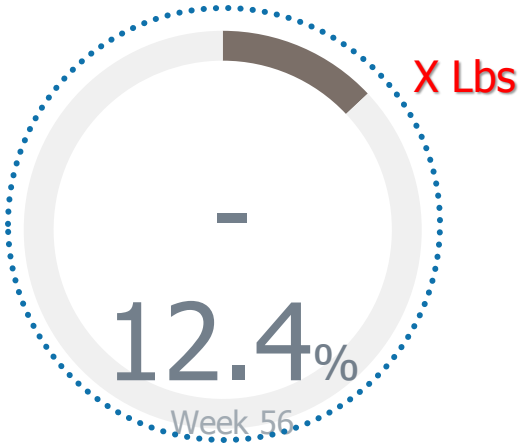


PLACEBO

ITT-LOCF
-1.2%

DRUG A 7.5mg/46mg

ITT-LOCF
-7.8%



DRUG A 15mg/92mg

ITT-LOCF
-9.8%

P<.0001 for both doses vs placebo, and 15 mg/92 mg vs 7.5 mg/46 mg at all time points for both completers and ITT-LOCF.

Qsymia [prescribing information]. Mountain View, CA: VIVUS, Inc; 2013; Data on file. VIVUS, Inc; Gadde KM et al. *Lancet.* 2011;377(9774):1341-1352.

"DRUG A" DIABETES REDUCTION

Patients without Diabetes – Progression to Diabetes

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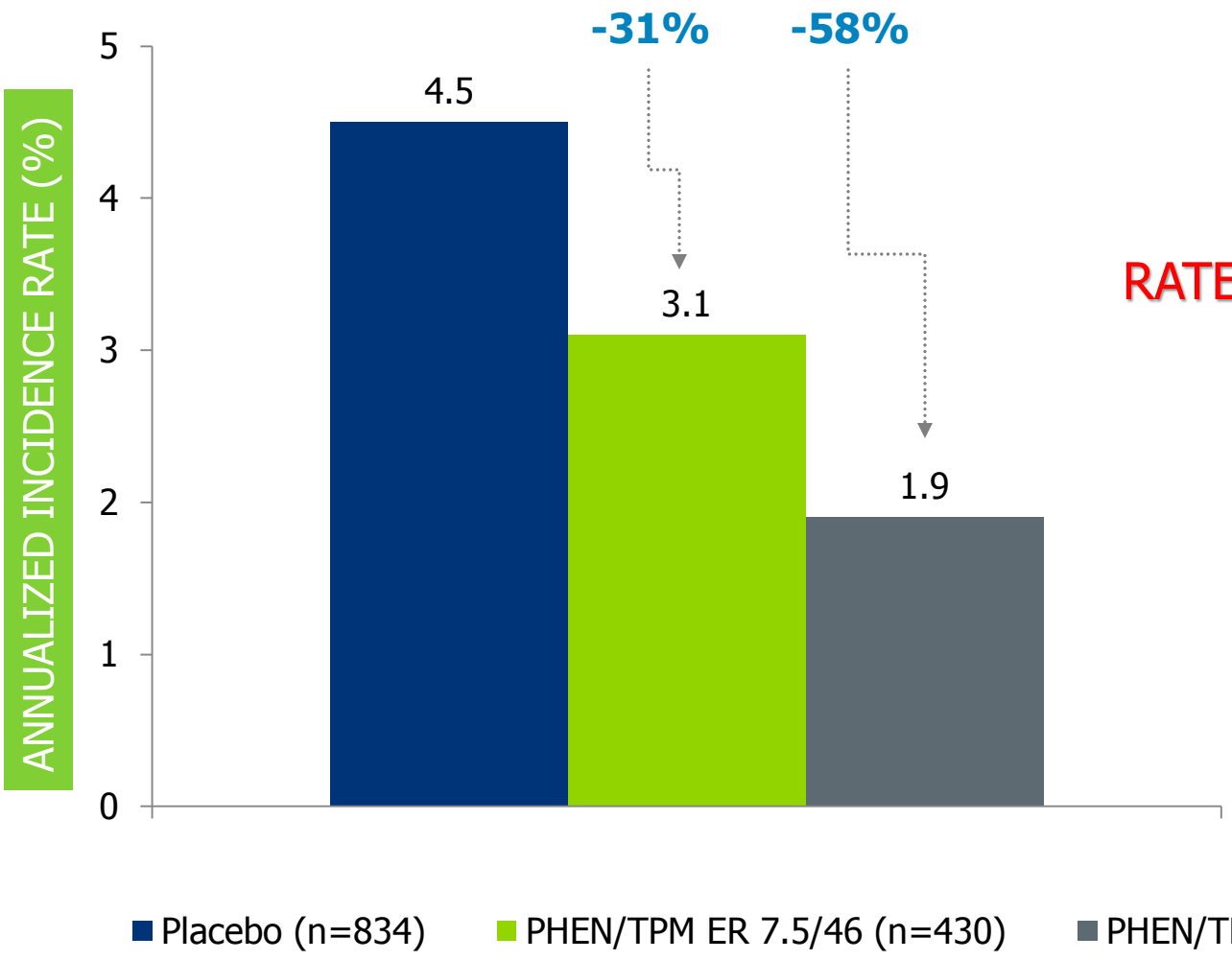

RATES OF DIABETES DROPPED **30-60%**

*Progression to diabetes defined as ≥2 consecutive visits with fasting glucose ≥126 mg/dL or 2-hour post oral glucose tolerance test glucose ≥200 mg/dL

Gadde KM, Allison DB, Ryan DH, et al. Lancet. 2011;377(9774):1341-1352

BENEFIT PLAN

DESIGN CONSIDERATIONS

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BENEFIT DESIGN CONSIDERATIONS

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BMI ≥25[1]

Treatment Options:

WELLNESS PROGRAMS

Expected Efficacy:

3% to 4% of initial weight[3,4]

Lack of long-term efficacy; weight regain without maintenance therapy[4,5]

1. NHLBI. October 2000. Available at: http://www.nhlbi.nih.gov/guidelines/obesity/prctgd_c.pdf. Accessed April 1, 2013. 2. FDA. Gastric Banding. December 2011. Available at: htpp://www.fda.gov/MedicalDevices/ProductsandMedicalProcedures/ImplantsandProsthetics/ GastricBanding/default.htm. Accessed February 28, 2013. 3. Sarwer DB, et al. *Curr Opin Endocrinol Diabetes Obes.* 2009;16:347-352.
4. Nguyen N, et al. *Obes Surg.* 2012;22:956-966. 5. Butryn ML, et al. *Psychiatr Clin North Am.* 2011;34:841-859. 6. Coleman E, et al. *N Eng J Med.* 2012;367:1577-1579. 7. Data on file. VIVUS, Inc. 8. Sjöström L. *J Intern Med.* 2013;273:219-234.

BENEFIT DESIGN CONSIDERATIONS

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BMI ≥25[1]

Treatment Options:

WELLNESS PROGRAMS

Expected Efficacy:

3% to 4% of initial weight[3,4]

Lack of long-term efficacy; weight regain without maintenance therapy[4,5]

≥30 + comorbidities or ≥40[2]
(laparoscopic)

≥35 + comorbidities or ≥40[1]
(open surgery)

Treatment Options:

OBESITY SURGERY

Expected Efficacy:

14% to 25% of initial weight[8]

<1% of obese patients undergo surgery due to perioperative risks and potential long-term complications[4]

1. NHLBI. October 2000. Available at: http://www.nhlbi.nih.gov/guidelines/obesity/prctgd_c.pdf. Accessed April 1, 2013. 2. FDA. Gastric Banding. December 2011. Available at: htpp://www.fda.gov/MedicalDevices/ProductsandMedicalProcedures/ImplantsandProsthetics/ GastricBanding/default.htm. Accessed February 28, 2013. 3. Sarwer DB, et al. *Curr Opin Endocrinol Diabetes Obes.* 2009;16:347-352.
4. Nguyen N, et al. *Obes Surg.* 2012;22:956-966. 5. Butryn ML, et al. *Psychiatr Clin North Am.* 2011;34:841-859. 6. Coleman E, et al. *N Eng J Med.* 2012;367:1577-1579. 7. Data on file. VIVUS, Inc. 8. Sjöström L. *J Intern Med.* 2013;273:219-234.

BENEFIT DESIGN CONSIDERATIONS

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BMI ≥25[1]	**BMI ≥27 + comorbidities or ≥30[1]**	**≥30 + comorbidities or ≥40[2]** (laparoscopic) **≥35 + comorbidities or ≥40[1]** (open surgery)
Treatment Options:	Treatment Options:	Treatment Options:
WELLNESS PROGRAMS	**LM & PHARMA-COTHERAPY**	**OBESITY SURGERY**
Expected Efficacy:	Expected Efficacy:	Expected Efficacy:
3% to 4% of initial weight[3,4]	**5% to 11%** of initial weight[6]	**14% to 25%** of initial weight[8]
Lack of long-term efficacy; weight regain without maintenance therapy[4,5]	Only ~3% of obese/overweight patients are prescribed weight loss drugs[7]	<1% of obese patients undergo surgery due to perioperative risks and potential long-term complications[4]

1. NHLBI. October 2000. Available at: http://www.nhlbi.nih.gov/guidelines/obesity/prctgd_c.pdf. Accessed April 1, 2013. 2. FDA. Gastric Banding. December 2011. Available at: htpp://www.fda.gov/MedicalDevices/ProductsandMedicalProcedures/ImplantsandProsthetics/ GastricBanding/default.htm. Accessed February 28, 2013. 3. Sarwer DB, et al. *Curr Opin Endocrinol Diabetes Obes.* 2009;16:347-352.
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BENEFIT DESIGN CONSIDERATIONS

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Treatment Options:	Treatment Options:	Treatment Options:
WELLNESS PROGRAMS	**LM & PHARMA-COTHERAPY**	**OBESITY SURGERY**
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BENEFIT DESIGN AND ECONOMIC MODEL

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LEVEL 0

Before/After Bariatric Surgery

- Surgeon contingent
- Highly narrow – and carries some risk
- Potential stepping stone to bariatric

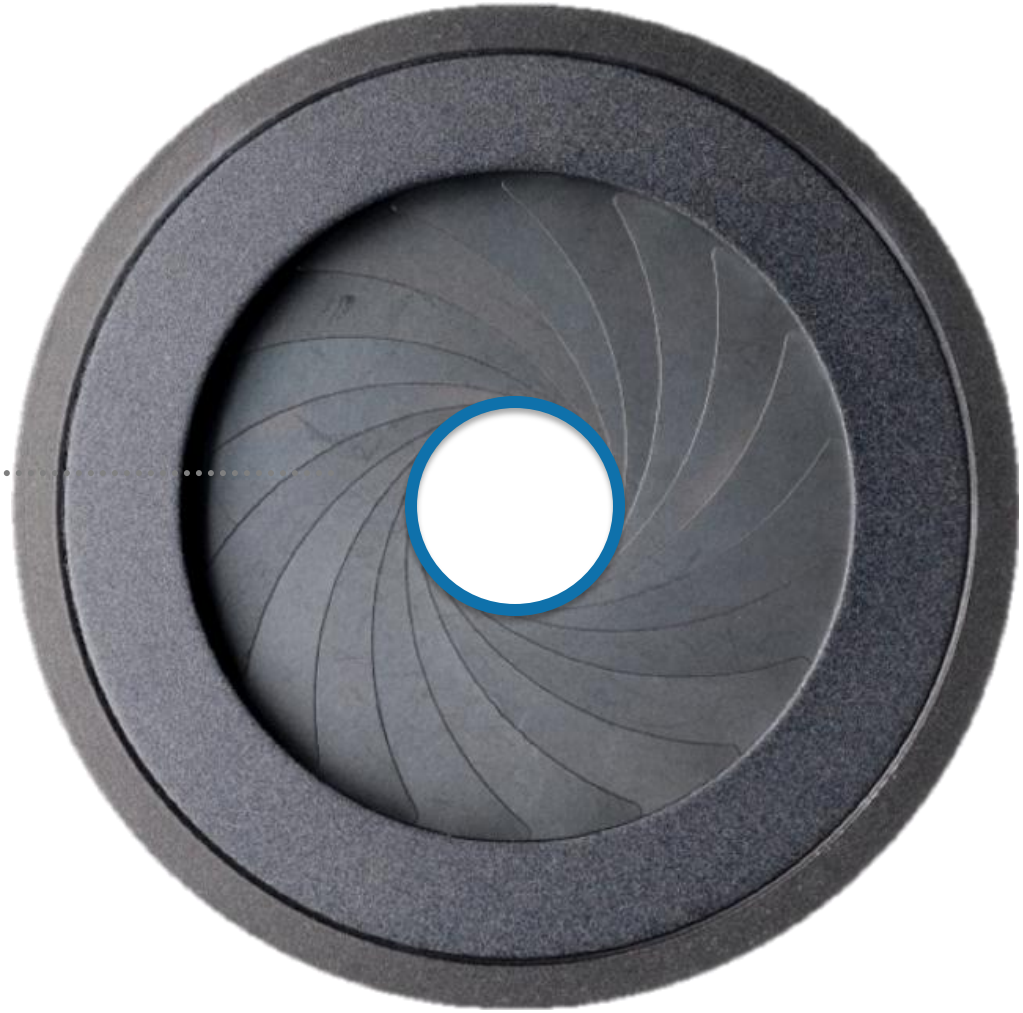
BENEFIT DESIGN AND ECONOMIC MODEL

InfoLock®

LEVEL 1

Disease Management Coverage

- Only for the relevant co-morbidities and targeted population



BENEFIT DESIGN AND ECONOMIC MODEL

InfoLock®

LEVEL 1

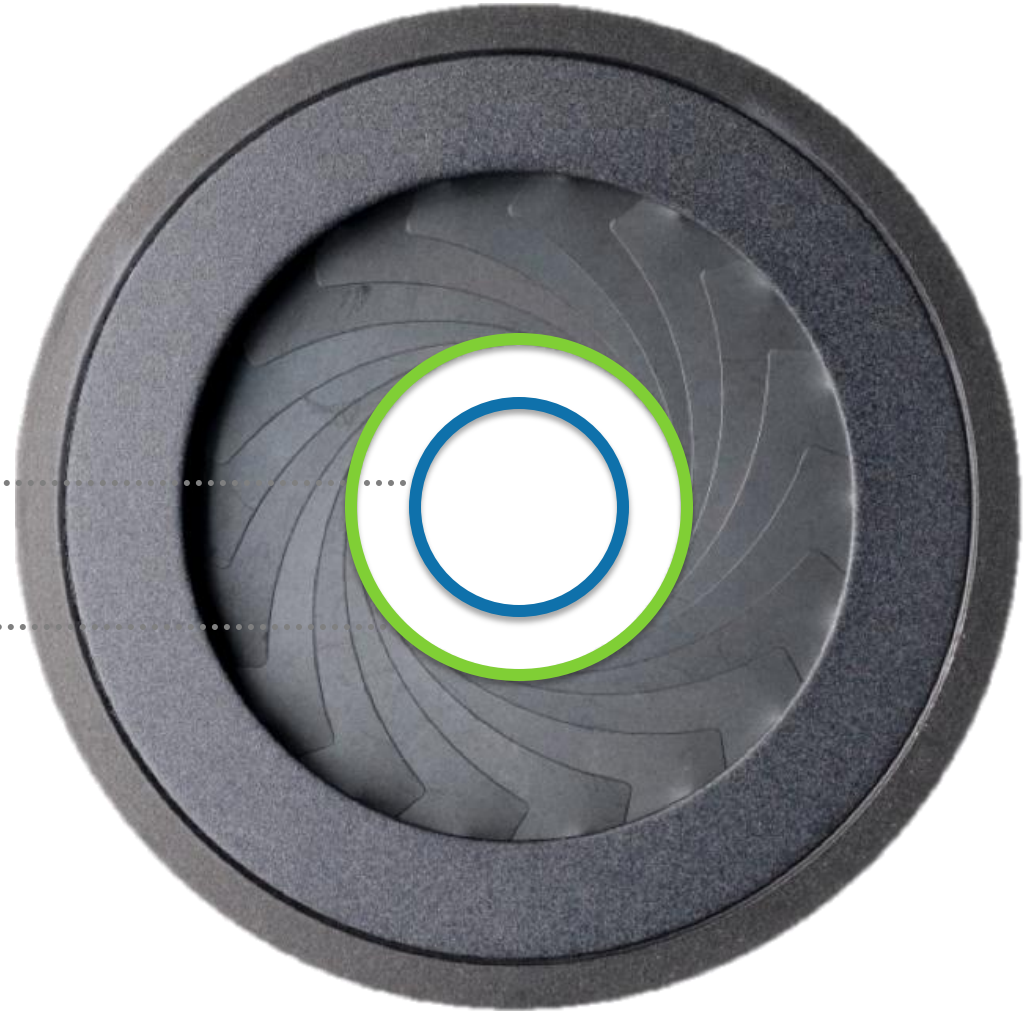
Disease Management Coverage

- Only for the relevant co-morbidities and targeted population

LEVEL 2

Prior Authorization Coverage

- Covered only for the slightly larger population
- Moderate co-pay



BENEFIT DESIGN AND ECONOMIC MODEL

InfoLock®

LEVEL 1

Disease Management Coverage

- Only for the relevant co-morbidities and targeted population

LEVEL 2

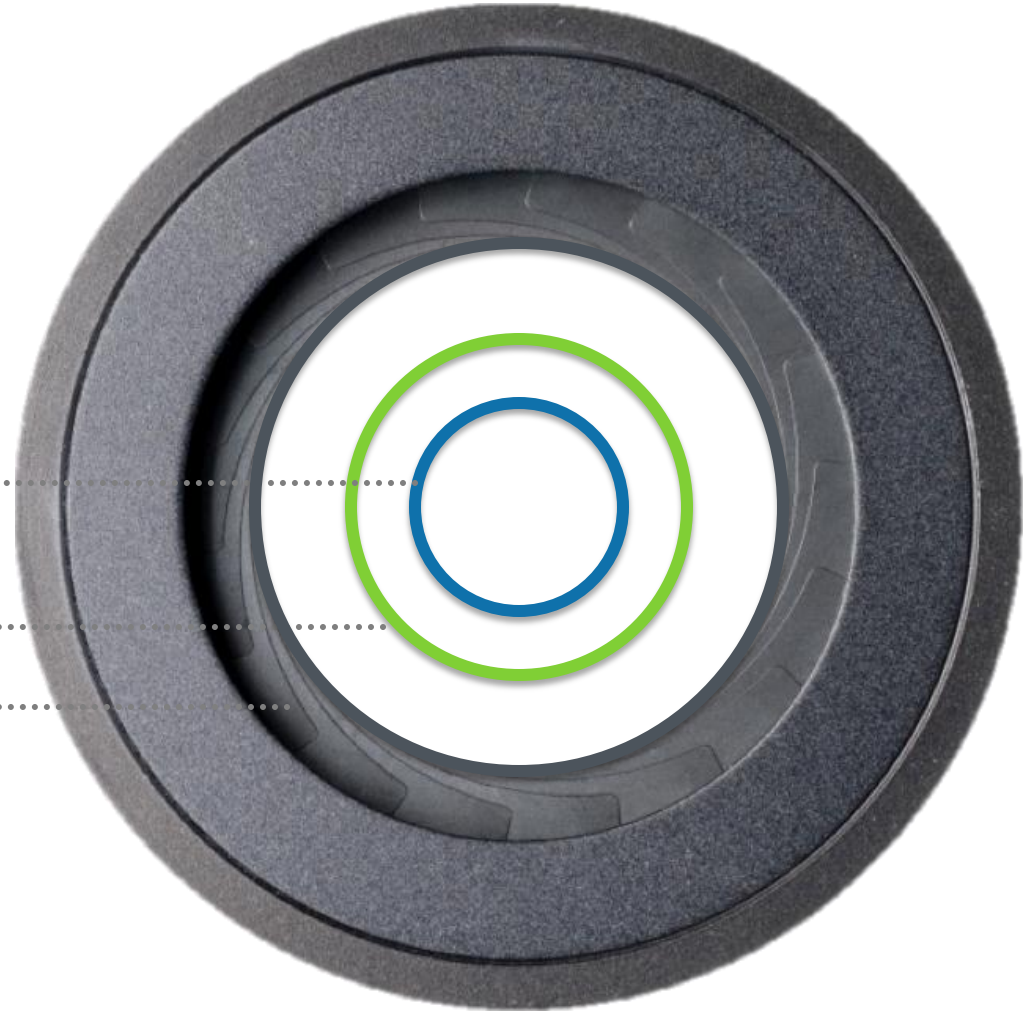
Prior Authorization Coverage

- Covered only for the slightly larger population

LEVEL 3

Fair Use Coverage

- Covered largest contingent of population – lowlikelihood of break-even



BUDGET IMPACT MODELER – CASE 1

InfoLock®

Model Overview | Population | Costs | Budget Impact | References

Select Patient Population

Obesity Grade: ○ Labeled Indication (BMI ≥ 27 with a comorbidity or BMI ≥ 30) ○ Grade 1 Obesity (BMI ≥ 30) ○ Grade 2 Obesity (BMI ≥ 35) ○ Grade 3 Obesity (BMI ≥ 40) ○ Plan Specific

Comorbidity Status: ◉ Pre-Diabetes ○ Diabetes ○ Hypertension ○ Dyslipidemia

Plan Characteristics

Plan Population	5,000	Turnover	10%
Percentage of Plan Population ≥18 years of age	76.0%	Qsymia Adoption Rate	40%
Prevalence of Overweight with comorbidity or Obesity	47.2%		

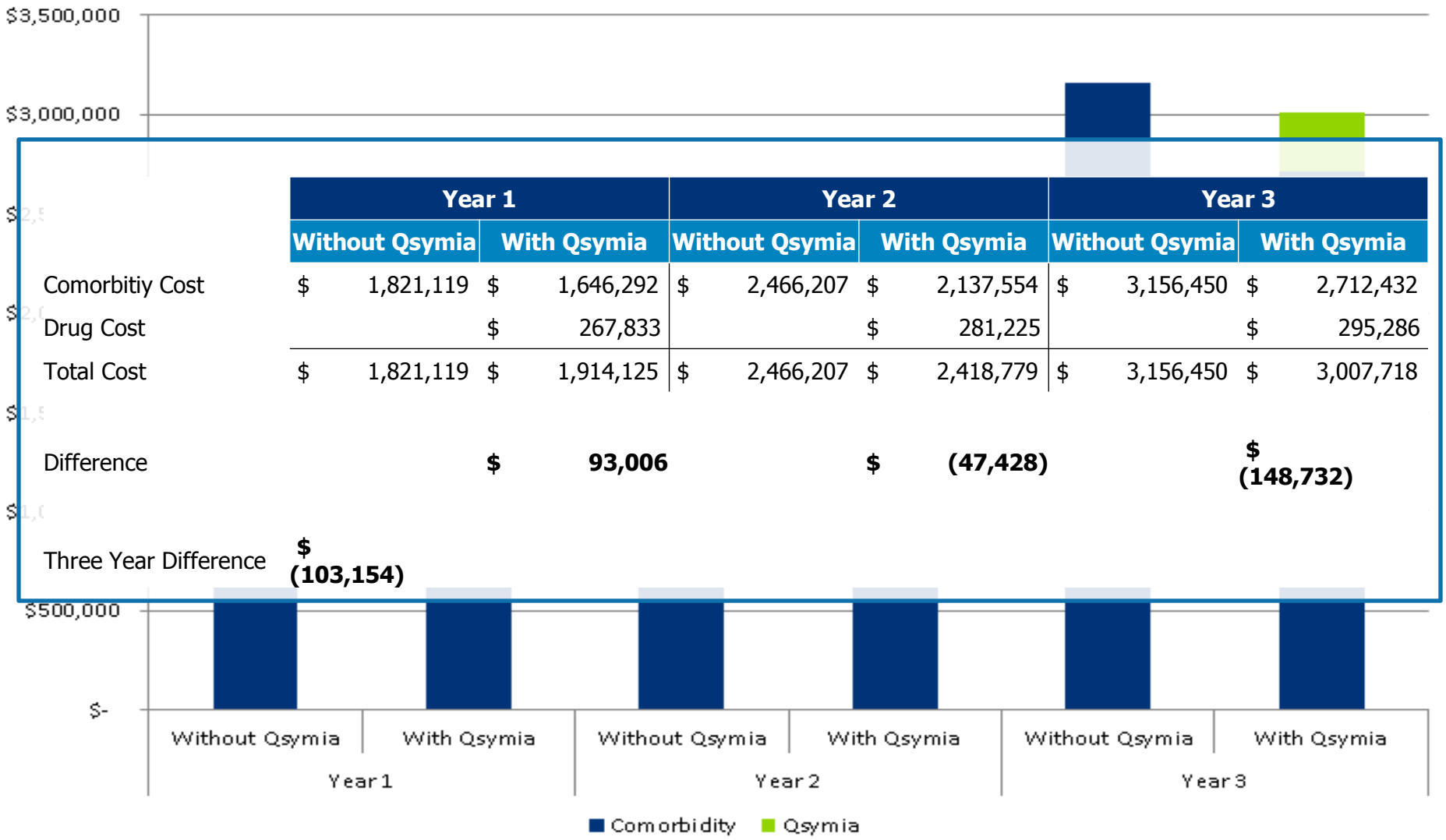
Comorbidity Characteristics

Prevalence of Pre-Diabetes	35.0%
Potential Patient Population	**628**

BUDGET IMPACT MODELER – CASE 1

InfoLock®

	Year 1		Year 2		Year 3	
	Without Qsymia	With Qsymia	Without Qsymia	With Qsymia	Without Qsymia	With Qsymia
Comorbitiy Cost	$ 1,821,119	$ 1,646,292	$ 2,466,207	$ 2,137,554	$ 3,156,450	$ 2,712,432
Drug Cost		$ 267,833		$ 281,225		$ 295,286
Total Cost	$ 1,821,119	$ 1,914,125	$ 2,466,207	$ 2,418,779	$ 3,156,450	$ 3,007,718
Difference		**$ 93,006**		**$ (47,428)**		**$ (148,732)**
Three Year Difference	**$ (103,154)**					



BUDGET IMPACT MODELER – CASE 2

InfoLock®

Model Overview | Population | Costs | Budget Impact | References

Select Patient Population

Obesity Grade: ○ Labeled Indication (BMI ≥ 27 with a comorbidity or BMI ≥ 30) ○ Grade 1 Obesity (BMI ≥ 30) ○ Grade 2 Obesity (BMI ≥ 35) ○ Grade 3 Obesity (BMI ≥ 40) ○ Plan Specific

Comorbidity Status: ◉ Pre-Diabetes ○ Diabetes ○ Hypertension ○ Dyslipidemia

Plan Characteristics

Plan Population	5,000	Turnover	50%
Percentage of Plan Population ≥18 years of age	76.0%	Qsymia Adoption Rate	40%
Prevalence of Overweight with comorbidity or Obesity	47.2%		

Comorbidity Characteristics

Prevalence of Pre-Diabetes	35.0%
Potential Patient Population	**628**

BUDGET IMPACT MODELER – CASE 2

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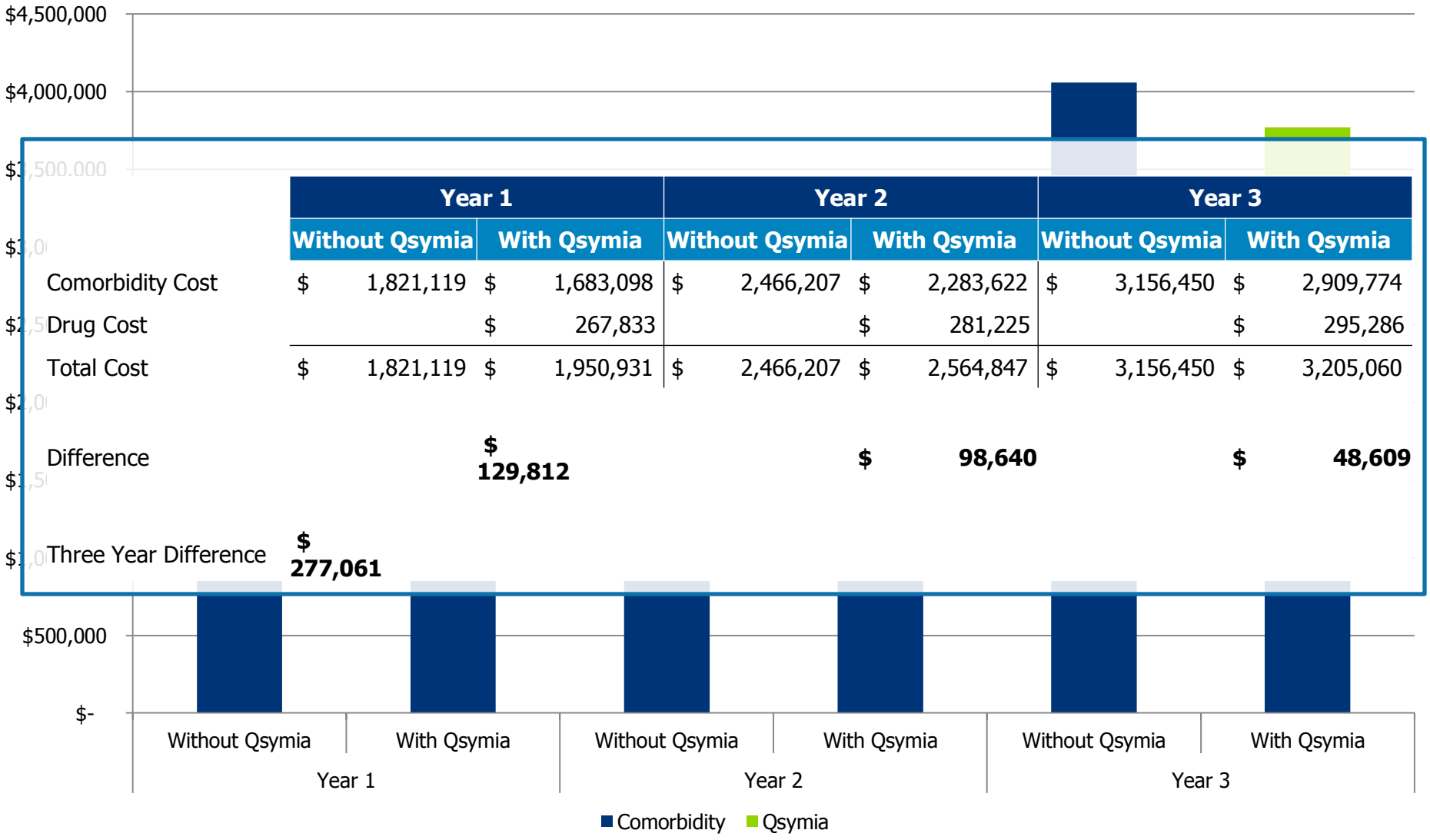

	Year 1		Year 2		Year 3	
	Without Qsymia	With Qsymia	Without Qsymia	With Qsymia	Without Qsymia	With Qsymia
Comorbidity Cost	$ 1,821,119	$ 1,683,098	$ 2,466,207	$ 2,283,622	$ 3,156,450	$ 2,909,774
Drug Cost		$ 267,833		$ 281,225		$ 295,286
Total Cost	$ 1,821,119	$ 1,950,931	$ 2,466,207	$ 2,564,847	$ 3,156,450	$ 3,205,060
Difference		**$ 129,812**		**$ 98,640**		**$ 48,609**
Three Year Difference	**$ 277,061**					

BUDGET IMPACT MODELER – CASE 3

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Select Patient Population

Obesity Grade: ◯ Labeled Indication (BMI ≥ 27 with a comorbidity or BMI ≥ 30) ◯ Grade 1 Obesity (BMI ≥ 30) ◯ Grade 2 Obesity (BMI ≥ 35) ◯ Grade 3 Obesity (BMI ≥ 40) ◯ Plan Specific

Comorbidity Status: ◉ Pre-Diabetes ◯ Diabetes ◯ Hypertension ◯ Dyslipidemia

Plan Characteristics

Plan Population	5,000	Turnover	10%
Percentage of Plan Population ≥18 years of age	76.0%	Qsymia Adoption Rate	60%
Prevalence of Overweight with comorbidity or Obesity	47.2%		

Comorbidity Characteristics

Prevalence of Pre-Diabetes	45.0%
Potential Patient Population	**807**

BUDGET IMPACT MODELER – CASE 3

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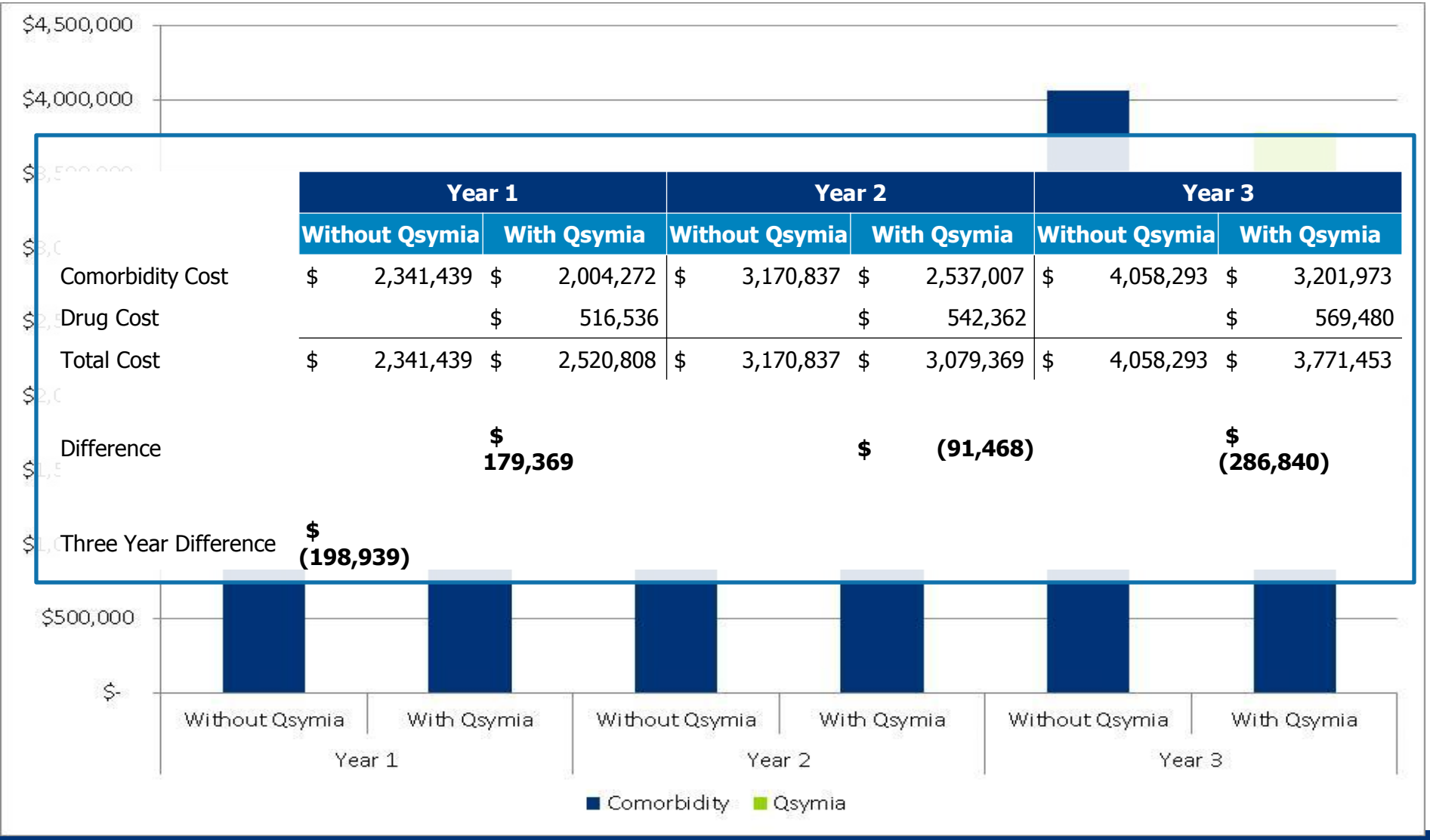
	Year 1		Year 2		Year 3	
	Without Qsymia	With Qsymia	Without Qsymia	With Qsymia	Without Qsymia	With Qsymia
Comorbidity Cost	$ 2,341,439	$ 2,004,272	$ 3,170,837	$ 2,537,007	$ 4,058,293	$ 3,201,973
Drug Cost		$ 516,536		$ 542,362		$ 569,480
Total Cost	$ 2,341,439	$ 2,520,808	$ 3,170,837	$ 3,079,369	$ 4,058,293	$ 3,771,453
Difference		**$ 179,369**		**$ (91,468)**		**$ (286,840)**
Three Year Difference	**$ (198,939)**					



CONCLUSION

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RISK MANAGEMENT

Employers retain more risk today - reform
Risks/costs associated with obesity gear the risk
Financial "Aperture" constantly changing

EVALUATING NEW ENTRANTS

Wellness programs of old have largely failed to produce – changing rapidly
Diabetes avoidance/suppression = $$$ not hitting the health plan
Each plan has a "break even" point – find yours

BENEFIT DESIGN AND ECONOMIC MODELING

Evaluate – no "head in the sand" approach
Benefit design must be tailored and bespoke to group makeup
Supressing risks/costs associated with obesity becoming core to the "job"

QUESTIONS?

Presented by Christian Moreno, Lockton Companies

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Our Mission

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insurance brokerage, employee benefits, and risk management

Our Goal

To be the best place to do business and to work

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