High-Cost Claims Initiative:
Employer Actions to Address High-Cost Claims

Employer Workshop

2024

National Alliance
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Agenda

Setting the Stage (25 minutes)

- Welcome and workshop goals overview
- High-cost claims trends and data-driven decision-making
- Pre-survey findings

Round Robin of Employers (35 minutes)

Breakout Work Time (45 minutes)

Idea Generation (30 minutes)

Deep Dive Discussion (1 hour)

Taking Action: Strategy Development Exercise (20 minutes)

Final Wrap-Up (10 minutes)

Introductions

National Alliance Healthcare Advancement Team

- Christina Bell, Director
- Amanda Green, Manager

Leading Subject Matter Expert

- Christine Hale, MD, MBA, SVP Chief Medical Officer, Clinical Consulting, Lockton

Coalitions

- Nevada Business Group on Health
- Florida Alliance for Healthcare Value
- Houston Business Coalition on Health
- Greater Cincinnati Employers Group on Health
- North Carolina Business Coalition on Health

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Workshop Goals

- ❑ Enhanced employer understanding and awareness of critical issues related to high-cost claims, resulting in increased adoption of cost-effective measures
- ❑ Empowered employers equipped with the knowledge and resources to gather relevant data and develop comprehensive action plans, leading to more effective strategies for managing high-cost claims
- ❑ Creation of a robust employer playbook that facilitates knowledge-sharing - enabling the dissemination and implementation of successful strategies for high-cost claims management.

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What's Really Driving Employer Health Plan Costs?

0.6% of a population drives 35% of employers' spend

High-cost claims are different

Specialty Medicines, especially injectables, are the fastest-growing driver of high-cost claimants

High-cost claimants are made up of cancers, kidney failure, sepsis, complex newborns and hemophilia

High-Cost Claimant Predictive Analytics can ***sometimes*** identify these individuals and target early interventions

Health care inflation is driven by price increases, not utilization, think new medical and Rx technologies

Chronic conditions are the direct cause of less than a quarter of medical and pharmacy claims over $50,000 (high-cost claims)

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Source: Lockton Companies.

Stop Loss Market Overview 2023

Cancer has been the top condition for over a decade. This year, CV took the #2 spot for the first time ever. Neonate claims continue to rise

The top 10 conditions have contributed to 72% of total reimbursements.

87% of employers had a stop loss claim from 2019 – 2022.

Sources: Sun Life 2024 High-cost claim and injectable drug trends analysis.

Top 20 High-Cost Claim Conditions

STOP LOSS CLAIM REIMBURSEMENTS

2023 rank	4 Year rank	Condition/Disease/Disorder	2023 reimbursements	2020-2023 reimbursements
1	1	Malignant Neoplasm	$415.6M	$1.31B
2	2	Cardiovascular	$165.8M	$510.4M
5	3	Leukemia, Lymphoma, Multiple Myeloma	$96.2M	$461.2M
3	4	Newborn/Infant Care	$140.8M	$408.1M
4	5	Orthopedics/Musculoskeletal	$121.8M	$389.0M
7	6	Respiratory	$81.6M	$287.9M
9	7	Sepsis	$79.4M	$285.4M
6	8	Gastrointestinal	$87.0M	$273.8M
8	9	Neurological	$79.4M	$263.4M
12	10	Urinary/Renal	$55.7M	$224.1M
10	11	Physician Treatment*	$63.7M	$193.5M
11	12	Congenital Anomaly (structural)	$56.8M	$185.6M
29	13	COVID-19	$6.8M	$135.0M
13	14	Mental and Behavioral Health	$38.1M	$121.5M
15	15	Cerebrovascular	$29.8M	$110.5M
17	16	Hemophilia/Bleeding	$28.8M	$104.1M
16	17	Malnutrition	$29.6M	$98.9M
18	18	Transplant	$27.3M	$98.8M
14	19	Blood and Blood-Forming Organs	$33.2M	$94.7M
19	20	Immune System	$25.0M	$91.8M

Stop Loss $1M+ Claimant Risk Drivers

Conditions with the highest number of million-dollar claims by year:
Million-dollar claims are also spread across many conditions, with every top 20 claim category experiencing a million-dollar+ claim in 2023. However, some conditions see more million-dollar claims than others. The conditions with the most million-dollar+ claims over the past four years are listed below:

2020	2021	2022	2023
Leukemia, Lymphoma, Multiple Myeloma	Leukemia, Lymphoma, Multiple Myeloma	Malignant Neoplasm	Malignant Neoplasm
Newborn/Infant Care	Malignant Neoplasm	Leukemia, Lymphoma, Multiple Myeloma	Newborn/Infant Care
Malignant Neoplasm	Newborn/Infant Care	Tied: Newborn/Infant Care and Cardiovascular	Cardiovascular
Cardiovascular	Tied: COVID-19 and Congenital Anomaly	Sepsis	Sepsis
Respiratory	Cardiovascular	COVID-19	Leukemia, Lymphoma, Multiple Myeloma

Majority condition for each claimant was used.

$1M+ claims continue to rise:

- Total $1M+ claims increased 50% from 2020-2023

$1M+ claims are disproportionately weighted toward younger plan members:

- Over half of all $1M+ claimants are under the age of 20; <2 years is the largest category
- This is more pronounced with claims > $3M

  -- 50% are for infants with congenital anomalies

  -- Long inpatient stays represent the largest bucket of cost

The top conditions for $1M+ claims are cancer, newborns, cardiovascular, and sepsis.

Source: Sun Life 2024 High-cost claim and injectable drug trends analysis.

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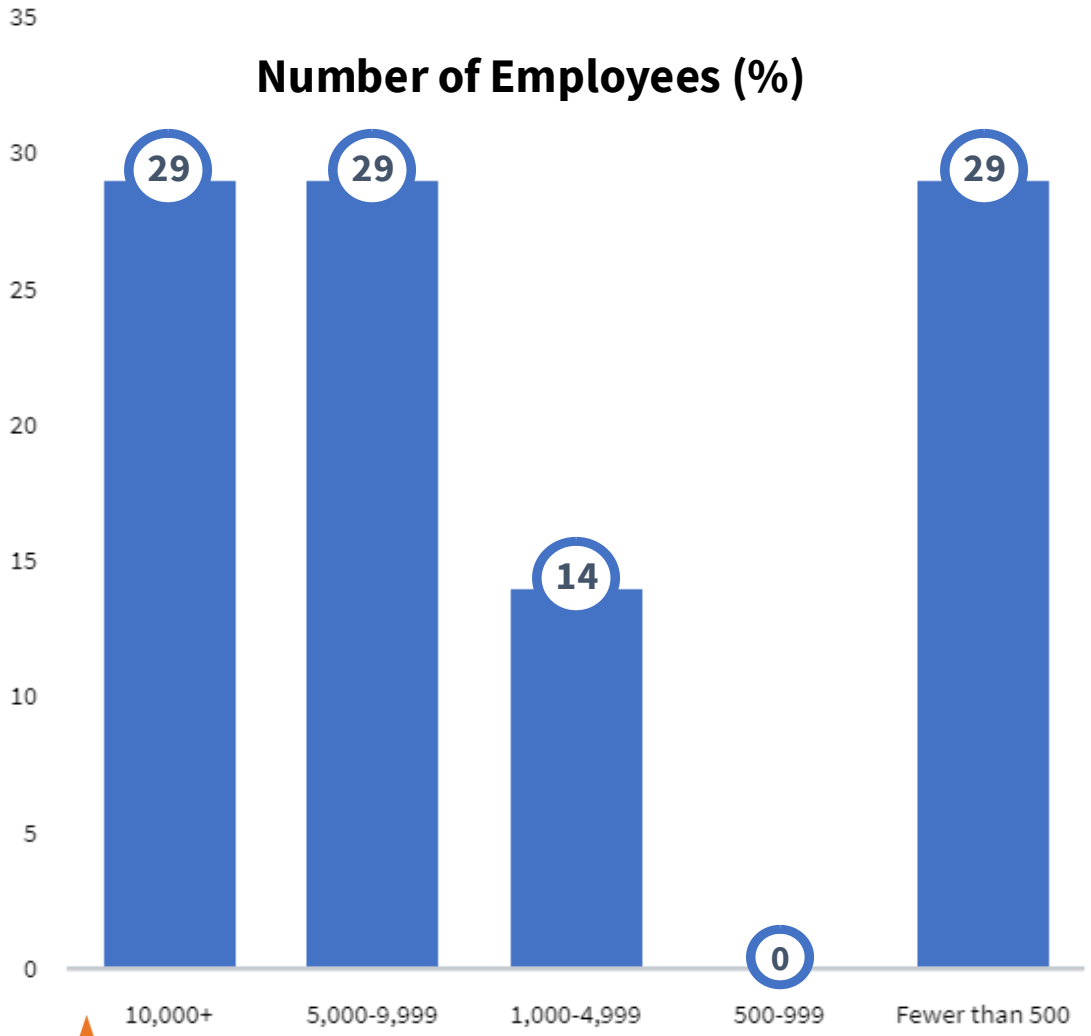
One Size Does NOT Fit All

- While there are common themes, the approach to managing high cost and clinically complex cases can **vary significantly** from employer to employer
- **Tactics range** from clinical interventions (e.g., second opinions, clinical trial access) to cost effectiveness tactics (e.g., site of care, drug formulation) to billing accuracy to plan design changes
- A combination of **member-specific and program-level interventions** will yield the greatest impact
- Understanding the nuances of what is driving a given plan's large claims experience is crucial to creating a plan that works…. **Data is key!**
- Employers should engage partners who are willing to **collaborate**. It takes a village.
- Continued vigilance, nimbleness, and innovation cannot be overlooked. New issues will continue to emerge over time

High-Cost Claims – Pre-Survey Demographics



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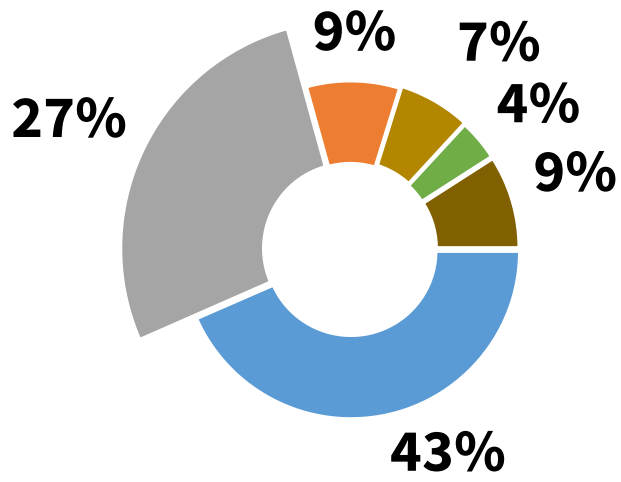
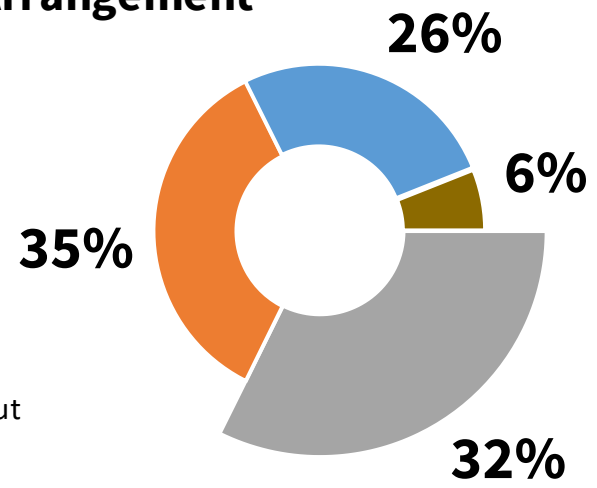
Type of Health Plan Offered

- PPO
- HDHP w/ HSA
- EPO/narrow network
- HMO
- Reference Based Pricing
- Other
  - OAP Plans
  - LDHP
  - ACO



PBM Arrangement

- Bundled
- Carve out, traditional
- Carve out, transparent
- Other
  - unknown
  - Moving next PY to carved out



How do you define a High-Cost Claim?

High-Cost Claims by the Numbers

94%

Employers are self-funded

68%

Employers have stop-loss coverage

39%

39% of employers are not at all confident in their ability to manage current/future High-Cost Claims

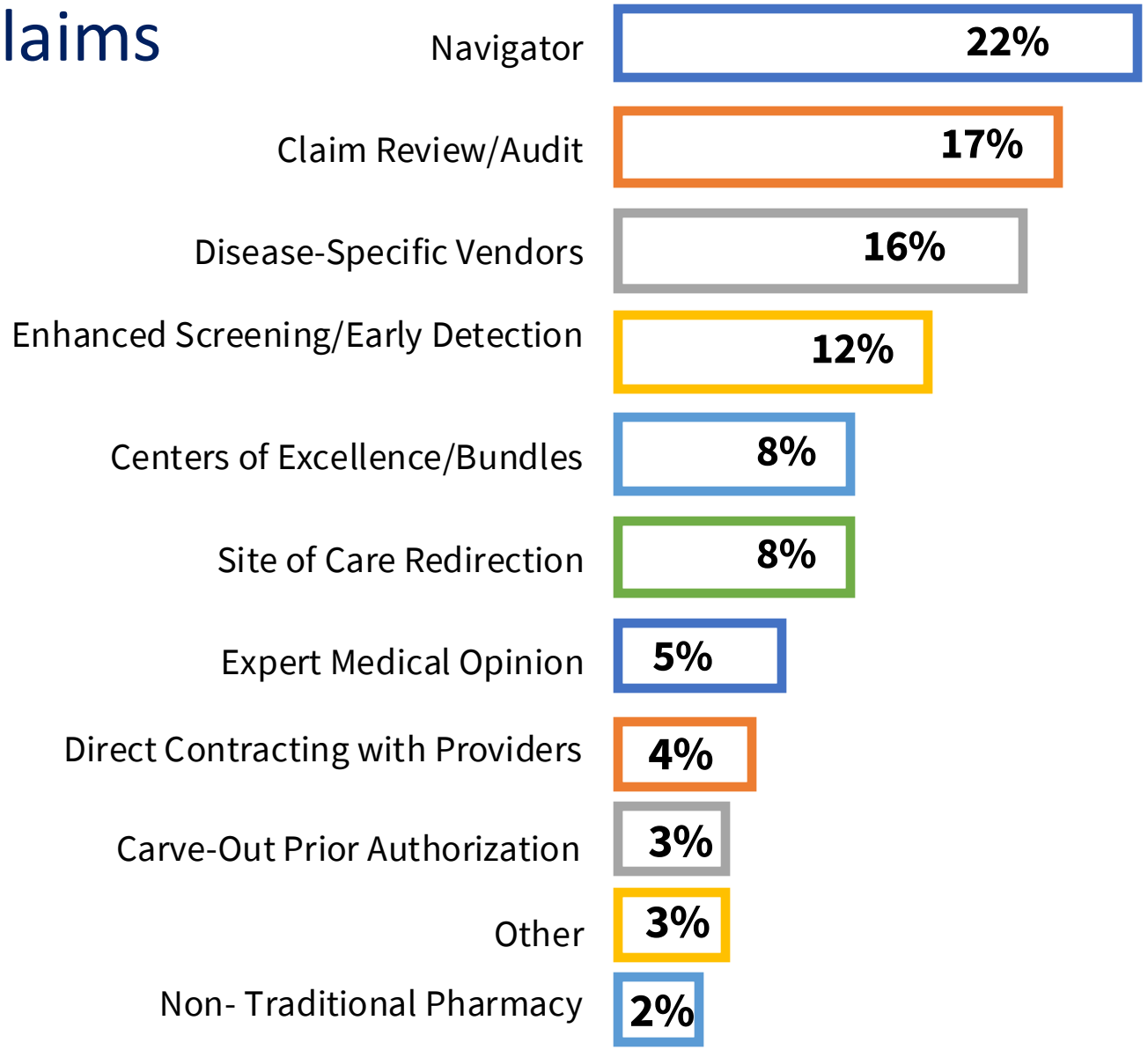
58%

58% of employers are somewhat confident in their ability to manage current/future High-Cost Claims

Strategies to Address High-Cost Claims

How satisfied are you with your strategies?

- Not satisfied, I know there is more that can be done.
- My lack of satisfaction is with understanding how the claims are being calculated, what criteria is being used to determine the claims and how stop loss insurance is calculated.
- … I'm disgusted at how much is being passed along to the plans regarding facility fees and medical devices. HCA charges an outrageous amount for implanted devices. I'd love to delve more into this because our large cost claimants have been largely due to the extreme markup on medical devices
- We are not satisfied with the current strategies we have in place to mitigate high-cost claims.
- We feel there is more that can be done at the level of care management.
- At the starting line



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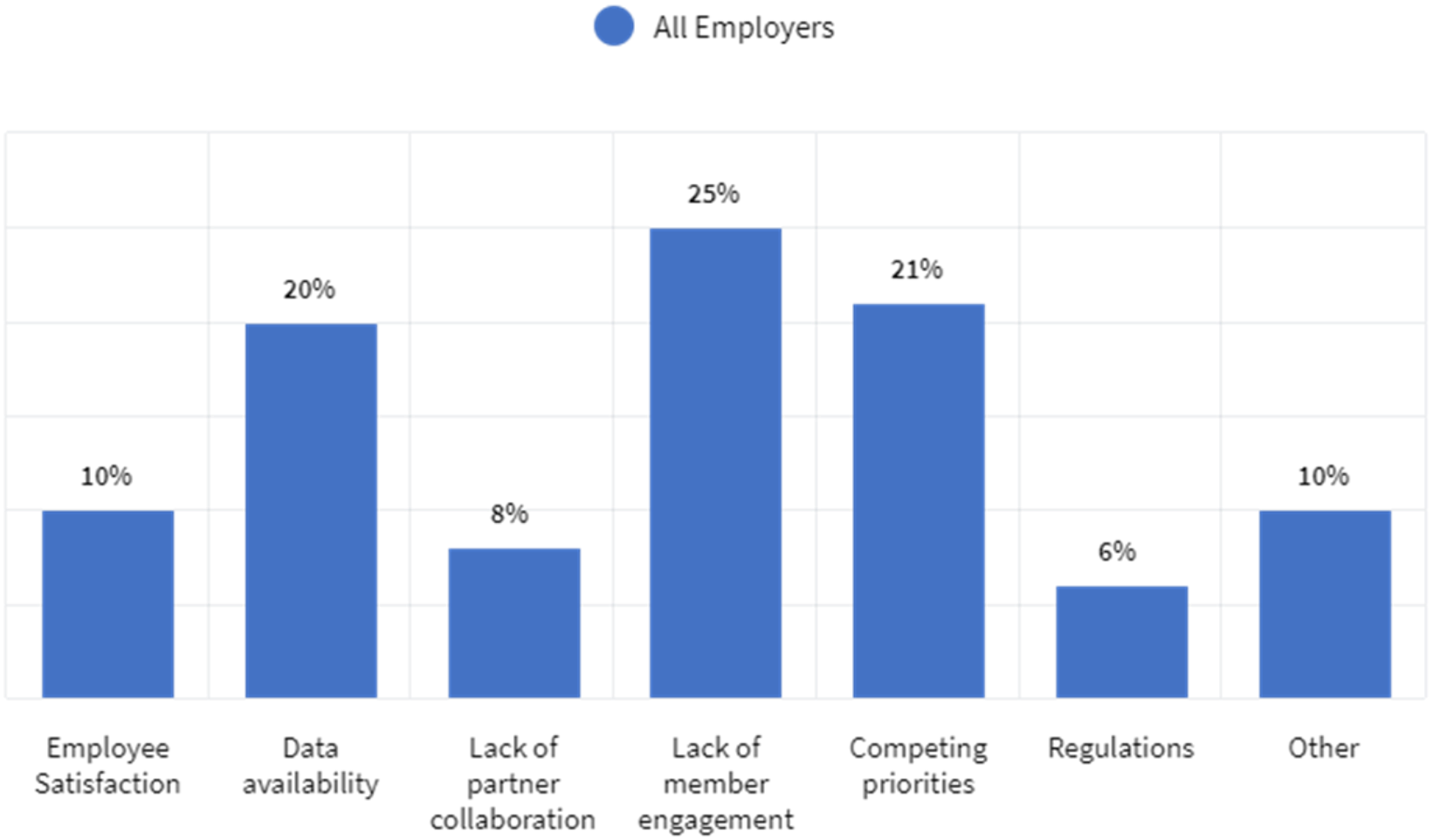
Other: Disease-specific programs through medical and Rx TPAs, such as Diabetes management, Blue Distinction Centers, etc.; On site medical clinic free for employees and their covered dependents 16+ to use; bundling stop loss w/ TPA so TPA has skin in the game

Barriers encountered while trying to address HCCs



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Conditions that make up your largest HCC spend

	Clinical Conditions
Cancer	23%
Cardiovascular	15%
Immune conditions	13%
Diabetes/Kidney Disease	10%
Genetic conditions	9%
Musculoskeletal	9%
Infections	6%
Neonates	5%
Rare disease	2%
Trauma/burns	1%
Mental/behavioral health	1%
Other	6%

Other Conditions: Transplant; Neonatal; skin and subcutaneous tissue (1), ne
system (2), digestive system (3); High Risk Pregnancy; Autism/Cerebral Palsy

Secondary/co-morbid conditions that make up your largest HCC spend

	Secondary Co/morbid Conditions
Cardiometabolic	**37%**
Obesity	**35%**
Mental/behavioral health	**10%**
Infections	**10%**
Other	**10%**

Other Secondary/co-morbid conditions: Complex GI conditions; Secondary tumors; Transplants and preemies; 57% of our HCC's have a mental health diagnosis. Number of members presenting with MH issues are going to continue to increase due to de-stigmatization of MH. We have partnered with a local MH resiliency group for first responders, and implemented a MH leave program for employee's who present with life threatening MH issues/emergencies.

Age demographics that make up your largest HCC spend

7%

7% of largest HCC spend is from under 20 age demographic

10%

10% of largest HCC spend is from under 20-40 age demographic.

55%

55% of largest HCC spend is from under 40-60 age demographic.

21%

21% of largest HCC spend is from 60+ age demographic

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Type of care having the greatest impact

- **25%** Inpatient care, medical
- **21%** Specialty medications billed via the pharmacy plan
- **17%** Specialty medication billed via the medical plan
- **16%** Inpatient care, surgical
- **12%** Outpatient care
- **4%** Other medications

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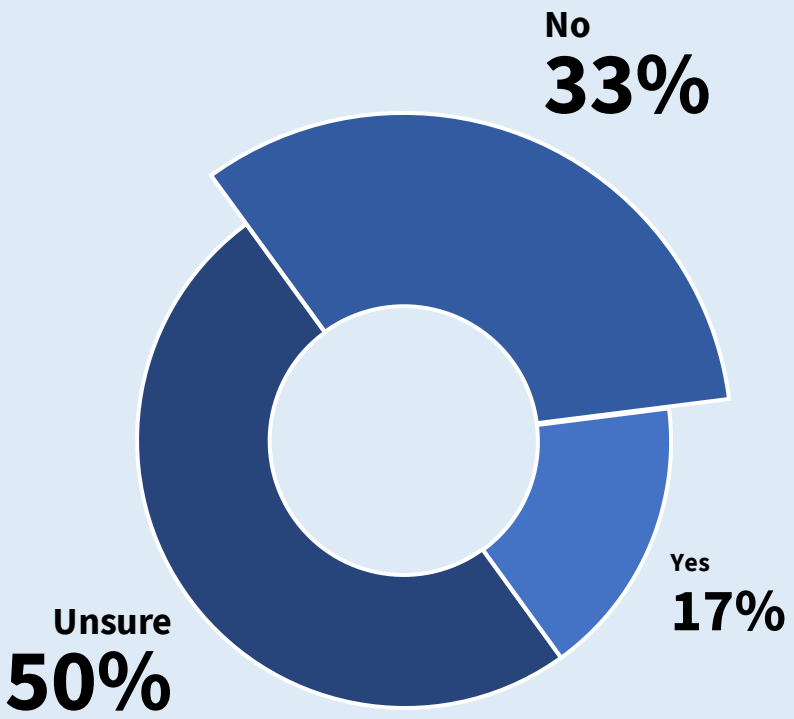
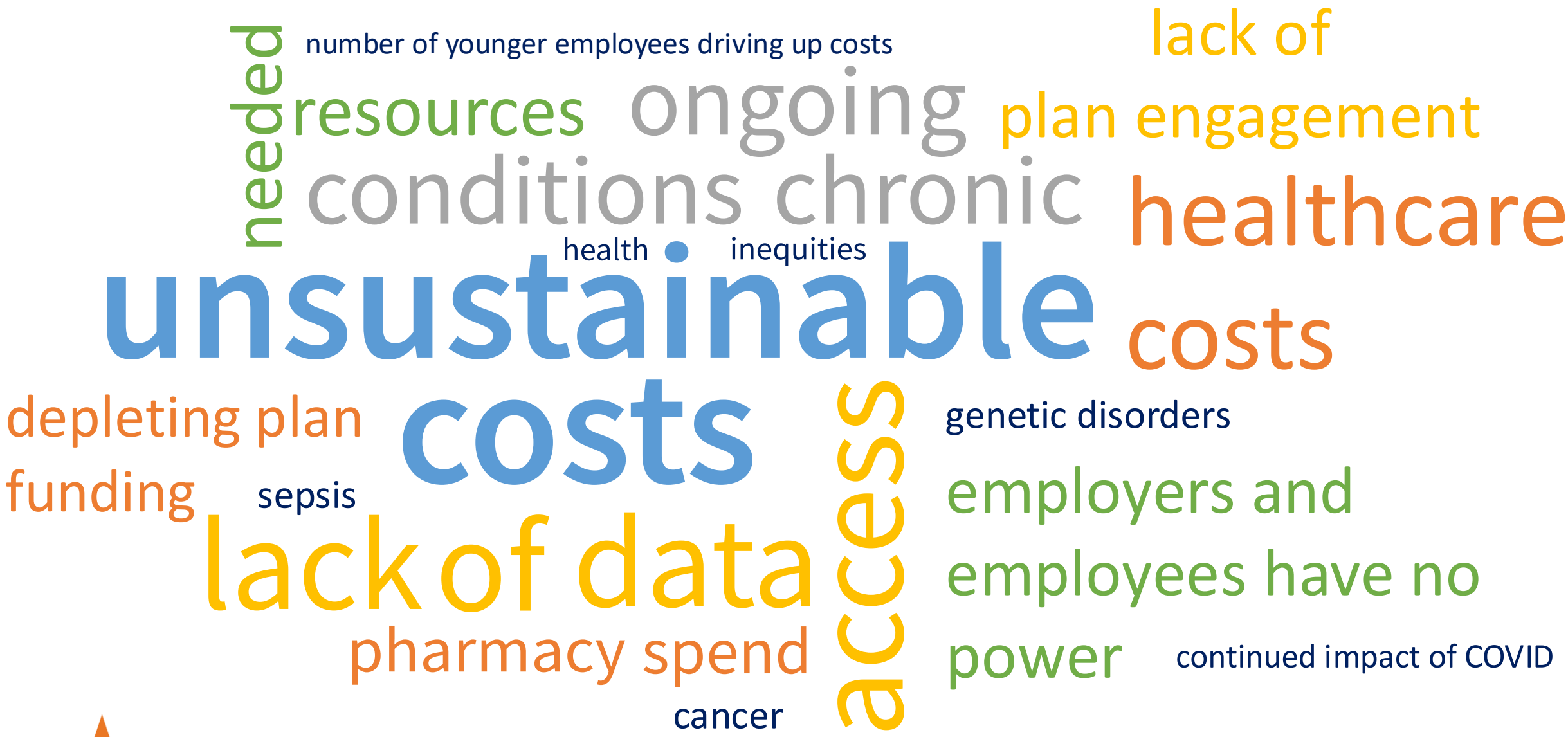
Are there certain providers contributing to disproportionate spend?



Concerns about future HCCs



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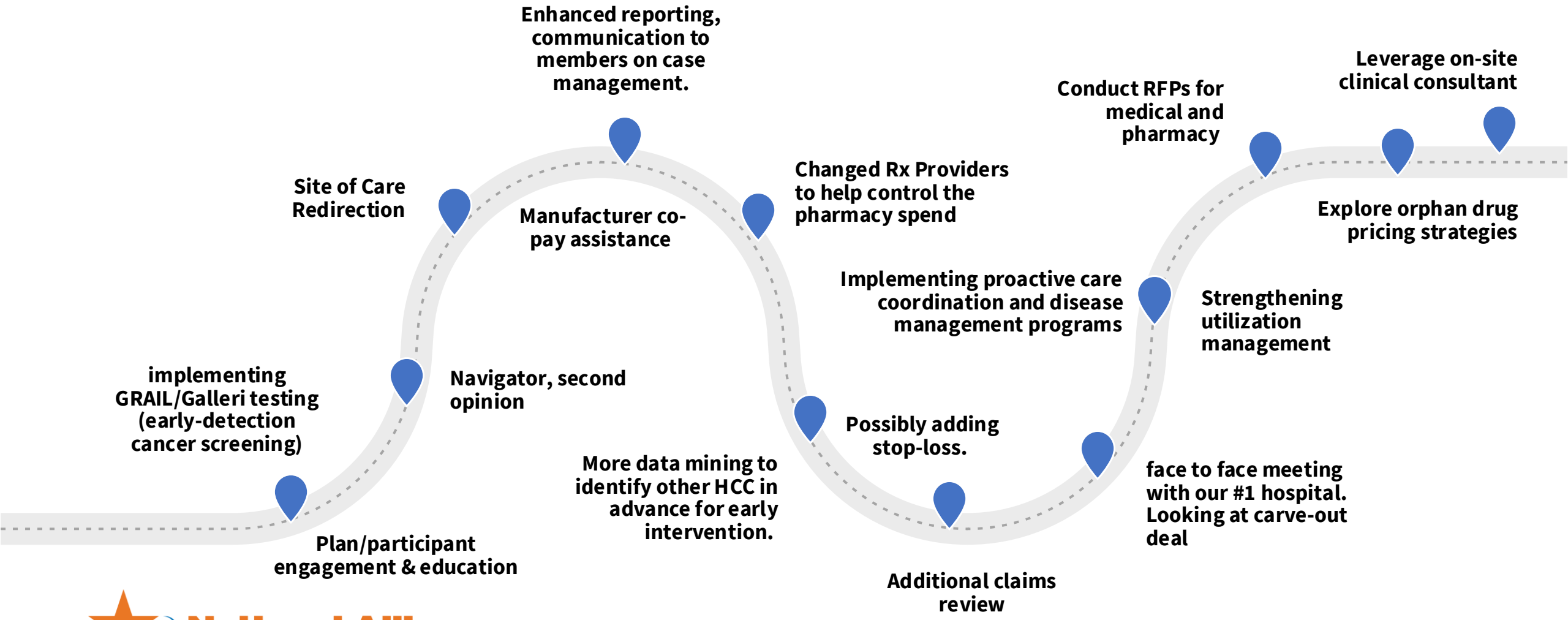
HCC interventions on your 2024/25 roadmap



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Round Robin and Discussion

Employers

- Name, employer, size, TPA/ASO, PBM, current/planned HCC initiatives
- What insights did you gather from your data-gathering process?
- What did you expect, not expect?
- What questions do you hope to get answered in today's session?

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Breakout Session
(45 Minutes)

Instructions for Breakout Session

- Pair up in groups of 2-3 employers OR work on your own
- If working in a group, try to work with others who are at a similar stage in their journey (e.g., struggling to get data, have data but need deeper insights, building/refining strategy)
- Work on completing the initial data assessment template in your playbook
- Once you have completed the initial assessment try to dig a little deeper into prominent areas of your large claims spend (see next page for sample deep dive questions)
- Be prepared to share some new insights you gathered when we return
- We will be circulating to assist with interpreting data, but don't hesitate to raise your hand if you need help!

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Sample Deep Dive Areas

- By disease
  - **Cancer** – What cancer types are most common? Are they screenable? What age are the affected members? Were they early or late stage? What type of care is driving cost (Rx vs IP vs OP)? If Rx, what are the most common medications? Where is the care being rendered?
  - **Cardiovascular** (incl stroke/peripheral) – What types of cardiac cases are they (procedural vs medical)? Are they due to chronic disease or other factors (e.g., congenital, post-infectious)? What co-morbid conditions are present (e.g., obesity, tobacco use)?
  - **Immune** (incl GI/derm/rheum) - What medications are most common? Are the running through medical or Rx plan? Where are they being administered? Are there variances/outliers in cost? Are the treatments working?
  - **Neonates** – What is average cost per day? Was level of care de-escalated? Were inhaled nitric oxide or ECMO used? Were there any surgical procedures? Were there any outlier providers?
  - **Infections** – What types of infections are presenting? Were there underlying risk factors (e.g., diabetes, cancer)? Was it present on admission or acquired? What cost drivers can you identify (e.g., intensive care, ECMO, surgery)?

Source: Lockton Companies.

Sample Deep Dive Areas (cont.)

- By disease
  - **Renal –** What is your overall prevalence of CKD? What proportion are on dialysis? What type of dialysis is it (hemo vs peritoneal)? What is cost per treatment? How long have they been on dialysis? How many have received a transplant?
  - **MSK** - What types of MSK cases are driving large claims (spine vs other)? Are they associated with trauma or underlying factors (e.g., cancer)? How much variation is there in procedural costs? What proportion of the costs are tied to implants?
- By spend type
  - **Inpatient** – How long was stay? What level of care? What is the cost per day? What treatments were rendered? Are there particular facilities that are outliers? Are they INN or OON? What was the payment methodology?
  - **Outpatient** – What was the major driver of costs (e.g., Surgery, ER, physician)? How much is due to medications running through the medical plan? In what location are these treatments being received (e.g., hospital, physician office, home)? Where do the members live (e.g., urban vs rural)?
  - **Pharmacy** – What are the most expensive and most common medications? How much variation is seen in dosing and/or cost? Do the members seem to be responding to treatment?

Source: Lockton Companies.

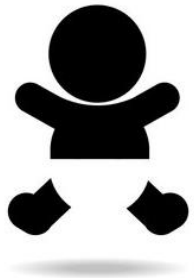
Break

(15 Minutes)

Idea Generation

(30 Minutes)

Trend: Neonates



Costs for neonatal intensive care have **increased dramatically** and are **highly unpredictable**. Cases in the multi-millions are now routine. Costs also vary widely and are often **not tied to differences in quality**. An estimated nearly 20% of stop loss claims are birth related.[7]

Approximately **1 in 10 live births are preterm** and may have ongoing sequelae.[2]

3 CDC
7 Progeny Health 2000

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Example Levers

PREVENTION: Prenatal care, managed fertility.

MEDICAL POLICIES: Clearly articulated and consistently implemented policies for specialized treatments (e.g., nitric oxide, ECMO).

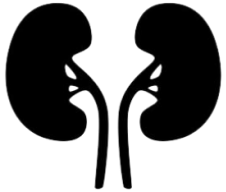
SPECIALIZED UTILIZATION MANAGEMENT: Frequent review of level of care and medical management.

SPECIALIZED CASE MANAGEMENT: Discharge planning, family education, nurse hotline for avoided ER visits and readmissions.

PAYMENT INNOVATION: Case rates, network design, and other novel approaches.

Source: Lockton Companies.

Trend: Chronic Kidney Disease and ESRD



Chronic kidney disease is present in **12% of individuals aged 45 to 64** and 6% of individuals aged 18 to 44.[2]

The cost of dialysis (per session) for private payors is estimated to be **6 times higher** than that for Medicare.[3] Lawmakers recently ruled that private plans can cap exposure at Medicare rates for eligible members.

2 CDC

3 Jama Network: Assessment of Spending for Patients Initiating Dialysis Care 2022

Example Levers

PREVENTION: Emphasis on aggressive management of risk factors (e.g., diabetes, hypertension), advances in medical management of CKD/ESRD, early involvement of nephrology and centers of excellence, mitigation of complications.

MEDICARE ENROLLMENT: Member education on Medicare eligibility, plan cap for eligible members.

SITE OF CARE: Network status, peritoneal dialysis and home hemodialysis.

TRANSPLANTATION: Consideration of pre-emptive transplant, coverage of associated costs (travel, etc.)

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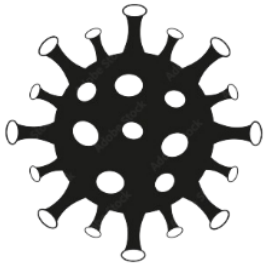
Source: Lockton Companies.

Trend: Sepsis



Sepsis is the **#1 killer of hospital inpatients** and a **top ten driver** of high-cost claims.[4,5] Sepsis claims rose dramatically during the COVID era, due to co-infection, hospital acquired infections, and delays in accessing care. **Each hour** sepsis treatment is delayed decreases survival by 7.6%.[6]

Example Levers

ACCESS: Ability to get timely evaluation of and treatment for predisposing conditions (e.g., other infections, immune suppression).

PREVENTION: Vaccines, masking, hand washing, isolating and other public health measures.

EARLY RECOGNITION AND INTERVENTION: Awareness campaigns, anti-microbials, other supportive care.

CARE ESCALATION: Transfer options for individuals needing a higher level of care.

DECISION SUPPORT: Understanding of patient and family goals, use of palliative care.

4 Sun Life: High-Cost Claims and Injectable Drug Trends Analysis 2022.
5 Sepsis Alliance 2022
6 PLOS One: The Golden Hour of Sepsis 2018.

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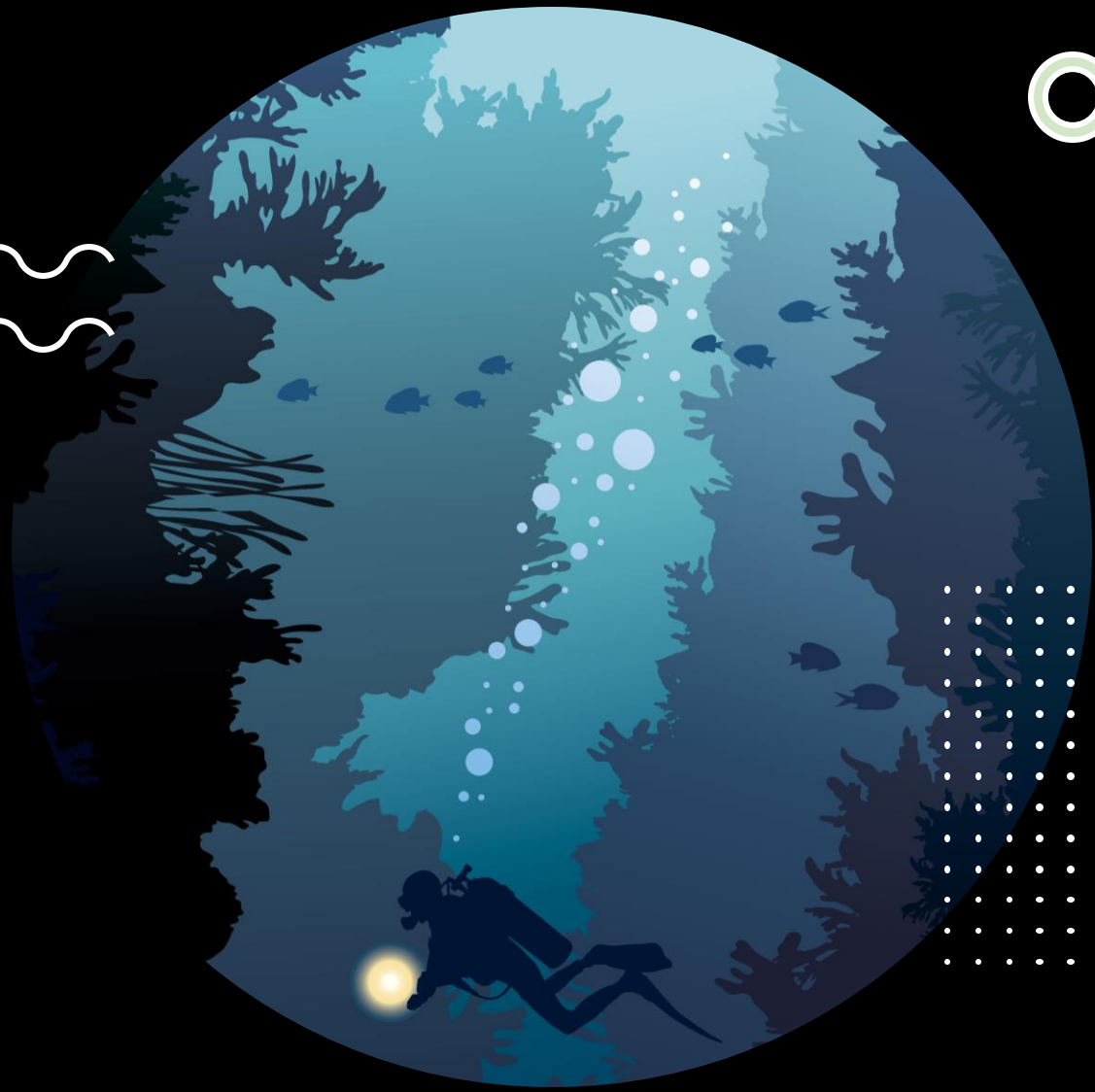
Source: Lockton Companies.

Deep Dive:
Cancer



Trend: Cancer

Cancer is the **#1 and #3 driver of high-cost claims**. The number of cancer claimants **increased 39%** from 2018 to 2021.

Due to delayed/missed screenings, we may see a 10% to 14% increase in new cancer diagnoses this year, including **more late-stage cancers**.[4]

4 Sun Life High-Cost Claims and Injectable Drug Trends Analysis 2022.

Example Levers

PREVENTION: Emphasis on health lifestyle (e.g., diet, exercise, smoking cessation) and risk factor (e.g., weight management).

EARLY DETECTION: Screening options (e.g., Cologuard, MCED tests) and accessibility (e.g., health fair, onsite clinic, mobile mammograms).

NAVIGATION: Emphasis on understanding goals of care and options (including palliative care), steerage to cost-effective providers.

SECOND OPINION: Routine vs. complex cancers, virtual vs. in person, direct to patient versus provider, triggers.

SITE OF CARE: Options for cancer treatments, e.g., office or private infusion center.

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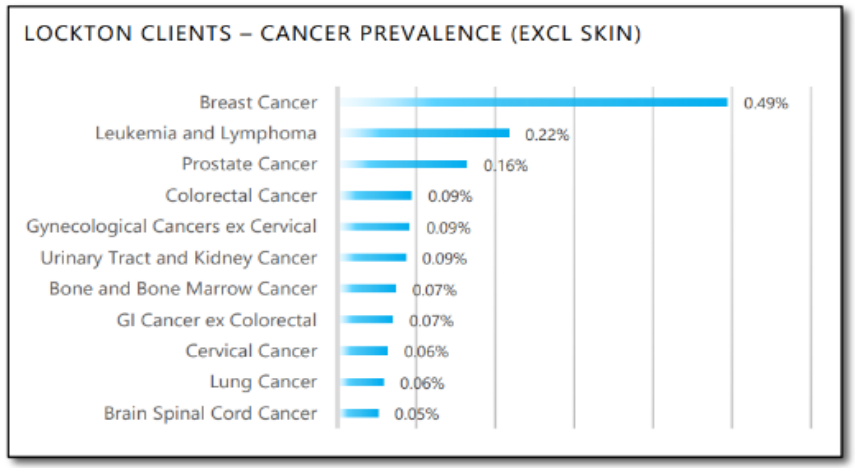
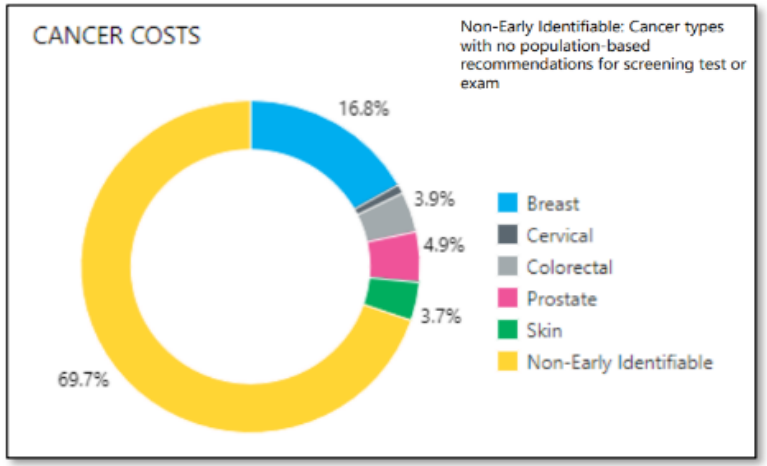
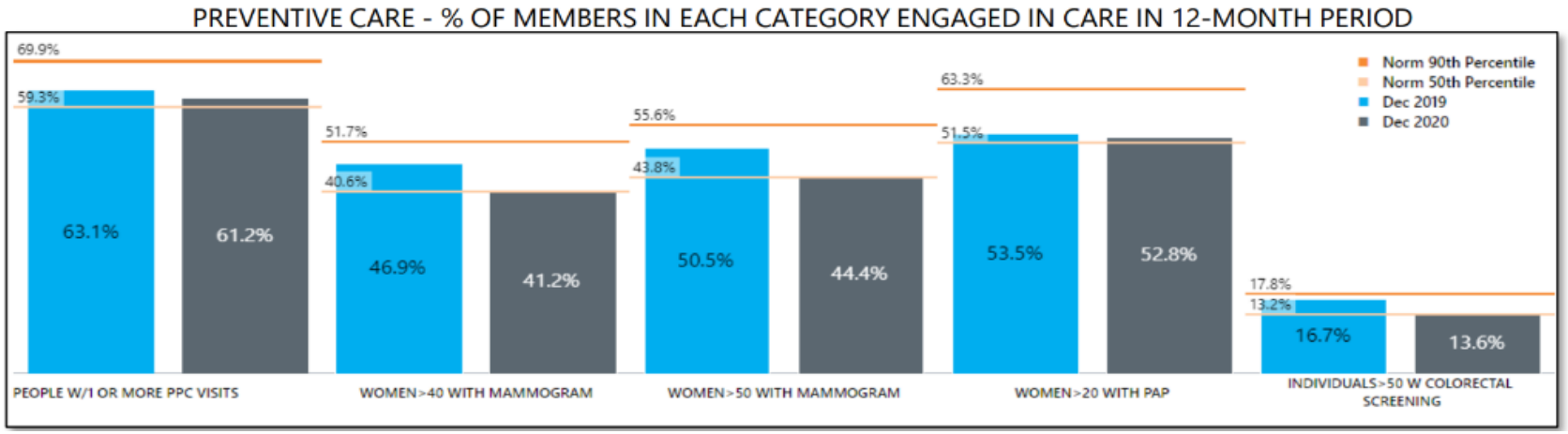
Source: Lockton Companies.

Self-Funded Employer Plans: Cancer Patterns – Lockton Clients[1]







Employers often pay 100% of a member's cancer costs, since these members typically exceed their out-of-pocket maximum

1 Lockton Infolock Book of Business representing over 800 self-funded employers and 3+ million lives.

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Source: Lockton Companies.

Oncology

Have we hit the breaking point with oncology drug prices?

Some see the upward trend in cancer drug costs as accelerating — and unsustainable. Value-based pathways might rearrange the incentives to put some downward pressure on prices. by PETER WEHRWEIN

Oncology Drug Prices

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Source: Lockton Companies.

Specialty Drugs: Cancer Treatments Driving Costs

Top 20 high-cost injectable drug trends

2022 rank	2023 rank	Injectable drug	Total cost	Average cost (and percentage change year over year)
1	1	Keytruda	$69.7M	$147.4K
2	2	Opdivo	$25.6M	$122.9K
3	3	Darzalax Faspro	$22.0M	$151.4K
4	4	Tepezza	$16.7M	$427.2K
18	5	Ultomiris	$15.4M	$548.9K ↑ +88%
7	6	Perjeta	$14.8M	$102K ↑ +25%
9	7	Adcetris	$14.0M	$286.4K
6	8	Neulasta	$12.4M	$31.4K
10	9	Ocrevus	$11.4M	$133.7K ↑ +36%
8	10	Yervoy	$10.3M	$149.5K
27	11	Gamunex-C, Gammaked	$9.3M	$112.9K ↑ +67%
26	12	Tecentriq	$9.1M	$168.8K ↑ +76%
44	13	Romiplostim	$8.8M	$230.9K ↑ +203%
25	14	Krystexxa	$8.7M	$459.9K ↓ -25%
13	15	Rylaze	$8.7M	$618.2K ↓ -24%
15	16	Gammagard	$7.7M	$87K ↑ +28%
12	17	Kadcyla	$7.6M	$159.3K
35	18	Enhertu	$7.5M	$139.3K
5	19	Soliris	$5.9M	$258.4K ↓ -47%
14	20	Spinraza	$5.7M	$357.9K

Immunotherapy drugs represent 5 of the top 10 high-cost injectable drugs: Keytruda (#1), Opdivo (#2), Darzalex Faspro (#3), Perjeta (#6) and Yervoy (#10).[1]

11

of top 20 highest cost injectables are for Cancer[1]

7

of top 20 are for autoimmune conditions

OVERALL TRENDS

- ✓ Cancer drugs top the list of high-cost treatments.[1]
- ✓ Immunotherapy treatment costs, $1M+ per patient, raising bioethics and economic concern [2]
- ✓ Increasing survival rates and maintenance drugs are reframing cancer cost considerations.
- ✓ One gene therapy (Spinraza) made the list, but small eligible populations and slow uptake have historically kept overall exposure down

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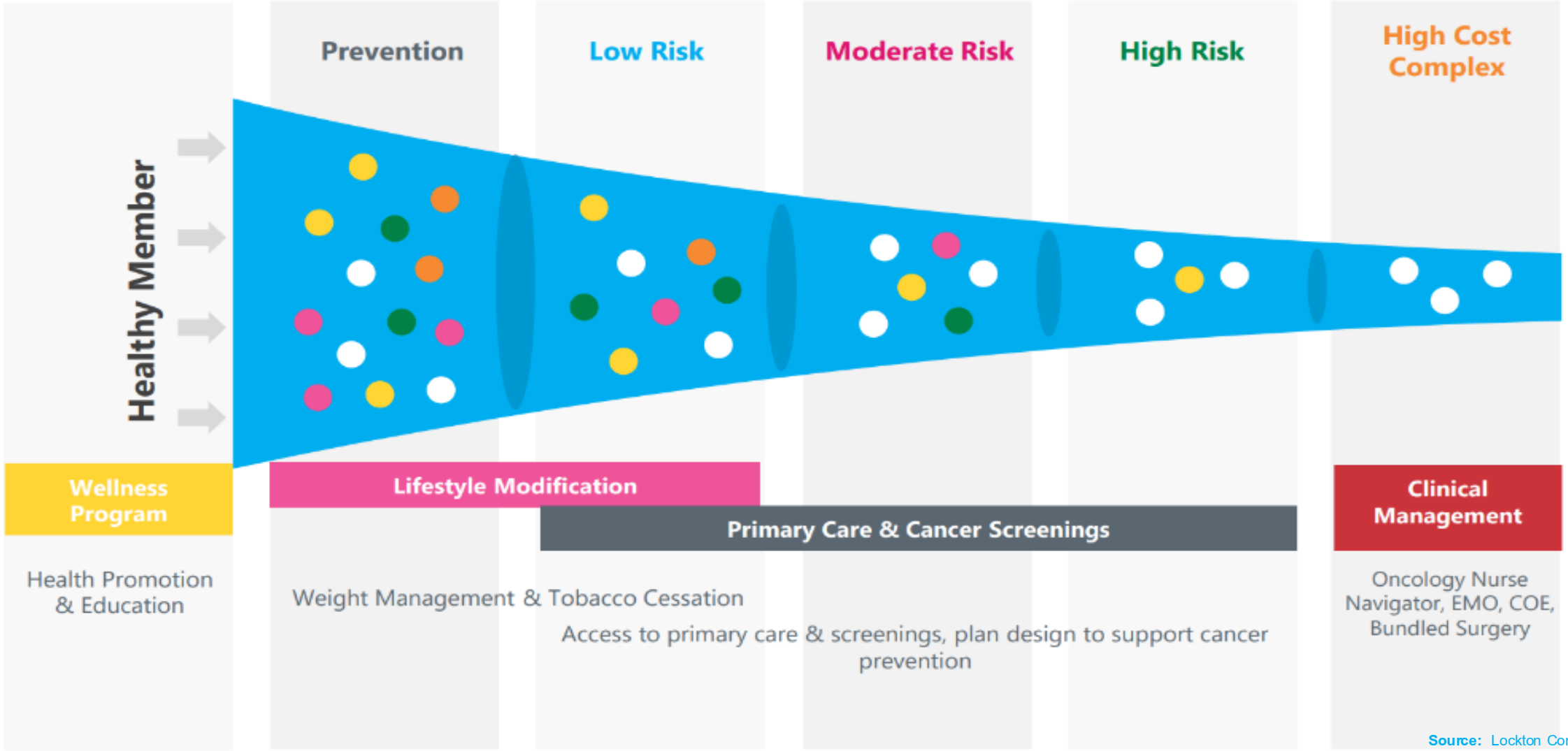
1 SOURCE: Sun Life
2 IPD Analytics.

Source: Lockton Companies.

Self-Funded Employer Cancer Strategy: From Population to Patient



Source: Lockton Companies.

The Self-Funded Employers: Cancer Strategies

Coverage and Plan Design	*Cost Management*	*Medical Management*
✓ Preventive screening coverage. ✓ Genetic testing and genomics. ✓ Specialty therapies and treatments. ✓ Center of Excellence (COE) and Networks of Excellence (NOE) as in-network only or incentivized by funding travel and waiving member out-of-pocket cost.	✓ Bundled payment models. ✓ Reference-based pricing (fixed provider payment using Medicare rate as reference + %). ✓ Outcomes-based pricing models (i.e., performance guarantees). ✓ Direct contracting (carve-out cancer services). ✓ Steerage incentives.	✓ Expert medical opinion/second medical opinion. ✓ NCI-Designated Cancer Centers as in-network only. ✓ Utilization Management – NCCN Guidelines applied to case reviews. ✓ COE/NOE - community oncologist alignment. ✓ Advocacy and navigation, including **site of care** ✓ Early identification and intercept. ✓ Clinical pathways. ✓ Provider quality analysis and specialist matching. ✓ Virtual care.

Source: Lockton Companies.

Example: Colorectal Cancer

Colorectal Cancer Disparities

Age

Colorectal Cancer (CRC) rates are rising in Americans under age 50 (now 12% of CRC cases).

Race/Ethnicity

- ✓ CRC rates in African Americans are the highest of any racial/ethnic group in the US.
- ✓ African Americans are 40% more likely to die from CRC than other groups.
- ✓ African Americans are more likely to be at a younger age than any other group when diagnosed with CRC.
- ✓ Mistrust of the health care system by African Americans, particularly men, is correlated with lower screening rates (fear of experimentation and intrusiveness of screening methods.

Socioeconomic Status and Geography

CRC screening rates are lowest among those with:

- ✓ Low socioeconomic status
- ✓ Fewer years of education
- ✓ Lack of affordable care
- ✓ Residence in rural areas

Opportunity

- ✓ Change coverage for CRC preventive screenings to start at age 45 for all members.
- ✓ Deploy culturally competent communication and health literacy campaign for CRC screening.
- ✓ Partner with a vendor/provider to deploy **home CRC screening kits** with culturally competent navigators to support members.
- ✓ Partner with a provider to bundle colonoscopy and polyp removal to avoid surprise member cost.

Source: Lockton Companies.

Multi-Cancer Early Detection (MCED)

What could help predict or prevent *future cancer*?

- Quit Genius
- WW Health Solutions
- OPTUM | Quit For Life®
- color
- INVITAE

What could help *detect cancer early*, today?

- Galleri®

Recommended single-cancer screenings

What could help *after cancer* is diagnosed?

- Memorial Sloan Kettering Cancer Center
- 2nd.MD
- access hope
- Grand Rounds Health

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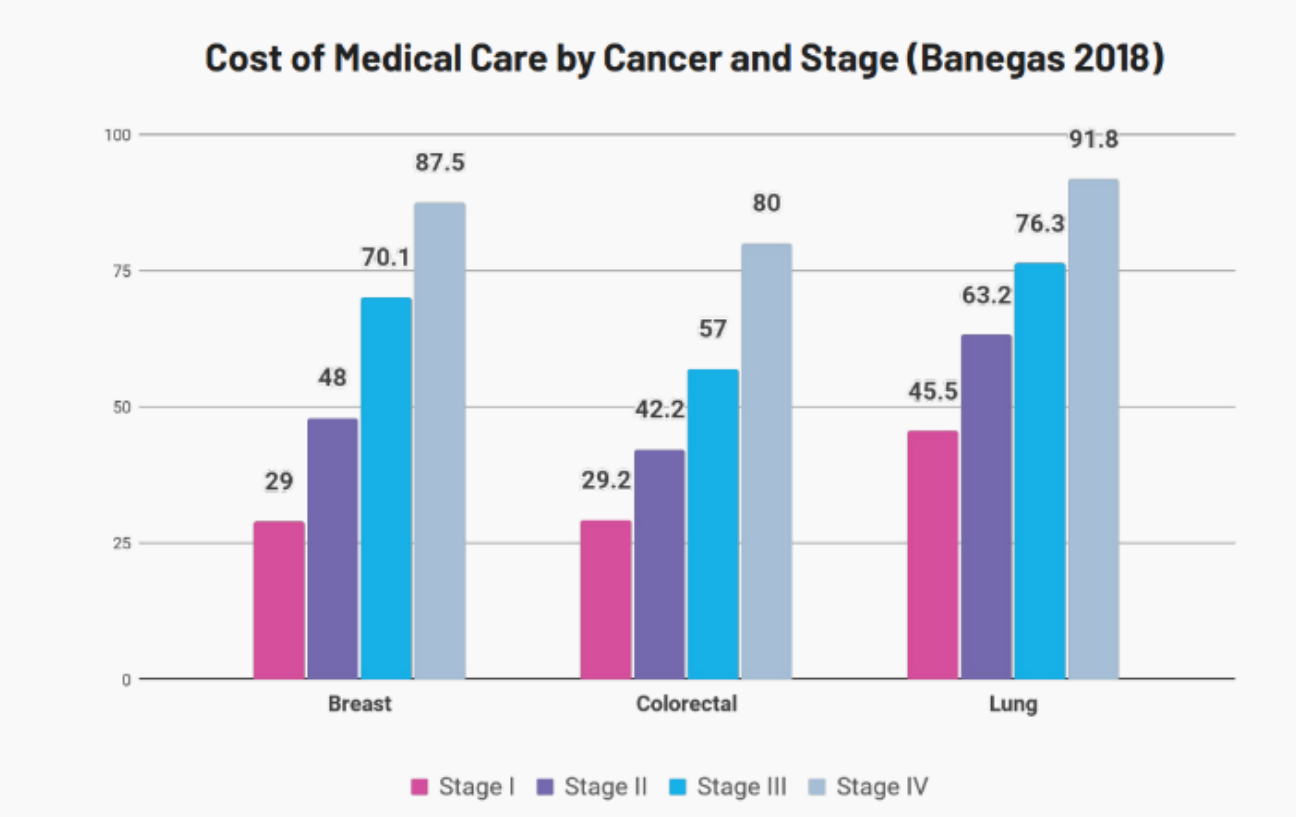
Source: Grail

Multi-Cancer Early Detection (Cont.)



- Goal of MCED testing is to catch cancers earlier, thus lowering treatment costs and improving outcomes
- Detects >50 cancers, many of which do not have current screening tests; NOT intended to replace current screening recommendations
- The Galleri test is commercially available, but not yet FDA approved, so not billable as a claim
- Screening is recommended for individuals over age 50 or 40-49 with certain risk factors
- Market price is currently ~$950; member cost share (up to 50%) is an option
- Test is relatively new to market – ROI is TBD

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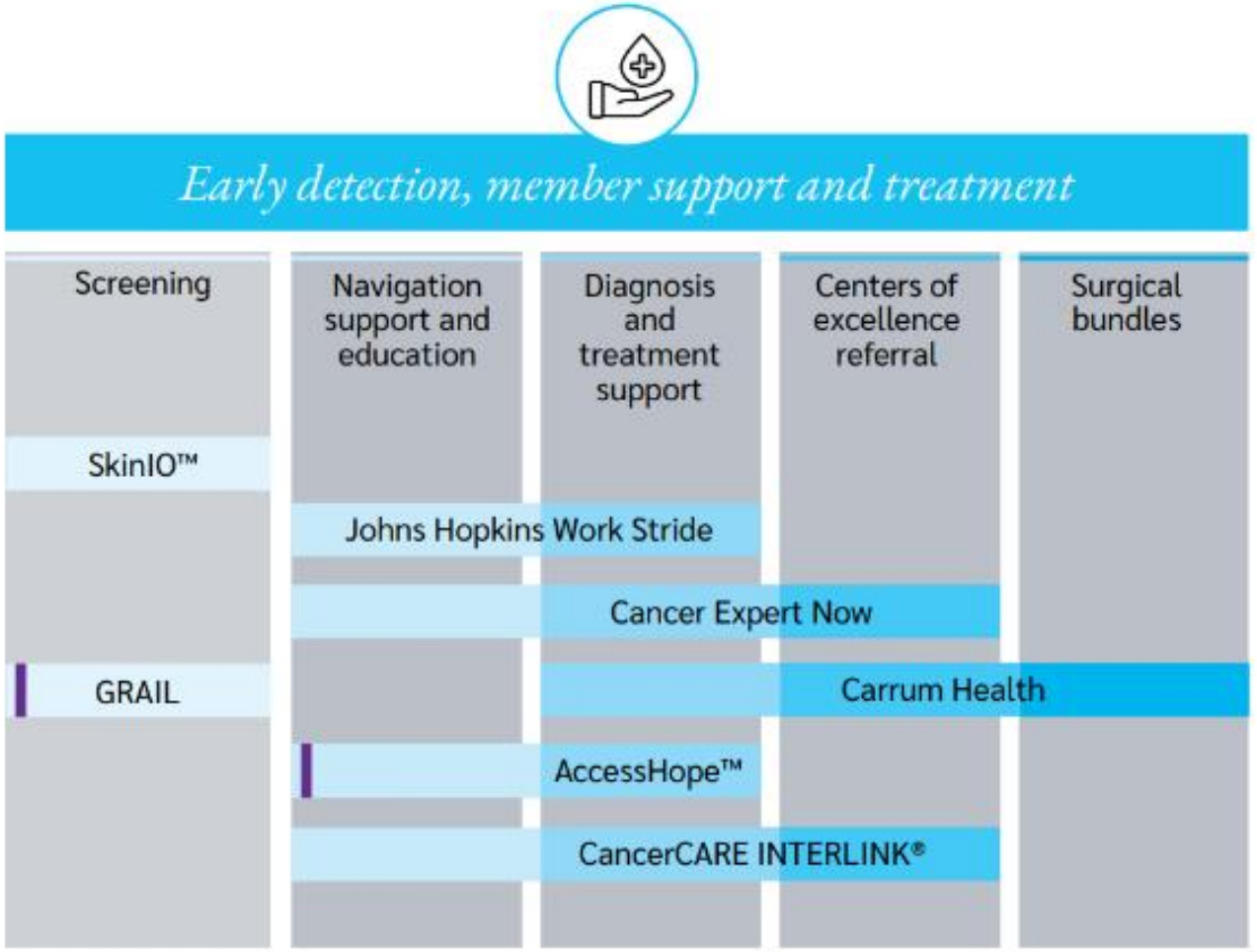
Source: Grail (graphic), Lockton Companies

Vendor Marketplace

The carved-out vendor marketplace offers solutions ranging from preventive screenings, genetic testing, navigation and treatment options to support members through their cancer diagnosis to treatment journey. Technology has allowed the genetic testing marketplace to advance, resulting in more options and competition. While genetic testing can be useful to screen for hereditary risk in certain individuals, population-based screening is not clinically or financially effective in most cases.

Vendors are recognizing the importance of creating an optimal member experience by developing interoperable relationships with other solutions, providing peace of mind for the member and continuity of care from surveillance to treatment. Here is a *sample* of vendors in the marketplace.



Bar between vendor represent a business relationship

* Reference glossary to define differences in screening and hereditary cancer risk. CDC Tier 1 Genomics Applications and their importance in public Health.

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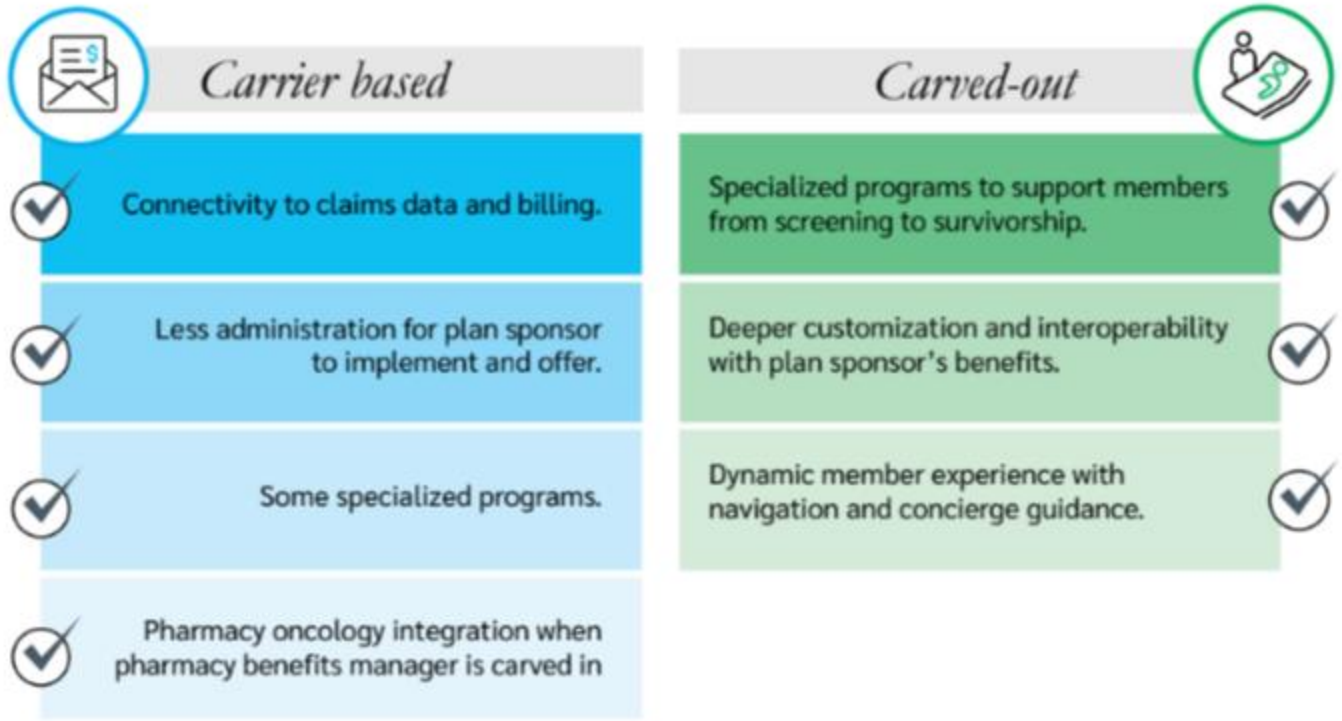
Source: Lockton Companies.

Choosing A Cancer Solution



When choosing between a carrier-based or carved-out cancer solution, the medical administrator should be a primary consideration. Carved-out solutions work best when a third-party administrator (TPA) is in place, allowing for deeper vendor integrations, nimbleness in contract and network agreements. Beyond administrator, carrier-based and carved-out solutions present unique attributes when considering the best fit.

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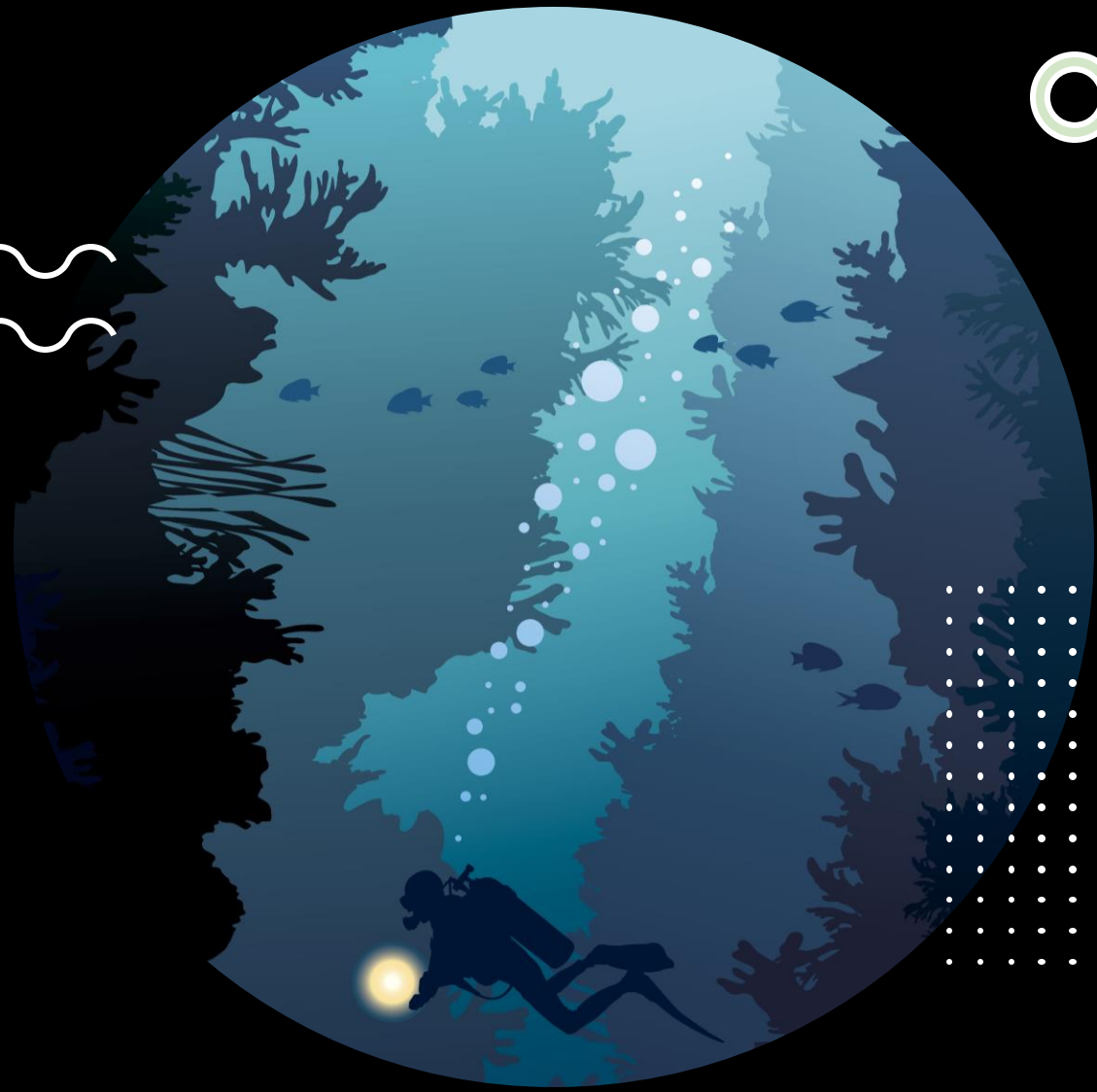
Source: Lockton Companies.

Deep Dive:
Specialty Pharmacy



Trend: Specialty Pharmacy

Less than 2% of the population uses specialty drugs, yet specialty pharmacy represents **51% of total pharmacy** spending.

Growth projected at 8% per year through 2025, largely driven by new-to-market drugs, including biosimilars, gene/cell therapies, and cancer drugs.[1]

Example Levers
SITE OF CARE: Administering medications (particularly infusions) in the most cost effective and convenient setting safely possible.
ACQUISITION: Procurement through pharmacy plan (vs. medical), use of 340b, drug formulation.
DRUG APPROPRIATENESS: Confirmation of medical diagnosis, evidence-based treatment, access to clinical trials, authorization via third party, targeted pharmacogenomics, biosimilars.
ELIMINATION OF WASTE: Shorter initial authorization, eliminating stockpiling, adherence management.

1 Evernorth 2022

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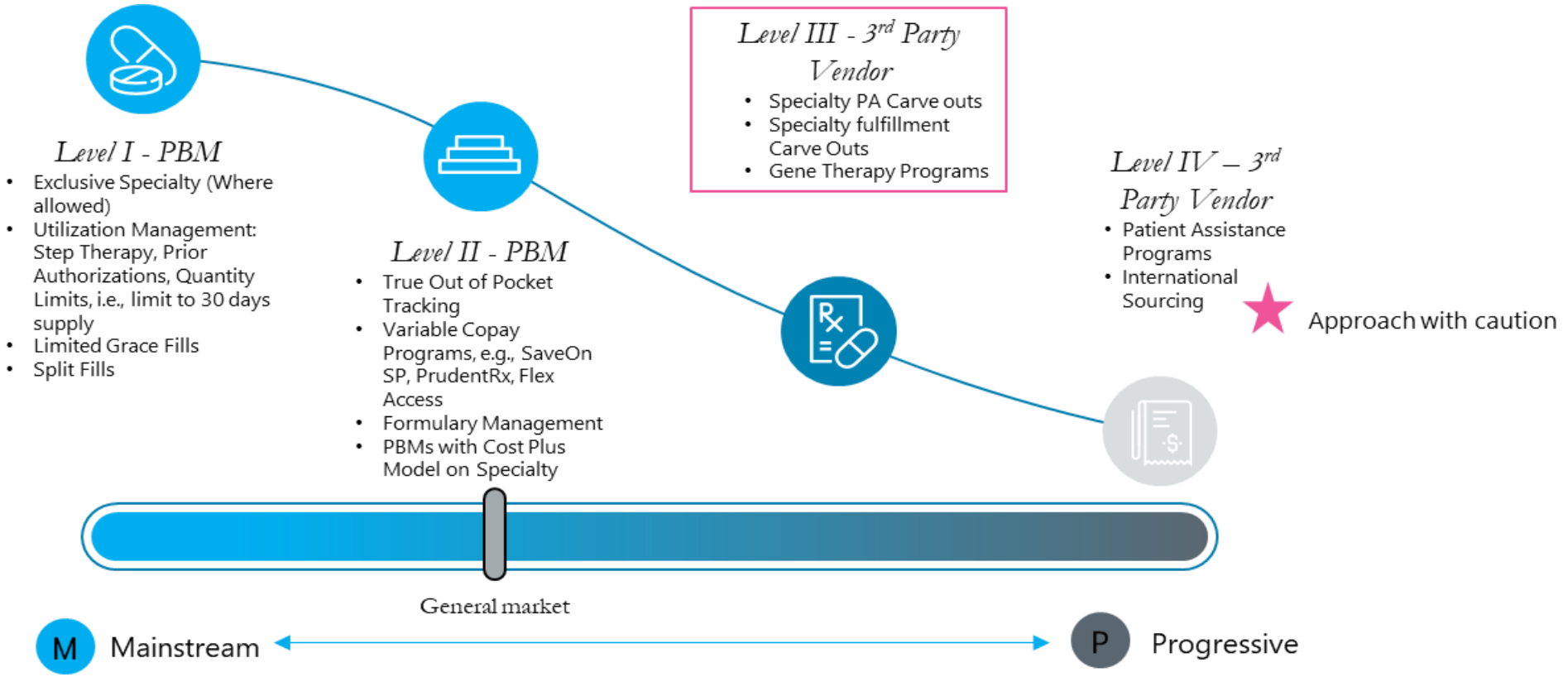
Source: Lockton Companies.

Specialty Pharmacy Cost Containment



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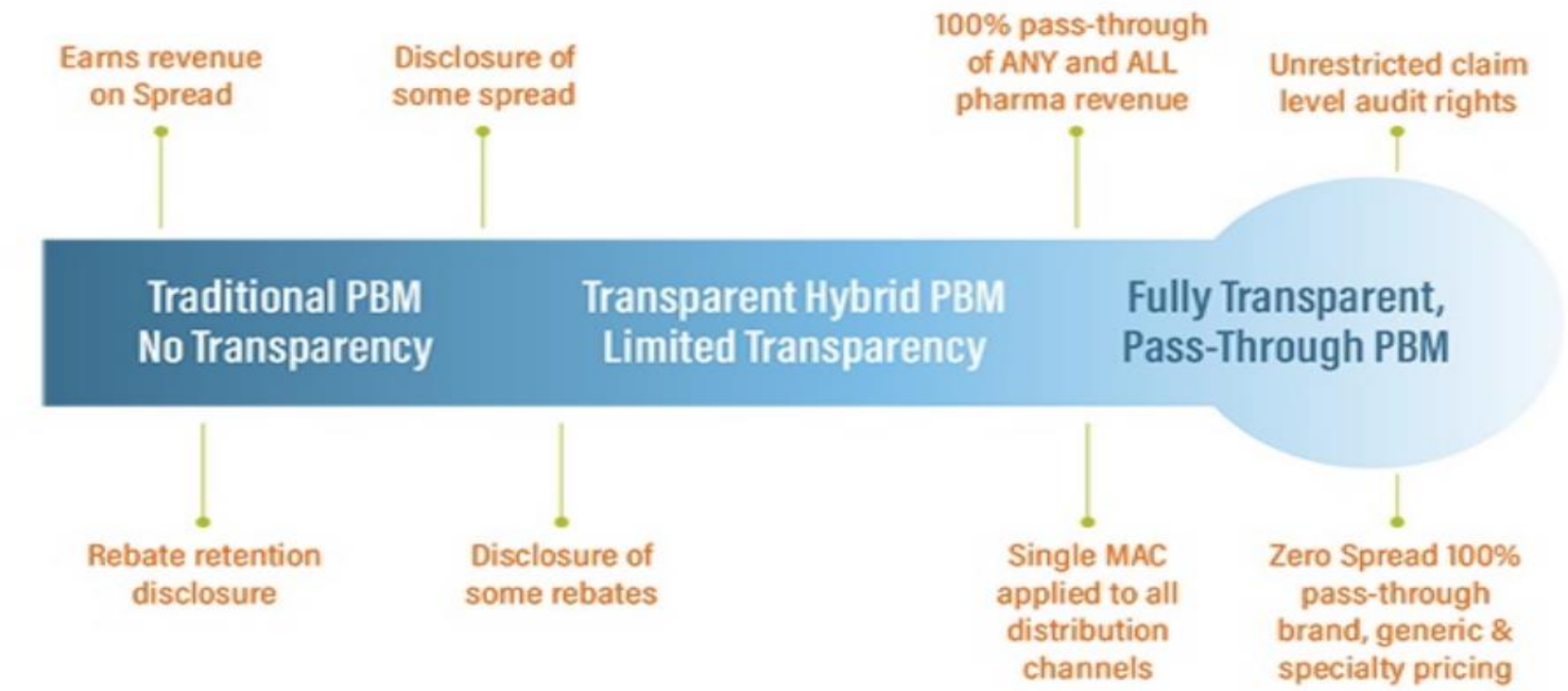
Source: Lockton Companies.

The Difference Between Traditional and Pass-Through PBMs



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Source: Navitus

Specialty Fulfillment Carve Out

Conflict of Interest

- ✓ If the PBM owns their own specialty pharmacy and profits from dispensing, can they be unbiased in decision making?

This strategy requires another vendor.

- ✓ PBM (for traditional medications), Specialty PBM (for drug management and dispensing), and TPA (for medical).

Not every PBM will allow Specialty carve-out.

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Source: Lockton Companies

Specialty PA Carve Out

- **Conflict of interest**
  - If the PBM owns their own specialty pharmacy and profits from dispensing, how closely are they looking at the PA criteria?
  - Pharma must approve the PBMs PA criteria in order to negotiate stronger rebates
- **This strategy uses third-party Prior Authorization criteria for tighter management**
  - Evidence Based Medicine vs. what is FDA approved

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Source: Lockton Companies.

Comparing the Big 3 to a Third Party

Comparing *Initial Approval Rates* of the *Top 5 Specialty Drugs*:

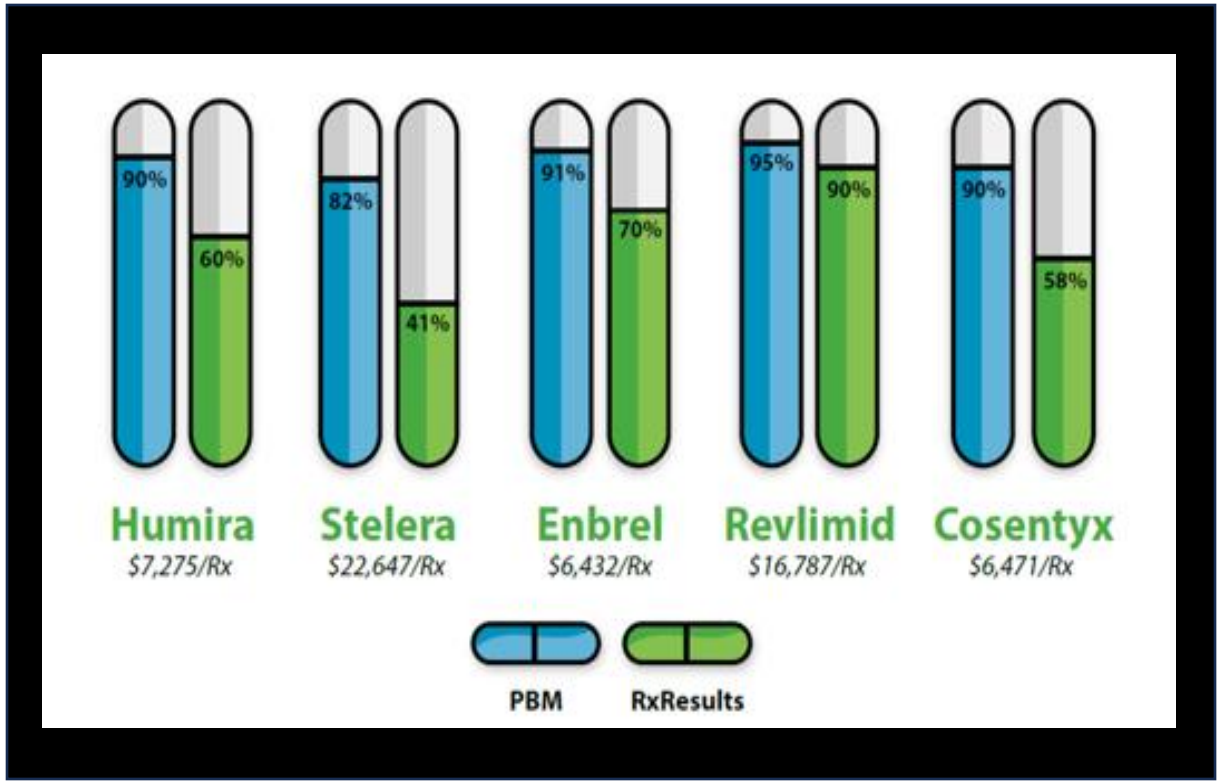

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Chart provided by RxResults

Can't I Simply Exclude Specialty Drugs?

Self-funded plan sponsors generally have latitude to provide only the benefits they want to provide and exclude those they don't.

BUT there are exceptions:

- ✓ **Federal Benefit Laws**: Federal law, such as ERISA and the Affordable Care Act, can impose requirements.
- ✓ **Federal Anti-Discrimination Laws** (ADA, ADEA, GINA, etc.) restrict an employer's discretion to discriminate in its provision of benefits.

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Source: Lockton Companies

Can I Send Members on High-Cost Meds to the Exchange?

Identifying the disabled and incentivizing them to take other coverage or making them eligible is **prohibited by HIPAA/ACA and the ADA**.

- ✓ We have seen employer take this risk (sometimes at the request of the disabled employee), but the employer should know that it is also at risk for a pay or play penalty, and the employee must pay taxes on any amount the employee receives from the employer as a reimbursement for the employee's exchange premium.

ERISA Section 510 prohibits a plan sponsor from interfering with or discriminating against a plan participant or beneficiary for exercising their rights under the plan.

Florida man wearing 'Who needs drugs' shirt busted with drugs: cops

John Balmer was charged with possession of marijuana and methamphetamine after he attempted to give a fellow shopper in Kmart a bag of 'green leafy substance.'

BY LEE MORAN / NEW YORK DAILY NEWS / Wednesday, January 7, 2015, 10:55 AM

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He certainly dressed for the occasion.

A Florida man was arrested for allegedly possessing pot and meth — while wearing a shirt that read: "Who needs drugs? Seriously, I have drugs."

John Balmer was detained in the Hudson Kmart on Monday, reports the Tampa Bay Times.

Pasco County Sheriff's Office said his black shirt was indeed telling the truth.

According to an arrest report, the 50-year-old was in line at the store when a deputy walked in.

Balmer spotted the law enforcer and allegedly tried to hand what was described as a "bag of green leafy substance" to the person behind him. But his line neighbor refused to accept it.

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Source: Lockton Companies.

Site of Care Opportunity

	Hospital (~$80B)	AIC (~$8B)	Physician Office (~$42B)	Home (~$19B)
Current % of Infusion Market	~55%	~5%	~30%	~10%
Descriptions/ Key Attributes	▪ Hospital covers majority of inpatient care situations (e.g. emergencies, post operation, etc.). ▪ Significant site-of-care shift occurring, given cost relative to alternatives.	▪ Treatment sent to the facility and administered/overseen by RNs on-site in an AIC. ▪ Continued growth in category increasing patient access points and convenience.	▪ Treatment administered on-site and overseen by the prescribing physician's staff in a physician office infusion center (OIC). ▪ Increased payor focus on "buy and bill" dynamics likely to influence growth opportunities.	▪ Medication and equipment typically sent directly to the patient's home. ▪ Nurse administers treatment to the patient over the length of visit and may train eligible patients for future self-administration.
	Care often delivered as part of acute in-patient treatment or in hospital-owned outpatient facility	*Ideal for patients receiving medication potentially not suitable for the home or by patient preference*	*Convenient option for patients receiving medication potentially not suitable for the home and preference for a single provider*	*Favored by patients who can conveniently, safely, and effectively receive treatment at home*
Service and Facility Fees	Yes	No	No	No
Average Cost per Infusion	*$5,500–$11,500*	*$3,500–$5,000*	*$3,500–$5,000*	*$1,700–$3,500*
Cost to Payor	*High*	*Low*	*Low*	*Low*

- Up to 50-90% savings by eliminating egregious **"buy and bill"** practices
- **Win-Win** for patients
- Many ambulatory infusion centers (AICs) and even some home infusion providers now offer certain **cancer therapies** (e.g., Keytruda)
- Some plans now require (with exceptions)
- Always run test claim to confirm pricing

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Source: Houlihan Lokey (graphic), Lockton Companies

J-code Lockout (aka White Bagging)

J-code lockouts are plan designs that can be implemented to **carve out a specific set of j-codes (specialty drugs) from the medical benefit** and instead are only payable on the pharmacy benefit.

- Requires providers and members to source the specific set of specialty drugs from the member's contracted specialty pharmacy.
- Potential to reduce the medical drug spend significantly

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It saves money? Sign me up!

Not so fast. It does save money but there are important things to consider:

- **Member disruption can be significant** as they will need to verify their provider is willing to get the specialty drug from the member's specialty pharmacy or find a provider who will
- When members are started on a new drug (first fill) **PA must be done prior to administration** or the claim may get denied and the member may face appeals and/or balance billing
- Enough medications (typically 30-50+) must be on the lockout list to prevent **possible discrimination fines**
- Medications must be on the **pharmacy plan formulary**
- Medical administrator needs to be able to operationalize the plan design change; there may be associated fees
- **Price checks** should be done in advance (e.g., test claims)
- Process for **maintaining/modifying** the lockout list should be implemented
- Draft plan language to address situations where medical plan coverage is acceptable (e.g., first fill, adverse reaction, no available provider) thus minimizing/eliminating the need for exceptions. **Exceptions** may risk not being covered by stop loss
- **Other options**: brown bagging (not recommended), clear bagging, gold bagging, case rate

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340B Program Notes

- ✓ Providers can, at their discretion, extend a portion of the 340B savings to insured patients (and by extension, their health plan)
- ✓ Patients MUST have an established relationship with the provider and have received documented services consistent with the grant for which the entity is 340b certified
- ✓ Some facilities will negotiate when they are already filling the drug, but more negotiation leverage is available if it would be new business (e.g., if the drug is currently being filled via an offsite specialty pharmacy)

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Source: Lockton Companies

Prescription Drug Importation

- ✓ The Federal Food, Drug, and Cosmetic Act (FDCA) prohibits the manufacture, sale, distribution or importation of unapproved drugs, adulterated drugs and misbranded drugs.
- ✓ Significantly, this prohibition relates no only to the individual receiving the drugs, but it extend to anyone involved in causing drugs to be imported into the U.S. in violation of the FDCA, even peripherally.
- ✓ Liability under the FDCA extends to an individual or business that plays a role in causing a drug to be imported.
- ✓ The FDCA provides for both civil and criminal liability for a violation in relation to prescription drug importation.

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Source: Lockton Companies

Pharmacogenomics PG(x)

Pharmacogenomic Indicators
Anticoagulants
Antihyperlipidemic
Oncology
ER Visits
Multiple Antidepressants
Multiple Antipsychotics
Multiple Opioids

- ✓ How variations in a person's genome impacts response to certain medications.
- ✓ Creates a member-specific genetic profile that estimates a drug's efficacy, guides dosage, and improves patient safety.
- ✓ Lowers risk and wasted resources of ineffective medications for both the member and employer.
- ✓ Adverse drug reactions (ADRs):
  - -- ADRs increase exponentially with 4 or more medications[1].
  - -- ADRs cost $136B each year[2].
  - -- Leading cause of hospitalization[2].
  - -- Average length of stay, cost, mortality for hospitalized patients with ADRs double than that of patients without ADRs

1. Jonson JA, Bootman JL. Drug-related morbidity and mortality. A cost-of-illness model. Arch Intern med 1995; 155(18):1949-1956.
2. Lazarou J, Pomeranz B, Corey PN. Incidence of adverse drug reactions in hospitalized patients: A meta-analysis of prospective studies. JAMA 1998; 279:1200-1205.
3. Classen DC er al.,. Adverse drug events in hospitalized patients. Excess length of stay, extra costs, and attributable mortality. JAMA 1997; 288(4): 301-306.

Source: Lockton Companies.

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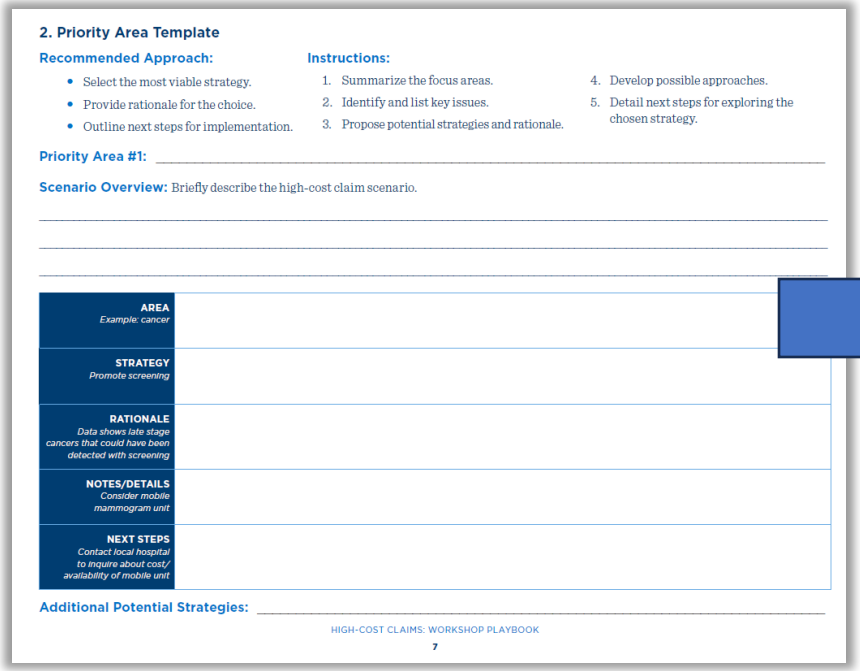
Strategy Development Exercise

(20 Minutes)

Determining Priorities, Strategy Development, and Taking Action

Select 2-3 priority areas (based on your data) that you would like to tackle in the coming year and begin to outline potential strategies, the rationale, and next steps



2. Priority Area Template

Recommended Approach:

- Select the most viable strategy.
- Provide rationale for the choice.
- Outline next steps for implementation.

Instructions:

1. Summarize the focus areas.
2. Identify and list key issues.
3. Propose potential strategies and rationale.
4. Develop possible approaches.
5. Detail next steps for exploring the chosen strategy.

Priority Area #1: _____

Scenario Overview: Briefly describe the high-cost claim scenario.

_____

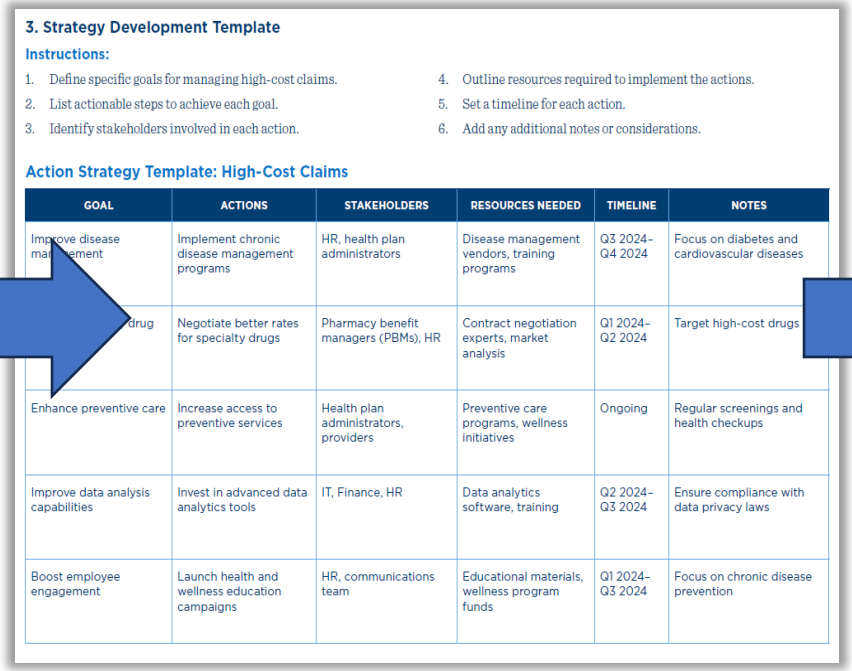
_____

_____

AREA *Example: cancer*	
STRATEGY *Promote screening*	
RATIONALE *Data shows late stage cancers that could have been detected with screening*	
NOTES/DETAILS *Consider mobile mammogram unit*	
NEXT STEPS *Contact local hospital to inquire about cost/ availability of mobile unit*	

Additional Potential Strategies: _____

HIGH-COST CLAIMS: WORKSHOP PLAYBOOK
7



3. Strategy Development Template

Instructions:

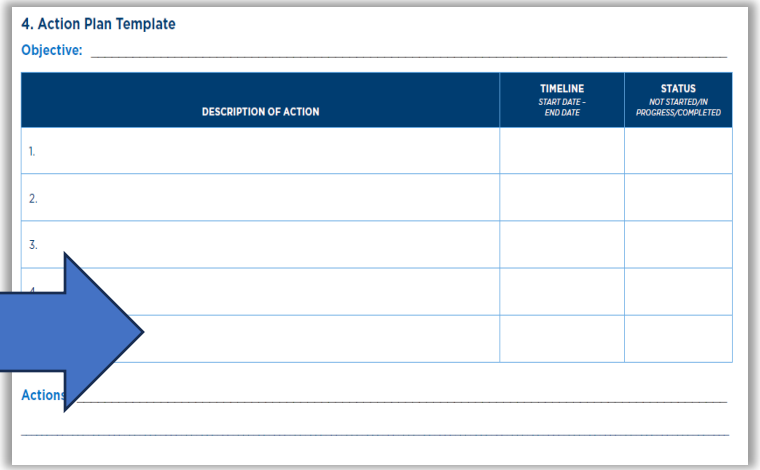
1. Define specific goals for managing high-cost claims.
2. List actionable steps to achieve each goal.
3. Identify stakeholders involved in each action.
4. Outline resources required to implement the actions.
5. Set a timeline for each action.
6. Add any additional notes or considerations.

Action Strategy Template: High-Cost Claims

GOAL	ACTIONS	STAKEHOLDERS	RESOURCES NEEDED	TIMELINE	NOTES
Improve disease ma[illegible]ement	Implement chronic disease management programs	HR, health plan administrators	Disease management vendors, training programs	Q3 2024-Q4 2024	Focus on diabetes and cardiovascular diseases
[illegible] drug	Negotiate better rates for specialty drugs	Pharmacy benefit managers (PBMs), HR	Contract negotiation experts, market analysis	Q1 2024-Q2 2024	Target high-cost drugs
Enhance preventive care	Increase access to preventive services	Health plan administrators, providers	Preventive care programs, wellness initiatives	Ongoing	Regular screenings and health checkups
Improve data analysis capabilities	Invest in advanced data analytics tools	IT, Finance, HR	Data analytics software, training	Q2 2024-Q3 2024	Ensure compliance with data privacy laws
Boost employee engagement	Launch health and wellness education campaigns	HR, communications team	Educational materials, wellness program funds	Q1 2024-Q3 2024	Focus on chronic disease prevention

Determine your strategy goals based on your priorities, what actions you would like to take, stakeholders you will involve, and timeline (1-2 years plan)

Flush out the immediate action steps that you can take to work towards your strategy goals and priorities. Identify milestones to measure progress, determine the resources needed, and identify potential barriers.



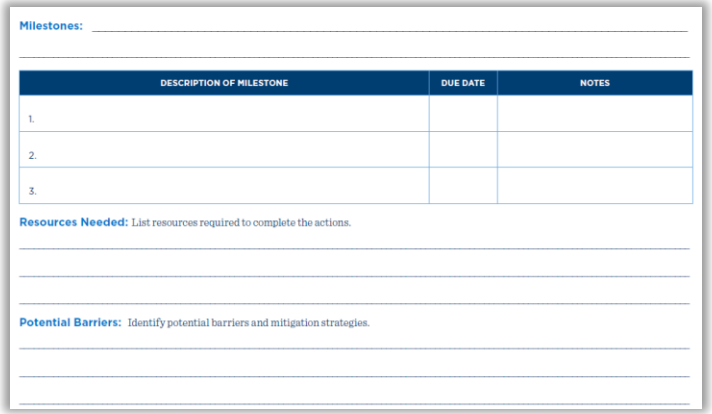
4. Action Plan Template

Objective: _____

DESCRIPTION OF ACTION	TIMELINE *START DATE - END DATE*	STATUS *NOT STARTED/IN PROGRESS/COMPLETED*
1.		
2.		
3.		
[illegible]		

Actions _____

_____



Milestones: _____

DESCRIPTION OF MILESTONE	DUE DATE	NOTES
1.		
2.		
3.		

Resources Needed: List resources required to complete the actions.

_____

_____

_____

Potential Barriers: Identify potential barriers and mitigation strategies.

_____

_____

_____

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Next Steps

- Continue with Coalition in-person workshops
- Coalitions provide summary report - after in-person meeting
- National Alliance 2-hour “report out” meeting
- Rollout final employer workshop playbook

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