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Mid-America Coalition on Health Care

## 5th Annual Workforce & Community Well-Being Forum

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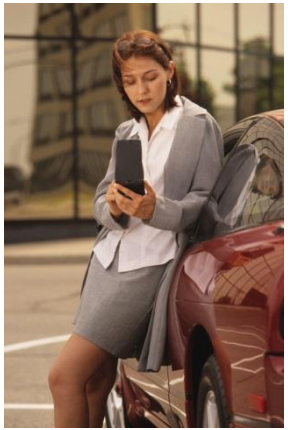

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# OUR MISSION

***"…to promote the health and well-being of current and future employees and their families by driving positive changes to contain healthcare costs and improve health outcomes"***

## Julie A. Smith

**Vice President, Human Resources**

**Board Chair**
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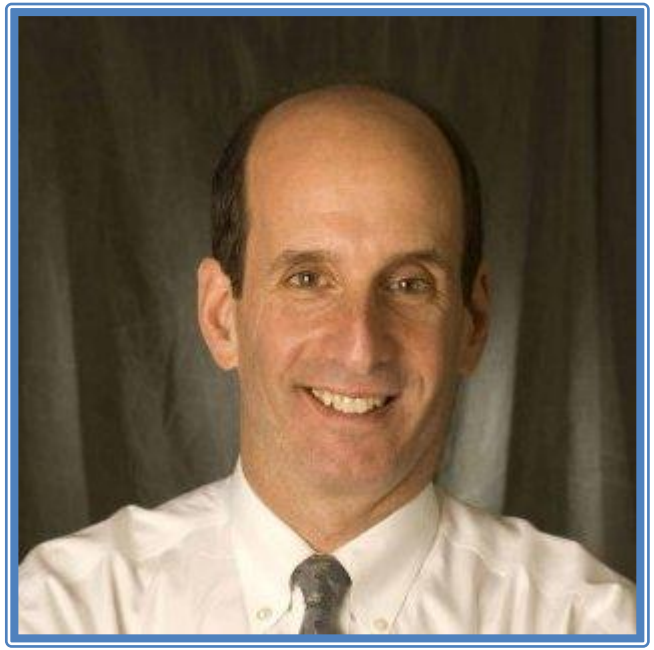
# Wage Matters: Emerging Evidence on the Impact of High-Deductible Health Plans



*Bruce Sherman, ScB, MS, MD*
*Medical Director*

CONDUENT™

# Wage Matters: Emerging Evidence on the Impact of High Deductible Plans

Bruce Sherman, MD

April 13, 2017

# Presentation content

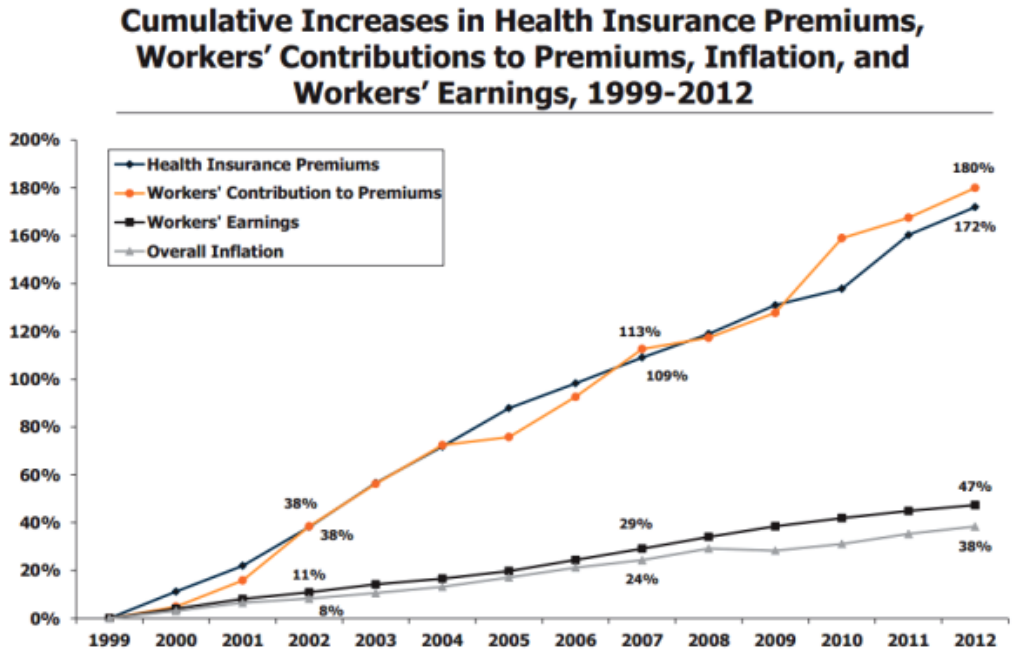
Current state of high deductible health plans

Low wage workers and health status

Impact of HDHPs on healthcare use by wage category

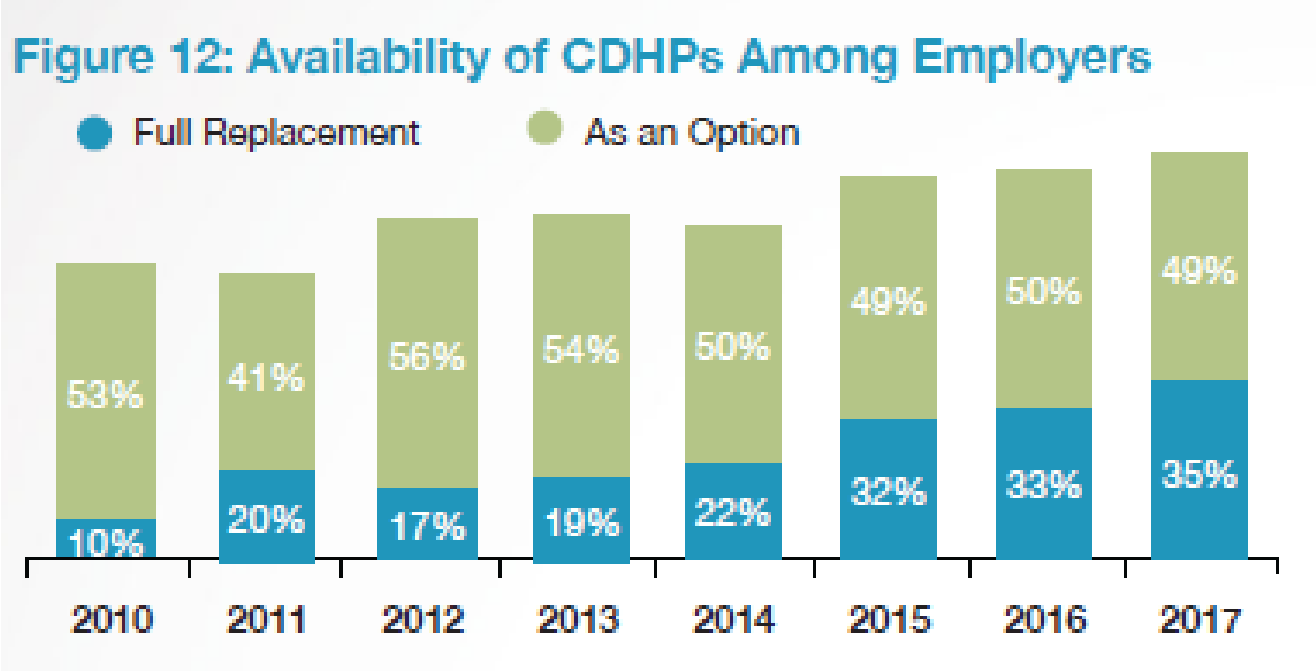
Implications for health benefits and the future

# Wage stagnation and benefits cost growth are making healthcare less affordable



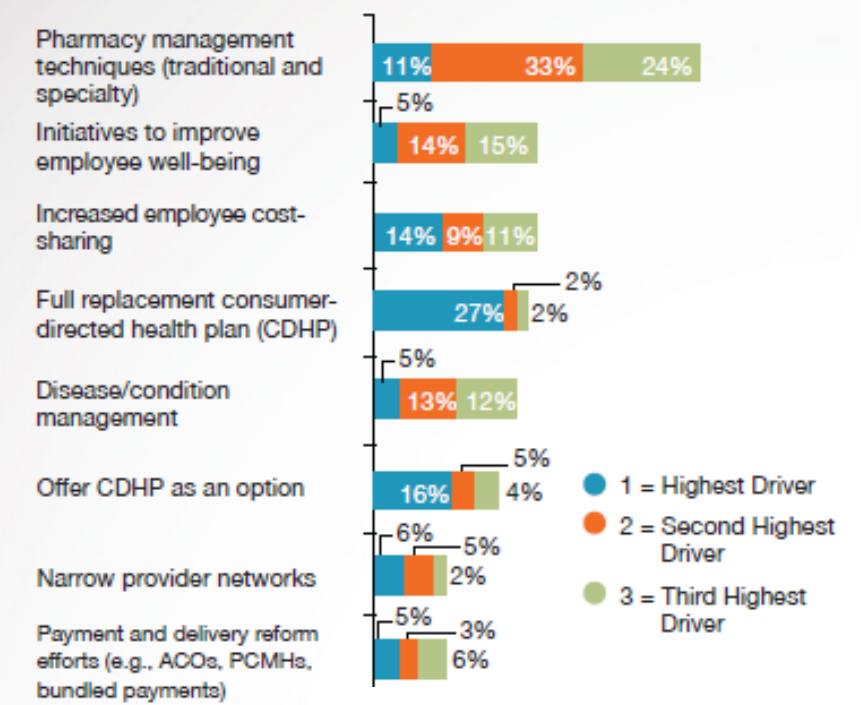

Source: Kaiser/HRET and EBRI

# Growth of CDHP options among employers



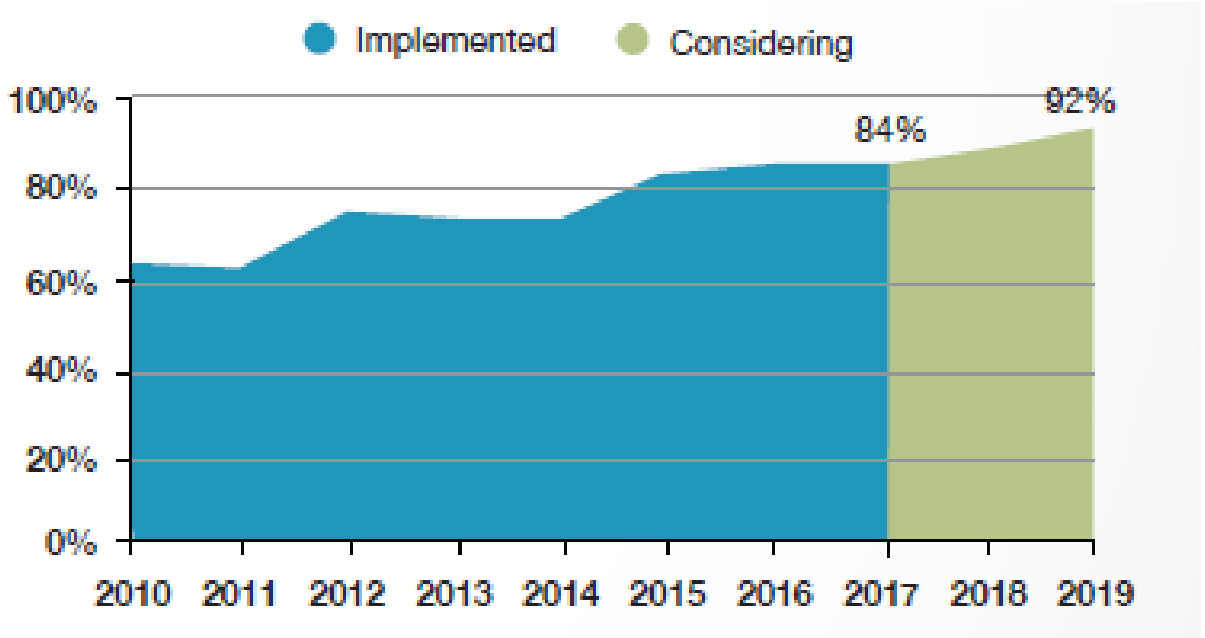

Source: Large Employers' 2017 Health Plan Design Survey, NBGH

# Employer perspectives on approaches to mitigate healthcare cost drivers




Source: Large Employers' 2017 Health Plan Design Survey, NBGH

# CDHPs becoming nearly universal before 2020




Source: Large Employers' 2017 Health Plan Design Survey, NBGH

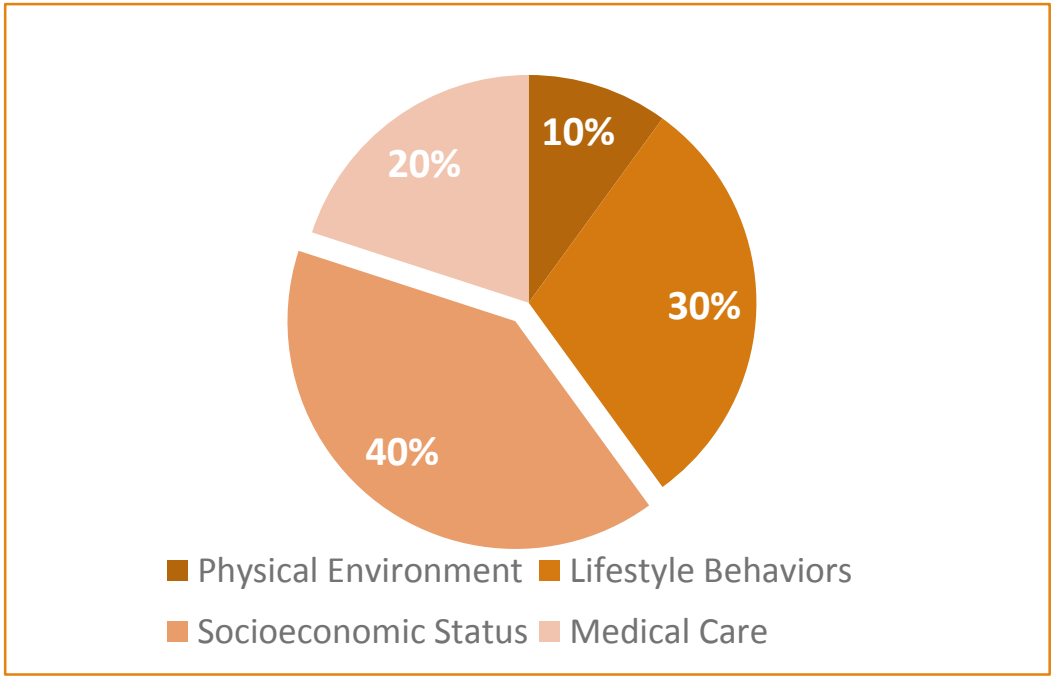
# HSAs and the new administration

Cornerstone of many proposals for ACA replacement

Assumes:

- Sufficient health literacy
- Sufficient resources
- Access to care
- Meaningful levels of consumerism engagement

# Determinants of health status




If socioeconomic status (social determinants of health) is so important, why aren't we paying more attention?

# Socioeconomic status impacts health

## Low-wage workers:

- Highest prevalence of unhealthy behaviors and chronic conditions
- Highest proportion of healthcare costs as a percentage of wages

## Differences in:

- Prioritization of personal health concerns relative to other life priorities
- Health literacy and healthcare consumerism engagement
- Patterns of healthcare use

# Poll question 1

Question: **What percentage of US adult workers has net pay of less than $30,000/year?**

A. Less than 10%

B. Between 10-20%

C. Between 20-30%

D. Between 30-40%

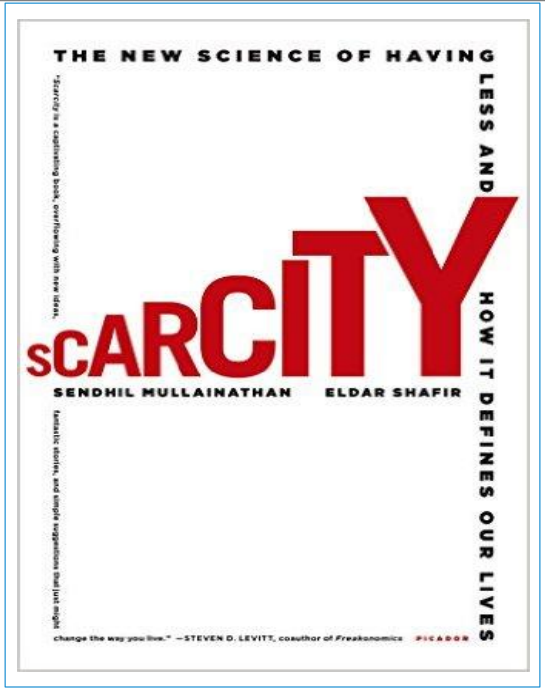
E. Between 40-50%

F. More than 50%

# Understanding human behaviors

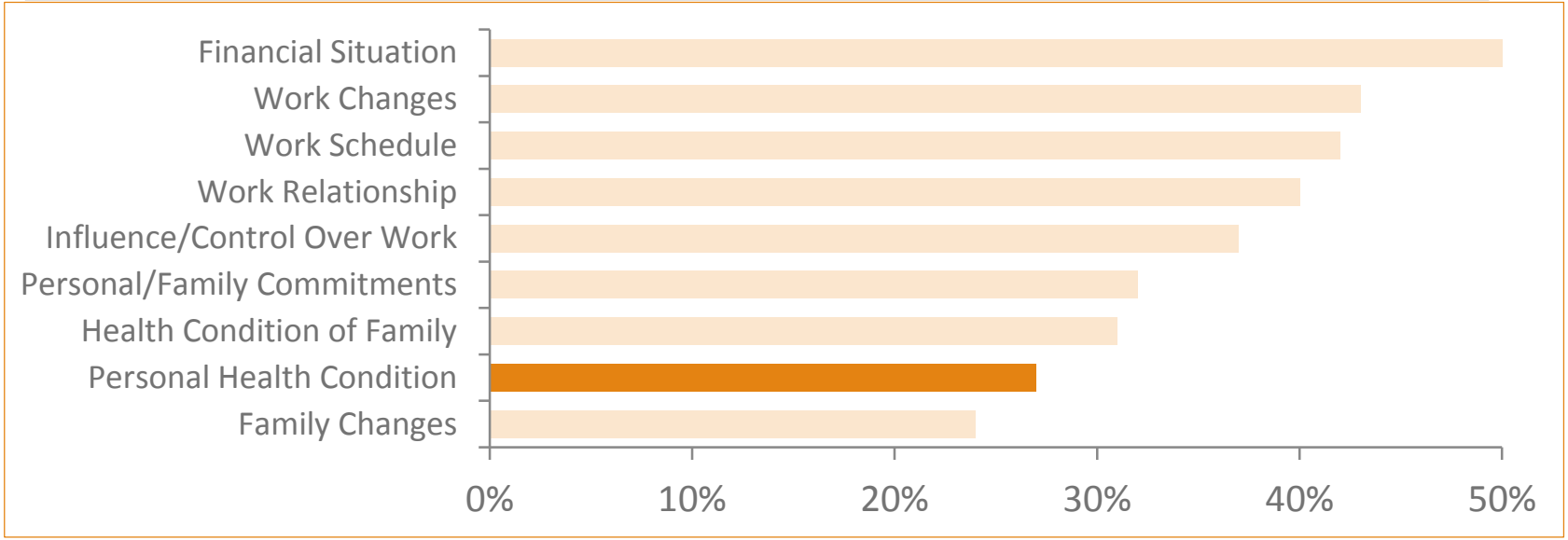
## A new vocabulary:

- **Tunneling:** focus on immediate priorities to the exclusion of other concerns
- **Bandwidth tax:** a consequence of tunneling, manifested by neglect for other concerns
- **Slack:** lack of concern when scarcity is not an issue




http://scholar.harvard.edu/sendhil/scarcity

# Factors that stress people most intensely

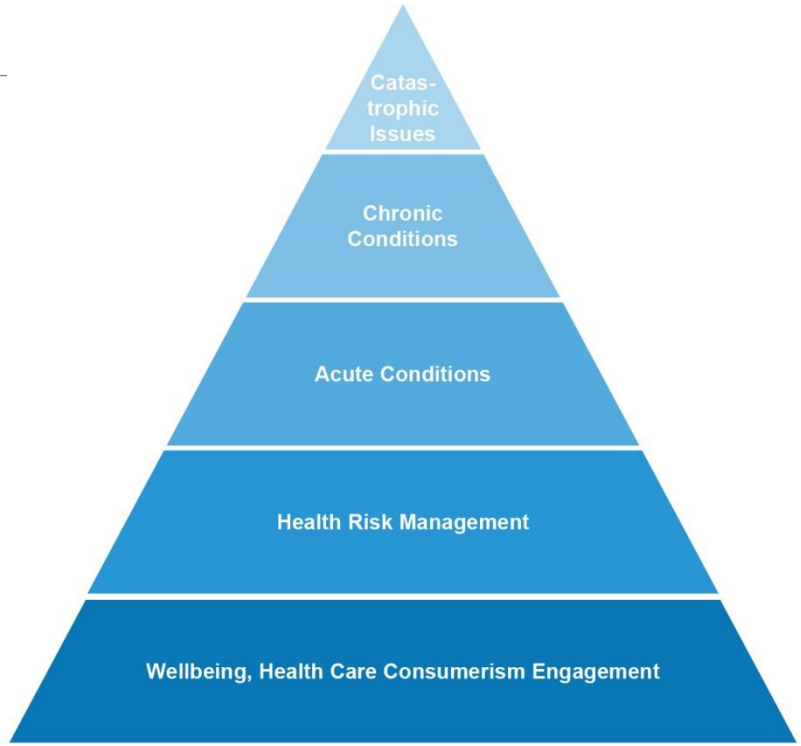



What does this mean for prioritization of personal health issues?

The Consumer Health Mindset Survey. Aon/NBGH/the futures co. , 2016.

## Maslow's hierarchy of needs…


## … applied to health benefits



# Low-wage workers face healthcare headwinds

## Wages failing to keep up with benefits costs

- Combined, premiums and deductibles approaching 25% of earnings

## Growing prevalence of high deductible health plans

- >80% of employers with HDHP option
- >30% of employers with full replacement HDHP

## Rising out-of-pocket costs for healthcare (except preventive services)

- Higher deductibles/out-of-pocket maximums
- Higher cost share

## Lack of employer recognition of the cost issue

- Benefits equality, not equity

# Analysis of low-wage worker healthcare use

**Objective:** Evaluate healthcare utilization patterns among workers by wage status

- Implications for healthcare consumerism engagement and benefit design
- Sets stage for evaluation of human capital impact on business outcomes

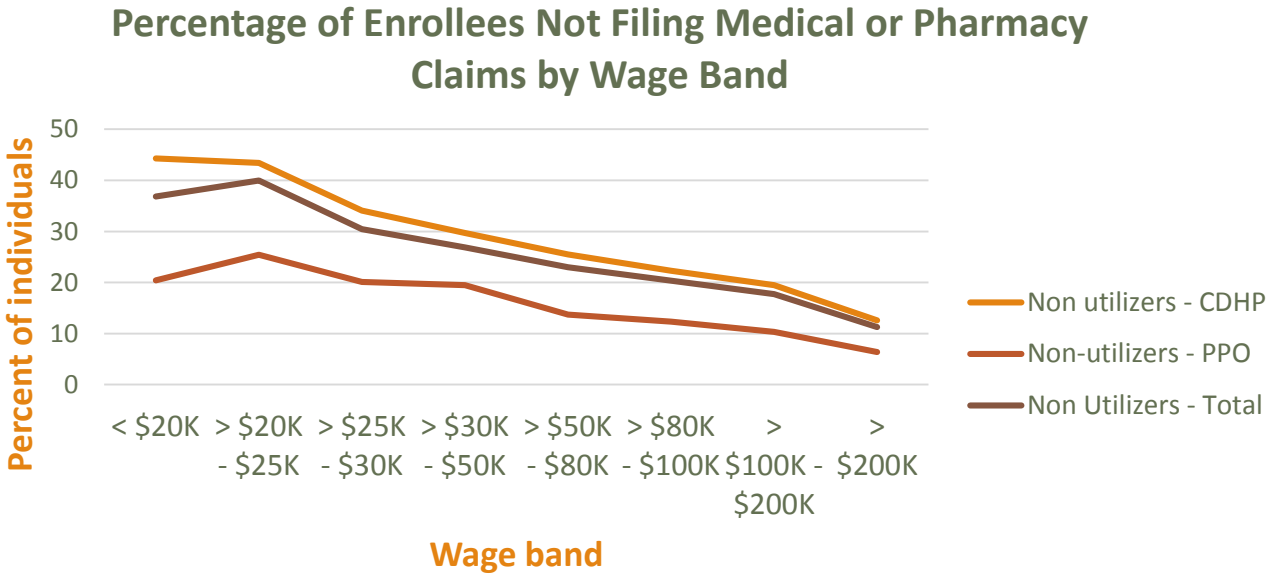
**Subjects:** Employees continuously enrolled in RightOpt during 2014

**Data:** All employer medical and pharmacy claims with earnings data for 2014

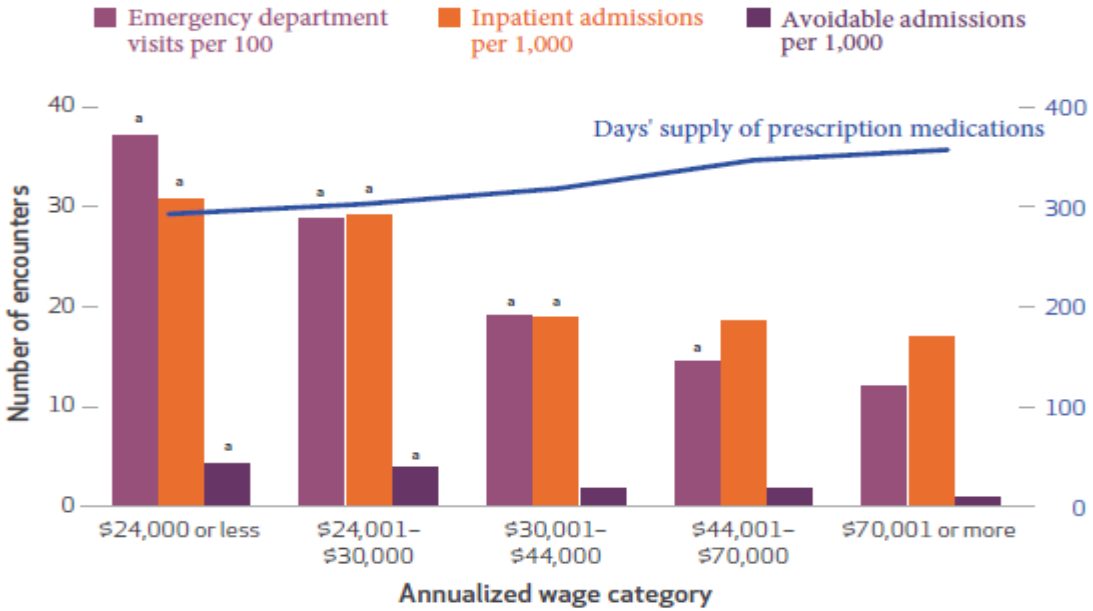
**Domains evaluated:**

- Demographics
- Out-of-pocket costs as a percentage of wage
- Non-use of healthcare services
- Healthcare utilization patterns and costs

# Low-wage workers use less healthcare – despite higher risk scores

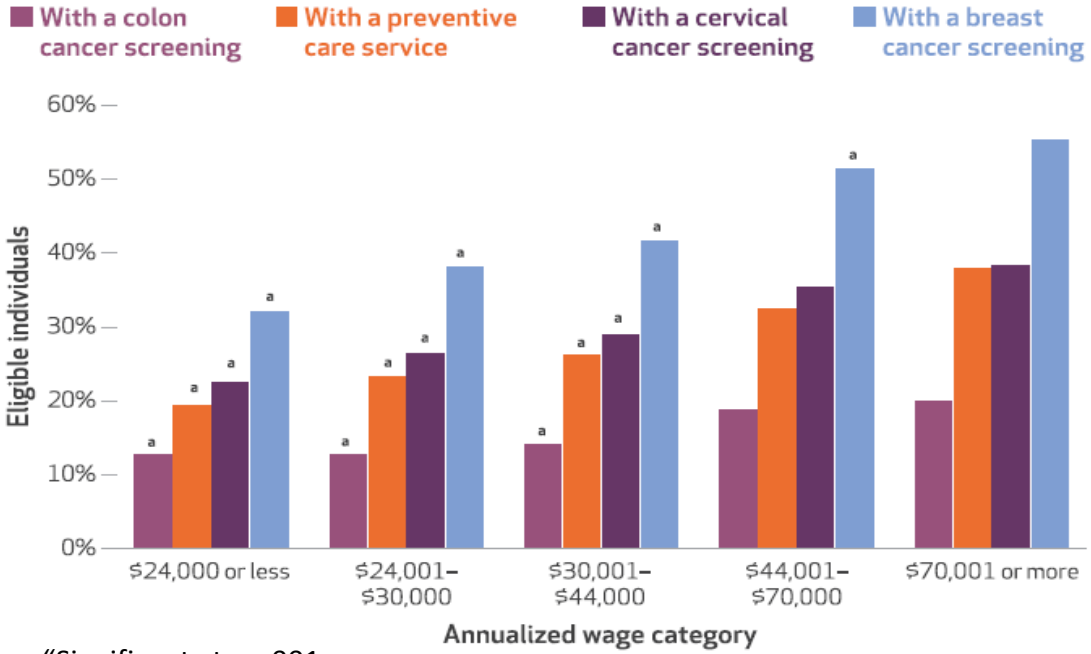


# Low wage workers use more ER and inpatient services




"Significant at p<.001

# High wage workers use the most preventive care services




"Significant at p<.001

# High wage earners have the highest healthcare costs – low-wage workers are next highest

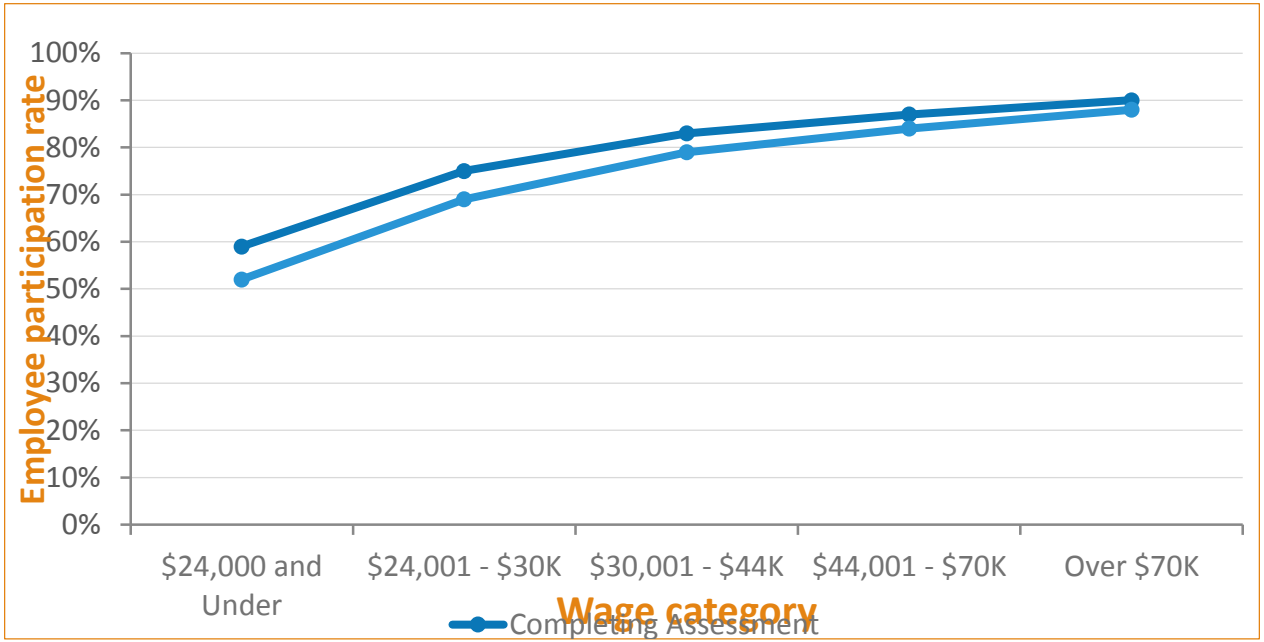

"Significant at p<.001

# Poll question 2

What's your perspective on this statement:
**Financial incentives are a primary source of motivation for low wage workers.**

a. Strongly agree
b. Agree
c. Not sure
d. Disagree
e. Strongly disagree

# Participation rates in health assessments, biometrics associated with wage status




RightOpt-Truven data warehouse – 2014 employee-only benefits enrollee data

# Healthcare utilization differs among biometric participants and non-participants

| Employee and Spouse Only | Biometric_Participation | Biometric_Non_Participation | RO Agg | MarketScan |
|---|---|---|---|---|
| Employees Avg Med or Rx | 14,110 | 10,262 | | |
| Members Avg Med or Rx | 17,034 | 12,196 | | |
| RRS_Concurrent | 1.43 | 1.40 | 1.34 | |
| Allowed Amount Med | $84,965,758 | $84,247,679 | | |
| Allowed Amount Rx | $27,085,416 | $16,505,974 | | |
| Allow Amt PMPY Med and Rx | $6,578 | $8,261 | $6,421 | $5,969 |
| Net Pay PMPY Med and Rx | $5,130 | $6,570 | $5,070 | $5,014 |
| Admits Per 1000 Acute | 60.23 | 91.75 | 61.87 | 60.32 |
| Admits Per 1000 Acute Avoidable | 4.99 | 9.18 | 4.91 | |
| Days LOS Admit Acute | 3.42 | 4.63 | 4.07 | 4.00 |
| Scripts Per 1000 Rx | 14,057 | 12,630 | 11,912 | 12,177 |
| Scripts Generic Efficiency Rx | 96.9% | 97.1% | 96.7% | 93.9% |
| Visits Per 1000 Office Med | 6,610 | 5,788 | 5,882 | 6,924 |
| Visits Per 1000 Prevent Adult | 456.91 | 344.95 | 401.84 | 424.20 |
| Visits Per 1000 ER | 283.49 | 590.10 | 292.80 | 227.51 |
| Ambulatory Sensitive ER Visits Per 1000 | 23.48 | 53.62 | 24.05 | - |

- Individual engagement in health exemplified by biometric screening participation status – with implications for healthcare use
- Major targeting opportunity to address/promote appropriate healthcare use.

# Key findings and implications

- Low-wage workers use healthcare in a more reactive and inefficient pattern, with associated comparatively higher expenditures
- By contrast, high-wage earners also have similarly high healthcare expenditures, perhaps due to a relative lack of barriers to care
- Cost of care relative to wages for low-wage workers is a major problem – but not the only problem
- Current benefits policy/practice direction will only make the situation worse for low wage workers

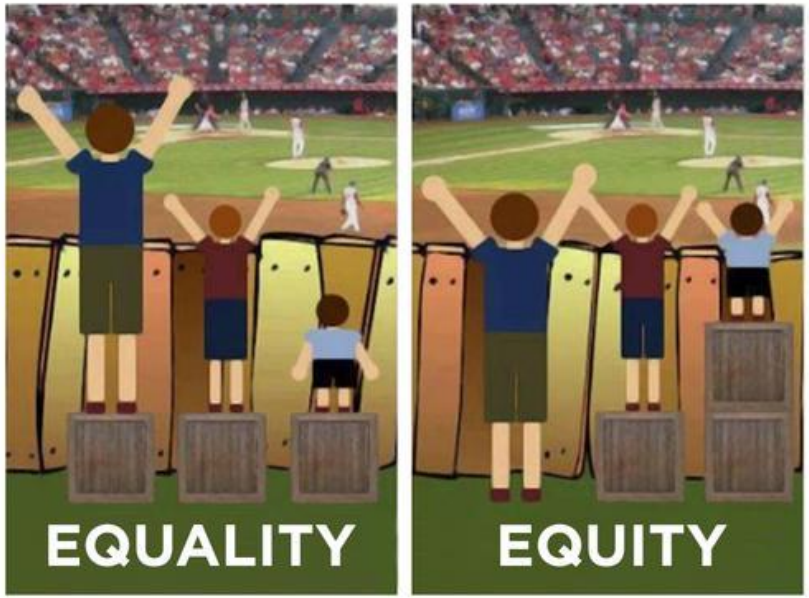
# For employers…

## Benefits strategy considerations for low-wage workers:

- Equality – or equity?
- Any impact of wage-based premiums?
- What impact are outcomes-based incentives having?
- What role for other incentives?
- How should well-being issues be addressed?



## Opportunities exist to rethink benefit designs for low-wage workers.

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# However…

- Low-wage workers also use care differently regardless of cost
- Other barriers may be even more problematic than cost for low-wage workers
- Low-wage workers seem less likely to use useful services and program and incentives, even when they are provided
- Simply subsidizing health benefits may not be enough to make a difference

And…

- higher wage earners with income-based utilization of healthcare – how should they be addressed?

# Summary

Low-wage workers use healthcare significantly differently from other benefits enrollees.

- Contributors include health literacy concerns, out-of-pocket costs, access barriers to healthcare services.

Scant available information as to the business impact of improving low-wage worker benefits.

Employers can:

- Seek to better understand low-wage worker health barriers and opportunities
- Consider approaches to reducing discriminatory practices (outcomes-based biometric incentives)
- Quantify current healthcare and illness-related lost productivity costs for low-wage workers prior to taking action.

Managed thoughtfully, low-wage worker health/well-being can have a profound impact on business performance.

# Thanks for your attention!

Bruce Sherman, MD
bws@case.edu

# Pharmaceutical Market Trends: Consolidation and Convergence of the Value Chain

*Alex Jung, BSM, CMP, CEBS*
*Partner & Managing Director*

PARTHENON EY

# Pharmaceutical Market Trends

External research and findings

Alex Jung

2017

# Alex Jung – Partner/Managing Director


Direct: 312-879-2778
Mobile: 847-722-3482
Email: Alex.Jung@ey.com
Office: 155 N Wacker Drive, Chicago


Alex is a partner in Parthenon-EY Strategy where she works primarily on growth strategy projects. She helps clients define and implement their strategy and build organizational capabilities to deliver sustainable business results both through organic and inorganic approaches. She is a thought leader in the industry and specializes in asset repurposing and optimizing value propositions.

Alex Jung is a partner in Parthenon EY. Prior to joining EY, she was the Senior Vice President of Walgreens Corporate Strategy based in Deerfield, IL.

Mrs. Jung has over 30 years of experience working on strategic growth and risk mitigation engagements. She began her career with Arthur Andersen and after ten years moved into consulting with Mercer as the leader of the National Health Care Analysis Unit, helping to architect one of the first data analytics platforms.

She later became the Managing Director for the General Board of Pension and Health Benefits of the United Methodist Church. Alex returned to consulting to lead the health care practice at Aon Consulting and their significant growth into the number one consulting firm in the space.

She is a regular speaker at events such as the California Governor's Women's Conference, World Healthcare Congress, Midwest Business Group on Health, Crain's Annual Health Care Conference, the Benefits Management Expo, the Self Insurance Association of America, John Marshall Law School, and HRMAC where she serves as the Chair for the Total Rewards Interest Group. She sits on the advisory board of the Michael Reese Health Trust and the Healthy Chicago initiative. She is also a member of the Board of Directors for the Respiratory Health Association and Chair of the Health and Wellness Council of the City of Chicago's Chamber of Commerce.

Alex has worked globally with Fortune 500 companies and has developed and implemented large scale strategy, operations and financial projects. She specializes in asset repurposing and value proposition development. Her domain expertise in healthcare spans from hospital operations, clinical intervention programs, benefit plan designs and funding, commercialization strategy for new products and growth strategies including M&A.

She has performed work on several large scale transactions, mergers and acquisitions including the divestiture of Walgreen's PBM, acquisition of AllianceBoots and other assets while at Walgreens. She also architected the health and wellness strategy for the company as part of the pharmacy transformation.

She has developed new business models, redesigned operating models,, labor models and workflow processes in many environments including real estate footprint redesign, go to market/commercialization strategies for new products and services including launch strategies for pharma and medical device companies. She has also helped redesign countless products, service offerings, medical devices and value propositions for providers, payers and patients.

She has been quoted in numerous articles in Kennedy Research, Forrester, Forbes Magazine, The Chicago Tribune, Business Insurance, Workforce Management Magazine, Crain's Chicago Business and other industry publications. She is on the editorial board of Inside Patient Care magazine.

## Education

- B.S., Business Management, Northeastern Illinois University, Northwestern University
- Licensed broker health, accident and life
- Certified project manager (CMP) and trained in Juran and W. Edward Deming Quality Process
- CEBS, International Foundation of Employee Benefits

## Knowledge & Skills

- Corporate and usiness strategy, asset repurposing and business model redesign
- Operations and process improvement
- Mergers & acquisitions
- Clinical program development
- Employee benefits strategy, plan design and funding strategies

## Industries

- Healthcare providers/hospitals/retail clinics
- Managed care/Insurance payers
- Life Sciences/Pharmaceuticals
- Medical Device/Diagnostics
- Clinical Interventions
- Consumer Products/Retail

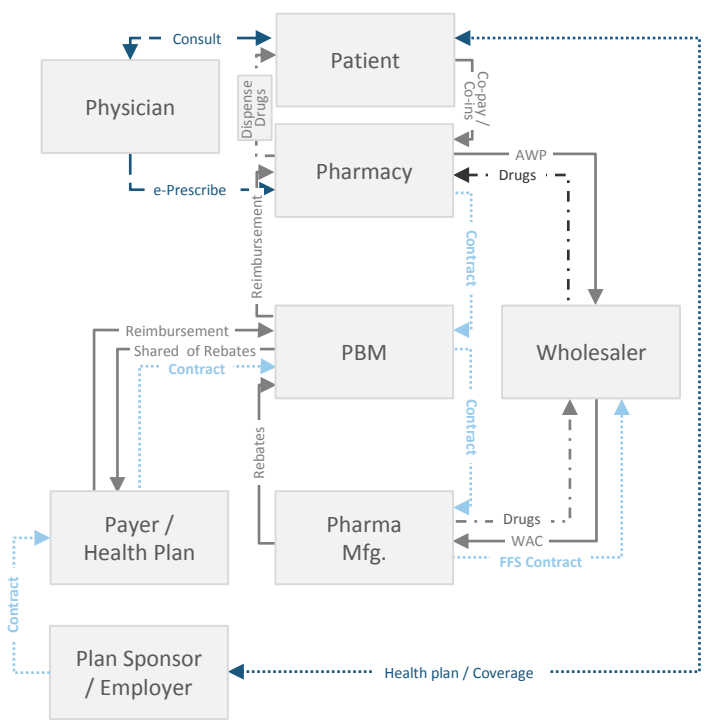
# Value-chain and key stakeholders

## There are several stakeholders that exist in the pharmacy value chain, each with different needs

### Mapping the Pharmacy Value Chain

| Stakeholder | What are their roles / needs? |
|---|---|
| Pharma Mfg. | ► Supplier / manufacturer of generic, branded, specialty, and biologics drugs |
| Wholesaler | ► Intermediary, group purchaser of drugs, distribution infrastructure |
| Pharmacy | ► Chain and community pharmacy, point of patient distribution |
| Patient | ► Consumer of prescription drugs and pharmacy services |
| Physician | ► Driver of script volume, drug mix and prescription trends |
| PBM | ► Intermediary for drug plan design, adjudication, and formularies |
| Payer / Health Plan | ► Health plan / insurer control cost associated with health spend |
| Plan Sponsor / Employer | ► Employers provide employee coverage |

### How do they collaborate / engage?



# Market Trends
## Several key factors across pharma and retailing shape the macro landscape

| Drug & Pharmacy Trends | |
|---|---|
| **Prescription Drug Growth** | ► Continued rise of chronic diseases in an aging population, new drug discoveries and longer mortality is driving more prescription volume |
| **Industry Pricing Pressures** | ► Pharmacies are facing pressure from declining payer reimbursement, growth in mail order and PBM strength |
| **Collaboration & Consolidation** | ► Recent acquisitions in the space have created convergence where just a handful of companies control drug discovery and distribution |
| **Emerging Therapies / Specialty Drugs** | ► Momentum in scientific discovery and genomics has resulted in more novel drugs, biologics, specialty medications and patient services |
| **Clinical Trends** | ► Pharmacies are increasingly offering clinical services in a retail setting, competition with providers and capturing more customer value |

| Pharmacy Retailing Trends | |
|---|---|
| **Retail Spend & Growth** | ► U.S. Drug Store sales hit $250B in 2015 and are expected grow 2.6% YoY to reach $284B by 2020 |
| **Efficient Footprint** | ► Retailers rationalizing footprint to make more efficient use of space and introducing reimbursable services to drive growth |
| **Omnichannel** | ► Growth in omnichannel solutions (mobile and eCommerce) shifting revenue sources but overall growth continues in all platforms |
| **Store Experience & Loyalty** | ► New store layouts, design, loyalty programs and customer experience improvements drive foot traffic into the store |
| **Technology** | ► Improvements in automation, operating systems, data analytics, handheld and mobile applications helping protect share |

Source: Parthenon-EY Analysis

# Prescription Drug Growth

## The aging US population and rise of chronic disease are likely to drive steady increase in drug spend / utilization

### Commentary

**Over the next three decades, the 65+ population is expected to increase at a rate of 1.7% per year**

- This increase in the 65+ age demographic will likely cause a corresponding rise in demand for pharmaceutical products
- Many of the regions with the highest growth rate in this population segment are located in the Midwest and Great Plains regions, where Nile already has a strong presence

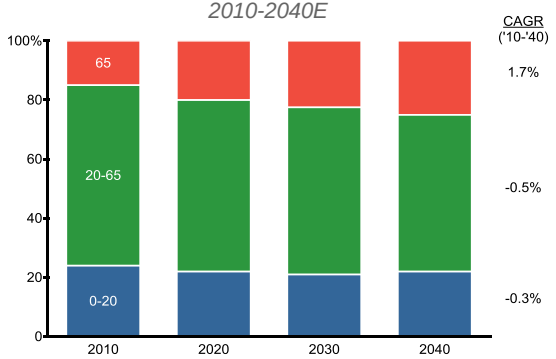
**Growth in chronic conditions in the U.S. has been rising in recent years and is forecasted to continue to rise**

- In 2014, chronic disease affected approximately 133m people in the U.S.; that figure is expected to rise to 157m by 2020
  - 81m people are expected to be affected by multiple chronic conditions by 2020
- Top growing chronic conditions include obesity, diabetes, heart disease, and depression

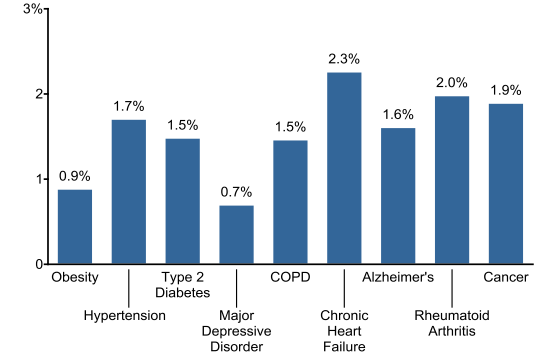
**Robust pharmaceutical pipeline and new specialty and biologic therapies will drive continued growth as well**

- By 2018, the FDA could approve 200 new drugs
- Most anticipated disease categories for FDA approvals include liver disease, oncology, HIV, multiple sclerosis, hepatitis C, psoriasis, rheumatoid arthritis, Parkinson's Disease, and atopic dermatitis

**Total U.S. Population by Age Group**
*2010-2040E*




**CAGR of Selected Chronic Conditions in U.S.**
*2015-2020E*




| 2015 Prevalence | 96m | 81m | 29m | 16m | 16m | 5m | 4m | 2m | 1m |
|---|---|---|---|---|---|---|---|---|---|

Source: 4D Healthware, CBO, CMS, CVS Caremark, National Health Council, National Health Statistics Group, Office of the Actuary; Parthenon-EY Analysis

# Collaboration & Consolidation

## Competitive dynamics in pharma and payer landscapes have changed due to significant recent M&A activity

### Commentary

**Significant M&A activity has occurred within healthcare in recent years, with this activity expected to continue for the foreseeable future**

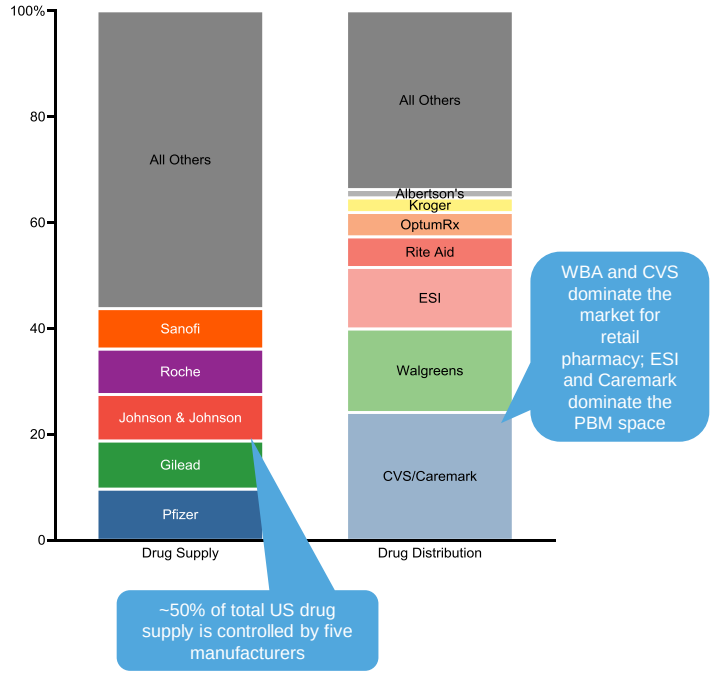
- 2014 and 2015were both record breaking years for M&A activity
- If recent proposed mergers between health insurers take place, three major players will dominate the insurance market by 2017

**Companies across the healthcare value chain utilize acquisitions to reduce costs and accelerate growth**

- As consumer trends continue to evolve across the retail industry, pharmacies and drug stores are being viewed as an integral provider between patients and physicians. As a result, acquisitions will become key to managing costs and streamlining care
- Executives are increasingly utilizing alliances to accelerate growth; 40% plan to enter alliances with other companies or competitors to help create value from underutilized assets
- Drug companies are looking beyond traditional M&A by acquiring “beyond-the-pill” products and services to bolster their portfolios and drug pipelines
- Independent hospitals and clinician groups will find it difficult to compete on their own. Attempting to generate more touchpoints with existing customer bases, large physician management companies are acquiring complementary groups

### Top Pharmaceutical Manufacturers and Distributors in U.S.

*2014 (Drug Supply), 2015 (Drug Distribution)*



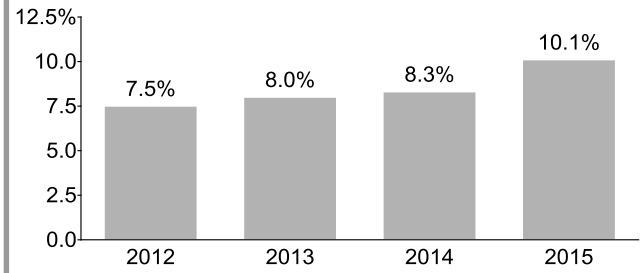

Source: Bain Global Healthcare Private Equity and Corporate Report, BMI, EY Global Capital Confidence Barometer, April 2016, PwC Top health industry trends and issues 2016; Parthenon-EY Analysis

# Industry Pricing Pressures

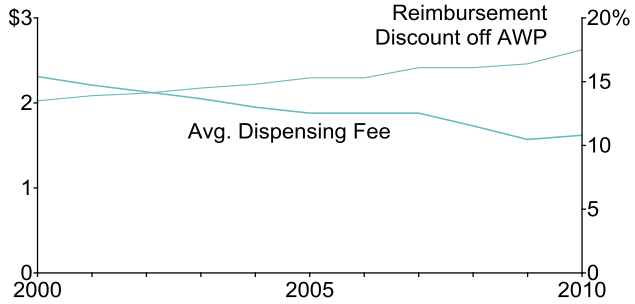
## Declining payer reimbursements, PBM strength, and mail order mandates are pressuring profits

**Declining payer reimbursement and high branded drug prices create a difficult reimbursement environment…**

YoY Growth of Branded Drug Prices in U.S.
*2012-2015*




Pharmacy Dispensing Fees and Reimbursement
*2000-2010*

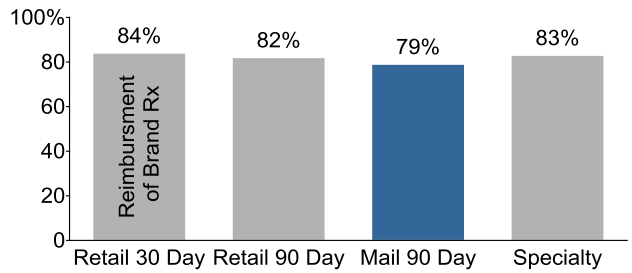



**…and new delivery models are putting pressure on reimbursement**

**Some plans mandate mail order for maintenance medications, meaning prescriptions must be filled by mail after the initial script is dispensed**

- **Lower costs:** Mail order pharmacies have a lower cost of dispensing and generate lower reimbursements
- **Generic price war:** Retail community pharmacies are competing more aggressively with the discounts offered by mail pharmacies
- **Low customer satisfaction:** Customer satisfaction with mail-order pharmacies continues to lag satisfaction with traditional walk-in retail pharmacies, according to J.D. Power

Pharmacy Reimbursement by Setting
*2015*

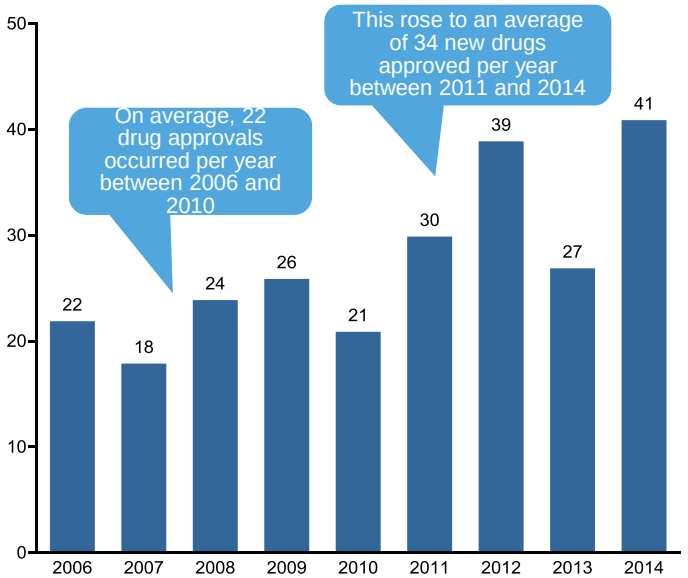



Source: Deloitte Global Life Science Report, Drug Channels Institute, J.D. Power, Morgan Stanley, NCPA, UBS; Parthenon-EY Analysis

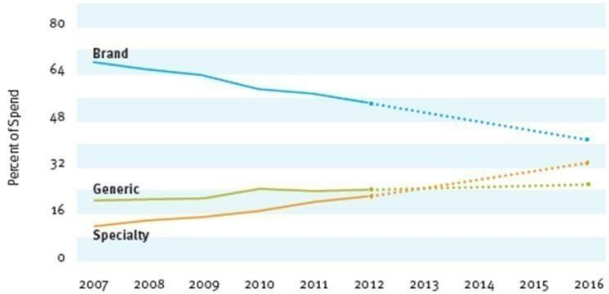
# Emerging Therapies/Specialty Drugs

## Strong growth in scientific discovery has resulted in significant new cures and specialty medications

**Number of NME Approvals by the FDA**
*2006-2014*




**Pharmacy Benefit Spend (By Drug Type)**
*2007-2016*




**High growth in specialty pharmaceuticals has been driven in part by significant profitability opportunities**

- 600 drugs are currently in Phase II or higher clinical trials, with cancer treatments dominating the pipeline
- Gross margins for non-hospital specialty pharmacies range from 13% to 30%
- Cost to patient for a one-month supply of specialty prescription is 28-times that of traditional prescription
- Specialty drugs are expected to increase from 27% of pharmacy industry revenues in 2015 to 44% in 2020

**Continuing the wave of innovation in scientific discovery, nearly 200 new drugs are forecasted to be launched in the next five years, with a high number of NMEs expected every year due to a rich specialty drugs pipeline**

Source: Drug Channels, FDA Center for Drug Evaluation and Research, "Global Outlook for Medicines Through 2018", IMS Health; Parthenon-EY Analysis

# Compliance considerations

## Regulations increase accountability for pharmacies in managing scripts, patient safety, and social responsibility

### Recent changes in regulatory and compliance policy will impact day-to-day operations…

**Federal False Claims Act**

- Strengthened by Affordable Care Act
- States must update their own false claims act laws to reflect federal changes
- Likely to expand liability for providers and opportunities for whistleblowers

**Corresponding Responsibility Rule (21 CFR 1306.04)**

- Rx must be "for a legitimate medical purpose" by prescriber "acting in the usual course of his professional practice"
- Prescriber is responsible, "but a corresponding responsibility rests with the pharmacist who fills the prescription"
- Liability risk increases as pharmacist is responsible for determining legitimate medical purpose of prescription

### …Therefore pharmacies are adjusting their strategies to address these changes

**Compliance Strategies**

**Know Your Patients & Prescribers**

- Check state databases (PDMPs)
- Manage physician pushback (AMA)

**Know Your Pharmacies**

- Look for outliers that dispense unusual amounts; determine what's driving and why
- Avoid "suspicious order" accusations

**Inform Your Pharmacists**

- Heightened training, checklists

**Preparing for State and Federal Audits**

**features:**

- Authority to request records to justify payments
- Ability to recoup overpayments
- Afford appeal rights to challenge state findings

**States are taking action primarily due to state budget pressures and increased federal requirements; potential areas for review include:**

- Incorrect diagnosis codes
- Failure to sufficiently document counseling
- Failure to use tamper-resistant prescription pads

Source: HCCA; Parthenon-EY Analysis

# Key Strategic Alliances

## Along with value chain consolidation, several interesting alliances are forming in the market

### Recent Alliances & Partnerships

#### Walgreens & OptumRx

**Description:**

- PBM OptumRx and Walgreens partnered to sell pharmacy and drug management services to clients. As part of the partnership, OptumRx will charge its customers less for certain drugs if patients fill prescriptions at Walgreens locations. The program applies to 90-day prescriptions aimed at maintaining chronic diseases

**Objective:**

- Through the partnership, Walgreens hopes to capture a larger share of the prescription market

**Industry Dynamic Implication:**

- The partnership may result in an increased share of the pharmaceutical market for WBA, and increased patient loyalty

**Commentary**

- *"It's a partnership aimed at improving costs"* – CEO, PBM

#### Target & CVS/Pharmacy

**Description:**

- CVS acquired Target's pharmacy and clinics for ~$1.9B. CVS now owns Target's 1,672 pharmacies through a store-within-a-store format. All Target pharmacies will be rebranded as CVS, and the clinics will become MinuteClinics. New target locations with pharmacies will also be CVS-branded

**Objective:**

- Target is able to focus on other business segments and drive additional in-store foot traffic, while CVS expands its brand presence in retail pharmacy

**Industry Dynamic Implication:**

- The partnership may result in increased share for CVS, as prescription programs attract customers to CVS locations

**Commentary**

- *"Today's milestone in our relationship with CVS Health is an important step in driving Target's strategic priorities forward while giving our guests easy access to industry-leading health care services"* – CEO, Mass Merchandiser

#### CVSHealth and CardinalHealth

**Description:**

- CVS Caremark and Cardinal Heath entered into a 10-year joint venture. The JV formed the largest entity in the U.S. to negotiate prices with drug manufacturers The JV sources and negotiates generic supply contracts for both CVS and Cardinal Health. CVS receives $25M quarterly payments from Cardinal Health as part of the JV

**Objective:**

- The JV will assist in generic drug sourcing and pricing for CVS, and allow Cardinal Health to expand its presence

**Industry Dynamic Implication:**

- CVS may gain a larger share of the generic drug market over the next 10 years due to its ability to negotiate lower generic drug prices as a result of the JV

**Commentary**

- *"We view this agreement positively as it provides an effective way to drive better purchasing through increased scale without a large capital commitment or increased complexity of international markets"* – Lisa Gill, Analyst, JP Morgan

**These narrow networks will increasingly challenge competitors and limit access to customers / patients**

Source: Columbus Business First, CVS Health, Forbes, Reuters, WSJ; Parthenon-EY Analysis

# Summary of Trend Implications

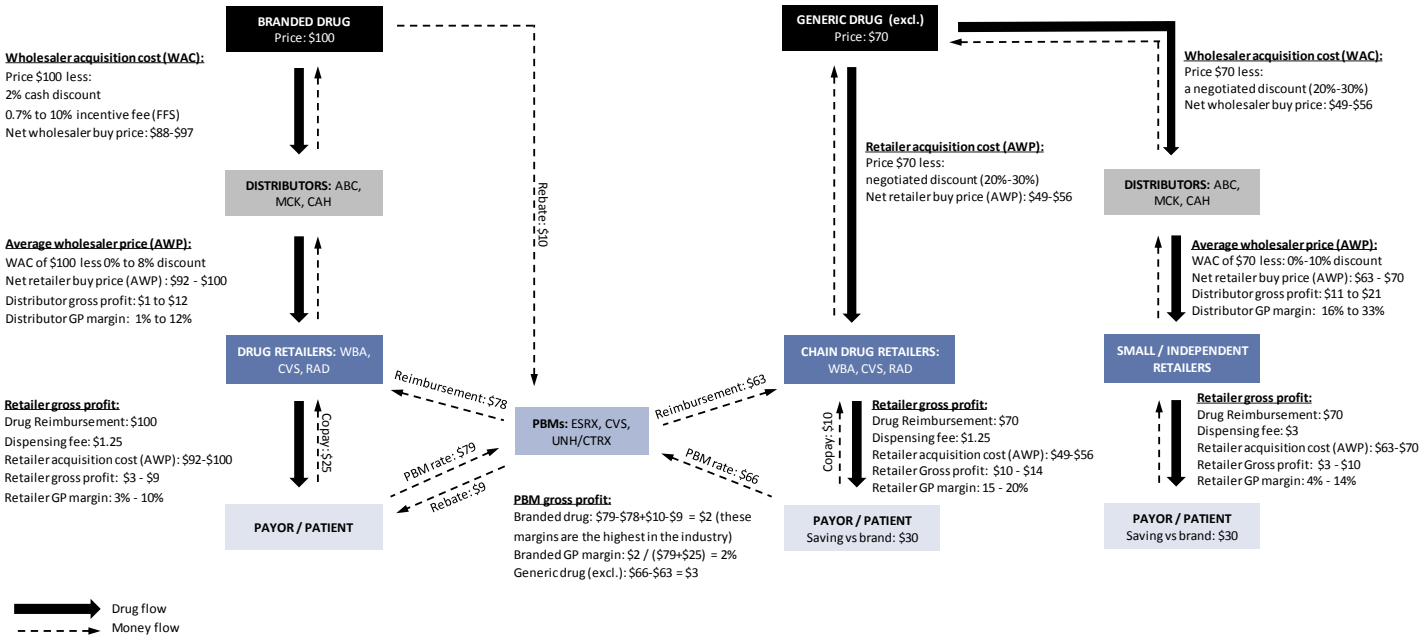
## Trends vary in expected impact but overall offer insights regarding potential for differentiation and strategic focus

| Drug & Pharmacy Trends | Impact | Commentary |
|---|---|---|
| Prescription Drug Growth |  | ➢ Aging of the U.S. population and the rise in chronic diseases will drive growth and likely necessitate focus on specialty drug offerings |
| Industry Pricing Pressures |  | ➢ Everyone is facing pressure from declining payer reimbursement, growth in mail order and PBM strength |
| Collaboration & Consolidation |  | ➢ Future expectations for collaborative efforts mirror existing conditions of dependence on alliances and M&A activity for growth and cost savings |
| Emerging Therapies / Specialty Drugs |  | ➢ Increases in generics and specialty drugs will require operational changes, although impacts in this area are currently occurring |
| Clinical Trends |  | ➢ Increasing clinical services offer the opportunity to capture additional revenue streams while increasing consumer touch points |

| Pharmacy Retailing Trends | Impact | Commentary |
|---|---|---|
| Retail Spend & Growth |  | ➢ Although slightly lagging forecasted total U.S. retail spending, drug stores sales are projected to grow at pace with recent historical rates |
| Efficient Footprint |  | ➢ Retailers are optimizing footprint and finding new ways to engage with customers and offer new services |
| Omnichannel |  | ➢ Retail trends and existing omnichannel offerings are likely to become increasingly important as shopping habits shift |
| Store Experience & Loyalty |  | ➢ Improved loyalty programs will increase stickiness in this market, making competitive offerings a key factor for success |
| Technology |  | ➢ Technology will continue to improve customer experiences and driving data-driven insights for strategy |

Source: Parthenon-EY Analysis

# Flow of Dollars



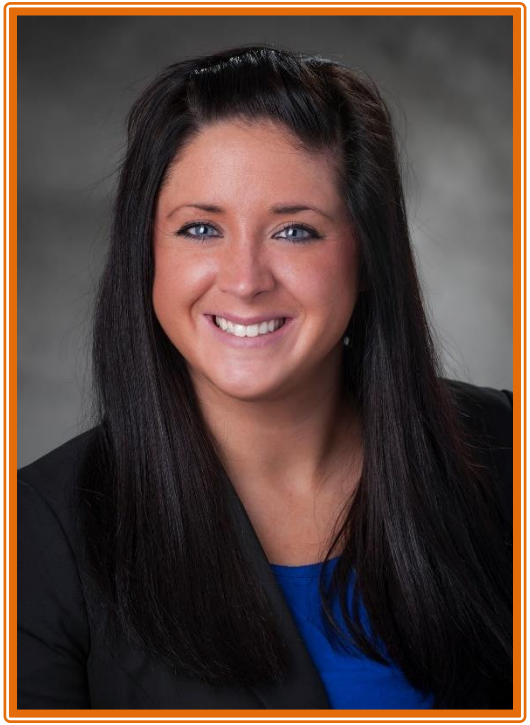
***Please visit our Exhibit Hall***

## Break Time!
## Please return by 10:30am

***"Building Better Lifestyle Habits to Create a Productive and High Performing Workforce"***

**Kristyn Mitich – Advocate Health**

# Building Better Lifestyle Habits to Create a Productive and High Performing Workforce



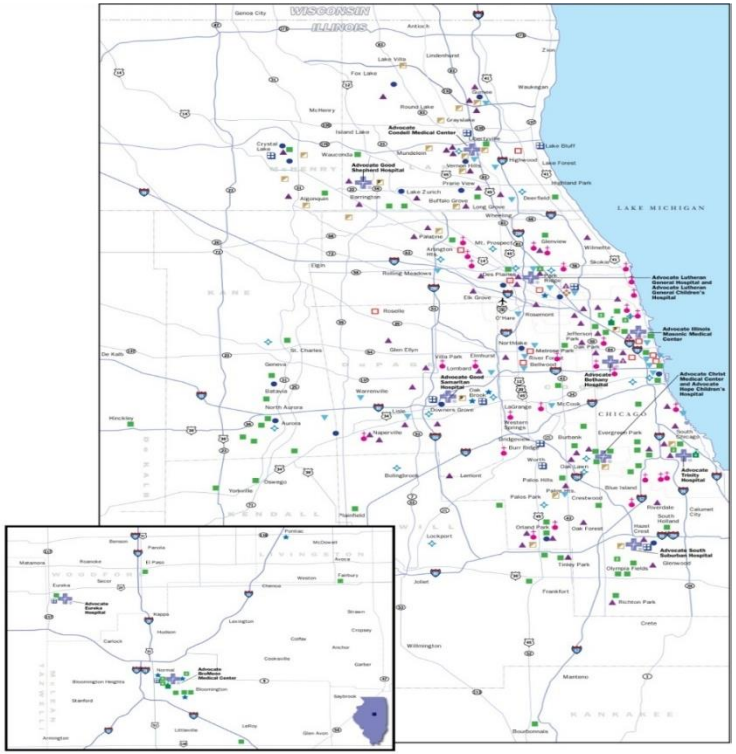
**Kristyn Mitich, ScB, IC, NCSF, CCWS**
**Manager, Health & Wellness**

Living Well

# Building Better Lifestyle Habits to Create a Productive and High Performing Workforce

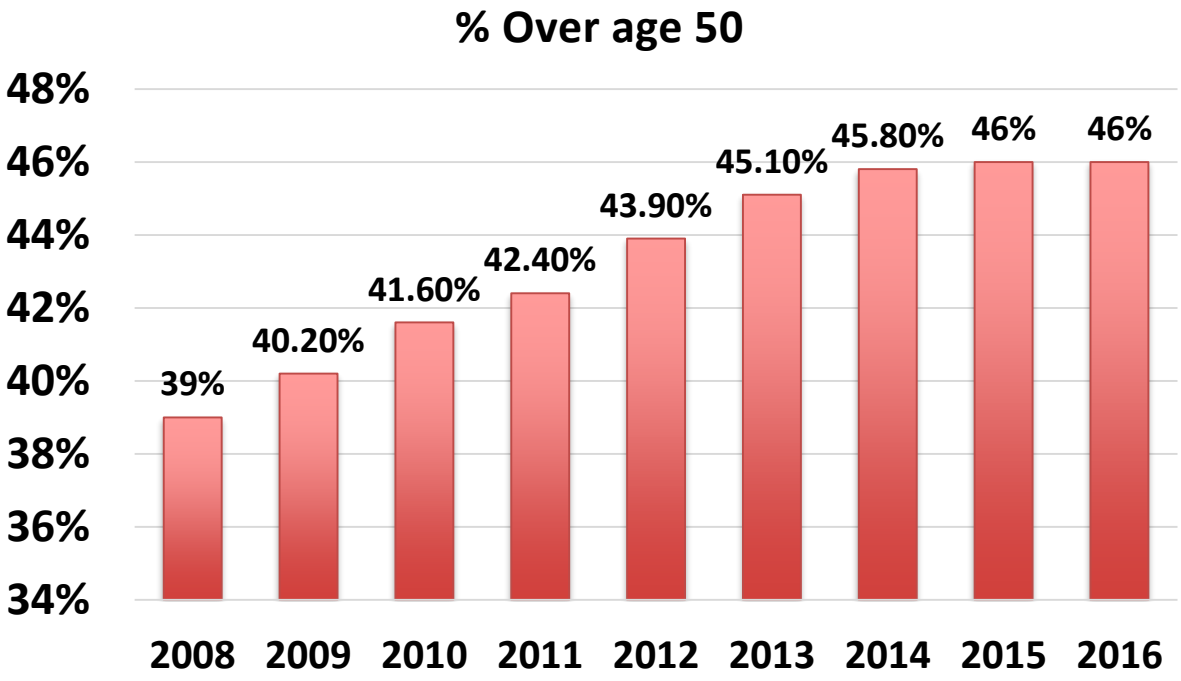
April 13, 2017| Kristyn Mitich, Healthe You Wellness Manager

# Advocate Health Care



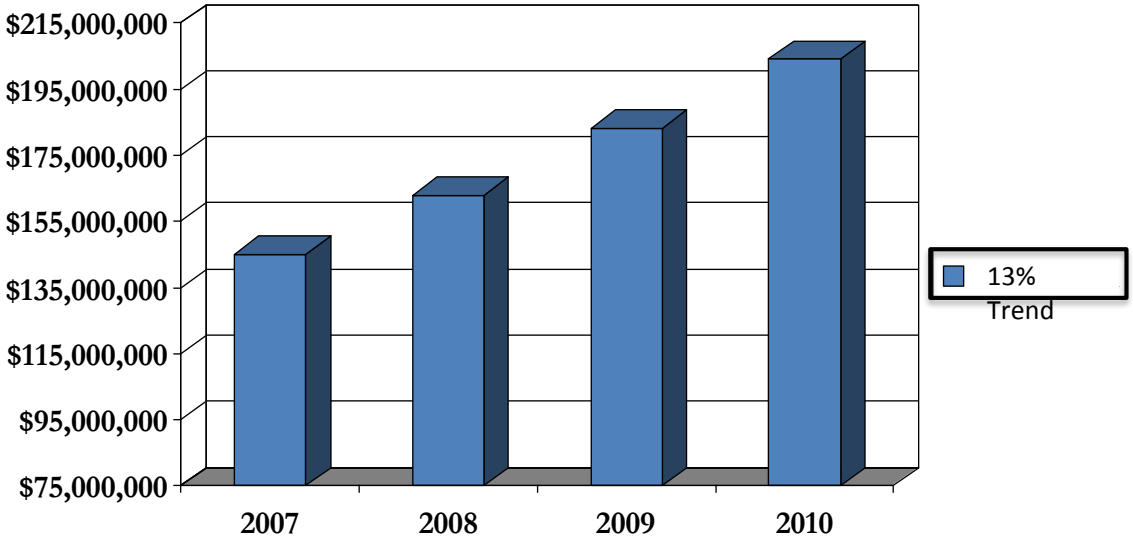

- 11 Hospitals
- Children's Hospital- 2 Campuses
- More than 250 sites of care
- State's largest medical group with more than 150 locations
- 38,000 Advocate Associates
- 6,000 Affiliated Physicians

# Advocate Population




**80% Female**

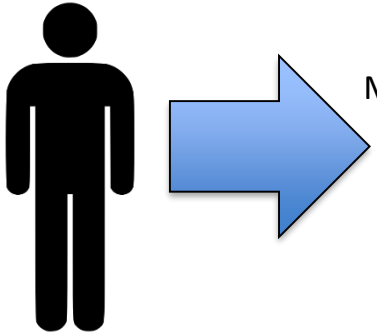
# AHC Health Plan Cost and Associate Premium Trend



# Obesity and Productivity

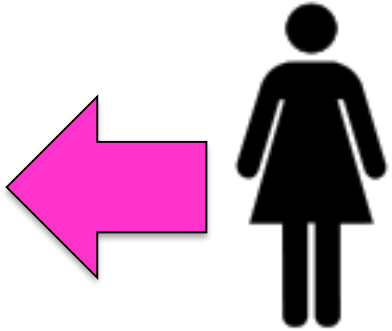
**Cost of Obesity Among Full-Time U.S. Employees= $73.1 billion**

- 82% are from medical expenses and presenteeism
- 18% is from absenteeism



Men- estimated cost of obesity in the workplace is **$33.8 billion**

- Presenteeism is 44% of this total



Women- estimated cost of obesity in the workplace is **$39.3 billion**

- Presenteeism is 38% of the total
- Medical expenses are 49% of the total

# Productivity Measures

**Annual Missed Workdays**

- Overweight men (25-29.9)= 0.5
- Obese men (30-39.9)= 5.9
- Overweight women (25-29.)= 0.5
- Obese women (30-39.9)= 6.3


**Annual Cost***

- Overweight men(25-29.9) = $322
- Obese men(30-39.9)= $6,087
- Overweight women(25-29.9)= $797
- Obese women(30-39.9)= $6,694

**Costs include medical expenses and lost productivity due to absenteeism and presenteeism specific to obesity.*

# BMI at Advocate

| Year | Total Screened | % with BMI Risk | Intervention | Incentive |
|---|---|---|---|---|
| 2010 | 6,204 | 58%<br>N=3,606 | • Telephonic coaching<br>• Online tools/resources | $600 (DRA) |

| Year | Total Screened | % with BMI Risk | Intervention | Incentive |
|---|---|---|---|---|
| 2010 | 6,204 | 58%<br>N=3,606 | • Telephonic coaching<br>• Online tools/resources | $600 (DRA) |
| **2011** | **8,073** | **50%<br>N=4,053** | • **Telephonic coaching**<br>• **Online tools/resources**<br>• **Indoor/Outdoor walking paths** | **$600 (DRA)** |

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| **2012** | **12,888** | **64%<br>N= 8,204** | • **Telephonic coaching**<br>• **Online tools/resources**<br>• **Indoor/Outdoor walking paths**<br>• **Raffle prizes- $100** | **$600 (DRA)** |

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| **2013** | **17,500** | **71%<br>N=12,429** | • **Telephonic coaching**<br>• **Online tools/resources**<br>• **Indoor/Outdoor walking paths**<br>• **Raffle Prizes- $100** | **$600 (DRA)** |

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| **2014** | **19,891** | **53%<br>N=10,474** | • **Telephonic coaching**<br>• **Online tools/resources**<br>• **Goal tracking**<br>• **Indoor/Outdoor walking paths**<br>• **Raffle Prizes- $500/$5,000** | **$600 (DRA)** |

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| **2015** | **13,822** | **64%- Time 1<br>N=9,077<br><br>59%- Time 2<br>N= 8,116** | • **Telephonic coaching**<br>• **Online tools/resources**<br>• **Indoor/Outdoor walking paths**<br>• **Raffle prizes- $500/$5,000** | **$400 for coaching<br>$200 for 3% BMI outcome (DRA)** |

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| **2016** | **13,847** | **50%- Time 1**<br>**N=6,889**<br><br>**42%- Time 2**<br>**N= 5,774** | • **Face to Face Coaching**<br>• **Million Step Challenge**<br>• **100 Fitness Visits**<br>• **"Better for Us"**<br>• **Online Tools/Resources**<br>• **Indoor/Outdoor Walking Paths**<br>• **Raffle Prizes- $500/$5,000** | **$400 for intervention**<br>**$200 for 3% BMI outcome (DRA)** |

# Face to Face Coaching

- Six- 15 minute sessions onsite with health coach
- Food logging and reporting
- Assignments to be completed before each session

| 2015 vs. 2016 | |
|---|---|
| **2015** | **2016** |
| 3 calls - 90 days | 6 sessions - 90 days |
| 82% completion | 90% completion |
| Average weight loss- 7.9 lbs | Average weight loss- 9.7 lbs |

# Million Step Challenge

- **4,500** Fitbits provided through Advocate subsidy
- **4,443** Fitbits synced to wellness platform
- **3,261** participants with over 1 million steps
- **1,374** participants achieved 1 million steps by 5/31/16
- Total steps achieved: **7.3 billion**
- Total weight lost: **7,262 lbs**

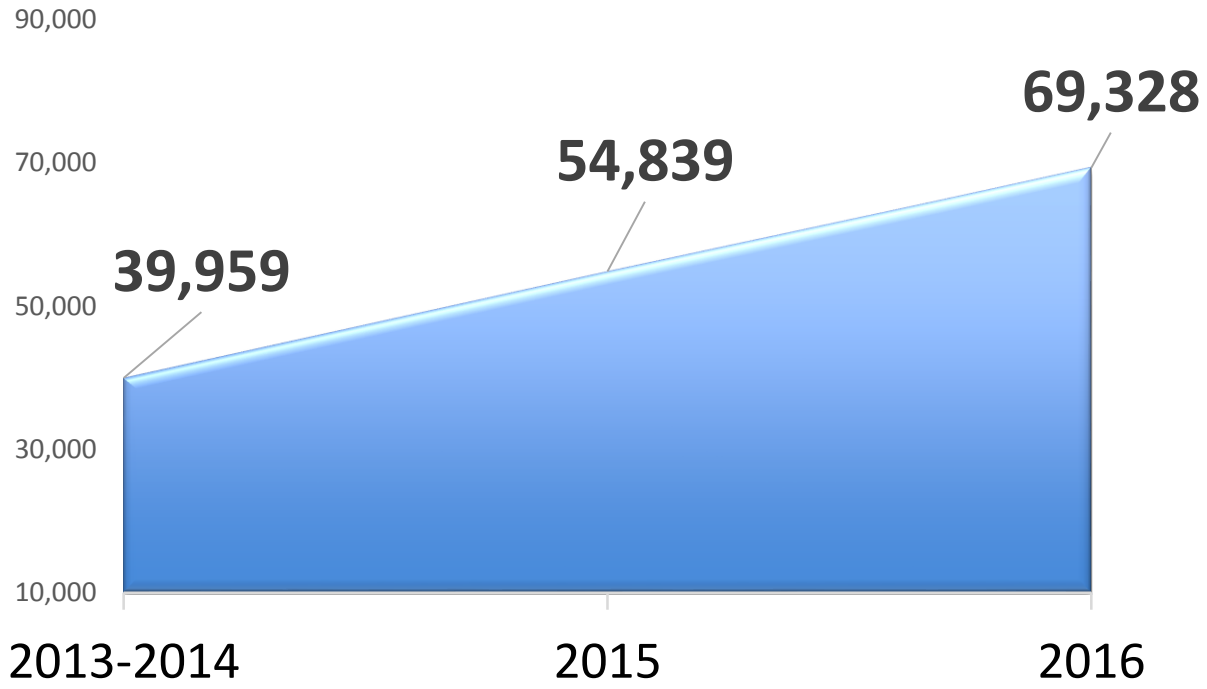
# Fitness 100 Club

- Visits tracked through Advocate Health Care sponsored fitness centers (7 total centers)
- Must complete 100 visits in calendar year
- Average weight loss of 8.8 lbs

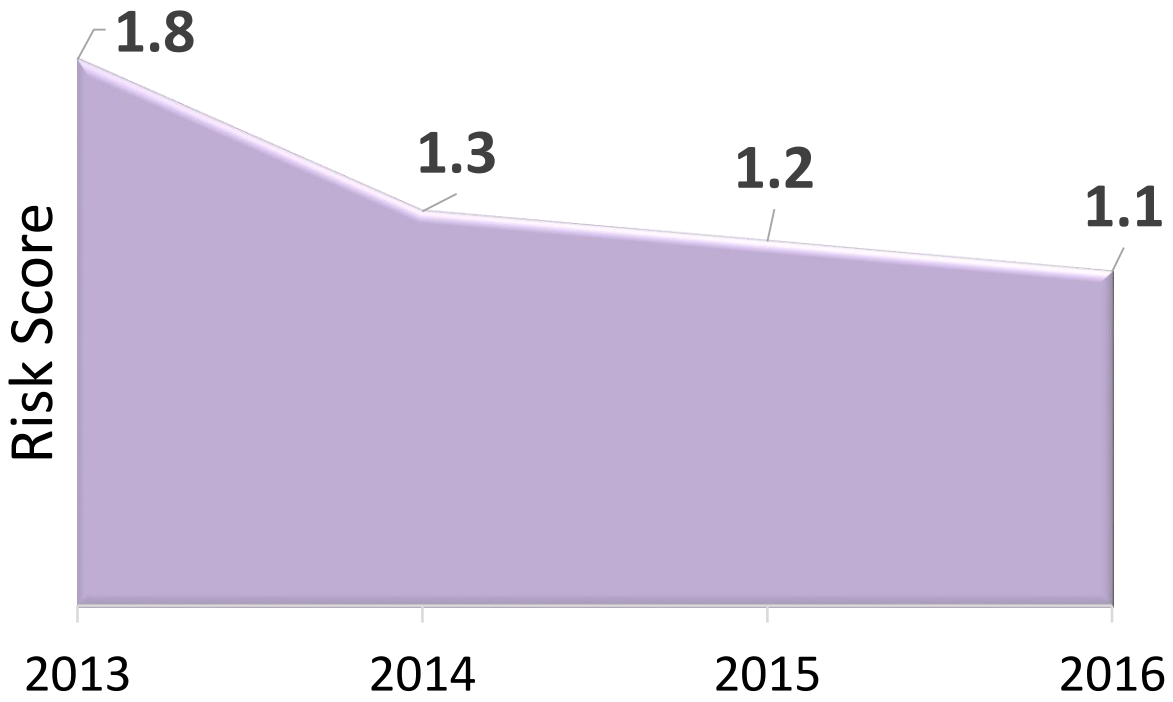
# Better for Us

- Removal of all sugar sweetened beverages in hospital cafeterias and vending
- Signage on healthier food items
- Calorie content posted on all menus
- Educational marketing about better food choices
- Taste test tables to sample alternative drink options

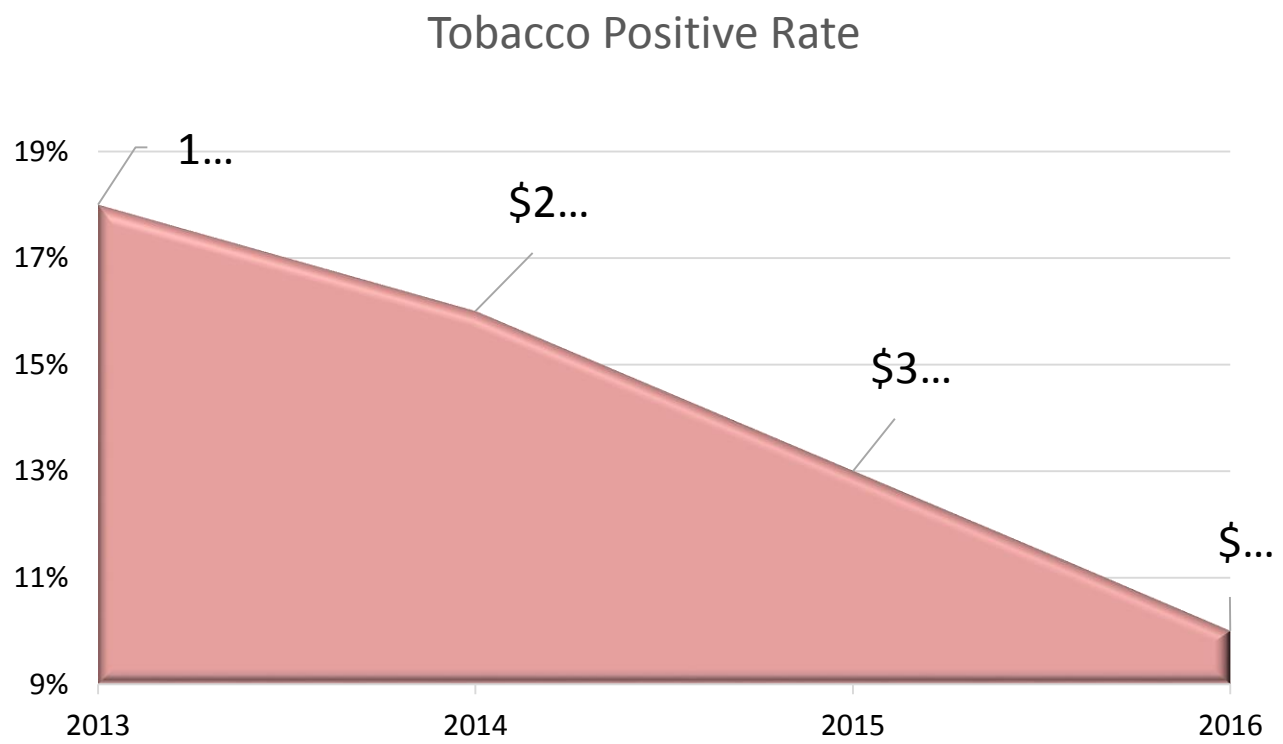
# Total Pounds Lost



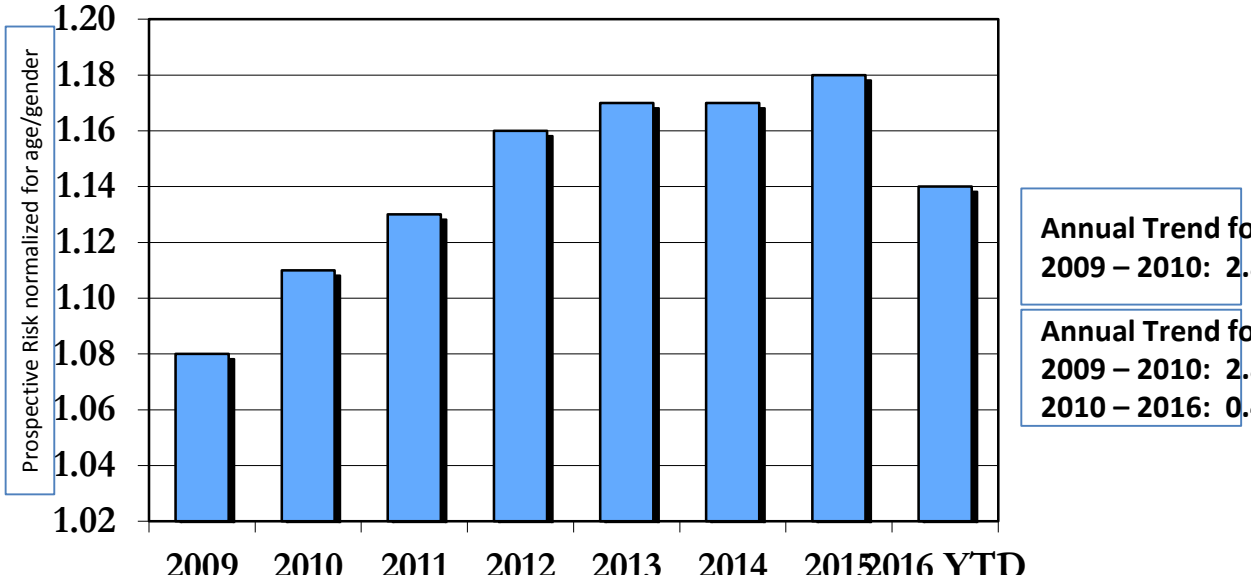
# Risk Score Trend



# Tobacco Surcharge



# Trend with Healthe You



# BMI Cost Avoidance

| Biometric | 2016 Improvement | Population Size 2015-2016 Improved | Annual Avoidance 2016 (per participant) | Total Estimated Avoidance |
|---|---|---|---|---|
| **BMI** (1) | (-1.27) BMI Units | 3,248 | $257 | **$834,736** |

1. Wang F. Association of Healthcare Costs with Per Unit Body Mass Index Increase.

# 2016 Cost Avoidance - Funding Our Future

**2015 Cohort n size = 10,894** **2016 Cohort n size = 10,423**

| Biometric | 2015 Improvement | 2016 Improvement | Population Size 2015 | Population Size 2016 | Annual Avoidance 2015 | Annual Avoidance 2016 | Total 2015 | Total 2016 |
|---|---|---|---|---|---|---|---|---|
| **BMI** (1) | (-1.50) BMI Units | (-1.27) BMI Units | 3,300 | 3,248 | $303 | $257 | $999,900 | **$834,736** |
| **Blood Pressure** (2) | < 130/85 mmHg | < 130/85 mmHg | 524 | 611 | $1,973 | $1,973 | $1,033,852 | **$1,205,503** |
| **Triglycerides** (2) | < 150 mg/dL | < 150 mg/dL | 858 | 792 | $1,443 | $1,443 | $1,238,094 | **$1,142,856** |
| **Glucose** (2) | < 100 mg/dL | < 100 mg/dL | 789 | 497 | $1,631 | $1,631 | $1,286,859 | **$810,607** |
| **Estimated Cost Avoidance:** | | | | | | | $4,558,705 | **$3,993,702** |


Sources:
1. Wang F. Association of Healthcare Costs with Per Unit Body Mass Index Increase.
2. Schultz A. Metabolic Syndrome in a Workplace: Prevalence, Co-Morbidities, and Economic Impact.

# Lessons Learned

- Requiring more “skin in the game” through interventions provides better outcomes
- Constantly evaluate program to meet needs of aging population
- Outcomes based incentives drive results
- MEASURE, MEASURE, MEASURE!

# Questions?

## *Please visit our Exhibit Hall*

**Lunch in the Exhibit Hall**
**Now until 12:15pm**

**Round 1 Breakout Sessions**
**start at 12:15pm**
**In Grand Salon, Salons C & F**

**Round 2 Breakout Sessions**
**start at 1:15pm**

**Break & Exhibit Hall**

**Panel Discussion at 2:30pm!**

# *Pharmacy Benefits Transformation*
# Panel Discussion

**Cheryl Larson**
**Vice President**
Midwest Business Group on Health
*The Source for Leading Health Benefits Professionals*

**Randy Vogenberg**
**Collaboration Lead**
National Institute of Collaborative Healthcare

**Dan Robson**
**General Manager**
MEDTRAKRx

**Todd Krueger**
**Chief Pharmacy Officer**
IDEAL THERAPEUTICS

Mid-America Coalition on Health Care

# Save The Date

nawhc
NATIONAL ASSOCIATION OF WORKSITE HEALTH CENTERS

***Employer-Directed Health Care***
***Key Considerations for Onsite, Near-site and Shared Clinics***

7:30am – 12:00 noon

**June 7, 2017**

Ball Conference Center
21350 West 153rd Street, Olathe, KS

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## Agenda

| | |
|---|---|
| 7:30 a.m. | Registration and Breakfast |
| 8:00 a.m. | Onsite Clinics 101 |
| 8:30 a.m. | The Employer's Perspective on Offering Health Care at the Worksite |
| 9:00 a.m. | Objectives and Measuring Clinic Performance |
| 9:30 a.m. | Break |
| 9:45 a.m. | Considerations for On-site and Shared-site Models |
| 10:00 a.m. | Integrated Delivery Networks and Near-site Clinics in the KC Market |
| 10:30 a.m. | SpecKC – How a narrow, high-performing Specialty Group could Benefit Your Clinic-model Strategy |
| 11:00 a.m. | Break |
| 11:15 a.m. | Q & A – Comprehensive Panel Discussion |
| 12:00 p.m. | Adjourn |

# THANK YOU
# MACHC STAFF & VOLUNTEERS GREATLY APPRECIATE YOUR LEADERSHIP

**Marsha Rodriguez, BS, MPA**
Office Administrator /
Project Manager

TECHNOLOGYSTICS INC
EXPERT TECHNOLOGY SOLUTIONS

**IT and Maintenance**

**Dave Fairchild, BA, BS, MA**
Webmaster

**Sally Carmichael, BFA**
Graphic & Website Designer

**Jean Mayhugh, BA, MHA**
Volunteer

**Ellen Ross, BA**
Volunteer

**Claire Ross, BA**
Volunteer

# THANK YOU!

Mid-America Coalition on Health Care

## Collaborating for Value!

***Follow us on Twitter @MidAmHealth***
***www.machc.org***