NavMD

WHITE PAPER

Stop the bleeding!

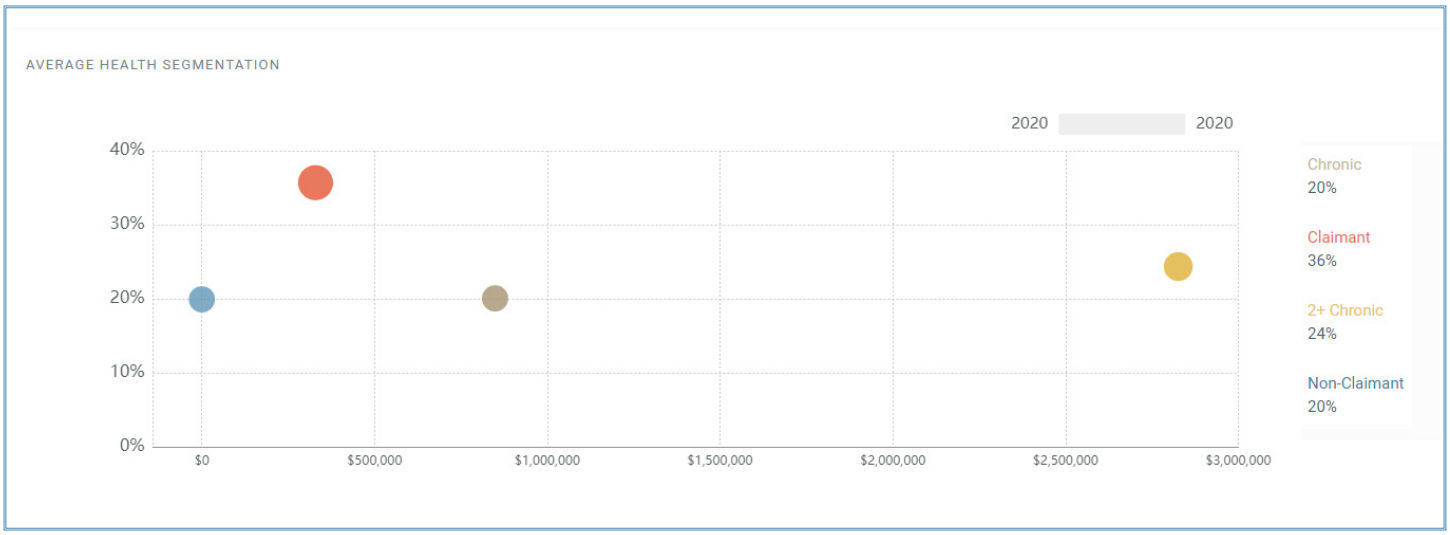
3 PROVEN WAYS

to save a significant amount of money on employee benefits

1. Not Addressing or Preventing Progression of Chronic Disease

Common Scenario: Diabetes and comorbid condition overlap.

This chart shows the average health segmentation of a typical health plan. The percentage of population and represented cost associated with the chronic disease burden. While 20% of the population are Non-Claimants (blue), 36% are Claimants (red) experiencing Conditions that are Acute (Non-Chronic), 20% of the population has one chronic condition (brown), while 24% of the population is polychronic/2 or more chronic conditions (yellow). The chronic disease burden population has significantly higher costs, where 24% of the population is over $2.3M versus those members experiencing Acute conditions at just over $300K.

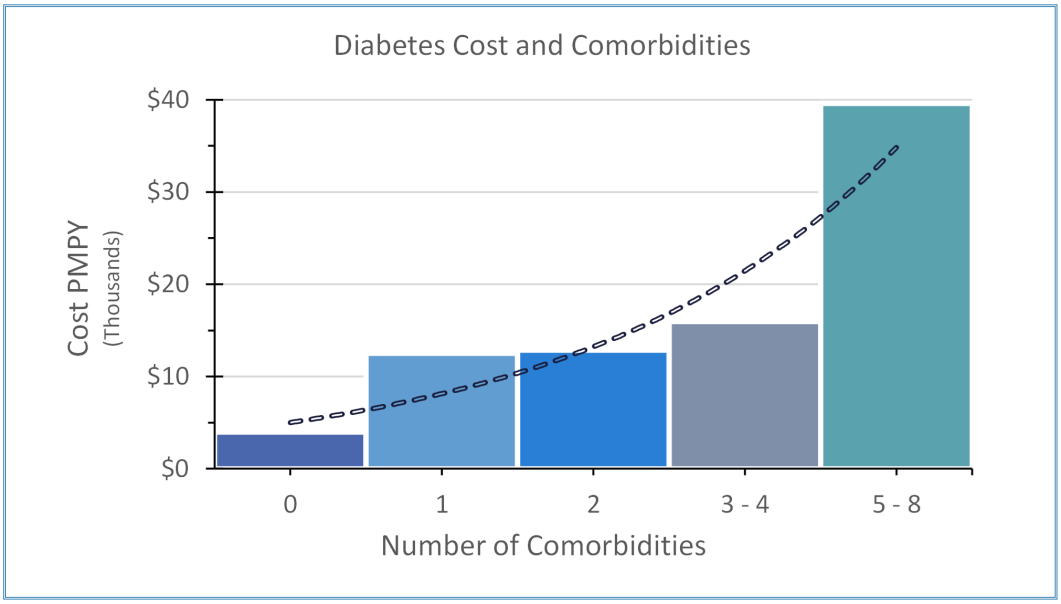


The Problem

The chronic disease burden associated with chronic and lifestyle conditions are significant contributors to driving health care costs. Costs and risk associated with chronic disease continue to rise. While also a reflection of population health, many chronic conditions are preventable, such as adult-onset Type 2 Diabetes. However, when a person is diagnosed with T2 Diabetes, it is not reversible. It becomes a chronic condition that a person must deal with for the rest of their life.

Data shows that Diabetes does not often occur in isolation.

- 98% of diabetics have at least one co-morbid condition while 90% of diabetics and more than one co-morbid condition (2+).
- The three most common co-morbidities associated with diabetes are hypertension (high blood pressure), hyperlipidemia (elevated cholesterol), and elevated BMI (overweight).
- Followed by other more serious comorbid conditions such as cardiovascular disease (heart disease), blindness, lower-extremity amputation (due to insufficient blood flow), and kidney disease (which may progress to dialysis).



Unmanaged diabetes is the leading cause of chronic renal failure and often the main cause of dialysis long term; the average annual cost for dialysis can exceed $500,000.

To stem the rising tide, compliance to evidence-based medicine guidelines (regular doctor visits, blood work, and medication adherence) are risk mitigators, and can reduce future costs. The industry has proven out that diabetics falling below 80% medical possession ratio for important medications and failing to meet standards based on evidence-based medicine are most at-risk of developing costly complications which in turn, paves the way for potentially catastrophic complications: thus, causing additional forward risk and cost to the health plan.

Members on a health plan must become more responsible for their own health.

The Solution

Alignment of benefit plan design with targeted strategies focused on the emerging at-risk populations with lifestyle or acquired conditions. The main goal is to increase pharmaceutical adherence and compliance with evidence-based medicine guidelines. Also, increasing engagement in high-touch programs designed to target and help the people who need it most. In addition, managing their condition(s) to avoid disease progression and catastrophic claims stemming from events like heart attack, stroke, or renal failure.

Examples of successful risk and cost mitigation tactics:

1. Plan Design

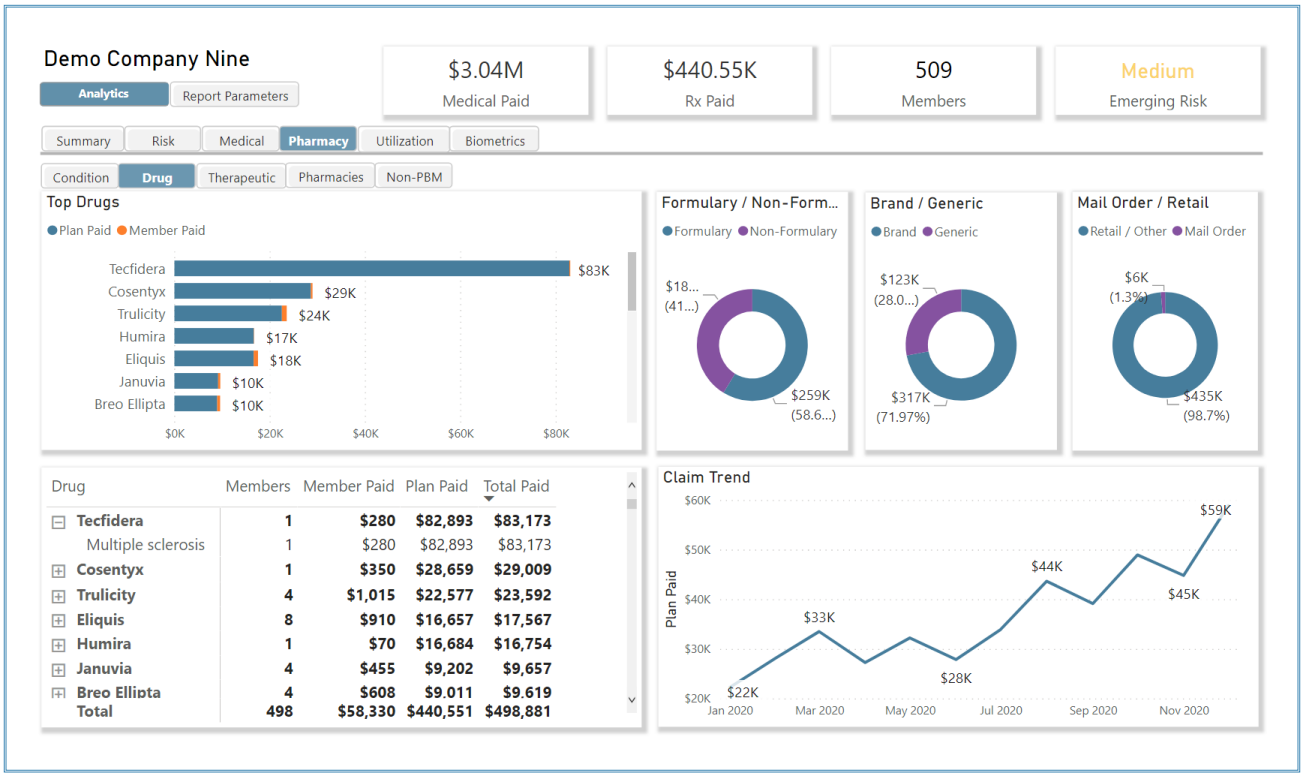
Instead of the traditional opt-in approach, try the opt-out method.

- **a.** For example, by virtue of the health plan design, members with chronic conditions will be held accountable for following treatment guidelines.
    - **i.** Those members that remain compliant with evidence-based medicine will get the best benefits (high plan) where services and preventive medications are paid by the plan.
    - **ii.** Those members that fall short of meeting the goals required by evidence-based medicine will fall to a more expensive plan (low plan) where more cost falls to the member.

2. Target Wellness Programs or Disease Management tailored to the needs of the specific needs of the population.

- **a.** For example, many wellness programs have failed because of the premise that only healthy people take advantage of the program's benefits. While not surprising, designing a program that targets the chronic disease population for education, one-on-one advocacy, and increased compliance and engagement makes sure the health plan is focused in the right areas to make a measurable impact on lowering cost and risk.

2. Not carving out Rx or focusing on Specialty Medications



The Problem

Specialty medications adjudicated as pharmacy claims or medical pharmacy claims ("J-Code" or Non-PBM drugs) can account for over 50% of the pharmaceutical expenditure for a health plan, while typically less than 5% of their membership is on specialty medication. These medicines have become a predominant driver of large claims. Specialty medication trend is now double-digit. These drugs are on the rise for treatments of certain conditions like Adult Rheumatoid Arthritis, Psoriasis, Multiple Sclerosis, and even a common condition like Diabetes.

The Solution

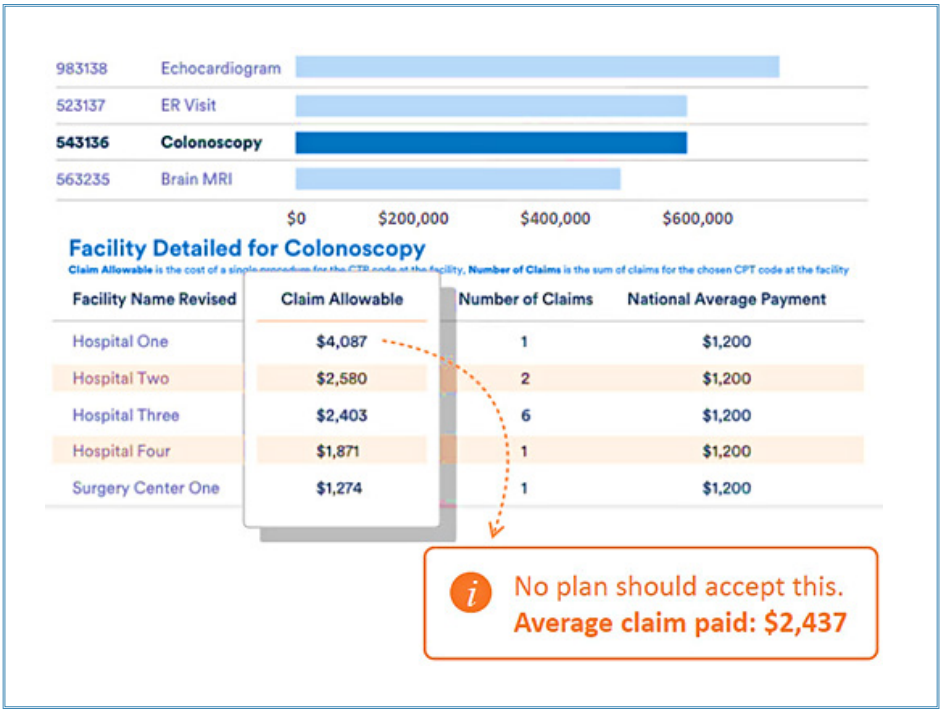
Carve out pharmacy benefits to a pharmacy benefits manager or a third-party vendor focused on specialty drug costs. There are programs designed to reduce or eliminate the cost associated with specialty drugs driving cost for a health plan. But first, you must carve out the drugs from the medical plan. Then, carving out specialty drugs from the PBM with point solutions that reduce cost for members and the plan that require specialty medications. Alone, these programs can impact the overall health plan by reducing overall health plan costs by 11% or more.

3. Failure to evaluate Provider Network Performance

Provider Profiling to Create Narrow Networks and use of Providing Medical Pricing Transparency Tools.

The Problem

Due to the lack of transparency of health care costs, many high-volume procedures and billing practices cause huge discrepancies in costs for services which are at the heart of overspending. Lab work, imaging, and outpatient facilities tend to be more cost effective outside the hospital setting. In many cases, facility providers account for the majority of costs and there is s For example. In this case, you can see the wide variance in cost associated with a simple colonoscopy procedure.



The Solution

Medical pricing transparency solutions are available and pricing matters. This is what enables strategies that reduce cost for both the health plan and member alike. Proven NavMD point solutions allow for complete visibility into cost drivers and where the opportunity is to incent members to choose high value providers or implement reference-based pricing.