
BLACK
& Employer Sponsored Health Plans
SWAN

BLACK SWAN

The term “Black Swan” was used in the 16th century discussion of impossibility (all swans known to Europeans are white.)

Explorers arriving in Australia discovered a species of what that is black .

The term is now used to refer to events that occur though they had not been thought to be impossible.

Key Objectives

1. "Black Swan" Events
   Why the Unexpected Can Be So Impactful

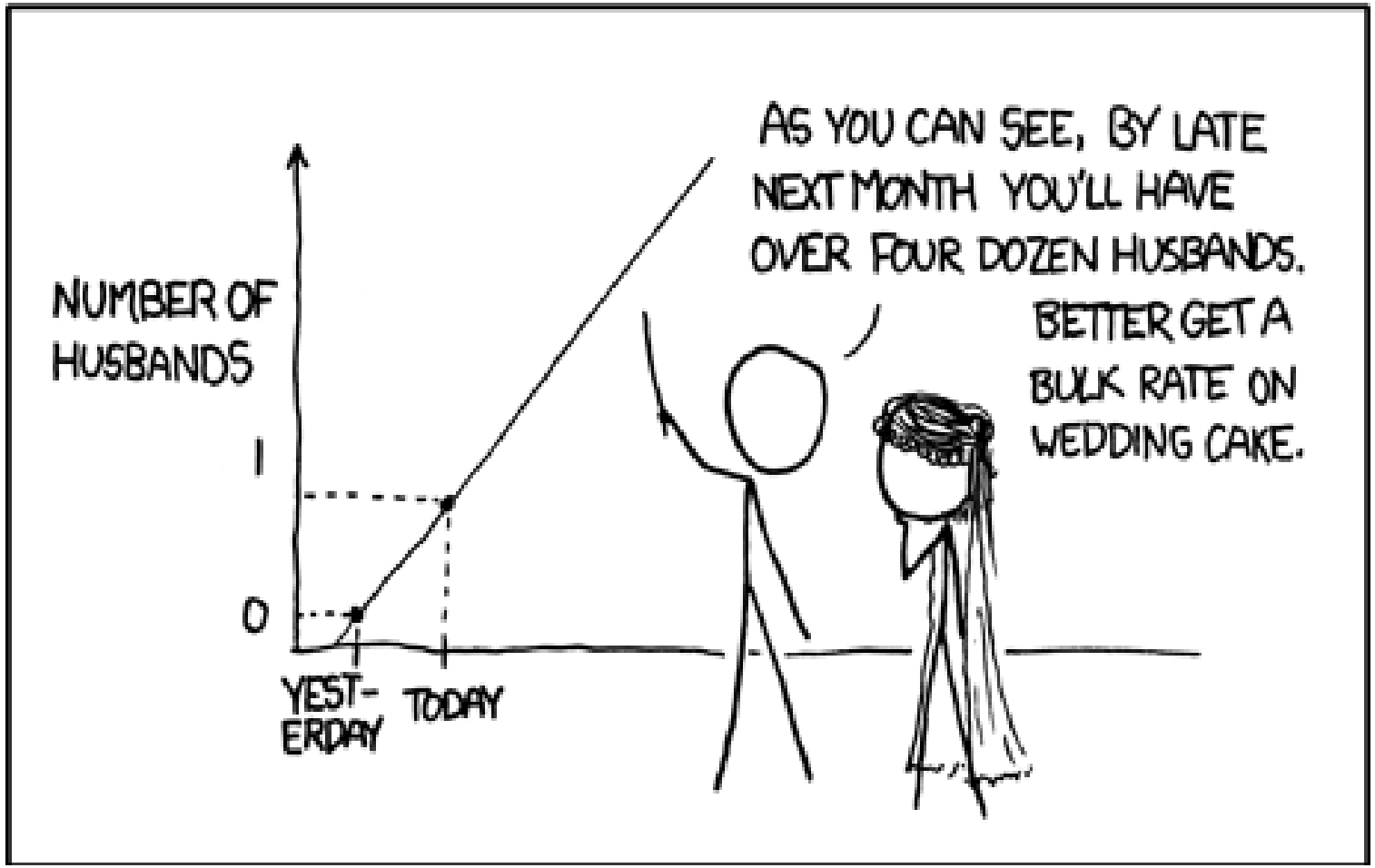
2. Health Care in a post "Black Swan" World:
   What happened & What We Thought We Knew

3. Key Trends and Strategies:
   Health and Welfare/Total Rewards in Post-Pandemic World

Black Swan Events

Disproportionate Impact of Random Event & Inductive Learning

MY HOBBY: EXTRAPOLATING



THE PURSUIT OF CURIOSITY

A Turkey

Is fed for 1000 days

Each passing day confirms to its statistics department that the human race cares about its welfare ‘with increased statistical significance”

On the 1001th day, a little before Thanksgiving, the turkey has a surprise

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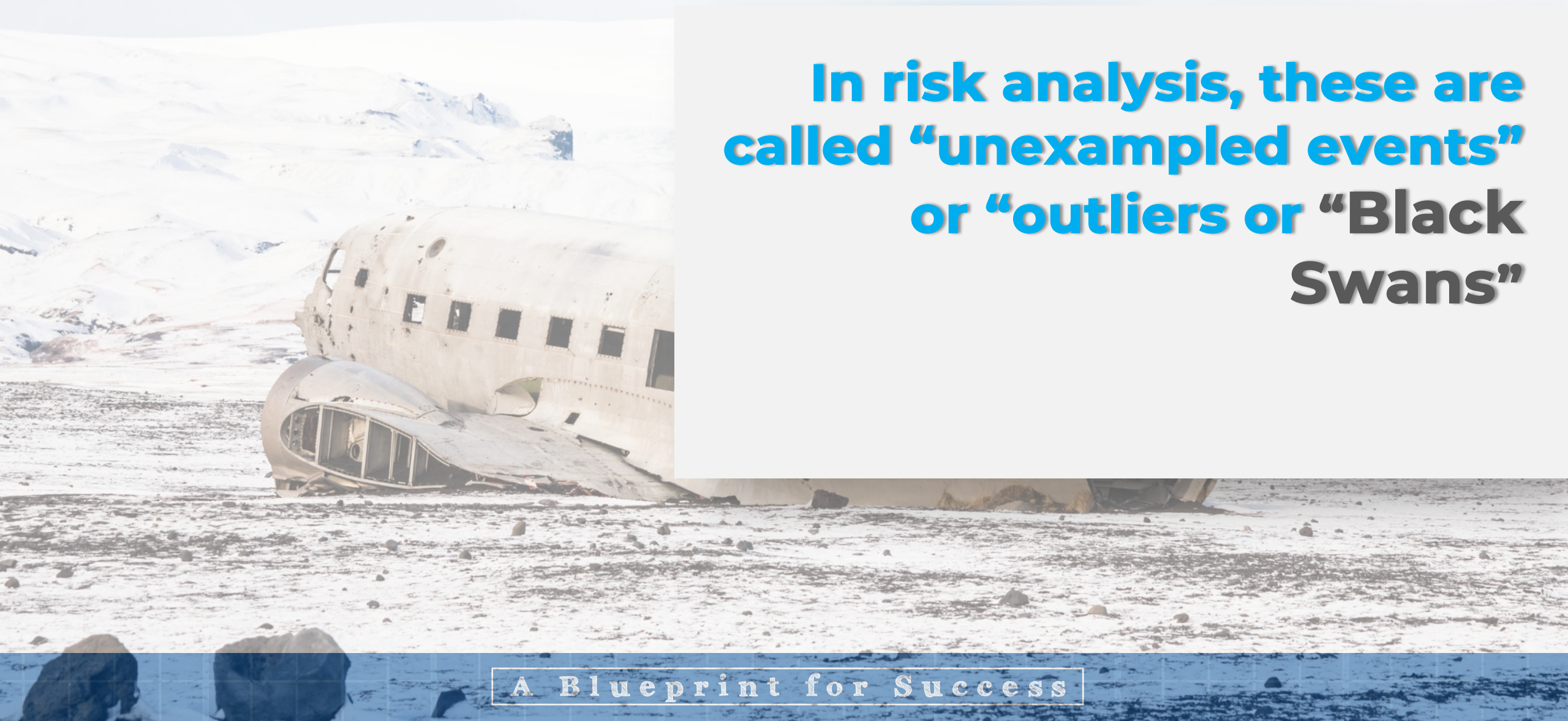

In risk analysis, these are called “unexampled events” or “outliers or “Black Swans”

A Blueprint for Success

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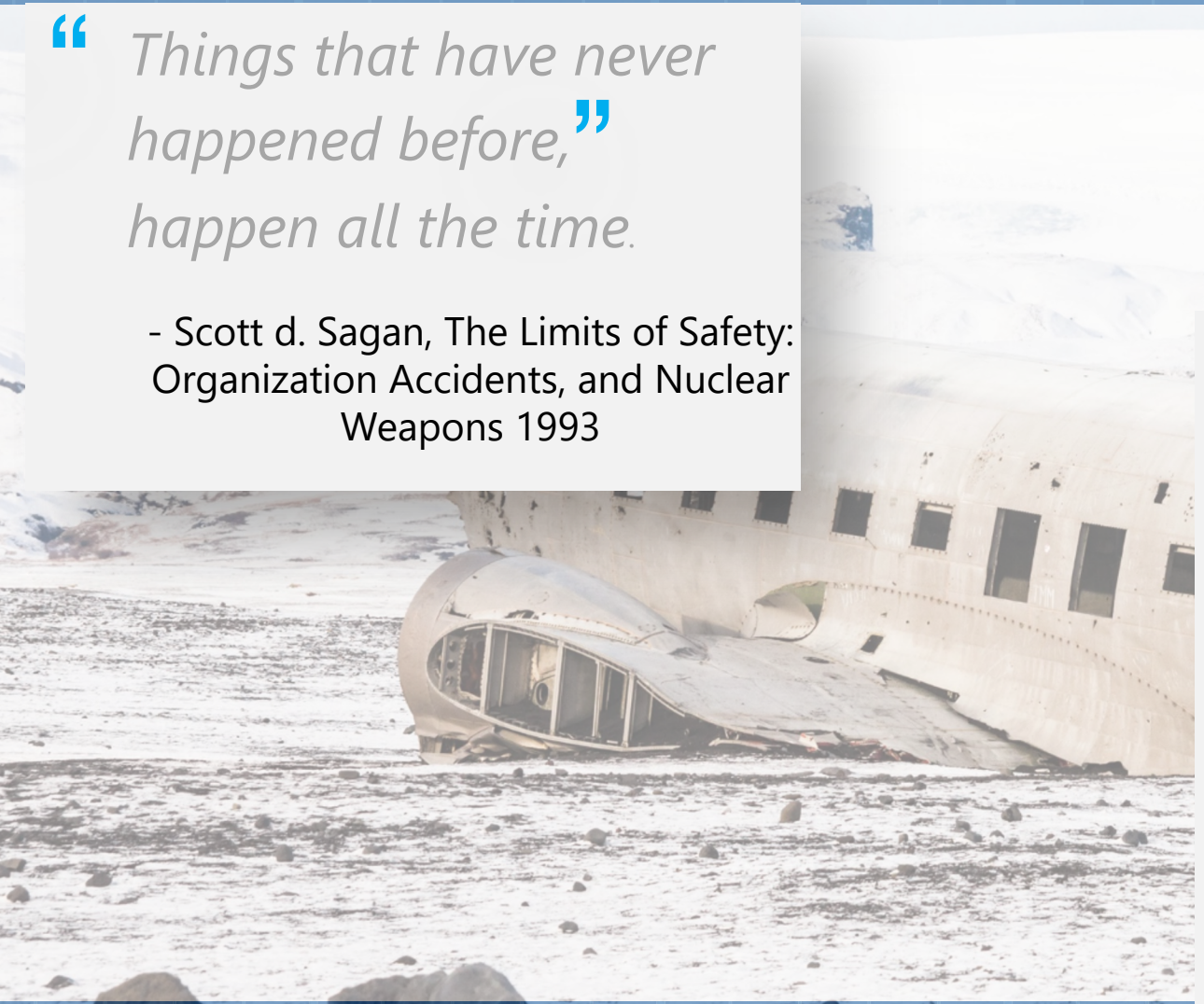
> *"Things that have never happened before, happen all the time."*
>
> - Scott d. Sagan, The Limits of Safety: Organization Accidents, and Nuclear Weapons 1993



Example of deductive reasoning:

- **Premise 1: All humans are mortal.**
- **Premise 2: Socrates is a human.**
- **Conclusion: Socrates is mortal.**

This is a valid argument. If the premises are true, then the conclusion must be true too.

Example of inductive reasoning:

•Premise: The sun has risen in the east every morning up until now.

•Conclusion: The sun will also rise in the east tomorrow.

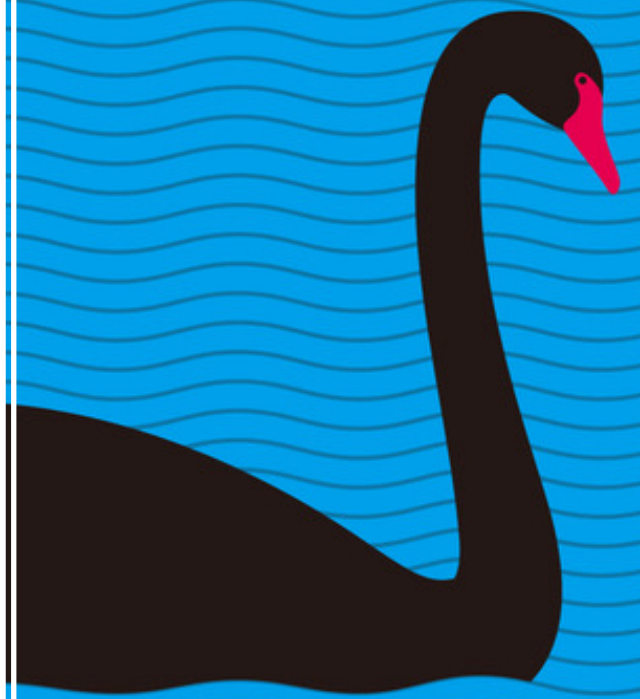
Black Swan

Characteristics

- **An outlier**
  - **Lies outside the realm of regular expectations**
  - **Nothing in the past can convincingly point to its possibility**
- **Carries an extreme impact**
- **In spite of its outlier status, it is often easy to produce an explanation for the event *after the fact***

Note that

- **a black swan event may be a surprise for some, but not for others; it's a subjective, knowledge-dependent notion**
- **Warnings about event may have been ignored because of strong personal and organizational resistance to changing beliefs and procedure**



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Rare Events Are Not all Black Swans

The Fukushima Daiichi tsunami (March 2011, 14m wave)

Was casued by a magnitude 9 earthquake

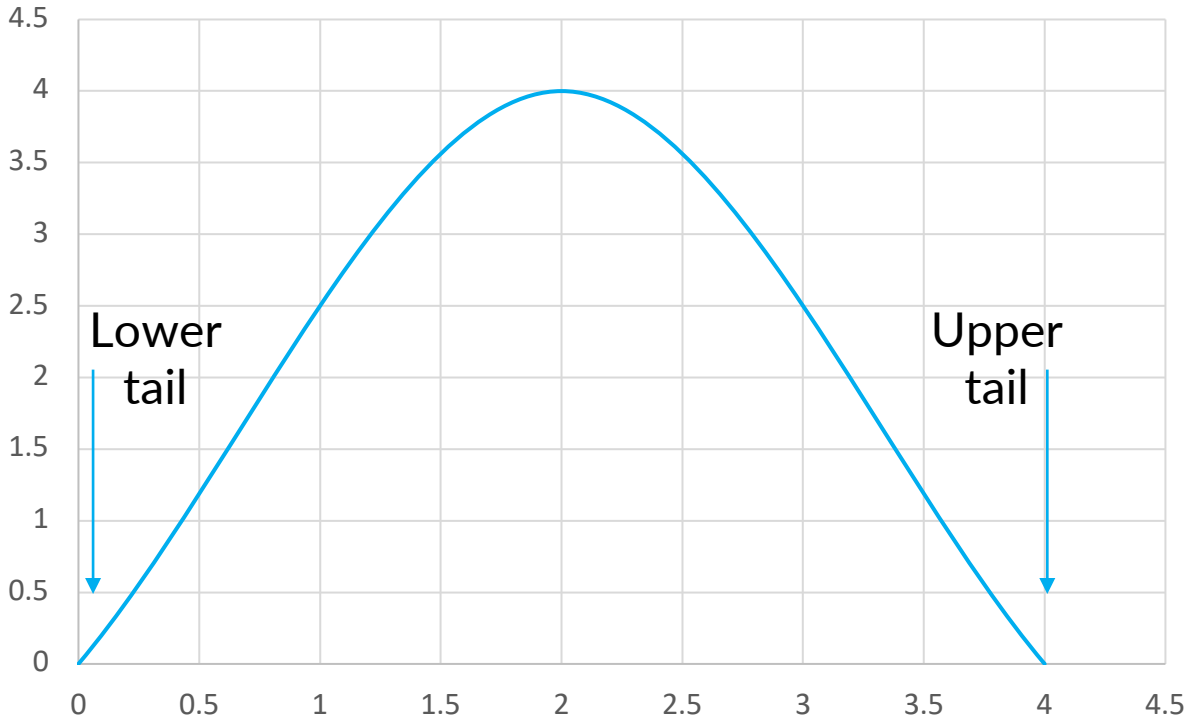
9th Century

Earthquake estimated 8.6 magnitude

17th Century

Earthquake of estimated 8.1 magnitude, 20m tsunami

Statistical modeling could have imagined the tsunami in 2001 using available historical modeling.

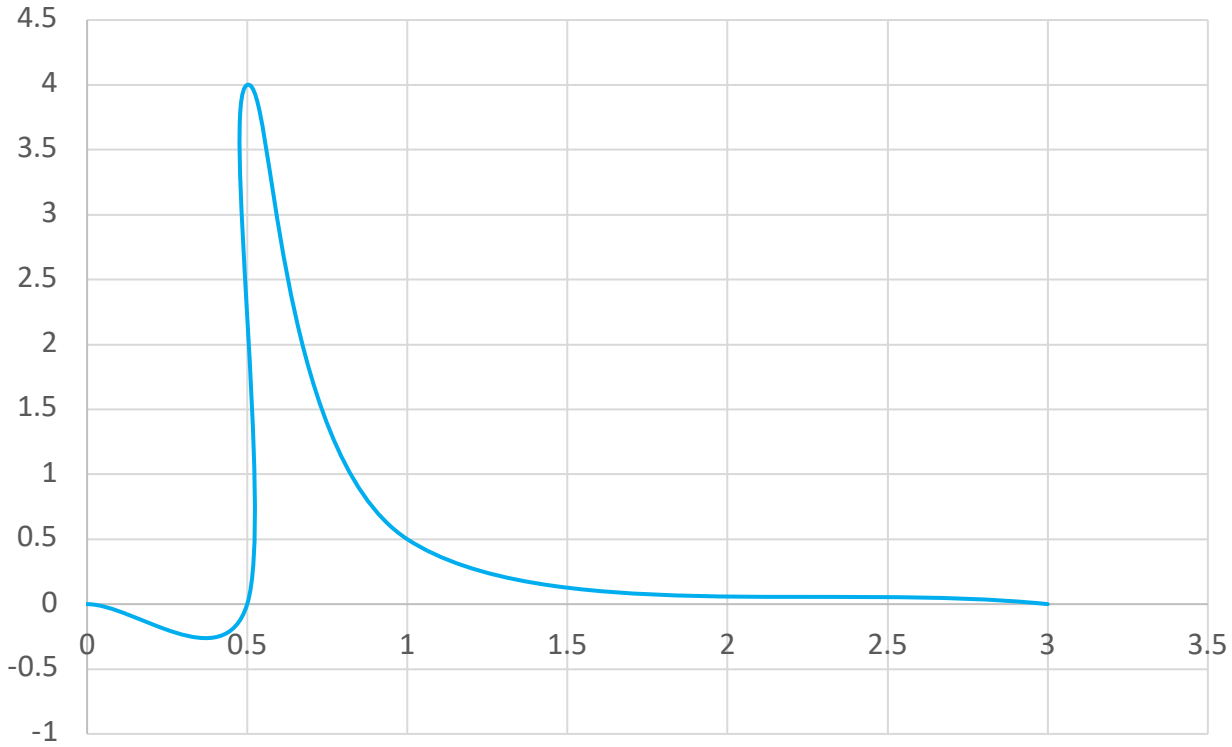


"Thin-tailed" Probability Distributions

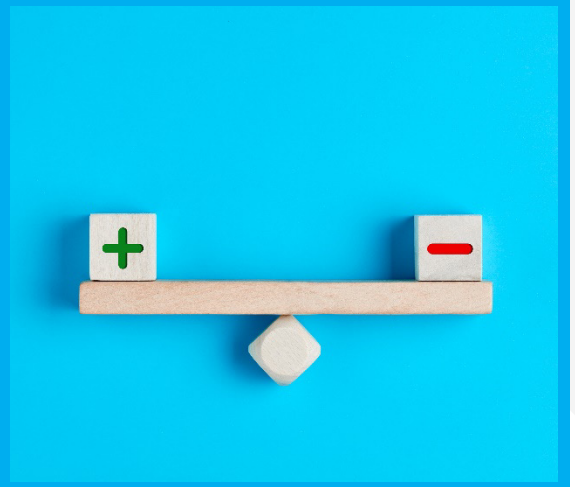
- The "tail" of a probability distribution is the part which is far away from the mean
- Normal (or Gaussian) distribution

"Fat-tailed" Probability Distributions

- Extreme events carry significant weight
  - Fairly high probability of something "unusual" occurring
- Large losses for workers compensation, energy released by earthquakes
- Pareto Distribution
- Asymmetric impact



Two Caricatures Of Probability Distributons



Mediocristan – "Thin Tailed"

Events are easy to predict

Exceptions occur, but don't carry large consequences

Extremistan – "Fat Tailed"

Exceptions can be everything

Winner takes all effect (sales of novels, albums)

Future is hard to predict from past information

(Inductive Reasoning misleading)

Black Swan Events

Are employer sponsored medical plans in “Extremistan”?

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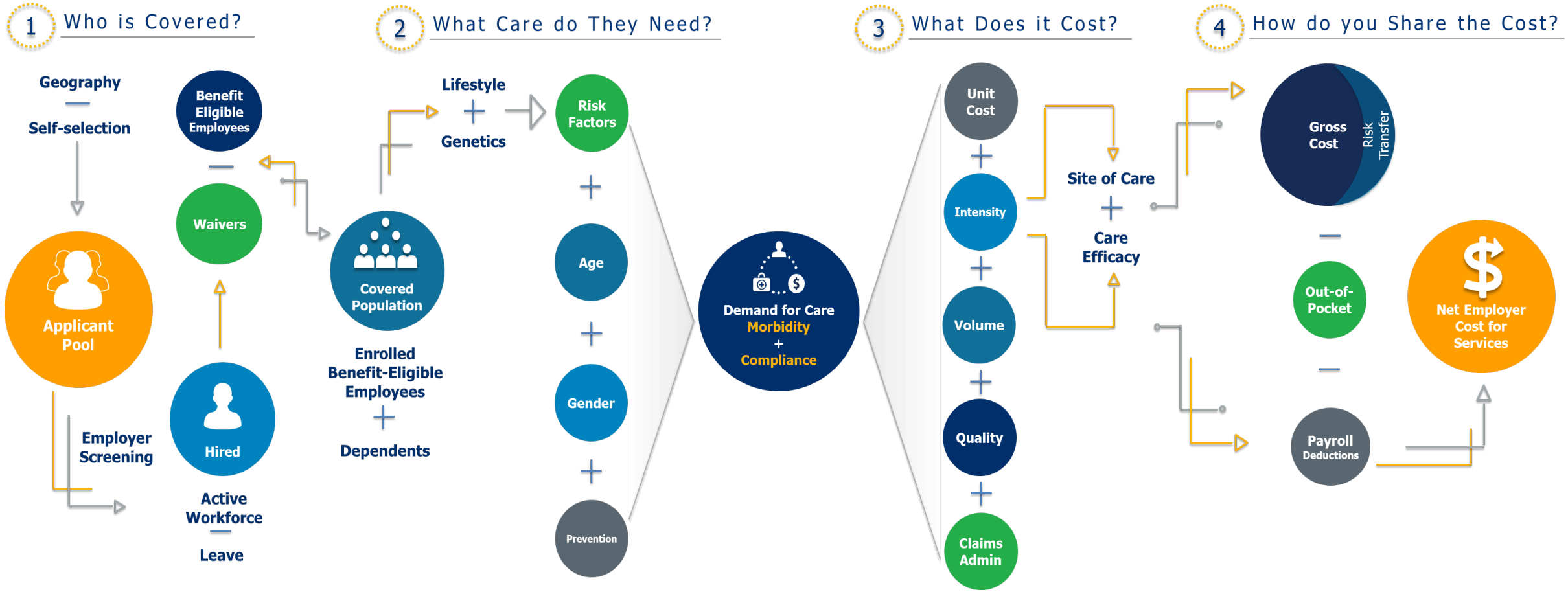
Employer Healthcare Calculus & Cost Continuum



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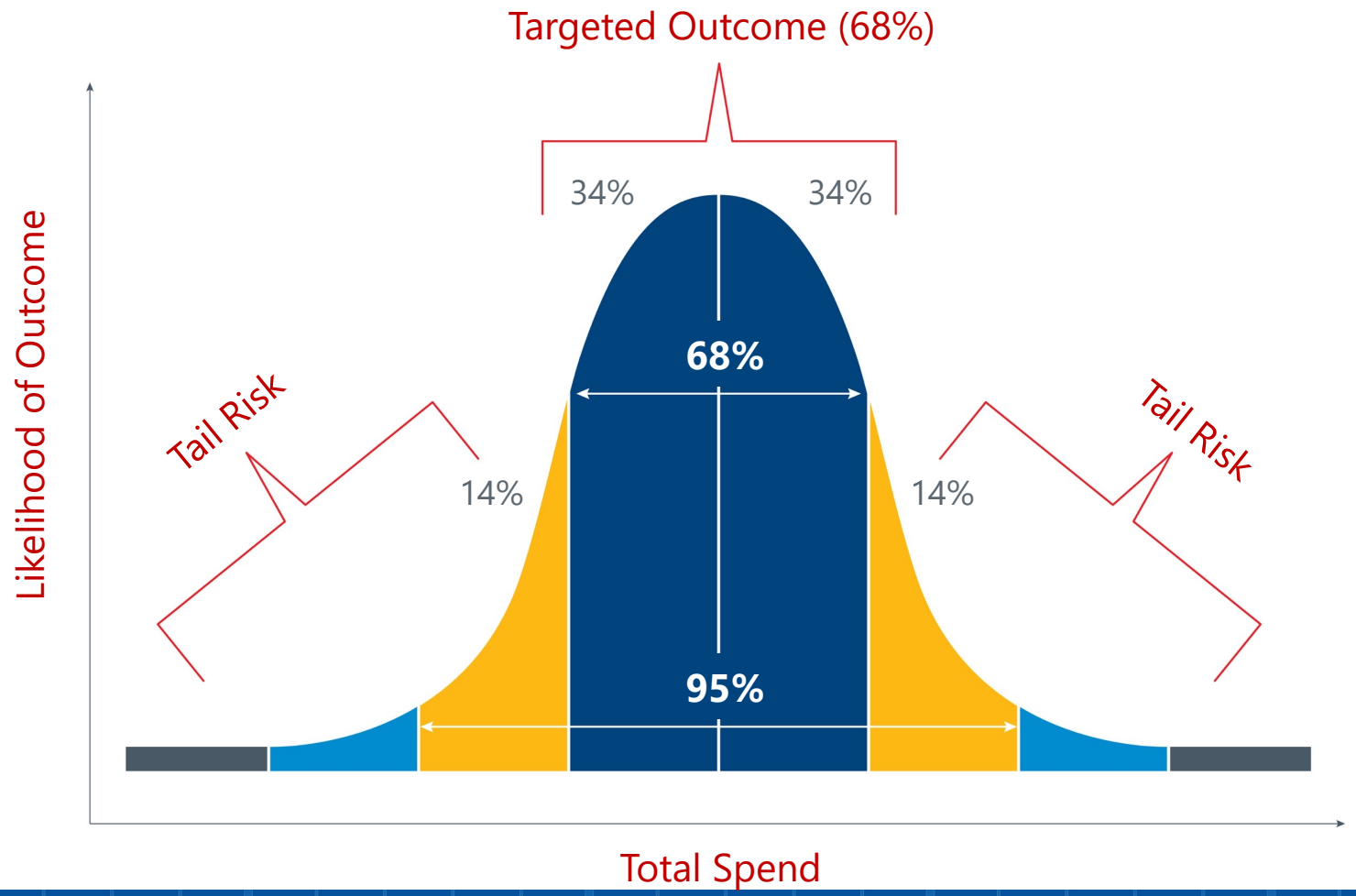
Bell Curve - Where is the Risk?



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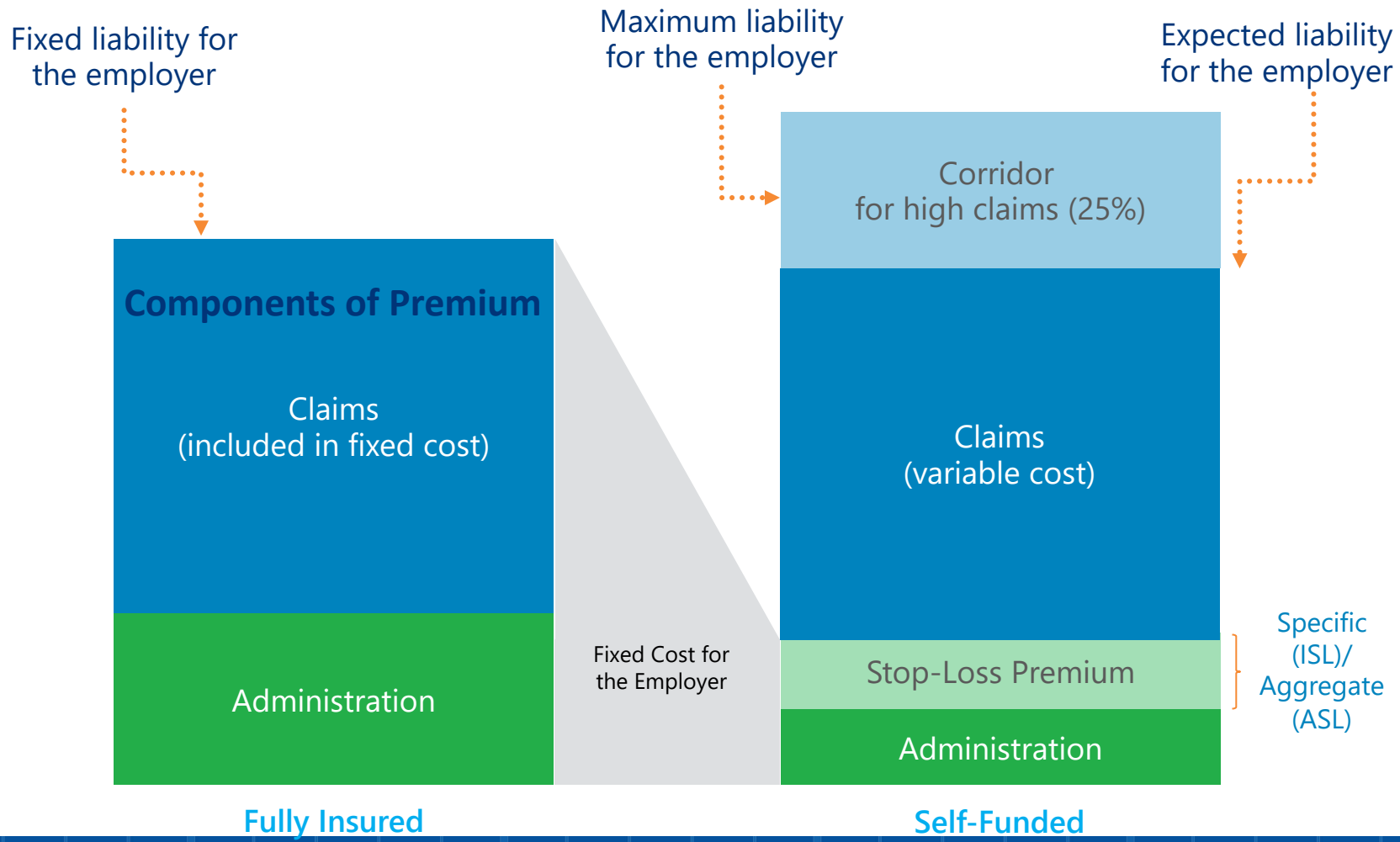
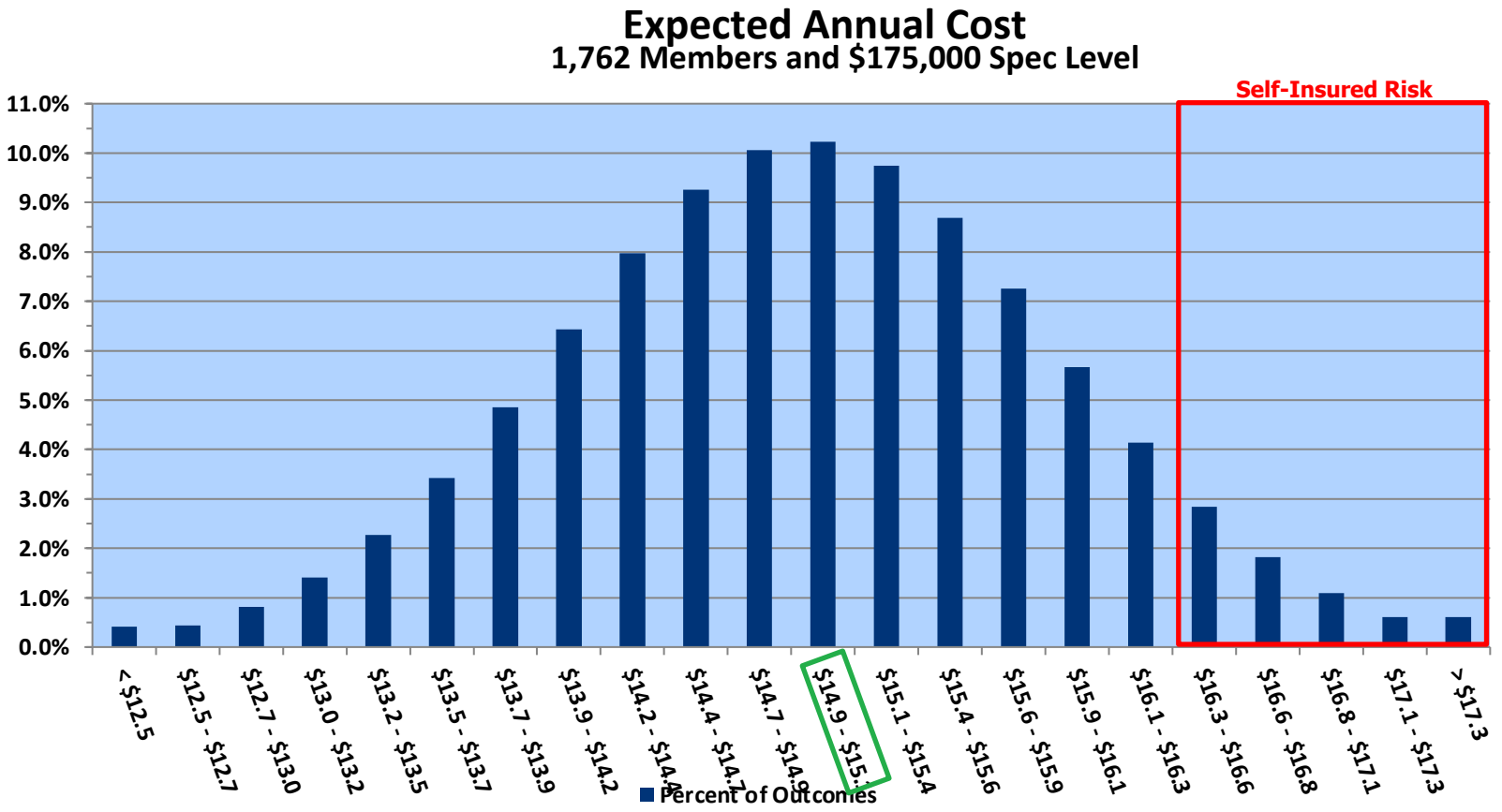


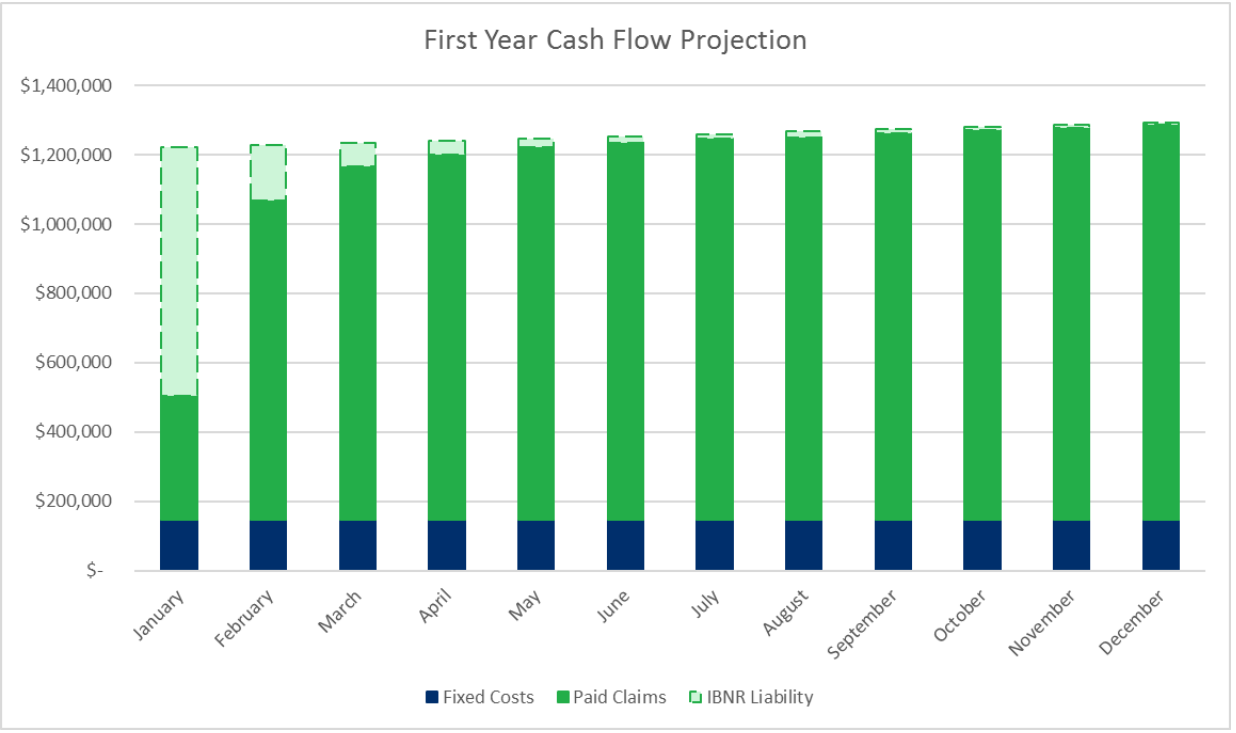
Risk Distribution



	5th Percent	25th Percent	50th Percent	75th Percent	95th Percent
Expected Annual Cost	$13,472,000	$14,380,000	$15,011,000	$15,642,000	$16,550,000
Expected Loss Ratio	90%	96%	100%	104%	110%

First Year Cash Flows

Cash Flow Advantage but IBNR Liability Established



- Self-funded plan only responsible for claims "incurred" January 1st or later. Due to claim lag, the cash outlay through the self-funded plan is lower in the early months as the claims incurred in first year mature
- The first year cash flow advantage is projected to be $1.1M
- There is a corresponding Incurred But Not Reported liability (IBNR) of approximately the same amount that is typically reflected on the Balance Sheet.
- Lockton Actuarial group will update the liability calculation on a regular basis.

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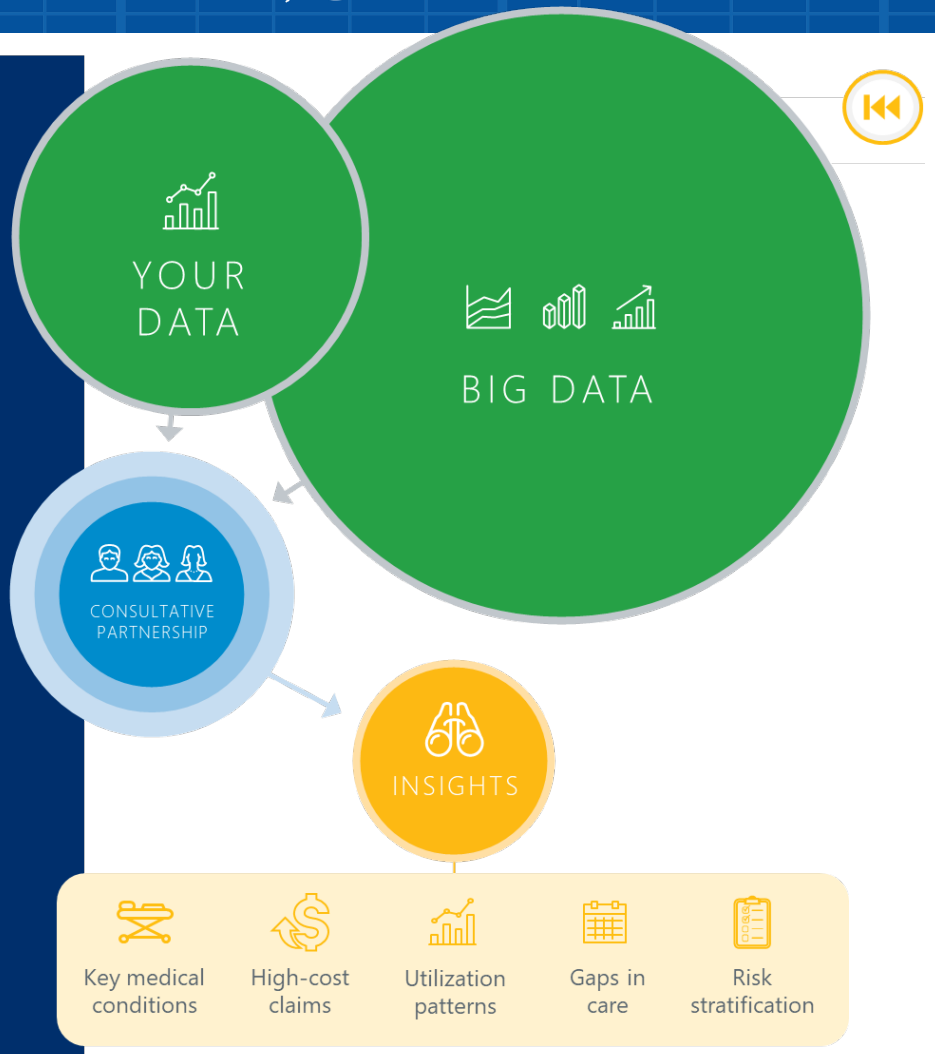
Action through insight

The big picture.

- Collect data from multiple, disparate sources.
- Transform and enrich data to make it meaningful.
- Skilled clinical experts to develop targeted solutions.
- Measure program performance on an ongoing basis.



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What is happening?

STEP 1

Know your population.

STEP 2

Determine what's driving trends.

STEP 3

Assess how population accesses and uses healthcare services.

STEP 4

Identify sickest patients; determine how to design the best program.

STEP 5

Identify care gaps that, when closed, could lead to fewer emergency room visits and inpatient admissions.

STEP 6

Together with you, consider your business objectives and design a comprehensive plan involving both population-level and individual-level health management solutions.

STEP 7

Measure and adjust, as needed.

Is what we are doing working?

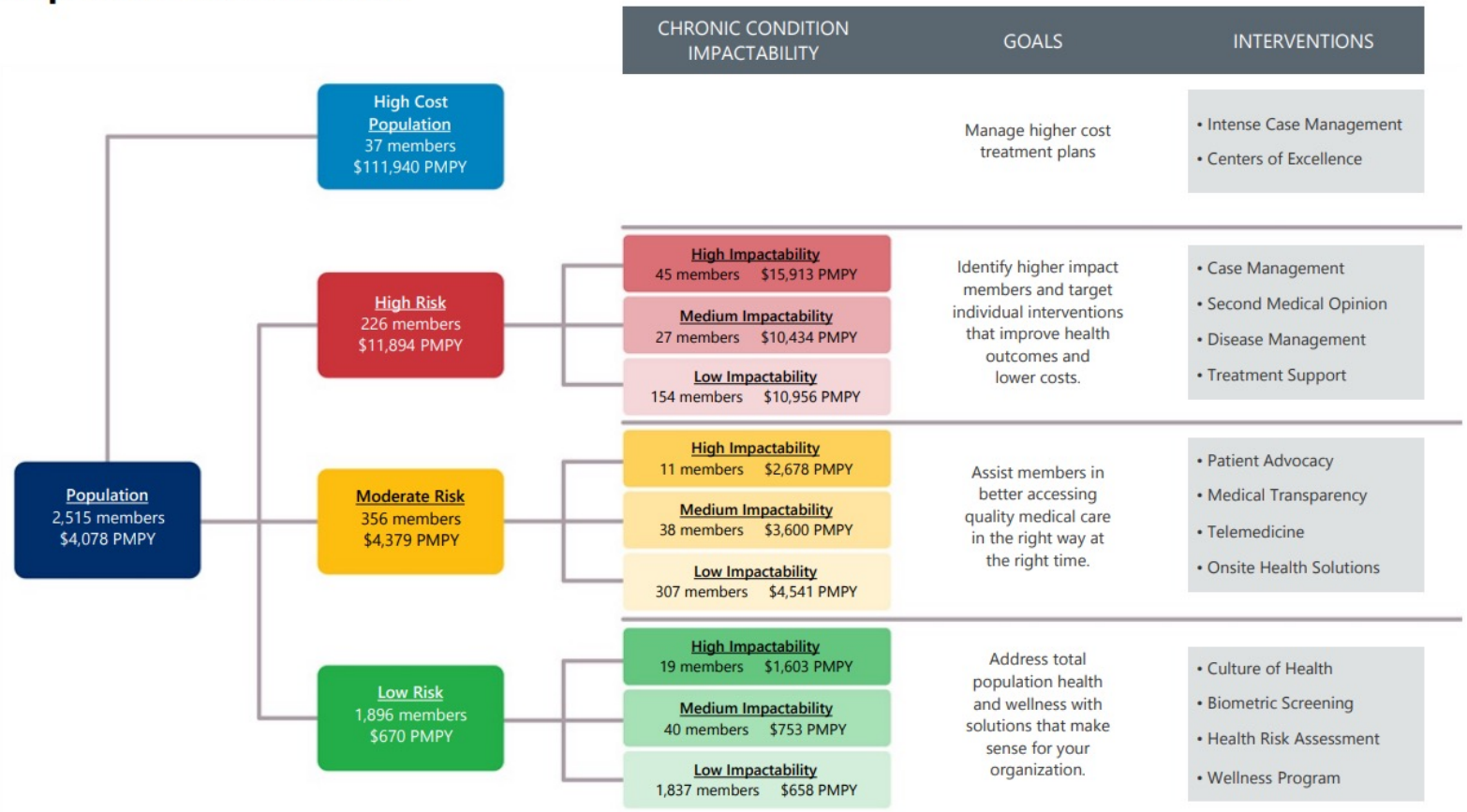
What should we do about it?

Strategy

Risk Stratification

infolock

Population Stratification



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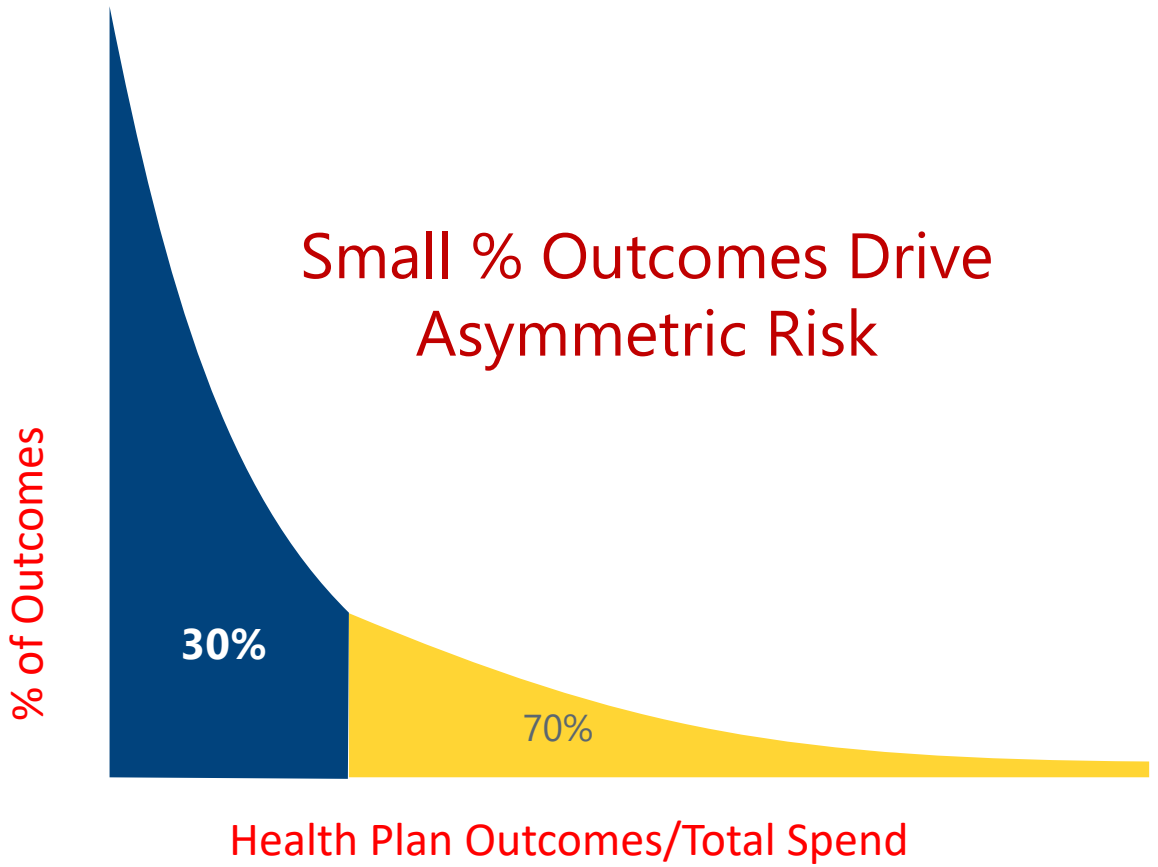
	Location A	Location B	Location C	Location D	Location E	Location F	Location G	Client Total	Book of Business
Number of Employer Groups	1	1	1	1	1	1	1	1	591
Number of Current Members	1,650	788	577	494	478	293	264	4,541	2,078,239
Members with Claim Activity	82.8%	82.4%	79.0%	81.2%	84.3%	76.8%	92.0%	82.4%	81.9%
Group High Cost Claimant % of Total Paid	57.4%	42.3%	43.2%	36.7%	22.0%	19.2%	62.1%	49.9%	33.7%
Paid Total PMPM	$645.61	$413.34	$310.85	$274.82	$381.12	$367.77	$555.54	$470.25	$406.27
Paid Medical PMPM	$536.00	$309.00	$225.85	$217.40	$295.85	$306.41	$291.30	$366.85	$316.59
> Inpatient Medical PMPM	$127.80	$74.67	$69.62	$88.84	$66.34	$156.47	$84.17	$97.89	$99.32
> Outpatient Medical PMPM	$246.72	$140.70	$65.32	$36.64	$146.98	$30.40	$63.90	$148.07	$108.86
> Office Medical PMPM	$125.47	$66.30	$50.74	$73.28	$59.39	$68.85	$74.03	$85.55	$63.75
> ER Medical PMPM	$32.43	$19.64	$35.11	$16.12	$21.82	$26.01	$9.77	$26.42	$27.89
> Others Medical PMPM	$3.58	$7.68	$5.07	$2.52	$1.32	$24.69	$59.43	$8.91	$16.76
Paid Rx PMPM	$109.61	$104.34	$85.00	$57.42	$85.27	$61.35	$264.24	$103.40	$89.68
Allowed Total PMPM	$722.09	$487.71	$369.04	$336.48	$452.76	$428.54	$650.79	$542.09	$483.56
Allowed Medical PMPM	$603.01	$369.92	$275.17	$268.96	$355.05	$358.07	$364.27	$427.47	$379.65
Allowed Rx PMPM	$119.08	$117.80	$93.88	$67.52	$97.71	$70.47	$286.52	$114.62	$103.90

Below BoB Norm — Above BoB Norm

Reality in the "Thin Tail" or Pareto World



The Employer Sponsored Health Plan "Black Swan"?

What we thought we knew, we didn't. Worse, we now think we knew!

Study Overview

Study Abstract

- COVID-19 significantly impacted the financial performance of self-funded medical plans. This study reviews recent claims experience across a large group of employers in order to quantify and identify the drivers of the impact.

Overall Plan Impact

- Each medical and prescription drug claims expense has deviated from actuarially established normative expectations:
- Med+Rx: **down 5.4%** = 4.4% of annual claims **/** Med Only: **down 8.4%** = 5.5% of annual claims **/** Rx Only: **up 6.0%** = 1.0% of annual claims

  Figures are based on plan paid claims compared to Actuarial Normative Expectation. Rx figured do not include rebates.

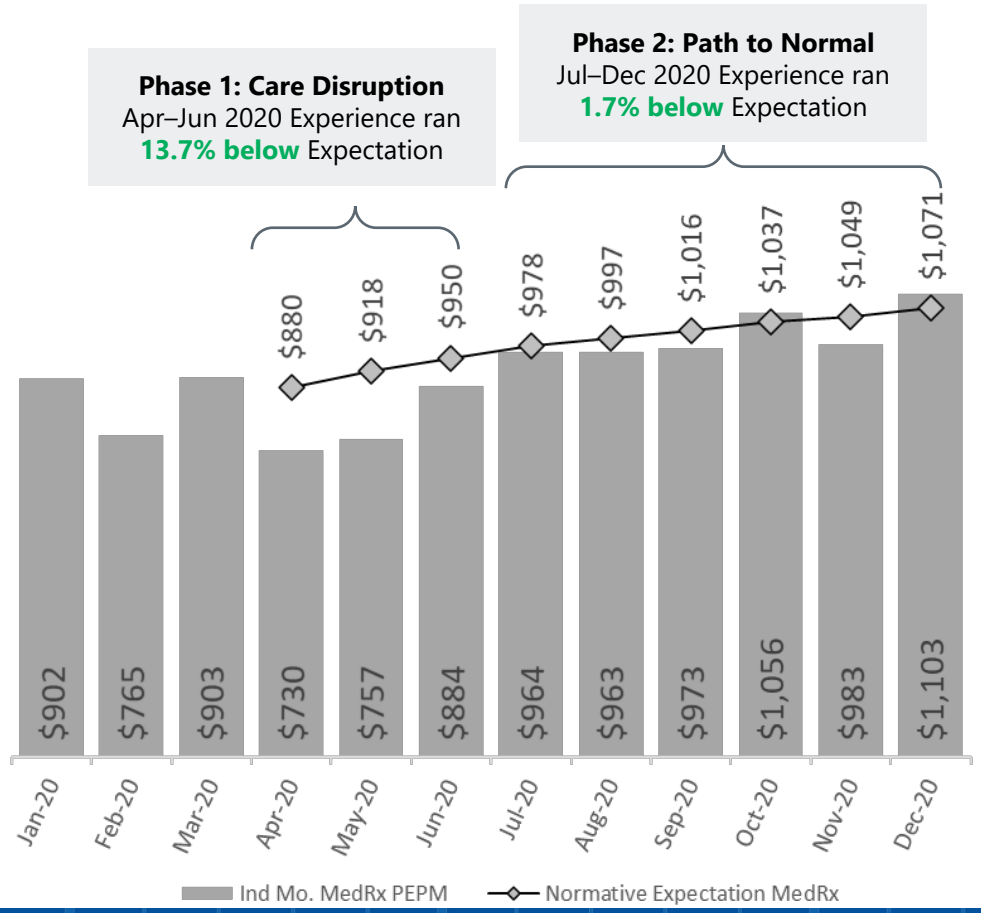
- Claims decreases significant between April and June, then reverted toward but did not exceed normative expectation between July and December
- Enrollment is **down 6.8%** from January to December 2020 but stabilized September through December

Identified Trend Drivers

- Outpatient Surgeries explain most of the observed decrease and have not yet rebounded to or above expected
- Rebound in claims since June is attributed to office visits for COVID specific diagnoses
- High Rx trends are observed over longer-term-trends expected to be mitigated by growing rebates not captured in this study.

Study Group Profiles	Financial Reporting	Data Warehouse
Purpose	Overall Financial Performance	Trend Driver Exploration
Plans	100	39
2019 Avg. Enrollment	236k Employees	401k Members
2019 Med+Rx Claims Spend	$2.6B Paid	$2.1B Allowed
Data Period	Apr – Dec 2020 Paid Months	Apr – Nov 2020 Paid Months

Lockton COVID-19 Study



Group Profile

- **100 Employers**
  - Min: 604, Max: 15,000
- Total Enrolled EEs: 252,000
- Total Plan Med + Rx claims: $2.7B

Results

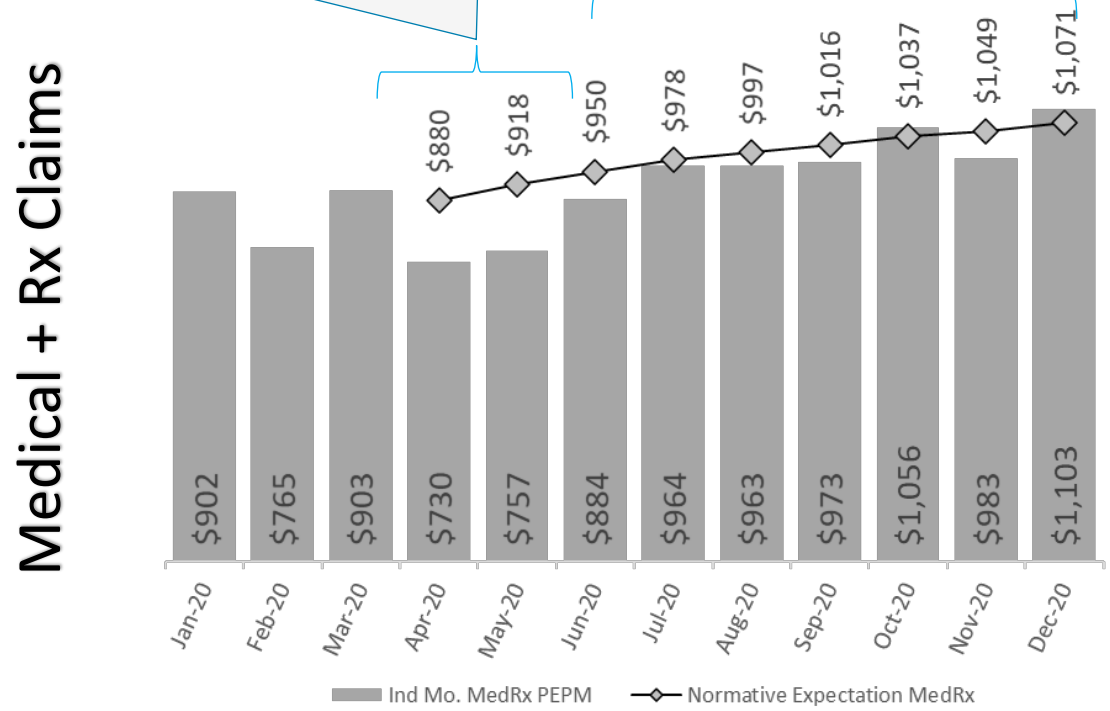
- Med & Rx: **Down 5.4%** **(April to December)**
- Med: **Down 8.4%**
- Rx: **Up 6.0%**
- Enrollment: Down 6.8% from January to December 2020
- Surgeries account for 54% of decreased med claims
- Lockton expects 50 – 60% of the decreased claims to return to the plan over the next 12 months

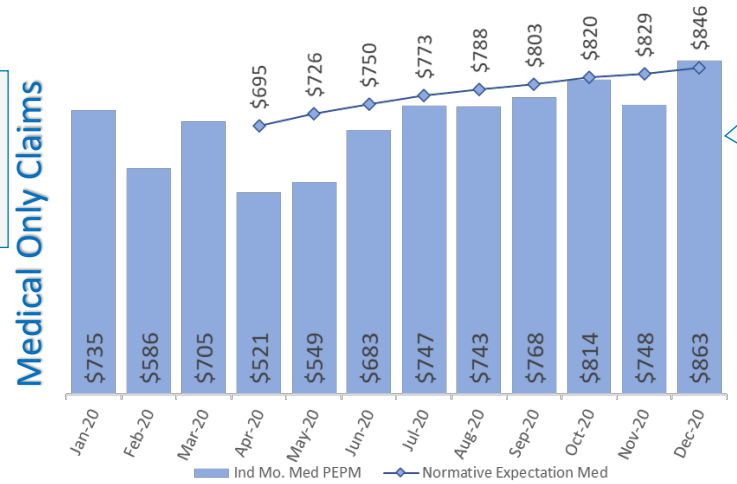
Note: Figures are compared to Actuarial Normative Expectation

Experience Overview

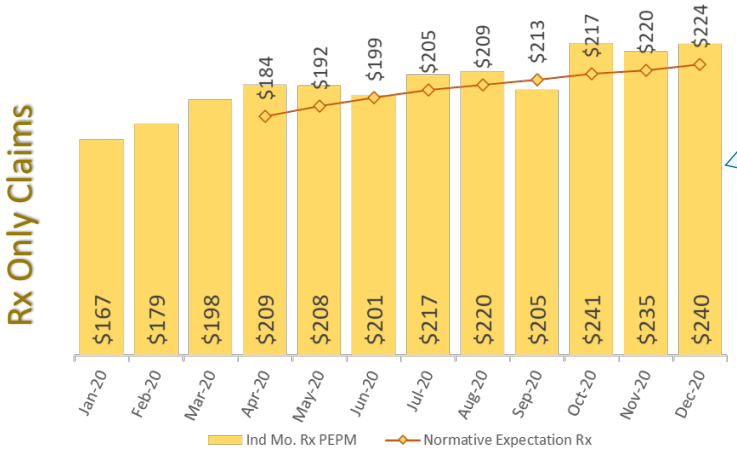
Phase 1: Care Disruption
Apr-Jun 2020 Experience ran **13.7% below** Expectation = 3.5% of annual claims

Phase 2: Path to Normal
Jul-Dec 2020 Experience ran **1.7% below** Expectation
= 1.0% of annual claims





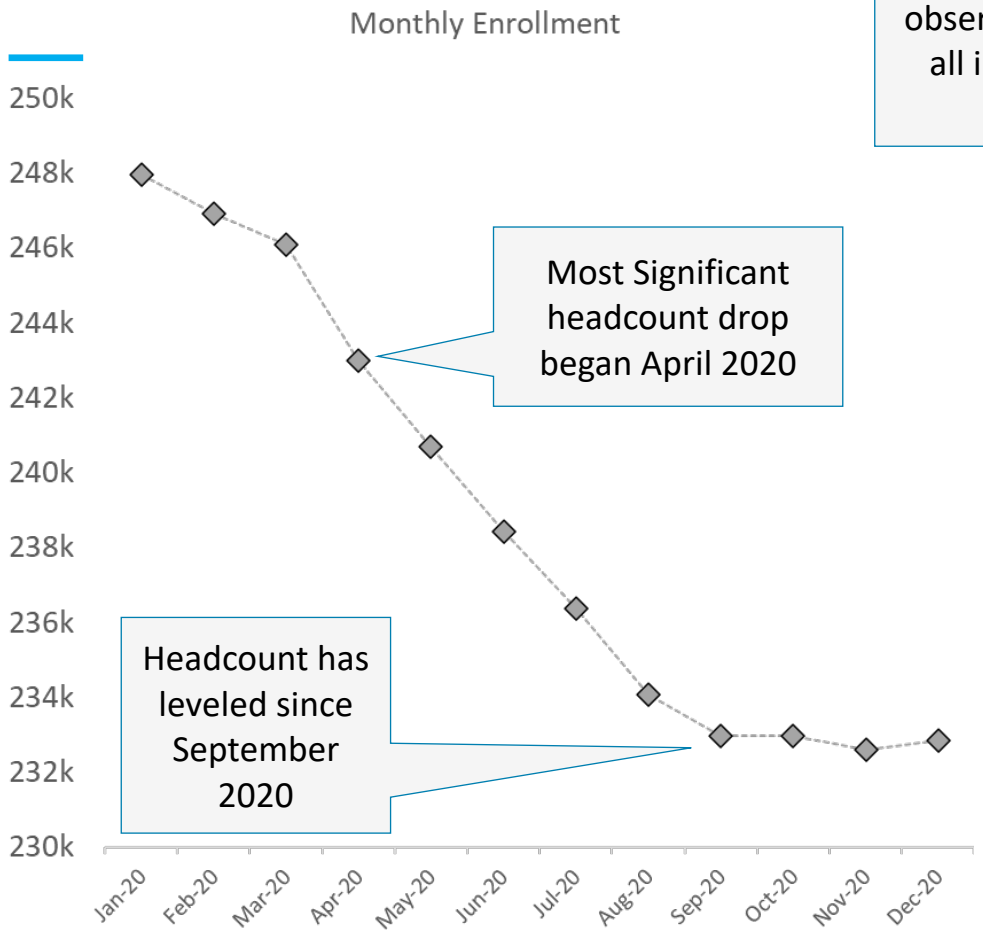
Medical Only
- Phase 1: 19.3% below
- Phase 2: 3.6% below



Rx Only
- Phase 1: 7.4% above
- Phase 2: 5.3% above

Note: Rx claims do not include Rebates

Plan Enrollment



Most Significant headcount drop began April 2020

Headcount has leveled since September 2020

Decreases are observed across all industries

Industry	Employers	Jan 2020	Dec 2020	% Change
Other (Retail, Tech, etc.)	33	67,398	58,008	-13.9%
Professional Services	27	52,528	49,907	-5.0%
Construction / Manufacturing	22	49,067	46,627	-5.0%
Healthcare	17	75,097	73,064	-2.7%
TOTAL		**244,090**	**227,606**	**-6.8%**

Most Significant decreases are observed in Energy

Sub Industry	Employers	Jan 2020	Dec 2020	% Change
Energy	4	8,063	5,978	-25.9%
Other	19	32,618	27,135	-16.8%
Food/Beverage	5	4,720	4,052	-14.2%
Engineering	3	7,758	7,109	-8.4%
Retail	2	14,239	13,734	-3.5%
Total	**33**	**67,398**	**58,008**	**-13.9%**

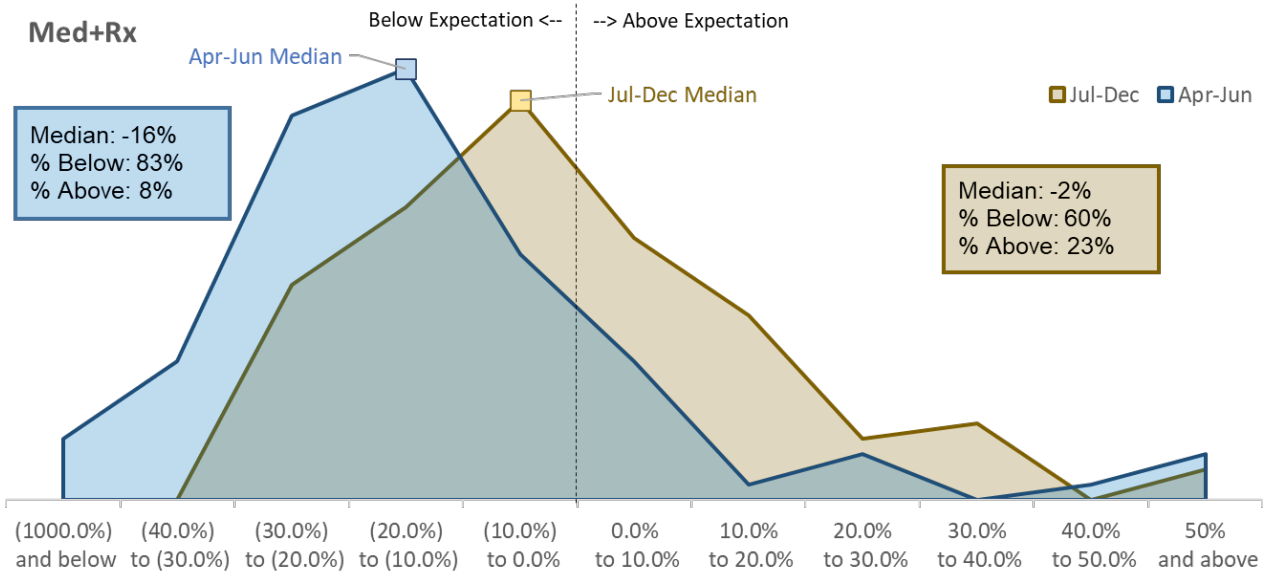
Distribution of Plan Experience

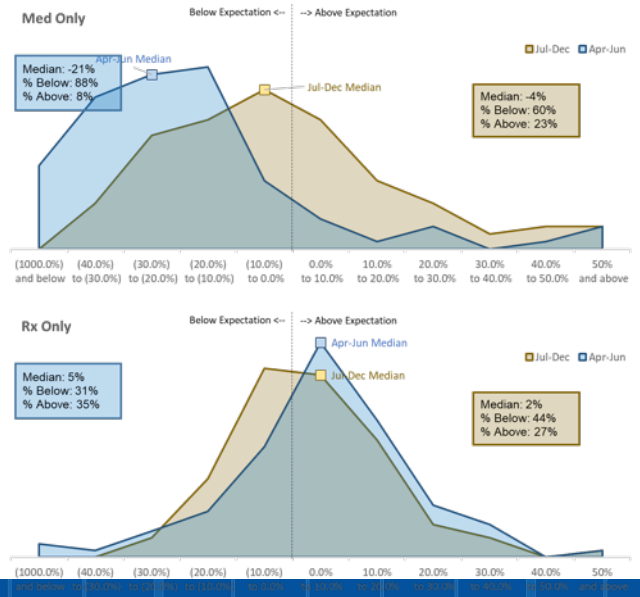
	Apr-Jun	Jul-Nov
% of Plans with Below Expectation	83%	60%
% of Plans Significantly* Below Expectation	67%	33%

Note: significance threshold 10% based on observed quarterly standard deviation

Rank	Industry	Count	Apr-Jun	Jul-Nov
1	Healthcare	17	-17.2%	-4.5%
2	Professional Services	27	-15.9%	-5.4%
3	Other (Retail, Tech, etc.)	33	-15.1%	0.1%
4	Construction/Manufacturing	22	-13.8%	1.0%

Note: Rank based on observed drop Apr-Jun 2020

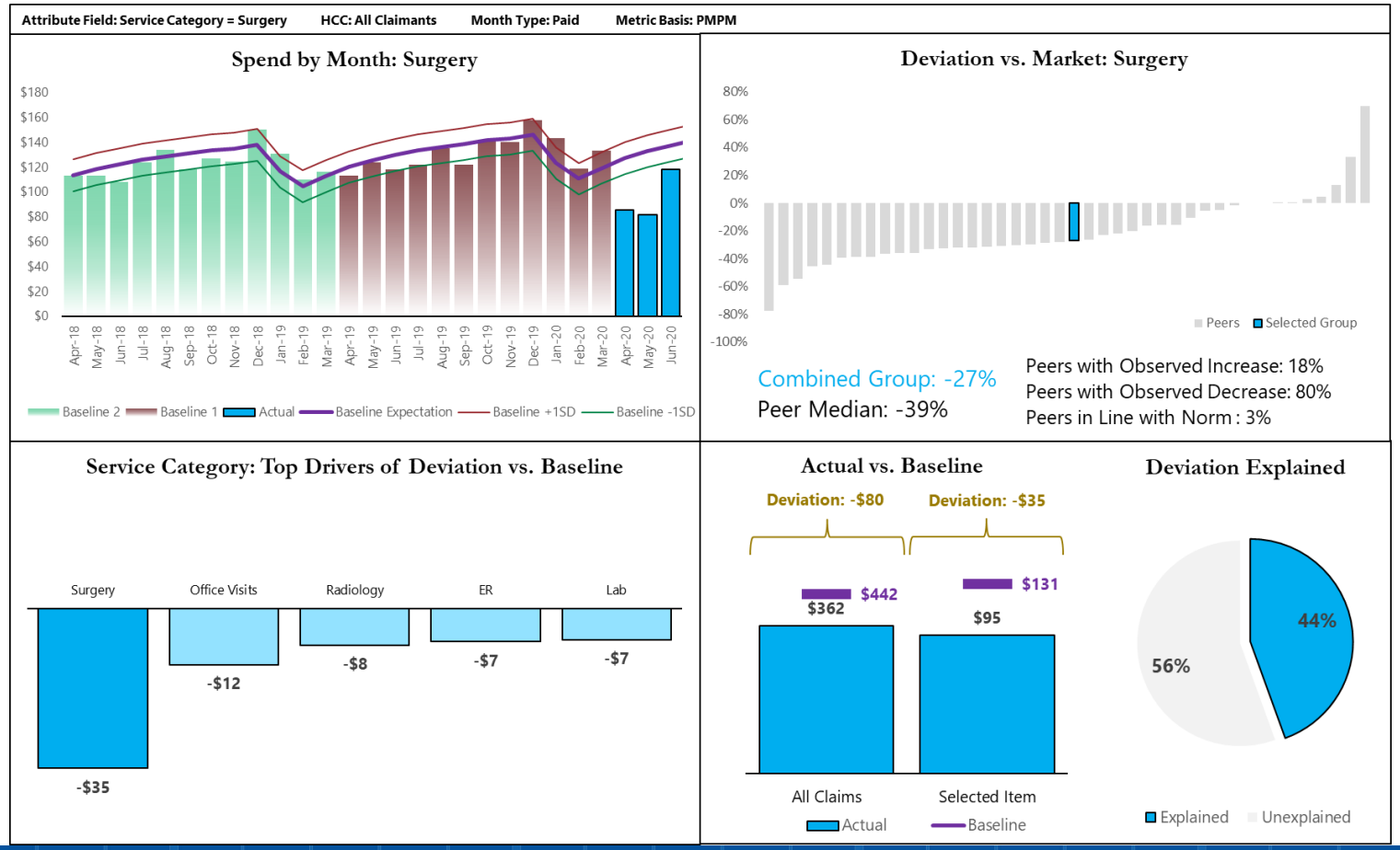




Statistical Screening – Phase 1 (April through June)

Surgical expenses ran within normal variance of baseline until April 2020 and returned within normal variance of baseline by July

Surgeries are the leading driver of deviation amongst service categories



80% of observed plans experienced decreases vs baseline-expectation

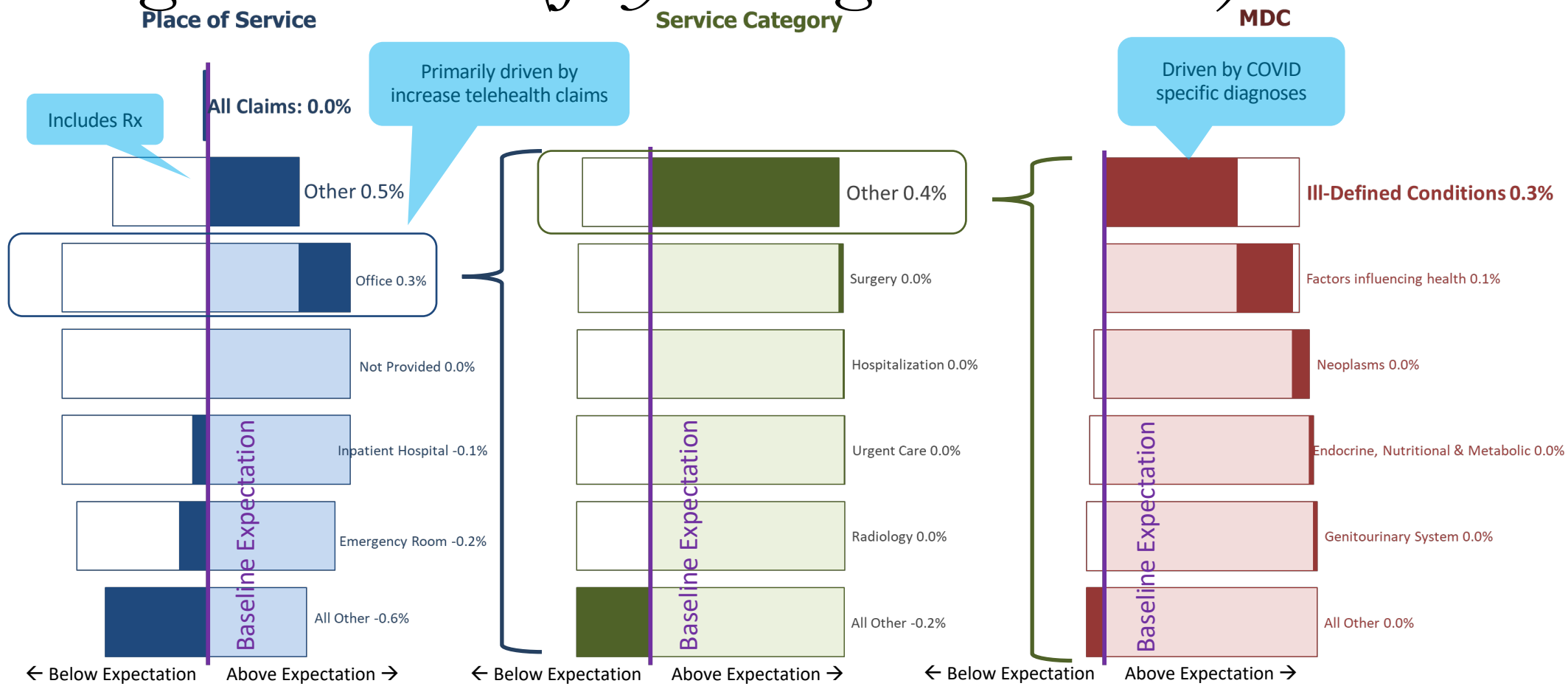
Drop-in surgeries explain 44% of overall observed deviation

Data Mining – Phase 2 (July through November)

Claims rebound has come primarily from office visits for Ill-defined conditions.

Key
Explained
Unexplained

Note: Data values represent deviation vs baseline expresses as a % of annual spend

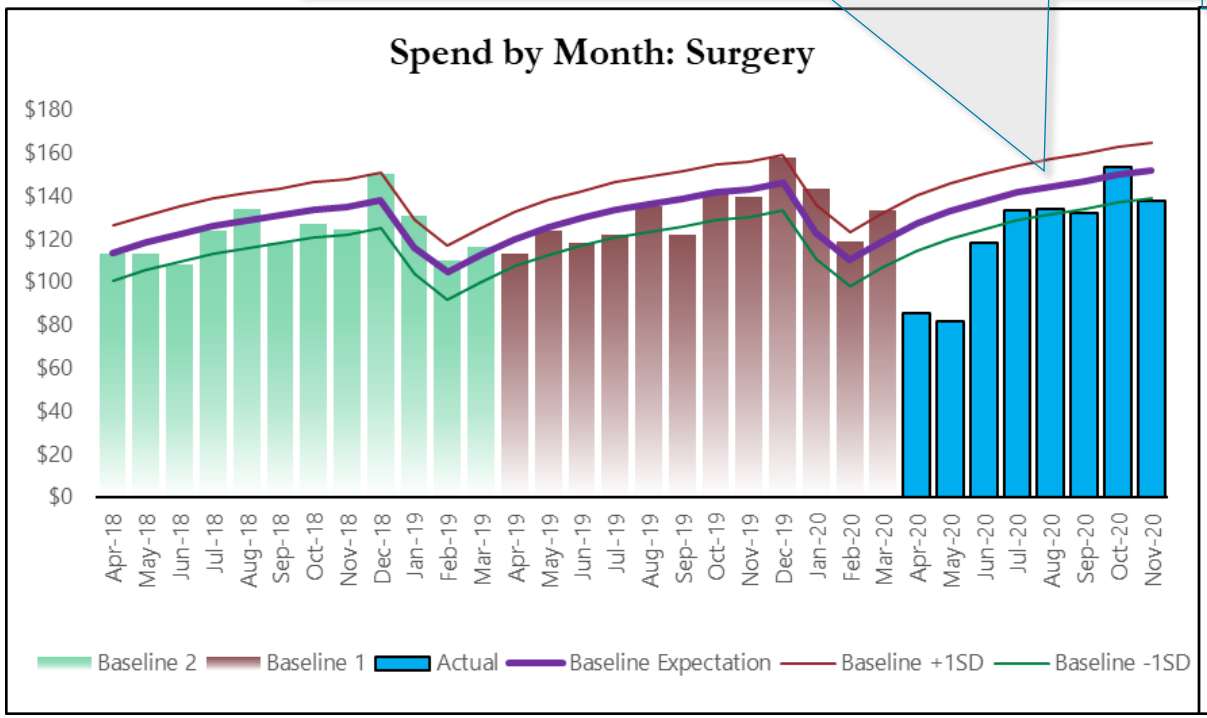


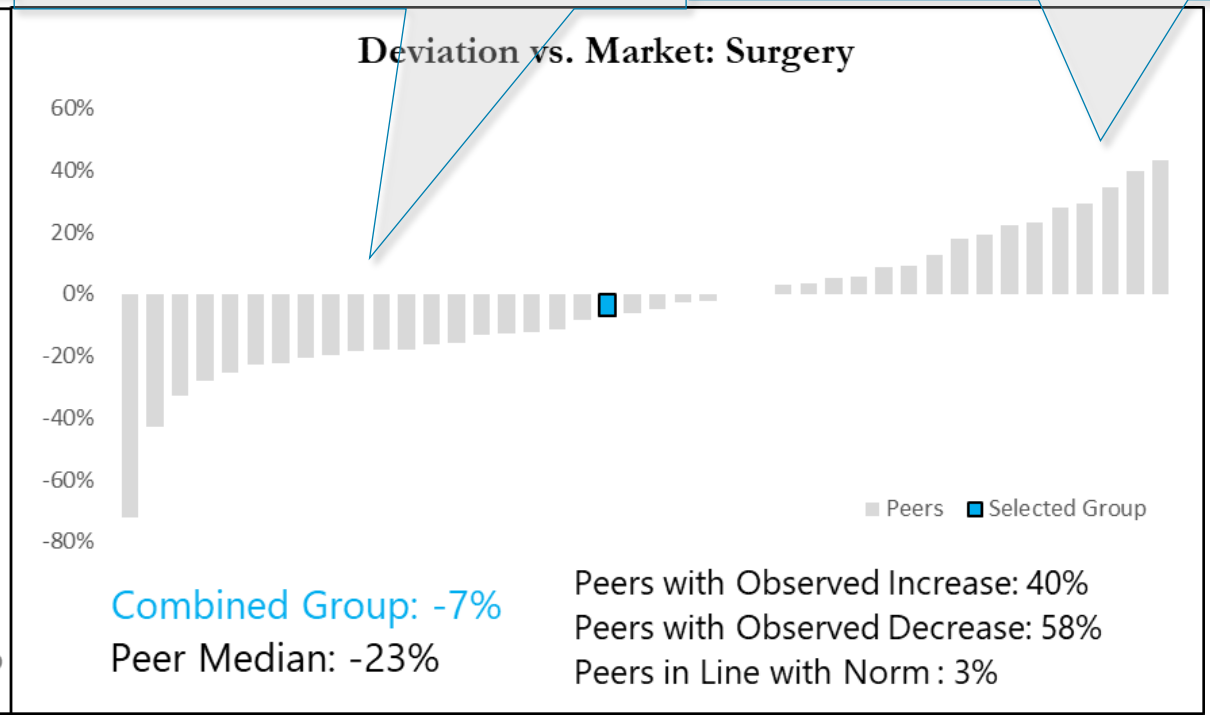
Statistical Screening – Phase 2 (July through November): Surgeries

Surgeries have rebounded toward but have not exceeded expectation

Majority of employers have experienced lower-than-expected surgeries

Some employers have experienced higher-than-expected surgeries





Post "Black Swan" World

Again, we thought we knew…..

Marketplace: Medical Trend Inflators

In a healthcare world that has seen an annual trend of 3-5%1, it's difficult to know exactly how future trend will be impacted by COVID-19

"Traditional" Inflators

- Aging population
- Rising labor costs
- Provider consolidation
- Specialty pharmacy
- Confusion/waste navigating the health system
- Clinical/technological advances
- Uncapped claims

"COVID-19" Inflators

NEW

- Deferred care
- Mental health/substance abuse
- 100% covered testing, treatment and telehealth
- Vaccines

Unit cost increases are sparking the need for change in the system and COVID-19 has magnified some of the opportunities

[1]Lockton trend study, March 2020.

Future Rush Modeling

- Apr – Oct experience deviation below norm equates to 2.8% of annual spend
- 66% of the drop in financial experience is expected to manifest into future claims expense

Service Category	Deviation % of Annual Spend	Expected Future Rush Likelihood	Future Rush % of Annual Spend
Surgery	-1.5%	High	1.1%
Office Visits	-0.6%	Moderate	0.3%
ER	-0.6%	Low	0.2%
Radiology	-0.4%	Low	0.1%
Lab	-0.4%	Moderate	0.2%
All Other	-0.7%	Low	0.0%
TOTAL	**-2.8%**		**1.9%**

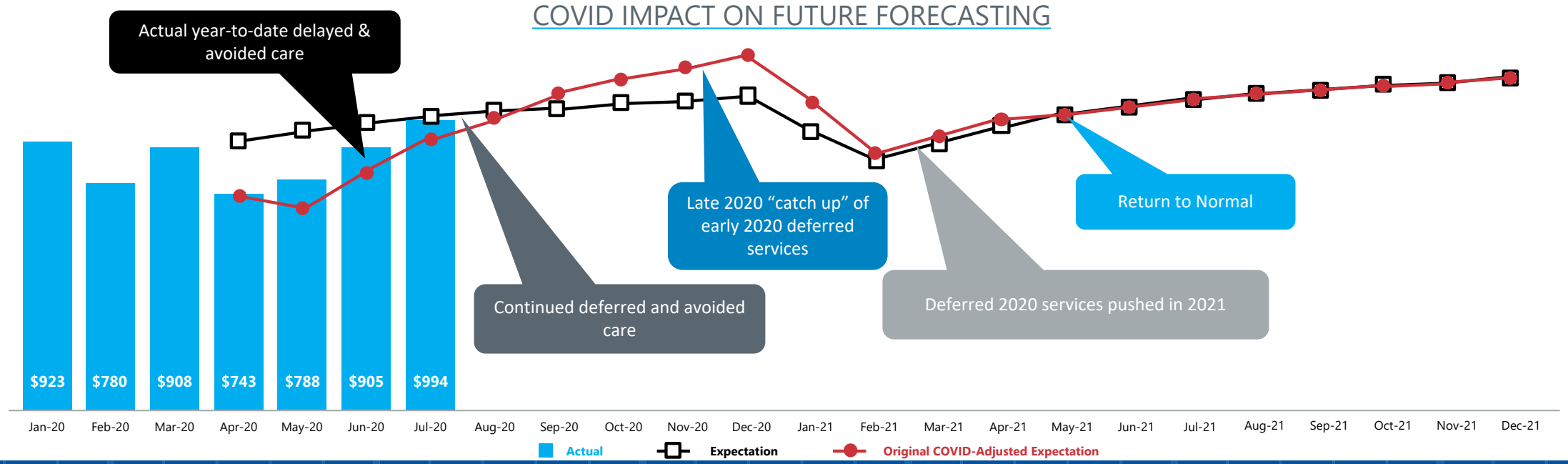
- Drop in surgical spend explains 52% of observed experience decrease. This category has the highest expected likelihood of future rush as delayed services are expected to continue to be need in the future
- The drop-in services like ER Visits are expected to have low likelihood of future claims rush (will largely be avoided care)

Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20
-0.6%	-0.7	-0.3%	-0.1%	-0.1%	-0.2%	0.1%
-0.2%	-0.2%	-0.1%	-0.1%	-0.1%	-0.1%	0.0%
-0.1%	-0.1%	-0.1%	-0.1%	-0.1%	-0.1%	-0.1%
-0.2%	-0.2%	0.0%	0.0%	0.0%	0.0%	0.0%
-0.1%	-0.1%	-0.1%	0.0%	0.0%	-0.1%	0.0%
0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
-1.2%	**-1.4%**	**-0.6%**	**-0.4%**	**-0.4%**	**-0.5%**	**-0.2%**

Forecasting

- Emerging Experience has supported Lockton's initially established COVID-19 forecasting
- Revising original estimates for emerging data would remove 1.1% from 2021 forecasting

	% of Annual Claims	
Year	**Original**	**Revised**
2020	-3.0%	-2.1%
2021	+1.5%	+0.4%



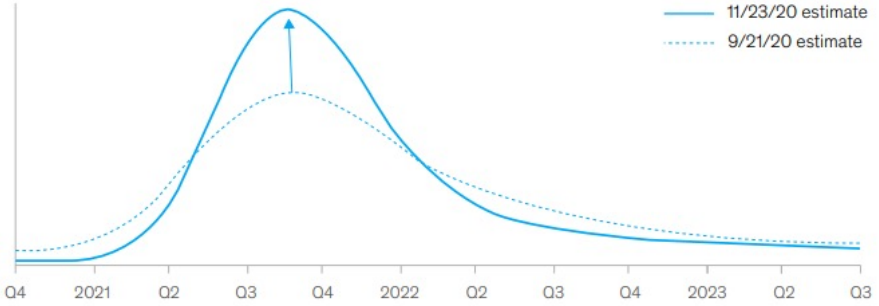
The End is Near(er)

- Current estimate is that herd immunity will be achieved by Q3/Q4 2021
- Variables
  - No safety issues
  - No supply chain issues
  - Vaccine acceptance rate
  - Long immunity duration
  - Meaningful natural immunity
  - Transmission prevention

Exhibit 1

Main effect of recent news is to increase confidence in Q3–Q4 2021 as most likely timeline to achieve herd immunity.

Probability of functional end[1] to COVID-19 pandemic in US[2] by quarter (illustrative)



Early herd immunity if:

- Vaccine rollout and adoption is faster than expected
- Natural immunity is significantly higher than realized

Peak probability of herd immunity (Q3/Q4 2021) driven by:

- Emergency use authorization (EUA) of 1+ candidates in Dec 2020/Jan 2021
- Biologic license application (BLA) (with full approval by March/April 2021)
- Approximately 6 months for manufacturing, distribution and sufficient adoption to reach herd immunity

Later herd immunity if one or more of the following occur:

- Safety issues delay EUA and/or BLA
- Manufacturing/supply chain issues slow rollout
- Adoption is slower than anticipated
- Duration of immunity is short
- Vaccine prevents disease progression but does not meaningfully reduce transmission

[1]A functional end to the epidemic is defined as reaching a point where significant, ongoing public-health measures are not needed to prohibit future spikes in disease and mortality (this might be achieved while there are still a number of people in particular communities who still have the disease, as is the case with measles).
[2]Timeline to functional end is likely to vary somewhat based on geography.
Source: Information compiled from a variety of public statements and sources (ie, *Atlantic*; CDC; Cell [June 2020]; FDA; MedRxiv; *Nature; Nature Reviews* [August 2020, July 2020]; *NY Magazine; Oxford Academic; PNAS; Science; Science Advances; Science Immunology* [June 2020]; WHO); interviews with relevant experts; and surveys conducted by McKinsey and others

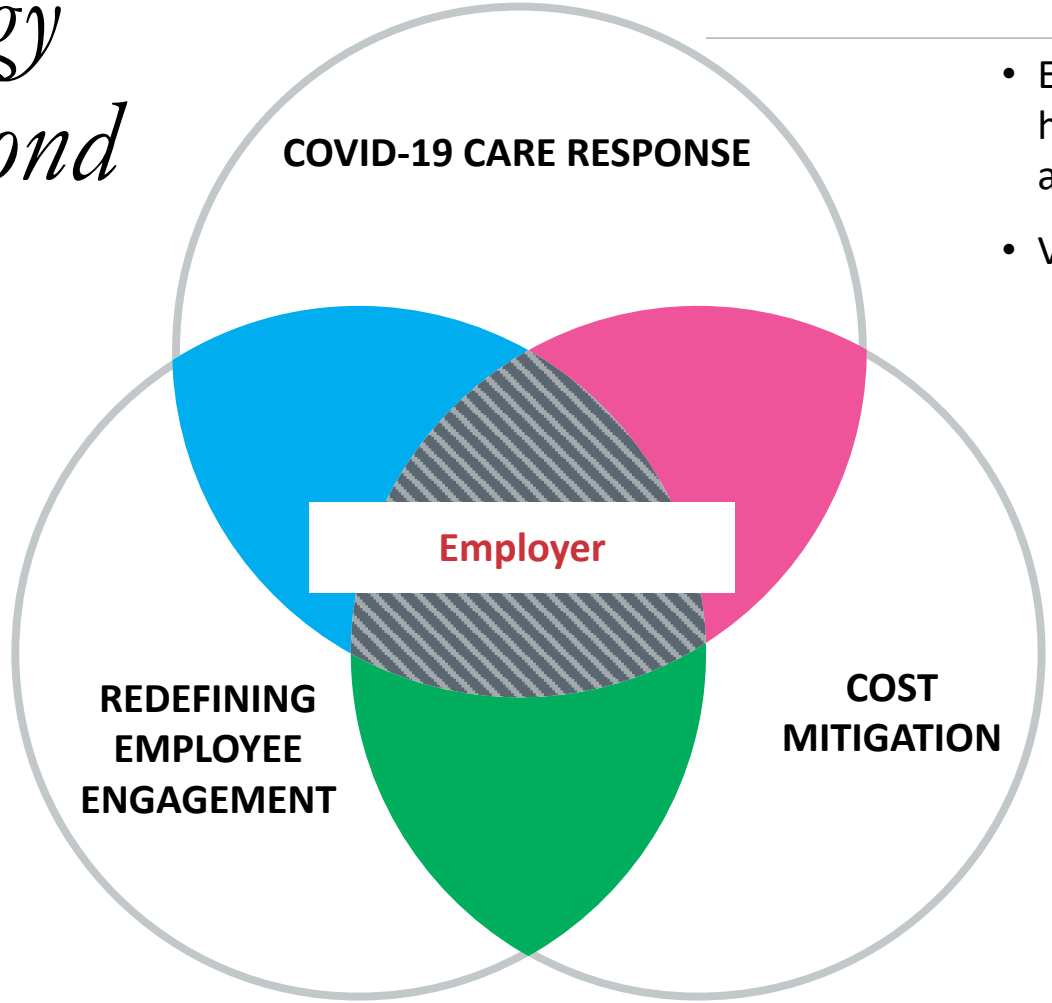
[1] "Pfizer and BioNTech conclude Phase 3 study of COVID-19 vaccine candidate, meeting all primary efficacy endpoints," Pfizer, November 18, 2020, pfizer.com.
[2] "Moderna's COVID-19 vaccine candidate meets its primary efficacy endpoint in the first interim analysis of the Phase 3 COVE study," Moderna, November 16, 2020, modernatx.com.

McKinsey & Company. When will the COVID-19 pandemic end? An update. Nov 23, 2020

Post "Black Swan" World

What does it mean for the future state?

Re-Think Strategy for 2021 & Beyond



- Emotional well-being/mental health and financial well-being awareness
- Virtual care and telemedicine

- Navigation
- Personalized healthcare technology
- Work perks evolution

- Alternative network solutions
- High-cost claimants clinical expertise
- Expanded PBM pricing and clinical options

COVID-19 Telemedicine

infolock

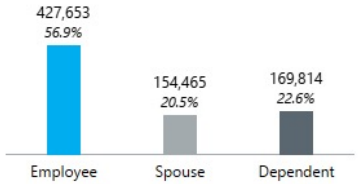
Demographics

702,874
93.5%

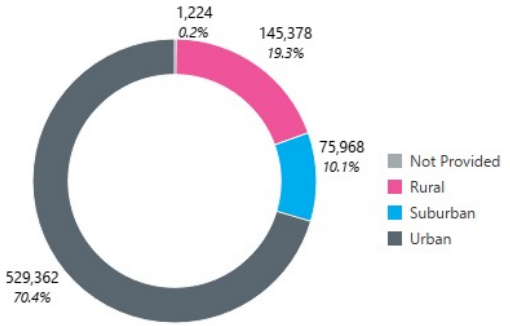
First Time Telemedicine Users

First time telemedicine users is defined as anyone with no telemedicine claim from 1/1/2018 - 2/28/2020.

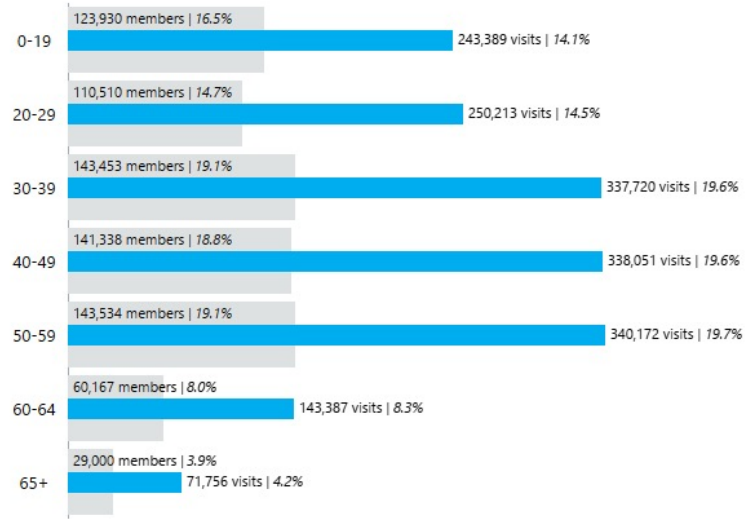
MEMBERS BY RELATIONSHIP



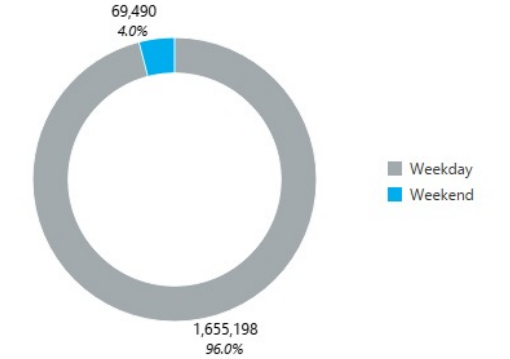
MEMBERS BY MSA CLASSIFICATION



MEMBERS AND VISITS BY AGE GROUP



VISITS BY WEEKEND VS WEEKDAY



Time Period
After 3/1/2020

COVID-19 Telemedicine

Dx Categories

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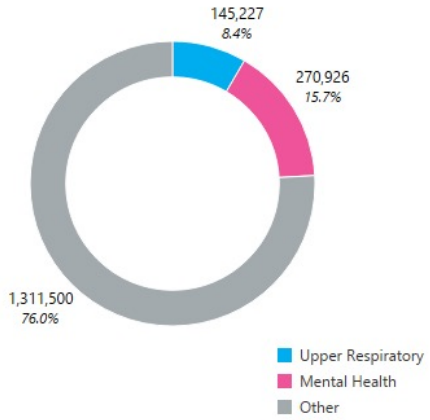
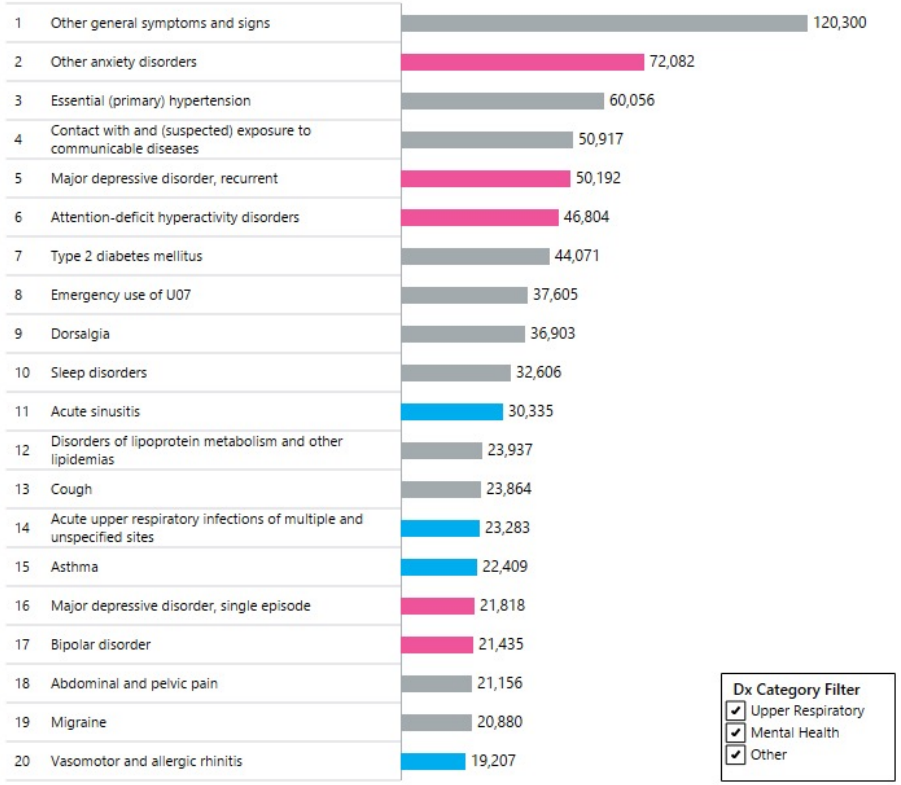
VISITS BY DIAGNOSIS CATEGORY



TOP 20 TELEMEDICINE DIAGNOSIS BY VISITS



TELEMEDICINE DIAGNOSES

Prior to COVID-19, upper respiratory symptoms such as asthma, allergies, sinusitis, etc. were some of the most frequent diagnoses for telemedicine visits. During COVID-19, visits for COVID like illnesses, chronic illness management, and mental health have increased.

Some of the most common diagnoses potentially related to COVID include cough, shortness of breath, fever, and suspected exposure to disease.

Dx Category Filter
- ☑ Upper Respiratory
- ☑ Mental Health
- ☑ Other

Time Period
After 3/1/2020

CONSTRUCTION FINANCIAL MANAGEMENT ASSOCIATION

THE PURSUIT OF CURIOSITY

The Evolution of Wellbeing in the Workplace

Comprehensive Wellbeing:

- Sam's Needs
- Joe's Needs
- Mary's Needs

Total Rewards

ABC Company

GENERATIONAL NEEDS COMPARISON

SAM

- Age 25
- New to Workforce
- Married
- No Children
- Student Debt

WHAT SAM WANTS:

- Mentoring
- Gym Reimbursement
- Flexible Work Arrangements
- Tuition Reimbursement
- Financial Education
- Mental Health Support
- Frequent Feedback on Performance

JOE

- Age 45
- 20 Years in the Workforce
- Single
- Has Three Children
- Wants to Save for Retirement

WHAT JOE WANTS:

- Financial Security
- Desire to Mentor
- Community Board Involvement
- 529 College Savings Account
- Remote Work Arrangements
- Family Care Resources
- Virtual Healthcare Access

MARY

- Age 58
- 32 Years in the Workforce
- Has Two Grandchildren
- Looking Towards Retirement and Time with Grandchildren

WHAT MARY WANTS:

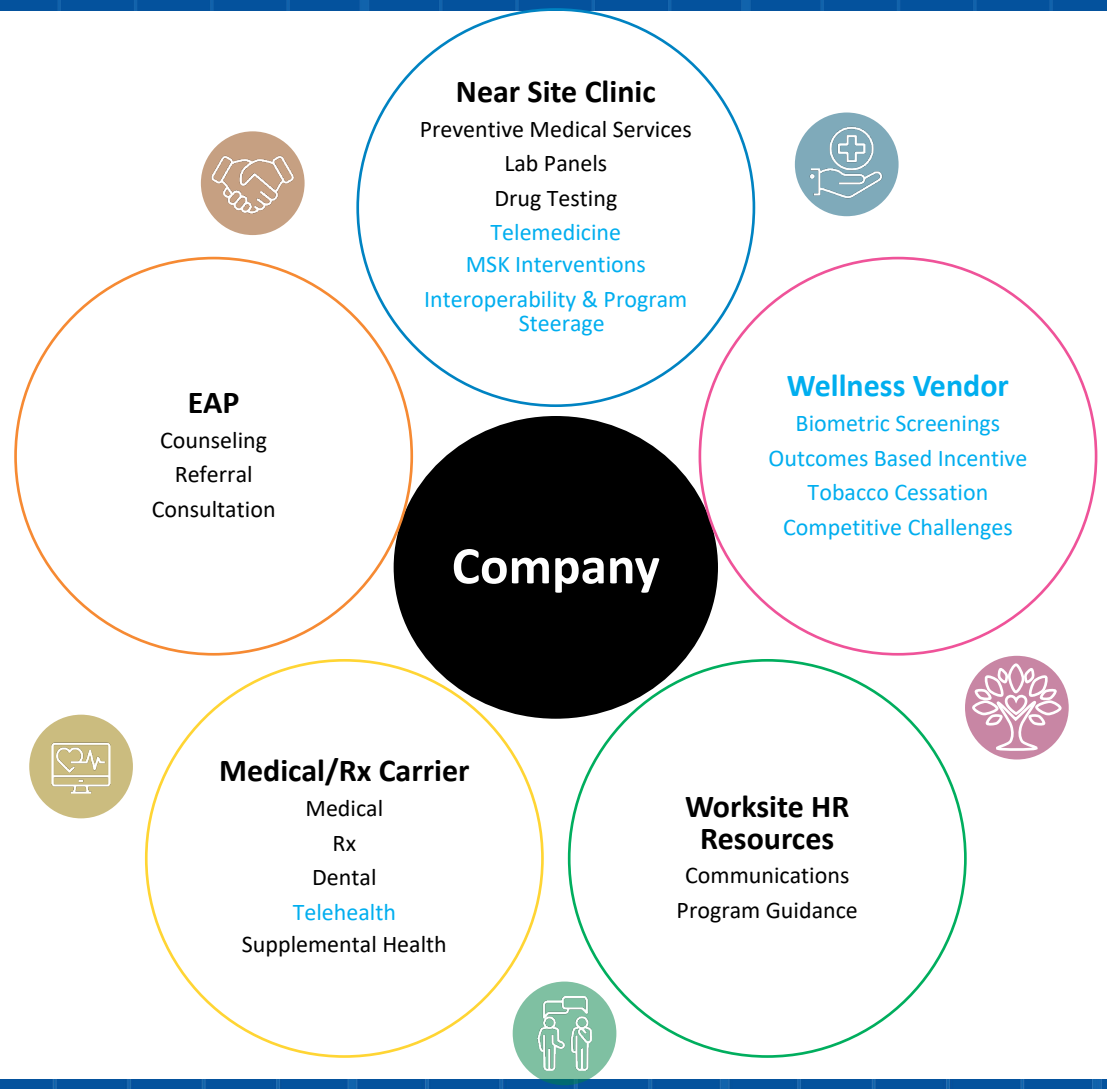
- Estate Planning
- Voluntary Benefits
- Pre-Retirement Counseling
- Wellness Screenings
- Modified Work Schedule
- Peer Support
- Personalized Healthcare Access

A Blueprint for Success

Ecosystem Approach

From Siloed Point Solutions to Synergistic Ecosystem Approach

- Use data to understand population health needs and determinants for the purpose of tailoring benefits strategy to population
- Take an inventory of all benefits, their purpose, population engagement, areas of program overlap and gaps
- Map employee and health plan member scenarios through the benefits, identify engagement barriers and disconnects, create an ecosystem strategy to simplify and improve the member experience
- Wrap with communication, engagement, incentive and pre-certification strategy
- Allows for valuable integration via referral and cross promotion of other benefits offered. Maximizes the value of the overall benefits strategy



High-cost Claimants

The impact of high-cost medical & Rx claims

The stop-loss industry is navigating the impact of COVID-19, specialty pharmacy and multi-million-dollar treatments like gene therapy:

Markets Continue to Harden

- Gene therapy treatments can cost between $2-$3M with a number of treatments in the pipeline seeking FDA approval
- COVID-19 claims have a wide range of cost and severity, with potential costly ICU stays and treatments.

Carrier Reactions

- Tightening up medical plan documents to address gene therapy coverage
- Documenting workforce changes (e.g., layoffs, furloughs) with their stop-loss carrier to ensure no claims reimbursement issues
- Evaluating their specific deductible threshold and aggregate stop-loss in light of changes to their headcount and appetite for risk

Employer Responses

- Programs are emerging to help mitigate the risk of costly gene therapy treatments
- 20% annual trend: Carriers are expecting to see higher catastrophic claim costs in 2021 partially due to COVID-19
- An increase in the number of inpatient admits due to COVID-19 is expected to drive aggregate stop-loss premium increases.

CONSTRUCTION FINANCIAL MANAGEMENT ASSOCIATION

THE PURSUIT OF CURIOSITY

What are Captives?

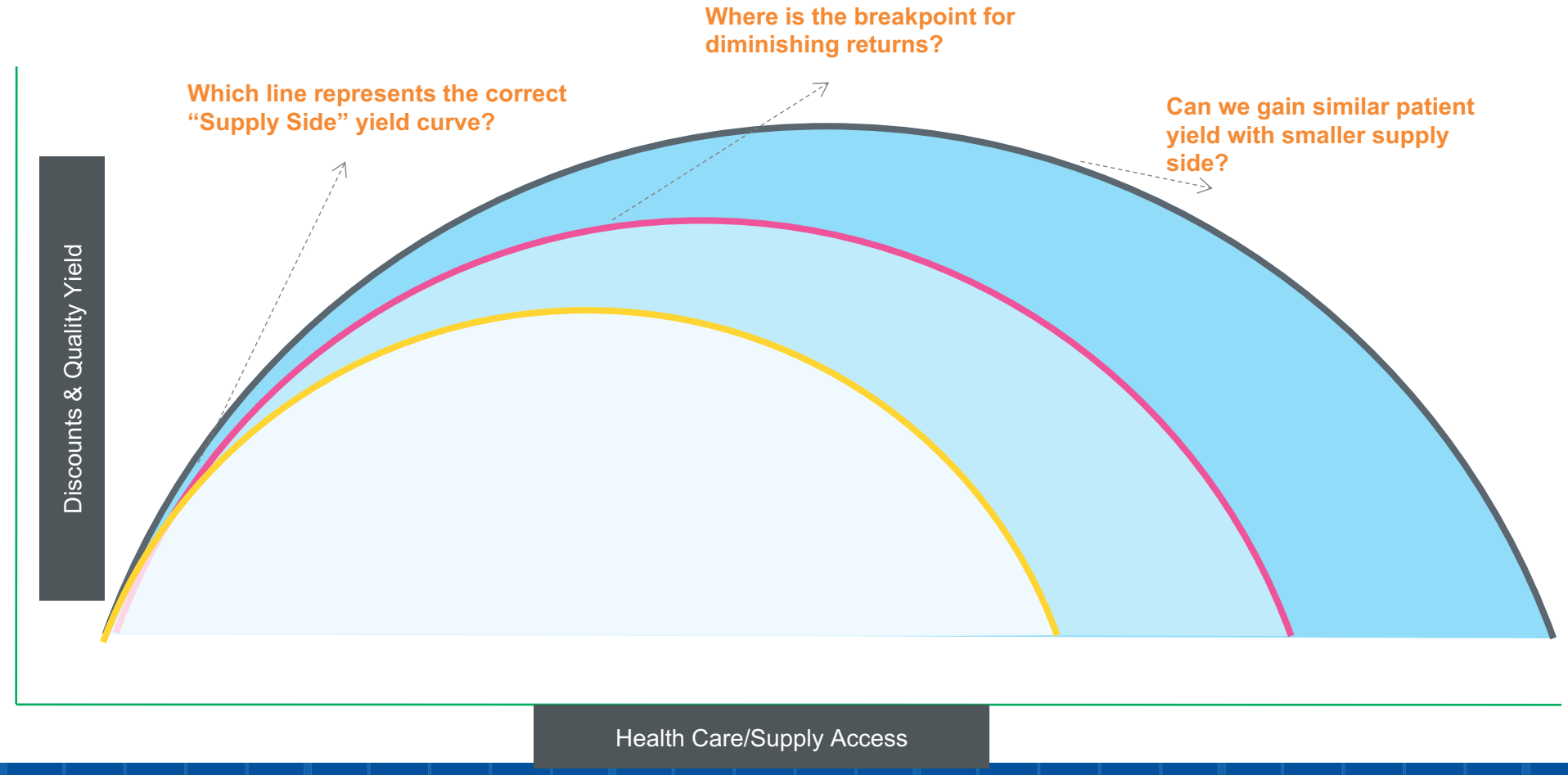
Captives are a member-based benefits solution that lets you experience the key advantages of a self-funded plan while sharing the risk with other members. This program will facilitate transparency of claims and impact long-term cost drivers by combining self-insurance and other key services and analytics.

Program Design Environment

	Member-owned with Centralized management.	Complete autonomy on plan design, including deductibles and co-pays.	Choice of third-party administrator (TPA) with select preferred rates.	Access to high-cost clinical claims consulting.
Fully Insured	Carrier-driven pricing with higher margins	Lack of claims transparency	Carrier-driven pooling levels and charges	
Captives	Reduced margins and less volatility with group purchasing	Claims transparency	Ability to share in stop-loss profitability	
Self-Funded	Reduced fixed costs and increased volatility year over year	Claims transparency	Profits retained by stop-loss carrier	

A Blueprint for Success

What the Future May Hold: PPO Network



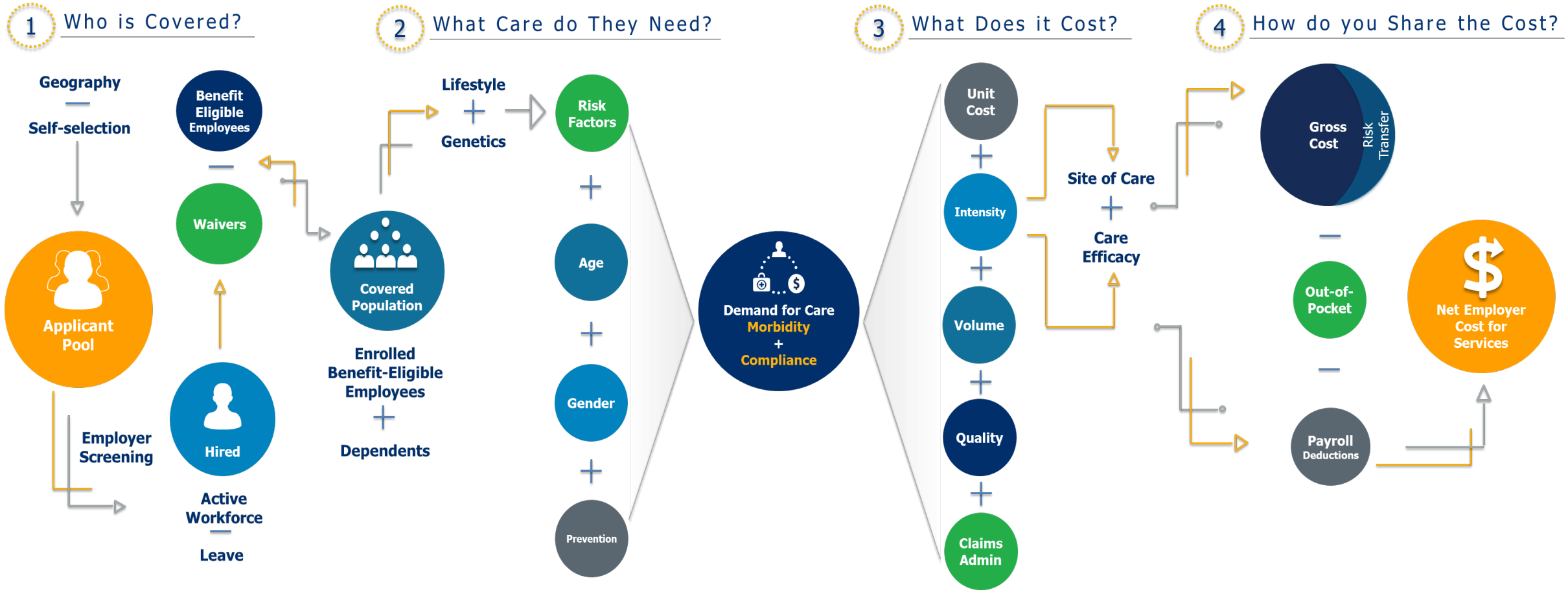
Strategic Direction & Positioning

Designing Benefits & Budgets/Cost Centers to Recruit and Retain Labor

CONSTRUCTION FINANCIAL MANAGEMENT ASSOCIATION

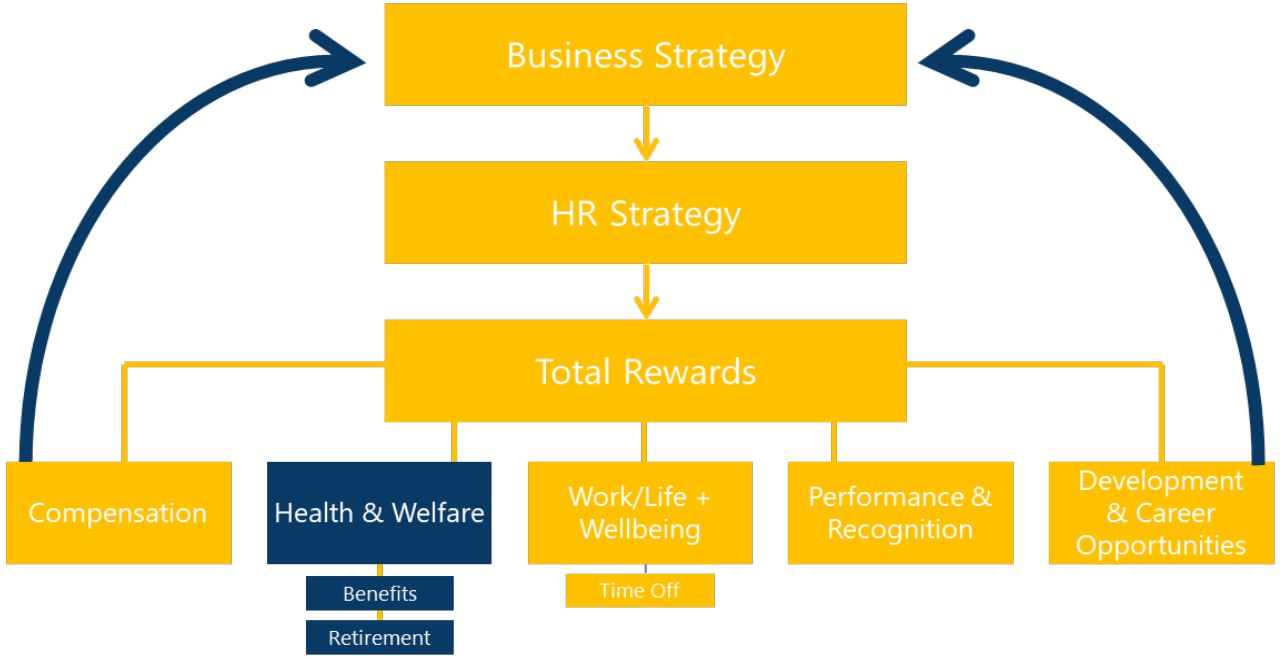
THE PURSUIT OF CURIOSITY

Employer Healthcare Calculus & Cost Continuum



A Blueprint for Success

Framing & Context for Decisions



TOTAL REWARDS

Everything that employees receive that they perceive to be of value as a result of the employment relationship.

EMPLOYEE VALUE PROPOSITION

The way that employees and candidates perceive a company's culture and total compensation package; a company's employment brand.

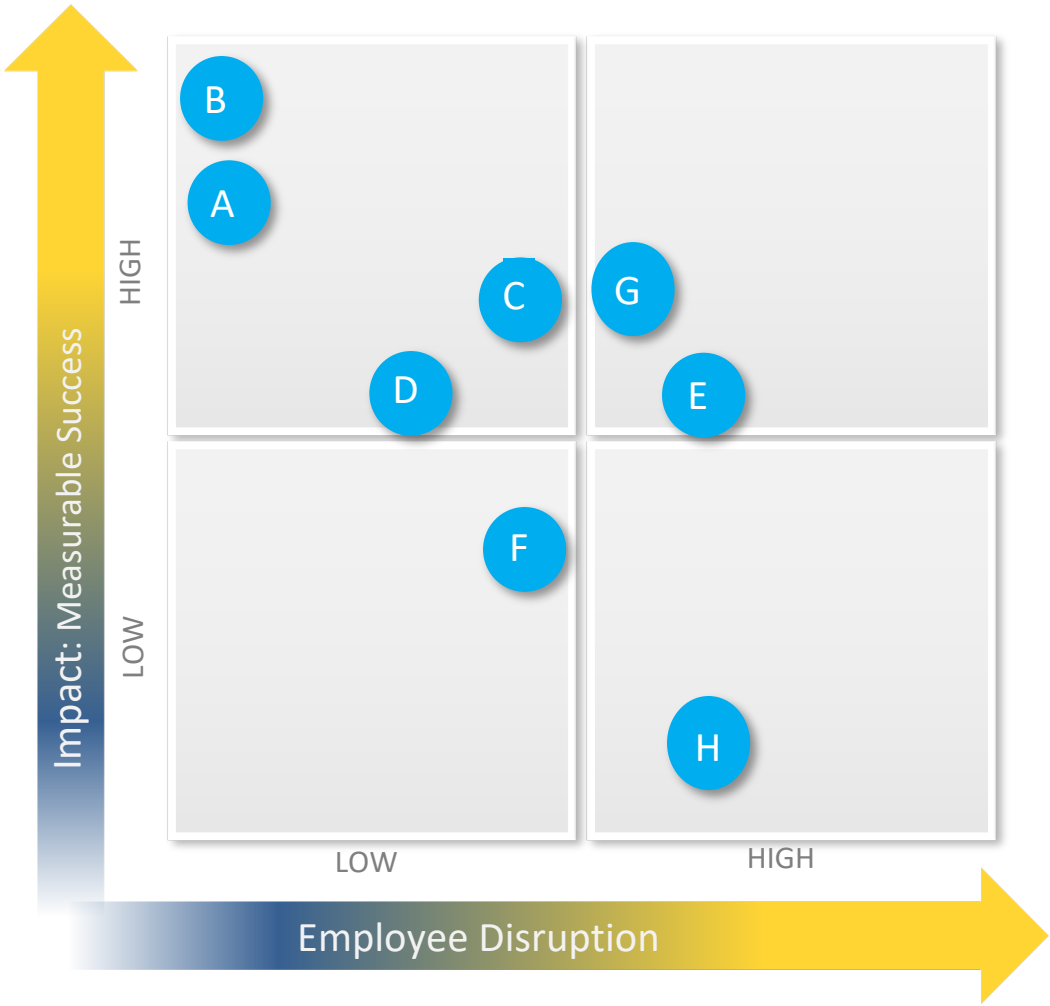
Strategic Execution

Benefit Plan Initiatives

Purchasing Efficiency

Tactical Initiatives

A. Funding methodology
B. Stop loss purchasing
C. High-cost claimants/chronic disease states
D. Outsourcing leave management
E. Carve-outs
   i. Pharmacy benefits managers
   ii. Specialty hospitals
   iii. Surgical management
   iv. Subrogation
F. Price transparency
G. Out-of-network reimbursement Levels (percent of Medicare)
H. Delivery Model: Cafeteria/Defined Contribution?



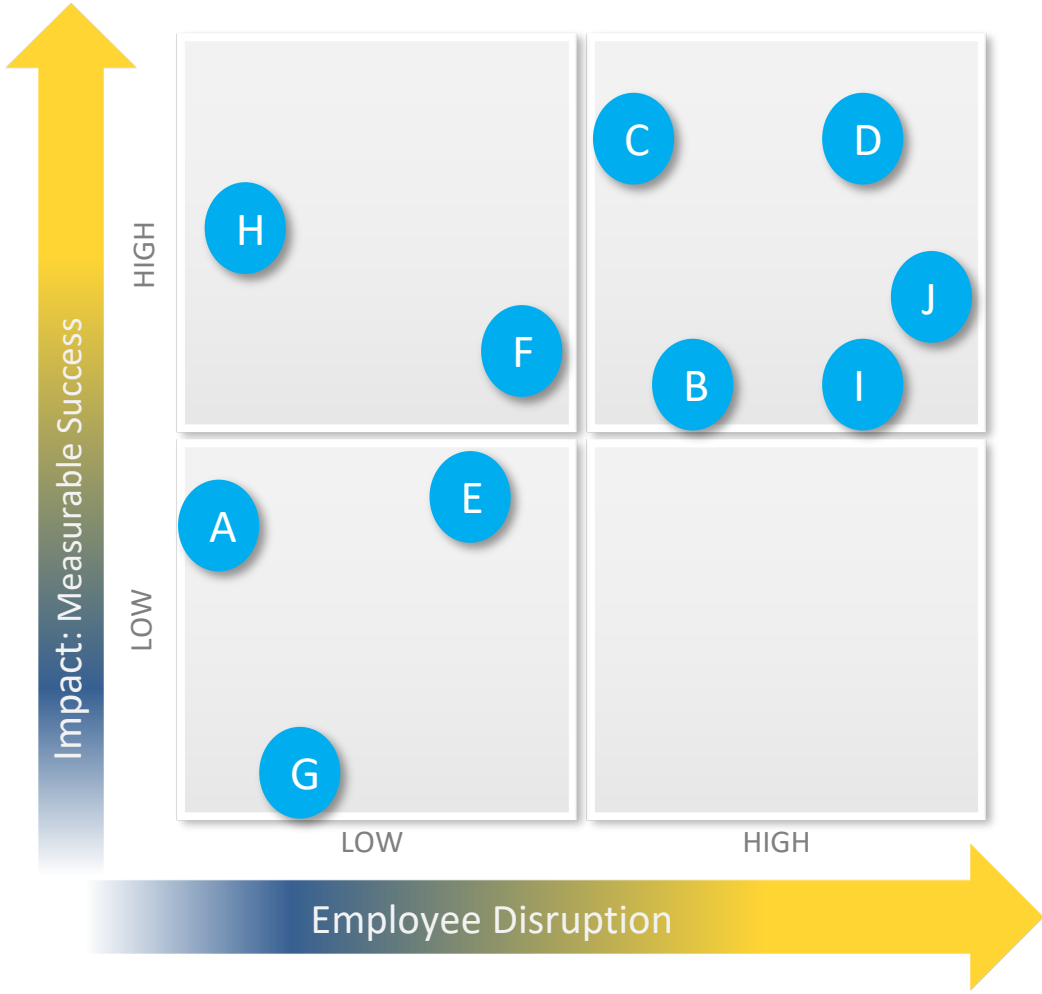
Strategic Execution

Benefit Plan Initiatives

Healthcare Delivery

Tactical Initiatives

A. National carrier-based provider networks
B. Centers of excellence (knees, hips, spine, cardiac, transplant, and rare cancers)
C. Specialty pharmacy management
D. Narrow network strategy
    i. Tiered network
    ii. High-performance network
E. Patient-centered medical home
F. Accountable care organizations
G. Telemedicine—virtual medicine
H. Onsite or near-site clinics
I. Medical tourism
J. Direct contracting with providers



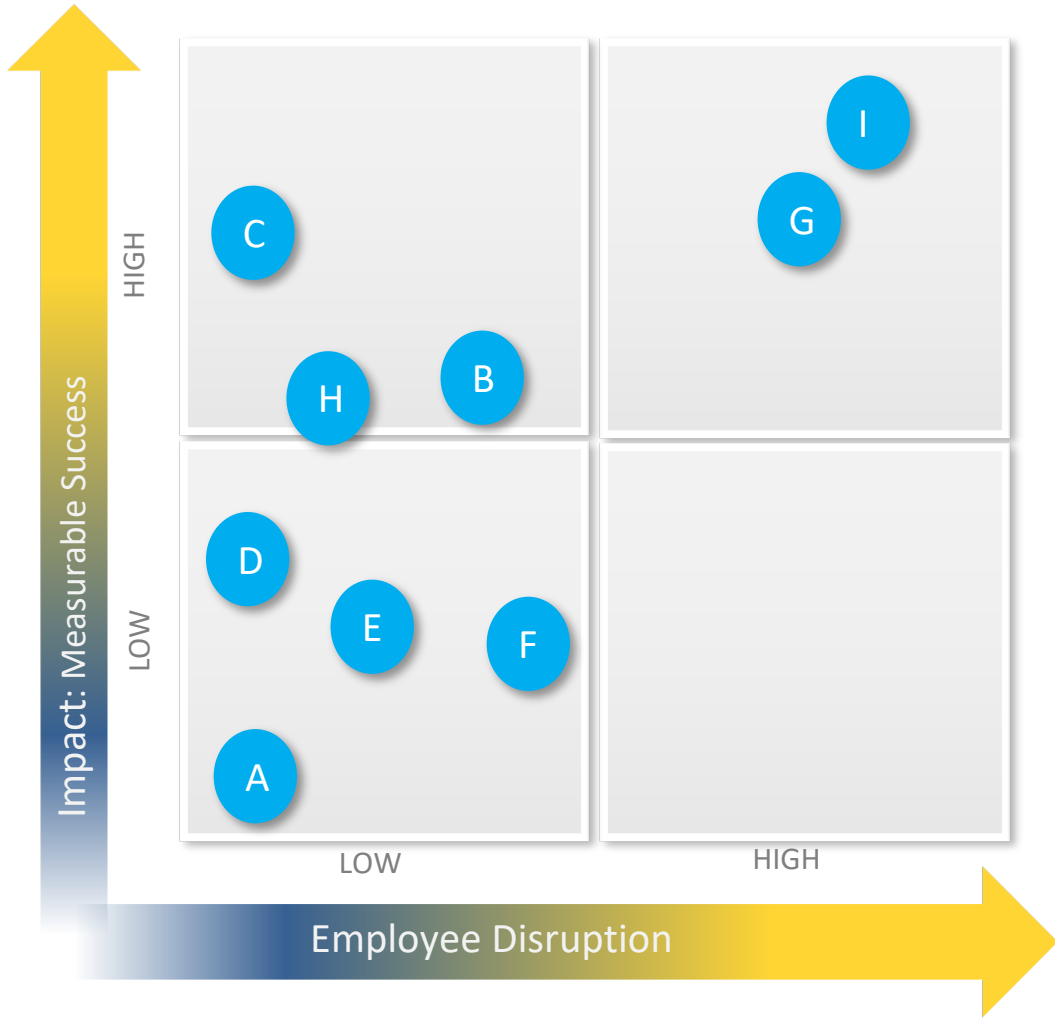
Strategic Execution

Benefit Plan Initiatives

Health and Risk Improvement

Tactical Initiatives

A. Tobacco cessation
B. Lifestyle coaching
C. Chronic disease management
D. Diabetes management
E. Weight management
F. Value-based designs
G. Wellness and health promotion
    i. Outcome-based strategies
H. Bariatric surgery
I. Integrated strategies around health and welfare, workers compensation and disability



Strategic Execution

Benefit Plan Initiatives

Eligibility Management

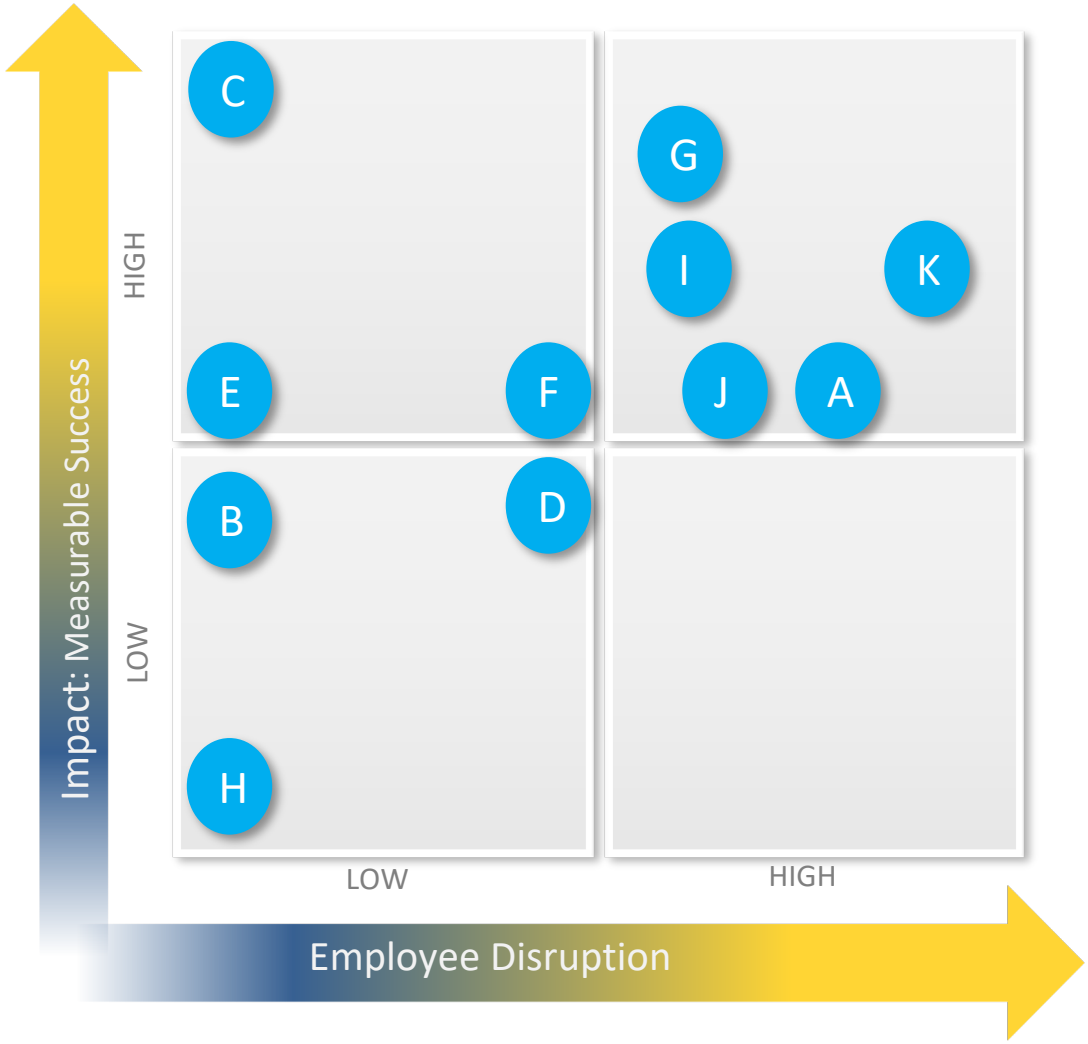
Tactical Initiatives

Employee Eligibility

A. Part-time eligibility
B. Waiver tracking and analysis—potential future enrollment
C. Workforce management
    i. Strict hours limitation
D. Retiree exchange strategy
E. Auto enrollment—for future compliance
F. Public exchange strategy for COBRA participants and variable-hour workforce

Dependent Eligibility

G. Contribution strategy
H. Adding domestic partner/same-sex spouse coverage
I. Working spouse surcharge
J. Dependent audits
K. Working spouse exclusion



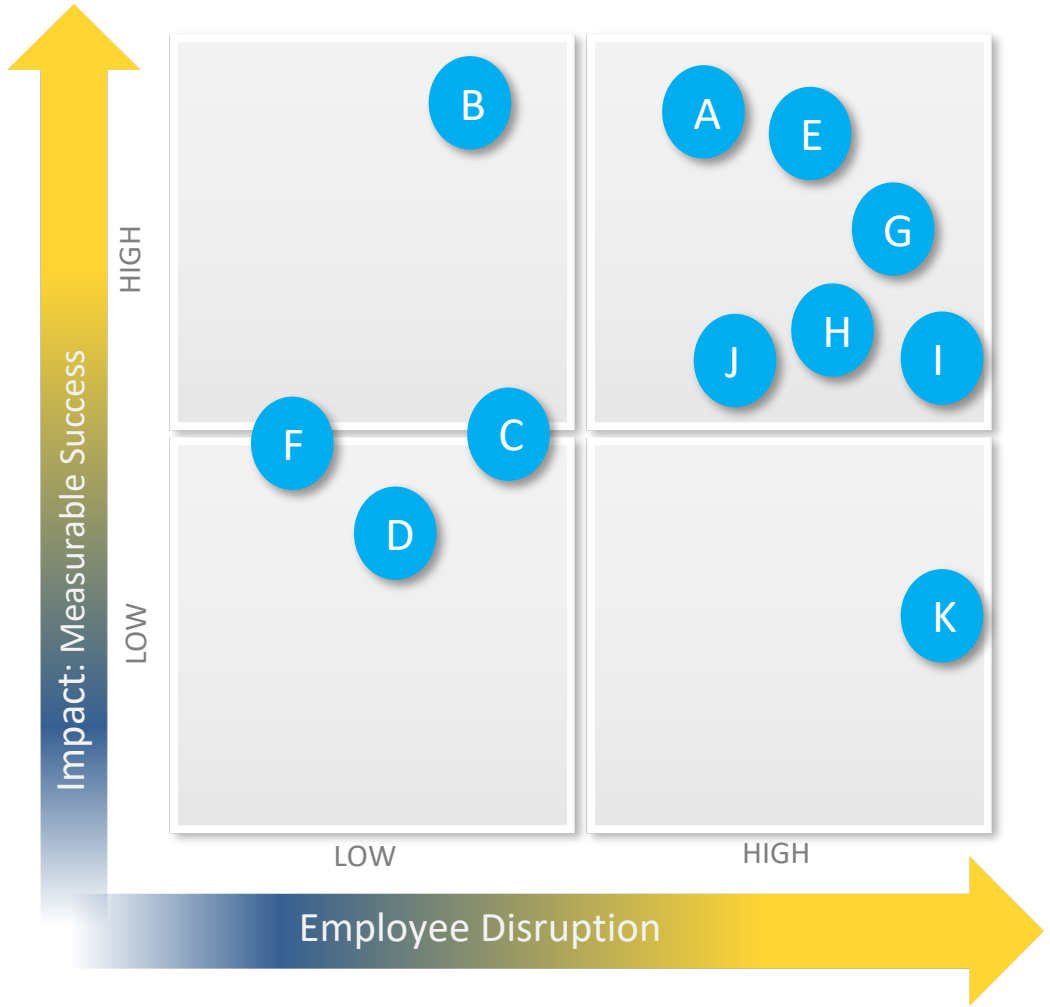
Strategic Execution

Benefit Plan Initiatives

Participant Experience

Tactical Initiatives

A. Indexing of plan elements and contributions
B. Medical and Rx clinical management
C. Step therapy
D. Prior authorization, etc.
E. Consumerism
F. Tobacco surcharge
G. Wellness-based contributions
H. Tiered networks
I. Reference-based pricing
J. Network-only plans
K. Defined contribution (on or off-exchange)



CONSTRUCTION FINANCIAL MANAGEMENT ASSOCIATION

THE PURSUIT OF CURIOSITY

IDEAL Profile

Through a series of questions posed to leadership, the IDEAL Profile identifies your collective belief system around how benefits should be offered to employees. This belief system drives what benefits you offer but also the overall strategy you use to get the most value out of your investment. The questions are designed to identify the corporate philosophy on the following:

I	D	E	A	L
Should you as the employer try to influence your employee's wellbeing with benefit offerings?	How much employee disruption can you tolerate when making changes to benefits, and where does this fall in the list of priorities?	Understanding how to remain economical is important to all companies; how does keeping cost low align with the other priorities?	Should employees be accountable for selecting benefits that best fit their needs or guided by their employer?	Do you as the employer view benefits as one of the ways to create loyalty to your company?

A high score in one or more of these categories represents a belief determined from responses to the survey questions.

CONSTRUCTION FINANCIAL MANAGEMENT ASSOCIATION

THE PURSUIT OF CURIOSITY

Determining Organizational IDEAL Profile

A Blueprint for Success

Key Takeaways

1. History is One Version of Events
   Inductive Reasoning/Learning Are Bad for Risk Management
2. What Used to Be, What is, & What Will Be:
   Covid-19 Changed Health Care Delivery models and Workforce/Demographic Trends
3. New Strategy – Total Rewards/Health and Welfare
   What Are the Goals: Retention, Recruit & Promote? What Benefit Plans Supports This?

Update - Appendix

Vaccination Penalties etc.

Incentivizing vaccinations

- *Outside* the health plan is an employment law issue; *inside* the health plan is an ERISA/HIPAA issue.
- By "inside the health plan" we mean the incentive is a plan-related incentive, such as a premium differential or adjustment to other cost sharing features, etc.
- ***Advantage*** of incentivizing inside the health plan: Likely ERISA preemption of state law-imposed restrictions on discriminating based on vaccination status.
- ***Disadvantage*** of incentivizing inside the health plan: Only so many levers you can pull, and limits on how far you can pull them.

A vaccination incentives initiative under a wellness program umbrella has several advantages, including likely ERISA preemption of state-based limitations, and a fairly clear set of rules.

Incentivizing vaccinations: Do's

- Do treat the program as an *activities-based* wellness program.
  - Offer reasonable alternatives or waivers to those who can't or shouldn't be vaccinated due to health status or can't/shouldn't in the allotted time frame.
- Do offer a religious accommodation.
- Do limit the value of the incentive, *when aggregated with other activities- or outcomes-based wellness incentives,* to 30% of the baseline.
  - Baseline if only employees are incentivized: Total cost of self-only coverage for the coverage option in which the employee is enrolled.
  - Baseline if family members are incentivized: Total cost of the coverage tier that includes the family members.

How to treat employer HSA contributions as incentives

If an employer's incentive in exchange for getting vaccinated is an HSA contribution, does that contribution count against the 30% limit?

There are arguments that the HSA contribution is not adequately medical plan related to count against the 30% (HSAs are not ERISA plans, for example), but we think the better view – and the likely view of federal regulators – is that the HSA contribution should count against the 30% limit.

Incentivizing vaccinations: Do's

- Do provide the incentive to those already vaccinated at the time the program is announced.
  - Don't penalize the "early adopters" for voluntarily doing what you now want the holdouts to do.
- Do maintain the confidentiality of vaccination status/records.

Watch ACA issues:

- ***Retroactive rewards:*** To avoid having to retroactively supply a reward or remove a surcharge, best practice is to:
  - Announce the program.
  - Give employees and, as applicable, dependents a reasonable time to comply.
  - Implement the incentive after the close of that reasonable time.

  Do the same for new hires…give them a reasonable opportunity – 60 days? 90 days? – to achieve your goal before providing the incentive or imposing the surcharge.

Incentivizing vaccinations: Dont's

- Don't condition medical plan *eligibility* on vaccination status.
- Don't impose premium or cost-sharing differentials *outside of a wellness program structure*…HIPAA nondiscrimination rules will bar that.
- Don't *exclude or limit coverage of COVID-19 treatment* for unvaccinated individuals who contract the virus…even if you think not being vaccinated is a "dangerous activity."
  - ADA issues; "court of public opinion" issues?
- Don't run the vaccination program's pre-screening questionnaire process or ask a vendor for that information.

Watch ACA issues:

- ***Affordability:*** For ACA affordability purposes, everyone is deemed to be *unvaccinated* and thus the surcharge is added to the cost of coverage reported on line 15 of the Form 1095-C.

  It's a moot point for individuals who enroll in the employer's plan anyway, are enrolled nowhere, or are enrolled in coverage elsewhere (other than an ACA marketplace), as they can't trigger an ACA penalty based on unaffordability of the employer's coverage offer…that penalty is triggered by ACA marketplace subsidies, and subsidies are not available to individuals enrolled elsewhere.

THANK YOU

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