PEBA
SC Retirement Systems and State Health Plan

**South Carolina Public Employee Benefit Authority**
*Serving those who serve South Carolina*

# Meeting Agenda

**|Health Care Policy Committee |Finance, Administration, Audit and Compliance Committee |Retirement Policy Committee| Board of Directors**
**Wednesday, June 26, 2024 | 202 Arbor Lake Drive., Columbia, SC 29223| 1st Floor Conference Room**

## Health Care Policy Committee |9:30 a.m.

I. Call to Order
II. Approval of Meeting Minutes – March 6, 2024
III. 2025 State Health Plan Approval of Benefits and Contributions
IV. MUSC Plan Update
V. The Relative Risk of Obesity and the Economy of Weight Loss Interventions
VI. Old Business/Director's Report
VII. Adjournment

***Notice of public meeting***
This notice is given to meet the requirements of the S.C. Freedom of Information Act and the Americans with Disabilities Act. Furthermore, this facility is accessible to individuals with disabilities, and special accommodations will be provided if requested in advance.

**PUBLIC EMPLOYEE BENEFIT AUTHORITY AGENDA ITEM**
**HEALTH CARE POLICY COMMITTEE**

**Meeting Date:** June 26, 2024

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**1. Subject**: Approval of 2025 State Health Plan of Benefits and Contributions

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**2. Summary:** Proviso 108.6, as contained in the Governor's Executive Budget and in the final versions of the FY 2025 Appropriations Act adopted by the House and Senate, provides for an 11.8 percent increase in the employer premium and a zero percent increase in the employee premium for the State Health Plan for the 2025 plan year.

Rob Tester will present contribution rates and plan design changes for the State Health Plan for the 2025 plan year. The contribution rates conform to the anticipated provisions of Proviso 108.6, and the plan design changes reflect proposals that achieve savings and/or enhance program value.

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**3. What is the Committee asked to do?** Recommend that the PEBA Board approve the State Health Plan of Benefits and Contributions for the 2025 plan year as presented.

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**4. Supporting Documents:**

(a) Attached: 1. Summary of 2025 State Health Plan of Benefits and Contributions

PEBA
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South Carolina Public Employee Benefit Authority
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# Approval of State Health Plan benefits and contributions for plan year 2025

## State Health Plan funding proviso from Appropriations Bill

**108.6. (PEBA: State Health Plan)** Of the funds authorized for the State Health Plan pursuant to Section 1 11 710(A)(2) of the 1976 Code, an employer premium increase of 11.8 percent and a subscriber premium increase of zero percent will result for the standard State Health Plan for Plan Year 2025. Notwithstanding the foregoing, pursuant to Section 1 11 710(A)(3), the Public Employee Benefit Authority may adjust the plan, benefits or contributions of the State Health Plan during Plan Year 2025 to ensure the fiscal stability of the Plan.

## 2025 Employer contributions

- 11.8% composite employer-only increase corresponds with funding provided in the annual Appropriations Bill.
- An employer-only increase of 11.8% and no subscriber increase equals a 9.7% overall increase in contributions.

| Coverage level | Rate |
|---|---|
| **Subscriber only** | $527.10 |
| **Subscriber/spouse** | $1,108.84 |
| **Subscriber/children** | $905.94 |
| **Full family** | $1,449.32 |

## 2025 Employee/retiree premiums (no change from 2024)

| Coverage level | Standard Plan and Medicare Supplemental Plan | Savings Plan |
|---|---|---|
| **Subscriber only** | $97.68 | $9.70 |
| **Subscriber/spouse** | $253.36 | $77.40 |
| **Subscriber/children** | $143.86 | $20.48 |
| **Full family** | $306.56 | $113.00 |

Employer rate changes for 2025 are contingent on the ultimate passage of the Annual Appropriations Bill.

## Program changes

### *New Federal Requirements*

#### IRA mandated changes for Medicare prescription drug coverage

The federal Inflation Reduction Act (IRA), enacted in 2022, is bringing about considerable change to the Medicare Part D prescription drug benefit. PEBA sponsors a group Part D plan, which now includes about 95,000 Medicare-eligible members. Two noteworthy changes addressing the Medicare beneficiary directly become effective with plan year 2025.

One, the Part D Standard Defined Benefit has been restructured. Beginning in 2025, a Part D beneficiary will have no out-of-pocket expense for prescriptions once the member cost share (known as TrOOP, or True Out-of-Pocket), reaches $2000 for the year. However, this amount is not what would be commonly understood as member cost share for a copay-based plan as is the State Health Plan. The Standard Defined Benefit for 2025 includes a $590 member deductible with the member paying 25% coinsurance in the Initial Coverage phase. PEBA Plan Part D members pay copays equal to that paid by non-Medicare members; however, for purposes of the Part D cost share accumulator, "phantom" cost share as embodied in the Standard Defined Benefit deductible and coinsurance count toward the TrOOP. Because of this methodology, PEBA Plan Part D members will pay copays only until the accumulator reaches the $2000 TrOOP, which is substantially lower than the current $8000 TrOOP. It is projected that around 28,000 Plan Medicare beneficiaries will reach the TrOOP limit next year and achieve zero cost share status. Our actuaries predict that having such a significant number of members with zero cost share for at least part of the year will have material cost impact on the Plan.

Two, the Medicare Prescription Payment Plan (M3P) solution becomes effective for 2025. Beginning in January, Medicare Part D members will have the option to pay out-of-pocket prescription drug costs in the form of capped monthly installment payments. Because of the Plan's fixed copay structure, it is not expected that we will have widespread uptake of this program, but we are obligated to offer it. There is an additional administrative fee to be paid to our pharmacy benefits contractor for each participant in the M3P program.

Federal subsidies associated with the group Part D offering, a material revenue source for the Plan, will be affected as part of the program restructuring. We will not have a clear picture of the revenue effects for 2025 until more information becomes available later this summer.

### *Managing the Plan*

#### Removal of patient cost share incentive for PCMH

The State Health Plan started its involvement with the Patient Centered Medical Homes (PCMH) program, managed by Plan medical administrator BlueCrossBlueShield of SC, in 2009 with a single practice located in the SC low country. Since that beginning, the program has evolved and grown exponentially, with 690 practice locations statewide (as of August 2023) now labelled as a PCMH. Since 2016, the Plan has provided a patient cost share incentive for services obtained at a PCMH. Physician office copays are waived and the regular 20% patient coinsurance is reduced to 10% if the visit is at a PCMH practice. In the ensuing years the Committee has regularly received presentations as to PCMH program status and updates. PEBA continues to view the PCMH program in a positive light.

Analysis initiated in early 2023 in response in part to the GLP-1 prescribing surge indicates that PCMH practices, in aggregate, provide no advantage to the Plan as to total cost of care in comparison to practices outside the program. BlueCross has been very responsive to PEBA's expressed concerns about total cost of care at PCMHs. Over the past several months BlueCross and PEBA have been engaged in a constructive process to address our ambitions to include cost considerations more prominently. These discussions continue to show progress and our team looks forward to continuing to participate in the PCMH program and work collaboratively toward achieving a better product.

While PEBA is looking forward to our ongoing work to improve the PCMH product, our belief is that the patient cost share incentive is not now appropriate. This incentive should be reserved to steer business to practices demonstrated to provide advantageous cost of care to Plan membership. It is proposed that the regular copay structure apply equally to PCMH-provided and non-PCMH-provided services effective in 2025. This action will save the Plan around $14 M/year. When our objective to include favorable total cost of care as an essential element of PCMH participation is realized, we may re-consider the patient cost share incentive.

**Application of normal copays to high-cost diabetic supplies**

When the State Health Plan began in 2000 applying copays to covered items purchased at the pharmacy, diabetic supplies were made up primarily of low-cost needles, syringes, lancets and test strips. Although these supplies were all extremely low cost, they were all brand-name products. The Plan elected to initiate an exception to allow all diabetic supplies to take the generic copay to better reflect their relative expense.

Over the next 20+ years, the complexity of diabetic supplies resulting from new technology and innovation has driven up the cost of the products substantially. Because of the use of the more sophisticated products instead of the old and reliable needles and syringes, there is a need to use copays to help drive patient behavior toward more economical services. While the "old-school" diabetic supplies would maintain their generic copayment, it is proposed that high-cost supplies such as Continuous Glucose Monitors, Insulin Pumps, and their associated supplies have applied the appropriate preferred or non-preferred brand copay going forward. It is our understanding that this copay treatment is more typical of how these products are handled in the general health insurance industry.

Members participating in the no-pay copay program may earn payment of a generic rather than brand copay for the high-cost supplies. This action is estimated to save the Plan around $1.87 M/year in direct expenditure, and potentially more through patient selection of less costly products.

**GLP-1s: 30-day fill limit and new Prior Approval process**

The GLP-1(Glucagon-like Peptide 1 agonists) class of medication became a major cost driver in the State Health Plan in 2023, and this year to date is proving to be no exception. GLP-1s refer to a class of medication designed for treatment of type 2 diabetes. This class has been around for several years—the newest and now best-known GLP-1 products are Ozempic and Mounjaro. Widespread misuse facilitated by social media promotion of GLP-1s has led to increased use for weight loss. Weight loss coverage is a Plan exclusion, and neither of these products is FDA-approved for weight loss. Early in 2023, PEBA staff identified around 1300 GLP-1 users with no diabetes diagnosis in their claim file. We have worked

diligently to identify on-line prescribers and block their ability to authorize this product inappropriately. Nonetheless, spend for GLP-1s continues to increase at an alarming pace.

In 2023, GLP-1 spend increased 47.8% ($10.24 to $15.13 per member per month) year-over-year from 2022. The number of patients taking a GLP-1 product during the year increased 37.0% (21,038 to 28,828).

This spending surge continues in 2024. Looking at quarter-over-quarter from Q1 2023 to 2024, GLP-1 expense grew 40.9% from $12.73 to $17.94 per member per month. The number of patients using this class increased 26.2% from 19,374 to 24,448.

Addressing this trend is a continuous process, and on an ongoing basis we explore potential solutions with the State Health Plan team. It is now recommended to limit supply of GLP-1 medication to 30 days per fill. This proposed action is by no means a fix to high GLP-1 expense growth, but we believe it will reduce waste as there are a material number of users who prove not to tolerate the product.

In addition, we are planning to put into place a new prior approval process for GLP-1s, labelled by our contractor as Encircle Rx, to more effectively review if individuals presenting with a GLP-1 prescription are qualified to obtain it under the terms of the Plan.

PEBA must resolve an ongoing contractual matter with its pharmacy benefit manager Express Scripts for these actions to become effective.

## ***Added Coverage***

### **Addition of BAHA services for children**

It is recommended to add coverage for Bone-Anchored Hearing Aids (BAHA) for persons aged 18 and under with hearing loss resulting from a congenital or surgically induced malformation of the external ear canal or middle ear. BAHAs are used for a different type of hearing loss than a cochlear implant. People hear sounds two different ways – air conduction and bone conduction. Patients who need a BAHA have normal inner ear function, but because of abnormalities of the outer ear and ear canal, sound waves cannot reach the inner ear – meaning they have no air conduction hearing. Use of BAHA is the solution under these circumstances, as it is anchored to the bone just above/behind the ear which amplifies the sound wave to increase bone conduction.

This is the primary treatment for hearing loss when children are born with an abnormal outer ear but a normal inner ear. Although use of this device is increasing we still project relatively small fiscal impact from this coverage addition, around $600,000/year.

### **Remove biofeedback exclusion**

The Plan of Benefits has had a longstanding exclusion for biofeedback. However, Blue Cross now includes in its medical policy coverage criteria for biofeedback for treatment of fecal incontinence and constipation. It is recommended that biofeedback be removed as a Plan exclusion, and we proceed with coverage under the narrow provisions of our administrator's medical policy. It is expected that financial impact will be negligible.

**6.19.2024**

**PUBLIC EMPLOYEE BENEFIT AUTHORITY AGENDA ITEM**
**HEALTH CARE POLICY COMMITTEE**

**Meeting Date:** June 26, 2024

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**1. Subject**: MUSC Plan Review

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**2. Summary:** After a review of 2023 financials for the MUSC Health Plan from Rob Tester, Dr. David Louder of MUSC Health will discuss updated quality metrics and overall activity within the MUSC system.

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**3. What is Committee asked to do?** Receive as information

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**4. Supporting Documents:**

(a) Attached: 1: SHP MUSC Loss Ratio Analysis 2023
2. MUSC Health Plan 2023 Review

**SHP, MUSC Health Plan H51, J51-J55 (Charleston and 4 community hospitals acquired in 2019)**

Claims Expenditure PSPY for Active Subscribers only

| | SHP less MUSC | MUSC within SHP | Δ |
|---|---|---|---|
| 2011 | $6,044 | $6,963 | 115.2% |
| 2012 | $6,567 | $7,555 | 115.0% |
| 2013 | $6,769 | $7,615 | 112.5% |
| | SHP | MUSC Plan | |
| 2014 | $6,712 | $7,845 | 116.9% |
| 2015 | $7,365 | $8,046 | 109.2% |
| 2016 | $7,823 | $8,079 | 103.3% |
| 2017 | $8,300 | $8,858 | 106.7% |
| 2018 | $8,594 | $8,602 | 100.1% |
| 2019 | $9,065 | $9,091 | 100.3% |
| 2020 | $9,579 | $9,347 | 97.6% |
| 2021 | $10,790 | $11,044 | 102.3% |
| 2022 | $11,060 | $10,747 | 97.2% |
| 2023 | $12,124 | $11,965 | 98.7% |

* MUSC refers to both MUSC and MUHA employees

Total Loss Ratio for Active Subscribers only

| | SHP less MUSC | MUSC within SHP | Δ |
|---|---|---|---|
| 2011 | 85.4% | 101.8% | 16.4 |
| 2012 | 89.6% | 105.7% | 16.1 |
| 2013 | 88.4% | 103.7% | 15.3 |
| | SHP | MUSC Plan | |
| 2014 | 87.9% | 103.4% | 15.5 |
| 2015 | 93.3% | 99.5% | 6.2 |
| 2016 | 92.6% | 94.2% | 1.6 |
| 2017 | 94.9% | 100.8% | 5.8 |
| 2018 | 94.9% | 95.1% | 0.2 |
| 2019 | 93.9% | 94.0% | 0.1 |
| 2020 | 99.1% | 97.4% | -1.7 |
| 2021 | 107.7% | 109.3% | 1.6 |
| 2022 | 107.6% | 105.2% | -2.3 |
| 2023 | 102.5% | 101.5% | -1.0 |

* MUSC refers to both MUSC and MUHA employees

Risk Adjusted Claims Expenditure PSPY for Active Subscribers only

| | SHP less MUSC | MUSC within SHP | Δ |
|---|---|---|---|
| 2011 | $6,044 | $6,781 | 112.2% |
| 2012 | $6,567 | $7,211 | 109.8% |
| 2013 | $6,769 | $7,396 | 109.3% |
| | SHP | MUSC Plan | |
| 2014 | $6,712 | $7,584 | 113.0% |
| 2015 | $7,365 | $7,991 | 108.5% |
| 2016 | $7,823 | $8,128 | 103.9% |
| 2017 | $8,300 | $9,055 | 109.1% |
| 2018 | $8,594 | $8,935 | 104.0% |
| 2019 | $9,065 | $9,625 | 106.2% |
| 2020 | $9,579 | $9,802 | 102.3% |
| 2021 | $10,790 | $11,280 | 104.5% |
| 2022 | $11,060 | $11,014 | 99.6% |
| 2023 | $12,124 | $12,399 | 102.3% |

Risk Adjusted Total Loss Ratio for Active Subscribers only

| | SHP less MUSC | MUSC within SHP | Δ |
|---|---|---|---|
| 2011 | 85.4% | 99.2% | 13.8 |
| 2012 | 89.6% | 101.0% | 11.4 |
| 2013 | 88.4% | 100.8% | 12.4 |
| | SHP | MUSC Plan | |
| 2014 | 87.9% | 100.2% | 12.3 |
| 2015 | 93.3% | 98.9% | 5.6 |
| 2016 | 92.6% | 94.3% | 1.6 |
| 2017 | 94.9% | 102.8% | 7.9 |
| 2018 | 94.9% | 98.7% | 3.8 |
| 2019 | 93.9% | 99.4% | 5.5 |
| 2020 | 99.1% | 101.9% | 2.9 |
| 2021 | 107.7% | 111.6% | 3.9 |
| 2022 | 107.6% | 107.7% | 0.2 |
| 2023 | 102.5% | 105.0% | 2.5 |

* MUSC refers to both MUSC and MUHA employees

updated 05.30.2024

* MUSC refers to both MUSC and MUHA employees

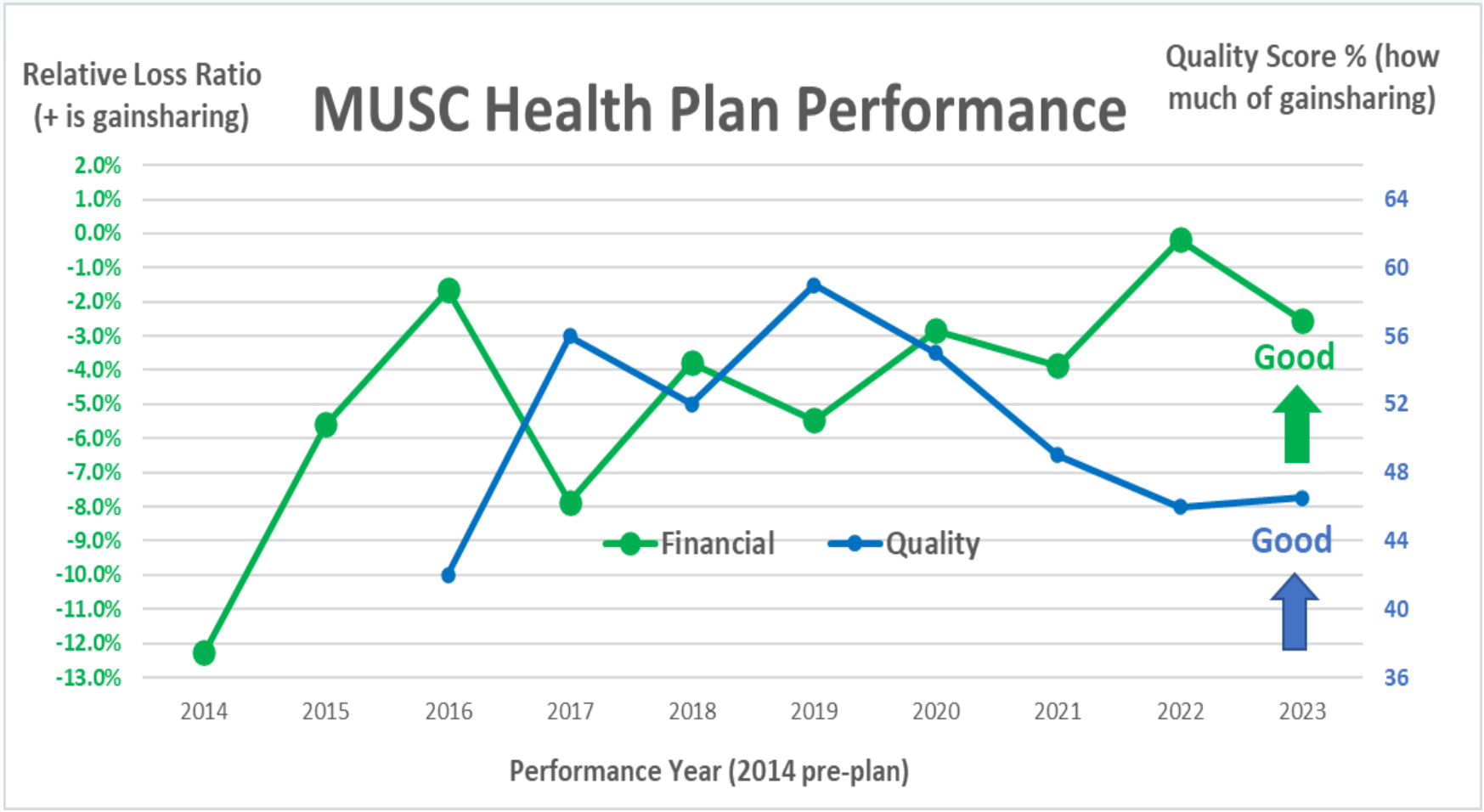
# MUSC Health Plan: 2023 Review

David Louder, MD, MBA
System Chief, Population Health
Executive Director, MUSC Health Alliance

June 26, 2024

PEBA
SC Retirement Systems and State Health Plan

# MUSC Health Plan




2023: 40 of 86 points

# 2023 Quality HEDIS measures

| | MUSC Health Plan | |
|---|---|---|
| Adults | 2022 | 2023 |
| BCS: Breast Cancer Screening | 78.43% | 85.65% |
| CCS: Cervical Cancer Screening | 78.35% | 79.06% |
| COL: Colorectal Cancer Screening | 58.64% | 65.41% |
| CDC: Hemoglobin A1c Control for Patients w/Diabetes | 36.24% | 63.26% |
| CDC: Kidney Health Evaluation for Patients w/Diabetes | 34.51% | 40.58% |
| Opioid monitoring | | 100.00% |
| Low-value testing – Vitamin D (added for 2023) | | n/a |
| Flu Vax | | 45.16% |
| Points earned | 22 of 40 | 26 of 35 |
| Kids | | |
| CIS: Childhood Immunization | 58.72% | 65.98% |
| IMA: Immunizations for Adolescents | 34.47% | 37.09% |
| 6+ well child visits 1-15 Months | 82.43% | 86.05% |
| 2+ well child visits 15-30 Months | 94.55% | 94.84% |
| Child/ Adolescent Well-Care Visits | 57.64% | 59.27% |
| CWP: Appropriate Testing Pharyngitis | 75.32% | 86.30% |
| BMI Percentile for ages 3-17 | 67.51% | 76.39% |
| Nutrition Counselling for ages 3-17 | 59.58% | 63.08% |
| Physical Activity Counselling for ages 3-17 | 54.59% | 60.11% |
| Low-value testing – Vitamin D (added for 2023) | | |
| Points earned | 12 of 27 | 10 of 27 |

- All rates from 2022 better in 2023
- 13 of 14 measures had points-thresholds increased from 2022 to 2023 (tougher to earn points)
- Internal MUSC Health performance scorecards include A1c, hypertension, and well-child visits
- CIS tough due to 2nd seasonal flu shot recommendation and all-or-nothing

# 2023 Quality HEDIS measures versus PCMH+ (patients in our primary care practices)

| | MUSC Health Plan | | 2023 PCMH+/PCMHKids | | |
|---|---|---|---|---|---|
| Adults | 2022 | 2023 | Upstate | PeeDee/Midl | CHS area |
| BCS: Breast Cancer Screening | 78.43% | 85.65% | 86% | 89% | 95% |
| CCS: Cervical Cancer Screening | 78.35% | 79.06% | 75% | 72% | 83% |
| COL: Colorectal Cancer Screening | 58.64% | 65.41% | 76% | 68% | 78% |
| CDC: Hemoglobin A1c Control for Patients w/Diabetes | 36.24% | 63.26% | 60% | 72% | 73% |
| CDC: Kidney Health Evaluation for Patients w/Diabetes | 34.51% | 40.58% | 42% | 45% | 39% |
| Opioid monitoring | | 100.00% | 50% | 57% | 64% |
| Low-value testing – Vitamin D (added for 2023) | | n/a | 22% | 17% | 12% |
| Flu Vax | | 45.16% | | | |
| Points earned | 22 of 40 | 26 of 35 | | | |
| Kids | | | | | |
| CIS: Childhood Immunization | 58.72% | 65.98% | 43% | 14% | 64% |
| IMA: Immunizations for Adolescents | 34.47% | 37.09% | 33% | 69% | 49% |
| 6+ well child visits 1-15 Months | 82.43% | 86.05% | 92% | 64% | 83% |
| 2+ well child visits 15-30 Months | 94.55% | 94.84% | 94% | 61% | 94% |
| Child/ Adolescent Well-Care Visits | 57.64% | 59.27% | 80% | 79% | 77% |
| CWP: Appropriate Testing Pharyngitis | 75.32% | 86.30% | 93% | 79% | 95% |
| BMI Percentile for ages 3-17 | 67.51% | 76.39% | 82% | 63% | 91% |
| Nutrition Counselling for ages 3-17 | 59.58% | 63.08% | 79% | 50% | 39% |
| Physical Activity Counselling for ages 3-17 | 54.59% | 60.11% | 79% | 48% | 32% |
| Low-value testing – Vitamin D (added for 2023) | | | 59% | 0% | 39% |
| Points earned | 12 of 27 | 10 of 27 | | | |

- MUSC HP (plan attribution) performance is similar to PCMH+ (primary care attribution)
- There is work still to be done

# 2023 Quality Performance
# Non-HEDIS

| Measure | 2019 | 2020 | 2021 | 2022 | 2023 |
|---|---|---|---|---|---|
| ED for asthma | 33 | 34 | 34 | 27 | 31 |
| ED – chronic/1000 | 6.7 | 4.2 | 5 | 4.2 | 5.4 |
| ED – non-urgent/1000 | 16.6 | 15.7 | 15 | 21.4 | 19.7 |
| ED – other/1000 | 148.1 | 140.4 | 178.9 | 187 | 193 |
| Readmissions – O:E | 1.73 | 1.14 | 1 | 0.91 | 1.25 |
| (all BC patients) | | | | | |

- ED visits rewards decreasing trend from prior year
- Readmissions Observed:Expected is MUSC compared to entire Blue Cross book of business

# Executive Health Plan Reports

| | Univ | MUHA CHS | Oburg | Flo | Mar | Lanc | Chester | Cola | Kersh | MCP |
|---|---|---|---|---|---|---|---|---|---|---|
| **Members** | 8616 | **10857** | 1293 | 1687 | **321** | 905 | 443 | 1003 | 594 | 1835 |
| **Avg Adult Age** | 41.5 | **39.9** | 42.7 | 43.7 | **45.4** | 41.6 | 44.6 | 43.4 | 44.1 | 43.3 |
| **% Adult Female** | **56%** | 66% | **67%** | 64% | 62% | 65% | 69% | 64% | 63% | 64% |
| | | | | | | | | | | |
| **Total PMPY (adult)** | 7545 | 8882 | 10012 | 9124 | 7293 | 9531 | 9609 | 10249 | 7487 | 8964 |
| **Plan PMPY (adult)** | 6364 | 7589 | 8626 | 7798 | 6159 | 8216 | 8265 | 8725 | 6231 | 7506 |
| | | | | | | | | | | |
| **Preventive biometric screening** | **4.2%** | **3.5%** | x | x | x | x | x | x | x | x |
| | | | | | | | | | | |
| **Dental enrolled** | 69% | 74% | 69% | 72% | 76% | 77% | 74% | **80%** | **80%** | 63% |
| **Dental Cleaning** | **65%** | 59% | 57% | 54% | 53% | **51%** | **51%** | 53% | 55% | 55% |
| | | | | | | | | | | |
| **Vision enrolled** | 73% | 77% | 81% | **89%** | **88%** | 86% | 91% | 82% | 83% | 85% |
| **Vision Exam** | **41%** | 39% | 29% | 37% | 36% | **26%** | 33% | 31% | 30% | 34% |

- Biometric screening rates much lower than State Health Plan
- Risk adjusted Plan expenditures highest in MUHA Charleston and Orangeburg

- Columbia/Kershaw highest enrollment in Dental
- Florence/Marion highest enrollment in Vision
- But University gets eyes and teeth checked the most!

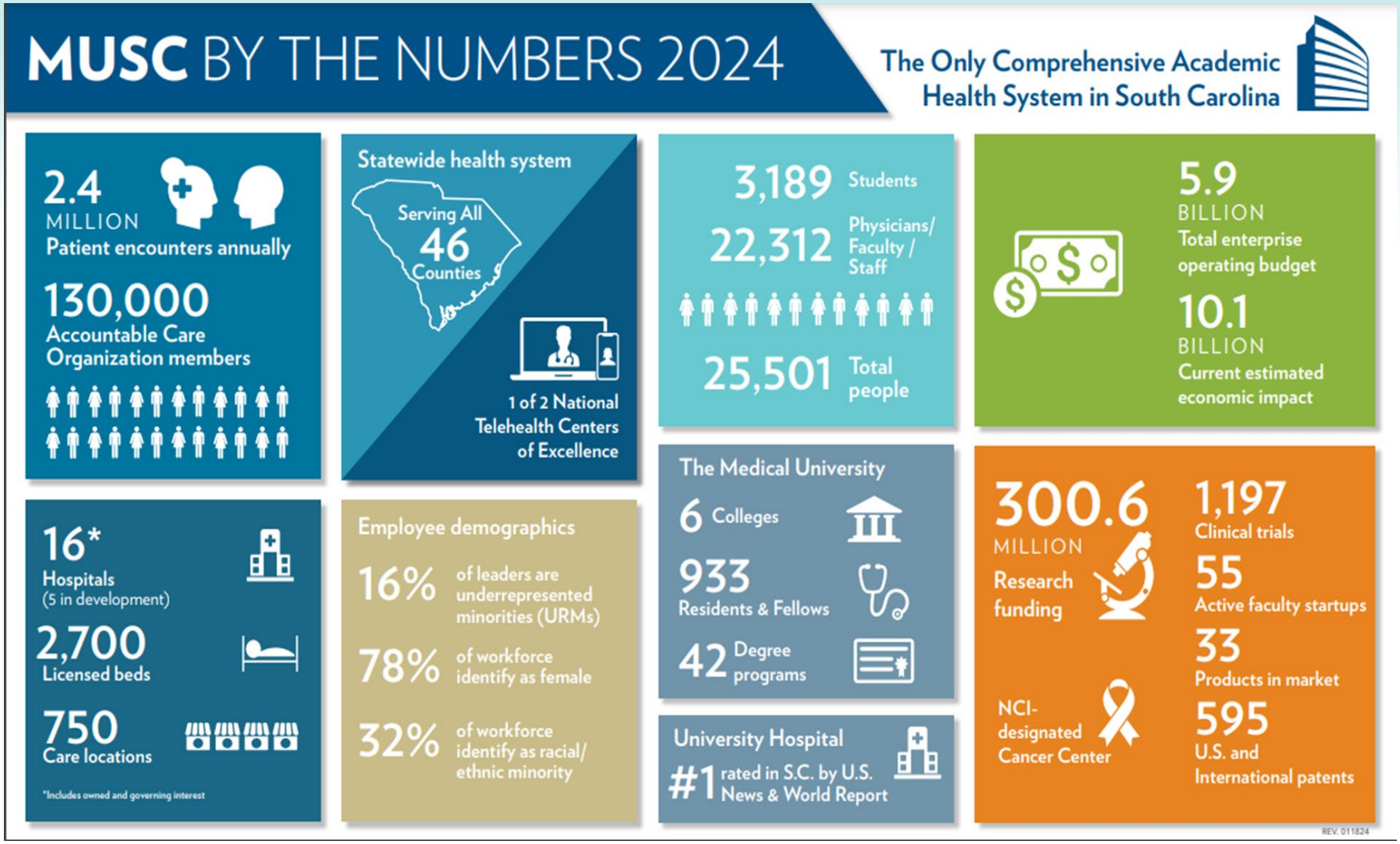
# Executive Health Plan Reports

| | Univ | MUHA | | | | | | | | MCP |
|---|---|---|---|---|---|---|---|---|---|---|
| | | CHS | Oburg | Flo | Mar | Lanc | Chester | Cola | Kersh | |
| Members | 8616 | 10857 | 1293 | 1687 | 321 | 905 | 443 | 1003 | 594 | 1835 |
| Avg Adult Age | 41.5 | 39.9 | 42.7 | 43.7 | 45.4 | 41.6 | 44.6 | 43.4 | 44.1 | 43.3 |
| Chronic condition prevalence rate | | | | | | | | | | |
| Any chronic | 30% | 33% | 46% | 48% | 52% | 40% | 50% | 48% | 43% | 42% |
| Multiple chronic | 13% | 16% | 29% | 29% | 35% | 24% | 28% | 28% | 23% | 23% |
| Asthma | 5% | 5% | 6% | 7% | 8% | 6% | 6% | 8% | 6% | 6% |
| Coronary artery disease | 2% | 2% | 3% | 5% | x | 5% | 5% | 6% | 6% | 4% |
| Diabetes | 7% | 10% | 19% | 18% | 21% | 14% | 18% | 17% | 14% | 15% |
| Hyperlipidemia | 18% | 18% | 29% | 30% | 36% | 26% | 27% | 29% | 27% | 26% |
| Hypertension | 15% | 19% | 33% | 34% | 38% | 29% | 39% | 31% | 29% | 25% |
| Covered preventive services rate | | | | | | | | | | |
| Breast cancer screening | 80% | 76% | 66% | 73% | 64% | 63% | 63% | 65% | 68% | 73% |
| Cervical cancer screening | 78% | 75% | 56% | 70% | 56% | 59% | 49% | x | x | 56% |
| Colorectal cancer screening | 72% | 69% | 30% | 43% | 35% | 42% | 33% | 34% | 29% | 25% |
| Well child visit - 0 to 17 | 76% | 69% | 57% | 48% | 49% | 45% | 33% | 55% | 48% | 55% |

- Chronic disease prevalence correlates with average age
  - Marion highest; Charleston/University lowest
- Cancer screenings and well child visits
  - Best in Charleston/University; lowest in Lancaster/Chester

# Addressing Performance Opportunities

- Quarterly meeting with MUSC Pop Health, MUSC HR, and PEBA: improving communications
- HR interest in improving biometric screening rates and providing these within MUSC Health
- Link childhood vaccinations to well-child visits; emphasize the importance of adolescent well visits
- Patient Education regarding appropriate ED utilization coupled with access to primary, urgent care, and tele-urgent care
- Continued system work on reducing readmissions
- MUSC Health Plan claims analytics and further integration into Epic EMR
- Pharmaco-economics analyst: fulltime hire
- New tools to better capture appropriate diagnoses for claims and risk adjustment




Aspirational Goal: Top Twenty in State Health Ranking in 20 years

Currently #36 - #40

# MUSC Health

Heather Farley, MD, MHCDS
Chief Wellbeing Officer

Michael de Arellano, PhD
Chief Equity Officer

Tamara Bourda, PhD, MBA, MPH, FACHE
Administrator Health Equity

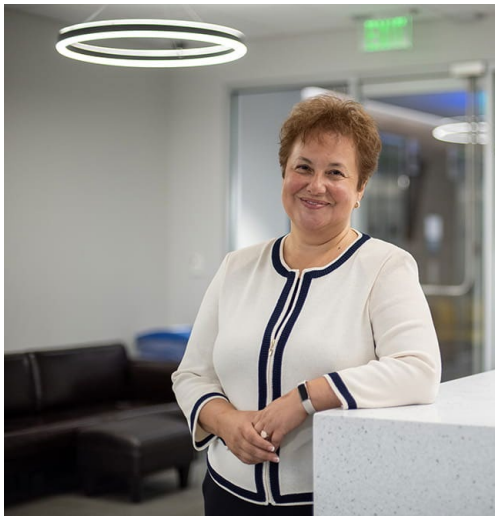
Davy Crockett, RN, MPA, LFACHE
Interim Chief Patient Experience Officer

Doug Lischke, MBA, CHFP
System CFO

# Future SC primary care doctor training

- New Primary Care Focused Residency Programs
  - 2024: Florence Internal Medicine
  - 2025: Lancaster Internal Medicine
  - 2025: Florence Family Medicine
  - TBD: Orangeburg

- Population Health core longitudinal curriculum



Tsveti Markova, MD, FAAFP
Chief Academic Integration Officer

Florence Medical Center nurses,
Led by Costa Cockfield, MSN, RN, NEA-BC

HEALTH STATEHOUSE

# State-funded testing of COVID-19 treatment needs SC volunteers

Legislators approve next phase of SC's first-ever funding of pharmaceutical research

BY: **JESSICA HOLDMAN** - JUNE 10, 2024 4:50 PM

Medical University of South Carolina Dr. Charlie Strange speaks to members of a legislative oversight panel Tuesday, May 28, 2024. The doctor is leading a state-funded clinical trial for a drug to treat the symptoms of COVID-19. (Screenshot of SCETV legislative livestream)

International collaboration for medication produced in SC

Addresses body's response to COVID; may be useful for other immune responses

# “Enhancing Oncology Model”

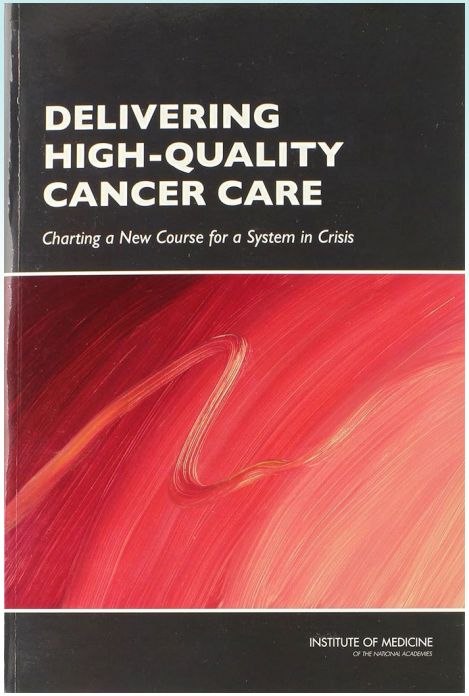
- **State Health Plan, Medicare, or Blue Cross Commercial**

- **Camden, Charleston, Orangeburg, Florence, more TBD**

- Provide **24/7 access**
- Provide **patient navigation**
- Complete **Documentation of a care plan**
- Treat with **nationally recognized clinical guidelines**.
- Identify **health-related social needs**
- Utilize data for **continuous quality improvement**

**Hollings Cancer Center and MUSC Goals**

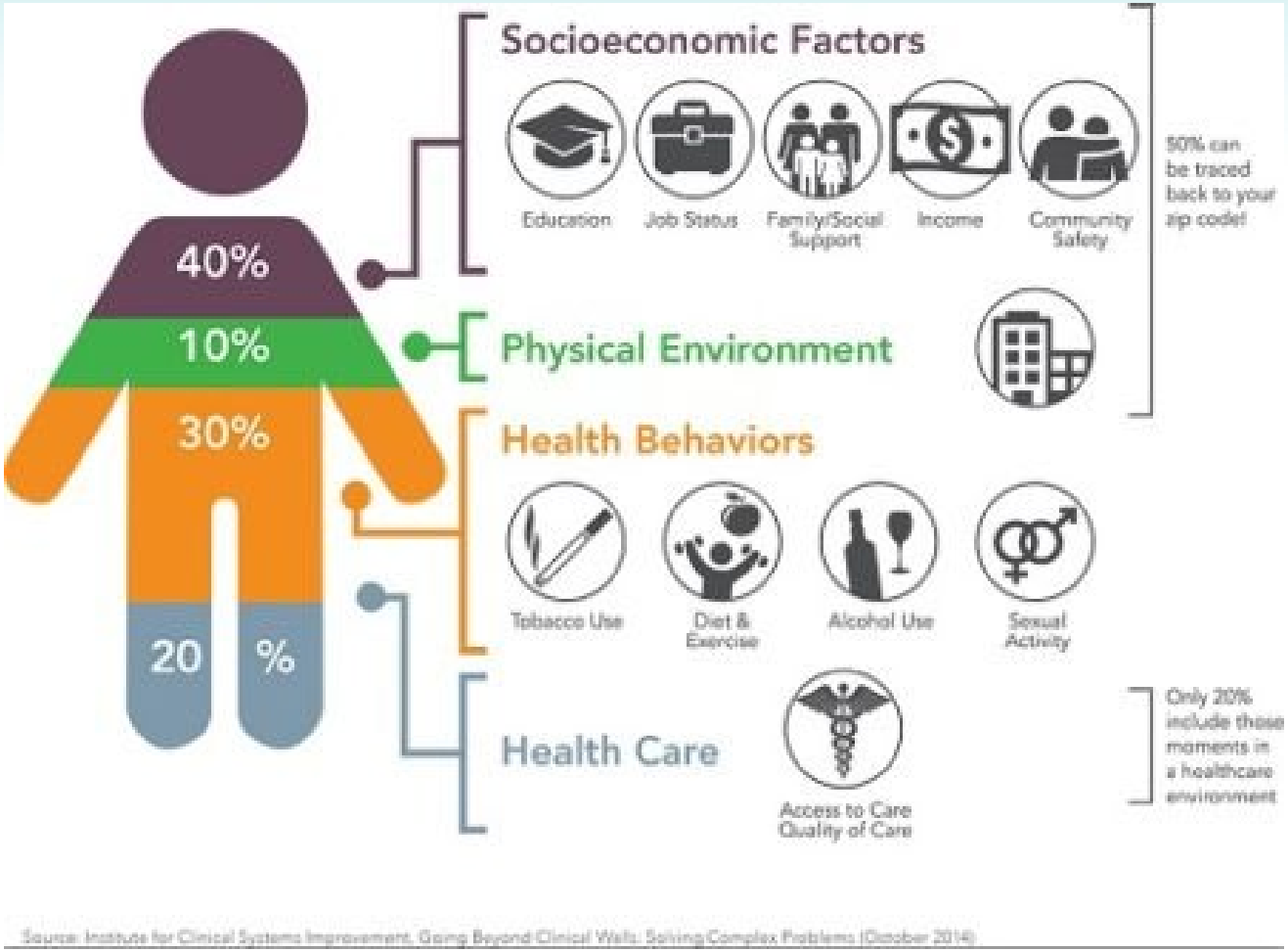
- Affiliate Network across the State
- Obtain next-level National Cancer Institute recognition
  - Current recognition is only one in SC
- Improve access to leading-edge and break-through therapies




Institute of Medicine, 2014

EOM for SHP:
36 Charleston
7 Florence
1 Kershaw
1 Orangeburg

# Impact of Social Determinants of Health




Screening for:
Housing
Food
Transportation
Financial

Results:
Decreased hospital admissions

Perhaps ED visits

Community Health Worker positions largely grant funded through CY24

**PUBLIC EMPLOYEE BENEFIT AUTHORITY AGENDA ITEM**
**HEALTH CARE POLICY COMMITTEE**

**Meeting Date:** June 26, 2024

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**1. Subject**: The Relative Risk of Obesity and the Economy of Weight Loss Interventions

---

**2. Summary:** The Relative Risk of Obesity and the Economy of Weight Loss Interventions addresses the prevalence in obesity in our state and nation, discusses qualitative and economic considerations relating to well-known obesity-countering strategies, and recounts PEBA-sponsored programs that have achieved success in helping our members' reach a healthier weight. Dr. Tripp Jennings of BlueCross and PEBA consultant Mike Madalena will present on this timely topic.

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**3. What is Committee asked to do?** Receive as information

---

**4. Supporting Documents:**

(a) Attached: The Relative Risk of Obesity and the Economy of Weight Loss Interventions

PEBA℠
SC Retirement Systems and State Health Plan

Serving those who serve South Carolina

# The Relative Risk of Obesity and the Economy of Weight Loss Interventions

June 26, 2024

Tripp Jennings, MD FACEP

Vice President, Clinical Innovations Officer, BlueCross BlueShield of South Carolina

Mike Madalena

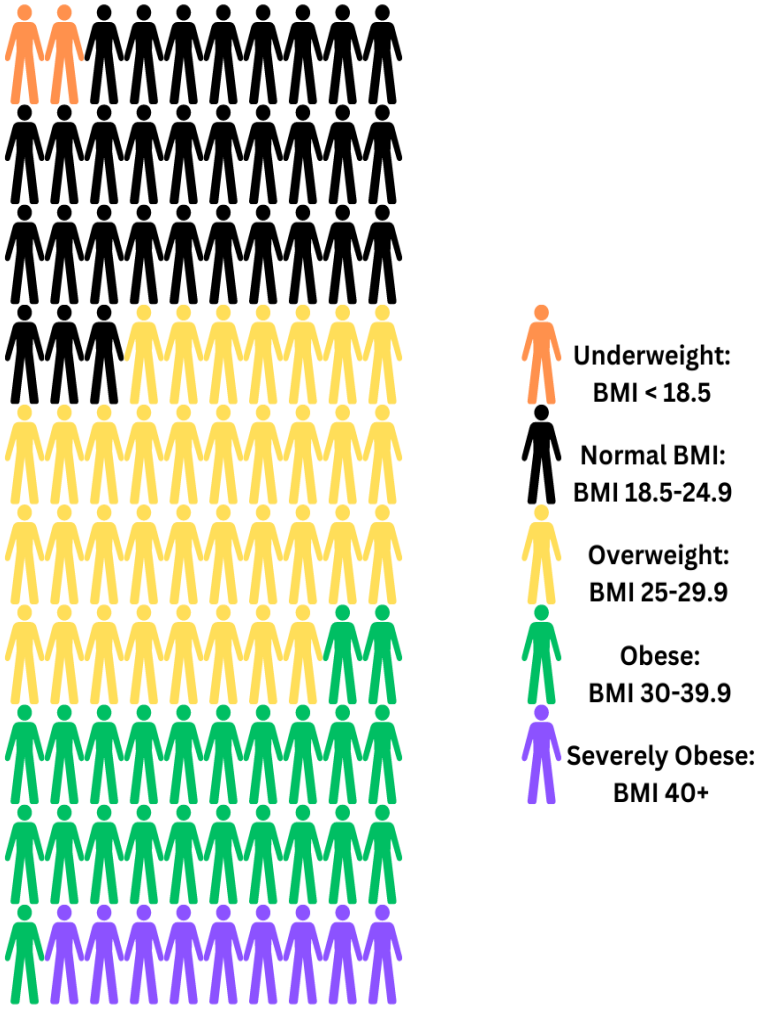
Consultant to PEBA/State Health Plan

# Agenda

- Obesity Overview
  - Prevalence in the United States, South Carolina, and State Health Plan
  - Incremental cost of obesity
  - Prevalence of conditions based on obesity
- Non-Covered Obesity Treatments
  - Pharmacological Treatment
  - Surgical Treatment
- Covered Behavioral Treatment for Obesity
- Conclusions

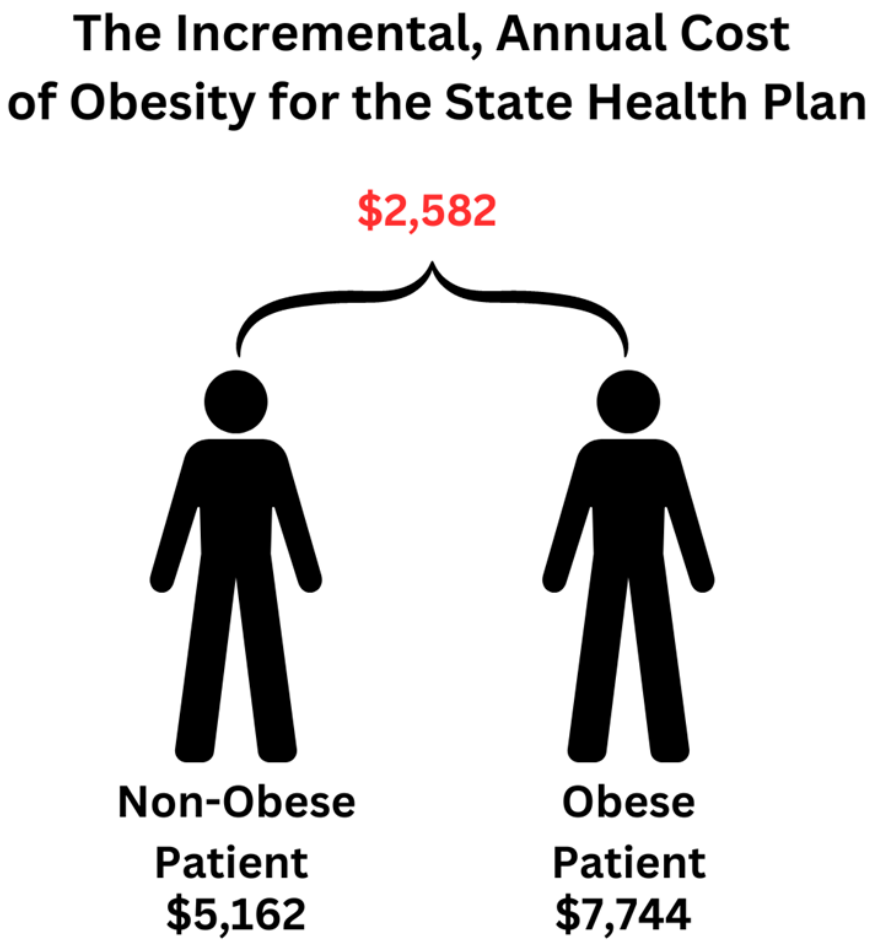
# Obesity in the United States and South Carolina

- In 2020, 66.7% of adults are overweight, including those with obesity (23.1%) [1] and severe obesity (8.8%).[2]
- CDC estimate for obesity (including severe obesity) in South Carolina is 36.2%.[1]



# Obesity in State Health Plan

- 39.7% of non-Medicare State Health Plan members are considered obese, with 9.1% having severe obesity.
- Obesity is linked to higher risk for many disease states, which leads to higher health care spend.
- Attention must be paid to the "incremental cost of obesity" of $2,582.
  - True cost of obesity.
  - Includes medical and pharmaceutical expenses.
- Even if every obese patient were to become non-obese, the State Health Plan would still experience significant health care spend.



# Disease Prevalence by Obesity Status within State Health Plan

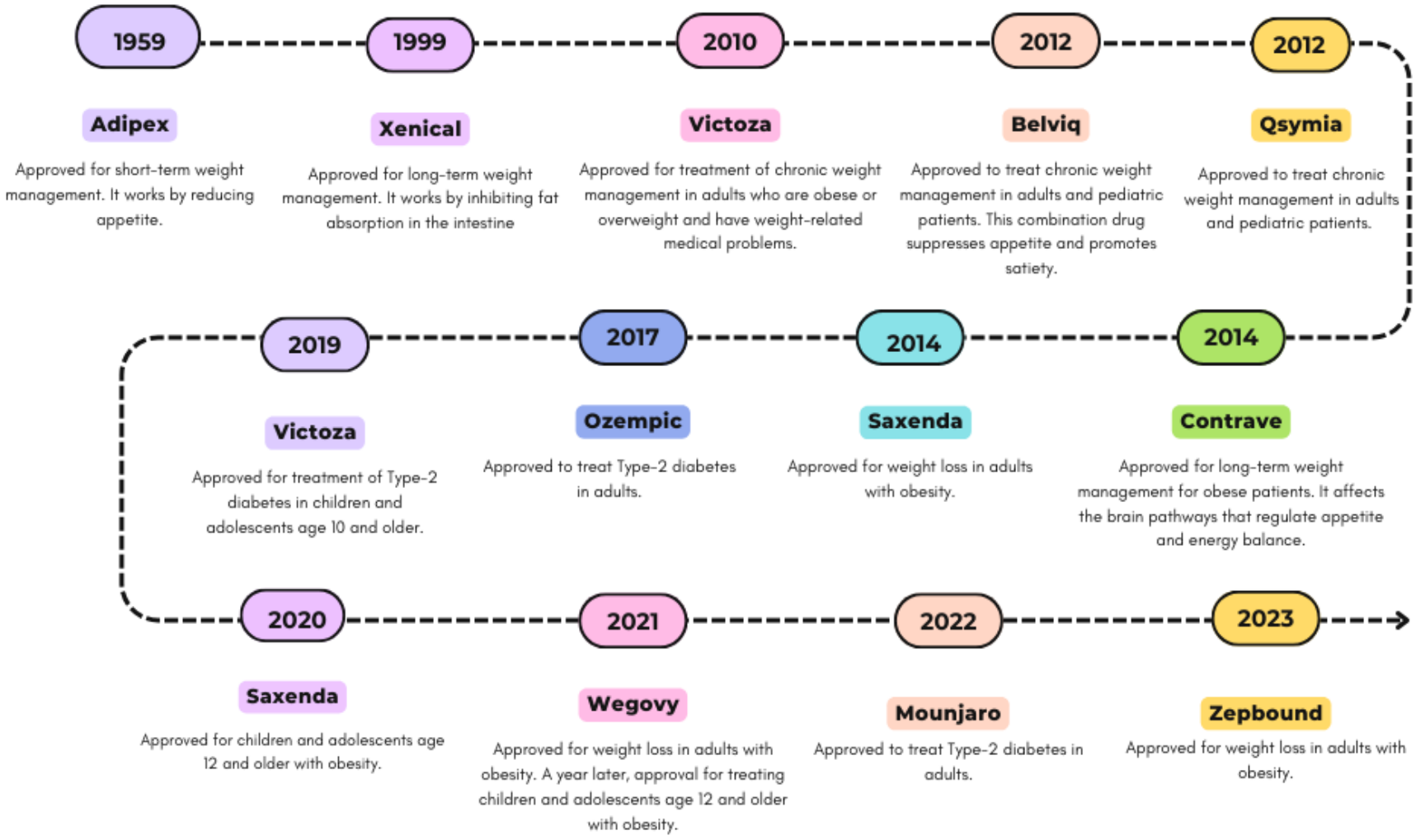
| Disease State | SHP Disease State Prevalence* | SHP Obese Risk Factor | SHP Non-Obese Risk Factor | Obesity Amplifier |
|---|---|---|---|---|
| Diabetes | 11.0% | 21.9% | 4.9% | 4.4 |
| Chronic Kidney Disease | 0.7% | 1.3% | 0.4% | 3.4 |
| Ischemic Heart Disease | 14.6% | 25.0% | 8.8% | 2.9 |
| Colon Conditions | 0.1% | 0.2% | 0.1% | 2.6 |
| Pain | 6.6% | 10.8% | 4.2% | 2.6 |
| Respiratory Conditions | 8.3% | 13.2% | 5.6% | 2.3 |
| Musculoskeletal Conditions | 24.4% | 35.7% | 18.1% | 2.0 |

* Primary SHP adult population

# Current Obesity Treatments

- Pharmacological Treatment
  - Background
  - Challenges
  - Economic viability
- Surgical Treatment
  - Background
  - Challenges
  - Economic viability
  - PEBA performance from 2011 pilot
- Covered Behavioral Treatment

# Timeline of FDA Approvals



# Pharmacological Treatment: Challenges

- **Lack of clear, sustainable health benefits**:
  - Continuous usage most likely necessary to sustain weight loss.[3]
  - 39-40% of weight loss from lean muscle mass.[4,5]
  - Limited absolute risk improvement of cardiovascular health.[6,7]
- **Lack of clear, immediate cost-effectiveness:**
  - Savings from GLP-1s are not immediate.[8]
  - The Congressional Budget Office: Savings would be less than the current net federal cost[9] and GLP-1s would need to cost 90% less to avoid increasing the national deficit.[10]
  - Institute for Cost Effectiveness Research: Costs did not meet cost-effectiveness threshold.[11]
  - The State Heath Plan would spend $1.48 million to avoid one of the major cardiovascular events studied.[6]

# Pharmacological Treatment: Economic Viability

## Calculation

- Price per Rx – Net of Rebates: $624.81
- Annual cost of prescription: $624.81 * 12 = $7,497.72
- Annual cost of complications: $194.86

## Ultimate ROI

| Incremental Cost of Obesity | Cost of Treatment | Complications | ROI |
|---|---|---|---|
| $2,582 | $7,498 | $195 | **0.34** ($2,582 / ($7,498 + $195) |

# Pharmacological Treatment: Economic Viability

**Other entities are experiencing a similar cost for GLP-1s and find it prohibitive**

**North Carolina state workers' health plan ending coverage for certain weight-loss drugs**

utmb Health

Faculty Group Practice Newsletter

Exploring Alternatives as Patients Lose Weight-Loss Medication Coverage

September 13, 2023 • 11:28 a.m.

**BCBS Michigan to drop weight loss drug coverage**

# Surgical Treatment: Background

- **What goes into the cost of bariatric surgery?**
  - Median cost of bariatric surgery itself.
  - 2 years of claims associated with bariatric surgery, including complications, and subsequent claims after 2-year mark.
  - Any necessary revisional surgery.
  - GLP-1s for one-third of patients.[12]
- **Who gets bariatric surgery?**
  - 1% of eligible patients ultimately obtain the surgery.[13]
    - Eligibility for bariatric surgery tends to be discretionary. We defined an eligible patient having a BMI >= 30.[14]
- **What do we count as savings?**
  - Diabetic remission.
    - Recent study tracked diabetic remission following bariatric surgery[15], and we applied those statistics to a prospective PEBA bariatric surgery population.

# Surgical Treatment: Challenges

## Revisional Surgery

- **What is revisional surgery?**
  - A secondary surgery following bariatric surgery to address weight loss failure or complications.
  - 7-15% prevalence rate.[16]
    - Probable, though uncommon, for a patient to undergo two or more revisional surgeries. Our analysis did not price for this possibility.
- **Weight loss failure:**
  - Considered to be the most common reason to obtain revisional surgery.[17]
  - Includes regaining lost weight or losing an insufficient amount of weight.
  - Generally, 20-25% of patients experience weight loss failure.[18]
- **Complications:**
  - Most common bariatric surgeries have complication rates of 5.8 to 8.0%.[19] Revisional surgery would correct the complication. However, revisional surgery also has an increased risk of complications.

## Selection Risk

- 28% of employers nation-wide cover bariatric surgery.[20]
- Only 1% of BCBSSC ASO groups cover bariatric surgery.
  - **Potential Magnet Effect:** PEBA could attract members specifically seeking bariatric surgery.
  - **Employment Strategy:** Family members might gain employment with one of the 800+ PEBA employers to obtain surgery coverage, then leave the State Health Plan.
- Subsequent high costs for PEBA while not reaping long-term health improvements and cost-savings.

# Surgical Treatment: Economic Viability

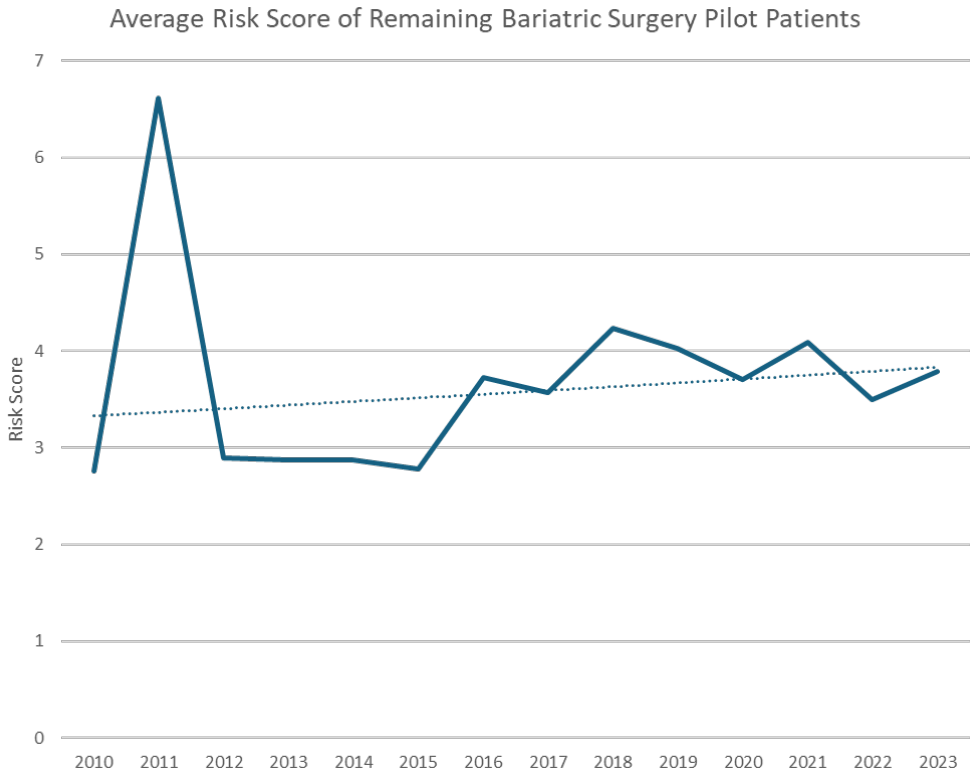
- Tracked expenses associated with bariatric surgery (including revisional surgery and GLP-1 utilization) patients for 12 years.
  - 1,332 unique bariatric surgery patients per year.
    - 1% of eligible population estimated to receive surgery in a year. Each year of new patients represents a "surgical round."
  - 160 unique revisional surgery patients per year.
    - 12% of bariatric surgery patients from previous surgical round assumed to receive revisional surgery the following year.
- Incorporated diabetic remission statistics to measure cost-savings.
- Total net expenses reflects the total cost of surgeries and claims after savings associated with diabetic remissions.
- ROIs are represented in 2024 dollars and population counts.

| Population | 12-Year Net Expense | ROI |
|---|---|---|
| Bariatric Surgery | $1,853,283,297 | **0.48** (Obesity Group Total Cost/Bariatric Surgery Total Cost) |
| Obesity Group | $886,401,058 (17,744 total accrued patients * $7,744 annual claim cost) | |

| Population | Per Capita per Year Expense | ROI |
|---|---|---|
| Bariatric Surgery | $8,703 | **0.89** (Obese Patient Per Capita Cost/Bariatric Patient Per Capita Cost) |
| Obesity Group | $7,744 | |

# Surgical Treatment: PEBA performance from 2011 pilot

- Per budget proviso, PEBA hosted a pilot in 2011 to cover bariatric surgery. 100 patients obtained the surgery, and we have tracked their risk scores and per capita spend since.
- All surgeries must be performed in a nationally designated ASMBS Center of Excellence for Bariatric Surgery, an ACS Bariatric Surgery Center Network Member, or a Blue Distinction Center for Bariatric Surgery.
- Criteria of eligible patients:
  - Must have a BMI over 40 kg/m², or over 35 kg/m² with a co-morbidity such as diabetes, hypertension, GERD, sleep apnea, or asthma.
  - Must also have been enrolled in the State Health Plan (Standard or Savings plans) for the past two years, have documented two failed weight loss attempts with their primary practitioner, completed a pre-operative psychological evaluation, and meet the bariatric surgical guidelines of AACE, TOS, and ASMBS.
- Results:
  - 65 of the original 100 patients remain at PEBA.
  - Risk scores and spend have not improved since the surgery.
  - 18.8% remaining pilot patients are taking a GLP-1.




| Population | Risk Scores | Per Capita Spend | Risk Adjusted Per Capita Spend |
|---|---|---|---|
| Remaining Pilot | 3.78421 | $15,168 | $4,121 |
| Relevant PEBA age-sex groups | 2.26996 | $8,736 | $3,849 |
| Difference (Pilot / PEBA) | 1.66708 | 173.6% | 107.1% |

# State Health Plan Coverage for Behavioral Treatment to Address Obesity

- Services included in BlueCross ASO contract:
  - My Health Planner
  - Strive (formerly Rally)
    - May 2017
- Weight management program (Wondr Health)
  - September 2018
- Diabetes reversal (Virta):
  - March 2023

# My Health Planner and Strive digital platforms

- Two digital platforms available to members to help them be engaged in improving their health.
- My Health Planner provides personalized care program for members that lets them engage with a care team manager via secure two-way chat, create and engage with a daily Health Checklist, read educational content and record their health status.
- Strive provides members with daily content and challenges to help motivate positive health changes by encouraging daily interaction. Members use this platform to qualify for the SHP's No-pay Copay program.

# Wondr Health

World-class behavior-change program

## Wondr goes beyond weight loss to transform whole-person health

**What we do**

Expert-led digital programs with weekly video lessons, content, coaching, & 24/7 wraparound support for weight management, stress & anxiety, sleep, physical activity, nutrition & more.

**Why we do it**

Delivers better, more sustainable outcomes; to help overcome emotional health obstacles & risks as participants discover their "new you"; to improve medication adherence & manage symptoms.

**Client impact**

Provides an end-to-end solution to meet the healthcare needs of a diverse workforce and a sustainable strategy to manage medical & drug costs for metabolic health conditions.

**State Health Plan unit cost**

Wondr Skills (12 weeks) - $38.50 – 10 claims filed
Wondr Up (12 weeks) - $25.00 – 7 claims filed
WondrLast (28 weeks) – no additional charges

$198 per participant for the life of the program

# Wondr Health

P E B A

## At a glance

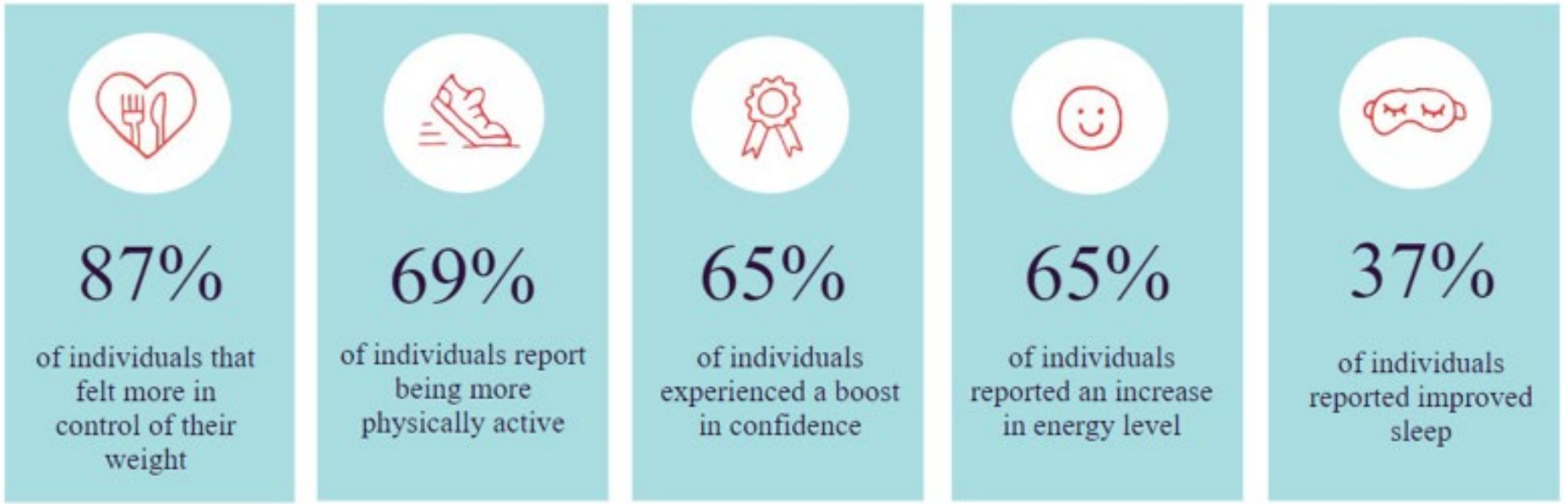
State Health Plan members, including spouses and dependents ages 18 and older, are eligible to apply. Medicare-primary members are also eligible to apply. Some medical conditions or body mass indexes (BMIs) might prevent you from participating in the program.

**September 2018 – February 2024**

- 93,081 participants accepted into Wondr
- Avg Starting BMI: 34.2
- Avg Starting age: 53
- 491,980 total Lbs lost
- Average Weight loss: **4.0%**
- 87% felt more in control of their weight

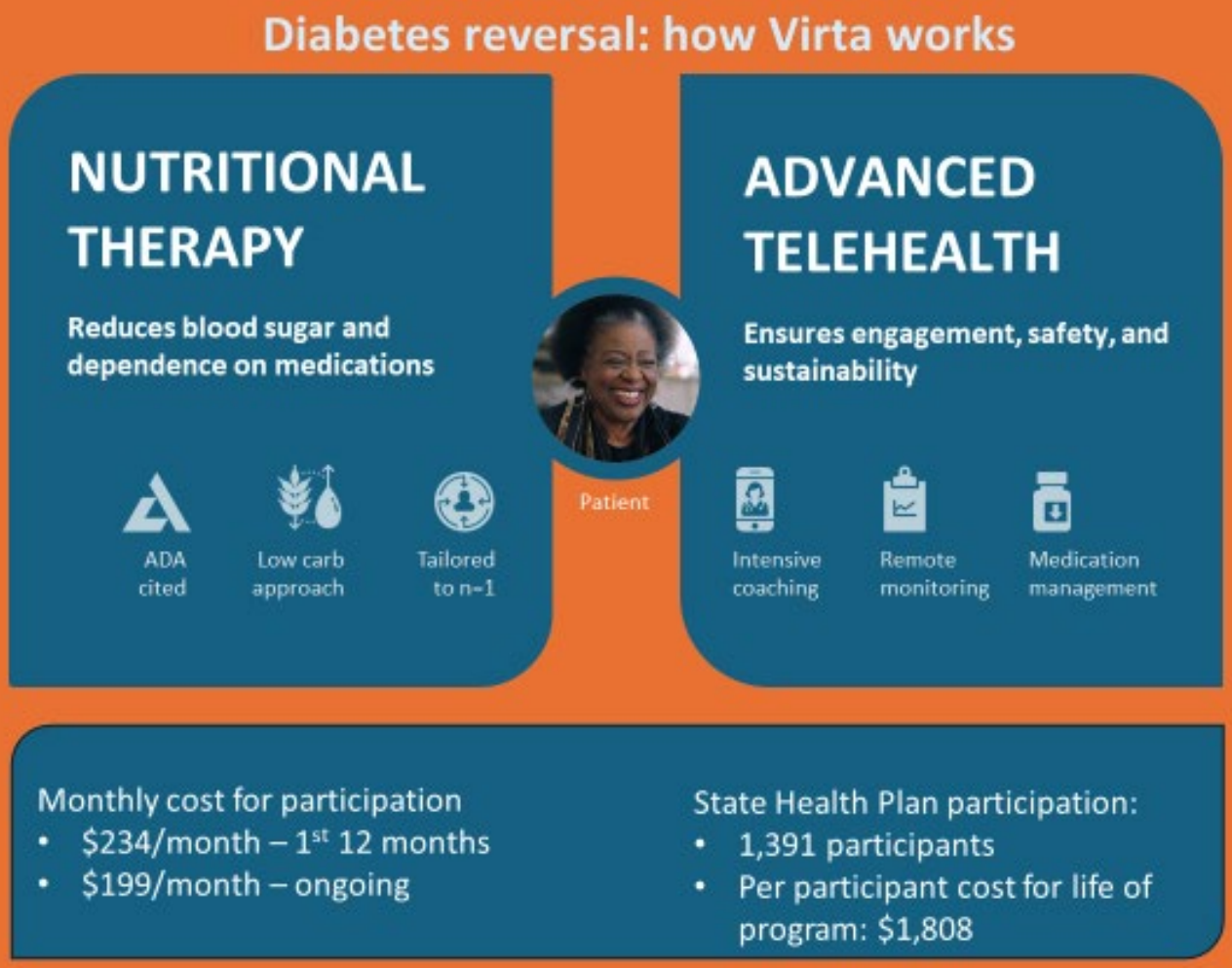
# Wondr Health

## Quality of Life Improvements




wondr HEALTH

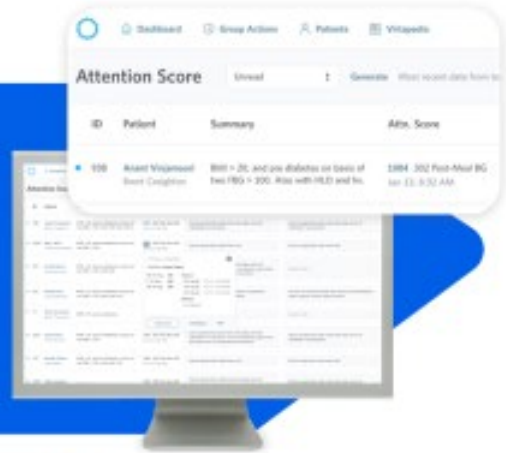
# Virta


Diabetes reversal: how Virta works
NUTRITIONAL THERAPY
Reduces blood sugar and dependence on medications
ADA cited
Low carb approach
Tailored to n=1
Patient
ADVANCED TELEHEALTH
Ensures engagement, safety, and sustainability
Intensive coaching
Remote monitoring
Medication management
Monthly cost for participation
• $234/month – 1st 12 months
• $199/month – ongoing
State Health Plan participation:
• 1,391 participants
• Per participant cost for life of program: $1,808
virta

# Virta

## Member experience: Clinical care






### Nutritional changes

Members engage in personalized carbohydrate restriction. Encouraged to eat until full; no calorie counting

### Health Coaching

Members engage in frequent chats with dedicated health coach team, with near daily interactions, tailored to the member's preferences

### Biomarker Logging

Members track ketones, weight, and subjective factors such as mood and hunger

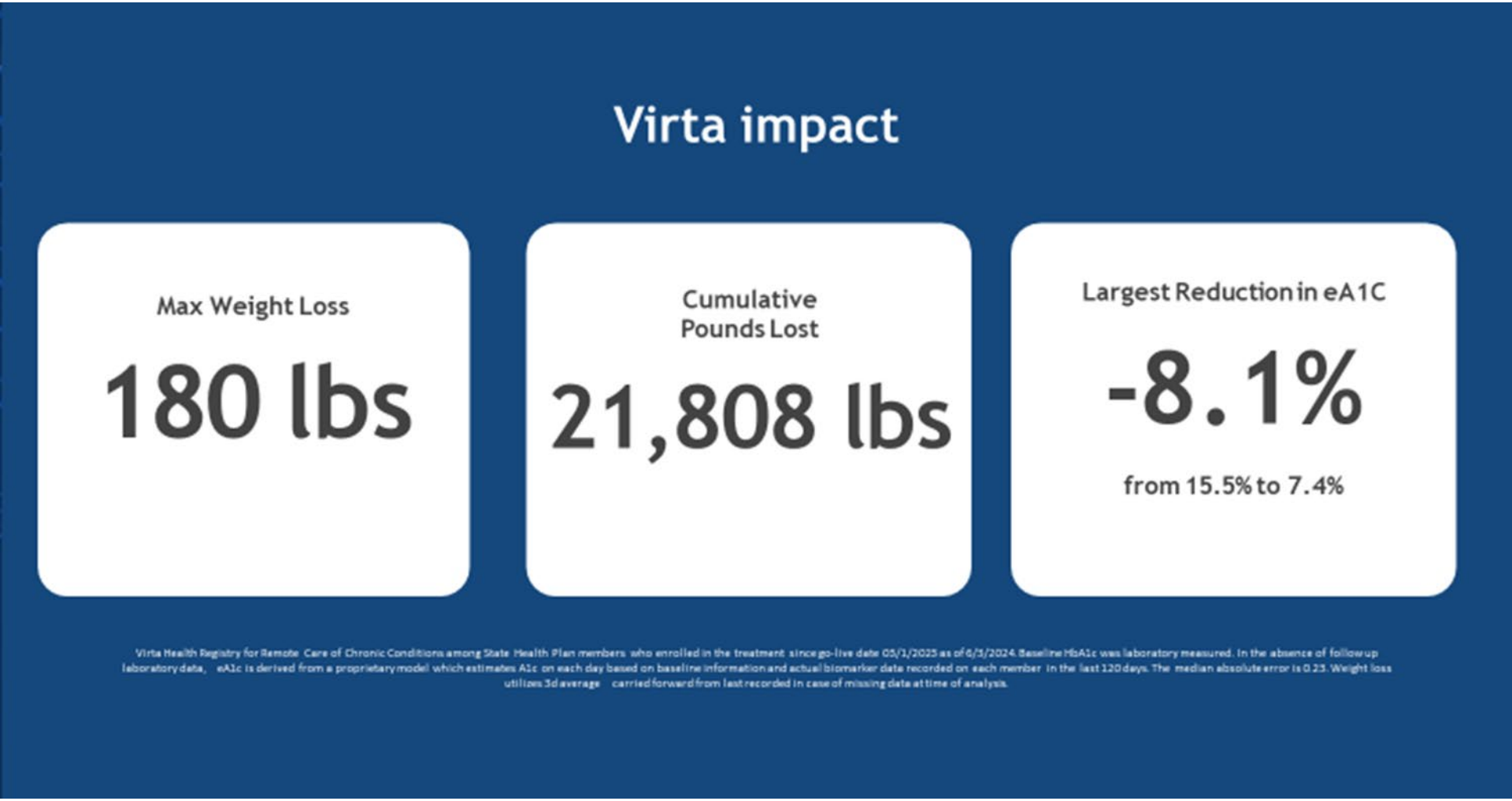
### Provider-led Deprescription

Providers monitor member biomarkers and focus on safe medication deprescription – getting people off of costly drugs like insulin or GLP-1s

* Providers = physicians & nurse practitioners

virta

# Virta


Virta impact
Max Weight Loss
180 lbs
Cumulative Pounds Lost
21,808 lbs
Largest Reduction in eA1C
-8.1%
from 15.5% to 7.4%
Virta Health Registry for Remote Care of Chronic Conditions among State Health Plan members who enrolled in the treatment since go-live date 05/1/2023 as of 6/3/2024. Baseline HbA1c was laboratory measured. In the absence of follow up laboratory data, eA1c is derived from a proprietary model which estimates A1c on each day based on baseline information and actual biomarker data recorded on each member in the last 120 days. The median absolute error is 0.23. Weight loss utilizes 3d average carried forward from last recorded in case of missing data at time of analysis.

# Conclusions

- PEBA must consider the true cost of obesity to its plan when deciding coverage for various treatments
- Both GLP-1s and bariatric surgery do not yield a positive return-on-investment and outweigh the cost of obesity.
- Behavioral programs are available to members and are a minimal expense.
  - PEBA will continue to evaluate these programs.

| Treatment Option for Obesity | Necessary Additional Contribution Increase for 2025 | Necessary Annual Dollar Amount for Treatment Options |
|---|---|---|
| Pharmacological | 9.8% | $311,129,949 |
| Surgical | 2.9% | $88,965,634 |

# Sources


1. CDC
2. CDC
3. Diabetes Obesity & Metabolism
4. NEJM
5. NEJM
6. NEJM
7. Dr. Eric Topol piece re Wegovy cardiovascular benefits
8. University of Southern California Schaeffer Center letter to CBO dated 11/2/2023
9. Leach et al.
10. CBO
11. ICER
12. International Journal of Obesity
13. Annals of Surgery
14. American Society for Metabolic and Bariatric Surgery
15. JAMA
16. Yale Medicine
17. Surgical Endoscopy
18. Springer
19. International Journal of Obesity
20. Society for Human Resource Management: Employee Benefits Annual Survey

# Appendix

- Pharmacological vs Surgical Treatment Analysis
- Surgical Treatment Cost
- Diabetes Savings from Surgical Treatment Calculation

# Pharmacological vs. Surgical Treatment Analysis

- Two separate analyses with separate populations in mind.
  - AOM: A comparison of the cost of treatment to the incremental cost of obesity.
    - *Why we studied it this way:*
      - Barring intentional plan design, AOMs have low barriers to entry and thus have a large population potential. We would need to compare the obese to the non-obese.
  - Bariatric surgery: A quasi-experimental design comparing the theoretical costs of bariatric surgery, associated claim costs after surgery, revisional surgery, and savings from diabetic remission to the total claim costs of the obese population.
    - *Why we studied it this way:*
      - There are more costs associated with bariatric surgery beyond the actual surgery, unlike AOMs. A broader view of what a bariatric surgery patient would cost was necessary to determine the full scope.
      - Bariatric surgery inherently creates subsets of a population. Only 1% of eligible patients end up obtaining the surgery. Their comparative peers, therefore, are eligible patients who do not obtain the surgery (obese patients).
        - Health improvements and subsequent savings are still represented in our analysis.

# Surgical Treatment Cost

**Year N Bariatric Surgery Patients Cost: First Year's Claims**

Eligible members (335,260) x Obesity Rate (.3973) = 133,199 Obese Members x Estimated Take-Up Rate (.01) = 1,332 Patients

1,332 Patients x (Annual Bariatric Surgery Expense of $34,036 + Annual Bariatric Surgery Patients' Claims of $14,107) = $64,126,374

**Bariatric Surgery Patients Cost: Second Year's Claims**

Eligible members (335,260) x Obesity Rate (.3973) = 133,199 Obese Members x Estimated Take-Up Rate (.01) = 1,332 Patients

1,332 Patients x (Annual Follow-up Bariatric Surgery Patients' Claims of $10,331) = $13,760,996

**Revisional Bariatric Surgery Patients Cost: First Year's Claims**

Eligible members (1,332) x Take-Up Rate (.12) = 160 Patients requiring revisional surgery

160 Patients x (Annual Revisional Bariatric Surgery Expense of $34,036 + Annual Revisional Bariatric Surgery Patients' Claims of $15,517) = $7,928,575

**Revisional Bariatric Surgery Patients Cost: Second Year's Claims**

Eligible members (1,332) x Take-Up Rate (.12) = 160 Patients requiring revisional surgery
(1,332 Bariatric Surgery Patients –160 Revisional Surgery Patients) x (N-2) x Obese Annual Claims $7,744.47) = All Previous Rounds' Bariatric Surgery's Annual Claim

160 Patients x (Annual Revisional Bariatric Surgery Patients' Claims of $11,364) = $1,818,270

**All Previous Rounds' Bariatric Surgery Annual Claim Cost Following Second Year of Claim Cost**

(1,332 Bariatric Surgery Patients –160 Revisional Surgery Patients) x (N-2) x Obese Annual Claims $7,744.47) = All Previous Rounds' Bariatric Surgery's Annual Claim Cost for Year N

**All Previous Rounds' Bariatric Surgery Annual Claim Cost Following Second Year of Claim Cost**

160 Revisional Surgery Patients x (N-3) x Obese Annual Claims ($7,744) = All Previous Rounds' Revisional Surgery Annual Claim Cost for Year N

**GLP-1 Utilization per Year N**

(Patient Count per Year N / 3) * $7,497.72 = GLP-1 Utilization per Year N

# Surgical Treatment Diabetic Remission Table

| Year | Round | | | | | | | | | | | | Patient Count | Total Diabetic Savings |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | | |
| 1 | 334 | | | | | | | | | | | | 334 | $1,885,272 |
| 2 | 268 | 334 | | | | | | | | | | | 603 | $3,399,427 |
| 3 | 211 | 268 | 334 | | | | | | | | | | 813 | $4,587,000 |
| 4 | 165 | 211 | 268 | 334 | | | | | | | | | 978 | $5,514,791 |
| 5 | 158 | 165 | 211 | 268 | 334 | | | | | | | | 1,136 | $6,405,471 |
| 6 | 131 | 158 | 165 | 211 | 268 | 334 | | | | | | | 1,267 | $7,143,993 |
| 7 | 120 | 131 | 158 | 165 | 211 | 268 | 334 | | | | | | 1,386 | $7,819,425 |
| 8 | 115 | 120 | 131 | 158 | 165 | 211 | 268 | 334 | | | | | 1,502 | $8,468,879 |
| 9 | 92 | 115 | 120 | 131 | 158 | 165 | 211 | 268 | 334 | | | | 1,594 | $8,988,442 |
| 10 | 84 | 92 | 115 | 120 | 131 | 158 | 165 | 211 | 268 | 334 | | | 1,677 | $9,459,760 |
| 11 | 115 | 84 | 92 | 115 | 120 | 131 | 158 | 165 | 211 | 268 | 334 | | 1,792 | $10,109,214 |
| 12 | 84 | 115 | 84 | 92 | 115 | 120 | 131 | 158 | 165 | 211 | 268 | 334 | 1,876 | $10,580,532 |

- **Health Improvements:**
  - Bariatric surgery can lead to health improvements, particularly in diabetic remission.
  - Literature indicates diabetic remission rates are not sustained at an aggregate level.
- **Savings Variability:**
  - Maximized savings from bariatric surgery are not constant due to fluctuating remission rates.
- **Diabetic Remission Rate:**
  - Calculated diabetic remission rate for the State Health Plan population based on literature.
  - Estimated savings from the cessation of diabetes treatment.
- **Cost of Diabetes Treatment:**
  - Diabetic treatment costs $5,640 per diabetic per year (based on PEBA claims).
- **Assumptions:**
  - Assumed 49.4% of bariatric surgery patients would be diabetic (according to literature).
  - Mimicked the diabetic remission rate from the literature.
  - Patient Count refers to the accruing number of diabetic patients have achieved remission for Years 1 through 12.

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