CHPA® CONSUMER HEALTHCARE PRODUCTS ASSOCIATION

Using the Medicare Advantage Over-the-Counter (OTC) Medicines Program as a Consumer Engagement Tool

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Executive Summary

The Medicare Advantage health insurance market represents an attractive and rapidly growing opportunity in the Consumer Healthcare and OTC Medicines industry.

As of 2021, nearly 18 million consumers have access to health-plan funded and administered OTC benefits with an average of $400 in OTC allowances per enrollee. This equates to a total of $7.1 billion in total allowances for OTC Medicines and other covered products. Most health plans, to date, have used their OTC benefits as a member acquisition tool, and, accordingly, utilization of OTC benefits is approximately 30% leaving nearly $5 billion in unused OTC allowances.

In a recent shift, health plans seeking new ways to retain enrollees, improve customer satisfaction, and identify new care management strategies are looking at OTC and other Supplemental Benefits as a tool. Our study shows health plan OTC programs, and the OTC medicines and other covered products, provide numerous benefits to health plans, including the following:

- The enrollees who use the OTC programs are typically those with greater healthcare need and are the same enrollees health plans seek to engage for other clinical and care management programs
- For certain medical conditions and cohorts, we see reduced medical costs and utilization, as well as improved outcomes for enrollees who use the OTC program (vs. those who do not)

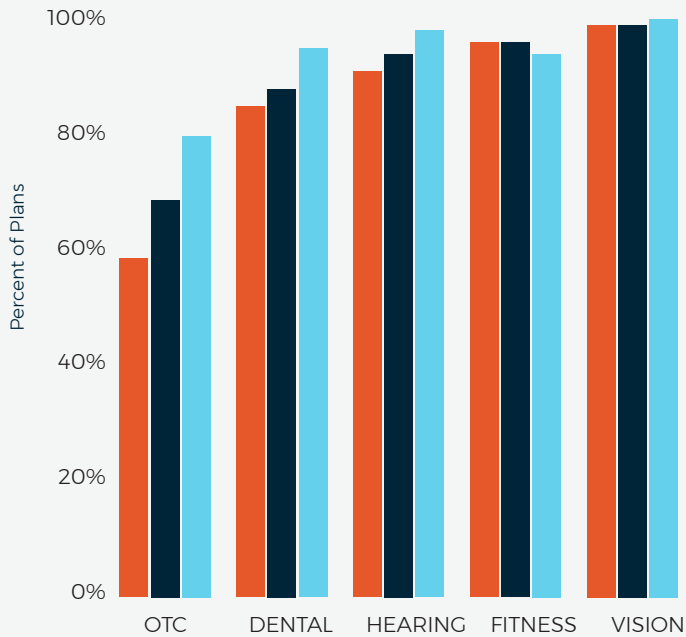
We believe this paradigm shift, paired with the data and evidence shown in studies like ours, creates an opportunity for consumer health organizations, OTC manufacturers, health plans, and policymakers to collaborate to take full advantage of the gains OTC programs provide. Notwithstanding the growth of OTC programs in the health insurance market, most health plans have taken a passive role in managing their OTC programs. We believe the above stakeholders can come together to maximize access and benefit levels (i.e., allowances), promote OTC to enrollees, and ensure OTC is used to its full potential as part of health plans' clinical and care management strategies, as well as part of the industry's effort to address Social Determinants of Health (SDoH) and health inequities.

Industry Overview & Background

Medicare Advantage Market & Supplemental Benefits

Medicare Advantage (MA) is the private market alternative to Medicare Fee-for-Service ("Traditional Medicare" or "Medicare FFS"), which is administered directly by the Centers for Medicare & Medicaid Service (CMS). MA plans are administered by private health insurance companies and typically bundle the various Medicare benefits, including *Hospital Insurance (Part A)*, *Medical Insurance (Part B)*, and, for many plans, *Prescription Drug Coverage (Part D)*, as well as additional benefits not covered by Traditional Medicare. Medicare Advantage initially started as the *Medicare+Choice* program, which was signed into law in 1997. The name changed to Medicare Advantage in 2003. Starting in the mid-2000s, the MA market grew at a notable and consistent yearly rate with total enrollment standing at 26 million in 2021, which accounts for over 42% of the total Medicare population. Accordingly, there has been continued focus, investment, and innovation in MA from various industry stakeholders, including insurers, provider organizations, investors, and the public sector.

Prevalence of Top Supplemental Benefits (2019-2021)



	OTC	DENTAL	HEARING	FITNESS	VISION
2019	58%	84%	90%	95%	98%
2020	68%	87%	93%	95%	98%
2021	79%	94%	97%	93%	99%

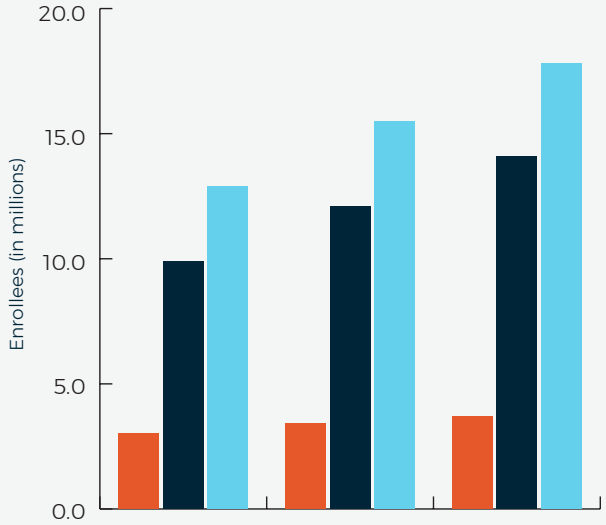
One area of innovation and rapid expansion in the MA market over the past five years is *Supplemental Benefits*. These are benefits not covered by Traditional Medicare, but CMS has granted insurers the option to provide them. There are two primary types of Supplemental Benefits: those that are offered to all enrollees within a given plan, such as Dental, Vision, and Over-the-Counter (OTC), and those that are offered towards targeted enrollee populations, such as those with chronic conditions. The latter are part of the Supplemental Benefits for the Chronically Ill (SSBCI) Program, which launched in 2019 and was expanded in 2020 to allow for a host of non-medical services, such as fresh food and produce, non-medical transportation, and other benefits.

Supplemental Benefits included in MA plans are funded by the health plan using the Bid-Rebate mechanism where the health plan offers a *Bid Rate* to CMS for administering the benefits covered by Traditional Medicare, which is compared to a *Benchmark Rate*. Any savings vs. the Benchmark Rate is rebated back to the health plan, which must be used to provide additional services to the health plan enrollees and can help increase the competitiveness of the plan offering. Typically, health plans will contract with third party vendors for the administration of Supplemental Benefits. Often, these contracts are on a utilization basis where the health plan incurs costs when the benefits are utilized by enrollees.

Over-the-Counter (OTC) Benefits

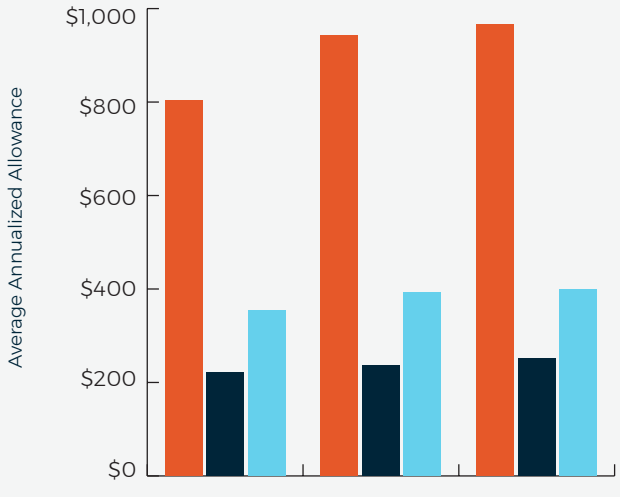
OTC is one of the most popular Supplemental Benefits. It is offered in nearly 80% of all Medicare plans offered and, as of 2021, nearly 18 million MA enrollees had access to an OTC benefit. OTC benefits are typically structured on an allowance basis where an enrollee is provided an allotted annual, quarterly, or monthly allowance with quarterly allowances being the most common. On an annualized basis, the average allowance per enrollee in 2021 was $400. There is, however, a wide degree of variability amongst plan types – notably Special Needs Plans (SNPs) offer higher allowances corresponding to the risk profile and morbidity of the population vs. non-SNPs. The average annualized allowance for SNP enrollees in 2021 was $967 vs. $250 for non-SNP enrollees. The total aggregate allowance for OTC in 2021 was $7.1 billion – increasing from $4.6 billion in 2019 and $6.1 billion in 2020 driven by an increase in enrollees, availability of plans including OTC, and per enrollee allowances.

MA Enrollees with OTC Benefit by Year



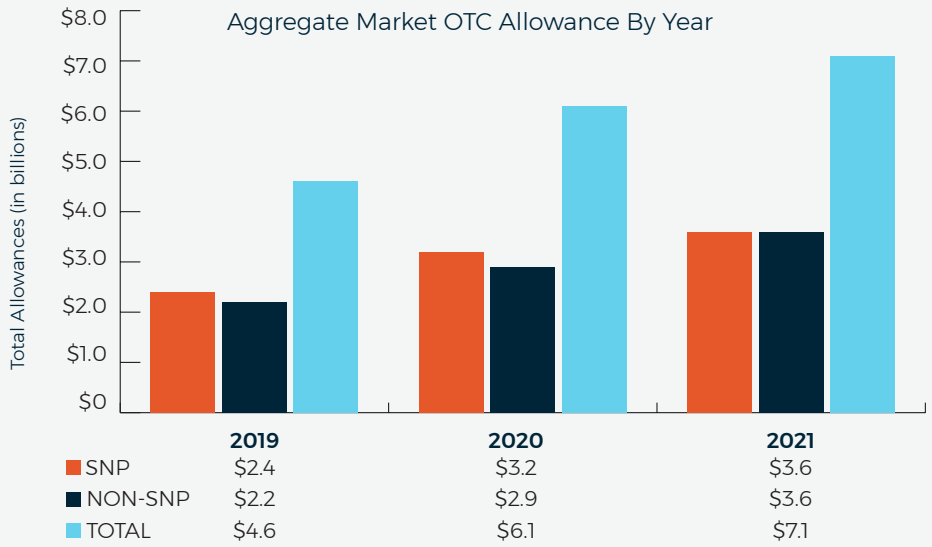
	2019	2020	2021
SNP	3.0	3.4	3.7
NON-SNP	9.9	12.1	14.1
TOTAL	12.9	15.5	17.8

Average Annualized OTC Allowance By Year



	2019	2020	2021
SNP	$804	$942	$967
NON-SNP	$221	$237	$251
TOTAL	$355	$392	$399

The MA OTC landscape largely mirrors the overall MA landscape with a small number of national plans accounting for most OTC enrollees and allowances. The top 5 health plans accounted for 67% of enrollees with OTC benefits and 74% of total OTC allowances in 2021. UnitedHealth Group and Humana accounted for nearly 50% of the enrollees and total allowances in 2021.



Top Health Plans Offering OTC Benefits (2021)

Organization	Enrollees	% of Enrollees	Total Allowances	% of Total Allowances
UnitedHealth Group	4.4M	25%	$1,988M	28%
Humana	4.1M	23%	$1,517M	21%
Anthem	1.2M	7%	$700M	10%
Centene	1.0M	6%	$639M	9%
CVS/Aetna	1.3M	7%	$421M	6%
All Other	5.8M	32%	$1,844M	26%
Total	**17.8M**	**100%**	**$7,109M**	**100%**

Most MA OTC Programs are offered via telephonic, online, and mail order channels. Over the past three years, retail and payment card driven programs have grown in popularity as a supplement to the traditional delivery channels. Typically, health plans will create a formulary or catalogue of approved OTC products, which are available for enrollees to purchase using the allocated allowances.

Like other Supplemental Benefits, most health plans today use OTC as primarily an enrollee acquisition and retention tool – i.e., they use the OTC benefit to improve the attractiveness and competitiveness of the plan benefit offering to new and existing enrollees. Accordingly, there is limited focus on OTC as part of the broader member engagement and care management strategy post-enrollment, and most health plans typically see 20-35% of enrollees utilize the benefit at least once a year. We believe this creates a significant untapped opportunity.

Opportunity Statement & Study Objective

Driven by the competitive dynamics and growth outlook of the MA market, health plans seek new methods to enhance their plan offerings, improve enrollee experience, and evolve their care management strategies. Given this, more health plans are now looking to Supplemental Benefits, including OTC, as a key tool to leverage. This is a shift from the historical use of OTC as a member acquisition and retention tool to one that is considered as part of a broader clinical, care management, and member engagement strategy. Underpinning this approach, is the value of OTC medications and products in addressing MA enrollees' clinical needs and improving their health outcomes.

Furthermore, with the growing emphasis on addressing Social Determinants of Health (SDoH), health-plan funded and administered OTC programs offer health plans a mechanism for engaging and offering value-added products and services to enrollees with greater social need, including those with financial vulnerability, inadequate access to transportation, and inadequate access to retail pharmacy locations. We believe there is an immediate opportunity for industry stakeholders, including health plans, medicine manufacturers, and policymakers to expand the scope and reach of health plan OTC programs, in MA as well as other markets such as Medicaid and the Affordable Care Act (ACA) markets, to take advantage of the potential benefits of the programs from a clinical, care management, and member engagement perspective.

Accordingly, the purpose of our study and analysis is to demonstrate the clinical opportunity health plan OTC programs offer.

Quantitative Analysis

Overview & Methodology

For our study, we analyzed the Medicare Advantage enrollee population for a regional health plan for a single benefit year. The population and methodology are described in the table below. The availability of the OTC benefit and utilization rates were in line with industry-wide availability and utilization rates for MA OTC programs.

Population Analyzed	• Approximately 35,000 Medicare Advantage enrollees for a regional health plan for a single benefit year – 2020
OTC Benefit Utilization within Population	• Approximately 30,000 enrollees had access to the OTC benefit (85% of total) • Approximately 10,000 enrollees used the OTC benefit (33% of those with benefit)
Core Metrics for Comparison	• Per Member Per Month (PMPM) Allowed Medical Costs • Per Member Per Month (PMPM) Allowed Prescription Pharmacy Costs • Inpatient Admission per 1,000 Enrollees • Enrollee Risk Score (an index for relative morbidity or actuarial risk for an enrollee)

Using the above core metrics, we segmented the population between health plan enrollees using the OTC benefit vs. those who did not use the OTC benefit (i.e., "Users" vs. "Non-Users"). We also segmented the results for various medical conditions for Users and Non-Users, which were calculated using the CMS HCC Risk Adjustment Model used for Medicare Advantage. We also segmented the results for Users based on various categories of OTC products purchased. We then compared results between Users and Non-Users with aggregations of the above core metrics.

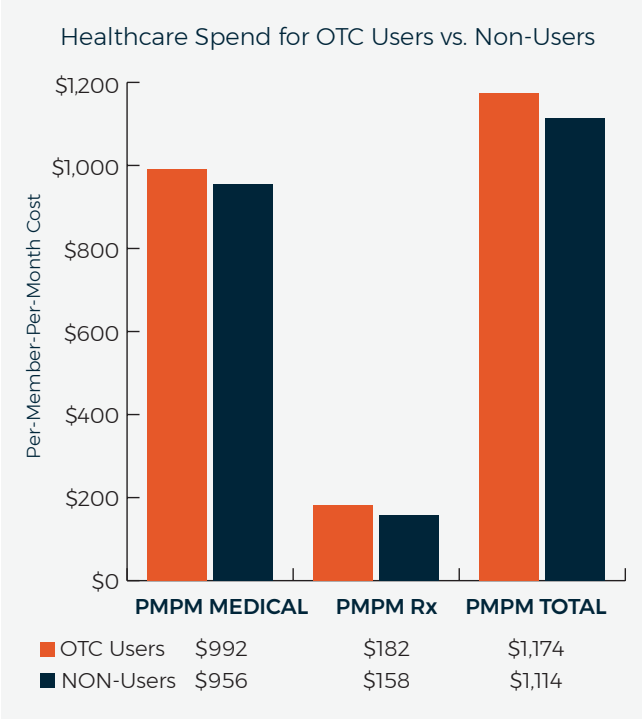
Further information and a more detailed explanation of our methodology may be found in the appendix.

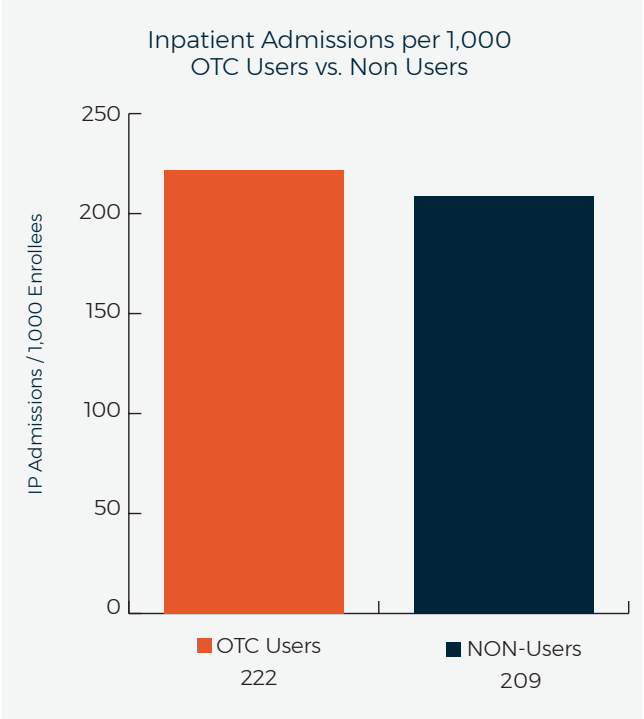
Findings

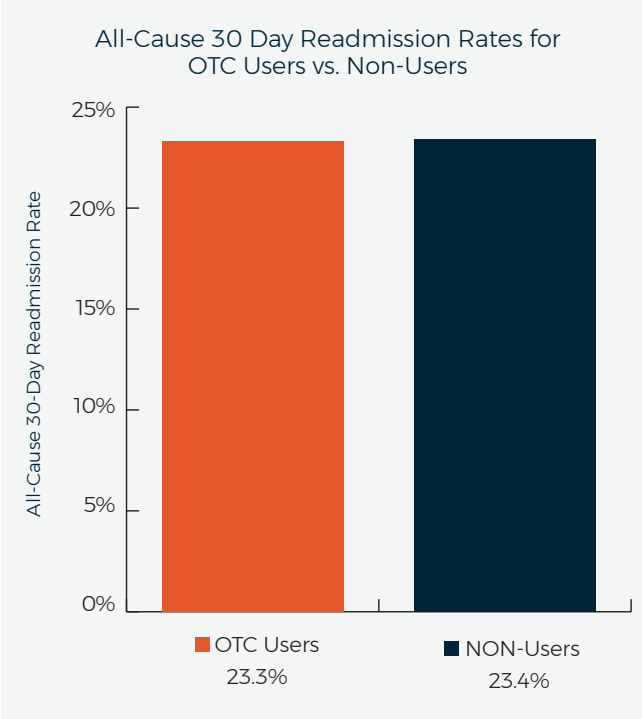
OTC Users vs. Non-Users: Aggregate Results
Our analysis showed OTC Users incurred higher Medical Costs and Pharmacy Costs with PMPM Medical Costs of $993 vs. $956 (4% higher) and PMPM Pharmacy Costs of $182 vs. $158 (16% higher). The notable difference in PMPM Pharmacy Costs may support a correlation between the use of prescription medications and OTC medications. OTC Users also showed a higher rate of Inpatient Admissions with 222 Admits per 1,000 Enrollees for OTC Users vs. 209 Admits per 1,000 Enrollees for Non-Users (7% higher). We believe these results demonstrate OTC Users are likely higher utilizers of healthcare services in general given the higher cost and utilization rates. We believe this presents an opportunity to health plans and industry stakeholders, as this enrollee population is often the target of various clinical, care management and member engagement programs. Health Plans and their partners often spend significant efforts and funds to engage these members for various programs and OTC programs present an opportunity to use existing touch points to drive additional engagement and interventions, such as addressing gaps in care, improving quality measures, and positively impact enrollee experience.

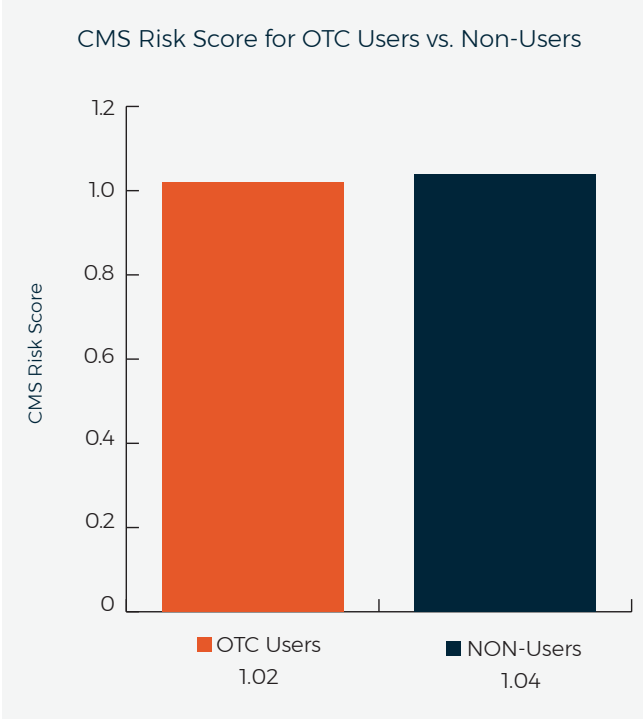
When evaluating All-Cause 30-Day Readmission Rates, we did not see a significant difference between OTC Users and Non-Users. OTC Users showed a 23.3% rate, while Non-Users showed a 23.4% rate (0.4% lower). We believe this is likely driven by the fact that this metric normalizes differences in utilization and morbidity across populations and the effect of OTC medications and products likely have limited effect on the typical drivers of readmissions.

Finally, when comparing CMS Risk Scores, we saw OTC Users showed a lower risk score than Non-Users with a weighted average risk score of 1.02 vs. 1.04 for Non-Users. This is a 2% difference, which at surface level does not seem significant, however a difference of this level can drive significant variability in *risk adjusted revenue* for health plans. Furthermore, we found this to be an interesting insight, especially given the higher cost and utilization profile of the OTC User population. In fact, when the cost and utilization measures are evaluated on a risk adjusted basis, the higher values for the OTC population are further exacerbated. While outside the scope of this analysis and an area of opportunity for further analysis, we believe the lower risk score for the OTC population is likely driven by incomplete data or under-coding of diagnosis codes vs. a true difference, especially given the cost and utilization results. We believe this presents an additional opportunity for health plans to use the OTC program and the engagement created with members through it to address potential cases of under-coding to ensure their risk scores reflect the true risk of the population.


Healthcare Spend for OTC Users vs. Non-Users
Per-Member-Per-Month Cost
$1,200
$1,000
$800
$600
$400
$200
$0
PMPM MEDICAL
PMPM Rx
PMPM TOTAL
OTC Users $992 $182 $1,174
NON-Users $956 $158 $1,114


Inpatient Admissions per 1,000
OTC Users vs. Non Users
IP Admissions / 1,000 Enrollees
250
200
150
100
50
0
OTC Users
222
NON-Users
209


All-Cause 30 Day Readmission Rates for
OTC Users vs. Non-Users
All-Cause 30-Day Readmission Rate
25%
20%
15%
10%
5%
0%
OTC Users
23.3%
NON-Users
23.4%


CMS Risk Score for OTC Users vs. Non-Users
CMS Risk Score
1.2
1.0
0.8
0.6
0.4
0.2
0
OTC Users
1.02
NON-Users
1.04

Results by OTC Product Category

In addition to aggregate level comparisons of OTC Users and Non-Users, we segmented results for OTC Users by individual categories of OTC products for comparison against Non-Users. This identified some interesting insights. While we saw similar trends for many of the Product Categories themselves where the cost and utilization rates were higher than Non-Users, this trend did not hold for certain categories and measures. For example, we saw certain product categories showed notably lower Inpatient Admission Rates, such as enrollees who purchased OTC products in the following categories: Eye & Ear Care (13% lower), Orthotic Braces & Orthopedic Supports (12% lower), Cough, and Cold & Allergy (8% lower), among others. This was also seen with Medical Costs in the following categories: Eye & Ear Care (8% lower), Orthotic Braces & Supports (6% lower), and Leg & Foot Care (4% lower), among others. Notably we saw overlap in some of the categories with the greatest difference. This indicates to us certain OTC products may have the opportunity to yield positive impact in outcomes and reducing medical costs, as part of a health plan's overall care management program. We did see certain categories where the utilization and cost metrics were also notably higher, such as Incontinence where Medical Costs were 14% higher and Inpatient Admissions were 18% higher than Non-Users.

In line with the aggregate analysis, where we saw OTC Users with 16% higher Pharmacy Costs, all product categories showed higher costs than Non-Users. The categories where the difference was the greatest were the following: Medication Management (24% higher), Incontinence (19% higher), and Orthotic Braces & Orthopedic Supports (17% higher). The categories where the difference was not as large as the aggregate OTC User population were the following: Eye & Ear Care (4% higher), Skin Health (5% higher), and Bath Safety (8% higher), and Leg & Foot Care (8% higher). As previously stated, we believe this highlights a correlation between the use of prescription medications and OTC medications, which is further illustrated with the fact we see the Medication Management category with the highest PMPM Pharmacy Costs ($196 vs. $186 for all OTC Users and $158 for Non-Users).

Category	PMPM Medical Cost	% vs. Non-User	PMPM Rx Cost	% vs. Non-User	IP Admits / 1,000	% vs. Non-User
Total OTC Population	**$992**	**4%**	**$182**	**16%**	**222**	**7%**
First Aid	$976	2%	$177	13%	213	2%
Oral & Dental Care	$971	2%	$181	15%	209	0%
Vitamins & Supplements	$965	1%	$177	12%	206	-1%
Pain & Fever Relief	$962	1%	$172	9%	202	-3%
Cough, Cold & Allergy	$931	-3%	$179	14%	193	-8%
Skin Health	$934	-2%	$166	5%	208	0%
Incontinence	$1,086	14%	$188	19%	245	18%
Stomach Remedies	$971	2%	$178	13%	214	2%
Home Medical	$990	4%	$172	9%	214	3%
Leg & Foot Care	$921	-4%	$169	8%	200	-4%
Bath & Safety	$964	1%	$170	8%	218	4%
Eye & Ear Care	$878	-8%	$164	4%	182	-13%
Orthotic Braces & Orthopedic Supports	$896	-6%	$184	17%	183	-12%
Medication Management	$1,077	13%	$196	24%	233	12%

Results by Medical Condition

Like our analysis segmented by OTC Product Category, segmenting the results by Medical Condition allows us to identify additional interesting insights with one additional benefit: We can compare OTC Users vs. Non-Users within the same Medical Condition Category cohort.

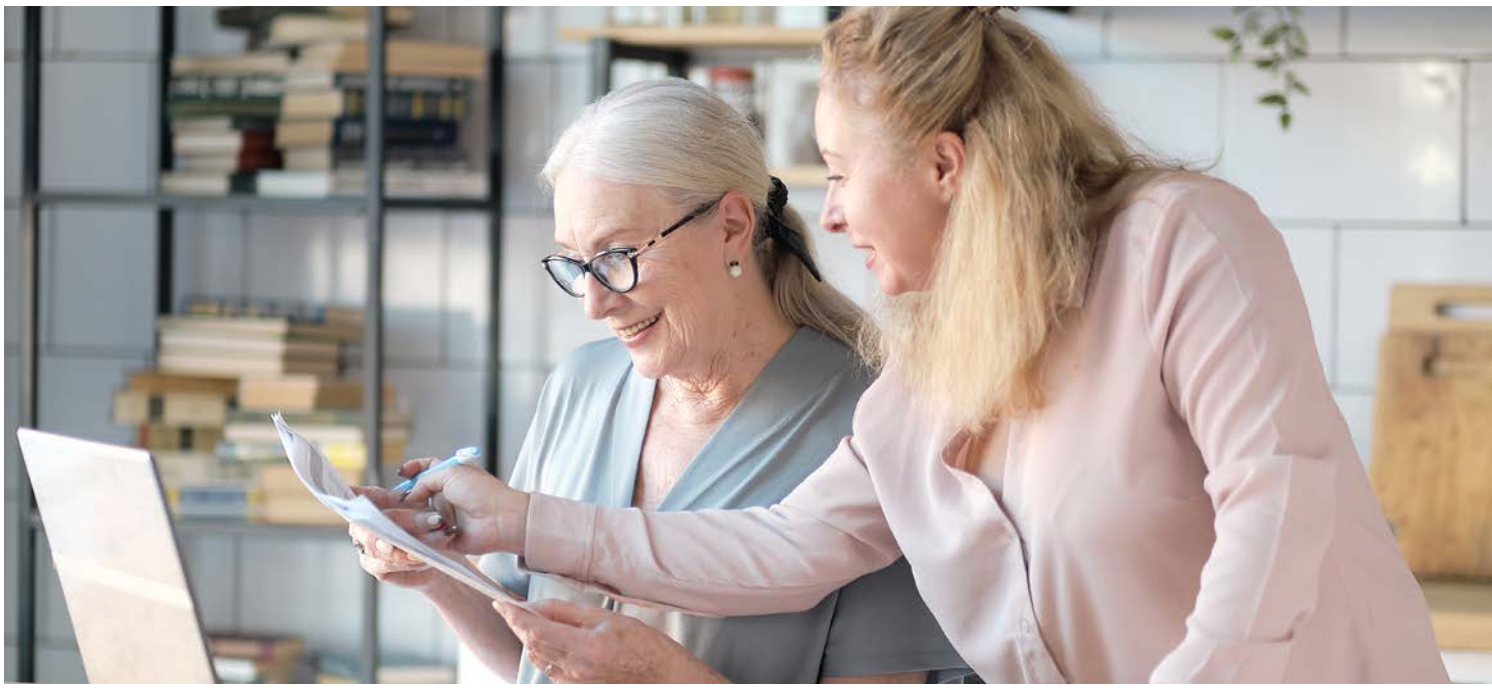
In line with the aggregate results, we see most Medical Condition cohorts with higher Medical Costs, Pharmacy Costs, and Inpatient Admissions for the OTC Users (vs. Non-Users). Some of the Medical Conditions with the greatest differences where Medical Costs are higher including Endocrine (19% higher), Falls (18% higher), and Stroke (18% higher). For Pharmacy Costs this includes Falls (60% higher), Respiratory (32% higher), and Arthritis (29% higher). We believe this, again, presents an opportunity for health plans to use the OTC program and its related member engagement channels to drive additional evaluation, monitoring, and potential interventions pertaining to these conditions.

There are, however, some notable Medical Conditions where OTC Users show lower costs and utilization figures. For Medical Costs this includes Obesity (62% lower) and Substance Abuse (29% lower). For Pharmacy Costs this includes Stroke (23% lower). For Inpatient Admissions this includes Respiratory (10% lower), Mobility (10%) and Arthritis (9% lower). For these conditions, especially those with lower Inpatient Admissions, we believe this is driven by the prevalence of effective OTC treatments and maintenance medications.

Medical Condition Category	PMPM Medical Cost	% vs. Non-User	PMPM Rx Cost	% vs. Non-User	IP Admits / 1,000	% vs. Non-User
Total OTC Population	**$992**	**4%**	**$182**	**16%**	**222**	**7%**
Diabetes	$1,380	13%	$332	20%	316	1%
Cardio	$1,914	14%	$320	14%	451	2%
Falls	$3,268	18%	$350	60%	914	6%
Septicemia	$3,444	13%	$477	15%	824	5%
Depression	$1,619	12%	$310	19%	357	-2%
Substance Abuse	$1,828	-29%	$330	22%	422	8%
Coagulation	$2,453	8%	$372	5%	578	0%
Obesity	$1,678	-62%	$357	27%	376	4%
Mobility	$1,975	3%	$393	31%	413	-10%
Stroke	$2,293	18%	$237	-23%	590	-1%
Psychosis	$1,769	6%	$330	13%	415	-2%
Endocrine	$2,949	19%	$468	25%	757	15%
Breast/Prostate Cancer	$1,252	12%	$195	-2%	254	15%
Graft	$4,109	11%	$339	4%	844	1%
Respiratory	$1,953	2%	$391	32%	409	-10%
Arthritis	$1,686	3%	$382	29%	345	-9%

Note: Enrollees with no medical condition are not shown in this table, however, are included in the Total OTC Population metrics.

Limitations & Opportunities for Further Analysis



While we believe our analysis provides valuable insight into the MA OTC program and the effect of OTC utilization across different product categories, enrollee cohorts, and medical conditions, there were some limitations to our analysis:

- **Limited Data Set and Population:** Our analysis was limited to a population size of approximately 30,000 MA enrollees for a regional health plan. In further analysis, we seek to expand our analysis to multiple regions or a national data set and multiple health plan populations of greater size. Given the focus and opportunity with Supplemental Benefits and OTC, we do see a growing interest in analysis of health plans' programs to uncover insights like these.
- **Limited Time Period & Moment in Time Analysis:** Our analysis includes only one year of data: 2020, which was also an unprecedented year in many ways due to the impact of the COVID-19 Pandemic. To ensure the validity of our analysis, we focused our analysis on making in-year comparisons only and evaluated the effect of outliers and macro-trends across various cohorts to eliminate any potential bias. Furthermore, we analyzed and compared aggregate trends for OTC utilization between 2019 and 2020 to ensure a reasonable expectation of generalizability of results from 2020 to other years. We acknowledge there are some impacts, such as a likely increase in delivery-based OTC programs vs. retail due to the COVID-19 pandemic and increased popularity of some products such as masks and alcohol-based hand sanitizers; however, we are confident the trends identified in our analysis are generalizable on a go-forward basis. In future analysis, we believe there is great value in performing a multi-year, longitudinal analysis, as this will also help identify potential long-term efforts of OTC medicines and products.
- **Non-Controlled Study:** Our analysis was not a controlled experiment. Rather we evaluated the potential effects of a treatment applied at a point in time (i.e., availability of an OTC benefit) and analyzed the effects. In future analysis, we believe a controlled study will allow for the most effective means of identifying and evaluating the effects and benefits of the MA OTC program.

Conclusions & Recommendations

We believe there is significant opportunity to use MA OTC programs to improve health outcomes and health plan enrollee experience as part of health plans' broader care management and enrollee experience programs. This includes the potential clinical value of OTC medicines, as well as the opportunity to maximize the engagement and touchpoints created through health plans' OTC programs. Through our study and analysis of the MA OTC program, we identified the following key insights:

- MA OTC programs create opportunities for health plans and other stakeholders to engage enrollees who have the greatest clinical need
- Certain OTC medicines and products can positively impact medical and pharmacy costs, utilization rates, and health outcomes
- Opportunities exist to align efforts with other health plan programs, such as Risk Adjustment and Quality initiatives
- OTC programs, in particular home delivery-based programs, provide a benefit and value to enrollees with SDoH challenges

Given the rapid adoption of Supplemental Benefits, in particular OTC, as well as continued support from CMS, we believe there is opportunity for collaboration amongst industry stakeholders in support of the MA OTC program, including consumer health consumer health organizations, OTC manufacturers, health plans, and other organizations in the OTC delivery chain.

High value areas of collaboration include:

- Partnership between consumer health organizations, OTC manufacturers, and health plans in program support, design and expansion related to MA OTC programs
- Further integration of health plan OTC programs into care management and enrollee experience focused programs, including awareness campaigns, education, and support for appropriate, informed utilization of programs
- Expansion of OTC programs in other government healthcare programs and insured markets, as well as value-based insurance design
- Further exploration and analysis of how OTC programs can be used to address social determinants of health in senior and non-senior populations

Appendix

Detailed Explanation of Overview & Methodology

For our study, we analyzed a population of over 35,000 Medicare Advantage enrollees for a regional health plan for a single benefit year – 2020. Within this population approximately 30,000 members had the OTC benefit available as part of their plan benefit offering. Approximately 10,000 member or 33% of the members offered the benefit used it at least once within the year, which is in line with industry utilization rates. Our analysis compared key cost, utilization, and risk metrics for members using the OTC benefit vs. those who were offered the benefit but did not use it.

The first step of our analysis was to calculate core cost, utilization, and risk measures for the enrollee population at an individual enrollee level.

- **Total Allowed Medical Cost:** This is the total medical cost, inclusive of health plan paid and member paid cost for medical services. When comparing this metric on an aggregate level across various cohorts, we calculated this metric on a per-member per-month basis to account for different cohort sizes and enrollment durations.
- **Total Allowed Prescription Pharmacy Cost:** This is the total cost, inclusive of health plan paid and member paid cost for prescription pharmacy services. When comparing this metric on an aggregate level across various cohorts, we calculated this metric on a per-member per-month basis to account for different cohort sizes and enrollment durations.
- **Total Number of Inpatient Admissions:** This is the total number of inpatient admissions. When comparing this metric on an aggregate level across various cohorts, we calculated this metric on a per 1,000 members basis to account for different cohort sizes.
- **Total Number of All-Cause 30-Day Inpatient Readmissions:** This is the total number of inpatient admissions where a subsequent inpatient admission occurred within 30-days of discharge. When comparing this metric on an aggregate level across various cohorts, we calculated this metric as a percent of total admissions within the cohort (i.e., as a rate) to account for different cohort sizes and morbidity.
- **Enrollee Risk Score:** CMS provides and administers a Risk Adjustment program, which, among other goals, is a mechanism to ensure health plans are compensated adequately for the risk of their enrollee population. Risk Scores are calculated using a demographic component based on age, sex, and entitlement reason and a diagnostic component, which is based on the enrollees' medical conditions as indicated by diagnosis codes using the CMS-HCC Risk Adjustment Model for Medicare Advantage. Risk Scores are normalized where 1.00 is the benchmark average risk of the total enrollee population as set by CMS. Accordingly, the CMS Risk Score is an accurate and relevant method to assess the healthcare burden of an individual member or an enrollee population. When comparing this metric on an aggregate level across various cohorts, we calculated this metric as an enrolled months weighted average basis to account for different cohort sizes and enrollment durations.

Using the above core metrics, we segmented the population between those that used the OTC benefit vs. those that did not use the OTC benefit (i.e., users vs. non-users). We also segmented the results for various medical conditions for both OTC Users and Non-Users, which were calculated using the CMS HCC Risk Adjustment Model used for Medicare Advantage. We also segmented the results for OTC Users based on various categories of OTC products purchased. We then compared results between OTC Users and Non-Users with aggregations of the above core metrics.

To test and ensure the validity of our analysis, we calculated metrics on both a raw and risk adjusted basis to account for differences in morbidity across various cohorts. We also evaluated the effect of removing outlier members from various cohorts.

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