EMPLOYERS HEALTH

A publication of Employers Health Coalition, Inc.
Spring/Summer 2017

EHconnect

Member Spotlight
JOANN STORES, INC.

Drug Price Inflation

A NEW FRONTIER: AHCA

Our Q&A with Kaylynn Ruf
Compensation and Benefits Analyst → 20

CVSHealth

Transform Diabetes Care™: Your Key to Helping Reduce Costs, Improve Care

Diabetes is one of the most prevalent and costly chronic conditions in the nation.[1] Now you can get in front of this trend and soften the financial impact with Transform Diabetes Care™. This comprehensive management solution utilizes advanced analytics to target and address each plan member's unique needs to help improve health outcomes. Best of all, it offers *single-digit trend guarantee for diabetes drugs to rein in escalating costs.**

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- **Help improve A1C** through controlled blood glucose readings and corrective coaching
- **Help improve adherence** through pharmacist counseling, as well as adherence and refill reminders available through the CVS Pharmacy® app
- **Help reduce health care costs** by providing exams and checks at MinuteClinic®, helping avoid potential complications
- **Encourage positive behavior changes** through education, coaching and peer-to-peer support

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- **Manage costs with a guarantee** that will help keep diabetes drug trend to single digits*
- **Contain costs** with up to 67 percent fewer complications and up to $36 million in potential savings from improved diabetes control**
- **Help reduce spend** on diabetes medication with our exclusive CVS Pharmacy® and CVS Caremark® Mail Service Pharmacy network

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Innovation. The ability to get ahead of the trends, solve for unique member needs and manage future financial impact. You can count on CVS Health to leverage our technology, scale and capabilities to deliver aggressive trend management and holistic clinical solutions such as Transform Diabetes Care. Your plan benefits with reduced medical costs through improved adherence, A1C control and support of positive behavior changes.

For more information about Transform Diabetes Care, contact your CVS Health Account Team.

1 Source: CDC.gov

*Our program employs several cost containment and clinical strategies to help produce additional savings. While the guarantee will vary by client according to plan population demographics and other programs implements by the client, an employer client's current spending on these diabetes drugs, and other factors, we have developed the program to help clients reduce trends for diabetes drugs to single-digit.

**Based on a model 100,000 life commercial client population and CVS Health analysis. Actual savings will vary based upon factors such as demographic changes, plan design changes, and law/regulation changes). Source: CVS Health Analysis, Gilmer et al., Diabetes Care, (2005), CDC Prevalence Data.

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Emily Clevenger, Editor

2017 Meetings&Events

Stay ahead with Employers Health and save these dates!
You can always find our events calendar at www.employershealthco.com/events
**Employer Members only*

JUN 22

2017 INNOVATIONS IN EMPLOYEE BENEFITS CONFERENCE

CINCINNATI, OH
COOPER CREEK
EVENT CENTER
7:30 AM-2 PM

BREAKFAST, REGISTRATION & EXHIBITS
7:30-8:30 AM

Topics include:

- *Understanding the Medical Specialty Drug Benefit*
- *How to Capture Attention and Drive Behavior*
- *Delivering Primary Care Health Services to the Workplace: The Right Model for the Right Time*
- *ACA Outlook: The Future of the Affordable Care Act*

Approved for 4 HRCI credits.
Pending approval of CE, PHR and SPHR credits!

Register now at employershealthco.com/events or call 614.336.2883! The registration deadline is June 15!

JUN 29

COLUMBUS MEMBER ROUNDTABLE*
MATT THE MILLER'S TAVERN – DUBLIN
12-1 PM

AUG 30

EMPLOYER HEALTH AND WEALTH WORKSHOP

COLUMBUS , OH
HILTON POLARIS
8 AM-3 PM

An exclusive employer event, topics include:

- *ACA Policy and Compliance*
- *Auditing of Retirement, Health and Welfare Plans*
- *FMLA*
- *ERISA*
- *Constructing a Bullet-Proof Wellness Program That Complies With EEOC Guidelines*

Pending approval for 5 HRCI and 6 CLE credits.

SEP 7

PBM TRENDS BOSTON
BOSTON MARRIOTT NEWTON
8:30-11 AM
BREAKFAST & REGISTRATION 7:30-8:30 AM

2017 ANNUAL MEMBERSHIP MEETING

SAVE THE DATE
NOV 30
CANTON, OH
KENT STATE UNIVERSITY
AT STARK (CONFERENCE CENTER)
8-10 AM

Message from Chris

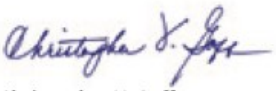
Welcome to the spring/summer issue of EH Connect. Although we are nearly halfway through 2017, many of the same hot topics from 2016 continue to make headlines. Drug price inflation and the uncertainty surrounding health care coverage are still top-of-mind for all benefits professionals. In this issue, Matt Harman, director of pharmacy, tackles the numerous components of drug price inflation and what employers can do to minimize its impact. Additionally, Garrett Brown, associate counsel, provides insight on the Republican plans to repeal and/or replace the Affordable Care Act.

The 2016 Employers Health Annual Report focuses on the strength of the coalition. As our membership continues to grow, it is important to reflect on what that really means for the organization. As we surpass the $1 billion mark in prescription drug spend, we continue to gain leverage in the market. This leverage provides us with the strength to negotiate the best possible pricing on behalf of more than 300 members. But, it is more than that. The growth of the coalition provides Employers Health members with more resources as they network with peers, access results from benchmarking surveys and more. In addition to the strength of a growing membership, members also benefit from an Annual Market Check and Pricing Improvement Analysis. In 2016, participating groups realized an average incremental price improvement of 7.18 percent on their pharmacy spend because of this process.

Further strengthening the organization, we have added three additional staff to our growing team. First, many may have already met or interacted with Travis Johns, who joined us in October as an account management specialist. He brings more than five years of prior account management experience and has been a welcome addition to an already strong account management team. Next, Kelly Drake joined us in March as an administrative assistant in the Canton office. Her diverse background includes teaching English in Japan, Kuwait and Oman. Finally, we welcomed Lisa Sturgill, CPA, as an accounting manager. Lisa works with our CFO to coordinate the Employers Health annual audit, prepare tax returns and ensure accurate distribution of member-related, pass-through funds. She brings more than four years of public accounting experience during which she advised clients in the not-for-profit and manufacturing industries.

Finally, the Employers Health Canton office has officially moved! Our new, nearly 18,000-square-foot headquarters in Jackson Township, Ohio is just down the road from our previous office. The new Canton address is 4771 Fulton Drive NW, Canton, OH 44718, so please be sure to update your records and stop in and see us. The new facility includes a larger meeting facility, which, as always, is available for member use at no charge.

As we continue to grow stronger, we thank you for your continued membership and confidence in the organization.



Christopher V. Goff
CEO & GENERAL COUNSEL

Welcome to our newest members!

- Alyfe Wellbeing Strategies
- Arizona Community Physicians
- Atrium Centers, Inc.
- Best Health Plan
- Cardiovascular Provider Resources
- Career Education Corporation
- City of Alliance
- City of Naperville
- Cobalt Boats, LLC
- Community Consolidated School District #15
- FCX Performance
- Forcht Group of Kentucky, LLC
- Graystone Consulting
- Hazleton Area School District
- Herschend Entertainment Center, LLC
- Interleukin Genetics
- Iron Workers District Council of Southern Ohio and Vicinity Benefit Trust
- Myers Industries, Inc.
- National Seating and Mobility
- NCH Corporation
- Northwestern Ohio Plumbers and Pipefitters Retirees Health and Welfare Plan
- Poudre School District
- SmithBucklin
- VNA Health Group
- Walbro, LLC
- Wendy's International, LLC
- Western and Southern Financial Group

A NEW FRONTIER:

The American Health Care Act AND BEYOND

WRITTEN BY: **GARRETT BROWN, JD** // *Associate Counsel*

The Trump Administration and Republican-controlled Congress have begun an attempt to advance certain objectives that have become dogmas during the election.

One such objective is to repeal and/or replace the Affordable Care Act (ACA). Unlike prior GOP efforts related to funding restrictions and legal challenges that were met with little success under President Obama, the pieces have potentially begun to fall in place for a substantive legislative action to meet its goals. However, with the passage of the American Health Care Act (AHCA) in the U.S. House of Representatives, plan sponsors should continue to monitor future health care reform legislation and looming tax reform policy that many believe could impact the tax deductibility of employee benefits.

While the AHCA may undergo significant changes or stall in the Senate, it is beneficial to understand the components of the bill and identify key elements. The AHCA was drafted to repeal and replace portions of the ACA and was introduced in the House on March 20, 2017. Following disagreement within the GOP, the bill was withdrawn on March 24, 2017. Specific points of contention were raised by the House Freedom Caucus, a group of conservative Republican members, rejecting any legislation that did not repeal insurance market reforms and mandates. The bill was amended to include a "Federal Invisible Risk-Sharing Program" and allow states to waive certain ACA market reform requirements. On May 4, 2017, the House voted to approve the AHCA with these changes.

AHCA Reform of Coverage Provisions

AHCA changes to the current regulatory environment can be broken into two primary focus areas – reform of coverage provisions and tax/revenue based changes. From a coverage perspective, there were a variety of changes, but select provisions include:

- immediately eliminating penalties associated with the requirements that most taxpayers obtain health insurance coverage and that large employers offer their employees coverage that meets specific standards and
- reducing the federal matching rate for adults made eligible for Medicaid through the ACA to equal the rate for other enrollees in the state.

Other coverage-related provisions included revising the rules for subsidies and tax credits for the nongroup market, appropriating funding for grants to states to reimburse insurers for certain high-cost claimants. The AHCA also seeks to relax the ACA's prohibitions on underwriting based on age and curtail some market reforms for the nongroup and small-group market related to minimum actuarial value.

AHCA Tax/Revenue Based Changes

Other components of the legislation would repeal or delay many of the changes the ACA made to the Internal Revenue Code. Notable changes include:

- repealing the surtax on certain high-income taxpayers' net investment income and
- repealing the annual fee on health insurance providers and further delaying the Cadillac Tax until 2026

Such changes run contrary to existing provisions of the ACA and are not compatible with continued operation. As originally proposed, some changes would reduce deficits by $935 billion. Other provisions, including the reduction in tax revenue, would increase deficits by $599 billion. Thus, the Congressional Budget

Office (CBO) estimated the net impact of the legislation would be the reduction in deficits by $337 billion from 2017-2026.

AHCA Provisions of Interest

Some provisions will likely be included in any successful GOP-backed legislation, so plan sponsors should take note. These themes include repeal of the:

- employer and individual mandates and
- rollback of Medicaid expansion.

AHCA Removal of Coverage Mandates

The repeal of the employer and individual mandates likely has the most direct impact on plan sponsors. Specifically, elimination of the individual mandate will impact the risk profile of the plan. If individuals are no longer required to purchase coverage, there is the potential for young and healthy plan members to forgo participation in an employer-sponsored plan. Under the AHCA, as originally drafted, the CBO asserted that approximately 2 million fewer people, as compared to projections with the ACA in place, would be enrolled in employment-based coverage in 2020, and that number would grow to roughly 7 million in 2026.

The potential for employees to forgo or seek coverage in the nongroup market will be impacted by an employer's ability to effectively communicate its benefit plan and demonstrate the value of the plan within the employer's total compensation package. More than ever, it would be important for employers to leverage resources to communicate with plan participants and facilitate informed decision-making. Participants would likely be flooded by information surrounding proposed legislation and the related changes to tax credit availability. Interestingly, the CBO believes that tax credits will be available to people with a broader range of incomes than the current tax credits under the ACA, albeit the total subsidy available per individual is likely reduced.

The elimination of some market reforms and actuarial value requirements would likely allow employers to revisit the balance between wages and health benefits. For example, without employer penalties for failure to offer coverage that meets specific affordability and minimum actuarial value requirements, "skinny plans" or stand-alone health reimbursement accounts could again be considered by plan sponsors. The CBO also estimates that fewer employers would offer health insurance because the legislation would change their incentives to do so. Thus, depending on industry and competitive forces, employers may consider eliminating benefits or reconfiguring staffing to allow more 30-hour-plus positions that would currently require an offer of coverage to be made.

Repeal of Medicaid Expansion

Despite its unpopularity with GOP governors whose states expanded Medicaid, the repeal or reduction of Medicaid expansion will likely remain a component of any health care reform proposal supported by the GOP. As introduced, the CBO estimated that the reduction in Medicaid would decrease direct spending by $880 billion over the 2017-2026 period. This reduction would stem primarily from lower enrollment throughout the period, culminating in 14 million fewer Medicaid enrollees by 2026. Thus, for employers with low income employees in states that have expanded Medicaid, it would be important for plan sponsors to anticipate that some employees may lose health care coverage following the state's response to a cutback in federal funding. For states that elect to continue to offer Medicaid at current levels, such states will likely need to locate additional revenue to offset this loss.

Non-AHCA Legislation Necessary to Reach GOP Consensus and Challenges Therein

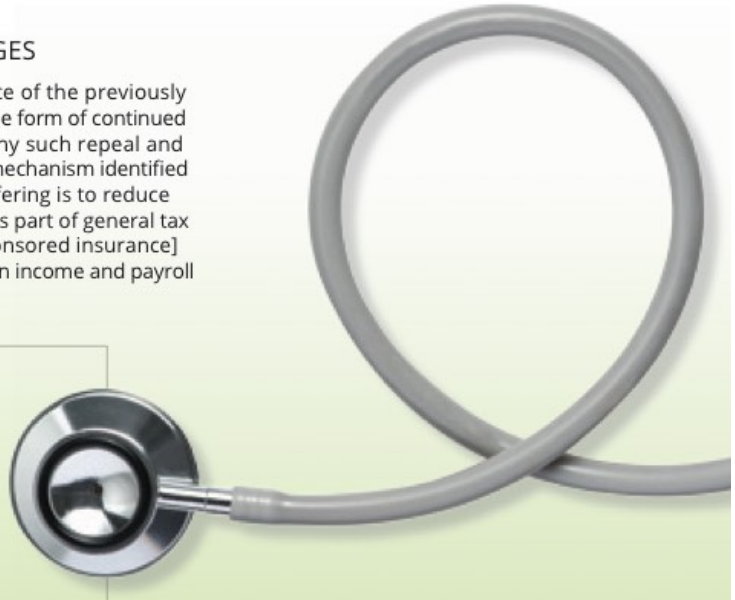
The passage of this bill in the House is only the first step in the legislative process. GOP establishment leaders were initially unable to reach consensus within the party due, in part, to the failure of the bill to pass muster with the conservative Freedom Caucus. To appease conservative members of the GOP and reach a consensus, a successful GOP bill would likely permit states to eliminate mandates surrounding coverage of mental health, substance abuse, maternity care and prescription drugs. It would also likely remove underwriting restrictions such as excluding consideration of health status and preexisting conditions. The elimination or reduction in requirements for fully insured medical products to offer essential health benefits would also likely be a necessary component. While the existence of such regulations is a driving force behind increasing premiums, the elimination of such regulations and the changes impacting Medicaid expansion contained in the AHCA are generally politically untenable for many Republicans because of the resulting loss of coverage for some constituents.

The loss of constituent coverage creates a serious counterweight to any GOP effort to repeal. Under the AHCA, as originally drafted, the CBO projected a significant net increase in uninsured Americans. The CBO projected such increases will culminate in an additional 24 million uninsured Americans in 2026, as compared to the ACA. This increase is primarily driven by a reduction in Medicaid and employment-based coverage. Thus, any successful overhaul would likely necessitate a mechanism to provide a level of coverage for populations that gained such coverage under the ACA.

The loss of constituent coverage creates a serious counterweight to any GOP effort to repeal. Under the AHCA, as originally drafted, the CBO projected a significant net increase in uninsured Americans. The CBO projected such increases will culminate in an additional 24 million uninsured Americans in 2026, as compared to the ACA.

POTENTIAL FOR ADDITIONAL REGULATORY CHANGES

While a potential repeal and replace plan that strikes a balance of the previously mentioned considerations may eventually succeed, ensuring some form of continued coverage – especially for high risk individuals – would make any such repeal and replacement costly, but much more politically palatable. A likely mechanism identified by many pundits to generate additional funding for such an offering is to reduce tax-favored treatment of employer-provided health care plans as part of general tax reform. According to the Tax Policy Center, "The [employer-sponsored insurance] exclusion cost the federal government an estimated $260 billion in income and payroll taxes in 2017 making it the single largest tax expenditure."



MECHANISMS TO CAPTURE TAX REVENUE INCLUDE:

- > *taxing the entire cost of such coverage*
- > *limiting the portion of cost that can be excluded, and*
- > *taxing the entire cost of such coverage, providing a refundable tax credit to all taxpayers to offset tax liability arising from the cost of coverage or purchasing coverage elsewhere.*

What Does This All Mean for Plan Sponsors?

Undoubtedly, traditional government policy seeks to facilitate and promote employer-sponsored benefits; the preferred tax treatment of employee benefits is only one such mechanism. However, as the cost of coverage has increased and the efficiency and viability of the current health care market have been called into question, one must consider if such treatment will always exist. Thus, it is important, now more than ever, for employers to become better purchasers of health care. While this may mean different things for different employers, such an approach necessitates purchasing health care in an affordable and sustainable manner.

Questions surrounding affordability and sustainability are what has placed health care, including medical and pharmacy costs, and health insurance in the news as well as in the crosshairs of government regulators. One need not look any further than the Cadillac Tax to note that there is a clear regulatory focus on the cost of coverage. And while the cost of coverage may be an easily identifiable measure to regulate, such total cost is at the center of affordability and sustainability.

To ensure the affordability and sustainability of its benefit plan, a plan must adopt strategies that address the cost of each unit of health care received and the number of health care units consumed. Thus, an improved purchasing strategy must include a focus on prevention, elimination of waste in the health care delivery system, a reduction in pricing variation, emphasis on population health, excellent clinical management, participant engagement and participant advocacy. This strategy must be at the core of all plan sponsor decision making, but the same tactics to affect such a strategy are not the same for all plan sponsors. For example, some opportunities may not be available to plans due to size requirements, and it may be necessary to leverage collective purchasing offerings to access such opportunities. Also, depending on participant demographics and participant education level, an employer may need to evaluate a variety of methods to engage participants. Similarly, such a strategy must be applied to decisions dictated by the changing regulatory environment.

Despite the potential for the elimination of key tenets of the ACA and the return to a pre-ACA regulatory environment, the question remains if such a return is possible considering vendor and provider consolidation. Will stalwart approaches to ACA edicts such as high deductible health plans in response to the Cadillac Tax still retain their prevalence in that environment? Or will the trend to offer high deductibles take a back seat to a more moderate approach focused on the "managed" in managed care and enhanced participant advocacy? The evaluation of such questions through the core tenets of the strategy above will be an employer's first step to ensuring the affordability and sustainability of its benefit offerings.

Sources:
1. https://www.cbo.gov/about/overview | 2. https://www.cbo.gov/publication/52486 | 3. https://waysandmeans.house.gov/wp-content/uploads/2017/03/03.06.17-AmericanHealthCareAct_Summary.pdf
4. http://www.taxpolicycenter.org/briefing-book/how-does-tax-exclusion-employer-sponsored-health-insurance-work

WHAT IS THE DEAL WITH DRUG PRICE INFLATION?

WRITTEN BY: **MATTHEW HARMAN, PHARMD, MPH** *// Director of Pharmacy*

Providing affordable and sustainable benefits is a primary goal for employers that offer prescription drug coverage. Recent press and public scrutiny over rapidly rising drug prices has revealed the struggle many plan sponsors experience in their efforts to achieve that goal. It is not a secret that annual drug price inflation has been happening for years. So, why are more headlines focused on this issue, and what can employers do about it?

As with most drug issues, the answer to those questions involves the 4Ps: Patients, Payers, Pharmacy benefit managers (PBMs) and Pharmaceutical manufacturers. Drug manufacturers and PBMs have been publicly playing the price hike blame game as patients become more exposed to those prices due to plan design changes set by the payer.

Due to growing pharmacy spend and trend, many employers now offer high deductible health plans (HDHPs) with the intent to promote consumerism among plan participants, with about thirty percent of covered employees enrolled in HDHPs as of 2016. The downstream effect of having a patient pay 100 percent of the drug cost every month until the deductible is hit has caused an influx of calls to benefits departments whenever a significant change in monthly prescription pricing occurs.

This is also true for plans that require coinsurance percentage payments for dispensed prescriptions as opposed to flat dollar copayments that by nature mask the impact of inflation.

As far back as last century, the annual average price inflation for all brand name medications was around 8 to 10 percent every year, while the net price after discount and rebates was about a percentage point lower. That all changed in 2013.

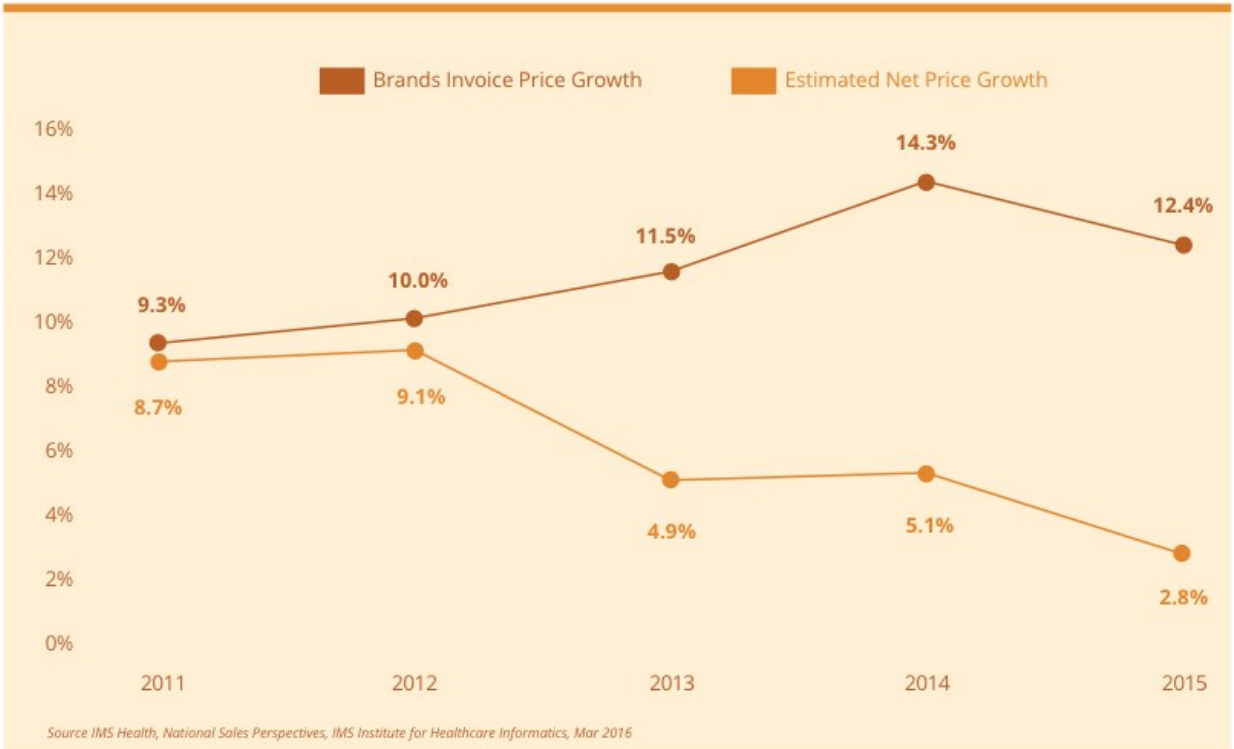
Responding to client pressure on annual price inflation, CVS/caremark became the first PBM to exclude drugs with therapeutic alternatives to drive larger rebates and reduce the net cost to the payer. The following year, in 2014, Express Scripts followed suit. Now with OptumRx on board, the three largest PBMs that make up roughly 75 percent of all drug claims offer exclusions on their standard formularies. It is no coincidence that average price inflation has ranged from 12 to 14 percent since the exclusionary strategy has been rolled out, but the resulting substantial increase in rebates has reduced the average net price growth to 3 to 5 percent annually. *(See Figure 1).* With effective contracting, employers should be utilizing those savings to help mitigate the growing trends, particularly in diabetes and specialty pharmacy where inflation is more rampant.

For the drugs that elude exclusions and remain on formulary, the cat-and-mouse game between drug makers and PBMs continues to play out. Unfortunately, it is not uncommon to see preferred brand drugs rise annually by double-digit percentages, especially those with generic or biosimilar competition approaching down the pipeline. This has led to contracted terms for about 90 percent of drugs between PBMs and manufacturers to set annual price increase thresholds that, if exceeded, would result in payments back to PBMs, which should then be passed back to the payer in the form of rebates. This is known as 'Price Inflation Protection' and pharmacy benefit contracts without it are leaving dollars on the table.

One question that continues to come up is who is benefitting from drug price inflation? At a high level, half of the 4Ps are feeling the brunt of price hikes, which would be the patients and payers, while the other half point fingers at one another. Pharmaceutical manufacturers state that the price increases are necessary to provide the larger rebates to PBMs with exclusions in order to gain market access, while PBMs point out that drug makers are ultimately the ones who set the price and determine how much to increase it throughout the year.

It is important to note that not all manufacturers are created equal, and a few have publicly stated price inflation would be limited. Some manufacturers have tainted the image for all due to large price hikes after purchasing the marketing rights to drugs they did not even spend the research dollars to discover, such as Gilead did with Sovaldi. A closer look at publicly reported annual profit margins over the last few years shows a range from 15 to 30 percent for most manufacturers, while the major PBMs are around 3 to 5 percent. That is not the only factor to consider and does not mean drug makers should not profit off the drugs they develop, but there appears to be room to limit increases to low single digits before public pressure leads to government intervention.

FIGURE 1



Source IMS Health, National Sales Perspectives, IMS Institute for Healthcare Informatics, Mar 2016

WHAT CAN EMPLOYERS DO?

INSTEAD OF digging further down the rabbit hole on why price inflation is occurring, let's touch on a few things plan sponsors can do to minimize its impact.

>> FIRST, the importance of solid contracting terms cannot be understated. If given the opportunity, some PBMs will not pass through rebates received from drug makers to the payers without explicit language in the contract. These terms may be tough to receive for small-to-midsize employers, so collaborating with a group purchasing organization to maximize leverage could provide value. ***Also, be sure your consultant clearly understands pharmacy benefits and is independent and objective*** in order to obtain the best terms possible for your organization.

>> BE ALERT ***and watch for plan changes that require immediate action.*** Some PBMs offer formularies that will exclude drugs that excessively inflate prices over a certain threshold, also known as hyperinflation. Even if your PBM does offer that formulary, prior authorization (PA) can be an effective tool to steer patients to less costly therapeutic alternatives, and this does not apply only to brand drugs. For example, some generic versions of extended release metformin have inflated to over $1,000 for a month's supply while one version remains around $20 to $40 per month. A simple PA to ensure the pharmacy technician grabs the lower cost medication can lead to substantial savings.

>> SET UP ***a more restrictive formulary*** that only allows brand drugs when no generic alternatives are available in specific therapeutic classes. This eliminates the brand price inflation that is often seen with me-too drugs and combination products.

Until recently, the U.S. pharmaceutical market has left the door open for regular drug price hikes with little oversight and caused growing concerns over unsustainable benefits. As more public light gets shined on price inflation, we will likely either see those responsible police themselves or force the politicians at the state and federal level to intervene. Before that occurs, or if the status quo remains, it is essential that payers protect the plan as much as possible from the largest driver of pharmacy trend by partnering with trustworthy supplier partners.

For reference information or to discuss further, please contact Matt at mharman@employershealthco.com.

2016 EMPLOYERS HEALTH MEMBER SATISFACTION

We survey our members annually to ensure we are on the right track and fulfilling our promise to serve as an extension of their benefits team. And, we continually receive a higher than industry average response rate. More than 1/3 of survey respondents have been members of EH for more than 10 years.

The top reasons members engage with Employers Health:

88% Group Purchasing

79% Learning & Networking Opportunities

60% Developing & Executing Strategies

54% Surveying & Benchmarking

100% Would Recommend EH membership

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On 5 point scale

100% of respondents plan to renew

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- Account management oversight, relationship management and issue resolution.

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- **24/7 Nurseline**, to answer health questions day or night
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ALCOHOL USE DISORDER*

WRITTEN BY:
EMILY A. KUHL, PH.D. //
Owner and operator of Right Brain/Left Brain, LLC, consultant to the Partnership for Workplace Mental Health™ and a medical writer and editor in the Washington, D.C. area

Excessive alcohol consumption costs the U.S. $240 billion annually, 72 percent of which is due to lost wages from reduced work productivity (Sacks et al., 2015). A vast majority – 80 percent – of U.S. adults who binge drink or drink heavily are either employed or are dependents of someone employed (Substance Abuse and Mental Health Services Administration [SAMHSA], 2007). By developing and enforcing a workplace plan that stresses early identification and quick referral, businesses can help reduce costs associated with hazardous drinking while assisting workers in getting the help they need.

What is Alcohol Use Disorder?

Alcohol use disorder (AUD) refers to severe and harmful drinking in which symptoms cause problems with everyday functioning and are often a source of great concern to others. These symptoms include, but are not limited to, drinking alcohol to excess; experiencing a craving or deep need to drink; an inability to cut back on drinking even though the individual wants to or needs to; and altering one's daily routine or activities in order to drink, like calling in sick to work or skipping social activities (American Psychiatric Association, 2013). AUD is a medical illness, not a condition of weak character or willpower. The National Institute on Alcohol Abuse and Alcoholism estimates that 17 million U.S. adults have AUD.

How Does AUD Affect the Workplace?

Approximately 6 percent of working adults report drinking to intoxication 1-3 times per month, and nearly 3 percent report doing so one or more times per week (Frone, 2008). Furthermore, about 15 percent of U.S. working adults say that they have used alcohol before or during work (Frone, 2006a). Problematic alcohol use can lead to a host of negative work-related outcomes. Health care costs for employees with AUD are double that of workers without alcohol use problems (Schneider Institute for Health Policy, 2001). Employees who use alcohol or illicit drugs are 3.5 times more likely to be involved in workplace accidents than those who don't abuse substances and are more likely to file workers' compensation claims (SAMHSA, 1999). And, overconsumption of alcohol means a greater likelihood of being unproductive on the job, including exhibiting poor work quality, taking excessive breaks, leaving work early and sleeping on the job (Harwood & Reichman, 2000). These same workers are also more likely to call in sick or arrive to work late (Harwood & Reichman).
It has been estimated that AUD accounts for 500 million lost workdays each year (SAMHSA, 1999). ***Industries with the highest rates of excessive alcohol use by workers include mining, construction, accommodation and food service,*** while the lowest rates appear to be among education, health care, social work and public administration industries (Bush & Lipari, 2015). Age-wise, employees 18 to 25 years old are 2.5 times more likely to engage in heavy drinking than workers age 26 and older (World Health Organization, 2014). Businesses with less than 25 employees have the highest percentage of workers engaging in problematic drinking, while companies with 500 or more workers have the lowest (Frone, 2006b).

Reprinted with permission from the Partnership for Workplace Mental Health™, American Psychiatric Association Foundation

Tips for Employers

Given the staggering statistics on the effects of substance use disorders in the workplace, how can employers make a difference? Businesses such as General Motors, Xerox Corporation and Chevron Texaco, as well as the federal government, have developed and implemented effective models of AUD screening and brief interventions. These efforts have led to employee-reported reductions in alcohol use, lower health care costs and health insurance expenditures, greater employee retention (and therefore less workforce turnover) and favorable returns on investment (Heirich & Sieckm, 2000; Musich et al., 2001; Selvik et al., 2004; Fleming et al., 2000).

Alcohol education and employee assistance programs (EAPs) appear to be particularly effective for helping workers self-identify as having problematic alcohol use, access treatment, and prevent relapse (Kelly-Weeder et al., 2011).

Based on the success of these programs and on the recommendations of prominent substance abuse and health care agencies such as SAMHSA, employers should consider the following strategies:

- Workplace testing for illicit drug and alcohol use is mandatory in some industries, such as certain government contractors or employees in public transportation, but is not required by everyone. Employers should consider enacting drug testing policies, which allow them to identify workers with AUD earlier and may help reduce employee turnover and worker compensation spending (Fortner et al., 2011).
- Know what your state does and does not permit when it comes to workplace drug testing. For instance, some states may require testing take place in a certified lab.
- While businesses can offer voluntary alcohol testing, no testing – voluntary or otherwise – should be conducted without a written substance use policy first being in place. Make sure all employees are aware of the policy, that it is written clearly and that it is readily accessible (e.g., through the company's intranet, on public display). Have your policy reviewed by a legal consultant to be certain it complies with your state's mandates.
- If possible, get an EAP in place. Leveraging your company's EAP is one of the simplest and most cost-effective ways to reduce AUD-related expenditures and negative outcomes by referring those struggling with AUD for diagnosis and treatment by a health care professional. If an EAP is not a part of your health plan, have resources on hand to help employees find local assistance.
- A vast majority of EAP referrals for alcohol assistance are self-referrals (Roman & Blum, 2002). Educational efforts to inform workers about AUD and its consequences increase the potential for self-referral (as well as peer-referral) and help create an environment that feels supportive rather than punitive or judgmental.
- Managers who display a positive attitude toward EAP use also foster greater acceptance and willingness on the part of employees to utilize your EAP's valuable services.
- Employee education can be informal, such as through the placement of posters or other signage in common areas (e.g., kitchens, hallways), or can be more structured, such as through health promotion programs or mandatory employee information sessions.
- The goal for supervisors is not to be able to diagnose AUD but to effectively recognize when the disorder may be present and quickly refer to the EAP (or to the community) for possible intervention. Mandatory training can ensure that your managers know what symptoms to look for and are familiar with your company's EAP coverage and procedures.
- Supervisors also should speak with human resources personnel to make sure they are aware of the company's policies regarding fitness for duty and disciplinary consequences for workers who fail to comply with these policies.

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Benefits Accelerator | Accelerate

A collaborative benefits management strategy for total population health

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Helping employers achieve better health outcomes with lower costs

Benefits Accelerator® is a value-based strategy that harnesses a robust technology platform, preferred vendors with proven concepts and results that emphasize heightened health status and well-being. This collaborative approach can accelerate a plan sponsor's objectives to control health care costs, improve health outcomes and streamline benefits administration.

Benefits Accelerator acts as a central hub to bring the essential capabilities together and then coordinates the activities with an employer-centered account management team. The team members act as "quarterbacks" to coordinate the experience, resulting in single-source accountability for outcomes, efficiencies and value delivered to the employer.

To learn how to accelerate your benefit strategies, visit www.benefitsaccelerator.com or call 330.305.6565.

Benefits Accelerator® Hub

UnitedHealthcare
unum
OPTUM

Benefits Accelerator Partners

Collaborative Strategy

The hub brings together integrated technology, world class partners and proven concepts through an annual active enrollment with a variety of preferred vendors, coordinated by an employer-centered Employers Health account management team.

Intended Outcomes

> ***Lower*** *compound annual growth rate of claims*
> ***Network utilization*** *of premier providers who have better outcomes and lower costs vs. their peers*
> ***Reduction*** *in the severity of high cost claimants through earlier intervention and integration of medical/disability service providers*
> ***More efficient*** *use of services through transparency tools and the member advocacy Hub experience*
> ***Higher*** *provider engagement eliminating duplicate procedures, waste and redundancy*
> ***Increased*** *primary care visits and preventive services; increased percent of members utilizing primary care*
> ***Reductions*** *in readmissions, inpatient stays, ER visits, outpatient surgical/diagnostics*

The Benefits Accelerator® Strategy

APPROACH

- ***Integrated hub:*** *National medical plan with integrated disability, tailored population health management, benefits administration*
- ***Accountability***
- *Addresses* ***holistic needs in a coordinated manner***

ENGAGEMENT

- *Outbound, inbound, in-market and* ***digital services***
- ***Advocacy services*** *offer a single contact point for health-related questions and concerns*

ECONOMIC VALUE

- ***Effective and efficient*** *– no redundancies of services*
- ***Advanced analytics*** *tie pre-sales savings projections to operating discipline, to outcomes measurement*

EFFICIENCY

- ***Network utilization*** *of preferred quality providers*
- ***Transparency*** *tools and advocacy for greater efficiency by users*
- *Increased use of* ***primary care, preventive services, and medication adherence***
- *Greater efficiency for* ***plan administrators***

A team of trusted advisors, acting as an extension of the benefits team

An EH account management professional will coordinate the plan sponsor's experience, including managing routine vendor summits to occur at a frequency required by the complexity of each account and the plan sponsor's needs.

Thank You!

Employers Health would like to thank its Contributor Members. Employers Health members benefit from the support that these Contributors provide to the membership and it is our hope that their support is noticed by our members when seeking solutions that each provide. Thank you to the following Contributor Members for your support:

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Member Spotlight

Kaylynn Ruf

COMPENSATION AND BENEFITS ANALYST,
JOANN FABRIC & CRAFT STORES

JOANN Fabric and Craft Stores was founded in 1943 with one retail location. Today, it is the nation's leading fabric and craft retailer with more than 850 stores in 49 states. From their headquarters in Hudson, Ohio, the company's team of eight human resources and benefits professionals manages the administration of benefits and HR for more than 23,000 team members throughout the country.

What is your current role with JOANN Stores and how/why did you get involved in the employee benefits industry?

I've been with JOANN for just over a year. I started out as a benefits analyst. My undergraduate degree is in biology and biostatistics, but I found that I really enjoyed human resources in school as well. I spent some time in recruiting and then training and development, but, ultimately, benefits was a natural move for me. It pairs my interest in HR with my analytical skills, while also incorporating some biology. When it is time for our annual vendor reviews, I get to test my memory from anatomy and chemistry.

I have recently taken on more responsibility in the compensation area as well, so my current role is compensation & benefits analyst. Becoming more "hands-on" in compensation has helped me on the benefits side because it gives me a holistic view of our team members' total rewards experience!

What has surprised you about working in benefits?

When I started in benefits, I had never gone through an annual enrollment – can you believe no one warned me about this?! The amount of time and detail that went into the process left me awestruck – it is so much more than just allowing people to enroll online! I think, however, the most surprising, and best, thing about benefits is just how different every day can be.

How does your company approach health benefits and overall well-being for your employees?

Our team members deliver an amazing customer service experience and inspire creativity in our customers every day. Our benefits department strives to meet that same goal for our internal customers. This starts with our plan management. We are extremely involved in all facets of our benefits. We collaborate closely with our vendors to ensure we are proactive in identifying and meeting our participant's needs and use our homegrown benchmarking, auditing and analysis processes to identify trends and ensure that we are providing a great product at a great value. This is where Employers Health is a valuable member of our team. The roundtables, education sessions and contract support we receive from Employers Health help us identify where we can incorporate improvements for our team members.

We have an internal call center. If a team member in any one of our 862 stores, three distribution centers, or Store Support Center needs support, they can call us first. This provides us the opportunity to maintain customer-focused touch points and provide positive, proactive messaging. It supports our department's goal of providing personalized supportive service for each team member while supporting our company's vision. #joannhappy

We are also unique in that our team owns more than just benefits. We are also the support team for compensation, company travel, rewards and recognition and the café – a team member favorite. By touching all of these plans and services, we can really impact a large part of the team member experience.

What benefits-related advice would you give a professional new to the industry?

Be ready and excited for change! I move from exploring the Affordable Care Act provisions, to learning the tax rules for welfare plans, to analyzing the medical claims for high cost claimants, all before lunch. That is what also makes benefits fun. Every day is a new journey, and something new is always happening. On any given day, a benefits professional is also a government affairs specialist, a statistician, a health care expert and more!

How has your organization been innovative in delivering employee benefits?

Our department captures any opportunity to extend our knowledge and identify trends. By leveraging relationships with Employers Health Solutions, other retailers and national retail-specific groups, we are always excited to engage in benefit plan discussions and debates. As a creative company, we are encouraged to explore alternatives and look at our offerings from a different perspective. Sometimes this means not adopting new tools or programs because we have identified an alternative process to meet our needs or because we discover the return on investment or long-term results might not materialize. Our selective choices in prescription management policies, medical management tools and additional voluntary benefits have allowed us to ensure we have plans that create positive results while maintaining costs and monitoring team member impact. We make the best decision for the company and for our team members, while always moving forward.

What are your thoughts on the future of employee benefits?

It is an exciting time of evolution in the benefits space. Systems, data and services are interacting to create experiences for consumers while allowing us more insight into trends and decision making than ever before. As a group that works in the retail space, we love the interplay that marketing, IT and benefits must have today to engage team members in their personal health stories. Partnerships with these groups have helped us further the science of benefits and that is what brings excitement to our team.

How long have you been engaged with Employers Health?

We joined Employers Health on January 1, 2016.

What value do you derive/perceive by being part of an organization like Employers Health?

Put simply, we value Employers Health because it provides us with tools that help us better serve our team members. We contract with CVS/caremark through Employers Health for Pharmacy Benefits Management services. Through this relationship, we receive superior pricing and customer service – a win for both our team members and the company. We have been extremely satisfied so far!

"By leveraging relationships with Employers Health Solutions, other retailers and national retail-specific groups, we are always excited to engage in benefit plan discussions and debates."

OptumRx: Helping you harness the power of pharmacy

Employers' biggest concerns

SPECIALTY DRUG COSTS

Average annual industry trend in specialty costs exceeds 21% over the last three years[1]

CONSUMER ENGAGEMENT

78% of employers cite lack of engagement as a top obstacle to a successful health and wellbeing program[3]

FRAGMENTED CARE

Poor health care coordination nearly doubles the cost of patient care[2]

OVERALL COST INCREASES

Total health care costs have increased 82% over the last ten years[4]

Beyond traditional pharmacy benefit management

At OptumRx®, we take a fresh approach to pharmacy benefits. One that uses our data, technology and leadership across the entire health care system to promote better care and deliver value. We help our clients manage not just pharmacy spend but clinical outcomes and medical spend, too. The result: smarter health care, easier system navigation and healthier outcomes.

PHARMACY BENEFIT MANAGEMENT

- Formulary and drug cost management
- Specialty pharmacy
- Clinical and utilization programs
- Network management
- Member services and adherence
- Home delivery

PHARMACY CARE SERVICES

smarter easier healthier

Delivering value where others can't

Together with Optum®, we bring the scale, resources, knowledge and perspective to transform pharmacy benefit management.

1.2 billion	80 billion	64 million	20 thousand	180 million
prescriptions processed	total pharmacy spend	pharmacy members served	physicians and nurses	lives of claims data

To learn how OptumRx can help you use pharmacy care services to drive better outcomes and lower costs, please email Jason Quillin, area vice president, sales, at jason.quillin@optum.com or visit **optum.com/optumrx**.

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Our Canton Headquarters has moved.
Our phone numbers will stay the same, but our address has changed. Please be sure to update your records!

employershealthco.com

Take note of our new address:

Northeast Ohio Office
4771 Fulton Drive, NW
Canton, OH 44718
330.305.6565

Central Ohio Office
5775 Perimeter Drive, Suite 100
Dublin, OH 43017
614.336.2883

Southwest Ohio Office
9032 Union Centre Blvd, Suite 202
West Chester, OH 45069
513.889.3952

Employers Health is a national coalition of employers passionately committed to providing resources, tools and advice that help plan sponsors provide access to high-quality health care benefits at a sustainable cost.