EMPLOYERS HEALTH

SUMMER 2022
A publication of Employers Health Coalition, Inc.

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IN THIS ISSUE

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SUMMER 2022

MESSAGE
FROM CHRIS GOFF

Christopher V. Goff
CEO & General Counsel

WELCOME TO OUR NEWEST CLIENTS

American Consolidated Natural Resources

Ameritas

Analog Devices

Bristol Hospice, LLC

City of Niles, OH

City of Omaha, NE

Cullen/Frost Bankers, Inc.

Cuyahoga County, OH

DLR Group, Inc.

Eagle Materials, Inc.

Gosiger Holdings, Inc.

Gusto

Howard County, MD

Union Home Mortgage Corp.

Vantage West Credit Union

It's been an exciting year so far at Employers Health. Our team has enjoyed getting back to in-person conferences, visiting clients, attending trade shows and just enjoying each other's company. While our virtual events were well-attended and beneficial, there is just no replacement for in-person interaction, and we were honored to see so many of you at both the Pharmacy Benefit Conference and Innovations in Benefits Conference.

An outstanding line-up of speakers joined us in Columbus, Ohio on March 16th to discuss the latest value-based strategies that help plan sponsors design and deliver comprehensive, yet affordable, pharmacy benefits. And, we had another excellent group of benefits experts join us at the Innovations in Benefits Conference in May. One positive result of the pandemic is that both conferences are now available virtually on demand. We know that many organizations are still facing travel restrictions, reduced workforces and high travel costs, so we wanted to be sure to share these innovative presentations with those who couldn't make the trip. If you haven't already, I encourage you to visit employershealthco.com/events to view sessions from these conferences.

In terms of new business, this year we added a record-breaking 40 new clients representing more than $250 million in new pharmacy spend to our more than $2.2 billion PBM purchasing programs. To support this growth, the team at Employers Health also continues to expand. We have added nine full-time employees to our team so far in 2022 in order to continue providing the best service and solutions to our clients. By fall, we anticipate adding several additional team members, including three new clinical pharmacy residents beginning July 1.

You'll hear from one of our new clinical team members, Tu Doan, on page 3 as he and Vice President of Clinical Solutions, Matt Harman, cover Innovation and Opposing Forces in the Generic Marketplace. Associate Counsel Madison Evans details The State of PBM Legislation and Important Federal Transparency Reminders on page 9. Finally, we hope you enjoy our Q&A with the 2021 Excellence in Benefits Recipient, Chris vanNatta of The Timken Company. The 2022 award will be presented at the Employers Health Annual Meeting this fall, so be sure to watch for details later this summer on how to nominate a deserving employee benefits professional.

My best wishes for a safe and enjoyable summer!

2022

On-Demand Webinars

Missed our in person conferences? You can still hear from the best and brightest professionals in pharmacy and employee benefits, as all presentations can be viewed on demand. These sessions provide exclusive insights into benefits trends and cover value-based strategies that help plan sponsors design and deliver comprehensive yet affordable pharmacy benefits.

Pharmacy Benefit Conference

- Biosimilars' Impact on Health Care Trends and Cost
- Addressing Gene Therapy Financial Challenges
- A Rocking Research Update on Biosimilar Uptake and Benefit Design Strategies: New mAbs on the Block
- Obesity Coverage Trends and the Financial Impact
- Active Clinical Management and the Impact on the Pharmacy Benefit Plan
- Federal and State Regulatory Efforts: Solving the Post-*Rutledge* Puzzle
- Employer Best Practices – An Employer Panel

Innovations in Benefits Conference

- Meaningful Mental Health Benefits in the Workplace: Innovations and New Consideration
- Measuring the Value of Virtual Care
- NeuroSelling® – The Science Behind World Class Communications
- Empowering Your Members to Enact Health Change
- Using Navigation to Eliminate Barriers to Care
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The Generic Marketplace: Innovation and Opposing Forces

by Tu Doan, PharmD | Clinical Advisor &
Matt Harman, PharmD, MPH | Vice President, Clinical Solutions

For decades, the message to employers was simple: promoting generic drug utilization will reduce spend to the plan and its participants. While that is still predominantly the case, several marketplace factors have created nuance to that message leading to confusion for patients and plan sponsors. The purpose of this article is to highlight some of these market dynamics and what employers should consider for a pharmacy benefit plan design that drives the lowest net spend.

Generic medications are FDA-approved drugs with the same active ingredient(s), mechanism(s), clinical benefits and risks as their branded counterparts. Due to the significantly lower profit margins compared to brands, generic drug manufacturers must rely on a large volume of products sold, novel purchasing alliances and optimizing their drug portfolio to stay competitive for formulary placements. In 2021, generic drugs accounted for approximately 87.5% of medications dispensed, while making up only 15.5% of total spend in the Employers Health book of business.

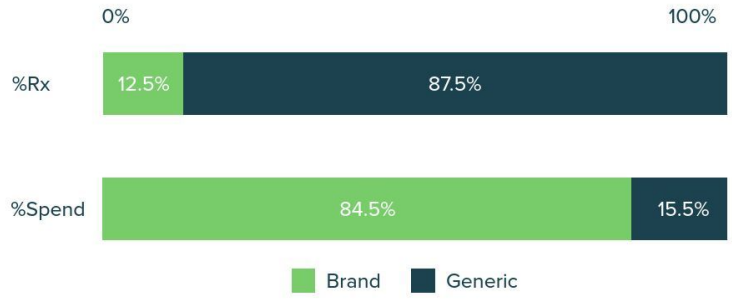
How the Competitive Landscape Impacts Plan Sponsors

As seen in FIGURE 1, the data validates the narrative that generic drugs account for a fraction of the annual spend despite making up the majority of market share by utilization. Over the years however, brand drug manufacturers have designed strategies to secure market share and compete with generic manufacturers.

01 Upon patent expiration and loss of exclusivity, brand manufacturers can provide deeper rebates to drive the brand's net cost below generic pricing, incentivizing formularies to prioritize brand coverage. This practice has been seen across pharmacy benefit managers (PBMs) and targets products such as Advair Diskus and Adderall XR. To minimize patient confusion, copays for these brand products need to mirror the plan's generic copay structure.

FIGURE 1

Generic Dispensing Rate vs. Spend



02 While short-term savings of lower net cost brands can be compelling, mass adoption of a brand-over-generic strategy can have serious long-term consequences. Along with already low profit margins for generic manufacturers, shrinking market share can lead to loss of financial viability for the product, unsustainability for the generic manufacturers and decreased long-term competition for expensive brand products.

Authorizing generics is another approach brand manufacturers use to gain market share upon loss of exclusivity. Brand manufacturers can create "authorized generics" (AGs), which are identical to the original brand but are sold in different packaging at a lower price. AGs can be manufactured by the innovator company or by a different manufacturer with their permission and often launch just before patent expiration of the branded drug. This practice allows the brand manufacturer to capture and maintain market share before competing generic products launch. AGs are often classified as single-source generics (SSGs) for contracting purposes, so it is important for plan sponsors to understand how SSGs are priced within PBM contracts.

Beyond the market share threats from brand competitors, generic drugs also face price pressure from consolidated buyer groups. Partnerships between wholesalers and distributors have catapulted their purchasing power, placing price pressure on generic manufacturers. In 2017, it was estimated that the top three pharmaceutical distributors (AmerisourceBergen, Cardinal Health and McKesson) captured 92% of market share.

In response to the threats of shrinking market share and downward pricing pressure, generic manufacturers are

also designing innovative approaches to remain competitive. Through direct exclusive partnerships with retailers, manufacturers can secure market share and long-term access to patients by creating their own branded versions of generics. Historically, private labeling was done with over-the-counter products that had direct exposure to patients. However, these partnerships have expanded into the prescription market such as the collaboration between Novo Nordisk and Walmart to create the privately labeled generic insulin analog called ReliOn. These partnerships provide manufacturers stable long-term market access while pharmacy retailers benefit from lower cost of goods and product loyalty. In a way, these deals vertically integrate the supply chain leading to higher efficiency and lower costs. The symbiotic relationship from which ReliOn was born helped secure the generic product's long-term sustainability and ultimately benefited patients, payors, retailers and manufacturers.

Generic manufacturers can also remain competitive by "branding" their generic medications. Products with complex chemical names can be branded by the generic manufacturers to help establish product recognition, "brand" loyalty and simplify communications between patients and prescribers. Branded generics are bioequivalent medications with identical active ingredients but varying inactive compounds and are NOT to be confused with authorized generics which are identical products to the brand. It is simply a marketing strategy that does not mean clinical superiority. See FIGURE 2

Despite pressures from multiple fronts, internal competition among generic manufacturers remains fierce where comparable generic products can have considerable price variations despite insignificant clinical differences between them. Over the last decade, the clinical team at Employers Health has identified numerous multi-source generic products with inflated price tags relative to their therapeutic equivalents. In response, customized programs have been created to protect plan sponsors from exposure to these avoidable costs. Examples of these custom programs are High-cost Generics 3.0 and Expensive Dosage Forms.

High-cost Generics 3.0

Within each therapeutic class, there are often multiple competing products with relatively similar efficacy and safety data. Unfortunately, prices can vary significantly among these comparable products, and the High-cost Generics 3.0 strategy targets two prevalent generics with multiple therapeutic alternatives.

01 Rosuvastatin (generic Crestor) is a medication indicated to treat high cholesterol with various competing drugs in the same therapeutic class (e.g., atorvastatin, simvastatin, etc.). Despite being generic with comparable efficacy and safety data, the cost of rosuvastatin remains significantly higher than other generic medications within its class. Due to potency differences between products in the same class, only one strength of rosuvastatin was targeted ensuring clinically appropriate conversion to other statin medications.

FIGURE 2

Brand Drug Name (Manufacturer)	Branded Generic Drug Name (Manufacturer)	Unbranded and/or Authorized Generic Drug Name
Advair (GSK)	Wixela (Mylan)	fluticasone propionate / salmeterol inhaler
Copaxone (Teva)	Glatopa (Sandoz)	glatiramer acetate injection
Synthroid (Abbott)	Levothroid (Mylan)	levothyroxine

02 Similarly, esomeprazole (generic Nexium) is an expensive generic medication indicated to treat heartburn. With multiple affordable over-the-counter and prescription alternatives in the same class (e.g., pantoprazole, lansoprazole, omeprazole, etc.), employers can see significant savings by steering members to lower-cost options.

Expensive Dosage Forms

Medications can be packaged in a variety of dosage forms such as tablets, capsules, suspensions, sprays and solutions. Equivalent generic medications regardless of dosage forms are often interchangeable when administered via the same route, yet certain dosage forms are marketed at an excessive cost despite having identical active compounds and no clear clinical advantage. For example, oral tizanidine capsules average about $51 per Rx while the tablet version of tizanidine costs roughly $3 for each prescription. The Expensive Dosage Forms program strategically excludes coverage of specific high-cost formulations of generic products while driving patients to the preferred alternatives via point-of-sale messaging at the pharmacy. Financial performance of this strategy showed plan sponsors who adopted it had an estimated annual savings of $0.13 per member per month, with less than 1% disruption of total eligible members.

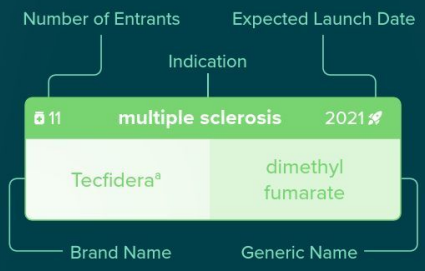
Specialty Generics

Compared to traditional markets, specialty drugs have a significantly smaller patient population due to the low prevalence of the disease states. Generic drug manufacturers' heavy reliance on high utilization volume has historically limited their participation in the specialty space. However, as the prices of branded specialty drugs continue to soar, plan sponsors must collaborate with PBMs, generic manufacturers and even lawmakers to expedite generic entrants and competition in the specialty drug market.

According to our collective pipeline insights, there are over 30 notable generic medications expected to launch in disease states ranging from oncology to multiple sclerosis (MS). Some notable entrants in recent months have been the generics for Tecfidera (MS), Truvada (HIV) and Revlimid (oncology) which led to increased discussion surrounding strategies for specialty generics.

The anticipated lower price tags of specialty generics prompted internal discussions among Employers Health teams regarding new overall effective discount (OED) rates. Discount negotiations of specialty generic effective rates (GER) separated from specialty brand effective rates (BER) will reflect the model in the non-specialty market. This helps plan sponsors more accurately negotiate competitive discounts especially if they have a particularly high specialty generic dispensing rate. Recent reports show that specialty generics make up about 21.5% of the specialty prescriptions in our book of business.

Notable Specialty Generics Pipeline



14	oncology	2022	
Revlimid[a]	lenalidomide		
01	Narcolepsy + cataplexy	2022	
Xyrem	sodium oxybate		
12	HIV	2020	
Truvada[a,b]	emcitrabine + tenofovir disproxil fumarate		
02	multiple sclerosis	2023-24	
Gilenya	fingolimod		
20	multiple sclerosis	2023	
Aubagio	teriflunomide		

[a] *at least one generic already launched*

[b] *HIV medications not always considered specialty by all PBMs*

Rolling entry of specialty generic drugs is prompting plan sponsors to review their copay tiering structure. On the non-specialty side, tiered formularies were created to incentivize generics (tier 1), preferred brands (tier 2) and non-preferred brands (tier 3). Plan sponsors may separate specialty drugs into their own 4th tier with a higher copay or coinsurance to:

1. Increase member awareness of the importance and costs of these specialty medications.
2. Promote good consumer habits by encouraging members to use lower-cost non-specialty items first.
3. Alleviate cost burden to the plan by partially sharing the cost with members.

Today, approximately 40% of Employers Health clients utilize a 4th tier specialty copay structure with an average specialty member cost share at 5% of overall cost. One issue with having only one tier for specialty is that patients do not have a financial incentive to take a specialty generic over a brand. To encourage patients to move to generics and minimize confusion, employers should consider having specialty generic copays mirror that of non-specialty generics. Plan sponsors utilizing specialty copay maximization programs may want to consider a zero-dollar copay for generics to remove the chance of patients paying more than what they did for a brand with coupons that eliminate out-of-pocket costs.

The growth of the specialty generic space and the evolution of the traditional generic drug supply chain highlight the need for employers to regularly review plan designs to encourage efficient plan spend. While the simplicity of generic messaging may be eroding, the opportunities for sound utilization management continue to rise. Collaborating with vendors that fully understand the generic marketplace will help employers from being branded with high spend and trend.

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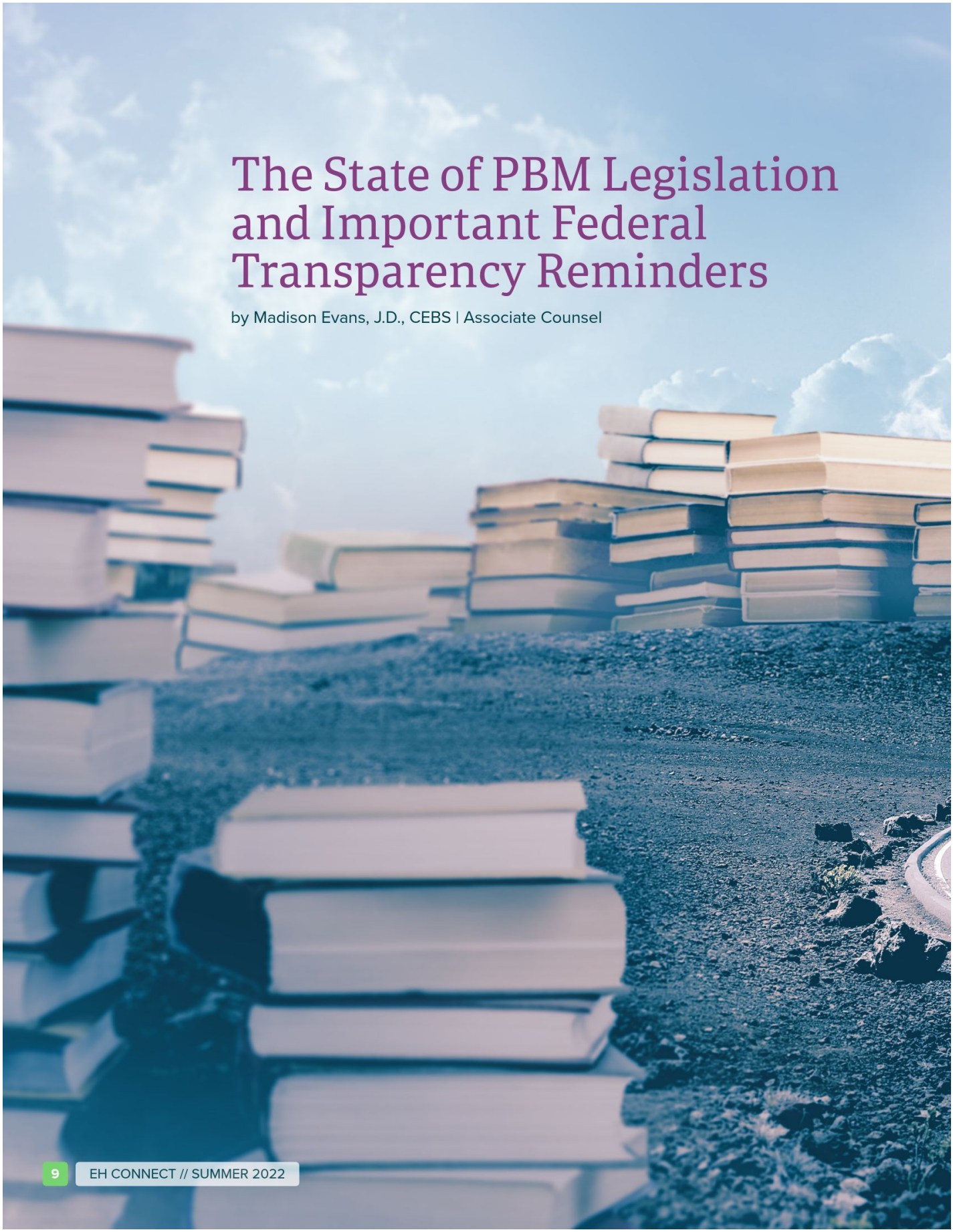
The State of PBM Legislation and Important Federal Transparency Reminders

by Madison Evans, J.D., CEBS | Associate Counsel



State Legislative Update: Rutledge and Its Aftermath

The last time this publication addressed state pharmacy benefit manager (PBM) legislation, readers were anticipating the final disposition of Rutledge v. Pharmaceutical Care Management Association (PCMA). As a background, Rutledge v. PCMA was a legal challenge to an Arkansas statute that set a pharmacy's reimbursement at a rate that, at a minimum, reflected the pharmacy's acquisition cost for the drug. The law also provided a robust appeals process to determine if reimbursement fell below that acquisition cost and even allowed a pharmacy to decline to dispense a drug to a participant in cases where the pharmacy determined the PBM's reimbursement would be less than the acquisition cost. The PCMA challenged the law arguing that it was preempted by the Employee Retirement Income Security Act (ERISA). ERISA is a federal law that regulates employer-sponsored benefit plans and provides express federal preemption of state laws that relate to an employee benefit plan. Plan sponsors rely on ERISA as it protects sponsors from having to comply with an irregular patchwork of state laws and supports nationally uniform plan administration.

The U.S. Court of Appeals for the 8th Circuit held that the law was preempted and thus unenforceable as applied to ERISA covered health plans. The Arkansas Attorney General appealed the 8th Circuit's decision to the United States Supreme Court. After multiple COVID-19 related delays, the court heard oral arguments in October 2020. In January 2021, the court released its highly anticipated opinion which ultimately reversed the lower court's decision. In a unanimous 8-0 ruling, the court held against ERISA preemption for the first time in decades. The court characterized the Arkansas law at issue as merely, "cost regulation." The court said that states were allowed to regulate reimbursement even if an ERISA plan experienced indirect increases in the costs of plan administration. The court acknowledged, however, that certain indirect economic effects of a law may necessitate preemption if such a law, "effectively dictate(s) plan choices." The court declined to describe an example of a situation that would warrant preemption of the state law.

This broad ruling has immediate implications for the regulation of PBMs and health benefit plans alike. Rutledge gives states expanded authority to regulate aspects of an ERISA plan, without defining the boundaries of such authority. In the aftermath of Rutledge, states continue to pass numerous bills seeking to regulate PBMs and the health benefit plans they administer benefits on behalf of.

States have introduced PBM legislation in the following areas:

- Restriction of mail service
- Restriction of specialty network options
- Banning preferred pharmacy arrangements
- Payment mandates/National Drug Acquisition Cost (NADAC) based pharmacy reimbursement
- Plan design restrictions including prohibition of copay accumulator programs
- Transparency disclosures

While many of these types of laws are distinguishable from the reimbursement law at issue in Rutledge, states may still be able to rely on Rutledge's precedent and general reasoning. For example, an Oklahoma district court recently upheld the state's Patient's Right to Pharmacy Choice Act using similar reasoning. The Oklahoma law went beyond merely cost regulation; the law required a PBM to allow any retail pharmacy the option to participate in its network if the pharmacy accepted the terms and conditions of the network and prohibited a PBM from incentivizing participants to use preferred in-network pharmacy providers. The district court said that, "while these provisions may alter the incentives and limit some of the options that an ERISA plan can use, none of the provisions forces ERISA plans to make any specific choices."

As anticipated, the 2022 state legislative sessions have been just as active. Many PBM bills that did not pass during the 2021 sessions (when legislatures were largely concerned with COVID-19 related issues) were reintroduced. State sessions follow a variety of schedules; many general assemblies will adjourn in spring or early summer, while others will remain in session through the end of the year. As employer-sponsored prescription drug benefit plans experience increased scrutiny at the state level, Employers Health will continue to monitor these developments and advocate for the interests of self-funded plan sponsors. Plan sponsors should pay special attention to these state developments and work with their current vendors and advisors to understand the financial and administrative implications of these limitations and, once armed with that knowledge, advocate for the interests of their organizations.

Now turning to an area that most plan sponsors are more attuned to monitoring...

Federal Regulatory Update:

Key Transparency Deadlines and Updates on Reporting Requirements

Transparency in Coverage Final Rule

What it is

The Transparency in Coverage Final Rule was released in October of 2020 by the Department of Health and Human Services, the Department of Labor and the Department of the Treasury (the departments) in response to the Trump Administration's Executive Order on Improving Price and Quality Transparency to Put Patients First. The rule aims to give consumers knowledge and access to pricing information through their health plans. It has a two-part approach: access to a member cost comparison tool and publication of three machine-readable files.

COMPONENT ONE

Member Price Comparison Tool

Plans must provide members with real-time accurate estimates of their cost-sharing liability for health care items and services from different providers. This information is to be provided via telephone and an internet-based cost estimator tool. The departments released a list of 500 initial items and services that are required to be available via the self-service tool for plan years that begin on or after January 1, 2023. Most of the items and services included in the initial wave are covered under the medical benefit. The remainder of all items and services covered by a plan will be required to be available via these self-service tools for plan years beginning on or after January 1, 2024. Most medical carriers have an existing cost estimator tool that meets the requirements of the rule and others will continue updating their systems to ensure that all required services are available by the rule's applicable effective date.

COMPONENT TWO

Publicly Available Machine-Readable Files

This second requirement is more complicated and will require synchronization between plans and their vendors. Plans must publish three machine-readable files in a publicly available format with monthly updates. The first file will include negotiated rates for all covered items and services between the plan and in-network medical providers. The second file must list both the historical payments to and billed charges from out-of-network medical providers. The third file will detail the in-network negotiated rates and historical net prices for all prescription drugs covered through the pharmacy benefit. The files must be posted in a standard format; the departments indicated that a JSON file is an acceptable format while Excel is not.

Deadline Status

The two files detailing the in and out-of-network information for medical providers are required to be publicly available for plan years that begin on or after July 1, 2022. The departments deferred enforcement of the prescription drug file requirement indefinitely pending notice and comment rulemaking regarding whether the requirement remains appropriate in light of the prescription drug reporting requirements under the Consolidated Appropriations Act (below).

Action Items

Plan sponsors should be prepared to work with their medical carriers to coordinate publication of the in and out-of-network files as the carrier is the entity with access to this information. The term "publicly available" means that the information published online must be accessible to any person free of charge and without conditions such as identity verification, credentials, a username or password, etc.

Consolidated Appropriations Act (CAA) Prescription Drug Reporting

What it is

These regulatory requirements implement the drug cost reporting provisions from the Consolidated Appropriations Act of 2021. Plans must provide specific reporting data on prescription drug spending to the departments. Utilizing the reported drug spending information, the departments will biannually release an aggregated report on drug pricing costs and trends beginning in 2023. The types of information that must be provided in the report include the top 50 most costly drugs, top 50 most frequently dispensed drugs, total rebate amounts, specific rebate information for the top 25 drugs with the highest dollar amount of rebates, etc. Readers may recall that the original CAA regulations also called for a member price comparison tool, but this requirement was determined to be duplicative of the comparison tool required for the Transparency in Coverage Final Rule. Thus, compliance with the Transparency in Coverage consumer comparison tool requirement (described above) is also sufficient for purposes of the CAA.

Deadline Status

Last August the departments delayed enforcement of these requirements to allow additional time for rule-making and for plan sponsors and PBMs to prepare for implementation. On November 22, 2021, the departments released an interim final rule (IFR) with a request for comments as well as a draft reporting form with instructions. Comments on the IFR were due January 24, 2022. Per the IFR, plans must submit reports for 2020 and 2021 by December 27, 2022. Reports will then be due each following June, based on information from the prior calendar year.

IFR clarifications

The IFR included some important clarifications for plans sponsors. Although the legal requirements to report under the CAA apply to plans and insurers, the departments recognize that plans will look to PBMs to assemble most, if not all, of the reporting. The departments will allow multiple entities to enter reporting information for a particular plan. This means that both the plan and the PBM can submit information to complete the plan's reporting requirements. Reporting will be done through the online Health Insurance Oversight System (HIOS) run by the Centers for Medicare and Medicaid Services (CMS) as CMS will be collecting the CAA reporting data on behalf of the departments. Readers should note that this is likely the first time that employer-sponsored health plans will have a nexus with this system.

To facilitate efficient reporting and useful data compilation, the departments will allow a PBM to aggregate most of the required data elements at the state and market levels. The original text of the CAA seemed to contemplate reporting on a plan-by-plan basis, but each PBM will now be able to aggregate the report information for all self-insured employer plans that it administers. Plans will still be responsible for some plan-specific inquiries such as plan identifying information, states where coverage is offered, number of participants, etc. While multiple entities can report required information, only the entity reporting will be able to view the file information it uploads and cannot view information reported by any other entity. This lack of visibility means that plans must work with their PBMs to confirm that all pertinent information has been reported in a timely manner. Even if a plan enters into an agreement with its PBM, the plan remains ultimately liable for the reporting.

Action Items

Given the interim nature of the rule and that the departments have requested comments on the rule, the requirements in this IFR are still subject to change. The departments indicated in the IFR that they plan to promptly issue final rules based on the collected public comments. Plan sponsors should anticipate final regulations from the departments this summer and watch for communications on next steps from their PBM. Sample reporting templates and instructions are available on the Prescription Drug Data Collection page of the CMS website.

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Noteworthy News

The Employers Health Canton, Ohio office recently volunteered at the Domestic Violence Project as part of the United Way of Greater Stark County's Day of Caring. The team spent the afternoon landscaping and painting.

Employers Health CEO Chris Goff was recently awarded the Gold Key Award on behalf of United Way of Greater Stark County. The award recognizes individuals who have continually demonstrated the highest degree of personal dedication and service in a voluntary capacity.

Chris Goff recently finished serving on the board for the Academy of Managed Care Pharmacy for eight years. While on the board, he served as treasurer for one year and chairman for two years.

Brooke Knollman, client solutions specialist, recently obtained her MBA with a concentration in Healthcare Management from Fitchburg State University.

Employers Health pharmacists, Kevin Wenceslao and Matt Harman are serving as president and director, respectively, of the Ohio-Kentucky Academy of Managed Care Pharmacists (AMCP).

A manuscript co-authored by Sean Godar, vice president, strategy and analytics, titled "An ecological study of a universal employee depression awareness and stigma reduction intervention: 'Right Direction'" was recently published in Frontiers in Psychiatry.


Dan Dorman


Patrick Michel


Alex Pantelas


Max Pollock

As the size and strength of our coalition membership continue to grow, so does our team. Welcome to Employers Health's newest team members – Client Solutions Specialists, Dan Dorman, Patrick Michel, Alex Pantelas and Max Pollock.

Vice President of Client Solutions, Kelly DiNardo and Client Solutions Specialist, Grant Goff, recently obtained the Certified Employee Benefits Specialist (CEBS) designation through the International Foundation of Employee Benefit Plans.

Through her work with the Junior League of Columbus, Client Solutions Specialist, Madison Simmons helped orchestrate a fundraiser that raised more than $5,000 to support local youth aging out of Ohio's foster care system.

Chris Goff was recently elected as Vice Chairman of the Board of Directors and a member of the Executive Committee for the Canton Regional Chamber of Commerce and also as a member of The University of Akron School of Law Alumni Association Board.

The Columbus, Ohio office recently made blankets for My Very Own Blanket, a non-profit dedicated to providing blankets to children in the foster care system.

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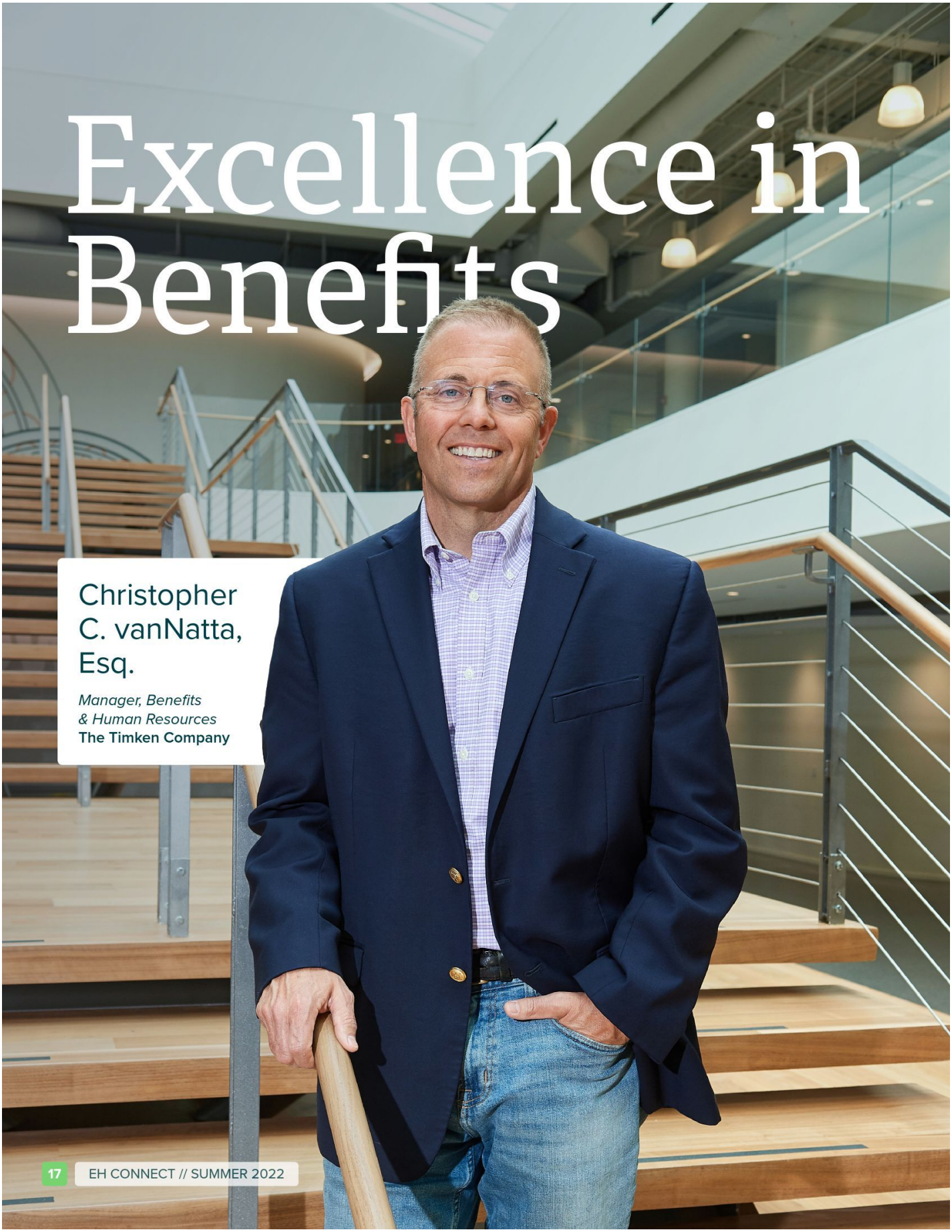
Excellence in Benefits



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We sat down with 2021 Excellence in Benefits award winner Chris vanNatta of The Timken Company to hear how he and his team are utilizing innovative solutions to succeed in benefits.

How long have you been in HR and where did you get your start?

I did not begin in HR; you might say I kind of backed into it. I'm a labor and employment lawyer by training. Of course, labor and employment law is the legal side of HR and in 2001 after completing my LL.M. (Master of Laws) in labor and employment law, which I achieved as an active duty Air Force judge advocate, I started working with HR professionals in the Air Force on federal civilian personnel matters. I continue today in the Air Force Reserve, but after leaving active duty and following a two-year period as in-house counsel at a telecom company in Washington, D.C., I was hired by Timken in 2006 to handle labor and associate relations. That is where the real transition into HR began. Then, in 2013 I moved into benefits, and while a small part of my role involves practicing employee benefits law, the vast majority of my time is spent overseeing global benefits for Timken, which is a pure HR position.

When it comes to human resources and benefits, how do you define success?

It seems to me that success is defined in two ways – engagement and impact. Engagement is important for obvious reasons. You can have the best benefits in the world, but if the employees do not know about them or can't use them effectively, then it doesn't matter. Sending letters to homes does not work well, and in a manufacturing company, email isn't much better. We have had to get creative to get the word out – and when we do, we increase our engagement tremendously.

As for impact, in today's employment environment, it is not enough to just offer the basic benefits. You need to create programs that will have a meaningful impact on our associates and their families to make their lives better. That is why we pursue programs like our fitness center with its virtual group exercise classes, our health and wellness center which includes a dietician to give nutrition advice and many other programs. It is very satisfying when someone who was previously diagnosed with Type 2 diabetes calls to inform us that their A1C has reduced to the point that they are off their medications!

How has The Timken Company been innovative in delivering health care benefits?

We tend to view ourselves as fast followers. We don't have the massive resources of some of the bigger companies in the country, like Walmart or Google, which makes it possible for those companies to be out in front of every innovation in health care. Instead, we need to do our due diligence and really understand what is being offered and whether it can help our associates. Therefore, we rely heavily on our partner experts, such as Employers Health, Lockton and CVS Caremark, to help us understand how such innovations might work for us specifically. As a result, we have been able to jump out and introduce innovative programs like PrudentRx (for specialty medications), Rx Savings Solutions (for prescription drug price transparency) and Virta (for Type 2 diabetes reversal). These programs, along with a few others, are delivering real results for the company and, most importantly, for our associates.

From the implementation of a diabetes reversal program to an outstanding onsite workout facility at your world headquarters, you have been instrumental in numerous projects to improve the health outcomes of Timken associates. Can you share why this is important to you and how the plan and its participants have benefitted?

Through our diabetes reversal program, Virta, we have actually had a number of associates and spouses reduce their blood sugar levels below the diabetes threshold and eliminate the need for their medications. Last year, through our weight loss program, Noom, 1,000 of our associates lost just over 8,000 pounds! Also, our health and wellness center (with access to an onsite clinical counselor) and our fitness center (with its virtual group exercise classes) have been very popular too. Simply put, programs like this make a difference in people's lives. No one has more of a vested interest in a group of employees than the employer. And, if we can deliver programs that attract, retain and motivate our associates, they are not only helping themselves but we are helping the company with increased productivity.

Can you share what you feel is your proudest accomplishment thus far in your career?

I am most proud of two things. First, I am thrilled about the benefits team we have built at Timken. I have eight people on my team and every one of them is conscientious and dedicated to serving the associates and their families, as well as the company. They work hard to create and administer our programs, and that team is the reason why we are achieving great results. Second, I am proud of the fact that our programs are actually improving the lives of our associates and their families with initiatives that are truly making a difference.

What do you see as the greatest challenge for benefits professionals?

While there are many challenges for benefits professionals in today's employment environment, I think the most important is dealing with the high cost of health care. It's no longer enough to try to come up with programs that reduce costs. Focusing only on these types of programs will simply lead to chasing rising costs without ever catching up because the cost of health care will never stop going up. It is the basic law of supply and demand. We all want to get better, which makes the demand for health care limitless. And, if demand is unlimited, suppliers can charge whatever they want and continue increasing costs as much as they want.

For employers, chasing health care costs is unsustainable. As a result, benefits professionals need to consider a different approach. They need to think about getting ahead of the cost problem by educating their workforce about healthy eating and providing resources to help their employees (and families) make lifestyle changes to get healthy. In the U.S., 75% of health care dollars are spent on diseases and conditions that are completely preventable (e.g., heart disease, high blood pressure and diabetes, to name a few). If employers can help their employees understand this and take action to get healthier, they can reduce the need for health care and, consequently, the money spent. Most people do not understand what it means to eat healthy. There is a lot of misinformation out there. Employers must be that trusted source of information and resources. After all, who cares more about their employees than the employer?!

What advice would you give others in your role?

First, you need a great team around you. As John C. Maxwell said, "Nothing of significance was ever achieved by an individual acting alone." Benefits is too complex and too vast to do anything worthwhile by oneself. My team is phenomenal, and it is the biggest reason we have enjoyed success. Second, you have to be willing to take some chances on new programs or offerings. Rx Savings Solutions and Virta were two such programs for us, and they have been fantastic additions to our benefits program lineup.

Have a story to share?
Contact us at
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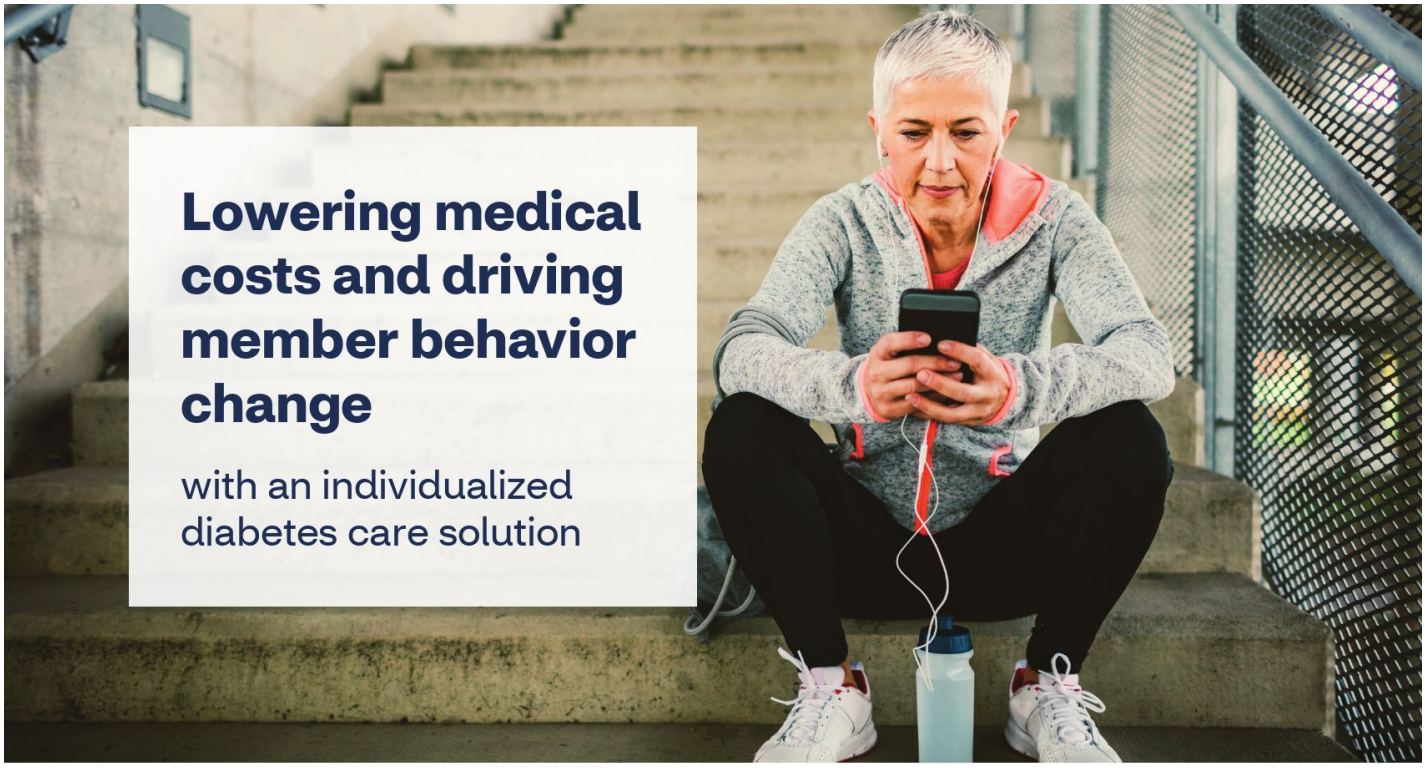

Lowering medical costs and driving member behavior change

with an individualized diabetes care solution

Diabetes is prevalent and costly to manage, and comorbidities like hypertension add to the complexity of care when plan members have both of those conditions. Left untreated, gaps in care can lead to increased payor medical costs, and poor outcomes for members.[1]

To help your members with diabetes close those gaps, we offer a solution that features customized support across five clinical impact areas, using early identification and unique touchpoints — both face-to-face and virtual — to help achieve reduction in A1C. Members that also have hypertension receive additional support to help lower blood pressure.[2]

27%
incremental gap closure for commercial members[3]

2:1
Guaranteed return on investment[4]

Up to **1.9%**
average A1C reduction[5]

Up to **15mm/Hg**
reduction in systolic blood pressure[6]

Your comprehensive diabetes care solution gets results, and members have positive experiences while reaching their health care goals. Contact your CVS Health Account team to learn more.

1. CVS Health Analytics, 2022. Data from Commercial group members using TDC since 2021 January program expansion. All data sharing complies with applicable law, our information firewall and any applicable contractual limitations. Actual results may vary depending on benefit plan design, member demographics, programs implemented by the plan and other factors. P1011260222
2. Support for hypertension is available at additional cost.
3. In pilot, subgroup analysis of the first group of participants outreached, intervention group compared to matched group of non-participants, where six months of data are available.
4. Conditions for ROI guarantee apply, and full guarantee requires final sign-off by CVS Caremark Actuarial and Underwriting.
5. Commercial member, uncontrolled A1C (A1C >= 7.1) and has high-value diabetic care gap. Fully compliant means that the member closes all open care gaps.
6. For commercial members not achieving good blood pressure control with hypertension (Grade 1 or 2) requiring medical therapy – SBP >140 or DBP >90. All data sharing complies with applicable law, our information firewall and any applicable contractual limitations. Actual results may vary depending on benefit plan design, member demographics, programs implemented by the plan and other factors. Client-specific modeling available upon request. P1008050221

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