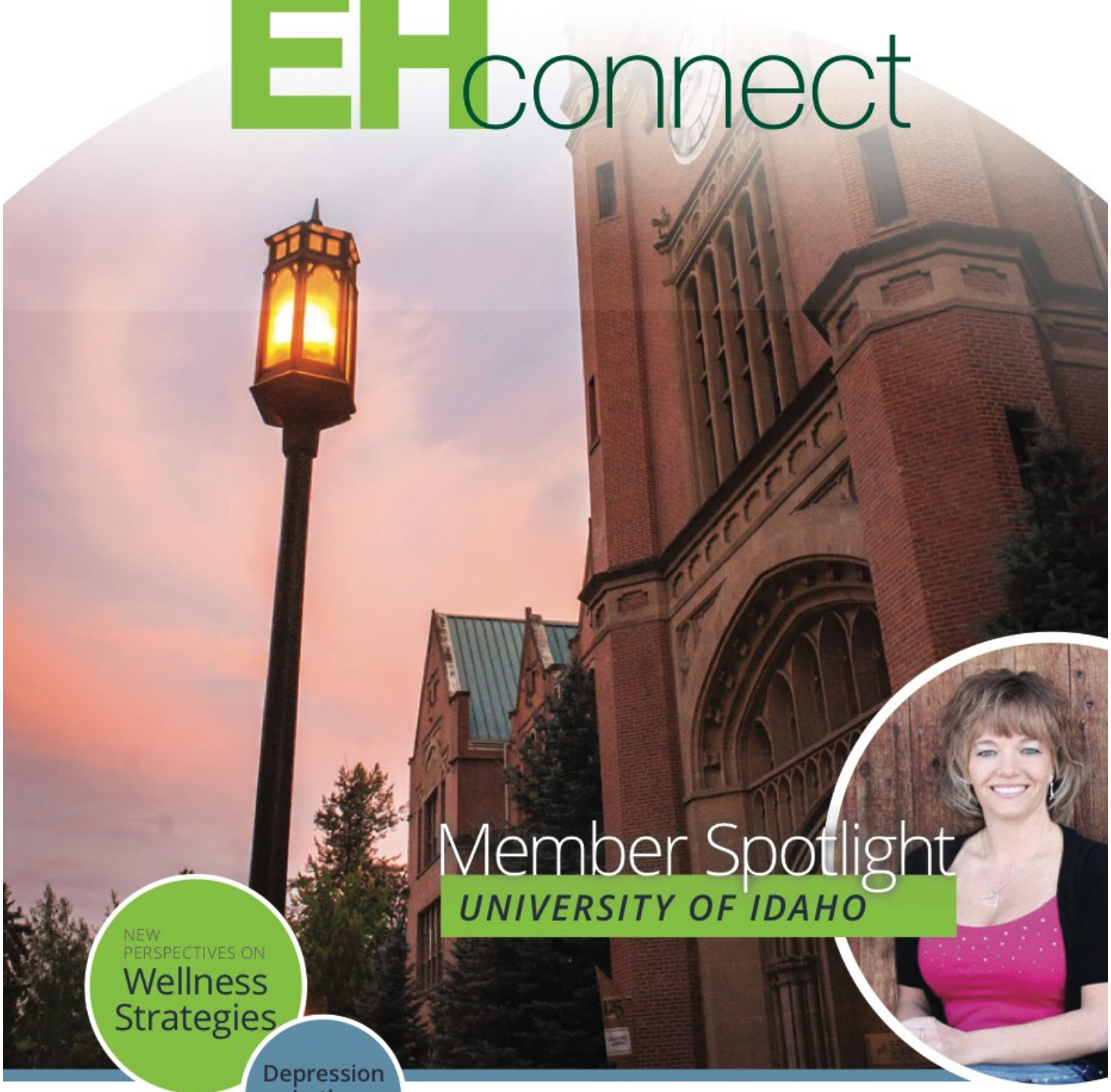
EMPLOYERS HEALTH

A publication of Employers Health Coalition, Inc.
Issue 2 | Spring 2015

EHconnect



Member Spotlight
UNIVERSITY OF IDAHO

NEW PERSPECTIVES ON
Wellness Strategies

Depression in the Workplace

Our Q&A with Brandi Terwilliger 20

THE UNIVERSITY OF IDAHO PHOTOGRAPHIC SERVICES

Chart the right course

IN PHARMACY BENEFIT MANAGEMENT

WITH CATAMARAN, YOUR ENDORSED PBM

FOR EMPLOYERS HEALTH

Stay well ahead of costs. Stay well ahead of health issues.

Stay well ahead with Catamaran

1 in 5	U.S. pharmacy claims processed on our technology
35	million members
400	million claims annually
85.6%	generic dispensing rate

Catamaran answers the demand for a scaled alternative to the traditional PBM model. We provide a tailored approach to meet unique client needs.

Catamaran delivers:

- Strong financial results
- Flexible solutions
- Highly personalized service

Contact your Employers Health representative for more information.

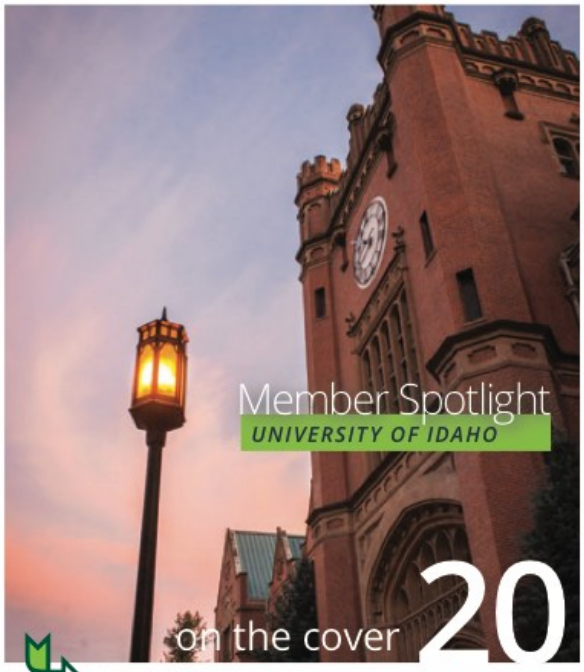
catamaran®

stay well ahead

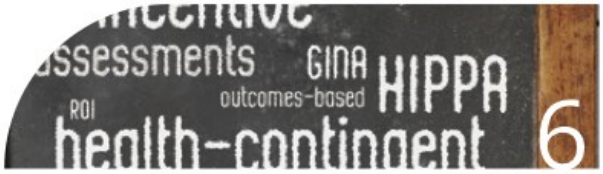
www.catamaranRx.com

Inside this Issue

Contents



Brandi Terwilliger, Director, Human Resources, University of Idaho



Recent Wellness Program Litigation and the Cadillac Tax: New Perspectives on Wellness Strategies

Managing the Complexity of Specialty Pharmacy Benefits

Depression in the Workplace: The Unexpected Threat to your Company

Eric Dublikar, Editor

2015 Meetings&Events

Stay ahead with Employers Health and save these dates!

2015 Annual Employer Symposia

Innovations in EMPLOYEE BENEFITS

June 18 | Cincinnati, Ohio
8 a.m. – 2 p.m.

Cooper Creek Event Center
4040 Cooper Road
Blue Ash, Ohio 45241

Join Employers Health for our second symposium of the year, held in Cincinnati, Ohio. Traditionally held in the fall, the Cincinnati symposium will be hosted on Thursday, June 18, 2015, at the Cooper Creek Event Center. This change was made to better accommodate members and sponsors. The topics will focus on innovations in employee benefits, including wellness strategies, ACA compliance and risk management.

Attendees can receive CE credits! Register today by visiting our website www.employershealthco.com/events.

MAY

MAY 21
Cleveland/Akron Benefits Roundtable
(employer members only)
Akron Family Restaurant, 12 – 1:30 p.m.

MAY 26
Columbus area Benefits Roundtable
(employer members only)
Employers Health Dublin office, 8:30 – 10 a.m.

MAY 28
Chicago area Benefits Roundtable
(employer members only)
Beam Suntory, Inc. Headquarters, 8:30 – 10 a.m.

JUN

JUN 4
Canton area Benefits Roundtable
(employer members only)
Location and time: Table Six Kitchen + Bar, 12 – 1:30 p.m.

JUN 11
PEEC Employer Private Exchange Summit
Columbus, Ohio, Nationwide Hotel and Conference Center

JUN 18
Annual Symposium
Cincinnati, Ohio, Cooper Creek Event Center, 8 a.m. – 2 p.m.
Attendees can receive CE credits!

JUL

JUL 9
Cleveland/Akron area Benefits Roundtable
(employer members only)
Akron Family Restaurant, 12 – 1:30 p.m.

JUL 16
Columbus area Benefits Roundtable
(employer members only)
Employers Health Dublin office, 8:30 – 10 a.m.

JUL 17
Tri-State Workplace Wellness Collaborative
Topic: Meet Cincinnati's healthiest employers and learn what makes them the healthiest in the region!
Location and time: TBD

AUG

AUG 4
Canton area Benefits Roundtable
(employer members only)
Location and time: TBD

AUG 20
Cincinnati/Dayton area Benefits Roundtable
(employer members only)
Interact for Health, 8:30 a.m.

SEP

SEP 2
Cleveland/Akron area Benefits Roundtable
(employer members only)
Akron Family Restaurant, 12 – 1:30 p.m.

SEP 11
Tri-State Workplace Wellness Collaborative
Topic: Consumerism & Advocacy – helping employers navigate the health care system
Location and time: TBD

OCT

OCT 8
Canton area Benefits Roundtable (employer members only)
Location and time: TBD

OCT 15
Columbus area Benefits Roundtable (employer members only)
Employers Health Dublin office, 8:30 – 10 a.m.

Cincinnati/Dayton area Benefits Roundtable
(employer members only)
Location: TBD, 8:30 a.m.

NOV

NOV 4
Cleveland/Akron area Benefits Roundtable
(employer members only)
Akron Family Restaurant, Time: TBD

NOV 13
Tri-State Workplace Wellness Collaborative
Topic: Elder care and work/life resource access
Location and time: TBD

DEC

DEC 2
Employers Health Annual Meeting
Kent State University at Stark, 8 – 10 a.m.

DEC 3
Canton area Benefits Roundtable (employer members only)
Location and time: TBD

DEC 17
Cincinnati/Dayton area Benefits Roundtable (employer members only)
Location: TBD, 8:30 a.m.

Industrialist Henry J. Kaiser was famously quoted as saying, "Problems are only opportunities in work clothes." As our members face today's health and welfare challenges, Employers Health is helping them see problems as opportunities to deliver better employee benefits, creating healthier and more engaged workforces.

Message from Chris

Our 2014 Annual Report illustrates how we turn problems into opportunities. Titled *A Collective Response,* the report looks back at 2014 highlights, emphasizes our core services and provides member testimonials that help personalize and demonstrate how we develop leading solutions. Prior to publishing the 2014 report, our 2013 Annual Report was recognized with a judge's choice award at the Canton Advertising Federation ADDY® Awards. With hundreds of advertising and marketing pieces nominated, it was one of three to win the coveted judge's choice award. We are proud to publish our work in these annual reports, and we hope you have an opportunity to read them each year.

Since our last edition of *EH Connect,* we've added two new staff members, with plans of adding four more in 2015. Wendy Hench, account management executive, came on board in 2014 and works closely with our members to provide client support, vendor management and strategic oversight. Prior to joining Employers Health, Wendy worked for the Rx Ohio Collaborative (RxOC), the Ohio Bankers League and a local TPA. As a former plan administrator of a multimillion dollar trust, she is experienced in self-funded medical, dental, vision, life insurance plans, compliance, human resources, reporting and training. Wendy earned a Bachelor of Science degree in Human Ecology from The Ohio State University.

We also welcomed Devon Feriance to our team. Devon serves as our education and events coordinator, ensuring that member organizations receive a highly valuable experience through educational meetings and employer programs. She's responsible for developing, executing and managing these events. Devon brings more than 11 years of ad agency experience having previously worked as an account and project manager helping clients develop and execute creative solutions for a wide-range of industries. She holds a bachelor's degree in Marketing from Walsh University where she graduated Magna Cum Laude.

In other staff news, we are pleased to announce that Debra Lawrence has been promoted as our new vice president of account management. Deb's career has included roles in human resource consulting with two notable firms as well as human resource executive-level positions. Previous positions include serving as director of HR at Rumpke; acting vice president, HR and director, employee benefits at Gibson Greetings; and vice president, administration and director of corporate affairs at Johnson Group Management. Deb's experience, accountability and vision will serve our members well.

As you read through this edition of *EH Connect,* note all of the collaborative efforts, strategies and tools that create opportunities in the coalition.

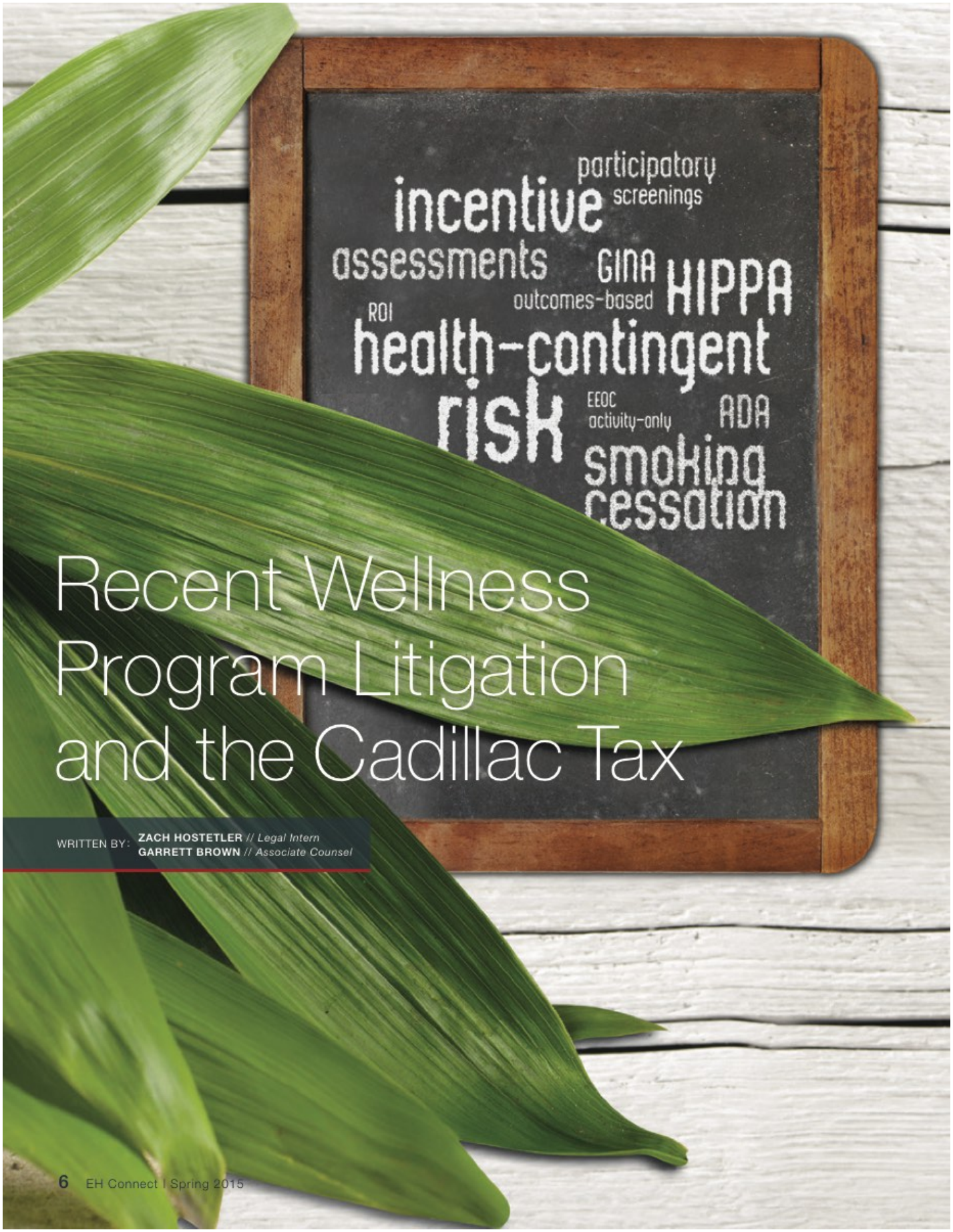
Thank you to Anthem, CVS Health and Catamaran for your sponsorship of this publication.

We hope you're enjoying spring, and thank you for giving Employers Health the *opportunity* to work with your organization.

Christopher V. Goff
CEO & GENERAL COUNSEL

Welcome to our newest members!

AM/NS Calvert, LLC
Athletico
Be Well Solutions
Bowling Green State University
Core Molding Technologies, Inc.
Daniel G. Schuster, Inc.
DeKalb County, GA
Goodyear Tire and Rubber Company
H-P Products, Inc.
IBEW Local 38 Health and Welfare Fund
IDEX Corporation
Little River Casino Resort
McCormick & Company, Inc.
Mutual of America
NES Rentals Holdings, Inc.
NOITU Insurance Trust Fund
Northern Virginia Electric Cooperative
Raritan Bay Health Services Corp.
Rea & Associates, Inc.
Rotary Corporation
Rudolph Libbe Group
Western Reserve Hospital



Recent Wellness Program Litigation and the Cadillac Tax

WRITTEN BY: **ZACH HOSTETLER** // *Legal Intern*
GARRETT BROWN // *Associate Counsel*

New Perspectives on Wellness Strategies

As plan sponsors grapple with rising claims cost, many have turned to wellness programs to not only reduce costs, but also to improve the well-being of their plan participants. With the impending Cadillac Tax threatening a 40 percent excise tax on high-cost health coverage, wellness programs could be a key element in plan sponsors' strategies to reduce claims cost and the overall cost of coverage.

For self-funded plan sponsors, the total cost of health coverage as regulated by the Cadillac Tax is primarily driven by (1) the unit cost of each claim and (2) the number of units consumed by plan participants. Many pundits suggest heading off this tax by increasing plan participant cost sharing, but not all plan sponsors are in a position to take such a step, and the plan sponsor will likely still retain the lion's share of the costs. Moreover, shifting premium cost sharing has no direct impact on the total cost of coverage.

Thus, plan sponsors evaluating the ROI of wellness programs must carefully review wellness programs as they present one of only a few means to potentially reduce the number of units of health care consumed by their plan participants.

Whether a plan sponsor has a robust or fledgling wellness program in place or has just begun considering one in light of the Cadillac Tax, recent litigation attacking wellness programs has given many plan sponsors pause. This article will provide a brief regulatory overview of the Health Insurance Portability and Accountability Act (HIPAA) wellness program regulations, as amended and promulgated by the Affordable Care Act (ACA); a summary of the recent Equal Employment Opportunity Commission (EEOC) litigation; and plan sponsor best practices.

Understanding how to construct a sound wellness program, compliant with the laws and regulations, is not only crucial to avoiding a complaint from the EEOC but also integral to the program's success and longevity.

Regulatory overview

The ACA categorizes wellness programs as either participatory or health-contingent depending on the program's standards for receiving a reward. While all programs are generally prohibited from discriminating against plan participants based on a health factor, a program's classification dictates the size of the reward a plan sponsor may make available to the plan participant and if it must offer a reasonable alternative standard (RAS).

Under a participatory program, such as incentivizing a participant's completion of a health risk assessment or reimbursement for a gym membership, the reward is not contingent upon satisfaction of a standard related to a health factor. These programs are not related to a health factor as there is no requirement that participants perform any physical activity or achieve a health-related outcome. A participatory program may offer an unlimited reward, but the plan sponsor should be aware of any potential tax implications of such program to the plan sponsor and plan participant.

Unlike participatory programs, health-contingent programs are strictly regulated by the ACA because under these programs the reward is contingent upon a participant satisfying a standard related to a health factor. Generally, health-contingent offerings must provide an RAS, and plan participants must be given an opportunity to qualify for the reward at least once every year. Health-contingent programs must also be reasonably designed to promote health or prevent disease. The size of the reward is limited to 30 percent of the total cost of coverage under such programs, but programs that involve a tobacco cessation component may increase the total reward to 50 percent.

Health-contingent programs are further divided into two subcategories: activity-only and outcome-based. An activity-only program, such as walking 30 minutes a day, requires the individual to complete an activity related to a health factor but does not require any specific health outcome. Activity-only programs must offer an RAS to individuals for whom it is medically inadvisable or unreasonably difficult due to a medical condition to participate. Plans are permitted to require physician verification of the need for an RAS under activity-only programs, but only if such request is reasonable under the circumstances.

An outcome-based program, such a maintaining a BMI of less than 25, requires a plan participant to attain or maintain a specific health outcome. Interestingly, the requirement that a plan participant not use or discontinue the use of tobacco products falls under this category. Outcome-based programs must provide an RAS to any individual who does not meet the initial standard or who requests an alternative. Plan sponsors must include a notice of the availability of the RAS in all materials describing the program. An example of this notice released by the Department of Labor (DOL) can be found on the DOL website.

Pending EEOC litigation

In 2014, the EEOC filed lawsuits against three employers claiming that the employers' wellness programs violated the Americans with Disabilities Act (ADA) and the Genetic Information Nondiscrimination Act (GINA). Due to these actions, it's important that plan sponsors are cautious when structuring wellness programs to ensure compliance with other federal laws.

In the first two suits, employer premium contributions were contingent upon the employee's participation in the plan's wellness program. These programs included a biometric screening and health risk assessment. In each case, if an employee failed to participate in the program for any reason, the employee was responsible for paying the entire premium. The EEOC asserts each program was not voluntary because of the significant penalty triggered for not participating and, citing the ADA, states that employers cannot require medical examinations or seek disability-related information from employees unless such an inquiry is part of a voluntary wellness program.

Although these cases are still pending, it is clear that the structure of these programs does not comply with ACA requirements and were seemingly low hanging fruit for the EEOC to challenge.

The EEOC filed its third suit, which was not decided on the merits, against Honeywell alleging violations of both the ADA and GINA. Plan sponsors should take specific note of this suit as this program appears to comply with ACA requirements and appears to be reasonably structured. Honeywell's program levied surcharges on employees who refused to participate in the wellness program. Among other components, the wellness program included a biometric screening for all plan participants including spouses if they were enrolled in the plan. Failure to participate in the program resulted in ACA compliant surcharges of up to $2,500 and discontinuation of employer HSA contributions of up to $1,500.

> Helping employees with the multiple facets affecting health risk factors is proving to be the most effective use of resources in improving workforce health and organizational performance.
>
> – Traci Barry, MS, senior director, strategic health initiatives, at Employers Health

Citing the ADA, the EEOC alleged that this program was not voluntary because of the additional cost placed on the employees if they did not participate. The EEOC also cited GINA, stating that the employer's request for genetic information was not voluntary and broadly asserted that the employer, acting as the plan sponsor, was seeking genetic information for underwriting purposes. Also, because GINA defines genetic information to include current medical information of family members, including relatives by affinity (e.g., spouse), the EEOC also alleged that the program resulted in the unlawful request of genetic information as it related to the employee.

Best practices

Nuanced ACA rules and recent EEOC litigation should serve to reinforce the need to carefully and strategically construct a wellness program.

"As more regulations dictate what a wellness program can and can't do, there is the shifting of focus from establishing penalties for non-participation in activities to creating an overall healthy and productive environment for employees, which enhances individuals' overall state of well-being," said Traci Barry, MS, senior director, strategic health initiatives at Employers Health. "Helping employees with the multiple facets affecting health risk factors is proving to be the most effective use of resources in improving workforce health and organizational performance."

Plan sponsors should continue to embrace or explore wellness programs but should do so on firm legal footing. Employers utilizing health-contingent programs should carefully review and understand the requirements surrounding reasonable alternative standards including, but not limited to, notice requirements and when such alternatives must be provided. Even if a wellness program complies with the ACA, plan sponsors must be aware of the interplay of other federal bodies of law such as GINA and the ADA. Specifically, plan sponsors must consider: (1) the voluntary nature of the program, (2) the type of information collected, (3) how information is collected, (4) how information is used and (5) recent EEOC proposed regulations published April 20, 2015 regarding EEOC enforcement approaches and wellness program design requirements.

It can be argued that progressive initiatives, such as wellness programs, stand in contrast to compliance activities. Likely, in many organizations, there is a tension between ardent wellness program advocates and wellness program skeptics who foresee the compliance burdens of such a program. However, uniting as a team to avoid the excise tax may align these interests and create a positive result for the plan.

References

1. *Incentives for Nondiscriminatory Wellness Programs in Group Health Plans (Final Rule), 78 Fed. Reg. 33157 (June 3, 2013).*
2. *Americans with Disabilities Act of 1990 (Pub.L. 101 -336).*
3. *Genetic Information Nondiscrimination Act of 2008 (Pub.L. 110 -233).*
4. *EEOC v. Orion Energy Systems (Civil Action No. 1:14-cv-01019).*
5. *EEOC v. Flambeau, Inc., (Civil Action No. 3:13-cv-00638).*
6. *EEOC v. Honeywell International, Inc., (Civil Action No.14-cv-04517-ADM-TNL).*
7. *Amendments to Regulations Under the Americans With Disabilities Act (Proposed Rule), 80 Fed. Reg. 21659 (April 20, 2015).*

Managing the Complexity of Specialty Pharmacy Benefits

Written By: **MATTHEW HARMAN, PharmD, MPH,** *// Director, Clinical Pharmacy Strategies*
MIKE STULL, MBA *// Chief Operating Officer*

Defining specialty

Specialty drugs do not have a consensus definition across all stakeholders in the specialty space, but they can generally be thought of as high-cost medications used to treat complex conditions. Often, these medications are biologically developed from a living organism into products such as hormones, proteins and vaccines.

However, some specialty drugs are derived chemically, similar to traditional medications, but still fall under the specialty umbrella because of the condition they treat and/or because they require extensive patient education, monitoring and management. Special storage and handling requirements, in addition to site-of-care administration are also common traits of specialty medications.

Infused medications for conditions such as rheumatoid arthritis and cancer make up about one-third of specialty spend and are unique because the infusion can occur at different sites of care, leading to high variability in expenditures. These sites of care generally fall into three main buckets: (1) outpatient hospital setting, (2) physician's office, and (3) patient's home. Not only does the price of the medication significantly vary between these settings, but the cost of administration does as well.

Medical vs. pharmacy benefit

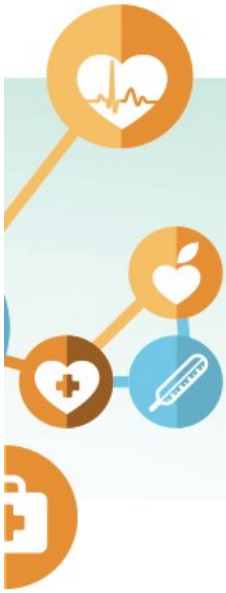
How and where the medication is administered has historically dictated what benefit would cover the cost of the specialty product. Specialty drugs billed under the pharmacy benefit are generally self-injectables or oral medications administered by the patient or caregiver and dispensed through a specialty or retail pharmacy.

Drugs billed under the medical benefit are typically administered by a health care professional through injection or infusion and given in the hospital, physician's office, clinic or the home. These medications are normally dispensed in bulk by specialty distributors, sent to physician offices and billed after administration, which makes tracking and management more difficult for plan sponsors.

Some medications can be billed under either benefit and moving them solely under the pharmacy benefit is one potential management strategy if your health plan is not actively managing utilization and reimbursement. This strategy can upset some providers because many are financially incentivized to favor medications that are administered onsite by a health care professional as opposed to self-injectables. This is especially true at hospitals and oncology offices where a significant portion of revenue is generated by infusion and support services.

Due to the high price tag surrounding these infusion services, manufacturers of newer oral medications have set the price of their tablets to match (and in some cases exceed) the price of the infused specialty medications.

A recent analysis by Milliman for CVS Health revealed that 53 percent of specialty drug costs were paid for under the medical benefit. This is consistent with other analyses conducted by large health plans. Thus, it is important to understand the billing process for specialty medications under each benefit and what determines a medication's benefit coverage.



Infused medications for conditions such as rheumatoid arthritis and cancer make up about one-third of specialty spend and are unique because the infusion can occur at different sites of care, leading to high variability in expenditures.

Pricing for specialty medications also varies between the pharmacy and medical benefit. Like most other medications, pricing under the pharmacy benefit typically involves a discount off a standard price like average wholesale price (AWP) plus a dispensing fee (in some cases this is waved) or administration fee. Most contracts also include rebates for specialty medications that help offset the high cost. Pricing under the pharmacy benefit is driven off the submitted National Drug Code (NDC). Under the medical benefit, providers are typically reimbursed on a percentage of charges methodology depending on the Health Care Procedure Coding System (HCPCS) code submitted.

Aggressive plans are moving to alternative reimbursement arrangements, such as a standard fee schedule or some type of cost-plus model. Rebates are typically not passed back to plan sponsors under the medical benefit.

Trends and implications

The growth of the specialty drug marketplace has been quite substantial over the last quarter century. Only 10 specialty medications were available in 1990, but more than 900 specialty drugs were in development in 2012. As new specialty medications reach the market, more patients will be eligible to utilize specialty medications for the first time. Another factor increasing utilization lies with the increased effectiveness and safety for some of these medications over their traditional counterparts to treat the complex conditions for which they were designed.

According to Prime Therapeutics, the average specialty drug costs 50 times more than the average traditional medication. Many factors are leading to the high price tag for specialty medications and driving the trend to where analysts predict that total specialty spend will make up half of total pharmacy spend by 2018, which currently is around 25-30 percent. Until more competition is created within drug classes, the ability of payers to exert downward pressure on prices will continue to be limited. Due to the lack of competition within therapeutic classes, the pricing power wielded by specialty manufacturers makes traditional tools of benefit design less effective (but not obsolete). It is worth noting that before an employer can effectively manage their specialty pharmacy benefit, the traditional drug side needs to have the proper strategies in place through benefit design (e.g. coinsurance, promote generics) and utilization management (e.g. step therapy, quantity limits).

Utilization and contract management strategies

By far the most commonly utilized way to manage specialty medications is to ensure appropriate utilization through prior authorization (PA). Specialty medications covered under the pharmacy benefit should typically be subjected to PA programs. Step therapy edits can be built into PA criteria for a few conditions, such as rheumatoid arthritis, that utilize specialty medications at later stages in the treatment algorithm and prefer traditional generic and brand medications first.

As mentioned earlier, PA programs on the medical side are much more difficult to perform due to the challenges of HCPCS coding, but are not impossible to implement depending on the medical carrier.

As for step therapy, this can be an effective method of preferring the best-in-class medication for the therapeutic category while allowing the plan sponsor to benefit from an increase in manufacturer rebates. Formulary exclusions are also prominent among the largest PBMs as mechanisms to drive better pricing.

The growth of the specialty drug marketplace has been quite substantial over the last quarter century. Only 10 specialty medications were available in 1990, but more than 900 specialty drugs were in development in 2012.

We strongly recommend 30-day supply quantity limits on most specialty medications for at least the first year of filling. If a member demonstrates consistent adherence for a chronic specialty medication over the course of the year, an authorization for a 90-day supply could be granted if the member requests this for convenience purposes and the plan's turnover rate is relatively low. Many specialty medications are associated with discontinuation of therapy due to unmanageable side effects, especially for cancer and multiple sclerosis medications, which can lead to waste and avoidable costs.

For traditional medications, plan sponsors generally expect their plan participants to share about one-fifth of the total drug cost. Considering that the average specialty medication is around $3,000 per 30-day prescription, many plan sponsors understand that the same level of member cost-sharing is unfeasible, so some have created a coinsurance specialty copay tier with a minimum and maximum dollar amount in order to increase patient cost share and highlight the significant expense of the medication to their members.

While these higher-tier plans have helped offset a small portion of the specialty cost, a reduction in utilization for specialty drugs is often observed as well. This can be seen as both good and bad. It is positive for the patients that were taking specialty medications before trying lower-cost traditional alternatives but could be negatively impacting adherence to therapies that have become the only option for some patients. These short-term savings on the pharmacy benefit can generate significant expense on the medical side due to complications of the untreated conditions, such as increased hospitalizations. A solid utilization management strategy and a separate but reasonable patient out-of-pocket tier are good first steps.

Finally, the importance of contracting and its ability to reduce price and increase rebates cannot be understated. As manufacturers continue to increase the price of their products each year, negotiated price protection after a certain percent increase can save the plan from experiencing double digit trends. Formulary exclusions are another effective means of cost mitigation and rebate enhancement now that some classes have multiple therapeutic options. Even with medication exclusions, patients still have access to at least one medication for their disease state, and if that medication is ineffective, the ability to receive excluded drugs through prior authorization is available.

Next steps

While not every strategy will work for every plan sponsor, sitting idle cannot be an option. Depending on the plan sponsor's appetite and ability to change plan design, multiple options exist to manage specialty pharmacy in the context of overall pharmacy and medical spend. *For more information, contact Employers Health clinical pharmacist Matt Harman at mharman@employershealthco.com.*

Important Questions for Employers to Consider

What medications are dispensed under the medical and pharmacy benefit plans? Where are the medications dispensed and administered?

What clinical management and formulary management programs are in place under the pharmacy and medical benefit plans? What have I implemented and what can I implement?

What are the costs associated with self-injectable medications and oral medications administered under the pharmacy plan versus the medical plan? Are there savings?

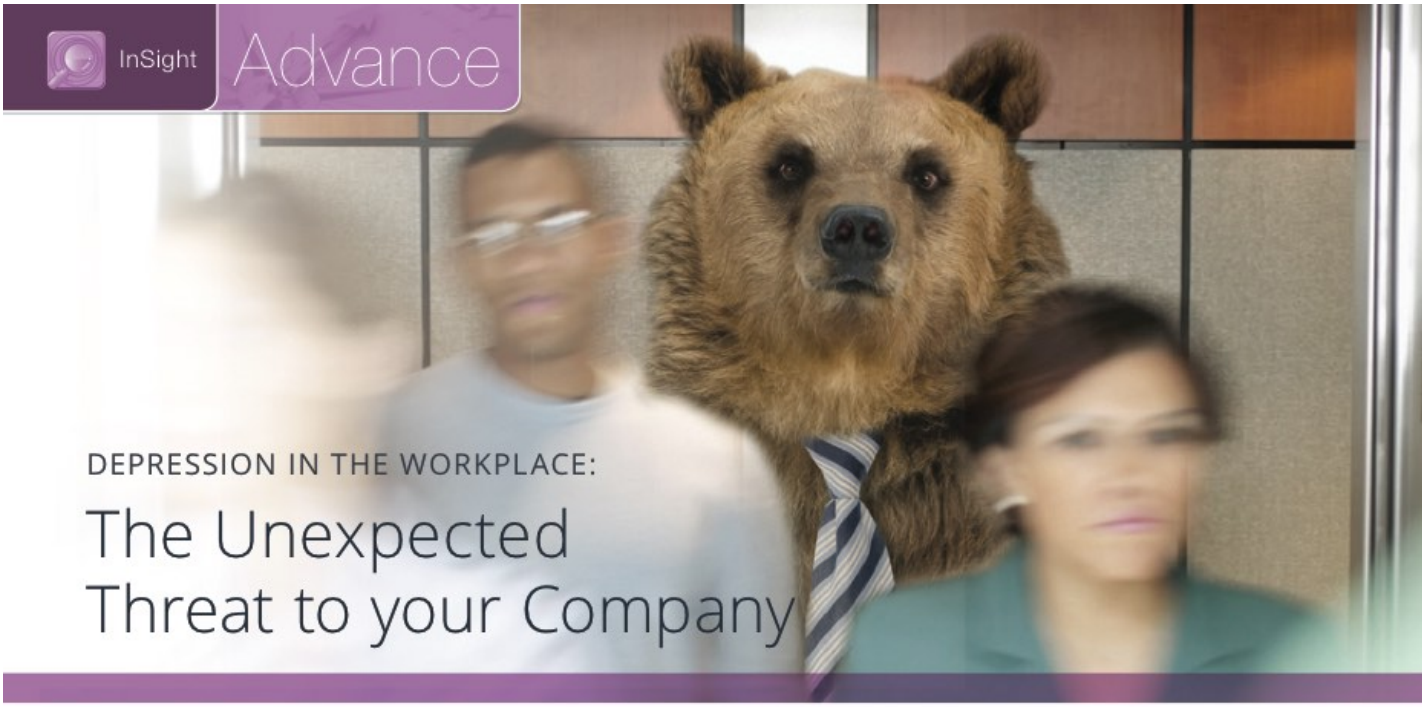
How does the health plan work with the pharmacy benefit manager to integrate data?

Are there differences between the participant's out-of-pocket costs depending on whether the drug is administered under the pharmacy plan or medical plan? Are adjustments warranted?

What does my contract say about pricing/reimbursement for specialty medications under both the medical and pharmacy plans?

Have I effectively managed my traditional drug spend? Are there opportunities (e.g. compound management, step therapy protocols) to reduce spend for traditional therapies in order to offset increasing costs for specialty medications?

Have I implemented formulary exclusion strategies offered by my PBM? Is there a reason not to do this? Does my stop-loss policy cover specialty medications administered under the pharmacy benefit?



DEPRESSION IN THE WORKPLACE:

The Unexpected Threat to your Company

As a first-of-its-kind initiative, *Right Direction* has received national attention for its leadership in addressing depression in the workplace. To validate the societal and economic burden of how depression impacts employers, Employers Health launched the results of *The Impact of Depression at Work Audit (IDeA) survey (Ipsos, 2014).**

Survey results revealed that nearly a quarter (23 percent) of U.S. respondents indicated they have been diagnosed with depression in their lifetime.

Depression is shown to negatively impact performance in the workplace. Of those respondents who had depression, two in five missed an average of 10 work days per year, due to their condition. Sixty-four percent reported that cognitive-related challenges, defined as difficulty concentrating, indecisiveness, and/or forgetfulness, had the most impact on their ability to perform tasks at work as normal. Presenteeism, or being at work but not engaged/productive, has been found to be exacerbated by these cognitive-related challenges.

Even though symptoms of depression make it difficult to perform adequately in the workplace, most employees with depression don't seek help due to the stigma associated with the condition. As an example, the IDeA survey found that more than half (58 percent) of survey participants who had received a diagnosis of depression indicated they had not informed their employer of their disease. This reluctance to discuss a diagnosis of depression is concerning because such fear could discourage people from seeking treatment and/or a flexible accommodation when needed. While they need not necessarily name the specific diagnosis, employees with depression should feel comfortable requesting a modification in work hours in order to go to medical appointments, for example.

The effect of depression on employee performance is directly affecting the financial bottom line. Data indicate that:

- **Depression costs employers $44 billion annually in lost productivity.**
- **Depression ranks among the top five disability claims globally (among cancer and cardiovascular conditions).**
- **Short-term disability claims for mental illness are growing by 10 percent annually.**
- **Two to four times more health care resources are used by employees with depression who do not receive treatment.**

Unfortunately, the survey reveals that 35 percent of managers lack resources to address depression with their employees.

Given the data, it is important that employers identify ways in which to address depression and mental health in the workplace through safe and confidential means to help employees get the help they need, while also realizing improvement in work performance.

For more information on Right Direction, visit rightdirectionforme.com

Resources for employers

Most employers offer an employee assistance program (EAP), designed to address employee wellness in the company. However, on average, only three percent of employees use counseling services available through their company's EAP.

The Right Direction initiative, developed by Employers Health and the Partnership for Workplace Mental Health, a program of the American Psychiatric Foundation, has become a valuable and free resource for employers. The initiative is designed to provide employers with the tools needed to educate employees about depression, reduce stigma and increase the chances of people seeking help. It offers employers a wealth of turn-key resources ranging from content for intranet sites to template PowerPoint presentations that can be customized to communicate the importance of addressing depression with the C-suite and managers.

"While employers play a vital role in leading the conversation of mental health with employees, unfortunately, many employers simply do not have the tools to address this sensitive subject," says Marcas Miles, senior director of marketing and communications with Employers Health. "The Right Direction initiative provides employers with the resources that raise awareness and reduce stigma around depression in order to provide a more productive workplace and supportive company culture."

Taking a step in the Right Direction: one organization's journey

Online Computer Library Center, Inc. (OCLC) is a nonprofit, membership, computer library service and research organization employing approximately 950 employees in the U.S. and 1,300 globally. OCLC connects libraries using a global network to collectively innovate and drive efficiencies in metadata creation, interlibrary loan, digitization, discovery and delivery.

Beginning in 2010, OCLC took a thorough look at its top claim drivers to determine where to focus its wellness program. As with most U.S. employers, OCLC found the following:

- One of the top three medications used through its medical plan were antidepressants.
- Depression was the fourth-highest diagnosed condition for employees on OCLC's medical plan.
- Over the past three years, there was a rise in disability claims related to mental health.

OCLC realized that even though EAP utilization by its employees was strong overall, there was a need for focused education on depression and mental health for employees and their dependents. OCLC rolled out Right Direction during Mental Health Awareness Week in October 2013, which coincided with onsite wellness screenings, as well as the company's Open Enrollment period. OCLC also hung posters throughout its office locations, incorporated Right Direction into management orientation training, hosted an awareness booth at its employee benefits fair, and included information about mental health in its communications campaign for several health-related awareness months.

Through these efforts, the company was able to personally talk to employees, as well as their spouses, to provide additional details about the initiative and the benefits involved. Following its depression awareness rollout, the team received emails from employees expressing happiness that OCLC was starting to address the issue; some even volunteered to help with future programming efforts around the initiative. There wasn't a single negative comment or question received.

Employers Health and the Partnership for Workplace Mental Health are working closely with the companies implementing Right Direction to ensure successful adoption of the initiative in their workplace.

"We're finding that employers are hungry for tools to increase awareness about depression and help encourage employees to use the EAP, mental health benefits and other services available through their company. Right Direction works beautifully to help an employer get the word about the availability of their resources to increase engagement" says Clare Miller, director of the Partnership for Workplace Mental Health.

By tackling depression in the workplace head on, employers will retain valued employees, secure less turnover and support a healthier, more productive workforce. All while improving the company's bottom line.

Signs of depression include deep feelings of sadness, loss of interest in activities, difficulty concentrating and loss of energy.

WRITTEN BY: **BRUCE SHERMAN, M.D., FCCP, FACOEM** // *Consulting Medical Director*

A GROWING FOCUS FOR EMPLOYERS

Cancer as a Chronic Condition

In the past several years, cancer has become an important focus for employers, for a number of reasons. Perhaps most significant is the fact that an increasing number of cancers are being identified in the workforce.

Better diagnostic testing, elimination of patient financial barriers to cancer screening, and an aging workforce all contribute to an increasing prevalence of cancer. Additionally, the obesity epidemic in the US predisposes individuals to several types of cancer, including colon, breast, prostate and uterus.

Recent successes with cancer care have shifted its status for many from a once-feared, often deadly disease to that of a chronic condition. New chemotherapy treatments, while costly, have yielded substantial clinical response for most types of cancer – and many of those available have a considerably better side effect and toxicity profile.

"The net result is that more individuals with cancer are living productive lives and remaining contributing members of the workforce," said Ron Finch, an independent consultant with Finch & Associates, LLC.

Costs of cancer

Perhaps the most important reason that cancer has become a priority focus for employers is cost.

"For the typical employer, approximately 2.4 percent of the beneficiary population is receiving active treatment for cancer, and it represents more than 10 percent of overall health care costs," Finch noted.

Notably, the rate of growth in cancer care costs has consistently exceeded the already-high medical inflation rate for the past several years. Detailed claims analysis indicates that chemotherapy is the primary driver of the rate of increase in cancer costs; however, complications of cancer care, including avoidable hospitalizations and ED visits likely comprise the greatest share of cancer care costs.

And unfortunately, for many, cancer extracts its toll not only on physical health, but on personal financial resources as well. Based on recent survey data, about 62 percent of personal bankruptcies are medically related. Most of those are attributable to cancer as the primary diagnosis. Even more sobering is that half of those filing medical bankruptcy have insurance.

Further, cancer contributes to diminished workforce productivity due to absence, as well as reduced on-the-job performance (presenteeism) typically due to chemotherapy side effects, including cognitive impairment ("chemo brain"). This productivity loss compounds overall employer medical and pharmacy costs for cancer care.

The employer's role

With a growing number of individuals having cancer yet continuing to work, it is essential that employers incorporate tactics to address the unique needs of this population. Considered options include benefit design support to

ensure that cancer is effectively treated, including access to clinical trials (which may ultimately lower employer benefit costs), reasonable copays for chemotherapy agents, as well as oncology care navigation services – shown to facilitate more timely treatment and decrease overall health care costs.

From a workplace perspective, employers can ensure that reasonable job accommodations exist for individuals with cancer. While it may well be premature to anticipate an array of physical work impairments, generally these individuals may need accommodation for treatment-related fatigue that may necessitate work at a slower pace, or rest periods during the day.

Additionally, and perhaps most importantly, well-being resource support for individuals with cancer can be a tremendous source of value – from dealing with changes in home life and/or financial stress, to dealing with the psychological implications of a new diagnosis of cancer. Employee assistance programs (EAPs) can be particularly helpful in this regard.

What can employers do?

Many opportunities exist for all employers to meaningfully and proactively address cancer in their workforce.

First, employers should promote early detection, by actively supporting and communicating their first dollar coverage for cancer screenings. Compliance rates remain low – even with first dollar coverage. Early diagnosis can result in the greatest opportunity for cure – with what is likely the most cost-effective care. To this end, it may be helpful to clarify misunderstandings among employees regarding costs of diagnosis.

Second, employers can encourage use of high-value cancer care practitioners. It may well be worth exploring the potential for cancer care centers of excellence as a means to guide individuals toward more effective and cost-efficient care. Incorporation of bundled pricing for common cancer diagnoses can help to align all stakeholders' interests in assuring that cancer patients receive the right care at the right time and in the right clinical venue.

Third, the opportunity for second opinion services for cancer diagnoses may merit consideration, particularly for patients in rural settings, where pathology skills may not correctly diagnose the type of cancer. This may lead to inappropriate and costly treatments without appreciable benefit. Many health plans have an available second opinion service as part of available offerings; a number of independent, third-party vendors can also provide this service.

Fourth, consider cancer care centers of excellence. But also recognize that this emotionally charged diagnosis often prompts individuals to stay close to home – and their family support. As a result, these programs may be underutilized despite their apparent value. At best, they may be able to provide a review of the diagnosis and treatment plan to affirm appropriateness.

Lastly, nurse oncology care coordinators can be an invaluable support to individuals with cancer – facilitating appointments, ensuring that non-clinical concerns are effectively addressed in a timely manner, and providing the navigation support that can help to overcome the sense of anxiety and helplessness that many individuals with cancer experience.

Helping our members implement evidence-driven benefits

Recognizing the importance of cancer to companies, Employers Health is currently working on a project to help employers address needs surrounding cancer treatment and prevention. Through the project – known as the Cancer in the Workplace Initiative – Employers Health will assess and analyze employer member's current benefit offerings and identify gaps where the employer can implement evidence-driven recommendations for cancer treatment and prevention. These cancer recommendations come directly from a professional guide developed by the National Business Group on Health and are based on clinical guidelines, which are translated into practical, usable terms to define and structure appropriate benefits.

The cancer initiative is free to members. Employers Health provides project staff to conduct an assessment and make recommendations to the participating employers – adding value by doing analysis and legwork for employers.

Employer members interested in learning more, can contact Communications Specialist Eric Dublikar at edublikar@employershealthco.com.

You're in control

and that's a healthy place to be

Anthem BlueCross BlueShield

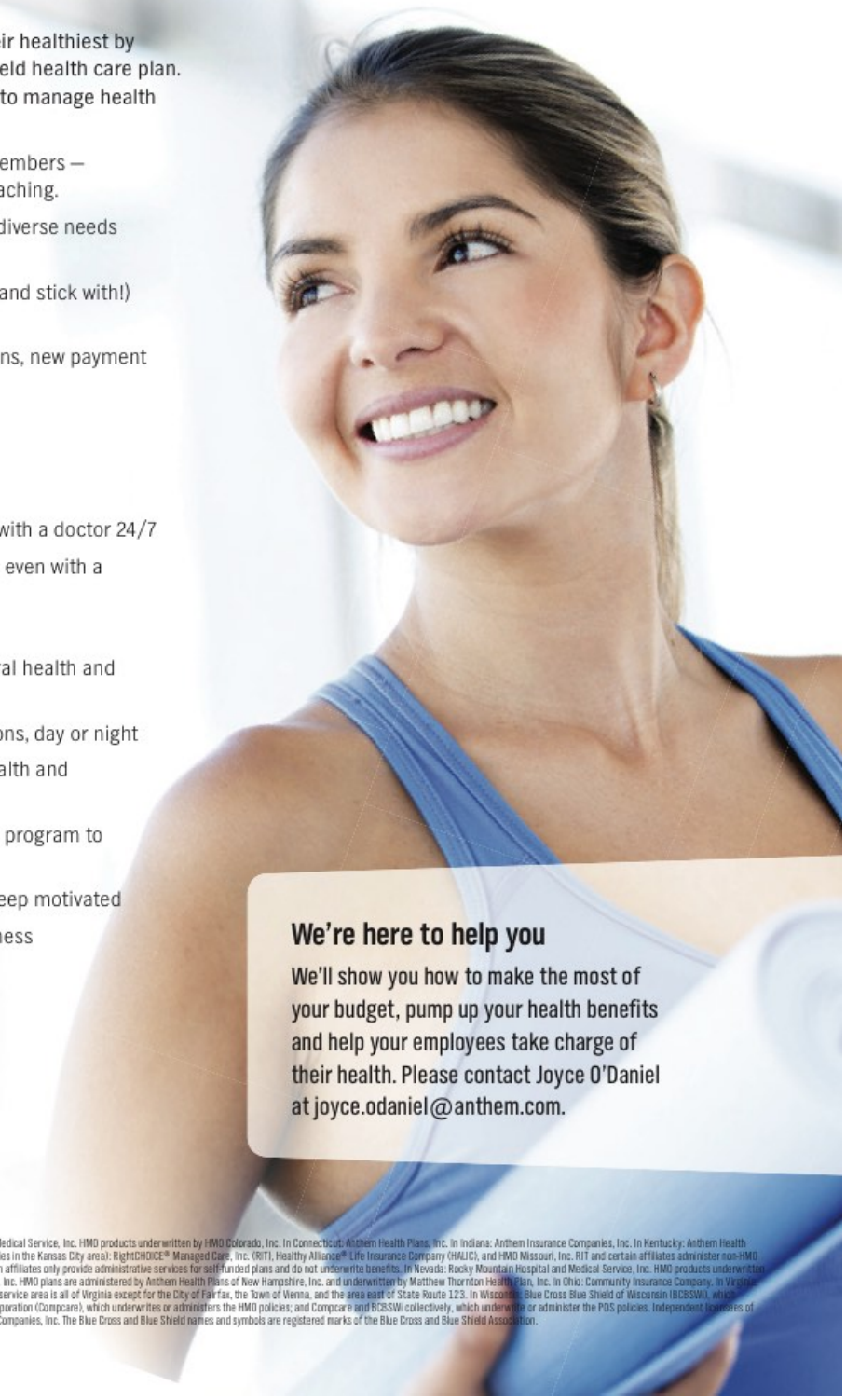
Get your employees pumped about being their healthiest by choosing an Anthem Blue Cross and Blue Shield health care plan. We provide simple, useful and effective ways to manage health care. That's why we:

- Make meaningful connections with our members — from online groups to personal health coaching.
- Develop leading health plans that reflect diverse needs in a changing market.
- Inspire kids and their families to choose (and stick with!) healthy habits.
- Help lower health care costs with new plans, new payment models and new technology.

You've got choices

Some of our programs include:

- **LiveHealth Online**, a two-way video chat with a doctor 24/7
- **ConditionCare** to help you live your best, even with a chronic condition
- **Future Moms** to support moms-to-be
- **Employee assistance program**, behavioral health and worksite wellness
- **24/7 NurseLine** to answer health questions, day or night
- **MyHealth Advantage** to help improve health and save money
- **Healthy Lifestyles**, a personalized online program to plan and achieve health goals
- **MyHealth Coach**, a dedicated coach to keep motivated
- **FitBit** fitness trackers for interactive wellness



We're here to help you

We'll show you how to make the most of your budget, pump up your health benefits and help your employees take charge of their health. Please contact Joyce O'Daniel at joyce.odaniel@anthem.com.

Benefits Accelerator | Accelerate

Private Exchange Evaluation Collaborative (PEEC) to Host Conference in Columbus

PRIVATE EXCHANGE EVALUATION COLLABORATIVE

Employers Health, a co-founder of PEEC, is pleased to invite employers to attend a special employer-only conference, **The Employer Private Exchange Summit in Columbus, Ohio on June 11.**

When	Thursday, June 11 7:30 a.m. – 4: 15 p.m.
Where	Nationwide Hotel and Conference Center 100 Green Meadows Drive South Lewis Center, OH 43035 (Just west of Polaris Mall at the intersection of State Route 23 and Polaris Parkway/E. Powell Road)
Gather	Gather more information, read the full agenda and register at www.thepeec.com

The Summit, which was successfully hosted in three other major cities, will provide employers a unique understanding of critical features, challenges and opportunities with private exchanges. Employers will learn from thought leaders, peers and gain insight from early adopter and health plan experiences with exchanges. A key feature is the opportunity to gather information and share experiences during employer-only, small-group forums. The Summits are free for Employers Health employer members and affordable for employers not part of a coalition.

The Columbus Employer Private Exchange Summit will cover the following topics:

- **Employer perspectives and intentions on benefits and exchanges.**
- **Legal considerations with respect to private exchanges.**
- **Deciding if a private exchange is right for your organization.**
- **Employer lessons learned and considerations with private exchanges.**
- **The current marketplace and future of exchanges.**
- **The insurance industry responses to private exchanges.**

A special feature of the Summit will be an employer-only roundtable session to enable attendees to share information, experiences and questions about exchanges, selection and implementation. Invited vendors and exhibitors will also be in attendance, giving employers the opportunity to gather more information on the types of exchanges being offered inthe marketplace.

Member Spotlight

The University of Idaho

Brandi Terwilliger

Director, Human Resources, University of Idaho

Employers Health recently caught up with one of its valued west-coast members – the University of Idaho. Founded in 1889 in Moscow, Idaho, the University of Idaho is consistently recognized as one of the best public colleges in America by The Princeton Review.

Brandi Terwilliger, director of human resources, has more than 24 years of HR/benefits experience and has served in HR with the university for more than three years. Brandi discussed with us how the University of Idaho approaches health benefits for its employee population, as well as innovative strategies to keep its "Vandals" healthy and productive.

What was your first role in the human resources/benefits field?

I was a human resources generalist for a school district and spent 21 years there working in multiple HR, benefit and accounting capacities.

How have things changed in the benefits profession?

Human resources and benefits is ever-changing. It is a multifaceted profession which requires you to be a specialist in numerous compliance, legal and regulatory areas. It is more important than ever to become a strategic partner within your organization and train key constituents to ensure compliance in these important areas.

In your current role, how do you define success?

I define success in my role as providing value, support and partnerships to others within the organization. The ability to achieve results and become a key resource to others in the organization is a factor of success. By doing these things, success could be measured by positive results for employees and my employer that help the overall mission.

What is your organization's approach to health benefits?

The University of Idaho has a hands-on approach when it comes to the management and administration of our self-funded benefits, as well as other voluntary benefit offerings. We are actively involved in resolving any potential issues or concerns from a vendor or employee.

We have established a Benefits Advisory Group, which is comprised of faculty, staff, retirees and key representatives across campus. The members of this advisory group seek input from colleagues to provide guidance to the benefits team and administration when making plan-design recommendations.

We try to create plan designs that tailor to the demographic of our employees, while remaining cognizant of the financial impact to employees and the institution. We understand the importance of retention and recruitment and the connection to benefit offerings. Our overall approach is to offer benefits that meet the needs of our current and potential employees in the most impactful, cost-effective way possible.

How has your organization been innovative in delivering health care benefits?

The University of Idaho made the decision several years ago to utilize a self-funded approach. For similarly situated employers, this approach is fairly unique in our geographic area. Self-funding has allowed us to tailor our benefits in a way that may not be available to other plans. We were able to offer benefits such as "Other Eligible Adult" years before the federal and/or state laws changed to allow for same-sex benefits.

Photo credit: The University of Idaho Photographic Services

Our Benefits Advisory Group supports the fringe benefits program by reviewing the performance of benefit plans, representing and communicating employee and retiree interests to the administration, and providing advice and recommendations for future plan design and cost sharing between the University and plan participants.

The benefits team works closely with the benefits consultants to strategize on positive benefit offerings, plan design changes and cost-saving strategies to create plans that meet the needs of our employees. Our hands-on approach with vendors, consultants and our third-party administrator allows us to be proactive in situations.

Health care reform is another area in which we've been proactive. We implemented the employer mandated requirements a year early in an effort to review the administrative and reporting processes that would be required by the Affordable Care Act. Although guidance is still being revised, we are able to adapt and find ways to address the requirements in new ways because of our past experience. Three years ago, we elected to carve out our prescription drug benefit from our medical benefit. This approach has enabled us to find new cost-saving measures, form new partnerships, and offer qualified retirees an Employer Group Waiver Plan (EGWP). We have employed a dedicated Benefits Accountant that has been able to assist in collecting appropriate data relating to our health plans, analyze and compare the data, and assist consultants with projections for upcoming years.

What are your thoughts on the future of the human resources/benefits profession?

The landscape of benefits will be changing over the next several years due partially to health care reform. The availability that the public marketplace offers combined with potential rebates could have an impact on employer plans. There is a potential for an increased availability of benefit plan offerings for employees and dependents that could impact costs. The role of the HR/benefits professional should have an advisory arm that educates people to become better health care consumers. It will be important to give individuals the tools to actively manage their costs, look for strategies to save money, as well as look for innovative ways to approach health care and future needs.

Health benefits is a confusing area for many employees. HR/benefit professionals need to focus on communication and education, as well as stay current on the ever-changing laws and compliance issues.

What advice would you give other human resources/benefit professionals?

Take things one day at a time and don't take challenges personally – use them as opportunities! Recognize the strengths of your team members and use those strengths to help with any weaknesses. Remember to show your team and other employees that they are a valued and important part of the overall success of the organization.

How long have you been engaged with Employers Health?

This will be the third year of our membership with Employers Health. When the University of Idaho carved out the prescription drug benefit in 2012, we engaged with Employers Health through its collective strategy program with CVS Health.

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

We view the relationship with Employers Health as a highly collaborative one – a relationship in which we share ideas, strategies and problem solve. Our membership allows us to stay current on market trends and prescription drug concerns, as well as gain a better view of the current and future PBM landscape. We are able to utilize the robust data that Employers Health can access that allows us to look at things from a more global view.

The University of Idaho
HR and Benefits Team

Back Row from Left to Right:
Delaine Flomer, Kim Ridle, Kelli Sirotzki
Judy Colbeck, Abigail Dallas

In Front Left to Right
Brandi Terwilliger, Kendra Rathbone

minute clinic®

Delivering Greater Access to Affordable Health Care

Our Company

MinuteClinic®, a subsidiary of CVS Caremark, is the largest provider of walk-in retail medical clinics in the United States. We provide high quality, affordable health care services in more than 850 select CVS/pharmacy® locations in 29 states and the District of Columbia. With more than 20 million patient visits, we are proud of our 95% customer satisfaction rating.

Our health care delivery model responds to patient needs, which makes access to high-quality medical treatment easier. Being located in CVS/pharmacy provides an additional level of convenience with easy access to pharmacists, prescriptions and over-the-counter medications. Combined, MinuteClinic and CVS/pharmacy are helping lead the advancement of health care for more Americans.

Qualified Practitioners and Services

Our certified family nurse practitioners and physician assistants are trained to diagnose, treat and write prescriptions when clinically appropriate.* We treat common illnesses and injuries, give vaccinations and offer screenings and other wellness services.

Additionally, our practitioners receive support from local physicians who serve as collaborating physicians. Collaborating physicians are on-call during all hours of operation to provide guidance and direction when necessary.

Clinical Quality

MinuteClinic brings innovation and sets new standards for clinical quality that exceed national guidelines established for store-based clinics. We base our treatments on the most current medical research and best practices. Our Electronic Medical Records is the heart of our quality control system, which ensures procedures are followed consistently. It guides our practitioners through the patient visit and alerts them when a condition should be referred elsewhere.

MinuteClinic is open 7 days a week, including evenings and weekends. No appointment is necessary. We accept most insurance plans and cash, checks and credit cards are also welcome.

For more information,
visit minuteclinic.com
or call **1.866.389.ASAP** (2727).

* In select states. Visit minuteclinic.com for details.

D4859MC14

EMPLOYERS HEALTH®
4143 Fulton Drive NW, Canton, OH 44718

2015 Annual Employer Symposia

Innovations in EMPLOYEE BENEFITS

ONLY $99
or FREE to Employers Health Employer Members

June 18 | Cincinnati, Ohio

8 a.m. - 2 p.m.
Cooper Creek Event Center, Blue Ash
4040 Cooper Rd, Blue Ash, Ohio 45241

REGISTER

Visit **employershealthco.com/events** or call **614.336.2883**

Deadlines for reservations/cancellations/refunds
Cincinnati: deadline is June 12, 2015

Payment must be received in advance. Substitutions are always welcome.

employershealthco.com

Northeast Ohio Office
4143 Fulton Drive NW
Canton, OH 44718
330.305.6565

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

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

Wisconsin Office
8383 Greenway Blvd., Suite 600
Middleton, WI 53562
608.826.7335

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.