EMPLOYERS HEALTH

Spring/Summer 2019
A publication of Employers Health Coalition, Inc.

EHCONNECT

IN THIS ISSUE

CVS pharmacy®

HealthHUB® Concept Stores

Health HUB®

At CVS Health, we continue to evolve our model to transform health care and the consumer experience. One of the foundational pieces of this goal is HealthHUB, a new community-based store concept focused on helping customers get well — and stay well — by offering a broader range of health care services, wellness products, and personalized care with the ease of walking into a local CVS Pharmacy®.

HealthHUB locations at CVS Pharmacy stores will be the testing ground for new service offerings and help us identify the solutions that are the most effective and scalable, and roll them out more broadly.

Advanced Pharmacy Services

Pharmacists will provide personalized care and support for patients with chronic conditions.

- Personalized education and counseling to better manage chronic conditions
- Diabetes support and services
- Blood pressure screening and management
- Smoking cessation

New Health Services

We will offer new services to help support better health outcomes and lower medical costs.

- Expanded MinuteClinic® services
- Nutritional services from licensed dietitians
- Community spaces for wellness events and benefits fairs
- On-demand health kiosks to monitor blood pressure, weight, and body mass index

HealthHUB will provide an entirely new consumer experience and help people on the path to better health!

Health services may vary by location. Check your local store for details. MinuteClinic® accepts most insurance plans. Be sure to verify coverage with your insurance company before your visit.

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NORTH CANTON, OH

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OCTOBER 2
SAN FRANCISCO

OCTOBER 3
SEATTLE

MESSAGE FROM CHRIS

Christopher V. Goff
CEO & General Counsel

The year is off to another strong start and we've added new team members and resources to meet the needs of our growing membership. As the industry continuously changes, Employers Health commits to staying aligned with the interests of our employer clients and transacting our business in a way that is both independent of perverse incentives and transparent to our clients and their consultants. It's a true differentiator for Employers Health in a market wrought with conflicts of interest.

Keeping with transparency, we are excited to announce a new pharmacy benefit offering for employers and plan sponsors across the country. After an 18-month search, we recently added EnvisionRx to our collaborative purchasing solutions for pharmacy benefit management. EnvisionRx provides an alternative model, delivering greater transparency, added flexibility and a robust set of clinical management solutions for plan sponsors.

We've also added a new medical benefit solution with UnitedHealthcare. This arrangement leverages the unit cost competitiveness of UHC with a focus on delivering better clinical outcomes and a better experience for patients. Our ultimate goal is to work collaboratively among our employer clients to lower the total cost of care while improving health and the quality of health care services.

To support our growing membership, we welcomed two new employees, with plans to add another in the coming months. Brett Pinson joined our team in January as an account management specialist, working to support the needs of clients throughout the country. Brett has previous account management experience and is currently working to obtain his Master of Business Administration degree from Ashland University. Rory Culberston joined our marketing and communications team as a marketing design and communications specialist. He is responsible for designing all necessary visual elements to communicate the Employers Health mission. Rory has worked in marketing and graphic design for the past 11 years, most recently as a creative and content supervisor.

PolyOne is our featured member spotlight for this issue. While PolyOne has participated in the Employers Health pharmacy program for many years, both of our organizations were also recently designated as Great Place to Work-Certified companies. You can learn more about this process and the benefits in the member spotlight featuring Director of Human Resources, Jeff Hudson at PolyOne. Additionally, we're excited to have Michael C. Bush, Great Place to Work, CEO speak at our 20th Annual Innovations in Benefits Conference on May 15.

I hope you enjoy the refreshed look of our magazine and the great content our team has prepared for this issue. First, our clinical team covers the pains of rheumatoid arthritis for both patients and payers. Next, Garrett Brown and Bryce Horomanski cover the reasons behind the growing gap between list and net prices of drugs. Finally, Glenn Kent, assistant professor of psychology at Jefferson College of Health Sciences, covers the importance of employee financial health.

Thank you for your participation in Employers Health and I hope to see many of you in Canton on May 15!

WELCOME TO OUR NEWEST MEMBERS

American Speech Language Hearing Association (ASHA)

Case Western Reserve University

Cornerstone Healthcare Group Holding Inc

Dolese Bros. Co.

Gilbert Unified School District

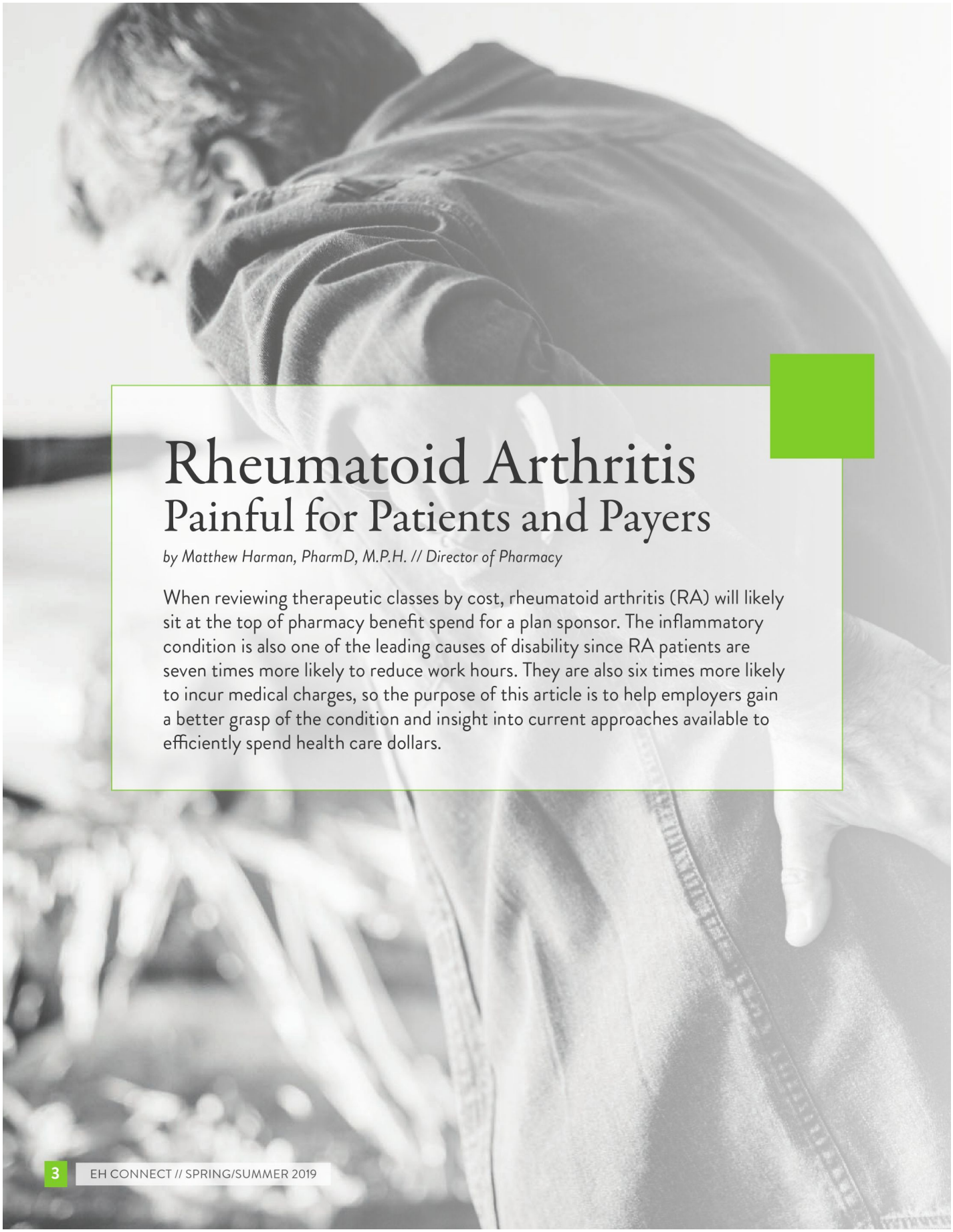
Lubbock Independent School District

Natixis North America, LLC

Pathways Health + Community Support, LLC

TEGNA Inc.

Township of Edison New Jersey



Rheumatoid Arthritis
Painful for Patients and Payers

by Matthew Harman, PharmD, M.P.H. // Director of Pharmacy

When reviewing therapeutic classes by cost, rheumatoid arthritis (RA) will likely sit at the top of pharmacy benefit spend for a plan sponsor. The inflammatory condition is also one of the leading causes of disability since RA patients are seven times more likely to reduce work hours. They are also six times more likely to incur medical charges, so the purpose of this article is to help employers gain a better grasp of the condition and insight into current approaches available to efficiently spend health care dollars.

Rheumatoid Arthritis Background

Impacting 1.3 million Americans, RA is a chronic autoimmune disease characterized by painful swelling mainly seen in the joints of the hands and feet. This swelling and pain occurs when the immune system attacks the tissue lining the joints, known as the synovium, that eventually leads to erosion of the joint. The exact cause of the condition is still unknown, but a variety of genetic and environmental factors have been shown to increase the risk of RA, such as smoking and obesity. It also impacts women two-to-three times more than men and the likelihood of diagnosis increases with age. Interestingly, the only risk factor shown to decrease the risk of developing RA is breastfeeding.

Symptoms of RA generally worsen in frequency and severity due to the progressive nature of the disease and can lead to complications in major organs, such as the heart, lungs and kidneys, and in the worst cases, death. If unproperly treated, RA patients may have an average life expectancy shortened by three-to-seven years, while those with persistent high disease activity (severe RA) may pass away 10-15 years earlier than expected.

The active phase of RA can often be sporadic and debilitating and is often referred to as a flare. Many RA patients experience flares with varying frequency, which is why patients often rotate among the various treatments. A 2013 survey of 1,000 RA patients showed that roughly three-fourths average at least one flare per month with only 4% stating the frequency was less than once a year.

This same survey asked the length of the last experienced flare with 65% reporting the flare lasting at least one week.

Rheumatoid Arthritis Treatment

While there is no cure for RA, the goal of therapy is to reduce joint inflammation and improve the capability to perform daily activities by fostering remission. Many patients will start with non-steroidal anti-inflammatory drugs (NSAIDs), such as ibuprofen, and need to change medications and/or add additional therapies to help reduce swelling and slow the progression of the disease. Disease-modifying antirheumatic drugs (DMARDs) are the first-line treatment for RA with the most commonly prescribed being methotrexate. As patients progress through the latest American College of Rheumatology (ACR) treatment recommendations, multiple non-specialty DMARDs are often beset by specialty biologic DMARDs, such as Humira, if moderate to high disease activity persists. If remission occurs, dosage reductions are suggested to minimize the onset of tolerance to the prescribed regimen. This is in line with the ACR recommended dosing in RA approach to "treat-to-target" based on mutual patient-prescriber consideration of patient priorities and given for at least three months before dose increases or decreases to achieve optimal therapeutic response.

Corticosteroids, such as prednisone, may be used to treat unrelenting disease activity as well as flares, but the ACR states corticosteroids should be used at the lowest possible dose for a short duration to offer a favorable risk/benefit ratio. Prolonged use of corticosteroids is associated with a higher mortality risk due to the variety of potential serious side effects, including (but not limited to): osteoporosis, cardiovascular disease, hyperglycemia and immunosuppression.

Impact to Employers

When compared to the population without RA, Americans with the condition have triple the direct health care costs, double the hospitalization rates and ten times the work disability rates. Of the direct costs, roughly two-thirds come from prescription products with the majority of spend occurring on the pharmacy benefit due to the high cost of self-injectable biologics. Studies have shown that the indirect costs associated with RA are slightly higher than the direct costs due to the reduced ability to perform activities at home and work (presenteeism) as well as missing work altogether (absenteeism). About 25% of employees with RA become work-disabled within the first two-to-three years of diagnosis.

Employees with RA face many challenges depending on their symptoms and job responsibilities that their employer could potentially help alleviate via workplace accommodations. A flexible work schedule can aid patients in dealing with morning joint stiffness issues as well as the ability to make appointments with their specialists. It is also beneficial to encourage employees to seek care from an occupational therapist in order to develop strategies to optimize productivity. Since lack of physical activity and smoking negatively impact RA, offering wellness programs and policies to promote healthier living could help slow disease progression.

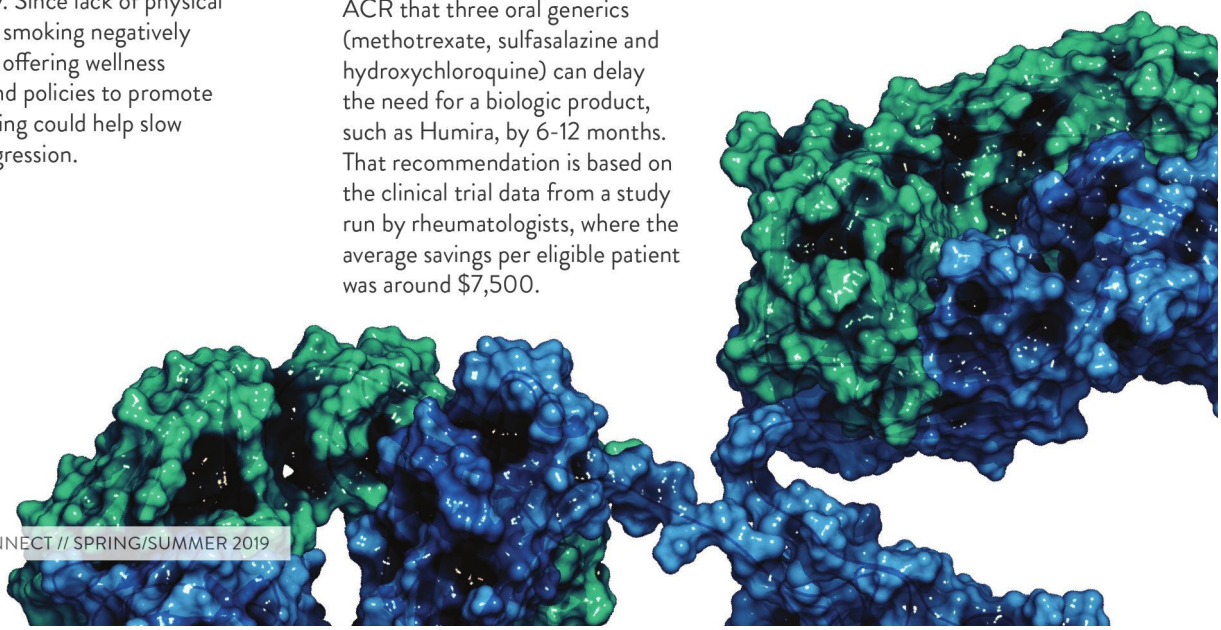
Strategies to Promote Optimal RA Spend

A comprehensive combination of formulary development, benefit design and utilization management are necessary to control RA spend and trend. Due to RA's high ranking in plan cost reports, some of the strategies to manage the class may be familiar from previous discussions with vendors, nonetheless it will be beneficial to highlight the range of options.

- Considering over a dozen biological products are available for the treatment of RA, Pharmacy Benefit Managers (PBMs) should be able to leverage competition in negotiations for rebates with manufacturers to reduce the overall net cost to the payer. This is generally done by placing drugs with higher net costs in non-preferred copay tiers or excluding them altogether from the formulary.

- Once the formulary is set, prior authorizations (PAs) with step therapy should be in place to ensure prescribing to guidelines and promoting lower cost alternatives. For example, one program for RA comes from the recommendation in the guidelines from the ACR that three oral generics (methotrexate, sulfasalazine and hydroxychloroquine) can delay the need for a biologic product, such as Humira, by 6-12 months. That recommendation is based on the clinical trial data from a study run by rheumatologists, where the average savings per eligible patient was around $7,500.

- Another way to control spend for RA biologics can be through the utilization of biosimilars, which tend be considered the "generic" versions of brand name biologics. For an in-depth look at biosimilars and strategies to promote usage, visit our website for the "Biosimilar Basics for Plan Sponsors" article of Winter 2016. Since that article was written, multiple biosimilars are now available for intravenous medication, Remicade (infliximab), to help lower costs under the medical benefit where it is typically billed. Unfortunately, infliximab biosimilars have had a slower uptake due to contracting for medical rebates, which are unlikely to be shared with the payer, and physician reimbursement being tied to the average sales price (ASP). As for the pharmacy benefit, we should see about seven biosimilars launched in 2023 for the top selling drug, Humira, with an outside chance one is launched in 2020. The number two selling drug, Enbrel, is in a patent dispute that should be settled by the courts in 2019. The ruling will determine if the biosimilar, Erelzi™, can be launched in 2019 or 2029, so many payers are anxiously awaiting the court's decision.



- Since both the medical and pharmacy benefit are impacted by RA drugs, site of care (SOC) alignment to promote the most cost-effective dispensing channel is an often-discussed strategy that has seen little adoption. The first priority is to ensure all self-administered drugs are being dispensed under the pharmacy benefit. For infused products, the three SOCs of outpatient hospital, physician's office and patient's home can offer wide varieties in both drug price and cost of administration. A 2013 study by CVS Health of the varying cost of Remicade and its administration can be seen in Figure 1. These results are not uncommon for other infused drugs at the hospital, but the medical policies to steer patients to lower cost sites has been slow. Medical carriers could create a network of Remicade biosimilar providers to utilize when new patients begin RA therapy.
- Value-based contracting is beginning to take hold via PBM and manufacturer negotiations to demonstrate value for existing RA products under the pharmacy benefit. If a drug is unable to control the progression of the disease or causes nonadherence due to side effects, the PBM should be able to receive additional manufacturer dollars in order to meet therapeutic class trend guarantees for the payer. The inclusion of medical claim data would enhance these types of programs significantly, but it has provided many obstacles for administration.
- Finally, specialty pharmacy programs that support patients adhering to these expensive medications are critical in controlling spend on the pharmacy benefit while reducing long-term implications that could impact the medical benefit.

Similar to how the condition of RA progresses, so have the products and strategies to promote more optimal spend. Hopefully employers and their vendors can utilize these opportunities to support the workforce impacted to enhance the quality of life and productivity of employees.

TO DISCUSS FURTHER, PLEASE CONTACT MATT HARMAN AT MHARMAN@EMPLOYERSHEALTHCO.COM.

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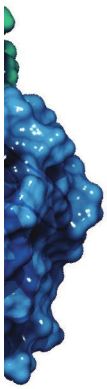


FIGURE 1

DRUG COST BY SITE OF SERVICE AVERAGE COST OF ADMINISTRATION

Remicade, Standard dosing of 70 kg patient

THE GROWING GAP
Between List and Net Prices of Drugs

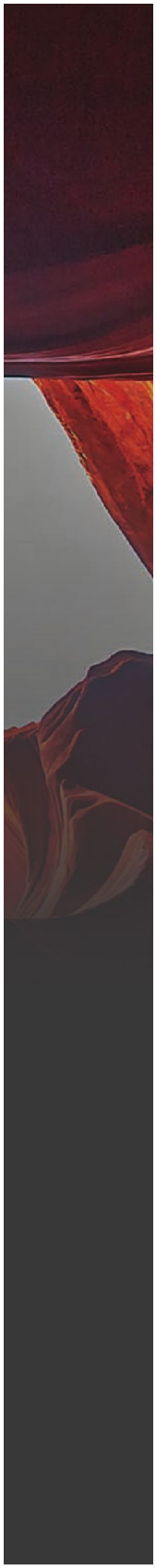
Bryce Horomanski, J.D., Associate Counsel // Garrett Brown, J.D., CEBS, Assistant General Counsel

The gap between list and net prices of drugs has been growing at a rate that many pundits have long speculated is unsustainable. Specifically, the steady increase in unit costs of branded medications and the presence of ever-increasing available rebates has created a significant gap between the list price and the "true" cost of the drug. While such increases in unit cost are theoretically countered by rebates, the beneficiary of such rebates is not always clear. This article will seek to further explain this dynamic, explain regulatory initiatives and provide plan sponsor considerations.

How We Reached This Point

Consumer Concerns

While many PBMs report flat or negative trend, the American public's yearly spending on prescription drugs continues to increase. This type of increased prescription pricing was most clearly seen in Mylan's EpiPen pricing increases. In 2009, pharmacies paid $103.50 for each two-pack of EpiPen Autoinjectors. By 2016, the price had risen to $608.61 for the same two-pack, a 505.11% increase. Many readers are familiar with this example, but while this drug is a commonly used example surrounding drug price inflation, it is also important to remember that this drug likely had a significant rebate, as a percentage of the list price, attached to it. Following wide reporting by the media and outrage over the price, Mylan launched an authorized generic of EpiPen with a list price of around $300. Hence, it can be assumed that the average rebate on the original EpiPen was more than 40% of the list price. As the consumer almost certainly did not directly benefit from any rebate associated with this drug, the ever-increasing list price was felt immediately. Thus, this highlights the reason rebates are top of mind for many regulators.



The List-to-Net Gap

As identified above, the list-to-net gap is the difference between manufacturers' list prices and the net prices paid to the manufacturers after rebates and discounts are considered. The difference between list price and net price has continued to widen over the past decade. There are a variety of contributors to this trend, including PBM market consolidation and increased adoption of exclusionary formularies, all stakeholders in the supply chain benefit when list price increases, advent of price protection rebates and, candidly, the growing appetite for rebates by entities that benefit therefrom, including purchasers.

However, there are three synergistic dynamics that suggest that this bubble could be nearing its expiration date. First, the public outcry and resulting political attention on the high list prices of drugs, made possible by rebates, has somewhat tempered list price increases. Second, the lack of price increases and the associated price protection rebates, many PBMs are over guaranteed and likely have much more of an appetite to explore alternative models or revenue streams. Third, while PBMs still retain a portion of manufacturer revenue, an ever-increasing number of contracts with their clients require a full or nearly full pass-through of these funds, particularly for carved-out plan sponsors. Thus, while thelist-to-net gap impacts all plan sponsors, its impact can vary greatly depending on a plan sponsor's contracted discounts and rebates. Ineffective contract definitions and reconciliation methodologies allow a plan's cost to rise compared to its prudently contracting peers.

Regulatory Efforts

Trump Administration's Blueprint

In the administration's blueprint, it put forth four concepts to achieve a reduction in prescription drug pricing for Medicare Part D.

The first concept sought to increase competition by preventing brand drug manufacturers and generic drug manufacturers from using the regulatory processes to extend their products' exclusivity in the market. **The administration's second concept** was to improve negotiation with pharma by changing Part D plan formulary standards and allow Part D plans to make mid-year substitutions from brand drugs to new-to-market generic drugs. **The final two concepts** most relevant to this article and introduced in the administration's blueprint was creating incentives to lower list prices and the reduction of patient out-of-pocket spending. While a specific methodology was not mandated, the administration presented general concepts that would result in lower prescription drug prices including the idea of applying a substantial portion of rebates at the point of sale.

While this blueprint did not provide a suggested regulatory scheme, its impact is certainly visible in the Health and Human Services ("HHS"), proposed rule.

Proposed Rule and Legislation

Health and Human Services ("HHS") introduced its proposed rule titled Fraud and Abuse; Removal of Safe Harbor Protection for Rebates Involving Prescription Pharmaceuticals and Creation of New Safe Harbor Protection for Certain Point-of-Sale Reductions in Price on Prescription Pharmaceuticals and Certain Pharmacy Benefit Manager Service Fees (the "Proposed Rule") in February 2019. The proposed rule seeks to modify the anti-kickback protection discount safe harbor by removing the ability to provide certain reductions in price or other remunerations (rebates) from a manufacturer to a Part D plan sponsor, a PBM in contract with a Part D plan sponsor, or Medicaid. The anti-kickback statute makes it a crime to exchange anything of value in an effort to induce the referral of health care program business unless such effort is covered by a safe harbor. By removing this safe harbor, drug manufacturers would no longer be able to provide rebate payments to plan sponsors or PBMs in exchange for the manufacturers' drugs being purchased by the associated prescription drug plan.

To compensate for the loss of rebates to PBMs and plan sponsors, the proposed rule looks to create two new safe harbors.

1 A safe harbor to allow for point-of-sale reductions in price on prescription pharmaceutical products (point-of-sale rebates). The idea behind this safe harbor would be to provide the consumer with the direct benefits of the negotiated rebate, thus reducing the out-of-pocket cost of the drug.

2 The second proposed safe harbor would allow the payment of service fees by a manufacturer to PBMs that provide certain legitimate services to the manufacturer. This safe harbor would allow the PBMs to continue to be compensated for certain administrative services, such as reporting, performed by the PBM. By requiring legitimate services to be provided, the proposed rule seeks to preclude PBMs from retaining any additional portion of the available manufacturer rebate, thus reducing the overall cost of drugs.

Plan Sponsor Questions

+ What is the cost to finance rebates at the point-of-sale?
+ If necessary, how and when will the rebates be reconciled?
+ How are rebates used today?
+ Must premium contributions be adjusted?
+ How will this impact current plan design?

To be clear, HHS's proposed rule, if made effective, would only regulate Medicare Part D plans, Medicaid Managed Care Organizations' and PBMs' contracts with Part D plan sponsors and not commercial drug plans. However, there is a growing sentiment in the Senate that substantially the same, if not exactly the same, regulations should be applied to the commercial market. In March 2019, Senator Mike Braun introduced legislation into the Senate to do just that.

Plan Sponsor Impact and Considerations

Regardless of if a change is market-driven or a regulatory requirement, plan sponsors must educate themselves about the considerations and financial impact of such an approach. Likely, the biggest question is how the financial operation of the plan will be impacted in the absence of the plan sponsor's receipt of rebates. Most plan sponsors use these rebates to offset the overall cost of their prescription programs and then derive premium contributions for participants based on the net program cost. Alternatively, some plan sponsors use these dollars to fund alternative benefits-related initiatives or programs. Prudent plan sponsors should begin evaluating the possible impact on plan costs and premium contributions should some or all of the rebate be applied at the point-of-sale.

It is also important to remember that, just as plan sponsors will seek to keep their financials constant, all parties in the supply chain will be attempting to do the same. As such, baring a significant change in the pricing model, any change will likely be a repackaging of the existing supply chain and associated processes. For example, the PBM does not receive a rebate at the point-of-sale from the manufacturer today. Rebates are paid retrospectively (60 and 270 days after the quarter in which the claim was processed) by manufacturers to PBMs after utilization data have been aggregated, validated and evaluated against contractual terms, such as market share targets, formulary positioning or price protection guarantees. This results in the PBM identifying an estimated collection and engaging in actual collections at a later point in time. The proposed rule does not impact this mechanism and it will likely continue to exist. This dynamic begs the question; what will be passed through at the point-of-sale? Will it be specific to that drug or a per channel guarantee? Assuming it must be some type of estimate, what is the time value of money to make these funds available prior to collections and how will this be reconciled?

These questions and many others are important to make the best decision for your plan. Also, understanding existing market dynamics and how a plan sponsor's PBM contract currently addresses rebates is helpful. As mentioned above, effective contract definitions, strong reconciliation methodology and effective market checks are all current steps that provide a counterbalance to rising list prices and will continue to benefit plan sponsors. While components may be repackaged, the combination of price and utilization driving total pharmacy costs still holds true.

to Consider

+ Must deductible and max-out-of-pocket levels be adjusted?
+ What is actually being applied at the point-of-sale?
+ Will rebates be applied before or after participant cost share?
+ Will this actually result in lower drug prices over time and more affordable options for plan sponsors and their participants?

Financial Health
Shutdowns, Snowballs and Sages

by Glenn Kent, Ph.D. // Assistant Professor of Psychology // Jefferson College of Health Sciences

What do shutdowns, snowballs and sages all have in common? Sounds like the beginning of a bad joke. The answer may surprise you as all three have to do with different aspects of financial health. In our country where indebtedness is the norm, the national debt in the United States just passed the $22 trillion mark[1], savings are low (a recent Board of Governors of the Federal Reserve System report[2] found 40% of people would need to borrow or sell something to cover a $400 emergency) and herd mentality in the financial world runs rampant (The Great Recession of 2008—need I say more), the need for improving our financial health is imperative. The foundation necessary to improve your financial situation is concentrated in understanding three main aspects of personal finance: creating an emergency fund, paying off debt and understanding human thought and behavior.

If more people committed to improving their financial wellness in these three areas, the recent government shutdown may have been less stressful for those federal employees impacted, for living debt free with money in the bank allows people to weather the financial storms in life and make their money work for them. Which is where the financial sages come in. Warren Buffett and others tend to have a similar message when it comes to success with money and this message can be the steady hand when life throws the inevitable curve ball. What follows is a discussion of three pillars of financial health: emergency funds, getting out of debt and understanding human psychology, that will help to lead individuals on a path to fiscal success. Like a bad joke, financial insecurity is no laughing matter, yet there are steps you can take.

Beginning in December 2018, the budget impasse between the 115th United States Congress and the president led to the longest federal government shutdown, 35 days, in the history of our country. The previous longest shutdown was 21 days. Although technically a partial shutdown, over 800,000 workers were affected, including FBI agents, FDA food inspectors and National Park Service staff to name a few. Some federal employees worked without pay, while others were furloughed, a temporary period of time during which employees are asked not to work and are not paid during this time. As this shutdown progressed, news stories began to circulate about how many of these government employees, now without an income, would not be able to meet their living expenses. The uncertainty about the length of the shutdown caused considerable concern, especially among employees living paycheck to paycheck. Politics aside, this government shutdown, indeed all shutdowns, highlight the need for emergency funds not just for government workers—but for everyone.

An emergency fund is an amount of money set aside, the primary goal of which is to be used for emergencies and other unexpected expenses. The *ideal* amount of money within this fund is three to six months of expenses. Thus, if your home has monthly outlays of $3,000, then your emergency fund should fall within $9,000—$18,000. Try not to obsess over this rule of thumb. The key is to have some funds set aside for unexpected, crucial situations. Of course, what qualifies as a *true* emergency will vary from situation to situation; however, it is probably safe to say that purchasing tickets to a concert by your favorite band would not qualify as an emergency, while repairing your car, which is your only means of transportation to work would qualify. The challenge for many is not only finding extra money to build their emergency fund, but also having the mental fortitude not to spend it frivolously. Luckily, there are solutions for both.

The money needed to sustain an emergency fund can usually be located by creating and sticking to a budget. In many circles, the word 'budget' has negative connotations—saying no, doing without, a life of restrictions, etc. In a more positive sense, a budget is like giving yourself a pay raise, because now you have an awareness of where you spend money, coupled with the intention of hitting a financial goal on an ongoing basis. The strength of budgets are their ability to provide monetary guiderails, so you do not drive off the proverbial financial cliff. Seen in this light, a change in mindset about budgets can be achieved. By consistently following a strict budget, less money is wasted, allowing your emergency fund to grow. If budgets are not your style, another strategy to building your emergency fund is to begin a part-time job with the sole purpose to finance your emergency reserves. Once funded, you can quit the job.

Now that you have an emergency fund, how do you avoid spending it on non-emergency expenses? Knowing yourself is the best strategy for success. In other words, identify a location and create a plan that protects you from *your* spending habits. Obviously, you want access to this money (it is needed in emergencies), but it should not be easy to spend. One strategy to resist temptation is to place this money in an account separate from your everyday accounts. In other words, these funds could be located at a bank different from your commonly used checking/savings accounts, which keeps it out of awareness and limits its use.

TEACH THE TEAM

Do all you can to teach, encourage and educate your employees about the value of budgets and the allocation of personal funds. For example, promote free budgeting apps (e.g., *EveryDollar* and *Mint*) and websites (e.g., *Personal Capital* and *Buxfer*). Finally, consider hiring a financial coach on an ad-hoc basis to specifically address the topic of budgeting and saving for emergencies.

The personal debt situation in America is bleak—just observe the numbers:

AVERAGE AMERICAN DEBT

STUDENT LOANS DEBT	$32,700[3]
CREDIT CARD BALANCE	$6,354[4]
MONTHLY CAR PAYMENT	$455[5]
HOUSEHOLD DEBT	$137,063[6]

The problems with debt are multifaceted. First, debt reduces the amount of money you are free to spend, which limits choices. Second, by definition, debt moves future consumption into the present[7]. In other words, borrowing money today requires you to pay it back into the future, which means less money available down the road. This can be problematic for the United States—the largest consumption-based economy in the world[8]. Third, the presence of debt makes it difficult to retire. For these and many other reasons, we should aim to be unlike most Americans when it comes to possessing personal debt.

So how does one get out of debt? The answer to this question has to do with the debt snowball—an approach to getting out of debt by first listing all debts from lowest to highest. Concentrate on paying off the smallest debt while making minimum payments on all other debts. Once this smallest debt is eliminated, roll that payment to the next highest debt. While not a mathematical approach to eliminating indebtedness (the order of payback is based on size of the loan, not its interest rate), the snowball approach is a psychological one. Eliminating the smallest debt allows for a quick, initial win, which is psychologically satisfying and helps build momentum and your likelihood of success. Put another way, the debt snowball is a solution for lack of progress and motivation.

The third pillar of personal finance success has its roots in the field of psychology. Simply put, psychology is the study of the human mind and behavior. Sages of the financial world understand and use human psychology to their advantage. Benjamin Graham (Warren Buffett's mentor) once said, "The investor's chief problem—and his worst enemy—is likely to be himself. In the end, how your investments behave is much less important than how you behave."[10]. Thus, triumph with your finances is predicated on keeping your emotions in check. It is about having the correct temperament, character and guts. It is about behavioral discipline.

Dave Ramsey[11], a financial radio show host who specializes in helping people get out of debt and build wealth, states that personal finance is 80% behavior and 20% knowledge. The list of fiscal sages who share similar beliefs about the power of behavior is noteworthy: Warren Buffett, Jack Bogle, Charlie Munger and Shelby M.C. Davis to name a few. Well-known authors, Carl Richards and Morgan Housel, also espouse the importance of actions and temperament as important ingredients to success with money. Morgan Housel, currently a partner at The Collaborative Fund and a former columnist at *The Motley Fool* and *The Wall Street Journal*, even created a hierarchy of investor needs—similar to Maslow's pyramid of the hierarchy of human needs found in any introduction to psychology textbook. According to Housel, investor behavior forms the base of investor needs and thus is the first 'need' to be mastered before anything else matters. He goes on to state, there is a, "preference for skills in a field [finance] where skills don't matter if they aren't matched with the right behavior."[12]. With so many sages of the financial world repeating a consistent refrain, it is a wise bet they are on to something. Heed their advice about improving your chances of success with money by spending a lot more time understanding your emotional brain rather than your financial brain.

THE BUDGET MINDSET

Continue to cultivate the budgeting mindset. Budgets rein in spending and raise awareness about consumption habits. Evidence[9] continues to suggest that people who live on a budget spend less and save more – this behavior pattern is associated with reduced debt over time. In addition, consider covering or supplementing the cost of turnkey financial classes focused on getting out of debt and building wealth (e.g., Dave Ramsey's Financial Peace University). Further, make it policy that every new staff member must, as part of the onboarding process, attend a budgeting/debt reduction class. Finally, restructure benefits to include paying off some or all an employee's student loans over time.

There you have it, the path to financial health is at least partially paved with shutdowns, snowballs and sages. Shutdowns serve as reminders of the importance of emergency funds, while the debt snowball represents an approach to achieve a debt-free status. Finally, sages of the investing world, past and present, continue to emphasize financial success as the process of understanding the psychology of the person each of us see in the mirror. While by no means complete, progress within these three domains will improve not only your success with money, but your relationship to it. Individuals are not alone, as employers can offer assistance to employees in the form of classes, benefits and nudges to improve the odds of success. The time is now to chart a new course with our finances—all joking aside.

REMINDER TO REMEMBER

Offer seminars on behavioral economics, the study about the way people make economic decisions as well as the rationality or irrationality driving these decisions[13]. Consider using the concept of nudges to help employees with their retirement savings. Employers are increasingly auto enrolling all employees into the employer's retirement plan. Employees who do not wish to have retirement contributions deducted from their paycheck must consciously opt out of the plan. As you can see, being enrolled in and making retirement contributions is the easier option (it happens automatically), yet employees can opt out if they wish (this takes conscious effort, is not automatic, yet preserves choice). Taking this concept a step further, employers may consider automatically increasing employee contributions each year by a predetermined percent, with the option to opt out requiring a deliberative effort on the part of the employee. Finally, do all you can to make saving or paying automatic for your employees. Automatic savings and/or payment plans allow employees to set it and forget it, thereby reducing errors, forgetfulness or missed payments due to unexpected financial emergencies.

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Noteworthy News

Numerous Employers Health employees have volunteered their time as part of the Stark Community Foundation's Summertime Kids Volunteer Review Committee through which they review and evaluate numerous grant requests to fund imaginative and unique summer programs with an emphasis on character and education.

Employers Health CEO, Chris Goff, was recently elected president of the Academy of Managed Care Pharmacy's Foundation Board of Trustees. He has also recently joined the United Way of Greater Stark County's Board of Directors and the Board of Trustees for the Ohio Foundation of Independent Colleges.

Traci Barry, senior director of business development, is currently serving her third year as president and treasurer of the Christianville Foundation in Haiti. Christianville was established to reach the poorest of people in Haiti with spiritual and humanitarian aid.

Sean Godar, director of solutions development, is serving on the editorial board of the Duke University Fuqua School of Business Duke Business Journal.

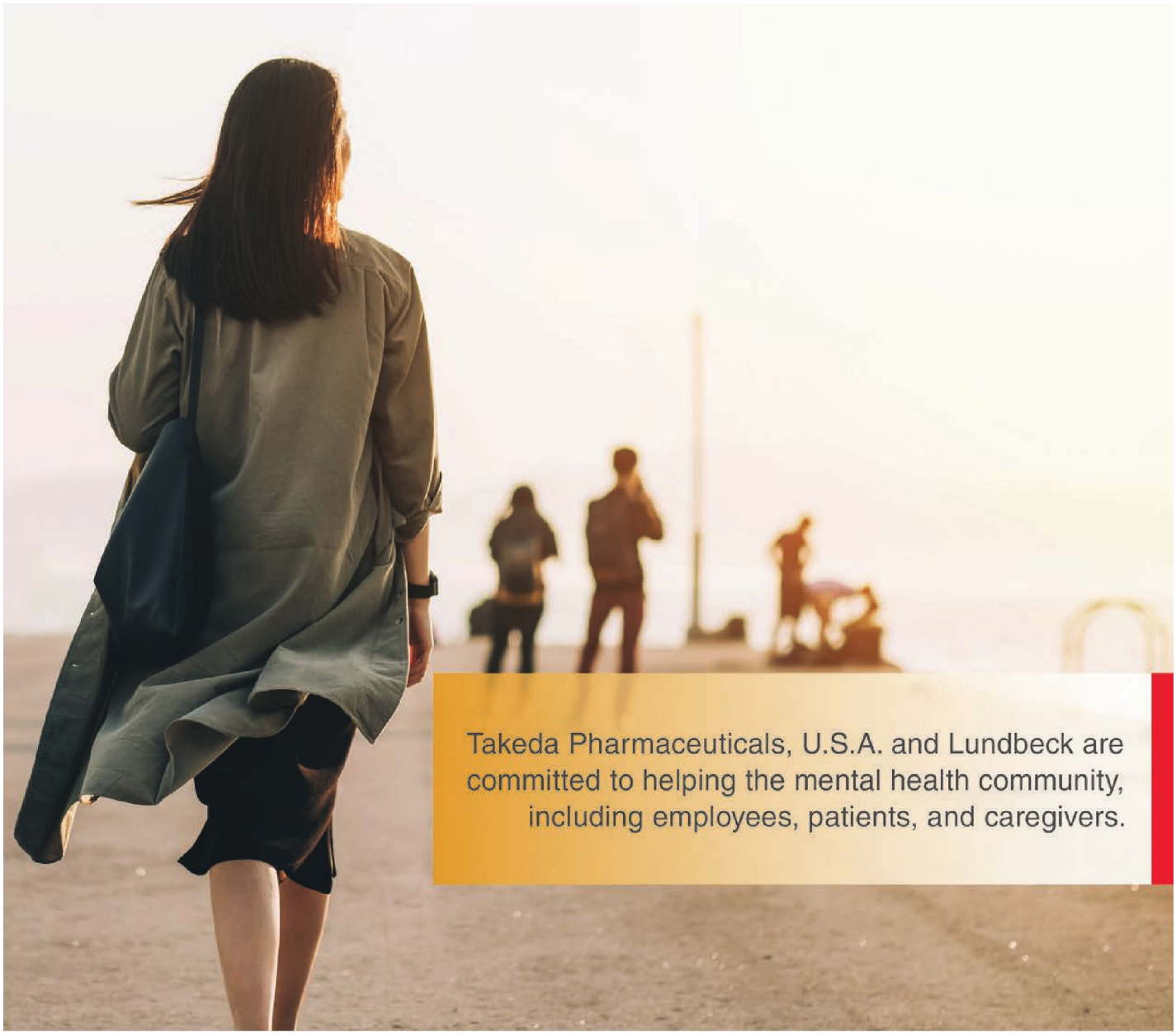
Employers Health account managers Josh Pedrozo, Travis Johns and Joe Stoffer, along with Assistant General Counsel, Garrett Brown, recently received the Certified Employee Benefit Specialist (CEBS) designation through the International Foundation of Employee Benefit Plans.

Pharmacy Resident Kevin Wenceslao presented his poster abstract, Evaluating the Effect of Exclusionary Formularies on Self-Insured Employers in a Group Purchasing Organization, at the Academy of Managed Care Pharmacy's Managed Care and Specialty Pharmacy Annual Meeting in March.

Mike Stull, Employers Health's chief marketing officer, was selected for the 12th Class of ystark! Twenty Under 40! Nominees were selected based on career acumen, community service and trusteeship and personal and professional achievements.

Account Management Specialist, Taylor Nervo, is serving on the United Way of Greater Stark County's Health Impact Council. United Way Impact Councils utilize data and facts about the Stark County community to allocate funds to programs and services working to solve the community's problems.

Lisa Oesch, accounting manager, recently graduated from the Leadership Stark County Spotlight program. Lisa is one of many Employers Health team members to complete the program to help immerse and grow young professionals in both their career and their community.



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MEMBER SPOTLIGHT

PolyOne is a global provider of specialized polymer materials, services and solutions. The organization's more than 6,000 associates serve more than 10,000 customers across a diverse range of industries including health care, transportation, packaging and more. They were recently recognized as a Great Place to Work, a result of the value they place on their people and their contributions through recognition programs, competitive pay, community involvement and opportunities to grow professionally and personally. We spoke with their Director of Human Resources, Jeff Hudson to learn more about what makes PolyOne a Great Place to Work.

Jeff Hudson // Director, Human Resources // PolyOne

Why / how did you choose to get involved in employee benefits?

PolyOne's director of compensation and benefits left the organization in 2017 and I was asked to assume her responsibilities until a replacement was identified. My time as the interim director for compensation and benefits went well and it eventually became a permanent part of my responsibilities. I am not a subject matter expert in employee benefits, but I have learned a great deal from our amazing benefits team at PolyOne, led by Maureen Borland, and through our partners like Employers Health.

How long have you been the director of human resources and how long have you been at PolyOne?

I have been with PolyOne for 15 years. I was the HR director for our Specialty Engineered Materials business from 2013-2017. I've been serving as our HR director for compensation, benefits, training and organizational development since 2017.

What has surprised you about working in benefits?

I was surprised to learn of the significant variation in costs of procedures from different providers. It truly pays to be educated on the options!

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

We have focused on educating our associates and providing tools to help them improve their health and reduce their costs. We have strong engagement in our Virgin Pulse wellness program and mobile app. We incentivize our associates to use Castlight to drive consumerism and reduce their and the company's cost.

How long have you been engaged with Employers Health?

PolyOne joined Employers Health in 2011 and we've been purchasing pharmacy benefits through the CVS program ever since. We also participate in their group purchasing solution for dental benefits through Delta Dental.

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

Besides the obvious financial benefits associated with purchasing benefits through a consortium, we gain great value from the insights and education opportunities that Employers Health provides. We are always seeking to learn and adopt best practices and Employers Health is an excellent resource in that pursuit.

Great Place To Work.®

Your organization was recently certified as a Great Place to Work (GPTW). Why did your organization seek this certification?

As we continue our never-ending quest to innovate and serve our customers with excellence, we've also made an important and ambitious cultural commitment to our associates: To become a top workplace. We see a clear connection between developing a culture of trust and our bottom line. By advancing the engagement of employees and their connection to each other and PolyOne, we drive business growth. We use the feedback from our employees that we receive through the Great Place to Work survey to create a consistent and positive work environment.

Can you tell us a little about the process and what it means for your company?

The process has two primary components:

1. Having our associates participate in the Great Place to Work survey and achieving overall scores greater than 70%.

2. Completing the Great Place to Work Culture Brief, a comprehensive questionnaire where we have the opportunity to describe the programs and practices that make our organization a great workplace.

We are extremely proud of the official GPTW certification and external affirmation of the work that we are doing to build a culture of trust. Yet the true value and ability to build a top workplace is internal, rooted among our great team of associates.

Did you have support from the leadership team in seeking this certification? How?

Our CEO and his leadership team are personally committed to making PolyOne a great workplace. Since 2017, we have brought together our top 125 leaders from around the globe twice a year for the explicit purpose of building a culture of trust at PolyOne. The leaders participate in skill building sessions where they learn and share best practices that they can then take back to their teams to improve the employee experience.

In addition, PolyOne holds several programs annually to develop our top talent and next generation of leaders. Our CEO and executive team get personally involved in the facilitation of these programs that focus on inspirational leadership, building trust and improving the employee experience. These programs have produced over 300 alumni, who serve as ambassadors for our journey to become a great place to work.

Employers Health is also certified as a Great Place to Work, so we understand the complexity of the certification process. With over 6,000 employees how did you manage such a large undertaking?

In 2018, we added a resource to our team, Mandy Matousek, to manage our talent and engagement processes. Mandy coordinates our participation in the GPTW survey and leads the completion of our Culture Brief. She also guides managers through understanding, sharing and taking action on their results. Mandy has been instrumental in helping us navigate the certification process and Great Place to Work's new survey platform, Emprising.

What advice would you give to other entities interested in becoming a great place to work?

Remember that becoming a great place to work is a journey, not a destination. Building and maintaining a culture of trust occurs each and every day in big and small ways. Sustained commitment to this journey from the senior leadership team is critical.

Benchmarking and learning from other companies is valuable. The Great Place to Work Summit is an excellent resource for this. PolyOne was excited to have representatives from across our functions and businesses attending this year's summit.

Jeff Hudson
Director, Human Resources

Kim Wymer
Senior Benefits Administrator

Maureen Borland
Human Resources Director, Benefits and Mergers and Acquisition

Melissa Kulbago
Senior Benefit Analyst, Health and Welfare Programs

Prescriptions — simplified

Providing patient-specific pharmacy information at the point of prescribing.

It happens all the time: After standing in line for a bit, you get to the pharmacy counter only to be told the prescription hasn't been approved yet. Or that it costs more than you expected. Or that your doctor needs to provide more information first.

OptumRx® **PreCheck MyScript™** helps avoid those surprises by giving physicians patient-specific pharmacy-benefit information up front. The tool integrates with any electronic medical record (EMR) system, making it easy for physicians to see, in real time:

- A medication's formulary placement
- The patient's cost share
- Prior authorization requirements and, often, on-the-spot approvals
- Clinical alerts such as duplication or potential interactions

It all adds up to more empowered physicians, smoother plan performance, and less pharmacy hassle for you.

PreCheck MyScript – making the health system work better for everyone

Saving time

19% **decrease** in physician costs[1]

32% **decrease** in pharmacist costs[1]

Saving money

Consumers **save** **$80** per script[1]

Clients **save** **$415** per switch[1]

Physicians **save** **$24** per PA[1]

Pharmacies **save** **$1.78** per script[1]

Better outcomes

20% of scripts with **alts** switched[2]

80% tier 3 shifts to **lower** tier drugs[1]

4% **higher** adherence[1]

>30% of PAs **initiated or avoided**[2]

1. Third party analysis of OptumRx claims data. November, 2018.
2. OptumRx internal data, within DrFirst EMR. November 2018.

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