EMPLOYERS HEALTH®

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# EHCONNECT

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NATIONAL DIRECTOR
OF HUMAN RESOURCES

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# 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.



OPTUMRx®

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# Events

Visit **employershealthco.com/events** to stay informed and learn more.

## 2019

**NOVEMBER 20** Annual Meeting @ CANTON, OH

## '20

**MARCH 18** PBM Conference @ COLUMBUS, OH

**MAY 13** Innovations in Benefits @ CANTON, OH

**JUNE** PBM Advisor Summit @ CLEVELAND, OH

**SEPTEMBER** Health & Wealth @ CLEVELAND, OH

## PHARMACY BENEFIT MANAGEMENT EMPLOYER ROUNDTABLES

### JANUARY

16 NASHVILLE

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4 SAN FRANCISCO
5 SEATTLE
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18 DALLAS
20 HOUSTON

### MARCH

5 DURHAM
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11 NEW YORK CITY
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### APRIL

7 INDIANAPOLIS
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23 CHICAGO

# MESSAGE FROM CHRIS

Christopher V. Goff
CEO & General Counsel

## WELCOME TO OUR NEWEST MEMBERS

Albany Molecular Research Inc.

Apergy

Automobile Club of Southern California

Board of County Commissioners of Washington County

Brill Inc.

Catholic Diocese of Pittsburgh

City of Columbus, OH

City of Hannibal, MO

Comfort Systems USA Inc.

Fond du Lac Band of Lake Superior Chippewa

Hillrom Inc.

Intertek Inc.

Manitowoc Company Inc.

MedRisk Inc.

Mitsubishi LogisNext Americas (MLNA)

Northern Arizona Public Employees Benefit Trust (NAPEBT)

Rackspace Us Inc.

Stein Mart Inc.

TridentUSA Health Services

Every dollar that Employers Health clients waste on health care expenses is a dollar that isn't invested in payroll, capital improvements or passed along to shareholders. For our government clients, each dollar could be put to better use in schools, parks or infrastructure programs. For employees and their families, it's a dollar not available for vacations, retirement, education or even day-to-day expenses. As benefits professionals and fiduciaries of plan dollars, it's our responsibility to ensure we are spending those dollars in a prudent manner. It's also a worthwhile pursuit that brings purpose to our work.

The team at Employers Health is passionate about helping clients maximize the value of each health care dollar. Our learning and networking programs facilitate best practice sharing among benefits professionals. Collective purchasing initiatives allow clients to work together to leverage the marketplace, resulting in lower costs, better outcomes and a better experience for the plan administrator and plan participants. Our team's expertise in pharmacy benefit management, legal and contracting, analytics and clinical management provide comprehensive and unbiased advice to our clients and their consultants.

Our commitment to providing clients with relevant solutions that maximize value has resulted in another solid year of growth. At the time of my writing, our team has secured more than $120 million in new pharmacy business. These new clients come from all industries, all geographies and are of various sizes. Perhaps more impressive, they utilize a variety of different consulting firms to evaluate our solutions. Independent, unbiased evaluation is foundational to prudent plan management, and we couldn't be prouder that so many consultants see the value that we consistently provide and recommend us to their clients. Thank you, as well, to our existing clients who willingly serve as references during these evaluation processes.

Our team continues to expand as we welcomed Christian Thomas and Jack Sullivan as actuarial and data analytics specialists. Both Christian and Jack graduated with actuarial science degrees from The Ohio State University and work in our Dublin, OH office. Kevin Wenceslao, PharmD completed his pharmacy residency with us in July and began his permanent position on our team as a clinical advisor. Kelsey Dieters, PharmD is our new pharmacy resident. She recently graduated from the University of Kentucky College of Pharmacy.

With Veterans' Day on November 11, we thought it only fitting to feature Disabled American Veterans as this edition's client spotlight. DAV has participated in our pharmacy program since 2014 and helps more than 1 million veterans every year connect with the health care, disability, employment, education and financial benefits they have earned. We are proud to have them as a client and to showcase their good work!

Enjoy this edition's great content, prepared for you by our team at Employers Health. First, our clinical team provides insight on the conflicting evidence surrounding the use of medical marijuana and what it means for employers. Next, our Director of Solutions Development and Co-Director of Right Direction, Sean Godar, shares why burnout may be the next major health crisis for your workforce and what you can do about it. And, finally, Dave Uldricks covers why PBM evaluations are often so complex.

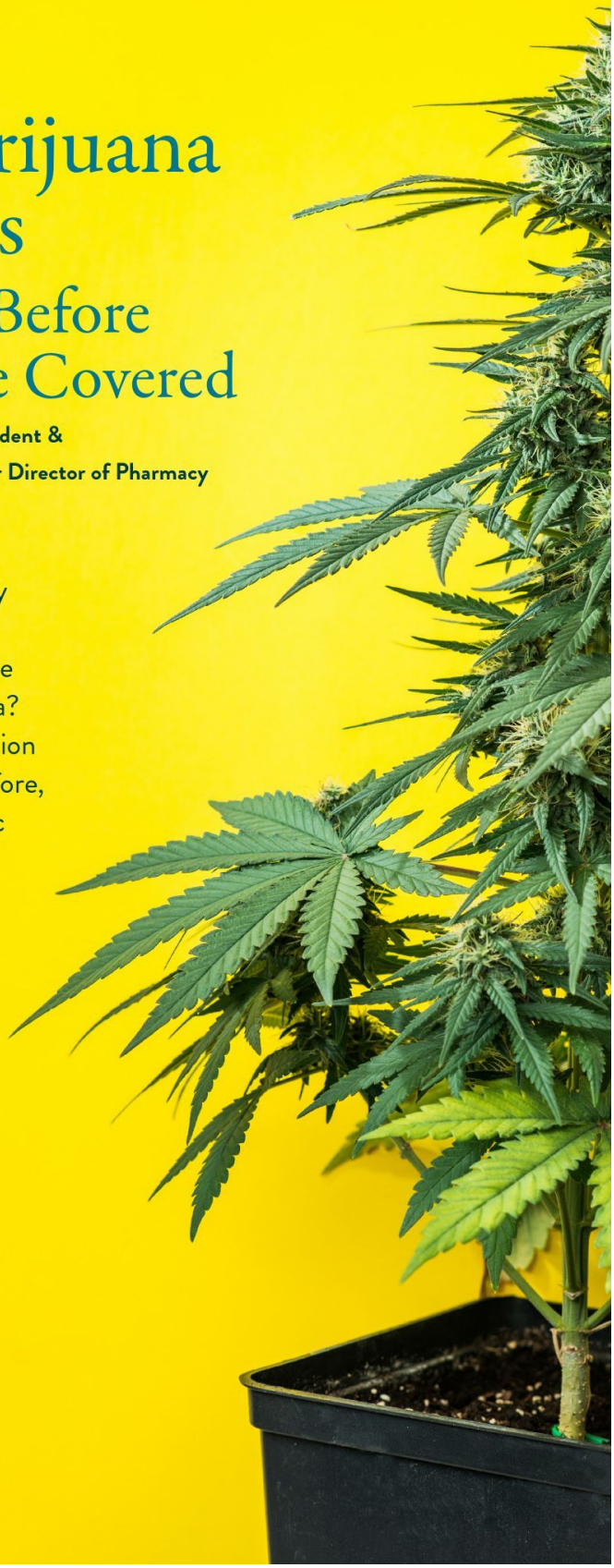
My thanks to each of you who help us continue our vision of maximizing the value of health care – creating better outcomes, delivering better experiences and putting dollars back in our clients' and their employees' budgets.

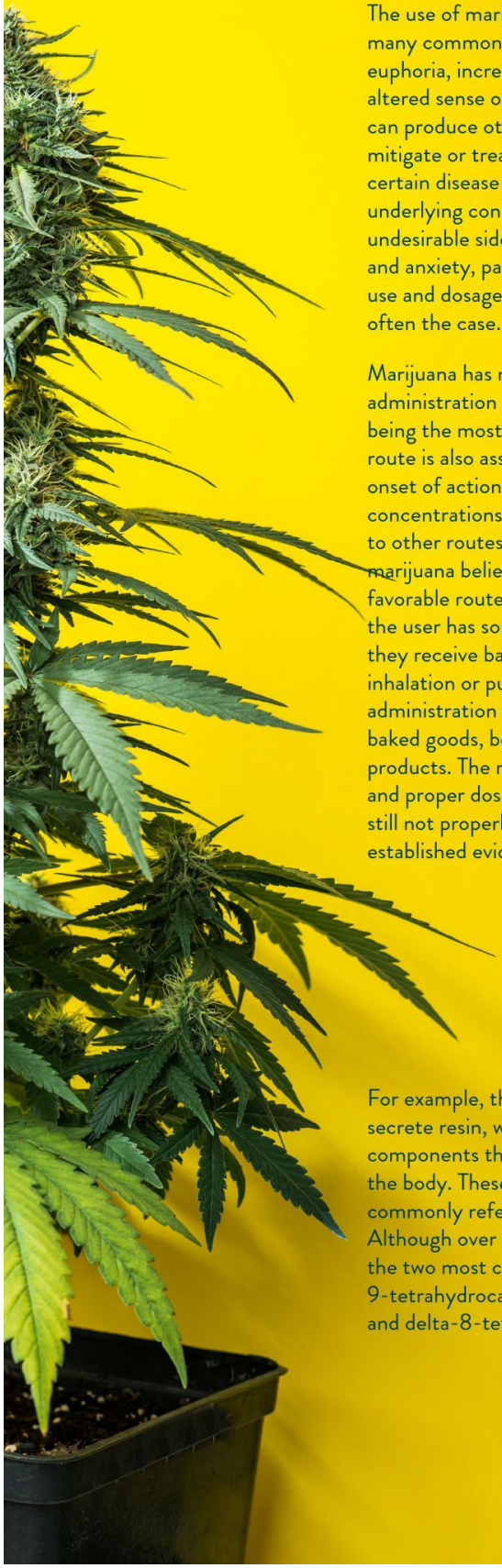
# Medical Marijuana & Employers

## A Clinical Dive Before Cannabis Can be Covered

**by Kelsey Dieters, PharmD // Pharmacy Resident &**
**Matthew Harman, PharmD, M.P.H. // Senior Director of Pharmacy**

As medical marijuana continues to gain approval at the state level, many questions arise regarding its safety and efficacy. Does scientific evidence support the use of medical marijuana? Should it be considered as a medication for certain disease states, and therefore, a covered benefit? This popular topic poses many challenges, including clinical, regulatory and ethical implications. In order to provide insight for employers, this article will highlight the pharmacology, therapeutic effects and conflicting evidence surrounding the use of medical marijuana.





## Marijuana Background

The use of marijuana is associated with many common effects, such as relaxation, euphoria, increased sociability, hunger and altered sense of time. However, marijuana can produce other effects that may help to mitigate or treat symptoms associated with certain disease states. It can also exacerbate underlying conditions and produce undesirable side effects, such as paranoia and anxiety, particularly if the method of use and dosage is not considered, as is often the case.

Marijuana has multiple routes of administration with inhalation or smoking being the most commonly utilized. This route is also associated with the quickest onset of action and higher maximum concentrations within the blood compared to other routes. Advocates of medical marijuana believe that inhalation is a favorable route of administration because the user has some control over the dose they receive based on the depth of inhalation or puff rate. Other routes of administration include oral lozenges, gums, baked goods, beverages, sprays and topical products. The relationship between routes and proper dosage is very individualized and still not properly defined due to the lack of established evidence and guidelines.

Marijuana is prepared from various strains of the Cannabis plant. Specific parts of the plant produce greater amounts of active compounds. For example, the flowering tops and leaves secrete resin, which contains the active components that produce effects within the body. These active components are commonly referred to as cannabinoids. Although over 100 cannabinoids are known, the two most commonly known are delta-9-tetrahydrocannabinol (delta-9-THC) and delta-8-tetrahydrocannabinol (delta-8-THC). THC is the primary compound responsible for producing an altered mental sensation commonly referred to as the "buzz" associated with marijuana. Additionally, cannabidiol (CBD) is another well-known cannabinoid that produces non-psychoactive effects within the body. Therefore, it is thought that CBD can help relieve symptoms associated with a disease without producing the "buzz" sensation.

## Pharmacology of CBD vs. THC

What produces these different effects between CBD and THC? When CBD and THC enter circulation, they mimic the naturally occurring cannabinoids in the body to act on cannabinoid receptors in order to produce both desired and unwanted effects. These cannabinoid receptors are in the brain as well as other organs throughout the body and make up the endocannabinoid system. Specifically, a receptor called CB1 is found throughout the central nervous system, which consists of the brain and spinal cord. Another receptor, called CB2, is present in cells and organs responsible for regulating immune functions as well as other functions.

THC can bind with CB1 receptors in the brain, which results in psychoactive effects, and the release of neurotransmitters. Neurotransmitters are chemical substances in the brain, such as dopamine, serotonin, norepinephrine, epinephrine and GABA. The exact mechanism of CBD is not completely understood, but research reports that CBD does not directly interact with the CB1 and CB2 receptors. CBD still results in an increase or decrease of neurotransmitters, but this occurs at a lesser extent compared to THC. These unique characteristics may contribute to its non-psychoactive properties and can even result in desired therapeutic effects. In fact, research reports that CBD shares many characteristics with anti-seizure medications and has anti-convulsant effects.

**SUBSTANTIAL OR CONCLUSIVE EVIDENCE**

Chronic Pain

Antiemetic

Patient-Reported Multiple Sclerosis Spasticity Symptoms

**MODERATE OR LIMITED EVIDENCE**

Short Term Sleep Disturbance

Increasing Appetite

Decreasing Weight Loss

Clinician Measured Multiple Sclerosis Spasticity

Tourette Syndrome

Anxiety

Post-Traumatic Stress Disorder

Traumatic Brain Injury or Intracerebral Hemorrhage

**INSUFFICIENT OR NO EVIDENCE**

Cancer

Schizophrenia

Dystonia

Epilepsy

Irritable Bowel Syndrome

Amyotrophic Lateral Sclerosis

Huntington's Chorea

Parkinson's Disease or L-DOPA Induced Dyskinesia

Spasticity Due to Spinal Cord Injury

**Figure 1: National Academy of Sciences Summary of Therapeutic Efficacy of Cannabis and Cannabinoids (2017)**

## Approved Disease States

Since we are still in the infancy of marijuana research in the endocannabinoid system, there is currently no definitive answer regarding the exact conditions in which marijuana would be efficacious. A 2017 resource, "The Health Effects of Cannabis and Cannabinoids", summarizes the conditions that have substantial or conclusive evidence for the use of medical marijuana. Researchers concluded that the strongest evidence currently supporting the use of medical marijuana is for three indications: 1) reduce nausea and vomiting associated with chemotherapy, 2) treat pain, and 3) relieve subjective spasticity in multiple sclerosis. **Figure 1,** is an excerpt from the "The Health Effects of Cannabis and Cannabinoids" and lists other conditions in which medical marijuana may help.

## Marijuana vs. Opioids for Pain

As of August 2019, three states (New York, Illinois and Colorado) allow legal prescribing of medical marijuana for any condition instead of a prescription for an opioid. Although this alternative can be viewed as a strategy to help combat the opioid crisis, it does not come without concern. For example, this new law allows medical marijuana to be prescribed in place of an opioid, but other medications may be more clinically appropriate. Critics argue that a physician could theoretically bypass evidence-based guidelines for the specific condition and prescribe medical marijuana to help treat the associated pain. On the other hand, supporters argue that the law allows for open conversation between physicians and patients for the legal use of medical marijuana.

From a clinical perspective, there are additional considerations that need to be addressed regarding this law. If a patient is prescribed medical marijuana and was previously taking an opioid, he or she will need to be counseled to not use them concurrently. Medical marijuana can result in significant adverse effects, which may be more prevalent when used in combinations with prescription medications or in younger populations. Furthermore, there is conflicting evidence regarding the efficacy of medical marijuana. While pain is one indication for which medical marijuana has more conclusive evidence in the literature, individual studies have mixed results. However, a 2018 study in the Medicaid population showed states with medical cannabis laws saw roughly a 6% drop in opioid prescription rates. Perhaps more importantly, a 2014 study published in the Journal of the American Medical Association found that the average opioid overdose mortality rate was 24.8% less in medical marijuana states.


**Figure 2: Legally Available Medical Marijuana Products**

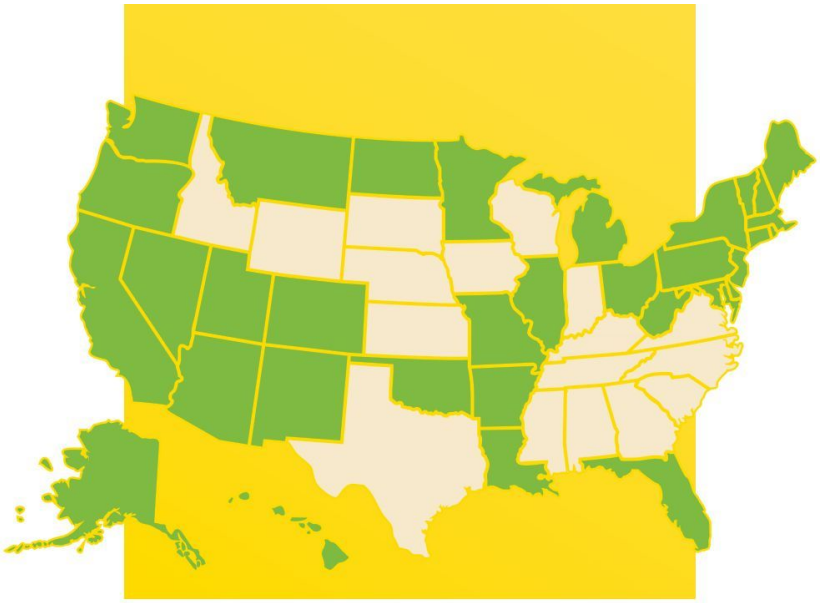


**Figure 3: States with Approved Medical Marijuana Programs (as of June 2019)**

## State Programs

The illegality of marijuana traces its history to highly questionable tactics by Harry Anslinger as the U.S.'s first commissioner of the Federal Bureau of Narcotics, but it is still considered illegal at the federal level today. With the exception of the few products listed in **Figure 2**, marijuana is labeled as a Schedule I drug under the Controlled Substances Act, which means the DEA believes it has a high potential for abuse without any accepted medical benefit. This classification not only limits its ability for insurance coverage, but also research for therapeutic safety and efficacy as well. However, many states have enacted medical marijuana laws specific to each state. As of October 2018, 33 states have implemented such laws. Although each state's law is different, most of the states permit the use of medical marijuana for the following conditions: cancer, AIDS/HIV, seizure disorders, specific types of pain and muscle spasms. Additional conditions may be approved depending on the state in which the patient resides. Other differences amongst states include: the amount of medical marijuana that can be purchased, the age of the patient, requirement for patient registration prior to use and residency requirements.

As new evidence emerges, medical marijuana will continue to raise questions and debates about coverage for employees outside of the workplace. It is worth noting that pharmacy benefit managers are not legally allowed to process claims for marijuana if it remains as a Schedule I drug by the DEA. Despite states permitting the use of medical marijuana for certain conditions, patients will still be responsible to cover the total cost and use will continue to be outside of medical records. Therefore, a patient's health care team will have limited awareness of potential drug and disease state interactions.

It appears the only thing evident about medical marijuana is that further evidence is needed in order to provide definitive answers regarding the true impact of medical marijuana as a treatment regimen, the potential for benefit coverage and appropriate utilization management strategies. As the smoke clears on this budding topic, look for future updates from the Employers Health team.


**TO DISCUSS FURTHER CONTACT**

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# Burnout

## The Latest Major Health Crisis to Affect the Workplace

by Sean Godar, Ph.D. // Director of Solutions Development
Co-Director of Right Direction

## Why is burnout important?

Burnout has been identified as a major health crisis in the U.S. workforce, leading to reduced job engagement, lower productivity, more frequent or extended sick leave, occupational change and even permanent withdrawal from work. Recent studies have found more than 1 in 5 workers experience feelings of burnout[1], figures that lead to an estimated cost of more than $125 billion in health care spending every year[2]. Moreover, burnout has been associated with increased health risks, including heart disease and type 2 diabetes[3].

## What is burnout?

Burnout is an occupational phenomenon caused by chronic job stress that leads to feelings of emotional exhaustion, indifference towards one's work and an absence of value or achievement in the workplace. The three main characteristics of burnout:

- Emotional exhaustion: feelings of fatigue due to work
- Depersonalization: unsympathetic or impersonal response and distant attitude toward one's job and recipients of one's service, care, treatment or instruction
- Professional efficacy: feelings of incompetence and lack of successful achievement and value in one's work

## What causes burnout?

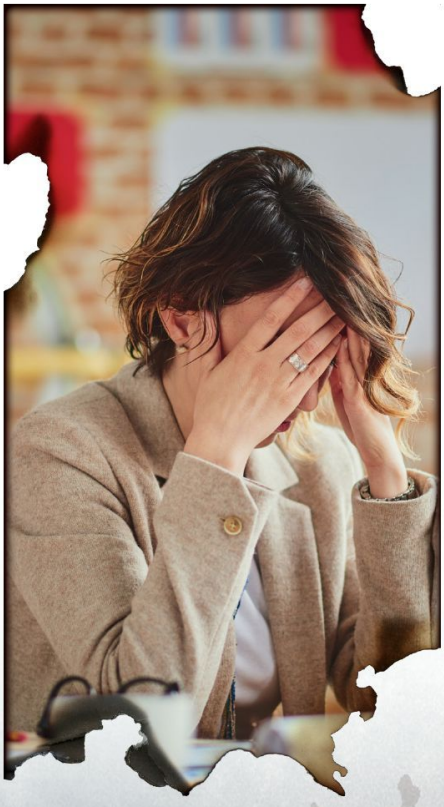
Research has identified six main risk factors[4-5] that contribute to burnout including workload, control, reward, community, fairness and values. Interestingly, effective managers can positively impact these factors[6] and increase employee value, level of engagement and productivity.

Work overload stems from feelings that an individual does not have the capacity or resources to meet job demands.

**One way to help combat work overload is to implement brief break periods (10-15 min) at regular intervals (every 90-120 min) throughout the day to renew mental resources for an overall higher and more sustained level of productivity.**

Another factor that contributes to burnout is perceived control over job-related decisions. Managers who promote independent thinking and decision-making facilitate employee engagement by conveying feelings of trust and value. Individuals are naturally more engaged and productive when they feel their opinions matter.

Similarly, reward and recognition of hard work and achievement reduces vulnerability to burnout by building trust, emotional security and a sense of impact. Recognition attaches value to a person's actions and communicates appreciation. It helps to confirm or validate an employee's competency, and conversely, the lack of recognition could imply inadequacy.



Another important factor that helps protect against burnout out is a supportive and inclusive environment, where an individual feels secure, comfortable and 'fits in' with his/her co-workers. When employees feel surrounded by unresolved conflict, vulnerable in their job security or experience discomfort interacting with co-workers they gradually develop feelings of anxiety, isolation and loneliness. This feeling can even permeate into their personal lives. As a result, these individuals are not as engaged or productive in their work. As a manager, it can be really powerful to reach out to that individual and 'check-in' by asking if there is anything you can do to help. This action conveys compassion and support for an individual as a person and not just an employee.

Fairness is also a key part of effective work environments. Employees should feel that company and managerial decisions are based on logic and fairness. It also helps if managers explain their rationale behind big decisions. This transparency helps promote security, trust and inclusiveness.

Lastly, value alignment plays an important role in protecting against burnout. It is important that company values align with personal values to reinforce personal motivation and fulfillment for their role and the company. When personal values align with work culture, employees feel more committed to the job and more engaged and productive in their work.

## How can you help prevent employee burnout?

Managers can have a major impact in helping to reduce employee burnout[7-8] Here are some key questions when evaluating your company, your management style and your employees to help identify potential pain points and areas that can be improved.

The first step to combat burnout is to start an open dialogue with employees by asking:

- Are their job expectations in line with management?
- Do they feel their workload is fair and balanced?
- Do they feel valued as an individual?
- Do they receive regular feedback, including rewards and recognition for hard work and achievements and ways they can improve and grow as a person and professional?
- Do performance work measures inspire them to improve?
- Is the workplace culture healthy?
- Are there policies in place to address unresolved conflicts?
- Does leadership promote inclusiveness, fairness and teamwork?
- Do employees feel listened to or are there opportunities to voice their opinions?
- Do they feel involved in decision processes?
- Do they feel their work is in line with their values and motivations?
- Do they feel their work has significance?

All these questions will help gauge an employee's risk for burnout. If they answer no, find out what support they need from the company and what help you can provide.

## For other information or resources on burnout in the workplace:

Recent Gallup articles[7-8] provide excellent information and recommendations for executives, managers, and human resource professionals on how to reduce burnout in employee populations.

There are also several excellent and validated surveys to assess burnout, including the Maslach Burnout Inventory – General Survey (MBI-GS), Bergen Burnout Inventory and the Utrecht Work Engagement Scale.

Remember, while burnout is becoming more prevalent, it can be largely prevented through small changes in management style and cultivating a strong workplace support system. Try to implement some of these tips and create a happier, healthier and more productive workplace.

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# EXCELLENCE IN BENEFITS AWARD

**presented by Employers Health, seeks to recognize an individual annually who has made meaningful impact in the field and/or delivery of employee benefits.**

Nominations will open December 2, 2019 and close on February 17, 2020. The 2020 award winner will be announced at the Employers Health Annual Innovations in Benefits Conference on May 13, 2020.

## EVALUATION PROCESS

The evaluation process:

1. All submissions will be anonymous (e.g., submitter and company information redacted) and sent to an evaluation panel for review.
2. All submissions will be reviewed and scored. The panel will rank and score submissions based on their contribution to the delivery of employee benefits.
3. The highest ranking submissions will be evaluated by the Employers Health Evaluation Committee to determine winner.

## Deadline is February 17, 2020

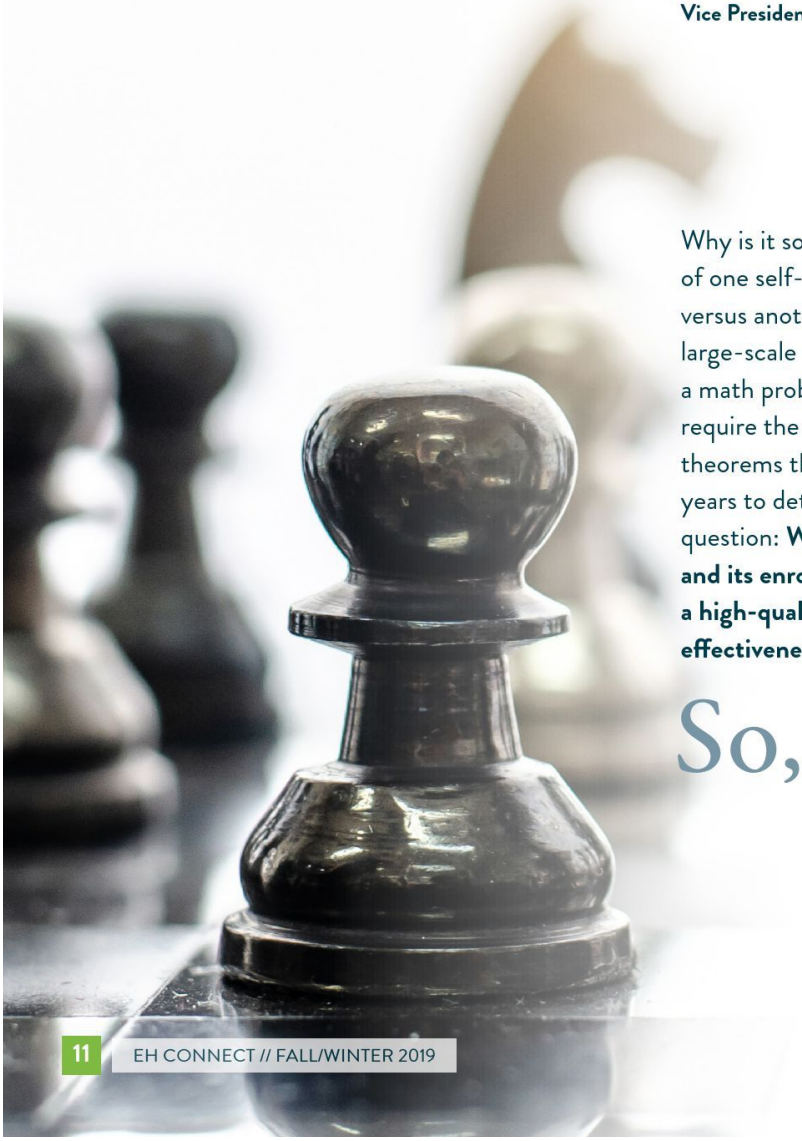
If you have any questions about this award or the process, please email eclevenger@employershealthco.com.

We look forward to receiving your submissions!

**Submit nominations and learn more at benefitsaward.com**

# PBM Evaluation Challenges

**by David Uldricks, J.D., LL.M. //**
**Vice President, PBM Contracting and Strategy**



Why is it so difficult to determine the value of one self-insured carve out PBM offering versus another? This isn't a life riddle or a large-scale socio-economic question. It's a math problem. As such, it should merely require the application of mathematical theorems that have existed for thousands of years to determine the answer to one basic question: **Which PBM will charge the plan and its enrollees the least while still providing a high-quality benefit in terms of clinical effectiveness and access.**

## So, why is this so hard?

To start, the pharmacy benefit is, and always has been, very complex. Every person covered under a benefit plan has his/her own unique set of treatment needs, and there always have been thousands of drugs available for prescribing – each with its own indications, therapeutic alternatives, price, etc. When broken down to the most granular level, a myriad of variables go into the process of ensuring that each patient has access to, is prescribed and utilizes medications that are clinically effective at the lowest possible cost.

Today, more drugs are available for prescribing and for more indications than ever. Intuitively, it makes sense that the complexity of the pharmacy benefit would grow along with the number of medications available for prescribing. But the complexity of the pharmacy benefit has grown at a much higher rate than the growth in the number of drugs available for prescribing thanks, in part, to the Drug Price Competition and Patent Term Restoration Act (popularly known as the Hatch-Waxman Act of 1984), and thanks, in part, to advances in technology.

The Hatch-Waxman Act changed U.S. patent laws in ways that significantly facilitated the entry of generic drugs into the pharmaceutical market. And it was very successful. Prior to the Hatch-Waxman Act only one-third of brand drugs had any kind of generic competition. Today, almost all drugs have direct or indirect generic competition, and almost all pharmacy benefit plans have generic dispensing rates above 80%. The rise of generic competition to brand drugs has provided massive savings to U.S. consumers and pharmacy benefit plans over the years. But there have been consequences.

Over the years following the passage of the Hatch-Waxman Act, advances in technology enabled brand drug manufacturers to focus their innovation efforts on the development of biologics and specialty drugs, and the fierce generic competition fostered by the Hatch-Waxman Act drove them to do so. Biologics are very expensive to manufacture, and even today the approval process for "generic" biologics (a.k.a. biosimilars or follow-on biologics) is much more cumbersome than the approval process for a traditional generic drug. These factors combine to create a significant obstacle for the development of robust generic competition to brand name biologics. That lack of generic competition in the biologics space has driven brand drug manufacturers to invest most of their resources into the development and marketing of biologics and specialty drugs.

**As a result, over the past two years the number of approvals for new biologics and specialty drugs has been roughly twice the number of approvals for new traditional brand drugs.**

And that rate is understated because many of the "new" traditional brand drugs coming to market are just modifications of existing brand drugs.

The dominance of biologics and specialty medications in pharmacy benefit plans will continue to increase for the foreseeable future, and the development of a robust generic market for biologics is in its infancy.

**Because biologics are so expensive, one utilizer of a biologic can significantly alter the financial health of a pharmacy benefit plan. For this reason, comprehensive formulary and clinical management strategies are more important than ever, and this has increased the complexity of pharmacy benefit management at an exponential rate.**

Given the importance of effectively managing the utilization of a pharmacy benefit, one would think that part of the evaluation of differing PBM programs would consider the cost effectiveness of the differing formularies and clinical programs. That does happen, but typically the analysis is centered around member disruption, and not so much on driving cost-effective utilization. This isn't because the evaluator is lazy or incompetent, it's because the evaluator rarely has all the needed information – namely, drug level rebates. And without drug level rebates it is impossible to determine whether one formulary does a better job than another in terms of driving the lowest net cost in a therapeutic class.

Drug level rebates are the most closely guarded secret for many PBMs, and the reluctancy to disclose them is frustrating, but it is not without merit. The rebates that a drug manufacturer pays to a PBM for any given drug can vary greatly among different PBMs. Part of the variance is due to the differing formulary and clinical management strategies each PBM adopts, but the other part of the variance is the negotiating power of the PBM itself. PBMs with high levels of negotiating power would lose much of that leverage if drug level rebates were public knowledge.

While PBMs rarely share drug level rebates, typically they offer rebate guarantees that are aggregated at some level along with discount guarantees that are also aggregated. The challenge for the evaluator is the construction of these guarantees often differs from PBM offering to PBM offering. For instance, claims adjudicated through a Veteran's Affairs benefit are typically excluded from rebate guarantees because the method for determining the pricing for these claims is regulated by federal law and is different from the commercial segment. Exclusions like these are straightforward and easy to identify and quantify. But today, many PBMs are adding stipulations to their discount and rebate guarantees that alter the way the guarantee is calculated and are based on information that is vague to all but the PBM. For example, many PBMs exclude limited distribution drugs from discount and rebate guarantees. What is considered a limited distribution drug may vary significantly from one PBM to another. And for any one PBM, what is considered a limited distribution drug today may not be considered a limited distribution drug tomorrow, and vice versa.

**The difference in what is considered a limited distribution drug between PBM offerings typically depends on contract language and the robustness of the PBM pharmacy network.**

PBMs that include single source brand and generic drugs in their definition of limited distribution drugs will have a much larger limited distribution drug list than PBMs that do not follow this practice. Similarly, PBMs with a thin pharmacy network will have a larger limited distribution drug list than PBMs with a robust pharmacy network.

Excluding limited distribution drugs from discount and rebate guarantees allows PBMs to make their guarantees artificially appear higher than they would without the exclusion because the exclusion reduces the number of claims the rebates are measured against. Today's PBM contracts are riddled with more guarantee stipulations that artificially inflate guarantees than ever. As a result, it is increasingly difficult to evaluate the true value of any particular PBM offering.

The construct of a PBM offering has little, if any, inherent financial value regardless of whether the offering is transparent or traditional, riddled with guarantee stipulations or not. The challenge for the evaluator is identifying the differences in PBM offerings and assigning a value to them. This is no small task and it is more difficult than ever, but it can be done through a lot of hard work, analysis and discussion with the PBM being evaluated. The key is to truly understand the pricing terms and to understand how the PBM's utilization management strategies will affect utilization in the future.

# Noteworthy News

Employers Health at Stark Parks' Quail Hollow Park

Chief Strategy Officer, Mike Stull, was re-elected to a 3-year term on the Delta Dental of Ohio Board of Directors.

Senior Director of Pharmacy, Matt Harman, recently spoke on a keynote panel at the World Biosimilar Congress in Basel, Switzerland.

Garrett Brown joined the Board of Directors at Pegasus Farm, a therapeutic equestrian center based in Stark County, Ohio.

Chris Goff was elected to the Board of Directors for The University of Akron Foundation.

Brett Pinson recently obtained his MBA through Ashland University.

Mike Stull was quoted in a Bloomberg article titled, "Employers Fear Squeeze from Genetic Cures That Cost Millions".

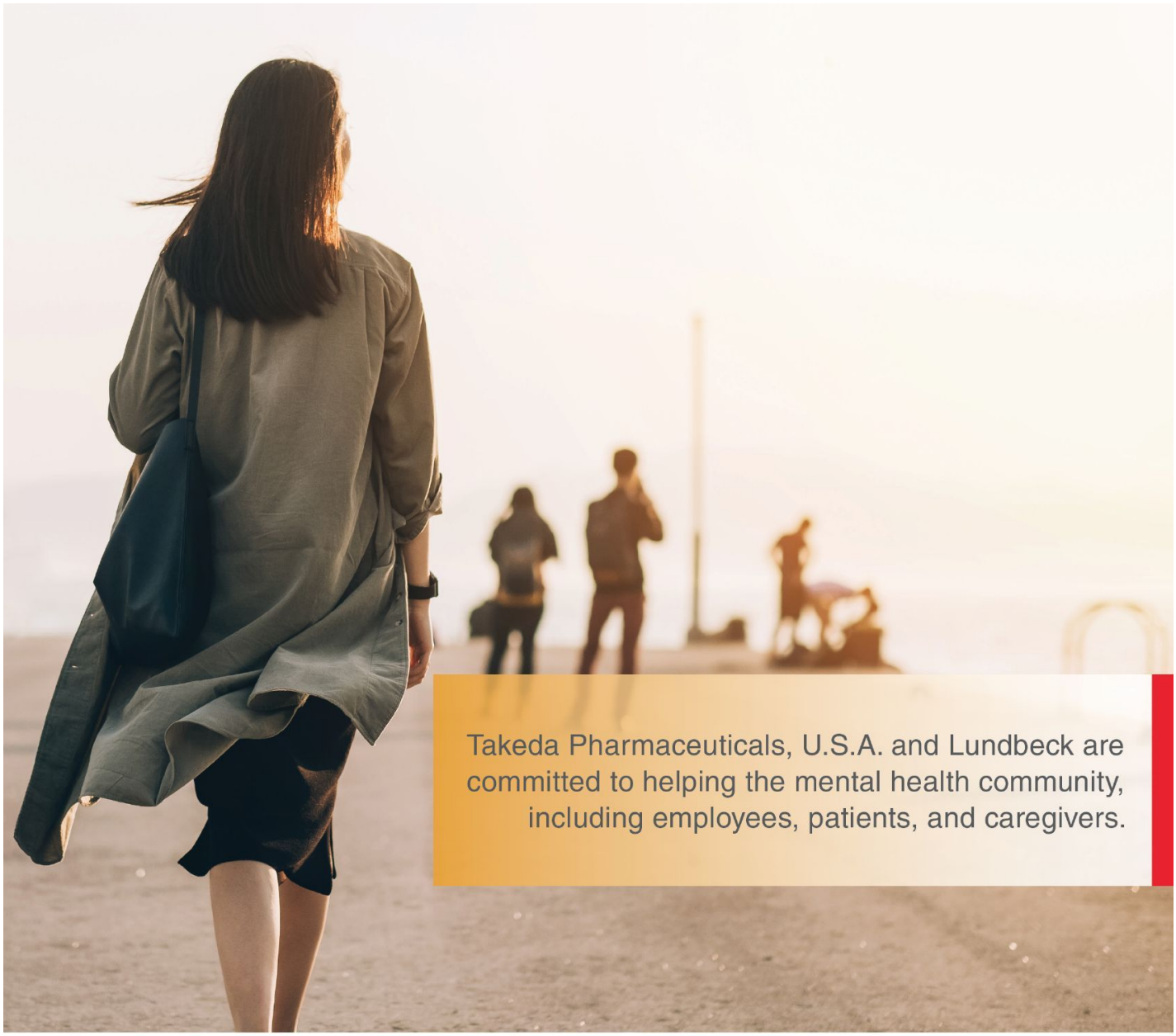
The Employers Health team assembled over 500 purse kits on behalf of United Way of Greater Stark County. The purses, packed with personal care items, were distributed to area not-for-profits.

Accounting Manager, Lisa Oesch, recently joined the Board of Directors of Beacon Charitable Pharmacy, a nonprofit providing prescription assistance to uninsured and underinsured residents of Stark and Carroll counties.

Sean Godar, director of solutions development and co-director of Right Direction, recently presented on the topics of Why Companies Should Focus on Mental Health and How to Create a More Mentally Healthy Workplace.

Brett Pinson, account management specialist, spoke to local high school students on the importance of leadership and character development.

The Employers Health Canton office recently volunteered at Stark Parks' Quail Hollow Park cleaning up the herb garden.

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# Member Spotlight

## Bryan "Cody" VanBoxel

**National Director of Human Resources**
**DAV (Disabled American Veterans)**

DAV is a congressionally-chartered nonprofit charity that provides a lifetime of support for veterans of all generations and their families. DAV helps more than 1 million veterans in positive, life-changing ways each year. Annually, DAV provides transportation for more than 625,000 veterans attending medical appointments and assists them with well over 200,000 benefit claims. In 2018 alone, they helped service members, veterans and their families receive over $20 billion in earned benefits. These are just a few examples of the many programs they oversee to help disabled veterans, their families and survivors.

They also tackle employment issues for veterans and have a robust partnership that facilitates more than 140 job fairs a year. Last year, they were featured in HR Magazine for a report they created called the Veterans Advantage: DAV Guide to Hiring & Retaining Veterans with Disabilities to educate employers on the benefits of hiring our nation's heroes.

## We sat down with Bryan "Cody" VanBoxel, DAV's national director of human resources, to learn more about his role at DAV.

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

I am truly passionate about serving the nonprofit sector and more specifically, our nation's disabled veterans and their families. As I have progressed and advanced throughout my managerial career, I have gained more exposure to employee benefits and welfare. I have found a genuine interest in taking care of those who are on the forefront of our mission. DAV is very unique in the sense that we often promote from within. Our three most senior leaders all started as junior VA benefits advocates, as did I, and all led our human resources efforts on their way up the chain. This gives a valued approach to taking care of our own, since we have been there. The benefits we provide and consider are not an afterthought, they are the same benefits we use or could have used as more junior employees.

**How long have you been engaged with Employers Health?**

We joined Employers Health in 2013.

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

As a former United States Marine, I will share one of my favorite Marine Corps adages: "Mission accomplishment, troop welfare." Intentionally linked to this military axiom or not, DAV has taken a strong cultural stance in proceeding in this fashion. The heartbeat of every day manifests itself in our first mission; fulfilling our promises to the men and women who have served. We, as an organization, check that box and in turn, we ensure that our employees are taken care of in the form of a competitive and robust benefit package. Our goal is to attract and retain the best advocates available, giving them a comfortable work-life balance. This in turn comes full circle to the completion of our mission at DAV.

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

DAV is not a sleepy little nonprofit. We have over 600 employees in more than 100 hundred locations, historically embracing technology and industry innovation. Just like any other similarly situated entity, we go through phases of growth, expansion and maturity. Today, we are in a solid growth phase. We have expanded our resources and are affecting the lives of ill and injured veterans like never before.

To ensure we recruit and retain the best in the business, we consistently educate ourselves on the benefit landscape to ensure we are bringing value to the table for our employees. The key for us specifically, has been putting the power to make decisions into our employee's hands. They have countless options for care, from a nurse line to care counselors. We also continue to develop resources to allow individuals to save money to both their benefit and ours. Some of the greatest innovators right now are those who are making health care benefits about mutual ownership and reward.

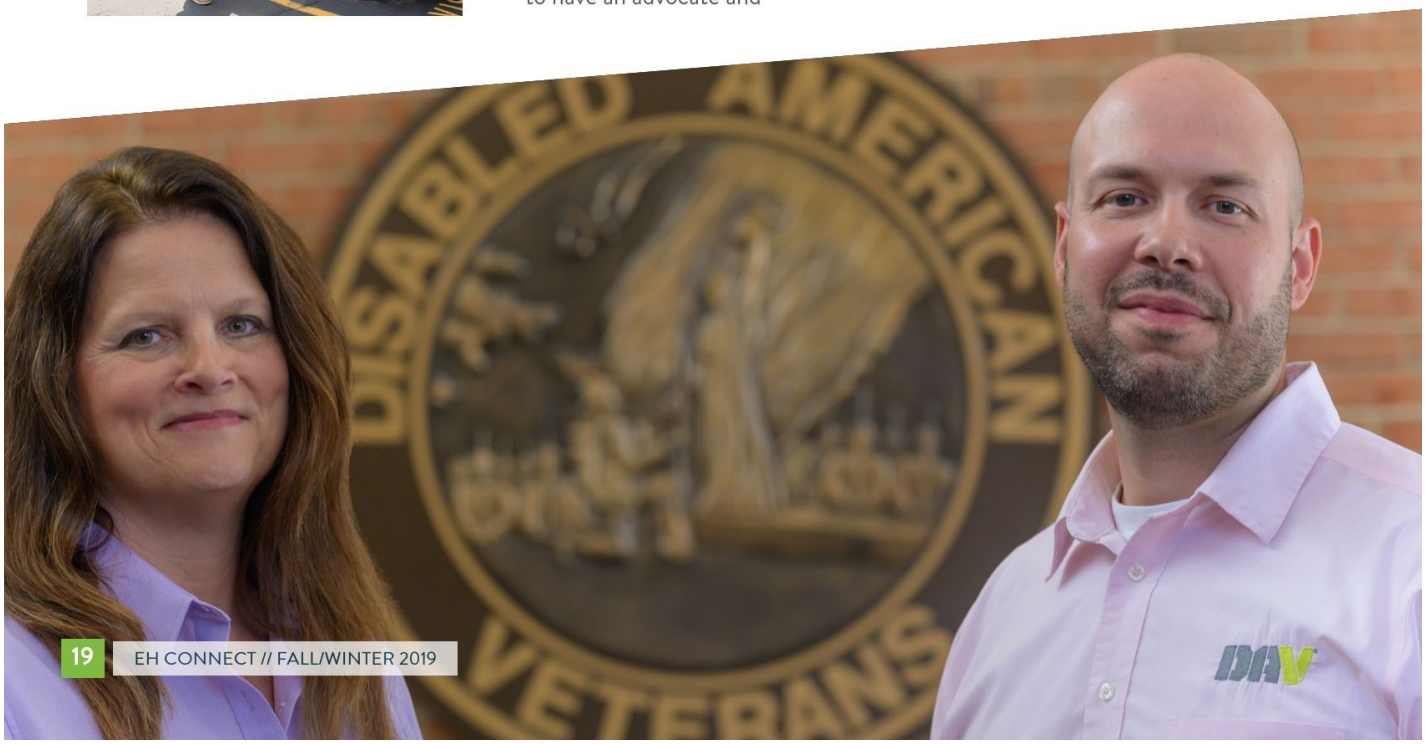

### What has surprised you about working in benefits?

Numbers. I approached benefits thinking we were going to streamline a health care plan and everything easily falls into place. I was entirely unprepared for the vastness of calculations, trends and expenses to consider. I fought to understand the inner workings of the processes and "numbers." I have a new-found appreciation for their value and have realized that we can accomplish a lot with a little bit of data.

### What are your thoughts on the future of employee benefits?

The landscape surrounding employee benefits is ever-changing, which makes it even more important to have an advocate and


ally like Employers Health. I think we have seen drastic change in the most recent decades, primarily surrounding our increased ability to capitalize on emerging technologies, especially in data analytics, which has become a tremendous resource and will continue to be one. The guessing game of what works, will work or has worked is less challenging than before. Forward-thinking organizations, like DAV, will continue to streamline resources and capitalize efficiencies by ensuring we continually engage the latest and greatest in the form of results, data and metrics.



# Transform Diabetes Care Expands to Improve Health for More Members

Our Transform Diabetes Care helps reduce the complexity of self-management and improve health outcomes for plan members with diabetes, and prevent the onset for those at risk of diagnosis. Since its launch, it has demonstrated positive clinical outcomes results[1]:

- 1.2 percentage point HbA1C improvement achieved at 6 months and sustained at 12 months*
- More than 50 percent of members with uncontrolled diabetes were moved to controlled status*

## Addressing More Areas of Care

CVS Health is introducing new components of the program to help members at risk of developing type 2 diabetes, and provide even greater support to those already diagnosed, including help managing hypertension — the most prevalent comorbidity. Our proprietary analytic engine analyzes pharmacy and medical data to help identify those who may be at risk for diabetes or hypertension. We can then enroll them in the appropriate prevention program. Participants of both programs will receive an app-based tool supported by education and digital coaching, as well as support from registered nurses, dieticians, exercise physiologists and behavioral therapists.

### Members enrolled in the diabetes prevention module will also receive:

- A connected digital scale
- Support from MinuteClinic practitioners who use screenings and targeted physical exams, as needed, to help prevent the onset of complications

### Members enrolled in the hypertension module will also receive:

- A connected blood pressure cuff
- Two annual metabolic visits at MinuteClinic at no cost

The diabetes prevention program goal is for 50 percent of enrolled members to lose at least five percent of their starting weight. The hypertension program goal is an average reduction in systolic blood pressure of 9 mmHg in a given population for patients with blood pressure greater than 130/80, and of 12 mmHg for those with greater than 140/90.

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1. Enterprise Evaluation and Population Health Analytics; TDCI, May 2019. p<.001.

*Among members with uncontrolled diabetes (HbA1C ≥ 7) engaged with a connected glucometer (testing ≥ 5x/month over three months prior to 6 and 12 month evaluations). Average HbA1C improvement measured at 6 months and 12 months following meter activation.

CVS Health uses and shares data as allowed by applicable law, and by our agreements and our information firewall.

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