Employers Health™

SPRING 2023
A publication of Employers Health Coalition, Inc.

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2022 Excellence in Benefits Award Recipient
Heather Beal

INSIDE

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Spring 2023

MESSAGE FROM CHRIS GOFF

Christopher V. Goff, Esq.
CEO & General Counsel

Spring is here and before we know it, it will be summer. Every year seems to go faster than the last. And with that, we're already almost halfway into the plan year. That means many of you are deep in evaluating new vendors, assessing plan design and reviewing contracts.

Please remember, our team at Employers Health is always here to help, whether it's reviewing an RFP, promoting an open position on your team or sitting in on a meeting. We are always eager to support you and your team.

We continue to grow our team to ensure you receive the support and service you've come to expect from Employers Health. I'm excited to share that the three pharmacy residents who joined us through our managed care pharmacy residency program in 2022 will remain with the organization as clinical advisors effective July 1, 2023. We will add two more pharmacy residents also on July 1. We've also hired an additional data analyst to assist in evaluating plan performance and drug pricing trends and projections.

This growth necessitates additional office space. We've officially outgrown our current location in Dublin, Ohio. This spring, our Dublin team members will be relocating to new office space conveniently located just north of the city of Columbus at 8890 Lyra Drive in The Pointe at Polaris. It will feature 30 offices and two meeting spaces with room to grow.

And, after three years of record sales growth, we've also outgrown our Canton, Ohio headquarters. Construction is underway for our second Canton location, conveniently positioned next to our existing office. We'll keep our current space while adding a second office consisting of 52,000 additional square feet and 70 offices. This location is scheduled to be completed in early 2025.

In our 40 years, we've grown from a two-person-led health care coalition comprised of 25 organizations representing over 20,000 employees in Stark County, Ohio, to more than 60 employees working to reduce health care costs for more than 315 companies covering 2.6 million lives throughout the United States. We're honored to have had so many of you with us along the way. We look forward to growing together over the next 40 years!

WELCOME TO OUR NEWEST CLIENTS

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Arctic Slope
Austal USA
Blessing Hospital
Broward Health
Chase Brexton Health Services
Choice Hotels International Inc.
Commercial Vehicle Group Inc.
CONMED Corporation
Cuyahoga Metropolitan Housing Authority
Depauw University
Dialysis Clinic Inc.
DISYS
Evergy Inc.
EXL Services
Grammer America Inc.
Hargrove & Associates Inc.
Howard County Public School System
Indiana Farm Bureau Insurance
Indiana Credit Union Consortium
Karl Storz Endoscopy
Konecranes Inc.
Madison County, IL
Mary Washington Healthcare
Memorial Healthcare
MKA International Inc.
Morton Salt
National Church Residences
Panera Bread
Pasadena Independent School District
PF Holdings
Pima Medical Institute
PrimeSource Building Products Inc.
RaceTrac Petroleum Inc.
rand* construction
Ropes & Gray
Techmer PM
Thrive Pet Healthcare
Turnpoint Services LLC
United Rentals
Washington Post Co.
Watco Companies
Western Alliance Bancorporation

Innovations in Benefits Conference Webinar Series

June

- **07** Legal and Regulatory Update: What Plan Sponsors Should Know
- **13** Why do we Continue to Witness "Enron-esque" Failures of Corporate Governance and Compliance?
- **15** Managing Specialty Inflammatory Conditions
- **22** Making the Most of Mental Wellness Benefits
- **28** Employer Innovations: A Panel Discussion on Today's Benefits Challenges

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WEBINAR

May 24, 2023
2 PM ET

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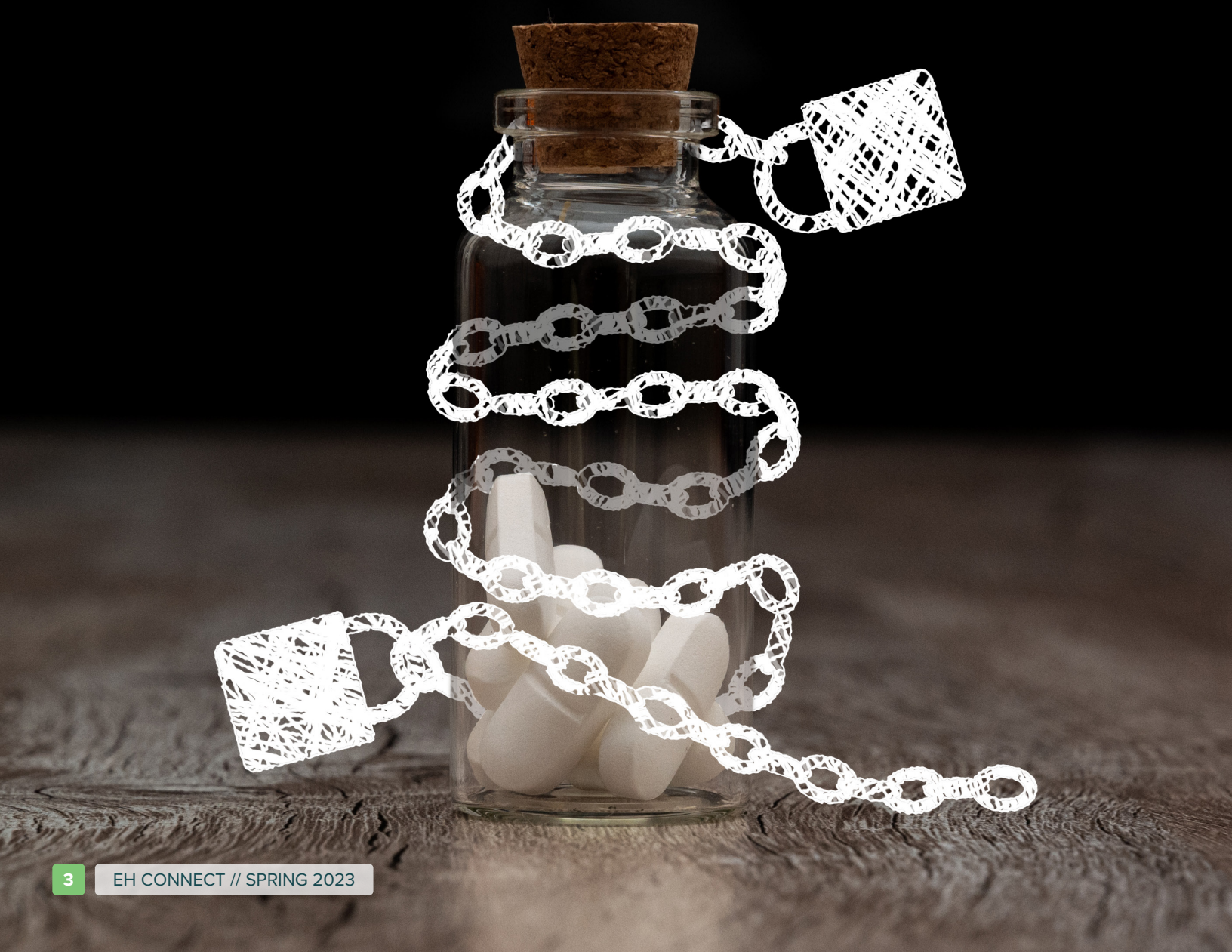
*EyeMed analysis of new business that transferred over from a prior benefits company. 2017.
A-2103-BC-285

State PBM Legislation: Why Plan Sponsors Should be Aware

Madison Evans, J.D., CEBS
Senior Vice President, Regulatory Compliance and External Affairs



It should come as no surprise that state laws seeking to regulate pharmacy benefit managers (PBMs) have increased exponentially over the past four years. These laws focus on a variety of areas in which PBMs operate including mail-order pharmacies, specialty and preferred networks, mandatory pharmacy reimbursement, point-of-sale rebates and copay accumulator programs. Understandably, these developments have come with significant confusion amongst plan sponsors, state regulators and PBM vendors alike. Some of these laws have been met with federal preemption challenges and are making their way through our federal court system.

Why PCMA v. Mulready could have far-reaching consequences for self-funded ERISA plans

The most significant ongoing legal challenge is PCMA v. Mulready, a case challenging the Oklahoma Patient's Right to Pharmacy Choice Act. The law in question was passed in 2019 and prohibits the utilization of preferred pharmacy networks or any incentivizing of the use of mail order pharmacies via cost-sharing discounts or reductions in copay amounts. The Oklahoma Insurance Department sought to enforce the law against self-funded ERISA plans.

The Pharmaceutical Care Management Association (PCMA), a trade association representing PBMs, sued the state of Oklahoma Insurance Commissioner Glen Mulready arguing that the law was preempted by the Employee Retirement Income Security Act (ERISA), a federal statute that seeks to establish one uniform law for self-funded ERISA plans. The state department of insurance was prohibited from enforcing the law until April 2022 when the court ruled that the law was indeed enforceable against ERISA plans. As a result of this ruling, plans operating in Oklahoma began receiving notice that certain plan designs were no longer viable options in Oklahoma. For example, all 90-day mail-order prescriptions were shifted to be filled as a 30-day supply at a retail pharmacy.

The PCMA has appealed this ruling to the 10th Circuit Court of Appeals. Historically, state laws seeking to regulate PBMs have only been enforceable against fully-insured plans and self-funded non-ERISA plans. This long-standing principle was weakened in 2020 after the United States Supreme Court's ruling in Rutledge v. PCMA. In Rutledge, the court upheld an Arkansas reimbursement law that said PBMs must reimburse pharmacies at a rate that is equal to or greater than a pharmacy's acquisition cost for a drug. The court said that this law was not preempted because it did not force plans to structure benefits in a particular way, it merely increased costs or altered incentives for PBMs. The Oklahoma Commissioner of Insurance contends that this ruling informs the Oklahoma case and that the 10th Circuit Court of Appeals should hold the same way.

Distinguishing Rutledge and Mulready

The PCMA argues that the Oklahoma law at issue in Mulready is different from the Rutledge law because the Oklahoma law does force plans to structure benefits in particular ways. The Oklahoma law forecloses the options of offering a narrow pharmacy network and incentivizing participants to use mail-order pharmacies with lower cost sharing. PCMA argues that these are key plan design choices that plan sponsors may elect in order to achieve substantial savings. The forced adoption of a broad network and the inability to set cost-sharing differentials drive up the costs of plan administration. The state of Oklahoma argues that the law regulates PBM operations and not the plan itself; ERISA does not preempt state regulation of an intermediary, even where the regulation increases plan costs. However, this ignores the functional reality that PBMs step into the shoes of a plan sponsor when administering a pharmacy benefit plan, ultimately causing the law to regulate the underlying benefit plan, not just the PBM.

While these laws may be passed with the intention to lower prescription drug costs and protect consumer pharmacy choices, the danger of increased state regulatory authority is the potential erosion of employer-sponsored health plan protections. These laws often result in increased costs to plan sponsors, which may ultimately be realized by participants in the form of higher premiums.

As a result of the Oklahoma law's implementation, member-cost-share is expected to increase by 11.9%.

On January 25, the Court of Appeals for the 10th Circuit, in a somewhat rare court order, asked the Department of Labor to file a brief weighing in on the case. This is significant because this law is the first of its kind that seeks to regulate ERISA plans. Similar laws have been struck down three times in four years; courts have ruled that ERISA preempted state PBM laws in North Dakota, Iowa and the District of Columbia. The Department of Labor's input in this case has the potential to be highly influential in the case's ultimate outcome and could influence how other circuits approach this issue in the future. Oral arguments will be held May 16.

Drug pricing reform continues to be a strong, bipartisan priority for Congress

The PBM industry continues to face additional pressure at the federal level. In the summer of 2022, the Federal Trade Commission (FTC) launched an inquiry into the PBM industry, requiring the six largest PBMs to provide information and records regarding their practices. The agency's inquiry came after months of increasing publicized pressure from Senator Chuck Grassley and other members of Congress. The inquiry will examine fees charged to unaffiliated pharmacies, the impacts that rebates and fees from drug manufacturers have on formulary design and the ultimate costs of drugs for participants.

The 118th Congress already introduced two bills in January of 2023 seeking further PBM reform: the Pharmacy Benefit Manager Transparency Act and the Prescription Pricing for the People Act. This is a strong signal that lawmakers will continue to prioritize prescription drug pricing reform, even after passage of the Inflation Reduction Act, the provisions of which are currently being implemented. The Senate held hearings in early 2023 considering a bill that would prohibit PBMs from engaging in spread pricing and require pass-through rebates.

The importance of ERISA preemption for employer-sponsored health plans and what exactly does all this mean for self-funded plan sponsors?

Pharmacy trade associations, patients, manufacturers, PBMs and lawmakers each have their own unique perspective on issues in the drug supply chain, none of which tells the entire story. While state laws regulating PBMs aim to rein in drug spending, one of the unintended consequences is increasing plan costs. When states regulate PBM's they also directly regulate the underlying prescription drug benefit plan and any plan design choices that a plan sponsor may utilize to provide valuable benefits to participants. As PBMs become more restricted in their ability to design networks, fewer options may be available to employers ultimately resulting in increased costs.

Plan sponsors choose to self-fund their health plans for a variety of reasons, including the ability to customize a plan to meet the specific needs of their workforce, increased flexibility and control of the plan and cost savings from reduced administrative and risk fees. Another fundamental reason that employers and unions choose to self-fund is the protection from disparate and potentially conflicting state regulations provided by ERISA.

Such increased restrictions contradict Congress's manifest purpose in enacting ERISA.

Final Thoughts

As an advocate for self-funded employers that operate businesses in many different states, Employers Health recognizes the importance in ensuring its clients are protected from burdensome and conflicting state regulations. At a minimum, it is vital that the employer's voice is brought to the table when considering these regulations and policies. Employers Health will continue to monitor developments in the Oklahoma case as well as other state legislative developments. While this year is sure to be an active one in Congress and state general assemblies, it is still unclear how much of the impact of this legislation will be shouldered by plan sponsors and participants.

TO LEARN MORE CONTACT

Madison Evans
mevans@employershealthco.com

Gene Therapy: Million Dollar Cures and Causes for Concern

Ha Eun Kim, PharmD
Pharmacy Resident

Matthew Harman, PharmD, MPH
Vice President, Clinical Solutions

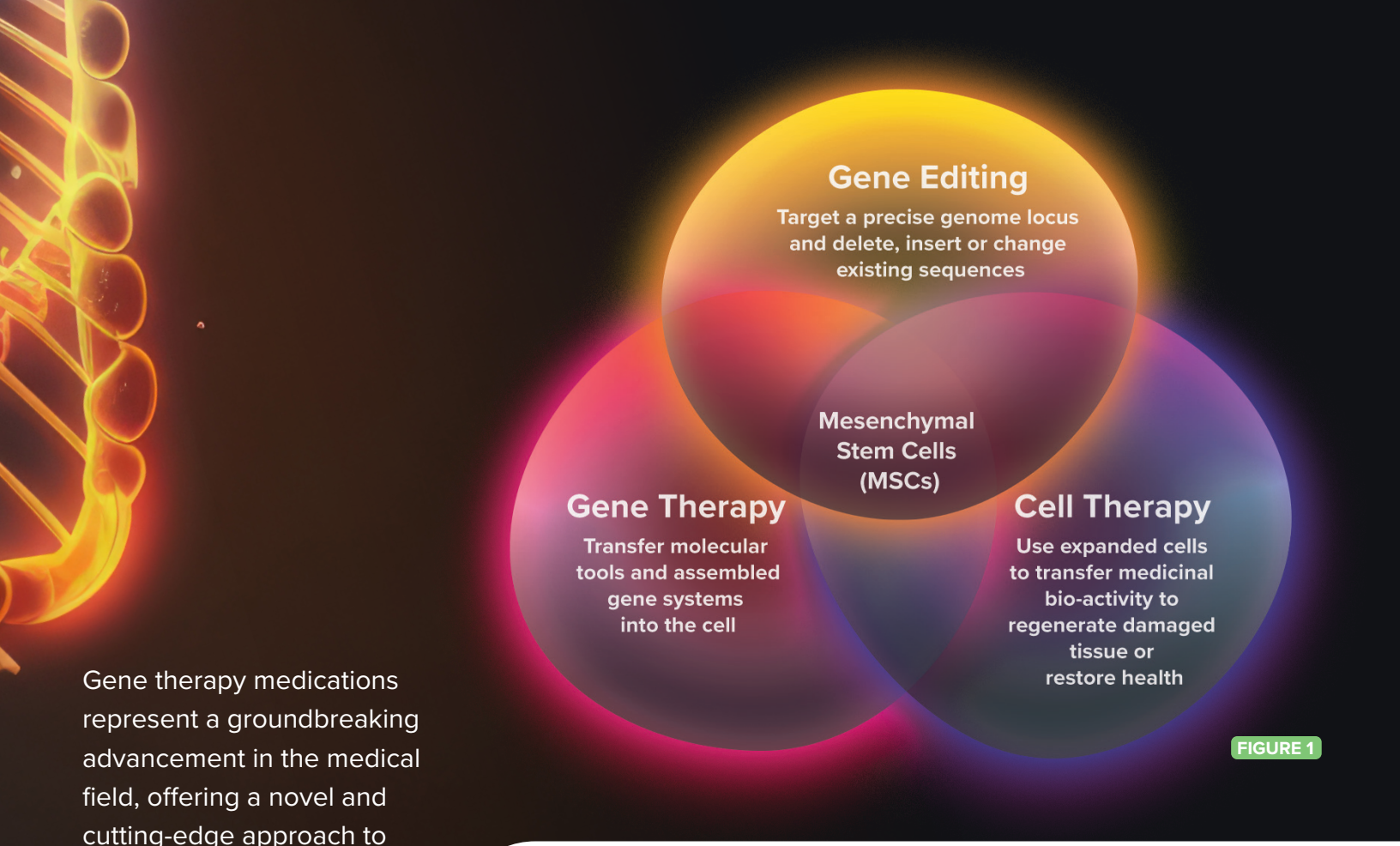


FIGURE 1

Gene therapy medications represent a groundbreaking advancement in the medical field, offering a novel and cutting-edge approach to treating various diseases and conditions at their genetic roots. These medications hold the promise of delivering long-lasting and even permanent cures for conditions that were previously deemed incurable, including various forms of cancer and hereditary disorders. However, the therapies do not come at a small price tag and may not always be effective. As employer plan sponsors, it is crucial to comprehend the magnitude of these treatments and their potential advantages and consequences for plan participants.

The History of Gene Therapy

The gene therapy industry has been gathering steam for decades. The global gene therapy market accounted for $2.05 billion in 2020 and is projected to be $12.29 billion by 2030.[1] The history of gene therapy dates back to the 1960s, when scientists first hypothesized that DNA sequences could help patients treat genetic disorders.[2] Today, there are six approved gene therapies with dozens more projected to launch throughout the decade including potential therapies for Duchenne muscular dystrophy and hemophilia A.[2,3]

Historically, most gene therapies are used to treat the rarest of conditions where the effects can last 5-to-20 years. Moving forward, gene therapy will be used to target both common and rare diseases offering "new hope for a different type of treatment".[4] Products in the pipeline will expand treatment options for familiar diseases such as Parkinson's and osteoarthritis for the broader population. With these latest advancements, patients with chronic conditions will have gene therapy alternatives that offer efficacy and consistency.

As seen in FIGURE 1, gene therapy, gene editing and cell therapy are fields of research with similar goals of treating various disease states by altering the blueprints at the microscopic level. Gene therapy transfers genetic material via a vector, or a carrier molecule, that delivers new healthy genetic content to a location where it can be utilized to counteract the effects of the mutated gene. Gene editing involves modifying and manipulating the genomic sequence to directly target and add, correct or remove harmful genes. Cell therapy involves administering viable cells into a patient's body to replace the malfunctioning and damaged cells but does not have any effect on the genes.[5]

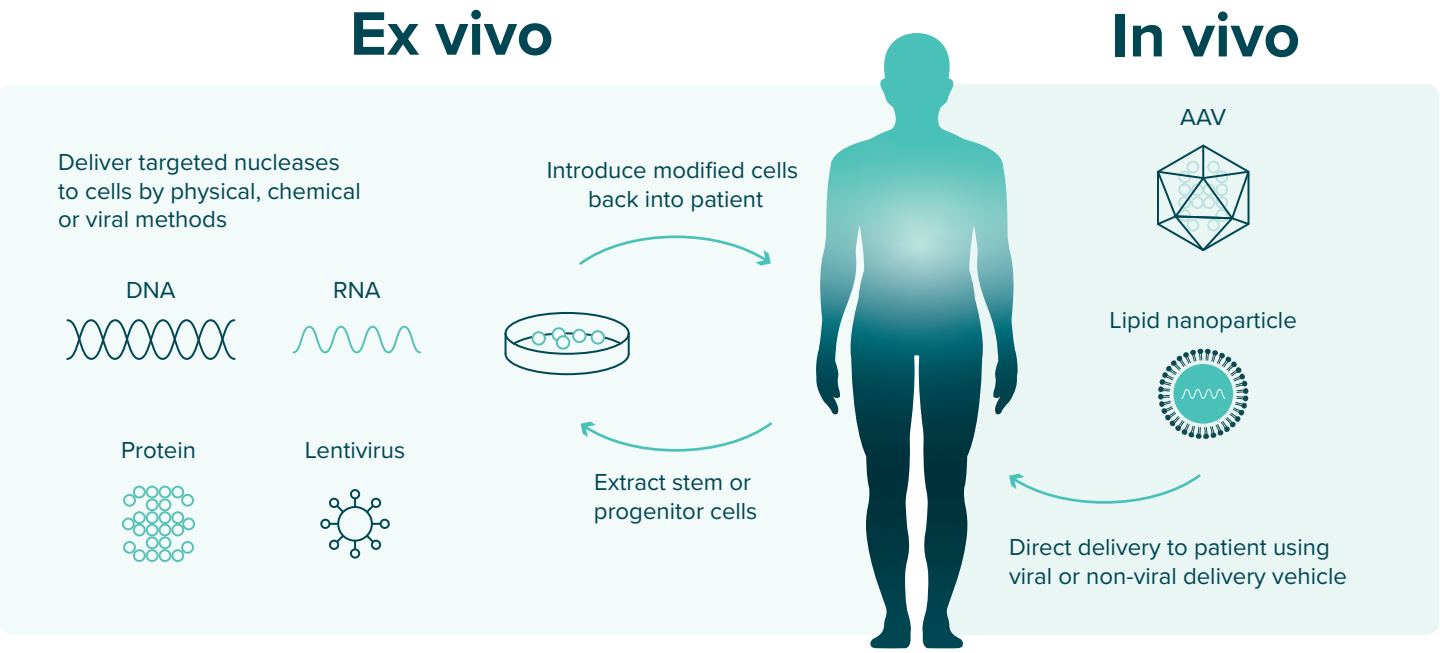


FIGURE 2

There are two main approaches to gene therapy: ex vivo and in vivo, pictured in FIGURE 2. In ex vivo, the target cells are removed, genetically altered and placed back into the patient. This approach is safer but is limited in that it can only be used when the disease allows the target cells to be removed. With in vivo, genetic material is administered directly to the target cells in the body through blood circulation or cerebrospinal fluid.[6] The procedure is simple, but it is more challenging to reach the targeted cell. These therapies are profoundly effective in treating patients, but they are also extraordinarily expensive.[6]

Gene Therapy Cost and Availability

Currently, six FDA-approved gene therapies are available. FIGURE 3 details these six therapies as well as the cost of how these conditions are primarily treated.

The most recently approved gene therapy, Adstiladrin, should be commercially available in the second half of 2023. It is the first gene therapy indicated for non-muscle invasive bladder cancer that will be directly competing with Merck's Keytruda. The pricing will not be published until closer to launch, but the manufacturer is aiming to make the therapy widely accessible. It is unique in that it will be administered once every three months for a total of four administrations. For invasive cancers, the response rate of 51% is strong, but it does give pause on what happens when the product is not effective.

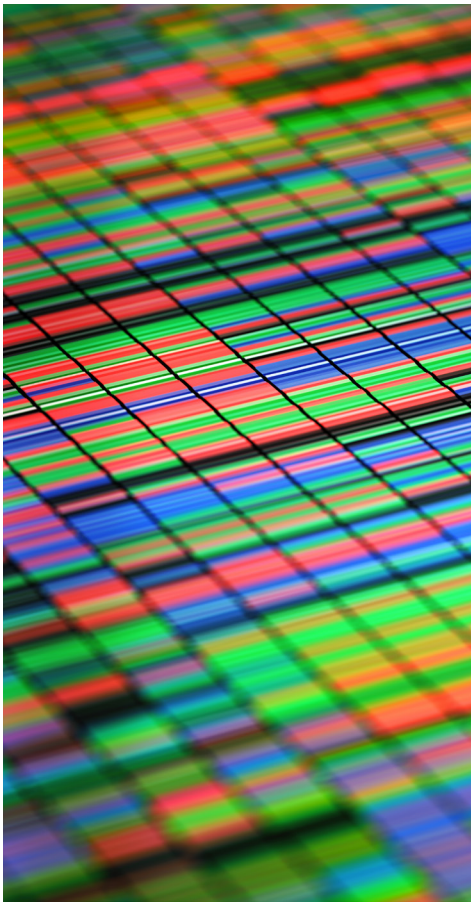
Just a month before Adstiladrin's approval, Hemgenix was approved by the FDA. It is indicated for hemophilia B, an extremely rare hereditary bleeding disorder caused by low levels of blood clotting Factor IX. Patients with hemophilia B experience spontaneous or excessive bleeding that can be life-threatening. Before approval of Hemgenix, the standard of care for hemophilia B consisted of episodic infusion therapy for mild or moderate and regular infusion for individuals with severe symptoms. As seen in FIGURE 3, Hemgenix is a one-time single-dose intravenous (IV) infusion that costs $3.5 million, however the cost benefits of this medication are seen long term as prophylactic blood infusions average about $668K annually per patient. It had an efficacy rate of 94% in clinical trials, so the vast majority of patients will see a benefit.

Unlike Hemgenix, Luxturna lacks alternative treatment options. It is the first FDA-approved gene therapy to treat patients with inherited retinal disease (IRD), which ultimately leads to progressive vision loss and potentially results in total blindness. Luxturna has demonstrated relatively safe and modest efficacy that varies by patient in terms of how substantial an improvement in vision is achieved.

Skysona received FDA approval last year for early active cerebral adrenoleukodystrophy (CALD), for boys 4-to-17 years old to slow the progression of neurologic decline. Progressive neurologic symptoms of CALD include hearing loss, diminished vision, gait instability, stiffness and seizures. If left untreated, within 2-to-3 years, symptoms can cause most neurologic function to be lost and total disability or even death. Current treatment available that serves as an alternative to Skysona is allogeneic hematopoietic stem cell transplantation (HSCT), but it requires a matching sibling donor and only about 30% of patients are a match.[8] Thus, the estimated major disability survival rate of 72% for treated patients is welcome news for those diagnosed with CALD.

Zolgensma is an IV infusion indicated for spinal muscular atrophy (SMA), a rare genetic disorder characterized by degeneration of nerve cells in the brainstem and spinal cord which results in progressive muscle weakness and atrophy. SMA disorder is classified by severity and Zolgensma infusion is limited to use in patients below 2 years old and competes with Evrysdi and Spinraza. In trials, 91% of patients who had symptoms of SMA prior to Zolgensma administration achieved the milestone of being free of permanent ventilation, so they are able to breathe on their own.

Lastly, Zynteglo, also known as beti-cel, is an alternative treatment for allogeneic hematopoietic cell transplantation (HCT). It is the first gene therapy to treat an inherited blood disorder called transfusion-dependent beta-thalassemia (TDT), where the patients are incapable of producing enough hemoglobin. TDT can lead to severe anemia and the patient can experience fatigue, weakness and shortness of breath. Of the 41 patients treated in trials, 89% achieved transfusion independence.



Gene Therapy	Indication	Approval Date	Wholesale Acquisition Cost* (WAC)*	Average Alternative Costs	Prevalence^
Adstiladrin	Non-muscle invasive bladder cancer	12/16/22	N/A*	Keytruda: $182K annually	0.243
Hemgenix	Hemophilia B	11/22/22	$3.5M (one-time cost)	Blood factor IX replacement: $668K annually	0.004
Luxturna	Inherited retinal disease (IRD)	12/19/17	$425K/eye	n/a	0.005
Skysona	Cerebral leukodystrophy (CALD)	09/16/22	$3M	Allogeneic hematopoietic stem cell transplantation (HCST): $150K	0.004
Zolgensma IV	Spinal muscular atrophy	05/24/19	$2.2M	Evrysdi: $300K annually; Spinraza: $765K year 1, $383K annually (maintenance)	0.053
Zynteglo	Beta thalassemia	08/17/22	$2.8M	Blood transfusions: $128K Exa-cel: $2.8M	0.00001

FIGURE 3

**Pricing is currently not available ^Shown as prevalence per thousand members*

Payment Models and Considerations

When reviewing gene therapy coverage, there are a few key challenges employers must consider.

1. **Therapeutic durability**
   As mentioned, gene therapies are one-time treatments with high upfront costs, but they can often be more cost-effective than alternative treatments over time. This can create a challenge if the long-term efficacy is insufficient. The projected savings will show in the following years as the patients stay within the plan and avoid alternative episodic treatments.

2. **Member mobility**
   For employers with high turnover, the estimated savings might not materialize since they cannot calculate the cost avoidance of other competing treatments. Payors face the risk of members leaving the plan before realizing the longitudinal savings of covering gene therapy.

3. **Robust pipeline**
   There are approximately 50-to-70 gene therapies projected to be approved by 2030. These therapies will have more than 170 indications for both rare and common diseases, which as discussed, can carry a 6-to-7 figure price tag. Clients who are considering covering the cost of these therapies must be informed and updated as they come to the market.

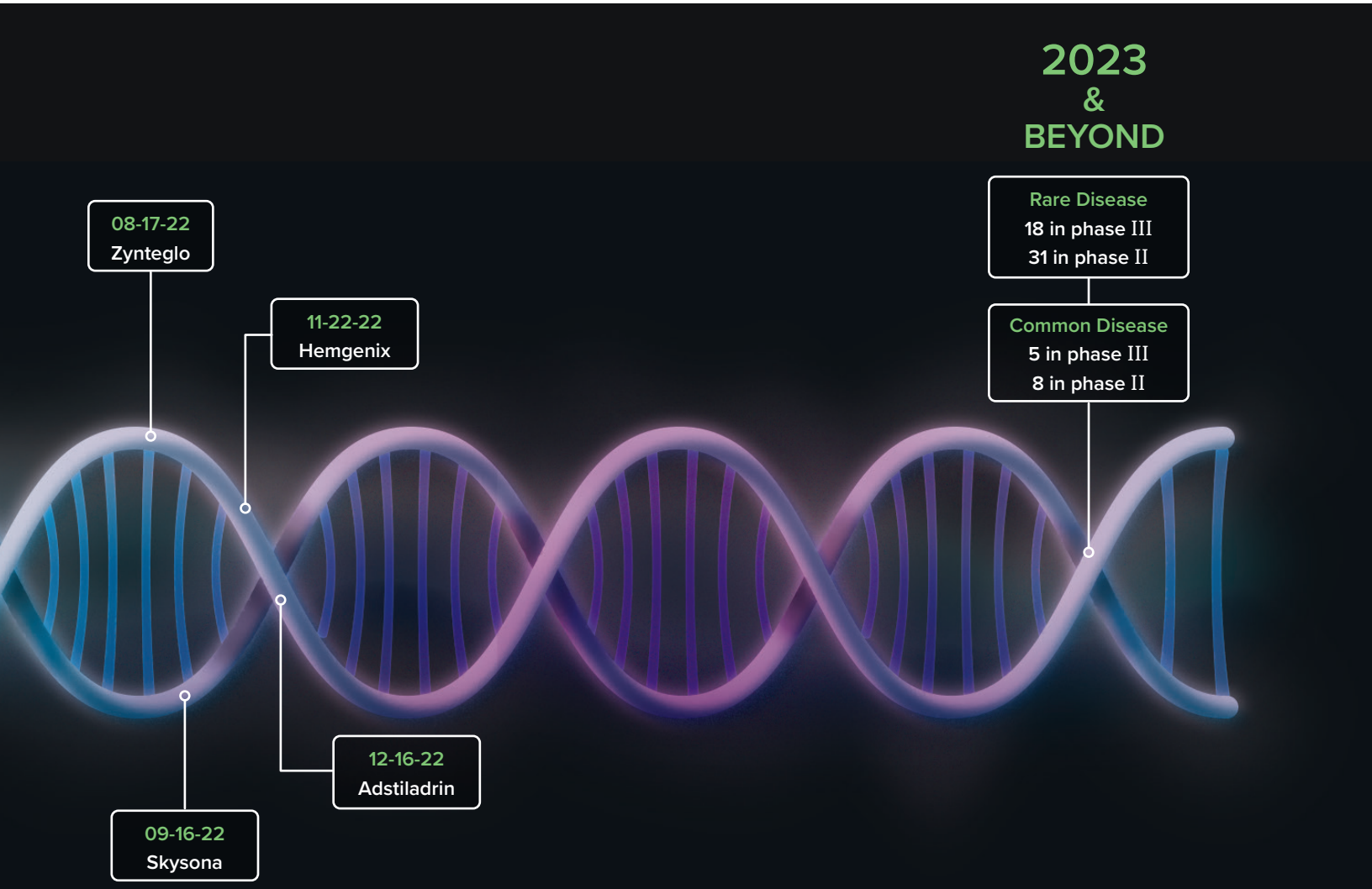
The Gene Therapy Pipeline FIGURE 4

Due to the high price tag of these therapies, there are several reimbursement models companies are offering to provide quality access for patients.

1. **Outcomes-based reimbursement**
   Outcomes-based reimbursement models can be utilized when payors select one, upfront, lump sum payment. A specific example of this is bluebird bio implementing an innovative strategy to support access to Zynteglo. If a patient fails to achieve and maintain transfusion independence for up to two years following treatment with Zynteglo, bluebird bio will reimburse the payors up to 80% of the cost of the therapy.[8]

2. **Warranty model**
   The warranty model guarantees the effectiveness of the therapy to the payor for a specific time period. It outlines what health care costs should not occur when the patient is receiving the gene therapy. When the patient incurs a cost listed in the warranty, the payor receives reimbursement for the incurred cost.[9]

3. **Financial bonds**
   A financial bond is a risk-sharing arrangement between the payor and the manufacturer which allows the payor to make payments for therapy at the end of the treatment. However, the payor must pay interest for the treatment until the bond expires. The clinical outcome of the treatment can be part of the bond. For instance, when the patient is not responsive to the therapy, the whole bond could be lost or the payor could pay partially.



The pharmaceutical industry is constantly innovating, which also requires payors and manufacturers to innovate to determine how these exceedingly expensive therapies will be paid for. Excluding coverage of these gene therapies is a very restrictive policy that some employers may explore, but this would prevent access to these potentially life-saving therapies and leave patients to spend plan dollars on less effective care.

One way employers can protect their organizations from these expensive therapies is with stop-loss insurance. This type of insurance is utilized to manage costs associated with large claims where the risk is transferred to a reinsurer. Outside of stop loss, there are other products that protect employers from high-cost claims associated with gene therapy.

- Embarc benefit protection was launched in 2019 by Cigna and currently covers Zolgensma and Luxturna. This program is a full carve out of a per member per month (PMPM) cost requiring prior authorization approval with no member cost share.
- In 2022, UnitedHealthcare launched Optum Gene Therapy Risk Protection which also covers Zolgensma and Luxturna. This program is different in that, it requires a deductible to be met before payment of the two covered options. This program is also a full PMPM carve out and includes utilization management and prior authorization criteria.
- Lastly, CVS Caremark and Aetna have their own program referred to as the GCIT Designated Network which stands for Gene-based, Cellular and Other Innovative Therapies network. This network consists of 75 designated providers that manage how these therapies are administered and sourced. This model is a hybrid design of Aetna's stop loss and CVS's payment plan type.

The three products listed previously are examples of programs created by major players in the health plan and pharmacy benefits space. Quite a few start-up companies have popped up to address the risk issue for small employers, but the details on these vendors are still too new to share at this time.

Clinical Recommendations for Employers Health Clients

While there is a lot to unpack when it comes to this topic, approved gene therapies must be administered by healthcare professionals in highly controlled environments. Thus, the products should be exclusively covered under the medical benefit. Most of the approved gene therapies are indicated for extremely rare diseases, but the good news is, they can be very effective, especially when compared to the current treatment options. Our recommendation is to understand your risk based on your population demographics and seek vendors that have developed risk-mitigating programs, so you can have a strategy and peace of mind if a costly gene therapy claim hits your plan.

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TO LEARN MORE CONTACT

the Employers Health Clinical Team
clinical@employershealthco.com

Noteworthy News

Madison Evans, senior vice president, regulatory compliance and external affairs, and Brett Pinson, client solutions executive, are serving as co-chairs of the United Way's Young Leader Society which works to educate, engage and inspire young students across Greater Stark County.

Client solutions team members Jay Withee and Matt Esterle obtained their MBAs with a concentration in management from Walsh University.

Madison Simmons, client solutions executive, recently joined the Central Ohio CEBS chapter's board of directors and the Columbus Young Professionals organization.

Client Solutions Specialist Alex Pantelas was appointed to the board of directors at the Serving Area Military (SAM) Center.

Taylor Conner, client solutions executive, recently began her second three-year term on the United Way of Greater Stark County's Community Impact Council.

Marketing director Emily Clevenger is serving a two-year term as chair of the Pro Football Hall of Fame Enshrinement Festival's Fashion Show Luncheon, one of the festival's inaugural events.

Client executives Nick Shatrich, Nick Smith and Matt Esterle joined the Pro Football Hall of Fame Enshrinement Festival Communications Committee.

Emma Grantier, sales and marketing operations specialist, graduated from the Leadership Stark County Spotlight program for young professionals and Emily Clevenger, director, marketing, graduated from the organization's Signature Program.

Jack Sullivan, actuarial and data analytics specialist, received his Associate of the Society of Actuaries (ASA) from the Society of Actuaries.

Accounting Manager Chad Sinkovich was recently elected to serve as the board treasurer for TomTod Ideas, a youth development nonprofit that listens to, honors and advocates for middle schoolers.

Events and Marketing Operations Specialist Rachelle Bruss is serving as race director for the 2nd annual #StrongLikeJ 5K, a fundraiser for the 33 JordynStrong Foundation which works to give hope and help to teens and their families after a cancer diagnosis. Rachelle has been involved with the organization since it's founding in 2018, previously serving as a board member and race committee member.

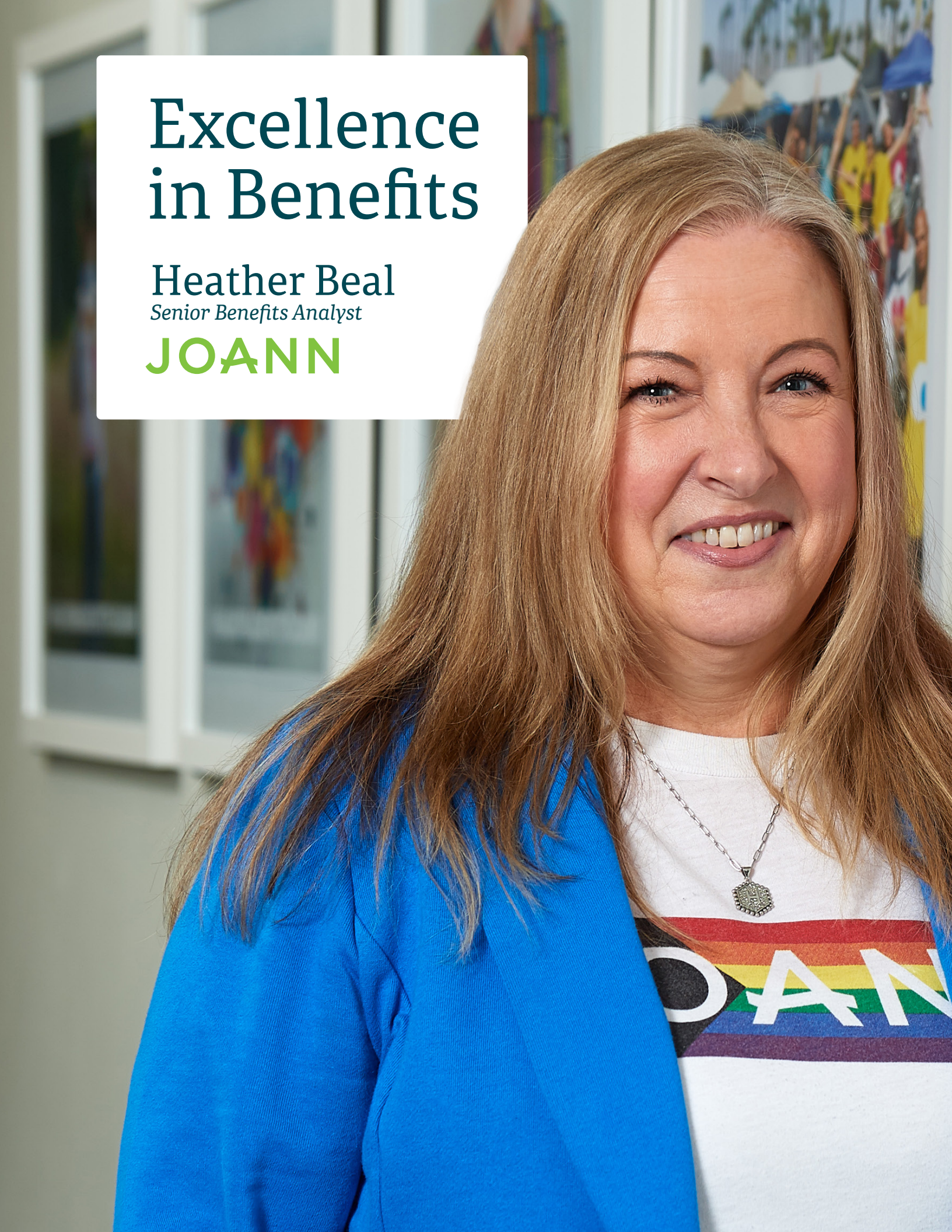
Business Development Executive Grant Goff presented to a group of high school students on the importance of LinkedIn as part of the C.A.M.P. Program, a non-profit dedicated to preparing high school students for success in their careers. CFO, Steve Burger was also appointed to the organization's operating committee.

Excellence in Benefits

Heather Beal

Senior Benefits Analyst

JOANN



JOANN is publicly traded and is the nation's leader in sewing and fabrics, employing over 22,000 full and part-time employees throughout 850 stores in 49 states. In a time when talent attraction and retention are more important and challenging than ever, Senior Benefits Analyst, Heather Beal, has worked to amplify the retail chain's benefits team. Her work has resulted in process improvement projects saving the organization hundreds of hours.

In 2021, the organization was able to keep employee premiums flat due to her hard work and diligence. **Read on to see the 2022 Excellence in Benefits Award Winner's keys to excellence.**

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

I've been in benefits for five and a half years. Nine years ago, after about 20 years in retail, I started with JOANN in team member relations and leave of absence before moving over to benefits.

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

To me, success means happy customers, whether external or internal. Providing the best benefit offerings results in the best outcomes for all of our team members. Better health outcomes for JOANN team members ultimately contribute to our success as a company.

Your Excellence in Benefits nomination frequently referenced your ability to make connections and get all parties working together. Why is this so important to you and how do you feel it contributes to your team's accomplishments?

This is important because you always achieve better results when working as a team. Everyone has a part in the greater whole and can bring their unique strengths and different perspectives to the table for the best possible outcome. I would not have achieved the success I have on my own.

You lead the company's annual open enrollment process. Can you share your tips for success for other benefits professionals?

It starts with good planning and organization skills with a solid plan for communications. Our plan year starts on February 1, so we start in August by having weekly meetings with our Human Resource Information System (HRIS) partners for a December open enrollment period. It's important to make sure all the right stakeholders are at the table. This allows us to approach the components of open enrollment in more manageable sections which set us up for a very successful event each year.

How has JOANN been innovative in delivering health care benefits?

Over the last several years we have developed both short-term and long-term goals with the overall business objective of improving well-being of all our team members. Healthier and happier team members result in happy customers and ultimately, organizational success. We have also put a focus on being more strategic in choosing the right partners and offerings. When our benefits partners understand and work with our overall business goals in mind, we are more likely to achieve our goal of improving wellness for our team members.

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

I am honored to have received the Excellence in Benefits award. I am so thankful to have had a group of my peers recognize me and the work I have done. It really shows how great of a team we have.

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

Cost and communication are always a challenge. First, finding the most beneficial and affordable benefits offerings for our team members in an environment of constantly rising health care costs is becoming increasingly difficult. And, successfully communicating those benefit offerings, especially with a diverse retail workforce, will always be a struggle. It's important to lean into your vendor partners to utilize their knowledge and expertise to make the most of their costly yet valuable services. We can have an excellent benefits package, but if we can't get members to participate, we aren't achieving our goals.

What advice would you give others in your role?

Be a good listener and a team player. Remember that the benefits offerings and programs you are implementing are for the greater good of the many team members in your organization.

Real-time digital tools

support CVS Specialty® patients throughout therapy

Symptom tracking helps patients stay connected to the right level of care

90% of patients received support
after completing their survey[1]

Intelligent medication monitoring helps ensure that medication is appropriate and working as intended

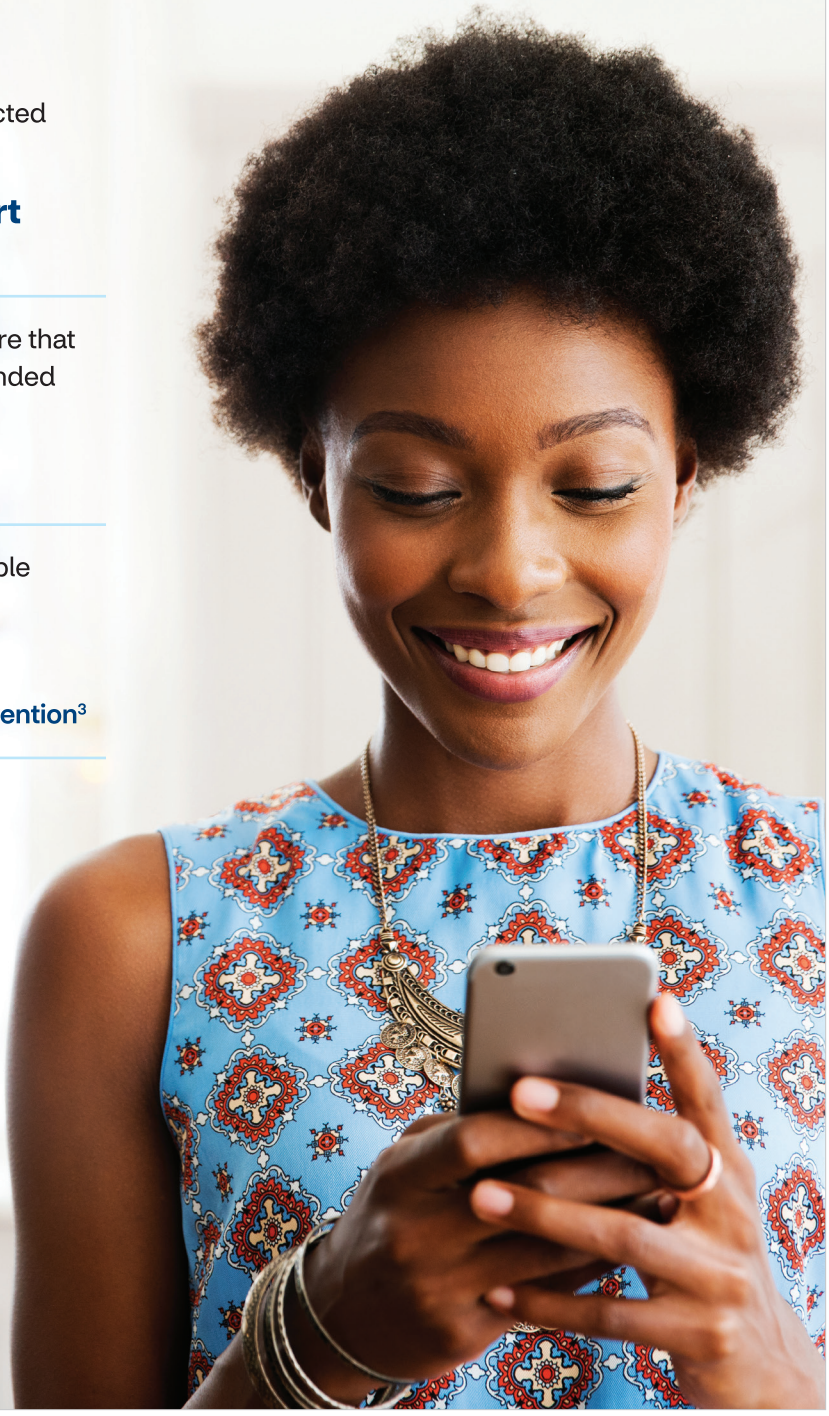
$3K savings
per successful intervention[2]

Supply management optimization helps enable timely refills to avoid excess accumulation

$2.3K in estimated savings
per targeted patient for each successful intervention[3]

Personalized reminders help patients stay adherent and on track with therapy

90% have opted in
to receiving digital communications[4]



Contact your CVS Health® account team to learn more about our digital tools and how they can help improve patient outcomes and lower your costs.

1. CVS Health, 2020. Data from August-November 2020. (P1007401220)

2. >$3,000 saved per successful intervention; CVS Specialty patients only. CVS Health Analytics, 2022. Estimated savings based on CVS Specialty data 1/1/21 – 12/31/21 representing successful intelligent medication monitoring (IMM) interventions. Actual results may vary depending on benefit plan design, member demographics, programs implemented by the plan and other factors. (P1012280622)

3. CVS Health, 2022. Estimated savings based on CVS Specialty data 1/1/21-10/31/21 representing successful supply management optimization (SMO) interventions. SMO referenced savings are specific to the following top nine specialty therapies: Rheumatoid Arthritis, Psoriasis, Inflammatory Bowel Disease, Hepatitis C, Multiple Sclerosis, Growth Hormone, Oncology, Hereditary Angioedema and Osteoporosis. As of January 4, 2022, SMO is available across most specialty therapies. (P1010051121)

4. CVS Caremark Analytics, 2021. Data from October 2021. Actively engaged defined as specialty patient with a fill in the last 30 days who logged in or responded to a 2 way short message service (SMS). (P1010071121)

CVS Health®

Employers Health™
4771 FULTON DRIVE NW
CANTON, OH 44718