Employers Health™

SUMMER 2024
A publication of Employers Health

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Maria Martin
Royal Caribbean Group

INSIDE

7 Tips for a Successful 2025 Open Enrollment

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Summer 2024

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MESSAGE FROM CHRIS GOFF

Christopher V. Goff, Esq.
President & CEO

As summer begins to slow down, it's hard to believe it will soon be fall. For those sending kids off to school shortly, best wishes for a successful school year. It's been an exciting year so far at Employers Health, with substantial growth and ongoing positive change, paving the way for more exciting opportunities.

After several years of record-setting growth, we continue to strengthen our purchasing power. To date, we've secured 31 new clients accounting for more than $352 million in pharmacy spend. To support this growth, we continue to add new resources to ensure you are receiving the support and service you expect from Employers Health.

Just 10 years ago, we had 21 team members. Today, our team has over 80 employees supporting clients across the United States and covering over 1.6 million lives. Our continued investment in human capital necessitates additional office space. Next month, some of the team will move into our new corporate headquarters, conveniently positioned next to our existing Canton office. On December 4, we will host a holiday open house at our new headquarters for clients, consultants and friends of Employers Health. Please watch for an invitation to arrive in the fall.

These positive changes would not be possible without the confidence and support of our clients and their consultants. Thank you for your ongoing trust that allows our organization and purchasing power to grow, which strengthens our ability to give back to our community. In April, Employers Health had the privilege of expressing gratitude to local educators by providing Panera Bread gift cards to 54 teachers nominated at the annual Stark County Educational Service Center awards. We were honored to support extraordinary Stark County teachers recognized for their unwavering dedication to educating and inspiring students.

Best wishes for the remainder of summer!

WELCOME TO OUR NEWEST CLIENTS

North Pocono School District

Florida Marine Transporters (FMT)

Lafayette Consolidated Government

American Bureau of Shipping Inc.

Arxada

Bath and Body Works

City Electric Supply

Globe Life & Accident Insurance Co.

OPERS and ODC

Station Casinos Inc.

The Hillman Group

Trinity Industries Inc.

Core Laboratories

Sage Hospitality Group

Ares Management Corp.

Berry Appleman & Leiden LLP

Bunzl Distribution Inc.

Ivy Rehab Network

Iconex, LLC

University of Chicago

Dallas Cowboys

Devon Energy Corporation

Do it Best Corp.

The Waldinger Corporation

Vaco Ltd.

Nelnet Inc.

Willow Bridge E.C.W. LLC

Olsson Inc.

Wayne County, Ohio

From NASH to MASH: *How the Renamed Fatty Liver Disease Will Make a Splash on Employer Trends*

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Clinical Advisor

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Matthew Harman, PharmD, MPH
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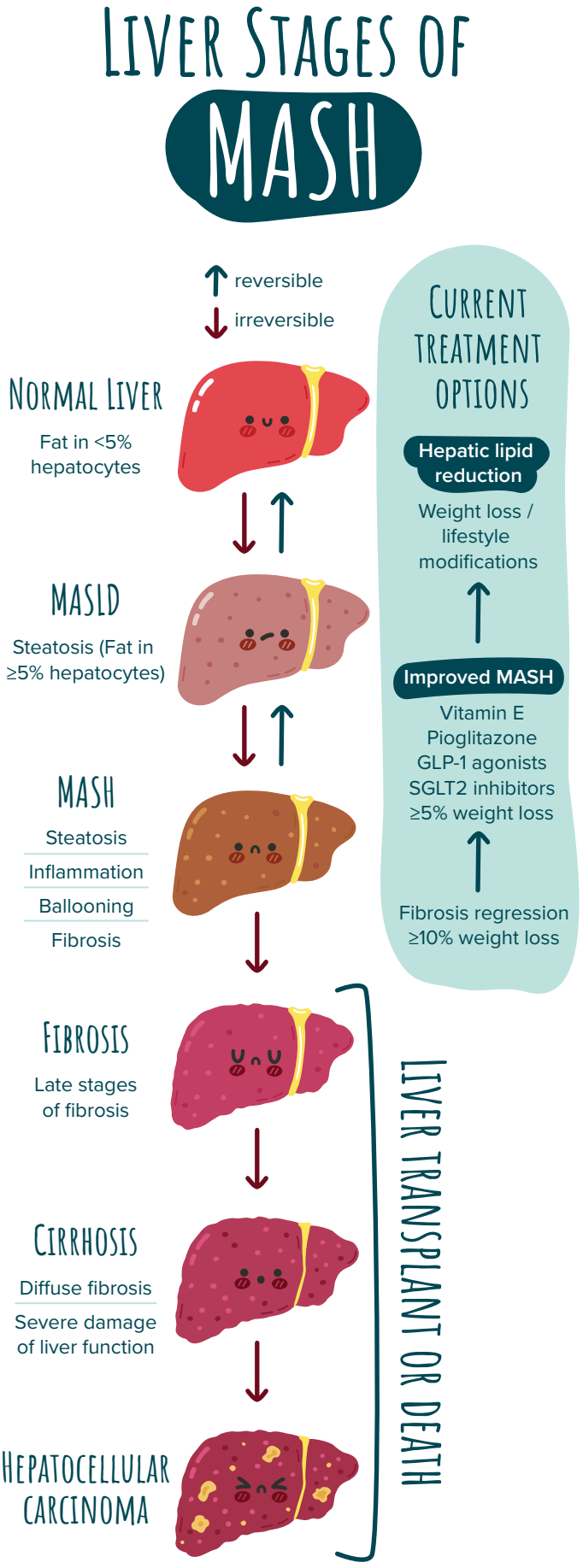
Please note: *Non-alcoholic steatohepatitis (NASH) has recently been renamed to metabolic dysfunction-associated steatohepatitis (MASH). Liver society experts, such as the American Association for the Study of Liver Diseases (AASLD), believe this new name better encompasses the condition and its causes.*

In 2018, the Employers Health clinical team published an article titled *"The Countdown to NASH: Employers Brace for the New Non-Specialty Condition,"* discussing how medications in the pipeline for the treatment of NASH, now known as MASH, were anticipated to be approved within the next few years. While not apparent at the time, it took an additional six years for the Food and Drug Administration (FDA) to approve a drug for its treatment. This article covers this condition, available treatments and the potential for management.

What is MASH?

MASH is characterized by inflammation, fat buildup and in advanced cases, fibrosis or scarring of the liver. MASH is estimated to affect between 1.5 to 6.5% of U.S. adults.

Nicknamed "the silent disease," patients typically present asymptomatic or with generalized symptoms. With a lack of symptoms, screening and diagnosis are difficult, leading experts to believe its prevalence may be larger than estimated. MASH is also linked to obesity, Type 2 diabetes and high cholesterol. Left untreated, MASH can progress into irreversible liver damage, known as cirrhosis, which can further progress into liver failure or cancer.



Over the years, the progression of this condition has become the biggest contributor to the rise in liver cancer and has replaced hepatitis C as the leading cause of liver transplantation. While certainly detrimental to patients, this disease is not without cost. Once this disease progresses into cirrhosis or liver cancer, annual costs to employer groups are estimated to be between $85,000 and $115,000. If a patient qualifies for a transplant costs increase further to an estimated $233,000 annually.
As MASH becomes more prevalent and researchers frantically search for a solution, multiple drugs are currently in the pipeline today.

How is MASH treated?

While AASLD guidelines recommend weight loss as the first strategy to reduce liver inflammation and fibrosis, there have been few options to treat MASH with medication. The quest has been on for decades to find a drug that not only resolves MASH but also helps to reduce fibrosis. Historically, vitamin E and pioglitazone have had some success in MASH resolution, but neither medication has strong evidence for reducing fibrosis.

In March 2024, the FDA approved Rezdiffra (resmetirom) as the first drug indicated for treating MASH. In clinical trials, depending on the dose, Rezdiffra was shown to improve fibrosis in 24.2 to 25.9% of participants compared to 14.2% of participants on a placebo.

Rezdiffra treatment resulted in MASH resolution in 25.9 to 29.9% of participants (depending on dose) compared to 9% of participants on a placebo. While Rezdiffra may have modest clinical effects, it is the first and only medication to succeed in reducing MASH activity and improving fibrosis.

Looking at the MASH pipeline, it may come as no surprise that GLP-1 medications could play a role in treatment, considering the relation of obesity and diabetes to MASH. Ongoing studies with semaglutide and tirzepatide are being conducted for the treatment of MASH as both combination therapy and monotherapy. Currently, the data are showing promising results in helping to reduce liver inflammation; however, like most medications used for MASH, there is little evidence to show a reduction in fibrosis.

MASH Pipeline

Product Name	Route	Drug Class	Manufacturer	Status	Estimated Approval
Wegovy (semaglutide)		GLP-1	Novo Nordisk	Phase III	2025
Lanifibranor		PPAR agonist	Inventiva	Phase III	2026
Aramchol		SCD1 inhibitor	Galmed Pharmaceuticals	Phase III	2027
Belapectin	IV	Galectin inhibitor	Galectin Therapeutics	Phase III	2025
Azemiglitazone		Thiazolidinedione	Cirius Therapeutics	Phase III	2025
Efruxifermin		Fibroblast growth factor mimetic	Akero Therapeutics	Phase III	2027

GLP-1: glucagon-like peptide 1; IV: intravenous; PPAR: peroxisome proliferator-activated receptor; SCD1: stearoyl-CoA desaturase 1

27 agents in Phase II

How might MASH be managed?

With Rezdiffra pricing at $47,400 per year combined with a robust MASH pipeline, it is imperative to begin considering how it will be managed going forward. As of April 2024, Rezdiffra remains on the new-to-market (NTM) block. Since it's the only approved product for this condition, management strategies to ensure proper use of Rezdiffra once it comes off NTM block are essential. Prior authorization criteria should require Rezdiffra to be prescribed by or in consultation with a gastroenterologist or hepatologist, with the prescriber being required to provide documentation of stage F2 to F3 fibrosis before treatment. These measures will ensure the appropriate patient populations are receiving necessary therapy and help reduce costs associated with inappropriate utilization.

Due to the high prevalence of MASH, employers should ask their medical carriers about the potential exposure to this condition. The ICD-10 code for the precursor to MASH is K76.0, known as metabolic dysfunction-associated steatotic liver disease (MASLD) and has an estimated prevalence of 32% of the U.S. population. The ICD-10 code for MASH is K75.81. Of those with MASH, about one-third of patients will be in the F2 and F3 fibrosis stages, the current target for prescription treatment.

Employers Health is here for you

As the treatment landscape for MASH matures, the Employers Health clinical team will continue to keep a close eye on clinical trials and the pipeline to ensure approved products for this indication have the appropriate utilization management strategies in place for its employer clients. When resources become available, we will be sure to keep clients updated.

TO LEARN MORE CONTACT

clinical@employershealthco.com

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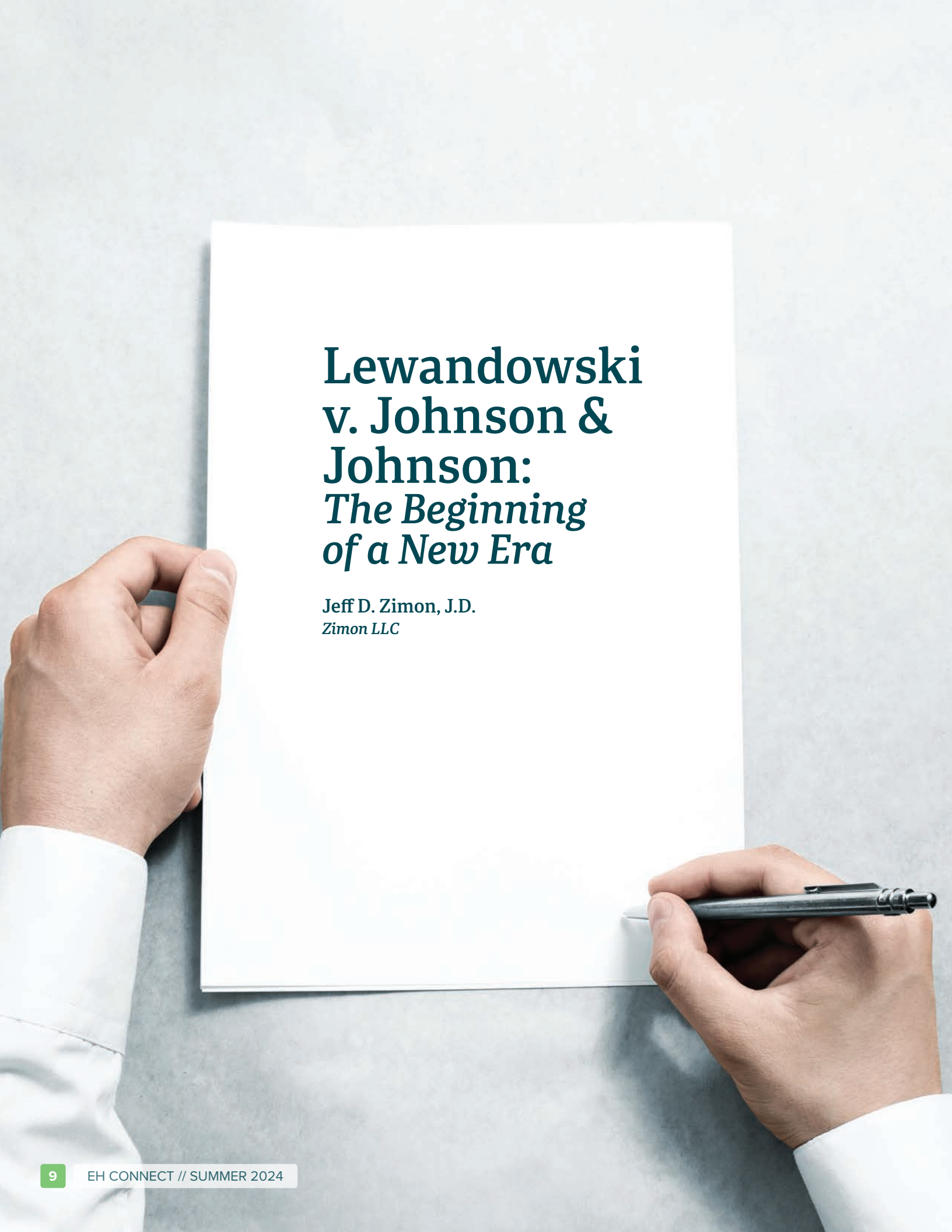

Lewandowski v. Johnson & Johnson: *The Beginning of a New Era*

Jeff D. Zimon, J.D.
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Lewandowski v. Johnson & Johnson is a game changer. Just like the 401(k) retirement plan fee cases brought on more than twenty years ago, this lawsuit has a real impact. Regardless of its outcome, the claims against Johnson & Johnson (J&J) in the proposed class action litigation brought by Ann Lewandowski have generated industry-wide focus and concerns regarding group health and prescription drug plan strategies, approaches and compliance. This lawsuit puts a spotlight on the fundamental principles of ERISA fiduciary responsibility and plan document compliance on all health and prescription drug plans.

Many important questions are being asked. Did the J&J internal fiduciary committee get it wrong? Are these claims legitimate? Would J&J allow its covered persons to pay such large amounts for drugs when lower-cost options are available? Does J&J not have a compliant prescription drug plan document and summary plan description?

Motivated by the lawsuit's claims, plan sponsors, benefits brokers, advisors and consultants are now evaluating the claims to understand the merits of the claims, the impact on health and prescription drug plans and how the claims affect their businesses. Naturally, a number of industry professionals have written commentaries on this lawsuit. Candidly, many commentators have overlooked important aspects and potential gaps in the claims. Notably, those of us with experience on both sides of the proverbial ERISA aisle, the retirement plan as well as the group benefit plan sides, immediately see the parallels of these ERISA fiduciary claims to those that continue to impact the retirement plan community. We immediately think about the nature of the allegations, how they likely will be pursued by the plaintiff and defended by the defendants.

The lawsuit basics

A study of this lawsuit, the parties and the claims begins with the basics. On February 5, 2024, Ann Lewandowski, a participant and covered person under what is described as the Group Health Benefits Plan of Johnson and Johnson and Affiliated Cos. sued J&J and an administrative committee, its individual members, including members of management, in a 75-page class action lawsuit. Plaintiff alleges various breaches of ERISA fiduciary duties best summarized at a high level as gross mismanagement of prescription drug benefits. These prescription drug benefits are provided under medical plans sponsored by J&J (the "J&J Rx plan"). Noting that J&J is also a pharmaceutical manufacturer, plaintiff alleges that mismanagement led to millions of dollars in higher payments, premiums, deductibles, co-insurance and more.

Notably, a complaint, which is the starting point of a lawsuit, has certain requirements. First, the plaintiff must have standing – or the right to bring the claim. Federal law is particular about this concept, which is derived from Article III of the U.S. Constitution. Next, if there is standing, the plaintiff must satisfy something referred to as the "notice pleading rules." The lawsuit does not have to contain every single assertion of fact or every allegation or point of proof. It must be sufficient to raise facts that demonstrate some type of violation of law, and under federal constitutional requirements, it must have resulted in some harm or damage. In response to the lawsuit, the J&J defendants must file an answer or they can move to dismiss the case in its entirety.

Unpacking the allegations is no simple task. And we will not address every claim in detail. To start, we will provide an overview of the claims. In general, the lawsuit claims assert that J&J, through its committee and individuals as ERISA fiduciaries, failed to:

- **Exercise required fiduciary prudence before selecting a pharmacy benefit manager (PBM).**
- **Exercise required fiduciary prudence in agreeing to make its ERISA plans and beneficiaries pay unreasonable prices for prescription drugs.**
- **Exercise required fiduciary prudence in agreeing to contract terms with its PBM that needlessly allows the PBM to enrich itself at the expense of the company's ERISA plans and their beneficiaries (including the failure to monitor the drug formularies, supervise conflicted third parties or to conduct an adequate review).**
- **Properly carve out their specialty drug program from their broader contract with the PBM.**
- **Protect plan assets and beneficiaries' interests (by failing to steer beneficiaries to lower cost options).**
- **Actively manage and oversee key aspects of the company's prescription drug program.**
- **Provide the ERISA required plan document and summary plan description upon request.**

No plan document/summary plan description?

A critical error would be to trivialize the allegation that J&J failed to produce the ERISA required Plan Document and Summary Plan Description (SPD). A properly constructed plan document/SPD is not only legally required but essential to the overall operation, management and delivery of prescription drug benefits. Besides, a clear claims procedure might have allowed the defendants to address certain claims before the lawsuit in an administrative process. The commonly provided prescription drug schedules of benefits, related flyers and hand-outs just don't cut it, especially when plan design calls for the management of prescription drug use and costs. Properly tuned documentation creates the rules to manage the various aspects of solid prescription drug benefit designs and includes formulary designations, step therapies, drug exclusions, specialty protocols, other exclusions and restrictions, carve-outs, potential patient advocacy and alternative funding, networks, supply rules, generic drug access and more.

Is it true that J&J does not have a plan document/SPD for the J&J Rx plan? Perhaps, but not likely. But, even if it does, the failure to produce such documents comes with a potential penalty of up to $110 per day per violation. If plaintiffs can generate multiple unmet requests on this point, with more than 130,000 employees, that theoretically adds up.

It is possible that J&J does not and did not have a full or complete plan document/SPD and that J&J used inadequate hand-out types of documentation. Why? Unlike group health insurers, PBMs have just not been in the plan document business. This is a huge gap in the industry that is potentially exposed by this lawsuit.

There are virtually no third-party resources for self-funded plans to obtain a separate prescription drug plan document/SPD, except for ERISA lawyers, which can be an expensive, but capable resource and EZ ERISA, at ezerisaplan.com, an existing compliance website that fortuitously launched a complete DocSmart Rx product last summer. (For full disclosure, this author created this compliance resource website some 10 years ago).

If J&J does not actually have a fully compliant plan document/SPD, everything that J&J would like to enforce and manage regarding the J&J Rx plan is subject to challenge and may be completely unenforceable.

So, it is important if you use a separate PBM for your prescription drug plan to make sure you have a fully compliant, complete prescription drug benefit plan document and SPD.

What is missing in the fiduciary claims?

Questions arise from the lawsuit that compel consideration of the ERISA fiduciary roles and responsibilities. How is the selection of a PBM an ERISA fiduciary function? Are all acts by the J&J Committee and its members subject to the ERISA fiduciary standards? Are actions by the PBM subject to the ERISA fiduciary rules? These questions are critically important in the evaluation of the claims, and in our learning about what we do to ensure that in the group health and prescription drug benefit space, we are complying with the ERISA standards.

Importantly, there seem to be concepts relating to an ERISA fiduciary relationship and fiduciary functions not stated concisely in the lawsuit. Critically important to the plaintiff's claims regarding the selection of its PBM, Express Scripts, is that the selection of an ERISA fiduciary is a fiduciary process. This raises the question as to whether Express Scripts is a fiduciary relative to the prescription drug benefit plan.

The threshold fact to determine fiduciary status is that Express Scripts must perform ERISA fiduciary functions for the J&J Rx plan to select Express Scripts as a fiduciary determination by the committee. This determination begins with an assessment of Express Scripts' roles and responsibilities as the PBM.

Notably, there are functions related to ERISA plans that are non-fiduciary functions that may be performed by the plan sponsor or third parties. Non-fiduciary functions include the sponsor's right to establish a plan's benefits and determine the rules and plan design for such a plan. Non-fiduciary functions also include ministerial acts. These often include basic calculations, which for prescription drug plans, include for example, the amount of a deductible or copay that applies to a prescription or determining if a particular supply line is in-network or out-of-network.

There are other functions that refer or relate to the exercise of any discretionary authority or control respecting management of such prescription drug plan, or the exercise of any authority or control over the disposition of the J&J Rx plan assets. Similar in concept to a third-party administrator that administers a self-funded group health plan, a PBM acts to administer prescription drug benefits. When a PBM has such discretionary responsibility or authority in the administration of an ERISA plan, the PBM is an ERISA fiduciary. For example, the approval of the payment of a prescription drug for a covered person is a fiduciary function. A PBM often controls and moves the plan's money to pay for a claim, which is the control over a plan asset and, again, a fiduciary function. The determination of medical necessity is generally a fiduciary function. Claims processing determinations and appeals are fiduciary functions. So, under ERISA, the selection of an ERISA fiduciary is a fiduciary function. In this case, the selection of Express Scripts as a PBM will likely be determined to be a fiduciary function, although all of the activities of Express Scripts are not fiduciary in nature.

It is repeatedly alleged that the defendants breached their fiduciary duty in the selection of Express Scripts as the PBM. Plaintiff repeatedly alleges that the PBM is in conflict and engages in tactics that harm the participants and that are designed to enrich the PBM. Specifically, plaintiff alleges that, "Defendants failed to engage in a prudent and reasoned decision-making process before agreeing to a PBM contract that requires the plans and their beneficiaries to pay Express Scripts … prices."

Caution is warranted because not all of the activities regarding the J&J Rx plan design or the conduct of the PBM are within the scope of fiduciary duties. The broad allegations about the pricing structures and a failure to use bargaining power and consider other strategies for the delivery of prescription drug benefits require a separate evaluation as to whether they are fiduciary functions. But, for this purpose, the threshold is met. The selection of Express Scripts is a fiduciary decision, to the extent that Express Scripts is providing fiduciary services.

There is learning from the alleged wrongdoing in this regard. We can consider how group benefits brokers, consultants and advisors evaluate prescription drug managers, PBMs and others. We can evaluate how we focus that effort to not only serve to meet the ERISA required functions, but also to build and maintain ERISA prescription drug plans that work for our participants and manage and control cost reasonably.

In many cases, unlike what is alleged in the lawsuit, group insurance brokers are looking to alternative methods and functions. The lawsuit alleges a failure to negotiate contracts. Contract negotiation and market evaluations are commonly done by many brokers and consultants. Buying power based upon a group insurance broker's customer base or the employ of group purchasing organizations are examples of how brokers employ buying power in negotiations. Assessment and evaluation of the deliverables, including drug categories, the application of formularies and related strategies, clinical evaluation of utilization, the consideration of other resources, bolt-on providers and other alternative providers is done by group insurance brokers as part of their work to assist employers in the efforts to deliver prescription drug benefits. Time will tell what J&J did here.

Fundamentally, ERISA fiduciary rules are not about the answer. The fiduciary standards also do not require that participants be offered or given the lowest-priced product or services. The standard mandates a process whereby the fiduciary engages in prudence and diligence, under the circumstances then prevailing to evaluate the role of a PBM fiduciary, as others would in the exercise of such a determination. So, many of the suggestions of alternatives made in the lawsuit might have been appropriate for consideration. But there is no fiduciary mandate in this regard. That said, if it can be shown that after a reasonable, prudent and diligent process, Express Scripts was still selected, then the fiduciary standards may have been satisfied. Of course, the opposite is also true. If a PBM was selected based upon a haphazard, limited or deficient process, then, the consequences that flow from such a potential failure expose the selecting fiduciaries to liability.

It will be very interesting to see what facts are demonstrated regarding the process and evaluations conducted by Aon, the broker for the J&J Rx plan. In the meantime, many brokers and consultants continue to diligently evaluate plans and programs of benefits, access buying power when appropriate, negotiate over pricing, services and availability and work to achieve the goals and objectives of the employer client appropriate for such circumstances. As such, many group benefits brokers are already assisting their clients in fulfilling their fiduciary responsibility relative to the selection of a PBM fiduciary for the delivery of group prescription drug benefits and, of course, a compliant prescription drug benefit plan document/SPD.

Author, Jeff Zimon, J.D. is an ERISA attorney with more than 30 years of experience. Jeff is the founder of Zimon LLC, a boutique ERISA and employee benefits law firm and is also the creator and founder of an industry-leading group benefits compliance resource, EZ ERISAPlan - ezerisaplan.com.

Noteworthy News

Employers Health CEO and President Chris Goff received the Good Scout Award from the Boy Scouts of America Buckeye Council. The Good Scout Award is given to community leaders for their impact within the community through their business and service.

Garrett Brown was recognized as part of the Canton Regional Chamber of Commerce's and The Canton Repository's 17th Annual 'Twenty under 40' class. The Twenty under 40! awards recognize Stark County leaders who have demonstrated dynamic social responsibility, are dedicated to the Stark County community and create a lasting impact.

Emily Clevenger, vice president, marketing and communications, joined the Greater Stark County Urban League's board of directors.

Client Solutions Specialist Nick Shatrich, joined the C.A.M.P. (Career Apprenticeship and Mentorship Program) advisory committee. C.A.M.P. is a nonprofit dedicated to preparing high school students for success in college and their careers.

Hannah Whitesel, clinical advisor recently became president of the Ohio-Kentucky Academy of Managed Care Pharmacy affiliate.

Travis Johns, vice president, client solutions and Nick Smith, client solutions specialist are serving as co-chairs of the National Alliance on Mental Illness (NAMI) Stark County's 6th Annual Golf Outing raising funds for those impacted by mental illness.

Client solutions executive Brooke Knollman recently joined the Butterfly of Hope Foundation board of directors, a nonprofit focused on preventing suicide by offering financial support to organizations providing education, resources and programs aimed at suicide prevention.

Chad Sinkovich, accounting manager received his MBA from Youngstown State University and joined the board of Canton for All People, an organization dedicated to improving the quality of life for the residents of downtown Canton.

Client solutions specialists Nick Smith, Alex Pantelas, Nick Shatrich and Regional Vice President, Business Development, Mike Buddenberg received their MBAs from Fitchburg State University.

Carrie Clemens, United Way, and Garrett Brown

General Counsel, Garrett Brown, was recognized by the United Way of Greater Stark County as the 2024 DeHoff Emerging Philanthropist Award recipient. The DeHoff Emerging Philanthropist Award was established in 2010 by Bob and Linda DeHoff to recognize a Stark County resident aged 45 and under who impacts Stark County through direct service and volunteer work.

Employers Health™

Save the Date

Women's Health and Wellness Forum

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Columbus, Ohio

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7 Tips for a Successful 2025 Open Enrollment

Open enrollment season is upon us! We know it can be a stressful time that requires a lot of planning and collaboration across teams. To help your benefits team ensure a successful open enrollment, we are giving you seven easy-to-follow tips.

1 Get Creative

Who said open enrollment has to be a drab process for your HR and benefits teams? In today's digital age, explore new ways to engage employees. Use prizes as incentives for registration or hold virtual information sessions with interesting topics to pull folks in. If you have a consulting team, lean into its creative resources and marketing intel to understand what has worked for other clients and their plan participants.

2 Be Proactive

Try to get ahead by establishing a timeline for open enrollment well in advance. Start by working backward from important milestones. Develop a list of key deliverables and deadlines. Once you have an outline of what open enrollment will look like in 2025, communicate your goals and timeframe to your vendor partners. This way, there is plenty of time for vendors to code and test plan changes, communicate information on new programs and send marketing materials or giveaways your way.

3 Communicate Effectively

You are busy and your employees are too. With a process like open enrollment, it can sometimes be hard to strike a balance between getting plan participants the information they need while not overwhelming them. If possible, work with your internal marketing team to develop a communications strategy that calls out the most important information and dates. Be sure to keep it clear and concise and engage with employees where they are – whether that be via email, hard copy, posters, etc.

4 Educate

Education is especially crucial for companies with younger populations. Familiar jargon and acronyms you and your HR team throw around every day, like "deductible," "OOP," "PPO," etc., can be foreign to new employees who may not have participated in open enrollment before. Define important terms and use them in real-world examples to equip your members with the knowledge they need for this year's open enrollment and beyond.

5 Time

Communicate the upcoming open enrollment timeframe to associates so they can plan accordingly and give plenty of time to make informed choices. Don't be afraid to send multiple email reminders or make company-wide calendar events with important due dates. It is good practice to have a solidified open and close period followed by a silent window for about a week after close in case employees take longer than anticipated.

6 Keep Your Door Open

Even with the most effective communications, there will always be questions from plan members. Keep an open-door policy and make sure you and your team are easy to reach for optimal open enrollment success. With workforces split between home and the office, it is important to have a streamlined process for answering questions. Virtual and in-person Q&A sessions and a thorough FAQ document posted on a company intranet are good ways to help your benefits team and associates.

7 Compliance

Above all, compliance needs to be at the forefront of open enrollment to protect your company and provide all the necessary information to the appropriate members. From plan changes to HIPAA, ERISA and COBRA, make sure that all your communications and strategies are legally sound.

Utilize the help of the team at Employers Health, your other vendors, internal team members and the tips above to ensure a successful open enrollment season. While detailed, it does not have to be a daunting task. And remember, even though it can be stressful, do your best to keep it fun!

Client Spotlight

Interview with Maria Martin

Director Global Benefits, Total Rewards
Royal Caribbean Group

Royal Caribbean Group

Royal Caribbean Group is a global cruise company headquartered in Miami, Florida, employing nearly 100,000 team members from more than 130 countries. With five cruise lines, Royal Caribbean Group operates the leading brands and innovates ship design to create some of the most remarkable ships in the world. Its mission to deliver the best vacation experiences responsibly provides the ultimate vacation experiences to millions of travelers each year.

Earlier this year, Maria Martin, Director Global Benefits, Total Rewards at Royal Caribbean received the Employers Health Excellence in Benefits Award. This award is presented annually to recognize individuals who have made a meaningful impact in the field and delivery of employee benefits. Maria has been instrumental in the organization's recognition as one of the Top 100 Healthiest Companies in the U.S. and spearheaded cost-saving initiatives that have ensured employees have access to affordable medications. Continue reading to learn more about Martin and how she embodies "Excellence in Benefits."

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

I have worked as a benefits professional for over 40 years, starting at an electronics company. Throughout my entire career, I have worked in insurance and joined the Royal Caribbean Group team in 1999 as the Director of Global Benefits and Recognition. I'm incredibly proud of the work I have done and the role I play in the benefits industry and cannot imagine doing anything else.

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

Success, to me, means offering top-quality benefits at an excellent value for both employees and the employer. It's about striking a balance between cost containment for the employer without compromising great care for employees. Providing great benefits at a great price with unique value helps to attract and retain employees, leading to success for the entire organization.

What are some qualities you believe make a great benefits professional?

Employee benefits are among the biggest expenses for most employers. To be successful in the benefits industry, you must have business acumen and be compassionate and empathetic toward others. You need to be passionate about ensuring others receive care and live healthier while being open to the different wants, needs and costs your population faces. Along with compassion, staying up to date on benefit trends and legislation and being able to adapt when changes are necessary is essential for every benefits professional to succeed at any organization.

The nomination stated that you always have your door open, what do you feel employees gain from having a boss who maintains a true open-door policy?

When managing others, it is important to lead with heart. Trust is a two-way street; employees need to know their boss is someone they can trust whenever, wherever. Being accessible to employees ensures that everyone feels seen and heard, ultimately benefiting the entire team.

How has Royal Caribbean Group been innovative in delivering health care benefits?

Our team's goal is to ensure every employee understands their benefits and feels comfortable asking for help. As a result, our benefits approach is rooted in evolving with the times to provide different communication channels. We host benefit awareness campaigns, annual wellness and vendor fairs and have an on-site clinic that corporate employees and their families can access to ensure our population receives the care and resources needed to live healthier lives.

We have maintained competitive benefits that exceed industry norms while keeping costs and expenses contained through our long-standing relationships with vendors. Thanks to Employers Health and CVS, we have seen a significant reduction in pharmacy claims. We're proud to work with organizations that share our mission in reducing health care costs for employees.

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

There is so much I am proud of, but Royal Caribbean Group's consistent recognition as one of the Top 100 Healthiest Companies in the U.S. is one of my proudest achievements. In 2023, we ranked 15th, which reminded us that we really are doing everything necessary for our employees to access a healthier lifestyle.

Being recognized as the 2024 Excellence in Benefits recipient is something I will always hold close as well. Knowing that my colleagues took the time to nominate me and share such kind remarks about our work and my leadership style means a lot to me. While recognition is great, I hope people will remember my career and say that I have a big heart for employees and was always able and willing to support them when needed. That is what matters the most.

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

As employers, we are trusted to provide employees and their families with exceptional health care, which comes with various challenges that all benefits professionals face. It can be difficult to control costs without compromising care, but in our roles, we must advocate for both sides to stay competitive. Balancing rising costs for the employer and the employee will always be our greatest challenge.

What is some of the best advice you have received in your career? What advice would you give to other benefits professionals?

Some of the best advice I have received and can give is to follow the three C's; be confident in yourself, open to change, and ask for clarity when needed. And always remember to give a smile – you never know what someone is going through, and it can make a world of a difference in someone's day.

Have a story to share?
Contact us at
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Maria Martin and Employers Health President and CEO, Chris Goff

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