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Spring 2025

MESSAGE
FROM CHRIS GOFF

Christopher V. Goff, Esq.
Chairman, President & CEO

Spring is here and before we know it, it will be summer. Soon, we'll be halfway into the plan year. We understand this can be a busy time of year, where you'll be evaluating new vendors, addressing plan design changes and reviewing contracts.

Please remember, the Employers Health team is here to help make your pharmacy benefit management (PBM) experience better. We are always eager to support your team and guide you in the complicated health benefits industry. To further our commitment to helping employers maximize the value of their pharmacy benefit plans, Employers Health is proud to share that we are adding a third PBM option, MedImpact.

Employers Health believes that there is no one-size-fits-all approach to pharmacy benefits; that's why we continue to explore new opportunities to bring added value to our clients and their participants. An innovative mid-market PBM, MedImpact offers clients more flexibility in designing their pharmacy benefit while maintaining competitive pricing guarantees. MedImpact will be available for new clients with a July 1, 2025 plan start date and beyond. We are grateful for this new relationship and the outcomes and experiences it will bring for plans and plan participants. Please do not hesitate to reach out to your client solutions representative with any questions regarding this new offering.

To build on this exciting momentum, our team is preparing for the in-person Annual Benefits Forum April 22 and 23 in Columbus, Ohio. This highly anticipated event will feature seasoned pharmacy consultants, benefits professionals and clinical management specialists covering the latest in employee and pharmacy benefit trends. If you are unable to attend, all sessions will be recorded and made available as webinars at a later time. A complete schedule of webinar dates can be found on page 11.

Best wishes for a great spring.

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Fiduciary Duties Under ERISA:
What Plan Sponsors Should Know

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

Recent health plan fee litigation has shed light on the importance of understanding what it means to be a fiduciary and how plan sponsors can fulfill their fiduciary obligations to group health plans. The primary cases, Lewandowski v. Johnson & Johnson and Navarro v. Wells Fargo et. al., are both employee-initiated challenges, alleging their employers' mismanagement of prescription drug plans. The lawsuits argue that the employers breached their fiduciary duties by paying inflated costs for certain generic specialty medications, which may have resulted in increased costs for plan participants and beneficiaries.

While these cases vary in terms of specific facts and the ultimate legal outcomes remain uncertain, they serve as a valuable reminder for plan sponsors to review their plan governance procedures and ensure appropriate plan administration.

The Employee Retirement Income Security Act (ERISA) sets basic standards of conduct for those who manage employee benefit plans and plan assets. ERISA's protections apply only to private-sector group health plans. The law does not cover public sector or church-sponsored plans.

Who is an ERISA fiduciary?

AN ERISA FIDUCIARY IS AN INDIVIDUAL WHO EXERCISES DISCRETIONARY AUTHORITY OVER PLAN ADMINISTRATION OR PLAN ASSETS.

Fiduciary status is based on the functions actually performed for the plan, not just a person's job title or assigned duties. Plan fiduciaries may include the "named fiduciary" in the plan document, plan administrators, trustees and the benefits selection committee.

Fiduciaries can hire third-party service providers to handle certain fiduciary functions. Contractual agreements allow providers to assume limited liability for the selected fiduciary function. For example, it is common for pharmacy benefit managers (PBMs) to accept limited fiduciary responsibility for the purpose of adjudicating claims and processing appeals for prescription drug benefit plans.

What duties are owed to plan participants?

ERISA imposes specific duties of fiduciaries that are owed to plan participants and beneficiaries. When making decisions, ERISA fiduciaries are required to act with:

- **Loyalty** – must act solely in the interest of plan participants and their beneficiaries
- **Prudence** – must carry out their duties with the care, skill and diligence of a prudent person
- **Plan conformity** – must act in accordance with the plan's documents, unless inconsistent with ERISA
- **Reasonability** – must pay only reasonable plan expenses

THE FOUNDATION OF FIDUCIARY DUTIES UNDER ERISA IS WELL-INFORMED, SOUND DECISION MAKING.

Notedly, ERISA fiduciary responsibilities do not require that plans always choose the lowest cost option available or minimize plan expenses entirely; the fiduciary must administer the plan using reasonable decision-making processes to benefit plan participants and beneficiaries. There are many unique considerations that each plan sponsor may consider when designing and administering a benefits plan in furtherance of plan participants' and beneficiaries' best interests.

It is important to note that some actions undertaken by plan fiduciaries are not fiduciary decisions. Settlor functions are decisions that relate to the formation, design or termination of ERISA plans. These types of decisions include changing employee contribution levels or eligibility rules, amending a plan or changing plan design and terminating all or part of a plan. This is an important distinction because many benefits professionals are confronted with the dual role of carrying out fiduciary responsibilities for the sole benefit of participants and beneficiaries and making business decisions about the benefits plan on behalf of the employer.

What are plan assets?

A plan's specific funding mechanism may also impact how the funds are treated under ERISA. Some health benefit plans are funded via a voluntary employees' beneficiary association (VEBA), a tax-exempt trust established by the employer to pay for employee benefits like health care. Assets in a VEBA trust are plan assets, whereas, when plan benefits are paid entirely from an employer's general assets, those amounts are not plan assets. This may prove to be an important distinction in current and future litigation.

Health plan fiduciary tips

To help fulfill fiduciary responsibilities and demonstrate an effective decision-making process, consider these best practices when managing your plan.

- Develop a sound process for selection and regular evaluation of vendors and plan service providers
- Engage an independent consultant
- Document the vendor selection process
- Engage in ongoing monitoring of plan service providers
- Analyze plan costs and seek to understand any impact on plan participants.
- Ensure required plan documents are complete, readily available and comply with ERISA's requirements
- Develop a compliance plan to keep track of required reporting and disclosure requirements
- Provide new and continuing education and training for decision makers and benefits administrators to help them understand the scope of fiduciary duties
- Keep records of meetings where plan decisions were made and include the rationale for those decisions
- Maintain a file that documents any other steps taken to meet fiduciary duties

Employers Health will continue to monitor changes in these health care fee litigation cases and update our library of resources accordingly. Regardless of any substantive legal developments, employers should continue to prioritize plan governance and engage in prudent decision-making processes.

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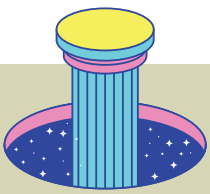

Employers Health 2024 Pharmacy Report:
Trends, Costs and Strategies

Catherine Berger, PharmD
Clinical Advisor

Ha Eun Kim, PharmD
Clinical Advisor

2024 in review

Within the pharmaceutical industry, 2024 key trends continued to gain momentum and exciting new developments continued to reshape the prescription drug landscape. It marked the growth of glucagon-like peptide-1 receptor agonists (GLP-1s) for both diabetes and weight management, while the launch of Humira biosimilars helped offset some of these costs across the market. Specialty products also continued to be a main contributor to the overall growth in spend with a 9% increase in gross cost among our book of business from 2023 to 2024. To help employers better understand the dynamic nature of managed care pharmacy, we're addressing how emerging pharmacy trends impacted our book of business and the clinical utilization management opportunities implemented by our team to help reduce costs for employers.

GLP-1s continued to grow in popularity

Ranked by total gross cost, three of the top five drugs in the Employers Health book of business include the GLP-1 medications, Ozempic (semaglutide), Mounjaro (tirzepatide) and Wegovy (semaglutide). In 2023, GLP-1s for both diabetes and weight loss accounted for 13.7% of total gross cost across the collective. In 2024, that number grew to 17.6%. Growth within this class is multifactorial, including updated guideline recommendations that now place GLP-1s as a first-line option for Type 2 diabetes, rising popularity on social media and the resolution of long-term shortages. The continuing upward trend of GLP-1 utilization has led many plan sponsors to closely examine spend management strategies within this drug class.

Most pharmacy benefit plans cover GLP-1s for the treatment of diabetes in alignment with American Diabetes Association recommendations.[1] Employers Health continues to recommend that plan sponsors utilize clinical edits such as confirming a diabetes diagnosis and/or a history of non-GLP-1 anti-diabetic medications to prevent off-label use for weight loss. Employers Health data found that by electing such edits, GLP-1 fill rates were reduced by approximately 22%, further limiting off-label use and resulting in millions of dollars in savings for plan sponsors across the book of business.

On the weight management side of GLP-1 medications, more plan sponsors under the Employers Health book of business moved to exclude weight loss medications in 2024 (57%) compared to 2023 (50%). While the decision to cover weight loss medications is specific to each plan sponsor, for those choosing to cover these medications, the Employers Health clinical team highly recommends implementing robust utilization management to ensure appropriate use and minimize unnecessary increases in spend. On average, plan sponsors that implement utilization management on weight loss drugs can expect to spend $11-14 per member per month (PMPM).

GLP-1 Cost Metrics for Diabetic and Weight Loss Indications

	2022	2023	2024
GLP-1 gross cost per member per month	$13.56	$24.84	$34.25
GLP-1 contribution to total gross cost	8.7%	13.7%	17.6%

Biosimilars gain momentum

While GLP-1s continue to gain momentum, one notable trend that helped normalize the overall increase in spend is the rise of biosimilars. When Humira (adalimumab) biosimilars first launched in 2023, market growth was limited due to formularies placing the biosimilars at parity with the reference product. This resulted in limited provider/patient uptake. However, 2024 marked the much-anticipated growth of Humira biosimilars, particularly for formularies that moved to exclude Humira.
An internal collective-wide analysis found that for Humira exclusionary formularies, over 90% of members switched to a preferred biosimilar product with a small percentage of members switching to an alternative biologic. Humira biosimilars offer an average 80-83% list price discount per prescription compared to Humira.

As biosimilars cultivate more awareness in the marketplace and providers develop more experience prescribing these products, it is expected that their adoption will continue to grow in the coming years. Already in 2025, we have seen the launch of Stelara (ustekinumab) biosimilars. With Stelara generating $20 billion in annual sales[2], biosimilars represent another key opportunity for plan sponsor savings. Of the big three PBMs, Optum Rx has announced its Stelara biosimilar strategy to exclude Stelara from the formulary and prefer its biosimilar, Wezlana, beginning July 1, 2025. Express Scripts will co-prefer an unnamed interchangeable biosimilar in 2025. CVS Caremark has not yet confirmed a strategy.

One of the biggest obstacles in the launch of Stelara biosimilars is product availability. Currently, seven biosimilars have been approved (see **FIGURE 1**), though as of the first quarter of 2025, only Wezlana has launched.

FIGURE 1 Approved Biosimilars (as of Q1 2025)

Product	Manufacturer	Approval Date	Interchangeability Status Granted?
Wezlana	Amgen	October 2023	Yes
Selarsdi	Teva	April 2024	No
Pyzchiva	Sandoz	June 2024	Yes
Otulfi	Fresenius	September 2024	Yes
Imuldosa	Accord	October 2024	No
Yesintek	Biocon	November 2024	No
Steqeyma	Celltrion	December 2024	No

Source: IPD Analytics

Savings strategies for Employers Health clients

Custom clinical strategies have been a pivotal approach to improving both financial management and patient outcomes for employers. By tailoring clinical criteria to the needs of our clients' patient populations, these strategies have significantly increased clinical efficacy, reduced drug costs and improved overall management. Employers Health's custom, data-driven clinical strategies ensure that members receive the most appropriate, cost-effective treatment, improving care quality by identifying opportunities for cost containment and avoiding unnecessary high-cost options.

In 2024, the Employers Health clinical team created custom clinical strategies for plan sponsors to adopt, resulting in plan savings throughout the year. As shown in **FIGURE 2** the highest possible cost avoidance from a single program came from Employers Health's anti-obesity prior authorization (PA), resulting in $40.52 PMPM. Groups that cover anti-obesity medication with the Employers Health PA saw an average cost avoidance of $17.79 PMPM. Compared to industry standards, Employers Health's anti-obesity strategy has more stringent PA criteria, requesting documentation of a body mass index (BMI) and a higher percentage of weight loss threshold for continuation of therapy.

The strategy with the second-highest cost avoidance was sleep step therapy. This strategy manages Xyrem, sodium oxybate and Lumryz, which help treat excessive daytime sleepiness due to narcolepsy. Employers Health's sleep step therapy strategy requires appropriate diagnoses and testing in addition to stepping through lower-cost alternatives. The highest cost avoidance experienced by implementing this strategy was $23.78 PMPM with an average of $4.38 PMPM. Combining all existing strategies, the total possible cost avoidance by groups with access to Employers Health custom clinical strategies can be up to $75.90 PMPM.

New strategies for 2025

In 2025, the pharmaceutical industry is expected to grow with new products. However, it will also bring new challenges and complexities to navigate. To be proactive, the Employers Health clinical team has created new utilization management strategies for employers. When developing our strategies, we utilize clinical guidelines and trial results to ensure we are promoting the use of effective, lower-cost alternatives when available. This approach ensures treatment remains accessible and sustainable for members.

This year, our clinical team is particularly excited to announce the rollout of newer strategies targeting higher-cost specialty medications. As aforementioned, specialty medications can be a main contributor to overall pharmacy expenditure, costing thousands to hundreds of thousands of dollars per month. Under a standard PBM arrangement, specialty medications are oftentimes already targeted by a specialty management program, requiring a member to go through a PA. However, the pace of innovation in specialty medications can outstrip the updates to management. By implementing custom clinical strategies around specialty drugs, plan sponsors can adapt more quickly to these changes and ensure members are receiving the most effective treatment available.

Driven by innovation and the need for cost-effective, high-quality care, it will be essential to stay ahead of these emerging trends while also balancing overall health care costs and ensuring optimal care. Clients who are seeking effective clinical management opportunities in 2025 are encouraged to explore Employers Health custom strategies supported by our clinical team's consultant counterparts.

TO LEARN MORE CONTACT
clinical@employershealthco.com

FIGURE 2

Custom Clinical Strategies

Program	Top Cost Avoidance PMPM	Average Cost Avoidance PMPM	Total Cost Avoidance
Employers Health anti-obesity PA	$40.52	$17.79	$6,560,920.26
Auvi-Q	$0.63	$0.16	$179,313.59
Dermatological bundle 1.0	$1.22	$0.19	$83,671.68
Descovy*	$2.54	$0.94	$369,772.05
Dry eyes	$3.56	$0.58	$22,609.04
Duexis/Vimovo	$0.41	$0.19	$26,519.04
Gastrointestinal motility	$1.02	$0.43	$215,551.08
High-cost generics 3.0	$0.94	$0.24	$362,608.15
High-cost generics 4.0	$0.53	$0.11	$25,475.04
Rosacea management	$0.75	$0.10	$529,074.30
Sleep step therapy	$23.78	$4.38	$2,085,165.00
Grand total	**$75.90**	**$25.11**	**$10,460,589.23**

Custom clinical strategy case studies based on Jan-Jun 2024 data

*Affordable Care Act FAQ Part 68 may limit ability to offer this program

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1. American Diabetes Association. Standards of Care in Diabetes 2025. https://diabetesjournals.org/care/article/48/Supplement_1/S181/157569/9-Pharmacologic-Approaches-to-Glycemic-Treatment
2. IPD Analytics. Rx Insights: 2025 Humira and Stelara Biosimilar Formulary Coverage. Published January 2025.

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MAY 20 The View from Washington: Legislative and Regulatory Outlook

MAY 22 Pharmacy Benefit Legal and Regulatory Update

MAY 27 The Latest in Cell and Gene Therapy

MAY 29 Best Practices for Health Plan Fiduciaries

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JUNE 12 Patient and Employer Perspectives Related to Alternative Funding Programs

JUNE 17 Keeping Up With GLP-1s

JUNE 19 Employers Health Client Solutions: Trends, Challenges and Strategies

JUNE 24 Pharmacy Benefits: Perspectives from Leading Consultants

JULY 01 Bridging the Gender Gap

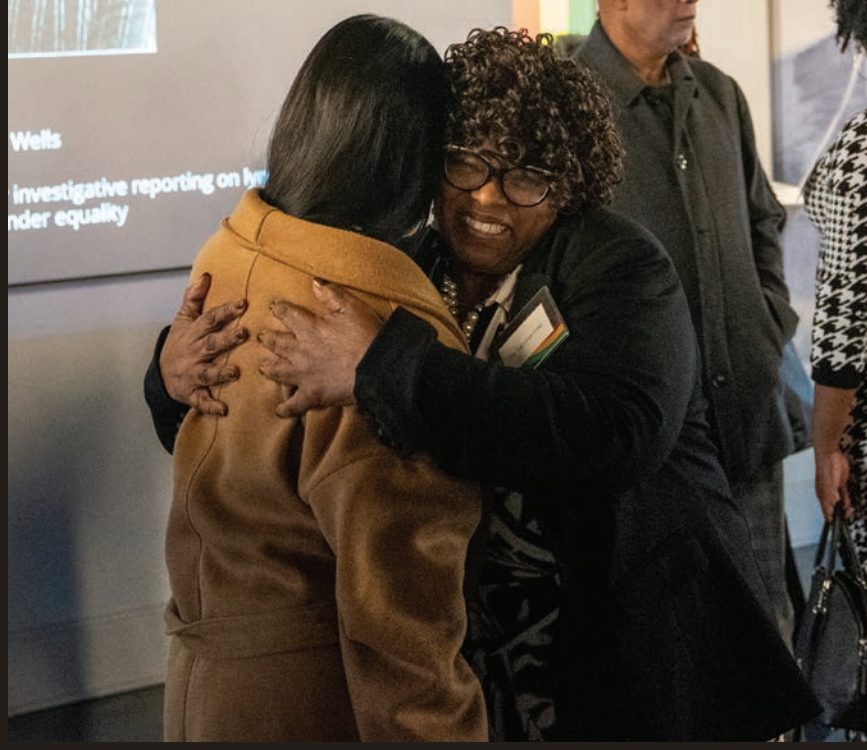
JULY 08 Innovators in Employee Benefits: An Employer Panel

JULY 10 Inflammatory Insights: Marketplace Momentum and Future Pipeline

JULY 15 Overcome Mounting Pressures on Rx Plan Design and Administration Through Solid Required Plan Documentation

JULY 17 Loneliness at Work: Urgency and Opportunity

JULY 23 From Design to Delivery: Creating a Seamless Experience for Maximum Engagement and Employee Satisfaction



Black History Month at Employers Health:
A Celebration of Culture and Community

Cassidy Burger
Content Marketing Specialist

In February, dozens of local community leaders, business owners and advocates came to Employers Health's Canton headquarters to participate in our second annual Black History Month luncheon. Led by Employers Health client solutions team members Matt Esterle, Nushong Kennedy and Style Henry, the luncheon provided an opportunity to reflect on, celebrate and gain wisdom from the remarkable accomplishments and invaluable contributions of individuals of African descent. Last year, Esterle spearheaded the luncheon after recognizing an opportunity to bring a meaningful celebration to his coworkers and community. His vision laid the foundation for a well-received annual event.

Matt Esterle, client solutions executive at Employers Health

"I'm thankful to work for a company that not only supports me, but also celebrates me," said Esterle. *"Events like this create a space where we can come together, learn from one another and appreciate the contributions of Black leaders throughout history."*

This year's luncheon was even bigger than the last, with faces old and new coming together to embrace the richness of diversity and foster discussion. Attendees were treated to a full array of soul foods and desserts and were encouraged to read and discuss quotes from famous Black entertainers, philosophers, athletes and more with their peers. During the event, attendees also heard an exciting update about a permanent exhibit dedicated to Stark County, Ohio's Black history, which will be housed at the William McKinley Presidential Library & Museum. The exhibit will provide a lasting tribute to the local Black community's impact and achievements.

Today, Black History Month has earned permanent and official recognition in our nation. The holiday is enjoyed by all ethnicities and has even been adopted internationally in several countries.

Since 1928, the Association for the Study of African American Life and History has chosen a theme that is endorsed by the President, with this year's theme being "African Americans and Labor." This theme celebrates the transformative contributions of Black workers, highlighting the impact of all forms of labor — paid, voluntary, skilled, unskilled, social justice efforts and advocacy — in shaping Black culture and history.

"At Employers Health, we strive to grow together, as a team and alongside our community, fostering a diverse environment where everyone can thrive personally and professionally," said Chris Goff, chairman, president and CEO of Employers Health.

Employers Health was honored to host this event celebrating Black History Month. We are committed to fostering inclusive spaces where diversity is celebrated, and history is honored. What started as a simple idea has grown into a valued tradition — one that will continue to inspire learning, conversation and appreciation for Black history in our community.

Understanding the Pharmacy Landscape:
Insights from 20 Years in Pharmacy Benefits

Mike Stull, MBA
Chief Sales Officer

The health care industry has garnered a lot of attention lately, especially regarding pharmacy benefit managers (PBMs). Due to the complex pharmacy landscape, clients often look to the Employers Health team to provide context on issues or opine on current events. After recently celebrating twenty years at Employers Health, we asked Chief Sales Officer Mike Stull to weigh in on some of the most common questions asked about the current state of pharmacy benefits.

Where are most of the state legislative efforts coming from?

Most of the legislation introduced at the state level is being promoted by independent retail pharmacies. They are small businesses within their states, so their voices resonate with lawmakers. These state laws are mainly about how independent pharmacies can get higher reimbursements from PBMs and, ultimately, purchasers and their plan participants. In my opinion, the idea that these state laws will save individuals money is a stretch. Some laws mandating minimum reimbursement and dispensing fees will absolutely increase prices.

How did PBMs get to be so large?

I would argue that PBMs must be large entities to effectively negotiate with other players in the supply chain. Pharmaceutical manufacturers are large entities given competitive protections through U.S. patent law, so to have any chance negotiating lower prices or better rebates, you need scale. Large pharmacy chains make up a majority of the retail network, with a handful of specialty pharmacies, owned mostly by the big PBMs, dominating the specialty dispensing channel. The three largest wholesale distributors control 90% or more of their respective pieces of the supply chain. So, without a single-payer system, entities negotiating for lower prices on behalf of patients and health care purchasers need leverage.

Why did the PBMs and the insurance carriers come together to form these vertically integrated organizations?

It seems each deal is a little unique in terms of how it came together, but at the end of the day what I see is an opportunity for the insurers to keep more of their premium dollars under their corporate umbrellas. The Affordable Care Act requires insurers to spend a specific percentage of premium dollars on health care services (medical loss ratio). So, if you acquire physician practices, hospitals, specialty pharmacies, etc., you can pay those entities for services AND still meet your statutory requirement. Whether we agree with it or not, the market provided the opportunity for this type of consolidation.

Will rebates ever go away?

In a perfect world, manufacturers would offer medications at a truly low price. Until that becomes a reality, purchasers need a way to negotiate additional discounts off the list price of brand drugs without running afoul of anti-competitive pricing settlements agreed to in the late 1990s between manufacturers and retail pharmacies. The answer lies in retrospective rebates.

Yes, rebates are distorted and serve as impediments to the inclusion of lower-priced, lower-rebated products in PBM contracts. These conflicts arise from purchasers demanding multiple years' worth of rebate guarantees and PBMs profiting from their own group purchasing organizations. If purchasers are going to give up rebates as their tool for negotiation, they need a good replacement. Plan sponsors continue to rely on rebate dollars to offset increased premium costs and so far, have been reluctant to explore point of sale rebates. Organizations promoting elimination of rebates the loudest are mostly competitors of or those negotiating against the big three PBMs.

How is the PBM industry different today than it was twenty years ago?

In the early 2000s, the costs for pharmacy were much less and even getting a rebate was the mark of an exceptional contract. We still had three dominant PBMs, although Optum Rx has taken the place of Medco after Medco was bought by Express Scripts. I remember when we started talking about specialty drugs and how eventually they would make up half of drug costs. Back then, we were debating which branded statin should be on formulary. The evolving market, including legislative and regulatory changes, and increased utilization has led purchasers to be more active in managing their pharmacy benefit than ever before. In turn, consultant practices geared specifically to pharmacy have grown substantially.

Regardless of these changes, the fundamental pharmacy strategies have stayed almost the same: have a solid contract, use plan design to promote desirable behavior and set appropriate clinical management strategies that balance your appetite for cost savings versus participant disruption. Today, having an independent and unbiased consultant is a must as purchasers' fiduciary duties are under scrutiny. A prudent process is key and using advisors who steer clients into their own collectives or products will be challenging to defend.

What are the biggest challenges for 2025?

For our clients, it's keeping up with the legislative and regulatory changes. There are plenty of state laws we believe are preempted by the Employee Retirement Income Security Act (ERISA,) but those challenges will need to work their way through the court system. Having a contract that can adjust and implementing adaptive plan designs is important.

Managing glucagon-like peptide 1 (GLP-1) spend for diabetes will continue to be a challenge given its newer position as a first-line therapy for Type 2 diabetes. I'd like to see health plans report more data on hemoglobin (A1c) levels and spend on diabetes conditions under the medical plan to see if these medications are having the desired impact. On the weight loss side, I'd hope to see prices come down now that both major products are off the shortage list. The direct-to-consumer strategies by the manufacturers will complicate the PBM rebate model for these drugs, meaning you shouldn't have a drug that cost $499 by going direct and $1,200 under the high-deductible plan (price before rebate).

Lastly, navigating the biosimilar landscape will be challenging, yet rewarding. There's an opportunity for plan savings with the launch of biosimilars for Stelara. Employers Health clients with CVS had great success moving utilization from Humira to its biosimilar products and we expect to see the same results with Stelara. Excluding these originator products from the formulary is the only way to get significant movement to the biosimilar, and I was happy to see CVS and some of the smaller PBMs make that move. The challenge with biosimilars is for consultants to be able to appropriately model the lower list prices, the expected utilization shift and the impact on rebate guarantees. We've already seen one of the major PBMs play pricing games in order to inflate its own value.

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Have a question for Mike? Scan the QR code to submit it for a chance to be featured in an episode of the Employers Health podcast, HR Benecast.

Client Spotlight

Interview with David Stewart

Benefits Manager
Diocese of Pittsburgh

Diocese of Pittsburgh

Founded in 1843, the Diocese of Pittsburgh is a community of 628,000 Catholics living in southwest Pennsylvania. With 60 parishes, its mission is to connect others to the teachings of the church. We recently spoke with the diocese's benefits manager, David Stewart. Passionate about connecting others to exceptional benefits, David has experienced firsthand the impact affordable benefits can have on a person's life, both personally and professionally.

In 2018, David developed liver failure due to metabolic dysfunction-associated steatohepatitis (MASH). After an eight-month battle with MASH, a condition that causes damage to the liver and can lead to cirrhosis and sometimes liver cancer, he received a life-changing liver transplant thanks to a generous cousin. Thankful for his great health and pharmacy benefits, David left the hospital just eight days after his procedure and was back to work in four months. Today, he takes only one anti-rejection specialty medication due to the transplant and is grateful for the ease and convenience of the CVS Specialty Pharmacy program.

With decades of experience in benefits management, David shares insights on his role, the diocese's approach to benefits and how his team stays informed on the latest in employee benefits.

How did you get your start in employee benefits?

I didn't begin my career in employee benefits. After graduating with a bachelor's degree in accounting, I went to work for the diocese as an accounting supervisor, overseeing accounting for the insurance fund, including benefits. When the diocese's benefits manager position opened in 1991, I applied and have now been in that role for more than 30 years.

How does the diocese approach health benefits and overall well-being for your employees?

We align our health benefits with the teachings of the Catholic Church. As a human right, the church believes everyone should have access to health care. The diocese provides coverage to every individual we can. In the southwestern corner of Pennsylvania, we have provided group benefit programs for up to 333 parishes, 150 schools, cemetery operations and all our priests, the heart of our organization. Compared to the industry, we have always provided high-quality health benefits programs with lower copays and deductibles.

In your experience, what benefits make the biggest difference in employee retention and engagement?

We do everything we can to provide a competitive package with lower deductibles, copays and employee contributions. It helps attract younger employees and retirees needing benefits until Social Security and Medicare begin. Our employees work here because they want to serve the church and providing them with high-quality, low-cost insurance allows them to participate in a great plan that helps them feel like they are giving back.

How has your organization been innovative in delivering health care benefits? Are there any specific initiatives or unique benefits to which your employees have responded positively?

We have added several well-received programs to help employees achieve and maintain better health and well-being. Some of the most popular initiatives help control specialty drug costs and give plan utilizers access to patient advocates who help guide them through the medical and prior authorization process. Additionally, our employees especially enjoy an enhanced wellness program we implemented with set weekly goals and short videos with tips for a successful health and wellness journey.

What measure or metrics does your team use to evaluate the success and impact of your pharmacy benefit programs?

We're always looking at the data behind all our programs to ensure their success and determine what we can do better. Our team meets with our patient advocates monthly to review their interactions with patients and the types of calls and questions they receive. Annually, we work with our benefit vendors to evaluate program statistics and success rates. Most importantly, we compare actual costs to actuarial projected costs, considering trends, drug enhancements and advances in medical procedures. All the above gives us the information we need to better understand our population and their needs, in turn, allowing us to make better plan decisions on their behalf.

How does your benefits team stay informed about new trends or changes in employee benefits?

Our team is small but awesome and incredibly hardworking. In addition to benefits, our team handles the property/casualty insurance programs for the diocese and manages a central payroll service covering more than 3,000 employees. Our busy team heavily relies on our broker and vendor partners to provide updates and new products as they come to market.

What do you feel is the biggest value your organization derives from Employers Health? How does it contribute to the diocese's overall benefits strategy and mission?

Employers Health has been a great resource, with an innovative, robust delivery system through CVS' advanced protocols for reviewing newly formulated drugs to the market and the flexibility to align our plans with the values and teachings of the church.

Have a story to share?
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info@employershealthco.com

CVS Weight Management™

Virtual care program designed to help members lose weight and drive medical and pharmacy savings for clients

UP TO
5:1 ROI
observed

Optimize clinical outcomes for members wherever they are in their weight loss journey

High engagement with members meeting virtually with their dedicated registered dietitian **monthly** and chatting and logging their biometrics **weekly**

13x TOTAL WEIGHT LOSS
For members previously struggling to lose weight on medication alone[1]

92% MEMBER SATISFACTION
"**My RD has changed my life for the better.** She's been wonderful and contributed to my success in weight loss tremendously. She is a fantastic motivator."
– Enrolled member

26% LESS CLIENT SPEND
on GLP-1s for weight loss compared to clients who did not adopt the program[2]

Dedicated clinical support

Dedicated registered dietitian meeting in a virtual setting. Board-certified providers, including endocrinologists

Flexible program components

For seamless integration with your pharmacy benefits and a better experience for your members

Engaging digital app

Health Optimizer uses FDA-cleared technology to deliver clinically-precise, AI-driven support and coaching[3]

Source: CVS Health Analytics, 2024. Weight Management Pilot Results. Data from August 2023 through September 2024. 265K Total Covered Lives, as of 9/30/24. Conditions for ROI guarantee apply, and full guarantee requires final sign-off by CVS Caremark Actuarial and Underwriting. Actual savings vary based on client benefit plan design, implementation, and promotion.

1. Reflects relative increase in total weight loss from weight management medication start before and after enrollment inCVS Weight Management.
2. Comparing pilot client to a comparable client peer group in Q3 2024.
3. Health Optimizer® diabetes capabilities are FDA-cleared ("Welldoc®"), intended for use by adults with type 1 or type 2 diabetes. For full labeling information, visit www.learn.welldoc.com/caremark. The other Health Optimizer app features are non-FDA-cleared and intended to promote general wellness and education/self-management of various cardiometabolic conditions.

CVS caremark™

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