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Western Alliance Bank



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Fall 2025

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Chairman, President & CEO

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MESSAGE FROM CHRIS GOFF

“The Employers Health team is experienced, very knowledgeable and responsive. They take the time to understand our organization and how it impacts our pharmacy decisions.” That quote, one of several included in our 2024 annual report, came directly from a client. It reflects our commitment to helping plan sponsors nationwide deliver meaningful value and pharmacy solutions.

Hopefully by now, you have received the 2024 Employers Health annual report, highlighting what was a transformative year for our team, clients and the pharmacy benefits industry overall. While 2024 marked a year of tremendous growth and milestones, 2025 has also had its share of success. We remain focused on our mission to provide your organization with high-quality pharmacy benefits coupled with the excellent service you have come to expect from Employers Health.

Our team has grown to over 100 dedicated colleagues working to provide the resources, tools and expertise needed to improve your pharmacy benefit management experience. As the industry grows and becomes more competitive, we understand that having access to timely and historical data is crucial to identifying trends, managing costs and driving better outcomes. This growth ensures we have the insight needed to help you make more informed decisions on behalf of your plan and its participants.

One of our greatest resources is the strategic advocacy and guidance we provide to help plan sponsors navigate an increasingly complex regulatory landscape. Our team of legal experts monitors proposals seeking to regulate pharmacy benefit managers across all 50 states and continues to educate legislators on the harmful impact these bills may have on plan sponsors. We remain committed to advocating on your behalf and providing timely, relevant updates.

This issue of EH Connect is one of many examples of the expert resources provided to you through Employers Health. On page 3, Patrick Henry, clinical advisor covers “Understanding the Rising Costs of Diabetes Management.” You’ll also hear from Madison Connor, senior vice president, regulatory compliance and external affairs as she discusses health care price transparency. Finally, we hope you enjoy this edition’s client spotlight featuring Barbara Kennedy, chief human resources officer at Western Alliance Bank.



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Understanding the Rising Costs of Diabetes Management

Patrick Henry, PharmD, MBA
Clinical Advisor



Tracking your blood sugar has never been as common or convenient as it is today. While GLP-1s continue to dominate headlines, there are several medical devices silently making an impact on diabetes trend for many plan sponsors: continuous glucose monitors (CGMs) and disposable insulin pumps (DIPs) — with the former beginning to see utilization in non-diabetics. As utilization in the diabetes space increases, plan sponsors should prepare for increases in spend and consider utilization management to prevent off-label utilization.

More members are prioritizing metabolic health

Metabolic health is a broad term that refers to how well you can digest and absorb nutrients from the food you eat. This includes mounting an adequate insulin response to a spike in blood sugar and maintaining healthy mechanisms to process fat in the blood through a balanced diet, exercise and adequate sleep. When these functions are disrupted, the risk of heart disease, Type 2 diabetes and stroke increase.

The most common way to track someone's blood sugar is through a CGM, a wearable device that works by placing a small sensor under the skin, transmitting readings via Bluetooth to a digital receiver. Although typically reserved for members with diabetes, we are seeing an uptick in CGM utilization from prediabetic members and even in those without diabetes. This can be attributed to CGM product innovation and an increased societal awareness of metabolic health, especially within the fitness community looking to better understand how their body responds to different foods and training regimens.



The science behind CGMs

CGMs typically include three distinct parts that connect to a patient's phone or a similar device to store and share blood sugar readings. With real-time, 24/7 readings, CGMs have significantly improved blood glucose monitoring for both patients and prescribers.



The sensor is usually placed on the back of the arm but can also be worn on the chest, abdomen or thigh to collect blood sugar readings.



The transmitter is attached to the sensor and sends all readings to the receiver to be stored for patient and prescriber review.



The receiver is used to store readings and transmit them to the prescriber.

CGMs are FDA-approved for all patients with diabetes; however, they have historically been used solely in those requiring multiple daily insulin injections. Insight into how blood sugar rises and falls can be valuable for patients and prescribers when evaluating diabetes management. Elevated glucose levels can increase the risk of complications such as heart disease, kidney disease and eye damage. Without CGMs, patients must prick their finger with a lancet and draw blood onto a test strip to see where their blood glucose is, often multiple times per day.

Clinical evidence suggests that CGMs can benefit all diabetics, regardless of insulin utilization. As a result, the 2025 American Diabetes Association (ADA) guidelines now recommend CGMs for patients on any insulin product, along with a consideration for anyone on glucose-lowering medication. These guidelines have caused a significant shift toward recommending these devices to more patients with diabetes to support positive treatment outcomes.

While there's been an increase in utilization across diabetics, we're beginning to see use in non-diabetics. As mentioned before, fitness enthusiasts are leveraging information from CGMs to see how their body responds to the food they eat to optimize their training regimen. These members may be seeking these devices through the medical or pharmacy benefit.

As CGM utilization grows in populations without insulin use or a diabetes diagnosis, it is becoming increasingly common for plan sponsors to implement utilization management controls on CGMs to mitigate trends in diabetes. Prior authorizations and quantity limits on CGMs can be added to restrict utilization to members with diabetes who are on a high-frequency insulin regimen and to prevent oversupply of these medical devices. While CGM guidelines are shifting, plan sponsors are continuously seeking new opportunities to manage the diabetes category.

Broader guidelines lead to bigger price tags

Year-to-date, diabetes is the top therapeutic class by gross spend so far across the Employers Health book of business (BoB). Dominated by expensive brand products, many plan sponsors tend to see high spend in this category. Insulin products have recently had significant price reductions, but the utilization of glucagon-like peptide-1 agonists (GLP-1s) has exploded over the last few years to drive an increasing trend in diabetes for many plan sponsors.

While not as expensive as GLP-1s, CGM utilization can greatly contribute to the overall trend in this class. CGMs account for approximately \$2.30 per member per month (PMPM) across our BoB, and we expect this number to rise as utilization increases. These devices are classified as durable medical equipment (DME), with CGMs previously only being accessible through the medical benefit. Now, CGMs are available under the pharmacy benefit based on the ease of administration, reductions in cost, improved patient access and additional utilization management options.

A second device that contributes to the increasing trend in diabetes is the disposable insulin pump (DIP). DIPs work with a CGM to administer insulin in a timely manner that aligns with the prescribed insulin regimen and responds to fluctuations in blood sugar throughout the day. Insulin pumps have been used for this purpose in the past, but standard pumps can be cumbersome for patients to use, as the pump must be carried at all times and is connected to the body via a tube running from the abdomen to the insulin pump device. DIPs allow members to apply a tubeless patch that administers insulin. Similarly to a CGM, it shares data via a patient's smartphone, creating a convenient experience for patients and providing reliable information for providers.

These devices will primarily benefit patients with diabetes on an intensive insulin regimen, so off-label utilization like we see in CGMs is not expected for these devices. Since DIPs and CGMs are often used together, plan sponsors may mirror the management of CGMs to ensure that DIPs are only available to the appropriate members.



Over-the-counter CGMs offer cost-saving potential

With the growing interest in metabolic health and the benefits that CGMs can provide to patients without an intensive insulin regimen, a popular CGM manufacturer, Dexcom, identified an opportunity to increase access to its products. Stelo, the first FDA-approved over-the-counter (OTC) CGM, was launched in August 2024 and is available without a prescription for \$99. This product is intended to be used by Type 2 diabetics who are not using insulin or those with prediabetes who would like to gain insight into how their lifestyle habits impact metabolic health. One primary difference between Stelo and prescription CGMs is that Stelo does not accurately monitor low blood sugar, so it is not an appropriate device for members on insulin therapy.

In addition to Stelo, there are two other CGM devices called Lingo and Lingo Rio that are available OTC. Lingo provides an option for health-conscious members without diabetes, while Lingo Rio is indicated for prediabetes or patients with diabetes who do not use insulin. These OTC monitors represent an opportunity for all members to access a CGM without utilizing the pharmacy benefit, which can minimize member disruption if enhanced CGM utilization management criteria are implemented.

Takeaways for employers

Employers have a few different options for managing CGMs and DIPs on the pharmacy benefit. The first option is to cover both products with no utilization management. This option can drive up costs as it allows for potential off-label utilization of CGMs by members that could otherwise benefit from OTC options. To maintain coverage with additional guardrails, employers can add prior authorizations to CGMs and DIPs to ensure that utilizers are on a high-frequency insulin regimen. Quantity limits can also be added on these devices to reduce stockpiling. Adding utilization management for these devices can protect the plan from unnecessary spend while ensuring access for members meets appropriate clinical criteria.

Another option available is to exclude CGMs and DIPs from the pharmacy plan entirely. Although this option can eliminate pharmacy spend for these devices, CGMs have been shown to positively influence diabetes management and patient outcomes. Patient access, cost and health outcomes are also significantly improved when patients can receive these devices through the pharmacy benefit instead of the medical benefit.

Looking forward

Our clinical team at Employers Health is actively monitoring updates in this space and working to develop additional CGM criteria to help our clients manage this class as treatment guidelines evolve. To minimize the impact of adding utilization management to CGMs, plan sponsors can educate members on the available OTC CGM options. If you would like to discuss how Employers Health is thinking about diabetes management and metabolic health, please contact our clinical team at clinical@employershealthco.com.



Scan the QR code to view our Four Ws of CGMs infographic — a great resource to educate your member population on the basics of CGMs.





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Patrick Henry, PharmD, MBA

Clinical Advisor

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Health Care Price Transparency:

Updates and Reminders for Employers

Madison Connor, J.D., CEBS

Senior Vice President, Regulatory Compliance and External Affairs



Since 2020, the U.S. government has implemented significant health care transparency laws aimed at helping plan sponsors evaluate health care spending and providing participants with greater insight into their cost-sharing for health care services. These requirements have slowly evolved as the Department of Health and Human Services, the Department of Labor and the Department of the Treasury (collectively, the departments) seek to streamline reporting, simplify requirements and glean actionable takeaways from available data.

This article summarizes the current key transparency requirements and discusses what the future may hold as health care fee litigation increases and as federal agencies continue to prioritize strict implementation and policy enforcement.

Transparency in Coverage (TiC) final rule

The TiC rule was issued in October of 2020 by the departments in response to a health transparency executive order released by the first Trump administration. The rule aims to give consumers access to item and service-specific pricing information through their health plans. **It consists of two main requirements:**

COST COMPARISON TOOL

Plans must provide members with real-time estimates of their cost-sharing liability for covered items and services. This information must be provided via an internet-based self-service cost estimator tool. While the rule had a phased-in approach, ultimately, all items and services covered by a plan were required to be available via a self-service tool by January 1, 2024.

Most medical carriers had existing versions of this tool and worked to expand capabilities to meet the comprehensive TiC requirements and ensure ongoing data accuracy for covered items and services.

MACHINE-READABLE FILES

The TiC rule also required plans to publish three machine-readable files (MRFs) in a publicly available format with monthly updates. The files consist of information regarding:

- 1 negotiated rates for all covered items and services between the plan and in-network medical providers,
- 2 historical payments to and billed charges from out-of-network medical providers and
- 3 negotiated rates and historical net prices for prescription drugs covered by the plan.

The prescription drug MRF has not yet been implemented; the departments announced an enforcement delay due to an ongoing lawsuit and confusion on whether the MRF was duplicative of other prescription drug reporting requirements (see next section). Updated guidance implementing the prescription drug MRF is expected by October 2025.

Consolidated Appropriations Act (CAA) of 2021

The CAA of 2021 included several provisions aimed at further increasing price transparency through more detailed prescription drug reporting, broker compensation disclosure requirements and protections against surprise medical bills. The law also called for a member cost comparison tool. While this requirement was largely duplicative of the cost comparison tool required by the TiC rule, the CAA additionally clarified that this cost information must also be made available by telephone upon request. Thus, compliance with the TiC requirements (described above) is also sufficient for purposes of the CAA, so long as the information is also available by telephone.



The CAA also required specific actions by plan sponsors including:

PRESCRIPTION DRUG DATA COLLECTION (RxDC) REPORTING

Annually, by June 1, plans must provide specific reporting data on prescription drug spending to the departments. The report must include information like the plan's top 50 most costly drugs, top 50 most frequently dispensed drugs, total rebate amounts by therapeutic class, specific rebate information for the top 25 drugs with the highest dollar amount of rebates, etc. Utilizing the collective information reported, the departments began to biannually release an aggregated report on drug pricing costs and trends starting in 2023.

Although the legal obligation to report under the CAA falls on plan sponsors, the departments recognize that plans must look to pharmacy benefit managers and other plan service providers to assemble most of the information needed to complete the reporting. The departments allow multiple entities to enter reporting information on behalf of a particular plan. Reporting is submitted through the online Health Insurance Oversight System (HIOS) run by the Centers for Medicare and Medicaid Services (CMS), as CMS collects the CAA reporting data on behalf of the departments.

GAG CLAUSE PROHIBITION COMPLIANCE ATTESTATION

The CAA also prohibits health plans from entering into contracts that contain "gag clauses," which are provisions that restrict the disclosure of specific cost or quality information. Prohibited gag clauses include limits on the scope or frequency of electronic access to deidentified claims. Plan sponsors must attest that they have not entered into agreements containing such restrictions by December 31 annually. Similar to the RxDC reporting, these attestations are submitted via the CMS HIOS website.

This requirement indirectly regulates plan service providers by making it illegal for plans to work with them if their contracts contain gag clauses. Accordingly, plan sponsors should work with their plan service providers to ensure their contracts are compliant so that the attestation can be completed and filed annually. Employers Health's PBM contracts do not contain gag clauses and explicit language addressing this requirement is included in our master services agreement.

Transparency requirements and deadlines at a glance:

Transparency in Coverage final rules

- Member cost comparison tool (ongoing requirement)
- Machine readable files (ongoing requirement)
 1. In-network provider rates for covered items and services
 2. Out-of-network allowed amounts and billed charges for covered items and services
 3. Negotiated rates and historical net prices for covered prescription drugs*

**Requirement not yet implemented*

Consolidated Appropriations Act of 2021

- RxDC reporting (due annually by June 1)
- Gag clause prohibition compliance attestation (due annually by December 31)
- Member cost comparison tool (ongoing requirement)
- Broker compensation disclosure (ongoing requirement)



Looking forward: What's next in health care price transparency?

Earlier this year, President Trump issued an executive order titled “Making America Healthy Again by Empowering Patients with Clear, Accurate, and Actionable Healthcare Pricing Information.” The order announced a continuation of his prior administration's focus on the TiC rules for hospitals and health plans by directing the departments to issue additional guidance on these requirements as well as implement the previously deferred prescription drug MRF. The departments responded less than 90 days later with Affordable Care Act FAQ Part 70, which addressed the forthcoming release of revised technical requirements for the MRFs that aim to eliminate duplicative data and reduce unnecessary fields to better contextualize data. The departments intend to finalize this guidance by October 1, 2025. Like in past transparency rule implementations, a series of CMS webinars will be available that explain the changes and provide technical assistance to plan sponsors.

What have we learned so far?

Compliance delays, data complexity and lack of patient awareness have lessened the initial impact of these transparency efforts. The MRFs are so massive and detailed that a standard computer is unable to open the files. While the member cost comparison tools were aimed at consumer price education and transparency, the objective behind the monthly publication of MRFs is for researchers to leverage these massive data sets to create more resources for health care purchasers and bring greater competition to the health care industry. However, in many instances, the MRFs lack consistent formatting, consist of estimates rather than “true” costs and contain sparse or duplicate information.

In May 2025, the departments issued several requests for information seeking commentary from stakeholders on how to update and improve the reporting format and data.

In November 2024, using aggregated data from the first two years of RxDC reporting, the departments released their initial report on prescription drug pricing trends and the impact of prescription drug rebates on patient out-of-pocket costs. Generally, the report found that gross drug prices have been growing more rapidly than prices net of rebates paid by manufacturers to PBMs. However, as with the MRFs, there were meaningful limitations with the initial years of reporting, which are being prioritized in future instruction templates. Additionally, vendors are encouraged to aggregate their book of business data at the state and market level, rather than each specific plan, and this has minimized the utility of this information for plan-specific insights.

Action items for employers

These reporting processes are very much still a work in progress. Moving forward, plans should be mindful of reporting deadlines and work with their plan service providers to ensure that all data will be submitted in a timely manner. Encouraging participants to take advantage of self-service cost estimator tools could minimize short-term cost-sharing liability for plan participants. This fall, plan sponsors should anticipate significant updates on the format of these reports from the Trump administration, although most of the compliance burden will fall to their plan service providers who will need to update standard reporting. Employers Health will continue to provide updates on new guidance and any reported findings from the departments.

TO LEARN MORE CONTACT
mconnor@employershealthco.com

Noteworthy News



**Employers
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Foundation

The Employers Health Foundation recently hosted its second annual golf outing. This year, all funds raised will benefit ArtsinStark, a cornerstone of Stark County's cultural landscape, using the arts to advance economic development, education and community well-being.

Chad Sinkovich, accounting manager joined the Muskingum University Alumni Council.

Travis Johns, director, client solutions was elected to second-vice president of the National Alliance on Mental Illness (NAMI) Stark County. NAMI Stark County provides advocacy, education, support and public awareness to empower and provide hope for recovery so that all individuals and families affected by mental illness can build better lives.

Alexis Sova, clinical advisor joined the central Ohio division of the American Heart Association's Young Professionals Board.

Nushong Kennedy, client solutions specialist received his Master of Business Administration with a specialization in project management from Southeastern Oklahoma State University.

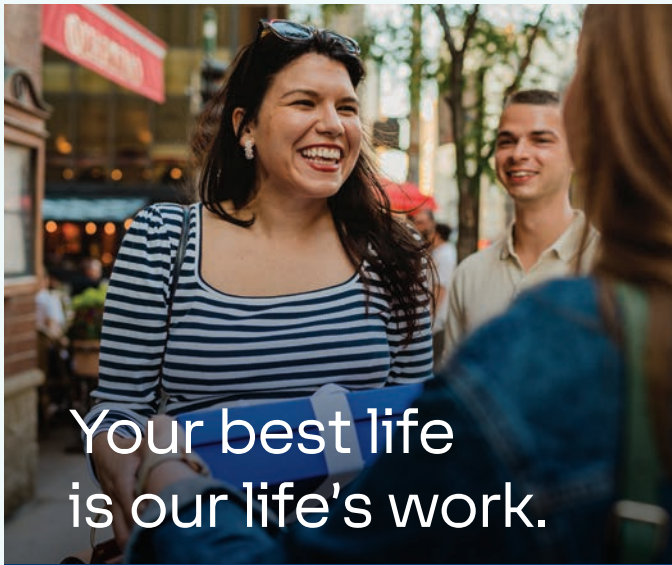
Mary Kender, client solutions specialist received her Master of Legal Studies with concentrations in contract management and business law from Arizona State University.

Madison Connor, senior vice president, regulatory compliance and external affairs was featured in Bloomberg Law's article, "PBM State Fights Will Live On After High Court's Petition Denial," providing insight on the U.S. Supreme Court's decision to not hear *Mulready v. PCMA*.

Ernesto Munoz, clinical advisor was nominated as a 2025 Leader of Impact by the central Ohio division of the American Heart Association. The Leader of Impact campaign is a nationwide initiative that engages community leaders to raise awareness and funds for heart health.

Client solutions specialists Trent Petit, Sam Gindlesberger, Dan Dorman and Liz Donley received their Certified Employee Benefit Specialist designations from the International Foundation of Employee Benefit Plans.

Earlier this year, Employers Health participated in the Akron-Canton Foodbank's annual food drive and later volunteered at its pantry, helping provide more than 8,000 meals to those in need in Stark County, Ohio.



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*Actor Portrayal

Client Spotlight

Interview with Barbara Kennedy

Chief Human Resources Officer
Western Alliance Bank



Western Alliance Bank

With more than \$80 billion in assets, Western Alliance Bancorporation is one of the country's top-performing banking companies. Its primary subsidiary, Western Alliance Bank, offers a full spectrum of tailored commercial banking solutions and consumer products, all delivered with outstanding service by banking and mortgage experts who put customers first. Serving clients across the country wherever business happens, Western Alliance Bank operates individual, full-service banking and financial brands with offices in key markets nationwide.

With a supportive culture focused on the health and well-being of employees and their families, Western Alliance Bancorporation's benefits strategy prioritizes cost savings without compromising high-quality care. Dedicated to excellence and implementing benefits strategies that encourage employee utilization, the organization's Chief Human Resources Officer Barbara Kennedy's team works to encourage employees to lead healthy lives. With an extensive career in benefits, Kennedy spoke with Employers Health about Western Alliance's distinctive offerings, what she enjoys most about working in the field and more.

How did you get your start in employee benefits?

I started working in benefits at a summer job in college. Early in my career, I had the opportunity to create an organization's human resources department from the ground up. This gave me no choice but to learn about the benefits industry quickly and provided me with the foundation to be successful today.

What do you feel is the most rewarding part of working in employee benefits?

Working in employee benefits allows me to help other people. Not only do we ensure the right benefits are offered, but we encourage program adoption and promote overall well-being for our people and their families, which is incredibly meaningful. Throughout my career, I have seen firsthand the positive impact benefits teams can have in helping to improve the health of others.

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

We provide a full suite of benefits designed to take care of our people and their dependents based on individual needs. Health is a priority at our organization, and we encourage our

people to make smart, healthy choices. We reinforce the importance of well-being during our wellness town halls and through regular communication. Everyone's health and wellness journey differs, so throughout the year, we provide healthy snacks and drinks, encourage preventive care and offer wellness challenges and activities. Our people are encouraged to get involved in their local wellness committees. One of our most unique offerings is hydroponic plant units to grow and distribute fresh herbs and vegetables to our people. Growing healthy food in the workplace aids in creating a culture of well-being, with the added benefit of fresh herbs and vegetables to use in their meals at home.

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

We understand how complex the health care system can be. Some of our people struggle navigating the health care system. To help, our health management provider offers a "personal assistant." This personal assistant provides personalized care by helping our people navigate the complex health care system and aiding them with their health needs.



What are your thoughts on the future of employee benefits? What changes do you feel employers should be preparing for in the coming years?

To control costs while still positively impacting the health of employees, organizations will need to take a more personalized approach to benefits. I believe as employees' health care needs continue to evolve, more individualized benefits and interactions are going to be crucial to help employees utilize their benefits and programs to their full potential.

What do you feel is the biggest value your organization derives from Employers Health?

The Employers Health team members are experts in pharmacy benefits. They take the time to understand our organization and population's needs. Employers Health develops the right offerings, proactively negotiates on our behalf, helps control costs and ensures everyone's needs from the top down are met.

How does Employers Health contribute to your organization's overall benefits strategy and mission?

Employers Health is always on the leading edge. It works in the best interests of its clients, and we have confidence that the team is doing what is best for our company and our people. Employers Health is always one step ahead!

What advice do you have for someone just getting started in employee benefits?

Be a role model for good health and your people will notice. Encourage, promote and communicate the importance of health and well-being. In this industry, you have a great opportunity to make a real difference in people's lives.

**Have a story to share?
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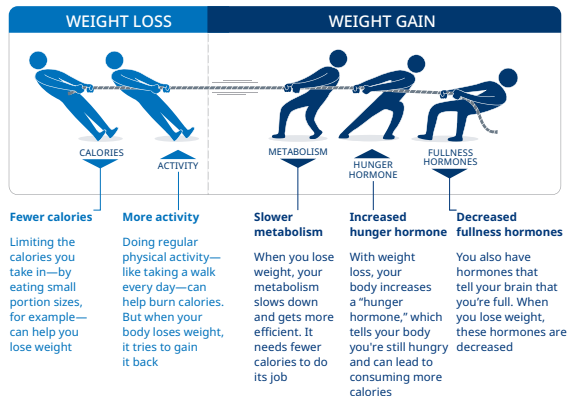
The Tug-of-War of Weight Management

The body's response to weight loss makes it hard to maintain progress

Science shows that after losing weight, the body tries to put it back on.

Following weight loss, the body's metabolism slows down and appetite hormones change, making you feel more hungry and less full.

Here is how it works:



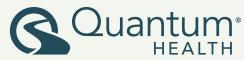
In a person with obesity, the body will try to put the weight back on for at least 12 months after weight loss

While healthy eating and increased physical activity are important, for many people it may not be enough to keep the weight off. Talk to your doctor to see how this may be affecting your efforts to lose weight.

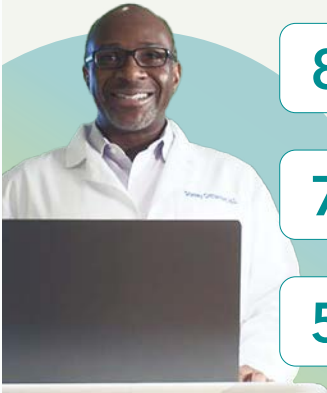
For more information, please go to www.TruthAboutWeight.com.

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Engaging digital app

Health Optimizer uses FDA-cleared technology to deliver clinically-precise, AI-driven support and coaching³

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 in CVS 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.

