Employers Health™

WINTER 2025
A publication of Employers Health

EHCONNECT

INSIDE

FEATURING

Client Spotlight

Monique Johnson
Willow Bridge

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™

Winter 2025

MESSAGE
FROM CHRIS GOFF

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

WELCOME TO OUR NEWEST CLIENTS

Middlesex County Joint Health Insurance Fund, NJ

Everon LLC

Catholic Charities, Diocese of Cleveland

The Blackstone Group

Pascua Yaqui Tribe Health Services Division

I'm often asked what makes up the composition of the Employers Health team. The short answer is, the team of account managers, pharmacists, lawyers, data and financial experts helps plan sponsors reduce pharmacy benefit costs through the power of group purchasing. The reality is, our work does not stop there.

Over 100 dedicated team members work behind the scenes to ensure your pharmacy plan meets the needs of your organization and employees. Most importantly, we serve as an advocate for your organization in the complex world of pharmacy benefits. This advocacy has never proven more powerful than it is now, especially given the regulatory pressures facing the industry.

That's where the power of group purchasing with Employers Health is essential. Our team is here to advocate collectively on behalf of the more than 475 plan sponsors and 2.2 million lives we cover. While PBM may be a small part of the many hats you wear, it's our year-round focus; we utilize our expertise to protect your plan and participants.

We will continue to provide updated resources, both in print — like this magazine — and online, to keep you informed about the evolving industry landscape. When it comes to doing what is right and representing your interests, we will always serve as your advocate. Just as our founders intended, we remain committed to helping reduce benefits costs for your organization, employees and their dependents.

The State of Pharmacy Benefits Legislation: 2025 in Review

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

This past year, states continued to pass comprehensive pharmacy benefit legislation focused on pharmacy reimbursements, network composition, patient affordability and market transparency. Many of these laws ban spread pricing, mandate higher reimbursements coupled with increased dispensing fees ranging from $10-$15 for independent pharmacies and prohibit exclusive or narrow pharmacy networks that incentivize participants to use in-network pharmacies.

Some notable, first-of-their-kind laws included Illinois HB 1697, which imposes a $15 covered life assessment on pharmacy benefit managers (PBMs) in the state. The fees will support a state prescription drug affordability fund that provides grants to independent pharmacies. Montana HB 740 requires a $15 minimum dispensing fee for independent pharmacies, the highest we've seen in the commercial market. Iowa SF 383 marked the first attempt to enforce a state copay accumulator program ban against the self-funded ERISA market.

Other state trends include the following:

Market conduct exams and plan reporting

Currently, there are 13 states in some phase of PBM market conduct examination, also referred to as assessments. More states are proposing this type of language in their PBM licensing and regulation bills. As the scope of these market examinations has broadened, some examinations have involved the disclosure of sensitive plan information.

In early 2025, many employer industry groups sounded the alarm when the Florida Office of Insurance Regulation sought access to de-identified claims information as part of its initial market conduct assessment. As state departments of insurance conclude these initial examinations and release findings, there could be adjustments to PBM compliance plans in response to those findings. Some states have even required certain reporting directly from group health plans and employers. There is an ongoing lawsuit in Arkansas where a union is challenging the National Average Drug Acquisition Cost (NADAC) reporting requirements, Rule 128.

Lack of consensus on ERISA preemption

In light of recent federal ERISA preemption decisions, some states have recognized the limits of state regulatory authority on ERISA plans, while others continue to assert that states may regulate private, self-funded employers. In 2024, the Washington legislature passed SB 5213, a law that prohibited mandatory mail and steering patients to PBM-affiliated pharmacies. The law contains explicit language stating that the state department of insurance does not have enforcement authority over ERISA plans and, therefore, the law would not apply to ERISA plans unless such plan opted into the regulation by providing notice to the state insurance commissioner.

On the contrary, North Dakota passed HB 1584 in April. It was a relatively simple bill that removed the existing exemption of self-funded ERISA plans from the state insurance code's definition of "covered entity." This provision greatly expanded the regulatory authority of the state commissioner over these types of plans and could create uncertainty in the future as new requirements are added to the state's insurance code.

Readers may recall earlier this year when the U.S. Supreme Court declined to review the 10th Circuit's decision upholding ERISA preemption in PCMA v. Mulready. Although this has been viewed as an effective endorsement of the 10th Circuit's ruling, the holding is only binding within that jurisdiction and is persuasive authority elsewhere. As we continue to see these 2025 state laws implemented, it's very likely that we will see additional legal challenges to enforcement of these restrictions against self-funded ERISA plans.

State regulatory actions

KY SENATE BILL 188

Kentucky SB 188 was passed in April of 2024 and went into effect on January 1, 2025. Originally, most PBMs interpreted the law as only applying to plans domiciled in Kentucky. That changed on June 30, 2025, when the Kentucky Department of Insurance (DOI) released a regulatory guidance memo[1] clarifying that, moving forward, the law would apply to out-of-state plans with lives in Kentucky filling at Kentucky pharmacies. This means that plans with eligible Kentucky claims, regardless of the plan's state of domicile, would have to reimburse independent pharmacies in the state at NADAC plus a $10.64 dispensing fee.

Also included in the memo was a clear indication that not all provisions of SB 188 were enforceable against ERISA plans. Referencing recent federal court decisions examining ERISA preemption of state PBM laws, the DOI stated that the anti-steering provisions of SB 188 were preempted by ERISA.

Laws that require minimum reimbursements to pharmacies are forms of cost regulation and are not preempted by ERISA. However, laws that dictate network structure or benefit design are preempted by ERISA.

IOWA SENATE FILE 383

In May, Iowa passed one of the most comprehensive PBM reform bills to date. Among other items, the bill banned spread pricing, prohibited steering to PBM-affiliated pharmacies and required independent pharmacies to be reimbursed at NADAC plus $10.68. Many of the provisions of this law were set to take effect July 1, 2025, less than two months after the law's passage. A group of employers from the Iowa Association of Business quickly filed a lawsuit to block the law from taking effect.

A federal judge promptly granted an injunction blocking many provisions of the law, holding that it was likely preempted by ERISA. Many vendors held off on implementing plan design changes while the litigation was ongoing. On September 24, 2025, the Iowa Department of Insurance and Financial Services released a regulatory memo[2] addressing the status of SF 383 and indicating that the law would be enforced by the department as the case proceeds. An additional lawsuit was then filed by the state's largest insurer, Wellmark, seeking clarity on whether the department can lawfully enforce a law that has been found to be preempted by ERISA.

Legislation to watch through the end of the year

Over the last few years, Ohio has considered several major PBM bills including a copay accumulator ban and minimum reimbursement requirement. At one point this summer, during the state's budgeting process, language was included that would have mandated all Ohio pharmacy claims to be reimbursed at NADAC plus a $10-$14 dispensing fee. Ultimately, this provision was not included in the final budget draft due to stakeholder opposition, but we do expect to see the proposal reemerge by the end of the year. Massachusetts and New Jersey also have pending PBM bills that could gain steam in the coming months.

It is vital for plan sponsors to remain aware of these state developments and how they could impact their pharmacy benefit plans. Employers Health understands how complicated and time-consuming it can be to stay on top of ongoing industry developments. Please remember, we are here to help. This includes calling pending legislation to the attention of employers, educating stakeholders on the potential impacts of proposals and communicating any changes that may need to be addressed by clients. **If you have any questions about specific states or bills, please reach out to your Employers Health representative or Madison Connor at mconnor@employershealthco.com.**

References

1. Kentucky Department of Insurance Bulletin 2025-03
2. Iowa Department of Insurance and Financial Services Bulletin 25-06

Key State Legislation Passed in 2025:

Minimum reimbursement

Spread pricing ban

Anti-steering restrictions

Rebate mandates

ALABAMA SB 252

ARKANSAS SB 103/104

CALIFORNIA SB 41

COLORADO HB 1094

IOWA SF 383

ILLINOIS HB 1697

INDIANA SB 140

LOUISIANA HB 264

MONTANA HB 740

NEBRASKA LB 198

NORTH CAROLINA SB 479

2026

Annual Benefits Forum

March 24-25, 2026
Columbus, Ohio

Attendees will gain exclusive insights into benefits trends, network with industry professionals, meet leading solutions providers and more.

SECURE YOUR SPOT

EMPLOYERSHEALTHCO.COM/ABF26

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- Personalized Employee Experiences
- Service-First Approach
- Omni-Channel Engagement
- Custom Communication Solutions

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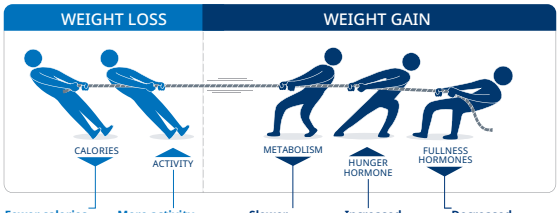
The Tug-of-War of Weight Management

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:



Fewer calories
Limiting the calories you take in—by eating small portion sizes, for example—can help you lose weight

More activity
Doing regular physical activity—like taking a walk every day—can help burn calories. But when your body loses weight, it tries to gain it back

Slower metabolism
When you lose weight, your metabolism slows down and gets more efficient. It needs fewer calories to do its job

Increased hunger hormone
With weight loss, your body increases a "hunger hormone," which tells your body you're still hungry and can lead to consuming more calories

Decreased fullness hormones
You also have hormones that tell your brain that you're full. When you lose weight, these hormones are decreased

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.

novo nordisk®

‘Weighing’ the Risks and Benefits of Obesity Coverage

Alexis Sova, PharmD
Clinical Advisor

Obesity continues to be one of the most debated topics among plan sponsors. The question is no longer as simple as, “Should we cover anti-obesity medications?” It’s redefining obesity benefits to plan sponsors’ needs, while protecting the long-term financial stability of the plan. Glucagon-like peptide-1s (GLP-1s) aren’t going anywhere. New Food and Drug Administration (FDA) approved indications of GLP-1s and consumer weight loss stories are keeping these products at the forefront of members’ minds.

Anti-obesity medications continue to gain momentum

To fully understand where obesity treatment is headed, it helps to look at where it all began.

- In 2014, Saxenda (liraglutide) was the first GLP-1 to be approved for the treatment of chronic weight management, demonstrating a 7.4% weight loss from baseline.
- In 2021, a newer generation GLP-1 weight loss product, Wegovy (semaglutide), was approved. While sharing a similar mechanism of action to Saxenda, Wegovy offered more than double the weight loss (15%-16%).
- Wegovy’s approval marked the first notable weight loss medication to come to market. Since the launch of Wegovy, Zepbound (tirzepatide) received FDA approval for the treatment of chronic weight management at the end of 2023, offering even more weight loss in clinical trials (20.9%) and a slightly different mechanism of action.

The pipeline is crowded with over a hundred medications in development for obesity treatment. By the end of 2025 and the beginning of 2026, it is expected that two oral products, semaglutide and orforglipron, will also gain FDA approval. For plan sponsors that cover obesity, these oral options may expand utilization with members who have been afraid to inject or have difficulty injecting medications.

Outside of the additional products expected to hit the market, there have been supplemental indication approvals for these medications. Wegovy has gained additional FDA-approved indications for the reduction of major adverse cardiovascular events in those with established cardiovascular disease (CVD) and obesity and for the treatment of a fatty liver condition, metabolic dysfunction-associated steatohepatitis (MASH). Zepbound has received an additional indication as the first and only medication to treat moderate-to-severe obstructive sleep apnea (OSA) in adults with obesity. These medications continue to prove their benefit in various conditions (**TABLE 1**).

TABLE 1

Obesity medications supplemental indication approval timeline[1]

OBESITY/OVERWEIGHT

- Semaglutide 25 mg; oral (Q4 2025)
- Orforglipron; oral (2026)
- Cagrilintide + semaglutide; SC (2027)
- Retatrutide; SC (2027)
- Survodutide; SC (2027)

OBESITY/OVERWEIGHT + CVD

- Semaglutide; oral (Q4 2025)
- Retatrutide; SC (2027)
- Survodutide; SC (2027)

OBESITY/OVERWEIGHT + OSA

- Orforglipron; oral (2027)
- Retatrutide; SC (2027)

OBESITY/OVERWEIGHT + OA OF KNEE

- Semaglutide; SC (Q4 2025)

OBESITY/OVERWEIGHT + CKD

- Tirzepatide; SC (2027)

OA: osteoarthritis; HF: heart failure; CKD: chronic kidney disease; OSA: obstructive sleep apnea; CVD: cardiovascular disease; SC: subcutaneous

GLP-1 supplemental indication approval timeline

(irrespective of obesity diagnosis)

MASH

- Survodutide; SC (2027)

ALZHEIMER'S

- Semaglutide; oral (2027)

MASH: metabolic dysfunction-associated steatohepatitis

Coverage decisions and utilization management opportunities

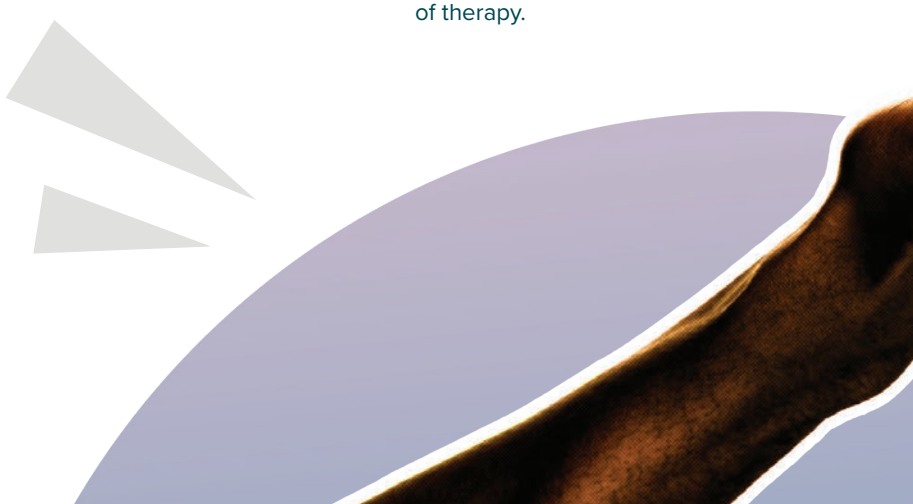
The latest report released from the Institute for Clinical and Economic Review (ICER)[2] highlights that on an individual basis, therapies like semaglutide and tirzepatide may be considered cost-effective for the treatment of obesity. However, at the population level, even a 1%-2% uptake could be cause for concern around overall affordability and sustainability of the plan. Plan sponsors that do cover obesity are encouraged to explore more innovative plan designs that balance access with cost.

The most common form of utilization management includes prior authorizations (PAs). These PAs require lifestyle changes before **and** while using anti-obesity medication, require members meet a specific percentage of obesity medication and require members to meet a specific percentage weight loss from baseline for continuation of therapy. Over 70% of Americans now meet the body mass index (BMI) criteria of ≥ 27, raising concerns whether standard PAs are enough to maintain access to members while also balancing financial concerns. As such, 14 of our plan sponsors have decided to close coverage over the last 18 months (**TABLE 2**). Some plan sponsors have even considered excluding GLP-1s while retaining coverage for older weight loss agents.

Plan sponsors wanting to still offer coverage are looking for stricter criteria. Beyond more traditional measures of adjusting the BMI threshold to ≥ 35, some plan sponsors have elected to offer coverage for those with comorbidities, where the clinical benefits may be more pronounced (e.g., obstructive sleep apnea, reducing major adverse cardiovascular events or metabolic liver disease). Other plan sponsors have explored refill threshold adjustments, supply limits, increased cost sharing and maximum allowable benefits to manage utilization.

For a month's supply of treatment, newer obesity medications can range from $1,000-$1,500. Refill threshold adjustments and supply limits help eliminate any stockpiling of medication or waste if members discontinue therapy, creating savings while preserving access. In contrast, increased cost-sharing may ease the financial burden on the plan, but can be a driver of low adherence. This raises the risk that employees will discontinue therapy before achieving clinically meaningful outcomes.

Alternatively, annual and lifetime maximum dollar limits are being heavily considered to cap employers' financial risk. This approach assists employees during the beginning of their weight loss journey and aims to sustain their weight loss through lifestyle changes once the maximum funding is reached. However, a major concern with this approach is the continuity of care and the potential for weight regain upon discontinuation of therapy.



Weight management programs

There's no one plan design that fits the needs of all of plan sponsors, but one solution has piqued plan sponsors' interest this year: weight management programs. In a recent survey conducted by our clinical team, we found that there is an increase in lifestyle and wellness platform endorsements. Survey results showed that while weight loss PAs are still heavily relied on, more plans are adding requirements for wellness programs and nutritional counseling. These options seem to offer the best balance between maintaining the member experience and providing cost savings. Some plan sponsors have opted for drug coverage tied to participation in weight management programs, which has demonstrated more savings than a voluntary approach and requires that members make active lifestyle changes while on therapy.

KEY TAKEAWAYS

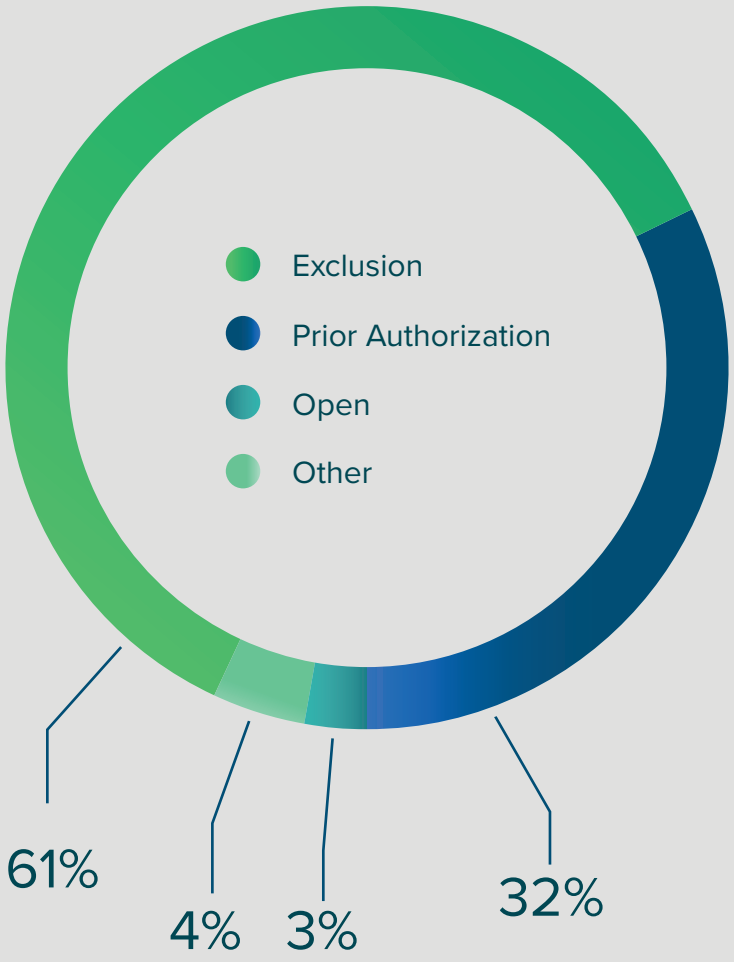
- Anti-obesity medications are not just here to stay but are expanding. New options and additional indications can be expected in the next two years.
- The introduction of oral weight loss options will likely cause increased interest, utilization and spend.
- PAs aren't always enough to keep costs down. Stricter criteria like electing coverage for those with comorbidities, refill threshold adjustments, supply limits, increased cost sharing and maximum allowable benefits are being explored by plan sponsors to mitigate costs.

While there is no universal approach to coverage, there are a multitude of opportunities available to plan sponsors to best fit their goals. The Employers Health clinical team is here to serve as a resource to inform and guide plan sponsors through these decisions to ensure they are making the 'right' decision for the plan and its members. Please contact our clinical team at **clinical@employershealthco.com** to learn the best weight loss coverage options for your plan.

TABLE 2

2025 PLAN SPONSOR COVERAGE DECISIONS

(1st Half 2025)



References

1. https://www.primetherapeutics.com/glp-1-pipeline-update-may-2025
2. https://icer.org/wpcontent/uploads/2025/09/ICER_Obesity_Draft-Report_For-Publication_090925.pdf

Noteworthy News

Nick Smith, client solutions executive and clinical team members Matt Harman and Ernesto Munoz received their Certified Employee Benefit Specialist designation from the International Foundation of Employee Benefit Plans.

Client solutions team members, Taylor Conner and Brett Pinson, were both promoted to senior director, client solutions.

Emily Clevenger, vice president, marketing and communications is chairing the Stark County Library Foundation's Holiday Home Tour — an annual fundraiser supporting the Stark County library.

Client solutions team members Liz Donley, Dan Dorman, Sam Gindlesberger, Megan Long, Alex Pantelas, Trent Petit, Nick Shatrich and Nick Smith were promoted to client solutions executives.

Haeun Kim, clinical advisor completed the Master of Business Administration program at Eastern University.

Clinical team members Kevin Wenceslao, Patrick Henry, Matt Harman and Ernesto Munoz received their Master of Business Administration degrees from Youngstown State University.

Chad Sinkovich was promoted to senior accounting manager.

Clinical advisors Courtney Keefe and Tu Doan were promoted to senior clinical advisors.

2026 Sightlines Series Webinars

PBM Fundamentals | January 15

PBM Contracting | March 3

Clinical Management Strategies | March 31

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Client Spotlight

Interview with Monique Johnson

Senior Director of Benefits
Willow Bridge

Willow Bridge

Founded in the heart of Texas in 1965, Willow Bridge has been creating places people want to call home for decades. A pioneer in the Texas residential industry, Willow Bridge has evolved into one of the largest multifamily managers and developers. At Willow Bridge, over 5,700 team members cultivate some of the nation's most exceptional residential communities. With a deep commitment to care for its people, both professionally and personally, it believes that when a team has the resources to allow them to bring their best selves to work, a stronger workplace is built. We met with Willow Bridge's senior director of benefits, Monique Johnson, to learn how the organization's approach to benefits and well-being helps employees feel supported at work and home.

Willow Bridge benefits team

How did you get your start in employee benefits?

My career in employee benefits began nearly 20 years ago. After returning from maternity leave with my twins, I accepted an administrator position that became the foundation of my benefits journey. What started as a meaningful way to reenter the workforce soon grew into a true passion. That role marked the beginning of a rewarding career.

In your career, how have you seen the industry change?

The industry has evolved immensely. On the positive side, employees continue to see benefits as a true extension of their compensation and are more vocal about what they need — whether that's mental health support, access to innovative treatments or family resources. My favorite responses are generated from our employee surveys and pulse checks; they are always insightful. There has also been a welcome shift toward holistic well-being, with programs that support not just health, but also financial wellness, family building and caregiving.

On the other hand, rising costs and intense pharmaceutical marketing have created pressure — with employees often requesting the newest drugs they see advertised, even when effective alternatives already exist. At the same time, the growing number of options, while valuable, can create confusion. The complexity of navigating different plans and resources can feel overwhelming, making proper education and communication more important than ever.

Your LinkedIn bio says that your "passion lies in creating benefit solutions that enhance the employee experience while driving organizational success." How do you bring that mentality to Willow Bridge's population?

I do so by ensuring our benefit offerings truly prioritize the needs of our employees and their families. We take time to understand not only what they need, but also what they value, so we can offer a comprehensive package that supports them both personally and professionally. We regularly invite feedback through new hire check-ins, Benefit Pulse and our annual employee engagement survey to help guide and strengthen our employee benefit strategy roadmap. By focusing on their well-being and making sure they feel heard and cared for, we allow employees to concentrate fully on delivering the best possible experience for our residents.

How does Willow Bridge approach health benefits and overall well-being for its employees?

Our commitment goes beyond a standard health and well-being plan; we're intentional about creating solutions that truly reflect the needs of our people. For example, when we saw a higher percentage of participants managing diabetes, prediabetes and cardiovascular concerns, we introduced proactive initiatives aimed at improving early outcomes before those conditions could progress. We've also added a scalable bone and joint digital solution that gives employees access to early intervention and support. By combining broad resources with individualized care, we're creating a well-rounded strategy that truly fosters the overall well-being of our employees and loved ones.

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

Employers Health is the catalyst for a multitude of enhancements for our organization through our relationship with CVS; it's exceedingly difficult to choose just one. First, PrudentRx plays a critical role by significantly reducing out-of-pocket costs for specialty medications. This is incredibly valuable as drugs with this label are often expensive but necessary to maintain quality of life. PrudentRx helps employees access these medications at little to no cost, even when manufacturer copay isn't available. This not only alleviates financial stress but also ensures employees can maintain the treatments they need without interruption. What's especially impactful is the personalized support specialists who guide employees through the program, making the whole experience smooth.

Then, we have ScriptSync, which adds real convenience by synchronizing prescription refills. For employees juggling multiple medications, this means fewer trips to the pharmacy and more organized medication management. It's a simple service, but one that really improves adherence and reduces hassle. We've been truly impressed with our Employers Health relationship, and we're only on year two!

Keeping up with benefits trends and news can be overwhelming. What resources does your team utilize to stay up to date?

Staying on top of benefit trends can feel overwhelming at times, but our team makes it a priority to stay informed so we can support our employees and organization effectively. Along with the guidance we receive through our broker, we really enjoy Employers Health's EH Connect magazine and the Sightlines webinar series. Both are great for receiving industry updates. Employers Health content is easy to digest but also ensures we're always aware of what's happening across the benefits landscape.

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

One of the most important pieces of advice I offer newcomers in employee benefits is to embrace flexibility and continuous learning. The employee benefits landscape evolves rapidly, shaped by innovations, shifting workforce expectations and frequent changes in laws and regulations. It's crucial to be able to stretch and grow with these trends while always keeping a keen eye on compliance requirements. Equally important is developing a strong moral compass to consistently do the right thing, especially when facing complex decisions. Treat every interaction as an opportunity to make complex information clear and accessible. Listen attentively, communicate transparently and remember that your work directly impacts the well-being of others. **The most rewarding benefits careers are built on a foundation of ongoing growth, sound judgment and a heartfelt commitment to guide people through their employment lifecycle.**

Have a story to share?
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