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FALL 2026
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ARTICLES

Evaluating GLP-1 Coverage for Diabetes: Key Factors Plan Sponsors Should Consider

The Course Ahead: Navigating CAA 2026 and FTC Settlements



FEATURE

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Doreen Hull
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*SOURCE FOR 5:1 ROI: Observed from gross savings from CVS Weight Management program across medical and pharmacy cost savings.
**SOURCE FOR 18% average weight loss: Reflects total weight loss from drug start.
***SOURCE FOR Employers Health™ success: CVS Health Analysis of Employers Health data performance, 1/1/25 - 6/30/2025.
CVS Health Analytics, 2025. CVS Weight Management Early Adopter Results. Actual savings vary based on client benefit plan design, implementation and promotion. Conditions for ROI guarantee apply, and full guarantee requires final sign-off by CVS® Actuarial and Underwriting.
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Evaluating GLP-1 Coverage for Diabetes: Key Factors Plan Sponsors Should Consider

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Clinical Advisor

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The Course Ahead: Navigating CAA 2026 and FTC Settlements

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

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Client Spotlight – 2026 Excellence in Benefits Award Winner

Interview with Doreen Hull
Midwest Public Risk

We sat down with this year's Excellence in Benefits Award winner, Doreen Hull, to learn how her empathetic approach to benefits has shaped her career and driven success for Midwest Public Risk.



Message From

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

As we near the end of another exciting year at Employers Health, we surpassed 500 clients, bringing our projected annual pharmacy spend to more than $6.5 billion. As our client base has grown, so has our organization, with exceptional new team members joining nearly every department. To our newest clients, welcome. We look forward to working alongside you to enhance your PBM experience and deliver greater value to your organization and plan participants.

As our team and purchasing power continue to grow, so does the industry. Since the beginning, Employers Health has been committed to providing best-in-class PBM solutions that evolve with the changing pharmacy landscape and our plan sponsors' needs. Now more than ever, plan sponsors are looking for solutions that are transparent, flexible and allow for more control over their pharmacy benefit. In response, we're proud to introduce our new solution, StarkRx.

StarkRx is a transparent, cost-plus pharmacy benefit solution designed for plan sponsors looking for an alternative to the traditional, one-size-fits-all PBM model. Anchored by Judi Rx (formerly Capital Rx) and its award-winning technology platform, clients can work seamlessly with innovators in the market and move faster to implement solutions to today's challenges. Employers Health, Judi Rx and our curated solution providers are looking forward to utilizing our combined expertise to help plan sponsors enhance their pharmacy plans. If you're interested in learning more about StarkRx, please reach out to your client solutions representative or visit our website at employershealthco.com/starkrx/.

Thank you for your continued support. Your trust allows us to continually evolve to meet the needs of employers and their employees throughout the country. We look forward to continuing to build on this momentum together.

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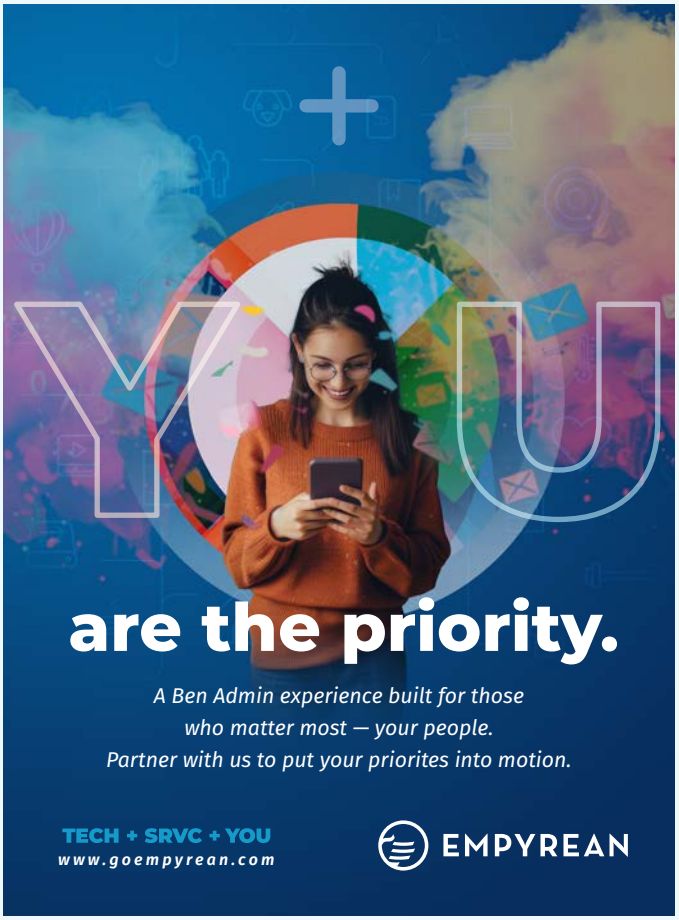
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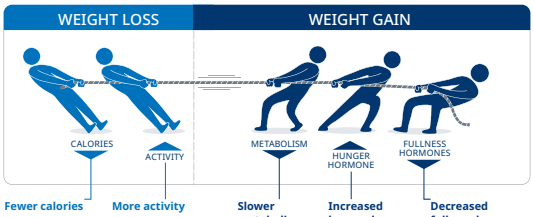
The Tug-of-War of Weight Management

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.

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Evaluating GLP-1 Coverage for Diabetes: Key Factors Plan Sponsors Should Consider

Jalyn Dickens, PharmD
Clinical Advisor



When glucagon-like peptide-1s (GLP-1s) were launched over 20 years ago, utilization and news coverage were scarce. Today, this class of medications has grown to include some of the best-selling drugs in the country.[1] Since 2005, there have been a total of nine GLP-1s approved for the treatment of Type 2 diabetes (T2D), comprised of six different active ingredients. As recommendations for GLP-1 use in diabetes expand and more drugs enter the pipeline, plan sponsors need to carefully assess coverage options.

Updated guidelines and expanded mechanisms of action are leading to an uptick in utilization

Before 2022, the American Diabetes Association (ADA) guidelines recommended GLP-1 therapy as a second-line treatment option for T2D. GLP-1s were specifically recommended for patients with atherosclerotic cardiovascular disease (ASCVD), chronic kidney disease (CKD) and weight management needs if metformin alone was not enough to achieve treatment goals. This recommendation often coincided with other classes of diabetic drugs, including sodium-glucose lowering transport 2 inhibitors (SGLT2i) such as Jardiance and Farxiga. Starting in 2022, guidelines shifted to focus more on the individual patient's additional comorbidities and management needs, ultimately opening the door to earlier use of GLP-1s in therapy.

Now, GLP-1s are recommended as first-line therapy for almost all cases of glucose-lowering or comorbidity needs. This has shifted utilization patterns to favor GLP-1s not only for current utilizers but also for those newly diagnosed with T2D. Book of business (BoB) data from one pharmacy benefit manager (PBM) showed that 34.7% of all diabetic utilizers used a diabetic GLP-1 in 2022 versus 52.4% in 2026. We expect this trend to continue as guidelines recommend GLP-1s for additional comorbidities.

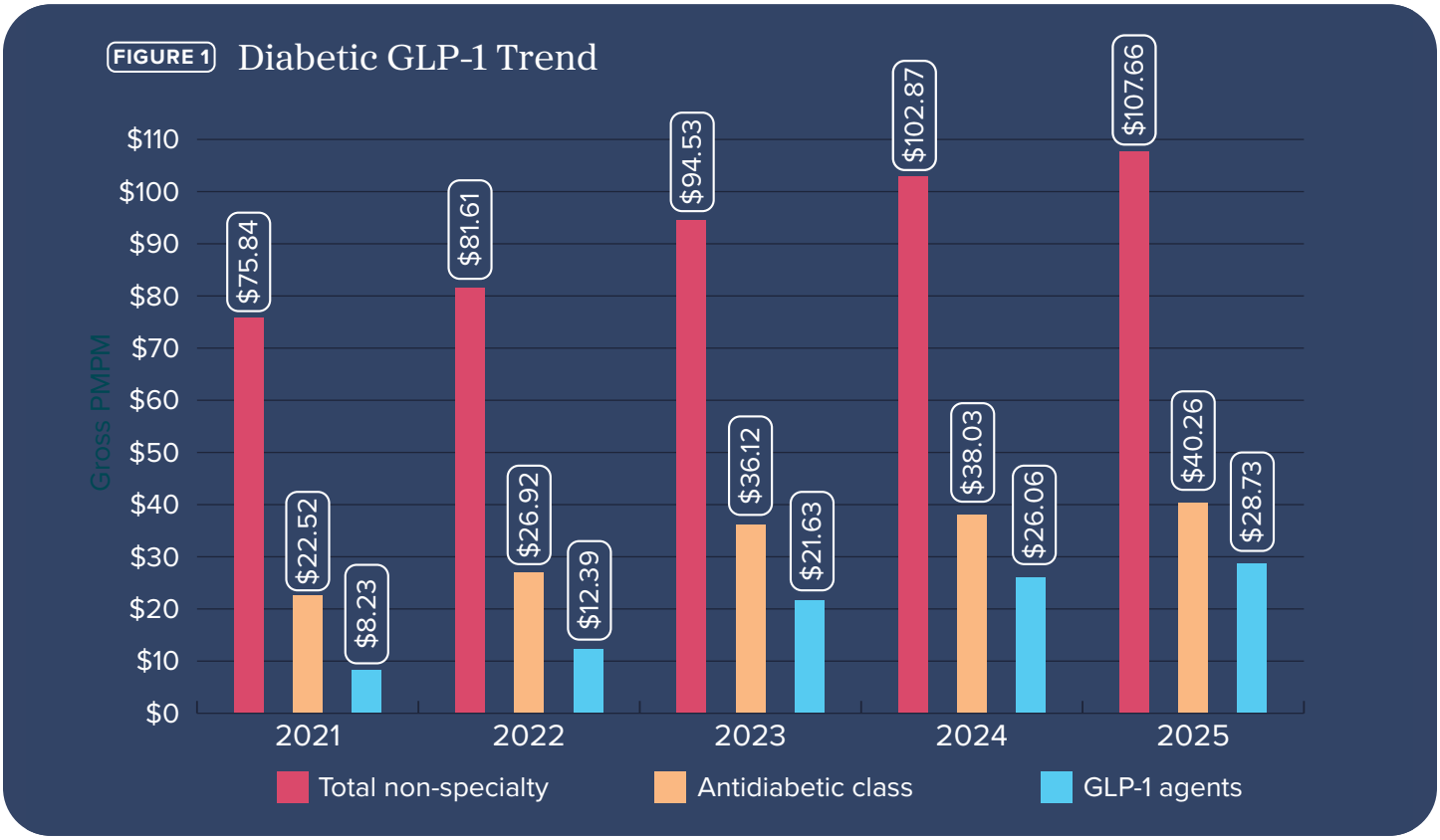
There are currently six products across four different active ingredients in the market, including both injectable and oral options. Newly identified mechanisms of action have contributed to improved product efficacy. Mounjaro is the most recently approved diabetic GLP-1 with a novel dual mechanism of action by targeting both GLP-1 and glucose-dependent insulinotropic polypeptide (GIP) receptors. A head-to-head trial of Mounjaro and Ozempic, the top two diabetic GLP-1s in the market, demonstrated that Mounjaro provided greater A1C and weight reduction compared to Ozempic's second-highest dose — driving increased utilization of Mounjaro over Ozempic.

Other notable marketplace updates include the rebrand of Rybelsus tablets. Since its approval in 2019, Rybelsus has been the first and only oral GLP-1 option available for T2D. Rybelsus was originally approved with 3 mg, 7 mg and 14 mg strengths. In 2024, a new Rybelsus formulation with additional strengths was approved. In May 2026, Novo announced that the new formulation of Rybelsus would officially be rebranded as Ozempic, with the intent to switch more patients over to Ozempic tablets while slowly phasing out the old formulation of Rybelsus.

GLP-1s consistently top Employers Health book of business trend

Over the past few years, antidiabetic drugs have consistently been in the top therapeutic class by total gross cost across our BoB. Diabetic GLP-1 trend has outpaced recent increases in both non-specialty trend and the diabetic class altogether **FIGURE 1**. Diabetic GLP-1s went from representing 37% of all antidiabetic gross cost per member per month (PMPM) in 2021 to 71% in 2025. Similarly, diabetic GLP-1s went from representing 11% of total non-specialty PMPM to 27% over the same timeframe. This trend is attributed to cost and increased utilization due to expanding treatment guidelines.

The average cost of a diabetic GLP-1 is around $1,200 per month before rebates. Between the high cost and utilization of these products, plan sponsors are experiencing significant financial burden. However, they may find relief soon due to upcoming list price reductions. Novo announced that starting January 2027, the price of Ozempic would be cut to $675 per one-month prescription, approximately a 50% reduction from current pricing. While there are still questions about what this means for rebate potential, plan sponsors are hoping that a lower upfront cost will reduce spend on this high-cost class.



Direct-to-consumer programs can be a pathway to coverage for some

Plan sponsors may start to reconsider coverage decisions due to underestimated pharmacy benefit trends and greater concerns of economic instability. Those who limit or exclude coverage of diabetic GLP-1s have an option for their members who still desire access to these medications. Direct-to-consumer (DTC) programs allow patients to bypass insurance and pay cash, often at a discounted price. While this can be a great option for some, plan sponsors must carefully weigh the pros and cons when considering sourcing products from a DTC platform.

DTC pricing may be unaffordable for some members — leading to a lack of adherence, potentially increasing a member's risk of experiencing complications and ultimately increasing costs for plan sponsors. Not only should the financial benefit of excluding coverage be considered when making decisions, but also the impact on members' long-term health and benefit experiences and satisfaction.

Employers Health and CVS Caremark exclusive management strategies

As guidelines evolve and indications expand, plan sponsors are seeking additional opportunities to manage the diabetic GLP-1 class. Employers Health has identified target areas within this drug class to provide plan sponsors under the CVS Caremark arrangement with stronger management opportunities.

One is a cumulative fill and quantity limit that aims to address duplicate therapy, early fills and medication stockpiling of GLP-1s. A 2024 study demonstrated that out of 5,713 cases reported to United States poison control centers associated with GLP-1 use, 997 (17.5%) were due to incorrect dosing and 115 (2%) were due to intentional misuse or abuse.[2] The goal of the cumulative fill strategy limits how much and how often a member could fill a GLP-1, ensuring that plan sponsors are not bearing the burden of costs associated with inappropriate use.

Another strategy addresses concurrent use of GLP-1s and dipeptidyl peptidase-4 inhibitors (DPP-4), including products such as Januvia and Tradjenta. Recent ADA guidelines have recommended that these two classes of products should not be used together due to overlapping mechanisms of action, which could increase the risk of adverse reactions. On average, our BoB saw 1 in 5 members concurrently utilizing both classes of medication. While this strategy will address unnecessary costs by preventing inappropriate use of these medications, the focus is also to encourage medication safety so that members can achieve more favorable outcomes.

New products in the pipeline will likely cause higher utilization

The diabetic GLP-1 market is already booming, and the pipeline will continue to evolve. As manufacturers compete for dominance in the market, especially with oral tablets, we expect to see multiple new products over the next three years. **FIGURE 2** showcases five GLP-1s used to treat T2D that will become available in the upcoming years.

Diabetic GLP-1s have proven their clinical benefits in the areas of T2D, ASCVD, CKD and weight management. As the market continues to change with price reductions, updates to currently approved drugs and novel drugs entering the pipeline for approval, employers continue to look for additional management opportunities. The clinical team at Employers Health is dedicated to evaluating and developing new strategies to help employers navigate coverage of this booming class and welcomes the opportunity to address any additional questions at clinical@employershealthco.com.

References

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FIGURE 2 Pipeline GLP-1s: Type 2 Diabetes

Drug Name	Route of Administration	Manufacturer	Indication	Estimated Approval Date	Estimated Cost
Potential Near-Term Approvals					
CagriSema (cagrilintide and semaglutide)	Once-weekly injection	Novo	Glycemic control in T2D	Late 2026	$5,000-$10,000 WAC/year
Mounjaro (tirzepatide)	Once-weekly injection	Eli Lilly	T2D with CVD	Approved August 2026	Current gross cost/ Rx: $1,058
orforglipron (LY3502970)	Once-daily oral tablet	Eli Lilly	Glycemic control in T2D	Late 2026	$5,000-$10,000 WAC/year Current gross cost/ Rx*: $642
Ozempic 25 mg (semaglutide)	Once-daily oral tablet	Novo	Glycemic control in T2D	Late 2026	Similar to current oral Ozempic strengths
retatrutide (LY3437943)	Once-weekly injection	Eli Lilly	Glycemic control in T2D	2027-2028	$5,000-$10,000 WAC/year

T2D: Type 2 diabetes; WAC: wholesale acquisition cost; CVD: cardiovascular disease
*Represents pricing of obesity product Foundayo, which contains the same active ingredient

Noteworthy News

Team members Dan Tyler, Bryce Horomanski, Morgan Tyler and Haeun Kim received their Certified Employee Benefit Specialist designations from the International Foundation of Employee Benefit Plans.

Taylor Conner, senior director, client solutions, joined the Canton Symphony Orchestra board.

Senior clinical advisors Catherine Berger and Courtney Keefe completed their Master of Business Administration degrees at Youngstown State University.

Megan Long, client solutions executive, received her Master of Health Administration degree from Louisiana State University.

Dan Dorman, client solutions executive, joined the National Alliance on Mental Illness (NAMI) Stark County Board.

Spencer Brown, sales operations executive, completed the Master of Business Administration program at Bowling Green State University.

2027 Annual Benefits Forum

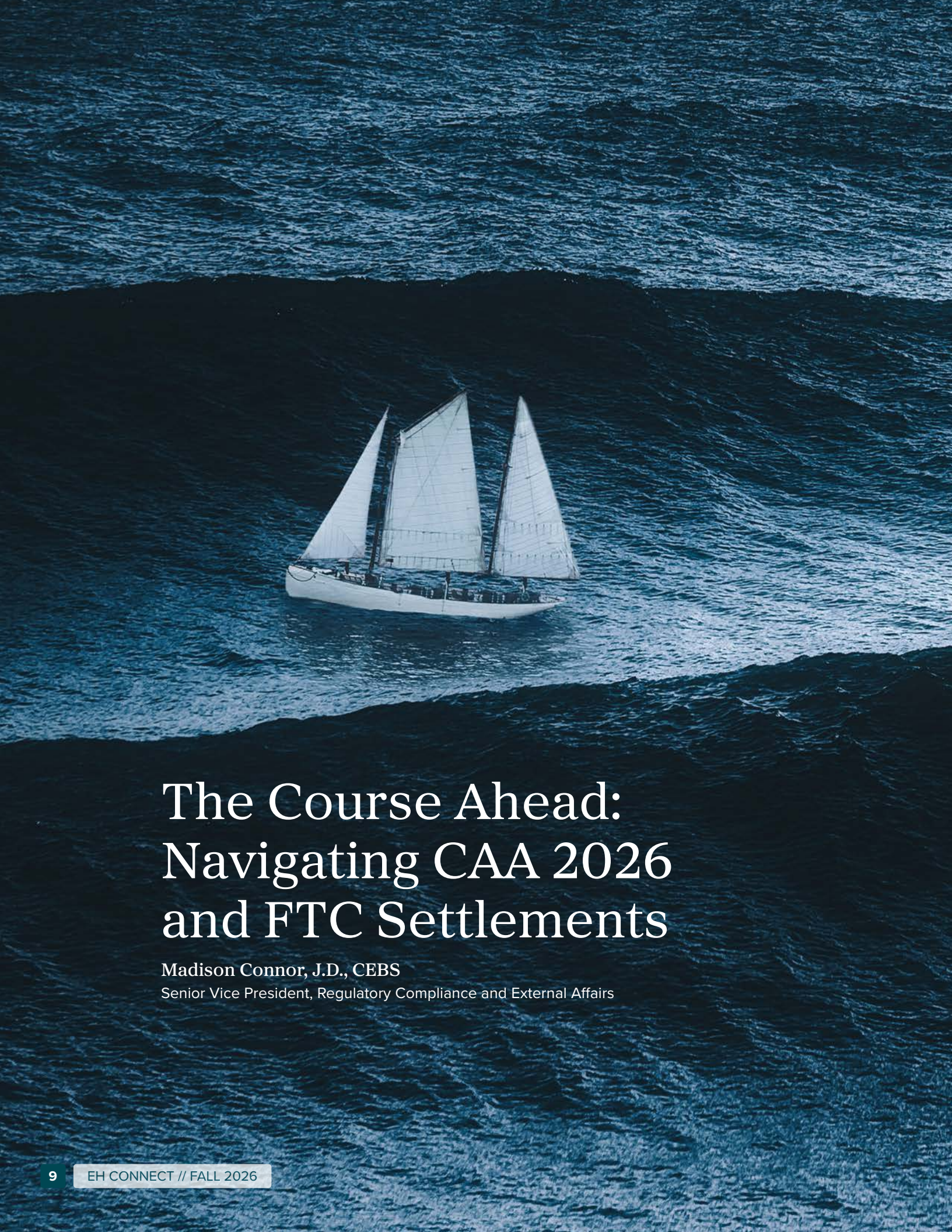
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The Course Ahead: Navigating CAA 2026 and FTC Settlements

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

In early February, Congress passed the Consolidated Appropriations Act of 2026 (CAA '26), a government funding bill enacting extensive federal changes to pharmacy benefit manager (PBM) contracting and oversight. One day later, the Federal Trade Commission (FTC) announced a landmark settlement with Express Scripts, the first of the big three PBMs to reach a settlement with the agency. A settlement with CVS Caremark followed in July, and a settlement with Optum Rx is expected shortly.

Together, these developments will shift how plans evaluate and contract for pharmacy benefit services in 2027 and beyond. Although finer details and the full impact for plan sponsors will become clearer as implementing regulations are proposed and finalized, here are the key takeaways for plan sponsors:

Consolidated Appropriations Act, 2026

The CAA '26 was signed into law on February 3, 2026. Its reforms focus on rebate pass-through requirements and increased transparency through detailed, standardized reporting from PBMs and expanded application of existing service provider disclosure requirements.

Effective date: The CAA '26 is effective for plan years beginning on or after August 3, 2028, (or January 1, 2029, for calendar-year plans).

Requirements:

- **Pass-through of rebates:** PBMs must pass through 100% of manufacturer compensation, including rebates, fees and other remuneration to the plan sponsor. This includes remuneration from group purchasing organizations (GPOs) and rebate aggregators in connection with the plan's drug utilization or spending. PBMs may retain transparent and quantifiable bona fide service fees.
- **PBM reporting to plans:** PBMs must provide standard reporting to plans every six months for each covered drug as well as total plan summary information. Reporting must include the following:
  - All compensation received by the PBM from the plan.
  - All compensation paid to pharmacies by the PBM.
  - Any spread collected between these two amounts.
  - Total rebates, fees and other remuneration received by the plan and PBM.
  - The amount the PBM paid to brokers or consultants for referrals.
  - Rationale for the formulary placement of certain high-cost drugs.
  - Any benefit design that favors PBM-affiliated pharmacies.
- **Plan notice to participants:** Plan sponsors must annually notify participants and beneficiaries of the PBMs' reporting obligations and provide relevant plan summary data upon request.

Federal Trade Commission Settlement Requirements

2027

- Low wholesale acquisition cost products are offered at parity on standard formularies
- Bids to incorporate 2028 standard offering requirements

2028

Standard offering requirements:

- Member costs are based on the net price of a drug
- TrumpRx purchases count toward member cost share
- GPO fees are delinked from the drug's list price
- An insulin affordability program caps member costs at $25 per month

2029

Standard offering requirements:

- No spread pricing
- Transition away from traditional rebate guarantees
- Point-of-sale rebates
- Cost plus reimbursement for retail community pharmacies

Next steps: The CAA '26 requires the Department of Health and Human Services, the Department of Labor (DOL) and the Department of the Treasury (collectively, the departments) to issue final regulations within 18 months after passage: August 3, 2027. These rules will clarify definitions and establish standardized processes for rebate remittance, audits and disclosures.

Anticipated impact: As a result of the changes, we anticipate PBMs will assume less financial risk and shift to fixed, fee-for-service arrangements. There will also be less reliance on traditional per-brand rebate guarantees as PBMs will be required to pass through 100% of the value they receive from manufacturers, including GPO fees and other fees tied to drug utilization. Since these fees can no longer be structured as a percentage of rebates, we expect PBMs to reallocate their compensation through alternative fees, such as per-claim or per-member fees. Enhanced drug-level rebate reporting will also provide greater visibility into net drug costs and give plan sponsors the ability to validate that the required pass-through is occurring.

Federal Trade Commission settlements

The FTC settlements mark the culmination of the insulin-pricing action the FTC brought in 2024 against the big three PBMs. Under the voluntary settlements, the PBMs have agreed to make the terms negotiated with the FTC available as a standard offering to plan sponsors beginning in 2027. The terms of the Express Scripts and CVS Caremark settlements are broadly aligned and do not materially differ from each other.

Effective date: All bid or request for proposal responses after January 1, 2027, will incorporate the terms of the standard offering. Various terms have staggered effective dates for applicability in 2028 and 2029.





Requirements:

Overall, these settlement terms reinforce several themes from the CAA ’26, including a broader market shift to net cost pricing models and removing list price-based compensation. Consistent with the consumer protection goals of the FTC, the settlement aims to shift value to the point of sale and reduce out-of-pocket costs for members.

Documentation process: While the big three PBMs must lead with the terms of the standard offering, the standard offering is not mandatory and plan sponsors can select an alternative model or arrangement. To deviate from the standard offering, plan sponsors must sign a template acknowledgment prepared by the FTC, stating in writing that they were made aware of the standard offering. The acknowledgment form is available now on the final page of the settlement.

Plan sponsors may include commentary with the acknowledgment explaining their reason for signing. This is an important consideration as plans look to document their fiduciary due diligence and demonstrate that their decision-making process was reasonable. The form will remain on file with the PBM and will not be sent to federal regulators.

Anticipated impacts: As plan sponsors prepare to evaluate the standard offering for post 1/1/27 bids, they should expect to see lower quarterly rebate revenue as manufacturer rebates are applied at the point of sale. This could increase overall plan costs, even as member out-of-pocket costs decline due to the savings passing directly to participants at the pharmacy counter. Cash flow and funding are also important factors to evaluate as there is typically a cost associated with implementing point of sale rebates due to the upfront funding adjustments that occur while waiting on manufacturer rebate payments. Plan sponsors should consider the total value of the arrangement, including rebates, point-of-sale discounts and all administrative and service fees when assessing the financial impact of the settlements.

Department of Labor rule pending final review

The White House has just finished reviewing a final rule that could require extensive PBM disclosures even sooner than the CAA ‘26 effective date. The same week the CAA ‘26 was enacted, the DOL released a proposed rule implementing stricter disclosure requirements for PBMs and covered service providers under ERISA §408(b)(2). There is significant overlap between the DOL’s proposed rule and the CAA reporting requirements. However, the DOL reporting would be required much sooner, 60 days after publication of the final rule (which is expected to be finalized by the end of 2026). Stakeholders have encouraged the DOL to withdraw its rule and align the requirements with the CAA ‘26 reporting so that vendors and plan sponsors do not have to report, digest and operationalize substantially the same information twice.

Final thoughts

While the CAA ‘26 and FTC standard offering will alter how PBMs are compensated and arm plan sponsors with more information, greater transparency does not automatically guarantee lower costs. As plan sponsors prepare to evaluate new offerings and pricing models beyond traditional per-brand guarantees, the overall financial value to the plan remains an important consideration.

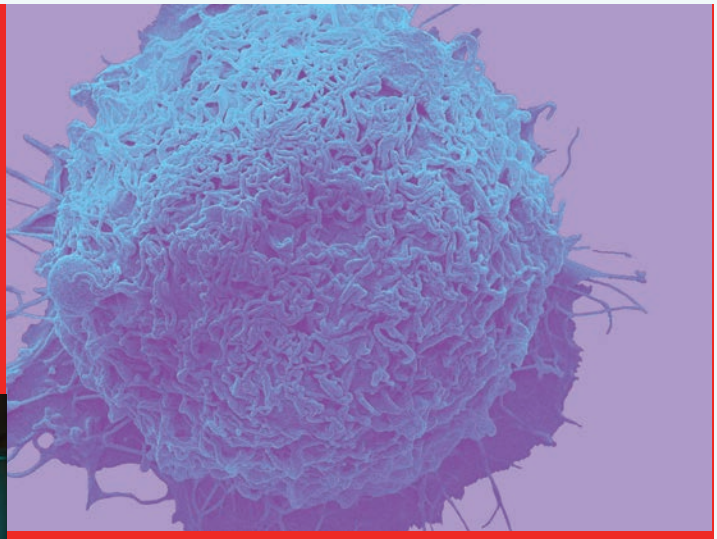
These developments will continue to evolve as PBMs determine how to comply with and operationalize these requirements, and the compliance approaches may vary across PBMs. Plan sponsors should work closely with their consultants and trusted pharmacy advisors to understand how these changes impact their specific plan, evaluate the full financial impact of emerging pricing models and use that analysis to inform a prudent, well-documented decision-making process.

For more information, please contact

Madison Connor at mconnor@employershealthco.com.

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Client Spotlight

Interview with Doreen Hull, 2026 Excellence in Benefits Award Winner

Benefit Services Director

Midwest Public Risk





Midwest Public Risk (MPR) is a trusted partner for a growing network of public entities across Missouri and Kansas. Serving more than 180 member organizations, MPR provides expert guidance, advocacy and innovative solutions to help members manage risk and deliver valuable employee benefits. At the core of this commitment is the MPR benefits team, dedicated to designing and administering comprehensive employee benefits programs that support both employers and their workforce.



Doreen Hull and Midwest Public Risk Benefits Manager Deb DeBoef at the 2026 Annual Benefits Forum.

Earlier this year, Doreen Hull, benefit services director at MPR, was honored with the Employers Health Excellence in Benefits Award. This award is presented annually to recognize individuals who have made a meaningful impact in employee benefits. Known for her delightful demeanor and passion for benefits, Doreen truly embodies "Excellence in Benefits." Our team had the opportunity to hear how her empathetic and practical approach to benefits leads to real success.

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

I had a very valuable start in benefits at a local third-party administrator. I was responsible for all steps in the benefits process: claims billing, system builds for claims, eligibility, stop loss and COBRA. Having behind-the-scenes access to the entire benefits journey back then still helps me understand today how all our decisions can impact other benefits factors. When I decided to leave that job and continue my career, a big decision was determining what aspect of benefits was the best fit for me — ultimately leading me to the customer service and sales side.

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

While we can't create a benefit plan that covers 100% of everything, we can be accountable for the decisions we make on behalf of our employees, including being fiscally responsible for all our costs. The human side of benefits is where I find success in my role. When a member comes to us for assistance, we want to help them find solutions that are affordable while still providing a great benefit plan.

Benefits can be hard to understand, and we find that clear communications that are easily accessible drive our success. When the employee says, "Thanks, I actually understand my benefits" or "Thank you for helping me make a decision," we know we've succeeded. Our team loves to hear members share how much time we save them.

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

A great benefits professional needs to be curious, an active listener and an educator. You need to always be looking for ways to improve a population's health, listen to feedback and effectively educate and communicate. There are so many different ways employees need and use their benefits, and no one solution is perfect for everyone. Some days it can wear on you emotionally to manage all the facets of the benefit plan, but it's important to remember all the good that you do as well.

In your nomination, it was mentioned that you try to create an enjoyable and educational culture for all employees. How do you approach creating a culture that employees want and are proud to be a part of?

While the needs of the people we serve are always changing and the options for healthcare are moving at a fast pace, our team still makes it a priority to stay educated and innovative on the latest in benefits. We continue to focus on the basics of keeping up with technology, customer service and ethics. Our team understands that it can be daunting to be the one who has to share price increases and tell people their requested care is denied. So, we try to use an empathetic approach to problem-solving to ensure we can handle hard conversations with care and practicality. Even in the midst of the work that needs to be done, we focus on the people at MPR. Employees are given the opportunity to recognize others in staff calls for servant leadership awards and can take advantage of a hybrid work schedule that fits their needs.

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

I am proud to say that when so many are struggling to find good healthcare, MPR remains an affordable option. My team's hard work always pays off and truly helps others. Professionally, earning my CEBS designation was a proud moment. I enjoyed the learning process and the reward was worth the work!

What is the best advice you have received in your career? What advice do you have for others?

Some of the best advice I received was to do your best with the information and skills you have. If you make a mistake, learn from the experience, but don't live in that mistake. My best advice is that you can't do it all. If you are part of a team, find the strengths and passions of each member of your team and make sure you let them be fully utilized. Giving your employees the power to be a part of the solution will help them learn, grow and succeed.





Do you have a colleague who goes above and beyond for their population?

Consider nominating them for the Employers Health Excellence in Benefits Award at **employershealthco.com/excellence-in-benefits** — nominations will close on January 18, 2027.

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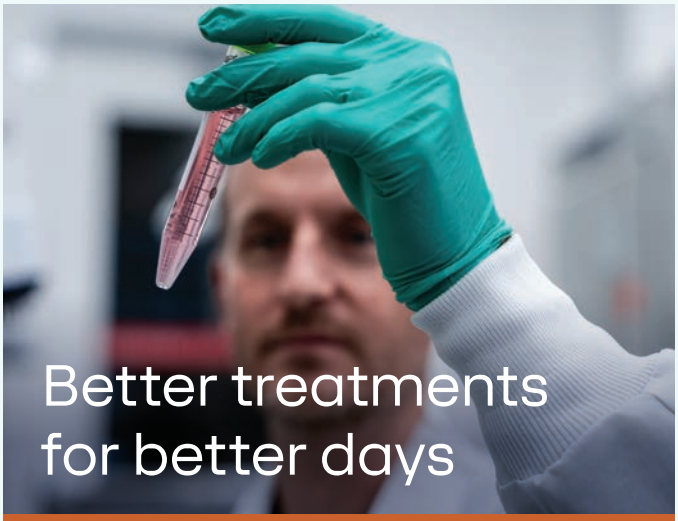
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