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MESSAGE FROM CHRIS GOFF

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

Over the past year, we've seen significant progress in our efforts to better serve our clients.

Last year, Employers Health experienced tremendous growth, and I'm pleased to announce that **we now support over 400 clients domiciled in 41 states, covering more than 1.9 million lives and spending over \$4 billion on pharmacy.** We're exceptionally proud of these milestones and eager to continue building on this momentum.

Each new year brings an opportunity to reflect on client feedback and to implement your suggestions wherever possible. A key measure of our success in meeting your expectations is our net promoter score (NPS), a rating based solely on a client's likelihood to recommend an organization to others. Employers Health is proud to report that we scored 87 (on a scale of -100 to 100) in our most recent client survey. We thank our clients for their continued support and remain optimistic that this number will only improve each year.

As a valued resource to our clients, our team takes immense pride in creating educational content and events that enhance the pharmacy benefit management experience. This includes our two-day Annual Benefits Forum, which will take place April 22 and 23 in Columbus, Ohio. Attendees will hear from seasoned pharmacy consultants, benefits

professionals, clinical management specialists and other industry experts covering the latest trends in employee and pharmacy benefits. As always, this event is complimentary for Employers Health clients. I encourage you to learn more and register at employershealthco.com/abf25.

In this issue, you'll hear from Kevin Wenceslao, director, clinical solutions on page 3, as he covers "Navigating Cancer Care: Managing Rising Incidence and Cost." On page 7, Madison Connor, senior vice president, regulatory compliance and external affairs discusses state pharmacy benefit laws. Finally, we hope you enjoy this edition's client spotlight featuring Susan Vining, human resources benefits leader at Hargrove & Associates Inc.

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Navigating Cancer Care: Managing Rising Incidence and Cost

Kevin Wenceslao, PharmD
Director, Clinical Solutions

Did you know it's predicted that 6 of the top 10 most common cancers (breast, prostate, melanoma, uterine corpus, pancreas and colorectal) in the 65 and under age group will see increases in cases throughout 2025?¹ And, young women are nearly twice as likely to be diagnosed with cancer than young men. While cancer cases continue to rise, so do the costs of treatment and care, making up 6% of total health care spending in the U.S.² With this growth comes greater threats to plan sponsor budgets and the need for more proactive measures to manage cancer holistically.

Within the Employers Health book of business, oncology is fifth in terms of net spend, costing approximately \$13.71 per member per month (PMPM) as of Q4 2024. Along with diabetes, it is projected that oncology will be a top trend driver into 2028.³ Following a brief stall during the pandemic, there has been slow and steady growth year-over-year as patients returned to doctors for visits and screenings. Unfortunately, delays in these visits have led to diagnosis and progression to later stages of cancer, necessitating more expensive therapies.

Oncology management

From a management perspective, controlling cancer costs can be divided into two approaches: prevention and treatment.

Oncology treatment and utilization management are typically handled very delicately under the pharmacy benefit. Oncology has historically been difficult to manage extensively. This is due to the high number of novel therapies, targeted mechanisms of cancer drugs and the sensitive nature of the disease state, where delays can negatively impact patient outcomes and disruption. At its most basic level, oncology agents should have a prior authorization (PA) that ensures the drug is being

prescribed to label and adhering to National Comprehensive Cancer Society (NCCN) guidelines. Usually, this involves confirming that the patient is seeing the right type of specialist, undergoing the necessary lab tests and receiving appropriate support services. However, we have witnessed a maturation in the management landscape due to competition within treatment classes, generic launches and biosimilar development. Certain types of cancer such as breast and prostate now have multiple options to choose from which can help with pricing and formulary selection.

As median list prices of cancer treatments continue to rise, many employers are becoming more open to placing coverage restrictions on this class. One study found the use of restrictions for payers rose from 17.6% to 33.5% between 2017 and 2021.⁴ For example, the Employers Health clinical team launched a custom clinical PA for the prostate cancer drug, Yonsa (~\$10,000 per Rx), which involves stepping through a generic for Zytiga

called abiraterone (~\$5,000 per Rx). While minimal differences were observed from a safety and efficacy perspective between Yonsa and abiraterone, a pathway of medical necessity was preserved to allow patients and providers to access Yonsa by providing appropriate clinical rationale. Regardless, the use of these traditional management methods remains limited, particularly for targeted and gene therapies. Instead, employers may find more value in holistic care and early prevention.

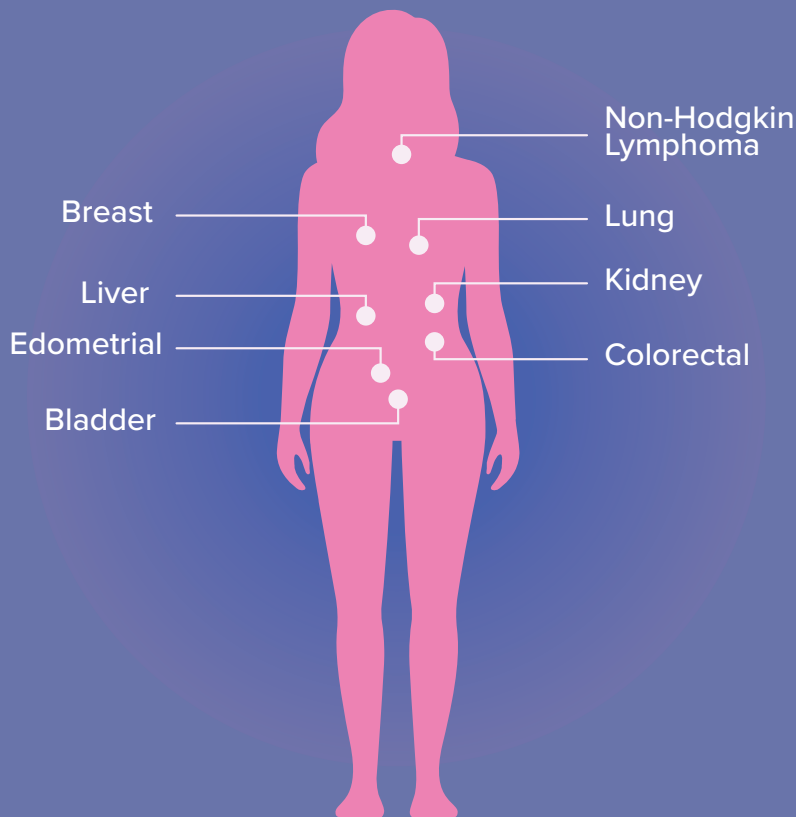
Cancer prevention best practices

Preventive measures involve promoting appropriate screenings and wellness visits to catch cancers early. As expected, early-stage diagnosis leads to better health outcomes and lower costs. While many employers provide free screenings and wellness visits, opportunities still exist to enhance employee communication and participation, target growing cancer areas and improve racial disparities within the system.

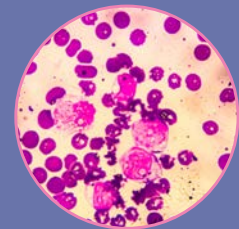
Employers Health recently collaborated with Genentech to provide plan sponsors with ideas to improve their plan design. Beyond incentivizing health care visits, recommendations include leveraging existing awareness weeks and months, providing additional reimbursement and time off for patients and even removing barriers to getting screened.

FIGURE 1 (located on page 5) highlights the general age ranges provided by various cancer-focused institutes on when people should receive screening. In its approach to improving cancer care, Genentech removed age restrictions for cervical, colorectal, prostate screenings and mammograms. Additionally, it expanded coverage to include breast MRIs, ultrasounds, colonoscopy preparation kits and genomic testing to reduce patient cost.

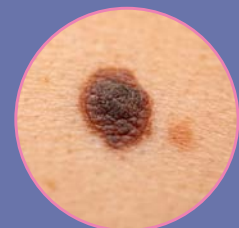
Common Cancers with Increasing Cases



Leukemia



Melanoma



While covering all these services and products may initially be a higher cost, these costs can often be offset through the early detection of cancer in plan participants. In a more targeted and financially conservative approach, plans do not necessarily have to turn on coverage for everything at once. Utilizing demographic health data can help employers identify high-risk populations to modify coverage in small but impactful ways.

Though a simple paragraph will not do this topic justice, it is important to talk about existing racial disparities in both prevention and follow-up treatment. While national trends may indicate one thing for the general populace, it is essential to understand that race and ethnicity are a significant factor in cancer. For instance, Black women have 40% higher mortality rates in breast cancer and two times higher rates in uterine corpus cancer despite similar incidence rates.⁴ This higher mortality rate in Black women can be partially attributed to the fact that Black women are less likely to receive a referral for a follow-up and mammogram after an abnormal result.¹ These disparities are extensive and numerous and can range from medical factors like tumor biology, underlying diseases or diagnostic differences, to nonmedical social detriments like income and health care access and literacy. Employers need to be aware of this dynamic, so they may utilize demographic data to tailor plan designs to address these gaps.

Simply providing free screenings may not be adequate; comprehensive support is needed to ensure appropriate follow-up, access to high-quality institutions and health care navigation assistance. Fortunately, employers are not alone in finding ways to address these challenges. National initiatives, such as Cancer Moonshot and the Persistent Poverty Initiative, are working to provide the funding, research and resources necessary to foster change.^{5,6}

So, what's next?

The approach we outlined is crucial in addressing the many challenges posed by cancer in the workplace. The landscape of cancer management is evolving with drug development, rising incidence and demographic shifts influencing employer strategies. Prioritizing preventive measures and expanding how employers cover benefits to catch cancer early can support better health outcomes while reducing long-term costs. Employers Health provides our clients and consultants with resources and market updates to assist in decision making regarding plan design beyond just pharmacy.

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TO LEARN MORE CONTACT
clinical@employershealthco.com

Recommended Cancer Screening Ages

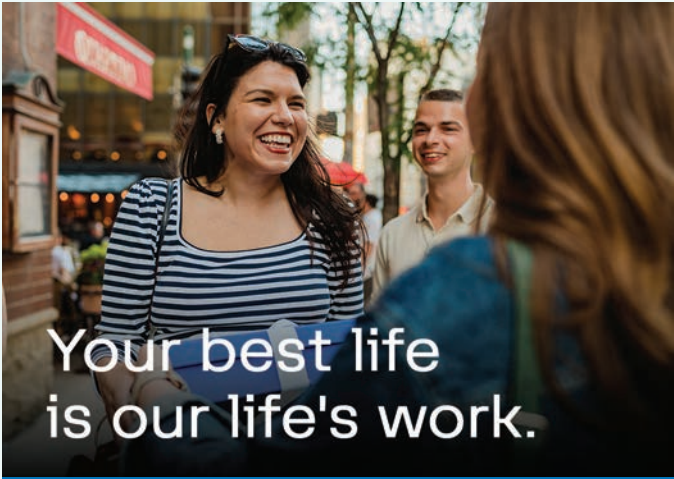
Screenings	Age	Cadence	Notes
Breast Cancer	≥ 40-45 through ≥ 75	Every 1-2 years	Frequency depends on guidelines
Cervical Cancer	21-25 through 65	Every 3-5 years	Frequency depends on test type
Colorectal Cancer	45-50 through ≥ 85	Every 1-10 years	Frequency depends on test type
Lung Cancer	≥ 50 through ≥ 80	Every year	Must meet specific smoking history to qualify for testing
Prostate Cancer	40-55 through ≥ 70	Every 1-4 years	Frequency depends on PSA levels

FIGURE 1

Guidelines based on National Comprehensive Cancer Society, U.S. Preventive Services Task Force and American Cancer Society



Scan the QR code for detailed cancer screening guidelines, reflecting the latest updates as of Q1 2025.



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State Pharmacy Benefit Laws May Get Second Look from US Supreme Court

Madison Connor, J.D., CEBS

Senior Vice President, Regulatory
Compliance and External Affairs



Since 2019, state legislatures have introduced hundreds of bills that regulate how pharmacy benefit managers (PBMs) operate and interact with pharmacies and health plans. While these proposals are primarily aimed at PBMs, the regulations impact the underlying benefit plans that the PBMs administer on behalf of employers. These laws vary widely in applicability and enforcement. One such law is currently before the U.S. Supreme Court to consider whether it is preempted by the Employee Retirement Income Security Act (ERISA).

ERISA explained

ERISA is a 1974 federal law that regulates employer-sponsored benefit plans and provides express federal preemption of any state laws that relate to an employee benefit plan. Congress's stated purpose in enacting ERISA was to provide nationally uniform and consistent regulation of plans across state lines. ERISA allows employers to design their benefit plans without state interference and ensures plans with participants in multiple states do not have to adhere to conflicting state directives.

Preemption clarity needed

In 2019, Oklahoma passed the Patient's Right to Pharmacy Choice Act. The Act included an "any willing pharmacy" provision requiring the admission of pharmacies that meet standard network requirements and prohibited plans from mandating or incentivizing certain pharmacy networks through cost-sharing discounts or lower copays. The Pharmaceutical Care Management Association (PCMA), the industry trade group representing PBMs, challenged the Act arguing that it was preempted by ERISA. The case is PCMA v. Mulready.

In 2022, an Oklahoma district court found that the Act was not preempted by ERISA. This meant that the law was deemed applicable to private self-funded plan sponsors. This decision raised the alarm with benefits advisors and multi-state employers with participants in Oklahoma, forcing them to act quickly as they determined how to comply with state-specific requirements in national plan designs. Employers that directed participants to preferred pharmacy networks or offered lower copays for mail-order prescriptions had to make changes to adapt to the new requirements. The Oklahoma Insurance Department has since clarified that the law was not intended to ban preferred networks but was primarily concerned with equalizing retail and mail order cost-sharing and copays.

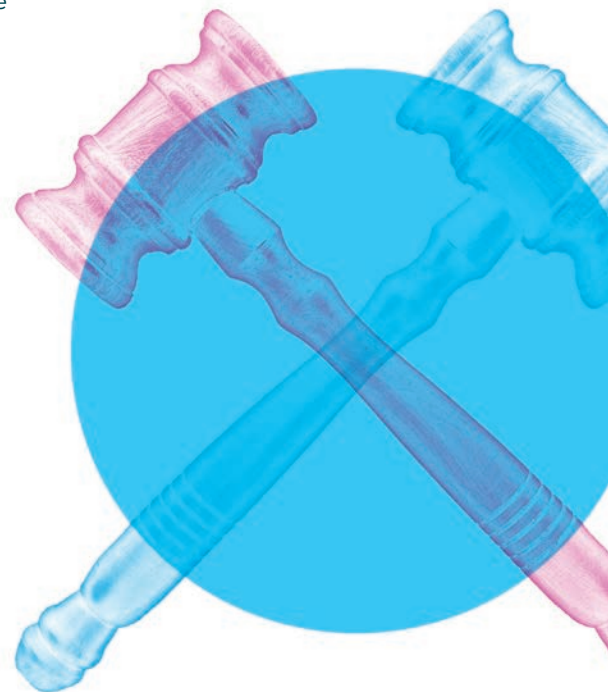
The PCMA immediately appealed the district court ruling to the U.S. Court of Appeals for the 10th Circuit, which ultimately reversed the lower holding and found that the law was preempted by ERISA. In response, the Oklahoma Insurance Commissioner's office has petitioned for review by the U.S. Supreme Court. In the fall of 2024, the Supreme Court asked the U.S. Solicitor General to file a brief with its input on the case. This request is a strong indication of the Court's interest in the case and the federal government's brief will likely carry significant influence.

The government's brief could be significantly delayed due to the presidential administration transition. Initially, the Court invited the Biden administration to file a brief offering its perspective on the case. While it remains uncertain how a new Trump administration may advise the court, the brief is expected to be filed by May, before the Court's summer recess begins.

What's at stake

With similar laws taking effect in many states, the Court's decision will have important legal and practical implications for ERISA plans and covered employees. This case could be the Court's first opportunity to consider the scope of ERISA preemption since its decision in *Rutledge v. PCMA*, where the Court articulated a narrower approach to ERISA preemption. *Rutledge* involved an Arkansas pharmacy reimbursement law that the Court ruled was not preempted by ERISA.

Since the 2020 *Rutledge* ruling, plan sponsors have been uncertain about how state laws apply to their benefit plans. States have broadly interpreted this ruling as allowing for complete state regulation of PBMs without regard to how the law impacts the underlying benefit plans. If the Court decides to reconsider the scope of ERISA preemption in the PBM space, it could provide much-needed clarification on the *Rutledge* decision's applicability and distinction between laws that mandate reimbursement levels and laws that dictate network composition, copay structure and other plan design features.



Other legal challenges to watch

The 10th Circuit's decision in *PCMA v. Mulready* is controlling precedent in the states that make up the 10th Circuit: Colorado, Kansas, New Mexico, Utah and Wyoming. Outside of the 10th Circuit, the case is not binding, but it may serve as persuasive authority. The chart below looks at some other prominent ERISA preemption cases that consider state pharmacy benefit regulations in other circuits. A difference of opinion on the same legal issue amongst circuits is a compelling reason for the Supreme Court to grant review.

Considerations for plan sponsors

As state legislative activity ramps up for the 2025 state sessions, employers should pay close attention to developments in the states where they have covered lives. Plan sponsors that have long benefited from ERISA's shield from state regulatory efforts must keep a watchful eye on existing and proposed regulations, given the mechanisms of application and recent legal challenges, and proceed with the knowledge that these efforts may only increase. Employers Health will continue to monitor developments as they arise and advocate for its plan sponsor clients.

TO LEARN MORE CONTACT
mconnor@employershealthco.com

Case Name

Jurisdiction

Details

ERIC, NLA and Cigna v. Minnesota Department of Commerce

U.S. District Court for the District of Minnesota

- Challenges department's open-network requirement, which plaintiffs argue interferes with employer plan design choices
- Argues that applying the law to out-of-state plans regulates out-of-state commerce in violation of U.S. constitutional requirements

McKee Foods Corporation v. BFP Inc. dba Thrifty MedPlus Pharmacy

U.S. District Court for the Eastern District of Tennessee

- Challenges Tennessee's "any willing pharmacy" law as preempted by ERISA because it restricts plan sponsors' ability to design tailored pharmacy networks and limits plans' ability to implement cost-saving measures



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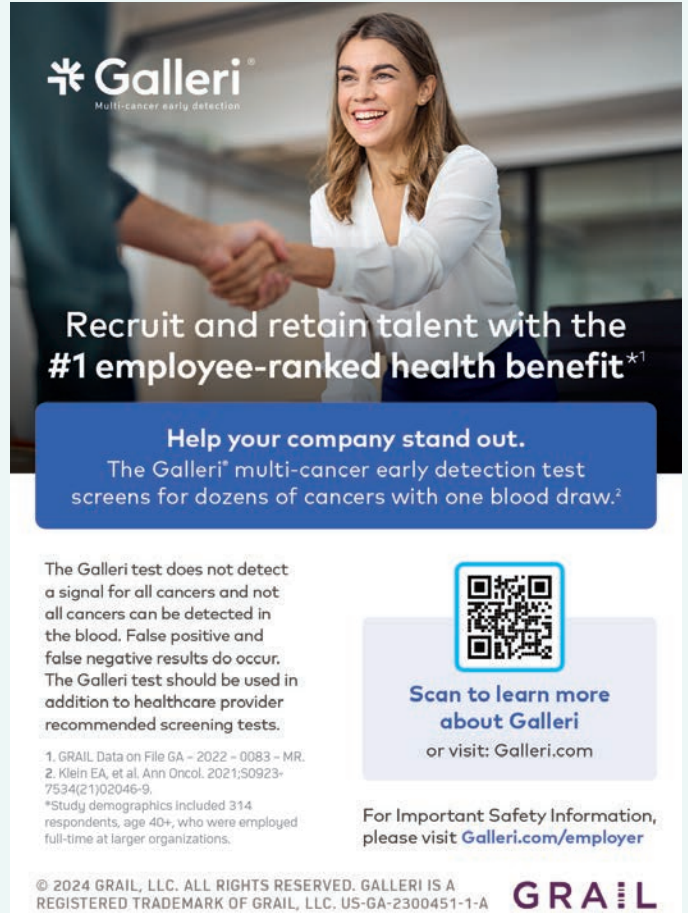




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1. GRAIL Data on File GA – 2022 – 0083 – MR.
2. Klein EA, et al. Ann Oncol. 2021;50923-7534(21)02046-9.
*Study demographics included 314 respondents, age 40+, who were employed full-time at larger organizations.

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Noteworthy News

Employers Health Chairman, President and CEO Chris Goff received the Outstanding Philanthropist Award at the Association of Fundraising Professionals' Northeast Ohio Chapter's 2024 National Philanthropy Day Awards. Nominated by the United Way of Greater Stark County for his extensive philanthropic impact in our community, this award honors individuals with a record of exceptional personal generosity, outstanding civic or charitable responsibility and impactful leadership that inspires others in philanthropy.

Megan Long, client solutions specialist was elected as a member of the board of directors of the Canton Ballet, one of Northeast Ohio's premier training grounds for classical ballet.

Chad Sinkovich, accounting manager was one of 30 certified public accountants nationwide selected for the four-day American Institute of Certified Public Accountants Leadership Academy program at Duke University. The program is designed to engage accounting and finance professionals in a self-examination of leadership to expand their competencies and empower them to become a leader within their organization, community and the accounting profession.

Chris Goff was honored with the NEOMED College of Pharmacy's Dean's Leadership Award. This award recognizes individuals and organizations that have greatly influenced the college of pharmacy and its students.

Bayley Porter, marketing operations specialist recently joined the Stark County Child & Adolescent (C&A) Behavioral Health's Let Your Light Shine committee. This committee focuses on fundraising efforts to support the non-profit in providing premier resources for emotional and behavioral health services and products that help children, youth and families succeed.

The Employers Health Foundation donated \$25,000 to the Los Angeles Fire Department Foundation to support its vital efforts to combat the devastating California wildfires. With clients in the region, Employers Health sought to support them, their families and communities during this difficult time.



In December, members of Employers Health's Canton office helped collect and organize Christmas gifts for families in need at the Serving Area Military (SAM) Center in Massillon, Ohio. The SAM Center assists local veterans and their families through community-led initiatives and programs to better the lives of those who have served.

Employers Health volunteers at the SAM Center



Protecting Your Funds: Why Employers Health is Moving to ACH

Cassidy Burger
Content Marketing Specialist

According to the 2024 Association for Finance Professionals® Payments Fraud and Control Survey Report, 80% of organizations were victims of payment fraud attacks/attempts in 2023, a 15% increase over the previous year. Additionally, fraud via interference with the United States Postal Service is up 10% from 2023¹. In 2025, Employers Health will no longer send rebate payments to clients via paper checks. For the protection of all parties, clients must utilize Automated Clearing House (ACH), an electronic network used to directly transfer funds between two bank accounts to receive payments.

The following real situation details the importance of utilizing ACH and directly contacting your Employers Health client solutions executive with any updated contact and bank information for enhanced security.

Fraud can happen to anyone, anywhere.

Recently, an email fraud scheme targeted a rebate payment intended for an Employers Health client. A fraudster impersonated the client, using her exact email address and signature to do so. Via email, the fraudster provided falsified bank account information in an attempt to redirect the funds. When asked to confirm over the phone, the fraudster refused to proceed.

Fortunately, through the due diligence and thorough verification process utilized by the Employers Health client solutions and finance teams, discrepancies were identified before bank information was updated. The client, unaware her email had been compromised, was quickly contacted by phone and confirmed the bank account information request was false.

What are the benefits of ACH?

Faster payments

Funds can be credited in less than three business days and are available immediately.

Security

Payments cannot be lost or stolen and reduce the risk of fraud, tampering and human error.

Convenience

Payments save time, eliminating trips to the bank.

Employers Health ensures your information is safe.

Our team takes your security seriously. New protocols have been adopted to ensure your information remains secure. Employers Health will never change ACH banking information without verbal confirmation from a phone number on record. When a change is requested, the Employers Health client solutions executive will call the main contact at the organization to confirm the request. Only after verbal confirmation, the client solutions executive will notify the accounting team to proceed with the change. We appreciate your understanding as we work together to combat potential scams.

Please contact your client solutions executive, or Employers Health CFO Steve Burger, with questions or concerns.

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- <https://www.afponline.org/training-resources/resources/survey-research-economic-data/details/payments-fraud>

Client Spotlight

Interview with Susan Vining

Human Resources Benefits Leader
Hargrove & Associates Inc.



Hargrove & Associates Inc.

Founded in Mobile, Alabama, in 1995, Hargrove & Associates Inc. (Hargrove) is a full-service engineering, procurement, construction, automation, life sciences and technical services firm. Now entering its 30th year, Hargrove has grown to more than 2,700 teammates across 19 offices globally. Through its family of companies, including Tormod and Hargrove Equipment Solutions, Hargrove supports clients across the full scope of asset life cycle management — from design and startup to operations, maintenance and even fabrication of customized equipment.

Hargrove's benefits team believes employee benefits are more than just a package — they're a reflection of an organization's mentality, trust and dedication to employees. Its team is committed to continuously improving and listening to employees, from entry-level to leadership, to ensure all employee needs are met. We recently spoke with Hargrove's human resources benefits leader, Susan Vining, to hear about Hargrove's approach to unique, affordable benefits.

How did you get your start in employee benefits?

I joined Hargrove in 2015 and now have more than two decades of human resources (HR) experience. I started as an HR coordinator, advanced to HR generalist and, in 2017, transitioned to benefits administration. As Hargrove has evolved, so have I — building and leading a dedicated benefits team.

Our team focuses on designing, delivering and administering a comprehensive benefits package that attracts top talent and fosters long-term retention. We are committed to expanding our offerings to meet the diverse needs of our workforce, ensuring our benefits remain innovative, competitive and impactful.

What do you feel is most rewarding about working in employee benefits?

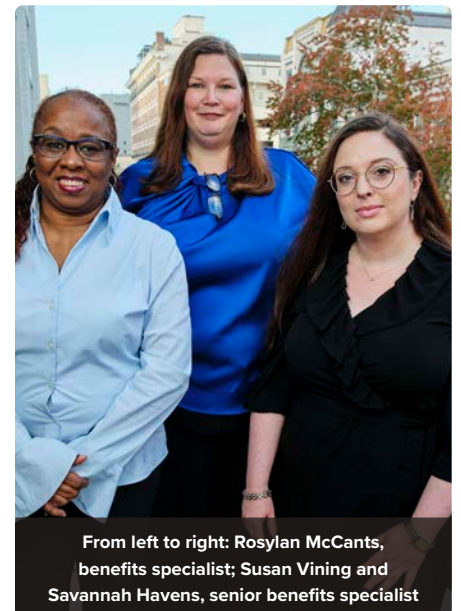
There is a deep sense of pride that comes from guiding someone through the complicated world of benefits and ensuring they understand and maximize the benefits they're entitled to. It's rewarding because it directly impacts their well-being and can often make a significant difference in the life of the team member and their family. You're not just giving answers; you're offering support that enhances their experience and security.

In benefits administration, the stakes are high. The detailed nature of benefit plans, the interaction with the PBM (pharmacy benefit manager) and the balancing act between the company's goals and teammates' needs can be a complex puzzle. When you successfully navigate those challenges, it's like solving a multi-layered problem, requiring critical thinking and creative solutions. It's this type of work that makes the result feel like a major achievement.

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

With a focus on personalized, relevant benefits, Hargrove is shifting toward a total rewards benefits approach. We want to ensure our employees are taken care of both physically, mentally and financially. Last year, we identified an opportunity to focus on our team's overall well-being. Our medical claims data started to reflect an increase in medical-enrolled employees who did not have any claims, indicating that many weren't receiving preventive testing. We want to encourage our team members to complete their preventive testing to identify potential issues before they arise.

To encourage preventive testing, we partnered with a service that offers at-home testing. Kits include a tape measure, a blood pressure cuff and even an at-home blood collection device for bloodwork. It also includes a health history and mental health screening. The cost of this at-home kit is processed as a preventive claim through our medical provider and will be provided to teammates this year.



From left to right: Rosylian McCants, benefits specialist; Susan Vining and Savannah Havens, senior benefits specialist

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?

Our approach to benefits management at Hargrove demonstrates a strong commitment to adaptability, communication and the active engagement of our team. We strive to stay ahead of the curve by monitoring industry trends and implementing benefits that meet the needs of today's workforce. A key focus is educating our teammates on their benefits. When they understand how to utilize their benefits effectively, they become more engaged, ask questions, explore benefit options and attend educational sessions. Educational sessions are a core part of our culture. We host webinars from different providers throughout the year and hold face-to-face open enrollment meetings in our U.S. offices.

One unique benefit we're proud to offer is genetic testing. When we first transitioned to a self-funded medical plan, it was like unlocking a door to a vault of information. One trend identified was an increase in late-stage cancer diagnoses, leading us to evaluate genetic testing benefits. This program helps identify genetic traits that may make someone more likely to develop certain types of cancer. By addressing potential concerns early, we improve health outcomes while mitigating long-term costs for our plan.



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

Employers Health plays a pivotal role in supporting our team's strong commitment to professional development. Continuous learning is essential for tackling the complex problems we face in employee benefits and Employers Health consistently provides relevant webinars that address the challenges we encounter. Another valuable resource is our benefits consultant, HUB International. Its team proactively delivers essential benchmarking analytics, keeping our team informed on emerging industry and legislative trends.

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

Employers Health serves as a trusted advocate, always ready to assist when we need help. Its support is consistent and dependable, often feeling like an extension of our own benefits team. Employers Health consistently keeps us informed on upcoming changes well in advance, ensuring we're always prepared before our team is impacted. Like many organizations, we're mindful of rising health care costs, but Employers Health negotiates better rebates and discounts with our pharmacy provider, helping to mitigate these increases.

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

From the beginning of our relationship with Employers Health, one of our non-negotiables was the experience our team would have when working with the Employers Health team. We place a high value on excellent customer service and the ability to receive timely answers, and Employers Health has consistently exceeded these expectations. Even after years of working together, their team's customer service remains exceptional.

While it's inevitable that not all questions can be answered with a "yes," our client solutions executive and clinical representatives take the time to explain the reasoning behind decisions. Employers Health's transparency allows us to effectively communicate and educate our team members, ensuring they fully understand the rationale behind any impactful decisions. In every interaction, Employers Health demonstrates a deep commitment to our success, and we couldn't be more satisfied with our relationship.

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

First and foremost, I want to say this: you will never get bored! The field of employee benefits is one of the most dynamic and evolving areas of HR, and that's not changing anytime soon. Benefits, especially health care, can be complex and sometimes overwhelming, but that's where the magic happens. Knowing that you are helping your teammates navigate these complexities and empowering them with understanding and access to resources is one of the most fulfilling aspects of employee benefits. What makes this journey even more rewarding are the partnerships we build along the way that provide critical support in delivering the best outcomes for our teams. So, if you're ready to step into a field where you'll learn every day, make a meaningful impact and support the people who make your organization thrive, I encourage you to dive in.


**Have a story to share?
Contact us at
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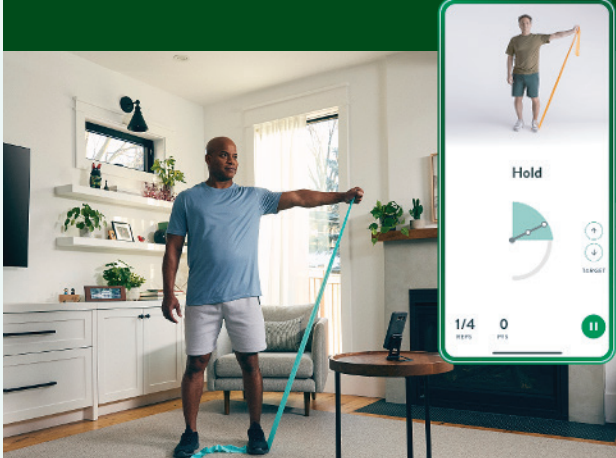
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When it comes to obesity, support employees with **The Weigh Forward**

Losing weight and keeping it off is hard because of how my body reacts to weight loss. Making a weight-management plan with my healthcare provider is important to my success— as is having coverage for an anti-obesity medicine because they can help me lose weight and maintain it!

Employers play an important role in providing access to treatment for employees with obesity

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