June 2, 2025

City of Joplin, Missouri

Medical PPO and Prescription Drug Request for Proposal Analysis Effective January 1, 2026

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Executive Summary

Background Information and the RFP Process

- On behalf of the City of Joplin, Missouri (the City), Segal prepared a Request for Proposal (RFP), which was sent to organizations capable of providing medical and prescription drug services to eligible City employees, retirees and dependents.
- Each medical and prescription drug bidder was asked to provide proposals for an administrative services only (ASO) arrangement for both medical and prescription drug services.
  - Currently the City has an ASO arrangement with UMR.
  - UMR is the third-party administration (TPA/ASO) affiliate of UnitedHealthcare (UHC), the largest business unit of UnitedHealth Group.
  - The City utilizes the UnitedHealthcare Choice Plus PPO network
- Each organization was asked to provide a proposal with an effective date of January 1, 2026.

Vendor	Submitted PPO Proposal	Submitted PBM Proposal
Anthem BlueCross BlueShield (Anthem)	◆	◆
Aetna Inc. (Aetna)	◆	◆
Cigna Healthcare Solutions (Cigna)		
UnitedHealthcare Services (UHC) *via UMR* (Incumbent)	◆	◆

- Cigna declined to quote stating they could not provide a competitive proposal.
- The following sections compare the proposals submitted by each bidder.

Executive Summary *(continued)*

Financial Overview of Medical PPO ASO Proposals

- The chart below highlights the key information relevant to the Medical PPO ASO RFP analysis:

Financial Proposal Highlights	UMR	Aetna	Anthem
Year 1 Administrative Fees (PEPM)*	$40.82	$33.39	$39.95
Administrative Fee Guarantee	5 Years, with Rate Increases from 2.5% - 3.0% each Year	5-Year Guarantee, 3 Years Flat, 3% Increases in Years 4 and 5	3-Year Guarantee, 2 Years Flat, 2.8% Increase in Year 3
Estimated Average Discount - Primary Network	70.1%	58.6%	66.8%
Estimated Network Penetration - Primary Network	98.8%	98.6%	98.4%
Allowances and Credits - 5-Year Total	$100,000	$161,000	$25,000
Guarantees - Total at Risk	$87,700	$54,300	$64,600

*PEPM= Per Employee Per Month

- Administrative fees above do not include credits associated with prescription drug rebates. All rebates are included in the pharmacy benefit management (PBM) analysis section of this report.
- The network discounts for bidders are based on a blend of bidder-reported discounts by 3-digit zip codes, bidder-reported discounts to Uniform Data Submission (UDS) and bidder-reported repricing results based on the City's actual 2024 experience.
- Anthem's proposal includes the BlueCard Program, which provides access to other Blues plans for members and dependents residing in states where Anthem is not the Blues plan. BlueCard fees are passed through via the claim files from the "host" Blues plan. These estimated fees are included in the administrative fees above, based on the City's utilization.

Executive Summary *(continued)*

Overall Financial Analysis Per Employee Per Month (PEPM)

- The financial summary table below illustrates the overall combined medical PPO and PBM first year plan (cost)/savings of each proposal compared to UMR's proposal to continue the current arrangement:

Description	UMR - Current	UMR	Aetna	Anthem
Medical Cost (PEPM)	$620	$620	$860	$700
Medical Administrative Fees (PEPM)	$40.82	$40.82	$33.89	$39.95
Prescription Drug Cost (PEPM)	$362	$253	$321	$259
Employee Assistance Program (PEPM)	$1.56	$2.38	$1.63	$1.83
Stop-Loss Insurance (PEPM)	TBD	TBD	TBD	TBD
HSA (PEPM)*	$0.00	$1.75	Not Provided	$2.45
Total Combined Cost (PEPM)	$1,024	$918	$1,217	$1,004
Total Annual Cost	**$6,662,500**	**$5,969,400**	**$7,914,300**	**$6,527,300**
Savings/(Cost) from Current		$693,100	($1,251,800)	$135,200
Percent from Current		-10.4%	18.8%	-2.0%

Actual experience may differ due to, but not limited to, such variables as changes in the regulatory environment, local market pressure, health trend rates and claims volatility. The accuracy and reliability of health projections decreases as the projection period increases. The actual experience in a self-funded plan could vary. As such, the projected costs are illustrative only and show a comparison of the vendors based on historical data; these costs should not be used for budgeting purposes.

- Total Annual costs are based on an assumed enrollment of 542 employees as of April 2025.
- All costs have been projected to January 1, 2026.
- Estimated rebates are included in the projected prescription drug costs.

*HSA PEPM costs would be applied only to those employees who have an HSA account; not all of the enrollment

Executive Summary *(continued)*

Overall Financial Analysis Aggregate Costs

Description	UMR - Current	UMR	Aetna	Anthem
Medical Costs				
Claims Cost	$4,032,500	$4,032,500	$5,593,400	$4,552,800
Administrative Fees	$265,500	$265,500	$220,400	$259,800
Total Medical Cost	$4,298,000	$4,298,000	$5,813,800	$4,812,600
Prescription Drug Costs				
Plan Cost Before Rebates	$3,224,900	$3,084,100	$3,104,600	$3,042,200
Rebates	($870,500)	($1,439,500)	($1,014,800)	($1,355,400)
Rx Plan Cost After Rebates	$2,354,400	$1,644,600	$2,089,800	$1,686,800
Total Medical + Rx Costs	$6,652,400	$5,942,600	$7,903,600	$6,499,400
Savings/(Cost) from Current	-	$709,800	($1,251,200)	$153,000
Percent Savings/(Cost) from Current	-	10.7%	(-18.8%)	2.3%

Note: Costs are based on an assumed enrollment of 542. Medical costs are based on the City's actual experience in calendar year 2024. All costs have been projected to January 1, 2026. Medical costs do not include EAP or HSA costs.

Actual experience may differ due to, but not limited to, such variables as changes in the regulatory environment, local market pressure, health trend rates and claims volatility. The accuracy and reliability of health projections decreases as the projection period increases. The actual experience in a self-funded plan could vary. As such, the projected costs are illustrative only and show a comparison of the vendors based on historical data; these costs should not be used for budgeting purposes.

Executive Summary *(continued)*

Financial Overview of PBM Proposals

Description	UMR - Current	UMR	Aetna	Anthem
Plan Cost Before Rebates	$3,224,900	$3,084,100	$3,104,600	$3,042,200
Rebates	$870,500	$1,439,500	$1,018,400	$1,355,400
Plan Cost After Rebates	$2,354,400	$1,644,600	$2,089,800	$1,686,800
Year 1 - Plan Cost Price Improvements		**$709,800**	**$264,600**	**$667,600**
Plan Cost Before Rebates	$3,583,500	$3,431,700	$3,430,100	$3,370,200
Rebates	$901,300	$1,706,700	$1,129,600	$1,556,500
Plan Cost After Rebates	$2,682,200	$1,725,000	$2,300,500	$1,813,700
Year 2 - Plan Cost Price Improvements		**$957,200**	**$381,700**	**$868,500**
Plan Cost Before Rebates	$4,000,600	$3,836,400	$3,808,200	$3,752,100
Rebates	$935,600	$1,933,600	$1,281,100	$1,798,000
Plan Cost After Rebates	$3,065,000	$1,902,800	$2,527,100	$1,954,100
Year 3 - Plan Cost Price Improvements		**$1,162,200**	**$537,900**	**$1,110,900**
Total 3-Year Plan Cost Savings		**$2,829,200**	**$1,184,200**	**$2,647,000**

Executive Summary *(continued)*

Claim Projections

- The cost projections represent estimated medical and prescription drug claims cost for the 2026 plan year
- Medical and Prescription drug costs have been trended from 2024 to 2026 using the following annual trend factors:
  - Medical: 7%
  - Prescription Drugs: 10%*
- Trend accounts for a combined increase of approximately $1,000,000 projecting claims from 2024 to 2026 or about $500,000 increase each year
- Any cost savings shown only reflect the difference between the current contract terms to the new proposed contract terms, they do not offset expected trend
- Each year, costs increase by trend so “savings” will be reduced due to annual trend increases

*Prescription drug trends incorporate several different factors (cost and use) based on drug type (generic, brand, specialty) and channel (retail, retail-90, mail, specialty). This factor illustrates an overall average trend.

Executive Summary *(continued)*

Stop-Loss Insurance

- In order to provide a proposal for stop-loss insurance, carriers typically require a minimum of 9 months of claims utilization for the current stop-loss period. For a January 1, 2026 effective date, carriers would require claims detail through at least September 30, 2025.
- Each finalist was asked to provide preliminary rates for comparison purposes. All of the premium rates proposed by the finalists were comparable to the current arrangement.
- A separate stop-loss RFP will be conducted in late 2025 in order to obtain firm stop-loss insurance quotes for January 1, 2026.

Executive Summary *(continued)*

Medical Plan Scoring

- The following table outlines the overall scoring for each of the bidders, broken out by the scoring categories included in the RFP

Category	Points	UMR	Aetna	Anthem
Financials	30.00	30.00	23.79	27.60
Capability	30.00	29.45	30.00	28.51
Network	15.00	13.76	15.00	14.30
Match Benefits	15.00	15.00	14.32	13.98
Organization	10.00	10.00	8.88	8.91
Subtotal	**100.00**	**98.21**	**91.99**	**93.30**

Executive Summary *(continued)*

Prescription Drug Plan Scoring

- The following table outlines the overall scoring for each of the bidders, broken out by the scoring categories included in the RFP

Category	Points	UMR	Aetna	Anthem
Financials	30.00	30.00	25.43	29.18
Capability	20.00	17.26	20.00	18.17
Formulary	20.00	20.00	11.05	10.76
Network	20.00	18.04	16.86	20.00
Organization	10.00	9.75	10.00	9.84
Subtotal	**100.00**	**95.05**	**83.34**	**87.95**

Executive Summary *(continued)*

Overall Medical and Prescription Drug Plan Scoring

- The following table outlines the overall scoring for each of the bidders, broken out by the scoring categories included in the RFP

Category	Points	UMR	Aetna	Anthem
Combined Total	**100.00**	**97.26**	**89.40**	**91.70**

- The medical and prescription drug scores are weighted 70% medical and 30% prescription drug, which aligns with projected costs

Executive Summary *(continued)*

Summary of Proposals

- UMR was the highest-scoring bidder overall, scored well in all categories, and was the highest bidder on:
  - Medical and Prescription Drug Financials
  - Medical Benefits
  - Prescription Drug Formulary
  - Medical Organization
- Aetna was the lowest-scoring bidder overall, scored well in all categories but Medical and Prescription Drug Financials, and was the highest-scoring bidder on:
  - Medical and Prescription Drug Capability which includes claims processing, customer service, EAP and wellness programs
  - Prescription Drug Organization which includes financial status and contractual questions
- Anthem was the second highest bidder overall, scored well in all categories, and was the highest bidder on:
  - Prescription Drug Network
- All bidders provided comprehensive and thoughtful responses, as is shown by the bidders' scores being very close to each other

Executive Summary *(continued)*

Health Savings Account (HSA) Qualified Plan Fact Sheet

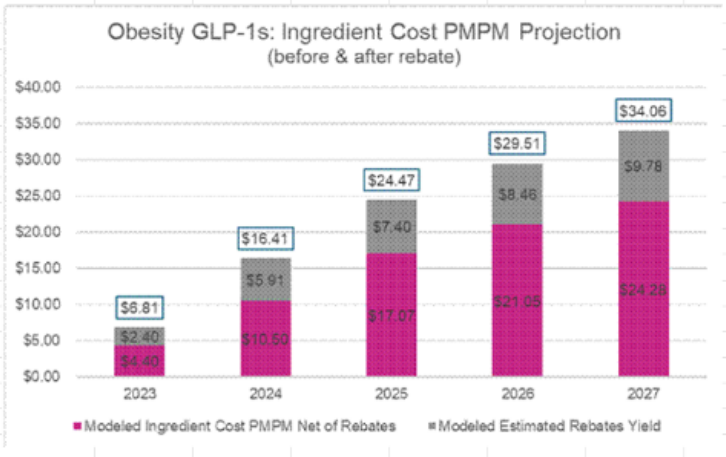
Item	Description
Deductible	All non-preventive services must be subject to the deductible, including office visits and prescription drugs – preventive services and prescription drugs may be covered at 100%
	The IRS sets a minimum deductible, which is indexed each year – it is $1,650 for individual coverage and $3,300 for family coverage for 2025
	Full family deductible applies - one or many individuals on a contract must reach the family deductible before any services move to coinsurance – the minimum family deductible is $3,300 for 2025
HSA	You can contribute tax-free to the HSA - $4,300 for individual coverage and $8,550 for family coverage and $1,000 “catch-up” contribution for those 55 and older
	Triple tax savings – no tax on contributions, no tax on earnings, no tax when taken out for qualified expenses
	You don’t lose your money if you don’t use it – it is a savings account, not a spending account
	Qualified expenses include medical, prescription drug, dental, vision and hearing out-of-pocket costs like an FSA, but you can also use it for COBRA, Medicare Advantage and long-term care premiums
	There is no time limit on reimbursing yourself for qualified expenses – make sure you keep receipts for your taxes in case you are audited
	It is portable - you can take it with you from employer to employer and use it in retirement
	If you use your HSA for non-qualified expenses, the reimbursement is subject to a 20% penalty and normal income taxes

Executive Summary *(continued)*

Weight-Loss Drugs – GLP-1s

- UMR has provided estimates of the cost impact of adding GLP-1 drugs for weight loss
- The gross cost increase for 2025 is 12% and the net cost increase (net of rebates) is 11.2%
  - 2024 gross costs: $24.47 PMPM increase x 1,151 members x 12 months = $337,980
  - 2024 net costs: $17.07 PMPM increase x 1,151 members x 12 months = $235,771

	2025	2026	2027
Gross of Rebates			
Projected Rx Claims	$2,789,200	$3,123,900	$3,498,800
Projected Employees	528	528	528
PEPM	$440.21	$493.04	$552.21
Projected BBs	1,143	1,143	1,143
PPPM	$203.35	$227.76	$255.09
OPTUM AOM BOB (PPPM)	$24.47	$29.51	$34.06
Impact on RX (gross)	12.0%	13.0%	13.4%
Net of Rebates			
Projected Rebates	($697,300)	($781,000)	($874,700)
Projected RX Claims (net of rebates)	$2,091,900	$2,342,900	$2,624,100
Projected BBs	1,143	1,143	1,143
PPPM	$152.52	$170.82	$191.32
OPTUM AOM BOB (PPPM) (net of rebates)	$17.07	$21.05	$24.28
Impact on RX (net of rebates)	11.2%	12.3%	12.7%



Recommendations

- **Medical/ Prescription Drug RFP:** Based on the final scoring, award the business to UMR – the incumbent
  - The medical discounts on the broad network have proven to be accurate and remain very competitive
  - The prescription drug rebates will increase substantially in the new contract period, so this should positively impact the net drug costs
- **HSA-Qualified Plan:** We recommend surveying the City's population to understand the desire for this plan
  - The HSA is an excellent way to save for healthcare expenses in retirement with triple tax savings, but the plan must comply with certain requirements – higher deductible, all services apply to the deductible, full family deductible – making them less attractive to some employees
  - If implemented, we would design a plan that is actuarially equivalent or lower to the current plan so it would not negatively impact the City's costs
- **Weight loss drugs (GLP-1s):** We recommend continuing to evaluate coverage for these drugs
  - At this point, the cost of these medications can be over $1,000 per month and medical cost savings have not yet been documented since these are newer medications on the market
  - Finding the right partners and programs to support members while on these medications is critical to ensure adherence to achieve meaningful weight loss and then to maintain it – new programs are starting, but there are no long-term studies showing their effectiveness
  - On May 12, 2025, President Trump signed an executive order (EO) on lowering prescription drug cost. It would provide most-favored-nation price targets to bring prices for American patients in line with comparably developed nations. If implemented, the EO could bring the costs for all drugs including weight loss drugs down significantly. As an example, Wegovy is $1,348 in the US and $328 in Germany[1].
  - We will evaluate allowing coverage to members who have a higher BMI (obese/morbidly obese). Currently UMR offers a program that will cover members who have a BMI of 30 or more (considered obese) or BMI of 27 with a weight-related comorbidty along with the Virta Weight Engage Program to support members with nutritional and other support while taking these medications.

1 How Do Prices of Drugs for Weight Loss in the U.S. Compare to Peer Nations' Prices? | KFF

Agenda

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  - **PBM Financial Details – Three Years**
  - **PBM Contractual Details**
  - **Inpatient Hospital Disruption**
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  - **Prescription Drug Formulary Disruption**
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  - **Financial Ratings**
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PBM Pricing Models

Traditional and Transparent

Traditional (Spread) PBM Pricing

Traditional PBM pricing is the older and more commonly used model. In this arrangement, the PBM negotiates with drug manufacturers and pharmacies for discounts and rebates. The PBM then charges its client a negotiated price for prescription drugs and pays the pharmacy a different price, typically a lower price. The difference between the two prices is the PBM's profit. Here are the pros and cons of traditional PBM pricing:

Pros:

- **Cost Predictability:** With a well negotiated PBM contract containing the correct terms and guarantee language, plans have a clearer understanding of what their overall pharmacy benefit costs will be, making budgeting more manageable.
- **Potential Cost Savings:** Traditional PBMs may be able to negotiate substantial discounts with manufacturers and pharmacies, resulting in cost savings for clients so long as they have competitively negotiated discounts with their PBM.

Cons:

- **Opacity:** The primary drawback of traditional PBM pricing is the lack of insight into what makes up their pharmacy benefit costs. Clients may not have full visibility into the actual costs, rebates, and discounts secured by the PBM, potentially leading to overpayment.
- **Conflict of Interest:** Traditional PBMs may be incentivized to choose higher-cost drugs or formulary options that offer larger rebates, which can conflict with the best interests of the client.

Transparent (Pass-Through) PBM Pricing

Transparent PBM pricing, on the other hand, offers greater visibility into the actual costs and fees associated with managing pharmacy benefits. With this model, PBMs pass on all discounts, rebates, and fees directly to the client, eliminating the profit "spread" that a traditional PBM makes between what they charge the client and what they pay the pharmacy. Transparent PBMs predominately generate revenue by charging a separate, fixed administrative fee for their services on each claim. Here are the pros and cons of transparent PBM pricing:

Pros:

- **Visibility:** Clients can see all costs, including discounts and rebates, ensuring that they know exactly where their money is going.
- **Fewer Conflicts of Interest:** Transparent PBMs have no incentive to favor higher-cost drugs or formulary options, as their revenue is derived solely from administrative fees.

Cons:

- **Administrative Costs:** While the administrative fees are fixed, they might be higher than the PBM markup in the traditional model, potentially increasing overall costs for clients.
- **Cost-management:** Transparent pricing can be more expensive than traditional pricing since the PBM isn't incentivized to aggressively manage the price a client pays a pharmacy.

PBM Financial Details – One-Year

- Bidders were asked to propose a 3-year contract term, assuming an effective date of January 1, 2026, for a self-funded traditional pricing arrangement that includes annual pricing and rebate guarantees and 100% pass-through of rebates for a $0 administrative fee for basic PBM services. Bidders were also asked to provide a secondary bid for a transparent pass-through arrangement of all discounts and rebates for a low administrative fee. Proposals were based on an average of 542 total lives.

Year 1 Projected Pricing Improvements	Current	UMR (Traditional)	UMR (Pass Through)	Aetna (Traditional)	Anthem (Traditional)	Anthem (Pass Through)
Gross Drug Cost (Before Rebates)	$3,422,300	$3,281,700	$3,281,700	$3,301,800	$3,239,400	$3,239,400
(+) Administrative Fees	$0	$0	$24,900	$0	$0	$15,500
(-) Member Cost Share	$197,400	$197,600	$197,600	$197,200	$197,200	$197,200
Net Drug Cost (Before Rebates)	$3,224,900	$3,084,100	$3,109,000	$3,104,600	$3,042,200	$3,057,700
(-) Rebates	$870,500	$1,439,500	$1,439,500	$1,014,800	$1,355,400	$1,355,400
Net Drug Cost (After Rebates)	$2,354,400	$1,644,600	$1,669,500	$2,089,800	$1,686,800	$1,702,300
Total Price Improvements After Rebates ($)		**$709,800**	**$684,900**	**$364,600**	**$667,600**	**$652,100**
Total Price Improvements After Rebates (%)		**30.1%**	**29.1%**	**11.2%**	**28.4%**	**27.7%**

Note: All projections are based on the following assumptions:

• Experience Period: Projections are based on the 1/1/2024 – 12/31/2024 claims experience provided by UMR trended to the three-year projection period. The 2025 guaranteed pricing, including minimum guaranteed rebates, from the current contract was used for all projected years of the "Current Terms" baseline.

• Segal normative trend is applied across all offers.

• Cost and Utilization for compound, vaccine, paper claim and other excluded products have been separated in this analysis and assumed to have similar costs under each projection. Generic dispensing rate (GDR) increases are applied in all years of the projection. These projections do not include guaranteed generic dispensing rates, clinical program costs or implementation credit allowances, if applicable. Financial guarantees may be adjusted for caveats made in the minimum contractual requirements.

• Each bidder provided a pricing offer tailored to the City. The total cost for the City was calculated individually for each bidder. Each bidder proposed specialty lists and drug pricing exclusions that were accounted for individually for each bidder in the total financial analysis.

• Member cost share was based on the current plan designs and current lives.

• An exclusive specialty network arrangement in place under the current contract and all bids

• Claims costs for Humira biosimilars have been adjusted based on the bidders' proposals.

The projections in this report are estimates of future costs and are based on information available to Segal at the time the projections were made. Segal has not audited the information provided. Projections are not a guarantee of future results. Actual experience may differ due to, but not limited to, such variables as changes in the regulatory environment, local market pressure, health trend rates and claims volatility. The accuracy and reliability of health projections decrease as the projection period increases. Segal's pricing guidance is not intended to provide legal advice. Issues involving the interpretation of laws/regulations should be referred to legal counsel for authoritative advice.

PBM Financial Details – Three-Years

- Bidders were asked to propose a 3-year contract term, assuming an effective date of January 1, 2026, for a self-funded traditional pricing arrangement that includes annual pricing and rebate guarantees and 100% pass-through of rebates for a $0 administrative fee for basic PBM services. Bidders were also asked to provide a secondary bid for a transparent pass-through arrangement of all discounts and rebates for a low administrative fee. Proposals were based on an average of 542 total lives.

3 Year Projected Pricing Improvements	Current	UMR (Traditional)	UMR (Pass Through)	Aetna (Traditional)	Anthem (Traditional)	Anthem (Pass Through)
Gross Drug Cost (Before Rebates)	$11,410,300	$10,954,200	$10,954,200	$10,943,100	$10,764,800	$10,764,800
(+) Administrative Fees	$0	$0	$75,100	$0	$0	$46,800
(-) Member Cost Share	$601,300	$602,000	$602,000	$600,200	$600,300	$600,300
Net Drug Cost (Before Rebates)	$10,809,000	$10,352,200	$10,427,300	$10,342,900	$10,164,500	$10,211,300
(-) Rebates	$2,707,400	$5,079,800	$5,079,800	$3,425,500	$4,709,900	$4,709,900
Net Drug Cost (After Rebates)	$8,101,600	$5,272,400	$5,347,500	$6,917,400	$5,454,600	$5,501,400
Total Price Improvements After Rebates ($)		**$2,829,200**	**$2,754,100**	**$1,184,200**	**$2,647,000**	**$2,600,200**
Total Price Improvements After Rebates (%)		**34.9%**	**34.0%**	**14.6%**	**32.7%**	**32.1%**

Note: All projections are based on the following assumptions:

• Experience Period: Projections are based on the 1/1/2024 – 12/31/2024 claims experience provided by UMR trended to the three-year projection period. The 2025 guaranteed pricing, including minimum guaranteed rebates, from the current contract was used for all projected years of the "Current Terms" baseline.

• Segal normative trend is applied across all offers.

• Cost and Utilization for compound, vaccine, paper claim and other excluded products have been separated in this analysis and assumed to have similar costs under each projection. Generic dispensing rate (GDR) increases are applied in all years of the projection. These projections do not include guaranteed generic dispensing rates, clinical program costs or implementation credit allowances, if applicable. Financial guarantees may be adjusted for caveats made in the minimum contractual requirements.

• Each bidder provided a pricing offer tailored to the City. The total cost for the City was calculated individually for each bidder. Each bidder proposed specialty lists and drug pricing exclusions that were accounted for individually for each bidder in the total financial analysis.

• Member cost share was based on the current plan designs and current lives.

• An exclusive specialty network arrangement in place under the current contract and all bids

• Claims costs for Humira biosimilars have been adjusted based on the bidders' proposals.

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PBM Contractual Details

Key Contractual Terms

- Bidders were asked to propose a 3-year contract term, assuming an effective date of January 1, 2026, for a self-funded traditional pricing arrangement that includes annual pricing and rebate guarantees and 100% pass-through of rebates for a $0 administrative fee for basic PBM services. Bidders were also asked to provide a secondary bid for a transparent pass-through arrangement of all discounts and rebates for a low administrative fee. Proposals were based on an average 542 total lives.
- Below is a summary of key contractual terms noted within each PBM's proposal, followed by clarification on any terms they disagreed with or partially agreed to.

Requested Terms	UMR	Aetna	Anthem
Allowances and Credits			
Implementation Allowance	N/A (incumbent)	$2,710 ($5 Per Member)	$100,000 (term of contract)
Annual General Pharmacy Allowance	$1,626 ($3 Per Member Per Year)	$1,084 ($2 Per Member Per Year)	
Market Check Rights			
Annual Market Check	● One time per term	● Not offered	● One time per term
Audit Rights			
Annual	●	●	●
Audit up to 24 Months	●	●	●
Termination Provisions			
Without Cause Rights	●	●	●
Termination Written Notice	●	●	● 90 Days
Penalty for Early Termination	● Retain earned but unpaid rebates	● Retain earned but unpaid rebates and no reconciliation	● $3 PEPM for remainder of initial term

Chart Key: ● Agreed ● Partially Agreed ● Disagreed

Inpatient Hospital Provider Disruption

Inpatient Hospital Provider Disruption

Provider Name	Provider City	Provider State	Provider Specialty Desc	Eligible Charges	UMR	Aetna	Anthem
FREEMAN HEALTH SYSTEM	Joplin	MO	HOSPITAL	$1,168,700	◆	◆	◆
MERCY HOSPITAL JOPLIN	Joplin	MO	HOSPITAL	$409,249	◆	◆	◆
RESEARCH MEDICAL CENTER	Kansas City	MO	HOSPITAL	$325,270	◆	◆	◆
CHILDRENS MERCY HOSPITAL	Kansas City	MO	HOSPITAL	$169,942	◆	◆	◆
L E COX MEDICAL CENTERS	Springfield	MO	HOSPITAL	$161,865	◆	◆	◆
GRAND FALLS CENTER FOR RECOVER	Joplin	MO	HOSPITAL	$146,355			
MERCY HOSP SPRINGFIE	Springfield	MO	HOSPITAL	$84,099	◆	◆	◆
COMMUNITY HOSPICES OF AMERICA	Joplin	MO	HOSPICE	$45,600	◆	◆	◆
BJH NORTH CAMPUS	Saint Louis	MO	HOSPITAL	$31,047	◆	◆	◆
SPRINGWOODS	Fayetteville	AR	HOSPITAL	$24,200	◆	◆	◆
NEOSHO MEMORIAL HOSPITAL	Chanute	KS	HOSPITAL	$17,392	◆	◆	◆
THE RECOVERY VILLAGE MARYLAND	Upper Marlboro	MD	HOSPITAL	$10,400	◆	◆	◆
AVALON JOPLIN	Joplin	MO	HOSPICE	$6,225	◆	◆	◆
FREEMAN NEOSHO HOSPITAL	Neosho	MO	HOSPITAL	$3,555	◆	◆	◆
NEW DIRECTIONS	Joplin	MO	HOSPITAL	$2,354	◆	◆	◆
PHELPS COUNTY REGIONAL MEDICAL	Rolla	MO	HOSPITAL	$0	◆	◆	◆
Total Count of In-Network Providers					**15**	**15**	**15**

◆ = In-Network Provider

= Out-of-Network Provider

Outpatient Hospital Provider Disruption

Top 25 Outpatient Hospital Provider Disruption

Provider Name	Provider City	Provider State	Provider Specialty Desc	Eligible Charges	UMR	Aetna	Anthem
FREEMAN HEALTH SYSTEM	Joplin	MO	HOSPITAL	$2,759,207	◆	◆	◆
MERCY HOSPITAL JOPLIN	Joplin	MO	HOSPITAL	$772,021	◆	◆	◆
UNIVERSITY OF KANSAS HOSPITAL	Kansas City	KS	HOSPITAL	$362,062	◆	◆	◆
MERCY SPECIALTY HOSPITAL SOUTH	Galena	KS	HOSPITAL	$324,890	◆	◆	◆
SURGICAL CTR	Joplin	MO	SURGERY CENTER	$297,780	◆	◆	◆
MIDWEST DIVISON OPRMC LLC	Leawood	KS	HOSPITAL	$259,221	◆	◆	◆
MERCY HOSPITAL CARTHAGE	Carthage	MO	HOSPITAL	$151,179	◆	◆	◆
32ND STREET SURGERY CENTER	Joplin	MO	SURGERY CENTER	$137,775	◆	◆	◆
L E COX MEDICAL CENTERS	Springfield	MO	HOSPITAL	$112,708	◆	◆	◆
MERCY HOSP SPRINGFIE	Springfield	MO	HOSPITAL	$101,524	◆	◆	◆
FAYETTEVILLE VAMC	Joplin	MO	HOSPITAL	$78,765	◆	◆	◆
MUSKOGEE VAMC	Joplin	MO	HOSPITAL	$59,511	◆	◆	◆
MD ANDERSON CANCER	Houston	TX	HOSPITAL	$53,386	◆	◆	◆
COX MONETT HOSPITAL	Monett	MO	#N/A	$41,634	◆	◆	◆
ARKANSAS CHILDRENS NORTHWEST I	Springdale	AR	HOSPITAL	$37,277	◆	◆	◆
MERCY HOSPITAL NORTHWEST ARKAN	Rogers	AR	HOSPITAL	$30,504	◆	◆	◆
SM PRAIRIE STAR	Lenexa	KS	SURGERY CENTER	$25,967	◆	◆	◆
KU MEDWEST AMBULATO	Leawood	KS	SURGERY CENTER	$23,484	◆	◆	◆
RESEARCH MEDICAL CENTER	Kansas City	MO	HOSPITAL	$22,808	◆	◆	◆
CHILDRENS MERCY HOSPITAL	Leawood	KS	HOSPITAL	$19,796	◆	◆	◆
FREEMAN NEOSHO HOSPITAL	Neosho	MO	HOSPITAL	$18,542	◆	◆	◆
CITIZENS MEMORIAL HOSPITAL	Bolivar	MO	HOSPITAL	$16,081	◆	◆	◆
BAPTIST MEDICAL CENTER LITTLE	Little Rock	AR	HOSPITAL	$14,651	◆	◆	◆
OCHSNER ST MARY	Morgan City	LA	HOSPITAL	$11,965	◆	◆	◆
BAYLOR SCOTT WHITE H	Woodway	TX	HOSPITAL	$8,863	◆	◆	◆
Total Count of In-Network Providers					**25**	**25**	**25**

◆ = In-Network Provider

= Out-of-Network Provider

Non-Hospital Provider Disruption

Top 50 Non-Hospital Provider Disruption

Provider Name	Provider City	Provider State	Provider Specialty Desc	Eligible Charges	UMR	Aetna	Anthem
UPPAL,GULSHAN,MD	Joplin	MO	NEUROLOGY	$2,061,324	◆	◆	◆
FOGARTY,CHERYL,A,MD	Joplin	MO	OBSTETRICS & GYNECOLOGY	$298,298	◆	◆	◆
QUEST DIAGNOSTICS	San Juan Capistrano	CA	INDEPENDENT LAB	$248,710	◆	◆	◆
GOODEN,DAVID,DO	Joplin	MO	ANESTHESIOLOGY	$156,229	◆	◆	◆
SMITH,SHARI,L,DO	Joplin	MO	PEDIATRICS	$120,767	◆	◆	◆
MATLOCK,STEPHEN,M,MD	Joplin	MO	DERMATOLOGY	$69,630	◆	◆	◆
JOSEPH,MICHAEL,E,MD	Joplin	MO	ALLERGY AND IMMUNOLOGY	$53,284	◆	◆	◆
MAY,DANICA,MD	Mission	KS	UROLOGY	$50,859	◆	◆	◆
LEE,SUNGHOON,MD	Springfield	MO	NEUROLOGICAL SURGERY	$49,736	◆	◆	◆
MEIER,KELLY,J,DO	Joplin	MO	PEDIATRICS	$43,294	◆	◆	◆
APRIA DME	Carl Junction	MO	DURABLE MEDICAL EQUIPMENT	$43,208	◆	◆	◆
CHILDRENS,MERCY HOSP AMB,MD	Kansas City	MO	AMBULANCE	$42,335	◆	◆	◆
BARNES,BRYAN,D,DO	Joplin	MO	FAMILY PRACTICE	$40,748	◆	◆	◆
NEWKIRK,MARY,APRN NP FNP	Webb City	MO	NURSE PRACTITIONER	$39,973	◆	◆	◆
KING,TAMI,PMHNP BC	Joplin	MO	PSYCHIATRY	$38,923	◆	◆	◆
HARGRODER,DAVID,E,MD	Carthage	MO	TRAUMATIC SURGERY	$36,833	◆	◆	◆
LABORATORY CORPORATION OF AMER	Overland Park	KS	INDEPENDENT LAB	$35,812	◆	◆	◆
BOREN,STEVEN,CRNA CNA RNA	Joplin	MO	NURSE ANESTHETIST	$35,607	◆	◆	◆
MORNINGSTAR,JULIE,LPC MS MA	Joplin	MO	COUNSELOR/THERAPIST	$34,950	◆	◆	◆
ROGERS,ALISON,M,MPT PT	Joplin	MO	PHYSICAL & OCCUPATIONAL THERAPY	$34,729	◆	◆	◆
SHAH,HEERAL,R,MD	Joplin	MO	OPHTHALMOLOGY	$33,470	◆	◆	◆
HANDOKO YANG,MAUREEN,MD PHD	Galena	KS	CHILD NEUROLOGY	$30,422	◆	◆	◆
WILSON,LUKE,A,MD	Galena	KS	RADIOLOGY	$23,964	◆	◆	◆
PORT,JOHN,D,MD PHD	Rochester	MN	RADIOLOGY DIAGNOSTIC	$23,646	◆	◆	◆
VO,MAI,V,MD	Springfield	MO	PEDIATRICS	$22,434	◆	◆	◆

◆ = In-Network Provider

= Out-of-Network Provider

Non-Hospital Provider Disruption *(continued)*

Top 50 Non-Hospital Provider Disruption *continued*

Provider Name	Provider City	Provider State	Provider Specialty Desc	Eligible Charges	UMR	Aetna	Anthem
HARRIS,ALYSSA,EPT	Joplin	MO	ELECTRODIAGNOSTIC MEDICINE	$22,406	◆	◆	
PERRY,AMY,PMHNP	Joplin	MO	PSYCHIATRY	$21,099	◆	◆	◆
WAGNER,KRISTIN,D,NP APRN FNP	Galena	KS	NURSE PRACTITIONER	$20,132	◆	◆	◆
WALKER,RENEE,A,DO	Joplin	MO	OTORHINOLARYNGOLOGY	$19,420	◆	◆	◆
COATS,ROBERT,A,CRNA	Galena	KS	NURSE ANESTHETIST	$18,330	◆	◆	◆
PHYSICIAN SERVICES O,,MD	O Fallon	MO	PUBLIC HEALTH	$18,095	◆		◆
ALLIANCE REHAB & MED EQUI	Ozark	MO	DURABLE MEDICAL EQUIPMENT	$17,581	◆	◆	◆
PFEFFER,SEAN,C,MD	Joplin	MO	FAMILY PRACTICE	$16,333	◆	◆	◆
PATTERSON,MEGAN,F,MD	Joplin	MO	ALLERGY AND IMMUNOLOGY	$16,289	◆	◆	◆
NATERA	Austin	TX	INDEPENDENT LAB	$15,600	◆	◆	◆
GAVULA,VERONICA,H,PA	Kansas City	MO	PHYSICIAN ASSISTANT	$15,363	◆	◆	◆
MAWD PATHOLOGY GROU	Joplin	MO	INDEPENDENT LAB	$15,021	◆	◆	◆
GREEN COUNTRY EMERG	Joplin	MO	EMERGENCY MEDICINE	$14,756	◆	◆	◆
BECK,PEGGY,A,LSCSW	Joplin	MO	SOCIAL WORKER	$14,640	◆	◆	◆
LINCARE	Carl Junction	MO	DURABLE MEDICAL EQUIPMENT	$14,583	◆	◆	◆
ANCHA,SUDHAKAR,MD	Joplin	MO	GASTROENTEROLOGY	$13,525	◆	◆	◆
METRO ER TRANSPORT	Joplin	MO	AMBULANCE	$13,494	◆	◆	
CARDIONET	Malvern	PA	LAB, X-RAY AND DIAGNOSTIC MEDICINE	$12,750	◆	◆	◆
PHELAN,NATHANIEL,M,MD	Joplin	MO	DERMATOLOGY	$12,032	◆	◆	◆
HOLMES,ERNEST,S,IV,MD	Neosho	MO	PEDIATRICS	$11,710	◆	◆	◆
BOCK,KELLY,CRNA	Joplin	AR	NURSE ANESTHETIST	$11,492	◆	◆	◆
PUTNAM,WAYNE,E,DO	Springfield	MO	RADIOLOGY DIAGNOSTIC	$11,171	◆	◆	◆
PATTERSON,CRAIG,MD	Joplin	MO	PATHOLOGY	$11,058	◆	◆	◆
BADWEY,TIMOTHY,M,MD	Kansas City	MO	ORTHOPEDIC SURGERY	$11,042	◆	◆	◆
CICCARELLI,JOHN	Lenexa	KS	ORTHOPEDIC SURGERY	$10,950	◆		◆
Total Count of In-Network Providers					**50**	**48**	**48**

◆ = In-Network Provider

= Out-of-Network Provider

Prescription Drug Formulary Disruption

- Formulary analysis is based on the City's historical claims experience, dates of service 1/1/24–12/31/24, and an average of 542 total lives.
- PBMs typically update their formulary a minimum of two times per year. The below is reflective of each PBM's current formulary.
- The table below illustrates potential member impact under each proposed formulary. Note: Members may be counted more than once if they are taking more than one impacted drug

	UMR	Aetna	Anthem
Formulary Proposed	Select	Standard	Direct Plus
Confirm the PBM agrees to grandfather the City's current formulary for up to 90 days following the contract effective date, with no impact on rebate guarantees.	●	●	●
Positive Member Impact			
Higher Copay Tier to a Lower Copay Tier	85	36	26
Negative Member Impact			
Excluded Drugs	0	39	58
Lower Copay Tier to a Higher Copay Tier	16	24	27
Total Negative Member Impact	**16**	**63**	**85**
Chart Key	● Agreed ● Disagreed		

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	UMR	Aetna	Anthem
Formulary Disruption			
Drug Name Category/Member Impact	**Select Formulary (Open)**	**Standard Control with ACSF**	**National Direct Plus**
Top Excluded Drugs	N/A	**Albuterol Sulfate** 22 members	**Synthroid/NP Thyroid** 12 members
	N/A	**Epinephrine** 11 members	**Symbicort** 10 members
	N/A	**Sutab** 4 members	**Vyvanse** 5 members
	N/A	**Victoza** 3 members	**Contour Test Strips** 5 members
	N/A	**Aimovig** 2 members	**Ventolin** 2 members
Top Negative Tier Placement Drugs	**Xyosted** 5 members	**BD Needles** 12 members	**Xyosted** 5 members
	Cequa 2 members	**NP Thyroid** 5 members	**Aimovig** 2 members
	Xifaxan 2 members	**Combivent Respimat** 4 members	**Rinvoq** 2 members
	Lagevrio 2 members	**Evotaz** 1 member	**Xolair** 1 member
	Veozah 1 member	**Taltz** 1 member	**Otezla** 1 member

PBM Plan Sponsor Fiduciary Obligations

Fiduciary Duty: Recently there have been lawsuits filed by employees and former participants in a self-insured employer sponsored health plan, asserting that the employer or plan sponsor breached its fiduciary duty under ERISA by mismanaging the plan's prescription drug benefits. While two of these lawsuits have recently been dismissed, it does not affect employers' continued emphasis on fiduciary governance. Plan fiduciaries will be better able to defend against future claims if they can show that they periodically conduct request for proposals (RFPs) to select a PBM, reviewed available market options (including traditional and transparent offers), compared all fees and costs, and negotiated favorable terms that contain appropriate rights for plan fiduciaries and maximize value for the plan.

Take 10 steps to satisfy fiduciary obligations

As plan sponsors move to address plan costs and ensure that they have a reasonable contract, it is important to keep in mind the plan's fiduciary duties. When selecting and monitoring their service providers, plan fiduciaries have an obligation to use a prudent decision-making process. Fiduciaries must act in the sole interests of their participants and beneficiaries, and follow well-established paths to ensure they make a prudent selection.

As part of this process, plan sponsors should consider taking these steps:

1. Examine whether the plan's selection process for service providers is appropriate.
2. Determine whether to create a special committee to monitor decision-making.
3. Scrupulously document all fiduciary decision-making processes.
4. Provide fiduciary training to all plan fiduciaries — as well non-fiduciaries involved in plan administration, so they know how to avoid inadvertently becoming fiduciaries — and update the training as necessary.
5. Periodically conduct requests for proposals (RFPs) to select a PBM. Issuing an RFP is particularly important when moving to a more transparent pass-through arrangement, both to ensure that the plan obtains the best contract and to eliminate concerns about modifying payment terms mid-agreement.
6. Be strategic about RFP vendors. Consider asking smaller PBMs to bid, and reserve the right to use different vendors for each component of the program (e.g., specialty pharmacy and utilization management).
7. Ensure that the professional advisors assisting the fiduciaries in conducting the RFP do not have any vested interest or compensation associated with the winning PBM. The advisor should not have a relationship to a PBM that would present a conflict of interest with the plan.
8. Ask professional advisors and legal counsel to closely scrutinize the PBM contract to ensure it accurately reflects the agreement, contains appropriate rights for the fiduciaries and maximizes value for the plan.
9. Include audit rights in the contract, both the right to audit payments under the agreement and the right to audit rebates. Make sure audit rights are clear. Plan sponsors should leverage audit rights to ensure that the PBM is complying with its agreement.
10. Consider performing a market check mid-contract to maintain competitive pricing through the contract terms.

Financial Ratings

Financial Ratings

- When available, Segal selects A.M. Best or Standard & Poor's rating because of their depth of coverage of insurance companies and overall reputation as a rating service. Several other rating services also provide ratings of insurance companies and managed care organizations.

	Aetna	Anthem	UMR
A.M. Best	A March 2024	A December 2023	December 2023
Standard and Poor's	A- December 2024	AA- April 2023	A+ July 2024

Segal believes it is important to consider the financial strength of insurance companies and managed care organizations that are candidates for initial selection or renewal as insurers or service providers to employee benefit plans. Therefore, we are providing the current claims paying ability rating that was available to us on the date this document was prepared for the insurance companies or managed care organizations under consideration.

When available, we select Standard & Poor's and A.M. Best because of their excellent overall reputation as rating services. In addition, they evaluate more insurance companies than most of the other comparable rating services. Several other rating services (e.g., Duff & Phelps and Moody's) also provide claims paying ability evaluations of insurance companies and managed care organizations. You may wish to consult these other services before making a decision regarding the initial selection or renewal of an insurance company or managed care organization.

Insurance company and managed care organization rating category explanations are attached. For example, Standard & Poor's ratings range from "Vulnerable" to "Secure". In particular, they regard "vulnerable" companies (i.e., ratings of BB+ and lower) to be at relatively serious risk in terms of meeting both claims and creditor obligations. Insurance companies in this category should be researched carefully before being selected.

Finally, Segal does not itself perform insurance company or managed care organization credit quality evaluations and does not offer any warranty as to the scope or reliability (e.g., with respect to an organization's ability to meet future obligations) of the insurance company or managed care organization evaluations performed by Standard & Poor's, A.M. Best, or any other rating services.

Segal is not responsible for providing monitoring on an ongoing basis.

Financial Rating Descriptions

A.M. Best

Rating*		Category
Investment Grade Or Secure		
A+	A++	Superior - "superior ability to meet their ongoing obligations to policyholders"
A	A-	Excellent - "excellent ability to meet their ongoing obligations to policyholders"
B+	B++	Good - "good ability to meet their ongoing obligations to policyholders"
Below Investment Grade Or Vulnerable		
B	B-	Fair - "fair ability to meet their current obligations to policyholders, but their financial strength is vulnerable to adverse changes in underwriting and economic conditions"
C+	C++	Marginal - "marginal ability to meet their current obligations to policyholders, but their financial strength is vulnerable to adverse changes in underwriting and economic conditions"
C	C-	Weak - "weak ability to meet their current obligations to policyholders, but their financial strength is very vulnerable to adverse changes in underwriting and economic conditions"
D	-	Poor - "poor ability to meet their current obligations to policyholders, but their financial strength is extremely vulnerable to adverse changes in underwriting and economic conditions"
E		Under Regulatory Supervision - "status assigned to insurers that are publicly placed, via court order into conservation or rehabilitation, or the international equivalent, or in the absence of a court order, clear regulatory action and has been taken to delay or otherwise limit policyholder payments."
F		In Liquidation - "status assigned to insurers that are publicly placed, via court order into liquidation after a finding of insolvency, or the international equivalent"
S		Rating Suspended - "status assigned to rated insurance companies to suspend the outstanding FSR when sudden and significant events impact operations and rating implications cannot be evaluated due to lack of timely or adequate information; or in cased when continued maintenance of the previously published rating opinion is in violation of evolving regulatory requirements."
NR		No Rating - "status assigned to insurance companies that are not rated; may include previously rated insurance companies or insurance companies that have never been rated by AM Best."

*Each Best's Financial Strength Rating Category from "A+" to "C" includes a Rating Notch to reflect a gradation of financial strength within the category. A Rating Notch is expressed with either a second plus "+" or a minus "-".

Financial Rating Descriptions

Standard and Poor's

Rating*	Category
	Investment Grade or Secure
AAA	Extremely strong capacity to meet its financial commitments. 'AAA' is the highest insurer financial enhancement rating assigned by S&P Global Ratings.
AA	Very strong capacity to meet its financial commitments. It differs from the highest-rated insurers only to a small degree.
A	Strong capacity to meet its financial commitments, but is somewhat more susceptible to the adverse effects of changes in circumstances and economic conditions than insurers in higher-rated categories.
BBB	Adequate capacity to meet its financial commitments. However, adverse economic conditions or changing circumstances are more likely to weaken the insurer's capacity to meet its financial commitments.
	Below Investment Grade or Vulnerable
BB	Less vulnerable in the near term than other lower-rated insurers. However, it faces major ongoing uncertainties and exposure to adverse business, financial, or economic conditions that could lead to the insurer's inadequate capacity to meet its financial commitments
B	More vulnerable than the insurers rated 'BB', but the insurer currently has the capacity to meet its financial commitments. Adverse business, financial, or economic conditions will likely impair the insurer's capacity or willingness to meet its financial commitments.
CCC	Currently vulnerable and is dependent upon favorable business, financial, and economic conditions to meet its financial commitments.
CC	Currently highly vulnerable.
D	Currently has failed to pay one or more of its financial obligations when it came due. A 'D' rating is assigned when S&P Global Ratings believes that the default will be a general default and that the obligor will fail to pay all or substantially all of its obligations as they come due.
SD	Currently has failed to pay one or more of its financial obligations when it came due. An 'SD' rating is assigned when S&P Global Ratings believes that the obligor has selectively defaulted on a specific issue or class of obligations, but it will continue to meet its payment obligations on other issues or classes of obligations.

*The ratings from "AA" to "CCC" may be modified by the addition of a plus or minus sign to refine relative standing within each category.

Report Caveats

- This bid analysis report is for the sole use of plan sponsor and its authorized representatives involved in the competitive bid. Some material provided by the bidders may be deemed proprietary and confidential to the bidder and may not be disclosed or shared with any third parties other than the authorized employees, directors, unless required by public disclosure laws or other legal requirements.
- The projections in this presentation are estimates of future costs and are based on information available to Segal at the time the projections were made. Segal has not audited the information provided. Projections are not a guarantee of future results. Actual experience may differ due to, but not limited to, such variables as changes in the regulatory environment, local market pressure, trend rates, and claims volatility. The accuracy and reliability of projections decrease as the projection period increases.