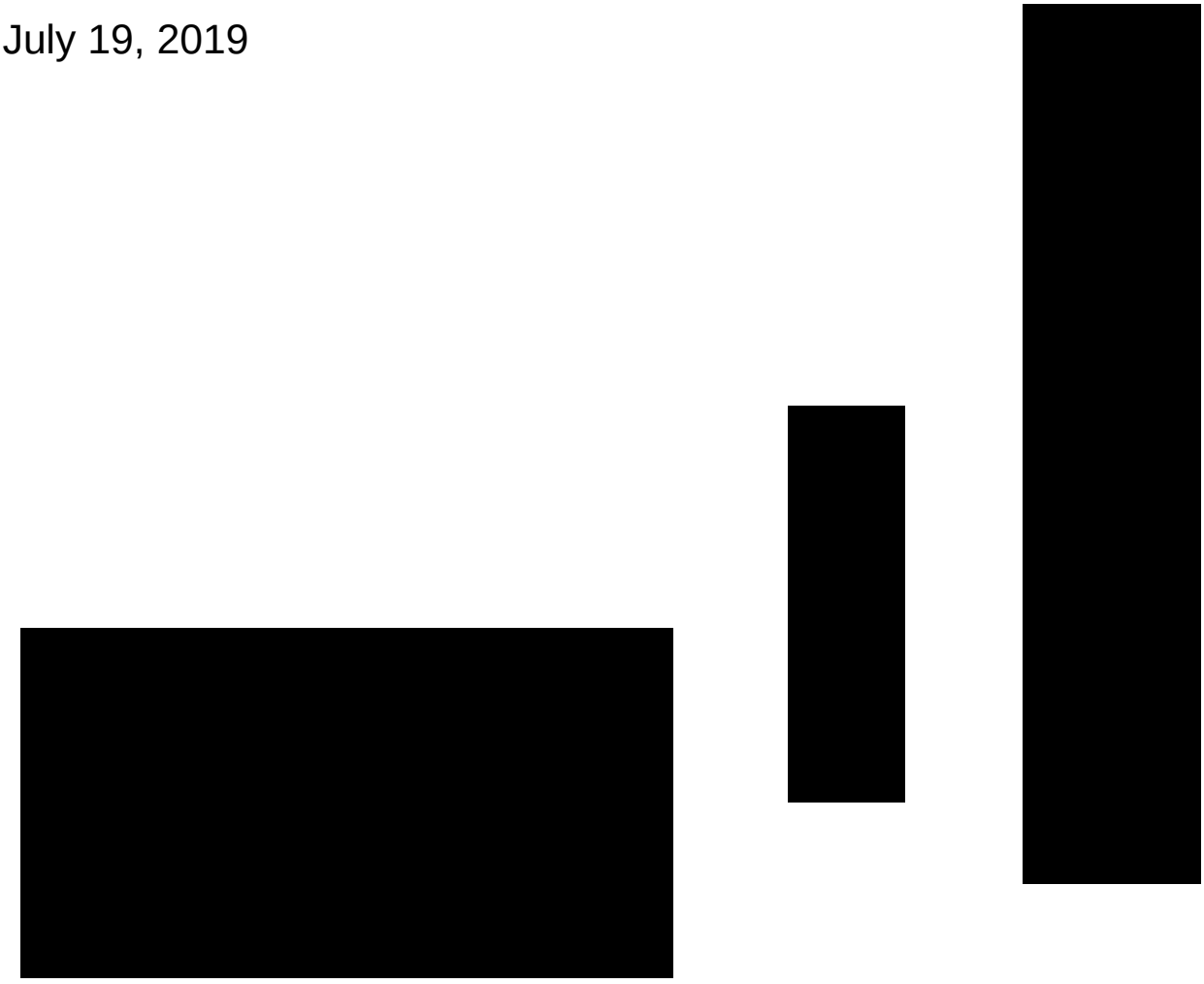
Willis Towers Watson

City of Milwaukee
Milwaukee County
Milwaukee County Transit System

Health Plan Administrator, Network and
PBM Market Assessment
July 19, 2019



Background

Since 2013 the City of Milwaukee (COM) has collaborated with other local public entities including Milwaukee County (MC), Milwaukee County Transit System (MCTS) and Milwaukee Public Schools to assess the efficiencies and savings that may be realized in purchasing medical plan, provider network and pharmacy benefit management (PBM) services collectively. The goal of the partnership is to make a difference and help keep health insurance affordable to the entities, employees and the taxpayers. Collectively these employers cover tens of thousands of employees, retirees and dependents under a variety of medical and pharmacy plan options.

The request for proposal (RFP) completed on behalf of these entities in 2013 confirmed UnitedHealthcare (UHC) represented the best choice for these organizations from a health plan administrative cost and network efficiency perspective and OptumRx was the best choice for a pharmacy benefit manager (PBM) beginning January 1, 2014.

The collaborative effort facilitated by Willis Towers Watson resulted in:

- The ability of each organization to maintain a separate contract with the vendors while recognizing the collective purchasing power these entities bring to prospective vendors
- Measurable improvements in financial terms compared with the initial renewal terms offered to each entity individually
- Additional service terms being agreed to by UHC and OptumRx
- Multi-year financial and service terms
- Alignment of the renewal dates for medical plan administration, network and PBM services
- Greater collaboration among the entities to address compliance, cost and health outcomes

The current agreements with UHC and OptumRx will expire on December 31, 2019.

Evaluation Process

Prudent due diligence requires that a periodic evaluation be conducted to confirm these vendors continue to represent the best solution for each of the entities individually, as well as assess whether there is a benefit to collectively obtaining the services. The COM, MC and MCTS, working in conjunction with Willis Towers Watson, decided it would be beneficial to collaborate again on the proposal and evaluation process for a health plan and PBM administrator.

Medical Plan Evaluation Process

A request for information (RFI) was issued for medical plan administrators to determine if a full RFP was necessary. The RFI focused on the following three areas:

1. Network access and disruption
2. Network discounts
3. Information regarding the carriers evolving strategy and philosophy towards network contracting, discounts, quality and patient outcome.

Network discounts and network utilization by plan participants determine the cost of each employer's sponsored health plan. The RFI process would determine if UHC still provided the deepest discounts and best network access. UHC's service to the employers has been more than acceptable; therefore, a compelling financial reason was needed to consider a change to a new administrator. Administrative expenses are less than 6% of the total health plan cost, with the biggest financial advantage coming from network discounts and access. A formal RFP process would be undertaken if another vendor offered superior discounts or network access.

The RFI was sent to the following carriers:

- Aetna
- Anthem
- Cigna
- Humana
- UnitedHealthcare

Carriers were provided with de-identified claims data (no patient data was provided) from 2018 to allow each carrier to reprice the charges based on their network discounts. In addition, this information allowed each carrier to measure how closely their network matched UHC's to determine potential network disruption. The RFI clearly indicated that each public entity would hold its own contract and have complete plan design autonomy.

Responses were received from all of the carriers noted above with the exception of Cigna, who indicated their network scope and discounts would not be competitive.

PBM Evaluation Process

On the PBM side, a detailed RFP was prepared and approved by each organization and sent to the following vendors:

- Anthem
- CVS Caremark
- EmpiRx
- Express Scripts
- Navitus
- OptumRx
- ProAct

This RFP focused on financial terms, service attributes and how each firm intended to manage pharmacy costs over time. The RFP clearly indicated each entity would hold its own PBM contract and have complete autonomy with respect to the design of the organization's plan and nature of the financial arrangement.

Responses were received from all of the vendors with the exception of EmpiRx, as they do not possess EGWP administrative capability. Although they have been working on partnerships with other firms to meet this need, they did not feel they could meet the requirements of the RFP.

Findings – Medical Plan Administration

The following is a summary of the results of the network repricing, access and disruption assessment for the City of Milwaukee.

	Humana	UHC Choice Plus	Aetna	Anthem (Est.)
In-Network Charges	$248,472,108	$254,758,168	$246,980,484	$249,626,000
In-Network Allowed	$127,456,086	$116,966,496	$148,611,871	$118,868,000
In-Network Discount	$121,016,022	$137,791,672	$98,368,613	$130,758,000
% Discount	48.7%	54.1%	39.8%	52.4%
Overall Total Discount	**$121,016,022**	**$137,927,571**	**$101,885,729**	**$133,092,000**
%	47.2%	53.8%	39.7%	51.9%
Difference to Anthem		1.7%		
		$2,352,605		

Since the last analysis was completed for the COM, MC and MCTS, Anthem has closed the gap with respect to discounts and network access; however, it still lags behind UHC. None of the other carriers' discount performance or network access comes close to UHC.

The analysis excludes carrier administration fees. While those fees differ across the carriers, the magnitude of those differences is small in comparison to the network discount and disruption impact and thus was not included for sake of expediting the RFI process.

A review of the network contracting strategies did not suggest Anthem would deliver a significant advantage to warrant a change.

Findings – PBM Services

The PBM assessment was more complex in terms of the scope and the number of potential choices available to each organization.

There are different approaches to funding coverage for active employees versus Medicare eligible retirees. There are also different pricing terms that can be selected for active employees.

- Active employees are covered under either a traditional or full pass though approach. These approaches are explained below. The COM utilizes a full pass-through approach, whereas MC and MCTS utilize the traditional approach.
- Retirees are covered under what is referred to as an Employer Group Waiver Plan (EGWP). The ACA wiped out the full benefits of the tax deduction available for retiree drug expenses in January 2013. This caused a significant increase in the use of EGWPs, as they greatly decrease administrative costs and increase the per participant Medicare support contribution substantially, which in general, is a superior approach to saving money versus applying for a subsidy even if the sponsoring organization is tax exempt.

Guaranteed or Traditional Pricing versus 100% Pass-Through

- Guaranteed or Traditional – every price component of the agreement is subject to guarantees, which the PBM must meet or pay the difference. Under such agreements, the plan is charged the same for every medication irrespective of where the drug is obtained. This creates a phenomenon known as spread, where the PBM can make money by reimbursing the pharmacy a lesser cost than was charged to the plan for dispensing or retaining portions of the rebates.

- Pass-Through - the client receives all the rebates, no spread; and only pays what the PBM pays the pharmacy.

Generally, one approach might be better in any given year depending on how the utilization patterns play out. However, a pass through agreement makes more sense if you are designing your plan to foster employee engagement in cost. For example, a coinsurance versus a co-pay design. This is the case for the COM but not MC or MCTS.

The table below shows an analysis of the initial PBM results received for the COM. The figures presented are for a three year contract term. The summary below reflects a high level assessment of placing a static mix of 2018 drugs through the current and proposed pricing arrangements. This information was utilized as the basis to select finalists for interviews and further negotiations.

		Difference	
Vendor Name	Rank	From Lowest	City of Milwaukee
Optum	2	$802,609	$103,124,976
CVS	1	$0	$102,322,367
Navitus	3	$1,154,769	$103,477,136
ProAct	6	$5,345,091	$107,667,458
Express Scripts	5	$4,667,821	$106,990,188
Anthem	4	$4,022,496	$106,344,863

Based on the analysis above, the COM, MC and MCTS decided to interview CVS Caremark and Navitus. As result of the interview process, each of the employers on the evaluation committee agreed that CVS Caremark's model was similar to Optum's and did not provide a significant material difference to warrant making a change if OptumRx would narrow the pricing gap. The interview with Navitus was intriguing, given their total transparency and 100% pass-through approach.

After interviewing CVS and Navitus, it was determined it would be appropriate to have OptumRx address the same questions. At the conclusion of the interview, the evaluation committee agreed if additional concessions on pricing and transparency could be obtained from OptumRx, entering into a new three-year agreement would be considered. Results of those negotiations are discussed in more depth in the following section.

The interviews also raised concerns about the integration of UHC and OptumRx with respect to servicing these clients. While there is integration between the two administrators, those efforts could be improved upon. As a result, the group requested significant steps be taken, assuming a three year contract is executed, concerning working more closely and in conjunction with one another to reduce cost trends and improve health outcomes.

Additional Negotiations

At the conclusion of the interviews, Willis Towers Watson facilitated a group discussion. This discussion focused on concessions the evaluation committee wished to obtain as part of entering into a new three-year agreement with both UHC and OptumRx for the upcoming years.

The results of the negotiations for the COM are summarized in the table below. UHC granted a small reduction in administrative fees. More importantly, OptumRx offered concessions that more than offset the initial modelled price advantage CVS offered.

		2020	2021	2022	Total
Total					$1,435,002
	Optum	$301,148	$356,923	$461,358	$1,119,430
	UHC	0	104,444	211,128	$315,572

In addition to the financial concessions noted above, the following were offered:

- At the end of each year, OptumRx will allow termination for convenience. If progress towards better integration is not realized, the group will have the opportunity to look elsewhere
- Up to 40% of the Service and Performance Guarantee fees are at risk for better service model integration via the section dedicated to Satisfaction with Account Management
- A detailed plan regarding how UHC and OptumRx would better integrate their efforts with respect to cost management and health outcomes

Recommendation

Based on discussions with the evaluation committee, Willis Towers Watson believes the needs of the COM, MC and MCTS are best served by entering into a new three-year agreement with UHC to provide medical plan administrative and network access services. The two primary reasons supporting this recommendation are:

1. Anthem discounts are lower than those provided by UHC
2. Anthem's provider network is not as expansive as the one offered by UHC

Reaching a decision concerning the pharmacy program was more difficult than medical administration and network access. After careful consideration, the group decided and Willis Towers Watson concurred that it is in the best interest of the entities to enter into a new three-year contract with OptumRx for the following reasons:

1. The commitment to address spread issues and generic medications
2. Commitments to better integrate efforts to control cost and utilization with UHC
3. The entities can terminate at the end of any year during the three-year term without penalty if no significant progress is made addressing the two issues noted above
4. An analysis of the financial terms did not reveal a significant difference if another PBM were selected

Willis Towers Watson will facilitate quarterly meetings with the COM, MC and MCTS individually and as a group to monitor the performance of UHC and OptumRx with regard to overall performance and integration. The first meeting will be held in January 2020.