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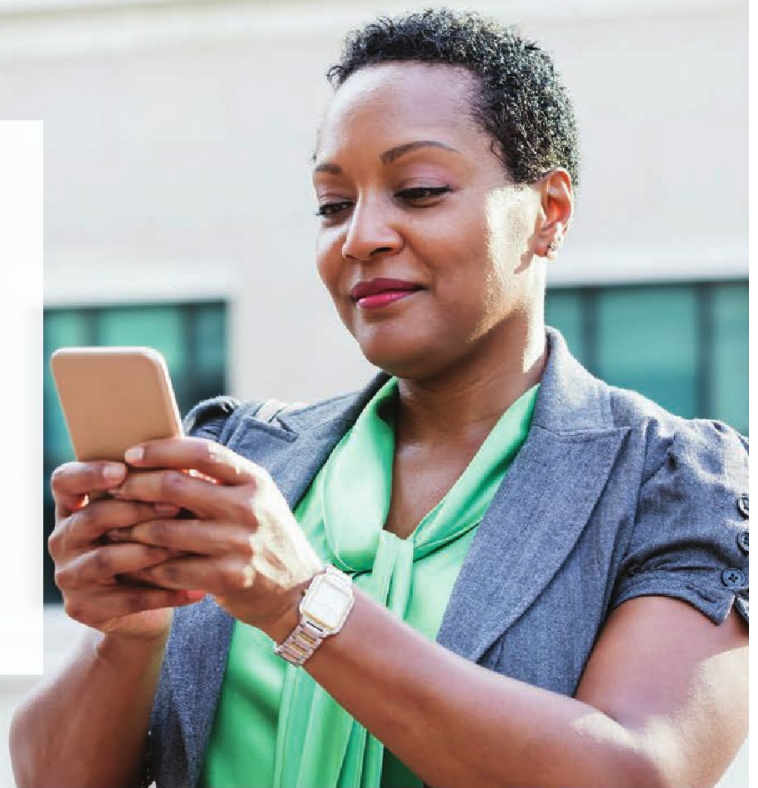
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EMPLOYER SPOTLIGHT



Engaging more plan members to help improve their health and reduce your spend

Population health solutions tailored to meet your needs



Getting members involved is critical to improving their health, but COVID-19 has made that challenging as lack of access and safety concerns caused many members to delay care. In fact:

- **41%** of U.S. adults delayed or avoided medical care¹
- **33%** of members have site of care gaps¹

To help members with specific health conditions get back on track, you can employ **configurable population health solutions** that focus on identifying the right opportunities to enable proactive engagement and create individualized member interventions. This can help reduce spend and improve health outcomes.

- **\$2,740** average savings per low acuity gap closed²
- **\$1,481** average savings per unnecessary emergency room gap closed²
- **2:1** return on investment³



\$2,740

average savings per
low acuity gap closed²



\$1,481

average savings per unnecessary
ER visit gap closed²



2:1

return on investment³

1. <https://www.cdc.gov/mmwr/volumes/69/wr/mm6936a4.htm>.

2. CVS Health Analytics, 2022. Data from January-September 2020. Savings projections are based on CVS Health data. Actual results may vary depending on benefit plan design, member demographics, programs implemented by the plan and other factors.

3. Guarantee based on return on investment (ROI) that is subject to terms and conditions. Savings will vary based upon a variety of factors including things such as plan design, demographics and programs implemented by the plan. Client-specific modeling available upon request. CVS Health uses and shares data as allowed by applicable law, and by our agreements and our information firewall.

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Fall 2022

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CEO & General Counsel

MESSAGE FROM CHRIS GOFF

As 2022 comes to a close, we are supporting more clients and their plan participants than ever. As a result of another strong sales season, we'll add over 60 new self-insured clients and nearly \$600 million in pharmacy spend to our book of business in 2023. Our growth is a testament to our team, our clients and their consultants who are aligned in purpose to ensure the prescription benefit is affordable and attractive to both the participants and plan sponsors. In a consolidating marketplace, the value for our clients to work together to negotiate their PBM contracts continues to grow!

As our team adds more clients and spend to our contracts, it's important that we continue adding talented individuals who can deliver the high level of service our clients expect and deserve. We've added eight new client executives and three new clinical team members in the past year. These investments in human capital ensure that we provide clients access to an outstanding PBM contract, experience exceptional service levels and meet their plans' performance and trend goals. Our commitment is to deliver on our promises and perform at the highest levels of competency, integrity and trustworthiness.

We understand that the market is presenting challenges to each of our clients, in terms of a tight labor market, inflationary pressures and general economic uncertainty over the next several quarters. Please know that our team is here to help however we can so that you can deliver on the promises you make to your organizations and colleagues. Part of that help is to continue to grow and retain our book-of-business, which in turn helps us negotiate better PBM contracts for each of you.

We hope to see you this fall at our Annual Meeting, available in person or virtually from the Pro Football Hall of Fame here in Canton, Ohio. My colleagues Garrett Brown and Madison Evans will share key regulatory updates and trends in plan strategy cost management. Plan compliance is a big task for our clients, and we hope that Garrett and Madison's presentation will offer useful insights.

My very best for a happy and healthy fourth quarter!

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Germantown School District
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Guest Commentary: Aligning Your Drug Plan for Success!

by George Huntley, CEO
Diabetes Leadership Council

The Diabetes Leadership Council (DLC) is a not-for-profit dedicated to securing effective, affordable health care and a discrimination-free environment for every person with diabetes.



The average health plan spends about 15%-20% of its costs on prescription drugs and 80%-85% of its costs on the major medical side of the plan (hospitals, doctors, labs, etc.). It is important to contain costs wherever possible, but it's similarly important to design plan coverage to drive overall cost efficiencies versus any single line item. The purpose of drug coverage is to promote health and healing and importantly, to reduce higher cost spend on the major medical side of the plan. Unfortunately, many drug plans unwittingly create disincentives to overall health in classic "tail-wagging the dog" fashion.

Most employer-based health plans receive rebates from their pharmacy benefit managers (PBMs) based on the utilization of certain prescription drugs by plan participants. PBMs negotiate rebates from pharmaceutical manufacturers in return for providing formulary access. This access is often exclusive for the winning manufacturer based on a class of drugs, for example, short-acting insulin.

The average rebate on a branded drug in the US is 48%¹. This means that the list price of any given drug is nearly double the net price that a plan is actually paying after rebates. In the case of insulin, rebates often exceed 80% of the list price. Health plans and employers may use these rebates to offset plan costs and reduce premiums, but that can leave patients paying the full, inflated price of their brand drugs during the deductible period of their high deductible plans and potentially lead to the costly results of medication non-compliance.

Consider these basic facts. According to the Centers for Disease Control and Prevention, chronic diseases are the leading causes of death and disability, driving \$3.7² trillion in annual health care costs. Those living with diabetes pay an additional \$9,600 in health care costs annually. We know that these chronic conditions are less costly when



appropriately managed. How many of us will give out apples in the lunchroom (before the pandemic when it was safe to have a basket of apples out) or pedometers to encourage walking?

At the same time, we may unintentionally design our drug plans to force some of our most vulnerable workers to potentially ration their medications due to affordability issues.

Industry data show that 69% of patients abandon prescriptions at the pharmacy counter when cost-sharing is above \$250³. Why then do we charge our valued employees inflated prices (sometimes double) for their drugs at the risk of them not taking them? Patients who are nonadherent to their drug

therapies are more likely to be absent from work, impacting productivity and are more likely to suffer painful and expensive complications of their conditions.

As mentioned, companies receiving these rebates typically use them to reduce overall plan costs and lower plan premiums for all participants. This works fine so long as chronic patients aren't being exposed to the inflated prices which drive these rebates during the deductible phase of their health plans. Put simply, if the plan design has the sick subsidizing the healthy, then the plan may not be designed to help the sick get healthy.

The major medical side of health plans automatically shares network discounts with plan participants. We don't give it a second thought. It's the value we provide our people as part of the health



benefit. But the drug side of the plan wasn't designed this way, in part by anti-trust litigation, pharmaceutical manufacturers and the PBMs. The result? PBMs negotiate additional discounts for products in the form of rebates, which are retrospective, not transparent and rarely reach the patient. The PBMs keep a percentage of the rebates for their efforts and historically these dollars have contributed to their healthy bottom lines. The high list price of drugs, and their corresponding high rebates, benefits nearly all entities in the supply chain, except the patient.

The obvious question though is, "What will it cost the plan to use rebates to offset the patient's cost for his/her individual drug?" The good news is it could cost the plan next to nothing if the logical offset is to raise premiums for all plan participants. The better news is that based on a recent actuarial study, any increase to premiums at all will be negligible – 4/10 of 1% for most plans. It should be noted that this small increase in plan premiums does not consider any savings that may result from having

healthier people in the plan. There is a strong argument to be made that this will save money for the plan, and all of its participants, as a whole.

Ensuring affordable access to medications is good for employee satisfaction, improves morale and productivity – and is simply good for your business. Self-insured employers have multiple options to accomplish this:

- Implement a preventive drug list that bypasses the deductible phase of a high-deductible plan and charges a flat copay for chronic medications like those for diabetes. New Medicare rules and state laws often put a price cap on insulins. Even if your plan isn't subject to these rules, this strategy allows your plan to be consistent.
- Place a reasonable max copay on co-insurance plans.
- Implement a program that shares point-of-sale discounts/rebates on the price of medications.

The Diabetes Leadership Council is a coalition of people with diabetes, parents of children with diabetes, allies and tireless volunteers dedicated to improving the lives of all people impacted by diabetes. It unites former leaders of national diabetes organizations, dedicated to securing effective, affordable health care and a discrimination-free environment for every person with diabetes. Diabetes is a common thread connecting DLC volunteers from different backgrounds, professions, geographies and political persuasions. These diverse experiences and areas of expertise help DLC examine tough problems from different perspectives to find consensus solutions. Learn more at diabetesleadership.org.

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3. <https://catalyst.phrma.org/69-percent-of-patients-abandon-medicines-when-cost-sharing-is-more-than-250>



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Monitoring Diabetes: A Review of the Most Expensive Chronic Condition

by Ernesto Munoz, PharmD | Pharmacy Resident &
Matt Harman, PharmD, MPH | Vice President, Clinical Solutions



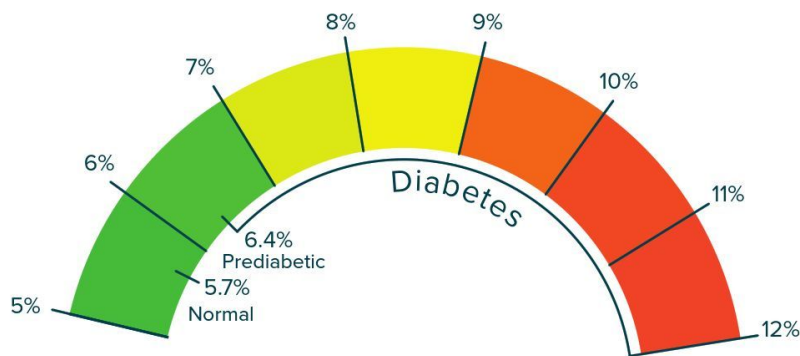
For every \$4 spent on health care in America, \$1 is used for the care of people with diabetes, making diabetes the most expensive chronic condition for plan sponsors. This ranking is due to the sheer prevalence of over 30 million Americans with diabetes combined with the advancements in treatment and complications of uncontrolled diabetes. In fact, the total economic cost of diabetes grew by 60% from 2007 to 2017.¹ Thus, it is important for employers to understand what has led to the current state of the condition and gain insight on potential actions for the betterment of the plan and its participants.

Diabetes Defined

To understand diabetes, you first need to understand insulin and its essential role in the body. Insulin is a hormone that allows the body to process sugar by preventing the accumulation of sugar in the bloodstream. Insufficient amounts of insulin can lead to many of the complications seen with diabetes. Type 1 diabetes mellitus (T1DM) occurs when the body's immune system attacks the pancreas and results in little to no production of insulin. Type 2 diabetes mellitus (T2DM) involves insulin resistance where the body no longer responds to the insulin properly and is more common in people who are obese or belong to an at-risk ethnic group.¹

When diabetes is left untreated, many complications can arise including kidney damage, nerve damage, loss of vision and an impaired response to wound healing. Kidney damage resulting from diabetes does not happen overnight, but over an extended period of time patients slowly lose essential function and will require dialysis or a kidney transplant to survive if left uncontrolled. Nerve damage and loss of vision can occur when there is too much sugar in the blood, which decreases patients' quality of life as they progress through this disease. Impaired wound healing can have downstream effects resulting in severe infections and/or amputations of extremities.²

The prevention of T2DM is achievable through lifestyle modifications. Before individuals develop T2DM, they are in a prediabetes phase, where the blood sugar is higher than normal but not high enough to receive the diagnosis of diabetes.³ An A1C test is done to measure the average amount of sugar in the blood over a period of three months. To illustrate the relation of A1C to diabetes, **FIGURE 1** highlights the range used in diagnosis.



Relation of A1C to Diabetes

FIGURE 1

According to diabetes treatment guidelines from the American Diabetes Association (ADA), metformin is usually the first-line medication that should be used. In instances with patients with diabetes and heart failure, an SGLT2 inhibitor like Jardiance, Farxiga or Invokana would be more appropriate due to the patient's comorbidities. SGLT2 inhibitors are a class of drugs that help lower blood sugars by preventing the kidneys from reabsorbing extra sugar and instead excreting it in the urine. A GLP-1 agonist like Ozempic and Trulicity may also be utilized sooner in patients with comorbidities like diabetes and those that have a high risk for a heart attack or stroke due to the reduction in A1C, blood pressure and inflammation of the cardiovascular system. Many studies have shown that these medications support earlier adoption in treatment due to better patient outcomes.⁴

Being diagnosed with diabetes is an overwhelming and stressful event where patients may believe that they must completely change the way they live their lives, which is why health care providers are essential in guiding and developing a treatment plan. Patients need a lot of support, and counseling is essential to ensure patients are adherent to medication and are being

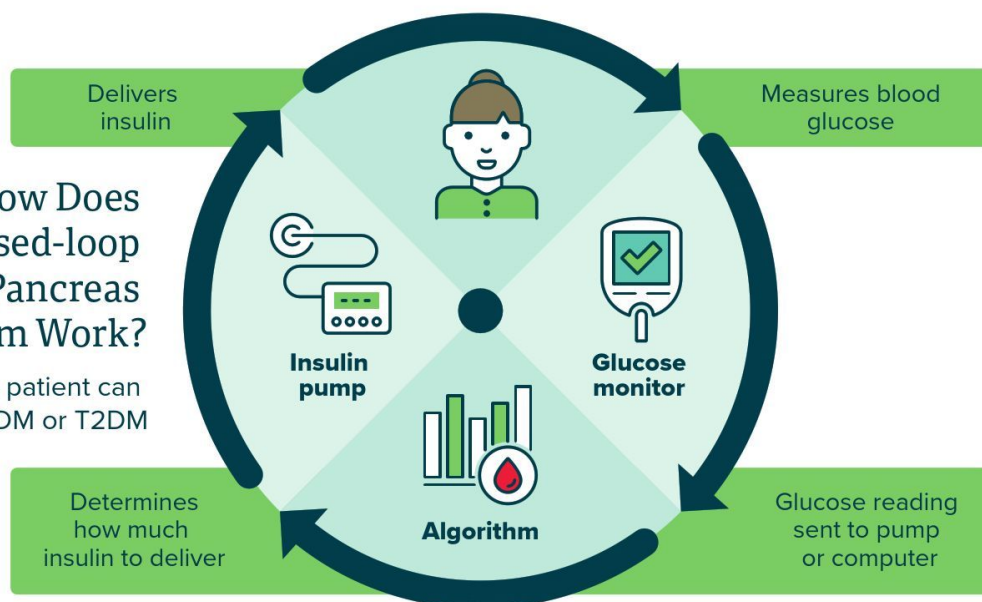
supported through lifestyle changes. The patients who see their prescribers and pharmacists on a regular basis are more likely to achieve better control of their disease, which can ultimately help reduce overall costs for the patient and plan sponsor.

Glucose Monitoring Systems and Benefit Coverage

Continuous glucose monitoring (CGM) systems are wearable devices that allow for frequent checks of blood sugar. Those with T1DM and T2DM benefit by reducing and potentially eliminating the need for fingerstick checks with greater control of their chronic condition.^{5,6} Insulin pumps are small devices that facilitate the delivery of rapid or short-acting insulin, providing continuous delivery and serving as an alternative to patients self-injecting. Larger insulin quantities can be delivered at mealtimes and work best for patients who require multiple daily injections of long-acting insulin. Most users have T1DM, but an increasing number of patients with T2DM are utilizing these pumps. Products like the Dexcom G6 CGM integrated with the Omnipod 5 may be referred to as a "closed loop system" or "artificial pancreas."

How Does a Closed-loop Artificial Pancreas System Work?

the patient can have T1DM or T2DM



Insulin pumps and CGMs were traditionally covered under the medical benefit due to being seen as durable medical equipment. The transition to covering these products under the pharmacy benefit is generally more cost effective and allows for greater access at the pharmacy counter. Insulin pumps and CGMs can be expensive and prescribed to patients unnecessarily, so it is critical to control costs with tools like prior authorizations. With average approval rates around 70%, it is important to ensure these systems are only being used for the intended purpose of closely monitoring and controlling blood sugar levels.^{7,8}

Insulin Now Classified as a Biologic

As technology continues to advance, new methods to treat chronic diseases continue to evolve, specifically with the treatment of biologics. Biologics are products used to diagnose, prevent,

treat or cure medical diseases and conditions. At the molecular level, these products are considered large and complex as they are produced through biotechnology in living systems like animal or plant cells. These products undergo a much more complicated manufacturing process compared to traditional oral medications. Historically, insulins were approved under the traditional new drug application (NDA), but in 2020 the approval pathway was switched to the biologic license application (BLA). This change in classification allowed for the entrance of biosimilars, which is believed to help create more competition in the marketplace. This was seen with the launch of Semglee, the first interchangeable biosimilar in the U.S. which is equivalent to the long-acting insulin, Lantus.

Biosimilars are defined as biological products that are highly similar to the existing Food and Drug Administration (FDA) approved reference product, have

no meaningful clinical differences and generally have a lower list price. While biosimilars allow for more competition in the marketplace, this does not indicate that biosimilars are automatically given interchangeability status. A separate application must be filed to gain this status, which allows pharmacists to substitute a script written for a biologic brand product at the pharmacy counter. As of today, a biosimilar lacking this status is treated as a new drug entirely and requires a new script.⁹

Managing Costs

Diabetes is the top ranked therapeutic class by cost in the Employers Health book of business due to the medications being highly branded and highly utilized. The maintenance nature of these medications leads to continuous dependency on the drug in order to control blood sugar. Therefore, long term utilization should be expected once the diagnosis is made and the medication is prescribed.

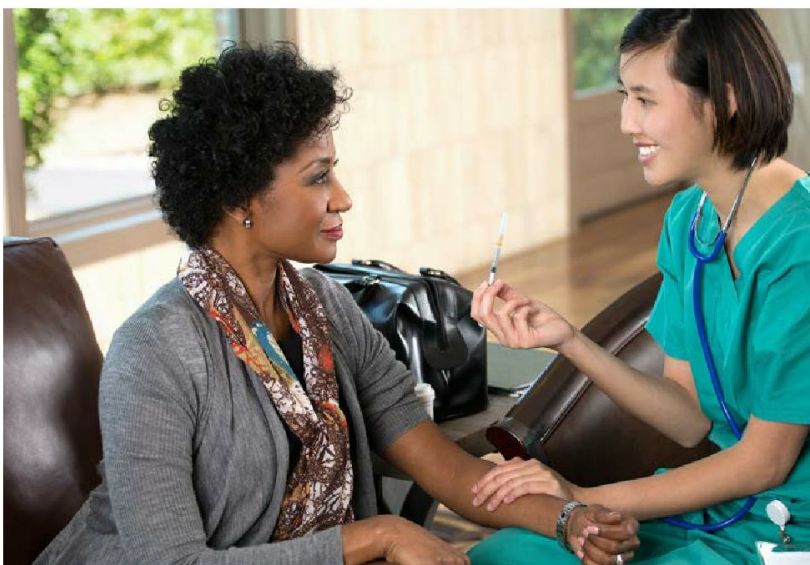
To promote proper utilization, employers should consider implementing prior authorization (PA) criteria that reflects ADA guidelines. The first step would be to confirm a diabetes diagnosis since some products may be used off-label for weight loss. Plan sponsors that exclude obesity drug coverage would especially benefit from this confirmatory step. Incorporating step therapy would also be beneficial because patients and prescribers may want to skip over effective generic options in favor of branded products due to commercial advertising. Finally, a PA would check that patients are taking medications that help reduce A1C levels effectively, continue to eat a balanced diet and adequately exercise to better control their chronic condition.

Plan sponsors understand how expensive certain medications can be for their members, so to combat the cost some employers have reduced the amount members spend on insulin and other diabetic treatments by capping out-of-pocket costs or eliminating member cost share altogether to promote adherence. While this approach may increase plan spend under the pharmacy benefit, the complications that occur when diabetes is left untreated could prove to be more costly due to increased doctor's visits and potential hospital stays. It is important to note that pairing \$0 coverage with a program that combines diet and exercise improves the chances of better patient health outcomes.¹⁰

Another opportunity for these highly branded and utilized drugs to see a reduction in cost is the loss of exclusivity. This happens when generics and biosimilars begin to enter the market and compete with the brand or reference product. The entrance of some biosimilars for insulins have already occurred while generics for other self-injectable products are predicted as early as 2023 **FIGURE 2**.

Drug	Class	Estimated LOE	2021 U.S. Sales	EH BoB 2021 Rank by Gross Cost
Lantus	Insulin	Already occurred	\$7.46B	180
NovoLog	Insulin	Already occurred	\$6.10B	15
Humalog	Insulin	Already occurred	\$5.48B	182
Onglyza	DPP-4	1H 2023	\$185M	840
Victoza	GLP-1	6/22/2024	\$4.22B	27
Tradjenta	DPP-4	5/02/2025	\$1.79B	292
Farxiga	SGLT2	10/04/2025	\$3.92B	11
Januvia	DPP-4	5/2027	\$7.52B	13
Invokana	SGLT2	7/14/2027	\$1.18B	243
Trulicity	GLP-1	12/07/2027	\$12.91B	3

FIGURE 2 Abbreviations: DPP-4, dipeptidyl peptidase-4; GLP-1, glucagon-like peptide 1; LOE, loss of exclusivity; SGLT2, sodium/glucose cotransporter 2



Many of these antidiabetic medications are expanding their indication into heart failure, which is seen with SGLT2 inhibitors like Farxiga, Invokana and Jardiance mentioned previously. Other expansions include drug injectables like Victoza being reformulated to Saxenda, and Ozempic to Wegovy for weight loss. Some injectables like Ozempic have expanded their dosage form to include oral tablets for patients that may not like or be able to inject themselves. A biosimilar for the biologic NovoLog, a fast-acting insulin, could be entering the market soon. Currently, there are no alternatives for this insulin but this biosimilar would also come with an interchangeability designation. This biosimilar will hopefully allow for an overall cost reduction for patients using fast-acting insulin.¹¹

While biologics and biosimilars are revolutionary in treating certain diseases, one recent drug approval has a strong chance to become the first choice for patients to better control their diabetes.

Mounjaro (tirzepatide) is a new and novel injectable drug with a dual action mechanism for T2DM that was approved in May 2022. This drug's unique mechanism has led to clinical trial data where it outperformed traditional GLP-1 medications in A1C reduction and weight loss.¹²

As new products for diabetes enter the market and create competition for existing products, the total cost of care for this disease state should decrease. In the meantime, employers should consider utilization management strategies to drive patients to appropriate therapeutic options and efficiently control the country's most costly chronic condition.

TO LEARN MORE CONTACT

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Key Takeaways:

1. A \$0 or reduced copay for diabetes medications may result in increased adherence and reduced complications.
2. Covering CGMs and insulin pumps under the pharmacy benefit provides better access to members to take full advantage of technology to manage their diabetes.
3. Requiring a prior authorization on diabetic products, CGMs and insulin pumps ensures that patients are being prescribed the appropriate therapy and avoiding unnecessary drug costs.
4. Considering robust patient management programs that utilize digital applications to relay a patient's clinical information, rather than only meeting with providers, can help members take a more proactive approach in getting the clinical support they require.

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A Change in Circumstances: 2023 Market Check

by David Uldricks, J.D., LL.M.
Senior Vice President, PBM Contracting and Strategy

When parties to a contract renegotiate or update the terms of their agreement prior to its expiration, the primary reason is to account for a change in circumstances. Changing circumstances are usually events that directly increase the cost or reduce the benefits for one or both of the parties which, if unaddressed, would cause the cost of continuing the agreement to exceed the cost of its termination. In the context of Pharmacy Benefit Management (PBM) contracts, changing circumstances are so common that contract renegotiation to address these issues has its own term of art – “Market Check”.

The pharmacy benefit management industry is exceptionally dynamic. Every year, new and more costly medicines hit the market, and every year indications for existing medicines expand. To say that the annual fluctuations in the cost and utilization of medicines are changing circumstances would be an understatement. To mitigate these dynamics, market checks are critical.

While not every PBM agreement has market check provisions, for those that do, the terms governing the market check may vary from agreement to agreement. In practice, regardless of the words written in the agreement, a market check should provide a vehicle for adjusting the financial arrangement to market norms, and it should provide a vehicle to add, delete or amend terms in the PBM contract related to programs and services so that the pharmacy benefit plan sponsor can effectively take advantage of all the pharmacy benefit manager and the industry have to offer.

Employers Health began the market check for the 2023 contract year in October 2021. The process concluded in August 2022. As with every market check, the primary objective was to adjust the financial guarantees to ensure every Employers Health client is confident that their pharmacy benefit

financial arrangement continues to provide the best pharmacy benefits at the best price, all in an ever-changing marketplace.

With the 2023 market check, Employers Health achieved record levels of improvement in terms of the value of the discount and rebate guarantees for the fourth consecutive year. And with that competitive pricing, Employers Health was able to attract and retain record levels of net client growth for the fourth consecutive year. More than 60 new clients accounting for nearly \$600 million in spend will be added to our collective purchasing power for 2023.

By any metric, Employers Health has been on a tear over the past several years, but we don't say that to brag. Certainly, the growth and development of the Employers Health business development, client solutions, clinical and analytics teams played a major role in this success. But the market check has been an integral part as well. To place the importance of the market check into perspective, **FIGURE 1** describes some of the differences between the 2023 agreements as memorialized through the recent market check, and the agreement as it existed 15 years ago in 2008.

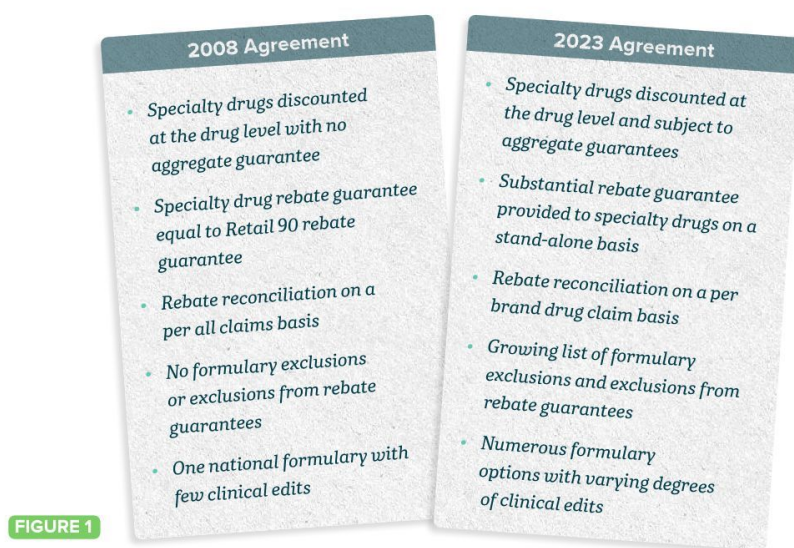


FIGURE 1

Between 2008 and now, a lot has happened. Although everyone knew they were coming, in 2008 most of today's specialty drugs were still in development. Today, specialty drugs represent over 40% of drug spend. And, strategies for controlling specialty drug spend are the centerpiece of the current pharmacy benefit management strategy. But as impactful as specialty drugs are, from a contracting and market check perspective, the increasing cost of brand medications overall, the mitigating impact of generic medications and the evolution of formulary and rebate strategies have been extremely important as well. **FIGURE 2** provides more insight.

The average cost of a brand prescription (both specialty and non-specialty) in the first half of 2022 is more than seven

times the average cost of a brand prescription in 2008. With specialty brand drugs averaging more than \$6,700 per prescription, this segment contributed significantly to that increase. But non-specialty brand drugs have increased in cost as well. In the first half of 2022, the average cost of a non-specialty brand drug was \$553.97, or just over four times as expensive as the average cost of a brand prescription in 2008. Fortunately, while the cost of brand medications has skyrocketed over the past 15 years, generic drug costs have decreased and generic drug use has increased, both serving to blunt the financial impact of the ever-increasing cost of brand drugs. Unfortunately, generic dispensing rates have plateaued and the comparative effectiveness of generic substitution as a cost savings measure is beginning to wane.

	2008	2022 ¹
Avg. Brand Drug Cost	\$137.90 ²	\$978.62
Avg. Generic Drug Cost	\$35.22 ³	\$30.59
Generic Dispensing Rate	64% ⁴	84%
Avg. Prescription Drug Cost	\$71.69 ⁵	\$179.15

FIGURE 2

Formulary and rebate strategies have become more sophisticated over the past 15 years. They too serve to lessen the financial impact of the ever-increasing cost of brand drugs. In 2008, formularies were relatively straightforward with few clinical edits. The rebates that were generated by 2008 formularies offset between 7% and 10% of drug spend. Today, numerous formulary options are available with varying levels of clinical edits and formulary exclusions. This sophistication has resulted in a significant increase in rebates. Today, rebates offset between 25% and 35% of pharmacy spend, and their importance as a brand drug cost mitigation strategy will continue to increase for the foreseeable future.

Today we are at the forefront of some dynamics that will likely shape pharmacy strategy over the next several years, if not well into the future. Alternative generic dispensing channels, brand over generic strategies, expanding formulary exclusions, additional clinical criteria and, of course, biosimilars will all play a role in mitigating the increasing cost of brand drugs in the future. market checks ensure that these strategies are available to leverage at the earliest possible time with maximum effectiveness.

TO LEARN MORE CONTACT

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Noteworthy News

The Walsh University Office of Alumni Relations honored Steve Burger with its Outstanding Achievement Award. Steve and all the 2022 recipients were recognized for their achievements, leadership and contributions to their professions, their communities and their alma mater. Steve is a 1990 and 2012 graduate of the university.

Chris Goff, Employers Health CEO, recently joined Northeast Ohio Medical School as an adjunct professor teaching Health Policy and Economics.

Employers Health Chief Financial Officer, Steve Burger, was recently named chair of The Stark Community Foundation Audit Committee. The Stark Community Foundation helps individuals, families, businesses and nonprofits support causes in our community and beyond.

Fifteen Employers Health team members earned a certificate in Data Analytics from Walsh University. This program covered how data are collected, stored and analyzed and how to implement technologies and data concepts.

Madison Evans, Employers Health associate counsel, recently joined the board for the Domestic Violence Project which offers safety, compassion, hope and healing to victims of domestic violence and their families.

Jay Withee, vice president of client solutions, was elected president of the board for TWi, an organization serving those with disabilities.

Employers Health attorneys, Garrett Brown and Madison Evans, presented at the Stark County Bar Association's Health Care Labor Law Seminar covering the topic, "State Statutes That Preempt ERISA Post *Rutledge v. PCMA*."



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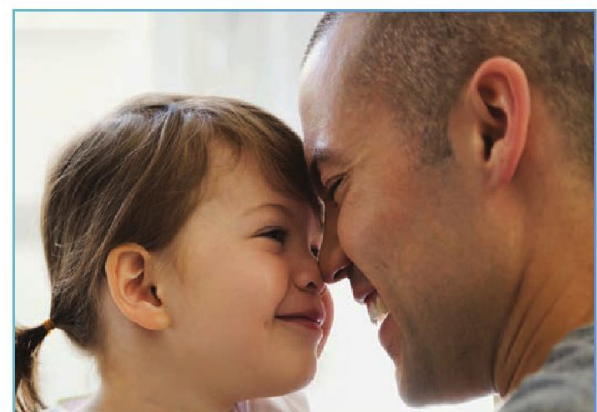
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Employer Spotlight



Doreen Hull
Benefit Services Director



Midwest Public Risk (MPR) is a not-for-profit, public entity risk pool representing the interests of public entities across Missouri and Kansas. Its customers rely on MPR to be a trusted advisor, advocate and resource for their risk management and health benefit needs. MPR offers a unique blend of services specifically tailored to meet the needs of local governments and school districts.

We recently sat down with MPR's benefit services director, Doreen Hull, to hear about its unique comprehensive employee benefits program which utilizes its purchasing power to provide, "excellence in benefit plans, competitive rates and superior service to its members."

How long have you been with MPR and why/how did you choose to get involved in employee benefits?

I began my career with Midwest Public Risk as the benefit services director in August of 2015. I will celebrate my 7-year anniversary soon. I started my employee benefits career working at a third-party administrator (TPA) where I was involved in a variety of roles. I found customer service was the piece that brought me the most career satisfaction. Being able to help someone understand their plans or make the best choice of plans is very rewarding. I accepted the role at MPR because we are close enough to the plan participants to hear their needs. We are focused in our approach which gives us the flexibility to make changes happen. Every year has been a new learning experience in the public sector.

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

The approach at MPR offers resources that we can include in our programs that balance maintaining affordability while also providing options to keep our employees healthy. We strive to find programs and services that are easy to use and make a difference in the lives of the people we serve. Our plans are more than covering sick care. Our program focuses on bringing information,

education and services to make plan members' well-being a priority. This is a comprehensive approach including physical, mental and financial services tailored to individual needs.

How has your organization been innovative in delivering health care benefits?

Our Benefit Advisory Committee is a forum for discussion, planning and learning. This committee consists of our members and employees who use the plan. The forum is designed to bring our members together and collaborate on best practices on coverages. Changes are decided on by the employees who are also the plan members. My team, in collaboration with MPR staff, is always looking ahead to the next steps to assist in helping our members and their employees get healthier.

Can you share what makes your workplace/benefit plan unique?

We are owned by our members and each employee at MPR takes accountability for our member's dollars and best interests. MPR's CEO and staff firmly believe and follow the practices of servant leadership.

A servant leader focuses primarily on the growth and well-being of people and the communities to which they belong. While traditional leadership generally involves the accumulation and exercise of power by one at the "top of the pyramid," servant leadership is different. The servant leader shares power, puts the needs of others first and helps people develop and perform as highly as possible.

- Robert K. Greenleaf, Founder of the modern servant leadership movement



MPR has created a Servant Leadership Recognition Program where employees are encouraged to recognize other staff for following the principles of servant leadership. Our team follows this in so many ways by hearing the voice of our membership in our strategies, planning and decisions and by working together for the success of our programs. The service we provide is for the people who manage our communities (law enforcement officers, firefighters, road and bridge workers and administrative staff). We have a direct connection with those who benefit from our hard work and make a difference in our communities.

At MPR we work to create a healthy and productive work-life balance. We offer our members impressive benefits and provide ongoing education on physical, mental and financial well-being. Recently, we created a mental health display reminding our team of all the mental and behavioral health resources available. We took a large puzzle and asked each staff member to take a piece of the puzzle and decorate it with their own message or design to share. Upon completion of all the pieces, we put them together and proudly display the final creation of words and designs in our office. Our goal is to have this physical display of positive goodwill as another way to improve our culture of well-being.



What has surprised you about working in benefits?

The level of trust that our members have in us. We are fortunate to have so many great members in our pool that support our efforts to be the best stewards of the program. It's important that they can put their trust in us so they can focus on the important work they are doing for our communities.

What are your thoughts on the future of employee benefits?

We will always need coverage and plans for sick care. The best future prioritizes the focus on how to spend our time, money and resources on preventing sick care while planning for the ongoing improvement of health and employee engagement for our population. We need to create a partnership, working together with the patient to find the best outcomes and be open to new ideas.

How long have you been engaged with Employers Health?

We joined Employers Health in 2019 and began participating in its pharmacy benefit program through CVS Health at that time.

What value do you derive by being part of an organization like Employers Health?

The insight, advice and objective opinions provided by our team at Employers Health are very valuable. The shared information and insights from other pools and organizations similar to ours help us to create the best program possible. Employers Health has also provided an additional layer of support for our team and helped our organization in complex PBM matters, helping to make us a big fish in the PBM's pond.

Have a story to share?
Contact us at
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