Medical claims Cost are just the claims data from the carrier; the premium or fixed costs displayed in the previous 2 exhibits are not included.

This is also on a per member basis, whereas the previous 2 exhibits are on a per employee basis.

This page and all norms going forward use the Medstat data.

If Rx dollars are entered into the Annual Prescription Drug Cost line in the GSF, this actual and norm number will include Rx. If nothing is entered on this line in the GSF, it will be medical only for the actual and norm, and footnoted as such.

If this norm is the reverse of the KFF norms on the previous pages, the admin/fixed costs and/or Rx could be the driver. Also if the group is fully insured, there loss ratio could be very low.

This exhibit is age/gender adjusted if the census is provided.
This summary page discusses the favorable and unfavorable areas of the current health plan to help with the analysis of healthcare costs.

Note that even in the standard report, the following areas are listed, which allow you to go back and build those pages if they are unfavorable: maternity, chiro, PT, Radiology.

A common differential between charges and paid is 40 – 50%. This varies by plan design, discount, non-covered services, subrogation and COB.

Use the Total Claim Payment figure in Alternative Modeling to get a more accurate figure for estimating plan savings. Use the Total Claim Payment multiplied by the percentage differential of the alternative plan.

The Total Claim Payment includes the claims paid over the specific, in a self-funded group.
Employee vs Dependent Claims

This exhibit illustrates the breakdown of your company's health care claim dollars paid on employees, spouses and dependents compared to the norm.

Methodology

Your company’s claims were analyzed separately for employees, spouses and dependents, for the total paid in each category.

Actual Paid

Norm Paid

For More Information...

Use Drill Down to analyze what factors are driving your total paid claims. For example:

- Access the Claims History Cube to evaluate the data by Relationship by CPT (procedure) code to see the source of the charges.
- Companies with a few ill dependents or employees can distort the percentages.
- This exhibit can be used to determine if the plan is being adversely selected against when spouse / dependent enrollment and utilization is high.

This exhibit show the ee/spouse/dependent cost relationship to illustrate how the employer will monitor changes or shifts costs to the appropriate member. These numbers represent the actual paid claims for employees, spouses and dependents claimants and not the actual total enrolled members.

Discussion Point: You should use this information over time to evaluate if dependent claims exceed the norm. This will help determine a need for further cost shifting discussions. (Suggest utilizing a Spousal Carveout plan design piece out of Broker Briefcase).

This exhibit is NOT age/gender adjusted if the census is provided.
This page portrays an overall picture of the location of healthcare claims occurred compared to the norm using the standard Centers for Medicare and Medicaid Services Place of Service coding.

Discussion Points:
- Drill down can be incorporated to help "dissect" claimant information. By selecting the Place of Service Summary from the Claims History Cube, you can discuss whether the employee or dependent is incurring the claim, and formulate proper education decisions directed either towards the employee or the dependent.
- The Other category includes codes that don't fall into other five main places of service categories such as ambulance, labs/x-rays and home health etc, or improper coding was associated with the claim and thus will typically be higher than the rest.
- This chart is driven only by the carrier's place of service codes. If no ER appears, either they do not have an emergency room place of service code or they are not using it. If there are no claims showing up on the ER category, they are usually included in the Outpatient Hospital category.
- Top 6 categories appear on this graph.

Focus on the top areas that vary from the norm and use Drill Down to find out what types of services are being rendered.

The Office POS includes things like chiro, OPMH, PT or surgical procedures and will not match the Office Visit pages later in the report, as those are a subset of this POS exhibit.

This exhibit is age/gender adjusted if a census is provided. It is not region, industry or plan type specific.
High Cost Claimants

Total paid claims were bundled by claimant to reveal high cost claims per claimant. This chart illustrates the top ten claimants by the most costly diagnosis.

Methodology

This analysis includes a study of claimants responsible for high cost claims. Dollars associated with these claimants include all claims paid for a claimant during the period.

For More Information...

Examining high cost claimants allows your company to observe how a small number of participants can be responsible for a large percentage of total claims. View the High Cost Claims Cube to examine the specific diagnoses that make up each of the high cost claimants.

This information helps your company:
- Set appropriate stop loss contracts
- Consider health risk appraisals if there is a theme in common illnesses
- Determine large case management opportunities.

Coupled with other information in this health plan report, your company can measure and observe general health risks present in your plan, particularly if observed and measured over multiple years.

Discussion Points:

The drill down component can be used to show details of the high cost claimants.
- Should case management be addressed?
- Is Stop Loss set an accurate level?

You can check the specific level noted on the group submission form.

You can see which claimants may have hit the specific stop loss by comparing the Total paid to the Liability at the bottom.
Drug Spend Continues to Increase, But Trend is Slowing

$ in Billions

15.9%
15.3%
13.4%
12.9%
12.4%
11.7%
10.7%
9.7%
9.2%

$140.8 $162.4 $184.1 $207.9 $235.6 $292.4 $360.1 $435.2 $519.8


*Note: 2002 – 2006 data are projections; Total Drug Spend includes uninsured expenditures.

Drug Spend Represents a Growing Proportion of Health Care Costs


The exhibit above illustrates that the implementation of trend, clinical, and benefit design programs can initially create member dissatisfaction. But, over time, their dissatisfaction will diminish and the more management incorporated into a drug plan, the greater the return on investment.
What changes did you make in your pharmacy benefit plan for 2004, or are you considering for 2005?

- Mandatory mail order for maintenance medication: 8%
- Mandatory generic where available: 11%
- Increased copays: 54%
- Closed formulary (where non-formulary brand drugs are reimbursed only with special approval): 3%
- Increased number of copay tiers: 12%
- Open formulary (where non-formulary brand is higher copay than formulary brand): 13%

$3,095.108 $2,25,905 $138,992 $776,725 $3,095.108 $2,25,905 $138,992 $776,725

Charges: Copy, Debit, Cheque, Insurance: Covered
Total: $776,725

Alternative Model: Simple

Alternative Model: ER Copy: $100

Alternative Model: Chiro:

Alternative Model: Advanced Consulting:

Office Visit Copy

Decision Master Warehouse
Plan Differences

<table>
<thead>
<tr>
<th>Members</th>
<th>Total Claims: 660</th>
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</thead>
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Comparison of Charges

Reduction in Liability: $499,875.77
200% for Copy

Comparison of Current Model vs. Advanced Consulting

Model Comparison Printable Version

DecisionMasterWarehouse
<table>
<thead>
<tr>
<th>Category</th>
<th>Consistency</th>
<th>Out of Network</th>
<th>In Network</th>
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<tbody>
<tr>
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<td>2%</td>
<td>30%</td>
</tr>
<tr>
<td>Patient Mental In Network</td>
<td>0%</td>
<td>2%</td>
<td>30%</td>
</tr>
<tr>
<td>Patient Physical Out of Network</td>
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<td>2%</td>
<td>10%</td>
</tr>
<tr>
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<td>0%</td>
<td>2%</td>
<td>3%</td>
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<tr>
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<td>2%</td>
<td>30%</td>
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<td>2%</td>
<td>37%</td>
</tr>
<tr>
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<td>2%</td>
<td>30%</td>
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<tr>
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<td>0%</td>
<td>2%</td>
<td>30%</td>
</tr>
<tr>
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<td>0%</td>
<td>2%</td>
<td>30%</td>
</tr>
<tr>
<td>Inpatient In Network</td>
<td>0%</td>
<td>2%</td>
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</tr>
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