Sample Company

Medical Claims Cost

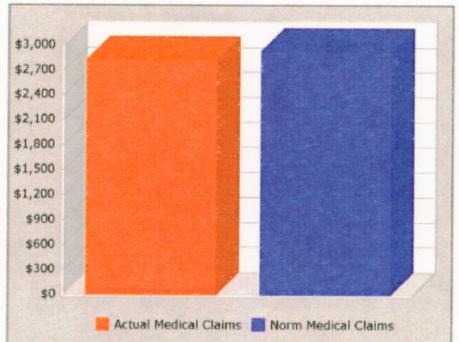
Your company's health care costs per member for medical claims costs are displayed (no administrative or fixed costs are included). Claim amounts represent claims paid during the period but not necessarily incurred during the period.

Methodology

Your medical claims costs were compared to benchmark data for similar employer plans based on region and industry. This comparison provides an opportunity to determine how the pure utilization and amount paid by the plan compares to a norm, exclusive of the administrative fees. This comparison is an overview of your claims costs; additional information on the subsequent pages will provide key areas to investigate further.

For More Information...

Focus on other pages of the management report where your plan varies compared with the norm. Then, use Drill Down and the recommendations on those exhibits to analyze what factors are driving cost and utilization within those specific areas.



Medical Claims Cost

Actual Medical Claims/Member	$2,830.24
Norm Medical Claims/Member	$2,934.64
Percent Over/Under Norm	-3.56%

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.

Sample Company

At - A - Glance

General Information	
Total Employees	302
Total Covered Lives	720
Total Claim Charges	$3,065,108
Total Claim Payments	$2,037,774

Area	Actual	Norm	Difference	Experience
Health Plan Costs	$8,001	$7,082	13%	Unfavorable
Medical Claims Costs	$2,830	$2,935	-4%	Favorable
IP Analysis - Admissions/1000	65	65	0%	Favorable
IP Analysis - Average Paid/Admission	$105	$9,879	-99%	Favorable
Maternity Admissions/1000	11	5	140%	Unfavorable
Maternity Average Paid/Admission	$5,856	$1,918	205%	Unfavorable
OP Surgery/1000	907	871	4%	Unfavorable
OP Surgery Average Paid	$177	$187	-6%	Favorable
ER Visits/1000	382	316	21%	Unfavorable
ER Average Paid	$104	$250	-58%	Favorable
Office Visits Visits/1000	2,811	3,099	-9%	Favorable
Office Visits Average Paid	$74	$37	101%	Unfavorable
Chiropractic Visits/1000	1,697	875	94%	Unfavorable
Chiropractic Average Paid/Visit	$38	$39	-3%	Favorable
Physical Therapy Visits/1000	0	135	-100%	Favorable
Physical Therapy Paid/Visit	$0	$85	N/A	Not Available
Radiology Visits/1000	976	1,059	-8%	Favorable
Radiology Paid/Visit	$169	$123	37%	Unfavorable
IPMH Admissions/1000	1	6	-76%	Favorable
IPMH Average Paid/Admission	$9,093	$3,986	128%	Unfavorable
OP Mental Health Visits/1000	681	723	-6%	Favorable
OP Mental Health Average Paid/Visit	$81	$77	6%	Unfavorable

Norm Source: "Employer Health Benefits 2002 Annual Survey" (#3369), The Henry J. Kaiser Family Foundation and Health Research and Educational Trust, Sept 2002.

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.

Sample Company

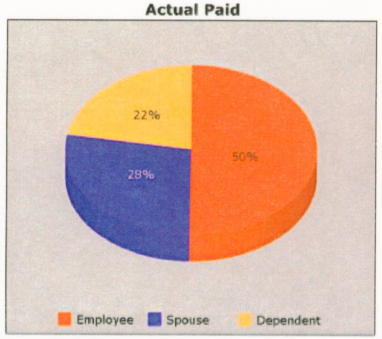
Employee vs Dependent Claims

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

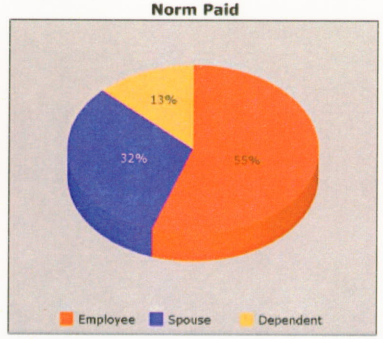
Methodology

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

Actual Paid



Norm Paid



	Actual	Norm	Variance
Employee	$1,022,713	$1,124,851	-9.08%
Spouse	$560,406	$651,680	-14.01%
Dependent	$454,655	$261,446	73.90%

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.

Sample Company

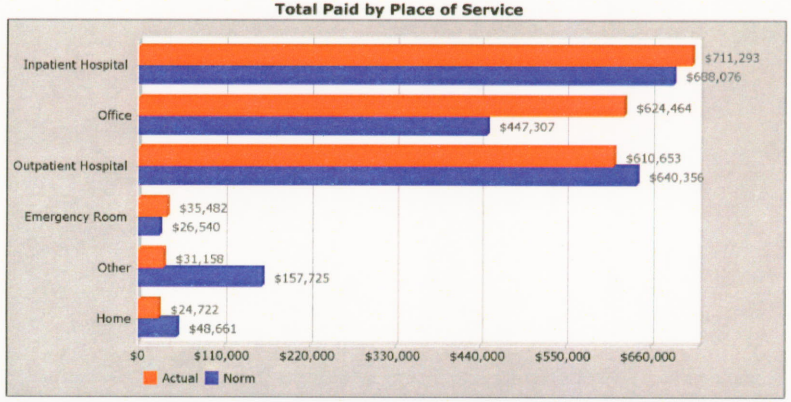
Claims By Place of Service

This analysis illustrates the distribution of paid claims among the various types of health care facilities used by your plan participants, as broken out by your claims administrator.

Methodology

The place of service categories used below are those prescribed by the Centers for Medicare & Medicaid Services (CMS). The paid amounts shown by each category contain both professional (physician fees, surgeon fees and anesthesiologist fees) and facility fees (hospital room and board, supplies and all ancillary services).

Total Paid by Place of Service



	Actual	Norm	Variance
Inpatient Hospital	35%	34%	3.37%
Office	31%	22%	39.61%
Outpatient Hospital	30%	31%	-4.64%
Emergency Room	2%	1%	33.69%
Other	2%	8%	-80.25%
Home	1%	2%	-49.20%

For More Information...

Access the **Claims History Cube**, by Place of Service in drill-down. Using this feature, you can further analyze your data by a number of different factors, including ICD9 (diagnosis) and CPT (procedure) code.

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.

Sample Company

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

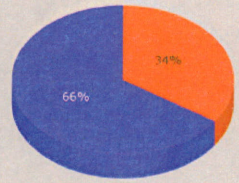
This analysis includes a study of claimants responsible for high cost claims. Dollars associated with these claimants include all claims paid for a claimant during the period.

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.



High Cost Claims Other Claims

Paid	Diagnosis
$127,819	ATRIAL FIBRILLATION
$98,289	ABDOMINAL PAIN UNSPECIFIED SITE
$85,192	ATHEROSCLEROSIS OF NATIVE ARTERIES OF THE EXTREMITIES WITH ULCERATION
$70,441	ACQUIRED SPONDYLOLISTHESIS
$61,825	PNEUMONIA ORGANISM UNSPECIFIED
$61,784	CORONARY ATHEROSCLEROSIS OF NATIVE CORONARY ARTERY
$55,811	SECONDARY AND UNSPECIFIED MALIGNANT NEOPLASM OF INTRA-ABDOMINAL LYMPH NODES
$55,505	CHRONIC CHOLECYSTITIS
$42,826	ACUTE MYOCARDIAL INFARCTION OF OTHER INFERIOR WALL INITIAL EPISODE OF CARE
$42,622	ACUTE APPENDICITIS WITH PERITONEAL ABSCESS
$702,114	**Total Paid**
$556,764	**Liability**

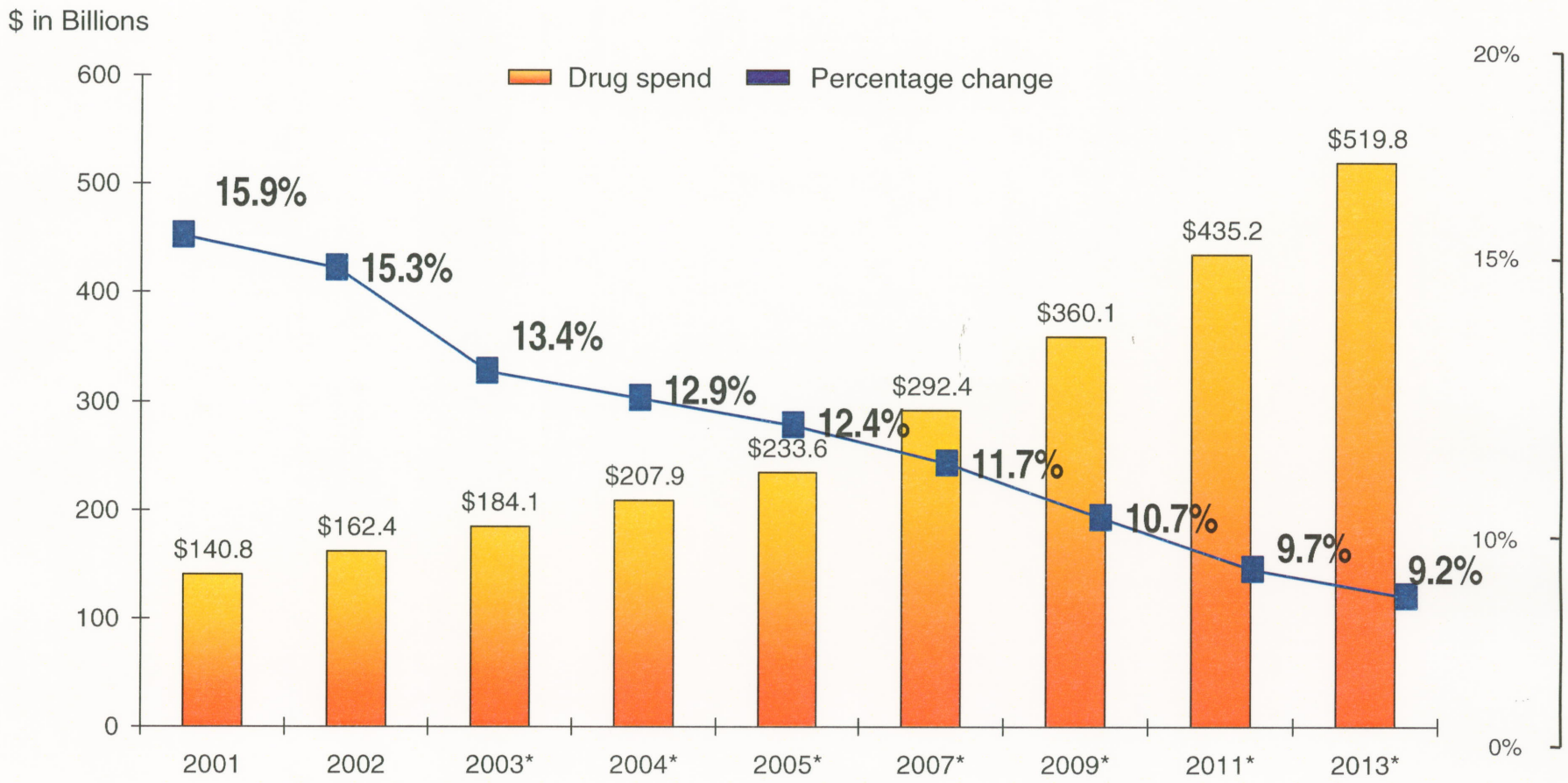
This page identifies the 10 high cost claimants, which are identified by a unique identifier. Primary diagnosis will be listed as the highest cost diagnosis and all other diagnosis are bundled in. You can view the other diagnosis for each claimant in the High Cost Claimant drill down cube.

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.

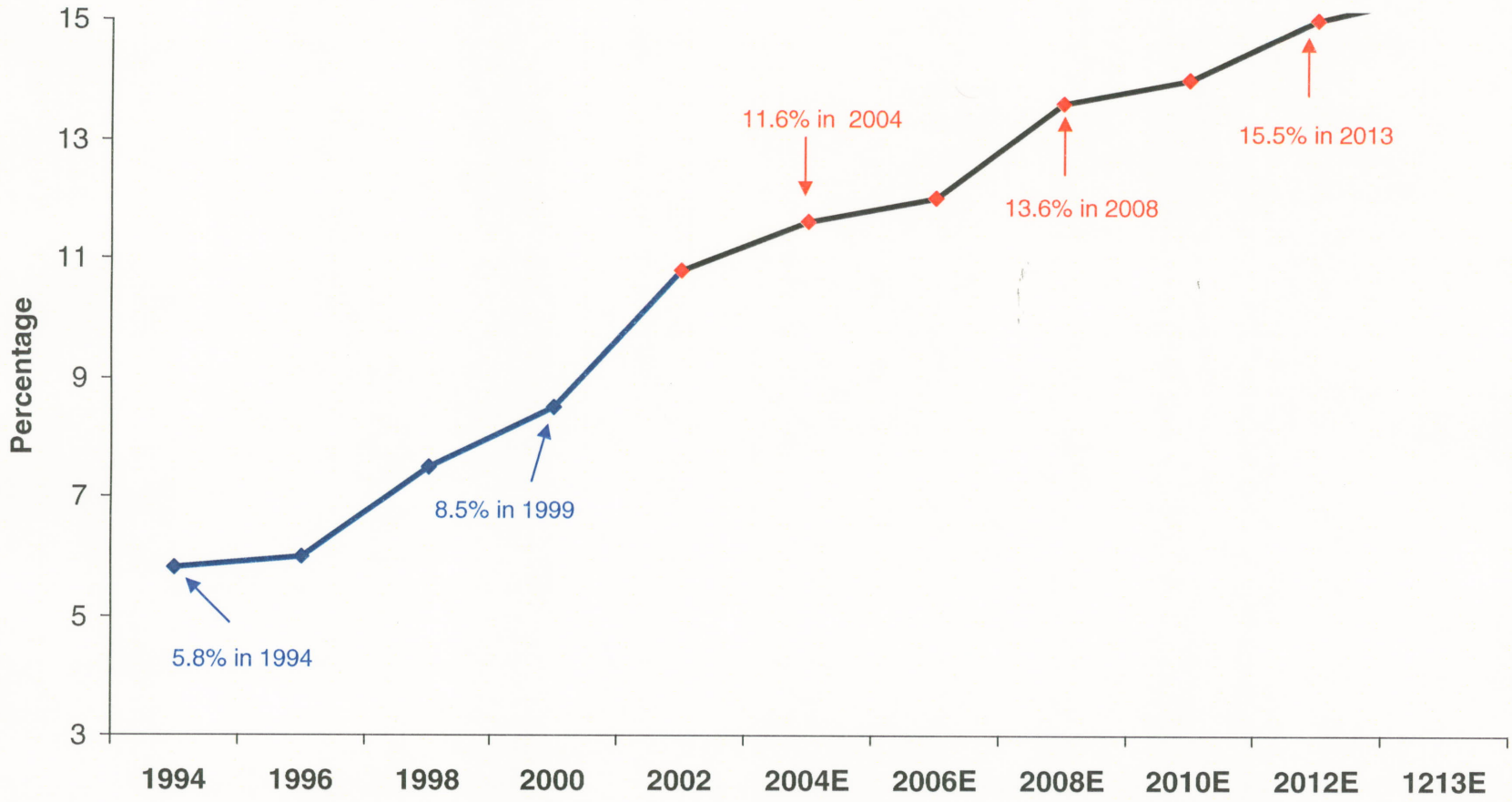
Drug Spend Continues to Increase, But Trend is Slowing



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

Source: U.S. Centers for Medicare & Medicaid Services (CMS), Office of the Actuary, 2004.

Drug Spend Represents a Growing Proportion of Health Care Costs

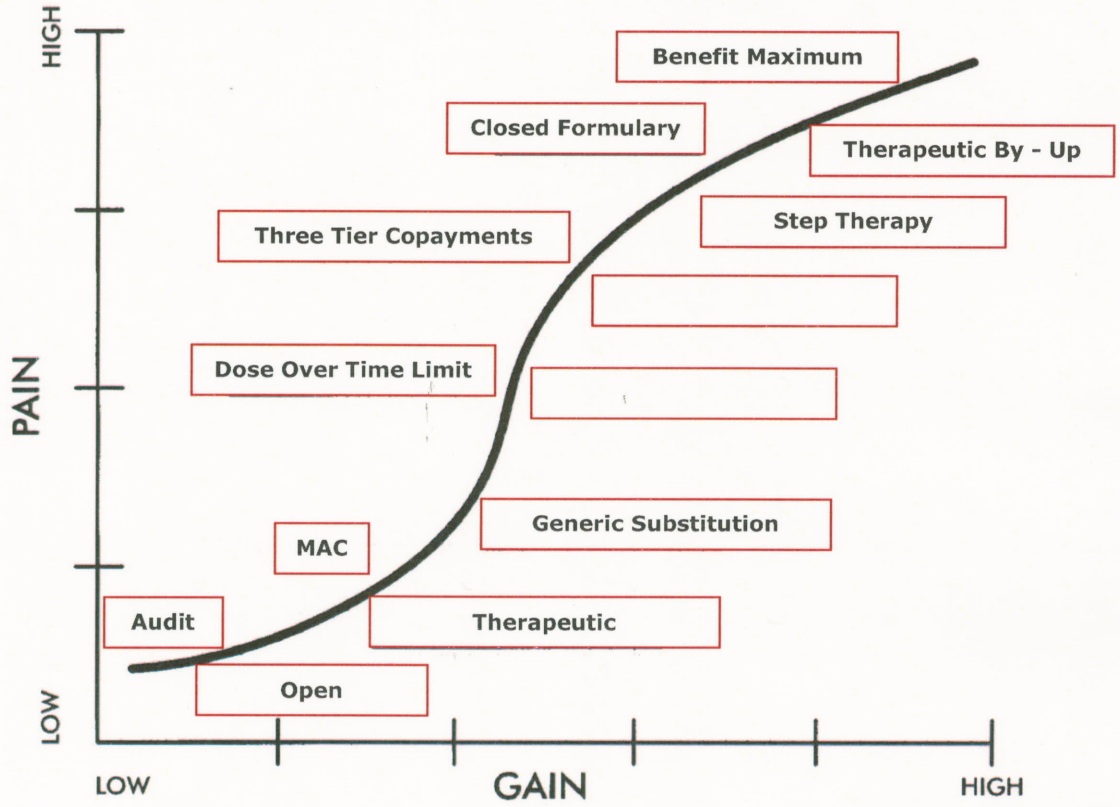


Note: 2003-2013 data are projections.

Source: U.S. Centers for Medicare & Medicaid Services (CMS). Office of the Actuary, 2004.

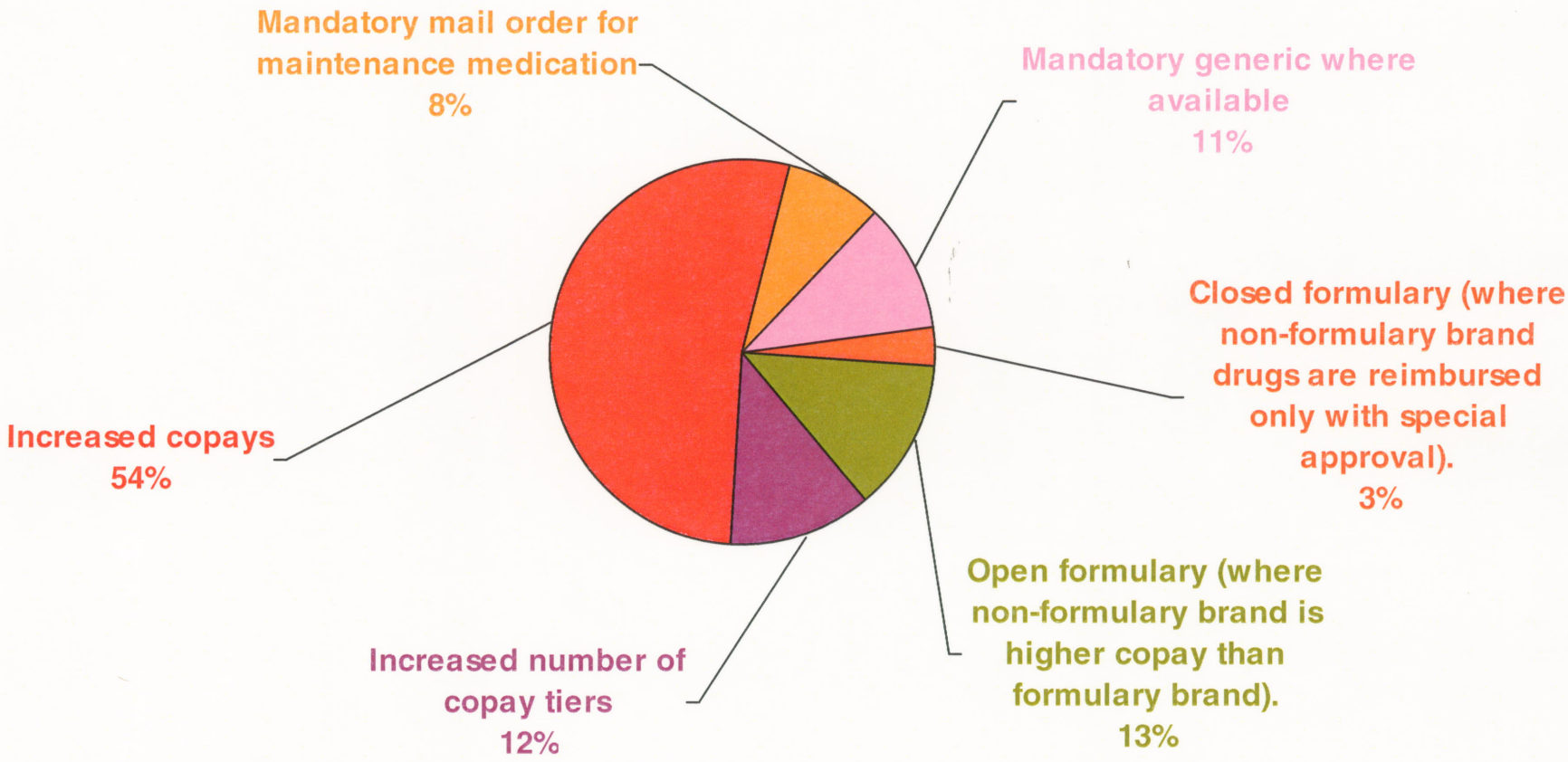
Pharmacy Program Options: PAIN VS. GAIN

✓	Audit
✓	Benefit Maximum
✓	Closed Formulary
✓	Coinsurance
✓	Dose Over Time Limits
✓	Generic Substitution
✓	MAC
✓	Open Formulary
✓	Prior Authorization
✓	Step Therapy
✓	Therapeutic Interchanges
✓	Therapeutic By-Up
✓	Three Tier Copayments



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?



Source: 2004 *EBN*/Hay Benefits Survey on Benefits Management.

DecisionMaster WAREHOUSE

Logout

Discussion Points | Management Report | Drill Down | Alternative Modeling

Analysis Home >> Alternative Modeling

ABC Company

Entire Company (#200077)

broker name: **Hylant Group, Inc. - Toledo**
carrier name: **ABC Carrier**
report period: **08/01/02 - 07/31/03**
analyst: **Jennifer Fenzl**

- Select another project

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Current Plan Design

Compare

Edit | T

Charges	Copay	Deductible	CoInsurance	Not Covered	Total Net Ch
$3,065,108	$0	$65,362	$44,937	$1,232	$2,95

Build New Model

Alternative Model: $400/$800

Compare

Edit | Tc

Charges	Copay	Deductible	CoInsurance	Not Covered	Tota Cha
$3,065,108	$31,450	$643,742	$143,492	$68,914	$2,17

Alternative Model: Advanced Consulting - $100 ER Copay

Compare

Edit | Tc

Charges	Copay	Deductible	CoInsurance	Not Covered	Tota Cha
$3,065,108	$15,500	$280,523	$150,623	$74,572	$2,54

Alternative Model: Advanced Consulting - $400 OON deductible

Compare

Edit | Tc

Charges	Copay	Deductible	CoInsurance	Not Covered	Tota Cha
$3,065,108	$0	$375,292	$130,725	$74,572	$2,48

Alternative Model: Advanced Consulting - Decrease OP Mental Health Visits

Compare

Edit | Tc

Charges	Copay	Deductible	CoInsurance	Not Covered	Tota Cha
$3,065,108	$0	$280,937	$147,809	$76,847	$2,55

Alternative Model: Advanced Consulting - HMO

Compare

Edit | Tc

Charges	Copay	Deductible	CoInsurance	Not Covered	Tota Cha

$3,065,108	$0	$280,937	$193,050	$74,572	$2,51

Alternative Model: Advanced Consulting - Office Visit Copay Compare

Edit | Tc

Charges	Copay	Deductible	CoInsurance	Not Covered	Tota Cha
$3,065,108	$33,500	$277,650	$145,155	$74,572	$2,53

Alternative Model: chiro Compare

Edit | Tc

Charges	Copay	Deductible	CoInsurance	Not Covered	Tota Cha
$3,065,108	$49,340	$278,372	$144,903	$56,242	$2,53

Alternative Model: ER Copay: $100 Compare

Edit | Tc

Charges	Copay	Deductible	CoInsurance	Not Covered	Tota Cha
$3,065,108	$18,700	$65,131	$44,661	$68,914	$2,86

Alternative Model: sample Compare

Edit | Tc

Charges	Copay	Deductible	CoInsurance	Not Covered	Tota Cha
$3,065,108	$25,905	$776,252	$138,982	$56,242	$2,06

DecisionMaster WAREHOUSE

Logout

Discussion Points | Management Report | Drill Down | Alternative Modeling

Analysis Home >> Alternative Modeling >> Model Comparison

ABC Company
Entire Company (#200077)

broker name: **Hylant Group, Inc. - Toledo**
carrier name: **ABC Carrier**
report period: **08/01/02 - 07/31/03**
analyst: **Jennifer Fenzl**

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Model Comparison Printable Version

Comparison of Current Model vs. Advanced Consulting - $100 ER Copay

Reduction in Liability: $409,687 13.9%

Comparison of Charges

	Current Model	Alternative	Difference
Gross Charges	$3,065,108	$3,065,108	$0
Copay Total	0	15,500	(15,500)
Deductible Total	65,362	280,523	(215,161)
Coinsurance Total	44,937	150,623	(105,686)
Total Not Covered	1,232	74,572	(73,340)
Total Net Charges	$2,953,577	$2,543,890	$409,687

Members

Total Claimants	660

Plan Differences

	Current Model	Alternative		Members Affected
Calendar Year In Network				
Deductible	0	225	660	100.0%
Coinsurance	0.0%	10.0%	567	85.9%
Maximum Out of Pocket	0	626	121	18.3%
Calendar Year Out of Network				
Deductible	100	225	629	95.3%
Coinsurance	20.0%	30.0%	567	85.9%
Maximum Out of Pocket	500	625	36	5.5%
Office Visit In Network				
In Network Coinsurance	0.0%	10.0%	459	69.5%
Office Visit Out of Network				
Out of Network Coinsurance	20.0%	30.0%	184	27.9%
Inpatient Hospital In Network				

In Network Coinsurance	0.0%	10.0%	29	4.4%
Inpatient Hospital Out of Network				
Out of Network Coinsurance	20.0%	30.0%	1	0.2%
Inpatient Surgery In Network				
In Network Coinsurance	0.0%	10.0%	25	3.8%
Inpatient Surgery Out of Network				
Out of Network Coinsurance	20.0%	30.0%	3	0.5%
Outpatient Surgery In Network				
In Network Coinsurance	0.0%	10.0%	129	19.5%
Outpatient Surgery Out of Network				
Out of Network Coinsurance	20.0%	30.0%	37	5.6%
Emergency Room In Network				
Copay	0	100	87	13.2%
In Network Coinsurance	0.0%	10.0%	85	12.9%
Emergency Room Out of Network				
Out of Network Coinsurance	20.0%	30.0%	31	4.7%
Chiropractic In Network				
In Network Coinsurance	0.0%	10.0%	73	11.1%
Maximum Visits	No Max	No Max	0	0.0%
Chiropractic Out of Network				
Out of Network Coinsurance	20.0%	30.0%	12	1.8%
Maximum Visits	No Max	No Max	0	0.0%
Inpatient Mental In Network				
In Network Coinsurance	0.0%	10.0%	2	0.3%
Apply to Deductible	No	Yes	2	0.3%
Apply to Coinsurance	No	Yes	2	0.3%
Maximum Amount	No Max	1,000	1	0.2%
Inpatient Mental Out of Network				
Out of Network Coinsurance	20.0%	30.0%	2	0.3%
Outpatient Mental In Network				
In Network Coinsurance	0.0%	10.0%	49	7.4%
Maximum Visits	35	20	4	0.6%
Outpatient Mental Out of Network				
Out of Network Coinsurance	20.0%	30.0%	25	3.8%
Maximum Visits	35	No Max	16	2.4%