HPI-DASHBOARD SPEC SHEET

PRODUCTION DATE/TIME	3/21/2024 10:34 AM
CLIENT NAME	Davidson Benefits Planning, LLC
GROUP NAME	City of Vancouver
TIME PERIOD	January 2023 through December 2023
MODE	Incurred Claims
MONTHS OF DATA	12
FUNDING TYPE	Self-Funded
PRIMARY NORM	2023 - National Projected
SECONDARY NORM	None
WEB PORTAL	https://dbp.hpiportal.com
PROJECT ID	V631833
PASSWORD	piwqdci
EMPLOYEE COUNT	564
MEMBER COUNT	1,537
GROSS BILLED CHARGES	$14,516,331.89
GROSS MEDICAL PAID	$7,158,071.71 (49.3%)
NET MEDICAL PAID	$7,158,071.71 (49.3%)

City of Vancouver

HPI-Dashboard™

Powered by Health Plan Intelligence™

Analysis for the Period

January 2023 through December 2023
Incurred Claims

Paid through February 2024

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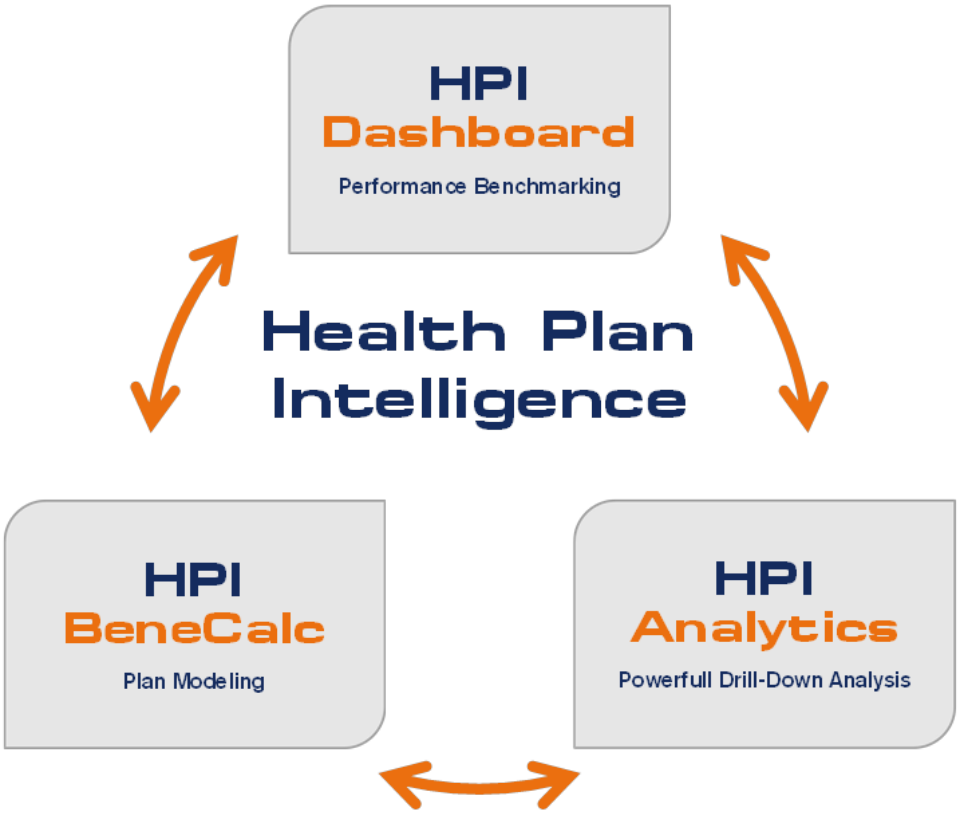
Introduction

There are many factors influencing the performance and cost of a group health plan… member demographics, plan design, misdirected care, chronic disease, high-cost providers, network performance, high utilization and more. Health Plan Intelligence℠ provides the opportunity to gain valuable insight into the underlying issues driving health care costs.
Health Plan Intelligence is a decision support suite of proprietary health care analysis tools which include the HPI-Dashboard, HPI-Analytics, and HPI- BeneCalc.



HPI-Dashboard℠ is a management-level report which provides a clear understanding of how your plan is performing. The HPI- Dashboard includes the evaluation and performance benchmarking of key health care utilization rates, unit costs, plan design efficiency, and the impact of specific diseases.

HPI-Analytics℠ provides access to unparalleled and powerful views of underlying, value-added health care data. Through HPI-Analytics you can apply multi-dimensional filters or "controls" which provide the opportunity to reveal hidden problem areas and potential opportunities.

HPI-BeneCalc℠ provides online access to various benefit modeling applications. Through HPI-BeneCalc you can model the potential financial and member impact of changes in plan design, medical inflation, network performance, fixed costs, stop-loss parameters, employee contributions and more.

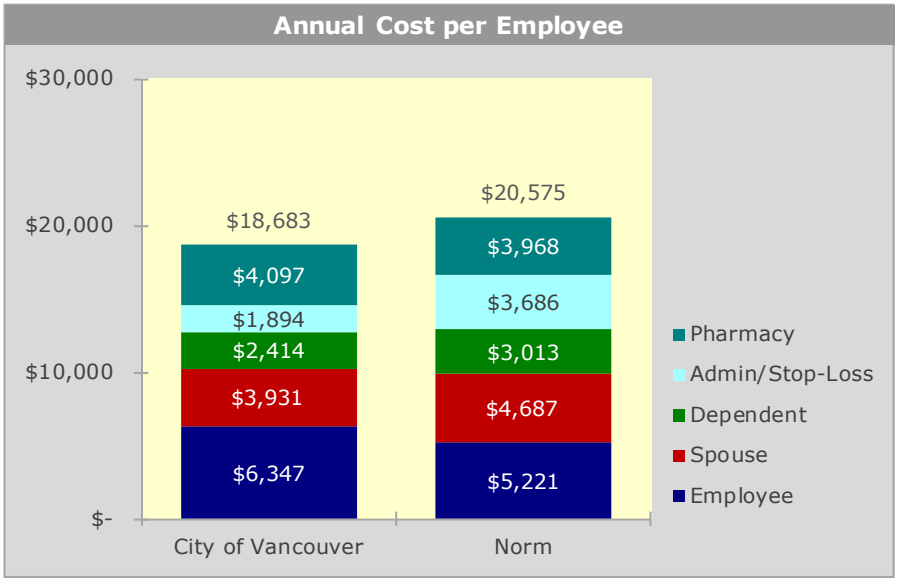
Membership and Plan Cost

Overall, City of Vancouver had 1,537 total plan participants. By allocating the annual combined claim costs among all plan members we can determine the approximate cost associated with providing health coverage for employees, spouses, and dependents. This Health Plan Intelligence analysis shows that approximately $4,717,707 of net combined claims were for employees, while $3,188,482 and $1,562,395 were for spouses and children respectively.

	Average Headcount			
Coverage Type	Employee	Spouse	Dependent	Total
Single Coverage	152	n/a	n/a	152
Family Coverage(s)	412	367	606	1,385
Total	564	367	606	1,537

Gross Medical Claims	$3,579,723	$2,216,889	$1,361,460	$7,158,072
Gross Pharmacy Claims	$2,499,691	$1,156,478	$200,934	$3,857,104
Gross Combined Claims	$6,079,414	$3,373,367	$1,562,395	$11,015,176
Approx Reimbursement*	$1,361,707	$184,885	$0	$1,546,593
Net Combined Claims	$4,717,707	$3,188,482	$1,562,395	$9,468,583
Net Combined Per Member	$8,365	$8,688	$2,578	$6,160
Net Combined Per Employee	$8,365	$5,653	$2,770	$16,788

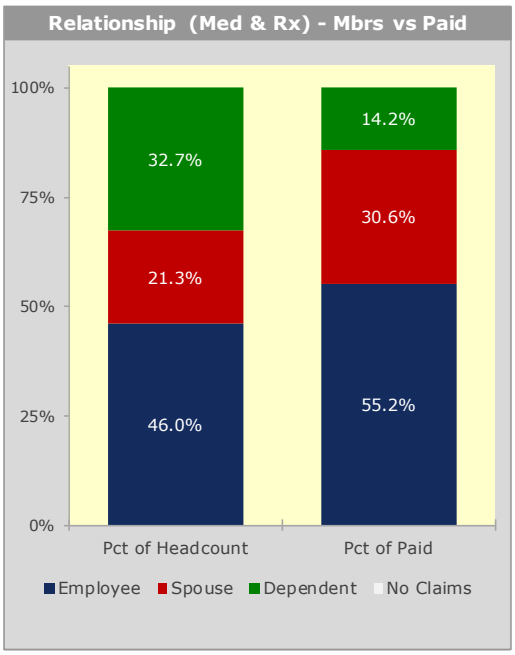
** Net claims represent the approximate amount after individual stop-loss reimbursement or pooling point. Net combined claims assume stop-loss is applied to both medical and pharmacy. The above calculations assume a $275,000 limit for any high cost individuals. The above reimbursement amounts are approximate. Actual amounts may vary based on specific contract provisions, timing of reimbursements, etc.*



During this reporting period, the City of Vancouver health plan cost was $18,683 per employee. This compares favorably with the normal health plan cost of $20,575 per employee. This normal health plan cost is based on the aggregate experience of the Health Plan Intelligence client base during the same approximate time period.

The above norm cost has been adjusted to reflect the exact membership ratios of City of Vancouver. For comparative purposes, it is important to adjust the expected plan cost based on actual membership ratios as "per employee" costs can be influenced by average contract size.

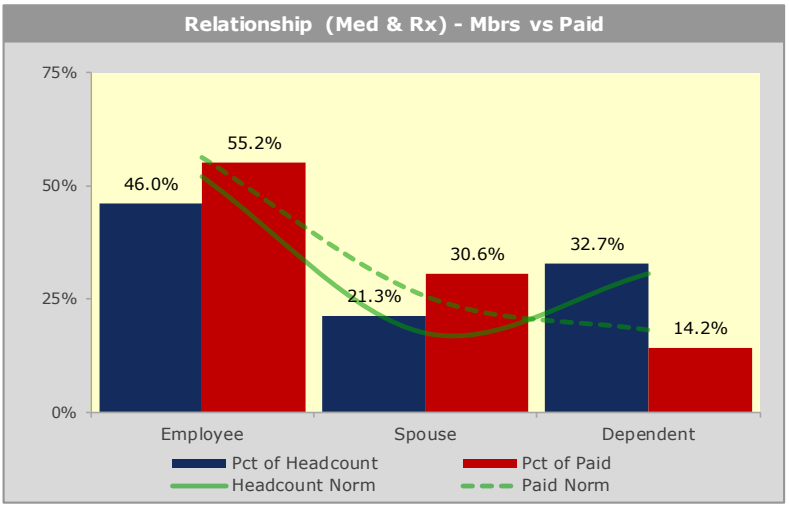
Demographics - Relationship

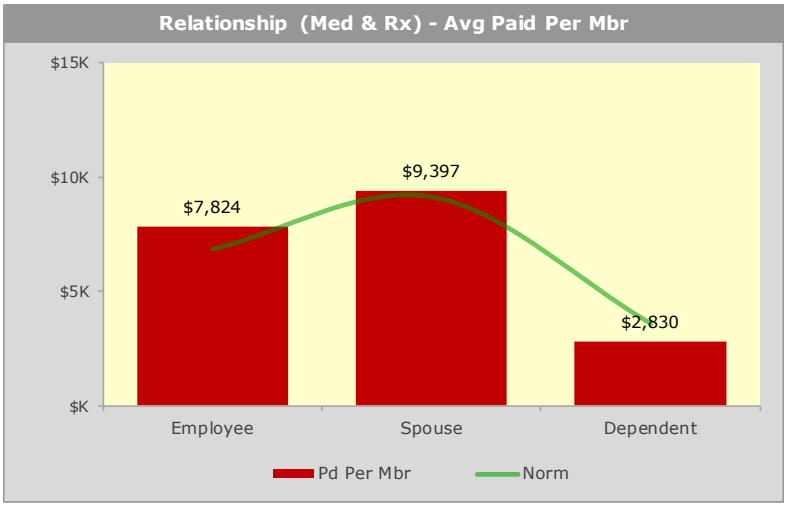


The concentration of health care expenses by relationship and age can have significant implications for effective plan design. We have highlighted claims by relationship in the following exhibits to assist in efforts to assess, target and contain overall healthcare spending.

The exhibit to the left shows the demographics of the group by relationship within the paid claims as a percent of overall covered headcount, vs. the percentage of their paid claims. Paid claims include combined gross medical and pharmacy dollars.

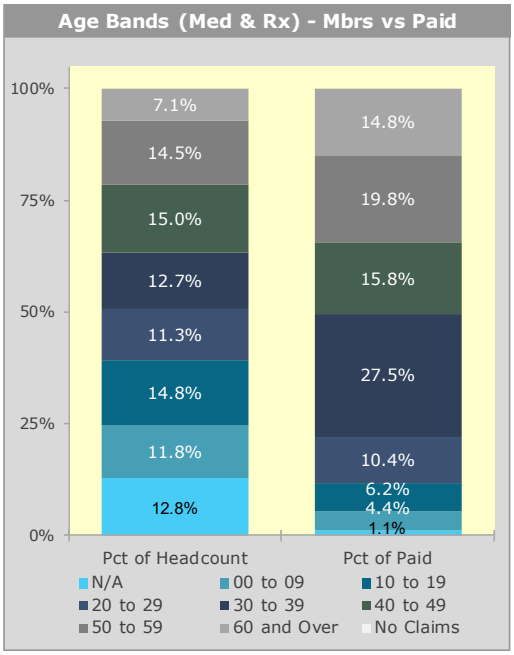
The exhibit to the right also highlights the demographics of the group by relationship within the paid claims as a percent of overall covered headcount, vs. the percentage of their paid claims, with the addition of the normative information. It includes combined gross medical and pharmacy dollars.





The exhibit to the left illustrates the average cost per member by relationship, compared to the norm. It includes combined gross medical and pharmacy dollars.

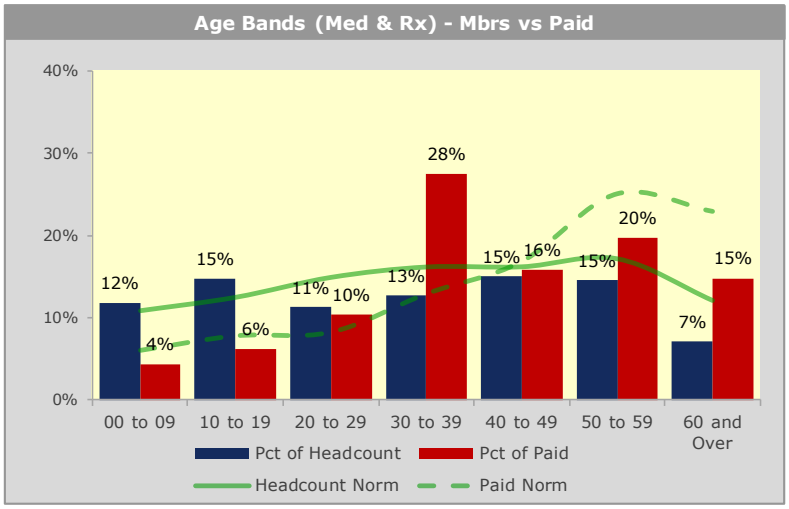
Demographics – Age Bands

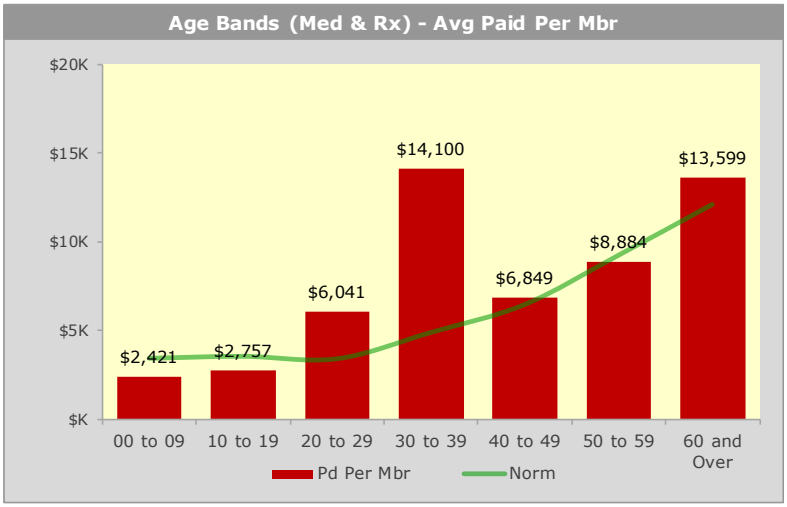


The charts included on this page continue to highlight the fact that a small population of members will likely account for a large percentage of a group's claims. In most cases, the highest concentration of health care claims will come from members over age 40. The exhibits on this page show member distribution by age.

The exhibit to the left shows the demographics of the group by age band within the paid claims as a percent of overall covered headcount, vs. the percentage of their paid claims. Paid claims include combined gross medical and pharmacy dollars.

The exhibit to the right also highlights the demographics of the group by age bands within the paid claims as a percent of overall covered headcount, vs. the percentage of their paid claims, with the addition of the normative information. It includes combined gross medical and pharmacy dollars.

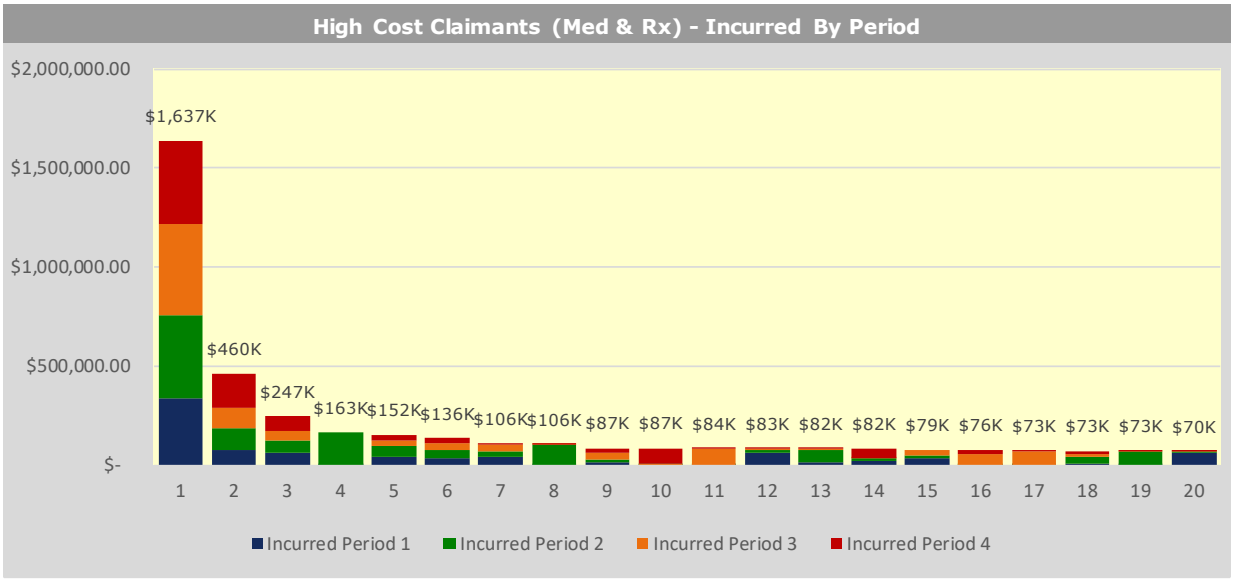




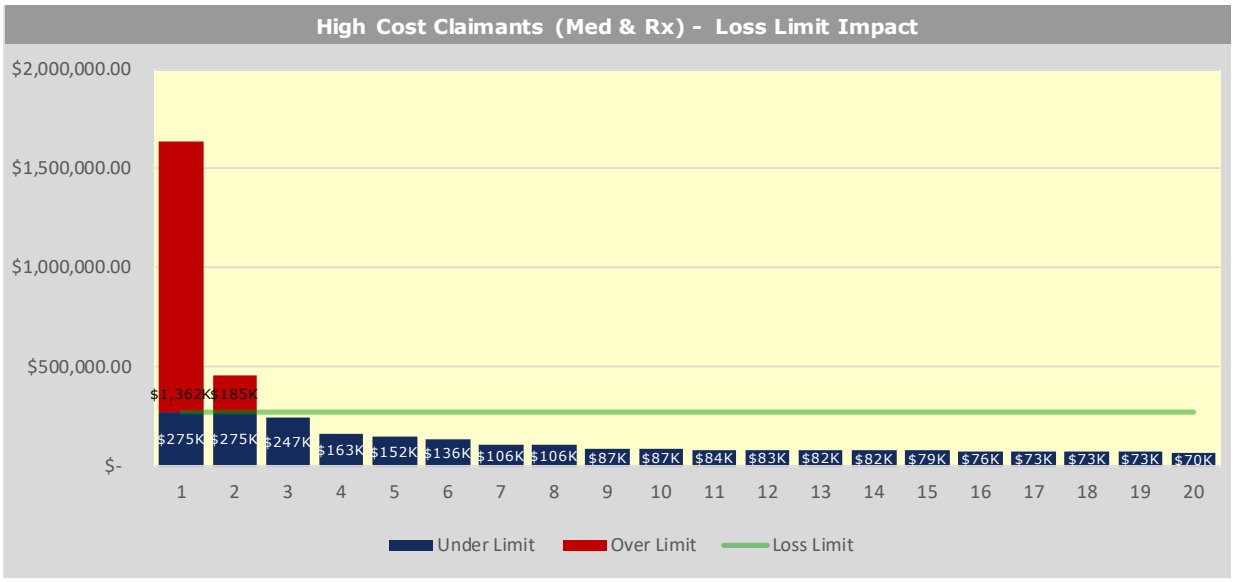
The exhibit to the left illustrates the average cost per member *with claims* by age band, compared to the norm. It includes combined gross medical and pharmacy dollars.

High Cost Claimants – Top 20

The following exhibts illustrate the total claims for the top 20 claimants and include combined gross medical and pharmacy dollars.



High cost claimants may change from year to year as some people experience acute, serious illness or injury and then recover (e.g.Appendicitis or Motor Vehicle Accident). These members are often noted by a large quarter of claims with subsequent smaller quarters or no additional claims. A share of the group, however, may continue to have high spending for longer periods, indicating a chronic illness or condition (e.g. Rheumatoid Arthritis treated with Specialty medications). These members can be described as *persistently high spending* members and will have multiple quarters with similar claims. These *persistently high spending* members may be appropriate for targeted intervention, like case management, wellness education or behavior modification through plan design changes.

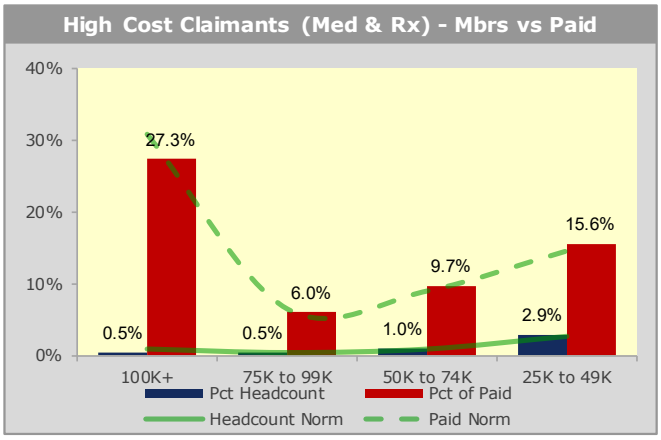


Please note- The above reimbursement amounts are approximate. Actual amounts may vary based on specific contract provisions, timing of reimbursements, etc.

High Cost Claimants – Impact

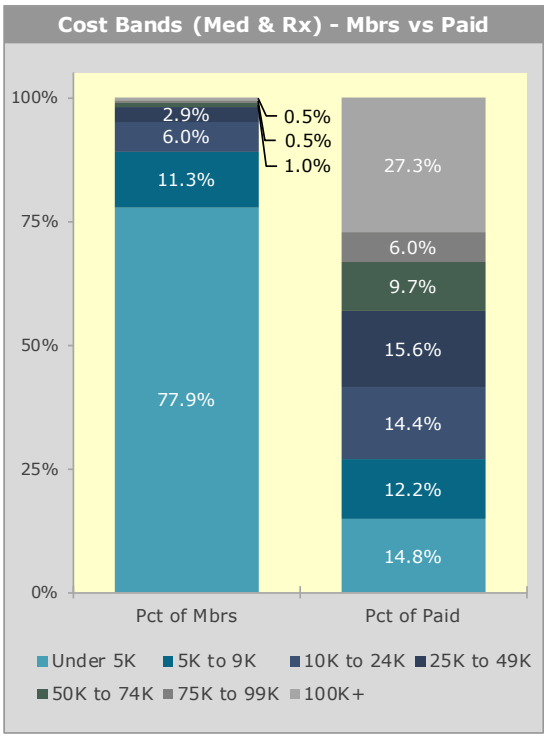
The following exhibits illustrate the impact that a small number of high cost claimants can have on a group's total spend. combined gross medical and pharmacy dollars.

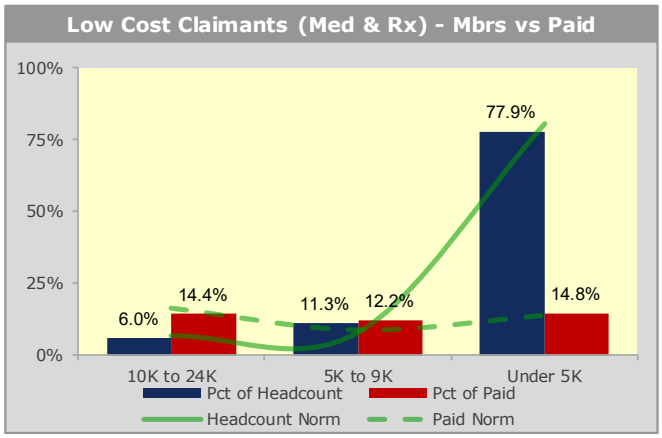
According to the US Department of Health & Human Services, a small proportion of patients, sometimes called high utilizers of health care, account for a large proportion of healthcare costs. In the US, 5% of patients incur approximately 50% of total costs while the bottom 50% of users account for less than 3% of total spend^.



In the chart above, the small population of high cost claimants consume a large percentage of the claim volume.

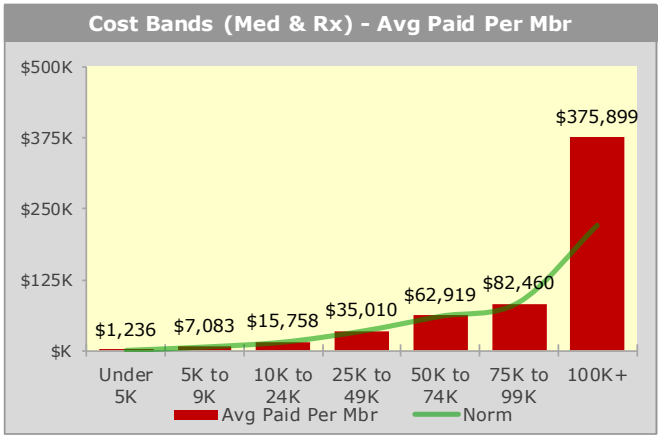
The chart below illustrates the inverse relationship between population size and claim volume for low and high utilizers.





Conversely, this second chart shows the lower cost claimants with a much larger percentage of the population but much lower overall claim volume.

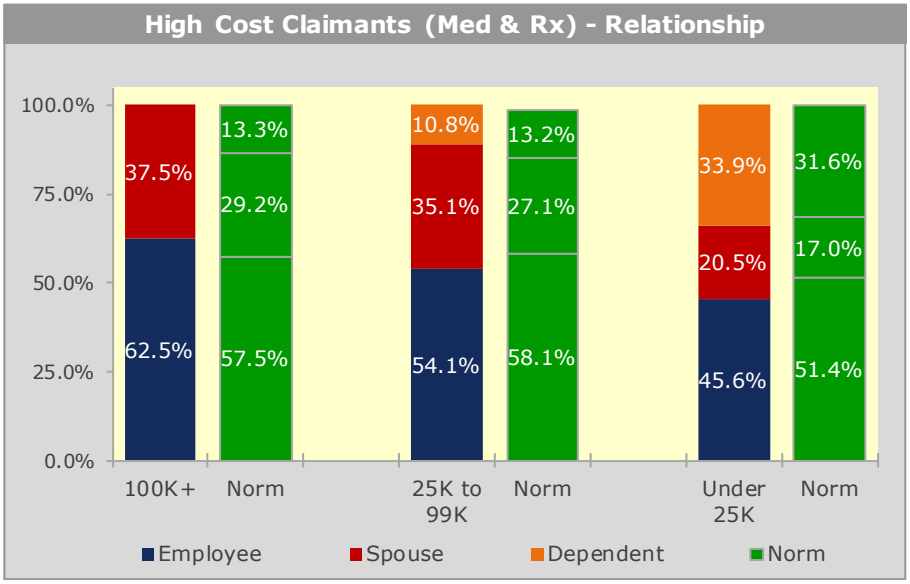
Lastly, the chart to the right summarizes the average cost per claimant, broken out by claim band and compared to the norm.



^According to: Statistical Brief #521, Concentration of Health Care Expenditures and Selected Characteristics of High Spenders, U.S. Civilian Noninstitutionalized Population, 2016; published in February 2019 by the MEPS (Medical Expenditure in Panel Survey) for the AHRQ (Agency in Healthcare Research & Quality, part of the US Department of Health & Human Services).

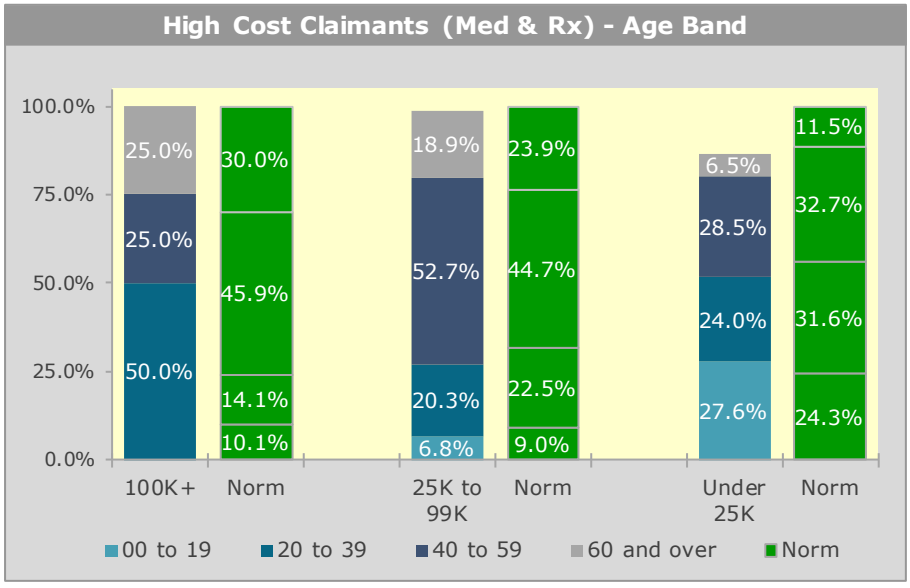
High Cost Claimants – Demographics

The following exhibits illustrate the distribution of relationships or age bands within three levels of consumption per claimant, versus the norm. The analysis includes combined gross medical and pharmacy dollars.



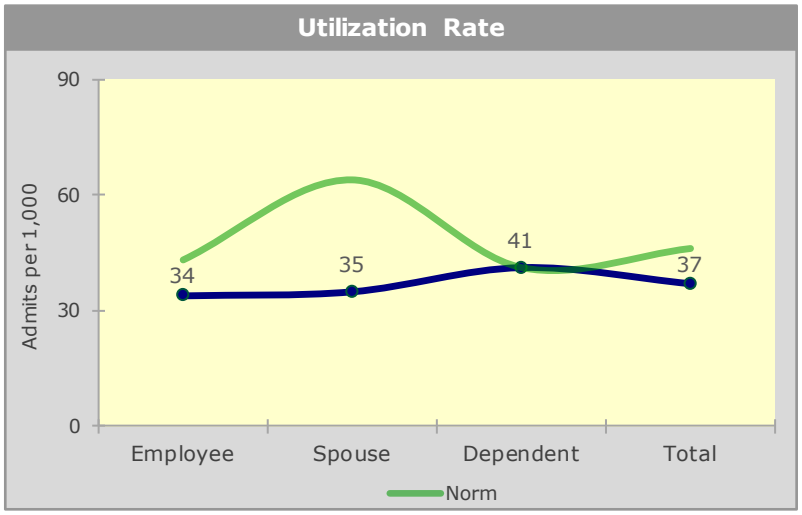
Membership can impact the performance of a group health plan. High cost claimants by relationship are shown in the exhibit to the left. Changes in the relative mix of membership can contribute to variances in overall health plan performance.

The distribution of health care costs is strongly age dependent. People with persistently high spending are, on average, a decade older than lower cost members#.
While high spending can occur at all ages, people age 40 and over account for almost 70% of all health spending in the US**.



Peterson-KFF Health System Tracker:
#"A look at people who have persistently high spending on health care.", 07/2019.
**How do health expenditures vary across the population?", 01/2019

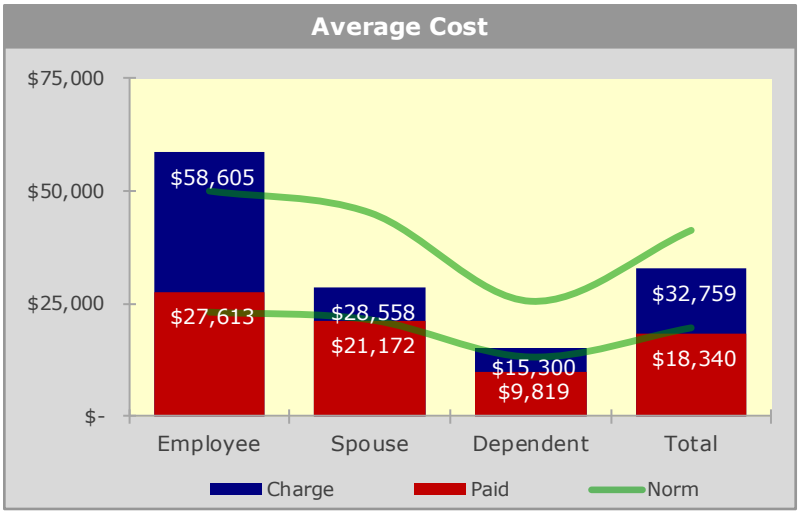
Inpatient Hospital

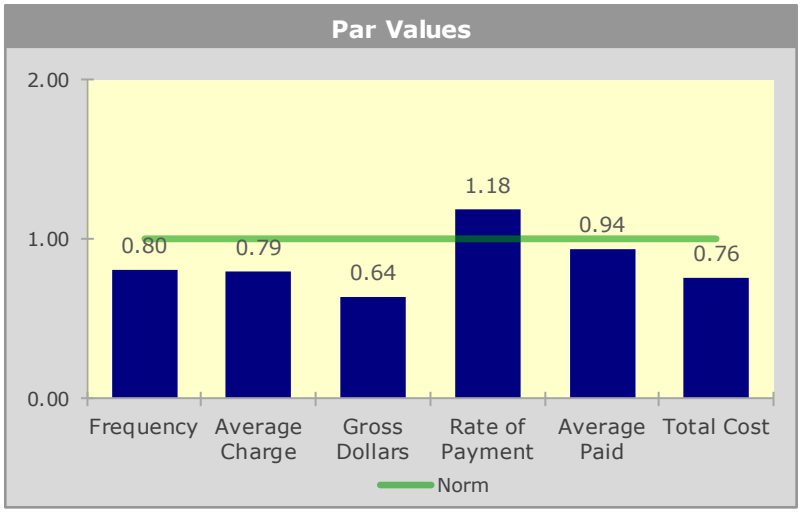


Inpatient hospital admissions are defined as episodes of care involving an overnight stay in a hospital or other inpatient facility. Inpatient admission rates per 1,000 represent a statistical measure of how many inpatient admissions occurred per 1,000 covered members.

The average cost per inpatient hospital stay can vary greatly. During this reporting period, the average cost per inpatient hospital admission is shown on the right. This average cost only represents the facility fee and does not include related professional or ancillary fees.

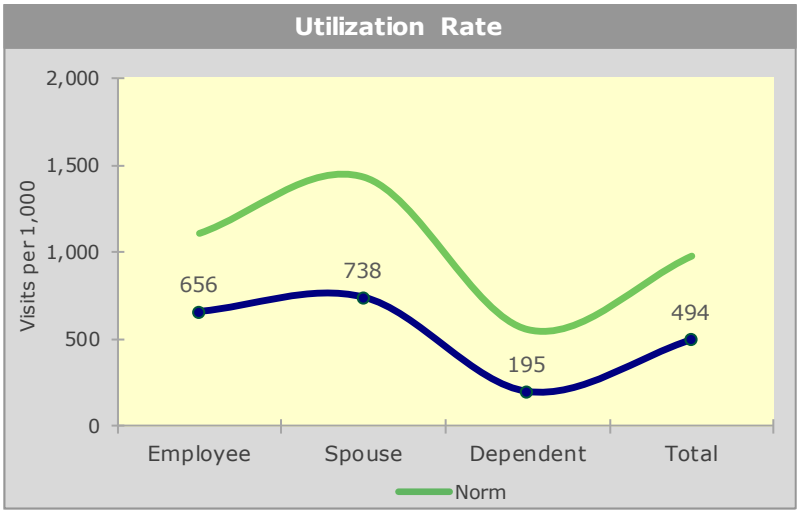
Please note: this data has been normalized to help reduce the influence of unusually high cost services. The normalization process typically results in the inclusion of roughly 97-98% of all services within this category.





Par values can be used to evaluate the relative performance of a health plan. Each of the values in the par analysis represents a percent variance from normal (1.00 = normal). The Rate of Payment measure reflects the relative impact of provider discounts, member cost sharing (deductibles, copayments, etc.) and other reductions from the amount charged resulting in the amount paid.

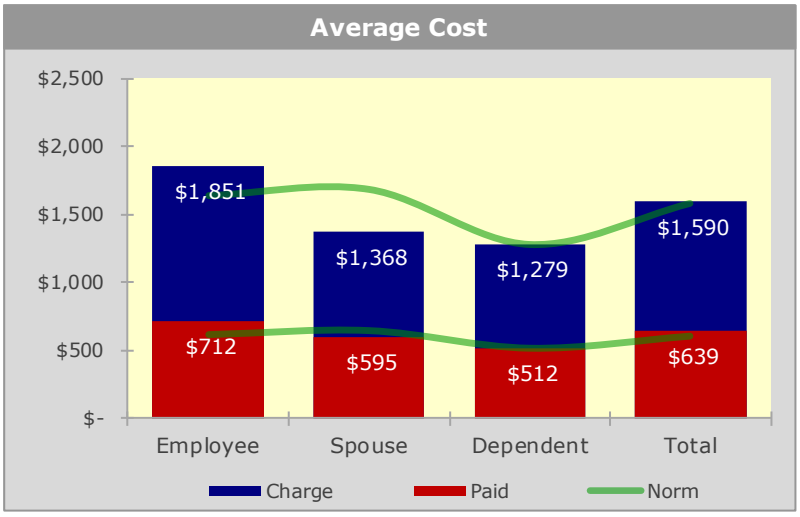
Outpatient Hospital

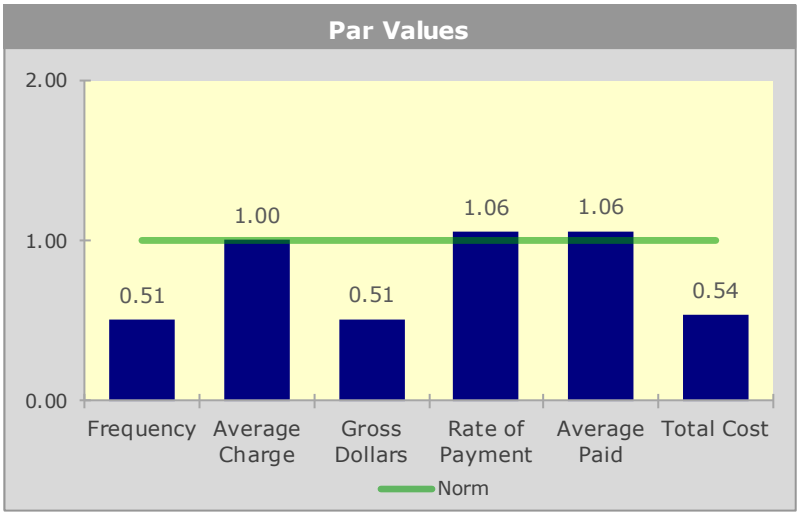


Outpatient hospital visits are defined as episodes of care involving hospital treatment without an overnight stay. Outpatient hospital visit rates per 1,000 represent a statistical measure of how many outpatient hospital visits occurred per 1,000 covered members.

During this reporting period, the average cost per outpatient hospital visit is shown on the right. This average cost represents the facility fee only and does not include any related professional or ancillary fees.

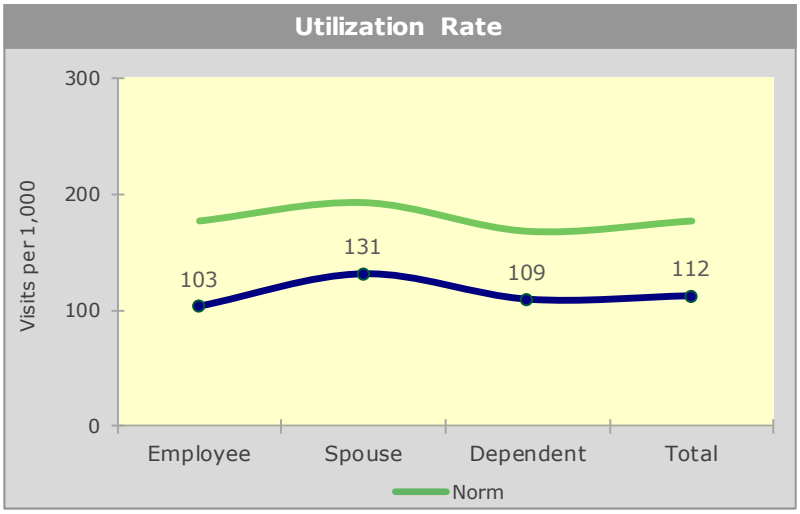
Please note: this data has been normalized to help reduce the influence of unusually high cost services. The normalization process typically results in the inclusion of roughly 97-98% of all services within this category.





Par analysis can be used to evaluate the relative performance of a health plan. Each of the values in the par analysis represents a percent variance from normal (1.00 = normal). The Rate of Payment measure reflects the relative impact of provider discounts, member cost sharing (deductibles, copayments, etc.) and other reductions from the amount charged resulting in the amount paid.

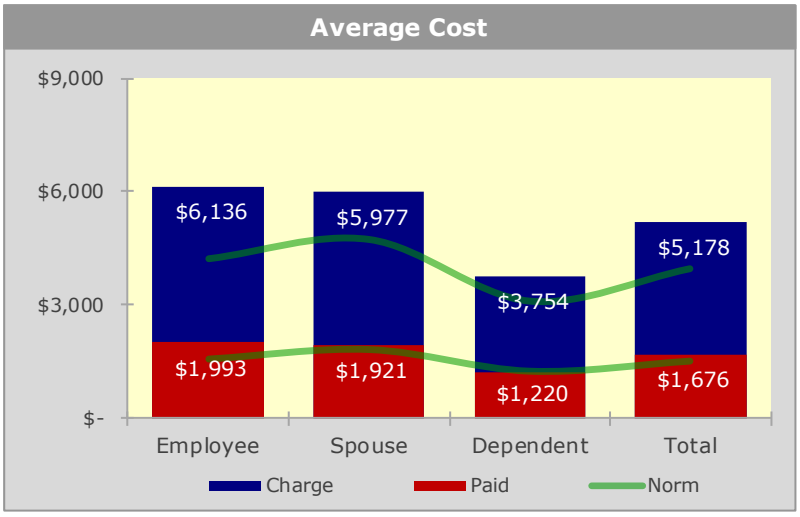
Emergency Room

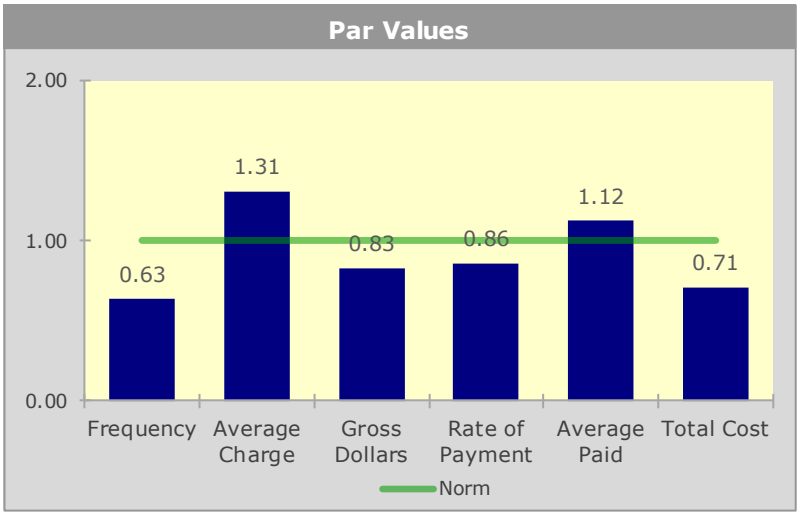


Emergency Room utilization is defined as episodes of care involving outpatient medical services that take place in the emergency room of a hospital or other medical care facility. Emergency room utilization rates per 1,000 represent a statistical measure of how many emergency room visits occurred per 1,000 covered members.

During this reporting period, the average cost per emergency room visit is shown in the right. This cost represents the facility fee only for emergency room services. Professional/physician fees are not included in these figures.

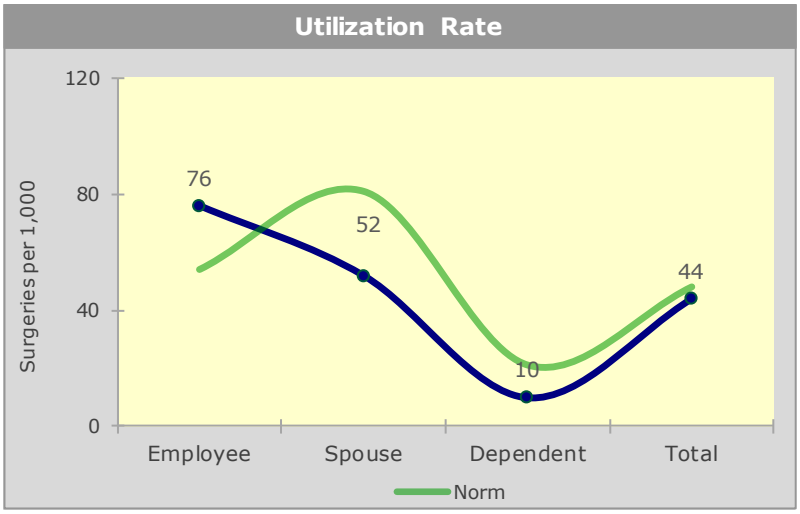
Please note: this data has been normalized to help reduce the influence of unusually high cost services. The normalization process typically results in the inclusion of roughly 97-98% of all services within this category.





Par analysis can be used to evaluate the relative performance of a health plan. Each of the values in the par analysis represents a percent variance from normal (1.00 = normal). The Rate of Payment measure reflects the relative impact of provider discounts, member cost sharing (deductibles, copayments, etc.) and other reductions from the amount charged resulting in the amount paid.

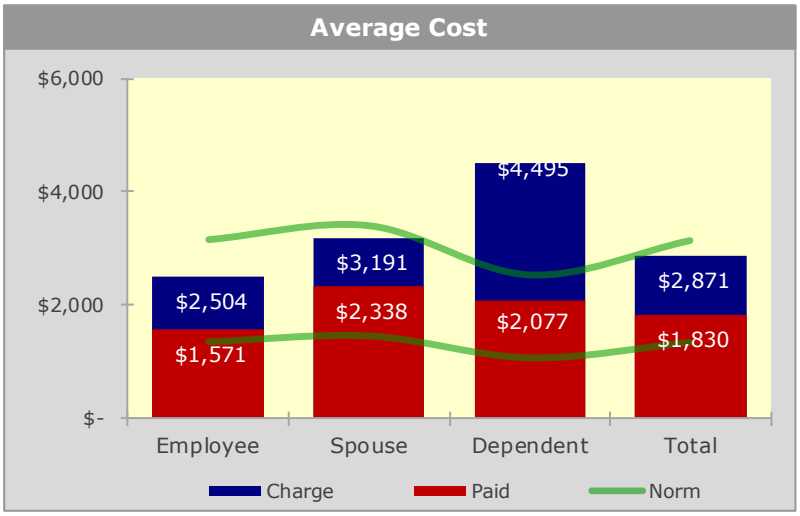
Inpatient Surgery

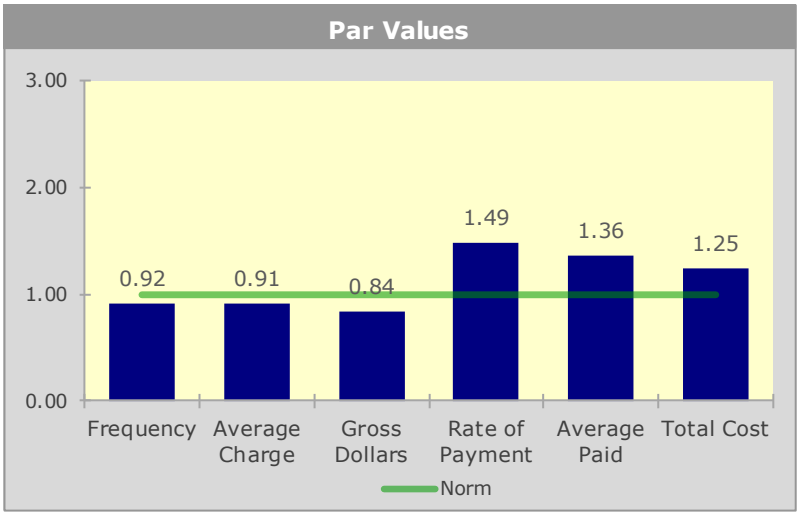


Inpatient Surgery utilization is defined as episodes of care involving the occurrence of surgical procedures which take place while admitted to a facility for overnight treatment. Inpatient Surgery utilization rates per 1,000 represent a statistical measure of how many inpatient surgical procedures occurred per 1,000 covered members.

During this reporting period, the average cost per inpatient surgical procedure is shown on the right. This cost represents the fee for the surgical procedure. These procedures may include assistant surgery and surgically coded anesthesia procedures.

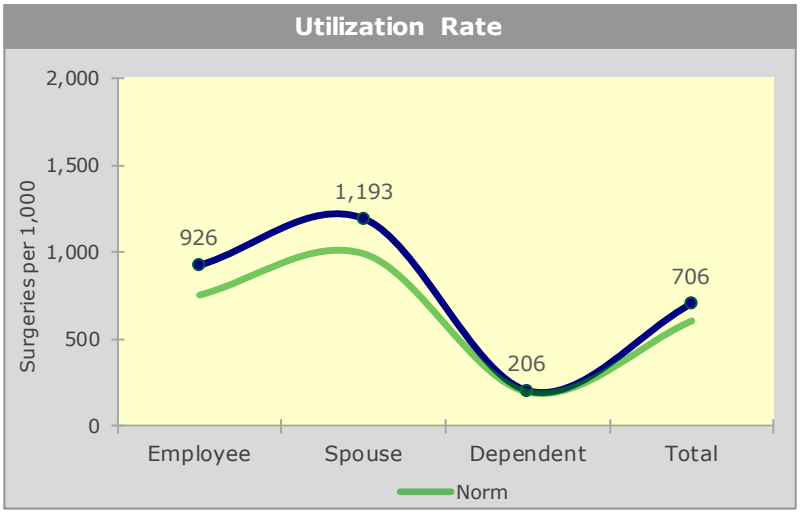
Please note: this data has been normalized to help reduce the influence of unusually high cost services. The normalization process typically results in the inclusion of roughly 97-98% of all services within this category.





Par analysis can be used to evaluate the relative performance of a health plan. Each of the values in the par analysis represents a percent variance from normal (1.00 = normal). The Rate of Payment measure reflects the relative impact of provider discounts, member cost sharing (deductibles, copayments, etc.) and other reductions from the amount charged resulting in the amount paid.

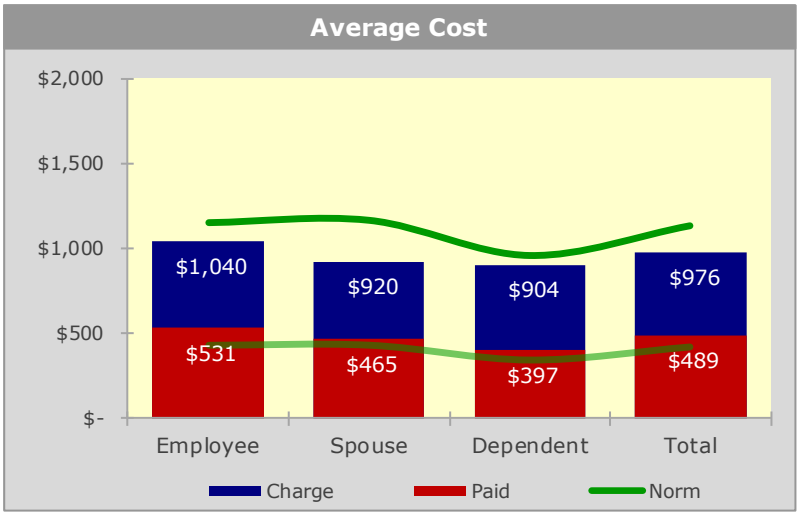
Outpatient Surgery

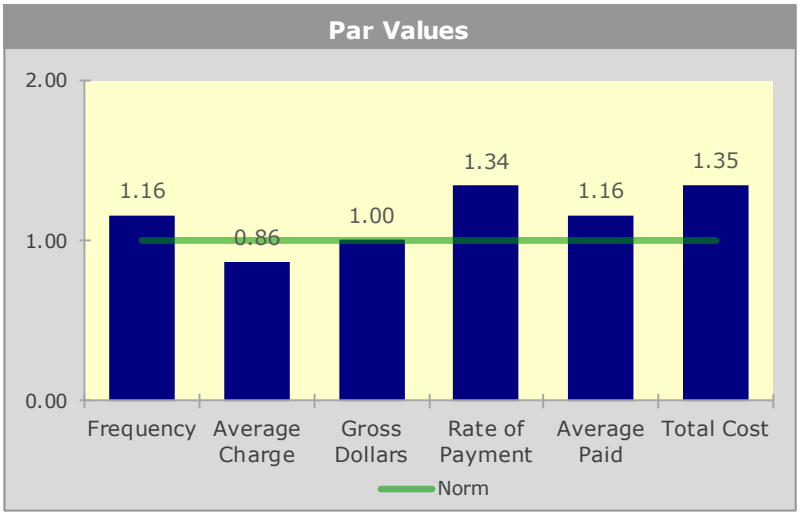


Outpatient Surgery utilization is defined as episodes of care involving the occurrence of surgical procedures which take place in an outpatient setting (hospital, surgical or other facility, as well as a physician office). Outpatient Surgery utilization rates per 1,000 represent a statistical measure of how many outpatient surgical procedures occurred per 1,000 covered members.

During this reporting period, the average cost per outpatient surgical procedure is shown on the right. This cost represents the fee for the surgical procedure. These procedures may include assistant surgery and surgically coded anesthesia procedures.

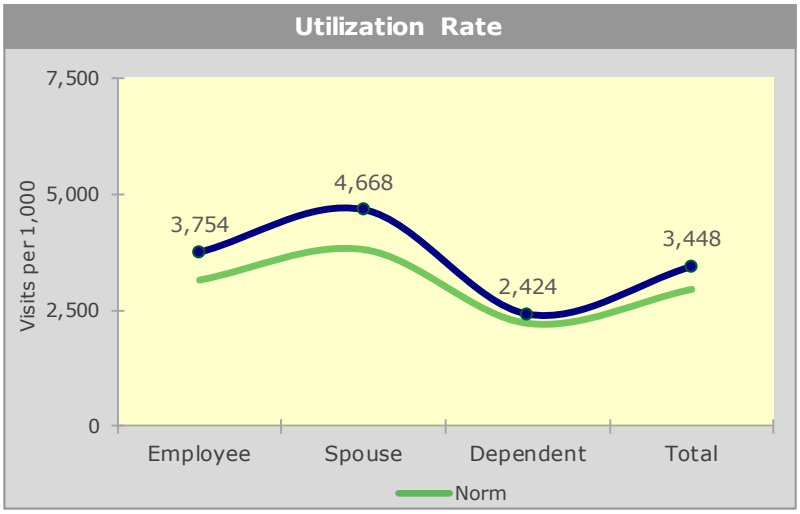
Please note: this data has been normalized to help reduce the influence of unusually high cost services. The normalization process typically results in the inclusion of roughly 97-98% of all services within this category.





Par analysis can be used to evaluate the relative performance of a health plan. Each of the values in the par analysis represents a percent variance from normal (1.00 = normal). The Rate of Payment measure reflects the relative impact of provider discounts, member cost sharing (deductibles, copayments, etc.) and other reductions from the amount charged resulting in the amount paid.

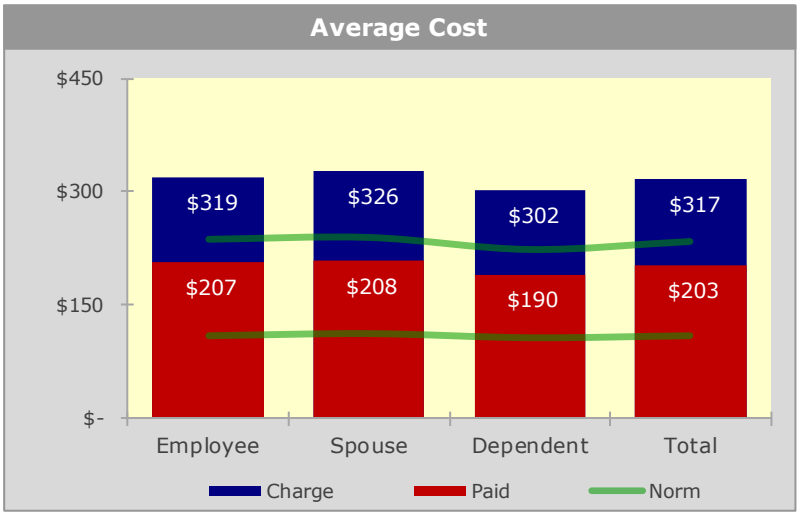
Physician Office Visits

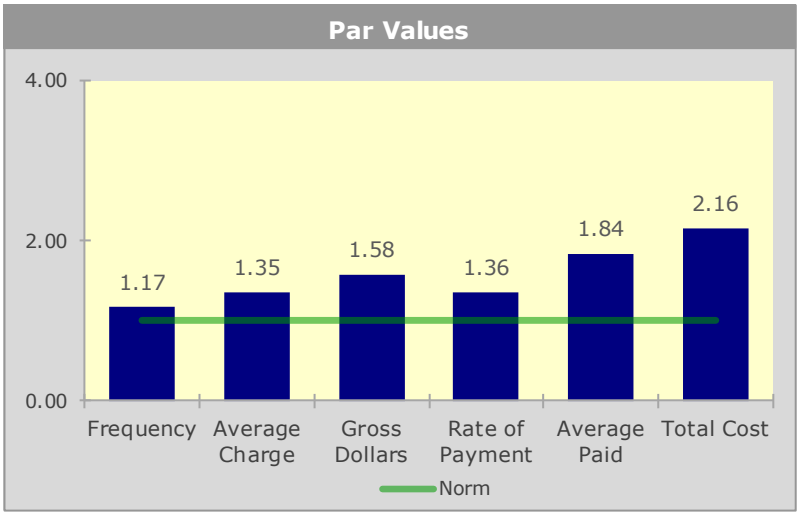


Physician Office Visit utilization is defined as episodes of care involving outpatient treatment taking place in a physician's office. Physician Office Visit utilization rates per 1,000 represent a statistical measure of how many physician office visits occurred per 1,000 covered members.

During this reporting period, the average cost per physician office visit is shown on the right. This cost represents fees associated with the office visit only and does not include related office services (lab, x-ray, blood work, etc.).

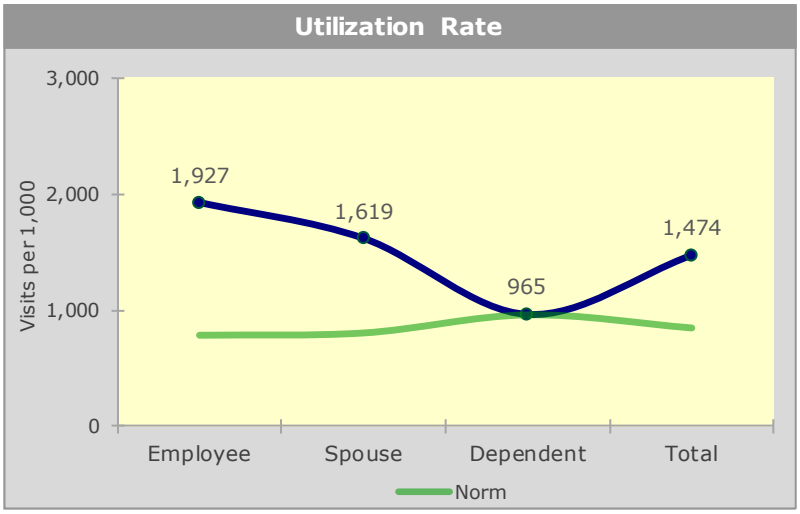
Please note: this data has been normalized to help reduce the influence of unusually high cost services. The normalization process typically results in the inclusion of roughly 97-98% of all services within this category.





Par analysis can be used to evaluate the relative performance of a health plan. Each of the values in the par analysis represents a percent variance from normal (1.00 = normal). The Rate of Payment measure reflects the relative impact of provider discounts, member cost sharing (deductibles, copayments, etc.) and other reductions from the amount charged resulting in the amount paid.

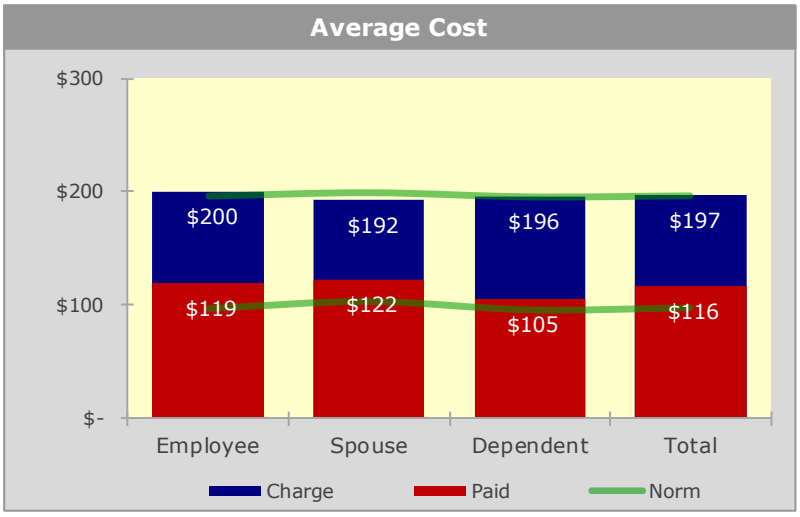
Mental Health Visits

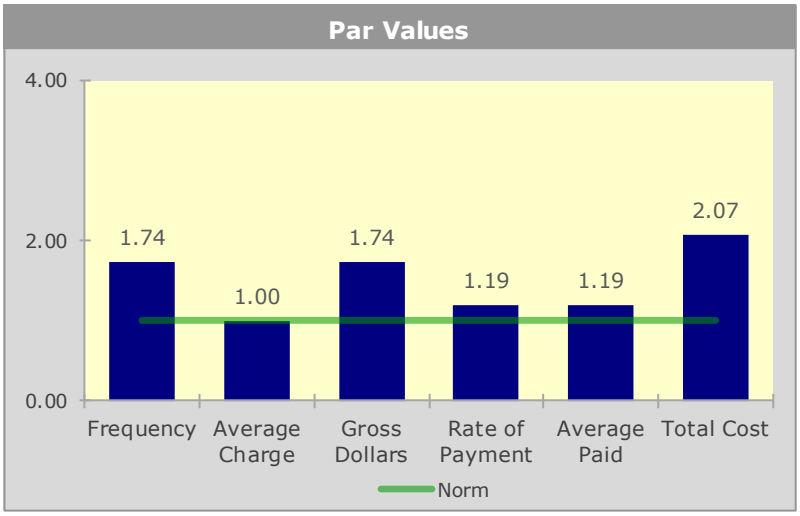


Mental Health utilization includes episodes of care involving the outpatient treatment of certain conditions by health care professionals which include physicians, psychologists, social workers, etc. These services must be coded with specific mental health treatment codes. Mental Health Visit utilization rates per 1,000 represents a statistical measure of how many outpatient mental health visits occurred per 1,000 covered members.

During this reporting period, the average cost per outpatient mental health visit is shown on the right. This cost represents the professional fee for these services. Related fees for other associated services are not included.

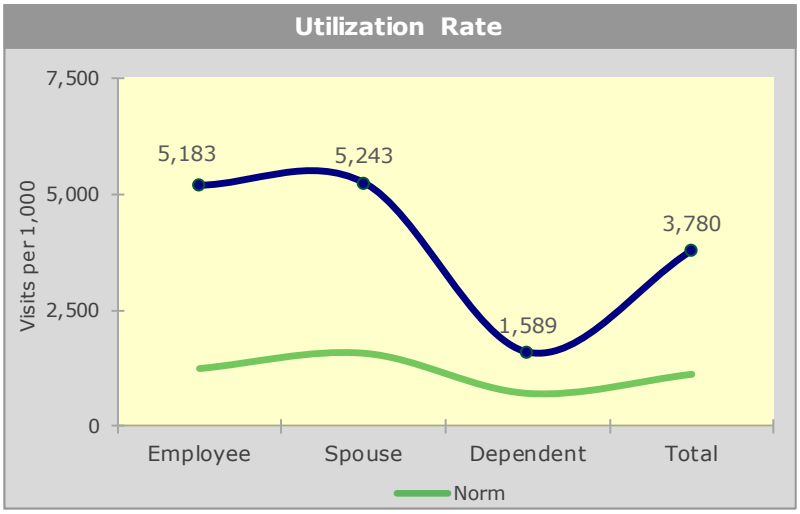
Please note: this data has been normalized to help reduce the influence of unusually high cost services. The normalization process typically results in the inclusion of roughly 97-98% of all services within this category.





Par analysis can be used to evaluate the relative performance of a health plan. Each of the values in the par analysis represents a percent variance from normal (1.00 = normal). The Rate of Payment measure reflects the relative impact of provider discounts, member cost sharing (deductibles, copayments, etc.) and other reductions from the amount charged resulting in the amount paid.

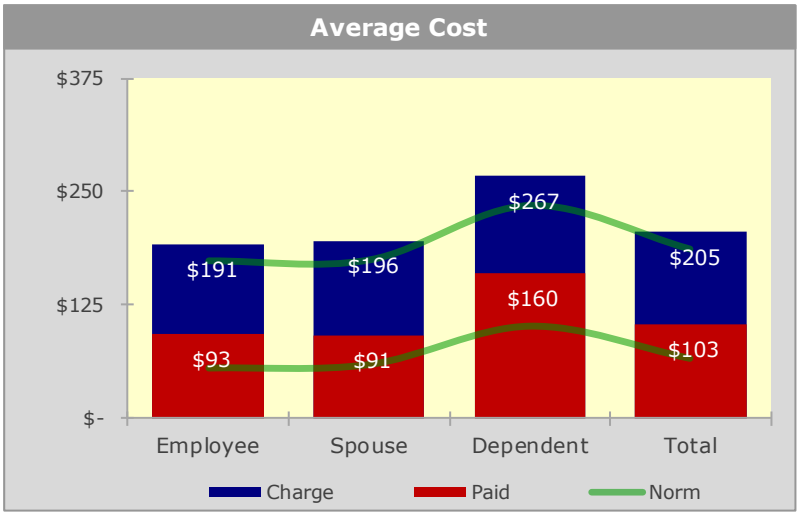
Physical Medicine Visits

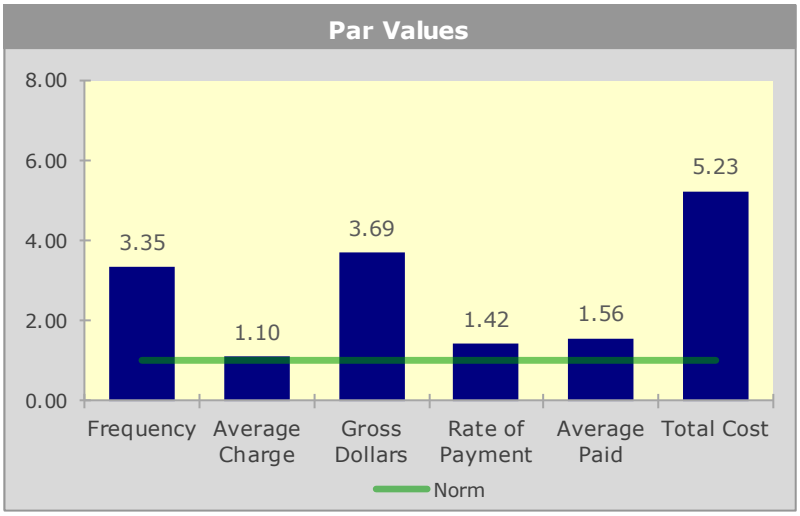


Physical medicine utilization is defined as episodes of care involving specific chiropractic and/or physical therapy procedures. Physical medicine patterns of treatment and associated utilization can vary greatly. Physical medicine utilization rates per 1,000 represent a statistical measure of how many physical medicine treatment encounters occurred per 1,000 covered members.

During this reporting period, the average cost per physical medicine visit is shown on the right. This average cost represents the professional fee for these services. Related radiology and other fees are not included.

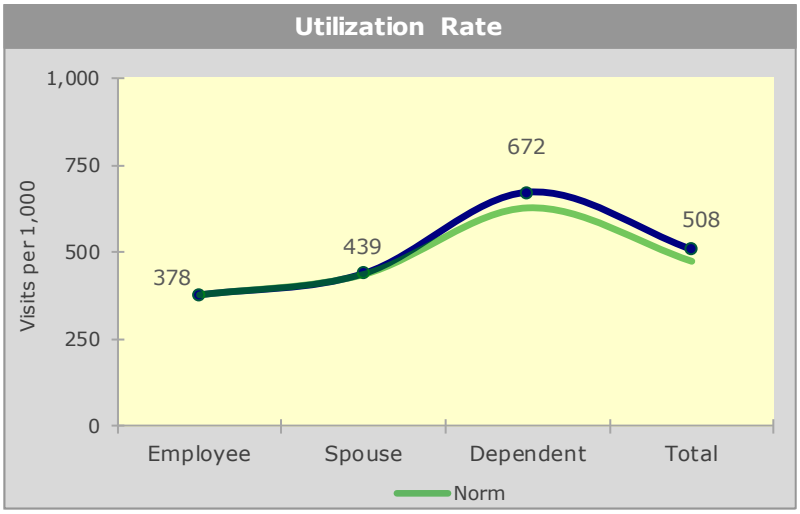
Please note: this data has been normalized to help reduce the influence of unusually high cost services. The normalization process typically results in the inclusion of roughly 97-98% of all services within this category.





Par analysis can be used to evaluate the relative performance of a health plan. Each of the values in the par analysis represents a percent variance from normal (1.00 = normal). The Rate of Payment measure reflects the relative impact of provider discounts, member cost sharing (deductibles, copayments, etc.) and other reductions from the amount charged resulting in the amount paid.

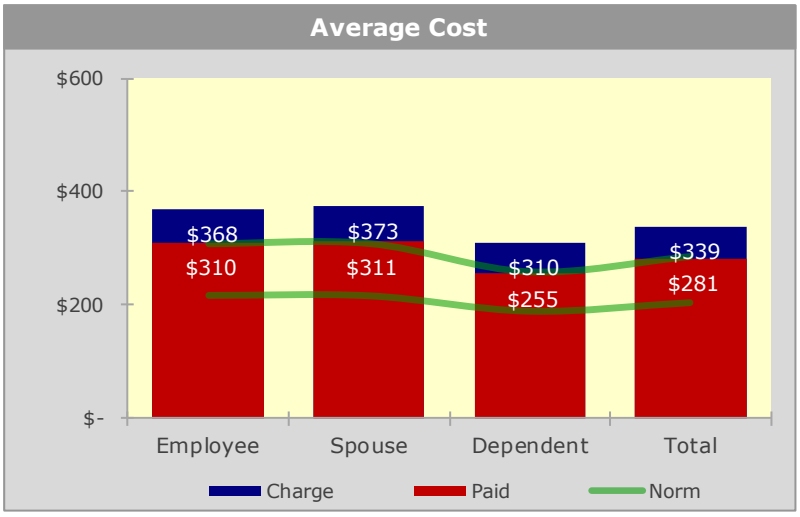
Wellness/Routine Visits

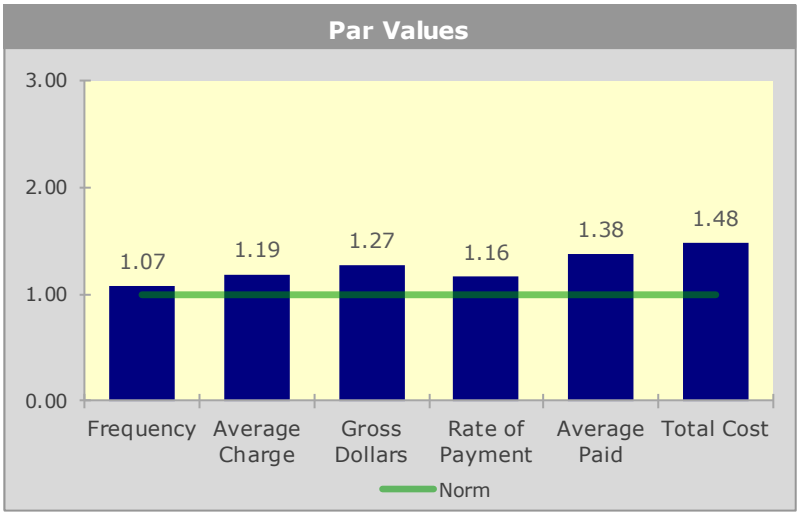


Wellness/Routine Visits are defined as episodes of care involving specific wellness-related procedures. These specific procedures are usually administered in a physician's office or clinic. Wellness/Routine Visit utilization rates per 1,000 represents a statistical measure of how many wellness or routine visits occurred per 1,000 covered members.

During this reporting period, the average cost per wellness/routine visit is shown on the right. This average cost represents the professional fee for these services. Related laboratory, radiology or other fees are not included.

Please note: this data has been normalized to help reduce the influence of unusually high cost services. The normalization process typically results in the inclusion of roughly 97-98% of all services within this category.





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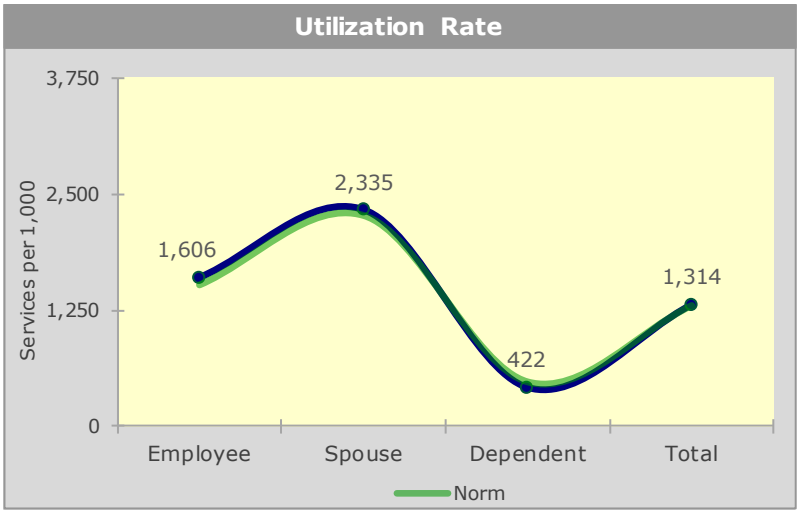
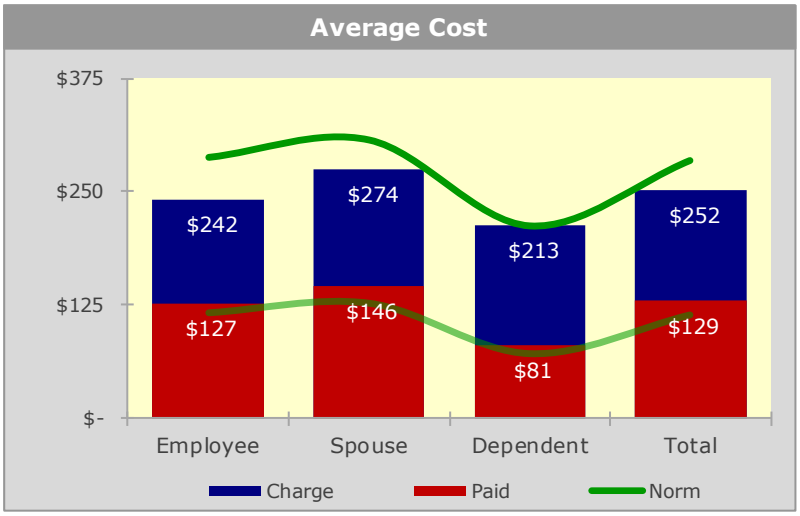
Radiology Services

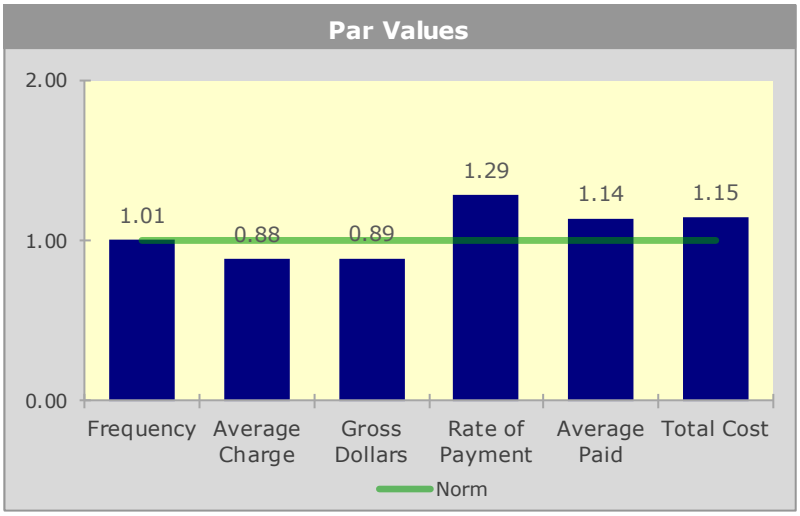


Radiology utilization is defined as episodes of care involving the occurrence of radiological procedures. These procedures may occur in a hospital, surgical or other facility, as well as clinic, physician, chiropractic, or other offices. Radiology utilization rates per 1,000 represent a statistical measure of how many radiology procedures occurred per 1,000 covered members.

During this reporting period, the average cost per radiology procedure is shown on the right. This average cost represents the fee for the radiology procedure only. The fees for other related procedures (physician visit, etc.) are not included.

Please note: this data has been normalized to help reduce the influence of unusually high cost services. The normalization process typically results in the inclusion of roughly 97-98% of all services within this category.





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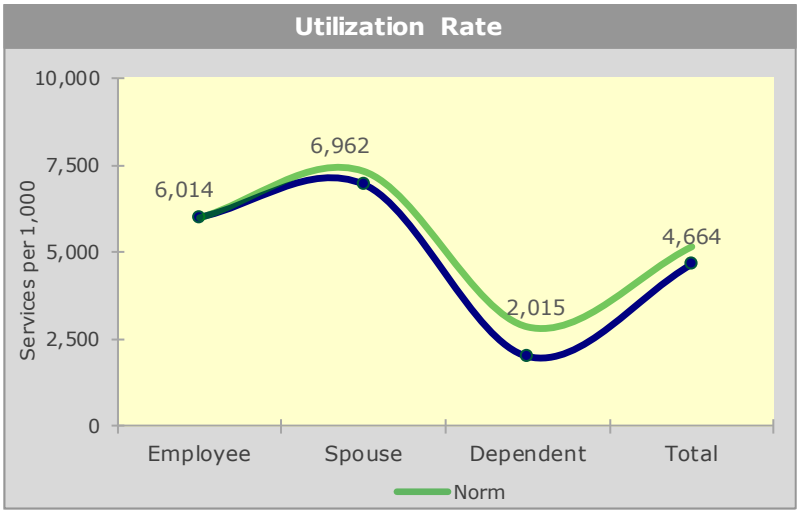
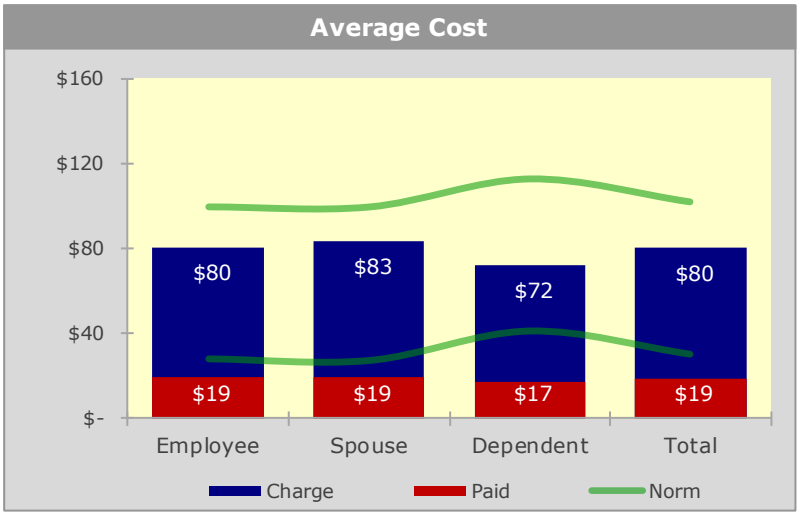
Laboratory Services

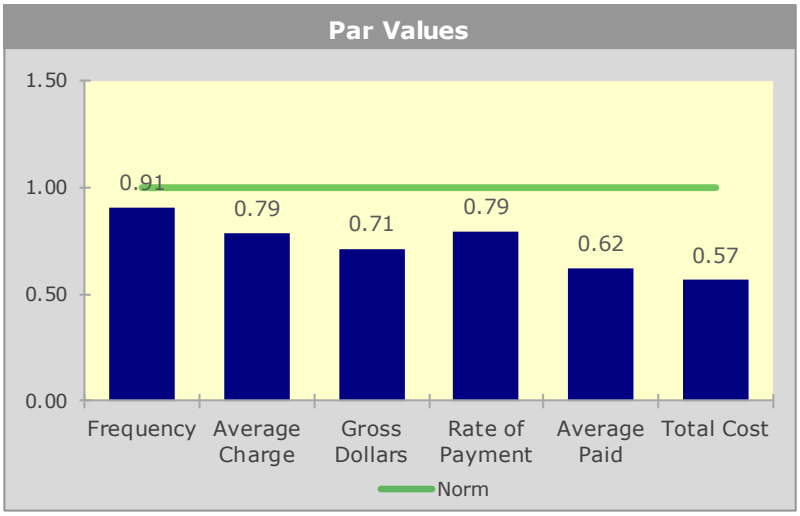


Laboratory utilization is defined as episodes of care involving the occurrence of laboratory procedures which take place in an inpatient, outpatient, or independent lab setting. These procedures are ofter related to other health care services. Laboratory utilization rates per 1,000 represent a statistical measure of how many laboratory procedures occurred per 1,000 covered members.

During this reporting period, the average cost per Laboratory procedure is shown on the right. This average cost represents the fee for the laboratory procedure only. The fees for other related procedures (physician visit, etc.) are not included.

Please note: this data has been normalized to help reduce the influence of unusually high cost services. The normalization process typically results in the inclusion of roughly 97-98% of all services within this category.





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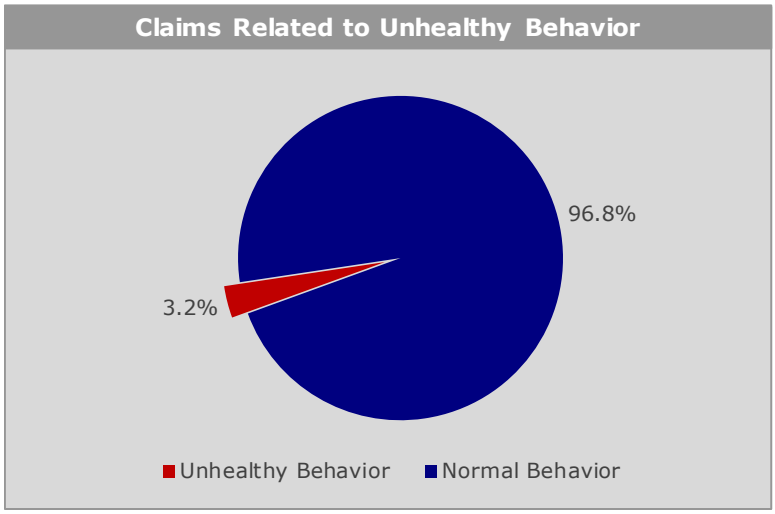
Claims Related to Behavior

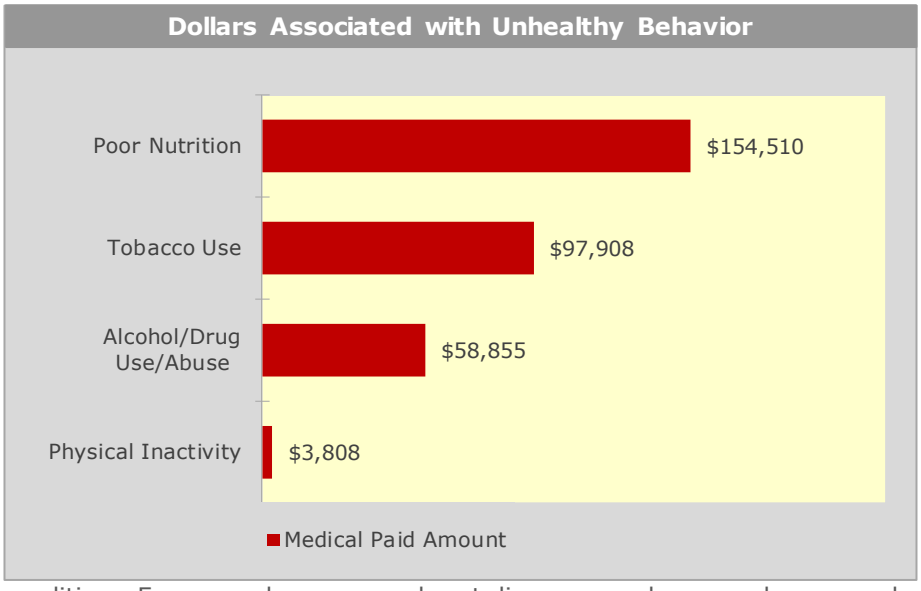
Certain lifestyle choices or behaviors can adversely affect an individual's health. This section of our analysis focuses on specific behaviors that can be considered "unhealthy". The behaviors have been categorized as follows: physical inactivity/sedentary lifestyle, poor nutrition, tobacco use, alcohol and drug use/abuse, and miscellaneous personal activities. These lifestyle choices can often lead to specific health problems.

The chart on the right indicates the percentage of total claims cost that may be associated with specific behaviors or lifestyle choices.

The claim dollars associated with these behaviors present a potential opportunity for cost savings. Benefit design, employee communication and employee support programs can influence changes in these behaviors.



Norm = 7.5%



The Office of Disease Prevention and Health Promotion, within the U.S. Department of Health and Human Services, maintains an ongoing initiative called "Healthy People" where specific health objectives are identified including illnesses that may be the result of lifestyle choices. While it is easy to pinpoint the cost of these illnesses, it is not completely clear which, if any, lifestyle choice or behavior may have caused the specific condition. For example, coronary heart disease may be caused or exacerbated by: physical inactivity, poor nutrition and/or tobacco use. Since health plan members may exhibit one or more of these traits, the dollars paid for coronary heart disease are included under each behavior.

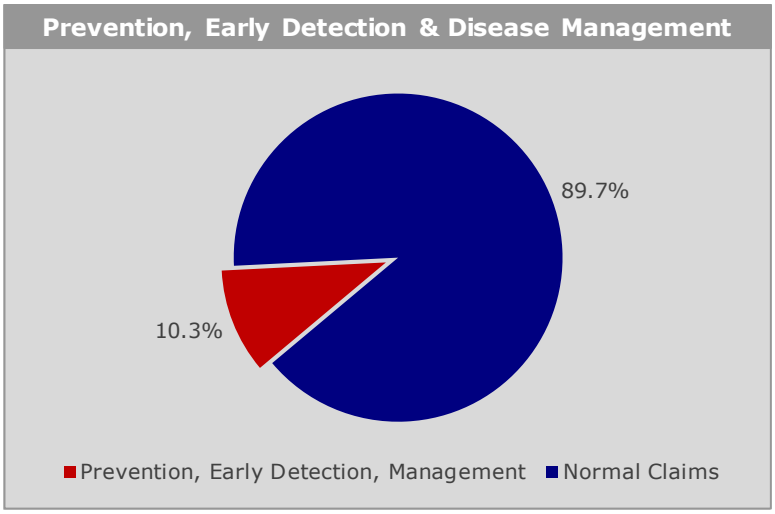
Healthy People provides science-based, 10-year national objectives for improving the health of all Americans. For three decades, Healthy People has established benchmarks and monitored progress towards these objectives.

Prevention & Early Detection

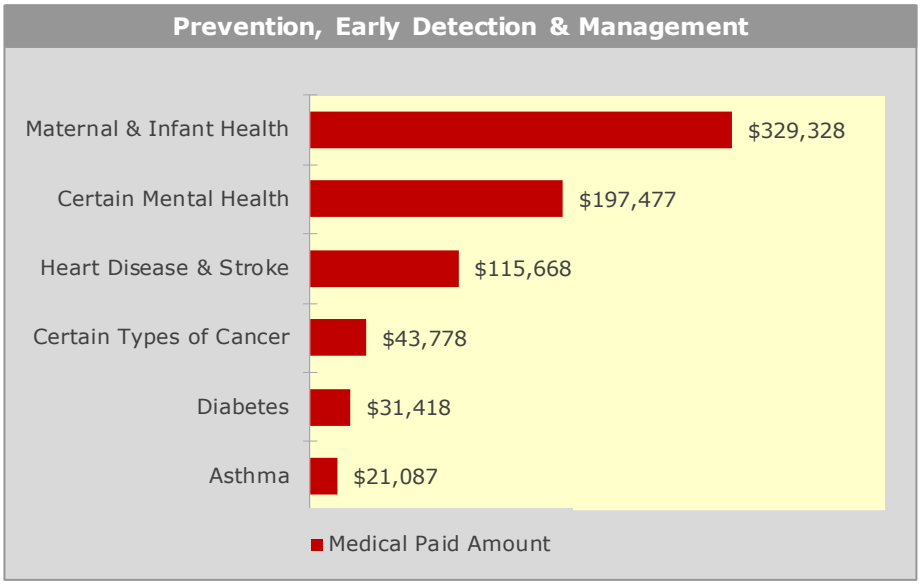
The severity and cost associated with certain medical conditions can be affected through preventative measures, early detection, and/or disease management programs. This analysis focuses on six health categories that provide opportunity for cost savings through these means. The categories include: heart disease and stroke, certain types of cancer, maternal and infant health, asthma, diabetes, and certain mental health conditions.

The chart on the right indicates the percentage of total claims attributable to the above referenced conditions that may be able to be reduced through prevention, early detection, and disease management.

The chart below provides information on each of these health categories. Examples of basic techniques for reducing costs in some of these areas are cited below.



Norm = 13.4%

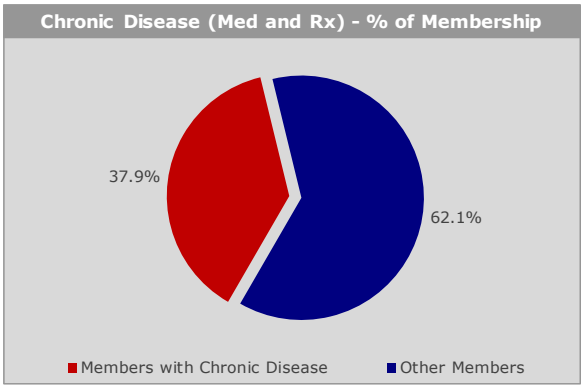


The costs for heart disease and stroke can be reduced through prevention and early detection (diet, exercise, regular screenings). The costs related to certain types of cancer can be reduced through early detection (breast cancer through mammography, etc.) Costs related to complications associated with maternal and infant health can be reduced through education on proper prenatal care. Asthma and certain mental health costs can be reduced through disease management efforts (appropriate diagnosis and use of drug therapies). The costs associated with diabetes can be influenced by changes in diet and exercise, regular health screenings, and aherence to drug threapies.

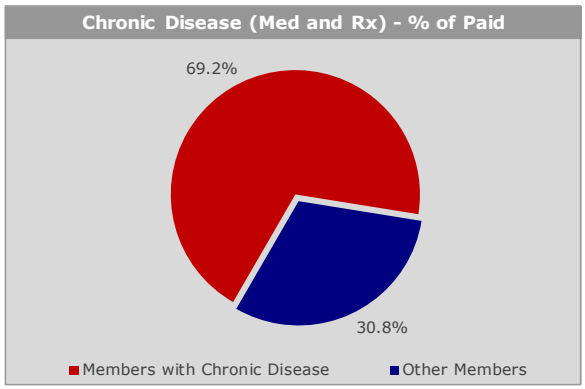
Chronic Disease Impact

The costs for members with chronic disease can have a dramatic impact on the overall performance of a health plan. This analysis focuses on six common chronic illnesses:

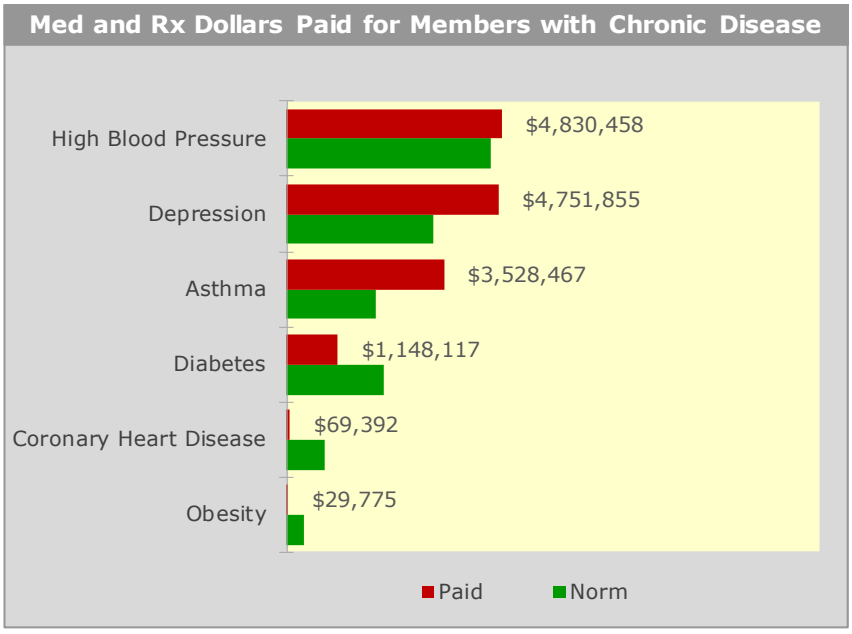
- ✓ Coronary Heart Disease
- ✓ Obesity
- ✓ High Blood Pressure
- ✓ Depression
- ✓ Asthma
- ✓ Diabetes



Norm = 41.6%



Norm = 69.8%

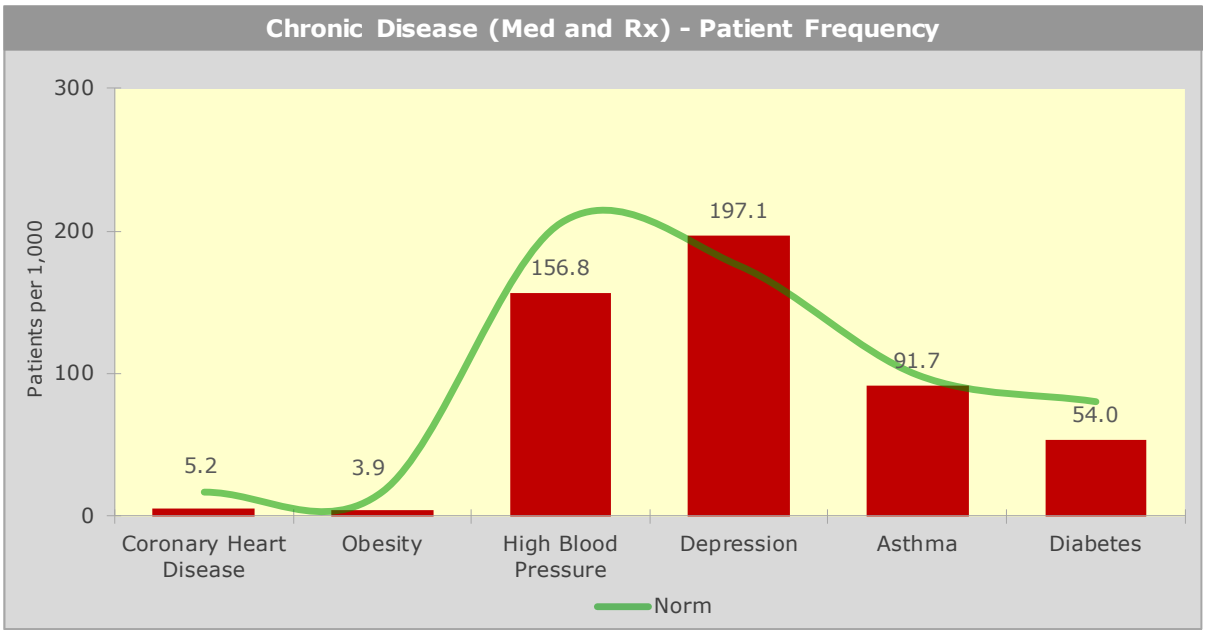


Members treated for one or more of these chronic diseases usually have other health problems which are considered comorbidities. The methodology employed in this analysis "rolls-up" the total claim cost, regardless of specific diagnosis, for any member treated with one or more of these chronic diseases. The claim costs for members treated with multiple chronic diseases may be included in more than one category in the chart (left). The analysis includes combined gross medical and pharmacy dollars.

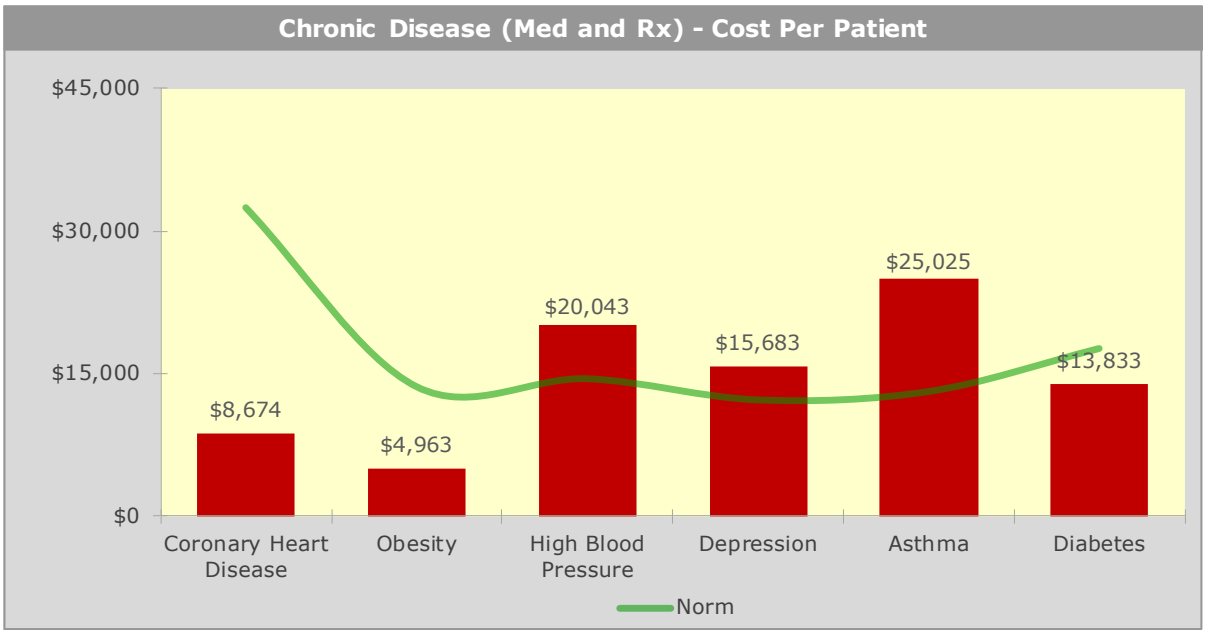
	Members	Annual Gross Med & Rx Paid	Average Per Member	Norm
All Members	1,537	$11,015,176	$7,167	$6,559
Members without Chronic Disease	955	$3,391,697	$3,552	$3,357
Members with Chronic Disease	582	$7,623,479	$13,099	$10,651

Chronic Disease Impact

Measuring and benchmarking actual patients per thousand can be an effective tool in better understanding the prevalence of specific chronic diseases within a population. The chart below illustrates the actual rate of patients per 1,000 for each chronic disease, relative to the normal rate per thousand. At a glance, you can easily identify the specific chronic diseases which within your population. The analysis includes combined gross medical and pharmacy dollars.

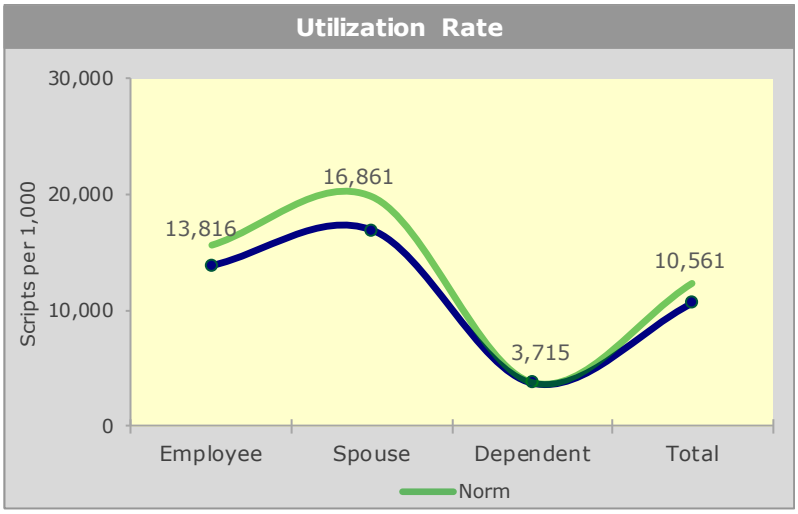


Measuring and benchmarking the total cost for patients with specific chronic diseases affords you the opportunity to better understand the average total cost of patients with diabetes, coronary heart disease, etc. The chart below illustrates the actual average total cost per patient, relative to the normal.



*IMPORTANT: High cost individuals will influence the average cost per patient.

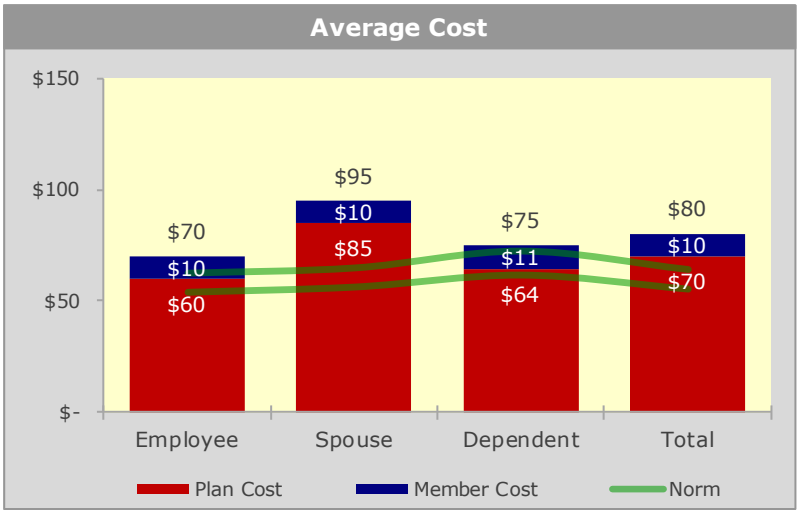
Prescription Drugs

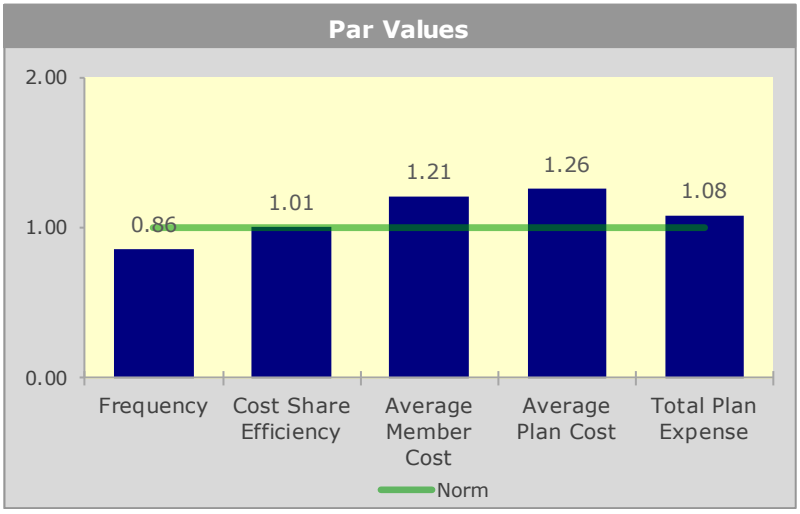


Prescription drug frequency is illustrated in the chart to the left. The number of actual scripts has been adjusted to represent a per 1,000 member average rate. Prescription drug utilization is measured for employees, spouses, dependent children, and the overall average utilization rate for the entire group. All script units are normalized to represent a 30-day supply per script. This eliminates the cost variability associated with longer or shorter periods of treatment.

The average cost per script is illustrated in the chart to the right. Both the member and employer costs are measured and benchmarked against prevailing normal costs.

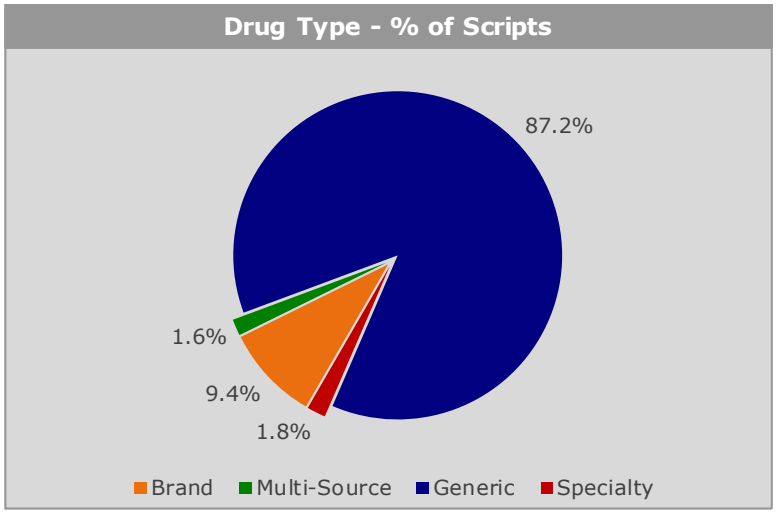
Please note: this data has been normalized by removing any known specialty drugs. Due to extremely low claim volume and significant cost, specialty drugs can easily skew performance metrics. Specialty drugs are included in the tables on page 20 and the Annual Cost per Employee chart on page 1.





Par analysis can be used to evaluate the relative performance of a pharmacy plan. Each of the values in the par analysis represents a percent variance from normal (1.00 = normal). Any value above 1.00 represents the percent variance above normal while any value below 1.00 represents the percent variance below normal.

Prescription Drugs



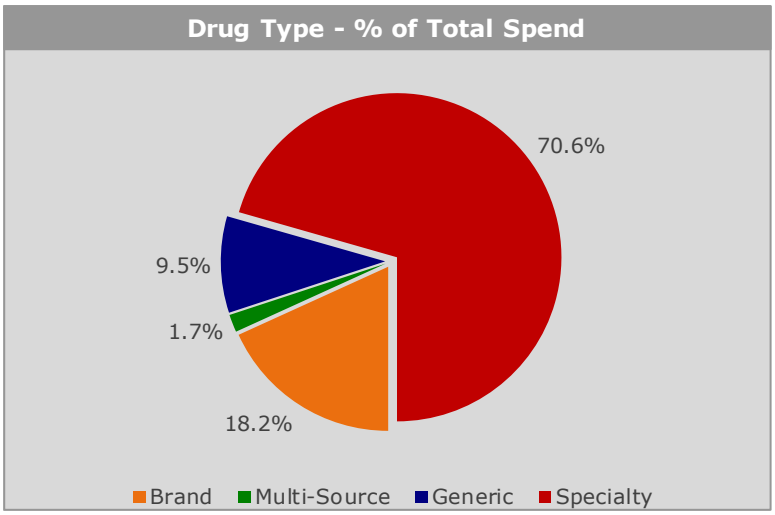
There are several factors which influence the cost associated with prescription drugs. The type of drug being dispensed (brand vs. generic) is often a key determinant of pharmacy cost. Brand drugs are generally considered more expensive (on average) than generic drugs.

Pharmacy plan designs often include cost share provisions specific to brand, generic, and possibly multi-source drugs.

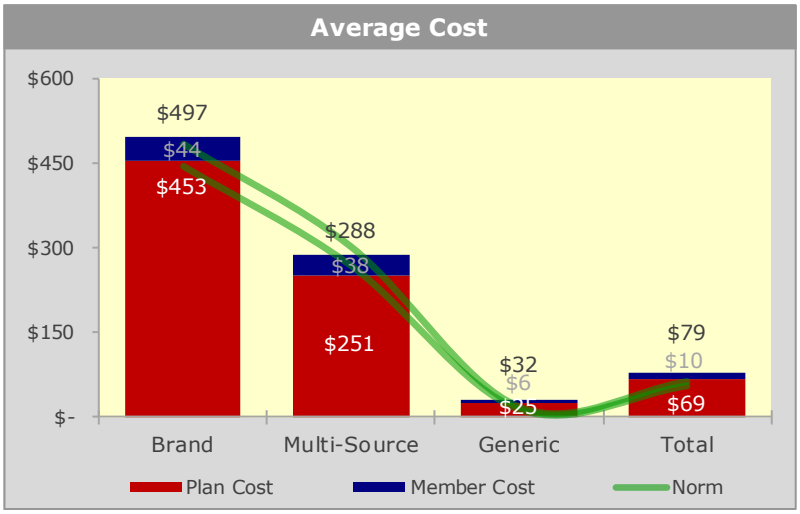
Norms: Brand: 8.2%, MS: 0.2%, Generic: 90.2%, Specialty: 1.5%

While brand drugs are usually dispensed less frequently – they tend to be more costly. The low dispense rate and high unit cost typically results in a disproportionately higher cost share relative to generic.

Specialty drugs take that to another level; they are usually associated with rare conditions and have a very low dispensing rate but tremendously high costs. Note: Specialty drugs are not categorized by their National Drug Code. We include drugs commonly identified as Specialty that may vary from your specific PBM or plan coverage.



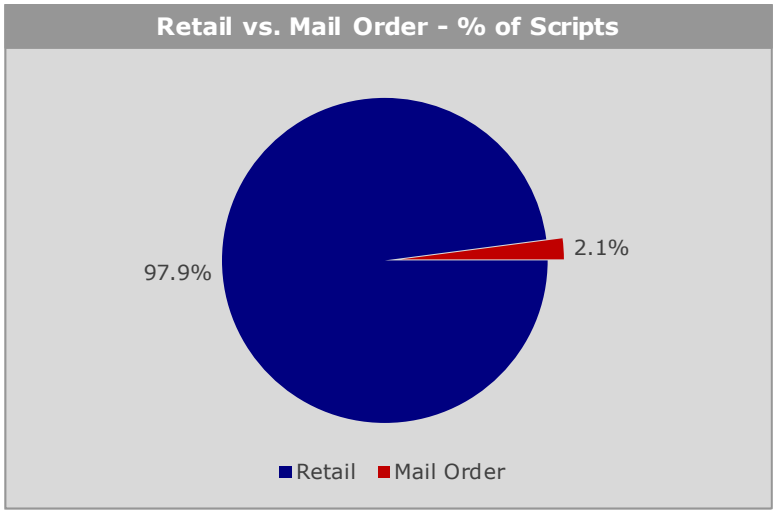
Norms: Brand: 30.1%, MS: 3.6%, Generic: 12.0%, Specialty: 54.3%



The unit costs for brand, multi-source, and generic drugs are displayed in the chart to the left.

All script units are normalized to represent a 30-day supply per script. This eliminates the cost variability associated with longer or shorter periods of treatment.

Prescription Drugs

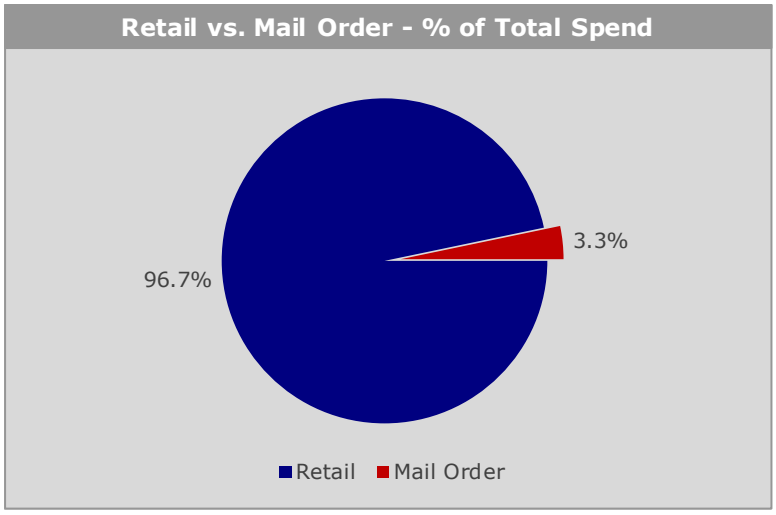


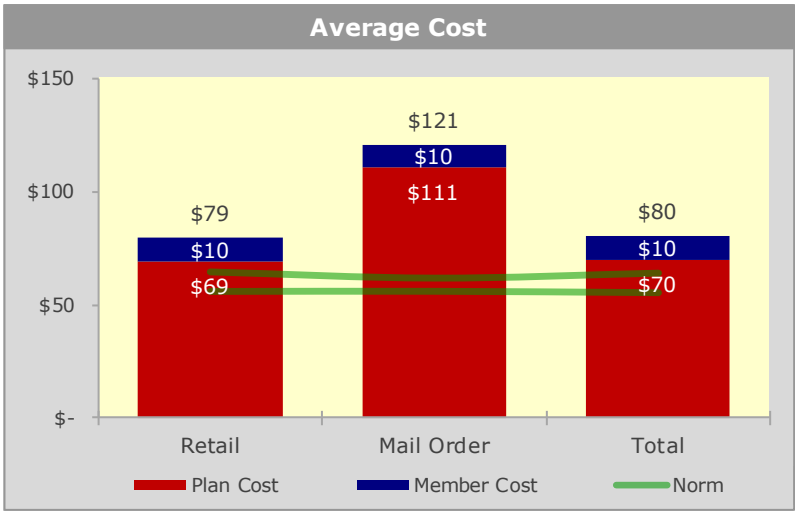
There are several factors which influence the cost associated with prescription drugs. The channel of distribution can play a role in both unit cost and quantity dispensed. Generally speaking – mail order drugs tend to be less costly (per day of treatment). For this reason, we analyze both channels on a 30-day cost basis.

Pharmacy plan designs often include cost share provisions specific to retail versus mail order prescriptions.

Mail order drugs tend to represent a relatively small percentage of the overall prescription drug activity. To offset this difference, we analyze both channels on a 30-day cost basis.

Please note: this data has been normalized by removing any known specialty drugs. Due to extremely low claim volume and significant cost, specialty drugs can easily skew performance metrics. Specialty drugs are included in the tables on page 20 and the Annual Cost per Employee chart on page 1.





The unit costs for retail versus mail order drugs are displayed in the chart to the left. These costs represent the member cost share, the plan (or employer) cost share, in addition to the combined total cost.

These average costs per script are normalized to represent a 30-day supply per script in both channels. This eliminates the cost difference associated with longer periods of treatment.

Prescription Drugs

These tables provide the top prescription drug therapeutic classes and drugs dispensed.

All drug types, including Specialty, are included in these tables.

All script counts represent one fill, regardless of number of days per fill.

Therapeutic Class by Total Cost

	Treatment Class	Patients	Scripts	Cost Summary			Cost per Script
				Member	Plan	Total	
1	Hematological Agents - Misc	5	51	$1,378	$1,397,732	$1,399,111	$27,434
2	Dermatologicals	249	582	$30,096	$421,183	$451,280	$775
3	Respiratory Agents - Misc.	1	15	$20,800	$369,343	$390,143	$26,010
4	Antineoplastics	17	78	$2,337	$284,882	$287,219	$3,682
5	Antidiabetics	69	446	$27,178	$278,147	$305,325	$685
6	Analgesics - Anti-Inflammat	108	232	$6,164	$101,826	$107,990	$465
7	Adhd/Anti-Narcolepsy/Anti-	105	708	$14,294	$88,168	$102,461	$145
8	Antiasthmatic And Bronchod	133	444	$13,438	$83,787	$97,225	$219
9	Psychotherapeutic And Neu	9	28	$781	$77,870	$78,651	$2,809
10	Antifungals	51	102	$1,313	$72,897	$74,210	$728
11	Antivirals	76	169	$1,923	$72,326	$74,249	$439
12	Anticoagulants	16	73	$4,956	$51,847	$56,803	$778
13	Antidepressants	270	1,291	$14,363	$50,883	$65,246	$51
14	Migraine Products	27	153	$3,747	$47,088	$50,835	$332
15	Vaccines	208	370	$95	$40,810	$40,905	$111
	Others		6,900	$85,634	$418,314	$503,948	$73
	Total		11,642	$228,496	$3,857,104	$4,085,601	$351

Drug Name by Total Cost

	Drug Name	Type	Treatment Class	Patients	Scripts	Cost Summary			Cost per Script
						Member	Plan	Total	
1	Haegarda	Specialty	Hematological Agents - Misc	1	13	$390	$607,782	$608,172	$46,782
2	Ruconest	Specialty	Hematological Agents - Misc	1	12	$720	$520,626	$521,346	$43,446
3	Trikafta	Specialty	Respiratory Agents - Misc.	1	15	$20,800	$369,343	$390,143	$26,010
4	Icatibant Acetate	Specialty	Hematological Agents - Misc	1	13	$130	$268,075	$268,205	$20,631
5	Stelara	Specialty	Dermatologicals	1	6	$6,780	$146,766	$153,546	$25,591
6	Ozempic	Brand	Antidiabetics	20	95	$9,283	$118,766	$128,049	$1,348
7	Lorbrena	Specialty	Antineoplastics	1	11	$0	$111,593	$111,593	$10,145
8	Dupixent	Specialty	Dermatologicals	4	30	$900	$104,886	$105,786	$3,526
9	Humira Pen	Specialty	Analgesics - Anti-Inflammat	2	16	$4,813	$99,458	$104,272	$6,517
10	Alunbrig	Specialty	Antineoplastics	1	4	$0	$79,556	$79,556	$19,889
11	Imbruvica	Specialty	Antineoplastics	1	5	$0	$76,240	$76,240	$15,248
12	Vumerity	Specialty	Psychotherapeutic And Neu	1	9	$540	$73,754	$74,294	$8,255
13	Cresemba	Brand	Antifungals	1	5	$780	$70,876	$71,656	$14,331
14	Cosentyx Sensoready Pen	Specialty	Dermatologicals	1	12	$15,960	$65,743	$81,703	$6,809
15	Skyrizi Pen	Specialty	Dermatologicals	1	3	$90	$59,730	$59,820	$19,940
	Others				11,393	$167,311	$1,083,908	$1,251,219	$110
	Total				11,642	$228,496	$3,857,104	$4,085,601	$351

Drug Name by Frequency

	Drug Name	Type	Treatment Class	Patients	Scripts	Cost Summary			Cost per Script
						Member	Plan	Total	
1	Levothyroxine Sodium	Generic	Thyroid Agents	76	310	$4,150	$4,760	$8,910	$29
2	Amphetamine/Dextroamphet	Generic	Adhd/Anti-Narcolepsy/Anti-	45	277	$2,933	$8,578	$11,511	$42
3	Bupropion Hydrochloride E	Generic	Antidepressants	57	219	$3,155	$8,081	$11,236	$51
4	Atorvastatin Calcium	Generic	Antihyperlipidemics	61	203	$0	$4,697	$4,697	$23
5	Oxycodone Hydrochloride	Generic	Analgesics - Opioid	75	203	$1,152	$3,303	$4,455	$22
6	Escitalopram Oxalate	Generic	Antidepressants	49	187	$1,435	$2,889	$4,324	$23
7	Lisinopril	Generic	Antihypertensives	48	163	$1,014	$1,357	$2,370	$15
8	Trazodone Hydrochloride	Generic	Antidepressants	42	158	$831	$2,084	$2,916	$18
9	Amoxicillin	Generic	Penicillins	131	153	$886	$626	$1,512	$10
10	Fluoxetine Hydrochloride	Generic	Antidepressants	43	148	$1,216	$4,323	$5,539	$37
11	Albuterol Sulfate Hfa	Generic	Antiasthmatic And Bronchod	91	148	$1,544	$5,545	$7,090	$48
12	Sertraline Hydrochloride	Generic	Antidepressants	46	143	$938	$1,248	$2,186	$15
13	Methylphenidate Hydrochlo	Generic	Adhd/Anti-Narcolepsy/Anti-	32	123	$1,407	$15,479	$16,886	$137
14	Amlodipine Besylate	Generic	Calcium Channel Blockers	35	121	$713	$817	$1,530	$13
15	Losartan Potassium	Generic	Antihypertensives	35	121	$1,136	$1,803	$2,939	$24
	Others				8,965	$205,986	$3,791,514	$3,997,500	$446
	Total				11,642	$228,496	$3,857,104	$4,085,601	$351

Quick Facts

Average Membership

Employee	564
Spouse	367
Dependent	606
Total Members	1,537

High-Level Claim Information

	Plan Cost	Net Charges	Net Payments	Rate of Pay
Per Employee	$18,683	$25,738	$12,692	49%
Per Member	$6,856	$9,445	$4,657	

Utilization Information

Utilization Category	Frequency	Average Charge	Network Penetration	Reported Discount	Average Paid	Plan Expense
Inpatient Hospital	**0.80**	**0.79**	100.0%	46.3%	0.94	**0.76**
Outpatient Hospital	**0.51**	1.00	96.4%	41.1%	1.06	**0.54**
Emergency Room	**0.63**	**1.31**	100.0%	55.9%	**1.12**	**0.71**
Inpatient Surgery	0.92	0.91	100.0%	24.4%	**1.36**	**1.25**
Outpatient Surgery	**1.16**	**0.86**	100.0%	40.2%	**1.16**	**1.35**
Office Visits	**1.17**	**1.35**	99.7%	22.4%	**1.84**	**2.16**
Mental Health Visits	**1.74**	1.00	92.3%	28.5%	**1.19**	**2.07**
Physical Medicine Visits	**3.35**	**1.10**	98.9%	40.3%	**1.56**	**5.23**
Wellness/Routine Visits	1.07	**1.19**	100.0%	16.2%	**1.38**	**1.48**
Radiology Services	1.01	**0.88**	100.0%	30.4%	**1.14**	**1.15**
Laboratory Services	0.91	**0.79**	98.5%	64.6%	**0.62**	**0.57**
Overall			97.2%	40.7%		

Any variance from normal (10% or greater) has been indicated
GREEN (favorable) or **RED** (unfavorable)

Service Cost Summary

Service Category	Annual Cost Per Employee	Annual Cost Per Member	Normal Cost Per Member
Inpatient Hospital Admission	$1,854	$680	$1,154
Outpatient Hospital Encounter	$1,886	$692	$957
Emergency Room Visit	$600	$220	$296
Inpatient Surgery	$221	**$81**	$68
Outpatient Surgery	$1,415	**$519**	$306
Physician Office Visit	$1,957	**$718**	$324
Mental Health Visit	$474	**$174**	$78
Physical Medicine	$1,064	**$390**	$80
Wellness/Routine Visit	$396	**$145**	$92
Radiology Services	$495	$182	$177
Laboratory Services	$287	$105	$169
Other Services	$2,044	$750	$1,054
Net Medical Claims	$12,692	$4,657	$4,754
Net Prescription Drugs	$4,097	$1,503	$1,456
Administration, Stop-Loss, etc.	$1,894	$695	$1,352
Total Plan Cost	$18,683	$6,855	$7,563

Condition Cost Summary – Medical Claims Only

General Health Condition	Annual Cost Per Employee	Annual Cost Per Member	Normal Cost Per Member
Infectious and Parasitic Diseases	$139	$51	$121
Neoplasms (Cancer)	$755	$277	$571
Diseases of the Blood	$126	$46	$54
Endocrine, Nutritional and Metabolic	$202	$74	$144
Mental, Behavioral and Neuro Disorders	$1,197	**$439**	$223
Nervous System Diseases	$750	**$275**	$175
Eye and Adnexa Diseases	$98	$36	$56
Ear and Mastoid Process Diseases	$113	**$42**	$28
Circulatory System Diseases	$794	$291	$378
Respiratory System Diseases	$629	**$231**	$154
Digestive System Diseases	$877	$322	$321
Skin/Subcutaneous Tissue Diseases	$274	**$101**	$55
Musculoskeletal/Connective Diseases	$2,512	**$922**	$480
Genitourinary System Diseases	$266	$98	$228
Pregnancy, Childbirth and the Puerperium	$733	**$269**	$252
Conditions during the Perinatal Period	$29	$11	$36
Congenital Abnormalities	$24	$9	$59
Symptoms, Signs and Abnormal Findings	$1,051	$386	$370
Injury, Poisoning/Other External Causes	$727	$267	$316
External Causes of Morbidity	$0	$0	$0
Health Status Factors and Services	$1,365	$501	$600
Special Purpose	$29	$11	N/A
Other Conditions	$0	$0	$10
Total	$12,692	$4,657	$4,754

Amounts displayed in **shading and bold** indicate experience more than 10% above the norm.

Amounts displayed in **bold** indicate experience 5-10% above the norm.