

# HPI-TREND SPEC SHEET

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PRODUCTION DATE/TIME      3/21/2024 10:48 AM

CLIENT NAME                      Davidson Benefits Planning, LLC

GROUP NAME                      City of Vancouver

OVERALL TIME PERIOD            2019 through 2023

DETAILED PERIOD SPECS			
Trend Label	Project ID	Reporting Period	Mode
2019	V829310	January 2019 through December 2019	Incurred Claims
2020	V222835	January 2020 through December 2020	Incurred Claims
2021	V172861	January 2021 through December 2021	Incurred Claims
2022	V574063	January 2022 through December 2022	Incurred Claims
2023	V631833	January 2023 through December 2023	Incurred Claims

# City of Vancouver

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## HPI-Trend<sup>tm</sup>

Analysis for the Period  
2019 through 2023



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# Table of Contents

TERMS OF USE .....	i
MEMBERSHIP AND PLAN COST.....	1
DEMOGRAPHICS - RELATIONSHIP .....	2
DEMOGRAPHICS - AGE BANDS .....	3
HIGH COST CLAIMANTS - IMPACT .....	4
HIGH COST CLAIMANTS - DEMOGRAPHIC .....	5
INPATIENT HOSPITAL .....	6
OUTPATIENT HOSPITAL .....	7
EMERGENCY ROOM .....	8
INPATIENT SURGERY .....	9
OUTPATIENT SURGERY .....	10
PHYSICIAN OFFICE VISITS .....	11
MENTAL HEALTH VISITS .....	12
PHYSICAL MEDICINE VISITS .....	13
WELLNESS/ROUTINE VISITS .....	14
RADIOLOGY SERVICES .....	15
LABORATORY SERVICES .....	16
CLAIMS RELATED TO BEHAVIOR, PREVENTION & EARLY DETECTION .....	17
CHRONIC DISEASE IMPACT .....	18
PHARMACY .....	19

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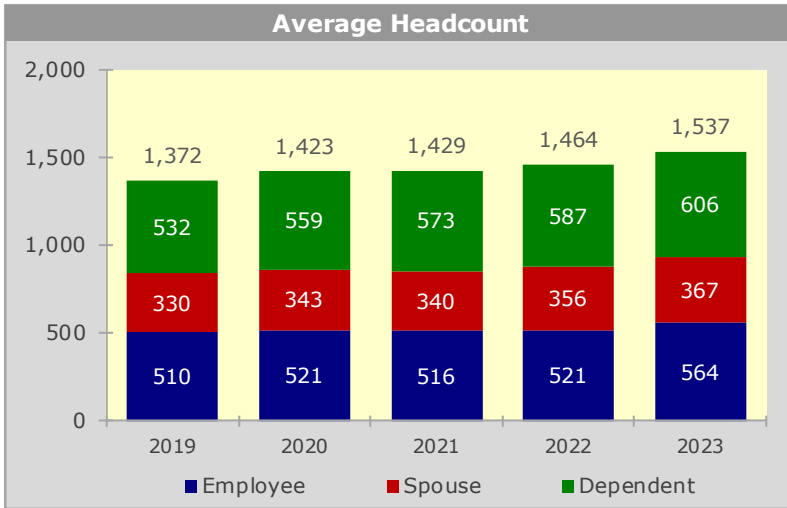
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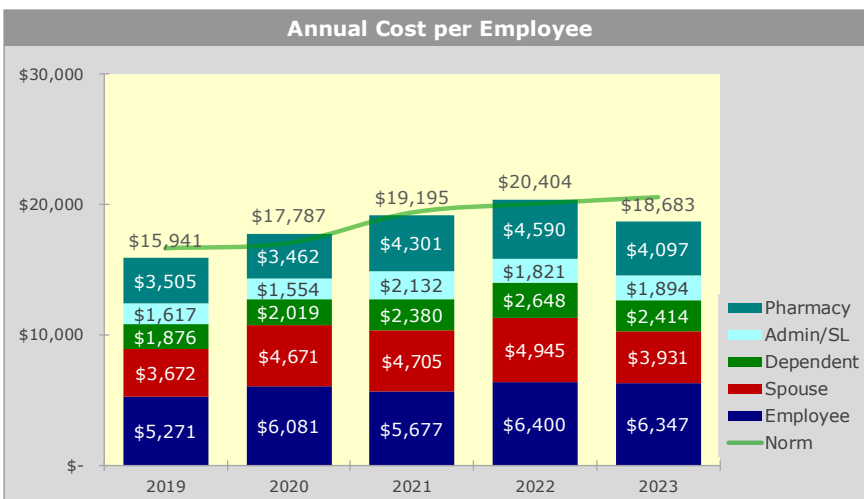
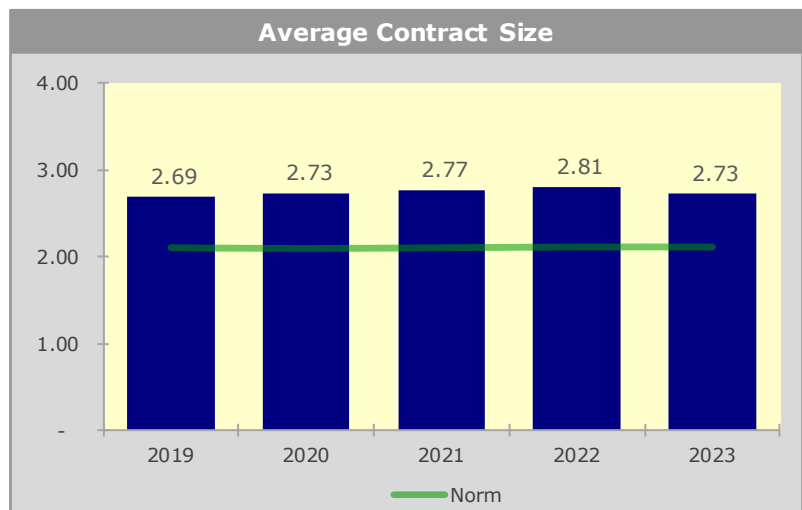
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# Membership and Plan Cost



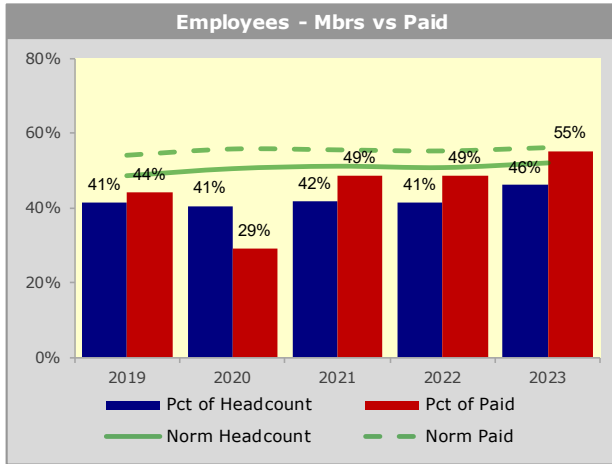
Membership plays an important role in the performance of a group health plan. The average number of employees, spouses, and dependent children are illustrated in the graph to the left. Changes in the relative mix of membership can contribute to variances in overall health plan performance.

The average members per contract are illustrated in the graph on the right. Members per contract represent the ratio of total average members per covered employee. If the member per contract ratio increases, the overall health care cost per employee will also likely increase; a decrease in member per contract ratio will likely reduce the overall health care costs on a per employee basis.



The annual cost per employee for the various components of health care costs is shown in the chart to the left. These cost components include (1) net medical claims (employee, spouse, and dependent); (2) administrative fees, fixed costs, and stop-loss premiums; and (3) prescription drug costs (if available).

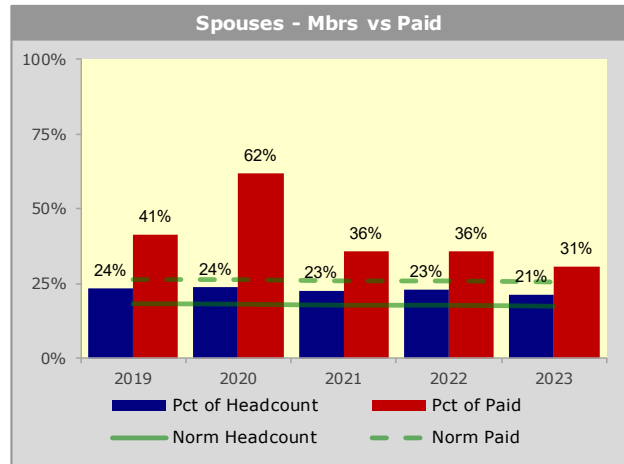
# Demographics - Relationship



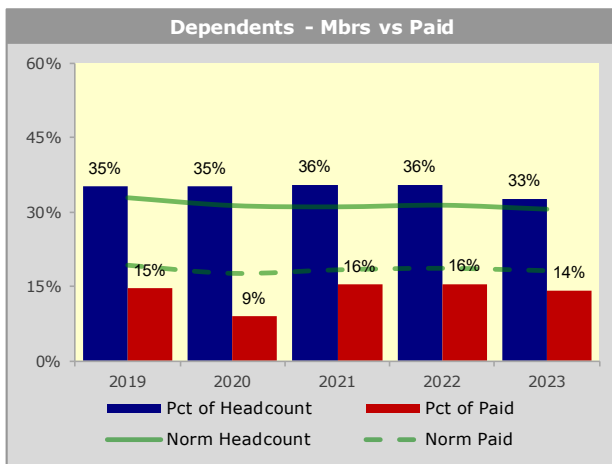
The concentration of health care expenses by relationship and age can have significant implications for effective plan design. We have highlighted claims by relationship in the following exhibits to assist in efforts to assess, target and contain overall healthcare spending.

The exhibit to the left illustrates the percent of paid claims for Employees *with claims* vs the percent of overall covered headcount, with the addition of the normative information.

The exhibit to the right illustrates the percent of paid claims for Spouses *with claims* vs the percent of overall covered headcount, with the addition of the normative information.



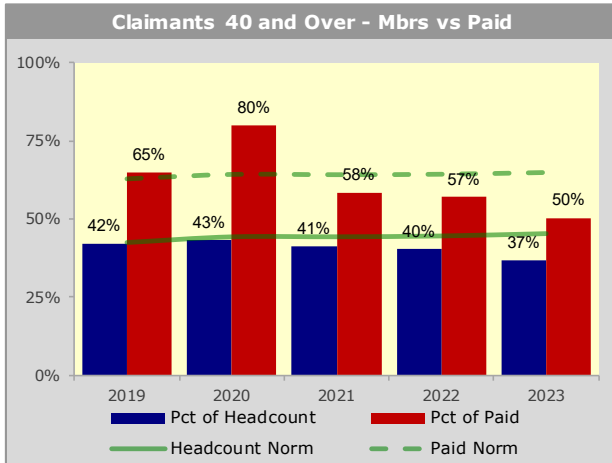
The exhibit to the left illustrates the percent of paid claims for Dependents *with claims* vs the percent of overall covered headcount, with the addition of the normative information.



The mix of Medical & Pharmacy vs Medical only may vary by year, but the norms and values will always match accordingly.

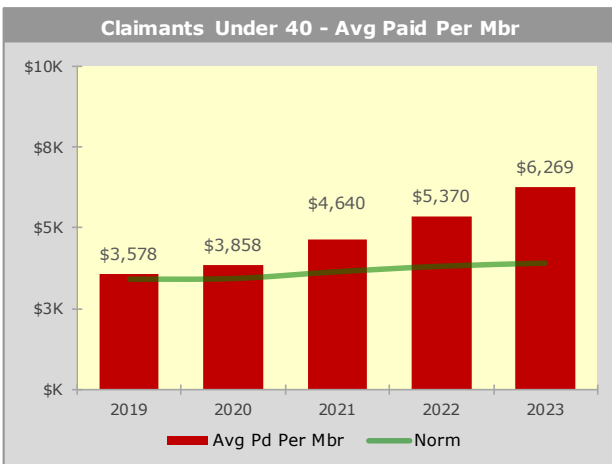
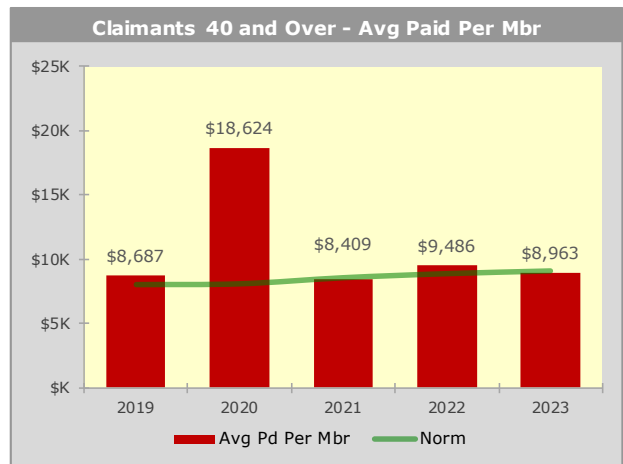
# Demographics – Age Bands

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 over and under age 40.



The exhibit to the left illustrates the trend over time for claimants over the age of 40 as a percent of the eligible members and as a percent of the plan paid dollars vs the norm.

The exhibit to the right illustrates the trend over time for claimants over the age of 40 on an average paid per member basis vs the norm.



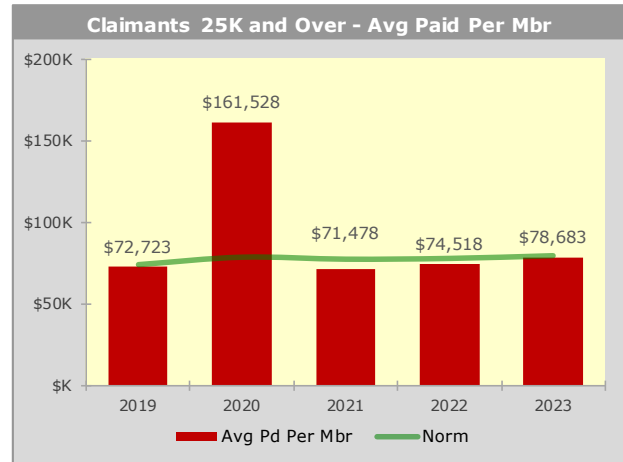
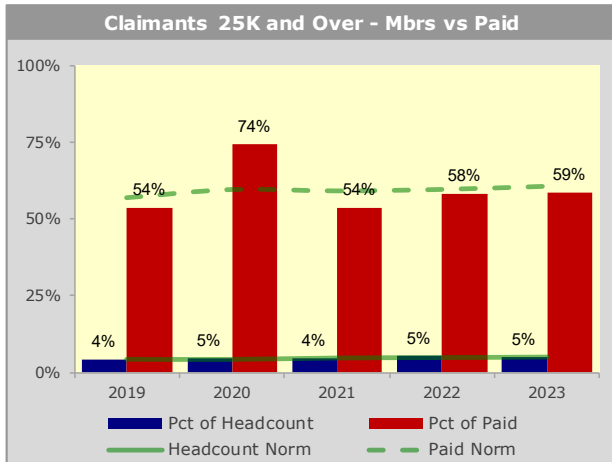
The exhibit to the left illustrates the trend over time for claimants *under* the age of 40 on an average paid per member basis vs the norm.

The mix of Medical & Pharmacy vs Medical only may vary by year, but the norms and values will always match accordingly.

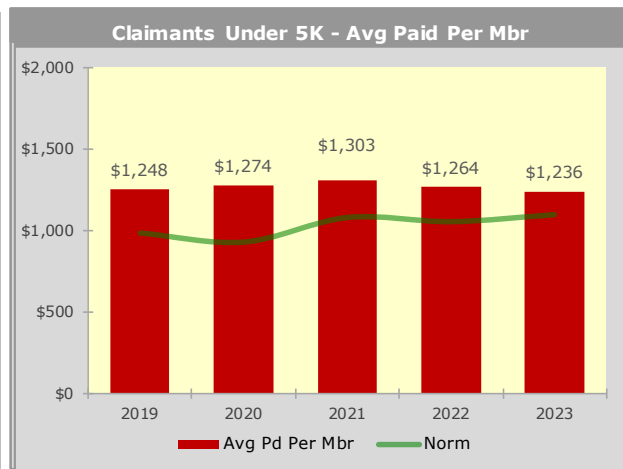
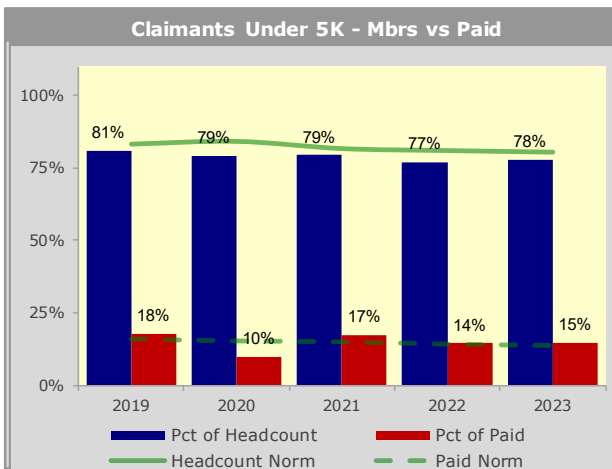
# High Cost Claimants - Impact

The following exhibits illustrate the trend over time for this group’s claimants consuming \$25,000 or more.

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<sup>^</sup>.



In the charts above, the small population of high cost claimants consume a large percentage of the claim volume and have a higher average paid per member, both compared to the norm.



Conversely, this second set of charts show the lower cost claimants with a much larger percentage of the population but much lower overall claim volume and much lower average paid per member, both compared to the norm

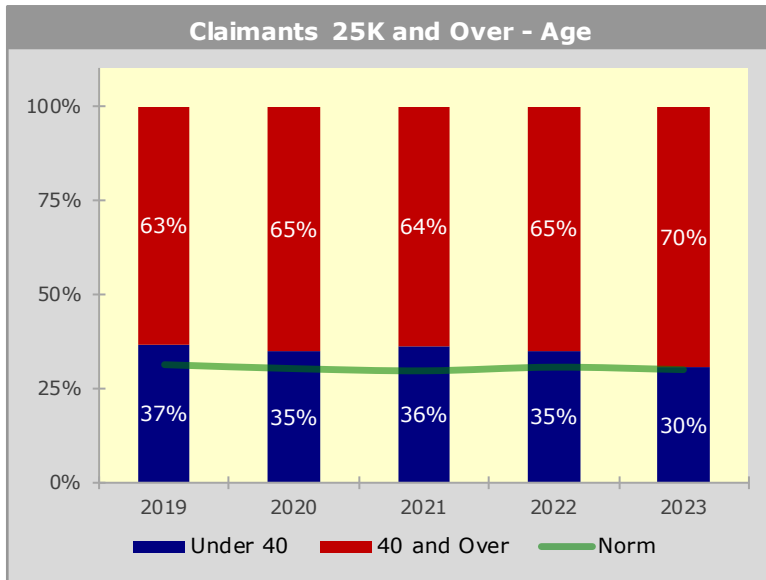
<sup>^</sup>According to: Statistical Brief #521, Concentration of Health Care Expenditures and Selected Characteristics of High Spenders, U.S. Civilian Noninstitutionalized Population, 2016; published in February 2019 by the MEPS (Medical Expenditure in Panel Survey) for the AHRQ (Agency in Healthcare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

The mix of Medical & Pharmacy vs Medical only may vary by year, but the norms and values will always match accordingly.



# High Cost Demographics – Demographics

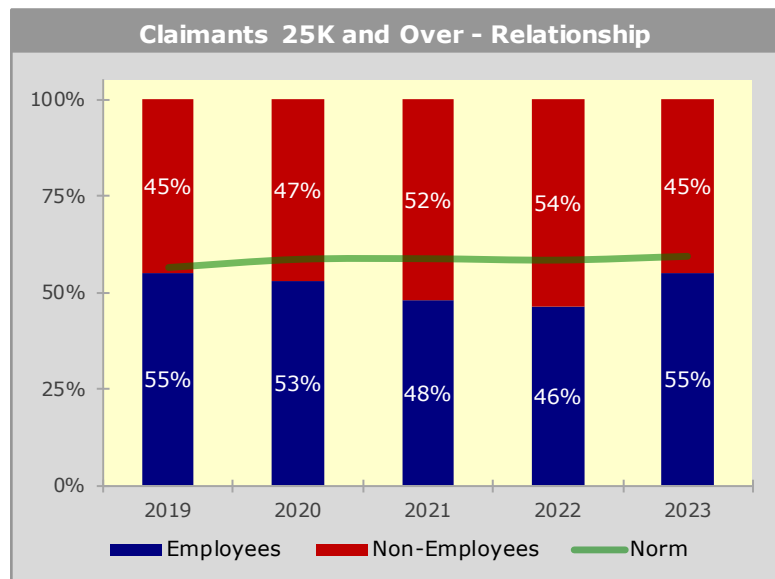
The following exhibits illustrate the demographic trend over time for this group’s claimants consuming \$25,000 or more.



The distribution of health care costs is strongly age dependent. And, while there are people with high spending at all ages, people age 40 and over account for almost 70% of all health spending in the US\*\*.

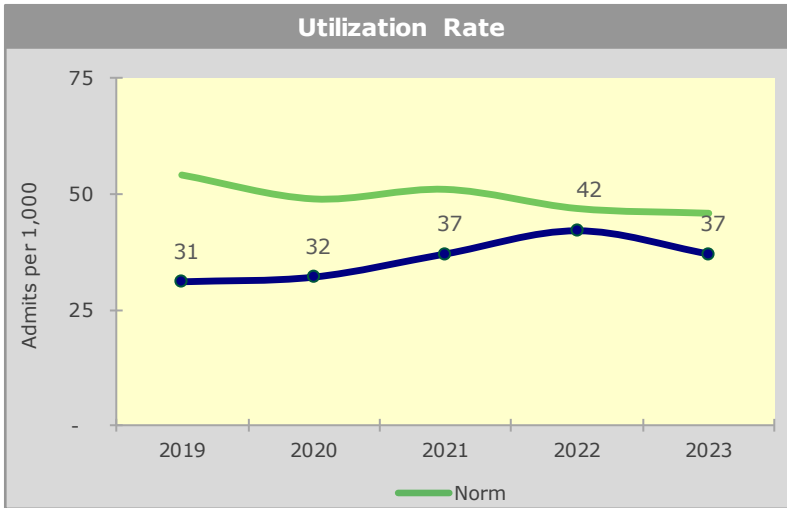
The exhibit to the left illustrates the demographic trend over time for claimants age 40 and Over vs. claimants Under 40, consuming \$25,000 in or more in combined medical and pharmacy claims, and compared to the norm.

The exhibit to the right illustrates the demographic trend over time for claimants consuming \$25,000 or more, broken out by Employees vs. Non-Employees, and compared to the norm.



\*\* Peterson-KFF Health System Tracker: "How do health expenditures vary across the population?", 01/2019  
The mix of Medical & Pharmacy vs Medical only may vary by year, but the norms and values will always match appropriately.-

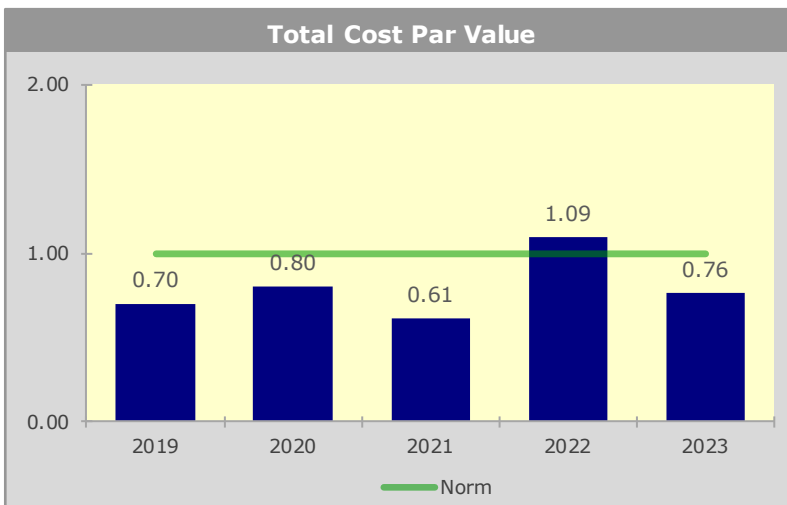
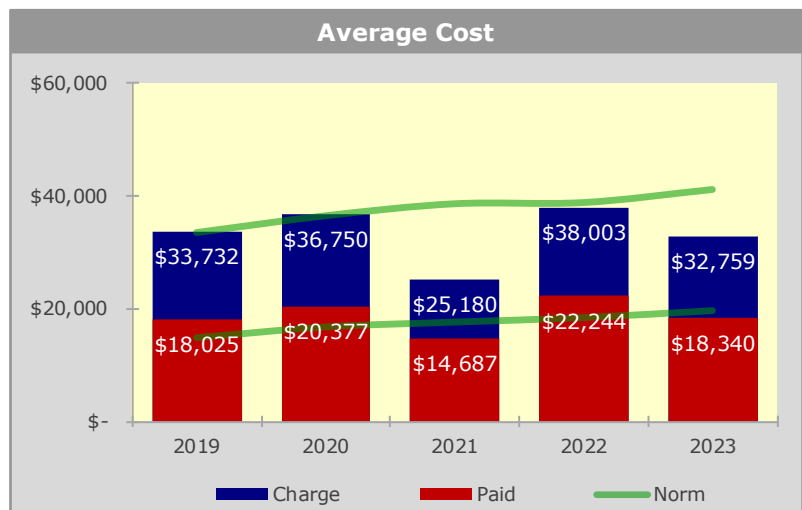
# Inpatient Hospital



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.

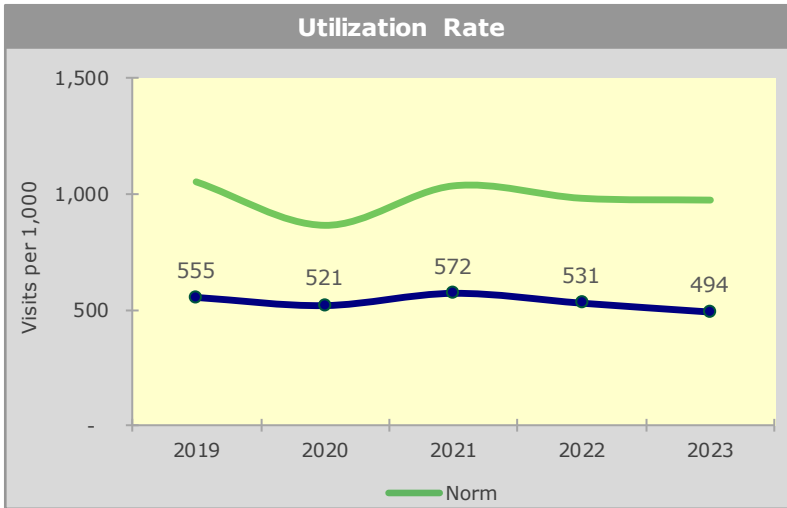
The average cost per inpatient hospital stay can vary greatly. During this reporting period, the average cost per inpatient hospital admission is shown on the right. This average cost only represents the facility fee and does not include related professional or ancillary fees.

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.



Each of the values in the par analysis represents a percent variance from normal (1.00 = normal). Total Cost represents the average cost per unit times the number of units. Total Cost is a measure of the total overall cost to the plan.

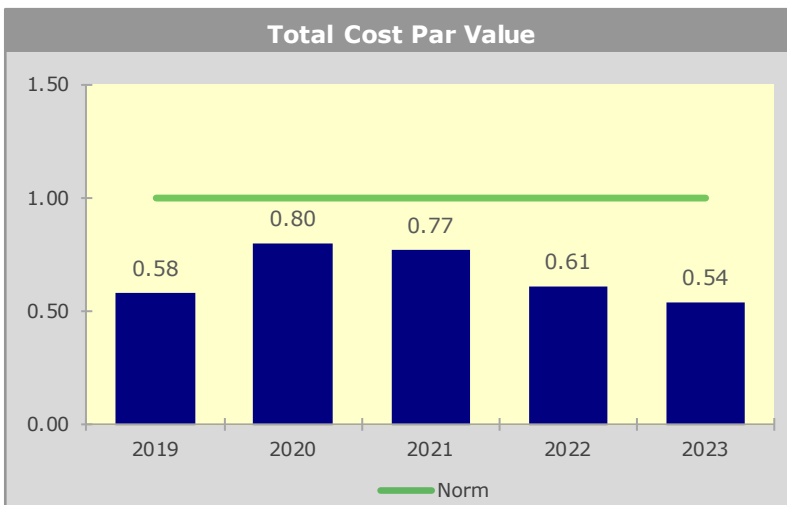
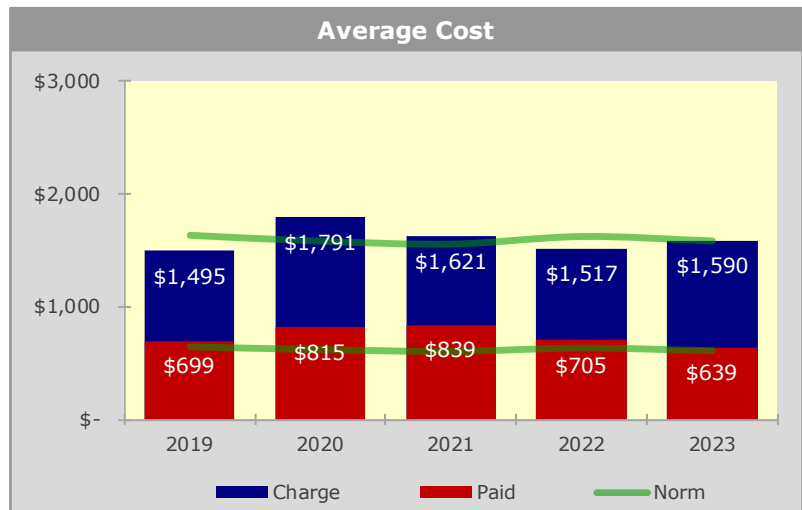
# Outpatient Hospital



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.

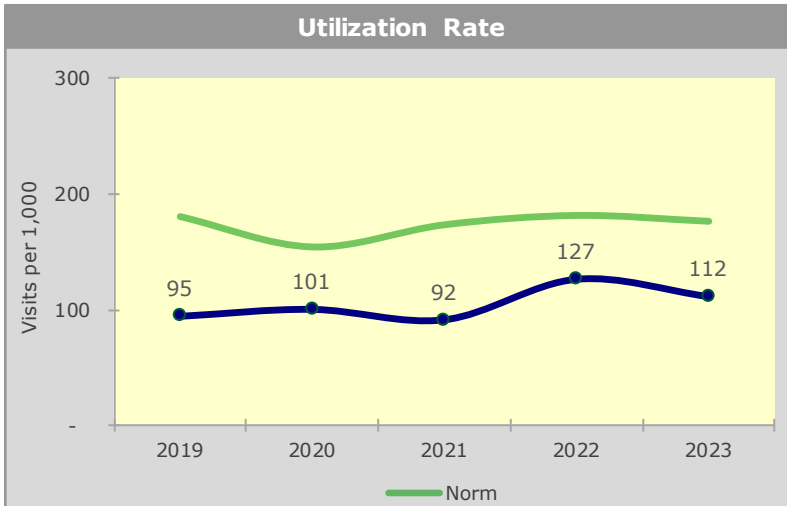
During this reporting period, the average cost per outpatient hospital visit is shown on the right. This average cost represents the facility fee only and does not include any related professional or ancillary fees.

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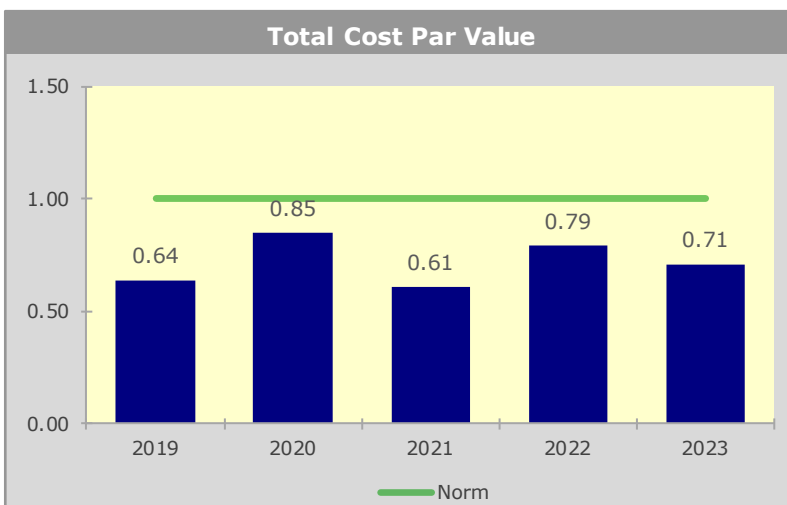
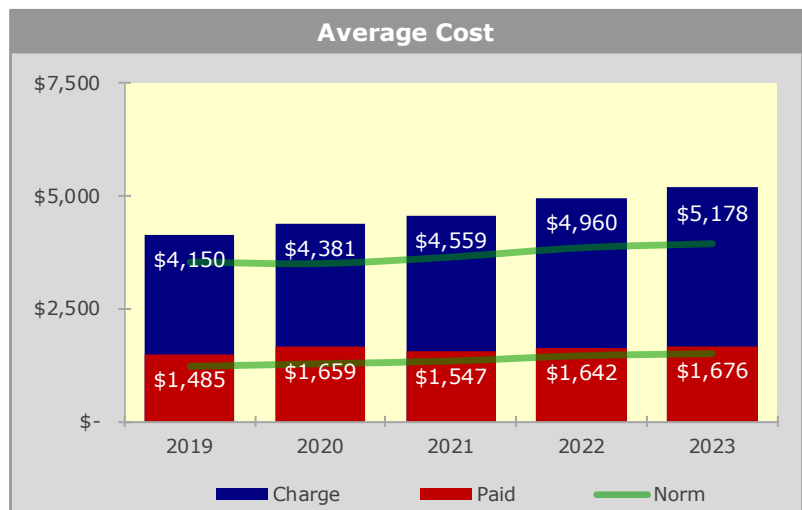
# Emergency Room



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.

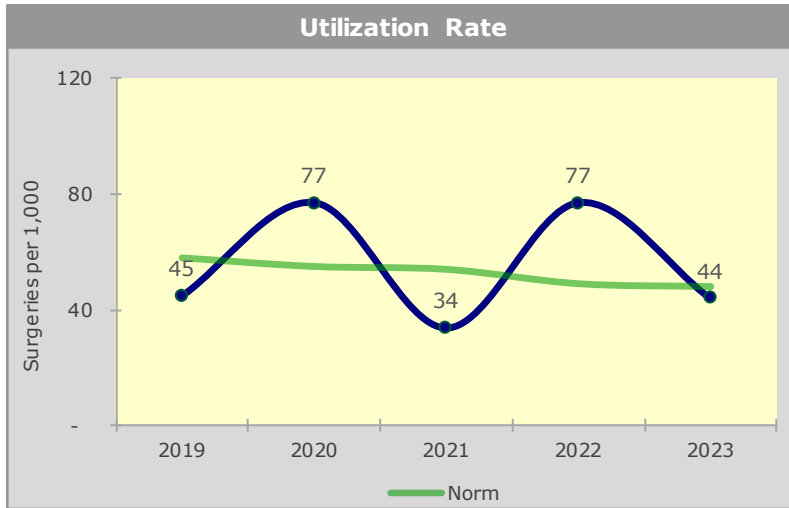
During this reporting period, the average cost per emergency room visit is shown in the right. This cost represents the facility fee only for emergency room services. Professional/physician fees are not included in these figures.

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.



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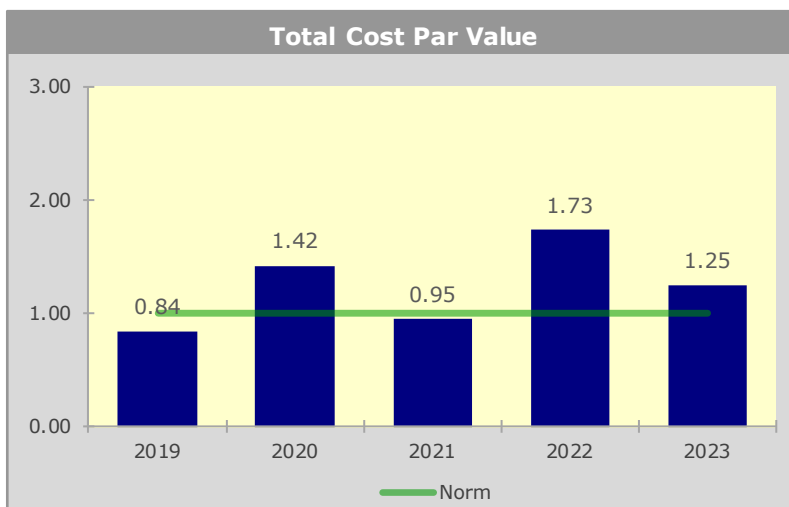
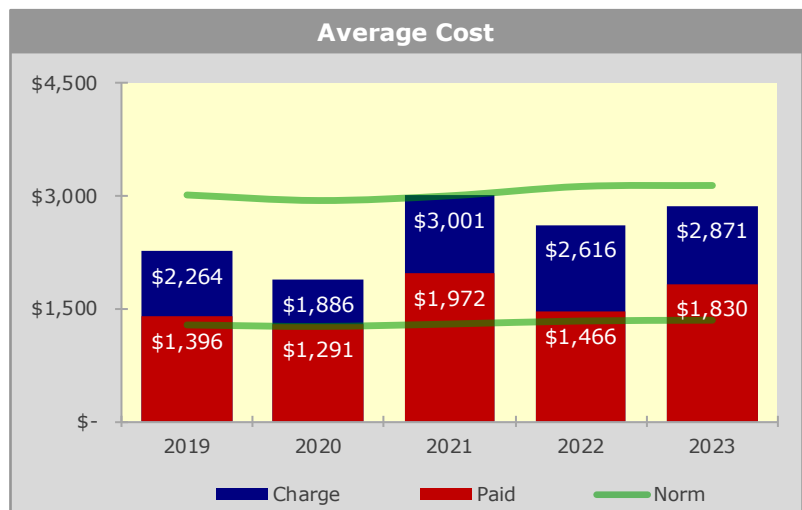
# Inpatient Surgery



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.

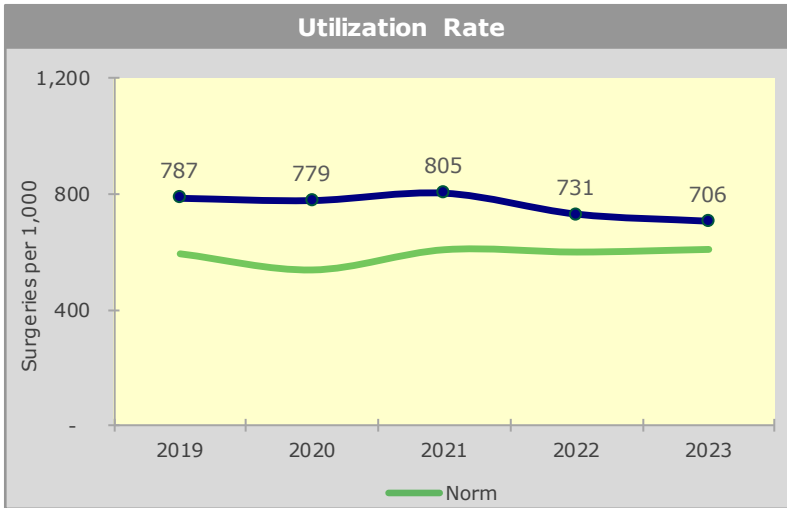
During this reporting period, the average cost per inpatient surgical procedure is shown on the right. This cost represents the fee for the surgical procedure. These procedures may include assistant surgery and surgically coded anesthesia procedures.

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.



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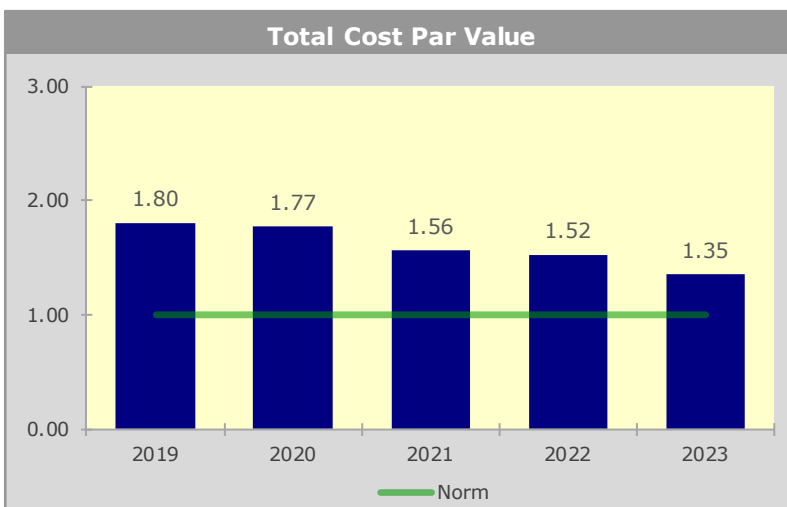
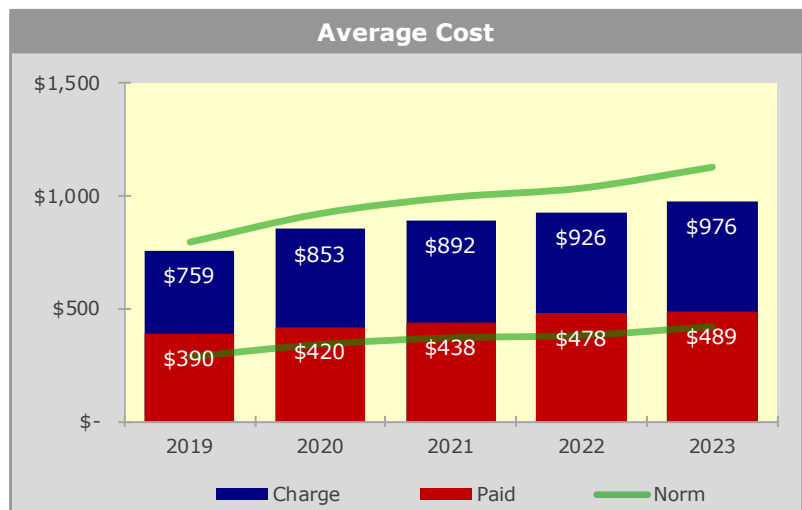
# Outpatient Surgery



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.

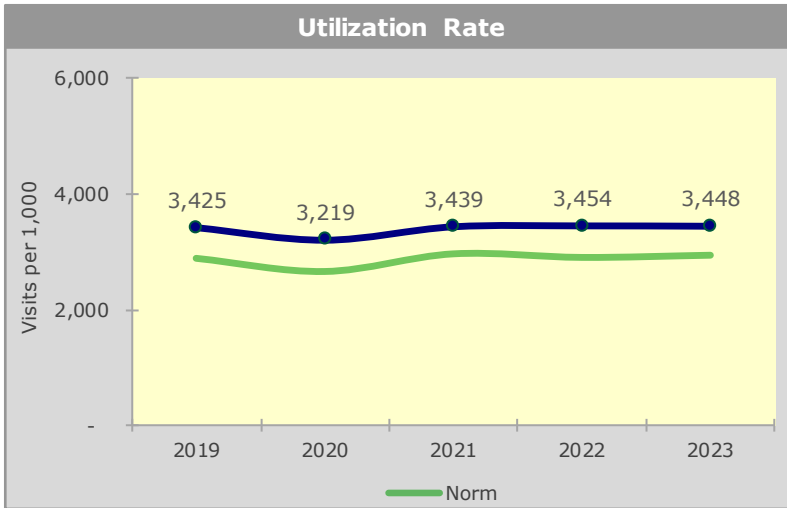
During this reporting period, the average cost per outpatient surgical procedure is shown on the right. This cost represents the fee for the surgical procedure. These procedures may include assistant surgery and surgically coded anesthesia procedures.

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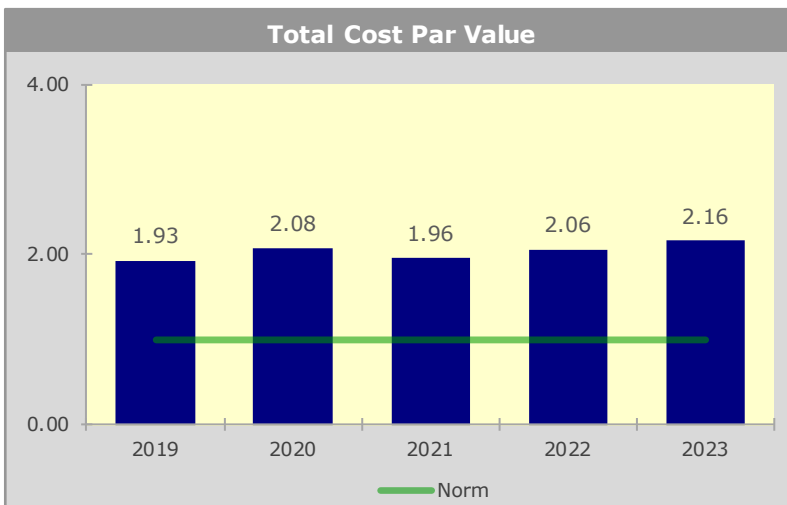
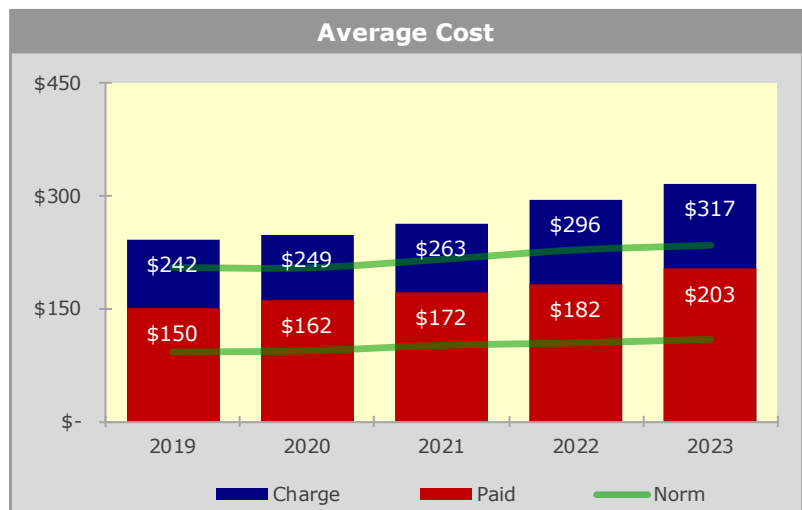
# Physician Office Visits



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.

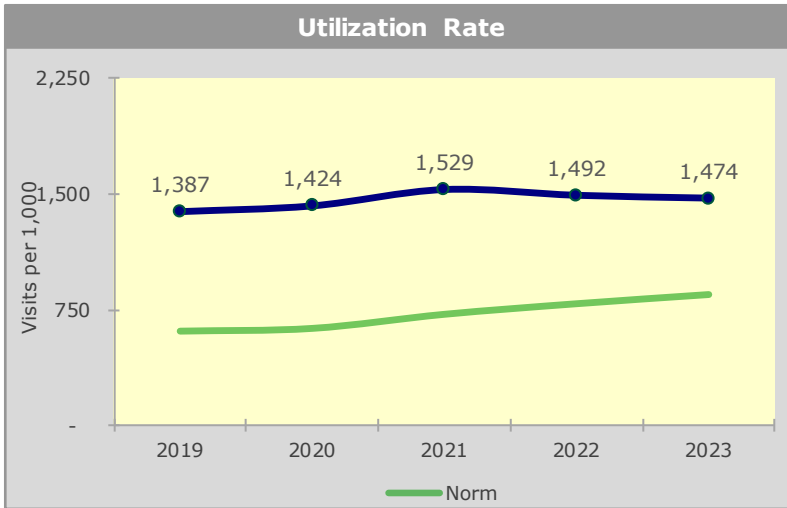
During this reporting period, the average cost per physician office visit is shown on the right. This cost represents fees associated with the office visit only and does not include related office services (lab, x-ray, blood work, etc.).

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.



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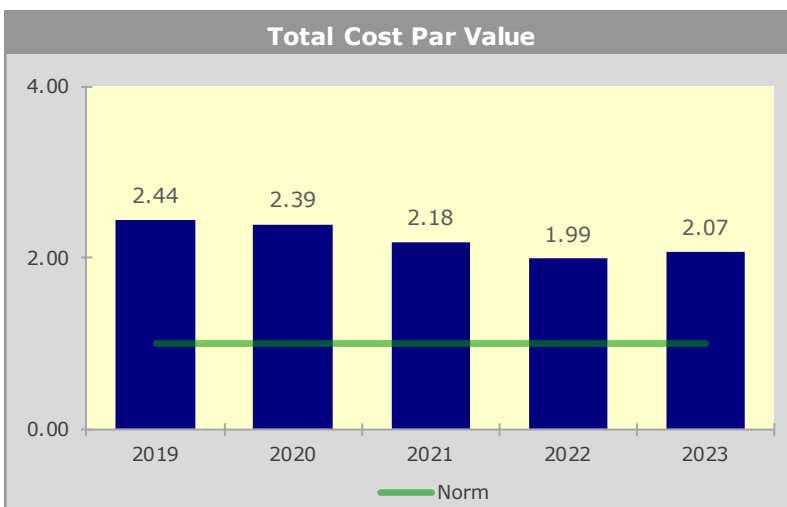
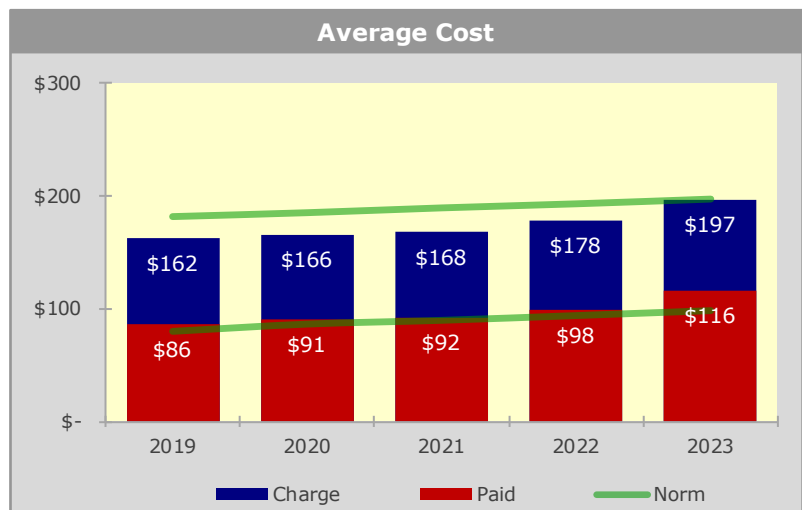
# Mental Health Visits



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.

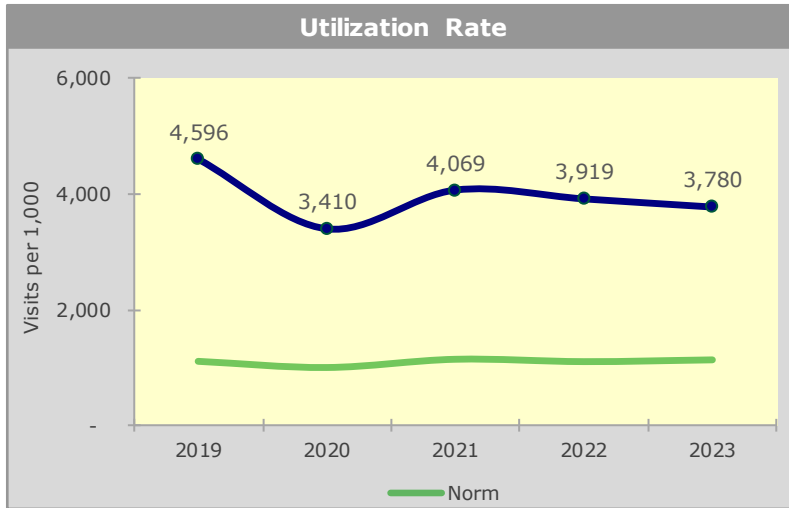
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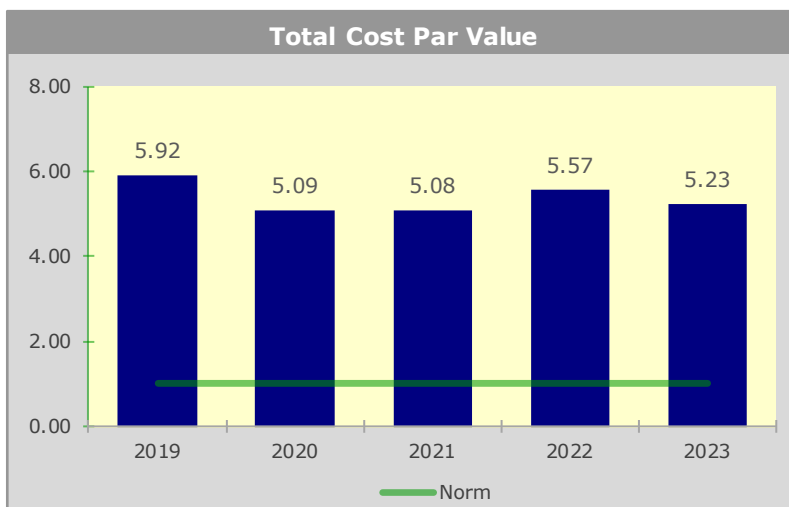
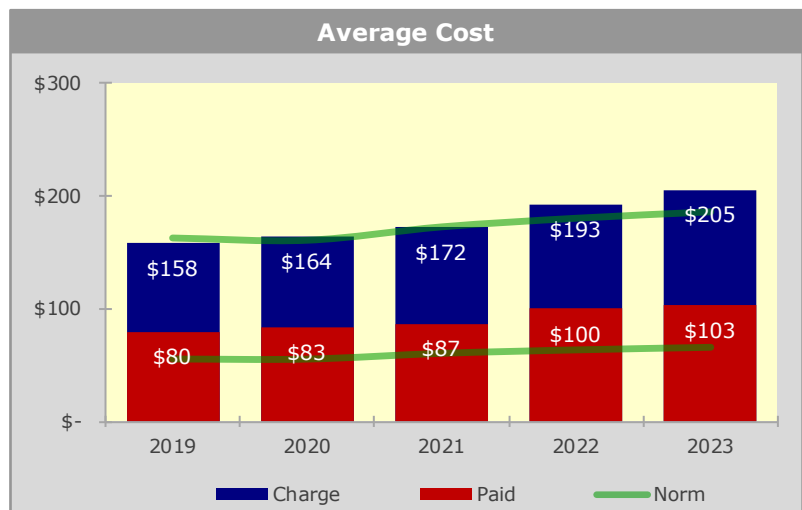
# Physical Medicine Visits



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.

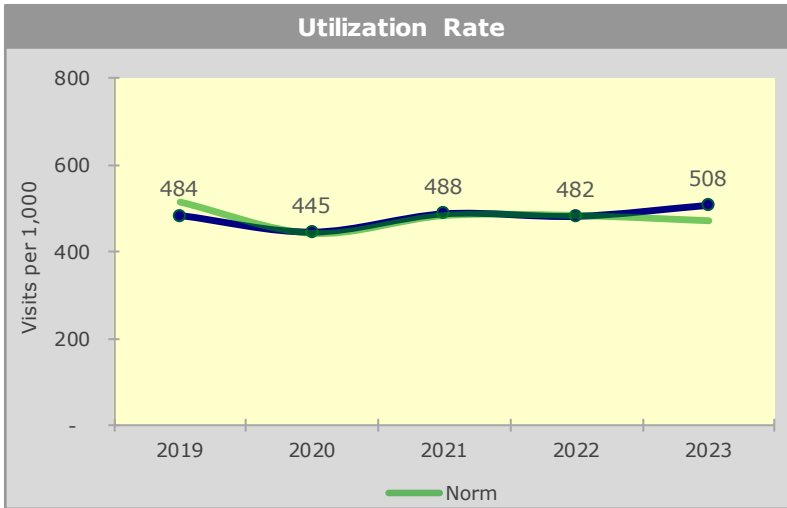
During this reporting period, the average cost per physical medicine visit is shown on the right. This average cost represents the professional fee for these services. Related radiology and other fees are not included.

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.



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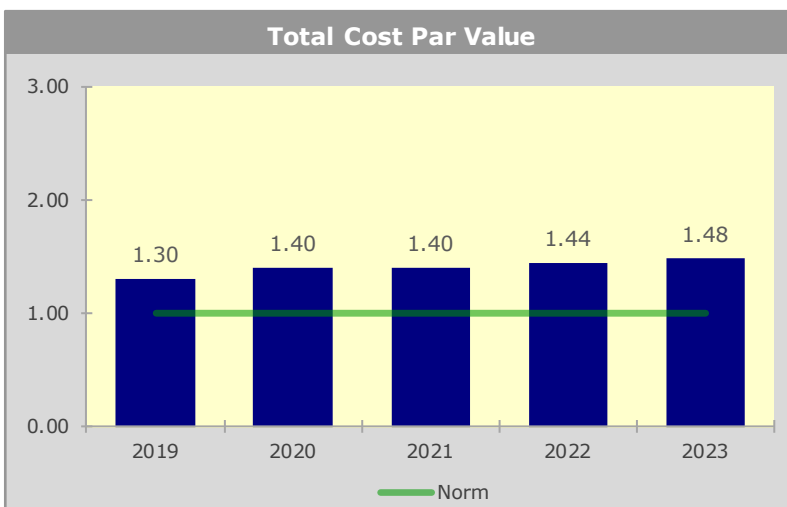
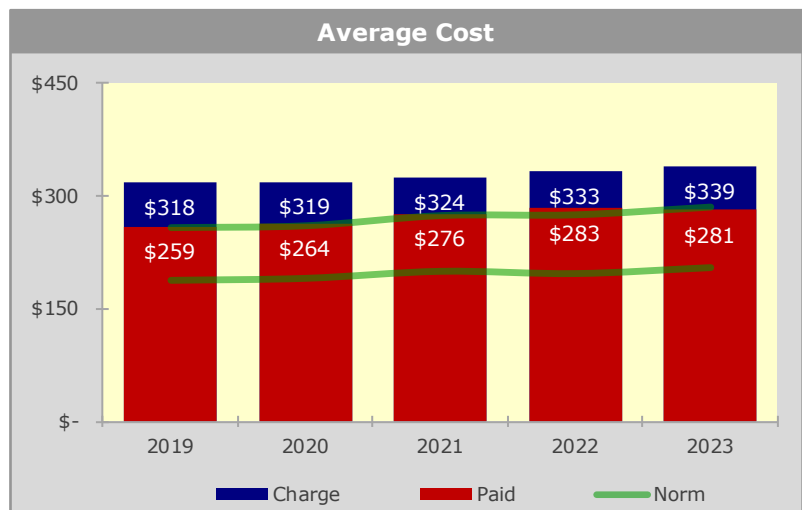
# Wellness/Routine Visits



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.

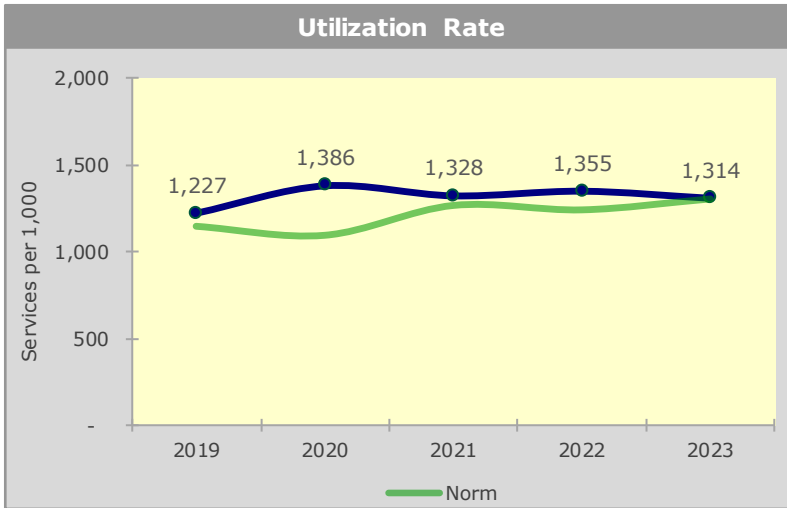
During this reporting period, the average cost per wellness/routine visit is shown on the right. This average cost represents the professional fee for these services. Related laboratory, radiology or other fees are not included.

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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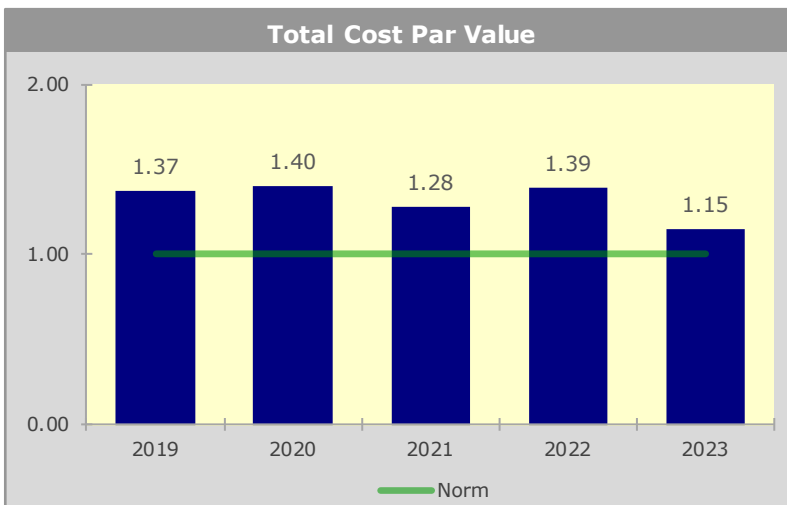
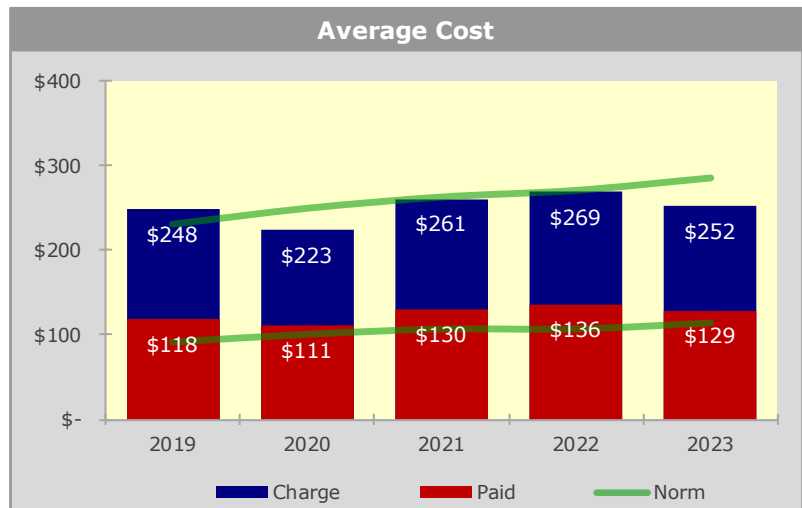
# Radiology Services



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.

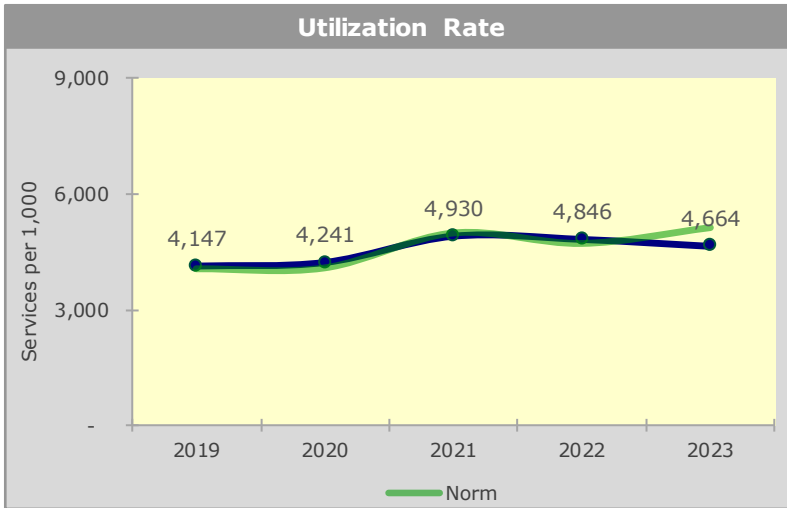
During this reporting period, the average cost per radiology procedure is shown on the right. This average cost represents the fee for the radiology procedure only. The fees for other related procedures (physician visit, etc.) are not included.

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.



Each of the values in the par analysis represents a percent variance from normal (1.00 = normal). Total Cost represents the average cost per unit times the number of units. Total Cost is a measure of the total overall cost to the plan.

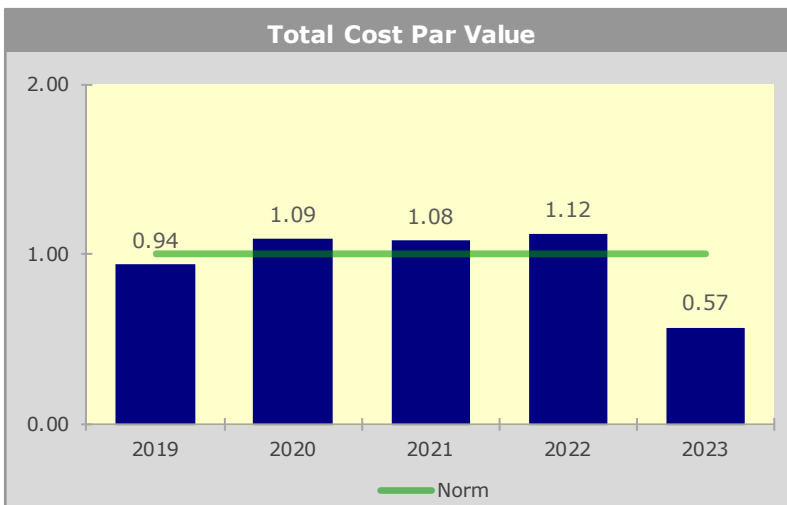
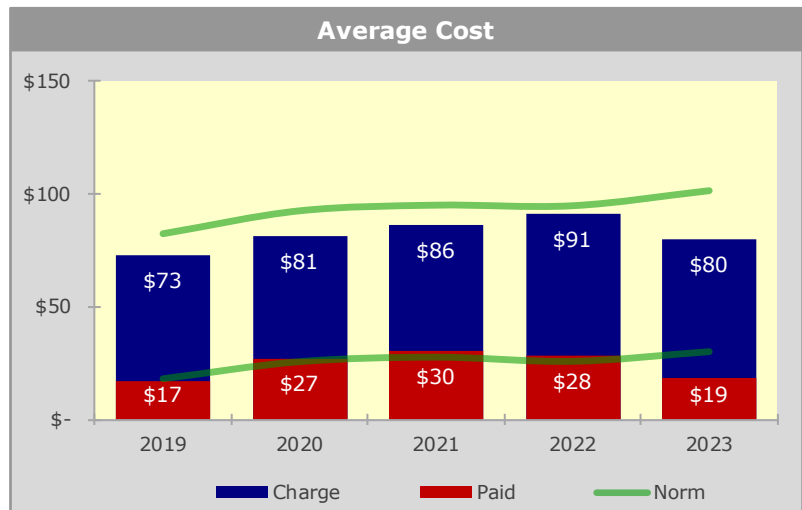
# Laboratory Services



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 often 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.

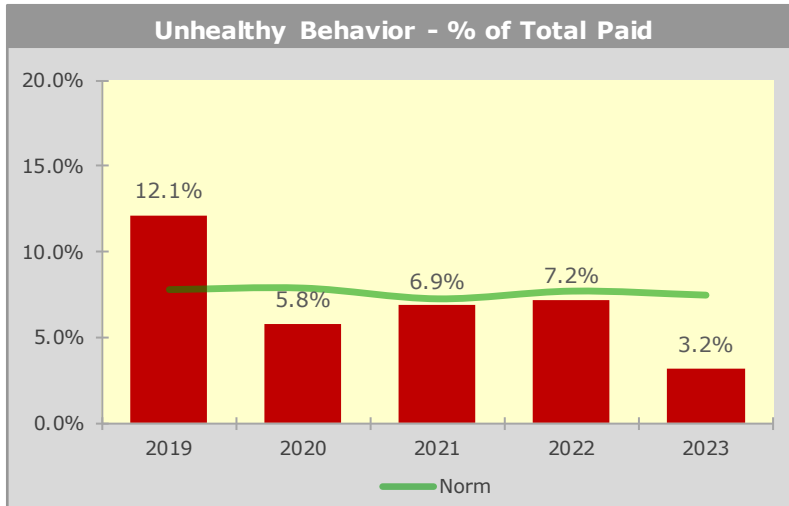
During this reporting period, the average cost per Laboratory procedure is shown on the right. This average cost represents the fee for the laboratory procedure only. The fees for other related procedures (physician visit, etc.) are not included.

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.



Each of the values in the par analysis represents a percent variance from normal (1.00 = normal). Total Cost represents the average cost per unit times the number of units. Total Cost is a measure of the total overall cost to the plan.

## Claims Related to Behavior

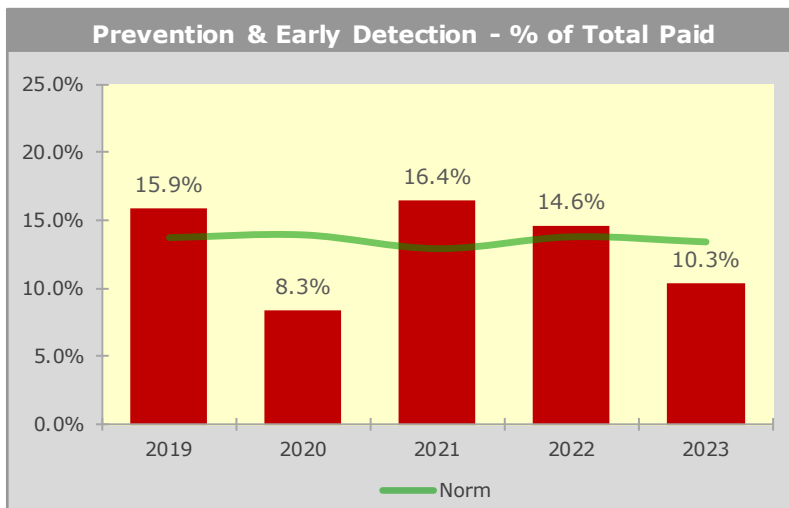


Certain lifestyle choices or behaviors can adversely affect an individual’s health. This section of our analysis focuses on specific behaviors that can be considered “unhealthy”. The behaviors have been categorized as follows: physical inactivity/sedentary lifestyle, poor nutrition, tobacco use, alcohol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

The above chart 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 health education and support programs can influence changes in these behaviors.

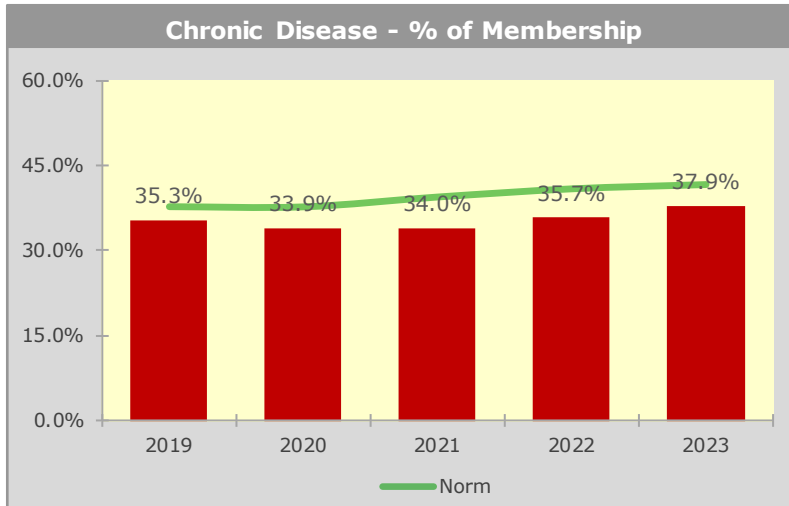
## Prevention & Early Detection



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.

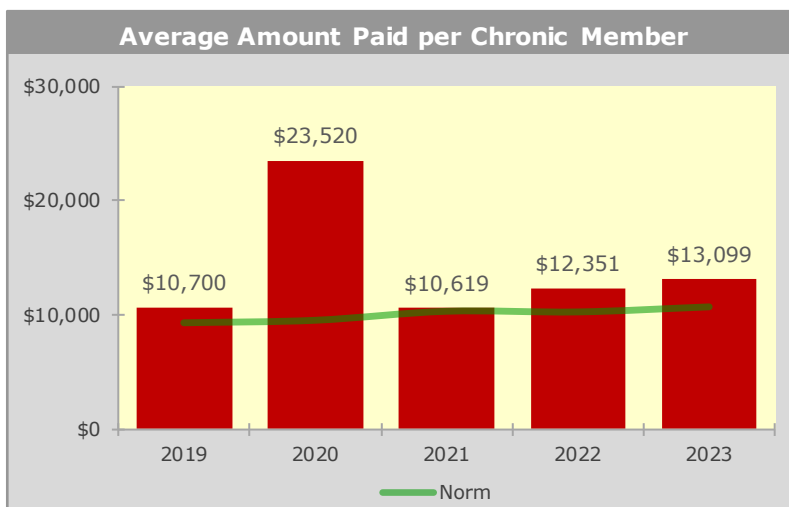
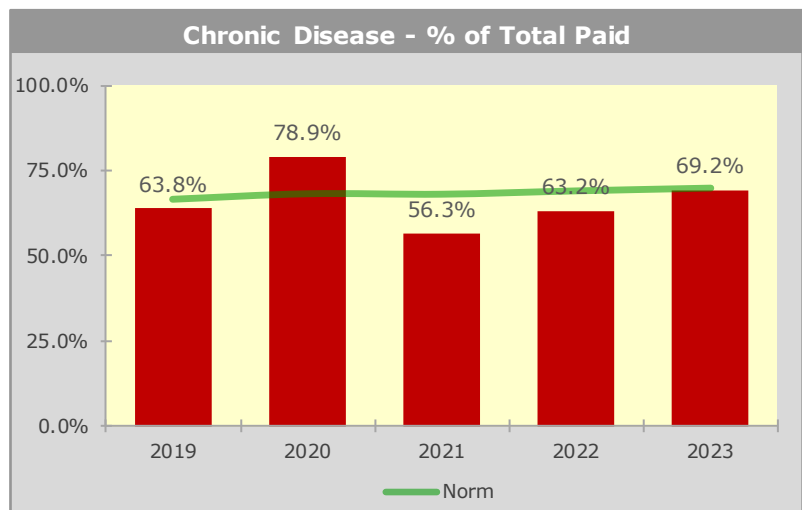
The above chart indicates the percentage of total claims attributable to the above referenced conditions that may be able to be reduced through prevention, early detection, and disease management.

# Chronic Disease Impact



Measuring the prevalence of chronic illness within a population is crucial to better understanding not only the retrospective health care costs for a group, but also the influence chronic patients may have in terms of future spend. The chart to the left illustrates the chronic disease patient prevalence over time. The figures represent the chronic disease population as a percent of total membership.

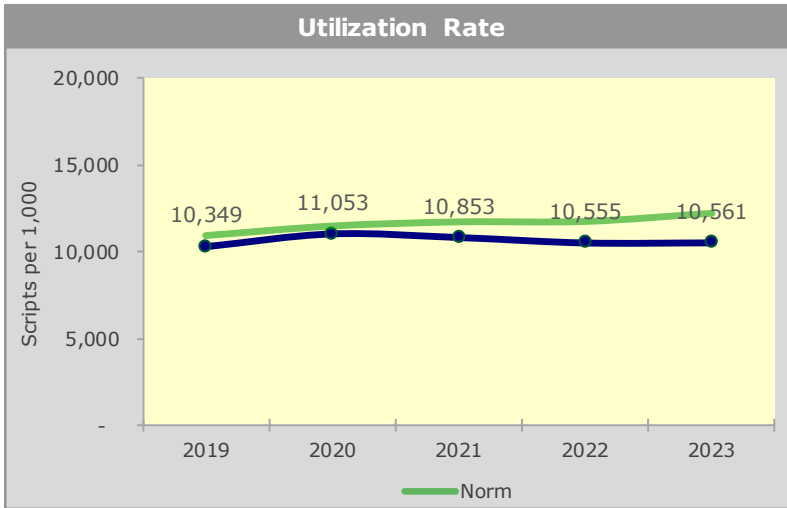
Patients with chronic illness often represent a disproportionate share of the overall medical spend for employer groups. In other words, a small percentage of members who have been diagnosed with one or more chronic diseases often represent a larger, or disproportionate share of the overall spend. The chart to the right illustrates the total cost for chronic disease patients as a percentage of an employer's overall spend.



The chart to the left indicates the average amount paid, in total, for members with chronic illness. These cost figures will include payments related directly to the patient's chronic disease, in addition to the costs for any comorbidities and unrelated disorders.

High cost members diagnosed with chronic illness may influence the figures in each of these charts.

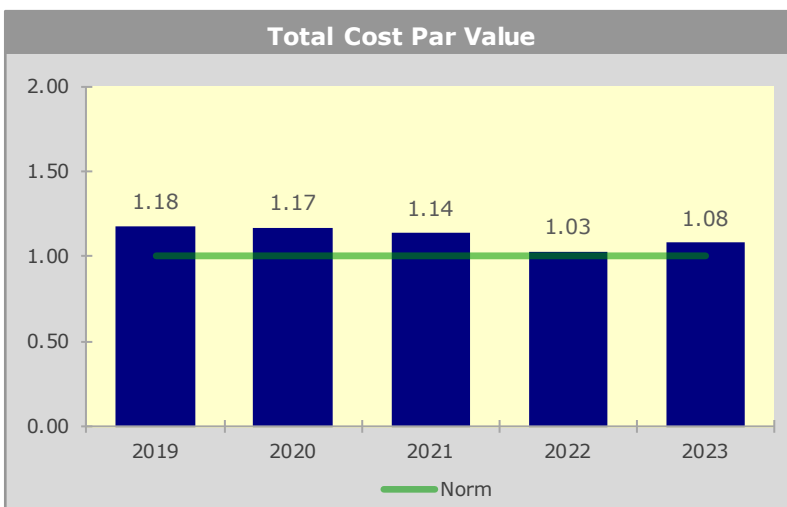
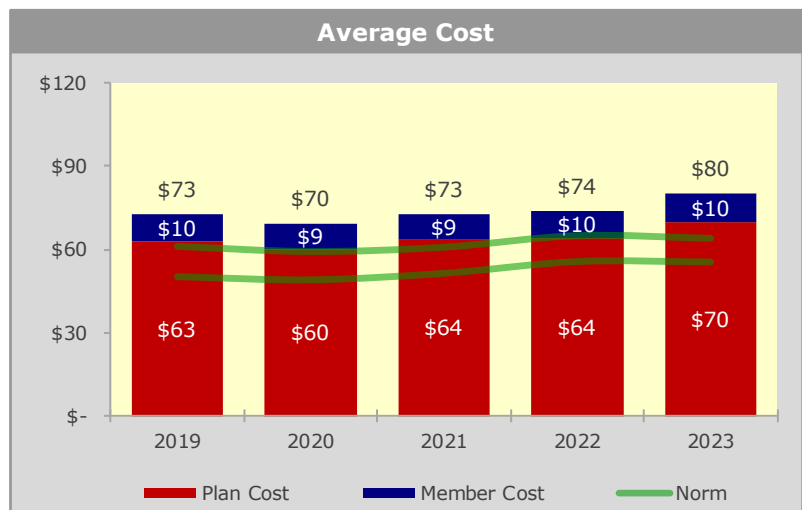
# Prescription Drugs



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.

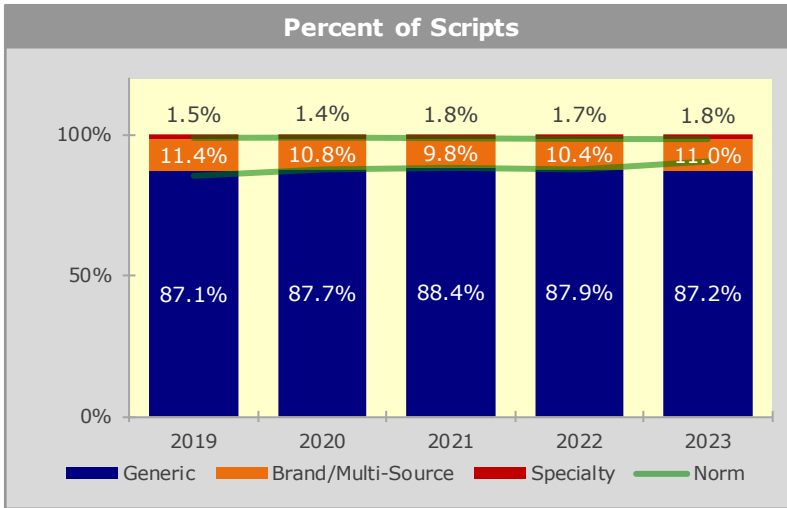
The average cost per script is illustrated in the chart to the right. Both the member and employer costs are measured and benchmarked against prevailing normal costs.

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

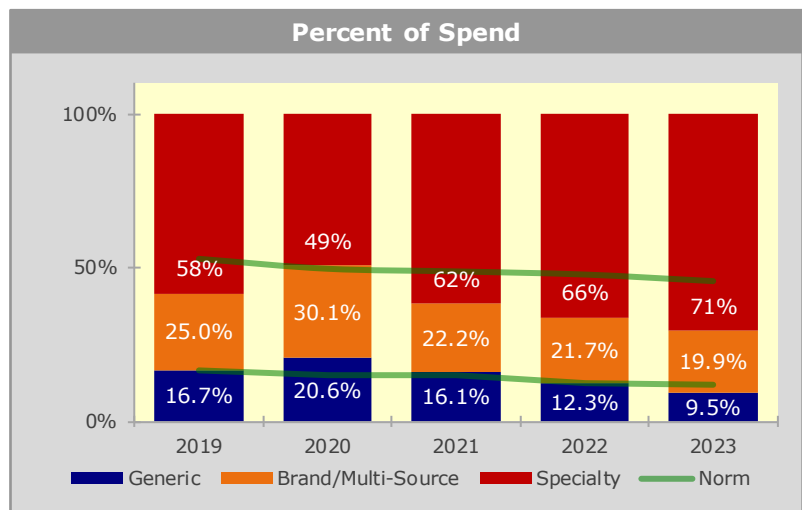


There are several factors which influence the cost associated with prescription drugs. The type of drug being dispensed (brand vs. generic) is often a key determinant of pharmacy cost. Brand drugs are generally considered more expensive (on average) than generic drugs.

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

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.

The exhibits above and to the right illustrate the impact that a tiny fraction of specialty drug scripts can have on the overall pharmacy spend.



The charts below illustrate the historical plan and member expense for generic, brand and multi-source drugs (specialty excluded). The cost for brand/multi-source drugs has been blended using a weighted average.

