UNITARIAN UNIVERSALIST ASSOCIATION OF CONGREGATIONS
Representing over 1,000 liberal religious congregations

March 19, 2009

UUA Health Plan Performance Review

Final Report

Strategic Benefit Advisors, Inc.

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Introduction

- The UUA initiated a process to conduct a performance review of its health plan. Specifically, the UUA Trustees are seeking to validate their decision to establish a self-insured medical plan for UU congregations, organizations and staff dispersed throughout the country.
  - A large percentage of entities were unable to secure comprehensive, affordable coverage independently.
  - The insurance market was unwilling to underwrite the risk since very little demographic and claims data were available.
- The Request for Proposal issued by the UUA included a broad range of topics that are addressed in this report, including:
  - Strategy to extend coverage to the uninsured population;
  - Review of the incumbent carrier and alternate carriers that may be willing to partner with UUA; and
  - Suggestions for ongoing plan management.

Introduction

- Based on our analysis and the feedback from various stakeholders, the UUA Health Plan is a successful program:
  - The benefits are generally competitive in the marketplace.
  - The cost and utilization analysis did not reveal significant aberrations in any of the key indicators. *(It is important to note that the claims experience is not fully credible given the size of the covered group and recent inception of the plan. Further, it is not unusual to see significant fluctuations in year-over-year statistics.)*
  - The feedback from the stakeholder interviews was overwhelmingly positive.
- The plan's success is most evident when we compare outcomes to the UUA objective: to make quality health insurance broadly available to our congregations, affiliates and staff.
- An area of concern for the UUA Health Plan is that, in certain instances, the premium is higher than what the congregations and/or employees can afford:
  - UUA has acknowledged that a contingent of uninsured employees remains as a result of this.
  - UUA has also acknowledged that the age-banded rates create an affordability barrier for some. It is our understanding that this continues to be an ongoing area of study for the Board of the UUA Employee Benefit Trust (EBT).

Introduction

- The remainder of this report documents our analysis and observations.
- We have offered suggestions and recommendations throughout this report for UUA to consider. Our suggestions and recommendations are based on our knowledge of UUA, our experience with other clients and our market expertise. We expect that the board members of the EBT may decide to adopt or discount certain recommendations.

Stakeholder Interviews

Stakeholder Interviews

- The purpose of the stakeholder interviews was to solicit information to assess the general strengths and weaknesses of and overall satisfaction with the UUA Health Plan.
- We were able to speak with 11 of the stakeholders identified by the UUA Health Plan Director. Each was eager to participate in the interview process and was generous with his/her time.
- The questions posed to the stakeholders included:
  - What do you like best/least about the UUA plan?
  - What problems have you or others had while using/accessing the plan?
  - What are the primary reasons that employees opt-out of the plan?
  - What are the biggest challenges facing the plan?
  - What suggestions do you have for improving the plan?
  - Is there anything else that you or others have seen in the market that should be considered by UUA?
- Questions were modified accordingly for UUA employees vs. outside advisors.

Stakeholder Interviews

Feedback from Plan Participants

- Cost
  - Rates are higher than some congregations/employees can afford.
  - There are varying levels of premium subsidy; examples include:
    - 80% subsidy for all employees
    - 100% for employees and 0% for dependents
    - 90% for employees; 50% for dependent children and 0% for spouse
  - Some congregations offer an opt-out bonus to encourage employees to take coverage elsewhere.
  - Employees with access through a spousal plan typically take that coverage because it is more affordable than the UUA plan.
  - Age-banded rates make that UUA plan cost-prohibitive for older employees.
  - The regional rating may be too specific in certain geographies where employees live within an hour of each other but pay different rates (although this can be confused with age-rate differences).

Stakeholder Interviews

Feedback from Plan Participants (cont.)

- Plan Design
  - Some consider the deductible and out-of-pocket costs to be a barrier to care.
  - Several people we spoke with were previously enrolled in an HMO, and they miss it. It was requested that the UUA consider providing an HMO (or similar) option.
  - Most consider the plan to be comprehensive. There were a few comments that there should be higher levels of coverage and richer benefit options, but these were limited.
- Highmark
  - Most are pleased with the network, indicating that they have access to their providers (a few noted that some employees had to change doctors when they joined the UUA plan, but this was not a major theme).
  - Overall, Highmark's customer service has been favorable. Members like that there is a dedicated UUA number and commented that the representatives are courteous. There were some specific complaints, but no major themes and nothing that was unique to UUA or Highmark.

Stakeholder Interviews

Feedback from Plan Participants (cont.)

- Overall feedback regarding the plan was very positive. In most instances, the interviewees did not have suggestions to improve the plan.
- Members generally feel that the UUA is working hard to provide a valuable benefit to many who would otherwise not have access. The larger congregations and UUA staff with whom we spoke felt good about contributing to this outcome.

Stakeholder Interviews

Feedback from EBT Board Members and Plan Advisors

- Most in this group provided consistent responses when we asked them about challenges facing the Health Plan. These include:
  - Achieving financial stability in this economy and as health care costs increase;
  - Increasing enrollment; and
  - Making the plan affordable to a broad population.
- The interviewees recognize that the age-banded rates prohibit some older employees from being able to afford the plan. However, they understand that the strategy is necessary to ensure the sustainability of the plan.
- There was unanimous concern for the "uninsured," and some confusion as to how to address this issue.
- All agree that the plan is being well-managed. There were no concerns about strategies that have not been explored.
- Feedback can best be summarized as: Keep up the good work, but don't get comfortable with the success to-date. The plan has to be diligently managed in order to remain sustainable.

RFP Questions

RFP Questions

- The UUA requested that we respond to seven broad topics outlined in the RFP, briefly summarized as follows:
  1. Strategy for enrolling the current uninsured population
  2. Analysis of how SBA would have consulted to UUA several years ago when first developing a health plan strategy
  3. Ranking Highmark against the best national carriers
  4. Carrier responsiveness to association business and ability to service UUA outside of the CBA
  5. Carrier positions on offering specialized (better defined as controversial) benefits
  6. Possible carve-out of Massachusetts participants to a local plan
  7. Carrier alternatives to Highmark
- The following pages in this section address these topics.

Strategy for enrolling the current uninsured population

- Most of the UUA entities are extremely price sensitive. Despite its market competitiveness, the UUA health plan is cost-prohibitive for some and there is concern that there is still a sizeable contingent that is uninsured as a result.
- Further, there are ineligible employees (e.g., those who do not meet the minimum hours requirements) that may not have access to health coverage.
- These issues (cost, access) are not at all unique to the UUA. Many organizations and industries struggle with the ability to offer access to affordable coverage.
  - Most recently, 37% of employers do not offer health coverage; 51% of employers with fewer than 10 employees do not offer health coverage.
- Unfortunately, there is no 'silver bullet' to solve this problem. UUA has implemented several innovative strategies, including consumer driven health care, age-banded rates and geographic rate adjustments. These are the remedies that we would typically recommend to address the affordability issue.
- Additional strategies considered/ implemented by other organizations include:
  - Limited medical plans
  - Wage-based contributions

Strategy for enrolling the current uninsured population (cont.)

- We understand that the UUA has attempted to collect data to better understand the eligible population vs. the enrolled population.
- There *may* be areas of the country where it makes sense to look at local health plans as an additional offering.
  - For example, there are currently 11 employees enrolled in California. If we found a high percentage of unenrolled/uninsured, we would explore if a local health plan such as Kaiser could offer a more cost-competitive plan.
- Recognizing that UUA has a large contingent in Massachusetts, we note that Massachusetts residents have access to the "Connector" as a result of Health Care Reform in the Commonwealth.

Limited Medical Plans

- Limited medical plans, also known as “mini-med” plans, provide limited medical coverage compared to traditional group plans.
  - Coverage is essentially limited to routine office visits and some prescription drug coverage.
  - There is typically a low dollar maximum.
- These plans have become a consideration for small employers who have very few employees and/or cannot afford to provide health coverage, and employers (e.g., retailers) that have a large contingent of ineligible (e.g., part-time) employees.
- For a healthy individual, this coverage can be adequate.
- Major downfalls of these plans include:
  - No coverage for acute or catastrophic conditions;
  - Coverage is not HIPAA-credible; and
  - Plans typically include pre-existing condition exclusions.

Limited Medical Plans (cont.)

- Limited medical plans are insured products that are offered through health insurers.
- Our concern with the UUA considering a limited medical plan is that it is less expensive than your current offerings and may be a preferred option for many employees.
  - Limited medical plans can negatively impact the experience of the UUA plan as they attract the favorable risk population.
- Limited medical plans do not appear to be consistent with UUA's objectives and value system; however, they may be appropriate for UUA if affordability continues to prevent enrollment in the UUA plans.
  - UUA can control the eligibility so that only employees who are not eligible for the UUA plan are eligible for the limited medical plan.
  - UUA could also consider allowing only employees who earn under a certain amount to be eligible.

Wage-Based Contributions

- Approximately 40% of large employers offer tiered employee contributions, based upon earnings.
  - We note that the large employers surveyed represent mostly Fortune 500 companies that typically have significant variances in compensation across their employee populations.
  - A few employers have also tiered benefits (e.g., deductible, out-of-pocket maximum) based upon earnings.
- The UUA recommends that congregations pay an average of 80% of the premium rate, but the actual contribution strategy is determined locally. We have found that the strategy varies considerably and we do not have data to determine if the aggregate subsidy is at least 80%.
  - The UUA EBT may want to consider adding Health Plan bylaws on contributions and offering assistance in how to possibly tier contributions so that lower wage earners have access to more affordable coverage.
  - This strategy must consider that lower-earners would therefore be subsidized by higher earners.
- We recognize that a number of UUA entities may be too small to consider this strategy, and/or may not have significant variances in earnings other than ministers.

UUA Health Plan Subsidy

- The EBT has indicated that they have accumulated sizeable gains net of the reserve for claims incurred by not reported (IBNR).
  - Estimates provided verbally to SBA are in excess of $2 million.
- The EBT can consider using some of this surplus to subsidize lower-income employees. Considerations include:
  - Premium holiday;
  - Contribution to HSA; and
  - Lower contribution rates.
- There is risk to this approach:
  - EBT does not know how many would qualify nor the impact that enrollment will have on the claims experience of the plan.
  - The subsidy is difficult to administer.
  - Spousal earnings should be a consideration but are not known/available.
- The EBT will require specific data to determine if this is a viable strategy.

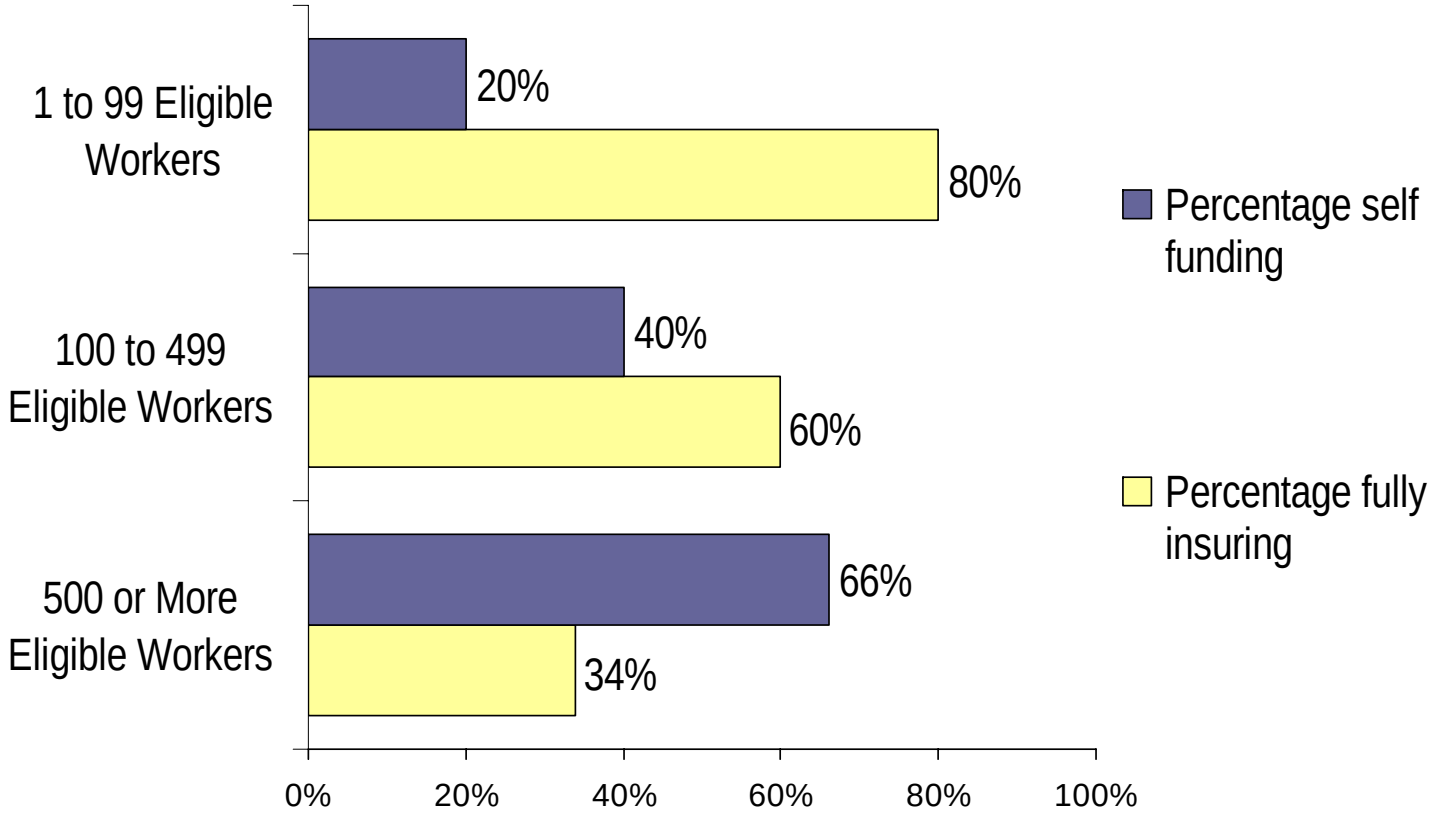
"Retrospective Consulting"

- If approached by a group with fewer than 700 employees and no claims experience, we would have substantial concerns with self-funding the risk. For an Association group with no revenue to support the program, we would have *not recommended this approach.*
- Our initial approach would be to aggressively negotiate an insured program and to surcharge the premiums to generate a reserve. We speculate that we would have been able to secure insured arrangements that could be extended to a majority of the eligible population, however:
  - The aggregate cost would have been higher than current and unaffordable to a greater population;
  - There would have been inconsistencies in benefit design; many of the plans would require higher out-of-pocket costs than the UUA PPO;
  - There would have been considerable premium fluctuations year-over-year;
  - There would have been entities for which we could not secure coverage;
  - Administration would have been complex; and
  - The program may have been highly fragmented.

Self-Insured Funding

- Recognizing that an insured program would not meet UUA objectives, we would initiate discussions of a self-insured program.
- In general, the best candidates for self-insurance are large, financially-sound organizations willing to assume their own benefits risk.
- Employers without adequate cash-flow flexibility or who require fixed budget numbers are not good candidates due to fluctuations that occur in paid claims experience.
- The more employees in the organization, the greater the propensity to self-insure.
  - Larger risk pools offer the ability to more accurately predict claims.
  - Smaller groups tend to be negatively impacted by claims fluctuations.
- All things being equal, self-insurance is less expensive due to lower administration costs (premium taxes, risk charges, profit) and the exemption from state-mandated benefits.
  - Smaller groups can benefit from insured arrangements when their claims are given only partial consideration (and lower manual rates result in a lower premium).
  - Market dynamics are an important consideration as carriers sometimes offer rates that are below expected cost, but we would not anticipate this opportunity for the UUA.

Funding by Organization Size



Source: Society for Human Resource Management, 2008

UUA Strategy

- Given that UUA did not meet critical criteria for self-insurance, your execution is to be commended on many levels.
  - Joining the CBA provided UUA access to a carrier that might otherwise be unwilling to offer coverage, even on a self-insured basis.
  - We suspect that UUA also learned lessons and best practices from other CBA groups that developed and implemented self-insured programs for similar populations, thereby preparing you to avoid or account for common pitfalls.
  - Establishing a separate Board of Trustees specific to the Health Plan demonstrates good fiduciary responsibility. UUA clearly targeted individuals with high expertise in a range of critical and relevant areas. However, this Board also demonstrates a deep knowledge of the organization and the plan, and is genuinely committed to its financial stability and success. While some Boards operate in practice only, this Board is of significant strategic value.
  - UUA utilized effective actuarial and legal consultants that dispense sound advice and develop accurate work product. From the work we reviewed, they appear to be strong business partners that are committed to your success.

UUA Strategy (cont.)

- The use of age-banded rates is a very effective way to avoid adverse selection of the plan. Without this approach, younger employees are less likely to enroll and plan experience may have been much different.
- The financial underwriting was conservative and included high margins to account for the uncertainty of the risk.
- Proper amounts of reinsurance were purchased to limit exposure to the plan.
- UUA did not effect the plan until the minimum enrollment was achieved. A positive example was set when the UUA's staff plan with Harvard Pilgrim was eliminated.
- The EBT Board and Plan Director are continuously reviewing plan performance and not resting on the laurels of success.

- Overall, UUA's strategy and execution were appropriately conservative, fiscally responsible and effectively monitored and managed.

Highmark Blue Cross Blue Shield

Background

- Highmark BCBS is a dominant health plan in Pennsylvania. It is an independent, local health plan that licenses the national Blue Cross Blue Shield network.
  - The BlueCard program aggregates providers from Blue companies across the country into a single network.
- Highmark BCBS's parent company, Highmark, Inc. is a not-for-profit company with several health plan subsidiaries that include:
  - Highmark BCBS serving the 29 counties of western PA.
  - Highmark BlueShield serving the 21 counties of central PA and the Lehigh Valley. Services provided in conjunction with Blue Cross of Northeastern PA and Independence Blue Cross. (Recent efforts to combine Highmark and Independence Blue Cross were unsuccessful.)
  - Keystone Health Plan West, an HMO serving western PA.
  - Several other Medicare, health, dental and vision companies.
- Highmark, Inc. reports total membership of over 4.5 million and revenues of $12.4 billion (2007).
- Highmark has received high financial strength ratings:
  - Standard & Poor's: A (strong)
  - A.M. Best: A (excellent)

Highmark Blue Cross Blue Shield

- Highmark has an excellent reputation for driving quality health care.
  - Encourages providers to achieve National Committee for Quality Assurance (NCQA) certification
  - Provider pay for performance (P4P) program considers evidence-based medicine and outcomes vs. cost alone
  - Highmark has received several prestigious technology awards
  - Strong focus on member engagement
  - Provides cost and quality data on hospitals and providers
  - Recent initiative to engage providers in educating members on heath care costs
- As noted earlier, Highmark is a local plan, so its efforts with the provider community are generally limited to PA (UUA has 20 enrolled employees in PA). However, its care management, technology and member engagement initiatives benefit the entire membership. Further, UUA benefits from similar provider initiatives of other local Blue plans.
- The BCBS network is appropriate with regard to breadth and depth. We generally see competitive discounts on a national basis, but further analysis would be required to determine if a more advantageous arrangement is available based upon UUA's specific population.

Highmark Blue Cross Blue Shield

- The current administrative fee of $37.82 is less than what UUA would pay as a stand-alone group (the carriers quoted a range of $40-$50).
  - It appears that UUA is getting a full suite of services for this fee.
- The reporting that UUA is receiving from Highmark is standard; while there is room for improvement it is more than we would typically see for a group of your size.
- Member service has been adequate based upon feedback from our interviews and the CBA member satisfaction survey .
  - 127 UUA members participated in a mail survey conducted on behalf of Highmark.
  - Overall satisfaction was 87% for UUA (network=89%; customer service=77%; claims=73%).
  - In our experience, a mail survey achieves low participation rates and can attract a higher percentage of those dissatisfied with the plan.
- In summary, we do not see any reason to recommend a change from Highmark but note that a competitive bidding is the most effective way to validate this decision.
  - We are aware that a full review of Highmark is being conducted by the CBA in conjunction with negotiations for the contract effective 2010-2012.

UUA Stand Alone Program

- The question of *can* UUA establish a stand-alone health plan and *should* it establish a stand-alone health plan is quite different.
- *Can* UUA establish a stand-alone health plan?
  - Yes -- the remainder of this section addresses carrier alternatives to Highmark.
- *Should* UUA establish a stand-alone health plan?
  - Not Recommended -- unless there are service and/or performance issues with Highmark, there is no visible advantage for the UUA to leave the CBA arrangement and contract directly for administrative services.
    - UUA is benefiting from the collective purchasing power of the CBA, as demonstrated by lower administrative costs, dedicated customer service and more comprehensive reporting.
    - UUA would have very little leverage to negotiate pricing and services on it own.
    - It is unlikely that UUA would find a similar peer group with another health plan and have the ability to benchmark against such peers.
    - As stated in the following pages, the market is not responsive to Association groups and would likely show interest only in a sizeable prospect (e.g., the CBA which has over 71,000 employee subscribers. To put this in perspective, UUA is less than 1% of the CBA membership.)

Market Analysis – UUA Stand Alone Program

- The geographical disbursement of the UUA membership requires a health plan with national service and network capabilities.
- SBA spoke with the following carriers on a blind basis regarding the UUA program, both in conjunction with the CBA and on a stand-alone basis:
  - Aetna
  - Blue Cross Blue Shield of Massachusetts
  - CIGNA Healthcare
  - Harvard Pilgrim Health Care
  - Health Plans, Inc. (TPA)
  - Tufts Health Plan
  - United Healthcare
- As this report is specific to the UUA, we spoke only with Massachusetts carriers that can support a national account.
  - There are other carriers throughout the country with national capabilities that UUA may consider as part of a larger purchasing group such as the CBA.

Carrier Overview

- Aetna, CIGNA and United Healthcare are large, national carriers with significant proprietary networks.
  - Fortune 200 companies each with health membership in the tens of millions.
  - These large health plans invest significantly in technology and other health management resources.
  - Each has strong care management programs.
- Harvard Pilgrim and Tufts are local Massachusetts health plans but both have strategic partnerships with national carriers that make them an option for the UUA.
  - Harvard Pilgrim has several PPO programs that utilize the national United Healthcare network outside of the Harvard Pilgrim service area. For groups with less than 1,000 employees, Harvard Pilgrim provides the customer service to all participants.
  - Tufts has a strategic partnership with CIGNA to offer “Carelink” which provides access to the national CIGNA provider network outside of the Tufts service area. Customer service and administration are shared although one primary administrator is designated.
  - Both United Healthcare and CIGNA can provide these same options, allowing access to the Harvard Pilgrim and Tufts networks, respectively.

Carrier Overview (cont.)

- Blue Cross Blue Shield of Massachusetts is a local health plan that (similar to Highmark) licenses the national BCBS network.
- Health Plans, Inc. is a third party administrator (TPA) that is wholly owned by Harvard Pilgrim .
  - They offer the pricing and flexibility of a TPA .
  - The Harvard Pilgrim network is utilized where applicable (HPI gets the same contracted reimbursement rates as Harvard Pilgrim).
  - HPI uses national PPO networks (PHCS/Multiplan) outside of the Harvard Pilgrim service area (they are not able to access the UHC network like Harvard Pilgrim).

Carrier Performance

- US News & World Reports ranks the country's *managed care* plans each year based upon performance data from the National Committee for Quality Assurance (NCQA), a not-for-profit organization dedicated to improving health care quality .
  - The three local MA plans made the 'Honor Roll' by appearing in the top 10 managed care plans *(Harvard Pilgrim ranked 1st; Tufts ranked 2nd; BCBSMA ranked 9th).*
- NCQA PPO accreditation for each carrier is as follows *(note that NCQA will survey health plans of all types on the same set of requirements after 2008, resulting in one Health Plan Accreditation vs. Managed Care and/or PPO)*
  - Aetna – 'Full' PPO Accreditation
  - Blue Cross Blue Shield of Massachusetts – 'Full' PPO Accreditation
  - CIGNA Healthcare - 'Full' PPO Accreditation
  - Harvard Pilgrim Health Care - *scheduled*
  - Highmark BCBS – *no PPO accreditation status*
  - Tufts Health Plan – 'Excellent' Health Plan Accreditation
  - United Healthcare- *scheduled*

Carrier Performance (cont.)

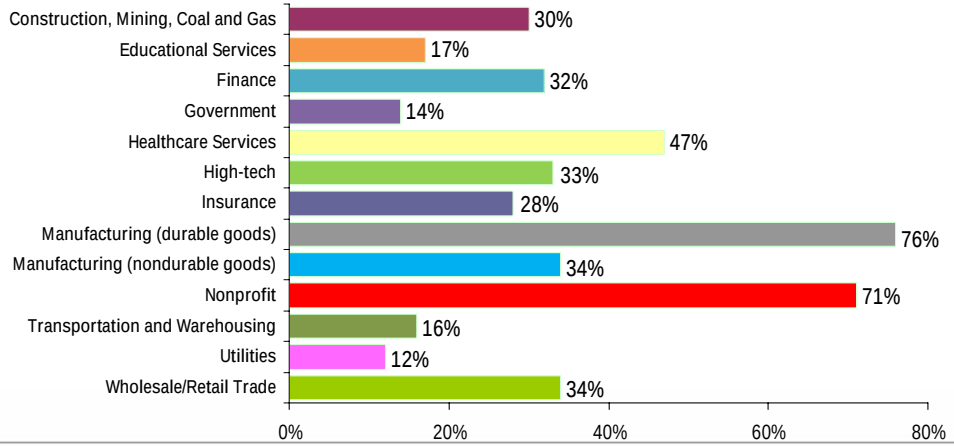
- While NCQA accreditation is important, we note that there are a number of other considerations when selecting a health plan, such as pricing, network access and member service.
  - It is difficult to rank Highmark against other carriers in areas such as negotiated discounts, claims processing accuracy and data transparency (as requested in the UUA RFP) without engaging in a Request for Information or similar analysis.
  - Absent such, we offer the following information:
    - Highmark Blue Cross and Blue Shield received the highest score across all regions included in the J.D. Power and Associates 2008 National Health Insurance Plan Study.
      - This study measured member satisfaction among 107 health plans throughout the country.
      - Key criteria included: coverage and benefits; choice of doctors, hospitals and pharmacies; information and communication; approval processes; claims processing; insurance statements; and customer service.
    - Highmark BCBS publically supports the "Four Cornerstones" of Value-Driven Health Care initiated by the U.S. Department of Health and Human Services.
      - This initiative calls for a commitment to Health IT Standards, Quality Standards, Price Standards and Incentives.

Market Responsiveness to Association Business

- While every insurer with whom we spoke has some association business, all but one (UHC) expressed strong hesitation when approached with the prospect of an association group.
  - UHC expressed a strong interest in association groups and has dedicated sales staff specifically courting broad associations (e.g., Bar Associations).
- All of the carriers with whom we spoke will consider an association a self-insured basis but will rarely underwrite the risk on an insured basis.
- The carriers cited a common set of criteria that they review for association groups:
  - Strict, defined rules for getting in and out of the plan
  - Longevity of the covered group
  - "Legality" of the association's ability to collectively purchase health coverage
  - Demonstrated financial responsibility
  - Applicability of small group health reform

Plan Design

- Each of the health plans we spoke with indicated that the plan sponsor has the discretion to determine the benefits that can be covered.
- When asked specifically about "controversial" coverages such as voluntary termination of pregnancy and sexual reassignment surgery, the health plans indicated that they would accommodate their clients' needs.
  - These are not standard benefits under insured products.
  - There are no rules regarding excluding nor including coverage for these services under a self-funded plan. *We note that clinical guidelines may be lacking for some procedures.*
- Coverage for same sex domestic partners has become increasingly more common, as evidenced by the percentage of employers that offer it:



Regional Plans

- The UUA RFP specifically inquired about implementing a local health plan for Boston where there is a large segment of the covered population.
- We are aware that the Boston members previously had an HMO through Harvard Pilgrim. These members are dealing with both the loss of first dollar coverage and the loss of the Harvard Pilgrim brand name.
  - Some members may associate the lower benefit levels with Highmark, and therefore have a less favorable opinion.
  - Any PPO is administratively more complex for members than an HMO; this can be a difficult change from an HMO.
- UUA would not gain any significant 'economic advantage' through a local health plan.
  - BCBS of Massachusetts is the largest health plan in the Commonwealth with regard to total membership.
  - Highmark pays the same contracted rates negotiated by BCBS of Massachusetts, although BCBS of Massachusetts pays Highmark some user fees for access to its network. These user fees do not apply to BCBS of Massachusetts direct customers. We have not found a significant discount differential between BCBS, Harvard Pilgrim and Tufts Health Plan.
  - Data aggregation is difficult which will hinder UUA's ability to measure and manage the overall health program.

Regional Plans (cont.)

- Members would not gain a significant advantage from a local, Massachusetts-based health plan.
  - The BCBS, Harvard Pilgrim and Tufts provider networks are *very* similar. We find little to no provider disruption when employers change plans amongst these carriers.
- The only advantage to the UUA in implementing a local plan is that it will satisfy members who perceive that local health plan(s) are better.
  - UUA can consider a higher-option health plan that is more similar to the HMO coverage the members had prior. However, the cost will be significant and likely unaffordable to most.
- Many multi-state employers offer health plans through multiple suppliers, but those employers:
  - Are typically much larger than UUA;
  - Insure the plans and choose suppliers based upon premium costs; and/or
  - Have union or other employee relations concerns that make it necessary.
- As discussed earlier, UUA can consider local/regional options where the UUA health plan cannot compete on cost *if it is driving a high uninsured rate as a result*. The impact on the self-funded program must be carefully evaluated in these circumstances.

Cost Management Strategies

Cost Management Tactics – Traditional

- Benefit plan changes – cost shifting to participant
- Increased employee contributions
- Wellness programs
- Consumer-driven plan as plan option
- Opt-out incentive
- Rx formulary
- Claims/eligibility audits
- Specialty carve-outs (Rx, disease management, etc.)

Cost Management Tactics – Aggressive

- Spousal surcharge
- Mandatory participation in care management programs
- Tiered employee contributions
- Health Risk Assessment as requirement for health plan enrollment
- Replace all copays with coinsurance
- Tiered networks
- Mandatory Rx programs (mail order, generic substitution)
- Total replacement consumer-driven plan

Care Management

- There are a number of specialty vendors that provide targeted management for:
  - Chronic/prevalent disease
  - High claimant/complex case
  - Maternity
  - Prescription drug programs
  - Behavioral health care
  - Health improvement/wellness
- Health plans typically lag the specialty market, making a business case to carve-out some of these programs.
  - We note that ROI can be subjective and can take several years to achieve.
  - Additional cost may make carve-out prohibitive.
- UUA will benefit from learning about the outcomes of other CBA groups that have implemented or are considering a carve-out programs.

Population Health Management

- Effective healthcare management requires a multi-dimensional approach

Health Promotion	Risk Management	Demand Management	Disease Management	Catastrophic Case Management
For those who are in good health • Information • Motivation • Preventive Screening	Those who are generally healthy but at risk due to inactivity, stress, high blood pressure, smoking, etc. • Health Screening •Targeted Intervention	For those with minor illness or injury • Self Care • Nurse Advice Line	Those with chronic disease such as diabetes and heart disease • Compliance • Risk Management	Such as trauma and cancer • Case Management • Decision Support

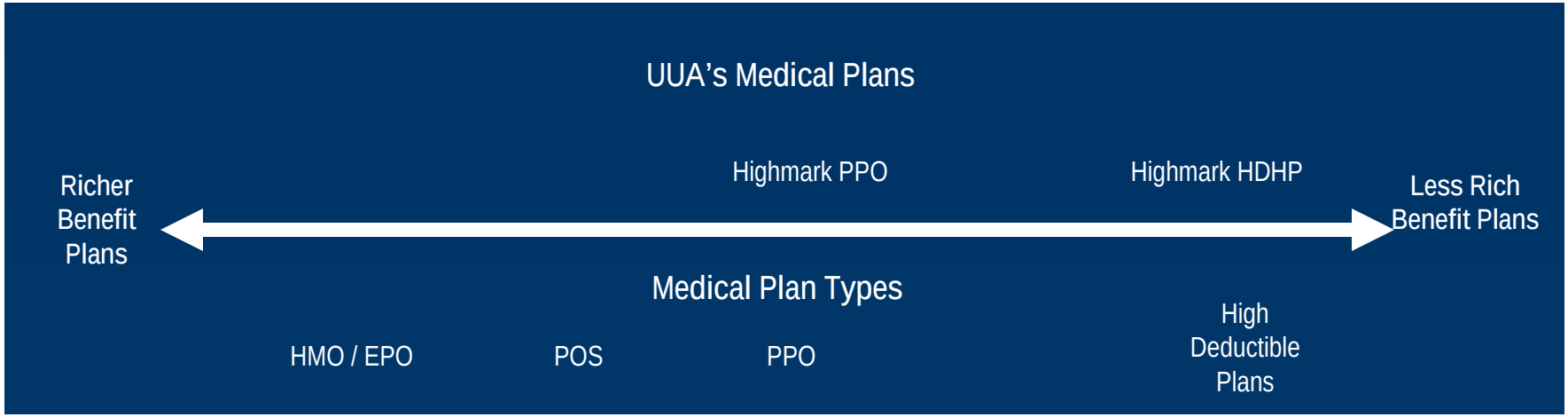
Low intensity/ low cost → High intensity/ high cost

Employer Focus on Wellness/Health Promotion

- Health care costs in the United States have outpaced both inflation and workers' earnings for the last twenty years.
- Each of the the most common chronic diseases—cancer, diabetes, hypertension, stroke, heart disease, pulmonary conditions, and mental disorders—has been linked to behavioral and/or environmental risk factors that broad-based prevention programs could impact*.
- There is little an employer can do to prevent true catastrophic events, but there is much that can be done to promote, encourage and incent healthy behavior changes.
- Opportunities through worksite wellness:
  - Help control long-term plan costs – the greater the number of individual risk factors, the higher the individual's health care costs; studies show that reducing risks in a stable population will positively impact costs over time.
  - Reduce absenteeism and increase productivity – a healthier employee misses less work and works more effectively.
  - Improve the overall quality of life for employees and their families.

* American Institute for Preventive Medicine, 2007

The Spectrum of Worksite Wellness



Spectrum of Wellness Approaches

Awareness & Education		Fitness & Nutrition Initiatives		Health Risk Assessments (HRA)		Wellness Coaching	Benefit & Cost Differentials		Hiring Practices
Articles, posters, email blasts, seminars, online portal, etc	Weight Watchers at Work, smoking cessation programs	Fitness discounts, onsite fitness facility, ergonomic education	Walking Programs, team challenges, healthy vending / cafeteria choices	Incentive-based HRA (raffles, gift certificates), HRA contribution differential	HRA participation required for health plan enrollment	Telephonic / online wellness coaching; onsite wellness coaching	Benefit differentials for wellness participation	Mandatory wellness programs for health plan enrollment	Wellness-based employment practices

Prevalence of Employer Wellness Initiatives

"Wellness program" – resources and information	78%	More prevalent (left side of spectrum)
Health screening program – e.g. high blood pressure, cholesterol	65%	
Smoking cessation program	54%	
Work / Life newsletter or column	53%	
Weight loss program	50%	
Preventive programs targeting those with chronic conditions	46%	Less prevalent (middle to right side of spectrum)
Onsite fitness center	43%	
Fitness center membership or reimbursement	38%	
Stress reduction program	26%	
Health care premium discount for health risk assessment completion	25%	
Health care premium discount for participation in wellness programs	18%	
Health care premium discount for non-tobacco use	17%	

SHRM 2007 Benefits Survey, Large Employers (500+ Employees)

Recommendations

Recommendations

Supplier Sourcing

- UUA is receiving value through the CBA's collective purchasing. We do not see compelling reasons for UUA to leave this arrangement.
  - UUA is receiving the benefit of lower administrative fees, dedicated customer service, and reporting and benchmarking against the larger CBA group.
  - UUA still has the flexibility and autonomy to supplement with additional programs .
- If UUA elects to consider alternatives to Highmark, we recommend the following carriers for consideration:
  - Aetna
  - Blue Cross Blue Shield of Massachusetts
  - CIGNA Healthcare
  - Harvard Pilgrim Health Care
  - Health Plans, Inc. (TPA)
  - Tufts Health Plan
  - United Healthcare

Recommendations

Supplier Sourcing (cont.)

- It is our understanding that the CBA is currently conducting a comprehensive review of Highmark to negotiate the most favorable terms for the upcoming contract period. The CBA should continue to conduct periodic bidding analyses to ensure that Highmark remains the best partner.
- Stop Loss:
  - Certain reinsurance markets have been extremely competitive. As a result, employers are bidding stop loss on a more frequent basis (sometimes annually).
  - We recognize that UUA conducted a stop loss marketing and aggressively negotiated Highmark's rate this past year. UUA may benefit from testing the stop loss market at renewal to ensure continued competitiveness of the Highmark rate. A competitive bidding also provides leverage in renewal negotiations.

Recommendations

Reporting

- The Highmark reports provided to us by the UUA contain high level data focused primarily on the financials of the health plan.
  - These reports do not contain enough specific information to guide UUA in its plan management and health management initiatives.
- The UUA should request that reporting be expanded to include better detail on the key cost drivers and clinical conditions of your covered population.
  - Such reporting would likely be on a semi-annual or annual basis.
  - Highmark should include, at least annually, a consultative summary of key clinical findings and program/intervention recommendations for UUA to consider.
- Highmark should also be able to provide more benchmark data for UUA to compare itself to the CBA group as well as Highmark's commercial book of business.
  - Highmark should be encouraged to provide adjusted benchmark data when it can to better match UUA's characteristics (i.e. adjusted for age/gender mix, industry and geography).
- Through expanded reporting, UUA will have better opportunity to translate data into useful information.

Recommendations

Program Management/Wellness

- We recommend that UUA focus additional efforts on helping to develop a workforce that:
  - Is better informed of their individual health status
  - Receives the appropriate preventive care, immunizations, and screenings
  - Understands and uses the information and resources available to manage their personal health
  - Is encouraged to improve or maintain health through medical plan incentives
- Methods to drive these outcomes include but are not limited to:
  - Personal health assessments resulting in individual health score and personal action plan
  - Online tools and resources
  - Disease management programs
  - Seminars/webinars focusing on various health issues
  - Team/group activities to encourage participation
  - Rewards (monetary or non-monetary), reduced employee contributions, or lower cost sharing at point-of-care for those who improve their health scores or participate in available programs

Recommendations

Program Management/Wellness (cont.)

- We recommend defining the overall health management program goals, working with internal and external constituents to build the program specifications, branding the program and then educating members.

Recommendations

Program Management/Wellness (cont.)

- We recommend that UUA work with Highmark to better understand what it is doing to help manage UUA members who fall into the following health status categories (we have included examples under each that UUA can consider):
  - High Risk – candidates for catastrophic care management
    - Require Highmark to report on case management activities for all claims over $75,000 on regular basis.
  - Chronic Disease – less stable, less compliant, at times poorly controlled
    - Require Highmark to report on all disease management programs (participation, outcomes and savings) on regular basis.
    - *We do not consider carve-out a viable option for the UUA group on a stand-alone basis, but the UUA should continue to evaluate joint purchasing opportunities with other CBA groups.*
  - Intermittent – compliant; well-controlled; milder conditions
    - Ensure access to Highmark's health care coaching and online tools.
    - Promote consistent wellness screenings and programs with individual follow-up.
  - Healthy – healthy and/or "undiagnosed"
    - Focus on prevention, education and incentives.
    - Offer worksite wellness programs, various benefit and discount programs.
    - Promote use of web-based tools.

Recommendations

Program Management/Wellness (cont.)

- Before engaging in a wellness strategy, UUA should ask themselves the following questions to determine the amount of time, effort and resources that should be dedicated
  1) Does senior leadership recognize the importance of wellness and are they willing to communicate that commitment to members? Will they actively participate in wellness initiatives?
  2) Will UUA allocate budget dollars to wellness programming? (If yes, how much?)
  3) Will UUA allocate staff members to wellness planning and programming? (If yes, how many?)
  4) Where does UUA want their program to be on the wellness spectrum: Low Intensity, Medium Intensity or High Intensity?
  5) Which does UUA view as the primary goal of their wellness program: educate members <u>or</u> foster behavior modification?
  6) How "intrusive" does UUA want to be? (carrot vs. stick approach)

Recommendations

Program Management/Wellness (cont.)

- We recommend a Personal Health Assessment (PHA) program as an initial wellness consideration for the UUA.
- This establishes a baseline to measure the health of the covered population and is the best opportunity to understand underlying risk factors and understand where wellness efforts should be targeted.
- Employee receives instant health score; relevant health content is pushed.
- Can (should) integrate with carrier's predictive modeling and care management programs.
- Strong incentive required to achieve the participation desired.
  - The use of incentives (and disincentives) in worksite wellness programs is rising.
  - Incentives are effective in driving participation among higher risk / those who need more motivation; healthy members are likely to participate anyway.
  - Without some incentive, sustained participation tends to be very low.
  - Employee contribution differential typically results in 75%+ employees taking the PHA.
- Should be required annually to measure year-over-year change/effectiveness.

Recommendations

Closing Remarks

- We note that the UUA EBT Board and other plan advisors are engaged and highly knowledgeable. The groups brings significant expertise and commitment to the UUA and is clearly a positive contributor to the plan's successful operation.
- UUA very closely monitors its program. This is an important influence on the plan's success and we recommend that this practice be continued.
  - In doing so, the UUA will continue to stay ahead of industry trends in order to effectively respond to and manage cost increases.

APPENDIX

Benchmarking

Key Survey Data

	UUA	Benchmark
PPO Design – In-Network		
Deductible (Ind – Fam)	$500-$1,000	$500-$1,000
Out-of-Pocket Limit (Ind – Fam)	$2,000-$4,000	$1,000- $1,500
Office Visit Copay	$20	$20
Hospital Stay Deductible – Coins.	$0 – 10%	$350- 20%
HMO Design		
Office Visit Copay - PCP	N/A	$15
Office Visit Copay - Specialist	N/A	$25
Emergency Room Copay	N/A	N/A
Inpatient Copay	N/A	$200
Plan Prevalence - Enrollment		
Offer PPO - % Enrolled	91%	75% - 58%
Offer HMO - % Enrolled	N/A	27% - 20%
Offer POS - % Enrolled	N/A	23% - 12%
Offer HDHP - % Enrolled	6%	15% - 8%
Employee Contributions as % of Premium		
PPO (Ind – Fam)	*20% - 20%*	15.9% - 23.0%
HMO (Ind – Fam)	N/A	16.4% - 23.3%
Plan Funding		
Insured	N/A	34%
Self-funded	✓	66%

Source: Kaiser Family Foundation and Health Research & Educational Trust, 2007 and 2008

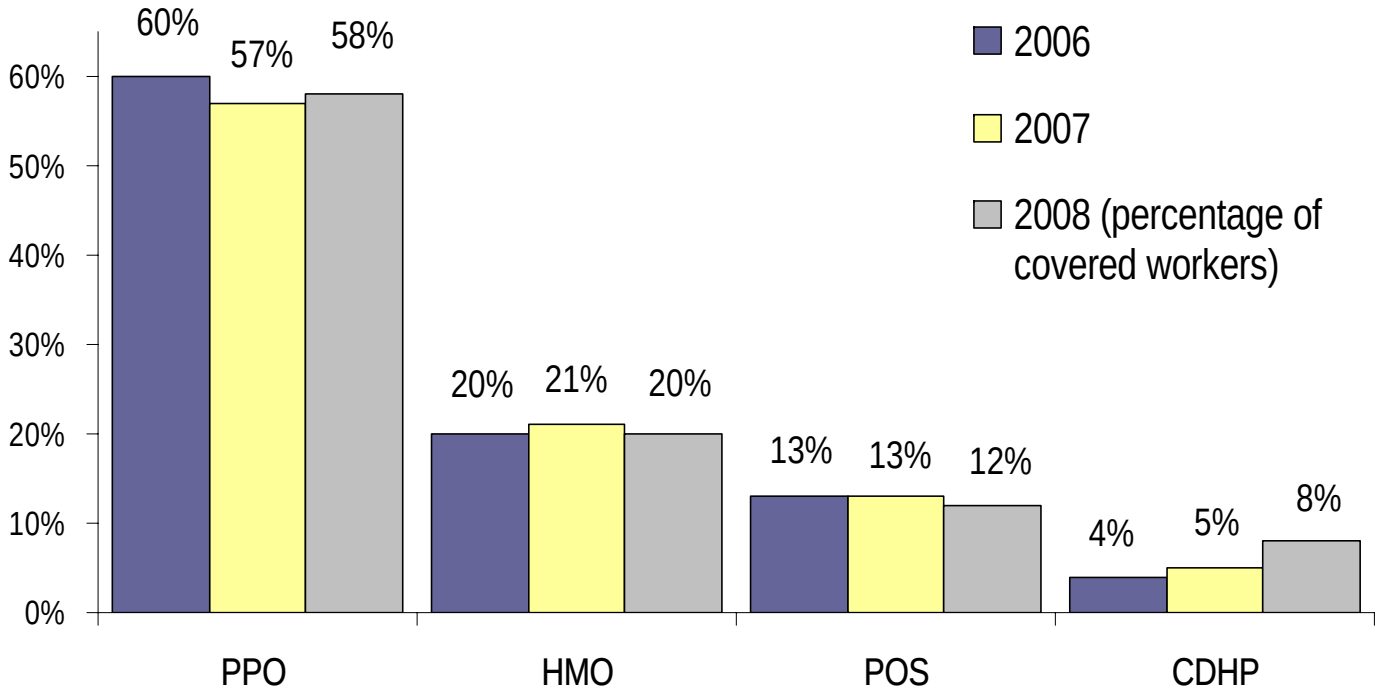
Key Survey Data *(cont.)*

- The UUA PPO health plan is competitive when compared to the national average PPO benefit design.
  - We note that many groups increased their deductible in 2009; early survey reports indicate that a $1,000 deductible will soon be the "norm."
  - The UUA out-of-pocket maximum of $2,000 single and $4,000 is higher than benchmark, but provides significant financial protection to members in the event of a catastrophic health event.
- We consider UUA to have the right product mix.
  - Kaiser's 2008 survey revealed that only 27% of firms with 200-999 employees offer an HMO.
  - UUA offers two different plans: a PPO and a High Deductible Health Plan. Only 9% of firms with 200-999 employees offer 3 or more plan types.

Source: Kaiser Family Foundation and Health Research & Educational Trust, 2007 and 2008

Enrollment by Plan Type

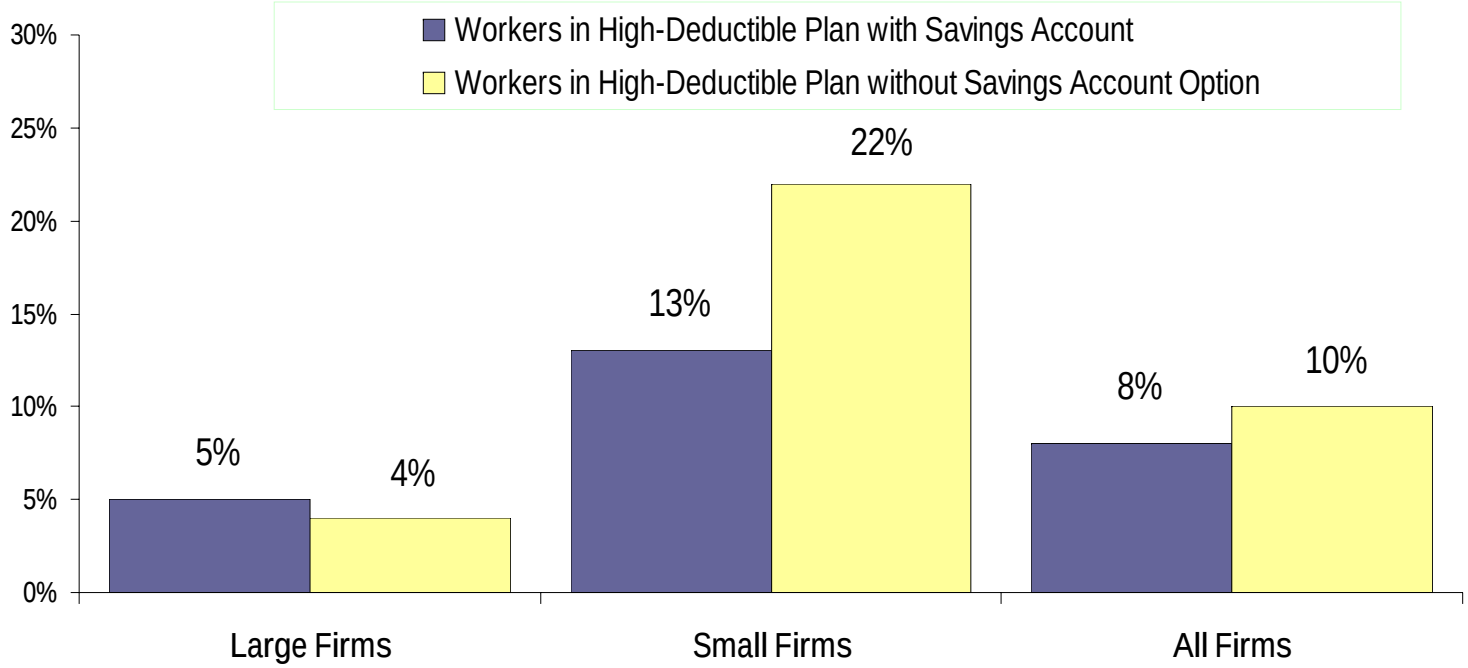
- On a national basis, PPOs are the most prevalent health plan.
  - Certain areas of the country (e.g., Massachusetts) have high HMO enrollment.



Source: Kaiser Family Foundation and Health Research & Educational Trust, 2008

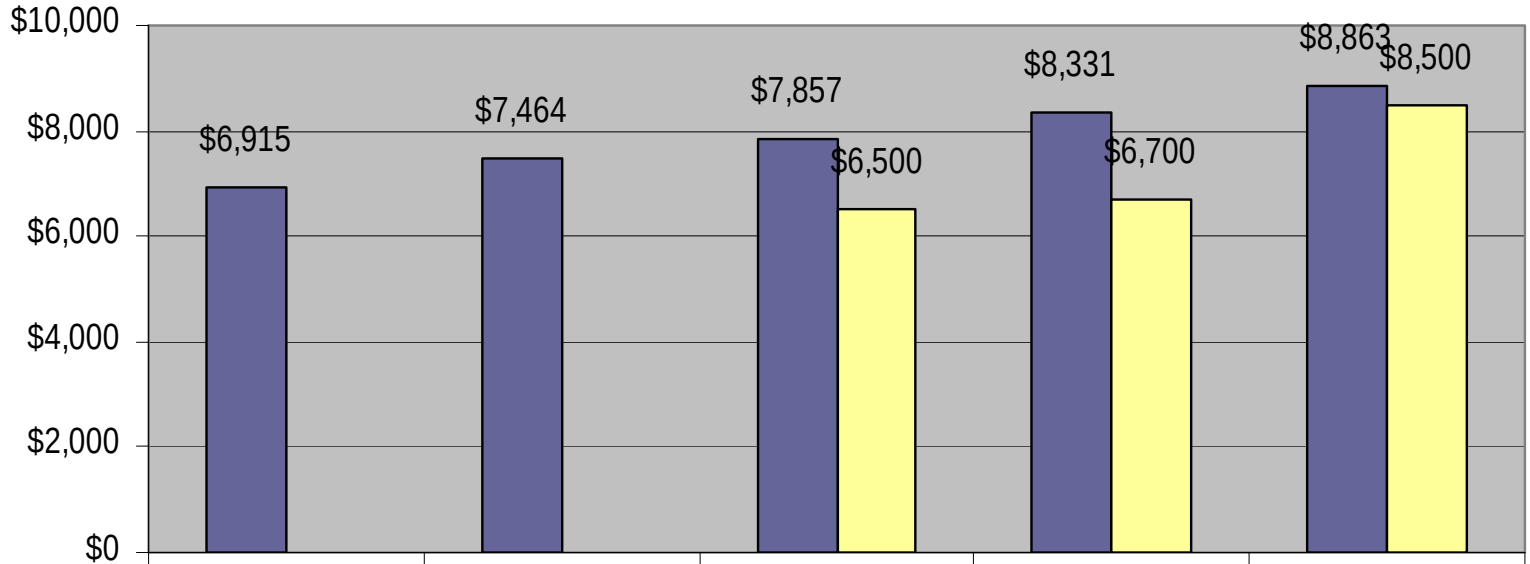
High Deductible Health Plan Enrollment

- Overall enrollment in HDHPs is still low, although higher enrollment is seen with smaller firms that tend to offer HDHP as a total replacement.
- UUA's HDHP enrollment is consistent with what we would expect when offered as a choice to a traditional plan (e.g., PPO).



Source: Kaiser Family Foundation and Health Research & Educational Trust, 2008

Annual Healthcare Costs per Employee



	2005	2006	2007	2008	2009*
National	$6,915	$7,464	$7,857	$8,331	$8,863
UUA			$6,500	$6,700	$8,500

*Projected. We note that UUA's projected 2009 costs are based upon projected required premium of $704.67 per employee per month as noted in Milliman's 10/15/08 letter, and that it includes 10% trend and 10% margin.

Data source for national PEPY cost: Hewitt Associates, 2008

Demographic Analysis

Demographic Analysis

Observations

- Currently, there are 750 enrolled employees with an average age of 48.2 years.
  - The small subset of 23 employees who have enrolled in Medicare coverage have an average age of 70.8 years.
- UUA has a predominantly female population with approximately 490 (68%) of enrolled employees being female, while the remaining 230 (32%) of enrolled employees are male.
- Sixty percent (60%) of enrolled employees have elected single coverage. Of those employees, 24% of them are over the age of 55.
- Employee contract type by region is consistent across all regions of the country with the following exceptions:
  - Seven percent (7%) of UUA employees carrying domestic partner coverage are located in the Western Region of the country.
  - The Midwest (16%) and Northeast (18%) contain the highest percentage of family contracts.

Demographic Analysis

Observations

- Overall, 33% of UUA subscribers are enrolled in the New England Region of the country. The next highest region is the South Atlantic region with 17% of UUA subscribers.
  - New England – *Maine, New Hampshire, Vermont, Massachusetts, Rhode Island, Connecticut*
  - Mid-Atlantic - *New York, Pennsylvania, New Jersey*
  - East North Central – *Wisconsin, Michigan, Illinois, Indiana, Ohio*
  - West North Central - *North Dakota, South Dakota, Nebraska, Kansas, Minnesota, Iowa, Missouri*
  - South Atlantic – *Delaware, Maryland, District of Columbia, Virginia, West Virginia, North Carolina, South Carolina, Georgia, Florida*
  - East South Central – *Kentucky, Tennessee, Mississippi, Alabama*
  - West South Central – *Oklahoma, Texas, Arkansas, Louisiana*
  - Mountain – *Idaho, Montana, Wyoming, Nevada, Utah, Colorado, Arizona, New Mexico*
  - Pacific – *Alaska, Washington, Oregon, California, Hawaii*
- The average UUA age by rating region is consistent; ranging from 46.8 years in the New England region to 50.8 years in the Pacific region.

Demographic Analysis

Key Demographics by Plan

	PPO	Medicare	Total
Employees	723	23	746
% of Total	*97%*	*3%*	*100%*
Percent Male	32.1%	39.1%	32.3%
vs. Total	*-1%*	*21%*	*0%*
Percent Female	67.9%	60.9%	67.7%
vs. Total	*0%*	*-10%*	*0%*
Average Age	47.5	70.8	48.2
vs. Total	*-1%*	*47%*	*0%*
Average Members/Contract	1.70	N/A	1.70

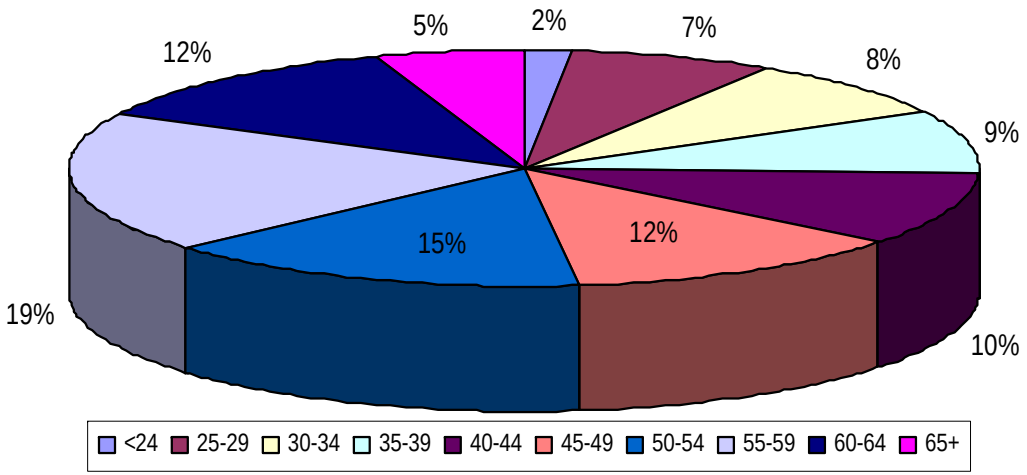
Demographic Analysis

Total Enrollment by Plan and Contract Type

	PPO		Medicare Plan	
	# of Employees	% of Total	# of Employees	% of Total
Employee Only	426	59%	18	78%
Employee + Domestic Partner	22	3%	0	0%
Employee + Spouse	98	14%	3	13%
Employee + Child	44	6%	0	0%
Employee + Children	22	3%	0	0%
Family	111	15%	2	9%
Total	723	100%	23	100%

Demographic Analysis

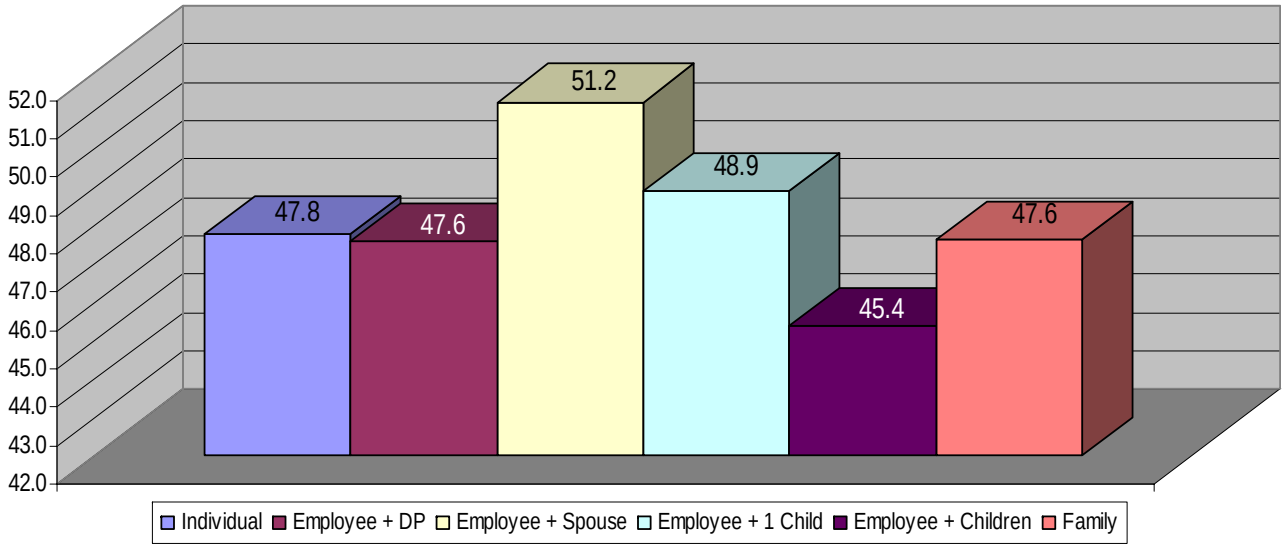
Employees by Age Band



	IND	TWO (EE + DP)	ESP (EE + Spouse)	E1D (EE + 1 Child)	ECH (EE + >1 Child)	FAM	Grand Total
<24	2%	0%	0%	0%	0%	0%	2%
25-29	7%	0%	0%	0%	0%	0%	7%
30-34	5%	0%	1%	0%	0%	1%	8%
35-39	4%	0%	1%	1%	0%	2%	9%
40-44	5%	0%	1%	1%	1%	3%	10%
45-49	6%	0%	2%	1%	0%	2%	12%
50-54	8%	1%	2%	1%	1%	3%	15%
55-59	10%	1%	3%	1%	0%	3%	19%
60-64	9%	0%	2%	0%	0%	0%	12%
65+	4%	0%	1%	0%	0%	0%	5%
Grand Total	60%	3%	14%	6%	3%	15%	100%

Demographic Analysis

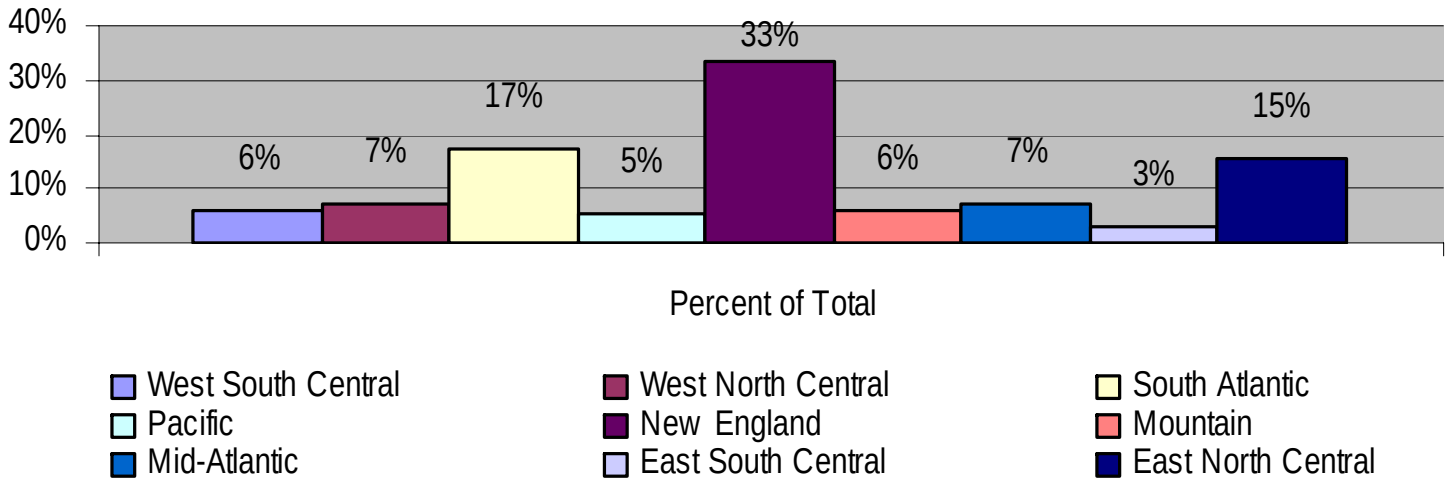
Average Employee Age by Gender and Contract Type



Average of age as of 01/2009	Gender		
Coverage Type	Male	Female	Grand Total
Individual	46.6	48.3	47.8
Employee + DP	49.3	46.8	47.6
Employee + Spouse	51.4	51.1	51.2
Employee + 1 Child	54.6	47.8	48.9
Employee + Children	47.5	45.1	45.4
Family	47.1	51.1	47.6
Grand Total	47.8	48.4	48.2

Demographic Analysis

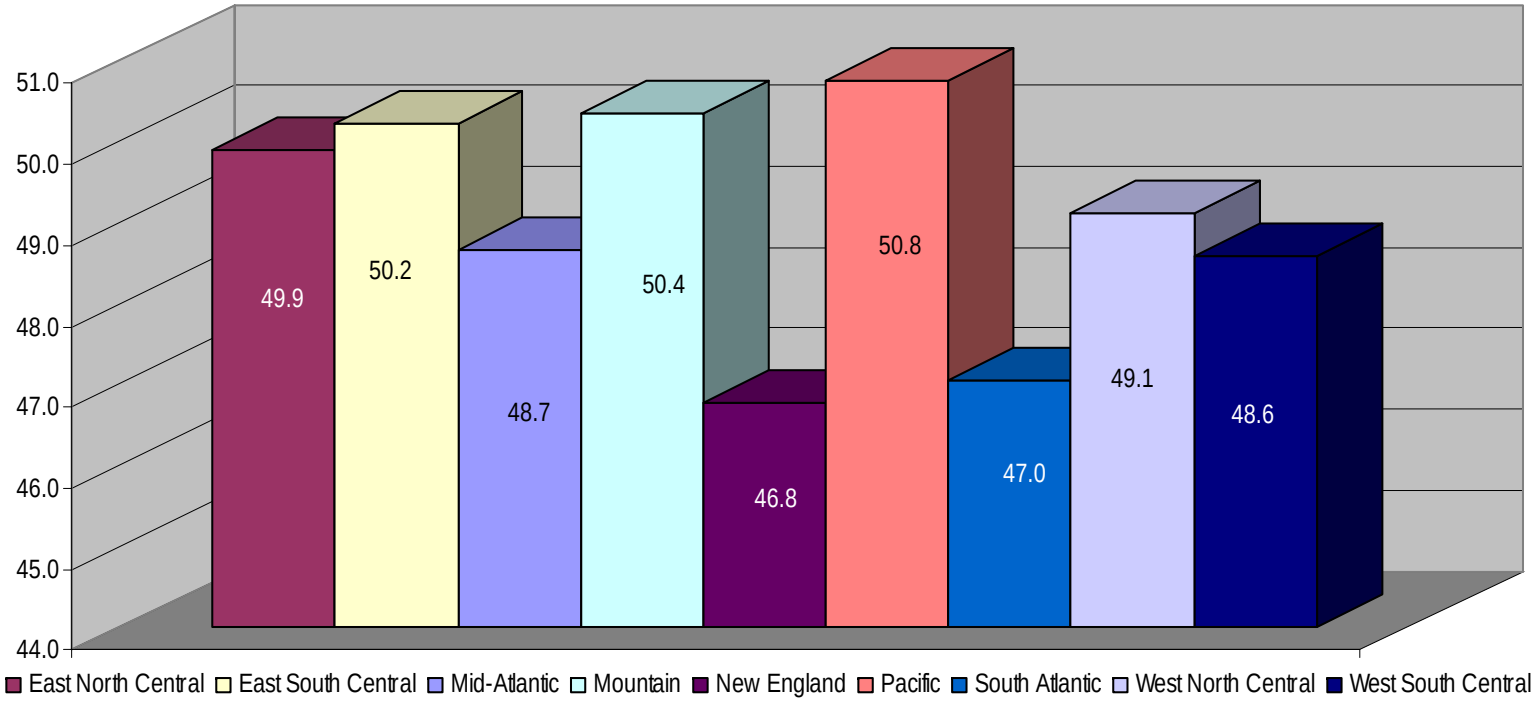
Employee Enrollment by US Census Bureau Division



Region	Percent of Total	Employees
West South Central	6%	43
West North Central	7%	53
South Atlantic	17%	130
Pacific	5%	38
New England	33%	248
Mountain	6%	44
Mid-Atlantic	7%	52
East South Central	3%	24
East North Central	15%	114
Total	100%	746

Demographic Analysis

Average Age By U.S. Census Bureau Division



Cost and Utilization Analysis

Cost and Utilization Analysis

Observations

- The percent of total claims in the $50K - $100K range increased from 10% in 2007 to 22% in 2008. The number of members within that category increased from 4 members in 2007 to 10 members in 2008.
  - The Highmark benchmark for large claims over $25,000 is 36% of total. There was a significant increase in both the number of large claims and the dollars associated with them for UUA. Large claims accounted for 37% of total claims in 2008 compared to 27% in 2007.
- Claims by place of service have remained consistent from 2007 to 2008.
- In 2008, 21% of inpatient admissions were associated with musculoskeletal, representing 45% of total inpatient claims. This was an increase over 2007, where musculoskeletal and connective tissue claims only accounted for 4.9% of total claims.
- Circulatory was the top inpatient diagnostic category in 2007. In 2008, UUA experienced a decrease in both the number of admissions and the average cost per admission.

Cost and Utilization Analysis

Observations

- UUA's inpatient hospital utilization statistics are significantly better than the Highmark book-of-business benchmarks.
  - In 2008, UUA had 56 admissions per 1,000 and 210 hospital days per 1,000 members, compared to the Highmark benchmarks of 76 and 365, respectively.
  - UUA's average length of stay (3.7 days) was also better than the Highmark benchmark of 4.8 days. However, this is up from 2.9 days in 2007.
  - UUA's payment per admission ($10,326) is significantly higher than Highmark's norm. This is likely due to the use of hospitals in higher-cost geographies.
- In UUA's outpatient statistics, medications as a percent of payments in 2008 increased to 12.3% from 3.5% in 2007. In addition, Therapeutic Radiology Services increased from 3.3% in 2007 to 8.6% in 2008.
- Beth Israel Deaconess was the most utilized facility by UUA members in 2008, based on total claims dollars ($196,000 or 12% of total facility claims).
  - Winchester Hospital (5%), The Nebraska Medical Center (4%), St. Elizabeth Medical Center (4%) and University Hospital (3%) round out the top five facilities utilized.

Cost and Utilization Analysis

Observations

- UUA's generic dispensing rate of 65% is lower than what we might expect given UUA's mandatory generic substitution. We do note that this is an increase over 2007 when the generic dispensing rate was 60%.
- UUA formulary utilization rate (brand formulary scripts divided by total brand scripts) has remained consistent year over year.
- The total cost per script per member for UUA increased 20% in 2008.
- The Central Nervous System therapeutic class accounts for 30% of total scripts and 31% of total prescription drug dollars. This same therapeutic class accounts for 5 of the top 10 scripts.
  - These prescriptions are used mostly to treat depression.

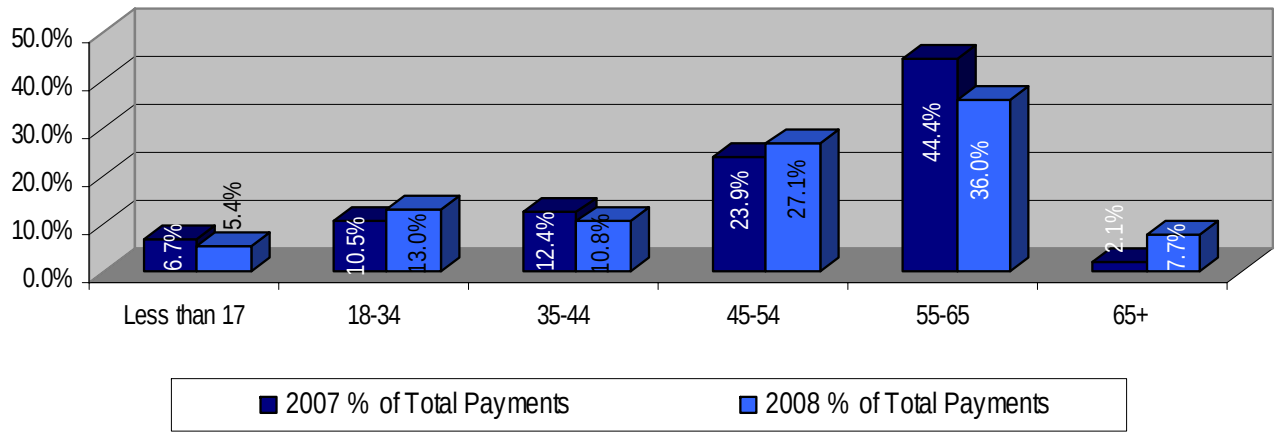
Cost and Utilization Analysis

Observations

- As stated earlier, it is not unusual to see change in year-over-year statistics for a group of UUA's size.
  - This change can be significant in certain categories where the number of members is low and/or when impacted by large claims.
- Highmark's reporting should be expanded to provide a better understanding of what conditions are driving overall medical costs.
  - We know that musculoskeletal and circulatory conditions are driving a high percentage of inpatient costs.
    - Musculoskeletal can be related to many conditions ranging from arthritis to obesity to "weekend warriors."
  - Prescription drug utilization is high with regard to anti-depressants and cholesterol lowering drugs.
    - This is consistent with almost every group health plan. UUA will want to work with Highmark to evaluate adherence in these and similar therapeutic groups to confirm that members are consistently taking their prescriptions.

Cost and Utilization Analysis

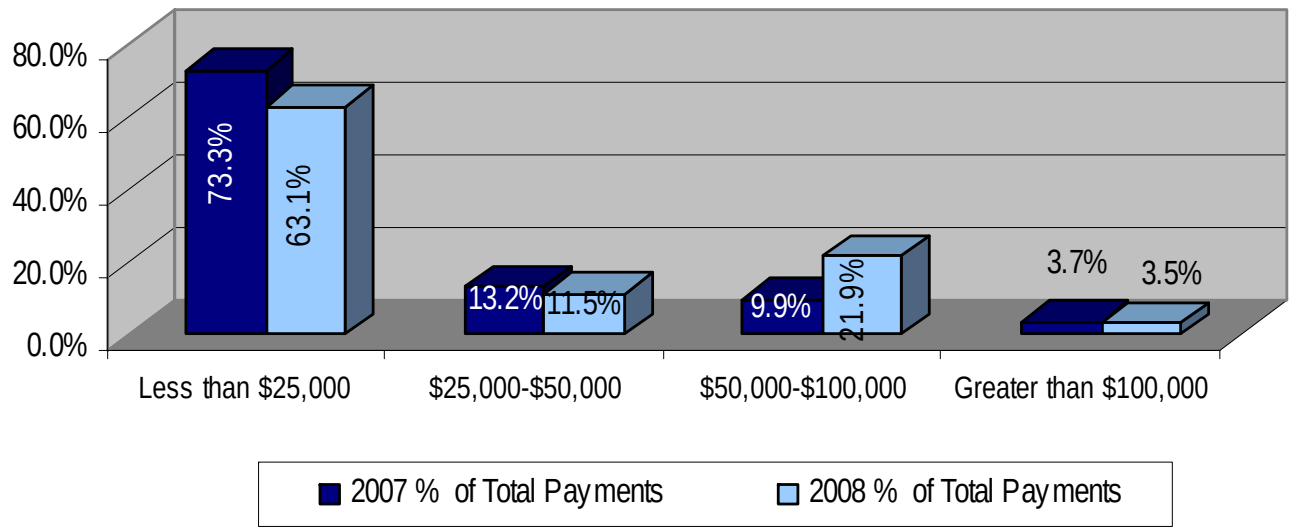
Claims Cost by Age Range



Age Band	2007 % of Total Payments	2008 % of Total Payments
Less than 17	6.7%	5.4%
18-34	10.5%	13.0%
35-44	12.4%	10.8%
45-54	23.9%	27.1%
55-65	44.4%	36.0%
65+	2.1%	7.7%
Total	100.0%	100.0%

Cost and Utilization Analysis

Claims Cost by Payment Range



Payment Range	2007 % of Total Payments	2008 % of Total Payments
Less than $25,000	73.3%	63.1%
$25,000-$50,000	13.2%	11.50%
$50,000-$100,000	9.9%	21.9%
Greater than $100,000	3.7%	3.5%
Total	100%	100%

Cost and Utilization Analysis

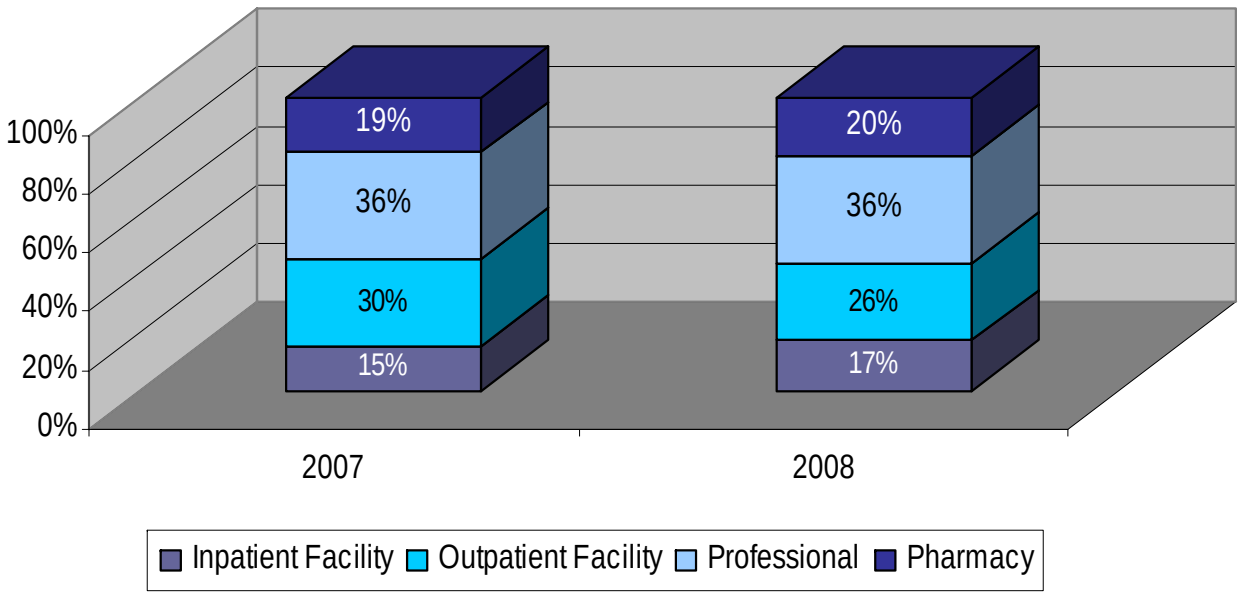
Large Claims over $25,000

	Number of Large Claims over $25K	Average Total Members	Claimants per 1,000 Lives	Large claim Dollars	Total Dollars	Percent Large Claims
2007	16	984	16.3	$803,936	$3,003,282	26.8%
2008	23	1,099	20.9	$1,381,240	$3,740,864	36.9%

2008 incurred claims paid through January 2009

Cost and Utilization Analysis

Claims by Place of Service



Cost and Utilization Analysis

Inpatient Hospital Utilization Statistics

	2007	2008	Highmark Benchmark
Payment per Admission	$9,033	$10,326	$8,919
Admissions per 1,000	52	56	76
Days per 1,000	152	210	365
Average Length of Stay	2.92	3.73	4.8

2008 incurred claims paid through January 2009

Cost and Utilization Analysis

Outpatient Utilization Statistics

	Services per 1,000	Payment per Member	% of Payments in '08	% of Payments in '07
Medications	307	$106.67	12.3%	3.5%
Operating Room Services	102	$79.36	9.1%	13.1%
Therapeutic Radiology Svc	136	$74.57	8.6%	3.3%
Laboratory Service	2,864	$71.64	8.2%	8.4%
Supplies	204	$60.96	7.0%	8.5%
Body Cat Scan	61	$40.88	4.7%	3.6%
Emergency Room	214	$32.48	3.7%	4.3%
Surgical Care	59	$31.13	3.6%	3.7%
Imaging Services	199	$29.51	3.4%	2.1%
Medical Therapy Service	38	$27.27	3.1%	2.6%

2008 incurred claims paid through January 2009

Cost and Utilization Analysis

Top 10 Facilities Ranked by Payment (Inpatient and Outpatient Combined)

	Total			
Rank	Provider Name	Admits	Total Paid	% of Total
1	Beth Israel Deaconess Medical Center	4	$196,264	12.1%
2	Winchester Hospital	0	$80,846	5.0%
3	The Nebraska Medical Center	2	$64,458	4.0%
4	St. Elizabeth Medical Center	1	$61,400	3.8%
5	University Hospital	0	$55,432	3.4%
6	Johns Hopkins Hospital	2	$54,506	3.4%
7	Lahey Clinic Hospital	2	$48,431	3.0%
8	Univ Hosp HSC Syracuse	0	$42,329	2.6%
9	York Hospital	1	$42,140	2.6%
10	Columbia St. Mary Hospital	0	$36,920	2.3%
Total Top 10 Facilities			$682,726	42.0%
Grand Total			$1,625,146	100%

2008 incurred claims paid through January 2009

Cost and Utilization Analysis

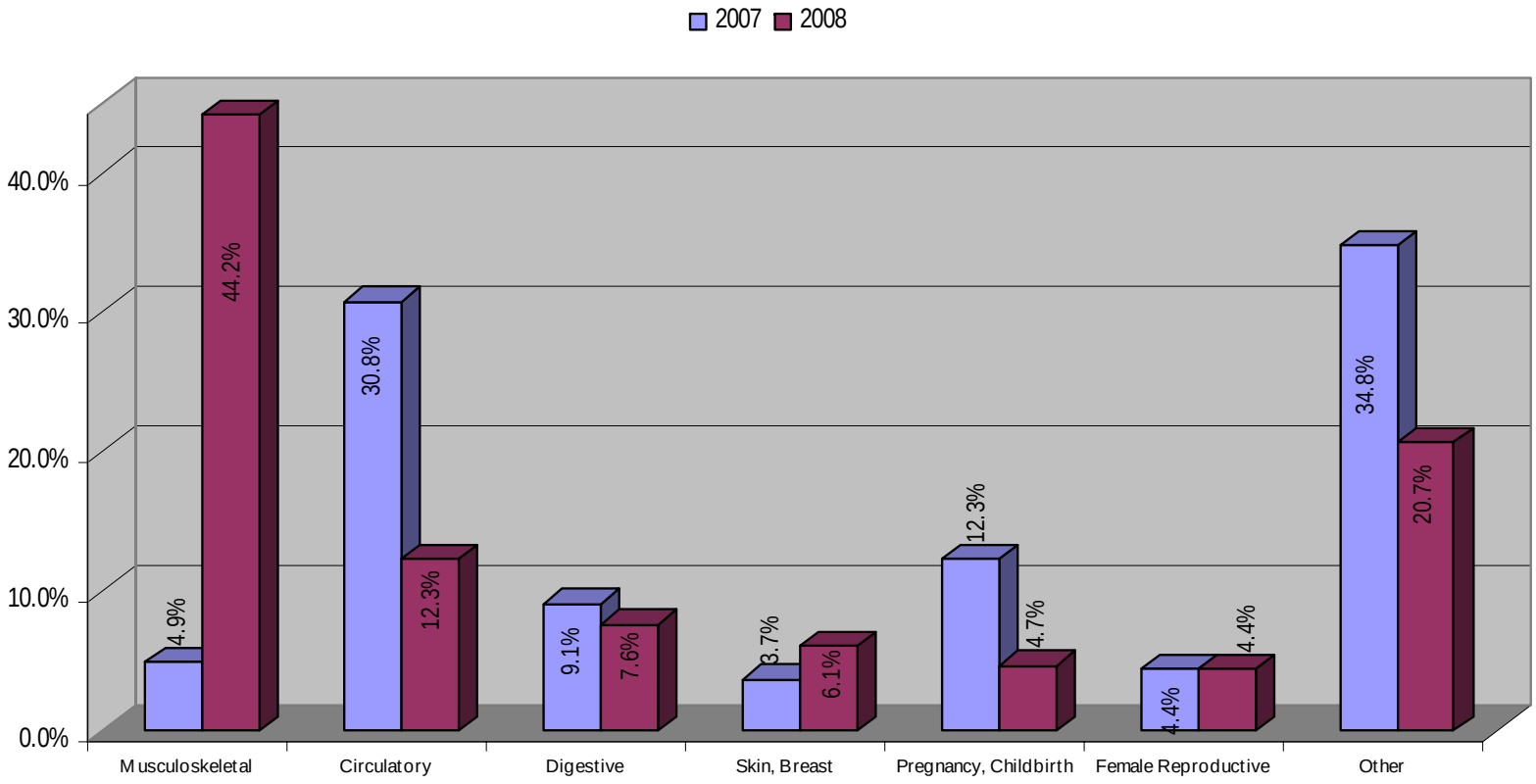
Top 15 Major Diagnostic Categories - Inpatient

Top 15 MDCs	Number of Admits	Percent of Total	Number of Days	Admits/1000	ALOS	Total Payments	Percent of Total Payments	Cost/Admit
Musculoskeletal	13	21%	70	12	5.4	$287,630	44.8%	$22,000
Circulatory	7	11%	12	6	1.7	$79,879	12.4%	$11,000
Digestive	8	13%	29	7	3.6	$49,741	7.7%	$6,000
Skin, Breast	3	5%	17	3	5.7	$39,732	6.2%	$13,000
Female Reproductive	6	10%	14	5	2.3	$30,562	4.8%	$5,000
Pregnancy, Childbirth	6	10%	17	5	2.8	$28,342	4.4%	$5,000
Other	1	2%	3	1	3.0	$19,147	3.0%	$19,000
Chemotherapy & Leukemia	1	2%	1	1	1.0	$18,534	2.9%	$19,000
Infections	2	3%	6	2	3.0	$18,032	2.8%	$9,000
Respiratory	3	5%	8	3	2.7	$17,222	2.7%	$6,000
Mental	2	3%	14	2	7.0	$15,936	2.5%	$8,000
Metabolic	1	2%	2	1	2.0	$10,422	1.6%	$10,000
Liver, Pancreas	2	3%	4	2	2.0	$9,947	1.5%	$5,000
Newborns	4	7%	15	4	3.8	$8,556	1.3%	$2,000
Alcohol/Drug Use	2	3%	21	2	10.5	$7,982	1.2%	$4,000
Grand Total	61	100%	233	56	3.8	$642,000	100%	$11,000

2008 incurred claims paid through January 2009

Cost and Utilization Analysis

Major Diagnostic Categories - Inpatient



2008 incurred claims paid through January 2009

Cost and Utilization Analysis

Prescription Drug - Utilization Summary

	CY 2007	CY 2008	% Difference ('08 vs. '07)
Retail Scripts Per Member			
Generic	6.7	7.6	13%
Brand (Generic Available)	0.30	0.26	-13%
Brand	4.1	3.6	-11%
Total Retail Scripts	11.0	11.4	4%
Mail Order Scripts Per Member			
Generic	0.4	0.4	-7%
Brand (Generic Available)	0.0	0.0	0%
Brand	0.4	0.4	-8%
Total Mail Scripts	0.8	0.8	-6%
TOTAL Scripts Per Member			
Generic	7.1	8.0	12%
Brand (Generic Available)	0.3	0.3	-10%
Brand	4.4	4.0	-11%
TOTAL Scripts	11.8	12.2	3%
Generic Dispensing Rate	60%	65%	9%
Mail Order Utilization Rate	7%	6%	-9%

2008 incurred claims paid through January 2009

Cost and Utilization Analysis

Prescription Drug - Cost Summary (Per Member Per Year)

	CY 2007	CY 2008	% Difference ('08 vs. '07)
Retail Cost Per Member			
Generic	$98	$120	22%
Brand (Generic Available)	$6	$11	76%
Brand	$353	$431	22%
Total Retail Cost	$457	$561	23%
Mail Order Cost Per Member			
Generic	$22	$21	-6%
Brand (Generic Available)	$0	$3	100%
Brand	$91	$99	9%
Total Mail Order	$113	$122	8%
TOTAL Cost Per Member			
Generic	$121	$141	17%
Brand Formulary	$6	$14	120%
Brand Non-Formulary	$443	$529	19%
GRAND TOTAL	$570	$683	20%

2008 incurred claims paid through January 2009

Cost and Utilization Analysis

Prescription Drug - Top Therapeutic Classes (Ranked by 2008 Payments)

Rank	Therapeutic Group	# of Scripts	% Total Scripts	Dollars	% Total Dollars	$/Script
1	Central Nervous System	3,970	29.6%	$234,381	31.2%	$59
2	Hormones & Synthetic Subst	2,261	16.9%	$88,758	11.8%	$39
3	Cardiovascular Agents	2,313	17.3%	$76,686	10.2%	$33
4	Antineoplastic Agents	158	1.2%	$68,987	9.2%	$437
5	Anti-Infective Agents	1,036	7.7%	$58,437	7.8%	$56
6	Gastrointestinal Drugs	509	3.8%	$44,898	6.0%	$88
7	Autonomic Drugs	508	3.8%	$36,121	4.8%	$71
8	Skin & Mucous Membrane	451	3.4%	$22,772	3.0%	$50
9	Blood Form/Coagul Agents	175	1.3%	$22,292	3.0%	$127
10	Immunosuppressants	18	0.1%	$17,073	2.3%	$948
Total		11,399	85.1%	$670,403	89.3%	$59
All Other		1,996	14.9%	$80,677	10.7%	$40
Grand Total		13,395	100.0%	$751,079	100.0%	$56

2008 incurred claims paid through January 2009

Cost and Utilization Analysis

Prescription Drug - Top Drugs (Ranked by Number of Scripts)

Rank	Drug Name	Description	# of Scripts	% Total Scripts	Dollars	% Total Dollars	$/Script
1	Levothyroxine Sodium	Hormones & Synthetic Subst	390	2.9%	$17	0.0%	$0
2	Lipitor	Cardiovascular Agents	278	2.1%	$25,294	3.4%	$91
3	Simvastatin	Cardiovascular Agents	254	1.9%	$1,873	0.2%	$7
4	Lisinopril	Cardiovascular Agents	252	1.9%	$41	0.0%	$0
5	Lexapro	Central Nervous System	227	1.7%	$16,597	2.2%	$73
6	Sertraline Hydrochloride	Central Nervous System	219	1.6%	$4,319	0.6%	$20
7	Apap/Hydrocodone Bitartrate	Central Nervous System	190	1.4%	$58	0.0%	$0
8	Atenolol	Cardiovascular Agents	187	1.4%	$0	0.0%	$0
9	Fluoxetine HCL	Central Nervous System	186	1.4%	$1,831	0.2%	$10
10	Zolpidem Tartrate	Central Nervous System	176	1.3%	$2,381	0.3%	$14
Total			2,359	17.6%	$52,411	7.0%	$22
Grand Total			13,395	100.0%	$751,079	100.0%	$56

2008 incurred claims paid through January 2009

Cost and Utilization Analysis

Prescription Drug - Top Drugs (Ranked by Total Dollars)

Rank	Drug Name	Therapeutic Group	# of Scripts	% Total Scripts	Dollars	% Total Dollars	$/Script
1	Lipitor	Cardiovascular Agents	278	2.1%	$25,294	3.4%	$91
2	Topamax	Central Nervous System	53	0.4%	$22,880	3.0%	$432
3	Pegasys	Antineoplastic Agents	11	0.1%	$19,190	2.6%	$1,745
4	EffexorR-XR	Central Nervous System	133	1.0%	$18,827	2.5%	$142
5	Humira	Immunosuppressants	12	0.1%	$16,804	2.2%	$1,400
6	Valtrex	Anti-Infective Agents	73	0.5%	$16,679	2.2%	$228
7	Lexapro	Central Nervous System	227	1.7%	$16,597	2.2%	$73
8	Atripla	Anti-Infective Agents	12	0.1%	$16,508	2.2%	$1,376
9	Zolinza	Antineoplastic Agents	2	0.0%	$16,192	2.2%	$8,096
10	Singulair	Unclassified Agents	131	1.0%	$13,395	1.8%	$102
Total			932	7.0%	$182,367	24.3%	$196
Grand Total			13,395	100.0%	$751,079	100.0%	$56

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