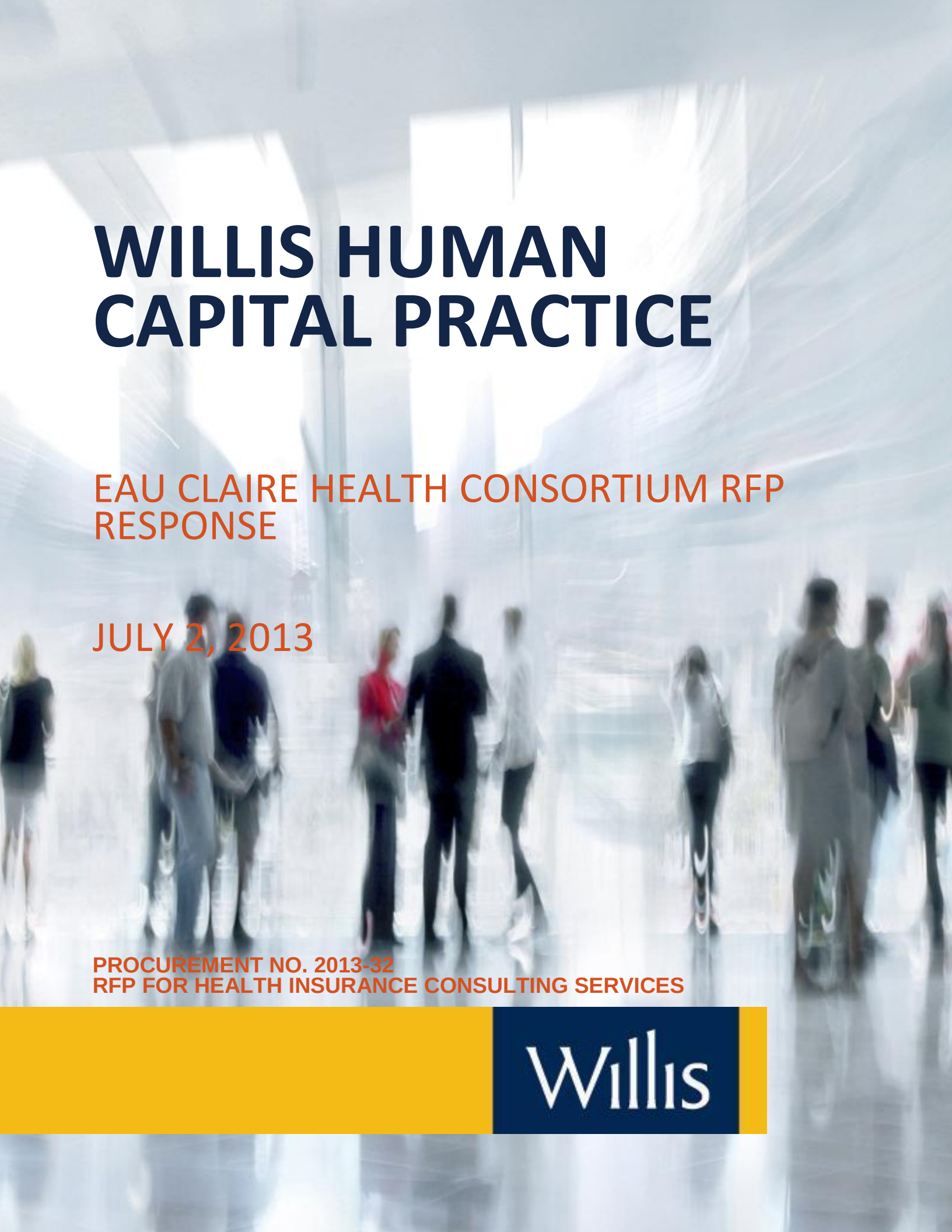

WILLIS HUMAN CAPITAL PRACTICE

EAU CLAIRE HEALTH CONSORTIUM RFP RESPONSE

JULY 2, 2013

PROCUREMENT NO. 2013-32
RFP FOR HEALTH INSURANCE CONSULTING SERVICES

Willis

WILLIS HUMAN CAPITAL PRACTICE

Eau Claire Health Consortium RFP Response

Your Willis *Public Sector Practice* team is pleased to provide this response to your request for proposal. These are interesting times for public sector employers across the state of Wisconsin. Amidst challenging budgets, declining state aid and the complexities of Healthcare Reform – employers are tasked with coming up with unique solutions.

Willis has assembled the finest suite of resources and the most professional and talented team of public sector expertise to help the Eau Claire Joint Commission accomplish these daunting tasks. If we are awarded your business, we will rapidly deploy these resources in a manner that is sure to meet the needs of this newly formed consortium.

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* Price Proposal is on a separate document.

Background Information

1. Briefly describe your firm's background, history and ownership structure including any parent, affiliated or subsidiary company or partnerships.

Willis is one of the world's leading risk management and insurance intermediaries. Our Firm has evolved by building our advisory and transactional capabilities into a worldwide, knowledge-based professional services organization. Our **"one team"** approach and our **Client Advocate model** combined with the usage of the latest technology are what our clients say "make us different". We are able to draw upon the talents and information found in any Willis office worldwide to consistently deliver the expertise, products, and services our clients require and expect of a premier broker/consultant.

Willis North America is wholly owned by Willis Group Holdings, we are a public company and listed on the New York Stock Exchange under the symbol WSH.

The Eau Claire Health Consortium will have full access to the *Willis Public Sector Practice Group* team. The *Willis Public Sector Practice Group* is a dedicated team of individuals that work together to bring the most comprehensive set of municipal benefit resources available. This group has been successful in facilitating positive change, controlling costs and implementing wellness programs in cities, counties and school districts throughout the State of Wisconsin. In total, Willis of Wisconsin has a working relationship with more than 100 public sector employers between Employee Benefits, Property & Casualty, Actuarial and Workers Compensation consulting.

Perhaps one of the primary differences our clients indicate they appreciate is the blended team approach Willis brings to the table. Our **"Team Approach"** enables us to provide a level of varying perspectives when working on the unique objectives identified by each of our Districts. Our team is committed to delivering a high-touch level of service that our Public Sector Clients expect and deserve. The team approach allows us to better accommodate the varied meeting requirements including attendance at both board and/or insurance committee meetings throughout the State. Our teams experience and track record of achieving positive results, anchored on our ability to build trust with both management and union groups has been the primary reason for our expansion and growth in this area.

Please Reference Exhibit 1 - Select Willis Clients.

2. Briefly describe the services your firm provides.

The first step in our consulting process would be to get an understanding of:

- What has been happening historically within each of the entities that make up the Consortium.
- What is the current state of each consortium participant (i.e. budget constraints, culture, contracts that may still be in place, etc.)
- What are some upcoming goals and objectives.

From there we would provide observations and recommendations to the consortium. We would also create a custom service plan that is designed to meet the unique needs, goals and objectives of each group within the Consortium and the Consortium as a whole. This custom service plan would include discussion and analysis on important topics such as feasibility of the consortium, direct contracting, health care reform consulting, on-site clinics, and expense reduction opportunities.

Please Reference Exhibit 2 - Willis Scope of Services for a listing of services.

3. **Describe the sources of revenue your firm receives and the percentage of revenue derived from all sources.**

Willis of Wisconsin, Inc.

		Percentage of Total Revenue
Employee Benefits	$21,641,914	60.15%
Employee Benefits - Small Business Unit	881,548	2.45%
Commerical Lines (P&C)	11,805,732	32.81%
Commerical Lines (P&C) - Small Business Unit	577,898	1.61%
Workers Comp. Third Party Administration	617,422	1.72%
Total 2012 Brokerage and Fees	**$35,524,514**	
Bonus commission	$350,312	0.97%
Investment Income	104,192	0.29%
Total 2012 Revenue	**$35,979,018**	

4. **Provide the addresses of your corporate office and the office(s) which will be providing services to this project.**

Corporate Headquarters
Willis North America
One World Financial Centre
200 Liberty Street
7th Floor
New York, NY 10281

Midwest Regional Headquarters
Willis
Willis Tower
233 South Wacker Drive
Suite 2000
Chicago, IL 60606

Wisconsin Operation Headquarters and Primary Service Location
Willis of Wisconsin, Inc.
400 North Executive Drive
Suite 300
Brookfield, WI 53005

5. Indicate the number of clients, employees and members for whom you provide or provided multi-employer benefit plan consulting services.

Now more than ever, employers are exploring the merits of buying groups and collaborative purchasing. Willis consultants across the country work with clients that collaborate to purchase insurance. Willis has hundreds of clients that partner together in this fashion, and thousands of employees who benefit. Members of the consultant team assigned to the Eau Claire Consortium have hands-on experience in advising multi-employer groups and collaborative partners.

Deciding to work and collaborate together for the purposes of insurance is a big step. If you really want to work together then you have got to give up some autonomy. Decisions become more difficult to make with varying parties. The passage of Act 10 does make it easier for municipal collaboration. There are opportunities for savings and leveraging the size of all three entities, but if you don't "Act like a group" the savings becomes less meaningful. The consortium and each of the entities have to ask themselves "Is achieving a certain level of savings worth partnering?"

6. Provide examples of your success in assisting clients in the formation of collaborative health care purchasing and negotiating healthcare costs for clients.

Milwaukee Municipal Collaboration

Willis works with Milwaukee County, the City of Milwaukee, Milwaukee Public Schools, and the Milwaukee County Transit System. These entities have not formed an official consortium or coalition, but they have taken initial steps towards collaborative purchasing. These entities felt it was important to agree and select one advisor for direction. All of these entities have selected Willis to serve in this capacity. A civic goal for all these taxing bodies is to act and function more in concert with each other. They face similar problems as any group; very different circumstances, issues, and often conflicting optimal solutions. The leadership position that we have established in each of the groups individually, have now put us in a better position to effectively lead this collaborative effort.

Collier County Health Care Consortium

The Collier County Health Care Consortium (CCHCC) is comprised of the following major Collier County employers.

- Collier County Government
- Collier County Sheriffs Department
- District School Board of Collier County
- NCH Healthcare System, Inc.

This group is committed to better understand the factors that drive health care costs and pursue a partnership with select local providers. Through this partnership the CCHCC employers wish to foster the creation of a process and strategy to ensure efficient delivery of health care that is appropriate provides optimal patient outcomes and supports prudent expenditures of financial resources. The CCHCC employers have approximately 11,100 employees covered under various medical plan options. When spouses and children are included with employees, the total number of covered lives is in excess of 22,100.

The CCHCC functions as a true consortium has had outstanding results in "bending their trend". They have experienced a 17% reduction in cost **($6.5 million)** in their first year of collaboration.

Employers Health Cooperative of Janesville

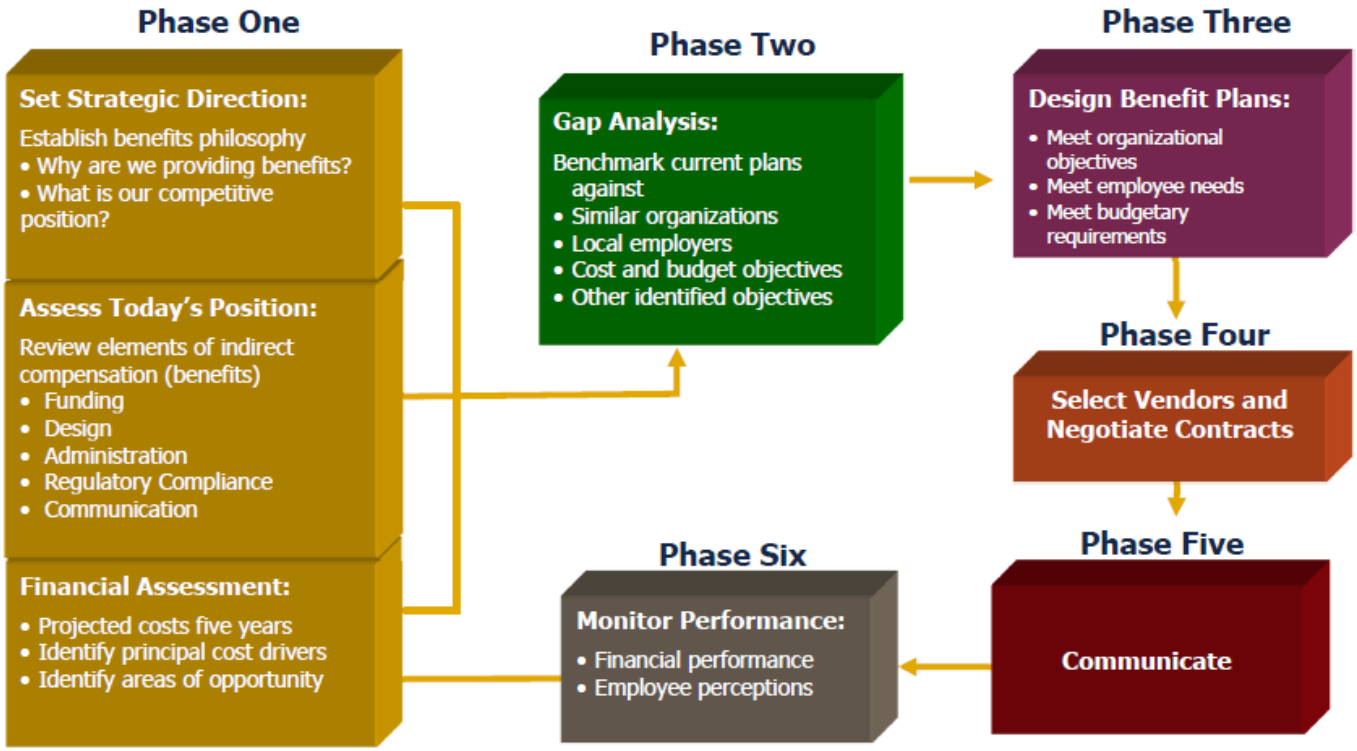
This cooperative was led by the City of Janesville and involved six additional major employers near Janesville. When the cooperative was initially formed all of the organizations had different TPA's. One of the first tasks that Willis assisted the cooperative with is conducting a Request For Proposal for TPA Services and Stop-Loss insurance. They ended up choosing a TPA, but did not pursue utilizing the same stop-loss carriers as there was no financial incentive to do so. Because every employer in the cooperative utilized the same TPA Willis was able to negotiate deeper discounts with Dean Health Systems. These discounts were able to be negotiated because the health system had to work with one payer instead of seven.

7. Does your organization have any financial or other interest in any service you are recommending or subcontracting with?

None.

8. Describe your philosophy of consulting principles and practices. Indicate how your firm maintains its status as an independent benefits consultant.

Our service philosophy begins with a discovery process, followed by strategic planning, and finishes with a stewardship report. We start each year formulating both a long-term strategy and developing a short-term action plan to accomplish annual District goals. Each year we revisit and update our strategy and action plan.



Willis works for you as our client, and we bring insurance companies to the table for your consideration.

Willis maintains its independence as an unbiased insurance consulting partner. One of the ways we accomplish this is through the *Willis Excellence Model*. WEM is our internal compliance process that ensures:

- Quality
- Full disclosure of all compensation
- Independent and accurate depiction of what potential insurance partners are offering

We pride ourselves in maintaining some of the strongest relationships with our carrier partners. These relationships play a key role in advocating for our clients. Because of our national presence and generating a very high volume of business with the key public sector markets, we are able to leverage this in attaining best price and best service model.

Specific Information in regards to this project

9. Provide an organizational chart or listing that includes names of all management personnel who will be assigned to this account. Include biographies.

Management Contacts

Willis is committed to providing an exception experience to the Eau Claire Health Consortium. Part of this commitment includes access to our senior leadership in an effort to maintain the highest level of accountability.

Dale A. Thoma
President and Managing Partner, Willis of Wisconsin, Inc.
Phone - 262.780.3476
Email – Dale.Thoma@Willis.com

In this capacity Dale has overall responsibility for the growth, profitability and staff in Wisconsin. Dale is actively involved in client retention, insurance company relationships, business development along with the ongoing recruitment and retention of staff. In addition, Dale represents the firm's interests in various local, state and national initiatives.

Dale joined the firm in 1999 as Executive Vice President and has held numerous positions leading up to his current role which he assumed in October, 2008. Prior to joining the firm, Dale was Director of Large Group Sales for Humana in their Milwaukee office. In addition, his prior experience includes working with Wausau Insurance Companies along with two major Hospital Systems in the development of their managed care subsidiaries. Collectively, he has over 25 years of experience in the insurance industry.

Dale has a BBA and a MBA, with an emphasis in marketing, from the University of Wisconsin, Eau Claire. He is past President of the Greater Milwaukee Employee Benefits Council and prior Board Member of the Wisconsin Association of Health Underwriters. In addition Dale has served on the Advisory Council for numerous insurance companies including Anthem, Principal and United Healthcare.

Lester Morales
Chief Growth Officer, Willis National Human Capital Practice

Role: Advocate Partner

Phone – 704.376.9161
Email – Lester.Morales@Willis.com

Lester re-joined Willis in September 2012 as an Executive Vice President and Chief Growth Officer for the North American Human Capital Practice. In this role Lester will focus on assisting the field offices with key customers and offering subject matter support in the area of on-site clinics. Another main focus for Lester, will be to work closely with the Regional Growth Teams to ensure local delivery of our "Beyond Benefits" value proposition.

This is a homecoming for Lester as he was a part of the Willis family for 7 years. During this time he was a Top 5 Consultant within the Human Capital Practice and was a consistent qualifier for the Exceptional Producers Council. His track record as an extremely talented and successful sales professional, combined with his business acumen and deep understanding of the Human Capital and health management sector, makes him uniquely qualified to lead our overall growth efforts and drive transformational growth within the North American HCP operation.

In May of 2011 Lester joined Healthstat, a leading provider of on-site primary care, high health risk intervention and disease management services, as the National Vice President of Sales. At Healthstat, he and his team maintain a relentless pursuit of finding dynamic solutions in order to help employers better the health of their employee population while reducing cost and giving their employees a wonderful employee benefit.

Lester is a graduate of The Florida State University with a Bachelor's of Science in Risk Management and Insurance. He speaks frequently at industry events about on-site clinics, self-funding, wellness, pharmacy carve-outs and other cost mitigation initiatives In his career Lester has received several industry and community accolades; Tampa Bay Business Journal's "30 under 30," Tampa Bay Times "Rising Stars," Business Buddies "Best in Business- Young Professional of the Year Nomination" .

Client Advocate Team
The Eau Claire Health Consortium Client Advocate Team is responsible for the strategy development, program logistics, day to day service and overall satisfaction of the insured members. The team has specific expertise in working with public sector employers.

Ryan L. Barbieri
Sr. Vice President, Willis of Wisconsin, Inc.
Member of the Willis Public Sector Practice Group

Role: Lead Consultant

Phone – 262.780.3251
Email – Ryan.Barbieri@Willis.com

Ryan Barbieri works in our employee benefits group assisting customers with insurance programs that best suit their needs including, fully insured, self-funded and consulting arrangements. As a member of the *Willis Public Sector Practice Group*, Ryan has demonstrated his ability to successfully work with school districts, counties and other areas of municipal benefit consulting. A hallmark of his practice is working with public sector employers on unique solutions that meet the needs of various stakeholders throughout an organization.

Ryan earned his BBA-Marketing and Management from Wisconsin Lutheran College located in Milwaukee, WI. Prior to joining Willis, he was with Wells Fargo (formerly Strong Capital Management) where he served as a Financial Advisor assisting with retirement plan arrangements for small businesses. Ryan is an active member of the community serving on various boards and through volunteer involvement.

Daniel J. Pecanac
Benefits Consultant, Willis of Wisconsin, Inc.
Member of the Willis Public Sector Practice Group

Role: Co-Consultant

Phone – 262.780.3398
Email – Daniel.Pecanac@Willis.com

Dan Pecanac works in our employee benefits group assisting customers with insurance programs that best suit their needs including, fully insured, self-funded and consulting arrangements. Dan is a member of the *Willis Public Sector Practice Group* and brings a unique understanding of how Wisconsin municipalities and school districts function.

Dan earned his BBS-Marketing from the University of Wisconsin-Milwaukee. Prior to joining Willis Dan worked in the financial services industry for over 13 years. He spent five years working in Public Finance where he assisted Wisconsin Municipalities and School Districts with the following:

- Financing and Refinancing of Projects
- Budget and Tax Impact Projections
- Referendum Services
- Cash-Flow Borrowing
- Liability Management and Projections

Dan's "hands on" experience working with the Public Sector gives him a detailed understanding of the ongoing challenges that municipalities and school districts are faced with.

John Dawson, FSA, MAAA
Sr. Vice President & Actuary, Willis of Wisconsin, Inc.
Member of the Willis Public Sector Practice Group

Role: Actuarial Consultant

Phone – 262.780.3270
Email – John.Dawson@Willis.com

John's professional experience spans more than two decades guiding employers, health care providers, insurance carriers, insurance regulators, and various governmental bodies on issues relating to insurance, risk management, and human resources. He joined the Willis team as an employee benefits leader more than 14 years ago.

He applies his experience helping employers in manage the cost, value, and risks associated with self insured benefit plans, with special emphasis on addressing issues relating to benefit design, funding, administration, employee communication, and regulatory compliance.

John has participated in evaluating provider reimbursement agreements, including discounted fee for service, per diems, and provider capitation. He has assisted in evaluating, establishing and managing direct contract arrangements between employers and health care providers, and negotiating ongoing terms of operation.

In addition to providing actuarial services to employer clients, John helps employers pursue strategic benefit planning to maintain benefit programs that are consistent with and supportive of corporate objectives. This activity includes working with middle and senior management to identify relevant corporate objectives, evaluate benefit plan performance against those objectives, identifying opportunities for improvement, developing action plans, managing execution, and monitoring results.

John holds a degree in Applied Mathematics with emphasis on business administration and computer applications from the University of Wisconsin-Stout.

Fellow of the Society of Actuaries and a Member of the American Academy of Actuaries.

Gail Michels
Sr. Client Manager, Willis of Wisconsin, Inc.

Role: Client Manager

Phone – 262.780.3352
Email – Gail.Michels@Willis.com

Gail joined Willis in the summer of 2006 as a Client Manager. She provides day to day employee benefit account management for our large employer groups.

Gail has developed an extensive background in client relations and account retention; building strong long lasting relationships have been an integral part of her career. Prior to joining Willis, Gail had an impressive background with Wells Fargo Advisory Services (formerly Strong Capital Management) where she served as a Financial Advisor assisting with investment needs as well as retirement plan arrangements.

Please Reference Exhibit 3 - Organizational Chart for the Willis Team.

10. Describe how you will staff the Eau Claire Health Consortium account. Clearly indicate how your organization will be prepared to accommodate the addition of this project to your client portfolio.

Above you will find the team of people directly responsible for the overall results and satisfaction of the stakeholders associated with the Consortium. However, a project of this scope with the complexities involved in addressing the *healthcare trend* and *net unit cost* of the program requires a team of talented people. **We do not believe that simply coming together for the sole purpose of buying insurance is going to accomplish your long term objectives.** You consulting team of Ryan, Dan, John and Gail are well positioned to draw from the local and national expertise found with Willis. Willis has made a significant investment in subject matter experts to ensure

you receive the most value and optimal results. The impact of having a deep team of subject matter experts is twofold:

1) Your Willis consultant team is able to spend more time driving the primary strategy for long term cost containment through a collaborative effort in Eau Claire; and
2) Operating within their area of expertise, this team can create efficiencies in the benefit administration process making City, County and School personnel more productive.

In addition to the Client Advocate team listed above, the following resources will be deployed for the Eau Claire Health Consortium:

Luke W. Allenson
Director of Data Analytics Team & Underwriting Consultant

Location: Wisconsin
Role: Provides Underwriting support

Phone – 262.780.3125
Email - Luke.Allenson@Willis.com

Luke and his team provides underwriting and risk analysis for Willis , which includes review of benefit utilizations, establishing premium equivalent rates as well as analyzing contribution and plan design strategies. Additionally he interfaces with carriers and vendors to maintain awareness of changing products and pricing strategies in the marketplace.

Prior to joining our firm, Luke served as an Underwriter at Coventry Healthcare and UPMC Health Plan both located in Pittsburgh, Pennsylvania. Luke holds a Bachelors degree in Risk Management Insurance from Gannon University.

Rebecca B. Lawrence, J.D.
Assistant Vice President

Location: Missouri
Role: Regional Employee Benefits Attorney – Willis National Legal Resource Group

Phone – 314.854.0270
Email – Rebecca.Lawrence@Willis.com

Rebecca Knoll Lawrence is an Employee Benefits Attorney in the National Legal & Research Group, North America and has been with the company since 1998. Her areas of expertise include the Health Insurance Portability and Accountability Act of 1996 (HIPAA), COBRA, Health Care Reform, cafeteria plans, life insurance plans, Qualified Medical Child Support Orders, Medicare Secondary Payer, ERISA, subrogation, Plan Document and SPD preparation and compliance, and acquisition and divestiture concerns from the health and welfare perspective. Rebecca is a co-author of the Willis Online Compliance Manual, a regularly updated reference on employee welfare benefits and related legal issues, for Willis and its clients. Rebecca has also created a number of Willis Employer Guides on various compliance topics. She is also a frequent contributor to Willis publications including HR Focus and Alerts.

Prior to joining Willis, Rebecca headed up the health & welfare compliance department at Columbia/HCA Healthcare Corporation and worked closely with division, market, and local facility contacts on a wide variety of

compliance issues. Her projects included re-drafting of plan documents for all national benefits offered by Columbia/HCA; contract negotiation of a national managed vision program; development of an internal process to track, investigate, and approve purported Qualified Medical Child Support Orders; and review of deal documents related to employee benefits in all facility acquisitions and divestitures. She has in-depth experience with plan administration from the very large-employer perspective.

Rebecca is a frequent webcast presenter for NLRG, covering topics such as ERISA Problem-Solving; COBRA: The Developing Law; Cafeteria Plan Construction; HIPAA Privacy compliance; Welfare Benefit Plan Issues; Qualified Medical Child Support Orders; Mergers and Acquisitions: A Closer Look; and Healthcare Reform. In additional, Rebecca served on the American Benefits Council taskforce in Washington, DC that met with the Treasury Department and developed a list of employer concerns that the taskforce asked the Department to consider when it issued HRA guidance.

Rebecca holds a J.D. from Washington & Lee University School of Law in Lexington, Virginia, and a B.A. in History with a minor in English from Southern Adventist University, summa cum laude.

Heidi A. Guetzkow
Sr. Health Outcomes Consultant

Location: Minnesota
Role: Regional wellness consultant – responsible for wellness strategy development

Phone - 763.302.7150
Email – Heidi.Guetzkow@Willis.com

Heidi Guetzkow joined the Human Capital Practice for Willis North America in September, 2012 and serves as a consultant for the Health Outcomes Practice in the Midwest Region, based out of the Minneapolis office.

Heidi provides consultative services to internal clients in the area of worksite wellness strategy design, implementation and evaluation. She provides guidance regarding incentive program design as it pertains to employee benefits and benefit plans. She assists clients with data analysis, business planning, vendor selection and helps with internal professional development in areas related to worksite wellness.

Prior to joining the Willis team, she worked in a similar role with a regional insurance brokerage company serving clients throughout the Midwest. She began her professional career as a recreation therapist in a physical rehabilitation setting. Heidi has over 15 years of wellness and health promotion experience in both the public and private sector.

Heidi is passionate about providing health and wellness resources to employers to assist in improving the health and well-being of their employees as well as creating a health culture at the worksites.

Heidi has a Bachelor of Science Degree in Recreation Therapy from Mankato State University. She has also received Faculty status by the Wellness Council of America (WELCOA).

Heidi currently serves as a community board member of the Ridgedale YMCA. She also serves on the Advisory Board for Hennepin County's Health@Work program and the Healthy Communities Task Force with the American Heart Association.

Melissa Snyder
Sr. Human Resources Consultant

Location: Illinois
Role: Regional HR consultant – provide support in the area of HR

Phone – 312.288.7142
Email – Melissa.Snyder@Willis.com

Melissa is a Senior Human Resources Consultant for the Willis Human Capital Practice. She has over 15 years of experience effectively leading the development and execution of human resource strategies, programs and systems in a range of industries, and also has expertise in business process outsourcing, benefits administration, and system implementations.

Prior to joining Willis, Melissa worked as an HR consultant, responsible for helping clients improve business results through the delivery of HR process transformation, strategy, change management, and technology leveraging services.

As a Management Consultant, Melissa played a key role in establishing a new HR Technology services group within Towers Perrin (now Towers Watson). She also was responsible for helping larger U.S. employers achieve administrative, economic, and strategic advantage through various outsourcing initiatives for Hewitt Associates (now Aon Hewitt).

Melissa has also served as Director of Human Resources at a non-profit organization where she drove the vision, thought leadership, and strategic initiatives for human resources. Melissa has a Master's degree with highest distinction in Business Administration (MBA) from Northwestern University's Kellogg Graduate School of Management and a Bachelor's degree in Finance from Indiana University.

Melissa has earned her designation as a Senior Professional in Human Resources and is currently pursuing the Certified Employee Benefits Specialist (CEBS) and Certified Compensation Professional (CCP) designations. She is a member of the Society for Human Resources Management.

Holly Flontek
Sr. Communications Consultant

Location: Illinois
Role: Regional Communications consultant – provide support in developing a consortium brand and campaign

Phone – 312.288.7396
Email – Holly.Flontek@Willis.com

Holly is the Senior Communications Consultant supporting Willis' Midwest region for the Human Capital Practice. Holly joined Willis after serving as a communications manager for a pharmacy benefit services provider for a number of years.

Holly has more than 10 years of communication experience in employee benefits, health care and financial services for a variety of small to mid-size companies. She specializes in developing innovative, customized and straight-forward communication solutions that drive awareness and action. Holly has managed corporate

branding, website and social media projects. She has experience in corporate, consulting and agency environments across a variety of industries. Earlier in her career, Holly worked in HR and benefits for a major health care system and a British outsourcing and technology consultancy.

Holly earned a B.S.B.A with an HR concentration from the University of Florida, and an M.S. in Health Sciences from the University of Central Florida. She completed her Group Benefits Associate (GBA) certification from the CEBS program in 2011.

11. Indicate how your office location and or any travel enhance or detract from your services for this project.

As a local insurance consultant with resources of a national organization, we are well positioned to meet your needs. Willis of Wisconsin manages employer relationships all across the state and across the country.

12. A description of the services you plan to provide.

The Willis Public Sector Practice Group has developed a Team of problem solvers, strategic planners, and expert negotiators. We accomplish our results by the skillful application of consulting resources, including: strategic planning, compliance, actuarial, health delivery, cost containment, and communications. We combine consulting expertise with local execution.

Our services include:

- Consultation on the overall design and funding of the health and welfare and voluntary benefit programs
- Monitoring of, and negotiations with, current and prospective insurance carriers and service vendors
- Modeling budget projections and employee contributions
- Ongoing monitoring of claims activity
- Ongoing vendor relationship support and monitoring of customer service standards
- Review of legal documents such as administrative agreements and summary plan descriptions
- Guidance on federal and state compliance issues, including consulting on Healthcare Reform

Please Reference Exhibit 2 - Willis Scope of Services for a listing of services.

Our goal is to provide the very best in technical and financial analysis combined with a strategic perspective and knowledge of best practices and emerging trends. However, our consulting role requires us to understand your company's current environment and future needs and ensure that all advice is both practical and appropriate.

Strategic Planning

In the development of a long-term benefits strategy, no detail is unimportant. Therefore, our initial focus includes a thorough review of all health and welfare benefit programs. Based on this review, we provide targeted recommendations pertaining to the appropriateness of plan design, funding and current strategy. Our review provides the platform for the collaborative development of a comprehensive benefits strategy.

Critical to this process is the performance of a Total Benefit Review, which allows Willis and our clients to fully understand all contractual and benefit provisions currently in place. The results of the review are of strategic value in determining the advisability of continued relationships with vendors based upon purchasing strategies,

vendor relationships and purchasing opportunities. Further, the review is useful in determining the administrative competence of each vendor and their commitment to the client. This review also provides background information and data necessary to evaluate and measure the effectiveness of plan design in determining strategy and ensuring the success of each program.

On-Going Consulting and Day to Day Program Management

As day-to-day benefit plan management issues arise, Willis is available to all of the members of our client's benefits staff, working as an adjunct. Our efforts focus on such areas as budgeting and finance issues, interpretation of plan documents and contract language, federal and state compliance issues, and the resolution of complex or sensitive claims issues. Our recommendations are grounded by financial analysis and full consideration of your organization's objectives and administrative realities.

Program Renewal Analysis: On behalf of our clients, Willis initiates and directs renewal negotiations with each plan administrator far in advance of the renewal date. Our high level of renewal activity makes us keenly aware of industry trends. We rely heavily on previously negotiated cost components and a variety of renewal formulas. Our experience and aggressive renewal posture continuously yields non-recourse savings to our clients.

Contract/Document Analysis: We work with clients and their various plan administrators to determine inadequate or missing documentation for all plans. Willis coordinates and reviews all group contracts, plan documents, certificates and booklets. We routinely identify areas where contractual language disproportionately favors the carrier/vendor, and have had success in negotiating more equitable terms on behalf of our clients. In addition, we carefully review "right to audit" language to ensure that our clients can thoroughly monitor the performance of their administrators.

Regulatory Compliance Services: Federal and State regulation of the employee benefits field has created a complex web of rules to which plan administrators must comply. Willis assists our clients by providing information on current regulations as needed, and by keeping our clients up-to-date on new legislation, landmark court cases, and other important regulatory developments.

Health Care Analysis: Evaluating health care networks can be complex and challenging, involving many variables that impact an employee's health care experience. Drawing employees into the healthcare process as "consumers" is a rapidly evolving trend that is transforming the healthcare marketplace. Our focus is to assist our clients in defining and implementing the approach best suited to achieving their objectives.

An important step throughout the plan year is to monitor plan performance to goals. We will track and measure operational results, clinical outcomes, financial controls, claim/member services, and best practices/quality of services among other key areas. Some of the measurements will come from external sources, although most can be obtained from your data. Additionally, to ensure the vendors are providing the highest levels of customer service, we propose surveying the employee population.

We can provide support for these surveys through multiple channels including formal surveys (paper or web-based), focus groups and other forms of feedback. When a survey is used, we can then consolidate the survey responses and compare them against the service levels agreed upon during implementation to gauge if the negotiated objectives have been met or exceeded.

The outcome measurements from the program's financial analysis will provide evidence against baseline trends, costs, outcomes and other indicators to compare improvements. Our project outcomes will have a targeted effect that can be measured and adjusted as needed. We will provide reports on a monthly, quarterly and/or

annual basis. These reports will assist us in monitoring the plans performance and highlighting any areas that need to be reviewed in future years. The level of detail included in each of these reports varies depending on the amount of claims experience agreed upon during the marketing process but may include the following reports:

Monthly Reports
Claims analysis
Budget performance analysis
Inflationary trend information

Quarterly Reports
Financial overview
Claim utilization
Claim trend analysis
Reserve analysis
Stop-loss deductible and attachment point tracking

Midterm Reports
Budget projections
Rate promulgations
Reserve adjustment analysis
Actuarial opinions

Year End Reports
Full financial overview
Reserve calculation with actuarial opinion provided
Cost comparisons (historical and industry wide)
Budget and rate update and review
Deficit/surplus analysis

Health Care Analysis

There are hundreds of managed care organizations operating in the United States. The list of organizations changes constantly. Medical care delivery, resources and provider practice patterns vary widely by region of the country, and even within each state, resulting in numerous types of provider contracts and approaches to managed care.

Our managed care evaluation resources are among the best in the industry. Our consultants have access to several in-house data resources. Also, our managed health plan database resources measure the performance of national and regional healthcare vendors. Utilizing these data tools, our collective experiences and additional market information, Willis assists its clients in developing cost effective, high quality health care purchasing strategies.

Financial Services/Claims Review

Proactive program decisions can only be made when fully informed of the program's current and projected financial performance. Willis monitors and tracks costs associated with each plan administrator on a monthly basis. We provide a monthly review of claim data and charged expenses measuring the performance of the plans throughout the plan year. Our review of claim data allows us to track and assess utilization patterns as well as significant claim occurrences and outcomes. To assist our clients in the task of forecasting benefit budget levels, Willis performs quarterly claim reviews that provide the basis for renewal projections. Discussions regarding financial performance begin well before the renewal and continue throughout the renewal negotiations. At the completion of each policy period, we prepare a year-end financial summary report encompassing design, utilization, performance guarantee metrics and the associated financial aspects of the program. In addition, this year-end report focuses on strategic issues relative to plan design and funding which may be considered during subsequent renewal negotiations.

WillisMed

The Consortium would be provided access to an additional analytical tool. WillisMed incorporates eligibility, medical, and pharmacy data feeds from carriers/TPAs to create a data warehouse with the ability to drill down to individual plan member detail on a de-identified basis. The tool has embedded predictive modeling capabilities based on an employer's specific demographics and health conditions of the plan membership. WillisMed allows

for the aggregation of members (cohorts) with similar characteristics or disease states. Cohorts become a powerful tool in gauging the effectiveness of wellness initiatives by clearly tracking and illustrating the cohort improvement in several areas including cost, hospital admissions, and ER visits.

Please Reference Exhibits 5 & 6 – Willis Med Sample Report & Summary Output, and Sample Dashboard Report.

Request for Proposal (RFP)

We will work jointly with you to identify potential markets that serve your needs and assist you with analyzing carrier networks for adequate physicians and hospitals in the areas where your employees live. Vendors will also be selected for their quality of service, available funding options, level of claim detail they will provide and their willingness to implement performance guarantees. Your Willis team will formulate an RFP based around: your objectives and performance expectations, current census, experience, plan design data and a questionnaire addressing each vendor's capabilities in multiple areas. This RFP will help you make informed choices about the carriers and vendors interested in servicing your benefits.

The quality of the RFP is an essential aspect of any competitive bidding since it is the primary source of information about each plan. The primary purpose of the RFP is to create a competitive environment and describe "risk" (if any) as clearly and accurately as possible. A quality RFP will clearly delineate and rank the critical objectives of the marketing effort. In our experience, a quality RFP increases the likelihood of receiving a broad range of competitive bids from qualified carriers who fully understand the program requirements and expectations.

Proposal Analysis and Carrier Selection

We ensure that the carrier selection process is performed at a level that meets the professional standards of our clients. To this end, Willis works closely with our clients to develop criteria upon which proposals are evaluated. We perform our analysis of each proposal based upon criteria developed in conjunction with our client.

The result of this comprehensive process is an extensive written report which provides background on the project, describes the process used in analyzing proposals, and applies client-specific evaluative criteria to each of the proposals submitted. We are also available to present our findings in person to members of the client's management team. Such a meeting may include a discussion outline supporting our verbal comments and serving as a supplement to the written report.

Coordinating carrier finalist interviews is a standard part of our involvement in the marketing efforts. We are present at as many interviews as deemed necessary by the client and participate as much or as little as desired. Regardless of our level of interaction with each finalist during the review, we prepare an agenda and questions designed to differentiate one finalist from another by highlighting proposal features, inconsistencies, and peculiarities. We are also available to help prepare for, and if appropriate, attend any internal client meetings as support in making final recommendations.

Plan Transition and Implementation

If a client chooses to work with a new carrier, it is imperative that commitments made during the proposal process be kept during the transition period. We routinely participate in implementation meetings with our client

and the selected carriers/vendors. We draft a comprehensive "Confirmation of Proposal" document which outlines the proposal and all subsequent commitments made by the carriers/vendors as understood by Willis and the client. We recommend that carriers/vendors be required to sign off on this "Confirmation of Proposal." This technique documents expectations, minimizes unresolved issues and becomes the basis of the contract which is the final guiding document.

Program Renewal Analysis

Upon completion of the renewal negotiations, we provide a thorough renewal analysis report focusing on the financial impact of the renewal to the client, contribution strategies, specific recommendations for contract renewal, and appropriate alternatives. If the terms of a renewal are anticipated in advance to be unacceptable to our client, a competitive marketing will be initiated to secure an alternative cost effective benefit solution.

Actuarial Services

Our actuarial resources enable us to assist you with the development of reserves for incurred but unpaid benefits for all self-insured plans, and actuarial certification of reserves for a VEBA trust, Calculation of COBRA and "working" rates for self-insured medical, dental and vision plans.

The primary role of our actuarial group for The Consortium is the analysis of collaborative buying opportunities and evaluation of what potential impact cost containment strategies will have on the net unit cost of claims for each of the participants. This becomes more complex when giving consideration to wellness programs and on-site / near-site clinic opportunities.

Employee Communications Review

Willis' employee communication process will run concurrently to the carrier implementation process. The Willis Employee Benefit Communication practice is a team of communication specialists who assist Willis clients with all their communication needs. Working jointly with your Willis benefits team, you will have the expertise and resources to design strategies and materials to effectively communicate your programs, throughout the plan year. Willis offers a full range of communication products from traditional print-based products (folders, handbooks, posters, etc.), to multi-media web-based communication products (video employee communication, enrollment and administration). Each product is uniquely designed with you in mind and carries your brand, logo and company colors.

Please Reference Exhibit 7 – Communication Examples.

As you can see, the Willis Consultative Process is very thorough and provides a formal structure to help us monitor your programs. It is quite likely that we would be in various stages of the process when providing guidance on more than one of your programs. Willis consultants routinely work with organizations on multiple plans with various challenges. The Willis Consultative Process lays the foundation from which we build short and long term strategies to help you better manage your costs.

13. Provide a time-frame of these services and describe how you can assure the implementation process is timely and as "seamless" as possible.

The timeframe for our services are driven by the goals and objectives of the consortium. At the on-set of the relationship with the consortium your Willis service team would create a custom client service plan. This client service plan would include strategy discussions that involve the Collaboration Opportunities listed on pages 36-45 of the shared services report.

Please Reference Exhibit 4 - Willis Sample Client Service Plan.

14. Identify any services you are unable to perform under this RFP.

The Willis team can provide all services that the Consortium is seeking in the targeted timeframes mentioned in both your proposal document and shared services report.

Exhibit 1

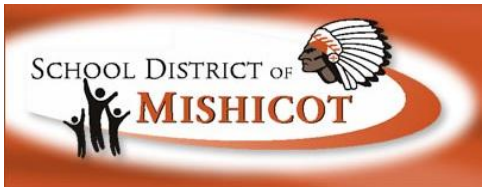
Select Willis Public Sector Clients

Select Willis Clients

MILWAUKEE PUBLIC SCHOOLS

WEST BEND JOINT SCHOOL DISTRICT #1

MUSKEGO NORWAY SCHOOLS



Select Willis Clients

City of Milwaukee

West Allis
WISCONSIN

CITY OF BROOKFIELD

City of Waukesha

JANESVILLE
Wisconsin's Park Place

CITY OF PEWAUKEE
The City in the Country

Willis

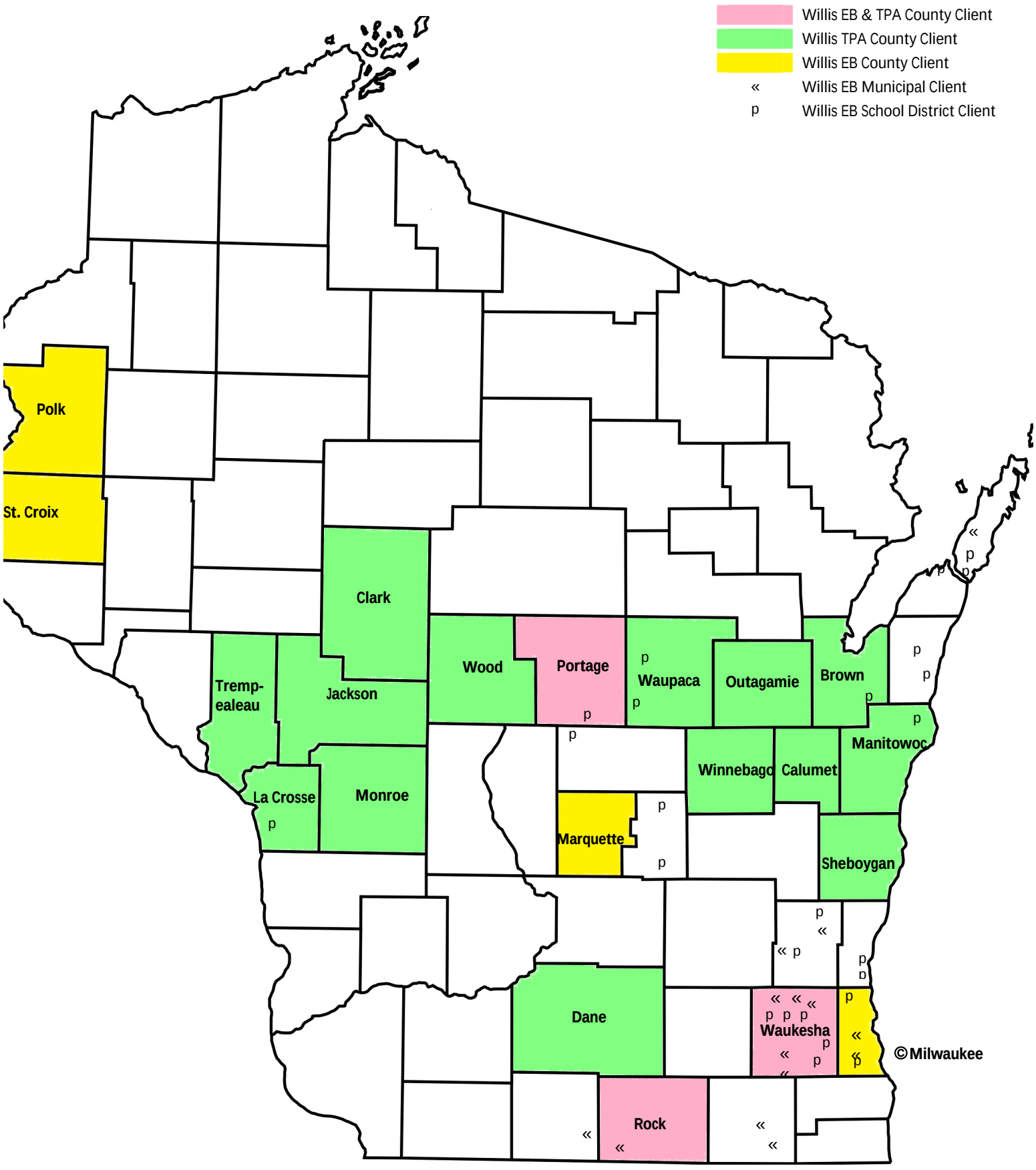

Willis EB & TPA County Client
Willis TPA County Client
Willis EB County Client
« Willis EB Municipal Client
p Willis EB School District Client
Polk
St. Croix
Clark
Tremp-
ealeau
Jackson
Wood
Portage
Waupaca
Outagamie
Brown
Manitowoc
La Crosse
Monroe
Winnebago
Calumet
Marquette
Sheboygan
Dane
Waukesha
Rock
©Milwaukee

Exhibit 2

Willis Scope of Services

Willis

SCOPE OF SERVICES

STRATEGY DEVELOPMENT	PROPOSED FEES
ANALYSIS ■ Conduct and develop long-term strategy plan and listening sessions to confirm all parties understanding of the major benefit objectives and how these impact district ■ Evaluate district market position in conjunction with the annual strategic planning, as tools are appropriate. May include the following: – Periodic review of employee demographics – Assist in the development of an employee survey, conduct survey and provide an executive summary detailing results – Discuss and deploy relevant **benchmarking data** ■ Discuss effectiveness of current communication strategy for business objectives, wellness programs, benefits education / enrollment and any culture change initiatives	**Included in Fee**
DEFINE OBJECTIVES ■ Provide recommendations for establishing and prioritizing health and welfare plan objectives based on district goals ■ Communicate opportunities to assist with branding the district ■ Provide recommendations for enhanced efficiency and effectiveness related to district's employee benefit programs ■ Propose communication alternatives that align with district objectives, culture and employee communication styles	**Included in Fee**
ORGANIZE FOR ACTION AND EXECUTE ■ Develop Client Service Plan to reflect agreed projects, to include assigned accountabilities and timeframes ■ Assemble appropriate local and national resources for projects identified ■ Determine communication standards amongst team members and structures for fulfilling on project timelines	**Included in Fee**

CORE BROKERAGE / CONSULTING	PROPOSED FEES
ACCOUNT MANAGEMENT ■ Facilitate productive direct relationships with all carriers/vendors by establishing regularly scheduled forums to help ensure carrier and vendor accountability in resolving issues with you promptly ■ Establish and assist you in monitoring carrier/vendor service and performance standards to the extent requested ■ Assist in the smooth resolution of elevated service issues ■ Act as an employee/employer advocate in the resolution of escalated claims issues ■ Identify and monitor potential catastrophic claims and work with case management to understand possible impact of large claims on plan performance ■ Maintain Willis customized client portals that include Willis deliverables and content tools.	**Included in Fee**
FINANCIAL ANALYSIS AND DATA ANALYTICS ■ Provide Dashboard Reporting on a scheduled basis (provided that experience reporting is available from carrier / vendor) to include: – Paid claims by month and plan – Actual vs. Projected – Summary of large claims activity – Preliminary renewal projections ■ Assess current funding arrangements for appropriateness and make recommendations as needed ■ Evaluate structure and performance of stop loss coverage and recommend alternatives as appropriate ■ Provide Decision Master Warehouse reporting, which includes actionable plan utilization data against normative data to support decisions around plan design changes, wellness initiatives, and communication strategies	**Included in Fee**

RENEWAL AND UNDERWRITING SERVICES ■ Conduct pre-renewal strategy discussion to determine specific goals, budget and needs to be achieved out of renewal negotiations ■ Review vendor renewal methodology, experience data, and assumptions against trend analysis for accuracy and logic ■ Perform renewal trend analysis from available diagnostic and normative data ■ Help negotiate renewals with vendors based on underwriting norms, trend analysis, and market leverage ■ Develop and present alternative plan options with associated financial and member impact analysis, as necessary to meet business objectives ■ Finalize benefit program design, rates, and fees (our work is administrative in nature and you retain full and final decision-making authority and discretion with respect to all plan issues) Provide up to **six (6)** versions of contribution modeling (employee/employer) based on enrollment and financial targets	**Included in Fee**
PLACEMENT ■ Market plan coverages as determined during the pre-renewal strategy discussion ■ Provide recommendations on vendors best suited to meet plan goals and objectives (you make all decisions with respect to which vendors to retain) ■ Evaluate carrier client support services and financial strength ratings ■ Provide comparison of plan features and costs ■ Assist in the scheduling of selected finalist site visits ■ Assist in the development of carrier/vendor performance guarantees with monetary penalties as appropriate ■ Assist you in negotiating with carriers / vendors ■ Provide notification to all bidders as to the final outcome ■ Review current electronic data transfer processes with vendors as appropriate	**Included in Fee**
ANNUAL ENROLLMENT ■ Assist in planning employee meetings, round tables, and health seminars and facilitate vendor / carrier participation ■ Create a communication strategy ■ Introduce technology solutions for communications and enrollment, such as text messaging and self-running audio/visual presentations, as appropriate ■ Coordinate vendor-sponsored communication material, as appropriate ■ Facilitate local enrollment meetings or webcast enrollment meetings ■ Design and implement customized benefits communication portal ■ Provide the trainer sessions for conducting annual enrollment meetings and self-running audio-visual presentations can be used in lieu of additional meetings	**Included in Fee**

REGULATORY AND COMPLIANCE - NLRG	PROPOSED FEE
Your client service team will have direct access to Willis' NLRG team. NLRG is a group of employee benefit experts that is comprised of specialized benefits attorneys and paraprofessionals with prior experience advising employers in the areas of ERISA, the Internal Revenue Code, and other laws affecting employee benefit plans and their application to employer plans, including HIPAA, COBRA, FMLA, FLSA, PHSA, etc. Services include: ■ Consulting Advice ■ Regulatory and Compliance Updates via Publications - News Flashes, Alerts, Newsletters ■ Comprehensive Online Compliance Manual with editable forms ■ Expert speakers for webcast trainings, local seminars / training and industry conferences ■ Please note that Willis is not a law firm and cannot provide you with any legal advice. NLRG is comprised of individuals with specialized employee benefits experience, including several licensed attorneys and several paraprofessionals; however, they are not acting as your attorneys. They do provide your client service team with up-to-date information and research on employee benefits matters. If you desire legal advice, or if your specific situation requires it, you should consult with attorneys of your own choosing.	**Included in Fee**
Compliance Excellence Review: After completing a web-based questionnaire with over 100 questions, across 4 sections, we generate a comprehensive report, with applicable solutions and resources for change. Areas covered include: ERISA, Cafeteria Plans, Group Health Plan Mandates and COBRA	**Included in Fee**
Coordinate Plan and SPD Review	**Included in Fee**
Provide signature ready Form 5500's (including DFVC filings) and Summary Annual Reports (where appropriate)	**Included in Fee**
HUMAN RESOURCES CONSULTING - HR PARTNER	PROPOSED FEE
HR Partner Consultants develop and maintain tools that add value beyond benefits, and keep you aligned with HR best practice and trends. These included our: ■ **HR Excellence Review**: After completing a web-based questionnaire covering 11 areas of HR responsibility, we generate a comprehensive report, with applicable solutions and resources for change. Areas covered include: Strategic HR Initiatives, Recruitment and Selection Practices, Workplaces Practices and Administration, Recordkeeping Practices, Family Medical Leave Compliance and Administration, Employee Engagement and Total Rewards Strategy, Performance Management Procedures, Career Development Initiatives, Training Programs and Practices, Compensation Administration and Employee Terminations Procedures ■ **Employer Guides and Tools:** Comprehensive guides that highlight best	Guidance and access to best in class samples, tools and resources **Included in Fee**

practices, recommendations, benchmarking, and step-by-step guidance. Includes supplemental tools for program development, implementation and evaluation. ■ **Market Ready Reports**: Our Market Ready Reports are compiled using 17 reputable survey sources and summarize market base pay and total cash compensation at the 25th, 50th, and 75th percentiles for over 500 intermediate-level benchmark jobs. These core deliverables cover essential HR related issues including, Compensation, Performance Management, Employee Engagement, Total Rewards, Paid and Unpaid Time Off, FMLA, and Training and Development.	
SEARCH WILLIS: Provides the advice and answers you need to complete your human resources tasks faster and easier, with 24/7 access to Search Willis, where you will find: ■ State and Federal Employment legal information. ■ State HR Law Comparison Chart. ■ Hundreds of time saving HR tools, such as checklists, forms, letters, calculators, etc. ■ An extensive library of pre-written, ready-to-use documents which can be customized by you to create HR policies and handbooks in minutes. ■ Job Description Manager, were you will find more than 2,400 pre-written job descriptions. ■ Everything you need to conduct employee or manager training on important workplace topics. Training toolkits include: PowerPoint training presentations, with trainer notes, handouts, activities, quizzes and professional recorded trainings. ■ Use the **Ask the Expert** feature, which allows you to e-mail questions to our HR experts and receive an answer back within one business day.	**Included in Fee**
WILLIS TRAINING SOLUTIONS - Over 100 web based courses and a learning management system to assign and track trainings	$10 PEPC
MEDIA AND COMMUNICATION – COMMUNICATION PRACTICE	PROPOSED FEE
■ Provide guidance on delivering a comprehensive communication strategy to tell your organization's specific story ■ Tackle a wide range of topics which may include enrollment, CDHPs, wellness, general education and change communications. ■ Offer options including benefit guides, posters, wallet cards, envelopes and innovative solutions (non-English speaking materials available) Develop annual enrollment benefits communication (Open Enrollment and New Hire) to educate and engage employees on benefit plans and options	**Included in Fee** Subject to Printing Fees Postage/Shipping/ Fulfillment Cost
ONDEMAND (TEMPLATE): Solutions utilize a web-based tool allowing your Willis Consultant to quickly design a professional communication campaign. With OnDemand you have access to a library of templates and graphics, faster delivery time and the flexibility to economically print as many or as few as needed.	Printing Fees Postage/Shipping/ Fulfillment Cost

BYDESIGN (SEMI-CUSTOM): Solutions are a semi-custom approach to your project providing turn-key branding for a unified campaign. A wide range of materials are available to address your enrollment, wellness, or general education campaigns.	**Included in Fee** Printing Fees Postage/Shipping/ Fullfillment Cost
HANDCRAFTED (CUSTOMIZED): Solutions are designed and developed by our Communication Specialists and offer custom graphics, layout and design. HandCrafted solutions allow companies the ability to adhere to their organization's identity standards and protocols, or develop a unique presentation for engaging benefit communications.	**Included in Fee** Printing Fees Postage/Shipping/ Fullfillment Cost
Communications Excellence Review: After completing a web-based questionnaire, we generate a comprehensive report, with applicable solutions and resources for change. Areas covered include: Measuring your Communication, Delivering Communications , Legally Required Communication and Communication/Plan Implementation.	**Included in Fee**
WILLIS ESSENTIALS COMMUNICATIONS LIBRARY: Communications templates for open enrollment (Benefit Guide, Employee Presentation, Enrollment Announcement, Common Enrollment Forms, etc.)	**Included in Fee**
STANDARD EDUCATIONAL MATERIALS: Health Calendars, Wellness Newsletters, relevant campaign topics and implementation tools.	**Included in Fee**
TOTAL COMPENSATION STATEMENTS: Benefits Statements customized for each employee to show the total value of employer-provided benefits.	**Included in Fee**
TEXT MESSAGING CAMPAIGN: Remind your employees about upcoming open enrollment dates, wellness events, or to send a special message out regarding their benefits.	**Included in Fee**
ADOBE PRESENTER: Online self-running presentations with audio.	**Included in Fee**
ELECTRONIC MEDIA DEVELOPMENT: Review and implement multi-media options appropriate for your organization.	**Included in Fee**
WELLNESS CONSULTING	PROPOSED FEE
WELLNESS CONSULTANTS - Consultative services provided by an experienced Wellness Consultant to assist with strategic planning, vendor selection, and general wellness program guidance. Services include: ■ Wellness consulting & advice for new or existing program development ■ Webinars ■ Market assessment and assistance with wellness vendor selection/recommendation ■ Provide templates, tool kits and guides ■ Assist with business plan creation, selection of goals & objectives, creating a budget ■ Introduce turnkey wellness programs ■ Review utilization data to determine appropriate wellness program design ■ Conduct annual Health & Productivity Survey & publish results for client benchmarking	**Included in Fee**

Exhibit 3

Organizational Chart

Organized For YOU

Eau Claire Health Care Consortium
Dedicated Client Advocacy Team

Management Points of Contact	Dale Thoma President, Willis of Wisconsin	Accountable For Overall Client Satisfaction
	Christine Steeno Sr. Vice President, Operations & Client Services	
Benefit Plan Design Strategic Planning Service	Ryan Barbieri Sr. Vice President, Co- Consultant	Accountable for Day to Day deliverables
	Dan Pecanac Benefits Consultant, Co-Consultant	
	John Dawson, FSA, MAAA Sr. Vice President, Actuary	
	Gail Michels Sr. Client Manager	
Consortium /& On-Site Clinic Strategist	Lester Morales Executive Vice President, Advocate Partner	Consortium & On-Site Clinic Expertise
Wellness Strategy	Heidi Guetzkow Wellness Consultant	Clinical Review of Onsite Medicine & Wellness
Reporting & Analytics Team	Luke Allenson Director, Data & Analytics	Regular Program Budget Analysis
Team of Placement Professionals	Cindy Logan Dir. Placement Practice	"Best In Class" Insurance Brokerage
Employee Benefits Attorney	Rebecca Lawrence Assistant Vice President	Consortium Legal Reference

Willis

Exhibit 4

Custom Client Service Plan
(Sample)

2013 Client Service Plan for Eau Claire Health Consortium

Key Deliverables	Owner	Client Role	Status	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Comments
Strategic Assessment and Planning																
Strategic Planning Session	Willis Team	Participate			Aug	Sept										Review goals and objectives of programs, carrier service issues, enrollment process and communication, current plans and plan designs, plan performance, and funding arrangements.
Facilitate *'Total Rewards Gap Assessment'*	Willis Team	Participate			8/1											
Coordinate appropriate '*Gap Assessments*'	G. Michels	Complete						Nov								
Review and present recommendations	Willis Team	Participate			8/15	9/1										
Marketplace Overview	R. Barbieri	Participate			8/15	9/1										
Collaborative Opportunities utilizing separate Insurance Companies	Willis Team	Participate			8/15											
Collaborative Opportunities utilizing one Health Insurance Company	Willis Team	Participate			8/15											
Funding Analysis Impact	D. Pecanac	Participate			8/15	9/1										
Benchmarking Results	G. Michels	Participate			8/15	9/1										
Deliver finalized *'Client Service Plan'*	Willis Team	Participate			8/15	9/1										
Perform feasibility Study on On-site health care facility for the three entities	Willis Team						Oct	Nov								
Perform feasibility Study on the collaborative purchase of health care by the three entities	Willis Team										Feb	Mar				
Renewal, Marketing and Placement																
Facilitate *'Pre-Renewal Meeting'*	D. Pecanac	Participate									Feb					
Update *'Client Service Plan'* with renewal schedule	G. Michels	N/A								Jan						
Market Plans	C. Logan					Sep	Oct	Nov	Dec							
Identify carrier / vendor selection criteria	C. Logan	Participate			8/13		Oct	Nov	Dec	Jan	Feb	3/28				
Finalize requirements documents	C. Logan	N/A					Oct	Nov	Dec							
Develop and distribute Request for Proposal (RFP)	C. Logan	N/A							Dec	Jan	Feb					
Vendor RFP responses due to Willis	C. Logan	N/A									2/23					
Review and summarize vendor responses	C. Logan	N/A									2/23	3/15				
Evaluate and negotiate renewal and /or marketing	C. Logan	N/A									Feb	Mar				
Present renewal and / or market results	C. Logan	Participate										Mar				
Facilitate finalist interviews, as applicable	C. Logan	Participate										Mar	Apr			
Finalize renewal and / or marketing with Client	C. Logan	Participate											Apr			
Finalize renewal and / or marketing with carriers	C. Logan	N/A											Apr			
Provide Contribution Modeling	C. Logan	Approval											Apr			

2013 Client Service Plan for Eau Claire Health Consortium

Key Deliverables	Owner	Client Role	Status	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Comments
Implementation and Enrollment																
Carrier and / or vendor implementation	Willis Team	Participate														
Facilitate implementation meeting with vendor	G. Michels	Participate														
Review electronic data transfer processes	G. Michels	Participate														
Conduct '*Communication Gap Assessment*'	H. Flontek	Participate														
Create a Communication Strategy	H. Flontek	Participate														
Develop Open Enrollment Materials	Willis Team															
Open Enrollment Newsletter Announcement	Willis Team	Approval														
Newsletter highlighting plan changes	Willis Team	Approval														
Adobe Presenter: Open Enrollment	Willis Team	Approval										3/1				
8 page Benefits Guide	Willis Team															
Plan open enrollment meetings (includes coordination of communication materials from vendors and participation by vendors in enrollment meetings)	Willis Team	Approval									Feb	X	X	May		
Annual Required Notices Distributed to Employers via Open Enrollment Toolkit (CHIPRA/Women's Cancer Rights, Medicare Creditable Coverage Part D Notice Provided to Employees etc.)	R. Lawrence	Distribute														
Coordinate Provision of Summary of Benefits and Coverage (SBC) to Employer	G. Michels															
Conduct enrollment meetings		Participate														
City of Eau Claire	Willis Team	Participate												Apr	May	
Eau Claire County	Willis Team	Participate					Oct	Nov								
Eau Claire Area School District	Willis Team	Participate												Apr	May	
		Participate														
Establish and / or update '*Willis Connect' site*	Willis Team	Participate									Feb	X	Apr			
Continuous Account Management																
SPD Review																
Request SPDs from Carrier	G. Michels															
Review SPDs Received from Carrier	G. Michels				Aug											
Provide SPDs to Employees	G. Michels	Distribute									Feb					
Deliver *'Dashboard Report'*	D. Pecanac	Attend		Jan			Apr		Jun	Jul	Aug	Sep	Oct	Nov	Dec	
Conduct Quarterly Review Meetings	D. Pecanac	Attend		Jan		Mar	Apr			Jul			Oct			
Facilitate Carrier / Utilization Review	Willis Team	Attend	**N/A**	Jan						Jul						
Coordinate Subject Matter Experts, as needed	Willis Team	N/A	**N/A**	Jul	X	X	X	X	X	X	X	X	X	X	Jun	
Provide Signature Ready 5500s	Willis Team	Participate														
Provide Requested "*Data Form*" and "*Carrier Contact Sheet*"		Responsible					10/15									
Provide Requested "**Schedule As**"		Responsible					10/15									
Process Form 5500		N/A					10/15									
Electronic Signature Completed		N/A					10/15									
Present and Deliver *'Client Advocacy Report' (CAR)*	Willis Team	Attend					10/15									

2013 Client Service Plan for Eau Claire Health Consortium

Key Deliverables	Owner	Client Role	Status	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Comments
Subject Matter Experts: Updates and Education																
Set up '*Willis Essentials*' Access	G. Michels	N/A														
Review '*Willis Essentials*' Resources	G. Michels	Attend		Jul												
Educational Webcast Series	G. Michels	Attend		7/16	8/20	9/17	10/15	11/19	12/17	1/15	2/19	3/19	4/16	5/21	6/18	Invitation and registration within HR Focus
HR Focus Electronic Newsletter	G. Michels	Read		7/11	8/8	9/12	10/10	11/14	12/12	1/10	2/14	3/14	4/11	5/9	6/13	
Local Office Seminars	G. Michels	Attend					4/2					9/5				Compensation; Benefit
HR Partner																
HR Gap Assessment	M. Snyder															
Assign Gap Assessment Review	M. Snyder	N/A			Aug			Nov								
Complete Gap Assessment Questionnaire	M. Snyder	Complete														
Review Responses and Prepare Report	M. Snyder	N/A														
Transmit Gap Assessment Report	M. Snyder	N/A				9/18	10/18									
Review Results and Recommendations	M. Snyder	Attend														
Review of Specific Employer Guides and Tools																
Paid Time Off (Vacation and Sick)	M. Snyder	Attend														
FMLA Administration Best Practices	M. Snyder	Attend						Nov								
California Leave Administration Best Practices	M. Snyder	Attend							Dec							Not applicable, not in California
Compensation Administration	M. Snyder	Attend														
Pay Structure Design	M. Snyder	Attend			Aug											
Performance Management	M. Snyder	Attend			Aug											
Succession Planning / Identification of HIPOs	M. Snyder	Attend										Mar				
Career Level Guides	M. Snyder	Attend								Jan						
Deploy applicable Solutions and Services																
Review '*Market Ready Report*'	M. Snyder	Attend														
Facilitate '*Willis Essentials*' Demo (HR Partner)	M. Snyder	Attend			Aug											
Facilitate '*Search Willis*' Demo	M. Snyder	Attend								Jan						
Review *Willis Training Solutions*		Attend		Jul												
Deploy applicable Scope Specific Projects																
Performance Management Gap Assessment	M. Snyder	Participate														
Total Rewards Gap Assessment	M. Snyder	Participate							Dec			Mar				
Custom Market Pricing ($)	M. Snyder	Participate				Sep	Oct									
Competitive Market Analysis ($)	M. Snyder	Participate														

2013 Client Service Plan for Eau Claire Health Consortium

Key Deliverables	Owner	Client Role	Status	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Comments
Health Outcomes																
Conduct '*Health Outcomes Gap Assessment*'																
Assign *'Health Outcomes Gap Assessment'*	H. Guetzkow	N/A				Sep			Dec							
I. Complete 'Gap Assessment' Questionnaire	Client	Complete				9/4										
II. Submit 'Data Request Form for Gap Assessment'	G. Michels	Complete				9/12										
Review responses and prepare report	H. Guetzkow	N/A				9/26										
Transmit 'Gap Assessment' results and report	H. Guetzkow	Review				9/18	10/18									
Review results and recommendations with client	H. Guetzkow	Attend					10/18									
III. Facilitate Programs and Policies Gap Review	H. Guetzkow	Participate						11/1								
Facilitate Program Design and Strategy Discussion	H. Guetzkow							11/1								
Securing Leadership Support	H. Guetzkow	Attend							Dec							
Creating a Strategy and Objectives	H. Guetzkow	Attend														
Establishing and Running a Wellness Committee	H. Guetzkow	Attend														
Program Components	H. Guetzkow	Attend														
Operating Budget	H. Guetzkow	Attend														
Program Evaluation	H. Guetzkow	Attend														
Market Overview and Vendor Selection																
Provide overview of market and vendor criteria	H. Guetzkow	Attend														
Complete '***Vendor Selection Criteria***'	H. Guetzkow	Complete								Jan						
Present vendor options based on selection criteria	H. Guetzkow	Attend								1/28						
Market and negotiate with applicable vendors	C. Logan	N/A									2/10					
Coordinate in vendor finalist meetings	G. Michels	Attend									2/10	3/10				
Facilitate Best Practice Guidelines for implementation	H. Guetzkow	Attend										Mar				
Manage implementation process	Willis Team	Participate											Apr			
Review of Specific Employer Guides and Tools																
Organizational Readiness and Engagement	Willis Team	Attend														
Establishing and Running a Wellness Committee	Willis Team	Attend								Jan						
Program Design and Components	Willis Team	Attend														
Planning and Hosting a Health Fair	Willis Team	Attend										Mar				
Health Education and Support Resources	Willis Team	Attend											Apr			
Program Evaluation	Willis Team	Attend												May		
Review Communication Resources on Willis Essentials and training resources on Search Willis	Willis Team	Attend														
Conduct 9 month check up of Programs	Willis Team	Attend			Aug											

2013 Client Service Plan for Eau Claire Health Consortium

Key Deliverables	Owner	Client Role	Status	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Comments
National and Legal Resources Group																
Conduct Appropriate Gap Assessment (s)																
ERISA Gap Assessment	R. Lawrence															
COBRA Gap Assessment	R. Lawrence									Jan	Feb					
Group Health Plan Mandates Gap Assessment	R. Lawrence											Mar	Apr			
Cafeteria Plans Gap Assessment	R. Lawrence					Sep	[illegible]	[illegible]	Dec							
Review of Specific Employer Guides and Tools																
COBRA	R. Lawrence	Attend														
Consumer Directed Plans	R. Lawrence	Attend							Dec							
ERISA Reporting and Disclosure	R. Lawrence	Attend			Aug											
Health Care Reform	R. Lawrence	Attend				Sep										
HIPAA	R. Lawrence	Attend						Nov								
USERRA	R. Lawrence	Attend									Feb					
Cafeteria Plans	R. Lawrence	Attend		Jul												
Medicare (MSP, Part D, and Payer Reporting)	R. Lawrence	Attend														
Health and Welfare Compliance Checklist																
Deploy applicable Scope Specific Projects																
Plan Compliance Audit ($)	Willis Team															
Plan Document Services ($)	Willis Team			Jul												
HIPAA Compliance ($)	Willis Team															

Exhibit 5

Sample WillisMed Report

&

Sample WillisMed Health Outcomes Summary

(Verisk Sample Report – Standard Deck)

Acme Corp.

October 2008 through September 2010

Full Cycle, Paid

Presented By:

Willis

Willis

Table of Contents

Introduction

Financial metrics are calculated on a paid basis during the time frame October 2008 through September 2010. Utilization metrics are calculated from claims incurred from October 2008 to September 2010.

Period-over-period comparisons are performed on selected reports within this package. The two periods selected for financial measures are:

1. Paid basis
    a. From October 2008 through September 2009
    b. To October 2009 through September 2010

All reported analyses reflect the financial time frame unless otherwise specified on the graphic, reflecting the utilization time frame. The periods selected for utilization measures are:

1. Incurred basis
    a. From October 2008 through September 2009
    b. To October 2009 through September 2010

Please Note:

1. This report displays Plan Paid Amounts unless otherwise specified.
2. Medical Plan Paid amount does not include any Dental, Vision or Lab specific claims.
3. Many dollar values are rounded to the nearest dollar for increased readability. However, calculated values (such as total sums) are calculated precisely and then rounded afterwards. This produces more accurate results, but may occasionally cause calculated fields to appear inexact.
4. This report requires at least 24 months of data in order to display a good comparative analysis for the reported population. Not having claims experience in the first 12 months will result in an incomplete report.
5. Some sections in the Appendix are dependent on previous sections. If the underlying previous sections are not requested, then the corresponding sections in the Appendix will not be populated.
6. The information contained in report has been produced from data provided to Verisk Health, which has not been independently verified by Verisk Health for accuracy or completeness. Additional information, including, but not limited to, any claims that have been incurred but not paid as of the date of this report, or claims that were subject to subsequent adjustment, should be considered before any action is taken on the basis of the contents of this report. This report does not constitute the provision of medical or legal advice by Verisk Health to any party.

1. SUMMARY OF FINDINGS

This report provides an analysis of the healthcare information for Acme Corp.. The information is based on eligibility, medical claims, and pharmacy claims data for employees and their families during the reporting period October 2008 through September 2010 on a paid basis. The cost figures below reflect the time frame specified.

Summary of Expenses Paid by Plan

Medical Claims	$31,932,026.59
Pharmacy Claims	$4,775,825.91
Total Claims	**$36,707,852.50**
PMPM Medical Expenses	$197.09
PMPM Pharmacy Expenses	$29.48
Total PMPM Expenses	**$226.57**

2. POPULATION CHARACTERISTICS

This section explores the aggregate demographic, economic and clinical characteristics of this population.

Section 2.1 contains the population's demographic characteristics, including the change in total and current membership levels; and age and gender breakouts with associated economics.

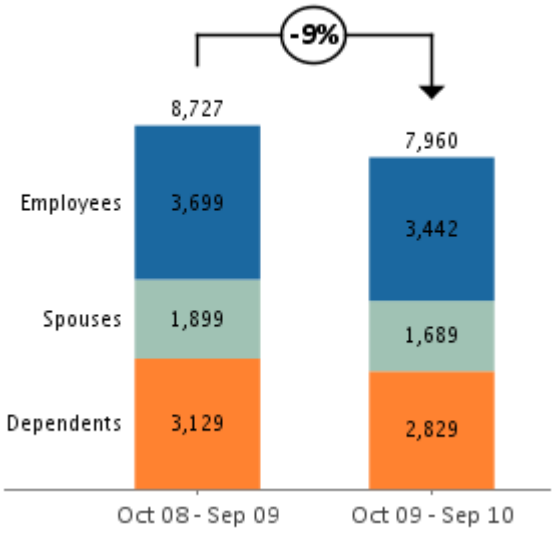
Section 2.2 details the population's high-level economic characteristics. This includes an assessment of the drivers of cost growth, such as change in member volume, change in PMPM, and medical versus pharmaceutical PMPM. Trends in total and PMPM costs over time - both medical and pharmaceutical - are calculated. Finally, cost distribution by spending band is explored. Deeper economic analyses into the drivers of pharmaceutical and medical expenses are detailed in *Section 3: Economic Findings and Opportunities.*

Section 2.3 analyzes the population's high-level clinical characteristics. The first breakout shows the relationship between age and disease burden (as quantified by the Relative Risk Score (RRS)) and the related Care Gap Index (CGI). These are analyzed both relative to each other and relative to the Verisk Health book of business benchmark. The second relationship describes the distribution of diseases across the population - identifying what is large or growing rapidly from a prevalence standpoint. The prevalence of high-frequency diseases is then shown relative to benchmarks.

2.1 Demographics

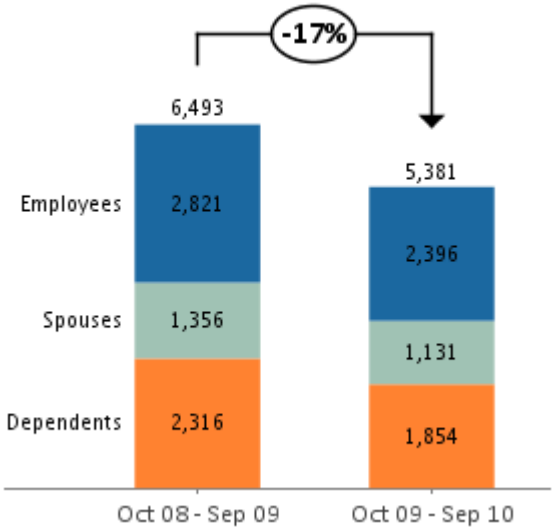
Figure 2.1.1 presents total membership change, by relationship status, from period one to period two. The percentage changes are also provided so that period-over-period trends can be evaluated. Figure 2.1.2 presents the distribution of current members in that specific period. For both total and current members, average PMPM is provided, where dependents typically spend the least amount per month. Finally, Figure 2.1.3 and Table 2.1.1 show the total claims paid and membership profile by age group and gender; in absolute terms employees and spouses typically constitute proportionally more spend than dependents.

Figure 2.1.1 Total Member Count by relationship status [1]



Member Growth	Average PMPM Oct 08 - Sep 09	Average PMPM Oct 09 - Sep 10	PMPM Growth
-6.9%	$270.62	$306.58	13.3%
-11.1%	$230.38	$328.69	42.7%
-9.6%	$107.84	$139.08	29.0%

Figure 2.1.2 Current Members



Member Growth	Average PMPM Oct 08 - Sep 09	Average PMPM Oct 09 - Sep 10	PMPM Growth
-15.1%	$262.92	$287.26	9.3%
-16.6%	$230.30	$252.45	9.6%
-19.9%	$107.64	$145.87	35.5%

[1] Refer to Appendix 5.1 for more information on member expenses by relationship status.

Figure 2.1.3 Claims Paid by Gender and Age [2]

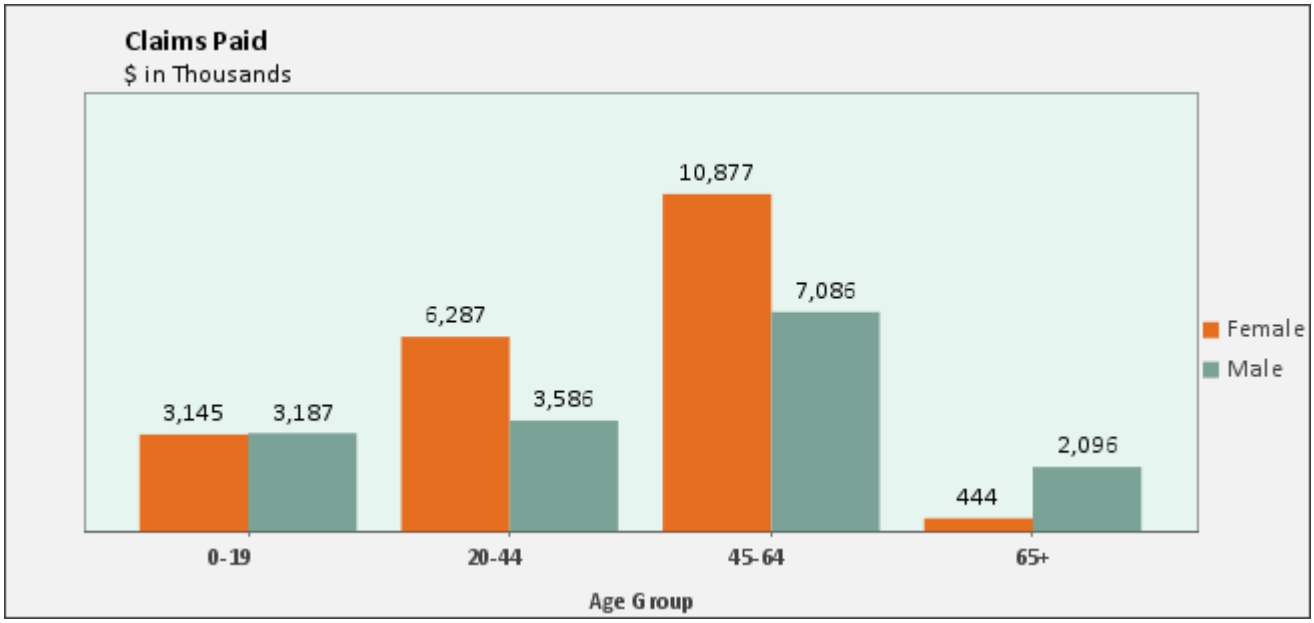


Table 2.1.1 Membership Profile [3]

	Female Member		Male Member		Total Member	
	Count	**Percent**	**Count**	**Percent**	**Count**	**Percent**
Employee	1,836	19.0%	2,269	23.5%	4,105	42.6%
Spouse	1,344	13.9%	721	7.5%	2,065	21.4%
Dependent	1,669	17.3%	1,804	18.7%	3,473	36.0%
Total	**4,849**	**50.3%**	**4,794**	**49.7%**	**9,643**	**100%**

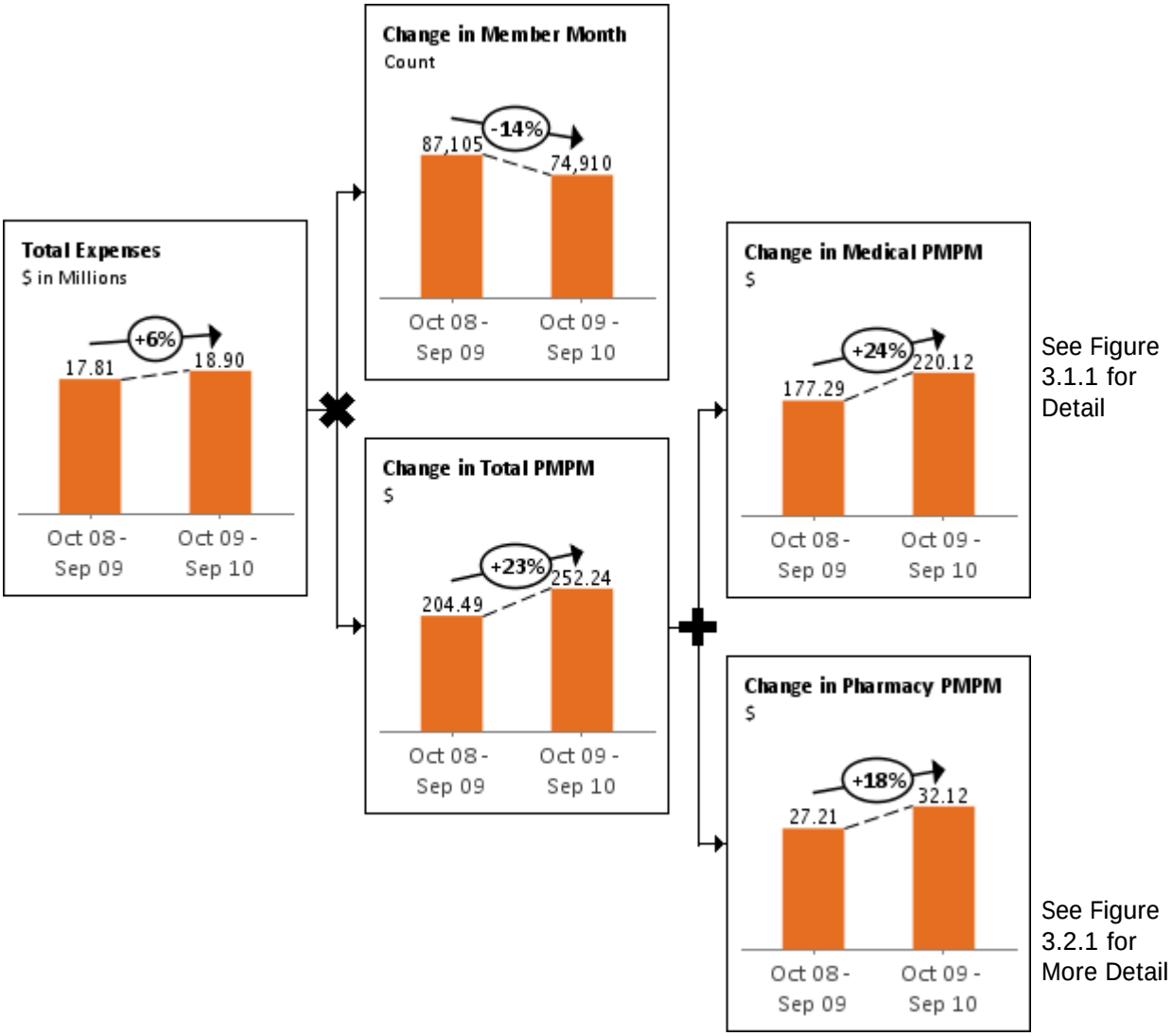
[2] ***Note:*** Average age for males is 32.7. Average age for females is 33.3.
Source: Explorer: Age groups in Demography module

[3] Source: Explorer - Gender and relationship flag on individuals module

2.2 Aggregate Economics

Figure 2.2.1 breaks out cost growth into discrete drivers, such as change in member volume, change in PMPM, and medical versus pharmaceutical PMPM. The change in Member Months will closely approximate the change in current members. This analysis help delineate whether absolute costs are growing because the population is growing, or the cost per member is growing. Further cost breakouts are present in *Section 3: Economic Findings and Opportunities.*

Figure 2.2.1 Distribution of Expenses [4]



See Figure 3.1.1 for Detail

See Figure 3.2.1 for More Detail

[4] Source: Explorer - Custom time frames from claims module for medical and pharmacy expenses. The distribution by employee and plan is calculated by Verisk Health.

Note: Medical PMPM includes Non-PBM drug spend

2.2.1 Monthly Comparison of Paid Claims

Figures 2.2.2 and 2.2.3 track monthly claim paid amounts for the most recent 24 months. Seasonality in claims paid (in terms of date incurred) is expected, with the highest monthly claims generally occurring in the winter. Claim volumes may also rise just before or after installation of a new health plan. Claims are presented both as total and PMPM calculations.

Figure 2.2.2 Medical and Pharmacy Claims- Total

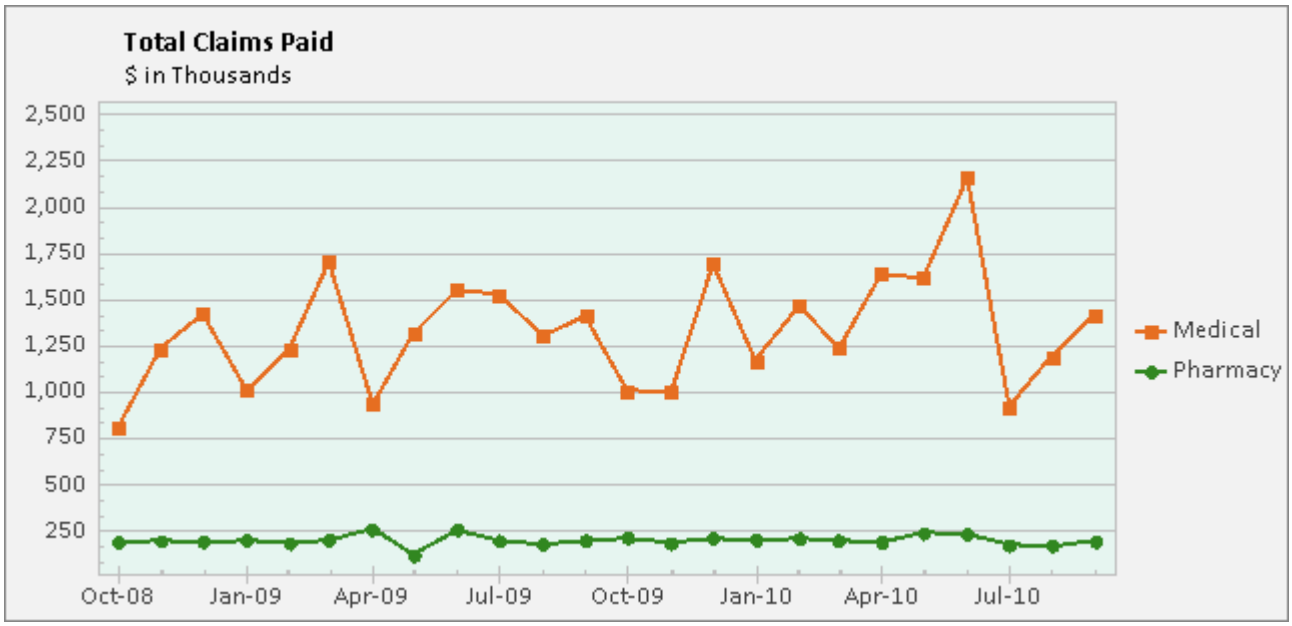
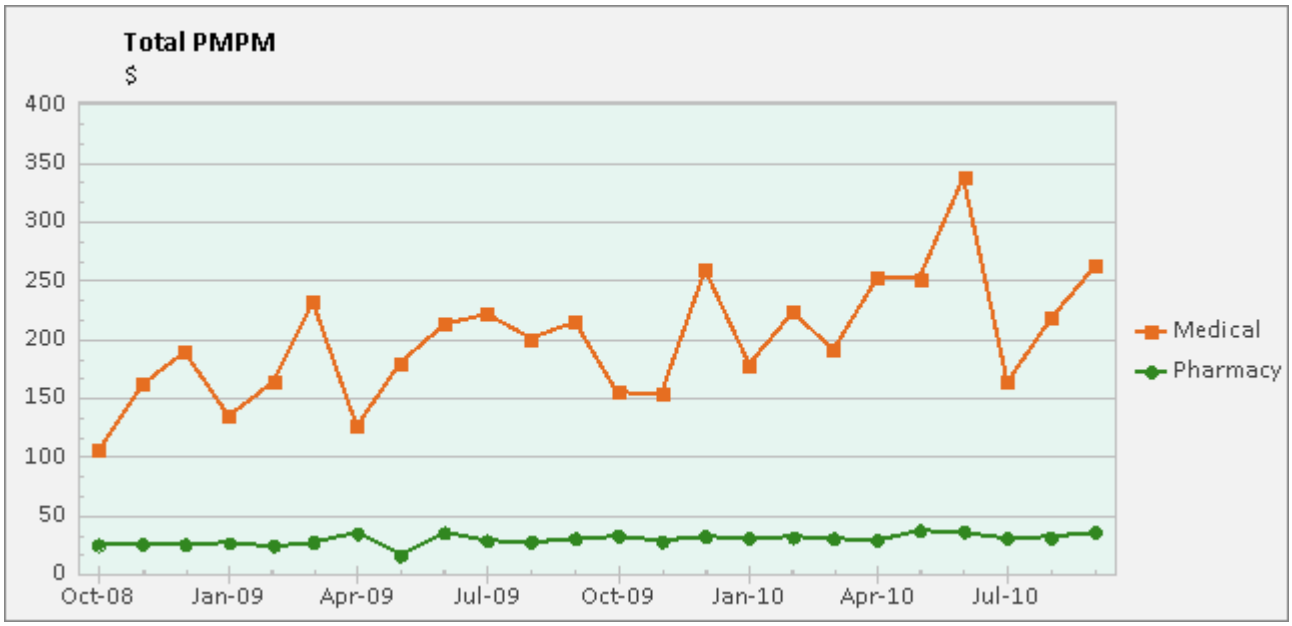


Figure 2.2.3 Medical and Pharmacy Claims-PMPM [5]



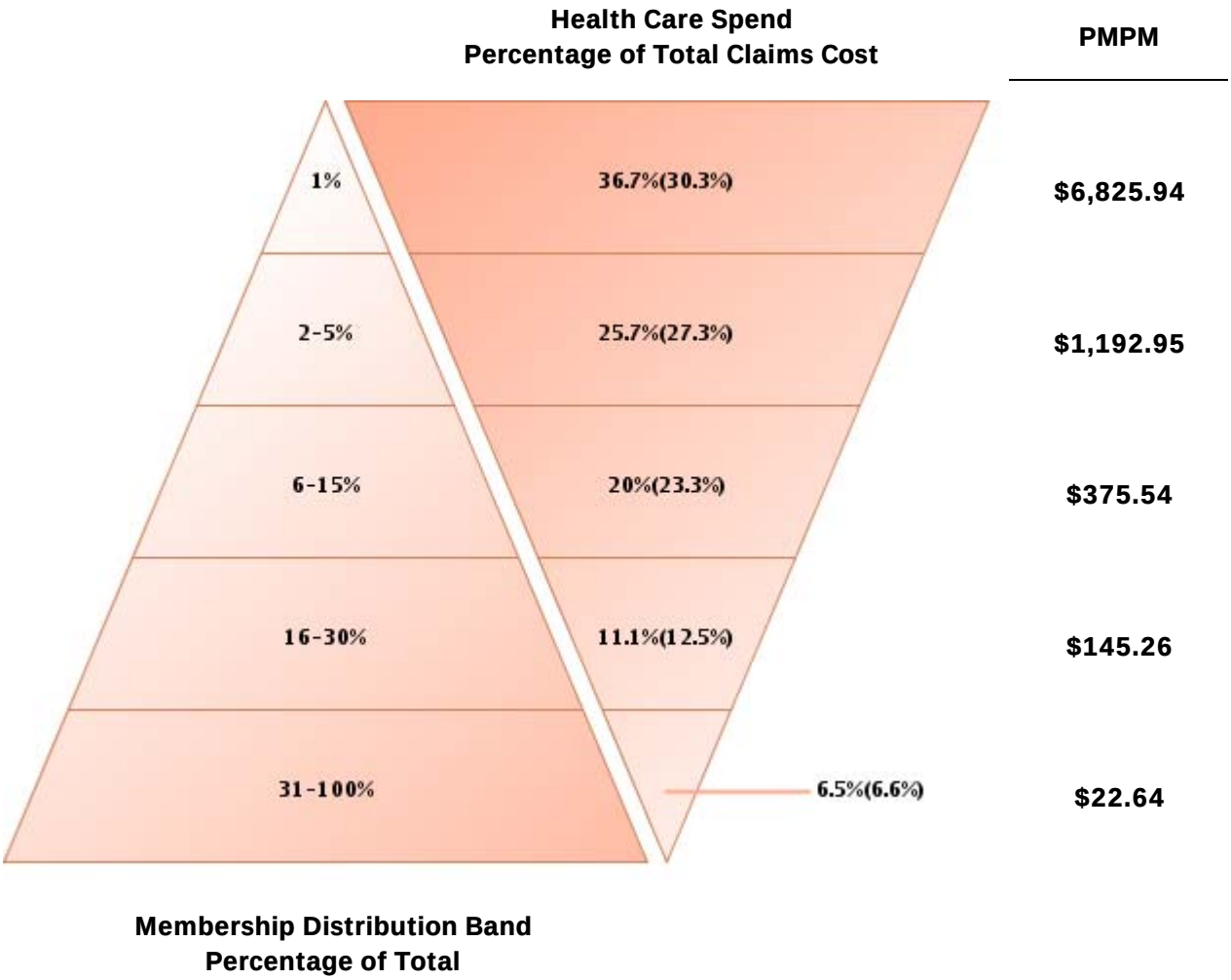
[5] Source: Explorer - PMPM calculated by dividing total paid by Member Month

Note: Refer to Table 5.2.1 and 5.2.2 in Appendix 5.2 for monthly detail.

2.2.2 Expense Distribution by Percent Spending Band

Figure 2.2.4 shows claim payments for 5 different population bands including both current and termed members. Members are ranked by total claims for purposes of creating the bands. For example, the band representing 1% of the population consists of the most expensive 1% of members; approximately one-third of the total claims expense is generally accounted for by this group. These members have extremely high claims expense and should be reviewed to verify their case management status. A significant number of members in the next two bands will be high risk members, often with multiple chronic conditions. The risk associated with these members, many of whom to date have not generated significant claims expense, can be further evaluated using the D2Explorer Expense Distribution module.

Figure 2.2.4 Claims Expense Distribution [6]



[6] Refer to Table 5.2.3 in Appendix 5.2 for further detail.

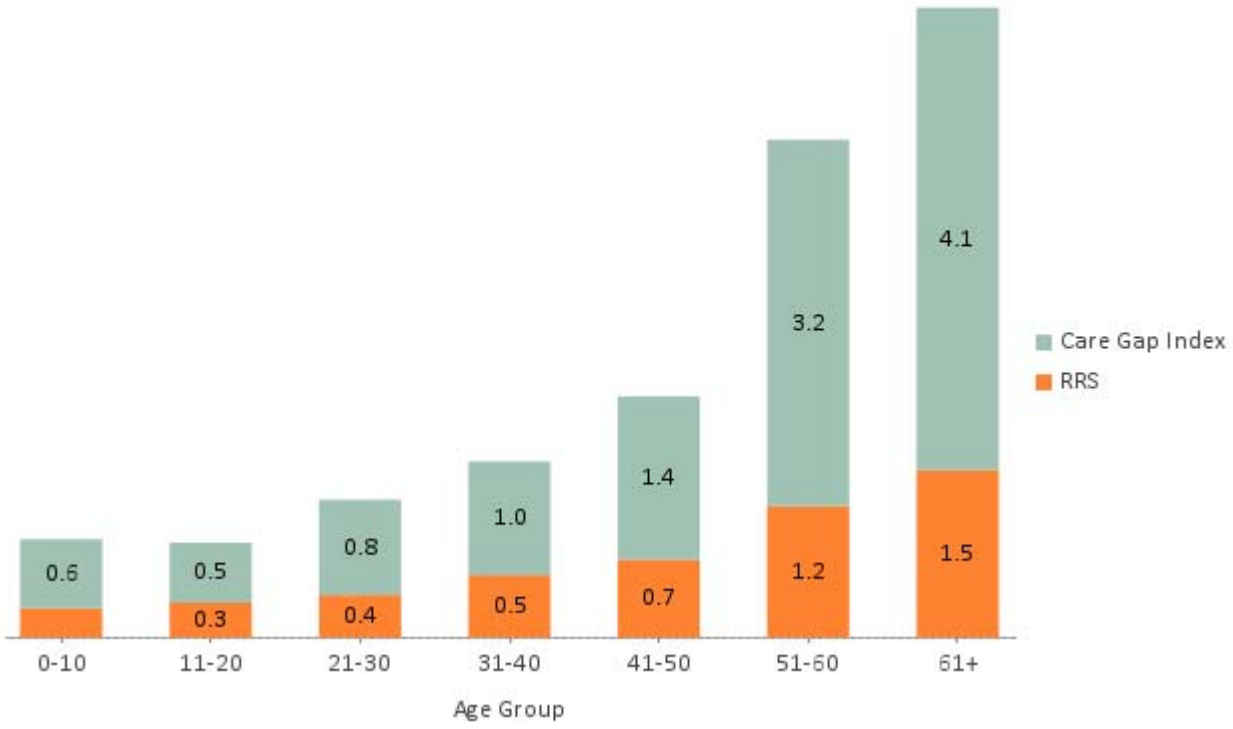
Source: Explorer - Expense Distribution module.

2.3 Clinical Disease Fingerprint

The RRS quantifies the disease burden of an individual member, while the Care Gap Index (CGI) quantifies the gaps in appropriate medical care that a member is receiving. Depending on the diseases that a member has, the extent of care gaps present serves as one assessment of the quality of care they receive.

Figures 2.3.1 show the relationship between the RRS and the CGI. As age increases, RRS and CGI usually increase proportionally. Figure 2.3.2 shows the RRS and CGI relative to benchmark performance and discusses how to determine the extent to which your CGI is driven by high disease burden or poor quality care.

Figure 2.3.1 Average Care Gap and RRS [7]



[7] Source: Explorer - Average of RRS and CGI fields, grouping members by age in the individuals module

Figure 2.3.2 shows the RRS and CGI relative to the VH Norm. Four scenarios are possible:

1. The population has a **higher RRS but a lower CGI** relative to the norm. This is a positive finding. The population has a higher disease burden, yet compliance with evidence-based medicine generates CGI lower than the norm.

2. The population has a **higher RRS and a higher CGI** relative to the norm. This is a mixed finding. The population is sicker than the VH norm. Because it is sicker, we expect gaps in care to be more prevalent as well. This population presents an opportunity to reduce care gaps and claims cost through disease management.

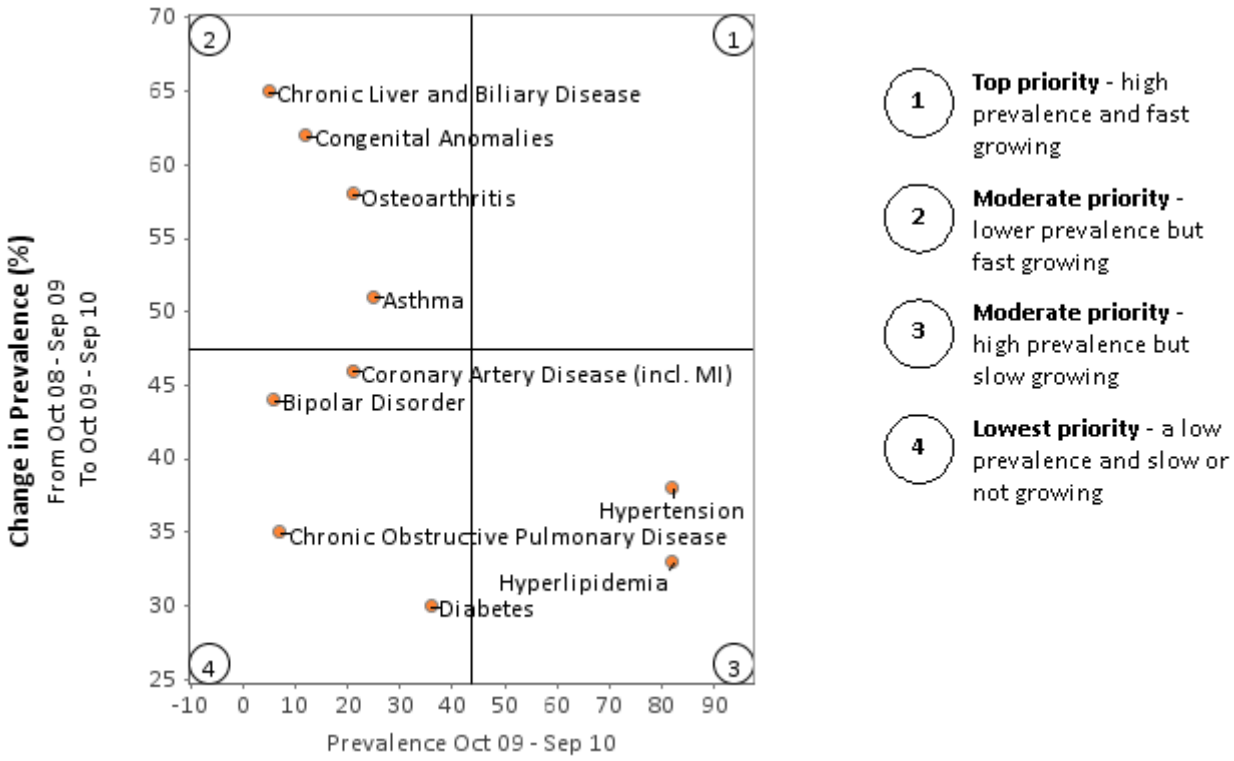
3. The population has a **lower RRS and a lower CGI** relative to the norm. This is a positive finding. The population is healthier than the VH norm and also enjoys correspondingly fewer gaps in care.

4. The population has a **lower RRS but a higher CGI** relative to the norm. This is a negative finding. Although the illness burden is low for this population, there exist disproportionate gaps in compliance with evidence-based care guidelines - either through member non-compliance or poor provider quality.

Figure 2.3.2 Spread of disease burden and gaps in care by age groups.

Figure 2.3.3 presents the top ten chronic diseases using the VH Disease classification scheme - this is the population's "disease fingerprint". Reducing the cost associated with these diseases is typically achieved with Disease Management programs; Disease management program typically reduce absolute utilization, and shift utilization from high cost setting to low cost settings.

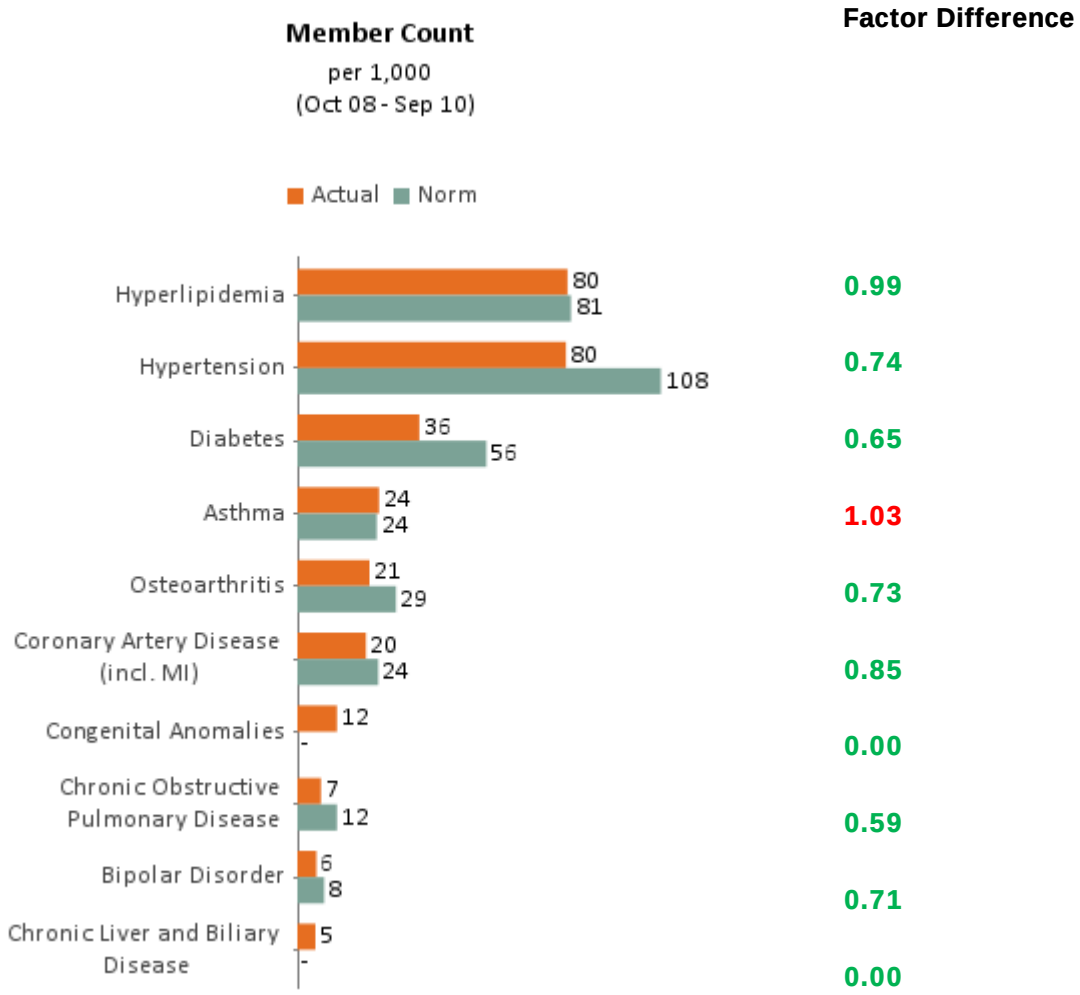
Figure 2.3.3 Prevalence and Growth of Top 10 Chronic Diseases [8]



[8] Source: Explorer - Disease Registry module: explore diagnostic group in medical claim type and sort by member per 1000

Figure 2.3.4 shows the prevalence of the population's top 10 chronic diseases relative to the Verisk Health Commercial Norm benchmark values. Diseases with a factor difference less than 1, labeled in green, have lower prevalence than the VH norm, while diseases labeled in red have higher prevalence. A high prevalence relative to the norm means that the high cost in claims is in part driven by intrinsic population disease burden, which can be addressed by Disease and Wellness Management programs.

Figure 2.3.4 Prevalence View of top 10 Chronic Diseases. [9]



[9] Refer to Appendix 5.3 for further details on utilization patterns.
Source: Explorer - Disease Registry for client values.

3. ECONOMIC FINDINGS AND OPPORTUNITIES

Economic findings are broken out into Medical and Pharmaceutical subsections.

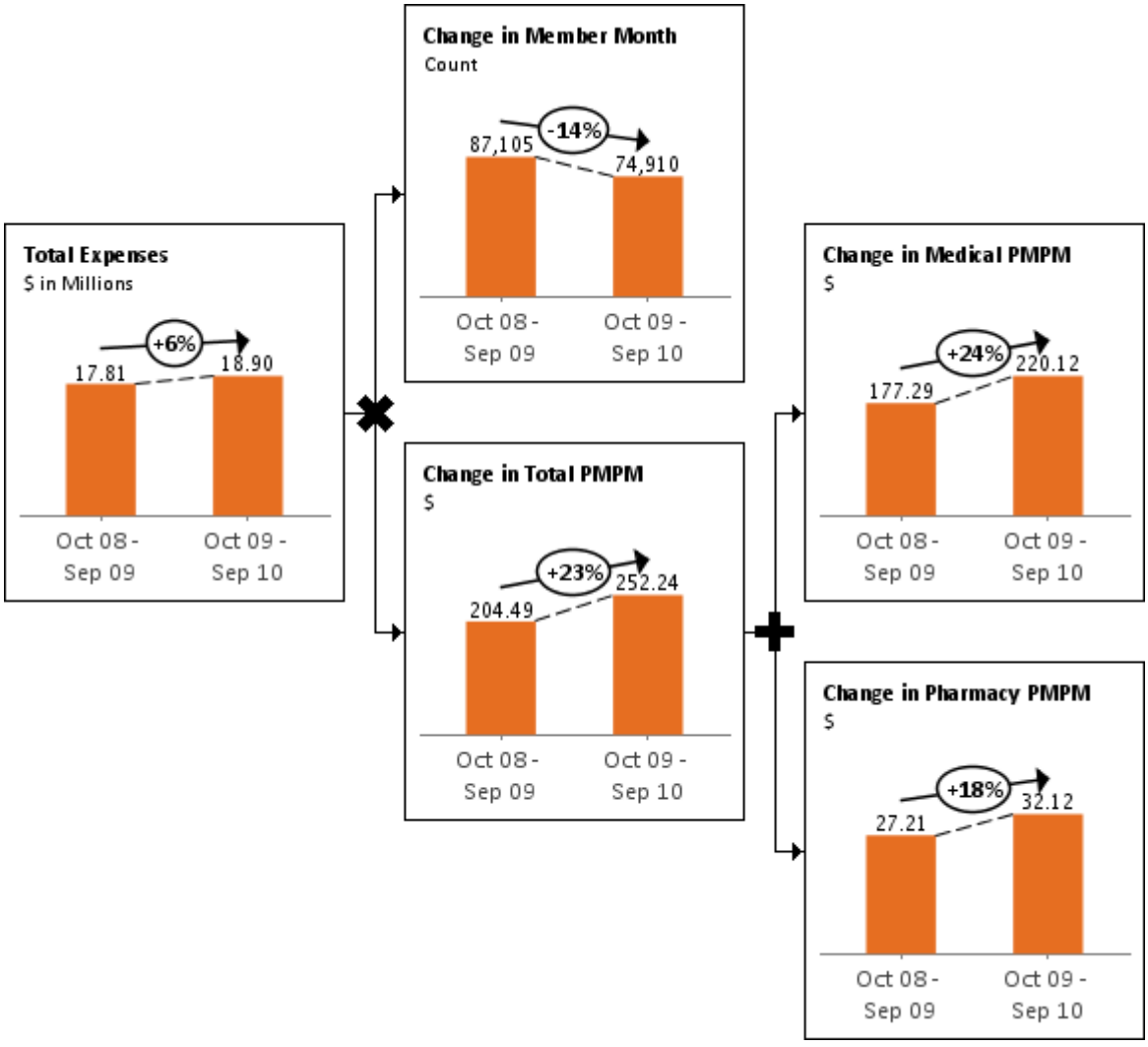
In section 3.1 - the Medical Economics subsection- this report examines:

- Factors that primarily impact *unit pricing,* including contract discount power and in versus out-of-network utilization rates. We also examine which geographic areas are associated with the most out-of-network spend.
- Factors that drive *utilization,* including specialty procedures and consultations, diagnostic testing, and the place of service. For these utilization-based drivers, we assess both changes in utilization and cost.

In section 3.2 - the Pharmaceutical section - this report examines:

- Drug classes that affect PBM drug spend, and whether the change in this spend is due to pricing growth or utilization growth. This section also details the highest cost drugs and opportunities for generic and branded switching.
- Overall Non-PBM drug spend: because this spend is a "medical" cost - not a PBM cost - the impact of these high-cost drugs is often hidden.

Figure 3.1 Expense Drivers

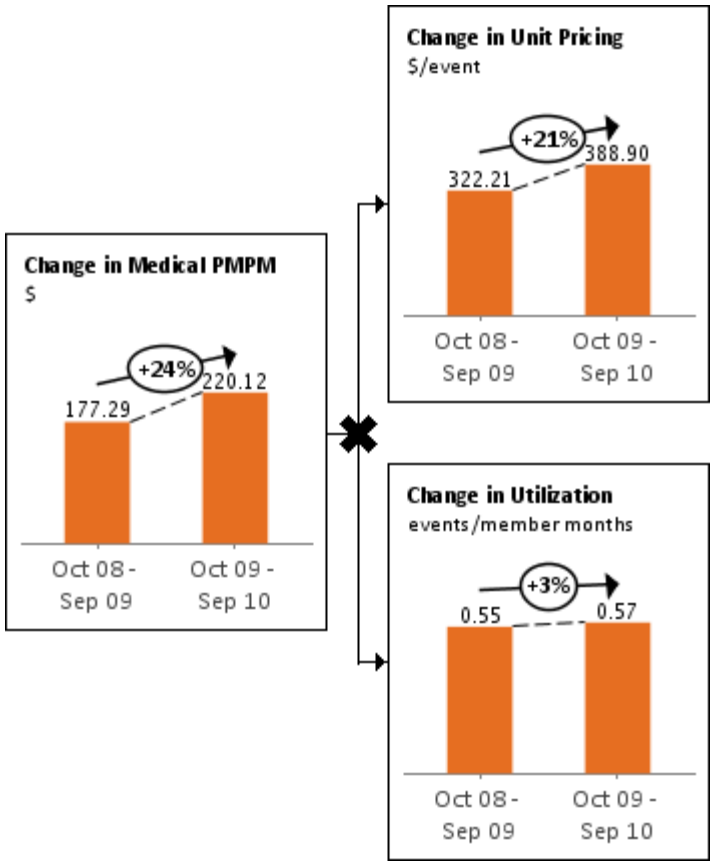


3.1 Medical Economics

Section 3.1 assesses medical economics - where cost increases are occurring, what is driving them, and how they can be controlled. While the areas and opportunities assessed are not additive, they are complementary. For example, managing Coronary Artery Disease more effectively can be expected to reduce the number of cardiac catheterizations, reduce the overall number of cardiology consultations, and move cardiology consultations from the inpatient setting to the lower-cost office setting.

Figure 3.1.1 shows the change in Medical expenses over time. This chart is related to chart 2.2.1 from our assessment of aggregate economics.

Figure 3.1.1 Medical Expense Growth over Time (Refer to Figure 3.1) [10]



Changes in unit pricing are typically a function of overall medical inflation, Payor discount power, and the amount of services that are delivered in-network versus out-of-network. Payor contracting is the primary lever to control this cost driver.

Changes in utilization are typically a function of the overall disease burden of a population, benefits design and physician referral patterns. Disease and Wellness management programs, rational benefits structuring, and close network management are the primary levers to control this cost driver.

[10] ***Note:*** Events are a distinct count of Member ID and Date of Service for the reported population and reporting period. Source: Explorer - Claims module with custom time frames

Section 3.1 will analyze the five areas listed directly below.

	What the analysis assesses	How excessive costs are incurred
Contract discount power	• The percent discount that a payor is able to achieve from provider	• Payors with weaker networks - and lower network discount rates - will pay higher per-unit costs
Network utilization	• The percentage and location of out-of-network claims occurrences	• On a per-unit basis, out-of-network costs are generally higher than in-network costs
Specialty procedures & consultations **Diagnostic testing** **Place of service**	• Costs are prioritized by total amount and growth rate • Cost growth drivers are disaggregated into change-in-utilization and change-in-price drivers	• High rates of utilization will drive excessive costs; utilization is typically driven by excessive specialty procedures or diagnostic testing • Excessive costs can also be driven by inappropriate location of care; for example, if a disease is treated in the ER instead of clinic

3.1.1 Network utilization and contract discounts

Table 3.1.1 details in-network (Par) and out-of-network (Non-Par) costs, ranked by plan paid, for the various networks used by your plan participants. This analysis also provides a comparison of discounts for the top ten participating networks. Most benefit plans utilize a provider network where providers have agreed to accept lower reimbursements in return for inclusion on a preferred provider list. Some out-of-network utilization is expected; examples are members seeing a provider while away from home (out-of-area claims), or seeing an out-of-network provider for an urgent or emergent healthcare condition. Out-of-network claims result in higher than expected claims expense for the service provided. A high incidence of out-of-network provider visits is usually an indication that there are access issues. These access issues can be impacted through network restructuring. Improved in-network usage can be accomplished by limiting coverage for out-of-network services.

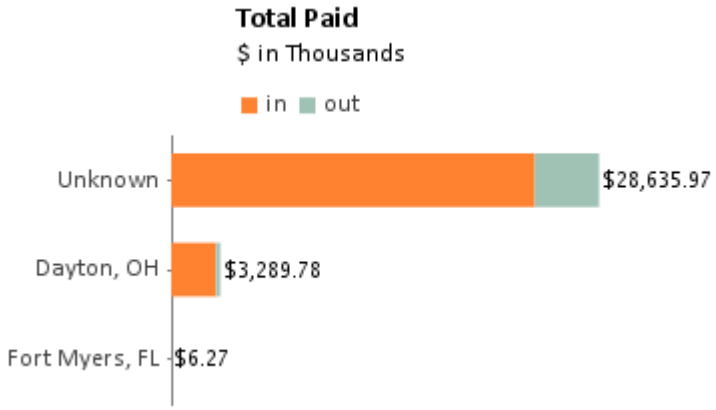
Table 3.1.1 Carrier Discounts and Network Utilization [11]

Network	Total					
	Claims Billed	Claims Allowed	Claims Paid	Employee Contribution	Network Discount	% Discount
Network - 002975	$37,410,324	$25,120,880	$20,346,607	$3,505,238	$12,289,444	32.9%
Network - 017444	$12,516,521	$7,500,554	$6,261,215	$1,073,977	$5,015,966	40.1%
Network - 020412	$814,500	$425,480	$424,057	$0	$389,020	47.8%
Network - 006685	$319,403	$221,315	$183,710	$36,480	$98,088	30.7%
Network - 009653	$163,788	$117,612	$111,482	$5,476	$46,176	28.2%
Network - 015589	$34,112	$22,059	$18,228	$3,592	$12,053	35.3%
Network - 001862	$45,064	$24,256	$16,398	$5,303	$20,808	46.2%
Network - 020041	$9,158	$1,783	$966	$817	$7,375	80.5%
All Other Par (In Network)	**$0**	**$0**	**$0**	**$0**	**$0**	**0.0%**
All Non-Par (Out Of Network)	**$9,564,487**	**$6,847,543**	**$4,569,362**	**$2,147,822**	**$2,716,944**	**28.4%**
Total	**$60,877,356**	**$40,281,482**	**$31,932,027**	**$6,778,706**	**$20,595,875**	**33.8%**

[11] Source: Explorer - Network Utilization module
Refer to Table 5.2.6 in Appendix 5.2 for network summary.

Figure 3.1.2 shows where out-of-network spend is being incurred. Efforts to move utilization in-network should begin with an understanding why members are seeing out-of-network (OON) providers in these areas.

Figure 3.1.2 Top 10 Cities for Out-of-Network Claims Paid [12]



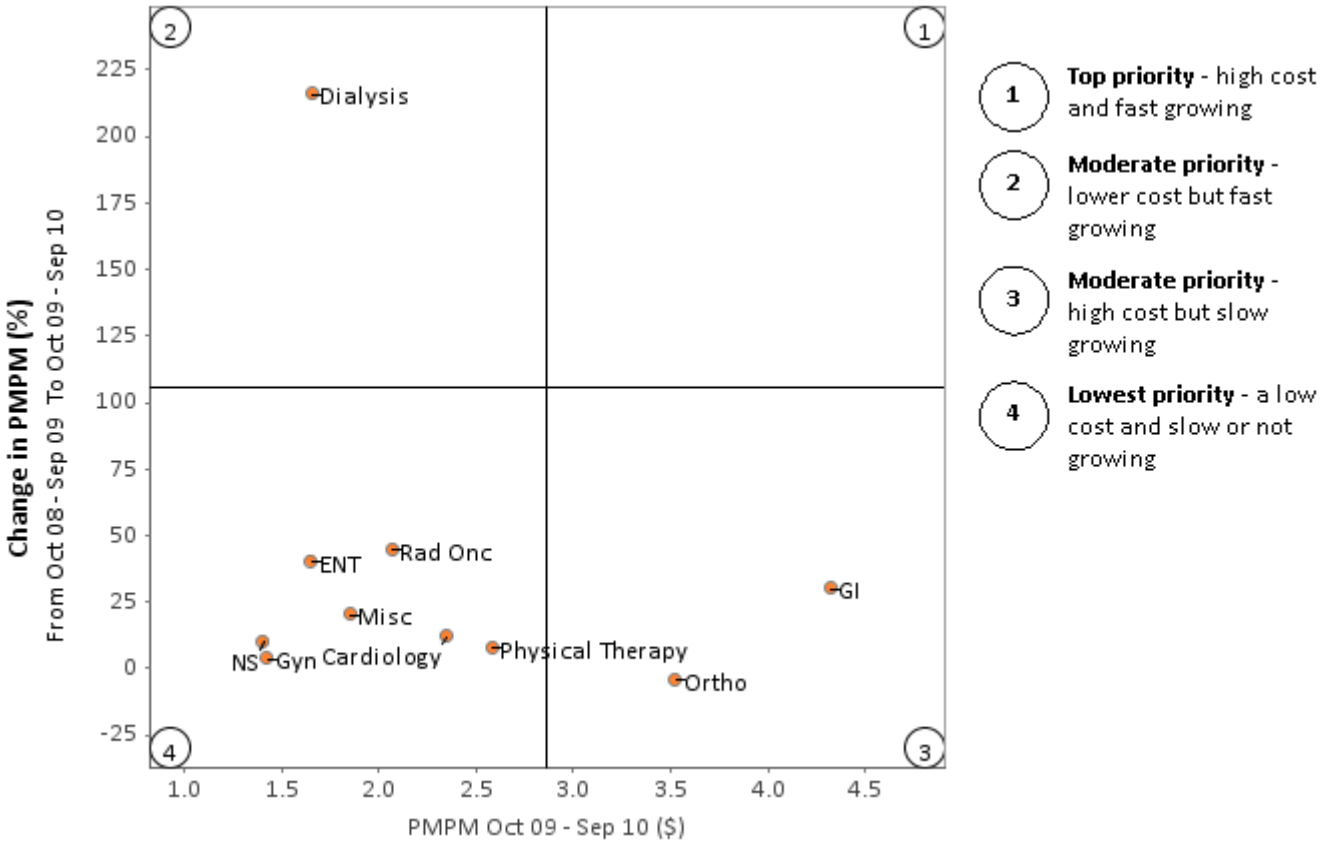
	OON Spend $ in Thousands	OON Spend	all OON Spend
Unknown	$4,281.54	15.0%	13.4%
Dayton, OH	$287.46	8.7%	0.9%
Fort Myers, FL	$0.36	5.8%	0.0%
Total = $4.57 M			

[12] Source: Explorer - "All-Zip" in Network utilization module sorted by greatest total paid

3.1.2 Specialty procedures/consultations

Specialty procedures, and the consultations that lead to those procedures, are a common driver of excess utilization. The chart below shows what procedures are large and are growing fast. Moving left to right on the horizontal axis, total costs incurred get larger. Moving bottom to top on the vertical axis, year-on-year growth in costs increases. Therefore, specialties in the upper right corner are both large and growing fast.

Figure 3.1.3 Cost drivers: Areas of cost and cost growth for specialty procedures and consultations [13]



[13] Source: Explorer – Drill by Unit & Specialty

The table below breaks down the cost driver for each category analyzed in the prior chart. This allows you to understand whether the changes in cost are driven by a change in pricing or a change in utilization. Also displayed is the average cost from the Verisk Health Normative Database, and the population's cost rank relative to the Norm.

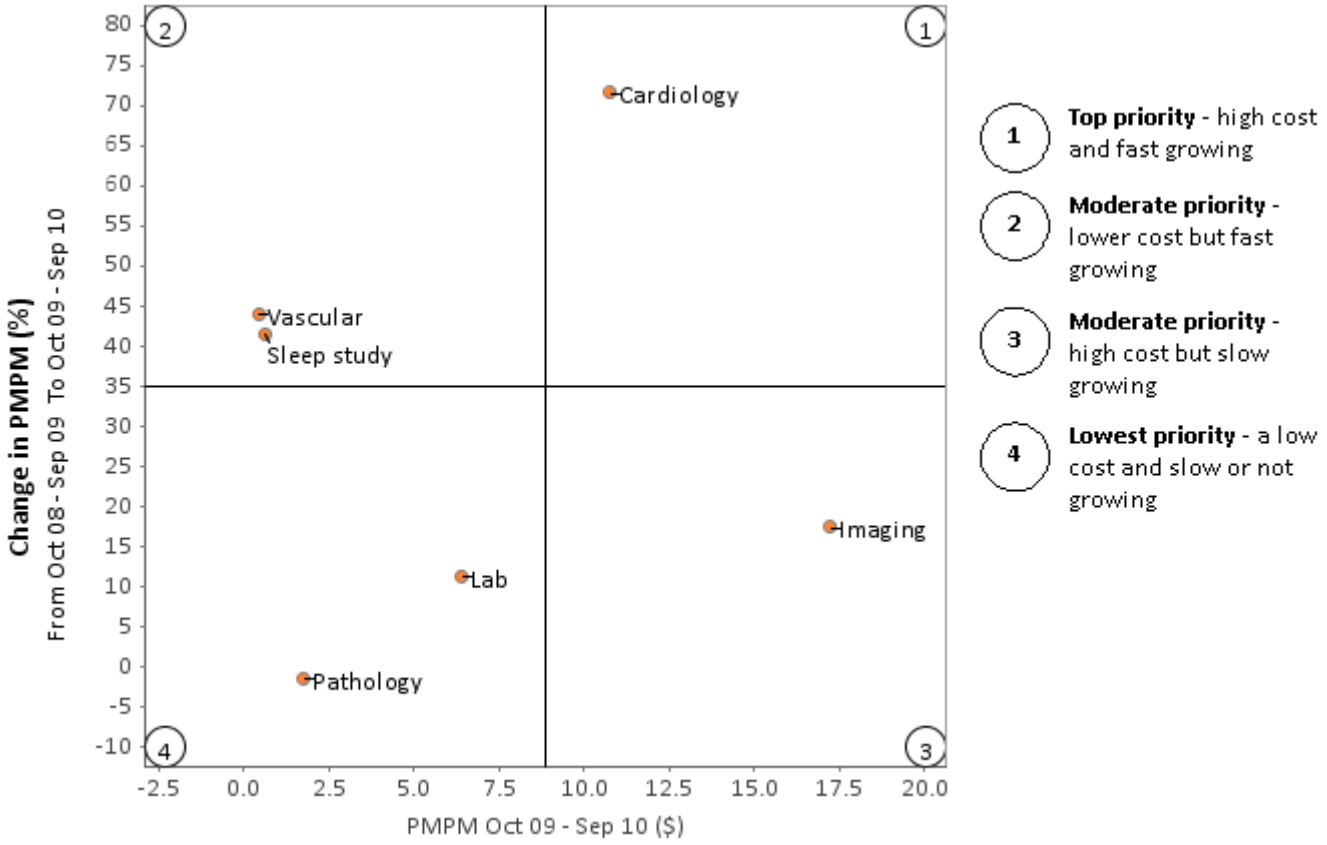
Table 3.1.2 Cost drivers: Change in unit price and change in utilization breakout for specialty procedures and consultations

Specialty Procedures / Consultations	Current PMPM	Change in PMPM	Change in Utilization per 1,000	Change in Unit Pricing	Norm value of PMPM	Percent Rank (Norm value = 50%)
GI	$4.32	30.3%	12.3%	16.1%	-	-
Ortho	$3.52	-4.1%	-2.8%	-1.3%	-	-
Physical Therapy	$2.58	8.1%	1.2%	6.8%	-	-
Cardiology	$2.35	12.3%	-2.2%	14.8%	-	-
Rad Onc	$2.07	45.0%	25.8%	15.2%	-	-
Misc	$1.85	20.6%	16.5%	3.5%	-	-
Dialysis	$1.66	215.9%	162.8%	20.2%	-	-
ENT	$1.65	40.6%	3.2%	36.2%	-	-
Gyn	$1.43	3.9%	1.0%	2.9%	-	-
NS	$1.41	10.3%	14.0%	-3.2%	-	-

3.1.3 Diagnostic Testing

The chart below shows what diagnostic tests are large and are growing fast. Moving left to right on the horizontal axis, total costs incurred get larger. Moving bottom to top on the vertical axis, year-on-year growth in costs increases. Therefore, tests in the upper right corner are both large and growing fast.

Figure 3.1.4 Cost drivers: Areas of cost and cost growth for diagnostic tests [14]



[14] Source: Explorer - Drill by procedure group

The table below breaks down the cost driver for each category analyzed in the prior chart. This allows you to understand whether the changes in cost are driven by a change in pricing or changes in utilization. Also displayed is the average cost from the Verisk Health Normative Database, and the population's cost rank relative to the Norm.

Table 3.1.3 Cost drivers: Change in unit price and change in utilization breakout for diagnostic tests

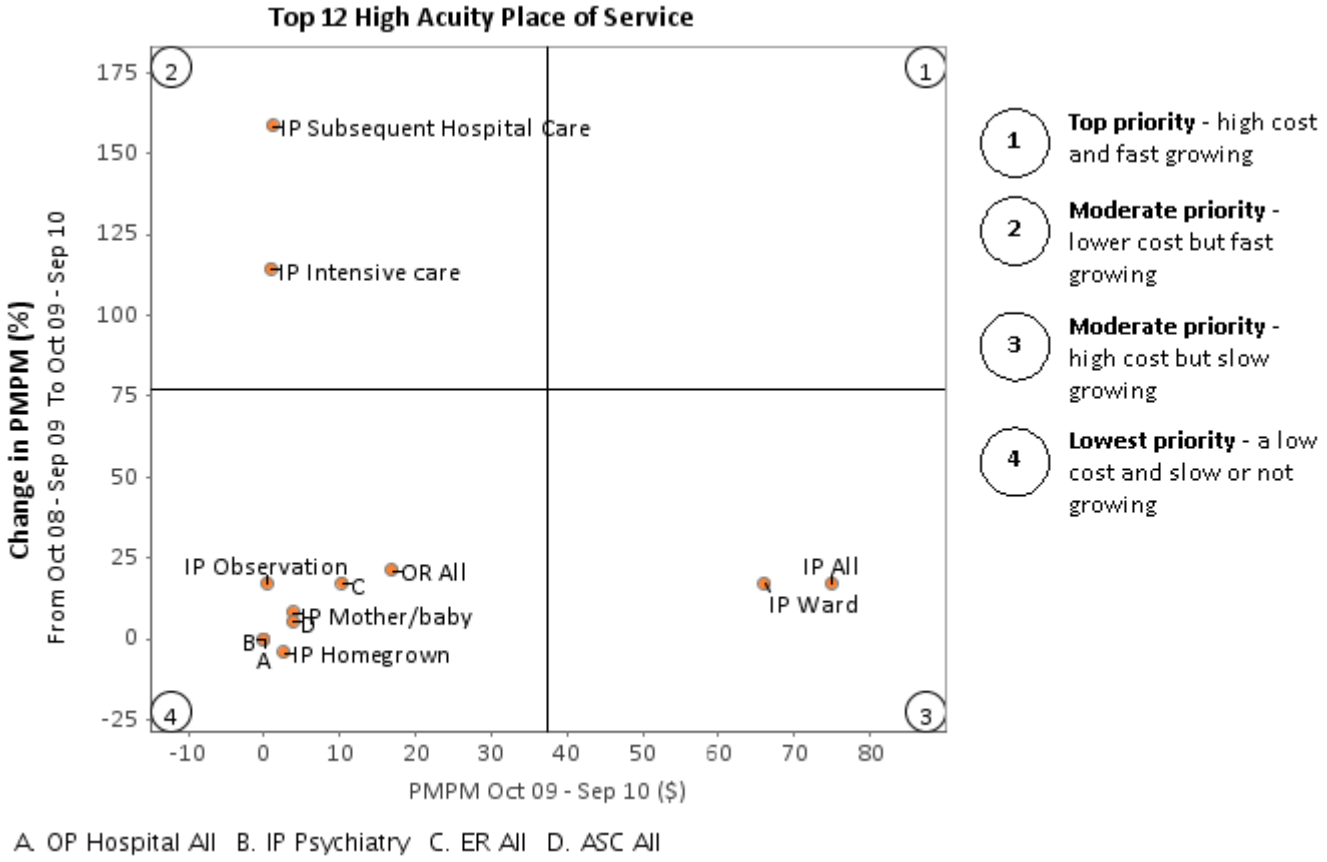
Testing Category	Subcategory	Current PMPM	Change in PMPM	Change in utilization per 1,000	Change in Unit pricing	Norm value of PMPM	Percent Rank(Norm value = 50%)
Cardiology	All	$10.77	71.6%	13.0%	24.7%	-	-
	Ultrasound/Doppler	$9.85	81.6%	16.3%	56.2%	-	-
	Cardiography	$0.82	10.3%	12.3%	-1.8%	-	-
	Electrophysiology	$0.09	-12.4%	-12.8%	0.4%	-	-
	Nuclear Medicine Imaging	$0.00	0.0%	0.0%	0.0%	-	-
Imaging	All	$17.24	17.4%	13.8%	-0.4%	-	-
	MRI	$4.88	25.7%	24.8%	0.7%	-	-
	CT	$4.42	13.6%	16.8%	-2.7%	-	-
	Plain film	$2.49	20.8%	3.6%	16.6%	-	-
	Nuc Med	$1.96	4.3%	1.9%	2.4%	-	-
	US	$1.82	20.5%	43.9%	-16.3%	-	-
	Not classified	$1.66	14.7%	16.0%	-1.2%	-	-
Lab	All	$6.41	11.3%	3.7%	7.3%	-	-
Pathology	All	$1.75	-1.5%	-11.3%	11.1%	-	-
Sleep study	All	$0.63	41.5%	35.7%	4.3%	-	-
Vascular	All	$0.44	44.0%	20.0%	19.9%	-	-

3.1.4 Place of service - Inpatient and high acuity

Monitoring the utilization patterns for chronic conditions offers valuable insight into benefit design and/or case and disease management program performance. In general, high utilization rates for such measures as inpatient admissions and emergency room services in these conditions bring into question the adequacy of outpatient care, plan design incentives to encourage outpatient care, and medical management performance.

The chart below shows which inpatient and high acuity places of service are large and are growing fast. Moving left to right on the horizontal axis, total costs incurred get larger. Moving bottom to top on the vertical axis, year-on-year growth in costs increases. Therefore, locations in the upper right corner are both large and growing fast.

Figure 3.1.5 Cost drivers: Areas of cost and cost growth for hospital and ASC based utilization [15]



[15] Source: Explorer - Drill by unit & service

The table below breaks down the cost driver for each category analyzed in the prior chart. This allows you to understand whether the changes in cost are driven by a change in pricing or a change in utilization. Also displayed is the average cost from the VH Normative Database, and the population's cost rank relative to the Norm.

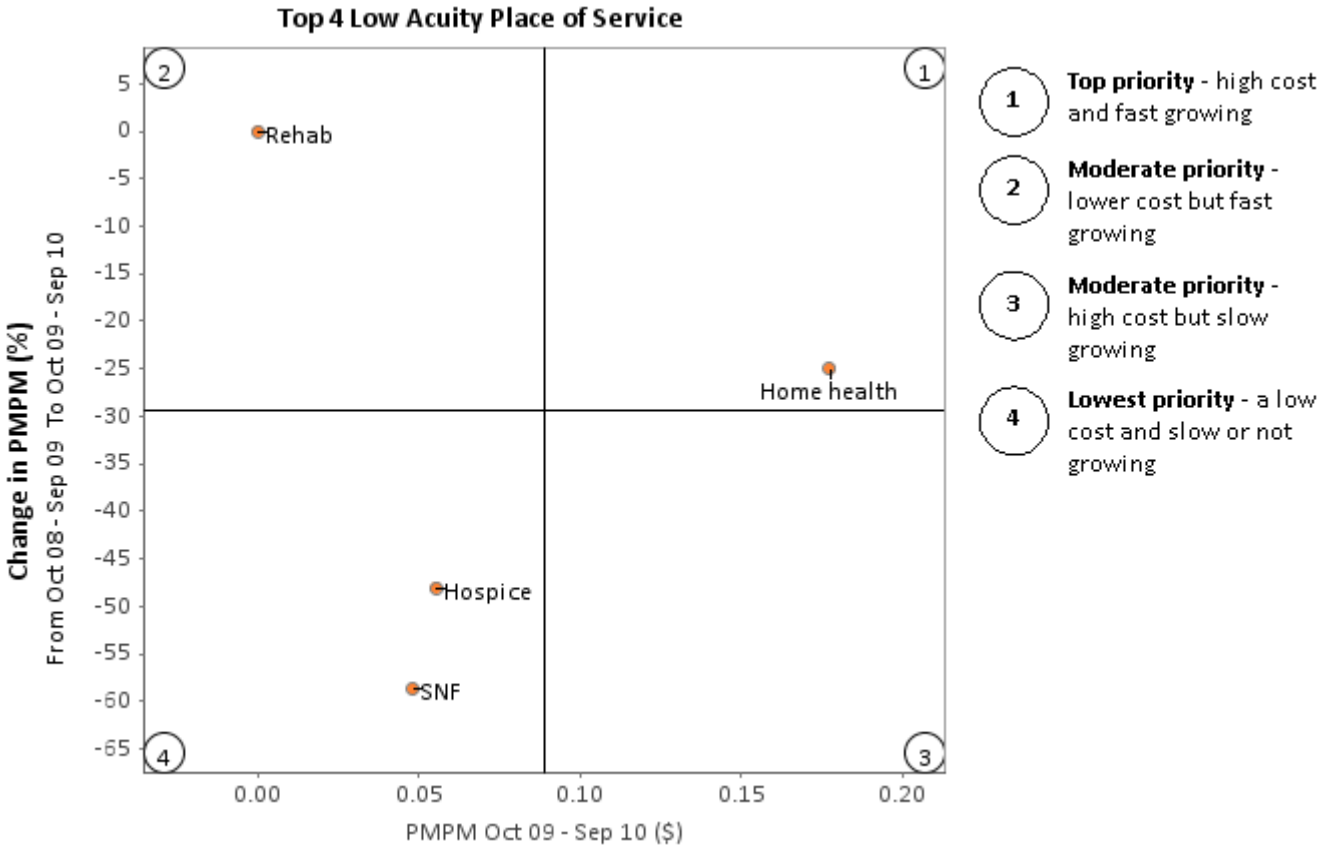
Table 3.1.4 Cost drivers: Change in unit price and change in utilization breakout for Inpatient and high acuity locations of care

Category	Subcategory	Current PMPM	Change in PMPM	Change in utilization per 1,000	Change in Unit pricing	Norm value of PMPM	Percent Rank(Norm value = 50%)
ASC	All	$3.77	5.6%	-7.1%	13.6%	-	-
ER	All	$10.33	17.4%	2.4%	14.6%	-	-
IP	All	$74.91	17.4%	2.4%	11.8%	-	-
	Ward	$66.10	17.2%	8.7%	7.8%	-	-
	Mother/baby	$3.80	8.2%	-18.0%	32.0%	-	-
	Homegrown	$2.65	-4.1%	-31.7%	40.5%	-	-
	Subsequent Hospital Care	$1.10	158.6%	74.9%	47.9%	-	-
	Intensive care	$0.89	114.6%	108.4%	3.0%	-	-
	Observation	$0.36	17.4%	47.6%	-20.4%	-	-
	Psychiatry	$0.00	0.0%	0.0%	0.0%	-	-
OP Hospital	All	$0.00	0.0%	0.0%	0.0%	-	-
OR	All	$16.89	21.4%	2.5%	18.5%	-	-

3.1.5 Place of service – Outpatient and low acuity (excluding office visits)

The chart below shows which outpatient and low-acuity places of service are large and are growing fast. Moving left to right on the horizontal axis, costs incurred by location get larger. Moving bottom to top on the vertical axis, year-on-year growth in costs increases. Therefore, locations in the upper right corner are both large and growing fast.

Figure 3.1.6 Cost drivers: Areas of cost and cost growth for outpatient and community based utilization (excluding office visits)



The table below breaks down the cost driver for each category analyzed in the prior chart. This allows you to understand whether the change in cost seen in chart 3.1.1 is driven by a change in unit price or a change in utilization. Also displayed is the average cost from the VH Normative Database and the population's cost rank relative to the Norm.

Table 3.1.5 Cost drivers: Change in unit price and change in utilization breakout for Outpatient and low acuity care (excluding office visits)

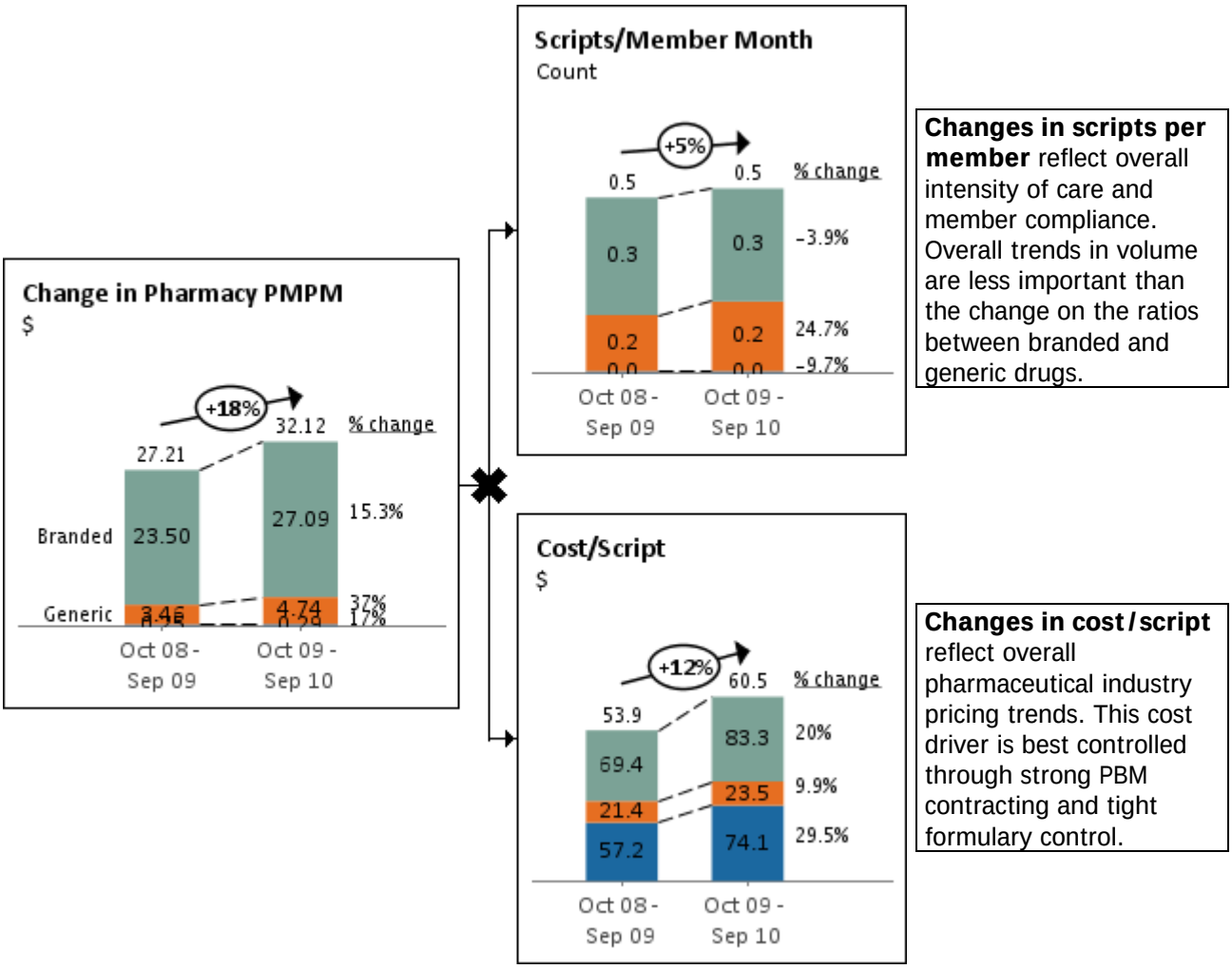
Category	Current PMPM	Change in PMPM	Change in Utilization per 1,000	Change in Unit Pricing	Norm value of PMPM	Percent Rank (Norm value = 50%)
Home health	$0.18	-25.0%	129.2%	-67.3%	-	-
Hospice	$0.06	-48.0%	-41.9%	-10.6%	-	-
SNF	$0.05	-58.7%	-54.4%	-9.5%	-	-
Rehab	$0.00	0.0%	0.0%	0.0%	-	-

3.2 Pharmacy Economics

Year-on-year growth in pharmacy expenses can be attributed to changes in Member Months and pharmacy PMPM cost, as shown in chart 2.2.1.

Increase or decrease of pharmacy PMPM is caused by changes in the number of prescriptions written per Member Month and changes in the cost per prescription.

Figure 3.2.1 Pharmacy Expenses (Refer to Figure 2.2.1) [16]



Changes in scripts per member reflect overall intensity of care and member compliance. Overall trends in volume are less important than the change on the ratios between branded and generic drugs.

Changes in cost/script reflect overall pharmaceutical industry pricing trends. This cost driver is best controlled through strong PBM contracting and tight formulary control.

[16] Source: Explorer - Pharmacy claim type in claims module. Scripts/Member Months and cost/script are calculated by Verisk Health.

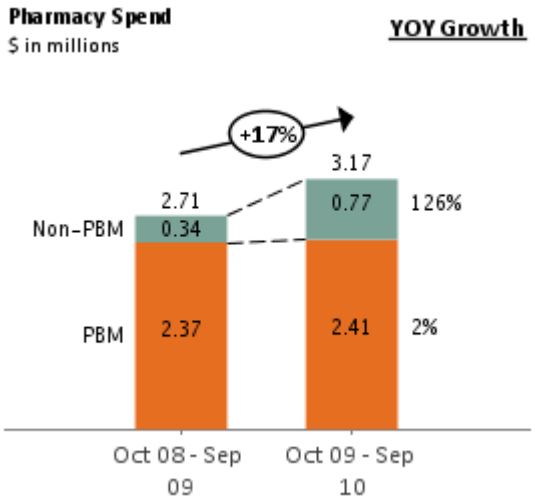
Note: 1) Pharmacy PMPM totals reflect branded, generic and non drug costs. Non drug costs include items like diabetic supplies and syringes which are generally negligible costs. Within the Medical Intelligence application, non- drug charges are located within the non-generic category.

3.2.1 Non-PBM Drug Spend

Non-PBM spend on pharmaceuticals is paid by Health Plan, not the PBM. It is therefore included in medical expenses and usually includes the J-Codes. However, many non-PBM drugs are exceptionally expensive and deserve special attention. Non-PBM drug spend is often best controlled through the use of contracting Specialty Pharmacy networks.

Figure 3.2.2 shows the total pharmacy spend as seen in chart 3.2.1, now with the non-PBM spend added in.

Figure 3.2.2 Distribution of Pharmacy Spend (Refer to Figure 3.2.1) [17]



The top 10 drugs driving non-PBM spend are listed in table 3.2.1, with unit price and utilization values broken out.

Table 3.2.1 Top 10 drugs driving non-PBM spend

Drug	Current PMPM	Change in PMPM	Change in # Scripts	Change in Unit Pricing	Norm value of PMPM	Percent Rank (Norm value = 50%)
Drugs Requiring Detail Codes	$2.36	242.8%	37.0%	115.3%	-	-
Trastuzumab	$2.10	1,099.5%	360.0%	124.2%	-	-
Injection Darbepoetin Alfa 5 Mcg	$0.85	694.5%	327.3%	59.9%	-	-
Pharmacy-R250	$0.61	16.0%	-15.9%	18.6%	-	-
Drugs - Epo Under 10,000 Units	$0.36	324.1%	148.5%	46.8%	-	-
Infliximab Injection	$0.32	-20.4%	-27.3%	-5.8%	-	-
Injection, Oxaliplatin, 0.5 Mg	$0.32	0.0%	0.0%	0.0%	-	-
Injection, Pegfilgrastim, 6 Mg-J2505	$0.30	0.0%	0.0%	0.0%	-	-

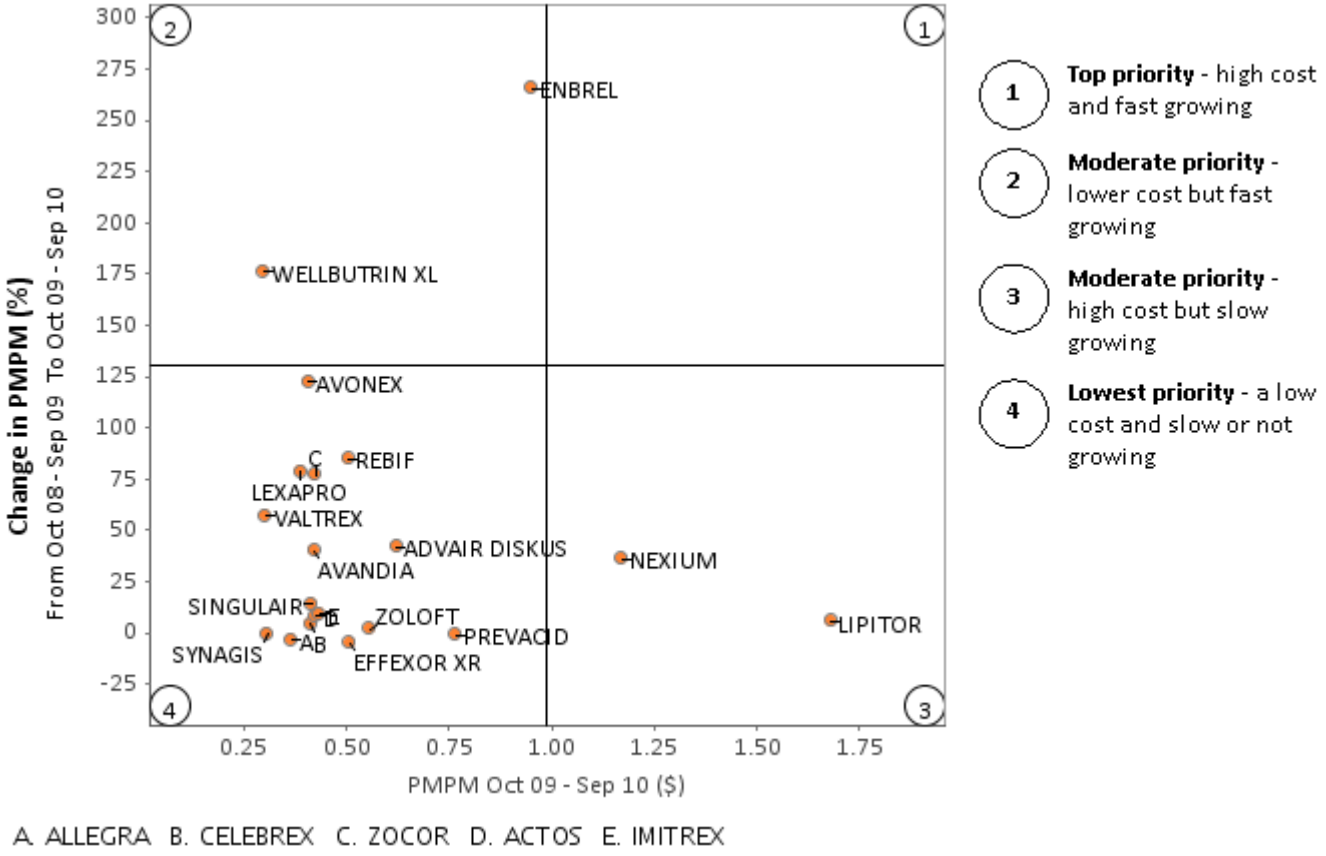
[17] Source: Explorer - Claims module

Drug	Current PMPM	Change in PMPM	Change in # Scripts	Change in Unit Pricing	Norm value of PMPM	Percent Rank (Norm value = 50%)
Drugs Unclassified Injecti	$0.23	213.8%	41.7%	90.5%	-	-
Pharmacy - Incident to Radiolo	$0.21	3.2%	-5.4%	-6.2%	-	-

3.2.2 PBM drug spend

The chart below shows which drugs are large and are growing fast. Moving left to right on the horizontal axis, total costs incurred by drug get larger. Moving bottom to top on the vertical axis, year-on-year growth in costs increases. Therefore, locations in the upper right corner are both large and growing fast. In general, drugs that do not have generic or branded substitutes will typically have the highest rates of cost inflation, but lower overall absolute costs.

Figure 3.2.3 Cost drivers: Areas of cost and cost growth by drug [18]



[18] Source: Explorer - Claims module

Table 3.2.2 Top 20 Drugs [19]

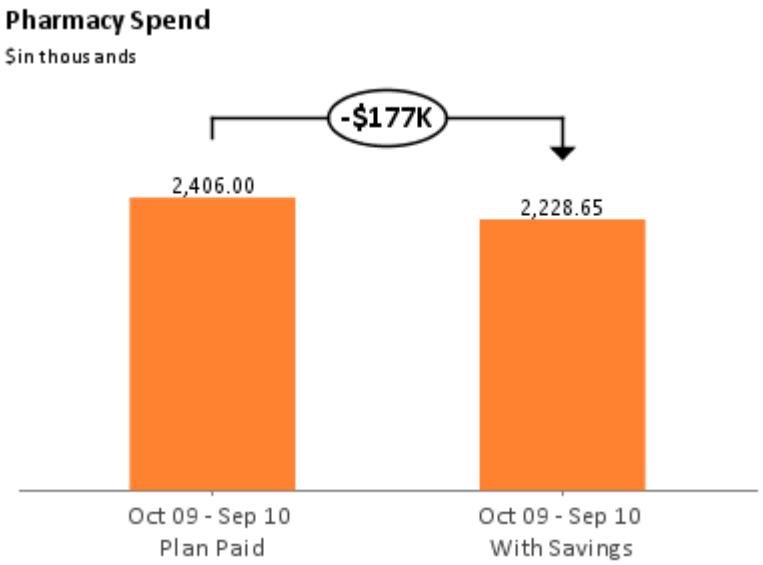
Drugs	Branded to Generic ratio	Current PMPM	Change in PMPM	Change in # Scripts	Change in Unit Pricing	Norm value of PMPM	Percent Rank (Norm value = 50%)
LIPITOR	0.00	$1.68	6.0%	-16.8%	9.6%	-	-
NEXIUM	0.00	$1.17	36.5%	10.7%	6.0%	-	-
ENBREL	0.00	$0.95	266.1%	410.0%	-38.3%	-	-
PREVACID	0.00	$0.76	-0.4%	-14.2%	-0.2%	-	-
ADVAIR DISKUS	0.00	$0.62	42.4%	7.8%	13.7%	-	-
ZOLOFT	0.00	$0.56	2.5%	-9.2%	-2.9%	-	-
EFFEXOR XR	0.00	$0.51	-4.5%	-24.3%	8.4%	-	-
REBIF	0.00	$0.50	85.2%	123.1%	-28.6%	-	-
IMITREX	0.00	$0.43	9.6%	-6.8%	1.1%	-	-
ACTOS	0.00	$0.42	8.6%	-14.3%	8.9%	-	-
ZOCOR	0.00	$0.42	77.3%	41.7%	7.6%	-	-
AVANDIA	0.00	$0.42	40.5%	13.0%	6.9%	-	-
SINGULAIR	0.00	$0.41	14.5%	-5.3%	4.0%	-	-
CELEBREX	0.00	$0.41	4.9%	-12.6%	3.2%	-	-
AVONEX	0.00	$0.40	122.8%	75.0%	9.5%	-	-
LEXAPRO	0.00	$0.39	79.2%	42.9%	7.8%	-	-
ALLEGRA	0.00	$0.36	-3.0%	-26.4%	13.3%	-	-
SYNAGIS	0.00	$0.30	0.0%	0.0%	0.0%	-	-
VALTREX	0.00	$0.30	57.5%	14.4%	18.5%	-	-
WELLBUTRIN XL	2.08	$0.30	176.8%	202.7%	-21.4%	-	-

[19] Source: Explorer - Claims module

3.2.3 Selected prescription cost avoidance opportunities

This cost avoidance analysis is a cost comparison between two therapeutically equivalent drugs. Substantial cost differences can exist between therapeutically equivalent drugs, regardless of whether they are brand or generic. In practice, physician prescribing patterns, consumer demand, and formulary benefit design drive drug utilization. If a less expensive alternative is identified, substitution or formulary design change should be approved by appropriate clinicians.

Figure 3.2.4 Pharmacy spend [20]

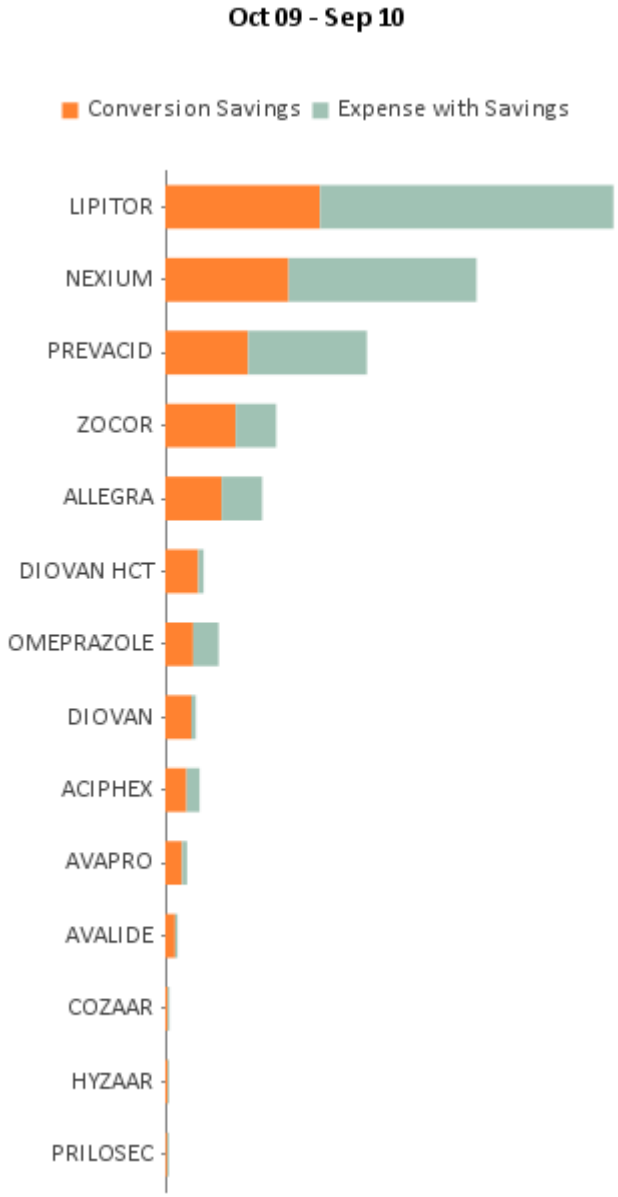


We estimate that savings of $177,343 in pharmaceutical spend from Oct 09 - Sep 10 exist.

[20] Source: VH identified savings – sum of positive potential savings in conversion analyzer module of Explorer Pharmacy plan paid – pharmacy claim type in claims module of Explorer

Our drug Conversion Analyzer feature compares the cost that a company pays for a drug, at the company level, to the average cost of a clinically equivalent substitute, at the portfolio level. The conversion opportunities we assess are non-controversial, clinically acceptable substitutions.

Figure 3.2.5 Savings opportunity through Conversion Analyzer [21]



	Plan Paid Pharmacy Expense $ in K	Alternate Drug	Conversion Savings	Expense With Savings $ in K
LIPITOR	$126.37	CRESTOR	34.5%	$82.76
NEXIUM	$87.75	PROTONIX	39.7%	$52.94
PREVACID	$56.83	PROTONIX	41.1%	$33.50
ZOCOR	$31.26	CRESTOR	63.4%	$11.43
ALLEGRA	$27.31	ZYRTEC	58.0%	$11.46
DIOVAN HCT	$10.80	BENICAR HCT	86.5%	$1.46
OMEPRAZOLE	$15.00	PROTONIX	52.1%	$7.19
DIOVAN	$8.60	BENICAR	85.5%	$1.25
ACIPHEX	$9.67	PROTONIX	62.0%	$3.68
AVAPRO	$6.12	BENICAR	77.0%	$1.41
AVALIDE	$3.42	BENICAR HCT	81.0%	$0.65
COZAAR	$1.20	BENICAR	61.2%	$0.46
HYZAAR	$1.13	BENICAR HCT	59.6%	$0.46
PRILOSEC	$1.01	PROTONIX	51.6%	$0.49
		Total =		**$209.13K**

[21] ***Note:***

1. The Potential Savings are calculated by comparing the Current Drug average cost for Acme Corp. to the average cost of the Alternate Drug derived from the selected group(s). This can occasionally lead to there being a cost avoidance opportunity from switching both to and from a drug and its substitute
2. Verisk Health does not take into consideration any pharmacy rebate information
3. Statin conversion opportunities account for differential drug potencies and dose sizes
4. Plavix and Celebrex opportunity calculations exclude members that meet standard prescribing indications for those drugs
5. Conversion savings refers to the percent of the plan paid pharmacy expense that can potentially be saved.

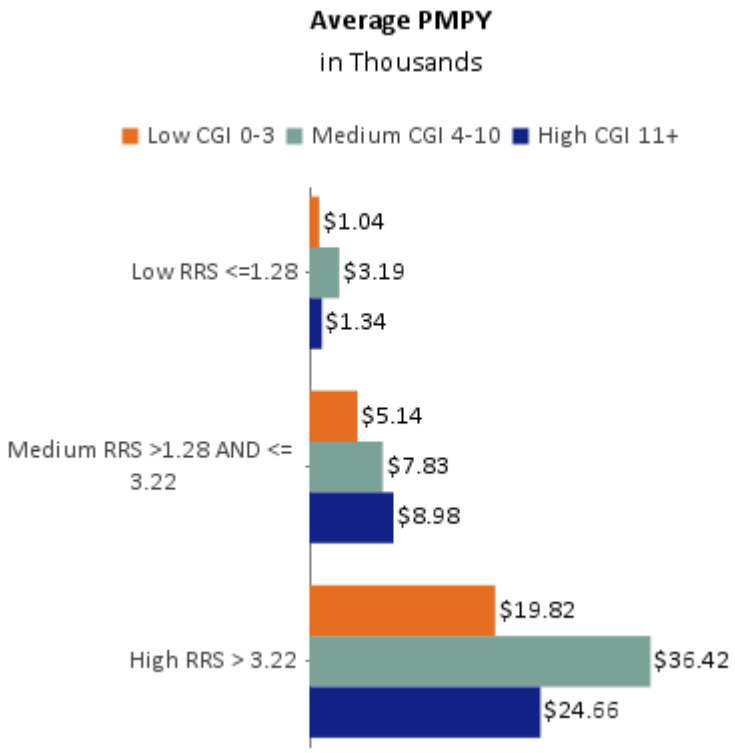
4 CLINICAL DEEP DIVES

4.1 General Clinical Quality Performance and Economic Opportunity

The RRS is a quantitative assessment of disease and risk burden at a population level. The Care Gap Index (CGI) quantifies the gaps identified for a population. Verisk Health utilizes these two factors to understand the association between disease burden, quality, and cost.

In figure 4.1.1, members are grouped by RRS, and then by CGI. Members with a high risk index generally incur higher costs and have more gaps in care. However, for each RRS bucket, corresponding decreases in care gaps (and the CGI) are associated with decreases in the total medical spend.

Figure 4.1.1 Member costs by Risk and CGI buckets [22]

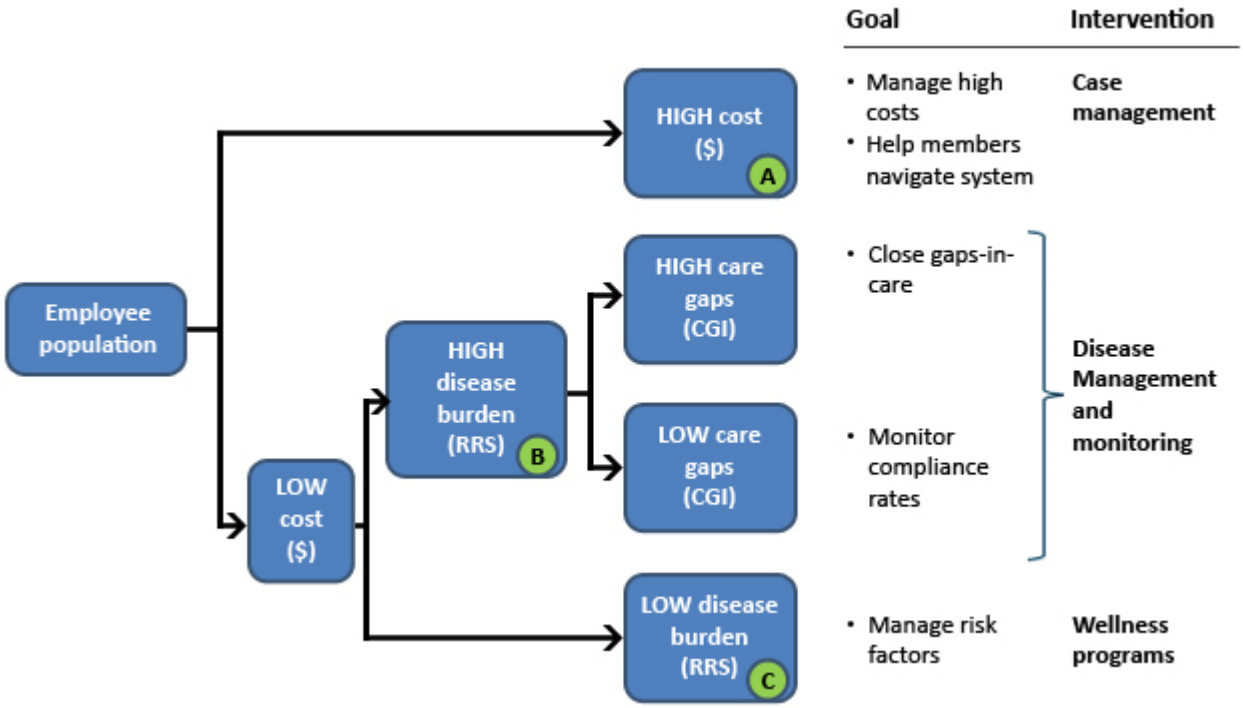


	Members Count	**Total Spend** $ in Millions
Low RRS <=1.28	4,194	7.49
	327	1.91
	4	0.01
Medium RRS >1.28 AND <= 3.22	466	4.55
	242	3.64
	11	0.19
High RRS > 3.22	46	1.72
	53	3.82
	4	0.19
	5,347	**23.52**

[22] Refer to Table 5.5.1 in Appendix 5.5 for further detail about RRS buckets.
Gautam Ph.D., Shiva, and Surya Singh, M.D. "Predicting Overall and Impactable Future Cost with the Verisk Health Risk Modeling System".
Note:
1. The ranges for risk index/relative risk score and care gap index are calculated based on an approximate distribution of 80%, 15%, and 5% of members for low, medium, and high groups respectively from the Verisk Health Normative database.
2. Members Count totals in the graph may vary from Total Current Members based on eligibility dates on the last month of the report period.

To stratify a total population for health management, we use the RRS (disease burden), the Care Gap Index (gaps in clinical care), and cost. Using these factors, any population can be comprehensively categorized into the mutually exclusive categories, each with specific interventions. Below is a graphical representation of the Verisk Health recommended classification approach. Sections 4.2 through 4.4 correspond to the recommended category-based interventions.

Figure 4.1.2 Framework for Population based Health Management [23]



A: Case Management opportunities:
Members with annual total spend greater than $25,000 are considered high cost and should be managed closely. The cut-off value of $25,000 can be modified while doing stratification within D2Explorer; we recommend choosing a cutoff point that is consistent with ones individual reinsurance threshold.

B: Disease Management opportunities:
Members with annual spending less than $25,000 are considered low cost. Of the low cost members, those with a disease burden greater than 95% of the population are considered high disease burden, and should be addressed through Disease Management monitoring and intervention. (As with the total cost cutoff, the disease burden cutoff that is chosen can be modified in D2Explorer).

Those with a high disease burden and numerous gaps in care (a high CGI) require disease management to reduce gaps and prevent high cost claims. On the other hand, members with high compliance rates - as manifest by a low care gap index should be monitored for continued compliance.

C: Wellness opportunities:
Members with low cost and low disease burden should be primarily addressed through Wellness Programs that reduce the risk factors for developing chronic diseases.

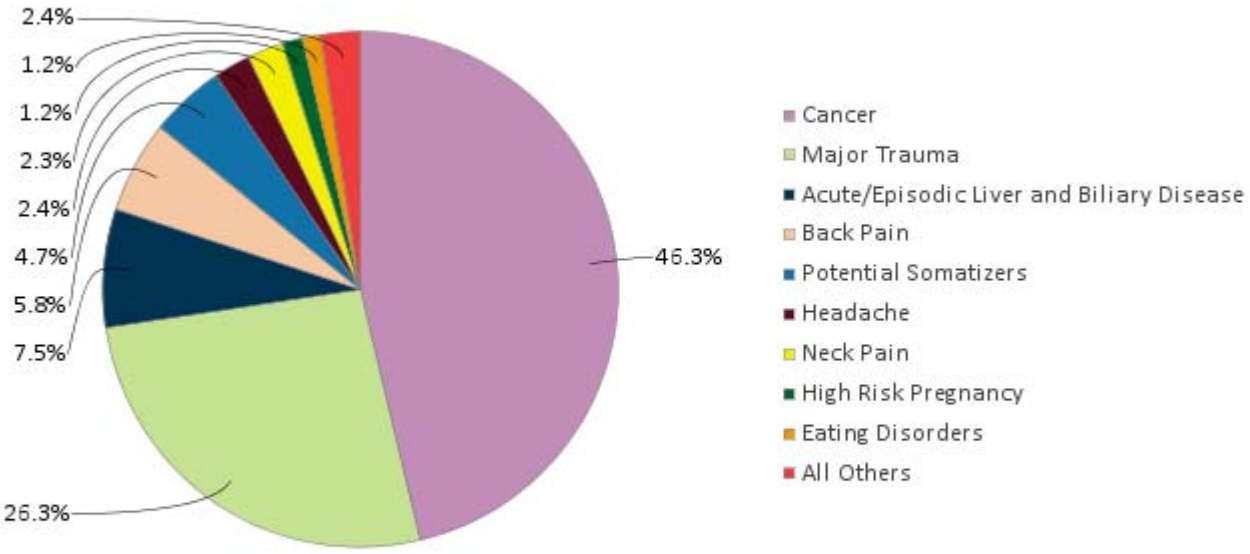
[23] Source: Explorer - Individual Module: stratify by RI, CGI, and cost

4.2 Case Management Opportunities

As discussed in Figure 4.1.2, Verisk Health uses the RRS, Care Gap Index (CGI) and total cost to stratify a population for Disease Management. Patients who have incurred a high total spend (>$25,000 PMPY) will generally benefit from Case Management. This corresponds to Category "A" in Figure 4.1.2. If the data is sent to Verisk Health, Sightlines Medical Intelligence can be used to assess what proportion of high-cost members is currently enrolled in Case Management.

Figure 4.2.1 displays the highest paid diagnoses for members of this population.

Figure 4.2.1 Frequency of primary diagnosis of high cost members (>$25,000 PMPY)



4.3 Disease Management Opportunities

As discussed in Figure 4.1.2, Verisk Health uses the RRS, Care Gap Index (CGI) and total cost to stratify a population for Disease management. Patients who are low cost, have a high RRS, and have a numerous addressable gaps in care (i.e., have a high CGI) will generally benefit from Disease Management. This corresponds to Category "B" in Figure 4.1.2.

Table 4.3.1 synthesizes the 'clinical condition'/disease severity and the associated Care Gap Index for the entire population across key 'clinical condition'/disease categories into a "heat map". Focused intervention (e.g. an initiative to increase compliance with ace-inhibitors and beta-blockers in patients with heart failure) based on this information can significantly improve health plan performance over time. These Quality & Risk Measures can become the basis for identification and stratification of plan participants for disease management and case management program participation.

Table 4.3.1 Verisk Health Quality & Risk Measures [24]

Clinical Condition	Disease Burden Summary	Care Gap Measure Performance Summary
Asthma	74.8%	-5.1%
Cardiac	-20.8%	27.4%
COPD	-27.8%	-24.4%
Diabetes	46.1%	2.1%
Geriatric	-10.1%	23.9%
Mental Health	-26.3%	-47.3%
Pregnancy	12.9%	126.4%
Renal Failure	156.9%	-49.4%

Performance Relative to Verisk Health Norms

- Good
- Average
- Poor

Please Note: If the underlying CPT codes for each laboratory test or panel are not submitted to Verisk Health in the medical claims then the compliance in the Quality and Risk Measures will appear lower than they actually are.

[24] Refer to Table 5.5.3 and 5.5.4 in Appendix 5.5 for further detail.
Note:

1. This analysis is based upon the full cycle period of data within D2Explorer; this is typically a 24 month period.
2. The results displayed in this table are based on current members.
3. COPD: Chronic Obstructive Pulmonary Disease

4.4 Wellness Management Opportunities

As discussed in Figure 4.1.2, Verisk Health uses the RRS, Care Gap Index (CGI) and total cost to stratify a population for Disease management. Patients who are well are most efficiently addressed through Wellness Programs. This corresponds to Category "C" in Figure 4.1.2.

Table 4.4.1 details screening and preventative tests - and the associated compliance with these tests - for the entire population. These data are benchmarked against the Verisk Health Commercial Norm. Wellness programs (e.g. an initiative to increase mammogram compliance rates) based on this information can significantly improve health plan performance on these measures.

Table 4.4.1 Preventative Measures [25]

Performance Relative to Verisk Health Norms

Good
Average
Poor

Group	Condition	Screening/Preventive	Variation from Norm
Both	>=50 years old	Patients without any colorectal cancer screening in the analysis period.	-2.4%
	>= 51 years old	Patients without long office visit in the last 2 years.	0.3%
Male	Men >50 years old	Men without PSA level in the last 2 years (controversial test).	6.1%
Female	Women >20 y/o	Women without pap smear in the last two years.	-2.4%
	Women between 40 and 49 y/o	Women without a mammogram performed at least every two years.	-0.3%
	Women between 21 and 65 y/o	Women without pap smear in the analysis period.	-1.6%
	Women >=49 y/o	Women without mammogram in last 12 months.	0.8%
	Women between 40 and 49 y/o	Women without mammogram in the analysis period.	-0.3%
	Women between 49 and 69 y/o	Women without mammogram in the last 18 months.	0.4%

Please Note: If the underlying CPT codes for each laboratory test or panel are not submitted to Verisk Health in the medical claims then the compliance in the Quality and Risk Measures will appear lower than they actually are.

[25] Refer to Table 5.5.2 in Appendix 5.5 for further detail.
Note:

1. This analysis is based upon the full cycle period of data within D2Explorer; this is typically a 24 month period.
2. The results displayed in this table are based on current members.

5 APPENDIX

5.1 Demographics

Table 5.1.1 Breakdown of membership by relationship

	Avg. Age	Members		Total Amount Billed	Employee Paid	Member Expenses	
		Total	Current			Total	% of Total
Employee	43.8	4,105	2,396	$34,126,878	$4,567,984	$20,181,233	55.0%
Spouse	45.9	2,065	1,131	$19,152,200	$2,284,945	$9,542,963	26.0%
Dependent	12.5	3,473	1,854	$12,378,500	$1,734,801	$6,983,657	19.0%
Total	**33.0**	**9,643**	**5,381**	**$65,657,578**	**$8,587,730**	**$36,707,852**	**100.0%**

5.2 Financial Analyses

Table 5.2.1 Medical and Pharmacy Claims by Month (Oct 08 - Sep 09)

Category	Paid Date												
	Oct-08	Nov-08	Dec-08	Jan-09	Feb-09	Mar-09	Apr-09	May-09	Jun-09	Jul-09	Aug-09	Sep-09	Total
Medical	$809,747	$1,231,517	$1,421,874	$1,010,211	$1,229,067	$1,705,589	$931,594	$1,313,336	$1,552,361	$1,522,349	$1,302,464	$1,412,596	$15,442,706
Medical PMPM	$106	$162	$189	$134	$164	$232	$126	$180	$213	$222	$200	$215	$2,142
Pharmacy	$189,676	$194,894	$191,575	$200,927	$183,602	$202,560	$257,591	$117,293	$256,713	$195,515	$180,439	$199,044	$2,369,829
Pharmacy PMPM	$25	$26	$25	$27	$24	$28	$35	$16	$35	$28	$28	$30	$327
Total	$999,422	$1,426,410	$1,613,449	$1,211,139	$1,412,669	$1,908,149	$1,189,185	$1,430,629	$1,809,075	$1,717,864	$1,482,902	$1,611,640	$17,812,535
Total PMPM	$130	$188	$214	$161	$188	$260	$161	$196	$248	$250	$228	$245	$2,469

Table 5.2.2 Medical and Pharmacy Claims by Month (Oct 09 - Sep 10)

Category	Paid Date												
	Oct-09	Nov-09	Dec-09	Jan-10	Feb-10	Mar-10	Apr-10	May-10	Jun-10	Jul-10	Aug-10	Sep-10	Total
Medical	$1,005,162	$999,428	$1,690,491	$1,167,602	$1,463,050	$1,239,727	$1,632,940	$1,612,138	$2,158,009	$917,864	$1,187,276	$1,415,636	$16,489,321
Medical PMPM	$154	$153	$259	$178	$223	$190	$253	$251	$338	$164	$219	$262	$2,644
Pharmacy	$213,292	$182,736	$210,167	$201,667	$207,485	$197,273	$189,027	$237,809	$231,903	$171,748	$170,231	$192,659	$2,405,996
Pharmacy PMPM	$33	$28	$32	$31	$32	$30	$29	$37	$36	$31	$31	$36	$386
Total	$1,218,453	$1,182,164	$1,900,658	$1,369,269	$1,670,535	$1,436,999	$1,821,967	$1,849,946	$2,389,912	$1,089,613	$1,357,507	$1,608,294	$18,895,318
Total PMPM	$187	$181	$291	$209	$255	$221	$282	$288	$374	$195	$250	$298	$3,029

Table 5.2.3 Expense Distribution

Band	# Members	Total Member Expenses	Avg. Expense per Member	% Total Paid	
				Actual	Norm
1%	96	$13,474,407	$140,358	36.7%	30.3%
2-5%	386	$9,445,791	$24,471	25.7%	27.3%
6-15%	964	$7,358,759	$7,634	20.0%	23.3%
16-30%	1,447	$4,060,946	$2,806	11.1%	12.5%
31-60%	2,893	$2,137,624	$739	5.8%	6.2%
61-100%	3,857	$230,326	$60	0.6%	0.4%
Total	**9,643**	**$36,707,853**	**$176,068**	**100.0%**	**100.0%**

This table shows medical claim payments in relation to the date when the claims were incurred (date of service). The table is useful for developing completion factors which allow forward projections of monthly payments and for estimating incurred but not reported (IBNR) claims.

Table 5.2.4 Medical Claim Lag Report [26]

Paid Date	Service Date													
	All Prior	Oct-09	Nov-09	Dec-09	Jan-10	Feb-10	Mar-10	Apr-10	May-10	Jun-10	Jul-10	Aug-10	Sep-10	Total
Oct-09	**$943,262**	$61,900												**$1,005,162**
Nov-09	**$475,701**	$468,554	$55,173											**$999,428**
Dec-09	**$464,320**	$342,290	$785,689	$98,192										**$1,690,491**
Jan-10	**$117,792**	$183,928	$286,050	$495,634	$84,198									**$1,167,602**
Feb-10	**$164,787**	$67,920	$171,139	$299,205	$629,384	$130,614								**$1,463,050**
Mar-10	**$183,464**	$27,006	$49,440	$85,381	$259,750	$527,028	$107,658							**$1,239,727**
Apr-10	**$181,096**	$15,366	$47,957	$45,754	$135,254	$520,426	$629,294	$57,793						**$1,632,940**
May-10	**$24,517**	$42,233	$40,809	$98,315	$67,374	$187,296	$475,057	$586,554	$89,982					**$1,612,138**
Jun-10	**$41,447**	$30,651	$15,203	$45,871	$113,566	$105,290	$384,432	$749,169	$597,112	$75,269				**$2,158,009**
Jul-10	**$18,010**	$3,947	$31,224	$6,517	$16,176	$19,760	$32,483	$53,590	$253,207	$459,893	$23,057			**$917,864**
Aug-10	**$6,827**	$2,209	$11,903	$85,815	$2,441	$10,419	$40,704	$110,481	$163,133	$462,312	$272,910	$18,122		**$1,187,276**
Sep-10	**$16,951**	$706	$4,234	$26,314	$8,241	$24,290	$18,242	$75,322	$85,514	$193,818	$456,056	$440,325	$65,625	**$1,415,636**
Total Plan Paid Medical	**$2,638,173**	**$1,246,709**	**$1,498,820**	**$1,286,998**	**$1,316,386**	**$1,525,124**	**$1,687,870**	**$1,632,910**	**$1,188,947**	**$1,191,291**	**$752,022**	**$458,447**	**$65,625**	**$16,489,321**

[26] ***Note:***

1. Utilization metrics are always calculated on an incurred basis.
2. The last two or three months of the year will show decreased values due to 'claims lag', and should be interpreted with caution.

Table 5.2.5: Medical Claim Lag Report and IBNR

Paid	Incurred													Monthly Paid			Lag	
	0Mths	1Mths	2Mths	3Mths	4Mths	5Mths	6Mths	7Mths	8Mths	9Mths	10Mths	11Mths	12+ Mths	Total	Current 12Mths	Prior 12Mths	Mthly	Qtly
Oct-09	$61,900	$511,711	$150,536	$46,703	$24,094	$62,473	$10,436	$11,099	$24,912	$7,719	$1,085	$1,323	$91,172	$1,005,162	$61,900	$943,262	2.88	
Nov-09	$55,173	$468,554	$219,046	$43,736	$77,700	$37,768	$4,039	$17,470	$57,157	$3,574	$1,658	$1,883	$11,670	$999,428	$523,727	$475,701	2.35	
Dec-09	$98,192	$785,689	$342,290	$88,943	$23,329	$46,508	$36,012	$4,315	$4,180	$1,479	$196,838	$16,255	$46,462	$1,690,491	$1,226,171	$464,320	2.99	2.79
Jan-10	$84,198	$495,634	$286,050	$183,928	$32,395	$37,530	$29,735	$6,354	$1,861	$1,748	$1,509	$830	$5,830	$1,167,602	$1,049,810	$117,792	1.96	
Feb-10	$130,614	$629,384	$299,205	$171,139	$67,920	$26,533	$15,262	$10,271	$15,911	$1,778	$1,598	$6,750	$86,684	$1,463,050	$1,298,263	$164,787	2.45	
Mar-10	$107,658	$527,028	$259,750	$85,381	$49,440	$27,006	$73,213	$6,828	$6,646	$10,788	$1,701	$532	$83,756	$1,239,727	$1,056,263	$183,464	2.66	2.37
Apr-10	$57,793	$629,294	$520,426	$135,254	$45,754	$47,957	$15,366	$25,869	$53,820	$7,319	$7,078	$536	$86,473	$1,632,940	$1,451,844	$181,096	2.68	
May-10	$89,982	$586,554	$475,057	$187,296	$67,374	$98,315	$40,809	$42,233	$8,088	$4,842	$2,307	$1,320	$7,959	$1,612,138	$1,587,621	$24,517	2.26	
Jun-10	$75,269	$597,112	$749,169	$384,432	$105,290	$113,566	$45,871	$15,203	$30,651	$10,193	$1,186	$1,889	$28,178	$2,158,009	$2,116,562	$41,447	2.47	2.47
Jul-10	$23,057	$459,893	$253,207	$53,590	$32,483	$19,760	$16,176	$6,517	$31,224	$3,947	$3,619	$2,713	$11,679	$917,864	$899,854	$18,010	2.17	
Aug-10	$18,122	$272,910	$462,312	$163,133	$110,481	$40,704	$10,419	$2,441	$85,815	$11,903	$2,209	$2,026	$4,801	$1,187,276	$1,180,449	$6,827	2.79	
Sep-10	$65,625	$440,325	$456,056	$193,818	$85,514	$75,322	$18,242	$24,290	$8,241	$26,314	$4,234	$706	$16,951	$1,415,636	$1,398,685	$16,951	2.46	2.50
Total														**$16,489,321**	**$13,851,149**	**$2,638,173**		
Average Monthly Paid														**$1,374,110**				
IBNR in Months																	**2.52**	

	Projected IBNR Based on Last Month's Lag	Projected IBNR Based on Last Quarter's Lag	Projected IBNR Based on Last Year's Average Lag
Incurred and Paid in Current Period	$13,851,149	$13,851,149	$13,851,149
Lag Factor	2.46	2.50	2.52
Incurred and Paid as a % of Total	0.79	0.79	0.79
Total Incurred	$17,430,359	$17,487,796	$17,539,130
Projected IBNR	$3,579,211	$3,636,647	$3,687,981

Table 5.2.6 Network Utilization and Contract Discount Summary

Network	Total					
	Claims Billed	Claims Allowed	Claims Paid	Employee Contribution	Network Discount	% Discount
All In Network	$51,312,870	$33,433,939	$27,362,665	$4,630,884	$17,878,931	34.8%
All Out-of-Network	$9,564,487	$6,847,543	$4,569,362	$2,147,822	$2,716,944	28.4%
Total	**$60,877,356**	**$40,281,482**	**$31,932,027**	**$6,778,706**	**$20,595,875**	**33.8%**

5.3 Disease Fingerprint

Table 5.3.1 presents utilization patterns of members with chronic conditions, ranked by number of members, for total office visits, emergency room visits and hospital admissions.

Table 5.3.1 Chronic Conditions Utilization Summary

Chronic Condition	# of Members	Members per 1000	Office Visits per 1000	ER Visits per 1000	Admissions per 1000	PMPY
Hyperlipidemia	540	80.0	6,276.1	197.4	108.0	$6,107.62
Hypertension	537	79.5	6,630.1	258.8	157.8	$9,392.36
Diabetes	244	36.1	6,954.5	264.8	202.2	$9,950.91
Asthma	163	24.1	7,588.5	272.3	112.6	$4,687.08
Osteoarthritis	144	21.3	8,669.1	281.6	217.2	$10,277.60
Coronary Artery Disease (incl. MI)	137	20.3	8,066.9	497.4	359.5	$15,542.75
Congenital Anomalies	79	11.7	7,337.4	292.3	270.4	$11,626.07
Chronic Obstructive Pulmonary Disease	47	7.0	9,660.7	556.4	493.2	$20,121.68
Bipolar Disorder	38	5.6	14,650.0	550.0	333.3	$5,451.58
Chronic Liver and Biliary Disease	36	5.3	9,756.7	476.3	368.8	$17,320.83
Rheumatoid Arthritis	32	4.7	8,544.2	339.2	254.4	$11,631.46
Cerebrovascular Disease	32	4.7	10,685.2	629.6	500.0	$20,214.64
Atrial Fibrillation	22	3.3	10,533.6	513.2	464.4	$44,582.51
Inflammatory Bowel Diseases	21	3.1	9,678.3	547.8	339.1	$9,816.14
Congestive Heart Failure	20	3.0	9,953.3	672.9	757.0	$37,044.80
Osteoporosis	19	2.8	5,388.9	222.2	83.3	$11,570.93
Coagulopathy	17	2.5	10,747.3	461.5	560.4	$37,107.64
Demyelinating Diseases	17	2.5	6,949.3	322.4	0.0	$10,851.12
Chronic Renal Failure	12	1.8	15,604.6	730.0	1,095.1	$68,882.00
Immune Disorders	11	1.6	16,980.2	948.6	996.0	$62,615.90
Major Organ Transplant	7	1.0	19,680.0	1,120.0	1,760.0	$105,368.58
Ulcerative Colitis	7	1.0	12,560.0	240.0	320.0	$10,184.17
HIV/Aids	5	0.7	6,117.6	352.9	235.3	$18,062.15
Cirrhosis	4	0.6	8,553.2	1,276.6	1,531.9	$36,185.91
Parkinson's Disease	4	0.6	18,875.0	375.0	125.0	$14,990.16
Schizophrenia	1	0.1	14,285.7	571.4	571.4	$4,837.75
Gaucher's Disease	1	0.1	14,000.0	1,500.0	1,500.0	$33,616.50

Note:

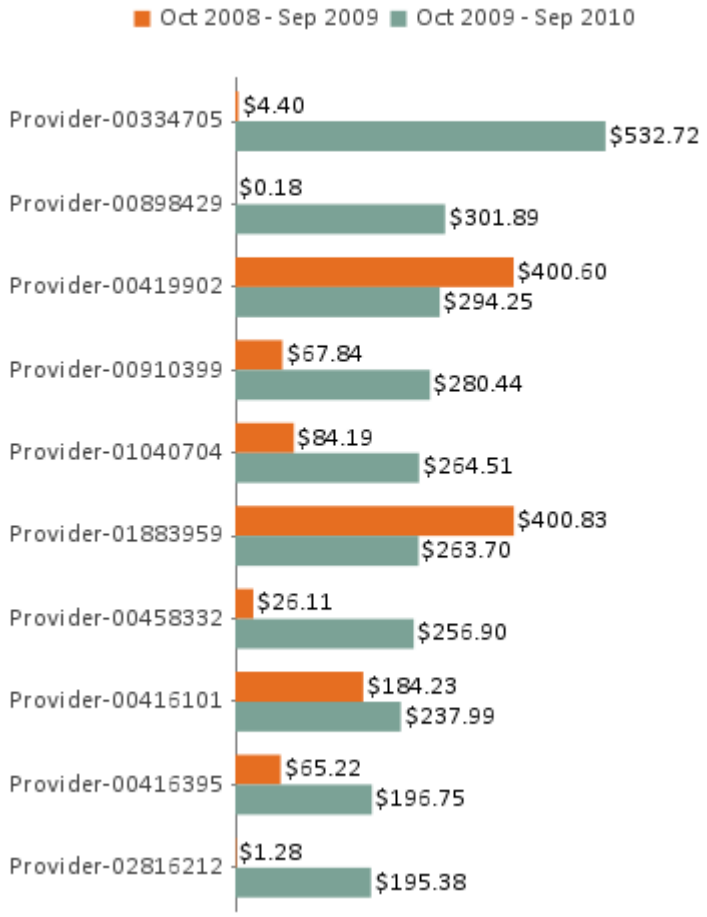
1. In this table a member can have multiple chronic conditions.
2. The results displayed in this table are based on claims incurred.

5.4 "Top 10" Analysis

5.4.1 Providers

Table 5.4.1 shows the top 10 providers, based on medical claim expenses, providing services to the members of your population. The providers generating the most claim expenses are usually institutional. Network changes or changes in provider reimbursement strategy may cause period-over-period percentage changes.

Table 5.4.1 Total Plan Paid ($K) by Providers



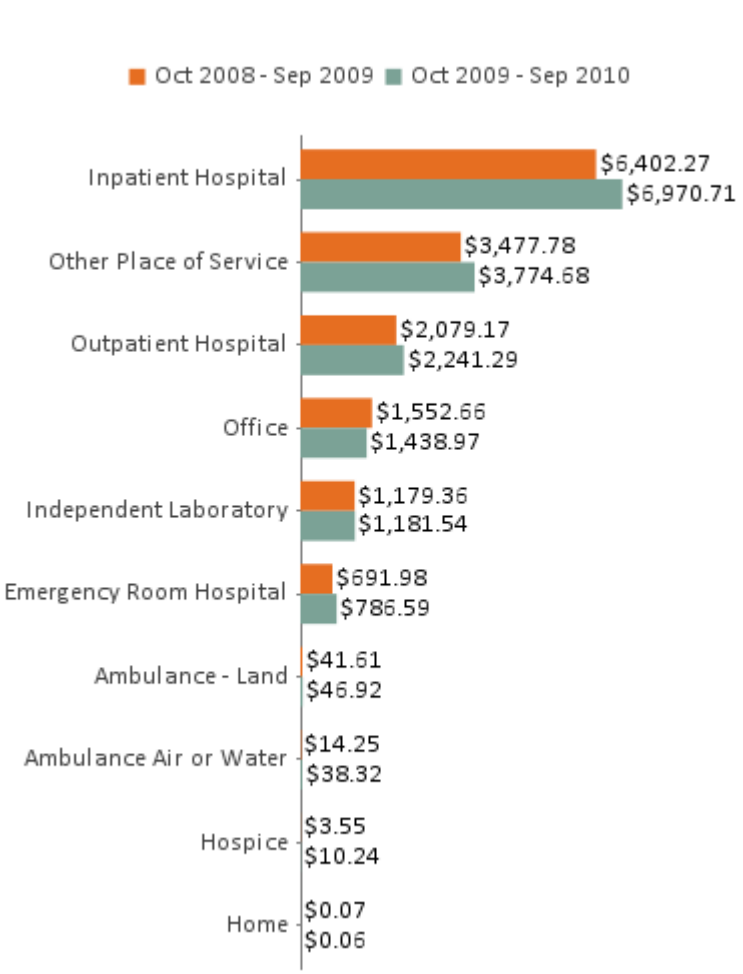
% of Total Plan Paid Oct 2009 - Sep 2010	% Change in Plan Paid
3.2%	11,997.2%
1.8%	170,237.1%
1.8%	-26.5%
1.7%	313.4%
1.6%	214.2%
1.6%	-34.2%
1.6%	884.0%
1.4%	29.2%
1.2%	201.7%
1.2%	15,110.0%

Provider	Oct 2008 - Sep 2009		Oct 2009 - Sep 2010		% Change in Plan Paid
	Plan Paid	% of Total Plan Paid	Plan Paid	% of Total Plan Paid	
Subtotal	$1,234,877	8.0%	$2,824,532	17.1%	128.7%
All Others	$14,207,829	92.0%	$13,664,789	82.9%	-3.8%
Total	$15,442,706	100.0%	$16,489,321	100.0%	6.8%

5.4.2 Places of Service

Table 5.4.2 shows places of service ranked according to medical claim expenses. Period-over-period percentage changes in Place of Service can be helpful when investigating changes in utilization patterns or when trying to understand the impact of plan design change. Increases in some categories may be appropriate. For example, outpatient hospital experience and office visits may increase as inpatient hospital services are more efficiently provided in the outpatient setting. Places of service experiencing large increases for many employers are Emergency Room, Outpatient Hospital, and Laboratory services.

Table 5.4.2 Total Plan Paid ($K) by Place of Service



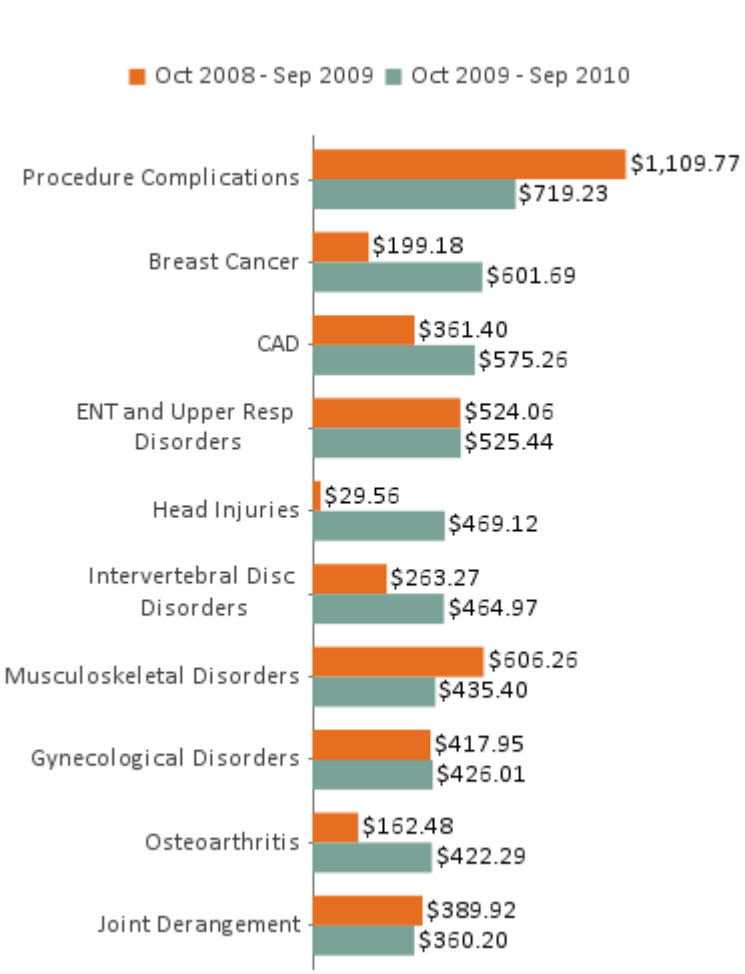
% of Total Plan Paid Oct 2009 - Sep 2010	% Change in Plan Paid
42.3%	8.9%
22.9%	8.5%
13.6%	7.8%
8.7%	-7.3%
7.2%	0.2%
4.8%	13.7%
0.3%	12.8%
0.2%	168.9%
0.1%	188.1%
0.0%	-14.4%

Service	Oct 2008 - Sep 2009		Oct 2009 - Sep 2010		% Change in Plan Paid
	Plan Paid	% of Total Plan Paid	Plan Paid	% of Total Plan Paid	
Subtotal	$15,442,706	100.0%	$16,489,321	100.0%	6.8%
All Others	$0	0.0%	$0	0.0%	0.0%
Total	$15,442,706	100.0%	$16,489,321	100.0%	6.8%

5.4.3 Diagnostic groups

Table 5.4.3 shows the top 10 diagnostic groups ranked according to medical claim expenses. Grouping of data into broad diagnostic categories assists in the identification of illness patterns that are unique to your population. Diagnostic groups with significant period-over-period increases should be examined in more detail. The distribution will be different depending on whether the group in question is Medicaid, Medicare or commercial. For a commercial population, diagnostic groups usually at or near the top of the list include ENT and upper respiratory disorders, gynecological disorders, and musculoskeletal conditions.

Table 5.4.3 Total Plan Paid ($K) by Diagnostic Groups



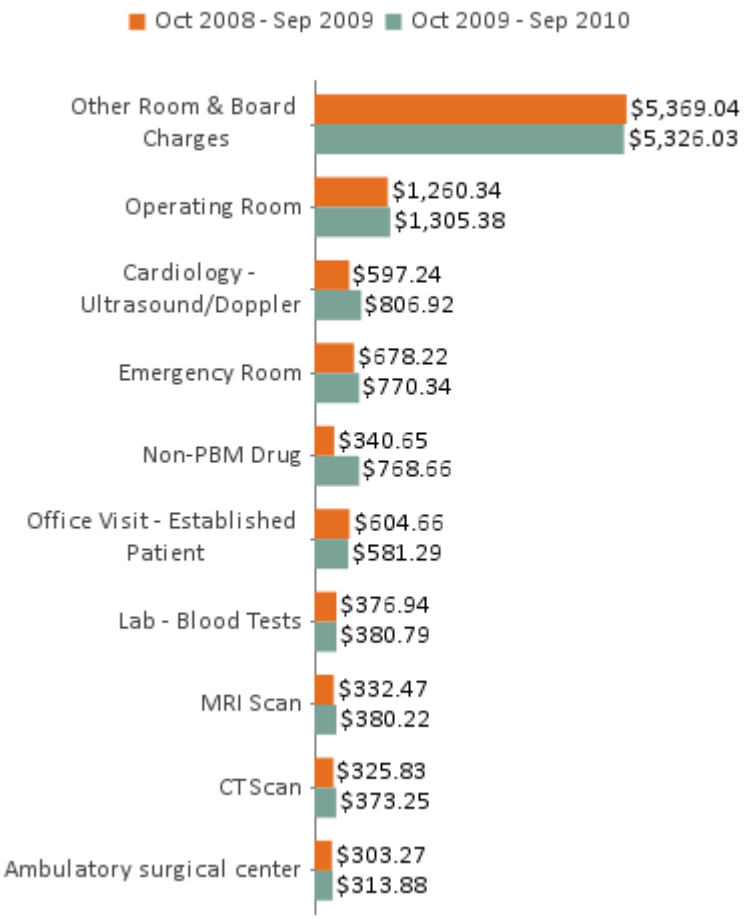
% of Total Plan Paid Oct 2009 - Sep 2010	% Change in Plan Paid
4.4%	-35.2%
3.6%	202.1%
3.5%	59.2%
3.2%	0.3%
2.8%	1,487.2%
2.8%	76.6%
2.6%	-28.2%
2.6%	1.9%
2.6%	159.9%
2.2%	-7.6%

Diagnostic Group	Oct 2008 - Sep 2009		Oct 2009 - Sep 2010		% Change in Plan Paid
	Plan Paid	% of Total Plan Paid	Plan Paid	% of Total Plan Paid	
Subtotal	$4,063,836	26.3%	$4,999,605	30.3%	23%
All Others	$11,378,870	73.7%	$11,489,716	69.7%	1%
Total	$15,442,706	100.0%	$16,489,321	100.0%	6.8%

5.4.4 Procedure groups

Table 5.4.4 shows the top 10 procedures, ranked according to medical claim expenses. For purposes of health plan analysis, period-over-period percentage changes may be more important than absolute dollars. Changes in membership must be considered when any such analysis is performed. Many employers are considering contracting with free-standing lab/x-ray facilities to better manage the growth in these areas.

Table 5.4.4 Total Plan Paid ($K) by Procedure Groups



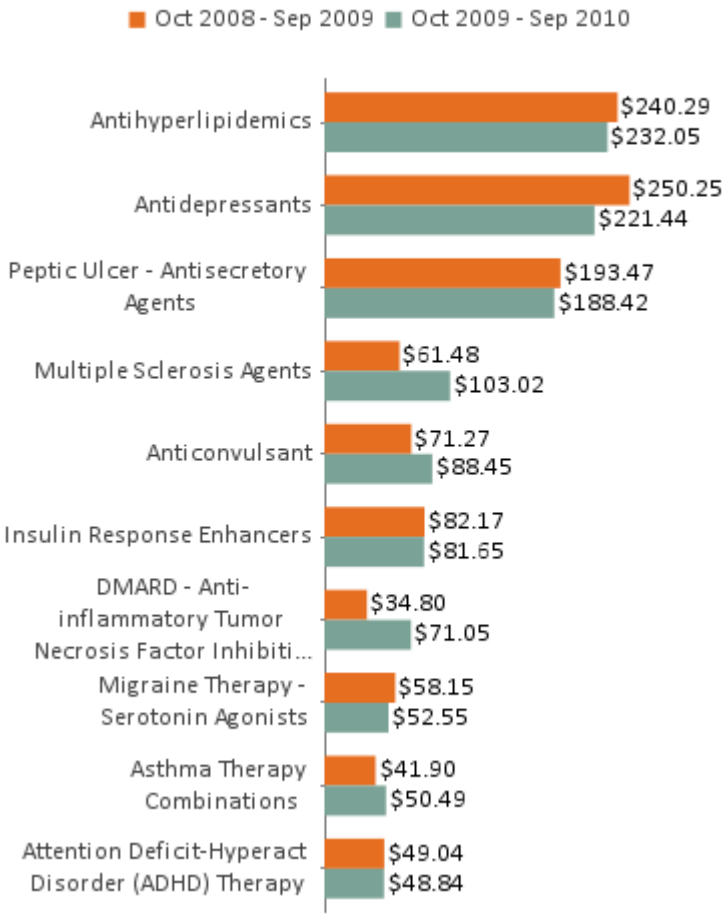
% of Total Plan Paid Oct 2009 - Sep 2010	% Change in Plan Paid
32.3%	-0.8%
7.9%	3.6%
4.9%	35.1%
4.7%	13.6%
4.7%	125.6%
3.5%	-3.9%
2.3%	1.0%
2.3%	14.4%
2.3%	14.6%
1.9%	3.5%

Procedure Group	Oct 2008 - Sep 2009		Oct 2009 - Sep 2010		% Change in Plan Paid
	Plan Paid	% of Total Plan Paid	Plan Paid	% of Total Plan Paid	
Subtotal	$10,188,649	66.0%	$11,006,765	66.8%	8.0%
All Others	$5,254,057	34.0%	$5,482,556	33.2%	4.3%
Total	$15,442,706	100.0%	$16,489,321	100.0%	6.8%

5.4.5 Therapeutic classes

Table 5.4.5 shows the top 10 therapeutic drug classes ranked according to pharmacy claim expenses. For a commercial population, antihyperlipidemics, antidepressants, and gastrointestinal drugs are usually the three most expensive therapeutic classes. The anticonvulsants class is of particular interest because of the increasing use of certain anticonvulsants for pain control. If the anticonvulsants fall in the top 10, institution of a drug utilization review program should be considered.

Table 5.4.5 Total Plan Paid ($K) by Therapeutic Class



% of Total Plan Paid Oct 2009 - Sep 2010	% Change in Plan Paid
9.6%	-3.4%
9.2%	-11.5%
7.8%	-2.6%
4.3%	67.6%
3.7%	24.1%
3.4%	-0.6%
3.0%	104.1%
2.2%	-9.6%
2.1%	20.5%
2.0%	-0.4%

Therapeutic Class	Oct 2008 - Sep 2009		Oct 2009 - Sep 2010		% Change in Plan Paid
	Plan Paid	% of Total Plan Paid	Plan Paid	% of Total Plan Paid	
Subtotal	$1,082,818	45.7%	$1,137,964	47.3%	5.1%
All Others	$1,287,011	54.3%	$1,268,033	52.7%	-1.5%
Total	$2,369,829	100.0%	$2,405,996	100.0%	1.5%

5.5 Clinical Quality Performance and Measures

Table 5.5.1 RRS bucket characteristics

RRS "Bucket"	RRS Range	% of Individuals	Average Age	Characteristics of individuals and types of care gaps in each range
Low	<=1.28	84.6%	31.31	Need screening tests only
Medium	>1.28 AND <= 3.22	13.4%	48.98	May or has a chronic disease and needs screening or recommended diagnostic testing/therapy
High	> 3.22	1.9%	51.3	Have chronic disease with complications, may also have some acute issues, and need more recommended diagnostic testing and/or therapy

Please Note: If the underlying CPT codes for each laboratory test or panel are not submitted to Verisk Health in the medical claims then the compliance in the Quality and Risk Measures will appear lower than they actually are.

Table 5.5.2 Wellness Measures

Screening/Preventative				% of Individual with Gap/Risk	
Group	Condition	Members with Condition	Description	Actual	Norm
Both	>= 51 years old	1,130	Patients without long office visit in the last 2 years.	26.2%	26.0%
	>=50 years old	1,244	Patients without any colorectal cancer screening in the analysis period.	70.4%	73.8%
Male	Men >50 years old	615	Men without PSA level in the last 2 years (controversial test).	61.3%	57.8%
Female	Women >20 y/o	1,872	Women without pap smear in the last two years.	45.6%	49.6%
	Women >=49 y/o	662	Women without mammogram in last 12 months.	58.9%	54.7%
	Women between 21 and 65 y/o	1,820	Women without pap smear in the analysis period.	44.9%	47.6%
	Women between 40 and 49 y/o	653	Women without mammogram in the analysis period.	51.9%	53.5%
		653	Women without a mammogram performed at least every two years.	51.9%	53.5%
	Women between 49 and 69 y/o	654	Women without mammogram in the last 18 months.	50.5%	48.5%

Table 5.5.3 Gaps in Care

Gaps in Care				% of Individual with Gap/Risk	
Clinical Condition		Members with Condition	Description	Actual	Norm
Asthma	Asthma	102	Patients without inhaled corticosteroids or leukotriene inhibitors in the analysis period.	40.2%	31.6%
		102	Patients without flu vaccination in the last 12 months.	80.4%	73.9%
		102	Patients without office visit in the analysis period.	0.0%	0.9%
		102	Patients without long office visit in the last 12 months.	18.6%	13.8%
		102	Patients without flu vaccination in the analysis period.	67.6%	65.6%
Cardiac	Anti-Hyperlipidemic Agents	507	Patients without laboratory tests in the last 12 months.	19.7%	17.9%

Gaps in Care				% of Individual with Gap/Risk	
Clinical Condition		Members with Condition	Description	Actual	Norm
	Atrial fibrillation	18	Patients without anticoagulant drugs in the analysis period.	50.0%	45.4%
	Atrial fibrillation on coumadin	9	Patients with prescription refill gaps of more than six months.	0.0%	80.1%
	Atrial Fibrillation on coumadin	9	Patients with more than sixty days between protimes.	11.1%	52.2%
	CAD	104	Patients without office visit in the analysis period.	1.0%	0.7%
		104	Patients without office visit in the last 12 months.	5.8%	2.2%
		104	Patients without antihyperlipidemic drugs in the analysis period.	26.9%	29.2%
		104	Patients without lipid profile test in the last 12 months.	30.8%	38.8%
		104	Patients without flu vaccination in the last 12 months.	93.3%	77.0%
		104	Patients without flu vaccination in the analysis period.	80.8%	70.0%
		104	Patients without long office visit in the last 12 months.	22.1%	9.4%
	CAD and Hypertension	41	Patients without antihypertensive drugs in the analysis period.	19.5%	13.6%
	CHF	14	Patients without beta-blocker drugs in the analysis period.	35.7%	33.6%
		14	Patients without annual LDL-C or lipid profile test in the analysis period.	42.9%	53.0%
		14	Patients without long office visit in the last 12 months.	14.3%	9.2%
		14	Patients without flu vaccination in the analysis period.	92.9%	62.9%
		14	Patients without ACE inhibitors or ARBs or vasodilator drugs in the analysis period.	28.6%	28.4%
		14	Patients without office visit in the analysis period.	0.0%	1.3%
	Digoxin	1	Patients without digoxin level in the last 12 months.	0.0%	75.4%
	Females < 55 years old	2,397	Women with diagnosis of CAD or MI who should be a candidate for genetic testing to evaluate for the LDLR (low density lipoprotein receptor) genetic variant.	0.3%	0.4%
	Hypertension	391	Patients without flu vaccination in the analysis period.	88.0%	75.8%

Gaps in Care				% of Individual with Gap/Risk	
Clinical Condition		Members with Condition	Description	Actual	Norm
		391	Patients without office visit in the last 12 months.	3.6%	2.6%
	Males < 45 years old	1,765	Men with diagnosis of CAD or MI who should be a candidate for genetic testing to evaluate for the LDLR (low density lipoprotein receptor) genetic variant.	0.4%	0.2%
	MI	9	Patients without beta-blocker drugs in the analysis period.	55.6%	23.2%
		9	Patients without statin drugs in the analysis period.	0.0%	25.7%
COPD	COPD	31	Patients without flu vaccination in the analysis period.	77.4%	63.9%
		31	Patients without COPD-related long office visit in the last 12 months.	61.3%	58.0%
		31	Patients without office visit in the analysis period.	0.0%	1.5%
Diabetes	Diabetes	165	Patients without flu vaccination in the analysis period.	79.4%	70.5%
		165	Patients without HbA1c test in the last 12 months.	20.6%	26.6%
		165	Patients without retinal eye exam in the last 12 months.	61.2%	69.4%
		165	Patients without lipid profile test in the last 12 months.	26.7%	32.5%
		165	Patients without ACE inhibitor or ARB drugs in the analysis period.	52.7%	42.3%
		165	Patients with insulin in the analysis period .	21.2%	23.2%
		165	Patients without statin drugs in the analysis period.	52.1%	47.5%
		165	Patients without long office visit in the last 12 months.	17.6%	13.4%
		165	Patients without serum creatinine in the last 12 months.	26.7%	27.0%
		165	Patients without micro or macroalbumin screening test in the last 12 months.	22.4%	21.3%
		165	Patients with oral antidiabetic agents in the analysis period.	69.1%	64.8%
		165	Patients with insulin and oral antidiabetic agents in the analysis period.	12.1%	13.8%
		165	Patients without office visit in the last 12 months.	1.8%	2.9%

Gaps in Care				% of Individual with Gap/Risk	
Clinical Condition		Members with Condition	Description	Actual	Norm
		165	Patients without semiannual HbA1c test.	77.0%	51.1%
General	All individuals	5,381	Patients with prescriptions for more than 15 drug classes in the analysis period.	1.0%	3.6%
	Opiates	508	Patients with more than six Oxycontin prescriptions in the analysis period.	1.8%	0.3%
Geriatric	>= 65 years old	79	Patients without long office visit in the last 12 months.	39.2%	31.7%
Mental Health	Depakote / Depakene	9	Patients without valproic acid level in the last six months.	77.8%	72.7%
	Depression	181	Patients without office visit in the last 12 months.	3.9%	9.0%
	Depression-related admission	6	Patients without mental health office visit within 14 days of discharge.	83.3%	93.8%
	Dilantin	7	Patients without dilantin level in the last 12 months.	71.4%	51.2%
	Lithium	4	Patients without lithium level in the last 6 months.	75.0%	62.5%
		4	Patients without serum creatinine test in the last 6 months.	50.0%	52.5%
Misc.	Demyelinating Disease	14	Patients without office visit in the last 12 months.	14.3%	2.9%
		14	Patients without office visit in the analysis period.	7.1%	1.2%
		14	Patients without flu vaccination in the analysis period.	92.9%	80.1%
	Inflammatory Bowel Disease	16	Patients without vaccination in the analysis period.	93.8%	79.2%
	Migraine/ Headache	46	Patients without office visit in the analysis period.	0.0%	0.6%
		46	Patients without office visit in the last 12 months.	2.2%	2.7%
	Rheumatoid Arthritis	20	Patients without flu vaccination in the analysis period.	80.0%	70.8%
		20	Patients without office visit in the last 12 months.	0.0%	1.7%
Osteoarthritis	Osteoarthritis	104	Patients with continuous use of opiates across the last 12 months.	2.9%	19.6%
Pregnancy	Pregnancy	96	Women with oral antidiabetic agents in the analysis period.	1.0%	0.5%
Renal Failure	Renal Failure/ESRD	9	Patients without lipid profile test in the last 12 months.	33.3%	58.1%

Gaps in Care				% of Individual with Gap/Risk	
Clinical Condition		Members with Condition	Description	Actual	Norm
		9	Patients without serum creatinine test in the last 12 months.	0.0%	41.7%
		9	Patients without office visit in the last 12 months.	0.0%	2.3%
		9	Patients without urinalysis in the last 12 months.	22.2%	40.2%
		9	Patients without flu vaccination in the analysis period.	55.6%	56.3%
	Renal Failure/ESRD-not on Dialysis	7	Patients without serum albumin test every three months.	85.7%	72.0%
	Renal Failure/ESRD-on Dialysis	2	Patients without annual serum albumin test.	0.0%	35.8%

Table 5.5.4 Risk Measures

Risk Measures				% of Individual with Gap/Risk	
Clinical Condition		Members with Condition	Description	Actual	Norm
Asthma	>60 years old with ER visits	60	Patients with asthma-related ER visit in the analysis period.	1.7%	0.2%
	Asthma	102	Patients with asthma-related ER visit in the analysis period.	13.7%	14.7%
		102	Patients with more than one hospitalization in the analysis period.	1.0%	5.2%
		102	Patients with asthma-related hospitalization in the analysis period.	1.0%	4.0%
Cancer	Cancer	103	Patients with melanoma.	7.8%	3.5%
		103	Patients with pancreatic cancer.	0.0%	0.5%
		103	Patients with liver or biliary cancers.	1.0%	0.5%
		103	Patients with lung cancer.	5.8%	3.4%
		103	Patients with colorectal cancer.	1.0%	5.8%
		103	Patients with lymphoma and lymphosarcoma.	5.8%	4.8%
		103	Patients with secondary malignancy.	3.9%	4.7%
		103	Patients with leukemia.	1.9%	2.5%
		103	Patients with urinary tract cancer.	5.8%	4.9%
		103	Patients with ENT cancer.	4.9%	2.0%
		103	Patients with upper GI cancer.	0.0%	0.9%
		103	Patients with skin cancer (excludes melanoma).	20.4%	28.1%
		103	Patients with breast cancer.	26.2%	22.1%

Risk Measures				% of Individual with Gap/Risk	
Clinical Condition		Members with Condition	Description	Actual	Norm
		103	Patients with infusions for oncology and hematology in the analysis period.	14.6%	13.6%
		103	Patients with cancer therapies in the last 12 months.	4.9%	14.1%
		103	Patients with miscellaneous cancer.	7.8%	9.1%
Cardiac	All individuals	5,381	Patients with chest pain-related ER visit in the analysis period.	1.2%	1.8%
		5,381	Patients with chest pain-related hospitalization in the analysis period.	0.3%	0.3%
	CAD	104	Patients with CABG in the analysis period.	2.9%	4.9%
		104	Patients on both antiarrhythmic and antiplatelet agents in the analysis period.	1.0%	1.8%
		104	Patients with peripheral vascular disease (PVD).	3.8%	4.7%
		104	Patients with cerebrovascular disease (CVD).	5.8%	6.2%
		104	Patients with hypertension.	31.7%	43.2%
		104	Patients with obesity.	0.0%	1.5%
		104	Patients with CAD-related hospitalization in the analysis period.	20.2%	17.7%
		104	Patients with MI-related hospitalization in the analysis period.	1.9%	6.2%
		104	Patients with antiplatelet or anticoagulants in the analysis period.	33.7%	40.4%
		104	Patients with depression.	5.8%	5.1%
		104	Patients with hyperlipidemia.	52.9%	38.3%
		104	Patients with nitrate class drugs in the analysis period.	18.3%	23.8%
		104	Patients with erythropoietin in the analysis period.	1.9%	1.8%
		104	Patients with cardiac catheterization in the analysis period.	37.5%	35.8%
		104	Patients with cardiac stenting in the analysis period.	18.3%	12.8%
		104	Patients with antidepressants in the analysis period.	17.3%	25.0%
		104	Patients with CAD-related ER visit in the analysis period.	6.7%	10.3%
		104	Patients with more than one hospitalization in the analysis period.	12.5%	14.8%
		104	Patients with complicated lipid disorders.	26.9%	19.4%

Risk Measures				% of Individual with Gap/Risk	
Clinical Condition		Members with Condition	Description	Actual	Norm
	CHF	14	Patients with CHF or pulmonary edema-related ER visit in the analysis period.	7.1%	17.3%
		14	Patients with renal failure.	7.1%	25.3%
		14	Patients with more than one hospitalization in the analysis period.	21.4%	34.1%
		14	Patients with CHF or pulmonary edema-related hospitalization in the analysis period.	14.3%	20.6%
	CHF-related admission	2	Patients with readmission within 30 days of CHF-related hospital discharge.	0.0%	6.7%
	MI	9	Patients with subsequent cardiac-related hospitalization in the analysis period.	44.4%	65.5%
COPD	COPD	31	Patients with more than one hospitalization in the analysis period.	9.7%	17.0%
		31	Patients with COPD-related ER visit in the analysis period.	9.7%	11.3%
		31	Patients with home oxygen in the analysis period.	16.1%	20.2%
		31	Patients with COPD-related hospitalization in the analysis period.	3.2%	10.3%
		31	Patients with tobacco use disorder.	3.2%	2.9%
	COPD-related admission	1	Patients with readmission within 30 days of COPD-related hospital discharge.	0.0%	14.0%
Diabetes	Diabetes	165	Patients with diabetes-related ER visit in the analysis period.	1.2%	3.9%
		165	Patients with diabetes-related hospitalization in the analysis period.	2.4%	2.4%
		165	Patients with more than one hospitalization in the analysis period.	4.8%	6.2%
		165	Patients without claims for home glucose testing supplies in the last 12 months.	51.5%	48.9%
		165	Patients with antiplatelet agent in the analysis period.	6.7%	8.3%
		165	Patients with drug augmented stress test in the analysis period.	3.6%	4.2%
		165	Patients with peripheral vascular disease (PVD).	1.8%	3.4%
		165	Patients with renal failure.	1.2%	6.2%
		165	Patients with amputation in the analysis period.	0.0%	0.3%
		165	Patients with ulcer or open wound.	6.1%	0.4%

Risk Measures				% of Individual with Gap/Risk	
Clinical Condition		Members with Condition	Description	Actual	Norm
		165	Patients with drugs for a serious, or potentially very high risk, cardiac condition in the analysis period.	2.4%	5.2%
		165	Patients with hyperlipidemia.	37.6%	26.1%
		165	Patients with CAD.	13.3%	12.4%
		165	Patients with depression.	6.1%	4.4%
		165	Patients with dialysis in the analysis period.	0.0%	0.9%
		165	Patients with erythropoietin in the analysis period.	0.0%	1.3%
		165	Patients with hypertension.	63.6%	71.2%
		165	Patients with obesity.	1.2%	2.2%
		165	Patients with complicated lipid disorders.	10.9%	13.0%
		165	Patients with test for creatinine clearance in the analysis period.	38.8%	37.8%
		165	Patients with retinopathy.	3.0%	2.8%
	Diabetes + Hypertension + Obesity	1	Patients without antihyperlipidemic drugs in the analysis period.	0.0%	34.9%
	Men > 60 years old	159	Patients with diabetes.	16.4%	17.4%
General	<10 years old with ER visits	155	Patients with two or more ER visits in the last 12 months.	9.0%	26.1%
	> $1,000 in ambulatory cost	1,559	Patients without office visit in the last 12 months.	4.9%	7.6%
	> 1 ER visit	270	Patients without office visit in the last 12 months.	8.9%	8.7%
	> 3 visits for Pain	131	Patients without pain management consultation in the analysis period.	0.0%	65.2%
	>10 years old with ER visits	855	Patients with two or more ER visits in the last 12 months.	12.0%	27.0%
	All individuals	5,381	Patients with hospice care claims in the analysis period.	0.0%	0.0%
		5,381	Individuals without any claim in the analysis period.	10.7%	15.7%
	ER Visits	1,010	Patients with ER visits on Saturday and/or Sunday.	35.6%	39.0%
	Home Health	22	Patients with home health cost of at least $10K in the analysis period.	0.0%	5.4%
	Home infusion	14	Patients with more than $5,000 paid in home infusion claims in the analysis period.	0.0%	14.3%
	Hospitalization	446	Patients without office visit within 7	68.2%	68.6%

Risk Measures				% of Individual with Gap/Risk	
Clinical Condition		Members with Condition	Description	Actual	Norm
			days after discharge.		
	Hypertension	391	Patients with more than one hospitalization in the analysis period.	3.8%	4.7%
	Individuals 16 to 50 y/o with $5,000 to $25,000 spend in the last 12 months	208	Patients identified as potential somatizers.	12.5%	2.1%
	Medical Cost > $1000	2,012	Patients with pharmacy costs >50% of their medical cost.	18.9%	19.7%
	Migraine/ Headache	46	Patients with migraine/ headache-related ER visit in the analysis period.	13.0%	19.2%
	Multiple Hospitalizations	69	Patients with more than two hospitalizations in the last six months.	2.9%	4.8%
	Office Visits	4,404	Patients with office visits to more than two types of specialists every three months.	0.0%	9.1%
	Pain Syndrome related ER visit	90	Patients without prior office visit(s) in the analysis period.	53.3%	31.5%
	Potential Somatizers	2	Patients with disease-related ER visit in the analysis period.	0.0%	55.7%
Geriatric	>= 65 years old	79	Patients with an ER visit in the last 12 months.	13.9%	18.7%
		79	Patients with antidepressants in the analysis period.	16.5%	15.6%
Mental Health	Depression	181	Patients with depression-related hospitalization in the analysis period.	3.3%	4.6%
		181	Patients with depression-related ER visit in the analysis period.	2.8%	4.9%
		181	Patients with more than one hospitalization in the analysis period.	5.5%	5.9%
	Depression-related admission	6	Patients without prior outpatient mental health office visit(s) in the analysis period.	50.0%	84.4%
	Depression-related ER visit	5	Patients without prior mental health-related office visit(s) in the analysis period.	40.0%	71.9%
Misc.	All individuals	5,381	Patients with gastric stapling, bypass, or banding procedures in the analysis period.	0.1%	0.1%
		5,381	Patients with Gaucher disease, with injections for the disease in the analysis period.	0.0%	0.0%
	Demyelinating	14	Patients with more than one	0.0%	5.8%

Risk Measures				% of Individual with Gap/Risk	
Clinical Condition		Members with Condition	Description	Actual	Norm
	Disease		hospitalization in the analysis period.		
	Female with cancer	62	Patients with female genital organ cancer.	11.3%	10.9%
	Inflammatory Bowel Disease	16	Patients with more than one hospitalization in the analysis period.	18.8%	9.4%
	Rheumatoid Arthritis	20	Patients with TNF drugs in the analysis period.	15.0%	20.6%
	Sleep Apnea	38	Patients with polysomnography study and CPAP in the analysis period.	50.0%	48.2%
	Women <40 y/o	1,452	Women with menopause before age 40.	0.0%	0.0%
Osteoarthritis	Osteoarthritis	104	Patients with hylan injections in the analysis period.	6.7%	0.6%
Pregnancy	Pregnancy	96	Women with high-risk pregnancy.	27.1%	7.2%
		96	Women with hospitalization for pregnancy-related diagnosis other than delivery.	3.1%	4.9%
		96	Pregnant women delivered with more than 15 prenatal visits.	0.0%	0.3%
		96	Pregnant women delivered with fewer than six prenatal visits.	0.0%	43.7%
		96	Women with pregnancy-related ER visit in the analysis period.	9.4%	10.1%
		96	Women with pregnancy or delivery complications.	89.6%	61.0%
Renal Failure	Renal Failure/ESRD	9	Patients with renal failure/ESRD-related hospitalization in the analysis period.	44.4%	8.6%
		9	Patients with renal failure/ESRD-related ER visit in the last 12 months.	0.0%	3.6%

Sample WillisMed Health Outcomes Summary

WillisMed Health Outcomes Report

ABC COMPANY

May 14, 2013

WillisMed Health Outcomes Report

ABC COMPANY

Table of Contents

The WillisMed Health Outcomes Report provides an analysis of the healthcare information for ABC COMPANY. The information is based on eligibility, medical claims, and pharmacy claims data for employees and their families during the reporting period Jan 2012 through Dec 2012 on a paid basis.

Objective

We use WillisMed to stratify your total population in order to create targeted interventions for health management, including but not limited to:

- Wellness Program Opportunities
- Disease Management Opportunities
- Case Management Opportunities
- Plan Design Opportunities
- Health Outcomes Incentive Design

Normative Database

Willis uses the Verisk normative database in order to compare your population's performance to a normative database containing data from 2,768 employer groups. The benchmarks include a representative cross-section of data by geography, age, and gender.

Year Over Year Trend Periods

Period One (P1): Paid from Jan 2011 to Dec 2011

Period Two (P2): Paid from Jan 2012 to Dec 2012

Executive Summary

Low Cost → **High Cost**

Low Disease Burden | **High Disease Burden**

Low Disease Burden	High Disease Burden	
70% of the population	**25%** of the population	**5%** of the population
12% of total medical expenses	**36%** of total medical expenses	**53%** of total medical expenses

Wellness Interventions

- Evidence based preventative services
- Health Risk Assessment (HRAs), with biometrics
- Targeted health education and communication
- Culture of health
- Tobacco-free workplace
- Incentives for engagement and health outcomes
- Engagement in lifestyle behavior change programs

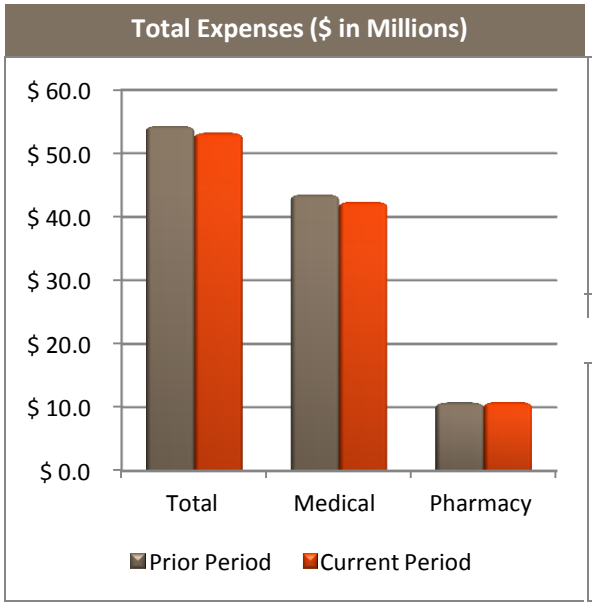
Disease Management

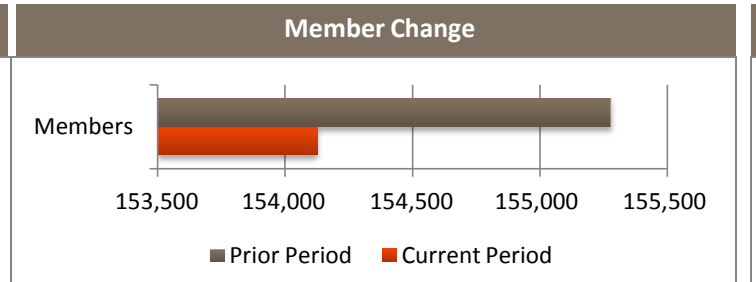
- Identifying individuals who are likely to incur high medical costs because of chronic illness
- Communication and resources for appropriate adherence to treatment guidelines
- Incentives for compliance with disease management programs

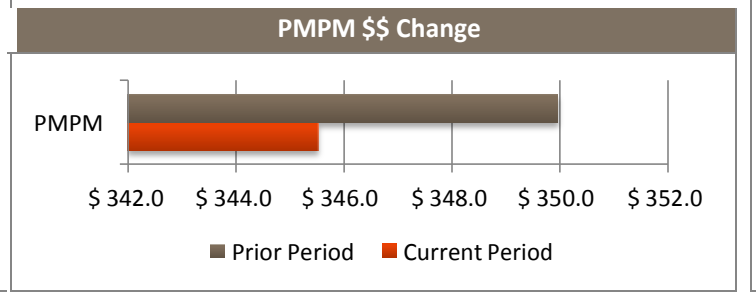
Case Management

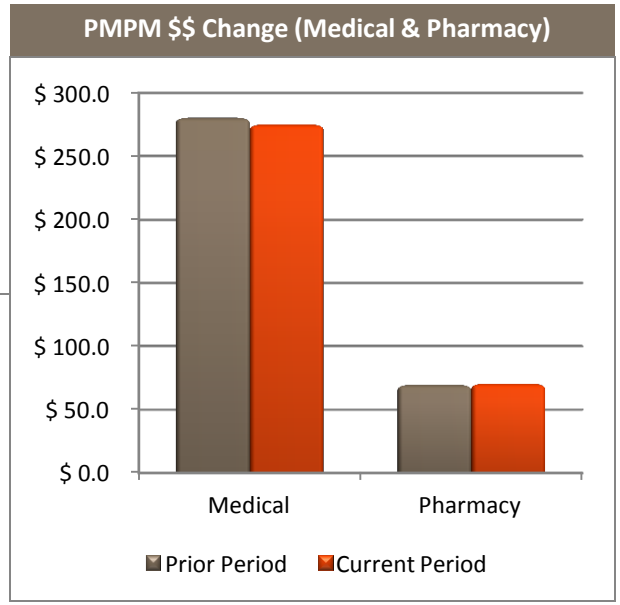
- Manage high cost
- Help members navigate system
- Quality of life measures
- Patient satisfaction
- Direct and indirect health care cost
- Morbidity / mortality data

Plan Costs









Cost Summary	Current Period	Prior Period	% Chg PP	Norm	% Chg Norm
Medical Place of Service PMPM Spend					
Inpatient	$82.5	$88.5	(6.8%)	$90.8	(9.2%)
Outpatient	$71.6	$79.0	(9.4%)	$83.4	(14.1%)
Office	$86.3	$82.8	4.2%	$56.0	54.2%
Other	$34.7	$30.2	15.0%	$35.9	(3.3%)

Cost Distribution	Members	Costs	Cst/Member	% of Cost	Norm	% Chg Norm
Expense Distribution						
1%	146	$14,219,369	$97,661	26.7%	30.5%	(3.8%)
2-5%	582	$13,924,601	$23,909	26.1%	27.6%	(1.4%)
6-15%	1,456	$11,612,840	$7,976	21.8%	22.9%	(1.1%)
16-30%	2,184	$7,359,054	$3,370	13.8%	12.2%	1.6%
31-60%	4,368	$5,341,651	$1,223	10.0%	6.3%	3.7%
61-100%	5,824	$797,654	$137	1.5%	0.5%	1.0%
Total	**14,560**	**$53,255,170**	**$3,658**			

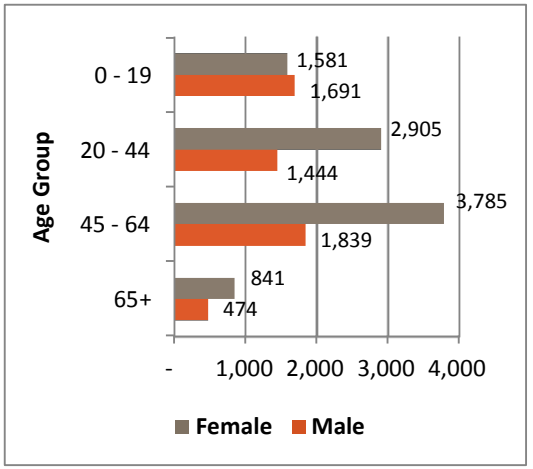
Comments

- Total expenses decreased by (2.0%) over the prior period driven by a (1.3%) decrease in PMPM cost and a (0.7%) decrease in member months
- PMPM Medical cost decreased by (1.9%), while PMPM Pharmacy cost increased by 1.4%
- Inpatient and Outpatient services represent 56.0% of the Medical PMPM cost while office visits make up 31.4% and all other services comprise 12.6%
- Total spend is skewed slightly more toward the high cost end of the distribution compared to the norm

Plan Utilization

Plan Demography and Risk Review	Current Period	Prior Period	% Chg PP	Norm	% Chg Norm
Current Employees	7,727	7,685	0.5%		-
Current Members	12,974	12,983	(0.1%)		-
Dependent Ratio	1.7	1.7	(0.6%)		-
Average Age	40.0	40.9	(2.2%)	36.0	11.2%
Utilization	**Current Period**	**Prior Period**	**% Chg PP**	**Norm**	**% Chg Norm**
Emergency Room Metrics					
ER Visits (per 1000)	161.4	167.1	(3.4%)	249.7	(35.4%)
% ER Visits Resulting in Admission	40.0%	35.8%	11.8%	37.5%	6.7%
Paid per ER Visit	$1,377	$1,354	1.7%	$1,014	35.8%
Inpatient Metrics					
Inpatient Days (per 1000)	442.2	477.6	(7.4%)	352.9	25.3%
Average Length of Stay (Days)	6.0	5.6	6.8%	4.8	25.1%
Total Admissions (per 1000)	74.1	85.5	(13.3%)	74.0	0.2%
Medical	24.8	26.4	(6.0%)	24.0	3.1%
Surgical	27.4	33.1	(17.1%)	24.6	11.6%
Maternity	17.3	21.3	(18.7%)	21.2	(18.5%)
Behavioral	4.7	4.8	(2.5%)	4.2	10.2%
Drug Utilization					
Pharmacy Scripts (per 1000)	11,422.3	20,554.5	(44.4%)	11,080.1	3.1%
Pharmacy Scripts - % Mail Order	25.1%	28.9%	(12.9%)	9.5%	165.0%
Pharmacy Scripts - % Brand Drugs	29.0%	39.6%	(26.9%)	31.0%	(6.4%)
Office Visit Utilization					
Total Office Visits (per 1000)	5,218.2	5,650.6	(7.7%)	4,011.4	30.1%
Regular Office Visits	3,971.7	4,447.0	(10.7%)	3,019.8	31.5%
Preventative Office Visits	513.4	539.4	(4.8%)	440.1	16.7%
Behavioral Health Office Visits	565.4	478.8	18.1%	415.0	36.2%
Consultations	159.0	176.2	(9.8%)	124.1	28.1%
Other Office Visits	8.6	9.2	(6.0%)	12.3	(30.0%)

Member Profile



Comments

- 37.4% of the members are male and 62.6% of the members are female
- 'ER visits' were less than the norm. 'Admission rates' and 'paid amounts for ER visits' were both more than the norm.
- Medical, Surgical, Behavioral are higher than the norm, while Maternity is lower than the norm
- Brand drug utilization is less than 'norm' and 'prior period'
- Preventative office visits accounted for 9.8% of total office visits

Preventative Measures

Evaluation of your populations compliance with evidence-based preventative services is critical and should be a key starting point. The U.S. spends billions on healthcare services of questionable value, while basic, evidence-based preventative services are not being performed as often as recommended.

The following details screening and preventative tests - and the associated compliance with these tests - for the entire population. This data is based on Verisk definitions and may differ from the Carrier/ASO standards.

Description	Members with Gap	Members	Actual	Norm
All individuals without any claim in the last 12 months	926	11,828	7.8%	14.8%
All individuals without flu vaccination in the last 12 months	9,986	11,828	84.4%	85.9%
All individuals between 6 months and 5 years old without flu vaccination in the last 12 months	216	364	**59.3%**	51.0%
All individuals > 50 years old without flu vaccination in the last 12 months	3,520	4,509	78.1%	84.9%
All individuals > = 51 years old without long office visit in the last 24 months	287	4,216	6.8%	17.4%
All individuals without a follow-up office visit within 2 weeks of a Chest pain-related ER visit	101	369	27.4%	43.1%
All individuals > = 50 years old without any colorectal cancer screening in the last 24 months	2,968	4,413	67.3%	72.2%
Men > 50 years old without PSA level in the last 24 months (controversial test)	453	1,222	37.1%	51.4%
Women > 20 years old without pap smear in the last 24 months	2,141	5,537	38.7%	48.4%
Women between 21 and 65 years old without pap smear in the last 24 months	1,715	4,946	34.7%	45.8%
Women between 40 and 49 years old without mammogram in the last 24 months	445	1,278	34.8%	47.2%
Women > = 49 years old without mammogram in last 12 months	1,711	3,435	49.8%	57.4%
Women between 49 and 69 years old without mammogram in the last 18 months	1,046	2,959	35.4%	44.3%

Relative Risk Score (RRS) and Care Gap Index (CGI) within the Population

We have use two factors to understand the association between disease burden, quality and cost within your population.

1. The **Relative Risk Score (RRS)** is a measure of resource use - in total cost or count of outcomes events - relative to an average person (RRS = 1.00).
   A relative risk score of 1.00 means that the person's risk burden (and predicted cost) is equal to the mean (average) in the sample. While a individual with a RRS of 1.50 is predicted to spend one and a half times (50% more) in resources compared to the average person in the benchmark sample.

2. The **Care Gap Index (CGI**) quantifies the gaps in appropriate medical care that a member is receiving. Depending on the diseases that a member has, the extent of care gaps present serves as one assessment of the quality of care they receive.

Members are grouped by RRS and then by CGI. This allows us to see the cost impact of those members with gaps in compliance with evidence-based care guidelines, either through member non-compliance or peer provider quality.

69.6% of the population is classified with a 'Low Care Gap Index' and the 'Average Care Gap Index' of 1.92 is higher than the norm of 1.14.

	Members	Percent of Members	Average PMPY	Spend ($ in millions)	Percent of Spend	Average Age
Low Relative Risk Score (< = 1.13)						
Low Care Gap Index (0 -2)	6,290	49.9%	$1,180	$16.2	14.4%	
Medium Care Gap Index (3 -4)	756	6.0%	$2,010	$3.9	3.5%	29.9
High Care Gap Index (+5)	227	1.8%	$3,070	$1.8	1.6%	
Subtotal Low RRS	**7,273**	**57.7%**	**$1,325**	**$21.9**	**19.5%**	
Medium Relative Risk Score (> 1.13 and < = 2.69)						
Low Care Gap Index (0 -2)	2,000	15.9%	$3,350	$15.6	13.8%	
Medium Care Gap Index (3 -4)	789	6.3%	$4,280	$8.8	7.8%	51.3
High Care Gap Index (+5)	675	5.4%	$4,440	$8.0	7.1%	
Subtotal Medium RRS	**3,464**	**27.5%**	**$3,774**	**$32.3**	**28.7%**	
High Relative Risk Score(> 2.69)						
Low Care Gap Index (0 -2)	488	3.9%	$9,080	$10.5	9.3%	
Medium Care Gap Index (3 -4)	449	3.6%	$13,420	$15.6	13.8%	59.5
High Care Gap Index (+5)	935	7.4%	$12,560	$32.2	28.7%	
Subtotal High RRS	**1,872**	**14.8%**	**$11,859**	**$58.2**	**51.8%**	
Total	**12,609**		**$3,562**	**$112.4**		

Top Chronic Conditions

The following chart contains the top chronic conditions / diseases based on total paid. This chart also presents utilization patterns of members with chronic conditions, for total office visits, emergency room visits and hospital admissions.

Diseases	Members per 1000		Total paid	PMPY		Office Visits per 1000		ER Visits per 1000		Admission per 1000	
	Actual	Norm		Actual	Norm	Actual	Norm	Actual	Norm	Actual	Norm
Hyperlipidemia	289	69	$ 23,926,457	$ 6,789	$ 7,409	8,283.4	6,979.5	219.3	263.8	119.2	101.9
*Hypertension	254	102	$ 23,771,755	$ 7,700	$ 9,029	8,883.2	7,292.8	278.6	409.8	151.6	177.7
*Diabetes	95	62	$ 10,865,123	$ 9,443	$ 11,512	9,884.6	7,907.6	327.7	472.2	198.2	219.0
Osteoarthritis	92	32	$ 10,739,367	$ 9,648	$ 14,645	11,581.4	10,461.6	297.3	515.1	201.2	284.0
Coronary Artery Disease (incl. MI)	51	20	$ 6,795,273	$ 10,972	$ 19,800	11,654.5	9,610.5	497.3	772.1	353.6	478.2
Asthma	52	20	$ 4,619,533	$ 7,233	$ 8,148	9,189.5	8,871.8	357.0	645.6	150.3	167.9
Chronic Renal Failure	19	6	$ 4,035,466	$ 17,942	$ 35,641	14,378.7	12,190.4	653.6	1,033.8	582.4	723.9
Chronic Obstructive Pulmonary Disease	26	9	$ 3,862,007	$ 12,559	$ 21,464	13,183.7	11,369.2	656.9	1,074.8	465.0	628.9
Cerebrovascular Disease	28	9	$ 3,565,309	$ 10,750	$ 25,874	13,383.9	10,709.1	600.0	1,146.9	358.8	697.1
Coagulopathy	11	3	$ 3,325,439	$ 25,696	$ 36,477	15,206.7	12,069.1	726.3	939.0	587.3	640.2

Comments

- Total paid represents all costs, including those for claims unrelated to the disease, for members with the disease. For example, a member with two chronic conditions would be counted under both chronic conditions along with their total paid dollars for all of their conditions.
- High specificity criteria of one inpatient or two outpatient claims is used to identify a member with a disease; Outpatient claims includes all non-inpatient claims.
- Ranking conditions by total paid for the member per year allows us to focus on the largest clinical drivers of cost.
- The Risk Index is based on a combination of diagnosed diseases, recommended procedures completed to address the diseases and prescription drugs administered to address the diseases. The organization's overall 'Risk Index' of 11.02 is higher than the norm of 5.58, with a higher than or equal to norm prevalence for 10 of the top 10 chronic conditions.

Clinical Condition: Diabetes

Description	Members with Gap	Members	Actual	Norm
Gaps in Care				
Patients without retinal eye exam in the last 12 months	780	1,053	**74.1%**	69.6%
Patients without retinal eye exam in the last 12 months and with HEDIS analog	771	973	**79.2%**	73.7%
Patients without semiannual HbA1c test in the last 24 months	750	981	**76.5%**	75.7%
Patients without statin drugs in the last 12 months	521	1,053	49.5%	49.6%
Patients without claims for home glucose testing supplies in the last 12 months	498	1,053	**47.3%**	46.3%
Risk				
Patients with hypertension or taking antihypertensive drugs	907	1,078	**84.1%**	71.7%
Patients with hyperlipidemia	869	1,078	**80.6%**	19.4%
Patients with oral antidiabetic agents in the analysis period	675	1,078	62.6%	64.3%
Patients with insulin in the analysis period	215	1,078	19.9%	25.4%
Men > 60 years old with diabetes	215	701	**30.7%**	18.1%

Clinical Condition: Cardiovascular Disease (including myocardial infarction)

Description	Members with Gap	Members	Actual	Norm
Gaps in Care				
Patients without ACE or ARB in the last 12 months	260	561	**46.3%**	44.4%
CAD Patients without lipid profile test in the last 12 months	252	561	**44.9%**	38.1%
CAD Patients without diabetes screening in the last 12 months	240	561	42.8%	44.5%
Patients without antihyperlipidemic drugs in the last 12 months	190	561	**33.9%**	26.0%
Patients who are taking only two of these agents: Beta-blockers, ACE/ARB, or Statins in the last 12 months	182	561	**32.4%**	30.8%
Risk				
Patients with hypertension or taking antihypertensive drugs	493	567	**86.9%**	86.0%
Patients with hyperlipidemia	459	567	**80.9%**	31.1%
Patients with chest pain-related ER visit in the analysis period	370	12,974	**2.9%**	2.1%
Patients with antiplatelet or anticoagulants in the analysis period	193	567	34.0%	41.7%
Patients with antidepressants in the analysis period	191	567	**33.7%**	24.9%

Clinical Condition: Congestive Heart Failure

Description	Members with Gap	Members	Actual	Norm
Gaps in Care				
Patients without LDL-C or lipid profile test in the last 12 months	78	134	**58.2%**	53.3%
Patients without beta-blocker drugs in the last 12 months	60	134	**44.8%**	34.1%
Patients without ACE inhibitors or ARBs or vasodilator drugs in the last 12 months	52	134	**38.8%**	37.3%
Patients who are taking only two of these agents: Beta-blockers, ACE/ARB, or diuretics in the last 12 months	34	134	25.4%	27.8%
Patients who are not taking Beta-blockers, ACE/ARB, or diuretics in the last 12 months	30	134	**22.4%**	18.4%
Risk				
Patients taking drugs that cause fluid retention (without affecting prostaglandins) in the analysis period	70	135	**51.8%**	41.7%
Patients taking drugs that affect prostaglandin to cause fluid retention in the analysis period	47	135	**34.8%**	22.1%
Patients with renal failure	31	135	**23.0%**	21.1%
Patients with CHF or pulmonary edema-related ER visit in the analysis period	16	135	11.9%	23.8%
Patients with CHF or pulmonary edema-related hospitalization in the analysis period	14	135	10.4%	23.4%

Clinical Condition: COPD (Pulmonary)

Description	Members with Gap	Members	Actual	Norm
Gaps in Care				
Patients without pneumococcal assessment or PPV vaccine in the last 24 months	225	250	**90.0%**	87.6%
Patients without Spiriva or Atrovent in the last 12 months	197	254	**77.6%**	63.6%
Patients without spirometry testing in the last 12 months	188	254	**74.0%**	66.1%
Patients without COPD-related long office visit in the last 12 months	139	254	54.7%	60.3%
Patients without pulmonary visits in the last 12 months, who have taken Advair Diskus 250/50 or Advair Diskus 500/50 in the last 24 months	33	50	**66.0%**	54.4%
Risk				
Patients taking oral steroids in the analysis period	150	256	**58.6%**	54.5%
Patients with more than two chest x-rays in the analysis period	103	256	**40.2%**	39.5%
Patients with more than two prescriptions of anticholinergics or beta-agonists in the analysis period	89	256	34.8%	47.2%
Patients with more than one prescription of oral steroids and antibiotics in the analysis period	86	256	**33.6%**	31.7%
Patients with any claim for tobacco use disorder in the analysis period	54	256	**21.1%**	4.6%

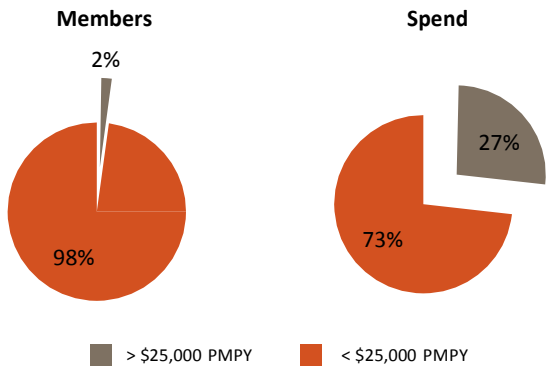
Clinical Condition: Asthma

Description	Members with Gap	Members	Actual	Norm
Gaps in Care				
Patients without spirometry test in the last 12 months	430	543	**79.2%**	65.0%
Patients without inhaled corticosteroids or leukotriene inhibitors in the last 12 months	292	543	**53.8%**	40.9%
HEDIS analog patients without appropriate medication for persistent asthma in the last 12 months	191	390	**49.0%**	14.8%
Patients without short-acting beta agonists in the last 12 months	40	131	**30.5%**	18.3%
Patients without other inhalers in the last 12 months, taking salmeterol in the last 12 months	22	86	**25.6%**	18.4%
Risk				
Patients with more than two nebulizers in the analysis period	309	553	55.9%	60.4%
Patients taking more than four inhalers in the analysis period	220	553	39.8%	43.5%
Patients with depression in the analysis period	164	553	**29.7%**	17.7%
Patients with more than three prescriptions for albuterol in the analysis period	151	553	27.3%	30.1%
Patients with more than four asthma-related office visits	135	553	**24.4%**	13.0%

The following summarizes patients who have incurred a high total spend (>$25,000 PMPY), based on total cost and diagnosis. These members will generally benefit from Case Management.

Top Paid Diagnosis	Members	Cost	Average Spend
Osteoarthritis	27	$1,518,192	$56,229
Lymphoma and Lymphosarcom	6	$1,190,190	$198,365
Breast Cancer	20	$1,143,548	$57,177
Drug Abuse and Dependence	9	$667,832	$74,204
Lower GI Disorders	11	$663,955	$60,360
Intervertebral Disc Disorders	10	$627,639	$62,764
Misc Cancers	8	$572,062	$71,508
Cerebral Degeneration	1	$526,642	$526,642
Metabolic Disorders	1	$477,615	$477,615
Colorectal Cancer	6	$467,819	$77,970
Demyelinating Diseases	9	$467,189	$51,910
ENT Cancers	6	$409,682	$68,280
Respiratory Failure	3	$384,145	$128,048
Septicemia	2	$345,879	$172,940
Gynecological Disorders	5	$344,962	$68,992
Diabetes Mellitus	6	$326,374	$54,396
Renal Failure	4	$325,891	$81,473
Back Pain	6	$317,476	$52,913
CAD	6	$304,138	$50,690
Congestive Heart Failure	1	$288,655	$288,655
All Other	140	$8,110,316	$57,931
Total > $25,000 PMPY	**287**	**$19,480,201**	**$67,875**

Case Management Impact



Comments

- Understand the case management vendor trigger points for identification of members to participate
- Understand how the vendor reaches out to the member to engage in the program
  - What is their success rate in members accepting?
  - What are the reasons that a member would not engage?
- Understand how the vendor reports cost savings from the case management program
- Understand the reporting provided by case management vendor

Employer Strategy Recommendations Continuum

Key Data Summary

-
-
-
-

	Basic	Moderate	Progressive
Plan Design	Traditional Plan Design (PPO, POS, ???) - Single - Tier Premium Differentials	Consumer Directed / Account Based Plans with HRA or HAS - Base contribution with potential to earn additional funding Multi - Tiered Premium Differential Preferred Plan Option earned	Full-Replacement CDH or Value Based Design - Employee earned contributions Premium Differential based on Health Outcomes Defined Contribution Approach?
Pharmacy Design	Rx: Two or Three-Tier Design Rx: Quantity Limits Rx: Precertification Employee education - encourage generic	Rx: Brand-Deductible Rx: Mandatory Mail Order / Generic Eliminate out-of-pocket Rx costs for select list of medications	PBM Carve out Specialty Rx Carve out Eliminate all out-of-pocket Rx costs for select Chronic Diseases
Health Management	Employee Health Education Health Risk Assessments Biometric Screenings Immunizations Health Vending / Cafeteria Self-care guides Nurse line	Tobacco Cessation Telephonic or web-based health coaching Behavior Change Programs Employee Wellness Portal Self Directed Learning Company Wide Challenges Culture of Health	Onsite Fitness Center Onsite Clinic Onsite Weight Management Programs Activity Tracking Device Onsite Health Coaching Company Sponsored Events and Activities Integration w/Social Media, Mobile Apps
Incentives	Incentives for Participation	Incentives for Improvement / Behavior Change	Incentives for Health Outcomes
Prevention and Disease Management	Promote Preventative Screening Services and Adherence Employee Education about Health Plan and DM Program Tools and Resources	Disease - Specific HRA's Assess Program Utilization and Compliance Targeted Communications by Disease Incentives for adherence to age/gender specific screenings Incentives for DM Engagement	Onsite Clinic (FT / MD) Incentives for Adherence Assess DM Program Compliance Assess Chronic Disease Risks and Care Gaps Telemedicine (web-video interface)
Communications	Employer Branded Carrier Materials Paper or Email	Total Rewards / Wellness Branded Messaging / Themes Personalization Total Reward Statements Video and Text	Social Media Mobile

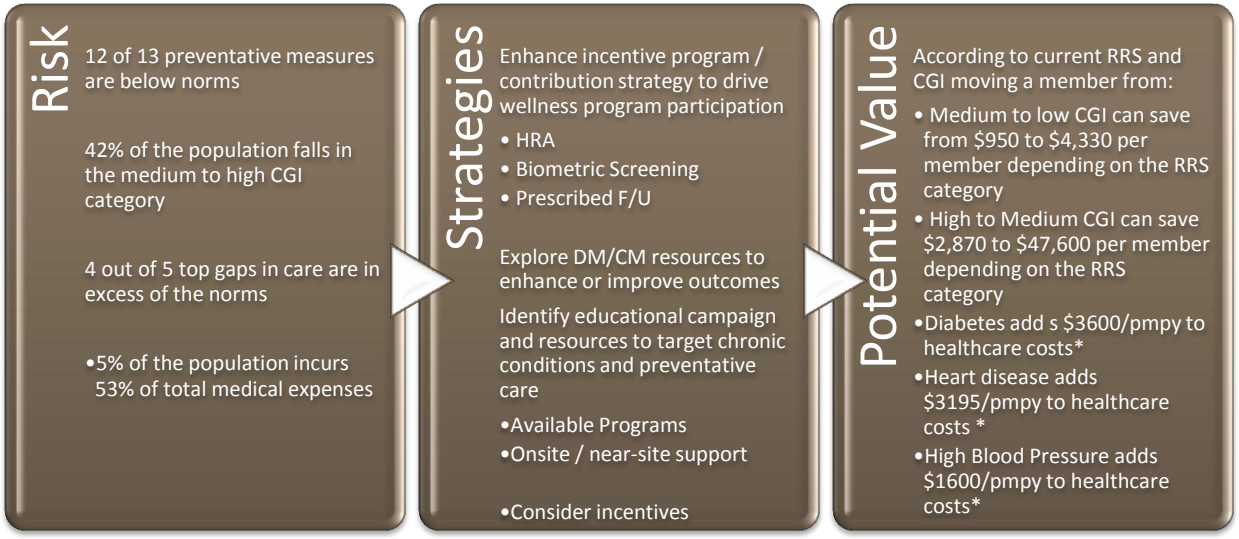
Call To Action

The data and analysis contained in the WillisMed Health Outcomes Report is intended to identify cost and utilization drivers for the purposes of creating a road map that outlines comprehensive health management strategies for the future - we term 'Call To Action'. Working with ABC COMPANY, we understand that a data driven strategic plan is vital to address the overall human capital needs for your organization and essential for managing your bottom line.

This document is intended to address the following overall goals that we understand to be important to you:

- Control healthcare cost
- Improve employee population health
- Attract, Recruit and Retain the best talent
- Improve overall employee engagement and productivity

As demonstrated in the WillisMed Health Outcomes Report; the continuum of strategies employers are using to address their human capital concerns spans from the most basic to the cutting edge aggressive. Understanding you as our client, we have laid out an actionable and measurable road map to help you achieve the goals important to your organization while focusing on the specific risks affecting your employee population.



* Source: Kaiser Permanente

As we look to implement the suggested strategies, we want to define the metrics that will measure program success; these points will be both financial and non financial in nature.

Employee Metrics

1. Utilization of specific programs including: wellness program activities, disease management programs and case management programs
2. Population health risks
3. Participation and satisfaction with programs and services

Organization Metrics

1. Medical and Pharmacy cost versus projected including: preventative screenings services usage, decreased chronic disease CGI and decreased RRS

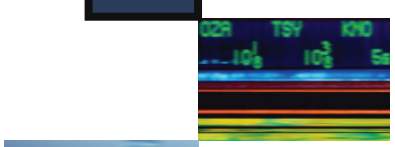
Exhibit 6

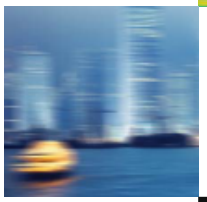
Sample Data Dashboard Report

Rolling 12-Month Dashboard Report

April 1, 2011 - March 31, 2012

The ABC Company, Inc.





ABC Company

Executive Summary

For the first 9 months of the 2011/2012 plan year, the plan is running at a total cost of $622 PEPM compared to $580 PEPM for the 2010/2011 plan year. Net plan cost has increased from $410 PEPM to $431 PEPM, an increase of 5.1%.

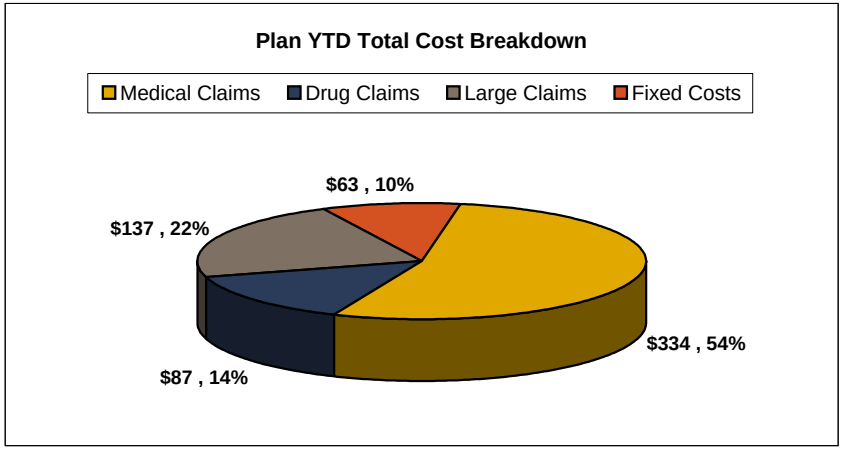
COBRA claims for the first 9 months represent approximately 7.5% of total paid claims compared to 9.5% in the prior plan year (medical & drug). Net COBRA cost has increased from $1,302 PEPM to $1,350 PEPM. COBRA participants account for 10.5% of large claimants and 14.4% of large claims (2.2% of total enrollment, 7.5% of total claims).

For the first 9 months, the medical plan is running at 95.6% of budgeted accrual (Expected Claims + Fixed Costs), resulting in a positive YTD variance of $1,258,674.

There are currently 57 individuals with total paid claims exceeding $50,000 in the first 9 months of the 2011/2012 plan year. 6 individuals have exceeded the $250,000 ISL deductible by a YTD total of $345,233.

Contribution Summary - Medical

Enrollment Tier	Enrollment	EE Cost	Total Cost	EE %
EE	25,271			
EE + SP	5,926			
EE + CH	4,996			
Family	7,555			
Total	**43,748**	**$8,350,607**	**$27,195,531**	**30.7%**



ABC Company

Year-Over-Year Performance Comparisons (July - March)

Total Cost Summary Plan Year-to-Date

	Cost Summary (Total Dollars)			Cost Summary (Dollars PEPM)			
	2011-2012	2010-2011	% Change	2011-2012	2010-2011	% Change	
Total Enrollment	43,748	41,845		43,748	41,845		
Average Enrollment	4,861	4,649	4.55%	4,861	4,649	4.55%	
Medical Claims	$19,122,835	$16,797,554	13.84%	$437.11	$401.42	8.89%	A
Rx Claims	$3,826,986	$3,187,747	20.05%	$87.48	$76.18	14.83%	B
COBRA Claims	$1,834,969	$2,286,323	(19.74%)	$41.94	$54.64	(23.23%)	C
Admin Costs	$1,806,643	$1,619,820	11.53%	$41.30	$38.71	6.68%	
Stop Loss Premium	$949,332	$698,812	35.85%	$21.70	$16.70	29.94%	
ISL Adjustments	($345,233)	($620,527)	(44.36%)	($7.89)	($14.83)	(46.78%)	D
Total Cost	$27,195,531	$23,969,728	13.46%	$621.64	$572.82	8.52%	
Employee Contribution	($8,350,607)	($7,145,147)	16.87%	($190.88)	($170.75)	11.79%	
Net Plan Cost	**$18,844,924**	**$16,824,582**	**12.01%**	**$430.76**	**$402.07**	**7.14%**	

YTD Accrual
$650.41

-4.4% Lower vs. Accrual

Claims Detail Plan Year-to-Date

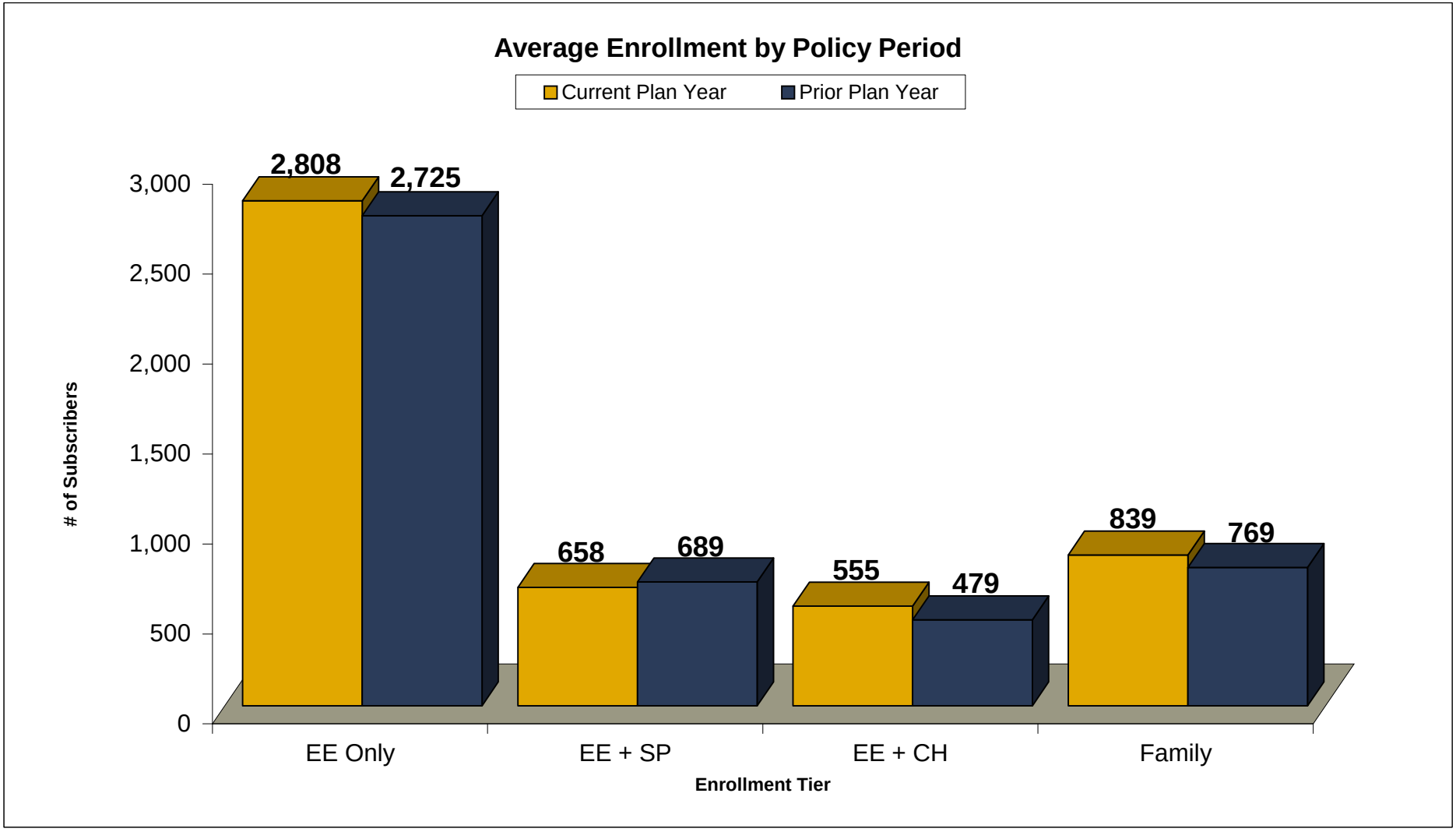
	2011-2012	2010-2011
Enrollment		
Employees	43,748	41,845
Total Claims	$24,439,557	$21,651,097
PEPM (A+B+C+D)	$558.64	$517.41
% Change	8.0%	
Claims < $50k	$14,611,784	$12,968,132
PEPM	$334.00	$309.91
% Change	7.8%	
Large Claims > $50k	$6,000,786	$5,495,218
PEPM	$137.17	$131.32
% of Total Claims	24.6%	25.4%
% Change	4.5%	
Rx Claims	$3,826,986	$3,187,747
PEPM	$87.48	$76.18
% Change	14.8%	

Large Claims Plan Year-to-Date

	2011-2012	2010-2011	Variance B / (W)	
Large Claims	$6,000,786	$5,495,218	($505,569)	
No. of Claimants	57	50	(7)	
Cost/Claimant	$105,277	$109,904	$4,627	
Variance Explanation			($505,569)	Severity + Volume
Severity				
[2010-2011 Cost/Claimant] - [2011-2012 Cost/Claimant] =			$4,627	Lower Cost per Claimant
2011-2012 Large Claimants Year-to-Date			57	
Severity Variance			$263,762	
Volume				
[2010-2011 Claimants] - [2011-2012 Claimants] =			(7)	Difference in # of Claimants
2010-2011 Cost/Claimant			$109,904	
Volume Variance			($769,330)	

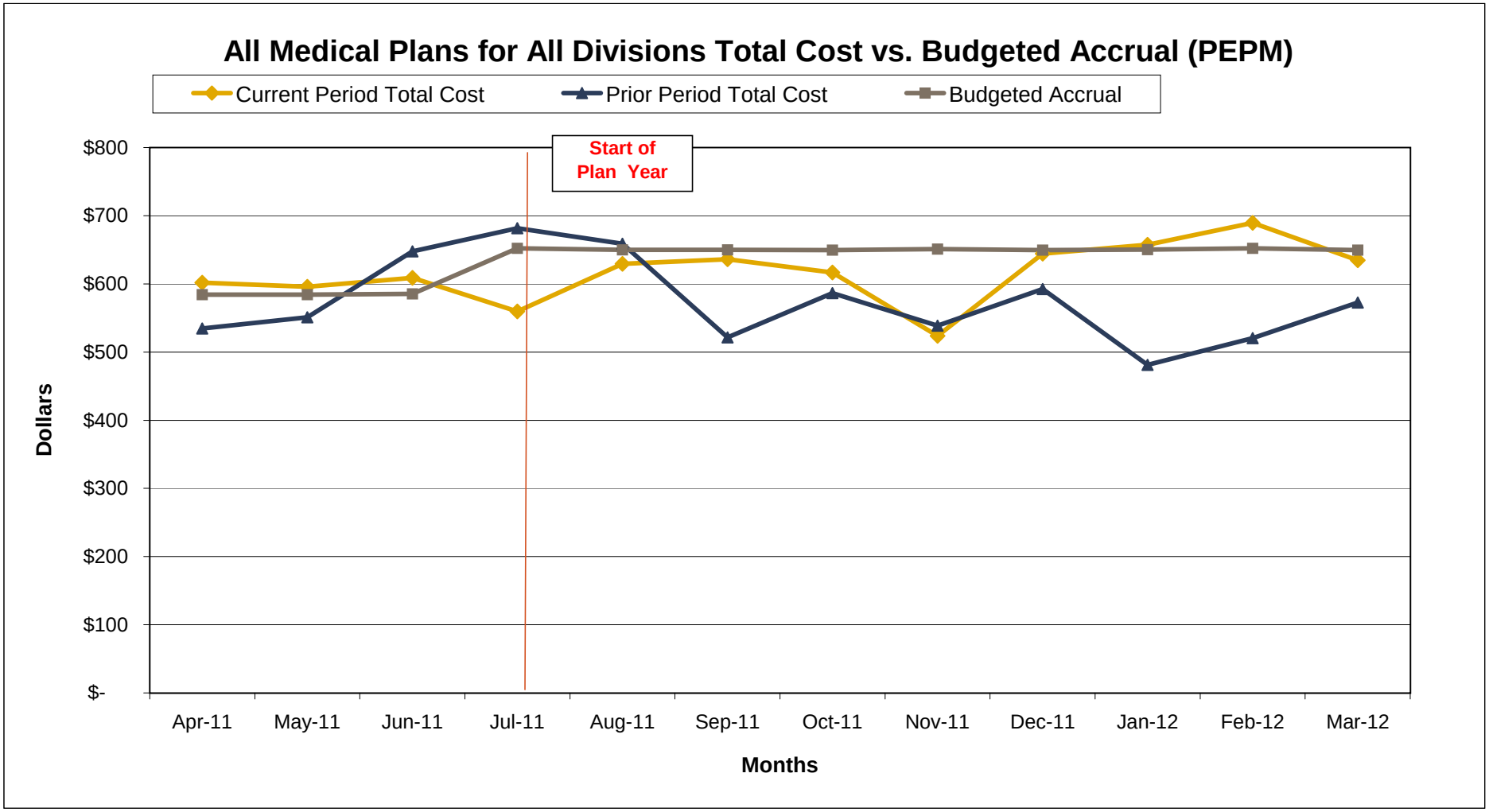
ABC Company

Enrollment Summary



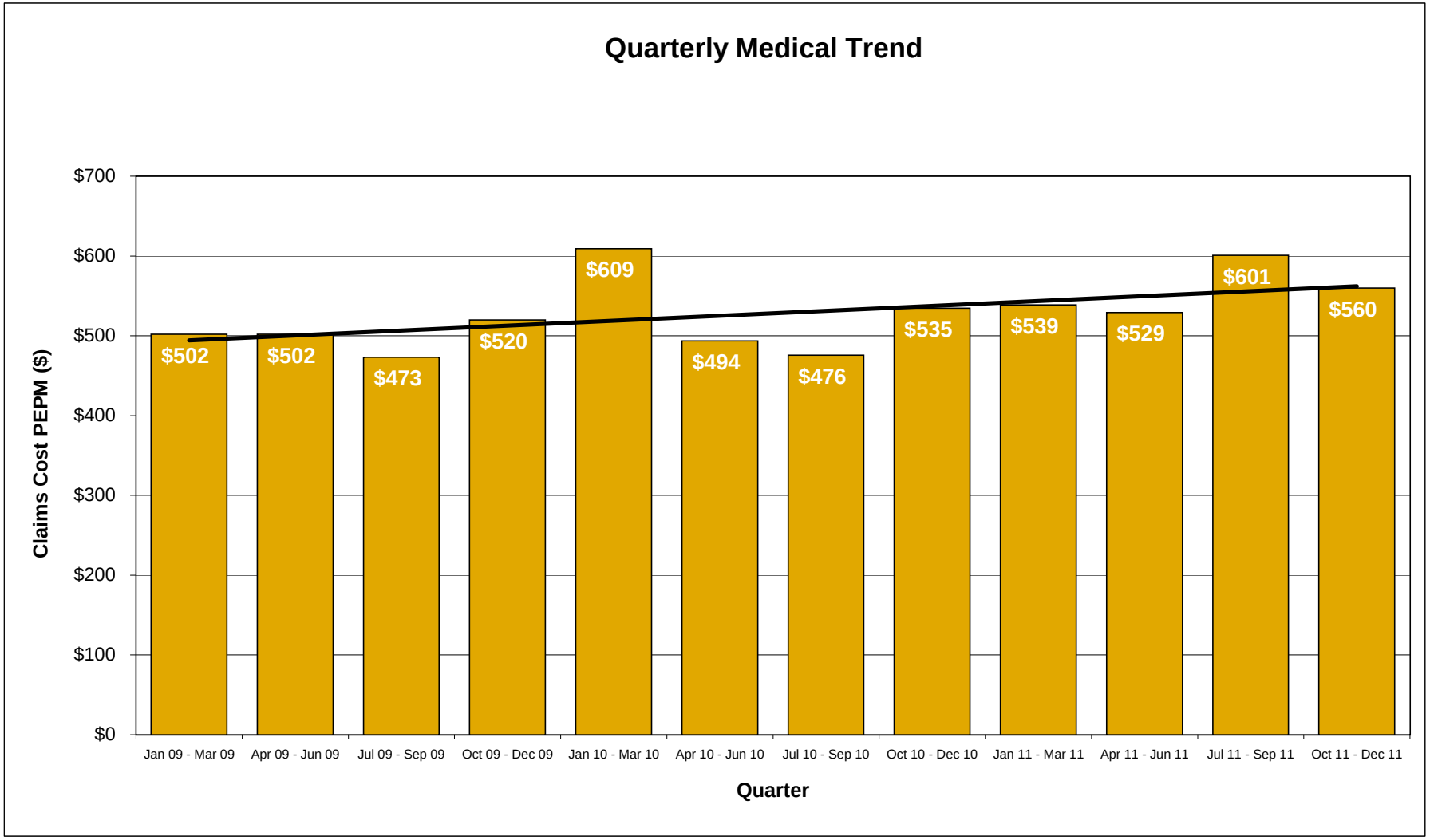
ABC Company

All Medical Plans for All Divisions - Rolling 12-Month Medical Cost Summary



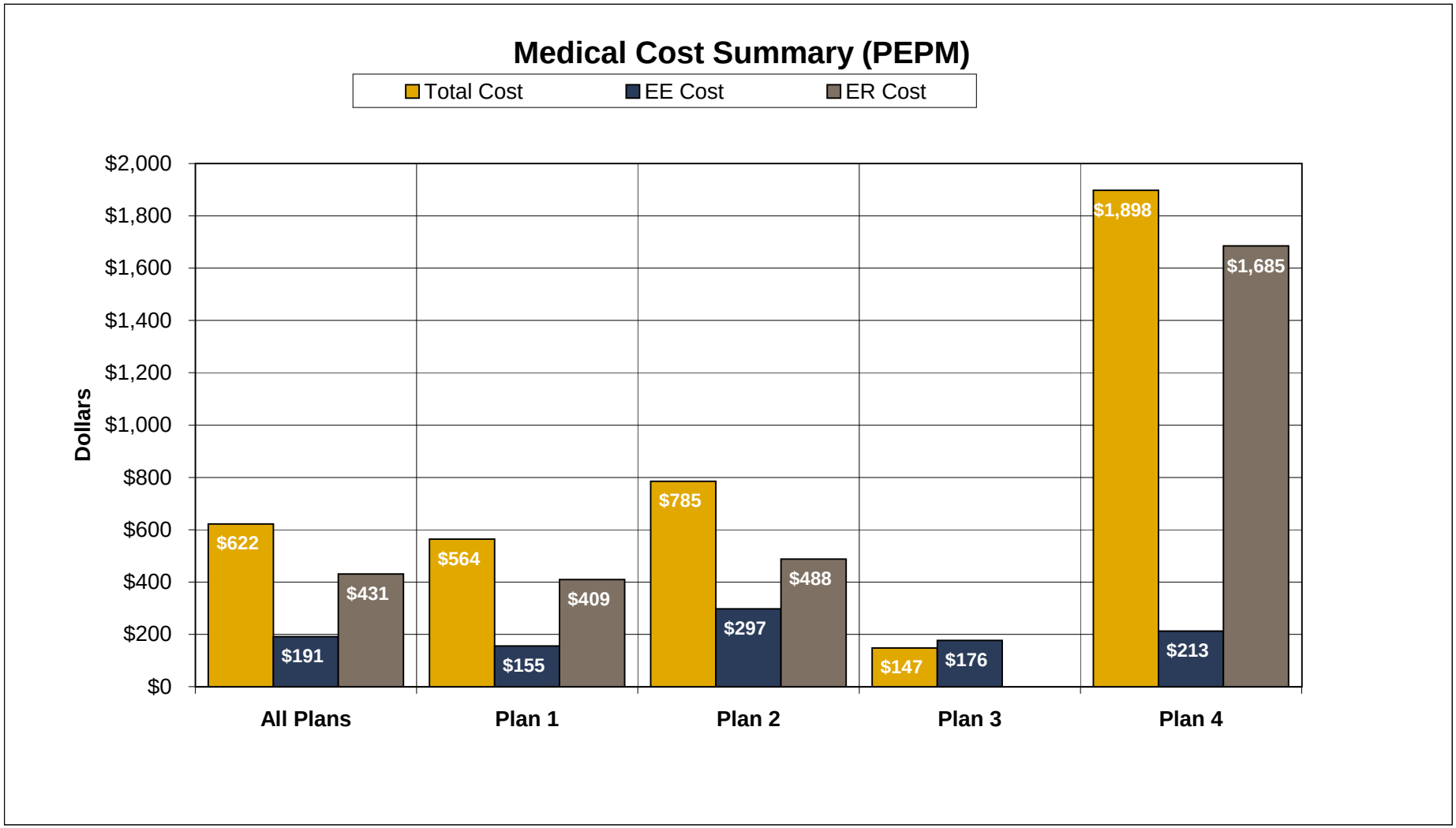
ABC Company

Quarterly Medical/Rx Claims PEPM



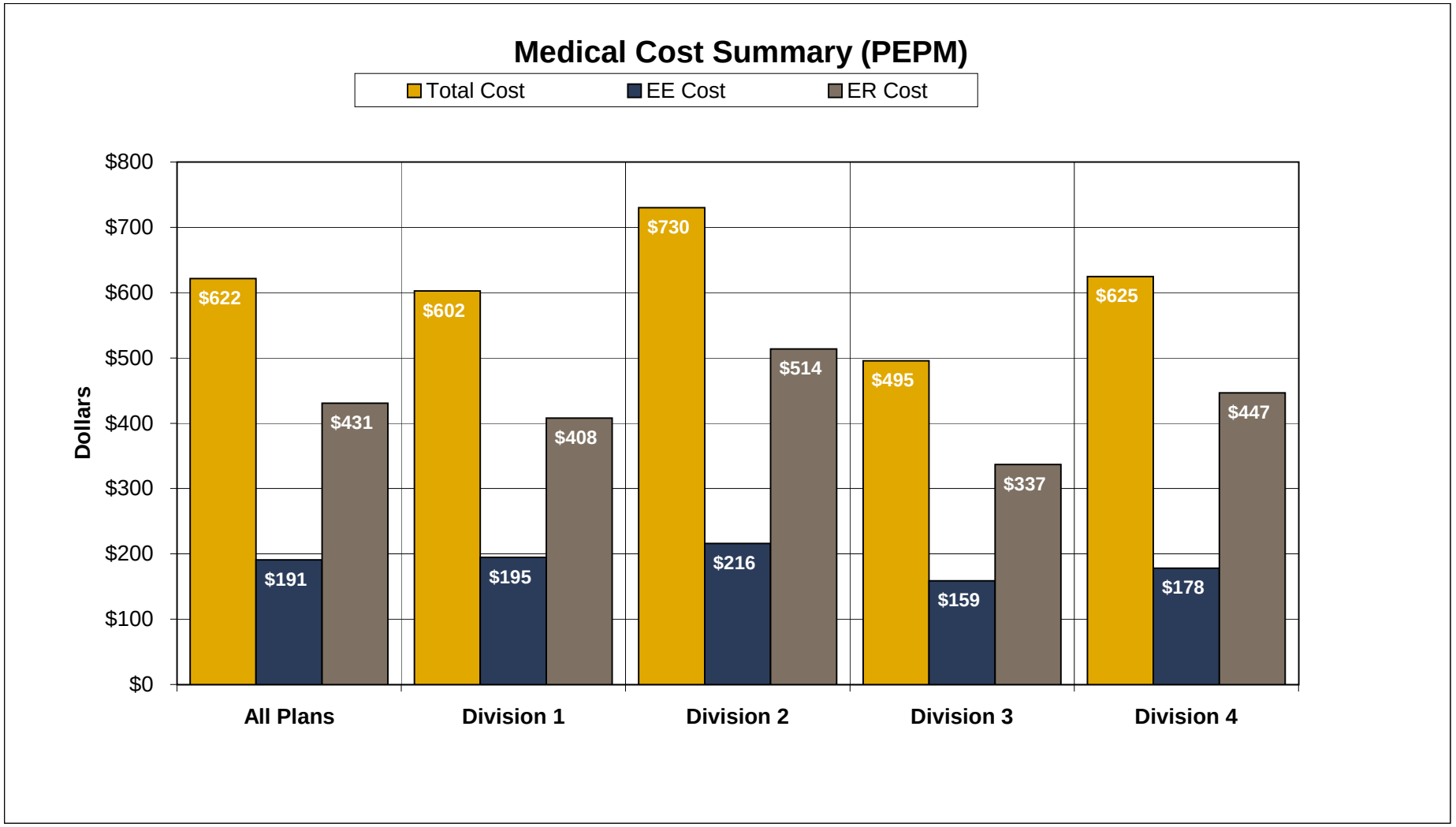
ABC Company

Medical Cost Comparison



ABC Company

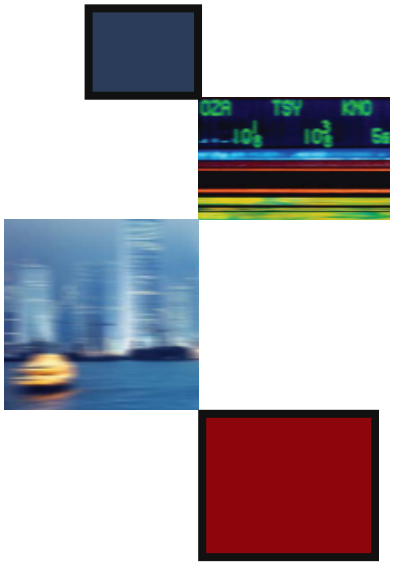
Medical Cost Comparison



Summary of Medical Plans

Enrollment, Claims & Plan Cost Recap

The ABC Company, Inc.



ABC Company

Medical Plan Summary - All Plans

Rolling 12 Months	No. of Employees	Medical Claims	Prescription Drug Claims	COBRA Paid Claims	Claims over ISL	Total Claims	Total Claims PEPM	Admin Fees	Stop Loss Fees	Total Cost	Total Cost PEPM	EE Cost	EE Cost PEPM	ER Cost	ER Cost PEPM
April-11	4,705	$2,104,610	$328,405	$189,986	($51,860)	$2,571,141	$546	$182,131	$78,574	$2,831,845	$602	$799,080	$170	$2,032,765	$432
May-11	4,700	$2,138,304	$340,179	$227,315	($165,595)	$2,540,203	$540	$181,937	$78,490	$2,800,630	$596	$796,507	$169	$2,004,123	$426
June-11	4,698	$1,994,842	$532,203	$313,821	($240,493)	$2,600,373	$554	$181,860	$78,457	$2,860,690	$609	$799,296	$170	$2,061,393	$439
July-11	4,804	$2,019,255	$355,497	$123,654	($112,173)	$2,386,233	$497	$198,387	$104,247	$2,688,866	$560	$925,171	$193	$1,763,695	$367
August-11	4,795	$2,022,970	$337,626	$396,714	($41,742)	$2,715,568	$566	$198,015	$104,052	$3,017,634	$629	$917,818	$191	$2,099,817	$438
September-11	4,766	$2,107,353	$390,524	$233,050	$20	$2,730,947	$573	$196,818	$103,422	$3,031,186	$636	$910,624	$191	$2,120,562	$445
October-11	4,802	$2,120,426	$388,630	$150,270	$0	$2,659,326	$554	$198,308	$104,203	$2,961,838	$617	$915,485	$191	$2,046,353	$426
November-11	4,810	$1,735,555	$397,553	$99,548	($16,454)	$2,216,202	$461	$198,637	$104,377	$2,519,216	$524	$916,988	$191	$1,602,227	$333
December-11	4,923	$2,135,942	$669,106	$104,050	($47,655)	$2,861,443	$581	$203,304	$106,829	$3,171,576	$644	$934,493	$190	$2,237,083	$454
January-12	4,953	$2,402,141	$385,105	$193,559	($36,437)	$2,944,368	$594	$204,543	$107,480	$3,256,391	$657	$940,536	$190	$2,315,855	$468
February-12	4,902	$2,330,417	$449,888	$309,777	($18,379)	$3,071,703	$627	$202,436	$106,373	$3,380,513	$690	$938,635	$191	$2,441,878	$498
March-12	4,993	$2,248,776	$453,057	$224,347	($72,412)	$2,853,768	$572	$206,195	$108,348	$3,168,310	$635	$950,857	$190	$2,217,453	$444
Current Period YTD	**43,748**	**$19,122,835**	**$3,826,986**	**$1,834,969**	**($345,233)**	**$24,439,557**	**$559**	**$1,806,643**	**$949,332**	**$27,195,531**	**$622**	**$8,350,607**	**$191**	**$18,844,924**	**$431**
Prior Period YTD	**41,845**	**$16,797,554**	**$3,187,747**	**$2,286,323**	**($620,527)**	**$21,651,097**	**$517**	**$1,619,820**	**$698,812**	**$23,969,728**	**$573**	**$7,145,147**	**$171**	**$16,824,582**	**$402**
Rolling 12 Months	**57,851**	**$25,360,591**	**$5,027,773**	**$2,566,091**	**($803,181)**	**$32,151,274**	**$556**	**$2,352,570**	**$1,184,852**	**$35,688,695**	**$617**	**$10,745,491**	**$186**	**$24,943,205**	**$431**
Prior Policy Period	**55,948**	**$23,035,310**	**$4,388,534**	**$3,017,445**	**($1,078,475)**	**$29,362,814**	**$525**	**$2,165,747**	**$934,332**	**$32,462,893**	**$580**	**$9,540,030**	**$171**	**$22,922,863**	**$410**

Represents current policy period 7/1/2011 through 3/31/2012

Represents prior policy period 7/1/2010 through 3/31/2011

Represents prior policy period 7/1/2010 through 6/30/2011

ABC Company

Medical Plan Summary - Plan 1

Rolling 12 Months	No. of Employees	Medical Claims	Prescription Drug Claims	COBRA Paid Claims	Claims over ISL	Total Claims	Total Claims PEPM	Admin Fees	Stop Loss Fees	Total Cost	Total Cost PEPM	EE Cost	EE Cost PEPM	ER Cost	ER Cost PEPM
April-11	3,472	$1,274,310	$185,954	$42,656	($6,445)	$1,496,475	$431	$134,401	$57,982	$1,688,859	$486	$477,024	$137	$1,211,835	$349
May-11	3,468	$1,483,677	$206,145	$94,520	($154,921)	$1,629,421	$470	$134,246	$57,916	$1,821,583	$525	$474,078	$137	$1,347,505	$389
June-11	3,460	$1,441,027	$314,923	$23,501	($240,417)	$1,539,034	$445	$133,937	$57,782	$1,730,753	$500	$474,268	$137	$1,256,484	$363
July-11	3,565	$1,602,119	$209,943	$25,860	($112,173)	$1,725,749	$484	$147,235	$77,361	$1,950,344	$547	$558,082	$157	$1,392,261	$391
August-11	3,565	$1,518,577	$212,086	$189,268	($41,742)	$1,878,189	$527	$147,235	$77,361	$2,102,784	$590	$554,877	$156	$1,547,906	$434
September-11	3,546	$1,509,704	$238,984	$75,056	$20	$1,823,764	$514	$146,450	$76,948	$2,047,162	$577	$551,066	$155	$1,496,096	$422
October-11	3,581	$1,520,629	$240,491	$33,383	$0	$1,794,503	$501	$147,895	$77,708	$2,020,106	$564	$556,705	$155	$1,463,401	$409
November-11	3,586	$1,225,928	$259,250	$34,246	$0	$1,519,424	$424	$148,102	$77,816	$1,745,342	$487	$555,602	$155	$1,189,740	$332
December-11	3,681	$1,408,450	$418,868	$34,932	($37,372)	$1,824,878	$496	$152,025	$79,878	$2,056,781	$559	$568,630	$154	$1,488,151	$404
January-12	3,701	$1,504,899	$241,078	$20,458	($35,190)	$1,731,245	$468	$152,851	$80,312	$1,964,408	$531	$569,787	$154	$1,394,621	$377
February-12	3,665	$1,766,236	$305,628	$51,970	($17,934)	$2,105,900	$575	$151,365	$79,531	$2,336,795	$638	$569,119	$155	$1,767,676	$482
March-12	3,740	$1,673,585	$264,692	$60,730	($34,718)	$1,964,289	$525	$154,462	$81,158	$2,199,909	$588	$576,832	$154	$1,623,076	$434
Current Period YTD	**32,630**	**$13,730,127**	**$2,391,020**	**$525,903**	**($279,110)**	**$16,367,940**	**$502**	**$1,347,619**	**$708,071**	**$18,423,630**	**$565**	**$5,060,703**	**$155**	**$13,362,927**	**$410**
Prior Period YTD	**31,099**	**$11,341,261**	**$1,891,243**	**$1,242,707**	**($430,758)**	**$14,044,453**	**$452**	**$1,203,842**	**$519,353**	**$15,767,649**	**$507**	**$4,359,502**	**$140**	**$11,408,147**	**$367**
Rolling 12 Months	**43,030**	**$17,929,141**	**$3,098,042**	**$686,580**	**($680,893)**	**$21,032,870**	**$489**	**$1,750,203**	**$881,751**	**$23,664,824**	**$550**	**$6,486,074**	**$151**	**$17,178,750**	**$399**
Prior Policy Period	**41,499**	**$15,540,275**	**$2,598,265**	**$1,403,384**	**($832,540)**	**$18,709,384**	**$451**	**$1,606,426**	**$693,033**	**$21,008,843**	**$506**	**$5,784,873**	**$139**	**$15,223,971**	**$367**

Represents current policy period 7/1/2011 through 3/31/2012

Represents prior policy period 7/1/2010 through 3/31/2011

Represents prior policy period 7/1/2010 through 6/30/2011

ABC Company

Medical Plan Summary - Plan 2

Rolling 12 Months	No. of Employees	Medical Claims	Prescription Drug Claims	COBRA Paid Claims	Claims over ISL	Total Claims	Total Claims PEPM	Admin Fees	Stop Loss Fees	Total Cost	Total Cost PEPM	EE Cost	EE Cost PEPM	ER Cost	ER Cost PEPM
April-11	1,218	$829,767	$141,943	$147,088	($45,415)	$1,073,383	$881	$47,149	$20,341	$1,140,872	$937	$319,500	$262	$821,372	$674
May-11	1,218	$653,189	$133,742	$132,554	($10,674)	$908,811	$746	$47,149	$20,341	$976,300	$802	$320,026	$263	$656,275	$539
June-11	1,224	$553,748	$216,970	$290,161	($76)	$1,060,803	$867	$47,381	$20,441	$1,128,625	$922	$322,625	$264	$806,001	$658
July-11	1,223	$416,182	$145,265	$97,664	$0	$659,111	$539	$50,510	$26,539	$736,160	$602	$364,238	$298	$371,922	$304
August-11	1,214	$497,268	$124,792	$206,946	$0	$829,006	$683	$50,138	$26,344	$905,488	$746	$360,089	$297	$545,399	$449
September-11	1,205	$596,367	$151,231	$157,930	$0	$905,528	$751	$49,767	$26,149	$981,443	$814	$357,555	$297	$623,888	$518
October-11	1,208	$594,486	$147,488	$116,887	$0	$858,861	$711	$49,890	$26,214	$934,965	$774	$356,952	$295	$578,013	$478
November-11	1,210	$506,564	$137,546	$65,137	($16,454)	$692,793	$573	$49,973	$26,257	$769,023	$636	$358,387	$296	$410,636	$339
December-11	1,229	$702,244	$249,791	$68,830	($10,283)	$1,010,582	$822	$50,758	$26,669	$1,088,009	$885	$362,942	$295	$725,068	$590
January-12	1,238	$827,572	$143,667	$173,029	($1,247)	$1,143,021	$923	$51,129	$26,865	$1,221,015	$986	$367,423	$297	$853,592	$689
February-12	1,223	$542,772	$143,953	$257,784	($445)	$944,064	$772	$50,510	$26,539	$1,021,113	$835	$366,190	$299	$654,923	$536
March-12	1,239	$574,153	$187,880	$163,392	($37,694)	$887,731	$716	$51,171	$26,886	$965,788	$779	$370,699	$299	$595,089	$480
Current Period YTD	**10,989**	**$5,257,608**	**$1,431,613**	**$1,307,599**	**($66,123)**	**$7,930,697**	**$722**	**$453,846**	**$238,461**	**$8,623,004**	**$785**	**$3,264,475**	**$297**	**$5,358,529**	**$488**
Prior Period YTD	**10,603**	**$5,435,737**	**$1,292,978**	**$1,034,882**	**($189,770)**	**$7,573,827**	**$714**	**$410,442**	**$177,070**	**$8,161,340**	**$770**	**$2,764,544**	**$261**	**$5,396,795**	**$509**
Rolling 12 Months	**14,649**	**$7,294,312**	**$1,924,268**	**$1,877,402**	**($122,288)**	**$10,973,694**	**$749**	**$595,524**	**$299,583**	**$11,868,801**	**$810**	**$4,226,625**	**$289**	**$7,642,177**	**$522**
Prior Policy Period	**14,263**	**$7,472,441**	**$1,785,633**	**$1,604,685**	**($245,935)**	**$10,616,824**	**$744**	**$552,121**	**$238,192**	**$11,407,137**	**$800**	**$3,726,694**	**$261**	**$7,680,443**	**$538**

Represents current policy period 7/1/2011 through 3/31/2012

Represents prior policy period 7/1/2010 through 3/31/2011

Represents prior policy period 7/1/2010 through 6/30/2011

ABC Company

Medical Plan Summary - Plan 3

Rolling 12 Months	No. of Employees	Medical Claims	Prescription Drug Claims	COBRA Paid Claims	Claims over ISL	Total Claims	Total Claims PEPM	Admin Fees	Stop Loss Fees	Total Cost	Total Cost PEPM	EE Cost	EE Cost PEPM	ER Cost	ER Cost PEPM
April-11	7	$0	$314	$242	$0	$556	$79	$271	$117	$944	$135	$1,559	$223	($615)	($88)
May-11	6	$527	$116	$241	$0	$884	$147	$232	$100	$1,216	$203	$1,406	$234	($190)	($32)
June-11	6	$67	$129	$159	$0	$355	$59	$232	$100	$687	$115	$1,406	$234	($719)	($120)
July-11	7	$630	$98	$130	$0	$858	$123	$289	$152	$1,299	$186	$1,637	$234	($338)	($48)
August-11	7	$408	$112	$155	$0	$675	$96	$289	$152	$1,116	$159	$1,637	$234	($521)	($74)
September-11	6	$165	$10	$64	$0	$239	$40	$248	$130	$617	$103	$789	$132	($172)	($29)
October-11	6	$148	$104	$0	$0	$252	$42	$248	$130	$630	$105	$789	$132	($159)	($27)
November-11	6	$205	$525	$165	$0	$895	$149	$248	$130	$1,273	$212	$789	$132	$484	$81
December-11	5	$461	$12	$288	$0	$761	$152	$207	$109	$1,076	$215	$712	$142	$364	$73
January-12	6	$189	$310	$72	$0	$571	$95	$248	$130	$949	$158	$1,116	$186	($167)	($28)
February-12	6	$83	$56	$23	$0	$162	$27	$248	$130	$540	$90	$1,116	$186	($576)	($96)
March-12	6	$10	($6)	$225	$0	$229	$38	$248	$130	$607	$101	$1,116	$186	($509)	($85)
Current Period YTD	**55**	**$2,299**	**$1,221**	**$1,122**	**$0**	**$4,642**	**$84**	**$2,272**	**$1,194**	**$8,107**	**$147**	**$9,702**	**$176**	**($1,595)**	**($29)**
Prior Period YTD	**71**	**$6,953**	**$1,882**	**$8,734**	**$0**	**$17,569**	**$247**	**$2,748**	**$1,186**	**$21,503**	**$303**	**$13,086**	**$184**	**$8,417**	**$119**
Rolling 12 Months	**74**	**$2,893**	**$1,780**	**$1,764**	**$0**	**$6,437**	**$87**	**$3,007**	**$1,511**	**$10,955**	**$148**	**$14,073**	**$190**	**($3,118)**	**($42)**
Prior Policy Period	**90**	**$7,547**	**$2,441**	**$9,376**	**$0**	**$19,364**	**$215**	**$3,484**	**$1,503**	**$24,351**	**$271**	**$17,458**	**$194**	**$6,893**	**$77**

Represents current policy period 7/1/2011 through 3/31/2012

Represents prior policy period 7/1/2010 through 3/31/2011

Represents prior policy period 7/1/2010 through 6/30/2011

ABC Company

Medical Plan Summary - Plan 4

Rolling 12 Months	No. of Employees	Medical Claims	Prescription Drug Claims	COBRA Paid Claims	Claims over ISL	Total Claims	Total Claims PEPM	Admin Fees	Stop Loss Fees	Total Cost	Total Cost PEPM	EE Cost	EE Cost PEPM	ER Cost	ER Cost PEPM
April-11	8	$524	$194	$0	$0	$718	$90	$310	$134	$1,161	$145	$997	$125	$164	$21
May-11	8	$914	$176	$0	$0	$1,090	$136	$310	$134	$1,533	$192	$997	$125	$536	$67
June-11	8	$0	$181	$0	$0	$181	$23	$310	$134	$624	$78	$997	$125	($373)	($47)
July-11	9	$324	$191	$0	$0	$515	$57	$354	$195	$1,064	$118	$1,214	$135	($150)	($17)
August-11	9	$6,717	$636	$0	$0	$7,353	$817	$354	$195	$7,902	$878	$1,214	$135	$6,688	$743
September-11	9	$1,117	$299	$0	$0	$1,416	$157	$354	$195	$1,965	$218	$1,214	$135	$751	$83
October-11	7	$5,163	$547	$0	$0	$5,710	$816	$275	$152	$6,137	$877	$1,038	$148	$5,099	$728
November-11	8	$2,858	$232	$0	$0	$3,090	$386	$314	$174	$3,578	$447	$2,210	$276	$1,368	$171
December-11	8	$24,787	$435	$0	$0	$25,222	$3,153	$314	$174	$25,710	$3,214	$2,210	$276	$23,500	$2,938
January-12	8	$69,481	$50	$0	$0	$69,531	$8,691	$314	$174	$70,019	$8,752	$2,210	$276	$67,809	$8,476
February-12	8	$21,326	$251	$0	$0	$21,577	$2,697	$314	$174	$22,065	$2,758	$2,210	$276	$19,855	$2,482
March-12	8	$1,028	$491	$0	$0	$1,519	$190	$314	$174	$2,007	$251	$2,210	$276	($203)	($25)
Current Period YTD	**74**	**$132,801**	**$3,132**	**$0**	**$0**	**$135,933**	**$1,837**	**$2,907**	**$1,606**	**$140,446**	**$1,898**	**$15,728**	**$213**	**$124,717**	**$1,685**
Prior Period YTD	**72**	**$11,028**	**$1,610**	**$0**	**$0**	**$12,638**	**$176**	**$2,787**	**$1,202**	**$16,628**	**$231**	**$8,014**	**$111**	**$8,614**	**$120**
Rolling 12 Months	**98**	**$134,239**	**$3,683**	**$0**	**$0**	**$137,922**	**$1,407**	**$3,836**	**$2,007**	**$143,764**	**$1,467**	**$18,719**	**$191**	**$125,045**	**$1,276**
Prior Policy Period	**96**	**$12,466**	**$2,161**	**$0**	**$0**	**$14,627**	**$152**	**$3,716**	**$1,603**	**$19,946**	**$208**	**$11,005**	**$115**	**$8,941**	**$93**

Represents current policy period 7/1/2011 through 3/31/2012

Represents prior policy period 7/1/2010 through 3/31/2011

Represents prior policy period 7/1/2010 through 6/30/2011

ABC Company

Large Claims Summary (through March 2012) - $50k+

Rank	Identifier	Division	Plan	Status	Current Month	YTD Claims	Claims Over ISL ($250k)	Net Paid Claims	Prior Year Lrg Claims
1	A	Division 1	Plan 1	Active	$0	$403,896	($153,896)	$250,000	No
2	D	Division 1	Plan 1	Active	$33,630	$337,493	($87,493)	$250,000	Yes
3	S	Division 2	Plan 2	Active	$37,581	$316,010	($66,010)	$250,000	No
4	J	Division 4	Plan 1	Active	$590	$285,484	($35,484)	$250,000	No
5	E	Division 2	Plan 1	Active	$499	$252,238	($2,238)	$250,000	No
6	AQ	Division 1	Plan 2	COBRA	$4,919	$250,113	($113)	$250,000	No
7	AG	Division 4	Plan 1	Active	$85,586	$244,383	$0	$244,383	No
8	AT	Division 1	Plan 1	Active	$679	$205,323	$0	$205,323	No
9	T	Division 1	Plan 1	Active	$9,324	$183,476	$0	$183,476	No
10	AX	Division 1	Plan 2	COBRA	$180,592	$180,592	$0	$180,592	No
11	V	Division 4	Plan 1	Active	$17	$179,615	$0	$179,615	No
12	AD	Division 1	Plan 1	Active	$707	$176,529	$0	$176,529	No
13	M	Division 2	Plan 2	Active	$11,081	$162,671	$0	$162,671	Yes
14	F	Division 1	Plan 1	COBRA	$0	$162,447	$0	$162,447	No
15	R	Division 4	Plan 1	Active	$19,285	$153,528	$0	$153,528	Yes
16	AE	Division 1	Plan 2	Active	($73)	$142,951	$0	$142,951	No
17	W	Division 1	Plan 1	Active	$10,355	$138,715	$0	$138,715	Yes
18	AF	Division 2	Plan 1	Active	$11,653	$132,814	$0	$132,814	No
19	G	Division 2	Plan 2	COBRA	$147	$127,343	$0	$127,343	Yes
20	N	Division 1	Plan 2	COBRA	$0	$126,409	$0	$126,409	Yes
21	AY	Division 4	Plan 1	Active	$117,326	$117,326	$0	$117,326	No
22	AH	Division 1	Plan 4	Active	$0	$114,566	$0	$114,566	No
23	X	Division 4	Plan 1	Active	$6,099	$114,024	$0	$114,024	Yes
24	O	Division 1	Plan 1	Active	$293	$104,143	$0	$104,143	No
25	B	Division 1	Plan 1	Active	$0	$100,652	$0	$100,652	No
26	C	Division 1	Plan 1	Active	$259	$96,701	$0	$96,701	Yes
27	AZ	Division 2	Plan 1	Active	$93,832	$93,832	$0	$93,832	No
28	H	Division 1	Plan 1	Active	$2,288	$93,122	$0	$93,122	No

ABC Company

Large Claims Summary (through March 2012) - $50k+

Rank	Identifier	Division	Plan	Status	Current Month	YTD Claims	Claims Over ISL ($250k)	Net Paid Claims	Prior Year Lrg Claims
29	L	Division 1	Plan 2	COBRA	$0	$92,954	$0	$92,954	Yes
30	Z	Division 4	Plan 1	Active	$105	$91,365	$0	$91,365	No
31	AL	Division 4	Plan 1	Active	$3,857	$86,517	$0	$86,517	No
32	AA	Division 2	Plan 2	Active	$0	$80,619	$0	$80,619	No
33	AI	Division 1	Plan 1	Active	$598	$77,062	$0	$77,062	No
34	P	Division 2	Plan 1	Active	$116	$73,552	$0	$73,552	No
35	AV	Division 1	Plan 1	Active	$13,506	$72,064	$0	$72,064	No
36	AJ	Division 1	Plan 2	Active	$911	$70,386	$0	$70,386	No
37	AU	Division 1	Plan 1	Active	$282	$68,529	$0	$68,529	No
38	BA	Division 4	Plan 1	Active	$67,174	$67,174	$0	$67,174	No
39	AK	Division 2	Plan 2	Active	$0	$66,594	$0	$66,594	No
40	U	Division 4	Plan 1	Active	$1,672	$66,593	$0	$66,593	No
41	Q	Division 1	Plan 1	Active	$0	$64,862	$0	$64,862	Yes
42	AO	Division 1	Plan 1	Active	$3,032	$64,201	$0	$64,201	No
43	AR	Division 2	Plan 1	Active	$4,615	$63,166	$0	$63,166	Yes
44	I	Division 4	Plan 2	Active	$0	$61,497	$0	$61,497	No
45	AN	Division 2	Plan 2	Active	$13	$61,425	$0	$61,425	No
46	AB	Division 4	Plan 1	Active	$0	$61,129	$0	$61,129	No
47	BB	Division 2	Plan 1	Active	$59,935	$59,935	$0	$59,935	No

Total Large Claims	**$782,485**	**$6,346,020**	**($345,233)**	**$6,000,786**

ABC Company

Self-Funded Medical Gap Analysis - Expected (through March 2012)

Plan 1	Accrual Rates*	x	Head Count	=	*Budgeted* Accruals	*Actual* Claims	Expenses	
EE Only	$404.00		18,136		$7,326,944			
EE + SP	$848.40		4,246		$3,602,306			
EE + CH	$727.20		4,155		$3,021,516			
Family	$1,171.61		6,093		$7,138,620			
Totals			32,630		$21,089,386	$16,367,940	$2,055,690	
Claims + Expenses			**$18,423,630**	=	**87.36%**		***Mar 12 vs. Accrual***	92.4%
Accrual Premium			**$21,089,386**				***YTD Accrual PEPM***	$646.32

Plan 2	Accrual Rates*	x	Head Count	=	*Budgeted* Accruals	*Actual* Claims	Expenses	
EE Only	$449.08		7,031		$3,157,481			
EE + SP	$943.07		1,669		$1,573,984			
EE + CH	$808.34		841		$679,814			
Family	$1,302.34		1,448		$1,885,788			
Totals			10,989		$7,297,068	$7,930,697	$692,307	
Claims + Expenses			**$8,623,004**	=	**118.17%**		***Mar 12 vs. Accrual***	121.4%
Accrual Premium			**$7,297,068**				***YTD Accrual PEPM***	$664.03

Plan 3	Accrual Rates*	x	Head Count	=	*Budgeted* Accruals	*Actual* Claims	Expenses	
EE Only	$404.00		53		$21,412			
EE + SP	$848.40		2		$1,697			
EE + CH	$727.20		0		$0			
Family	$1,171.61		0		$0			
Totals			55		$23,109	$4,642	$3,465	
Claims + Expenses			**$8,107**	=	**35.08%**		***Mar 12 vs. Accrual***	29.8%
Accrual Premium			**$23,109**				***YTD Accrual PEPM***	$420.16

Plan 4	Accrual Rates*	x	Head Count	=	*Budgeted* Accruals	*Actual* Claims	Expenses	
EE Only	$404.00		51		$20,604			
EE + SP	$848.40		9		$7,636			
EE + CH	$727.20		0		$0			
Family	$1,171.61		14		$16,403			
Totals			74		$44,642	$135,933	$4,513	
Claims + Expenses			**$140,446**	=	**314.60%**		***Mar 12 vs. Accrual***	48.2%
Accrual Premium			**$44,642**				***YTD Accrual PEPM***	$603.27

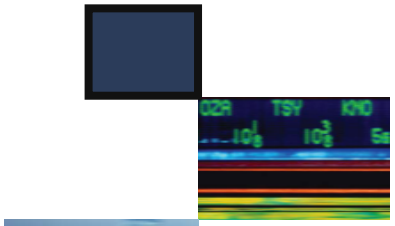
Claims Runout						**$345**	**$0**	

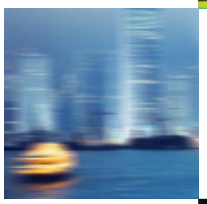
Summary (All Groups)			**43,748**		**$28,454,205**	**$24,439,557**	**$2,755,975**	
Claims + Expenses			**$27,195,531**	=	**95.58%**		***Mar 12 vs. Accrual***	99.2%
Accrual Premium			**$28,454,205**				***YTD Accrual PEPM***	$650.41

Appendix: Summary of Divisions

Enrollment, Claims & Plan Cost Recap

The ABC Company, Inc.





ABC Company

Medical Plan Summary - Division 1

Rolling 12 Months	No. of Employees	Medical Claims	Prescription Drug Claims	Claims over ISL	Total Claims	Total Claims PEPM	Admin Fees	Stop Loss Fees	Total Cost	Total Cost PEPM	EE Cost	EE Cost PEPM	ER Cost	ER Cost PEPM
April-11	2,101	$841,040	$172,795	($5,882)	$1,007,953	$480	$81,330	$35,087	$1,124,369	$535	$369,711	$176	$754,658	$359
May-11	2,096	$1,113,376	$189,438	($154,921)	$1,147,893	$548	$81,136	$35,003	$1,264,032	$603	$363,907	$174	$900,125	$429
June-11	2,091	$1,063,538	$276,008	($240,941)	$1,098,605	$525	$80,943	$34,920	$1,214,467	$581	$365,735	$175	$848,732	$406
July-11	2,161	$1,187,831	$190,292	($112,173)	$1,265,950	$586	$89,231	$46,894	$1,402,074	$649	$422,864	$196	$979,210	$453
August-11	2,147	$892,167	$178,288	($41,742)	$1,028,713	$479	$88,653	$46,590	$1,163,955	$542	$418,251	$195	$745,704	$347
September-11	2,124	$998,077	$202,836	$20	$1,200,933	$565	$87,703	$46,091	$1,334,726	$628	$414,085	$195	$920,641	$433
October-11	2,111	$863,140	$202,124	$0	$1,065,264	$505	$87,170	$45,809	$1,198,243	$568	$410,697	$195	$787,546	$373
November-11	2,121	$633,761	$208,158	$0	$841,919	$397	$87,581	$46,026	$975,526	$460	$411,243	$194	$564,283	$266
December-11	2,163	$773,796	$323,959	($19,205)	$1,078,550	$499	$89,316	$46,937	$1,214,803	$562	$416,403	$193	$798,400	$369
January-12	2,177	$1,194,545	$207,784	($18,163)	$1,384,166	$636	$89,894	$47,241	$1,521,301	$699	$421,804	$194	$1,099,497	$505
February-12	2,128	$1,206,103	$237,174	($16,495)	$1,426,782	$670	$87,870	$46,178	$1,560,830	$733	$416,077	$196	$1,144,753	$538
March-12	2,105	$885,531	$233,003	($33,743)	$1,084,791	$515	$86,920	$45,679	$1,217,390	$578	$412,363	$196	$805,027	$382
Current Period YTD	**19,237**	**$8,634,951**	**$1,983,618**	**($241,502)**	**$10,377,067**	**$539**	**$794,339**	**$417,443**	**$11,588,848**	**$602**	**$3,743,787**	**$195**	**$7,845,061**	**$408**
Prior Period YTD	**19,428**	**$7,422,792**	**$1,756,076**	**($196,828)**	**$8,982,040**	**$462**	**$752,058**	**$324,448**	**$10,058,546**	**$518**	**$3,389,170**	**$174**	**$6,669,375**	**$343**
Rolling 12 Months	**25,525**	**$11,652,905**	**$2,621,859**	**($643,246)**	**$13,631,518**	**$534**	**$1,037,747**	**$522,453**	**$15,191,717**	**$595**	**$4,843,140**	**$190**	**$10,348,577**	**$405**
Prior Policy Period	**25,716**	**$10,440,746**	**$2,394,317**	**($598,572)**	**$12,236,491**	**$476**	**$995,466**	**$429,457**	**$13,661,415**	**$531**	**$4,488,524**	**$175**	**$9,172,891**	**$357**

Represents current policy period 7/1/2011 through 3/31/2012

Represents prior policy period 7/1/2010 through 3/31/2011

Represents prior policy period 7/1/2010 through 6/30/2011

ABC Company

Medical Plan Summary - Division 2

Rolling 12 Months	No. of Employees	Medical Claims	Prescription Drug Claims	Claims over ISL	Total Claims	Total Claims PEPM	Admin Fees	Stop Loss Fees	Total Cost	Total Cost PEPM	EE Cost	EE Cost PEPM	ER Cost	ER Cost PEPM
April-11	957	$763,082	$78,277	($45,415)	$795,944	$832	$37,045	$15,982	$848,971	$887	$181,282	$189	$667,689	$698
May-11	967	$547,032	$69,582	($10,674)	$605,940	$627	$37,433	$16,149	$659,521	$682	$185,135	$191	$474,386	$491
June-11	965	$545,369	$103,830	($76)	$649,123	$673	$37,355	$16,116	$702,594	$728	$184,640	$191	$517,954	$537
July-11	982	$368,874	$79,895	$0	$448,769	$457	$40,557	$21,309	$510,635	$520	$214,613	$219	$296,022	$301
August-11	978	$758,277	$62,827	$0	$821,104	$840	$40,391	$21,223	$882,718	$903	$209,765	$214	$672,953	$688
September-11	973	$607,933	$82,016	$0	$689,949	$709	$40,185	$21,114	$751,248	$772	$209,475	$215	$541,773	$557
October-11	979	$673,296	$72,158	$0	$745,454	$761	$40,433	$21,244	$807,131	$824	$212,817	$217	$594,314	$607
November-11	985	$426,865	$70,163	($16,454)	$480,574	$488	$40,681	$21,375	$542,629	$551	$212,848	$216	$329,780	$335
December-11	1,005	$696,962	$139,500	($10,283)	$826,179	$822	$41,507	$21,809	$889,494	$885	$218,034	$217	$671,460	$668
January-12	1,017	$603,125	$66,820	($2,914)	$667,031	$656	$42,002	$22,069	$731,102	$719	$218,142	$214	$512,960	$504
February-12	1,013	$497,483	$75,828	($517)	$572,794	$565	$41,837	$21,982	$636,613	$628	$219,027	$216	$417,586	$412
March-12	1,022	$657,971	$100,011	($38,079)	$719,903	$704	$42,209	$22,177	$784,289	$767	$220,431	$216	$563,857	$552
Current Period YTD	**8,954**	**$5,290,786**	**$749,218**	**($68,248)**	**$5,971,756**	**$667**	**$369,800**	**$194,302**	**$6,535,858**	**$730**	**$1,935,153**	**$216**	**$4,600,706**	**$514**
Prior Period YTD	**8,156**	**$4,227,439**	**$666,788**	**($189,770)**	**$4,704,457**	**$577**	**$315,719**	**$136,205**	**$5,156,381**	**$632**	**$1,569,767**	**$192**	**$3,586,614**	**$440**
Rolling 12 Months	**11,843**	**$7,146,269**	**$1,000,907**	**($124,412)**	**$8,022,764**	**$677**	**$481,633**	**$242,548**	**$8,746,945**	**$739**	**$2,486,210**	**$210**	**$6,260,735**	**$529**
Prior Policy Period	**11,045**	**$6,082,922**	**$918,477**	**($245,935)**	**$6,755,465**	**$612**	**$427,552**	**$184,452**	**$7,367,468**	**$667**	**$2,120,825**	**$192**	**$5,246,643**	**$475**

Represents current policy period 7/1/2011 through 3/31/2012

Represents prior policy period 7/1/2010 through 3/31/2011

Represents prior policy period 7/1/2010 through 6/30/2011

ABC Company

Medical Plan Summary - Division 3

Rolling 12 Months	No. of Employees	Medical Claims	Prescription Drug Claims	Claims over ISL	Total Claims	Total Claims PEPM	Admin Fees	Stop Loss Fees	Total Cost	Total Cost PEPM	EE Cost	EE Cost PEPM	ER Cost	ER Cost PEPM
April-11	563	$199,460	$38,060	$0	$237,520	$422	$21,794	$9,402	$268,716	$477	$79,563	$141	$189,153	$336
May-11	547	$193,635	$34,593	$0	$228,228	$417	$21,174	$9,135	$258,537	$473	$77,829	$142	$180,708	$330
June-11	533	$228,588	$72,433	$0	$301,021	$565	$20,632	$8,901	$330,555	$620	$76,512	$144	$254,043	$477
July-11	531	$173,508	$39,316	$0	$212,824	$401	$21,930	$11,523	$246,277	$464	$87,341	$164	$158,936	$299
August-11	530	$142,647	$35,146	$0	$177,793	$335	$21,889	$11,501	$211,183	$398	$85,968	$162	$125,215	$236
September-11	532	$190,248	$42,013	$0	$232,261	$437	$21,972	$11,544	$265,777	$500	$84,821	$159	$180,956	$340
October-11	552	$205,584	$40,816	$0	$246,400	$446	$22,798	$11,978	$281,176	$509	$87,048	$158	$194,128	$352
November-11	544	$187,317	$37,293	$0	$224,610	$413	$22,467	$11,805	$258,882	$476	$86,723	$159	$172,159	$316
December-11	567	$188,598	$71,419	$0	$260,017	$459	$23,417	$12,304	$295,738	$522	$89,148	$157	$206,590	$364
January-12	562	$227,987	$31,144	$0	$259,131	$461	$23,211	$12,195	$294,537	$524	$87,786	$156	$206,751	$368
February-12	555	$294,316	$37,134	$0	$331,450	$597	$22,922	$12,044	$366,415	$660	$87,430	$158	$278,985	$503
March-12	639	$182,396	$40,494	$0	$222,890	$349	$26,391	$13,866	$263,147	$412	$98,508	$154	$164,639	$258
Current Period YTD	**5,012**	**$1,792,601**	**$374,775**	**$0**	**$2,167,376**	**$432**	**$206,996**	**$108,760**	**$2,483,132**	**$495**	**$794,772**	**$159**	**$1,688,360**	**$337**
Prior Period YTD	**4,453**	**$2,110,806**	**$351,240**	**$0**	**$2,462,046**	**$553**	**$172,376**	**$74,365**	**$2,708,787**	**$608**	**$642,125**	**$144**	**$2,066,662**	**$464**
Rolling 12 Months	**6,655**	**$2,414,284**	**$519,861**	**$0**	**$2,934,145**	**$441**	**$270,596**	**$136,199**	**$3,340,940**	**$502**	**$1,028,677**	**$155**	**$2,312,263**	**$347**
Prior Policy Period	**6,096**	**$2,732,489**	**$496,326**	**$0**	**$3,228,815**	**$530**	**$235,976**	**$101,803**	**$3,566,594**	**$585**	**$876,030**	**$144**	**$2,690,565**	**$441**

Represents current policy period 7/1/2011 through 3/31/2012

Represents prior policy period 7/1/2010 through 3/31/2011

Represents prior policy period 7/1/2010 through 6/30/2011

ABC Company

Medical Plan Summary - Division 4

Rolling 12 Months	No. of Employees	Medical Claims	Prescription Drug Claims	Claims over ISL	Total Claims	Total Claims PEPM	Admin Fees	Stop Loss Fees	Total Cost	Total Cost PEPM	EE Cost	EE Cost PEPM	ER Cost	ER Cost PEPM
April-11	1,084	$466,679	$63,608	($563)	$529,724	$489	$41,962	$18,103	$589,788	$544	$168,523	$155	$421,265	$389
May-11	1,090	$488,336	$69,806	$0	$558,142	$512	$42,194	$18,203	$618,539	$567	$169,635	$156	$448,903	$412
June-11	1,109	$438,670	$112,430	$525	$551,625	$497	$42,929	$18,520	$613,075	$553	$172,409	$155	$440,666	$397
July-11	1,130	$393,484	$65,206	$0	$458,690	$406	$46,669	$24,521	$529,880	$469	$200,354	$177	$329,526	$292
August-11	1,140	$608,058	$79,900	$0	$687,958	$603	$47,082	$24,738	$759,778	$666	$203,833	$179	$555,945	$488
September-11	1,137	$525,508	$82,296	$0	$607,804	$535	$46,958	$24,673	$679,435	$598	$202,243	$178	$477,192	$420
October-11	1,160	$506,958	$95,250	$0	$602,208	$519	$47,908	$25,172	$675,288	$582	$204,923	$177	$470,365	$405
November-11	1,160	$562,371	$106,728	$0	$669,099	$577	$47,908	$25,172	$742,179	$640	$206,174	$178	$536,005	$462
December-11	1,188	$542,510	$172,354	($18,167)	$696,697	$586	$49,064	$25,780	$771,541	$649	$210,908	$178	$560,633	$472
January-12	1,197	$547,765	$101,635	($15,360)	$634,040	$530	$49,436	$25,975	$709,451	$593	$212,804	$178	$496,647	$415
February-12	1,206	$620,636	$121,408	($1,367)	$740,677	$614	$49,808	$26,170	$816,655	$677	$216,101	$179	$600,554	$498
March-12	1,227	$724,436	$102,338	($590)	$826,184	$673	$50,675	$26,626	$903,485	$736	$219,555	$179	$683,930	$557
Current Period YTD	**10,545**	**$5,031,726**	**$927,115**	**($35,484)**	**$5,923,357**	**$562**	**$435,509**	**$228,827**	**$6,587,692**	**$625**	**$1,876,895**	**$178**	**$4,710,797**	**$447**
Prior Period YTD	**9,808**	**$5,075,619**	**$660,864**	**($233,930)**	**$5,502,553**	**$561**	**$379,668**	**$163,794**	**$6,046,014**	**$616**	**$1,544,084**	**$157**	**$4,501,930**	**$459**
Rolling 12 Months	**13,828**	**$6,425,411**	**$1,172,959**	**($35,522)**	**$7,562,848**	**$547**	**$562,593**	**$283,653**	**$8,409,094**	**$608**	**$2,387,463**	**$173**	**$6,021,631**	**$435**
Prior Policy Period	**13,091**	**$6,469,304**	**$906,708**	**($233,968)**	**$7,142,044**	**$546**	**$506,753**	**$218,620**	**$7,867,416**	**$601**	**$2,054,652**	**$157**	**$5,812,764**	**$444**

Represents current policy period 7/1/2011 through 3/31/2012

Represents prior policy period 7/1/2010 through 3/31/2011

Represents prior policy period 7/1/2010 through 6/30/2011

ABC Company

Medical Plan Summary - Active Employee Summary

Rolling 12 Months	No. of Employees	Medical Claims	Prescription Drug Claims	Claims over ISL	Total Claims	Total Claims PEPM	Admin Fees	Stop Loss Fees	Total Cost	Total Cost PEPM	EE Cost	EE Cost PEPM	ER Cost	ER Cost PEPM
April-11	4,583	$2,104,610	$328,405	($51,297)	$2,381,718	$520	$177,408	$76,536	$2,635,662	$575	$732,217	$160	$1,903,445	$415
May-11	4,581	$2,138,304	$340,179	($165,595)	$2,312,888	$505	$177,331	$76,503	$2,566,721	$560	$731,082	$160	$1,835,639	$401
June-11	4,579	$1,994,842	$532,203	($241,018)	$2,286,027	$499	$177,253	$76,469	$2,539,750	$555	$732,090	$160	$1,807,660	$395
July-11	4,686	$2,019,255	$355,497	($112,173)	$2,262,579	$483	$193,514	$101,686	$2,557,778	$546	$852,084	$182	$1,705,694	$364
August-11	4,684	$2,022,970	$337,626	($41,742)	$2,318,854	$495	$193,431	$101,643	$2,613,927	$558	$846,841	$181	$1,767,086	$377
September-11	4,658	$2,107,353	$390,524	$20	$2,497,897	$536	$192,357	$101,079	$2,791,332	$599	$841,456	$181	$1,949,876	$419
October-11	4,692	$2,120,426	$388,630	$0	$2,509,056	$535	$193,765	$101,816	$2,804,638	$598	$850,184	$181	$1,954,454	$417
November-11	4,705	$1,735,555	$397,553	($16,454)	$2,116,654	$450	$194,302	$102,099	$2,413,055	$513	$854,107	$182	$1,558,948	$331
December-11	4,819	$2,135,942	$669,106	($47,655)	$2,757,393	$572	$199,011	$104,572	$3,060,976	$635	$872,057	$181	$2,188,919	$454
January-12	4,855	$2,402,141	$385,105	($36,437)	$2,750,809	$567	$200,497	$105,354	$3,056,660	$630	$879,581	$181	$2,177,079	$448
February-12	4,800	$2,330,417	$449,888	($18,379)	$2,761,926	$575	$198,226	$104,160	$3,064,312	$638	$871,152	$181	$2,193,160	$457
March-12	4,890	$2,248,776	$453,057	($72,412)	$2,629,421	$538	$201,943	$106,113	$2,937,476	$601	$882,431	$180	$2,055,045	$420
Current Period YTD	**42,789**	**$19,122,835**	**$3,826,986**	**($345,233)**	**$22,604,588**	**$528**	**$1,767,046**	**$928,521**	**$25,300,155**	**$591**	**$7,749,893**	**$181**	**$17,550,262**	**$410**
Prior Period YTD	**40,667**	**$16,797,554**	**$3,187,747**	**($386,597)**	**$19,598,704**	**$482**	**$1,574,220**	**$679,139**	**$21,852,062**	**$537**	**$6,478,801**	**$159**	**$15,373,261**	**$378**
Rolling 12 Months	**56,532**	**$25,360,591**	**$5,027,773**	**($803,143)**	**$29,585,221**	**$523**	**$2,299,038**	**$1,158,029**	**$33,042,288**	**$584**	**$9,945,282**	**$176**	**$23,097,006**	**$409**
Prior Policy Period	**54,410**	**$23,035,310**	**$4,388,534**	**($844,507)**	**$26,579,337**	**$489**	**$2,106,211**	**$908,647**	**$29,594,195**	**$544**	**$8,674,190**	**$159**	**$20,920,005**	**$384**

Represents current policy period 7/1/2011 through 3/31/2012

Represents prior policy period 7/1/2010 through 3/31/2011

Represents prior policy period 7/1/2010 through 6/30/2011

ABC Company

Medical Plan Summary - COBRA Summary

Rolling 12 Months	No. of Employees	Medical Claims	Prescription Drug Claims	Claims over ISL	Total Claims	Total Claims PEPM	Admin Fees	Stop Loss Fees	Total Cost	Total Cost PEPM	EE Cost	EE Cost PEPM	ER Cost	ER Cost PEPM
April-11	122	$165,651	$24,335	($563)	$189,423	$1,553	$4,723	$2,037	$196,183	$1,608	$66,863	$548	$129,320	$1,060
May-11	119	$204,075	$23,240	$0	$227,315	$1,910	$4,606	$1,987	$233,909	$1,966	$65,425	$550	$168,484	$1,416
June-11	119	$281,323	$32,498	$525	$314,346	$2,642	$4,606	$1,987	$320,940	$2,697	$67,206	$565	$253,734	$2,132
July-11	118	$104,442	$19,212	$0	$123,654	$1,048	$4,873	$2,561	$131,088	$1,111	$73,087	$619	$58,001	$492
August-11	111	$378,179	$18,535	$0	$396,714	$3,574	$4,584	$2,409	$403,707	$3,637	$70,977	$639	$332,730	$2,998
September-11	108	$214,413	$18,637	$0	$233,050	$2,158	$4,460	$2,344	$239,854	$2,221	$69,168	$640	$170,686	$1,580
October-11	110	$128,552	$21,718	$0	$150,270	$1,366	$4,543	$2,387	$157,200	$1,429	$65,301	$594	$91,899	$835
November-11	105	$74,759	$24,789	$0	$99,548	$948	$4,334	$2,279	$106,161	$1,011	$62,881	$599	$43,280	$412
December-11	104	$65,924	$38,126	$0	$104,050	$1,000	$4,293	$2,257	$110,600	$1,063	$62,436	$600	$48,164	$463
January-12	98	$171,281	$22,278	$0	$193,559	$1,975	$4,045	$2,127	$199,731	$2,038	$60,955	$622	$138,776	$1,416
February-12	102	$288,121	$21,656	$0	$309,777	$3,037	$4,211	$2,213	$316,201	$3,100	$67,483	$662	$248,718	$2,438
March-12	103	$201,558	$22,789	$0	$224,347	$2,178	$4,252	$2,235	$230,834	$2,241	$68,426	$664	$162,408	$1,577
Current Period YTD	**959**	**$1,627,229**	**$207,740**	**$0**	**$1,834,969**	**$1,913**	**$39,597**	**$20,810**	**$1,895,376**	**$1,976**	**$600,714**	**$626**	**$1,294,662**	**$1,350**
Prior Period YTD	**1,178**	**$2,039,102**	**$247,221**	**($233,930)**	**$2,052,393**	**$1,742**	**$45,600**	**$19,673**	**$2,117,666**	**$1,798**	**$666,346**	**$566**	**$1,451,321**	**$1,232**
Rolling 12 Months	**1,319**	**$2,278,278**	**$287,813**	**($38)**	**$2,566,053**	**$1,945**	**$53,532**	**$26,822**	**$2,646,408**	**$2,006**	**$800,209**	**$607**	**$1,846,199**	**$1,400**
Prior Policy Period	**1,538**	**$2,690,151**	**$327,294**	**($233,968)**	**$2,783,477**	**$1,810**	**$59,536**	**$25,685**	**$2,868,698**	**$1,865**	**$865,840**	**$563**	**$2,002,858**	**$1,302**

Represents current policy period 7/1/2011 through 3/31/2012

Represents prior policy period 7/1/2010 through 3/31/2011

Represents prior policy period 7/1/2010 through 6/30/2011

Exhibit 7

Communication Examples

Willis Essentials

Willis Office/Client Solution

Online database with communication templates in Word and PowerPoint

- Sample communication strategies
- Benefit guides
- Wellness and benefit posters, newsletters, flyers
- Health care reform sample language
- Employer guides to communicating consumerism, wellness and more

WillisConnect

Willis Office/Client Solution

Employee portal created by Willis offices and maintained by Client

- Benefits information
  - Client forms and FAQs
  - Carrier links
  - Newsletters
  - Plan summaries
  - Job openings
- Client information
  - CEO messages
  - Holidays and events
  - Mission and vision

OnDemand

Willis Office Solution

Online tool for Willis office to create communications

- Variety of communication templates for benefits guides, newsletters, etc.
- Designed to print communications quickly and cost-effectively
- PDF available for nominal fee (if Client doesn't want to print)

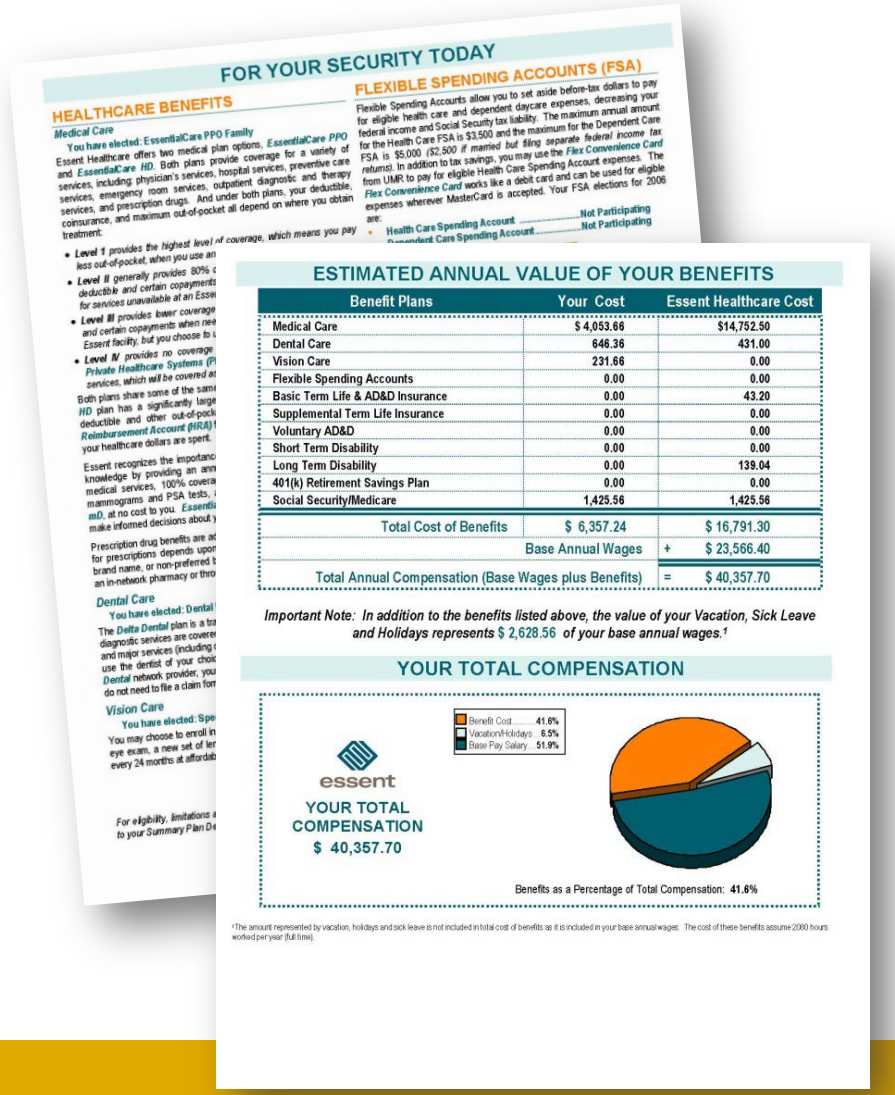
Adobe Presenter

Willis Office Solution

Tool for Willis offices to create PowerPoint presentations with audio narration

- Accessed through an email link for Client employees to view at work or home
- Choice of graphic looks

Total Rewards Statements



FOR YOUR SECURITY TODAY

HEALTHCARE BENEFITS

FLEXIBLE SPENDING ACCOUNTS (FSA)

ESTIMATED ANNUAL VALUE OF YOUR BENEFITS

Benefit Plans	Your Cost	Essent Healthcare Cost
Medical Care	$ 4,053.66	$14,752.50
Dental Care	646.36	431.00
Vision Care	231.66	0.00
Flexible Spending Accounts	0.00	0.00
Basic Term Life & AD&D Insurance	0.00	43.20
Supplemental Term Life Insurance	0.00	0.00
Voluntary AD&D	0.00	0.00
Short Term Disability	0.00	0.00
Long Term Disability	0.00	139.04
401(k) Retirement Savings Plan	0.00	0.00
Social Security/Medicare	1,425.56	1,425.56
Total Cost of Benefits	$ 6,357.24	$ 16,791.30
Base Annual Wages	+	$ 23,566.40
Total Annual Compensation (Base Wages plus Benefits)	=	$ 40,357.70

Important Note: In addition to the benefits listed above, the value of your Vacation, Sick Leave and Holidays represents $ 2,628.56 of your base annual wages.[1]

YOUR TOTAL COMPENSATION

essent

YOUR TOTAL COMPENSATION

$ 40,357.70

Benefit Cost..... 41.6%
Vacation/Holidays... 6.5%
Base Pay Salary... 51.9%

Benefits as a Percentage of Total Compensation: 41.6%

[1]The amount represented by vacation, holidays and sick leave is not included in total cost of benefits as it is included in your base annual wages. The cost of these benefits assume 2080 hours worked per year (full time).

Willis Office Solution

- Statements available on *Broker Briefcase*
- Low cost/no cost
- Templated solutions

Vendor Solutions

- Custom printed statements
- Custom online statements

Translation Services

Willis Office Solution

- Some Spanish materials available in Word on *Willis Essentials*

Vendor Solution

- Almost any document can be translated
- Vendor can match a specific dialect
- Cost varies based on number of words

Custom Print Communications

Vendor Solution

- Created and supported through external vendors which have been vetted through the communication practice
- Print and electronic media
- Design and communication partners charge creative and print fees
- Custom communication timing: three to four months

Custom Digital Communications

Communication Practice/Vendor Solution

- Text messaging campaigns
- Internet/intranet pages
- Social media
- QR Codes
  - Barcode squares
  - Use smart phone to access site
  - Good fit for younger workforce
  - Great fit for high tech employees
  - Complimentary communication tool

Custom Flip Books

Communication Practice Solution

- Interactive, digital documents
- Increase interest and engagement
- Can include multimedia, such as video, website links and live bookmarks
- Works on tablets too
- Complimentary

Custom Video Postcards

Vendor Solution

- One-to-three minute videos
- Professionally produced
- Cutting edge way to engage employees
- Distributed via email to employees' inboxes
- Views can be tracked and measured

Communication Measurement

Communication Practice Solution

- Take the pulse of employees before beginning a communication campaign
- Use surveys to provide quantitative data so you know whether a campaign is successful
- Engage employees and obtain in-depth qualitative data through focus groups
- Administer surveys easily using tools such as Survey Monkey and Zoomerang

Communication Process: Next Steps

1. Conduct communication gap assessment
2. Meet with Client to:
   - Review gap assessment results
   - Evaluate Client's goals and employee audience
3. Develop strategic communication plan and deliverables
4. Determine best way to implement plan and timing