Report Definitions

Employer eServices® Cost & Utilization Reporting

version 1.1

United Healthcare

The reports available to a user depend on the level of reporting they have, (e.g., Standard, Select, and Expanded). Within this document, each report definition contains its level identifier.

For more information, please refer to the Sample Report Package.

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● Report is available at this service level

± Report includes information for fully insured funding only

† Report includes information for ASO funding only

Financial Reports

Claim Expenses by Size of Payment

Provides counts of claimants and total claim payments within incremental dollar ranges.

The report is useful for determining the number of payments with large losses, as well as claim payments above certain thresholds.

Claim Expenses by Size of Payment – Core

Provides counts of claimants and total claim payments within incremental dollar ranges.

The report is useful for determining the number of payments with large losses, as well as claim payments above certain thresholds.

Claim Lag Study

Identifies the time lapse between the date a service was incurred and the date the claim was processed.

The report is useful for establishing appropriate factors when determining the volume of claims incurred but not yet submitted and processed for payment.

Detail Payment (Self-insured policies)

Provides check transaction information for payments of ASO claims. Each transaction contains confidential, individually identifiable health information for the subscriber and claimant associated with the claim.

Detail Payment – Non-Confidential

Provides check transaction information for payments of ASO and fully insured claims. No protected health information (PHI) is contained on this report.

Financial Managed Ad Hoc

Allows you to select the metrics and attributes you want to use to create a customized financial report.

Large Loss Claim Payments (Self-insured policies)

Provides a detailed profile of each claimant above a selected dollar threshold or within a given range. The report is useful for evaluating stop-loss coverage and understanding variations in trend.

Payments by Benefit Type

Distributes reimbursement amounts based upon services offered under a benefit package.

The report is useful for reviewing all lines of coverage and the correlation of use between subscribers and dependents.

Payments by Month

Distributes reimbursement amounts based upon the month they are booked to the financial accounting system. Claims are shown in total and separately for Medical, Managed Pharmacy, Dental and Capitation.

Premium Managed Ad Hoc (Fully Insured)

Allows you to select the metrics and attributes you want to use to create a custom premium report.

Premium vs Claims Incurred Including IBNR – Underwriting – Basic (Fully Insured)

This report provides a monthly comparison of incurred claim expenses to billed premium for current and prior periods for 24 months by Bill/Service dates. The experience period is based on the last month of data loaded minus the most recent 2 months.

This report will also include estimated amounts for Incurred-but-not-reported (IBNR) claims, allowing customers to evaluate the ability of premium to support estimated claim expenses for a common period. Additionally, expenses will be reported in the month they were incurred versus the month they were paid, thus isolating benefit changes and the impact they have on customer experience.

Premium vs Claims Incurred Including IBNR – Underwriting – Non-Standard (Fully Insured)

This report provides a monthly comparison of incurred claim expenses to the billed premium for current and prior periods. IBNR factors are applied in this report. You select the experience period by Bill/Service Dates.

This report will also include estimated amounts for IBNR claims, allowing customers to evaluate the ability of premium to support estimated claim expenses for a common period. Additionally, expenses will be reported in the month they were incurred versus the month they were paid, thus isolated benefit changes and the impact they have on customer experience.

Premium vs Claims Incurred Including IBNR – Underwriting – Non-Standard – Core

This report provides a monthly comparison of incurred claim expenses to the billed premium for current and prior periods. IBNR factors are applied in this report. You select the experience period by Bill/Service Dates.

This report will also include estimated amounts for incurred-but-not-reported (IBNR) claims, allowing customers to evaluate the ability of premium to support estimated claim expenses for a common period. Additionally, expenses will be reported in the month they are incurred versus the month they were paid, thus isolating benefit changes and the impact they have on customer experience.

Managed Pharmacy Reports

Key Generic Substitution Indicators by Month

This report provides a month-to-month account of the rate of generic substitutions for multisource pharmaceuticals (i.e., brand-name drugs with a generic equivalent).

The report contrasts the average ingredient cost for generic drugs against the averages for single-source drugs (i.e., brand-name only), and multisource drugs that were dispensed in their brand-name form.

Finally, the report calculates the percentage of times multisource pharmaceuticals were dispensed in their brand-name form (i.e., dispensed as written – DAW) as the result of a physician's order, a patient's directive, a state law, and other factors.

Managed Pharmacy Ad Hoc

Allows you to select the metrics and attributes you want to use to create a custom managed pharmacy report.

Managed Pharmacy Cost and Utilization by Month

Provides a monthly count of pharmaceutical orders filled at retail establishments and via home delivery, as well as orders dispensed in generic and brand forms.

The report is useful for monitoring trends associated with managed pharmacy benefits, and contains monthly, per member and per prescription calculations for plan and HRA net paid amounts.

Managed Pharmacy Critical Indicators

Uses a variety of metrics to gauge the effectiveness of a managed pharmacy product and monitor changes in utilization.

The report consists of the following sections:

Managed Pharmacy Critical Indicators – Current Period – Detail

- Each metric is distributed by retail and home delivery.
- Shows number of claimants and prescriptions during the current reporting period.
- Shows the rate at which pharmaceuticals were dispensed in a single source brand-name form, in the brand-name form when a generic equivalent existed (i.e., multisource), and the generic form.

- Calculates the rate of generic substitutions for multisource pharmaceuticals.
- Calculates the percentage of times multisource pharmaceuticals were dispensed in the brand-name form (i.e., dispensed as written — DAW) as the result of a physician's order, a patient's directive, a state law, and other factors.
- Calculates the average number of prescriptions dispensed during the current period on a per member per year (PMPY) and per claimant basis.
- Calculates the average total net paid during the current period on a per member per month (PMPM), per claimant per period, per prescription basis.
- Calculates the average copay per prescription, days' supply, and ingredient cost per day of therapy.

Managed Pharmacy Critical Indicators – Current Period – Total

- Shows the cumulative results of retail plus home delivery for all metrics listed in the first section of the report.

Managed Pharmacy Critical Indicators – Prior Period – Detail

- Shows prior period results for the metrics contained in the first section of the report.

Managed Pharmacy Critical Indicators – Prior Period – Total

- Shows cumulative results of retail plus home delivery for all metrics contained in the third section of the report.

Managed Pharmacy Critical Indicators – Percent Change – Detail

- Shows the difference between the results contained in the first and third sections of the report.

Managed Pharmacy Critical Indicators – Percent Change – Total

- Shows the difference between the results contained in the second and fourth section of the report.

Managed Pharmacy Plan Performance

Demonstrates contributing costs (ingredient costs, dispensing fee, sales tax) and costs reductions (discounts, deductibles, coinsurance, copays) to the plan and HRA net paid amounts for prescriptions filled within the chosen reporting period.

The report is useful for evaluating how the plan's various drug tiers and submission methods are distributed based on cost and utilization. It is also useful for examining a

drug tier or submission method's cost savings (via discounts and employee cost sharing). The report consists of the following sections:

Managed Pharmacy Plan Performance – Detail

- Contains results split by pharmaceutical orders filled at retail establishments and via home delivery for generic drugs (Tier 1), brands on the preferred drug list (Tier 2), and brands not on the preferred drug list (Tier 3).
- Includes per member per month (PMPM) results for employee cost sharing, and the plan and HRA net paid amounts.

Managed Pharmacy Plan Performance – Subtotals by Tier

- Contains the sum of retail plus home delivery amounts for each of the three tiers.
- Uses a distinct count to calculate the number of claimants. Any claimant with multiple claims within a tier is counted only once.
- Includes per member per month (PMPM) results for employee cost sharing, and the plan and HRA net paid amounts.

Managed Pharmacy Plan Performance – Total

- Contains the sum of the three tiers.
- Uses a distinct count to calculate the number of claimants. Any claimant with multiple claims is counted only once.
- Includes per member per month (PMPM) results for employee cost sharing, and the plan and HRA net paid amounts.

Managed Pharmacy Utilization by Age Group

Displays metrics within discrete age ranges for the number of prescriptions filled by claimants, as well as the associated costs of those prescription claims. The report consists of the following sections:

Managed Pharmacy Utilization by Age Group – Detail

- Shows the number of claimants and prescriptions filled per age band during the reporting period.
- Calculates the average number of prescriptions per member per year (PMPY) within each age band.
- Calculates the average number of prescriptions filled by claimants within each band.
- Provides plan and HRA net paid totals for prescription orders filled by claimants within each age band, and analyzes these totals based upon per member per month (PMPM), per claimant, and per prescription averages.

Managed Pharmacy Utilization by Age Group – Total

- Provides a cumulative total of all age bands for each of the metrics displayed in the first section of this report.

Top Drug Utilization Ranked by Net Paid

Ranks pharmaceuticals with the highest net paid amounts. The report consists of the following sections:

Top Drugs

- Shows the number of claimants and prescriptions for each drug.
- Shows the plan and HRA net paid amounts for each drug.
- Calculates which percentage each drug is of the total number of prescriptions within this population.
- Calculates which percentage the total net paid amount for each drug is of the total net paid amount for all prescription drugs within this population.
- Calculates per prescription cost for each drug.
- Calculates the average days' supply and ingredient cost per day of therapy for each drug.

All Other Drugs

- Shows the cumulative results for all drugs not listed in the first section of the report.

Total Drugs

- Shows the cumulative results of the first and second section of the report.

Top Drug Utilization Ranked by Volume

Ranks pharmaceuticals that have the highest levels of use. The report consists of the following sections:

Top Drugs

- Shows the number of claimants and prescriptions for each drug.
- Shows the plan and HRA net paid amounts for each drug.
- Calculates which percentage each drug is of the total number of prescriptions within this population.
- Calculates which percentage the total net paid amount for each drug is of the total net paid amount for all prescription drugs within this population.

- Calculates per prescription cost for each drug.
- Calculates the average days' supply and ingredient cost per day of therapy for each drug.

All Other Drugs

- Shows the cumulative results for all drugs not listed in the first section of the report.

Total Drugs

- Shows the cumulative results of the first and second section of the report.

Top Therapeutic Class Utilization Ranked by Net Paid

Ranks FDB standard therapeutic classes with the highest total net paid amounts. The report consists of the following sections:

Top Therapeutic Classes

- Shows the number of claimants and prescriptions for each therapeutic class.
- Shows the plan and HRA net paid amounts for each therapeutic class.
- Calculates the percentage.
- Calculates the percentage of total net paid dollars each therapeutic class is of the cumulative total net paid amount for all therapeutic classes.
- Calculates per prescription cost for each therapeutic class.
- Shows the rate at which pharmaceuticals within each class were dispensed in a generic form, single source brand-name form, and in the brand-name form when a generic equivalent existed (i.e., multisource).
- Calculates the rate of generic substitutions for multisource pharmaceuticals.

All Other Therapeutic Classes

- Shows the cumulative results for all therapeutic classes not listed in the first section of the report.

Total Therapeutic Classes

- Shows the cumulative results of the first and second section of the report.

Top Therapeutic Class Utilization Ranked by Volume

Ranks FDB standard therapeutic classes with the highest levels of drug orders filled. The report consists of the following sections:

Top Therapeutic Classes

- Shows the number of claimants and prescriptions for each therapeutic class.
- Shows the plan and HRA net paid amounts for each therapeutic class.
- Calculates the percentage of total net paid dollars each therapeutic class is of the cumulative total net paid amount for all therapeutic classes.
- Calculates per prescription cost for each therapeutic class.
- Shows the rate at which pharmaceuticals within each class were dispensed in a generic form, single source brand-name form, and in the brand-name form when a generic equivalent existed (i.e., multisource).
- Calculates the rate of generic substitutions for multisource pharmaceuticals.

All Other Therapeutic Classes

- Shows the cumulative results for all therapeutic classes not listed in the first section of the report.

Total Therapeutic Classes

- Shows the cumulative results of the first and section of the report.

Medical Reports

Bill Count by Month

Provides a count of the number of unique bills for a service or set of services within the reporting period. Results for each month are allocated by the Medicare status of active and retired employees. The report is useful for billing purposes.

Claim Experience

Provides a variety of statistical trend information regarding the cost and use of health care services.

The report is useful for monitoring changes in a plan's performance, and when considering changes to a plan. If changes are made, it serves as a good early indicator of the revised plan's performance.

The report consists of the following sections:

Enrollment Detail

- Shows averages for the number of subscribers, number of members, and contract size during the prior and current reporting periods.
- The degree of difference between the two reporting periods is expressed as a percentage (i.e., percent change).

Prior Benefit Cost Sharing – Prior to COB

- Contains a graphical representation of employer costs versus employee costs during the prior reporting period.
- The amounts do not consider any coordination of benefits (COB).

Current Benefit Cost Sharing – Prior to COB

- Contains a graphical representation of employer versus employee costs during the current reporting period.
- The amounts do not consider COB.

Benefit Cost Sharing Detail

- Shows the percentage of employer costs relative to the total costs (i.e., employer cost sharing) during the prior and current reporting periods.
- The degree of difference between the two reporting periods is expressed as a percentage (i.e., percent change).

Claim Cost by Health Care Cost Category

- Contains a graphical representation of per member per month (PMPM) costs for facility inpatient, facility outpatient, pharmacy, and professional claims.

Claim Cost by Health Care Cost Category Detail

- Shows total net paid and PMPM costs attributed to each health care cost category during the prior and current reporting periods.
- The degree of difference between the PMPM during the two reporting periods is expressed as a percentage (i.e., percent change PMPM).

Other Claim Cost

- Shows total net paid and PMPM costs attributed to capitation during the prior and current reporting periods.
- The degree of difference between PMPM during the two reporting periods is expressed as a percentage (i.e., percent change PMPM).

Total Costs

- Shows the sum of health care claims plus capitation for total net paid and PMPM amounts during the prior and current reporting periods.
- The degree of difference between PMPM for the two reporting periods is expressed as a percentage (i.e., percent change PMPM).

Outpatient and Professional Utilization by Health Care Cost Category

- Shows the number of outpatient facility services and professional visits (i.e., visits to a primary care physician, OB/GYN, specialist, or allied health professional) that occurred within the current and prior reporting periods.
- Each service and visit is equivalent to one unit.
- Shows the number of units per 1000, as well as the total net paid per unit for both reporting periods.
- The degree of difference between the number of units per 1000 and total net paid per unit for the two reporting periods is expressed as a percentage (i.e., percent change units per 1000 and percent change net paid per unit).

Cost by Diagnosis Chapter

- Shows the total net paid and PMPM amounts attributed to selected diagnoses during the prior and current reporting periods.
- Amounts attributed to diagnoses not displayed on the report are grouped under all other diagnosis chapters.

- The degree of difference between the PMPM amounts for the two reporting periods is expressed as a per centage (i.e., percent change PMPM).

Inpatient Utilization

- Shows the number of days and number of admissions for the prior and current reporting period.
- Shows the average number of days and admissions per 1000 for the prior and current reporting periods. The degree of difference between the two reporting periods is expressed as a percentage.
- Shows the total net paid per day and per admission for the prior and current reporting periods. The degree of difference between the two reporting periods is expressed as a percentage.

Cost and Utilization by Procedure

Compares the volume and expense of procedures between the current and prior reporting periods. Results for these two periods make this report ideal for identifying trends and patterns across a broad category of procedures.

The report consists of the following sections:

Cost and Utilization by Procedure – Details

- Displays results for each procedure performed during the prior and current reporting periods.
- Employs a distinct count to calculate the number of claimants. Any claimant with multiple claims for the same procedure is counted only once.
- Includes PMPM results for the covered and total net paid amounts.

Costs and Utilization by Procedure – Totals

- Displays the sum of all procedures performed during the prior and current reporting periods.
- Employs a distinct count to calculate the number of claimants. Any claimant with multiple claims is counted only once.
- Includes PMPM results for the covered and total net paid amounts.

Cost and Utilization Summary

Provides a “dashboard” view of metrics that measure and compare your benefit plan's performance from one period to the next. The report is a quick and consolidated resource for information on key cost drivers and trends.

Distribution of Discounts

Shows savings achieved through contracted, specially negotiated, customer specific, and other discounts, as well as via shared savings and prompt payment programs.

Distribution of Ineligible Charges

Shows savings achieved through plan provisions and health care cost management programs (i.e., duplicate bills, reasonable and customary reductions, benefit limits, pre-existing conditions, abuse and fraud, medical claim review, maximum non-network reimbursement programs, and other ineligible charges).

Distribution of Other Savings

Shows savings and reductions achieved through a coordination of benefits with other commercial carriers and Medicare, as well as via provider sanctions and all other savings.

Healthcare Cost Management Summary

Provides information on the dollar impact of network management and plan provisions through the display of all submitted charges, covered amounts, discounts, cost sharing amounts and net paid amounts for health care expenses.

The report consists of the following sections:

HCCMS Excluding Managed Rx

- Shows the savings from the original submitted charges for medical claims.
- Includes PMPM results for the plan and HRA net paid amounts.

HCCMS Managed Pharmacy Costs

- Shows the cumulative savings for the first two sections.
- Shows which percent of the covered amount is relative to employee cost sharing (i.e., deductible, copay, coinsurance), and other savings.
- Includes PMPM results for the plan and HRA net paid amounts.

Cost Sharing and Summary Statistics

- Shows the cumulative savings for the first two sections.
- Shows which percent of the covered amount is relative to employee cost sharing (i.e., deductible, copay, coinsurance), and other savings.
- Includes PMPM results for the net paid amount.

Inpatient Event Ad Hoc

Allows you to select the metrics and variables you want to use to create a custom inpatient event report.

Inpatient Utilization and Costs by Admission Type

Summarizes the types of inpatient health care activity during a specified reporting period.

The report is useful for evaluating inpatient utilization patterns within broad types of acute and non-acute care settings.

The report consists of the following sections:

Inpatient Utilization and Costs by Admission Type – Detail

- Shows averages for admissions per 1000, and days per 1000.
- Calculates the average covered and total net paid amounts per admission and per day.

Inpatient Utilization and Costs by Admission Type – Total

- Shows the cumulative results of all admission types for each metric displayed in the first section of the report.

Inpatient Utilization by Diagnosis

Shows metrics for the prior and current reporting period that compare the volume and duration (i.e., number of days, and average length of stay) of admissions within each ICD9 diagnosis chapter. Also, compares the covered amount for claims within each ICD9 diagnosis chapter, and calculates the average covered amount per admission and per day.

Medical Dollar Ad Hoc Discount / Medical Dollar Ad Hoc Provider

These managed ad hocs contain a set of attributes and metrics from which you can select to build your own report to examine medical costs.

Medical Utilization Ad Hoc

Allows you to select the metrics and variables you want to use to create a custom medical utilization report.

Network Utilization

Shows eligible charges reduced via contracted discounts during the current and prior reporting periods. It compares these reductions across network benefit levels for participating and non-participating providers.

The report is useful for reviewing plan performance relative to providers participating in UnitedHealthcare networks.

Outpatient Utilization by Diagnosis

Displays metrics for the prior and current reporting period that compares the volume of outpatient services and frequency of encounters within each ICD9 diagnosis chapter. Also, compares the covered amount for claims within each ICD9 diagnosis chapter, and calculates the average covered amount per service and per encounter.

The report consists of the following sections:

Outpatient Utilization by Diagnosis – Detail

- Shows results for each diagnosis chapter.
- The report employs a distinct count to calculate the number of claimants. Any claimant with multiple claims within the same diagnosis chapter is counted only once.

Outpatient Utilization by Diagnosis – Total

- Shows the cumulative results of all diagnosis chapters for each metric displayed in the first section of the report.
- The report employs a distinct count to calculate the number of claimants. Any claimant with multiple claims is counted only once.

Top Hospitals Ranked by Total Net Paid

Ranks hospitals based upon the total payments associated with each of these facilities. The report consists of the following sections:

Top Hospitals

- Lists the hospital's name and city/state location.
- Shows the number of inpatient admissions, inpatient days and outpatient services rendered at each hospital.
- Shows the covered amount and total net paid for both inpatient events and outpatient services for each hospital.
- Calculates the total net paid for both inpatient events and outpatient services for each hospital.

All Other Hospitals

- Shows the cumulative results for all hospitals not listed in the first section of the report.

Total Hospitals

- Shows the cumulative results of the first and second section of the report.

Top Physicians Ranked by Total Net Paid

Ranks physicians based upon the total payments associated with each of these providers. The report consists of the following sections:

Top Physicians

- Lists the physicians' name, state location, and provider participation status.
- Shows the number of claimants, unique encounters, and services rendered by each physician.
- Shows the covered amount and total net paid attributed to each physician.

All Other Physicians

- Shows the cumulative results for all physicians not listed in the first section of the report.

Total Physicians

- Shows the cumulative results of the first and second section of the report.

Utilization and Costs by Provider Type

Displays the number of claimants, number of units (days or services), as well as covered and net paid amounts in total, per unit, and per member per month.

The report contains the following sections:

Costs by Provider Type – Detail

- Shows number of claimants for each provider type.
- Shows the covered and total net paid amounts for each provider type.
- Calculates the “per member per month” (PMPM) average for the covered and total net paid amounts.
- Calculates the average covered and total net paid amounts per claimant.

Costs by Provider Type – Total

- Shows the cumulative results of all provider types for each metric displayed in the first section of the report.

Utilization by Provider Type

- Shows the number of units (i.e., inpatient events, professional visits, and outpatient services) for each provider type.
- Shows the average covered and total net paid amounts per unit.

Utilization by Age Group

Displays the distribution of claimants, charges, and paid dollars by claimant age range. Claimants are counted and dollars are summed by demographic age range.

The report consists of the following sections:

Utilization by Age Group – Detail

- Shows average member and total claimant counts for each age group.
- Shows covered, plan, and HRA net paid amounts for each age group.
- Calculates the “per member per month” (PMPM) average for the covered, plan and HRA net paid amounts.
- Calculates the average covered and plan and HRA net paid amounts per claimant.

Utilization by Age Group – Total

- Shows the cumulative results of all age groups for each metric displayed in the first section of the report.

Utilization by Diagnosis

Compares the claim volume and total net paid amounts between the current and prior time periods for selected diagnosis chapters.

The report is useful for assessing morbidity patterns and the effect on health care use. The report consists of the following sections:

Utilization by Diagnosis – Detail

- Shows results for each diagnosis chapter.
- The report employs a distinct count to calculate the number of claimants and claimants per 1000. Any claimant with multiple claims within the same diagnosis chapter is counted only once.
- Includes per member per month (PMPM) results for the total net paid amounts.

Utilization by Diagnosis – Total

- Shows the sum for all diagnosis chapters.
- The report employs a distinct count to calculate the number of claimants and claimants per 1000. Any claimant with multiple claims is counted only once.
- Includes PMPM results for the total net paid amounts.

Membership Reports

Membership by Market

Provides a count of subscribers and dependents by geographic region.

The report is useful for understanding the geographic distribution of the population.

Membership by Month

Provides a count of subscribers and their dependents during each month of the reporting period.

The report is useful for evaluating changes in membership over time.

Membership Managed Ad Hoc

Allows you to select the metrics and attributes you want to use to create a custom membership report.

Membership with Demographic and Geographic Factors

Provides a count of subscribers and dependents categorized by gender and age range.

The report is useful for evaluating the impact of a population's demographics on the benefit plan's overall performance.