



# GRIFFIN CONSULTING

## FOCUS ON HEALTH

"DATA IS EXPENSIVE  
INFORMATION IS PRICELESS"

**PRESENTED TO:**

**Mid Size Employer**

**INCURRED MEDICAL AND PHARMACY:**

January 01, 2003 - December 31, 2003

**PAID THROUGH:**

March 31, 2004

**AN ENHANCED SERVICE DELIVERED BY:**

Griffin Consulting Group, Inc.  
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## About Our Analysis

Welcome to Griffin Consulting’s Employer Group Analysis. This is a functional tool for building a comprehensive understanding of health plan performance for a specific population. This analysis will point you to opportunities for improvement within your health benefits program by clarifying relationships between plan design, demographics and claims experience.

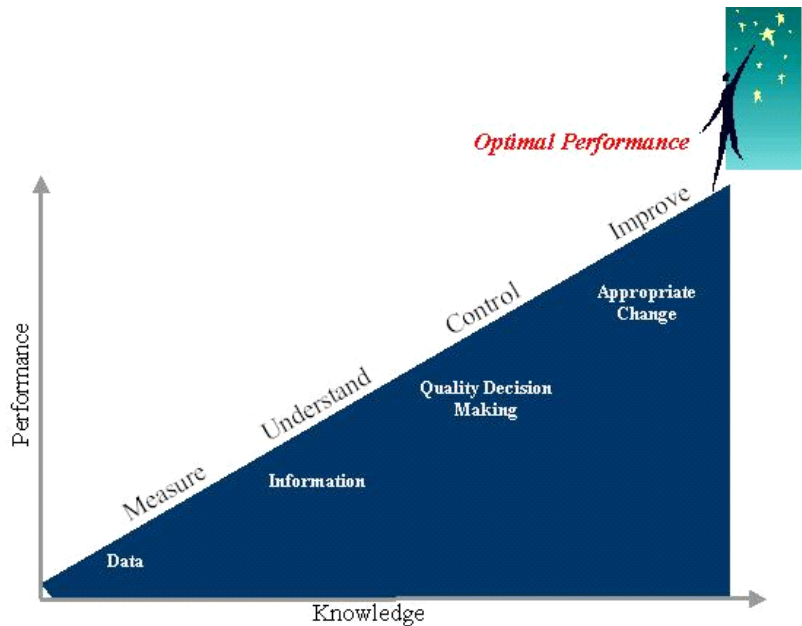
Our analysis begins with high-level and summary information, including cost per employee, followed by progressively

focused data, including comparative norms. Unless otherwise noted, normative values are derived from a 2,000,000-member data set representing a variety of health plans throughout the United States. Report cards and graphics are used to simplify the presentation of information throughout the analysis. If you still need to know more, our web based services provide on-line capability to “drill- down” on areas of concern and to “slice and dice” at all points in between. This includes:

- Provider
- Relationship
- Age
- Gender
- Dollar Value of Claims
- Diagnosis
- Procedure
- Specialty

Additional information about *Griffin Consulting's* web services can be found on page 35 of this analysis.

In summary, *focus on health* is a comprehensive tool that assists you in truly understanding the performance of your health plan. Once you have Information, you are ready to begin developing actionable strategies focused on your unique objectives and issues.





# Client Report Card

Financial	Actual	Norm	Variation	Page
Per Employee Total Cost (net stop loss if applicable)	\$6,725	\$5,921	■	6
High Cost Population (% of enrollees accounting for 80% of total paid)	16%	20%	■	28

Demographic Measures	Actual	Norm	Variation	Page
Dependents per Emp	1.1	1.4	■	7
Gender (% Female)	59%	51%	■	7
Average Age	29	37	■	8

Claims Cost PMPM by Service Category	Actual	Norm	Variation	Page
Total Medical Claims	\$209.46	\$155.85	■	6
Inpatient Hospital	\$64.16	\$29.97	■	12
Outpatient Hospital	\$56.79	\$20.41	■	13
Emergency Room	\$6.57	\$3.82	■	14
Inpatient Surgery	\$14.26	\$6.67	■	15
Outpatient Surgery	\$3.85	\$8.64	■	16
Office Visits - Medical	\$10.81	\$7.57	■	17
Mental Health Visits	\$0.29	\$1.70	■	18
Chiropractic	\$0.54	\$3.35	■	19
Wellness/Routine Care	\$1.51	\$1.97	■	20
Prescription Drugs	\$41.80	\$34.13	■	21

Network Performance	Actual	Norm	Variation	Page
Network Penetration Rate (in-network charges)	70%	79%	■	24
Benefit to Charge Ratio (Overall)	59%	54%	■	25
Network Discount	1%	Varies by Geography	N/A	25

Clinical/Behavior Issues	Actual	Norm	Variation	Page
Lifestyle Related Claims (% of members)	16%	22%	■	30
Prevention (% of members)	24%	19%	■	31
Chronic Disease (% of members)	19%	20%	■	32

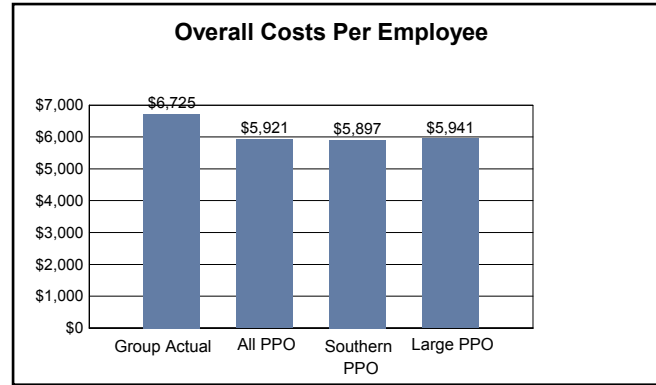
■	Experience is positive compared to norm (10% or more)
□	Experience is similar to norm (+/- 0 to 9% of norm)
■	Experience is negative compared to norm (10% or more)



# Financial and Demographics

## Financial Summary

At **\$6,725 per employee**, your group's annual health care cost is **14% above** than the broadest comparison group: PPO Plans Nationally. Comparison data is based upon the Kaiser/HRET Survey of Employer Sponsored Health Benefits: 2003. Using this survey we are able to include administrative costs and premiums as well as adjust for variances in enrollment mix (single/family) that may not be accounted for through other methods. Comparative data is also provided by geographic region and size. Unless otherwise noted, this is the only external data source cited throughout this analysis.



Coverage	Employee	Spouse	Dependent	Total
<b>Total</b>	558	232	357	1,147
<b>Medical Paid</b>	\$1,943,639	\$633,375	\$305,936	\$2,882,950
<b>Pharmacy Paid</b>	\$397,790	\$130,705	\$46,813	\$575,308
<b>Total Claims Paid</b>	\$2,341,429	\$764,080	\$352,749	\$3,458,258
<b>Total Paid Per Member</b>	\$4,196	\$3,293	\$988	\$3,015
<b>Total Paid Per Employee</b>	\$4,196	\$1,369	\$632	\$6,198
<b>Est. Admin Expenses (PE)</b>				\$758
<b>Total Plan Expenses (PE)</b>				<b>\$6,956</b>
<b>Total Plan Expenses (PE) (net of Est. Stop Loss Reimbursements)</b>				<b>\$6,725</b>

Claim costs may have been adjusted to reflect individual stop loss limits.

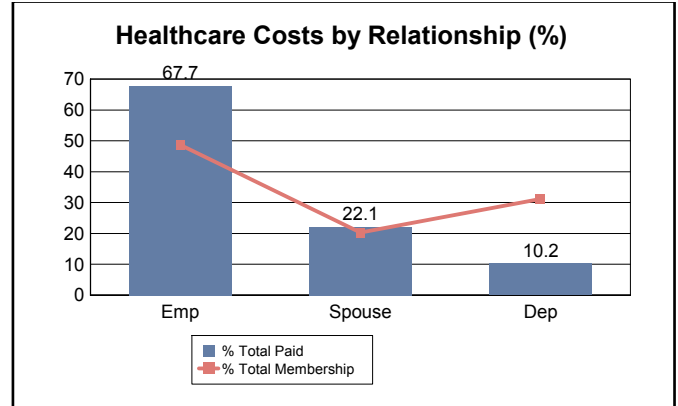
Individual Stop Loss Limit (A)	# of Claimants Exceeding Limit (B)	Actual Expense for Stop Loss Claimants	Net Exposure to Plan (A*B)
\$75,000	5	\$503,691	\$375,000



## Demographics

### Claims Cost: Member Relationship

Claims costs can be impacted by severe variations in the demographics of your group relative to any comparison population. The demographic characteristics evaluated in this analysis focus on dependent relationship and ratio of dependents per covered employee, the gender mix of the population and the age of the participants across all coverage categories. The relationship of claim costs to the specific demographic breakdown is noted in the exhibits on the following pages.



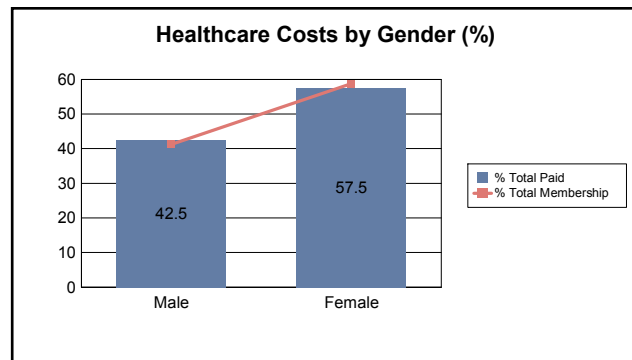
Based upon enrollment data provided for this analysis, your group covers **1.1** dependents for every covered employee. This compares to **1.4** dependents for every covered employee within the comparison group. Employees represent **48.7%** of plan membership, yet account for **67.7%** of total claims. Family members account for the remaining **51.4%** of the membership and **32.3%** of the claims. Additional breakdown among spouses and dependents is indicated on the table above.

Additional detail on the profile of members is shown in the following table. While females represent **76.9%** of the covered employee population, they represent **58.8%** of the total membership in the plan. Females typically cost more than males, largely because of expenses associated with pregnancy and childbirth.

### Member Count: Gender and Relationship

	Male	Female	Total
Employee	129	429	558
Spouse	161	71	232
Dependent	183	174	357
<b>Total</b>	<b>473</b>	<b>674</b>	<b>1,147</b>

During this particular period, females accounted for **57.5%** of total costs and males the remaining **42.5%**. The average annual claims cost per female participant was **\$2,949**, while the yearly cost for male participants was **\$3,109**. Additional detail on cost by gender and relationship is available through drill down analysis.



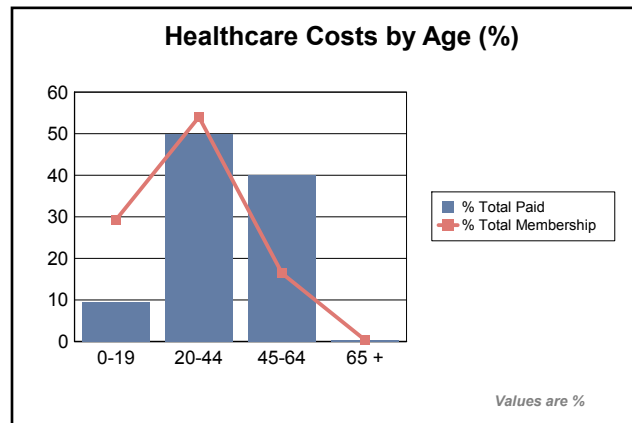


Using the enrollment data provided for this analysis, we have summarized membership by gender and age band in the following table. In reviewing the age bands, dependent children typically represent the vast majority of members in the 0-19 age band. The two middle age bands (20-44 and 45-64) primarily represent employees or spouses that, most often, are not yet eligible for Medicare. Depending upon plan rules for eligibility, the final age band (65+) may reflect a significant share of Medicare eligible participants.

**Member Count: Gender and Age Group**

	0-19	20-44	45-64	65 +	Total
<b>Male</b>	170	225	76	2	473
<b>Female</b>	165	395	112	2	674
<b>Total</b>	335	620	188	4	1,147

The graph to the right indicates the percentage of members in a given age band, as well as the percentage of total costs of members in the particular subgroup. In general, as members get older, the cost attributable to their health care also increases. For your group, members older than 45 (the two highest age bands) represented 16.7% of total membership, while at the same time accounted for 40.5% of total paid claims. The average age of your group was 29 years old.



The table to the right provides information on the cost associated with each demographic segment. Within each of the previously discussed segments, the actual cost per member is summarized. If desired, additional detail and segmentation can be provided through drill down analysis.

Age / Gender Subcategory	Employees	Spouses	Dependents	All	
0-19	Male		\$1,178	\$1,178	
	Female	\$74	\$830	\$904	
				\$995	
20-44	Male	\$2,960	\$1,188	\$324	\$1,878
	Female	\$3,502	\$2,519	\$1,104	\$3,297
				\$2,782	
45-64	Male	\$12,371	\$9,897		\$11,004
	Female	\$5,067	\$4,090		\$4,884
				\$7,358	
65 +	Male	\$11,447	\$91		\$5,769
	Female	\$3,746	\$1,388		\$2,567
				\$4,168	
All	Male	\$5,506	\$3,453	\$1,117	\$3,109
	Female	\$3,802	\$2,932	\$852	\$2,949
				\$3,015	



## Expense Distribution

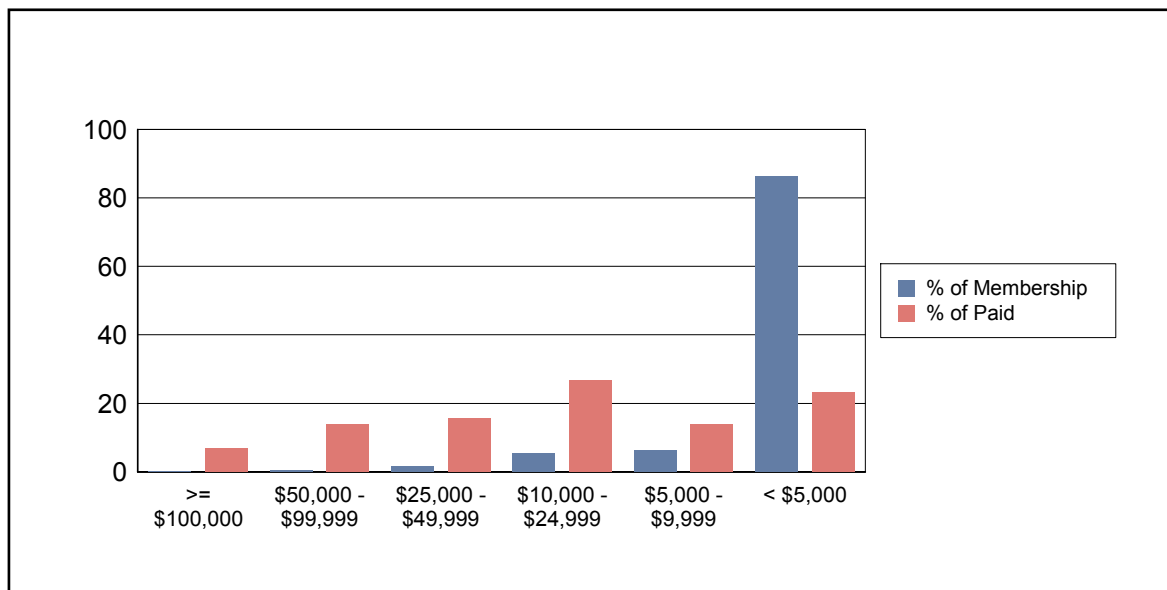
The following table outlines the expense banding within the group, and provides a comparison view to the normative database. This exhibit demonstrates the disproportionate impact that small numbers of acute members can have on the total cost of health care.

### Distribution Detail

Total member costs as summarized within each cost band. Detailed information about each band is summarized below.

Distribution of Claims	Members	Total Paid	Paid Per Member	% of Member	% of Members (Norm)	% of Total Paid	% of Total Paid (Norm)
>= \$100,000	2	\$241,947	\$120,974	0.2%	0.2%	7.0%	17.0%
\$50,000 - \$99,999	6	\$474,404	\$79,067	0.5%	0.4%	13.7%	10.8%
\$25,000 - \$49,999	17	\$536,193	\$31,541	1.5%	0.9%	15.5%	13.3%
\$10,000 - \$24,999	62	\$922,277	\$14,875	5.4%	3.4%	26.7%	22.1%
\$5,000 - \$9,999	70	\$481,359	\$6,877	6.1%	4.8%	13.9%	14.8%
< \$5,000	990	\$802,078	\$810	86.3%	90.4%	23.2%	22.0%
All	1,147	\$3,458,258	\$3,015	100.0%	0.0%	100.0%	0.0%

### Comparison of % of Membership to % of Paid Claims



Additional claims bands and comparisons to normative data are available through drill-down analysis.



## Utilization Summary

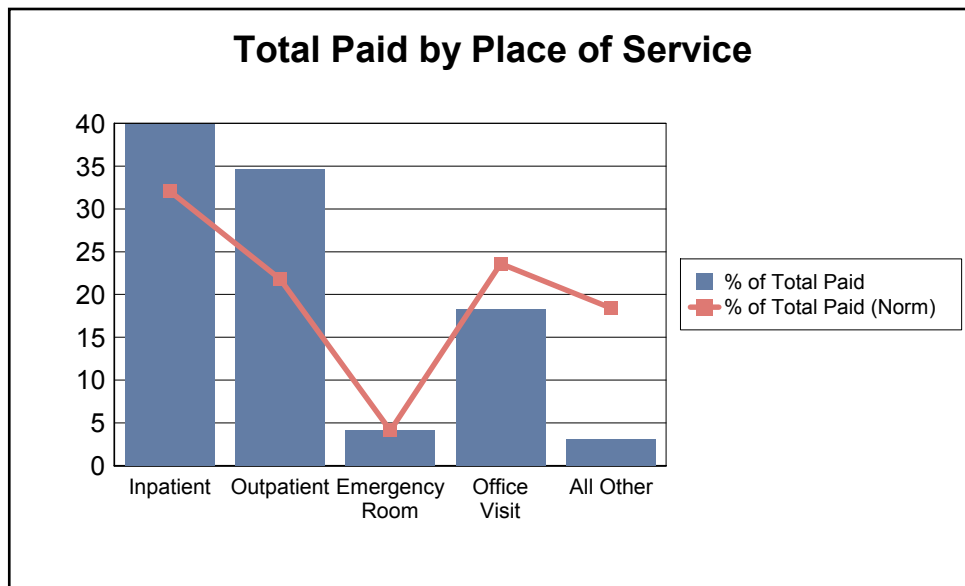
The utilization summary begins with place of service and moves to a more detailed type of service measure as you proceed through the analysis.

The body of the utilization analysis summarizes each high level type of service with regard to frequency, unit cost, payment rates, providers used, conditions treated and member relationship. Normative data is used to highlight variations that may require action.

### Total Costs by Place of Service

The following table outlines total medical utilization by place of service. This includes the total paid claims for care in that setting.

	Paid Claims	Admit/Event	Admit/Events per 1000	Paid per Admit/Event	% of Total Paid
Inpatient	\$1,149,525	124	108	\$9,270	39.9%
Outpatient	\$998,952	787	686	\$1,269	34.7%
Emergency Room	\$118,448	261	228	\$454	4.1%
Office	\$527,450	4,637	4,043	\$114	18.3%
All Other	\$88,575	273	238	\$324	3.1%



Pharmacy dollars are not included in this section.



### Utilization Performance Snapshot

Service	Frequency Factor (a)	Charge Factor (b)	Gross Charge Variance (c=a*b)	Payment Factor (d)	Payment Variance (e=c*d)	Reference Page
Inpatient Hospital	■	■	■	□	■	12
Outpatient Hospital	□	■	■	□	■	13
Emergency Room	■	■	■	□	■	14
Inpatient Surgeries	■	■	■	□	■	15
Outpatient Surgeries	□	□	□	□	□	16
Office Visits	■	□	■	□	■	17
Mental Health Visits	□	□	□	□	□	18
Chiropractic	□	□	□	□	□	19
Wellness/Routine Care	□	□	□	□	□	20
Prescription Drug	□	■	■	■	■	21

■	Experience is positive compared to norm (10% or more)
□	Experience is similar to norm (+/- 0 to 9% of norm)
■	Experience is negative compared to norm (10% or more)

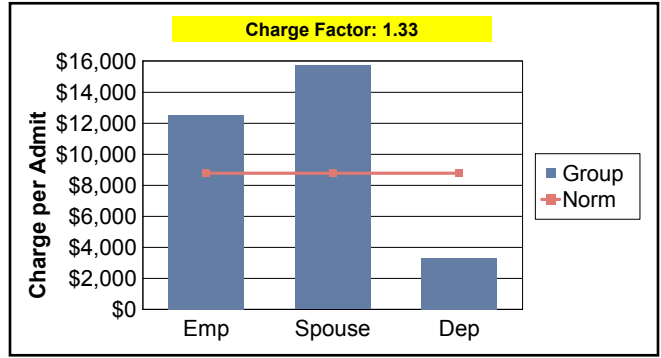
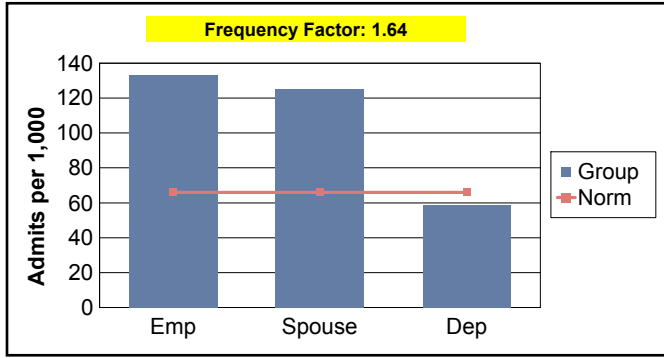
Frequency, Charge and Payment Factors are used to compare a group’s experience to the performance of our normative client database. In combination, these factors all contribute to the resulting claims experience and cost to the plan sponsor. The specific values for these items are highlighted in yellow throughout the next several pages.

Frequency Factor (a) reflects the utilization or use of services on a rate per 1000 members as compared to our norms. Charge Factor (b) reflects the “unit cost” or charge for each service in a given category. These two “Factors” drive the Gross Charges (a x b = c) and associated variances relative to norms. A more precise definition of the service is provided on the specific page for the service category.

Payment Factor compares the “benefits to charge ratio” of your plan to our normative database. If this ratio is 10% higher or lower than normal it is coded as such in the table above. The final column, Payment Variance (e) reflects the end result of all previously referenced factors. If you have a significant Payment Variance (e), you can identify whether Frequency (a), Charge (b) or Payment Rate (d) were contributing factors.



### Inpatient Hospital



	Actual	Norm	Variance
Gross Charges	\$1,451,244	\$665,404	218.1 %
Benefits Paid	\$883,074	\$412,551	214.1 %
Benefits to Charge	0.61	0.62	
	<b>Payment Factor</b>	<b>0.98</b>	

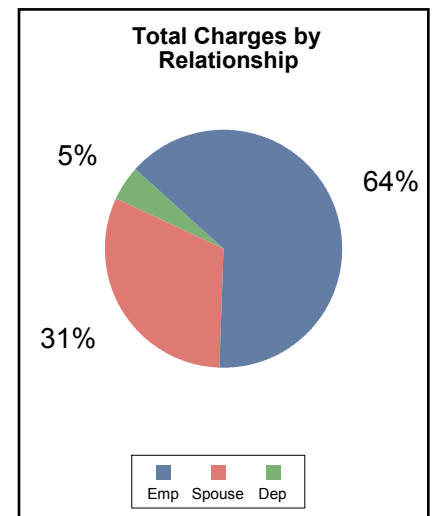
The graphs and table above represent how many services were rendered and how much was charged and paid in this service category. Inpatient admissions are defined as care that occurs within a hospital setting and involves an overnight stay. Costs shown reflect those for the facility only. During this reporting period there were **124** admits, which was approximately **64% above** normal. The average unit charge of **\$11,704** was **33% above** normal.

The questions of who, where and why are answered in the tables and chart below. Top Providers and Top Conditions are ranked by total charges processed (admits x charge per admit). The pie chart provides a breakdown of total charges by member relationship. A total of **98** members utilized this particular service category.

Top Providers	In versus Out of Network	Admits	Charge per Admit
ATHENS REGIONAL MEDI, CAL CENTE	PAR	5	\$39,072
NORTHEAST GEORGIA ME, DICAL CEN	PAR	4	\$22,019
QHG OF SC, INC(DBA)CA, ROLINAS HO	PAR	2	\$30,353
CAROLINAS MEDICAL CE, NTER-56139	PAR	1	\$57,492
MACON NORTHSIDE,	PAR	1	\$56,722

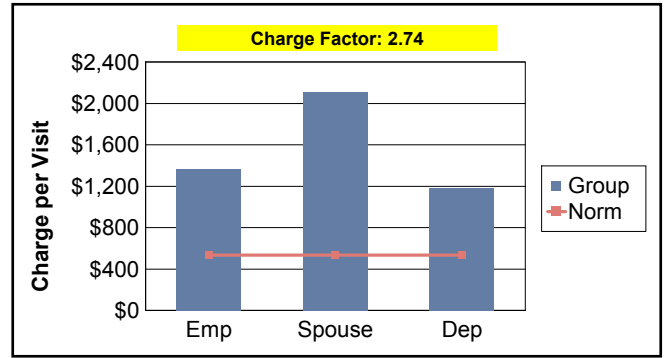
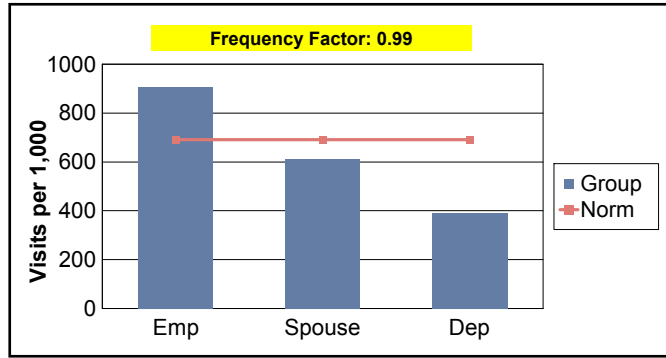
  

Top Conditions	Members	Admits	Charge per Admit
CAD +/- CABG	3	3	\$48,166
Pregnancy Complications	11	13	\$9,600
Intervertebral Disc Disorders	3	3	\$32,668
Gynecological Disorders	5	6	\$14,071
Pneumococcal and Other Pneumonia	3	3	\$26,385





## Outpatient Hospital



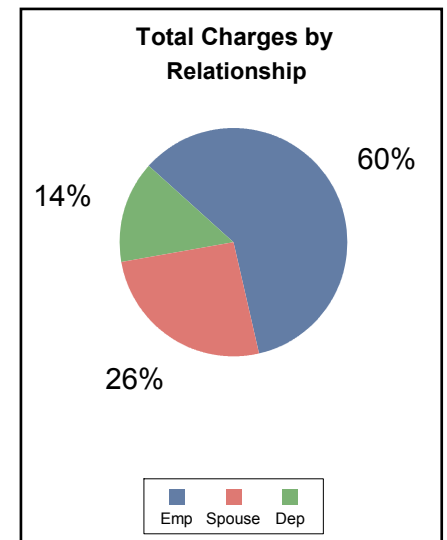
	Actual	Norm	Variance
Gross Charges	\$1,157,180	\$425,699	271.8 %
Benefits Paid	\$781,643	\$280,961	278.2 %
Benefits to Charge	0.68	0.66	
	<b>Payment Factor</b>	<b>1.03</b>	

The graphs and table above represent how many services were rendered and how much was charged and paid in this service category. Outpatient care is defined as care that occurs within a hospital setting that does not involve an overnight stay. Costs shown reflect those for the facility only. During this reporting period there were **787** visits, which was approximately **1% below** normal. The average unit charge of **\$1,470** was **174% above** normal.

The questions of who, where and why are answered in the tables and chart below. Top Providers and Top Conditions are ranked by total charges processed (visits x charge per visit). The pie chart provides a breakdown of total charges by member relationship. A total of **356** members utilized this particular service category.

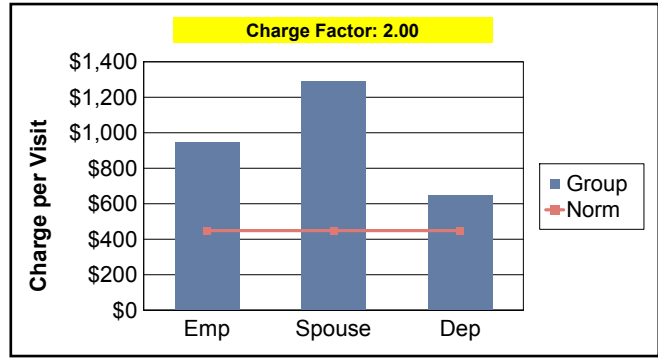
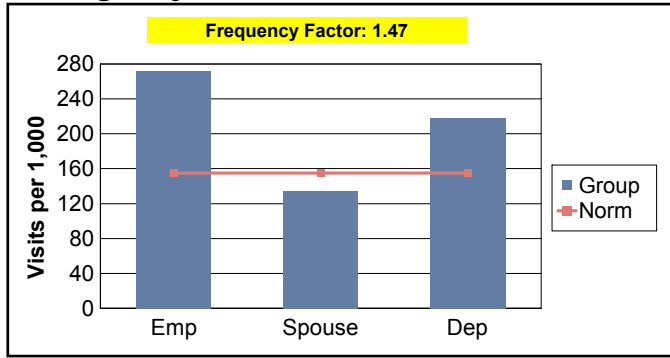
Top Providers	In versus Out of Network	Visits	Charge per Visit
DCA-ROYSTON,	NON-PAR	6	\$14,940
PALMYRA MEDICAL CENT, ER-58109	NON-PAR	11	\$6,346
ATHENS REGIONAL MEDI, CAL CENT	PAR	14	\$4,234
STEPHENS COUNTY HOSP, ITAL	PAR	58	\$919
PHOEBE PUTNEY HOSP,	NON-PAR	21	\$1,900

Top Conditions	Members	Visits	Charge per Admit
Chronic Renal Failure	1	7	\$13,147
Gynecological Disorders	18	26	\$3,189
Intervertebral Disc Disorders	12	21	\$3,415
Joint Derangement and Other	20	34	\$1,853
Misc Urinary Symptoms	2	4	\$15,537





## Emergency Room



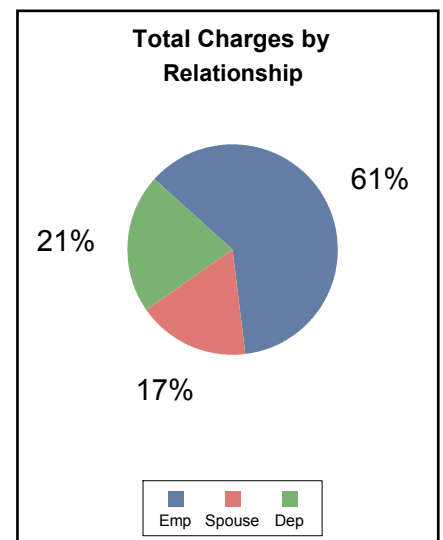
	Actual	Norm	Variance
Gross Charges	\$234,401	\$79,668	294.2 %
Benefits Paid	\$90,486	\$52,581	172.1 %
Benefits to Charge	0.39	0.66	
	<b>Payment Factor</b>	<b>0.59</b>	

The graphs and table above represent how many services were rendered and how much was charged and paid in this service category. Emergency Room care is defined as care involving outpatient medical services that take place in the emergency room of a hospital. Costs shown reflect those for the facility only. During this reporting period there were **261** visits, which was approximately **47% above** normal. The unit charge for each visit of **\$898** was **100% above** normal.

The questions of who, where and why are answered in the tables and chart below. Top Providers and Top Conditions are ranked by total charges processed (visits x charge per visit). The pie chart provides a breakdown of total charges by member relationship. A total of **183** members utilized this particular service category.

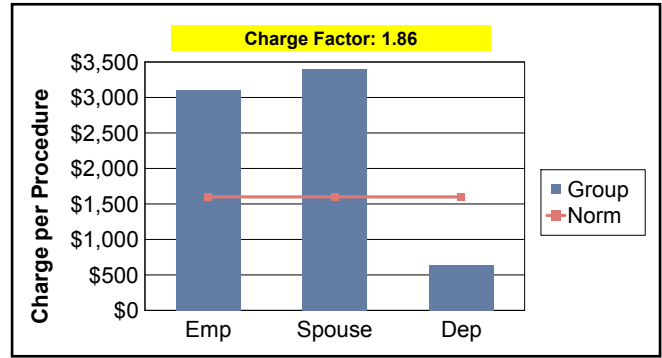
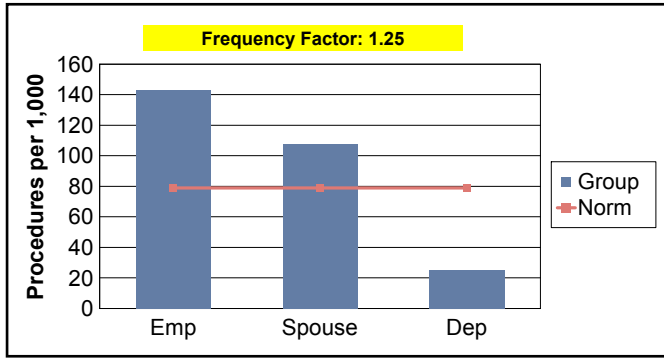
Top Providers	In versus Out of Network	Visits	Charge per Visit
STEPHENS COUNTY HOSP, ITAL	PAR	21	\$926
NORTHEAST GEORGIA ME, DICAL CE	PAR	13	\$1,345
SPALDING REGIONAL HO, SPITAL	PAR	2	\$4,780
SOUTHEAST ALABAMA ME, D CENTE	PAR	1	\$9,425
RAPIDES REGIONAL MED, ICAL CTR	PAR	3	\$3,075

Top Conditions	Members	Visits	Charge per Visit
Sprains and strains of joints and adjacent i	23	27	\$837
Abdominal Pain	14	15	\$1,453
Chest Pain	7	8	\$2,030
Back Pain	7	19	\$621
Migraine Disorder	5	9	\$1,289





### Inpatient Surgery



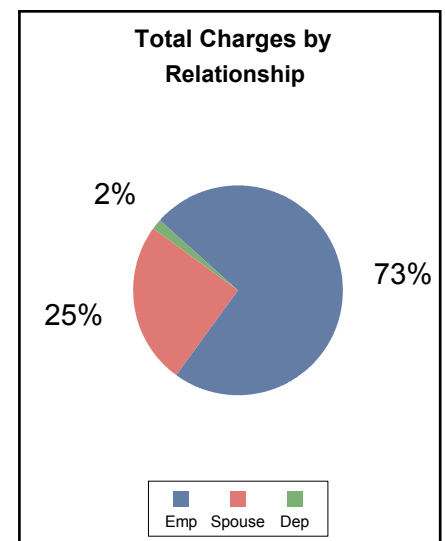
	Actual	Norm	Variance
Gross Charges	\$339,485	\$145,824	232.8 %
Benefits Paid	\$196,331	\$91,869	213.7 %
Benefits to Charge	0.58	0.63	
	<b>Payment Factor</b>	<b>0.92</b>	

The graphs and table above represent how many services were rendered and how much was charged and paid in this service category. Inpatient Surgery is defined as care involving surgical procedures that take place within a hospital setting that involves an overnight stay. Costs shown reflect those for all professional services coded as surgical procedures. During this reporting period there were **114** surgical procedures, which was approximately **25% above** normal. The unit charge for each surgery of **\$2,978** was **86% above** normal.

The questions of who, where and why are answered in the tables and chart below. Top Providers and Top Conditions are ranked by total charges processed (surgeries x charge per surgery). The pie chart provides a breakdown of total charges by member relationship. A total of **63** members utilized this particular

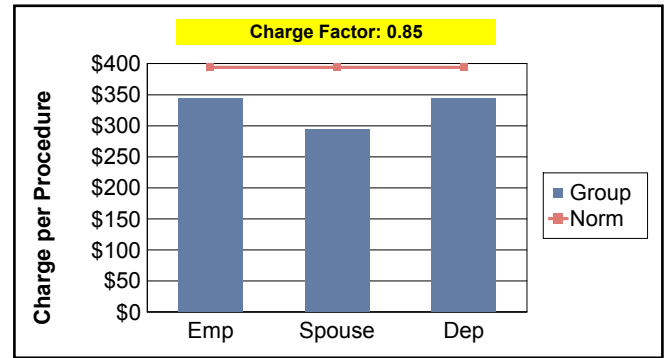
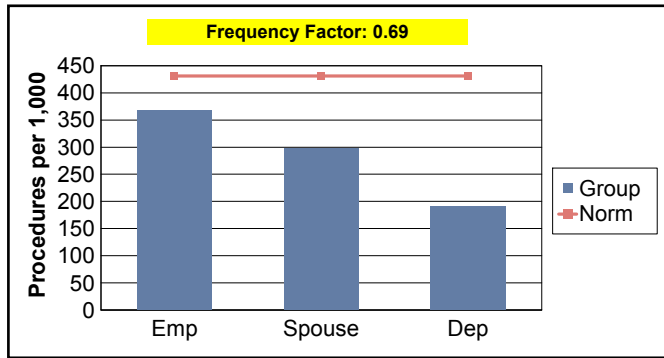
Top Providers	In versus Out of Network	Procedures	Charge per Procedure
HOLLIDAY, PETER	PAR	1	\$41,894
MCCUE, SEAN	NON-PAR	1	\$19,000
ADDRERHOLT, J.G.	PAR	1	\$18,368
JOHNSON, JOE H	PAR	1	\$11,053
MEDICAL CENTER OF AN, ESTHESIOLOGICAL	PAR	7	\$1,164

Top Conditions	Members	Procedures	Charge per Procedure
Intervertebral Disc Disorders	3	4	\$21,503
Gynecological Disorders	6	13	\$3,073
CAD +/- CABG	2	5	\$6,795
Normal Delivery	11	12	\$2,271
Pregnancy Complications	6	8	\$2,431





## Outpatient Surgery



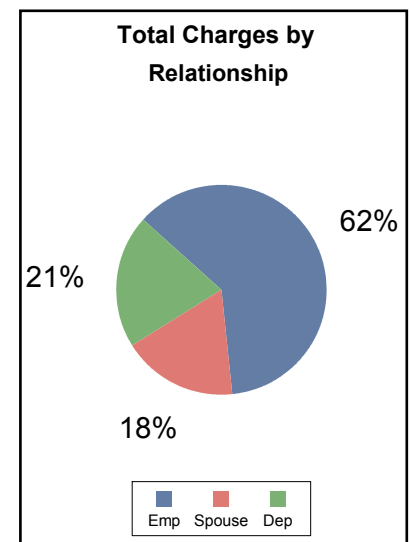
	Actual	Norm	Variance
Gross Charges	\$114,151	\$194,884	58.6 %
Benefits Paid	\$53,015	\$118,879	44.6 %
Benefits to Charge	0.46	0.61	
	<b>Payment Factor</b>	<b>0.75</b>	

The graphs and table above represent how many services were rendered and how much was charged and paid in this service category. Outpatient Surgery is defined as care involving surgical procedures that take place within an outpatient hospital setting and does not involve an overnight stay. Costs shown reflect those for all professional services coded as surgical procedures. During this reporting period there were **342** surgical procedures, which was approximately **31% below** normal. The unit charge for each surgery of **\$334** was **15% below** normal.

The questions of who, where and why are answered in the tables and chart below. Top Providers and Top Conditions are ranked by total charges processed (surgeries x charge per surgery). The pie chart provides a breakdown of total charges by member relationship. A total of **220** members utilized this particular service category.

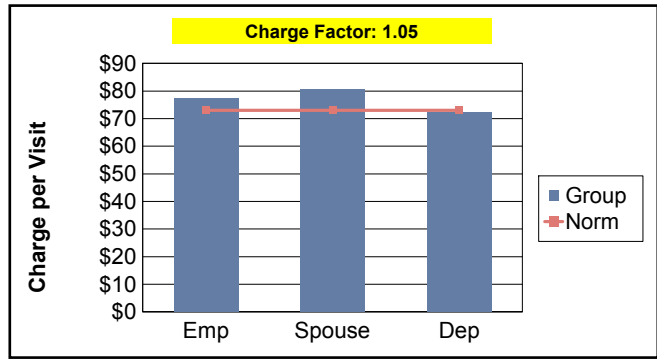
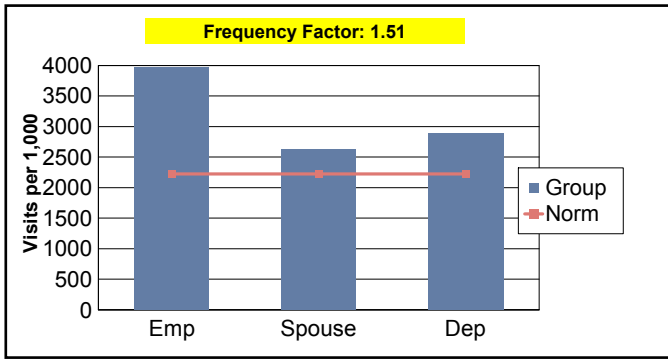
Top Providers	In versus Out of Network	Procedures	Charge per Procedure
ISELL MEDICAL CLINI, C	PAR	1	\$2,805
MIDDLE GA UROLOGY,	PAR	2	\$1,350
GEORGIA EYE INSTITUT, E, INC.	PAR	2	\$1,332
ENT ASSOC OF S.W. GA,	NON-PAR	4	\$640
MORROW, RICHARD	PAR	1	\$2,500

Top Conditions	Members	Procedures	Charge per Procedure
Fracture of upper limb	8	15	\$502
Malignant Skin Disease	6	8	\$818
Gynecological Disorders	19	21	\$268
Diseases of the ear and mastoid process	16	21	\$248
Kidney Stones and Nephritis	2	2	\$2,450





### Office Visits



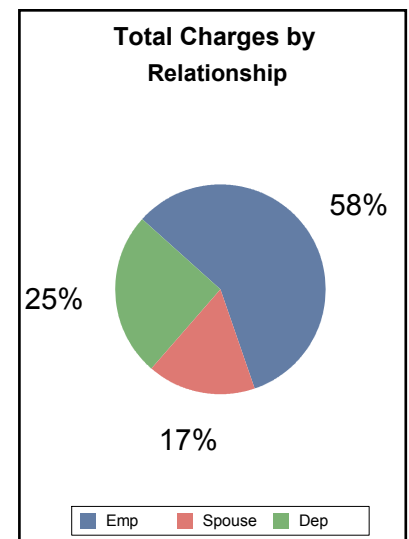
	Actual	Norm	Variance
Gross Charges	\$294,864	\$186,154	158.4 %
Benefits Paid	\$148,722	\$104,247	142.7 %
Benefits to Charge	0.50	0.56	
	<b>Payment Factor</b>	<b>0.89</b>	

The graphs and table above represent how many services were rendered and how much was charged and paid in this service category. Office Visits are defined as the charge for the office visit only and not related services (lab, x-ray, etc.). During this reporting period there were **3,851** visits, which was approximately **51% above** normal. The unit charge for each visit of **\$77** was **5% above** normal.

The questions of who, where and why are answered in the tables and chart below. Top Providers and Top Conditions are ranked by total charges processed (visits x charge per visit). The pie chart provides a breakdown of total charges by member relationship. A total of **961** members utilized this particular service category.

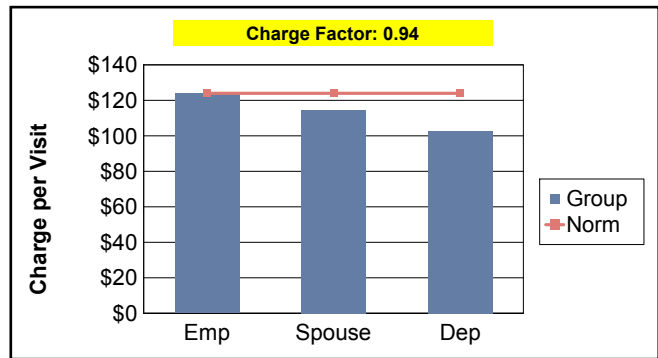
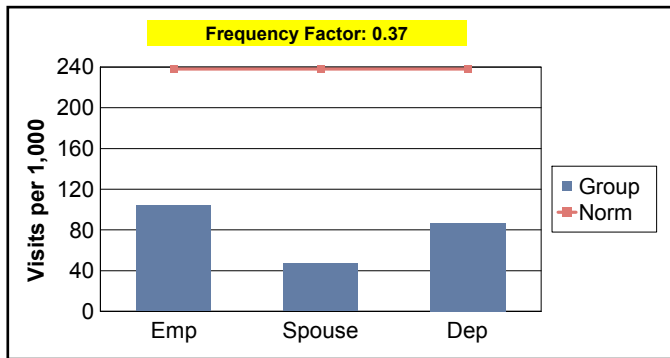
Top Providers	In versus Out of Network	Visits	Charges per Visit
COAN, MARC S	PAR	45	\$72
TOCCOA CLINIC,	PAR	36	\$78
MINKS, ROBIN D	PAR	43	\$60
FORDYCE, JAMES W	NON-PAR	19	\$118
SOUTHCOAST MEDICAL G, ROUP	PAR	20	\$95

Top Conditions	Members	Visits	Charges per Visit
Diseases of the ear and mastoid process	133	245	\$72
Gynecological Disorders	94	142	\$90
Upper Resp Tract Inf	134	170	\$64
Acute Sinusitis	107	125	\$70
Arthritis, excluding back pain	67	98	\$88





### Mental Health Visits



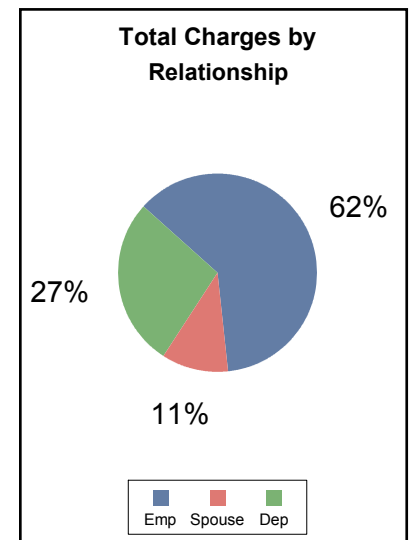
	Actual	Norm	Variance
Gross Charges	\$11,633	\$33,922	34.3 %
Benefits Paid	\$4,048	\$23,406	17.3 %
Benefits to Charge	0.35	0.69	
	<b>Payment Factor</b>	<b>0.51</b>	

The graphs and table above represent how many services were rendered and how much was charged and paid in this service category. Mental Health Office Visits are defined as the charge for the office visit with specific psychiatric procedure codes only. During this reporting period there were **100** visits, which was approximately **63% below** normal. The average unit charge of **116** was **6% below** normal.

The questions of who, where and why are answered in the tables and chart below. Top Providers and Top Conditions are ranked by total charges processed (visits x charge per visit). The pie chart provides a breakdown of total charges by member relationship. A total of **21** members utilized this particular service category.

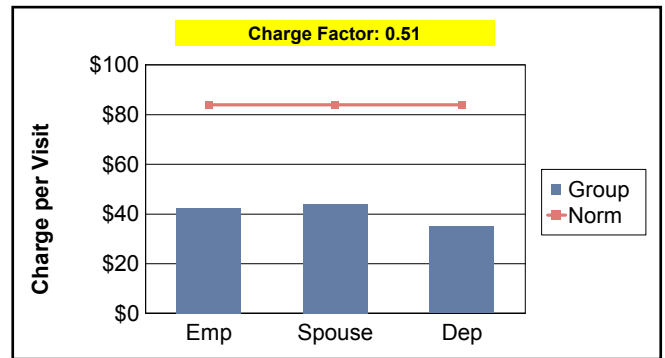
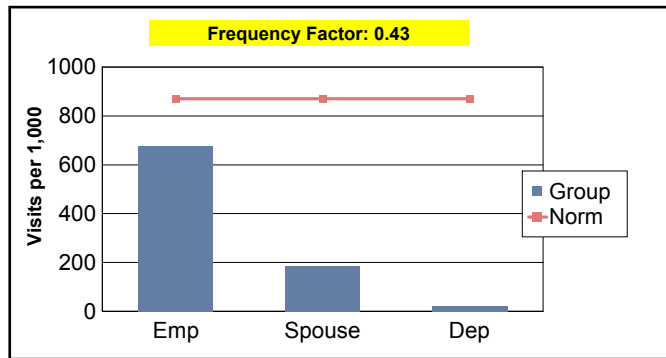
Top Providers	In versus Out of Network	Visits	Charges per Visit
TRANT, TIMOTHY	PAR	12	\$146
GATEWAY COMMUNITY SE, RVICE BRI	NON-PAR	8	\$202
SABIN, JAMES	NON-PAR	13	\$100
SKINNER AND ASSOCIAT, ES	NON-PAR	8	\$125
FRESH TOUCH COUNSEL, NG CENTEF	PAR	12	\$80

Top Conditions	Members	Visits	Charges per Visit
Major depressive disorder	8	41	\$109
Neurotic disorders	3	19	\$126
Drug dependence	2	9	\$189
Depressive reaction	2	9	\$135
Anxiety state, unspecified	1	8	\$80





### Chiropractic Visits



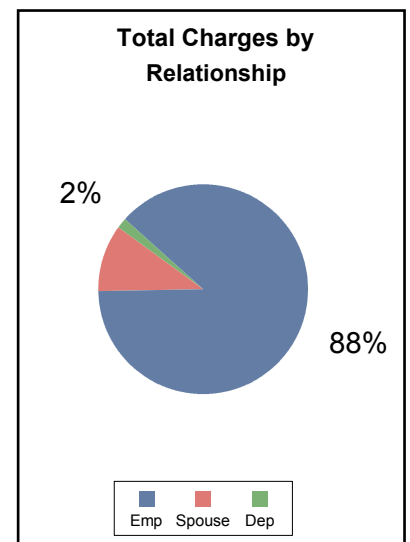
	Actual	Norm	Variance
Gross Charges	\$18,231	\$83,820	21.8 %
Benefits Paid	\$7,460	\$46,101	16.2 %
Benefits to Charge	0.41	0.55	
	<b>Payment Factor</b>	<b>0.75</b>	

The graphs and table above represent how many services were rendered and how much was charged and paid in this service category. Chiropractic Office Visits are defined as the charge for the office visit with specific chiropractic procedure codes only. During this reporting period there were **429** visits, which was approximately **57% below** normal. The average unit charge of **\$43** was **49% below**.

The questions of who, where and why are answered in the tables and chart below. Top Providers and Top Conditions are ranked by total charges processed (visits x charge per visit). The pie chart provides a breakdown of total charges by member relationship. A total of **59** members utilized this particular service category.

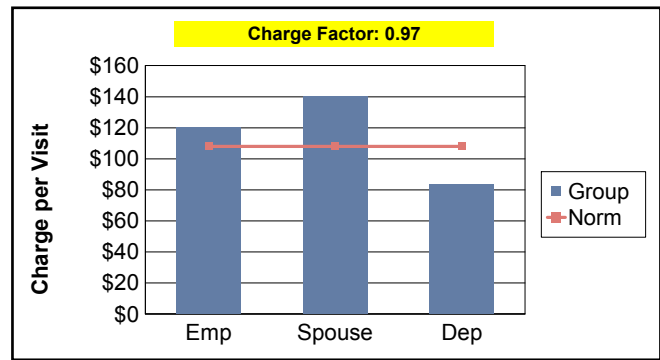
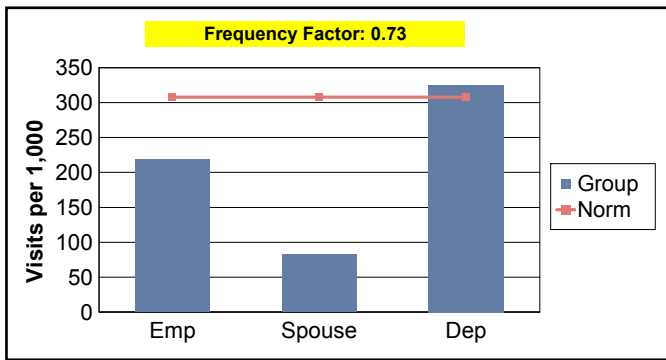
Top Providers	In versus Out of Network	Visits	Charges per Visit
CHIRO FIRST CLINIC,	PAR	43	\$60
GREMMELS CHIROPRACTI, C INC	PAR	61	\$36
KILRAINE CHIROPRACTI, C	PAR	22	\$50
MANKIEWICZ, CARL	NON-PAR	30	\$30
TOWNE DOCTOR PC,	PAR	19	\$46

Top Conditions	Members	Visits	Charges per Visit
Sprains and strains of joints and adjacen	7	132	\$45
Spine and Feet deformities	25	116	\$41
Back Pain	8	68	\$42
Misc Nerve and Muscle Symptoms	6	29	\$50
Head and Neck Symptoms	6	30	\$47





## Wellness and Routine Care



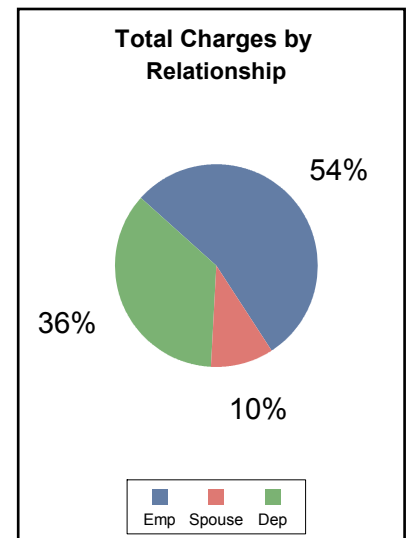
	Actual	Norm	Variance
Gross Charges	\$27,047	\$38,166	70.9 %
Benefits Paid	\$20,789	\$27,098	76.7 %
Benefits to Charge	0.77	0.71	
	<b>Payment Factor</b>	<b>1.08</b>	

The graphs and table above represent how many services were rendered and how much was charged and paid in this service category. Wellness and Routine Office Visits are defined as the charge for the office visit with specific wellness and routine procedure codes only. During this reporting period there were **257** visits, which was approximately **27% below**. The average unit charge of **\$105** was **3% below** normal.

The questions of who, where and why are answered in the tables and chart below. Top Providers and Top Conditions are ranked by total charges processed (visits x charge per visit). The pie chart provides a breakdown of total charges by member relationship. A total of **198** members utilized this particular service category.

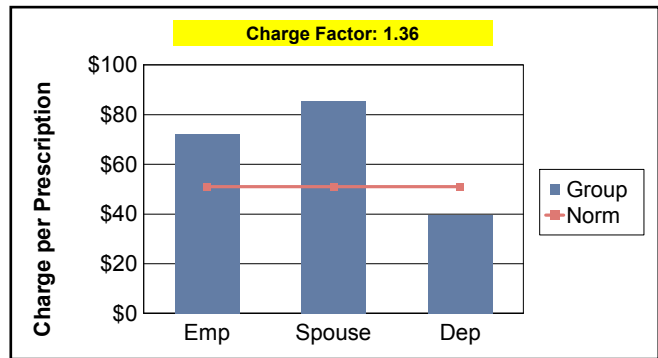
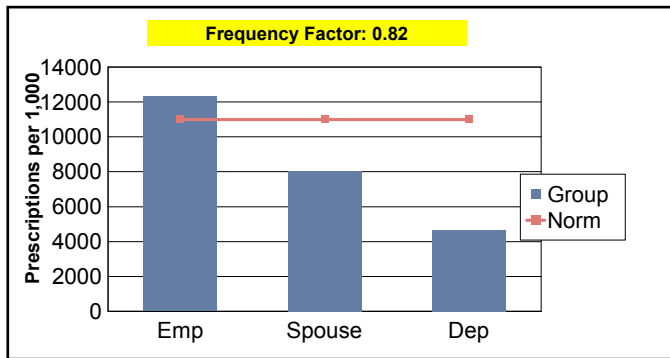
Top Providers	In versus Out of Network	Visits	Charges per Visit
MILLER, JERRY	PAR	7	\$119
HATCHETT, THOMAS	PAR	5	\$143
ATHENS OBSTETRICS &, GYNECOLC	PAR	4	\$140
KIDSMED, LLC,	NON-PAR	4	\$121
RAYBON, R BRIAN	PAR	3	\$158

Top Conditions	Members	Visits	Charges per Visit
Gyn Exam	128	128	\$125
Screening PE Infant	57	109	\$83
General Examination	11	12	\$135
Pre-natal health	1	2	\$45
Diphtheria-tetanus-pertussis DPT	1	1	\$60





## Prescription Drugs



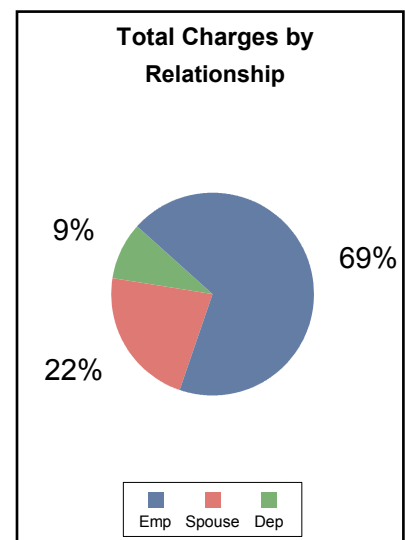
	Actual	Norm	Variance
Gross Charges	\$720,977	\$643,493	112.0 %
Benefits Paid	\$575,308	\$469,750	122.5 %
Benefits to Charge	0.80	0.73	
	<b>Payment Factor</b>	<b>1.10</b>	

The graphs and table above represent how many services were rendered and how much was charged and paid in this service category. Prescription drugs are defined as those drugs delivered through a specific pharmacy benefit. This does not include drugs administered directly through a provider. During this reporting period there were **10,403** prescriptions, which was approximately **18% below** normal. The average unit charge of **\$69** was **36% above** normal.

The questions of who, where and why are answered in the tables and chart below. Top Pharmacy and Top Brand Name Drugs are ranked by total charges processed (prescriptions x charge per prescription). The pie chart provides a breakdown of total charges by member relationship. A total of **1,019** members utilized this particular service category.

Top Prescribing Providers	In versus Out of Network	Scripts	Paid per Script
SIRMANS, GLENDA-BS2273251	N/A	25	\$650
PARKER, ROBERT-AM8391548	N/A	12	\$928
LOONEY, ANITA-BC1253068	N/A	184	\$56
WADE, JANE-BM1684047	N/A	77	\$127
CHEEK, LORENE-AY1212339	N/A	85	\$108

Top Drugs	Members	Scripts	Paid per Script
Antidepressants	208	652	\$99
Gastrointestinal Drugs, Misc.	113	374	\$168
Unclassified Agents	79	169	\$278
Antihyperlipidemic Drugs	65	185	\$188
Interferons	4	21	\$1,589

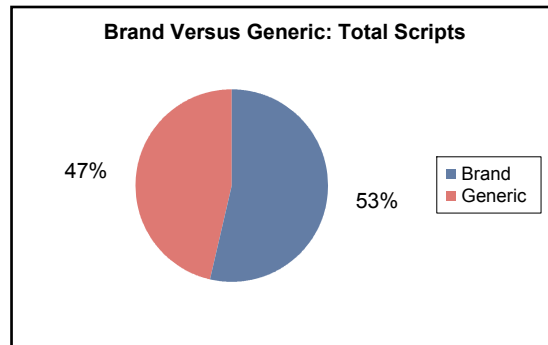
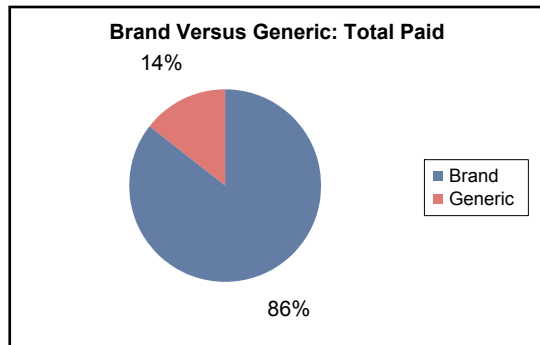




## Brand vs. Generic

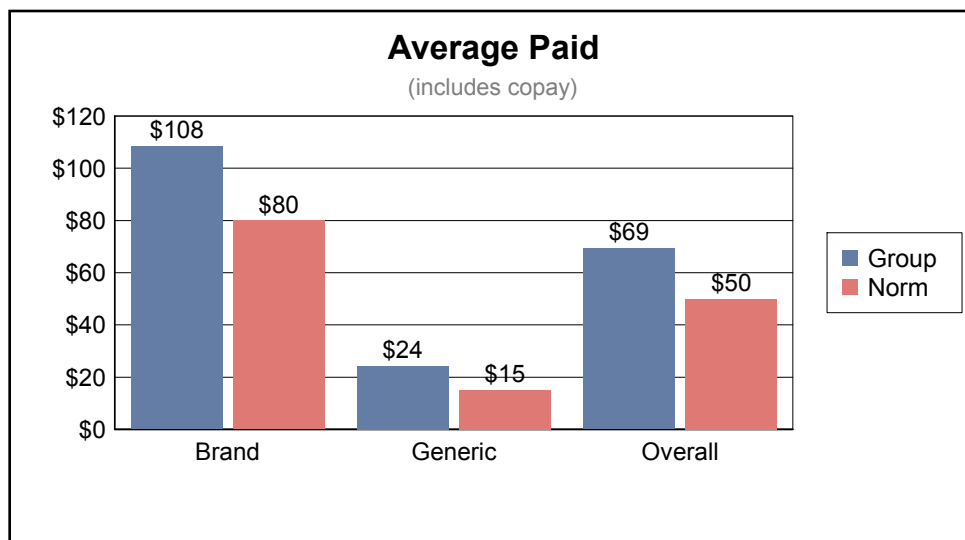
The use of appropriate generic replacement drugs can yield significant cost savings for plan sponsors. While generics do not exist for all branded drugs, providing incentives to maximize the use of generic alternatives is important to overall cost containment in the prescription drug area.

The graph to the left shows the percentage of total paid represented by generic and branded drugs. The graph on the right shows the percentage of total scripts within each category.



## Average Paid by Drug Type

The cost of prescription drugs can vary significantly depending on the type of drug (brand versus generic). The graphs that follow summarize average charges for each type. The graph represents average paid plus copay for retail and mail order distribution.





### Rx Costs by Distribution Type

The average cost per script and per day for both the plan sponsor and the member are shown in the table below.

		Cost Per Script		Cost Per Day	
		Employer	Employee	Employer	Employee
<b>R</b>	Brand	\$88.53	\$19.84	\$2.34	\$0.52
<b>R</b>	Generic	\$17.09	\$7.29	\$0.70	\$0.30
	<b>Total</b>	<b>\$55.30</b>	<b>\$14.00</b>	<b>\$1.75</b>	<b>\$0.44</b>

Compared to virtually all other health care services, prescription drugs are the most similar to other consumer goods in the way that they are purchased. With the growing trend toward consumer responsibility, it is very important to understand the dynamics of member cost sharing for prescription drug benefits. In the table below, plan sponsor and employee costs are documented by distribution source, type of drug and in total.

		Employer Cost		Employee Cost		Total Cost	
		Dollars	Percent	Dollars	Percent	Dollars	Percent
<b>R</b>	Brand	\$492,606	81.7 %	\$110,393	18.3 %	\$602,999	100%
<b>R</b>	Generic	\$82,701	70.1 %	\$35,277	29.9 %	\$117,978	100%
	<b>Total</b>	<b>\$575,308</b>	<b>79.8 %</b>	<b>\$145,669</b>	<b>20.2 %</b>	<b>\$720,977</b>	<b>100%</b>

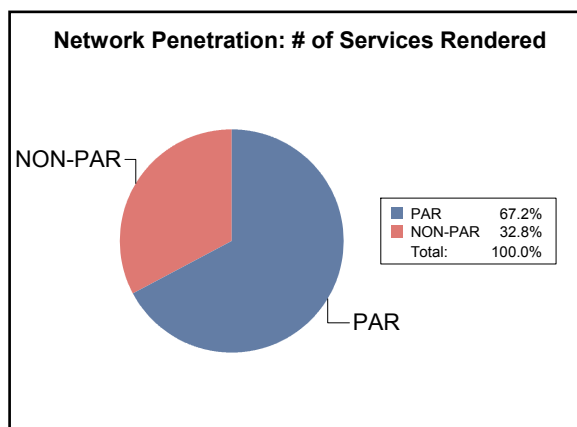
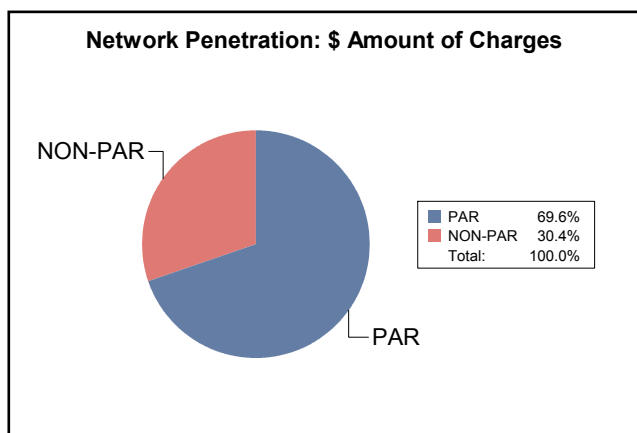


## Network Analysis

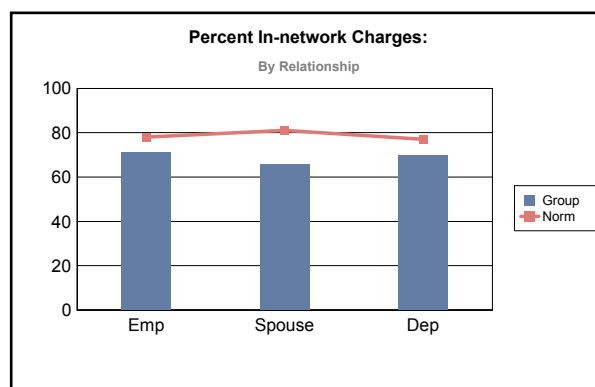
In this section, we look at the impact that participating provider networks have on the performance of your overall health plan. This network analysis includes an evaluation of the penetration rates or percentage of services and dollars flowing through network providers. This is further broken by service type, place of service and member relationship so that a more focused evaluation of improvement opportunities can be performed. Benefit to charge ratios and discounts (when available) are also provided to assess cost management issues related to plan design and the provider network contracts.

### Network Penetration Rates

Network penetration rates represent the percentage of claims that went to participating (PAR) or network providers. The graph on the right reflects the percentage of services rendered that went to PAR providers, while the graph on the left reflects the dollar amount of claims.



Certain member types may utilize PAR providers to a greater or lesser frequency than others. The chart to the right shows network penetration by member relationship. Opportunities for member education may be present if significant variation exists across member types.





## Place of Service Evaluation

The table below summarizes network performance by place of service to assist in evaluation of network adequacy and performance. Facility charges have been divided between inpatient and outpatient care, professional fees, and all other services summarized collectively. Additional place of service detail is available through drill down analysis as necessary.

		Covered Charge	% of Charges	Discount	Discount % off of Charges	Benefits Paid	Benefit To Charge Ratio (excl. discount)	Benefit To Charge Ratio -Overall
Inpatient	NON-PAR	\$421,507	22.1	\$0	0.0	\$245,113	58.2	58.2
	PAR	\$1,484,501	77.9	\$0	0.0	\$904,412	60.9	60.9
	<b>Sub Total</b>	<b>\$1,906,007</b>		<b>\$0</b>		<b>\$1,149,525</b>		<b>60.3</b>
Outpatient	NON-PAR	\$721,501	39.7	\$0	0.0	\$497,031	68.9	68.9
	PAR	\$1,097,173	60.3	\$0	0.0	\$620,370	56.5	56.5
	<b>Sub Total</b>	<b>\$1,818,674</b>		<b>\$0</b>		<b>\$1,117,401</b>		<b>61.4</b>
Professional	NON-PAR	\$307,168	31.4	\$0	0.0	\$148,163	48.2	48.2
	PAR	\$670,053	68.6	\$0	0.0	\$379,287	56.6	56.6
	<b>Sub Total</b>	<b>\$977,221</b>		<b>\$0</b>		<b>\$527,450</b>		<b>54.0</b>
All Other	NON-PAR	\$30,649	18.3	\$0	0.0	\$16,148	52.7	52.7
	PAR	\$136,423	81.7	\$0	0.0	\$72,427	53.1	53.1
	<b>Sub Total</b>	<b>\$167,072</b>		<b>\$0</b>		<b>\$88,575</b>		<b>53.0</b>
Total	NON-PAR	\$1,480,825	30.4	\$0	0.0	\$906,454	61.2	61.2
	PAR	\$3,388,149	69.6	\$0	0.0	\$1,976,496	58.3	58.3
	<b>Grand Total</b>	<b>\$4,868,974</b>		<b>\$0</b>		<b>\$2,882,950</b>		<b>59.2</b>



## Network Opportunities by Service Type

The table below provides further detail by service type and is organized by lowest network penetration rate (by dollars). A low network penetration rate may indicate the need for additional providers of this type of service or member dissatisfaction with the provider panel.

Service Type	Network Charge	Non Network Charge	Network Penetration
Rural Health Clinic	\$35	\$300	10.5 %
Comprehensive Outpatient Rehabilitator	\$1,150	\$1,766	39.4 %
Ambulatory Surgical Center	\$6,498	\$8,719	42.7 %
Outpatient Hospital	\$878,759	\$621,355	58.6 %
Other Place of Service	\$950	\$588	61.8 %
Office	\$670,053	\$307,168	68.6 %
Emergency Room Hospital	\$208,041	\$89,661	69.9 %
Inpatient Hospital	\$1,484,501	\$421,507	77.9 %
Home	\$74,608	\$17,731	80.8 %
Independent Laboratory	\$58,962	\$4,027	93.6 %

## Plan Design and Network Performance

Plan design performance is evaluated by looking at net payments as a percentage of total covered charges (before discounts). This “benefit to charge ratio” is used to assess what the plan paid as a percentage of the gross charge from the various provider types (PAR vs. Non-PAR). Network charges are offset by discounts and plan design (deductibles, coinsurance, etc.), whereas non-network charges are usually offset by plan design only. A typical goal would be to have the plan pay approximately the same net percentage regardless of provider used. When available, network discounts have been reported.



## Specific Provider Utilization

The tables below specifically identify the top ten providers within each of the major place of service categories previously referenced. Each table ranks the group of providers by total charges flowing through the particular provider source. If a significant number of non-PAR providers appears in these tables, it may be appropriate to evaluate education or other contracting options for the particular geographic area involved. Additional detail is available via drill down analysis as necessary.

<b>Top Facilities - Inpatient</b>				
	<b>Network</b>	<b>Admits</b>	<b>Total Charges</b>	<b>Charge Per Admit</b>
ATHENS REGIONAL MEDI, CAL CENTER	PAR	5	\$195,359	\$39,072
NORTHEAST GEORGIA ME, DICAL CENTER	PAR	4	\$88,075	\$22,019
QHG OF SC,INC(DBA)CA, ROLINAS HOSPITA L	PAR	2	\$60,707	\$30,353
CAROLINAS MEDICAL CE, NTER-561398929	PAR	1	\$57,492	\$57,492
MACON NORTHSIDE,	PAR	1	\$56,722	\$56,722
MEDICAL CENTER OF CE, NTRAL GEORGIA	PAR	1	\$54,081	\$54,081
SHELBY BAPTIST MEDIC, AL HOSPITAL	PAR	3	\$51,961	\$17,320
STEPHENS COUNTY HOSP, ITAL	PAR	5	\$47,846	\$9,569
TALLAHASSEE COMMUNIT, Y HOSP.	PAR	1	\$43,841	\$43,841
HOLLIDAY, PETER	PAR	1	\$42,026	\$42,026

<b>Top Facilities - Outpatient</b>				
	<b>Network</b>	<b>Visits</b>	<b>Total Charges</b>	<b>Charge Per Visit</b>
DCA-ROYSTON,	NON-PAR	6	\$89,642	\$14,940
PALMYRA MEDICAL CENT, ER-581091107	NON-PAR	11	\$69,804	\$6,346
ATHENS REGIONAL MEDI, CAL CENTER	PAR	14	\$59,375	\$4,241
STEPHENS COUNTY HOSP, ITAL	PAR	58	\$53,273	\$919
PHOEBE PUTNEY HOSP,	NON-PAR	21	\$39,896	\$1,900
GRADY GENERAL HOSPIT, AL	NON-PAR	10	\$37,244	\$3,724
PARKWAY MEDICAL CENT, ER	NON-PAR	7	\$32,245	\$4,606
SPALDING REGIONAL HO, SPITAL	PAR	6	\$30,222	\$5,037
FAIRVIEW PARK HOSPIT, AL	NON-PAR	9	\$29,118	\$3,235
FORDYCE, JAMES W	NON-PAR	5	\$22,329	\$4,466

<b>Top Professional</b>				
	<b>Network</b>	<b>Visits</b>	<b>Total Charges</b>	<b>Charge Per Visit</b>
BETHESDA CANCER CENT, ER	PAR	14	\$14,265	\$1,019
SOUTHEASTERN GYNECOL, OGIC ONCOLOGY	PAR	6	\$12,568	\$2,095
DIAGNOSTIC SERVICE,	NON-PAR	2	\$9,406	\$4,703
THE CENTER FOR WOMEN, 'S HEALTH, P-582327608	PAR	18	\$7,320	\$407
MULTI-CARE HEALTH &, REHAB, LLC	NON-PAR	28	\$7,146	\$255
AMERI SOUTH MOBILITY,	NON-PAR	1	\$7,000	\$7,000
COAN, MARC S	PAR	51	\$6,945	\$136
COLONIAL FAMILY PRAC, TICE	PAR	7	\$6,875	\$982
FORDYCE, JAMES W	NON-PAR	20	\$6,860	\$343
MEDICAL RESOURCES II,, INC	NON-PAR	1	\$6,806	\$6,806



## Large Claim and Potential Emerging High Risk Analysis

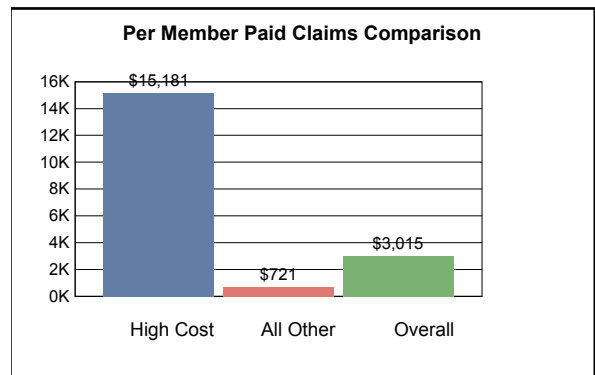
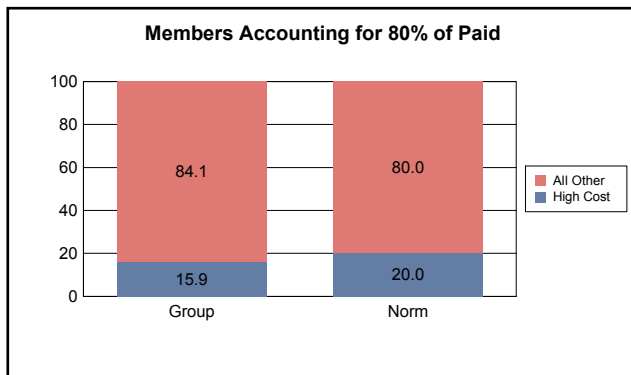
Catastrophic events and costly episodes of care can have a negative impact on overall plan performance. Additionally, they can skew actual performance causing decisions to be made on individual episodes versus overall trends. This section identifies cases where total paid dollars exceed a certain amount and separately reports on performance of various subsets of claims.

When used in the tables and graphs below, the term “high cost” reflects those members accounting for 80% of total paid claims.

### Large Claims

% of Members	Members	Total Paid Claims	Avg Paid Per Member	% of Total	Avg Paid Per Member-Norm	% of Total-Norm
1%	12	\$875,758	\$72,980	25.3%	\$138,933	28.0%
2-5%	46	\$970,663	\$21,101	28.1%	\$34,683	28.0%
6-15%	117	\$889,059	\$7,599	25.7%	\$11,413	23.0%
16-30%	175	\$426,816	\$2,439	12.3%	\$4,279	13.0%
31-60%	350	\$243,700	\$696	7.1%	\$1,280	8.0%
61-100%	467	\$52,262	\$112	1.5%	\$180	1.0%

### High Cost PMPM Impact



### High Cost Diagnoses

Diagnostic Group	Total Paid Claims for Condition	Members	Average Paid Per Member
Intervertebral Disc Disorders	\$201,950	17	\$11,879
Gynecological Disorders	\$173,613	37	\$4,692
CAD +/- CABG	\$170,610	10	\$17,061
Gall Bladder Disease	\$139,421	13	\$10,725
Pregnancy Complications	\$106,883	21	\$5,090
Joint Derangement and Other	\$70,297	29	\$2,424



## Potential Emerging High Risk Members

This analysis looks for individuals who have not incurred high dollar amounts, yet are presenting a number of factors that raise their risk index. These are people who carry a high risk to consume health care resources, but have not yet incurred high costs. In other words, the opportunity to intervene may still exist for these individuals.

Our process makes use of diagnostic codes, procedure codes, pharmacy codes, and quality indicators. Each diagnostic code, procedure code, and drug has been assigned a numeric value (based on expert assessment of the degree of risk associated with the drug, diagnosis, or procedure). These values are summed, for individual patients, to yield the Risk Index (RI). If a negative quality indicator exists (such as no HbA1c tests for a diabetic) it acts as a multiplier and increases the Risk Index. The higher the index is the more likely high cost claims will occur. Any individual with a Risk Index greater than 20 is considered High Risk (HR) in this analysis. All others are defined as Low Risk (LR).

The table below further segregates High Risk claimants between High Cost (HC) and Low Cost (LC). High Cost members are those that have incurred claims in excess of \$20,000. All others are defined as Low Cost. The purpose of the table below is to illustrate the variance in cost between HRHC members and HRLC members. On a global basis, it demonstrates the potential future cost if care for High Risk Low Cost (HRLC) members is not actively managed.

### Member Risk Profile

	Members	% of Membership	Per Member Costs	Total Costs
High Risk High Cost (HRHC)	25	2.2%	\$46,056	\$1,151,411
High Risk Low Cost (HRLC)	73	6.4%	\$7,102	\$518,480
All Other	1,049	91.5%	\$1,705	\$1,788,366

### Clinical Risk Exposure

Very often, there are common diseases present in both the HRHC and HRLC groups. Exposure to risk is calculated by taking the per member (PM) costs of the group currently expending high resource (HRHC) and extrapolates the potential high cost end point to the HRLC members. The table below summarizes the potential cost associated with specific conditions that are not managed proactively.

Disease	HRHC Members (a)	HRLC Members (b)	HRHC PM Costs (c)	HRLC PM Costs (d)	Variance (e = c - d)	Change to HRHC Exposure (f = e * b)
CAD +/- CABG	5	4	\$32,683	\$1,651	\$31,032	\$124,127
Intervertebral Disc Disorders	7	7	\$22,915	\$1,237	\$21,678	\$151,744
Misc Urinary Symptoms	1	3	\$62,846	\$87	\$62,759	\$188,277
Pneumococcal and Other Pneumonia	3	4	\$20,326	\$85	\$20,242	\$80,966
Secondary Malig Lymph nodes, Resp, D	1	2	\$51,581	\$497	\$51,084	\$102,169
Pregnancy Complications	2	10	\$21,120	\$1,167	\$19,954	\$199,536
Gall Bladder Disease	4	2	\$8,134	\$6,697	\$1,437	\$2,873
Atrial Fibrillation and Flutter	3	1	\$10,618	\$0	\$10,618	\$10,618
Misc diseases of respiratory system	3	1	\$9,270	\$66	\$9,204	\$9,204
Malig Neoplasm Kidney	2	2	\$12,197	\$2,009	\$10,188	\$20,375
<b>Total Potential Exposure</b>						<b>\$889,889</b>



## Lifestyle, Preventative and Chronic Issues

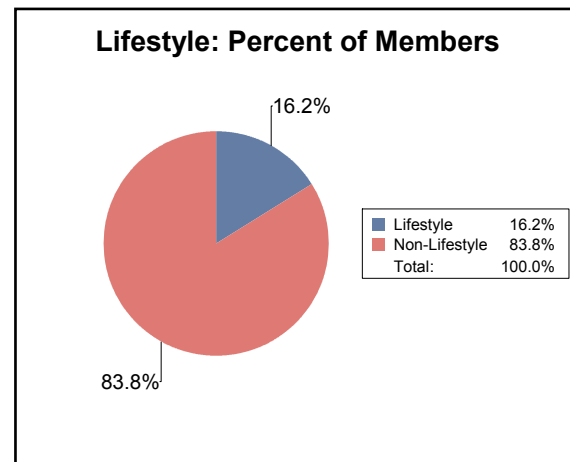
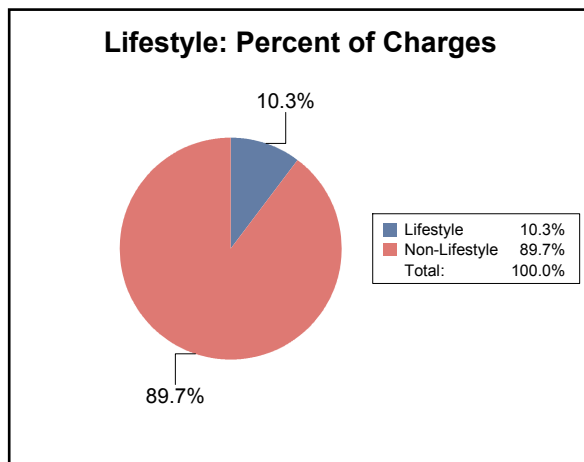
This section presents a review of opportunities as they relate to member lifestyles or specific preventable or chronic conditions within your group. Throughout this section of the analysis, we work to identify the percentages of claims attributable to specific conditions as well to identify the percentage of the population that may represent opportunity for improvement.

### Lifestyle Related Claims

Lifestyle related claims represent medical claim dollars associated with conditions linked to certain behaviors. These behaviors have been quantifiably linked with medical diagnoses identified in the National Center for Healthcare Statistics “Healthy People 2000” initiative, as well as internal research and review. Because members often have multiple conditions, claims may be included in multiple areas.

The choices members make in terms of lifestyle behaviors can be driven by complicated influences. These choices ultimately can influence how the member feels as well as the costs they represent to the health plan. By understanding what lifestyle choices have the greatest impact on your health plan, strategies in the area of consumerism and wellness can be initiated.

### Total Cost Impact of Lifestyle Related Claims



### Cost Breakdown by Lifestyle Behavior

Lifestyle Group	Members	Lifestyle Related Charges	All Medical Charges	Lifestyle Per Member	All Medical Per Member
Chronic Liver Disease or Cirrhosis	3	\$3,555	\$81,567	\$1,185	\$27,189
COPD	51	\$35,137	\$460,342	\$689	\$9,026
Coronary Heart Disease	29	\$286,546	\$973,570	\$9,881	\$33,571
Diabetes	45	\$25,763	\$1,022,413	\$573	\$22,720
High Cholesterol	86	\$18,150	\$1,138,030	\$211	\$13,233
Morbid Obesity	6	\$35,507	\$276,286	\$5,918	\$46,048
Skin Cancer	9	\$23,655	\$172,642	\$2,628	\$19,182
Stroke	9	\$36,023	\$229,535	\$4,003	\$25,504
Substance Abuse or Dependence	5	\$36,596	\$62,358	\$7,319	\$12,472
Tobacco Use Disorder	3	\$233	\$9,041	\$78	\$3,014

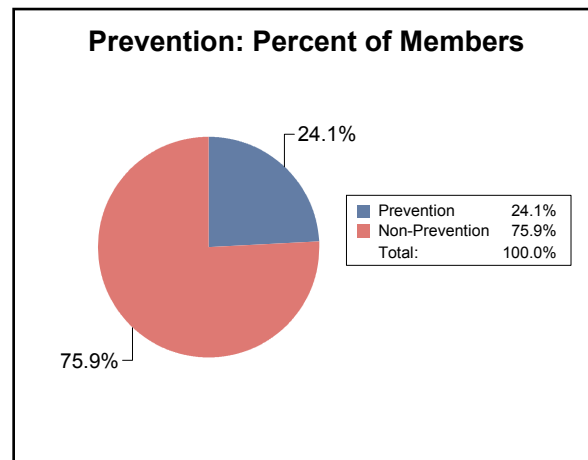
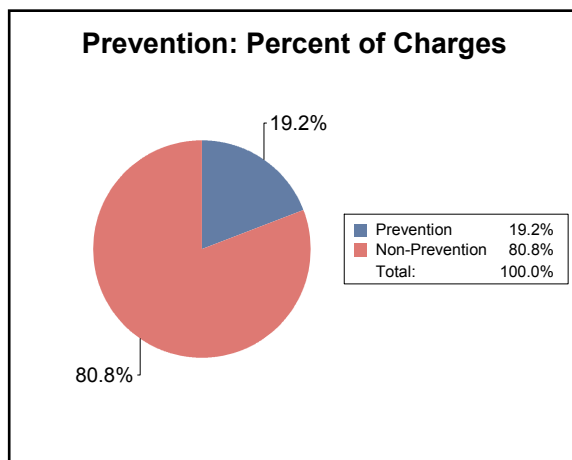


## Prevention Opportunities

Certain conditions may be preventable or result in reduced severity through early detection and proactive management. This section helps outline the incidence of these conditions in your population and look for additional opportunities to intervene.

Once identified, preventable conditions with the greatest impact in your health plan can be targeted with specific initiatives. This can be done by utilizing a variety of resources including wellness programs, current vendor relationships, medical care management programs such as case management, utilization management, disease management and community partners.

### Total Cost Impact of Prevention Claims



### Cost Breakdown by Prevention Category

Prevention Group	Members	Prevention Related Charges	All Medical Charges	Prevention Per Member	All Medical Per Member
Asthma	27	\$6,143	\$176,727	\$228	\$6,545
Breast Cancer	2	\$2,673	\$5,700	\$1,336	\$2,850
Colorectal Cancer	1	\$2,279	\$9,811	\$2,279	\$9,811
Coronary Heart Disease	29	\$286,546	\$973,570	\$9,881	\$33,571
Depression	21	\$45,518	\$282,267	\$2,168	\$13,441
Diabetes	45	\$25,763	\$1,022,413	\$573	\$22,720
Fetal Complications	7	\$16,228	\$129,821	\$2,318	\$18,546
Fetal Morbidity/Mortality	2	\$2,414	\$28,759	\$1,207	\$14,379
High Blood Pressure	85	\$37,026	\$1,003,547	\$436	\$11,806
High Cholesterol	86	\$18,150	\$1,138,030	\$211	\$13,233
Maternity	56	\$399,027	\$603,457	\$7,125	\$10,776
Morbid Obesity	6	\$35,507	\$276,286	\$5,918	\$46,048
Skin Cancer	9	\$23,655	\$172,642	\$2,628	\$19,182
Stroke	9	\$36,023	\$229,535	\$4,003	\$25,504

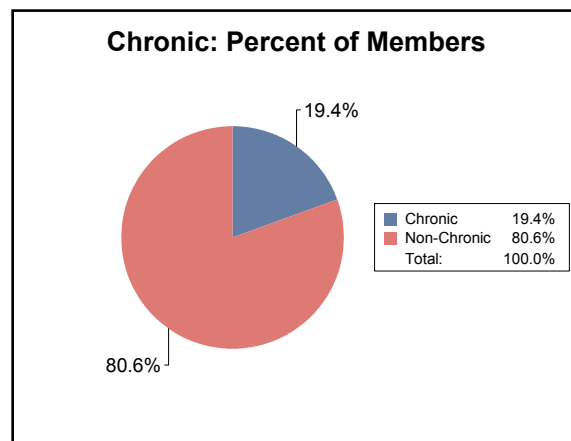
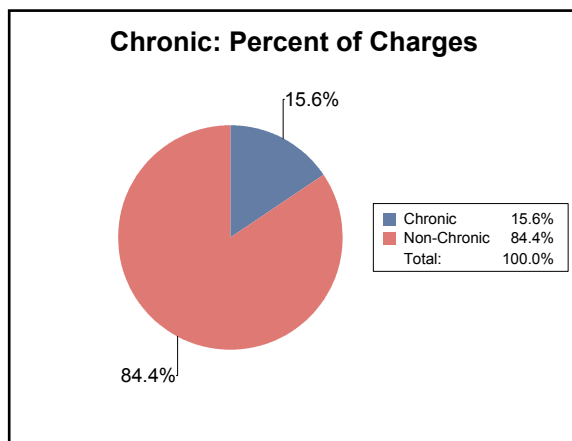


## Chronic Illness

Certain conditions are chronic and ongoing in nature. These diseases usually have a normal progress of increasing severity and cost if not treated properly. This section helps outline the incidence of these conditions in your population and looks for additional opportunities to intervene.

Once identified, the chronic conditions with the greatest impact in your health plan can be targeted with specific initiatives. This can be done by utilizing a variety of resources including wellness programs, current vendor relationships, medical care management programs such as case management, utilization management, disease management and community partners.

### Total Cost Impact of Chronic Illness



### Cost Breakdown by Chronic Illness

Chronic Group	Members	Chronic Related Charges	All Medical Charges	Chronic Per Member	All Medical Per Member
Asthma	27	\$6,143	\$176,727	\$228	\$6,545
Atherosclerosis	2	\$1,092	\$7,450	\$546	\$3,725
CHF	4	\$1,457	\$388,777	\$364	\$97,194
COPD	51	\$35,137	\$460,342	\$689	\$9,026
Coronary Heart Disease	29	\$286,546	\$973,570	\$9,881	\$33,571
Depression	21	\$45,518	\$282,267	\$2,168	\$13,441
Diabetes	45	\$25,763	\$1,022,413	\$573	\$22,720
Intervertebral Disorders	35	\$301,358	\$790,158	\$8,610	\$22,576
Low Back Syndrome	64	\$57,660	\$692,545	\$901	\$10,821



## Potential Delivery or Quality Issues

This section summarizes how care is being provided to members relative to certain generally accepted standards. Your experience is evaluated noting areas where your group performs below or above expectations. If the percentage meeting the quality criteria is low, it may be appropriate to provide additional member education or to evaluate provider practice patterns more closely.

Quality issues are reviewed over the total data set period, which may not be the same as the preceding sections. Additionally, criteria for defining groups of members (e.g. diabetics) can vary from the preceding sections. As such, there may be variations in the numbers of members identified.

Issue	Criteria	# of Members	Meeting Criteria	Not Meeting Criteria	% Meeting Criteria
Atrial fibrillation	Anticoagulated	2	1	1	50.00%
Atrial fibrillation + anticoagulation	Monthly protime	1	1	0	100.00%
CHF	ACE inhibitor, ARB, or vasodilator	2	2	0	100.00%
CHF	ACE inhibitor, or ARB, or vasodilator, and a beta blocker	2	0	2	0.00%
MI	On beta-blockers	3	2	1	66.67%
MI	On a statin	3	0	3	0.00%
Diabetes	Annual HgbA1c test	33	21	12	63.64%
Diabetes	Annual eye exam	33	11	22	33.33%
Diabetes	Annual lipid profile	33	23	10	69.70%
ER visits	No ER visits on Saturday and/or Sunday	254	164	90	64.57%
ER visits	No more than 1 ER visit within 12 months	254	210	44	82.68%
>60 y/o with >3 Rx	Visit PCP every 6 months	19	0	19	0.00%
Anti-Hyperlipidemic agents	Annual liver function tests	71	36	35	50.70%
Cancer	Injectable chemotherapy for cancer diagnosis	13	1	12	7.69%
Hospitalized members	PCP visit within 7 days	130	0	130	0.00%
Migraine headaches		9	8	1	88.89%
Physical medicine		104	42	62	40.38%
Women having breast ultrasound	Office visit within 30 days	12	8	4	66.67%
Women >20 y/o	Pap smear at least every 2 years	542	260	282	47.97%
Women >49 y/o	Annual mammogram	91	32	59	35.16%



## **Summary and Recommendations**



## **Data Technologies**



## Appendix A: Glossary

**ACE Inhibitor** Any of a class of drugs that cause vasodilation (the expanding of a blood vessel) and are used to treat hypertension and heart failure.

**AMA** American Medical Association. The non-profit organization develops and promotes standards in medical practice, research, and education. The AMA develops and publishes the Current Procedural Terminology codes (see CPT-4).

**Ambulatory** Services performed in an outpatient setting.

**Anticoagulant** Chemical that prevents the clotting of blood.

**Atrial Fibrillation** Muscular twitching involving individual muscle fibers of the atria acting without coordination; carries with it a significant risk for stroke.

**ASW** Age Sex Weight. This is a factor used to adjust population results based upon age and sex. I-On uses your data to create a population specific ASW factor for comparative purposes.

**Barrett's Esophagus** Pre-cancerous condition arising in members with chronic reflux of stomach contents into the esophagus.

**Beta Blocker** Any of various drugs used in treating hypertension or arrhythmia; decreases force and rate of heart contractions by blocking certain receptors of the autonomic nervous system.

**CABG** Coronary Artery Bypass Graft. Procedure that involves replacing diseased (narrowed) coronary arteries with veins obtained (grafted) from the patient's lower extremities. This procedure has proven to extend the lives of individuals with coronary artery disease.

**CAD** Coronary Artery Disease. When the coronary arteries become narrowed or completely occluded; ultimately, this is the underlying cause of a heart attack.

**Carpal Tunnel Syndrome** A condition characterized by pain and numbing or tingling sensations in the hand and caused by compression of a nerve in the carpal tunnel at the wrist.

**Case Management** Also referred to as Care Management; it is a clinical program that provides the management and coordination of patient care service for high-risk individuals in the community. The goal is to identify the high-risk individuals and intervene with an effective management plan. The program's key functions are patient screening, assessments, care planning, ongoing monitoring and evaluation.

**CCI** Correct Coding Initiative. The Centers for Medicare and Medicaid Services (CMS) developed the National Correct Coding Initiative to promote national correct coding methodologies and to eliminate improper coding. The CCI edits are based on CPT coding conventions, current standards of medical and surgical coding practice, input from specialty societies, and analysis of current coding practice.



**CHF** Congestive Heart Failure.

**CMMS** Centers for Medicare and Medicaid Services (Formerly HCFA). The organization is a division within US Health and Human Services and is responsible for administering the Medicare program.

**Colonoscopy** Visual examination of the colon with a lighted scope.

**Co-morbidity** The presence of coexisting or additional diseases with reference to an initial diagnosis or with reference to the index condition that is the subject of study; having two or more conditions at one time.

**Consult Upcoding** When a referring physician submits a follow up consult code within 14 days after the date of an initial consult.

**COPD** Chronic Obstructive Pulmonary Disease.

**CPT-4** Common Procedural Terminology. Standard codes for procedures and services. Licensed from the AMA. Currently in its 4<sup>th</sup> edition.  
Nomenclature: five numeric digits (12345).

**Cycle Period** Beginning and end date of claims contained in database; based on incurred date of service.

**Demography** The age, sex, city, state, zip code, and phone number of the population contained in I-On.

**Diagnosis** The act or process of identifying or determining the nature and cause of a disease or injury through evaluation of patient history, examination, and review of laboratory data. The opinion derived from such an evaluation.

**Diuretics** Substance that causes less water to be reabsorbed by the kidney; causing water to be excreted from the body.

**DME** Durable Medical Equipment. These items assist the recovering patients receive their care at home and the following items are representative of the category: canes, walkers, wheelchairs, and oxygen tanks

**DRG** Diagnosis-Related Group. A system for classifying inpatient care by relating common characteristics such as diagnosis, treatment, and age to an expected consumption of hospital resources and length of stay. Its purpose is to provide a framework for specifying case mix and to reduce hospital costs and reimbursements and it forms the cornerstone of the prospective payment system.

**Dx** Diagnosis. Please see Diagnosis.

**ER Frequent Fliers** Members who have more than **two** ER visits within a one year period.

**ERM** Evaluate and Management CPT4 procedure codes.



**Esophagitis** Inflammation of the esophagus (long tube that runs from the pharynx to the stomach).

**ETG** Episode Treatment Groups. An industry standard for illness classification that captures all clinically relevant services and prescriptions provided during a patient's treatment and organizes the data into "episodes of care."

**Event** Usually an event is a Service unit equals claims line. Some clients use business rules to classify all the treatments associated with one hospital admission as a single event.

**Events per 1000** The per 1000 represents 1000 members for a complete year. The most typical Event per 1000 is Hospital Days / 1000. Benchmarks are developed to compare one group to another to determine the effectiveness of their plans.

**Fund Type** Medical Groups entering risk contracts have segregated their risks depending upon which fund the claim is charged. There are usually 3 funds: professional, institutional, and pharmacy. Segregation by fund represents the amount of control the physician group has in controlling that specific type of costs.

**Global Fee Period** AMA and HCFA recognize that most surgical procedures that are performed as part of the entire surgical package. In many cases, these codes are billed for different dates of service, but some can be billed on the same date of service.

**HCFA** Health Care Financing Administration that is now the Center for Medicare and Medicaid Services. Please see CMMS.

**HCPCS** HCFA Common Procedure Coding System. Standardized coding system used to process Medicare claims. Nomenclature: Alphanumeric five characters (A1234).

**HEDIS** Health Plan Employer Data and Information Set. Standardized performance measurements designed to ensure that purchasers and consumers have information necessary to reliably compare the performance of managed health care plans. Sponsored and maintained by the National Committee for Quality Assurance (NCQA). Currently in its 3<sup>rd</sup> edition.

**High Drug Cost Mbrs** Members with greater than \$1,000 in commercial pharmacy benefit spend or \$3,000 in Medicare pharmacy benefit for the cycle period.

**HIPAA** Health Insurance Portability and Accountability Act

**IBNR** Incurred But Not Reported. This is an accounting term that estimates the dollar amount of medical expenses that have been incurred but not yet been paid.

**ICD-9** International Classification of Diseases. Standard diagnoses codes used to identify member's medical problem or condition. It is used by most ambulatory care settings and recognized by most insurance carriers. Currently in this 9<sup>th</sup> revision.



**Imputed Primary Physician** Physician who provides the initial care for a patient, and may refer the

**Physician** patient to a specialist; used by I-On consulting medical directors.

**In-Network** Member that has services provided within a predefined network of providers and vendors, typically at a nominal cost to member. Lipid Profile usually includes the total cholesterol, high density lipoprotein cholesterol, triglycerides, and the calculated low density lipoprotein cholesterol.

**MAP** Medical Action Plans. See Care Management.

**Medicaid** A program in the United States, jointly funded by the states and the federal government, that reimburses hospitals and physicians for providing care to qualifying people who cannot finance their own medical expenses.

**Medicare** Medical Care; A program under the U.S. Social Security Administration that reimburses hospitals and physicians for medical care provided to qualifying people who are usually over 65 years old.

**Member** A member is either a subscriber or a dependent. When all Subscribers and Dependents are combined together, they represent the total membership.

**Member Months** Each month that a member has medical coverage is considered a "member month". A member having coverage for a complete year has 12 member months.

**Myocardial Infarction** Destruction of heart tissue resulting from obstruction of the blood supply to the heart muscle. Also called a "heart attack".

**NDC** National Drug Code. Industry standard for drug classification and serves as a universal product identifier for human drugs. Nomenclature: 10-digit, 3-segment number.

**Out-of-Area** Typically used to define a geographical area (30-mile diameter as in-area)

**Panel A** group of members that are assigned to a PCP or business unit. (Levels I - IV in I-On are considered panels of members.)

**PBM** Pharmacy Benefit Manager. Most employers and health plans contract with a PBM to coordinate all the activities relating to paying and tracking pharmacy claims. Examples: AdvancePCS, Caremark, Express Scripts, MedImpact.

**PCP** Primary Care Physician. PCPs provide general health and well being care to membership. Health plans may use PCPs as gatekeepers (see Gatekeepers). The *PCP* also refers to the 4<sup>th</sup> level of data aggregation within the I-On Hierarchy.



**PCP Type** Types of primary care physicians include: General Practitioners, Family Practice and Internal Medicine. Some health plans will consider OB/GYN as PCPs. *PCP Types* also refers to the 3<sup>rd</sup> level of data aggregation within the I-On hierarchy.

**Plan Type** Can be either Commercial or Medicare. *Plan Type* also refers to the highest level of data aggregation within the I-On hierarchy.

**PMPM** Per Member per Month. Medical costs are typically expressed in PMPM. The calculation is a function of total spend (for selected category) over total applicable member months. Please see *Member Months*.

**POS** Point of Service. This type of plan allows members to “opt-out” of getting a referral from their PCP prior to treatment. However, the member usually will have a higher copayment or coinsurance.

**PPO** Preferred Provider Organization. This type of plan allows to members to see any physician or allied health care provider in the network without a referral. Typically PPOs have a coinsurance and copayment.

**Preferred Vendor** Vendor designated as being vendor-of-choice and therefore, members are encouraged to use these vendors.

**Prescribing Physician** The physician who write the prescription for the drug for the patient.

**Procedure** The member is has a treatment performed by an allied health provider. The treatment may be laboratory, radiology, surgery, etc.

**Procedure Upcoding** The upcoding of a procedure to a more expensive code due to either intentional misuse, a lack of understanding of a code’s definition, or a general miscoding of a procedure

**Proton Pump Inhibitor** A group of anti-ulcer medications.

**Provider** Institution or professional which provides healthcare services to patients

**Revenue Code** Standardized hospital major revenue-producing centers; identify categories of service like lab, pharmacy and nuclear medicine. Hospitals use codes to group charges for itemized hospital services. Nomenclature: alphanumeric (R-123).

**Rx** This is a standard abbreviation for a Prescription or Pharmacy claim.

**Rx Class** Please see Therapeutic Class.

**Service** In I-On, refers to location where visit, procedure, or “service” etc was performed. EG: Inpatient, Outpatient, SNF, Emergency, etc.

**Service Units** These are also referred to as treatment units. Certain ancillary procedures will perform multiple treatment units during a visit. Physical Therapy and Respiratory Therapy are examples. The intensity of the service is measured by review the number of services units per visit on average for the population. *I-On defines a Service Unit as a Claim.*



**Specialty** An area of concentration, focus or expertise for the healthcare professional. Examples include Pediatrics, Cardiology, Physical Therapy, Oncology, Internal Medicine, etc.

**Spike** Fluctuation in cost or utilization compared to similar entities. The average cost or utilization being defined as 1.0. A spike of 3.0 indicates the cost of utilization is 300 percent or three times the average for the providers in the database.

**Statins** Any of a class of lipid-lowering drugs that reduce serum cholesterol.

**Subscriber Flag** Identifies member's status within the health plan where "S" is used for the subscriber and "D" for dependent.

**Surface Fund** Fund type/referred to also as SVC Fund.

**Team Groups** within a TPA

**Therapeutic Class** Classification of drugs relating to the treatment of like diseases or disorders. EG: Therapeutic class = Antihistamines. Drugs within this class include (brand name) = Allegra, Claritin, Flonase, etc.

**Time Period** Medical and Rx Explorer data can be broken down into yearly, quarterly, and monthly time periods.

**TNF** Tumor Necrosis Factor

**TOS** Type of Service. Please see Service.

**Total Cost for Cohort** The cost incurred for the Age/Sex band on the Member Demographics for the whole group during the study time period.

**TPA** Third Party Administrator. Within self-funded employer plans, the TPA is the entity responsible for administering health plan on behalf of the employer. Usually they will handle eligibility and adjudication of medical, dental and vision claims at a minimum.

**UM** Utilization Management. The UM Company is the entity responsible for managing high cost patients covered under a health plan. Historically, most UM Companies have concentrated on reducing the Hospital length of stay and diverting hospital admissions since Hospital costs account for 50% of the medical dollar spent.

**Unbundling** Billing services separately that should be billed using one code for the same patient, same provider, and same date of service

**Unique Member** A member may have many treatments by the same provider. When determining how many members are being treated, the member is only counted once. The single count of the member is called a unique member.

**Vendor** The entity paid for the service. The Vendor may be a hospital, physician, or allied health provider. Examples: laboratory, pharmacy, surgeon, imaging center, etc.

THE MANAGED HEALTHCARE DATA GUYS