Milliman MedInsight Employer Group Report

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Employer Group Report

Prepared for: Dane County

Based on Claims Incurred from:

July 2014 through June 2015

November 13, 2015

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I. Introduction

The data provided throughout this report is based on Dane County's specific claim information for the reporting period. WEA Trust's overall book of County/Municipality business is used to provide comparative benchmarks. In addition, the report will provide certain comparative data using Milliman Regional Benchmarks for commercial health plans. WEA Trust utilizes the Milliman MedInsight reporting tool to provide utilization, benchmark, and financial data. This report is designed to best represent a true financial and utilization picture for your specific insured population. A rigorous review and reconciliation process occurred to verify the accuracy and completeness of the data used to support this report.

Reporting Dates

This report is based on all paid medical and pharmacy claims that were incurred with dates of service between December 2013 and June 2015 that were paid by the health plan prior to September 2015. We have included 3 months of claims run out to more fully account for the time lag between when a claim is incurred and when it is presented for payment. No completion factors were used for the development of this report. For comparative purposes, we have included two distinct time periods.

A summary of premiums, allowed charges and plan paid amounts by incurred year/month is provided in section 8.1 to help you reconcile the data in these exhibits to your financial reports.

Claim Experience

Prior period	: December 2013 through June 2014, paid through September 2015
Current period	: July 2014 through June 2015, paid through September 2015

Risk Scores

Prior	: June 2014
Current	: June 2015

EBM

EBM Ending Month	: June 2015

Data Availability

The report is built using medical and pharmacy claims data as well as membership, enrollment and provider information. Milliman relies on the data availability of WEA Trust when running this report. Throughout the report, you will find both paid amount and allowed amount metrics. The paid amount is the amount paid to the provider by the health plan on a claim and the allowed amount is the total amount paid to the provider from all sources.

Clients Included in This Report

- Dane County

Benchmarks

Throughout the report you will find comparisons of your actual data to WEA Trust comparative benchmarks and to Milliman benchmarks.

Comparative Benchmarks: The comparative benchmarks are a summary of WEA Trust's County/Municipality business loaded into and analyzed by the MedInsight system. The comparative benchmarks are not adjusted for demographic mix and average benefit design however, the risk scores can be used to understand the population differences.

Milliman Benchmarks: Milliman benchmarks were developed by summarizing Milliman's commercial database which is derived from data collected from health plans throughout the United States and includes about 87 million commercial member months of experience. The Milliman benchmarks are adjusted to account for WEA Trust's area factors (by MSA), demographic mix and average benefit design.

Financial Adjustments

Included in several tables in the report are financial amounts associated to fees and adjustments that are not specific to an individual member. These adjustments are comprised of items such as reinsurance premiums and recoveries, provider incentive programs and pharmacy rebates. These adjustments are calculated at an aggregate level and applied as a per member per month basis.

II. Executive Summary

This report provides Dane County with a summary of your healthcare information. The report covers a broad range of topics including population metrics, medical economics, pharmacy economics, preventive services and medical management. The tables and figures within the report provide financial, utilization and price metrics and how they have changed over time and how they compare to benchmarks. It also provides a comparison of the current time period to the prior time period.

The medical loss ratio provided in table 2.1 shows the percentage of Dane County's premiums that are spent on medical expenses by service category.

2.1: Prior Year and Current Year Total Paid Amounts

HCG Setting	Prior	Current	Trend
Average Members	3,800	6,595	73.6%
Medical Claims			
Facility Inpatient	$3,304,457	$5,909,849	78.8%
Facility Outpatient	$6,063,906	$10,601,959	74.8%
Professional	$10,031,387	$18,428,773	83.7%
Ancillary	$557,225	$1,336,958	139.9%
Pharmacy Claims			
Prescription Drug	$3,847,907	$7,801,346	102.7%
Total Premiums	$18,887,566	$34,244,244	81.3%
Total Paid Amounts	$23,804,881	$44,078,885	85.2%
Medical Loss Ratio (MLR)	126.0%	128.7%	

	Prior	Current	Trend
Medical Claims PMPM			
Facility Inpatient	$72.46	$74.67	3.0%
Facility Outpatient	$132.98	$133.96	0.7%
Professional	$219.98	$232.85	5.8%
Ancillary	$12.22	$16.89	38.2%
Pharmacy Claims PMPM			
Prescription Drug	$84.38	$98.57	16.8%
Total Premiums PMPM	$414.19	$432.68	4.5%
Total Claims PMPM	$522.03	$556.94	6.7%

It is important to compare your actual experience to other benchmarks. In table 2.2, as well as throughout the report, you will find comparisons of your experience to a WEA Trust comparative benchmark and a Milliman benchmark where appropriate. For most metrics you want your group's experience metric to be at or less than the benchmarks. It is important to note that the benchmarks are to be used as points of comparison and not absolute indicators of quality and efficiency.

The overall (MARA) average risk score is also provided so you can assess whether the health care risk of your population has increased from the prior period to the current period, and how the risk of your population compares to the average risk within WEA Trust comparative benchmark.

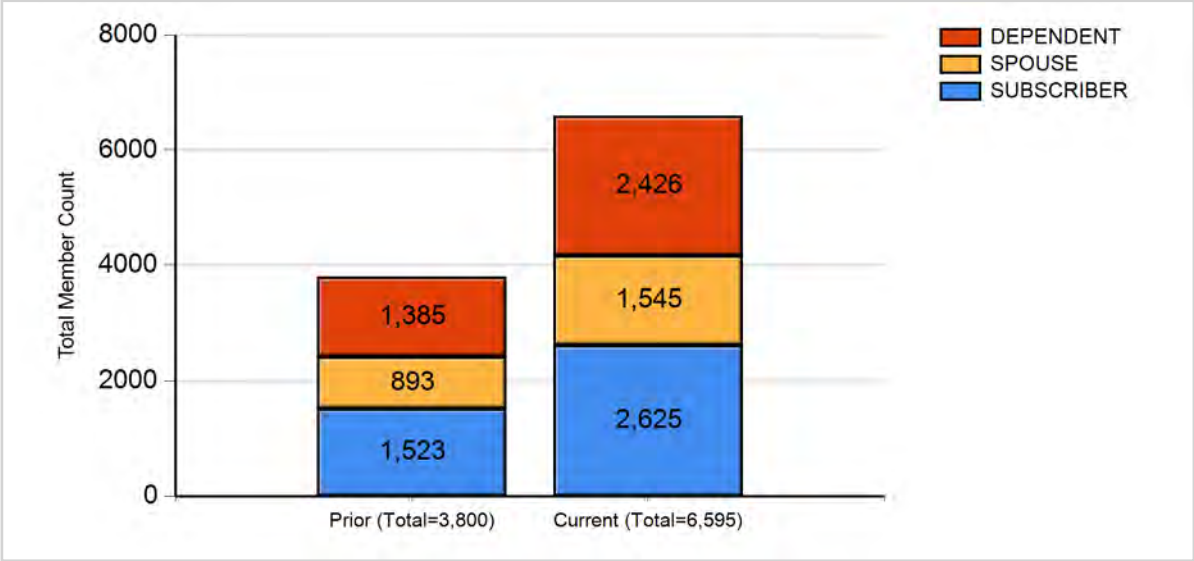
2.2: Current Year Health Cost Guideline (HCG) Category Benchmarks

HCG Categories	Utilization per 1000				
	Prior	Current	Trend	Comparative Benchmark	Milliman Benchmark
Hospital Inpatient Days	296.6	308.4	4.0%	278.1	262.4
I11 - Medical	63.4	92.6	46.1%	83.7	67.6
I12 - Surgical	78.4	92.0	17.4%	79.5	61.8
I13 - Psychiatric	12.1	17.3	42.8%	19.8	18.6
I14 - Alcohol and Drug Abuse	14.5	8.5	-41.3%	10.5	17.3
I21 - Mat Norm Delivery	19.2	13.8	-28.2%	14.3	13.5
I22 - Mat Csect Delivery	6.3	14.6	130.5%	13.5	9.0
I23 - Well Newborn	13.9	8.2	-41.3%	9.4	13.1
I24 - Other Newborn	6.6	8.9	36.0%	7.7	15.5
I25 - Maternity Non-Delivery	3.4	2.4	-29.1%	1.8	1.6
I31 - SNF	78.7	50.0	-36.4%	37.9	44.4
Hospital Outpatient Emergency Room	250.8	275.5	9.9%	258.5	167.8
Hospital Outpatient Radiology CT/MRI/PET	64.2	67.8	5.6%	67.8	57.4
Physician Office/Home Visits	3,293.1	3,319.1	0.8%	3,159.3	3,542.0
Prescription Drugs	13,713.9	13,027.8	-5.0%	12,267.8	
Concurrent Risk Score	*1.81*	*1.97*		*1.83*	

III. Population Metrics

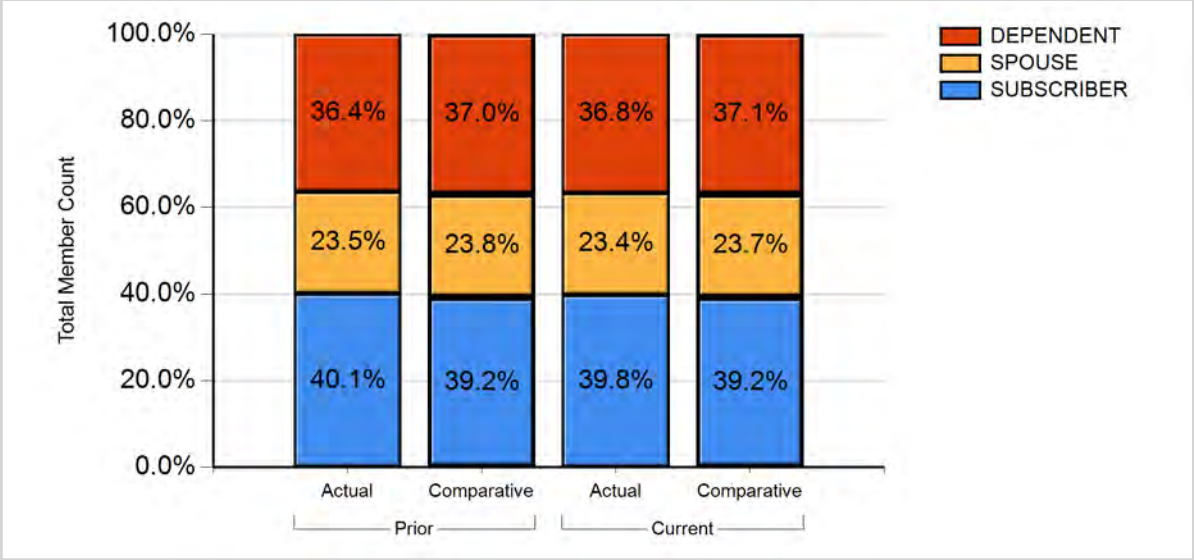
One important component to understanding your healthcare information is to understand your population. It is important to know the age, gender and relationship distribution of your population to understand the utilization and costs of services. For example, in figure 3.1 you will find your total population as well as the distribution of your population by relationship. If your employee to dependent ratio changes over time, it will impact your overall cost per employee. For example, if your percent of dependents to total members in the prior period increased in the current period, holding all other variables constant your cost per employee would go up.

3.1: Total Member Count by Relationship



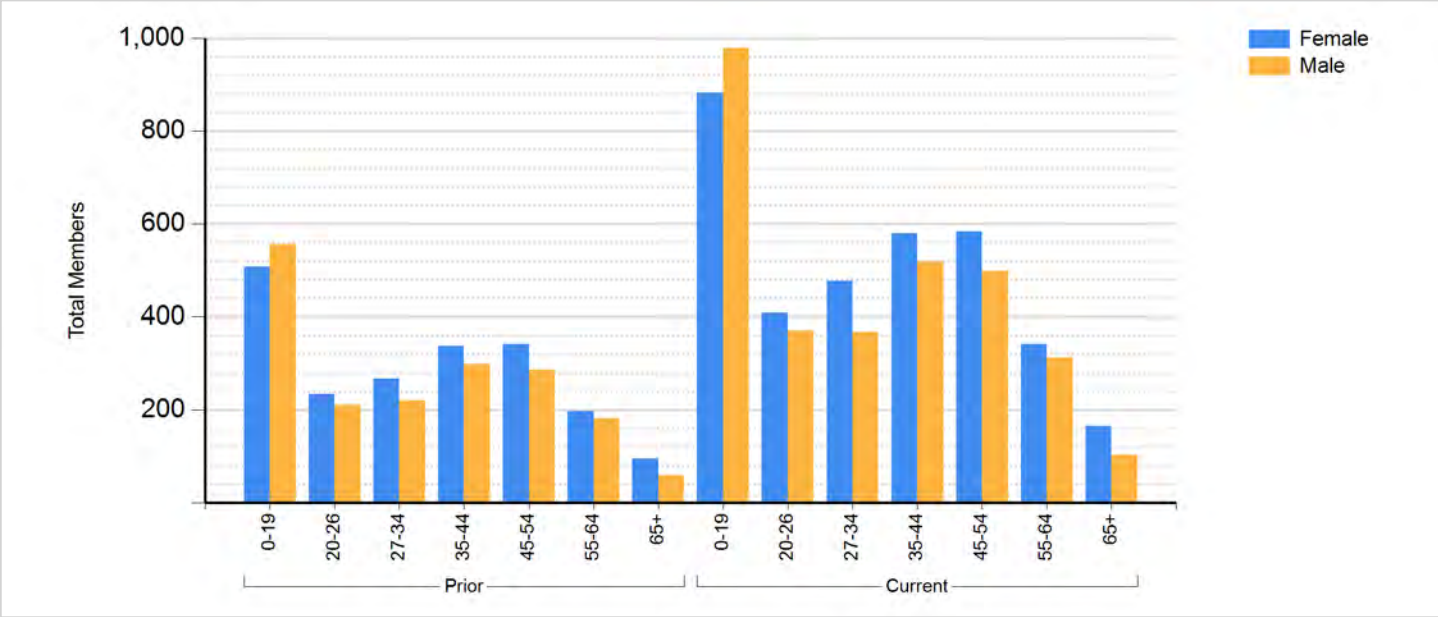
In figure 3.2 we have included a benchmark to help you understand where Dane County compares to other employers at WEA Trust.

3.2: Percent of Total Membership by Relationship



It is also important to understand your distribution of membership by age and gender. Males between the ages of 19 and 35 tend to be less costly than females of the same age range primarily due to maternity costs. Reviewing your age and gender distribution across multiple time periods provides some insight in predicting future years' healthcare spend.

3.3: Total Membership Age Distribution by Gender



In addition, understanding your population by tier provides insight on your healthcare expenditures by employee. In table 3.4 and table 3.5 we compare the current year and prior year tier coverage, paid amounts and percent of member cost sharing.

3.4: Tier Analysis for the Current Year

	Members	% Total	Paid	% Total	Paid PMPM	% Member Cost Sharing
Family	5,464	82.8%	$34,695,683	78.7%	$529.20	1.8%
Single	622	9.4%	$5,670,437	12.9%	$759.81	2.1%
Single Medicare	230	3.5%	$1,187,084	2.7%	$430.57	5.7%
Family Medicare	130	2.0%	$564,559	1.3%	$362.83	6.0%
Individual + spouse	73	1.1%	$1,260,584	2.9%	$1,439.02	1.5%
Special Medicare	63	1.0%	$606,959	1.4%	$802.86	2.5%
Special Medicare 2+Fmly	8	0.1%	$25,041	0.1%	$269.26	6.6%
Special Medicare 1+2	7	0.1%	$54,119	0.1%	$668.13	2.5%
Total	**6,595**	**100.0%**	**$44,078,885**	**100.0%**	**$556.94**	**2.0%**

3.5: Tier Analysis for the Prior Year

	Members	% Total	Paid	% Total	Paid PMPM	% Member Cost Sharing
Family	3,148	82.8%	$18,860,287	79.2%	$499.29	1.8%
Single	363	9.6%	$3,013,204	12.7%	$691.58	2.2%
Single Medicare	134	3.5%	$599,820	2.5%	$374.19	6.6%
Family Medicare	76	2.0%	$363,528	1.5%	$400.80	5.7%
Individual + spouse	42	1.1%	$646,465	2.7%	$1,287.78	1.4%
Special Medicare	30	0.8%	$199,969	0.8%	$555.47	4.0%
Special Medicare 2+Fmly	2	0.0%	$5,049	0.0%	$240.41	5.7%
Special Medicare 1+2	6	0.2%	$116,559	0.5%	$1,513.75	1.4%
Total	**3,800**	**100.0%**	**$23,804,881**	**100.0%**	**$522.03**	**2.1%**

IV. Medical Economics

This report utilizes Milliman methodologies to stratify claims into Health Cost Guideline (HCG) Categories. The HCG methodology classifies healthcare claims data into groupings of similar types of services and calculates utilization measures.

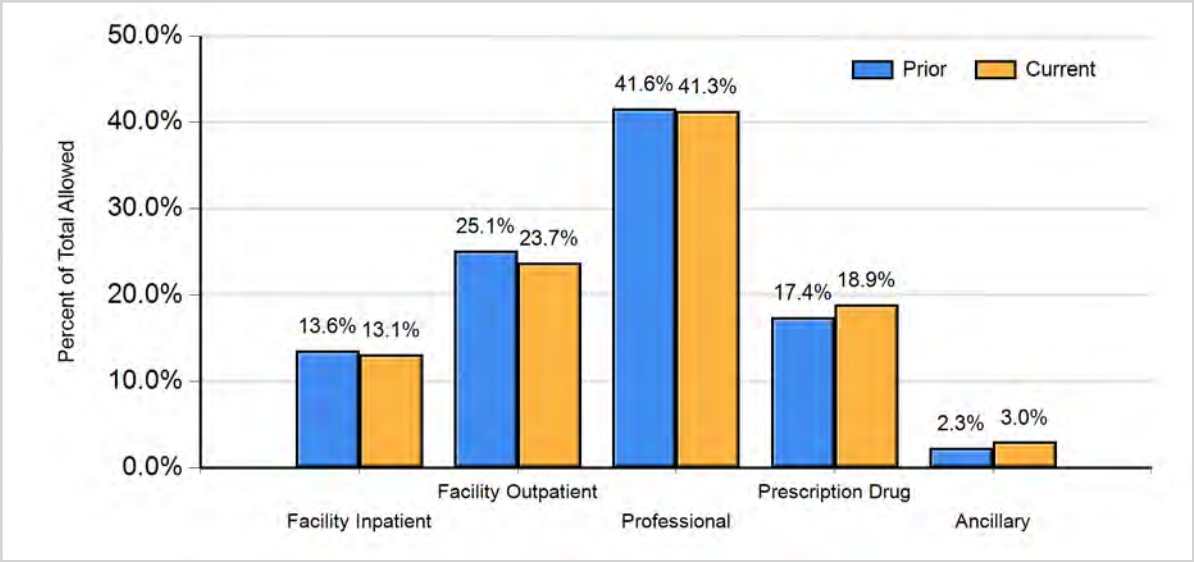
In table 4.1, you can compare current year, prior year, comparative benchmarks, and Milliman benchmarks for allowed PMPMs by high level HCG service category. The benchmark data was developed by summarizing Milliman's managed care database which is derived from data collected from health plans throughout the United States and includes about 81 million commercial member months of experience. The benchmarks are adjusted to account for WEA Trust's area factors (by metropolitan statistical area (MSA)), demographic mix and average benefit design adjustments.

4.1: Allowed PMPM by Service Category

Allowed PMPM	Prior	Current	Trend	Comparative Benchmark	Milliman Benchmark
Facility Inpatient	$72.47	$74.68	3.1%	$79.95	$103.58
Facility Outpatient	$133.65	$134.71	0.8%	$148.04	$154.72
Professional	$221.76	$234.64	5.8%	$238.22	$171.29
Prescription Drug	$92.90	$107.34	15.5%	$98.77	
Ancillary	$12.24	$16.94	38.5%	$16.88	$7.23
Total	**$533.01**	**$568.31**	**6.6%**	**$581.86**	**$436.82**
Concurrent Risk Score	*1.81*	*1.97*		*1.83*	

In figure 4.2, we show you the percent of your total healthcare spend by HCG service category. You should see physician services accounting for most of your Allowed dollars, with outpatient services accounting for another large portion of your healthcare spend. By comparing your prior year distribution to your current year distribution, you will be able to determine the impact of your employer initiatives.

4.2: Allowed Amount by HCG Category



Tables 4.3 through 4.7 list out the specific HCG line items for each of the HCG service categories. These tables provide you with utilization per 1,000; allowed per utilization and allowed PMPMs as well as trend comparisons. In each of these tables, attention should be paid to categories that have a PMPM trend of greater than 10% or less than – 10% and a PMPM greater than $1.00.

4.3: Hospital Inpatient Trend Analysis

HCG Categories	Days per 1000			Allowed per Day			Allowed PMPM		
	Prior	Current	Trend	Prior	Current	Trend	Prior	Current	Trend
Hospital Inpatient (HIP)									
I11 - Medical	63.4	92.6	46.1%	$3,218	$2,226	-30.8%	$17.01	$17.18	1.0%
I12 - Surgical	78.4	92.0	17.4%	$6,601	$5,994	-9.2%	$43.14	$45.97	6.6%
I13 - Psychiatric	12.1	17.3	42.8%	$1,862	$1,631	-12.4%	$1.88	$2.35	25.1%
I14 - Alcohol and Drug Abuse	14.5	8.5	-41.3%	$774	$1,128	45.8%	$0.93	$0.80	-14.5%
I21 - Mat Norm Delivery	19.2	13.8	-28.2%	$2,370	$2,213	-6.6%	$3.79	$2.54	-32.9%
I22 - Mat Csect Delivery	6.3	14.6	130.5%	$2,604	$1,528	-41.3%	$1.37	$1.85	35.3%
I23 - Well Newborn	13.9	8.2	-41.3%	$725	$940	29.7%	$0.84	$0.64	-23.9%
I24 - Other Newborn	6.6	8.9	36.0%	$2,954	$2,194	-25.7%	$1.62	$1.64	1.0%
I25 - Maternity Non-Delivery	3.4	2.4	-29.1%	$4,496	$2,914	-35.2%	$1.28	$0.59	-54.0%
I31 - SNF	78.7	50.0	-36.4%	$92	$268	190.1%	$0.60	$1.12	84.5%
Total	**296.6**	**308.4**	**4.0%**	**$2,932**	**$2,906**	**-0.9%**	**$72.47**	**$74.68**	**3.1%**

4.4: Hospital Outpatient Trend Analysis

HCG Categories	Cases per 1000			Allowed per Case			Allowed PMPM		
	Prior	Current	Trend	Prior	Current	Trend	Prior	Current	Trend
Hospital Outpatient (HOP)									
O11 - Emergency Room	250.8	275.5	9.9%	$997	$970	-2.8%	$20.84	$22.26	6.8%
O12 - Surgery	207.4	164.7	-20.6%	$2,364	$2,989	26.4%	$40.85	$41.02	0.4%
O13 - Radiology General	181.8	188.5	3.6%	$519	$501	-3.4%	$7.86	$7.87	0.2%
O14 - Radiology - CT/MRI/PET	64.2	67.8	5.6%	$2,016	$1,969	-2.3%	$10.79	$11.12	3.1%
O15 - Pathology/Lab	349.5	323.1	-7.5%	$217	$261	19.9%	$6.33	$7.02	10.9%
O16 - Pharmacy	127.9	159.2	24.5%	$1,686	$940	-44.3%	$17.97	$12.47	-30.6%
O17 - Cardiovascular	41.1	45.5	10.8%	$700	$677	-3.3%	$2.40	$2.57	7.1%
O18 - PT/OT/ST	275.8	290.5	5.3%	$338	$302	-10.7%	$7.78	$7.32	-5.9%
O31 - Psychiatric	12.9	21.1	63.4%	$323	$602	86.3%	$0.35	$1.06	204.5%
O32 - Alcohol & Drug Abuse	15.3	15.0	-1.7%	$353	$1,086	207.5%	$0.45	$1.36	202.4%
O41 - Other	1,026.3	1,125.2	9.6%	$153	$164	6.7%	$13.12	$15.34	16.9%
O51 - Preventive	165.5	184.8	11.7%	$357	$344	-3.5%	$4.92	$5.30	7.8%
Total	**2,718.4**	**2,860.8**	**5.2%**	**$590**	**$565**	**-4.2%**	**$133.65**	**$134.71**	**0.8%**

4.5: Physician Trend Analysis

HCG Categories	Utilization per 1000			Allowed per Utilization			Allowed PMPM		
	Prior	Current	Trend	Prior	Current	Trend	Prior	Current	Trend
Professional (PHY)									
P11 - Inpatient Surgery	72.9	76.7	5.2%	$1,604	$1,375	-14.3%	$9.74	$8.79	-9.8%
P13 - Inpatient Anesthesia	28.7	24.0	-16.5%	$934	$947	1.4%	$2.23	$1.89	-15.3%
P14 - Outpatient Surgery	356.3	362.5	1.7%	$990	$988	-0.2%	$29.39	$29.85	1.6%
P15 - Office Surgery	341.8	345.7	1.1%	$229	$228	-0.3%	$6.52	$6.57	0.8%
P16 - Outpatient Anesthesia	87.1	94.6	8.6%	$619	$585	-5.6%	$4.49	$4.61	2.6%
P21 - Maternity	34.2	28.0	-18.0%	$1,844	$1,907	3.4%	$5.26	$4.46	-15.2%
P31 - Inpatient Visits	166.3	185.6	11.6%	$233	$320	37.5%	$3.23	$4.95	53.5%
P32 - Office/Home Visits	3,293.1	3,319.1	0.8%	$123	$125	1.5%	$33.79	$34.58	2.3%
P33 - Urgent Care Visits	295.5	287.5	-2.7%	$113	$121	6.6%	$2.79	$2.90	3.7%
P34 - Office Administered Drugs	478.7	509.6	6.5%	$222	$310	39.5%	$8.85	$13.15	48.6%
P35 - Allergy Testing	17.9	19.4	8.5%	$218	$324	48.8%	$0.32	$0.52	61.3%
P36 - Allergy Immunotherapy	98.4	91.9	-6.6%	$118	$142	20.8%	$0.97	$1.09	12.7%
P37 - Miscellaneous Medical	442.9	364.2	-17.8%	$166	$187	13.0%	$6.12	$5.69	-7.1%
P40 - Preventive Other	559.7	565.5	1.0%	$155	$156	0.9%	$7.22	$7.36	2.0%
P41 - Preventive Immunizations	816.8	1,385.7	69.6%	$69	$59	-14.1%	$4.66	$6.80	45.8%
P42 - Preventive Well Baby Exams	89.2	81.9	-8.2%	$160	$177	10.7%	$1.19	$1.21	1.6%
P43 - Preventive Physical Exams	379.5	419.1	10.4%	$212	$215	1.8%	$6.69	$7.52	12.4%
P44 - Vision Exams	341.8	320.1	-6.4%	$150	$157	4.7%	$4.28	$4.20	-2.0%
P45 - Hearing and Speech Exams	30.8	31.1	1.0%	$135	$139	2.5%	$0.35	$0.36	3.5%
P51 - ER Visits and Observation Care	201.3	216.2	7.4%	$250	$266	6.5%	$4.19	$4.80	14.4%
P53 - Physical Therapy	548.1	506.7	-7.6%	$143	$158	11.0%	$6.51	$6.69	2.7%
P54 - Cardiovascular	257.6	280.8	9.0%	$150	$146	-2.7%	$3.22	$3.41	6.0%
P55 - Radiology IP	83.9	100.1	19.2%	$131	$112	-14.6%	$0.92	$0.94	1.9%
P56 - Radiology OP - General	441.3	451.2	2.2%	$104	$86	-17.0%	$3.83	$3.25	-15.2%
P57 - Radiology OP- CT/MRI/PET	155.0	156.3	0.9%	$349	$339	-2.8%	$4.51	$4.42	-1.9%
P58 - Radiology Office - General	635.5	642.4	1.1%	$156	$173	11.2%	$8.26	$9.28	12.4%
P59 - Radiology Office - CT/MRI/PET	78.2	96.7	23.8%	$1,705	$1,716	0.6%	$11.10	$13.83	24.6%
P61 - Pathology/Lab - Inpatient & Outpatient	186.3	165.4	-11.2%	$270	$289	6.7%	$4.20	$3.98	-5.3%
P63 - Pathology/Lab - Office	4,054.4	4,148.8	2.3%	$67	$64	-3.4%	$22.52	$22.26	-1.2%
P65 - Chiropractor	980.8	799.2	-18.5%	$44	$42	-3.5%	$3.58	$2.82	-21.3%
P66 - Outpatient Psychiatric	953.7	1,345.2	41.1%	$128	$105	-17.6%	$10.15	$11.79	16.2%
P67 - Outpatient Alcohol & Drug Abuse	1,284.7	2,718.3	111.6%	$6	$3	-51.0%	$0.65	$0.68	3.8%
Total	**17,792.5**	**20,139.4**	**13.2%**	**$150**	**$140**	**-6.5%**	**$221.76**	**$234.64**	**5.8%**

4.6: Prescription Trend Analysis

HCG Categories	Scripts per 1000			Allowed per Script			Allowed PMPM		
	Prior	Current	Trend	Prior	Current	Trend	Prior	Current	Trend
Prescription Drug (RX)									
P81 - Prescription Drugs	13,713.9	13,027.8	-5.0%	$81	$99	21.6%	$92.90	$107.34	15.5%
Total	**13,713.9**	**13,027.8**	**-5.0%**	**$81**	**$99**	**21.6%**	**$92.90**	**$107.34**	**15.5%**

4.7: Ancillary Trend Analysis

HCG Categories	Utilization per 1000			Allowed per Utilization			Allowed PMPM		
	Prior	Current	Trend	Prior	Current	Trend	Prior	Current	Trend
Ancillary									
P82 - Private Duty Nursing/Home Health	3.9	26.7	576.0%	$667	$429	-35.6%	$0.22	$0.95	335.2%
P83 - Ambulance	37.4	40.8	9.1%	$804	$738	-8.2%	$2.50	$2.51	0.2%
P84 - DME and Supplies	462.4	556.6	20.4%	$88	$106	20.9%	$3.37	$4.91	45.5%
P85 - Prosthetics	9.2	6.8	-25.9%	$697	$420	-39.8%	$0.54	$0.24	-55.4%
P89 - Benefits Glasses/Contacts	1.1	2.4	130.5%	$158	$112	-28.9%	$0.01	$0.02	63.8%
P99 - Benefits Other	177.9	326.4	83.5%	$377	$305	-19.0%	$5.59	$8.31	48.6%
Total	**691.8**	**959.8**	**38.7%**	**$212**	**$212**	**-0.2%**	**$12.24**	**$16.94**	**38.5%**

Another important component of understanding your healthcare spend analysis is understanding contractual savings generated by the health plan. Table 4.8 represents your current period savings due to these agreements, compared to the prior period. From this table, you can see the breakout of billed charges, contractual agreements, and employee out of pocket.

4.8: Savings Trends

Dollars	Prior	Current	Percent Change
Billed	$48,420,344	$93,366,635	92.8%
Contractual Savings	$24,114,583	$48,387,999	100.7%
Allowed Charges	$24,305,761	$44,978,636	85.1%
Employee Out of Pocket	$500,582	$899,623	79.7%
Total Paid	**$23,804,881**	**$44,078,885**	**85.2%**

Key savings ratios compared to benchmarks averages across all WEA Trust groups are provided below.

4.9: Savings Compared to Benchmarks

Ratios	Prior	Current	Comparative Benchmark
Discount (Savings/Billed)	49.8 %	51.8 %	48.1 %
Employee Costs as percent of allowed	2.1 %	2.0 %	4.5 %
Employer paid as percent of allowed	97.9 %	98.0 %	95.5 %

Table 4.10 displays allowed charges, reported discounts, employer paid amounts and employee paid (cost share) amounts by participating and nonparticipating providers in the network. A comparison of the current period to the prior period is also shown. By looking at provider spending patterns, you can determine your out-of-network usage and identify possible opportunities for employee education and potential future cost savings.

4.10: Network Utilization

	Prior		Current	
	Dollars	% Total	Dollars	% Total
Participating Provider				
Allowed Charges	$23,852,611	98.1%	$44,220,888	98.3%
Employer Paid	$23,364,429	98.1%	$43,341,545	98.3%
Employee Paid	$488,014	97.5%	$879,352	97.7%
Non-Participating Provider				
Allowed Charges	$453,150	1.9%	$757,749	1.7%
Employer Paid	$440,453	1.9%	$737,340	1.7%
Employee Paid	$12,568	2.5%	$20,271	2.3%

Table 4.11, lists your top 20 billing providers.

4.11: Top 20 Billing Providers by Paid Amount

Billing Provider	Prior		Current	
	Paid	Percent of Total Paid	Paid	Percent of Total Paid
B_200003286 - Uw Health	$5,454,791	22.9%	$9,257,697	21.0%
B_200003306 - Uw Health	$5,516,043	23.2%	$9,242,788	21.0%
B_200002008 - Dean Health Systems, Inc	$1,223,406	5.1%	$2,732,782	6.2%
B_200001778 - Meriter Hospital, Inc	$1,729,794	7.3%	$2,671,751	6.1%
B_200005003 - St Mary's Hospital	$549,408	2.3%	$1,162,223	2.6%
B_200000080 - Meriter Medical Group, Inc	$522,375	2.2%	$993,304	2.3%
B_800000971 - Uw Health Outpatient Pharmacy	$79,212	0.3%	$529,905	1.2%
B_800001761 - Diplomat Specialty Pharmacy	$80,443	0.3%	$447,549	1.0%
B_200005114 - Madison Surgery Center, Inc	$256,818	1.1%	$398,472	0.9%
B_800002501 - Walgreen Drug Store	$155,267	0.7%	$310,533	0.7%
B_200002680 - Wildwood Family Clinic, Sc	$156,130	0.7%	$287,342	0.7%
B_800002648 - Meriter Outpatient Pharmacy	$175,512	0.7%	$254,914	0.6%
B_200001877 - Stoughton Hospital Association	$118,431	0.5%	$245,493	0.6%
B_200001896 - Sauk Prairie Memorial Hospital	$134,344	0.6%	$239,419	0.5%
B_200010424 - Coram Alternative Site Services, Inc	$10,772	0.0%	$235,500	0.5%
B_200002729 - Shared Magnetic Resonance Imaging	$102,384	0.4%	$232,743	0.5%
B_800001111 - Walgreen Drug Store	$112,290	0.5%	$221,183	0.5%
B_200003310 - Associated Physicians Llp	$134,316	0.6%	$212,304	0.5%
B_800002320 - Walgreen Drug Store	$101,869	0.4%	$198,737	0.5%
B_200003238 - University Of Wi Systems	$84,665	0.4%	$190,603	0.4%
All Other Providers	$7,106,611	29.9%	$14,013,642	31.8%
Total	**$23,804,881**	**100.0%**	**$44,078,885**	**100.0%**

In table 4.12 we have grouped claim paid amounts into cost ranges. Organizing claims by claim ranges allows you to see how many members are accounting for most of the claim costs. It gives insight to those who did not utilize the plan and those who did. It also provides additional data points to consider when you are evaluating plan design changes.

4.12: Current Period Claim Cost Ranges based on Total Paid Amount

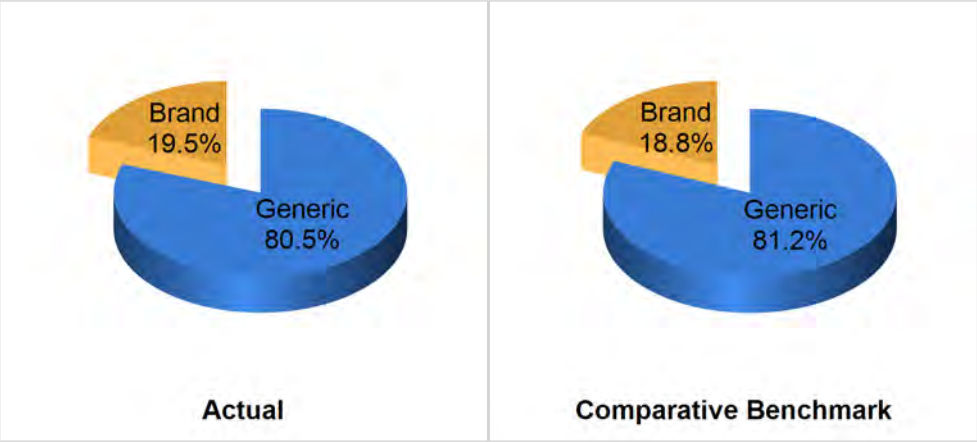
Claim Cost Buckets	Member Count	Total Allowed	Total Paid	Paid/Allowed	Inpatient Paid	Outpatient Paid	Professional Paid	Pharmacy Paid	Other Paid
$0	629	$756	$0	0%	$0	$0	$0	$0	$0
$1-250	599	$81,980	$73,753	90%	$0	$4,190	$60,302	$8,350	$912
$251-500	558	$222,719	$207,153	93%	$374	$19,040	$163,759	$22,272	$1,708
$501-1,000	910	$707,808	$669,399	95%	$218	$74,861	$500,986	$84,876	$8,457
$1,001-1,500	657	$862,195	$817,065	95%	$0	$113,583	$566,156	$122,444	$14,883
$1,501-2,000	459	$835,458	$798,031	96%	$1,216	$110,930	$528,692	$121,315	$35,879
$2,001-2,500	359	$847,296	$806,179	95%	$5,307	$123,757	$508,488	$140,859	$27,769
$2,501-3,000	303	$872,303	$833,751	96%	$6,315	$143,190	$485,483	$154,617	$44,146
$3,001-4,000	458	$1,664,204	$1,588,327	95%	$15,681	$286,477	$848,426	$335,539	$102,204
$4,001-5,000	317	$1,478,191	$1,416,507	96%	$27,503	$278,281	$754,276	$296,173	$60,275
$5,001-7,500	592	$3,766,982	$3,644,878	97%	$64,440	$840,405	$1,919,056	$678,148	$142,829
$7,501-10,000	324	$2,898,048	$2,809,685	97%	$53,146	$761,681	$1,268,994	$614,509	$111,356
$10,001-15,000	380	$4,774,440	$4,670,890	98%	$258,351	$1,390,053	$2,007,835	$860,761	$153,890
$15,001-20,000	180	$3,148,769	$3,094,013	98%	$182,995	$907,502	$1,283,885	$589,512	$130,119
$20,001-25,000	110	$2,484,774	$2,443,971	98%	$164,376	$613,368	$1,045,677	$564,181	$56,370
$25,001-50,000	216	$7,340,667	$7,263,413	99%	$1,076,562	$1,890,766	$2,872,715	$1,289,219	$134,150
$50,001-75,000	50	$3,050,455	$3,029,798	99%	$770,997	$715,446	$793,133	$685,979	$64,243
$75,001-100,000	23	$2,052,563	$2,042,520	100%	$624,682	$620,204	$674,161	$96,307	$27,167
$100,001-150,000	15	$1,764,903	$1,757,495	100%	$264,150	$366,998	$706,693	$367,835	$51,819
$150,001-500,000	21	$4,780,719	$4,769,680	100%	$1,831,529	$1,302,213	$1,266,852	$240,018	$129,068
$500,000+	2	$1,343,403	$1,342,376	100%	$562,006	$39,015	$173,206	$528,434	$39,715
Total	**7,162**	**$44,978,634**	**$44,078,885**	**98%**	**$5,909,849**	**$10,601,959**	**$18,428,773**	**$7,801,346**	**$1,336,958**

V. Pharmacy Detail

Prescription drug costs are usually a large portion of an employer's overall healthcare spend. In this section we focus on pharmacy costs for National Drug Classification (NDC) drugs. Drugs administered in an inpatient, outpatient, or office setting are discussed in the Medical Economics section.

In figure 5.1, you will see a comparison of your brand and generic utilization. If your generic usage is less than 75% then you should review your pharmacy benefit design. Even though the member contributes more dollars per script for brand name pharmaceuticals, brand name drugs drive a higher health care spend.

5.1: Current Year Pharmacy Brand Generic Utilization Summary



In table 5.2 we show your total pharmacy costs, total scripts and allowed per script. We have also provided the distribution of pharmacy costs by source. You can see from this table that the amount per script is significantly higher for your single source brand name drugs. Shifting utilization to generics will decrease your total pharmacy spend.

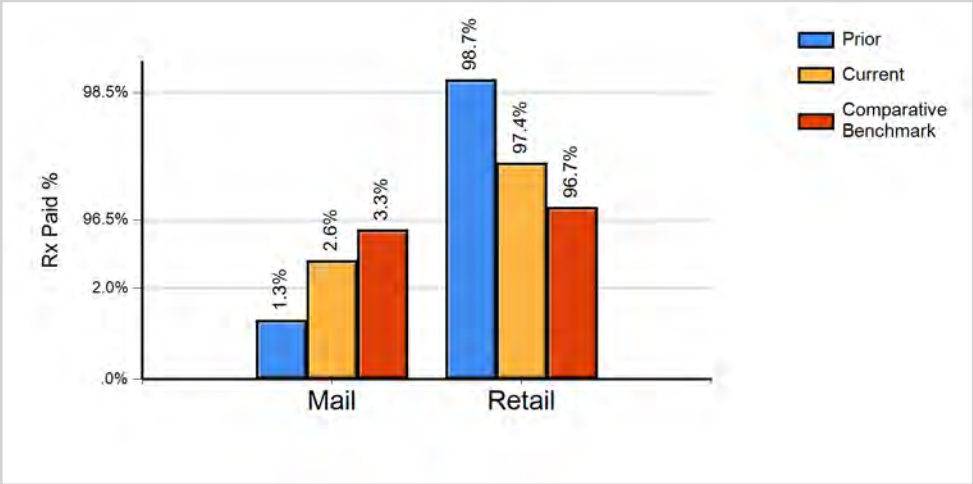
5.2: Pharmacy Utilization and Costs by Source

Prescription Source	Scripts	% Total	Allowed	% Total	Scripts per 1,000	Allowed per Script	% Out of Pocket	Paid	% Total
GENERIC	69,180	80.5%	$2,374,003	27.9%	10,489.1	$34	18.1%	$1,944,846	24.9%
MSB	1,194	1.4%	$338,747	4.0%	181.0	$284	7.8%	$312,305	4.0%
N/A	114	0.1%	$3,932	0.0%	17.3	$34	24.2%	$2,979	0.0%
OTC	3,618	4.2%	$186,866	2.2%	548.6	$52	2.1%	$182,939	2.3%
SSB	11,672	13.6%	$5,579,604	65.7%	1,769.7	$478	4.2%	$5,346,840	68.5%
Other	146	0.2%	$11,995	0.1%	22.1	$82	4.7%	$11,436	0.1%
Total	**85,924**	**100.0%**	**$8,495,147**	**100.0%**	**13,027.8**	**$99**	**8.2%**	**$7,801,346**	**100.0%**

* MSB: Multi Source Brand, OTC: Over the Counter, SSB: Single Source Brand

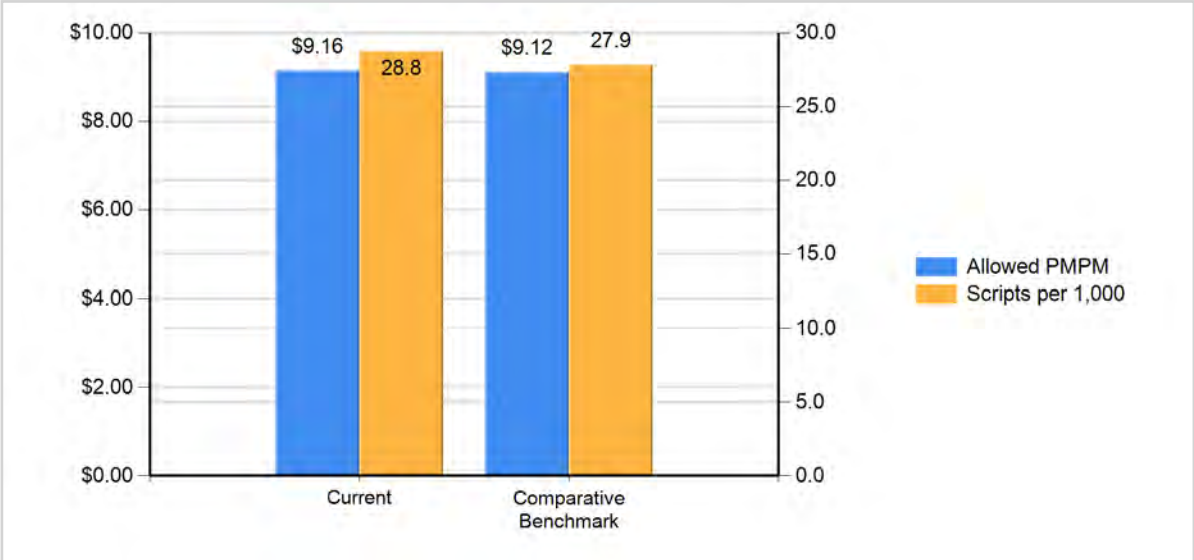
Figure 5.3 displays the distribution of retail versus mail prescription drug usage for Dane County compared to the Compartive Benchmark.

5.3: Prescription Drug Retail/Mail Distribution



In figure 5.4, you find a comparison of specialty drugs provided to your members at a pharmacy. You're able to see if your population is utilizing specialty drugs more than the comparative benchmark.

5.4: Comparison of Specialty Drug Utilization



Prescription drugs are classified into therapeutic classes for reporting and analytical purposes. By looking at drugs by therapeutic class, you can draw conclusions about the general health of your population and opportunities for education and wellness programs. Table 5.5 shows your top 20 therapeutic classes by total allowed amount.

5.5: Top 20 Prescription Drug Therapeutic Classes

Therapeutic Class	Allowed	% Total	Scripts	% Total	Scripts per 1,000	Scripts per 1,000 Comparative Benchmark	Allowed per Script
ANTIDIABETICS	$931,573	11.0%	3,756	4.4%	569.5	522.4	$248
ANALGESICS - ANTI-INFLAMMATORY	$708,336	8.3%	1,781	2.1%	270.0	262.6	$398
ANTIASTHMATIC AND BRONCHODILATOR AGENTS	$666,781	7.8%	3,819	4.4%	579.0	525.5	$175
HEMATOPOIETIC AGENTS	$584,779	6.9%	266	0.3%	40.3	36.3	$2,198
PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.	$492,119	5.8%	361	0.4%	54.7	48.3	$1,363
ANTIHYPERLIPIDEMICS	$457,649	5.4%	4,737	5.5%	718.2	714.0	$97
ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY/ANOREXIANTS	$440,799	5.2%	2,648	3.1%	401.5	353.0	$166
DERMATOLOGICALS	$354,613	4.2%	2,711	3.2%	411.0	378.3	$131
ANTIVIRALS	$335,789	4.0%	927	1.1%	140.6	123.6	$362
ANTIPSYCHOTICS/ANTIMANIC AGENTS	$246,039	2.9%	900	1.0%	136.5	111.0	$273
ANTIDEPRESSANTS	$238,328	2.8%	8,956	10.4%	1,357.9	1,247.9	$27
GASTROINTESTINAL AGENTS - MISC.	$183,513	2.2%	377	0.4%	57.2	54.3	$487
ANALGESICS - OPIOID	$172,964	2.0%	3,977	4.6%	603.0	573.4	$43
CONTRACEPTIVES	$152,170	1.8%	2,147	2.5%	325.5	341.8	$71
OPHTHALMIC AGENTS	$148,032	1.7%	1,590	1.9%	241.1	210.5	$93
ULCER DRUGS	$141,423	1.7%	3,899	4.5%	591.2	580.9	$36
DIAGNOSTIC PRODUCTS	$134,329	1.6%	870	1.0%	131.9	118.7	$154
ANTICONVULSANTS	$131,230	1.5%	3,082	3.6%	467.3	426.2	$43
NASAL AGENTS - SYSTEMIC AND TOPICAL	$123,508	1.5%	2,229	2.6%	338.0	292.0	$55
Unknown	$96,485	1.1%	301	0.4%	45.6	40.9	$321
Top 20 Therapeutic Class Total	$6,740,459	79.3%	49,334	57.4%	7,480.0	6,961.7	$137
Other Than Top 20 Therapeutic Class Total	$1,754,687	20.7%	36,590	42.6%	5,547.8	5,306.0	$48
Total	**$8,495,147**	**100.0%**	**85,924**	**100.0%**	**13,027.8**	**12,267.8**	**$99**

VI. Preventive Services

By providing members with high quality preventive services, the goal is not only to improve members' immediate health, but reduce your healthcare costs in the long term. It is important for the employer to educate employees, spouses and dependents on the importance of preventive services. The first step in educating members is to understand what preventive services are being utilized by your population. In table 6.1 we show the core preventive services your members are receiving as well as a WEA Trust comparative benchmark.

6.1: Key Preventive Services

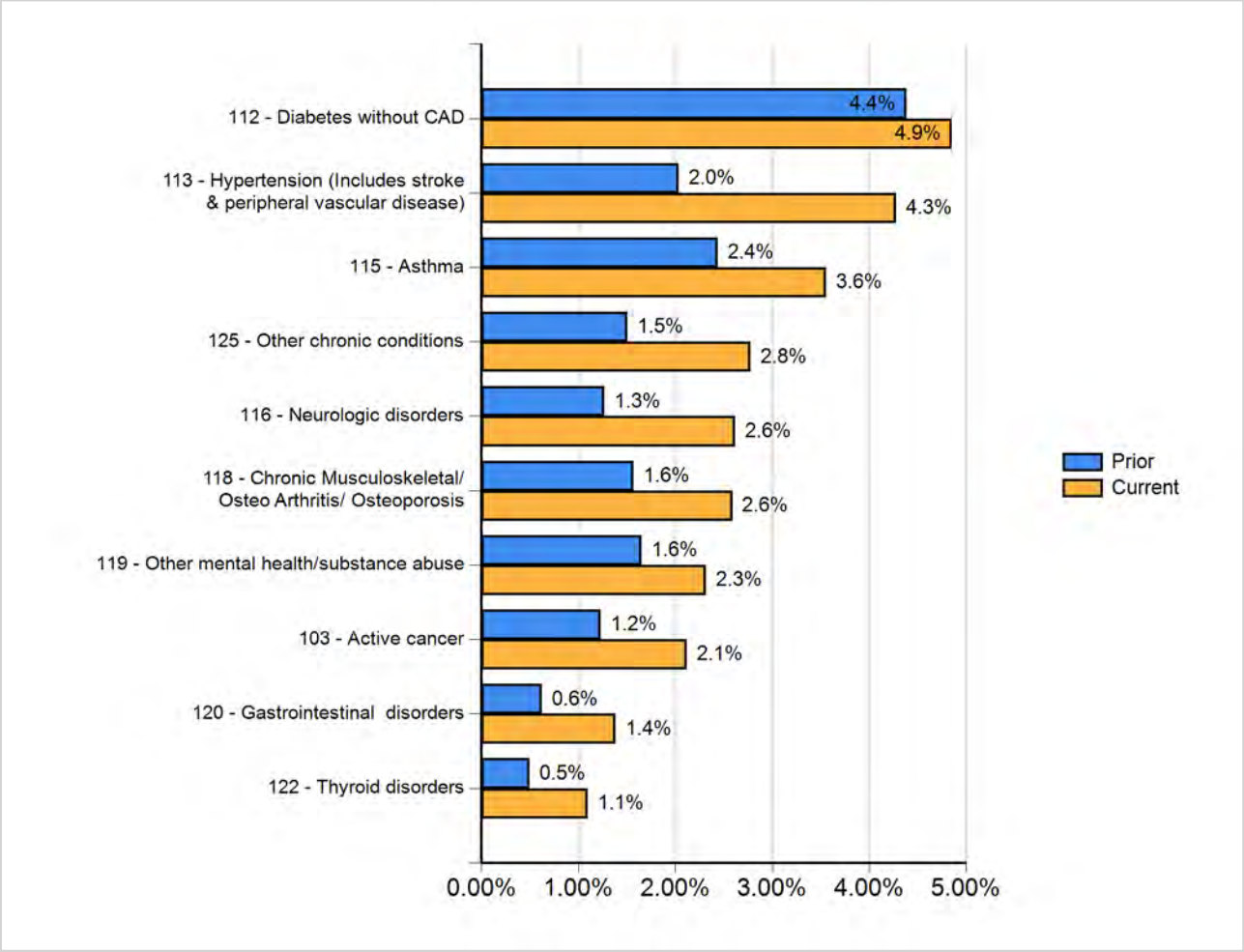
Preventive Service	Percent of Eligible Population Receiving Services		Number of Members Receiving Preventive Services
	Comparative Benchmark	Current	
BCS_2013 - Breast Cancer Screening	73%		
CCS_2012 - Cervical Cancer Screening	82%		
CHL_16-20_2012 - Chlamydia Screening in women (16-20)	37%	40%	47
CHL_21-24_2012 - Chlamydia Screening in women (21-24)	51%	52%	70
CHL_TOTAL_2012 - Chlamydia Screening in women (16-24)	45%	46%	117
CIS - COMBO10_2012 - Childhood Immunization Status, Combination 10	0%	0%	0
CIS - COMBO2_2012 - Childhood Immunization Status, Combination 2	3%	0%	0
CIS - COMBO3_2012 - Childhood Immunization Status, Combination 3	3%	0%	0
CIS - COMBO4_2012 - Childhood Immunization Status, Combination 4	0%	0%	0
CIS - COMBO5_2012 - Childhood Immunization Status, Combination 5	3%	0%	0
CIS - COMBO6_2012 - Childhood Immunization Status, Combination 6	3%	0%	0
CIS - COMBO7_2012 - Childhood Immunization Status, Combination 7	0%	0%	0
CIS - COMBO8_2012 - Childhood Immunization Status, Combination 8	0%	0%	0
CIS - COMBO9_2012 - Childhood Immunization Status, Combination 9	3%	0%	0
CIS - DTaP_2012 - Childhood Immunization Status, DTaP	11%	0%	0
CIS - FLU_2012 - Childhood Immunization Status, Influenza	27%	26%	12
CIS - HA_2012 - Childhood Immunization Status, Hepatitis A	56%	62%	29
CIS - HB_2012 - Childhood Immunization Status, Hepatitis B	5%	0%	0
CIS - HiB_2012 - Childhood Immunization Status, HiB	14%	0%	0

Preventive Service	Percent of Eligible Population Receiving Services		Number of Members Receiving Preventive Services
	Comparative Benchmark	Current	
CIS - IPV_2012 - Childhood Immunization Status, IPV	12%	2%	1
CIS - MMR_2012 - Childhood Immunization Status, MMR	86%	81%	38
CIS - PC_2012 - Childhood Immunization Status, Pneumococcal conjugate	11%	0%	0
CIS - RT_2012 - Childhood Immunization Status, Rotavirus	11%	0%	0
CIS - VZV_2012 - Childhood Immunization Status, VZV	88%	85%	40
COL_2012 - Colorectal Cancer Screening	32%		
IMA - Combo1_2012 - Combination of One MEN Vaccine and One Tdap Vaccine or Td Vaccine	12%	5%	3
IMA_MEN_2012 - One Meningococcal Conjugate or Meningococcal Polysaccharide Vaccine	26%	22%	14
IMA_TdapTd_2012 - One Tdap or Td Vaccine	19%	8%	5

VII. Medical Management

Understanding the disease burden, wellness and overall risk of your population is critical to understanding your healthcare spend. Using a methodology developed by Milliman called Chronic Condition Hierarchical Groups (CCHGs), health plans and employers can analyze disease populations. The CCHGs allow you to see what proportion of your members are falling into various disease populations. In figure 7.1, you see your top 10 medical CCHGs as a percent of your total member months.

7.1: Top 10 Medical CCHGs by Member Months



In addition to understanding what CCHGs your population is falling into, you will also want to understand your allowed amounts per member per month by CCHG. Table 7.2 displays the member months trend and average allowed per patient per month trend for each CCHG. The benchmark comparison for member months by CCHG allows you to see if your population has a higher prevalence of certain conditions compared to WEA Trust book of business.

7.2: Member Months and Average Allowed per Patient per Month by CCHG

CCHG	Prevalence - Percent of Member Months			Average Allowed per Patient per Month		
	Current	Prior	Comparative Benchmark	Current	Prior	% Change
104 - Renal failure - post transplant	0.6%	0.3%	0.5%	$4,515.90	$4,338.44	4.1%
106 - HIV	0.0%	0.0%	0.0%	$4,492.67	$3,407.72	31.8%
103 - Active cancer	2.1%	1.2%	2.0%	$3,758.13	$4,803.69	-21.8%
105 - Liver disease (Hepatitis, Cirrhosis) – post transplant	0.3%	0.1%	0.3%	$2,524.55	$2,856.31	-11.6%
107 - Severe rheumatic & other connective tissue disease	0.8%	0.5%	0.7%	$2,417.01	$2,016.02	19.9%
108 - Severe heart failure/transplant/rheumatic heart disease/non-rheumatic valvular heart disease	1.0%	0.5%	0.9%	$1,976.75	$2,129.04	-7.2%
117 - Mental retardation/disability congentia anomaly	0.6%	0.4%	0.6%	$1,395.62	$2,420.38	-42.3%
110 - Both CAD & diabetes	0.2%	0.2%	0.2%	$1,339.39	$3,267.02	-59.0%
116 - Neurologic disorders	2.6%	1.3%	2.4%	$1,329.45	$1,680.58	-20.9%
111 - CAD without diabetes	0.7%	0.2%	0.6%	$1,320.60	$2,497.43	-47.1%
114 - COPD	0.3%	0.2%	0.3%	$1,296.72	$1,685.24	-23.1%
118 - Chronic Musculoskeletal/ Osteo Arthritis/ Osteoporosis	2.6%	1.6%	2.6%	$1,144.03	$1,823.86	-37.3%
102 - Severe dementia	0.2%	0.0%	0.1%	$1,007.50	$1,292.22	-22.0%
123 - Dermatologic disorders	0.3%	0.2%	0.3%	$932.69	$966.22	-3.5%
119 - Other mental health/substance abuse	2.3%	1.6%	2.2%	$914.06	$1,031.34	-11.4%
112 - Diabetes without CAD	4.9%	4.4%	4.4%	$896.24	$1,176.94	-23.8%
124 - Unhealthy newborns and preemies	0.2%	0.1%	0.2%	$828.46	$2,338.64	-64.6%
120 - Gastrointestinal disorders	1.4%	0.6%	1.5%	$762.93	$1,487.86	-48.7%
115 - Asthma	3.6%	2.4%	3.3%	$731.24	$970.40	-24.6%
113 - Hypertension (Includes stroke & peripheral vascular disease)	4.3%	2.0%	4.2%	$685.25	$591.70	15.8%
122 - Thyroid disorders	1.1%	0.5%	1.1%	$574.88	$706.10	-18.6%
125 - Other chronic conditions	2.8%	1.5%	2.9%	$572.79	$832.42	-31.2%
101 - Major psychosis	0.1%	0.0%	0.1%	$571.76	$619.67	-7.7%
109 - Hemophilia & sickle cell & chronic blood disorders	0.0%	0.0%	0.0%	$311.16	$294.57	5.6%

CCHG	Prevalence - Percent of Member Months			Average Allowed per Patient per Month		
	Current	Prior	Comparative Benchmark	Current	Prior	% Change
NA - No CCHG Category		0.0%	0.0%			
Total	**100.0%**	**100.0%**	**100.0%**	**$568.31**	**$533.01**	**6.6%**

Now we will shift focus to looking at your population at the member level. Table 7.3 gives insight into whom are your current high cost members and the amount of healthcare spend they account for during the current year. The CCHG description listed in table 7.3 is the primary clinical condition for a specific member during the current period. The member key included in these tables is an encrypted key that is consistent throughout this report, but is not consistent between report periods or identifiable to the actual member.

7.3: Current High Cost Members

Member Key	Paid	CCHG Code Description
925751	$798,796	Renal failure - post transplant
928200	$543,580	Renal failure - post transplant
927690	$487,445	Active cancer
928560	$463,983	Active cancer
930567	$351,568	Severe rheumatic & other connective tissue disease
928706	$316,450	Severe heart failure/transplant/rheumatic heart disease/non-rheumatic valvular heart disease
926949	$290,039	Active cancer
928785	$233,150	Renal failure - post transplant
930337	$222,095	Active cancer
928929	$198,346	Active cancer

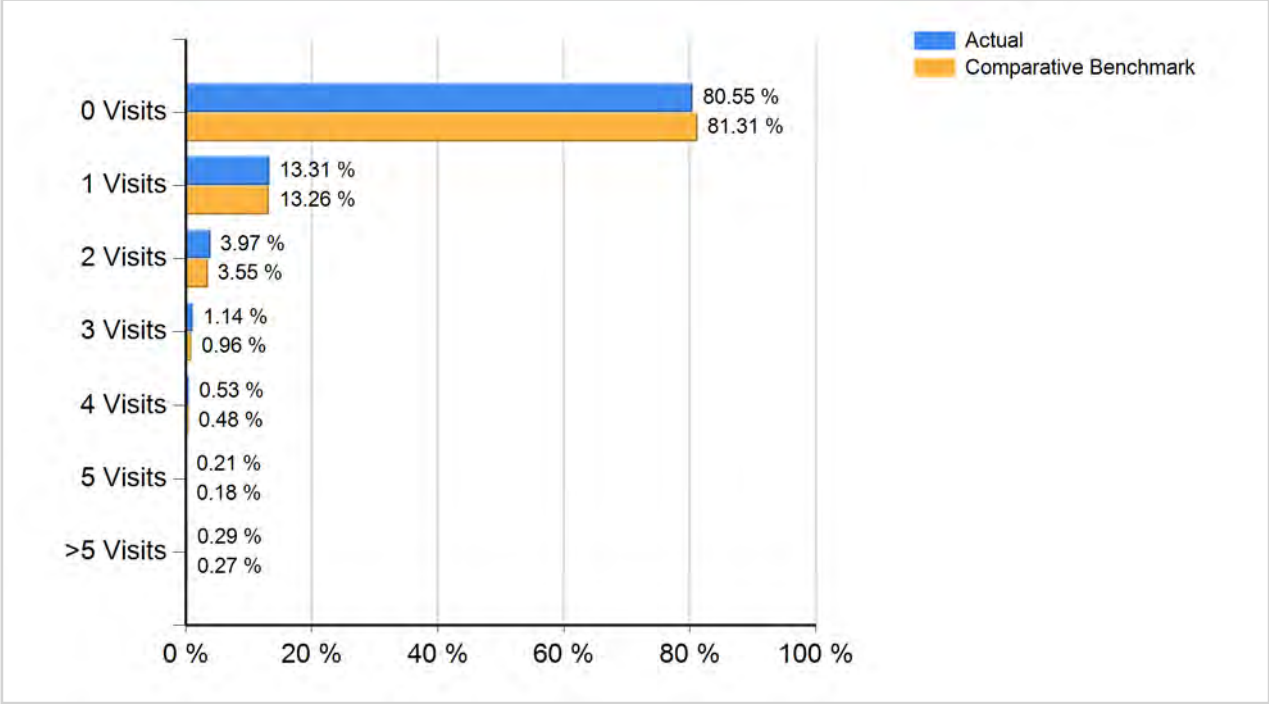
Another component of medical management is identifying where your population is receiving services. In table 7.4 you see an estimate of how many members are going to the ER for non-emergent services. This table is based on analytics layered into the MedInsight system using the New York University (NYU) avoidable ER methodology. If you have a high number of avoidable ER visits, you should review your ER and urgent care copays. You would like to shift these services into an office or urgent care setting where the cost of the services is typically less.

7.4: Avoidable ER Visits

Avoidable ER Visits - New York University (NYU) Methodology	Current Avoidable ER Visits	Current ER Visits	ER Visits % Avoidable	
			Current	Comparative
NYU_EM_PA_N/A - Emergent Visits - Preventable/Avoidable (Estimate).	57	1767	3%	3%
NYU_EM_PT_N/A - Emergent Visits - Primary Care Treatable (Estimate).	407	1767	23%	23%
NYU_NON_EM_N/A - Non Emergent Visits (Estimate).	415	1767	23%	24%
Total	**878**	**1767**	**50%**	**50%**

In figure 7.5 you can see what percent of your population is utilizing the ER and what percent of your population is not utilizing the ER. Your utilization percentages should be similar to the comparative benchmark.

7.5: ER Utilization Benchmark



To complete the medical management picture, it is important to understand if your population is receiving all of the optimal services. For example, a member with high cholesterol should be receiving LDL-C screenings. By looking at evidence based measures coded using nationally developed standards, such as NCQA HEDIS technical specifications, you can see your members are receiving the quality of care they should.

7.6: Evidence Based Measures (EBMs)

EBM Measure Description	EBM %			Compliant	Population	EBM Measure Source
	Comparative	Current	Prior			
AAP_2044_2012 - Adults Access to Preventive/Ambulatory Health Services (20-44)	96%					HEDIS
AAP_4564_2012 - Adults Access to Preventive/Ambulatory Health Services (45-64)	97%					HEDIS
AAP_Total_2012 - Adults Access to Preventive/Ambulatory Health Services (Age 20+)	97%					HEDIS
ACCM_ACEIs/ARB_2013 - Adherence to Certain Chronic Condition Medications	80%	81%		524	650	NQF -0542
ACCM_Levothyroxine_2013 - Adherence to Certain Chronic Condition Medications	88%	90%		334	370	NQF -0542
ACCM_Statin_2013 - Adherence to Certain Chronic Condition Medications	77%	78%		546	704	NQF -0542
ACEARB_2010 - Members age 18-75 years old who had CHF and LVSD who received ACEI or ARB drugs.	43%	38%		6	16	HEDIS
ADD1_2012 - Follow-Up Care for Children Prescribed ADHD Medication, Initiation Phase	33%	33%		1	3	HEDIS
ADD2_2012 - Follow-Up Care for Children Prescribed ADHD Medication, Continuation & Maintenance Phase	0%	0%		0	1	HEDIS
AMB_ED_2012 - Ambulatory Care - ED Visits	2%	3%	2%	1967	76803	HEDIS
AMB_OP_2012 - Ambulatory Care - Outpatient Visits	44%	48%	47%	36720	76803	HEDIS
ASM_05_11_2012 - Members aged 05-11 with persistent asthma who had appropriate medication during the measurement year.	100%					HEDIS
ASM_12_18_2012 - Members aged 12-18 with persistent asthma who had appropriate medication during the measurement year.	100%					HEDIS
ASM_19_50_2012 - Members aged 19-50 with persistent asthma who had appropriate medication during the measurement year.	100%					HEDIS
ASM_51_64_2012 - Members aged 51-64 with persistent asthma who had appropriate medication during the measurement year.	100%					HEDIS
ASM_TOTAL_2012 - Members aged 05-64 with persistent asthma who had appropriate medication during the measurement year.	100%					HEDIS
AWC_2013 - Adolescent Well-Care Visits	15%	16%		158	999	HEDIS
BCS_2013 - Breast Cancer Screening	73%					HEDIS
CAP_M12_24_2012 - Children and Adolescents Access to Primary Care Practitioners 12m-24m	94%	94%		59	63	HEDIS
CAP_M25_Y6_2012 - The percentage of members 25 months - 6 years of age who had a visit with a PCP	92%	93%		308	331	HEDIS
CAP_Y07_11_2012 - The percentage of members 7-11 years of age who had a visit with a PCP	87%					HEDIS
CAP_Y12_19_2012 - Children and Adolescents Access to Primary Care Practitioners 12y-19y	87%					HEDIS
CCS_2012 - Cervical Cancer Screening	82%					HEDIS
CDC-EYE_2012 - Eye exam (retinal) performed	70%	73%		232	317	HEDIS

EBM Measure Description	EBM %			Compliant	Population	EBM Measure Source
	Comparative	Current	Prior			
CDC-HBA1C_2012 - Hemoglobin A1c (HbA1c) testing	93%	92%		293	317	HEDIS
CDC-LDLC_2012 - LDL-C Screening	81%	81%		256	317	HEDIS
CDC-NEP_2012 - Medical attention for nephropathy	86%	85%		271	317	HEDIS
CHF-IP_Mortality-IP_2013 - In-Hospital Congestive Heart Failure Mortality	0%	0%		0	6	IQI-16
CHL_16-20_2012 - Chlamydia Screening in women (16-20)	37%	40%		47	117	HEDIS
CHL_21-24_2012 - Chlamydia Screening in women (21-24)	51%	52%		70	135	HEDIS
CHL_TOTAL_2012 - Chlamydia Screening in women (16-24)	45%	46%		117	252	HEDIS
CIS - COMBO10_2012 - Childhood Immunization Status, Combination 10	0%	0%		0	47	HEDIS
CIS - COMBO2_2012 - Childhood Immunization Status, Combination 2	3%	0%		0	47	HEDIS
CIS - COMBO3_2012 - Childhood Immunization Status, Combination 3	3%	0%		0	47	HEDIS
CIS - COMBO4_2012 - Childhood Immunization Status, Combination 4	0%	0%		0	47	HEDIS
CIS - COMBO5_2012 - Childhood Immunization Status, Combination 5	3%	0%		0	47	HEDIS
CIS - COMBO6_2012 - Childhood Immunization Status, Combination 6	3%	0%		0	47	HEDIS
CIS - COMBO7_2012 - Childhood Immunization Status, Combination 7	0%	0%		0	47	HEDIS
CIS - COMBO8_2012 - Childhood Immunization Status, Combination 8	0%	0%		0	47	HEDIS
CIS - COMBO9_2012 - Childhood Immunization Status, Combination 9	3%	0%		0	47	HEDIS
CIS - DTaP_2012 - Childhood Immunization Status, DTaP	11%	0%		0	47	HEDIS
CIS - FLU_2012 - Childhood Immunization Status, Influenza	27%	26%		12	47	HEDIS
CIS - HA_2012 - Childhood Immunization Status, Hepatitis A	56%	62%		29	47	HEDIS
CIS - HB_2012 - Childhood Immunization Status, Hepatitis B	5%	0%		0	47	HEDIS
CIS - HiB_2012 - Childhood Immunization Status, HiB	14%	0%		0	47	HEDIS
CIS - IPV_2012 - Childhood Immunization Status, IPV	12%	2%		1	47	HEDIS
CIS - MMR_2012 - Childhood Immunization Status, MMR	86%	81%		38	47	HEDIS
CIS - PC_2012 - Childhood Immunization Status, Pneumococcal conjugate	11%	0%		0	47	HEDIS
CIS - RT_2012 - Childhood Immunization Status, Rotavirus	11%	0%		0	47	HEDIS
CIS - VZV_2012 - Childhood Immunization Status, VZV	88%	85%		40	47	HEDIS
CMC-LDLC_2012 - LDL-C screening	100%					HEDIS
CMS-HWUR_2013 - CMS Hospital-Wide Unplanned Readmission	20%	22%		110	505	CMS , NQF - 1789
COL_2012 - Colorectal Cancer Screening	32%					HEDIS
GEN_ADHD_N/A - Generic ADHD Medication Use	76%	78%	74%	1526	1968	Milliman
GEN_AHT_N/A - Generic AHT Medication Use	98%	99%	99%	3245	3290	Milliman
GEN_SSRI_N/A - Generic SSRI Medication Use	99%	99%	98%	5198	5245	Milliman
GEN_STATIN_N/A - Generic STATIN Medication Use	73%	69%	62%	1829	2668	Milliman

EBM Measure Description	Comparative	EBM % Current	Prior	Compliant	Population	EBM Measure Source
HAART_2011 - Highly Active Anti-Retroviral Treatment	50%	100%		1	1	CLIENT
HIV_CD4_A_2011 - HIV Disease Monitoring - 2 or more CD4 tests (w 182 day gap)	67%	50%		1	2	CLIENT
HIV_CD4_B_2011 - HIV Disease Monitoring - Two or more CD4 tests	67%	50%		1	2	CLIENT
HIV_CD4_C_2011 - HIV Disease Monitoring - One CD4 test	33%	50%		1	2	CLIENT
HIV_CD4_D_2011 - HIV Disease Monitoring - No CD4 tests	0%	0%		0	2	CLIENT
HIV_OV_A_2011 - HIV Disease Monitoring - Two or more office visits with a 182 day gap	100%	100%		2	2	CLIENT
HIV_OV_B_2011 - HIV Disease Monitoring - Two or more office visits	100%	100%		2	2	CLIENT
HIV_OV_C_2011 - HIV Disease Monitoring - Exactly one office visit	0%	0%		0	2	CLIENT
HIV_OV_D_2011 - HIV Disease Monitoring - No office visits	0%	0%		0	2	CLIENT
HIV_VL_A_2011 - HIV Disease Monitoring - Two or more Viral Load tests with 182 day gap	67%	50%		1	2	CLIENT
HIV_VL_B_2011 - HIV Disease Monitoring - Two or more Viral Load tests	100%	100%		2	2	CLIENT
HIV_VL_C_2011 - HIV Disease Monitoring - One Viral Load test	0%	0%		0	2	CLIENT
HIV_VL_D_2011 - HIV Disease Monitoring - No Viral Load tests	0%	0%		0	2	CLIENT
IMA - Combo1_2012 - Combination of One MEN Vaccine and One Tdap Vaccine or Td Vaccine	12%	5%		3	65	HEDIS
IMA_MEN_2012 - One Meningococcal Conjugate or Meningococcal Polysaccharide Vaccine	26%	22%		14	65	HEDIS
IMA_TdapTd_2012 - One Tdap or Td Vaccine	19%	8%		5	65	HEDIS
LBP_2012 - Use of Imaging Studies for Low Back Pain	84%	85%		103	121	HEDIS
LPA_2011 - Lipid profile anually	72%	71%	51%	397	556	CLIENT
MPM1_2012 - Annual Monitoring for Members on ACE Inhibitors or ARBs	90%	91%		390	427	HEDIS
MPM2_2012 - Annual Monitoring for Members on Digoxin	100%	100%		9	9	HEDIS
MPM3_2012 - Annual Monitoring for Members on Diuretics	90%	90%		378	419	HEDIS
MPM4_2012 - Annual Monitoring for Members on Anticonvulsants	50%	38%		5	13	HEDIS
MRI_LS_LBP_2013 - MRI of Lumbar Spine for Low Back Pain	21%	21%		12	58	OP # 8
NYU_EM_N/A - Emergent Visits - Necessary (Estimate).	12%	12%	11%	206	1767	NYU
NYU_EM_PA_N/A - Emergent Visits - Preventable/Avoidable (Estimate).	3%	3%	3%	57	1767	NYU
NYU_EM_PT_N/A - Emergent Visits - Primary Care Treatable (Estimate).	23%	23%	23%	407	1767	NYU
NYU_INJ_N/A - ER Visit - Injury	24%	24%	22%	429	1767	NYU
NYU_NON_EM_N/A - Non Emergent Visits (Estimate).	24%	23%	27%	415	1767	NYU
NYU_PSYCH_N/A - ER Visit - Mental Health	1%	1%	1%	16	1767	NYU
NYU_SA_N/A - ER Visit - Substance Abuse	1%	1%	1%	11	1767	NYU
NYU_UNC_N/A - ER Visit - Unclassified	12%	13%	13%	227	1767	NYU
PBH_2010 - Persistence of Beta-Blocker Treatment After a Heart Attack	100%	100%	0%	7	7	HEDIS

EBM Measure Description	EBM %			Compliant	Population	EBM Measure Source
	Comparative	Current	Prior			
PPC_POSTPARTUM_2012 - Postpartum care	22%	24%	64%	13	55	HEDIS
PPC_PRENATAL_2012 - Prenatal care	49%	51%	50%	28	55	HEDIS
PQI_1_2012 - All non-maternal, not transfered discharges age 18 years and older with Diabetes for short-term complications.	0%	0%	0%	0	5020	AHRQ
PQI_10_2012 - All non-maternal, not transfered discharges of age 18 years and older with diagnosis code for hypovolemia.	0%	0%	0%	0	5020	AHRQ
PQI_11_2013 - All non-maternal, not transf, non-sickle cell, non-immunocompromised discharges age >= 18 w/ bact pneumonia admission.	0%	0%	0%	0	5020	AHRQ
PQI_12_2012 - All non-maternal, not transf, non-kidney/urinary, non-immunocompromised discharges age >= 18 with urinary tract infect.	0%	0%	0%	0	5020	AHRQ
PQI_13_2012 - All non-maternal, not transfered, non-cardiac, discharges of age 18 years and older with angina without procedure.	0%	0%	0%	0	5020	AHRQ
PQI_14_2012 - All non-maternal, not transfered discharges of age 18 years and older with uncontrolled diabetes admission.	0%	0%	0%	0	5020	AHRQ
PQI_15_2012 - All non-maternal, not transf, non-cystic fribrosis, non-anomalies resp discharges of age >= 18 years with adult asthma.	0%	0%	0%	0	1975	AHRQ
PQI_16_2012 - All non-maternal, not transfered, non-trauma discharges of age >= 18 with Lower-extremity amputation with diabetes.	0%	0%	0%	0	5020	AHRQ
PQI_2_2012 - All non-maternal, not transfered discharges age 18 years and older with perforations or abscesses of appendix.	0%	0%	0%	0	9	AHRQ
PQI_3_2012 - All non-maternal, not transfered discharges age 18 years and older with diabetes long-term complications.	0%	0%	0%	0	5020	AHRQ
PQI_5_2012 - All non-maternal, not transfered discharges age 18 years and older with COPD admission.	0%	0%	0%	0	3045	AHRQ
PQI_7_2013 - All non-maternal, not transfered, non-cardiac, non-kidney hemodialysis discharges age >= 18 with hypertension admission.	0%	0%	0%	0	5020	AHRQ
PQI_8_2012 - All non-maternal, not transfered, non-cardiac, discharges age >= 18 years with Congestive Heart Failure (CHF) admission.	0%	0%	0%	0	5020	AHRQ
PQI_9_2012 - All non-transfered discharges for newborn births with diagnosis code for less than 2500 grams birthweight.	0%	0%	0%	0	83	AHRQ
PUR-A_2013 - Pressure Ulcer Rate in Adults	0%	0%		0	135	PSI#3
RER_2011 - Mental Health Readmission Rate	9%	9%	12%	9	99	CLIENT
W15 - FIVE_2012 - Well-Child Visits in the First 15 Months of Life, five well child visit	28%	32%		8	25	HEDIS
W15 - FOUR_2012 - Well-Child Visits in the First 15 Months of Life, four well child visit	8%	8%		2	25	HEDIS
W15 - ONE_2012 - Well-Child Visits in the First 15 Months of Life, one well child visit	0%	0%		0	25	HEDIS
W15 - SIX OR MORE_2012 - Well-Child Visits in the First 15 Months of Life, six or more well child visit	50%	48%		12	25	HEDIS
W15 - THREE_2012 - Well-Child Visits in the First 15 Months of Life, three well child visit	0%	0%		0	25	HEDIS
W15 - TWO_2012 - Well-Child Visits in the First 15 Months of Life, two well child visit	5%	4%		1	25	HEDIS
W15 - ZERO_2012 - Well-Child Visits in the First 15 Months of Life, zero well child visit	10%	8%		2	25	HEDIS

EBM Measure Description	EBM %			Compliant	Population	EBM Measure Source
	Comparative	Current	Prior			
W34_2012 - Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life	77%	78%		211	269	HEDIS

· HEDIS is the Healthcare Effectiveness Data and Information Set which is a set of quality metrics maintained by the National Committee for Quality Assurance (NCQA).

· The Prevention Quality Indicators (PQIs) is a set of measures that can be used with hospital inpatient discharge data to identify quality of care for "ambulatory care sensitive conditions." These are conditions for which good outpatient care can potentially prevent the need for hospitalization or for which early intervention can prevent complications or more severe disease. The PQIs are population based and adjusted for covariates. The PQIs are maintained by the Agency for Healthcare Research and Quality (AHRQ).

· The New York University (NYU) algorithm of potentially avoidable ER visits evaluates members who visited the emergency department and categorizes the visit into three primary categories: Non-Emergent, Primary Care Treatable, and Preventable/Avoidable.

VIII. Summary of Amounts Paid

This summary allows you to reconcile what you have paid to WEA Trust and tie to the numbers in this report.

		Incurred in Month	Incurred in Month	
Year Month	Premium	Paid	Medical	Rx
2013-12	$2,569,101	$2,993,117	$2,371,365	$621,753
2014-01	$2,726,274	$3,207,019	$2,698,268	$508,751
2014-02	$2,720,782	$3,164,537	$2,672,854	$491,683
2014-03	$2,722,633	$3,239,874	$2,692,494	$547,380
2014-04	$2,711,677	$3,420,581	$2,891,543	$529,038
2014-05	$2,717,749	$4,006,702	$3,440,585	$566,116
2014-06	$2,719,349	$3,773,051	$3,189,865	$583,186
2014-07	$2,724,215	$3,438,040	$2,833,910	$604,130
2014-08	$2,717,999	$3,319,389	$2,751,753	$567,636
2014-09	$2,707,857	$3,551,668	$2,934,031	$617,637
2014-10	$2,707,483	$4,142,544	$3,420,245	$722,299
2014-11	$2,715,425	$3,376,105	$2,749,799	$626,306
2014-12	$2,718,511	$3,708,528	$2,896,152	$812,376
2015-01	$2,972,649	$3,776,232	$3,118,395	$657,837
2015-02	$2,971,786	$3,761,351	$3,184,592	$576,758
2015-03	$2,982,075	$3,725,858	$3,054,477	$671,381
2015-04	$3,004,346	$3,752,736	$3,130,842	$621,895
2015-05	$3,008,383	$3,691,782	$3,043,543	$648,239
2015-06	$3,013,514	$3,834,652	$3,159,800	$674,852
Current	**$34,244,244**	**$44,078,885**	**$36,277,539**	**$7,801,346**
Prior	**$18,887,566**	**$23,804,881**	**$19,956,974**	**$3,847,907**
Total	**$53,131,810**	**$67,883,766**	**$56,234,514**	**$11,649,253**

IX. Conclusion

This report is intended to provide you with an overall picture of your healthcare experience. From this report, WEA Trust hopes you are able to identify opportunities to focus on for short-term and long-term change. The intent of this report is to give you insight into actionable items that you and WEA Trust can put into place to improve the quality and efficiency of your members' healthcare.

Comparisons of your experience from the prior year to the current year will also let you monitor your performance over time. It is important to understand the trends of your population and your healthcare spend so you can manage future outcomes. A comparison of your experience to benchmarks is also critical. Knowing how you are performing compared to others will help you determine the areas that you may excel at as well as the areas that you can focus on for future change.

X. Glossary

Term	Definition
Actual Result	Your organization's performance.
Admits	Number of patients admitted to the hospital for an overnight stay.
Admits / Cases	Hospital Inpatient - Number of patients admitted to the hospital for an overnight stay. Hospital Outpatient (Emergency Room, Surgery) - Number of patients treated in the Emergency Room or Surgery, but did not stay at the hospital overnight. All Other - N/A
Age Category	The age ranges into which the patients are grouped.
Allowed Amount	See *Amount Allowed*
Allowed per Utilization	Amount Allowed/Utilization. The sum of amount allowed divided by the total number of units of utilization in a given time period. The unit of utilization varies by service category.
Allowed PMPM	Total Amount Allowed / Member Months in period
ALOS	Average Length of Stay (Number of Inpatient days / Number of Admits).
Amount Allowed	Total allowed to be paid to the provider for services provided. *Includes all patient responsibility and coordination of benefits payments.*
Amount Paid	The total amount paid to the provider by the insurance plan for a specific service. Equal to provider contractual allowed amount less patient cost sharing and other insurer payments.
Ancillary Services	Medical services that are typically provided and billed by an entity other than a physician or hospital. Examples of these services are ambulance, durable medical equipment and home health services.
Annual Utilization per 1,000	(Utilization/Cumulative Member months) * 1000 * 12 The following example illustrates how the formula is applied. Between month A and month B, employer XYZ had 4,278 inpatient days. Member months for the period was 178,515 Using the formula above, we calculate the annual days per 1,000 for the period as follows: Utilization (days) during a given period: 4,278 Member months during the same period: 178,515 Average Days per Member per Month: 0.02396 Multiply 0.02396 by 1000 to convert to a per 1000 rate 23.96 Normalize monthly average to annual rate by multiplying by 23.96 by 12= 287.52
Average Number of Members	Member months in reporting period divided by the number of months in period.
Average Demographic Risk Score per Member	The average risk score for a group of members calculated considering demographic factors (age, gender, etc.)
Average Prospective Risk Score per Member	The average risk score for a group of members calculated with base year claims data to predict future risk for a group of members.
Average Retrospective Risk Score per Member	The average risk score for a group of members calculated with base year claims data to determine a risk score for the base year.
Billed Amount	Total amount for which the plan was billed for services by the provider(s).

Term	Definition
CCHG	Chronic Condition Hierarchical Groups allow you to see what proportion of your members are falling into various disease populations as well as the proportion of your population that is healthy.
Capitation	A method of hospital or physician payment where the provider is paid a predetermined amount per member for a specified period of time for all medical services of a defined type.
Claims Lag	The number of months behind the most recent paid month to maximize the amount of incurred claims.
Concurrent Risk Score	Historic Risk Score for each member based on the previous twelve months.
Contractual Savings	The dollar amounts saved due to the health plans negotiated agreements with health care providers for services.
Coordination of Benefits (COB)	When a patient is covered by multiple insurance plans, the claims get sent to the primary insurer first.
Co-pay PMPM	The total fixed amount all patients must pay for a provider's services at the time of service per total number of member months in a given time period.
Cost Sharing Amount	Cost Sharing Amount paid by patient including co-pays, deductibles, co-insurance and maximum allowed benefits.
Days	Number of inpatient days.
Generic	Generic prescription drugs.
Health Cost Guideline (HCG) Categories	The HCG categorizes health care claims data into Milliman's Health Cost Guidelines categories (which are categories of similar types of services) and calculates utilization measures. The Inpatient and Outpatient Hospital sections contain only facility costs. They do not contain professional costs related to inpatient or outpatient hospital care. The Physician section contains professional costs. The Other section contains other miscellaneous costs.
Length of Stay (LOS)	Number of Inpatient days for a particular claim
MARA	Milliman Advanced Risk Adjuster: Risk classification system developed by Milliman.
Medical Expenses	Medical claims (claim forms CMS 1450 and/or CMS 1500).
Medical Loss Ratio	*Total Paid Claims ÷ Premiums*
Member Month	A member month is equal to one month of enrollment for one member. If a member is enrolled for two months, the member month count for the two month period is two. If two members are each only enrolled for one month, then the member month count for that period is also two.
Members	Number of members enrolled during the period.
Non-Preferred Brand	Prescription drugs not included in plan's formulary (list of prescriptions recommended or preferred by the health plan) and is not generic.
Paid Amount	Amount that the health plan paid to a provider for services or claims. (also referred to as Amount Paid)
Paid Month	The date the claim was paid in year and month format.
Paid PMPM	Paid per member per month. Total amount Paid by health plan to providers divided by the total number of member months in the specified time period.
Percent of Total Allowed	Amount Allowed for a given category / Total Amount Allowed across all reported categories for all patients.

Term	Definition
Predicted Future Annual Cost	Predicted Future Annual Cost calculated as Comparative Benchmark Paid PMPM * 12 * Prospective Risk Score.
Premiums	Amount that an employer pays to the health plan on behalf of covered subscribers.
Prospective Risk Score	Future Risk Score for each member based on medical conditions identified.
Specialty Drug	High-cost prescription drugs that treat complex conditions and require special handling and administration.
Therapeutic Class	Classification of similar medications used to treat a specific condition or disease.
Tier	Contract levels comprised of subscribers, spouses and other dependents. For example, a three tier structure includes single, two party and family contracts.
Total Medical	Sum of *Medical Expenses*, *Drug Expenses*, and *Other Financial Adjustments.*
Utilization	Total number of days for all inpatient stays during a period or the total number of procedures for all professional services during a period.