



DEMO HEALTH PLAN PERFORMANCE REPORT



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 CHAPTER DESCRIPTION

This chapter provides gross financial and membership information for Client B based on paid claims and enrollment from the current and prior annual reporting periods. The claims have not been aggregated or summarized, so all transactions are reflected based on the paid date for each individual transaction. This means that original claims are reflected based on the original processing date and adjustments are based on the date of the adjustment, even if the original claim was processed at a different time.

The first report provides a breakdown of key gross expenditures, from billed amount to paid amount, for the two reporting periods. This report may highlight key measures where there have been dramatic changes in the last year, and their potential impact on gross paid expenses.

The second report displays the percentage of the billed amounts accounted for by discounts and the allowed amount. Also presented is the percentage of the allowed amount accounted for by member cost sharing, COB, Medicare COB and the paid amount. It is important to monitor how these expense categories impact the overall costs over time. For example, changes to the plan design may be reflected by a change in the proportion of member cost sharing to the allowed amount, and ultimately what is the liability of the plan, changes in the percentage of discounts may reflect provider contract changes or shifts in provider-mix, and changes in COB amounts may reflect a change in benefits or a changed focus to capture funds from these sources.

The third report presents gross allowed and paid amounts by service category, along with percentages these amounts by service category are to the total allowed amount and total paid amount. This breakdown provides a high level view of what service categories areas are driving expenses and potentially highlights areas for further attention.

The fourth report provides information on overall membership. The next two tables display how membership has changed by employee status and how the average contract size by coverage tier has changed. Monitoring these membership characteristics can provide important information about trends in the covered population.

The final reports focus on how expenditures are distributed by claimant. The distribution of claimants by paid amount shows the percentage of claimants at different levels of total annual payments and how this distribution has changed over time. Analysis of this report can highlight the impact of high cost claimants on the overall costs. The distribution of claimants by member cost sharing shows the percentage of claimants at different levels of out of pocket expenses. This report helps determine the impact of any changes in plan design on member cost sharing.

Data Note

Reporting is based on paid, 12-month rolling periods.

Current reporting period represents claims paid from Jan'06 to Dec'06.

Prior reporting period represents claims paid from Jan'05 to Dec'05.

Raw claims for all active, retiree under 65, retiree 65 and over and COBRA members are reported (if available).

 SUMMARY OF FINDINGS

Paid expenses increased by \$5,846,210, from \$19,730,852 to \$25,577,062.

DEMO discounts increased by \$5,069,642, from \$25,435,358 to \$30,505,000.

Member cost sharing expenses decreased by \$96,791, from \$5,851,947 to \$5,755,157.

Membership increased by 929 members.

SUMMARY OF FINANCIAL MEASURES

Report Description: This report provides an overview of Client B's health care expenses from billed to paid as well as providing a percent change in these expenses between the two reporting periods. Some key financial measures are displayed below. These metrics include plan performance measures, such as the degree of discounts the plan was able to achieve, as well as COB and Medicare COB recoveries that the plan was able to receive based on other insurance contributing to the overall expenses. Information is also provided on the amount of overall health care expenses that the member was directly responsible for, through deductibles, coinsurance or co-payments. Finally, the report provides information on the level and percent changes in paid expenses, which represents Client B's liability. Definitions of these financial measures can be found in the glossary.¹

Client B			
	JAN'06-DEC'06	JAN'05-DEC'05	% CHANGE
BILLED	\$69,548,382	\$58,250,779	19.4%
NOT COVERED	\$4,683,306	\$3,273,820	43.1%
DISCOUNT	\$30,505,000	\$25,435,358	19.9%
ALLOWED	\$34,360,075	\$29,541,602	16.3%
MEMBER COST SHARING	\$5,755,157	\$5,851,947	-1.7%
COB	\$498,430	\$363,297	37.2%
MEDICARE COB	\$2,695,428	\$3,737,613	-27.9%
PAID	\$25,577,062	\$19,730,852	29.6%

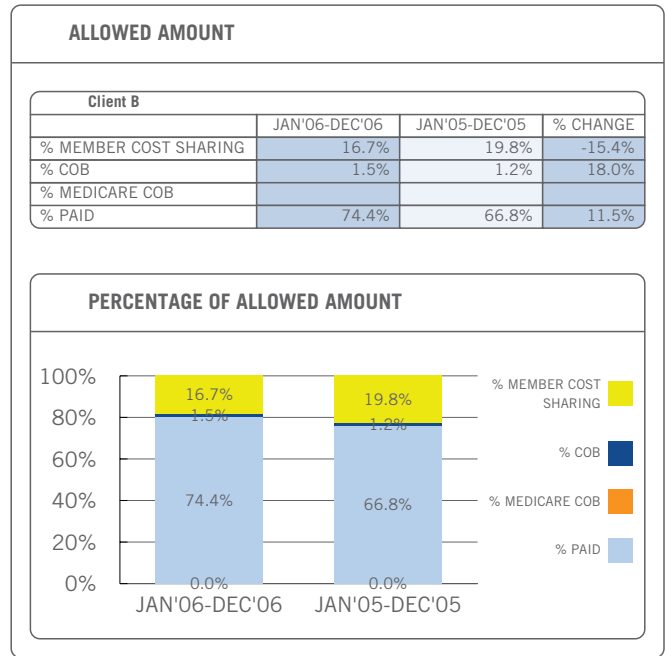
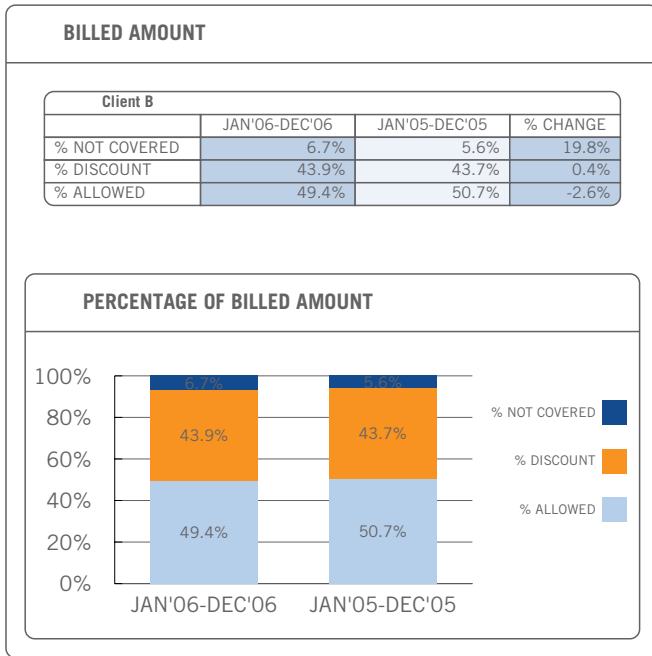
- ⊙ **Billed:** The billed amount increased by \$11,297,602 (19.4% increase).
- ⊙ **Not Covered:** The not covered amount increased by \$1,409,487 (43.1% increase).
- ⊙ **Discount:** The discount amount increased by \$5,069,642 (19.9% increase).
- ⊙ **Allowed:** The allowed amount increased by \$4,818,474 (16.3% increase).
- ⊙ **Member Cost Sharing:** The member cost sharing amount decreased by \$96,791 (1.7% decrease).
- ⊙ **COB/Medicare COB:** Total COB recoveries decreased by \$907,052 (22.1% decrease).
- ⊙ **Paid:** The paid amount increased by \$5,846,210 (29.6% increase).



¹Financials may vary from ASO Financial Reporting.

COMPONENTS OF BILLED AND ALLOWED AMOUNTS

Report Description: The breakdown of and amount of change in Client B's billed and allowed amounts are analyzed below. The discount amount, not covered amount and allowed amount are presented as a percentage of the billed amount. The member cost sharing amount, COB recoveries, and paid amount are presented as a percentage of the allowed amount.



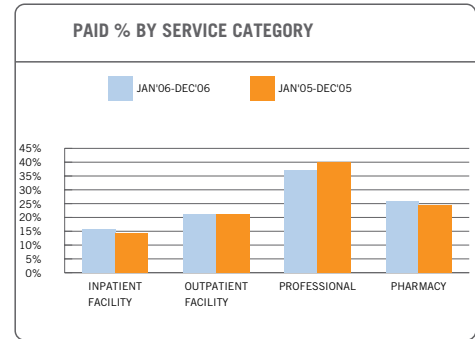
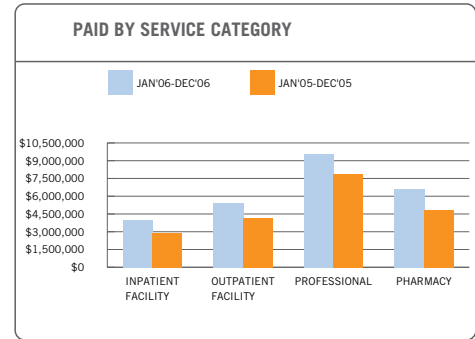
Billed Amount: The allowed amount was 49.4% of the billed amount for the current reporting period, which remained the same from the prior reporting period. Discounts were 43.9% of the billed amount, which remained the same from the prior reporting period. The remaining not covered amount was 6.7% of the billed amount, which increased 19.8% from the prior reporting period.

Allowed Amount: The paid amount was 74.4% of the allowed amount for the current reporting period, which increased 11.5% over the prior reporting period. The member cost sharing amount decreased 15.4% from 19.8% to 16.7% of the allowed amount.

KEY FINANCIAL MEASURES BY SERVICE CATEGORY

Report Description: The percent change in the allowed and paid amounts by service category (inpatient facility, outpatient facility, professional and pharmacy) is analyzed to determine which service categories have contributed to the overall percent change in these key financial measures in the last year.

Client B		JAN'06-DEC'06	JAN'05-DEC'05	% CHANGE
INPATIENT FACILITY	ALLOWED	\$5,611,197	\$5,324,084	5.4%
	ALLOWED %	16.3%	18.0%	-9.4%
	PAID	\$3,963,565	\$2,809,578	41.1%
	PAID %	15.5%	14.2%	8.8%
OUTPATIENT FACILITY	ALLOWED	\$7,654,447	\$6,712,849	14.0%
	ALLOWED %	22.3%	22.7%	-2.0%
	PAID	\$5,359,287	\$4,117,580	30.2%
	PAID %	21.0%	20.9%	0.4%
PROFESSIONAL	ALLOWED	\$12,872,269	\$10,712,006	20.2%
	ALLOWED %	37.5%	36.3%	3.3%
	PAID	\$9,490,988	\$7,872,734	20.6%
	PAID %	37.1%	39.9%	-7.0%
PHARMACY	ALLOWED	\$8,222,163	\$6,792,662	21.0%
	ALLOWED %	23.9%	23.0%	4.1%
	PAID	\$6,597,220	\$4,788,853	37.8%
	PAID %	25.8%	24.3%	6.3%
MANAGEMENT SERVICES	ALLOWED	\$0	\$0	
	ALLOWED %	0.0%	0.0%	
	PAID	\$166,001	\$142,107	16.8%
	PAID %	0.6%	0.7%	-9.9%
SUMMARY	ALLOWED	\$34,360,075	\$29,541,602	16.3%
	ALLOWED %	100.0%	100.0%	0.0%
	PAID	\$25,577,062	\$19,730,852	29.6%
	PAID %	100.0%	100.0%	0.0%



Change in Paid: Overall paid expenses increased 29.6%. Paid by service category showed Inpatient Facility, with a change of 41.1%, and Pharmacy, with a change of 37.8%, were the primary drivers of this percent change. Outpatient Facility and Professional had paid expense changes of 30.2% and 20.6%, respectively.

Paid % by Service Category: In terms of the proportion of overall paid expenses by service category, Professional paid expenses accounted for 37.1% of the overall paid expenses during the current reporting period, which decreased 7.0% over the prior reporting period. The next highest service category was Pharmacy, which accounted for 25.8% of the overall paid expenses and increased 6.3% over the prior reporting period.

MEMBERSHIP

Report Description: This report provides a high-level view of Client B's membership, broken down by employee status. These numbers show if a certain employee status was a key driver to any changes in overall membership between the current reporting period and the prior reporting period. In addition, the average contract size by coverage tier for Client B is provided.

Client B			
AVERAGE ENROLLED MEMBERSHIP BY EMPLOYEE STATUS			
EMPLOYEE STATUS	JAN'06-DEC'06	JAN'05-DEC'05	% CHANGE
ACTIVE	9,412	8,406	12.0%
RETIREE UNDER 65	169	187	-9.4%
RETIREE 65 AND OVER	484	491	-1.5%
COBRA	86	138	-37.8%
SUMMARY	10,151	9,222	10.1%

Client B			
AVERAGE CONTRACT SIZE BY COVERAGE TIER			
COVERAGE TIER	JAN'06-DEC'06	JAN'05-DEC'05	% CHANGE
EMPLOYEE ONLY	1.00	1.00	-0.2%
EMPLOYEE + ONE	2.00	2.00	-0.1%
EMPLOYEE + DEPENDENT(S)	2.53	2.51	0.8%
FAMILY	3.92	3.92	0.1%
SUMMARY	2.15	2.17	-0.9%

Membership by Employee Status: Client B's overall membership increased 10.1%. The change in membership by employee status showed: actives increased 12.0%, retirees under 65 decreased 9.4%, retirees 65 and over remained stable and COBRA members decreased 37.8%.

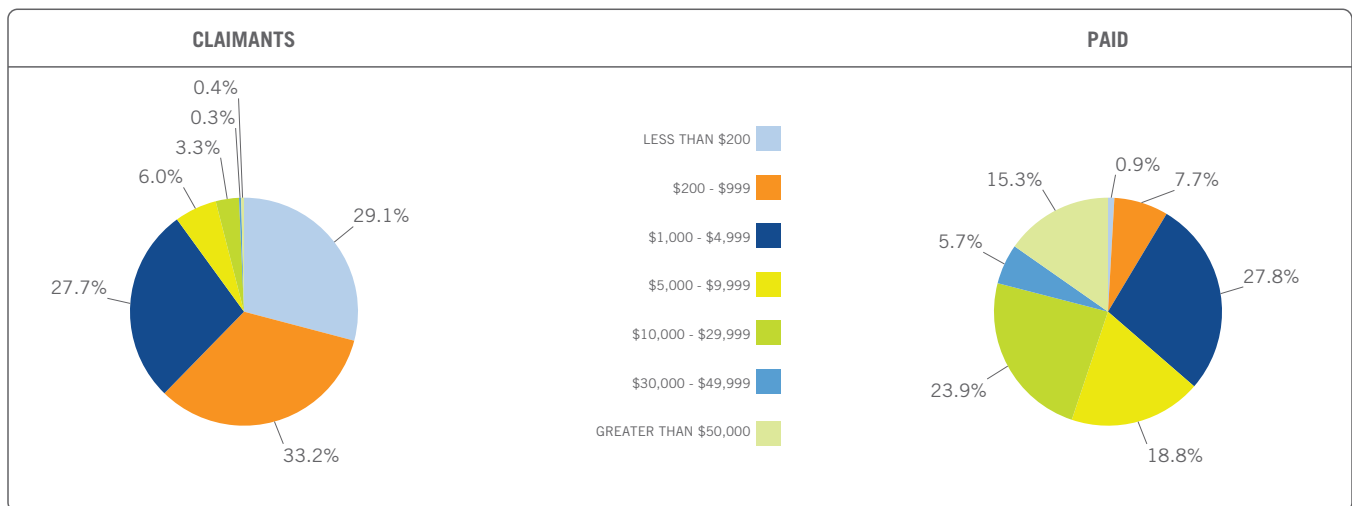
Contract Size by Coverage Tier: Over the two reporting periods, the contract size for Client B remained stable from 2.17 to 2.15.

PAID EXPENSE DISTRIBUTION BY CLAIMANT

Report Description: The distribution of paid expense by claimant, including any changes that have occurred in the last year, is analyzed below. The table below shows if there were significant changes in the proportion of claimants in the paid amount ranges and if there were any changes in the average paid per claimant amount over the two reporting periods. The graphs display the percentage of claimants and paid expenses for the current reporting period.¹

Client B										
PAID	JAN'06-DEC'06					JAN'05-DEC'05				
	CLAIMANTS	CLAIMANTS %	PAID	PAID %	PAID/ CLAIMANT	CLAIMANTS	CLAIMANTS %	PAID	PAID %	PAID/ CLAIMANT
LESS THAN \$200	3,398	29.1%	\$224,984	0.9%	\$66	3,497	32.4%	\$232,863	1.1%	\$67
\$200 - \$999	3,874	33.2%	\$1,988,928	7.7%	\$513	3,631	33.7%	\$1,835,832	9.1%	\$506
\$1,000 - \$4,999	3,234	27.7%	\$7,195,358	27.8%	\$2,225	2,796	25.9%	\$6,360,294	31.4%	\$2,275
\$5,000 - \$9,999	697	6.0%	\$4,876,007	18.8%	\$6,996	523	4.9%	\$3,606,263	17.8%	\$6,895
\$10,000 - \$29,999	389	3.3%	\$6,188,823	23.9%	\$15,910	275	2.6%	\$4,276,367	21.1%	\$15,550
\$30,000 - \$49,999	39	0.3%	\$1,470,334	5.7%	\$37,701	34	0.3%	\$1,350,472	6.7%	\$39,720
GREATER THAN \$50,000	45	0.4%	\$3,974,515	15.3%	\$88,323	26	0.2%	\$2,616,943	12.9%	\$100,652
SUMMARY	11,676	100.0%	\$25,918,949	100.0%	\$2,220	10,782	100.0%	\$20,279,033	100.0%	\$1,881

Client B			
PAID	% CHANGE		
	CLAIMANTS	PAID	PAID/ CLAIMANT
LESS THAN \$200	-2.8%	-3.4%	-0.6%
\$200 - \$999	6.7%	8.3%	1.5%
\$1,000 - \$4,999	15.7%	13.1%	-2.2%
\$5,000 - \$9,999	33.3%	35.2%	1.5%
\$10,000 - \$29,999	41.5%	44.7%	2.3%
\$30,000 - \$49,999	14.7%	8.9%	-5.1%
GREATER THAN \$50,000	73.1%	51.9%	-12.2%
SUMMARY	8.3%	27.8%	18.0%



The proportion of claimants who received less than \$200 in services in the current reporting period was 29.1%, which decreased 10.3% over the prior reporting period. These claimants spent 0.9% of the total paid expenses and the average paid expense per claimant was \$66.

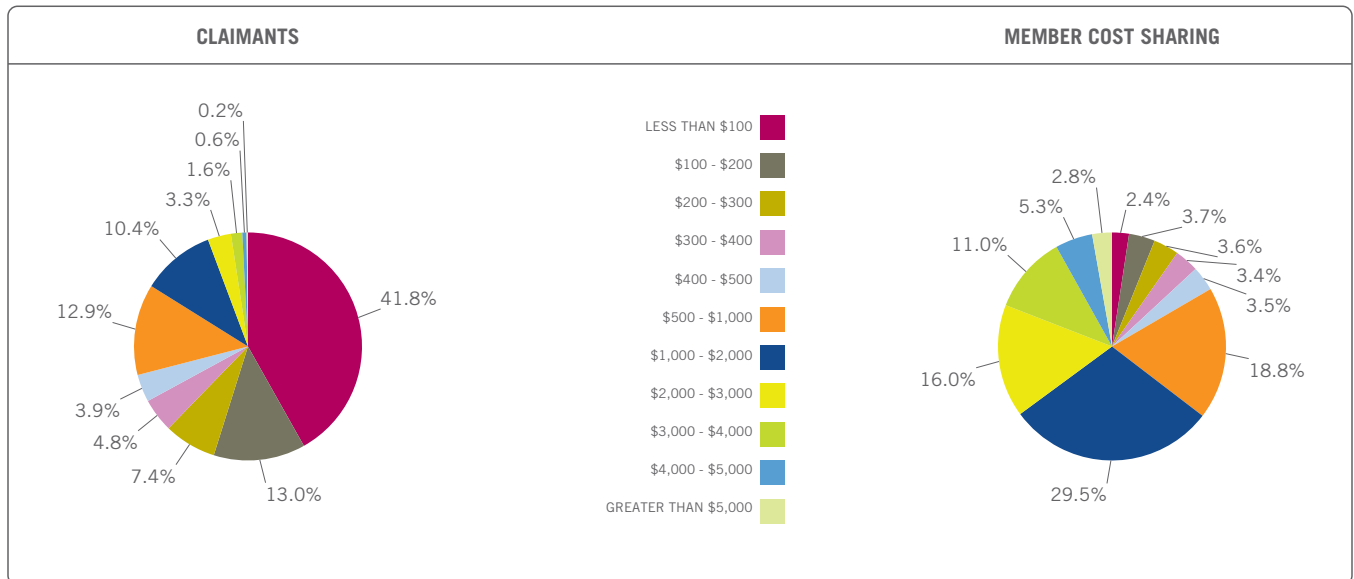
0.7% of claimants had expenses over \$30,000, which increased 29.3% over the prior reporting period. These claimants spent 21.0% of the total paid expenses and the average paid expense per claimant was \$64,820.

¹This is a claimant analysis, where only members who have submitted a claim are included.

MEMBER COST SHARING DISTRIBUTION BY CLAIMANT

Report Description: The impact of cost sharing provisions are analyzed to determine the overall liability incurred by the member. This report provides a distribution of claimants by their total member cost sharing expenses in the current reporting period as well as the prior reporting period. If changes have been made to plan design, this report helps analyze what the impact of those changes have been to the member. The graphs display the percentage of claimants and member cost sharing expenses for the current reporting period.¹

Client B											
MEMBER COST SHARING	JAN'06-DEC'06				JAN'05-DEC'05				% CHANGE		
	CLAIMANTS	CLAIMANTS %	MEMBER COST SHARING	MEMBER COST SHARING %	CLAIMANTS	CLAIMANTS %	MEMBER COST SHARING	MEMBER COST SHARING %	CLAIMANTS	MEMBER COST SHARING	
LESS THAN \$100	4,875	41.8%	\$142,290	2.4%	4,265	39.6%	\$122,134	2.1%	14.3%	16.5%	
\$100 - \$200	1,520	13.0%	\$216,875	3.7%	1,450	13.4%	\$211,133	3.6%	4.8%	2.7%	
\$200 - \$300	864	7.4%	\$210,767	3.6%	898	8.3%	\$217,886	3.7%	-3.8%	-3.3%	
\$300 - \$400	565	4.8%	\$195,326	3.4%	580	5.4%	\$200,579	3.4%	-2.6%	-2.6%	
\$400 - \$500	457	3.9%	\$203,775	3.5%	454	4.2%	\$202,793	3.4%	0.7%	0.5%	
\$500 - \$1,000	1,508	12.9%	\$1,092,255	18.8%	1,250	11.6%	\$902,749	15.3%	20.6%	21.0%	
\$1,000 - \$2,000	1,217	10.4%	\$1,716,846	29.5%	1,071	9.9%	\$1,512,419	25.7%	13.6%	13.5%	
\$2,000 - \$3,000	385	3.3%	\$931,462	16.0%	461	4.3%	\$1,136,524	19.3%	-16.5%	-18.0%	
\$3,000 - \$4,000	189	1.6%	\$642,032	11.0%	235	2.2%	\$802,562	13.6%	-19.6%	-20.0%	
\$4,000 - \$5,000	70	0.6%	\$306,469	5.3%	81	0.8%	\$356,797	6.1%	-13.6%	-14.1%	
GREATER THAN \$5,000	26	0.2%	\$160,785	2.8%	37	0.3%	\$224,552	3.8%	-29.7%	-28.4%	
SUMMARY	11,676	100.0%	\$5,818,882	100.0%	10,782	100.0%	\$5,890,127	100.0%	8.3%	-1.2%	



Over the two reporting periods, the average member cost sharing expense per claimant decreased 8.8% from \$546 to \$498. Claimants with under \$200 in member cost sharing expenses increased 11.9%. Claimants with member cost sharing expenses in the range of \$500 - \$1000 showed the most growth at 20.6%.

¹This is a claimant analysis, where only members who have submitted a claim are included.

CHAPTER DESCRIPTION

The Key Indicators report is intended to provide key metrics for Client B's claims and eligibility experience. Year-over-year changes and comparisons to the benchmark are provided as well. Typically, when analyzing the health plan's overall performance in the last year, two sets of questions are asked:

1. What is the percent change in membership and paid expenses? For paid expenses, is it driven by utilization, price or both?
2. How does Client B's experience compare to the benchmark? For paid expenses, is the difference driven by utilization, price or both?

The report provides a high-level breakdown of year-over-year changes and comparisons to the benchmark and also highlights the effects that utilization and price had on these differences. Graphs are also provided that show the proportion of paid PMPM by service category and the percent changes in expenses, utilization and price by service category.

SUMMARY OF FINDINGS

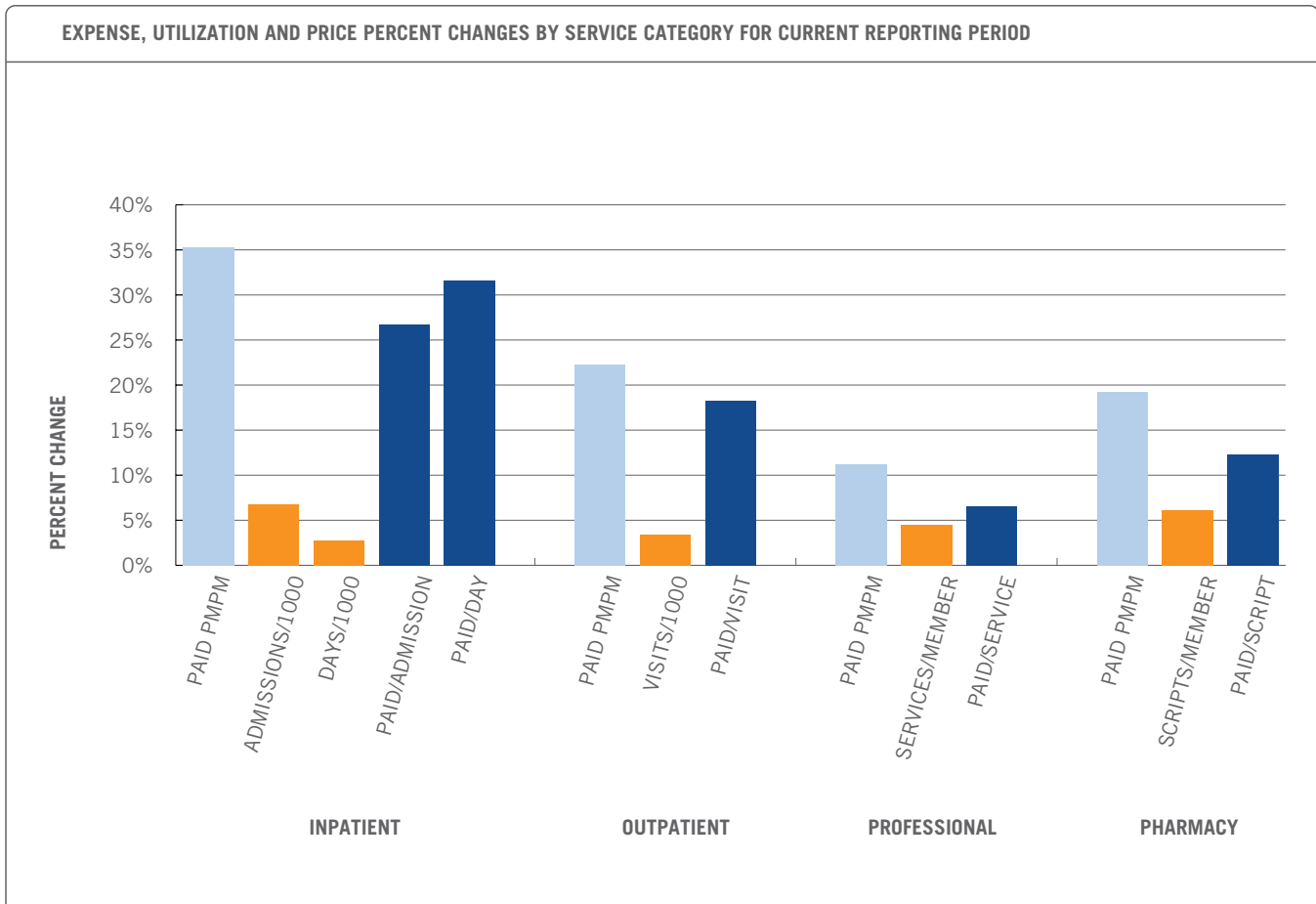
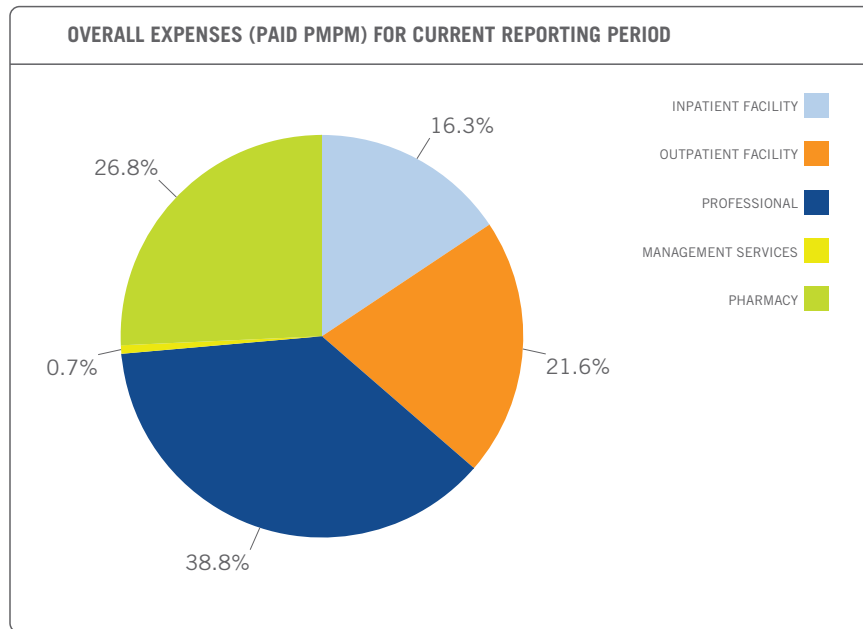
Overall membership increased 10.8%. Contract size remained stable and the average age remained stable. The demographic index, which measures the potential impact of changes in age and gender (demographic mix) on paid expenses, remained stable.

Overall paid PMPM increased 19.3%. For paid PMPM by service category, inpatient facility increased 35.2%, outpatient facility increased 22.2%, professional increased 11.2% and pharmacy increased 19.2%.

KEY INDICATORS

	Client B			BENCHMARK	% VARIANCE
	NOV'05-OCT'06	NOV'04-OCT'05	% CHANGE		
DEMOGRAPHICS					
AVERAGE SUBSCRIBERS	4,661	4,169	11.8%		
AVERAGE DEPENDENTS	5,368	4,884	9.9%		
AVERAGE MEMBERS	10,030	9,052	10.8%		
AVERAGE CONTRACT SIZE	2.15	2.17	-0.9%		
AVERAGE AGE (YEARS)	34.7	34.8	-0.1%		
PROPORTION OF MALES	41.1%	41.5%	-0.8%	43.2%	-4.7%
PROPORTION OF FEMALES	58.9%	58.5%	0.6%	56.8%	3.6%
PROPORTION OF CHILDBEARING FEMALES (20-44 YEARS)	25.4%	25.5%	-0.2%	24.6%	3.3%
DEMOGRAPHIC INDEX	0.9304	0.9280	0.3%	0.9260	0.5%
OVERALL EXPENSES (PAID PMPM)					
INPATIENT FACILITY	\$32.40	\$23.96	35.2%	\$31.70	2.2%
OUTPATIENT FACILITY	\$42.76	\$35.00	22.2%	\$40.51	5.6%
PROFESSIONAL	\$76.94	\$69.20	11.2%	\$75.71	1.6%
MANAGEMENT SERVICES	\$1.37	\$1.24	10.5%	\$1.13	20.8%
PHARMACY	\$53.13	\$44.59	19.2%	\$48.32	10.0%
TOTAL PAID PMPM	\$198.18	\$166.15	19.3%	\$192.32	3.0%
INPATIENT FACILITY UTILIZATION AND PRICE					
ADMISSIONS/1000	59.4	55.7	6.7%	53.7	10.7%
DAYS/1000	278.9	271.4	2.7%	252.1	10.6%
AVERAGE LENGTH OF STAY (ALOS)	4.7	4.9	-3.7%	4.6	1.0%
ALLOWED/ADMISSION	\$8,825	\$8,739	1.0%	\$9,346	-5.6%
ALLOWED/DAY	\$1,880	\$1,793	4.9%	\$2,012	-6.5%
PAID/ADMISSION	\$6,543	\$5,164	26.7%	\$7,086	-7.7%
PAID/DAY	\$1,394	\$1,059	31.6%	\$1,526	-8.6%
OUTPATIENT FACILITY UTILIZATION AND PRICE					
VISITS/1000	936.2	905.5	3.4%	834.1	12.2%
ALLOWED/VISIT	\$768	\$749	2.6%	\$810	-5.1%
PAID/VISIT	\$548	\$464	18.2%	\$583	-6.0%
EMERGENCY ROOM VISITS/1000	136.5	134.4	1.5%	142.0	-3.9%
EMERGENCY ROOM ALLOWED/VISIT	\$972	\$900	8.0%	\$891	9.1%
EMERGENCY ROOM PAID/VISIT	\$734	\$631	16.4%	\$675	8.8%
PROFESSIONAL UTILIZATION AND PRICE					
VISITS/MEMBER	8.0	7.8	2.3%		
SERVICES/MEMBER	15.9	15.2	4.4%	15.3	3.7%
ALLOWED/VISIT	\$155	\$144	7.2%		
ALLOWED/SERVICE	\$78	\$74	5.1%	\$78	-0.3%
PAID/VISIT	\$115	\$106	8.7%		
PAID/SERVICE	\$58	\$55	6.5%	\$59	-2.0%
OFFICE VISITS/MEMBER	6.6	6.5	2.3%		
OFFICE SERVICES/MEMBER	13.6	13.0	4.7%	13.1	3.3%
OFFICE ALLOWED/VISIT	\$125	\$117	7.2%		
OFFICE ALLOWED/SERVICE	\$61	\$59	4.7%	\$62	-0.7%
OFFICE PAID/VISIT	\$95	\$90	6.1%		
OFFICE PAID/SERVICE	\$47	\$45	3.6%	\$48	-2.2%
PHARMACY UTILIZATION AND PRICE					
PRESCRIPTIONS/MEMBER	12.9	12.1	6.1%	12.1	6.0%
GENERIC DISPENSING RATE	55.8%	50.1%	11.4%	55.8%	0.0%
ALLOWED/PRESCRIPTION	\$63	\$62	1.7%	\$63	-0.6%
PAID/PRESCRIPTION	\$50	\$44	12.3%	\$49	2.1%

KEY INDICATORS, CONTINUED



CHAPTER DESCRIPTION

This chapter presents information on key expense, utilization and price metrics for Client B, how they have changed over time and how they compare to the benchmark. The first report analyzes the percent change in payments PMPM by several factors, including changes in the size of the population (member months), changes in the age and gender mix of the population (demographic mix), changes in high cost claimant experience, and changes in the utilization and price of services. Each factor is analyzed in isolation by service category. The results can assist in identifying areas of concern and in focusing cost control efforts on areas where the impact is likely to be greatest. Plan design changes can also affect change but are outside the scope of this analysis.

The next group of reports displays information on changes in expenses, utilization and price by service category for Client B. The proportion of in-network expenses and utilization is also provided as is a comparison of prices by network indicator for all services by service category.

The final group of reports presents information on how Client B's experience compares to the benchmark for expenses, utilization and price by service category. Network experience is also compared to the benchmark for each measure.

Data Note

Reporting is based on incurred, 12-month rolling periods with 2 months run-out.

Current reporting period represents claims incurred Nov'05 through Oct'06 and paid through Dec'06.

Prior reporting period represents claims incurred Nov'04 through Oct'05 and paid through Dec'05.

Claims for active, retiree under 65, retiree 65 and over and COBRA members are reported.

SUMMARY OF FINDINGS

The overall paid PMPM percent change was 19.3%. The most important driver of percent change for Client B's paid PMPM was Price of Services. This component was followed by High Cost Claimants and by Utilization of Services, respectively.

When compared to the benchmark for the current reporting period, Client B's overall paid PMPM was slightly higher. By service category, services per 1,000 were higher for inpatient facility, higher for outpatient facility, slightly higher for professional and higher for pharmacy. Also, paid per service was lower for inpatient facility, lower for outpatient facility, similar for professional and slightly higher for pharmacy.

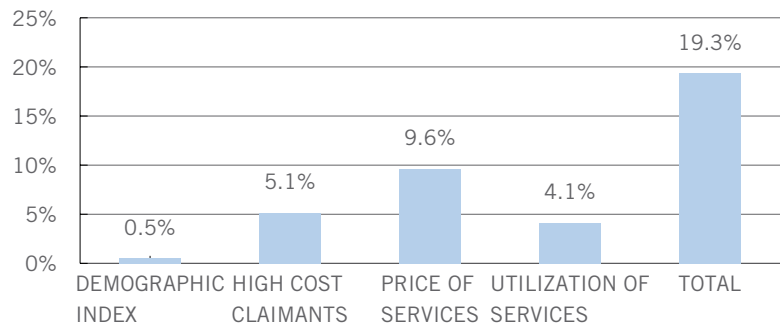
Client B's in-network paid percent stayed the same between the current and prior reporting periods and was comparable to the benchmark.

COMPONENTS OF CHANGE

Report Description: Client B's annual change in paid PMPM is analyzed to determine the impact of four factors on the change: changes in demographic composition, paid expenses associated with high cost claimants (claimants with annual paid expenses greater than \$30,000), service price and service utilization.

PAID PMPM	
NOV'05-OCT'06	\$198
NOV'04-OCT'05	\$166
DIFFERENCE	\$32
% CHANGE	19.3%

COMPONENTS OF CHANGE	
DEMOGRAPHIC INDEX	0.5%
HIGH COST CLAIMANTS	5.1%
PRICE OF SERVICES	9.6%
UTILIZATION OF SERVICES	4.1%
TOTAL	19.3%



PMPM PERCENTAGE POINTS	INPATIENT FACILITY	OUTPATIENT FACILITY	PROFESSIONAL	PHARMACY
DEMOGRAPHIC INDEX	0.2%	0.2%	0.2%	-0.7%
HIGH COST CLAIMANTS	13.5%	5.4%	3.3%	1.7%
PRICE OF SERVICES	19.8%	14.0%	4.6%	12.1%
UTILIZATION OF SERVICES	1.7%	2.6%	3.1%	6.0%
TOTAL	35.2%	22.2%	11.2%	19.2%

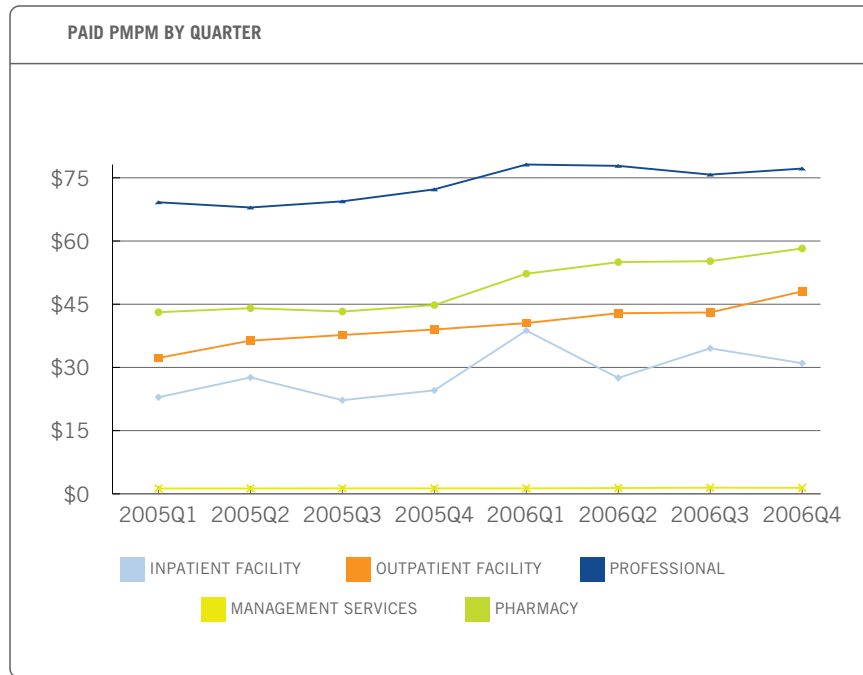
Between the current and the prior reporting periods, Client B's PMPM expenses increased 19.3%. Several factors contributed to this change:

- ⦿ Increase in Demographics: The demographic index of the underlying population increased between the reporting periods, accounting for 0.5 percentage point in the overall PMPM change.
- ⦿ Increase in High Cost Claimants: 5.1% of the 19.3% change was the result of an expense increase associated with high cost claimants.
- ⦿ Increase in Price: The unit price per service increased 9.6%. This can sometimes be attributed to a change in the mix and complexity of services, as well as technological advances in the medical field.
- ⦿ Increase in Utilization: 4.1% of the change was the result of higher utilization, driven primarily by Pharmacy and Professional services.

EXPENSE: MEASURES, PERCENT CHANGE AND IN-NETWORK EXPERIENCE

Report Description: Client B's percent change in paid PMPM and in-network paid percentages for the most recent reporting periods are presented in the table below. Measures are displayed overall and by service categories (inpatient facility, outpatient facility, professional, management services and pharmacy). The graph shows the paid PMPM amount by quarter for each service category.

Client B		NOV'05-OCT'06	NOV'04-OCT'05	% CHANGE
INPATIENT FACILITY	PAID PMPM	\$32.40	\$23.96	35.2%
	IN-NETWORK PAID %	99.0%	99.0%	0.1%
OUTPATIENT FACILITY	PAID PMPM	\$42.76	\$35.00	22.2%
	IN-NETWORK PAID %	99.9%	99.7%	0.2%
PROFESSIONAL	PAID PMPM	\$76.94	\$69.20	11.2%
	IN-NETWORK PAID %	97.1%	94.6%	2.5%
MANAGEMENT SERVICES	PAID PMPM	\$1.37	\$1.24	10.5%
	IN-NETWORK PAID %			
SUBTOTAL MEDICAL	PAID PMPM	\$153.47	\$129.40	18.6%
	IN-NETWORK PAID %	97.4%	95.9%	1.6%
PHARMACY	PAID PMPM	\$53.13	\$44.59	19.2%
	IN-NETWORK PAID %	100.0%	100.0%	0.0%
TOTAL	PAID PMPM	\$198.18	\$166.15	19.3%
	IN-NETWORK PAID %	98.1%	96.9%	1.1%



Inpatient Facility: Inpatient facility paid PMPM increased between the two reporting periods and the percent of in-network paid expense stayed the same.

Outpatient Facility: Outpatient facility paid PMPM increased between the two reporting periods and the percent of in-network paid expense stayed the same.

EXPENSE: MEASURES, PERCENT CHANGE AND IN-NETWORK EXPERIENCE, CONTINUED

Professional: Professional paid PMPM increased between the two reporting periods and the percent of in-network paid expense slightly increased.

Pharmacy: Pharmacy paid PMPM increased between the two reporting periods and the percent of in-network paid expense stayed the same.

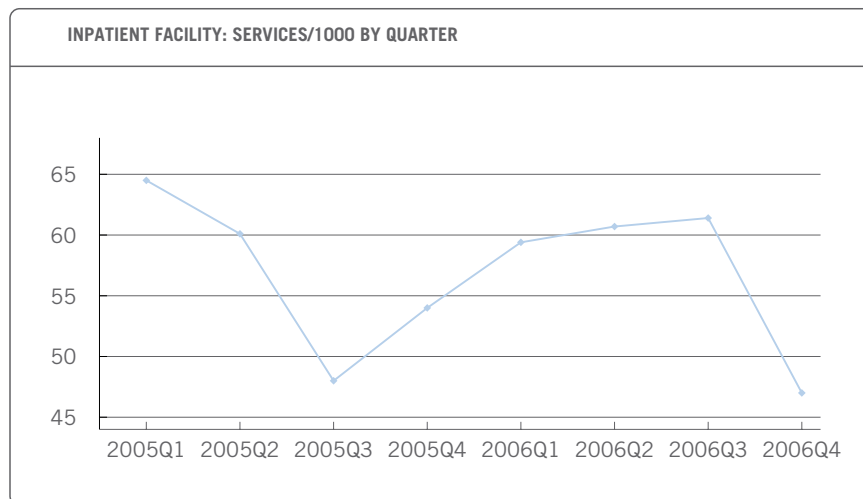
Total: Overall paid PMPM increased between the two reporting periods and the percent of in-network paid expense stayed the same.¹

¹Total paid PMPM measures are based on medical member months.

UTILIZATION: MEASURES, PERCENT CHANGE AND IN-NETWORK EXPERIENCE

Report Description: Client B's percent change in utilization rates and in-network usage percentages for the most recent reporting periods are displayed by service categories (inpatient facility, outpatient facility, professional and pharmacy). The largest utilization percent change, Inpatient Facility with 6.7%, is graphed by quarter below.

Client B		NOV'05-OCT'06	NOV'04-OCT'05	% CHANGE
INPATIENT FACILITY	SERVICES/1000	59.4	55.7	6.7%
	IN-NETWORK SERVICES %	98.5%	98.8%	-0.3%
	DAYS/1000	278.9	271.4	2.7%
	IN-NETWORK DAYS %	97.1%	94.8%	2.4%
OUTPATIENT FACILITY	SERVICES/1000	936.2	905.5	3.4%
	IN-NETWORK SERVICES %	99.9%	99.7%	0.2%
PROFESSIONAL	SERVICES/1000	15,855.5	15,187.1	4.4%
	IN-NETWORK SERVICES %	97.5%	96.2%	1.3%
	VISITS/1000	8,011.8	7,832.3	2.3%
	IN-NETWORK VISITS %	96.7%	95.2%	1.5%
PHARMACY	SERVICES/1000	12,853.0	12,111.9	6.1%
	IN-NETWORK SERVICES %	100.0%	100.0%	0.0%



Inpatient Facility: Inpatient facility admissions per 1,000 increased and days/1,000 increased slightly between the two reporting periods. The percent of in-network admissions was comparable and percent of in-network days was comparable in the current reporting period.

Outpatient Facility: Outpatient facility visits per 1,000 increased between the two reporting periods. The percent of in-network visits was comparable in the current reporting period.

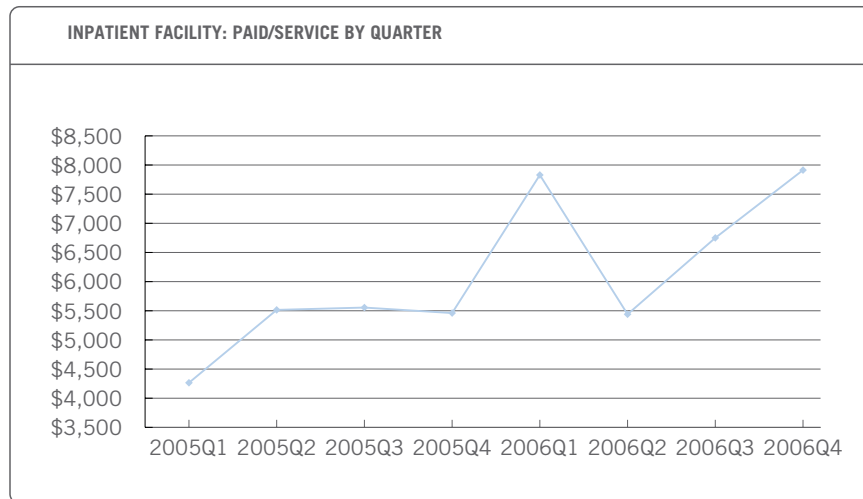
Professional: Professional services per 1,000 increased and visits per 1,000 slightly increased between the two reporting periods. The percent of in-network services was comparable and percent of in-network visits was comparable in the current reporting period.

Pharmacy: Pharmacy scripts per 1,000 increased between the two reporting periods.

PRICE: MEASURES, PERCENT CHANGE AND IN-NETWORK EXPERIENCE

Report Description: Client B's percent change in average prices and in-network prices for the most recent reporting periods are displayed by service categories (inpatient facility, outpatient facility, professional and pharmacy). The largest price percent change, Inpatient Facility with 26.7%, is graphed by quarter below.

Client B		NOV'05-OCT'06	NOV'04-OCT'05	% CHANGE
INPATIENT FACILITY	PAID/SERVICE	\$6,543	\$5,164	26.7%
	IN-NETWORK PAID/SERVICE	\$6,578	\$5,172	27.2%
OUTPATIENT FACILITY	PAID/SERVICE	\$548	\$464	18.2%
	IN-NETWORK PAID/SERVICE	\$548	\$464	18.2%
PROFESSIONAL	PAID/SERVICE	\$58	\$55	6.5%
	IN-NETWORK PAID/SERVICE	\$58	\$54	7.7%
	PAID/VISIT	\$115	\$106	8.7%
	IN-NETWORK PAID/VISIT	\$116	\$105	9.8%
PHARMACY	PAID/SERVICE	\$50	\$44	12.3%
	IN-NETWORK PAID/SERVICE	\$50	\$44	12.3%



Inpatient Facility: Inpatient facility paid/admission increased between the two reporting periods. In-network paid/admission was higher in the current reporting period.

Outpatient Facility: Outpatient facility paid/visit increased between the two reporting periods. In-network paid/visit was higher in the current reporting period.

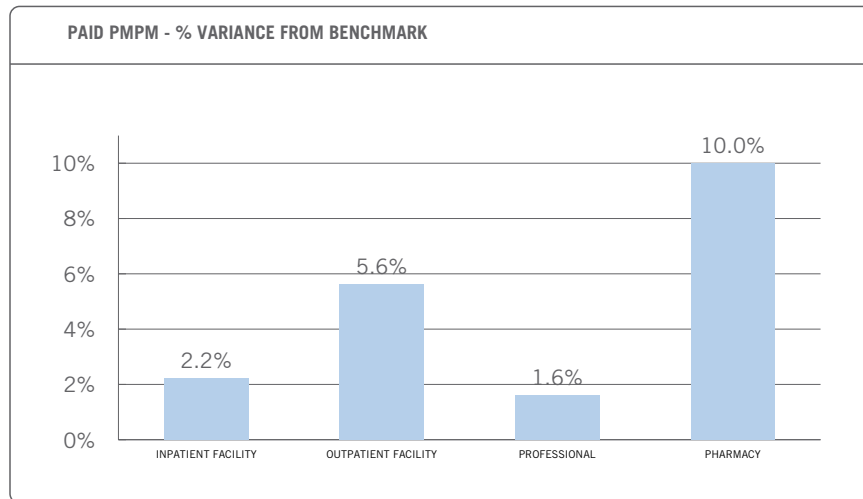
Professional: Professional paid/service increased and paid/visit increased between the two reporting periods. In-network paid/service was higher and in-network paid/visit was higher in the current reporting period.

Pharmacy: Pharmacy paid/script increased between the two reporting periods. In-network paid/script was higher in the current reporting period.

COMPARISON TO BENCHMARK: EXPENSE AND IN-NETWORK EXPERIENCE

Report Description: Client B's paid PMPM and in-network paid percentages are compared to the benchmark for the most recent reporting period in the table below. Measures are displayed overall and by service categories (inpatient facility, outpatient facility, professional and pharmacy). The graph shows paid PMPM variance from benchmark by service category.¹

		Client B	BENCHMARK	% VARIANCE
INPATIENT FACILITY	PAID PMPM	\$32.40	\$31.70	2.2%
	IN-NETWORK PAID %	99.0%	99.2%	-0.2%
OUTPATIENT FACILITY	PAID PMPM	\$42.76	\$40.51	5.6%
	IN-NETWORK PAID %	99.9%	98.8%	1.1%
PROFESSIONAL	PAID PMPM	\$76.94	\$75.71	1.6%
	IN-NETWORK PAID %	97.1%	95.9%	1.2%
MANAGEMENT SERVICES	PAID PMPM	\$1.37	\$1.13	20.8%
	IN-NETWORK PAID %			
SUBTOTAL MEDICAL	PAID PMPM	\$153.47	\$149.04	3.0%
	IN-NETWORK PAID %	97.4%	96.7%	0.7%
PHARMACY	PAID PMPM	\$53.13	\$48.32	10.0%
	IN-NETWORK PAID %	100.0%	100.0%	0.0%
TOTAL	PAID PMPM	\$198.18	\$192.32	3.0%
	IN-NETWORK PAID %	98.1%	97.5%	0.6%



Inpatient Facility: Inpatient facility paid PMPM was similar to the benchmark for the current reporting period. The percent of in-network paid expense was comparable to the benchmark.

Outpatient Facility: Outpatient facility paid PMPM was higher than the benchmark for the current reporting period. The percent of in-network paid expense was comparable to the benchmark.

Professional: Professional paid PMPM was similar to the benchmark for the current reporting period. The percent of in-network paid expense was comparable to the benchmark.

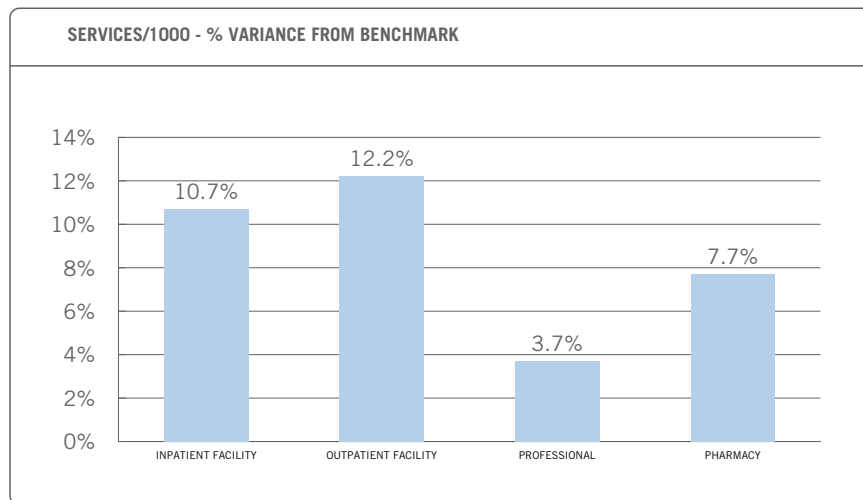
Pharmacy: Pharmacy paid PMPM was higher than the benchmark for the current reporting period. The percent of in-network paid expense was comparable to the benchmark.

¹Total paid PMPM measures are based on medical member months.

COMPARISON TO BENCHMARK: UTILIZATION AND IN-NETWORK EXPERIENCE

Report Description: Client B's utilization and in-network utilization percentages are compared to the benchmark for the most recent reporting period in the table below. Measures are displayed overall and by service categories (inpatient facility, outpatient facility, professional and pharmacy). The graph shows the services/1,000 variance from benchmark by service category.

		Client B	BENCHMARK	% VARIANCE
INPATIENT FACILITY	SERVICES/1000	59.4	53.7	10.7%
	IN-NETWORK SERVICES %	98.5%	98.7%	-0.2%
OUTPATIENT FACILITY	SERVICES/1000	936.2	834.1	12.2%
	IN-NETWORK SERVICES %	99.9%	99.7%	0.2%
PROFESSIONAL	SERVICES/1000	15,855.5	15,292.6	3.7%
	IN-NETWORK SERVICES %	97.5%	97.4%	0.1%
PHARMACY	SERVICES/1000	12,853.0	11,938.8	7.7%
	IN-NETWORK SERVICES %	100.0%	100.0%	0.0%



Inpatient Facility: Inpatient facility admissions per 1,000 were higher than the benchmark for the current reporting period. The percent of in-network admissions was comparable to the benchmark.

Outpatient Facility: Outpatient facility visits per 1,000 were higher than the benchmark for the current reporting period. The percent of in-network visits was comparable to the benchmark.

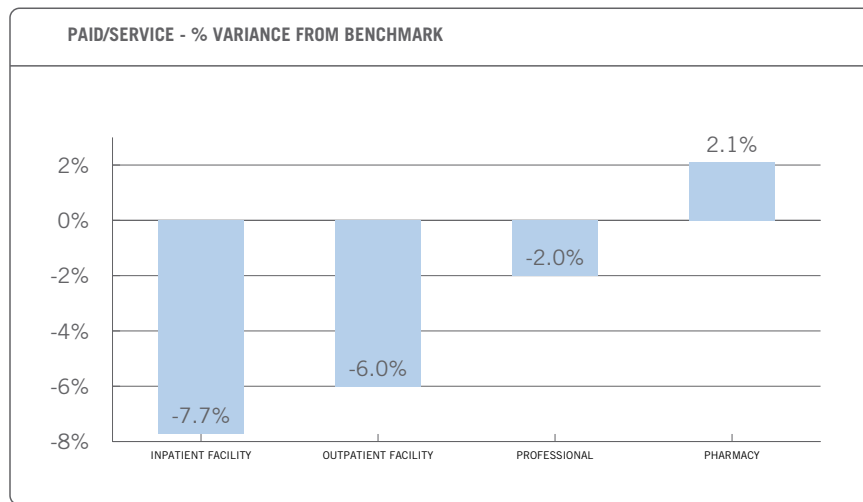
Professional: Professional services per 1,000 were slightly higher than the benchmark for the current reporting period. The percent of in-network services was comparable to the benchmark.

Pharmacy: Pharmacy scripts per 1,000 were higher than the benchmark for the current reporting period. The percent of in-network scripts was comparable to the benchmark.

COMPARISON TO BENCHMARK: PRICE AND IN-NETWORK EXPERIENCE

Report Description: Client B's average and in-network prices are compared to the benchmark for the most recent reporting period in the table below. Measures are displayed overall and by service categories (inpatient facility, outpatient facility, professional and pharmacy). The graph shows the percent variance from benchmark by service category.

		Client B	BENCHMARK	% VARIANCE
INPATIENT FACILITY	PAID/SERVICE	\$6,543	\$7,086	-7.7%
	IN-NETWORK PAID/SERVICE	\$6,578	\$7,128	-7.7%
OUTPATIENT FACILITY	PAID/SERVICE	\$548	\$583	-6.0%
	IN-NETWORK PAID/SERVICE	\$548	\$578	-5.1%
PROFESSIONAL	PAID/SERVICE	\$58	\$59	-2.0%
	IN-NETWORK PAID/SERVICE	\$58	\$59	-0.9%
PHARMACY	PAID/SERVICE	\$50	\$49	2.1%
	IN-NETWORK PAID/SERVICE	\$50	\$49	2.1%



Inpatient Facility: Inpatient facility average paid/admission was lower than the benchmark for the current reporting period. The in-network paid/admission was lower than the benchmark.

Outpatient Facility: Outpatient facility average paid/visit was lower than the benchmark for the current reporting period. The in-network paid/visit was lower than the benchmark.

Professional: Professional average paid/service was comparable to the benchmark for the current reporting period. The in-network paid/service was comparable to the benchmark.

Pharmacy: Pharmacy average paid/script was slightly higher than the benchmark for the current reporting period. The in-network paid/script was comparable to the benchmark.

 CHAPTER DESCRIPTION

The enrollment chapter presents descriptive information on Client B's subscribers and dependents enrolled in DEMO. The ability to track changes in the characteristics of Client B's enrolled population is critical information for effective plan management. Information on membership size, age and gender are presented for subscribers and dependents for the current and prior reporting periods. Enrollment by age band is shown for both subscribers and dependents for the current reporting period. Finally, the proportion of Client B's enrollment by coverage tier is presented.

Data Note

Current reporting period represents membership incurred Nov'05 through Oct'06.

Prior reporting period represents membership incurred Nov'04 through Oct'05.

 SUMMARY OF FINDINGS

Membership size increased 10.8% from 9,052 to 10,030 between the two reporting periods. The average number of subscribers increased 11.8% and the average number of dependents increased 9.9%. The average contract size remained stable from 2.17 to 2.15.

Overall, the gender mix of the membership was 41.1% male and 58.9% female in the current reporting period. Average age was 34.7 years which remained stable from the prior reporting period. Summarizing the two factors, the demographic index changed from 0.9983 to 1.0009 over the two reporting periods.

Males accounted for a lower proportion of subscribers than did females in the current reporting period. Males made up a higher proportion of dependents than did females in the current reporting period.

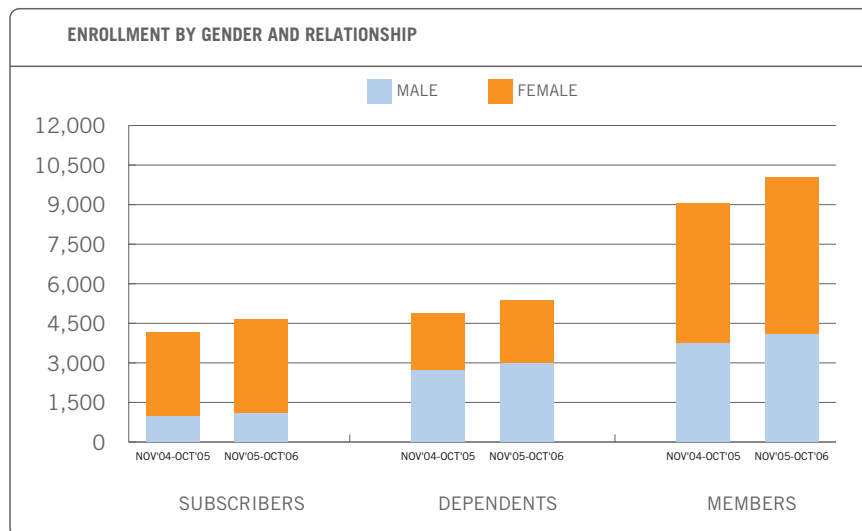
Subscribers fell most commonly into the 30-39 age band and dependents were most populous in the <1-19 age band.

Enrollment by coverage tier showed employee only increased 14.7%, employee + one increased 4.8%, employee + dependents increased 16.0% and family increased 8.4% over the two reporting periods.

ENROLLMENT OVERVIEW

Report Description: The average number of subscribers, dependents, members and average contract size for Client B are shown below in addition to the average age, overall proportion of males, females, childbearing females 20-44 years and the demographic index factor.

Client B			
	NOV'05-OCT'06	NOV'04-OCT'05	% CHANGE
AVERAGE SUBSCRIBERS	4,661	4,169	11.8%
AVERAGE DEPENDENTS	5,368	4,884	9.9%
AVERAGE MEMBERS	10,030	9,052	10.8%
AVERAGE CONTRACT SIZE	2.15	2.17	-0.9%
AVERAGE AGE (YEARS)	34.7	34.8	-0.1%
PROPORTION OF MALES	41.1%	41.5%	-0.8%
PROPORTION OF FEMALES	58.9%	58.5%	0.6%
PROPORTION OF CHILDBEARING FEMALES	25.4%	25.5%	-0.2%
DEMOGRAPHIC INDEX	1.0009	0.9983	0.3%



Size: Client B's overall membership increased 10.8% between the two reporting periods. Subscribers increased 11.8% and dependents increased 9.9%. Average contract size remained stable from 2.17 to 2.15.

Gender: The proportion of males remained stable between the two reporting periods. In addition, the demographic index remained stable.

Relationship:

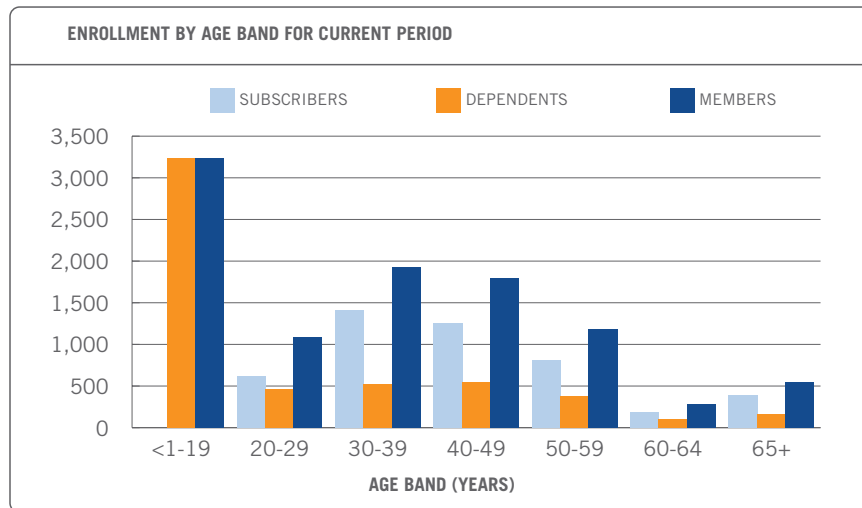
Subscriber - The proportion of male subscribers remained stable over the two reporting periods and the proportion of female subscribers remained stable.

Dependents - The proportion of male dependents remained stable and the proportion of female dependents remained stable.

ENROLLMENT BY AGE AND GENDER

Report Description: Client B's average age of subscribers (employees), dependents (spouse and/or children) and total members and overall percent change are displayed in the table below, as well as the average age by gender for the two reporting periods. The graph shows various age bands for the current reporting period, broken down by subscribers, dependents and total members.

Client B							
AVERAGE AGE (IN YEARS) BY GENDER							
	NOV'05-OCT'06			NOV'04-OCT'05			% CHANGE
	MALE	FEMALE	SUMMARY	MALE	FEMALE	SUMMARY	
SUBSCRIBERS	45.7	43.6	44.2	45.7	43.7	44.3	-0.1%
DEPENDENTS	28.6	22.9	26.2	28.7	22.8	26.2	-0.1%
MEMBERS	34.1	35.2	34.7	34.1	35.3	34.8	-0.1%



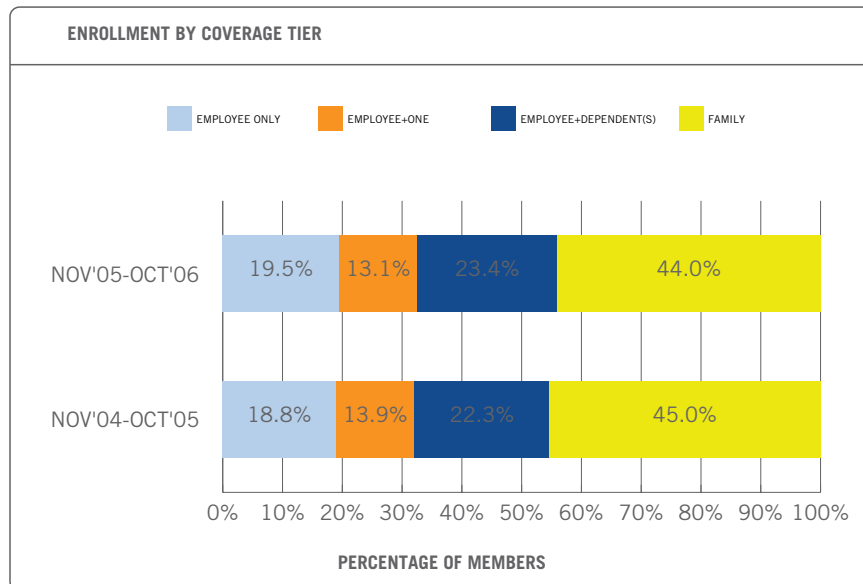
Subscriber Age: The average age for subscribers remained stable from 44.3 to 44.2 between the two reporting periods. In the current reporting period, males were older than females and most subscribers fell into the 30-39 age band.

Dependent Age: The average age for dependents remained stable from 26.2 to 26.2 between the two reporting periods. In the current reporting period, males were older than females and most dependents fell into the <1-19 age band.

ENROLLMENT BY COVERAGE TIER

Report Description: The average number of members and proportion of members in each coverage tier for the two reporting periods are displayed in the graph below.

Client B						
	NOV'05-OCT'06		NOV'04-OCT'05		% CHANGE	
	AVG MEMBERS	% MEMBERS	AVG MEMBERS	% MEMBERS	AVG MEMBERS	% MEMBERS
EMPLOYEE ONLY	1,951	19.5%	1,702	18.8%	14.7%	3.5%
EMPLOYEE+ONE	1,314	13.1%	1,254	13.9%	4.8%	-5.4%
EMPLOYEE+DEPENDENT(S)	2,347	23.4%	2,023	22.3%	16.0%	4.7%
FAMILY	4,417	44.0%	4,074	45.0%	8.4%	-2.1%
SUMMARY	10,030	100.0%	9,052	100.0%	10.8%	0.0%



Employee Only: Client B's enrollment increased 14.7% in average members.

Employee + One: Average members increased 4.8% over the two reporting periods.

Employee + Dependent(s): Across the periods, average members increased 16.0%.

Family: Enrollment increased 8.4% for the family coverage tier.

 CHAPTER DESCRIPTION

This chapter focuses on Client B's inpatient facility admission experience. Inpatient expenses continue to be a major component of medical benefit expenditures for most employers. Inpatient services have the highest average expenses, and although national utilization percent changes have shown moderation in the last several years, some employers have begun to see increases in admission rates and lengths of stay. Patients with complex and costly conditions are much more likely to experience inpatient care. Traditionally, an inpatient stay for certain types of conditions has been a trigger for referral to care management. Finally, inpatient utilization is frequently a component of patient outcome measurement, because successful care management is often measured through the absence or reduction of inpatient care. A thorough understanding of what is driving utilization and price in this area is an important prerequisite to effective management.

Client B's percent changes and differences from the benchmark are presented for key expense and utilization metrics for total inpatient facility-related expense, including the professional claims associated with the admissions. Linking the professional services to the facility component of the inpatient stay is an important enhancement of this report. The professional services provided during a stay can sometimes be as costly as the facility component. Also, the professional claims contain details about the type and frequency of surgical procedures delivered during the admission.

In-network experience is also analyzed to examine percent changes and variances from the benchmark for inpatient facility. By examining this rate, Client B's benefit managers can evaluate if the plan design is working appropriately to encourage in-network utilization.

To gain an understanding of the clinical conditions driving Client B's inpatient experience, the leading Major Diagnostic Categories (MDC) are presented. This level of detail allows Client B to understand why members are being admitted and can help pinpoint conditions with rising changes that may need to be addressed through plan or employer-based interventions.

A more detailed look at inpatient experience separates maternity from non-maternity admissions. This distinction is important because the rate of maternity admissions is driven by factors largely beyond the employer's control (i.e., the demographic mix of employees and dependents). Key statistics for non-maternity admissions (medical, surgical, mental health/substance abuse and nonacute) are presented with percent change and benchmark comparisons. A special focus on maternity care analyzes these admissions by type: deliveries, non-deliveries and normal newborns. Delivery admissions are further sub-categorized by delivery type to examine the rate of Caesarean (C-section) deliveries. The rate of C-section deliveries in the U.S. hit an all-time high in 2004, at 29.1% of all births; government efforts to lower the rate to the target 15% have been unsuccessful. While Caesarean births are sometimes medically necessary, factors such as convenience are driving the rate too high, some experts contend. This delivery method carries with it risks that aren't acceptable if a C-section isn't necessary to preserve the health of the mother or baby, doctors say.

Data Note

Reporting is based on incurred, 12-month rolling periods with 2 months run-out.

Current reporting period represents claims incurred Nov'05 through Oct'06 and paid through Dec'06.

Prior reporting period represents claims incurred Nov'04 through Oct'05 and paid through Dec'05.

Claims for active, retiree under 65, retiree 65 and over and COBRA members are reported.

 SUMMARY OF FINDINGS

Inpatient paid PMPM increased 35.2% between the two reporting periods for inpatient facility and increased 25.1% for inpatient professional. For the current reporting period, inpatient facility paid PMPM was similar to the benchmark and inpatient professional paid PMPM was higher than the benchmark. Inpatient facility paid/admission increased 26.7% between the two reporting periods and increased 17.2% for inpatient professional.

In-network experience stayed the same for total inpatient facility paid expenses, stayed the same for admissions and stayed the same for days. Compared to the in-network benchmark experience, paid expenses were comparable, admissions were comparable and days were comparable.

The proportion of patients with at least one admission increased 8.3% between the two reporting periods. The proportion of patients with more than one admission per year decreased 11.3%.

The leading three Major Diagnostic Categories (MDC) in the current reporting period based on paid PMPM were Pregnancy, Childbirth & The Puerperium, Diseases & Disorders Of The Circulatory System and Diseases & Disorders Of The Musculoskeletal System & Conn Tissue. The leading three based on admissions/1,000 were Pregnancy, Childbirth & The Puerperium, Diseases & Disorders Of The Circulatory System and Diseases & Disorders Of The Musculoskeletal System & Conn Tissue.

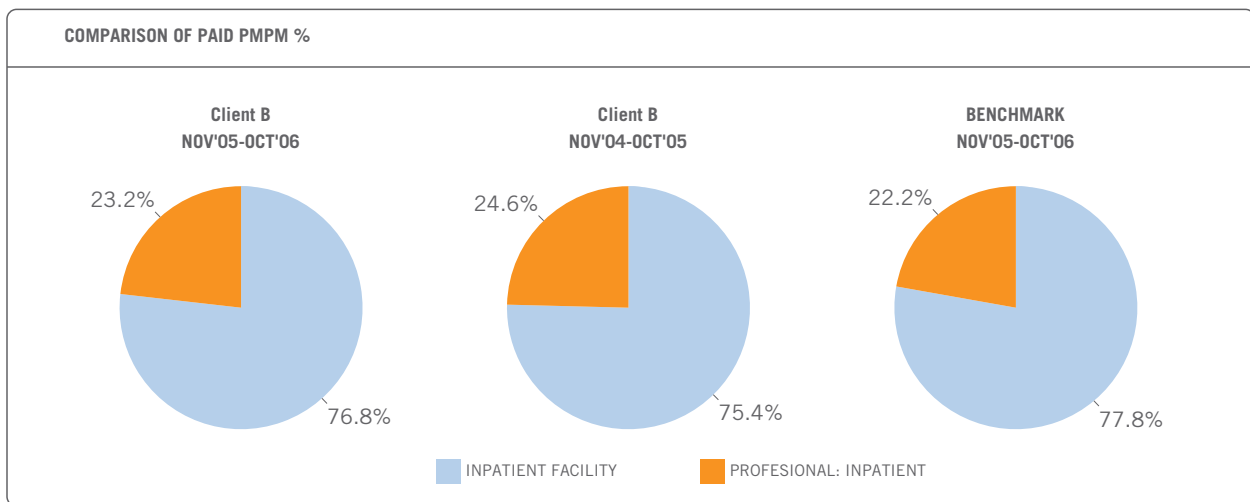
For non-maternity admissions between the two reporting periods, paid PMPM decreased 6.2% for medical admissions, increased 43.0% for surgical admissions, increased 48.6% for mental health/substance abuse admissions and increased 130.4% for non-acute admissions. Medical admissions/1,000 decreased 18.6%, surgical admissions/1,000 increased 10.3%, mental health/substance abuse admissions/1,000 increased 18.0% and non-acute admissions/1,000 increased 80.5%.

In the current reporting period, deliveries made up 91.7% of maternity admissions, non-deliveries accounted for 7.6% and normal newborns were 0.7%. Overall between the two reporting periods, inpatient maternity paid PMPM increased 91.3%, admissions/1,000 increased 40.7%, days/1,000 increased 53.0% and paid/admission increased 35.9%. The C-section delivery rate in the current reporting period was 42.9%. This rate increased 5.8% from the prior reporting period, and was similar to the benchmark.

TOTAL INPATIENT FACILITY AND PROFESSIONAL EXPENSES

Report Description: Inpatient admissions are typically comprised of two components. The first is the total expenses reported by the facility. The other component is the related professional expenses incurred during the admission. The total inpatient claims experience is displayed below. All facility and professional claims reporting is based on an inpatient place of service.

		Client B				
		NOV'05-OCT'06	NOV'04-OCT'05	% CHANGE	BENCHMARK	% VARIANCE
INPATIENT FACILITY	PAID	\$3,899,837	\$2,602,860	49.8%		
	PAID PMPM	\$32.40	\$23.96	35.2%	\$31.70	2.2%
	PAID PMPM %	76.8%	75.4%	1.9%	77.8%	-1.2%
	ADMISSIONS	596	504	18.3%		
	PAID/ADMISSION	\$6,543	\$5,164	26.7%	\$7,086	-7.7%
PROFESSIONAL: INPATIENT	PAID	\$1,175,449	\$848,376	38.6%		
	PAID PMPM	\$9.77	\$7.81	25.1%	\$9.04	8.0%
	PAID PMPM %	23.2%	24.6%	-5.8%	22.2%	4.4%
	ADMISSIONS	596	504	18.3%		
	PAID/ADMISSION	\$1,972	\$1,683	17.2%	\$2,021	-2.4%
TOTAL INPATIENT	PAID	\$5,075,285	\$3,451,236	47.1%		
	PAID PMPM	\$42.17	\$31.77	32.7%	\$40.74	3.5%
	PAID PMPM %	100.0%	100.0%	0.0%	100.0%	0.0%
	ADMISSIONS	596	504	18.3%		
	PAID/ADMISSION	\$8,516	\$6,848	24.4%	\$9,106	-6.5%



Expense: Inpatient facility paid expenses PMPM increased 35.2% and professional inpatient paid expenses PMPM increased 25.1%. Compared to the benchmark, Client B had similar inpatient facility expenses and higher professional inpatient expenses.

The proportion of inpatient facility expenses (paid PMPM %) to total inpatient expenses remained the same. The proportion of professional inpatient expenses to total inpatient expenses decreased 5.8%. Compared to the benchmark, Client B had a similar proportion of inpatient facility expenses and a similar proportion of professional inpatient expenses.

Price: Paid per admission increased 26.7% for inpatient facility admissions and increased 17.2% for professional inpatient admissions. Compared to the benchmark, Client B's paid/admission were lower for inpatient facility admissions and slightly lower for professional inpatient admissions.

IN-NETWORK EXPERIENCE COMPARISONS

Report Description: The table below reflects the percentage of paid expenditures, admissions and number of days for inpatient admissions. Paid expenditures reflect inpatient facility claims only; associated professional claims are not measured. These percentages show how much of Client B's inpatient experience occurred at in-network facilities.

	Client B			BENCHMARK	% VARIANCE
	NOV'05-OCT'06	NOV'04-OCT'05	% CHANGE		
IN-NETWORK PAID %	99.0%	99.0%	0.1%	99.2%	-0.2%
IN-NETWORK SERVICES %	98.5%	98.8%	-0.3%	98.7%	-0.2%
IN-NETWORK DAYS %	97.1%	94.8%	2.4%	96.9%	0.2%

In-Network Paid %: The amount of in-network paid expenditures for Client B stayed the same from the prior reporting period and was comparable to the benchmark.

In-Network Services %: Client B stayed the same for in-network admissions from the prior reporting period and was comparable to the benchmark.

In-Network Days %: The percentage of days in-network for Client B stayed the same from the prior reporting period and was comparable to the benchmark.

MULTIPLE INPATIENT ADMISSIONS

Report Description: The table below shows the frequency of inpatient admissions for all of Client B's claimants during the current reporting period. Inpatient paid expenses are based on the inpatient facility claims only. Inpatient professional expenses are not reported.

IP ADMITS	NOV'05-OCT'06				NOV'04-OCT'05			
	CLAIMANTS	CLAIMANTS %	IP PAID	IP PAID %	CLAIMANTS	CLAIMANTS %	IP PAID	IP PAID %
0	11,482	95.9%			10,223	96.2%		
1	424	3.5%	\$2,642,394	67.8%	335	3.2%	\$1,590,329	61.1%
2	49	0.4%	\$685,420	17.6%	46	0.4%	\$479,232	18.4%
3	8	0.1%	\$116,545	3.0%	16	0.2%	\$282,996	10.9%
4	6	0.1%	\$323,848	8.3%	4	0.0%	\$115,694	4.4%
5+	5	0.0%	\$131,630	3.4%	2	0.0%	\$134,609	5.2%
SUMMARY	11,974	100.0%	\$3,899,837	100.0%	10,626	100.0%	\$2,602,860	100.0%

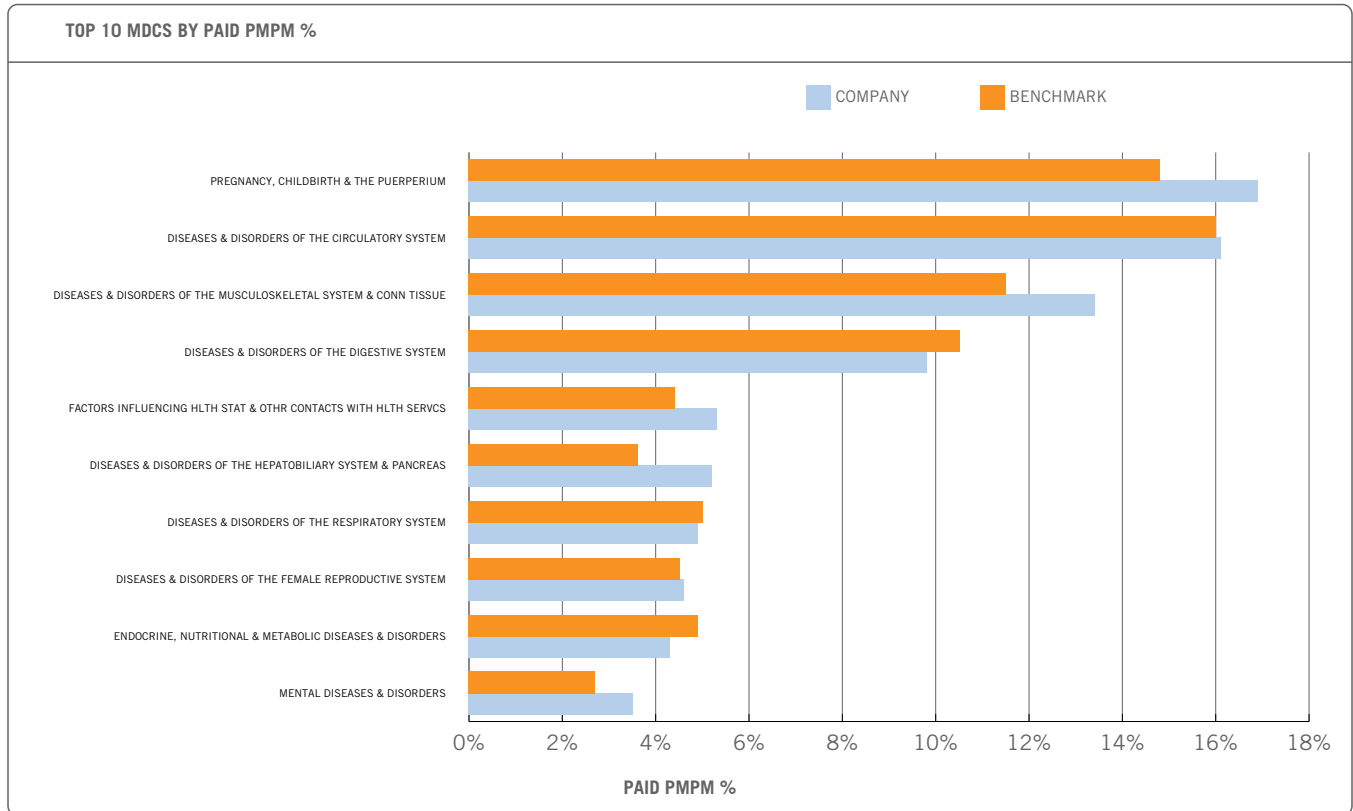
Proportion of all claimants who had one or more admissions: During the current reporting period, 4.1% of Client B's claimants had an inpatient admission, which increased 8.3% from the prior reporting period.

Proportion of all claimants who had one admission: Out of the 4.1% of claimants who had an inpatient admission, 86.2% had only one admission, which increased 3.7% over the prior reporting period. The proportion of inpatient paid expenses for these claimants increased 10.9% from the prior reporting period.

Proportion of all claimants who had multiple admissions: 13.8% of the claimants who had an inpatient admission were admitted multiple times during the current reporting period, which decreased 18.1% over the prior reporting period. 32.2% of the inpatient facility paid expenses were attributed to claimants with multiple admissions in the current reporting period compared to 38.9% reported in the prior reporting period.

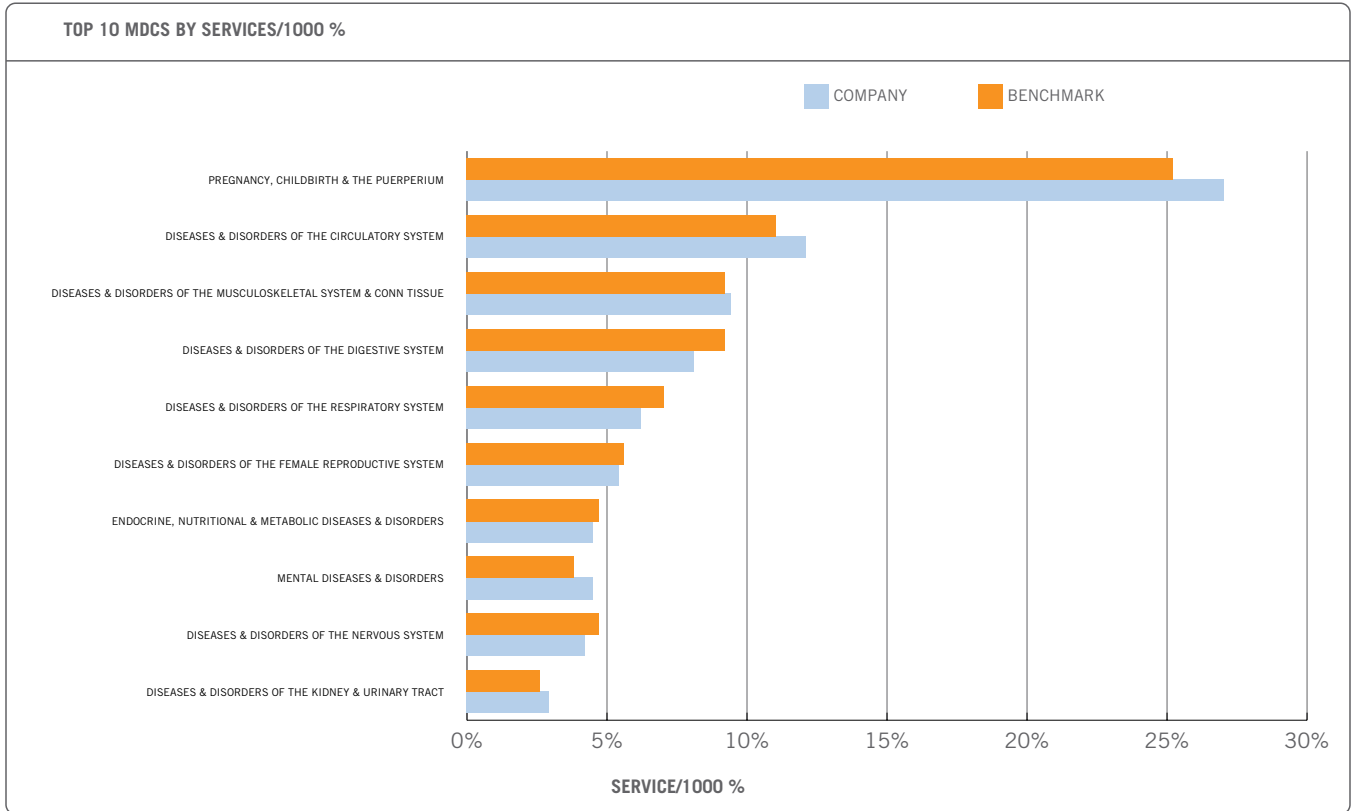
TOP ADMISSIONS BY MAJOR DIAGNOSTIC CATEGORY

Report Description: Major Diagnostic Categories (MDC) are based on Diagnostic Related Groups (DRG) and are available only in inpatient reports. Below are separate graphs charting the top ten MDCs' individual percent contributions for expense and utilization during the current reporting period and compared to the benchmark. When combined together, the top ten MDCs contribute 84.0% and 84.2% to the total expense and utilization measures, respectively.



Top MDCs by Expense: The three diagnostic categories with the highest paid expenses for Client B were Pregnancy, Childbirth & The Puerperium, Diseases & Disorders Of The Circulatory System and Diseases & Disorders Of The Musculoskeletal System & Conn Tissue. The paid PMPM was higher compared to the benchmark for Pregnancy, Childbirth & The Puerperium, similar compared to the benchmark for Diseases & Disorders Of The Circulatory System and higher compared to the benchmark for Diseases & Disorders Of The Musculoskeletal System & Conn Tissue.

TOP ADMISSIONS BY MAJOR DIAGNOSTIC CATEGORY, CONTINUED

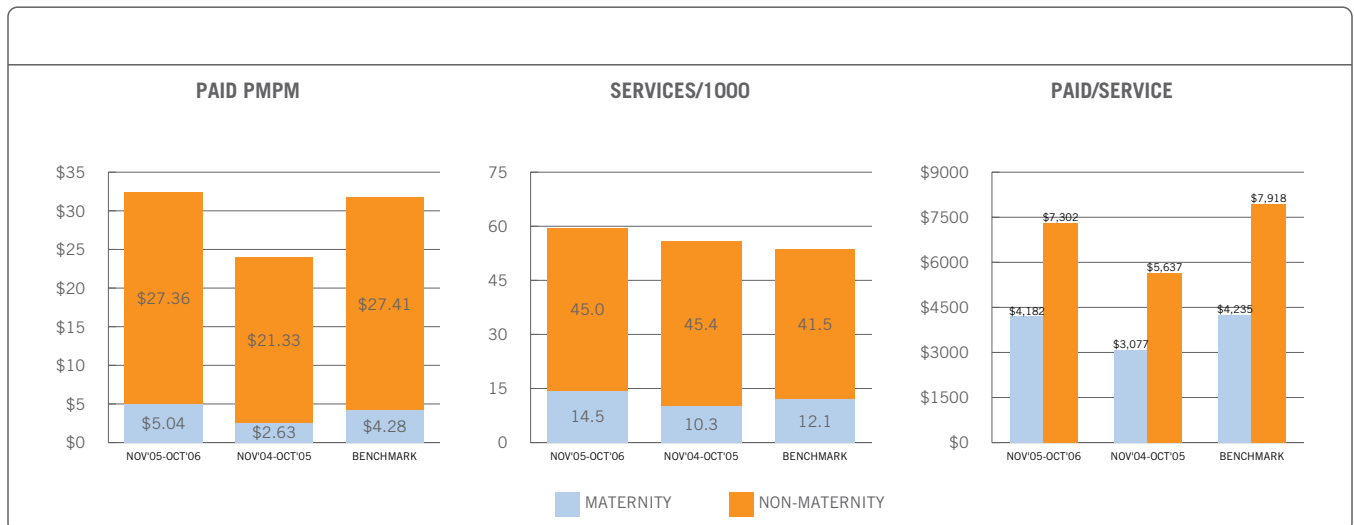


Top MDCs by Utilization: The three diagnostic categories with the highest admissions for Client B were Pregnancy, Childbirth & The Puerperium, Diseases & Disorders Of The Circulatory System and Diseases & Disorders Of The Musculoskeletal System & Conn Tissue. Utilization was higher compared to the benchmark for Pregnancy, Childbirth & The Puerperium, higher compared to the benchmark for Diseases & Disorders Of The Circulatory System and similar compared to the benchmark for Diseases & Disorders Of The Musculoskeletal System & Conn Tissue.

MATERNITY VS. NON-MATERNITY ADMISSIONS

Report Description: The admission category Maternity as shown in the table below is a summation of deliveries, non-deliveries and normal newborns. The admission category Non-Maternity includes all other admission types such as medical, surgical, mental health/substance abuse and non-acute. The graphs display how much of the total inpatient admission measure is represented by maternity and non-maternity. Expense measures are based on the inpatient facility component only. Inpatient professional claims are not reported.

		Client B				
		NOV'05-OCT'06	NOV'04-OCT'05	% CHANGE	BENCHMARK	% VARIANCE
MATERNITY	PAID	\$606,432	\$286,131	111.9%		
	PAID PMPM	\$5.04	\$2.63	91.3%	\$4.28	17.6%
	SERVICES	145	93	55.9%		
	SERVICES/1000	14.5	10.3	40.7%	12.1	19.1%
	DAYS	473	279	69.5%		
	DAYS/1000	47.2	30.8	53.0%	37.9	24.4%
	AVERAGE LENGTH OF STAY	3.3	3.0	8.7%	3.1	5.6%
	PAID/SERVICE	\$4,182	\$3,077	35.9%	\$4,235	-1.2%
	PAID/DAY	\$1,282	\$1,026	25.0%	\$1,371	-6.5%
NON-MATERNITY	PAID	\$3,293,404	\$2,316,729	42.2%		
	PAID PMPM	\$27.36	\$21.33	28.3%	\$27.41	-0.2%
	SERVICES	451	411	9.7%		
	SERVICES/1000	45.0	45.4	-1.0%	41.5	8.2%
	DAYS	2,324	2,178	6.7%		
	DAYS/1000	231.7	240.6	-3.7%	214.2	8.2%
	AVERAGE LENGTH OF STAY	5.2	5.3	-2.8%	5.1	1.1%
	PAID/SERVICE	\$7,302	\$5,637	29.5%	\$7,918	-7.8%
	PAID/DAY	\$1,417	\$1,064	33.2%	\$1,553	-8.7%
SUMMARY	PAID	\$3,899,837	\$2,602,860	49.8%		
	PAID PMPM	\$32.40	\$23.96	35.2%	\$31.70	2.2%
	SERVICES	596	504	18.3%		
	SERVICES/1000	59.4	55.7	6.7%	53.7	10.7%
	DAYS	2,797	2,457	13.8%		
	DAYS/1000	278.9	271.4	2.7%	252.1	10.6%
	AVERAGE LENGTH OF STAY	4.7	4.9	-3.7%	4.6	1.0%
	PAID/SERVICE	\$6,543	\$5,164	26.7%	\$7,086	-7.7%
	PAID/DAY	\$1,394	\$1,059	31.6%	\$1,526	-8.6%



 MATERNITY VS. NON-MATERNITY ADMISSIONS, CONTINUED

Expense: Inpatient facility paid PMPM expenses for maternity admissions increased 91.3% and non-maternity admissions increased 28.3% over the two reporting periods. When compared to the benchmark, Client B had higher maternity expenses and similar non-maternity expenses.

Utilization: Inpatient facility admissions per 1,000 for maternity services increased 40.7% and non-maternity services remained relatively stable over the two reporting periods. Client B's utilization was 19.1% higher than the benchmark for maternity admissions and 8.2% higher than the benchmark for non-maternity admissions.

The number of days per 1,000 members for maternity admissions increased 53.0% and non-maternity admissions decreased slightly over the two reporting periods. Client B was 24.4% higher than the benchmark for maternity days and 8.2% higher than the benchmark for non-maternity days.

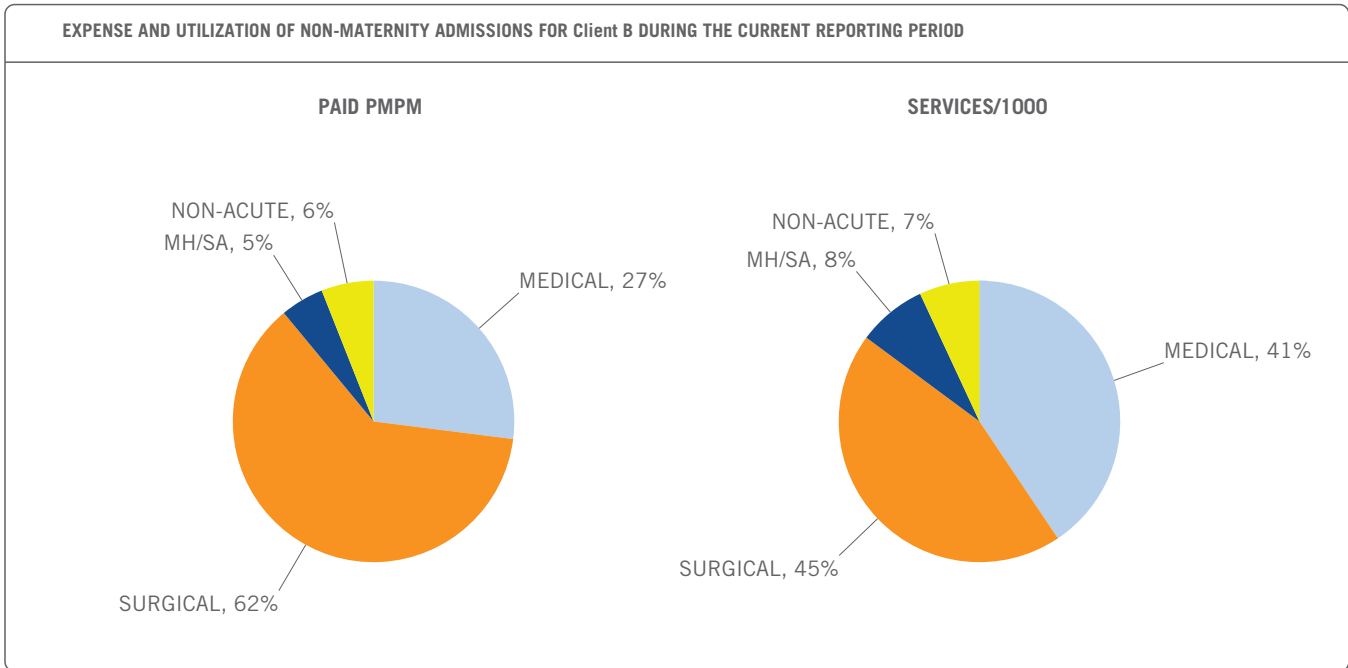
Price: Paid per admission increased 35.9% for maternity services and increased 29.5% for non-maternity services. Compared to the benchmark, Client B's paid per admission was similar for maternity admissions and lower for non-maternity admissions.

NON-MATERNITY ADMISSIONS ANALYSIS

Report Description: The table below breaks down total Non-Maternity into separate admission types: medical, surgical, mental health/substance abuse and non-acute. Non-acute refers to admissions for rehabilitation, skilled nursing facilities and hospice care. Paid expenses, admissions, days and duration of stay by admission type are displayed in the table below. The paid amount is based on the inpatient facility component only. Inpatient professional statistics are not reported.

		Client B				
		NOV'05-OCT'06	NOV'04-OCT'05	% CHANGE	BENCHMARK	% VARIANCE
MEDICAL	PAID	\$881,725	\$848,860	3.9%		
	PAID PMPM	\$7.33	\$7.81	-6.2%	\$7.71	-5.0%
	SERVICES	183	203	-9.9%		
	SERVICES/1000	18.2	22.4	-18.6%	17.7	3.1%
	DAYS	717	936	-23.4%		
	DAYS/1000	71.5	103.4	-30.9%	75.7	-5.5%
	AVERAGE LENGTH OF STAY	3.9	4.6	-15.0%	4.2	-7.3%
	PAID/SERVICE	\$4,818	\$4,182	15.2%	\$5,232	-7.9%
	PAID/DAY	\$1,230	\$907	35.6%	\$1,237	-0.6%
SURGICAL	PAID	\$2,035,077	\$1,284,879	58.4%		
	PAID PMPM	\$16.91	\$11.83	43.0%	\$17.27	-2.1%
	SERVICES	204	167	22.2%		
	SERVICES/1000	20.3	18.4	10.3%	19.0	6.9%
	DAYS	808	664	21.7%		
	DAYS/1000	80.6	73.4	9.8%	76.9	4.7%
	AVERAGE LENGTH OF STAY	4.0	4.0	-0.4%	4.0	-1.0%
	PAID/SERVICE	\$9,976	\$7,694	29.7%	\$10,892	-8.4%
	PAID/DAY	\$2,519	\$1,935	30.2%	\$2,723	-7.5%
MENTAL HEALTH/ SUBSTANCE ABUSE	PAID	\$164,559	\$99,916	64.7%		
	PAID PMPM	\$1.37	\$0.92	48.6%	\$1.03	32.8%
	SERVICES	34	26	30.8%		
	SERVICES/1000	3.4	2.9	18.0%	2.7	24.8%
	DAYS	307	180	70.6%		
	DAYS/1000	30.6	19.9	53.9%	23.9	27.9%
	AVERAGE LENGTH OF STAY	9.0	6.9	30.4%	8.7	3.7%
	PAID/SERVICE	\$4,840	\$3,843	25.9%	\$4,545	6.5%
	PAID/DAY	\$536	\$555	-3.4%	\$522	2.7%
NON-ACUTE	PAID	\$212,044	\$83,075	155.2%		
	PAID PMPM	\$1.76	\$0.76	130.4%	\$1.41	25.3%
	SERVICES	30	15	100.0%		
	SERVICES/1000	3.0	1.7	80.5%	2.1	41.5%
	DAYS	492	398	23.6%		
	DAYS/1000	49.1	44.0	11.6%	37.7	30.2%
	AVERAGE LENGTH OF STAY	16.4	26.5	-38.2%	17.6	-7.0%
	PAID/SERVICE	\$7,068	\$5,538	27.6%	\$7,981	-11.4%
	PAID/DAY	\$431	\$209	106.5%	\$453	-4.8%
SUMMARY	PAID	\$3,293,404	\$2,316,729	42.2%		
	PAID PMPM	\$27.36	\$21.33	28.3%	\$27.41	-0.2%
	SERVICES	451	411	9.7%		
	SERVICES/1000	45.0	45.4	-1.0%	41.5	8.2%
	DAYS	2,324	2,178	6.7%		
	DAYS/1000	231.7	240.6	-3.7%	214.2	8.2%
	AVERAGE LENGTH OF STAY	5.2	5.3	-2.8%	5.1	1.1%
	PAID/SERVICE	\$7,302	\$5,637	29.5%	\$7,918	-7.8%
	PAID/DAY	\$1,417	\$1,064	33.2%	\$1,553	-8.7%

NON-MATERNITY ADMISSIONS ANALYSIS. CONTINUED



Medical: Over the two reporting periods, Client B's expense (paid PMPM) decreased 6.2%, utilization (admissions/1,000) decreased 18.6% and price (paid/admission) increased 15.2% for medical admissions. In addition, the average length of stay decreased 15.0%. Compared to the benchmark, Client B had lower expenses, slightly higher utilization, lower price and shorter length of stay.

Surgical: Over the two reporting periods, Client B's expense increased 43.0%, utilization increased 10.3% and price increased 29.7% for surgical admissions. In addition, the average length of stay remained relatively stable. Compared to the benchmark, Client B had similar expenses, higher utilization, lower price and similar length of stay.

Mental Health/Substance Abuse: Over the two reporting periods, Client B's expense increased 48.6%, utilization increased 18.0% and price increased 25.9% for mental health/substance abuse admissions. In addition, the average length of stay increased 30.4%. Compared to the benchmark, Client B had higher expenses, higher utilization, higher price and slightly longer length of stay.

Non-Acute: Over the two reporting periods, Client B's expense increased 130.4%, utilization increased 80.5% and price increased 27.6% for non-acute admissions. In addition, the average length of stay decreased 38.2%. Compared to the benchmark, Client B had higher expenses, higher utilization, lower price and slightly shorter length of stay.

MATERNITY ADMISSIONS ANALYSIS

Report Description: The table below breaks down total Maternity into the separate admission types: deliveries, non-deliveries and normal newborns. The admission type deliveries combines claims for a mother and newborn into one admission when possible. Non-deliveries refer to admissions for false labor and other pregnancy-related conditions not resulting in a delivery. Normal newborns refers to normal newborn claims that could not be attached to a mother's admission. The paid amount is based on the inpatient facility component only. Inpatient professional claims are not reported.

		Client B				
		NOV'05-OCT'06	NOV'04-OCT'05	% CHANGE	BENCHMARK	% VARIANCE
DELIVERIES	PAID	\$564,288	\$264,928	113.0%		
	PAID PMPM	\$4.69	\$2.44	92.2%	\$4.01	17.1%
	SERVICES	133	79	68.4%		
	SERVICES/1000	13.3	8.7	52.0%	11.1	19.3%
	DAYS	440	234	88.0%		
	DAYS/1000	43.9	25.8	69.7%	35.2	24.5%
	AVERAGE LENGTH OF STAY	3.3	3.0	11.7%	3.1	5.5%
	PAID/SERVICE	\$4,243	\$3,354	26.5%	\$4,326	-1.9%
	PAID/DAY	\$1,282	\$1,132	13.3%	\$1,379	-7.0%
NON-DELIVERIES	PAID	\$41,581	\$19,887	109.1%		
	PAID PMPM	\$0.35	\$0.18	88.7%	\$0.27	27.3%
	SERVICES	11	11	0.0%		
	SERVICES/1000	1.1	1.2	-9.7%	0.8	29.7%
	DAYS	29	39	-25.6%		
	DAYS/1000	2.9	4.3	-32.9%	2.2	31.5%
	AVERAGE LENGTH OF STAY	2.6	3.5	-25.6%	2.6	2.5%
	PAID/SERVICE	\$3,780	\$1,808	109.1%	\$3,852	-1.9%
	PAID/DAY	\$1,434	\$510	181.2%	\$1,498	-4.3%
NORMAL NEWBORNS	PAID	\$563	\$1,316	-57.2%		
	PAID PMPM	\$0.00	\$0.01	-61.4%	\$0.01	-28.3%
	SERVICES	1	3	-66.7%		
	SERVICES/1000	0.1	0.3	-69.9%	0.2	-45.0%
	DAYS	4	6	-33.3%		
	DAYS/1000	0.4	0.7	-39.8%	0.5	-18.4%
	AVERAGE LENGTH OF STAY	4.0	2.0	100.0%	2.7	50.0%
	PAID/SERVICE	\$563	\$439	28.4%	\$432	30.3%
	PAID/DAY	\$141	\$219	-35.8%	\$162	-13.2%
SUMMARY	PAID	\$606,432	\$286,131	111.9%		
	PAID PMPM	\$5.04	\$2.63	91.3%	\$4.28	17.6%
	SERVICES	145	93	55.9%		
	SERVICES/1000	14.5	10.3	40.7%	12.1	19.1%
	DAYS	473	279	69.5%		
	DAYS/1000	47.2	30.8	53.0%	37.9	24.4%
	AVERAGE LENGTH OF STAY	3.3	3.0	8.7%	3.1	5.6%
	PAID/SERVICE	\$4,182	\$3,077	35.9%	\$4,235	-1.2%
	PAID/DAY	\$1,282	\$1,026	25.0%	\$1,371	-6.5%

 MATERNITY ADMISSIONS ANALYSIS. CONTINUED

Deliveries: Over the two reporting periods, Client B's expense (paid PMPM) increased 92.2%, utilization (admissions/1,000) increased 52.0% and price (paid/admission) increased 26.5% for delivery admissions. In addition, the average length of stay increased 11.7%. Compared to the benchmark, Client B had higher expenses, higher utilization, slightly lower price and slightly longer length of stay.

Non-Deliveries: Over the two reporting periods, Client B's expense increased 88.7%, utilization decreased 9.7% and price increased 109.1% for non-delivery admissions. In addition, the average length of stay decreased 25.6%. Compared to the benchmark, Client B had higher expenses, higher utilization, slightly lower price and similar length of stay.

Normal Newborns: Over the two reporting periods, Client B's expense decreased 61.4%, utilization decreased 69.9% and price increased 28.4% for normal newborns admissions. In addition, the average length of stay increased 100.0%. Compared to the benchmark, Client B had lower expenses, lower utilization, higher price and longer length of stay.

MATERNITY RATE ANALYSIS BY DELIVERY TYPE

Report Description: The analysis below breaks down delivery admissions into two types: C-section and vaginal deliveries. Utilization, expense, price and duration of stay are displayed below for Client B and compared to the benchmark. The allowed and paid amounts are based on the inpatient facility component only. Inpatient professional claims are not reported.

DELIVERY TYPE		Client B			BENCHMARK	% VARIANCE
		NOV'05-OCT'06	NOV'04-OCT'05	% CHANGE		
C-SECTION	SERVICES %	42.9%	40.5%	5.8%	41.3%	3.8%
	SERVICES/1000	5.7	3.5	60.8%	4.6	23.8%
	AVERAGE LENGTH OF STAY	4.4	4.2	4.7%	4.0	7.7%
	ALLOWED %	58.6%	51.5%	13.9%	54.2%	8.2%
	ALLOWED PMPM	\$3.23	\$1.63	98.2%	\$2.55	26.6%
	PAID %	59.5%	53.3%	11.8%	54.7%	8.8%
	PAID PMPM	\$2.79	\$1.30	114.8%	\$2.19	27.4%
	ALLOWED/SERVICE	\$6,826	\$5,538	23.3%	\$6,678	2.2%
	PAID/SERVICE	\$5,894	\$4,411	33.6%	\$5,730	2.9%
VAGINAL	SERVICES %	57.1%	59.5%	-4.0%	58.7%	-2.6%
	SERVICES/1000	7.6	5.2	45.9%	6.5	16.2%
	AVERAGE LENGTH OF STAY	2.5	2.1	17.6%	2.5	1.1%
	ALLOWED %	41.4%	48.5%	-14.7%	45.8%	-9.7%
	ALLOWED PMPM	\$2.28	\$1.54	48.4%	\$2.16	5.6%
	PAID %	40.5%	46.7%	-13.4%	45.3%	-10.6%
	PAID PMPM	\$1.90	\$1.14	66.5%	\$1.81	4.6%
	ALLOWED/SERVICE	\$3,612	\$3,552	1.7%	\$3,975	-9.1%
	PAID/SERVICE	\$3,004	\$2,634	14.1%	\$3,337	-10.0%
SUMMARY	SERVICES %	100.0%	100.0%	0.0%	100.0%	0.0%
	SERVICES/1000	13.3	8.7	52.0%	11.1	19.3%
	AVERAGE LENGTH OF STAY	3.3	3.0	11.7%	3.1	5.5%
	ALLOWED %	100.0%	100.0%	0.0%	100.0%	0.0%
	ALLOWED PMPM	\$5.51	\$3.17	74.0%	\$4.71	17.0%
	PAID %	100.0%	100.0%	0.0%	100.0%	0.0%
	PAID PMPM	\$4.69	\$2.44	92.2%	\$4.01	17.1%
	ALLOWED/SERVICE	\$4,989	\$4,356	14.5%	\$5,091	-2.0%
	PAID/SERVICE	\$4,243	\$3,354	26.5%	\$4,326	-1.9%

Percent of Utilization and Expense: 42.9% of Client B's maternity admissions resulted in a C-section delivery, which increased 5.8% from the prior reporting period and was similar to the benchmark. These C-sections contributed 59.5% of Client B's maternity expenses, up from 53.3% in the prior reporting period and was higher when compared to the benchmark of 54.7%.

Overall C-Section Changes: Client B's C-section admissions/1,000 increased 60.8% between the two reporting periods. Paid PMPM expenses increased 114.8% and paid/admission increased 33.6% for C-sections.

Comparison to Benchmark: In comparison to the benchmark, Client B reported higher C-section paid PMPM expenses, higher C-section admissions/1,000 and slightly higher C-section paid/admission.

CHAPTER DESCRIPTION

The outpatient facility chapter analyzes expense and utilization specifically related to services provided in the outpatient facility setting. The visit types that are analyzed include ambulatory surgery, emergency room, radiology, dialysis and observation room. The expenses presented in this chapter are for facility expenses only. The professional component of these visits are not discussed in this chapter.

The first report presents expenses and utilization by visit type. Overall ambulatory surgery, emergency room and high cost radiology rates are presented and are also focused on in greater detail in other reports in this chapter. Other visit types of interest include dialysis and observation room. The expenses associated with dialysis can swing dramatically because one new person on dialysis can have a dramatic impact in dialysis expenses. It is estimated that dialysis expenses for one patient receiving treatment over the course of a year can exceed \$50,000 for the dialysis alone.

Ambulatory surgery has seen some growth in recent years as more procedures have shifted to the ambulatory setting and standards of care have changed. Specifically, laparoscopic procedures have moved more procedures to the outpatient setting. In general, the standard of care recommendation change that members over 50 receive a screening colonoscopy has resulted in an increase in the number of these procedures performed. For the most part, the increase in ambulatory surgery has resulted in decreases in the number of short-stay surgical admissions.

Emergency room is an area of particular interest for many payers. Emergency rooms are an expensive use of resources and are sometimes used to provide primary care rather than urgent care. Changes to plan design have often been implemented to effect changes in the utilization for these services. If changes in plan design have occurred, then the impact of those changes can be analyzed. The first emergency room report provides a summary of expenses and utilization related to emergency room use. The next emergency room analysis identifies members who have frequently used the emergency room in the current and prior reporting periods. There are also times when people with chronic conditions require an emergency room visit. These emergency room visits could potentially be avoided if the member's chronic illness is being properly controlled. The last report looks at expenses and utilization associated with non-emergent care. These are conditions that would typically be considered primary care in most situations.

High cost radiology is also an area of growing interest for many payers. The radiology report in this chapter specifically focuses on the facility portion of those expenses. The professional expenses for high cost radiology are discussed in the professional chapter. High cost radiology has been a focus in recent years as the expenses associated with these services has risen dramatically.

Data Note

Reporting is based on incurred, 12-month rolling periods with 2 months run-out.

Current reporting period represents claims incurred Nov'05 through Oct'06 and paid through Dec'06.

Prior reporting period represents claims incurred Nov'04 through Oct'05 and paid through Dec'05.

Claims for active, retiree under 65, retiree 65 and over and COBRA members are reported.

SUMMARY OF FINDINGS

Expenses for outpatient facility visits increased 22.2%, from \$35.00 PMPM to \$42.76 PMPM. Visits increased 3.4% and price increased 18.2% over the two reporting periods.

Ambulatory surgery paid expenses increased 33.0%. Ambulatory surgery paid expenses accounted for 38.7% of the total outpatient facility paid expenses in the current reporting period. Visits increased 9.6% and price increased 21.3% over the two reporting periods.

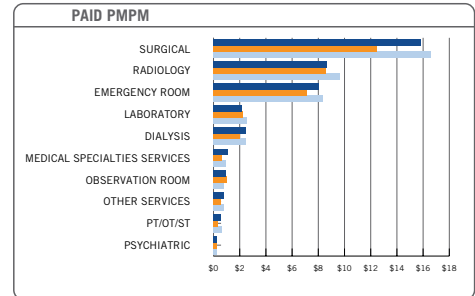
Expenses for emergency room visits increased 18.2%. Emergency room expenses accounted for 19.5% of the total outpatient facility paid expenses in the current reporting period. Visits remained relatively stable and price increased 16.4% over the two reporting periods.

Expenses for radiology services increased 12.8%. High cost radiology, which includes CT scans, MRIs and nuclear medicine represent a significant portion of these expenses. Expenses for CT scans increased 13.0%, increased 18.7% for MRIs and decreased 19.5% for nuclear medicine.

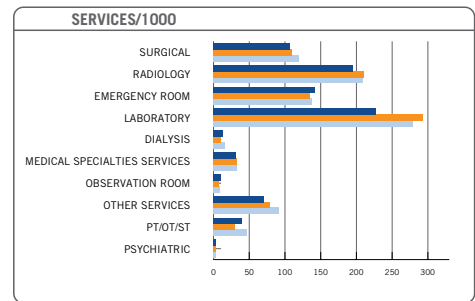
OUTPATIENT FACILITY SERVICES BY VISIT TYPE

Report Description: Expense, utilization and price measures are displayed in the tables below for outpatient facility services by visit type. The professional component of these visits are not reported. The graphs compare each visit type for the two reporting periods and to the benchmark. The visit type Other Services refers to all visits that could not be classified into the other visit types that are displayed below. An analysis of percent change and comparison to the benchmark are provided below by visit type. Selected visit types are explored in greater detail later in this chapter.

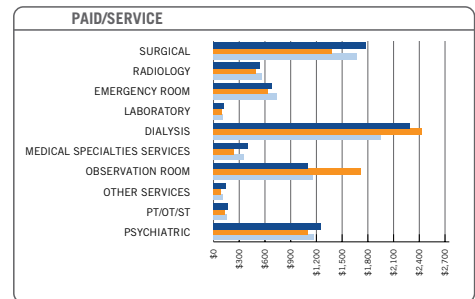
PAID PMPM	Client B			BENCHMARK	% VARIANCE
	NOV'05-OCT'06	NOV'04-OCT'05	% CHANGE		
SURGICAL	\$16.53	\$12.43	33.0%	\$15.81	4.6%
RADIOLOGY	\$9.61	\$8.52	12.8%	\$8.66	10.9%
EMERGENCY ROOM	\$8.35	\$7.06	18.2%	\$7.98	4.6%
LABORATORY	\$2.50	\$2.21	13.1%	\$2.14	17.1%
DIALYSIS	\$2.46	\$2.01	22.3%	\$2.42	1.4%
MEDICAL SPECIALTIES SERVICES	\$0.94	\$0.62	52.7%	\$1.04	-9.0%
OBSERVATION ROOM	\$0.79	\$1.01	-21.1%	\$0.89	-10.9%
OTHER SERVICES	\$0.78	\$0.56	39.5%	\$0.78	-0.3%
PT/OT/ST	\$0.59	\$0.32	83.7%	\$0.54	8.7%
PSYCHIATRIC	\$0.21	\$0.26	-18.5%	\$0.25	-12.9%
SUMMARY	\$42.76	\$35.00	22.2%	\$40.51	5.6%



SERVICES/1000	Client B			BENCHMARK	% VARIANCE
	NOV'05-OCT'06	NOV'04-OCT'05	% CHANGE		
SURGICAL	119.0	108.6	9.6%	106.9	11.3%
RADIOLOGY	207.9	209.8	-0.9%	194.0	7.2%
EMERGENCY ROOM	136.5	134.4	1.5%	142.0	-3.9%
LABORATORY	278.5	293.0	-4.9%	226.1	23.2%
DIALYSIS	15.2	9.9	52.4%	12.7	18.9%
MEDICAL SPECIALTIES SERVICES	32.3	32.0	0.8%	31.0	4.1%
OBSERVATION ROOM	8.3	7.1	17.1%	9.7	-14.9%
OTHER SERVICES	90.7	78.0	16.3%	69.9	29.8%
PT/OT/ST	45.7	29.8	53.1%	39.4	16.0%
PSYCHIATRIC	2.2	2.9	-23.6%	2.4	-6.9%
SUMMARY	936.2	905.5	3.4%	834.1	12.2%



PAID/SERVICE	Client B			BENCHMARK	% VARIANCE
	NOV'05-OCT'06	NOV'04-OCT'05	% CHANGE		
SURGICAL	\$1,666	\$1,374	21.3%	\$1,774	-6.1%
RADIOLOGY	\$554	\$487	13.8%	\$536	3.5%
EMERGENCY ROOM	\$734	\$631	16.4%	\$675	8.8%
LABORATORY	\$108	\$91	19.0%	\$113	-4.9%
DIALYSIS	\$1,946	\$2,425	-19.7%	\$2,283	-14.8%
MEDICAL SPECIALTIES SERVICES	\$350	\$231	51.4%	\$401	-12.6%
OBSERVATION ROOM	\$1,151	\$1,709	-32.6%	\$1,100	4.7%
OTHER SERVICES	\$103	\$86	19.9%	\$134	-23.2%
PT/OT/ST	\$155	\$130	20.0%	\$166	-6.3%
PSYCHIATRIC	\$1,169	\$1,095	6.7%	\$1,249	-6.4%
SUMMARY	\$548	\$464	18.2%	\$583	-6.0%



NOV'05-OCT'06 NOV'04-OCT'05 BENCHMARK

OUTPATIENT FACILITY SERVICES BY VISIT TYPE, CONTINUED

Expense: Overall, Client B's change in paid PMPM for outpatient facility visits was 22.2%, which was 5.6% above the benchmark. A comparison of paid PMPM by visit type shows that ambulatory surgery was slightly higher than the benchmark, emergency room was slightly higher than the benchmark and radiology was 10.9% above the benchmark.

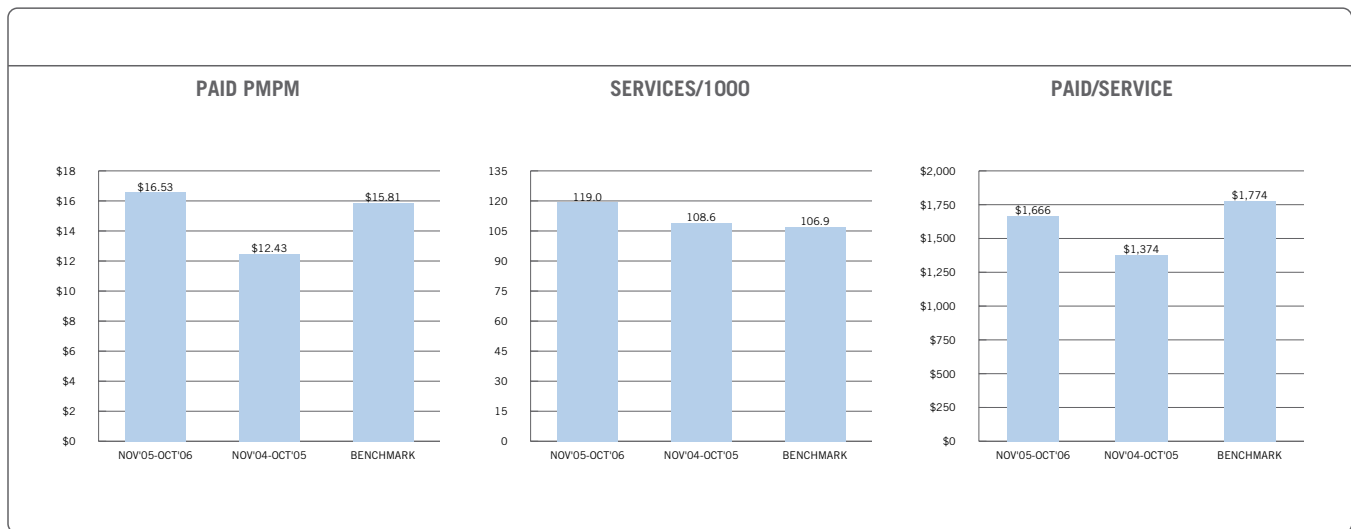
Utilization: The change in outpatient facility visits/1,000 was 3.4%, which was 12.2% higher than the benchmark. A comparison of visits/1,000 by visit type shows that ambulatory surgery was 11.3% higher than the benchmark, emergency room was slightly lower than the benchmark and radiology was 7.2% higher than the benchmark.

Price: The overall change in the paid per visit was 18.2% and was 6.0% lower than the benchmark. Paid per visit for emergency room was 8.8% higher than the benchmark, 6.1% lower than the benchmark for ambulatory surgery and slightly higher than the benchmark for radiology.

AMBULATORY SURGERY SUMMARY

Report Description: Client B's ambulatory surgery experience is summarized below and compared to the benchmark. As new techniques and technologies become available, the potential to move more surgical procedures into the ambulatory setting has increased. This shift from the inpatient setting to the outpatient setting can generate significant overall expense savings. Also, the increased public awareness around screening colonoscopies for early detection of colon cancer has typically increased the percent change for these procedures in recent years.

	Client B			BENCHMARK	% VARIANCE
	NOV'05-OCT'06	NOV'04-OCT'05	% CHANGE		
ALLOWED	\$2,797,987	\$2,326,887	20.2%		
ALLOWED PMPM	\$23.25	\$21.42	8.5%	\$21.83	6.5%
PAID	\$1,989,281	\$1,350,220	47.3%		
PAID PMPM	\$16.53	\$12.43	33.0%	\$15.81	4.6%
SERVICES	1,194	983	21.5%		
SERVICES/1000	119.0	108.6	9.6%	106.9	11.3%
ALLOWED/SERVICE	\$2,343	\$2,367	-1.0%	\$2,450	-4.4%
PAID/SERVICE	\$1,666	\$1,374	21.3%	\$1,774	-6.1%



Overall Change: Client B's ambulatory surgery expense (paid PMPM) increased 33.0%, utilization (visits/1,000) increased 9.6% and price (paid/visit) increased 21.3%.

Comparison to Benchmark: Client B was slightly higher than the benchmark for ambulatory surgery expenses (paid PMPM), 11.3% higher than the benchmark in utilization rate and 6.1% lower than the benchmark in price.

TOP AMBULATORY SURGICAL PROCEDURES

Report Description: Using the ICD-9 procedure codes that have been submitted on the ambulatory surgical claims, the following report shows the five highest ambulatory surgical procedures based on total outpatient facility expenses.

Ambulatory Surgical Procedures: Ambulatory surgeries accounted for 38.7% of the total outpatient facility expenses in the current reporting period.

The top five paid ambulatory surgical procedures accounted for 30.5% of the total ambulatory surgical visits and 38.4% of the total ambulatory surgical expenses.

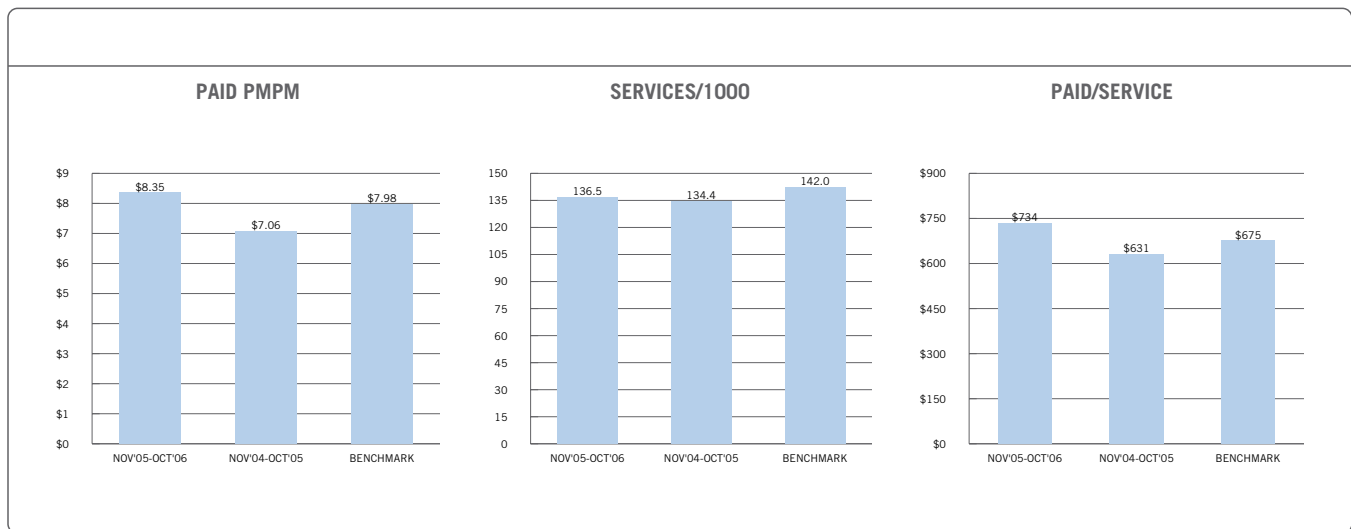
The highest paid PMPM ambulatory surgical procedure was Musculoskeletal: Other. Over the two reporting periods, paid PMPM decreased 19.5%, visits/1,000 decreased 24.1% and paid/visit increased 6.0% for this procedure.

Client B		NOV'05-OCT'06	NOV'04-OCT'05	% CHANGE
MUSCULOSKELETAL: OTHER				
ALLOWED		\$257,880	\$302,157	-14.7%
ALLOWED PMPM		\$2.14	\$2.78	-23.0%
PAID		\$210,441	\$235,834	-10.8%
PAID PMPM		\$1.75	\$2.17	-19.5%
SERVICES		69	82	-15.9%
SERVICES/1000		6.9	9.1	-24.1%
ALLOWED/SERVICE		\$3,737	\$3,685	1.4%
PAID/SERVICE		\$3,050	\$2,876	6.0%
DIGESTIVE: OTHER				
ALLOWED		\$242,698	\$103,348	134.8%
ALLOWED PMPM		\$2.02	\$0.95	112.0%
PAID		\$182,243	\$66,289	174.9%
PAID PMPM		\$1.51	\$0.61	148.1%
SERVICES		176	105	67.6%
SERVICES/1000		17.5	11.6	51.3%
ALLOWED/SERVICE		\$1,379	\$984	40.1%
PAID/SERVICE		\$1,035	\$631	64.0%
CARDIOVASCULAR: CARDIAC CATHETERIZATION				
ALLOWED		\$183,949	\$211,972	-13.2%
ALLOWED PMPM		\$1.53	\$1.95	-21.7%
PAID		\$128,823	\$77,834	65.5%
PAID PMPM		\$1.07	\$0.72	49.4%
SERVICES		26	19	36.8%
SERVICES/1000		2.6	2.1	23.5%
ALLOWED/SERVICE		\$7,075	\$11,156	-36.6%
PAID/SERVICE		\$4,955	\$4,097	20.9%
URINARY SYSTEM				
ALLOWED		\$149,645	\$54,555	174.3%
ALLOWED PMPM		\$1.24	\$0.50	147.6%
PAID		\$127,103	\$42,653	198.0%
PAID PMPM		\$1.06	\$0.39	169.0%
SERVICES		47	22	113.6%
SERVICES/1000		4.7	2.4	92.8%
ALLOWED/SERVICE		\$3,184	\$2,480	28.4%
PAID/SERVICE		\$2,704	\$1,939	39.5%
NOSE, MOUTH & PHARYNX: OTHER				
ALLOWED		\$140,471	\$97,885	43.5%
ALLOWED PMPM		\$1.17	\$0.90	29.5%
PAID		\$116,006	\$73,461	57.9%
PAID PMPM		\$0.96	\$0.68	42.5%
SERVICES		46	36	27.8%
SERVICES/1000		4.6	4.0	15.3%
ALLOWED/SERVICE		\$3,054	\$2,719	12.3%
PAID/SERVICE		\$2,522	\$2,041	23.6%
ALL OTHERS				
ALLOWED		\$1,823,344	\$1,556,970	17.1%
ALLOWED PMPM		\$15.15	\$14.33	5.7%
PAID		\$1,224,665	\$854,150	43.4%
PAID PMPM		\$10.18	\$7.86	29.4%
SERVICES		830	719	15.4%
SERVICES/1000		82.8	79.4	4.2%
ALLOWED/SERVICE		\$2,197	\$2,165	1.4%
PAID/SERVICE		\$1,475	\$1,188	24.2%
SUMMARY				
ALLOWED		\$2,797,988	\$2,326,887	20.2%
ALLOWED PMPM		\$23.25	\$21.42	8.5%
PAID		\$1,989,281	\$1,350,220	47.3%
PAID PMPM		\$16.53	\$12.43	33.0%
SERVICES		1,194	983	21.5%
SERVICES/1000		119.0	108.6	9.6%
ALLOWED/SERVICE		\$2,343	\$2,367	-1.0%
PAID/SERVICE		\$1,666	\$1,374	21.3%

EMERGENCY ROOM SUMMARY

Report Description: Emergency room (ER) is an area of particular concern for many payers. Emergency rooms are an expensive use of resources and are sometimes used to provide primary care rather than urgent care. The overall percent change in expense and utilization specifically for ER is displayed below. Other analyses in this chapter will delve further into the emergency room utilization.

	Client B			BENCHMARK	% VARIANCE
	NOV'05-OCT'06	NOV'04-OCT'05	% CHANGE		
ALLOWED	\$1,330,816	\$1,095,456	21.5%		
ALLOWED PMPM	\$11.06	\$10.08	9.6%	\$10.54	4.9%
PAID	\$1,004,725	\$767,383	30.9%		
PAID PMPM	\$8.35	\$7.06	18.2%	\$7.98	4.6%
SERVICES	1,369	1,217	12.5%		
SERVICES/1000	136.5	134.4	1.5%	142.0	-3.9%
ALLOWED/SERVICE	\$972	\$900	8.0%	\$891	9.1%
PAID/SERVICE	\$734	\$631	16.4%	\$675	8.8%



Overall Change: Client B's expense (paid PMPM) increased 18.2% for emergency room visits, the visit rate (visits/1,000) remained relatively stable and price (paid per visit) increased 16.4%.

Comparison to Benchmark: Client B was slightly higher than the benchmark for emergency room paid PMPM, slightly lower than the benchmark for visit rate and 8.8% higher than the benchmark for price.

FREQUENT USERS OF THE EMERGENCY ROOM

Report Description: The proportion of emergency room visits that are due to the patients who have visited the ER multiple times during the two reporting periods are analyzed below. Sometimes, the utilization of ER services by these members needs to be scrutinized because these members may be using the ER for primary care rather than for emergent care.

ER VISITS	CLAIMANTS		ER VISITS		ER PAID	
	NOV'05-OCT'06	NOV'04-OCT'05	NOV'05-OCT'06	NOV'04-OCT'05	NOV'05-OCT'06	NOV'04-OCT'05
0	10,925	9,690				
1	857	756	857	756	\$651,532	\$495,156
2	142	130	284	260	\$196,942	\$151,148
3	26	29	78	87	\$48,961	\$51,758
4	10	7	40	28	\$16,332	\$17,875
5	4	9	20	45	\$9,340	\$29,567
6	3	2	18	12	\$10,885	\$11,738
7	1	1	7	7	\$8,318	\$1,652
8	1		8		\$7,442	
9	1	1	9	9	\$488	\$8,322
10+	4	1	48	13	\$54,486	\$168
SUMMARY	11,974	10,626	1,369	1,217	\$1,004,725	\$767,383

ER VISITS	% CLAIMANTS		% ER VISITS		% ER PAID	
	NOV'05-OCT'06	NOV'04-OCT'05	NOV'05-OCT'06	NOV'04-OCT'05	NOV'05-OCT'06	NOV'04-OCT'05
0	91.2%	91.2%				
1	7.2%	7.1%	62.6%	62.1%	64.8%	64.5%
2	1.2%	1.2%	20.7%	21.4%	19.6%	19.7%
3	0.2%	0.3%	5.7%	7.1%	4.9%	6.7%
4	0.1%	0.1%	2.9%	2.3%	1.6%	2.3%
5	0.0%	0.1%	1.5%	3.7%	0.9%	3.9%
6	0.0%	0.0%	1.3%	1.0%	1.1%	1.5%
7	0.0%	0.0%	0.5%	0.6%	0.8%	0.2%
8	0.0%		0.6%		0.7%	
9	0.0%	0.0%	0.7%	0.7%	0.0%	1.1%
10+	0.0%	0.0%	3.5%	1.1%	5.4%	0.0%
SUMMARY	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

Proportion of all claimants who had one or more ER visits: During the current reporting period, 8.8% of Client B's claimants had an ER visit compared to 8.8% in the prior reporting period.

Proportion of all claimants who had just one ER visit: Out of the 8.8% of claimants that had an ER visit, 81.7% had only one ER visit, which remained stable over the prior reporting period. The proportion of ER paid expenses for these claimants remained the same from the prior reporting period.

Proportion of all claimants who had multiple ER visits: 18.3% of the claimants who had an ER visit went to the ER more than once during the current reporting period, which decreased 4.8% from the prior reporting period. 35.2% of the ER paid expenses were attributed to claimants with multiple ER visits in the current reporting period compared to 35.5% reported in the prior reporting period.

EMERGENCY ROOM VISITS FOR CHRONIC CONDITIONS

Report Description: The 3-digit principal diagnosis was used to identify selected chronic conditions. A list of these diagnosis codes can be found in the glossary. Proper management and control of patients with chronic conditions should minimize the need for emergency room services, so high rates of ER visits for these conditions or high percent changes in these visits should be analyzed further. Expenses, visits and price are provided overall for these selected chronic conditions as well as by chronic condition.

Chronic Conditions: The overall change in paid PMPM for ER visits related to chronic conditions was -3.0%. The change in the visit rate decreased 5.7% and the change in the price slightly increased.

The top three chronic conditions in terms of total ER visits were Migraine, Asthma and Chronic Bronchitis. These conditions accounted for 84.3% of the total ER visits for chronic conditions evaluated in this analysis.

Client B		NOV'05-OCT'06	NOV'04-OCT'05	% CHANGE
CHRONIC CONDITION				
ASTHMA	ALLOWED	\$15,818	\$7,954	98.9%
	ALLOWED PMPM	\$0.13	\$0.07	79.5%
	PAID	\$11,228	\$5,684	97.5%
	PAID PMPM	\$0.09	\$0.05	78.3%
	CLAIMANTS	21	10	110.0%
	SERVICES	24	11	118.2%
	SERVICES/1000	2.4	1.2	96.9%
	ALLOWED/SERVICE PAID/SERVICE	\$659	\$723	-8.9%
		\$468	\$517	-9.5%
MIGRAINE	ALLOWED	\$22,246	\$19,182	16.0%
	ALLOWED PMPM	\$0.18	\$0.18	4.7%
	PAID	\$16,346	\$14,039	16.4%
	PAID PMPM	\$0.14	\$0.13	5.1%
	CLAIMANTS	11	18	-38.9%
	SERVICES	30	31	-3.2%
	SERVICES/1000	3.0	3.4	-12.7%
	ALLOWED/SERVICE PAID/SERVICE	\$742	\$619	19.8%
		\$545	\$453	20.3%
DIABETES MELLITUS	ALLOWED	\$2,563	\$7,996	-67.9%
	ALLOWED PMPM	\$0.02	\$0.07	-71.1%
	PAID	\$1,653	\$6,422	-74.3%
	PAID PMPM	\$0.01	\$0.06	-76.8%
	CLAIMANTS	4	7	-42.9%
	SERVICES	4	10	-60.0%
	SERVICES/1000	0.4	1.1	-63.9%
	ALLOWED/SERVICE PAID/SERVICE	\$641	\$800	-19.9%
		\$413	\$642	-35.6%
HEART FAILURE	ALLOWED	\$7,263	\$10,784	-32.6%
	ALLOWED PMPM	\$0.06	\$0.10	-39.2%
	PAID	\$4,262	\$5,375	-20.7%
	PAID PMPM	\$0.04	\$0.05	-28.4%
	CLAIMANTS	4	4	0.0%
	SERVICES	4	5	-20.0%
	SERVICES/1000	0.4	0.6	-27.8%
	ALLOWED/SERVICE PAID/SERVICE	\$1,816	\$2,157	-15.8%
		\$1,066	\$1,075	-0.9%
HYPERTENSION	ALLOWED	\$4,761	\$4,097	16.2%
	ALLOWED PMPM	\$0.04	\$0.04	4.9%
	PAID	\$1,778	\$2,158	-17.6%
	PAID PMPM	\$0.01	\$0.02	-25.7%
	CLAIMANTS	3	8	-62.5%
	SERVICES	3	8	-62.5%
	SERVICES/1000	0.3	0.9	-66.2%
	ALLOWED/SERVICE PAID/SERVICE	\$1,587	\$512	209.9%
		\$593	\$270	119.7%
CHRONIC BRONCHITIS	ALLOWED	\$3,287	\$1,712	92.0%
	ALLOWED PMPM	\$0.03	\$0.02	73.3%
	PAID	\$2,449	\$1,412	73.5%
	PAID PMPM	\$0.02	\$0.01	56.6%
	CLAIMANTS	2	2	0.0%
	SERVICES	5	2	150.0%
	SERVICES/1000	0.5	0.2	125.6%
	ALLOWED/SERVICE PAID/SERVICE	\$657	\$856	-23.2%
		\$490	\$706	-30.6%
SUMMARY	ALLOWED	\$55,938	\$51,725	8.1%
	ALLOWED PMPM	\$0.46	\$0.48	-2.4%
	PAID	\$37,716	\$35,089	7.5%
	PAID PMPM	\$0.31	\$0.32	-3.0%
	CLAIMANTS	44	49	-10.2%
	SERVICES	70	67	4.5%
	SERVICES/1000	7.0	7.4	-5.7%
	ALLOWED/SERVICE PAID/SERVICE	\$799	\$772	3.5%
		\$539	\$524	2.9%

EMERGENCY ROOM VISITS FOR NON-EMERGENT CARE

Report Description: Selected 3-digit principal diagnosis codes were also used to identify ER visits for non-emergent care. The leading 5 non-emergent conditions ranked by number of claimants are displayed in the table. A complete list of non-emergent diagnosis codes can be found in the glossary. This analysis is used to help identify the proportion of ER visits that the payer may be able to shift to the primary care setting based on changes in plan design.

Non-Emergent Care: ER visits related to these selected non-emergent conditions accounted for 9.0% of total ER visits during this period, and also represented 7.2% of the total facility paid PMPM for all ER visits. The average price for these visits was \$591.

The change in facility expenses (paid PMPM) for ER visits related to non-emergent care was 11.8%. The change in the visit rate was 0.9% and the change in price was 10.7%.

The top three non-emergent conditions in terms of claimants were General Symptoms, Acute Pharyngitis and Acute Bronchitis And Bronchiolitis. These conditions accounted for 89.4% of all the non-emergent ER visits in the current reporting period.

Client B		NOV'05-OCT'06	NOV'04-OCT'05	% CHANGE
3-DIGIT PRINCIPAL DIAGNOSIS				
780 GENERAL SYMPTOMS	ALLOWED	\$91,385	\$83,145	9.9%
	ALLOWED PMPM	\$0.76	\$0.77	-0.8%
	PAID	\$65,408	\$54,532	19.9%
	PAID PMPM	\$0.54	\$0.50	8.3%
	CLAIMANTS	83	73	13.7%
	SERVICES	88	81	8.6%
	SERVICES/1000	8.8	8.9	-1.9%
	ALLOWED/SERVICE	\$1,038	\$1,026	1.2%
	PAID/SERVICE	\$743	\$673	10.4%
	462 ACUTE PHARYNGITIS	ALLOWED	\$5,573	\$2,145
ALLOWED PMPM		\$0.05	\$0.02	134.5%
PAID		\$2,987	\$865	245.2%
PAID PMPM		\$0.02	\$0.01	211.6%
CLAIMANTS		17	10	70.0%
SERVICES		17	10	70.0%
SERVICES/1000		1.7	1.1	53.4%
ALLOWED/SERVICE		\$328	\$215	52.8%
PAID/SERVICE		\$176	\$87	103.1%
466 ACUTE BRONCHITIS AND BRONCHIOLITIS		ALLOWED	\$1,484	\$2,576
	ALLOWED PMPM	\$0.01	\$0.02	-48.0%
	PAID	\$824	\$991	-16.9%
	PAID PMPM	\$0.01	\$0.01	-25.0%
	CLAIMANTS	5	10	-50.0%
	SERVICES	5	11	-54.5%
	SERVICES/1000	0.5	1.2	-59.0%
	ALLOWED/SERVICE	\$297	\$234	26.8%
	PAID/SERVICE	\$165	\$90	82.9%
	490 BRONCHITIS, NOT SPECIFIED AS ACUTE OR CHRONIC	ALLOWED	\$2,531	\$480
ALLOWED PMPM		\$0.02	\$0.00	375.7%
PAID		\$1,791	\$207	766.9%
PAID PMPM		\$0.01	\$0.00	682.4%
CLAIMANTS		5	2	150.0%
SERVICES		5	2	150.0%
SERVICES/1000		0.5	0.2	125.6%
ALLOWED/SERVICE		\$506	\$240	110.8%
PAID/SERVICE		\$358	\$103	246.8%
487 INFLUENZA		ALLOWED	\$1,799	\$817
	ALLOWED PMPM	\$0.01	\$0.01	98.8%
	PAID	\$617	\$517	19.3%
	PAID PMPM	\$0.01	\$0.00	7.7%
	CLAIMANTS	4	2	100.0%
	SERVICES	4	2	100.0%
	SERVICES/1000	0.4	0.2	80.5%
	ALLOWED/SERVICE	\$450	\$408	10.1%
	PAID/SERVICE	\$154	\$258	-40.3%
	ALL OTHER	ALLOWED	\$1,531	\$1,941
ALLOWED PMPM		\$0.01	\$0.02	-28.8%
PAID		\$1,057	\$1,587	-33.4%
PAID PMPM		\$0.01	\$0.01	-39.9%
CLAIMANTS		4	4	0.0%
SERVICES		4	4	0.0%
SERVICES/1000		0.4	0.4	-9.7%
ALLOWED/SERVICE		\$383	\$485	-21.1%
PAID/SERVICE		\$264	\$397	-33.4%
SUMMARY		ALLOWED	\$104,303	\$91,104
	ALLOWED PMPM	\$0.87	\$0.84	3.3%
	PAID	\$72,683	\$58,699	23.8%
	PAID PMPM	\$0.60	\$0.54	11.8%
	CLAIMANTS	118	101	16.8%
	SERVICES	123	110	11.8%
	SERVICES/1000	12.3	12.2	0.9%
	ALLOWED/SERVICE	\$848	\$828	2.4%
	PAID/SERVICE	\$591	\$534	10.7%

RADIOLOGY SUMMARY

Report Description: This report analyzes the facility expenses and utilization associated with radiology services provided in the outpatient facility setting. The three service categories of CT scans, MRIs and nuclear medicine are high cost radiology services. The professional expenses for these services are discussed separately in the professional chapter of this report. High cost radiology has been a source of growing interest and concern because the utilization for these services has increased dramatically in recent years. Client B's expense, utilization and price percent changes are displayed below.

Client B		NOV'05-OCT'06	NOV'04-OCT'05	% CHANGE
DETAILED SERVICE TYPE				
THERAPEUTIC RADIOLOGY	PAID PMPM	\$3.88	\$3.25	19.2%
	SERVICES/1000	18.9	14.0	35.0%
	PAID/SERVICE	\$2,457	\$2,783	-11.7%
CT SCAN	PAID PMPM	\$2.22	\$1.97	13.0%
	SERVICES/1000	25.4	24.5	3.7%
	PAID/SERVICE	\$1,050	\$963	9.0%
MRI	PAID PMPM	\$1.56	\$1.32	18.7%
	SERVICES/1000	21.6	24.3	-11.0%
	PAID/SERVICE	\$866	\$650	33.3%
OTHER IMAGING	PAID PMPM	\$0.63	\$0.65	-2.1%
	SERVICES/1000	71.8	77.5	-7.4%
	PAID/SERVICE	\$106	\$100	5.8%
DIAGNOSTIC RADIOLOGY: OTHER	PAID PMPM	\$0.55	\$0.62	-11.4%
	SERVICES/1000	61.9	59.9	3.4%
	PAID/SERVICE	\$106	\$124	-14.3%
NUCLEAR MEDICINE	PAID PMPM	\$0.53	\$0.66	-19.5%
	SERVICES/1000	7.4	9.4	-21.4%
	PAID/SERVICE	\$870	\$850	2.4%
ALL OTHER	PAID PMPM	\$0.22	\$0.05	336.8%
	SERVICES/1000	0.8	0.1	622.1%
	PAID/SERVICE	\$3,372	\$5,573	-39.5%
SUMMARY	PAID PMPM	\$9.61	\$8.52	12.8%
	SERVICES/1000	207.9	209.8	-0.9%
	PAID/SERVICE	\$554	\$487	13.8%

Outpatient facility radiology expenses accounted for 22.5% of total outpatient facility expenses in the current reporting period. The change in these expenses from the prior reporting period was -7.7%.

The highest expense radiology test during the current reporting period was Therapeutic Radiology. These services contributed 40.4% of total outpatient facility radiology expenses and 9.1% of total outpatient facility radiology visits/1,000. Changes showed expenses increased 19.2% and utilization increased 35.0%.

The second highest expense radiology test was CT Scan, which contributed another 23.1% to overall expenses and 12.2% to utilization. Expense change for these services increased 13.0% and utilization slightly increased.

 CHAPTER DESCRIPTION

Professional services encompass all the services provided by physicians and other clinicians, ancillary services and medical services and supplies. There are several analyses of professional services provided in this chapter. These analyses present percent changes and compare results to the benchmark.

The first report analyzes the expense, utilization and price of professional services by the place of service. These services may be provided in any setting, including inpatient facilities, outpatient facilities, offices or other settings.

The second report analyzes the expense, utilization and price of professional services by service type. Physician and other clinician services include surgical procedures, evaluation and management (E&M) services, anesthesia services, physical/occupational/speech therapy services and other medical services. Ancillary services include radiology and laboratory/pathology services. Medical services and supplies are also included in the professional service category. This service type represents services that have been submitted with a HCPCS (Healthcare Common Procedure Coding System) code.

The third report analyzes expenses, utilization and price of professional visits performed by primary care physicians (PCPs) and specialists. Care by specialists can be more expensive and may require referrals; therefore, the proportion of office visits with specialists and PCPs are compared.

The fourth report analyzes expenses, utilization and price for preventive visits. Preventive visits are recommended for healthy members so that their overall health can be reviewed with a clinician. Clinicians typically perform the proper screening for these members and also review personal lifestyle choices made by individual members that may have short and long term health consequences. While these services have not always been covered by health plans in the past, they are seen as beneficial to managing the overall health of members by providing both education and an opportunity for early identification of disease signs and symptoms.

The last report focuses on high cost radiology services. High cost radiology has seen significant growth in recent years, resulting in more analytic interest. Predefined groupings of CPT-4 (Current Procedure Terminology) procedure codes related to high cost radiology have been applied to the data and facilitate this type of analysis.

Data Note

Reporting is based on incurred, 12-month rolling periods with 2 months run-out.

Current reporting period represents claims incurred Nov'05 through Oct'06 and paid through Dec'06.

Prior reporting period represents claims incurred Nov'04 through Oct'05 and paid through Dec'05.

Claims for active, retiree under 65, retiree 65 and over and COBRA members are reported.

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SUMMARY OF FINDINGS

Overall paid expenses for professional services increased 11.2% from the prior reporting period, utilization increased 4.4% and price increased 6.5%.

In the current reporting period, professional services in the office accounted for 68.6% of the total professional paid expenses, outpatient accounted for 14.2%, inpatient accounted for 13.7% and other settings accounted for 3.5%.

Evaluation & Management and Surgical accounted for 49.5% of the total professional paid expenses in the current reporting period. The highest utilized service types, Evaluation & Management and Pathology & Laboratory, accounted for 56.0% of the total professional services/1,000. Other and Anesthesia were the highest priced professional service types at \$713/service and \$505/service respectively.

Primary care accounted for 56.7% of all office visit expenses and specialty visits accounted for the remaining 43.3%. Expenses for primary care increased 5.6% and expenses for visits to specialists increased 10.4%.

Preventive visits accounted for 5.9% of all professional expenses. Expenses for these services increased 7.3%. Utilization for these services increased 5.0% and price remained relatively stable.

Professional expenses for high cost diagnostic radiology decreased 22.5% in the current reporting period, utilization slightly decreased and price decreased 20.1%.

PLACE OF SERVICE ANALYSIS

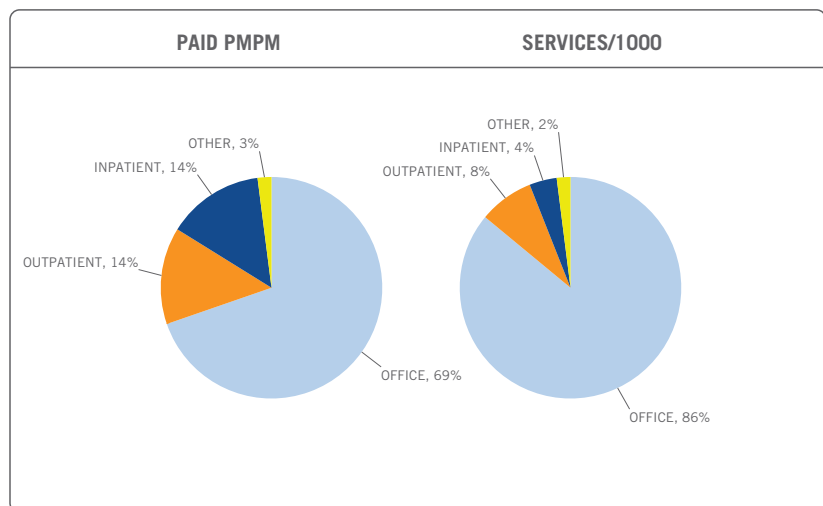
Report Description: Overall expense, utilization and price measures are displayed for professional services by place of service. The pie charts below show the proportion that each place of service represents of total paid PMPM and services/1,000 for all professional in the current reporting period.

Expense: Over the current reporting period, 68.6% of Client B's paid expenses occurred in the office setting, which remained stable. Professional services in the outpatient and inpatient facility setting together contributed 27.9% of the total professional paid expenses, with changes of 9.3% and 24.5% respectively.

Utilization: 82.8% of Client B's professional visits/1,000 occurred in the office, which remained relatively stable.

Price: Paid/visit increased 6.1% for office visits, increased 6.7% for outpatient visits and increased 28.7% for inpatient visits.

PLACE OF SERVICE		Client B			BENCHMARK	% VARIANCE
		NOV'05-OCT'06	NOV'04-OCT'05	% CHANGE		
OFFICE	ALLOWED	\$8,334,316	\$6,862,308	21.5%		
	PAID	\$6,354,535	\$5,288,384	20.2%		
	PAID PMPM	\$52.80	\$48.68	8.5%	\$52.26	1.0%
	VISITS	66,567	58,752	13.3%		
	VISITS/1000	6,637.0	6,490.2	2.3%		
	SERVICES	136,017	117,303	16.0%		
	SERVICES/1000	13,561.5	12,958.2	4.7%	13,132.0	3.3%
	PAID/VISIT	\$95	\$90	6.1%		
PAID/SERVICE	\$47	\$45	3.6%	\$48	-2.2%	
OUTPATIENT	ALLOWED	\$1,906,959	\$1,697,039	12.4%		
	PAID	\$1,318,177	\$1,088,195	21.1%		
	PAID PMPM	\$10.95	\$10.02	9.3%	\$10.83	1.2%
	VISITS	8,062	7,100	13.5%		
	VISITS/1000	803.8	784.3	2.5%		
	SERVICES	12,506	10,818	15.6%		
	SERVICES/1000	1,246.9	1,195.0	4.3%	1,168.9	6.7%
	PAID/VISIT	\$164	\$153	6.7%		
PAID/SERVICE	\$105	\$101	4.8%	\$111	-5.2%	
INPATIENT	ALLOWED	\$1,679,484	\$1,279,572	31.3%		
	PAID	\$1,265,956	\$918,050	37.9%		
	PAID PMPM	\$10.52	\$8.45	24.5%	\$9.84	6.8%
	VISITS	4,668	4,355	7.2%		
	VISITS/1000	465.4	481.1	-3.3%		
	SERVICES	6,901	6,402	7.8%		
	SERVICES/1000	688.1	707.2	-2.7%	634.7	8.4%
	PAID/VISIT	\$271	\$211	28.7%		
PAID/SERVICE	\$183	\$143	27.9%	\$186	-1.4%	
OTHER	ALLOWED	\$520,895	\$397,152	31.2%		
	PAID	\$321,193	\$222,921	44.1%		
	PAID PMPM	\$2.67	\$2.05	30.0%	\$2.77	-3.7%
	VISITS	2,051	1,707	20.2%		
	VISITS/1000	204.5	188.6	8.4%		
	SERVICES	3,601	2,957	21.8%		
	SERVICES/1000	359.0	326.7	9.9%	357.0	0.6%
	PAID/VISIT	\$157	\$131	19.9%		
PAID/SERVICE	\$89	\$75	18.3%	\$93	-4.2%	
SUMMARY	ALLOWED	\$12,441,654	\$10,236,071	21.5%		
	PAID	\$9,259,861	\$7,517,549	23.2%		
	PAID PMPM	\$76.94	\$69.20	11.2%	\$75.71	1.6%
	VISITS	80,356	70,901	13.3%		
	VISITS/1000	8,011.8	7,832.3	2.3%		
	SERVICES	159,025	137,480	15.7%		
	SERVICES/1000	15,855.5	15,187.1	4.4%	15,292.6	3.7%
	PAID/VISIT	\$115	\$106	8.7%		
PAID/SERVICE	\$58	\$55	6.5%	\$59	-2.0%	

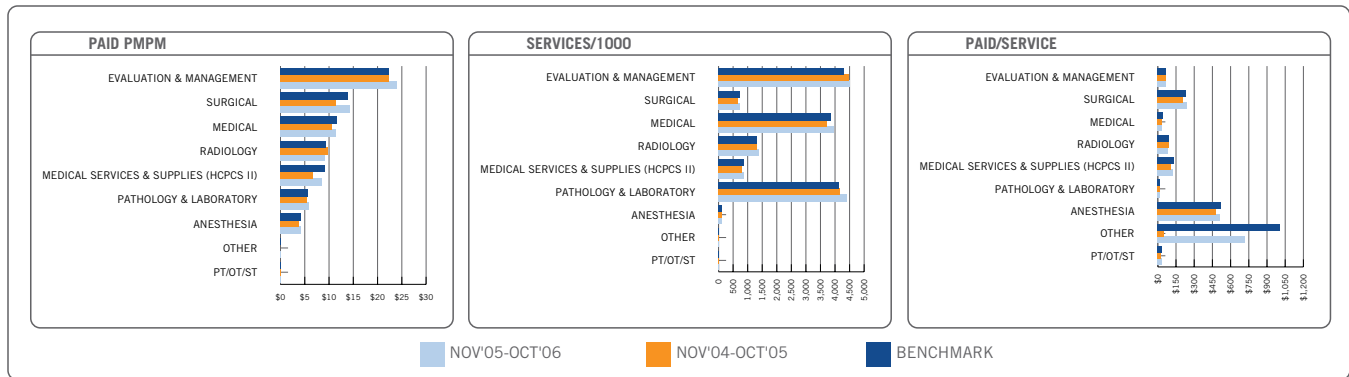


SERVICE TYPE ANALYSIS

Report Description: Overall expense, utilization and price measures for professional services by service type are presented to the right.

The bar graphs below compare expense, utilization and price for each professional service type for the current and prior reporting periods and to the benchmark.

SERVICE TYPE		Client B			BENCHMARK	% VARIANCE
		NOV'05-OCT'06	NOV'04-OCT'05	% CHANGE		
EVALUATION & MANAGEMENT	PAID PMPM	\$23.92	\$22.22	7.6%	\$22.27	7.4%
	SERVICES/1000	4,499.0	4,474.7	0.5%	4,308.0	4.4%
	PAID/SERVICE	\$64	\$60	7.1%	\$62	2.8%
SURGICAL	PAID PMPM	\$14.20	\$11.24	26.3%	\$13.76	3.2%
	SERVICES/1000	724.7	663.4	9.2%	734.3	-1.3%
	PAID/SERVICE	\$235	\$203	15.6%	\$225	4.5%
MEDICAL	PAID PMPM	\$11.33	\$10.58	7.1%	\$11.45	-1.0%
	SERVICES/1000	3,948.1	3,718.9	6.2%	3,842.6	2.7%
	PAID/SERVICE	\$34	\$34	0.9%	\$36	-3.7%
RADIOLOGY	PAID PMPM	\$9.14	\$9.63	-5.1%	\$9.36	-2.4%
	SERVICES/1000	1,356.3	1,313.9	3.2%	1,314.7	3.2%
	PAID/SERVICE	\$81	\$88	-8.1%	\$85	-5.4%
MEDICAL SERVICES & SUPPLIES (HCPCS II)	PAID PMPM	\$8.38	\$6.64	26.3%	\$9.08	-7.6%
	SERVICES/1000	842.1	777.6	8.3%	865.4	-2.7%
	PAID/SERVICE	\$119	\$102	16.6%	\$126	-5.1%
PATHOLOGY & LABORATORY	PAID PMPM	\$5.79	\$5.28	9.6%	\$5.59	3.7%
	SERVICES/1000	4,381.8	4,144.6	5.7%	4,126.3	6.2%
	PAID/SERVICE	\$16	\$15	3.7%	\$16	-2.3%
ANESTHESIA	PAID PMPM	\$4.14	\$3.61	14.7%	\$4.16	-0.6%
	SERVICES/1000	98.4	91.2	7.8%	96.8	1.7%
	PAID/SERVICE	\$505	\$475	6.4%	\$516	-2.2%
OTHER	PAID PMPM	\$0.03	\$0.00	6339.7%	\$0.03	-2.4%
	SERVICES/1000	0.5	0.1	351.3%	0.4	37.6%
	PAID/SERVICE	\$713	\$50	1327.0%	\$1,006	-29.1%
PT/OT/ST	PAID PMPM	\$0.01	\$0.01	121.0%	\$0.01	27.1%
	SERVICES/1000	4.7	2.7	76.8%	4.1	14.1%
	PAID/SERVICE	\$32	\$25	25.0%	\$29	11.4%
SUMMARY	PAID PMPM	\$76.94	\$69.20	11.2%	\$75.71	1.6%
	SERVICES/1000	15,855.5	15,187.1	4.4%	15,292.6	3.7%
	PAID/SERVICE	\$58	\$55	6.5%	\$59	-2.0%



Expense: Over the current reporting period, Client B's top three paid service types were Evaluation & Management, Surgical and Medical.

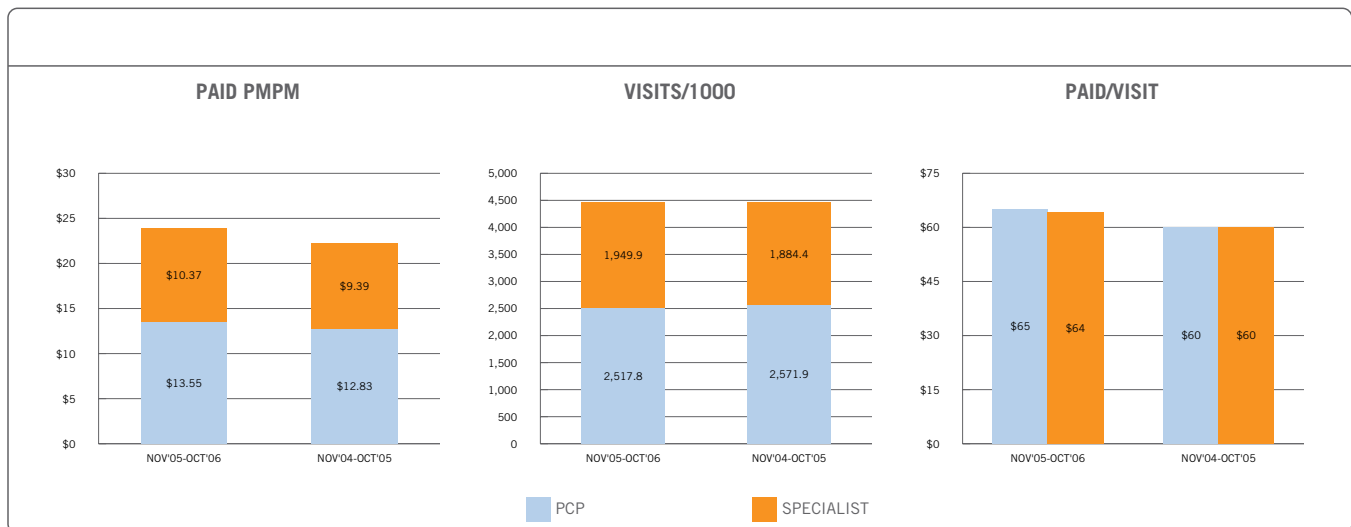
Utilization: The highest utilized service type was Evaluation & Management which was 4.4% higher than the benchmark. Next was Pathology & Laboratory which was 6.2% higher than the benchmark, followed by Medical.

Price: The most expensive service type, Other, was priced 29.1% lower than the benchmark. Anesthesia was second highest and was comparable to the benchmark. Surgical was third and was slightly higher than the benchmark.

PRIMARY CARE PHYSICIAN VS. SPECIALIST ANALYSIS

Report Description: This analysis presents statistics on the proportion of evaluation and management (E&M) physician visits with primary care physicians versus other medical and surgical specialties. Primary care physicians (PCP) are providers whose specialties are either Family Practice, General Practice, Internal Medicine, Pediatrics or Family Nurse Practitioner. All other specialties are considered specialists. Client B's expense, utilization and price percent changes are displayed in the table below. The stacked expense and utilization bar graphs display the proportion of PCP versus specialty care and the side-by-side graph compares price.

Client B		NOV'05-OCT'06	NOV'04-OCT'05	% CHANGE
PCP	ALLOWED PMPM	\$18.01	\$17.34	3.8%
	PAID PMPM	\$13.55	\$12.83	5.6%
	VISITS/1000	2,517.8	2,571.9	-2.1%
	PAID/VISIT	\$65	\$60	7.9%
SPECIALIST	ALLOWED PMPM	\$15.60	\$14.30	9.1%
	PAID PMPM	\$10.37	\$9.39	10.4%
	VISITS/1000	1,949.9	1,884.4	3.5%
	PAID/VISIT	\$64	\$60	6.7%
SUMMARY	ALLOWED PMPM	\$33.61	\$31.64	6.2%
	PAID PMPM	\$23.92	\$22.22	7.6%
	VISITS/1000	4,467.2	4,456.3	0.2%
	PAID/VISIT	\$64	\$60	7.4%



Expense: PCPs received 56.7% of paid PMPM for Client B, which remained stable from the prior reporting period. The remaining 43.3% was paid to specialty providers, which increased slightly from the prior reporting period.

Utilization: 56.4% of Client B's visits/1,000 were performed by PCPs. This rate slightly decreased over the prior reporting period. Specialty providers performed the remaining 43.6% of visits/1,000 during the current reporting period, which slightly increased from the prior reporting period.

Price: During the current reporting period, specialty providers were paid 1.0 times more per visit than PCPs (\$64 vs. \$65 respectively). The paid per visit amount for PCPs increased 7.9% and the paid per visit amount for specialty providers increased 6.7% over the two reporting periods.

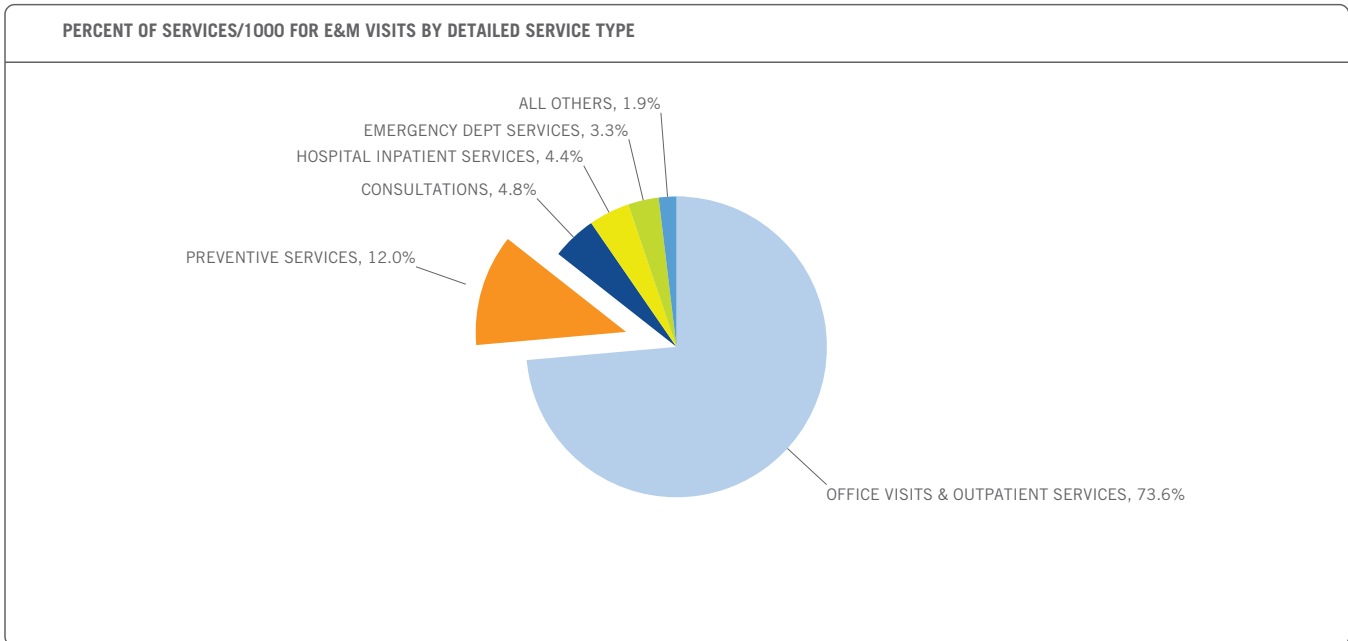
PREVENTIVE VISITS

Report Description: Preventive visits are encouraged by health plans because these visits are typically used to perform proper screenings and educate patients on healthy lifestyle choices. Changes for these visits may be interesting to analyze, especially if plan design changes have been implemented that may have affected the delivery of these services, either positively or negatively. Expense, utilization and price percent changes are displayed below. The number of members in each age category is used to calculate what proportion of members received new/established preventive visits over the current and prior reporting periods.

Client B		NOV'05-OCT'06	NOV'04-OCT'05	% CHANGE
PREVENTIVE VISITS				
AGE < 1	PAID PMPM	\$36.41	\$32.33	12.6%
	SERVICES/1000	5,894.3	5,439.3	8.4%
	PAID/SERVICE	\$74	\$71	3.9%
	% MEMBERS WITH PREVENTIVE VISIT	75.4%	73.5%	2.6%
AGE 1-4	PAID PMPM	\$9.24	\$9.22	0.1%
	SERVICES/1000	1,388.5	1,409.8	-1.5%
	PAID/SERVICE	\$80	\$79	1.7%
	% MEMBERS WITH PREVENTIVE VISIT	57.6%	56.4%	2.1%
AGE 5-11	PAID PMPM	\$3.31	\$3.17	4.1%
	SERVICES/1000	472.8	462.1	2.3%
	PAID/SERVICE	\$84	\$82	1.8%
	% MEMBERS WITH PREVENTIVE VISIT	34.6%	33.6%	3.0%
AGE 12-17	PAID PMPM	\$3.70	\$3.14	17.9%
	SERVICES/1000	480.0	418.3	14.8%
	PAID/SERVICE	\$92	\$90	2.7%
	% MEMBERS WITH PREVENTIVE VISIT	33.8%	30.1%	12.3%
AGE 18-39	PAID PMPM	\$3.72	\$3.57	4.4%
	SERVICES/1000	412.6	406.8	1.4%
	PAID/SERVICE	\$108	\$105	2.9%
	% MEMBERS WITH PREVENTIVE VISIT	29.3%	28.6%	2.6%
AGE 40-64	PAID PMPM	\$4.97	\$4.54	9.5%
	SERVICES/1000	506.4	475.6	6.5%
	PAID/SERVICE	\$118	\$114	2.8%
	% MEMBERS WITH PREVENTIVE VISIT	39.4%	36.8%	7.0%
AGE > 64	PAID PMPM	\$1.54	\$2.01	-23.6%
	SERVICES/1000	156.6	201.7	-22.4%
	PAID/SERVICE	\$118	\$120	-1.6%
	% MEMBERS WITH PREVENTIVE VISIT	13.7%	17.6%	-22.0%
SUMMARY	PAID PMPM	\$4.51	\$4.21	7.3%
	SERVICES/1000	540.6	514.7	5.0%
	PAID/SERVICE	\$100	\$98	2.2%
	% MEMBERS WITH PREVENTIVE VISIT	37.2%	35.5%	4.7%

EVALUATION & MANAGEMENT		NOV'05-OCT'06	NOV'04-OCT'05	% CHANGE
SUMMARY	PAID PMPM	\$23.92	\$22.22	7.6%
	SERVICES/1000	4,499.0	4,474.7	0.5%
	PAID/SERVICE	\$64	\$60	7.1%

PREVENTIVE VISITS, CONTINUED



Overall: During the current reporting period, 5.9% of Client B's professional paid PMPM and 3.4% of professional services/1,000 were for preventive visits. In terms of evaluation and management visits, 12.0% of professional services/1,000 were specifically for preventive visits.

Expense: Client B's paid PMPM expenses for preventive visits increased 7.3% from \$4.21 PMPM to \$4.51 PMPM over the two reporting periods.

Utilization: Client B's utilization rate for preventive visits increased 5.0% compared to the prior reporting period.

Price: The paid per service change between the two reporting periods for Client B remained relatively stable, with \$100/service in the current reporting period and \$98/service in the prior reporting period.

Proportion of Preventive Visits by Age Category: Overall, 37.2% of members received a preventive visit in the current reporting period. This proportion increased 4.7% from the prior reporting period. Results by age category can be viewed in the table on the previous page.

HIGH COST DIAGNOSTIC RADIOLOGY

Report Description: High cost diagnostic radiology refers to expensive diagnostic radiology exams that have the potential to be over-utilized. These tests include CT scans, MRIs, PET scans and nuclear medicine. Client B's expense, utilization and price percent changes are displayed below, in addition to the number of claimants who received these services.

Client B		NOV'05-OCT'06	NOV'04-OCT'05	% CHANGE
DETAILED SERVICE TYPE				
RADIOLOGY: MRI	PAID	\$230,287	\$298,706	-22.9%
	PAID PMPM	\$1.91	\$2.75	-30.4%
	CLAIMANTS	540	483	11.8%
	SERVICES	753	690	9.1%
	SERVICES/1000	75.1	76.2	-1.5%
	PAID/SERVICE	\$306	\$433	-29.4%
RADIOLOGY: CT	PAID	\$167,880	\$180,862	-7.2%
	PAID PMPM	\$1.39	\$1.66	-16.2%
	CLAIMANTS	690	617	11.8%
	SERVICES	1,530	1,404	9.0%
	SERVICES/1000	152.5	155.1	-1.6%
	PAID/SERVICE	\$110	\$129	-14.8%
NUCLEAR MEDICINE: OTHER	PAID	\$68,821	\$65,151	5.6%
	PAID PMPM	\$0.57	\$0.60	-4.7%
	CLAIMANTS	218	213	2.3%
	SERVICES	488	488	0.0%
	SERVICES/1000	48.7	53.9	-9.7%
	PAID/SERVICE	\$141	\$134	5.6%
RADIOLOGY: MRA	PAID	\$11,933	\$13,218	-9.7%
	PAID PMPM	\$0.10	\$0.12	-18.5%
	CLAIMANTS	45	39	15.4%
	SERVICES	58	52	11.5%
	SERVICES/1000	5.8	5.7	0.7%
	PAID/SERVICE	\$206	\$254	-19.1%
NUCLEAR MEDICINE: PET	PAID	\$0	\$151	-100.0%
	PAID PMPM	\$0.00	\$0.00	-100.0%
	CLAIMANTS	1	2	-50.0%
	SERVICES	1	2	-50.0%
	SERVICES/1000	0.1	0.2	-54.9%
	PAID/SERVICE	\$0	\$76	-100.0%
SUMMARY	PAID	\$478,920	\$558,088	-14.2%
	PAID PMPM	\$3.98	\$5.14	-22.5%
	CLAIMANTS	1,199	1,093	9.7%
	SERVICES	2,830	2,636	7.4%
	SERVICES/1000	282.2	291.2	-3.1%
	PAID/SERVICE	\$169	\$212	-20.1%

Professional high cost radiology expenses accounted for 5.2% of total professional expenses in the current reporting period. The change in these expenses from the prior reporting period was -22.5%.

The leading high cost radiology test during the current reporting period was Radiology: MRI. These services contributed 48.1% of total diagnostic radiology expenses and 26.6% of total diagnostic radiology services/1,000. Expenses for these services decreased 30.4% and service utilization remained relatively stable.

The second highest radiology test was Radiology: CT, which contributed another 35.1% to overall expenses and 54.1% to utilization. Expenses for these services decreased 16.2% and service utilization remained relatively stable.

 CHAPTER DESCRIPTION

Pharmacy includes all outpatient, non-professional prescription drug services provided to Client B's members. These services are categorized into generic, preferred brand, non-preferred brand and specialty drugs. Once the patent for a brand drug expires, a generic version of the drug which is the same chemically as the brand version, can be available at cheaper prices. Generic drugs are less expensive because generic manufacturers do not have the investment expenses of a new drug developer. When appropriate, plan sponsors encourage the use of generics over brand drugs. Preferred brand drugs are those that appear on the plan's approved list of brands. Non-preferred brand drugs are all other brand drugs which generally have equally effective and less expensive generic equivalents and/or have one or more preferred brand options. Specialty drugs generally have unique uses, require special dosing or administration, are typically prescribed by a specialist provider and are significantly more expensive than alternative drugs or therapies.

This chapter presents percent changes information on key expense, utilization and price metrics for these four categories of prescription drugs. When available, metrics for the current reporting period are compared to the benchmark. The dispensing rate for generic drugs (the percent of total drugs prescribed that were generic) is also discussed in terms of percent changes and benchmark. Next, the potential savings Client B could realize if the generic substitution rate was increased by 20% are presented.

Descriptive information on the leading 25 prescription drugs is provided based on frequency of prescriptions, total paid expenses and price (paid per prescription). Expense, utilization and price percent changes are presented for the top drugs ranked by total paid expenses.

Prescription drugs are also classified by therapeutic class and therapeutic group. Expense, utilization and price percent changes are presented for the leading 25 therapeutic drug classes and the leading 50 therapeutic groups. Benchmark information is also included.

Data Note

Reporting is based on incurred, 12-month rolling periods with 2 months run-out.

Current reporting period represents claims incurred Nov'05 through Oct'06 and paid through Dec'06.

Prior reporting period represents claims incurred Nov'04 through Oct'05 and paid through Dec'05.

Claims for active, retiree under 65, retiree 65 and over and COBRA members are reported.

 SUMMARY OF FINDINGS

Overall paid PMPM for prescription drugs increased 19.2% for Client B in the current reporting period. Generic drug paid PMPM increased 91.3%, preferred brand paid PMPM increased 9.2%, non-preferred brand paid PMPM remained stable and specialty drug paid PMPM increased 353.5%.

In the current reporting period, utilization increased 6.1% overall for Client B. Utilization increased 18.2% for generics, slightly decreased for preferred brand, decreased 9.1% for non-preferred brand and increased 72.2% for specialty drugs.

Client B's overall paid per prescription increased 12.3% in the current reporting period. Paid per prescription increased 61.9% for generics, increased 13.6% for preferred brand, increased 11.2% for non-preferred brand and increased 163.4% for specialty drugs.

Generic drugs were dispensed at a 55.8% rate in the current reporting period, which was an increase over the prior reporting period and similar to the benchmark. Increasing the generic substitution rate by 20% would have saved \$66,628 for Client B.

The leading prescription drugs, based on total paid expenses, were Nexium, Lipitor and Topamax in the current reporting period. These drugs accounted for 8.6% of total paid expenses. For the top drug, Nexium, paid PMPM increased 250.6%, utilization increased 247.3% and paid per script remained stable.

The therapeutic classes with the highest paid PMPM in the current reporting period were Central Nervous System Agents, Cardiovascular Therapy Agents and Gastrointestinal Therapy Agents. The fastest growing therapeutic classes in terms of paid PMPM for Client B were Eating Disorder Therapy, Electrolyte Balance-Nutritional Products and Mouth-Throat-Dental - Preparations. Difference from the paid PMPM benchmark was greatest for Eating Disorder Therapy, Antineoplastics and Diagnostic Agents.

Antihyperlipidemic - HMG CoA Reductase Inhibitors, ACE Inhibitors and Diuretic - Thiazides and Related were the benchmark's three mostly frequently prescribed therapeutic groups in the current reporting period.

PRESCRIPTION DRUG UTILIZATION AND EXPENSE

Report Description: For the current and prior reporting periods, Client B's prescription drug utilization and expenses are displayed below by pharmacy tier (generic, preferred brand, non-preferred brand, specialty and other) and overall experience. In addition, the dispensing rate for each of the pharmacy tiers has been calculated. Benchmark data has been included for comparison.

NOV'05-OCT'06						
	GENERIC	PREFERRED BRAND	NON-PREFERRED BRAND	SPECIALTY	OTHER	SUMMARY
SERVICES	71,178	31,540	22,369	105	2,264	127,456
SERVICES/MEMBER	7.2	3.2	2.3	0.0	0.2	12.9
DISPENSING RATE	55.8%	24.7%	17.6%	0.1%	1.8%	100.0%
ALLOWED	\$1,619,902	\$3,805,343	\$2,309,655	\$142,589	\$140,355	\$8,017,843
ALLOWED PMPM	\$13.61	\$31.98	\$19.41	\$1.20	\$1.18	\$67.38
PAID	\$1,461,351	\$3,102,304	\$1,500,374	\$139,129	\$119,712	\$6,322,870
PAID PMPM	\$12.28	\$26.07	\$12.61	\$1.17	\$1.01	\$53.13
ALLOWED/SERVICE	\$23	\$121	\$103	\$1,358	\$62	\$63
PAID/SERVICE	\$21	\$98	\$67	\$1,325	\$53	\$50

NOV'04-OCT'05						
	GENERIC	PREFERRED BRAND	NON-PREFERRED BRAND	SPECIALTY	OTHER	SUMMARY
SERVICES	54,304	29,588	22,183	55	2,185	108,315
SERVICES/MEMBER	6.1	3.3	2.5	0.0	0.2	12.1
DISPENSING RATE	50.1%	27.3%	20.5%	0.1%	2.0%	100.0%
ALLOWED	\$1,145,295	\$3,203,228	\$2,113,233	\$28,779	\$209,761	\$6,700,296
ALLOWED PMPM	\$10.67	\$29.85	\$19.69	\$0.27	\$1.95	\$62.44
PAID	\$688,750	\$2,562,317	\$1,338,537	\$27,668	\$167,635	\$4,784,907
PAID PMPM	\$6.42	\$23.88	\$12.47	\$0.26	\$1.56	\$44.59
ALLOWED/SERVICE	\$21	\$108	\$95	\$523	\$96	\$62
PAID/SERVICE	\$13	\$87	\$60	\$503	\$77	\$44

BENCHMARK						
	GENERIC	PREFERRED BRAND	NON-PREFERRED BRAND	SPECIALTY	OTHER	SUMMARY
SERVICES						
SERVICES/MEMBER	6.8	3.0	2.2	0.0	0.2	12.1
DISPENSING RATE	55.8%	24.4%	17.9%	0.1%	1.7%	100.0%
ALLOWED						
ALLOWED PMPM	\$12.95	\$29.86	\$18.73	\$1.35	\$1.06	\$63.94
PAID						
PAID PMPM	\$11.32	\$23.46	\$12.13	\$1.31	\$0.87	\$49.09
ALLOWED/SERVICE	\$23	\$121	\$103	\$1,399	\$61	\$63
PAID/SERVICE	\$20	\$95	\$67	\$1,358	\$50	\$49

 PRESCRIPTION DRUG UTILIZATION AND EXPENSE, CONTINUED

Expense: Overall pharmacy paid PMPM increased 19.2% between the two reporting periods. This amount was higher compared to the benchmark for the current reporting period. Paid PMPM for generics increased 91.3% and was higher compared to the benchmark. Paid PMPM for preferred brand drugs increased 9.2% and was higher compared to the benchmark. Paid PMPM for non-preferred brand drugs remained stable and was slightly higher compared to the benchmark. Paid PMPM for specialty drugs increased 353.5% and was lower compared to the benchmark.

Utilization: Overall pharmacy scripts per member increased 6.1% between the two reporting periods. This amount was higher compared to the benchmark for the current reporting period. Prescriptions per member for generics increased 18.2% and was higher compared to the benchmark. Prescriptions per member for preferred brand drugs slightly decreased and was higher compared to the benchmark. Prescriptions per member for non-preferred brand drugs decreased 9.1% and was slightly higher compared to the benchmark. Prescriptions per member for specialty brand drugs increased 72.2%.

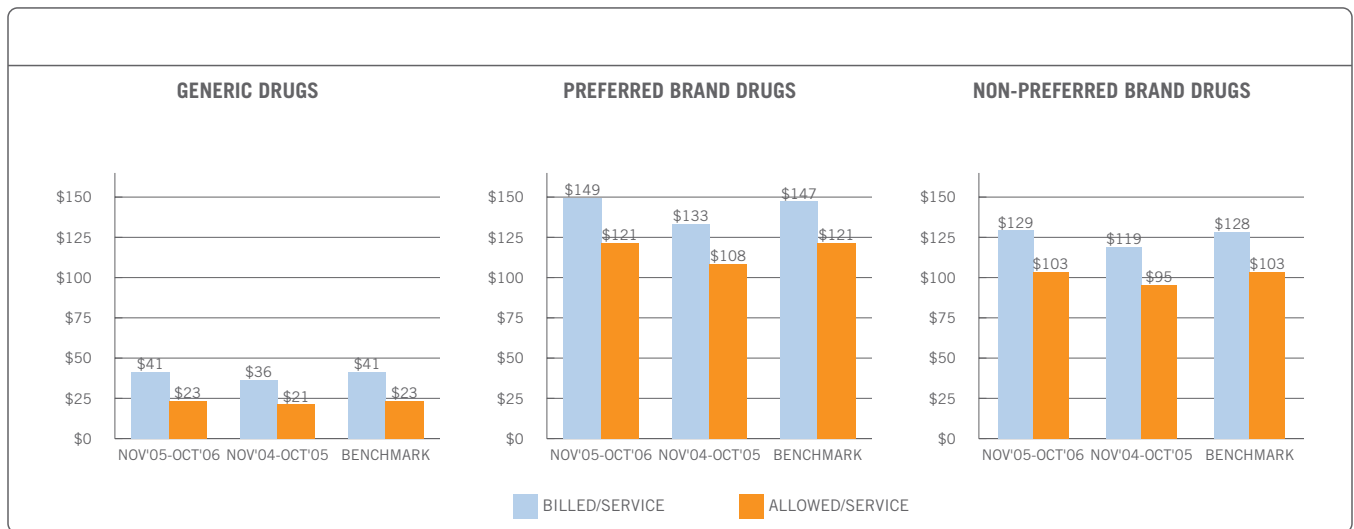
The dispensing rate for generic drugs was 55.8% in the current reporting period, which was an increase compared to the prior reporting period and similar to the benchmark. The dispensing rate for preferred brand drugs was 24.7% in the current reporting period, which was a decrease compared to the prior reporting period and similar to the benchmark. The dispensing rate for non-preferred brand drugs was 17.6% in the current reporting period, which was a decrease compared to the prior reporting period and similar to the benchmark. The dispensing rate for specialty drugs was 0.1% in the current reporting period, which was an increase compared to the prior reporting period.

Price: Overall pharmacy paid per script increased 12.3% between the two reporting periods. This amount was slightly higher compared to the benchmark for the current reporting period. Paid/script for generics increased 61.9% and was slightly higher compared to the benchmark. Paid/script for preferred brand drugs increased 13.6% and was slightly higher compared to the benchmark. Paid/script for non-preferred brand drugs increased 11.2% and was similar compared to the benchmark. Paid/script for specialty drugs increased 163.4%.

AVERAGE CHARGES PER PRESCRIPTION

Report Description: Client B's prescription drug average charges per prescription are displayed below by pharmacy tier (generic, preferred brand, non-preferred brand, specialty and other) and overall experience. Benchmark data has been included for comparison.

		Client B				
		NOV'05-OCT'06	NOV'04-OCT'05	% CHANGE	BENCHMARK	% VARIANCE
GENERIC	BILLED/SERVICE	\$41	\$36	14.0%	\$41	0.2%
	ALLOWED/SERVICE	\$23	\$21	7.9%	\$23	-0.8%
PREFERRED BRAND	BILLED/SERVICE	\$149	\$133	12.0%	\$147	1.1%
	ALLOWED/SERVICE	\$121	\$108	11.4%	\$121	-0.2%
NON-PREFERRED BRAND	BILLED/SERVICE	\$129	\$119	9.0%	\$128	0.7%
	ALLOWED/SERVICE	\$103	\$95	8.4%	\$103	-0.2%
SPECIALTY	BILLED/SERVICE	\$1,638	\$627	161.1%	\$1,697	-3.5%
	ALLOWED/SERVICE	\$1,358	\$523	159.5%	\$1,399	-2.9%
OTHER	BILLED/SERVICE	\$80	\$121	-33.9%	\$78	2.9%
	ALLOWED/SERVICE	\$62	\$96	-35.4%	\$61	1.6%
SUMMARY	BILLED/SERVICE	\$85	\$81	4.7%	\$85	0.5%
	ALLOWED/SERVICE	\$63	\$62	1.7%	\$63	-0.6%



Generic Drugs: The average allowed charge per generic drug prescription increased 7.9% in the current reporting period. The average allowed charge was comparable to the benchmark. Savings (the difference between billed and allowed charges) increased to \$18 per prescription.

Preferred Brand Drugs: The average allowed charge per preferred brand prescription increased 11.4% in the current reporting period. The average allowed charge was comparable to the benchmark. Savings increased to delta_billed_pre per prescription.

Non-Preferred Brand Drugs: The average allowed charge per non-preferred brand prescription increased 8.4% in the current reporting period. The average allowed charge was comparable to the benchmark. Savings increased to \$26 per prescription.

Specialty Drugs: The average allowed charge per specialty prescription increased 159.5% in the current reporting period. Savings increased to \$280 per prescription.

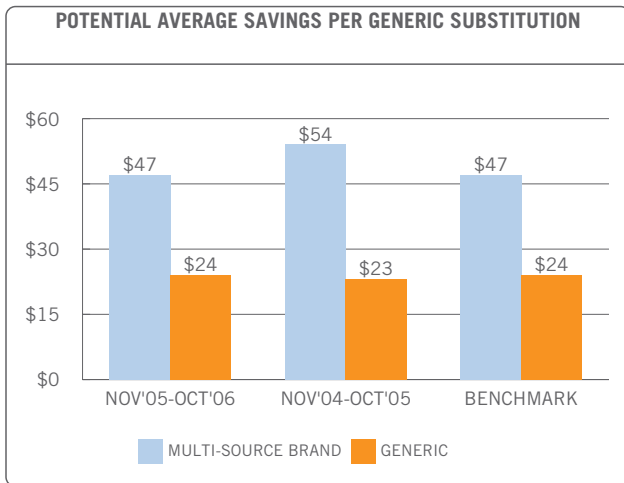
GENERIC PRESCRIPTION DRUG UTILIZATION

Report Description: Potential generic prescriptions per member, generic substitution rate and potential average savings per generic substitution are displayed below for Client B and the benchmark. Potential generic prescriptions are generic drugs and multi-source brand drugs (drugs that are available from more than one manufacturer and have at least one generic equivalent alternative available). The generic substitution rate is calculated as the percentage of potential generic prescriptions that were filled as generic. Potential savings per generic substitution is the difference between the allowed charge for multi-source brand drugs and the allowed charge for generic drugs.

SERVICES/MEMBER	Client B			BENCHMARK	% VARIANCE
	NOV'05-OCT'06	NOV'04-OCT'05	% CHANGE		
GENERIC	6.6	5.5	19.5%	6.2	5.7%
MULTI-SOURCE BRAND	1.5	1.9	-21.9%	1.4	4.9%
SUMMARY	8.0	7.4	9.0%	7.6	5.6%
GENERIC SUBSTITUTION RATE	81.7%	74.5%	9.7%	81.6%	0.1%

Potential generic prescriptions per member increased 9.0% in the current reporting period and was 5.6% above the benchmark.

The generic substitution rate increased 9.7% in the current reporting period and was comparable to the benchmark.



In the most recent reporting period, potential savings totaled \$23 per generic substitution, which was 49.1% of the charges for multi-source branded drugs with generic equivalents.

Converting just 20% of the utilization of multi-source brand drugs to generics in the current reporting period would have yielded an estimated \$66,628 in savings for Client B.

TOP PRESCRIPTION DRUGS BY UTILIZATION, EXPENSE AND PRICE

Report Description: The leading 25 prescription drugs in the current reporting period are displayed below. The first table ranks drugs by the number of prescriptions. The second table ranks drugs by total paid expenses. The third table ranks drugs by average paid per prescription. The last table displays expense, utilization and price percent changes between the two reporting periods for Client B's top 25 highest paid drugs.

TOP 25 PRESCRIPTION DRUGS BY NUMBER OF PRESCRIPTIONS FOR Client B					
DRUG NAME	DRUG TYPE	THERAPEUTIC CLASS	PHARMACY TIER	SERVICES	% SERVICES
HYDROCHLOROTHIAZIDE	MULTI-SOURCE BRAND	CARDIOVASCULAR THERAPY AGENTS	GENERIC	2,491	2.0%
LIPITOR	SINGLE-SOURCE BRAND	CARDIOVASCULAR THERAPY AGENTS	PREFERRED BRAND	2,364	1.9%
ATENOLOL	GENERIC	CARDIOVASCULAR THERAPY AGENTS	GENERIC	1,826	1.4%
NEXIUM	SINGLE-SOURCE BRAND	GASTROINTESTINAL THERAPY AGENTS	PREFERRED BRAND	1,706	1.3%
METFORMIN HCL	GENERIC	ENDOCRINE	GENERIC	1,566	1.2%
FEXOFENADINE HCL	GENERIC	RESPIRATORY THERAPY AGENTS	GENERIC	1,524	1.2%
ZYRTEC	SINGLE-SOURCE BRAND	RESPIRATORY THERAPY AGENTS	NON PREFERRED BRAND	1,513	1.2%
HYDROCODONE W/ACETAMINOPHEN	GENERIC	ANALGESIC, ANTI-INFLAMMATORY OR ANTIPYRETIC	GENERIC	1,482	1.2%
SYNTHROID	MULTI-SOURCE BRAND	ENDOCRINE	PREFERRED BRAND	1,460	1.1%
LISINAPRIL	GENERIC	CARDIOVASCULAR THERAPY AGENTS	GENERIC	1,431	1.1%
ALBUTEROL	GENERIC	RESPIRATORY THERAPY AGENTS	GENERIC	1,261	1.0%
LEXAPRO	SINGLE-SOURCE BRAND	CENTRAL NERVOUS SYSTEM AGENTS	NON PREFERRED BRAND	1,200	0.9%
IBUPROFEN	GENERIC	ANALGESIC, ANTI-INFLAMMATORY OR ANTIPYRETIC	GENERIC	1,170	0.9%
AMOXICILLIN	GENERIC	ANTI-INFECTIVE AGENTS	GENERIC	1,092	0.9%
NORVASC	SINGLE-SOURCE BRAND	CARDIOVASCULAR THERAPY AGENTS	NON PREFERRED BRAND	1,092	0.9%
SINGULAIR	SINGLE-SOURCE BRAND	RESPIRATORY THERAPY AGENTS	NON PREFERRED BRAND	1,077	0.8%
ALPRAZOLAM	GENERIC	CENTRAL NERVOUS SYSTEM AGENTS	GENERIC	1,051	0.8%
TOPROL XL	SINGLE-SOURCE BRAND	CARDIOVASCULAR THERAPY AGENTS	PREFERRED BRAND	1,026	0.8%
PREVACID	SINGLE-SOURCE BRAND	GASTROINTESTINAL THERAPY AGENTS	NON PREFERRED BRAND	951	0.7%
OXYCODONE W/ACETAMINOPHEN	GENERIC	ANALGESIC, ANTI-INFLAMMATORY OR ANTIPYRETIC	GENERIC	938	0.7%
AZITHROMYCIN	GENERIC	ANTI-INFECTIVE AGENTS	GENERIC	931	0.7%
PROTONIX	SINGLE-SOURCE BRAND	GASTROINTESTINAL THERAPY AGENTS	PREFERRED BRAND	887	0.7%
WELLBUTRIN XL	SINGLE-SOURCE BRAND	CENTRAL NERVOUS SYSTEM AGENTS	PREFERRED BRAND	871	0.7%
AMOX TR-POTASSIUM CLAVULANATE	GENERIC	ANTI-INFECTIVE AGENTS	GENERIC	858	0.7%
EFFEXOR XR	SINGLE-SOURCE BRAND	CENTRAL NERVOUS SYSTEM AGENTS	PREFERRED BRAND	850	0.7%
ALL OTHER PRESCRIPTION DRUGS				94,838	74.4%
SUMMARY				127,456	100.0%

TOP 25 PRESCRIPTION DRUGS BY TOTAL PAID AMOUNT FOR Client B					
DRUG NAME	DRUG TYPE	THERAPEUTIC CLASS	PHARMACY TIER	PAID	% PAID
NEXIUM	SINGLE-SOURCE BRAND	GASTROINTESTINAL THERAPY AGENTS	PREFERRED BRAND	\$235,667	3.7%
LIPITOR	SINGLE-SOURCE BRAND	CARDIOVASCULAR THERAPY AGENTS	PREFERRED BRAND	\$186,312	2.9%
TOPAMAX	SINGLE-SOURCE BRAND	CENTRAL NERVOUS SYSTEM AGENTS	PREFERRED BRAND	\$123,383	2.0%
ADVAIR DISKUS	SINGLE-SOURCE BRAND	RESPIRATORY THERAPY AGENTS	PREFERRED BRAND	\$120,036	1.9%
ENBREL	SINGLE-SOURCE BRAND	ANALGESIC, ANTI-INFLAMMATORY OR ANTIPYRETIC	NON PREFERRED BRAND	\$116,133	1.8%
PREVACID	SINGLE-SOURCE BRAND	GASTROINTESTINAL THERAPY AGENTS	NON PREFERRED BRAND	\$109,759	1.7%
EFFEXOR XR	SINGLE-SOURCE BRAND	CENTRAL NERVOUS SYSTEM AGENTS	PREFERRED BRAND	\$107,051	1.7%
WELLBUTRIN XL	SINGLE-SOURCE BRAND	CENTRAL NERVOUS SYSTEM AGENTS	PREFERRED BRAND	\$106,981	1.7%
ZOCOR	MULTI-SOURCE BRAND	CARDIOVASCULAR THERAPY AGENTS	PREFERRED BRAND	\$95,858	1.5%
PROTONIX	SINGLE-SOURCE BRAND	GASTROINTESTINAL THERAPY AGENTS	PREFERRED BRAND	\$93,617	1.5%
LAMICTAL	SINGLE-SOURCE BRAND	CENTRAL NERVOUS SYSTEM AGENTS	PREFERRED BRAND	\$90,048	1.4%
VALTREX	SINGLE-SOURCE BRAND	ANTI-INFECTIVE AGENTS	PREFERRED BRAND	\$88,558	1.4%
FEXOFENADINE HCL	GENERIC	RESPIRATORY THERAPY AGENTS	GENERIC	\$77,699	1.2%
ACTOS	SINGLE-SOURCE BRAND	ENDOCRINE	PREFERRED BRAND	\$71,055	1.1%
SINGULAIR	SINGLE-SOURCE BRAND	RESPIRATORY THERAPY AGENTS	NON PREFERRED BRAND	\$64,177	1.0%
LOVENOX	SINGLE-SOURCE BRAND	HEMATOLOGICAL AGENTS	NON PREFERRED BRAND	\$64,149	1.0%
HUMIRA	SINGLE-SOURCE BRAND	ANALGESIC, ANTI-INFLAMMATORY OR ANTIPYRETIC	SPECIALTY	\$62,480	1.0%
COPAXONE	SINGLE-SOURCE BRAND	MULTIPLE SCLEROSIS AGENTS	PREFERRED BRAND	\$60,073	1.0%
IMITREX	SINGLE-SOURCE BRAND	CENTRAL NERVOUS SYSTEM AGENTS	PREFERRED BRAND	\$59,591	0.9%
ZOLOFT	MULTI-SOURCE BRAND	CENTRAL NERVOUS SYSTEM AGENTS	PREFERRED BRAND	\$56,015	0.9%
SIMVASTATIN	GENERIC	CARDIOVASCULAR THERAPY AGENTS	GENERIC	\$53,192	0.8%
AVANDIA	SINGLE-SOURCE BRAND	ENDOCRINE	PREFERRED BRAND	\$51,855	0.8%
ADDERALL XR	SINGLE-SOURCE BRAND	CENTRAL NERVOUS SYSTEM AGENTS	NON PREFERRED BRAND	\$50,186	0.8%
LEXAPRO	SINGLE-SOURCE BRAND	CENTRAL NERVOUS SYSTEM AGENTS	NON PREFERRED BRAND	\$48,364	0.8%
ACIPHEX	SINGLE-SOURCE BRAND	GASTROINTESTINAL THERAPY AGENTS	NON PREFERRED BRAND	\$44,770	0.7%
ALL OTHER PRESCRIPTION DRUGS				\$4,085,861	64.6%
SUMMARY				\$6,322,870	100.0%

TOP PRESCRIPTION DRUGS BY UTILIZATION, EXPENSE AND PRICE, CONTINUED

TOP 25 PRESCRIPTION DRUGS BY AVERAGE PAID PER PRESCRIPTION FOR Client B				
DRUG NAME	DRUG TYPE	THERAPEUTIC CLASS	PHARMACY TIER	PAID/SERVICE
TERRAMYCIN IM	UNKNOWN	ANTINEOPLASTICS	GENERIC	\$6,326
SUTENT	UNKNOWN	ANTINEOPLASTICS	GENERIC	\$6,326
SUTENT	UNKNOWN	ANTINEOPLASTICS	OTHER	\$4,736
NEXAVAR	SINGLE-SOURCE BRAND	ANTINEOPLASTICS	NON PREFERRED BRAND	\$4,571
GLEEVEC	SINGLE-SOURCE BRAND	ANTINEOPLASTICS	PREFERRED BRAND	\$3,300
TARCEVA	SINGLE-SOURCE BRAND	ANTINEOPLASTICS	NON PREFERRED BRAND	\$2,813
FOLLISTIM AQ	SINGLE-SOURCE BRAND	ENDOCRINE	SPECIALTY	\$2,689
SUTENT	SINGLE-SOURCE BRAND	ANTINEOPLASTICS	GENERIC	\$2,616
REBIF	SINGLE-SOURCE BRAND	MULTIPLE SCLEROSIS AGENTS	SPECIALTY	\$2,202
TERRAMYCIN IM	SINGLE-SOURCE BRAND	ANTINEOPLASTICS	GENERIC	\$2,067
NEUPOGEN	SINGLE-SOURCE BRAND	HEMATOLOGICAL AGENTS	PREFERRED BRAND	\$1,996
ENBREL	SINGLE-SOURCE BRAND	ANALGESIC, ANTI-INFLAMMATORY OR ANTIPYRETIC	OTHER	\$1,972
FUZEON	SINGLE-SOURCE BRAND	ANTI-INFECTIVE AGENTS	NON PREFERRED BRAND	\$1,959
GONAL-F RFF	SINGLE-SOURCE BRAND	ENDOCRINE	SPECIALTY	\$1,749
HUMIRA	SINGLE-SOURCE BRAND	ANALGESIC, ANTI-INFLAMMATORY OR ANTIPYRETIC	OTHER	\$1,674
VALCYTE	SINGLE-SOURCE BRAND	ANTI-INFECTIVE AGENTS	PREFERRED BRAND	\$1,628
LUPRON DEPOT	SINGLE-SOURCE BRAND	ENDOCRINE	OTHER	\$1,508
HUMIRA	SINGLE-SOURCE BRAND	ANALGESIC, ANTI-INFLAMMATORY OR ANTIPYRETIC	SPECIALTY	\$1,488
BETASERON	SINGLE-SOURCE BRAND	MULTIPLE SCLEROSIS AGENTS	PREFERRED BRAND	\$1,458
PEGASYS	SINGLE-SOURCE BRAND	ANTI-INFECTIVE AGENTS	PREFERRED BRAND	\$1,456
COPAXONE	SINGLE-SOURCE BRAND	MULTIPLE SCLEROSIS AGENTS	PREFERRED BRAND	\$1,430
KYTRIL	SINGLE-SOURCE BRAND	GASTROINTESTINAL THERAPY AGENTS	SPECIALTY	\$1,419
ENBREL	SINGLE-SOURCE BRAND	ANALGESIC, ANTI-INFLAMMATORY OR ANTIPYRETIC	NON PREFERRED BRAND	\$1,399
AVONEX ADMINISTRATION PACK	SINGLE-SOURCE BRAND	MULTIPLE SCLEROSIS AGENTS	PREFERRED BRAND	\$1,379
COPEGUS	MULTI-SOURCE BRAND	ANTI-INFECTIVE AGENTS	SPECIALTY	\$1,377
ALL OTHER PRESCRIPTION DRUGS				\$46
SUMMARY				\$50

Utilization: The top three most frequently prescribed drugs were Hydrochlorothiazide, Lipitor and Atenolol. These drugs accounted for 5.2% of all prescriptions in the current reporting period.

Expense: The top three prescription drugs with the highest paid expenses were Nexium, Lipitor and Topamax. These drugs accounted for 8.6% of the total paid amount for all prescriptions in the current reporting period.

Price: The top three most expensive prescribed drugs (paid per prescription) were Terramycin Im, Sutent and Sutent. When compared to the average paid per prescription for all drugs in the current reporting period, Terramycin Im was 128 times more expensive, Sutent and Sutent were 128 and 95 times more expensive, respectively.

TOP PRESCRIPTION DRUGS BY UTILIZATION, EXPENSE AND PRICE, CONTINUED

EXPENSE, UTILIZATION AND PRICE PERCENT CHANGES FOR THE TOP 25 PRESCRIPTION DRUGS BY TOTAL PAID PMPM FOR Client B									
DRUG NAME	PAID PMPM			SERVICES/1000			PAID/SERVICE		
	NOV'05-OCT'06	NOV'04-OCT'05	% CHANGE	NOV'05-OCT'06	NOV'04-OCT'05	% CHANGE	NOV'05-OCT'06	NOV'04-OCT'05	% CHANGE
NEXIUM	\$1.98	\$0.56	250.6%	172.0	49.5	247.3%	\$138	\$137	1.0%
LIPITOR	\$1.57	\$1.46	7.2%	238.4	242.2	-1.6%	\$79	\$72	8.9%
TOPAMAX	\$1.04	\$0.71	46.8%	59.0	45.8	28.7%	\$211	\$185	14.1%
ADVAIR DISKUS	\$1.01	\$0.92	9.5%	80.6	81.5	-1.2%	\$150	\$136	10.8%
ENBREL	\$0.98	\$0.93	5.5%	8.4	7.9	5.4%	\$1,399	\$1,398	0.1%
PREVACID	\$0.92	\$1.00	-7.6%	95.9	109.8	-12.7%	\$115	\$109	5.8%
EFFEXOR XR	\$0.90	\$0.92	-2.7%	85.7	95.0	-9.8%	\$126	\$117	7.9%
WELLBUTRIN XL	\$0.90	\$0.43	111.2%	87.8	52.4	67.5%	\$123	\$97	26.1%
ZOCOR	\$0.81	\$1.22	-34.1%	75.7	127.8	-40.7%	\$128	\$115	11.2%
PROTONIX	\$0.79	\$0.71	10.9%	89.4	88.0	1.6%	\$106	\$97	9.1%
LAMICTAL	\$0.76	\$0.62	23.0%	33.8	29.7	13.6%	\$269	\$248	8.3%
VALTREX	\$0.74	\$0.64	16.0%	57.4	53.1	8.0%	\$156	\$145	7.3%
FEXOFENADINE HCL	\$0.65			153.7			\$51		
ACTOS	\$0.60	\$0.51	16.1%	51.8	47.0	10.4%	\$138	\$131	5.2%
SINGULAIR	\$0.54	\$0.43	24.3%	108.6	96.9	12.0%	\$60	\$54	11.0%
LOVENOX	\$0.54	\$0.39	36.9%	7.7	5.7	34.4%	\$844	\$828	1.9%
HUMIRA	\$0.53	\$0.08	548.5%	4.2	0.8	441.1%	\$1,488	\$1,241	19.8%
COPAXONE	\$0.50	\$0.53	-5.6%	4.2	5.0	-15.8%	\$1,430	\$1,276	12.1%
IMITREX	\$0.50	\$0.36	41.0%	31.5	25.6	22.9%	\$191	\$166	14.7%
ZOLOFT	\$0.47			70.3			\$80		
SIMVASTATIN	\$0.45			47.9			\$112		
AVANDIA	\$0.44	\$0.36	21.4%	43.4	42.4	2.3%	\$121	\$102	18.6%
ADDERALL XR	\$0.42	\$0.30	42.8%	59.0	49.3	19.6%	\$86	\$72	19.4%
LEXAPRO	\$0.41	\$0.37	10.1%	121.0	122.7	-1.4%	\$40	\$36	11.6%
ACIPHEX	\$0.38	\$0.29	31.7%	35.7	31.1	14.8%	\$126	\$110	14.7%

Client B's expense, utilization and price percent changes were measured between the two reporting periods for the top 25 prescription drugs ranked by total paid amount. Prescription drugs new to the market will not show any prior reporting period experience.

TOP THERAPEUTIC DRUG CLASSES BY EXPENSE AND UTILIZATION

Report Description: For the current reporting period, the leading 25 therapeutic drug classes ranked by paid expenses are shown below. The second table displays expense, utilization and price measures for the current reporting period, percent changes between the two reporting periods and percent variance from the benchmark for Client B's leading 25 therapeutic drug classes.

TOP 25 THERAPEUTIC DRUG CLASSES BY TOTAL PAID AMOUNT FOR Client B				
THERAPEUTIC CLASS	PAID	% PAID	SERVICES	% SERVICES
CENTRAL NERVOUS SYSTEM AGENTS	\$1,396,575	22.1%	19,795	15.5%
CARDIOVASCULAR THERAPY AGENTS	\$1,000,548	15.8%	29,516	23.2%
GASTROINTESTINAL THERAPY AGENTS	\$667,205	10.6%	6,151	4.8%
RESPIRATORY THERAPY AGENTS	\$563,592	8.9%	12,826	10.1%
ANTI-INFECTIVE AGENTS	\$553,717	8.8%	12,536	9.8%
ENDOCRINE	\$532,544	8.4%	13,926	10.9%
ANALGESIC, ANTI-INFLAMMATORY OR ANTIPYRETIC	\$448,717	7.1%	9,532	7.5%
CONTRACEPTIVES	\$174,859	2.8%	6,875	5.4%
DERMATOLOGICAL	\$174,384	2.8%	4,047	3.2%
MULTIPLE SCLEROSIS AGENTS	\$169,051	2.7%	109	0.1%
HEMATOLOGICAL AGENTS	\$157,004	2.5%	1,303	1.0%
ANTINEOPLASTICS	\$119,094	1.9%	589	0.5%
IMMUNOSUPPRESSIVE AGENTS	\$67,374	1.1%	186	0.1%
GENITOURINARY THERAPY	\$60,635	1.0%	1,368	1.1%
OPHTHALMIC AGENTS	\$49,606	0.8%	1,741	1.4%
LOCOMOTOR SYSTEM	\$35,810	0.6%	1,302	1.0%
COGNITIVE DISORDER THERAPY	\$27,043	0.4%	232	0.2%
DIAGNOSTIC AGENTS	\$20,500	0.3%	301	0.2%
VAGINAL PRODUCTS	\$18,141	0.3%	537	0.4%
EATING DISORDER THERAPY	\$17,868	0.3%	192	0.2%
ELECTROLYTE BALANCE-NUTRITIONAL PRODUCTS	\$15,634	0.2%	1,640	1.3%
MOUTH-THROAT-DENTAL - PREPARATIONS	\$10,166	0.2%	599	0.5%
IMPOTENCE AGENTS	\$9,845	0.2%	612	0.5%
OTIC	\$8,330	0.1%	342	0.3%
CHEMICAL DEPENDENCY, AGENTS TO TREAT	\$6,302	0.1%	111	0.1%
ALL OTHER THERAPEUTIC CLASSES	\$18,327	0.3%	1,088	0.9%
SUMMARY	\$6,322,870	100.0%	127,456	100.0%

The top three paid therapeutic drug classes for Client B were Central Nervous System Agents, Cardiovascular Therapy Agents and Gastrointestinal Therapy Agents. Together these therapeutic classes accounted for 48.5% of the total paid amount and 43.5% of all prescriptions in the current reporting period.

TOP THERAPEUTIC DRUG CLASSES BY EXPENSE AND UTILIZATION, CONTINUED

EXPENSE, UTILIZATION AND PRICE PERCENT CHANGES FOR TOP 25 THERAPEUTIC DRUG CLASSES BY TOTAL PAID PMPM FOR Client B									
THERAPEUTIC CLASS	PAID PMPM			SERVICES/1000			PAID/SERVICE		
	NOV05-OCT06	% CHANGE	% VARIANCE	NOV05-OCT06	% CHANGE	% VARIANCE	NOV05-OCT06	% CHANGE	% VARIANCE
CENTRAL NERVOUS SYSTEM AGENTS	\$11.74	18.4%	9.6%	1,996.2	5.0%	3.8%	\$71	12.7%	5.6%
CARDIOVASCULAR THERAPY AGENTS	\$8.41	26.0%	5.1%	2,976.5	4.2%	7.2%	\$34	20.9%	-1.9%
GASTROINTESTINAL THERAPY AGENTS	\$5.61	18.0%	20.1%	620.3	6.2%	12.2%	\$108	11.1%	7.1%
RESPIRATORY THERAPY AGENTS	\$4.74	30.6%	3.8%	1,293.4	11.5%	4.8%	\$44	17.2%	-1.0%
ANTI-INFECTIVE AGENTS	\$4.65	22.8%	3.4%	1,264.2	8.5%	1.2%	\$44	13.2%	2.2%
ENDOCRINE	\$4.48	11.3%	2.1%	1,404.3	2.3%	7.3%	\$38	8.9%	-4.8%
ANALGESIC, ANTI-INFLAMMATORY OR ANTIPYRETIC	\$3.77	6.8%	8.7%	961.2	12.0%	6.6%	\$47	-4.7%	2.0%
CONTRACEPTIVES	\$1.47	27.1%	-0.9%	693.3	-3.0%	1.2%	\$25	31.0%	-2.1%
DERMATOLOGICAL	\$1.47	15.6%	9.5%	408.1	7.1%	10.8%	\$43	7.9%	-1.1%
MULTIPLE SCLEROSIS AGENTS	\$1.42	-14.1%	9.0%	11.0	-24.4%	19.3%	\$1,551	13.6%	-8.6%
HEMATOLOGICAL AGENTS	\$1.32	21.6%	8.0%	131.4	2.6%	9.1%	\$120	18.5%	-1.0%
ANTINEOPLASTICS	\$1.00	18.5%	34.1%	59.4	7.1%	18.7%	\$202	10.6%	13.0%
IMMUNOSUPPRESSIVE AGENTS	\$0.57	-0.2%	25.3%	18.8	15.7%	7.5%	\$362	-13.8%	16.5%
GENITOURINARY THERAPY	\$0.51	21.8%	9.9%	138.0	4.6%	12.4%	\$44	16.5%	-2.2%
OPHTHALMIC AGENTS	\$0.42	14.3%	6.1%	175.6	0.8%	10.0%	\$28	13.4%	-3.5%
LOCOMOTOR SYSTEM	\$0.30	48.6%	14.5%	131.3	14.1%	7.0%	\$28	30.2%	7.0%
COGNITIVE DISORDER THERAPY	\$0.23	29.5%	25.8%	23.4	18.9%	17.8%	\$117	8.9%	6.8%
DIAGNOSTIC AGENTS	\$0.17	70.2%	31.2%	30.4	50.0%	19.1%	\$68	13.5%	10.2%
VAGINAL PRODUCTS	\$0.15	49.6%	12.3%	54.2	9.1%	11.4%	\$34	37.2%	0.9%
EATING DISORDER THERAPY	\$0.15	2638.0%	56.9%	19.4	5671.7%	58.1%	\$93	-52.6%	-0.8%
ELECTROLYTE BALANCE-NUTRITIONAL PRODUCTS	\$0.13	127.3%	1.4%	165.4	8.7%	3.6%	\$10	109.2%	-2.2%
MOUTH-THROAT-DENTAL - PREPARATIONS	\$0.09	98.1%	12.5%	60.4	16.4%	8.5%	\$17	70.2%	3.7%
IMPOTENCE AGENTS	\$0.08	10.6%	-13.8%	61.7	2.0%	-2.3%	\$16	8.4%	-11.8%
OTIC	\$0.07	42.4%	1.1%	34.5	17.3%	0.1%	\$24	21.4%	1.0%
CHEMICAL DEPENDENCY, AGENTS TO TREAT	\$0.05	67.9%	21.3%	11.2	72.6%	28.3%	\$57	-2.7%	-5.4%

For the highest paid therapeutic class, Central Nervous System Agents, paid PMPM expense increased 18.4%, prescriptions/1,000 increased 5.0% and paid per prescription increased 12.7%. Compared to the benchmark, this therapeutic drug class had higher paid PMPM expenses, slightly higher prescriptions/1,000 and higher paid per prescription expenses.

For the second highest paid therapeutic class, Cardiovascular Therapy Agents, paid PMPM expense increased 26.0%, prescriptions/1,000 increased 4.2% and paid per prescription increased 20.9%. Compared to the benchmark, this therapeutic drug class had higher paid PMPM expenses, higher prescriptions/1,000 and similar paid per prescription expenses.

For the third highest paid therapeutic class, Gastrointestinal Therapy Agents, paid PMPM expense increased 18.0%, prescriptions/1,000 increased 6.2% and paid per prescription increased 11.1%. Compared to the benchmark, this therapeutic drug class had higher paid PMPM expenses, higher prescriptions/1,000 and higher paid per prescription expenses.

TOP THERAPEUTIC GROUPS FOR BENCHMARK

TOP 50 THERAPEUTIC GROUPS RANKED BY NUMBER OF PRESCRIPTIONS FOR CURRENT REPORTING PERIOD					
RANK	THERAPEUTIC GROUP	THERAPEUTIC CLASS	PHARMACY TIER	SERVICES/1000	PAID/SERVICE
1	ANTIHYPERTENSIVE - HMG COA REDUCTASE INHIBITORS	CARDIOVASCULAR THERAPY AGENTS	PREFERRED BRAND	315.0	\$87
2	ACE INHIBITORS	CARDIOVASCULAR THERAPY AGENTS	GENERIC	284.3	\$13
3	DIURETIC - THIAZIDES AND RELATED	CARDIOVASCULAR THERAPY AGENTS	GENERIC	269.5	\$8
4	ANTIDEPRESSANT - SELECTIVE SEROTONIN REUPTAKE INHIBITORS (SSRIS)	CENTRAL NERVOUS SYSTEM AGENTS	GENERIC	241.2	\$26
5	ANALGESIC NARCOTIC HYDROCODONE COMBINATIONS	ANALGESIC, ANTI-INFLAMMATORY OR ANTIPIRETYC	GENERIC	239.6	\$9
6	CONTRACEPTIVE ORAL - MONOPHASIC	CONTRACEPTIVES	GENERIC	236.6	\$27
7	AMINOPENICILLINS	ANTI-INFECTIVE AGENTS	GENERIC	231.1	\$8
8	ANTIANKXIETY AGENT - BENZODIAZEPINES	CENTRAL NERVOUS SYSTEM AGENTS	GENERIC	216.3	\$8
9	PEPTIC ULCER - PROTON PUMP INHIBITORS	GASTROINTESTINAL THERAPY AGENTS	PREFERRED BRAND	214.0	\$124
10	BETA BLOCKERS CARDIAC SELECTIVE	CARDIOVASCULAR THERAPY AGENTS	GENERIC	201.8	\$8
11	ORAL ANTIDIABETIC - BIGUANIDES	ENDOCRINE	GENERIC	192.9	\$12
12	COX NON-SPECIFIC INHIBITORS - PROPIONIC ACID DERIVATIVES	ANALGESIC, ANTI-INFLAMMATORY OR ANTIPIRETYC	GENERIC	157.7	\$9
13	CONTRACEPTIVE ORAL - TRIPHASIC	CONTRACEPTIVES	GENERIC	153.3	\$26
14	ANTIHISTAMINES - 2ND GENERATION - PIPERAZINES	RESPIRATORY THERAPY AGENTS	NON PREFERRED BRAND	149.2	\$29
15	THYROID HORMONES	ENDOCRINE	GENERIC	146.8	\$9
16	ASTHMA THERAPY - BETA ADRENERGIC AGENTS	RESPIRATORY THERAPY AGENTS	GENERIC	141.3	\$10
17	GLUCOCORTICIDS	ENDOCRINE	GENERIC	139.2	\$8
18	THYROID HORMONES	ENDOCRINE	PREFERRED BRAND	138.4	\$3
19	ANTIDEPRESSANT - SELECTIVE SEROTONIN REUPTAKE INHIBITORS (SSRIS)	CENTRAL NERVOUS SYSTEM AGENTS	NON PREFERRED BRAND	133.1	\$47
20	BETA BLOCKERS CARDIAC SELECTIVE	CARDIOVASCULAR THERAPY AGENTS	PREFERRED BRAND	128.1	\$17
21	ANTIHISTAMINES - 2ND GENERATION - PIPERIDINES	RESPIRATORY THERAPY AGENTS	GENERIC	126.6	\$53
22	PEPTIC ULCER - PROTON PUMP INHIBITORS	GASTROINTESTINAL THERAPY AGENTS	NON PREFERRED BRAND	123.3	\$119
23	DERMATOLOGICAL - GLUCOCORTICOID	DERMATOLOGICAL	GENERIC	119.3	\$20
24	ATTENTION DEFICIT-HYPERACTIVITY (ADHD) THERAPY, STIMULANT-TYPE	CENTRAL NERVOUS SYSTEM AGENTS	NON PREFERRED BRAND	117.7	\$77
25	ANTIDEPRESSANT - SELECTIVE SEROTONIN REUPTAKE INHIBITORS (SSRIS)	CENTRAL NERVOUS SYSTEM AGENTS	PREFERRED BRAND	116.6	\$77
26	MACROLIDES	ANTI-INFECTIVE AGENTS	GENERIC	116.1	\$28
27	DIURETIC - POTASSIUM SPARING-THIAZIDE & RELATED COMBINATIONS	CARDIOVASCULAR THERAPY AGENTS	GENERIC	114.9	\$8
28	ASTHMA THERAPY - LEUKOTRIENE RECEPTOR ANTAGONISTS	RESPIRATORY THERAPY AGENTS	NON PREFERRED BRAND	112.0	\$60
29	ANTIHYPERTENSIVE - HMG COA REDUCTASE INHIBITORS	CARDIOVASCULAR THERAPY AGENTS	GENERIC	109.0	\$68
30	CALCIUM CHANNEL BLOCKERS - DIHYDROPYRIDINES	CARDIOVASCULAR THERAPY AGENTS	NON PREFERRED BRAND	107.9	\$28
31	SEDATIVE-HYPNOTIC - GABA-RECEPTOR MODULATORS	CENTRAL NERVOUS SYSTEM AGENTS	NON PREFERRED BRAND	105.2	\$30
32	CONTRACEPTIVE ORAL - MONOPHASIC	CONTRACEPTIVES	PREFERRED BRAND	102.1	\$31
33	SKELETAL MUSCLE RELAXANT - CENTRAL MUSCLE RELAXANTS	LOCOMOTOR SYSTEM	GENERIC	101.5	\$13
34	ACE INHIBITORS-DIURETIC COMBINATIONS	CARDIOVASCULAR THERAPY AGENTS	GENERIC	101.5	\$12
35	ORAL ANTIDIABETIC - SULFONYLUREA DERIVATIVES	ENDOCRINE	GENERIC	98.3	\$15
36	ANALGESIC NARCOTIC AGONISTS	ANALGESIC, ANTI-INFLAMMATORY OR ANTIPIRETYC	GENERIC	95.5	\$79
37	ANALGESIC NARCOTIC OXYCODONE COMBINATIONS	ANALGESIC, ANTI-INFLAMMATORY OR ANTIPIRETYC	GENERIC	93.7	\$21
38	ANGIOTENSIN II RECEPTOR BLOCKERS (ARBs)	CARDIOVASCULAR THERAPY AGENTS	PREFERRED BRAND	93.2	\$44
39	NASAL CORTICOSTEROIDS	RESPIRATORY THERAPY AGENTS	PREFERRED BRAND	88.2	\$52
40	INSULIN - HUMAN	ENDOCRINE	PREFERRED BRAND	88.2	\$106
41	ANGIOTENSIN II RECEPTOR BLOCKER-DIURETIC COMBINATION	CARDIOVASCULAR THERAPY AGENTS	PREFERRED BRAND	88.0	\$48
42	AMINOPENICILLIN - BETA-LACTAMASE INHIBITOR COMBINATIONS	ANTI-INFECTIVE AGENTS	GENERIC	86.7	\$38
43	ANTIDEPRESSANT - SEROTONIN-NOREPINEPHRINE REUPTAKE INHIBITORS (SNRIS)	CENTRAL NERVOUS SYSTEM AGENTS	PREFERRED BRAND	83.4	\$124
44	ANTIDEPRESSANT - NOREPINEPHRINE & DOPAMINE REUPTAKE INHIBITORS (NDRIS)	CENTRAL NERVOUS SYSTEM AGENTS	PREFERRED BRAND	81.5	\$118
45	ESTROGENS	ENDOCRINE	PREFERRED BRAND	81.3	\$23
46	THIAZOLIDINEDIONES (PPAR-GAMMA AGONISTS)	ENDOCRINE	PREFERRED BRAND	80.7	\$129
47	DIURETIC - LOOP	CARDIOVASCULAR THERAPY AGENTS	GENERIC	79.3	\$8
48	ASTHMA THERAPY - BETA ADRENERGIC-GLUCOCORTICOID COMBINATIONS	RESPIRATORY THERAPY AGENTS	PREFERRED BRAND	75.2	\$148
49	ANTIFUNGAL - TRIAZOLES	ANTI-INFECTIVE AGENTS	GENERIC	74.5	\$14
50	CEPHALOSPORIN - 1ST GENERATION	ANTI-INFECTIVE AGENTS	GENERIC	74.2	\$10

CHAPTER DESCRIPTION

Because high cost claimants (HCC) can be a significant driver in Client B's overall percent changes, analyzing the impact and characteristics of this population is important. Depending on the threshold that is used to define high cost claimants, 0.5% of the claimants can account for 20% of the overall expenses for all health care services. This analysis also shows the types of conditions that are prevalent for the high cost claimants. Some of these conditions may be amenable to case management opportunities.

The first report shows the proportion of high cost claimants to the total claimants and the proportion of paid expenses associated with high cost claimants relative to total paid expenses.

The next report shows the percent changes in paid expenses for high cost claimants by service category. It also shows what proportion of expenses for high cost claimants are for inpatient, outpatient, professional and pharmacy services.

The final report provides a distribution of high cost claimants by condition. This report identifies those conditions that are most prevalent among the high cost claimants during the current reporting period.

Data Note

Reporting is based on incurred, 12-month rolling periods with 2 months run-out.

Current reporting period represents claims incurred Nov'05 through Oct'06 and paid through Dec'06.

Prior reporting period represents claims incurred Nov'04 through Oct'05 and paid through Dec'05.

Claims for active, retiree under 65, retiree 65 and over and COBRA members are reported.

SUMMARY OF FINDINGS

Expenses for high cost claimants increased 38.1% from \$30.84 PMPM to \$42.58 PMPM in the current reporting period. The number of high cost claimants increased 39.7% from 58 to 81 and the paid expense per claimant increased 9.5% from \$57,755 to \$63,262.

During the current reporting period, high cost claimants represented 0.7% of total claimants and accounted for 20.7% of total paid expenses. The average paid expense per claimant was \$2,071 while the average paid expense per high cost claimant was \$63,262.

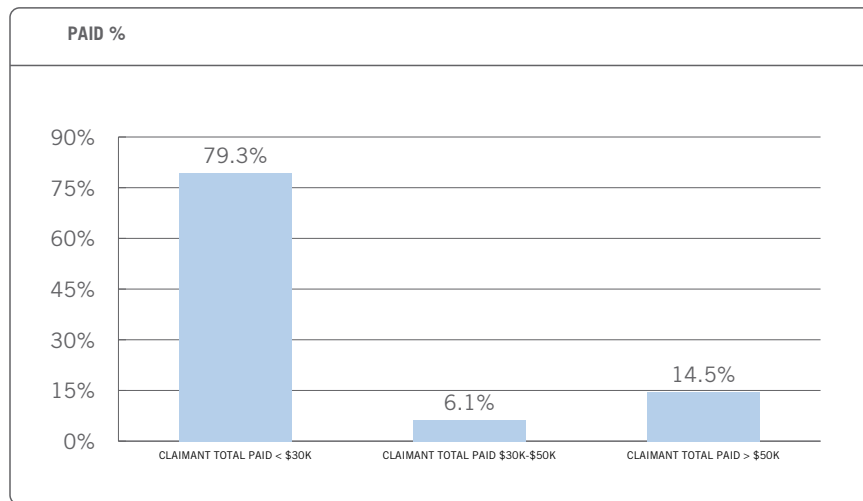
For high cost claimants' paid expenses, inpatient facility accounted for 37.4% of total HCC paid expenses, outpatient facility accounted for 28.9%, professional accounted for 25.4% and pharmacy accounted for 8.1%.

Out of the \$5,124,262 in paid expenses for high cost claimants, Neoplasms accounted for 27.6%, Circulatory accounted for 17.3% and Digestive accounted for 10.3%.

HIGH COST CLAIMANTS OVERVIEW

Report Description: Two thresholds, \$30,000 and \$50,000, are used to group Client B claimants into three distinct categories as shown in the table. High cost claimants are identified as spending \$30,000 or more in the current reporting period. For the current reporting period, the proportion of claimants, the percentage of total paid, the paid per claimant amount and paid PMPM are displayed below for each claimant category.

Client B						
	CLAIMANTS	CLAIMANTS %	PAID	PAID %	PAID/CLAIMANT	PAID PMPM
CLAIMANT TOTAL PAID < \$30K	11,893	99.3%	\$19,669,368	79.3%	\$1,654	\$163.43
CLAIMANT TOTAL PAID \$30K-\$50K	40	0.3%	\$1,519,819	6.1%	\$37,995	\$12.63
CLAIMANT TOTAL PAID > \$50K	41	0.3%	\$3,604,443	14.5%	\$87,913	\$29.95
SUMMARY	11,974	100.0%	\$24,793,630	100.0%	\$2,071	\$206.00



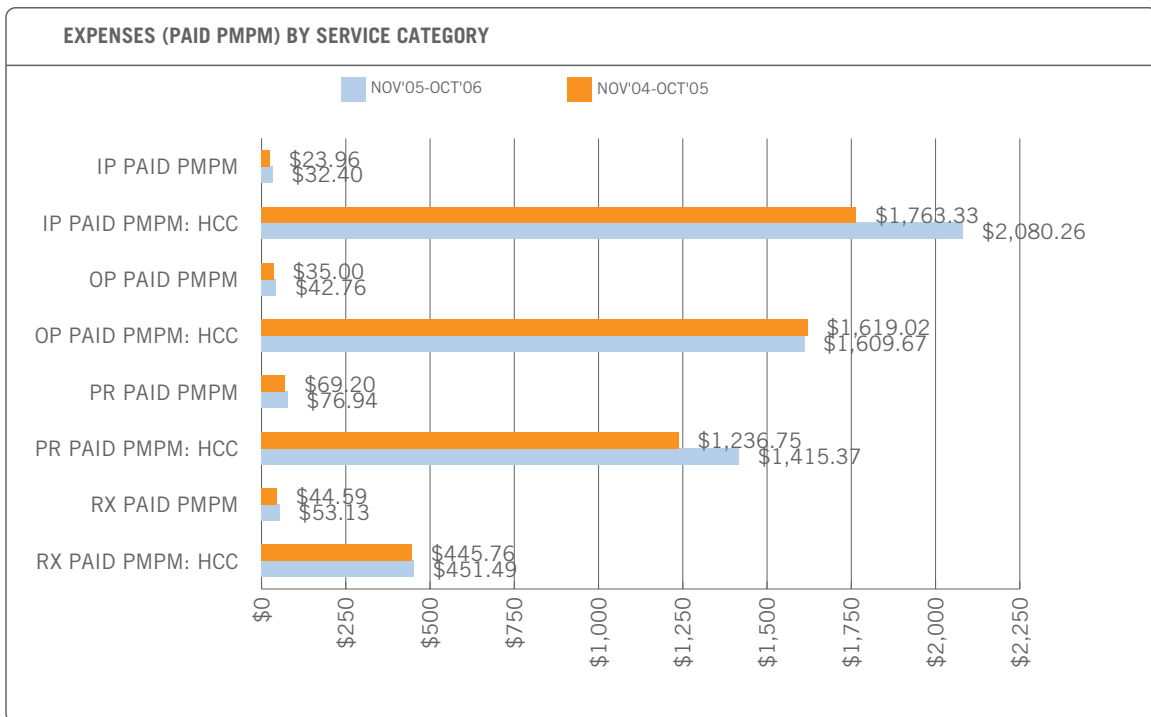
Prevalence: There were 81 high cost claimants (0.7% of all claimants) each with paid expenses of \$30,000 or more during the current reporting period.

Expense: This small percentage of high cost claimants consumed 20.7% of all paid expenses.

EXPENSES BY SERVICE CATEGORY

Report Description: Paid PMPM measures are compared by service category (inpatient facility, outpatient facility, professional and pharmacy) and over the two reporting periods for the two groups of claimants. The group HCC represents high cost claimants with paid expenses of \$30,000 or more.

Client B			
	NOV'05-OCT'06	NOV'04-OCT'05	% CHANGE
IP PAID PMPM	\$32.40	\$23.96	35.2%
IP PAID PMPM: HCC	\$2,080.26	\$1,763.33	18.0%
OP PAID PMPM	\$42.76	\$35.00	22.2%
OP PAID PMPM: HCC	\$1,609.67	\$1,619.02	-0.6%
PR PAID PMPM	\$76.94	\$69.20	11.2%
PR PAID PMPM: HCC	\$1,415.37	\$1,236.75	14.4%
RX PAID PMPM	\$53.13	\$44.59	19.2%
RX PAID PMPM: HCC	\$451.49	\$445.76	1.3%



Inpatient: The overall paid PMPM for inpatient facility admissions increased 35.2% between the two reporting periods. High cost claimants increased 18.0% in paid PMPM.

Outpatient: Paid PMPM for overall outpatient facility visits increased 22.2%. The high cost claimant changes in paid PMPM remained stable.

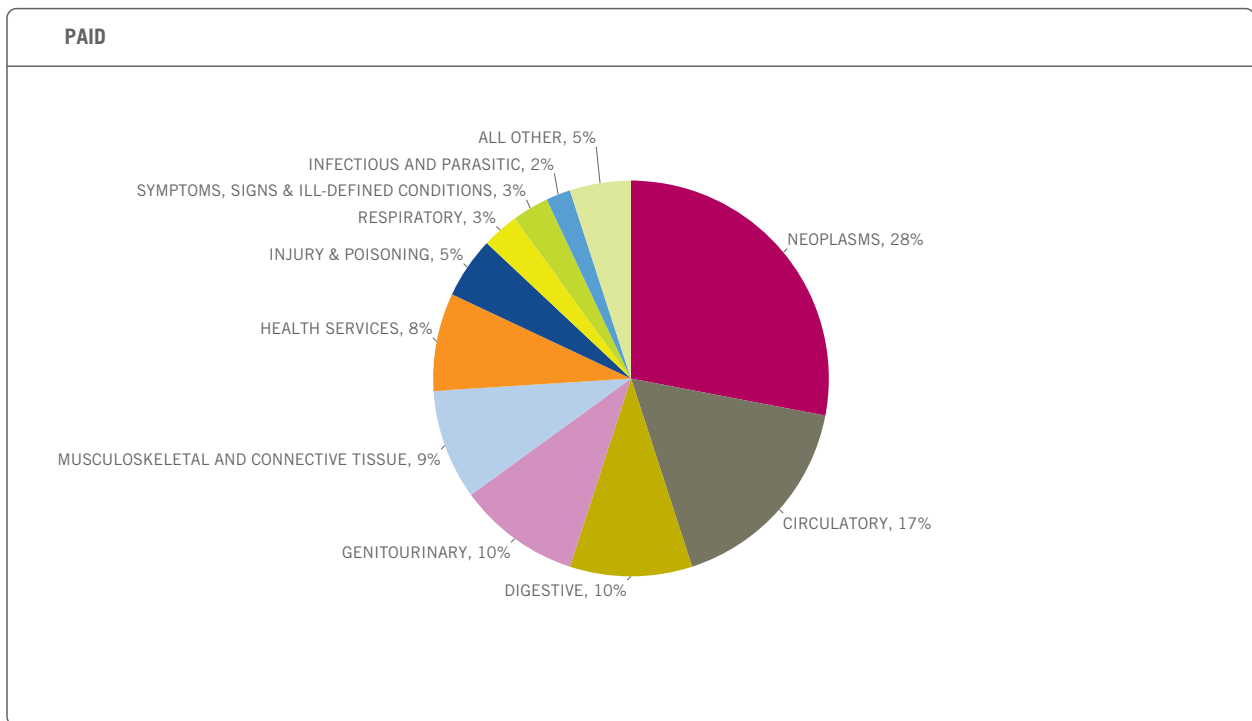
Professional: For professional services, Client B experienced an overall paid PMPM change of 11.2% as compared to the high cost claimant paid PMPM change of 14.4%.

Pharmacy: Overall, pharmacy prescription changes in paid PMPM increased 19.2%. For high cost claimants, paid PMPM remained stable.

TOP LEADING DIAGNOSTIC CATEGORIES

Report Description: The top ten leading ICD-9 diagnostic categories for each claimant with paid expenses of \$30,000 or more is shown below for the current reporting period. For each category, the corresponding average age band and various expense measures have been summarized.

Client B								
	CLAIMANTS	AVG AGE BAND	ALLOWED	ALLOWED/CLAIMANT	PAID	PAID/CLAIMANT	PAID PMPM	
NEOPLASMS	21	45-49	\$1,494,159	\$71,150	\$1,415,329	\$67,397	\$11.76	
CIRCULATORY	12	50-54	\$934,076	\$77,840	\$884,908	\$73,742	\$7.35	
DIGESTIVE	9	45-49	\$560,930	\$62,326	\$527,521	\$58,613	\$4.38	
GENITOURINARY	6	40-44	\$640,186	\$106,698	\$508,678	\$84,780	\$4.23	
MUSCULOSKELETAL AND CONNECTIVE TISSUE	9	50-54	\$472,738	\$52,526	\$442,413	\$49,157	\$3.68	
HEALTH SERVICES	8	50-54	\$460,873	\$57,609	\$410,395	\$51,299	\$3.41	
INJURY & POISONING	4	30-34	\$283,522	\$70,881	\$271,239	\$67,810	\$2.25	
RESPIRATORY	4	45-49	\$159,393	\$39,848	\$143,801	\$35,950	\$1.19	
SYMPTOMS, SIGNS & ILL-DEFINED CONDITIONS	2	45-49	\$151,442	\$75,721	\$140,167	\$70,084	\$1.16	
INFECTIOUS AND PARASITIC	1	35-39	\$141,594	\$141,594	\$120,396	\$120,396	\$1.00	
ALL OTHER	N/A	N/A	\$279,950	N/A	\$259,415	N/A	\$2.16	
SUMMARY	81	45-49	\$5,578,862	\$68,875	\$5,124,262	\$63,262	\$42.58	



Neoplasms 27.6% and Circulatory 17.3% were the top two paid diagnosis categories for all high cost claimants during the current reporting period. Together these categories comprised 40.7% of all high cost claimants.

Digestive, Genitourinary and Musculoskeletal And Connective Tissue were the next diagnoses totaling another 28.9% of all HCC paid expenses and 29.6% of all high cost claimants.

ASTHMA

Program Overview

All members who are invited into the program (referred to as "Basic Participation") receive a "Take Charge of Your Asthma" guide, a quarterly newsletter, and can order a FREE Peak Flow Meter and/or FREE Spacer. Members who decide to fully participate in the program (referred to as "Full Participation") receive "The Asthma Sourcebook", a comprehensive asthma reference book, and a personal asthma organizer. Children fully participating in the program also receive an age-appropriate book about asthma. Upon request, members receive individualized education and support from a registered nurse. For more information about this program, call 1-800-218-5295 or visit bcbsnc.com.

AVERAGE MEMBERSHIP FOR THE MOST RECENT PERIOD				Client B	
PROGRAM PARTICIPATION	BCBSNC NORM	ACTIVITY OVER THE LIFE OF THE PROGRAM		ACTIVITY FROM THROUGH	
BASIC PARTICIPATION (% OF TOTAL CURRENT MEMBERSHIP INVITED TO PARTICIPATE)					
FULL PARTICIPATION (% OF INVITED)					
OTHERS FULLY PARTICIPATING (NOT INVITED DURING THE PERIOD)					
TOTAL FULLY PARTICIPATING					
PARTICIPANTS REFERRED TO BCBSNC CASE MANAGEMENT OR HEALTH LINE BLUE CASE MANAGEMENT (% OF TOTAL FULLY PARTICIPATING)					

Members must complete a brief health survey to receive full participation benefits.

Members who indicate on their enrollment survey that they wish to work with a nurse are referred to a BCBSNC Case Manager or a nurse at Health Line Blue. Members are also referred to Case Management if they have a hospital admission authorization for asthma.

Member Health Partnerships is a Service Mark of Blue Cross Blue Shield of North Carolina

Health Line Blue is a Service Mark of the Blue Cross and Blue Shield Association

DIABETES

Program Overview

All members who are invited into the program (referred to as "Basic Participation") receive a "Take Charge of Your Diabetes" guide, a quarterly newsletter, a blood sugar testing brochure, and can order a FREE blood glucose meter. Members who decide to fully participate in the program (referred to as "Full Participation") receive "Diabetes A-Z"; "Diabetes Meal Planning Made Easy"; a quarterly newsletter about diabetes and related conditions; reimbursement for their annual dilated retinal exam copay (up to \$30); and a 24-month diabetes wall calendar. Upon request, members receive individualized education and support from a registered nurse. Blue Care, Blue Choice, Blue Options, and Blue Advantage members have the deductible waived for diabetes supplies once they enroll in the MHP-Diabetes program. For more information about this program, call 1-800-218-5295 or visit bcbsnc.com.

AVERAGE MEMBERSHIP FOR THE MOST RECENT PERIOD		Client B			
PROGRAM PARTICIPATION	BCBSNC NORM	ACTIVITY OVER THE LIFE OF THE PROGRAM		ACTIVITY FROM THROUGH	
BASIC PARTICIPATION (% OF TOTAL CURRENT MEMBERSHIP INVITED TO PARTICIPATE)					
FULL PARTICIPATION (% OF INVITED)					
OTHERS FULLY PARTICIPATING (NOT INVITED DURING THE PERIOD)					
TOTAL FULLY PARTICIPATING					
PARTICIPANTS REFERRED TO BCBSNC CASE MANAGEMENT OR HEALTH LINE BLUE CASE MANAGEMENT (% OF TOTAL FULLY PARTICIPATING)					

Members must complete a brief health survey to receive full participation benefits.

Members who indicate on their enrollment survey that they wish to work with a nurse are referred to a BCBSNC Case Manager or a nurse at Health Line Blue. Members are also referred to Case Management if they have a hospital admission authorization for diabetes.

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PREGNANCY

Program Overview

All members who are invited into the program (referred to as "Basic Participation") receive information about Group B strep and the signs and symptoms of preterm labor. Members who enroll in the program (referred to as "Full Participation") receive a choice of two books on topics such as normal pregnancy, multiple births, diabetes and pregnancy, having a second child, single motherhood, breast feeding, and newborn and child care. Additional customized materials based upon the stage of their pregnancy, post-delivery information and resources including information on post-partum depression, a child health record, and contact information for Health Line Blue are also included. Upon request, members receive individualized education and support from a registered nurse. Members are also eligible for a 30 percent discount on selected breast pumps and accessories. For more information about this program, call 1-800-218-5295 or visit the pregnancy website at bcbsnc.com.

AVERAGE MEMBERSHIP FOR THE MOST RECENT PERIOD		Client B			
PROGRAM PARTICIPATION	BCBSNC NORM	ACTIVITY OVER THE LIFE OF THE PROGRAM		ACTIVITY FROM THROUGH	
BASIC PARTICIPATION (% OF TOTAL CURRENT MEMBERSHIP INVITED TO PARTICIPATE)					
FULL PARTICIPATION (% OF INVITED)					
OTHERS FULLY PARTICIPATING (NOT INVITED DURING THE PERIOD)					
TOTAL FULLY PARTICIPATING					
PARTICIPANTS REFERRED TO BCBSNC CASE MANAGEMENT OR HEALTH LINE BLUE CASE MANAGEMENT (% OF TOTAL FULLY PARTICIPATING)					

Members must complete a brief health survey to receive full participation benefits.

Members who indicate on their enrollment survey that they wish to work with a nurse are referred to a BCBSNC Case Manager or a nurse at Health Line Blue. Members are also referred to Case Management if they have a hospital admission authorization for preterm labor.

Member Health Partnerships is a Service Mark of Blue Cross Blue Shield of North Carolina

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FIBROMYALGIA AND MIGRAINE

Program Overview

This program is offered to members who suffer from migraine headaches or fibromyalgia. Members who are invited into the program (referred to as "Basic Participation") receive educational materials and tools to help them take charge of their health. Members who enroll in the program (referred to as "Full Participation") receive a comprehensive condition-specific book ("50 Ways to Control Migraines" or "New Hope for People with Fibromyalgia"), the Member Health Partnerships organizer for tracking medical history, family history, medications and other treatments; and customized condition-specific educational materials addressing 16 different conditions (e.g. chronic sinusitis, osteoporosis, back pain, depression), health risks (e.g. high cholesterol, high blood pressure) and/or lifestyle changes (e.g. stress management, smoking cessation).

Upon request, members receive individualized education and support from a registered nurse. For more information about this program, call 1-800-218-5295 or visit bcbsnc.com.

AVERAGE MEMBERSHIP FOR THE MOST RECENT PERIOD					
PROGRAM PARTICIPATION	BCBSNC NORM	Client B			
		ACTIVITY OVER THE LIFE OF THE PROGRAM		ACTIVITY FROM THROUGH	
BASIC PARTICIPATION (% OF TOTAL CURRENT MEMBERSHIP INVITED TO PARTICIPATE)					
FULL PARTICIPATION (% OF INVITED)					
OTHERS FULLY PARTICIPATING (NOT INVITED DURING THE PERIOD)					
TOTAL FULLY PARTICIPATING					
PARTICIPANTS REFERRED TO BCBSNC CASE MANAGEMENT OR HEALTH LINE BLUE CASE MANAGEMENT (% OF TOTAL FULLY PARTICIPATING)					

Members must complete a brief health survey to receive full participation benefits.

Members who indicate on their enrollment survey that they wish to work with a nurse are referred to a BCBSNC Case Manager or a nurse at Health Line Blue.

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HEART DISEASE: CONGESTIVE HEART FAILURE PROGRAM

Program Overview

The Member Health Partnerships - Heart Disease program is a comprehensive heart disease education program designed to provide members with educational tools, resources, and financial incentives that will help them improve their control of their cardiac condition and live happier, more productive lives. The program has two components: a congestive heart failure component and a post-cardiac event component.

The Congestive Heart Failure program is offered to members with congestive heart failure. All members who are identified for the program (referred to as "Basic Participation") receive comprehensive self-management tools (a Signs and Symptoms Magnet, Weight & Symptom Log, Medication Record, and a Daily Sodium/Fluid Intake Log) and educational materials ("Learning to Live with Heart Failure" self-care handbook, "Little Book of Heart Wisdom: Taking Medications", a brochure that includes tips on how to limit dietary sodium, and a quarterly newsletter about heart failure and related conditions). Members are also eligible for a 30% discount on selected blood pressure monitors, heart rate monitors, and scales. Members who complete a health risk assessment survey (referred to as "Full Participation") receive a book of their choice ("Success with Heart Failure: Help and Hope for Those with Congestive Heart Failure" or "Congestive Heart Failure: What You Should Know"); and a pillbox to help organize medications. Upon request, members receive individualized education and support from a registered nurse.

Members who work with a BCBSNC Case Manager are managed using the Telescale, an interactive home-monitoring device that allows members to send daily weight and symptom information to their Case Manager via a telephone line. The Case Manager contacts patients who are experiencing worsening symptoms or weight gain, and works with the member or the member's physician to facilitate appropriate adjustments to the member's treatment or self-care regimen. For more information about this program, call 1-800-218-5295 or visit bcbsnc.com.

AVERAGE MEMBERSHIP FOR THE MOST RECENT PERIOD		Client B			
PROGRAM PARTICIPATION	BCBSNC NORM	ACTIVITY OVER THE LIFE OF THE PROGRAM		ACTIVITY FROM THROUGH	
BASIC PARTICIPATION (% OF TOTAL CURRENT MEMBERSHIP INVITED TO PARTICIPATE)					
FULL PARTICIPATION (% OF INVITED)					
OTHERS FULLY PARTICIPATING (NOT INVITED DURING THE PERIOD)					
TOTAL FULLY PARTICIPATING					
PARTICIPANTS REFERRED TO BCBSNC CASE MANAGEMENT OR HEALTH LINE BLUE CASE MANAGEMENT (% OF TOTAL FULLY PARTICIPATING)					

Members who indicate on their enrollment survey that they wish to work with a nurse are referred to a BCBSNC Case Manager or a nurse at Health Line Blue. Members are also referred to Case Management if they have a hospital admission authorization for heart failure.

Members must complete a brief health survey to receive full participation benefits.

Member Health Partnerships is a Service Mark of Blue Cross Blue Shield of North Carolina

Health Line Blue is a Service Mark of the Blue Cross and Blue Shield Association

Telescale is a registered mark of Cardiocom, LLC

HEART DISEASE: POST-CARDIAC EVENT PROGRAM

Program Overview

The Post-Cardiac Event program provides outreach which promotes appropriate follow-up after a cardiac event such as heart attack, bypass surgery, or angioplasty.

Members receive educational materials and tools which focus on cholesterol management techniques such as lifestyle modifications, as well as the importance of adherence to medication regimes. Materials include a cardiac rehabilitation workbook and a week-by-week calendar with heart-healthy tips. Members who complete a program survey receive an American Heart Association cookbook. In addition, the program addresses psychosocial issues related to heart disease, such as depression, behavior change and family support. Initial contact occurs 60 to 90 days post-discharge when members are more likely to resume unhealthy behaviors and serves as a reminder of the importance of healthy lifestyle changes.

AVERAGE MEMBERSHIP FOR THE MOST RECENT PERIOD		Client B			
PROGRAM PARTICIPATION	BCBSNC NORM	ACTIVITY OVER THE LIFE OF THE PROGRAM		ACTIVITY FROM THROUGH	
BASIC PARTICIPATION (% OF TOTAL CURRENT MEMBERSHIP INVITED TO PARTICIPATE)					
FULL PARTICIPATION (% OF INVITED)					
OTHERS FULLY PARTICIPATING (NOT INVITED DURING THE PERIOD)					
TOTAL FULLY PARTICIPATING					
PARTICIPANTS REFERRED TO BCBSNC CASE MANAGEMENT OR HEALTH LINE BLUE CASE MANAGEMENT (% OF TOTAL FULLY PARTICIPATING)					

Members must complete a brief health survey to receive full participation benefits.
 Member Health Partnerships is a Service Mark of Blue Cross Blue Shield of North Carolina
 Health Line Blue is a Service Mark of the Blue Cross and Blue Shield Association

HEALTHY LIFESTYLE CHOICES

Program Overview

This program consists of a comprehensive set of health improvement services being offered to prevent and reduce obesity. It is available to any member interested in making lifestyle changes; members do not need to be overweight to join. Members who are invited into the program (referred to as "Basic Participation") receive educational materials and tools to help them take charge of their health. Members who enroll in the program (referred to as "Full Participation") receive free self-help tools such as a pedometer and lifestyle diary and free access to an interactive online weight loss program. Materials are customized to the member's health status and readiness to make lifestyle changes. In addition, fully participating members will be allowed six medical nutrition therapy visits, for which copay and coinsurance will be waived. Coverage of FDA-approved weight loss drugs for the long-term treatment of obesity is also available.

AVERAGE MEMBERSHIP FOR THE MOST RECENT PERIOD		Client B			
PROGRAM PARTICIPATION	BCBSNC NORM	ACTIVITY OVER THE LIFE OF THE PROGRAM		ACTIVITY FROM THROUGH	
BASIC PARTICIPATION (% OF TOTAL CURRENT MEMBERSHIP INVITED TO PARTICIPATE)					
FULL PARTICIPATION (% OF INVITED)					
OTHERS FULLY PARTICIPATING (NOT INVITED DURING THE PERIOD)					
TOTAL FULLY PARTICIPATING					
PARTICIPANTS REFERRED TO BCBSNC CASE MANAGEMENT OR HEALTH LINE BLUE CASE MANAGEMENT (% OF TOTAL FULLY PARTICIPATING)					

Members must complete a brief health survey to receive full participation benefits.

Effective 10/01/2005 at group renewal.

Prior plan approval is required; members must be fully participating in the Healthy Lifestyle Choices program. Effective 10/01/2005 at group renewal.

Member Health Partnerships is a Service Mark of Blue Cross Blue Shield of North Carolina

Health Line Blue is a Service Mark of the Blue Cross and Blue Shield Association

 SPECIALTY CARE

Program Overview

This program is offered to members who have ALS, CIDP, Cystic Fibrosis, Dermatomyositis, Gaucher Disease, Hemophilia, Myasthenia Gravis, Multiple Sclerosis, Parkinson's Disease, Polymyositis, Rheumatoid Arthritis, Scleroderma, Sickle Cell Disease, and/or Systemic Lupus Erythematosus. Program participants receive customized, disease-specific educational materials; special access to a patient Web site with information, resources, live educational events, self-care tools and peer-to-peer support (www.accordant.com); ongoing personal health evaluations via telephone with individualized attention from a nurse who understands the member's needs and can help the member prevent complications and provide tips for staying in the best possible health; and 24-hour telephonic access to a team of health care professionals who are knowledgeable about the member's condition and who can answer questions, locate resources and provide extra support for the member and his/her family.

AVERAGE MEMBERSHIP FOR THE MOST RECENT PERIOD				Client B	
PROGRAM PARTICIPATION	BCBSNC NORM	ACTIVITY OVER THE LIFE OF THE PROGRAM	ACTIVITY FROM THROUGH		
FULLY PARTICIPATING MEMBERS (% OF TOTAL CURRENT MEMBERSHIP)					

This is an opt-out program so all members who have these conditions are automatically enrolled.
 Member Health Partnerships is a Service Mark of Blue Cross Blue Shield of North Carolina

3-digit Principal Diagnosis: Grouping of principal diagnoses based on the first three digits of the ICD-9 diagnosis code

Allowed: Amount considered eligible for payment by the plan

Allowed PMPM: Amount considered eligible for payment by the plan per member per month. It is calculated as:
 $\text{Allowed} / \text{Member Months}$

Allowed/Day: Amount considered eligible for payment by the plan per inpatient day. It is calculated as: $\text{Allowed} / \text{Days}$

Allowed/Service: Amount considered eligible for payment per admit (inpatient facility), per visit (outpatient facility and professional) or per script (prescription Rx). It is calculated as: $\text{Allowed} / \text{Services}$

Average Contract Size: The average number of members per subscriber. It is calculated as: $\text{Medical Members} / \text{Medical Subscribers}$

Average Length of Stay: Admit last date of service minus admit first date of service (plus 1 if last day=first day). It is calculated as: $\text{Days} / \text{Services}$

Benchmark: Represents the DEMO book of business that is loaded into DART. All national accounts as well as all local accounts with more than 100 members have been loaded into DART.

Billed: Amount submitted for payment by the provider

Billed/Service: Amount submitted for payment by the provider per admit (inpatient facility), per visit (outpatient facility and professional) or per script (prescription Rx). It is calculated as: $\text{Billed} / \text{Services}$

Childbearing Females: The total number of members who are women between the ages of 20 and 44 years. The proportion of childbearing females is calculated as: $\text{Member Months for Women between 20-44 years} / \text{Member Months}$

Chronic Conditions: Identified by the following 3-digit principal diagnosis codes: 250 Diabetes Mellitus, 346 Migraine, 401 Essential Hypertension, 402 Hypertensive Heart Disease, 428 Heart Failure, 491 Chronic Bronchitis, and 493 Asthma. Hypertension represents a summation of measures for codes 401 and 402.

Claimants: Number of individual members submitting a claim

COB: Portion of amount considered eligible for payment that has been paid by another insurance company (Coordination of Benefits)

Coinsurance: Portion of covered amount member is responsible to pay for the claim

Co-payment: Flat rate that the member is responsible to pay for the claim

CPT: Current Procedural Terminology published by the American Medical Association (AMA)

Days: Count of days

Days/1000: Number of inpatient days per 1,000 members. It is calculated as: $(\text{Days} / \text{Member Months}) * 1000 * 12$

Deductible: Portion of annual deductible amount member is responsible to pay applied to the claim

Delivery: Refers to an inpatient facility admission where claims for a mother and newborn are combined into one admission when possible

Demographic Index: A numeric factor that measures the expense deviation of a population from that of a benchmark population based on their age and gender. The demographic index is measured by calculating the paid PMPM for each age/gender band for the plan book of business. A demographic weight is assigned to each age/gender band by taking that paid PMPM for the specific age/gender band and then dividing it by the paid PMPM overall. For example, the paid PMPM for 40-45 Females is \$325 and the overall paid PMPM for the plan book of business is \$100. The demographic weight of the 40-45 F age/gender band is 3.25. These weights are then applied to the demographic mix for the particular company to come up with a demographic index. If the demographic index has not been normalized for the company, then a result higher than 1 means that the demographic mix of your population would indicate that your population would be more expensive, based on the demographic mix, than the overall population for the plan. If the demographic index is less than 1.00, that would indicate that your expenses should be less than the plan book of business. In many cases, after the demographic index has been calculated for a company, it is then normalized to 1.00 over the three year period for the company. This means that the interpretation of the demographic index would be based specifically on changes on the demographic mix within the company. The demographic index cannot be used to analyze differences in your demographic mix to the overall plan book of business.

Detailed Service Type: Classification based on CPT -- detailed level (HDMS Generated)

Diagnostic Radiology: Refers to radiology services used for diagnostic purposes, as opposed to therapeutic purposes

Discount: Amount of reduction from billed amount that has been negotiated with the provider

Dispensing Rate: The proportion of total drugs claims a certain drug or drug type is being dispensed

DRG: Diagnosis Related Group, a classification of hospital case types into groups expected to have similar hospital resource use. The groupings are based on diagnoses, procedures, age, gender and the presence of complications or co-morbidities.

Drug Type: An indicator on each Rx claim that tells whether a script is single source brand, multi source brand, generic drug or a non-drug item. Single source brand identifies those drugs that are available from only one manufacturer and have no generic equivalent available. Multi source brand identifies those drugs that are available from more than one manufacturer and have at least one generic equivalent alternative available.

Generic: Indicates that the NDC code represents a generic drug

Generic Substitution Rate: Proportion of potential generic prescriptions that were filled as generic. It is calculated as: Number of generic scripts / Number of scripts

HCC: High Cost Claimant, a claimant with total paid amount over a specified threshold (e.g., \$30,000 or \$50,000) within the twelve month reporting period

HCPCS: Healthcare Common Procedure Coding System, a coding system comprised of CPT-4 (Current Procedural Terminology) codes used to identify medical services and procedures furnished by physicians and other health care professionals and other products, supplies and services not included in the CPT-4 codes

High Cost Diagnostic Radiology: Refers to expensive radiology exams that have the potential to be over-utilized

Infused Drugs: Refers to CPT codes starting with J on the professional file which usually represent infused drugs and are identified by specific NDC codes on the Rx file (HDMS Generated)

In-Network Days %: Percent of days for in-network claims. It is calculated as: In-Network Days / Days

In-Network Paid %: Percent of total paid expenses for in-network claims. It is calculated as: In-Network Paid / Paid

In-Network Paid/Service: Paid per admission (inpatient facility), per visit (outpatient facility and professional) or per script (prescription Rx). It is calculated as: In-Network Paid / In-Network Services

In-Network Services %: Percent of services for in-network claims. It is calculated as: In-Network Services / Services

Inpatient Facility: Refers to Inpatient Institutional Facility claims

IP Paid: Inpatient facility paid amount

IP Paid PMPM: Inpatient facility paid amount per member per month

Leading ICD-9 Diagnostic Category: For each patient, summarize total paid amount for each diagnosis and its corresponding MDC. The MDC with the greatest paid amount for the patient becomes the Leading ICD-9 Diagnostic Category for the reporting period (HDMS Generated)

Management Services: Prospective payments made for each member for management of mental health and chemical dependency services in addition to DEMO's 24-hour wellness information line

MCC: Master Clinical Classification, set of higher-level categories based upon the principal diagnosis of the claim (HDMS Generated)

MDC (DRG): Major Diagnostic Category based on DRG, available only in inpatient reports

Medicare COB: Portion of amount eligible for payment that has been paid by Medicare

Member Cost Sharing: Total amount that is the responsibility of the claimant. It is calculated as: (Copay + Deductible + Coinsurance)

Member Months: Count of months of eligibility for members

Non-Acute: Refers to inpatient facility admissions for rehabilitation, skilled nursing facilities and hospice care

Non-Delivery: Refers to inpatient facility admissions for false labor and other pregnancy-related conditions not resulting in a delivery

Non-Emergent Care: Identified by the following 3-digit principal diagnosis codes: 461 Acute Sinusitis, 462 Acute Pharyngitis, 466 Acute Bronchitis and Bronchiolitis, 473 Chronic Sinusitis, 487 Influenza, 490 Bronchitis, Not Specified as Acute or Chronic, 780 General Symptoms, V67 Follow-up Examination and V70 General Medical Examination

Normal Newborn: Refers to inpatient facility admissions for normal newborns where the newborn claim could not be attached to a mother's claim

Not Covered: Amount considered not eligible for payment by the plan (excludes the discount amount)

OP Paid PMPM: Outpatient facility paid amount per member per month

Outpatient Facility: Refers to Outpatient Institutional Facility claims

Paid: Amount paid to the provider by the plan

Paid PMPM: Amount paid to the provider by the plan per member per month. It is calculated as: $\text{Paid} / \text{Member Months}$

Paid/Claimant: Amount paid to the provider by the plan per claimant. It is calculated as: $\text{Paid} / \text{Claimants}$

Paid/Day: Amount paid to the provider by the plan per inpatient day. It is calculated as: $\text{Paid} / \text{Days}$

Paid/Service: Amount paid to the provider by the plan per admission (inpatient facility), per visit (outpatient facility and professional) or per script (prescription Rx). It is calculated as: $\text{Paid} / \text{Services}$

Paid/Visit: Amount paid to the professional provider by the plan per visit. It is calculated as: $\text{Paid} / \text{Visits}$

Pharmacy Tier: An indicator on each Rx claim that tells whether a prescription is generic, preferred brand, non-preferred brand, specialty, or other

Place of Service: An indicator of whether the professional services were rendered during an inpatient admission, outpatient visit, office visit, or other

PMPM: Per member per month

Potential Generic Prescription: Multi-source brand (drugs that are available from more than one manufacturer and have at least one generic equivalent alternative available) and generic drugs

PR Paid PMPM: Professional paid amount per member per month

Preventive Visits: Professional office visits that are considered precautionary and are defined for new and established patients as CPT service codes in the range of 99381-99397

Procedure Code: AMA Current Procedure Terminology (CPT) indicating type of visit, procedure or service

Reporting Period: Twelve month time period included in report (e.g., current, prior)

Rx Paid: Prescription drug paid amount per member per month

Service Type: HDMS classification based on principal diagnosis or ICD-9 Procedure Code (HDMS Generated)

Services: Number of admissions (inpatient facility), number of visits (outpatient facility), number of claim lines (professional), or number of scripts (prescription Rx)

Services/1000: Number of services per 1,000 members. It is calculated as: $(\text{Services} / \text{Member Months}) * 1000 * 12$

Services/Member: Number of services per member. It is calculated as: $(\text{Services} / \text{Member Months}) * 12$

Therapeutic Drug Class: Used to categorize or group prescription drugs which are considered similar by the disease they treat or by the effect they have on the body

Visits: Number of professional visits, where a visit is defined as a set of all professional services that occur on the same date for the same claimant and the same professional provider. A visit relates to a physician interaction with a patient and the place of service can be the office, inpatient facility or outpatient facility.

Visits/1000: Number of professional visits per 1,000 members. It is calculated as: $(\text{Visits} / \text{Member Months}) * 1000 * 12$