BlueCross BlueShield of New Mexico

Blue Insight
Monthly Financial Report

NEW MEXICO RETIREE HEALTH CARE
AUTHORITY: ALL

000296702 - ADVANTAGE VALUE PLAN

07/01/2017 to 06/30/2018

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BlueCross BlueShield of New Mexico

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Data Parameters

Current Period: The current reporting period represents claims paid from July 1, 2017 through June 30, 2018.

Prior Period: The prior reporting period represents claims paid from July 1, 2016 through June 30, 2017.

The report includes medical claims only.

Reporting Segments: ALL

Characteristics: ALL

Group/Sections: ALL

Member MSA: ALL

Group: 000296702 - ADVANTAGE VALUE PLAN

Reporting Support Contact Information

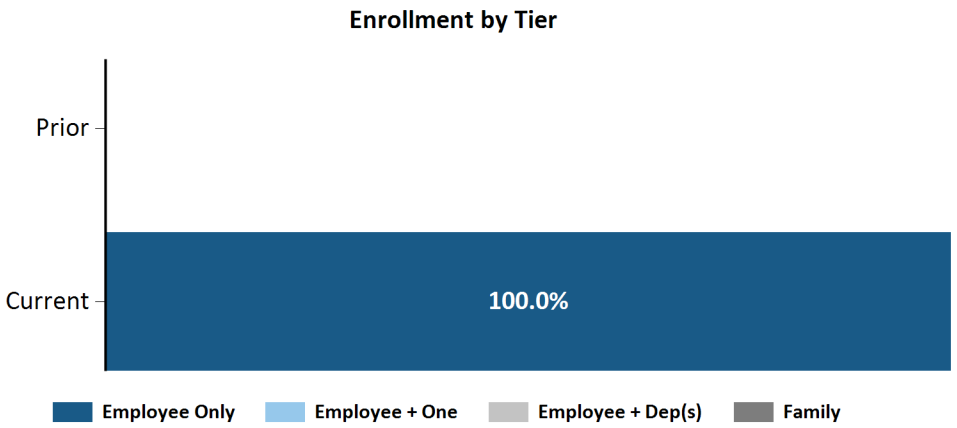
For reporting support, please contact Client Reporting Service Center
Email: client_reporting@bcbsil.com
Phone: 1-877-837-1866
Hours of Operation: Monday - Friday: 8:00am - 5:00pm CT

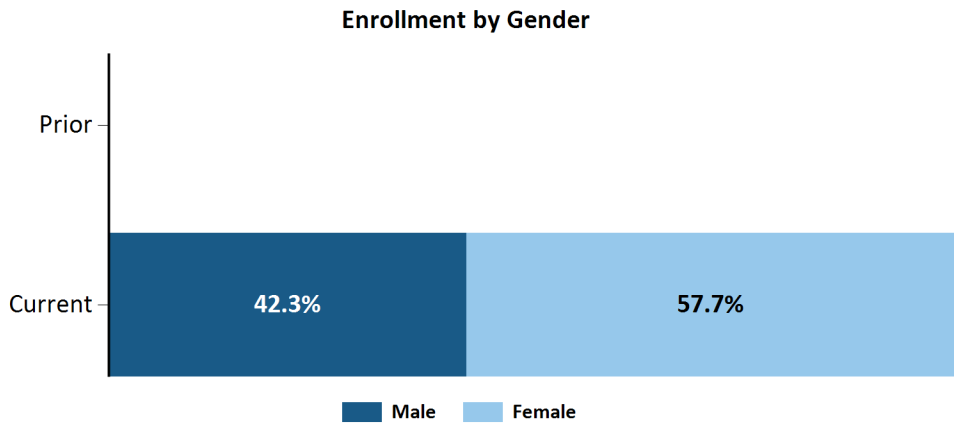
Report prepared on 11/01/2019

Enrollment Overview

Report Description: Provides the current enrollment based on the current period.

Month	Medical Subscribers	Medical Members
Jul 2017		
Aug 2017		
Sep 2017		
Oct 2017		
Nov 2017		
Dec 2017		
Jan 2018	406	406
Feb 2018	427	427
Mar 2018	432	432
Apr 2018	446	446
May 2018	461	461
Jun 2018	463	463





Enrollment Overview

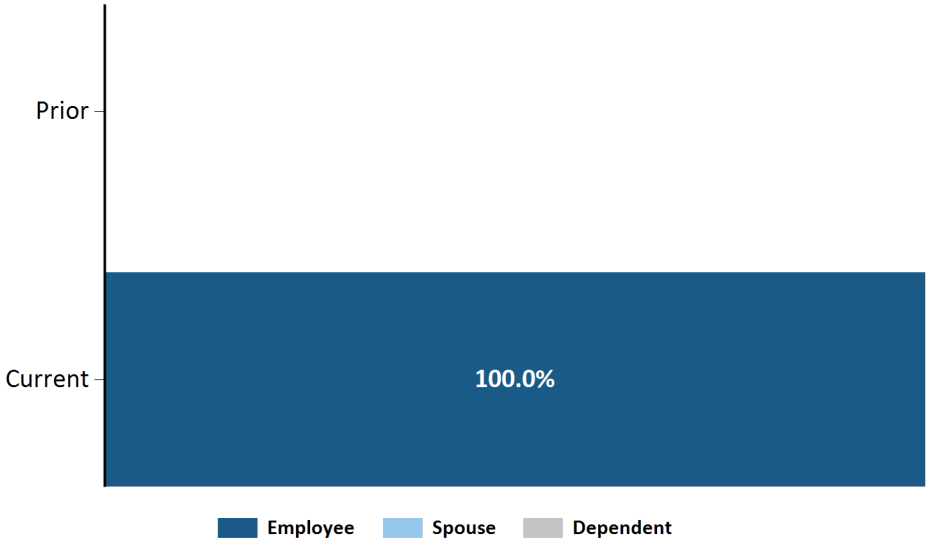
Report Description: Provided medical demographics for the current period compared to the prior period and percent change.

Medical Demographics

	Jul 2016 - Jun 2017	Jul 2017 - Jun 2018	% Change
Average Membership		**439**	**0.0%**
Employee		439	
Spouse			
Dependent			
Average Contract Size		1.0	
Average Age		**51.2**	
Employee		51.2	
Spouse			
Dependent			
% Under 30		18.0%	
% 30 to 49		4.7%	
% 50 to 64		76.7%	
% 65+		0.6%	
Gender			
Proportion of Males		42.3%	
Proportion of Females		57.7%	
Females Ages 20-44		6.7%	

- Overall, membership **remained stable at 0.0%** between reporting periods
- The average age was 51.2 and **remained stable by 0.0%** between reporting periods.
- Contract size **remained stable by 0.0%** between reporting periods.
- Females between the ages of 20 and 44 **increased from 0.0% to 6.7%** between reporting periods.

Average Medical Membership



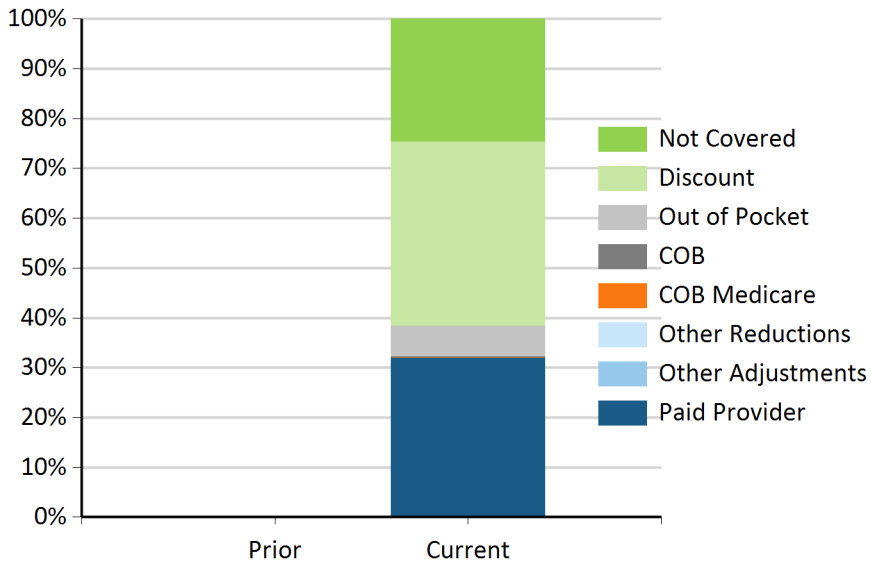
Financial Overview: Financial Summary

Report Description: Provides a breakdown of the medical order of reduction from billed to paid for the current month, current period, prior period and a percent change. This report may highlight key measures and their potential impact on paid expenses.

Medical Order of Reduction

Paid Month	Jun 2018	Jul 2016 - Jun 2017	Jul 2017 - Jun 2018	% Change
Billed	$352,949	$1,545,020		
Not Covered	$63,512	$380,993		
Covered	$289,438	$1,164,027		
Discount	$97,068	$569,807		
Allowed	$192,370	$594,220		
Out of Pocket	$14,627	$97,050		
COB	$198	$831		
COB Medicare	$399	$525		
Other Reductions	$0	$0		
Other Adjustments	($31)	($31)		
Paid - Provider	$177,177	$495,845		
Other Payments	$2	$6		
Medical Paid	$177,179	$495,851		

Breakdown of Billed Amount



Group Liability Breakdown

Paid Month	Jun 2018	Jul 2016 - Jun 2017	Jul 2017 - Jun 2018	% Change
Medical Paid	$177,179	$495,851		
VBC Payments		$0		
Total Paid Claims	$177,179	$495,851		
Recoveries	$0	$0		
Total Paid Claims + Recoveries	$177,179	$495,851		
Fees & Credits	$9,459	$53,710		
HCA Draft Amount	$0	$0		
Group Liability	$186,638	$549,562		

Fees and Credits Breakdown

Paid Month	Jun 2018	Jul 2016 - Jun 2017	Jul 2017 - Jun 2018	% Change
Access Fee	$0	$0		
Admin Fee	$9,459	$53,710		
ASO Adjustments	$0	$0		
Aggregate Stop Loss	$0	$0		
Specific Stop Loss	$0	$0		
Extra Fees	$0	$0		
ASO Other Services	$0	$0		
ASO All Other	$0	$0		
Summary	**$9,459**	**$53,710**		

Other reductions *includes penalties, workers compensation savings, and subrogation savings.*
Other payments *includes Blue Card access fees and surcharges. Also displayed are other adjustments.*

Financial Overview: Network Overview

Report Description: This report displays the discount amount, discount percent, paid amount and paid percent for medical claims split by Medicare/Non-Medicare, in/out of network and service category for the current period.

Medicare Primary Indicator	Network Indicator	Service Category	Covered	Discount	Discount %	Paid	% Of Paid
No	In Network	Facility Inpatient	$180,934	$116,445	64.4%	$52,547	10.6%
		Facility Outpatient	$632,551	$250,649	39.6%	$346,832	69.9%
		Professional	$347,147	$200,361	57.7%	$96,259	19.4%
		Summary	**$1,160,632**	**$567,455**	**48.9%**	**$495,639**	**100.0%**
	Out of Network	Facility Inpatient					
		Facility Outpatient					
		Professional					
		Summary					
	Summary		**$1,160,632**	**$567,455**	**48.9%**	**$495,639**	**100.0%**
Yes	In Network	Facility Inpatient					
		Facility Outpatient	$341			$24	
		Professional	$3,054	$2,352	77.0%	$189	
		Summary	**$3,395**	**$2,352**	**69.3%**	**$213**	
	Out of Network	Facility Inpatient					
		Facility Outpatient					
		Professional					
		Summary					
	Summary		**$3,395**	**$2,352**	**69.3%**	**$213**	
Summary			**$1,164,027**	**$569,807**	**49.0%**	**$495,851**	**100.0%**

Key Findings: The overall network savings discount (excluding Medicare) was **48.9%** for the current period. The in-network paid percent was **100.0%** for the current period.

Financial Overview: Blue Card Savings Analysis

BlueCross BlueShield of New Mexico

Report Description: The Blue Card Savings report illustrates the value of having access to other BCBS contracts within the United States through the Blue Card program. Savings from BCBS network discounts are passed to the client, providing savings on potentially costly out of state claims that would otherwise be paid at full provider billed amount.

Jul 2017 - Jun 2018

Par Plan State	Billed	Allowed	Effective Allowed Rate	Discount	Paid	Effective Paid Rate	Blue Card Access Fee
TX	$275,974	$39,144	14.2%	$104,445	$34,006	12.3%	$0
AZ	$2,331	$168	7.2%	$150	$99	4.3%	$6
CO	$517	$0	0.0%	$0	$0	0.0%	$0
FL	$1,109	$0	0.0%	$0	$0	0.0%	$0
MT	$615	$0	0.0%	$0	$0	0.0%	$0
Not Available	$1,264,474	$554,909	43.9%	$465,212	$461,746	36.5%	$0
All Other Non-Blue Card	$1,264,474	$554,909	43.9%	$465,212	$461,746	36.5%	$0
Summary	**$1,545,020**	**$594,220**	**38.5%**	**$569,807**	**$495,851**	**32.1%**	**$6**

Key Findings: TX had the greatest Blue Card savings amount, with a Discount amount of **$104,445**. The overall Effective Allowed Rate for the current period was **38.5%**.

Financial Overview: Medical Claim Expense Distribution

BlueCross BlueShield of New Mexico

Report Description: The distribution of medical paid expense by claimant and the average medical paid per claimant amount are shown for the current period.

Paid Band	Claimants	Claimants %	Paid	Paid %	Paid/Claimant
Less than $200	161	50.3%	$9,123	1.8%	$57
$200 - $1,000	105	32.8%	$48,610	9.8%	$463
$1,001 - $5,000	41	12.8%	$89,066	18.0%	$2,172
$5,001 - $10,000	9	2.8%	$54,860	11.1%	$6,096
$10,001 - $30,000	2	0.6%	$44,725	9.0%	$22,363
$30,001 - $50,000	1	0.3%	$37,920	7.6%	$37,920
Summary <= $50,000	**319**	**99.7%**	**$284,304**	**57.3%**	**$891**

Paid Band	Claimants	Claimants %	Paid	Paid %	Paid/Claimant
$50,001 - $75,000					
$75,001 - $100,000					
$100,001 - $150,000					
$150,001 - $200,000					
$200,001 - $250,000	1	0.3%	$211,547	42.7%	$211,547
$250,001 - $500,000					
$500,001+					
Summary $50,001 or Greater	**1**	**0.3%**	**$211,547**	**42.7%**	**$211,547**
Combined Summary	**320**	**100.0%**	**$495,851**	**100.0%**	**$1,550**

Key Findings: The proportion of claimants who received less than $200 in services for the current period was **50.3%**. These claimants spent **1.8%** of the total paid expenses and the average paid expense per claimant was **$57**. **0.3%** of claimants had expenses over $50,001 for the current period. These claimants spent **42.7%** of the total paid expenses and the average paid expense per claimant was **$211,547**.

Financial Overview: High Cost Claimants

BlueCross BlueShield of New Mexico

Report Description: This report provides a detailed listing of the top 20 high cost claimants with paid expenses of $50,000 or more for the current period.

Jul 2017 - Jun 2018

Encrypted Member ID	Relationship	Age/Gender Band	Leading Diagnostic Category	Inpatient Paid	Outpatient Paid	Professional Paid	Paid	Currently Enrolled
7792617970453240831	Subscriber	Male 60-64	Neoplasms	$0	$209,423	$2,124	**$211,547**	Yes
High Cost Claimant Total				**$0**	**$209,423**	**$2,124**	**$211,547**	

Financial Overview: Medical Out of Pocket

BlueCross BlueShield of New Mexico

Report Description: Provides a distribution of claimants by their total medical out of pocket expenses for the current period compared to the prior period and percent change. This report helps determine the impact of any changes in plan design on out of pocket.

Claimant Distribution by Out of Pocket Expense Bands

	Jul 2016 - Jun 2017				Jul 2017 - Jun 2018				% Change	
Out of Pocket Band	**Claimants**	**Claimants %**	**Out of Pocket**	**Out of Pocket %**	**Claimants**	**Claimants %**	**Out of Pocket**	**Out of Pocket %**	**Claimants Change**	**Out of Pocket Change**
Less than $100					195	60.9%	$5,995	6.2%	0.0%	0.0%
$101 - $200					45	14.1%	$5,907	6.1%	0.0%	0.0%
$201 - $300					22	6.9%	$5,335	5.5%	0.0%	0.0%
$301 - $400					15	4.7%	$4,985	5.1%	0.0%	0.0%
$401 - $500					5	1.6%	$2,331	2.4%	0.0%	0.0%
$501 - $750					10	3.1%	$5,672	5.8%	0.0%	0.0%
$751 - $1,000					4	1.3%	$3,340	3.4%	0.0%	0.0%
$1,001 - $1,500					4	1.3%	$5,425	5.6%	0.0%	0.0%
$1,501 - $2,000					7	2.2%	$12,042	12.4%	0.0%	0.0%
$2,001 - $2,500					4	1.3%	$8,792	9.1%	0.0%	0.0%
$2,501 - $3,000					3	0.9%	$8,281	8.5%	0.0%	0.0%
$3,001 - $4,000					1	0.3%	$3,802	3.9%	0.0%	0.0%
$4,001 - $5,000					2	0.6%	$8,644	8.9%	0.0%	0.0%
$Greater than $5,001					3	0.9%	$16,500	17.0%	0.0%	0.0%
Summary		**100%**		**100%**	**320**	**100%**	**$97,050**	**100%**	**0.0%**	**0.0%**

Out of Pocket Expense by Coverage Tier

	Jul 2017 - Jun 2018									
Coverage Tier	**Allowed**	**Deductible**	**Deductible % of Allowed**	**Copayment**	**Copay % of Allowed**	**Coinsurance**	**Coins % of Allowed**	**Out of Pocket**	**OPX % of Allowed**	**Paid**
Employee Only	$594,220	$41,169	6.9%	$32,684	5.5%	$23,197	3.9%	$97,050	16.3%	$495,851
Summary	**$594,220**	**$41,169**	**6.9%**	**$32,684**	**5.5%**	**$23,197**	**3.9%**	**$97,050**	**16.3%**	**$495,851**

This is a claimant analysis, where only members who had a claim are included. The tables exclude all medical enrolled members that did not submit a claim.

This report is based on claim data and may not reflect client specific benefits being applied to member out of pocket. Please contact your Account Executive for ACCUMS reporting.

Financial Overview: Lag Report

BlueCross BlueShield of New Mexico

Report Description: Displays, by paid month, the medical dollars paid and the corresponding month incurred for a 12 month rolling paid period (if available for your account). This report provides insight into the monthly claim lag and can help identify IBNR.

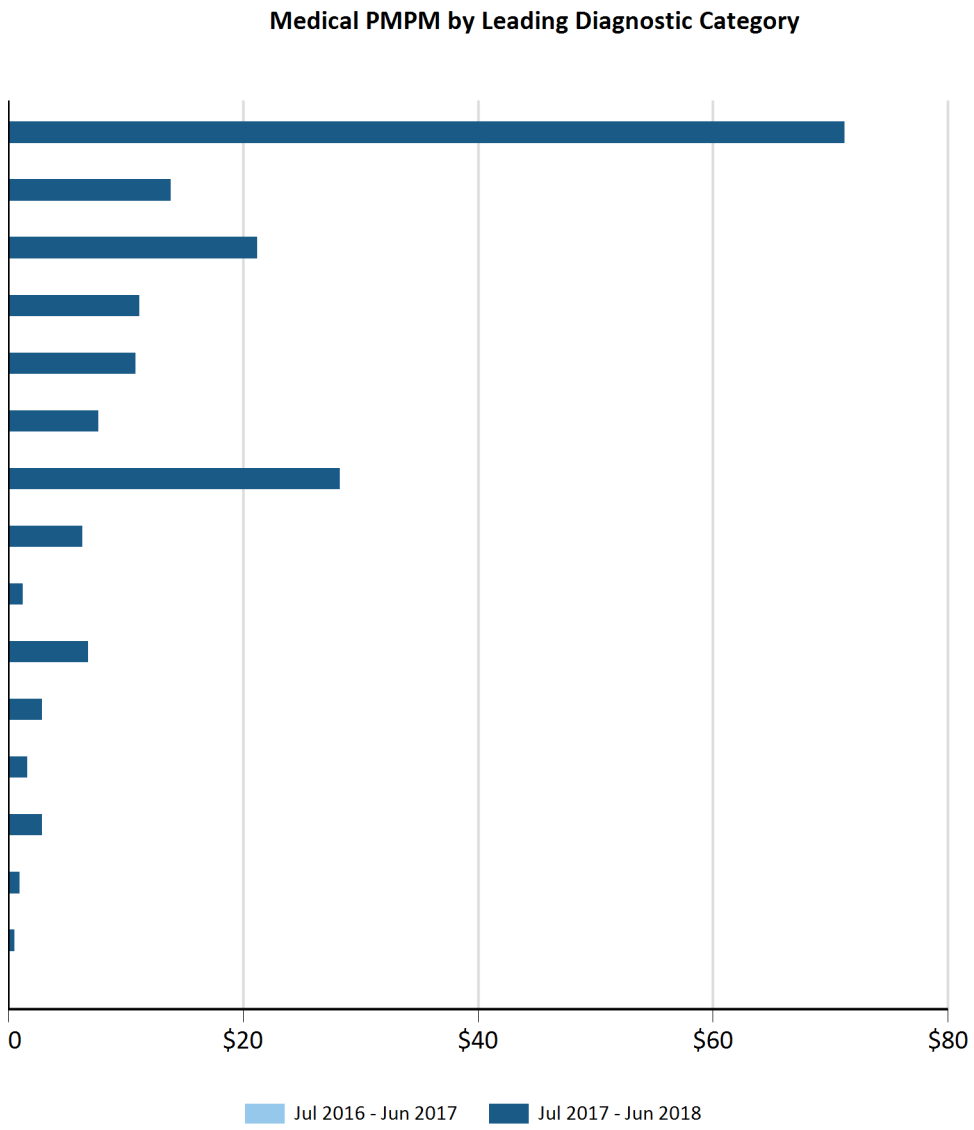
Incurred Month	Paid Month												
	Jul 2017	Aug 2017	Sep 2017	Oct 2017	Nov 2017	Dec 2017	Jan 2018	Feb 2018	Mar 2018	Apr 2018	May 2018	Jun 2018	**Summary**
Jul 2016													
Aug 2016													
Sep 2016													
Oct 2016													
Nov 2016													
Dec 2016													
Jan 2017													
Feb 2017													
Mar 2017													
Apr 2017													
May 2017													
Jun 2017													
Jul 2017													
Aug 2017													
Sep 2017													
Oct 2017													
Nov 2017													
Dec 2017													
Jan 2018							$25,166	$17,914	$6,253	$10,282	$2,433	$5,179	**$67,228**
Feb 2018								$22,494	$58,131	$21,508	$723	$73	**$102,930**
Mar 2018									$39,112	$37,380	$537	$757	**$77,785**
Apr 2018										$26,992	$17,019	$31,728	**$75,739**
May 2018											$32,729	$96,348	**$129,076**
Jun 2018												$43,094	**$43,094**
Summary							**$25,166**	**$40,408**	**$103,496**	**$96,162**	**$53,441**	**$177,179**	**$495,851**

Financial Overview: Overall Medical Paid PMPM by Leading Diagnostic Category

BlueCross BlueShield of New Mexico

Report Description: Lists the top 15 overall paid expense across inpatient facility, outpatient facility, and professional settings by leading diagnostic categories for the current month, current period, prior period and percent change.

Paid Period	Jun 2018	Jul 2016 - Jun 2017	Jul 2017 - Jun 2018	% Change
Leading Diagnostic Category	**Paid PMPM**	**Paid PMPM**	**Paid PMPM**	**Paid PMPM**
Neoplasms	$256		$71	0.0%
Injury/Poisoning	$36		$14	0.0%
Symptoms/Ill-Defined	$33		$21	0.0%
Genitourinary	$19		$11	0.0%
Musculoskeletal	$16		$11	0.0%
Endocrine	$8		$8	0.0%
Circulatory	$4		$28	0.0%
Respiratory	$3		$6	0.0%
Skin Diseases	$2		$1	0.0%
Nervous System	$1		$7	0.0%
Mental Health	$1		$3	0.0%
Infectious/Parasitic	$1		$2	0.0%
Digestive	$1		$3	0.0%
Residual/Unclassified	$0		$1	0.0%
Blood Diseases	$0		$1	0.0%
All Other Values	$0		$1	0.0%
Summary	**$383**		**$188**	**0.0%**



Key Findings: The top three Leading Diagnostic Categories in the current reporting month based on Paid PMPM were **Neoplasms, Injury/Poisoning, and Symptoms/Ill-Defined**.

Appendix: ICD Category Definitions

Complications of Pregnancy, Childbirth and the Puerperium: Includes vaginal and cesarean deliveries and complications of pregnancy, such as ectopic and molar pregnancies. Puerperium refers to 42 days following childbirth and expulsion of the placenta. Refers to the mother only.

Conditions Influencing Health Status: This includes post-surgical states, organ / tissue transplants, artificial limbs and replacements. Examples include knee replacements and kidney transplant status.

Conditions in the Perinatal Period: Perinatal refers to the period beginning after the 28th week of gestation and ending 28 days after birth. Problems can include hemorrhage, digestive disorders, respiratory distress syndrome and disorders relating to short gestation and unspecified low birth weight.

Congenital Anomalies: Includes the treatment of any condition present at birth. This includes Spina Bifida, cleft palate, Down's Syndrome, heart disease, kidney displacement & polycystic kidney disease.

Diseases of the Blood and Blood Forming Organs: Includes any problems associated with white or red blood cells, platelets or plasma. An example includes Anemia, a deficiency in red blood cells.

Diseases of the Circulatory System: Includes problems with the heart, blood vessels and circulation. Some common diagnoses include Coronary Artery Disease, cardiovascular disease, and stroke.

Diseases of the Digestive System: Includes the treatment of any organ or area of the body pertaining to digestion. These areas include the mouth/teeth, esophagus, stomach, intestines, gall bladder, liver and pancreas. Diagnoses include: Esophageal Reflux, Gastroenteritis, Appendicitis and hernias.

Diseases of the Genitourinary System: Includes problems related to the kidneys, bladder and male and female genitalia. Common diagnoses include Hematuria, Urinary Tract Infection, Acute or Chronic Renal Failure and Calculus of Kidney (stones).

Diseases of the Nervous System: Includes treatment for disorders of the Central and Peripheral Nervous systems. Diagnoses include: Carpal Tunnel Syndrome, Obstructive Sleep Apnea, Epilepsy, Multiple Sclerosis, Alzheimer's Disease and Migraine headaches.

Diseases of the Respiratory System: Includes treatment for diagnoses such as Asthma, Pneumonia, Emphysema, Pharyngitis, Sinusitis, Bronchitis and COPD. These can be acute or chronic in nature.

Diseases of the Skin and Subcutaneous Tissue: This involves any condition relating to the skin or beneath the skin, including hair and nails. Some conditions include Acne, Corns, Cellulitis, Psoriasis, Dermatitis and fungal infections.

Appendix: ICD Category Definitions

Ears and Mastoid: Includes any condition pertaining to the ear or the mastoid process. The mastoid process is the portion of the temporal bone extending down behind the ear. Diagnoses include Otitis Media, Tinnitus, Menieres Disease, Hearing Loss and Labyrinthitis.

Endocrine, Nutritional and Metabolic Diseases: Endocrine disorders include those of the endocrine glands and includes the thyroid, pituitary, pancreas, ovaries and testes. Disorders include Diabetes, thyroid disease, Obesity, Hyperlipidemia, Cystic Fibrosis and any disease affecting the immune system.

Health Services: This includes elective surgeries, other procedures & aftercare, rehabilitation and dialysis. Specific examples include: long-term medication use, Physical Therapy and chemotherapy.

Health Services: Reproduction and Development: Include services pertaining to the child only. For example, normal pregnancy, post-partum care and exam or health supervision of an infant or child.

Infectious and Parasitic Diseases: Includes diseases caused by microbes outside of the body that infect and cause damage within the body. These diseases are recognized as communicable or transmissible. Diagnoses include HIV, Hepatitis, Colitis & intestinal disruptions such as food poisoning.

Injury and Poisoning: Includes treatment for injuries to the body or for any poison ingested. Diagnoses include sprains & strains, fractures, burns and lead poisoning. Patients are most commonly seen in the emergency room for acute conditions.

Mental Health: Refers to a group of disorders causing severe disturbances in thinking, feeling or relating. Includes treatment of any condition that affects mood or behavior. The most common diagnoses include anxiety disorders, depressive disorders and schizophrenia.

Musculoskeletal and Connective Tissue Disease: Includes orthopedic treatment, which would involve anything related to the bones, muscles, joints and soft tissue. Diagnoses: Arthritis, Tendonitis, back disorders, disc disorders, rheumatism, and scoliosis. These diagnoses are more chronic in nature.

Neoplasms: Includes any abnormal growth of cells, either benign or malignant (cancer). Though these can be found at any spot of the body, some of the most common forms include neoplasms of the breast, prostate, stomach and brain. Other examples include Leukemia and Hodgkin's Disease.

Other Circumstances: This includes convalescent care and follow-ups to surgeries and examinations.

Potential Health Hazards: Personal or family history of diseases or disorders; e.g., breast cancer.

Appendix: ICD Category Definitions

Procreative and Contraceptive Management: This includes artificial insemination, fertility testing, genetic counseling, family planning, sterilizations and contraceptive management.

Signs, Symptoms and Ill-Defined Conditions: Includes signs, symptoms, abnormal lab results and ill-defined conditions for which no known cause can be found. For example, a patient may experience chest pain, but no known cause is found.

Substance Abuse: Includes behavior marked by the use of chemically active agents, such as prescription or illicit drugs, alcohol or tobacco. Cognitive, behavioral and physiological symptoms indicate that the person continues use of the substance.

Without Reported Diagnosis: This includes general medical examinations, gynecological exams, mammogram screenings, preventive services, physicals and special screenings for neoplasms.

Glossary

Admin Fees: The charge to an account for HCSC's operational cost of doing business.

Administrative Services Only (ASO): A contract between HCSC and a self-funded plan where HCSC performs administrative services only and does not assume any financial risk. Services usually include claims processing but may include other services such as actuarial analysis and utilization review.

Aggregate: Constituting or amounting to a whole. For example, an aggregate account report includes data for the entire account.

Aggregate Stop Loss: A form of reinsurance that provides protection for medical expenses above a certain limit, generally on a year-by-year basis. Aggregate stop loss provides protection against the accumulation of total claims for a group as a whole exceeding a stated level.

Allowed: Amount considered eligible for payment by the plan

ASO Adjustments: An amount added or deducted from ASO (Administrative Services Only) fees. This includes Stop Loss Reimbursements.

Average Age: The difference between the claimant's year of enrollment and year of birth. Calculated using the measure Average Age divided by the members represented in the report.

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

Average Dependents: Calculated using the measure Member Months (filtered on the Relationship = Dependents) divided by the number of months in the report.

Average Ingredient Cost: Represents the cost of the medication and is determined from the lowest submission of the pharmacy network rate, Usual & Customary amount, or Maximum Allowable Cost (MAC)

Average Members: Calculated using the measure Member Months divided by the number of months included in the report.

Average Subscribers: Calculated using the measure Subscriber Months divided by the number of months included in the report.

Billed: Amount submitted for payment by the provider

Billing and Accounts Receivable System (BARS): An HCSC financial system where all Administrative Services Only (ASO) customer bills are generated.

Blue Card Access Fee: Interplan Teleprocessing Services fee charged on out-of-state claims for accessing the local plan's provider network

Brand Formulary: Brand name medications that are listed on the formulary

Brand Non-Formulary: Brand name medications that are not listed on the formulary

Claimants: Number of individual members submitting a claim

Claim Lag: The amount of time between the date a claim is incurred and the date the claim payment is made.

Glossary

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

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

COBRA Members: Consolidated Omnibus Budget Reconciliation Act - A federal law which requires most employers sponsoring group health plans to offer employees and their families the opportunity for a temporary extension of health coverage (called continuation coverage) when coverage under the plan would otherwise end.

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

Coverage Tier: Eligibility tiers which stratify enrollment data based on the employee and others enrolled under the employee's coverage. Varying benefits can be assigned to tiers.

Covered Amount: Amount eligible for payment based on the terms of the medical/dental benefits agreement.

DAW/1: Indicates that the physician has specified 'do not substitute' on the prescription.

DAW2: Indicates that the Physician has allowed a substitution, but the patient requested brand to be dispensed

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

Dental Loss Ratio: Calculated as the Dental Paid Claims Amount divided by the Billed Dental Premium Amount

Dental Paid Claims: An amount paid to cover the Health Plan's liability for dental services provided to members for claims that have been processed and approved for payment

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

Discount %: For medical claims, the discount percent is calculated as Discount / Covered

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

Drug Type: An indicator on each Rx claim that tells whether a prescription is single source brand, multi-source brand or generic item.

Effective Discount %: The effective discount percentage is calculated as: Discount / (Discount + Paid)

Fees and Credits: Includes all account-specific member and account level fees. Can include Specific Stop Loss, Aggregate Stop Loss, Administration, Access Fees, ASO Adjustments (either debits or credits), Rx Credits and other miscellaneous fees.

Females (20-44 years): The total number of members who are women between the ages of 20 and 44 years. The proportion of females (20-44 years) is calculated as: Member Months for Women between 20-44 years / Member Months

Formulary Compliance Rate: The percentage of drugs dispensed that were included in the formulary

Glossary

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

Generic Drugs: A medication for which the patent has expired, allowing any manufacturer to produce and distribute the product under the chemical name.

Generic Substitution Rate: The rate in which generics were dispensed when a generic was available. It is calculated by Number of generic Rxs / (Number of generic Rxs + Number of multi-source brand Rxs)

Group Liability: Total Claim Expense plus Fees and Credits

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

IBNR: An acronym for 'incurred but not reported'. IBNR claims are that group which are incurred before the fund reserving date, but not reported until after that date.

Ingredient Cost: The cost of the drug minus any taxes or dispensing fees

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

Inpatient Facility: Refers to Facility Inpatient claims

International Classification of Diseases (ICD): An official list of categories of diseases, physical and mental, issued by the World Health Organization (WHO).

Leading ICD 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 Diagnostic Category for the reporting period

MAC Program Savings: Savings achieved by using the MAC (maximum allowable cost) discount on generic medications

Medical Paid Claims: An amount paid to cover the Health Plan's liability for medical (healthcare) services provided to members for claims that have been processed and approved for payment

Medical/Pharmacy Loss Ratio: Calculated as the combined Medical and Pharmacy Paid Claims Amount divided by the total Billed Premium Amount for Medical and Pharmacy, where appropriate

Member Months: Count of months of eligibility for members

Multi-Source Brand: Brand name medications with a generic equivalent

Network Indicator: An indicator that shows whether the claim was processed as in-network (e.g., in the Preferred Provider Organization network) or out-of-network and paid accordingly

Network Savings Discount: The discount that is applied when a member receives services from a contract provider.

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

Glossary

Other Adjustments: Minor payments or credits not captured in other specific expense measures

Other Payments: Combination of Blue Card access fees and surcharge expenses

Other Reductions: Combination of maximum reductions, penalties, workers compensation savings, and subrogation savings

Out of Pocket: Total amount that is the responsibility of the claimant. It is calculated as: (Copay + Deductible + Coinsurance)

Outpatient Facility: Refers to Facility Outpatient claims

Paid: Total amount paid by the plan, including access fees, adjustments, and surcharges

Paid-Provider: Amount paid to the provider by the plan

Paid/Claimant: Amount paid to the provider by the plan per claimant. It is calculated as: Paid / Claimants

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: Paid / Services

Paid PEPM: Amount paid to the provider by the plan per employee per month. It is calculated as: Paid / Subscriber Member Months

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

Penalty: Amount charged to the user of health care services for a non-approved contractual service

PEPM: Per employee per month

Pharmacy Discount %: For pharmacy claims, the discount percent is calculated as Discount / (Discount + Allowed)

Pharmacy Paid Claims: An amount paid to cover the Health Plan's liability for pharmacy services provided to members for claims that have been processed and approved for payment

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

Plan Eligibility: Eligibility derived directly from the plan's enrollment system. It excludes eligibility created during data processing for claims without matching records in the enrollment system.

PMPM: Per member per month

Glossary

Premium: An agreed upon fee paid to the Health Plan for coverage of medical and/or dental benefits for an established benefit period and set intervals

Professional: Services provided by physicians or other professional providers

Recoveries: Subrogation and/or Reimbursements for claims that are included in BARS but not in HCSC's data warehouse (since some of the reimbursements could be for members or claims that are no longer in our data warehouse). Recoveries are loaded from the BARS System and included in Blue Insight for reconciliation purposes.

Rx Credit Fees: Drug rebates that are credited back to the account.

Rx Paid PEPM: Prescription drug paid amount per employee per month

Rx Paid PMPM: Prescription drug paid amount per member per month

Service Category: A classification based on claim type

Service Type: Classification based on principal diagnosis or ICD Procedure Code

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: (Services / Member Months) * 1000 * 12

Single Source Brand: Brand name medications with no generic equivalent

Specialty Drugs: Medications that generally have unique uses, require special dosing or administration, are typically prescribed by a specialist provider and are significantly more costly than alternative drugs or therapies.

Specific Stop Loss: A form of reinsurance that provides protection for medical expenses above a certain limit, generally on a year-by-year basis. Specific (or individual) stop loss limits the cost of eligible medical expenses for each covered individual.

Subrogation Savings: Portion of amount eligible for payment originally paid by the plan but that has since been recovered through a legal action

Surcharge: Amount charged as a tax by certain States on facility claims

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

Total Paid: The total amount of medical and pharmacy dollars paid to cover healthcare services provided to members for claims that have been processed and approved for payment

Total Paid Claims + Recoveries: The total amount paid by the plan plus any amount recovered through subrogation.

Workers Compensation Savings: Portion of amount eligible for payment that has been paid a third party Workers Compensation carrier