Client Information Insights (CII)

Report Fact Sheets

ANTHEM

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D-01 – Financial and Utilization Dashboard

Report Number:	D-01
Report Section:	Dashboards
Report Name:	Financial and Utilization Dashboard (Paid Claims)
Time View:	Paid Dates w/an option for user to select Incurred
Paid Amounts Available:	The following options are available: Standard Reporting Paid Amount + HRA – *Default* Reporting Paid Amount
Time Periods Available:	The following options are available: Rolling 12 months – *Default* Rolling 3 months Plan year to date Calendar year to date
Fully Insured/ASO Account Status:	Available for both Fully Insured and ASO Accounts
Report Suppression Rules:	The Financial Dashboard does not contain report level suppression rules like many of the other CII reports. Instead, there are some quadrants that have built-in suppression rules: Quadrant 1 – Medical and Pharmacy Paid Amount Summary - If the payment innovation dollars are $0 for both the current and prior periods, then the entire Payment Innovation section (i.e., all rows and section header) will be suppressed. Quadrant 2 – High Cost Claimants with Paid Amounts – This quadrant will be suppressed if the average medical and/or pharmacy membership in the current period for a client segment is less than 30. Quadrant 7 – Paid Amount by Setting - This quadrant will be suppressed if the average medical and/or pharmacy membership in the current period for a client segment is less than 30. Quadrant 9 – Pharmacy Highlights - This quadrant will be suppressed if the average medical and/or pharmacy membership in the current period for a client segment is less than 30.
Cell Level Suppression Rules:	Medical and Pharmacy Paid Amount Summary: If there is no Pharmacy coverage then suppress the Pharmacy and Total Paid rows and display the message "Results are not shown because the current period average pharmacy membership is 0, which is less than the threshold of 30." High Cost Claimants: If there is no Pharmacy coverage then suppress the Total HCC Paid Amount Rx row and display the message "Results are not shown because the current period average pharmacy membership is 0, which is less than the threshold of 30." Paid Amount by Setting: If there is no Pharmacy coverage then suppress the Pharmacy section of the bar graph and display the message "Results are not shown because the current period average pharmacy membership is 0, which is less than the threshold of 30."

	Pharmacy Highlights: If there is no Pharmacy coverage then suppress this whole quadrant and display the message "Results are not shown because the current period average pharmacy membership is 0, which is less than the threshold of 30." Quadrant 9 - If a certain report cell does not meet the threshold of 5, the data for that cell will be listed as an asterisk, along with an asterisk for any total or subtotal based on that cell of data.	
Early or Standard Report Production?	Early *(By End of 2nd Week of Month)*	Standard *(By End of 4th Week of Month)* ✓
Hover Description:	Plan cost, utilization and membership highlights for key indicators	
Report Description and Analytic Notes:	Provides nine distinct views of key plan data covering medical membership, medical and pharmacy paid claims, high-cost claimant overview, paid claims distribution (by cost band) and medical claims utilization and unit cost detail by setting (Inpatient, Outpatient, Professional). Use this report as a starting point to identify utilization patterns and key plan cost drivers, such as high dollar claimants or excessive/inappropriate utilization of certain services. By including two periods of claims data (if available), trend patterns emerge and the impact of past benefit design changes can be quantified.	
Matches Reports:	The metrics on the Financial Dashboard will match related metrics based on paid dates in other CII reports.	

Report Facts:

General Report Facts	
1	The Financial and Utilization Dashboard is based on paid dates (as opposed to incurred dates like the Clinical Dashboard). However, there is an option for the user to select incurred dates.
2	Only Medical coverage and Pharmacy coverage are contained within the report.
3	The Financial and Utilization Dashboard is comprised of 9 different reports. The majority of reports or quadrants provide comparisons between the current and prior time periods. The Pharmacy Highlights and Medical Summary quadrants are based on current period data only.
4	The Pharmacy section will only be shown if an account has Pharmacy coverage through Anthem (i.e., external Pharmacy data is not included in this report).
5	The benchmark refers to the CII 2.0 Anthem Book of Business *excluding Medicare Primary*.
Q1- Medical and Pharmacy Paid Amount Summary	
1	The Prior Trend is calculated based on the Prior Period 1 vs. the Prior Period 2.
2	If an account does not have pharmacy coverage, the Pharmacy and Total Paid Amount rows will be suppressed and the following message will appear "Results are not shown because the current period average pharmacy membership is 0, which is less than the threshold of 30."
3	As of October 2015, a new Payment Innovation section has been added to the Medical and Pharmacy Paid Amount Summary table. The Payment Innovation section represents dollars for both the Clinical Coordination and Shared Savings financials for Blue Distinction Total Care (BDTC)/Enhanced Personal Health Care (EPHC).
4	This is the only quadrant on the Financial Dashboard that includes payment innovation information. This information is not included in the HCC section or in any other quadrants.
5	The Clinical Coordination data is available from January 1, 2013 forward and the Shared Savings data is available from January 1, 2014 forward. It is important to point out that, depending on the time period selected, the trend percentages may be impacted.
6	Payments may be billed as enhanced fee schedules or as S&G claims. These payments will appear as regular claims expenses to the customer. Payments may also be billed to customers as a per

	attributed per month (PaMPM) payment that appears under "Other Provider Payments" on the invoice. This is the information that will be summarized in the payment innovation section of the report.
7	Payment innovation financials reflect historical corrections in the month during which the correction is made. As a result, claims are not retroactively adjusted and the financials may appear higher or lower for a particular month if there is a lot of adjustment activity.
8	If the payment innovation dollars are $0 in both the current and prior periods, the entire Payment Innovation section (i.e., all rows and section header) will be suppressed.
Q2-High Cost Claimants with Paid Amounts > $XX,XXX	
1	The default paid amount threshold chosen for the High Cost Claimant reports will also be used in this HCC quadrant of the Dashboard.
2	The Percent Paid In Network is constrained by the *Network Provider* Indicator = 'Y'.
3	The High Cost Claimant Summary section is based on both medical coverage and pharmacy coverage except for the 'Total HCC Paid Amount Med'.
4	If an account does not have pharmacy coverage, the Pharmacy PMPM and PEPM rows will be suppressed and the following message will appear "Results are not shown because the current period average pharmacy membership is 0, which is less than the threshold of 30."
5	Since this HCC quadrant includes both Medical and Pharmacy claims, it may not match the F-02 Medical Paid Claims Distribution Report's Current Paid Amount Thresholds summaries (i.e., $25,000 and above, $50,000 and above, etc.) since that report is based on Medical claims only. The Medical Paid Claims Distribution report totals will be lower because only those with medical claims over the threshold will be counted. The Financial Dashboard and the HCC reports are both counting Medical and Pharmacy to determine members over the threshold.
Q3-Membership Summary	
1	The member count percentages are based on the number of medical and/or pharmacy members enrolled as of the end of the reporting period.
Q4-Relationship Highlights	
1	This quadrant displays the total membership count by relationship (subscriber, spouse, dependent, and unassigned).
2	A pie chart displaying the breakdown of the paid medical dollars by member relationship by subscriber, spouse, dependent, and unassigned.
3	'Unassigned' is used when a relationship value is missing.
Q5-Medical Membership Summary by Age Band and Gender	
1	This quadrant provides a summary view of the group's population based on age range and gender. If a gender is unknown or unassigned, it is excluded from this summary. The percentage of total membership for each age range is displayed for females vs. males. The distribution by age range is helpful in understanding the utilization data, particularly clinical expenses that may be more prevalent for certain age groups. Average age by relationship is provided in this quadrant.
2	This table also shows the average age for total subscribers/employees and members. This information is useful in understanding the demographics of the group.
3	Below the Medical Membership Overview graph there is a small table showing the Average Medical and Pharmacy Paid Per Claimant for the current vs. prior period for males vs. females. If an account does not have pharmacy coverage, the title will say 'Average Medical Paid Per Claimant'.
Q6-Utilization Breakdown	
1	This report provides a high level overview of the most commonly cited utilization metrics for the Inpatient Facility, Outpatient Facility and Professional settings.
2	In the Inpatient Facility section, only *Acute* Admits and Days are counted in this sub-section and are labeled as such. Acute care refers to a pattern of health care in which a patient is treated for a brief but severe episode of illness, or for treatment following accidental injury or other trauma or during recovery from surgery. Acute care is usually given in a hospital by specialized personnel and it may

	involve intensive or emergency care. This pattern of care is often necessary for only a short time, unlike chronic or custodial care that may be administered in a rehabilitation, long-term care or skilled nursing facility.
Q7-Paid Amount by Setting	
1	There is a Paid Amount by Setting bar graph comparing the Paid Amount PMPM for three time periods.
Q8-Paid Claims Distribution	
1	The Paid Claims Distribution graph shows the percentage of claimants and paid claims with medical and/or pharmacy coverage that are within the dollar ranges indicated on the graph for the current and prior reporting periods.
2	Each claimant is included only once in the Paid Range that corresponds to the amount paid for that claimant.
3	The available paid amount ranges in the report are as follows: < $0 $0 - $249 $250 - $999 $1,000 - $4,999 $5,000 - $9,999 $10,000 - $24,999 $25,000 - $49,999 $50,000 - $99,999 > $99,999
Q9-Pharmacy Highlights	
1	The top ten drugs selected in the Pharmacy Highlights section are based on the highest Rx paid amounts and are listed in descending order of paid amount.
2	This quadrant is based on the Current Period only. There is no Prior Period comparison.
3	If an account does not have pharmacy coverage, this quadrant will be suppressed on the Dashboard and the following message will appear "Results are not shown because the current period average pharmacy membership is 0, which is less than the threshold of 30."

Glossary:

Term	Description
Medical and Pharmacy Paid Amount Summary	
Blue Distinction Total Care (BDTC)	BDTC establishes value based provider contracts that reimburse providers for demonstrated improvements in patient health outcomes and cost efficiencies. BDTC is the brand name for all value based payment innovation models across all blues plans, both Anthem Inc. and non-Anthem Inc. plans. The Anthem Inc. Enhanced Personal Health care (EPHC) model is a part of BDTC.
Enhanced Personal Health Care (EPHC)	EPHC is the Anthem Inc. brand name for our patient centered medical home model. The EPHC brand name is applicable in the 14 Anthem Inc. plan state local markets. This value-based reimbursement payment innovation model reimburses providers for demonstrable improvements in patient health outcomes and cost efficiency as opposed to the traditional fee for service provider contract. See Blue Distinction Total Care (BDTC) definition for additional information.
Paid Amount	Paid Amount is the net benefit issued for services provided under the Plan. It represents the amount Paid after all pricing guidelines have been applied, including provider discounts, and all non-covered, third-party/Medicare, copayment,

	coinsurance and deductible amounts have been subtracted. Health Reimbursement Account (HRA) payments are included in the paid amount (if selected).
Paid Amount Per Member Per Month (PMPM)	The average amount paid per member per month. It is a financial measure that is derived by dividing Paid Amount by Member Months. It is most commonly used as an indicator of financial trend.
Paid Amount Per Employee Per Month (PEPM)	The average amount paid per employee per month. It is a financial measure that is derived by dividing total Paid Amount by total Employee Months.
Payment Innovation	The Payment Innovation section of the Medical and Pharmacy Paid Amount Summary table is new (added October 2015) and contains the paid amounts and PMPMs for both the clinical coordination and provider performance (shared savings) payments. The entire payment innovation section will be suppressed if there is no payment innovation paid amount activity in the current and prior periods.
Payment Innovation Paid Amount	The amount paid for both the clinical coordination and provider performance (shared savings) payments for Blue Distinction Total Care (BDTC)/Enhanced Personal Health Care (EPHC). Clinical coordination payments compensate providers for the medical services they deliver outside of face-to-face patient visits. Those services could include care planning, maintaining health registries, enhancing access (such as responding to emails or offering web-based visits) or following up with patients via phone or email to make sure that they are engaged in their health care. This type of proactive clinical coordination improves health and reduces costs. Provider performance payments – also known as shared savings – reward providers for successfully managing the quality and overall health care costs of our members participating in these programs. Clinical quality metrics are focused on such aspects of care as managing chronic conditions and compliance with preventive health guidelines (e.g., preventive health screenings, vaccinations, etc.) while the cost evaluation examines the relative savings associated with delivering care (e.g., reducing costs for diabetic patients, fewer avoidable ER visits, fewer readmissions, etc.).
Payment Innovation PMPM	The average amount paid for payment innovation per member per month. It is a financial measure that is derived by dividing the total payment innovation paid amount by total medical member months. Note that this report includes payment innovation PMPM rather than per attribution member per month (PaMPM).
Total Paid Amount with Payment Innovation	This represents the total amount paid for medical and pharmacy plus the payment innovation paid amount.
Total PMPM with Payment Innovation	The average amount paid for medical, pharmacy and payment innovation per member per month. It is a financial measure that is derived by dividing the total paid amount with payment innovation by the total *medical* member months.
Period	The time period that the report is based on.
Trend	Trend is the percent change of any metric from the prior period to the current period. To calculate Trend subtract the prior period value from the current period value and then divide the result by the prior period value.
High Cost Claimants with Paid Amounts > $X	
High Dollar Claimant Paid Amount	The paid amount for members who have had claims in excess of the high cost claimant threshold during the reporting period.

High Dollar Claimant Paid Amount PEPM	PEPM (Per Employee Per Month) is the average amount paid per employee per month for members who have had claims in excess of our high cost claimant threshold during the reporting period. It is a financial measure that is derived by dividing total Paid Amount by total Member Months. It is most commonly used as an indicator of financial trend.
High Dollar Claimant Paid Amount PMPM	PMPM (Per Member Per Month) is the average amount paid per member per month for members who have had claims in excess of our high cost claimant threshold during the reporting period. It is a financial measure that is derived by dividing total Paid Amount by total Member Months. It is most commonly used as an indicator of financial trend.
Large Claimants > $X Percent of Total Paid Amount	Amount paid for members who exceeded the high cost claimant threshold, expressed as a percentage of total paid. Default threshold is $50,000, but can be modified.
Large Claimants > $50,000 Percent of Total Paid amount	Amount paid for members who exceeded the high cost claimant threshold, expressed as a percentage of total paid. Default threshold is $50,000, but can be modified.
Large Claimants > $50,000 Percent of All Members	Number of Members who exceeded the high cost claimant threshold, expressed as a percentage of the total of all members. Default threshold is $50,000, but can be modified.
Paid Amount	Paid Amount is the net benefit issued for services provided under the Plan. It represents the amount Paid after all pricing guidelines have been applied, including provider discounts, and all non-covered, third-party/Medicare, copayment, coinsurance and deductible amounts have been subtracted. Health Reimbursement Account (HRA) payments are included in the paid amount (if selected).
Paid Amount Per Employee Per Month (PEPM)	The average amount paid per employee per month. It is a financial measure that is derived by dividing total Paid Amount by total Employee Months.
Paid Amount Per Member Per Month (PMPM)	The average amount paid per member per month. It is a financial measure that is derived by dividing Paid Amount by Member Months. It is most commonly used as an indicator of financial trend.
Period	The time period that the report is based on.
Trend	Trend is the percent change of any metric from the prior period to the current period. To calculate Trend subtract the prior period value from the current period value and then divide the result by the prior period value.
Membership Summary	
Commercial Benchmark	Benchmark refers to a normative value against which plan metrics are compared. Benchmarks in CII include data from all Anthem accounts in the Client Information Insights database. The benchmark excludes Anthem Medicare Primary members.
Contract Size	The average number of members per contract (e.g., employees/subscribers). This represents the average family size for a group.
Members	Members represent all employees and dependents, eligible for coverage under a plan of benefits during the time period represented.
Period	The time period that the report is based on.
Subscriber(s)	Subscribers are the Contract holders for the Plan. Subscribers are usually Employees.
Trend	Trend is the percent change of any metric from the prior period to the current period. To calculate Trend subtract the prior period value from the current period value and then divide the result by the prior period value.
Relationship Highlights	

Child/Other Dependent	Represents the child or other dependent eligible for coverage under the subscriber's benefit plan.
Employee/Self	Represents the employee or subscriber who holds coverage.
Members	Members represent all employees and dependents, eligible for coverage under a plan of benefits during the time period represented.
Paid Amount	Paid Amount is the net benefit issued for services provided under the Plan. It represents the amount Paid after all pricing guidelines have been applied, including provider discounts, and all non-covered, third-party/Medicare, copayment, coinsurance and deductible amounts have been subtracted. Health Reimbursement Account (HRA) payments are included in the paid amount (if selected).
Relationship	The relationship of the member to the contract holder. The values are Employee/Self, Spouse/Partner, Child/Other Dependent or Unassigned.
Spouse/Partner	Represents the wife, husband or domestic partner eligible for coverage under the subscriber.
Medical Membership Summary by Age Band and Gender	
Age Range	This refers to the grouping of members into pre-defined age brackets.
Gender	The sex of the member (i.e., Male or Female).
Utilization Breakdown	
Acute Admissions	Admissions that took place in an Acute Inpatient Hospital Facility are for conditions that would not be considered long term (e.g., residential treatment admissions, skilled nursing facility). Acute represents a pattern of health care in which a patient is treated for a brief but severe episode of illness. Acute care is usually given in a hospital by specialized personnel and it may involve intensive or emergency care. This pattern of care is often necessary for only a short time, unlike chronic care.
Acute Admissions per 1000	The number of admissions for acute care per 1000 members with medical coverage.
Acute Average Length of Stay	The average length of hospital stay for acute inpatient admissions for the reporting period. It is derived by dividing the total acute days by total acute stays/admissions.
Acute Days per 1000	The number of days for acute admissions per 1000 members enrolled with medical coverage.
Period	The time period that the report is based on.
Professional Services	Professional Services refers to the category of services rendered by professional outside of an Inpatient or Outpatient Facility. Included are services provided by physicians and non-physicians, psychologists, nurse practitioners, optometrists, home health, therapists and others.
Services per 1000	The number of services rendered by a provider per 1000 members with medical coverage.
Visit	The number of visits is based on the count of unique patients, service dates, and provider combinations. For claims that have had adjustments, visits will be reported with the most recent iteration of the claim (as opposed to following the dollars as they are adjusted).
Visits per 1000	A utilization measure that refers to the average annualized number of Visits per 1000 members eligible for coverage for the period.
Paid Amount by Setting	

Inpatient	Inpatient refers to the facility provider and to claims for services provided under the medical coverage in an inpatient setting. Unless otherwise noted an Inpatient Facility could be Acute, Non-Acute or a Long Term Care Facility.
Outpatient	Identifies a facility provider type or site of service where non-inpatient services are provided.
Paid Amount Per Member Per Month (PMPM)	The average amount paid per member per month. It is a financial measure that is derived by dividing Paid Amount by Member Months. It is most commonly used as an indicator of financial trend.
Period	The time period that the report is based on.
Pharmacy Paid PMPM	The average amount paid for Pharmacy per member per month. It is a financial measure that is derived by dividing total Pharmacy Paid Amount by total Pharmacy Member Months.
Professional	Professional refers to a provider of medical services rendered, other than by an Inpatient or Outpatient Facility. Included are physicians and non-physicians, psychologists, nurse practitioners, optometrists, home health, therapists and others.
Paid Claims Distribution	
Paid Amount	Paid Amount is the net benefit issued for services provided under the Plan. It represents the amount Paid after all pricing guidelines have been applied, including provider discounts, and all non-covered, third-party/Medicare, copayment, coinsurance and deductible amounts have been subtracted. Health Reimbursement Account (HRA) payments are included in the paid amount (if selected).
Paid Amount Range	Paid Amount Range refers to distinct dollar range groupings based on individual member paid claims.
Percent of Total Claimants	This metric is derived by dividing the unique claimant count in each diagnosis range by the total number of unique claimants.
Period	The time period that the report is based on.
Unique Claimants	A unique count of members who have incurred expenses under the plan and have submitted a claim.
Pharmacy Highlights	
Drug Name	The product name for the prescription.
Paid Amount - Total Pharmacy	Paid Amount is the net benefit issued for services provided under the Plan for Pharmacy claims. It represents the amount Paid after all pricing guidelines have been applied, including provider discounts, and all non-covered, third-party/Medicare, copayment, coinsurance and deductible amounts have been subtracted. Health Reimbursement Account (HRA) payments are included in the paid amount (if selected).
Paid Per Script	Paid Per Script is the average net paid amount per prescription dispensed. This measure is derived by dividing the total net paid amount for all prescriptions by the total number of prescriptions.
Percent of Total Paid Amount	The percent of Total Paid Amount is calculated by dividing the amount paid for the category by the total paid amount, expressed as a percentage.
Scripts	The number of individual prescriptions associated with all Pharmacy claims for the period.

D-02 – Clinical Dashboard

Report Number:	D-02	
Report Section:	Dashboards	
Report Name:	Clinical Dashboard (Incurred Medical Claims)	
Time View:	Incurred Dates w/an option for user to select Paid	
Pre-defined* Paid Amount Parameter Available?	The following options are available: Standard Reporting Paid Amount + HRA – *Default* Reporting Paid Amount	
Pre-defined* Time Period Parameter Available?	The following options are available: Rolling 12 months – *Default* Rolling 3 months Plan year to date Calendar year to date	
Fully Insured/ASO Account Status:	Available for both Fully Insured and ASO Accounts	
Report Suppression Rules:	If the average <u>medical</u> membership in the current period for a client segment is less than 30, the report will be suppressed. If the average <u>pharmacy</u> membership in the current period for a client segment is less than 30, the report will be suppressed.	
Cell Level Suppression Rules:	None	
Early or Standard Report Production?	<u>Early</u> *<u>(By End of 2nd Week of Month)</u>*	<u>Standard</u> *<u>(By End of 4th Week of Month)</u>* ✓
Hover Description:	Clinical metrics summary including Health Risk Index	
Report Description and Analytic Notes:	Provides a summary of incurred and paid claims for the leading targeted program conditions, health conditions, and lifestyle related conditions, along with a Health Risk Index. Use this report to view a Health Risk Index measuring the group's risk score (based upon paid claims data) compared to the Book of Business (BOB) benchmark. A higher score than '1' indicates a higher level of utilization and a higher level of risk; a score lower than '1' indicates lower risk. Use this report to identify specific prevalent health conditions impacting the costs and utilization for the group.	
Matches Reports:	The metrics on the Clinical Dashboard will match related metrics based on incurred dates in other CII 2.0 reports.	

<u>Report Facts</u>:

General Report Facts	
1	The Clinical Dashboard is based on incurred dates (as opposed to paid dates like the Financial and Utilization Dashboard). The one exception is the Top Health Conditions by paid amount quadrant which is based on paid dates.
2	There is an option for the user to select Paid dates.
3	All of the metrics in the Clinical Dashboard exhibits are based on Medical claims only since Pharmacy claims do not contain diagnoses.
4	The Clinical Dashboard is comprised of 4 different report exhibits. All of the exhibits display metrics

	for the current time period, prior time period and Benchmark.
5	The current period will always include 3 months of claims lag in order for the majority of claims to be captured.
6	The benchmark refers to the CII 2.0 Anthem Book of Business *excluding Medicare Primary*.
Q1-Top Five Target Program Conditions Compared to Benchmark – Prevalence per 1000 for Targeted Program Conditions	
1	Target program conditions are based on Clinical Conditions which classify every principal diagnosis into one of 200 conditions. There are 10 Target Program Conditions. From the list of 10, the top five, based on paid amounts, are displayed in the Clinical Dashboard report.
2	Target program conditions are those health conditions that are persistent or otherwise long-lasting in their effects. Many highlighted in this report are the most costly among all conditions and are a leading cause of death.
3	For this report, the list of Target Program Conditions include the following: Asthma Cancer Maternity Coronary Artery Disease Hypertension Depression Diabetes Congestive Heart Failure (CHF) Chronic Obstructive Pulmonary Disease (COPD) Low Back Pain
4	The Top Five Targeted Program Conditions report displays the prevalence per 1000 (based on paid amount) for target program conditions in the current and prior periods compared to the benchmark.
5	The difference between this quadrant and quadrant 3 is that this report shows prevalence per 1000 for targeted program conditions.
6	The 'Percent of Claims Paid for Target Program Conditions' graph is based on the 'Percent of Paid Amount for Target Program Conditions'.
Q2-Top Five Health Conditions by Claims Paid and Relationship – This report is based on paid amount	
1	Each of the categories on this report is based on a range of ICD (International Classification of Diseases) codes.
2	For each of the top five Health Condition categories on this summary report, there is a graphic display of the relative paid amounts, shown as a percentage, by Subscriber, Spouse and Child.
Q3-Top Five Target Program Conditions Compared to Benchmark – Percent of Claims Paid for Targeted Program Conditions	
1	Target program conditions are based on Clinical Conditions which classify every principal diagnosis into one of 200 conditions. There are 10 Target Program Conditions. From the list of 10, the top five, based on paid amounts, are displayed in the Clinical Dashboard report.
2	Target program conditions are those health conditions that are persistent or otherwise long-lasting in their effects. Many highlighted in this report are the most costly among all conditions and are a leading cause of death.
3	For this report the list of Targeted Program Conditions include the following: Asthma Cancer Maternity Coronary Artery Disease Hypertension Depression Diabetes

	Congestive Heart Failure (CHF) Chronic Obstructive Pulmonary Disease (COPD) Low Back Pain
4	The Top Five Target Program Conditions report displays the percentage of claims paid for target program conditions in the current and prior periods compared to the benchmark.
5	The difference between this quadrant and quadrant 1 is that this report shows percent of claims paid for targeted program conditions.
Q4-Health Risk Index	
1	The Health Risk Index is a measure that shows a projection of the population's likely level of risk indicated and is calculated based on the population's age, gender, and diagnoses reported on claims. A higher score than '1' indicates a higher level of utilization and a higher level of risk; a score lower than '1' indicates lower risk.
2	The Health Risk Index for the group displays the current period and prior period compared to the Anthem benchmark as noted above in the general report facts section.
3	The Benchmark Health Risk Index represents a standard or norm and is set at 1.00 on this report. A group with a higher risk score than Benchmark would indicate that the group's population is less healthy than the overall Benchmark population.
4	The Health Risk Index uses data that are age/sex adjusted.
5	This quadrant is based on incurred and paid claims during a specific time period.

Glossary:

Term	Description
Top Five Target Programs Conditions Compared to Benchmark	
Commercial Benchmark	Benchmark refers to a normative value against which plan metrics are compared. Benchmarks in CII include data from all Anthem accounts in the Client Information Insights database. The benchmark excludes Anthem Medicare Primary members.
Paid Amount	Paid Amount is the net benefit issued for services provided under the Plan. It represents the amount Paid after all pricing guidelines have been applied, including provider discounts, and all non-covered, third-party/Medicare, copayment, coinsurance and deductible amounts have been subtracted. Health Reimbursement Account (HRA) payments are included in the paid amount (if selected).
Period	The time period that the report is based on.
Prevalence	The proportion of the population found to have a condition. It is derived by comparing the number of claimants found to have the condition with the total number of members, and is expressed per 1000 members.
Prevalence per 1000	The average number of patients who received services provided under medical coverage, per 1000 unique members with medical coverage.
Target Program Conditions	A defined list of conditions that have Anthem programs such as Asthma, Diabetes, COPD, CAD, CHF, etc.
Top Five Health Conditions by Claims Paid and Relationship	
Child/Other Dependent	Represents the child or other dependent eligible for coverage under the subscriber's benefit plan.
Commercial Benchmark	Benchmark refers to a normative value against which plan metrics are compared. Benchmarks in CII include data from all Anthem accounts in the Client Information Insights database. The benchmark excludes Anthem Medicare Primary members.
Employee/Self	Represents the employee or subscriber who holds coverage.
Health Conditions	A range of diagnosis codes classified together into a Health Condition Category (e.g.,

Category	Neoplasms, Injury and Poisoning, etc.).
Paid Amount	Paid Amount is the net benefit issued for services provided under the Plan. It represents the amount Paid after all pricing guidelines have been applied, including provider discounts, and all non-covered, third-party/Medicare, copayment, coinsurance and deductible amounts have been subtracted. Health Reimbursement Account (HRA) payments are included in the paid amount (if selected).
Percent of Total Paid Amount	The percent of Total Paid Amount is calculated by dividing the amount paid for the category by the total paid amount, expressed as a percentage of total paid.
Period	The time period that the report is based on.
Relationship	The relationship of the member to the contract holder. The values are Employee/Self, Spouse/Partner, Child/Other Dependent or Unassigned.
Spouse/Partner	Represents the wife, husband or domestic partner eligible for coverage under the subscriber.
Top Five Target Program Conditions Compared to Benchmark	
Commercial Benchmark	Benchmark refers to a normative value against which plan metrics are compared. Benchmarks in CII include data from all Anthem accounts in the Client Information Insights database. The benchmark excludes Anthem Medicare Primary members.
Paid Amount	Paid Amount is the net benefit issued for services provided under the Plan. It represents the amount Paid after all pricing guidelines have been applied, including provider discounts, and all non-covered, third-party/Medicare, copayment, coinsurance and deductible amounts have been subtracted. Health Reimbursement Account (HRA) payments are included in the paid amount (if selected).
Percent of Total Paid Amount	The percent of Total Paid Amount is calculated by dividing the amount paid for the category by the total paid amount, expressed as a percentage.
Period	The time period that the report is based on.
Target Program Conditions	A defined list of conditions that have Anthem programs such as Asthma, Diabetes, COPD, CAD, CHF, etc.
Health Risk Index	
Commercial Benchmark	Benchmark refers to a normative value against which plan metrics are compared. Benchmarks in CII include data from all Anthem accounts in the Client Information Insights database. The benchmark excludes Anthem Medicare Primary members.
Health Risk Index	The Health Risk Index is a diagnostic and age/sex adjusted projection of the populations likely level of risk for the period indicated. The Benchmark is presented for comparison. A higher score than ‘1’ indicates a higher level of utilization and a higher level of risk; a score lower than ‘1’ indicates lower risk.
Period	The time period that the report is based on.
Variance to Commercial Benchmark	The difference between the group's current period value and the commercial benchmark.

F-01 – Membership and Paid Amount by Month

Report Number:	F-01	
Report Section:	Financial Reports	
Report Name:	Membership and Paid Amount by Month	
Time View:	Paid Dates w/an option for user to select Incurred	
Paid Amounts Available:	The following options are available: • Standard Reporting Paid Amount + HRA – *Default* • Reporting Paid Amount	
Time Period :	This report always shows the most recent 36 months of data.	
Fully Insured/ASO Account Status:	Available for both Fully Insured and ASO accounts	
Report Suppression Rules:	None. Tables within the report will not display when the following criteria are met: • If both the average medical membership and the average pharmacy membership are 0, then suppress the "Medical and Pharmacy" table • If both the average dental membership and the average vision membership are 0, then suppress the "Specialty Products" (dental and vision) table • Payment Innovation columns will not display when the Payment Innovation dollars are $0 in both the current and prior periods. • If the medical capitation dollars are $0 in both current and prior periods, the entire Medical Capitation column will be suppressed	
Cell Level Suppression Rules:	None	
Early or Standard Report Production?	Early *(By End of 2nd Week of Month)* ✓	Standard *(By End of 4th Week of Month)*
Hover Description:	Member/subscriber counts and paid amounts by month, including summaries by YTD and CY quarter.	
Report Description and Analytic Notes:	Displays a month by month view plus Current YTD totals and totals for the last five quarters of the group's membership and financials for the "Segment" (population) reflected in the report. Data provided is for the most recent 36 months. Use this report to view your group's plan YTD or Quarterly membership and financials. Information includes PMPM and PEPM averages for multiple variations of time periods to determine trends or view YTD experience.	
Matches Reports:	The membership and paid amounts, excluding Payment Innovation amounts, in this report are intended to match the membership and paid amounts in other reports in the package when comparing the same time period and segment of the group's population. Payment Innovation amounts will match the Financial Dashboard, the only other report with these financials. The monthly medical capitation amounts on the F-01 Membership and Paid Amount by Month report will match the monthly medical capitation amounts on the F04 Premium and Expense Summary report for WGS groups with capitation payment arrangement.	

Report Facts:

1	This report includes Medical, Pharmacy, Dental and Vision subscribers, members and paid amounts by month for the most recent 36 months.
2	Year to date (YTD) and quarterly subtotals are available. Note that subtotals may not be a full quarter depending on date run, i.e. the "QTR" member month's totals are based on the time period selected. For example if the Report Period is based on February through January, the "QTR 1 yyyy" total for the prior period will include the February and March member months, not January, February and March.
3	This report is an 'early view' report meaning that it is available earlier in the month than some of the other standard reports (i.e., by the end of the 2nd week of the month).
4	As of October 2015, new Payment Innovation columns were added. The Payment Innovation section represents dollars for both the Clinical Coordination and Shared Savings financials for Blue Distinction Total Care (BDTC)/Enhanced Personal Health Care (EPHC).
5	The Clinical Coordination data is available from January 1, 2013 forward and the Shared Savings data is available from January 1, 2014 forward.
6	Payment Innovation financials reflect historical corrections in the month during which the correction is made. As a result, claims are not retroactively adjusted and the financials may appear higher or lower for a particular month if there is considerable adjustment activity.
7	If the Payment Innovation dollars are $0 in both the current and prior periods, the entire Payment Innovation section (i.e., all rows and section header) will be suppressed.
8	As of June 2016, a medical capitation column was added for WGS groups with capitation payment arrangements

Glossary:

Term	Description
Member Months	The sum of members for each month for the reporting period. Only members covered at the end of each month are counted.
Medical Subscribers	The number of subscribers with medical coverage by month.
Medical Members	The number of members (includes subscribers) with medical coverage by month.
Pharmacy Subscribers	The number of subscribers with pharmacy coverage by month.
Pharmacy Members	The number of members (includes subscribers) with pharmacy coverage by month.
Dental Subscribers	The number of subscribers with dental coverage by month.
Dental Members	The number of members (includes subscribers) with dental coverage by month.
Vision Subscribers	The number of subscribers with vision coverage by month.
Vision Members	The number of members (includes subscribers) with vision coverage by month.
Paid Amounts	Paid Amount is the net benefit issued for services provided under the Plan. It represents the amount paid after all pricing guidelines have been applied, including provider discounts, and all non-covered, third-party/Medicare, copayment, coinsurance and deductible amounts have been subtracted. Health Reimbursement Account (HRA) payments are included in the paid amount if selected. The Total Payment Innovation column represents the paid amount for clinical coordination and provider performance (shared savings).
Total Medical	Paid Amount is the net benefit issued for services provided under the Plan for Medical claims. It represents the amount paid after all pricing guidelines have been applied, including provider discounts, and all non-covered, third-party/Medicare,

	copayment, coinsurance and deductible amounts have been subtracted. Health Reimbursement Account (HRA) payments are included in the paid amount if selected.
Total Pharmacy	Paid Amount is the net benefit issued for services provided under the Plan for Pharmacy claims. It represents the amount paid after all pricing guidelines have been applied, including provider discounts, and all non-covered, third-party/Medicare, copayment, coinsurance and deductible amounts have been subtracted. Health Reimbursement Account (HRA) payments are included in the paid amount if selected.
Total Dental	Paid Amount is the net benefit issued for services provided under the Plan for Dental claims. It represents the amount paid after all pricing guidelines have been applied, including provider discounts, and all non-covered, third-party/Medicare, copayment, coinsurance and deductible amounts have been subtracted.
Total Vision	Paid Amount is the net benefit issued for services provided under the Plan for Vision claims. It represents the amount paid after all pricing guidelines have been applied, including provider discounts, and all non-covered, copayment, coinsurance and deductible amounts have been subtracted.
Medical PMPM	The average amount paid per member per month. It is a financial measure that is derived by dividing Total Medical under Paid Amounts by Medical Members under Member Months.
Payment Innovation PMPM	The average amount paid for Payment Innovation per member per month. It is a financial measure that is derived by dividing the Total Payment Innovation under Paid Amounts by Total Medical under Member Months. Note that this report includes Payment Innovation PMPM rather than per attribution member per month (PaMPM).
Pharmacy PMPM	The average amount paid per member per month. It is a financial measure that is derived by dividing Total Pharmacy under Paid Amounts by Pharmacy Members under Member Months.
Dental Paid PMPM	The average amount paid per member per month. It is a financial measure that is derived by dividing Total Dental under Paid Amounts by Dental Members under Member Months.
Vision Paid PMPM	The average amount paid per member per month. It is a financial measure that is derived by dividing Total Vision under Paid Amounts by Vision Members under Member Months.
Medical PEPM	The average amount paid per subscriber (employee) per month. It is a financial measure that is derived by dividing Total Medical under Paid Amounts by Medical Subscribers under Member Months.
Pharmacy PEPM	The average amount paid per subscriber (employee) per month. It is a financial measure that is derived by dividing Total Pharmacy under Paid Amounts by Pharmacy Subscribers under Member Months.
Dental Paid PEPM	The average amount paid per subscriber (employee) per month. It is a financial measure that is derived by dividing Total Dental under Paid Amounts by Dental Subscribers under Member Months.
Vision Paid PEPM	The average amount paid per subscriber (employee) per month. It is a financial measure that is derived by dividing Total Vision under Paid Amounts by Vision Subscribers under Member Months.
Total Payment Innovation	The amount paid for both the clinical coordination and provider performance (shared savings) payments for Blue Distinction Total Care (BDTC)/Enhanced Personal Health Care (EPHC).

	Clinical coordination payments compensate providers for the medical services they deliver outside of face-to-face patient visits. Those services could include care planning, maintaining health registries, enhancing access (such as responding to emails or offering web-based visits) or following up with patients via phone or email to make sure that they are engaged in their health care. This type of proactive clinical coordination improves health and reduces costs. Provider performance payments – also known as shared savings – reward providers for successfully managing the quality and overall health care costs of our members participating in these programs. Clinical quality metrics are focused on such aspects of care as managing chronic conditions and compliance with preventive health guidelines (e.g., preventive health screenings, vaccinations, etc.) while the cost evaluation examines the relative savings associated with delivering care (e.g., reducing costs for diabetic patients, fewer avoidable ER visits, fewer readmissions, etc.).
Total Paid Amount with Payment Innovation	This represents the total amount paid for Medical and Pharmacy plus the Payment Innovation paid amount.
Blue Distinction Total Care (BDTC)/Enhanced Personal Health Care (EPHC)	BDTC establishes value based provider contracts that reimburse providers for demonstrated improvements in patient health outcomes and cost efficiencies. BDTC is the brand name for all value based payment innovation models across all blues plans, both Anthem Inc. and non-Anthem Inc. plans. The Anthem Inc. Enhanced Personal Healthcare (EPHC) model is a part of BDTC. EPHC is the Anthem Inc. brand name for our patient centered medical home model. The EPHC brand name is applicable in the 14 Anthem Inc. plan state local markets. This value-based reimbursement payment innovation model reimburses providers for demonstrable improvements in patient health outcomes and cost efficiency as opposed to the traditional fee for service provider contract.
Medical Capitation	Represents the total pre-negotiated paid amount for health care services.

F-01A – Medical Paid Amounts and Plan Savings

Report Number:	F-01A	
Report Section:	Financial Reports	
Report Name:	Medical Paid Amounts and Plan Savings	
Time View:	Paid Dates w/an option for user to select Incurred	
Time Periods Available:	The following options are available: • Rolling 12 months – *Default* • Rolling 3 months • Plan year to date • Calendar year to date	
Fully Insured/ASO Account Status:	Available for both Fully Insured and ASO Accounts	
Report Suppression Rules:	This report will be suppressed if the medical **or** pharmacy membership is less than 30.	
Cell Level Suppression Rules:	None	
Early or Standard Report Production?	Early *(By End of 2nd Week of Month)*	Standard *(By End of 4th Week of Month)* ✓
Hover Description:	Medical costs by setting and network status	
Report Description and Analytic Notes:	Provides a breakdown of submitted medical charges by covered, non-covered, cost sharing (copay, deductible, and coinsurance), discounts, etc. by setting (Inpatient, Outpatient, Professional) and In/Out of Network. Use this report when you need to understand the financial flow from charges to paid amount.	
Matches Reports:	The In and Out of Network and Total Paid Amounts on this report will match to the In and Out of Network and Total Paid Amounts on the Utilization by Setting Paid View report. The Inpatient dollars in this report include all dollars for both Acute and Non-Acute Inpatient claims. It will not match the inpatient total in any report that just includes Acute Stays such as Inpatient Facility Utilization by Service Category.	

Report Facts:

1	The report is broken into three sections (rows): a) Breakdown of in and out of network claims by setting; b) Summarized total of the first section for In and Out of Network totals only; and c) Summary of the savings and discount amounts. This section does not total to the above as it excludes third party and Medicare payments.
2	Deductible, copayment, and coinsurance member cost shares are included.
3	To be consistent with all other CII reports, it is essential to include all medical claims, including third-party and Medicare claims, in the upper tables of the report. However, to ensure the validity of the discount percentage calculation, only claims where the employer plan is primary are included in the Discount Calculation table.

4	Report is based on medical coverage only (i.e., pharmacy is not included).
5	The Paid Amount without HRA, the HRA Paid Amount and the Paid Amount with HRA are separate columns on this report so different paid amount options are not required.
6	For WGS accounts with an HMO, encounter claims with zero paid dollars will be excluded from the financial metrics.
6	The Member Cost Share as shown in the Fast Facts section is the sum of deductible, coinsurance, copay (includes patient pay differential amount), and member sanctions penalty amount. The member cost share for WGS groups with HMO products will not include the member liability for encounter claims that have been excluded from this report. This is stated on the report in the Fast Fact for impacted groups.
7	The following Fast Fact and footnote will appear only for WGS groups and any segments that include these products. **Fast Facts:** 1. Your member cost share was $XXX. This may not include the entire cost share for members covered under a capitated arrangement. **NOTE:** Costs and charges for services under a capitated arrangement are primarily excluded from financials, including member out of pocket expenses.

Glossary:

Term	Description
Allowed Amount	Allowed amount represents that portion of the Charge Submitted that is eligible for benefit consideration.
Charge Submitted	The Charge Submitted is the amount billed by the provider for services rendered. It represents the gross charge amount before applying pricing guidelines or deducting third-party, copayment, coinsurance or deductible amounts.
Coinsurance	Coinsurance is a member out of pocket amount, generally expressed as a percentage of the allowed amount, for which the member is responsible.
Copay	Copayment is a member out of pocket amount, usually expressed as a flat dollar amount, for which the member is responsible.
Covered Expense Amount	Covered Expense is the amount to be considered for payment under the plan.
Deductible	Amount of eligible expense a member is responsible for paying each benefit period before the health plan will make payment for eligible benefits.
Discount Amount	Discount is the amount for any plan pricing reductions provided under medical coverage. This includes reasonable and customary charge discounts, negotiated discounts, fee schedule discounts, prompt payment discounts, etc.
Discount Percent	Percent of discount amount based on covered charges for medical services. The Discount percentage includes only cases where Anthem is the primary payer.
HRA Amount	Total Health Reimbursement Account dollars expended during the reporting period for Medical claims (if applicable).
In-Network	In-Network refers to services rendered by participating Network providers (i.e., providers under contract with Anthem to provide services at a discounted rate).

Inpatient Facility	Inpatient Facility refers to the facility provider and to claims for services provided under the medical coverage in an inpatient setting. Unless otherwise noted an Inpatient Facility could be Acute, Non-Acute or a Long Term Care Facility.
Member Cost Share	Member Cost Share is the sum of deductible, coinsurance, copay (includes patient pay differential amount), and member sections penalty amount.
Member Sanctions Penalties Amount	Applicable to all medical claims, this refers to an amount deducted from the Allowed amount prior to the payment of a benefit as a result of member sanctions and penalties such as non-compliance with plan provisions (i.e., Pre-certification).
Non Covered Amount	Represents the portion of the Charge Submitted that is not covered due to plan exclusions. Non-Covered Amounts typically include such items as physician services that are not medically necessary, over the counter medicines, rental costs and fees for television or telephone during a hospital stay.
Other	Other plan specific exclusions not included in any of the other financial columns.
Out-of-Network	Refers to services rendered by non-participating Network providers (i.e., provider not under contract with Anthem).
Outpatient Facility	Identifies a facility provider type or site of service where non-inpatient services are provided. Outpatient Facilities include, but are not limited to, hospital outpatient departments, emergency rooms, free-standing facilities such as ambulatory surgical centers, medical centers, clinics or independent laboratories or imaging centers.
Paid Amount	Paid Amount is the net benefit issued for services provided under the Plan. It represents the amount Paid after all pricing guidelines have been applied, including provider discounts, and all non-covered, third-party/Medicare, copayment, coinsurance and deductible amounts have been subtracted. Health Reimbursement Account (HRA) payments are included in the paid amount (if selected).
Percent of Total	The percent of Total Paid Amount is calculated by dividing the amount paid for the category by the total paid amount, expressed as a percentage.
Professional	Professional refers to a provider of medical services rendered, other than by an Inpatient or Outpatient Facility. Included are physicians and non-physicians, psychologists, nurse practitioners, optometrists, home health, therapists and others.
Third Party Savings / Medicare	The amount paid by other plans as the primary carrier.

F-02 – Medical Paid Claims Distribution

Report Number:	F-02	
Report Section:	Financial Reports	
Report Name:	Medical Paid Claims Distribution	
Time View:	Paid Dates w/an option for user to select Incurred	
Paid Amounts Available:	The following options are available: Standard Reporting Paid Amount + HRA – *Default* Reporting Paid Amount	
Time Periods Available:	The following options are available: Rolling 12 months – *Default* Rolling 3 months Plan year to date Calendar year to date	
Fully Insured/ASO Account Status:	Available for both Fully Insured and ASO Accounts.	
Report Suppression Rules:	This report will be suppressed if the medical **or** pharmacy membership is less than 30.	
Cell Level Suppression Rules:	None	
Early or Standard Report Production?	Early *(By End of 2nd Week of Month)*	Standard *(By End of 4th Week of Month)* ✓
Hover Description:	Claimants and total paid amounts by payment bands showing current, prior and benchmark data	
Report Description and Analytic Notes:	Illustrates the volume of claimants and total claims dollars at various thresholds. Includes a further breakdown for current and prior paid amount thresholds as well as the list of commercial benchmarks. Use this report to demonstrate the impact of large claimants on trend as well as the change in the distribution of claims and claimants (including members with no claims) between periods.	
Matches Reports:	The Paid Amount Totals column for the sum of all of the dollar ranges (i.e., the Total – All Claimants row) will match to the Financial Dashboard Medical Paid Amount.	

Report Facts:

1	This report includes Medical claims and claimants. Pharmacy data is not included in this report.
2	The available paid amount ranges in the report are as follows: < $0 $0 - $999 $1,000 - $1,999 $2,000 - $2,999 $3,000 - $3,999 $4,000 - $4,999 $5,000 - $9,999 $10,000 - $24,999 $25,000 - $49,999

	$50,000 - $74,999 $75,000 - $99,999 $100,000 and over If there are no claimants or paid dollars under any of the above dollar ranges that dollar range category will still show the Paid Amount benchmark. Each claimant is included only once in the Paid Range that corresponds to the amount paid for that claimant.
3	The Current and Prior Paid Amount Threshold summaries are accumulations of the more granular ranges above.
4	A Fast Fact at the top of the report provides a count of total unique members who did not file a claim within the time period represented on the report.
5	The benchmark refers to the CII 2.0 Anthem Book of Business *excluding Medicare Primary*.
6	Since this report is based on Medical claims only, the Current Paid Amount Thresholds summaries (i.e., $25,000 and above, $50,000 and above, etc.) may not match the High Cost Claimant reports or the Financial Dashboard High Cost Claimant quadrant as these two reports include pharmacy.

Glossary:

Term	**Description**
Average Per Claimant	The average paid per claimant is the net amount paid divided by the total number of claimants.
Commercial Benchmark	Benchmark refers to a normative value against which plan metrics are compared. Benchmarks in CII include data from all Anthem accounts in the Client Information Insights database. The benchmark excludes Anthem Medicare Primary members.
Paid Amount	Paid Amount is the net benefit issued for services provided under the Plan. It represents the amount Paid after all pricing guidelines have been applied, including provider discounts, and all non-covered, third-party/Medicare, copayment, coinsurance and deductible amounts have been subtracted. Health Reimbursement Account (HRA) payments are included in the paid amount (if selected).
Paid Amount Range	Paid Amount Range refers to distinct dollar range groupings based on individual member paid claims.
Paid Amount Thresholds	Paid Amount Threshold refers to alternative range groupings of paid amounts and member counts for the current and prior periods.
Percent of Total Claimants	This metric is derived by dividing the unique claimant count in each diagnosis range by the total number of unique claimants.
Percent of Total Paid Amount	The percent of Total Paid Amount is calculated by dividing the amount paid for the category by the total paid amount, expressed as a percentage.
Period	The time period that the report is based on.
Unique Claimants	A unique count of members who have incurred expenses under the plan and have submitted a claim.

F-03 – Medical and Pharmacy Claim Lag

Report Number:	F-03	
Report Section:	Financial Reports	
Report Name:	Medical and Pharmacy Claim Lag	
Time View:	Paid	
Paid Amounts Available:	The following options are available: Standard Reporting Paid Amount + HRA – *Default* Reporting Paid Amount	
Time Period:	This report always shows the most recent 36 months of data.	
Fully Insured/ASO Account Status:	ASO Only. Fully Insured version can be requested on an exception basis.	
Report Suppression Rules:	The following suppression rules apply: This report will be suppressed if the medical **or** pharmacy membership is less than 30. Minimum premium funding is considered the same as ASO funding, therefore, the same rules for ASO will apply. Groups that have a mix of insured and ASO funding should have at least 100 subscribers associated with the ASO funded portion of the plan. In these situations, the lag report would only be produced for the ASO component. Should not be produced for Insured Groups or any Anthem Balanced Funding (ABF) funding types. ABF (defined as a hybrid ASO type of funding) is designed for groups that have less than 100 subscribers but it may get sold for accounts that have more than 100 subscribers.	
Cell Level Suppression Rules:	None	
Early or Standard Report Production?	Early *(By End of 2nd Week of Month)* ✓	Standard *(By End of 4th Week of Month)*
Hover Description:	Paid amounts listed for 36 incurred and 36 paid months, to illustrate claim lag (triangle report)	
Report Description and Analytic Notes:	Displays paid claims dollars by medical, pharmacy, and medical and pharmacy combined. The paid data is displayed by Paid month (columns at the top) and by Incurred month (shown in rows). Use this report to view claims paid and incurred by month and year to help understand payment patterns for calculating IBNR (incurred but not reported) as well as detecting variations in claims processing volume, such as the impact of large claims or system improvements or outages.	
Matches Reports:	The paid amount on the Lag report is intended to match the medical paid amount on other reports in the package when comparing the same time period. The Lag report is a 'paid' report and will not match to any of the reports displaying 'incurred' data. In addition, the Lag report shows the paid data by incurred month. This may cause the user to think the data has been pulled based on the incurred period when it is not.	

Report Facts:

1	Reports will only be produced for ASO accounts (see report suppression rules above).
2	As mentioned above, the Lag Report (aka Triangle Report) is initially only available for Administrative Services Only (ASO) groups. If the group, as a whole, includes Fully Insured Segment(s), that data is included in the Total Account segment (if available) report. Accounts or Segments that are only Fully Insured will not generate a Lag Report.
3	This report is available for Medical Only, Pharmacy Only and Medical and Pharmacy Combined.
4	This report does not offer the Paid/Incurred Time View Parameter option.

Glossary:

Term	Description
Current Period	This is the most recent time period based on date parameters in the report.
Paid Amount	Paid Amount is the net benefit issued for services provided under the Plan. It represents the amount Paid after all pricing guidelines have been applied, including provider discounts, and all non-covered, third-party/Medicare, copayment, coinsurance and deductible amounts have been subtracted. Health Reimbursement Account (HRA) payments are included in the paid amount (if selected).
Paid Month	The month in which the claim dollars were paid.
Incurred Month	The month during which the claim service was rendered.
Incurred Amount	The sum of the paid amounts across the incurred months in each row.

F-04 – Premium and Expense Summary

Report Number:	F-04	
Report Section:	Financial Reports	
Report Name:	Premium and Expense Summary	
Time View:	Paid Date	
Time Periods Available:	The following options are available: • Rolling 12 months - *Default* • Rolling 3 months • Calendar Year to Date • Plan Year to Date	
Fully Insured/ASO Account Status:	Available for Fully Insured	
Report Suppression Rules:	No Report Suppression, but for WGS groups, if the medical capitation dollars are $0 in both current and prior periods, the entire Medical Capitation column will be suppressed.	
Cell Level Suppression Rules:	No Cell Level Suppression	
Early or Standard Report Production?	Early *(By End of 2nd Week of Month)*	Standard *(By End of 4th Week of Month)* ✓
Hover Description:	Month by month view of subscriber and member counts, paid claims amount and premiums by product; for 12 months	
Report Description and Analytic Notes:	This report provides a month by month view of Subscriber and Member Enrollment, Premium and Paid Claims by Medical and Pharmacy for the reporting period.	
Matches Reports:	Medical and Pharmacy Subscribers and Members on this report match the Contracts and Member Counts on the Enrollment and Demographics report. The overall totals in the Paid Claims table for each individual Product Type will match to other reports that include paid amounts by product. The monthly medical capitation amounts on the F-01 Membership and Paid Amount by Month report will match the monthly medical capitation amounts on the F04 Premium and Expense Summary report for WGS groups with capitation payment arrangement.	

Report Facts:

1	The Product Type valid values are Medical, Pharmacy and Unassigned. Unassigned will include where Product Type is unavailable.
2	The Subscriber and Member counts, for both Medical and Pharmacy, are based on enrollment counts for active members as of the last day of each month for the reporting period.
3	The number of contracts and member months by month are categorized by the following contract types: 1) Subscriber; 2) Subscriber & Spouse/Dependent; 3) Subscriber & Child/Children; and 4) Family. An additional column titled 'Other' consists of members with missing contract types in the data.
4	The Paid Amount without HRA, the HRA Paid Amount and the Paid Amount with HRA are separate columns on this report.
5	The Premium column in the above table is for Medical and Pharmacy Premium combined. The Medical vs. Pharmacy Premium are shown separately in the second table.

6	The Premium column does not include premium for dental or vision.
7	A third table is provided to show Pharmacy Subscriber and Member enrollment counts.
8	ACA (Affordable Care Act) Exchange Fees, ACA Insurer Fees, ACA Reinsurance Fees are included in the Premium reported.
9	The premium dollars reported are based on Billed premium and may not balance back to Invoice or to Finance reporting. The CII report is extracting what is categorized as Premium and ACA Fees in EDWard.
10	As of June 2016, a medical capitation column was added for WGS groups with capitation payment arrangements.

Glossary:

Term	Description
Medical Contracts	The number of employees/subscribers with medical coverage.
Subscriber(s)	Subscribers are the Contract holders for the Plan. Subscribers are usually Employees.
Spouse/Partner	Represents the wife, husband or domestic partner eligible for coverage under the subscriber.
Child/Children	The child or dependent of the contract holder.
Family	A count of contracts for subscribers who have elected 'family' coverage.
Other	Represents the child or other dependent eligible for coverage under the subscriber's benefit plan.
Medical Contracts-Total Contracts-Month	Total medical subscribers by Month for Total Account Enrollment.
Member Months	The sum of members for each month for the reporting period.
Paid Claims-Medical	Sum of Paid Amount for Medical claims.
Paid Claims-HRA	Sum of Paid Amount for the Health Reimbursement Account (HRA).
Paid Claims-Pharmacy	Sum of Paid Amount for Pharmacy claims.
Paid Amount - Total	Paid Amount is the net benefit issued for services provided under the Plan. It represents the amount Paid after all pricing guidelines have been applied, including provider discounts, and all non-covered, third-party/Medicare, copayment, coinsurance and deductible amounts have been subtracted. Health Reimbursement Account (HRA) payments are included in the paid amount (if selected).
Premium Amount-Medical	Premium Amount for Medical coverage.
Premium Amount-Pharmacy	Premium Amount for Pharmacy coverage.
Total Premium	Sum of Total Premium dollars for Medical and Pharmacy coverage's.
Medical Capitation	This represents the total pre-negotiated paid amount for health care services.

HCC-01 – High Cost Claimant without Member Name

Report Number:	HCC-01	
Report Section:	High Cost Claimants Reports	
Report Name:	High Cost Claimant without Member Name	
Time View:	Paid Dates w/an option for user to select Incurred	
HCC Thresholds Available:	The following options are available: • $25,000 • $50,000 - *Default* • $75,000 • $100,000 • $200,000	
Paid Amounts Available:	The following options are available: • Standard Reporting Paid Amount + HRA – *Default* • Reporting Paid Amount	
Time Periods Available:	The following options are available: • Rolling 12 months – *Default* • Rolling 3 months • Plan year to date • Calendar year to date	
Fully Insured/ASO Account Status:	Available for both Fully Insured and ASO Accounts	
Report Suppression Rules:	No Report Suppression Rules apply	
Cell Level Suppression Rules:	No Cell Level Suppression Rules apply	
Early or Standard Report Production?	Early *(By End of 2nd Week of Month)* ✓	Standard *(By End of 4th Week of Month)*
Hover Description:	Member listing, with encrypted IDs (excluding PHI), who have met the specified threshold of paid claims	
Report Description and Analytic Notes:	Provides a listing of members (scrambled ID) who have met a specified threshold within a given time period. It is sorted by descending paid amounts and details the relationship, age group, health condition, primary and secondary medical diagnoses, and coverage type. It breaks medical and pharmacy dollars as well as what is paid by primary and secondary diagnoses and contributing current month paid dollars. Use this report to identify claimants with high costs. This report may show common health conditions that have resulted in excessive costs and can identify potential opportunities for early detection, educational and/or wellness initiatives.	
Matches Reports:	HCC-01A High Cost Claimant with Member Name	

Report Facts:

1	The Claimant ID is scrambled to avoid member identification.
2	The Primary Health Condition and Diagnosis data are based on medical claims. Since pharmacy data does not have diagnosis codes included, it cannot be associated with these fields.
3	This report includes a field to indicate whether the member is still active as of the end of the reporting period or has terminated.

4	This report is an 'early view' report meaning that it is available earlier in the month than some of the other standard reports (i.e., by the end of the 2nd week of the month).
5	The 'Most Recent Month' column refers to the *medical* amount paid for the high cost claimant during the most recent month in the current reporting period.
6	This report is based on Paid Dates with an option for the user to select Incurred Dates.
7	Since this report includes both Medical and Pharmacy claims, it may not match the F-02 Medical Paid Claims Distribution Report's Current Paid Amount Thresholds summaries (i.e., $25,000 and above, $50,000 and above, etc.) since that report is based on Medical claims only.
8	California Local Fully Insured groups do not have access to this report. An internal copy is available for those groups.
9	Members can appear in this report on more than one line due to multiple relationship statuses given the life events they experienced, i.e., marriage, COBRA, becoming an employee for the same company when they were once a spouse etc. In these instances, costs are combined to determine if they meet the threshold (i.e. 50K default). Then, should they have those costs split based on multiple relationship status codes, they will appear under the same rank number and MCID; however, the costs will be split based on that relationship status code. For example, if a member was a spouse on the plan for part of the year and had $20K in costs, but then became a policyholder later in the year and had $40K in costs, they would meet the criteria to be shown on the report, but appear as two lines. A high level sample would be: **Rank MCID Relationship Total Paid** 20 1234 Employee/Self $40,000.00 Spouse/Partner $20,000.00 The report will list both lines; however, will not repeat the rank order and MCID.

Glossary:

Term	Description
Paid Amount	Paid Amount is the net benefit issued for services provided under the Plan. It represents the amount Paid after all pricing guidelines have been applied, including provider discounts, and all non-covered, third-party/Medicare, copayment, coinsurance and deductible amounts have been subtracted. Health Reimbursement Account (HRA) payments are included in the paid amount (if selected).
Paid Amount - Medical	Paid Amount is the net benefit issued for services provided under the Plan for Medical claims. It represents the amount Paid after all pricing guidelines have been applied, including provider discounts, and all non-covered, third-party/Medicare, copayment, coinsurance and deductible amounts have been subtracted. Health Reimbursement Account (HRA) payments are included in the paid amount (if selected).
Paid Amount - Pharmacy	Paid Amount is the net benefit issued for services provided under the Plan for Pharmacy claims. It represents the amount Paid after all pricing guidelines have been applied, including provider discounts, and all non-covered, third-party/Medicare, copayment, coinsurance and deductible amounts have been subtracted. Health Reimbursement Account (HRA) payments are included in the paid amount (if selected).
High Dollar Claimant Paid Amount	The paid amount for members who have had claims in excess of the high cost claimant threshold during the reporting period.
All Other Claimants Paid Amount	Paid amount for all other claimants not meeting the threshold criteria.
High Dollar Claimant	PMPM (Per Member Per Month) is the average amount paid per member per month

Paid Amount PMPM/Other claimant Paid Amount PMPM	for members who have had claims in excess of our high cost claimant threshold during the reporting period. It is a financial measure that is derived by dividing total Paid Amount by total Member Months. It is most commonly used as an indicator of financial trend.
Large Claimants > $50,000 Percent of Total Paid amount	Amount paid for members who exceeded the high cost claimant threshold, expressed as a percentage of total paid. Default threshold is $50,000, but can be modified.
Large Claimants > $50,000 Percent of All Members	Number of Members who exceeded the high cost claimant threshold, expressed as a percentage of the total of all members. Default threshold is $50,000, but can be modified.
Scrambled Claimant ID	An encoded or encrypted Id for a claimant so that a member's identification is not known.
Active (Yes/No)	An indicator to determine if the member is currently enrolled with the group.
Relationship	The relationship of the member to the contract holder. The values are Employee/Self, Spouse/Partner, Child/Other Dependent or Unassigned.
Age Range	This refers to the grouping of members into pre-defined age brackets.
Rank	The order based upon the highest paid amount.
Primary Health Condition Category	The health condition category associated with the primary diagnosis code.
Primary Medical Diagnosis Contributing to High Cost	The primary diagnosis associated with the highest paid amount for the claimant.
Secondary Medical Diagnosis Contributing to High Cost	The secondary diagnosis associated with the highest paid amount for the claimant.
Paid Amount By Setting - Primary Medical Diagnosis (Dx)	The paid amount for inpatient, outpatient and professional services associated with the primary diagnosis for each claimant.
Paid Amount By Setting - Secondary Medical Diagnosis	The paid amount for inpatient, outpatient and professional services associated with the secondary diagnosis for each claimant.
Paid Amount By Setting - All Other Medical Diagnosis (Dx)	The paid amount for inpatient, outpatient and professional services associated with all other diagnoses that are not included in the report.

HCC-02 – Top Five Health Conditions for High Cost Claimants

Report Number:	HCC-02	
Report Section:	High Cost Claimants Reports	
Report Name:	Top Five Health Conditions for High Cost Claimants	
Time View:	Paid Dates w/an option for user to select Incurred	
HCC Thresholds Available:	The following options are available: $25,000 $50,000 - *Default* $75,000 $100,000 $200,000	
Paid Amounts Available:	The following options are available: Standard Reporting Paid Amount + HRA - *Default* Reporting Paid Amount	
Time Periods Available:	The following options are available: Rolling 12 months - *Default* Rolling 3 months Calendar year to date Plan year to date	
Fully Insured/ASO Account Status:	Available for both Fully Insured and ASO Accounts. Fully Insured accounts require a PHI waiver.	
Report Suppression Rules:	None	
Cell Level Suppression Rules:	If Unique Claimants, HCC Currently Active or Claimants who were HC Claimants in Previous Period is greater than zero and less than or equal to 5, for any Primary Diagnosis or in the 'All Other' row then that metric will be suppressed and replaced with an asterisk. Totals will not be suppressed.	
Early or Standard Report Production?	Early *(By End of 2nd Week of Month)*	Standard *(By End of 4th Week of Month)* ✓
Hover Description:	Top 5 Health Conditions for members exceeding the high cost claimant threshold	
Report Description and Analytic Notes:	Identifies the leading health conditions found in those members with claims in excess of the high cost claimant threshold, during a specific time period. The health conditions are sorted in descending total paid amount and show breakdowns by diagnosis and setting. This report can be used to determine the number and percentage of claimants who are driving the total medical costs as it relates to the leading health conditions. This report can also be used to identify wellness opportunities and initiatives.	
Matches Reports:	The high dollar claimant total paid amount on this report will match the high dollar claimant totals on the High Cost Claimant reports.	

Report Facts:

1	This report has a count of unique claimants for each of the Top Five Health Conditions and the total is also a count of unique claimants that make up this High Cost Claimant sub-population. Therefore, a single member on this report could be represented in all five of the health conditions if that member had at least one paid claim in each of the 5 Health Conditions on the report. It is for this reason that the claimants on the Top Five Health Condition report cannot be summed.
2	This report reflects the top five most costly health conditions and, within each Health Condition, lists the claimant count and claims spend for the top five primary diagnoses. Remaining diagnoses within a Health Condition are assigned "All Other".
3	Use column “High Cost Claimants Currently Active” to determine the number of High Cost Claimants who are currently enrolled. The column “Claimants who were HC claimants in previous period” denotes the number of these claimants who were High Cost Claimants in the previous time period. These two columns can be used in conjunction to assist you in determining future claims spend.
4	Use column “Most Recent Month” to determine the proportion of total claims spend that occurred in the most recent reporting month. If the claim dollars are close to the total paid amount, it may indicate that this is a relatively new claim; whereas if the claim dollars are small or $0, it may indicate that this is not an ongoing claim.
5	Pharmacy data is provided at a ‘total’ level. Pharmacy claims would not be included with the "Primary DX" and "All Other DX" categories. It would be listed separately. Inpatient, Outpatient, Professional and Pharmacy categories will also equal the ‘total’.
6	This report is based on Paid Dates with an option for the user to select Incurred Dates.
7	This report contains two different paid amount sections that can be added together to equal the Total Paid Amount: Inpatient + Outpatient + Professional + Pharmacy = Total Paid Amount Primary Dx + All Other Dx + Pharmacy = Total Paid Amount

Glossary:

Term	Description
Health Condition Category	A range of diagnosis codes classified together into a Health Condition Category (e.g., Neoplasms, Injury and Poisoning, etc.).
Primary Diagnosis	The primary diagnosis associated with the claimant.
Claimant	Claimant refers to a member who has incurred expenses under the plan and has submitted a claim.
Unique Claimants	A unique count of members who have incurred expenses under the plan and have submitted a claim.
High Cost Claimants Currently Active	Number of high cost claimants currently active.
Claimants who were HC claimants in previous period	Number of claimants who were high cost claimants in previous period.
Paid Amount	Paid Amount is the net benefit issued for services provided under the Plan. It represents the amount Paid after all pricing guidelines have been applied, including provider discounts, and all non-covered, third-party/Medicare, copayment,

	coinsurance and deductible amounts have been subtracted. Health Reimbursement Account (HRA) payments are included in the paid amount (if selected).
Inpatient	Inpatient refers to the facility provider and to claims for services provided under the medical coverage in an inpatient setting. Unless otherwise noted an Inpatient Facility could be Acute, Non-Acute or a Long Term Care Facility.
Outpatient	Identifies a facility provider type or site of service where non-inpatient services are provided.
Professional	Professional refers to a provider of medical services rendered, other than by an Inpatient or Outpatient Facility. Included are physicians and non-physicians, psychologists, nurse practitioners, optometrists, home health, therapists and others.
All Other DX	All Other where diagnosis is not primary.
Paid Amount - Pharmacy	Paid Amount is the net benefit issued for services provided under the Plan for Pharmacy claims. It represents the amount Paid after all pricing guidelines have been applied, including provider discounts, and all non-covered, third-party/Medicare, copayment, coinsurance and deductible amounts have been subtracted. Health Reimbursement Account (HRA) payments are included in the paid amount (if selected).
Paid Amount - Total	Paid Amount is the net benefit issued for services provided under the Plan. It represents the amount Paid after all pricing guidelines have been applied, including provider discounts, and all non-covered, third-party/Medicare, copayment, coinsurance and deductible amounts have been subtracted. Health Reimbursement Account (HRA) payments are included in the paid amount (if selected).
High Dollar Claimant Paid Amount PMPM	Total High Cost Claimant Paid Amount PMPM (Per Member Per Month) is the average amount paid per member per month for members who have had claims in excess of our high cost claimant threshold during the reporting period. It is a financial measure that is derived by dividing total Paid Amount by total Member Months. It is most commonly used as an indicator of financial trend.

MEM-01 – Enrollment and Demographics

Report Number:	MEM-01	
Report Section:	Membership Reports	
Report Name:	Enrollment and Demographics	
Time View:	This report will always be based on an 'as of date' (which is the end of the current period).	
Time Periods Available:	The following options are available: Rolling 12 months – *Default* Rolling 3 months Plan year to date Calendar year to date	
Fully Insured/ASO Account Status:	Available for both Fully Insured and ASO Accounts	
Report Suppression Rules:	None	
Cell Level Suppression Rules:	None	
Early or Standard Report Production?	Early *(By End of 2nd Week of Month)*	Standard *(By End of 4th Week of Month)* ✓
Hover Description:	Medical and pharmacy member and subscriber counts by month with comparison to benchmark data	
Report Description and Analytic Notes:	This report can be used to understand a client's demographics and includes the number of members, contracts, and member months as well as average age, gender splits and Medical membership distribution compared to the book of business (BOB) benchmark. This report may provide insight about specific segments as well as growth and change within a client's population.	
Matches Reports:	The 'total' Member Count in the 'Gender, Average Age and Member Count at End of Current Period' table should match the 'Total Members' in the 'Current Member Months' table for the last month in the current reporting period.	

Report Facts:

1	The Enrollment and Demographics Report shows a summary of contracts and member months by month and by contract type for both Medical and Pharmacy separately. Average age and member counts are provided by gender with a comparison to the book of business benchmark. Bar graphs are provided to show the medical and pharmacy member counts by gender and age range for the current and prior periods with a comparison to the Commercial book of business benchmark.
2	This report includes comparisons to the commercial benchmark. The benchmark refers to the CII 2.0 Anthem Book of Business *excluding Medicare Primary*.
3	The Subscriber and Member counts, for both Medical and Pharmacy, are based on enrollment counts for active members as of the last day of each month for the reporting period.
4	The age band is based on the age of the member as of the end of the time period.
5	Enrollment trend is a useful measure because of its strong correlation to changes in plan costs.
6	Member Months, used for calculating average members on the Enrollment and Demographics report, are also used in the calculation of metrics in other reports that use enrollment, such as paid Per Member Per Month (PMPM).

7	The Medical and Pharmacy graphs entitled “Membership Distribution Compared to Benchmark” provide a summary view of the group’s population based on age range and gender. The percentage of total membership for each age range is displayed with a comparison to the prior period and to the current period benchmark. The distribution by age range is helpful in understanding the utilization data, particularly clinical expenses that may be more prevalent for certain age groups.
8	The “Gender, Average Age and Member Count” table displays current period member counts and percentages by gender with a comparison to the benchmark. This table also shows average age by gender for the subscriber and for total members. This information is useful in analyzing the utilization trends which can differ for a female or male dominated population or by the average age of the enrollees.
9	On the “Gender, Average Age and Member Count” table the sort order is Female, Male, and Unassigned. The unassigned row will only appear if there are members with missing gender information in the data.
10	This report provides 3 different Fast Facts. Fast Facts provide useful analytical information about report measures. Changes to significant measures from the prior to the current period or variances to the current period benchmark will be highlighted.
11	The number of contracts and member months by month are categorized by the following contract types: 1) Subscriber; 2) Subscriber & Spouse/Dependent; 3) Subscriber & Child/Children; and 4) Family. An additional row titled ‘Other’ may appear if there are members with missing contract types in the data.
12	The contracts and members from the “Contracts by Month” and “Current Member Months” tables represent the average contracts and members enrolled in the current period.
13	This report also provides a comparison between the current period totals vs. the prior period totals.

Glossary:

Term	**Description**
Average Age	The average age of the members in a particular category as of the end of the reporting period.
Average Contract	The average number of contracts (e.g., subscribers/employees) enrolled during the time period.
Benchmark	Benchmark refers to a normative value against which plan metrics are compared. Benchmarks in CII include data from all Anthem accounts in the Client Information Insights database. The benchmark excludes Anthem Medicare Primary members.
Contract Type	Contract Type describes the coverage tier elected by the subscriber. Examples of the values are Subscriber, Subscriber & Spouse/Dependent, Subscriber & Child/Children and Family.
Gender	The sex of the member (i.e., Male or Female).
Medical Contract	The number of employees/subscribers with medical coverage.
Member Count	Total Member Count as of the end of the reporting period.
Member Months	The sum of members for each month for the reporting period.
Members	Members represent all employees and dependents, eligible for coverage under a plan of benefits during the time period represented.
Pharmacy Contract	The number of employees/subscribers with pharmacy coverage.
Subscriber(s)	Subscribers are the Contract holders for the Plan. Subscribers are usually Employees.
Trend	Trend is the percent change of any metric from the prior period to the current period. To calculate Trend subtracts the prior period value from the current period value and then divide the result by the prior period value.

MEM-02 – Membership Listing

Report Number:	MEM-02	
Report Section:	Membership Reports	
Report Name:	Membership Listing	
Time View:	This report will always be based on an 'as of date' (which is the end of the current period).	
Time Periods Available:	The following options are available: Rolling 12 months – *Default* Rolling 3 months Plan year to date Calendar year to date	
Fully Insured/ASO Account Status:	Available for both Fully Insured and ASO Accounts	
Report Suppression Rules:	None	
Cell Level Suppression Rules:	None	
Early or Standard Report Production?	Early *(By End of 2nd Week of Month)* ✓	Standard *(By End of 4th Week of Month)*
Hover Description:	Listing of active members for the current period.	
Report Description and Analytic Notes:	This report is a list of the active members for an account as of the end of the current period. Use this report to confirm that individual members are showing up correctly as 'active' and have accurate information.	
Matches Reports:	NA	

Report Facts:

1	The Membership Listing lists one record per active member and includes both member demographic information such as gender and birth date as well as relevant group information like Group ID, Subgroup ID, etc. to which the member belongs.
2	Access to this report is limited to only those users who have access to PHI.
3	This report is an 'early view' report meaning that it is available earlier in the month than some of the other standard reports (i.e., by the end of the 2nd week of the month).
4	Only members who are active as of the last day of the month for the current reporting period will be included in this report.
5	The member effective date is based on the effective date of the member within the subgroup and may be different than the member's original effective date with the employer.
6	The 'Other Carrier Primary' field designates whether Anthem is the primary carrier (including Medicare or any other health insurance carrier).
7	This report is sorted by Group ID, Subgroup, Subscriber ID, and Member Code.
8	Member Code is depicted by the following three options: Employee/Self Spouse/Partner Child/Other Dependent

	If a member code is unknown or missing it will be assigned to a fourth category: 'Unassigned'.
9	To optimize efficiencies with this large, detailed report, it will be available in Excel format only (i.e., a PDF version will not be available). Unlike other CII 2.0 reports, this report will need to be run as needed. This report will not be available for packaging with other CII reports, but can be exported on its own.

Glossary:

Term	Description
Group ID	A number uniquely assigned to the organization that purchased products or services. Created from Purchaser Organization Number where Purchaser Organization Type Code = 03 (Group). A client can have one or more Group IDs. However, the majority of clients have only 1 Group ID. A Group ID will look like the following: 123456.
Group Name	Group Name is the name assigned to the organization that purchased products or services.
Subgroup	A number uniquely assigned to the organization that purchased products or services. Created from Purchase Organization Number where Purchaser Organization Type Code = 04 (Subgroup). A client can have multiple subgroups per Group ID and subgroups are used to capture more detail. A subgroup may look like the following: 123456-PPO, or 123456-HMO.
Package Number	Package Number identifies a set of benefits bundled into a package that has been offered to the customer.
Subscriber ID	Subscriber Identifier is an identifier for a specific Member who applied for coverage and typically has financial responsibility (premiums due, liabilities due) for health coverage (i.e. the 'subscriber' role).
Health Card ID	Health Card Identifier is the identifier used for a particular Member on his/ her Health Card.
Member Code	The source code for family member within the family.
Member Code Description	Reporting relationship description between a Member and a Subscriber. Member Code is depicted by the following three options: Employee/Self Spouse/Partner Child/Other Dependent
Handicapped Indicator	An indicator (Y/N) used to identify if the member is handicapped.
Student Indicator	An indicator (Y/N) used to identify if the member is a student.
Dependent ID	Identifies member's relationship to the subscriber.
Member Gender	The sex of the member (i.e., Male or Female).
Member Birth Date	Member birth date is the date that the Member was born.
Subscriber Last Name	Last name of the subscriber.
Subscriber First Name	First name of the subscriber.
Member Last Name	Last name of the member.
Member First Name	First name of the member.

RX-01 – Top Ten Therapeutic Drug Categories by Paid Amount

Report Number:	RX-01	
Report Section:	Pharmacy Reports	
Report Name:	Top Ten Therapeutic Drug Categories by Paid Amount	
Time View:	Paid Dates w/an option for user to select Incurred	
Paid Amounts Available:	The following options are available: • Standard Reporting Paid Amount + HRA – *Default* • Reporting Paid Amount	
Time Periods Available:	The following options are available: • Rolling 12 months – *Default* • Rolling 3 months • Plan year to date • Calendar year to date	
Fully Insured/ASO Account Status:	Available for both Fully Insured and ASO Accounts	
Report Suppression Rules:	This report will be suppressed if the pharmacy average membership is less than 30.	
Cell Level Suppression Rules:	If the Scripts in any row including Subtotal, All Other and Total are greater than zero and less than or equal to 5, then Scripts, Unique Claimants, Paid per Script, Paid per Generic Script and Paid per Brand Script will be suppressed and replaced with an asterisk. If Unique Claimants in any row including Subtotal or Total rows are greater than zero and less than or equal to 5, then the Unique Claimant metric in that row will be suppressed and replaced with an asterisk.	
Early or Standard Report Production?	Early *(By End of 2nd Week of Month)*	Standard *(By End of 4th Week of Month)* ✓
Hover Description:	Displays cost and utilization data for the top ten therapeutic categories by paid amount, including the top 3 drugs for each category	
Report Description and Analytic Notes:	This report displays information about the top ten therapeutic categories determined by paid amount, and the top three drugs within each category also determined by paid amount. Use this report to provide insight into pharmacy utilization patterns as well as the most costly drugs.	
Matches Reports:	The following measures on the Top Ten Therapeutic Drug Categories by Paid Amount and Utilization Report match the following 'Total' measures on the Pharmacy Key Indicators by Retail and Mail Order Report: • Total Unique Claimants • Scripts • Paid Amount • Paid Amount per Script • Paid Amount PMPM The following measures on the Top Ten Therapeutic Drug Categories by Paid Amount and Utilization Report match the following 'Total' measures on the Prescription Drug Performance Report: • Scripts • Paid Amount • Paid Amount per Script • Generic Index The following measures on the Top Ten Therapeutic Drug Categories by Paid Amount and Utilization Report match the following 'Total' measures on	

	the Prescription Days Supply by Drug Source Report: • Unique Claimants • Scripts • Paid Amount The following measures on the Top Ten Therapeutic Drug Categories by Paid Amount and Utilization Report match the following 'Total' measures on the Top 25 Prescribed Drugs by Paid Amount: • Unique Claimants • Scripts • Paid Amount • Paid Amount per Script • Paid Amount PMPM The following measures on the Top Ten Therapeutic Drug Categories by Paid Amount and Utilization Report match the following 'Total' measures on the Top 25 Specialty Drugs Report: • Unique Claimants • Scripts • Paid Amount • Paid Amount per Script The following measures on the Top Ten Therapeutic Drug Categories by Paid Amount and Utilization Report match the following 'Total' measures on Medical and Pharmacy Paid Amount Summary and Pharmacy Highlights (Financial Dashboard Report) : • Scripts • Paid Amount • Paid Amount PMPM • Paid Amount per Script

Report Facts:

1	The top ten therapeutic drug categories shown on this report are based on the highest paid categories. Within the top ten therapeutic categories are the top 3 drugs based on the highest paid amount.
2	The 'Subtotal' represents the summarization of the ten top therapeutic categories. It includes *all drugs* within the therapeutic category, not just the top 3 drugs which are shown. Therefore, if you add the columns in the report they will not add up to the 'Subtotal'.
3	'All Other' represents the remaining therapeutic categories (i.e., other than the top ten).
4	This report contains a 'Fast Fact' at the top indicating the percentage that the top ten therapeutic categories represent of all prescriptions.
5	The Generic Index information can be found in the 'Fast Fact' box. This information is calculated at the Subtotal, All Other and Total levels as opposed to for each individual drug on the report.
6	This report will suppress if there are less than 30 pharmacy members for Fully Insured groups or if a client does not have pharmacy coverage.

Glossary:

Term	Description
Claimants Per 1000	The average number of claimants per 1000 members eligible for coverage for the period. Calculated as: Claimants/(Members/1000)

Generic Index	The % of Generic prescriptions (a drug sold or dispensed under its chemical name as a less expensive alternative to the Brand Name drug) utilized.
Paid Amount	Paid Amount is the net benefit issued for services provided under the Plan. It represents the amount Paid after all pricing guidelines have been applied, including provider discounts, and all non-covered, third-party/Medicare, copayment, coinsurance and deductible amounts have been subtracted. Health Reimbursement Account (HRA) payments are included in the paid amount (if selected).
Paid Amount Per Member Per Month (PMPM)	The average amount paid per member per month. It is a financial measure that is derived by dividing Paid Amount by Member Months. It is most commonly used as an indicator of financial trend.
Paid Per Brand Script	The average net paid amount per Brand prescription dispensed. This measure is derived by dividing the total net paid amount for all Brand prescriptions by the total number of Brand prescriptions.
Paid Per Generic Script	The average net paid amount per Generic prescription dispensed. This measure is derived by dividing the total net paid amount for all Generic prescriptions by the total number of Generic prescriptions.
Paid Per Script	Paid Per Script is the average net paid amount per prescription dispensed. This measure is derived by dividing the total net paid amount for all prescriptions by the total number of prescriptions.
PMPM Trend	PMPM Trend is the percent change of any metric from the prior period to the current period. To calculate Trend subtract the prior period value from the current period value and then divide the result by the prior period value * 100.
Scripts	The number of individual prescriptions associated with all Pharmacy claims for the period.
Therapeutic Category	A classification used to characterize drug products based on the therapeutic effects of the drug.
Top 3 Drugs	Top 3 drugs utilized within the Therapeutic Category based on Paid Amount.
Unique Claimants	A unique count of members who have incurred expenses under the plan and have submitted a claim.

RX-02 – Pharmacy Key Indicators by Retail and Mail Order – Generic vs. Brand

Report Number:	RX-02	
Report Section:	Pharmacy Reports	
Report Name:	Pharmacy Key Indicators by Retail and Mail Order - Generic vs. Brand	
Time View:	Paid Dates w/an option for user to select Incurred	
Paid Amounts Available:	The following options are available: Standard Reporting Paid Amount + HRA – *Default* Reporting Paid Amount	
Time Periods Available:	The following options are available: Rolling 12 months – *Default* Rolling 3 months Plan year to date Calendar year to date	
Fully Insured/ASO Account Status:	Available for both Fully Insured and ASO Accounts	
Report Suppression Rules:	This report will be suppressed if the pharmacy average membership is less than 30.	
Cell Level Suppression Rules:	None	
Early or Standard Report Production?	Early *(By End of 2nd Week of Month)*	Standard *(By End of 4th Week of Month)* ✓
Hover Description:	Displays scripts, costs and claimants data by Retail and Mail Order, by generic and brand	
Report Description and Analytic Notes:	This report displays key information about pharmaceutical claims divided by both brand/generic as well as formulary/non-formulary for the current period, and compares totals to the prior period. Use this report to monitor pharmacy utilization patterns and ensure members are optimizing plan design features.	
Matches Reports:	The following measures on the Pharmacy Key Indicators by Retail and Mail Order Report match the same measures on the Prescription Drug Performance Report: • Generic, Brand and Total Scripts • Generic, Brand and Total Ingredient Cost per Script • Generic, Brand and Total Member Out of Pocket per Script • Generic, Brand and Total % of Total Scripts • Generic, Brand and Total Paid Amount The following measures on the Pharmacy Key Indicators by Retail and Mail Order Report match the same measures on the Prescription Days Supply by Drug Source Report: • Retail, Mail Order and Total Scripts • Retail, Mail Order and Total Member Out of Pocket • Retail, Mail Order and Total Paid Amount The following measures on the Pharmacy Key Indicators by Retail and Mail Order Report match the same measures on the Top 25 Prescribed Drugs by Paid Amount Report:	

	• Total Scripts • Total Ingredient Cost • Total Ingredient Cost per Script • Total Paid Amount • Total Paid Amount per Script • Total PMPM The following measures on the Pharmacy Key Indicators by Retail and Mail Order Report match the same measures on the Top Five Therapeutic Drug Categories by Paid Amount with Utilization Report: • Total Scripts • Total Paid Amount • Total Paid Amount Per Script • Total Paid Amount PMPM The following measures on the Pharmacy Key Indicators by Retail and Mail Order Report match the same measures on the Top 25 Specialty Drugs Report: • Total Scripts • Total Ingredient Cost • Total Ingredient Cost per Script • Total Paid Amount • Total Paid Amount Per Script Drug Source Report: • Retail, Mail Order and Total Scripts • Retail, Mail Order and Total Member Out of Pocket • Retail, Mail Order and Total Paid Amount The following measures on the Pharmacy Key Indicators by Retail and Mail Order Report match the same measures on the Top 25 Prescribed Drugs by Paid Amount Report: • Total Scripts • Total Ingredient Cost • Total Ingredient Cost per Script • Total Paid Amount • Total Paid Amount per Script • Total PMPM The following measures on the Pharmacy Key Indicators by Retail and Mail Order Report match the same measures on the Top Five Therapeutic Drug Categories by Paid Amount with Utilization Report: • Total Scripts • Total Paid Amount • Total Paid Amount Per Script • Total Paid Amount PMPM The following measures on the Pharmacy Key Indicators by Retail and Mail Order Report match the same measures on the Top 25 Specialty Drugs Report:

	• Total Scripts • Total Ingredient Cost • Total Ingredient Cost per Script • Total Paid Amount • Total Paid Amount Per Script

Report Facts:

1	The Pharmacy Key Indicators by Retail and Mail Order report is broken out into two tables: Generic vs. Brand and Formulary vs. Non-Formulary. In each of these tables, there are three sections: Retail, Mail Order and Total (Retail + Mail Order). The measures are identical in each section.
2	This report also provides a comparison between the current period totals vs. the prior period totals.
3	This report will suppress if there are less than 30 pharmacy members or if a client does not have pharmacy coverage.
4	'Retail' is the dispensing of prescribed drugs or supplies directly to a consumer by a local pharmacy in small amounts, usually a 30 day supply or less, at the non-discounted price.
5	'Mail Order' is the dispensing of prescribed drugs or supplies, at a discount, for an extended period of time, usually 90 days, and delivered via mail.
6	'Brand' refers to prescription drugs that are manufactured and marketed under a registered trade name or trademark.
7	'Generic' refers to drugs sold or dispensed under their chemical names as a less expensive alternative to the Brand Name drug.
8	'Formulary' refers to a listing of Brand Name and Generic Drugs routinely covered by the pharmacy plan without special approval. Consumers purchasing formulary drugs receive the most competitively priced medications, usually at a lower out of pocket expense.
9	'Non-Formulary' refers to the dispensing of Brand Name drugs that do not appear on the list of approved drugs (i.e. the list of Formulary drugs).

Glossary:

Term	Description
% Total Scripts	Prescriptions for the stated category (e.g. retail prescriptions) divided by Total Prescriptions of the grouped category (e.g. Retail/Mail Order).
Brand	Prescription drugs that are manufactured and marketed under a registered trade name or trademark.
Claimants	Claimant refers to a member who has incurred expenses under the plan and has submitted a claim.
Formulary	Formulary refers to a listing of Brand name and Generic Drugs routinely covered by the pharmacy plan without special approval. Consumers purchasing formulary drugs receive the most competitively priced medications, usually at a lower out of pocket expense.
Generic	A drug sold or dispensed under its chemical name as a less expensive alternative to the Brand Name drug.
Ingredient Cost	The sum of the cost of drug components for prescriptions filled.

Ingredient Cost per Script	The average ingredient cost per prescription.
Mail Order	Mail Order (RX) is the dispensing of prescribed drugs or supplies, at a discount, for an extended period of time, usually 90 days, and delivered via mail.
Member Out of Pocket	Member Out of Pocket (OOP) is the total of the member cost share which is derived by summing the Deductible, Coinsurance and Copay amounts.
Member Out of Pocket per Script	The member average Out of Pocket expense (Deductible, Coinsurance/Copay) per prescription. It is derived by dividing total Pharmacy Out of Pocket amount by the total number of prescriptions.
Non-Formulary	Non-Formulary Brand refers to the dispensing of Brand Name drugs that do not appear on the list of approved drugs (i.e. the list of Formulary drugs).
Paid Amount	Paid Amount is the net benefit issued for services provided under the Plan. It represents the amount Paid after all pricing guidelines have been applied, including provider discounts, and all non-covered, third-party/Medicare, copayment, coinsurance and deductible amounts have been subtracted. Health Reimbursement Account (HRA) payments are included in the paid amount (if selected).
Paid per Script	Paid Per Script is the average net paid amount per prescription dispensed. This measure is derived by dividing the total net paid amount for all prescriptions by the total number of prescriptions.
Period	The time period that the report is based on.
Pharmacy Paid PMPM	The average amount paid for Pharmacy per member per month. It is a financial measure that is derived by dividing total Pharmacy Paid Amount by total Pharmacy Member Months.
Retail	Retail (RX) is the dispensing of prescribed drugs or supplies directly to a consumer by a local pharmacy in small amounts, usually a 30 day supply or less, at the non-discounted price.
Scripts	The number of individual prescriptions associated with all Pharmacy claims for the period.

RX-03 – Prescription Drug Performance Report

Report Number:	RX-03	
Report Section:	Pharmacy Reports	
Report Name:	Prescription Drug Performance Report	
Time View:	Paid Dates w/an option for user to select Incurred	
Paid Amounts Available:	The following options are available: Standard Reporting Paid Amount + HRA – *Default* Reporting Paid Amount	
Time Periods Available:	The following options are available: Rolling 12 months – *Default* Rolling 3 months Plan year to date Calendar year to date	
Fully Insured/ASO Account Status:	Available for both Fully Insured and ASO Accounts	
Report Suppression Rules:	This report will be suppressed if the pharmacy average membership is less than 30.	
Cell Level Suppression Rules:	None	
Early or Standard Report Production?	Early *(By End of 2nd Week of Month)*	Standard *(By End of 4th Week of Month)* ✓
Hover Description:	Displays brand and generic drug information with benchmark comparisons	
Report Description and Analytic Notes:	This report displays key information about pharmaceutical claims divided by both brand/generic for current and prior periods compared to current period commercial benchmarks. Use this report to monitor pharmacy utilization patterns and ensure members are optimizing plan design features.	
Matches Reports:	The following measures on the Prescription Drug Performance Report match the same measures on the Pharmacy Key Indicators by Retail and Mail Order Report: Generic, Brand and Total Scripts Generic, Brand and Total Ingredient Cost per Script Generic, Brand and Total Member Out of Pocket per Script Generic, Brand and Total % of Total Scripts Generic, Brand and Total Paid Amount The following 'Total' measures on the Prescription Drug Performance Report match the Total measures on the Top Five Therapeutic Drug Categories by Paid Amount with Utilization Report: Scripts Paid Amount Paid Amount per Script The following measures on the Prescription Drug Performance Report match the Prescription Days Supply by Drug Source Report: Total Scripts Total Paid Amount	

	Average Days Supply/Days Supply Per Script The following 'Total' metrics on the Prescription Drug Performance Report match the Top 25 Prescribed Drugs by Paid Report: Scripts Ingredient Cost per Script Total Paid Amount Paid Amount Per Script The following measures on the Prescription Drug Performance Report match the 'Total All Drugs' on the Top 25 Specialty Drugs Report: Scripts Average Days Supply/Days Supply Per Script Ingredient Cost per Script Paid Amount Paid Amount per Script

Report Facts:

1	This report also provides a comparison between the current period totals vs. the prior period totals.
2	This report includes comparisons to the commercial benchmark. The benchmark refers to the CII 2.0 Anthem Book of Business *excluding Medicare Primary.*
3	There are three sections in the Prescription Drug Performance Report. They are Generic, Brand and Total. The measures are identical in each section.
4	This report will suppress if there are less than 30 pharmacy members or if a client does not have pharmacy coverage.
5	'Brand' refers to prescription drugs that are manufactured and marketed under a registered trade name or trademark.
6	'Generic' refers to drugs sold or dispensed under their chemical names as a less expensive alternative to the Brand Name drug.
7	'Controlled substance' refers to a drug which has been declared by federal or state law to be illegal for sale or use, but may be dispensed under a physician's prescription.
8	In consultation with the WellPoint Pharmacy team a recommendation was made to include Cross Brand drugs in the Generic category. This impacts the results when comparing CII 1.0 to 2.0. Generic will be higher in CII 2.0, and brand will be less.

Glossary:

Term	Description
Average Days Supply	The average number of days for which drugs were supplied for prescriptions filled. It represents the number of days of drug therapy covered by a prescription (e.g., a 30 day supply).
Brand	Prescription drugs that are manufactured and marketed under a registered trade name or trademark.
Commercial Benchmark	Benchmark refers to a normative value against which plan metrics are compared. Benchmarks in CII include data from all Anthem accounts in the Client Information Insights database. The benchmark excludes Anthem Medicare Primary members.
Generic	A drug sold or dispensed under its chemical name as a less expensive alternative to the Brand Name drug.
Generic Index	The % of Generic prescriptions (a drug sold or dispensed under its chemical name as a less expensive alternative to the Brand Name drug) utilized.
Ingredient Cost per Script	The average ingredient cost per prescription.
Member Out of Pocket per Script	The member average Out of Pocket expense (Deductible, Coinsurance/Copay) per prescription. It is derived by dividing total Pharmacy Out of Pocket amount by the total number of prescriptions.
Paid Amount	Paid Amount is the net benefit issued for services provided under the Plan. It represents the amount Paid after all pricing guidelines have been applied, including provider discounts, and all non-covered, third-party/Medicare, copayment, coinsurance and deductible amounts have been subtracted. Health Reimbursement Account (HRA) payments are included in the paid amount (if selected).
Paid per Script	Paid Per Script is the average net paid amount per prescription dispensed. This measure is derived by dividing the total net paid amount for all prescriptions by the total number of prescriptions.
Percent Controlled Substance Scripts	Medications that the U.S. Food and Drug Administration has classified as potentially habit forming or addicting. The percent of controlled substance prescriptions is the number of controlled substance prescriptions divided by the total number of prescriptions.
Percent Formulary	Formulary is a list of drugs approved for coverage under a drug benefit. The percent formulary is the proportion of total prescriptions that are Formulary.
Percent Multi Source Brand	Multi-Source drugs are those available in both brand-name and generic versions from a variety of manufacturers. Percent Multi-Source Brand is the proportion of total prescriptions that are Multi-Source Brand prescriptions. This metric is derived by dividing the number of Multi-Source Brand prescriptions by total prescriptions.
Percent Scripts Dispensed as Written (DAW1)	DAW1 (Dispensed as Written) means the pharmacist is to provide the prescription exactly as it was written. The percent is the number of DAW prescriptions divided by the total prescriptions.
Percent Scripts Dispensed as Written-Member Choice (DAW2)	DAW2 (Dispensed as Written-Member Choice) are prescriptions that the member has requested be Dispensed as Written. The percent is derived by dividing the number of DAW2 prescriptions by the total prescriptions.
Percent Single Source Brand	Single Source drugs are under patent protection and sold under a brand name by the manufacturer. No generic version is available. Percent Single Source Brand is the proportion of total prescriptions that are Single Source Brand prescriptions. This metric is derived by dividing the number of Single Source Brand prescriptions by total prescriptions.
Percent of Total Paid	The percent of Total Paid Amount is calculated by dividing the amount paid for the

Amount	category by the total paid amount, expressed as a percentage.
Percent of Total Scripts	The percent of total prescriptions is calculated for each drug by dividing the number of prescriptions for each drug by total prescriptions.
Period	The time period that the report is based on.
Scripts	The number of individual prescriptions associated with all Pharmacy claims for the period.

RX-04 – Prescription Days' Supply by Drug Source

Report Number:	RX-04	
Report Section:	Pharmacy Reports	
Report Name:	Prescription Days' Supply by Drug Source	
Time View:	Paid Dates w/an option for user to select Incurred	
Paid Amounts Available:	The following options are available: Standard Reporting Paid Amount + HRA – *Default* Reporting Paid Amount	
Time Periods Available:	The following options are available: Rolling 12 months – *Default* Rolling 3 months Plan year to date Calendar year to date	
Fully Insured/ASO Account Status:	Available for both Fully Insured and ASO Accounts	
Report Suppression Rules:	This report will be suppressed if the pharmacy average membership is less than 30.	
Cell Level Suppression Rules:	None	
Early or Standard Report Production?	Early *(By End of 2nd Week of Month)*	Standard *(By End of 4th Week of Month)* ✓
Hover Description:	Displays scripts, claimants and costs data by Source for Retail and Mail Order with benchmark comparison	
Report Description and Analytic Notes:	Provides a comparison of key metrics for prescriptions divided by brand/generic designations for retail and mail order sources. Use this report to monitor pharmacy utilization patterns.	
Matches Reports:	The following measures on the Prescription Days Supply by Drug Source Report match the following measures on the Top Five Therapeutic Drug Categories by Paid Amount with Utilization Report: Scripts Unique Claimants Paid Amount The following measures on the Prescription Days Supply by Drug Source Report match the same measures on the Pharmacy Key Indicators by Retail and Mail Order Report: Retail, Mail Order and Total Scripts Retail, Mail Order and Total Member Out of Pocket Retail, Mail Order and Total Paid Amount The following measures on the Prescription Days Supply by Drug Source Report match the same measures on the Prescription Drug Performance Report: Total Scripts Total Paid Amount	

	Average Days Supply/Days Supply Per Script The following 'Total' metrics on the Prescription Days Supply by Drug Source Report match the Top 25 Prescribed Drugs by Paid Report: Scripts Ingredient Cost per Script Total Paid Amount Paid Amount Per Script The following measures on the Prescription Days Supply by Drug Source Report match the same measures on the Top 25 Specialty Drugs Report: Total Scripts Total Unique Claimants Days Supply per Script Total Paid Amount

Report Facts:

1	This report includes comparisons to the commercial benchmark. The benchmark refers to the CII 2.0 Anthem Book of Business *excluding Medicare Primary.*
2	There are three sections to the Prescription Days Supply by Drug Source report. They are Retail, Mail Order and Total (Retail + Mail Order). The measures are identical in each section.
3	Under the Retail, Mail Order and Total Table, there are two pie charts: one for Paid Amount and one for the number of prescriptions.
4	This report is based on the Current Period only. There is no Prior Period comparison.
5	Note that Retail + Mail Order Claimants may not equal Total Claimants. This is because one claimant can have both retail and mail order prescriptions and would be counted under each category. A single claimant will only be counted once under Total Claimants.
6	This report will suppress if there are less than 30 pharmacy members or if a client does not have pharmacy coverage.
7	The Paid Amount graph displays the % of pharmacy paid amounts distributed by the following values: Retail Single Source Brand Retail Generic Retail Multi Source Brand Mail Order Single Source Brand Mail Order Generic Mail Order Multi Source Brand Values that have not been populated will be categorized under 'Unassigned'.
8	The Scripts graph displays the % of pharmacy scripts distributed by the following values: Retail Single Source Brand Retail Generic Retail Multi Source Brand Mail Order Single Source Brand

	Mail Order Generic Mail Order Multi Source Brand Values that have not been populated will be categorized under 'Unassigned'.
9	An unassigned row is present under the Retail, Mail Order or Total sections when there are drug claims with no specific Drug Source. An OTC (over the counter) or Unknown value would fall into this row.

Glossary:

Term	Description
Commercial Benchmark	Benchmark refers to a normative value against which plan metrics are compared. Benchmarks in CII include data from all Anthem accounts in the Client Information Insights database. The benchmark excludes Anthem Medicare Primary members.
Days Supply	Days Supply Rx is the number of days for which drugs were supplied for prescriptions filled. It represents the number of days of drug therapy covered by a prescription.
Days Supply Percent	The percent of the Days Supply per prescription for each drug source.
Generic	A drug sold or dispensed under its chemical name as a less expensive alternative to the Brand Name drug.
Mail Order	Mail Order (RX) is the dispensing of prescribed drugs or supplies, at a discount, for an extended period of time, usually 90 days, and delivered via mail.
Member Out of Pocket per Script	The member average Out of Pocket expense (Deductible, Coinsurance/Copay) per prescription. It is derived by dividing total Pharmacy Out of Pocket amount by the total number of prescriptions.
Multi-Source Brand	A Multi-Source drug is one available in both brand-name and generic versions from a variety of manufacturers.
Paid Amount	Paid Amount is the net benefit issued for services provided under the Plan. It represents the amount Paid after all pricing guidelines have been applied, including provider discounts, and all non-covered, third-party/Medicare, copayment, coinsurance and deductible amounts have been subtracted. Health Reimbursement Account (HRA) payments are included in the paid amount (if selected).
Paid Amount per Days Supply	This metric is derived by dividing the Pharmacy Paid Amount by Days Supply.
Retail	Retail (RX) is the dispensing of prescribed drugs or supplies directly to a consumer by a local pharmacy in small amounts, usually a 30 day supply or less, at the non-discounted price.
Single Source Brand	A Single Source drug is under patent protection and sold under a brand name by the manufacturer. No generic version is available.
Scripts	The number of individual prescriptions associated with all Pharmacy claims for the period.
Unique Claimants	A unique count of members who have incurred expenses under the plan and have submitted a claim.

RX-05 – Top 25 Prescribed Drugs by Paid Amount

Report Number:	RX-05	
Report Section:	Pharmacy Reports	
Report Name:	Top 25 Prescribed Drugs by Paid Amount	
Time View:	Paid Dates w/an option for user to select Incurred	
Paid Amounts Available:	The following options are available: Standard Reporting Paid Amount + HRA – *Default* Reporting Paid Amount	
Time Periods Available:	The following options are available: Rolling 12 months – *Default* Rolling 3 months Plan year to date Calendar year to date	
Fully Insured/ASO Account Status:	Available for both Fully Insured and ASO Accounts	
Report Suppression Rules:	This report will be suppressed if the pharmacy average membership is less than 30.	
Cell Level Suppression Rules:	If the Unique Claimants in any row including 'Total Top 25 Drugs' and 'All Product Names' rows are greater than zero and less than or equal to 5, then the Unique Claimant metric in that row will be suppressed and replaced with an asterisk. If Scripts in any row including the 'Total Top 25 Drugs', Total All Other Drugs' and 'All Product Names' rows are greater than zero and less than or equal to 5, then Scripts, Percent Scripts, Ingredient Cost per Script and Paid Amount per Script will be suppressed and replaced with an asterisk.	
Early or Standard Report Production?	Early *(By End of 2nd Week of Month)*	Standard *(By End of 4th Week of Month)* ✓
Hover Description:	Displays scripts, claimants and costs data for the top 25 drugs, based on paid amount, includes benchmark PMPMs	
Report Description and Analytic Notes:	This report displays information about the top 25 prescribed drugs based on paid amount. Use this report to gauge whether members are properly selecting prescriptions based on plan formulary to maximize efficacy and minimize out-of-pocket costs. Also use this report to provide insight into what drugs are impacting the overall pharmacy costs for a group.	
Matches Reports:	The following metrics on the Top 25 Prescribed Drugs by Paid Amount match the same measures on the Top Five Therapeutic Drug Categories by Paid Amount with Utilization Report: Total Scripts Total Unique Claimants Total Paid Amount Total Paid Amount per Script Total Paid Amount PMPM The following measures on the Top 25 Prescribed Drugs by Paid Amount Report match the same measures on the Pharmacy Key Indicators by Retail and Mail	

	Order Report: Total Scripts Total Ingredient Cost Total Ingredient Cost per Script Total Paid Amount Total Paid Amount per Script Total PMPM The following 'Total' metrics on the Top 25 Prescribed Drugs by Paid Amount Report match the same measures on the Prescription Drug Performance Report : Scripts Ingredient Cost per Script Total Paid Amount Paid Amount Per Script The following 'Total' metrics on the Top 25 Prescribed Drugs by Paid Amount Report match the same measures on the Prescription Days Supply by Drug Source Report: Scripts Ingredient Cost per Script Total Paid Amount Paid Amount Per Script The following 'Total' metrics on the Top 25 Prescribed Drugs by Paid Amount Report match the same measures on the Top 25 Specialty Drugs Report: Scripts Unique Claimants Days Supply per Script Ingredient Cost Ingredient Cost per Script Paid Amount Paid Amount per Script

Report Facts:

1	The top 25 prescribed drugs in this report are listed in order of descending paid amount.
2	This report contains a subtotal of the top 25 prescribed drugs, as well as a subtotal for 'all other drugs', in addition to the combined total listed as 'All Product Names'.
3	Drugs are identified on the report by drug name. Brand names are listed where available, but in some cases generic names may appear as well. Therapeutic Class is also shown to provide information regarding the purpose of the drug.
4	This report includes comparisons to the commercial benchmark. The benchmark refers to the CII 2.0 Anthem Book of Business *excluding Medicare Primary*.
5	This report is based on the Current Period only. There is no Prior Period comparison.

6	This report will suppress if there are less than 30 pharmacy members or if a client does not have pharmacy coverage.

Glossary:

Term	Description
Commercial Benchmark	Benchmark refers to a normative value against which plan metrics are compared. Benchmarks in CII include data from all Anthem accounts in the Client Information Insights database. The benchmark excludes Anthem Medicare Primary members.
Days Supply per Script	Days Supply Rx is the number of days for which drugs were supplied for prescriptions filled. It represents the number of days of drug therapy covered by a prescription.
Drug Name	The product name for the prescription.
Ingredient Cost	The sum of the cost of drug components for prescriptions filled.
Ingredient Cost per Script	The average ingredient cost per prescription.
Paid Amount	Paid Amount is the net benefit issued for services provided under the Plan. It represents the amount Paid after all pricing guidelines have been applied, including provider discounts, and all non-covered, third-party/Medicare, copayment, coinsurance and deductible amounts have been subtracted. Health Reimbursement Account (HRA) payments are included in the paid amount (if selected).
Paid Amount Per Member Per Month (PMPM)	The average amount paid per member per month. It is a financial measure that is derived by dividing Paid Amount by Member Months. It is most commonly used as an indicator of financial trend.
Paid per Script	Paid Per Script is the average net paid amount per prescription dispensed. This measure is derived by dividing the total net paid amount for all prescriptions by the total number of prescriptions.
Percent Paid Amount	The percent of Total Paid Amount is calculated by dividing the amount paid for the category by the total paid amount, expressed as a percentage.
Percent of Total Scripts	The percent of total prescriptions is calculated for each drug by dividing the number of prescriptions for each drug by total prescriptions.
Rank	The order based upon the highest paid amount.
Scripts	The number of individual prescriptions associated with all Pharmacy claims for the period.
Therapeutic Class	A classification used to characterize drug products based on the therapeutic effects of the drug.
Unique Claimants	A unique count of members who have incurred expenses under the plan and have submitted a claim.

RX-06 – Top 25 Specialty Drugs

Report Number:	RX-06	
Report Section:	Pharmacy Reports	
Report Name:	Top 25 Specialty Drugs	
Time View:	Paid Dates w/an option for user to select Incurred	
Paid Amounts Available:	The following options are available: Standard Reporting Paid Amount + HRA – *Default* Reporting Paid Amount	
Time Periods Available:	The following options are available: Rolling 12 months – *Default* Rolling 3 months Plan year to date Calendar year to date	
Fully Insured/ASO Account Status:	Available for both Fully Insured and ASO Accounts	
Report Suppression Rules:	The Pharmacy Dispensed Specialty Drug table will be suppressed if the average pharmacy membership is less than 30. The Medical Dispensed Specialty Drug table will be suppressed if the average medical membership is less than 30.	
Cell Level Suppression Rules:	**Pharmacy Dispensed Specialty Drugs Section** Scripts If the Scripts in any row including the 'Total Top 25 Specialty Drugs' and 'Total All Drugs' rows are greater than zero and less than or equal to 5, then Scripts, Unique Claimants, Ingredient Cost, Paid Amount per Script, and Member Out of Pocket per Script will be suppressed and replaced with an asterisk. If 'All Other Specialty Drugs' or 'All Other Drugs' Scripts are greater than zero and less than or equal to 5, then Scripts, Ingredient Cost per Script, Paid Amount per Script, and Member Out of Pocket per Script will be suppressed in those rows and replaced with an asterisk. Unique Claimants If the Unique Claimants in any row including the 'Total Top 25 Specialty Drugs' and 'Total All Drugs' rows are greater than zero and less than or equal to 5, then Unique Claimants in that row will be suppressed and replaced with an asterisk. **Medical Dispensed Specialty Drugs Section** Claims If the Claims in any row are greater than zero and less than or equal to 5, then Claims, Unique Claimants, Covered Amount per Claim, Paid Amount per Claim and Member Out of Pocket per Claim will be suppressed in that row and in the 'Total Administered Claims' row and replaced with an asterisk. Unique Claimants If the Unique Claimants in any row or in the 'Total Administered Claims' row are greater than zero and less than or equal to 5, then the Unique Claimants in that row will be suppressed and replaced with an asterisk.	
Early or Standard Report Production?	Early *(By End of 2nd Week of Month)*	Standard *(By End of 4th Week of Month)* ✓

Hover Description:	Top 25 Specialty drugs split by Pharmacy coverage and by Medical coverage, displaying scripts, claimants and costs
Report Description and Analytic Notes:	This report displays key information about the top 25 pharmacy and medical dispensed specialty drugs by paid amount. Use this report to determine if specific specialty drugs, used to treat specific complex health conditions, have impacted the overall costs for a group. Also use this report to identify opportunities for implementing cost savings initiatives and as a trigger for potential care management referrals.
Matches Reports:	The following measures on the Top 25 Specialty Drugs Report will match the same measures on the Top Five Therapeutic Drug Categories by Paid Amount with Utilization Report: Total Scripts Total Unique Claimants Total Paid Amount Total Paid Amount per Script The following measures on the Top 25 Specialty Drugs Report will match the same measures on the Pharmacy Key Indicators by Retail and Mail Order Report: Total Scripts Total Ingredient Cost Total Ingredient Cost per Script Total Paid Amount Total Paid Amount Per Script The following measures on the Top 25 Specialty Drugs Report will match the same measures on the Prescription Drug Performance Report: Total Scripts Total Average Days Supply/Days Supply Per Script Total Ingredient Cost per Script Total Paid Amount Total Paid Amount per Script The following measures on the Top 25 Specialty Drugs Report will match the same measures on the Prescription Days Supply by Drug Source Report: Total Scripts Total Unique Claimants Total Days Supply per Script Total Paid Amount The following metrics on the Top 25 Specialty Drugs Report will match the same 'Total' metrics on the Top 25 Prescribed Drugs by Paid Amount Report: Scripts Unique Claimants Days Supply per Scrip Ingredient Cost Ingredient Cost per Script Paid Amount Paid Amount per Script

Report Facts:

1	This report is broken out into two sections: 'Pharmacy Dispensed Specialty Drugs', processed under the pharmacy plan and 'Medical Dispensed Specialty Drugs', processed under the medical plan.
2	This is the only pharmacy report that contains suppression rules for medical members as well as pharmacy members. This is due to the fact that Medical Dispensed Specialty Drugs are also included in this report.
3	The Pharmacy Dispensed Specialty Drug table will be suppressed if the average pharmacy membership is less than 30. The Medical Dispensed Specialty Drug table will be suppressed if the average medical membership is less than 30.
4	The member out of pocket information contained within this report gives a better understanding of possible financial hardship for patients given the high cost of these drugs.
5	This report is based on the Current Period only. There is no Prior Period comparison.
Pharmacy Dispensed Specialty Drugs	
6	The top 25 prescribed specialty drugs in this report are listed in order of descending paid amount.
7	Specialty Drugs are injectable and non-injectable drugs typically having one or more of several key characteristics, including but not limited to: Frequent dosing adjustments and intensive clinical monitoring to decrease the potential for drug toxicity and increase the probability for beneficial treatment outcomes; Intensive patient training and compliance assistance to facilitate therapeutic goals; Limited or exclusive product availability and distribution; Specialized product handling and/or administrative requirements; and/or Cost in excess of $500 for a 30-day supply. These high cost drugs are actively managed by the Pharmacy Management's Prior Authorization Program.
8	There are more than 500 drugs that are considered Specialty Drugs for CII reporting purposes.
9	Specialty drugs are identified on the Specialty Drug report by name. Therapeutic Class is also shown to provide information regarding the purpose of the drug.
10	This section of the report contains a subtotal of the 'Total Top 25 Specialty Drugs'. In addition, there is a subtotal for 'All Other Specialty Drugs', and another subtotal for 'All Other Drugs' (i.e., non-specialty). The combined total is listed as 'Total All Drugs'.
11	Two new columns have been added to this report: Member Out of Pocket and Member Out of Pocket per Claim. These two columns did not exist in the CII 2.0 version of this report.
12	The 'Total Top 25 Specialty Drugs' is a summarization of the list of top 25 specialty drugs contained within the report, except for the Unique Claimants which is a distinct count of claimants with the top 25 specialty drugs.
13	The 'All Other Specialty Drugs' subtotal is a summarization of all of the specialty drugs that did not make it into the top 25 based on paid amount.
14	'All Other Drugs' is a summarization of all non-specialty drugs.
15	The 'Total All Drugs' is a combination for all specialty drugs and non-specialty drugs and will match bottom-line totals on other pharmacy reports.

Medical Dispensed Specialty Drugs	
16	This section of the report contains specialty drug medical claims identified via J-Codes. The J-Codes (i.e., medical procedure codes) are listed if they meet the top 25 based on paid amount.
17	A 'J-code' is just one of the many HCPCS codes that were originally developed to report injectable drugs that generally cannot be self-administered such as, chemotherapy, immunosuppressive drugs, and inhalation solutions as well as some orally-administered drugs.
18	The primary diagnoses are based on the principal diagnoses on the medical claims associated with the J Codes.
19	In CII 2.0, this report contained Percent Claim and Percent Paid Amount columns. These two columns have been removed from this report in order to add the following new columns: Paid Amount per Claim Member Out of Pocket Member Out of Pocket per Claim
20	The 'Total Administered Claims' is the summarization for *all* J-Code claims (i.e. all claims with a J-Code Procedure Code). It is not a total of the top 25 J-Codes shown on the report.

Glossary:

Term	Description
Claims	Claims is the number of claims records received.
Covered Amount	The amount to be considered for payment under the plan.
Covered Amount per Claim	The Covered Expense Amount divided by the number of claims.
Days Supply per Script	Days Supply Rx is the number of days for which drugs were supplied for prescriptions filled. It represents the number of days of drug therapy covered by a prescription.
Drug Name	The product name for the prescription.
Ingredient Cost	The sum of the cost of drug components for prescriptions filled.
Ingredient Cost per Script	The average ingredient cost per prescription.
J-Code and Primary Diagnosis	J-Code relates to permanent codes used to report injectable drugs that ordinarily cannot be self-administered: chemotherapy, immunosuppressive drugs and inhalation solutions as well as some orally administered drugs. The Primary Diagnosis is the principal diagnosis on the medical claims associated with the J Codes.
Member Out of Pocket	The member average Out of Pocket expense (Deductible, Coinsurance/Copay) per claim. It is derived by dividing the total Out of Pocket amount by the total number of Claims.
Member Out of Pocket per Script	The member average Out of Pocket expense (Deductible, Coinsurance/Copay) per prescription. It is derived by dividing total Pharmacy Out of Pocket amount by the total number of prescriptions.
Paid Amount	Paid Amount is the net benefit issued for services provided under the Plan. It represents the amount Paid after all pricing guidelines have been applied, including provider discounts, and all non-covered, third-party/Medicare, copayment, coinsurance and deductible amounts have been subtracted. Health Reimbursement Account (HRA) payments are included in the paid amount (if selected).

Paid Amount per Claim	The Paid Amount Per Claim is derived by dividing the Total Paid amount by the number of claims.
Paid per Script	Paid Per Script is the average net paid amount per prescription dispensed. This measure is derived by dividing the total net paid amount for all prescriptions by the total number of prescriptions.
Percent Generic	Percent Generic is the percentage of total scripts that are Generic. This metric is derived by dividing Generic Scripts by Total Scripts.
Percent Paid Amount	The percent of Total Paid Amount is calculated by dividing the amount paid for the category by the total paid amount, expressed as a percentage.
Scripts	The number of individual prescriptions associated with all Pharmacy claims for the period.
Therapeutic Class	A classification used to characterize drug products based on the therapeutic effects of the drug.
Unique Claimants	A unique count of members who have incurred expenses under the plan and have submitted a claim.

U-01 – Utilization by Setting

Report Number:	U-01	
Report Section:	Utilization Reports	
Report Name:	Utilization by Setting	
Time View:	Paid Dates w/an option for user to select Incurred	
Paid Amounts Available:	The following options are available: • Standard Reporting Paid Amount + HRA - *Default* • Reporting Paid Amount	
Time Periods Available:	The following options are available: • Rolling 12 months - *Default* • Rolling 3 months • Plan year to date • Calendar year to date	
Fully Insured/ASO Account Status:	Available for both Fully Insured and ASO Accounts	
Report Suppression Rules:	If the average medical membership in the current period for a client segment is less than 30, the report will be suppressed.	
Cell Level Suppression Rules:	If any of the unique claimant values are greater than zero and less than or equal to 5, that cell will be suppressed and replaced with an asterisk. If any of the values in the Admission row are greater than zero and less than or equal to 5, that cell will be suppressed and the value will be replaced with an asterisk.	
Early or Standard Report Production?	Early *(By End of 2nd Week of Month)*	Standard *(By End of 4th Week of Month)* ✓
Hover Description:	Cost and utilization metrics by setting, includes in/out of network data and benchmarks	
Report Description and Analytic Notes:	Provides utilization and unit cost metrics for inpatient, outpatient and professional services across 3 periods – the current period and two prior periods. Also includes count of unique claimants for Inpatient, Outpatient and Professional as well as metrics for in/out of network and a book of business benchmark comparison.	
Matches Reports:	Metrics on this report will match similar metrics to other reports when paid data are used.	

Report Facts:

1	This report provides a comprehensive view of the most commonly cited utilization and financial metrics for the Inpatient Facility, Outpatient Facility and Professional settings. In the Utilization by Setting – Paid View report, all data are based on paid dates.
2	The current and prior memberships used for calculations in this report include Average Subscribers and Average Members. Averages are derived by taking total Subscriber months and Member months and dividing each by the number of months in the report period – usually 12 months.
3	**Inpatient Facility:** This first sub-section includes aggregate and average utilization and financial measures for both the current and prior periods with book of business benchmarks for comparison. Only *Acute* Admits and Days are counted in this sub-section. All acute admit metrics are labeled as such. Although the admits and days per 1000 and the average length of stay applies only to acute hospital stays, this sub-section provides financial metrics (Total Paid and PMPM) for Acute admits and for Total Inpatient – which includes all stays, acute and non-acute.
4	On occasion the inpatient total paid amount can be less than the acute inpatient paid amount. This will happen when the overall non-acute claims result in a negative total. The negative non-acute claims will be reflected in the inpatient total paid amount but not in the acute inpatient paid

	amount.
5	**Outpatient Facility:** The Outpatient Facility sub-section is divided into 3 parts; Emergency Room, Non-Emergency Room and Total Outpatient Facility (ER and Non ER combined). Financial and Utilization measures, for the current and prior periods, are displayed for each of the three sections as well as trend data and comparisons to Book of Business benchmarks.
6	**Professional:** The Professional Services sub-section is divided into 3 categories: 1) Primary Care, 2) Specialty Care and Other, and 3) Total Professional. All Primary Care metrics are defined as specialty types such as Family Practice, Internal Medicine and Preventive Medicine, among others. Provider Specialty labeling is based on Provider Type codes.
7	All Specialty Care and Other metrics are defined as specialties that include Allergy & Immunology, Endocrinology & Metabolism and Oncology and many more. Provider Specialty labeling is based on Provider Type codes.
8	In the Total Professional sub-section, the metrics for Primary Care and Specialty Care and Other are combined. Overall counts of Visits and Services and Total Paid Amounts are displayed along with visits and services per 1000, amount paid per visit and per service.
9	**Total:** This final sub-section displays the overall Total Paid, Paid Amount PEPM (Per Employee Per Month) and Paid Amount PMPM (Per Member Per Month). PEPM is calculated by dividing the Total Paid amount by the Employee Months for the period. PMPM is calculated by dividing the Total Paid Amount by the Member Months for the period. For each of these metrics, trend is calculated and a comparison to a Book of Business benchmark is provided.
10	Two columns were added to show paid dollars for In-Network vs. paid dollars for Out-of-Network. In-Network is derived based on the network status of the provider as opposed to how the claim was paid.
11	The benchmark is for the current period.
12	The benchmark refers to the CII 2.0 Anthem Book of Business *excluding Medicare Primary.*
13	For WGS accounts with HMO, the metrics displaying "paid per" will no longer be calculated using encounter claims, providing more precise financial reporting for those services reimbursed under a fee for service arrangement rather than a capitated arrangement. Utilization metrics such as the unique claimant count, admissions, days, etc. will continue to include all members. The following footnote will appear only for WGS groups and any segments that include these products: **NOTE:** Capitation costs and charges for services under a capitated arrangement are excluded from financials. Counts for admissions, days, visits and services include all claimants, but claimants with capitated arrangements are excluded from calculations for paid per admission, per day, per visit and per service amounts.

Glossary:

Term	Description
Acute Admissions	Admissions that took place in an Acute Inpatient Hospital Facility are for conditions that would not be considered long term (e.g., residential treatment admissions, skilled nursing facility). Acute represents a pattern of health care in which a patient is treated for a brief but severe episode of illness. Acute care is usually given in a

	hospital by specialized personnel and it may involve intensive or emergency care. This pattern of care is often necessary for only a short time, unlike chronic care.
Acute Admissions per 1000	The number of admissions for acute care per 1000 members with medical coverage.
Acute Average Length of Stay	The average length of hospital stay for acute inpatient admissions for the reporting period. It is derived by dividing the total acute days by total acute stays/admissions.
Acute Days	The total number of days for acute hospital admissions.
Acute Days per 1000	The number of days for acute admissions per 1000 members enrolled with medical coverage.
Average Members	The average number of members per month with coverage during the time period. Each member is counted once for each month of their eligibility. The total is then averaged across the total number of months of eligibility.
Average Subscribers	The average number of employees/contracts per month with coverage during the time period. Each employee/contract is counted once for each month of their eligibility. The total is then averaged across the total number of months of eligibility.
Commercial Benchmark	Benchmark refers to a normative value against which plan metrics are compared. Benchmarks in CII include data from all Anthem accounts in the Client Information Insights database. The benchmark excludes Anthem Medicare Primary members.
Inpatient Facility	Inpatient Facility refers to the facility provider and to claims for services provided under the medical coverage in an inpatient setting. Unless otherwise noted an Inpatient Facility could be Acute, Non-Acute or a Long Term Care Facility.
In-Network	In-Network refers to services rendered by participating Network providers (i.e., providers under contract with Anthem to provide services at a discounted rate).
Out of Network	Refers to services rendered by non-participating Network providers (i.e., provider not under contract with Anthem).
Outpatient Facility	Identifies a facility provider type or site of service where non-inpatient services are provided. Outpatient Facilities include, but are not limited to, hospital outpatient departments, emergency rooms, free-standing facilities such as ambulatory surgical centers, medical centers, clinics or independent laboratories or imaging centers.
Paid Amount	Paid Amount is the net benefit issued for services provided under the Plan. It represents the amount Paid after all pricing guidelines have been applied, including provider discounts, and all non-covered, third-party/Medicare, copayment, coinsurance and deductible amounts have been subtracted. Health Reimbursement Account (HRA) payments are included in the paid amount (if selected).
Paid Amount Per Member Per Month (PMPM)	The average amount paid per member per month. It is a financial measure that is derived by dividing Paid Amount by Member Months. It is most commonly used as an indicator of financial trend.
Period	The time period that the report is based on.
Professional	Professional refers to a provider of medical services rendered, other than by an Inpatient or Outpatient Facility. Included are physicians and non-physicians, psychologists, nurse practitioners, optometrists, home health, therapists and others.
Services	The service count typically represents the units submitted on the claim. However, for certain services such as anesthesia, blood, medical supplies, injections, and ambulance services, the number of services will be counted as 1.
Services per 1000	The number of services rendered by a provider per 1000 members with medical coverage.
Trend	Trend is the percent change of any metric from the prior period to the current period. To calculate Trend subtract the prior period value from the current period value and then divide the result by the prior period value.
Variance to Commercial	The difference between the group's current period value and the commercial

Benchmark	benchmark.
Visit	The number of visits is based on the count of unique patients, service dates, and provider combinations. For claims that have had adjustments, visits will be reported with the most recent iteration of the claim (as opposed to following the dollars as they are adjusted).
Visits per 1000	A utilization measure that refers to the average number of Visits per 1000 members eligible for coverage for the period. Visits are annualized for the time period on the report.

U-01A - Inpatient Facility Utilization by Service Category

Report Number:	U-01A	
Report Section:	Utilization Reports	
Report Name:	Inpatient Facility Utilization by Service Category	
Time View:	Paid Dates w/an option for user to select Incurred	
Paid Amounts Available:	The following options are available: Standard Reporting Paid Amount + HRA - *Default* Reporting Paid Amount	
Time Periods Available:	The following options are available: Rolling 12 months - *Default* Rolling 3 months Plan year to date Calendar year to date	
Fully Insured/ASO Account Status:	Available for both Fully Insured and ASO Accounts	
Report Suppression Rules:	If the average medical membership in the current period for a client segment is less than 30, the report will be suppressed.	
Cell Level Suppression Rules:	If any of the Admission or Days values are greater than zero and less than or equal to 5, that cell and its total will be suppressed and replaced with an asterisk. In addition, the associated Average LOS will be suppressed and be replaced with an asterisk as well. If there is no data in the Unknown row, that row will be suppressed even if there is Benchmark data in the Unknown row.	
Early or Standard Report Production?	Early *(By End of 2nd Week of Month)*	Standard *(By End of 4th Week of Month)* ✓
Hover Description:	Provides the detail of inpatient claims as shown in the Utilization by Setting report (U-01)	
Report Description and Analytic Notes:	Provides Inpatient facility utilization statistics (admits, days, LOS, and cost) and Paid Amount PMPM for 3 periods (current and two prior periods) by service category. Also includes Book of Business (BOB) benchmark comparison to identify outliers. (Note that this is a 'facility' only report and, as such, excludes the outpatient and professional component.)	
Matches Reports:	This report will match to similar metrics on other reports when like paid data are used.	

Report Facts:

1	Use this report to show the distribution of Inpatient cost and utilization among the various service categories in comparison to the prior period and to the BOB (Book of Business) benchmark.
2	There are eight admit types, shown as Inpatient Services Categories on the report: Maternity Medical Surgical Mental Health/Substance Abuse Skilled Nursing Well Newborn Rehab Unknown
3	If an inpatient service category is missing or does not fit into one of the categories above, it will be labeled as 'unknown'.
4	For this report, CII 1.0 used DRGs to categorize inpatient admissions. In CII 2.0, we are using inpatient types of service to categorize inpatient admissions.
5	Note that this is a 'facility' only report and, as such, excludes the outpatient and professional component.
6	The benchmark refers to the CII 2.0 Anthem Book of Business *excluding Medicare Primary*.

Glossary:

Term	Description
Admissions	The number of reimbursable overnight stays within an inpatient acute or residential treatment facility.
Admissions per 1000	The number of inpatient admissions per 1000 members with medical coverage.
Average LOS	The average length of stay (LOS) for admissions for the reporting period. It is derived by dividing the total number of inpatient days (i.e., length of stay) by the total number of admissions.
Commercial Benchmark	Benchmark refers to a normative value against which plan metrics are compared. Benchmarks in CII include data from all Anthem accounts in the Client Information Insights database. The benchmark excludes Anthem Medicare Primary members.
Days	The count of inpatient days on facility claims associated with admissions. It is based on the days that were reported on facility claims containing room and board services.
Days per 1000	The average number of inpatient hospital days per 1000 members enrolled with medical coverage.
Inpatient Service Category	Inpatient Service Category refers to the type of admission. These categories include: Maternity, Medical, Surgical, Mental Health/Substance Abuse, Skilled Nursing, Well Newborn, Rehab and Unknown.
Paid Amount	Paid Amount is the net benefit issued for services provided under the Plan. It represents the amount Paid after all pricing guidelines have been applied, including provider discounts, and all non-covered, third-party/Medicare, copayment, coinsurance and deductible amounts have been subtracted. Health Reimbursement Account (HRA) payments are included in the paid amount (if selected).

Paid Amount Per Member Per Month (PMPM)	The average amount paid per member per month. It is a financial measure that is derived by dividing Paid Amount by Member Months. It is most commonly used as an indicator of financial trend.
Trend	Trend is the percent change of any metric from the prior period to the current period. To calculate Trend subtract the prior period value from the current period value and then divide the result by the prior period value.
Variance to Commercial Benchmark	The difference between the group's current period value and the commercial benchmark.

U-01B – Outpatient Facility Utilization by Service Category

Report Number:	U-01B	
Report Section:	Utilization Reports	
Report Name:	Outpatient Facility Utilization by Service Category	
Time View:	Paid Dates w/an option for user to select Incurred	
Paid Amounts Available:	The following options are available: Standard Reporting Paid Amount + HRA - *Default* Reporting Paid Amount	
Time Periods Available:	The following options are available: Rolling 12 months - *Default* Rolling 3 months Plan year to date Calendar year to date	
Fully Insured/ASO Account Status:	Available for both Fully Insured and ASO Accounts	
Report Suppression Rules:	If the average medical membership in the current period for a client segment is less than 30, the report will be suppressed.	
Cell Level Suppression Rules:	No cell level suppression rules apply.	
Early or Standard Report Production?	Early *(By End of 2nd Week of Month)*	Standard *(By End of 4th Week of Month)* ✓
Hover Description:	Provides the detail of outpatient claims as shown in the Utilization by Setting report (U-01)	
Report Description and Analytic Notes:	Provides Outpatient facility utilization statistics (visits, services and cost) and Paid Amount PMPM for 3 periods (current, and two prior periods) by service category. Also includes Book of Business (BOB) benchmark comparison to identify outliers. (Note that this is a 'facility' only report and, as such, excludes the inpatient and professional component.)	
Matches Reports:	This report will match to similar metrics on other reports when paid data are used.	

Report Facts:

1	This report displays distinct and descriptive Outpatient Facility Service Categories such as Emergency Department, Surgery, Lab/Pathology, Radiology, PT/ST/OT, Behavioral Health/Substance Abuse, Pharmacy, Home Health Services and All Other Outpatient Services.
2	Note that this is a 'facility' only report and, as such, excludes the inpatient and professional component.
3	The benchmark refers to the CII 2.0 Anthem Book of Business *excluding Medicare Primary*.
4	Outpatient services are categorized using Type of Service codes (TOS).
5	The following is a list of Outpatient categories used in the report: Emergency Room Surgery Maternity Other Lab & Pathology Pharmacy & Blood

	Radiology Unknown
6	Observation stays are inpatient stays that are less than 24 hours in length. The primary reporting category is Other. However, it is possible that some stays will be bundled with Emergency Room, Surgery, Oncology, IV therapy or Dialysis visits.

Glossary:

Term	Description
Commercial Benchmark	Benchmark refers to a normative value against which plan metrics are compared. Benchmarks in CII include data from all Anthem accounts in the Client Information Insights database. The benchmark excludes Anthem Medicare Primary members.
Paid Amount	Paid Amount is the net benefit issued for services provided under the Plan. It represents the amount Paid after all pricing guidelines have been applied, including provider discounts, and all non-covered, third-party/Medicare, copayment, coinsurance and deductible amounts have been subtracted. Health Reimbursement Account (HRA) payments are included in the paid amount (if selected).
Paid Amount Per Member Per Month (PMPM)	The average amount paid per member per month. It is a financial measure that is derived by dividing Paid Amount by Member Months. It is most commonly used as an indicator of financial trend.
Service Category	A category of services rendered by any provider, other than an inpatient or outpatient facility, across all service settings. Included are physician services, durable medical equipment, hospice, home health care, ambulance, nursing services, medical supplies, all therapies, etc.
Services	The service count typically represents the units submitted on the claim. However, for certain services such as anesthesia, blood, medical supplies, injections, and ambulance services, the number of services will be counted as 1.
Services per 1000	The number of services rendered by a provider per 1000 members with medical coverage.
Trend	Trend is the percent change of any metric from the prior period to the current period. To calculate Trend subtract the prior period value from the current period value and then divide the result by the prior period value.
Variance to Commercial Benchmark	The difference between the group's current period value and the commercial benchmark.
Visits	The number of visits is based on the count of unique patients, service dates, and provider combinations. For claims that have had adjustments, visits will be reported with the most recent iteration of the claim (as opposed to following the dollars as they are adjusted).
Visits per 1000	A utilization measure that refers to the average annualized number of Visits per 1000 members eligible for coverage for the period. Visits are annualized for time period on report.

U-01C - Professional Utilization by Service Category

Report Number:	U-01C	
Report Section:	Utilization Reports	
Report Name:	Professional Utilization by Service Category	
Time View:	Paid Dates w/an option for user to select Incurred	
Paid Amounts Available:	The following options are available: Standard Reporting Paid Amount + HRA - *Default* Reporting Paid Amount	
Time Periods Available:	The following options are available: Rolling 12 months - *Default* Rolling 3 months Plan year to date Calendar year to date	
Fully Insured/ASO Account Status:	Available for both Fully Insured and ASO Accounts	
Report Suppression Rules:	If the average medical membership in the current period for a client segment is less than 30, the report will be suppressed.	
Cell Level Suppression Rules:	No cell level suppression rules apply.	
Early or Standard Report Production?	Early *(By End of 2nd Week of Month)*	Standard *(By End of 4th Week of Month)* ✓
Hover Description:	Provides the detail of professional claims as shown in the Utilization by Setting report (U-01)	
Report Description and Analytic Notes:	Provides Professional facility utilization statistics (visits, services and cost) and Paid Amount PMPM for 3 periods (current, and two prior) by service category. Also includes Book of Business (BOB) benchmark comparison to identify outliers. (Note that this is a 'facility' only report and, as such, excludes the inpatient and outpatient component).	
Matches Reports:	This report will match to similar metrics on other reports when paid data are used.	

Report Facts:

1	This report displays various metrics for a full range of Medical Professional Service Categories. Included are descriptive Professional Service Categories for services rendered at both the Inpatient and Outpatient settings.
2	Professional Categories include, but are not limited to, all specialty and non-specialty physician services and the professional component of Lab and Radiology services, and other professional services.
3	Note that this is a 'facility' only report and, as such, excludes the outpatient and inpatient component.
4	The benchmark refers to the CII 2.0 Anthem Book of Business *excluding Medicare Primary*.
5	Professional services are categorized using Type of Service codes (TOS).

6	The following is a list of Professional categories used in the report: Professional – IP Surgery Professional – Maternity Professional – OP Surgery Professional – IP Visits MH/SA Professional – Therapeutic Injections Professional – Office/Home Visits Professional – Medical Professional – Preventive Services Other Professional Professional – Lab & Pathology Professional – Radiology Professional – Other Professional – Unknown
7	The Online Care section of the report will always appear, regardless of whether the client has the Online Care benefit. If the client does not have the Online Care benefit or if the client does have the Online Care benefit but there is no data, a zero will be shown for each Online Care Metric.

Glossary:

Term	Description
Commercial Benchmark	Benchmark refers to a normative value against which plan metrics are compared. Benchmarks in CII include data from all Anthem accounts in the Client Information Insights database. The benchmark excludes Anthem Medicare Primary members.
Paid Amount	Paid Amount is the net benefit issued for services provided under the Plan. It represents the amount Paid after all pricing guidelines have been applied, including provider discounts, and all non-covered, third-party/Medicare, copayment, coinsurance and deductible amounts have been subtracted. Health Reimbursement Account (HRA) payments are included in the paid amount (if selected).
Paid Amount Per Member Per Month (PMPM)	The average amount paid per member per month. It is a financial measure that is derived by dividing Paid Amount by Member Months. It is most commonly used as an indicator of financial trend.
Service Category	A category of services rendered by any provider, other than an inpatient or outpatient facility, across all service settings. Included are physician services, durable medical equipment, hospice, home health care, ambulance, nursing services, medical supplies, all therapies, etc.
Services	The service count typically represents the units submitted on the claim. However, for certain services such as anesthesia, blood, medical supplies, injections, and ambulance services, the number of services will be counted as 1.
Services per 1000	The number of services rendered by a provider per 1000 members with medical coverage.
Trend	Trend is the percent change of any metric from the prior period to the current period. To calculate Trend subtract the prior period value from the current period value and then divide the result by the prior period value.
Variance to Commercial Benchmark	The difference between the group's current period value and the commercial benchmark.
Visits per 1000	A utilization measure that refers to the average annualized number of Visits per 1000 members eligible for coverage for the period.

U-02 - Behavioral Health/Substance Abuse Utilization

Report Number:	U-02	
Report Section:	Utilization Reports	
Report Name:	Behavioral Health/Substance Abuse Utilization	
Time View:	Paid Dates w/an option for user to select Incurred	
Paid Amounts Available:	The following options are available: • Standard Reporting Paid Amount + HRA - *Default* • Reporting Paid Amount	
Time Periods Available:	The following options are available: • Rolling 12 months - *Default* • Rolling 3 months • Plan year to date • Calendar year to date	
Fully Insured/ASO Account Status:	Available for both Fully Insured and ASO accounts	
Report Suppression Rules:	If the average medical membership in the current period for a client segment is less than 30, the report will be suppressed.	
Cell Level Suppression Rules:	• **Inpatient Acute and Residential Treatment** ○ If Claimants is greater than zero and less than or equal to 5, then that metric along with its associated Paid Amount per Claimant and Trend will be suppressed and replaced with an asterisk. ○ If Admissions is greater than zero and less than or equal to 5, then Admissions will be suppressed and replaced with an asterisk. • **Partial Hospital Program and Intensive Outpatient Program** ○ If Claimants is greater than zero and less than or equal to 5, then that metric along with its associated Visit per Claimant and Trend will be suppressed and replaced with an asterisk. ○ If Visits is greater than zero and less than or equal to 5, then Visits will be suppressed and replaced with an asterisk. • **Professional Inpatient** ○ If Claimants is greater than zero and less than or equal to 5, then that metric along with its associated Visits per Claimant and Trend will be suppressed and replaced with an asterisk. ○ If Visits is greater than zero and less than or equal to 5, then then that metric along with its associated Paid Amount per Visit and Trend will be will be suppressed and replaced with an asterisk. ○ If Admissions is greater than zero and less than or equal to 5, then Admissions will be suppressed and replaced with an asterisk. • **Professional Outpatient** ○ If Claimants is greater than zero and less than or equal to 5, then that metric along with its associated Visit per Claimant and Trend will be suppressed and replaced with an asterisk. ○ If Visits is greater than zero and less than or equal to 5, then Visits along with its associated Paid Amount per Visit and Trend will be suppressed and replaced with an asterisk.	
Early or Standard Report Production?	Early *(By End of 2nd Week of Month)*	Standard *(By End of 4th Week of Month)* ✓

Hover Description:	Behavioral Health and Substance Abuse cost and utilization metrics by setting for current and prior paid periods, includes benchmarks
Report Description and Analytic Notes:	Provides a breakdown of behavioral health and substance abuse cost and utilization by setting and by type of service (behavioral health vs. substance abuse). Report includes separate Behavioral Health and Substance Abuse benchmarks.
Matches Reports:	This report will balance to the BH Top 10 Major Diagnoses report, and also to the "Mental Disorders" row in the Total Health Conditions by Paid Amount Report.

Report Facts:

1	Behavioral Health (Mental Health and Substance Abuse) are identified by diagnosis codes. See Fact #15 for ICD-9 codes and Fact #16 for ICD-10 codes used to select Behavioral Health data.
2	This report does not include Protected Health Information (PHI).
3	All metrics in this report are based on claim paid dates. Current and Prior period measures are displayed along with a calculation of Trend.
4	The Benchmark is based on the current reporting period.
5	The Benchmark refers to the CII 2.0 Anthem Book of Business *excluding Medicare Primary*.
6	Under the Facility Services section, the Inpatient Acute and Residential Treatment sub-sections include Inpatient Acute, Residential Treatment, Partial Hospitalization and Intensive Outpatient Program. Applicable Facility Services are based on a combination of Type of Service codes, Revenue codes and ICD diagnoses.
7	The Inpatient Acute and Residential Treatment sub-sections under Facility Services include these measures: Claimants, Days, Paid Amount, Admissions, Claimants per 1000, Days per 1000, Paid Amount per Claimant, Paid Amount per Day, Paid Amount PMPM, Admissions per 1000.
8	The Partial Hospital Program and Intensive Outpatient Program sub-sections under Facility Services include these measures: Claimants, Visits, Visits per 1000, Visits per Claimant, Paid Amount, Paid Amount per Visit, Paid Amount PMPM.
9	Under the Professional Services section, the report includes Professional – Inpatient and Professional – Outpatient sub-sections. Professional services are based on Type of Service codes and ICD diagnoses.
10	The Professional – Inpatient sub-section under Professional Services includes these measures: Claimants, Visits, Visits per 1000, Visits per Claimant, Paid Amount, Paid Amount per Visit, Paid Amount PMPM, Admissions, Admissions per 1000.
11	The Professional – Outpatient sub-section under Professional Services includes these measures: Claimants, Member Utilization %, Visits, Visits per 1000, Visits per Claimant, Paid Amount, Paid Amount per Visit, Paid Amount PMPM.
12	The All Services Combined section displays measures for all services combined. It includes: Paid Amount, Paid Amount PEPM (Per Employee Per Month) and Paid Amount PMPM (Per Member Per Month) are displayed in this sub-section. Separate totals are shown for Behavioral Health and Substance Abuse.
13	Data that will be suppressed for the Current or Prior period within a report section if there are 5 or less claimants for that section. Data suppressed will be: – Inpatient Acute: Claimants, Paid Amount, Admissions, Paid Amount per Claimant and Paid Amount per Day – Residential Treatment: Claimants, Paid Amount, Admissions, Paid Amount per Claimant and Paid Amount per Day

	– Partial Hospital Program: Claimants, Visits, Visits per Claimant, Paid Amount, Paid Amount per Visit – Intensive Outpatient Program: Claimants, Visits, Visits per Claimant, Paid Amount, Paid Amount per Visit – Professional Inpatient: Claimants, Visits, Visits per Claimant, Paid Amount, Paid Amount per Visit, Admissions – Professional Outpatient: Claimants, Visits, Visits per Claimant, Paid Amount, Paid Amount per Visit – All Services Combined: Paid Amount
14	The Trend column displays Current Period minus Prior Period divided by Prior Period multiplied by 100. Current and Prior periods will reflect behavioral health/substance abuse membership for the period. It is possible that either period may include less than 12 months of membership.
15	For WGS accounts with HMO, the metrics displaying "paid per" will no longer be calculated using encounter claims, providing more precise financial reporting for those services reimbursed under a fee for service arrangement rather than a capitated arrangement. Utilization metrics, such as; the unique claimant count, admissions, days, etc. will continue to include all members. The following footnote will appear only for WGS groups and any segments that include these products: **NOTE:** Capitation costs and charges for services under a capitated arrangement are excluded from financials. Counts for days, admissions, and visits include all claimants, but claimants with capitated arrangements are excluded from calculations for paid per claimant, per day and per visit amounts.
16	The following ICD9 diagnosis codes are used to determine Mental Health/Behavioral Health (codes that are not shaded) and Substance Abuse (codes shaded in gray):

Mental, Behavioral and Neurodevelopmental Disorders

Organic Psychotic Conditions (290-294)

Dementias	290
Alcohol induced mental disorders	291
Drug induced mental disorders	292
Transient mental disorders due to conditions classified elsewhere	293
Persistent mental disorders due to conditions classified elsewhere	294

Other nonorganic psychoses (295-299)

Schizophrenic disorders	295
Episodic mood disorders	296
Delusional disorders	297
Other nonorganic psychoses	298
Pervasive developmental disorders	299

Neurotic Disorders, Personality Disorders, and Other Nonpsychotic Mental Disorders (300-316)

Anxiety, dissociative and somatoform disorders	300
Personality Disorders	301
Sexual and gender identity disorders	302
Alcohol dependence syndrome	303
Drug dependence	304
Nondependent abuse of drugs	305
Physiological malfunction arising from mental disorders	306
Special symptoms or syndromes, NEC	307
Acute reaction to stress	308
Adjustment reaction	309

Specific nonpsychotic mental disorders due to brain damage	310
Depressive disorder, NEC	311
Disturbance of conduct, NEC	312
Disturbance of emotions specific to childhood and adolescence	313
Hyperkinetic syndrome of childhood	314
Specific delays in development	315
Psychotic factors associated with diseases classified elsewhere	316
Intellectual Disabilities (317-319)	
Mild intellectual disabilities	317
Other specified intellectual disabilities	318
Unspecified intellectual disabilities	319

17 The following ICD10 diagnosis codes are used to determine Mental Health/Behavioral Health (codes that are not shaded) and Substance Abuse (codes shaded in gray):

Mental, Behavioral and Neurodevelopmental Disorders

Mental disorders due to known physiological conditions (F01-F09)	
Vascular dementia	F01
Dementia in other diseases classified elsewhere	F02
Unspecified dementia	F03
Amnestic disorder due to known physiological condition	F04
Delirium due to known physiological condition	F05
Other mental disorders due to known physiological condition	F06
Personality and behavioral disorders due to known physiological condition	F07
Unsp mental disorder due to known physiological condition	F09
Mental and behavioral disorders due to psychoactive substance use (F10-F19)	
Alcohol related disorders	F10
Opioid related disorders	F11
Cannabis related disorders	F12
Sedative, hypnotic, or anxiolytic related disorders	F13
Cocaine related disorders	F14
Other stimulant related disorders	F15
Hallucinogen related disorders	F16
Nicotine dependence	F17
Inhalant related disorders	F18
Other psychoactive substance related disorders	F19
Schizophrenia, schizotypal, delusional, and other non-mood psychotic disorders (F20-F29)	
Schizophrenia	F20
Schizotypal disorder	F21
Delusional disorders	F22
Brief psychotic disorder	F23
Shared psychotic disorder	F24
Schizoaffective disorders	F25
Oth psych disorder not due to a sub or known physiol cond	F28
Unsp psychosis not due to a substance or known physiol cond	F29

Mood [affective] disorders (F30-F39)	
Manic episode	F30
Bipolar disorder	F31
Major depressive disorder, single episode	F32
Major depressive disorder, recurrent	F33
Persistent mood [affective] disorders	F34
Unspecified mood [affective] disorder	F39
Anxiety, dissociative, stress-related, somatoform and other nonpsychotic mental disorders (F40-F48)	
Phobic anxiety disorders	F40
Other anxiety disorders	F41
Obsessive-compulsive disorder	F42
Reaction to severe stress, and adjustment disorders	F43
Dissociative and conversion disorders	F44
Somatoform disorders	F45
Other nonpsychotic mental disorders	F48
Behavioral syndromes associated with physiological disturbances and physical factors (F50-F59)	
Eating disorders	F50
Sleep disorders not due to a substance or known physiological condition	F51
Sexual dysfunction not due to a substance or known physiological condition	F52
Puerperal psychosis	F53
Psych & behavrl factors assoc w disord or dis classd elswhr	F54
Abuse of non-psychoactive substances	F55
Abuse of antacids	F550
Abuse of antacids	F550
Abuse of antacids	F550
Abuse of antacids	F550
Abuse of herbal or folk remedies	F550
Abuse of herbal or folk remedies	F551
Abuse of herbal or folk remedies	F551
Abuse of herbal or folk remedies	F551
Abuse of laxatives	F551
Abuse of laxatives	F552
Abuse of laxatives	F552
Abuse of laxatives	F552
Abuse of steroids or hormones	F552
Abuse of steroids or hormones	F553
Abuse of steroids or hormones	F553
Abuse of steroids or hormones	F553
Abuse of vitamins	F553
Abuse of vitamins	F554
Abuse of vitamins	F554
Abuse of vitamins	F554

Abuse of other non-psychoactive substances	F554
Abuse of other non-psychoactive substances	F558
Abuse of other non-psychoactive substances	F558
Abuse of other non-psychoactive substances	F558
Unspecified behavioral syndromes associated with physiological disturbances and physical factors	F59
Disorders of adult personality and behavior (F60-F69)	
Specific personality disorders	F60
Impulse disorders	F63
Gender identity disorders	F64
Paraphilias	F65
Other sexual disorders	F66
Other disorders of adult personality and behavior	F68
Unspecified disorder of adult personality and behavior	F69
Intellectual disabilities (F70-F79)	
Mild intellectual disabilities	F70
Moderate intellectual disabilities	F71
Severe intellectual disabilities	F72
Profound intellectual disabilities	F73
Other intellectual disabilities	F78
Unspecified intellectual disabilities	F79
Pervasive and specific developmental disorders (F80-F89)	
Specific developmental disorders of speech and language	F80
Specific developmental disorders of scholastic skills	F81
Specific developmental disorder of motor function	F82
Pervasive developmental disorders	F84
Other disorders of psychological development	F88
Unspecified disorder of psychological development	F89
Behavioral and emotional disorders with onset usually occurring in childhood and adolescence (F90-F98)	
Attention-deficit hyperactivity disorders	F90
Conduct disorders	F91
Emotional disorders with onset specific to childhood	F93
Disorders of social functioning with onset specific to childhood and adolescence	F94
Tic disorder	F95
Other behavioral and emotional disorders with onset usually occurring in childhood and adolescence	F98
Unspecified mental disorder (F99)	F99

Glossary:

Term	Description
Admissions	The number of reimbursable overnight stays within an inpatient acute or residential treatment facility.
Admissions per 1000	The number of days for acute admissions per 1000 members enrolled with medical coverage.
Average Members	The average number of members per month with coverage during the time period. Each member is counted once for each month of their eligibility. The total is then averaged across the total number of months of eligibility.
Average Subscribers	The average number of employees/contracts per month with coverage during the time period. Each employee/contract is counted once for each month of their eligibility. The total is then averaged across the total number of months of eligibility.
Behavioral Health	Behavioral Health is a category of care, and plan benefits, covering the treatment of Mental Health and Substance Abuse disorders. Claims are defined based on the diagnosis code ranges noted above.
Claimants	Claimant refers to a member who has incurred expenses under the plan and has submitted a claim.
Claimants per 1000	The average number of claimants per 1000 members eligible for coverage for the period. Calculated as: Claimants/(Members/1000.
Commercial Benchmark	Benchmark refers to a normative value against which plan metrics are compared. Benchmarks in CII include data from all Anthem accounts in the Client Information Insights database. The benchmark excludes Anthem Medicare Primary members.
Days	The count of inpatient days on facility claims associated with admissions. It is based on the days that were reported on facility claims containing room and board services.
Days per 1000	The average number of inpatient hospital days per 1000 members enrolled with medical coverage.
Facility Services	Services rendered at an inpatient acute, residential treatment facility, partial hospital program or intensive outpatient program.
Inpatient Acute	Inpatient Acute Facility refers to an institution that provides care for conditions that are not considered "long term care." Acute represents a pattern of health care in which a patient is treated for a brief but severe episode of illness. Acute care is usually given in a hospital by specialized personnel and it may involve intensive or emergency care. This pattern of care is often necessary for only a short time, unlike chronic care.
Intensive Outpatient Program	Intensive Outpatient Program is a structured, short-term treatment modality that provides multidisciplinary services for covered individuals with an active psychiatric or substance abuse related illness. These programs, which serve as alternatives to inpatient or partial hospital care, meet at least three times per week, providing a minimum of three hours of treatment per session supervised by a licensed mental health professional.

Member Utilization %	The rate of utilization for members of the health plan. Calculated using the number of claimants divided by average number of members and expressed as a percentage.
Paid Amount	Paid Amount is the net benefit issued for services provided under the Plan. It represents the amount Paid after all pricing guidelines have been applied, including provider discounts, and all non-covered, third-party/Medicare, copayment, coinsurance and deductible amounts have been subtracted. Health Reimbursement Account (HRA) payments are included in the paid amount (if selected).
Paid Amount Per Employee Per Month (PEPM)	The average amount paid per employee per month. It is a financial measure that is derived by dividing total Paid Amount by total Employee Months.
Paid Amount Per Member Per Month (PMPM)	The average amount paid per member per month. It is a financial measure that is derived by dividing Paid Amount by Member Months. It is most commonly used as an indicator of financial trend.
Paid Amount per Claimant	The Paid Amount Per Claimant is derived by dividing the Total Paid amount by the number of claimants.
Paid Amount per Day	The average amount paid for an inpatient acute day (derived by dividing the total paid amount by the number of acute inpatient days).
Paid Amount per Visit	The average amount paid per visit for outpatient or professional claims.
Partial Hospital Program	Partial hospitalization (sometimes called day treatment) is a structured, short-term treatment modality that offers nursing care and active treatment in a program that is operable at a minimum of six (6) hours per day, five (5) days per week. Covered Individuals are not cared for on a 24-hour per day basis and typically leave the program each evening and/or weekends.
Period	The time period that the report is based on.
Professional Services	Professional Services refers to the category of services rendered by professional outside of an Inpatient or Outpatient Facility. Included are services provided by physicians and non-physicians, psychologists, nurse practitioners, optometrists, home health, therapists and others.
Professional – Inpatient	Professional Inpatient services would include professional services provided in an inpatient setting which are not included in the overall hospital per diem services. Included would be services such as physician visits and consultations.
Professional – Outpatient	Professional Outpatient treatment is a level of care in which a mental health professional, licensed to practice independently, provides care to individuals in an outpatient setting, whether to the covered individual, in family therapy or in a group therapeutic setting.
Residential Treatment	Residential treatment is defined as specialized treatment that occurs in a residential treatment center. These facilities are typically designated residential, sub-acute or intermediate care facilities and may occur in care systems that provide multiple levels of care.
Substance Abuse	Substance Abuse deals with the treatment of patients who are dependent upon substances such as drugs or alcohol. Diagnoses include alcohol withdrawal, drug psychosis

	or pathological drug intoxication. Substance Abuse is based on the Major 3 digit Diag Codes (291, 292, 303-305).
Trend	Trend is the percent change of any metric from the prior period to the current period. To calculate Trend subtract the prior period value from the current period value and then divide the result by the prior period value.
Variance to Commercial Benchmark	The difference between the group's current period value and the commercial benchmark.
Visits	The number of visits is based on the count of unique patients, service dates, and provider combinations. For claims that have had adjustments, visits will be reported with the most recent iteration of the claim (as opposed to following the dollars as they are adjusted).
Visits per 1000	A utilization measure that refers to the average number of Visits per 1000 members eligible for coverage for the period.
Visits per Claimant	The number of visits divided by the number of claimants.

U-02A - Behavioral Health Top Ten Major Diagnoses by Paid Amount

Report Number:	U-02A	
Report Section:	Utilization Reports	
Report Name:	Behavioral Health Top Ten Major Diagnoses by Paid Amount	
Time View:	Paid Dates w/an option for user to select Incurred	
Paid Amounts Available:	The following options are available: • Standard Reporting Paid Amount + HRA - *Default* • Reporting Paid Amount	
Time Periods Available:	The following options are available: • Rolling 12 months - *Default* • Rolling 3 months • Plan year to date • Calendar year to date	
Fully Insured/ASO Account Status:	Available for both Fully Insured and ASO accounts	
Report Suppression Rules:	If the average medical membership in the current period for a client segment is less than 30, the report will be suppressed.	
Cell Level Suppression Rules:	If the Unique Claimant count is greater than zero and less than or equal to 5 for any of the major diagnoses or in the All Other or Total rows, the Unique Claimant will be suppressed for that row as will the Paid Amount per Claimant. The metrics that are suppressed will be replaced with an asterisk.	
Early or Standard Report Production?	Early *(By End of 2nd Week of Month)*	Standard *(By End of 4th Week of Month)* ✓
Hover Description:	Top 10 Behavioral Health diagnoses by paid amount and setting, includes benchmarks	
Report Description and Analytic Notes:	Lists the top 10 behavioral health diagnoses in descending order with all other diagnoses combined reported under All Other Behavioral Health. Indicates the number of unique claimants, average paid amount per claimant, paid amount PMPM for current and prior periods including trend, plus a comparison to benchmark. Use this report when trying to determine the major diagnoses contributing to behavioral health claims cost.	
Matches Reports:	This report will balance to the BH Top 10 Major Diagnoses report, and also to the "Mental Disorders" row in the Total Health Conditions by Paid Amount Report.	

Report Facts:

1	Behavioral Health (Mental Health and Substance Abuse) are identified by diagnosis codes. See Fact #11 for ICD-9 codes and Fact #12 for ICD-10 codes used to select Behavioral Health data.
2	Report does not include Protected Health Information (PHI).
3	The time period selected determines the span of time the report is based on.
4	The selection of the top 10 Behavioral Health major diagnoses for this report is based on the total paid amount for each major diagnosis during the time period selected except as noted above.
5	All metrics in this report are based on claim paid dates. Current and Prior period measures are displayed along with a calculation of Trend.
6	Report includes data based on claims for medical services only. Pharmacy claims are not included as diagnosis codes are not available on pharmacy claims.
7	The All Other Behavioral Health reporting is the sum of all other major diagnoses that are not specifically identified as one of the top 10.

8	The Benchmark is based on the current reporting period.
9	The Benchmark refers to the CII 2.0 Anthem Book of Business *excluding Medicare Primary*.
10	The Quality Measure section displays the percentage of hospital discharges for depressive neuroses or psychoses where a follow-up outpatient visit occurred within 30 days of that discharge. This measure is useful in that it identifies the proportion of individuals who are seeking follow-up care after an inpatient stay for depressive neurosis or psychosis diagnoses.
11	For WGS accounts with HMO, the metrics displaying "paid per" will no longer be calculated using encounter claims, providing more precise financial reporting for those services reimbursed under a fee for service arrangement rather than a capitated arrangement. Utilization metrics such as the unique claimant count, admissions, days, etc. will continue to include all members. The following footnote will appear only for WGS groups and any segments that include these products: **NOTE:** Capitation costs and charges for services under a capitated arrangement are excluded from financials. Unique claimants by major diagnosis include those claimants with capitated arrangements, but these claimants are excluded from the paid amount per unique claimant.
12	The following ICD9 diagnosis codes are used to determine Mental Health/Behavioral Health (codes that are not shaded) and Substance Abuse (codes shaded in gray):

Mental, Behavioral and Neurodevelopmental Disorders

Organic Psychotic Conditions (290-294)

Dementias	290
Alcohol induced mental disorders	291
Drug induced mental disorders	292
Transient mental disorders due to conditions classified elsewhere	293
Persistent mental disorders due to conditions classified elsewhere	294

Other nonorganic psychoses (295-299)

Schizophrenic disorders	295
Episodic mood disorders	296
Delusional disorders	297
Other nonorganic psychoses	298
Pervasive developmental disorders	299

Neurotic Disorders, Personality Disorders, and Other Nonpsychotic Mental Disorders (300-316)

Anxiety, dissociative and somatoform disorders	300
Personality Disorders	301
Sexual and gender identity disorders	302
Alcohol dependence syndrome	303
Drug dependence	304
Nondependent abuse of drugs	305
Physiological malfunction arising from mental disorders	306
Special symptoms or syndromes, NEC	307
Acute reaction to stress	308
Adjustment reaction	309
Specific nonpsychotic mental disorders due to brain damage	310
Depressive disorder, NEC	311
Disturbance of conduct, NEC	312
Disturbance of emotions specific to childhood and adolescence	313
Hyperkinetic syndrome of childhood	314

Specific delays in development	315
Psychotic factors associated with diseases classified elsewhere	316
Intellectual Disabilities (317-319)	
Mild intellectual disabilities	317
Other specified intellectual disabilities	318
Unspecified intellectual disabilities	319

13 The following ICD10 diagnosis codes are used to determine Mental Health/Behavioral Health (codes that are not shaded) and Substance Abuse (codes shaded in gray):

Mental, Behavioral and Neurodevelopmental Disorders	
Mental disorders due to known physiological conditions (F01-F09)	
Vascular dementia	F01
Dementia in other diseases classified elsewhere	F02
Unspecified dementia	F03
Amnestic disorder due to known physiological condition	F04
Delirium due to known physiological condition	F05
Other mental disorders due to known physiological condition	F06
Personality and behavioral disorders due to known physiological condition	F07
Unsp mental disorder due to known physiological condition	F09
Mental and behavioral disorders due to psychoactive substance use (F10-F19)	
Alcohol related disorders	F10
Opioid related disorders	F11
Cannabis related disorders	F12
Sedative, hypnotic, or anxiolytic related disorders	F13
Cocaine related disorders	F14
Other stimulant related disorders	F15
Hallucinogen related disorders	F16
Nicotine dependence	F17
Inhalant related disorders	F18
Other psychoactive substance related disorders	F19
Schizophrenia, schizotypal, delusional, and other non-mood psychotic disorders (F20-F29)	
Schizophrenia	F20
Schizotypal disorder	F21
Delusional disorders	F22
Brief psychotic disorder	F23
Shared psychotic disorder	F24
Schizoaffective disorders	F25
Oth psych disorder not due to a sub or known physiol cond	F28
Unsp psychosis not due to a substance or known physiol cond	F29
Mood [affective] disorders (F30-F39)	
Manic episode	F30
Bipolar disorder	F31
Major depressive disorder, single episode	F32
Major depressive disorder, recurrent	F33

Persistent mood [affective] disorders	F34
Unspecified mood [affective] disorder	F39
Anxiety, dissociative, stress-related, somatoform and other nonpsychotic mental disorders (F40-F48)	
Phobic anxiety disorders	F40
Other anxiety disorders	F41
Obsessive-compulsive disorder	F42
Reaction to severe stress, and adjustment disorders	F43
Dissociative and conversion disorders	F44
Somatoform disorders	F45
Other nonpsychotic mental disorders	F48
Behavioral syndromes associated with physiological disturbances and physical factors (F50-F59)	
Eating disorders	F50
Sleep disorders not due to a substance or known physiological condition	F51
Sexual dysfunction not due to a substance or known physiological condition	F52
Puerperal psychosis	F53
Psych & behavrl factors assoc w disord or dis classd elswhr	F54
Abuse of non-psychoactive substances	F55
Abuse of antacids	F550
Abuse of antacids	F550
Abuse of antacids	F550
Abuse of antacids	F550
Abuse of herbal or folk remedies	F550
Abuse of herbal or folk remedies	F551
Abuse of herbal or folk remedies	F551
Abuse of herbal or folk remedies	F551
Abuse of laxatives	F551
Abuse of laxatives	F552
Abuse of laxatives	F552
Abuse of laxatives	F552
Abuse of steroids or hormones	F552
Abuse of steroids or hormones	F553
Abuse of steroids or hormones	F553
Abuse of steroids or hormones	F553
Abuse of vitamins	F553
Abuse of vitamins	F554
Abuse of vitamins	F554
Abuse of vitamins	F554
Abuse of other non-psychoactive substances	F554
Abuse of other non-psychoactive substances	F558
Abuse of other non-psychoactive substances	F558
Abuse of other non-psychoactive substances	F558

Unspecified behavioral syndromes associated with physiological disturbances and physical factors	F59
Disorders of adult personality and behavior (F60-F69)	
Specific personality disorders	F60
Impulse disorders	F63
Gender identity disorders	F64
Paraphilias	F65
Other sexual disorders	F66
Other disorders of adult personality and behavior	F68
Unspecified disorder of adult personality and behavior	F69
Intellectual disabilities (F70-F79)	
Mild intellectual disabilities	F70
Moderate intellectual disabilities	F71
Severe intellectual disabilities	F72
Profound intellectual disabilities	F73
Other intellectual disabilities	F78
Unspecified intellectual disabilities	F79
Pervasive and specific developmental disorders (F80-F89)	
Specific developmental disorders of speech and language	F80
Specific developmental disorders of scholastic skills	F81
Specific developmental disorder of motor function	F82
Pervasive developmental disorders	F84
Other disorders of psychological development	F88
Unspecified disorder of psychological development	F89
Behavioral and emotional disorders with onset usually occurring in childhood and adolescence (F90-F98)	
Attention-deficit hyperactivity disorders	F90
Conduct disorders	F91
Emotional disorders with onset specific to childhood	F93
Disorders of social functioning with onset specific to childhood and adolescence	F94
Tic disorder	F95
Other behavioral and emotional disorders with onset usually occurring in childhood and adolescence	F98
Unspecified mental disorder (F99)	F99

Glossary:

Term	Description
Commercial Benchmark	Benchmark refers to a normative value against which plan metrics are compared. Benchmarks in CII include data from all Anthem accounts in the Client Information Insights database. The benchmark excludes Anthem Medicare Primary members.

Inpatient Facility	Inpatient Facility refers to the facility provider and to claims for services provided under the medical coverage in an inpatient setting. Unless otherwise noted an Inpatient Facility could be Acute, Non-Acute or a Long Term Care Facility.
Major Diagnosis	Major Diagnosis refers to the principal diagnosis description based on the first three digits of the five digit diagnosis code. All diagnoses with the same first three digits will be rolled up into a single Major Diagnosis.
Outpatient Facility	Identifies a facility provider type or site of service where non-inpatient services are provided. Outpatient Facilities include, but are not limited to, hospital outpatient departments, emergency rooms, free-standing facilities such as ambulatory surgical centers, medical centers, clinics or independent laboratories or imaging centers.
Paid Amount Per Claimant	The Paid Amount Per Claimant is derived by dividing the Total Paid amount by the number of claimants.
Percent Total (Paid Amount by Setting)	The percent of Total Paid Amount is calculated by dividing the amount paid for the category by the total paid amount, expressed as a percentage.
Period	The time period that the report is based on.
Professional	Professional refers to a provider of medical services rendered, other than by an Inpatient or Outpatient Facility. Included are physicians and non-physicians, psychologists, nurse practitioners, optometrists, home health, therapists and others.
Quality Measure	The number of patients who had an ambulatory follow-up outpatient visit with a behavioral health practitioner within 30 days of discharge from an admission for depressive neurosis or psychosis, expressed as a percentage of the total number of patients who had an admission for depressive neurosis or psychosis.
Total Paid (Paid Amount by Setting)	Total Paid under the Paid Amount by Setting (Inpatient, Outpatient, Professional) section is the net benefit issued for services provided under the plan. It represents the amount paid after all pricing guidelines were applied, including provider discounts and all non-covered, third-party/Medicare, copayment, coinsurance and deductible amounts were subtracted.
Trend (Paid Amount PMPM)	Trend is the percent change of any metric from the prior period to the current period. To calculate Trend subtract the prior period value from the current period value and then divide the result by the prior period value.
Unique Claimants	A unique count of members who have incurred expenses under the plan and have submitted a claim.
Variance to Commercial Benchmark	The difference between the group's current period value and the commercial benchmark.

U-03 - Utilization by Top 25 Facility Providers

Report Number:	U-03	
Report Section:	Utilization Reports	
Report Name:	Utilization by Top 25 Facility Providers	
Time View:	Paid Dates w/an option for user to select Incurred	
Paid Amounts Available:	The following options are available: • Standard Reporting Paid Amount + HRA - *Default* • Reporting Paid Amount	
Time Periods Available:	The following options are available: • Rolling 12 Months - *Default* • Rolling 3 months • Calendar year to date • Plan year to date	
Fully Insured/ASO Account Status:	Available for both Fully Insured and ASO Accounts	
Report Suppression Rules:	If the average medical membership in the current period for a client segment is less than 30, the report will be suppressed.	
Cell Level Suppression Rules:	If the Unique Claimant count is greater than zero and less than or equal to 5 for any Provider or in the All Other Provider or Total rows, the Unique Claimant will be suppressed for that row as will the Paid Amount per Claimant. The metrics that are suppressed will be replaced with an asterisk.	
Early or Standard Report Production?	Early *(By End of 2nd Week of Month)*	Standard *(By End of 4th Week of Month)* ✓
Hover Description:	Top 25 in-network and out-of-network facilities by paid amount, by inpatient and outpatient settings	
Report Description and Analytic Notes:	Displays the top 25 In-Network and Out-of-Network providers for the Inpatient and Outpatient settings. This report can help you identify areas of opportunity to promote the use of In-Network utilization.	
Matches Reports:	Total Paid Amounts for In-Network and Out-of-Network Inpatient and Outpatient Facilities match the Medical Paid Amounts and Plan Savings (F-01A) Report. Combined In-Network and Out-of-Network totals for Inpatient and Outpatient Facilities match the Utilization by Setting (U-01) report. The Total number of In-Network and Out-of-Network visits for Outpatient Facility matches the "current" visits on the Utilization by Setting (U-01) report.	

Report Facts:

1	This report provides a comprehensive view of the highest utilized providers for the plan for both Inpatient and Outpatient facilities for both In-Network and Out-of-Network claims. The providers on the report are selected based on the highest paid amounts and not based on the volume of unique claimants utilizing any providers.
2	Only a current period view is available for this report (prior period is not available).
3	The same provider may sometimes appear in both the In-Network and Out-of-Network sections of the report. This can occur when a provider's network status changes.

4	Total paid amounts are shown In-Network and Out-Of-Network for Inpatient and Outpatient as well as a combined total for each type of facility.
5	The report is sorted by Paid Amount in descending order within each section (i.e, In-Network and Out-of-Network).
6	For Outpatient Facilities, visit counts may include multiple visits by unique claimants.
7	A row for "All Other Providers" for Inpatient and Outpatient facilities for both In-Network and Out-Of-Network providers illustrates a full picture of total paid within each category. It represents the total for all Inpatient or Outpatient providers that are not part of their respective top 25.
8	In-Network and Out of Network is defined via the Network Provider Indicator. In-Network is where this indicator is set to 'Y'. Out of Network is where this indicator is not equal to 'Y'. In other words, in-network vs. out-of-network status is not based on how the claim was paid, but rather on whether the provider is a contracted facility.
9	Note the same provider may be reported on multiple lines if they have a different spelling of the name or are associated with different cities.
10	The sum of unique claimants in the rows broken out by facility name may not match the total number of unique claimants in the Total. This is because a claimant may visit more than one provider. They would be counted under each provider, but only counted once in the total.
11	For WGS accounts with HMO, the metrics displaying "paid per" will no longer be calculated using encounter claims, providing more precise financial reporting for those services reimbursed under a fee for service arrangement rather than a capitated arrangement. Utilization metrics such as the unique claimant count, admissions, days, etc. will continue to include all members. The following footnote will appear only for WGS groups and any segments that include these products: **NOTE:** Capitation costs and charges for services under a capitated arrangement are excluded from financials. Unique claimant counts and visits include all members with claims, but financial calculations (e.g. paid per claimant) exclude claimants covered under a capitated service arrangement.

Glossary:

Term	Description
In-Network	In-Network refers to services rendered by participating Network providers (i.e., providers under contract with Anthem to provide services at a discounted rate).
Inpatient Facility	Inpatient Facility refers to the facility provider and to claims for services provided under the medical coverage in an inpatient setting. Unless otherwise noted an Inpatient Facility could be Acute, Non-Acute or a Long Term Care Facility.
Out of Network	Refers to services rendered by non-participating Network providers (i.e., provider not under contract with Anthem).
Outpatient Facility	Identifies a facility provider type or site of service where non-inpatient services are provided. Outpatient Facilities include, but are not limited to, hospital outpatient departments, emergency rooms, free-standing facilities such as ambulatory surgical centers, medical centers, clinics or independent laboratories or imaging centers.
Paid Amount	Paid Amount is the net benefit issued for services provided under the Plan. It represents the amount Paid after all pricing guidelines have been applied, including provider discounts, and all non-covered, third-party/Medicare, copayment, coinsurance and deductible amounts have been subtracted. Health Reimbursement

	Account (HRA) payments are included in the paid amount (if selected).
Paid Amount per Claimant	The paid amount per claimant is the total paid amount divided by the number of claimants.
Percent of Total	The percent of Total Paid Amount is calculated by dividing the amount paid for the category by the total paid amount, expressed as a percentage.
Provider Name and Location	A concatenation of the Provider Name, city and state for which the claims were incurred. Note the same provider may be reported on multiple lines if they have a different spelling of the name or are associated with different cities.
Unique Claimants	A unique count of members who have incurred expenses under the plan and have submitted a claim.
Visits	The number of visits is based on the count of unique patients, service dates, and provider combinations. For claims that have had adjustments, visits will be reported with the most recent iteration of the claim (as opposed to following the dollars as they are adjusted).

U-04 - Utilization by Professional Specialty

Report Number:	U-04	
Report Section:	Utilization Reports	
Report Name:	Utilization by Professional Specialty	
Time View:	Paid Dates w/an option for user to select Incurred	
Paid Amounts Available:	The following options are available: • Standard Reporting Paid Amount + HRA - *Default* • Reporting Paid Amount	
Time Periods Available:	The following options are available: • Rolling 12 Months - *Default* • Rolling 3 months • Calendar year to date • Plan year to date	
Fully Insured/ASO Account Status:	Available for both Fully Insured and ASO Accounts	
Report Suppression Rules:	If the average medical membership in the current period for a client segment is less than 30, the report will be suppressed.	
Cell Level Suppression Rules:	If the Unique Claimant count is greater than zero and less than or equal to 5 in any row, the metric will be suppressed. This holds true for Unique Claimants that are greater than zero and less than or equal to 5 in the 'Primary Care', 'Specialty Care and Other' and 'Total Professional' rows themselves. Any metric that is suppressed will be replaced with an asterisk.	
Early or Standard Report Production?	Early *(By End of 2nd Week of Month)*	Standard *(By End of 4th Week of Month)* ✓
Hover Description:	Professional paid amount and utilization split by in/out of network and by primary and specialty care service	
Report Description and Analytic Notes:	Provides In-Network vs. Out-of-Network cost and utilization by Professional specialty for primary care and specialists. Use this report to identify professional specialty categories utilized by plan members and to show cost and utilization metrics by in-network and out-of-network. This report will help to identify which specialties have the highest out-of-network utilization.	
Matches Reports:	In the Total Section of this report, Primary Care totals will match those Primary Care Totals on U-01 (Utilization by Setting – Paid View).	

Report Facts:

1	In this report, each row displays various measures by Provider Specialty. In the first sub-section, Primary Care providers are shown. Under the Primary Care section, provider specialty categories such as Family Practice, Internal Medicine and Preventive Medicine, among others, can be found.
2	Following the Primary Care section is a larger section for Specialty Care and Other. Under this sub-section, providers shown include Allergy & Immunology, Endocrinology & Metabolism and Oncology as well as many more.
3	Following the Specialty Care and Other sub-section, there is a Total Professional sub-section that shows the grand total where all applicable measures are summarized.
4	Claimant counts are not summed because a single claimant can have services with multiple providers. To arrive at a unique count of claimants, the claimant totals are recalculated in each sub-total line.

5	There are three column groupings for this report to separate the data based on In-Network, Out-of-Network and Total. In the In-Network, Out-of-Network and Totals Sections, Visits, Services and Unique Claimants are counted and the total Paid Amount for each Provider category is shown. In the Total section, In-Network and Out-of-Network visits, services and paid amounts are combined. There is also a calculation of Percent of Total. This measure shows the percentage of the grand total amount paid that is attributable to each provider category.
6	The report is sorted by Paid Amount in descending order within each section (i.e., In-Network and Out-of-Network). Specialties are sorted alphabetically by specialty name.
7	Only a current period view is available for this report (prior period is not available).

Glossary:

Term	Description
In-Network	In-Network refers to services rendered by participating Network providers (i.e., providers under contract with Anthem to provide services at a discounted rate).
Out-of-Network	Refers to services rendered by non-participating Network providers (i.e., provider not under contract with Anthem).
Paid Amount	Paid Amount is the net benefit issued for services provided under the Plan. It represents the amount Paid after all pricing guidelines have been applied, including provider discounts, and all non-covered, third-party/Medicare, copayment, coinsurance and deductible amounts have been subtracted. Health Reimbursement Account (HRA) payments are included in the paid amount (if selected).
Primary Care	A Primary Care provider is a physician or physician assistant who cares for a patient's overall health needs. Primary care providers specialize in General Practice, Family Practice, Internal Medicine, and Pediatrics.
Services	The service count typically represents the units submitted on the claim. However, for certain services such as anesthesia, blood, medical supplies, injections, and ambulance services, the number of services will be counted as 1.
Specialty	The legally recognized field of practice of a physician.
Specialty Care and Other	Specialty care is defined as those specialties not equal to professional primary care providers. Examples include Obstetrics & Gynecology, Anesthesiology, Dermatology , Radiology, Psychiatry, Surgery, etc.
Unique Claimants	A unique count of members who have incurred expenses under the plan and have submitted a claim.
Visits	The number of visits is based on the count of unique patients, service dates, and provider combinations. For claims that have had adjustments, visits will be reported with the most recent iteration of the claim (as opposed to following the dollars as they are adjusted).

U-05 - Emergency Room Savings Opportunity Analysis

Report Number:	U-05	
Report Section:	Utilization Reports	
Report Name:	Emergency Room Savings Opportunity Analysis	
Time View:	Paid Dates w/an option for user to select Incurred	
Paid Amounts Available:	The following options are available: • Standard Reporting Paid Amount + HRA - *Default* • Reporting Paid Amount	
Time Periods Available:	The following option is available: • Rolling 12 Months	
Fully Insured/ASO Account Status:	Available for both Fully Insured and ASO Accounts	
Report Suppression Rules:	If the average medical membership in the current period for a client segment is less than 30, the report will be suppressed.	
Cell Level Suppression Rules:	No cell level suppression.	
Early or Standard Report Production?	Early *(By End of 2nd Week of Month)*	Standard *(By End of 4th Week of Month)* ✓
Hover Description:	Emergency Room Savings Opportunity Analysis	
Report Description and Analytic Notes:	Provides the utilization metrics for low intensity (aka avoidable) Emergency Room visits for the current period and two prior periods. The report includes benchmarks for three utilization metrics. Use this report to illustrate the savings potential directly related to low intensity visits that can be appropriately diverted to a less costly setting such as urgent care facilities, retail clinics, doctor's office or online/telephonic visit services.	
Matches Reports:	The Total ER Visits will match the number of Total ER Visits on the Utilization by Setting Report. The Average Members will match Average Medical Members metrics on other CII 2 reports.	

Report Facts:

1	This report provides a review of emergency room visits and costs specific to diagnoses that are considered low intensity, or visits that do not require the intensive care provided through an ER department. The low intensity diagnoses are considered avoidable ER visits.
2	The purpose of this report is to illustrate the potential savings in medical costs had the member chosen an urgent care or retail clinic in place of a hospital emergency room.
3	The term "avoidable" is defined as one of a selected group of ICD-9 and ICD-10 codes that are considered low intensity in reference to the level of care that is needed to treat the illness/injury. For the purpose of this report, "avoidable" should be interpreted as "potentially avoidable."
4	The ER visit is a unique count of visits based on the patient ID, the service date and outpatient facility provider.
5	ER costs on this report include the outpatient facility costs, as well as the professional ER costs relating to the visit. Professional expenses for ambulance services to the ER are not included in the ER costs.

6	The ambulatory emergency room visits are limited to those visits that did not result in an inpatient admission, did not include surgery and did not include revenue codes for Observation or Urgent Care. Note: Ambulatory ER Visits is a subset of the Total ER Visits that is shown on the Utilization by Setting Report.
7	Since some hospital facilities may have urgent care centers as part of their facility, ER visits that have revenue codes for urgent care are removed.
8	The total of all ER visits follow the reporting logic of the Utilization by Setting report for ER visits.
9	There are 535 ICD-9 codes and 4,385 ICD-10 codes identified as low intensity, where a visit to an ER is not necessary and could have been avoided if other urgent care, retail clinic facilities or online/telephonic services were available and utilized by the patient.
10	The Emergency Room - Savings Opportunity Analysis Report will only be available as a ROLLING 12 MONTH report. This is due to seasonality changes and their impact to the data (i.e. flu season).
11	Potential Savings Opportunity Trend percentages for the 5% savings, 10% savings and 15% savings metrics will always equal Total Potential Savings Opportunity Trend metric.
12	A Bar Chart displays the top five diagnoses based on the number of avoidable ER visits, with a 2nd sort based on the highest dollar amount paid.
13	Offset Cost Value will be refreshed annually during January. Admins on the Lights On CII 2 Team will be responsible for entering this value on an annual basis. The updated value will be developed by the Anthem Research and Development Team (fka Advanced Analytics) and stored for each year. The Offset Cost Value to be used will be based on the last date of the reporting period. That is, if the last date is in 2013, then the 2013 value will be used; if the last date is in 2014, then the 2014 value will be used (as it relates to the offset cost for the different time periods shown).
14	Offset Cost Value is calculated to create the average cost of the alternative place of service for the low intensity/avoidable diagnoses. The logic includes: • Urgent Care, Retail Clinics and LiveHealth Online visits • Commercial ASO and Fully Insured business • All States (Anthem and non-Anthem) • Low Intensity diagnosis codes only • Primary Coverage • Cases must have Evaluation & Management (E&M) codes to be counted (no immunization/lab only visits).
15	The offset cost is subtracted from the average cost of the avoidable ER visits to determine the potential savings amount per visit. The potential savings amount times the number of visits equals the total potential savings amount.
16	A benchmark is included for the avoidable ER visits per 1000, paid PMPM and average cost per avoidable ER visit. The benchmark is for the current period and includes the variance of the group metrics to the benchmark.
17	The Benchmark will be based on a Rolling 12 Month commercial population, updated each month to reflect a rolling 12 month metric. The Benchmark will be using the same Rolling 12 data as the Account's data for its metrics for the current period. This is to ensure the benchmark data will allow for related comparison against the account. See examples below: Example 1: In January 2015, report would be: Paid Jan 1, 2014 – Dec 31, 2014 for both account metrics and benchmark metrics. Example 2: In May 2015, report would be: Paid May 1, 2014 – April 30, 2015 for both

	account metrics and benchmark metrics. Example 3: In August 2015, report would be: Paid Aug 1, 2014 – July 31, 2015 for both account metrics and benchmark metrics
18	The report uses the primary (first) diagnosis code on the claim to determine if the visit was for a low intensity/avoidable diagnosis.
19	The benchmark refers to the CII 2.0 Anthem Book of Business *excluding Medicare Primary*.
20	For WGS accounts with HMO, the metrics displaying "paid per" will no longer be calculated using encounter claims, providing more precise financial reporting for those services reimbursed under a fee for service arrangement rather than a capitated arrangement. Utilization metrics such as the unique claimant count, admissions, days, etc. will continue to include all members. The following footnote will appear only for WGS groups and any segments that include these products: **NOTE:** Capitation costs and charges for services under a capitated arrangement are excluded from financials. Potential Savings Opportunity assumes fee for service payment arrangement and does not reflect savings under a capitated arrangement.

Glossary:

Term	Description
Average Cost per Avoidable ER Visits	The average cost is the paid amount divided by the number of avoidable ER visits. Avoidable visits are those with one of the identified ICD-9 or ICD-10 diagnosis codes which are considered "low intensity" conditions.
Average Membership	The average number of members per month with coverage during the time period. Each member is counted once for each month of their eligibility. The total is then averaged across the total number of months of eligibility.
Avoidable ER cost	The Avoidable ER cost is the Paid Amount for ER visits that have a "low intensity" diagnosis code. Paid Amount is the net benefit issued for services provided under the Plan. It represents the amount Paid after all pricing guidelines have been applied, including provider discounts, and all non-covered, third-party/Medicare, copayment, coinsurance and deductible amounts have been subtracted. Health Reimbursement Account (HRA) payments are included in the paid amount (if selected).
Avoidable ER Visits Paid Amount PMPM	The average amount paid per member per month. It is a financial measure that is derived by dividing the Paid Amount for the avoidable ER visits by Member Months. It is most commonly used as an indicator of financial trend. Avoidable visits are those with one of the identified ICD-9 or ICD-10 diagnosis codes.
Avoidable ER Visits per 1000 Members	The number of ambulatory ER visits per 1000 members with medical coverage. Avoidable visits are those with one of the identified ICD-9 or ICD-10 diagnosis codes.
Commercial Benchmark	Benchmark refers to a normative value against which plan metrics are compared. Benchmarks in CII include data from all Anthem accounts in the Client Information Insights database. The benchmark excludes Anthem Medicare Primary members.
Less Offset Cost: Retail/Urgent Visit	The offset cost is the average cost of a visit at a non-ER facility (i.e. Urgent Care, Retail Clinic and LiveHealth Online visit). It is used to determine the potential savings amount per avoidable ER visit (i.e. Savings per visits redirected).
Low Intensity	Low Intensity is synonymous with "avoidable" and is considered the diagnosis codes that can generally be treated in an alternative setting from a facility emergency room.
Percentage of	The percentage of the 'all ambulatory ER visits' that were for avoidable diagnoses.

Avoidable ER Visits to All Ambulatory ER Visits	The calculation is Total Avoidable ER visits divided by Total of *All* Ambulatory ER visits.
Period (ER SOA report)	The time period that the report is based on. This report includes the current rolling 12 month period with comparisons to two prior periods.
Savings if 5% of Avoidable ER Visits Redirected	Five percent of the Total Potential Savings Opportunity amount.
Savings if 10% of Avoidable ER Visits Redirected	Ten percent of the Total Potential Savings Opportunity amount.
Savings if 15% of Avoidable ER Visits Redirected	Fifteen percent of the Total Potential Savings Opportunity amount.
Savings per Visit Redirected	This is the sum of the calculation of the average cost of the avoidable ER visit minus the offset cost. It is the potential savings amount per visit if the visit was at an urgent care, retail clinic facility or LiveHealth Online versus the hospital ER.
Total Avoidable ER Visits	Avoidable ER visits are visits made to a hospital emergency room, excluding visits resulting in an admission, involving surgery or observation and having a diagnosis code defined as low intensity (i.e. avoidable). There are 535 ICD-9 and 4,385 ICD-10 codes identified as low intensity.
Total of all Ambulatory ER Visits	All ER Visits excluding visits resulting in admission, visits for surgery, visits for observation and visits that do not have a revenue code for urgent care.
Total of all ER Visits	The sum of all ER Visits.
Total Potential Savings Opportunity	This is the total potential savings amount if all avoidable ER visits were redirected to a non-ER facility. It is the sum of the Total Avoidable ER Visits times the Savings per visit redirected.
Variance to Commercial Benchmark	The difference between the group's current period value and the commercial benchmark.

U-06 – Clinical Engagement and Utilization

Report Number:	U-06	
Report Section:	Utilization	
Report Name:	Clinical Engagement and Utilization	
Time View:	Paid Dates	
Time Periods Available:	Rolling 12 months	
Fully Insured/ASO Account Status:	Available for both Fully Insured and ASO Accounts	
Report Suppression Rules:	This report will be suppressed if the medical membership is less than 30.	
Cell Level Suppression Rules:	Several cells in this report will be suppressed and replaced with an asterisk if they do not meet the threshold of 5, along with an asterisk for any total or subtotal based on that cell of data. Pharmacy columns will be suppressed if the client has not purchased a pharmacy product.	
Early or Standard Report Production?	Early *(By End of 2nd Week of Month)*	Standard *(By End of 4th Week of Month)* ✓
Hover Description:	Demonstrates key clinical metrics for both the overall client population and members who are engaged in a Health and Wellness clinical program.	
Report Description and Analytic Notes:	A summary report that shows a client's membership and how they are engaged/not engaged in any clinical program, and to what extent services are being utilized compared with the entire membership population.	
Matches Reports:	None	

Report Facts:

1	The report is based on paid dates.
2	The report is based on a rolling 12 month period only. Other time period options and custom report options are not available.
3	This report is a standard view report.
4	The clinical programs captured in engagement are those managed on the Healthy Returns System (HRS) only.
5	The Commercial Benchmark is the Anthem commercial business excluding members where Medicare is primary.
6	Reason codes for Members Outreached To, Not Engaged are as follows: • **In Process:** The member is in the process of outreach for engagement. In Process trumps all other reasons for non-engagement. • **Lost Coverage/Ineligible:** The member lost program eligibility through the health plan. • **Invalid Phone:** The member does not have a valid phone number. • **Could Not Reach Member:** The member was unable to be reached telephonically. This is typically due to the inability to reach the member on the phone number provided. • **Member Declined:** The member was successfully contacted but subsequently either gave verbal refusal to participate in any aspect of the program, verbal refusal to participate due to lack of interest, or verbal refusal to participate due to his/her perception that the condition does not require management at this time. • **Other:** Reasons not aligning to any of the first 5 listed. These are miscellaneous categories that are either too small or yet undefined. Examples include members who are deceased, closed for

	triage review, or transferred to another clinical program.
7	Although not specifically listed on the report, this report uses the following programs when considering engagement. Behavioral Health Resource Center Behavioral Health Case Management Autism Spectrum Disorder Case Management (Includes some Integrated Models) Transplant Bariatric NICU ComplexCare Disease Management Health Support Maternity Management Health Coach As a reminder, Engaged is defined as follows: *A member is engaged at any point during the reporting period. This is a subset of "Members Enrolled". Each program may have a slightly different definition of engaged (i.e., all Health Assessment questions answered for CM, answered at least one fundamental HIP/PAT Health Assessment question for DM/HS). There is a qualifying assessment submission for the program subsequent to the case/episode begin date and prior to the end date.*

Glossary:

Term	Description
Enrollment	A member is enrolled at any point for any program during the reporting period. Each program may have a slightly different definition of enrolled (i.e., member consent documented for MHC/HS/CXC). This is a subset of "Members Identified for Targeted Coaching".
Engagement	A member is engaged at any point during the reporting period. This is a subset of "Members Enrolled". Each program may have a slightly different definition of engaged (i.e., all Health Assessment questions answered for CM, answered at least one fundamental HIP/PAT Health Assessment question for DM/HS). There is a qualifying assessment submission for the program subsequent to the case/episode begin date and prior to the end date.
ConditionCare (Disease Management)	Disease management members identified as high/moderate risk intensity at any time during the reporting period. ConditionCare includes Diabetes, Heart Failure, Asthma, Chronic Obstructive Pulmonary Disorder (COPD), and Coronary Artery Disease (CAD).
Health Support (HS)	Members in Vascular at Risk, Oncology, or Musculoskeletal programs identified as high/moderate risk and reported at their highest level of intensity during the reporting period.
Case Management (CM)	Any reportable program case during the reporting period. Includes the following programs: Case Management (Includes some Integrated Models)

	Transplant Bariatric NICU
Behavioral Health (BH)	Any reportable program case during the reporting period. Includes the following programs: Behavioral Health Resource Center Behavioral Health Case Management Autism Spectrum Disorder
MyHealth Coach (MHC)	Any reportable program case during the reporting period. MyHealth Coach proactively reaches out to those members who are at risk for serious health issues or have current medical needs, and any member can call in for assistance.
ComplexCare (CxC)	Any reportable program case during the reporting period. ComplexCare reaches out to members with multiple health care issues who are at risk for frequent and high levels of medical care in order to offer support and assistance in managing their health care needs.
FutureMoms Maternity (FM)	Any reportable program case during the reporting period. The FutureMoms program employs specialized, nurse health coaches with experience in pregnancy to assist mothers-to-be by providing information and coaching, allowing the member to make good decisions that may result in healthier pregnancies.
Total Members	Members associated with the client during the reporting period
Total Members Identified for Management	Total members identified for management are those members with a reportable program case during the reporting period. This includes cases of all intensities.
Members identified for Targeted Coaching	Members identified for Targeted Coaching are managed telephonically at any point during the reporting period. Subset of 'Total Members Identified for Management.'
Members Outreached to, Not Engaged	This is a subset of "Members Identified for Targeted Coaching". Based on the last non-open status reason. Enrollment status not applicable to not engaged. A non-engaged member may or may not be enrolled. Multiple non-open statuses on the same day have this trumping order (which is based on the order displayed on the report): Lost Coverage/Ineligible, Invalid Phone Number, Could Not Reach Member, Member Declined, Other. In Process trumps all other reasons for non-engagement. Definitions of reasons for non-engagement are as follows: • **In Process:** The member is in the process of outreach for engagement. In Process trumps all other reasons for non-engagement. • **Lost Coverage/Ineligible:** The member lost program eligibility through the health plan. • **Invalid Phone:** The member does not have a valid phone number. • **Could Not Reach Member:** The member was unable to be reached telephonically. This is typically due to the inability to reach the member on the phone number provided. • **Member Declined:** The member was successfully contacted but subsequently either gave verbal refusal to participate in any aspect of the program, verbal refusal to participate due to lack of interest, or verbal refusal to participate due to his/her perception that the condition does not require management at this time. • **Other:** Reasons not aligning to any of the first 5 listed. These are miscellaneous categories that are either too small or yet undefined. Examples include members who are deceased, closed for triage review, or transferred to another clinical program.
High Cost Claimants/	The number of members, both engaged and total, who have had claims in excess of

1000-	the high cost claimant threshold per 1000 members, during the reporting period.
Non High Cost Claimants / 1000	The number of members both engaged and total, who did not have claims in excess of the high cost claimant threshold per 1000 members, during the reporting period.
Inpatient Admissions / 1000	The number of admissions for both engaged and total acute care per 1000 members with medical coverage.
Inpatient Days / 1000	The number of days for both engaged and total acute admissions per 1000 members enrolled with medical coverage.
30 Days Readmission Rate	The proportion of all qualifying admissions, for engaged and total members during the reporting period, that result in a readmission for any diagnosis (all cause) within 30 days of discharge. Certain exclusions apply; Aligns with 2015 HEDIS specifications.
ER Visits / 1000	The number of emergency room visits per 1000 for both engaged and total members enrolled with medical coverage. Aligns with Tier 1 and Tier 2 Quick Care Options designations.
Avoidable ER Visits/1000	The number of ambulatory ER visits per 1000 members, both engaged and total, with medical coverage. Avoidable visits are those with one of the identified ICD-9 or ICD-10 diagnosis codes.
Health Risk Index	The Health Risk Index is a diagnostic and age/sex adjusted projection of the populations likely level of risk for the period indicated. The Benchmark is presented for comparison. A higher score than '1' indicates a higher level of utilization and a higher level of risk; a score lower than '1' indicates lower risk.
Number of Deliveries	Number of deliveries, based on claims, for total members and members engaged in any program reflected in this report.
C Section Rate	Subset of 'Number of Deliveries' classified as caesarian section for total members and members engaged in any program reflected in this report.

MCC-01 - Total Health Conditions by Paid Amount

Report Number:	MCC-01	
Report Section:	Medical Claim – Clinical Reports	
Report Name:	Total Health Conditions by Paid Amount	
Time View:	Paid Dates w/an option for user to select Incurred	
Paid Amounts Available:	The following options are available: • Standard Reporting Paid Amount + HRA - *Default* • Reporting Paid Amount	
Time Periods Available:	The following options are available: • Rolling 12 months - *Default* • Rolling 3 months • Plan year to date • Calendar year to date	
Fully Insured/ASO Account Status:	Available for both Fully Insured and ASO Accounts	
Report Suppression Rules:	If the average medical membership in the current period for a client segment is less than 30, the report will be suppressed.	
Cell Level Suppression Rules:	If the Unique Claimant count is greater than zero and less than or equal to 5 in any row, the Unique Claimant and its associated Paid Amount per Claimant will be suppressed. This holds true for Unique Claimants that are greater than zero and less than or equal to 5 in the 'Total' row also. In the Summary Paid section, if the Unique Claimant or the Paid Amount per Unique Claimant is greater than zero and less than or equal to 5, the metric will be suppressed as will the Trend. Any metric that is suppressed will be replaced with an asterisk. The entire row of the Unknown category will be suppressed if there is no data available.	
Early or Standard Report Production?	Early *(By End of 2nd Week of Month)*	Standard *(By End of 4th Week of Month)* ✓
Hover Description:	All health conditions ranked by paid amount showing claimants and paid amount by setting	
Report Description and Analytic Notes:	Displays all medical health conditions ranked by total paid amount. A count of claimants, paid amounts by setting and PMPM for the current and prior periods are also shown. The current period PMPM is compared to the book of business (BOB) benchmark. Use this report to determine what health conditions had the highest cost and utilization for plan members. Comparisons to the prior period and to the BOB benchmark will help to determine if wellness initiatives or education programs would be beneficial.	
Matches Reports:	**All CII Reports** The overall totals should match all CII reports where overall Total Paid amounts are shown. **Ten Paid Health Conditions by Relationship and PMPM (MCC-01A)** The Paid Amounts, PMPM (Per Member Per Month) Total, Trend and Variance to	

	the Benchmark will match by health condition category. **Top Five Health Conditions Paid with Top Three Diagnoses (MCC-01B)** The overall Total will match the overall Total Paid amounts by setting (Inpatient, Outpatient and Professional).

Report Facts:

1	The report is sorted in descending order by Total Paid Amount per Health Condition Category.
2	The report contains a total of all conditions by setting.
3	The report includes a graph that shows the top 5 health conditions in reverse order displaying the paid amount PMPM for benchmark, current and prior.
4	The benchmark refers to the CII 2.0 Anthem Book of Business excluding Medicare Primary.
5	Trend on this report represents the change in PMPM (Per Member Per Month) from the Prior Period to the Current Period.
6	Percent Variance shows the difference in PMPM between the Current Period and the Benchmark.
7	This report includes a table that provides a comparison of Total Paid, Claimant counts and Paid per Claimant averages for the current and prior periods.
8	For each Health Condition Category on this report, a count of unique claimants is shown. Within each Health Condition category, no claimant can be counted more than once, regardless of the number of different diagnoses they were treated for within that Health Condition. However, since it is possible for any member to have had services for diagnoses in multiple Health Conditions during the reporting period, that claimant will be counted once in each Health Condition for which they received treatment. The count of claimants on the overall Total line on this report is a unique count of claimants. Each claimant is counted only once in this total regardless of the number of Health Conditions for which they received treatment. For this reason, the count of unique claimants for each Health Condition cannot be summed to arrive at the Total unique claimants.
9	For WGS accounts with HMO, the metrics displaying “paid per” will no longer be calculated using encounter claims, providing more precise financial reporting for those services reimbursed under a fee for service arrangement rather than a capitated arrangement. Utilization metrics such as the unique claimant count, admissions, days, etc. will continue to include all members. The following footnote will appear only for WGS groups and any segments that include these products: **NOTE:** Capitation costs and charges for services under a capitated arrangement are excluded from financials. Unique claimants by condition include those claimants with capitated arrangements, but these claimants are excluded from the paid amount per unique claimant.

MCC-01A - Top Ten Paid Health Conditions by Relationship and PMPM

Report Number:	MCC-01A	
Report Section:	Medical Claim – Clinical Reports	
Report Name:	Top Ten Paid Health Conditions by Relationship and PMPM	
Time View:	Paid Dates w/an option for user to select Incurred	
Paid Amounts Available:	The following options are available: Standard Reporting Paid Amount + HRA - *Default* Reporting Paid Amount	
Time Periods Available:	The following options are available: Rolling 12 months - *Default* Rolling 3 months Plan year to date Calendar year to date	
Fully Insured/ASO Account Status:	Available for both Fully Insured and ASO Accounts	
Report Suppression Rules:	If the average medical membership in the current period for a client segment is less than 30, the report will be suppressed.	
Cell Level Suppression Rules:	The Total Claimants and % of Total will be suppressed for each health condition and associated diagnosis if the count is less than 5.	
Early or Standard Report Production?	Early *(By End of 2nd Week of Month)*	Standard *(By End of 4th Week of Month)* ✓
Hover Description:	Top 10 health conditions by paid amount, by relationship and PMPM	
Report Description and Analytic Notes:	Summarizes the leading health conditions by relationship as well as by PMPM. Use this report to assess the potential for wellness initiatives for members affected by these conditions. It can also be used to follow the cost trends of the more prevalent conditions, and to target those conditions that have the greatest cost savings potential.	
Matches Reports:	**All CII Reports** The overall totals should match all CII reports where overall Total Paid amounts are shown. **Total Health Conditions by Paid Amount (MCC-01)** The Paid Amounts, PMPM (Per Member Per Month) Total, Trend and Variance to the Benchmark will match by diagnosis category. **Top Five Health Conditions Paid with Top Three Diagnoses (MCC-01B)** The overall Total will match the overall Total Paid amounts by setting (Inpatient, Outpatient and Professional).	

Report Facts:

1	The selection of the Top Ten Health Conditions Categories is based on the Total Paid amount for each Health Condition. The Top Ten Health Conditions on this report match the first ten health conditions shown on the MCC-01 Total Health Conditions by Paid Amount since that report is sorted in descending order by Total Paid Amount. If there is a tie for the last item in a ranking for Top 10, the report will display the tied items.

	The top-10 will only include Health Conditions Categories whose paid amounts are greater than zero for the current period.
2	In addition to the relationship categories Employee/Self, Spouse/Partner and Child/Other Dependent there is an "Unassigned" category which will include any claimant that cannot be assigned to one of the three relationship categories because the enrollment record may not contain the necessary relationship code.
3	The All Other category shows the values for all Health Conditions that are not included in the Top Ten Health Conditions displayed in this report.
4	PMPM for this report is calculated individually for each relationship category and, therefore, uses only that relationship category's membership and paid amount in the calculation. Using each relationship category membership as the denominator in the PMPM calculation for this report allows a User to assess the impact of the individual category (i.e. employee, spouse, child) to the costs.
5	Trend on this report represents the change in PMPM (Per Member Per Month) from the Prior Period to the Current Period for each respective relationship category.
6	Percent Variance shows the difference in PMPM between the Current Period and the Benchmark.
7	The benchmark refers to the CII 2.0 Anthem Book of Business *excluding Medicare Primary*.
8	If there is a tie for the last item in a ranking for Top 10, the report must display all the items that tied.
9	Also included in this report is a graph that shows a PMPM by Relationship comparison for the Top Five Health Conditions.

Glossary:

Term	Description
Commercial Benchmark	Benchmark refers to a normative value against which plan metrics are compared. Benchmarks in CII include data from all Anthem accounts in the Client Information Insights database. The benchmark excludes Anthem Medicare Primary members.
Child/Other Dependent	Represents the child or other dependent eligible for coverage under the subscriber's benefit plan.
Employee/Self	Represents the employee or subscriber who holds coverage.
Health Conditions Category	A range of diagnosis codes classified together into a Health Condition Category (e.g., Neoplasms, Injury and Poisoning, etc.).
Paid Amount	Paid Amount is the net benefit issued for services provided under the Plan. It represents the amount Paid after all pricing guidelines have been applied, including provider discounts, and all non-covered, third-party/Medicare, copayment, coinsurance and deductible amounts have been subtracted. Health Reimbursement Account (HRA) payments are included in the paid amount (if selected).
Percent Variance to Commercial Benchmark PMPM	Percentage variance difference between the group's current period value and the commercial benchmark.
Paid Amount Per Member Per Month (PMPM)	The average amount paid per member per month. It is a financial measure that is derived by dividing Paid Amount by Member Months. It is most commonly used as an indicator of financial trend.
PMPM Trend	PMPM Trend is the percent change of any metric from the prior period to the current period. To calculate Trend subtract the prior period value from the current period value and then divide the result by the prior period value * 100.

Relationship	The relationship of the member to the contract holder. The values are Employee/Self, Spouse/Partner, Child/Other Dependent or Unassigned.
Spouse/Partner	Represents the wife, husband or domestic partner eligible for coverage under the subscriber.
Unassigned	The “unassigned” category includes any claimant that cannot be assigned to one of the three relationship categories because the enrollment record may not contain the necessary relationship code.

MCC-01B - Top Five Health Conditions Paid with Top Three Diagnoses

Report Number:	MCC-01B	
Report Section:	Medical Claim – Clinical Reports	
Report Name:	Top Five Health Conditions Paid with Top Three Diagnoses	
Time View:	Paid Dates w/an option for user to select Incurred	
Paid Amounts Available:	The following options are available: Standard Reporting Paid Amount + HRA - *Default* Reporting Paid Amount	
Time Periods Available:	The following options are available: Rolling 12 months - *Default* Rolling 3 months Plan year to date Calendar year to date	
Fully Insured/ASO Account Status:	Available for both Fully Insured and ASO Accounts	
Report Suppression Rules:	If the average medical membership in the current period for a client segment is less than 30, the report will be suppressed.	
Cell Level Suppression Rules:	If the Unique Claimants count in any row including the 'Subtotal', 'All Other' and 'Total' rows is greater than zero and less than or equal to 5, then the Unique Claimant and Percent of Total in that row will be suppressed and replaced with an asterisk.	
Early or Standard Report Production?	Early *(By End of 2nd Week of Month)*	Standard *(By End of 4th Week of Month)* ✓
Hover Description:	Top 5 health conditions based on total paid amount, showing the top 3 diagnoses	
Report Description and Analytic Notes:	Shows the paid amounts by setting for the top three diagnoses within the leading health conditions. Also displayed is the number of claimants for each condition and comparisons to the book of business (BOB) benchmark. Use this report to identify opportunities for wellness initiatives, care management services and specific programs that target the top health conditions.	

Matches Reports:	**<u>All CII Reports</u>** The overall totals should match all CII reports where overall Total Paid amounts are shown. **<u>Total Health Conditions by Paid Amount (MCC-01)</u>** The overall totals and PMPM (Per Member Per Month – Current and Prior) Totals will match. The totals for each of the top 5 health conditions should match the total for the top 5 health conditions on the Total Health Conditions by Paid Amount (MCC-01) report. **<u>Ten Paid Health Conditions by Relationship and PMPM (MCC-01A)</u>** The overall totals and PMPM (Per Member Per Month – Current and Prior) Totals will match. The totals for each of the top 5 health conditions should match the total for the top 5 health conditions on the Ten Paid Health Conditions by Relationship and PMPM (MCC-01A) report.

<u>Report Facts</u>:

1	The selection of Top Five Health Conditions is based on the Total Paid amount for each Health Condition. The Top Five Health Conditions on this report match the first five health conditions shown on the MCC-01 Total Health Conditions by Paid Amount report since that report is sorted in descending order by Total Paid Amount. If there is a tie for the last item in a ranking for Top 5, the report will display all tied items. The top-5 will only include Health Conditions Categories whose paid amounts are greater than zero for the current period.
2	The Health Condition Total (bold) line should match the other report totals.
3	For each Diagnosis displayed on this report, a count of unique claimants is shown. Within each Diagnosis, no claimant can be counted more than once, regardless of the number of services rendered for that claimant for that specific diagnosis. However, since it is possible for any member to have had services for more than one of the diagnoses shown for each health condition, that claimant will be counted once in each diagnosis for which they received treatment. The count of claimants on the overall Total line on this report is a unique count of claimants. Each claimant is counted only once in this total regardless of the number of diagnoses or health conditions for which they received treatment. For this reason, the count of unique claimants for each diagnosis cannot be summed to arrive at the Total unique claimants.
4	The benchmark refers to the CII 2.0 Anthem Book of Business *excluding Medicare Primary*.

Glossary:

Term	Description
Commercial Benchmark	Benchmark refers to a normative value against which plan metrics are compared. Benchmarks in CII include data from all Anthem accounts in the Client Information Insights database. The benchmark excludes Anthem Medicare Primary members.
Diagnosis	In healthcare, diagnostic codes are used to group and identify diseases, disorders, symptoms, etc.
Health Conditions Category	A range of diagnosis codes classified together into a Health Condition Category (e.g., Neoplasms, Injury and Poisoning, etc.).
Inpatient	Inpatient refers to the facility provider and to claims for services provided under the medical coverage in an inpatient setting. Unless otherwise noted an Inpatient Facility could be Acute, Non-Acute or a Long Term Care Facility.
Outpatient	Identifies a facility provider type or site of service where non-inpatient services are provided.
Paid Amount	Paid Amount is the net benefit issued for services provided under the Plan. It represents the amount Paid after all pricing guidelines have been applied, including provider discounts, and all non-covered, third-party/Medicare, copayment, coinsurance and deductible amounts have been subtracted. Health Reimbursement Account (HRA) payments are included in the paid amount (if selected).
Paid Amount Per Member Per Month (PMPM)	The average amount paid per member per month. It is a financial measure that is derived by dividing Paid Amount by Member Months. It is most commonly used as an indicator of financial trend.
Percent of Total Unique Claimants	This metric is derived by dividing the unique claimant count in each diagnosis range by the total number of unique claimants.
Professional	Professional refers to a provider of medical services rendered, other than by an Inpatient or Outpatient Facility. Included are physicians and non-physicians, psychologists, nurse practitioners, optometrists, home health, therapists and others.
Period	The time period that the report is based on
Unique Claimants	A unique count of members who have incurred expenses under the plan and have submitted a claim.

MCC-02 Top Ten Target Program Conditions by Relationship, Setting and PMPM

Report Number:	MCC-02	
Report Section:	Medical Claim – Clinical Reports	
Report Name:	Top Ten Target Program Conditions by Relationship, Setting and PMPM	
Time View:	Incurred Dates w/an option for user to select Paid Dates	
Paid Amounts Available:	The following options are available: • Standard Reporting Paid Amount + HRA - *Default* • Reporting Paid Amount	
Time Periods Available:	The following options are available: • Rolling 12 months - *Default* • Rolling 3 months • Plan year to date • Calendar year to date	
Fully Insured/ASO Account Status:	Available for both Fully Insured and ASO Accounts	
Report Suppression Rules:	If the average medical membership in the current period for a client segment is less than 30, the report will be suppressed.	
Cell Level Suppression Rules:	• For each Program Condition, If the Unique Claimants count is greater than zero and less than or equal to 5, then that Unique Claimant will be suppressed and replaced with an asterisk. This includes the 'Total' for the Program Condition as well as the 'Subtotal'. • The "unassigned" relationship category Unique Claimant count will never be suppressed.	
Early or Standard Report Production?	Early *(By End of 2nd Week of Month)*	Standard *(By End of 4th Week of Month)* ✓
Hover Description:	Top ten target/chronic conditions by relationship and setting	
Report Description and Analytic Notes:	Summarizes the top ten target program conditions by relationship, number of claimants, total paid amount by dollars and PMPM, and by setting, for the current period as compared to the prior period and to the book of business (BOB) benchmark. Use this report to determine prevalence of target program conditions within the group and to determine potential opportunities for specific programs, strategies or initiatives to impact the members with these conditions.	
Matches Reports:	Clinical Dashboard – Top Ten Target Program Conditions	

Report Facts:

1	Sorted by Paid Amount PMPM, this report is based on - Medical Only Claims - incurred dates of service
2	Report provides - total of all Paid Amounts for all Relationships - subtotals for top ten conditions and all other conditions - grand totals for all conditions and PMPM
3	Displays top ten Target Program Conditions by paid amount in descending order - If there is a tie for the last item in a ranking for Top ten, the report must display all the items

	that tied - If the paid amount for any of the conditions is $0, only list the top-X that have paid amounts greater than zero
4	All field values explicitly defined in the report columns should appear on the report, even if there is no data with that value for a given client. If that occurs, the column would not be suppressed, but would instead show 0s.
5	The benchmark refers to the CII 2.0 Anthem Book of Business *excluding Medicare Primary*.
6	The following 10 target program conditions are included in this report: • Congestive Heart Failure (CHF) • Asthma • Chronic Obstructive Pulmonary Disease (COPD) • Diabetes • Hypertension • Depression • Low Back Pain • Cancer • Maternity • Coronary Artery Disease (CAD)

Glossary:

Term	Description
Child/Other Dependent	Represents the child or other dependent eligible for coverage under the subscriber's benefit plan.
Commercial Benchmark	Benchmark refers to a normative value against which plan metrics are compared. Benchmarks in CII include data from all Anthem accounts in the Client Information Insights database. The benchmark excludes Anthem Medicare Primary members.
Employee/Self	Represents the employee or subscriber who holds coverage.
Inpatient	Inpatient refers to the facility provider and to claims for services provided under the medical coverage in an inpatient setting. Unless otherwise noted an Inpatient Facility could be Acute, Non-Acute or a Long Term Care Facility.
Outpatient	Identifies a facility provider type or site of service where non-inpatient services are provided.
Paid Amount	Paid Amount is the net benefit issued for services provided under the Plan. It represents the amount Paid after all pricing guidelines have been applied, including provider discounts, and all non-covered, third-party/Medicare, copayment, coinsurance and deductible amounts have been subtracted. Health Reimbursement Account (HRA) payments are included in the paid amount (if selected).
Paid Amount Per Member Per Month (PMPM)	The average amount paid per member per month. It is a financial measure that is derived by dividing Paid Amount by Member Months. It is most commonly used as an indicator of financial trend.

Prevalence - Percent Variance to Commercial Benchmark	Percentage variance between Current Prevalence and Commercial Benchmark Prevalence.
Prevalence per 1000	The average number of patients who received services provided under medical coverage, per 1000 unique members with medical coverage.
Period	The time period that the report is based on.
Professional	Professional refers to a provider of medical services rendered, other than by an Inpatient or Outpatient Facility. Included are physicians and non-physicians, psychologists, nurse practitioners, optometrists, home health, therapists and others.
Spouse/Partner	Represents the wife, husband or domestic partner eligible for coverage under the subscriber.
Top ten Target Program	A defined list of conditions that have Anthem programs such as Asthma, Diabetes, COPD, CAD, CHF, etc.
Unassigned	“Unassigned” category includes any claimant that cannot be assigned to one of the three relationship categories because the enrollment record may not contain the necessary relationship code.
Unique Claimants	A unique count of members who have incurred expenses under the plan and have submitted a claim.
Variance to Commercial Benchmark	The difference between the group's current period value and the commercial benchmark.

MCC-03 - Preventive Care Services

Report Number:	MCC-03	
Report Section:	Medical Claim – Clinical Reports	
Report Name:	Preventive Care Services	
Time View:	Incurred	
Paid Amounts Available:	The following options are available: Standard Reporting Paid Amount + HRA - *Default* Reporting Paid Amount	
Time Periods Available:	This report is based on a 'point in time' only and the user will be able to choose the 'as of' date.	
Fully Insured/ASO Account Status:	Available for both Fully Insured and ASO Accounts	
Report Suppression Rules:	If the average medical membership in the current period for a client segment is less than 30, the report will be suppressed.	
Cell Level Suppression Rules:	If the Eligible Members metrics are greater than zero and less than or equal to 5 for any category, the Eligible Members, Members Receiving Care and Current Percent Compliance metrics will be suppressed and replaced with an asterisk.	
Early or Standard Report Production?	Early *(By End of 2nd Week of Month)*	Standard *(By End of 4th Week of Month)* ✓
Hover Description:	Displays member compliance for preventive and wellness care measures, based on incurred data.	
Report Description and Analytic Notes:	Displays each preventive care category, identifying eligible member, counts of members receiving care for the current period as compared to the prior period and to the Book of Business benchmark. The report also contains a return to compliance column now that shows how many users who were eligible, but not compliant last month are still eligible and compliant this month. Use this report to identify areas of opportunity for benefit changes to encourage and promote preventive care. Also use this report to identify opportunities to educate the member about the importance of preventive visits, routine screenings, and regular provider visits.	
Matches Reports:	This report will not match any other CII 2.0 report. The Preventive Care Services report is unique and represents a subset of the total experience. It affects only those members that have had services in specific report categories.	

Report Facts:

1	The Preventive Care Services Report is based on the following preventive care categories: Breast Cancer Screening Cervical Cancer Screening Colon Cancer Screening Well Adolescent Visits - 12 through 17 Years Well Adult Visits - Men 18 through 64 Years Well Adult Visits - Women 18 through 64 Years

	Well Baby Visits - Birth through 15 Months Well Child Visits - 3 through 6 Years To see how each of the above preventive care categories are created, please refer to the Glossary below.
2	For all Preventive Care categories, the utilization rate is based on a Rate of Compliance, which is the percentage of Eligible Members who received any Preventive Care service applicable to each respective category.
3	Within this report, the preventive care categories are based on the rules and guidelines for each individual category listed (see glossary for each measure).
4	Eligible membership in Preventive Care categories is not mutually exclusive, if a member meets the eligibility requirement. An adult male may be an eligible member in the Adult Well Care and Colon Cancer during the same report period. Furthermore, a member can be eligible in both the Adult and Adolescent categories if that member reaches the Adult age of 18 years at any time during the reporting period.
5	The benchmark refers to the CII 2.0 Anthem Book of Business *excluding Medicare Primary*.
6	This report does not include an option to change the Incurred vs. Paid Date. However, functionality is available to modify the end date using the parameter option.

Glossary:

Term	Description
Breast Cancer Screening	Identifies women ages 42 to 69 years old with evidence of breast cancer screening over the last 2 years (excluding women with past history of breast cancer).
Cervical Cancer Screening	Identifies women 24 to 64 years of age who received cervical cancer screening during the last 3 years.
Colon Cancer Screening	Identifies members aged 51 to 75 years old who have up to date colorectal cancer screening.
Commercial Benchmark	Benchmark refers to a normative value against which plan metrics are compared. Benchmarks in CII include data from all Anthem accounts in the Client Information Insights database. The benchmark excludes Anthem Medicare Primary members.
Eligible Members	Eligible Member refers to those members who meet the age, gender and enrollment qualifications for each respective Preventive Care Category. The count of Eligible Members will be based on an average or a unique count for the reporting period.
Members Receiving Care	Members who received preventive services for defined preventive care measures during the reporting period.
Percent Compliance	The compliance rate is expressed as a percentage of eligible members, for each respective category, who had at least one of the applicable services performed during the reporting period. The rate of compliance is calculated by dividing the eligible member count for each category into the count of unique members receiving care.
Period	The time period that the report is based on.
Preventive Care	Preventive Care refers to routine services and screenings for conditions such as Colon, Prostate, Cervical and Breast Cancer and Cholesterol, where early detection will often result in a more favorable outcome.

Return to Guideline Compliance	Changes in the compliance rate from the prior time period for each category. Members must be eligible in the last time period and in the current time period to be included in the calculation. The rate of members going from non-compliant to compliant is calculated as follows: Of the members eligible for the rule last month and still eligible this month, count those members that went from non-compliant to compliant for each well visit.
Well Adolescent Visits – 12 through 17 Years	This measure is used to assess the percentage of enrolled children 12 to 17 years old at end of the measurement year who received at least one well-care visit during the measurement year. This is the AWC HEDIS 2014 utilization measure.
Well Adult Visits - Men 18 through 64 Years	Identifies the percentage of enrolled men >= 18 to < 65 years old at end of the measurement year who received at least one well-care visit during the measurement year.
Well Adult Visits – Women 18 through 64 Years	Identifies the percentage of enrolled women >= 18 to < 65 years old at end of the measurement year who received at least one well-care visit during the measurement year.
Well Baby Visits – Birth through 15 Months	Identifies the percentage of enrolled children turning 15 months old during the measurement year who received six or more well-care visits during their first 15 months of life.
Well Child Visits – 3 through 6 Years	This measure identifies the percentage of enrolled children 3 to 6 years old at end of the measurement year who received at least one well-care visit during the measurement year.

MCC-04 - Top 25 Episode Treatment Groups

Report Number:	MCC-04	
Report Section:	Medical Claim – Clinical Reports	
Report Name:	Top 25 Episode Treatment Groups	
Time View:	Incurred Only	
Time Periods Available:	The following options are available: Rolling 12 months - *Default* Rolling 3 months Plan year to date Calendar year to date	
Fully Insured/ASO Account Status:	Available for both Fully Insured and ASO Accounts	
Report Suppression Rules:	If the average medical membership in the current period for a client segment is less than 30, the report will be suppressed. If all financial fields for a table are 0, the table is suppressed.	
Cell Level Suppression Rules:	If the Unique Claimants count is greater than zero and less than or equal to 5 in any row the metric will be suppressed and replaced with an asterisk. If the 'All Other' Unique Claimants is greater than zero and less than or equal to 5 then the Unique Claimant 'Subtotal' will be suppressed.	
Early or Standard Report Production?	Early *(By End of 2nd Week of Month)*	Standard *(By End of 4th Week of Month)* ✓
Hover Description:	Cost and utilization metrics for leading Episode Treatment Groups (ETGs)	
Report Description and Analytic Notes:	Outlines the leading episode groups by paid amount, number of claimants, episode details in comparison to the book of business benchmark. Use this report to identify the top episode groups within a particular population and to target wellness opportunities and wellness initiatives.	
Matches Reports:	The top five Episode Summary Groups on this report match the top five Episode Summary Groups on the Top Five Episode Groups Drill Down report (MCC-04A).	

Report Facts:

1	Episode Treatment Groups are updated on a quarterly basis, but the report will be run on a monthly basis. Data for the most recent quarter is included in CII 2.0 for the current time period, and data for the prior period will display the concurrent prior time period.
2	An Episode includes all services for a member, for a medical condition. An Episode is specific to a member and includes medical care, including lab and diagnostic radiology, along with pharmacy expenses. Lab, diagnostic radiology or pharmacy data alone will not trigger an Episode, but will be included once an Episode is created. Chronic Episodes (e.g. diabetes, asthma, COPD, etc.) are measured over a one year period.
3	Episodes allow you to analyze the entire course of treatment for a condition. They provide useful data for analyzing how conditions are being treated and the cost of the treatment plans.
4	Prescription drugs are included in Episodes based on clinical relevance and proximity in time. For example, drugs related to Appendicitis are included when utilized 7 days prior and 90 days post treatment, while drugs for Allergic Rhinitis are included 180 days pre or post the medical treatment.
5	Not all claim records are assigned to an Episode, e.g. a diagnostic claim that is not tied to a qualifying medical claim to start an Episode.
6	Episodes are closed when there are no new claims/encounters received for that course of

	treatment during a defined period. This period is referred to as the "clean period." The clean period can range from 30 to 120 days, depending on the type of acute Episode. Clean period requirements are specified for each ETG. Acute episodes have a defined start and end date, based on the member's eligibility and claim dates of service. Examples of the different clean periods: Bronchitis has a clean period of 30 days; Appendicitis has a clean period of 90 days. There are no "clean periods" for chronic diseases/conditions or well care. Chronic episodes are closed at the end of a calendar year (for reporting purposes). A new Episode is initiated when claims/encounters are received during the next calendar year.
7	Diabetes Episodes are considered chronic but have different clean periods depending on severity of acute flare-ups. For example: Diabetes Mellitus, Chronic Maintenance is, as the name suggests, considered chronic with no clean period, closing at the end of the calendar year. Diabetic conditions considered Chronic with Acute Flare-ups may have different clean periods: Diabetes with Leg Ulcer & Cellulitis Diabetes with Retinal Hemorrhage Diabetes with Other Severe Complication Diabetes with Gangrene & Osteomyelitis (Osteomyelitis = bone infection)
8	Claimant counts are based on unique claimants who have had claims for a specific Episode Summary Group. A single claimant may be included in the claimant count for multiple Episode Summary Groups.
9	The benchmark refers to the CII 2.0 Anthem Book of Business *excluding Medicare Primary*.

Glossary:

Term	**Description**
Commercial Benchmark	Benchmark refers to a normative value against which plan metrics are compared. Benchmarks in CII include data from all Anthem accounts in the Client Information Insights database. The benchmark excludes Anthem Medicare Primary members.
Episode Count	The number of episodes for all members in the reporting period.
Episodes Per 1000	The average number of episodes of care per 1000 members with medical coverage.
Episodes Per 1000 Trend	Episodes per 1,000 Trend is a measure that shows the percent change in the Average Episodes per 1,000 utilization rate, from the prior period to the current period.
Episode Treatment Group	A summarization of the inpatient, outpatient, and prescription drug treatment related to a given course of illness, with links to all of the underlying detail. ETG's are regarded as the industry standard for episodic patient classification.
Paid Amount	Paid Amount is the net benefit issued for services provided under the Plan. It represents the amount Paid after all pricing guidelines have been applied, including provider discounts, and all non-covered, third-party/Medicare, copayment, coinsurance and deductible amounts have been subtracted. Health Reimbursement Account (HRA) payments are included in the paid amount (if selected).

Paid Amount Per Member Per Month (PMPM)	The average amount paid per member per month. It is a financial measure that is derived by dividing Paid Amount by Member Months. It is most commonly used as an indicator of financial trend.
Percent of Total Episodes	The percent of total episodes is calculated by dividing the individual Episode Count by the Total Episode count, expressed as a percentage.
Unique Claimants	A unique count of members who have incurred expenses under the plan and have submitted a claim.

MCC-04A Top Five Episode Groups, Drilldown with Top Three Episodes

Report Number:	MCC-04A	
Report Section:	Medical Claim – Clinical Reports	
Report Name:	Top Five Episode Groups, Drilldown with Top Three Episodes	
Time View:	Incurred Only	
Time Periods Available:	The following options are available: Rolling 12 months - *Default* Rolling 3 months Plan year to date Calendar year to date	
Fully Insured/ASO Account Status:	Available for both Fully Insured and ASO Accounts	
Report Suppression Rules:	If the average medical membership in the current period for a client segment is less than 30, the report will be suppressed. If all financial fields for a table are 0, the table is suppressed.	
Cell Level Suppression Rules:	If the Unique Claimants count in any row including the 'Subtotal', 'All Other' or 'Total' row is greater than zero and less than or equal to 5, the metric will be suppressed and replaced with an asterisk.	
Early or Standard Report Production?	Early *(By End of 2nd Week of Month)*	Standard *(By End of 4th Week of Month)* ✓
Hover Description:	Top 5 Episode Summary Groups with the top 3 Episodes showing cost, utilization and benchmark	
Report Description and Analytic Notes:	Identifies the top 5 Episode groups including details of the top drivers within each category with comparison to the commercial benchmark. Use this report to formulate strategies to impact the health of members as well as to decrease costs and utilization.	
Matches Reports:	The total paid amount should match the total paid amount on other reports.	

Report Facts:

1	An Episode includes all services for a member, for a medical condition. An Episode is specific to a member and includes medical care, including lab and diagnostic radiology, along with pharmacy expenses. Lab, diagnostic radiology or pharmacy data alone will not trigger an Episode, but will be included once an Episode is created. Chronic Episodes (e.g. diabetes, asthma, COPD, etc.) are measured over a one year period.
2	Episode Treatment Groups are updated on a quarterly basis, but the report will be run on a monthly basis.
3	Episodes allow you to analyze the entire course of treatment for a condition. They provide useful data for analyzing how conditions are being treated and the cost of the treatment plans.
4	Prescription drugs are included in Episodes based on clinical relevance and proximity in time. For example, drugs related to Appendicitis are included when utilized 7 days prior and 90 days post treatment, while drugs for Allergic Rhinitis are included 180 days pre or post the medical treatment.
5	Not all claim records are assigned to an Episode, e.g. a diagnostic claim that is not tied to a qualifying medical claim to start an Episode.
6	Episodes are closed when there are no new claims/encounters received for that course of treatment during a defined period. This period is referred to as the "clean period." Clean period requirements are specified for each ETG. Acute episodes have a defined start and end date, based on the

	member's eligibility and claim dates of service. Examples of the different clean periods: Bronchitis has a clean period of 30 days; Appendicitis has a clean period of 90 days. There are no "clean periods" for chronic diseases/conditions or well care. Chronic episodes are closed at the end of a calendar year for reporting purposes. A new Episode is initiated when claims/encounters are received during the next calendar year.
7	Diabetes Episodes are considered chronic but have different clean periods depending on severity of acute flare-ups. For example: Diabetes Mellitus, Chronic Maintenance is, as the name suggests, considered chronic with no clean period, closing at the end of the calendar year. Diabetic conditions considered Chronic with Acute Flare-ups may have different clean periods: Diabetes with Leg Ulcer & Cellulitis Diabetes with Retinal Hemorrhage Diabetes with Other Severe Complication Diabetes with Gangrene & Osteomyelitis (Osteomyelitis = bone infection)
8	Claimant counts are based on unique claimants who have had claims for a specific Episode Summary Group. A single claimant may be included in the claimant count for multiple Episode Summary Groups.
9	The benchmark refers to the CII 2.0 Anthem Book of Business *excluding Medicare Primary*.

Glossary:

Term	Description
Commercial Benchmark	Benchmark refers to a normative value against which plan metrics are compared. Benchmarks in CII include data from all Anthem accounts in the Client Information Insights database. The benchmark excludes Anthem Medicare Primary members.
Episode Count	The number of episodes for all members in the reporting period.
Episodes Per 1000	The average number of episodes of care per 1000 members with medical coverage.
Episodes Per 1000 Trend	Episodes per 1,000 Trend is a measure that shows the percent change in the Average Episodes per 1,000 utilization rate, from the prior period to the current period.
Episode Treatment Group	A summarization of the inpatient, outpatient, and prescription drug treatment related to a given course of illness, with links to all of the underlying detail. ETG's are regarded as the industry standard for episodic patient classification.
Episode Treatment Summary Group	An Episode Summary Group is made up of Episode Groups that are related, most commonly, by diagnosis (e.g., Pregnancy). It is an aggregation of Episode Treatment Groups (ETGs) for related conditions. For example, the Episode Treatment Summary Group for "Pregnancy" would include ETGs of "Pregnancy w/Delivery" and "Pregnancy not yet Delivered."

Paid Amount	Paid Amount is the net benefit issued for services provided under the Plan. It represents the amount Paid after all pricing guidelines have been applied, including provider discounts, and all non-covered, third-party/Medicare, copayment, coinsurance and deductible amounts have been subtracted. Health Reimbursement Account (HRA) payments are included in the paid amount (if selected).
Paid Amount Per Member Per Month (PMPM)	The average amount paid per member per month. It is a financial measure that is derived by dividing Paid Amount by Member Months. It is most commonly used as an indicator of financial trend.
Unique Claimants	A unique count of members who have incurred expenses under the plan and have submitted a claim.

MCC-05 - Lifestyle Conditions by Paid Amount

Report Number:	MCC-05	
Report Section:	Medical Claim – Clinical Reports	
Report Name:	Lifestyle Conditions by Paid Amount	
Time View:	Incurred Dates w/an option for user to select Paid Dates	
Paid Amounts Available:	The following options are available: • Standard Reporting Paid Amount + HRA - *Default* • Reporting Paid Amount	
Time Periods Available:	The following options are available: • Rolling 12 months - *Default* • Rolling 3 months • Plan year to date • Calendar year to date	
Fully Insured/ASO Account Status:	Available for both Fully Insured and ASO Accounts	
Report Suppression Rules:	If the average medical membership in the current period for a client segment is less than 30, the report will be suppressed.	
Cell Level Suppression Rules:	If the Unique Claimants count for any Lifestyle Condition or in the 'Total of All Lifestyle Conditions' row is greater than zero and less than or equal to 5, then the Unique Claimants and its associated Paid Amount per Claimant will be suppressed and replaced with an asterisk.	
Early or Standard Report Production?	Early *(By End of 2nd Week of Month)*	Standard *(By End of 4th Week of Month)* ✓
Hover Description:	Top 20 lifestyle conditions ranked by paid amount with comparisons to Commercial benchmark	
Report Description and Analytic Notes:	Shows potentially avoidable diagnostic conditions which are generally associated with specific lifestyle choices and health risk factors. Use this report to identify wellness opportunities or initiatives aimed at increasing the state of health of the group and to reduce utilization of services for these conditions.	
Matches Reports:	**All CII Reports** The total paid amount should match all CII reports where overall Total Paid amounts are shown.	

Report Facts:

1	This report shows conditions that *may* have direct or indirect connection to Lifestyle choices and/or behaviors. A Lifestyle related health condition is a disease or condition associated with how a person or group of people live; they are those conditions where there is a reasonably strong association with a Lifestyle behavior such as smoking, alcohol, diet or exercise and a health condition such as diabetes, high blood pressure or lung cancer . There are some conditions, Parkinson's Disease for instance, that may affect one's lifestyle but are not caused by a lifestyle choice. Such diseases would not be included among the lifestyle related conditions shown in this report. The intent of this report is to show that there are numerous health conditions that could have been brought about or exacerbated by choices the member made regarding lifestyle. There is no evidence to show, for any individual claimant, that there is an actual

	connection between the Health Conditions shown on the report and the lifestyle choices that may be related to it.
2	There are 46 health conditions that are related to Lifestyle choices. The selection of the top 20 lifestyle conditions shown on this report is based on highest paid amount. The report is sorted in descending order of total paid amount per lifestyle condition.
3	The top twenty lifestyle conditions are shown on the report. All other lifestyle conditions are summarized in the 'All Other Lifestyle Conditions' category.
4	There is a paid amount total summary for 'All Lifestyle Conditions', 'All Non-Lifestyle Conditions' and a 'Total' for Lifestyle and Non-Lifestyle Conditions combined.
5	The Total of All Lifestyle Conditions (Paid Amount) is the total claim expense for conditions most commonly associated with lifestyle behaviors.
6	The benchmark refers to the CII 2.0 Anthem Book of Business *excluding Medicare Primary*.
7	There are 3 fast facts on this report based on the following: • Claims attributed to specific Lifestyle conditions make up ***X%*** of the total dollars spent. • ***X Lifestyle Condition*** represents the primary Lifestyle Related Condition by paid amount and is ***X%*** of the total paid claims amount in the current period. • ***X Lifestyle Condition*** represents the highest Lifestyle Related Condition per 1000 and is ***X%*** below the Benchmark.
8	Under the Lifestyle Behaviors section, lifestyle behaviors are given a 'D' or 'I' to indicate Direct Association or Indirect Association. Direct Association means that scientific studies have shown that the condition ***is*** affected as a direct result of the behavior indicated. Indirect Association means that scientific studies have shown that the condition ***may be*** affected as a result of the behavior indicated.
9	The report includes a graph that shows the lifestyle associated expenses by behavior. The dollars represented in this graph reflect all Lifestyle conditions and are not limited to the top 20 displayed in the report.
10	The expenses associated with each of the behaviors in the graph are not mutually exclusive. Expenses associated with one behavior may also be counted in another behavior.
11	For each Lifestyle Condition on this report, a count of unique claimants is shown. Within each Lifestyle Condition category, no claimant can be counted more than once, regardless of the number of different diagnoses they were treated for within that condition. However, since it is possible for any member to have had services for diagnoses in multiple lifestyle conditions during the reporting period, that claimant will be counted once in each Lifestyle Condition for which they received treatment. The count of unique claimants on the 'Total of All Lifestyle Conditions' line on this report is a unique count of claimants. Each claimant is counted only once in this total regardless of the number of lifestyle conditions for which they received treatment. For this reason, the count of unique claimants for each Lifestyle Condition cannot be summed to arrive at the 'Total of All Lifestyle Conditions' unique claimants.
12	Lifestyle conditions are based on diagnoses. Since Prescription Drug claims do not have diagnoses, only Medical claims are used for this report.
13	A Lifestyle Condition may be linked to more than one Lifestyle choice or behavior. Coronary Artery Disease, for instance, is linked to Obesity, Lack of physical activity, Tobacco use, Alcohol use, Poor nutrition and Stress/anxiety/depression.
14	The link between many of the Lifestyle conditions and the Lifestyle behavior associated with that condition may not seem obvious in many cases. Breast Cancer, for instance, is linked to Obesity, Lack of Physical Exercise, Tobacco Use, Alcohol Use and Poor Nutrition. According to the American Cancer Society, women who have 2 to 5 drinks a day have about 1 and a half times the risk of women who drink no alcohol. According to the Mayo Clinic, being overweight or obese increases the risk of breast cancer especially if obesity occurs later in life, particularly after menopause. Many of the Lifestyle behaviors that may lead to Breast Cancer are related such as Lack of Physical Exercise and Poor Nutrition which may lead to Obesity.
15	For WGS accounts with HMO, the metrics displaying "paid per" will no longer be calculated using

	encounter claims, providing more precise financial reporting for those services reimbursed under a fee for service arrangement rather than a capitated arrangement. Utilization metrics such as the unique claimant count, admissions, days, etc. will continue to include all members. The following footnote will appear only for WGS groups and any segments that include these products: **NOTE:** Capitation costs and charges for services under a capitated arrangement are excluded from financials. Unique claimants by lifestyle condition include those claimants with capitated arrangements, but these claimants are excluded from the paid amount per unique claimant.

Glossary:

Term	Description
Commercial Benchmark	Benchmark refers to a normative value against which plan metrics are compared. Benchmarks in CII include data from all Anthem accounts in the Client Information Insights database. The benchmark excludes Anthem Medicare Primary members.
Direct Association	Direct Association means that scientific studies have shown that the lifestyle condition ***is*** affected as a direct result of the lifestyle behavior indicated.
Indirect Association	Indirect Association means that scientific studies have shown that the lifestyle condition ***may be*** affected as a result of the lifestyle behavior indicated.
Lifestyle Behaviors	Lifestyle behaviors are people's way of life, habits and behaviors that can have an effect on their health. There are 8 lifestyle behaviors that may contribute to the lifestyle conditions shown on this report: • Overweight/Obesity • Lack of Physical Activity • Tobacco Use • Alcohol/Substance Abuse • Poor Nutrition Practice • Excessive Sun Exposure • Stress/Anxiety/Depression • Unsafe Sexual Behavior
Lifestyle Condition	Lifestyle Conditions refers to Health Conditions that may be affected by Lifestyle Choices. An example would be the relationship between Obesity and Cardiovascular Disease.
Paid Amount	Paid Amount is the net benefit issued for services provided under the Plan. It represents the amount Paid after all pricing guidelines have been applied, including provider discounts, and all non-covered, third-party/Medicare, copayment, coinsurance and deductible amounts have been subtracted. Health Reimbursement Account (HRA) payments are included in the paid amount (if selected).
Paid Amount Per Claimant	The Paid Amount Per Claimant depicts the average amount paid per claimant and is derived by dividing the total paid amount by the number of claimants.
Paid Amount PMPM	The average amount paid per member per month. It is a financial measure that is derived by dividing Paid Amount by Member Months. It is most commonly used as an indicator of financial trend.
Prevalence	Measure of the presence of a condition across the eligible membership. Defined as the number of claimants with the lifestyle condition divided by the current eligible membership.

Prevalence Per 1000	The average number of patients who received services provided under medical coverage, per 1000 unique members with medical coverage.
Prevalence Trend	Percentage variance between Current Prevalence and Commercial Benchmark Prevalence.
Unique Claimants	A unique count of members who have incurred expenses under the plan and have submitted a claim.

MCC-06 – Vision Benefit Utilization

Client Information Insights Report Fact Sheets

Report Number:	MCC-06	
Report Section:	Medical Claim – Clinical Reports	
Report Name:	Vision Benefit Utilization	
Time View:	Paid Dates w/an option for user to select Incurred	
Time Periods Available:	The following options are available: • Rolling 12 months - *Default* • Rolling 3 months • Plan year to date • Calendar year to date	
Fully Insured/ASO Account Status:	Available for both Fully Insured and ASO Accounts	
Report Suppression Rules:	If the average **medical and vision** membership in the current period for a client segment is less than 30, the report must be suppressed. Report is also suppressed if group does not have both medical and vision coverage or if there are no members in the cardiac/diabetes member count for both the current and prior periods.	
Cell Level Suppression Rules:	Any cell with a count <=5 is replaced with an asterisk along with an asterisk for any total or subtotal based on that cell of data.	
Early or Standard Report Production?	Early *(By End of 2nd Week of Month)*	Standard *(By End of 4th Week of Month)* ✓
Hover Description:	Demonstrates key clinical metrics for the overall client population and members who are engaged in a vision benefit program.	
Report Description and Analytic Notes:	A summary report that shows a client's membership enrolled in both Medical and Vision Coverage and how they are engaged/not engaged in any clinical program, and to what extent services are being utilized compared with the entire membership population.	
Matches Reports:	Will not tie out to other CII reports because in this report we are only counting medical members who elected vision coverage.	

Report Facts:

1	The clinical programs captured in engagement are those managed on the Healthy Returns System (HRS).
2	A client must have both Medical and Vision coverage combined under the same group number and/or set up in advance in order to qualify to receive this report.
3	This report shows the Vision Benefit Utilization for Vision Exam and/or Materials for the Current vs Prior period for Members with Cardiac or Diabetic Medical Claim Diagnoses for the time period shown on the report.
4	A member must have a diagnosis of cardiac or diabetes in either their primary diagnosis or in the next four levels of diagnoses to be considered either a cardiac or diabetic member.
5	The Commercial Benchmark reflects accounts with both medical and vision benefits combined under the same group number and/or set up in advance.
6	The 'Total Medical Members with Vision Benefit' will not tie out to other CII reports because in this report we are only counting medical members who elected vision coverage. If the member doesn't have vision coverage, the member is not counted in claims or membership counts for the PMPMs.
7	'Members Not Engaged' plus 'Members Engaged' should equal 'Members Identified for Targeted

	Coaching'.
8	Members must have been identified for any clinical management in at least one of the months that they had vision coverage in order to count them in the clinical section of the report (i.e., last 4 rows of the table).
9	Although not specifically listed on the report, this report uses the following programs when considering engagement: <u>Condition Care Programs:</u> • Condition Care • Health Support • MyHealth Coach • Complex Care • Future Moms • Behavioral Health CM/BHR <u>Case Management Programs</u>: • Case Management • Bariatric • Transplant • Autism Spectrum As a reminder, Engaged is defined as follows: *A member is engaged at any point during the reporting period. This is a subset of "Members Identified for Targeted Coaching". Each program may have a slightly different definition of engagement (i.e., all Health Assessment questions answered for CM, answered at least one fundamental HIP/PAT Health Assessment question for DM/HS). There is a qualifying assessment submission for the program subsequent to the case/episode begin date and prior to the end date.*
10	Vision utilization metrics count unique members, not unique claims, for the specified service codes. E.g. Exam Utilization = Number of unique members that had an exam divided by the total number of unique members.
11	Trend on this report represents the percent change in Members and PMPM (Per Member Per Month) from the Prior Period to the Current Period for each respective category.
12	Exams and Materials in this report are categorized using the same codes as in the other CII vision reports that include Exams and Materials.
13	This report uses the same set of diagnosis codes as the CII Target Program reports for Cardiac and Diabetes.

<u>Glossary</u>:

Term	Description
Commercial Benchmark	The Commercial Benchmark is the Anthem commercial business groups with both Medical and Vision benefits and excludes members where Medicare is primary.
Total Medical Members with Vision Benefit	Total Member Count of the population that had both (simultaneous) Medical and Vision coverage at some point within the given reporting period.

Cardiac Members	Total Member Count of the population that had both Medical and Vision coverage, and have at least one Medical claim with a Diagnosis of Cardiac in either the primary diagnosis or any of the four following diagnosis codes, at some point within the given reporting period.
Diabetes Members	Total Member Count of the population that had both Medical and Vision coverage, and have at least one Medical claim with a Diagnosis of Diabetes in either the primary diagnosis or any of the four following diagnosis codes, at some point within the given reporting period.
Members Identified for Care Management	The number of members for the [Cardiac or Diabetes] population that have both Medical and Vision coverage with a reportable program case at some time during the reporting period. This includes cases for all intensities.
Members Identified for Targeted Coaching	The subset of "Members Identified for Care Management" who are targeted for telephonic management at any point during the reporting period. For disease management and health support this includes members stratified as high and moderate risk. Members Identified for Targeted Coaching = Members Engaged + Members Not Engaged.
Members not Engaged (Care Management)	Total Member Count of the [Cardiac or Diabetes] population that had both Medical and Vision coverage at some point within the given reporting period and did not meet the criteria for engagement for any of the included care management programs at any time during the Vision coverage period. Definitions of reasons for non-engagement are as follows: • **In Process:** The member is in the process of outreach for engagement. In Process trumps all other reasons for non-engagement. • **Lost Coverage/Ineligible:** The member lost program eligibility through the health plan. • **Invalid Phone:** The member does not have a valid phone number. • **Could Not Reach Member:** The member was unable to be reached telephonically. This is typically due to the inability to reach the member on the phone number provided. • **Member Declined:** The member was successfully contacted but subsequently either gave verbal refusal to participate in any aspect of the program, verbal refusal to participate due to lack of interest, or verbal refusal to participate due to his/her perception that the condition does not require management at this time. • **Other:** Reasons not aligning to any of the first 5 listed. These are miscellaneous categories that are either too small or yet undefined. Examples include members who are deceased, closed for triage review, or transferred to another clinical program.
Members Engaged (Care Management)	The subset of "Members Identified for Care Management" who engaged with any program during the reporting period. The definition for engagement is aligned with the definition in our current clinical reporting. Member engagement definitions may vary by program but generally involve answering questions on a program-specific assessment. For reporting purposes, if a member was ever engaged in any one clinical program the member is considered engaged.
Medical PMPM	The Medical Per Member Per Month cost for the population that have both Medical and Vision coverage at some point within the given reporting period. It is a financial measure that is derived by dividing total Medical Paid Amount by total Medical Member Months.
Trend	Trend is the percent change of any metric from the prior period to the current period. To calculate Trend subtract the prior period value from the current period

	value and then divide the result by the prior period value. (Current - Prior)/Prior*100
Exam	Vision exam is the cost of the examination of the eyes and vision by a qualified provider such as an optometrist or ophthalmologist.
Material	Materials under Vision coverage include all lenses, add-ons for lenses, frames, contact lenses and the fitting fee for contact lenses.

MCC-07 – Dental Benefit Utilization

Client Information Insights Report Fact Sheets

Report Number:	MCC-07	
Report Section:	Medical Claim – Clinical Reports	
Report Name:	Dental Benefit Utilization	
Time View:	Paid Dates w/an option for user to select Incurred	
Time Periods Available:	The following options are available: • Rolling 12 months - *Default* • Rolling 3 months • Plan year to date • Calendar year to date	
Fully Insured/ASO Account Status:	Available for both Fully Insured and ASO Accounts	
Report Suppression Rules:	If the average **medical and dental** membership in the current period for a client segment is less than 30, the report must be suppressed. Report is also suppressed if group does not have both medical and dental coverage or if there are no members in the cardiac/diabetes member count for both the current and prior periods.	
Cell Level Suppression Rules:	Any cell with a count <=5 is replaced with an asterisk along with an asterisk for any total or subtotal based on that cell of data.	
Early or Standard Report Production?	Early *(By End of 2nd Week of Month)*	Standard *(By End of 4th Week of Month)* ✓
Hover Description:	Demonstrates key clinical metrics for the overall client population and members who are engaged in a Dental benefit program.	
Report Description and Analytic Notes:	A summary report that shows a client's membership enrolled in both Medical and Dental Coverage and how they are engaged/not engaged in any clinical program, and to what extent services are being utilized compared with the entire membership population.	
Matches Reports:	Will not tie out to other CII reports because in this report we are only counting medical members who elected dental coverage.	

Report Facts:

1	The clinical programs captured in engagement are those managed on the Healthy Returns System (HRS).
2	A client must have both Medical and Dental coverage combined under the same group number and/or set up in advance in order to qualify to receive this report.
3	This report shows the Dental Benefit Utilization for Dental services for the Current vs Prior period for Members with Cardiac or Diabetic Medical Claim Diagnoses for the time period shown on the report.
4	A member must have a diagnosis of cardiac or diabetes in either their primary diagnosis or in the next four levels of diagnoses to be considered either a cardiac or diabetic member.
5	The Commercial Benchmark reflects accounts with both medical and dental benefits combined under the same group number and/or set up in advance.
6	The 'Total Medical Members with Dental Benefit' will not tie out to other CII reports because in this report we are only counting medical members who elected dental coverage. If the member doesn't have dental coverage, the member is not counted in claims or membership counts for the PMPMs.
7	'Members Not Engaged' plus 'Members Engaged' should equal 'Members Identified for Targeted Coaching'.

8	Members must have been identified for any clinical management in at least one of the months that they had dental coverage in order to count them in the clinical section of the report (i.e., last 4 rows of the table).
9	Although not specifically listed on the report, this report uses the following programs when considering engagement. <u>Condition Care Programs:</u> • Condition Care • Health Support • MyHealth Coach • Complex Care • Future Moms • Behavioral Health CM/BHR <u>Case Management Programs</u>: • Case Management • Bariatric • Transplant • Autism Spectrum As a reminder, Engaged is defined as follows: *A member is engaged at any point during the reporting period. This is a subset of "Members Identified for Targeted Coaching". Each program may have a slightly different definition of engagement (i.e., all Health Assessment questions answered for CM, answered at least one fundamental HIP/PAT Health Assessment question for DM/HS). There is a qualifying assessment submission for the program subsequent to the case/episode begin date and prior to the end date.*
10	Dental utilization metrics count unique members, not unique claims, for the specified service codes. E.g. Preventive and Diagnostic Utilization = Number of unique members that had a preventive or diagnostic procedure divided by the total number of unique members.
11	Trend on this report represents the percent change in Members and PMPM (Per Member Per Month) from the Prior Period to the Current Period for each respective category.
12	This report uses the same set of diagnosis codes as the CII Target Program reports for Cardiac and Diabetes.
13	The dental utilization categories can be found in the Dental BOT Table (BOT_CII_DNTL_RPTG_CTGRY). Note that we are using the column entitled 'clinical' because there is one code difference between this report and existing Dental reports that utilize these same categories. Code D4910 is both a preventive and periodontics code. For the Dental Specialty Clinical reports we are considering this as Preventive (as opposed to Periodontics) because it is one of the services that counts toward the 3rd dental cleaning.

<u>Glossary</u>:

Term	Description
Commercial Benchmark	The Commercial Benchmark is the Anthem commercial business groups with both Medical and Dental benefits and excludes members where Medicare is primary.
Total Medical	Total Member Count of the population that had both (simultaneous) Medical and

Members with Dental Benefit	Dental coverage at some point within the given reporting period.
Cardiac Members	Total Member Count of the population that had both Medical and Dental coverage, and have at least one Medical claim with a Diagnosis of Cardiac in either the primary diagnosis or any of the four following diagnosis codes, at some point within the given reporting period.
Diabetes Members	Total Member Count of the population that had both Medical and Dental coverage, and have at least one Medical claim with a Diagnosis of Diabetes in either the primary diagnosis or any of the four following diagnosis codes, at some point within the given reporting period.
Members Identified for Care Management	The number of members for the [Cardiac or Diabetes] population that have both Medical and Dental coverage with a reportable program case at some time during the reporting period. This includes cases for all intensities.
Members Identified for Targeted Coaching	The subset of "Members Identified for Care Management" who are targeted for telephonic management at any point during the reporting period. For disease management and health support this includes members stratified as high and moderate risk. Members Identified for Targeted Coaching = Members Engaged + Members Not Engaged.
Members not Engaged (Care Management)	Total Member Count of the [Cardiac or Diabetes] population that had both Medical and Dental coverage at some point within the given reporting period and did not meet the criteria for engagement for any of the included care management programs at any time during the Dental coverage period. Definitions of reasons for non-engagement are as follows: • **In Process:** The member is in the process of outreach for engagement. In Process trumps all other reasons for non-engagement. • **Lost Coverage/Ineligible:** The member lost program eligibility through the health plan. • **Invalid Phone:** The member does not have a valid phone number. • **Could Not Reach Member:** The member was unable to be reached telephonically. This is typically due to the inability to reach the member on the phone number provided. • **Member Declined:** The member was successfully contacted but subsequently either gave verbal refusal to participate in any aspect of the program, verbal refusal to participate due to lack of interest, or verbal refusal to participate due to his/her perception that the condition does not require management at this time. • **Other:** Reasons not aligning to any of the first 5 listed. These are miscellaneous categories that are either too small or yet undefined. Examples include members who are deceased, closed for triage review, or transferred to another clinical program.
Members Engaged (Care Management)	The subset of "Members Identified for Care Management" who engaged with any program during the reporting period. The definition for engagement is aligned with the definition in our current clinical reporting. Member engagement definitions may vary by program but generally involve answering questions on a program-specific assessment. For reporting purposes, if a member was ever engaged in any one clinical program the member is considered engaged.
Medical PMPM	The Medical Per Member Per Month cost for the population that have both Medical and Dental coverage at some point within the given reporting period. It is a financial measure that is derived by dividing total Medical Paid Amount by total Medical Member Months.

Trend	Trend is the percent change of any metric from the prior period to the current period. To calculate Trend subtract the prior period value from the current period value and then divide the result by the prior period value. (Current - Prior)/Prior*100
Preventive & Diagnostic	Percentage of members who received preventive or diagnostic treatment during the time period on the report. Preventive and Diagnostic care includes oral exams, x-rays and cleanings.
Restoration	Percentage of members who received restorative dental treatment during the time period on the report. Restorative care includes fillings, crowns, dentures and bridges.
All Other	All other Dental Procedures not included in Preventive & Diagnostic and Restoration.

CDHP-01 - CDHP Monthly Financial Report

Report Number:	CDHP-01	
Report Section:	Consumer Driven Health Plan(CDHP) Reports	
Report Name:	CDHP Monthly Financial Report	
Time View:	Paid	
Time Period:	Plan Year to Date	
Fully Insured/ASO Account Status:	Available for both Fully Insured and ASO Accounts	
Report Suppression Rules:	If the average medical membership in the current period for a client segment is less than 30, the report will be suppressed. If all financial fields for a table are 0, the table is suppressed.	
Cell Level Suppression Rules:	None	
Early or Standard Report Production?	Early *(By End of 2nd Week of Month)*	Standard *(By End of 4th Week of Month)* ✓
Hover Description:	Snapshot of monthly subscriber and member counts, paid and out of pocket amounts for the CDHP product	
Report Description and Analytic Notes:	The report is a financial breakdown by month of deductible, coinsurance, and dollars paid, including dollars from CDHP accounts, by account type (Health Reimbursement Account or Health Savings Account). Accumulator dollars by month and HRA and HSA accounts as a percentage of dollars paid are represented.	
Matches Reports:	This report is not directly comparable to any other CDHP report. While HRA and Extra Bucks dollars are included on the Monthly Financial report, as well as, the HRA Balance Report and the Extra Bucks Summary, these dollars cannot be directly compared as the Monthly Financial Report is based on paid dates (regardless of whether HRA or HSA+ is rollover from a previous benefit year) while the other two reports are reporting HRA / Extra Bucks dollars for the current benefit year.	

Report Facts:

1	The Monthly Financial Report has up to three possible tables depending on the client's plans. For clients with HRA, the first table will be the "Health Reimbursement (HRA) Plans – Includes Health Incentive Accounts (HIA) and HIA+." For those clients who have Qualified HealthCare Expenses (QHE), the QHE table is second. For those clients with HSA, the "Health Savings Account (HSA Plans)" table is last. The tables will only be shown if there is data.
2	A client can have either internal Anthem pharmacy (ESI) or contract directly with an external Pharmacy Benefit Manager (PBM) vendor, e.g., Medco, Caremark, or ESI. The CDHP Monthly Financial report is the only client report which includes dollars from these external pharmacy vendors. If a client contracts directly with a PBM and that PBM sends data to Anthem (Medco, Caremark, ESI), data from this external PBM is included in HRA amounts, Extra Bucks amounts, out of pocket amounts, and paid amounts.
3	If there are less than 30 average HRA members in the reporting period or there is $0 in the HRA table, the entire HRA table will be suppressed. For HSA, the entire table will be suppressed if there are less than 30 average HSA members in the reporting period. Since the majority of our clients don't have QHE, this table will be suppressed if there is $0. An entire table will be suppressed if all the financial columns are $0. The Suppression Message for members' constraint will read: This report does not meet the minimum threshold requirement. The Suppression Message for financials' constraint will read: This report does not have HRA/HSA financial information for the

	specified period.
4	This report is Plan Year to Date so the reporting period begins with the most recent renewal month. For example, when the report is run in July 2015 and the segment has a January renewal date, the reporting period will be from January 2015 – June 2015.
5	This report provides an option for users to change the reporting period end date.
HRA	
6	The HRA table has subscriber and member medical counts by month.
7	HRA dollars can be used for Qualified Health Expenses (QHE) and are reflected in the QHE section of the report. Any HRA dollars used to offset QHE expenses will reduce the HRA account balance for the member.
QHE	
8	The QHE (Qualified Health Expenses) table is available for clients who have QHE. The table is a breakdown of how the HRA dollars for QHE were used, e.g., for medical, pharmacy, dental, vision, or other expenses. The sum of the Total HRA for Qualified Health Expenses will match the Total HRA for Qualifying Health Expenses in the HRA table. This table is suppressed if the client does not have QHE or if all dollars are zero. QHE are expenses which can be reimbursed out of a member's HRA account and thus decrement the HRA dollars.
HSA	
9	The HSA table has subscriber and member medical counts by month.
10	HSA products include HSA and HSA+ products. HSA+ products are considered HSA products, but there are two accounts with a HSA+ product. One is an HSA bank account; the other is a notional account, usually administered by LITES. The notional account is referred to as an ExtraBucks account (EBA). Dollars in the ExtraBucks account can only be used after the deductible is met.

Glossary:

Term	Description
Lumenos	Legacy name for CDHP products
LITES	The claims processing system for HRA and ExtraBucks accounts. LITES is the administrator for the HRA and ExtraBucks accounts included in this report.
HRA	Health Reimbursement Accounts (HRA) Plans are notional accounts (virtual financial accounts) that belong to and are funded by the Employer. An HRA account is used to cover eligible benefits up to the maximum amount available in the account. HRA Plans (on LITES) are automatically debited as claims are processed. In the Health Reimbursement Account Plan section of the Monthly Financial report, Health Incentive Account (HIA) and Health Incentive Account Plus (HIA+) Plans are also included. The HIA Plan combines a traditional PPO plan with specified incentives stored in a notional account while the HIA+ Plan is like the HRA, except the notional account is funded by Anthem instead of the Employer.
HIA	Health Incentive Account (HIA) Plans are notional accounts funded by incentives.
HIA+	Health Incentive Account+ (HIA+) Plans are like HRA plans, except the notional account is funded by Anthem instead of the Employer.
HSA	Health Savings Account (HSA) Plans are bank accounts that are owned by the employee and funded by the employee and/or the employer. The employee

	determines if/when these funds are used. The HSA Plan features an integrated financial health bank account through our partner BenefitWallet (formerly Mellon Bank). Both the HSA and the health plan are subject to certain regulations defined by the IRS / US Treasury Department, such as, a minimum deductible for the health plan and a contribution maximum for the HSA.
HSA+	Health Savings Accounts Plus (HSA+) plans serve as transition plan from a HRA to an HSA. HRA dollars are called ExtraBucks and are funded from the prior year HRA rollover dollars or from incentives earned.
ExtraBucks	The ExtraBucks Account is a notional account used to house rollover HRA dollars (HRA dollars will roll into the ExtraBucks Account upon selection by the consumer of the HSA+ plan) and/or earned incentive dollars. Due to IRS regulations for HSA Products, the Extra Bucks Account dollars cannot be used until the member has satisfied their minimum required deductible for the given year. The Extra Bucks Account dollars shown under the HSA Plan in the Monthly Financial Report represent dollars paid from the Extra Bucks Account for claims.
Mellon Bank	Former name of our financial partner who administered HSA bank accounts. Now known as BenefitWallet.
Notional Account	A notional account is a virtual bank account used for the administration of HRA account dollars.
BenefitWallet	Current name of our financial partner who administers HSA bank accounts. Formerly known as Mellon Bank.
Flex	The Flex system is a WGS system that handles MIA (My Incentive Account) and FSA (Flex Spending Accounts). Flex also handles QHE (Qualified Health Expenses) claims for WGS, and Flex interfaces with LITES to use HRA dollars for QHE expenses. Nasco QHE claims are not handled by Flex. Other than QHE, Flex dollars are not included in the Monthly Financial Report.
QHE	Qualified Health Expenses (QHE) are qualified services that are not usually covered by typical health plans, but which can be paid for with funds from your HRA (e.g., OTC drugs, infertility treatments, smoking cessation programs, doctor prescribed weight loss programs). However, expenses for Qualified Health Expenses do not apply toward the Traditional Health Coverage component of the plan, but they do use up HRA dollars.
External pharmacy	Clients can choose to contract directly with a PBM for pharmacy. This is referred to as external pharmacy as the client pays the PBM, not Anthem. The client has carved-out pharmacy. However, these external pharmacy vendors may still be integrated with LITES. The current external vendors integrated with LITES are Medco, Caremark, and ESI. External pharmacy data is stored separately from internal pharmacy data. This data for external pharmacy is only available as part of the CDHP reporting package.
Internal pharmacy	Client can contract with Anthem for their pharmacy. The client will then use ESI, and this will be referred to as Internal pharmacy. This is included on standard non-CDHP client reports, as well as on the CDHP Monthly Financial Report.
Caremark	External pharmacy PBM integrated with LITES
Medco	External pharmacy PBM integrated with LITES
ESI	Express Scripts. ESI is Anthem's pharmacy. However, a client can choose to contract directly with ESI (as opposed to going through Anthem). In this situation, a client would have ESI as an external PBM.
Paid Month	Paid Month refers to the month the claims were paid. The Monthly Financial report is by paid month.
Paid Amount	Paid Amount is the net benefit issued for services provided under the Plan. It

	represents the amount Paid after all pricing guidelines have been applied, including provider discounts, and all non-covered, third-party/Medicare, copayment, coinsurance, and deductible amounts have been subtracted.
Benefit year	The HRA and ExtraBucks notional accounts are for a benefit year, i.e., a calendar year or a plan year. Unused dollars from one benefit year may be available for rollover in a future benefit year, i.e., available to pay funds in future benefit years.
Rollover	Unused dollars in a notional account which are available for use for claims in later benefit years.
Subscribers	The number of employees with medical coverage in a CDHP plan (i.e., HRA, HIA, HIA+, or HSA) during the month shown.
Members	The number of members with medical coverage (i.e. subscriber, spouse/domestic partner, or other dependent) enrolled in a CDHP plan (i.e., HRA, HIA, HIA+, or HSA) during the month shown.
Paid Amount HRA Medical	Total Health Reimbursement Account dollars expended during the reporting period for Medical claims.
Paid Amount HRA Pharmacy	Total Health Reimbursement Account dollars expended during the reporting period for Pharmacy claims.
QHE HRA Total Amount	Total Health Reimbursement Account dollars expended during the reporting period for QHE claims. HRA dollars funding QHE expenses are only for WGS and Nasco claim systems.
Healthcare Total Paid Amount Employer HRA	Total Health Reimbursement Account dollars expended during the reporting period including Medical, Pharmacy, and Qualified Healthcare Expenses where applicable.
Deductible	Amount of eligible expense a member is responsible for paying each benefit period before the health plan will make payment for eligible benefits.
Coinsurance and Copay	Coinsurance is a member out of pocket amount, calculated as a percentage of the allowed amount, for which the member is responsible. Copayment is a member out of pocket amount, usually expressed as a flat dollar amount, for which the member is responsible.
Employer Traditional Coverage Paid Amount	Shows the dollars paid out of the traditional health coverage (claims after health account, deductible, and other member out of pocket costs) for all claims during the reporting period. Includes both medical and pharmacy (internal and external) claim dollars paid.
Total Paid Amount Post HRA	Total claims dollars expended during the reporting period (Health Reimbursement Account Total Amount and Employer Traditional Health Coverage Paid Amount). HRA dollars are funded by the employer.
% HRA Total Paid Amount	Percentage of HRA dollars to the employer's total payout (traditional health coverage plus HRA, the post-HRA payment)
Paid Amount Qualified Healthcare Expenses - Medical	Total QHE dollars expended during the reporting period for Medical Services.
Paid Amount Qualified Healthcare Expenses - Pharmacy	Total QHE dollars expended during the reporting period for Pharmacy Services.
Paid Amount Qualified Healthcare Expenses - Dental	Total QHE dollars expended during the reporting period for Dental Services.
Paid Amount Qualified	Total QHE dollars expended during the reporting period for Vision Services.

Healthcare Expenses - Vision	
Total Paid Amount Qualified Healthcare Expenses - Other	Total QHE dollars expended during the reporting period for Other Services (i.e., for services not classified as Medical, Pharmacy, Vision, or Dental).
Total Paid Amount Qualified Healthcare Expenses - Total	Total QHE dollars expended during the reporting period for Medical, Pharmacy, Dental, Vision and Other Services combined.
Extra Bucks/Paid Amount HSA and Other	Extra Buck notional account dollars expended during the reporting period for Medical and Pharmacy (both Internal and External) claims.
Paid Amount HSA	Total Health Savings Account dollars expended during the reporting period. This is only available if BenefitWallet / Mellon Bank is the HSA custodian.
THC + HSA + EBA	Total claims dollars expended during the reporting period (Paid Amount HSA and Employer Traditional Health Coverage Paid Amount and Extra Bucks and Other Account Payout).
% Extra Bucks Total Paid Amount	Percentage of Extra Bucks Paid Amount to the total payment for claims (Traditional Health Coverage + HSA payments + Extra Bucks payments)
% HSA Total Paid Amount	Percentage of HSA Paid Amount to the total payment for claims (Traditional Health Coverage + HSA payments + Extra Bucks payments)

CDHP-02 - CDHP Health Reimbursement Account Balance

Report Number:	CDHP-02	
Report Section:	Consumer Driven Health Plan(CDHP) Reports	
Report Name:	CDHP HRA Balance Report	
Time View:	Point in Time for an account/benefit year's As of Date; for the current period, the As of Date must be between the benefit start and benefit end dates being reported	
Fully Insured/ASO Account Status:	Available for both Fully Insured and ASO Accounts	
Report Suppression Rules:	If the average medical membership in the current period for a client segment is less than 30, the entire report will be suppressed.	
Cell Level Suppression Rules:	This report has row level suppression. If the dollars are zero for both the current and prior period for the Adjustment Amount (under Additions) row, then the entire row will be suppressed. If the dollars are zero for both the current and prior period for the 'Adjustment Amount (Forfeitures)' row which is under the Forfeitures title, then the entire row will be suppressed.	
Early or Standard Report Production?	Early *(By End of 2nd Week of Month)*	Standard *(By End of 4th Week of Month)* ✓
Hover Description:	Summary of HRA balances (HRA, HIA and HIA+)	
Report Description and Analytic Notes:	This report provides account level financial details, such as, Additions, Forfeitures, and Subtractions (Claims Paid) on the Health Reimbursement Account (HRA/HIA/HIA+). This report shows rollover from previous benefit years, employer contribution, incentives paid to the HRA, forfeitures when subscribers terminate or switch coverage, claims payments during the benefit year being reported, and remaining HRA balances for the benefit year. Use this report to see potential client liability for HRA payments.	
Matches Reports:	The HRA Ending Balance on this report equals the average HRA ending balance in the HRA Balance by Range Report multiplied by the total number of subscribers on the HRA Balance by Range Report for the same benefit year and point in time (subject to rounding). The HRA Balance Report will not match the Monthly Financial Report because the Monthly Financial Report is paid claims regardless of whether HRA is paid from the current benefit year or from the previous year's rollover, and the HRA dollars are coming from the claims systems in the Monthly Financial Report. The HRA Account Balance report is by account year and coming from the CDHP (LITES) system. There could also be timing issues. The Incentive and Utilization report lists incentives, and the HRA Account Balance includes the row Employer Incentives. The Incentive report is plan year to date while the HRA Account Balance is reporting for an account year. While these incentive amounts should match, the Incentive and Utilization report only reports on incentives that flow through Hallmark, the incentives processing vendor, while the HRA Account Balance report includes incentives funded into the LITES notional accounts. There could be timing issues, as well as, manual or other adjustments funding LITES, such as, special incentives that do not flow through Hallmark.	

Report Facts:

1	The CII 2.0 CDHP HRA Balance Report, as well as, all CII 2.0 CDHP reports have data through the current reporting period. The CII 2.0 CDHP reports do not lag one reporting month as CII 1.0 CDHP reports did.
2	The report will include two benefit periods and report balances As of a Point in Time (PIT). For example, if a report is run in June 2014, the As of Date will be the previous month's ending date, i.e., May 2014. The current benefit year is determined by the benefit year beginning and ending dates that include this As of Date. For a calendar year benefit year, the current period would be January 2014 – December 2014, and we would report As of May 2014. We would then get the prior period reporting dates (January 2013 – December 2013) and report on the prior year As of the same PIT, e.g., May 2014.
3	If there is more than one current benefit year that include the As of Date, the report will separate each of the benefit years. The current and prior periods for one set of benefit years will display first, and the report for the other set of benefit years will display in a separate table. The entire report will display for each set of current and prior benefit years, including headers and footnotes. Group – 100 – Sub Group – 00 Benefit Start and End dates: July 2013 – June 2014 Group – 100 – Sub Group – 01 Benefit Start and End dates: Jan. 2014 – Dec. 2014 The first table will display data for July 2013 – June 2014 and the corresponding prior period while the next table will display data for Jan. 2014 – Dec. 2014 and the corresponding prior period.
4	Dollars for terminated subscribers are included in this report. When a subscriber terminates, his HRA balance is forfeited and will appear under the Forfeitures in the field "Product Type Switch or Termination of Employment." However, as claims can still be paid for incurred dates when he was active, the report includes the terminated member, and the forfeited amount is adjusted accordingly as claims incurred during the subscriber's active time period are paid from the HRA.
5	Unused HRA dollars from the prior year are available to be used in the current year. These HRA dollars are included in the HRA Beginning Balance. If a claim incurred in the prior year is paid, the HRA Beginning Balance for the current year is adjusted to show this amount was used for a prior period's claim.
6	While there may be a rollover limit from one year to the next (from the prior benefit period to the current benefit period), the HRA dollars are never lost for the prior period (to which they belong) due to exceeding the rollover amount. The dollars exceeding rollover are only lost for the current period. For example, for clients that have a rollover maximum, if there are $750 left in the HRA Account at the end of the prior period and the rollover limit is $500, then only the $500 can be rolled over to the current period. However, the full $750 is available for claims run-out in the prior period (i.e., the benefit period to which the HRA dollars belong).
7	While claims data, membership, and HRA dollars used on a claim are available from the claim source system, e.g., WGS, ACES, or NASCO, it is the LITES system which has the HRA banking details for the notional account. LITES administers HRA accounts and provides these account details (e.g., employer contributions, additions, forfeitures, and starting and ending balances), which would not be available from any other source. The notional account banking details from LITES are at the subscriber level. Move to Addendum
8	Claims incurred during an account period always use the HRA dollars from that account period first, before using remaining HRA dollars from other periods.
9	If an entire group terminates, the HRA dollars will be forfeited, and the HRA Ending Balance will become 0. The dollars will be forfeited and appear under Forfeitures in the row "Product Type Switch or Termination of Employment." However, these dollars are still available to be used for claims incurred during the active period, subject to any run-out rules.

10	The ending balance from the prior period should equal the beginning balance of the current period (**if the reports are run for the same "As of Date"**). However, we often compare reports from one month to the next, and the ending balance for a report with an "As of Date" of Dec. 31 will probably not equal the beginning balance for a report run with the "As of Date" of the next month (January). Data is sent to us monthly, at the end of the month. It is possible claims that occurred in the prior period were paid during January of the following year, reducing the HRA Beginning Balance going into the current year.
11	When comparing reports run in different months (different "As of Dates"), the HRA beginning balance may not be the same. In later months, more claims from the previous period may have been paid, thus reducing the HRA beginning balance rolling from the prior period into the current period.
12	When comparing reports from one month to the next, often when going into a new benefit year, the ending balance for a report with an "As of Date" of Dec. 31 will not equal the beginning balance for a report run with the "As of Date" of the next month (January). Members may terminate the plan at the end of the previous benefit year, e.g., Dec. 31, so the starting balance going into the next benefit year will be lower as there could be forfeitures for the terminated members.
13	The Employer Incentives are those incentives that are funded into the members' notional account. They will not necessarily match the Incentive and Utilization report as the Incentive report is based on a rolling paid 12 months whereas the HRA Account Balance is based on account year. Additionally, it is possible for timing issues and other non-Hallmark incentives to be added to the HRA notional account.
14	This report is for HRA, HIA, and HIA+ notional accounts housed at LITES (the claims processing system for HRA and ExtraBucks accounts. LITES is the administrator for the HRA and ExtraBucks accounts reported on.). The HSA+ Extra Bucks notional accounts are reported in a separate report.
15	The Total Funds to be Committed are calculated by taking the Additions minus the Forfeitures. The HRA Ending Balance is calculated by taking the HRA Beginning Balance plus Total Funds to be Committed minus Total Subtractions.
16	This report provides an option for users to change the reporting period end date.

Glossary:

Term	Description
Lumenos	Legacy name for CDHP products
LITES	The claims processing system for HRA and ExtraBucks accounts. LITES is the administrator for the HRA and ExtraBucks accounts reported on.
HRA	Health Reimbursement Accounts (HRA) Plans are notional accounts (virtual financial accounts) that belong to and are funded by the employer. An HRA account is used to cover eligible benefits up to the maximum amount available in the account. HRA Plans (on LITES) are automatically debited as claims are processed. In the Health Reimbursement Account Plan section of the Monthly Financial report, Health Incentive Account (HIA) and Health Incentive Account Plus (HIA+) Plans are also included. The HIA Plan combines a traditional PPO plan with specified incentives stored in a notional account while the HIA+ Plan is like the HRA, except the notional account is funded by WellPoint instead of the employer.
HIA	Health Incentive Account (HIA) Plans are notional accounts funded by incentives.
HIA+	Health Incentive Account+ (HIA+) Plans are like HRA plans, except the

	notional account is funded by WellPoint instead of the employer.
Benefit year	The HRA and ExtraBucks notional accounts are for a benefit year, i.e., a calendar year or a plan year. Unused dollars from one benefit year may be available for rollover in a future benefit year, i.e., available to pay funds in future benefit years.
Rollover	Unused dollars in a notional account which are available for use for claims in later benefit years.
EDWard	Enterprise Data Warehouse and Reporting Depot; data warehouse used as source of reporting data
Hallmark Business Connections	Third party vendor who administers Anthem Health Rewards and CDHP incentives
Notional Account	A notional account is a virtual bank account used for the administration of HRA account dollars.
Point in Time	Point in Time; As of Date for the HRA Account Balance report
Beginning Balance as of MMM-YY	Rollover into current benefit year As of the month and year specified; includes balance rollovers from previous benefit years
Additions	Additions into the HRA notional account
Balance Transfer (under Additions)	Balance Transfer Credit Amount. Also included balance transfers due to product type upgrades. Dollars transferred when a subscriber moves from an HIA to an HRA (product type upgrades) these dollars are debits in the HIA product type record and will be reported as a credit in the HRA product type record for the subscriber and benefit year.
Employer Contributions	Employer contributions to HRA account. Dollars contributed to the Fund by the Employer Employer Allocation
Employer Incentives	Sum of all incentive allocations into the HRA account for the benefit year for all activity and milestones
Adjustment Amount (Additions)	Positive HRA account adjustments
Total Additions	Sum of all account additions
Forfeitures	Forfeiture section
Product Type Switch or Termination of Employment	Forfeitures when subscriber moves from an HRA to HIA or HSA account, or dollars forfeited when subscriber terminates
Benefit Year Roll Over Maximum	Benefit Year Max Forfeitures; Forfeitures when the HRA ending balance exceeds the rollover max established for the product in which the subscriber is enrolled at the end of the benefit year
Balance Transfer Debits	Dollars transferred when a subscriber moves between CDHP products. These dollars are debits in the previous product type record and will be reported as a credit in the new product type record for the subscriber and benefit year.
Adjustment Amount(Forfeitures)	Negative HRA account adjustments
Total Forfeitures	Sum of account forfeitures
Total Funds to be Committed	Additions minus forfeitures
Subtractions	Claims Paid

Claims Paid	Claims Paid
Total Subtractions	Sum of Subtractions
HRA Ending Balance	Ending HRA Balance Formula: Beginning Balance + Balance Transfer Credits + Employer Contributions + Adjustments + Incentives - Claim Payments – Product Type Switch Forfeitures – Benefit Year Rollover Maximum Forfeitures - Balance Transfer Debits

CDHP-03 - CDHP Health Reimbursement Account Balance by Range

Report Number:	CDHP-03	
Report Section:	Consumer Driven Health Plan(CDHP) Reports	
Report Name:	CDHP Health Reimbursement Account Balance by Range	
Time View:	Point in Time for an account/benefit year's As of Date; for the current period, the As of Date must be between the benefit start and benefit end dates being reported	
Fully Insured/ASO Account Status:	Available for both Fully Insured and ASO Accounts	
Report Suppression Rules:	If the average medical membership in the current period for a client segment is less than 30, the report is suppressed.	
Cell Level Suppression Rules:	The column for Unassigned Contract Type will be suppressed if the total number of subscribers for the Unassigned Contract Type is zero.	
Early or Standard Report Production?	Early *(By End of 2nd Week of Month)*	Standard *(By End of 4th Week of Month)* ✓
Hover Description:	Breakdown of HRA ending balances by coverage tier as of a point in time	
Report Description and Analytic Notes:	This report provides a breakdown by coverage tier of the HRA (HRA, HIA, and HIA+) account ending balances by count of subscribers within a dollar range. The data is provided as of a point in time (i.e., As of Date) based on the client's plan year, not a rolling 12 month period. The report can be used to count the number of subscribers with HRA balances within each dollar range, thus showing potential liability for HRA payments. The report also shows the average HRA balance and the percentage of subscribers with positive balances.	
Matches Reports:	This report is not similar to any other report although it does use the same HRA ending balance data as the HRA balance report. Therefore, for the Total Coverage, the number of subscribers multiplied by the average HRA balance should equal the HRA ending balance on the HRA Account Summary report for the same plan year (subject to rounding).	

Report Facts:

1	The CII 2.0 CDHP Health Reimbursement Account Balance by Range Report, as well as, all CII 2.0 CDHP reports have data through the current reporting period. The CII 2.0 CDHP reports do not lag one reporting month as CII 1.0 CDHP reports did.
2	The data in this report comes from the HRA notional accounts housed in LITES (the claims processing system for HRA and ExtraBucks accounts). The ending balances are reported as of a point in time, and the HRA ending balances are reported at the subscriber level.
3	All HRA products (HRA, HIA, HIA+) accounts are included in this report. The Extra Bucks notional accounts (for HSA+) products are not included in this report.
4	The report is provided as of a point in time (i.e., As of Date) based on the client's plan year, not a rolling 12 month period. The As of Date is the previous month's end date. If the report is run in January, the As of Date is the previous December. The As of Date is used to determine the benefit year start and end dates being reported for the current period.
5	The following are coverage tiers: Subscriber, Subscriber & Child/Children, Subscriber & Spouse/Dependent, Family, Unassigned, and Total Coverage (which includes all coverage tiers).

	Unassigned is when a coverage tier is unknown.
6	The # Subscribers is a count of subscribers with HRA ending balances within a dollar range within the coverage tier.
7	The % Total Subscribers is the percentage of subscribers in a dollar range within the coverage tier.
8	The Average HRA Balance is the average HRA balance for a subscriber within the coverage tier.
9	The % Subscribers with Positive Balance is the % of subscribers who have a positive balance within the coverage tier.
10	This report provides an option for users to change the reporting period end date.

Glossary:

Term	Description
Lumenos	Legacy name for CDHP products
LITES	The claims processing system for HRA and ExtraBucks accounts. LITES is the administrator for the HRA and ExtraBucks accounts included in this report.
HRA	Health Reimbursement Accounts (HRA) Plans are notional accounts (virtual financial accounts) that belong to and are funded by the employer. An HRA account is used to cover eligible benefits up to the maximum amount available in the account. HRA Plans (on LITES) are automatically debited as claims are processed. In the CDHP Account Balance by Range report, Health Incentive Account (HIA) and Health Incentive Account Plus (HIA+) Plans are also included. The HIA Plan combines a traditional PPO plan with specified incentives stored in a notional account while the HIA+ Plan is like the HRA, except the notional account is funded by Anthem instead of the employer.
HIA	Health Incentive Account (HIA) Plans are notional accounts funded by incentives.
HIA+	Health Incentive Account+ (HIA+) Plans are like HRA plans, except the notional account is funded by Anthem instead of the employer.
Benefit year	The HRA notional accounts are for a benefit year, i.e., a calendar year or a plan year.
Notional Account	A notional account is a virtual bank account used for the administration of HRA account dollars.
As of Date	The Point in Time when the Health Reimbursement Account balances and subscriber counts are calculated. The As of Date is the previous month's end date. If the report is run in January, the As of Date is the previous December. The As of Date is used to determine the benefit year start and end dates being reported for the current period.
Contract Type	Contract Type describes the coverage tier elected by the subscriber. Examples of the values are Subscriber, Subscriber & Spouse/Dependent, Subscriber & Child/Children, and Family.
HRA ending balance	The HRA ending balance is the ending balance of the subscriber's HRA account at the "As of Date" on the report.
# Subscribers	The number of subscribers enrolled in an HRA product ("HRA employees") on the "As of Date" for the corresponding coverage tier/HRA balance range.
% Subscribers with Positive Balance	The number of Health Reimbursement Account (HRA) subscribers with a positive HRA balance on the "As of Date" divided by the Total number of HRA subscribers in the corresponding coverage tier.

% Total Subscribers	The percentage of HRA subscribers in the corresponding HRA Balance Range for the applicable Coverage Tier/Total column.
Average HRA Balance	The summary of all Health Reimbursement Account (HRA) balances for the corresponding coverage tier divided by the number of HRA subscribers enrolled in that coverage tier. The HRA balances and HRA subscriber counts are taken per the "As of Date" on the report.

CDHP-04 - CDHP HSA Transaction Summary

Report Number:	CDHP-04	
Report Section:	Consumer Driven Health Plan(CDHP) Reports	
Report Name:	CDHP HSA Transaction Summary	
Time View:	Paid	
Time Period:	Plan Year to Date	
Fully Insured/ASO Account Status:	Available for both Fully Insured and ASO Accounts	
Report Suppression Rules:	If the average medical membership in the current period for a client segment is less than 30, this report is suppressed.	
Cell Level Suppression Rules:	None	
Early or Standard Report Production?	Early *(By End of 2nd Week of Month)*	Standard *(By End of 4th Week of Month)* ✓
Hover Description:	Summary of account activity for the HSA plans	
Report Description and Analytic Notes:	This report provides a view of account activity for the Health Savings Account (HSA and HSA+) plans for both the current and the prior period. It includes credits and debits into the HSA account.	
Matches Reports:	This report does not match any other CII reports as this data comes from an external source (BenefitWallet). The report will also not balance to the HSA Balance by Range Report as this report is based on Plan Year to Date, and the HSA Balance by Range Report is based on a Point in Time.	

Report Facts:

1	The CII 2.0 HSA Transaction Summary Report, as well as, all CII 2.0 CDHP reports have data through the current reporting period. The CII 2.0 CDHP reports do not lag one reporting month as CII 1.0 CDHP reports did.
2	HSA financial information is displayed only when the employer selects BenefitWallet (formerly Mellon Bank) as their HSA custodian. When employees are given the alternative to 'opt out' of the bank chosen by their employer, their data will not be included in this report.
3	This report includes activity for both HSA and HSA+ products.
4	The report first lists credits to the account, then debits, and finally mutual fund activity. The row Transaction Summary is the sum of Total Credits and Total Debits. Credit transactions add funds to the HSA account while debit transactions remove funds from the HSA account.
5	The dollars in the HSA account are owned by the employee and are portable, allowing employees to retain ownership of the funds upon termination from the plan/client. Anthem is not authorized to provide HSA reporting at the member level because the member owns the dollars in his/her HSA account.
6	Contributions into an HSA account can be made by an employee, an employer, or by incentive activity.
7	For both the current and the prior periods, the report will show dollars for each credit and debit transaction, as well as, the percentage of the Total Credits for each credit transaction and the percentage contribution to Total Debits for each debit transaction.
8	The sum of the Total Debit percentage and the Transaction Summary percentage will equal the sum of the Total Credits.

9	This report is Plan Year to Date so the reporting period begins with the most recent renewal month.
10	This report provides an option for users to change the reporting period end date.

Glossary:

Term	Description
HSA	Health Savings Account (HSA) Plans are bank accounts that are owned by the employee and funded by the employee and/or the employer. The employee determines if/when these funds are used. The HSA Plan features an integrated financial health bank account through our partner BenefitWallet (formerly Mellon Bank). Both the HSA and the health plan are subject to certain regulations defined by the IRS / US Treasury Department, such as, a minimum deductible for the health plan and a contribution maximum for the HSA.
HSA+	Health Savings Accounts Plus (HSA+) plans serve as transition plans from a HRA to an HSA. HRA dollars are called ExtraBucks and are funded from the prior year HRA rollover dollars or from incentives earned. HSA+ plans also have an HSA piece which will be included in this report if the custodian is BenefitWallet.
Mellon Bank	Former name of our financial partner who administered HSA bank accounts. Now known as BenefitWallet.
BenefitWallet	Current name of our financial partner who administers HSA bank accounts. Formerly known as Mellon Bank.
Current Period	References the current rolling 12 month time period on which the report is based.
Prior Period	Prior is the earlier rolling 12 month period used for comparison to the current period.
Custodian (Trustee)	The entity (i.e., BenefitWallet) that manages the funds in the account.
Credit Transactions	Transactions that add funds to the HSA account, e.g., employer and employee contributions, Interest, and Credit Adjustments.
Employer Contribution	The total amount of Employer Contributions for all subscribers for the period.
Employee Contribution	The total amount of Employee's Contributions for the period.
Interest/Other Credit Adjustments	Interest accrued and credit adjustments applied to an Employee's Health Savings Account.
Trustee Credit Transfers	Transactions crediting the Health Savings Account for funds transferred into the account from another Health Savings Account. Example: Client had another bank and moved to BenefitWallet.
Total Credits	Sum of Employer Contributions, Employee Contributions, Interest/Other Credit Adjustments, and Trustee Credit Transfers
Debit Transactions	Transactions that subtract funds from the HSA account, e.g., debit adjustments
Debits/Other Debit Adjustments	Transactions that subtract funds from the HSA account, e.g., checks written, point-of-service electronic debits, and debit adjustments processed against the Employee's Health Savings Account.
Trustee Debit Transfers	Transactions debiting the HSA account for funds transferred from the account into another HSA account. Example: The trustee is BenefitWallet, and the client choses a new bank. Members had an option to move funds from BenefitWallet to a new bank.
Total Debits	Sum of Debit/Other Debit Adjustments and Trustee Debit Transfers
Transaction Summary	Subtraction of Total Debits from Total Credits.
Mutual Fund Activity	Activity for HSA funds invested in mutual funds
HSA Dollars moved into a Mutual Fund (Debits)	Sum of the client's Debit HSA mutual fund transactions.

Mutual Fund dollars moved into the HSA (Credits)	Sum of the client's Credit HSA mutual fund transactions.

CDHP-05 - CDHP HSA Balance by Range

Report Number:	CDHP-05	
Report Section:	Consumer Driven Health Plan(CDHP) Reports	
Report Name:	CDHP HSA Balance by Range	
Time View:	Point in Time for an account/benefit year's As of Date; for the current period, the As of Date must be between the benefit start and benefit end dates being reported	
Fully Insured/ASO Account Status:	Available for both Fully Insured and ASO Accounts	
Report Suppression Rules:	If the average medical membership in the current period for a client segment is less than 30, the report will be suppressed.	
Cell Level Suppression Rules:	The column for Unassigned Contract Type will be suppressed if the total number of subscribers for the Unassigned Contract Type is zero.	
Early or Standard Report Production?	Early *(By End of 2nd Week of Month)*	Standard *(By End of 4th Week of Month)* ✓
Hover Description:	Breakdown of HSA ending balances by coverage tier as of a point in time	
Report Description and Analytic Notes:	This report provides a breakdown by coverage tier of the HSA balances remaining by count of subscribers within a dollar range. The data is provided as of a point in time (i.e., As of Date), not a rolling 12 month period. This report can be used to assess the current account year distribution, by dollar range, of Health Savings Account (HSA) balances. The report is only available if the client has BenefitWallet as its HSA custodian.	
Matches Reports:	This report cannot be compared to any other report. The report will also not balance to the HSA Transaction Summary Report as this report is based on a Point and Time and the HSA Transaction Summary is produced for the most recent 12 month period.	

Report Facts:

1	The CII 2.0 CDHP HSA Balance by Range Report, as well as, all CII 2.0 CDHP reports have data through the current reporting period. The CII 2.0 CDHP reports do not lag one reporting month as CII 1.0 CDHP reports did.
2	HSA financial information is displayed only when the employer selects BenefitWallet (formerly Mellon Bank) as their HSA custodian. When employees are given the alternative to 'opt out' of the bank chosen by their employer, their data will not be included in this report.
3	This report includes activity for both HSA and HSA+ products.
4	The dollars in the HSA account are owned by the employee and are portable, allowing employees to retain ownership of the funds upon termination from the plan/client. Anthem is not authorized to provide HSA reporting at the member level because the member owns the dollars in his/her HSA account.
5	Contributions into an HSA account can be made by an employee, an employer, or by incentive activity.
6	The ending balances are reported as of a point in time. For HSA reporting, the As Of Date (aka 'point in time') would be the same as the current period ending date.
7	The following are coverage tiers: Subscriber, Subscriber & Child/Children, Subscriber & Spouse/Dependent, Family, Unassigned, and Total Coverage (which includes all coverage tiers). Unassigned is when a coverage tier is unknown.

8	The # Subscribers is a count of subscribers with HSA ending balances within a dollar range within the coverage tier.
9	The % Total Subscribers is the percentage of subscribers in a dollar range within the coverage tier.
10	The Average HSA Balance is the average HSA balance for a subscriber within the coverage tier.
11	The % Subscribers with Positive Balance is the % of subscribers who have a positive balance within the coverage tier.
12	This report provides an option for users to change the reporting period end date.

Glossary:

Term	Description
HSA	Health Savings Account (HSA) Plans are bank accounts that are owned by the employee and funded by the employee and/or the employer. The employee determines if/when these funds are used. The HSA Plan features an integrated financial health bank account through our partner BenefitWallet (formerly Mellon Bank). Both the HSA and the health plan are subject to certain regulations defined by the IRS / US Treasury Department, such as, a minimum deductible for the health plan and a contribution maximum for the HSA.
HSA+	Health Savings Accounts Plus (HSA+) plans serve as transition plans from a HRA to an HSA. The HRA dollars for a HSA+ plan are called ExtraBucks and are funded from the prior year HRA rollover dollars or from incentives earned. These ExtraBuck dollars are not part of this HSA Balance by Range report. HSA+ plans also have an HSA account which will be included in this report if the custodian is BenefitWallet.
Mellon Bank	Former name of our financial partner who administered HSA bank accounts. Now known as BenefitWallet.
BenefitWallet	Current name of our financial partner who administers HSA bank accounts. Formerly known as Mellon Bank.
Point in Time	Point in Time. Ending balances are reported as of a point in time. This As of Date (point in time) is the ending date of the current period being reported.
As of Date	The Point in Time when the Health Savings Account balances and subscriber counts are calculated.
Contract Type	Contract Type describes the coverage tier elected by the subscriber. Examples of the values are Subscriber, Subscriber & Spouse/Dependent, Subscriber & Child/Children, and Family.
HSA ending balance	The HSA ending balance is the ending balance of the subscriber's HSA account at the "As of Date" on the report.
# Subscribers	The number of subscribers enrolled in an HSA product on the "As of Date" for the corresponding coverage tier/HSA balance range.
% Subscribers with Positive Balance	The number of Health Savings Account (HSA) subscribers with a positive HSA balance on the "As of Date" divided by the Total number of HSA subscribers in the corresponding coverage tier.
% Total Subscribers	The percentage of HSA subscribers in the corresponding HSA Balance Range for the applicable Coverage Tier/Total column.
Average HSA Balance	The summary of all Health Savings Account (HSA) balances for the corresponding

	coverage tier divided by the number of HSA subscribers enrolled in that coverage tier. The HSA balances and HSA subscriber counts are taken per the "As of Date" on the report.

CDHP-06 - CDHP Extra Bucks Account (EBA) Summary

Report Number:	CDHP-06	
Report Section:	Consumer Driven Health Plan(CDHP) Reports	
Report Name:	CDHP Extra Bucks Account (EBA) Summary	
Time View:	Point in Time for an account/benefit year's As of Date; for the current period, the As of Date must be between the benefit start and benefit end dates being reported	
Fully Insured/ASO Account Status:	Available for both Fully Insured and ASO Accounts	
Report Suppression Rules:	If the average medical membership in the current period for a client segment is less than 30, the entire report will be suppressed.	
Cell Level Suppression Rules:	This report has row level suppression. If the dollars are zero for both the current and prior period for the Adjustment Amount (under Additions) row, then the entire row will be suppressed. If the dollars are zero for both the current and prior period for the 'Adjustment Amount (Forfeitures)' row which is under the Forfeitures title, then the entire row will be suppressed.	
Early or Standard Report Production?	Early *(By End of 2nd Week of Month)*	Standard *(By End of 4th Week of Month)* ✓
Hover Description:	Snapshot of account activity for the HSA Extra Bucks Account (rollover HRA dollars and/or earned incentive dollars)	
Report Description and Analytic Notes:	This report provides account level financial details, such as, Additions, Forfeitures, and Subtractions (Claims Paid) on the Extra Bucks Account (the notional account piece of an HSA+ product). This report shows rollover from previous benefit years, employer contributions, incentives paid to the Extra Bucks account, forfeitures when subscribers terminate or switch coverage, claims payments during the benefit year being reported, and remaining Extra Bucks balances for the benefit year. Use this report to see potential client liability for Extra Bucks Account payments.	
Matches Reports:	This report will not match any other CII report.	

Report Facts:

1	The CII 2.0 CDHP Extra Bucks Account (EBA) Summary, as well as, all CII 2.0 CDHP reports have data through the current reporting period. The CII 2.0 CDHP reports do not lag one reporting month as CII 1.0 CDHP reports did.
2	The report will include two benefit periods and report balances As of a Point in Time (PIT). For example, if a report is run in June 2014, the As of Date will be the previous month's ending date, i.e., May 2014. The current benefit period is determined by the benefit period beginning and ending dates that include this As of Date. For a calendar year benefit year, the current period would be January 2014 – December 2014, and we would report As of May 2014. We would then get the prior period reporting dates (January 2013 – December 2013) and report on the prior year As of the same PIT, e.g., May 2014.
3	If there is more than one current benefit year that include the As of Date, the report will separate each of the benefit years. The current and prior periods for one set of benefit years will display first, and the report for the other set of benefit years will display in a separate table. The entire report will display for each set of current and prior benefit years, including headers and footnotes. Group – 100 – Sub Group – 00 Benefit Start and End dates: July 2013 – June 2014 Group – 100 – Sub Group – 01 Benefit Start and End dates: Jan. 2014 – Dec. 2014 The first table will display data for July 2013 – June 2014 and the corresponding prior period while

	the next table will display data for Jan. 2014 – Dec. 2014 and the corresponding prior period. In determining the prior benefit period, the prior benefit ending date will be one month before the current period's beginning date.
4	Dollars for terminated subscribers are included in this report. When a subscriber terminates, his Extra Bucks balance is forfeited and will appear under the Forfeitures in the field "Product Type Switch or Termination of Employment." However, as claims can still be paid for incurred dates when he was active, the report includes the terminated member, and the forfeited amount is adjusted accordingly as claims are paid from the Extra Bucks account during the subscriber's active time period.
5	Unused Extra Bucks dollars from the prior period are available to be used in the current period. These Extra Bucks dollars are included in the Beginning Balance. If a claim incurred in the prior period is paid, the Beginning Balance for the current period is adjusted to show this amount was used for a prior period's claim, i.e., fewer Extra Bucks dollars are available for current year claims (fewer Extra Bucks dollars from the prior year are rolled over into the current year).
6	While there may be a rollover limit from one year to the next (from the prior year to the current year), the Extra Bucks dollars are never lost for the prior period (to which they belong) due to exceeding the rollover amount. The dollars exceeding rollover are only lost for the current period. For example, for clients that have a rollover maximum, if there are $750 left in the Extra Bucks Account at the end of the prior periodand the rollover limit is $500, then only the $500 can be rolled over to the current period. However, the full $750 is available for claims run-out in the prior period.
7	Claims incurred during an account period always use the Extra Bucks dollars from that account period first, before they use remaining Extra Bucks dollars rolled over from previous periods.
8	If an entire group terminates, the Extra Bucks dollars will be forfeited, and the Extra Bucks Ending Balance will become 0. The dollars will be forfeited and appear under Forfeitures in the row "Product Type Switch or Termination of Employment." However, these dollars are still available to be used for claims incurred during the active period, subject to any run-out rules.
9	The ending balance from the prior year should equal the beginning balance of the current year (**if the reports are run for the same "As of Date"**). However, we often compare reports from one month to the next, and the ending balance for a report with an "As of Date of Dec. 31 will probably not equal the beginning balance for a report run with the "As of Date" of the next month (January). Data is sent to us monthly, at the end of the month. It is possible claims that occurred in the prior year were paid during January of the following year, reducing the Extra Bucks Beginning Balance going into the current year.
10	When comparing reports run in different months (different "As of Dates"), the Extra Bucks beginning balances may not be the same. In later months, more claims from the previous year may have been paid, thus reducing the Extra Bucks beginning balance rolling from the prior period into the current period.
11	When comparing reports from one month to the next, often when going into a new benefit year, the ending balance for a report with an "As of Date" of Dec. 31 will not equal the beginning balance for a report run with the "As of Date" of the next month (January). Members may terminate the plan at the end of the previous benefit year, e.g., Dec. 31, so the starting balance going into the next benefit year will be lower as there could be forfeitures for the terminated members.
12	The Employer Incentives are those incentives that are funded into the members' notional account. They will not necessarily match the Incentive and Utilization report as the Incentive report is based on a rolling paid 12 months whereas the Extra Bucks Account Summary is based on account year. Additionally, it is possible for timing issues and other non-Hallmark incentives to be added to the Extra Bucks notional account.
13	This report is for Extra Bucks notional accounts (for an HSA+ plan) housed at LITES. The HRA notional accounts (HRA plans) are reported in a separate report.

14	The Total Funds to be Committed are calculated by taking the Additions minus the Forfeitures. The Extra Bucks Account (EBA) Ending Balance is calculated by taking the Extra Bucks Beginning Balance plus Total Funds to be Committed minus Total Subtractions.
15	This report provides an option for users to change the reporting period end date.

Glossary:

Term	Description
Lumenos	Legacy name for CDHP products
LITES	The claims processing system for HRA and Extra Bucks accounts. LITES is the administrator for the HRA and Extra Bucks accounts reported on.
HRA	Health Reimbursement Accounts (HRA) Plans are notional accounts (virtual financial accounts) that belong to and are funded by the employer. An HRA account is used to cover eligible benefits up to the maximum amount available in the account. HRA Plans (on LITES) are automatically debited as claims are processed.
HIA	Health Incentive Account (HIA) Plans are notional accounts funded by incentives.
HIA+	Health Incentive Account+ (HIA+) Plans are like HRA plans, except the notional account is funded by WellPoint instead of the employer.
Extra Bucks Account (EBA)	The Extra Bucks Account is a notional account used to house rollover HRA dollars (HRA dollars will roll into the Extra Bucks Account upon selection by the consumer of the HSA Plus plan) and/or earned incentive dollars. Due to IRS regulations for HSA Products, the Extra Bucks Account dollars cannot be used until the member has satisfied their minimum required deductible for the given year.
Benefit year	The HRA and Extra Bucks notional accounts are for a benefit year, i.e., a calendar year or a plan year. Unused dollars from one benefit year may be available for rollover in a future benefit year, i.e., available to pay funds in future benefit years.
Rollover	Unused dollars in a notional account which are available for use for claims in later benefit years.
EDWard	Enterprise Data Warehouse and Reporting Depot; data warehouse used as source of reporting data
Hallmark Business Connections	Third party vendor who administers Anthem Health Rewards and CDHP incentives
Notional Account	A notional account is a virtual bank account used for the administration of HRA account dollars.
Point in Time	Point in Time; As of Date for the EBA Summary report
Beginning Balance as of MMM-YY	Rollover into current benefit year As of the month and year specified; includes balance rollovers from previous benefit years
Additions	Additions into the EBA notional account
Balance Transfer (under Additions)	Balance Transfer Credit Amount. Also included balance transfers due to product type upgrades.
Employer Contributions	Employer contributions to EBA account. Dollars contributed to the Fund by the Employer Employer Allocation
Employer Incentives	Sum of all incentive allocations into the EBA account for the benefit year for all activity and milestones

Adjustment Amount (Additions)	Positive account adjustments
Total Additions	Sum of all account additions
Forfeitures	Forfeiture section
Product Type Switch or Termination of Employment	Forfeitures when subscriber moves from a plan or dollars forfeited when subscriber terminates
Benefit Year Roll Over Maximum	Benefit Year Max Forfeitures; Forfeitures when the EBA ending balance exceeds the rollover max established for the product in which the subscriber is enrolled at the end of the benefit year
Balance Transfer Debits	Dollars transferred when a subscriber moves between CDHP products. These dollars are debits in the previous product type record and will be reported as a credit in the new product type record for the subscriber and benefit year.
Adjustment Amount(Forfeitures)	Negative HRA account adjustments
Total Forfeitures	Sum of account forfeitures
Total Funds to be Committed	Additions minus forfeitures
Subtractions	Claims Paid
Claims Paid	Claims Paid
Total Subtractions	Sum of Subtractions
EBA Ending Balance	Ending EBA Balance Formula: Beginning Balance + Balance Transfer Credits + Employer Contributions + Adjustments + Incentives - Claim Payments – Product Type Switch Forfeitures – Benefit Year Rollover Maximum Forfeitures - Balance Transfer Debits

CDHP-07 - CDHP Utilization and Incentive Report

Report Number:	CDHP-07	
Report Section:	Consumer Driven Health Plan(CDHP) Reports	
Report Name:	CDHP Utilization and Incentive Report	
Time View:	Based on Disbursement/Activity Dates	
Time Period:	Plan Year to Date	
Fully Insured/ASO Account Status:	Available for both Fully Insured and ASO Accounts	
Report Suppression Rules:	If the average medical membership in the current period for a client segment is less than 30, this report will be suppressed.	
Cell Level Suppression Rules:	None	
Early or Standard Report Production?	Early *(By End of 2nd Week of Month)*	Standard *(By End of 4th Week of Month)* ✓
Hover Description:	Displays the incentive programs offered by Hallmark, providing a count of subscribers and members who have earned incentives	
Report Description and Analytic Notes:	This report provides a summary of the incentives being earned by the client's membership. It provides details on subscriber and membership engagement in the incentive programs. Only incentives flowing through Hallmark, the incentives processing vendor, are reported. Using this report, clients can assess the financial impact of incentives for their CDHP plan and on member engagement and healthy behaviors. The report also provides insight into the utilization of the various incentive programs. The report only shows incentives for activities that the member has completed, is eligible for under the incentive rules, and for which a disbursement has been made. It cannot be used to see all possible incentives for which a group is eligible as only incentives with disbursements (payouts) are shown.	
Matches Reports:	This report does not always match the incentive data on the HRA Account Balance and the Extra Bucks Account Summary reports as those two reports use LITES as their source and show incentive dollars into subscribers' accounts per benefit account year. The CDHP Utilization and Incentive report is Plan Year to Date and only includes incentives which go through the Hallmark incentives rules engine. The data on the CDHP Utilization and Incentive Report is sourced from the incentives vendor Hallmark, not from the HRA administrator, e.g., LITES.	

Report Facts:

1	The CII 2.0 CDHP Utilization and Incentive Report, as well as, all CII 2.0 CDHP reports have data through the current reporting period. The CII 2.0 CDHP reports do not lag one reporting month as CII 1.0 CDHP reports did.
2	For incentive reporting, this report only uses the Hallmark disbursement data.
3	This report may not include all activities for a member. While members may complete activities through the activity vendors (e.g., WebMD, Healthways, HealthMedia), these activities must be sent to the Hallmark rules incentive process (i.e., the rules engine) to determine whether the activities

	will result in an incentive disbursement. There may be rules for gatekeepers (activities that are prerequisites, such as, health risk assessment), member relationship, and frequency of completing activities and being incented. These rules will determine if an activity results in an incentive disbursement.
4	This report cannot be used to view all the possible incentives offered to a group. Only the programs that have incented member activity will be shown on the report. For a complete list of incentives offered, please contact your Account Management Representative.
5	If the average medical membership in the current period for a client segment is less than 30, this report will be suppressed. If the average medical membership for HRA products in the current period for a client segment is less than 30, the HRA table is suppressed. Likewise, if the average medical membership for HSA products in the current period for a client segment is less than 30, the HSA table is suppressed
6	Under the Employer Incentives section, only employers with both HRA and HSA plans will show both tables. The HRA section will be suppressed if the employer only has an HSA Plan. Similarly, if the employer only has an HRA plan, the HSA section will be suppressed.
7	HRA includes HRA, HIA, and HIA+ while HSA includes HSA and HSA+ plans.
8	The Utilization and Incentive report is organized by CDHP product (HRA-Health Reimbursement Account and HSA-Health Savings Account), reward type (AD-Account Deposit, PC-Premium Contribution, GC-Gift Card, RM-Reimbursement), milestone, and activity. The report is data driven and will show the milestone and activity names as they are passed from the activity vendor. If an activity did not result in a reward, an incentive for that activity will not be listed on this report.
9	Presently, there are four reward types: AD – Account Deposit GC – Gift Card PC – Premium Contribution RM - Reimbursement
10	AD is an Account Deposit where the incentive disbursement is credited into a notional (HRA, HIA, HIA+, HSA+ Extra Bucks) account or into an HSA account. For HRA, HIA, HIA+, and Extra Bucks accounts, the incentive is Paid as the dollars have been deposited into a LITES account, and LITES has acknowledged the money has been credited to the member. HSA disbursements are Earned as there is no acknowledgement from the bank that the subscriber's account was credited.
11	GC is a Gift Card where Hallmark has issued a gift card to a member. These are Earned incentives as we do not know if the GC has been used.
12	PC is a Premium Contribution where a wellness credit is applied against a subscriber's premiums. These are Earned incentives.
13	RM is a reimbursement, e.g., for a gym membership.
14	There are two incentive platforms: direct and points. With the direct platform, activities (subject to the rules engine) equate to disbursements. With the points platform, activities result in points which can be accumulated and later redeemed. This Utilization and Incentive report does not show how many points a member has. As the report is based on disbursements, the report only shows disbursements when points are redeemed. Additionally, the points redeemed may equate to many activities completed by the member. Therefore, the milestone and activity name for a points redemption will be Redeemed Points since no single activity can be associated with the disbursement.
15	A member will be counted once per reward type, milestone, and activity combination during a reporting period even if he/she may have received more than one incentive during the reporting period. The member will be counted based on the member relationship status. All incentive disbursements will be included in the Incentive Amount.

16	The incentive dollars and member counts are grouped by member relationship, e.g., by subscriber, by spouse/partner, and by child/other relationship.
17	The CDHP Demographics section will include all enrolled CDHP members even if they did not receive any incentives, and it shows membership at the end of the reporting period
18	This report provides an option for users to change the reporting period end date.

Glossary:

Term	Description
Account Deposits	Reward type where incentives are credited to either a HRA account or to a HSA account.
CDHP Category Code	Type of CDHP product and account (i.e. HRA, HIA, HIA+, HSA, and HSA+).
Enrolled CDHP Members	A count of the total number of members enrolled in the CDHP product by Contract Type (i.e., Subscriber, Subscriber & Spouse/Dependent, Subscriber & Child, Family, Total Members).
Gift Cards	Reward type where incentives are issued as a Gift Card.
Reward Type	Form of payment for an incentive. Incentives can be credited to members' accounts (Account Deposit), issued as a Gift Card, appear as a wellness credit or Premium Contribution, or be a Reimbursement.
Milestone	This refers to a Vendor milestone that a member has reached on the activity vendor (e.g., webMD or HealthMedia) website. Most incentives are at the milestone level, and more than one activity can be associated with a milestone. Examples of milestones: ConditionCare: Asthma, FutureMoms, Online Questionnaire, etc. The Milestone name on the report is the name provided by the activity vendor.
Activity	Vendor activity that a member has completed on the activity vendor (e.g., webMD or HealthMedia) website. Examples of activities: Program completion, Health assessment completion, Completing the tobacco cessation program. The Activity name on the report is the name provided by the activity provider.
Notional Account	A notional account is a virtual bank account used for the administration of HRA account dollars.
Incentive Amount	Sum of the incentive dollars for all members totaled by the CDHP Category Code, reward type, milestone, activity, and the member relationship.
Subscriber	Count of unique members for the CDHP Category Code, reward type, milestone, activity, and subscriber relationship
Spouse/Partner	Count of unique members for the CDHP Category Code, reward type, milestone, activity, and spouse/partner relationship
Child/Other	Count of unique members for the CDHP Category Code, reward type, milestone, activity, and child/other relationship
Total	Count of unique members for the CDHP Category Code, reward type, milestone, and activity.
Points Redeemed	On the points platform, points accumulate for activities and milestones and are then redeemed for an incentive. As these redeemed points can equate to more than one activity, both the activity and the milestone will be called "Points Redeemed" instead of listing the actual activities and milestones completed.
Premium Contributions	Reward type where incentives are issued as a premium contribution or wellness credit.
Total Account Deposits	Sum of the incentive dollars for all members, for all milestones and activities, for the reward type of Account Deposit.

Total All Incentives	Sum of the incentive dollars for all members for all milestones, activities, and reward types.
Total Gift Cards	Sum of the incentive dollars for all members for all milestones and activities for the reward type of Gift Card.
Total Premium Contributions	Sum of the incentive dollars for all members for all milestones and activities for the reward type of Premium Contribution.

CDHP-08 - Deductible and Coinsurance Report

Report Number:	CDHP-08	
Report Section:	Consumer Driven Health Plan(CDHP) Reports	
Report Name:	CDHP Deductible and Coinsurance Report	
Time View:	Plan Year to Date	
Fully Insured/ASO Account Status:	Available for both Fully Insured and ASO Accounts	
Report Suppression Rules:	If the average medical membership in the current period for a client segment is less than 30, the report will be suppressed.	
Cell Level Suppression Rules:	The Upfront Deductible table (current) will be suppressed if the entire table has 0 members or if the dollars are 0 (or less) for the current period. The Upfront Deductible table (prior) will be suppressed if the entire table has 0 members or if the dollars are 0 (or less) for the prior period.	
Early or Standard Report Production?	Early *(By End of 2nd Week of Month)*	Standard *(By End of 4th Week of Month)* ✓
Hover Description:	Distribution of Employee Counts for deductible, coinsurance/copay, and out-of-pocket dollars by dollar ranges and by coverage tiers	
Report Description and Analytic Notes:	This report can be used to assess the distribution of employee counts by dollar range of Employee Out of Pocket amounts (Deductible, Copay & Coinsurance). Comparisons among the coverage tiers can be made and the Current Period metrics can be compared to those of the Prior Period. Separate tables have been prepared for Upfront Deductible, Deductible, Coinsurance/Copay, and for Combined Out of Pocket amounts. The reports will show the number of subscribers who are close to the deductible limits and close to entering the traditional health coverage part of their CDHP plan.	
Matches Reports:	This report will not match any other CDHP report as deductible and coinsurance/copay information is not available on any other report except the CDHP Monthly Financial. The CDHP Monthly Financial report shows actual deductible and coinsurance/copay dollars as opposed to dollar ranges and is reported by paid date while the CDHP Deductible and Coinsurance report has dollars based on incurred dates for claims paid during the reporting period to accurately report member out-of-pocket expenses during the benefit plan year.	

Report Facts:

1	This report contains four tables per reporting period. They are: Upfront Deductible, Deductible, Coinsurance and Copay, and Member Out of Pocket. Definitions for these 4 categories are shown in the glossary below.
2	For each of the tables, we are summing the deductibles, coinsurance, and out of pocket for all members in the employee's contract. In other words, the dollars are at the subscriber level as opposed to the member level.
3	Reports are for both the current and the prior reporting periods. The Current Period is based on the renewal month and year and can vary by group segment. The Prior Period is also based on the renewal month and year and can vary by group segment. For segments with subgroups with different renewal months, the Renewal Period will be based on the subgroup with the highest membership across the segment.
4	This report is based on incurred dates for claims paid through the reporting period end date. Additionally, the claims must have occurred during the benefit year that we are currently reporting. This is not a rolling 12 month report, but rather begins with renewal month and year and reports

	that benefit year's data until the current benefit period is complete. For example, with a July renewal date, we will report the following: In September 2013 – 7/1/2013 – 8/31/2013 In October 2013 – 7/1/2013 – 9/30/2013 In June 2014 – 7/1/2013 – 5/31/2014 In July 2014 – 7/1/2013 – 6/30/2014 (complete 12 months of data at benefit end date of 6/30/14) In August 2014 – 7/1/2014 – 7/31/2014 At benefit year end, the current reporting period will include a complete 12 months of data.
5	Data in each table will be suppressed if the average number of members for CDHP is less than 30 for the reporting period (due to low volume suppression rules).
6	The Upfront Deductible table (for both current and prior periods) will be suppressed if the whole table is showing 0 members or 0 dollars.
7	Upfront deductible is the subset of deductible which cannot be reimbursed out of the subscriber's HRA account. Clients must have purchased 'Deductible First' (aka Deductible Before HRA) for any data to appear under Upfront Deductible.
8	This report includes dollars for HRA, HIA, HIA+, HSA, and HSA+ products. For clients with multiple plans, e.g., HRA and HSA, the reports will combine all of them together.
9	The Deductible table includes all deductible amounts as well as upfront deductible (if applicable) for those clients with the 'Deductible Before HRA' option. This is different from legacy reporting where the Upfront Deductible is not included in the legacy report's Annual Deductible.
10	The report does not distinguish between in-network and out-of-network deductibles. They are counted together for a subscriber.
11	The contract types are divided into the following categories: Family, Subscriber, Subscriber & Child/Children, Subscriber & Spouse/Dependent, and Total Coverage.
12	The Deductible and Out of Pocket reports do not include any reimbursement out of Flexible Spending Account (FSA) or MyIncentive Account (MIA) plans.
13	This report provides an option for users to change the reporting period end date as it is a Plan Year to Date report.

Glossary:

Term	Description
HSA	Health Savings Account (HSA) Plans are bank accounts that are owned by the employee and funded by the employee and/or the employer. The employee determines if/when these funds are used. The HSA Plan features an integrated financial health bank account through our partner BenefitWallet (formerly Mellon Bank). Both the HSA and the health plan are subject to certain regulations defined by the IRS / US Treasury Department, such as, a minimum deductible for the health plan and a contribution maximum for the HSA.
HSA+	Health Savings Accounts Plus (HSA+) plans serve as transition plans from a HRA to an HSA. The HRA dollars for a HSA+ plan are called ExtraBucks and are funded from the prior year HRA rollover dollars or from incentives earned. These ExtraBuck dollars are not part of this HSA Balance by Range report. HSA+ plans also have an HSA account which will be included in this report if the custodian is BenefitWallet.
HRA	Health Reimbursement Accounts (HRA) Plans are notional accounts (virtual financial

	accounts) that belong to and are funded by the employer. An HRA account is used to cover eligible benefits up to the maximum amount available in the account. HRA Plans (on LITES) are automatically debited as claims are processed. In the Health Reimbursement Account Plan section of the Monthly Financial report, Health Incentive Account (HIA) and Health Incentive Account Plus (HIA+) Plans are also included. The HIA Plan combines a traditional PPO plan with specified incentives stored in a notional account while the HIA+ Plan is like the HRA, except the notional account is funded by WellPoint instead of the employer.
HIA	Health Incentive Account (HIA) Plans are notional accounts funded by incentives.
HIA+	Health Incentive Account+ (HIA+) Plans are like HRA plans, except the notional account is funded by WellPoint instead of the employer.
Contract Type	Contract Type describes the coverage tier elected by the subscriber. Examples of the values are Subscriber, Subscriber & Spouse/Dependent, Subscriber & Child/Children, and Family.
Coinsurance and Copay	Amount for which a member is responsible (not including deductible). Once employees have met their annual deductible amount, traditional health coverage begins. Then, the plan and employee share the cost for additional services through Coinsurance. Note that any Copay amounts would be included with Coinsurance.
Current	The current time period is based on the plan benefit start date through the current month.
Current Renewal Year	The current renewal year corresponds to the plan benefit start date. It determines the first month of the reporting period.
Deductible	The Deductible table of this report includes the upfront deductible met for employers with the Deductible Before HRA/Deductible First option. For employers who do not have that option, the deductible is the regular deductible.
Dollar Range	Range of deductible, coinsurance and copay dollars paid by subscriber.
Total Coverage	Total subscribers (enrolled during reporting period) with deductible, coinsurance and copays that fall within the range for all coverage tiers specified.
Total Member Out of Pocket	Total of payments for health services paid by member. Total consists of Deductible + Coinsurance + Copay.
Upfront Deductible	For employers who purchase the Deductible Before HRA/Deductible First option, the Upfront Deductible is the amount that must be paid by the member before any dollars can be reimbursed from the HRA. For this report, it is the amount of upfront deductible that has been met.

DEN-01 - Dental Membership

Report Number:	DEN-01	
Report Section:	Dental	
Report Name:	Dental Membership	
Time View:	This report will always be based on an 'as of date' (which is the end of the current period).	
Time Periods Available:	The following options are available: Rolling 12 months – *Default* Rolling 3 months Plan year to date Calendar year to date	
Fully Insured/ASO Account Status:	Available for both Fully Insured and ASO Accounts	
Report Suppression Rules:	If the average Dental membership in the current period for a client segment is 1 or less, the report must be suppressed.	
Cell Level Suppression Rules:	There are no cell level suppression rules.	
Row/Column Level Suppression Rules:	The 'Other' Contract Type row will be suppressed if the values = 0.	
Early or Standard Report Production?	Early *(By End of 2nd Week of Month)*	Standard *(By End of 4th Week of Month)* ✓
Hover Description:	Dental membership by contract type by month for the current period with comparisons to the prior period and benchmark	
Report Description and Analytic Notes:	This report displays dental subscribers and members by month and by contract type for the current period. Averages for the current period are compared to the prior period and to benchmark. Use this report to analyze Dental membership trends and characteristics such as the distribution of membership by contract type. This report may also be useful in estimating the impact of proposed changes to Dental plan provisions, such as Orthodontia, that may affect one age group more than another. Enrollment Trend is a useful measure because of its strong correlation to changes in plan costs.	
Matches Reports:	The Total Members on the DEN01 - Dental Membership report will match the Total Members on the DEN02 – Dental Enrollment & Claims report. The Total Contracts on the DEN01 – Dental Membership report will match the Total Subscribers on the DEN02 - Dental Enrollment & Claims report.	

Report Facts:

1	The Average Age is derived by taking all of the member ages and dividing by the total number of members.
2	The Average Age - Benchmark represents the average ages of all Dental membership for all accounts contained within the CII database.
3	The Total Members under the Membership by Contract Type table may not tie out to the Membership by Age/Gender tables as the Membership by Age/Gender is based on an average of the current period.

4	The Average Current Period membership counts under the Membership by Contract Type are based on an average taken over the current period indicated. The average represents the sum of Dental Member Counts for each month divided by the number of months for which eligible members exist with dental coverage. Therefore, if the segment only has dental membership for 3 months of the period, the denominator would be 3.
5	The Total Contracts represents the number of subscribers who have elected dental coverage under one of the dental contract types. This number will not match the 'Subscriber' contract type as the Subscriber contract type represents only the number of Contracts who elected 'Subscriber only' coverage.
6	The Subscriber/Employee and Member counts are based on enrollment counts as of the end of each reporting period.
7	This report includes comparisons to the commercial benchmark. The benchmark is based on all dental accounts contained within the CII database.
8	In the initial release an account must have medical coverage in order to be eligible to receive CII dental reports. In other words, accounts with dental only coverage would not be eligible for CII as an account must meet the active enrolled medical subscriber criteria in order to receive CII. Effective May 2016, CII reporting to standalone dental and vision clients are available.
9	Unlike the majority of our other CII reports, the Dental reports currently do not have cell level suppression rules (e.g., specific cells are not suppressed if the volume is less than or equal to 5).
10	If the average dental membership in the current period for a client segment is 1 or less, the report will be suppressed.
11	The 'Other' Contract Type row will be suppressed if the values = 0.

Glossary:

Term	Description
Age Range	This refers to the grouping of members into pre-defined age brackets.
Average (Members)	Average Members is derived by dividing the sum of Member Counts for each month by the number of months in the reporting period
Average Age	The average age of the members in a particular category as of the end of the reporting period.
Average Members per Contract	The average number of members per contract (e.g., employees/subscribers). This represents the average family size for a group.
Benchmark	Benchmark refers to a normative value against which plan metrics are compared. Benchmarks in CII include data from all Anthem accounts in the Client Information Insights database. The benchmark excludes Anthem Medicare Primary Members.
Contract Type	Contract Type describes the coverage tier elected by the subscriber. Examples of the values are Subscriber, Subscriber & Spouse/Dependent, Subscriber & Child/Children and Family.
Current (Period)	This is the most recent time period based on date parameters in the report.
Gender	The sex of the member (i.e., Male or Female).
Member Count	Total Member Count as of the end of the reporting period.
Member Months	The sum of members for each month for the reporting period.
Members	Members represent all employees and dependents, eligible for coverage under a plan of benefits during the time period represented.
Prior (Period)	References the earlier time period used for comparison to the current period.
Subscriber(s)	Subscribers are the Contract holders for the Plan. Subscribers are usually Employees.
Total Contracts	Total Contracts refers to a count of the Subscribers who have elected coverage

	under one of the coverage tiers.
Trend	Trend is the percent change of any metric from the prior period to the current period. To calculate Trend, subtract the prior period value from the current period value and then divide the result by the prior period value.

DEN-02 - Dental Enrollment and Claims

Report Number:	DEN-02	
Report Section:	Dental	
Report Name:	Dental Enrollment & Claims	
Time View:	Paid Dates w/an option for user to select Incurred	
Time Periods Available:	The following options are available: Rolling 12 months – *Default* Rolling 3 months Plan year to date Calendar year to date	
Fully Insured/ASO Account Status:	Available for both Fully Insured and ASO Accounts	
Report Suppression Rules:	If the average Dental membership in the current period for a client segment is 1 or less, the report must be suppressed.	
Cell Level Suppression Rules:	There are no cell level suppression rules.	
Row/Column Level Suppression Rules:	The 'Other' Contract Type column will be suppressed if the values = 0.	
Early or Standard Report Production?	Early *(By End of 2nd Week of Month)*	Standard *(By End of 4th Week of Month)* ✓
Hover Description:	Dental member and subscriber counts by month including paid amounts for a 12-month period	
Report Description and Analytic Notes:	This report displays month by month counts of dental subscribers, members and claimants as well as paid amounts for a 12-month period. Use this report to analyze Dental membership trends and characteristics such as the distribution of membership by contract type. This report may also be useful in estimating the impact of proposed changes to Dental plan provisions.	
Matches Reports:	The Total Members on the DEN01 - Dental Membership report will match the Total Members on the DEN02 – Dental Enrollment & Claims report. The Total Contracts on the DEN01 – Dental Membership report will match the Total Subscribers on the DEN02 - Dental Enrollment & Claims report.	

Report Facts:

1	The Subscriber and Member counts are based on enrollment counts as of the end of each reporting period.
2	Number of Claims is a count of claims paid for the period.
3	Paid Claims is the total of the net benefit issued for services provided under the Plan. It represents the amount paid after all pricing guidelines have been applied, including provider discounts, and all non-covered, third-party/Medicare, copayment, coinsurance and deductible amounts have been subtracted.
4	Percent of Total Paid Claims represents each month's percent of the total paid for the reporting period. This metric is calculated by dividing the monthly paid amount by the total paid claims.
5	Unlike the majority of our other CII reports, the Dental reports currently do not have cell level suppression rules (e.g., specific cells are not suppressed if the volume is less than or equal to 5).

6	This report is based on Paid Dates with an option for the user to select Incurred Dates.
7	If the average Dental membership in the current period for a client segment is 1 or less, the report will be suppressed.
8	In the initial release an account must have medical coverage in order to be eligible to receive CII dental reports. In other words, accounts with dental only coverage would not be eligible for CII as an account must meet the active enrolled medical subscriber criteria in order to receive CII. Effective May 2016, CII reporting to standalone dental and vision clients are available.

Glossary:

Term	Description
Average (Members)	Average Members is derived by dividing the sum of Member Counts for each month by the number of months in the reporting period.
Average Members per Contract	The average number of members per contract (e.g., employees/subscribers). This represents the average family size for a group.
Claims	Claims is the number of claims records received.
Claims Paid	Represents the total dollars paid for claims submitted.
Contract Type	Contract Type describes the coverage tier elected by the subscriber. Examples of the values are Subscriber, Subscriber & Spouse/Dependent, Subscriber & Child/Children and Family.
Member Count	Total Member Count as of the end of the reporting period.
Members	Members represent all employees and dependents, eligible for coverage under a plan of benefits during the time period represented.
Paid Amount - Total	Paid Amount is the net benefit issued for services provided under the Plan. It represents the amount Paid after all pricing guidelines have been applied, including provider discounts, and all non-covered, third-party/Medicare, copayment, coinsurance and deductible amounts have been subtracted.
Percent of Total Paid Amount	The percent of Total Paid Amount is calculated by dividing the amount paid for the category by the total paid amount, expressed as a percentage.
Subscriber(s)	Subscribers are the Contract holders for the Plan. Subscribers are usually Employees.

DEN-03 - Dental Claims Summary by Service Category

Report Number:	DEN-03	
Report Section:	Dental	
Report Name:	Dental Claims Summary by Service Category	
Time View:	Paid Dates w/an option for user to select Incurred	
Time Periods Available:	The following options are available: Rolling 12 months – *Default* Rolling 3 months Plan year to date Calendar year to date	
Fully Insured/ASO Account Status:	Available for both Fully Insured and ASO Accounts	
Report Suppression Rules:	If the average Dental membership in the current period for a client segment is 1 or less, the report must be suppressed.	
Cell Level Suppression Rules:	There are no cell level suppression rules.	
Row/Column Level Suppression Rules:	The 'All Other' row will be suppressed if the values = 0.	
Early or Standard Report Production?	Early *(By End of 2nd Week of Month)*	Standard *(By End of 4th Week of Month)* ✓
Hover Description:	Dental utilization and costs for dental services by procedure category with PMPM comparisons to current and prior periods and benchmark	
Report Description and Analytic Notes:	This report displays number of claimants and procedures as well as member out of pocket costs and paid amounts for dental services by procedure category. Paid Amount PMPMs are provided comparing the current vs. prior periods as well as to benchmark. Use this report to identify aggregate and average cost and utilization trends for specific Dental service categories. PMPM averages for the current period are compared to the prior period and to a BOB Benchmark.	
Matches Reports:	The total paid amount on DEN-03 Dental Claims Summary by Service Category will match the total paid amount on the DEN-04 Dental Network Utilization & Plan Savings report and the total Paid Claims on DEN02- Dental Enrollment & Claims report. The total Unique Claimants on DEN-03 Dental Claims Summary by Service Category will match the total Unique Claimants on the DEN-04 Dental Network Utilization & Plan Savings report	

Report Facts:

1	The dental service categories are based on American Dental Association (ADA) codes and procedures. The following service categories are currently available on the Dental Claims Summary by Service Category report: Preventive & Diagnostic (e.g. routine cleaning and exams) Restorative: Minor (e.g. fillings, single restorative crowns)

	Restorative: Endodontics (e.g. root canal procedures) Restorative: Periodontics (e.g. care for gum disease) Restorative: Oral Surgery (e.g. removal of impacted wisdom teeth) Restorative: Major (e.g. implants and implant supported crowns) Restorative: Prosthodontic (e.g. dentures) Orthodontia (e.g. braces) General Adjunctive (e.g. anesthesia, consultations, drugs) All Other - All Dental Service codes that are not included in any of the nine categories shown above will be assigned to the All Other category.
2	Any Service Category that does not contain data of any kind will be excluded from the report.
3	Unlike the majority of our other CII reports, the Dental reports currently do not have cell level suppression rules (e.g., specific cells are not suppressed if the volume is less than or equal to 5).
4	If the average Dental membership in the current period for a client segment is 1 or less, the report will be suppressed.
5	This report includes comparisons to the commercial benchmark. The benchmark is based on all dental accounts contained within the CII database.
6	In the initial release an account must have medical coverage in order to be eligible to receive CII dental reports. In other words, accounts with dental only coverage would not be eligible for CII as an account must meet the active enrolled medical subscriber criteria in order to receive CII. Effective May 2016, CII reporting to standalone dental and vision clients are available.

Glossary:

Term	Description
Benchmark	Benchmark refers to a normative value against which plan metrics are compared. Benchmarks in CII include data from all accounts in the Client Information Insights database. The benchmark excludes Anthem Medicare Primary members.
Current (Period)	The most recent time period based on date parameters in the report.
Member Out of Pocket	Member Out of Pocket (OOP) is the total of the member cost share which is derived by summing the Deductible, Coinsurance and Copay amounts.
Number of (Dental) Procedures	The Number of Procedures is a count of each service performed for members who received Dental treatment.
Paid Amount	Paid Amount is the net benefit issued for services provided under the Plan. It represents the amount paid after all pricing guidelines have been applied, including provider discounts, and all non-covered, third-party/Medicare, copayment, coinsurance and deductible amounts have been subtracted.
Percent of Procedures	The Percent of Procedures displays each Service Category's proportion of the overall total number of procedures for the reporting period.
PMPM	PMPM (Per Member Per Month) is the average amount paid per member per month during the reporting period. It is a financial measure that is derived by dividing the Total Paid Amount by Total Member Months.
Prior (Period)	References the earlier time period used for comparison to the current period.
Service Category – Dental	Dental procedures are grouped into one of several Service Categories based on the type of procedures being performed. These categories will often correspond to different benefit levels available within a plan – such as Preventive & Diagnostic, Restorative (Minor, Endodontics, Periodontics, Oral Surgery, Major, and Prosthodontics), Orthodontia, and General Adjunctive.
Unique Claimants	A unique count of members who have incurred expenses under the plan and have submitted a claim. A member is only counted once.

DEN-04 - Dental Network Utilization and Plan Savings

Report Number:	DEN-04	
Report Section:	Dental	
Report Name:	Dental Network Utilization and Plan Savings	
Time View:	Paid Dates w/an option for user to select Incurred	
Time Periods Available:	The following options are available: Rolling 12 months – *Default* Rolling 3 months Plan year to date Calendar year to date	
Fully Insured/ASO Account Status:	Available for both Fully Insured and ASO Accounts	
Report Suppression Rules:	If the average Dental membership in the current period for a client segment is 1 or less, the report must be suppressed.	
Cell Level Suppression Rules:	There are no cell level suppression rules.	
Row/Column Level Suppression Rules:	The Coordination of Benefits Savings and Other Reduction Amount columns will be suppressed if the values = $0.	
Early or Standard Report Production?	Early *(By End of 2nd Week of Month)*	Standard *(By End of 4th Week of Month)* ✓
Hover Description:	Breakdown of dental claimants and costs for In vs. Out of Network	
Report Description and Analytic Notes:	Provides a breakdown of claimant counts, submitted dental charges by covered, non-covered, cost sharing (copay, deductible, coinsurance), discounts and paid amount for In- vs. Out-of-Network for the current period. This report can be used to assess potential Network access or utilization issues. It can also be used to show the possible impact of proposed changes to plan provisions involving Networks discounts or employee cost sharing.	
Matches Reports:	The total paid amount on DEN-04 Dental Network Utilization & Plan Savings will match the total paid amount on the DEN-03 Dental Claims Summary by Service Category report and the total Paid Claims on DEN02- Dental Enrollment & Claims report	

Report Facts:

1	Network status is based on how the claim was paid.
2	The Coordination of Benefits Savings and Other Reduction Amount columns will be suppressed if the values = $0.
3	Unlike the majority of our other CII reports, the Dental reports currently do not have cell level suppression rules (e.g., specific cells are not suppressed if the volume is less than or equal to 5).
4	If the average Dental membership in the current period for a client segment is 1 or less, the report must be suppressed.
5	In the initial release an account must have medical coverage in order to be eligible to receive CII dental reports. In other words, accounts with dental only coverage would not be eligible for CII as an account must meet the active enrolled medical subscriber criteria in order to receive CII. Effective May 2016, CII reporting to standalone dental and vision clients are available.

Glossary:

Term	Description
Allowed Amount	Allowed amount represents that portion of the Charge Submitted that is eligible for benefit consideration.
Charge Submitted	The Charge Submitted is the amount billed by the provider for services rendered. It represents the gross charge amount before applying pricing guidelines or deducting third-party, copayment, coinsurance or deductible amounts.
Coinsurance/Copay	Coinsurance is a member out of pocket amount, generally expressed as a percentage of the allowed amount, for which the member is responsible. Copayment is a member out of pocket amount, usually expressed as a flat dollar amount, for which the member is responsible.
Coordination of Benefits Savings	Coordination of Benefits (COB) Savings Amount is the reduction in the Plan's payment amount to reflect the Plan as a secondary payor.
Covered Expense Amount	Covered Expense is the amount to be considered for payment under the plan.
Current (Period)	This is the most recent time period based on date parameters in the report.
Deductible	Amount of eligible expense a member is responsible for paying each benefit period before the health plan will make payment for eligible benefits.
In-Network	In-Network refers to services rendered by participating Network providers (i.e., providers under contract to provide services at a discounted rate).
Network Savings	Network Savings is the amount of the negotiated savings, or pricing reductions, associated with participation in the Dental Network.
Network Status	Network status is based on how the claim was paid.
Non Covered Amount	Represents the portion of the Charge Submitted that is not covered due to plan exclusions.
Other Reduction Amount	Other Reduction Amount is the amount of any other plan-specific reductions that may exist under the Dental Plan.
Out-of-Network	For Managed Dental plans, benefits paid for services rendered by non-participating providers.
Paid Amount	Paid Amount is the net benefit issued for services provided under the Plan. It represents the amount Paid after all pricing guidelines have been applied, including provider discounts, and all non-covered, third-party/Medicare, copayment, coinsurance and deductible amounts have been subtracted.
Percent Network Savings	Network Savings percent refers to the proportion of the total Covered Expense Amount that is derived from Network Savings. This metric is calculated by dividing the Network Savings Amount by the Total Covered Expense Amount.
Percent Paid Amount	The Percent Paid Amount is calculated by dividing the amount paid for the category by the total paid amount, expressed as a percentage.
Unique Claimants	A unique count of members who have incurred expenses under the plan and have submitted a claim.

VIS-01 - Vision Membership

CII View Order #:	VIS-01	
Report Name:	Vision Membership	
Report Section:	Vision	
Time View:	This report will always be based on an 'as of date' (which is the end of the current period).	
Time Periods Available:	The following options are available: Rolling 12 months – *Default* Rolling 3 months Plan year to date Calendar year to date	
Fully Insured/ASO Account Status:	Available for both Fully Insured and ASO Accounts	
Report Suppression Rules:	If the average Vision membership in the current period for a client segment is 1 or less, the report must be suppressed.	
Cell Level Suppression Rules:	No Cell Level Suppression Rules apply	
Early or Standard Report Production?	Early *(By End of 2nd Week of Month)*	Standard *(By End of 4th Week of Month)* ✓
Hover Description:	Vision membership by contract type and by age/gender for current and prior periods	
Report Description:	Shows average membership counts by contract type for the current and prior report periods. Membership distribution by age range and gender is also displayed with average age by gender compared to a Book of Business benchmark. The graph shows % Utilization by Age Range.	
Analytic Notes:	This report can be used to assess the demographics of the population by viewing the average membership by contract type, gender and age range and % utilization by age range. Average age is also displayed with a comparison to a benchmark. This comparison facilitates the assessment of the group's average age against a reliable normative value.	
Matches Reports:	The Total Members on the VIS01- Vision Membership report under the Membership by Contract Type will match the Members on the VIS02 – Vision Monthly Member Utilization Detail report and the Member count under the Key Indicators section on the VIS03 – Vision Utilization Summary report The Total Contracts on the VIS01 – Vision Membership report will match the Total Subscribers on the VIS02- Vision Monthly Member Utilization Detail report.	

Report Facts:

1	The member counts are based on enrollment counts as of the end of each reporting period.
	The Total Members under the Membership by Contract Type table may not tie out to the Membership by Age/Gender tables as the Membership by Age/Gender is based on a average of the current period.
2	The Total Contracts under the Membership by Contract Type table represents the number of subscribers who have elected vision coverage under one of the vision contract types.
3	The Average Current Period membership counts under the Membership by Contract Type are based

	on an average taken over the current period indicated. The average represents the sum of Vision Member Counts for each month divided by the number of months for which eligible members exist with vision coverage so if the segment only has vision membership for 3 months of the period, the denominator would be 3.
4	In the initial release an account must have medical coverage in order to be eligible to receive CII vision reports. In other words, accounts with vision only coverage would not be eligible for CII as an account must meet the active enrolled medical subscriber criteria in order to receive CII.
5	For the Utilization Percentage in the Vision Membership and Utilization by Age Range graph, note that the number of members seeking vision services is not a measure shown in any of the tables in this report but is related to the number of claimants on the VIS-02 Vision Monthly Member Utilization Detail report and is only used to calculate the Utilization percentage for the graph. Claimant Counts by Age Range are not displayed in any of the Vision reports but can be derived by multiplying overall Total Members by the Utilization % for each Age Range. The sum of these Claimant Counts by Age Range will equal the Claimant Count on the Total line of VIS-02 Monthly Member Utilization Detail. Also note that the utilization percentages will not sum to 100% across age ranges like the Membership % does. This is because not all members eligible for vision coverage have sought vision treatment and filed a vision claim.
6	The Average Age – Benchmark is based on the CII Book of Business (i.e., the average age for all accounts that have vision coverage and are eligible to receive the CII reports).
7	The Vision Membership by Age Range and Gender chart graphs the results for the Membership by Age/Gender table for the current period with Male and Female breaks by age group.
8	Unlike the majority of our other CII reports, the Vision reports currently do not include low volume suppression (LVS) rules.
9	There are no cell level suppression rules for any of the CII vision reports.
10	This report includes comparisons to the commercial benchmark. The benchmark is based on all vision accounts contained within the CII database.
11	If the average Vision membership in the current period for a client segment is 1 or less, the report must be suppressed.

Glossary:

Term	Description
Age Range	This refers to the grouping of members into age brackets.
Average (Members)	Average Members is derived by dividing the sum of Member Counts for each month by the number of months in the reporting period.
Average Age	The Average Age is derived by summing all member ages and dividing by the number of members.
Average Members per Contract	Average Members per Contract, is an average number of members in each contract.
Average Members per Family	Average Members per Family is the average family size.
Benchmark	Benchmark refers to a normative value against which plan metrics are compared. Benchmarks in CII include data from all accounts in the Client Information Insights database.

Contract Type	Contract Type describes the coverage tier elected by the subscriber. Examples of the values are Employee, Employee & Spouse, Employee & Child/Children and Family.
Current (Period)	References the current time period on which the report is based.
Members	Members represent all employees and dependents, eligible for coverage under a plan of benefits during the time period represented.
Membership %	Membership % represents the percent of total membership for each Age Bracket. This metric is derived by dividing the Member Count for each Age Bracket by overall Total Average Membership.
Gender	Gender of the claimant (i.e. male, female).
Percent Change	Percent change is the variance from the prior period to the current period expressed as a percentage.
Prior (Period)	References the earlier time period used for comparison to the current period.
Total Contracts	Total Contracts refers to a count of the Subscribers who have elected coverage under one of the coverage tiers.
Total Members	The Total Members is a sum of the Average members by contract type.
Utilization %	Utilization % is the percent of overall Total Members, for each Age Range, that have had 1 or more Vision claims during the period. This metric is derived by dividing the Claimant Count for each Age Range by overall Total Average Members.

VIS-02 - Vision Monthly Member Utilization Detail

CII View Order #:	VIS-02	
Report Name:	Vision – Monthly Member Utilization Detail	
Report Section:	Vision	
Time View:	Paid Dates w/an option for user to select Incurred	
Time Periods Available:	The following options are available: Rolling 12 months – *Default* Rolling 3 months Plan year to date Calendar year to date	
Fully Insured/ASO Account Status:	Available for both Fully Insured and ASO Accounts	
Report Suppression Rules:	If the average Vision membership in the current period for a client segment is 1 or less, the report must be suppressed.	
Cell Level Suppression Rules:	No Cell Level Suppression Rules apply	
Early or Standard Report Production?	Early *(By End of 2nd Week of Month)*	Standard *(By End of 4th Week of Month)* ✓
Hover Description:	Vision member and subscriber counts by month including utilization and paid amounts for exams and materials	
Report Description:	This report displays month by month counts of subscribers, members and claimants as well as provides utilization and cost information for vision exams and materials for the current period.	
Analytic Notes:	This report can be used to identify trends in cost and utilization for vision services and materials. Month by month metrics are displayed to show paid amounts for exams and materials (eyewear and contact lenses). This report also displays the volume and price range for frames which helps to identify the presence of a trend toward higher retail costs for this item.	
Matches Reports:	The Total Members on the VIS02 – Vision Monthly Member Utilization Detail report should match the Total Membership on the VIS01- Vision Membership report under the Membership by Contract Type and the Member count under the Key Indicators section on the VIS03 – Vision Utilization Summary report. The Total Subscribers on the VIS02 – Vision Monthly Member Utilization report should match the Total Contracts (aka Total Subscribers) on the VIS01 Vision Membership report. The Unique Claimants on the VIS02 – Vision Monthly Member Utilization Detail report should match the Unique Claimants on the VIS03 – Vision Utilization Summary report. The total of Exams and the total Exam Paid Amount on the VIS02 – Vision Monthly Member Utilization Detail report should match the Number of Exams and the Paid Amount Exams on the VIS-04 Vision Network Utilization report.	

Report Facts:

1	In the initial release an account must have medical coverage in order to be eligible to receive CII vision reports. In other words, accounts with vision only coverage would not be eligible for CII as an account must meet the active enrolled medical subscriber criteria in order to receive CII.
2	The Subscribers and Member counts are based on enrollment counts as of the end of each month.
3	Note that the Percentage columns are not all calculated similarly. The % Exam Utilization and % Materials Utilization are calculated based on the number of members who utilize their vision benefit plan (i.e., the % of members who file a vision claim for exams or materials). As such, the denominator used in these two calculations is the number of vision members. The % Eyewear Utilization and % Contact Lenses, on the other hand, represent percentages of claimants who have filed a material claim and together should add to 100%. The denominator used in these two calculations is based on the number of vision material claims submitted.
4	If the average Vision membership in the current period for a client segment is 1 or less, the report must be suppressed.
5	Data prior to 5/1/2012 does not include all procedure codes for exams and materials. Claim dollar amounts are not impacted. Utilization percentages may appear lower due to these exclusions.
6	This report is divided into the following sections; Members, Exams, Eyewear, Contact Lenses and Total Material Summary for Eyewear and Lens category.
7	There are no cell level suppression rules for any of the CII vision reports.
8	This report is based on Paid Dates with an option for the user to select Incurred Dates.
9	The Exams, Eyewear, Contact Lenses and Total Materials columns on the report represent counts of Unique Claimants. As such, the Eyewear and Contact Lenses may not add up to the Total Materials column as claimants can get both Eyewear and Contact Lenses. When that occurs, a claimant would be counted under both the Eyewear column and the Contact Lenses column but would only be counted once under Total Materials since the column represents a count of Unique Claimants. Similarly, if you add Exams, Eyewear, Contact Lenses and Total Materials, they may not add up to the Unique Claimants column for the same reason.

Glossary:

Term	Description
Unique Claimants	A unique count of members who have incurred expenses under the plan and have submitted a claim. A member is only counted once.
Contact Lenses	Contact Lenses are small disks that are held in place over the cornea by surface tension and correct vision defects.
Exams (vision)	Vision exam is the cost of the examination of the eyes and vision by a qualified provider such as an optometrist or ophthalmologist.
Eyewear	Eyewear includes glasses (lenses, frames and other charges related to the glasses such as anti-reflective lenses, scratch resistant lenses, etc.).
Materials (Vision)	Materials under Vision coverage include all lenses, add-ons for lenses, frames, contact lenses and the fitting fee for contact lenses.
Subscribers	Represents all subscribers eligible for coverage under a plan of benefits during the time period represented

Members	Members represent all employees and dependents, eligible for coverage under a plan of benefits during the time period represented.
Paid Amount Contacts	The claims paid amount for Contact Lenses.
Paid Amount Exams (Vision)	The claims paid amount for vision plan exams.
Paid Amount Eyewear	The claims paid amount for eyewear (eyeglasses, excluding contact lenses).
Percent Contact Lenses	Percent Contact Lenses is the percentage of vision claims paid for materials that were for contact lenses.
Percent Exam Utilization (Vision)	Percent Exam Utilization is the percentage of average vision plan members with claims for vision exams.
Percent Eyewear Utilization (Vision)	Percent Eyewear is the percentage of vision claims paid for materials that were for eyewear.
Percent Materials Utilization (Vision)	Percent vision materials (glasses, contact lenses and fit for contact lenses) Utilization is the percentage of average vision plan members with claims for vision eyewear (i.e. glasses, contact lenses).
Reporting Period	The reporting period is the month and year in which the vision services and costs were reported.
Total Materials (Vision)	Total material is the grouping of all vision supplies such as frames and lenses.
Total Paid Amount	The amount paid for vision services provided under the vision plan coverage.

VIS-03 - Vision Utilization Summary

CII View Order #:	VIS-03	
Report Name:	Vision – Utilization Summary	
Report Section:	Vision	
Time View:	Paid Dates w/an option for user to select Incurred	
Time Periods Available:	The following options are available: Rolling 12 months – *Default* Rolling 3 months Plan year to date Calendar year to date	
Fully Insured/ASO Account Status:	Available for both Fully Insured and ASO Accounts	
Report Suppression Rules:	If the average Vision membership in the current period for a client segment is 1 or less, the report must be suppressed.	
Cell Level Suppression Rules:	No Cell Level Suppression Rules apply	
Early or Standard Report Production?	Early *(By End of 2nd Week of Month)*	Standard *(By End of 4th Week of Month)* ✓
Hover Description:	Key vision indicators, utilization metrics and lens options/ treatments for current and period periods with comparisons to benchmark	
Report Description:	This report displays key vision utilization indicators for the current and prior periods including member counts, claimant counts and member months. Utilization metrics are displayed as a percent of claimants utilizing these services.	
Analytic Notes:	Use this report to assess the relative utilization of key vision services and materials. The percent of utilization by claimant for each service is also displayed. This report can be used to identify trends in vision services utilization and cost.	
Matches Reports:	The Member counts for current and prior periods on the VIS03 – Vision Utilization Summary report should match the Total Members on the VIS01 – Vision Membership report and the VIS02 – Vision Monthly Member Utilization Detail report. The Unique Claimants on the VIS03 – Vision Utilization Summary report should match the Unique Claimants on the VIS02 – Vision Monthly Member Utilization Detail report.	

Report Facts:

1	The member counts are based on enrollment counts as of the end of each reporting period.
2	The "Unique Claimants" reflects the vision patients who have received exams, eyeglasses, contacts, etc. The data also gives the percentage of vision patients that received different types of lenses such as Single, Bifocal, Progressive, etc. Note that the table showing Percent of Claimants Receiving Services is based on vision claimants who have received these types of services. Patients can be counted in more than one category. They are not mutually exclusive. For example, one patient could be counted multiple times if they received an exam, contacts, etc.
3	The following categories will be reported in the Percent Claimants Receiving Services table *if there is data to report (otherwise they will be suppressed):* Exams

	Materials Contact Lenses Complete Pair Eyeglasses Frame Only Lenses Only Single Vision Lenses Bifocal Lenses Trifocal Lenses Progressive Lenses Other Lenses
4	The following categories will be reported in the Percent Lens Option/Treatment table *if there is data to report (otherwise they will be suppressed):* Scratch Resistance Scratch Resistance - Children Polycarbonate Polycarbonate - Children Anti-Reflective U-V Tinted Photochromic Photochromic - Children High Index
5	The Exams and Materials Utilization graph shows the percentage of claimants with utilization for the current/prior periods as well as the Benchmark in any of the following categories *if there is data to report (otherwise they will be suppressed)*: Exams Materials
6	The Percent Material Type Utilization graph shows the percentage of claimants with utilization for the current/prior periods as well as the Benchmark in any of the following categories *if there is data to report (otherwise they will be suppressed)*: Contact Lenses Complete Pair Eyeglasses Frame Only Lenses Only
7	The Percent Lens Distribution graph shows the percentage of claimants with utilization for the current/prior periods as well as the Benchmark in any of the following categories *if there is data to report (otherwise they will be suppressed)*: Single Vision Lenses Bifocal Lenses Progressive Lenses Other Lenses
8	The Percent Lens Option Treatment graph shows the percentage of claimants with utilization for the current/prior periods as well as the Benchmark in any of the following categories *if there is data to report (otherwise they will be suppressed)*: Scratch Resistance Polycarbonate Photochromic Anti-Reflective U-V

	Tinted High Index
9	The Frame Purchases Distribution by Retail Price table shows the *charges submitted* for frames within each dollar range for the current time period. The dollar ranges are categorized as follows: $0-$100 $101-$130 $131-$160 $161-$190 $191-$220 $221-$250 $251+
10	The Lens Distribution graph and the Lens Option graph will be suppressed from the report if all values are 0%.
11	In the initial release an account must have medical coverage in order to be eligible to receive CII vision reports. In other words, accounts with vision only coverage would not be eligible for CII because an account must meet the active enrolled medical subscriber criteria in order to receive CII.
12	If the average Vision membership in the current period for a client segment is 1 or less, the report must be suppressed.
13	This report includes comparisons to the commercial benchmark. The benchmark is based on all vision accounts contained within the CII database.
14	This report is based on Paid Dates with an option for the user to select Incurred Dates.
15	There are no cell level suppression rules for any of the CII vision reports.

Glossary:

Term	Description
Average Paid Amount per Claimant	The average paid per claimant is the net amount paid divided by total claimants.
Unique Claimants	A unique count of members who have incurred expenses under the plan and have submitted a claim. A member is only counted once.
Current (Period)	References the current time period on which the report is based.
Member Months	Member Months is the sum of the monthly member counts for each month of the reporting period.
Members	Members represent all employees and dependents, eligible for coverage under a plan of benefits during the time period represented.
Percent Claimants receiving services (Vision)	This measure provides the percentage of Vision members who have had paid Vision services, split by service categories such as Exams, Materials (eyeglasses and contact lenses combined), Eyeglasses, Contact Lenses, Frames Only, the different type of Lenses only (single vision, bifocal, etc.).
Prior (Period)	References the earlier time period used for comparison to the current period.

VIS-04 - Vision Network Utilization

CII View Order #:	VIS-04	
Report Name:	Vision – Network Utilization	
Report Section:	Vision	
Time View:	Paid Dates w/an option for user to select Incurred	
Time Periods Available:	The following options are available: Rolling 12 months – *Default* Rolling 3 months Plan year to date Calendar year to date	
Fully Insured/ASO Account Status:	Available for both Fully Insured and ASO Accounts	
Report Suppression Rules:	If the average Vision membership in the current period for a client segment is 1 or less, the report must be suppressed.	
Cell Level Suppression Rules:	No Cell Level Suppression Rules apply	
Early or Standard Report Production?	Early *(By End of 2nd Week of Month)*	Standard *(By End of 4th Week of Month)* ✓
Hover Description:	Vision utilization and savings amounts for In vs. Out of Network providers with exam and material counts and paid amounts provided for the top 5 network retailers and independent providers	
Report Description:	This report displays a summary of In-Network and Out-of-Network utilization and savings amounts for In-Network retail vs. independent providers for the current period. A separate table provides information on vision exams and materials for the top five Network retailers and independent providers along with the percentage of transactions that occurred during the weekend.	
Analytic Notes:	This report can be used to assess potential Network access or utilization issues. It can also be used to show the possible impact of proposed changes to plan provisions involving Networks. It provides insight into the average cost for services and materials for the top 5 individual retailers. This report can be used to identify areas of opportunity for promoting the use of Network retailers.	
Matches Reports:	The 'Total' Number of Exams and 'Total' Paid Amount Exams on the VIS-04 Vision Network Utilization report match the 'Total' Exams and 'Total' Paid Amount Exams on the VIS-02 Vision – Monthly Member Utilization Detail report. The Materials 'Total' row on the VIS-04 report match the Total Materials 'Total' row on the VIS-02 Vision – Monthly Member Utilization Detail report.	

Report Facts:

1	The Top 5 Retailers in the first table on the report are selected based on the sum of the Paid Amount Exams plus the Paid Amount Materials columns. When more than 5 Network Retailers are used during the paid period, a category of Other Retailers will appear.
2	The data is summarized by provider based on a category code such as retailer or independent provider. When there are missing values, the data will fall under 'unassigned'.
3	In the initial release an account must have medical coverage in order to be eligible to receive CII vision reports. In other words, accounts with vision only coverage would not be eligible for CII as an

	account must meet the active enrolled medical subscriber criteria in order to receive CII.
4	If the average Vision membership in the current period for a client segment is 1 or less, the report must be suppressed.
5	There are no cell level suppression rules for any of the CII vision reports.
6	This report is based on Paid Dates with an option for the user to select Incurred Dates.
7	This report includes comparisons to the commercial benchmark. The benchmark is based on all vision accounts contained within the CII database.

Glossary:

Term	Description
Current (Period)	References the current time period on which the report is based.
Materials (Vision)	Materials under Vision coverage include all lenses, add-ons for lenses, frames, contact lenses and the fitting fee for contact lenses.
Network Choice	The data shown in this table is the total paid amount for vision exams and materials.
Network	For Vision plans, Network identifies providers who are participating Network providers (i.e., providers under contract) which include the Top 5 Retailers, Other Retailers and Independent Providers or vision providers who are Out-of-Network.
Number of Exams (Vision)	The count of paid Vision exams.
Paid Amount Exams (Vision)	The total paid amount of Vision exams.
Paid Amount Materials (Vision)	The total paid amount for lenses, frames and contact lenses.
Percent of Weekend Transactions (Vision)	The Percent of Weekend Transaction is the number of transactions occurring on Saturday or Sunday shown as a percentage of the total number of transactions.
Percent Paid Amount of Total Exams (Vision)	The Percent of Paid Amount of Total Exams is the percentage of the paid Vision exams for each provider listed on the report to the total paid amount for all Vision exams.
Percent Paid Amount of Total Materials (Vision)	The Percent of Paid Amount of Total Materials is the percentage of the paid amount for Materials (includes lenses, frames and contact lenses) for each provider listed on the report to the total paid amount for Materials.
Prior (Period)	References the earlier time period used for comparison to the current period.
Benchmark	Benchmark refers to a normative value against which plan metrics are compared. Benchmarks in CII include data from all accounts in the Client Information Insights database.