



NextLogical
Benefit Strategies, LLC

Integrated Health Risk Management

The Next Logical Solution for Managing Healthcare Costs

An Advanced Strategy *for* Self-funded Plan Sponsors

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The Healthcare Cost Challenge

General Overview

In 2003, the average healthcare cost per employee rose to \$6,215¹. That equates to an average increase in employer-sponsored health insurance premiums of 13.9%. Again in 2004, employers and other benefit plan sponsors are facing double-digit increases – with premiums projected to rise another 13%². According to the consulting firm of Towers Perrin, this will mark the fifth straight year of double-digit healthcare cost increases³.

For the past several years, medical trend has been driven by prescription drug trend which, according to Express Scripts, a leading national pharmacy benefit manager, increased at a rate of 18.5% in 2002 and is projected to grow by 15.5% in 2003 and 16.0% in 2004.⁴ Once considered an ancillary benefit, prescription drug benefits typically account for 15-25% of total covered healthcare expenditures.

Further compounding the health cost problem is the failure of traditional managed care initiatives to adequately control costs. According to an April 2001 report on managed benefit plans, IOMA reports, “The impact of managed healthcare on costs appears to be decreasing overall.”⁵

In a poll conducted by Watson Wyatt Worldwide, the Washington Business Group on Health, and the Healthcare Financial Management Association, employers indicated little confidence in managed health care plans, and said they are abandoning large national HMOs and eliminating point-of-service plans.⁶

Challenges Inherent in the Current System

Sixty-seven percent of employers with at least 500 active workers self-insured their PPO plans in 2000.⁷ Still, administrative services only (ASO) and third-party administrator-based plans suffer from lack of data integration and failure to maximize cost management opportunities.

¹ *Business Insurance* v37, no49 pp 1, 23 Dec 8, 2003

² *Employee Benefit News* v18 no1 pp 31-33 Jan 2004

³ *Business Week* no3854 pp 42-43 Oct 20, 2003

⁴ *Express Scripts, Inc. 2002 Drug Trend Report* Jun 2003

⁵ *IOMA's Report on Managing Benefits Plans* no04-01 p 7 Apr 2001

⁶ *Human Resource Executive* v15 no6 pp 76-79 May 1, 2001

⁷ *Business Insurance* v35 no8 pp 3-4 Feb 19, 2001

The lack of integration between health plan sponsors, vendors, members and providers has created isolated “data silos” within specific benefit plan functions. For example, information captured through prescription drug card processing, although timely and rich in content, is rarely integrated on a member-specific level with the disease management or overall utilization management function. Valuable clinical data remains locked inside legacy systems or in the hands of plan vendors unable to effectuate its use.

Traditional eligibility management and claims adjudication systems are ill-suited to address emerging issues of health risk identification and management. Advanced clinical systems with proven predictive capabilities are seldom utilized and virtually never integrated within the medical management program.

These missed opportunities not only impact the quality of life and health for employees and dependents, they lead to excessive losses for the risk-bearing entities of the healthplan, specifically plan sponsors and excess-loss insurance carriers. Ultimately, the increased cost to plan sponsors and members takes the form of unmitigated trend continually driving specific stop-loss premiums and aggregate claims liability higher.

Approximately 75% of all patients in doctor's offices are the "Worried Well". As such, many office visits involve those individuals who have self-limiting illnesses and do not actually require services of the doctor, but may not understand how to access information that could have prevented an otherwise needless visit. Oftentimes this lack of information and understanding results in inappropriate utilization of resources, such as Emergency Room visits for situations which may have been better-addressed through self-care or a doctor's office appointment.

This phenomenon is confirmed by both the American Hospital Association and the American Medical Association which report that approximately 55.4% of the yearly 97.4 million emergency room visits are medically unnecessary⁸, while approximately 25% of the 762 million yearly physician office visits are medically inappropriate as well.⁹

Furthermore, in a major study reported in the New England Journal of Medicine, researchers found that patients receive appropriate care only 54% of the time. The study states, "There is little systematic information about the extent to which standard processes involved in health care - a key element of quality - are delivered in the United States." Further, appropriate medical care varied widely across the United States. Such deficiencies "pose serious threats to the health of the American public".

⁸ American Hospital Association

⁹ American Medical Association

Study results:

- 54.9% - The proportion of recommended preventive care provided
- 53.5% - The proportion of recommended acute care provided
- 56.1% - The proportion of recommended care provided for chronic conditions
- Range of 52.2% to 58.5% - Adherence to the medical processes involved in follow-up care
- 65% of patients with high blood pressure received recommended care
- Only 45% of heart attack patients received beta-blockers, which have been proven to reduce the risk of dying by 23%.
- Only 33% of patients had been screened for colorectal cancer; routine screening and follow-up care could prevent about 9,600 deaths a year.¹⁰

Approaches to Controlling Rising Healthcare Costs

Employer reactions to cost increases vary widely; however, the most common response has been to shift an increasing burden of cost to employees and their covered dependents. In 2001, according to an IOMA report on managed benefit plans, “Over 51 percent of employers cited increased employee cost sharing as the most successful way to control benefit costs. Among employers with more than 500 workers, almost 60 percent increased employee cost sharing.”¹¹

Self-funded employers have implemented more flexible options in the light of frustrations arising from the rapid increase in health care costs. About 70 percent of employers polled by Watson Wyatt Worldwide, the Washington Business Group on Health, and the Healthcare Financial Management Association plan to raise employee premiums, while half will increase copayment percentages. About 14 percent of the firms will reduce or eliminate coverage for some health services as a result of rising costs.¹²

This strategy of cost-shifting to employees has little changed in the last few years. A Business Week article, entitled “Get Used to the Pain”, noted that, in order to contain costs, many employers are considering increasing the percentage of healthcare premiums that employees are expected pay. Additionally, copayments and deductibles have steadily increased, with the average deductible for workers using In-network services in preferred provider organization plans rising 57% between 2000 and 2003. In fact, many small businesses are reaching a point where they may have to completely eliminate their healthcare plans¹³.

¹⁰ *New England Journal of Medicine* 348;26 Jun 26, 2003

¹¹ *IOMA's Report on Managing Benefits Plans* no05-01 pp 4-6, 1 May 2001

¹² *Human Resource Executive* v15 no6 pp 76-79 May 1, 2001

¹³ *Business Week* no 3854 pp 42-43 Oct 20, 2003

Cost-shifting occurs in primarily two ways: Increased employee contributions and decreased benefit plan coverage, both of which represent a short-term strategy of redistributing cost rather than eliminating it altogether. Increased employee contributions can diminish participation levels and threaten the financial integrity of the plan. Ironically, increased healthcare cost burdens in the form of benefit reductions, designed to save the plan money, can create a disincentive for members to seek the care they need, thereby increasing long-term health risks and costs.

The downstream effects of illness in the workforce and increased caregiver responsibilities on the part of employees, in terms of disability costs, increased sick days, lost productivity, etc., are just beginning to be quantified; however, the consensus among industry experts is that these costs far outpace actual healthcare costs. Clearly, making healthcare benefits unaffordable or reducing coverage does not represent a viable long-term strategy.

Since the early 2000s, consumer-driven health plans (CDHP) have been quickly gaining in popularity; however, health benefits experts are skeptical about the ability of these plans to deliver real cost savings to plan members who need the most care and, subsequently, to plan sponsors. Health Affairs magazine notes, “Because of the CDHP design, it is expected that only healthy individuals will participate in these plans.” The article goes on to summarize the results of a recent study: “An analysis of demographic data and a simulation comparing out-of-pocket health expenses between a traditional comprehensive benefit plan and a first generation CDHP revealed that the moderately sick lost the most money under a CDHP. The healthy group in this study saved an average of \$584 with a consumer-directed plan. The slightly sick lost an average of \$250 while the moderately lost an average of \$581. The very sick gained an average of \$300”¹⁴. The goal of most employer-sponsored health plans is to provide care to sick members – those who need the most help – and not to benefit the healthy. Clearly, consumer-driven plans have the potential of delivering greater benefits to healthy plan members and thereby increasing overall costs to the plan sponsor.

An article in Employee Benefit News overviewed a more effective approach: “Employers face both rising health care costs and a need to provide attractive and affordable benefits to recruit and retain good workers. They might be tempted to reduce benefits or pass on more costs to employees, but experts say these are not the only options. Four innovative ways are available to employers to help them maximize the return from health care benefit investments. These involve the use of care counselors, appropriate prescription drug plan design, caregiver support and data mining.”¹⁵

¹⁴ *Health Affairs* v23 no1 pp 186-193 Jan-Feb 2004

¹⁵ *Employee Benefit News* v15 no8 pp 17-18, 28 Jun 15, 2001

Health benefits consultants agree, “Employers can realize a return on investment by focusing on those chronic conditions that result in inordinate expense for a relatively small number of cases and developing strategies to effectively manage these conditions”¹⁶

A combination of short- and long-term strategies is most effective for cost management, with a focus on controllable healthcare costs. Elements that can effectively control rising medical costs are patient care management, disease management for employees with chronic conditions and health status improvement support to encourage reduction in lifestyle risk. Addressing diabetes, heart disease and other chronic conditions, as well as, obesity which often leads to serious long-term health impairment, can help stave off medical costs in the long run¹⁷.

The ideal approach to managing healthcare costs involves prospectively identifying at-risk healthplan members and empowering them with reliable information and clinical support to ensure that they receive the right care, from the right provider, in the right setting and at the right time. The right approach leverages hands-on clinical support with advanced information technology.

Once popularized as “population-based health risk management”, this concept has evolved, in part due to advances in data mining techniques and artificial intelligence algorithms, to address the present and future healthcare needs of specific plan members. Once identified, members can be presented with opportunities to better manage their disease states, thereby improving member satisfaction, quality of health and quality of life, as well as, lowering overall healthplan expenditures.

¹⁶ Towers Perrin Do's And Don'ts for Short-term Health Care Cost Management, *Business Wire*, April 29, 2002

¹⁷ *Employee Benefits Journal* v28 no4 pp 71-77 Dec 2003

The NextLogical Health Risk Management Solution

Current information systems technology has enabled the development and implementation of a fully integrated, advanced, health risk identification and management program which is, at the same time, proactive, compassionate and empowering to plan members and which delivers significant cost savings to the plan sponsor.

The goal for all healthcare systems is to improve the health status of populations. One problem in providing healthcare to any population is the lack of coordination among all of the providers of healthcare. For example, in the vast majority of healthcare systems in the United States, it is uncommon for a patient's primary Physician to be advised of every medication currently being prescribed to the patient and the patient's compliance with dosing and refills.

A recent Harvard-led study found that one-fourth of patients with health problems say they have suffered from a medical mistake or prescription error in the past two years. According to Robert Blendon, the Harvard professor who led the study, "The biggest risk is when you're seeing multiple doctors who are doing lots of tests and prescribing a lot of drugs. It's lack of coordination. If you're taking Coumadin [a blood thinner] given by one doctor, then maybe you shouldn't be taking another drug given by another doctor."

The study also found that those patients who went to more than two doctors complained of errors almost twice as much as those who went to just one or two physicians. Blendon said the survey showed a crying need for Care Managers, too, for those who see more than two doctors a year. Care Managers not only could help reduce errors but also could help cut costs. "This is only 10 percent of patients," he said, "but they're an expensive 10 percent."¹⁸

The integrated Health Risk Management approach works to reduce these deficits in care by leveraging patient-specific clinical information flowing through the benefits plan in order to ensure that treating physicians have all of the information available regarding their patients (i.e. complete listing of all drugs being used, patient rate of compliance with existing drug therapies, etc.) and then enhancing communications between patients, care givers, providers and care managers.

¹⁸ Study Finds Healthcare Error Prone, John Dorschner, *Miami Herald*, May 6, 2003

In order to maximize quality of care and reduce plan expenses, the integrated HRM program addresses two fundamental facts. First, patients require support upon entering the healthcare system and, secondly, the health plan has a unique opportunity to provide Physicians with both information and care manager support to enhance their interactions with patients. For this reason, support systems have been put into place to enhance physicians' and patients' abilities to achieve the appropriate care in the most appropriate setting. A knowledgeable patient supported by a physician and an expert care staff can achieve high quality care at a lower cost.

The Health Risk Management program integrates patients, plan sponsors, physicians, and non-physician providers into a value-added, non-confrontational relationship. At its most basic level, HRM endeavors to bring patients to the right level of care the first time. This effort is supported by an ongoing monitoring of healthcare services (inpatient, outpatient, ambulatory, diagnostic and pharmacy), with emphasis on the appropriateness of care related to diagnosis, timeliness of services, medical necessity, cost-effectiveness, setting and quality of care.

HRM is most effective if it is done prospectively. Retrospective analysis can be used to assess the effectiveness of an HRM program. Concurrent Review, Disease Management and Case Management allow for better prospective decisions and have the greatest impact on improving quality and lowering cost.

The building blocks of healthcare are the decisions by patients and physicians about plans for care. From these care plans, multiple events occur, each of which incurs a cost. The sum of the cost of these units, not just the specific cost per unit, has the greatest impact on the overall cost and outcome of patient care. NextLogical believes that patients and physicians must be partners in healthcare decisions – only with their active and knowledgeable input can utilization of health resources be adequately controlled. The emphasis is on identifying ahead of time all variables that may have an impact on the patient's medical care, in order to anticipate needs and problems.

Health Risk Management Functions

In its most advanced form, the integrated HRM approach features:

- A fully integrated system structured around the Health Risk Management (HRM) hub.
- Defined health information channels between plan vendors.
- Clinical triggers built into medical and pharmaceutical claims streams for utilization management intervention.
- Clinical expertise and analytical tools to filter and enhance raw data.

Integrated Health Risk Management

- Proactive data-screening tools to identify members for specific disease management programs and/or case management.
- Member access to clinical support from concerned Registered Nurse Care Managers.
- Improved communications between plan vendors, patients, caregivers and providers.
- Proprietary benefit plans designed to incentivize and reward positive consumer behavior, as well as, to optimize plan performance.
- Ongoing monitoring of claims and utilization with real-time reports to the plan sponsor and stop-loss carrier via internet access.
- Aggressively negotiated vendor agreements including preferred fee arrangements and contractual provisions.
- Preferred renewal terms defined at initial case implementation.

The core components of the integrated solution are:

- Medical Management:
 - Preadmission Certification/Concurrent Review/ Discharge Planning
 - Demand Management – Health Advocacy
 - Disease Management
 - Case Management
 - Specialty Programs – i.e. Maternity
- Third-party Administration:
 - Claims Processing
 - Eligibility and Billing Management
- Clinical Data Analysis and Reporting
- Patient Risk Identification, Stratification and Coordination with Medical Management
- Pharmacy Benefit Management
- Provider Network Management (PPO)
- Stop-loss Insurance

The integrated HRM program is structured to efficiently channel data from medical claims administration, the pharmacy benefit manager (PBM), the preferred provider network, and other plan vendors into the medical management function to initiate disease or case management or complete the clinical puzzle for the Care Manager.

NextLogical Benefit Strategies, LLC

NextLogical Benefit Strategies is dedicated to helping companies provide the highest quality healthcare at the lowest possible cost by employing advanced health risk identification and management tools through an integrated administrative solution which is proactive, compassionate and empowering to the member.

Healthcare delivery and financing is a complex, dynamic and interactive system. NextLogical's expert advice, progressive technology and caring approach, results in enhanced benefits and dramatic cost reductions. At NextLogical, we focus on controlling the 85% of the average health plan—claims—through integrated data analysis driving proactive disease management.

Aaron C. Davis, President

Aaron is primarily responsible for understanding the employee benefits needs of NextLogical's clients and crafting advanced health risk management and administrative solutions for implementation. He is actively involved in customer service, development of product specifications, selection of administrative partners, plan design and integration.

Prior to forming NextLogical, Aaron was the founding partner and Director of Self-funding Sales for Mather Benefit Administrators (dba The Mather Companies) where, in just three years, he grew the client base to more than 55,000 members in 48 states.

Aaron was also a founding partner and Executive Vice President of Integrated Healthcare Resources Group (IHRG) in Baltimore, Maryland which was capitalized by Phoenix/Home Life. IHRG specialized in the design and implementation of administrative solutions for large self-funded employers.

Prior to forming IHRG, Aaron served as a Senior Consultant for FirstHealth, the nation's largest Third-Party Administrator (TPA), and held senior-level employee benefits consulting and sales positions with a regional TPA (Group Benefit Services) and with CIGNA Corporation.

Aaron began his career in health information systems as the Assistant Director of Operations and Management Information Systems (MIS) Manager for Heritage Health Systems, a national health maintenance organization (HMO). His unique insight into administrative systems, managed care operations and health information technologies is a valuable resource for NextLogical and its clients.

Since 1985, Aaron has been involved in virtually all aspects of employee benefits administration and consulting and is recognized as an expert in self-funding plan design, administration, health risk management and decision support systems.

Aaron is a graduate of Western Maryland College in Westminster, Maryland with a Bachelor of Arts (BA) degree in Political Science/Pre-law and Business Administration. He holds Life/Health and Property/Casualty licenses in several states. Aaron enjoys spending time with his wife and four boys, reading, serving in his church, coaching his sons' soccer teams and playing indoor soccer.

Danielle L. Koziol, RN, CCM – Vice President, Medical Management

Danielle has over 18 years of Nursing Experience and nearly 14 years experience in the healthcare insurance industry. She is a licensed Registered Nurse in the State of Maryland and a Certified Case Manager with the Commission of Case Management. Prior to joining NextLogical, Danielle served as the Vice President of Medical Management for Fidelity Insurance Group (a subsidiary of United Healthcare) and for the Group's predecessor organization, Fidelity Insurance Company/Health Care 2000, for 13 years. In addition to her Medical Management responsibilities, under Danielle's direction, Fidelity Insurance Group's PPO provider network, PMG, grew from 9,000 providers to nearly 50,000. Danielle was also instrumental in designing, implementing and managing the exclusive Disease Management program currently being used by the City of Baltimore's 7,000 employees.

Danielle has particular expertise in all facets of Health Risk Management including Utilization Review, Demand Management, Clinical Data Analysis, Disease Management, Case Management, Predictive Modeling, Management Reporting and Employee Communications. Accordingly, Danielle is responsible for developing, implementing and managing advanced Health Risk Management solutions for NextLogical's clients.

Recognizing that the healthcare and medical environment is rapidly changing and there are tremendous pressures to control costs, NextLogical develops customized programs for employer clients to ensure the most clinically and cost-appropriate medical care while addressing individualized patient needs.

Previously, after extensive work in the hospital arena, Danielle worked for a large national home healthcare and temporary staffing company as Director of Nursing. In this position, she supervised over 300 health care providers and obtained contracts with various insurance companies to provide services to their members.

Lucille G. Listorti, Senior Account Manager

As Senior Account Manager, Lucille is primarily responsible for the implementation and overall management of all NextLogical clients. Lucille also serves as an excellent resource for clients on all aspects of benefit plan design, employee cost-sharing and legislative compliance. Lucille has served hundreds of employers with as few as 50 employees to as many as 20,000. For clients such as Adelphia Communications, Lucille is viewed as a valuable extension of their HR Department.

Lucille has been involved in all aspects of employee benefits, communications, implementation, administration, ongoing service and renewal support for more than 20 years. Lucille has held senior management positions with Mather Benefit Administrators and Integrated Healthcare Resources Group (IHRG). She also served as Senior Account Representative for FirstHealth, the nation's largest third-party administrator (TPA), where she was responsible for the account management and retention of \$7 million in revenue from key clients for the MidAtlantic region. Lucille also provided training, new product development and support for the high-level service team.

Lucille was also a claims manager for a local TPA where she was responsible for the training and development of services, products and procedures for the company. Her extensive background in claims auditing, adjudication, plan design, funding alternatives and data analysis has proven to be a valuable resource for assisting clients in the evaluation of key components of their benefit plan, such as plan design, cost containment and financial risk management.

Lucille holds licenses for insurance coverages in several states and has particular expertise in alternately financed health and welfare programs; plan design, funding and analysis of self-insured healthcare programs; employee communications; benefits plan implementation; legislative compliance; stop-loss negotiations and coordination; healthcare claims systems and operations; billing and eligibility administration; problem resolution; client relations; data analysis and management reporting; and plan renewal.

Lucille has continued her studies at the University of Maryland Baltimore County in Business Management. She is also a candidate in the Certified Employee Benefits Specialist (CEBS) program sponsored by Wharton School.

Richard Sien, Senior Consultant

As Senior Consultant, Richard is primarily responsible for analyzing the benefits needs of NextLogical clients and then structuring workable solutions. He is actively involved in customer service, product specifications, plan design, implementation and renewal.

Richard has extensive knowledge in the employee health benefits environment. He has worked with large and mid-sized employers in both human resource and employee benefits capacities. As the Director of Benefits for an 80,000 employee health care company, Richard was responsible for a benefit plan that had members in 48 states. In this capacity, he was exposed to a wide array of complex benefits situations and was able to gain vast knowledge of the industry. Dealing with a combination of union and non-union employees, Richard learned the complexities associated with managing benefits plans for organized labor groups. Working with over 400 locations, Richard managed one national self-funded medical plan along with nearly 40 fully insured small market Health Maintenance Organizations (HMOs).

In addition to working with large employers, Richard has worked as a benefits manager for a mid-size non-profit organization with over 400 employees. This experience offered Richard the opportunity to work in a more intimate environment. In this position, Richard successfully implemented the first version of our Employee Benefit Information System (EBIS) – FocalBenefits.

In both the large and mid-size employer environments, Richard has demonstrated his ability to affect quality improvements to benefit plans. He has consistently been able to streamline the complex benefit enrollment process to enable his employers to maintain a competitive advantage. Over the years, Richard has gained a large number of high quality contacts in the industry that afford him the opportunity to deliver to NextLogical's clients a vast library of information and solutions.

Richard is a graduate of the University of Maryland – College Park with a Bachelor of Science (BS) degree in Finance. He holds Life and Health licenses in several states. Richard enjoys spending time with his family, supporting the Maryland Terrapins and is an Emergency Medical Technician (EMT)/firefighter currently serving as Chairman of the Laurel Volunteer Rescue Squad.

Barry V. Bowen, PhD, Consultant / Facilitator

Barry is primarily responsible for identifying large employers for whom NextLogical's suite of health risk management products and services are particularly useful. Barry is adept at introducing large benefit plan sponsors such as AholdUSA (Giant Food), USAirways, Laborers' Health and Safety Fund of North America, etc. to advanced health risk management strategies.

Barry was a Professor of Political Science at the University of Baltimore for 26 years, six of which he served as Dean of the College of Liberal Arts. He is a graduate of the United States Naval Academy and is a former Naval Aviator. Barry's PhD dissertation was in the field of Government Science and Technology Policy.

For the last ten years, Barry has been active in the securities and insurance industry as a consultant/facilitator.

Lilli B. DuVal, Senior Consultant

Lilli has been a contracted consultant with NextLogical since 2003. She is also a founding Partner and serves as President and CEO of Illumination Medical, Inc. Illumination Medical is a unique, specialty consulting organization which identifies high-risk medical populations. Additionally, Illumination oversees contracted service providers on behalf of our clients, such as medical case management services, disease management services and pharmacy benefit managers, who have been contracted to manage risk. Illumination employs clinical professionals who measure and monitor outcomes of implemented medical and disease management services.

Lilli has served in executive-level positions within the healthcare and pharmacy benefit management industries since 1982. She is a legislative member of the California Small Business Association and has lectured extensively on high-risk population management utilizing data and clinical professional oversight.

Formerly, Lilli served as the Vice President of Strategic Market Development And Vice President of Sales for PCN, a national pharmacy benefit management and healthcare information management company providing services to Medicaid Managed Care Plans, Self-funded Employer Groups, Health & Welfare Trust Funds, Third Party Administrators, HMO's and other Managed Care Organizations. MedIntelligence, the clinical offering from PCN, provides healthcare information management services to the health care industry, and focuses on improving outcomes – both clinical and financial.

Lilli was also a founding executive and Vice President of Operations for ValueRx/RxNet, a PBM now owned by Express Scripts.

As a former Health and Life Insurance Broker with seven years of experience, Lilli understands the dynamics of health care delivery, financing and risk management.

Lilli attended California State University, Fresno where she earned a B.A. in Psychology in 1974. Born in Hillsboro, Illinois, she has been a resident of California since 1957. Lilli is married with two children, a family dog, and a wonderful husband of eight years. She is a believer in God, Family, and Country; is an avid traveler; and enjoys golfing, walking, gardening and reading.

David J. Gibson, MD, Consultant

Dr. Gibson has been a contracted consultant with NextLogical since 2003. He is Rheumatologist who resides in Carmichael, California. In addition to

having practiced medicine for over 20 years, Dr. Gibson has held academic appointments in Internal Medicine, Rheumatology and Immunology at five separate Medical Schools. He serves on multiple committees for the California Medical Association. He has been the president of four different health insurance companies and has served as the CEO for one of the largest medical groups in the United States.

Dr. Gibson co-founded Illumination Medical, Inc. in 2003 and serves as Chief Operating Officer. Illumination Medical is a unique, specialty consulting organization with virtually no competitors. Illumination Medical's core competency centers upon evolving problems faced by all health plans. Actuarial support, administrator and PBM auditing, and traditional claims-based benefit design activities are all still important but no longer fully meet the evolving needs of health plans in today's market. It is now incumbent upon health plan administrators to manage proactively using current data rather than reactively using past experience.

Dr. Gibson has written and lectured extensively on the economic issues confronting health care. He regularly contributes editorials to the Sierra Sacramento Valley Medical Society and lectures at both California State University Sacramento and at the University of California, Davis School of Medicine.

Dr. Gibson is also the Chief Executive Officer of The Fraud Prevention Bureau (FPI), a California-based non-profit organization. FPI is a business league whose purpose is to promote the common business interests of health care providers by preventing, detecting and eradicating fraud in the healthcare industry. To accomplish this mission, FPI conducts active programs of research, education, consulting, and network management. All of these activities are aimed at elevating ethical standards of health care providers and eliminating fraud in the industry.

FPI comes out of the joint task force consisting of the Federal Bureau of Investigation and the MediCal Fraud Prevention Bureau. This task force has investigated more than 500 Medi-Cal providers over the last few years. These investigations produced a 100% conviction rate. The task force charged 314 individuals with \$200,000,000 fraud. To this date, 195 have been convicted with \$72,000,000 restitution recovered. The senior agents, both state and FBI, have joined FPI on a full-time basis and make up the operational core of the organization.

Dr. Gibson also serves as the Medical Director for Pharmaceutical Care Network (PCN). Based in Sacramento, California, PCN is a full service pharmacy benefit management and healthcare information management company providing services to Medicaid Managed Care Plans, self-funded employer groups, Health & Welfare Trust Funds, Third Party Administrators,

HMOs and other Managed Care Organizations. MedIntelligence, the clinical offering from PCN, provides healthcare information management services to the health care industry, and focuses on improving outcomes - both clinical and financial. Dr. Gibson serves as the Chairman of the Pharmacy and Therapeutics (P&T) Committee for PCN and has responsibility for developing the company's formulary. He also serves as the Chairman of the Quality Assurance activities for PCN, functioning as a delegated manager for a number of NCQA-qualified MCOs.

Formerly, Dr. Gibson has held numerous executive-level positions in the healthcare field, including: President of The Pacific Development Group; Chief Executive Officer of RxPhysician.com; Chief Medical Officer – American Research and Development for CASIO Manufacturing Corporation; Chief Medical Consultant for Longs Drug Stores and RxAmerica; Vice President, Medical Affairs & Chief Medical Officer for Omni Health Care; Founder and President of Medical Technology Transfer Corporation; Chief Executive Officer of UCLA Medical Group Practice; Vice President for Medical Affairs & CMO in Florida for Metropolitan Life Insurance Company (MetLife); President and Chief Executive Officer of Avanti Health Systems; and Partner in Santa Barbara Medical Foundation Clinic

Dr. Gibson practiced clinical Rheumatology within the Department of Medicine with academic appointments at both UCLA and the University of Southern California (USC). He also served as President of the Santa Barbara Society of Internal Medicine.

Dr. Gibson received his B.A., Liberal Arts in 1967 from Asbury College; M.D., 1971 from University of Kentucky; Internship and Residency in Internal Medicine, 1973 from University of Indiana; and Research Fellow – Rheumatology, 1975 from Harvard University.

Dr. Gibson's academic appointments include: Harvard University; National Institutes of Health Research Fellow; Clinical Proctor, Internal Medicine; Louisiana State University School of Medicine (LSU), Clinical Associate Professor of Medicine – Rheumatology; University of California Los Angeles School of Medicine, Clinical Associate Professor of Medicine – Rheumatology; University of Southern California School of Medicine, Clinical Associate Professor of Medicine – Rheumatology; and University of Texas Medical School, Houston, Clinical Associate Professor of Medicine – Rheumatology.

Dr. Gibson is an experienced clinician with a strong academic background, broad range of senior management experience and a record of success in leading both start-up and established companies and projects. He is the associate editor of SSVMedicine, the official publication of the Sierra

Sacramento Valley Medical Society (SSVMS) and is a member of the Medical Practices Committee for the California Medical Association (CMA).

Clients We Have Served

AAI Corporation, Acterna (TTC), Adelphia Communications Corporation, Advance Business Systems, AholdUSA (Giant Food), AIMCO, AllEnergy, Allied-Signal, American Radiology Services, Anadac Corporation, Anderson Automotive Group, Apex Environmental, Automated Sciences Group, Automation Research Systems, Baltimore County Government, Baltimore County Public Schools, Becton Dickinson, Bethlehem Steel, CACI, Cambridge International, Carey International, Cargill, Carroll County Public Schools, Chili's/Chesapeake Bay Seafood House, Congressional Country Club, E&G Classics, Eastern Savings Bank, Embassy Dairy, Esskay Meats, EU Services, Fiber Products, Fox Chevrolet, Frederick Computers Plus, Griffith Consumers Company, Harbor Hospital Center, Harford County Board of Education, Harford County Government, Healthy Housing, Hospitality Partners, HR Tech, Information Integration, Jorge Scientific Corporation, Maryland Association of Non-Public Special Education Facilities, Maryland Association of Realtors, Maryland Motor Truck Association, Maryland Primary Care Physicians, Maryland School for the Blind, Maryland Wire Belts, May Company/Hecht's, Metropolitan Hotels, Montgomery Ward, Morton Thiokol, Murray Guard, Niro Atomizer, North Arundel Hospital, Northwest Hospital Center, Payless Shoes, Pepsi-Cola East, Precision Auto Care, Primo Electric, Printing & Imaging Industries of Maryland, PSI Associates, Pyramid Environmental, R&H Motor Cars/Russel Motor Cars, RK&K, Sandy Spring National Bank, Sequel Youth Services, Shelter Properties, Shore Stop/Carl King, Stone & Webster Corporation, Strine Printing Company, Symphony Health Services, SYSCOM, System Automation Corporation, Tate Access Floors, Tate Engineering, Textilease Corporation, The Bozzuto Group, The Enterprise Group, The Martin Pollak Project, The Peterson Companies, United Mine Workers, United Press International, USTrust, W.R. Grace, WBAL