



State of Wisconsin
Health Care Utilization Summary

May 2009

Prepared by:



2008 STATE OF WISCONSIN UTILIZATION REPORT
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State of Wisconsin

Section 1: State Employee Trust Funds

Insuring **Wisconsin's** Health *Since 1946*

State Employee Trust Funds

Executive Summary

Member / Demographic Data

Total enrollment was 13,461 as of January 2009, down from 13,957 members in January 2008. This reduction in enrollment is due to a 16% decrease in the enrollment in the standard plan (3,885 down to 3,272) and the gradual decrease in enrollment in the Medicare Plus \$1M Plan (9,835 down to 9,649). Although we saw an overall decrease, the SMP population did increase from 148 members in January 2008 to 540 members in January 2009 due to the expansion on the service area and provider network.

The **Standard Plan** membership is much older than the normative distribution with 41.5% of membership over the age of 55 compared to the benchmark of 16.7%. 71.7% of the Standard Plan participants live within Wisconsin. Much of the Standard Plan population is located near larger metropolitan areas in Wisconsin with 25.5% of the population living in Dane County and 14.2% living in Milwaukee County.

The ages of the **SMP Plan** members are also older than the normative population with 54.5% of membership over the age of 45 compared to the benchmark of 35.2%. The SMP Plan membership is almost entirely within Wisconsin, with a majority of the population living in Florence, Bayfield and Burnett Counties. Only 3.4% of the population lives outside of Wisconsin. In 2009, the SMP Plan will no longer be offered in Burnett County however it will be available in Crawford and Pierce Counties along with an expansion of the network providers available in Minnesota and Michigan. This change has resulted in an increase in the population from 147 members in December 2008 to 540 members in January 2009.

State Employee Trust Funds

Executive Summary

Claims Data

Summary

In 2008, the Standard Plan was 157.8% higher in overall PMPM claims costs than the SMP Plan. The largest contributor to this difference is the anti-selection that the Standard Plan is subject to versus the other options available to the membership. Members who utilize healthcare services are generally willing to make a larger premium contribution and incur modest cost sharing provisions within the benefit plan in exchange for the broader panel of providers. A second factor is the difference in demographics between the two plans. The Standard Plan tends to attract an older population as the plan is the only out of state offering and the plan has a larger provider panel which is preferred by aging individuals who tend to seek more medical care. In 2008, the difference in the demographics would project the Standard Plan to cost 17.0% more than the SMP plan. Third, the Standard Plan's enrollment is generally in more expensive urban areas such as Milwaukee and Dane Counties. Lastly, the small size of the SMP Plan (148 lives as of January 2008) compared to the larger Standard Plan (3,885 as of January 2008) adds to the variability of the results.

Standard Plan

The Standard Plan has seen a 9.5% increase in overall claim costs between 2007 and 2008, in line with independent trend estimates

The Standard Plan's costs were 48.1% above the benchmark in 2008, which is similar to the 2007 percentage of 47.9%. The variance to the benchmark is primarily a result of the anti-selection resulting from the Dual Choice Enrollment. Other contributing factors include the location of the Standard Plan's enrolled membership (the higher cost urban areas) and the rich benefit design (relative to the benchmark).

A review of claims by Major Diagnostic Category helps explain some of the benchmark variance as well. Higher than expected costs associated with gastric bypass procedures (\$8.35 PMPM), combined with an above average outpatient psychiatric benefit and overall higher than expected large claim activity all contributed to the actual claim results being higher than the benchmark.

The Standard Plan has 51 members with claims over \$100,000 for a total of \$10,621,101 in claim costs, compared to 36 members in 2008. These 51 members represent 27.6% of total claims paid under the Standard Plan. The expected percent of claims over \$100,000 for a

group of this size is 7.0%, while the actual is 14.4%. The Standard Plan members pay 2.6% of their own medical claims as compared to the benchmark of 6.7%.

WPS paid 63.6% of submitted charges on behalf of the plan.

SMP Plan

For the SMP Plan, the year over year medical PMPM trend was -20.1%, influenced substantially by the change in membership and volatility related to the small population. The SMP Plan was 32.8% below the benchmark for 2008. The Prescription Drug category is higher than benchmark, but considering the small size, there is a lack of credibility in the results.

A review of claims by Major Diagnostic Category shows a few categories with significant deviations from the benchmark. Due to the small size of the population, individual health conditions of each member can affect each category and is provided for informational purposes only.

The SMP Plan did not have any members who exceeded \$100,000 in 2008. The SMP Plan members pay almost nothing towards their own medical claims (in the form of cost sharing), unlike the members of most large groups who pay an average of about 7-8% of their medical claims.

WPS paid 72.2% of submitted charges on behalf of the plan.

Medicare

The Medicare Plus \$1M Plan has seen stable results over the last 2 years. The year over year medical PMPM trend from 2007 to 2008 was 3.7%.

WPS paid 6.3% of submitted charges on behalf of the plan. 77.0% of the charges were paid by Medicare.

State Employee Trust Funds

Executive Summary

Provider Data

For the **Standard Plan**, the top 20 facilities provide 58.2% of the total facility charges for the plan. By far, the largest percent of claims (14.7%) and number of patients (595) came from the University of Wisconsin hospital. 44.7% of professional charges are from the top 20 providers. The University of Wisconsin Medical Foundation is the leading professional provider with 11.4% of claims and 792 patients. Over half the top providers for facility and professional are from Dane and Milwaukee Counties where a majority of the population resides, however we did see an increase use of out of state providers in 2008.

For the **SMP Plan**, the top 15 facilities provide 100.0% of the total facility charges for the plan. The largest percentage of paid claims is from Dickinson County Memorial Hospital (35.3%) in Iron Mountain, MI. 80.0% of the professional charges are from the top 20 professional providers. The SMDC Medical Center in Duluth, MN is the leading professional provider (28.7%). Most charges are from regional facilities due to the HMO-type coverage and the limited service area.

State Employee Trust Funds

Executive Summary

Benchmarks

The benchmarks used in this report are derived from the experience of WPS large group and self funded business. In general, these groups are a combination of private and public employers, ranging in size from 51 employees to 5,000. All groups have their primary location and the majority of their population in Wisconsin. Only groups with a full year of experience with WPS were included to avoid any biases resulting from seasonality.

Demographic benchmarks are based on calendar year 2008 data. For Medicare classes, demographic benchmarks are based on comparable WPS Medicare enrollment as appropriate.

Claim cost benchmarks are also based on calendar year 2008 data. To make the claim benchmarks more meaningful, they have been adjusted for demographic differences between the specific population profiled in each report and the population in the WPS benchmark. For example, an older population may be expected to have higher prescription drug costs but lower maternity costs. Unless otherwise specified, each claim based benchmark has had such an adjustment made, including not only PMPM costs but days/1,000 and cost/day. The factors that go into each adjustment are unique to the particular claim-based statistic. Claim benchmarks are not adjusted, however, for plan benefit differences between the average represented in the WPS benchmark and the specific reported ETF class.

State Employee Trust Funds

Group Demographics

Monthly Membership

The Monthly Cost and Membership report (Exhibit 1-A) shows monthly membership for the Standard, SMP and Medicare Plus \$1M Plans from January 2007 through January 2009.

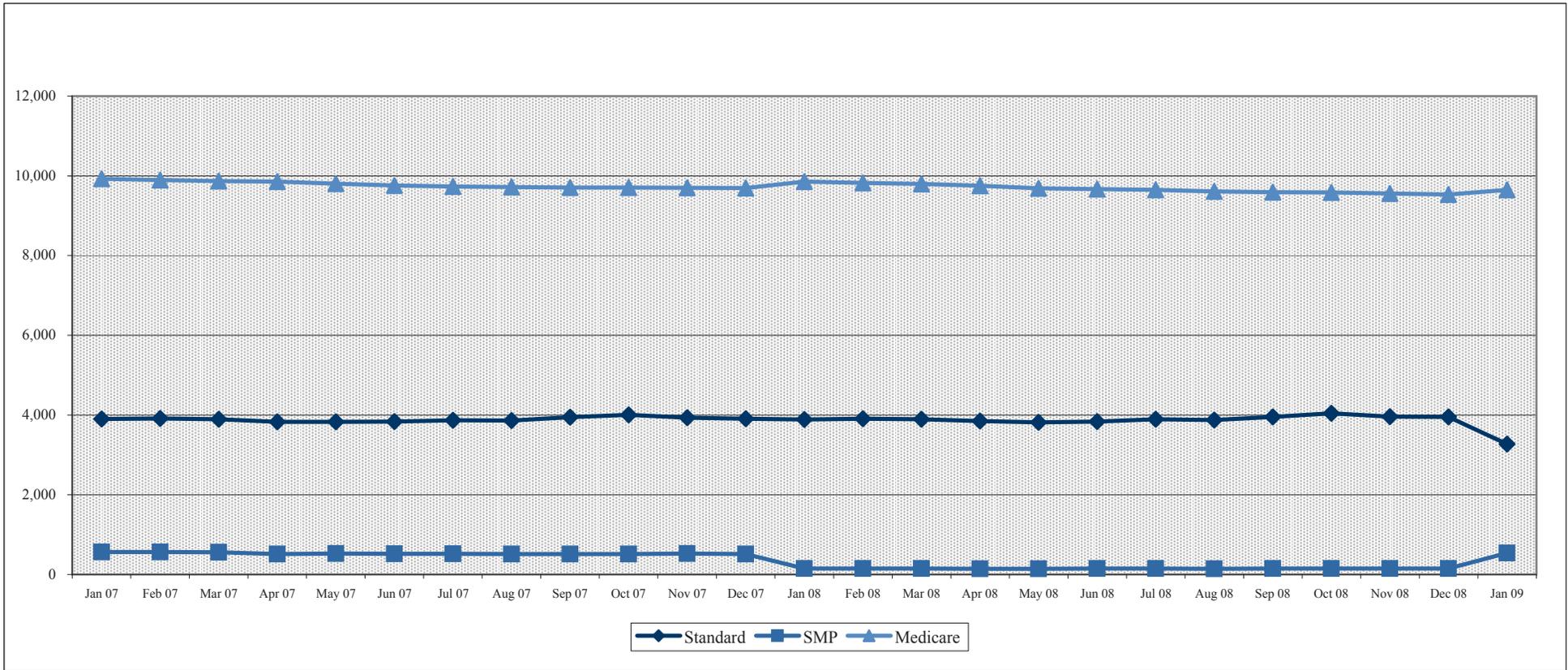
Enrollment in the **Standard Plan** remained level between 2007 and 2008 with an average of 3,906 members per month in 2008 compared to 3,893 members per month in 2007. Monthly membership within each year stayed relatively stable with increases seen in September and October of each year. In January 2009, the enrollment decreased 16% to 3,272 members from the 2008 average enrollment. The enrollment decrease is partly due to the expansion of the out of state provider network in Minnesota and Michigan within the SMP Plan. The Standard Plan's enrollment in Minnesota decreased by 263 members in January 2009 at the same time the SMP Plan's enrollment in Minnesota increased by 221 members. Additionally, there was a loss of membership in the Dane County (120 members) and Milwaukee County (65 members).

SMP Plan enrollment averaged 147 members per month in 2008 compared to 528 members per month in 2007. This reduction is the result of a reduced service area in which the plan is available, dropping from 12 counties in 2007 to 9 counties in 2008. In January 2009, enrollment increased to 540 members mainly due to the addition of 2 counties to the service area and the expansion of the out of state provider network in Minnesota and Michigan.

The **Medicare Plus \$1M Plan** enrollment is experiencing a very gradual decline in membership. Between January 2007 and December 2008, enrollment dropped from 9,924 to 9,532, or a reduction of 4%, over the course of the two years. In January 2009, the enrollment increased 1% to 9,649 members.

STATE EMPLOYEE TRUST FUNDS
Monthly Membership
January 2007 through January 2009

Exhibit 1-A



EFFECTIVE MONTH																									
	Jan 07	Feb 07	Mar 07	Apr 07	May 07	Jun 07	Jul 07	Aug 07	Sep 07	Oct 07	Nov 07	Dec 07	Jan 08	Feb 08	Mar 08	Apr 08	May 08	Jun 08	Jul 08	Aug 08	Sep 08	Oct 08	Nov 08	Dec 08	Jan 09
Standard	3,901	3,912	3,891	3,831	3,831	3,838	3,867	3,860	3,944	4,005	3,932	3,905	3,885	3,910	3,892	3,847	3,819	3,838	3,893	3,877	3,951	4,046	3,962	3,951	3,272
SMP	564	563	555	514	522	519	517	513	514	515	523	511	148	149	150	144	144	146	146	145	146	148	148	147	540
Medicare	9,924	9,891	9,867	9,854	9,803	9,759	9,732	9,717	9,707	9,709	9,699	9,694	9,853	9,820	9,795	9,749	9,689	9,668	9,646	9,612	9,592	9,583	9,560	9,532	9,649

State Employee Trust Funds

Group Demographics

Enrollment by Plan

The Enrollment by Plan report (Exhibit 2-A) shows the December 2008 membership for the Standard, SMP and Medicare Plus \$1M Plans at the class level. For each class, member average age and gender distribution is shown. The age/gender factor is included as an index intended to represent expected plan cost based on the age and gender of each member, without regard to plan design, health, etc. The age/gender factor is not shown for the Medicare Plus \$1M Plan, where coordination of benefits with Medicare has an overwhelming impact on plan cost.

The average age of the Standard Plan is 43.6 years, 4.5 years older than the 39.1 average age of the smaller SMP Plan. Based on the age/gender factors for December 2008, we would expect the demographics alone would cause the Standard Plan to be 17.0% higher in claim costs than the SMP Plan, everything else being equal.

STATE EMPLOYEE TRUST FUNDS

Enrollment by Plan

December 2008

Exhibit 2-A

Plan	Class	# of Members	Average Member Age	Member Gender Distribution Female	Member Age/ Gender Factor
Standard	Regular	2,918	43.0	52.5%	1.614
	Graduate Assistant (including GA continuation)	384	28.1	51.0%	0.921
	Continuation	21	41.8	47.6%	1.353
	Annuitants	628	56.0	70.7%	2.311
Subtotal		3,951	43.6	55.2%	1.656
SMP	Regular	124	35.7	47.6%	1.240
	Graduate Assistant (including GA continuation)	0	0.0	0.0%	0.000
	Continuation	0	0.0	0.0%	0.000
	Annuitants	23	57.5	39.1%	2.358
Subtotal		147	39.1	46.3%	1.415
Medicare Plus One Million	Single	4,458	80.3	71.9%	N/A
	One Over	220	70.0	8.6%	N/A
	Two Over	4,854	76.0	50.1%	N/A
Subtotal		9,532	77.9	59.3%	N/A
ETF Grand Total		13,630	67.5	58.0%	N/A

State Employee Trust Funds

Group Demographics

Member Census Grids

The Member Census Grid breaks down the December 2008 membership into age and gender categories for the Standard, SMP and Medicare Plus \$1M Plans. The Standard and SMP distributions are compared to a benchmark distribution based on WPS large group business as described in the Executive Summary. The benchmark distribution for the Medicare plan is based on WPS Medicare Supplement business.

Standard Plan

The Standard Plan membership (Exhibit 3-A) shows the plan having a much older population than the normative distribution with 41.5% of membership over the age of 55 compared to the benchmark of 16.7%. The broad provider panel and out of state membership produce an upward bias on the average age. Older members tend to seek more medical care and tend to select a broader panel of providers for that care. Secondly, the Standard Plan is the only out of state offering. Therefore, all retirees who move out of state will select the Standard Plan, again contributing to a higher average age.

Also corresponding to the older than expected membership is the smaller than expected population of children with only 16.2% of the membership under the age of 20 compared to the benchmark of 29.4%. The Standard Plan also has a higher than normal female population with 55.2% female, compared to the benchmark of 51.7%.

SMP Plan

The SMP Plan membership (Exhibit 3-B) also shows the plan having an older population than the normative distribution with 54.5% of membership over the age of 45 compared to the benchmark of 35.2%. The SMP Plan has a higher than normal male population with 53.7% male compared to the benchmark of 48.4%.

Medicare

The Medicare Plus \$1M Plan membership is shown in Exhibit 3-C. The Medicare Plus \$1M Plan population has an older population than the WPS Medicare Supplement population.

**STATE EMPLOYEE TRUST FUNDS
Member Census Grid - Standard
December 2008**

Exhibit 3-A

FEMALE			
Age Band	# of Members	% of Total	Benchmark
< 20	327	8.3%	14.3%
20 - 24	138	3.5%	3.5%
25 - 29	105	2.7%	3.5%
30 - 34	98	2.5%	3.5%
35 - 39	94	2.4%	3.8%
40 - 44	126	3.2%	4.5%
45 - 49	154	3.9%	5.0%
50 - 54	216	5.5%	4.8%
55 - 59	302	7.6%	4.4%
60 - 64	499	12.6%	3.0%
65 +	123	3.1%	1.4%
Total	2,182	55.2%	51.7%

MALE			
Age Band	# of Members	% of Total	Benchmark
< 20	315	8.0%	15.1%
20 - 24	128	3.2%	3.2%
25 - 29	108	2.7%	2.8%
30 - 34	71	1.8%	3.2%
35 - 39	72	1.8%	3.5%
40 - 44	94	2.4%	4.0%
45 - 49	106	2.7%	4.4%
50 - 54	163	4.1%	4.3%
55 - 59	222	5.6%	3.8%
60 - 64	329	8.3%	2.6%
65 +	161	4.1%	1.5%
Total	1,769	44.8%	48.4%

TOTAL			
Age Band	# of Members	% of Total	Benchmark
< 20	642	16.2%	29.4%
20 - 24	266	6.7%	6.7%
25 - 29	213	5.4%	6.3%
30 - 34	169	4.3%	6.7%
35 - 39	166	4.2%	7.3%
40 - 44	220	5.6%	8.5%
45 - 49	260	6.6%	9.4%
50 - 54	379	9.6%	9.1%
55 - 59	524	13.3%	8.2%
60 - 64	828	21.0%	5.6%
65 +	284	7.2%	2.9%
Total	3,951	100.0%	100.0%



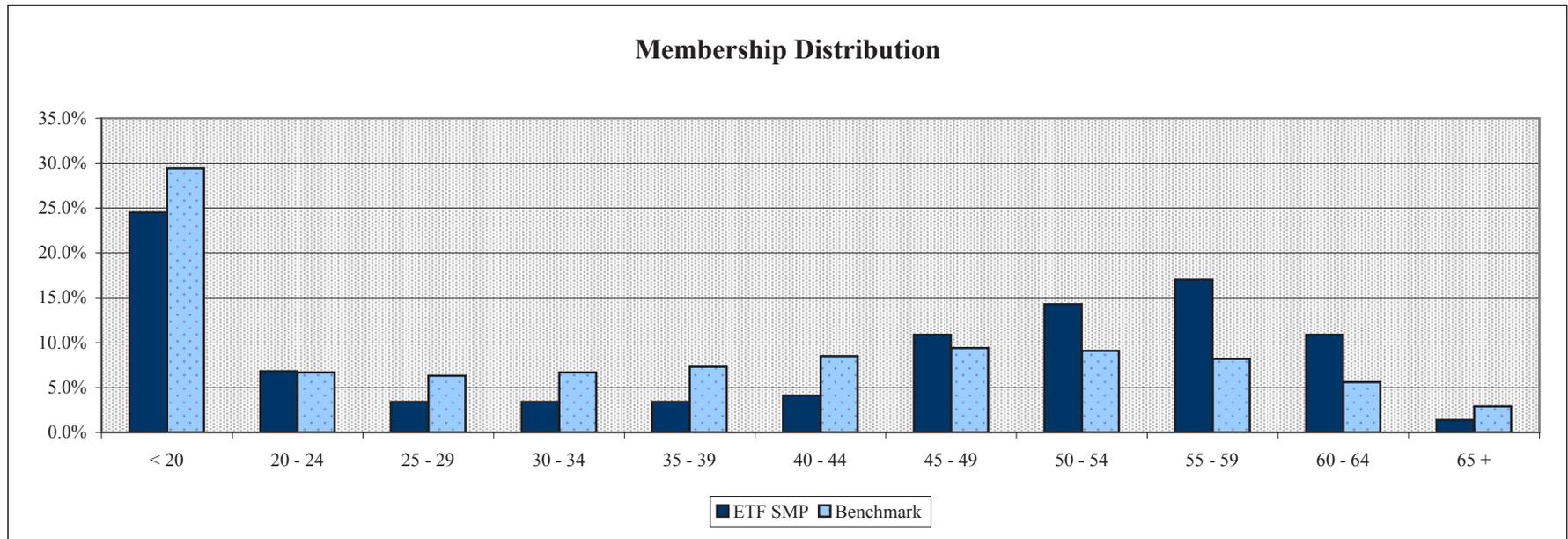
**STATE EMPLOYEE TRUST FUNDS
Member Census Grid - SMP
December 2008**

Exhibit 3-B

FEMALE			
Age Band	# of Members	% of Total	Benchmark
< 20	19	12.9%	14.3%
20 - 24	5	3.4%	3.5%
25 - 29	0	0.0%	3.5%
30 - 34	3	2.0%	3.5%
35 - 39	2	1.4%	3.8%
40 - 44	3	2.0%	4.5%
45 - 49	10	6.8%	5.0%
50 - 54	9	6.1%	4.8%
55 - 59	10	6.8%	4.4%
60 - 64	7	4.8%	3.0%
65 +	0	0.0%	1.4%
Total	68	46.3%	51.7%

MALE			
Age Band	# of Members	% of Total	Benchmark
< 20	17	11.6%	15.1%
20 - 24	5	3.4%	3.2%
25 - 29	5	3.4%	2.8%
30 - 34	2	1.4%	3.2%
35 - 39	3	2.0%	3.5%
40 - 44	3	2.0%	4.0%
45 - 49	6	4.1%	4.4%
50 - 54	12	8.2%	4.3%
55 - 59	15	10.2%	3.8%
60 - 64	9	6.1%	2.6%
65 +	2	1.4%	1.5%
Total	79	53.7%	48.4%

TOTAL			
Age Band	# of Members	% of Total	Benchmark
< 20	36	24.5%	29.4%
20 - 24	10	6.8%	6.7%
25 - 29	5	3.4%	6.3%
30 - 34	5	3.4%	6.7%
35 - 39	5	3.4%	7.3%
40 - 44	6	4.1%	8.5%
45 - 49	16	10.9%	9.4%
50 - 54	21	14.3%	9.1%
55 - 59	25	17.0%	8.2%
60 - 64	16	10.9%	5.6%
65 +	2	1.4%	2.9%
Total	147	100.0%	100.0%



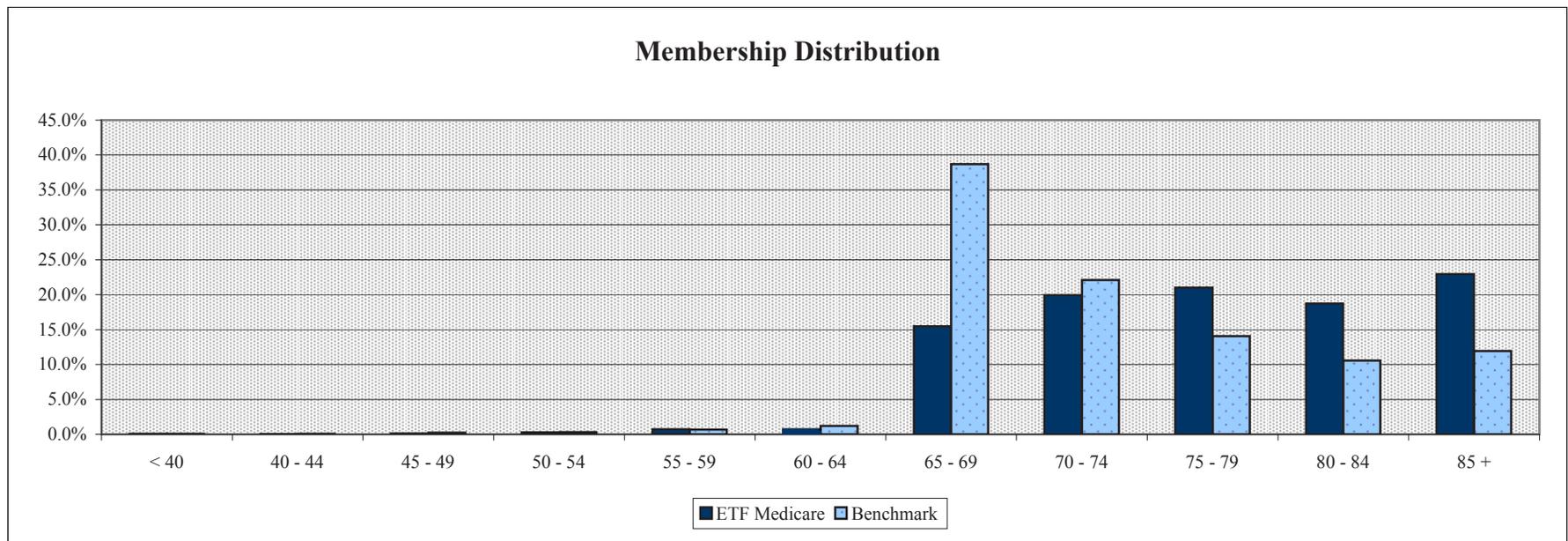
STATE EMPLOYEE TRUST FUNDS
Member Census Grid - Medicare Plus One Million
December 2008

Exhibit 3-C

FEMALE			
Age Band	# of Members	% of Total	Benchmark
< 40	3	0.0%	0.0%
40 - 44	2	0.0%	0.0%
45 - 49	9	0.1%	0.2%
50 - 54	19	0.2%	0.2%
55 - 59	54	0.6%	0.4%
60 - 64	45	0.5%	0.6%
65 - 69	892	9.4%	20.9%
70 - 74	1,032	10.8%	11.5%
75 - 79	1,081	11.3%	7.9%
80 - 84	1,060	11.1%	6.2%
85 +	1,460	15.3%	8.6%
Total	5,657	59.3%	56.4%

MALE			
Age Band	# of Members	% of Total	Benchmark
< 40	4	0.0%	0.0%
40 - 44	1	0.0%	0.0%
45 - 49	4	0.0%	0.1%
50 - 54	7	0.1%	0.2%
55 - 59	16	0.2%	0.3%
60 - 64	24	0.3%	0.6%
65 - 69	581	6.1%	17.8%
70 - 74	868	9.1%	10.6%
75 - 79	921	9.7%	6.2%
80 - 84	724	7.6%	4.4%
85 +	725	7.6%	3.4%
Total	3,875	40.7%	43.6%

TOTAL			
Age Band	# of Members	% of Total	Benchmark
< 40	7	0.1%	0.1%
40 - 44	3	0.0%	0.1%
45 - 49	13	0.1%	0.2%
50 - 54	26	0.3%	0.3%
55 - 59	70	0.7%	0.7%
60 - 64	69	0.7%	1.2%
65 - 69	1,473	15.5%	38.7%
70 - 74	1,900	19.9%	22.1%
75 - 79	2,002	21.0%	14.0%
80 - 84	1,784	18.7%	10.6%
85 +	2,185	22.9%	11.9%
Total	9,532	100.0%	100.0%



State Employee Trust Funds

Group Demographics

Wisconsin Enrollment

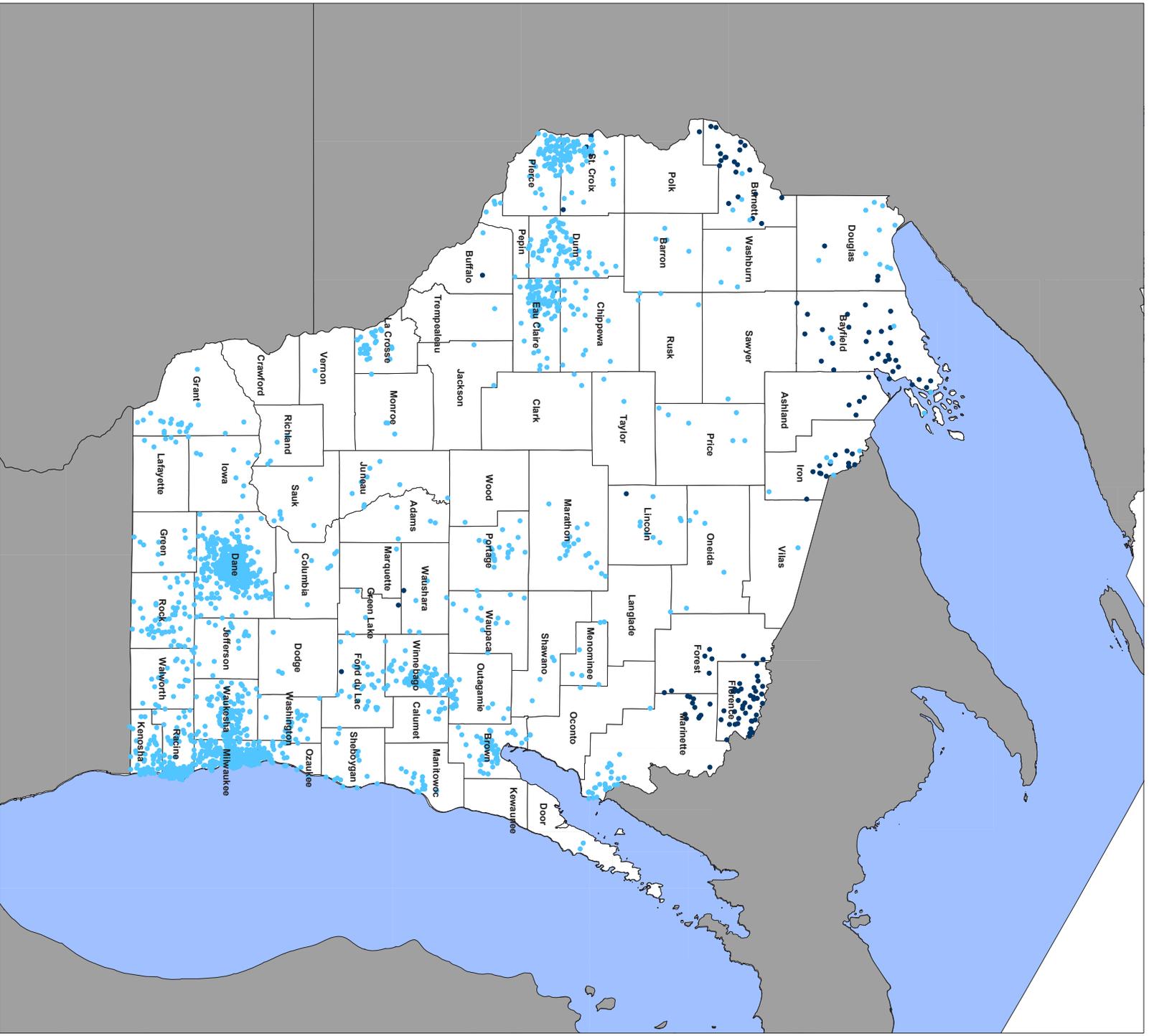
The Wisconsin Enrollment map (Exhibit 4-A) visually shows how the membership for the Standard and SMP Plans are dispersed throughout Wisconsin. The map shows enrollment as of December 1, 2008. Each of the dots represents one address. Members of the SMP plan that appear to be living outside the available SMP county region are usually either dependent students or members with zip codes that cross county lines. Exhibit 4-B shows the same information numerically.

71.7% of the **Standard Plan** participants live within Wisconsin. Much of the Standard Plan population is located near larger metropolitan areas in Wisconsin with 25.5% of the population living in Dane County and 14.2% living in Milwaukee County.

The **SMP Plan** membership is almost entirely within Wisconsin. Of that population, the membership tends to reside in the more rural areas with a majority of the population on the northern fringes of the state. 55.8% of the SMP Plan participants live in 3 counties, Florence, Bayfield, and Burnett. In 2009, Burnett County will no longer be part of the SMP service area, however two additional counties, Crawford and Pierce, will be available under the SMP plan.

STATE EMPLOYEE TRUST FUNDS
Enrollment By County
December 2008

Exhibit 4-A



Standard

SMP

STATE EMPLOYEE TRUST FUNDS
Enrollment By County
December 2008

Exhibit 4-B

County	STANDARD		SMP	
	# of Members	% of Members	# of Members	% of Members
ADAMS	2	0.1%	0	0.0%
ASHLAND	1	0.0%	9	6.1%
BARRON	7	0.2%	0	0.0%
BAYFIELD	3	0.1%	24	16.3%
BROWN	44	1.1%	0	0.0%
BUFFALO	4	0.1%	1	0.7%
BURNETT	4	0.1%	22	15.0%
CALUMET	9	0.2%	0	0.0%
CHIPPEWA	17	0.4%	0	0.0%
CLARK	2	0.1%	0	0.0%
COLUMBIA	8	0.2%	0	0.0%
CRAWFORD	0	0.0%	0	0.0%
DANE	1,006	25.5%	0	0.0%
DODGE	4	0.1%	0	0.0%
DOOR	2	0.1%	0	0.0%
DOUGLAS	10	0.3%	4	2.7%
DUNN	68	1.7%	0	0.0%
EAU CLAIRE	91	2.3%	1	0.7%
FLORENCE	0	0.0%	36	24.5%
FOND DU LAC	24	0.6%	1	0.7%
FOREST	0	0.0%	10	6.8%
GRANT	25	0.6%	0	0.0%
GREEN	8	0.2%	0	0.0%
GREEN LAKE	7	0.2%	0	0.0%
IOWA	7	0.2%	0	0.0%

County	STANDARD		SMP	
	# of Members	% of Members	# of Members	% of Members
IRON	4	0.1%	13	8.8%
JACKSON	1	0.0%	0	0.0%
JEFFERSON	13	0.3%	0	0.0%
JUNEAU	8	0.2%	0	0.0%
KENOSHA	38	1.0%	0	0.0%
KEWAUNEE	0	0.0%	0	0.0%
LACROSSE	29	0.7%	0	0.0%
LAFAYETTE	0	0.0%	0	0.0%
LANGLADE	2	0.1%	0	0.0%
LINCOLN	11	0.3%	1	0.7%
MANITOWOC	14	0.4%	0	0.0%
MARATHON	19	0.5%	0	0.0%
MARINETTE	24	0.6%	14	9.5%
MARQUETTE	1	0.0%	2	1.4%
MENOMINEE	5	0.1%	0	0.0%
MILWAUKEE	560	14.2%	0	0.0%
MONROE	3	0.1%	0	0.0%
OCONTO	4	0.1%	0	0.0%
ONEIDA	3	0.1%	0	0.0%
OUTAGAMIE	25	0.6%	0	0.0%
OZAUKEE	46	1.2%	0	0.0%
PEPIN	4	0.1%	0	0.0%
PIERCE	89	2.3%	1	0.7%
POLK	0	0.0%	0	0.0%
PORTAGE	20	0.5%	0	0.0%

County	STANDARD		SMP	
	# of Members	% of Members	# of Members	% of Members
PRICE	7	0.2%	0	0.0%
RACINE	143	3.6%	0	0.0%
RICHLAND	4	0.1%	0	0.0%
ROCK	47	1.2%	0	0.0%
RUSK	0	0.0%	0	0.0%
SAUK	9	0.2%	0	0.0%
SAWYER	2	0.1%	0	0.0%
SHAWANO	4	0.1%	0	0.0%
SHEBOYGAN	14	0.4%	0	0.0%
ST CROIX	37	0.9%	3	2.0%
TAYLOR	1	0.0%	0	0.0%
TREMPEALEAU	2	0.1%	0	0.0%
VERNON	1	0.0%	0	0.0%
VILAS	1	0.0%	0	0.0%
WALWORTH	28	0.7%	0	0.0%
WASHBURN	3	0.1%	0	0.0%
WASHINGTON	25	0.6%	0	0.0%
WAUKESHA	120	3.0%	0	0.0%
WAUPACA	14	0.4%	0	0.0%
WAUSHARA	2	0.1%	0	0.0%
WINNEBAGO	88	2.2%	0	0.0%
WOOD	5	0.1%	0	0.0%
OUT OF STATE	1,118	28.3%	5	3.4%
Totals	3,951	100.0%	147	100.0%

State Employee Trust Funds

Group Demographics

Out of State Enrollment

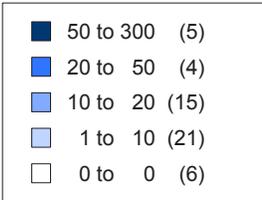
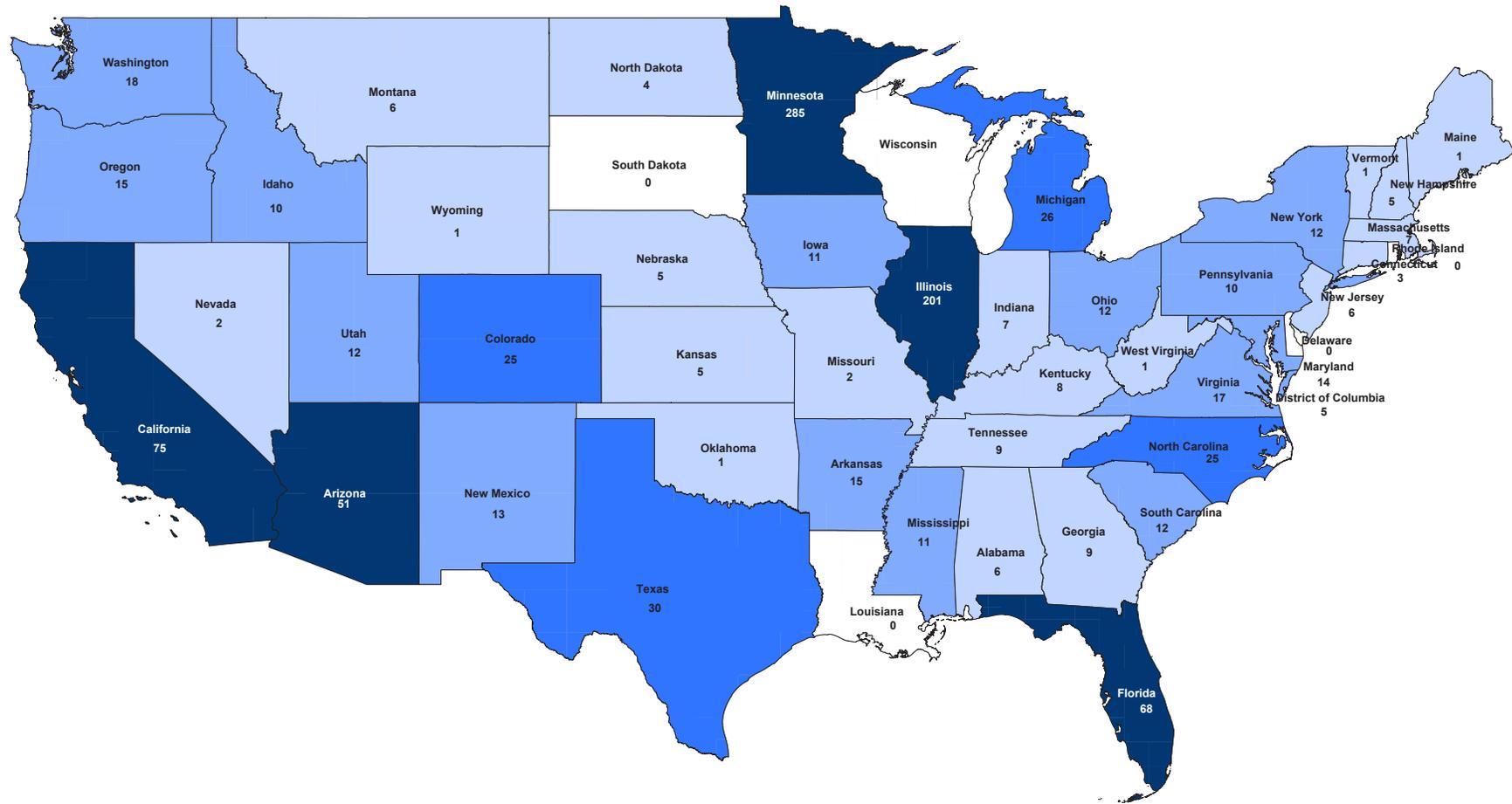
The United States Enrollment Map in Exhibit 5-A visually depicts how the enrollment in the Standard and SMP Plans are spread throughout the United States. The out of state enrollment is based on the member's address as of December 2008 and could change as members relocate. The map displays the number of Standard and SMP Plan members living in each state along with a shading scheme in which higher population areas are represented with increasingly darker shading. Exhibit 5-B shows the same information numerically.

The **Standard Plan** has 28.3% of the population living outside the state of Wisconsin. Membership is dispersed over 45 states with an additional 50 members living internationally. 46.6% of the out of state enrollment lives along the Wisconsin border with the largest number of members living in Minnesota (285 members or 25.5%) and Illinois (201 members or 18.0%). Another area of membership concentration is in typical retirement states with 20.0% of the out of state membership residing in California (75), Florida (68), Arizona (50) and Texas (30).

The **SMP Plan** in comparison has only 3.4% of the population or 5 members living outside the state of Wisconsin. 3 members reside in Michigan. These individuals are likely employees living on the Wisconsin border. One member resides in Arizona and one member lives internationally. The SMP Plan does have some provider coverage in the states bordering Wisconsin however the plan does not have any non-emergency provider coverage in other states.

**STATE EMPLOYEE TRUST FUNDS
Out of State Enrollment
December 2008**

Exhibit 5-A



STATE EMPLOYEE TRUST FUNDS
Out of State Enrollment
December 2008

Exhibit 5-B

STANDARD					SMP									
State	# of Members	% of Members	# of Members	% of Members	State	# of Members	% of Members	# of Members	% of Members	State	# of Members	% of Members	# of Members	% of Members
ALABAMA	6	0.5%	0	0.0%	MAINE	1	0.1%	0	0.0%	OREGON	15	1.3%	0	0.0%
ALASKA	0	0.0%	0	0.0%	MARYLAND	14	1.3%	0	0.0%	PENNSYLVANIA	10	0.9%	0	0.0%
ARIZONA	50	4.5%	1	20.0%	MASSACHUSETTS	7	0.6%	0	0.0%	RHODE ISLAND	0	0.0%	0	0.0%
ARKANSAS	15	1.3%	0	0.0%	MICHIGAN	23	2.1%	3	60.0%	SOUTH CAROLINA	12	1.1%	0	0.0%
CALIFORNIA	75	6.7%	0	0.0%	MINNESOTA	285	25.5%	0	0.0%	SOUTH DAKOTA	0	0.0%	0	0.0%
COLORADO	25	2.2%	0	0.0%	MISSISSIPPI	11	1.0%	0	0.0%	TENNESSEE	9	0.8%	0	0.0%
CONNECTICUT	3	0.3%	0	0.0%	MISSOURI	2	0.2%	0	0.0%	TEXAS	30	2.7%	0	0.0%
DELAWARE	0	0.0%	0	0.0%	MONTANA	6	0.5%	0	0.0%	UTAH	12	1.1%	0	0.0%
FLORIDA	68	6.1%	0	0.0%	NEBRASKA	5	0.4%	0	0.0%	VERMONT	1	0.1%	0	0.0%
GEORGIA	9	0.8%	0	0.0%	NEVADA	2	0.2%	0	0.0%	VIRGINIA	17	1.5%	0	0.0%
HAWAII	10	0.9%	0	0.0%	NEW HAMPSHIRE	5	0.4%	0	0.0%	WASHINGTON	18	1.6%	0	0.0%
IDAHO	10	0.9%	0	0.0%	NEW JERSEY	6	0.5%	0	0.0%	WASHINGTON DC	5	0.4%	0	0.0%
ILLINOIS	201	18.0%	0	0.0%	NEW MEXICO	13	1.2%	0	0.0%	WEST VIRGINIA	1	0.1%	0	0.0%
INDIANA	7	0.6%	0	0.0%	NEW YORK	12	1.1%	0	0.0%	WYOMING	1	0.1%	0	0.0%
IOWA	11	1.0%	0	0.0%	NORTH CAROLINA	25	2.2%	0	0.0%	FOREIGN	50	4.5%	1	20.0%
KANSAS	5	0.4%	0	0.0%	NORTH DAKOTA	4	0.4%	0	0.0%	Totals	1,118	100.0%	5	100.0%
KENTUCKY	8	0.7%	0	0.0%	OHIO	12	1.1%	0	0.0%					
LOUISIANA	0	0.0%	0	0.0%	OKLAHOMA	1	0.1%	0	0.0%					

State Employee Trust Funds

Group Demographics

Dual Choice Changes

The Dual Choice Enrollment Changes by Plan report (Exhibit 6-A) shows the January 2009 enrollment reflecting changes that occurred during the Dual Choice Enrollment. The enrollment changes are numerical differences relative to December 2008. The change in Member Age/Gender shows how much plan costs changed between 2008 and 2009 due to demographic factors. The age/gender factor is not shown for the Medicare Plus \$1M Plan, where coordination of benefits with Medicare has an overwhelming impact on plan cost.

Exhibit 6-A shows total enrollment for all plans was 13,461 members as of January 2009, which is down 169 members from the 13,630 members in the plan in December 2008. The Standard Plan experienced a loss of 679 members, or 17.2% of the membership, during Dual Choice Enrollment. In contrast, the SMP enrollment increased by 393 members. The contrasting enrollment change for the Standard Plan and SMP Plan in January was partly due to the expansion of the out of state provider network in Minnesota and Michigan within the SMP Plan. The Standard Plan enrollment in Minnesota decreased by 263 members in January 2009 at the same time the SMP Plan enrollment in Minnesota increased by 221 members. Additionally, the increase in the SMP Plan enrollment was due to the expansion of the SMP plan into Crawford and Pierce counties. The Medicare Plus \$1M membership increased by 117 individuals in January 2009.

The change in age/gender for the Standard Plan was 4.05%. The positive change means the plan is expected to be 4.05% more expensive demographically in 2009 on a per member basis as a result of the loss of membership loss and overall aging of the population. This increase in expense would be in addition to regular increases in cost and utilization. The SMP plan in contrast, is expected to be 1.79% less expensive demographically in 2009 due to the increased percentage of regular members who are much younger than their annuitant counterparts.

STATE EMPLOYEE TRUST FUNDS
Dual Choice Enrollment Changes by Plan
December 2008 to January 2009

Exhibit 6-A

Plan	Class	January 2009 Membership	Change in Membership from December 2008	Change in Member Age/ Gender
Standard	Regular	2,285	-633	4.24%
	Graduate Assistant (including GA continuation)	352	-32	1.14%
	Continuation	25	4	-15.40%
	Annuitants	610	-18	1.96%
Subtotal		3,272	-679	4.05%
SMP	Regular	509	385	7.44%
	Graduate Assistant (including GA continuation)	3	3	N/A
	Continuation	1	1	N/A
	Annuitants	27	4	0.53%
Subtotal		540	393	-1.79%
Medicare Plus One Million	Single	4,474	16	N/A
	One Over	229	9	N/A
	Two Over	4,946	92	N/A
Subtotal		9,649	117	N/A
ETF Grand Total		13,461	-169	N/A

State Employee Trust Funds

Plan Utilization

Paid Per Member Per Month Costs

The Paid Medical and Drug PMPM report (Exhibit 7-A) displays the average amount paid per member each month for the Standard, SMP and Medicare Plus \$1M Plans incurred from January 2007 through December 2008. The PMPM costs for each plan represent medical and drug claims paid through the end of March 2009.

Standard Plan

The Standard Plan has seen a 9.5% increase in claim costs between 2007 and 2008. Independent trend estimates for medical claims for 2008 were 10-12% thus the Standard Plan ran slightly better than expected. The monthly spikes in claim costs are generally due to large claim activity that occurred in those months.

In 2008, the Standard Plan was 157.8% higher in overall claims costs on a PMPM basis when compared to the SMP Plan. The largest factor to this difference is the anti-selection that the Standard Plan is subject to versus the other options available to the membership. Members who utilize healthcare services are generally willing to make a larger premium contribution and incur modest cost sharing provisions within the benefit plan in exchange for the broader panel of providers. A second factor is the difference in demographics between the two plans which would project the Standard Plan to cost 17.0% more than the SMP Plan. The Standard Plan tends to attract an older population as the plan is the only out of state offering. Third, the Standard Plan's enrollment is generally in more expensive urban areas such as Milwaukee and Dane Counties.

SMP Plan

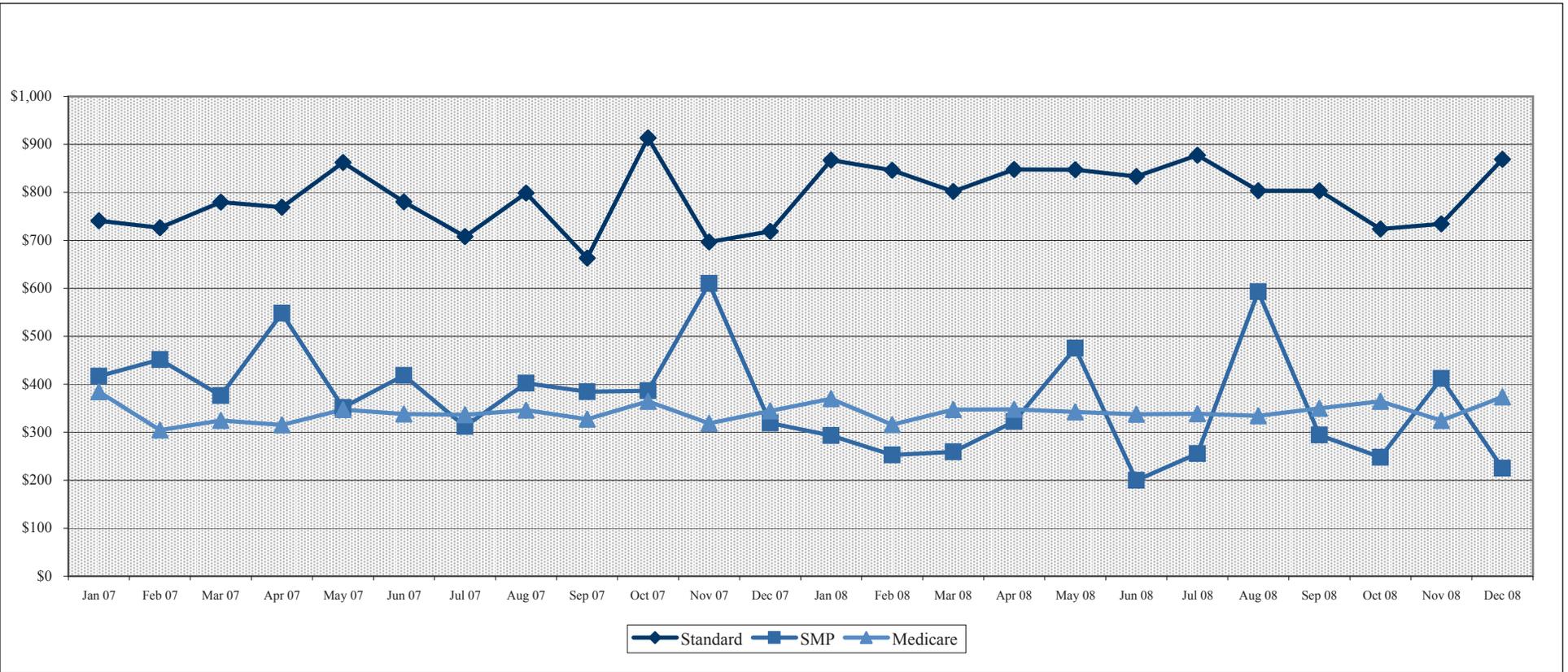
The SMP Plan did not have a credible level of membership in 2008 to do meaningful trend analysis. However, for informational purposes, the SMP plan saw a 20.1% decrease in claims costs between 2007 and 2008.

Medicare

The Medicare Plus \$1M Plan has seen stable results over the last 2 years. We would expect this population to have stable results since Medicare is the primary payer and the plan has a large population. The year over year medical PMPM trend from 2007 to 2008 was 3.1%, which is below the WPS Medicare supplement trend. We would naturally expect a small increase in the medical claims each year due to the benefit changes Medicare makes annually and medical cost and utilization trend.

STATE EMPLOYEE TRUST FUNDS
Paid Medical and Drug PMPM
Paid Through March 2009

Exhibit 7-A



INCURRED MONTH																								
	Jan 07	Feb 07	Mar 07	Apr 07	May 07	Jun 07	Jul 07	Aug 07	Sep 07	Oct 07	Nov 07	Dec 07	Jan 08	Feb 08	Mar 08	Apr 08	May 08	Jun 08	Jul 08	Aug 08	Sep 08	Oct 08	Nov 08	Dec 08
Standard	\$740.96	\$726.30	\$779.74	\$768.77	\$862.49	\$780.48	\$707.95	\$798.51	\$662.93	\$913.36	\$696.34	\$718.80	\$867.35	\$846.31	\$801.72	\$848.00	\$847.34	\$833.00	\$877.45	\$803.72	\$803.22	\$723.43	\$734.53	\$868.65
SMP	\$417.11	\$451.33	\$376.26	\$548.28	\$351.70	\$418.45	\$311.92	\$402.03	\$384.19	\$386.45	\$610.29	\$319.10	\$293.13	\$252.56	\$259.09	\$322.36	\$475.36	\$199.85	\$255.33	\$593.11	\$294.39	\$247.85	\$411.73	\$224.93
Medicare	\$384.63	\$304.62	\$324.43	\$315.26	\$347.45	\$337.91	\$336.58	\$346.12	\$327.22	\$364.71	\$318.43	\$344.26	\$369.88	\$316.03	\$346.97	\$347.65	\$342.07	\$337.38	\$338.64	\$334.38	\$350.08	\$364.33	\$324.52	\$373.52

State Employee Trust Funds

Plan Utilization

PMPM by Type of Service

The Total PMPM by Type of Service reports (8-A and 8-C) provide a breakdown of the PMPM by major type of service compared to the benchmark. The pie chart also provides an overview of the percentage of the PMPM each major type of service is contributing to the total PMPM plus a comparison to the benchmark. The actual PMPM costs are for claims incurred January 2008 – December 2008 and paid through the end of March 2009. The Paid PMPM by Type of Service reports (8-B, 8-D, and 8-E) show the same actual data, but compare 2007 to 2008.

Standard Plan

The Standard Plan in Exhibit 8-A shows that the percentage breakdown by major type of service is similar to the benchmark with a slightly smaller percentage falling into the physician category and a little more falling into the facility inpatient and other services categories.

The bottom chart in Exhibit 8-A shows that the total PMPM cost is 48.1% above the benchmark. For comparison purposes, last year the Standard Plan was 47.9% above the benchmark. The inpatient facility PMPM cost is 63.4% above the benchmark and outpatient facility is 50.6% above the benchmark. The physician PMPM cost is 28.0% above the benchmark. The drug paid PMPM cost is 52.6% above the benchmark and roughly in line with the variance of the non-drug paid costs. Lastly, the other services category is 70.1% over the norm. The largest contributor to the differential in the other services category is the psychiatric/AODA benefit sub-category which is \$18.51 above the norm. Every \$1.00 PMPM represented in the graph is equivalent to \$46,871 in annual plan costs for the Standard Plan.

Exhibit 8-B compares the Standard Plan's paid PMPM costs for 2007 to 2008, showing a 9.5% increase between the two years. Facility inpatient and physician costs increased more than expected at 20.6% and 16.6% on a PMPM basis respectively. The outpatient facility category actually decreased in 2008 from 2007, which was the category that had the largest increase in the prior year. The remaining categories increased at or below expected levels

SMP Plan

Exhibit 8-C shows the percentage breakdown by type of service for the SMP Plan is very different than the benchmark, with a larger than expected percentage falling into the facility outpatient and drug categories and an unusually small percentage falling into the facility inpatient category. These results are due to the volatile nature of this very small population.

In total the SMP Plan is well below the benchmark overall. The SMP plan was below the benchmark in all categories except for prescription drugs which was 10.4% higher than the benchmark.

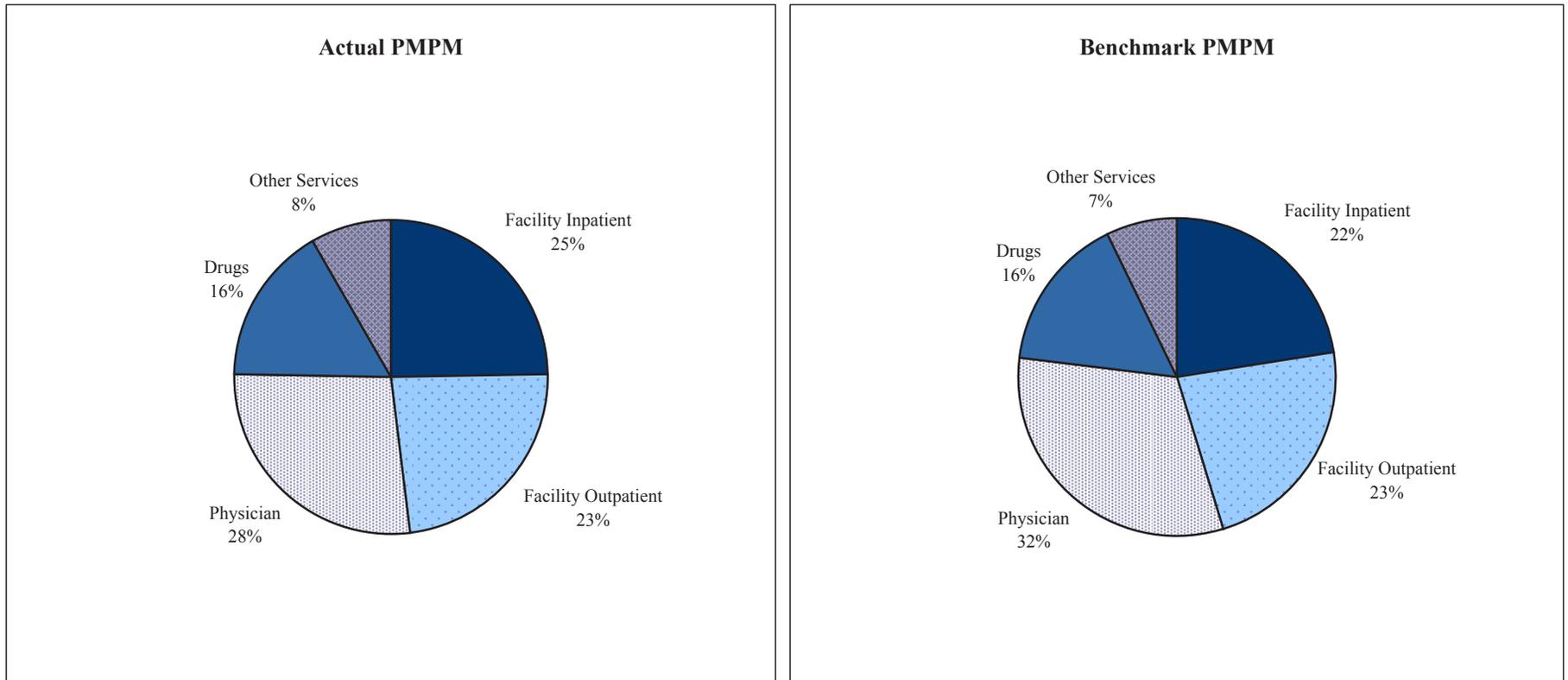
Exhibit 8-D compares the SMP Plan's paid PMPM costs for 2007 to 2008, showing a 20.1% decrease in PMPM cost. Prescription drug costs increased by 44.7% while the rest of the categories were significantly lower in 2008. Due to the continued decrease in membership that occurred in 2008, we would expect this degree of variability.

Medicare

The Medicare Plus \$1M Plan in Exhibit 8-E compares paid PMPM costs for 2007 to 2008. The medical segment of the paid PMPM cost accounts for only 38.6% of the payments made under the plan due to the impact of coordination of benefits with Medicare. In total the PMPM increased by 3.1% in 2008. Prescription drug costs increased by 2.7%, while the medical categories experienced increases averaging 3.7%.

STATE EMPLOYEE TRUST FUNDS
Total PMPM by Type of Service - Standard
Incurred January 2008 - December 2008 Paid Through March 2009

Exhibit 8-A



	Actual	Benchmark	Difference	
			\$	%
Facility Inpatient	\$203.12	\$124.32	\$78.80	63.4%
Facility Outpatient	\$190.35	\$126.40	\$63.95	50.6%
Physician	\$224.23	\$175.15	\$49.08	28.0%
Drugs	\$134.71	\$88.30	\$46.41	52.6%
Other Services	\$68.31	\$40.15	\$28.16	70.1%
Totals	\$820.72	\$554.32	\$266.40	48.1%

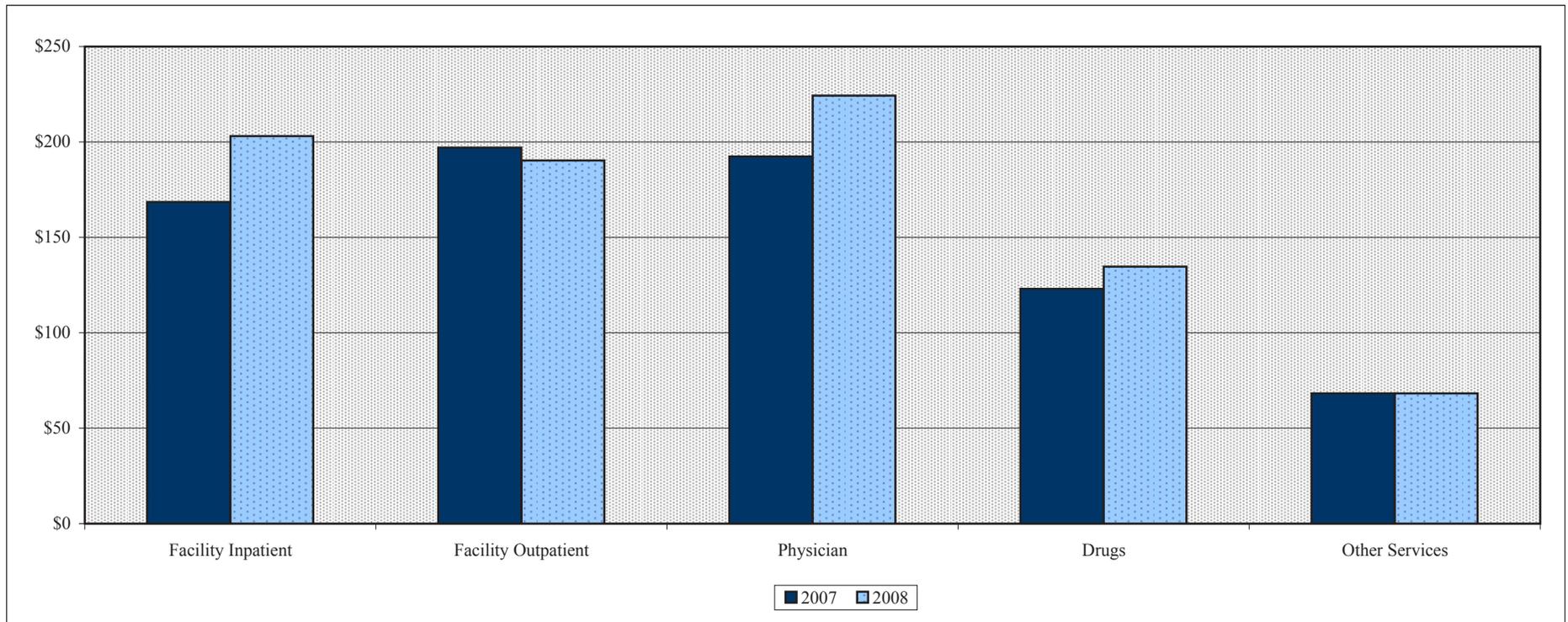
Note: Drug includes prescription and injectables

Note: Benchmark data has been age/sex adjusted to correspond to the population included in this exhibit

* Each \$1.00 paid PMPM = \$46,871 in plan costs.

STATE EMPLOYEE TRUST FUNDS
Total PMPM by Type of Service - Standard
Comparison of 2008 to 2007

Exhibit 8-B



	2007 *	2008 **	Difference	
			\$	%
Facility Inpatient	\$168.49	\$203.12	\$34.63	20.6%
Facility Outpatient	\$197.08	\$190.35	-\$6.73	-3.4%
Physician	\$192.35	\$224.23	\$31.88	16.6%
Drugs	\$123.02	\$134.71	\$11.69	9.5%
Other Services	\$68.28	\$68.31	\$0.03	0.0%
Totals	\$749.22	\$820.72	\$71.50	9.5%

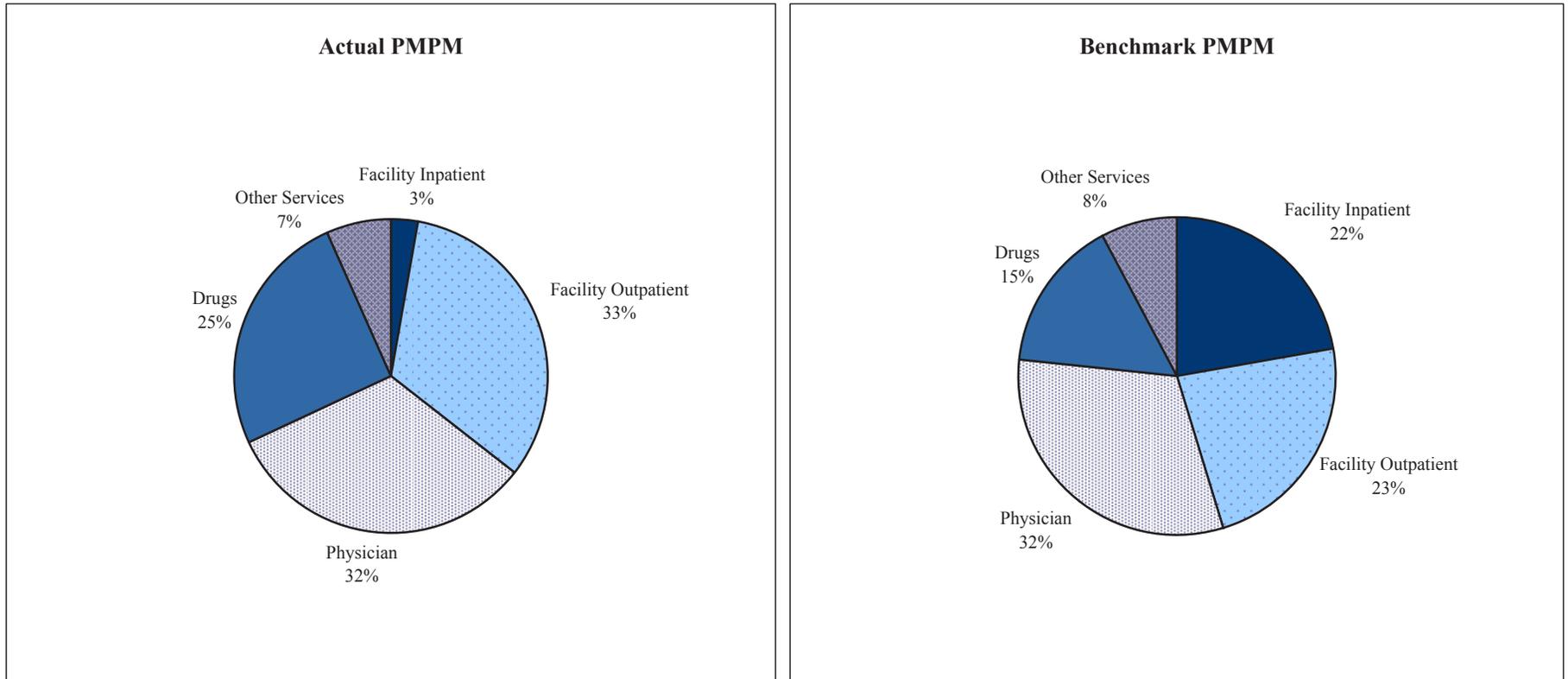
Note: Drug includes prescription and injectables

* Each \$1.00 paid PMPM = \$46,800 in plan costs.

** Each \$1.00 paid PMPM = \$46,871 in plan costs.

STATE EMPLOYEE TRUST FUNDS
Total PMPM by Type of Service - SMP
 Incurred January 2008 - December 2008 Paid Through March 2009

Exhibit 8-C



	Actual	Benchmark	Difference	
			\$	%
Facility Inpatient	\$9.19	\$105.52	-\$96.33	-91.3%
Facility Outpatient	\$104.06	\$108.33	-\$4.27	-3.9%
Physician	\$103.45	\$149.78	-\$46.33	-30.9%
Drugs	\$80.57	\$72.95	\$7.62	10.4%
Other Services	\$21.20	\$37.10	-\$15.90	-42.9%
Totals	\$318.47	\$473.68	-\$155.21	-32.8%

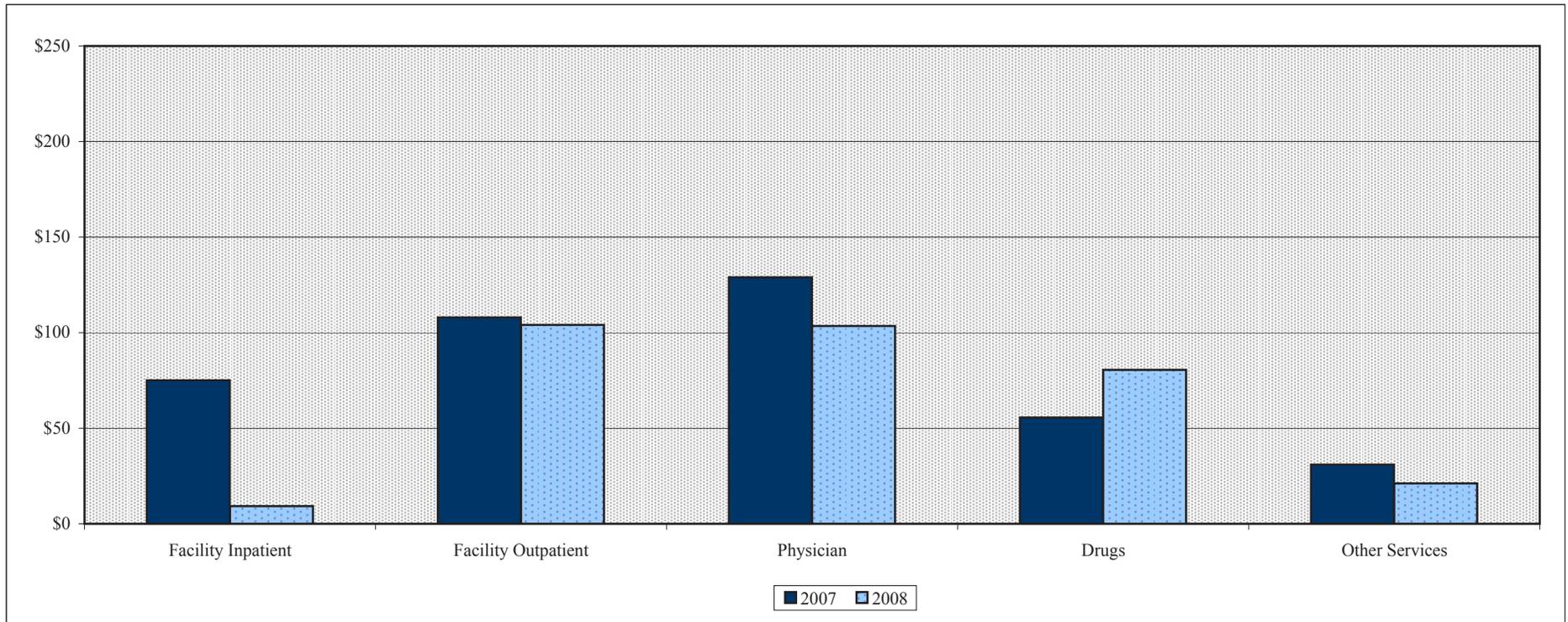
Note: Drug includes prescription and injectables

Note: Benchmark data has been age/sex adjusted to correspond to the population included in this exhibit

* Each \$1.00 paid PMPM = \$1,761 in plan costs.

STATE EMPLOYEE TRUST FUNDS
Total PMPM by Type of Service - SMP
Comparison of 2008 to 2007

Exhibit 8-D



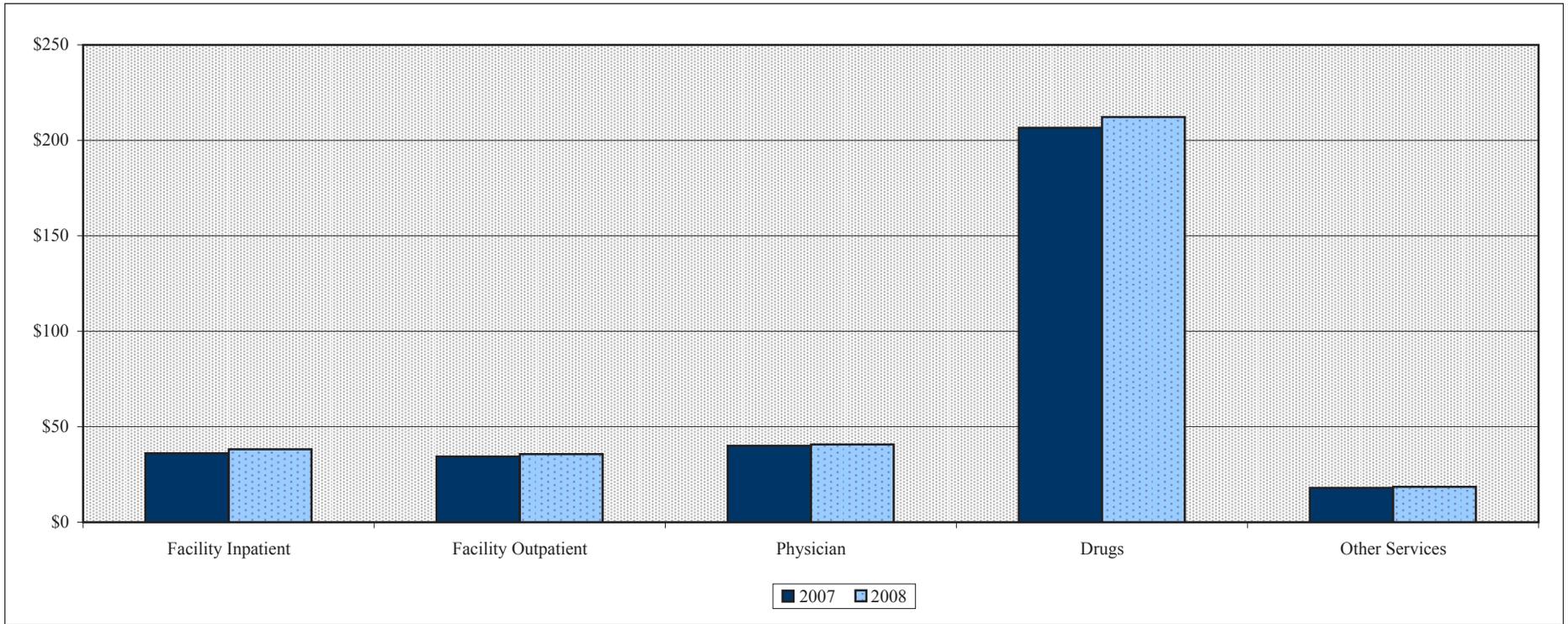
	2007 *	2008 **	Difference	
			\$	%
Facility Inpatient	\$75.07	\$9.19	-\$65.88	-87.8%
Facility Outpatient	\$107.94	\$104.06	-\$3.88	-3.6%
Physician	\$129.05	\$103.45	-\$25.60	-19.8%
Drugs	\$55.67	\$80.57	\$24.90	44.7%
Other Services	\$31.01	\$21.20	-\$9.81	-31.6%
Totals	\$398.74	\$318.47	-\$80.27	-20.1%

Note: Drug includes prescription and injectables

* Each \$1.00 paid PMPM = \$6,392 in plan costs.

** Each \$1.00 paid PMPM = \$1,761 in plan costs.

STATE EMPLOYEE TRUST FUNDS
Total PMPM by Type of Service - Medicare Plus One Million
Comparison of 2008 to 2007



	2007 *	2008 **	Difference	
			\$	%
Facility Inpatient	\$36.05	\$38.23	\$2.18	6.0%
Facility Outpatient	\$34.43	\$35.73	\$1.30	3.8%
Physician	\$40.09	\$40.71	\$0.62	1.5%
Drugs	\$206.58	\$212.23	\$5.65	2.7%
Other Services	\$17.92	\$18.51	\$0.59	3.3%
Totals	\$335.07	\$345.41	\$10.34	3.1%

Note: Drug includes prescription and injectables
 * Each \$1.00 paid PMPM = \$117,541 in plan costs.
 ** Each \$1.00 paid PMPM = \$116,099 in plan costs.

State Employee Trust Funds

Plan Utilization

Type of Service Detail

The Type of Service Detail report provides an overview of paid medical costs on a PMPM basis divided into 5 major service categories and further divided into 26 subcategories. The Actual PMPM costs are compared to the benchmark PMPM to help determine where the plan is experiencing higher than normal claim costs. The comparison to the benchmark is displayed as a PMPM difference and as a percentage difference. The actual PMPM cost are for claims incurred January 2008 – December 2008 and paid through the end of March 2009.

Standard Plan

The Standard Plan in Exhibit 9-A was 48.1% above the benchmark in 2008. The variance to the benchmark is primarily a result of the anti-selection resulting from the Dual Choice Enrollment. Other contributing factors include the location of the Standard Plan's enrolled membership (the higher cost urban areas) and the rich benefit design. Since the percentage comparison can be deceiving, it is more important to look at the PMPM difference with \$1.00 PMPM being equivalent to \$46,871 in annual plan costs. Below are some areas that stand out relative to the benchmark and some analysis on what is driving the higher costs:

- Facility Inpatient – The majority of dollars are for surgical/medical services. Within surgical/medical, \$5.26 PMPM is due to gastric bypass procedures not generally included in the norm. Another contributor to the overage is higher than expected large claim activity. For the 51 claimants over \$100,000, 51.0% of their claims fall into the inpatient facility category and drive a higher than expected PMPM. Also, psych/AODA services were 191.4% above the benchmark, however this is a \$3.74 PMPM decrease from 2007. The Standard Plan's benefit design in the psych/AODA sub-category is more comprehensive than the typical commercial plan, which is often limited to the Wisconsin state mandate.
- Facility Outpatient – Higher than expected costs in this category are reflective of the relative morbidity of the Standard Plan's population. Greater use of diagnostic services such as CT scans, MRIs and lab work has lead to cost variances versus the norm for outpatient radiology and pathology services. Costs in the other services category are \$25.02 PMPM above the benchmark, however 16.1% lower than last year. The primary drivers of this category are higher than expected use of cancer pharmaceuticals and therapies. Psych/AODA services are still well above the norm but the PMPM only increased slightly from 2007 to 2008.

- Physician – The surgery category is \$17.44 PMPM above the benchmark. Gastric bypass procedures have added \$2.62 to the Paid PMPM cost. Costs for these procedures are not generally accounted for in the benchmark. Another contributor is the 51 high cost claimants, who had 6.24% of their claims in this category. The Physician Other category is \$12.92 PMPM above the norm and is driven by higher than expected diagnostic testing, anesthesia, and consultations.
- Drug – The prescription drug costs are higher than the benchmark, however they are in line with the plan's performance overall. The injectable drug category in comparison is 72.4% above the benchmark. Specialty drugs can have exceptionally high mark-ups when provided in a physician's office. Certain drugs are often less costly to the plan if provided through the PBM or a specialty pharmacy. Select drugs can be self-injected by the patient in their own home, which is often viewed positively by the member. Taking a proactive approach, contract/benefit language should be reviewed so specialty drugs can be more effectively managed in the future.
- Other services – The other services category is \$28.16 PMPM above the benchmark. The major contributor to the variance is the Psychiatric /AODA cost which is \$18.51 PMPM above the benchmark. Although this sub-category is well above the norm, it is a \$3.88 PMPM reduction from 2007. The Standard Plan's benefit design in this sub-category is more comprehensive than the typical commercial plan, which is often limited to the Wisconsin state mandate.

SMP Plan

The SMP Plan in Exhibit 9-B by comparison is well below the benchmark for 2008. For the plan \$1.00 PMPM represented in the chart is equivalent to \$1,761 in annual plan costs.

- Inpatient Facility – This category is running better than the benchmark. However, the maternity costs are higher than expected. This is an example of the volatility seen when claims experience of a small population is split too finely. The SMP population had only 1 maternity case at a typical cost.
- Outpatient Facility — This category by contrast is running slightly below the norm. On a dollar basis, the Radiology and Other sub-categories are running above the norm. Higher than expected therapy and cardiology costs led to the overage in the outpatient-other category.

- Physician – This category is running below expected. Once again the maternity sub-category is higher than expected but is only 1 case as mentioned above.
- Drug – The prescription drug PMPM cost is running 38.6% below the norm, while injectable drug costs are running 274.4% above the norm. Injectable drugs are high cost, low frequency events which warrant special attention. With the smaller SMP population, if someone requires these types of services, one individual can drive the costs above the norm.
- Other Services – The Chiropractic sub-category is \$1.83 above the norm which is a function of the region in which the SMP population resides. In the northern region, chiropractic care is more commonly used in comparison to other areas of the state.

STATE EMPLOYEE TRUST FUNDS
Type of Service Detail - Standard
Incurred January 2008 - December 2008 Paid Through March 2009

TYPE OF SERVICE	DETAIL	ACTUAL	BENCHMARK	DIFFERENCE	
		PMPM	PMPM	\$	%
FACILITY INPATIENT	SURGICAL/MEDICAL	\$187.61	\$115.91	\$71.70	61.9%
	PSYCH/AODA	\$5.77	\$1.98	\$3.79	191.4%
	MATERNITY	\$6.26	\$4.90	\$1.36	27.8%
	OTHER	\$3.48	\$1.53	\$1.95	127.5%
Subtotal		\$203.12	\$124.32	\$78.80	63.4%
FACILITY OUTPATIENT	SURGICAL/MEDICAL	\$30.37	\$24.39	\$5.98	24.5%
	RADIOLOGY	\$52.65	\$33.89	\$18.76	55.4%
	PATHOLOGY	\$25.77	\$15.10	\$10.67	70.7%
	EMERGENCY ROOM	\$6.14	\$4.28	\$1.86	43.5%
	PSYCH/AODA	\$2.72	\$1.06	\$1.66	156.6%
	OTHER	\$72.70	\$47.68	\$25.02	52.5%
Subtotal		\$190.35	\$126.40	\$63.95	50.6%
PHYSICIAN	OFFICE VISIT	\$28.40	\$21.63	\$6.77	31.3%
	RADIOLOGY	\$37.63	\$34.08	\$3.55	10.4%
	PATHOLOGY	\$27.74	\$21.49	\$6.25	29.1%
	SURGERY	\$70.35	\$52.91	\$17.44	33.0%
	ANESTHESIA	\$13.94	\$11.69	\$2.25	19.2%
	MATERNITY	\$2.21	\$2.31	-\$0.10	-4.3%
	OTHER	\$43.96	\$31.04	\$12.92	41.6%
Subtotal		\$224.23	\$175.15	\$49.08	28.0%
DRUGS	PRESCRIPTIONS	\$110.85	\$74.46	\$36.39	48.9%
	INJECTABLES	\$23.86	\$13.84	\$10.02	72.4%
Subtotal		\$134.71	\$88.30	\$46.41	52.6%
OTHER SERVICES	PSYCH/AODA	\$23.98	\$5.47	\$18.51	338.4%
	CHIROPRACTIC	\$3.86	\$3.58	\$0.28	7.8%
	THERAPIES	\$9.12	\$4.47	\$4.65	104.0%
	AMBULANCE	\$2.08	\$2.33	-\$0.25	-10.7%
	WELL BABY EXAM	\$0.42	\$0.37	\$0.05	13.5%
	DURABLE MEDICAL EQUIPMENT	\$9.21	\$6.00	\$3.21	53.5%
	OTHER	\$19.64	\$17.93	\$1.71	9.5%
Subtotal		\$68.31	\$40.15	\$28.16	70.1%
Grand Total		\$820.72	\$554.32	\$266.40	48.1%

Note: Benchmark data has been age/sex adjusted to correspond to the population included in this exhibit

* Each \$1.00 paid PMPM = \$46,871 in plan costs.

STATE EMPLOYEE TRUST FUNDS
Type of Service Detail - SMP
Incurred January 2008 - December 2008 Paid Through March 2009

TYPE OF SERVICE	DETAIL	ACTUAL	BENCHMARK	DIFFERENCE	
		PMPM	PMPM	\$	%
FACILITY INPATIENT	SURGICAL/MEDICAL	\$6.11	\$99.69	-\$93.58	-93.9%
	PSYCH/AODA	\$0.00	\$2.02	-\$2.02	-100.0%
	MATERNITY	\$3.08	\$2.69	\$0.39	14.5%
	OTHER	\$0.00	\$1.12	-\$1.12	-100.0%
Subtotal		\$9.19	\$105.52	-\$96.33	-91.3%
FACILITY OUTPATIENT	SURGICAL/MEDICAL	\$17.19	\$21.10	-\$3.91	-18.5%
	RADIOLOGY	\$33.22	\$28.56	\$4.66	16.3%
	PATHOLOGY	\$9.20	\$12.72	-\$3.52	-27.7%
	EMERGENCY ROOM	\$2.42	\$3.94	-\$1.52	-38.6%
	PSYCH/AODA	\$0.00	\$1.10	-\$1.10	-100.0%
	OTHER	\$42.03	\$40.91	\$1.12	2.7%
Subtotal		\$104.06	\$108.33	-\$4.27	-3.9%
PHYSICIAN	OFFICE VISIT	\$17.84	\$18.83	-\$0.99	-5.3%
	RADIOLOGY	\$14.97	\$28.04	-\$13.07	-46.6%
	PATHOLOGY	\$12.60	\$18.57	-\$5.97	-32.1%
	SURGERY	\$24.89	\$45.78	-\$20.89	-45.6%
	ANESTHESIA	\$6.19	\$9.95	-\$3.76	-37.8%
	MATERNITY	\$1.67	\$1.27	\$0.40	31.5%
	OTHER	\$25.29	\$27.34	-\$2.05	-7.5%
Subtotal		\$103.45	\$149.78	-\$46.33	-30.9%
DRUGS	PRESCRIPTIONS	\$37.74	\$61.51	-\$23.77	-38.6%
	INJECTABLES	\$42.83	\$11.44	\$31.39	274.4%
Subtotal		\$80.57	\$72.95	\$7.62	10.4%
OTHER SERVICES	PSYCH/AODA	\$1.35	\$5.69	-\$4.34	-76.3%
	CHIROPRACTIC	\$5.14	\$3.31	\$1.83	55.3%
	THERAPIES	\$1.42	\$3.92	-\$2.50	-63.8%
	AMBULANCE	\$0.00	\$2.01	-\$2.01	-100.0%
	WELL BABY EXAM	\$0.59	\$0.63	-\$0.04	-6.3%
	DURABLE MEDICAL EQUIPMENT	\$1.80	\$5.21	-\$3.41	-65.5%
	OTHER	\$10.90	\$16.33	-\$5.43	-33.3%
Subtotal		\$21.20	\$37.10	-\$15.90	-42.9%
Grand Total		\$318.47	\$473.68	-\$155.21	-32.8%

Note: Benchmark data has been age/sex adjusted to correspond to the population included in this exhibit

* Each \$1.00 paid PMPM = \$1,761 in plan costs.

State Employee Trust Funds

Plan Utilization

Inpatient Utilization

The Inpatient Utilization report compares annual inpatient days per 1,000, admits per 1,000, average length of stay, cost per day, cost per admit, and inpatient PMPM cost to the benchmark for the 5 major inpatient service categories. Days/1,000 is the annual average number of hospital days utilized by a population of 1,000 members which is calculated by taking (Total Days/Member Months)*12,000. The Admits/1,000 is the annual number of admits that occur within a typical population of 1,000 members which is calculated by taking (Total Admits/Member Months)*12,000. The Days/1,000 and Admits/1,000 are calculations that allow a comparison of one population to another regardless of group size. Average Length of Stay (ALOS) shows the average length of hospitalization experienced for the entire group (Total Days/Total Admits). Cost per Day is an average of the cost per hospital day (Total Cost/Total Days). The cost per admit is an average of the cost per hospital admission (Total Cost/Total Admits). Lastly the inpatient PMPM is the per member per month cost incurred by the plan. Beyond the numerical comparison, a percentage has been included as observed in the pie charts, including a comparison to the benchmark.

Standard Plan

For the Standard Plan in Exhibit 10-A, the total PMPM inpatient facility costs exceed the benchmark total PMPM by 63.4% for 2008. There are two main reasons for this result. First, the group experienced a higher than expected admission rate. This is especially true of the Surgical and Psych/AODA categories which both had twice the expected admission rate. The second reason is a higher than expected cost per admit. The Standard Plan's population lives in higher cost urban areas such as Madison and Milwaukee so we would expect a slightly higher cost for this reason. Also, surgical admits are more expensive than other types of admissions and since the admission rate for surgical procedures was twice the expected level, the overall cost per admit is skewed higher. Lastly, Psych/AODA services are higher than expected, as the benchmark data generally reflects a lower benefit level.

SMP

No SMP report due to small size of block and lack of credibility.

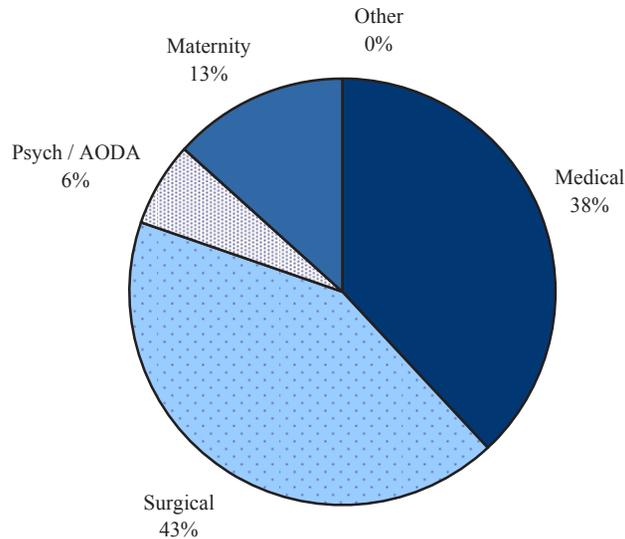
STATE EMPLOYEE TRUST FUNDS
Inpatient Utilization - Standard
Incurred January 2008 - December 2008 Paid Through March 2009

Exhibit 10-A

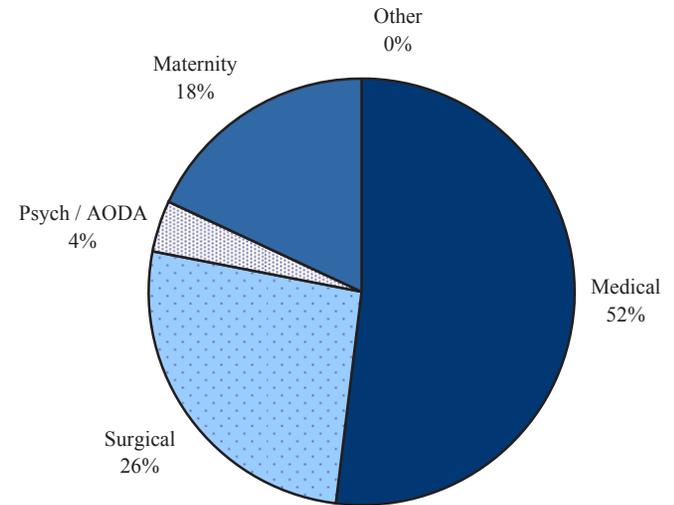
ACTUAL						
	Medical	Surgical	Psych / AODA	Maternity	Other	Total
Days/1000	152	251	38	28	38	507
Admits/1000	37	41	6	13	N/A	97
ALOS	4.08	6.14	6.43	2.20	N/A	5.25
Cost/Day	\$4,191	\$6,428	\$1,829	\$2,717	\$1,095	\$4,811
Cost/Admit	\$17,110	\$39,454	\$11,767	\$5,989	N/A	\$25,254
PMPM	\$52.93	\$134.68	\$5.77	\$6.26	\$3.48	\$203.12
% of Paid	26.06%	66.31%	2.84%	3.08%	1.71%	100.00%

BENCHMARK						
	Medical	Surgical	Psych / AODA	Maternity	Other	Total
Days/1000	182	111	17	34	42	386
Admits/1000	40	20	3	14	N/A	77
ALOS	4.55	5.55	5.67	2.43	N/A	5.01
Cost/Day	\$3,744	\$6,331	\$1,361	\$1,696	\$431	\$3,757
Cost/Admit	\$17,268	\$35,464	\$7,342	\$3,915	N/A	\$21,463
PMPM	\$57.09	\$58.82	\$1.98	\$4.90	\$1.53	\$124.32
% of Paid	45.92%	47.31%	1.59%	3.94%	1.23%	100.00%

% OF ADMITS FOR ACTUAL



% OF ADMITS FOR BENCHMARK



Note: Benchmark data has been age/sex adjusted to correspond to the population included in this exhibit

State Employee Trust Funds

Plan Utilization

Claim Costs by Major Diagnostic Categories (MDC)

The Claim Costs by Major Diagnostic Categories report divides medical claim costs into 25 mutually exclusive diagnostic categories. The diagnoses in each MDC correspond to a single organ system and, in general, are associated with a particular medical specialty. The actual PMPM cost by major diagnostic category is compared to the WPS benchmark PMPM. The Actual PMPM costs show calendar year results, comparing 2007 to 2008, each with three months run-out.

Prior exhibits have shown the **Standard Plan's** costs exceed the benchmark overall. Exhibit 11-A shows this deviation by MDC. Variation from the benchmark can be the result of many different factors. Since the benchmark is not adjusted for plan differences we can attribute some variation to non-standard benefits included in the Standard Plan. One example of this is gastric bypass procedures which contributed \$8.35 PMPM to MDC 10. Without this non standard benefit, MDC 10 would only be slightly above the benchmark. Although we are continuing to see a high incidence of gastric bypass procedures, the number of patients has dropped off significantly in 2008 to 15 patients compared to 25 in 2006 and 27 in 2007. A second instance of non-standard benefit variance is MDC 19 where the outpatient psychiatric benefit is adding over \$10.00 PMPM of additional costs beyond the WI state mandated level of benefits which is the typical plan design of the benchmark PMPM.

Another reason for variances from the benchmark can be the case mix of large claim activity. This is what happened for MDC 1 and MDC 18 where the 51 high cost patients accounted for \$33.89 PMPM in MDC 1 and \$18.03 PMPM in MDC 18. This change in case mix also leads to the large increase in MDC 1 and MDC 18 between 2007 and 2008

For the Standard Plan \$1.00 PMPM in claim costs represented in the chart is equivalent to \$46,871 annual in plan costs.

The **SMP Plan**, shown in Exhibit 11-B, is experiencing lower than expected PMPM Cost overall. Due to the small size of this group, the splitting of claims into numerous categories creates a lot of volatility which can be seen in large positive and negative comparisons. The individual health conditions of each member can affect a single sub-category. Therefore, this graph is for informational purposes only.

For the SMP Plan \$1.00 PMPM in claim cost represented in the charts is equivalent to \$1,761 in annual plan costs.

STATE EMPLOYEE TRUST FUNDS
Claim Costs by Major Diagnostic Categories - Standard
Comparison of 2008 to 2007

Exhibit 11-A

MDC CODE	MAJOR DIAGNOSTIC CATEGORY DESCRIPTION	2007	2008	BENCHMARK PMPM **	DIFFERENCE	
		ACTUAL PMPM *	ACTUAL PMPM **		2008 to 2007	2008 to BENCHMARK
1	Nervous System Diseases and Disorders (D/D)	\$42.90	\$65.54	\$21.82	52.8%	200.3%
2	Eye D/D	\$17.07	\$21.30	\$13.18	24.8%	61.6%
3	Ear, Nose, Mouth and Throat D/D	\$24.30	\$24.94	\$18.11	2.6%	37.7%
4	Respiratory System D/D	\$24.33	\$29.23	\$21.39	20.1%	36.6%
5	Circulatory System D/D	\$66.54	\$63.32	\$60.91	-4.8%	4.0%
6	Digestive System D/D	\$53.10	\$57.62	\$41.49	8.5%	38.9%
7	Liver, Gallbladder, Biliary Ducts and Pancreas D/D	\$13.33	\$7.19	\$16.34	-46.1%	-56.0%
8	Muscles, Bones, and Connective Tissue D/D	\$106.20	\$136.68	\$90.92	28.7%	50.3%
9	Skin, Subcutaneous Tissue (fat and connective) and Breast D/D	\$40.53	\$44.95	\$28.01	10.9%	60.5%
10	Endocrine, Nutritional and Metabolic D/D (included diagnoses related to obesity, diabetes and hormones)	\$34.77	\$26.51	\$16.17	-23.8%	63.9%
11	Kidney and Urinary Tract D/D	\$19.08	\$24.26	\$16.59	27.1%	46.2%
12	Male Reproductive System D/D	\$6.34	\$4.19	\$7.11	-33.9%	-41.0%
13	Female Reproductive System D/D	\$10.78	\$16.17	\$14.12	50.0%	14.5%
14	Pregnancy, Childbirth, and After Delivery Diagnoses	\$5.62	\$11.22	\$8.50	99.6%	32.0%
15	Newborns, and Newborns with Conditions Originating Shortly Before or After Birth	\$1.65	\$1.38	\$1.91	-16.4%	-27.6%
16	Blood and Blood Forming Organ D/D (including spleen) and Immune System Disorders	\$6.42	\$7.51	\$7.11	17.0%	5.7%
17	Bone Marrow D/D and Poorly Differentiated Cancers	\$46.67	\$38.60	\$22.91	-17.3%	68.5%
18	Infectious and Parasitic Diseases	\$3.05	\$19.99	\$5.07	555.4%	294.6%
19	Behavioral Health Diagnoses	\$41.80	\$34.28	\$9.79	-18.0%	250.0%
20	Alcohol/Drug Use and Alcohol/Drug Induced Organic Mental Disorders	\$1.31	\$0.77	\$0.88	-41.2%	-12.7%
21	Injuries, Poisoning and Toxic Effects of Drugs	\$6.55	\$3.83	\$4.35	-41.5%	-11.9%
22	Burns	\$0.09	\$0.06	\$0.06	-33.3%	-2.5%
23	Other Miscellaneous Services Including Health Screenings, Medical Exams and Rehabilitation	\$65.56	\$65.24	\$47.92	-0.5%	36.1%
24	Multiple Significant Trauma	\$0.96	\$2.39	\$1.22	149.0%	95.9%
25	Human Immunodeficiency Virus Infections	\$0.10	\$0.14	\$0.05	40.0%	173.1%
0	Ungroupable	\$2.57	\$2.59	\$3.95	0.8%	-34.4%
Total		\$641.62	\$709.90	\$479.86	10.6%	47.9%

Note: Benchmark data has been age/sex adjusted to correspond to the population included in this exhibit

Note: The MDC descriptions used in last year's report have been modified in an attempt to help readers understand the type of data that is contained in each category

* Each \$1.00 paid PMPM = \$46,800 in plan costs.

** Each \$1.00 paid PMPM = \$46,871 in plan costs.

STATE EMPLOYEE TRUST FUNDS
Claim Costs by Major Diagnostic Categories - SMP
Comparison of 2008 to 2007

Exhibit 11-B

MDC CODE	MAJOR DIAGNOSTIC CATEGORY DESCRIPTION	2007	2008	BENCHMARK PMPM **	DIFFERENCE	
		ACTUAL PMPM *	ACTUAL PMPM **		2008 to 2007	2008 to BENCHMARK
1	Nervous System Diseases and Disorders (D/D)	\$10.52	\$5.02	\$20.14	-52.3%	-75.1%
2	Eye D/D	\$5.09	\$9.30	\$10.59	82.7%	-12.1%
3	Ear, Nose, Mouth and Throat D/D	\$12.51	\$13.73	\$17.74	9.8%	-22.6%
4	Respiratory System D/D	\$11.05	\$1.68	\$17.37	-84.8%	-90.3%
5	Circulatory System D/D	\$34.17	\$25.15	\$54.29	-26.4%	-53.7%
6	Digestive System D/D	\$40.61	\$51.42	\$36.74	26.6%	40.0%
7	Liver, Gallbladder, Biliary Ducts and Pancreas D/D	\$10.76	\$0.12	\$13.61	-98.9%	-99.1%
8	Muscles, Bones, and Connective Tissue D/D	\$78.70	\$52.90	\$77.18	-32.8%	-31.5%
9	Skin, Subcutaneous Tissue (fat and connective) and Breast D/D	\$12.76	\$10.50	\$21.32	-17.7%	-50.8%
10	Endocrine, Nutritional and Metabolic D/D (included diagnoses related to obesity, diabetes and hormones)	\$5.91	\$4.70	\$13.25	-20.5%	-64.5%
11	Kidney and Urinary Tract D/D	\$7.74	\$1.71	\$15.08	-77.9%	-88.7%
12	Male Reproductive System D/D	\$5.94	\$4.46	\$7.21	-24.9%	-38.2%
13	Female Reproductive System D/D	\$6.63	\$17.39	\$10.30	162.3%	68.9%
14	Pregnancy, Childbirth, and After Delivery Diagnoses	\$15.53	\$5.00	\$4.96	-67.8%	0.8%
15	Newborns, and Newborns with Conditions Originating Shortly Before or After Birth	\$7.23	\$0.79	\$2.45	-89.1%	-67.8%
16	Blood and Blood Forming Organ D/D (including spleen) and Immune System Disorders	\$13.68	\$3.06	\$6.19	-77.6%	-50.6%
17	Bone Marrow D/D and Poorly Differentiated Cancers	\$35.18	\$27.52	\$19.14	-21.8%	43.8%
18	Infectious and Parasitic Diseases	\$1.37	\$0.62	\$4.12	-54.7%	-84.9%
19	Behavioral Health Diagnoses	\$6.48	\$1.90	\$9.13	-70.7%	-79.2%
20	Alcohol/Drug Use and Alcohol/Drug Induced Organic Mental Disorders	\$0.91	\$0.00	\$0.97	-100.0%	-100.0%
21	Injuries, Poisoning and Toxic Effects of Drugs	\$2.59	\$0.55	\$4.18	-78.8%	-86.8%
22	Burns	\$0.06	\$0.00	\$0.07	-100.0%	-100.0%
23	Other Miscellaneous Services Including Health Screenings, Medical Exams and Rehabilitation	\$32.61	\$42.47	\$40.70	30.2%	4.4%
24	Multiple Significant Trauma	\$0.00	\$0.00	\$1.57	0.0%	-100.0%
25	Human Immunodeficiency Virus Infections	\$0.00	\$0.00	\$0.05	0.0%	-100.0%
0	Ungroupable	\$0.46	\$0.78	\$3.84	69.6%	-79.7%
Total		\$358.49	\$280.77	\$412.17	-21.7%	-31.9%

Note: Benchmark data has been age/sex adjusted to correspond to the population included in this exhibit

Note: The MDC descriptions used in last year's report have been modified in an attempt to help readers understand the type of data that is contained in each category

* Each \$1.00 paid PMPM = \$6,392 in plan costs.

** Each \$1.00 paid PMPM = \$1,761 in plan costs.

State Employee Trust Funds

Provider Utilization

Top 20 Providers

The Top 20 Provider reports display the top 20 Facility and Professional Providers sorted by total paid charges. Within the facility report, charges have also been broken out by Inpatient and Outpatient paid charges for additional analysis. The Paid % shows the percentage of the group's total facility or professional charges from a specific provider.

Facility

The report for the **Standard Plan** (Exhibit 12-A) shows that the top 20 facilities provided 58.2% of the total facility charges for the plan. By far, the largest percent of claims and number of patients came from the University of Wisconsin hospital. Second was Rochester Methodist Hospital in Rochester, MN and third was Meriter Hospital in Madison. Nearly half of the top 20 facility providers are located in the Dane and Milwaukee County areas where a majority of the Standard Plan population resides. In 2008, the Standard Plan had an increase in the use of out of state providers. This is likely due to members seeking more specialized care and also an increase in the percentage of out of state membership.

The report for the **SMP Plan** (Exhibit 12-B) shows that the top 15 facilities provide 100% of the total facility charges for the plan. The largest percentage of paid claims was from Dickinson County Memorial Hospital in Iron Mountain, MI. The provider with the second highest amount of paid claims was the Memorial Medical Center in Ashland, followed by Burnett Medical Center in Grantsburg.

Professional

The **Standard Plan** (Exhibit 12-C) received 44.7% of professional charges from the top 20 providers. Once again the University of Wisconsin Medical Foundation is the leading professional provider which corresponds to the top facility charges for the plan. Like the facility charges we see half of the providers are from the Dane and Milwaukee Counties regions plus an increase in the utilization of out of state providers.

The **SMP Plan** (Exhibit 12-D) received 80.0% of the paid claims from the top 20 professional providers. SMDC Medical Center in Duluth, MN was the largest provider, receiving 28.7% of the overall payments. Second in line was Minnesota Oncology Hematology in Minneapolis, MN receiving 16.2% in payments although this was due to one member. Like the facility charges, we see a majority of the professional charges are received at regional facilities due to the HMO-type coverage and the limited service area. You can also see some services were received in Minnesota and Michigan since the SMP does have limited coverage in the states surrounding Wisconsin.

STATE EMPLOYEE TRUST FUNDS
Top 20 Facility Providers - Standard
Incurred January 2008 - December 2008 Paid Through March 2009

Exhibit 12-A

	Facility Provider	City	State	# of Unique Patients	Inpatient Paid Claims	Outpatient Paid Claims	Total Paid Claims	Paid %
1	UNIVERSITY WI HSP CL AUTHORITY	MADISON	WI	595	\$1,081,467	\$1,630,130	\$2,711,597	14.7%
2	ROCHESTER METHODIST HOSPITAL	ROCHESTER	MN	38	\$888,466	\$230,691	\$1,119,157	6.1%
3	MERITER HOSPITAL INC	MADISON	WI	141	\$621,215	\$300,042	\$921,257	5.0%
4	COLUMBIA ST MARYS HOSPITAL COL	MILWAUKEE	WI	192	\$292,857	\$409,153	\$702,010	3.8%
5	ST MARYS HOSP MED CTR	MADISON	WI	29	\$401,339	\$63,579	\$464,918	2.5%
6	RIVER FALLS AREA HOSPITAL	RIVER FALLS	WI	65	\$225,333	\$234,875	\$460,208	2.5%
7	AURORA HEALTH CARE METRO	MILWAUKEE	WI	30	\$394,869	\$59,356	\$454,225	2.5%
8	FROEDTERT MEM LUTH HOSP	MILWAUKEE	WI	118	\$128,416	\$304,147	\$432,563	2.3%
9	SACRED HEART HOSP	EAU CLAIRE	WI	19	\$313,961	\$118,137	\$432,098	2.3%
10	ST MARYS HSP-ROCHESTER	ROCHESTER	MN	23	\$250,856	\$136,215	\$387,071	2.1%
11	FAIRVIEW UNIVERSITY MED CTR	MINNEAPOLIS	MN	36	\$223,234	\$137,664	\$360,898	2.0%
12	NORTHWESTERN MEMORIAL HOSPITAL	CHICAGO	IL	19	\$257,363	\$71,585	\$328,948	1.8%
13	MERCY MEDICAL CTR	OSHKOSH	WI	36	\$179,050	\$98,974	\$278,024	1.5%
14	ASPIRUS WAUSAU HOSPITAL INC	WAUSAU	WI	13	\$233,091	\$41,124	\$274,215	1.5%
15	ALL SAINTS ST MARYS MED CTR	RACINE	WI	83	\$104,994	\$160,369	\$265,363	1.4%
16	WAUKESHA MEMORIAL HOSPITAL INC	WAUKESHA	WI	37	\$133,614	\$116,048	\$249,662	1.4%
17	CHILDRENS HOSPITAL OF WISCONSI	MILWAUKEE	WI	40	\$191,673	\$56,242	\$247,915	1.3%
18	LAKELAND MED CTR	ELKHORN	WI	20	\$34,415	\$186,601	\$221,016	1.2%
19	CONDELL MEDICAL CENTER	LIBERTYVILLE	IL	12	\$130,411	\$85,202	\$215,613	1.2%
20	LUTHER HOSPITAL	EAU CLAIRE	WI	35	\$22,761	\$187,483	\$210,244	1.1%
Top 20 Total				1,581	\$6,109,385	\$4,627,617	\$10,737,002	58.2%
All Other Facility Charges				1,539	\$3,411,416	\$4,294,439	\$7,705,856	41.8%
Total Facility Charges				3,120	\$9,520,801	\$8,922,056	\$18,442,858	100.0%

STATE EMPLOYEE TRUST FUNDS
Top 20 Facility Providers - SMP
Incurred January 2008 - December 2008 Paid Through March 2009

Exhibit 12-B

	Facility Provider	City	State	# of Unique Patients	Inpatient Paid Claims	Outpatient Paid Claims	Total Paid Claims	Paid %
1	DICKINSON COUNTY MEMORIAL HOSP	IRON MOUNTAIN	MI	30	\$10,765	\$59,665	\$70,430	35.3%
2	MEMORIAL MED CTR INC	ASHLAND	WI	10	\$0	\$36,680	\$36,680	18.4%
3	BURNETT MEDICAL CENTER INC	GRANTSBURG	WI	15	\$5,428	\$22,491	\$27,919	14.0%
4	ST MARYS MED CTR	DULUTH	MN	4	\$0	\$20,435	\$20,435	10.2%
5	GRAND VIEW HOSP	IRONWOOD	MI	7	\$0	\$11,366	\$11,366	5.7%
6	SMDC MEDICAL CENTER	DULUTH	MN	2	\$0	\$7,276	\$7,276	3.6%
7	MERCY HEALTH CTR	DUBUQUE	IA	1	\$0	\$5,838	\$5,838	2.9%
8	IRON CO COMM HOSPITAL	IRON RIVER	MI	4	\$0	\$5,581	\$5,581	2.8%
9	LAKEVIEW MED CTR	RICE LAKE	WI	1	\$0	\$4,791	\$4,791	2.4%
10	SPOONER HEALTH SYSTEM	SPOONER	WI	1	\$0	\$4,022	\$4,022	2.0%
11	ST MARYS HOSPITAL OF SUPERIOR	SUPERIOR	WI	2	\$0	\$1,619	\$1,619	0.8%
12	AURORA BAYCARE MED CTR	GREEN BAY	WI	1	\$0	\$1,528	\$1,528	0.8%
13	DIVINE SAVIOR HOSP	PORTAGE	WI	1	\$0	\$1,521	\$1,521	0.8%
14	MARQUETTE GENERAL HOSPITAL INC	MARQUETTE	MI	1	\$0	\$285	\$285	0.1%
15	CHILDRENS HOSPITAL ST PAUL	SAINT PAUL	MN	1	\$0	\$162	\$162	0.1%
Top 15 Total				81	\$16,193	\$183,260	\$199,453	100.0%
All Other Facility Charges				0	\$0	\$0	\$0	0.0%
Total Facility Charges				81	\$16,193	\$183,260	\$199,453	100.0%

STATE EMPLOYEE TRUST FUNDS
Top 20 Professional Providers - Standard
Incurred January 2008 - December 2008 Paid Through March 2009

Exhibit 12-C

	Professional Provider	City	State	# of Unique Patients	Total Paid Claims	Paid %
1	UW MEDICAL FOUNDATION	MADISON	WI	792	\$1,692,011	11.4%
2	MAYO CLINIC ROCHESTER	ROCHESTER	MN	111	\$932,032	6.3%
3	DEAN MEDICAL CTR	MADISON	WI	291	\$634,155	4.3%
4	MEDICAL COLLEGE OF WISCONSIN	MILWAUKEE	WI	216	\$488,741	3.3%
5	ONCOLOGY ALLIANCE SC	RACINE	WI	14	\$440,066	3.0%
6	MARSHFIELD CLINIC	MARSHFIELD	WI	87	\$337,401	2.3%
7	MIDELFORT CLINIC MHS	EAU CLAIRE	WI	101	\$300,643	2.0%
8	AURORA ADVANCED HEALTHCARE	MILWAUKEE	WI	163	\$298,926	2.0%
9	COLUMBIA ST MARYS HOSPITAL COL	MILWAUKEE	WI	225	\$297,448	2.0%
10	SEATTLE CANCER TREATMENT	RENTON	WA	1	\$178,115	1.2%
11	AURORA MEDICAL GROUP OSHKOSH	OSHKOSH	WI	173	\$140,011	0.9%
12	WISCONSIN RENAL CARE GRP	MILWAUKEE	WI	1	\$121,924	0.8%
13	NORTHWESTERN MEDICAL FACULTY	CHICAGO	IL	26	\$118,680	0.8%
14	WHEATON FRANCISCAN MEDICAL	MILWAUKEE	WI	127	\$112,976	0.8%
15	AFFINITY MEDICAL GROUP	NEENAH	WI	60	\$100,800	0.7%
16	SMDC MED CTR DULUTH CLINIC	DULUTH	MN	40	\$98,775	0.7%
17	GUNDERSEN CLINIC LTD	LA CROSSE	WI	30	\$86,139	0.6%
18	MINNESOTA ONCOLOGY HEMATOLOGY	MINNEAPOLIS	MN	8	\$85,076	0.6%
19	MADISON PSYCH & PSYCH SVC	MADISON	WI	25	\$83,429	0.6%
20	ARA CRYSTAL LAKE DIALYSIS	CRYSTAL LAKE	IL	1	\$83,289	0.6%
Top 20 Total				2,492	\$6,630,637	44.7%
All Other Professional Charges				10,512	\$8,199,889	55.3%
Total Professional Charges				13,004	\$14,830,526	100.0%

STATE EMPLOYEE TRUST FUNDS
Top 20 Professional Providers - SMP
Incurred January 2008 - December 2008 Paid Through March 2009

Exhibit 12-D

	Professional Provider	City	State	# of Unique Patients	Total Paid Claims	Paid %
1	SMDC MED CTR DULUTH CLINIC	DULUTH	MN	24	\$84,588	28.7%
2	MINNESOTA ONCOLOGY HEMATOLOGY	MINNEAPOLIS	MN	1	\$47,641	16.2%
3	BURNETT MEDICAL CENTER INC	GRANTSBURG	WI	14	\$14,778	5.0%
4	DICKINSON COUNTY MEMORIAL HOSP	IRON MOUNTAIN	MI	27	\$12,108	4.1%
5	BENISHEK CECCONI AND TERRIAN	IRON MOUNTAIN	MI	7	\$9,479	3.2%
6	HENKE & RYAN PC	IRON MOUNTAIN	MI	5	\$7,206	2.4%
7	MARSHFIELD CLINIC	MARSHFIELD	WI	4	\$7,111	2.4%
8	INGALLS FAMILY MEDICINE CLINIC	WEBSTER	WI	9	\$6,835	2.3%
9	NORTHERN LIGHTS CLINIC SC	MARINETTE	WI	2	\$6,510	2.2%
10	RADIOLOGY ASSOC IRON MTN	IRON MOUNTAIN	MI	19	\$6,471	2.2%
11	ST MARYS HOSPITAL INC	RHINELANDER	WI	9	\$5,801	2.0%
12	PEDIATRIC SURGICAL ASSOC	SAINT PAUL	MN	1	\$4,035	1.4%
13	ENT PROF ASSOC SC	ASHLAND	WI	2	\$3,628	1.2%
14	CORAM ALTERNATE SITES SRV INC	MENDOTA HTS	MN	1	\$3,558	1.2%
15	ST CROIX REGIONAL MEDICAL CTR	ST CROIX FLS	WI	3	\$3,068	1.0%
16	NORTHERN MICHIGAN ANESTHESIA	IRON MOUNTAIN	MI	3	\$2,893	1.0%
17	ST LUKES HOSP	DULUTH	MN	3	\$2,769	0.9%
18	RETINA VITREOUS CONSULTANTS OF	MILWAUKEE	WI	1	\$2,721	0.9%
19	RAY CAMERON	IRON MOUNTAIN	MI	4	\$2,443	0.8%
20	GRAND VIEW HOSP	IRONWOOD	MI	3	\$2,428	0.8%
Top 20 Total				142	\$236,071	80.0%
All Other Professional Charges				152	\$58,886	20.0%
Total Professional Charges				294	\$294,957	100.0%

State Employee Trust Funds

Provider Utilization

Out of Network Utilization

The Out of Network Utilization reports (Exhibit 13-A and 13-B) display the top 20 out of network facility providers and top 20 out of network professional providers for the Standard Plan sorted by total paid charges. Within the facility report, charges have been broken out by Inpatient and Outpatient paid charges for additional analysis.

Facility

The **Standard Plan** out of network facility utilization in 2008 was 9.1% of the total facility claims for the plan which is higher than last year's facility utilization number of 6.5%. Of the 9.1% out of network utilization, 5.1% was at Aurora Health Care which was eliminated from the network in 2008. Out of network utilization for all other providers was only 4.1% and thus a decrease from 2007.

Professional

The **Standard Plan** out of network professional utilization was 11.4% of the total professional claims for the plan in 2008, compared to 10.2% in 2007. Of the 11.4% out of network utilization, 1.1% was received at Aurora Health Care which was eliminated from the Standard Plan network in 2008. For all other providers, out of network utilization was 10.3% and similar to 2007.

STATE EMPLOYEE TRUST FUNDS
Facility Out of Network Utilization - Standard
Incurred January 2008 - December 2008 Paid Through March 2009

Exhibit 13-A

	Facility Provider	City	State	# of Unique Patients	Inpatient Paid Claims	Outpatient Paid Claims	Total Paid Claims
1	AURORA HEALTH CARE METRO	MILWAUKEE	WI	27	\$392,605	\$47,335	\$439,940
2	LAKELAND MED CTR	ELKHORN	WI	19	\$34,415	\$172,859	\$207,274
3	AURORA PSYCHIATRIC HOSPITAL	WAUWATOSA	WI	3	\$113,634	\$11,553	\$125,187
4	SELECT SPECIALTY HOSPITAL	MADISON	WI	1	\$97,056	\$0	\$97,056
5	WEST ALLIS MEMORIAL HOSPITAL	WEST ALLIS	WI	10	\$8,059	\$52,484	\$60,543
6	ARA CRYSTAL LAKE DIALYSIS	CRYSTAL LAKE	IL	1	\$0	\$51,376	\$51,376
7	AURORA BEHAVIORAL HEALTH CENTE	MILWAUKEE	WI	14	\$24,653	\$24,489	\$49,142
8	SELECT SPECIALTY HOSPITAL	WEST ALLIS	WI	1	\$38,670	\$0	\$38,670
9	LAKEVIEW SPECIALTY HOSPITAL	WATERFORD	WI	1	\$27,034	\$0	\$27,034
10	FOOT & ANKLE SURG CTR LTD	DES PLAINES	IL	2	\$0	\$22,686	\$22,686
11	YALE NEW HAVEN HOSPITAL	NEW HAVEN	CT	1	\$21,265	\$0	\$21,265
12	SE WISCONSIN SURGICAL SUITES S	KENOSHA	WI	2	\$0	\$20,476	\$20,476
13	WISCONSIN RENAL CARE GRP	MILWAUKEE	WI	1	\$0	\$19,960	\$19,960
14	AURORA MEDICAL CENTER OSHKOSH	OSHKOSH	WI	13	\$0	\$19,773	\$19,773
15	AURORA SHEBOYGAN MED CTR	SHEBOYGAN	WI	1	\$0	\$16,172	\$16,172
16	MILWAUKEE COUNTY BEHAVIORAL HE	MILWAUKEE	WI	2	\$13,913	\$918	\$14,831
17	BETHANY HOSPITAL	CHICAGO	IL	2	\$0	\$14,624	\$14,624
18	900 NORTH MICHIGAN SURG CTR	CHICAGO	IL	1	\$0	\$13,196	\$13,196
19	CAMPBELL CO MEM HOSP	GILLETTE	WY	1	\$0	\$12,860	\$12,860
20	NATIONWIDE CHILDRENS HOSPITAL	COLUMBUS	OH	2	\$5,482	\$5,928	\$11,410
TOTAL				105	\$776,786	\$506,689	\$1,283,474

STATE EMPLOYEE TRUST FUNDS
Professional Out of Network Utilization - Standard
Incurred January 2008 - December 2008 Paid Through March 2009

Exhibit 13-B

	Professional Provider	City	State	# of Unique Patients	Total Paid Claims
1	AURORA HEALTH CENTER	SHEBOYGAN	WI	173	\$128,565
2	WISCONSIN RENAL CARE GRP	MILWAUKEE	WI	1	\$119,227
3	MADISON PSYCH & PSYCH SVC	MADISON	WI	25	\$83,429
4	ARA CRYSTAL LAKE DIALYSIS	CRYSTAL LAKE	IL	1	\$83,289
5	THOMAS MILHORAT	MANHASSET	NY	1	\$82,388
6	NEUROSURGICAL ASSOCIATES OF SW	NORWALK	CT	1	\$34,349
7	WOMENS PSYCHIATRIC CENTER OF W	MADISON	WI	7	\$30,222
8	WISCONSIN PSYCHOTHERAPY & HE	MADISON	WI	4	\$29,925
9	GREAT LAKES NEUROSURGICAL	MILWAUKEE	WI	1	\$23,531
10	NORTHWESTERN MEDICAL FACULTY	CHICAGO	IL	7	\$19,748
11	NEWPORT PROFESSIONALS LTD	MEQUON	WI	7	\$16,969
12	PAOLO BOLOGNESE MD	GREAT NECK	NY	1	\$16,608
13	RIVERHILL PSYCHIATRIC ASSOCIAT	MANITOWOC	WI	3	\$16,542
14	MANKATO CLINIC LTD	MANKATO	MN	1	\$13,177
15	ASPEN MEDICAL GRP	SAINT PAUL	MN	14	\$11,654
16	MARCI M GITTLEMAN PHD	MADISON	WI	3	\$11,610
17	ROBERT A GRUENBERT PSYD	GLENDALE	WI	4	\$10,878
18	SILVER SPRING PSYCHIATRIC ASSO	MILWAUKEE	WI	6	\$10,742
19	JOHN S ROGERSON MD SC	MADISON	WI	4	\$10,357
20	S S B M F C	SANTA BARBARA	CA	3	\$10,254
TOTAL				267	\$763,462

State Employee Trust Funds

Large Claims

High Cost Patients

The High Cost Patients report in Exhibit 14-A lists the plan members with claims over \$100,000 for claims incurred January 2008 – December 2008 and paid through March 2009 for the Standard, SMP and Medicare Plus \$1M Plans. The Primary Condition is the condition associated with the largest percentage of claim payments and therefore may not be representative of a patient's complete condition. The Care Management section shows the type of care management provided on each case. For a detailed description of care management processes please reference the Care Management Description on the next page.

In general, cancer diagnoses accounted for 35.8% of the high dollar cases and 40.3% of the total high dollar claims. All Standard and SMP Plan members received a form of intensive care management. Some members did not receive typical case management services as their condition did not warrant intensive care following their inpatient stay.

The **Standard Plan** has 51 members with claims over \$100,000 for a total of \$10,621,101 in claim costs which is up 15 members from 2007. Of these 51 members, 35 are employees, 14 are spouses, and 2 are dependents. Another way to break down these members is that 37 are regular members, 9 are annuitants, and 5 are graduate assistants. 41 of the members reside in state and 10 are out of state. These 51 members represent 27.6% of total claims paid under the Standard Plan. The expected percent of claims over \$100,000 for a group of this size is 7.0%, whereas for the Standard Plan, they have 14.4% of claims over \$100,000. Therefore, large claim activity is much higher than expected.

The **SMP Plan** did not have any members who exceeded \$100,000 in paid claims in 2008.

The **Medicare Plus \$1M Plan** has 2 members with claims over \$100,000 for a total \$250,425 in claim costs for 2008. These 2 members reside in WI. Both members incurred significant pharmaceutical costs that were not covered by Medicare. One individual had 98.9% of their costs from prescription drugs received through Navitus while the other individual had 27.6% of their costs in prescription drugs and 68.4% of their costs in injectible drugs.

State Employee Trust Funds

Large Claims

Care Management Descriptions

The following is a brief description of the care management categories used in the High Cost Patient report.

Utilization Management helps ensure members achieve proper utilization of services, while maximizing their health care benefits, as well as determining the most appropriate level of care. Care Management nurses monitor patient care through preadmission or precertification review, inpatient admission and concurrent review, discharge planning with referrals to Case or Chronic Condition (Disease) Management nurses, and outpatient services review.

Outpatient Preauthorization is a review of specific outpatient services, including surgical services, diagnostic services, and referrals, and a determination that these services meet the criteria for medical necessity under the member's benefit plan.

Medical Review is an additional process in the Medical Affairs area that does post-claim review to ensure that those services that received prior approval are billed appropriately, and/or that services billed are covered by the member's plan, and are medically necessary.

Case Management is assessing, planning and facilitating services for members involved in an acute or catastrophic medical situation. The Case Manager focuses on managing the utilization of benefits, within the confines of the policy, in the most effective manner; ensuring quality of care is not compromised. Examples of Case Management are inpatient rehabilitation cases, long term inpatient cases, or short term home care cases that require skilled nursing visits and/or intravenous (IV) therapy. All of these cases are closely managed by the case managers.

Chronic Condition (Disease) Management utilizes a proactive approach through education, treatment and appropriate care to prevent long-term and unnecessary complications of chronic disease. Through education, the Chronic Condition Manager empowers members to take ownership of their health, decreasing future health risks, minimizing the need for medical services, and ultimately improving the quality of life.

Behavioral Health Management provides both inpatient as well as outpatient reviews which are performed by individuals specifically licensed in the behavioral health field. All managed care services, including utilization management, case management, chronic condition (disease) management, and outpatient preauthorization, are performed by this team.

STATE EMPLOYEE TRUST FUNDS
High Cost Patients (over \$100,000)
Incurred January 2008 - December 2008 Paid Through March 2009

Exhibit 14-A

	Patient Status	Plan	Care Management	Primary Condition	Total Paid
1	CANCELLED	STANDARD	UM, CM	MYELOID LEUKEMIA	\$825,333
2	CANCELLED	STANDARD	Preauth, UM, CM	OCCLUSION OF CEREBRAL ART	\$573,164
3	CANCELLED	STANDARD	Preauth, UM, CM	SEPTICEMIA	\$424,415
4	CANCELLED	STANDARD	UM, CM	MYELOID LEUKEMIA	\$367,048
5	CANCELLED	STANDARD	Preauth, UM, CM	OCCLUSION OF CEREBRAL ART	\$337,066
6	ACTIVE	STANDARD	Preauth, UM, CM	DIS OF MUSCLE/LIG/FASCIA	\$307,437
7	ACTIVE	STANDARD	UM	MALIGNANT NEOPLASM BRAIN	\$300,746
8	CANCELLED	STANDARD	Preauth, UM, CM	COMPL PECULIAR TO CERTAIN	\$300,480
9	ACTIVE	STANDARD	CM	MALIG NEO FEMALE BREAST	\$291,794
10	ACTIVE	STANDARD	Preauth, UM, CM	OTH CELLULITIS AND ABSCES	\$285,711
11	ACTIVE	STANDARD	UM, CM	MYELOID LEUKEMIA	\$276,884
12	ACTIVE	STANDARD	Preauth, UM, CM	SPONDYLOSIS AND ALLIED DI	\$274,046
13	ACTIVE	STANDARD	Preauth, UM, CM	CHRONIC RENAL FAILURE	\$268,442
14	ACTIVE	STANDARD	UM, CM	SEPTICEMIA	\$263,439
15	ACTIVE	STANDARD	UM, CM	UNSPECIFIED NEOPLASM	\$253,856
16	ACTIVE	STANDARD	UM	OTHER BRAIN CONDITIONS	\$242,587
17	ACTIVE	STANDARD	UM, CM	CHRONIC RENAL FAILURE	\$241,513
18	CANCELLED	STANDARD	Preauth, CM	MALIG NEO FEMALE BREAST	\$239,029
19	ACTIVE	STANDARD	Preauth, UM, CM	HODGKIN'S DISEASE	\$237,772
20	CANCELLED	STANDARD	UM, CM	MALIGNANT NEOPLASM COLON	\$230,427
21	ACTIVE	STANDARD	UM, DM	OTH DISEASE OF ENDOCARDIU	\$192,364
22	ACTIVE	STANDARD	Preauth, UM, CM	OTH CONGENITAL ANOMALIES	\$191,846
23	ACTIVE	STANDARD	UM, CM	POLYARTERITIS NODOSA & AL	\$182,957
24	ACTIVE	STANDARD	UM, CM	HERPES ZOSTER	\$181,155
25	ACTIVE	STANDARD	Preauth, UM, CM	LYMPHOID LEUKEMIA	\$178,542
26	ACTIVE	STANDARD	UM, CM	FRACTURE OF PELVIS	\$168,929
27	ACTIVE	STANDARD	CM in 2009	ENCOUNTR PROC/AFTRCR NEC	\$161,530
28	ACTIVE	STANDARD	UM	OTH ANEURYSM	\$158,720
29	CANCELLED	STANDARD	UM, CM	OTH MAL NEO LYMPH/HISTIO	\$155,207
30	ACTIVE	STANDARD	Preauth, UM, BH, CM	OTH DISORDERS OF BREAST	\$149,000
31	ACTIVE	MEDICARE PLUS ONE MILLION	Medicare Prime	OTH NONINF GASTROENTERIT	\$140,218
32	ACTIVE	STANDARD	CM	MALIGNANT NEO STOMACH	\$138,166

Preauth = Outpatient Preauthorization UM = Utilization Management CM = Case Management DM = Chronic Care (Disease) Management BH = Behavioral Health Management

STATE EMPLOYEE TRUST FUNDS
High Cost Patients (over \$100,000)
Incurred January 2008 - December 2008 Paid Through March 2009

Exhibit 14-A

	Patient Status	Plan	Care Management	Primary Condition	Total Paid
33	ACTIVE	STANDARD	UM, CM	OTH CEREBRAL DEGENERATION	\$130,539
34	ACTIVE	STANDARD	Preauth, UM, CM	COMPL PECULIAR TO CERTAIN	\$126,165
35	CANCELLED	STANDARD	CM	MALIGNANT NEOPLASM COLON	\$126,050
36	ACTIVE	STANDARD	UM, CM	BENIGN NEO NERVOUS SYST	\$123,036
37	ACTIVE	STANDARD	UM, CM	ABNORMALITY PELVIC ORGANS	\$113,493
38	ACTIVE	STANDARD	UM, CM	TIBIA & FIBULA FRACTURE	\$112,836
39	ACTIVE	STANDARD	UM, CM	OTH CONGENITAL ANOMALIES	\$112,543
40	ACTIVE	MEDICARE PLUS ONE MILLION	DM declined	CHRONIC PULMONARY HEART D	\$110,207
41	ACTIVE	STANDARD	UM, CM	OTH MAL NEO LYMPH/HISTIO	\$109,694
42	ACTIVE	STANDARD	Preauth, UM, CM	OSTEOARTHRISIS AND ALLIED	\$109,067
43	ACTIVE	STANDARD	Preauth, UM, CM	OSTEOARTHRISIS AND ALLIED	\$108,888
44	ACTIVE	STANDARD	Preauth, UM, CM	BRONCHIECTASIS	\$108,380
45	ACTIVE	STANDARD	Preauth, BH, CM	MALIG NEOPL UTERUS BODY	\$107,749
46	ACTIVE	STANDARD	CM	MALIG NEO FEMALE BREAST	\$106,563
47	ACTIVE	STANDARD	UM, DM	OTH FORMS CHRONIC ISCHEMI	\$105,534
48	ACTIVE	STANDARD	Preauth, UM, CM	ULCERATIVE COLITIS	\$104,653
49	ACTIVE	STANDARD	Preauth, UM	AORTIC ANEURYSM	\$104,604
50	ACTIVE	STANDARD	BH, CM	NEUROTIC DISORDERS	\$103,942
51	ACTIVE	STANDARD	UM, CM	OTH FORMS CHRONIC ISCHEMI	\$103,675
52	ACTIVE	STANDARD	UM, DM	OSTEOARTHRISIS AND ALLIED	\$103,496
53	ACTIVE	STANDARD	UM, CM	PERITONITIS	\$100,591
Total					\$10,871,526

Preauth = Outpatient Preauthorization UM = Utilization Management CM = Case Management DM = Chronic Care (Disease) Management BH = Behavioral Health Management

Note: Total paid includes medical and drug data

State Employee Trust Funds

Member Cost Share

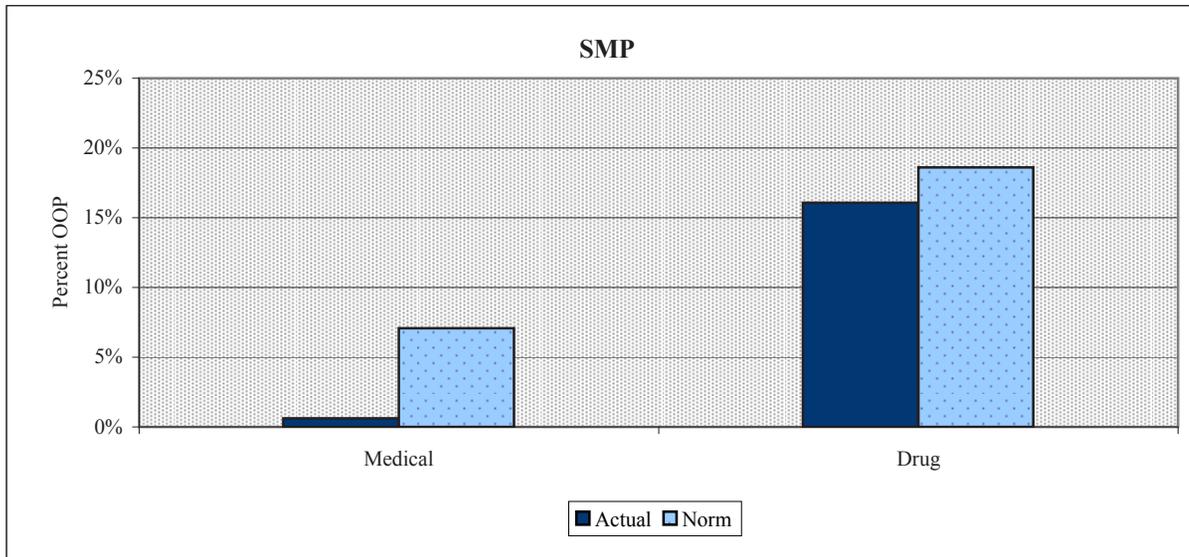
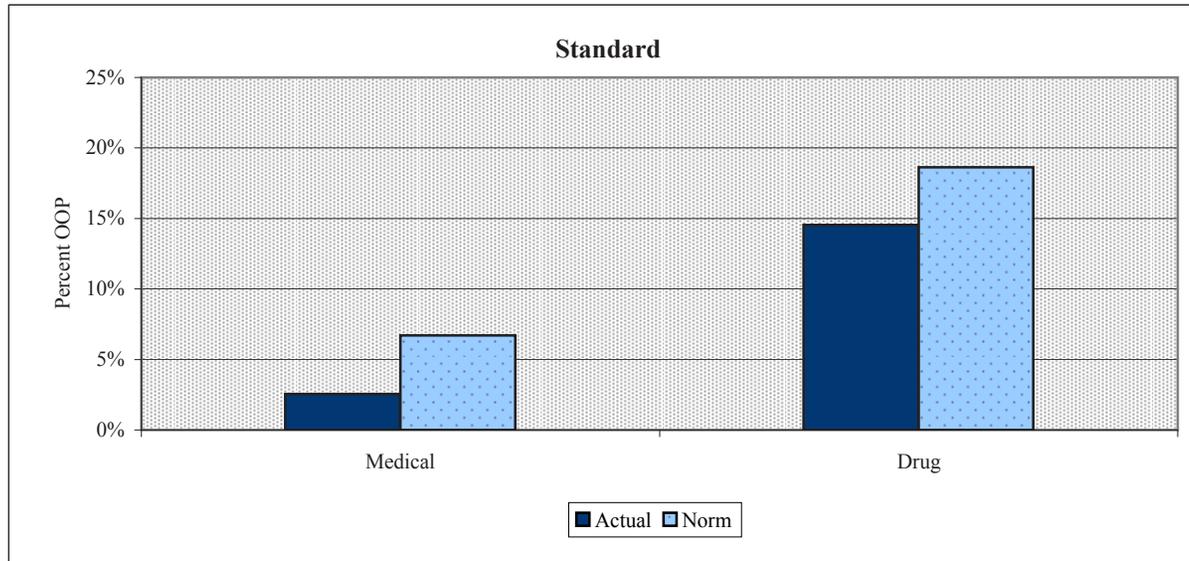
Medical and Drug Cost Sharing

The Medical and Drug Cost Sharing graphs in Exhibit 15-A show the percent of eligible medical and drug claim costs paid by the member. This percentage is compared to the WPS benchmark.

The **Standard Plan** members pay about 2.6% of their own medical claims as compared to the benchmark of 6.7%. The prescription drug cost share is slightly closer to our normative benchmark with the Standard Plan around 14.5% and the benchmark at 18.6%.

The **SMP Plan** members by comparison pay almost nothing towards their own medical claims (in the form of cost sharing), unlike the members of most large groups who pay an average of about 7.0% of their medical claims. The SMP cost share for prescription drugs is just over 16% compared to the benchmark of 18.6%. Even though the Standard and SMP Plans have the same prescription drug benefit, they have slightly different drug utilization profiles, which is the result of each plan's unique blend of treated conditions.

STATE EMPLOYEE TRUST FUNDS
Medical and Drug Cost Sharing
Incurred January 2008 - December 2008 Paid Through March 2009



Note: Benchmark data has been age/sex adjusted to correspond to the population included in this exhibit

State Employee Trust Funds

Member Cost Share

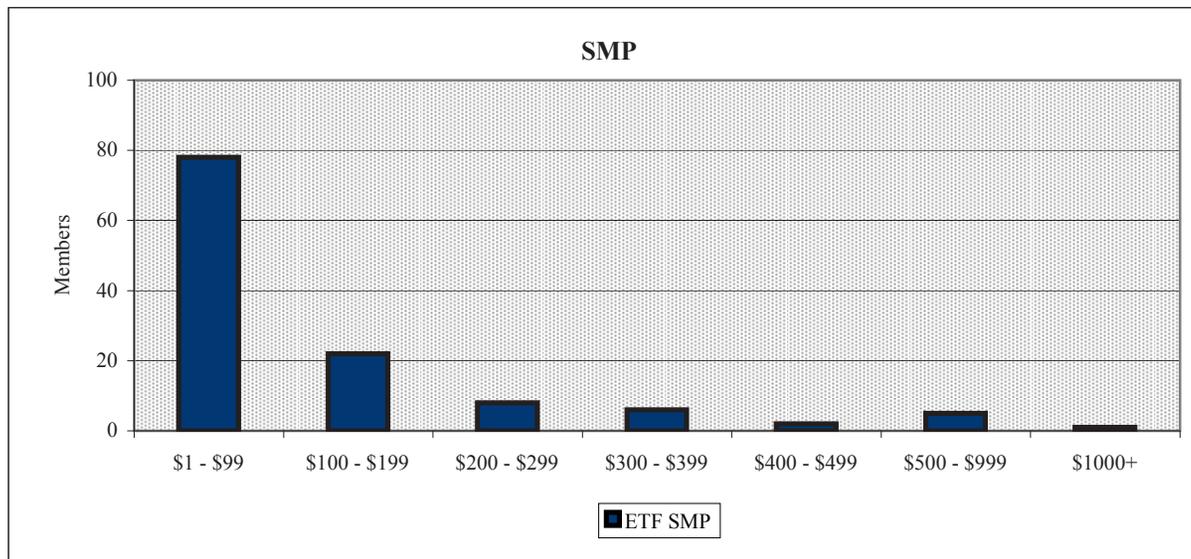
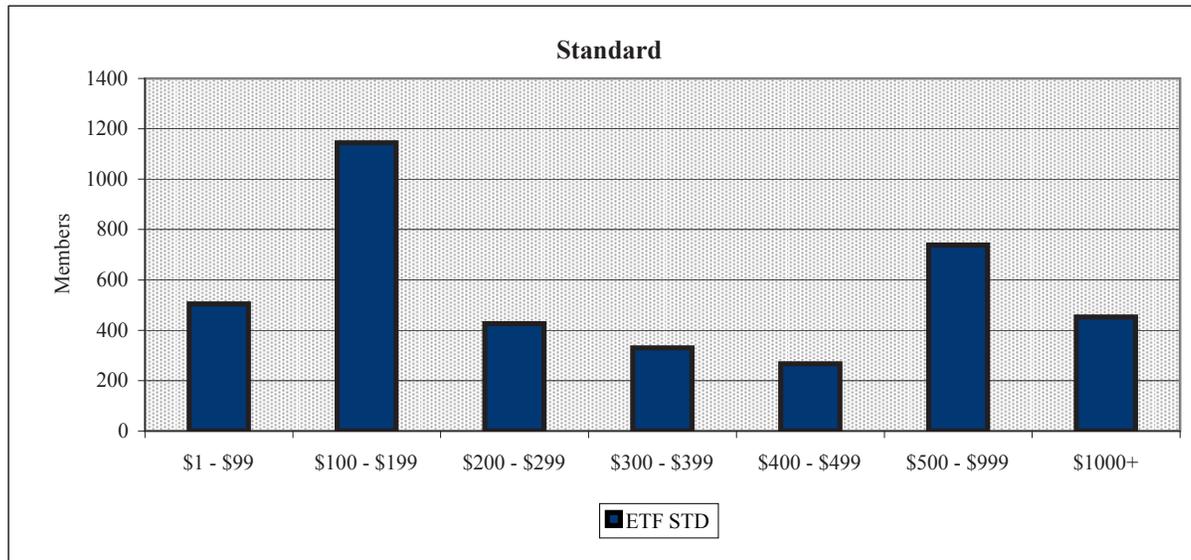
Medical and Drug Out of Pocket by Member

The Medical and Drug Out of Pocket by Member bar graph shown in Exhibit 16-A divides members with out of pocket cost sharing into categories based on the annual amount of out of pocket costs they paid in 2008. The annual out of pocket for each member includes medical and prescription drug costs.

The **Standard Plan** has a large disparity between the members as far as out of pocket costs. A good portion of members pay between \$100 and \$200 out of pocket annually. There are also around 750 members in the \$500 to \$999 range but it is important to note the range for this category is larger than the previous categories. Lastly, there are over 400 members who pay over \$1,000 out of pocket annually.

The **SMP Plan** by comparison has a large number of all members paying between \$1 and \$99 in cost sharing. Most of the cost sharing comes from prescription drug copays.

STATE EMPLOYEE TRUST FUNDS
Medical and Drug Out of Pocket by Member
Incurred January 2008 - December 2008 Paid Through March 2009



State Employee Trust Funds

Medical Claims Cost Savings

Medical Claim Savings Analysis

The Medical Claim Saving Analysis in Exhibit 17-A takes the charges submitted on behalf of the ETF members and details the savings that take place before the final payments are made to the providers. The submitted charges represent medical claims only. The charges are split between the Standard, SMP and Medicare Plus \$1M Plans for claims incurred January 2008 through December 2008 and paid through the end of March 2009. Exhibit 17-B provides a summary of the savings by plan along with a pie chart that provides the percentage of savings in each category combining all plans.

For the **Standard Plan**, WPS paid 63.6% of submitted charges on behalf of the plan. Of the 36.4% savings, 18.6% came from pricing cutbacks from the network providers. Another 11.9% of savings was received from the rejection of duplicate charges or charges that were not eligible. Another 3.4% of savings was received by rejection of non-covered services. The Standard Plan also had 1.7% of charges paid by the members with deductibles, coinsurance and copays. The savings due to third party liability is small at this time but these types of recoveries can be long term and may take several years to be completed.

For the **SMP Plan**, WPS paid 72.2% of submitted charges on behalf of the plan. Of the 27.8% savings, 16.9% was saved on claims rejected for duplicate submission, non-eligible claims, and services not covered by the plan. Another 9.2% was received from pricing cutbacks from network providers. In comparison to the Standard Plan, the SMP Plan members contributed only 0.4% in out-of-pocket costs. The SMP Plan does have some out-of-pocket costs in the form of ER Copays and coinsurance on DME and Outpatient Psychiatric Visits. The total seen in the copayment segment is not just ER copays but also encompasses coinsurance amounts that do not apply to the annual out-of-pocket maximum for a member.

For the **Medicare Plus \$1M Plan**, WPS paid 6.3% of submitted charges on behalf of the plan. Payments made by Medicare have an overwhelming impact on savings by accounting for 77.0% of the submitted charges. The second highest savings, 15.3%, came from the rejection of duplicate or non-eligible charges.

As seen in the pie chart in Exhibit 17-B, the total payments made by WPS for all plan types in 2008 was 16.2% of submitted charges. With the Medicare population's impact, 64.1% of the savings was provided by Medicare, followed by 14.8% in rejections for duplicates and non-eligible services and 3.2% in pricing cutback.

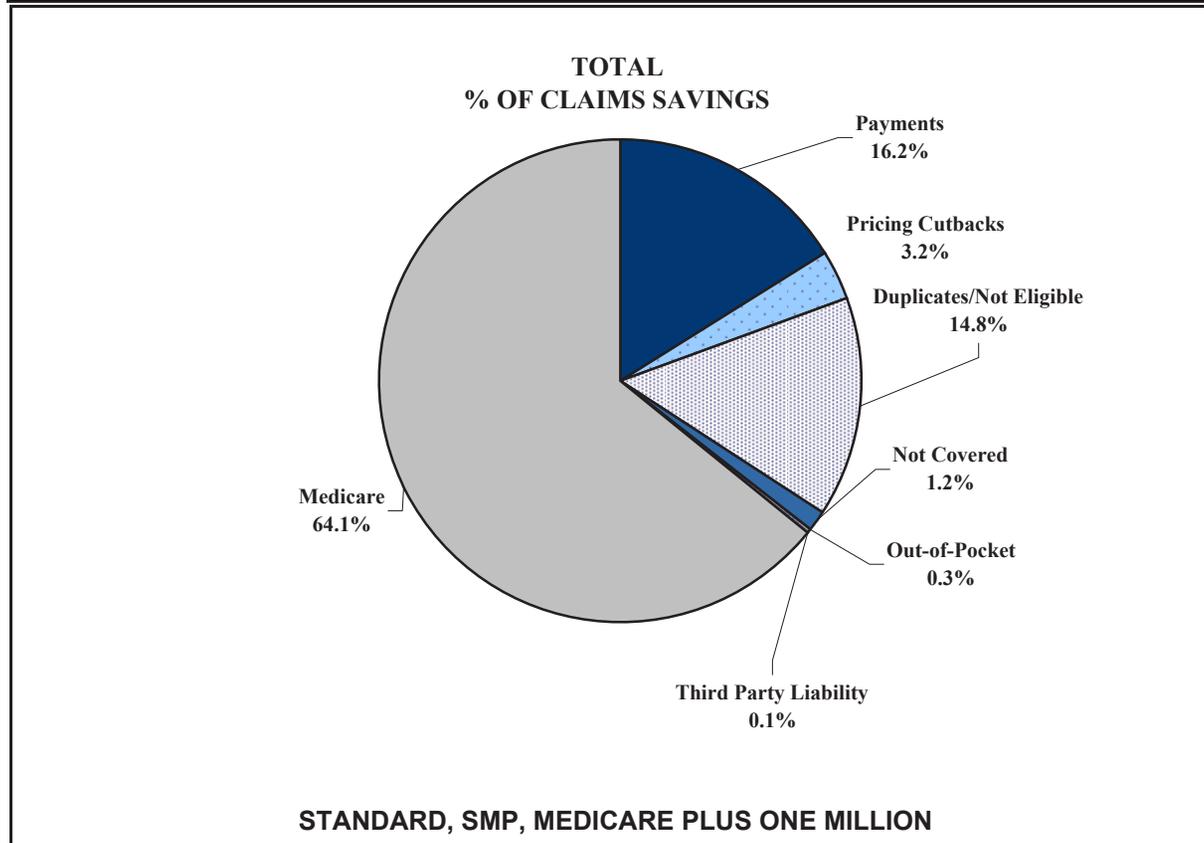
STATE EMPLOYEE TRUST FUNDS
Medical Claims Savings Analysis
Incurred January 2008 - December 2008 Paid Through March 2009

Exhibit 17-A

Category	STANDARD		SMP		MEDICARE PLUS ONE MILLION	
	\$ Amount	% of Total	\$ Amount	% of Total	\$ Amount	% of Total
Submitted Charges	\$52,347,024	100.0%	\$684,563	100.0%	\$255,665,678	100.0%
Duplicates/Not Eligible	\$6,232,685	11.9%	\$45,036	6.6%	\$39,185,974	15.3%
Pricing Cutbacks	\$9,735,235	18.6%	\$62,912	9.2%		
Out-of-Pocket						
Deductible	\$562,121	1.1%	\$0	0.0%	\$0	0.0%
Coinsurance	\$305,026	0.6%	\$308	0.0%	\$68,033	0.0%
Copayments	\$600	0.0%	\$2,751	0.4%	\$0	0.0%
Total	\$867,747	1.7%	\$3,059	0.4%	\$68,033	0.0%
Not Covered						
Medical Necessity	\$365,213	0.7%	\$1,096	0.2%	\$48,535	0.0%
Inappropriate Provider	\$50,010	0.1%	\$0	0.0%	\$19,720	0.0%
Benefit Maximum	\$84,480	0.2%	\$168	0.0%	\$247,394	0.1%
Experimental/Fertility	\$78,705	0.2%	\$0	0.0%	\$15,810	0.0%
Dental	\$31,348	0.1%	\$0	0.0%	\$22,555	0.0%
Custodial	\$1,957	0.0%	\$0	0.0%	\$178,915	0.1%
Code Review	\$756,961	1.4%	\$14,664	2.1%	\$67,167	0.0%
Contact Lens/Hearing Aid	\$11,150	0.0%	\$592	0.1%	\$101,372	0.0%
Drugs	\$0	0.0%	\$0	0.0%	\$270,996	0.1%
No Referral	\$0	0.0%	\$0	0.0%	\$0	0.0%
All Other	\$399,622	0.8%	\$54,190	7.9%	\$912,896	0.4%
Total	\$1,779,446	3.4%	\$70,710	10.3%	\$1,885,359	0.7%
Third Party Liability						
Workers Compensation	\$146,579	0.3%	\$2,454	0.4%	\$863	0.0%
Subrogation	\$9,958	0.0%	\$0	0.0%	\$10,893	0.0%
Coordination of Benefits	\$177,183	0.3%	\$3,639	0.5%	\$0	0.0%
Total	\$333,720	0.6%	\$6,093	0.9%	\$11,756	0.0%
Medicare	\$127,705	0.2%	\$2,345	0.3%	\$196,761,757	77.0%
Payments	\$33,273,739	63.6%	\$494,408	72.2%	\$16,061,502	6.3%

STATE EMPLOYEE TRUST FUNDS
Medical Claims Savings Analysis Summary
 Incurred January 2008 - December 2008 Paid Through March 2009

	STANDARD		SMP		MEDICARE PLUS ONE MILLION	
	\$ Amount	% of Total	\$ Amount	% of Total	\$ Amount	% of Total
Payments	\$33,273,739	63.6%	\$494,408	72.2%	\$16,061,502	6.3%
Pricing Cutbacks	\$9,735,235	18.6%	\$62,912	9.2%		
Duplicates/Not Eligible	\$6,232,685	11.9%	\$45,036	6.6%	\$39,185,974	15.3%
Not Covered	\$1,779,446	3.4%	\$70,710	10.3%	\$1,885,359	0.7%
Out-of-Pocket	\$867,747	1.7%	\$3,059	0.4%	\$68,033	0.0%
Third Party Liability	\$333,720	0.6%	\$6,093	0.9%	\$11,756	0.0%
Medicare	\$127,705	0.2%	\$2,345	0.3%	\$196,761,757	77.0%





State of Wisconsin

Section 2: Wisconsin Public Employers

Insuring **Wisconsin's** Health *Since 1946*

Wisconsin Public Employers

Executive Summary

Member / Demographic Data

Total enrollment was 397 members as of January 2009, down 8 from the 405 members in the plan in December 2008. Overall, membership remained quite stable however the Standard Plan lost 20 members, SMP gained 7 members and the Medicare Carve-out Plan gained 5 members.

The **Standard Plan** membership is much older than the normative distribution with 67.4% of membership over the age of 50 compared to the benchmark of 25.8%. 79.1% of the Standard Plan participants live within Wisconsin.

The age of the **SMP Plan** members is slightly older than the benchmark with a higher than expected membership between the ages of 40 – 59 with 50% of the membership compared to the benchmark of 35.2%. The SMP Plan membership is entirely within Wisconsin and in the more rural areas with a majority of the population in the northern fringe of Wisconsin. For the SMP Plan all of the membership is within Marinette and Pepin Counties.

Wisconsin Public Employers

Executive Summary

Claims Data

Standard Plan

The Standard Plan has seen a 29.3% increase in medical claim costs between 2007 and 2008. The Standard Plan was 18.3% above the benchmark in 2008. The small population of the Standard Plan results in large variances in claim costs from year to year which happened to be worse than expected in 2008.

The Standard Plan had two members exceed \$100,000 in claim costs. The Standard Plan members pay 4.6% of their own medical claims as compared to the benchmark of 6.2%.

WPS paid 77.4% of submitted charges on behalf of the plan.

SMP Plan

For the SMP Plan, the year over year medical PMPM trend was 6.7%. The SMP Plan was 0.4% above the benchmark in 2008. The small population of the SMP Plan results in large variances in claim cost from year to year.

The SMP Plan did not have any members exceed \$100,000 in claim costs. The SMP Plan members pay 0.9% towards their own medical claims (in the form of cost sharing), unlike the members of most large groups who pay an average of about 7.8% of their medical claims.

WPS paid 83.1% of submitted charges on behalf of the plan.

Medicare Carve-out Plan

The Medicare Carve-out Plan has seen stable results over the last 2 years. The year over year medical PMPM trend from 2007 to 2008 was 6.8%.

WPS paid 6.1% of submitted charges on behalf of the plan. 75.2% of the charges were paid by Medicare.

Wisconsin Public Employers

Executive Summary

Provider Data

For the **Standard Plan**, the top 20 facilities provide 94.3% of the total facility charges for the plan. 60.2% of professional charges are from the top 20 providers. Aurora Health Care in Milwaukee was the top facility provider and Orthopedic Surgeons of WI in Milwaukee was the top professional provider.

For the **SMP Plan**, the top 7 facilities provide 100.0% of the total facility charges for the plan. 87.7% of the paid claims are from the top 20 professional providers. Dickinson County Memorial Hospital in Iron Mountain, Michigan was the largest provider of Facility and Professional services.

Wisconsin Public Employers

Executive Summary

Benchmarks

The benchmarks used in this report are derived from the experience of WPS large group and self funded business. In general, these groups are a combination of private and public employers, ranging in size from 51 employees to 5,000. All groups have their primary location and the majority of their population in Wisconsin. Only groups with a full year of experience with WPS were included to avoid any biases resulting from seasonality.

Demographic benchmarks are based on calendar year 2008 data. For Medicare classes, demographic benchmarks are based on comparable WPS Medicare enrollment as appropriate.

Claim cost benchmarks are also based on calendar year 2008 data. To make the claim benchmarks more meaningful, they have been adjusted for demographic differences between the specific population profiled in each report and the population in the WPS benchmark. For example, an older population may be expected to have higher prescription drug costs but lower maternity costs. Unless otherwise specified, each claim based benchmark has had such an adjustment made, including not only PMPM costs but days/1,000 and cost/day. The factors that go into each adjustment are unique to the particular claim-based statistic. Claim benchmarks are not adjusted, however, for plan benefit differences between the average represented in the WPS benchmark and the specific reported ETF class.

Wisconsin Public Employers

Group Demographics

Monthly Membership

The Monthly Membership report (Exhibit 1-B) shows monthly membership and incurred claims for the Standard, SMP and Medicare Carve-out Plans from January 2007 through January 2009.

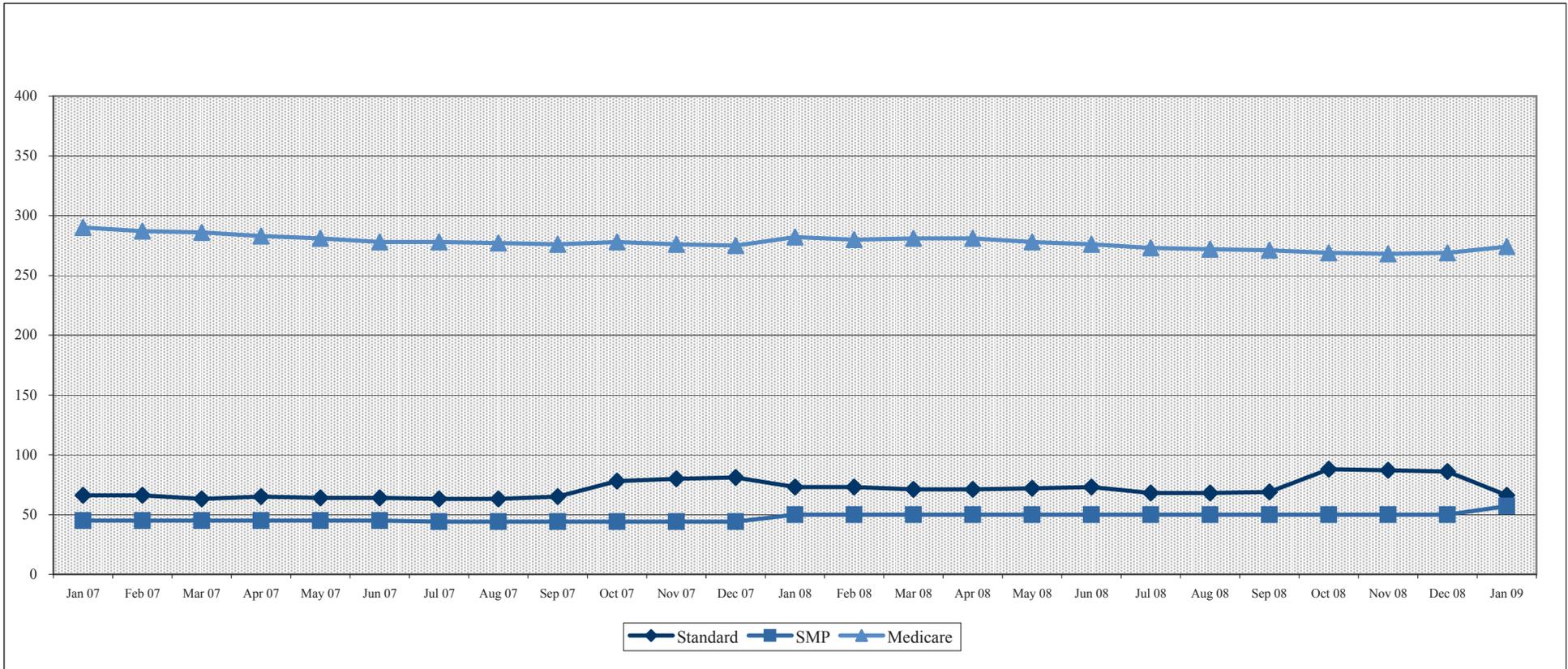
Enrollment on the **Standard Plan** averaged 68 members per month in 2007 and increased to an average of 75 in 2008. The membership over the course of the year remained fairly stable with increases beginning in October of each year.

SMP Plan enrollment averaged 45 members per month in 2007 and increased to an average of 50 per month in 2008. The membership remained very stable within each year with no seasonal fluctuation

The **Medicare Carve-out Plan** enrollment averaged 280 members per month in 2007 and decreased to 275 members per month in 2008. The membership declined gradually over the course of the two years, beginning with 290 members in January 2007 and ending at 269 in December of 2008, a 7% reduction in membership during the 2 years.

**WISCONSIN PUBLIC EMPLOYERS
Monthly Membership
January 2007 through January 2009**

Exhibit 1-B



EFFECTIVE MONTH																										
	Jan 07	Feb 07	Mar 07	Apr 07	May 07	Jun 07	Jul 07	Aug 07	Sep 07	Oct 07	Nov 07	Dec 07	Jan 08	Feb 08	Mar 08	Apr 08	May 08	Jun 08	Jul 08	Aug 08	Sep 08	Oct 08	Nov 08	Dec 08	Jan 09	
Standard	66	66	63	65	64	64	63	63	65	78	80	81	73	73	71	71	72	73	68	68	69	88	87	86	66	
SMP	45	45	45	45	45	45	44	44	44	44	44	44	50	50	50	50	50	50	50	50	50	50	50	50	50	57
Medicare	290	287	286	283	281	278	278	277	276	278	276	275	282	280	281	281	278	276	273	272	271	269	268	269	274	

Wisconsin Public Employers

Group Demographics

Enrollment by Plan

The Enrollment by Plan report (Exhibit 2-B) shows the December 2008 membership for the Standard, SMP and Medicare Carve-out Plans at the class level. For each class, member average age and gender distribution is shown. The age/gender factor is included as an index intended to represent expected plan cost based on the age and gender of each member, without regard to plan design, health, etc. The age/gender factor is not shown for the Medicare Carve-out Plan, where coordination of benefits with Medicare has an overwhelming impact on plan cost.

WISCONSIN PUBLIC EMPLOYERS

Exhibit 2-B

Enrollment by Plan

December 2008

Plan	Class	# of Members	Average Member Age	Member Gender Distribution Female	Member Age/Gender Factor
Classic Standard	Milwaukee	17	51.8	47.1%	1.980
	Waukesha	2	57.0	50.0%	2.105
	Dane	16	49.9	62.5%	1.891
	Rest of State	40	47.7	50.0%	1.719
	Annuitants	6	58.7	83.3%	2.317
	Continuation	0	0.0	0.0%	0.000
	Medicare	262	76.0	58.8%	N/A
Subtotal		343	69.8	57.7%	1.862
Deductible Classic Standard	Milwaukee	0	0.0	0.0%	0.000
	Waukesha	0	0.0	0.0%	0.000
	Dane	0	0.0	0.0%	0.000
	Rest of State	0	0.0	0.0%	0.000
	Annuitants	0	0.0	0.0%	0.000
	Continuation	0	0.0	0.0%	0.000
	Medicare	7	74.1	57.1%	N/A
Subtotal		7	74.1	57.1%	0.000
Standard Preferred	Milwaukee	0	0.0	0.0%	0.000
	Waukesha	1	52.0	0.0%	1.594
	Dane	0	0.0	0.0%	0.000
	Rest of State	0	0.0	0.0%	0.000
	Annuitants	0	0.0	0.0%	0.000
	Continuation	0	0.0	0.0%	0.000
	Medicare	0	0.0	0.0%	N/A
Subtotal		1	52.0	0.0%	1.594
Deductible Standard Preferred	Milwaukee	0	0.0	0.0%	0.000
	Waukesha	0	0.0	0.0%	0.000
	Dane	0	0.0	0.0%	0.000
	Rest of State	2	39.5	100.0%	1.287
	Annuitants	2	54.5	50.0%	2.144
	Continuation	0	0.0	0.0%	0.000
	Medicare	0	0.0	0.0%	N/A
Subtotal		4	47.0	75.0%	1.715
SMP	Local	50	36.5	50.0%	1.239
	Annuitants	0	0.0	0.0%	0.000
	Continuation	0	0.0	0.0%	0.000
Subtotal		50	36.5	50.0%	1.239
Deductible SMP	Local	0	0.0	0.0%	0.000
	Annuitants	0	0.0	0.0%	0.000
	Continuation	0	0.0	0.0%	0.000
Subtotal		0	0.0	0.0%	0.000
WPE Grand Total		405	65.5	56.8%	N/A

Wisconsin Public Employers

Group Demographics

Member Census Grids

The Member Census Grid breaks down the December 2008 membership into age and gender categories for the Standard, SMP and Medicare Carve-out Plans. The Standard and SMP distributions are compared to a benchmark distribution based on WPS large group business as described in the Executive Summary. The benchmark distribution for the Medicare Carve-out Plan is based on WPS Medicare Carve-out business.

Standard Plan

The Standard Plan membership (Exhibit 3-D) appears to be much older than the normative distribution with 67.4% of membership over the age of 50 compared to the benchmark of 25.8%. Older members tend to seek more medical care and tend to select a broader panel of providers for that care. Since the Standard Plan has a broader panel of providers, this causes the average age to be higher.

Also contributing to the older than expected membership is the smaller than expected population of children with only 4.7% of the membership under the age of 20 compared to the benchmark of 29.4%. The Standard Plan also has a slightly higher than normal population of females with 54.7% female as compared to the benchmark of 51.7%.

SMP Plan

The SMP Plan membership (Exhibit 3-E) has a higher than expected membership between the ages of 40 – 59 with 50% of the membership compared to the benchmark of 35.2%.

Medicare Carve-out Plan

The Medicare Carve-out Plan membership is shown in Exhibit 3-F. The population is in line with the benchmark distribution.

**WISCONSIN PUBLIC EMPLOYERS
Member Census Grid - Standard
December 2008**

Exhibit 3-D

FEMALE			
Age Band	# of Members	% of Total	Benchmark
< 20	1	1.2%	14.3%
20 - 24	1	1.2%	3.5%
25 - 29	0	0.0%	3.5%
30 - 34	4	4.7%	3.5%
35 - 39	4	4.7%	3.8%
40 - 44	1	1.2%	4.5%
45 - 49	4	4.7%	5.0%
50 - 54	10	11.6%	4.8%
55 - 59	11	12.8%	4.4%
60 - 64	9	10.5%	3.0%
65 +	2	2.3%	1.4%
Total	47	54.7%	51.7%

MALE			
Age Band	# of Members	% of Total	Benchmark
< 20	3	3.5%	15.1%
20 - 24	2	2.3%	3.2%
25 - 29	1	1.2%	2.8%
30 - 34	1	1.2%	3.2%
35 - 39	2	2.3%	3.5%
40 - 44	4	4.7%	4.0%
45 - 49	0	0.0%	4.4%
50 - 54	7	8.1%	4.3%
55 - 59	7	8.1%	3.8%
60 - 64	9	10.5%	2.6%
65 +	3	3.5%	1.5%
Total	39	45.3%	48.4%

TOTAL			
Age Band	# of Members	% of Total	Benchmark
< 20	4	4.7%	29.4%
20 - 24	3	3.5%	6.7%
25 - 29	1	1.2%	6.3%
30 - 34	5	5.8%	6.7%
35 - 39	6	7.0%	7.3%
40 - 44	5	5.8%	8.5%
45 - 49	4	4.7%	9.4%
50 - 54	17	19.8%	9.1%
55 - 59	18	20.9%	8.2%
60 - 64	18	20.9%	5.6%
65 +	5	5.8%	2.9%
Total	86	100.0%	100.0%



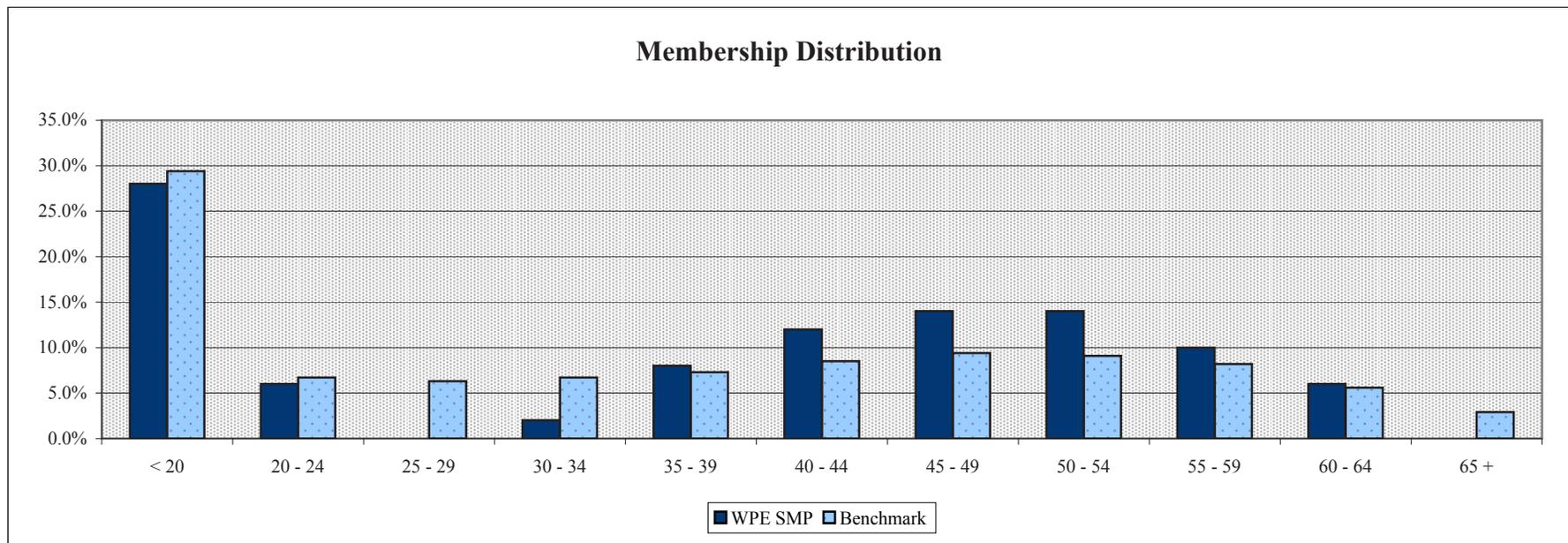
**WISCONSIN PUBLIC EMPLOYERS
Member Census Grid - SMP
December 2008**

Exhibit 3-E

FEMALE			
Age Band	# of Members	% of Total	Benchmark
< 20	5	10.0%	14.3%
20 - 24	3	6.0%	3.5%
25 - 29	0	0.0%	3.5%
30 - 34	1	2.0%	3.5%
35 - 39	2	4.0%	3.8%
40 - 44	2	4.0%	4.5%
45 - 49	5	10.0%	5.0%
50 - 54	3	6.0%	4.8%
55 - 59	3	6.0%	4.4%
60 - 64	1	2.0%	3.0%
65 +	0	0.0%	1.4%
Total	25	50.0%	51.7%

MALE			
Age Band	# of Members	% of Total	Benchmark
< 20	9	18.0%	15.1%
20 - 24	0	0.0%	3.2%
25 - 29	0	0.0%	2.8%
30 - 34	0	0.0%	3.2%
35 - 39	2	4.0%	3.5%
40 - 44	4	8.0%	4.0%
45 - 49	2	4.0%	4.4%
50 - 54	4	8.0%	4.3%
55 - 59	2	4.0%	3.8%
60 - 64	2	4.0%	2.6%
65 +	0	0.0%	1.5%
Total	25	50.0%	48.4%

TOTAL			
Age Band	# of Members	% of Total	Benchmark
< 20	14	28.0%	29.4%
20 - 24	3	6.0%	6.7%
25 - 29	0	0.0%	6.3%
30 - 34	1	2.0%	6.7%
35 - 39	4	8.0%	7.3%
40 - 44	6	12.0%	8.5%
45 - 49	7	14.0%	9.4%
50 - 54	7	14.0%	9.1%
55 - 59	5	10.0%	8.2%
60 - 64	3	6.0%	5.6%
65 +	0	0.0%	2.9%
Total	50	100.0%	100.0%



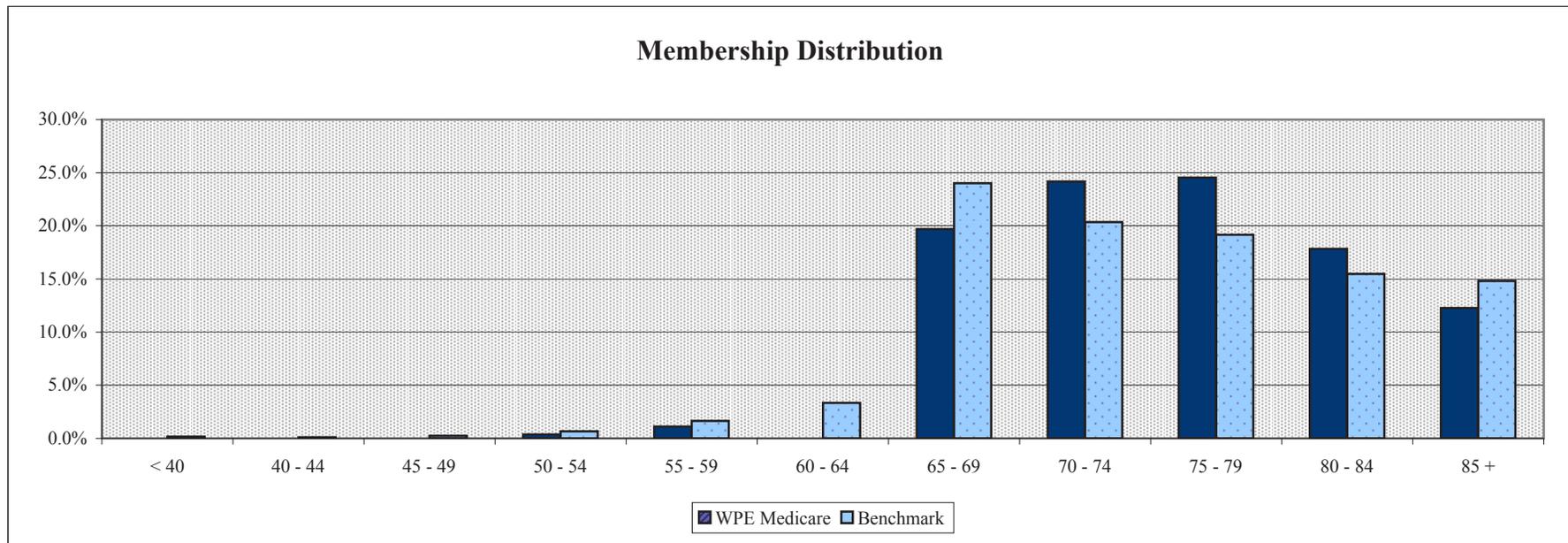
**WISCONSIN PUBLIC EMPLOYERS
Member Census Grid - Medicare
December 2008**

Exhibit 3-F

FEMALE			
Age Band	# of Members	% of Total	Benchmark
< 40	0	0.0%	0.1%
40 - 44	0	0.0%	0.1%
45 - 49	0	0.0%	0.1%
50 - 54	1	0.4%	0.4%
55 - 59	3	1.1%	1.0%
60 - 64	0	0.0%	1.8%
65 - 69	33	12.3%	13.7%
70 - 74	36	13.4%	11.9%
75 - 79	37	13.8%	11.3%
80 - 84	26	9.7%	9.8%
85 +	22	8.2%	10.6%
Total	158	58.7%	60.7%

MALE			
Age Band	# of Members	% of Total	Benchmark
< 40	0	0.0%	0.1%
40 - 44	0	0.0%	0.1%
45 - 49	0	0.0%	0.1%
50 - 54	0	0.0%	0.3%
55 - 59	0	0.0%	0.7%
60 - 64	0	0.0%	1.5%
65 - 69	20	7.4%	10.3%
70 - 74	29	10.8%	8.4%
75 - 79	29	10.8%	7.9%
80 - 84	22	8.2%	5.7%
85 +	11	4.1%	4.2%
Total	111	41.3%	39.3%

TOTAL			
Age Band	# of Members	% of Total	Benchmark
< 40	0	0.0%	0.2%
40 - 44	0	0.0%	0.1%
45 - 49	0	0.0%	0.2%
50 - 54	1	0.4%	0.7%
55 - 59	3	1.1%	1.6%
60 - 64	0	0.0%	3.3%
65 - 69	53	19.7%	24.0%
70 - 74	65	24.2%	20.4%
75 - 79	66	24.5%	19.2%
80 - 84	48	17.8%	15.5%
85 +	33	12.3%	14.8%
Total	269	100.0%	100.0%



Wisconsin Public Employers

Group Demographics

Wisconsin Enrollment

The Wisconsin Enrollment map (Exhibit 4-C) visually shows how the membership for the Standard and SMP plans are dispersed throughout Wisconsin. The map shows enrollment as of December 1, 2008. Each of the dots represents one address. Exhibit 4-D shows the same information numerically.

79.1% of the **Standard Plan** participants live within Wisconsin. The Standard Plan population is spread out among 26 counties in Wisconsin with 14.0% of the population living in Dane County, and 8.1% in Milwaukee County.

The **SMP Plan** membership in comparison is entirely within Marinette and Pepin Counties. As of January 2008, the SMP plan was no longer available in Marinette County. Due to a few zip codes that overlap county lines, these members are actually from Florence County, however their address maps to Marinette County. As of January 2009, the SMP plan will no longer be available in Burnett County, but has now become available in Crawford and Pierce Counties.

Wisconsin Public Employers

Group Demographics

Out of State Enrollment

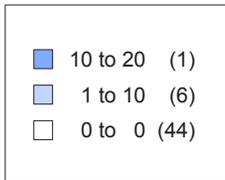
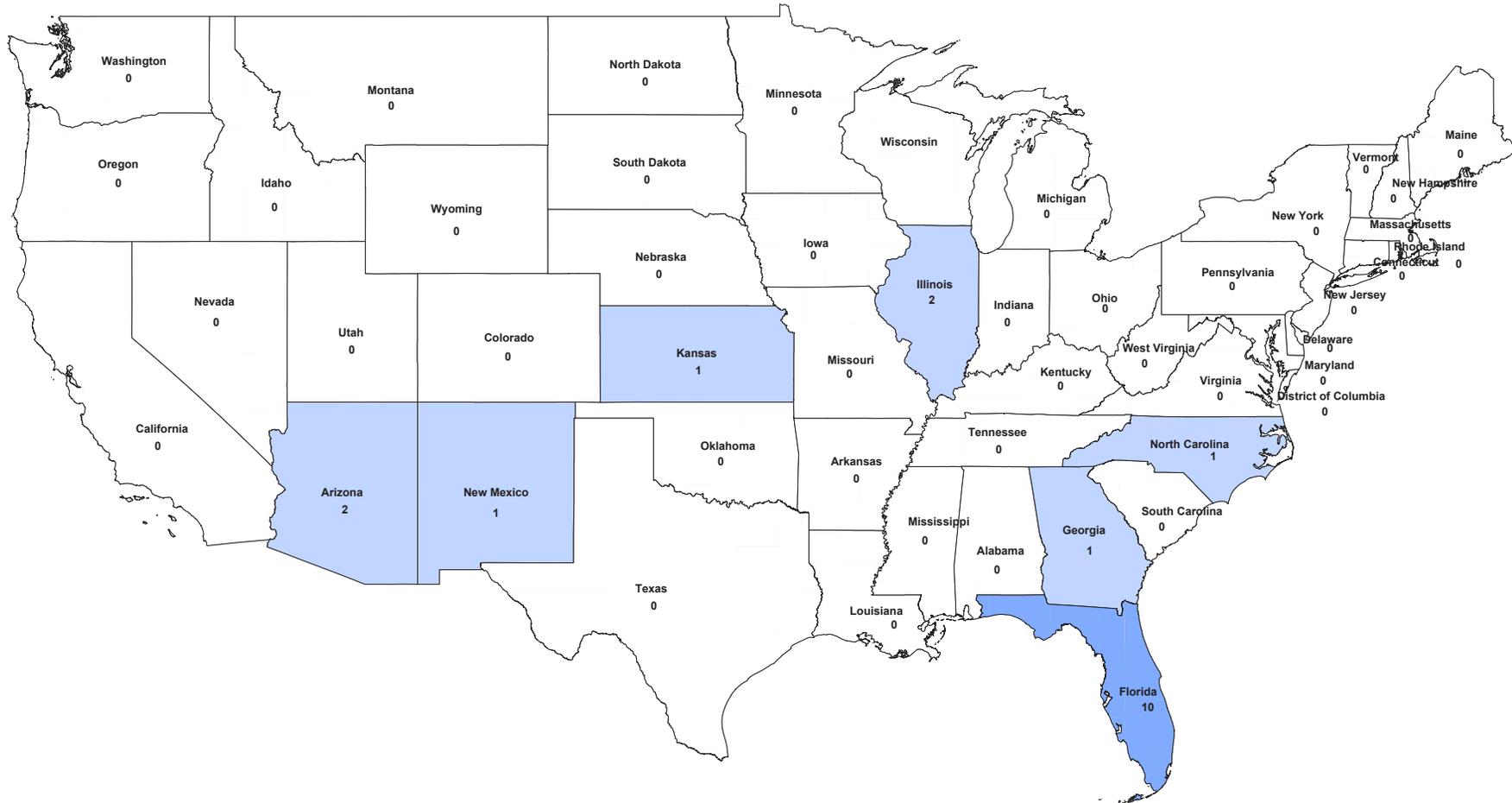
The United States Enrollment Map (Exhibit 5-C) visually depicts how the enrollment in the Standard and SMP plans are spread throughout the United States. The out of state enrollment is based on the member's address as of December 1, 2008 and could change as members relocate. The map displays the number of Standard and SMP plan members living in each state along with a shading scheme in which higher population areas are represented with increasingly darker shading. Exhibit 5-D shows the same information numerically.

The **Standard Plan** has 20.9% of the population living outside the state of Wisconsin with the membership dispersed over 7 states. 83.5% of the out of state membership live in the typical retirement states.

The **SMP Plan** in comparison does not have members residing outside of Wisconsin.

**WISCONSIN PUBLIC EMPLOYERS
Out of State Enrollment
December 2008**

Exhibit 5-C



**WISCONSIN PUBLIC EMPLOYERS
Out of State Enrollment
December 2008**

Exhibit 5-D

STANDARD					SMP					STANDARD					SMP				
State	# of Members	% of Members	# of Members	% of Members	State	# of Members	% of Members	# of Members	% of Members	State	# of Members	% of Members	# of Members	% of Members	State	# of Members	% of Members	# of Members	% of Members
ALABAMA	0	0.0%	0	0.0%	MAINE	0	0.0%	0	0.0%	OREGON	0	0.0%	0	0.0%	PENNSYLVANIA	0	0.0%	0	0.0%
ALASKA	0	0.0%	0	0.0%	MARYLAND	0	0.0%	0	0.0%	RHODE ISLAND	0	0.0%	0	0.0%	SOUTH CAROLINA	0	0.0%	0	0.0%
ARIZONA	2	11.1%	0	0.0%	MASSACHUSETTS	0	0.0%	0	0.0%	SOUTH DAKOTA	0	0.0%	0	0.0%	TENNESSEE	0	0.0%	0	0.0%
ARKANSAS	0	0.0%	0	0.0%	MICHIGAN	0	0.0%	0	0.0%	TEXAS	0	0.0%	0	0.0%	UTAH	0	0.0%	0	0.0%
CALIFORNIA	0	0.0%	0	0.0%	MINNESOTA	0	0.0%	0	0.0%	VERMONT	0	0.0%	0	0.0%	VIRGINIA	0	0.0%	0	0.0%
COLORADO	0	0.0%	0	0.0%	MISSISSIPPI	0	0.0%	0	0.0%	WASHINGTON	0	0.0%	0	0.0%	WASHINGTON DC	0	0.0%	0	0.0%
CONNECTICUT	0	0.0%	0	0.0%	MISSOURI	0	0.0%	0	0.0%	WEST VIRGINIA	0	0.0%	0	0.0%	WYOMING	0	0.0%	0	0.0%
DELAWARE	0	0.0%	0	0.0%	MONTANA	0	0.0%	0	0.0%	FOREIGN	0	0.0%	0	0.0%					
FLORIDA	10	55.6%	0	0.0%	NEBRASKA	0	0.0%	0	0.0%										
GEORGIA	1	5.6%	0	0.0%	NEVADA	0	0.0%	0	0.0%										
HAWAII	0	0.0%	0	0.0%	NEW HAMPSHIRE	0	0.0%	0	0.0%										
IDAHO	0	0.0%	0	0.0%	NEW JERSEY	0	0.0%	0	0.0%										
ILLINOIS	2	11.1%	0	0.0%	NEW MEXICO	1	5.6%	0	0.0%										
INDIANA	0	0.0%	0	0.0%	NEW YORK	0	0.0%	0	0.0%										
IOWA	0	0.0%	0	0.0%	NORTH CAROLINA	1	5.6%	0	0.0%										
KANSAS	1	5.6%	0	0.0%	NORTH DAKOTA	0	0.0%	0	0.0%										
KENTUCKY	0	0.0%	0	0.0%	OHIO	0	0.0%	0	0.0%										
LOUISIANA	0	0.0%	0	0.0%	OKLAHOMA	0	0.0%	0	0.0%										
										Totals	18	100.0%	0	0.0%					

Wisconsin Public Employers

Group Demographics

Dual Choice Changes

The Dual Choice Enrollment Changes by Plan report (Exhibit 6-B) shows the January 2009 enrollment reflecting changes that occurred during the Dual Choice Enrollment. The enrollment changes are numerical differences relative to December 2008. The change in Member / Age Gender show how much plan costs changed between 2008 and 2009 due to demographic factors. The age/gender factor is not shown for the Medicare Carve-out Plan, where coordination of benefits with Medicare has an overwhelming impact on plan cost.

**WISCONSIN PUBLIC EMPLOYERS
Dual Choice Enrollment Changes by Plan
December 2008 to January 2009**

Exhibit 6-B

Plan	Class	January 2009 Membership	Change in Membership from December 2008	Change in Member Age/ Gender
Classic Standard	Milwaukee	13	-4	14.32%
	Waukesha	1	-1	-24.26%
	Dane	10	-6	7.67%
	Rest of State	26	-14	8.31%
	Annuity	8	2	1.63%
	Continuation	0	0	0.00%
	Medicare	266	4	N/A
Subtotal		324	-19	9.87%
Deductible Classic Standard	Milwaukee	0	0	0.00%
	Waukesha	0	0	0.00%
	Dane	0	0	0.00%
	Rest of State	4	4	0.00%
	Annuity	0	0	0.00%
	Continuation	0	0	0.00%
	Medicare	8	1	N/A
Subtotal		12	5	0.00%
Standard Preferred	Milwaukee	0	0	0.00%
	Waukesha	0	-1	-100.00%
	Dane	0	0	0.00%
	Rest of State	0	0	0.00%
	Annuity	0	0	0.00%
	Continuation	0	0	0.00%
	Medicare	0	0	N/A
Subtotal		0	-1	-100.00%
Deductible Standard Preferred	Milwaukee	0	0	0.00%
	Waukesha	0	0	0.00%
	Dane	0	0	0.00%
	Rest of State	0	-2	-100.00%
	Annuity	4	2	-40.44%
	Continuation	0	0	0.00%
	Medicare	0	0	N/A
Subtotal		4	0	-25.56%
SMP	Local	57	7	-5.67%
	Annuity	0	0	0.00%
	Continuation	0	0	0.00%
Subtotal		57	7	-5.67%
Deductible SMP	Local	0	0	0.00%
	Annuity	0	0	0.00%
	Continuation	0	0	0.00%
Subtotal		0	0	0.00%
WPE Grand Total		397	-8	N/A

Wisconsin Public Employers

Plan Utilization

Paid Per Member Per Month Costs

The Paid Medical and Drug PMPM report (Exhibit 7-B) displays the average amount paid per member each month for the Standard, SMP and Medicare Carve-out Plans incurred from January 2007 through December 2008. The PMPM costs for each plan represent medical and drug claims paid through the end of March 2009.

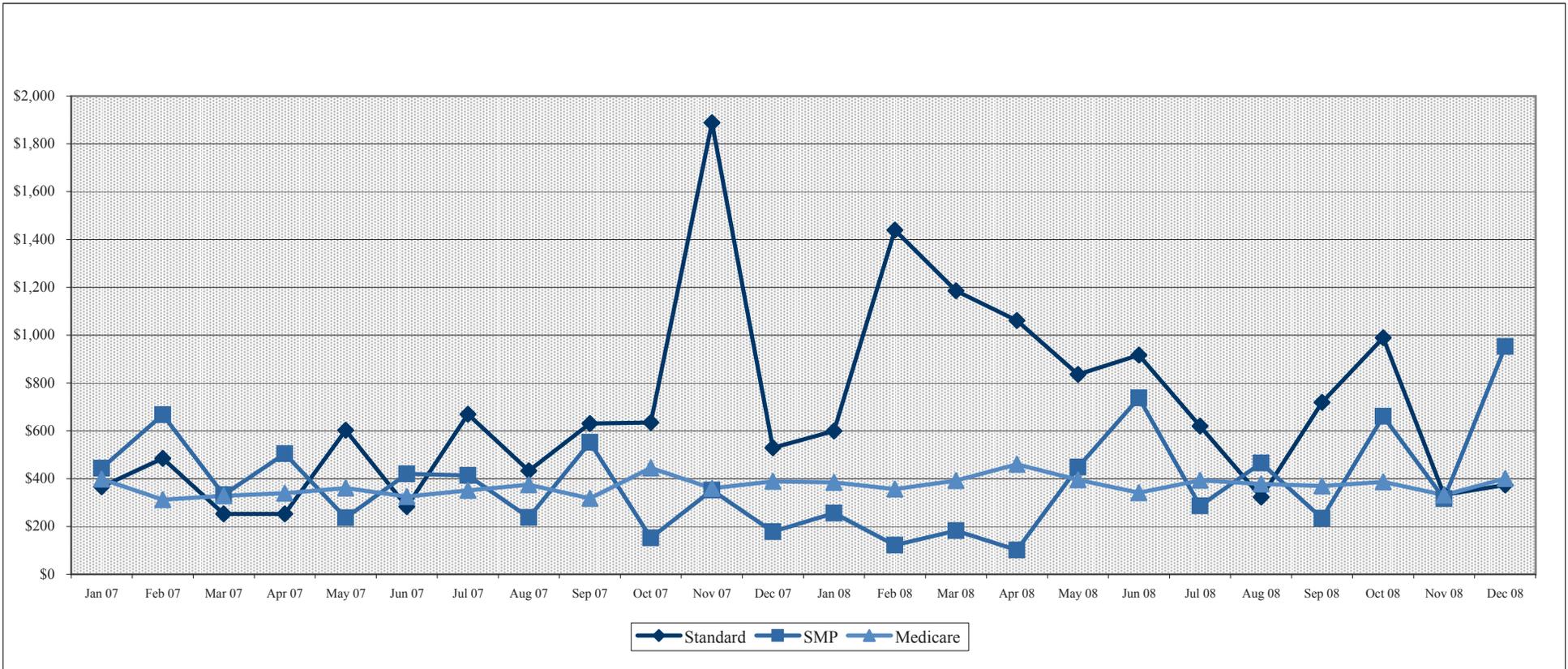
The **Standard Plan** has seen a 29.3% increase in total paid claim costs between 2007 and 2008. Independent trend estimates for medical claims for 2008 were 10-12%, thus the plan performed worse than anticipated. The standard plan had two individuals with annual claims over \$100,000. That fact has contributed to the unfavorable year over year claim results. The small population of the Standard Plan naturally leads to instability in the monthly claim results, as the larger spikes in claims are generally due to large claim activity that occurred in those months.

The **SMP Plan** has seen an increase in claims over the last year. The small number of members enrolled on the plan result in claim cost variance from month to month and year to year. The total paid PMPM trended up 6.7% from 2007 to 2008 which is still below trend estimates for 2008.

The **Medicare Carve-out Plan** has seen stable results over the last 2 years. We would expect this population to have stable results since Medicare is the primary payer. The year over year PMPM trend from 2007 to 2008 was 6.7%. We would naturally expect an increase in the medical claims each year due to the benefit changes Medicare makes annually and medical cost trend and utilization.

**WISCONSIN PUBLIC EMPLOYERS
Paid Medical and Drug PMPM
Paid Through March 2009**

Exhibit 7-B



	INCURRED MONTH																							
	Jan 07	Feb 07	Mar 07	Apr 07	May 07	Jun 07	Jul 07	Aug 07	Sep 07	Oct 07	Nov 07	Dec 07	Jan 08	Feb 08	Mar 08	Apr 08	May 08	Jun 08	Jul 08	Aug 08	Sep 08	Oct 08	Nov 08	Dec 08
Standard	\$365.79	\$485.33	\$252.90	\$252.73	\$602.95	\$283.36	\$669.57	\$433.38	\$630.23	\$634.74	\$1,888.97	\$529.19	\$599.26	\$1,439.86	\$1,186.13	\$1,061.34	\$835.55	\$916.82	\$620.08	\$322.52	\$719.66	\$989.48	\$332.39	\$373.86
SMP	\$444.12	\$667.32	\$332.37	\$503.80	\$236.63	\$420.02	\$413.62	\$238.10	\$552.31	\$152.14	\$352.20	\$177.93	\$256.33	\$121.66	\$182.62	\$101.52	\$448.11	\$737.37	\$285.81	\$465.14	\$234.21	\$661.44	\$316.58	\$952.22
Medicare	\$398.39	\$312.15	\$328.75	\$339.30	\$360.32	\$325.56	\$350.46	\$374.48	\$316.97	\$444.67	\$359.65	\$388.54	\$384.59	\$356.17	\$392.50	\$459.89	\$394.72	\$341.32	\$393.21	\$377.75	\$369.13	\$386.54	\$332.02	\$400.86

Wisconsin Public Employers

Plan Utilization

PMPM by Type of Service

The Total PMPM by Type of Service reports (8-F and 8-H) provide a breakdown of the PMPM by major type of service compared to the benchmark. The pie chart also provides an overview of the percentage of the PMPM each major type of service is contributing to the total PMPM plus a comparison to the benchmark. The total PMPM cost are for claims incurred January 2008 – December 2008 and paid through the end of March 2009. Exhibits 8-G and 8-I show the same actual data, but compare 2007 to 2008.

Standard Plan

The Standard Plan in Exhibit 8-F shows that the percentage breakdown by major type of service is similar to the benchmark, the facility inpatient and outpatient costs make up a larger percent of the total costs while the drugs make up less. The total PMPM cost is 18.3% above the benchmark. The inpatient facility PMPM cost is 45.2% above the benchmark and outpatient facility is 28.5% above the benchmark. The Standard Plan did experience some high cost claim activity which is directly correlated with inpatient charges. The physician PMPM cost is 14.1% above the benchmark. The drug paid PMPM cost is 19.5% below the benchmark. Lastly, the other services category is 2.9% over the norm. Every \$1.00 PMPM represented in the graph is equivalent to \$899 in annual plan costs for the Standard Plan.

Exhibit 8-G shows how claims on the Standard Plan on a PMPM basis have increased from 2007 to 2008. Medical Claims increased by 29.3%, most notably facility inpatient is up 66.6%.

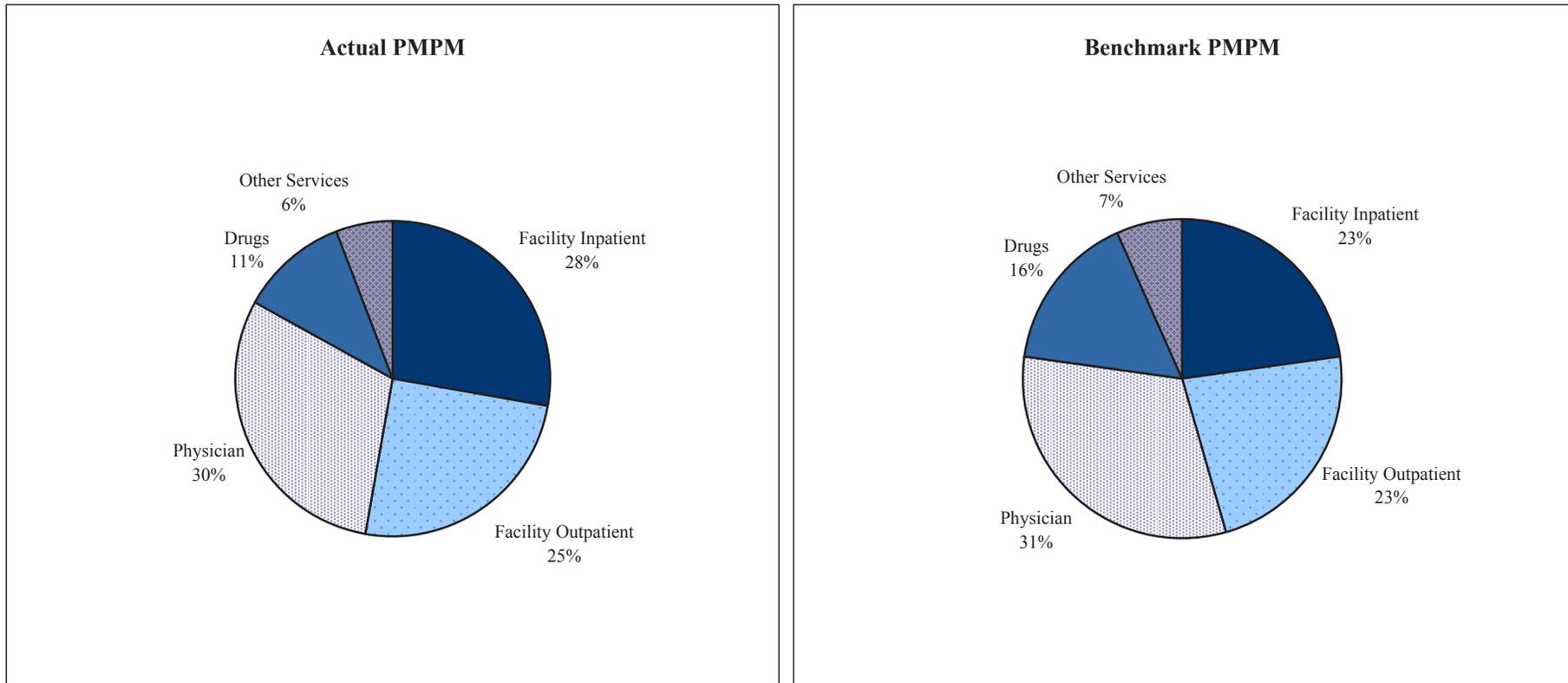
SMP Plan

Exhibit 8-H shows the percentage breakdown by type of service for the SMP Plan is significantly different than the benchmark. Facility inpatient claims comprise a much larger percentage while physician and other services comprise a much smaller percentage of the total plan costs than would be expected. In total, the SMP plan is only 0.4% above the benchmark. The facility inpatient

claims are 59.0% higher than the benchmark and the drugs are 16.4% above the norm. However, the following are all below the norms: facility outpatient (6.2%), physician (23.3%), and other services (56.8%).

Exhibit 8-I shows the SMP Plan's paid PMPM costs by type of service, comparing 2007 to 2008. Claim costs have increased 6.7% on average between the two years, which is lower than expected. However, facility inpatient claims increased by 264.0%, and drugs increased by 50.6% while all other categories decreased.

**WISCONSIN PUBLIC EMPLOYERS
Total PMPM by Type of Service - Standard
Incurred January 2008 - December 2008 Paid Through March 2009**



	Actual	Benchmark	Difference	
			\$	%
Facility Inpatient	\$216.44	\$149.06	\$67.38	45.2%
Facility Outpatient	\$193.04	\$150.19	\$42.85	28.5%
Physician	\$235.62	\$206.52	\$29.10	14.1%
Drugs	\$85.80	\$106.56	-\$20.76	-19.5%
Other Services	\$44.88	\$43.61	\$1.27	2.9%
Totals	\$775.78	\$655.94	\$119.84	18.3%

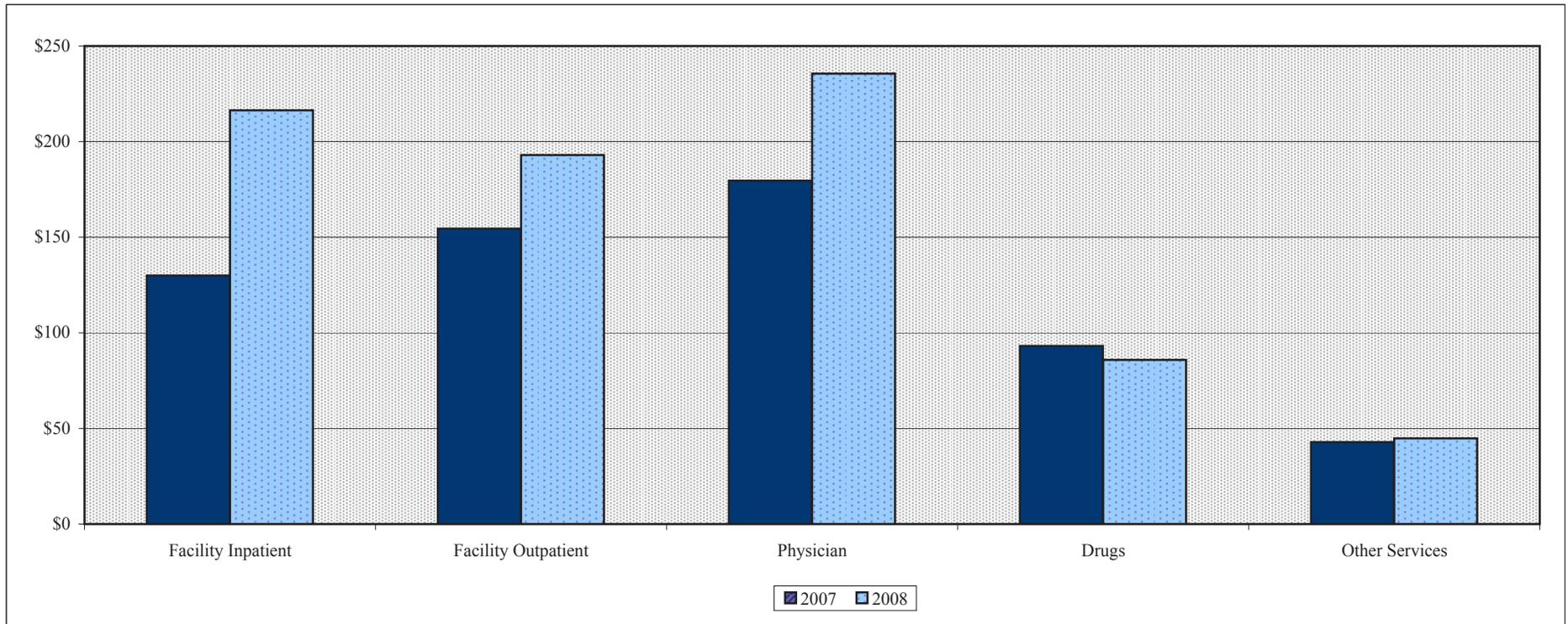
Note: Drug includes prescription and injectables

Note: Benchmark data has been age/sex adjusted to correspond to the population included in this exhibit

* Each \$1.00 paid PMPM = \$899 in plan costs.

WISCONSIN PUBLIC EMPLOYERS
Total PMPM by Type of Service - Standard
Comparison of 2008 to 2007

Exhibit 8-G



	2007 *	2008 **	Difference	
			\$	%
Facility Inpatient	\$129.91	\$216.44	\$86.53	66.6%
Facility Outpatient	\$154.53	\$193.04	\$38.51	24.9%
Physician	\$179.49	\$235.62	\$56.13	31.3%
Drugs	\$93.15	\$85.80	-\$7.35	-7.9%
Other Services	\$42.85	\$44.88	\$2.03	4.7%
Totals	\$599.93	\$775.78	\$175.85	29.3%

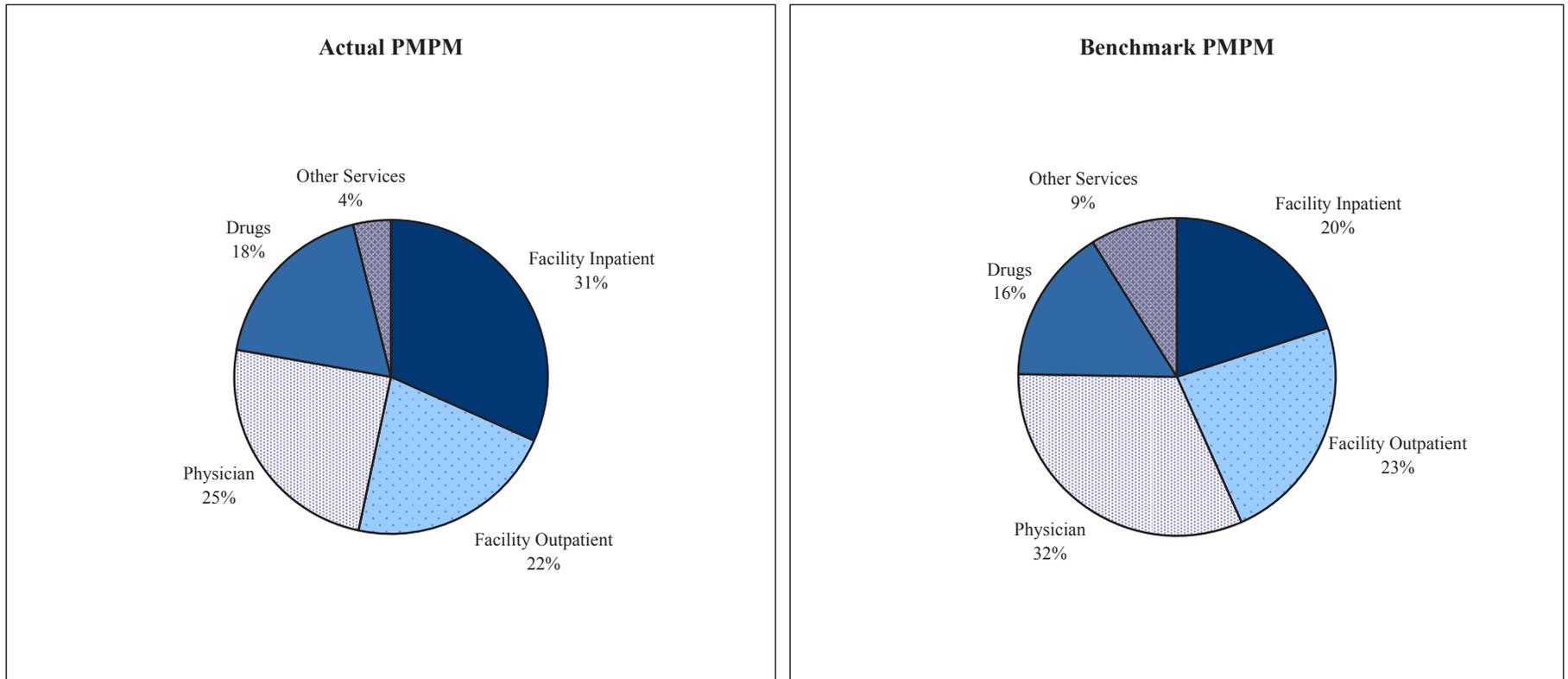
Note: Drug includes prescription and injectables

* Each \$1.00 paid PMPM = \$818 in plan costs.

** Each \$1.00 paid PMPM = \$899 in plan costs.

WISCONSIN PUBLIC EMPLOYERS
Total PMPM by Type of Service - SMP
Incurred January 2008 - December 2008 Paid Through March 2009

Exhibit 8-H



	Actual	Benchmark	Difference	
			\$	%
Facility Inpatient	\$125.51	\$78.96	\$46.55	59.0%
Facility Outpatient	\$86.13	\$91.78	-\$5.65	-6.2%
Physician	\$97.54	\$127.15	-\$29.61	-23.3%
Drugs	\$72.69	\$62.47	\$10.22	16.4%
Other Services	\$15.03	\$34.78	-\$19.75	-56.8%
Totals	\$396.90	\$395.14	\$1.76	0.4%

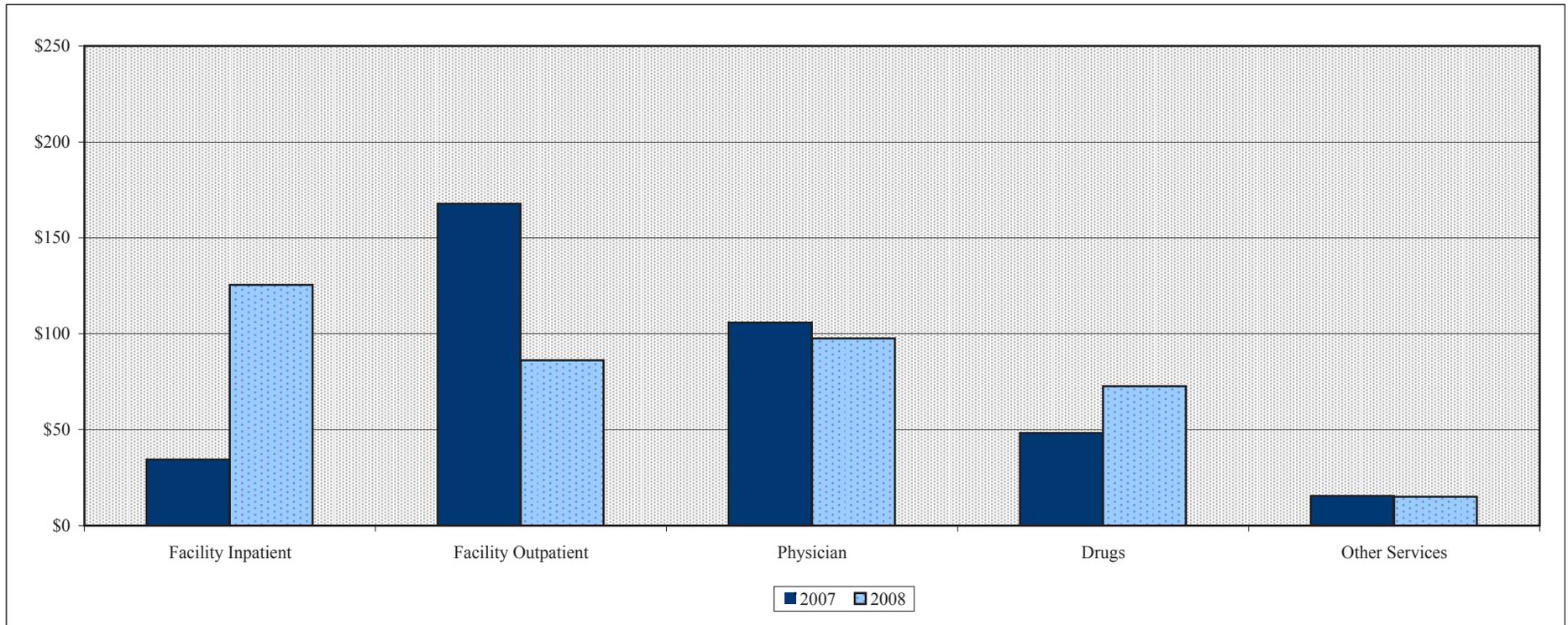
Note: Drug includes prescription and injectables

Note: Benchmark data has been age/sex adjusted to correspond to the population included in this exhibit

* Each \$1.00 paid PMPM = \$600 in plan costs.

WISCONSIN PUBLIC EMPLOYERS
Total PMPM by Type of Service - SMP
Comparison of 2008 to 2007

Exhibit 8-I



	2007 *	2008 **	Difference	
			\$	%
Facility Inpatient	\$34.48	\$125.51	\$91.03	264.0%
Facility Outpatient	\$167.76	\$86.13	-\$81.63	-48.7%
Physician	\$105.88	\$97.54	-\$8.34	-7.9%
Drugs	\$48.26	\$72.69	\$24.43	50.6%
Other Services	\$15.47	\$15.03	-\$0.44	-2.8%
Totals	\$371.85	\$396.90	\$25.05	6.7%

Note: Drug includes prescription and injectables

* Each \$1.00 paid PMPM = \$522 in plan costs.

** Each \$1.00 paid PMPM = \$600 in plan costs.

Wisconsin Public Employers

Plan Utilization

Type of Service Detail

The Type of Service Detail report provides an overview of paid medical costs on a PMPM basis divided into 5 major service categories and further divided into 26 subcategories. The Actual PMPM costs are compared to the Benchmark PMPM to help determine where the plan is experiencing higher than normal claim costs. The comparison to the Benchmark is displayed as a PMPM difference and as a percentage difference. The Actual PMPM cost are for claims incurred January 2008 – December 2008 and paid through the end of March 2009.

Standard Plan

The Standard Plan (Exhibit 9-C) was 18.3% above the benchmark in 2008. Due to the very small size of this group, the health conditions of a few members can have a significant impact on individual sub-categories. Therefore, meaningful conclusions cannot always be made. Since the percentage comparison can be deceiving, it is more important to look at the PMPM difference with \$1.00 PMPM being equivalent to \$899 in annual plan costs. Below are some areas that stand out relative to the benchmark and some analysis on what is driving the higher costs.

- Facility Inpatient – All of dollars here are for surgical/medical services. The higher than expected results in this category are directly correlated to the high cost patients.
- Outpatient Facility – The surgical/medical sub-category is 84.5% above the norm. This overage is driven by the health conditions of this small population.
- Physician – Surgery and Anesthesia sub-categories are running well above the norm. Claim costs for these two services are highly correlated to the high inpatient facility claims.
- Drug – The prescription drug costs are in line with the benchmark while injectible drugs are well below the benchmark.

- Other services – The other services category is slightly above the benchmark. The major contributors to the variance is the Psych/AODA sub-category which is \$9.19 PMPM above the benchmark and the Therapy sub-category which is \$7.62 PMPM above the benchmark.

SMP Plan

The SMP Plan in Exhibit 9-D by comparison is 0.4% above the benchmark for 2008. Due to the very small size of this group, the health conditions of a few members can have a significant impact on individual sub-categories. Therefore, meaningful conclusions cannot always be made. For the plan \$1.00 PMPM represented in the chart is equivalent to \$600 in annual plan costs.

- Inpatient Facility – The Psych/AODA sub-category is 758.1% above the norm.
- Outpatient Facility – Overall this category is 6.2% below the benchmark. While radiology (123.3%) and pathology (95.4%) are both above the norms; all other sub-categories are all well below the norms.
- Physician – This category is 23.3% below the benchmark.
- Drug – The prescription drug PMPM cost is running 37.9% above the norm and the injectable drug costs are running 99.3% below norm. Overall the drug cost is 16.4% higher than the benchmark for 2008.
- Other Services – The Chiropractic sub-category is \$5.01 PMPM above the norm which is a function of the region in which the SMP population resides. In the northern region, chiropractic care is more commonly used in comparison to other areas of the state.

WISCONSIN PUBLIC EMPLOYERS

Type of Service Detail - Standard

Incurred January 2008 - December 2008 Paid Through March 2009

Exhibit 9-C

TYPE OF SERVICE	DETAIL	ACTUAL PMPM	BENCHMARK PMPM	DIFFERENCE \$	DIFFERENCE %
FACILITY INPATIENT	SURGICAL/MEDICAL	\$216.44	\$142.78	\$73.66	51.6%
	PSYCH/AODA	\$0.00	\$1.90	-\$1.90	-100.0%
	MATERNITY	\$0.00	\$2.51	-\$2.51	-100.0%
	OTHER	\$0.00	\$1.87	-\$1.87	-100.0%
Subtotal		\$216.44	\$149.06	\$67.38	45.2%
FACILITY OUTPATIENT	SURGICAL/MEDICAL	\$53.26	\$28.87	\$24.39	84.5%
	RADIOLOGY	\$38.22	\$40.91	-\$2.69	-6.6%
	PATHOLOGY	\$18.82	\$18.22	\$0.60	3.3%
	EMERGENCY ROOM	\$6.55	\$4.49	\$2.06	45.9%
	PSYCH/AODA	\$3.48	\$1.04	\$2.44	234.6%
	OTHER	\$72.71	\$56.66	\$16.05	28.3%
Subtotal		\$193.04	\$150.19	\$42.85	28.5%
PHYSICIAN	OFFICE VISIT	\$17.91	\$24.74	-\$6.83	-27.6%
	RADIOLOGY	\$30.29	\$40.69	-\$10.40	-25.6%
	PATHOLOGY	\$28.18	\$25.57	\$2.61	10.2%
	SURGERY	\$108.75	\$63.69	\$45.06	70.7%
	ANESTHESIA	\$19.44	\$13.81	\$5.63	40.8%
	MATERNITY	\$0.00	\$1.18	-\$1.18	-100.0%
	OTHER	\$31.05	\$36.84	-\$5.79	-15.7%
Subtotal		\$235.62	\$206.52	\$29.10	14.1%
DRUGS	PRESCRIPTIONS	\$85.25	\$89.85	-\$4.60	-5.1%
	INJECTABLES	\$0.55	\$16.71	-\$16.16	-96.7%
Subtotal		\$85.80	\$106.56	-\$20.76	-19.5%
OTHER SERVICES	PSYCH/AODA	\$14.57	\$5.38	\$9.19	170.8%
	CHIROPRACTIC	\$2.48	\$4.13	-\$1.65	-40.0%
	THERAPIES	\$12.79	\$5.17	\$7.62	147.4%
	AMBULANCE	\$0.70	\$2.65	-\$1.95	-73.6%
	WELL BABY EXAM	\$0.00	\$0.07	-\$0.07	-100.0%
	DURABLE MEDICAL EQUIPMENT	\$9.08	\$7.02	\$2.06	29.3%
	OTHER	\$5.26	\$19.19	-\$13.93	-72.6%
Subtotal		\$44.88	\$43.61	\$1.27	2.9%
Grand Total		\$775.78	\$655.94	\$119.84	18.3%

Note: Benchmark data has been age/sex adjusted to correspond to the population included in this exhibit

* Each \$1.00 paid PMPM = \$899 in plan costs.

WISCONSIN PUBLIC EMPLOYERS
Type of Service Detail - SMP
Incurred January 2008 - December 2008 Paid Through March 2009

TYPE OF SERVICE	DETAIL	ACTUAL	BENCHMARK	DIFFERENCE	
		PMPM	PMPM	\$	%
FACILITY INPATIENT	SURGICAL/MEDICAL	\$106.89	\$72.02	\$34.87	48.4%
	PSYCH/AODA	\$18.62	\$2.17	\$16.45	758.1%
	MATERNITY	\$0.00	\$3.84	-\$3.84	-100.0%
	OTHER	\$0.00	\$0.93	-\$0.93	-100.0%
Subtotal		\$125.51	\$78.96	\$46.55	59.0%
FACILITY OUTPATIENT	SURGICAL/MEDICAL	\$3.35	\$18.01	-\$14.66	-81.4%
	RADIOLOGY	\$53.88	\$24.13	\$29.75	123.3%
	PATHOLOGY	\$20.99	\$10.74	\$10.25	95.4%
	EMERGENCY ROOM	\$0.80	\$3.63	-\$2.83	-78.0%
	PSYCH/AODA	\$0.51	\$1.29	-\$0.78	-60.5%
	OTHER	\$6.60	\$33.98	-\$27.38	-80.6%
Subtotal		\$86.13	\$91.78	-\$5.65	-6.2%
PHYSICIAN	OFFICE VISIT	\$14.07	\$16.53	-\$2.46	-14.9%
	RADIOLOGY	\$15.86	\$24.18	-\$8.32	-34.4%
	PATHOLOGY	\$10.51	\$16.33	-\$5.82	-35.6%
	SURGERY	\$30.79	\$38.14	-\$7.35	-19.3%
	ANESTHESIA	\$10.83	\$8.37	\$2.46	29.4%
	MATERNITY	\$0.00	\$1.81	-\$1.81	-100.0%
	OTHER	\$15.48	\$21.79	-\$6.31	-29.0%
Subtotal		\$97.54	\$127.15	-\$29.61	-23.3%
DRUGS	PRESCRIPTIONS	\$72.62	\$52.67	\$19.95	37.9%
	INJECTABLES	\$0.07	\$9.80	-\$9.73	-99.3%
Subtotal		\$72.69	\$62.47	\$10.22	16.4%
OTHER SERVICES	PSYCH/AODA	\$1.44	\$6.67	-\$5.23	-78.4%
	CHIROPRACTIC	\$8.33	\$3.32	\$5.01	150.9%
	THERAPIES	\$1.25	\$3.76	-\$2.51	-66.8%
	AMBULANCE	\$0.40	\$1.63	-\$1.23	-75.5%
	WELL BABY EXAM	\$0.00	\$0.00	\$0.00	0.0%
	DURABLE MEDICAL EQUIPMENT	\$0.08	\$4.30	-\$4.22	-98.1%
	OTHER	\$3.53	\$15.10	-\$11.57	-76.6%
Subtotal		\$15.03	\$34.78	-\$19.75	-56.8%
Grand Total		\$396.90	\$395.14	\$1.76	0.4%

Note: Benchmark data has been age/sex adjusted to correspond to the population included in this exhibit

* Each \$1.00 paid PMPM = \$600 in plan costs.

Wisconsin Public Employers

Plan Utilization

Inpatient Utilization

The Inpatient Utilization report compares annual inpatient days per 1,000, admits per 1,000, average length of stay, cost per day, cost per admit, and inpatient PMPM cost to the benchmark for the 5 major inpatient service categories. Days/1,000 is the annual average number of hospital days utilized by a population of 1,000 members which is calculated by taking $(\text{Total Days}/\text{Member Months}) \times 12,000$. The Admits/1,000 is the annual number of admits that occur within a typical population of 1,000 members which is calculated by taking $(\text{Total Admits}/\text{Member Months}) \times 12,000$. The Days/1,000 and Admits/1,000 are calculations that allow a comparison of one population to another regardless of group size. Average Length of Stay (ALOS) shows the average length of hospitalization experienced for the entire group $(\text{Total Days}/\text{Total Admits})$. Cost per Day is an average of the cost per hospital day $(\text{Total Cost}/\text{Total Days})$. The cost per admit is an average of the cost per hospital admission $(\text{Total Cost}/\text{Total Admits})$. Lastly the inpatient PMPM is the per member per month cost incurred by the plan. Beyond the numerical comparison, a percentage has been included as observed in the pie charts, including a comparison to the benchmark.

Standard Plan

The totals for the Standard Plan in Exhibit 10-B are generally below the benchmark in all inpatient statistics except Surgical. Due to the small size of this group the inpatient claim results are highly volatile from year to year and accurate predictions of future trends cannot be made. Of the total inpatient costs that were incurred, 84.09% were in the surgical sub-category. This year the group did have two members with annual claims over \$100,000 and both individuals had inpatient surgical stays which contributed to this result.

SMP

No SMP report due to small size of block and lack of credibility.

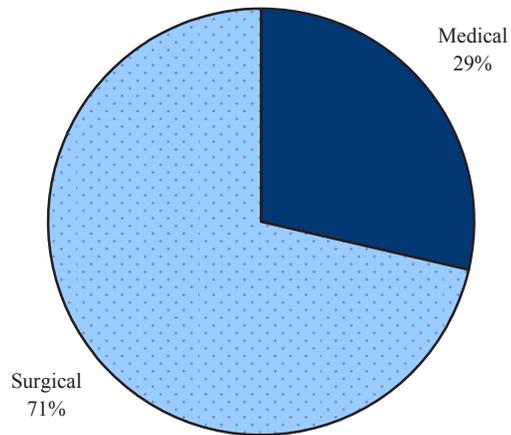
**WISCONSIN PUBLIC EMPLOYERS
Inpatient Utilization - Standard
Incurred January 2008 - December 2008 Paid Through March 2009**

Exhibit 10-B

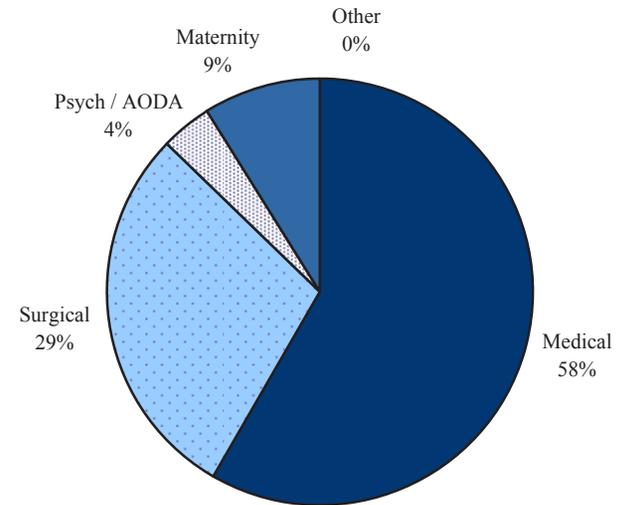
ACTUAL						
	Medical	Surgical	Psych / AODA	Maternity	Other	Total
Days/1000	53	254	0	0	0	307
Admits/1000	27	67	0	0	N/A	94
ALOS	2.00	3.80	0.00	0.00	N/A	3.29
Cost/Day	\$7,739	\$8,612	\$0	\$0	\$0	\$8,460
Cost/Admit	\$15,477	\$32,724	\$0	\$0	N/A	\$27,797
PMPM	\$34.43	\$182.00	\$0.00	\$0.00	\$0.00	\$216.43
% of Paid	15.91%	84.09%	0.00%	0.00%	0.00%	100.00%

BENCHMARK						
	Medical	Surgical	Psych / AODA	Maternity	Other	Total
Days/1000	222	135	17	17	51	442
Admits/1000	46	23	3	7	N/A	79
ALOS	4.83	5.87	5.67	2.43	N/A	5.59
Cost/Day	\$3,901	\$6,596	\$1,361	\$1,696	\$431	\$4,036
Cost/Admit	\$19,507	\$40,063	\$6,950	\$3,315	N/A	\$25,856
PMPM	\$70.33	\$72.45	\$1.90	\$2.51	\$1.87	\$149.06
% of Paid	47.18%	48.60%	1.27%	1.68%	1.25%	100.00%

% OF ADMITS FOR ACTUAL



% OF ADMITS FOR BENCHMARK



Note: Benchmark data has been age/sex adjusted to correspond to the population included in this exhibit

Wisconsin Public Employers

Plan Utilization

Claim Costs by Major Diagnostic Categories (MDC)

The Claim Costs by Major Diagnostic Categories report divides medical claim costs into 25 mutually exclusive diagnostic categories. The diagnoses in each MDC correspond to a single organ system and, in general, are associated with a particular medical specialty. The actual PMPM cost by major diagnostic category is compared to the WPS benchmark PMPM. The Actual PMPM costs show calendar year results, comparing 2007 to 2008, each with three months run-out.

The **Standard Plan**, shown in Exhibit 11-C is experiencing higher than expected PMPM Cost overall. This deviation is broken down by MDC. Due to the small size of this group, the splitting of claims into small categories is highly volatile which is can be seen in large positive and negative comparisons. The individual health conditions of each member can affect a single sub-category. Therefore, this graph is for informational purposes only. For the Standard Plan \$1.00 PMPM in claim cost represented in the charts is equivalent to \$899 in annual plan costs.

The **SMP Plan**, shown in Exhibit 11-D is slightly below the benchmark overall. Once again the small size of this segment is creating large volatility in the results of individual categories which is seen in the large positive and negative comparisons. Therefore, this graph is for informational purposes only. For the SMP plan \$1.00 PMPM in claim cost represented in the charts is equivalent to \$600 in annual plan costs.

WISCONSIN PUBLIC EMPLOYERS
Claim Costs by Major Diagnostic Categories - Standard
Comparison of 2008 to 2007

Exhibit 11-C

MDC CODE	MAJOR DIAGNOSTIC CATEGORY DESCRIPTION	2007	2008	BENCHMARK PMPM **	DIFFERENCE	
		ACTUAL PMPM *	ACTUAL PMPM **		2008 to 2007	2008 to BENCHMARK
1	Nervous System Diseases and Disorders (D/D)	\$20.04	\$7.19	\$24.68	-64.1%	-70.9%
2	Eye D/D	\$11.30	\$3.24	\$16.24	-71.3%	-80.0%
3	Ear, Nose, Mouth and Throat D/D	\$5.43	\$17.30	\$18.17	218.6%	-4.8%
4	Respiratory System D/D	\$1.76	\$2.09	\$25.86	18.8%	-91.9%
5	Circulatory System D/D	\$41.69	\$58.12	\$80.72	39.4%	-28.0%
6	Digestive System D/D	\$48.23	\$71.48	\$48.15	48.2%	48.4%
7	Liver, Gallbladder, Biliary Ducts and Pancreas D/D	\$4.16	\$29.10	\$20.63	599.5%	41.1%
8	Muscles, Bones, and Connective Tissue D/D	\$222.59	\$309.97	\$109.33	39.3%	183.5%
9	Skin, Subcutaneous Tissue (fat and connective) and Breast D/D	\$19.82	\$21.52	\$32.56	8.6%	-33.9%
10	Endocrine, Nutritional and Metabolic D/D (included diagnoses related to obesity, diabetes and hormones)	\$11.45	\$43.00	\$19.24	275.5%	123.5%
11	Kidney and Urinary Tract D/D	\$2.99	\$4.87	\$20.76	62.9%	-76.5%
12	Male Reproductive System D/D	\$3.21	\$7.44	\$10.00	131.8%	-25.6%
13	Female Reproductive System D/D	\$23.27	\$21.53	\$15.05	-7.5%	43.1%
14	Pregnancy, Childbirth, and After Delivery Diagnoses	\$9.55	\$0.00	\$5.28	-100.0%	-100.0%
15	Newborns, and Newborns with Conditions Originating Shortly Before or After Birth	\$0.00	\$0.00	\$0.71	0.0%	-100.0%
16	Blood and Blood Forming Organ D/D (including spleen) and Immune System Disorders	\$5.19	\$1.99	\$8.31	-61.7%	-76.0%
17	Bone Marrow D/D and Poorly Differentiated Cancers	\$0.35	\$0.16	\$29.52	-54.3%	-99.5%
18	Infectious and Parasitic Diseases	\$0.20	\$4.52	\$5.92	2160.0%	-23.7%
19	Behavioral Health Diagnoses	\$15.45	\$15.51	\$9.25	0.4%	67.8%
20	Alcohol/Drug Use and Alcohol/Drug Induced Organic Mental Disorders	\$2.07	\$0.00	\$0.89	-100.0%	-100.0%
21	Injuries, Poisoning and Toxic Effects of Drugs	\$0.03	\$3.11	\$4.98	10266.7%	-37.5%
22	Burns	\$0.00	\$0.00	\$0.04	0.0%	-100.0%
23	Other Miscellaneous Services Including Health Screenings, Medical Exams and Rehabilitation	\$57.96	\$68.10	\$54.27	17.5%	25.5%
24	Multiple Significant Trauma	\$0.00	\$0.00	\$1.69	0.0%	-100.0%
25	Human Immunodeficiency Virus Infections	\$0.00	\$0.00	\$0.07	0.0%	-100.0%
0	Ungroupable	\$0.32	\$0.28	\$3.79	-12.5%	-92.6%
Total		\$507.06	\$690.52	\$566.09	36.2%	22.0%

Note: Benchmark data has been age/sex adjusted to correspond to the population included in this exhibit

Note: The MDC descriptions used in last year's report have been modified in an attempt to help readers understand the type of data that is contained in each category

* Each \$1.00 paid PMPM = \$818 in plan costs.

** Each \$1.00 paid PMPM = \$899 in plan costs.

WISCONSIN PUBLIC EMPLOYERS
Claim Costs by Major Diagnostic Categories - SMP
Comparison of 2008 to 2007

Exhibit 11-D

MDC CODE	MAJOR DIAGNOSTIC CATEGORY DESCRIPTION	2007	2008	BENCHMARK PMPM **	DIFFERENCE	
		ACTUAL PMPM *	ACTUAL PMPM **		2008 to 2007	2008 to BENCHMARK
1	Nervous System Diseases and Disorders (D/D)	\$1.89	\$4.56	\$18.85	141.3%	-75.8%
2	Eye D/D	\$1.57	\$0.00	\$7.43	-100.0%	-100.0%
3	Ear, Nose, Mouth and Throat D/D	\$7.60	\$3.12	\$16.46	-58.9%	-81.0%
4	Respiratory System D/D	\$20.09	\$12.11	\$12.69	-39.7%	-4.6%
5	Circulatory System D/D	\$41.65	\$32.38	\$36.61	-22.3%	-11.6%
6	Digestive System D/D	\$43.58	\$30.85	\$32.05	-29.2%	-3.8%
7	Liver, Gallbladder, Biliary Ducts and Pancreas D/D	\$12.37	\$0.00	\$10.68	-100.0%	-100.0%
8	Muscles, Bones, and Connective Tissue D/D	\$70.16	\$99.71	\$63.17	42.1%	57.8%
9	Skin, Subcutaneous Tissue (fat and connective) and Breast D/D	\$6.71	\$9.67	\$18.12	44.1%	-46.6%
10	Endocrine, Nutritional and Metabolic D/D (included diagnoses related to obesity, diabetes and hormones)	\$16.47	\$9.56	\$10.92	-42.0%	-12.4%
11	Kidney and Urinary Tract D/D	\$30.59	\$9.64	\$11.51	-68.5%	-16.3%
12	Male Reproductive System D/D	\$0.42	\$0.00	\$3.46	-100.0%	-100.0%
13	Female Reproductive System D/D	\$48.73	\$15.53	\$11.69	-68.1%	32.9%
14	Pregnancy, Childbirth, and After Delivery Diagnoses	\$0.00	\$0.00	\$9.36	0.0%	-100.0%
15	Newborns, and Newborns with Conditions Originating Shortly Before or After Birth	\$0.00	\$0.00	\$2.75	0.0%	-100.0%
16	Blood and Blood Forming Organ D/D (including spleen) and Immune System Disorders	\$8.12	\$6.57	\$5.13	-19.1%	28.1%
17	Bone Marrow D/D and Poorly Differentiated Cancers	\$0.00	\$0.15	\$13.14	0.0%	-98.9%
18	Infectious and Parasitic Diseases	\$1.79	\$49.89	\$3.13	2687.2%	1492.0%
19	Behavioral Health Diagnoses	\$0.96	\$24.78	\$9.29	2481.3%	166.9%
20	Alcohol/Drug Use and Alcohol/Drug Induced Organic Mental Disorders	\$0.00	\$0.00	\$0.97	0.0%	-100.0%
21	Injuries, Poisoning and Toxic Effects of Drugs	\$0.91	\$3.59	\$3.78	294.5%	-5.0%
22	Burns	\$0.00	\$0.00	\$0.07	0.0%	-100.0%
23	Other Miscellaneous Services Including Health Screenings, Medical Exams and Rehabilitation	\$9.83	\$12.19	\$36.03	24.0%	-66.2%
24	Multiple Significant Trauma	\$0.00	\$0.00	\$1.69	0.0%	-100.0%
25	Human Immunodeficiency Virus Infections	\$0.00	\$0.00	\$0.03	0.0%	-100.0%
0	Ungroupable	\$1.50	\$0.00	\$3.44	-100.0%	-100.0%
Total		\$324.94	\$324.30	\$342.47	-0.2%	-5.3%

Note: Benchmark data has been age/sex adjusted to correspond to the population included in this exhibit

Note: The MDC descriptions used in last year's report have been modified in an attempt to help readers understand the type of data that is contained in each category

* Each \$1.00 paid PMPM = \$522 in plan costs.

** Each \$1.00 paid PMPM = \$600 in plan costs.

Wisconsin Public Employers

Provider Utilization

Top 20 Providers

The Top 20 Provider reports display the top 20 Facility and Professional Providers sorted by total paid charges. Within the facility report, charges have also been broken out by inpatient and outpatient paid charges for additional analysis. The Paid % shows the percentage of the group's total facility or professional charges from a specific provider.

Facility

The report for the **Standard Plan** in Exhibit 12-E shows that the top 20 facilities provide 94.3% of the total facility charges for the plan. The largest percent of claims came from Aurora Health Care in Milwaukee. The second largest percent of claims came from St. Francis Hospital in Milwaukee. You will note that most of the hospitals in the top 20 treated only one patient. Since the Standard Plan is available nationwide, we see providers from various regions and states.

The report for the **SMP Plan** in Exhibit 12-F shows that the top 7 facilities provide 100% of the total facility charges for the plan. The vast majority of claims came from Dickinson County Memorial Hospital in Iron Mountain, Michigan. This hospital also saw the most patients with 19 patients. Due to the HMO type coverage and limited plan area of the SMP plan we would expect to see a majority of services received at a finite number of hospitals within the SMP region.

Professional

The **Standard Plan** shown in Exhibit 12-G received 60.2% of professional charges from the top 20 providers. The top professional provider is Orthopedic Surgeons of Wisconsin in Milwaukee. Once again most providers in the top 20 only treated one patient. The second largest percent of claims came from the UW Medical Foundation in Madison.

The **SMP Plan** in Exhibit 12-H received 87.7% of the paid claims from the top 20 professional providers. Dickinson Memorial Hospital was again the top provider in both paid dollars and patients treated. You will note that over half of the services were provided in Iron Mountain, Michigan.

WISCONSIN PUBLIC EMPLOYERS
Top 20 Facility Providers - Standard
Incurred January 2008 - December 2008 Paid Through March 2009

Exhibit 12-E

	Facility Provider	City	State	# of Unique Patients	Inpatient Paid Claims	Outpatient Paid Claims	Total Paid Claims	Paid %
1	AURORA HEALTH CARE METRO	MILWAUKEE	WI	3	\$67,984	\$6,306	\$74,290	20.2%
2	ST FRANCIS HOSPITAL	MILWAUKEE	WI	1	\$46,948	\$18,348	\$65,296	17.7%
3	UNIVERSITY WI HSP CL AUTHORITY	MADISON	WI	5	\$36,841	\$17,248	\$54,089	14.7%
4	SAINT MICHAELS HOSPITAL	STEVENS POINT	WI	1	\$24,162	\$0	\$24,162	6.6%
5	ST MARYS HOSP OZAUKEE	MEQUON	WI	2	\$0	\$18,921	\$18,921	5.1%
6	NORTHWOODS SURGERY CENTER LLC	WOODRUFF	WI	1	\$0	\$16,318	\$16,318	4.4%
7	WHEATON FRANCISCAN HEALTHCARE	MILWAUKEE	WI	1	\$11,374	\$3,402	\$14,776	4.0%
8	FROEDTERT MEM LUTH HOSP	MILWAUKEE	WI	2	\$0	\$12,599	\$12,599	3.4%
9	CUMBERLAND MEMORIAL HOSPITAL	CUMBERLAND	WI	2	\$0	\$10,217	\$10,217	2.8%
10	AMERY REGIONAL MED CTR	AMERY	WI	1	\$0	\$9,590	\$9,590	2.6%
11	AURORA MEDICAL CTR HARTFORD	HARTFORD	WI	1	\$7,267	\$2,194	\$9,461	2.6%
12	YAVAPAI REGIONAL MEDICAL CTR	PRESCOTT	AZ	1	\$0	\$6,847	\$6,847	1.9%
13	ST LUKES BAPTIST HOSPITAL	SAN ANTONIO	TX	1	\$0	\$6,512	\$6,512	1.8%
14	FORT HEALTHCARE INC	FORT ATKINSON	WI	3	\$0	\$4,483	\$4,483	1.2%
15	HOWARD YOUNG MED CTR	WOODRUFF	WI	2	\$0	\$3,855	\$3,855	1.0%
16	THE CENTER FOR DIGESTIVE HEALT	MILWAUKEE	WI	1	\$0	\$3,631	\$3,631	1.0%
17	MORTON PLANT HEALTH SVCS	LARGO	FL	1	\$0	\$3,375	\$3,375	0.9%
18	SARASOTA MEMORIAL HOSPITAL	SARASOTA	FL	3	\$0	\$3,273	\$3,273	0.9%
19	FLAMBEAU MEDICAL CENTER INC	PARK FALLS	WI	1	\$0	\$3,028	\$3,028	0.8%
20	VERDE VALLEY MEDICAL CTR	COTTONWOOD	AZ	1	\$0	\$2,450	\$2,450	0.7%
Top 20 Total				34	\$194,576	\$152,597	\$347,173	94.3%
All Other Facility Charges				26	\$0	\$20,944	\$20,944	5.7%
Total Facility Charges				60	\$194,576	\$173,541	\$368,117	100.0%

WISCONSIN PUBLIC EMPLOYERS
Top 20 Facility Providers - SMP
Incurred January 2008 - December 2008 Paid Through March 2009

Exhibit 12-F

	Facility Provider	City	State	# of Unique Patients	Inpatient Paid Claims	Outpatient Paid Claims	Total Paid Claims	Paid %
1	DICKINSON COUNTY MEMORIAL HOSP	IRON MOUNTAIN	MI	19	\$40,558	\$36,363	\$76,921	60.6%
2	BELLIN MEMORIAL HOSP	GREEN BAY	WI	1	\$17,047	\$1,475	\$18,522	14.6%
3	BELLIN PSYCH CTR	GREEN BAY	WI	1	\$11,172	\$0	\$11,172	8.8%
4	MARQUETTE GENERAL HOSPITAL	MARQUETTE	MI	5	\$6,531	\$2,596	\$9,127	7.2%
5	CHIPPEWA VALLEY HOSPITAL	DURAND	WI	3	\$0	\$6,777	\$6,777	5.3%
6	LUTHER HOSPITAL	EAU CLAIRE	WI	2	\$0	\$3,871	\$3,871	3.0%
7	NIAGARA HEALTH CTR	NIAGARA	WI	1	\$0	\$595	\$595	0.5%
Top 7 Total				32	\$75,308	\$51,677	\$126,985	100.0%
All Other Facility Charges				0	\$0	\$0	\$0	0.0%
Total Facility Charges				32	\$75,308	\$51,677	\$126,985	100.0%

WISCONSIN PUBLIC EMPLOYERS
Top 20 Professional Providers - Standard
Incurred January 2008 - December 2008 Paid Through March 2009

Exhibit 12-G

	Professional Provider	City	State	# of Unique Patients	Total Paid Claims	Paid %
1	ORTHOPEDIC SURGEONS OF WI SC	MILWAUKEE	WI	1	\$20,767	8.2%
2	UW MEDICAL FOUNDATION	MADISON	WI	10	\$18,821	7.4%
3	DEAN MEDICAL CTR	MADISON	WI	6	\$16,795	6.6%
4	SAINT MICHAELS HOSPITAL	STEVENS POINT	WI	5	\$14,679	5.8%
5	SPORTS MEDICINE & ORTHOPEDIC	GREENFIELD	WI	1	\$8,602	3.4%
6	NORTHERN WI BONE & JOINT CTR L	MINOCQUA	WI	1	\$7,567	3.0%
7	AURORA HEALTH CENTER	SHEBOYGAN	WI	5	\$7,099	2.8%
8	MARSHFIELD CLINIC-MINOCQUA CTR	MINOCQUA	WI	10	\$6,740	2.7%
9	ST CROIX ORTHOPAEDICS PA	STILLWATER	MN	1	\$5,034	2.0%
10	ANESTHESIOLOGY ASSOC OF WI	MILWAUKEE	WI	2	\$4,936	2.0%
11	THE PROGRESSIVE STEP CORP	DELAVAN	WI	1	\$4,822	1.9%
12	MIDWEST ANESTHESIA CONSULTANTS	MILWAUKEE	WI	1	\$4,715	1.9%
13	DJO LLC	APPLETON	WI	1	\$4,658	1.8%
14	MEDICAL COLLEGE OF WISCONSIN	MILWAUKEE	WI	6	\$4,649	1.8%
15	WHEATON FRANCISCAN MEDICAL	MILWAUKEE	WI	3	\$4,445	1.8%
16	SURGI PLUS CLINIC SC	MILWAUKEE	WI	1	\$4,293	1.7%
17	LAKEFRONT WELLNESS CENTER SC	PEWAUKEE	WI	4	\$3,417	1.4%
18	M M PHYSICAL THERAPY LLC	S MILWAUKEE	WI	1	\$3,399	1.3%
19	CENTER FOR PHYSICAL EXCELLENCE	PRESCOTT	AZ	1	\$3,308	1.3%
20	FORT HEALTHCARE INC	FORT ATKINSON	WI	2	\$3,293	1.3%
Top 20 Total				63	\$152,039	60.2%
All Other Professional Charges				220	\$100,621	39.8%
Total Professional Charges				283	\$252,660	100.0%

WISCONSIN PUBLIC EMPLOYERS
Top 20 Professional Providers - SMP
Incurred January 2008 - December 2008 Paid Through March 2009

Exhibit 12-H

	Professional Provider	City	State	# of Unique Patients	Total Paid Claims	Paid %
1	DICKINSON COUNTY MEMORIAL HOSP	IRON MOUNTAIN	MI	17	\$7,264	10.7%
2	RADIOLOGY ASSOC IRON MTN	IRON MOUNTAIN	MI	11	\$6,887	10.2%
3	JOHN M COOK MD PC	IRON MOUNTAIN	MI	3	\$5,064	7.5%
4	MARQUETTE GENERAL HOSPITAL	MARQUETTE	MI	8	\$4,741	7.0%
5	SURG SPECIALISTS GREEN BAY	GREEN BAY	WI	1	\$4,674	6.9%
6	BELLIN MEMORIAL HOSP	GREEN BAY	WI	9	\$4,178	6.2%
7	LM OAKRIDGE MHS	MONDOVI	WI	6	\$4,107	6.1%
8	MIDELFORT CLINIC MHS	EAU CLAIRE	WI	3	\$3,392	5.0%
9	NORTHERN MICHIGAN ANESTHESIA	IRON MOUNTAIN	MI	1	\$2,627	3.9%
10	BELLIN ANESTHESIA ASSOC SC	GREEN BAY	WI	1	\$2,430	3.6%
11	RANDALL E KEIN DC SC	DURAND	WI	2	\$2,366	3.5%
12	BELLIN PSYCH CTR	GREEN BAY	WI	1	\$2,008	3.0%
13	BEGRES CHIROPRACTIC	IRON MOUNTAIN	MI	7	\$1,872	2.8%
14	PATHOLOGY CONSULTANTS OF GREEN	GREEN BAY	WI	1	\$1,327	2.0%
15	CHIPPEWA VALLEY HOSPITAL	DURAND	WI	3	\$1,171	1.7%
16	NARAYAN AMARNANI MD SC	GREEN BAY	WI	1	\$1,159	1.7%
17	BENISHEK CECCONI AND TERRIAN	IRON MOUNTAIN	MI	2	\$1,023	1.5%
18	AURORA HEALTH CENTER	SHEBOYGAN	WI	1	\$1,009	1.5%
19	GREEN BAY ONCOLOGY LTD	IRON MOUNTAIN	MI	1	\$1,000	1.5%
20	ANESTH MARQUETTE PC	MARQUETTE	MI	1	\$998	1.5%
Top 20 Total				80	\$59,297	87.7%
All Other Professional Charges				29	\$8,297	12.3%
Total Professional Charges				109	\$67,594	100.0%

Wisconsin Public Employers

Large Claims

High Cost Patients

The High Cost Patients report (Exhibit 14-B) lists the plan members with claims over \$100,000 for claims incurred January 2008 – December 2008 and paid through March 2009 for the Standard, SMP and Medicare Carve-out Plans. The Primary Condition is the condition associated with the largest percentage of claim payments and therefore may not be representative of a patient's complete condition. The Care Management section shows the type of care management provided on each case. For a detailed description of care management processes please reference the Care Management Description on the next page.

The Standard Plan has 2 members with claims over \$100,000 for a total of \$221,132 in claim costs.

There are no high cost claimants, defined as members who have more than \$100,000 in claims in the most recent 12 month period, on the SMP Plan or Medicare Carve-Out Plan.

Wisconsin Public Employers

Large Claims

Care Management Descriptions

The following is a brief description of the care management categories used in the High Cost Patient report.

Utilization Management helps ensure members achieve proper utilization of services, while maximizing their health care benefits, as well as determining the most appropriate level of care. Care Management nurses monitor patient care through preadmission or precertification review, inpatient admission and concurrent review, discharge planning with referrals to Case or Chronic Condition (Disease) Management nurses, and outpatient services review.

Outpatient Preauthorization is a review of specific outpatient services, including surgical services, diagnostic services, and referrals, and a determination that these services meet the criteria for medical necessity under the member's benefit plan.

Medical Review is an additional process in the Medical Affairs area that does post-claim review to ensure that those services that received prior approval are billed appropriately, and/or that services billed are covered by the member's plan, and are medically necessary.

Case Management is assessing, planning and facilitating services for members involved in an acute or catastrophic medical situation. The Case Manager focuses on managing the utilization of benefits, within the confines of the policy, in the most effective manner; ensuring quality of care is not compromised. Examples of Case Management are inpatient rehabilitation cases, long term inpatient cases, or short term home care cases that require skilled nursing visits and/or intravenous (IV) therapy. All of these cases are closely managed by the case managers.

Chronic Condition (Disease) Management utilizes a proactive approach through education, treatment and appropriate care to prevent long-term and unnecessary complications of chronic disease. Through education, the Chronic Condition Manager empowers members to take ownership of their health, decreasing future health risks, minimizing the need for medical services, and ultimately improving the quality of life.

Behavioral Health Management provides both inpatient as well as outpatient reviews which are performed by individuals specifically licensed in the behavioral health field. All managed care services, including utilization management, case management, chronic condition (disease) management, and outpatient preauthorization, are performed by this team.

WISCONSIN PUBLIC EMPLOYERS
High Cost Patients (over \$100,000)
Incurred January 2008 - December 2008 Paid Through March 2009

Exhibit 14-B

Patient Information		Plan	Care Management	Primary Condition	Total Paid
1	ACTIVE	STANDARD	Preauth, UM, CM	OSTEOARTHROSIS AND ALLIED	\$116,044
2	CANCELLED	STANDARD	Preauth, UM, CM	OSTEOARTHROSIS AND ALLIED	\$105,088
Total					\$221,132

Preauth = Outpatient Preauthorization UM = Utilization Management CM = Case Management DM = Chronic Care (Disease) Management BH = Behavioral Health Management

Note: Total paid includes medical and drug data

Wisconsin Public Employers

Member Cost Share

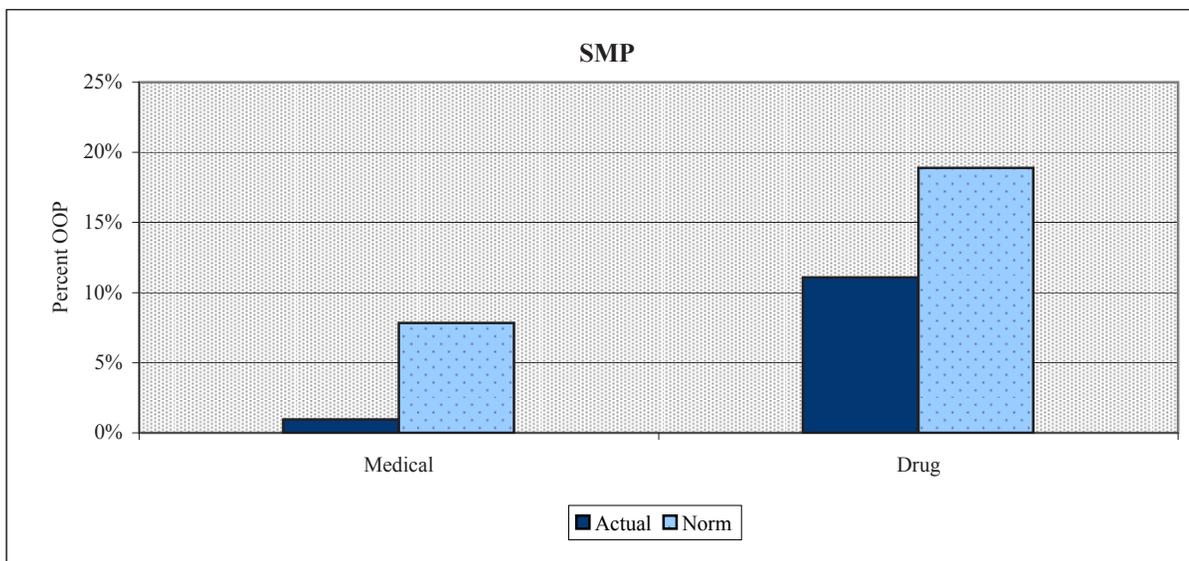
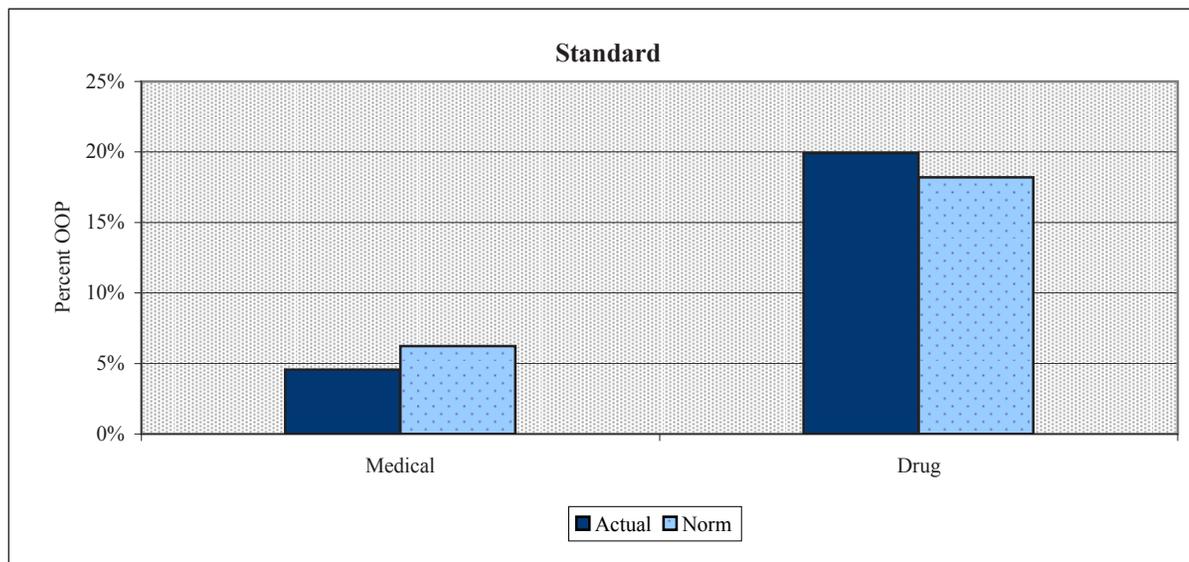
Medical and Drug Cost Sharing

The Medical and Drug Cost Sharing graphs (Exhibit 15-B) show the percent of eligible medical and drug claim costs paid by the member. This percentage is compared to the WPS Benchmark.

The **Standard Plan** members pay about 4.6% of their own medical claims as compared to the benchmark of 6.2%. The prescription drug cost share is above our normative benchmark with the Standard Plan around 19.9% and the benchmark at 18.2%.

The **SMP Plan** members by comparison pay a smaller amount towards their own medical claims (in the form of cost sharing). Unlike the members of most large groups who pay an average of about 7.8% of their medical claims, SMP Plan members pay 0.9%. The SMP cost share for prescription drugs is below the benchmark of 18.9% at 11.1%. Even though the Standard and SMP plans have the same prescription drug benefit, they have slightly different drug utilization profiles, the result of each plan's unique blend of treated conditions.

**WISCONSIN PUBLIC EMPLOYERS
 Medical and Drug Cost Sharing
 Incurred January 2008 - December 2008 Paid Through March 2009**



Note: Benchmark data has been age/sex adjusted to correspond to the population included in this exhibit

Wisconsin Public Employers

Member Cost Share

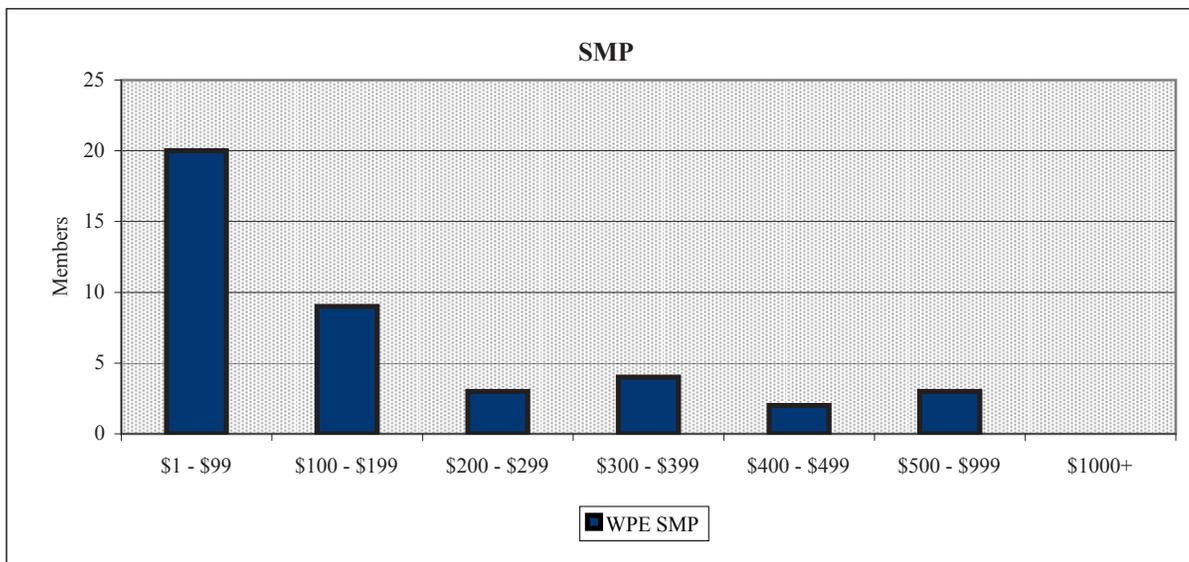
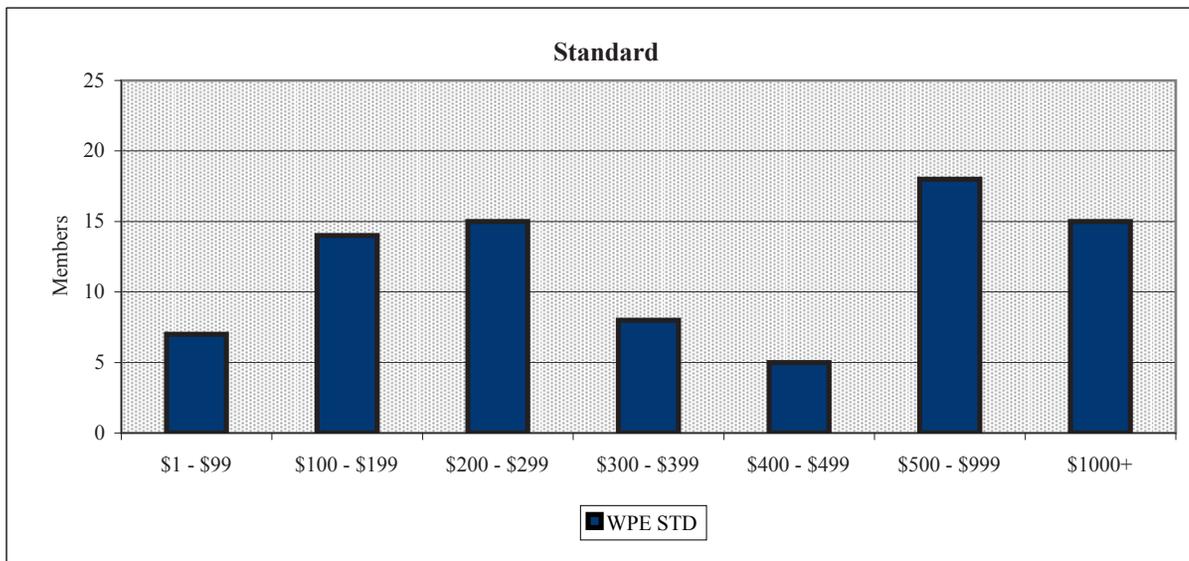
Medical and Drug Out of Pocket by Member

The Medical and Drug Out of Pocket by Member bar graph (Exhibit 16-B) divides members with out of pocket cost sharing into categories based on the annual amount of out of pocket costs they paid in 2008. The annual out of pocket for each member includes medical and prescription drug costs.

The **Standard Plan** has a large disparity between the members as far as out of pocket costs. The distribution of out of pocket costs are fairly evenly distributed across the different categories, however there appears to be a bias towards the higher out of pocket costs. There are 15 members who pay over \$1,000 out of pocket annually. Also, there are over 18 members in the \$500 to \$999 range but it is important to note the range for this category is larger than the previous categories.

The **SMP Plan** by comparison has a large number of members paying between \$1 and \$99 in cost sharing. Most of the cost sharing comes from prescription drug copays.

WISCONSIN PUBLIC EMPLOYERS
Medical and Drug Out of Pocket by Member
Incurred January 2008 - December 2008 Paid Through March 2009



Wisconsin Public Employers

Medical Claims Cost Savings

Medical Claim Savings Analysis

The Medical Claim Saving Analysis in Exhibit 17-C takes the charges submitted on behalf of the ETF members and details the savings that take place before the final payments are made to the providers. The submitted charges represent medical claims only. The charges are split between the Standard, SMP and Medicare Carve-out Plans for claims incurred January 2008 through December 2008 and paid through the end of March 2009. Exhibit 17-D provides a summary of the savings by plan along with a pie chart that provides the percentage of savings in each category combining all plans.

For the **Standard Plan**, WPS paid 77.4% of submitted charges on behalf of the plan. Of the 22.6% savings, 9.1% came from pricing cutbacks from the network providers. Another 9.7% was saved on claims rejected for duplicate submission, non-eligible claims, and services not covered by the plan. The Standard Plan also had 3.7% of charges paid by the members with deductibles, coinsurance and copays.

For the **SMP Plan**, WPS paid 83.1% of submitted charges on behalf of the plan. Of the 16.9% savings, 9.2% was received from pricing cutbacks from network providers. Another 5.9% was saved on claims rejected for duplicate submission, non-eligible claims, and services not covered by the plan. In comparison to the Standard Plan, the SMP plan members contributed only 0.8% in out-of-pocket costs. The SMP plan does have some out-of-pocket costs in the form of ER Copays, coinsurance on DME and Outpatient Psychiatric Visits. The savings due to third party liability is small at this time, but these types of recoveries can be long term and may take several years to be completed.

For the **Medicare Carve-out Plan**, WPS paid 6.1% of submitted charges on behalf of the plan. Payments made by Medicare have an overwhelming impact on savings by accounting for 75.2% of the submitted charges. The second highest savings percentage, 15.8%, came from the rejection of duplicate or non-eligible charges.

As seen in the pie chart in Exhibit 17-D, the total payment made by WPS for all plan types in 2008 was 14.0% of submitted charges. With the Medicare population's impact, 67.4% of the savings was provided by Medicare, followed by 14.6% in rejections for duplicates and non-eligible services.

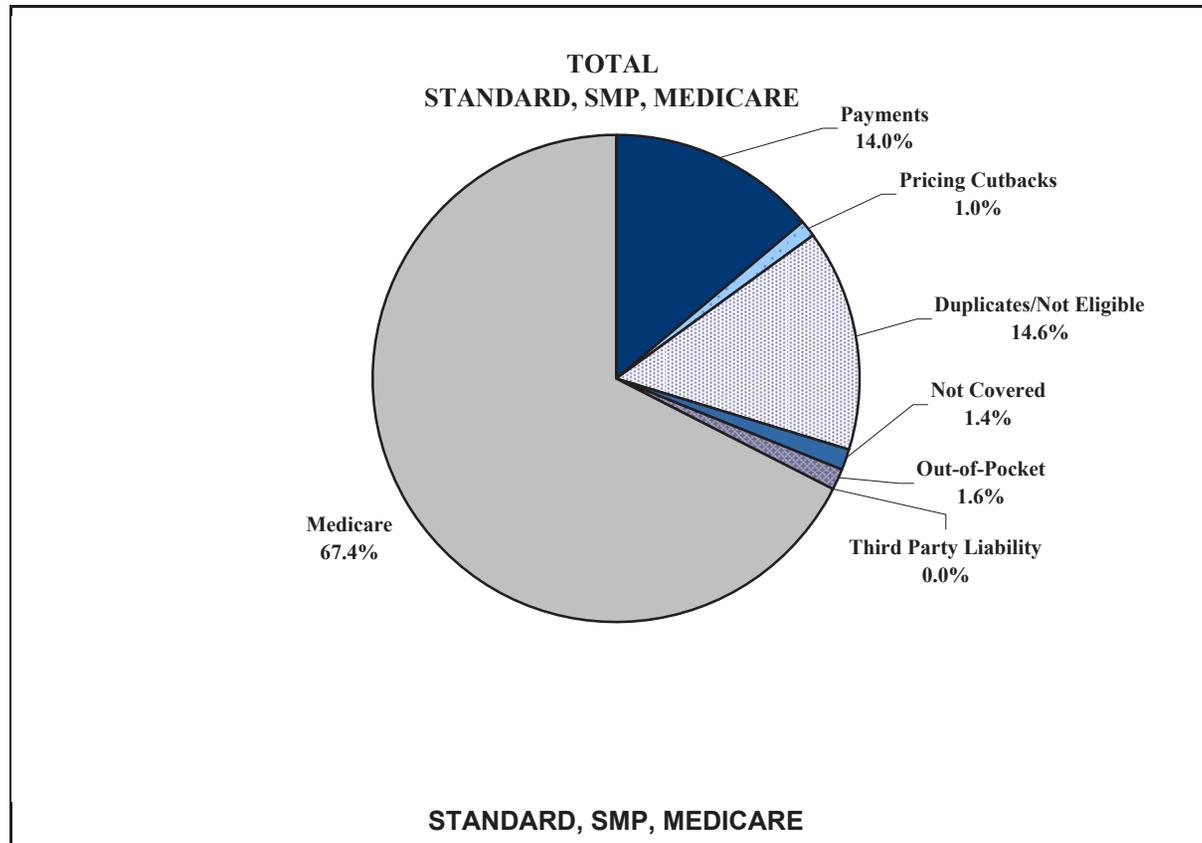
WISCONSIN PUBLIC EMPLOYERS
Medical Claims Savings Analysis
Incurred January 2008 - December 2008 Paid Through March 2009

Exhibit 17-C

Category	STANDARD		SMP		MEDICARE	
	\$ Amount	% of Total	\$ Amount	% of Total	\$ Amount	% of Total
Submitted Charges	\$801,812	100.0%	\$234,135	100.0%	\$8,559,945	100.0%
Duplicates/Not Eligible	\$42,545	5.3%	\$2,007	0.9%	\$1,353,186	15.8%
Pricing Cutbacks	\$73,020	9.1%	\$21,590	9.2%		
Out-of-Pocket						
Deductible	\$15,751	2.0%	\$1,120	0.5%	\$41,458	0.5%
Coinsurance	\$13,057	1.6%	\$551	0.2%	\$75,893	0.9%
Copayments	\$936	0.1%	\$182	0.1%	\$656	0.0%
Total	\$29,743	3.7%	\$1,852	0.8%	\$118,007	1.4%
Not Covered						
Medical Necessity	\$8,246	1.0%	\$0	0.0%	\$993	0.0%
Inappropriate Provider	\$820	0.1%	\$435	0.2%	\$345	0.0%
Benefit Maximum	\$3,718	0.5%	\$331	0.1%	\$46,061	0.5%
Experimental/Fertility	\$0	0.0%	\$0	0.0%	\$0	0.0%
Dental	\$1,210	0.2%	\$0	0.0%	\$473	0.0%
Custodial	\$0	0.0%	\$0	0.0%	\$8,659	0.1%
Code Review	\$18,550	2.3%	\$0	0.0%	\$1,925	0.0%
Contact Lens/Hearing Aid	\$76	0.0%	\$0	0.0%	\$4,490	0.1%
Drugs	\$0	0.0%	\$0	0.0%	\$0	0.0%
No Referral	\$0	0.0%	\$0	0.0%	\$0	0.0%
All Other	\$2,660	0.3%	\$10,870	4.6%	\$22,498	0.3%
Total	\$35,279	4.4%	\$11,636	5.0%	\$85,444	1.0%
Third Party Liability						
Workers Compensation	\$0	0.0%	\$0	0.0%	\$0	0.0%
Subrogation	\$0	0.0%	\$0	0.0%	\$0	0.0%
Coordination of Benefits	\$0	0.0%	\$2,474	1.1%	\$0	0.0%
Total	\$0	0.0%	\$2,474	1.1%	\$0	0.0%
Medicare	\$450	0.1%	\$0	0.0%	\$6,433,629	75.2%
Payments	\$620,777	77.4%	\$194,576	83.1%	\$517,912	6.1%

**WISCONSIN PUBLIC EMPLOYERS
 Medical Claims Savings Analysis Summary
 Incurred January 2008 - December 2008 Paid Through March 2009**

	STANDARD		SMP		MEDICARE	
	\$ Amount	% of Total	\$ Amount	% of Total	\$ Amount	% of Total
Payments	\$620,777	77.4%	\$194,576	83.1%	\$517,912	6.1%
Pricing Cutbacks	\$73,020	9.1%	\$21,590	9.2%		
Duplicates/Not Eligible	\$42,545	5.3%	\$2,007	0.9%	\$1,353,186	15.8%
Not Covered	\$35,279	4.4%	\$11,636	5.0%	\$85,444	1.0%
Out-of-Pocket	\$29,743	3.7%	\$1,852	0.8%	\$118,007	1.4%
Third Party Liability	\$0	0.0%	\$2,474	1.1%	\$0	0.0%
Medicare	\$450	0.1%	\$0	0.0%	\$6,433,629	75.2%





State of Wisconsin

Section 3: Integrated Care Management

Insuring **Wisconsin's** Health *Since 1946*

State Employee Trust Funds

Executive Summary

Savings and Care Management Services

- Care Management savings were almost \$3.3 million in 2008.
 - Savings increased more than 13% (\$3.3M vs. \$2.9M) over 2007.
 - Savings were 8% (\$3.3M of \$40.0M) of total paid claims in 2008.
 - Savings included pharmacy management of specialty injectable drugs that resulted in \$103K in savings in 2008.
- Care Management services were provided to all ETF Standard Plan members with claims greater than \$100K.
- Cancer was the most common diagnosis for cases with paid claims over \$100K.
 - 38% (n = 21 of 55) of high dollar cases.
 - 42% (n = \$4.6M of \$11.1M) of high dollars.
- PMPM costs compared to benchmarks are high in diagnostic categories driven by behavioral health conditions, strokes, cancer, obesity, arthritis and infections.
- Bariatric surgery costs continue to contribute to a high PMPM in the obesity category, but no cases were in the high dollar report.
- 80 members participated in Chronic Care Management, a program that provides disease specific health education and prevention from registered nurses who provide coaching and assist with setting self-care goals.
 - 51% (n = 41 of 80) of participants had cardiac diagnoses.
 - 41% (n = 33 of 80) of participants were members with diabetes.
 - 8% (n = 6 of 80) of participants were members with asthma with multiple conditions, managed by diabetic or cardiac care managers or complex case managers.

Preventive Quality Screenings

- Mammography screening rates continue above the national PPO average (74.7% vs. 66.9%).
- Cervical cancer screening rates increased almost 20% in 2008, but remain below the national PPO average (63.2% vs. 73.5%).
- Clinical Quality measures for Diabetic Care are at or near the national PPO benchmarks, but rates are down slightly from 2007. HbA1c testing rate was 75.7% versus the benchmark of 75.6%; LDL-C testing was 69.5% versus the benchmark of 72.7%.
- Quality screenings provide an opportunity for member education and engagement through medical management programs and/or member communications (i.e. emails, postcard reminders or newsletters).

Wellness Program

- In 2008, WPS Wellness provided a variety of free on-line resources for ETF members.
- In 2009, customized wellness programs, health risk appraisals, biometric screenings and wellness coaching sessions (i.e. smoking cessation) are available for your consideration.

State Employee Trust Funds

Care Management

Conditions Impacting Top Major Diagnostic Categories* (MDC) by PMPM

The age of ETF's population may account for high PMPM in categories related to cancer, arthritis, joint replacement, strokes, diabetes and cataracts. Members ages 55-64 years old are 34% of ETF's Standard Plan membership, compared to 14% for the benchmark (per Exhibit 3-A). All categories except MDC 2 were impacted by members with claims greater than \$100K.

The top MDC by PMPM claims costs with the most significant variation to the benchmark:

- Behavioral Health (MDC 19) claims were driven by members with psychotic conditions and depression. These conditions accounted for nearly 57% (n = \$1.2M of \$2.1M) of behavioral health paid claims. ETF Standard Plan non-standard mental health benefit may impact these costs.
- Nervous System (MDC 1) conditions related to strokes, cerebral degeneration, viral infection and cancer of the brain and nervous system impacted PMPM. These claims were 38% (n = \$1.5M of \$4.0M) of nervous system claims.
- Cancer (MDC 17) claims for chemotherapy, radiation therapy, bone marrow transplants and lymphoma (cancer of the immune system) accounted for 64% (n = \$1.6M of \$2.5M) of total cancer claims in this group.
- Endocrine, Nutritional, and Metabolic (MDC 10) PMPM was driven by claims related to obesity and diabetes. Claims for these conditions were 53% (n = \$1.0M of \$1.9M) of paid dollars in this category.
- Skin and Breast (MDC 9) cancers and cellulitis were 50% (n = \$1.5M of \$3.0M) of claims in this group.
- Muscle and Bone (MDC 8) conditions related to medical back problems, total joint replacements and arthritis were 44% (n = \$4.0M of \$9.0M) of total claims for this category.
- Infections (MDC 18) of the blood (septicemia) were responsible for 62% (n = \$620K of \$1.0M) of paid claims for infections.
- Eye (MDC 2) conditions related to cataracts were 48% (\$1.0M of \$2.1M) of paid claims for all eye conditions.

* Per Data Dashboard DRG and Diagnosis data - coverage dates December 2007 to November 2008 Paid through March 2009

STATE EMPLOYEE TRUST FUNDS
Claim Costs by Major Diagnostic Categories (Partial Listing) - Standard
Top MDC's with Greatest Variation to the Benchmark

Exhibit 1

MDC CODE	MAJOR DIAGNOSTIC CATEGORY DESCRIPTION	2007	2008	BENCHMARK PMPM **	DIFFERENCE	
		ACTUAL PMPM *	ACTUAL PMPM **		2008 to 2007	2008 to BENCHMARK
8	Muscles, Bones, and Connective Tissue D/D	\$106.20	\$136.68	\$90.92	28.7%	50.3%
1	Nervous System Diseases and Disorders (D/D)	\$42.90	\$65.54	\$21.82	52.8%	200.3%
9	Skin, Subcutaneous Tissue (fat and connective) and Breast D/D	\$40.53	\$44.95	\$28.01	10.9%	60.5%
17	Bone Marrow D/D and Poorly Differentiated Cancers	\$46.67	\$38.60	\$22.91	-17.3%	68.5%
19	Behavioral Health Diagnoses	\$41.80	\$34.28	\$9.79	-18.0%	250.0%
10	Endocrine, Nutritional and Metabolic D/D (included diagnoses related to obesity, diabetes and hormones)	\$34.77	\$26.51	\$16.17	-23.8%	63.9%
18	Infectious and Parasitic Diseases	\$3.05	\$19.99	\$5.07	555.4%	294.6%

Note: Sorted by 2008 actual PMPM.

Note: Benchmark data has been age/sex adjusted to correspond to the population included in this exhibit.

* Each \$1.00 paid PMPM = \$46,800 in plan costs.

** Each \$1.00 paid PMPM = \$46,871 in plan costs.

State Employee Trust Funds

Care Management

Conditions Managed for High Cost Cases

All ETF Standard Plan members with high dollar claims received care management services.

- Cancer:
 - 38% (n = 21 of 55) of high dollar cases.
 - 42% (n = \$4.6M of \$11.1M) of high dollars.
 - One member had catastrophic claims (\$825K) for cancer treatment and related complications.

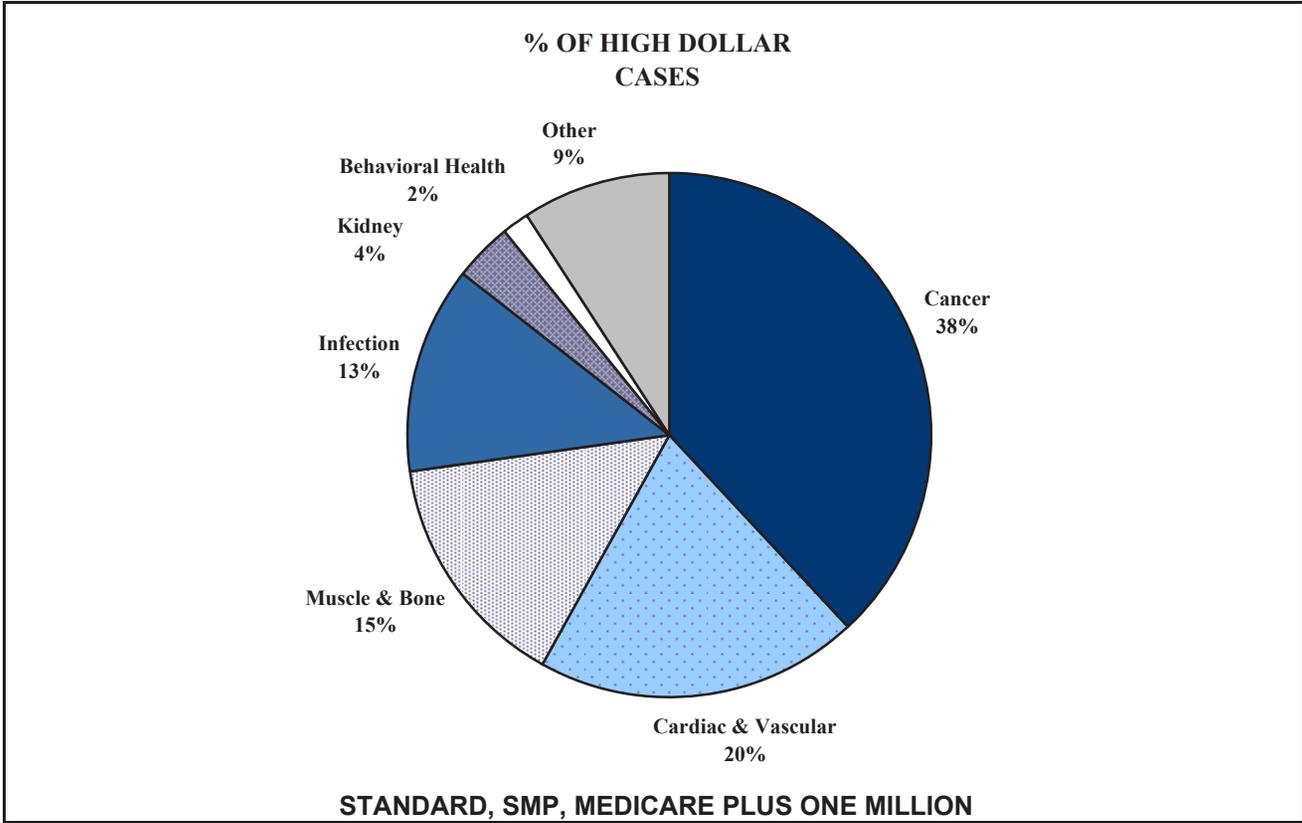
- Cardiac and vascular conditions:
 - 20% (n = 11 of 55) of high dollar cases.
 - 21% (n = \$2.4M of \$11.1M) of high dollars.
 - One member had large claims (\$573K) for a stroke, craniotomy, post-operative infection, and inpatient admissions to both an acute brain injury facility and an acute rehabilitation center.

- Muscle and bone conditions (fractures, back surgery and arthritis):
 - 15% (n = 8 of 55) of high dollar cases.
 - 10% (\$1.1M of \$11.1M) of high dollars.
 - Highest claim (\$274K) in this category was for a member with spinal fusion surgery that resulted in admission to the intensive care unit for 4 days.

- Infections:
 - 13% (n = 7 of 55) of high dollar cases.
 - 15% (\$1.6M of \$11.1M) of high dollars.
 - Two cases accounted for 43% (\$732K of \$1.7M) of high dollar paid claims in this category:
 - One infection was the result of an untreated cancer. Claims for this untreated cancer were more than \$424K. (Member chose not to treat this cancer).
 - The other case involved a member with a history of infections and multiple admissions, including a 24 day stay for necrotizing fasciitis, a rare infection of the skin and subcutaneous tissue. Claims totaled more than \$307K.
 - None of the infections were a complication of recent medical care.

**STATE EMPLOYEE TRUST FUNDS
High Dollar Claims by Diagnosis
Incurred January 2008 - December 2008 Paid Through March 2009**

Diagnosis	% of High Dollar Cases	% of High Dollars	# of Cases	Paid Dollars
Cancer	38%	42%	21	\$4,621,509
Cardiac & Vascular	20%	21%	11	\$2,360,615
Muscle & Bone	15%	10%	8	\$1,098,392
Infection	13%	15%	7	\$1,688,914
Kidney	4%	5%	2	\$509,955
Behavioral Health	2%	1%	1	\$103,942
Other	9%	6%	5	\$709,331
Total	100%	100%	55	\$11,092,658



State Employee Trust Funds

Care Management

ETF Bariatric Surgery Experience

WPS responded to ETF's concerns about the variation in the cost of bariatric surgery and created a Centers of Excellence (COE) approach in 2007 for ETF Standard Plan members meeting medical necessity criteria for bariatric surgery. Centers of Excellence facilities are certified by Centers for Medicare & Medicaid Services and the programs (hospital and surgeon combinations) are certified by the American Society of Bariatric Surgeons as a COE.

- Member selection of COE vs. non-COE increased significantly in 2008 compared to 2007.*
 - 93% (n = 14 of 15) utilized COE in 2008.
 - 56% (n = 15 of 27) utilized COE in 2007.
- Decrease of 44% (27 vs.15) in the number of primary bariatric procedures in 2008 compared to 2007; similarly our WPS Book of Business saw a 49% (53 vs. 27) decrease in bariatric surgeries during the same time period. Even though our data shows a decrease in bariatric procedures, national predictions are for increased bariatric surgeries in 2009.
- Decrease in 2008 PMPM of 49% (\$18.21 vs. \$9.23) compared to 2007 is attributed to the decrease in the number of bariatric procedures and the COE approach.
- Only one non-COE case during 2008 was an inpatient procedure for nearly \$46K compared to 12 COE inpatient cases averaging nearly \$30K per case.
- PMPM costs remain high compared to the benchmark:
 - 2008 ETF incidence rate of 3.84 per 1,000 members for bariatric surgery is more than seven times the WPS book of business incidence rate of 0.53 per 1,000 members for bariatric surgery.
 - Fewer ETF members to allocate costs when compared to book of WPS business.
 - ETF members may use the WPS plan exclusively for bariatric procedures resulting in adverse selection. During 2007, 59% (n = 16 of 27) of members with bariatric surgery termed by January 2008. During 2008, 67% (n = 10 of 15) of members with bariatric surgery termed by March 2009.
- Total number of ETF bariatric cases is small; however we are seeing a pattern of decreasing costs similar to national trends for COE programs.

Note: Costs are calculated based on allowed amounts. WPS Book of Business data excludes ETF members.

* In 2007, twenty-seven members had a primary bariatric procedure; one of these members also had a revision of a previously placed lap band.

**STATE EMPLOYEE TRUST FUNDS
Bariatric Cost Per Case and PMPM**

	EMPLOYEE STATE TRUST FUNDS				WPS BOOK OF BUSINESS	
	Incurred in 2007 Paid Through March 2008		Incurred in 2008 Paid Through March 2009		Incurred in 2008 Paid Through March 2009	
	Bariatric Surgery		Bariatric Surgery		Bariatric Surgery	
	Inpatients	Outpatients	Inpatients	Outpatients	Inpatients	Outpatients
COE Cases	13	2*	12	2	8	1
PMPM	\$8.38	\$0.62	\$7.59	\$0.66	\$0.31	\$0.03
Cost / case	\$30,172	\$14,578	\$29,652	\$15,415	\$23,226	\$16,112
Non-COE Cases	9	4	1	0	18	0
PMPM	\$7.17	\$2.04	\$0.98	\$0.00	\$1.02	\$0
Cost / case	\$37,261	\$23,980	\$45,877	\$0	\$34,547	\$0
Total Cases	22	6*	13	2	26	1
PMPM by treatment setting	\$15.55	\$2.66	\$8.57	\$0.66	\$1.33	\$0.03
Total Members	27		15		27	
Total PMPM	\$18.21		\$9.23		\$1.36	

Note: Costs calculated based on allowed amounts.

Note: WPS Book of Business excludes ETF members.

Note: WPS Book of Business members with bariatric surgery in 2007 totaled 53 members.

* One case was a revision of a previously placed lap band, not the primary procedure.

State Employee Trust Funds

Care Management

Care Management Services

Case Management is assessing, planning and facilitating services for members involved in an acute or catastrophic medical situation. The Case Manager focuses on managing the utilization of benefits in the most effective manner within the confines of the policy while ensuring quality of care is not compromised. Examples of Case Management are inpatient rehabilitation cases, long term inpatient cases, or short term home care cases that require skilled nursing visits and/or intravenous (IV) therapy. All of these cases are closely managed by the case manager.

Chronic Care (Disease) Management utilizes a proactive approach through education, treatment and appropriate care to prevent long-term and unnecessary complications of chronic conditions. Through education, the Chronic Care Manager empowers members to take ownership of their health, decreasing future health risks, minimizing the need for medical services, and ultimately, improving the quality of life.

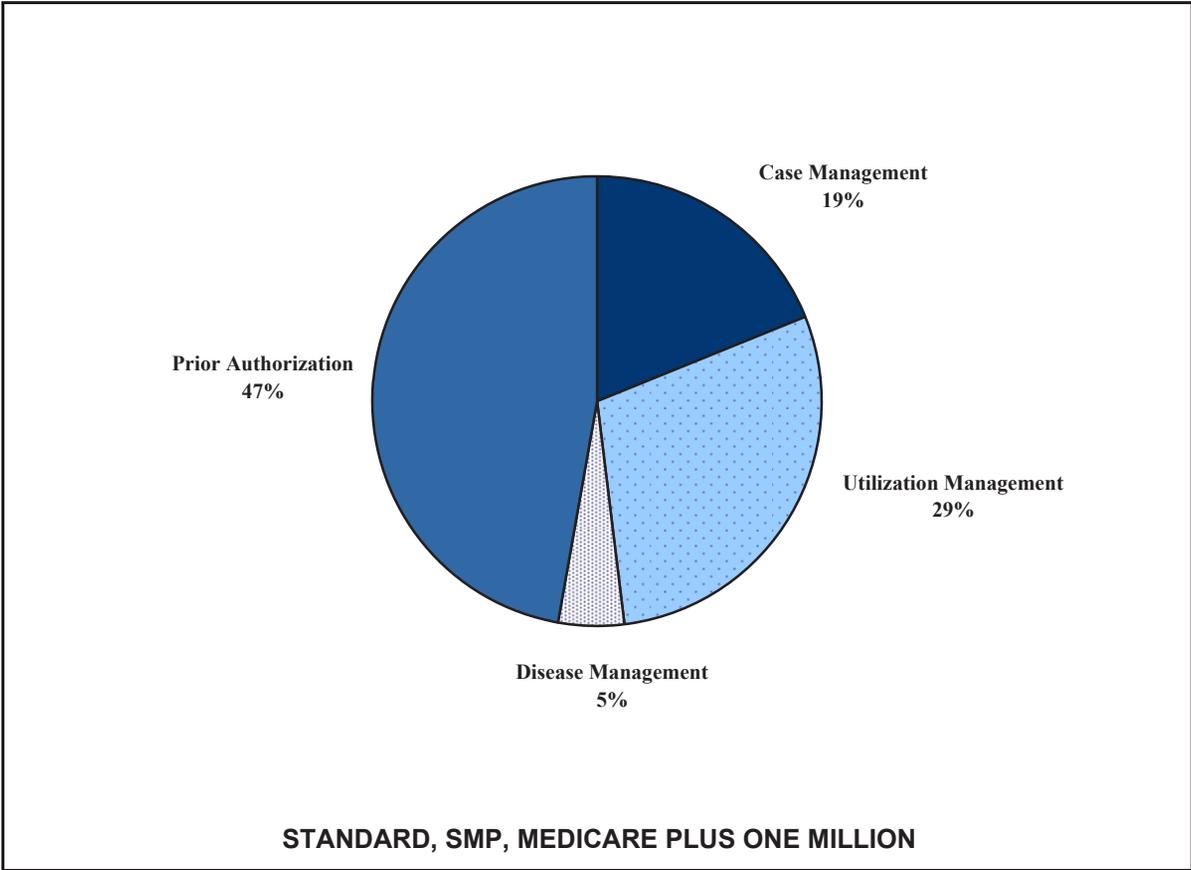
Medical Review is an additional process in the Medical Affairs area that does post-claim review to ensure that those services that received preauthorization are billed appropriately, and services not requiring preauthorization are covered by the member's plan, and are medically necessary.

Preauthorization is the review of specific outpatient services (including surgical services, diagnostic services, and referrals) and a determination that these services meet the criteria for medical necessity under the member's benefit plan.

Utilization Management helps ensure members achieve proper utilization of services, while maximizing their health care benefits, as well as determining the most appropriate level of care. Care Management nurses monitor patient care through preadmission or pre-certification review, inpatient admission and concurrent review, discharge planning with referrals to Case or Chronic Care Management nurses and outpatient services review.

STATE EMPLOYEE TRUST FUNDS
Care Management Summary
Calendar Year 2008

Care Management Category	# of Cases
Case Management	293
Utilization Management	453
Disease Management	74
Prior Authorization	735
Total	1,555



State Employee Trust Funds

Care Management

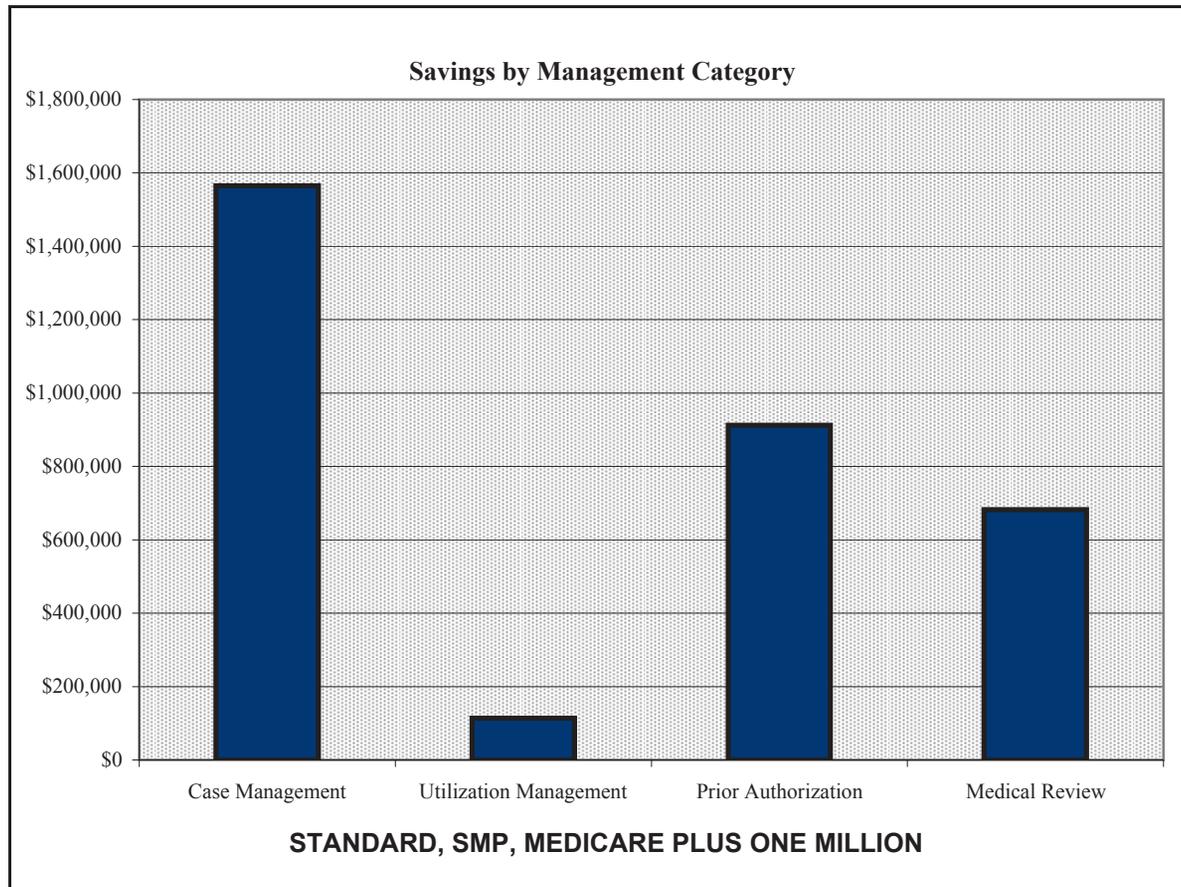
Care Management Savings

- In 2008, WPS Care Management saved ETF almost \$3.3 million dollars, an increase of more than 13% (\$3.3M vs. \$2.9M) compared to 2007. Savings were 8% (\$3.3M of \$40.0M) of total paid claims in 2008. Savings included pharmacy management of specialty injectable drugs that resulted in \$103K in savings in 2008.
- Utilization savings reflect renewed focus within hospitals to decrease length of stay and avoid unnecessary hospital days. This has resulted in fewer denied days by our Utilization Management staff.
- Only hard savings are included – future savings from Chronic Care (Disease) Management are not included. Hard savings are realized from avoided hospital days, avoided/denied services, or negotiated rate reductions.
- Savings include Medical Review, an additional process in the Medical Affairs area that does post-claim review to ensure:
 - Services that received preauthorization are billed appropriately.
 - Services not requiring preauthorization are covered by the member's plan, and medically necessary.
- Preauthorization savings include savings realized from managing the purchase and administration of specialty injectable drugs. Our clinical staff intervenes when we preauthorize these drugs to insure they are obtained in-network, and that the member is trained on self-administration. When given at home, these self-injectable medications avoid the expense incurred when the drugs are purchased and administered in a doctor's office. In addition to the financial savings, it is more convenient for the member since they no longer have to make multiple trips to the clinic for treatment.

**STATE EMPLOYEE TRUST FUNDS
Care Management Savings
Calendar Year 2008**

Exhibit 5

Care Management Category	Savings
Case Management	\$1,564,810
Utilization Management	\$113,314
Prior Authorization	\$912,234
Medical Review	\$681,754
Total	\$3,272,112



State Employee Trust Funds

Care Management

Health Status Measure (HSM)

Health Status Measure (HSM) is a predictor of a member's risk for future care and related costs. Our predictive modeling tool helps improve the effectiveness and productivity of our case and chronic care managers by identifying at-risk members before their conditions and costs escalate. This enables us to enroll members in Case and Care Management programs at a much earlier stage.

Our software uses multiple algorithms, including severity indices. One of these indices, Burden of Illness (BOI), ranks members based on severity and complications. These scores are categorized into an HSM. Members with higher HSM scores are identified and screened for our chronic care management program.

Conditions managed in 2008 included asthma, diabetes, hypertension and heart disease.

- Total number of ETF members with these conditions increased 10% (1,192 vs. 1,082) since 2007. Members with asthma and high blood pressure drove the increase in chronic conditions.
- ETF members with high HSM scores increased 25% (71 vs. 57) compared to 2007.
- Chronic Care Management services focus on members with higher HSM scores.

STATE EMPLOYEE TRUST FUNDS

HSM Table
Calendar Year 2008

Exhibit 6

HSM Severity Score	Members with				
	Asthma	Diabetes	Hypertension	Heart Disease	Total
10	2	7	7	2	18
9	1	4	2	1	8
8	3	5	7	1	16
7	8	7	12	2	29
6	6	8	13	2	29
5	8	19	41	16	84
4	25	49	107	18	199
3	33	47	136	19	235
2	58	53	164	12	287
1	104	27	144	12	287
Total	248	226	633	85	1,192
CY 2007	179	228	596	79	1,082

State Employee Trust Funds

Care Management

Chronic Care Management (CCM)

Formerly known as disease management, CCM focuses on members with Asthma, Congestive Heart Failure, Coronary Artery Disease (including Hypertension and High Cholesterol), Diabetes, and Alcohol & Drug Abuse.

The mission of this area is to proactively identify members with existing and potential medical issues, help them navigate the healthcare system, educate them on their condition, and empower them to make positive lifestyle changes. During 2008, our opt-in program had a 7% (n = 80 of 1,192) participation rate for ETF members identified with selected chronic conditions. Less than 10% participation is typical of opt-in programs. Our opt-in program identifies members for participation in CCM through a data analysis process called predictive modeling. Identified members are then invited to enroll in CCM programs.

In 2008, we continued to develop our opt-out CCM program that was available for renewing groups in 2009. The opt-out model presumes members identified for CCM are enrolled in the program and they must decline verbally or in writing if they chose not to participate.

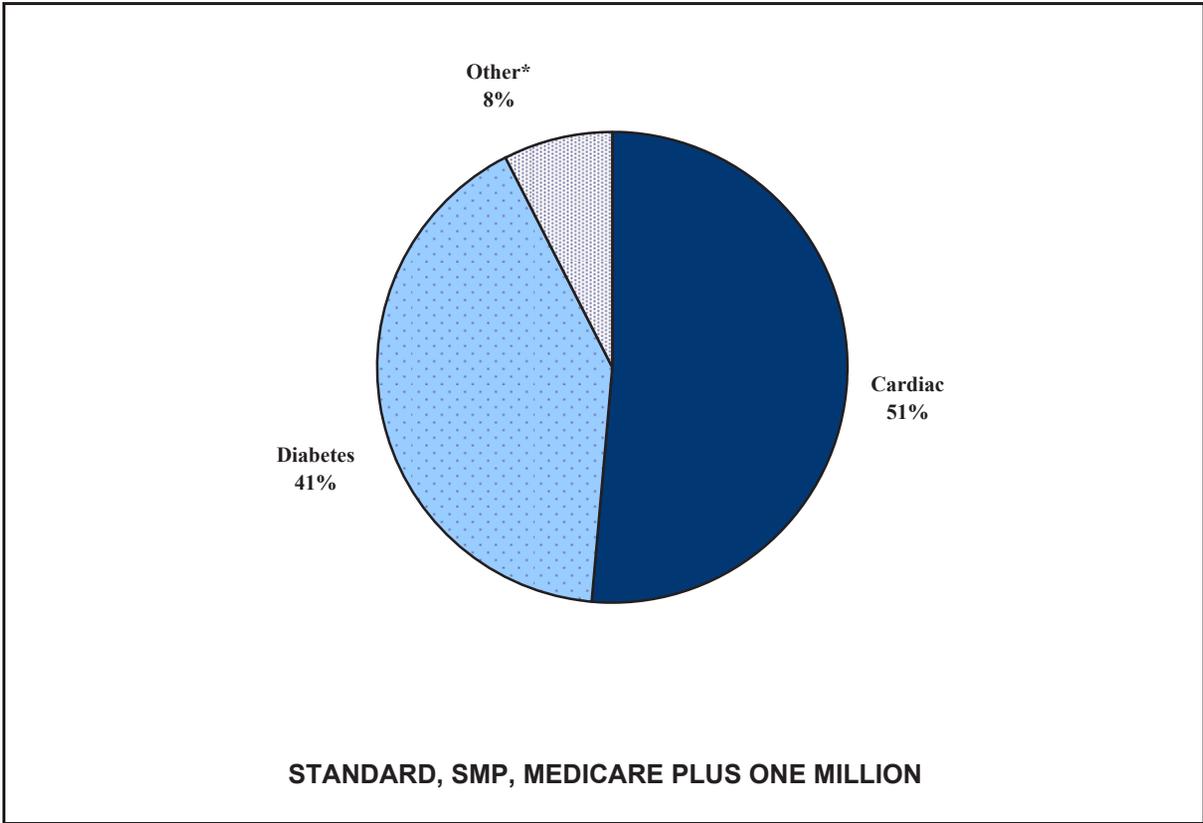
ETF members with cardiac and diabetic conditions received the majority (93% = 74 of 80) of our chronic care management services.

Our Great Beginnings pre-natal program, now part of case management, provides services to members with high risk pregnancies. As an example, the RN care manager worked with a member on the high dollar report with a history of pre-term deliveries to prevent a prolonged inpatient hospital admission. The RN care manager arranged extensive home care services with an in-network provider, supplied printed educational materials, and was available by telephone for this member. As a result, only 6 days of inpatient stays during the pregnancy and a 1 week inpatient stay just prior to the delivery for ongoing monitoring were incurred. These intensive home care services avoided a lengthy inpatient admission for this high risk member and her newborn.

STATE EMPLOYEE TRUST FUNDS
Chronic Conditions - Managed Cases
Calendar Year 2008

Chronic Conditions	Open Cases	Closed Cases	Total Cases
Cardiac	27	14	41
Diabetes	16	17	33
Other*	6	0	6
Total	49	31	80

*Other = Members with asthma provided services by diabetic or cardiac care managers or complex case managers (including behavioral health).



State Employee Trust Funds

Care Management

Behavioral Health Outpatient Visits

- Behavioral Health (BH) outpatient visits have decreased over the past three years. Since 2006:
 - Members with greater than twenty visits have decreased almost 23% (191 vs. 148).
 - Members with less than twenty visits have decreased almost 9% (540 vs. 494).
 - Overall BH outpatient visits decreased 12% (731 vs. 642).

- Decrease in BH outpatient visits impacted by:
 - Ongoing review of all cases with greater than twenty visits.
 - Requiring physicians to complete and submit treatment plans for review by our physician advisor prior to authorizing additional visits.

STATE EMPLOYEE TRUST FUNDS
Behavioral Health Outpatient Visits
Calendar Year 2006 - 2008

Number of Visits	Members		
	2006	2007	2008
1-19	540	507	494
20-30	79	75	60
31-40	44	28	45
41-50	28	25	24
51-60	10	14	11
61-70	9	10	4
71-80	1	7	0
81-90	3	5	3
91-100	6	3	0
>100	11	1	1
Total - All Visits	731	675	642
Total - Visits > 20	191	168	148

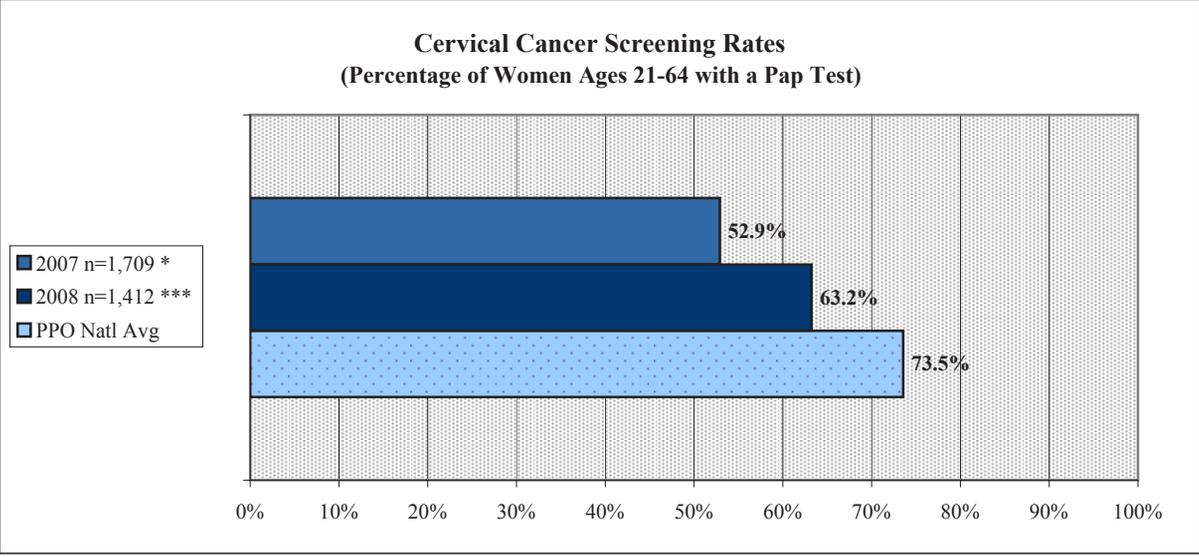
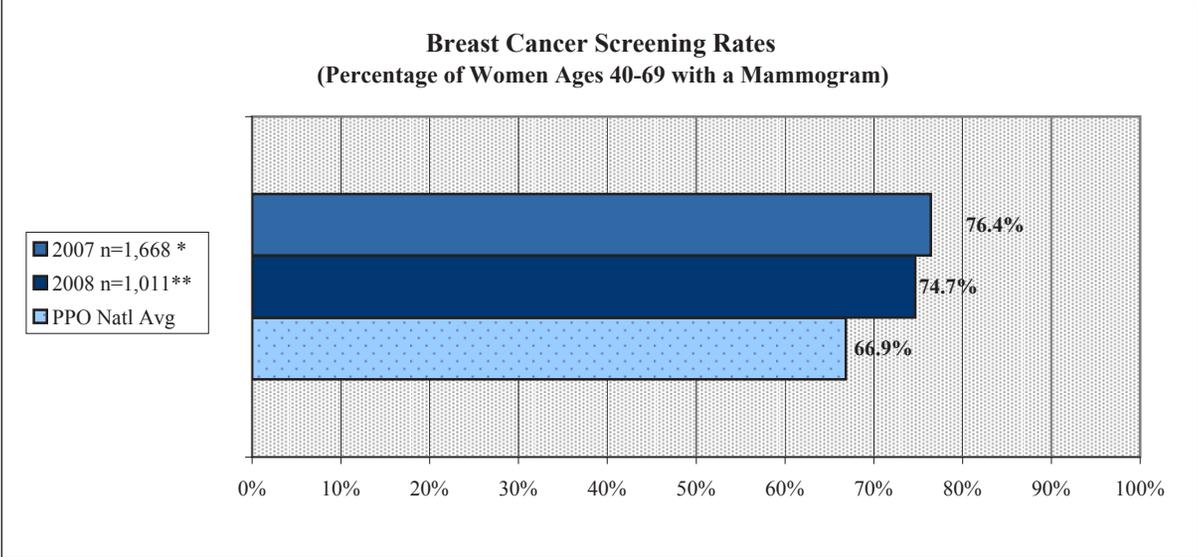
State Employee Trust Funds

Care Management

Quality Measures for Chronic Conditions and Health Care Screening

- Health care performance measures provide information about a provider's quality of clinical care and a comparison to national PPO benchmarks. Note, however, the Standard Plan is an atypical PPO plan in that it is an older population with 41.5% of membership over the age of 55 compared to the WPS benchmark of 16.7%.
- ETF's breast cancer screening rate for women ages 40 to 69 who received a mammogram within the past two years (2007-2008) remains more than 10% (74.7% vs. 66.9%) above the PPO national average, though ETF's rate is down 2% (76.4% vs. 74.7%) since 2007.
- ETF's screening rate for cervical cancer for women ages 21 to 64 who received a Pap test within the past three years (2006-2008) increased nearly 20% (52.9% vs. 63.2%) compared to last year. Portion of increase is attributed to availability of three years of data that was not available last year (ETF contracted with WPS in 2006).
- Quality measures for ETF's diabetic population ages 18 to 75 include rates for HbA1c and LDL-C testing in 2008.
 - Screening rates are slightly below last years rates: HbA1c testing down 5% (79.9% vs. 75.7%) and LDL-C down 3% (71.9 vs. 69.5).
 - HbA1c testing rate matches the PPO national rate of 75%.
 - LDL-C testing rate of 69.5% is 4% below PPO national rate of 72.7%.
- Quality measures offer opportunities for focused member education and engagement through medical management programs and/or member communications (i.e. emails, postcard reminders or newsletters).
- Additional quality measures for chronic conditions and preventive health care screenings will be available third quarter of 2009, for 2008 data.

**STATE EMPLOYEE TRUST FUNDS
Screening Rates - Standard and SMP**



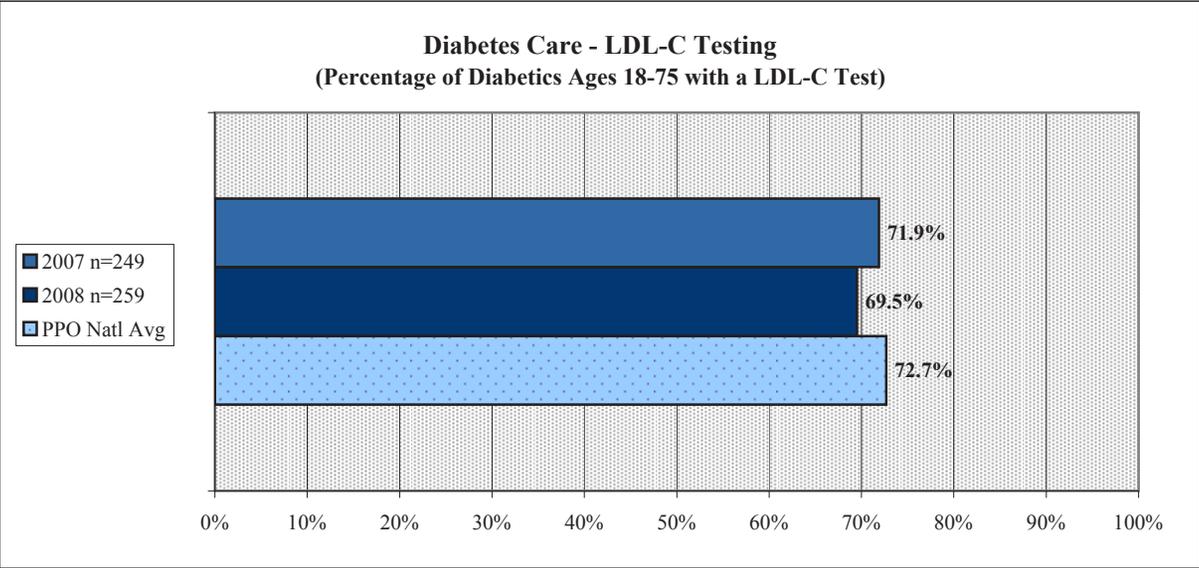
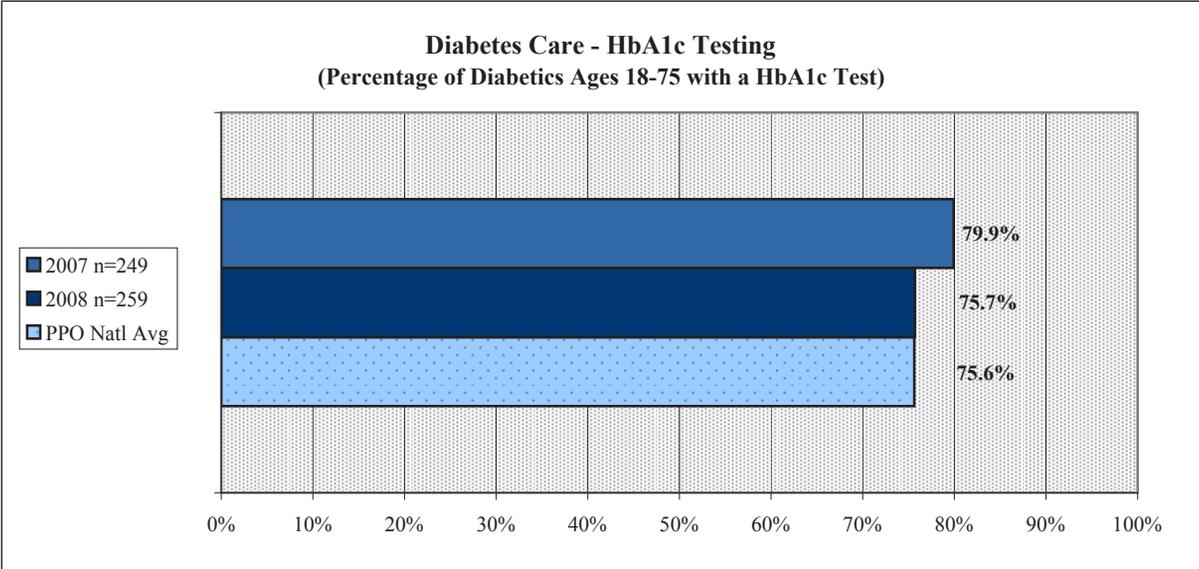
Note: National PPO average is for 2007 data. Average for 2008 data is not yet available.

* 2007 rate includes screenings performed in 2006 or 2007.

** 2008 rate includes screenings performed in 2007 or 2008.

*** 2008 rate includes screenings performed in 2006, 2007 or 2008.

**STATE EMPLOYEE TRUST FUNDS
Diabetes Measures - Standard and SMP**



Note: National PPO average is for 2007 data. Average for 2008 data is not yet available.

State Employee Trust Funds

Care Management

Wellness and Prevention Programs

Included in the WPS Integrated Care Management programs is a comprehensive Wellness program that encourages healthy lifestyles, promotes healthy decision making and provides the support needed to develop healthy habits.

Available at no additional charge through the WPS member portal are:

On-Line Resources

- WPS provides an **online health encyclopedia** from Healthwise. The Healthwise® Knowledgebase contains more than 3,200 evidence-based topics on health conditions, medical tests and procedures, medications, and everyday health and wellness issues.
- **HealthSense Rewards™**, a WPS program that provides discounted access to a variety of health clubs.
- **WPS Alive & Well Newsletter** (PDF version on Web site) is published on a bi-monthly basis. Available through the WPS Member Health Center portal.
- **Health and Wellness Resource Guide** (PDF version on Web site) that refers your employees to approximately 200 local organizations, helping you to further enhance your worksite wellness program.
- **Web Journals (blogs)** WPS' wellness team offers expert insight on health and wellness-related topics in a blog featured on the Health Center page (published twice a month).
- **Weekly / Monthly email Wellness Tips** (available on disc) specific to your employees needs (Nutrition and Weight Management, General Wellness and/or Physical Activity).

For 2009 Wellness Services available at cost:

Health Risk Appraisal

Available in a paper format (includes on-site distribution and/or collection), or on-line (includes web portal set up). Both are administered by WPS Wellness and include an Aggregate Report presented to senior level management; individual results presented telephonically to each employee; recommendations for company consideration; a customized Wellness Action Plan to implement among your employees; and communication and advertising materials to communicate your programs.

Biometric Screening This service is billed at cost and arranged through local providers or State wide vendor.

Wellness Coaching Sessions Six month telephonic coaching sessions can be purchased for an additional fee.

State Employee Trust Funds

Care Management

2008 Care Management Satisfaction

Satisfaction Rating: 97%

Satisfaction Survey Comments:

- (WPS) was very helpful in optimizing the recovery process. The care coordinator was an expert, experienced, personable, and very supportive.
- The service provided by (WPS) was very good. The care manager was very professional, friendly and exceptionally helpful!
- My nurse was personal, professional, and approachable with any and all issues relating to my surgery and recovery. I thank you for all your help in such a stressful time in my life.
- I was incredibly impressed with the time and genuine concern Ann had for my care and progress. I always knew I had an excellent resource.
- Many thanks for the help in a difficult time!
- Rosalynn – you helped me turn things around with great encouragement! Since I started my program I lost 40 lbs. My blood pressure and blood numbers are great (the meds help too)! I feel the best I have felt in 25 yrs. I walk 3-5 miles a day, bicycle another 6-10 miles and do 20 minutes of weight training everyday. At least I am on the right track! Thanks.