



State of Wisconsin
Health Care Utilization Summary

May 2010

Prepared by:



2009 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 12,782 as of January 2010, down from 13,420 members in January 2009. This reduction in enrollment from January 2009 to January 2010 is due to a 7.2% decrease in the enrollment in the Standard Plan, a 51.2% decrease in the SMP Plan and 1.3% decrease in enrollment in the Medicare Plus \$1M Plan. The large decrease in enrollment in the SMP population was due to the introduction of an HMO option with Minnesota providers and the loss of 2 counties from the SMP service area.

The **Standard Plan** membership is much older than the normative distribution with 41.8% of membership over the age of 55 compared to the benchmark of 17.5%. 76.9% of the Standard Plan participants live within Wisconsin. Much of the Standard Plan population is located near larger metropolitan areas in Wisconsin with 29.2% of the population living in Dane County and 15.2% living in Milwaukee County.

The ages of the **SMP Plan** members are also older than the normative population with 39.3% of membership over the age of 50 compared to the benchmark of 26.6%. In 2009, only 54.6% of the SMP Plan membership resided within Wisconsin. Of the 54.6% members, 41.0% lived in 3 counties, Pierce, St. Croix and Florence. A majority of the out of state members are located in Minnesota. In 2010, the SMP Plan service area will no longer include Pierce and Buffalo Counties. In addition, an HMO option involving Minnesota providers is available to the employees. The change in plan availability has resulted in a decrease in the population from 571 members in December 2009 to 263 members in January 2010.

State Employee Trust Funds

Executive Summary

Claims Data

Summary

In 2009, the Standard Plan was 134.3% 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 2009, the difference in the demographics would project the Standard Plan to cost 21.7% 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 compared to the larger Standard Plan adds to the variability of the results.

Standard Plan

The Standard Plan has seen a 0.0% increase in overall claim costs between 2008 and 2009, and well below independent trend estimates.

The Standard Plan's costs were 37.8% above the benchmark in 2009, which is below the 2008 percentage of 48.1%. The variance to the benchmark is primarily a result of the anti-selection resulting from the dual choice open 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. The largest variance is seen in MDCs that include costs associated with gastric bypass procedures and outpatient psychiatric benefits which both have higher utilization and have benefit levels not typical of the benchmark groups.

The Standard Plan has 36 members with claims over \$100,000 for a total of \$6,676,563 in claim costs, compared to 51 members in 2009. These 36 members represent 21.0% of total claims paid under the Standard Plan. The expected percent of claims over \$100,000 for a group of this size is 9.0%, while the Standard Plan is slightly higher at 9.7%. The Standard Plan members pay 2.5% of their own medical claims as compared to the benchmark of 6.9%.

WPS paid 66.9% of submitted charges on behalf of the plan.

SMP Plan

For the SMP Plan, the year over year medical PMPM trend was 10.0%. The SMP Plan was 28.0% below the benchmark in 2009, 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 had one member who exceeded \$100,000 in 2009, with a total of \$127,385 in paid claims. 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 60.4% 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 2008 to 2009 was 4.4%.

WPS paid 6.4% of submitted charges on behalf of the plan. 76.7% of the charges were paid by Medicare.

State Employee Trust Funds

Executive Summary

Provider Data

For the **Standard Plan**, the top 20 facilities provide 57.7% 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. 45.8% of professional charges are from the top 20 providers. The University of Wisconsin Medical Foundation is the leading professional provider. Almost half the top providers for facility and professional services are from Dane and Milwaukee Counties where a majority of the population reside, however we did see a continued use of out of state providers in 2009.

For the **SMP Plan**, the top 20 facilities provide 95.6% of the total facility charges for the plan. The largest percentage of paid claims is from River Falls Area Hospital. 62.9% of the professional charges are from the top 20 professional providers. River Falls Medical Clinic is the leading professional provider. In 2009, the SMP Plan expanded the network to include many providers in Minnesota and Michigan which lead to a large increase in the number of providers used by SMP Plan members.

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 2009 data. For Medicare classes, demographic benchmarks are based on comparable WPS Medicare enrollment as appropriate.

Claim cost benchmarks are also based on calendar year 2009 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/1000 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 benefit represented in the WPS benchmark and the specific reported ETF class.

State Employee Trust Funds

Summary Level Cost and Membership

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 2008 through January 2010.

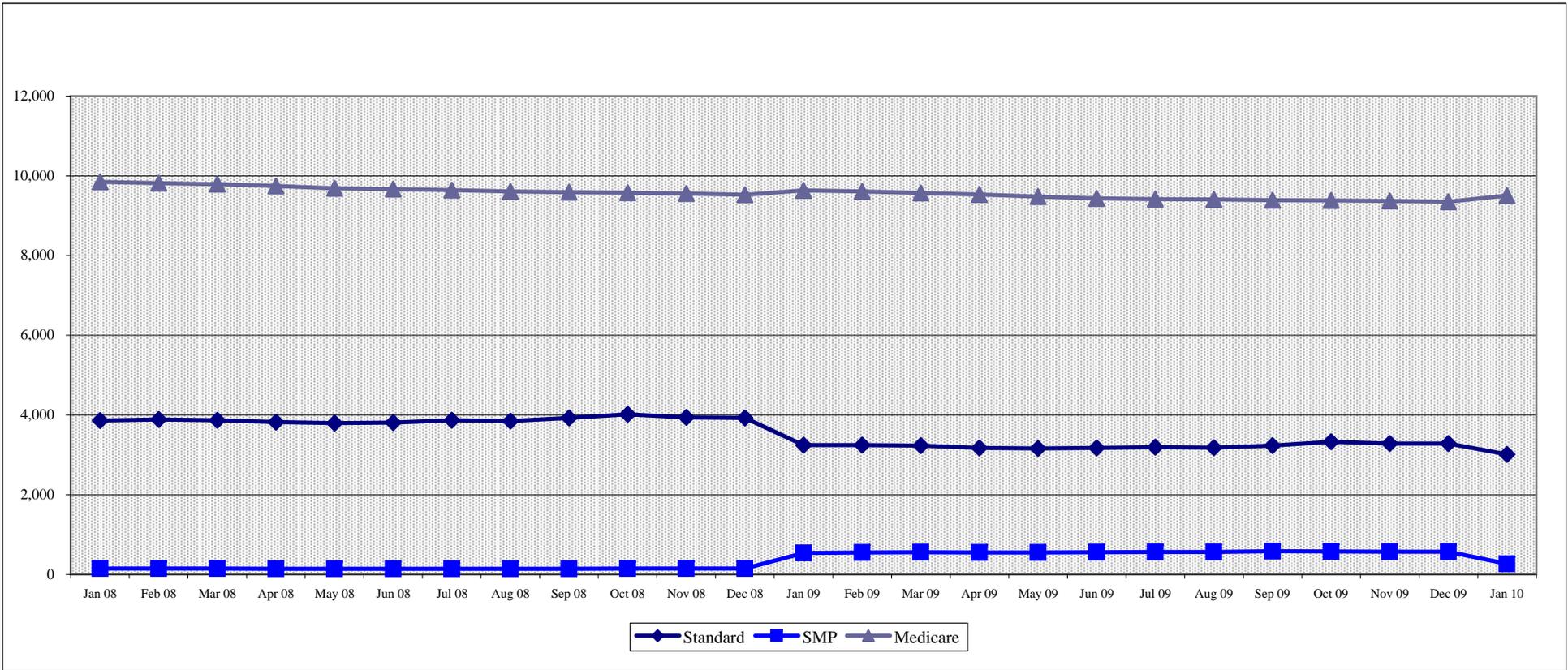
Enrollment in the **Standard Plan** decreased between 2008 and 2009 with an average of 3,229 members per month in 2009 compared to 3,881 members per month in 2008. Monthly membership within each year stayed relatively stable with increases seen in September and October of each year. In January 2010, the enrollment decreased 6.8% to 3,011 members from the 2009 average enrollment. The 2010 enrollment decrease appears to be across all regions with the largest loss in membership in the Dane County (83 members) and Milwaukee County (72 members).

SMP Plan enrollment averaged 561 members per month in 2009 compared to 146 members per month in 2008. This increase was due to the addition of 2 counties to the SMP service area and the expansion of the out of state provider network in Minnesota and Michigan. In January 2010, enrollment decreased to 263 members mainly due to the introduction of an HMO option with Minnesota providers and the loss of 2 counties from the SMP service area.

The **Medicare Plus \$1M Plan** enrollment is experiencing a very gradual decline in membership. Between January 2008 and December 2009, enrollment dropped from 9,849 to 9,352, or a reduction of 5.0%, over the course of the two years. In January 2010, the enrollment increased 1.7% to 9,508 members.

STATE EMPLOYEE TRUST FUNDS
Monthly Membership
January 2008 through January 2010

Exhibit 1-A



EFFECTIVE MONTH																									
	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	Feb 09	Mar 09	Apr 09	May 09	Jun 09	Jul 09	Aug 09	Sep 09	Oct 09	Nov 09	Dec 09	Jan 10
Standard	3,859	3,885	3,867	3,822	3,794	3,812	3,868	3,852	3,926	4,020	3,940	3,929	3,245	3,243	3,231	3,177	3,164	3,173	3,195	3,179	3,236	3,328	3,287	3,285	3,011
SMP	148	149	150	143	143	145	145	144	145	147	147	146	539	548	555	552	550	560	566	563	582	575	570	571	263
Medicare	9,849	9,816	9,791	9,746	9,686	9,665	9,643	9,609	9,589	9,577	9,554	9,524	9,636	9,607	9,572	9,529	9,479	9,435	9,416	9,408	9,392	9,380	9,371	9,352	9,508

State Employee Trust Funds

Group Demographics

Enrollment by Plan

The Enrollment by Plan report (Exhibit 2-A) shows the December 2009 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 43.7 years, 6.2 years older than the 37.5 average age of the smaller SMP Plan. Based on the age/gender factors for December 2009, we would expect the demographics alone would cause the Standard Plan to be 21.7% higher in claim costs than the SMP Plan, everything else being equal.

STATE EMPLOYEE TRUST FUNDS

Exhibit 2-A

Enrollment by Plan

December 2009

Plan	Class	# of Members	Average Member Age	Member Gender Distribution Female	Member Age/Gender Factor
Standard	Regular	2,412	43.3	51.6%	1.634
	Graduate Assistant (including GA continuation)	330	27.9	50.3%	0.949
	Continuation	26	39.4	50.0%	1.336
	Annuitants	517	55.7	72.3%	2.290
Subtotal		3,285	43.7	54.7%	1.666
SMP	Regular	531	36.4	51.6%	1.314
	Graduate Assistant (including GA continuation)	8	29.3	50.0%	0.943
	Continuation	1	47.0	100.0%	1.515
	Annuitants	31	58.5	54.8%	2.415
Subtotal		571	37.5	51.8%	1.369
Medicare Plus One Million	Single	4,395	80.4	71.6%	N/A
	One Over	199	70.2	9.5%	N/A
	Two Over	4,758	76.2	50.1%	N/A
Subtotal		9,352	78.0	59.3%	N/A
ETF Grand Total		13,208	67.7	57.9%	N/A

State Employee Trust Funds

Group Demographics

Member Census Grids

The Member Census Grid breaks down the December 2009 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 41.8% of membership over the age of 55 compared to the benchmark of 17.5%. 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 16.0% of the membership under the age of 20 compared to the benchmark of 29.1%. The Standard Plan also has a higher than normal female population with 54.7% female, compared to the benchmark of 51.9%.

SMP Plan

The SMP Plan membership (Exhibit 3-B) also shows the plan having an older population than the normative distribution with 39.3% of membership over the age of 50 compared to the benchmark of 26.6%. The gender distribution of the SMP Plan is similar to the benchmark population.

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.

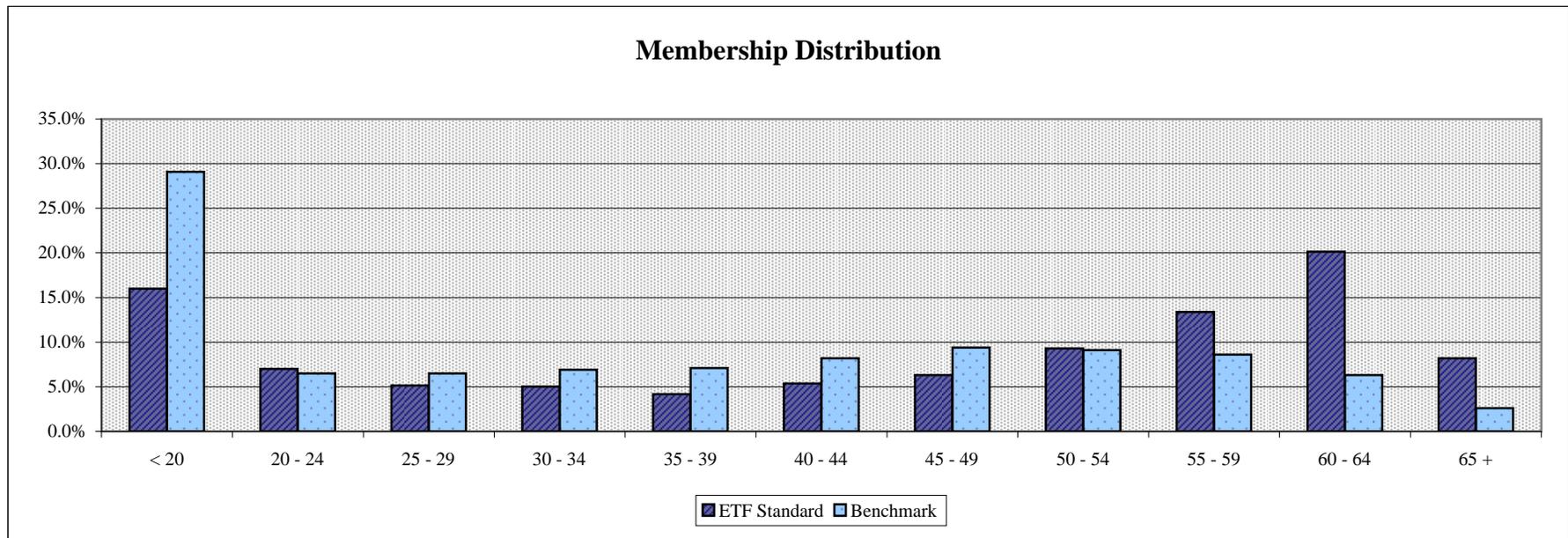
STATE EMPLOYEE TRUST FUNDS
Member Census Grid - Standard
December 2009

Exhibit 3-A

FEMALE			
Age Band	# of Members	% of Total	Benchmark
< 20	256	7.8%	14.2%
20 - 24	128	3.9%	3.5%
25 - 29	87	2.6%	3.6%
30 - 34	84	2.6%	3.6%
35 - 39	73	2.2%	3.7%
40 - 44	99	3.0%	4.4%
45 - 49	118	3.6%	5.0%
50 - 54	183	5.6%	4.9%
55 - 59	253	7.7%	4.7%
60 - 64	403	12.3%	3.2%
65 +	114	3.5%	1.2%
Total	1,798	54.7%	51.9%

MALE			
Age Band	# of Members	% of Total	Benchmark
< 20	269	8.2%	14.9%
20 - 24	102	3.1%	3.0%
25 - 29	82	2.5%	2.9%
30 - 34	81	2.5%	3.3%
35 - 39	64	1.9%	3.4%
40 - 44	77	2.3%	3.8%
45 - 49	89	2.7%	4.4%
50 - 54	122	3.7%	4.2%
55 - 59	187	5.7%	3.9%
60 - 64	259	7.9%	3.1%
65 +	155	4.7%	1.4%
Total	1,487	45.3%	48.1%

TOTAL			
Age Band	# of Members	% of Total	Benchmark
< 20	525	16.0%	29.1%
20 - 24	230	7.0%	6.5%
25 - 29	169	5.1%	6.5%
30 - 34	165	5.0%	6.9%
35 - 39	137	4.2%	7.1%
40 - 44	176	5.4%	8.2%
45 - 49	207	6.3%	9.4%
50 - 54	305	9.3%	9.1%
55 - 59	440	13.4%	8.6%
60 - 64	662	20.2%	6.3%
65 +	269	8.2%	2.6%
Total	3,285	100.0%	100.0%



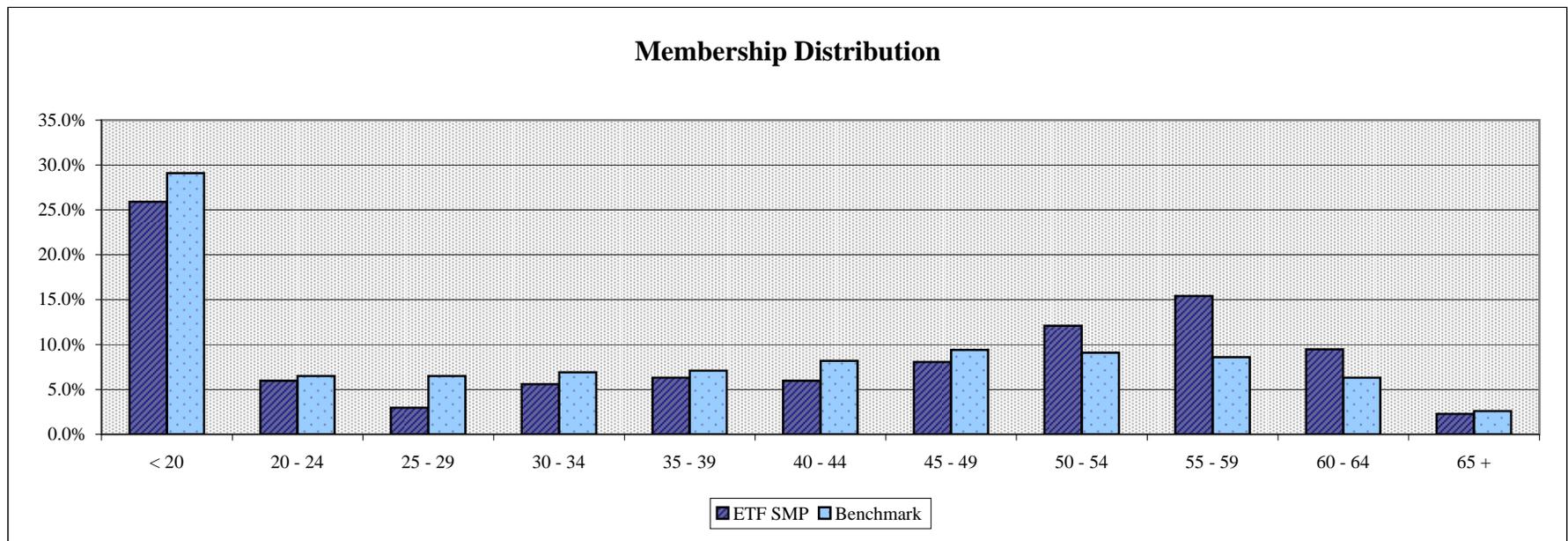
**STATE EMPLOYEE TRUST FUNDS
Member Census Grid - SMP
December 2009**

Exhibit 3-B

FEMALE			
Age Band	# of Members	% of Total	Benchmark
< 20	73	12.8%	14.2%
20 - 24	17	3.0%	3.5%
25 - 29	8	1.4%	3.6%
30 - 34	19	3.3%	3.6%
35 - 39	20	3.5%	3.7%
40 - 44	15	2.6%	4.4%
45 - 49	30	5.3%	5.0%
50 - 54	36	6.3%	4.9%
55 - 59	45	7.9%	4.7%
60 - 64	28	4.9%	3.2%
65 +	5	0.9%	1.2%
Total	296	51.8%	51.9%

MALE			
Age Band	# of Members	% of Total	Benchmark
< 20	75	13.1%	14.9%
20 - 24	17	3.0%	3.0%
25 - 29	9	1.6%	2.9%
30 - 34	13	2.3%	3.3%
35 - 39	16	2.8%	3.4%
40 - 44	19	3.3%	3.8%
45 - 49	16	2.8%	4.4%
50 - 54	33	5.8%	4.2%
55 - 59	43	7.5%	3.9%
60 - 64	26	4.6%	3.1%
65 +	8	1.4%	1.4%
Total	275	48.2%	48.1%

TOTAL			
Age Band	# of Members	% of Total	Benchmark
< 20	148	25.9%	29.1%
20 - 24	34	6.0%	6.5%
25 - 29	17	3.0%	6.5%
30 - 34	32	5.6%	6.9%
35 - 39	36	6.3%	7.1%
40 - 44	34	6.0%	8.2%
45 - 49	46	8.1%	9.4%
50 - 54	69	12.1%	9.1%
55 - 59	88	15.4%	8.6%
60 - 64	54	9.5%	6.3%
65 +	13	2.3%	2.6%
Total	571	100.0%	100.0%



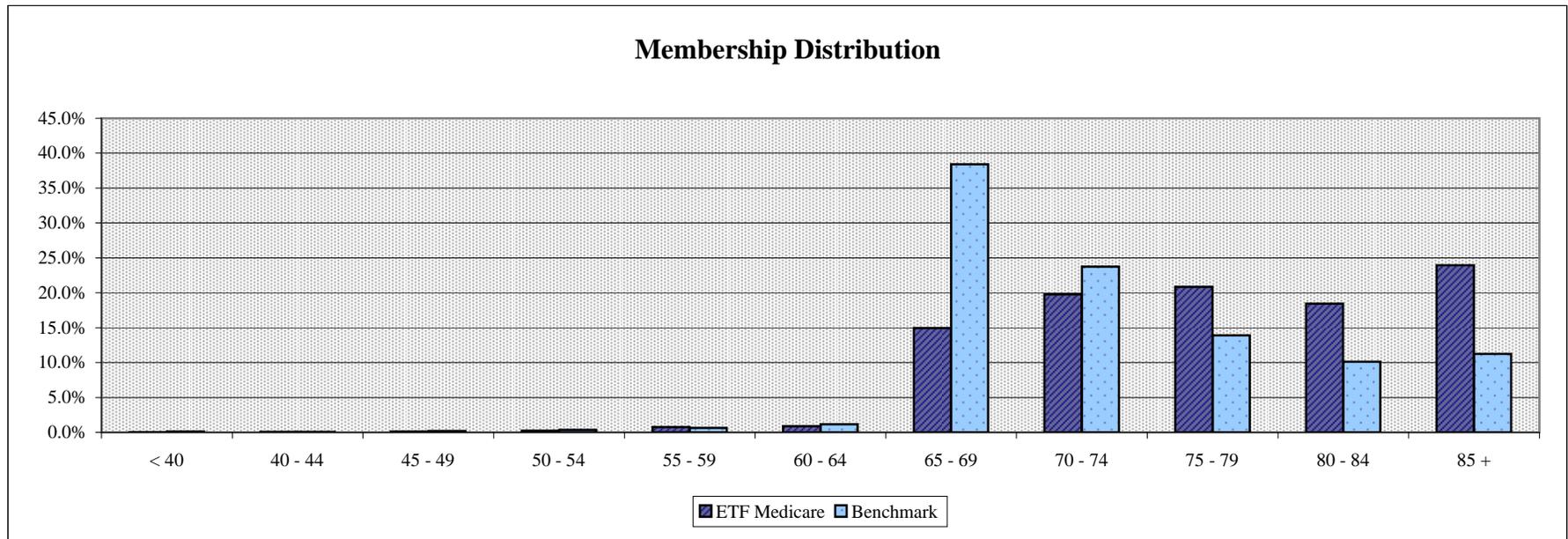
STATE EMPLOYEE TRUST FUNDS
Member Census Grid - Medicare Plus One Million
December 2009

Exhibit 3-C

FEMALE			
Age Band	# of Members	% of Total	Benchmark
< 40	1	0.0%	0.1%
40 - 44	4	0.0%	0.0%
45 - 49	8	0.1%	0.1%
50 - 54	14	0.1%	0.2%
55 - 59	55	0.6%	0.4%
60 - 64	57	0.6%	0.7%
65 - 69	849	9.1%	20.8%
70 - 74	1,015	10.9%	12.3%
75 - 79	1,043	11.2%	7.5%
80 - 84	1,024	10.9%	5.9%
85 +	1,480	15.8%	8.0%
Total	5,550	59.3%	56.0%

MALE			
Age Band	# of Members	% of Total	Benchmark
< 40	2	0.0%	0.0%
40 - 44	2	0.0%	0.1%
45 - 49	2	0.0%	0.1%
50 - 54	7	0.1%	0.1%
55 - 59	17	0.2%	0.2%
60 - 64	25	0.3%	0.5%
65 - 69	547	5.8%	17.6%
70 - 74	832	8.9%	11.4%
75 - 79	909	9.7%	6.3%
80 - 84	700	7.5%	4.2%
85 +	759	8.1%	3.3%
Total	3,802	40.7%	44.0%

TOTAL			
Age Band	# of Members	% of Total	Benchmark
< 40	3	0.0%	0.1%
40 - 44	6	0.1%	0.1%
45 - 49	10	0.1%	0.2%
50 - 54	21	0.2%	0.3%
55 - 59	72	0.8%	0.7%
60 - 64	82	0.9%	1.2%
65 - 69	1,396	14.9%	38.4%
70 - 74	1,847	19.7%	23.7%
75 - 79	1,952	20.9%	13.9%
80 - 84	1,724	18.4%	10.1%
85 +	2,239	23.9%	11.3%
Total	9,352	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, 2009. 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.

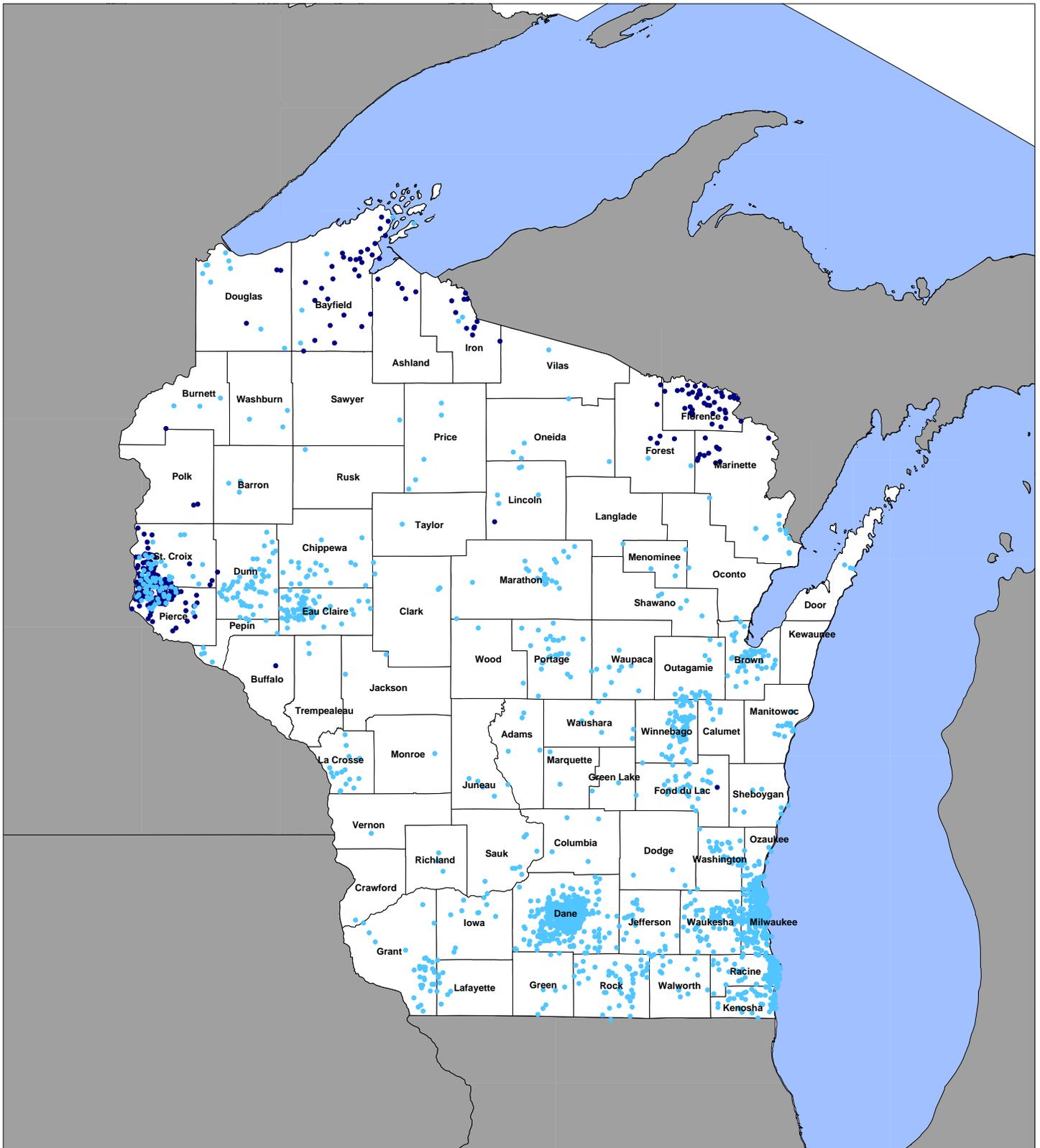
76.9% of the **Standard Plan** members lived within Wisconsin. Much of the Standard Plan population is located near larger metropolitan areas in Wisconsin with 29.2% of the population living in Dane County and 15.2% living in Milwaukee County.

In 2009, only 54.6% of the **SMP Plan** members lived within Wisconsin as compared to 96.6% in 2008. The geographic shift was due to the expansion of the SMP provider network in Minnesota and Michigan. Of the population living in Wisconsin, the membership tends to reside in the more rural areas. 41.0% of the SMP Plan participants live in 3 counties, Pierce, St. Croix, and Florence. In 2010, Pierce and Buffalo Counties will no longer be part of the SMP service area.

STATE EMPLOYEE TRUST FUNDS

Exhibit 4-A

Enrollment By County December 2009



● Standard

● SMP

STATE EMPLOYEE TRUST FUNDS
Enrollment By County
December 2009

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%	8	1.4%
BARRON	3	0.1%	0	0.0%
BAYFIELD	2	0.1%	26	4.6%
BROWN	44	1.3%	0	0.0%
BUFFALO	3	0.1%	1	0.2%
BURNETT	3	0.1%	1	0.2%
CALUMET	7	0.2%	0	0.0%
CHIPPEWA	21	0.6%	0	0.0%
CLARK	0	0.0%	0	0.0%
COLUMBIA	5	0.2%	0	0.0%
CRAWFORD	4	0.1%	0	0.0%
DANE	958	29.2%	0	0.0%
DODGE	2	0.1%	0	0.0%
DOOR	3	0.1%	0	0.0%
DOUGLAS	11	0.3%	4	0.7%
DUNN	56	1.7%	0	0.0%
EAU CLAIRE	68	2.1%	0	0.0%
FLORENCE	0	0.0%	35	6.1%
FOND DU LAC	25	0.8%	1	0.2%
FOREST	2	0.1%	8	1.4%
GRANT	38	1.2%	0	0.0%
GREEN	7	0.2%	0	0.0%
GREEN LAKE	6	0.2%	0	0.0%
IOWA	7	0.2%	0	0.0%

County	STANDARD		SMP	
	# of Members	% of Members	# of Members	% of Members
IRON	2	0.1%	11	1.9%
JACKSON	1	0.0%	0	0.0%
JEFFERSON	18	0.5%	0	0.0%
JUNEAU	5	0.2%	0	0.0%
KENOSHA	34	1.0%	0	0.0%
KEWAUNEE	0	0.0%	0	0.0%
LACROSSE	17	0.5%	0	0.0%
LAFAYETTE	0	0.0%	0	0.0%
LANGLADE	1	0.0%	0	0.0%
LINCOLN	8	0.2%	1	0.2%
MANITOWOC	12	0.4%	0	0.0%
MARATHON	22	0.7%	0	0.0%
MARINETTE	11	0.3%	14	2.5%
MARQUETTE	2	0.1%	0	0.0%
MENOMINEE	5	0.2%	0	0.0%
MILWAUKEE	501	15.2%	0	0.0%
MONROE	1	0.0%	0	0.0%
OCONTO	4	0.1%	0	0.0%
ONEIDA	1	0.0%	0	0.0%
OUTAGAMIE	22	0.7%	0	0.0%
OZAUKEE	41	1.2%	0	0.0%
PEPIN	4	0.1%	0	0.0%
PIERCE	51	1.6%	151	26.3%
POLK	0	0.0%	2	0.4%
PORTAGE	24	0.7%	0	0.0%

County	STANDARD		SMP	
	# of Members	% of Members	# of Members	% of Members
PRICE	5	0.2%	0	0.0%
RACINE	104	3.2%	0	0.0%
RICHLAND	3	0.1%	0	0.0%
ROCK	40	1.2%	0	0.0%
RUSK	0	0.0%	0	0.0%
SAUK	14	0.4%	0	0.0%
SAWYER	2	0.1%	0	0.0%
SHAWANO	5	0.2%	0	0.0%
SHEBOYGAN	9	0.3%	0	0.0%
ST CROIX	25	0.8%	49	8.6%
TAYLOR	1	0.0%	0	0.0%
TREMPEALEAU	2	0.1%	0	0.0%
VERNON	1	0.0%	0	0.0%
VILAS	2	0.1%	0	0.0%
WALWORTH	22	0.7%	0	0.0%
WASHBURN	3	0.1%	0	0.0%
WASHINGTON	27	0.8%	0	0.0%
WAUKESHA	100	3.0%	0	0.0%
WAUPACA	10	0.3%	0	0.0%
WAUSHARA	3	0.1%	0	0.0%
WINNEBAGO	78	2.4%	0	0.0%
WOOD	7	0.2%	0	0.0%
OUT OF STATE	757	23.1%	259	45.4%
Totals	3,285	100.0%	571	100.0%

State Employee Trust Funds

Group Demographics

Out of State Enrollment

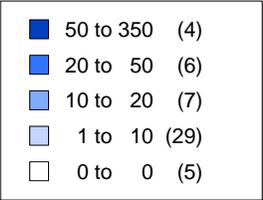
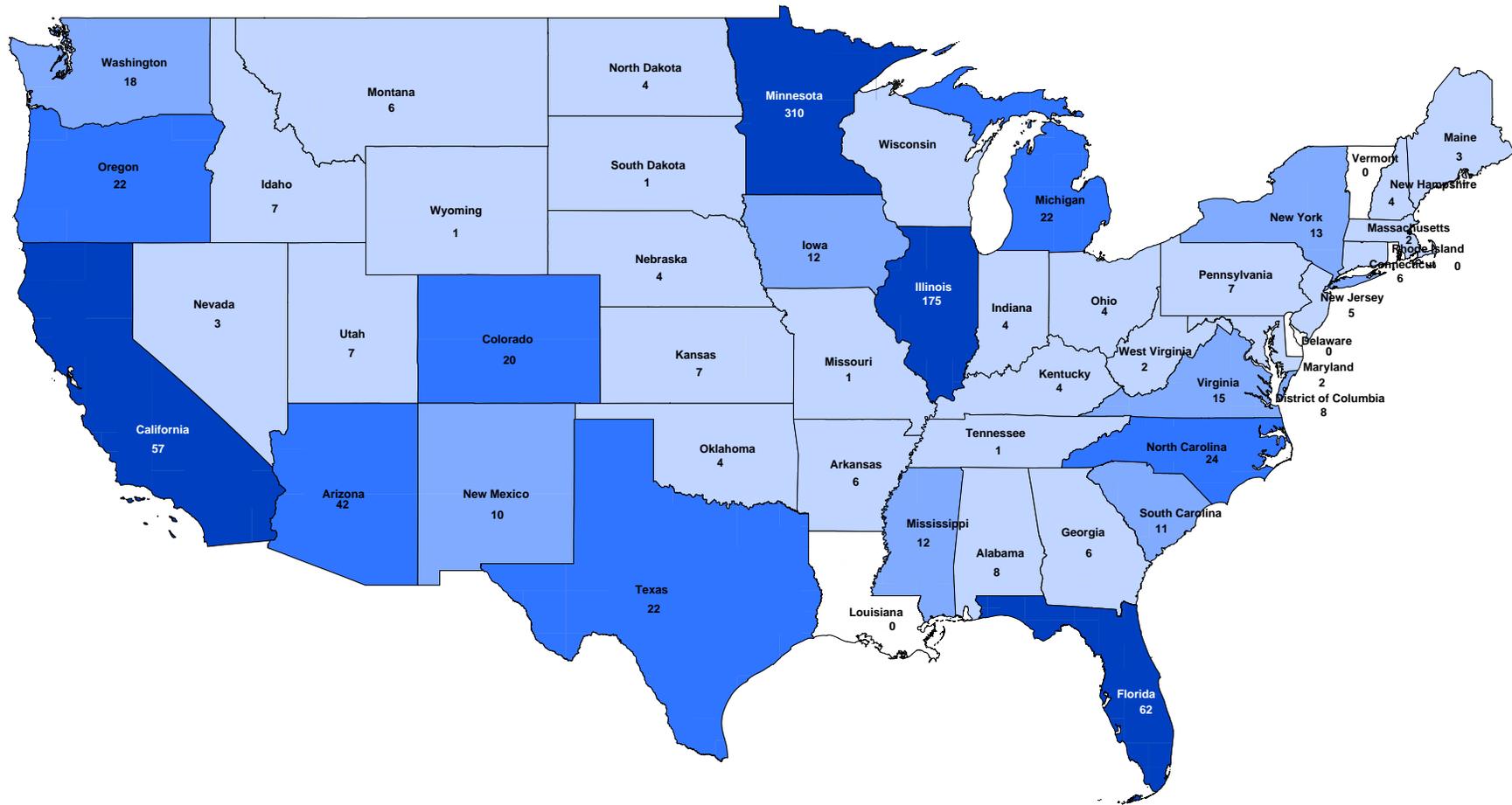
The United States Enrollment Map in Exhibit 5-A visually depicts how the enrollment in the Standard and SMP Plans are spread throughout the United States. The out of state enrollment is based on the member's address as of December 2009 and could change as members relocate. The map displays the number 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 23.1% or 757 members living outside the state of Wisconsin. The number of members who reside outside the state of Wisconsin decreased by 361 members from 2008. The decrease in membership was largely due to the expansion of the SMP provider network in Minnesota and Michigan. This expansion allowed many of the members living in Minnesota to join the SMP plan. The out of state membership is dispersed over 45 states with an additional 43 members living outside the United States. 35.0% of the out of state enrollment lives along the Wisconsin border with the largest number of members living in Illinois (175 members or 23.1%). Another area of membership concentration is in typical retirement states with 24.3% of the out of state membership residing in Florida (62), California (57), Arizona (41) and North Carolina (24).

The **SMP Plan** in comparison has 45.4% of the population or 259 members living outside the state of Wisconsin. This is a large increase over the 5 members living out of state in 2008. As noted above, this increase was due to the expansion of the SMP provider network in Minnesota and Michigan. Of the 259 members living out of state, 249 members live in Minnesota. The remaining 10 members live in Connecticut (4), Michigan (3), Iowa (2) and Arizona (1). The SMP Plan does have 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 2009**

Exhibit 5-A



STATE EMPLOYEE TRUST FUNDS
Out of State Enrollment
December 2009

Exhibit 5-B

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	8	1.1%	0	0.0%	MAINE	3	0.4%	0	0.0%	OREGON	22	2.9%	0	0.0%					
ALASKA	0	0.0%	0	0.0%	MARYLAND	2	0.3%	0	0.0%	PENNSYLVANIA	7	0.9%	0	0.0%					
ARIZONA	41	5.4%	1	0.4%	MASSACHUSETTS	2	0.3%	0	0.0%	RHODE ISLAND	0	0.0%	0	0.0%					
ARKANSAS	6	0.8%	0	0.0%	MICHIGAN	19	2.5%	3	1.2%	SOUTH CAROLINA	11	1.5%	0	0.0%					
CALIFORNIA	57	7.5%	0	0.0%	MINNESOTA	61	8.1%	249	96.1%	SOUTH DAKOTA	1	0.1%	0	0.0%					
COLORADO	20	2.6%	0	0.0%	MISSISSIPPI	12	1.6%	0	0.0%	TENNESSEE	1	0.1%	0	0.0%					
CONNECTICUT	2	0.3%	4	1.5%	MISSOURI	1	0.1%	0	0.0%	TEXAS	22	2.9%	0	0.0%					
DELAWARE	0	0.0%	0	0.0%	MONTANA	6	0.8%	0	0.0%	UTAH	7	0.9%	0	0.0%					
FLORIDA	62	8.2%	0	0.0%	NEBRASKA	4	0.5%	0	0.0%	VERMONT	0	0.0%	0	0.0%					
GEORGIA	6	0.8%	0	0.0%	NEVADA	3	0.4%	0	0.0%	VIRGINIA	15	2.0%	0	0.0%					
HAWAII	9	1.2%	0	0.0%	NEW HAMPSHIRE	4	0.5%	0	0.0%	WASHINGTON	18	2.4%	0	0.0%					
IDAHO	7	0.9%	0	0.0%	NEW JERSEY	5	0.7%	0	0.0%	WASHINGTON DC	8	1.1%	0	0.0%					
ILLINOIS	175	23.1%	0	0.0%	NEW MEXICO	10	1.3%	0	0.0%	WEST VIRGINIA	2	0.3%	0	0.0%					
INDIANA	4	0.5%	0	0.0%	NEW YORK	13	1.7%	0	0.0%	WYOMING	1	0.1%	0	0.0%					
IOWA	10	1.3%	2	0.8%	NORTH CAROLINA	24	3.2%	0	0.0%	FOREIGN	43	5.7%	0	0.0%					
KANSAS	7	0.9%	0	0.0%	NORTH DAKOTA	4	0.5%	0	0.0%										
KENTUCKY	4	0.5%	0	0.0%	OHIO	4	0.5%	0	0.0%										
LOUISIANA	0	0.0%	0	0.0%	OKLAHOMA	4	0.5%	0	0.0%										
										Totals	757	100.0%	259	100.0%					

State Employee Trust Funds

Group Demographics

Dual Choice Changes

The Dual Choice Enrollment Changes by Plan report (Exhibit 6-A) shows the January 2010 enrollment reflecting changes that occurred during the Dual Choice Enrollment. The enrollment changes are numerical differences relative to December 2009. The change in Member Age/Gender shows how much plan costs changed between 2009 and 2010 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 12,782 members as of January 2010, which is down 426 members from the 13,208 members in the plan in December 2009. The Standard Plan experienced a loss of 274 members, or 8.3% of the membership, during Dual Choice Enrollment. Likewise, the enrollment in the SMP plan decreased by 308 members. The decreased enrollment in the SMP plan was due to the loss of Pierce and Crawford counties from the SMP service area and the addition of an HMO option with Minnesota providers. The SMP Plan enrollment in Minnesota decreased by 115 members in January 2010 due to this change. The Medicare Plus \$1M membership increased by 156 individuals in January 2010.

The change in age/gender for the Standard Plan was 2.56%. The positive change means the plan is expected to be 2.56% more expensive demographically in 2010 on a per member basis as a result of the loss of membership 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 2.74% less expensive demographically in 2010 due change in demographics in the regular class members and to the loss of half of the older annuitant population.

STATE EMPLOYEE TRUST FUNDS
Dual Choice Enrollment Changes by Plan
December 2009 to January 2010

Exhibit 6-A

Plan	Class	January 2010 Membership	Change in Membership from December 2009	Change in Member Age/ Gender
Standard	Regular	2,197	-215	1.89%
	Graduate Assistant (including GA continuation)	275	-55	1.36%
	Continuation	22	-4	2.59%
	Annuitants	517	0	0.73%
Subtotal		3,011	-274	2.56%
SMP	Regular	236	-295	-4.64%
	Graduate Assistant (including GA continuation)	6	-2	5.16%
	Continuation	1	0	0.00%
	Annuitants	20	-11	-2.74%
Subtotal		263	-308	-2.74%
Medicare Plus One Million	Single	4,393	-2	N/A
	One Over	203	4	N/A
	Two Over	4,912	154	N/A
Subtotal		9,508	156	N/A
ETF Grand Total		12,782	-426	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 2008 through December 2009. The PMPM costs for each plan represent medical and drug claims paid through the end of March 2010.

Standard Plan

The Standard Plan has seen a 0.0% increase in claim costs between 2008 and 2009. Independent trend estimates for medical claims for 2009 were 9.5% - 12.0% thus the Standard Plan ran better than expected. The monthly spikes in claim costs are generally due to large claim activity that occurred in those months.

In 2009, the Standard Plan was 134.3% 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 21.7% 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 generally resides in more expensive urban areas such as Milwaukee and Dane Counties.

SMP Plan

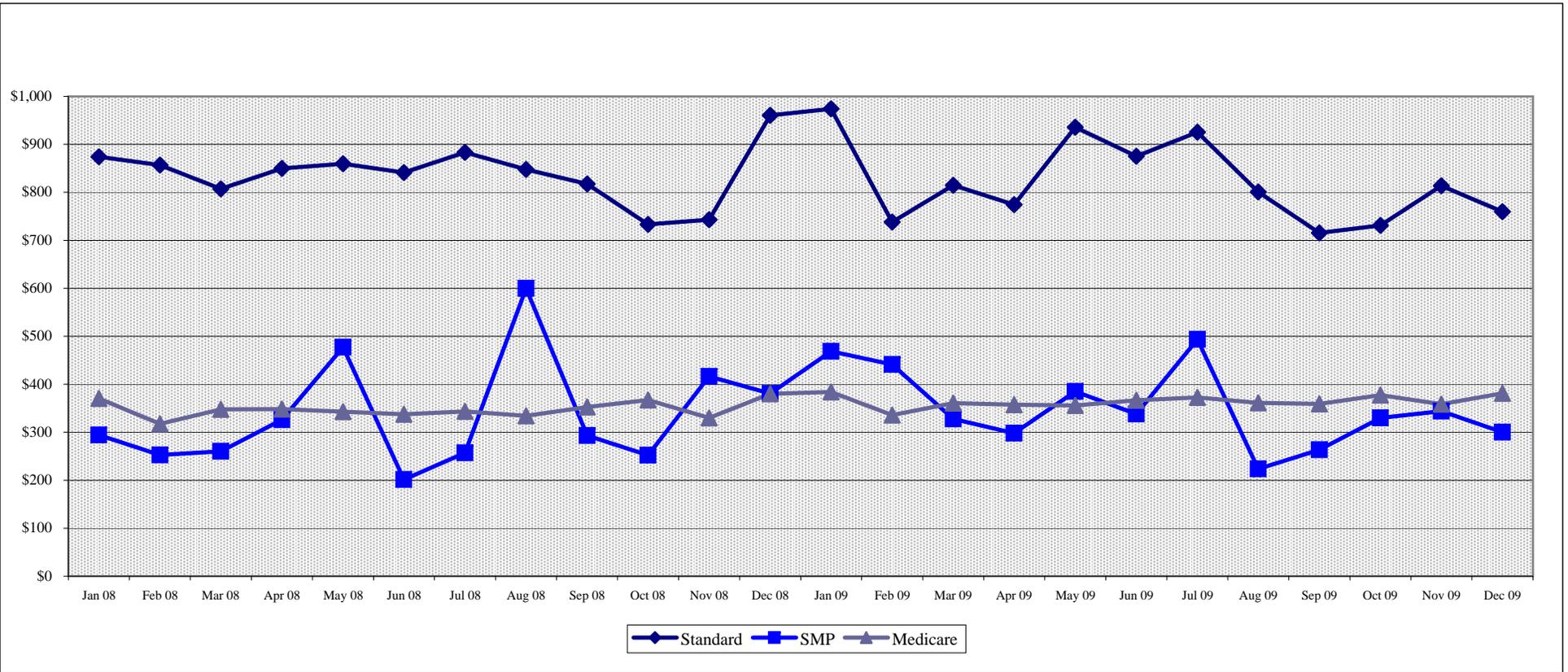
The SMP Plan's annual shifts in membership does not allow for a meaningful trend analysis. However, for informational purposes, the SMP plan saw a 10.0% increase in claims costs between 2008 and 2009.

Medicare

The Medicare Plus \$1M Plan has seen slight increase in PMPM 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 2008 to 2009 was 4.4%, 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 2010

Exhibit 7-A



	INCURRED MONTH																							
	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	Feb 09	Mar 09	Apr 09	May 09	Jun 09	Jul 09	Aug 09	Sep 09	Oct 09	Nov 09	Dec 09
Standard	\$874.12	\$857.10	\$806.99	\$849.74	\$859.38	\$841.40	\$883.37	\$847.81	\$817.51	\$733.41	\$742.81	\$960.46	\$973.91	\$737.97	\$814.69	\$774.52	\$935.89	\$875.29	\$925.64	\$800.68	\$715.54	\$730.97	\$813.72	\$759.66
SMP	\$294.39	\$252.56	\$260.49	\$326.00	\$477.25	\$201.53	\$256.81	\$599.84	\$293.26	\$252.12	\$416.55	\$380.51	\$468.57	\$441.31	\$327.93	\$297.96	\$385.18	\$338.02	\$493.49	\$223.61	\$263.58	\$330.17	\$344.15	\$299.96
Medicare	\$370.64	\$317.71	\$347.89	\$348.28	\$342.75	\$337.37	\$343.41	\$334.22	\$352.68	\$367.18	\$329.79	\$379.98	\$383.93	\$335.87	\$360.94	\$357.27	\$356.02	\$366.60	\$372.48	\$361.25	\$358.97	\$377.35	\$358.59	\$381.21

State Employee Trust Funds

Plan Utilization

PMPM by Type of Service Reports

The Total PMPM by Type of Service reports (Exhibits 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 2009 – December 2009 and paid through the end of March 2010. The Paid PMPM by Type of Service reports (Exhibits 8-B, 8-D, and 8-E) show the same actual data, but compare 2008 to 2009.

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 and facility inpatient categories and a little more falling into the facility outpatient, other services and drug categories.

The bottom chart in Exhibit 8-A shows that the total PMPM cost is 37.8% above the benchmark. For comparison purposes, last year the Standard Plan was 48.1% above the benchmark. The inpatient facility PMPM cost is 28.3% above the benchmark and outpatient facility is 52.0% above the benchmark. The physician PMPM cost is 17.4% above the benchmark. The drug paid PMPM cost is 57.7% above the benchmark which is higher than the medical only costs which are averaging 33.9% over the benchmark. Lastly, the other services category is 66.5% over the benchmark. The largest contributor to the differential in the other services category is the psychiatric/AODA benefit sub-category which is \$19.10 above the benchmark. Every \$1.00 PMPM represented in the graph is equivalent to \$38,752 in annual plan costs for the Standard Plan.

Exhibit 8-B compares the Standard Plan's paid PMPM costs for 2008 to 2009, showing a 0.0% increase between the two years. Drug costs increased more than expected at 14.1%. The inpatient facility category actually decreased in 2009 from 2008, which was the category that had the largest increase in the prior year and reflects the lower number of high cost members. The remaining categories increased below expected levels.

SMP Plan

Exhibit 8-C shows the percentage breakdown by type of service for the SMP Plan is slightly different than the benchmark, with a larger percentage falling into the facility outpatient, drug and other categories and a smaller percentage in the physician and facility inpatient categories.

In total the SMP Plan is 28.0% below the benchmark. The SMP plan was well below the benchmark in all categories.

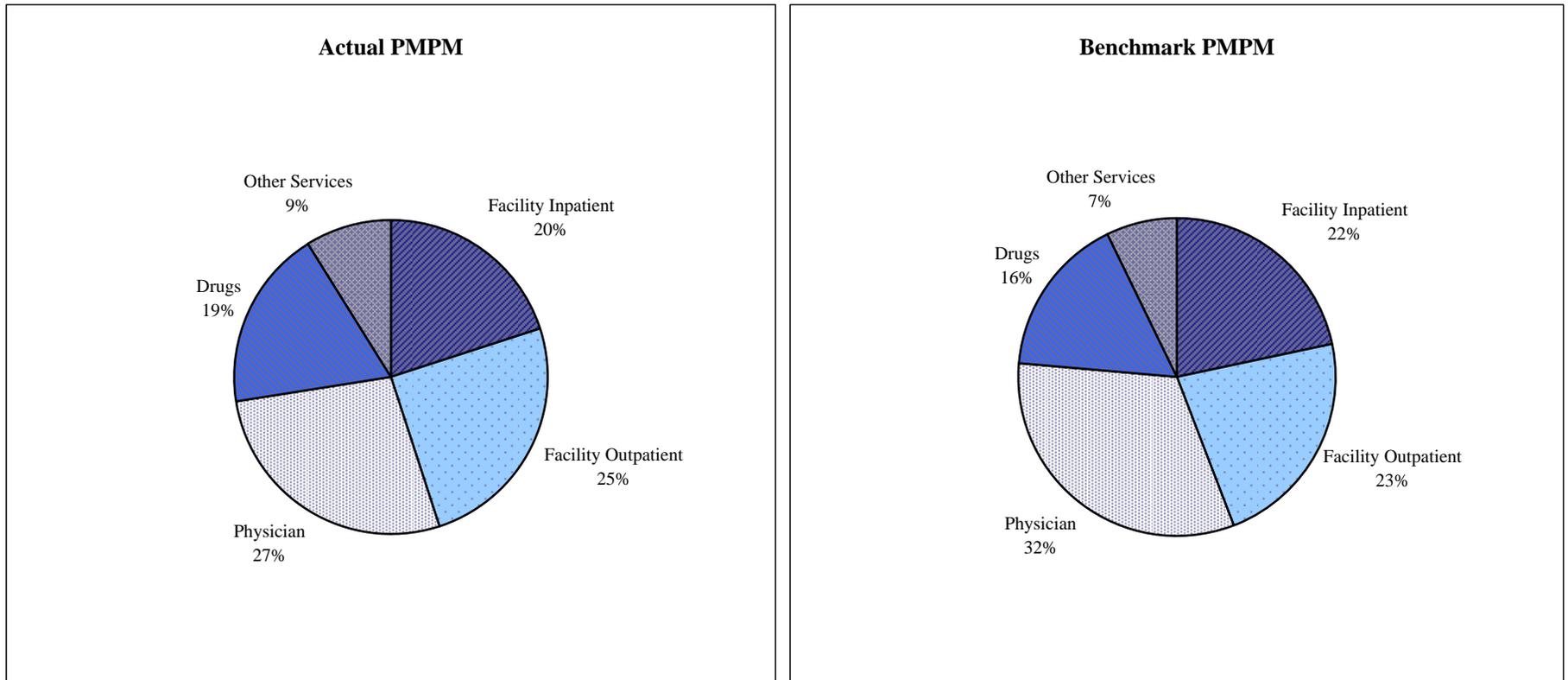
Exhibit 8-D compares the SMP Plan's paid PMPM costs for 2008 to 2009, showing an overall 10.0% increase in PMPM cost. Inpatient facility increased by 574.0% which is due to an exceptionally low PMPM in 2008. The other services category also saw an increase of 54.5%. All other categories experienced a decrease in costs. Due to the large change in membership each year, we would expect this degree of variability.

Medicare

The Medicare Plus \$1M Plan in Exhibit 8-E compares paid PMPM costs for 2008 to 2009. The medical segment of the paid PMPM cost accounts for only 38.2% of the payments made under the plan due to the impact of coordination of benefits with Medicare. In total the PMPM increased by 5.4% in 2009. Prescription drug costs increased by 6.1% while the medical categories experienced single digit increases, averaging 4.4%.

STATE EMPLOYEE TRUST FUNDS
Total PMPM by Type of Service - Standard
Incurred January 2009 - December 2009 Paid Through March 2010

Exhibit 8-A



	Actual	Benchmark	Difference	
			\$	%
Facility Inpatient	\$165.18	\$128.76	\$36.42	28.3%
Facility Outpatient	\$205.25	\$135.03	\$70.22	52.0%
Physician	\$224.80	\$191.42	\$33.38	17.4%
Drugs	\$153.68	\$97.46	\$56.22	57.7%
Other Services	\$72.04	\$43.28	\$28.76	66.5%
Totals	\$820.95	\$595.95	\$225.00	37.8%

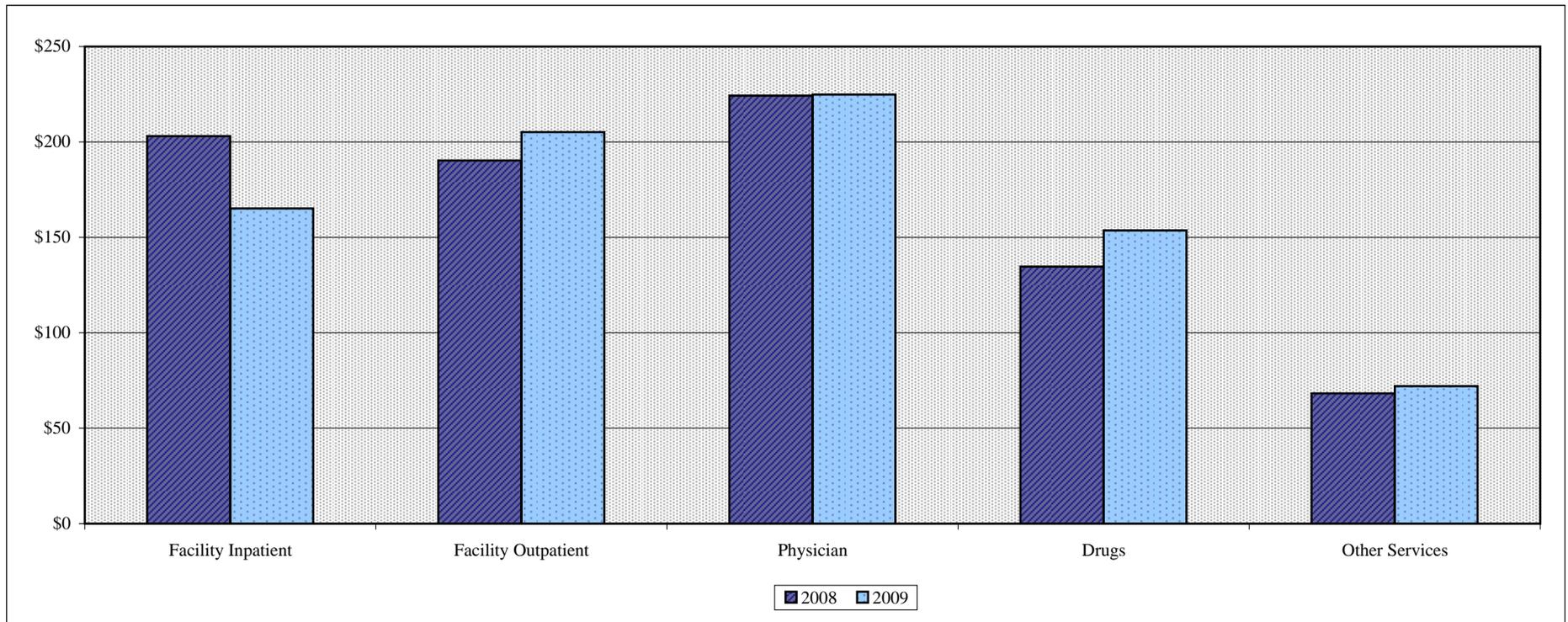
Note: Drug includes prescription and injectables

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

* Each \$1.00 paid PMPM = \$38,752 in plan costs.

STATE EMPLOYEE TRUST FUNDS
Total PMPM by Type of Service - Standard
Comparison of 2009 to 2008

Exhibit 8-B



	2008 *	2009 **	Difference	
			\$	%
Facility Inpatient	\$203.12	\$165.18	-\$37.94	-18.7%
Facility Outpatient	\$190.35	\$205.25	\$14.90	7.8%
Physician	\$224.23	\$224.80	\$0.57	0.3%
Drugs	\$134.71	\$153.68	\$18.97	14.1%
Other Services	\$68.31	\$72.04	\$3.73	5.5%
Totals	\$820.72	\$820.95	\$0.23	0.0%

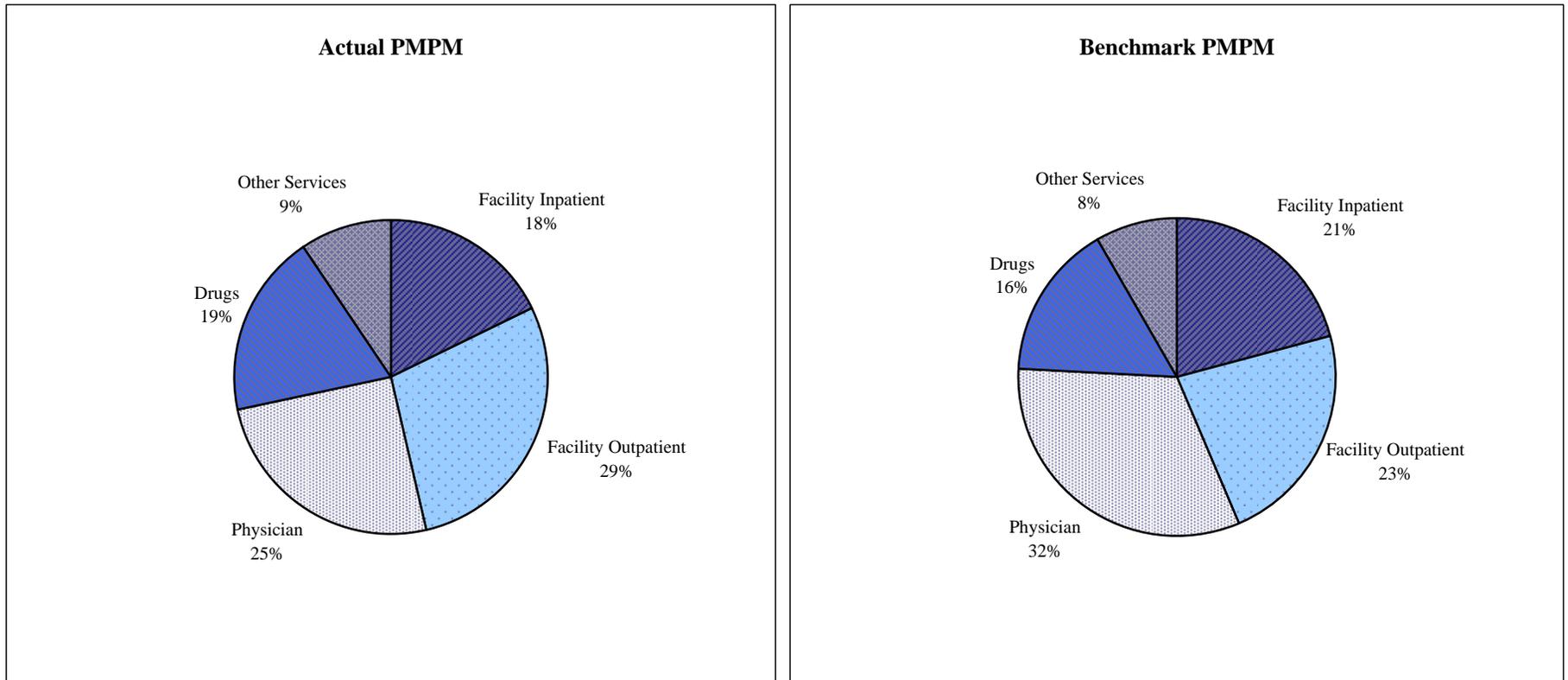
Note: Drug includes prescription and injectables

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

** Each \$1.00 paid PMPM = \$38,752 in plan costs.

STATE EMPLOYEE TRUST FUNDS
Total PMPM by Type of Service - SMP
 Incurred January 2009 - December 2009 Paid Through March 2010

Exhibit 8-C



	Actual	Benchmark	Difference	
			\$	%
Facility Inpatient	\$61.94	\$101.83	-\$39.89	-39.2%
Facility Outpatient	\$100.89	\$110.54	-\$9.65	-8.7%
Physician	\$88.48	\$157.17	-\$68.69	-43.7%
Drugs	\$66.25	\$77.00	-\$10.75	-14.0%
Other Services	\$32.76	\$40.29	-\$7.53	-18.7%
Totals	\$350.32	\$486.83	-\$136.51	-28.0%

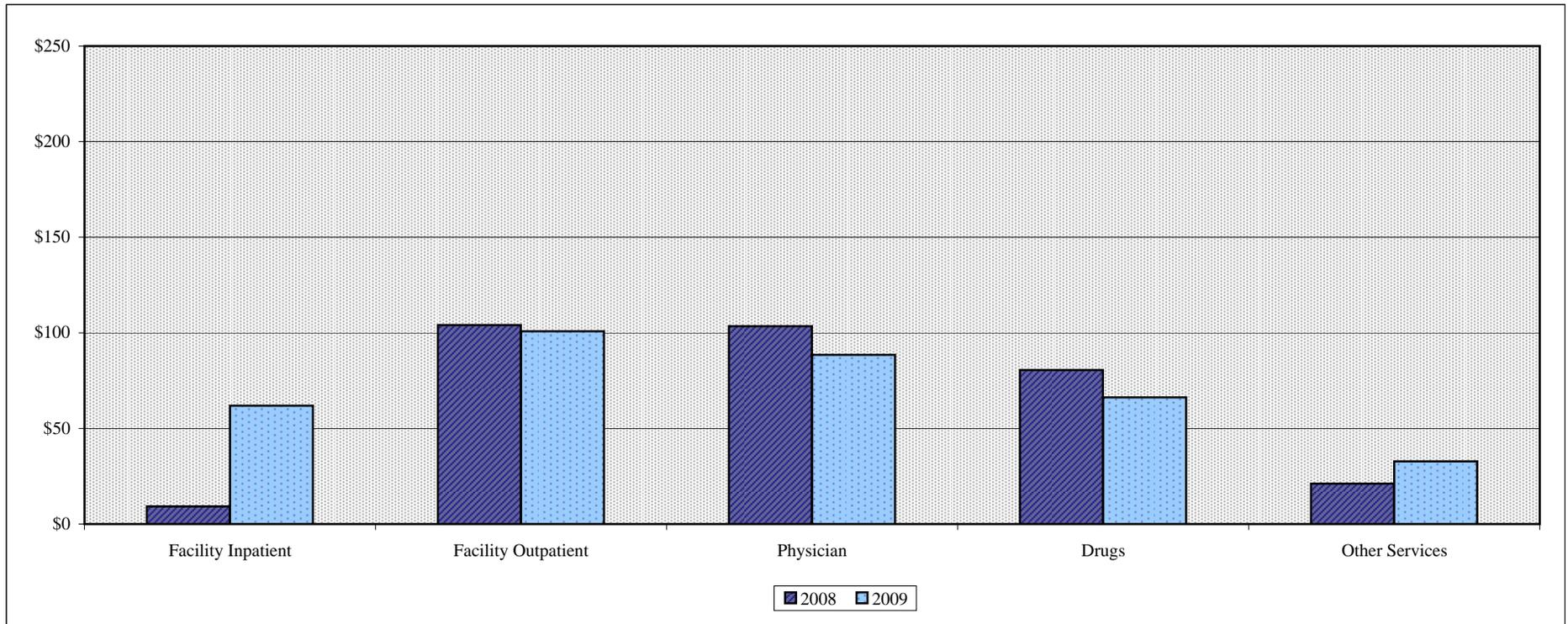
Note: Drug includes prescription and injectables

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

* Each \$1.00 paid PMPM = \$6,731 in plan costs.

STATE EMPLOYEE TRUST FUNDS
Total PMPM by Type of Service - SMP
Comparison of 2009 to 2008

Exhibit 8-D



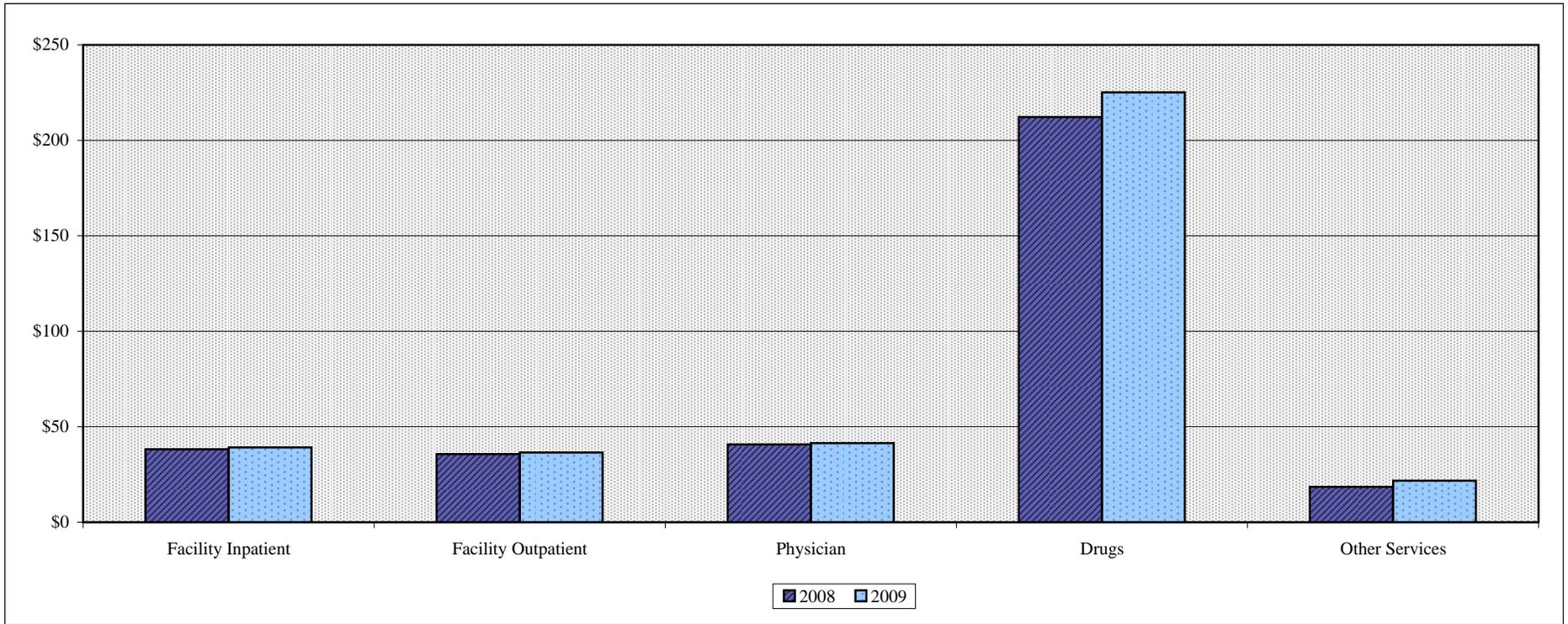
	2008 *	2009 **	Difference	
			\$	%
Facility Inpatient	\$9.19	\$61.94	\$52.75	574.0%
Facility Outpatient	\$104.06	\$100.89	-\$3.17	-3.0%
Physician	\$103.45	\$88.48	-\$14.97	-14.5%
Drugs	\$80.57	\$66.25	-\$14.32	-17.8%
Other Services	\$21.20	\$32.76	\$11.56	54.5%
Totals	\$318.47	\$350.32	\$31.85	10.0%

Note: Drug includes prescription and injectables

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

** Each \$1.00 paid PMPM = \$6,731 in plan costs.

STATE EMPLOYEE TRUST FUNDS
Total PMPM by Type of Service - Medicare Plus One Million
Comparison of 2009 to 2008



	2008 *	2009 **	Difference	
			\$	%
Facility Inpatient	\$38.23	\$39.20	\$0.97	2.5%
Facility Outpatient	\$35.73	\$36.58	\$0.85	2.4%
Physician	\$40.71	\$41.44	\$0.73	1.8%
Drugs	\$212.23	\$225.14	\$12.91	6.1%
Other Services	\$18.51	\$21.79	\$3.28	17.7%
Totals	\$345.41	\$364.15	\$18.74	5.4%

Note: Drug includes prescription and injectables
 * Each \$1.00 paid PMPM = \$116,099 in plan costs.
 ** Each \$1.00 paid PMPM = \$113,573 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 2009 – December 2009 and paid through the end of March 2010.

Standard Plan

The Standard Plan in Exhibit 9-A was 37.8% above the benchmark in 2009. The variance to the benchmark is primarily a result of the anti-selection resulting from the dual choice open enrollment. Other contributing factors include the location of the Standard Plan's enrolled membership (the higher cost urban areas) and the comprehensive 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 \$38,752 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 sub-category, \$10.30 PMPM is due to gastric bypass procedures not generally included in the norm. Also, psych/AODA services were 168.2% above the benchmark; however this is a \$1.21 PMPM decrease from 2008. The Standard Plan's benefit design in the psych/AODA sub-category has historically been more comprehensive than the typical commercial plan. Lastly, the other sub-category is higher than expected which is due to higher utilization of Skilled Nursing Facilities. In 2009, 6 of the 36 high cost members required these services, accounting for \$4.85 PMPM.
- Facility Outpatient – Higher than expected costs in this category are reflective of the relative morbidity of the Standard Plan's population. In general, the Standard Plan population utilizes more diagnostic services such as CT scans, MRIs, and lab work which are reflected in the higher than expected radiology and pathology services. An additional contributor to the Radiology sub-category is the case mix of the high cost members. In 2009, 33 of the high cost members contributed \$12.74 PMPM to this category. Costs in the other services category are \$29.55 PMPM above the benchmark, and 13.4% higher than last year. The primary drivers of this category are higher than expected use of cancer pharmaceuticals and other outpatient services by the high cost members who contributed \$20.33 PMPM to this sub-category. Psych/AODA services are still well above the norm but the PMPM only increased \$1.31 PMPM from 2008 to 2009.

- Physician – The surgery category is \$8.25 PMPM above the benchmark. Gastric bypass procedures have added \$5.50 to the paid PMPM cost. Costs for these procedures are not generally accounted for in the benchmark. The office visit subcategory is \$6.84 PMPM above the norm and attributed to a combination of higher than expected number of visits and higher than expected cost per visit. The Physician Other category is \$6.82 PMPM above the norm and is driven by higher than expected cost and utilization of dialysis services, diagnostic testing, consultations, and cardiovascular procedures.
- Drug – The total drug costs are 57.7% over the benchmark in 2009 and an \$18.97 PMPM increase over 2008. The PMPM variance for drug costs is higher than the variance of the medical only cost which is 33.9% above benchmark. The prescription drug costs are 58.1% higher than the benchmark, and the injectable drug cost is similar at 55.6% 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 \$28.76 PMPM above the benchmark. The major contributor to the variance is the Psychiatric /AODA cost which is \$19.10 PMPM above the benchmark. Although this sub-category is well above the norm, it increased less than 2% from the 2008 PMPM. 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 2009. For the plan \$1.00 PMPM represented in the chart is equivalent to \$6,731 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 result when claims experience of a small population is split too finely. Although the PMPM appears above average, the SMP population had only 4 maternity admits at a typical cost per admit.
- Outpatient Facility – This category is running slightly below the norm overall. On a dollar basis, the Surgical/Medical sub-category is running above the norm. The higher than expected PMPM in this sub-category is the result of both higher than expected utilization and higher than expected cost per procedure.
- Physician – This category is running below expected. All sub-categories are well below the benchmark with the exception of office visits. This is the result of the cost per visit and utilization being slightly above expected levels.
- Drug – The prescription drug PMPM cost is running 11.8% below the norm, while injectable drug costs are running 24.2% below the norm.

- Other Services – Once again this category is running below the benchmark in total. The Chiropractic sub-category is \$0.85 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. Also the ambulance sub-category is above the benchmark. This is due to one large air ambulance service.

STATE EMPLOYEE TRUST FUNDS
Type of Service Detail - Standard
Incurred January 2009 - December 2009 Paid Through March 2010

TYPE OF SERVICE	DETAIL	ACTUAL	BENCHMARK	DIFFERENCE	
		PMPM	PMPM	\$	%
FACILITY INPATIENT	SURGICAL/MEDICAL	\$148.02	\$119.92	\$28.10	23.4%
	PSYCH/AODA	\$4.56	\$1.70	\$2.86	168.2%
	MATERNITY	\$6.46	\$4.84	\$1.62	33.5%
	OTHER	\$6.14	\$2.30	\$3.84	167.0%
Subtotal		\$165.18	\$128.76	\$36.42	28.3%
FACILITY OUTPATIENT	SURGICAL/MEDICAL	\$30.84	\$24.38	\$6.46	26.5%
	RADIOLOGY	\$53.28	\$36.74	\$16.54	45.0%
	PATHOLOGY	\$27.92	\$14.90	\$13.02	87.4%
	EMERGENCY ROOM	\$6.77	\$4.97	\$1.80	36.2%
	PSYCH/AODA	\$4.03	\$1.18	\$2.85	241.5%
	OTHER	\$82.41	\$52.86	\$29.55	55.9%
Subtotal		\$205.25	\$135.03	\$70.22	52.0%
PHYSICIAN	OFFICE VISIT	\$30.54	\$23.70	\$6.84	28.9%
	RADIOLOGY	\$40.52	\$35.84	\$4.68	13.1%
	PATHOLOGY	\$30.44	\$24.53	\$5.91	24.1%
	SURGERY	\$68.53	\$60.28	\$8.25	13.7%
	ANESTHESIA	\$14.10	\$13.20	\$0.90	6.8%
	MATERNITY	\$2.48	\$2.50	-\$0.02	-0.8%
	OTHER	\$38.19	\$31.37	\$6.82	21.7%
Subtotal		\$224.80	\$191.42	\$33.38	17.4%
DRUGS	PRESCRIPTIONS	\$127.49	\$80.63	\$46.86	58.1%
	INJECTABLES	\$26.19	\$16.83	\$9.36	55.6%
Subtotal		\$153.68	\$97.46	\$56.22	57.7%
OTHER SERVICES	PSYCH/AODA	\$24.44	\$5.34	\$19.10	357.7%
	CHIROPRACTIC	\$3.70	\$4.08	-\$0.38	-9.3%
	THERAPIES	\$9.46	\$4.71	\$4.75	100.8%
	AMBULANCE	\$3.30	\$2.24	\$1.06	47.3%
	WELL BABY EXAM	\$0.56	\$0.42	\$0.14	33.3%
	DURABLE MEDICAL EQUIPMENT	\$9.82	\$5.96	\$3.86	64.8%
	OTHER	\$20.76	\$20.53	\$0.23	1.1%
Subtotal		\$72.04	\$43.28	\$28.76	66.5%
Grand Total		\$820.95	\$595.95	\$225.00	37.8%

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

* Each \$1.00 paid PMPM = \$38,752 in plan costs.

STATE EMPLOYEE TRUST FUNDS
Type of Service Detail - SMP
Incurred January 2009 - December 2009 Paid Through March 2010

TYPE OF SERVICE	DETAIL	ACTUAL	BENCHMARK	DIFFERENCE	
		PMPM	PMPM	\$	%
FACILITY INPATIENT	SURGICAL/MEDICAL	\$55.61	\$94.13	-\$38.52	-40.9%
	PSYCH/AODA	\$0.00	\$1.69	-\$1.69	-100.0%
	MATERNITY	\$5.83	\$4.36	\$1.47	33.7%
	OTHER	\$0.50	\$1.65	-\$1.15	-69.7%
Subtotal		\$61.94	\$101.83	-\$39.89	-39.2%
FACILITY OUTPATIENT	SURGICAL/MEDICAL	\$24.54	\$20.12	\$4.42	22.0%
	RADIOLOGY	\$28.55	\$29.52	-\$0.97	-3.3%
	PATHOLOGY	\$8.47	\$11.97	-\$3.50	-29.2%
	EMERGENCY ROOM	\$3.58	\$4.53	-\$0.95	-21.0%
	PSYCH/AODA	\$0.38	\$1.25	-\$0.87	-69.6%
	OTHER	\$35.37	\$43.15	-\$7.78	-18.0%
Subtotal		\$100.89	\$110.54	-\$9.65	-8.7%
PHYSICIAN	OFFICE VISIT	\$22.98	\$20.33	\$2.65	13.0%
	RADIOLOGY	\$9.90	\$28.45	-\$18.55	-65.2%
	PATHOLOGY	\$9.81	\$20.45	-\$10.64	-52.0%
	SURGERY	\$23.01	\$48.96	-\$25.95	-53.0%
	ANESTHESIA	\$7.88	\$10.72	-\$2.84	-26.5%
	MATERNITY	\$1.35	\$2.25	-\$0.90	-40.0%
	OTHER	\$13.55	\$26.01	-\$12.46	-47.9%
Subtotal		\$88.48	\$157.17	-\$68.69	-43.7%
DRUGS	PRESCRIPTIONS	\$56.17	\$63.70	-\$7.53	-11.8%
	INJECTABLES	\$10.08	\$13.30	-\$3.22	-24.2%
Subtotal		\$66.25	\$77.00	-\$10.75	-14.0%
OTHER SERVICES	PSYCH/AODA	\$2.82	\$5.69	-\$2.87	-50.4%
	CHIROPRACTIC	\$4.58	\$3.73	\$0.85	22.8%
	THERAPIES	\$2.34	\$4.05	-\$1.71	-42.2%
	AMBULANCE	\$4.60	\$1.82	\$2.78	152.7%
	WELL BABY EXAM	\$0.89	\$0.92	-\$0.03	-3.3%
	DURABLE MEDICAL EQUIPMENT	\$1.43	\$4.89	-\$3.46	-70.8%
	OTHER	\$16.10	\$19.19	-\$3.09	-16.1%
Subtotal		\$32.76	\$40.29	-\$7.53	-18.7%
Grand Total		\$350.32	\$486.83	-\$136.51	-28.0%

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

* Each \$1.00 paid PMPM = \$6,731 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/1000 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)*12000. The Admits/1000 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)*12000. The Days/1000 and Admits/1000 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 28.3% in 2009. Although the inpatient facility costs are above the norm, the PMPM decreased by \$37.94 from 2008 and reflects a decrease in high cost claimants. There are two main reasons for the Standard Plan exceeding the benchmark. First, the group experienced a higher than expected admission rate. This is especially true of the Surgical and Psych/AODA categories which both had almost twice the expected admission rate. The higher admission rate is also reflected in a higher than expected days/1000. The second reason is a higher than expected cost per day. 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 services are more expensive than other types of inpatient services and since the admission rate for surgical procedures is almost twice the expected level, the overall cost per day 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.

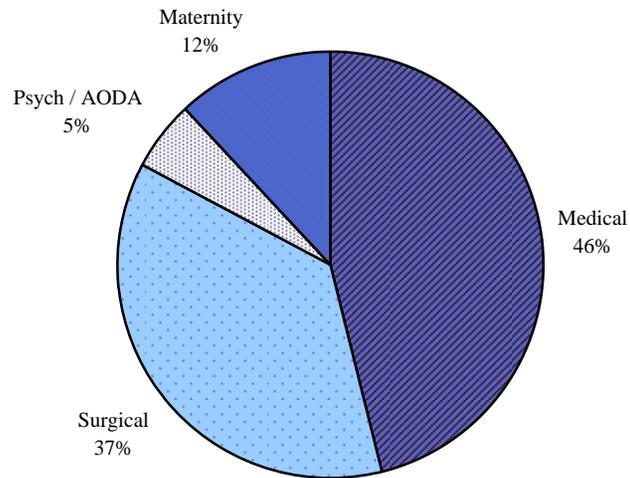
STATE EMPLOYEE TRUST FUNDS
Inpatient Utilization - Standard
 Incurred January 2009 - December 2009 Paid Through March 2010

Exhibit 10-A

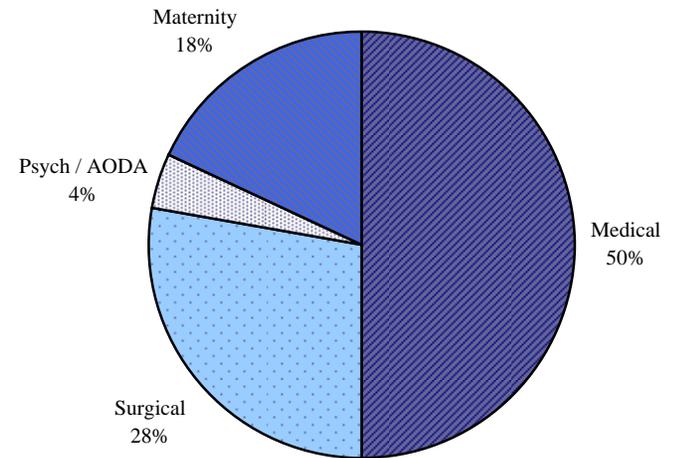
ACTUAL						
	Medical	Surgical	Psych / AODA	Maternity	Other	Total
Days/1000	166	107	38	32	97	440
Admits/1000	43	34	5	11	N/A	93
ALOS	3.83	3.15	7.29	2.81	N/A	4.62
Cost/Day	\$4,588	\$9,443	\$1,425	\$2,407	\$761	\$4,495
Cost/Admit	\$17,567	\$29,787	\$10,397	\$6,764	N/A	\$20,783
PMPM	\$63.47	\$84.55	\$4.56	\$6.46	\$6.14	\$165.18
% of Paid	38.42%	51.19%	2.76%	3.91%	3.72%	100.00%

BENCHMARK						
	Medical	Surgical	Psych / AODA	Maternity	Other	Total
Days/1000	199	94	16	31	39	379
Admits/1000	36	20	3	13	N/A	72
ALOS	5.53	4.70	5.33	2.38	N/A	5.26
Cost/Day	\$3,546	\$7,773	\$1,262	\$1,886	\$691	\$4,016
Cost/Admit	\$19,561	\$36,807	\$6,949	\$4,076	N/A	\$23,677
PMPM	\$58.12	\$61.80	\$1.70	\$4.84	\$2.30	\$128.76
% of Paid	45.13%	48.00%	1.32%	3.76%	1.79%	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 2008 to 2009, 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 related services which contributed \$16.26 PMPM to MDC 10. Without this non standard benefit, MDC 10 would be closer to the benchmark. The Standard Plan did see an increase in gastric bypass related services in 2009 with 25 members receiving bariatric related services compared to 15 in 2008. This increase accounted for an annual increase of \$7.91 PMPM in gastric bypass costs alone. 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. We could see a change to the benchmark number in 2010 for outpatient psychiatric benefits as groups implement the new federally mandated mental health benefit levels which are similar to the benefits offered under the Standard Plan.

Another reason for variances from the benchmark can be the case mix of large claim activity. This is what happened for MDC 9 and MDC 16 where the 36 high cost patients accounted for \$19.62 PMPM in MDC 9 and \$10.56 PMPM in MDC 16. This change in case mix also led to the large increase in MDC 7 and MDC 12 between 2008 and 2009

For the Standard Plan \$1.00 PMPM in claim costs represented in the chart is equivalent to \$38,752 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 sub-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 \$6,731 in annual plan costs.

STATE EMPLOYEE TRUST FUNDS
Claim Costs by Major Diagnostic Categories - Standard
Comparison of 2009 to 2008

Exhibit 11-A

MDC CODE	MAJOR DIAGNOSTIC CATEGORY DESCRIPTION	2008	2009	BENCHMARK PMPM **	DIFFERENCE	
		ACTUAL PMPM *	ACTUAL PMPM **		2009 to 2008	2009 to BENCHMARK
1	Nervous System Diseases and Disorders (D/D)	\$65.54	\$38.93	\$30.51	-40.6%	27.6%
2	Eye D/D	\$21.30	\$19.80	\$14.52	-7.0%	36.3%
3	Ear, Nose, Mouth and Throat D/D	\$24.94	\$26.04	\$20.16	4.4%	29.2%
4	Respiratory System D/D	\$29.23	\$25.01	\$22.13	-14.4%	13.0%
5	Circulatory System D/D	\$63.32	\$60.01	\$56.76	-5.2%	5.7%
6	Digestive System D/D	\$57.62	\$52.44	\$44.95	-9.0%	16.7%
7	Liver, Gallbladder, Biliary Ducts and Pancreas D/D	\$7.19	\$14.49	\$10.22	101.5%	41.7%
8	Muscles, Bones, and Connective Tissue D/D	\$136.68	\$133.52	\$100.57	-2.3%	32.8%
9	Skin, Subcutaneous Tissue (fat and connective) and Breast D/D	\$44.95	\$50.81	\$26.59	13.0%	91.1%
10	Endocrine, Nutritional and Metabolic D/D (included diagnoses related to obesity, diabetes and hormones)	\$26.51	\$39.16	\$16.27	47.7%	140.7%
11	Kidney and Urinary Tract D/D	\$24.26	\$17.91	\$16.74	-26.2%	7.0%
12	Male Reproductive System D/D	\$4.19	\$10.67	\$8.07	154.7%	32.1%
13	Female Reproductive System D/D	\$16.17	\$18.98	\$18.53	17.4%	2.4%
14	Pregnancy, Childbirth, and After Delivery Diagnoses	\$11.22	\$11.26	\$9.21	0.4%	22.3%
15	Newborns, and Newborns with Conditions Originating Shortly Before or After Birth	\$1.38	\$3.43	\$2.50	148.6%	37.1%
16	Blood and Blood Forming Organ D/D (including spleen) and Immune System Disorders	\$7.51	\$15.72	\$6.58	109.3%	139.0%
17	Bone Marrow D/D and Poorly Differentiated Cancers	\$38.60	\$25.04	\$22.49	-35.1%	11.3%
18	Infectious and Parasitic Diseases	\$19.99	\$9.68	\$6.01	-51.6%	61.1%
19	Behavioral Health Diagnoses	\$34.28	\$35.35	\$9.60	3.1%	268.1%
20	Alcohol/Drug Use and Alcohol/Drug Induced Organic Mental Disorders	\$0.77	\$0.24	\$0.56	-68.8%	-56.8%
21	Injuries, Poisoning and Toxic Effects of Drugs	\$3.83	\$5.87	\$4.48	53.3%	31.0%
22	Burns	\$0.06	\$0.11	\$0.56	83.3%	-80.2%
23	Other Miscellaneous Services Including Health Screenings, Medical Exams and Rehabilitation	\$65.24	\$66.26	\$54.31	1.6%	22.0%
24	Multiple Significant Trauma	\$2.39	\$2.81	\$0.89	17.6%	216.6%
25	Human Immunodeficiency Virus Infections	\$0.14	\$0.16	\$0.03	14.3%	398.7%
0	Ungroupable	\$2.59	\$9.75	\$12.07	276.4%	-19.3%
Total		\$709.90	\$693.45	\$515.32	-2.3%	34.6%

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.

** Each \$1.00 paid PMPM = \$38,752 in plan costs.

STATE EMPLOYEE TRUST FUNDS
Claim Costs by Major Diagnostic Categories - SMP
Comparison of 2009 to 2008

Exhibit 11-B

MDC CODE	MAJOR DIAGNOSTIC CATEGORY DESCRIPTION	2008	2009	BENCHMARK PMPM **	DIFFERENCE	
		ACTUAL PMPM *	ACTUAL PMPM **		2009 to 2008	2009 to BENCHMARK
1	Nervous System Diseases and Disorders (D/D)	\$5.02	\$7.49	\$24.55	49.2%	-69.5%
2	Eye D/D	\$9.30	\$19.46	\$10.53	109.2%	84.8%
3	Ear, Nose, Mouth and Throat D/D	\$13.73	\$13.33	\$19.59	-2.9%	-32.0%
4	Respiratory System D/D	\$1.68	\$3.41	\$17.77	103.0%	-80.8%
5	Circulatory System D/D	\$25.15	\$55.52	\$45.08	120.8%	23.2%
6	Digestive System D/D	\$51.42	\$27.95	\$37.89	-45.6%	-26.2%
7	Liver, Gallbladder, Biliary Ducts and Pancreas D/D	\$0.12	\$3.33	\$7.93	2675.0%	-58.0%
8	Muscles, Bones, and Connective Tissue D/D	\$52.90	\$54.41	\$79.25	2.9%	-31.3%
9	Skin, Subcutaneous Tissue (fat and connective) and Breast D/D	\$10.50	\$16.33	\$20.85	55.5%	-21.7%
10	Endocrine, Nutritional and Metabolic D/D (included diagnoses related to obesity, diabetes and hormones)	\$4.70	\$4.72	\$12.72	0.4%	-62.9%
11	Kidney and Urinary Tract D/D	\$1.71	\$4.30	\$13.70	151.5%	-68.6%
12	Male Reproductive System D/D	\$4.46	\$3.98	\$6.31	-10.8%	-37.0%
13	Female Reproductive System D/D	\$17.39	\$16.34	\$15.41	-6.0%	6.1%
14	Pregnancy, Childbirth, and After Delivery Diagnoses	\$5.00	\$6.87	\$9.04	37.4%	-24.0%
15	Newborns, and Newborns with Conditions Originating Shortly Before or After Birth	\$0.79	\$2.76	\$3.47	249.4%	-20.5%
16	Blood and Blood Forming Organ D/D (including spleen) and Immune System Disorders	\$3.06	\$0.67	\$5.27	-78.1%	-87.3%
17	Bone Marrow D/D and Poorly Differentiated Cancers	\$27.52	\$5.00	\$16.88	-81.8%	-70.4%
18	Infectious and Parasitic Diseases	\$0.62	\$0.29	\$5.16	-53.2%	-94.4%
19	Behavioral Health Diagnoses	\$1.90	\$4.38	\$9.31	130.5%	-52.9%
20	Alcohol/Drug Use and Alcohol/Drug Induced Organic Mental Disorders	\$0.00	\$0.33	\$0.59	0.0%	-44.1%
21	Injuries, Poisoning and Toxic Effects of Drugs	\$0.55	\$1.51	\$3.99	174.5%	-62.2%
22	Burns	\$0.00	\$0.09	\$0.75	0.0%	-88.1%
23	Other Miscellaneous Services Including Health Screenings, Medical Exams and Rehabilitation	\$42.47	\$38.69	\$44.47	-8.9%	-13.0%
24	Multiple Significant Trauma	\$0.00	\$0.00	\$0.96	0.0%	-100.0%
25	Human Immunodeficiency Virus Infections	\$0.00	\$0.00	\$0.03	0.0%	-100.0%
0	Ungroupable	\$0.78	\$3.00	\$11.63	284.6%	-74.2%
Total		\$280.77	\$294.16	\$423.13	4.8%	-30.5%

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.

** Each \$1.00 paid PMPM = \$6,731 in plan costs.

State Employee Trust Funds

Provider Utilization

Top 20 Provider Reports

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 57.7% 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 Meriter Hospital in Madison and third was Columbia St. Mary's Hospital in Milwaukee. Nearly half of the top 20 facility providers are located in the Madison and Milwaukee metropolitan areas where 44.4% of the Standard Plan population resides. In 2009, the Standard Plan's utilization of out of state providers remained level even though the out of state membership decreased. This is likely due to members seeking more specialized care and the individual conditions of the membership living out of state.

The report for the **SMP Plan** (Exhibit 12-B) shows that the top 20 facilities provide 95.6% of the total facility charges for the plan which is down from 100% last year. In 2009, the SMP plan expanded the provider network in Minnesota and Michigan which lead to an increase in the number of possible providers. The largest percentage of paid claims was from River Falls Area Hospital in River Falls, WI. The provider with the second highest amount of paid claims was Fairview University Medical Center in Minneapolis, MN, followed by Dickenson County Memorial Hospital in Iron Mountain, MI.

Professional

The **Standard Plan** (Exhibit 12-C) received 45.8% 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. Mayo Clinic in Rochester, MN was the second largest provider which is similar to 2008. Like the facility charges we see half of the providers are from the Madison and Milwaukee regions. We also saw a small decrease in the utilization of out of state providers which is most likely due to the decrease in out of state population.

The **SMP Plan** (Exhibit 12-D) received 62.9% of the paid claims from the top 20 professional providers. River Falls Medical Clinic in River Falls, WI was the largest provider, receiving 9.8% of the overall payments. A close second was Duluth Clinic in Ashland, WI receiving 8.0% in payments. The SMP network expanded in 2009 to include many providers in Minnesota and Michigan. Due to this 17 of the 20 top providers are based outside the state of Wisconsin.

STATE EMPLOYEE TRUST FUNDS
Top 20 Facility Providers - Standard
Incurred January 2009 - December 2009 Paid Through March 2010

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	559	\$795,138	\$1,636,952	\$2,432,090	16.9%
2	MERITER HOSPITAL INC	MADISON	WI	131	\$876,403	\$282,314	\$1,158,717	8.1%
3	COLUMBIA ST MARYS HOSPITAL COL	MILWAUKEE	WI	171	\$169,559	\$539,088	\$708,647	4.9%
4	FROEDTERT MEM LUTH HOSP	MILWAUKEE	WI	106	\$128,790	\$260,098	\$388,888	2.7%
5	ST MARYS HOSP MED CTR	MADISON	WI	32	\$309,977	\$66,050	\$376,027	2.6%
6	MD ANDERSON CANCER CTR	HOUSTON	TX	5	\$62,279	\$243,478	\$305,757	2.1%
7	UNIVERSITY HOSPITAL	AURORA	CO	2	\$277,100	\$9,325	\$286,425	2.0%
8	CLEVELAND CLINIC FOUNDATION	CLEVELAND	OH	2	\$95,489	\$162,623	\$258,112	1.8%
9	RIVER FALLS AREA HOSPITAL	RIVER FALLS	WI	26	\$194,918	\$52,737	\$247,655	1.7%
10	ROCHESTER METHODIST HOSPITAL	ROCHESTER	MN	29	\$102,136	\$144,544	\$246,680	1.7%
11	MERCY MEDICAL CTR	OSHKOSH	WI	31	\$75,197	\$157,024	\$232,221	1.6%
12	AURORA HEALTH CARE METRO	MILWAUKEE	WI	30	\$135,455	\$79,631	\$215,086	1.5%
13	WAUKESHA MEMORIAL HOSPITAL INC	WAUKESHA	WI	28	\$89,099	\$115,888	\$204,987	1.4%
14	HOLY FAMILY MEMORIAL MEDICAL	MANITOWOC	WI	7	\$84,138	\$108,723	\$192,861	1.3%
15	ALL SAINTS ST MARYS MED CTR	RACINE	WI	61	\$24,791	\$167,054	\$191,845	1.3%
16	LUTHER HOSPITAL	EAU CLAIRE	WI	31	\$80,771	\$99,182	\$179,953	1.3%
17	SACRED HEART HOSP	EAU CLAIRE	WI	15	\$29,826	\$147,797	\$177,623	1.2%
18	UNITED HOSPITAL SYSTEM INC	KENOSHA	WI	32	\$23,875	\$145,650	\$169,525	1.2%
19	ST MARYS HOSPITAL ROCHESTER	ROCHESTER	MN	13	\$92,218	\$74,637	\$166,855	1.2%
20	FRANCISCAN SKEMP MEDICAL CENTE	LA CROSSE	WI	4	\$116,184	\$27,806	\$143,990	1.0%
Top 20 Total				1,315	\$3,763,343	\$4,520,601	\$8,283,944	57.7%
All Other Facility Charges				1,305	\$2,637,728	\$3,432,735	\$6,070,464	42.3%
Total Facility Charges				2,620	\$6,401,071	\$7,953,336	\$14,354,408	100.0%

STATE EMPLOYEE TRUST FUNDS
Top 20 Facility Providers - SMP
Incurred January 2009 - December 2009 Paid Through March 2010

Exhibit 12-B

	Facility Provider	City	State	# of Unique Patients	Inpatient Paid Claims	Outpatient Paid Claims	Total Paid Claims	Paid %
1	RIVER FALLS AREA HOSPITAL	RIVER FALLS	WI	84	\$277,457	\$218,757	\$496,214	45.3%
2	FAIRVIEW UNIVERSITY MED CTR	MINNEAPOLIS	MN	23	\$28,921	\$84,889	\$113,810	10.4%
3	DICKINSON COUNTY MEMORIAL HOSP	IRON MOUNTAIN	MI	30	\$12,711	\$73,243	\$85,954	7.8%
4	REGINA MEDICAL CTR	HASTINGS	MN	4	\$14,180	\$39,185	\$53,365	4.9%
5	LAKEVIEW MEMORIAL HOSPITAL	STILLWATER	MN	12	\$20,169	\$29,807	\$49,976	4.6%
6	MEMORIAL MED CTR INC	ASHLAND	WI	13	\$0	\$42,553	\$42,553	3.9%
7	CHILDRENS HOSPITAL ST PAUL	SAINT PAUL	MN	12	\$30,699	\$11,349	\$42,048	3.8%
8	HEALTHEAST ST JOHNS HOSP	MAPLEWOOD	MN	15	\$13,304	\$16,479	\$29,783	2.7%
9	HIGH POINTE SURGERY CENTER	LAKE ELMO	MN	3	\$0	\$23,535	\$23,535	2.1%
10	LANDMARK SURGERY CTR	SAINT PAUL	MN	2	\$0	\$16,239	\$16,239	1.5%
11	MINNESOTA VALLEY SURGERY CTR	BURNSVILLE	MN	1	\$0	\$14,827	\$14,827	1.4%
12	REGIONS HOSPITAL	SAINT PAUL	MN	12	\$6,355	\$7,482	\$13,837	1.3%
13	WOODWINDS HEALTH CAMP	WOODBURY	MN	11	\$0	\$11,779	\$11,779	1.1%
14	GILLETTE CHILDRENS HOSPITAL	SAINT PAUL	MN	4	\$8,460	\$3,131	\$11,591	1.1%
15	HUDSON HOSPITAL INC	HUDSON	WI	3	\$0	\$9,738	\$9,738	0.9%
16	PARK NICOLLET METHODIST HOSPIT	ST LOUIS PARK	MN	4	\$0	\$7,085	\$7,085	0.6%
17	ST LUKES HOSP	DULUTH	MN	2	\$0	\$6,726	\$6,726	0.6%
18	NORTHSTAR HEALTH SYSTEM	IRON RIVER	MI	4	\$2,056	\$4,527	\$6,583	0.6%
19	MINNESOTA EYE LASER & SCT	BLOOMINGTON	MN	1	\$0	\$6,554	\$6,554	0.6%
20	HENNEPIN COUNTY MEDICAL CTR	MINNEAPOLIS	MN	3	\$0	\$5,709	\$5,709	0.5%
Top 20 Total				243	\$414,312	\$633,594	\$1,047,906	95.6%
All Other Facility Charges				44	\$2,669	\$45,426	\$48,095	4.4%
Total Facility Charges				287	\$416,981	\$679,020	\$1,096,001	100.0%

STATE EMPLOYEE TRUST FUNDS
Top 20 Professional Providers - Standard
Incurred January 2009 - December 2009 Paid Through March 2010

Exhibit 12-C

	Professional Provider	City	State	# of Unique Patients	Total Paid Claims	Paid %
1	UW MEDICAL FOUNDATION	MADISON	WI	775	\$1,671,568	13.4%
2	MAYO CLINIC ROCHESTER	ROCHESTER	MN	83	\$741,458	5.9%
3	DEAN MEDICAL CTR	MADISON	WI	259	\$588,030	4.7%
4	MEDICAL COLLEGE OF WISCONSIN	MILWAUKEE	WI	198	\$469,647	3.8%
5	ONCOLOGY ALLIANCE SC	RACINE	WI	12	\$282,038	2.3%
6	TENNESSEE ONCOLOGY PLLC	NASHVILLE	TN	1	\$251,698	2.0%
7	MIDELFORT CLINIC MHS	EAU CLAIRE	WI	77	\$239,464	1.9%
8	MARSHFIELD CLINIC	MARSHFIELD	WI	74	\$204,796	1.6%
9	COLUMBIA ST MARYS HOSPITAL COL	MILWAUKEE	WI	219	\$187,513	1.5%
10	AURORA ADVANCED HEALTHCARE	MILWAUKEE	WI	106	\$146,742	1.2%
11	AURORA MEDICAL GROUP OSHKOSH	OSHKOSH	WI	119	\$128,120	1.0%
12	WHEATON FRANCISCAN MEDICAL GRO	BROOKFIELD	WI	122	\$109,988	0.9%
13	UNIVERSITY PHYSICIANS INC	AURORA	CO	2	\$99,092	0.8%
14	MADISON PSYCH & PSYCH SVC	MADISON	WI	27	\$96,701	0.8%
15	MADISON SURGERY CENTER INC	MADISON	WI	20	\$94,942	0.8%
16	AFFINITY MEDICAL GROUP	NEENAH	WI	54	\$90,740	0.7%
17	MADISON MEDICAL AFFILIATES INC	MEQUON	WI	106	\$89,746	0.7%
18	ASSOCIATED PHYSICIANS LLP	MADISON	WI	106	\$86,480	0.7%
19	PHYSICIANS REFERRAL SVC	HOUSTON	TX	5	\$83,881	0.7%
20	HOLY FAMILY MEMORIAL MEDICAL	MANITOWOC	WI	10	\$66,185	0.5%
Top 20 Total				2,375	\$5,728,829	45.8%
All Other Professional Charges				8,470	\$6,790,060	54.2%
Total Professional Charges				10,845	\$12,518,889	100.0%

STATE EMPLOYEE TRUST FUNDS
Top 20 Professional Providers - SMP
Incurred January 2009 - December 2009 Paid Through March 2010

Exhibit 12-D

	Professional Provider	City	State	# of Unique Patients	Total Paid Claims	Paid %
1	RIVER FALLS MEDICAL CLINIC	RIVER FALLS	WI	142	\$86,467	9.8%
2	DULUTH CLINIC ASHLAND	ASHLAND	WI	22	\$70,427	8.0%
3	UNIVERSITY OF MINNESOTA PHYS	MINNEAPOLIS	MN	17	\$53,549	6.1%
4	ST CROIX ORTHOPAEDICS PA	STILLWATER	MN	18	\$35,094	4.0%
5	ALLINA MEDICAL CLINIC WOODBURY	WOODBURY	MN	46	\$35,071	4.0%
6	ASPEN MEDICAL GRP	SAINT PAUL	MN	23	\$33,464	3.8%
7	STILLWATER MEDICAL GROUP PA	STILLWATER	MN	43	\$26,478	3.0%
8	ST PAUL HEART CLINIC PA	SAINT PAUL	MN	17	\$25,020	2.8%
9	HEALTHEAST CLINIC WOODBURY	WOODBURY	MN	42	\$23,653	2.7%
10	PARK NICOLLET CLINIC	MINNEAPOLIS	MN	21	\$21,017	2.4%
11	LANDMARK SURGERY CTR	SAINT PAUL	MN	8	\$20,765	2.3%
12	LIFE LINK III	MINNEAPOLIS	MN	1	\$19,963	2.3%
13	RIVER FALLS AREA HOSPITAL	RIVER FALLS	WI	33	\$18,920	2.1%
14	GROUP HEALTH PLAN INC	SAINT PAUL	MN	21	\$16,224	1.8%
15	ASSOCIATED EYE CARE	STILLWATER	MN	34	\$13,492	1.5%
16	DICKINSON COUNTY MEMORIAL HOSP	IRON MOUNTAIN	MI	24	\$13,366	1.5%
17	ASSOCIATED ANESTHESIOLOGISTS P	SAINT PAUL	MN	9	\$12,416	1.4%
18	DERMATOLOGY CONSULTANTS PA	SAINT PAUL	MN	27	\$10,824	1.2%
19	BENISHEK CECCONI AND TERRIAN	IRON MOUNTAIN	MI	5	\$10,124	1.1%
20	ST LUKES HOSP	DULUTH	MN	5	\$9,388	1.1%
Top 20 Total				558	\$555,722	62.9%
All Other Professional Charges				757	\$328,139	37.1%
Total Professional Charges				1,315	\$883,861	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 2009 was 6.4% of the total facility claims for the plan which is lower than last year's out of network facility utilization number of 9.1%. The largest out of network facility provider was Aurora Health Care Metro, which accounted for 1.5% of the total facility utilization. In 2008, Aurora Health Care facilities were eliminated from the Standard Plan network. In 2009, the total utilization at Aurora Health Care facilities was 2.3% of the total facility charges which was down from 3.5% in 2008. For all other providers, out of network utilization was 4.1% which is the same as last year.

Professional

The **Standard Plan** out of network professional utilization was 12.9% of the total professional claims for the plan in 2009, compared to 11.4% in 2008. The top out of network provider was Aurora Advanced Healthcare with 1.2% of total professional charges. Advanced Healthcare was eliminated from the Standard Plan network in 2009 as they joined Aurora Health Care. In 2008, Advanced Healthcare accounted for 2.0% of professional charges, thus utilization at Advanced Healthcare professionals has decreased in 2009. The next closest provider was Aurora Health Center with 1.0% of professional charges which is a slight decrease from 2008. For all other providers, out of network utilization was 10.7% and similar to the previous year.

STATE EMPLOYEE TRUST FUNDS
Facility Out of Network Utilization - Standard
Incurred January 2009 - December 2009 Paid Through March 2010

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	30	\$135,455	\$79,631	\$215,086
2	WEST ALLIS MEMORIAL HOSPITAL	WEST ALLIS	WI	10	\$22,560	\$46,366	\$68,927
3	HILLVIEW HLTH CARE CT	LA CROSSE	WI	1	\$63,842	\$0	\$63,842
4	AURORA MEDICAL CENTER OSHKOSH	OSHKOSH	WI	8	\$29,191	\$22,090	\$51,281
5	BELMONT NURSING & REHAB CTR	MADISON	WI	1	\$45,064	\$0	\$45,064
6	AURORA MED CTR MANITOWOC CNTY	TWO RIVERS	WI	2	\$33,314	\$10,290	\$43,604
7	SOUTHEAST WISCONSIN SURGICAL	KENOSHA	WI	1	\$0	\$37,973	\$37,973
8	CLARIAN HEALTH PARTNERS	INDIANAPOLIS	IN	3	\$12,403	\$12,135	\$24,538
9	AURORA MEMORIAL HOSPITAL OF	BURLINGTON	WI	9	\$0	\$24,012	\$24,012
10	FOREIGN PROVIDER	MONONA	WI	9	\$9,552	\$2,227	\$11,779
11	MANITOWOC SURGERY CENTER LLC	MANITOWOC	WI	1	\$0	\$11,749	\$11,749
12	MENDOTA MENTAL HEALTH INSTITUT	MADISON	WI	2	\$6,477	\$3,856	\$10,333
13	MENTAL HEALTH CENTER OF DANE C	MADISON	WI	1	\$0	\$9,894	\$9,894
14	PACIFIC SHORES HOSPITAL	OXNARD	CA	1	\$7,919	\$0	\$7,919
15	SUN CITY WEST SURGERY CENTER	SURPRISE	AZ	1	\$0	\$7,237	\$7,237
16	NORTH SHORE SURGICAL CTR	MILWAUKEE	WI	2	\$0	\$6,639	\$6,639
17	HOLLAND HOME FULTON	GRAND RAPIDS	MI	1	\$6,277	\$75	\$6,352
18	CARON TREATMENT CENTER	WERNERSVILLE	PA	1	\$6,300	\$0	\$6,300
19	KNIGHTSBRIDGE SURGERY CTR	COLUMBUS	OH	1	\$0	\$5,715	\$5,715
20	AUDIE L MURPHY VA HOSP	SAN ANTONIO	TX	2	\$0	\$4,903	\$4,903
TOTAL				87	\$378,354	\$284,792	\$663,146

STATE EMPLOYEE TRUST FUNDS
Professional Out of Network Utilization - Standard
Incurred January 2009 - December 2009 Paid Through March 2010

Exhibit 13-B

	Professional Provider	City	State	# of Unique Patients	Total Paid Claims
1	AURORA ADVANCED HEALTHCARE	MILWAUKEE	WI	106	\$146,742
2	AURORA HEALTH CTR	WEST ALLIS	WI	119	\$128,120
3	MADISON PSYCH & PSYCH SVC	MADISON	WI	27	\$96,701
4	UNIVERSITY PHYSICIANS INC	AURORA	CO	1	\$42,317
5	WOMENS PSYCHIATRIC CENTER OF W	MADISON	WI	8	\$40,163
6	WISCONSIN PSYCHOTHERAPY & HE	MADISON	WI	4	\$29,457
7	RAUL J RODRIGUEZ MD	DELRAY BEACH	FL	1	\$28,288
8	TWIN CITIES SPINE CENTER	MINNEAPOLIS	MN	1	\$26,249
9	OMNIFLIGHT HELICOPTERS INC	FORT PIERCE	FL	1	\$21,484
10	PHI AIR MEDICAL	INDIANAPOLIS	IN	1	\$19,142
11	WISCONSIN RENAL CARE GRP	MILWAUKEE	WI	1	\$18,341
12	MARCI M GITTLEMAN PHD	MADISON	WI	2	\$18,338
13	DRJ & ASSOCIATES LLC	MEQUON	WI	4	\$17,690
14	ROBERT A GRUENBERT PSYD	GLENDALE	WI	4	\$14,301
15	RIVERHILL PSYCHIATRIC ASSOCIAT	MANITOWOC	WI	3	\$12,798
16	MADISON COUNSELING SVC	MADISON	WI	4	\$12,389
17	FOX VALLEY PSYCHIATRIC ASSOC	APPLETON	WI	3	\$11,439
18	KASS CLINICS LLC	SAINT LOUIS PARK	MN	1	\$10,792
19	MAYFIELD CLINIC	CINCINNATI	OH	1	\$10,716
20	JOHN S ROGERSON MD SC	MADISON	WI	7	\$10,555
TOTAL				299	\$716,019

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 2009 – December 2009 and paid through March 2010 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 Case Management Description on the next page.

The **Standard Plan** has 36 members with claims over \$100,000 for a total of \$6,676,563 in claim costs which is down 15 members from 2008. Of these 36 members 21 are employees, 12 are spouses, and 3 are dependents. Another way to break down these members is that 25 are regular members, 9 are annuitants, 1 is a graduate assistant, and 1 is on continuation. 32 of the members reside in state and 4 are from out of state. These 36 members represent 21.0% of total claims paid under the Standard Plan. The expected percent of claims over \$100,000 for the benchmark groups is 9.0%, whereas for the Standard Plan, they have 9.7% of claims over \$100,000. Therefore, large claim activity is slightly higher than expected.

The **SMP Plan** did have one individual with claims over \$100,000 for a total of \$127,385 in claims in 2009. This one member represented 5.4% of the total claims paid under the SMP Plan.

The **Medicare Plus \$1M Plan** has 3 members with claims over \$100,000 for a total \$365,530 in claim costs for 2009. These 3 members reside in WI. 2 of the members incurred significant pharmaceutical costs that were not covered by Medicare. One individual had 92.6% of their costs from prescription drugs received through Navitus while the other individual had 33.6% of their costs in prescription drugs and 60.7% of their costs in injectable drugs. The last individual incurred a majority of their claims while being a member of the Standard Plan, but for informational purposes 64.0% of the member's claims were for injectable drugs which may or may not have been covered by Medicare.

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 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 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 management, and outpatient preauthorization, are performed by this team.

STATE EMPLOYEE TRUST FUNDS
High Cost Patients (over \$100,000)
Incurred January 2009 - December 2009 Paid Through March 2010

Exhibit 14-A

	Patient Status	Plan	Care Management	Primary Condition	Total Paid
1	ACTIVE	STANDARD	Preauth, UM, CM	OTHER ACQUIRED DEFORMITY	\$392,730
2	ACTIVE	STANDARD	Preauth	ACQ HEMOLYTIC ANEMIA	\$374,173
3	ACTIVE	STANDARD	UM, CM	HODGKIN'S DISEASE	\$340,162
4	ACTIVE	STANDARD	Preauth, UM, CM	CARDIOMYOPATHY	\$323,010
5	ACTIVE	STANDARD	UM, CM	SEPTICEMIA	\$292,095
6	CANCELLED	STANDARD	UM, CM, CCM	ENCOUNTR PROC/AFTRCR NEC	\$277,131
7	CANCELLED	STANDARD	Preauth, UM	INTERVERTEBRAL DISC DIS	\$251,409
8	ACTIVE	STANDARD	Preauth, UM, CM	ENCOUNTR PROC/AFTRCR NEC	\$247,725
9	ACTIVE	STANDARD	UM, CM, CCM	RADIUS & ULNA FRACTURE	\$241,185
10	ACTIVE	STANDARD	Preauth, UM	MALIGN NEOPL PROSTATE	\$239,176
11	ACTIVE	STANDARD	UM, CM	CHRONIC ULCER OF SKIN	\$238,987
12	ACTIVE	STANDARD	Preauth, UM, BH, CM	CHRONIC RENAL FAILURE	\$222,519
13	CANCELLED	STANDARD	Preauth, UM, CM	MALIG NEO FEMALE BREAST	\$221,970
14	CANCELLED	STANDARD	Preauth, UM, CM	MALIG NEO FEMALE BREAST	\$194,751
15	CANCELLED	STANDARD	Preauth, UM	INTERVERTEBRAL DISC DIS	\$172,826
16	ACTIVE	STANDARD	Preauth, CM	MALIG NEO FEMALE BREAST	\$172,556
17	CANCELLED	STANDARD	Preauth, UM, CM, CCM	ENCOUNTR PROC/AFTRCR NEC	\$168,673
18	ACTIVE	STANDARD	Preauth, UM, CCM	ENCOUNTR PROC/AFTRCR NEC	\$158,316
19	ACTIVE	STANDARD	UM, CM	OTH MAL NEO LYMPH/HISTIO	\$151,834
20	ACTIVE	MEDICARE PLUS ONE MILLION	Medicare Prime	AFFECTIVE PSYCHOSES	\$148,362
21	ACTIVE	STANDARD	Preauth, CM	ENCOUNTR PROC/AFTRCR NEC	\$137,437
22	ACTIVE	STANDARD	Preauth, UM, CM	OTH DISORDERS OF ARTERIES	\$135,972
23	ACTIVE	SMP	Preauth, UM, CM	MALIG NEOPL UTERUS BODY	\$127,385
24	CANCELLED	STANDARD	UM, CM	MALIGNANT NEOPLASM LIVER	\$126,458
25	ACTIVE	STANDARD	UM, CM	OTH SURGICAL COMPL NEC	\$123,619
26	ACTIVE	STANDARD	UM, CM	MALIGNANT NEOPLASM BRAIN	\$121,530
27	ACTIVE	STANDARD	UM, CM	CHRONIC ULCER OF SKIN	\$121,486
28	ACTIVE	STANDARD	Preauth, UM, CCM	OSTEOARTHRISIS AND ALLIED	\$119,297
29	ACTIVE	STANDARD	UM, BH, CM	PILONIDAL CYST	\$118,806
30	ACTIVE	STANDARD	UM, CM	REHABILITATION PROCEDURE	\$117,475
31	ACTIVE	STANDARD	Preauth, UM, CCM	ACUTE MYOCARDIAL INFARCTI	\$112,961
32	ACTIVE	STANDARD	Preauth, Declined CM	MALIG NEO FEMALE BREAST	\$112,632

Preauth = Outpatient Preauthorization UM = Utilization Management CM = Case Management CCM = Chronic Care Management BH = Behavioral Health Management

STATE EMPLOYEE TRUST FUNDS
High Cost Patients (over \$100,000)
Incurred January 2009 - December 2009 Paid Through March 2010

Exhibit 14-A

	Patient Status	Plan	Care Management	Primary Condition	Total Paid
33	ACTIVE	MEDICARE PLUS ONE MILLION	CCM	CHRONIC PULMONARY HEART D	\$110,889
34	ACTIVE	STANDARD	Preauth, UM	OSTEOARTHROSIS AND ALLIED	\$110,517
35	ACTIVE	STANDARD	Preauth, UM	MAL NEO UTERINE ADNEXA	\$108,866
36	ACTIVE	STANDARD	Preauth, UM, CM	MULTIPLE MYELOMA ET AL	\$108,394
37	ACTIVE	STANDARD	Preauth, UM	CARDIAC DYSRHYTHMIAS	\$108,368
38	ACTIVE	STANDARD	UM	CONDUCTION DISORDERS	\$106,680
39	ACTIVE	MEDICARE PLUS ONE MILLION	BH, CM	AFFECTIVE PSYCHOSES	\$106,278
40	ACTIVE	STANDARD	Preauth, UM, CM	INTERVERTEBRAL DISC DIS	\$104,838
Total					\$7,169,478

Preauth = Outpatient Preauthorization UM = Utilization Management CM = Case Management CCM = Chronic Care Management BH = Behavioral Health Management

Note: Total paid includes medical and drug data

State Employee Trust Funds

Member Cost Share

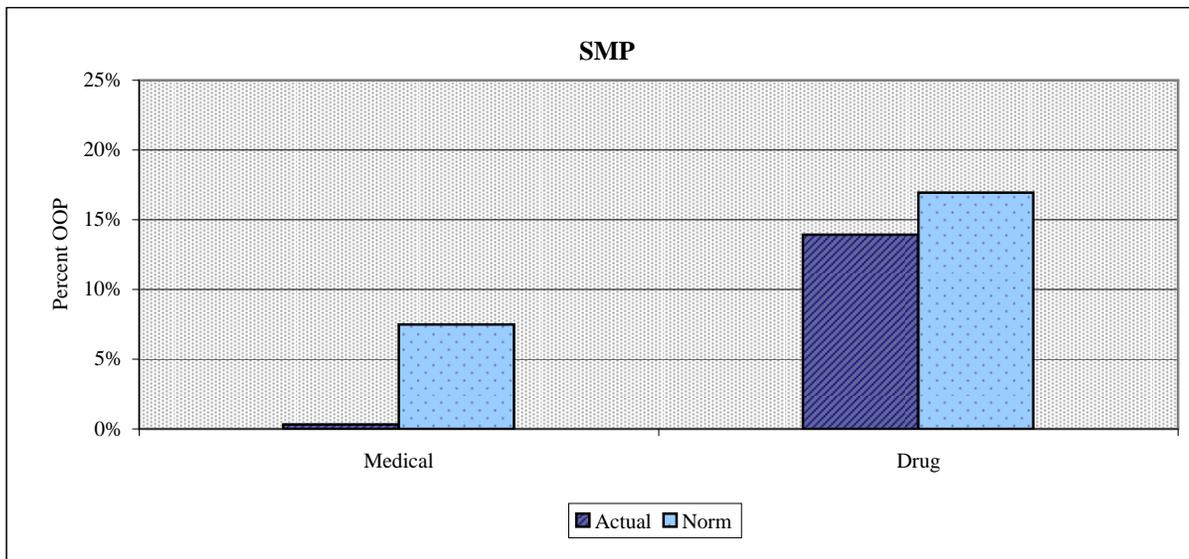
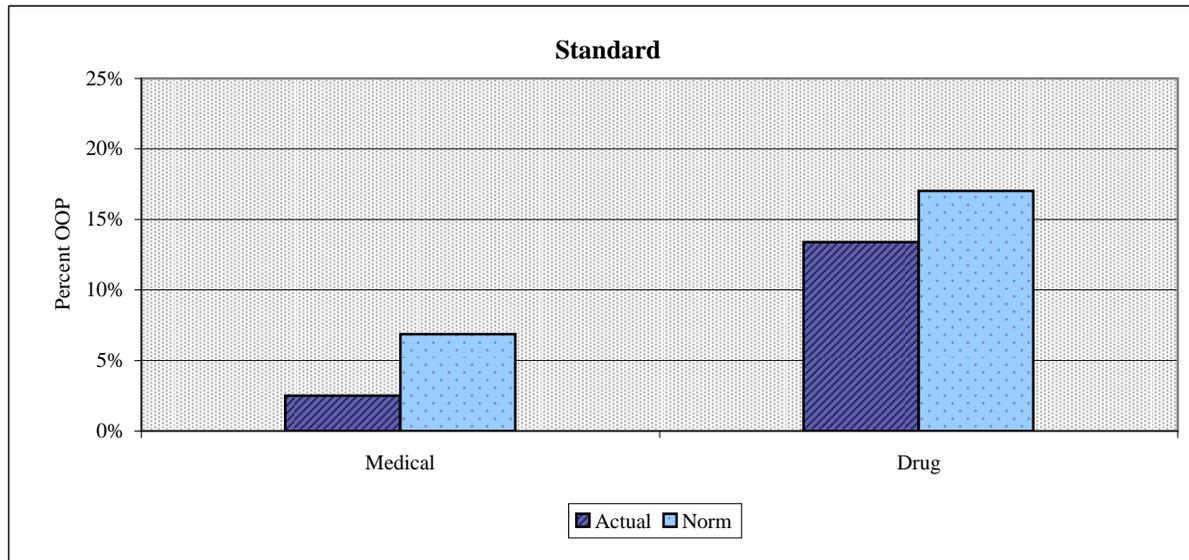
Medical and Drug Cost Sharing

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 2.5% of their own medical claims as compared to the benchmark of 6.9%. The prescription drug cost share is slightly closer to our normative benchmark with the Standard Plan around 13.4% and the benchmark at 17.0%.

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 7.5% of their medical claims. The SMP cost share for prescription drugs is 13.9% compared to the benchmark of 16.9%. 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 2009 - December 2009 Paid Through March 2010



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

State Employee Trust Funds

Member Cost Share

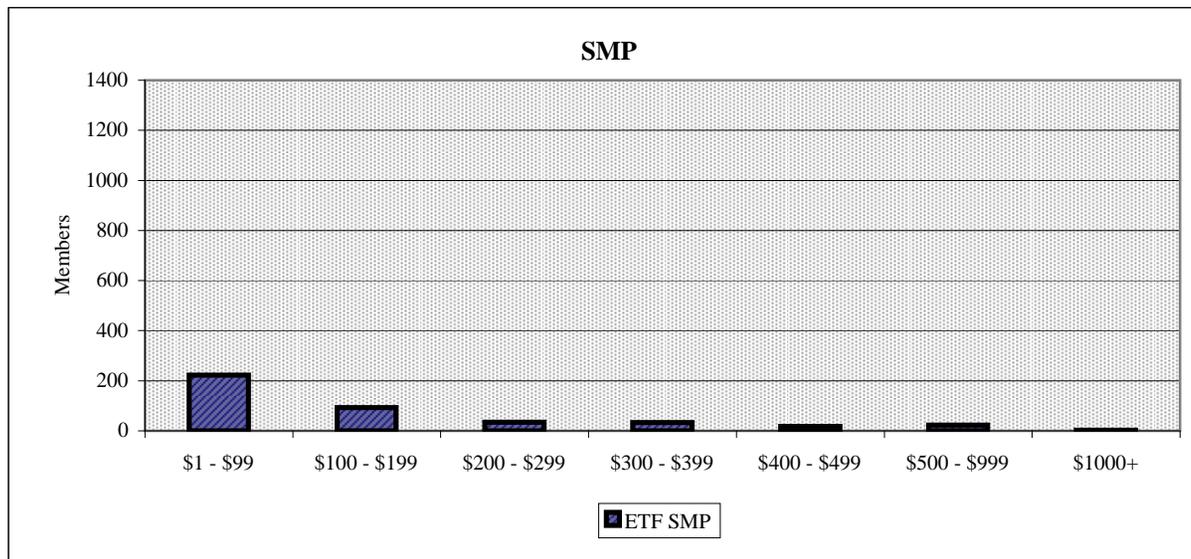
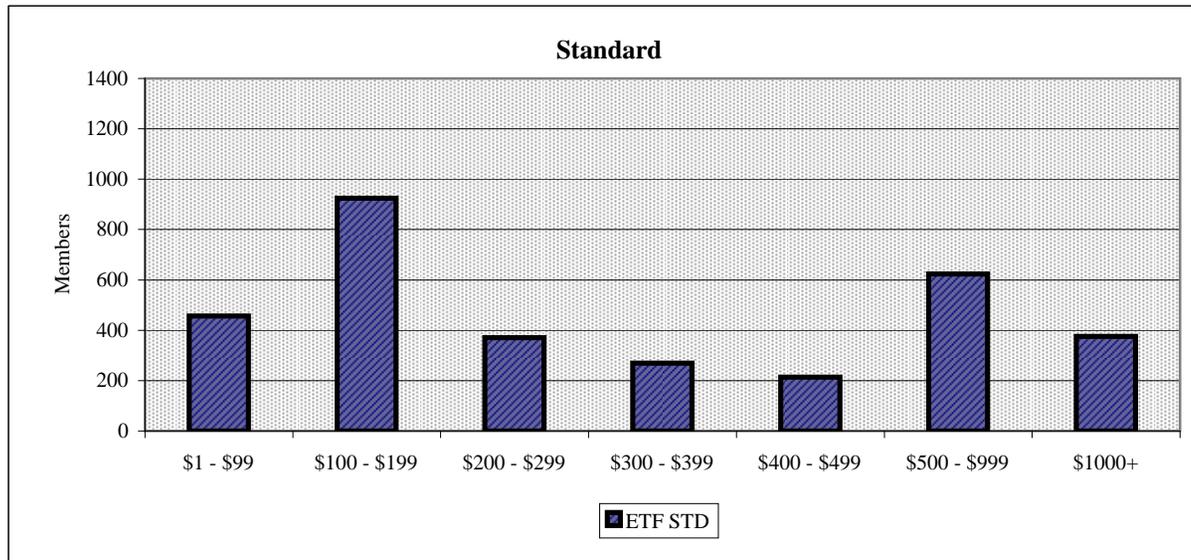
Medical and Drug Out of Pocket by Member

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 each member paid in 2009. 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 greatest number of members paid between \$100 and \$200 out of pocket annually. There are also over 600 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 376 members who paid over \$1000 out of pocket in 2009.

The **SMP Plan** by comparison has the largest number of members paying between \$1 and \$99 in cost sharing. From there, the number of members declines steadily as the out of pocket amount goes up. Most of the cost sharing comes from prescription drug copays.

STATE EMPLOYEE TRUST FUNDS
Medical and Drug Out of Pocket by Member
Incurred January 2009 - December 2009 Paid Through March 2010



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 2009 through December 2009 and paid through the end of March 2010. 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 66.9% of submitted charges on behalf of the plan. Of the 33.1% savings, 20.5% came from pricing cutbacks from the network providers. Another 7.2% of savings was received from the rejection of duplicate charges or charges that were not eligible. Another 3.1% 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 60.4% of submitted charges on behalf of the plan. Of the 39.6% savings, 18.5% was saved on claims rejected for duplicate submission, non-eligible claims, and services not covered by the plan. Another 19.7% was received from pricing cutbacks from network providers. In comparison to the Standard Plan, the SMP Plan members contributed only 0.2% in out of pocket costs. The SMP Plan does have some medical 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 6.4% of submitted charges on behalf of the plan. Payments made by Medicare have an overwhelming impact on savings by accounting for 76.7% of the submitted charges. The second highest savings, 16.0%, 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 2009 was 15.0% of submitted charges. With the Medicare population's impact, 65.8% of the savings was provided by Medicare, followed by 14.8% in rejections for duplicates and non-eligible services and 2.9% in pricing cutback.

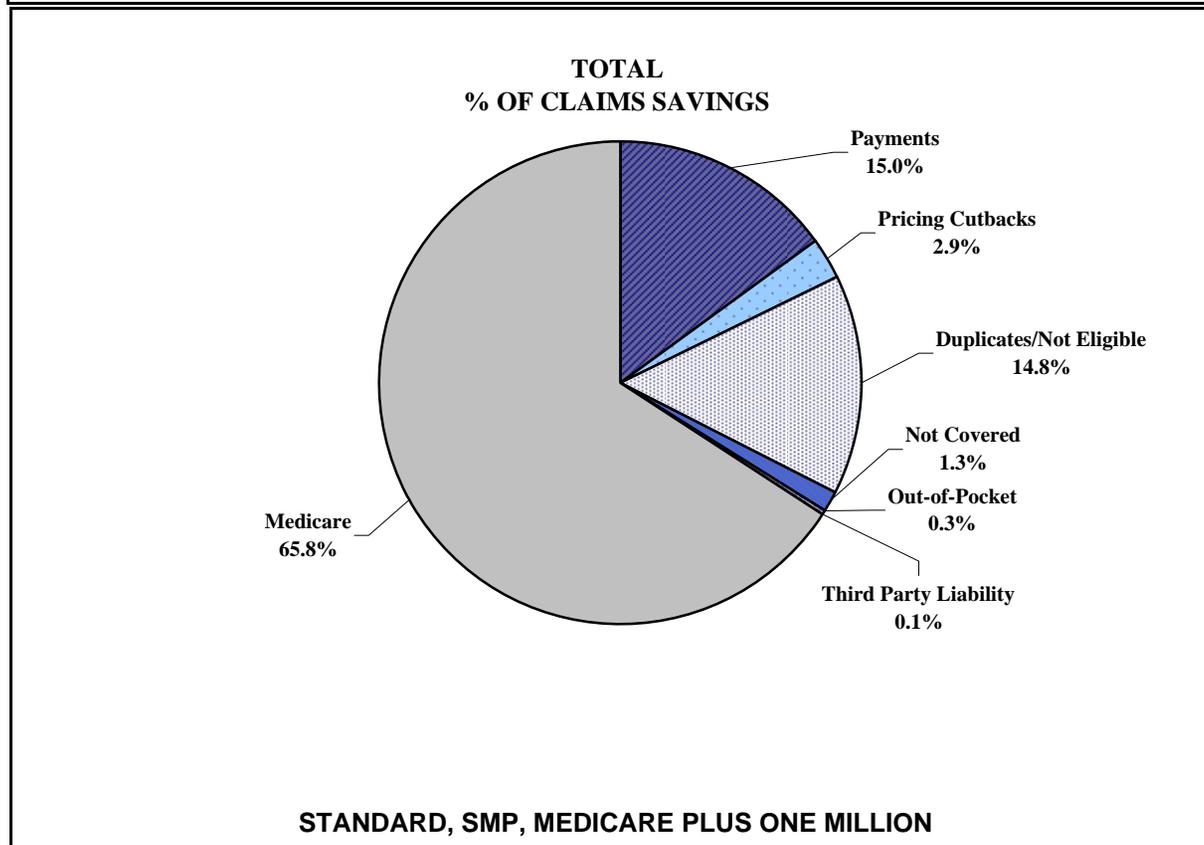
STATE EMPLOYEE TRUST FUNDS
Medical Claims Savings Analysis
Incurred January 2009 - December 2009 Paid Through March 2010

Exhibit 17-A

Category	STANDARD		SMP		MEDICARE PLUS ONE MILLION	
	\$ Amount	% of Total	\$ Amount	% of Total	\$ Amount	% of Total
Submitted Charges	\$40,189,603	100.0%	\$3,275,805	100.0%	\$260,353,096	100.0%
Duplicates/Not Eligible	\$2,896,910	7.2%	\$346,043	10.6%	\$41,617,590	16.0%
Pricing Cutbacks	\$8,222,489	20.5%	\$644,701	19.7%		
Out-of-Pocket						
Deductible	\$445,404	1.1%	-\$700	0.0%	-\$1,636	0.0%
Coinsurance	\$248,446	0.6%	\$1,658	0.1%	\$66,495	0.0%
Copayments	\$469	0.0%	\$5,289	0.2%	\$0	0.0%
Total	\$694,319	1.7%	\$6,246	0.2%	\$64,860	0.0%
Not Covered						
Medical Necessity	\$245,170	0.6%	\$23,517	0.7%	\$31,032	0.0%
Inappropriate Provider	\$50,313	0.1%	\$2,705	0.1%	\$2,533	0.0%
Benefit Maximum	\$44,925	0.1%	\$719	0.0%	\$251,890	0.1%
Experimental/Fertility	\$103,777	0.3%	\$712	0.0%	\$47,647	0.0%
Dental	\$30,987	0.1%	\$5,195	0.2%	\$23,860	0.0%
Custodial	\$4,342	0.0%	\$0	0.0%	\$796,446	0.3%
Code Review	\$451,877	1.1%	\$40,979	1.3%	\$43,285	0.0%
Contact Lens/Hearing Aid	\$22,529	0.1%	\$1,178	0.0%	\$125,655	0.0%
Drugs	\$0	0.0%	\$0	0.0%	\$128,244	0.0%
No Referral	\$0	0.0%	\$0	0.0%	\$0	0.0%
All Other	\$287,728	0.7%	\$182,973	5.6%	\$912,896	0.4%
Total	\$1,241,648	3.1%	\$257,978	7.9%	\$2,363,488	0.9%
Third Party Liability						
Workers Compensation	\$22,793	0.1%	\$1,920	0.1%	\$1,011	0.0%
Subrogation	\$2,219	0.0%	\$151	0.0%	\$3,334	0.0%
Coordination of Benefits	\$126,214	0.3%	\$21,908	0.7%	\$0	0.0%
Total	\$151,225	0.4%	\$23,980	0.7%	\$4,345	0.0%
Medicare	\$107,681	0.3%	\$16,817	0.5%	\$199,728,287	76.7%
Payments	\$26,875,330	66.9%	\$1,980,040	60.4%	\$16,574,527	6.4%

STATE EMPLOYEE TRUST FUNDS
Medical Claims Savings Analysis Summary
 Incurred January 2009 - December 2009 Paid Through March 2010

	STANDARD		SMP		MEDICARE PLUS ONE MILLION	
	\$ Amount	% of Total	\$ Amount	% of Total	\$ Amount	% of Total
Payments	\$26,875,330	66.9%	\$1,980,040	60.4%	\$16,574,527	6.4%
Pricing Cutbacks	\$8,222,489	20.5%	\$644,701	19.7%		
Duplicates/Not Eligible	\$2,896,910	7.2%	\$346,043	10.6%	\$41,617,590	16.0%
Not Covered	\$1,241,648	3.1%	\$257,978	7.9%	\$2,363,488	0.9%
Out-of-Pocket	\$694,319	1.7%	\$6,246	0.2%	\$64,860	0.0%
Third Party Liability	\$151,225	0.4%	\$23,980	0.7%	\$4,345	0.0%
Medicare	\$107,681	0.3%	\$16,817	0.5%	\$199,728,287	76.7%





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 450 members as of January 2010, up 40 from the 410 members in the plan in December 2009. The increase in membership is due to an additional of 43 members to the SMP Plan and 17 members to the Medicare Carve-out Plan. In comparison, the Standard Plan lost 20 members.

The **Standard Plan** membership is much older than the normative distribution with 65.1% of membership over the age of 50 compared to the benchmark of 26.6%. 76.4% of the Standard Plan participants live within Wisconsin.

The age of the **SMP Plan** members is similar to the benchmark however the SMP Plan has a slightly higher than expected concentration of membership between the ages of 35 - 55 with 46.4% of the membership compared to the benchmark of 33.8%. The SMP Plan membership is entirely within Wisconsin and lives in the rural areas with all of the population living along the northern and western borders of Wisconsin. The membership is contained within Bayfield, Crawford, Marinette and Pepin Counties.

Wisconsin Public Employers

Executive Summary

Claims Data

Standard Plan

The Standard Plan had a minimal 0.7% increase in medical claim costs between 2008 and 2009. The Standard Plan was 15.8% above the benchmark in 2009.

The Standard Plan had one member exceed \$100,000 in claim costs. Standard Plan members pay 5.8% of their own medical claims as compared to the benchmark of 6.4%.

WPS paid 75.9% of submitted charges on behalf of the plan.

SMP Plan

The SMP Plan had a large increase of 31.5% in medical claim costs between 2008 and 2009. The SMP Plan was 25.5% above the benchmark in 2009. 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 1.4% towards their own medical claims (in the form of cost sharing), unlike the members of most large groups who pay an average of about 8.1% of their medical claims.

WPS paid 59.4% 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 PMPM trend from 2008 to 2009 was 2.0%.

WPS paid 5.3% of submitted charges on behalf of the plan. 77.7% of the charges were paid by Medicare.

Wisconsin Public Employers

Executive Summary

Provider Data

For the **Standard Plan**, the top 20 facilities provide 96.7% of the total facility charges for the plan. 65.2% of professional charges are from the top 20 providers. The University of Wisconsin Hospital was the top facility provider by both the paid claim amount and the number of unique patients seen. Similarly, the University of Wisconsin Medical Foundation was the top professional provider by both the paid claim amount and the number of unique patients seen.

For the **SMP Plan**, the top 10 facilities provide 100.0% of the total facility charges for the plan. 88.7% of the paid claims are from the top 20 professional providers. Dickinson County Memorial Hospital in Iron Mountain, Michigan was the largest facility provider and Marquette General Hospital in Marquette, Michigan was the top professional provider service.

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 employees. 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 2009 calendar year data. For Medicare classes, demographic benchmarks are based on comparable WPS Medicare enrollment as appropriate.

Claim cost benchmarks are also based on 2009 calendar year 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/1000 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 benefit represented in the WPS benchmark and the specific reported ETF class.

Wisconsin Public Employers

Summary Level Membership

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 2008 through January 2010.

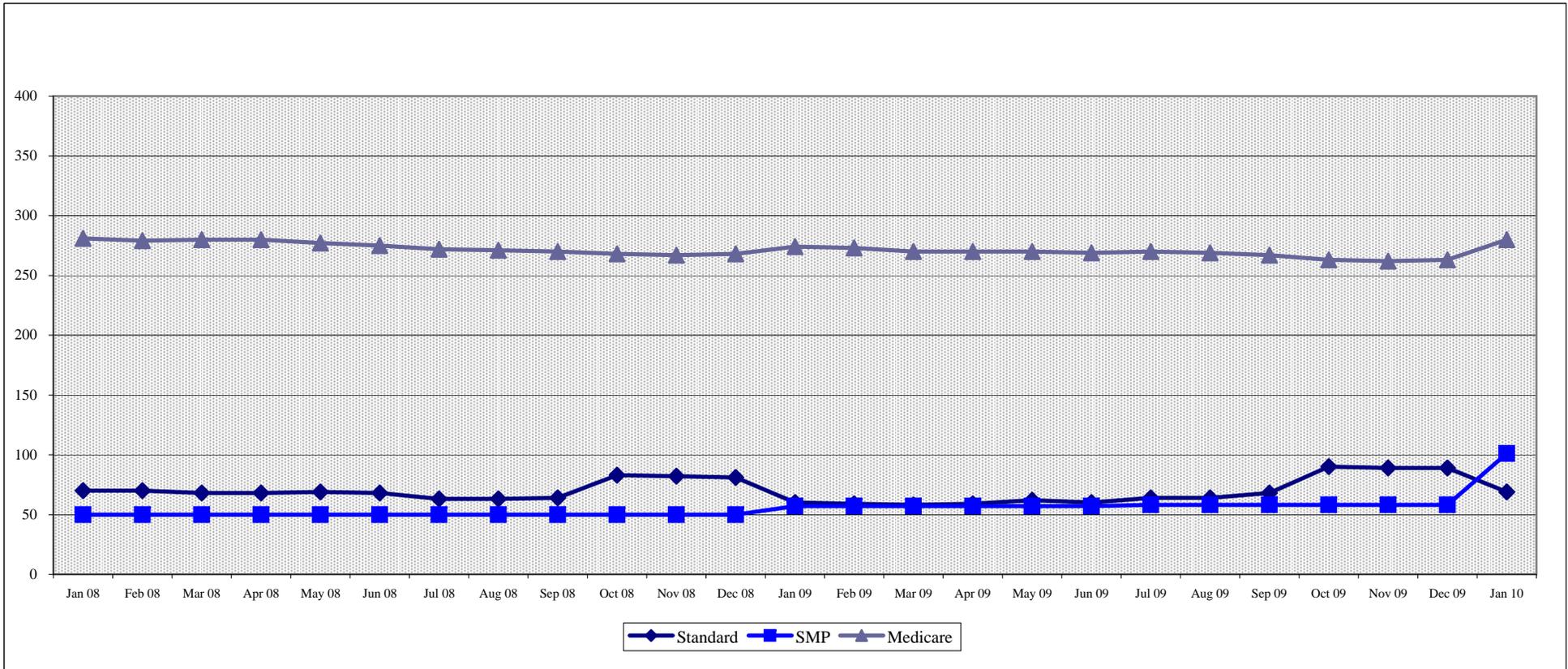
Enrollment on the **Standard Plan** averaged 71 members per month in 2008 and 69 members per month in 2009. The membership over the course of the year remained fairly stable with increases beginning in October of each year.

SMP Plan enrollment averaged 50 members per month in 2008 and increased to an average of 58 members per month in 2009. The membership remained stable within each year with no seasonal fluctuation.

The **Medicare Carve-out Plan** enrollment averaged 274 members per month in 2008 and decreased to 268 members per month in 2009. The membership declined gradually over both 2008 and 2009 with a total loss of 18 members over the two year period.

**WISCONSIN PUBLIC EMPLOYERS
Monthly Membership
January 2008 through January 2010**

Exhibit 1-B



	EFFECTIVE MONTH																									
	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	Feb 09	Mar 09	Apr 09	May 09	Jun 09	Jul 09	Aug 09	Sep 09	Oct 09	Nov 09	Dec 09	Jan 10	
Standard	70	70	68	68	69	68	63	63	64	83	82	81	60	59	58	59	62	60	64	64	68	90	89	89	69	
SMP	50	50	50	50	50	50	50	50	50	50	50	50	57	57	57	57	57	57	58	58	58	58	58	58	58	101
Medicare	281	279	280	280	277	275	272	271	270	268	267	268	274	273	270	270	270	269	270	269	267	263	262	263	280	

Wisconsin Public Employers

Group Demographics

Enrollment by Plan

The Enrollment by Plan report (Exhibit 2-B) shows the December 2009 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 2009

Plan	Class	# of Members	Average Member Age	Member Gender Distribution Female	Member Age/Gender Factor
Classic Standard	Milwaukee	12	57.0	41.7%	2.335
	Waukesha	1	52.0	0.0%	1.594
	Dane	20	50.1	60.0%	1.883
	Rest of State	34	45.2	47.1%	1.648
	Annuity	8	59.5	62.5%	2.431
	Continuation	0	0.0	0.0%	0.000
	Medicare	256	76.5	57.8%	N/A
Subtotal		331	70.5	56.2%	1.903
Deductible Classic Standard	Milwaukee	0	0.0	0.0%	0.000
	Waukesha	2	32.0	50.0%	0.867
	Dane	0	0.0	0.0%	0.000
	Rest of State	5	41.4	60.0%	1.388
	Annuity	0	0.0	0.0%	0.000
	Continuation	0	0.0	0.0%	0.000
	Medicare	7	74.1	57.1%	N/A
Subtotal		14	56.4	57.1%	1.239
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	0	0.0	0.0%	0.000
	Annuity	0	0.0	0.0%	0.000
	Continuation	0	0.0	0.0%	0.000
	Medicare	0	0.0	0.0%	N/A
Subtotal		0	0.0	0.0%	0.000
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	3	52.0	66.7%	1.838
	Annuity	4	33.8	50.0%	1.277
	Continuation	0	0.0	0.0%	0.000
	Medicare	0	0.0	0.0%	N/A
Subtotal		7	41.6	57.1%	1.517
SMP	Local	58	34.9	46.6%	1.213
	Annuity	0	0.0	0.0%	0.000
	Continuation	0	0.0	0.0%	0.000
Subtotal		58	34.9	46.6%	1.213
Deductible SMP	Local	0	0.0	0.0%	0.000
	Annuity	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		410	64.5	54.9%	N/A

Wisconsin Public Employers

Group Demographics

Member Census Grids

The Member Census Grid breaks down the December 2009 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) is much older than the normative distribution with 65.1% of membership over the age of 50 compared to the benchmark of 26.6%. 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, a greater number of older members select this plan. 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 contributing to the older than expected membership is the smaller than expected population of children with only 7.9% of the membership under the age of 20 compared to the benchmark of 29.1%. The gender distribution of the Standard Plan is similar to the benchmark population.

SMP Plan

The SMP Plan membership (Exhibit 3-E) has a higher than expected membership between the ages of 35–55 with 46.4% of the membership as compared to the benchmark of 33.8%.

Medicare Carve-out Plan

The Medicare Carve-out Plan membership is shown in Exhibit 3-F. The population has an older population than the WPS Medicare Carve-out population.

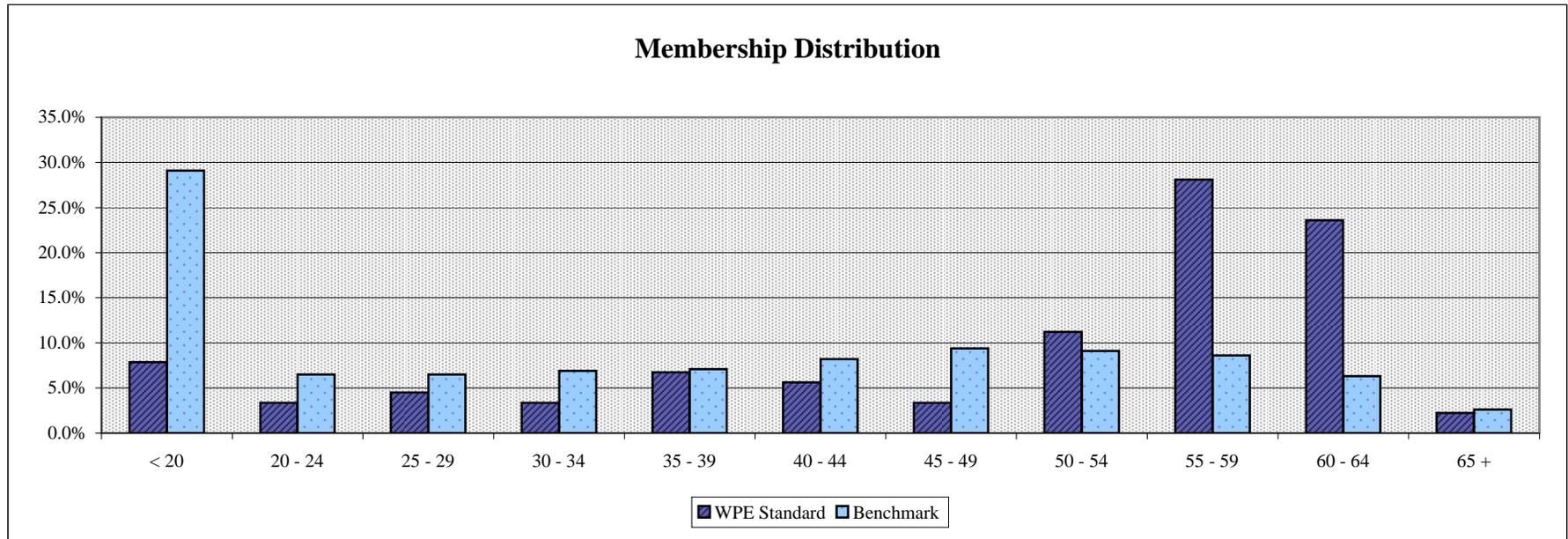
**WISCONSIN PUBLIC EMPLOYERS
Member Census Grid - Standard
December 2009**

Exhibit 3-D

FEMALE			
Age Band	# of Members	% of Total	Benchmark
< 20	4	4.5%	14.2%
20 - 24	0	0.0%	3.5%
25 - 29	1	1.1%	3.6%
30 - 34	2	2.2%	3.6%
35 - 39	5	5.6%	3.7%
40 - 44	2	2.2%	4.4%
45 - 49	2	2.2%	5.0%
50 - 54	7	7.9%	4.9%
55 - 59	14	15.7%	4.7%
60 - 64	9	10.1%	3.2%
65 +	0	0.0%	1.2%
Total	46	51.7%	51.9%

MALE			
Age Band	# of Members	% of Total	Benchmark
< 20	3	3.4%	14.9%
20 - 24	3	3.4%	3.0%
25 - 29	3	3.4%	2.9%
30 - 34	1	1.1%	3.3%
35 - 39	1	1.1%	3.4%
40 - 44	3	3.4%	3.8%
45 - 49	1	1.1%	4.4%
50 - 54	3	3.4%	4.2%
55 - 59	11	12.4%	3.9%
60 - 64	12	13.5%	3.1%
65 +	2	2.2%	1.4%
Total	43	48.3%	48.1%

TOTAL			
Age Band	# of Members	% of Total	Benchmark
< 20	7	7.9%	29.1%
20 - 24	3	3.4%	6.5%
25 - 29	4	4.5%	6.5%
30 - 34	3	3.4%	6.9%
35 - 39	6	6.7%	7.1%
40 - 44	5	5.6%	8.2%
45 - 49	3	3.4%	9.4%
50 - 54	10	11.2%	9.1%
55 - 59	25	28.1%	8.6%
60 - 64	21	23.6%	6.3%
65 +	2	2.2%	2.6%
Total	89	100.0%	100.0%



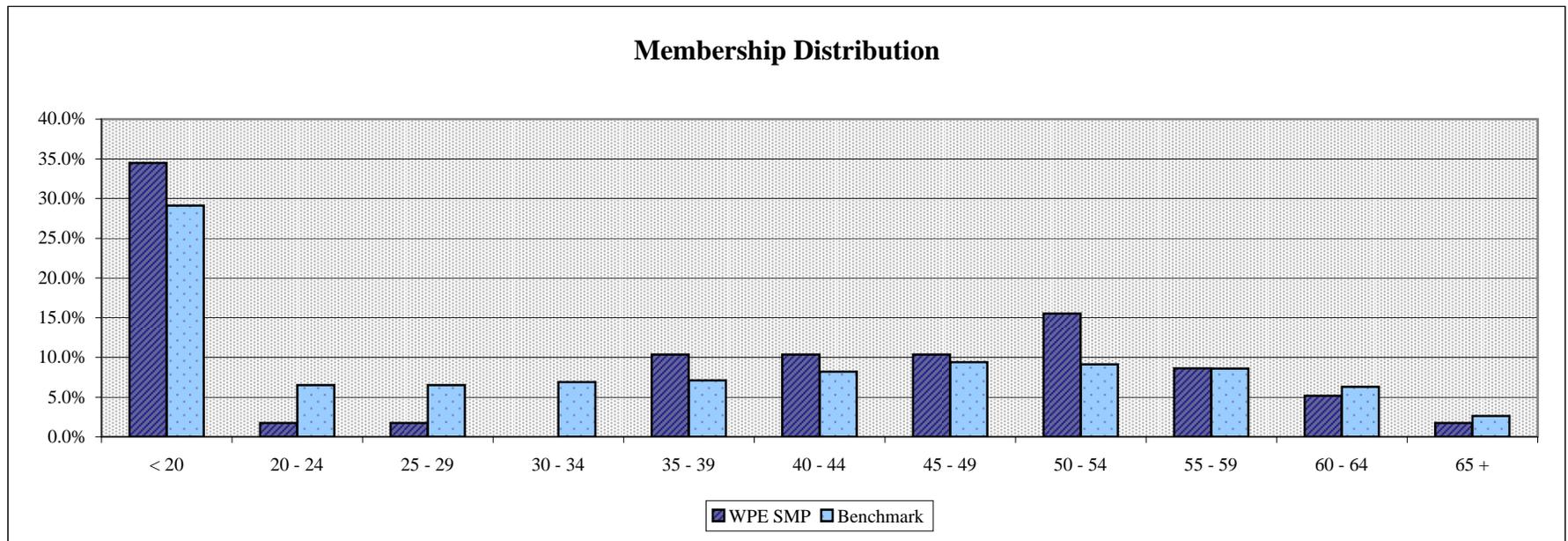
**WISCONSIN PUBLIC EMPLOYERS
Member Census Grid - SMP
December 2009**

Exhibit 3-E

FEMALE			
Age Band	# of Members	% of Total	Benchmark
< 20	7	12.1%	14.2%
20 - 24	1	1.7%	3.5%
25 - 29	1	1.7%	3.6%
30 - 34	0	0.0%	3.6%
35 - 39	3	5.2%	3.7%
40 - 44	3	5.2%	4.4%
45 - 49	3	5.2%	5.0%
50 - 54	4	6.9%	4.9%
55 - 59	3	5.2%	4.7%
60 - 64	1	1.7%	3.2%
65 +	1	1.7%	1.2%
Total	27	46.6%	51.9%

MALE			
Age Band	# of Members	% of Total	Benchmark
< 20	13	22.4%	14.9%
20 - 24	0	0.0%	3.0%
25 - 29	0	0.0%	2.9%
30 - 34	0	0.0%	3.3%
35 - 39	3	5.2%	3.4%
40 - 44	3	5.2%	3.8%
45 - 49	3	5.2%	4.4%
50 - 54	5	8.6%	4.2%
55 - 59	2	3.4%	3.9%
60 - 64	2	3.4%	3.1%
65 +	0	0.0%	1.4%
Total	31	53.4%	48.1%

TOTAL			
Age Band	# of Members	% of Total	Benchmark
< 20	20	34.5%	29.1%
20 - 24	1	1.7%	6.5%
25 - 29	1	1.7%	6.5%
30 - 34	0	0.0%	6.9%
35 - 39	6	10.3%	7.1%
40 - 44	6	10.3%	8.2%
45 - 49	6	10.3%	9.4%
50 - 54	9	15.5%	9.1%
55 - 59	5	8.6%	8.6%
60 - 64	3	5.2%	6.3%
65 +	1	1.7%	2.6%
Total	58	100.0%	100.0%



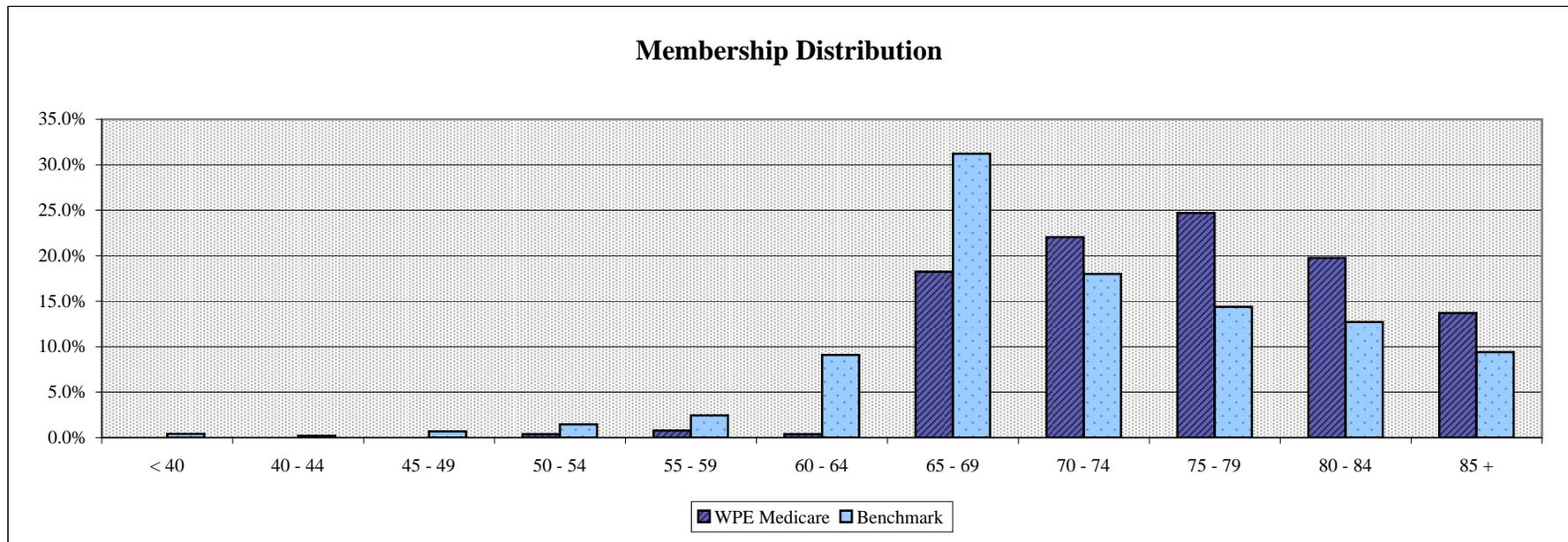
**WISCONSIN PUBLIC EMPLOYERS
Member Census Grid - Medicare
December 2009**

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%	0.3%
50 - 54	1	0.4%	0.9%
55 - 59	2	0.8%	1.7%
60 - 64	1	0.4%	4.9%
65 - 69	28	10.6%	16.0%
70 - 74	33	12.5%	9.7%
75 - 79	37	14.1%	7.5%
80 - 84	28	10.6%	7.2%
85 +	22	8.4%	6.3%
Total	152	57.8%	54.7%

MALE			
Age Band	# of Members	% of Total	Benchmark
< 40	0	0.0%	0.3%
40 - 44	0	0.0%	0.1%
45 - 49	0	0.0%	0.4%
50 - 54	0	0.0%	0.6%
55 - 59	0	0.0%	0.8%
60 - 64	0	0.0%	4.2%
65 - 69	20	7.6%	15.2%
70 - 74	25	9.5%	8.3%
75 - 79	28	10.6%	6.8%
80 - 84	24	9.1%	5.5%
85 +	14	5.3%	3.1%
Total	111	42.2%	45.3%

TOTAL			
Age Band	# of Members	% of Total	Benchmark
< 40	0	0.0%	0.4%
40 - 44	0	0.0%	0.2%
45 - 49	0	0.0%	0.7%
50 - 54	1	0.4%	1.5%
55 - 59	2	0.8%	2.4%
60 - 64	1	0.4%	9.1%
65 - 69	48	18.3%	31.2%
70 - 74	58	22.1%	18.0%
75 - 79	65	24.7%	14.4%
80 - 84	52	19.8%	12.7%
85 +	36	13.7%	9.4%
Total	263	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, 2009. Each of the dots represents one address. Exhibit 4-D shows the same information numerically.

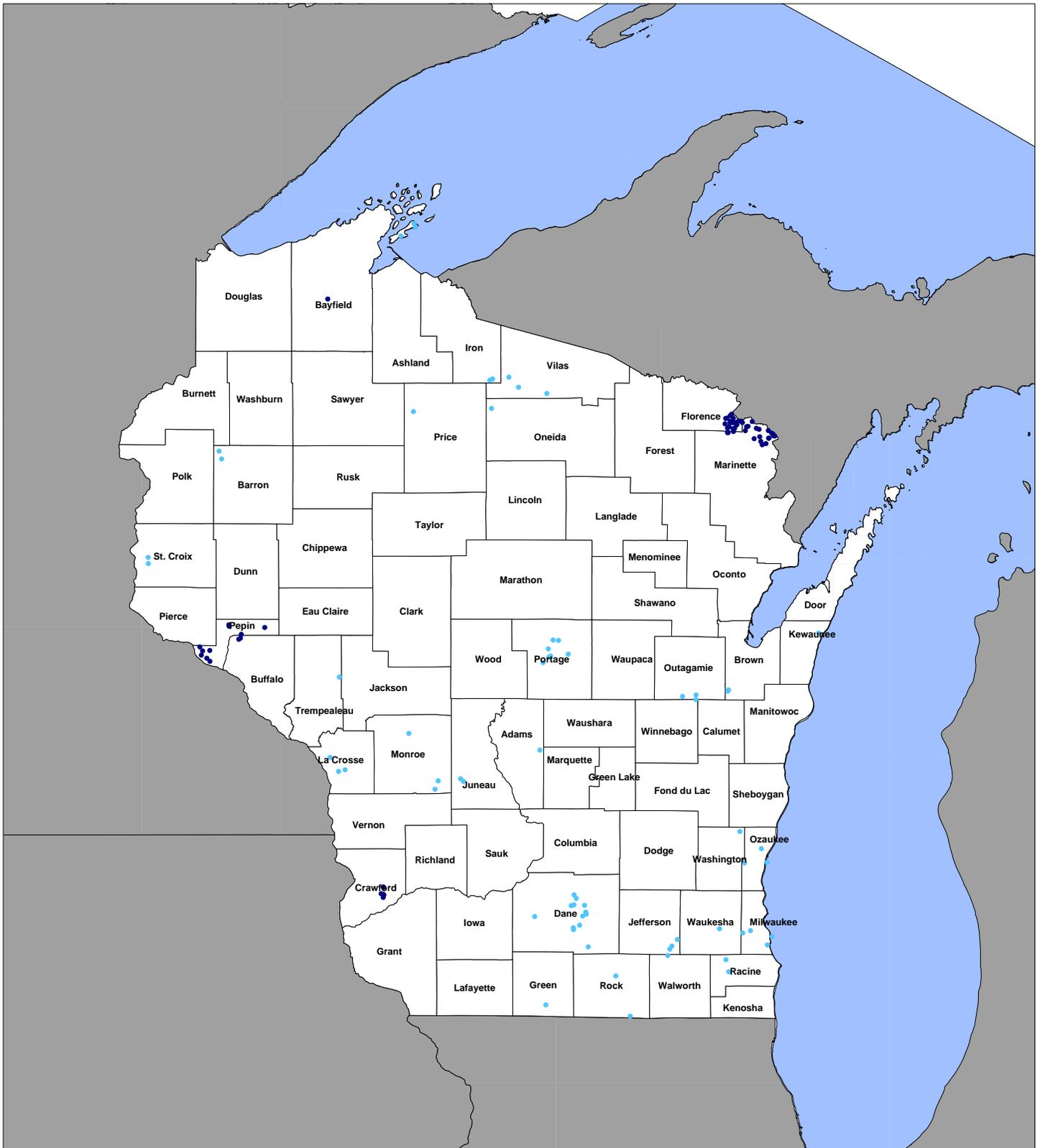
76.4% of the **Standard Plan** participants lived within Wisconsin. The Standard Plan population was spread out among 22 counties in Wisconsin with 14.6% of the population living in Dane County and 7.9% in Portage County.

The **SMP Plan** membership, in comparison, lived in 4 counties including Bayfield, Crawford, Marinette and Pepin.

WISCONSIN PUBLIC EMPLOYERS

Exhibit 4-C

Enrollment By County December 2009



● Standard

● SMP

WISCONSIN PUBLIC EMPLOYERS
Enrollment By County
December 2009

Exhibit 4-D

County	STANDARD		SMP	
	# of Members	% of Members	# of Members	% of Members
ADAMS	1	1.1%	0	0.0%
ASHLAND	3	3.4%	0	0.0%
BARRON	2	2.2%	0	0.0%
BAYFIELD	0	0.0%	1	1.7%
BROWN	0	0.0%	0	0.0%
BUFFALO	0	0.0%	0	0.0%
BURNETT	0	0.0%	0	0.0%
CALUMET	0	0.0%	0	0.0%
CHIPPEWA	0	0.0%	0	0.0%
CLARK	0	0.0%	0	0.0%
COLUMBIA	0	0.0%	0	0.0%
CRAWFORD	0	0.0%	6	10.3%
DANE	13	14.6%	0	0.0%
DODGE	0	0.0%	0	0.0%
DOOR	0	0.0%	0	0.0%
DOUGLAS	0	0.0%	0	0.0%
DUNN	0	0.0%	0	0.0%
EAU CLAIRE	0	0.0%	0	0.0%
FLORENCE	0	0.0%	0	0.0%
FOND DU LAC	0	0.0%	0	0.0%
FOREST	0	0.0%	0	0.0%
GRANT	0	0.0%	0	0.0%
GREEN	1	1.1%	0	0.0%
GREEN LAKE	0	0.0%	0	0.0%
IOWA	0	0.0%	0	0.0%

County	STANDARD		SMP	
	# of Members	% of Members	# of Members	% of Members
IRON	0	0.0%	0	0.0%
JACKSON	0	0.0%	0	0.0%
JEFFERSON	4	4.5%	0	0.0%
JUNEAU	2	2.2%	0	0.0%
KENOSHA	0	0.0%	0	0.0%
KEWAUNEE	1	1.1%	0	0.0%
LACROSSE	3	3.4%	0	0.0%
LAFAYETTE	0	0.0%	0	0.0%
LANGLADE	0	0.0%	0	0.0%
LINCOLN	0	0.0%	0	0.0%
MANITOWOC	0	0.0%	0	0.0%
MARATHON	0	0.0%	0	0.0%
MARINETTE	0	0.0%	39	67.2%
MARQUETTE	0	0.0%	0	0.0%
MENOMINEE	0	0.0%	0	0.0%
MILWAUKEE	3	3.4%	0	0.0%
MONROE	3	3.4%	0	0.0%
OCONTO	0	0.0%	0	0.0%
ONEIDA	0	0.0%	0	0.0%
OUTAGAMIE	5	5.6%	0	0.0%
OZAUKEE	3	3.4%	0	0.0%
PEPIN	0	0.0%	12	20.7%
PIERCE	0	0.0%	0	0.0%
POLK	0	0.0%	0	0.0%
PORTAGE	7	7.9%	0	0.0%

County	STANDARD		SMP	
	# of Members	% of Members	# of Members	% of Members
PRICE	3	3.4%	0	0.0%
RACINE	2	2.2%	0	0.0%
RICHLAND	0	0.0%	0	0.0%
ROCK	2	2.2%	0	0.0%
RUSK	0	0.0%	0	0.0%
SAUK	0	0.0%	0	0.0%
SAWYER	0	0.0%	0	0.0%
SHAWANO	0	0.0%	0	0.0%
SHEBOYGAN	0	0.0%	0	0.0%
ST CROIX	2	2.2%	0	0.0%
TAYLOR	0	0.0%	0	0.0%
TREMPEALEAU	1	1.1%	0	0.0%
VERNON	0	0.0%	0	0.0%
VILAS	4	4.5%	0	0.0%
WALWORTH	0	0.0%	0	0.0%
WASHBURN	0	0.0%	0	0.0%
WASHINGTON	1	1.1%	0	0.0%
WAUKESHA	2	2.2%	0	0.0%
WAUPACA	0	0.0%	0	0.0%
WAUSHARA	0	0.0%	0	0.0%
WINNEBAGO	0	0.0%	0	0.0%
WOOD	0	0.0%	0	0.0%
OUT OF STATE	21	23.6%	0	0.0%
Totals	89	100.0%	58	100.0%

Wisconsin Public Employers

Group Demographics

Out of State Enrollment

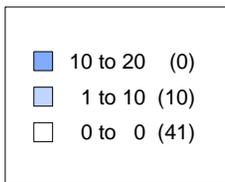
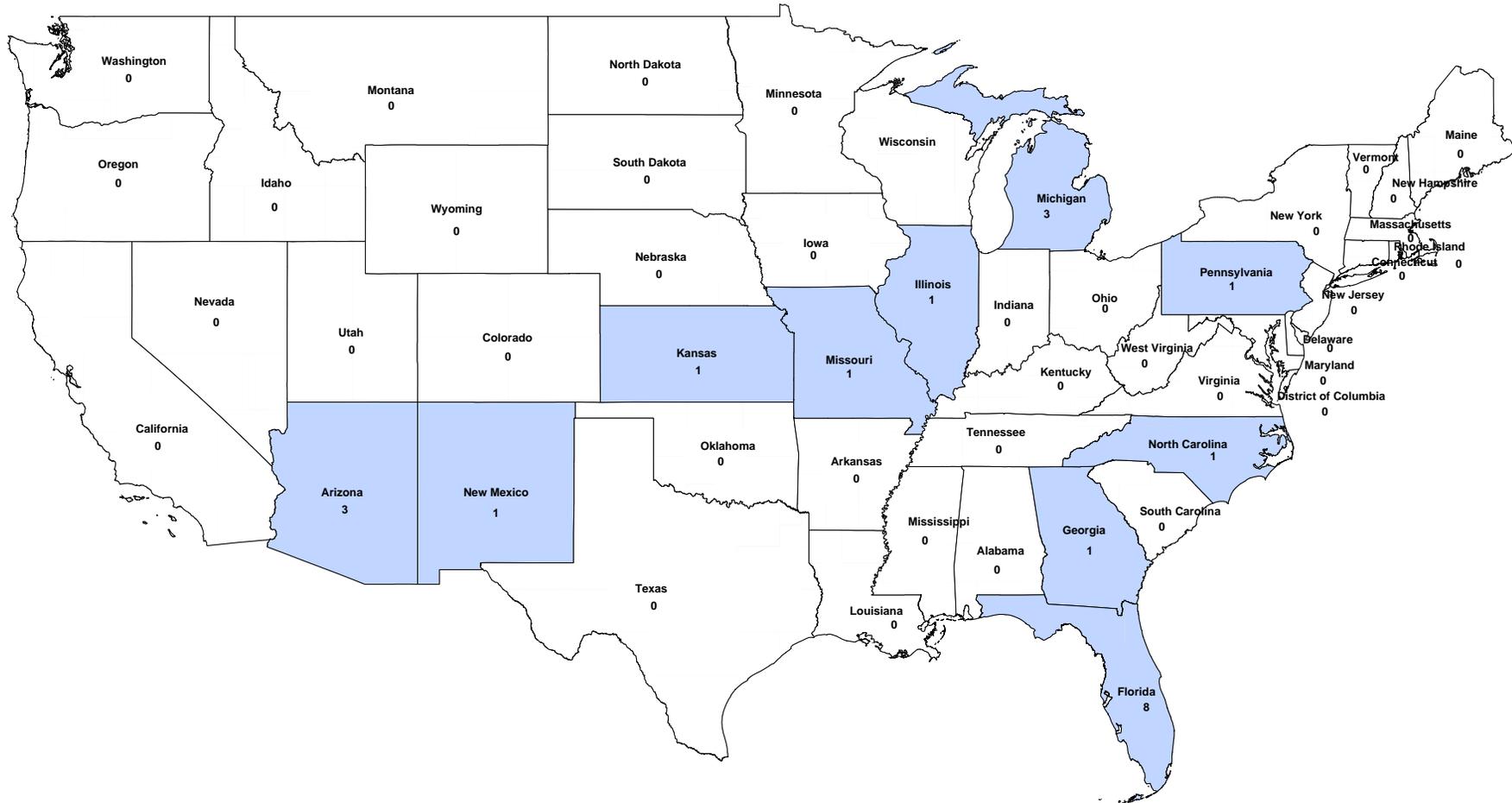
The United States Enrollment Map (Exhibit 5-C) visually depicts how the enrollment in the Standard and SMP plans are spread throughout the United States. The out of state enrollment is based on the member's address as of December 1, 2009 and could change as members relocate. The map displays the number 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 23.6% of the population living outside the state of Wisconsin with the membership dispersed over 10 states. 66.8% are in Southern states, 28.7% in the Midwest, and 4.8% live on the east coast.

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

**WISCONSIN PUBLIC EMPLOYERS
Out of State Enrollment
December 2009**

Exhibit 5-C



**WISCONSIN PUBLIC EMPLOYERS
Out of State Enrollment
December 2009**

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	1	4.8%	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	3	14.3%	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	3	14.3%	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	1	4.8%	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	8	38.1%	0	0.0%	NEBRASKA	0	0.0%	0	0.0%										
GEORGIA	1	4.8%	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	1	4.8%	0	0.0%	NEW MEXICO	1	4.8%	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	4.8%	0	0.0%										
KANSAS	1	4.8%	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	21	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 2010 enrollment reflecting changes that occurred during the Dual Choice Enrollment. The enrollment changes are numerical differences relative to December 2009. The change in Member / Age Gender show how much plan costs changed between 2009 and 2010 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 2009 to January 2010**

Exhibit 6-B

Plan	Class	January 2010 Membership	Change in Membership from December 2009	Change in Member Age/ Gender
Classic Standard	Milwaukee	13	1	-0.70%
	Waukesha	3	2	-18.59%
	Dane	9	-11	18.28%
	Rest of State	28	-6	2.10%
	Annuity	8	0	0.02%
	Continuation	0	0	0.00%
	Medicare	265	9	N/A
Subtotal		326	-5	3.91%
Deductible Classic Standard	Milwaukee	0	0	0.00%
	Waukesha	0	-2	-100.00%
	Dane	0	0	0.00%
	Rest of State	3	-2	18.64%
	Annuity	0	0	0.00%
	Continuation	0	0	0.00%
	Medicare	15	8	N/A
Subtotal		18	4	32.90%
Standard Preferred	Milwaukee	0	0	0.00%
	Waukesha	0	0	0.00%
	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	0	0.00%
Deductible Standard Preferred	Milwaukee	0	0	0.00%
	Waukesha	0	0	0.00%
	Dane	0	0	0.00%
	Rest of State	1	-2	42.30%
	Annuity	4	0	0.00%
	Continuation	0	0	0.00%
	Medicare	0	0	N/A
Subtotal		5	-2	1.80%
SMP	Local	38	-20	-24.09%
	Annuity	0	0	0.00%
	Continuation	0	0	0.00%
Subtotal		38	-20	-24.09%
Deductible SMP	Local	63	63	0.00%
	Annuity	0	0	0.00%
	Continuation	0	0	0.00%
Subtotal		63	63	0.00%
WPE Grand Total		450	40	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 2008 through December 2009. The PMPM costs for each plan represent medical and drug claims paid through the end of March 2010.

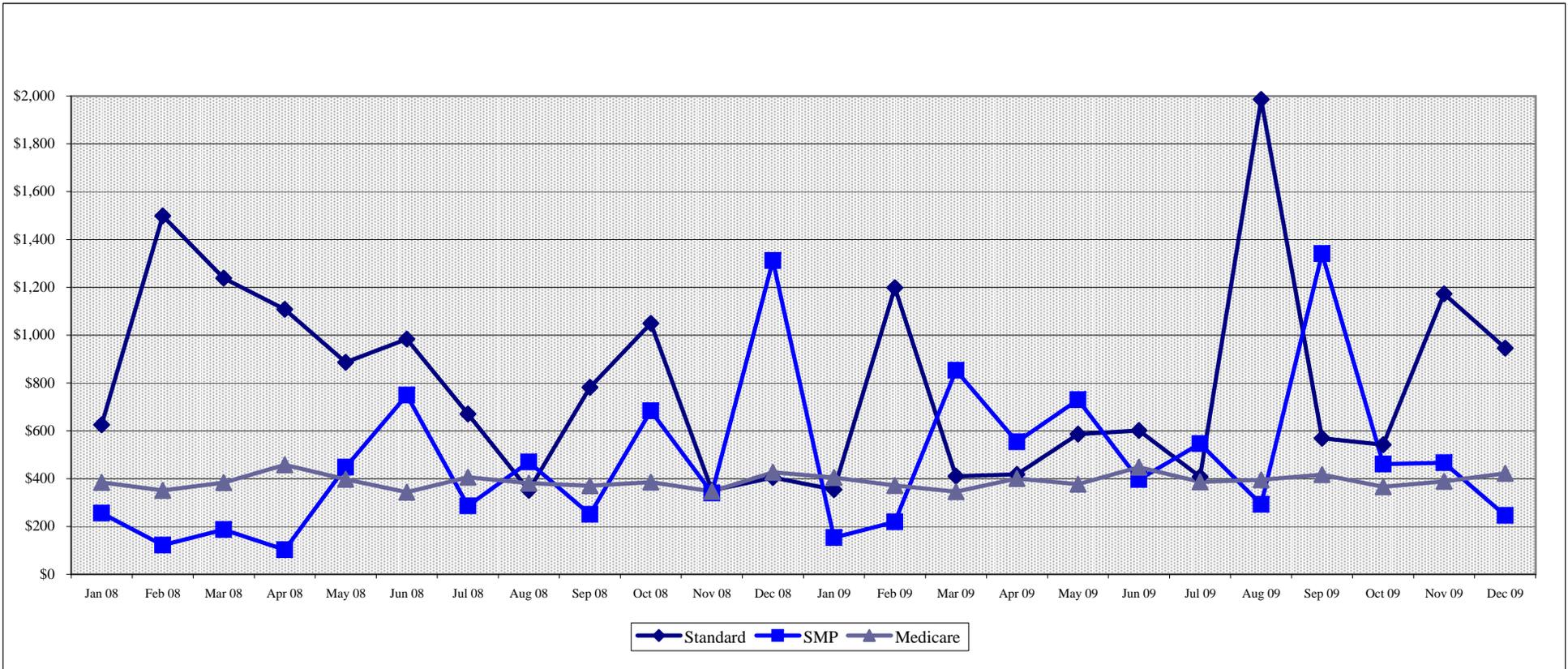
The **Standard Plan** has seen a 0.7% increase in total paid claim costs between 2008 and 2009. Independent trend estimates for medical claims for 2009 were 9.5% - 12.0%, thus the plan performed better than anticipated. By contrast the total paid claims in the prior year increased by 29.3%. Therefore, the seemingly small increase from 2008 to 2009 is a function of the higher than expected claim costs in 2008. The large monthly spikes in claim costs are generally due to large claim activity that occurred in those months.

The **SMP Plan** has seen a large increase in claims over the last year. The SMP Plan's annual shifts in membership does not allow for a meaningful trend analysis. However, for informational purposes, the SMP plan saw a 31.5% increase in claims costs between 2008 and 2009 which was well above trend estimates.

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 2008 to 2009 was 2.0%. We would naturally expect an increase in the medical claims each year due to the benefit changes Medicare makes annually and medical cost and utilization trend.

**WISCONSIN PUBLIC EMPLOYERS
Paid Medical and Drug PMPM
Paid Through March 2010**

Exhibit 7-B



	INCURRED MONTH																							
	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	Feb 09	Mar 09	Apr 09	May 09	Jun 09	Jul 09	Aug 09	Sep 09	Oct 09	Nov 09	Dec 09
Standard	\$624.95	\$1,498.59	\$1,238.46	\$1,108.53	\$886.11	\$984.24	\$671.15	\$351.26	\$781.58	\$1,049.61	\$350.89	\$404.44	\$354.49	\$1,198.54	\$410.90	\$417.85	\$586.26	\$601.55	\$407.97	\$1,985.69	\$568.80	\$542.54	\$1,173.01	\$946.32
SMP	\$256.33	\$121.66	\$186.94	\$102.52	\$448.11	\$748.96	\$285.81	\$469.31	\$250.20	\$683.25	\$339.73	\$1,312.41	\$153.45	\$218.80	\$853.56	\$553.53	\$730.14	\$395.91	\$546.89	\$292.60	\$1,341.68	\$461.32	\$466.83	\$246.35
Medicare	\$384.15	\$350.97	\$383.19	\$457.45	\$396.88	\$343.39	\$406.42	\$381.63	\$369.94	\$385.91	\$346.33	\$426.40	\$405.50	\$371.49	\$345.60	\$400.96	\$376.68	\$447.97	\$387.07	\$394.84	\$416.38	\$365.62	\$388.69	\$422.10

Wisconsin Public Employers

Plan Utilization

PMPM by Type of Service Reports

The Total PMPM by Type of Service reports (Exhibits 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 2009 – December 2009 and paid through the end of March 2010. Exhibits 8-G and 8-I show the same actual data, but compare 2008 to 2009.

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 outpatient and other services costs make up a slightly larger percent of the total costs while the drugs and facility inpatient costs make up slightly less.

The total PMPM cost is 15.8% above the benchmark in 2009, which is an improvement from 2008 which was 18.3% above the benchmark. The other services' PMPM cost is 48.0% above the benchmark and the outpatient facility PMPM cost is 27.9% above the benchmark. The physician PMPM cost is 12.9% above the benchmark. The inpatient facility PMPM cost is 7.8% above the benchmark. Lastly, the drug category is 1.8% over the norm. Every \$1.00 PMPM represented in the graph is equivalent to \$822 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 2008 to 2009. Total Claims stayed almost constant between 2008 and 2009 with a slight increase of 0.7%. The inpatient facility decreased 26.0%, however, drugs increased 30.9% and other services increased by 49.4%.

SMP Plan

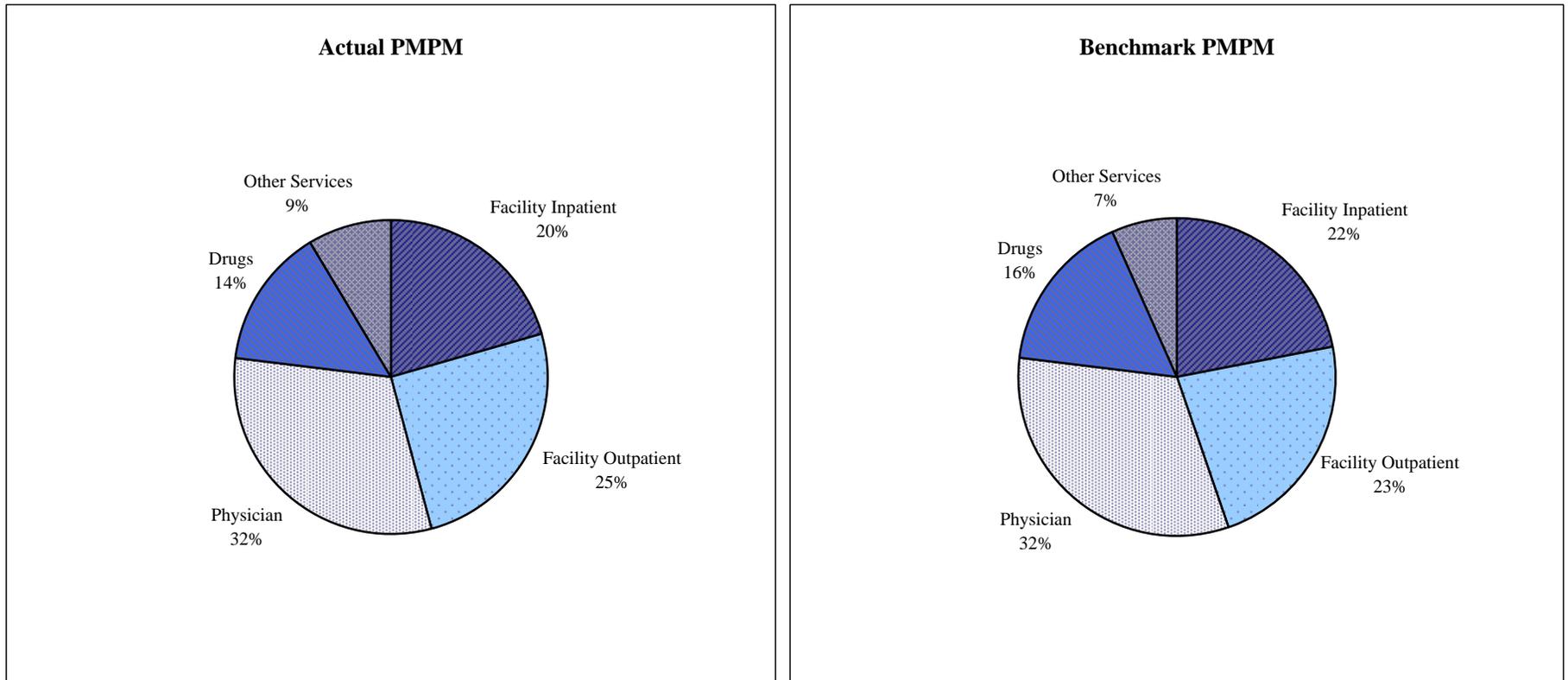
Exhibit 8-H shows the percentage breakdown by type of service for the SMP Plan is significantly different than the benchmark. Facility outpatient and drug claims comprise a much larger percentage while physician, facility inpatient and other services comprise a smaller percentage of the total plan costs than would be expected. This year the SMP plan in total is 25.5% above the benchmark. This difference is due to the higher than benchmark PMPM of both drugs and outpatient facility claims which were 123.2% and

79.6% above the benchmark respectively. The other 3 categories were well below the benchmark: facility inpatient (34.9%), physician (14.2%), and other services (9.0%).

Exhibit 8-I shows the SMP Plan's paid PMPM costs by type of service, comparing 2008 to 2009. Claim costs have increased 31.5% on average between the two years. Facility Inpatient claims was the only category to decrease from 2008 to 2009 with a decrease of 57.7%. The other four categories increased as follows: Other services, 129.9%; drugs, 102.6%; facility outpatient, 98.8%; and physician 18.8%.

WISCONSIN PUBLIC EMPLOYERS
Total PMPM by Type of Service - Standard
Incurred January 2009 - December 2009 Paid Through March 2010

Exhibit 8-F



	Actual	Benchmark	Difference	
			\$	%
Facility Inpatient	\$160.09	\$148.46	\$11.63	7.8%
Facility Outpatient	\$196.99	\$153.96	\$43.03	27.9%
Physician	\$244.90	\$216.99	\$27.91	12.9%
Drugs	\$112.28	\$110.27	\$2.01	1.8%
Other Services	\$67.04	\$45.30	\$21.74	48.0%
Totals	\$781.30	\$674.98	\$106.32	15.8%

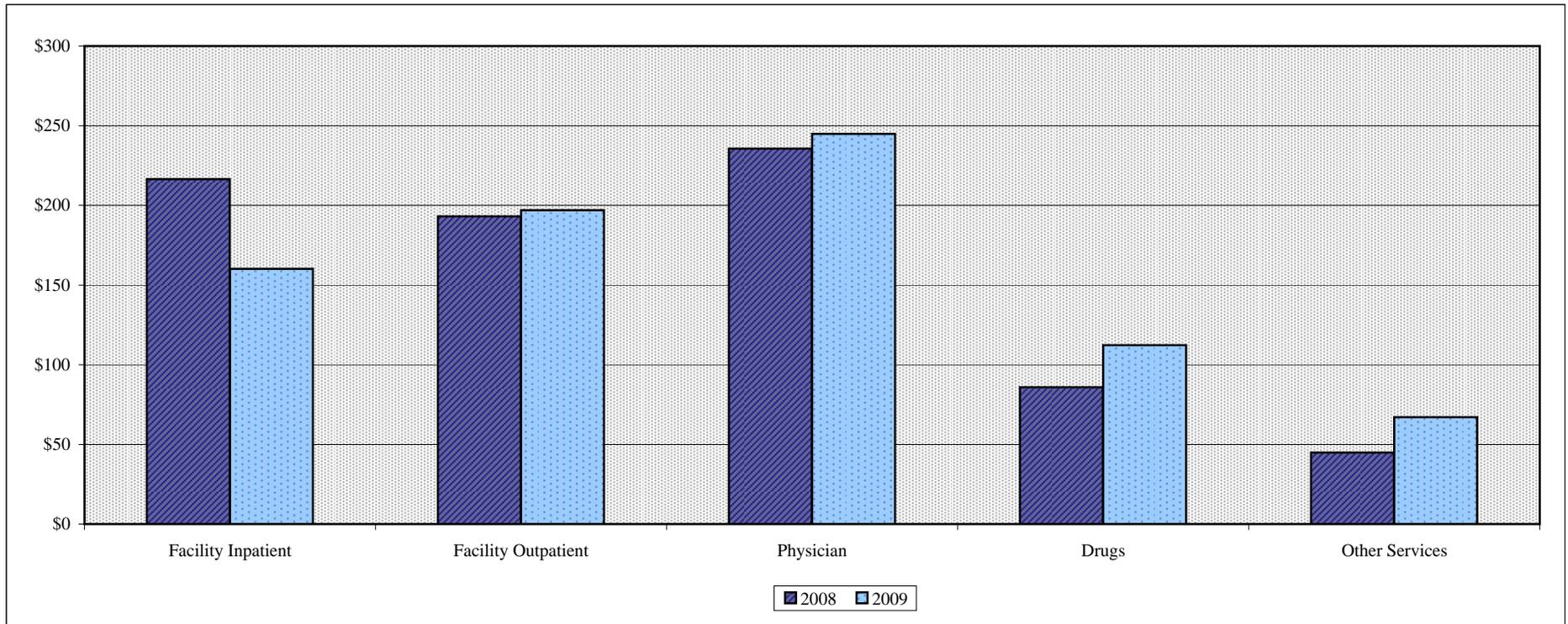
Note: Drug includes prescription and injectables

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

* Each \$1.00 paid PMPM = \$822 in plan costs.

**WISCONSIN PUBLIC EMPLOYERS
Total PMPM by Type of Service - Standard
Comparison of 2009 to 2008**

Exhibit 8-G



	2008 *	2009 **	Difference	
			\$	%
Facility Inpatient	\$216.44	\$160.09	-\$56.35	-26.0%
Facility Outpatient	\$193.04	\$196.99	\$3.95	2.0%
Physician	\$235.62	\$244.90	\$9.28	3.9%
Drugs	\$85.80	\$112.28	\$26.48	30.9%
Other Services	\$44.88	\$67.04	\$22.16	49.4%
Totals	\$775.78	\$781.30	\$5.52	0.7%

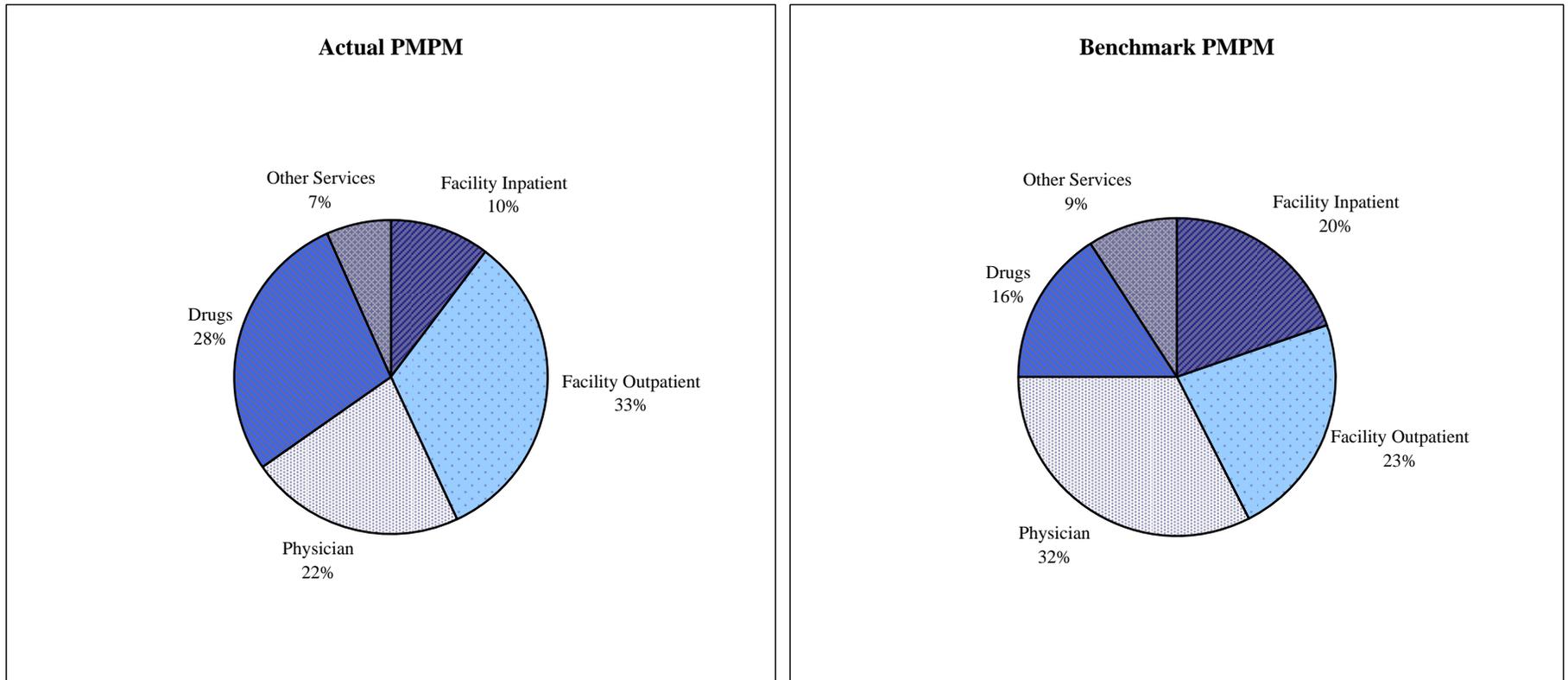
Note: Drug includes prescription and injectables

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

** Each \$1.00 paid PMPM = \$822 in plan costs.

WISCONSIN PUBLIC EMPLOYERS
Total PMPM by Type of Service - SMP
 Incurred January 2009 - December 2009 Paid Through March 2010

Exhibit 8-H



	Actual	Benchmark	Difference	
			\$	%
Facility Inpatient	\$53.10	\$81.54	-\$28.44	-34.9%
Facility Outpatient	\$171.26	\$95.35	\$75.91	79.6%
Physician	\$115.91	\$135.04	-\$19.13	-14.2%
Drugs	\$147.28	\$66.00	\$81.28	123.2%
Other Services	\$34.55	\$37.95	-\$3.40	-9.0%
Totals	\$522.10	\$415.88	\$106.22	25.5%

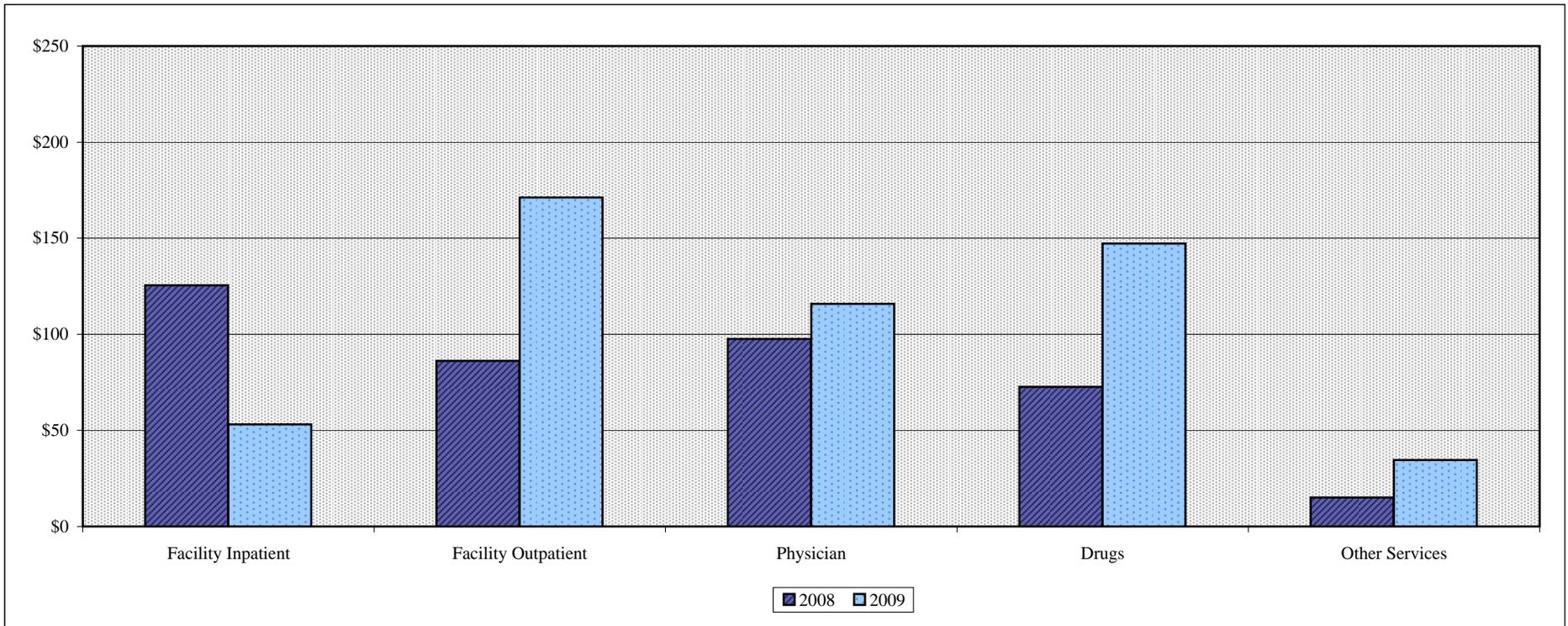
Note: Drug includes prescription and injectables

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

* Each \$1.00 paid PMPM = \$690 in plan costs.

WISCONSIN PUBLIC EMPLOYERS
Total PMPM by Type of Service - SMP
Comparison of 2009 to 2008

Exhibit 8-I



	2008 *	2009 **	Difference	
			\$	%
Facility Inpatient	\$125.51	\$53.10	-\$72.41	-57.7%
Facility Outpatient	\$86.13	\$171.26	\$85.13	98.8%
Physician	\$97.54	\$115.91	\$18.37	18.8%
Drugs	\$72.69	\$147.28	\$74.59	102.6%
Other Services	\$15.03	\$34.55	\$19.52	129.9%
Totals	\$396.90	\$522.10	\$125.20	31.5%

Note: Drug includes prescription and injectables

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

** Each \$1.00 paid PMPM = \$690 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 2009 – December 2009 and paid through the end of March 2010.

Standard Plan

The Standard Plan (Exhibit 9-C) was 15.8% above the benchmark in 2009. 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 \$822 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.

- Other Services – This category is considerably above the norm. Major contributors to the variance are the ambulance sub-category which is \$9.45 above and the psych/AODA sub-category which is \$6.07 above the norm.
- Outpatient Facility – The surgical/medical sub-category is 81.3% above the norm. This overage is mainly driven by the health condition of the high cost claimant. Furthermore, the psych/AODA sub-category was \$6.97 above the benchmark.
- Physician – Surgery, other, and pathology sub-categories are running well above the norm.
- Inpatient Facility – The only sub-category of inpatient facility with claim costs in 2009 was surgical/medical. This sub-category was 12.7% above the norm.
- Drug –Overall, the drug costs are in line with the benchmark. The prescription drug costs are 22.9% above the benchmark while the injectable drugs are well below the benchmark.

SMP Plan

The SMP Plan in Exhibit 9-D by comparison is 25.5% 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 \$690 in annual plan costs.

- Drug - Overall the drug costs are 123.2% above the benchmark. The injectable sub-category is 219.0% above the norm and the prescription sub-category is 103.1% above the norm.
- Outpatient Facility – This is the second highest category above the benchmark (79.6% above overall). The two highest sub-categories are pathology (194.8% above) and radiology (182.3% above).
- Other Services – Chiropractic care is still well above the norm. This year, the chiropractic care sub-category was \$6.33 PMPM above the benchmark. With the exception of therapies, the other five sub-categories are below the benchmark PMPM costs.
- Physician – Five out of the seven sub-categories were below the norm. Overall, this category is 14.2% below the benchmark.
- Inpatient Facility – The SMP Plan members did not have any Psych/AODA, maternity or other sub-category services in 2009. The surgical/medical sub-category was also 29.0% below the norm. This resulted in SMP Plan inpatient services being 34.9% below the benchmark in total.

WISCONSIN PUBLIC EMPLOYERS

Type of Service Detail - Standard

Incurred January 2009 - December 2009 Paid Through March 2010

Exhibit 9-C

TYPE OF SERVICE	DETAIL	ACTUAL PMPM	BENCHMARK PMPM	DIFFERENCE \$	DIFFERENCE %
FACILITY INPATIENT	SURGICAL/MEDICAL	\$160.09	\$142.04	\$18.05	12.7%
	PSYCH/AODA	\$0.00	\$1.65	-\$1.65	-100.0%
	MATERNITY	\$0.00	\$2.16	-\$2.16	-100.0%
	OTHER	\$0.00	\$2.61	-\$2.61	-100.0%
Subtotal		\$160.09	\$148.46	\$11.63	7.8%
FACILITY OUTPATIENT	SURGICAL/MEDICAL	\$50.30	\$27.74	\$22.56	81.3%
	RADIOLOGY	\$33.88	\$42.57	-\$8.69	-20.4%
	PATHOLOGY	\$22.80	\$17.27	\$5.53	32.0%
	EMERGENCY ROOM	\$7.03	\$5.12	\$1.91	37.3%
	PSYCH/AODA	\$8.12	\$1.15	\$6.97	606.1%
	OTHER	\$74.86	\$60.11	\$14.75	24.5%
Subtotal		\$196.99	\$153.96	\$43.03	27.9%
PHYSICIAN	OFFICE VISIT	\$22.80	\$26.39	-\$3.59	-13.6%
	RADIOLOGY	\$44.04	\$40.68	\$3.36	8.3%
	PATHOLOGY	\$32.58	\$28.19	\$4.39	15.6%
	SURGERY	\$87.33	\$69.99	\$17.34	24.8%
	ANESTHESIA	\$16.30	\$15.01	\$1.29	8.6%
	MATERNITY	\$0.00	\$1.10	-\$1.10	-100.0%
	OTHER	\$41.85	\$35.63	\$6.22	17.5%
Subtotal		\$244.90	\$216.99	\$27.91	12.9%
DRUGS	PRESCRIPTIONS	\$112.10	\$91.23	\$20.87	22.9%
	INJECTABLES	\$0.18	\$19.04	-\$18.86	-99.1%
Subtotal		\$112.28	\$110.27	\$2.01	1.8%
OTHER SERVICES	PSYCH/AODA	\$11.29	\$5.22	\$6.07	116.3%
	CHIROPRACTIC	\$3.03	\$4.53	-\$1.50	-33.1%
	THERAPIES	\$6.70	\$5.25	\$1.45	27.6%
	AMBULANCE	\$11.84	\$2.39	\$9.45	395.4%
	WELL BABY EXAM	\$0.00	\$0.00	\$0.00	0.0%
	DURABLE MEDICAL EQUIPMENT	\$7.04	\$6.61	\$0.43	6.5%
	OTHER	\$27.14	\$21.30	\$5.84	27.4%
Subtotal		\$67.04	\$45.30	\$21.74	48.0%
Grand Total		\$781.30	\$674.98	\$106.32	15.8%

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

* Each \$1.00 paid PMPM = \$822 in plan costs.

WISCONSIN PUBLIC EMPLOYERS

Exhibit 9-D

Type of Service Detail - SMP

Incurred January 2009 - December 2009 Paid Through March 2010

TYPE OF SERVICE	DETAIL	ACTUAL PMPM	BENCHMARK PMPM	DIFFERENCE \$	%
FACILITY INPATIENT	SURGICAL/MEDICAL	\$53.10	\$74.77	-\$21.67	-29.0%
	PSYCH/AODA	\$0.00	\$1.75	-\$1.75	-100.0%
	MATERNITY	\$0.00	\$3.67	-\$3.67	-100.0%
	OTHER	\$0.00	\$1.35	-\$1.35	-100.0%
Subtotal		\$53.10	\$81.54	-\$28.44	-34.9%
FACILITY OUTPATIENT	SURGICAL/MEDICAL	\$11.33	\$17.36	-\$6.03	-34.7%
	RADIOLOGY	\$71.14	\$25.20	\$45.94	182.3%
	PATHOLOGY	\$30.16	\$10.23	\$19.93	194.8%
	EMERGENCY ROOM	\$7.03	\$4.20	\$2.83	67.4%
	PSYCH/AODA	\$0.15	\$1.36	-\$1.21	-89.0%
	OTHER	\$51.45	\$37.00	\$14.45	39.1%
Subtotal		\$171.26	\$95.35	\$75.91	79.6%
PHYSICIAN	OFFICE VISIT	\$22.71	\$18.15	\$4.56	25.1%
	RADIOLOGY	\$14.48	\$24.36	-\$9.88	-40.6%
	PATHOLOGY	\$11.72	\$17.78	-\$6.06	-34.1%
	SURGERY	\$33.60	\$41.84	-\$8.24	-19.7%
	ANESTHESIA	\$11.91	\$9.11	\$2.80	30.7%
	MATERNITY	\$0.00	\$1.88	-\$1.88	-100.0%
	OTHER	\$21.49	\$21.92	-\$0.43	-2.0%
Subtotal		\$115.91	\$135.04	-\$19.13	-14.2%
DRUGS	PRESCRIPTIONS	\$110.91	\$54.60	\$56.31	103.1%
	INJECTABLES	\$36.37	\$11.40	\$24.97	219.0%
Subtotal		\$147.28	\$66.00	\$81.28	123.2%
OTHER SERVICES	PSYCH/AODA	\$1.70	\$6.18	-\$4.48	-72.5%
	CHIROPRACTIC	\$9.87	\$3.54	\$6.33	178.8%
	THERAPIES	\$4.27	\$3.75	\$0.52	13.9%
	AMBULANCE	\$0.00	\$1.56	-\$1.56	-100.0%
	WELL BABY EXAM	\$0.55	\$0.60	-\$0.05	-8.3%
	DURABLE MEDICAL EQUIPMENT	\$1.86	\$4.18	-\$2.32	-55.5%
	OTHER	\$16.30	\$18.14	-\$1.84	-10.1%
Subtotal		\$34.55	\$37.95	-\$3.40	-9.0%
Grand Total		\$522.10	\$415.88	\$106.22	25.5%

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

* Each \$1.00 paid PMPM = \$690 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/1000 is the annual average number of hospital days utilized by a population of 1,000 members which is calculated by taking $(\text{Total Days}/\text{Member Months}) \times 12000$. The Admits/1000 is the annual number of admits that occur within a typical population of 1,000 members which is calculated by taking $(\text{Total Admits}/\text{Member Months}) \times 12000$. The Days/1000 and Admits/1000 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 most inpatient statistics. 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, 83.1% were in the surgical sub-category compared to the benchmark of 49.3%.

SMP

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

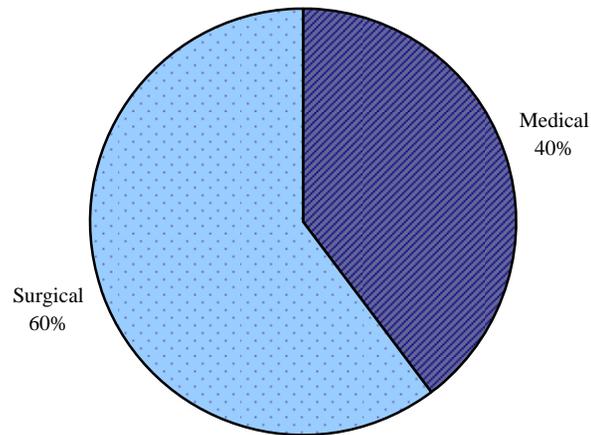
**WISCONSIN PUBLIC EMPLOYERS
Inpatient Utilization - Standard
Incurred January 2009 - December 2009 Paid Through March 2010**

Exhibit 10-B

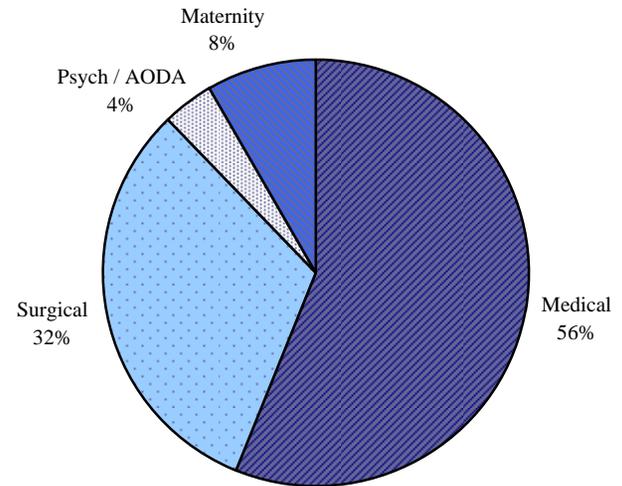
ACTUAL						
	Medical	Surgical	Psych / AODA	Maternity	Other	Total
Days/1000	73	58	0	0	0	131
Admits/1000	29	44	0	0	N/A	73
ALOS	2.50	1.33	0.00	0.00	N/A	1.80
Cost/Day	\$4,447	\$27,339	\$0	\$0	\$0	\$14,621
Cost/Admit	\$11,118	\$36,452	\$0	\$0	N/A	\$26,318
PMPM	\$27.05	\$133.03	\$0.00	\$0.00	\$0.00	\$160.08
% of Paid	16.90%	83.10%	0.00%	0.00%	0.00%	100.00%

BENCHMARK						
	Medical	Surgical	Psych / AODA	Maternity	Other	Total
Days/1000	233	111	16	13	45	418
Admits/1000	41	23	3	6	N/A	73
ALOS	5.68	4.83	5.33	2.17	N/A	5.73
Cost/Day	\$3,657	\$8,016	\$1,262	\$1,886	\$691	\$4,259
Cost/Admit	\$21,265	\$40,012	\$6,687	\$3,581	N/A	\$27,398
PMPM	\$68.88	\$73.16	\$1.65	\$2.16	\$2.61	\$148.46
% of Paid	46.40%	49.28%	1.11%	1.45%	1.76%	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 2008 to 2009, 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 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 \$822 in annual plan costs for 2009.

The **SMP Plan**, shown in Exhibit 11-D is above 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 \$690 in annual plan costs for 2009 and benchmark data.

WISCONSIN PUBLIC EMPLOYERS
Claim Costs by Major Diagnostic Categories - Standard
Comparison of 2009 to 2008

Exhibit 11-C

MDC CODE	MAJOR DIAGNOSTIC CATEGORY DESCRIPTION	2008	2009	BENCHMARK PMPM **	DIFFERENCE	
		ACTUAL PMPM *	ACTUAL PMPM **		2009 to 2008	2009 to BENCHMARK
1	Nervous System Diseases and Disorders (D/D)	\$7.19	\$43.78	\$35.03	508.9%	25.0%
2	Eye D/D	\$3.24	\$2.99	\$17.42	-7.7%	-82.8%
3	Ear, Nose, Mouth and Throat D/D	\$17.30	\$27.64	\$20.25	59.8%	36.5%
4	Respiratory System D/D	\$2.09	\$14.21	\$25.81	579.9%	-44.9%
5	Circulatory System D/D	\$58.12	\$125.51	\$71.71	115.9%	75.0%
6	Digestive System D/D	\$71.48	\$44.02	\$50.54	-38.4%	-12.9%
7	Liver, Gallbladder, Biliary Ducts and Pancreas D/D	\$29.10	\$0.69	\$11.64	-97.6%	-94.1%
8	Muscles, Bones, and Connective Tissue D/D	\$309.97	\$138.51	\$117.02	-55.3%	18.4%
9	Skin, Subcutaneous Tissue (fat and connective) and Breast D/D	\$21.52	\$20.02	\$28.80	-7.0%	-30.5%
10	Endocrine, Nutritional and Metabolic D/D (included diagnoses related to obesity, diabetes and hormones)	\$43.00	\$71.40	\$18.80	66.0%	279.7%
11	Kidney and Urinary Tract D/D	\$4.87	\$6.66	\$19.89	36.8%	-66.5%
12	Male Reproductive System D/D	\$7.44	\$59.39	\$11.69	698.3%	408.0%
13	Female Reproductive System D/D	\$21.53	\$21.10	\$18.03	-2.0%	17.1%
14	Pregnancy, Childbirth, and After Delivery Diagnoses	\$0.00	\$0.00	\$5.77	0.0%	-100.0%
15	Newborns, and Newborns with Conditions Originating Shortly Before or After Birth	\$0.00	\$0.00	\$1.40	0.0%	-100.0%
16	Blood and Blood Forming Organ D/D (including spleen) and Immune System Disorders	\$1.99	\$1.90	\$7.53	-4.5%	-74.8%
17	Bone Marrow D/D and Poorly Differentiated Cancers	\$0.16	\$1.31	\$27.44	718.8%	-95.2%
18	Infectious and Parasitic Diseases	\$4.52	\$0.77	\$7.01	-83.0%	-89.0%
19	Behavioral Health Diagnoses	\$15.51	\$11.42	\$8.95	-26.4%	27.6%
20	Alcohol/Drug Use and Alcohol/Drug Induced Organic Mental Disorders	\$0.00	\$3.28	\$0.53	0.0%	524.5%
21	Injuries, Poisoning and Toxic Effects of Drugs	\$3.11	\$6.66	\$4.85	114.1%	37.2%
22	Burns	\$0.00	\$0.00	\$0.66	0.0%	-100.0%
23	Other Miscellaneous Services Including Health Screenings, Medical Exams and Rehabilitation	\$68.10	\$62.35	\$60.22	-8.4%	3.5%
24	Multiple Significant Trauma	\$0.00	\$0.00	\$0.81	0.0%	-100.0%
25	Human Immunodeficiency Virus Infections	\$0.00	\$0.00	\$0.04	0.0%	-100.0%
0	Ungroupable	\$0.28	\$5.61	\$11.91	1903.6%	-52.9%
Total		\$690.52	\$669.22	\$583.75	-3.1%	14.6%

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.

** Each \$1.00 paid PMPM = \$822 in plan costs.

WISCONSIN PUBLIC EMPLOYERS
Claim Costs by Major Diagnostic Categories - SMP
Comparison of 2009 to 2008

Exhibit 11-D

MDC CODE	MAJOR DIAGNOSTIC CATEGORY DESCRIPTION	2008	2009	BENCHMARK PMPM **	DIFFERENCE	
		ACTUAL PMPM *	ACTUAL PMPM **		2009 to 2008	2009 to BENCHMARK
1	Nervous System Diseases and Disorders (D/D)	\$4.56	\$5.52	\$20.81	21.1%	-73.5%
2	Eye D/D	\$0.00	\$0.63	\$8.02	0.0%	-92.1%
3	Ear, Nose, Mouth and Throat D/D	\$3.12	\$20.55	\$18.70	558.7%	9.9%
4	Respiratory System D/D	\$12.11	\$23.95	\$14.84	97.8%	61.4%
5	Circulatory System D/D	\$32.38	\$54.07	\$35.52	67.0%	52.2%
6	Digestive System D/D	\$30.85	\$20.32	\$33.56	-34.1%	-39.5%
7	Liver, Gallbladder, Biliary Ducts and Pancreas D/D	\$0.00	\$0.00	\$6.51	0.0%	-100.0%
8	Muscles, Bones, and Connective Tissue D/D	\$99.71	\$118.53	\$66.68	18.9%	77.8%
9	Skin, Subcutaneous Tissue (fat and connective) and Breast D/D	\$9.67	\$51.03	\$18.14	427.7%	181.3%
10	Endocrine, Nutritional and Metabolic D/D (included diagnoses related to obesity, diabetes and hormones)	\$9.56	\$58.60	\$10.56	513.0%	454.8%
11	Kidney and Urinary Tract D/D	\$9.64	\$7.71	\$11.33	-20.0%	-31.9%
12	Male Reproductive System D/D	\$0.00	\$0.00	\$3.94	0.0%	-100.0%
13	Female Reproductive System D/D	\$15.53	\$1.17	\$14.38	-92.5%	-91.9%
14	Pregnancy, Childbirth, and After Delivery Diagnoses	\$0.00	\$0.00	\$7.89	0.0%	-100.0%
15	Newborns, and Newborns with Conditions Originating Shortly Before or After Birth	\$0.00	\$0.00	\$3.86	0.0%	-100.0%
16	Blood and Blood Forming Organ D/D (including spleen) and Immune System Disorders	\$6.57	\$4.02	\$4.34	-38.8%	-7.3%
17	Bone Marrow D/D and Poorly Differentiated Cancers	\$0.15	\$2.63	\$13.19	1653.3%	-80.1%
18	Infectious and Parasitic Diseases	\$49.89	\$0.64	\$4.26	-98.7%	-85.0%
19	Behavioral Health Diagnoses	\$24.78	\$2.41	\$9.05	-90.3%	-73.4%
20	Alcohol/Drug Use and Alcohol/Drug Induced Organic Mental Disorders	\$0.00	\$0.00	\$0.64	0.0%	-100.0%
21	Injuries, Poisoning and Toxic Effects of Drugs	\$3.59	\$1.16	\$3.57	-67.7%	-67.5%
22	Burns	\$0.00	\$0.00	\$1.04	0.0%	-100.0%
23	Other Miscellaneous Services Including Health Screenings, Medical Exams and Rehabilitation	\$12.19	\$25.55	\$38.47	109.6%	-33.6%
24	Multiple Significant Trauma	\$0.00	\$0.00	\$0.91	0.0%	-100.0%
25	Human Immunodeficiency Virus Infections	\$0.00	\$0.00	\$0.03	0.0%	-100.0%
0	Ungroupable	\$0.00	\$12.68	\$11.06	0.0%	14.7%
Total		\$324.30	\$411.17	\$361.28	26.8%	13.8%

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.

** Each \$1.00 paid PMPM = \$690 in plan costs.

Wisconsin Public Employers

Provider Utilization

Top 20 Provider Reports

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 96.7% of the total facility charges for the plan. The University of Wisconsin Hospital in Madison received the largest percent of claim dollars. The second largest percent of claims came from North Memorial Health Center in Robbinsdale, MN as the result of one patient. You will note that most of the hospitals in the top 20 treated a small number of patients. 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 10 facilities provide 100% of the total facility charges for the plan. Over half of the claims came from Dickinson County Memorial Hospital in Iron Mountain, Michigan. This hospital also saw the most patients with 27 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 65.2% of professional charges from the top 20 providers. The top professional provider is the University of Wisconsin Medical Foundation in Madison. The second largest percent of claims came from Gundersen Clinic in La Crosse. Once again, the providers in the top 20 each treated a minimal number of patients.

The **SMP Plan** in Exhibit 12-H received 88.7% of the paid claims from the top 20 professional providers. Marquette General Hospital was the top provider in dollars paid, however the Radiology Associates in Iron Mountain, Michigan treated the largest number of patients.

WISCONSIN PUBLIC EMPLOYERS
Top 20 Facility Providers - Standard
Incurred January 2009 - December 2009 Paid Through March 2010

Exhibit 12-E

	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	9	\$31,937	\$23,722	\$55,659	19.0%
2	NORTH MEM HEALTH CTR	ROBBINSDALE	MN	1	\$50,863	\$0	\$50,863	17.3%
3	CUMBERLAND MEMORIAL HOSPITAL	CUMBERLAND	WI	3	\$0	\$30,897	\$30,897	10.5%
4	MERITER HOSPITAL INC	MADISON	WI	2	\$26,555	\$846	\$27,401	9.3%
5	ST MARYS MED CTR	DULUTH	MN	1	\$18,736	\$1,162	\$19,898	6.8%
6	LAKEVIEW MEMORIAL HOSPITAL	STILLWATER	MN	1	\$0	\$18,779	\$18,779	6.4%
7	SAINT MICHAELS HOSPITAL	STEVENS POINT	WI	4	\$0	\$12,606	\$12,606	4.3%
8	OAKLEAF SURGICAL HOSPITAL	EAU CLAIRE	WI	1	\$0	\$9,848	\$9,848	3.4%
9	AMERY REGIONAL MED CTR	AMERY	WI	1	\$0	\$9,744	\$9,744	3.3%
10	MEMORIAL MED CTR INC	ASHLAND	WI	1	\$0	\$7,349	\$7,349	2.5%
11	ORTHOPAEDIC HOSPITAL OF WISCON	GLENDALE	WI	1	\$0	\$7,126	\$7,126	2.4%
12	HEALTHSOUTH/GEISINGER	DANVILLE	PA	1	\$0	\$5,964	\$5,964	2.0%
13	FORT HEALTHCARE INC	FORT ATKINSON	WI	3	\$0	\$4,832	\$4,832	1.6%
14	GEISINGER MEDICAL CTR	DANVILLE	PA	1	\$0	\$4,104	\$4,104	1.4%
15	ST MARYS HOSP OZAUKEE	MEQUON	WI	2	\$0	\$3,998	\$3,998	1.4%
16	AURORA HEALTH CARE METRO	MILWAUKEE	WI	1	\$0	\$3,792	\$3,792	1.3%
17	ST VINCENT HOSP	SANTA FE	NM	1	\$3,500	\$170	\$3,670	1.3%
18	ROGERS MEMORIAL HOSPITAL	OCONOMOWOC	WI	1	\$0	\$2,700	\$2,700	0.9%
19	WISCONSIN SURGERY CTR	MILWAUKEE	WI	1	\$0	\$2,278	\$2,278	0.8%
20	SARASOTA MEM HOSP	SARASOTA	FL	3	\$0	\$2,256	\$2,256	0.8%
Top 20 Total				39	\$131,591	\$152,173	\$283,764	96.7%
All Other Facility Charges				16	\$0	\$9,753	\$9,753	3.3%
Total Facility Charges				55	\$131,591	\$161,926	\$293,517	100.0%

WISCONSIN PUBLIC EMPLOYERS
Top 20 Facility Providers - SMP
 Incurred January 2009 - December 2009 Paid Through March 2010

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	27	\$11,855	\$67,215	\$79,070	51.1%
2	MARQUETTE GENERAL HOSPITAL	MARQUETTE	MI	11	\$23,349	\$7,381	\$30,730	19.9%
3	CHIPPEWA VALLEY HOSPITAL	DURAND	WI	4	\$0	\$18,536	\$18,536	12.0%
4	LUTHER HOSPITAL	EAU CLAIRE	WI	2	\$0	\$18,526	\$18,526	12.0%
5	RIVER FALLS AREA HOSPITAL	RIVER FALLS	WI	4	\$1,437	\$4,600	\$6,037	3.9%
6	ST VINCENT HOSPITAL	GREEN BAY	WI	1	\$0	\$743	\$743	0.5%
7	AURORA BAYCARE MED CTR	GREEN BAY	WI	1	\$0	\$624	\$624	0.4%
8	PRAIRIE DU CHIEN MEMORIAL HOSP	PR DU CHIEN	WI	1	\$0	\$247	\$247	0.2%
9	NORTHSTAR HEALTH SYSTEM	IRON RIVER	MI	1	\$0	\$209	\$209	0.1%
10	BELLIN HLTH FAM MED CTR IRON M	IRON MOUNTAIN	MI	1	\$0	\$83	\$83	0.1%
Top 10 Total				53	\$36,641	\$118,164	\$154,805	100.0%
All Other Facility Charges				0	\$0	\$0	\$0	0.0%
Total Facility Charges				53	\$36,641	\$118,164	\$154,805	100.0%

WISCONSIN PUBLIC EMPLOYERS
Top 20 Professional Providers - Standard
Incurred January 2009 - December 2009 Paid Through March 2010

Exhibit 12-G

	Professional Provider	City	State	# of Unique Patients	Total Paid Claims	Paid %
1	UW MEDICAL FOUNDATION	MADISON	WI	10	\$36,328	14.2%
2	GUNDERSEN CLINIC LTD	LA CROSSE	WI	3	\$19,297	7.5%
3	ST CROIX ORTHOPAEDICS	AMERY	WI	1	\$17,120	6.7%
4	SAINTE MICHAELS HOSPITAL	STEVENS POINT	WI	6	\$14,947	5.8%
5	FOOT & ANKLE CLINIC LLP	CUMBERLAND	WI	2	\$11,617	4.5%
6	MARSHFIELD CLINIC-MINOCQUA CTR	MINOCQUA	WI	7	\$7,287	2.8%
7	ST MARYS MEDICAL CENTER INC	DULUTH	MN	2	\$6,630	2.6%
8	CDI	WAUWATOSA	WI	1	\$6,521	2.5%
9	ASPIRUS OP THERAPY SERVICES	WAUSAU	WI	1	\$5,371	2.1%
10	CUMBERLAND CLINIC SC	CUMBERLAND	WI	3	\$5,286	2.1%
11	NORTH MEMORIAL CARDIOVASCULAR	ROBBINSDALE	MN	1	\$4,367	1.7%
12	LAKESHORE MEDICAL CLINIC	MILWAUKEE	WI	3	\$4,218	1.6%
13	MEDICAL COLLEGE OF WISCONSIN	MILWAUKEE	WI	3	\$4,082	1.6%
14	AMERICARE RESPIRATORY SERVICES	LOS ALAMITOS	CA	1	\$3,618	1.4%
15	CITY OF ASHLAND FIRE DEPARTMEN	ASHLAND	WI	1	\$3,585	1.4%
16	DAVIS DUEHR DEAN	MADISON	WI	5	\$3,572	1.4%
17	OBSTETRICAL & GYNECOLOGICAL CA	EAU CLAIRE	WI	1	\$3,414	1.3%
18	LAKEFRONT WELLNESS CENTER SC	PEWAUKEE	WI	4	\$3,377	1.3%
19	WISCONSIN SLEEP	MADISON	WI	1	\$3,337	1.3%
20	TCP INTERNAL MEDICINE APPLETON	APPLETON	WI	1	\$3,318	1.3%
Top 20 Total				57	\$167,292	65.2%
All Other Professional Charges				191	\$89,273	34.8%
Total Professional Charges				248	\$256,565	100.0%

WISCONSIN PUBLIC EMPLOYERS
Top 20 Professional Providers - SMP
Incurred January 2009 - December 2009 Paid Through March 2010

Exhibit 12-H

	Professional Provider	City	State	# of Unique Patients	Total Paid Claims	Paid %
1	MARQUETTE GENERAL HOSPITAL	MARQUETTE	MI	11	\$49,618	38.5%
2	MIDELFORT CLINIC MHS	EAU CLAIRE	WI	4	\$10,862	8.4%
3	DICKINSON COUNTY MEMORIAL HOSP	IRON MOUNTAIN	MI	19	\$9,175	7.1%
4	RADIOLOGY ASSOC IRON MTN	IRON MOUNTAIN	MI	20	\$5,190	4.0%
5	RIVER FALLS MED CL ELLSWORTH	ELLSWORTH	WI	5	\$4,485	3.5%
6	CHIPPEWA VALLEY ORTHOPEDICS AN	DURAND	WI	2	\$3,747	2.9%
7	SURG ASC MARQUETTE PC	MARQUETTE	MI	2	\$3,520	2.7%
8	ANESTH MARQUETTE PC	MARQUETTE	MI	2	\$3,491	2.7%
9	BELLIN HLTH FAM MED CTR IRON M	IRON MOUNTAIN	MI	10	\$3,463	2.7%
10	BENISHEK CECCONI AND TERRIAN	IRON MOUNTAIN	MI	2	\$2,934	2.3%
11	LUTHER MIDELFORT OAKRIDGE MHS	OSSEO	WI	1	\$2,541	2.0%
12	BIANCOS PHYSICAL THERAPY	KINGSFORD	MI	2	\$2,285	1.8%
13	FRANCISCAN SKEMP MEDICAL CTR	PRAIRIE DU CHIEN	WI	3	\$2,105	1.6%
14	DURAND CHIROPRACTIC	DURAND	WI	4	\$2,081	1.6%
15	BEGRES CHIROPRACTIC	IRON MOUNTAIN	MI	7	\$1,739	1.3%
16	JOHN L LOEWEN MD SC	NIAGARA	WI	2	\$1,645	1.3%
17	CHIPPEWA VALLEY HOSPITAL	DURAND	WI	3	\$1,644	1.3%
18	PULMONARY & PRIMARY CARE ASSOC	IRON MOUNTAIN	MI	1	\$1,568	1.2%
19	ENDOCRINOLOGY ASSOC GREEN BAY	GREEN BAY	WI	1	\$1,174	0.9%
20	UROLOGY ASSOC OF IRON MOUNTAIN	IRON MOUNTAIN	MI	1	\$1,081	0.8%
Top 20 Total				102	\$114,348	88.7%
All Other Professional Charges				48	\$14,557	11.3%
Total Professional Charges				150	\$128,905	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 2009 – December 2009 and paid through March 2010 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 Case Management Description on the next page.

The **Standard Plan** has one member with claims over \$100,000 with a total of \$134,764 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 the **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 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 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 management, and outpatient preauthorization, are performed by this team.

WISCONSIN PUBLIC EMPLOYERS
High Cost Patients (over \$100,000)
Incurred January 2009 - December 2009 Paid Through March 2010

Exhibit 14-B

Patient Information		Plan	Care Management	Primary Condition	Total Paid
1	ACTIVE	STANDARD	UM, Declined CCM	OTH FORMS CHRONIC ISCHEMI	\$134,764
Total					\$134,764

Preauth = Outpatient Preauthorization UM = Utilization Management CM = Case Management CCM = Chronic Care Management BH = Behavioral Health Management

Note: Total paid includes medical and drug data

Wisconsin Public Employers

Member Cost Share

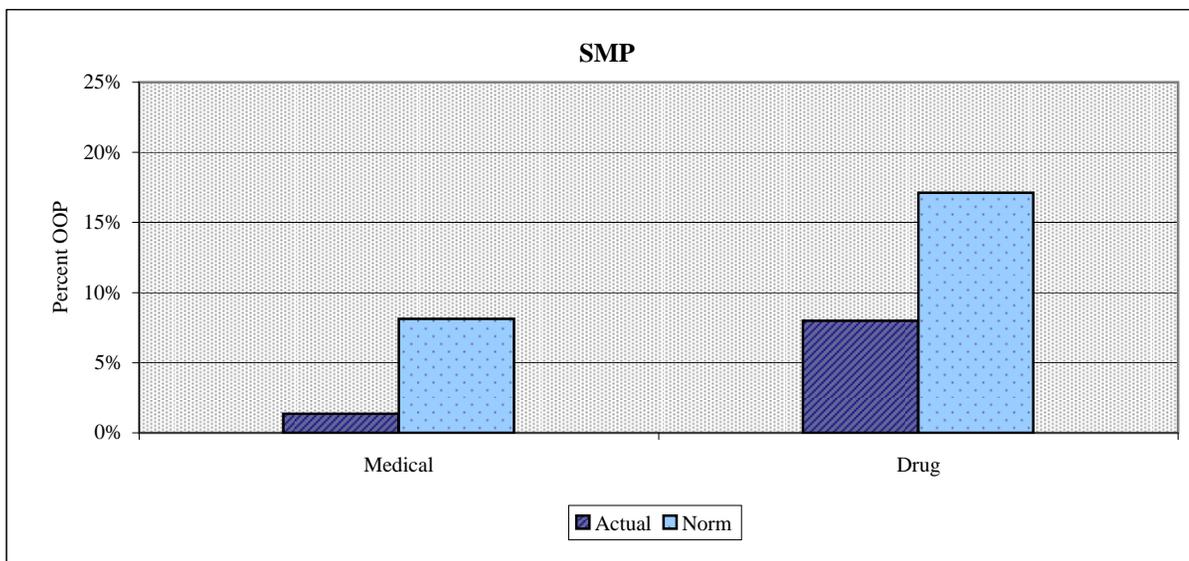
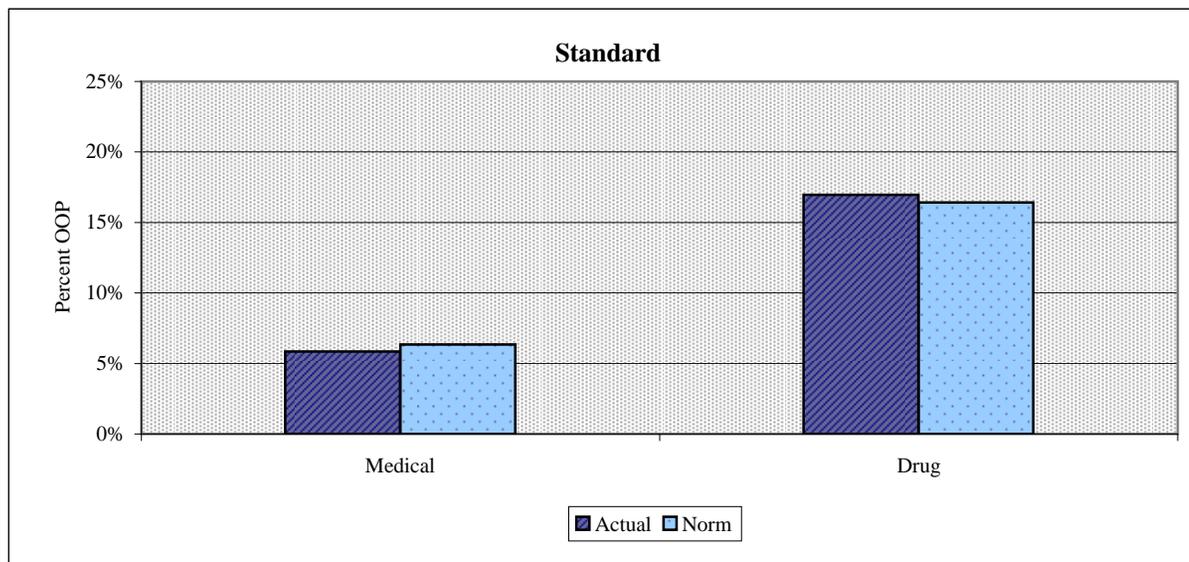
Medical and Drug Cost Sharing

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 5.8% of their own medical claims as compared to the benchmark of 6.4%. The prescription drug cost share is remarkably close to the benchmark (17.0% and 16.4% respectively).

The **SMP Plan** members by comparison pay a smaller amount towards their own medical claims (in the form of cost sharing). SMP Plan members pay an average of 1.4% compared to the benchmark of 8.1%. The SMP cost share for prescription drugs is also considerably below the benchmark of 17.1% at 8.0%. 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 2009 - December 2009 Paid Through March 2010**



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

Wisconsin Public Employers

Member Cost Share

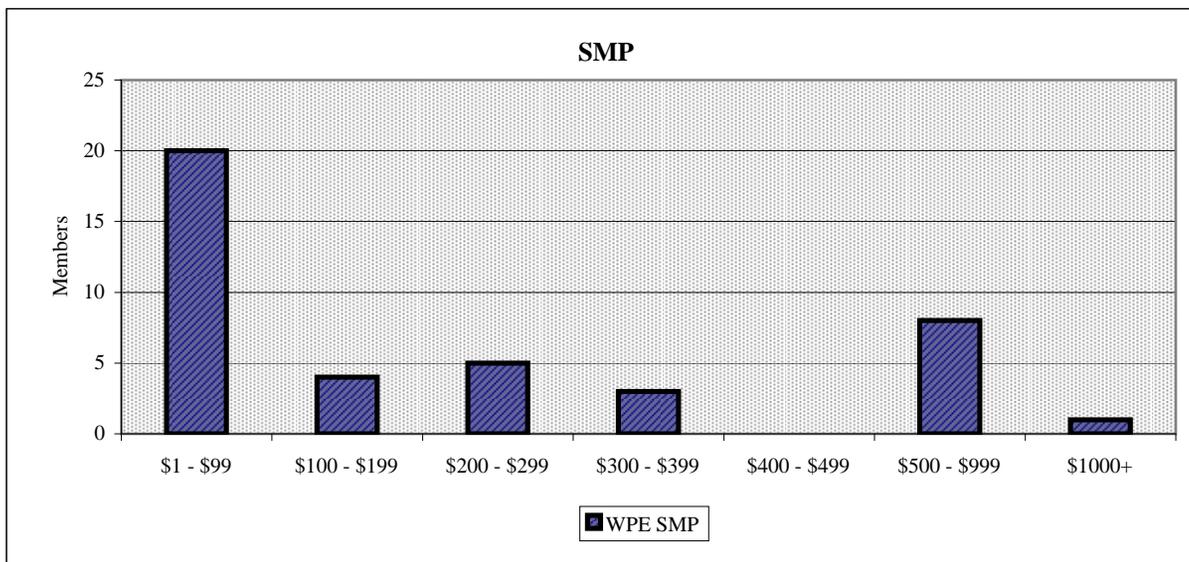
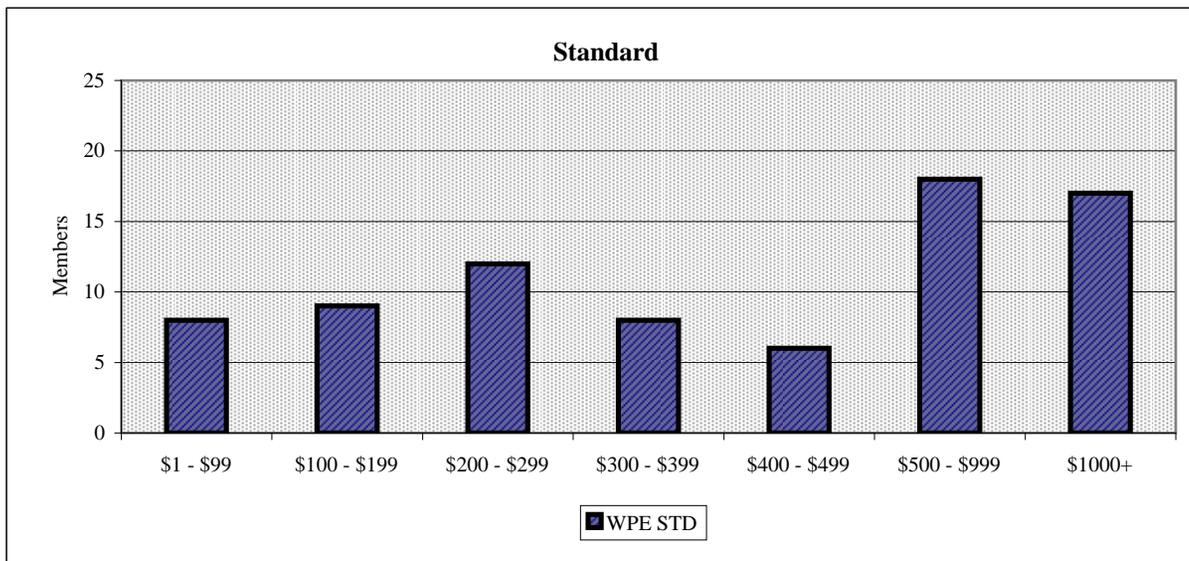
Medical and Drug Out of Pocket by Member

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 2009. 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. 44.9% of members pay over \$500 out of pocket annually.

The **SMP Plan** by comparison has a large number of members paying between \$1 and \$99 in cost sharing (48.8%). Only 22.0% of members pay over \$500 out of pocket annually. Most of the cost sharing comes from prescription drug copays.

WISCONSIN PUBLIC EMPLOYERS
Medical and Drug Out of Pocket by Member
Incurred January 2009 - December 2009 Paid Through March 2010



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 2009 through December 2009 and paid through the end of March 2010. 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 75.9% of submitted charges on behalf of the plan. Of the 24.1% savings, 11.8% came from pricing cutbacks from the network providers. Another 7.3% was saved on claims rejected for duplicate submission, non-eligible claims, and services not covered by the plan. The Standard Plan also had 4.7% of charges paid by the members with deductibles, coinsurance and copays.

For the **SMP Plan**, WPS paid 59.4% of submitted charges on behalf of the plan. Of the 40.6% savings, 11.2% was received from pricing cutbacks from network providers. Another 7.0% 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 was 21.4%. The large percentage under the coordination of benefits category of third party liability, is due to one large claim that was paid for by another carrier since WPS was determined to be the secondary carrier.

For the **Medicare Carve-out Plan**, WPS paid 5.3% of submitted charges on behalf of the plan. Payments made by Medicare have an overwhelming impact on savings by accounting for 77.7% of the submitted charges. The second highest savings percentage, 14.0%, 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 2009 was 13.0% of submitted charges. With the Medicare population's impact, 68.6% of the savings was provided by Medicare, followed by 12.9% in rejections for duplicates and non-eligible services.

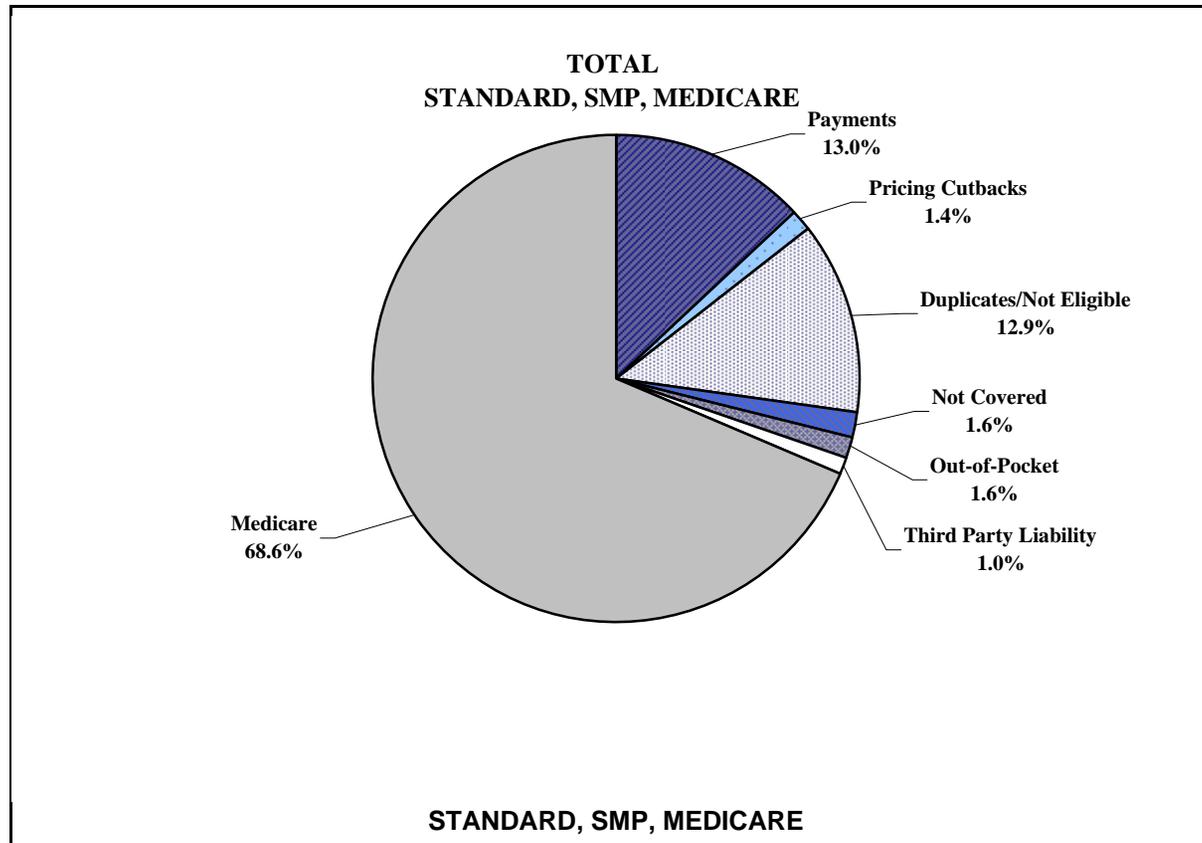
WISCONSIN PUBLIC EMPLOYERS
Medical Claims Savings Analysis
Incurred January 2009 - December 2009 Paid Through March 2010

Exhibit 17-C

Category	STANDARD		SMP		MEDICARE	
	\$ Amount	% of Total	\$ Amount	% of Total	\$ Amount	% of Total
Submitted Charges	\$724,654	100.0%	\$477,320	100.0%	\$8,827,885	100.0%
Duplicates/Not Eligible	\$30,211	4.2%	\$21,075	4.4%	\$1,235,282	14.0%
Pricing Cutbacks	\$85,451	11.8%	\$53,678	11.2%		
Out-of-Pocket						
Deductible	\$16,234	2.2%	\$1,736	0.4%	\$41,260	0.5%
Coinsurance	\$17,261	2.4%	\$2,002	0.4%	\$79,933	0.9%
Copayments	\$628	0.1%	\$185	0.0%	\$1,122	0.0%
Total	\$34,123	4.7%	\$3,923	0.8%	\$122,315	1.4%
Not Covered						
Medical Necessity	\$1,574	0.2%	\$0	0.0%	\$236	0.0%
Inappropriate Provider	\$0	0.0%	\$590	0.1%	\$5,673	0.1%
Benefit Maximum	\$8,157	1.1%	\$0	0.0%	\$33,868	0.4%
Experimental/Fertility	\$0	0.0%	\$0	0.0%	\$0	0.0%
Dental	\$2,818	0.4%	\$0	0.0%	\$488	0.0%
Custodial	\$0	0.0%	\$0	0.0%	\$4,488	0.1%
Code Review	\$7,928	1.1%	\$0	0.0%	\$1,687	0.0%
Contact Lens/Hearing Aid	\$0	0.0%	\$0	0.0%	\$3,441	0.0%
Drugs	\$0	0.0%	\$0	0.0%	\$0	0.0%
No Referral	\$0	0.0%	\$0	0.0%	\$0	0.0%
All Other	\$2,292	0.3%	\$12,030	2.5%	\$71,739	0.8%
Total	\$22,769	3.1%	\$12,620	2.6%	\$121,620	1.4%
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	\$60	0.0%	\$102,317	21.4%	\$0	0.0%
Total	\$60	0.0%	\$102,317	21.4%	\$0	0.0%
Medicare	\$1,959	0.3%	\$0	0.0%	\$6,863,268	77.7%
Payments	\$550,082	75.9%	\$283,707	59.4%	\$465,885	5.3%

**WISCONSIN PUBLIC EMPLOYERS
 Medical Claims Savings Analysis Summary
 Incurred January 2009 - December 2009 Paid Through March 2010**

	STANDARD		SMP		MEDICARE	
	\$ Amount	% of Total	\$ Amount	% of Total	\$ Amount	% of Total
Payments	\$550,082	75.9%	\$283,707	59.4%	\$465,885	5.3%
Pricing Cutbacks	\$85,451	11.8%	\$53,678	11.2%		
Duplicates/Not Eligible	\$30,211	4.2%	\$21,075	4.4%	\$1,235,282	14.0%
Not Covered	\$22,769	3.1%	\$12,620	2.6%	\$121,620	1.4%
Out-of-Pocket	\$34,123	4.7%	\$3,923	0.8%	\$122,315	1.4%
Third Party Liability	\$60	0.0%	\$102,317	21.4%	\$0	0.0%
Medicare	\$1,959	0.3%	\$0	0.0%	\$6,863,268	77.7%





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

- WPS Care management generated savings of \$3.55 million in 2009, an increase of 8.7 percent from 2008 when savings totaled \$3.27 million and an increase of more than 22 percent over 2007 when savings totaled \$2.9 million.
- 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.
- The largest portions of savings resulted from pre-authorization activities of outpatient services (\$1.52 million) and medical review activities (\$1.31million).
- Medical review is a process in Medical Management that does post-claim (retrospective) review to ensure:
 - Services that received pre-authorization are billed appropriately.
 - Services not requiring pre-authorization are covered by the member's plan, and are medically necessary.
- Participation in chronic care management (CCM) increased 86 percent—with 149 cases in 2009 vs. 80 cases in 2008. Management of cardiac-related conditions occurred in 73 cases (48.9 percent); the largest category. Diabetes was the next most frequently managed condition, with 48 cases (32.2 percent).
- All ETF Standard Plan, SMP and Medicare \$1 Million members with high dollar claims received care management services. Significant reduction in the high cost cases and total amount paid in 2009 (n = 40; \$7.2M) compared to 2008 (n = 55; \$11.1M).

Preventive Health Screening Services Quality Indicators

- Preventive health screenings such as Pap tests, mammograms and diabetic testing can help members avoid preventable emergency room and inpatient care and improve quality of care and quality of life.
- Mammography screening rates increased since 2008 and continue above the national PPO average (75.5 percent vs. 66.0 percent).

- Cervical cancer screening rates increased almost 20 percent in 2008 and increased another 11.4 percent in 2009, but remain below the national PPO average (70.4 percent vs. 74.0 percent).
- Diabetic care indicators are trending slightly lower and are below the national PPO benchmarks. The 2009 HbA1c testing rate was 66.3 percent versus the National PPO benchmark of 79.5 percent; LDL-C testing was 67.0 percent versus the benchmark of 74.7 percent.
- In response to these trends, performance improvement initiatives are underway on these services that include member education and engagement through medical management programs and/or member communications (i.e. emails, postcard reminders or newsletters).

Wellness Program

- Wellness programs work hand-in-glove with Medical Management and Chronic Care Management to empower individuals to prevent health problems, facilitate early detection and treatment of potentially serious conditions and successfully manage chronic conditions they may have. The Wellness program is a key component in Value Based Benefit Design.
- In 2009, WPS Wellness provided a variety of free on-line resources for ETF members.
- In 2010, customized wellness programs, health risk appraisals, biometric screenings and wellness coaching sessions (i.e. smoking cessation, weight and stress management) 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, and chronic conditions. Members ages 55-64 years old are 34 percent of ETF's Standard Plan membership, compared to 15 percent for the benchmark (per Exhibit 3-A).

The top 10 MDCs by PMPM claims costs with the most significant variation to the benchmark (greater than 30%) and at least 5% increase from 2008 include:

- Behavioral Health (MDC 19) claims were driven by members with psychotic conditions and depression. These conditions accounted for nearly 56% (n = \$763K of \$1.4M) of behavioral health paid claims. ETF Standard Plan non-standard mental health benefit may impact these costs.
- Endocrine, Nutritional, and Metabolic (MDC 10) PMPM was driven by claims related to obesity and diabetes. Claims for these conditions were 70% (n = \$1.1M of \$1.5M) of paid dollars in this category.
- Skin and Breast (MDC 9) cancers and cellulitis were 53% (n = \$1.1M of \$2.0M) of claims in this group.

The other top 10 MDCs by PMPM claims costs with the most significant variation to the benchmark (greater than 30%) but slightly less than the 2008 PMPM is:

- Muscle and Bone (MDC 8) conditions related to medical back problems, total joint replacements and arthritis were 44% (n = \$2.3M of \$5.2M) of total claims for this category.

* Per Data Dashboard DRG and Diagnosis data - coverage dates January 2009 to December 2009 Paid through March 2010.

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

Exhibit 1

MDC CODE	MAJOR DIAGNOSTIC CATEGORY DESCRIPTION	2008	2009	BENCHMARK PMPM **	DIFFERENCE	
		ACTUAL PMPM *	ACTUAL PMPM **		2009 to 2008	2009 to BENCHMARK
8	Muscles, Bones, and Connective Tissue D/D	\$136.68	\$133.52	\$100.57	-2.3%	32.8%
23	Other Miscellaneous Services Including Health Screenings, Medical Exams and Rehabilitation	\$65.24	\$66.26	\$54.31	1.6%	22.0%
5	Circulatory System D/D	\$63.32	\$60.01	\$56.76	-5.2%	5.7%
6	Digestive System D/D	\$57.62	\$52.44	\$44.95	-9.0%	16.7%
9	Skin, Subcutaneous Tissue (fat and connective) and Breast D/D	\$44.95	\$50.81	\$26.59	13.0%	91.1%
10	Endocrine, Nutritional and Metabolic D/D (included diagnoses related to obesity, diabetes and hormones)	\$26.51	\$39.16	\$16.27	47.7%	140.7%
1	Nervous System Diseases and Disorders (D/D)	\$65.54	\$38.93	\$30.51	-40.6%	27.6%
19	Behavioral Health Diagnoses	\$34.28	\$35.35	\$9.60	3.1%	268.1%
3	Ear, Nose, Mouth and Throat D/D	\$24.94	\$26.04	\$20.16	4.4%	29.2%
17	Bone Marrow D/D and Poorly Differentiated Cancers	\$38.60	\$25.04	\$22.49	-35.1%	11.3%

Note: Sorted by 2009 actual PMPM.

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

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

** Each \$1.00 paid PMPM = \$38,752 in plan costs.

State Employee Trust Funds

Care Management

Conditions Managed for High Cost Cases

All ETF Standard Plan, SMP and Medicare \$1 Million members with high dollar claims received care management services. Significant reduction in the high cost cases and total amount paid in 2009 (n = 40; \$7.2M) compared to 2008 (n = 55; \$11.1M).

- Cancer:
 - 45% (n = 18 of 40) of high dollar cases.
 - 44% (n = \$3.1M of \$7.2M) of high dollars.
 - One member had large claims (\$340K) for cancer treatment and related complications.

- Muscle and bone conditions (fractures, back surgery and arthritis):
 - 13% (n = 5 of 40) of high dollar cases.
 - 11% (\$759K of \$7.2M) of high dollars.
 - Two of the five members have termed. We anticipate continued high claims from only one member of the remaining three.

- Behavioral Health:
 - 8% (n = 3 of 40) of high dollar cases.
 - 5% (n = \$373K of \$7.2M) of high dollars.
 - There are significant medical and pharmacy claims included in the total paid but the underlying condition is behavioral health related. Medical and Behavioral health management is in-process.

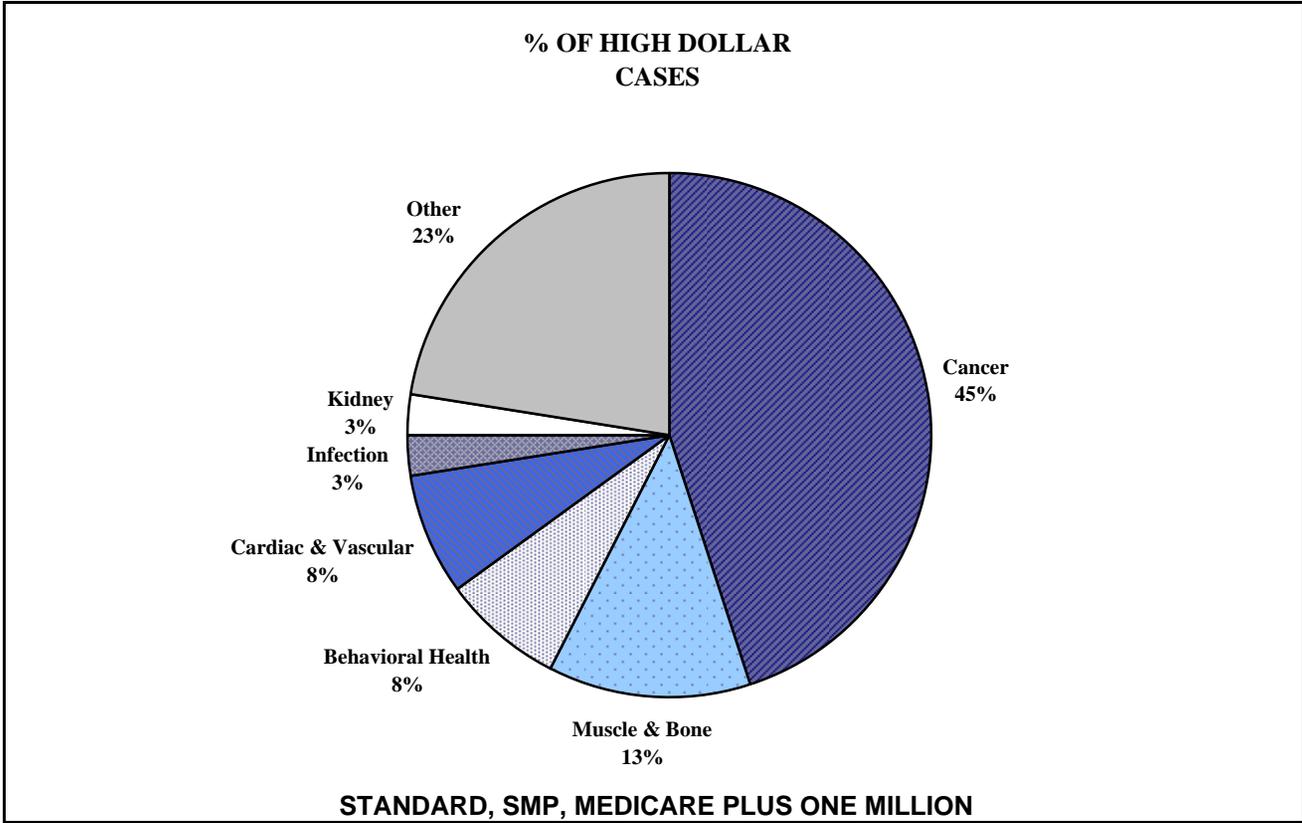
- Cardiac and vascular conditions:
 - 8% (n = 3 of 40) of high dollar cases.
 - 8% (n = \$572K of \$7.2M) of high dollars.
 - Two of the three members we anticipate continued high claims.

- Infections:
 - 3% (n = 1 of 40) of high dollar cases.
 - 2% (\$121K of \$7.2M) of high dollars.
 - The infection was not a complication of recent medical care

- Other:
 - 23% (n = 9 of 40) of high dollar cases.
 - 28% (\$2.0M of \$7.2M) of high dollars.
 - Trauma (n=3; \$465K) is the top category in “Other”; anticipate continued high claims from only one member.

STATE EMPLOYEE TRUST FUNDS
High Dollar Claims by Diagnosis
 Incurred January 2009 - December 2009 Paid Through March 2010

Diagnosis	% of High Dollar Cases	% of High Dollars	# of Cases	Paid Dollars
Cancer	45%	44%	18	\$3,123,363
Muscle & Bone	13%	11%	5	\$758,886
Behavioral Health	8%	5%	3	\$373,446
Cardiac & Vascular	8%	8%	3	\$571,943
Infection	3%	2%	1	\$121,486
Kidney	3%	3%	1	\$222,519
Other	23%	28%	9	\$1,997,834
Total	100%	100%	40	\$7,169,478



State Employee Trust Funds

Care Management

ETF Bariatric Surgery Experience

WPS created a bariatric surgery Centers of Excellence (COE) approach in 2007 for ETF Standard Plan members. 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.

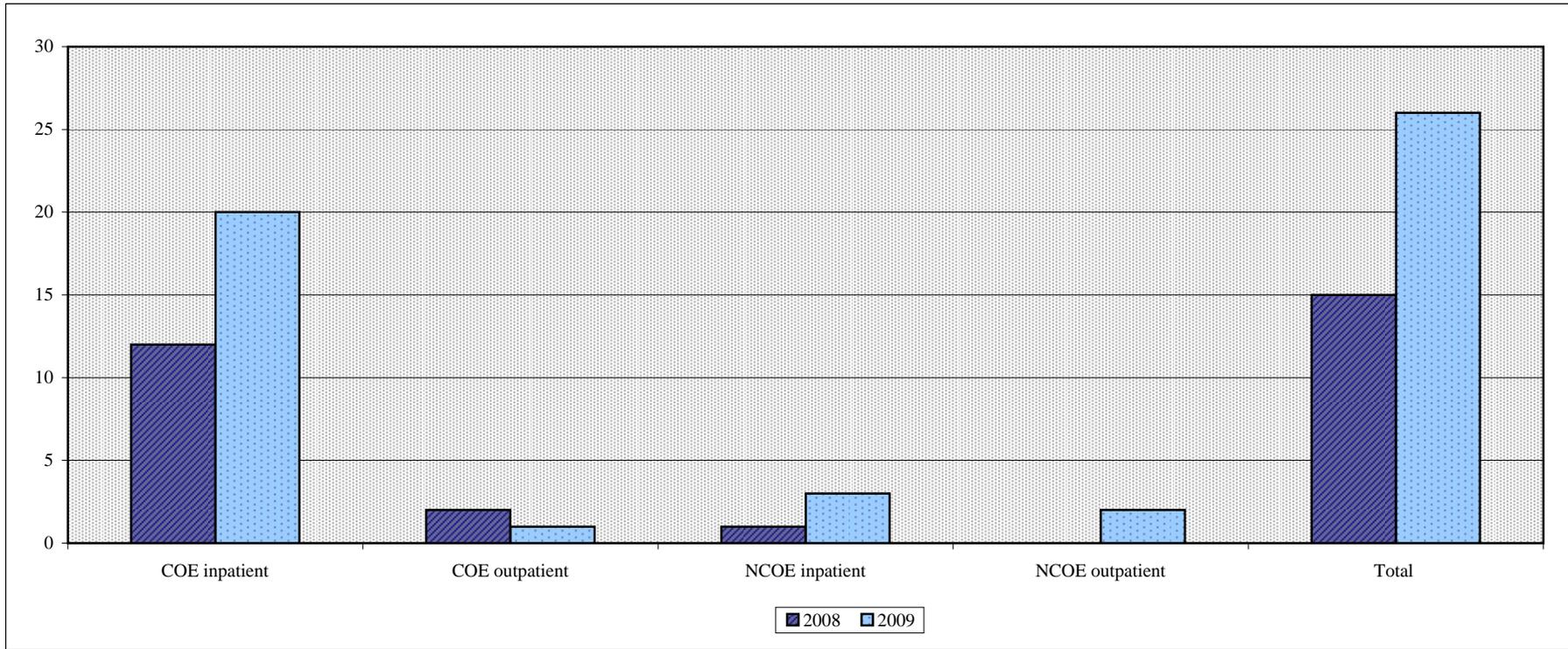
- Member selection of COE vs. non-COE increased significantly since 2007*. Eighty-one (81%) percent (21 of 26) utilized a Center of Excellence for inpatient or outpatient bariatric procedures in 2009. This compares with 93 percent (14 of 15) that utilized a COE in 2008 and 52 percent (15 of 27) 2007.
- As anticipated, the number of primary bariatric procedures increased in 2009, with 26 compared to 15 in 2008. Similarly our WPS Book of Business saw a 14 percent (31 vs. 27) increase in bariatric surgeries during the same time period.
- ETF PMPM for bariatric procedures increased from \$9.23 in 2008 to \$16.44 in 2009, primarily on case volume.
- Average cost per inpatient case increased 4.7 percent to \$31,047 in Center of Excellence settings, but remained substantially below the average cost per inpatient case in non-Center of Excellence facilities, where average costs were 41.3 percent higher (\$43,889).
- PMPM costs remain high compared to the benchmark, but average costs per inpatient COE case were comparable at \$31,047 for ETF and \$30,438 for the Benchmark.
 - 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 percent (n = 16 of 27) of members with bariatric surgery termed by January 2008.
 - During 2008, 67 percent (n = 10 of 15) of members with bariatric surgery termed by March 2009.
 - During 2009, 50 percent (n = 13 of 26) of members with bariatric surgery termed by March 2010.

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
Number of Bariatric Procedures
Comparison of 2009 to 2008

Exhibit 3-A



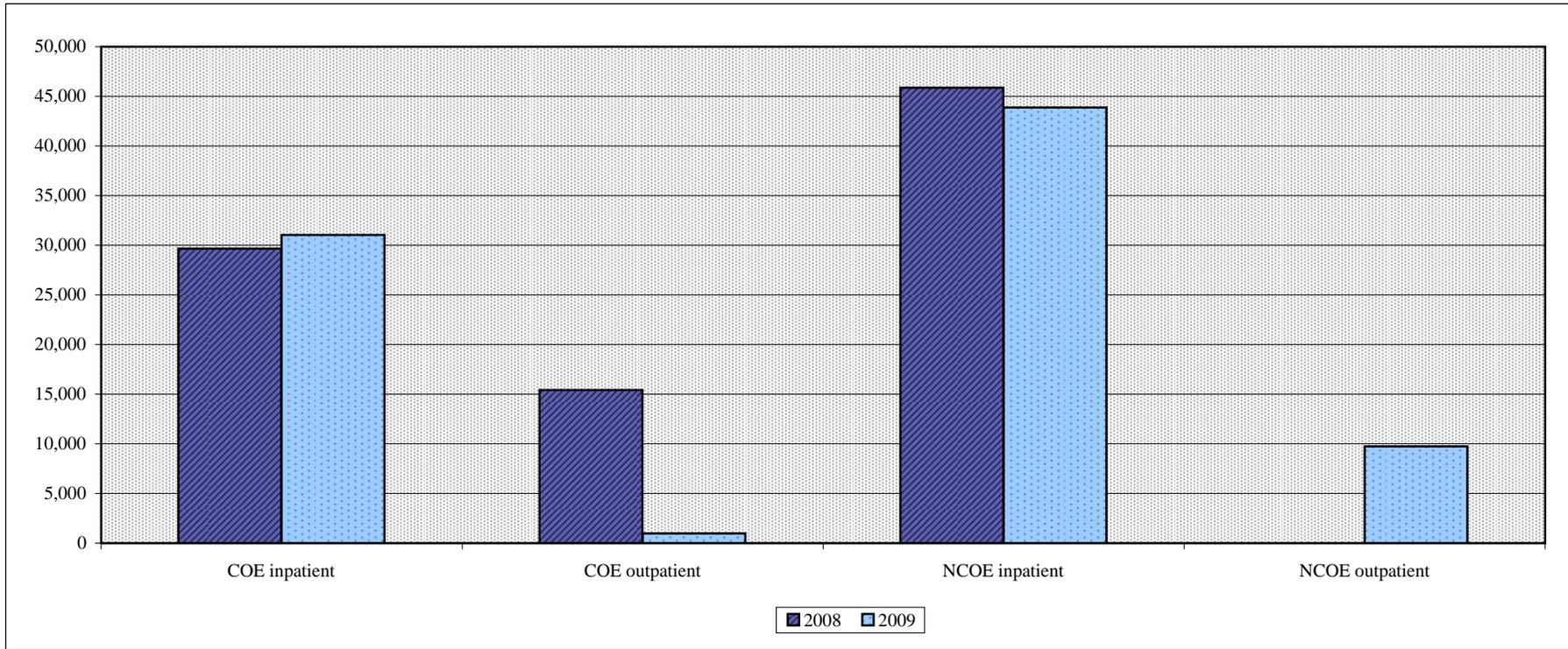
	2008	2009
COE inpatient	12	20
COE outpatient	2	1
NCOE inpatient	1	3
NCOE outpatient	0	2
Total	15	26

Note: COE = Center of Excellence

Note: NCOE = Non Center of Excellence

STATE EMPLOYEE TRUST FUNDS
Bariatric Procedure - Average Cost Comparison by Setting
Comparison of 2009 to 2008

Exhibit 3-B



	2008	2009
COE inpatient	\$29,652	\$31,047
COE outpatient	\$15,415	\$977
NCOE inpatient	\$45,877	\$43,889
NCOE outpatient	\$0	\$9,734

Note: COE = Center of Excellence

Note: NCOE = Non Center of Excellence

State Employee Trust Funds

Care Management

Care Management Services

Case Management (CM) involves planning and facilitating acute care services. The Case Manager focuses on the utilization of benefits in the most effective manner under the policy while ensuring high quality care. 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.

Chronic Care Management (CCM) utilizes a proactive approach through identification, education and appropriate care to prevent avoidable 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.

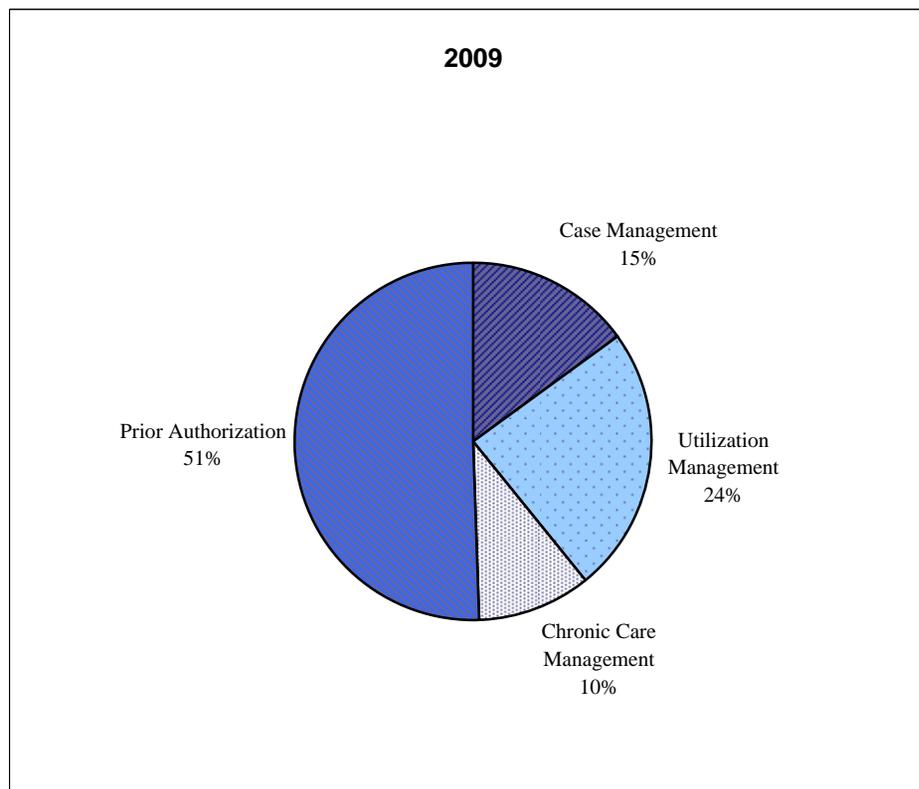
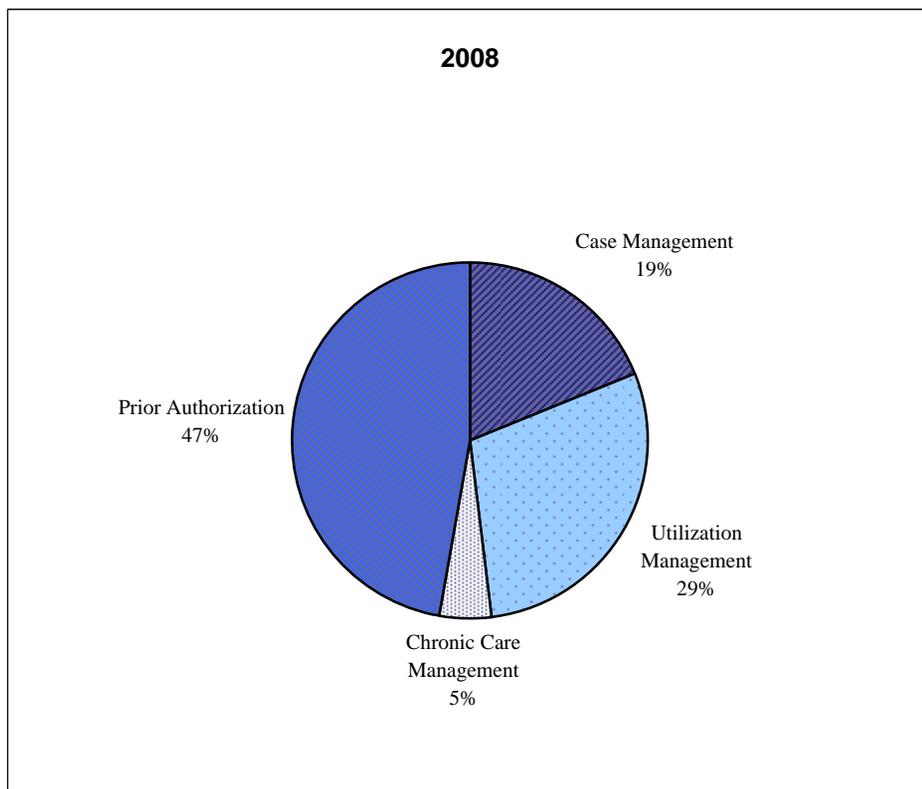
Medical Review is a process in Medical Management that does post-claim (retrospective) review to ensure that those services that received preauthorization are billed appropriately, and services not requiring preauthorization are covered by the member's plan, and are medically necessary.

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 proper utilization of services, while maximizing health care benefits and determining the most appropriate level of care. Care Management nurses monitor 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
Comparison of 2009 to 2008**

Care Management Category	# of Cases	
	2008	2009
Case Management	293	217
Utilization Management	453	353
Chronic Care Management	74	149
Prior Authorization	735	734
Total	1,555	1,453



STANDARD, SMP, MEDICARE PLUS ONE MILLION

State Employee Trust Funds

Care Management

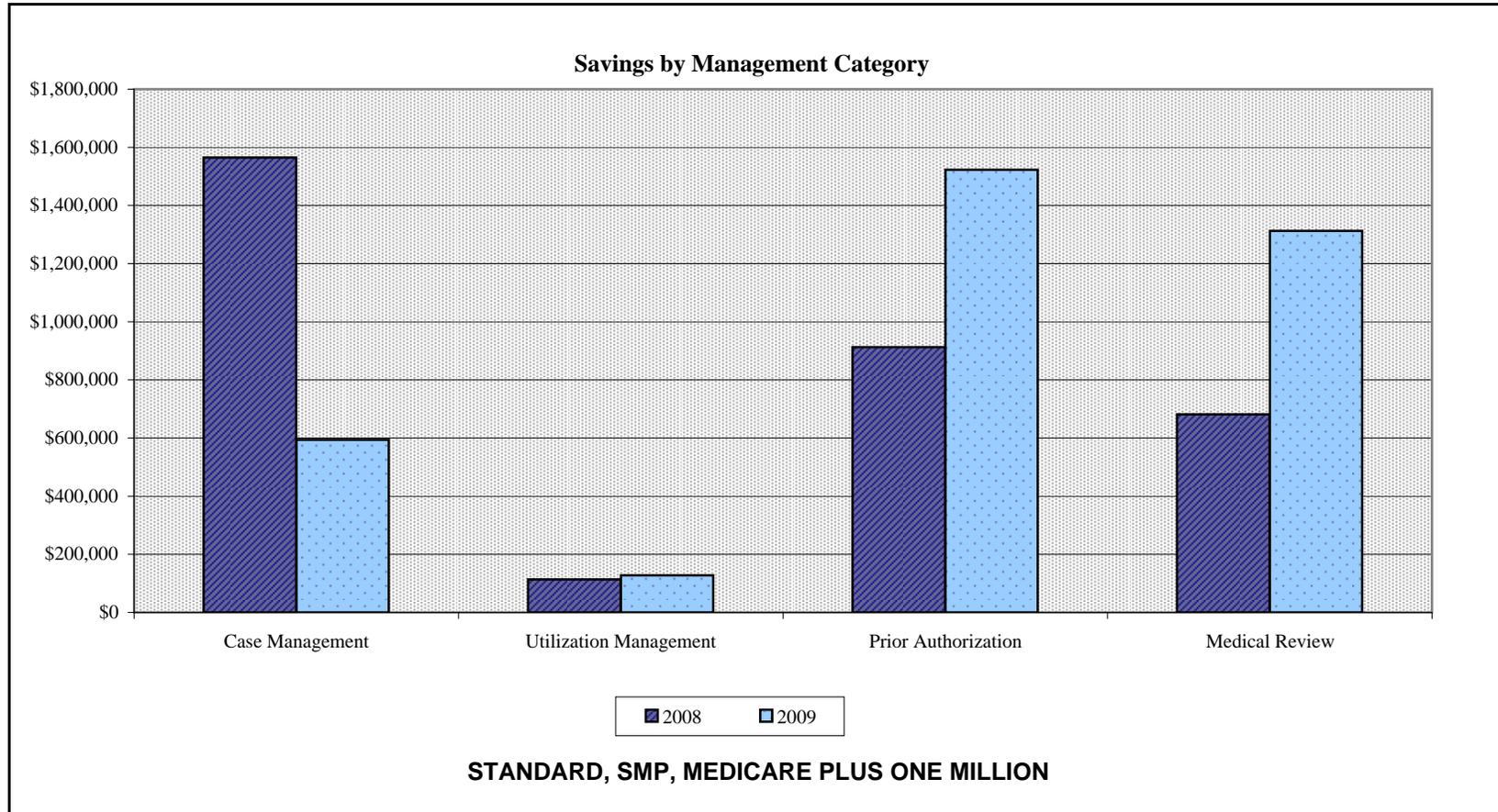
Care Management Savings

- WPS Care management generated savings of \$3.55 million in 2009, an increase of 8.7 percent from 2008 when savings totaled \$3.27million and an increase of more than 22 percent over 2007 when savings totaled \$2.9 million.
- 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.
- The largest portions of savings resulted from pre-authorization activities of outpatient services (\$1.52 million) and medical review activities (\$1.31million).
- Medical review is a process in Medical Management that does post-claim (retrospective) review to ensure:
 - Services that received pre-authorization are billed appropriately.
 - Services not requiring pre-authorization are covered by the member's plan, and are medically necessary.
- Participation in chronic care management (CCM) increased 86 percent—with 149 cases in 2009 vs. 80 cases in 2008. Management of cardiac-related conditions occurred in 73 cases (48.9 percent); the largest category. Diabetes was the next most frequently managed condition, with 48 cases (32.2 percent).

STATE EMPLOYEE TRUST FUNDS
Care Management Savings
Comparison of 2009 to 2008

Exhibit 5

Care Management Category	Savings	
	2008	2009
Case Management	\$1,564,810	\$593,834
Utilization Management	\$113,314	\$127,287
Prior Authorization	\$912,234	\$1,522,603
Medical Review	\$681,754	\$1,312,270
Total	\$3,272,112	\$3,555,994



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 2009 included asthma, diabetes, hypertension and heart disease.

- Total number of ETF members with these conditions decreased 3.4 percent from 1,192 in 2008 to 1,151 in 2009. There were 1,082 in 2007.
- ETF members with high HSM scores (7 to 10) have continued to increase:
 - 2009 = 87 (an increase of 22.5 percent from 2008)
 - 2008 = 71 (an increase of 24.6 percent from 2007)
 - 2007 = 57
- Chronic Care Management services focus on members with higher HSM scores.

STATE EMPLOYEE TRUST FUNDS

HSM Table
Calendar Year 2009

Exhibit 6

HSM Severity Score	Members with				
	Asthma	Diabetes	Hypertension	Heart Disease	Total
10	1	4	4	3	12
9	3	4	9	2	18
8	6	10	17	3	36
7	2	4	11	4	21
6	4	4	11	1	20
5	14	25	50	6	95
4	32	49	102	18	201
3	25	53	134	25	237
2	38	52	152	17	259
1	65	34	144	9	252
Total	190	239	634	88	1,151
CY 2008	248	226	633	85	1,192

State Employee Trust Funds

Care Management

Chronic Care Management (CCM)

CCM focuses on members with asthma, congestive heart failure, coronary artery disease (including hypertension and high cholesterol), diabetes, and alcohol or drug abuse.

Members with chronic conditions are proactively identified and outreach is provided to help them navigate the healthcare system, manage their condition and make positive lifestyle changes.

Participation in chronic care management (CCM) increased 86 percent—149 cases in 2009 vs. 80 cases in 2008. Management of cardiac-related conditions occurred in 73 cases (48.9 percent); the largest category. Diabetes was the next most frequently managed condition, with 48 cases (32.2 percent).

Great Beginnings

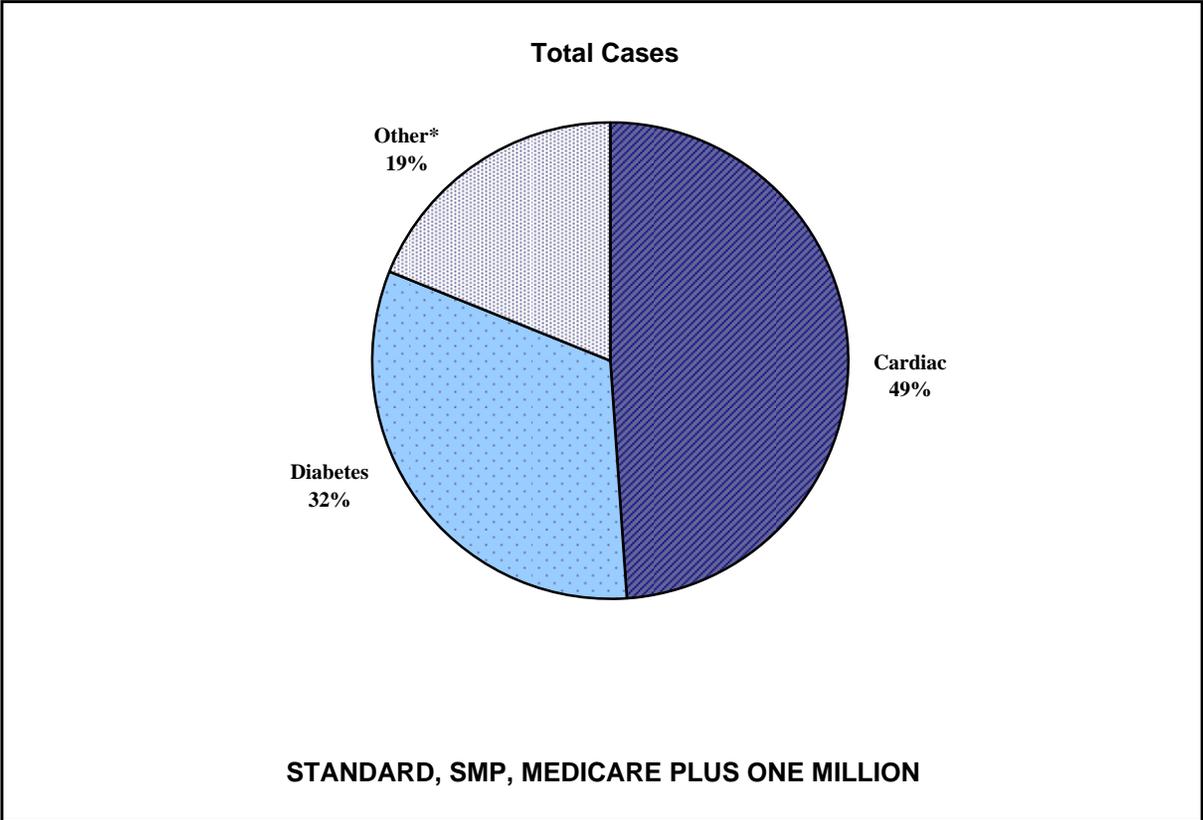
Our Great Beginnings pre-natal case management program provides services to members with high risk pregnancies. This is an example of how the program can improve outcomes and reduce costs:

A member was pregnant with twins with two separate amniotic sacs but one shared placenta. This can be serious if the placenta is not able to pass enough nutrition to both growing babies. The WPS Care Manager provided print educational material and telephone contact during the pregnancy and verified that the specialist and facility providing care were in the member's network. The care manager coordinated serial ultrasounds to monitor the growth of the twins and services from a Maternal Fetal Medicine specialist due to the high risk condition. The pregnancy resulted in a normal, non-surgical delivery of healthy twins. The mother and her twins were all able to go home two days after delivery without any home care.

**STATE EMPLOYEE TRUST FUNDS
Chronic Conditions - Managed Cases
Calendar Year 2009**

Chronic Conditions	Open Cases	Closed Cases	Total Cases
Cardiac	41	32	73
Diabetes	21	27	48
Other*	7	21	28
Total	69	80	149

*Other = Members with other chronic conditions, such as asthma or kidney disease.



State Employee Trust Funds

Care Management

Behavioral Health Outpatient Visits

- Behavioral Health (BH) outpatient visits have decreased over the past four years. Since 2006:
 - Members with greater than twenty visits have decreased consistently:
 - 2006 = 191
 - 2007 = 168 (12 percent reduction)
 - 2008 = 148 (12 percent reduction)
 - 2009 = 121 (18 percent reduction)
 - Members with less than twenty visits have also shown consistent reduction in the same period:
 - 2006 = 540
 - 2007 = 507 (6.1 percent reduction)
 - 2008 = 494 (2.6 percent reduction)
 - 2009 = 419 (15.2 percent reduction)
 - Overall, the number of members with behavioral health outpatient visits has decreased 26 percent between 2006 and 2009 (731 vs. 540).

- From 2008 to 2009, the total number of visits among those with twenty or more visits in the year has also been reduced 17.7 percent from 5,358 in 2008 to 4,411 in 2009.

- Decrease in BH outpatient visits impacted by:
 - Medical management 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 - 2009

Number of Visits	Members			
	2006	2007	2008	2009
1-19	540	507	494	419
20-30	79	75	60	53
31-40	44	28	45	33
41-50	28	25	24	23
51-60	10	14	11	5
61-70	9	10	4	3
71-80	1	7	0	0
81-90	3	5	3	2
91-100	6	3	0	0
>100	11	1	1	2
Total - All Visits	731	675	642	540
Total - Visits 20+	191	168	148	121

State Employee Trust Funds

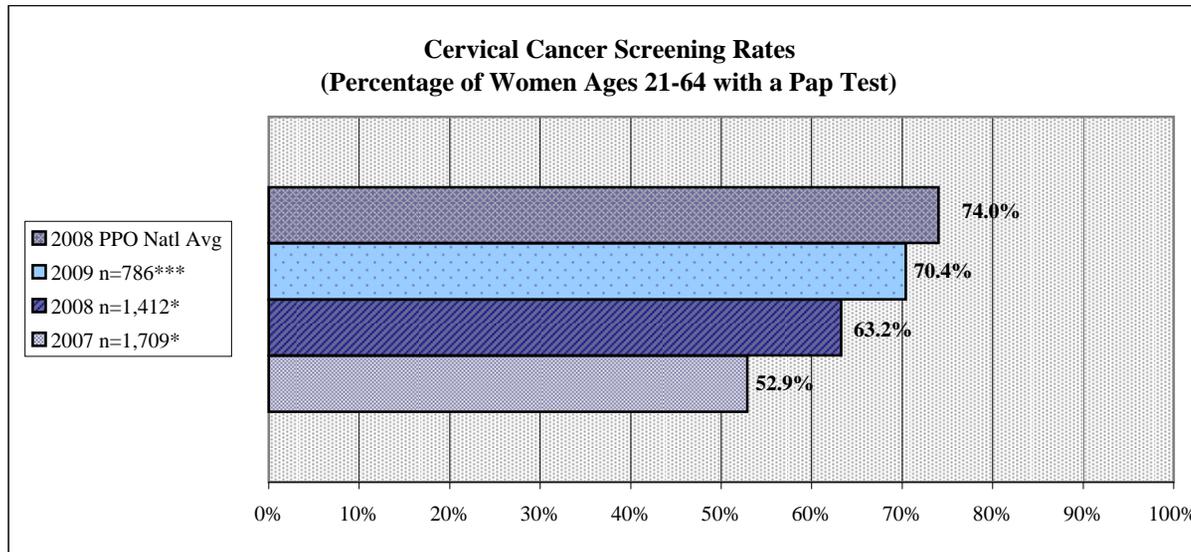
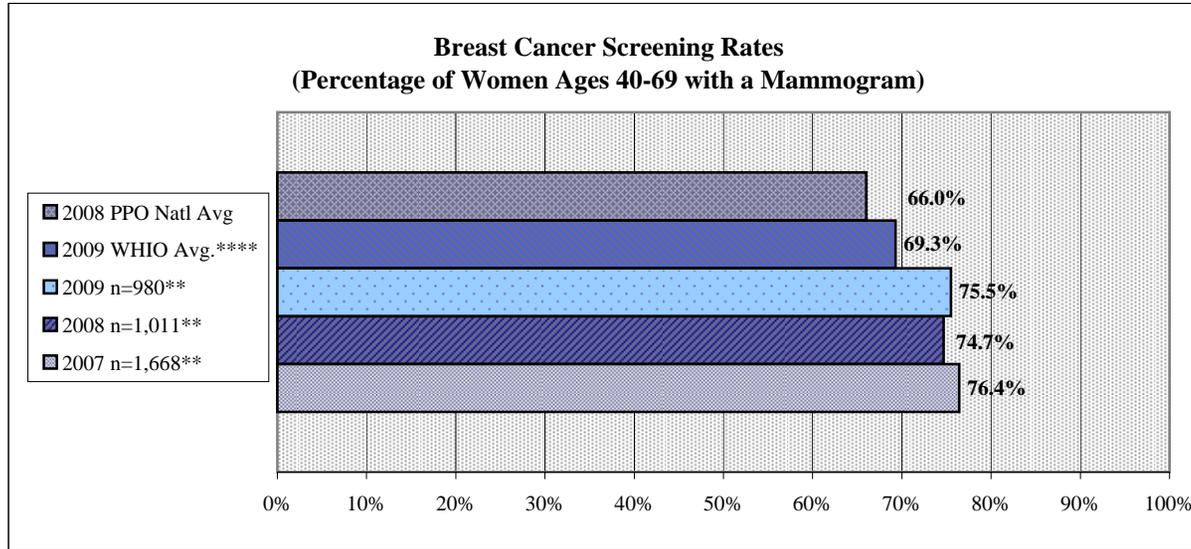
Care Management

Quality Measures for Chronic Conditions and Health Care Screening

- Preventive health screenings such as Pap tests, mammograms and diabetic testing can help members avoid preventable emergency room and inpatient care and improve quality of care and quality of life.
- Mammography screening rates increased since 2008 and continue above the national PPO average (75.5 percent vs. 66.0 percent).
- Cervical cancer screening rates increased almost 20 percent in 2008 and increased another 11.4 percent in 2009, but remain below the national PPO average (70.4 percent vs. 74.0 percent).
- Diabetic care indicators are trending slightly lower and are below the national PPO benchmarks. The 2009 HbA1c testing rate was 66.3 percent versus the National PPO benchmark of 79.5 percent; LDL-C testing was 67.0 percent versus the benchmark of 74.7 percent.
- In response to these trends, performance improvement initiatives are underway on these services that include member education and engagement through medical management programs and/or member communications (i.e. emails, postcard reminders or newsletters).

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

Exhibit 9-A



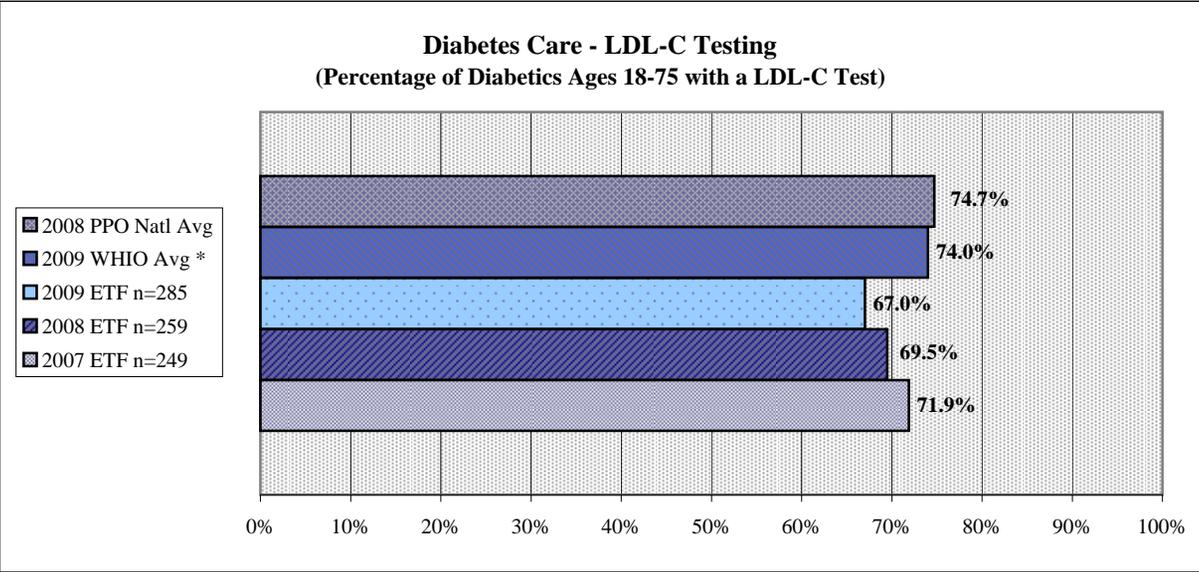
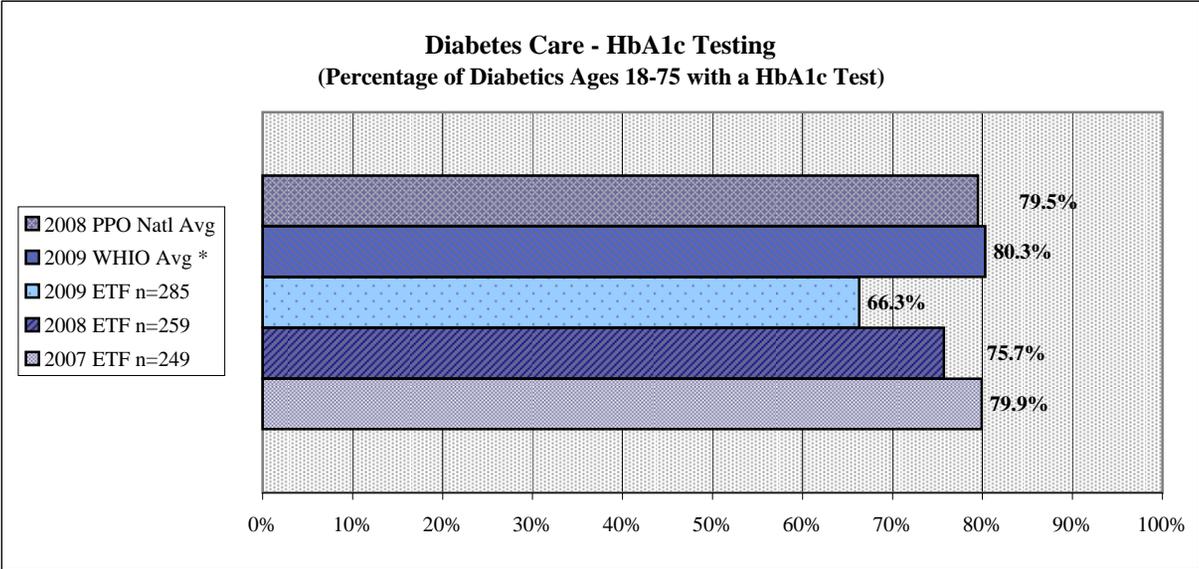
* Rate includes screenings performed in the reporting year.

** Rate includes screenings performed in the reporting year or one year prior.

*** Rate includes screenings performed in the reporting year or two years prior.

**** WHIO Data: 10/01/07-9/30/09, paid through 12/31/09; PPO only; all Residents.

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



* WHIO Data: 10/01/07-9/30/09, paid through 12/31/09; PPO only; all Residents.

State Employee Trust Funds

Care Management

Wellness and Prevention Programs

A comprehensive Wellness program is included in WPS Integrated Care Management.

- Wellness programs work hand-in-glove with Medical Management and Chronic Care Management to empower individuals to prevent health problems, facilitate early detection and treatment of potentially serious conditions and successfully manage chronic conditions they may have. The Wellness program is a key component in Value Based Benefit Design.
- In 2010, customized wellness programs, health risk appraisals, biometric screenings and wellness coaching sessions (i.e. smoking cessation, weight and stress management) are available for your consideration. ***Preventive Health Guidelines*** are coming soon.

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.
- **Wellness 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 2010 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 are mailed 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

2009 Care Management Satisfaction

Satisfaction Rating: 97 percent (123 of 127) of survey respondents rated WPS care management 4 or 5 with 5 being the best rating.

Satisfaction Survey Comments:

1. "(WPS) case manager was Pam Szymanski-she was very easy to work with & she was very professional."
2. "Stephanie-Wow, what great customer service!"
3. "Michelle Wanke has proved to be a caring, professional person. She greatly reduced the burden of stress & worry during this troublesome time. My heartfelt thanks go out to her."