AGENDA AND NOTICE OF MEETING

State of Wisconsin
Group Insurance Board Meeting
Tuesday, February 12, 2008
8:30 a.m.

Holiday Inn
1109 Fourier Drive
Madison, Wisconsin

Documents for this meeting are available on-line at:
http://etf.wi.gov/boards/board_gib.htm
To request a printed copy of the agenda items, please contact
Sharon Walk, at (608) 267-2417.

Times shown are estimates only.
⬅ *Denotes action item.*

8:30 a.m. ⬅ **1. Consideration of Minutes of November 6, 2007, Meeting**

8:35 a.m. ⬅ **2. Election of Officers**

8:40 a.m. **3. Health Insurance**
- Guidelines/Uniform Benefits Timeline & Discussion
- Dual-Choice Enrollment Statistics
- Report on Health Plan Employer Data and Information Set (HEDIS®) and Consumer Assessment of Health Plans Survey (CAHPS®)
- Pharmacy Benefit Manager Audit

9:30 a.m. ⬅ **4. Proposed *Scope Statement* Concerning Amendments to Wisconsin Administrative Code ETF 11.11, Relating to Appointment of Board Counsel**

9:45 a.m. **5. Miscellaneous**
- Legislative Update
- Revised 2008 Meeting Dates
- Correspondence and Complaint Summary
- Local Employers Joining or Leaving the Wisconsin Group Health and Income Continuation Insurance Programs as of 12/31/2007
- Pending Appeals Status Report
- Future Items for Discussion

9:50 a.m. ⬅ ***6. Rebid of the Long-Term Disability Insurance and Income Continuation Insurance Contract**

10:15 a.m. ⬅ ***7. Wisconsin Physicians Service Contract Bid**

10:25 a.m. **8. Announcement of Action Taken on Business Deliberated on During Closed Session**

10:30 a.m. **9. Adjournment**

***** **The Board may be required to meet in closed session pursuant to the exemptions contained in Wis. Stats. § 19.85(1)(e) to discuss the use of public employee trust funds. If a closed session is held, the Board will reconvene into open session for further actions on these and subsequent agenda items.**

The meeting location is handicap accessible. If you need other special accommodations due to a disability, please contact Sharon Walk, Department of Employee Trust Funds, PO Box 7931, Madison, WI 53707-7931. Telephone number: (608) 267-2417. Wisconsin Relay Service: 7-1-1. e-mail: sharon.walk@etf.state.wi.us.

MINUTES OF MEETING

DRAFT

STATE OF WISCONSIN
GROUP INSURANCE BOARD

Tuesday, November 6, 2007

Department of Employee Trust Funds
801 West Badger Road
Madison, Wisconsin

BOARD PRESENT:	Martin Beil Jennifer Donnelly Eileen Mallow
BOARD PRESENT VIA CONFERENCE CALL:	Stephen Frankel, Chair Cindy O'Donnell, Vice-Chair Esther Olson, Secretary Robert Baird Jeannette Bell Janis Doleschal David Schmiedicke Gary Sherman
PARTICIPATING ETF STAFF:	Dave Stella, Secretary Tom Korpady, Administrator, Division of Insurance Services Sharon Walk, Group Insurance Board Liaison
OTHERS PRESENT:	Deb Carstensen, Department of Administration Liz Doss-Anderson, Division of Management Services Rhonda Dunn, Office of the Secretary Charlotte Gibson, Department of Justice (via conference call) Bill Kox, Director, Health Benefits and Insurance Plans Bureau Sari King, Division of Retirement Services Ann McCarthy, Division of Management Services Beth Ritchie, University of Wisconsin System Administration John Verberkmoes, American Federation of Teachers-Wisconsin

Stephen Frankel, Chair, Group Insurance Board (Board), called the meeting to order at 8:32 a.m.

ANNOUNCEMENTS

Mr. Korpady announced that the Employee Trust Funds (ETF) Board appointed Dave Stella as Secretary of the Department of Employee Trust Funds at its September 2007 meeting. Following the appointment, Mr. Stella asked Rhonda Dunn to continue in her position as Executive Assistant. Mr. Stella also appointed Bob Conlin to fill the position of Deputy Secretary. Mr. Conlin had been serving as the Department's Director of Legislation, Communications and Planning.

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CONSIDERATION OF MINUTES OF AUGUST 28, 2007, MEETING

MOTION: Ms. Mallow moved approval of the open and closed session minutes of the August 28, 2007, meeting as submitted by the board liaison. Ms. Olson seconded the motion, which passed without objection on a voice vote.

PROPOSED SCOPE STATEMENT CONCERNING AMENDMENTS TO WISCONSIN ADMINISTRATIVE CODE ETF 11.11

Mr. Korpady referred the Board to a memo in the meeting packet regarding proposed amendments to Wisconsin Administrative Code ETF 11.11. He noted that the Department is asking the Board to approve a scope statement that would provide the Board with flexibility in the use of legal counsel. The Board expressed concern that the scope statement, as written, appeared to remove the Department of Justice as the counsel to the Board. The Board asked staff to rewrite the proposal and present it for consideration at the next meeting.

MOTION: Mr. Sherman moved to return the proposed scope statement to the Department for further amendments. Ms. O'Donnell seconded the motion, which passed without objection on a voice vote.

MISCELLANEOUS

Mr. Korpady referred the Board to several miscellaneous items in the meeting packet. He noted that 2008 Board meetings would be held at the Holiday Inn, 1109 Fourier Drive in Madison. Mr. Sherman mentioned that the November 4, 2008, Board meeting occurs on the date of the 2008 Presidential Election. The board liaison agreed to reschedule this meeting.

MOTION TO CONVENE IN CLOSED SESSION

Mr. Frankel announced that the Board would convene in closed session pursuant to the exemptions contained in Wis. Stat. § 19.85 (1) (a) for the purpose of quasi-judicial deliberations. Assistant Attorney General Charlotte Gibson, Ms. Walk and Ms. McCarthy were invited to remain during the closed session discussion.

MOTION: Mr. Beil moved to convene in closed session pursuant to the exemptions contained in Wis. Stat. § 19.85 (1) (a) for the purpose of quasi-judicial deliberations. Ms. Olson seconded the motion, which passed on the following roll call vote:

Members Voting Aye: Baird, Beil, Bell, Doleschal, Donnelly, Frankel, Mallow, O'Donnell, Olson, Schmiedicke, and Sherman

Members Voting Nay: None

The Board convened in closed session at 9:00 a.m. and reconvened in open session at 9:45 a.m.

ANNOUNCEMENT OF ACTION TAKEN ON BUSINESS DELIBERATED DURING CLOSED SESSION

Mr. Frankel announced that the Board took the following action during the closed session:

Appeal No. 2006-065-GIB. The Board voted to adopt the hearing examiner's proposed decision with amendments as recommended by counsel.

Appeal No. 2006-075-GIB. The Board voted to adopt a final decision holding that the covered service included the entire continuum of service as provided by Pacific International.

ADJOURNMENT

MOTION: Ms. Mallow moved adjournment. Ms. Olson seconded the motion, which passed without objection on a voice vote.

The Board adjourned at 9:47 a.m.

Dated Approved: _____

Signed: _____
Esther Olson, Secretary
Group Insurance Board

STATE OF WISCONSIN
Department of Employee Trust Funds
David A. Stella
SECRETARY

801 W Badger Road
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Madison WI 53707-7931

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CORRESPONDENCE MEMORANDUM

DATE: January 28, 2008

TO: Group Insurance Board

FROM: Sharon Walk
Board Liaison

SUBJECT: Election of Officers

By statute, the Group Insurance Board must elect new officers at the first meeting of each calendar year. The current officers and the expiration dates of their terms on the Board are shown below.

Chair	Steve Frankel	5/1/09
Vice-Chair	Cindy O'Donnell	Ex Officio
Secretary	Esther Olson	5/1/09

It has been past practice for new officers to assume their duties effective immediately following the meeting at which they were elected.

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Enclosure/Roster

Reviewed and approved by Pamela Henning, Administrator, Division of Management Services.

_____ _____
Signature Date

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CORRESPONDENCE MEMORANDUM

DATE: January 15, 2008

TO: Group Insurance Board

FROM: Bill Kox, Director, Health Benefits & Insurance Plans
Joan Steele, Manager, Alternate Health Plans

SUBJECT: GUIDELINES/Uniform Benefits – Timeline and Discussion Regarding Contract Changes and Clarifications for Year 2009

In the past, a staff discussion group has developed recommendations for changes to the GUIDELINES and Uniform Benefits for the next contract year; recently, Board members or their designated staff have also participated. Should the Board wish to continue this process for contract year 2009, we are providing the following information on the expected issues and timelines for the development of the GUIDELINES.

The anticipated timeline for the 2009 contract is as follows:

- With the input of the Board's actuary, staff establishes preliminary recommendations for changes/clarifications for the 2009 contract year. The health plans have been asked to identify any issues that warrant clarification in the GUIDELINES or Uniform Benefits.
- On or about February 19, an Employee Trust Funds (ETF) staff discussion group will meet to identify issues to be included in the first draft of the GUIDELINES.
- On or about February 22, ETF will send health plans a draft of the 2009 GUIDELINES/ Administrative Provisions and Uniform Benefits. Health plans will have until February 29 to return their comments on the draft.
- On or about March 4, the discussion group will meet to finalize recommendations to the Board. The discussion group's deadline for finalizing its recommendations is March 26.
- The recommendations are set for approval at the Board's April 15 meeting.

<u>The following briefly summarizes several issues for the 2009 contract that may be reviewed during this process.</u> Participants, health plans or staff members have raised these issues over the course of the past year. We also welcome any comments or suggestions from the Board.

In addition, some items may have associated costs, while others are simply clarifications of existing practice (with no expected cost). Cost factors, if any, will be identified by the discussion group and presented to the Board in the final recommendation.

Reviewed and approved by Tom Korpady, Division of Insurance Services.

_____ _____
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Changes to the Guidelines/Administrative Provisions:

- Consider the availability of a Tier 2 State Maintenance Plan.
- Require health plans to incorporate ETF's pharmacy data into all aspects of disease management. Health plans will also be expected to fully incorporate pharmacy claims data into data reporting, including, but not limited to, HEDIS data, information requested on the disease management survey, and catastrophic claims data. Where appropriate, such as for catastrophic claims data, health plans will be expected to separate pharmacy claims from ETF's pharmacy benefit manager from any pharmacy claims that are paid by the health plan.
- Require health plans to submit an annual utilization report.
- Consider an employer's request to specify a minimum benefit level for the optional dental benefit in order to avoid a potential gap in coverage when services are not covered by the dental benefit or by the DentalBlue supplemental dental plan (e.g., diagnostic services).
- Limit the amount of the pharmacy portion of the premium reimbursed to health plans when health plans fail to notify the Department on a timely basis of direct pay contracts that have terminated.
- Specify that employers may not make premium adjustments in fraudulent situations.
- Revise the definition of "dependent" to comply with recent legislation that allows coverage to continue for up to one year for dependents who are full-time students and who require a medical leave of absence.
- Consider extending to annuitants the right to switch health plans when the policy lifetime maximum is met, or when adding a newly-eligible dependent per recent federal Health Insurance Portability and Accountability Act (HIPAA) regulations.
- Specify the effective date and handling of premium when switching health plans, as permitted by the recent HIPAA regulations.

Changes to the Local Contract:

- Consider adding a surcharge to local employers who have been unsuccessful in removing "opt-out" provisions from labor agreements that provide financial incentives to employees who decline coverage in this program.
- Discuss additional underwriting requirements.
- Consider requiring Medicare to be the primary payer for local employers with fewer than twenty employees.

Changes to Uniform Benefits:

- Consider the following benefit additions:
  - Increasing the benefit limit for hearing aids.
  - Removing the requirement for biofeedback to be provided by a physical therapist.
  - Provide coverage for marriage and couples counseling.
- Suggestions for ways to free up dollars if needed to offset benefit additions:
  - Implement a copayment for certain imaging services, such as magnetic resonance imaging (MRI) and computed tomography (CT) scans.
  - Increase pharmacy copayments.

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CORRESPONDENCE MEMORANDUM

DATE: January 23, 2008

TO: Group Insurance Board

FROM: Sonya Sidky, Project Manager
Division of Insurance Services

SUBJECT: 2008 Dual-Choice Enrollment Results

This memo highlights and explains major shifts in participant enrollment during the 2008 Dual-Choice enrollment period. **This report is for information only. No Board action is required.**

Attached are the 2008 Dual-Choice charts for total contracts, active state employees, state retirees and continuants, graduate assistants and continuants, and local employees, retirees and continuants. These charts provide December 2007 and January 2008 contract counts and the number of Dual-Choice applications that were filed by health plan. The number of contracts gained or lost by health plan is broken down by coverage type (single and family). The percentage change in total contracts for each plan is included.

The change in contract counts from December 2007 to January 2008 is largely a result of subscribers changing health plans during the Dual-Choice enrollment period. However these numbers also reflect other changes, such as health insurance cancellations and new coverage.

Approximately 5,772 applications were submitted during the Dual-Choice enrollment period, of which 5,264 switched health plans and 736 switched coverage types. The break down by employee type is as follows:

Active state employees accounted for 53.6% (3,093) of the applications.
State retirees and continuants accounted for 16.7% (962) of the applications.
Local employees, retirees and continuants accounted for 27.3% (1,578) of the applications.
Graduate assistants and continuants accounted for 2.4% (139) of the applications.

There were 39% fewer Dual-Choice applications submitted for 2008 (5,772) than there were for 2007 (9,528). There were 736 family type changes, of which 500 remained in the same health plan. Although nearly twice as many Dual-Choice applications were submitted for 2007 than for 2008, about half of all Dual-Choice applications submitted for 2007 were filed because subscribers had to switch health plans. The loss of the CompcareBlue Aurora Family plan in 2007 accounted for 1,590 Dual-Choice updates and the introduction of Security Health Plan in 2007 accounted for 3,260 Dual-Choice selections. This means that there were about the same number of applications filed for 2007 and for 2008, based on subscribers who had a choice.

Reviewed and approved by Tom Korpady, Division of Insurance Services.

_____ _____
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CHANGES IN HEALTH PLANS

There are no health plan changes from 2007 to 2008. Note that Arise Health Plan was formerly known as WPS Prevea Health Plan; Anthem BCBS Northwest was formerly known as CompcareBlue Northwest; and Anthem BCBS Southeast was formerly known as CompcareBlue Southeast.

TIERING CHANGE FROM 2007 TO 2008

Humana-Western changed from a Tier-2 health plan in 2007 to a Tier-1 health plan in 2008. With the goal of lowering its provider cost structure in the western region of the state, Humana-Western ended its Health Maintenance Organization (HMO) contract with PreferredOne, and replaced it with a proprietary HMO network. Despite the move to Tier-1, Humana-Western lost 57.4% of its contracts because of the change in providers. This was not entirely unexpected, because Humana had estimated that approximately 60% of Humana-Western membership would be affected by the changes. Although Humana-Western did gain some contracts by becoming a Tier-1 health plan, it did not gain nearly enough contracts (86) to make up for the contracts it lost (1,324). Most subscribers switching out of Humana-Western chose GHC-Eau Claire.

FAMILY TYPE CHANGES AND HEALTH INSURANCE CANCELLATIONS

Of the 5,772 Dual-Choice applications filed, 736 (8%) included coverage level changes. There were slightly more subscribers who increased their level of coverage from single to family (424) than there were subscribers who decreased coverage from family to single (293). There were 307 subscribers who decided to cancel their health insurance coverage effective 12/31/2007.

HEALTH MAINTENANCE ORGANIZATIONS (HMO) CONTRACTS GAINED AND LOST

Major contract gainers include:

- GHC-Eau Claire had a net increase of 1,105 contracts (26.3%). The majority of the contracts came from Humana-Western (1,038).
- Unity-Community had a net gain of 678 contracts, which represents a 43.0% increase. Most gains came from Physicians Plus (396), Mercycare (210), and Dean Health Plan (74) participants.

Major contract losers include:

- Humana-Western had a net decrease of 1,324 contracts (57.4%). The majority of contracts were lost to GHC-Eau Claire (1,038), the Standard Plan (220), and Anthem BCBS Northwest (113).
- Physicians Plus had a net decrease of 540 contracts (4.9%). The majority of contracts were lost to Unity-Community (396).
- Mercycare had a net decrease of 192 contracts (21.8%). There were 210 contracts lost to Unity-Community.
- The State Maintenance Plan (SMP) had a net decrease of 146 contracts (65.5%). Contracts were lost to several health plans, including Arise Health Plan (40), Humana-Western (40), UnitedHealthcare NE (36), and GHC-Eau Claire (23).

CONTRACT SHIFTS BETWEEN HEALTH PLANS

Of the 5,264 contract shifts between plans, the major shifts were as follows:

- 1,038 switched from Humana-Western to GHC-Eau Claire (638 are active state contracts; 333 are retirees and continuant contracts).
- 396 switched from Physicians Plus to Unity-Community (379 are local contracts).
- 220 switched from Humana-Western to the Standard Plan (138 are active state contracts).
- 210 switched from Mercycare to Unity-Community (204 are local contracts).
- 204 switched from Dean to Humana-Eastern (174 are active state contracts).
- 162 switched from Physicians Plus to Dean Health Plan (125 are local contracts).
- 157 switched from Anthem BCBS Southeast to Humana-Eastern (111 are local contracts).
- 113 switched from Humana-Western to Anthem BCBS Northwest (91 are active state contracts).
- 103 switched from Dean Health Plan to Anthem BCBS Southeast (86 are active state contracts).
- 103 switched from Humana-Eastern to UnitedHealthcare SE (75 are local contracts).

SOUTHERN WISCONSIN

In the Southern region, there were 1,783 applications submitted, with 1,514 subscribers switching health plans. The major shifts were as follows:

- 337 switched from Physicians Plus to Unity-Community.
- 152 switched from Mercycare to Unity-Community
- 94 switched from Dean to Unity-UW.
- 91 switched from Physicians Plus to Dean.

There were more Dual-Choice applications filed by local employees, retirees, and continuants (816) in Southern Wisconsin than there were for active state employees (758), state retirees and continuants (124), and graduate assistants and continuants (85).

In 2007, the Unity-Community premium for locals ($405.80) was more expensive than the premium for Physicians Plus ($386.20) and Mercycare ($368.50). Once again, Unity-Community ($412.10) replaces Physician Plus ($434.40) as the low-cost plan in Adams, Columbia, Grant, Green, Iowa, Richland, and Sauk Counties and replaces Mercycare ($435.60) as the low cost health plan in Rock and Jefferson Counties.

SOUTHEASTERN WISCONSIN

In the Southeastern region, there were 1,425 applications submitted, with 1,351 subscribers switching health plans. The major shifts were as follows:

- 191 switched from Dean Health Plan to Humana-Eastern.
- 154 switched from Anthem BCBS Southeast to Humana-Eastern.
- 103 switched from Humana-Eastern to UnitedHealthcare SE.
- 99 switched from Dean Health Plan to Anthem BCBS Southeast.

There were more Dual-Choice applications filed by active state employees (774) than by local employees, retirees, and continuants (448), state retirees and continuants (162), and graduate assistant and continuants (41).

Dean Health Plan lost contracts as a result of losing providers such as the Delavan Clinic in Delavan, the Internal Medicine and Pediatrics Clinic in Whitewater, the Aurora Lakeland Medical Center in Elkhorn, the Aurora Rehabilitation Hospital in Delavan, and the Aurora Health Center in Lake Geneva.

Although most of Humana-Eastern's expansion is in Northeastern Wisconsin, Humana-Eastern also increased its providers in Southeastern Wisconsin, newly becoming qualified in Racine County for 2008. This may help explain the shifts to Humana-Eastern. For locals, Humana-Eastern became more expensive (from $659.70 in 2007 to $795.40 in 2008; increase=$135.70), compared to UnitedHealthcare SE (from $555.70 in 2007 to $597.50 in 2008; increase=$41.80) and thus lost 75 local contracts to UnitedHealthcare SE.

NORTHEASTERN WISCONSIN
In the Northeastern region, there were 549 applications submitted, with 482 subscribers switching health plans. The major shifts were as follows:

- 66 switched from UnitedHealthcare NE to Network Health Plan.
- 61 switched from Arise Health Plan to Network Health Plan.
- 44 switched from UnitedHealthcare NE to Humana-Eastern.
- 36 switched from SMP to Arise Health Plan.
- 34 switched from SMP to UnitedHealthcare NE.
- 32 switched from UnitedHealthcare NE to Arise Health Plan.

There were more Dual-Choice applications filed by active state employees (332) than by local employees, retirees, and continuants (125), state retirees and continuants (92), and graduate assistant and continuants (0).

Network Health Plan gained contracts because it expanded its presence into Northeastern Wisconsin, newly qualifying in Brown and Door Counties. In Brown County, Network Health Plan added the Prevea Clinic in DePere and Green Bay, and the St. Mary's and St. Vincent hospitals in Green Bay. In Door County, Network Health Plan added the North Shore Medical Clinic and the Door County Memorial Hospital in Sturgeon Bay. SMP is no longer available in Marinette County for 2008 in the state and local programs, which explains the shift in contracts from SMP into Arise Health Plan and UnitedHealthcare NE, which are the qualified health plans in Marinette County. Arise Health Plan began offering dental in 2008, which may also explain why it gained contracts from SMP.

WESTERN WISCONSIN
In the Western region, there were 1,590 applications submitted with 1,528 subscribers switching health plans. The major shifts were as follows:

- 993 switched from Humana-Western to GHC-Eau Claire.
- 124 switched from Humana-Western to the Standard Plan.
- 104 switched from Humana-Western to Anthem BCBS Northwest.

Although there were more Dual-Choice applications filed by active state employees (957) than by state retirees and continuants (486), the Western region accounted for the highest proportion (51%) of Dual-Choice applications filed by state retirees and continuants. There were 142 Dual-Choice applications submitted by local employees, retirees, and continuants and 5 Dual-Choice applications submitted by graduate assistants and continuants.

As discussed at the beginning of this memo, Humana-Western lowered its cost structure for 2008 by eliminating high-cost providers such as the Mayo Clinic. As a result of the network changes, Humana-Western lost qualification status in Barron, Dunn, Pepin and Polk Counties and lost qualification and presence in Buffalo, Burnett, LaCrosse, Monroe, Trempealeau, and Washburn Counties. Furthermore, Humana-Western will no longer have out-of-state providers available, except

on a referral basis to the Allina System in Minneapolis. GHC-Eau Claire, a health plan that has gained contracts from Humana-Western over the last couple of years, gained the majority of the contracts because it is Tier-1 health plan that covers much of the Humana-Western service area. Although Humana-Western only slightly increased its premium for state retirees and continuants from 2007 to 2008, GHC-Eau Claire continues to be slightly cheaper than Humana-Western. Subscribers living near the border of Wisconsin and Minnesota may have elected Anthem BCBS Northwest or the Standard Plan for better access to Minnesota providers than is available through Humana-Western or GHC-Eau Claire.

NORTHERN WISCONSIN
In the Northern region there were 200 applications submitted, with 177 switching health plans. The major shifts were as follows:

- 55 switched from Security Health Plan to Arise Health Plan.
- 22 switched from Security Health Plan to the Standard Plan.
- 21 switched from SMP to GHC-Eau Claire.

There were more Dual-Choice applications filed by active state employees (113) than by state retirees and continuants (52), local employees, retirees and continuants (33), and graduate assistant and continuants (2).

Arise Health Plan may have gained contracts as a result of adding dental for 2008 and adding the Aspiris Network to more directly compete with Security Health Plan.

OUT-OF-STATE
There were 225 applications submitted by out-of-state subscribers, with 212 subscribers switching health plans.

- 96 switched from Humana-Western to the Standard Plan.
- 43 switched from Humana-Western to GHC-Eau Claire.

There were more Dual-Choice applications filed by active state employees (159) than by state retirees and continuants (46), local employees, retirees and continuants (14), and graduate assistant and continuants (6).

The explanation for the contract shifts from Humana-Western to the Standard Plan and GHC-Eau Claire may be due to the fact that subscribers living in Minnesota do not have access to the Mayo Clinic through Humana-Western in 2008.

Attachments:
Table 1: 2008 Dual-Choice Statistics All Contracts: New Coverage, Old Coverage and Net Change in Contracts by Health Plan

Table 2: 2008 Dual-Choice Statistics—Active State Employees

Table 3: 2008 Dual-Choice Statistics—Local Employees, Retirees and Continuants

Table 4: 2008 Dual-Choice Statistics—Graduate Assistants and Continuants

Table 5: 2008 Dual-Choice Statistics—State Retirees and Continuants

Table 1: 2008 Dual-Choice Statistics All Contracts: New Coverage, Old Coverage and Net Change in Contracts by Health Plan

NEW COVERAGE	SINGLE	FAMILY	GRAD SINGLE	GRAD FAMILY	MED SINGLE	MED FAMILY 1	MED FAMILY 2	Total
ANTHEM BCBS NORTHWEST	29	91	0	0	0	3	0	123
ANTHEM BCBS SOUTHEAST	46	109	7	3	5	2	4	176
ARISE HEALTH PLAN	50	100	0	0	0	2	1	153
DEAN HEALTH PLAN	173	271	4	3	6	4	5	466
GHC-EAU CLAIRE	300	640	1	2	97	55	99	1,194
GHC-SCW	43	62	18	13	3	1	0	140
GUNDERSEN LUTHERAN HEALTH PLAN	32	72	0	0	5	1	2	112
HEALTH TRADITION	20	42	1	0	0	0	0	63
HUMANA-EASTERN	161	316	9	13	56	23	55	633
HUMANA-WESTERN	24	46	0	0	13	6	10	99
MEDICAL ASSOCIATES HEALTH PLAN	3	8	0	0	0	0	0	11
MERCYCARE HEALTH PLAN	23	40	0	0	1	1	0	65
NETWORK HEALTH PLAN	57	123	0	0	3	5	4	192
PHYSICIANS PLUS MERITER & UW	70	144	6	8	9	3	4	244
SECURITY HEALTH PLAN	31	53	2	0	9	4	2	101
SMP	1	1	0	0	0	2	0	4
SMP (LOCAL)	4	3	0	0	0	0	0	7
STANDARD PLAN	93	136	5	5	59	17	87	402
STANDARD PLAN DANE (LOCAL)	1	2	0	0	0	0	1	4
STANDARD PLAN MILWAUKEE (LOCAL)	0	0	0	0	1	0	0	1
STANDARD WISCONSIN (LOCAL)	1	1	0	0	2	0	3	7
STANDARD - WAUKESHA (LOCAL)	0	0	0	0	0	0	0	0
STANDARD WISCONSIN PPP	0	0	0	0	0	0	0	0
UNITEDHEALTHCARE NE	47	98	0	0	2	2	1	150
UNITEDHEALTHCARE SE	106	196	1	0	4	2	3	312
UNITY-COMMUNITY	148	575	0	3	3	4	1	734
UNITY-UW HEALTH	94	187	14	15	1	3	1	315
WPS PATIENT CHOICE PLAN 1	9	29	3	2	2	0	0	45
WPS PATIENT CHOICE PLAN 2	8	9	0	1	1	0	0	19
TOTAL CONTRACTS GAINED	**1,574**	**3,354**	**71**	**68**	**282**	**140**	**283**	**5,772**

**Note that the net change in contracts only refers to dual-choices (excludes new coverage and cancellations), therefore the net change in contracts added to the December counts will not add up to the January counts.*

Table 1: 2008 Dual-Choice Statistics All Contracts: New Coverage, Old Coverage and Net Change in Contracts by Health Plan

OLD COVERAGE	SINGLE	FAMILY	GRAD SINGLE	GRAD FAMILY	MED SINGLE	MED FAMILY 1	MED FAMILY 2	Total
ANTHEM BCBS NORTHWEST	18	39	0	0	9	4	9	79
ANTHEM BCBS SOUTHEAST	84	124	6	3	20	8	12	257
ARISE HEALTH PLAN	19	56	0	1	1	3	2	82
DEAN HEALTH PLAN	247	556	9	5	37	10	24	888
GHC EAU CLAIRE	23	44	0	0	9	6	7	89
GHC-SCW	50	51	20	10	4	0	0	135
GUNDERSEN LUTHERAN HEALTH PLAN	11	18	0	0	0	1	0	30
HEALTH TRADITION	28	56	0	0	5	3	1	93
HUMANA EASTERN	79	149	5	1	7	1	2	244
HUMANA WESTERN	344	754	2	5	122	60	136	1423
MEDICAL ASSOCIATES HEALTH PLAN	4	20	0	0	0	0	0	24
MERCYCARE HEALTH PLAN	51	204	0	0	0	2	0	257
NETWORK HEALTH PLAN	30	62	0	0	7	1	9	109
PHYSICIANS PLUS MERITER & UW	183	562	11	2	11	5	10	784
SECURITY HEALTH PLAN	45	66	0	1	7	10	11	140
SMP	36	110	0	0	0	4	0	150
SMP (LOCAL)	0	0	0	0	0	0	0	0
STANDARD PLAN	192	88	30	5	18	5	10	348
STANDARD PLAN DANE (LOCAL)	2	0	0	0	0	0	0	2
STANDARD PLAN MILWAUKEE (LOCAL)	2	0	0	0	0	0	1	3
STANDARD WISCONSIN (LOCAL)	5	2	0	0	0	0	1	8
STANDARD - WAUKESHA (LOCAL)	0	0	0	0	0	0	0	0
STANDARD WISCONSIN PPP	0	1	0	0	0	0	0	1
UNITEDHEALTHCARE NE	56	108	0	0	12	5	21	202
UNITEDHEALTHCARE SE	24	34	0	0	14	11	10	93
UNITY COMMUNITY	20	33	0	0	1	1	1	56
UNITY UW HEALTH	86	102	17	4	6	2	8	225
WPS PATIENT CHOICE PLAN 1	8	23	1	2	0	0	0	34
WPS PATIENT CHOICE PLAN 2	2	14	0	0	0	0	0	16
TOTAL CONTRACTS LOST	**1649**	**3276**	**101**	**39**	**290**	**142**	**275**	**5772**

**Note that the net change in contracts only refers to dual-choices (excludes new coverage and cancellations), therefore the net change in contracts added to the December counts will not add up to the January counts.*

Table 1: 2008 Dual-Choice Statistics All Contracts: New Coverage, Old Coverage and Net Change in Contracts by Health Plan

NET CHANGE	SINGLE	FAMILY	GRAD SINGLE	GRAD FAMILY	MED SINGLE	MED FAMILY 1	MED FAMILY 2	Total	DEC 2007 CONTRACTS*	JAN 2008 CONTRACTS
ANTHEM BCBS NORTHWEST	11	52	0	0	-9	-1	-9	44	449	467
ANTHEM BCBS SOUTHEAST	-38	-15	1	0	-15	-6	-8	-81	2482	2356
ARISE HEALTH PLAN	31	44	0	-1	-1	-1	-1	71	778	855
DEAN HEALTH PLAN	-74	-285	-5	-2	-31	-6	-19	-422	23074	22716
GHC EAU CLAIRE	277	596	1	2	88	49	92	1105	4204	5440
GHC-SCW	-7	11	-2	3	-1	1	0	5	8407	8402
GUNDERSEN LUTHERAN HEALTH PLAN	21	54	0	0	5	0	2	82	2203	2341
HEALTH TRADITION	-8	-14	1	0	-5	-3	-1	-30	2105	2029
HUMANA EASTERN	82	167	4	12	49	22	53	389	7104	7711
HUMANA WESTERN	-320	-708	-2	-5	-109	-54	-126	-1324	2305	914
MEDICAL ASSOCIATES HEALTH PLAN	-1	-12	0	0	0	0	0	-13	485	478
MERCYCARE HEALTH PLAN	-28	-164	0	0	1	-1	0	-192	882	701
NETWORK HEALTH PLAN	27	61	0	0	-4	4	-5	83	4586	4719
PHYSICIANS PLUS MERITER & UW	-113	-418	-5	6	-2	-2	-6	-540	11116	10778
SECURITY HEALTH PLAN	-14	-13	2	-1	2	-6	-9	-39	3436	3525
SMP	-35	-109	0	0	0	-2	0	-146	223	71
SMP (LOCAL)	0	0	0	0	0	0	0	0	13	20
STANDARD PLAN	-188	-85	-30	-5	-18	-5	-10	-341	9307	9368
STANDARD PLAN DANE (LOCAL)	91	136	5	5	59	17	87	400	42	48
STANDARD PLAN MILWAUKEE (LOCAL)	-1	2	0	0	0	0	0	1	97	98
STANDARD WISCONSIN (LOCAL)	-5	-2	0	0	1	0	-1	-7	90	90
STANDARD - WAUKESHA (LOCAL)	0	0	0	0	0	0	0	0	17	17
STANDARD WISCONSIN PPP	1	0	0	0	2	0	3	6	0	1
UNITEDHEALTHCARE NE	-9	-10	0	0	-10	-3	-20	-52	4485	4554
UNITEDHEALTHCARE SE	82	162	1	0	-10	-9	-7	219	2075	2456
UNITY COMMUNITY	128	542	0	3	2	3	0	678	1588	2330
UNITY UW HEALTH	8	85	-3	11	-5	1	-7	90	12527	12848
WPS PATIENT CHOICE PLAN 1	1	6	2	0	2	0	0	11	323	366
WPS PATIENT CHOICE PLAN 2	6	-5	0	1	1	0	0	3	74	91
TOTAL NET CHANGE	**-75**	**78**	**-30**	**29**	**-8**	**-2**	**8**	**0**	**261**	**309**

**Note that the net change in contracts only refers to dual-choices (excludes new coverage and cancellations), therefore the net change in contracts added to the December counts will not add up to the January counts.*

Table 2: 2008 Dual-Choice Statistics--Active State Employees

HEALTH PLAN	ADDITIONS		DELETIONS		NET CHANGE		TOTAL NET CHANGE	DEC 2007 CONTRACTS*	JAN 2008 CONTRACTS	PERCENT CHANGE (due to dual-choices)
	SINGLE	FAMILY	SINGLE	FAMILY	SINGLE	FAMILY				
ANTHEM BCBS NORTHWEST	26	72	10	25	16	47	63	182	230	**35%**
ANTHEM BCBS SOUTHEAST	39	107	63	93	-24	14	-10	1,834	1,830	**-1%**
ARISE HEALTH PLAN	32	77	6	9	26	68	94	423	514	**22%**
DEAN HEALTH PLAN	99	112	165	414	-66	-302	-368	14,043	13,580	**-3%**
GHC-EAU CLAIRE	217	537	20	28	197	509	706	3,259	4,033	**22%**
GHC-SCW	29	41	34	37	-5	4	-1	3,645	3,671	**0%**
GUNDERSEN LUTHERAN HEALTH PL	22	36	5	12	17	24	41	1,220	1,300	**3%**
HEALTH TRADITION	8	16	19	38	-11	-22	-33	1,286	1,236	**-3%**
HUMANA-EASTERN	149	309	47	85	102	224	326	5,761	6,176	**6%**
HUMANA-WESTERN	20	41	260	626	-240	-585	-825	1,428	556	**-58%**
MEDICAL ASSOCIATES HEALTH PLA	1	5	3	18	-2	-13	-15	359	347	**-4%**
MERCYCARE HEALTH PLAN	9	8	7	18	2	-10	-8	441	433	**-2%**
NETWORK HEALTH PLAN	26	40	27	57	-1	-17	-18	3,709	3,680	**0%**
PHYSICIANS PLUS MERITER & UW	50	121	50	102	0	19	19	6,199	6,264	**0%**
SECURITY HEALTH PLAN	22	48	24	41	-2	7	5	2,776	2,853	**0%**
SMP	0	0	31	106	-31	-106	-137	183	47	**-75%**
STANDARD PLAN	75	127	182	82	-107	45	-62	1,361	1,379	**-5%**
UNITEDHEALTHCARE NE	37	80	30	71	7	9	16	3,061	3,149	**1%**
UNITEDHEALTHCARE SE	39	81	14	21	25	60	85	462	629	**18%**
UNITY-COMMUNITY	15	50	10	12	5	38	43	416	481	**10%**
UNITY-UW HEALTH	73	148	68	83	5	65	70	8,654	8,747	**1%**
WPS PATIENT CHOICE PLAN 1	6	29	5	19	1	10	11	262	286	**4%**
WPS PATIENT CHOICE PLAN 2	7	7	2	14	5	-7	-2	59	63	**-3%**
TOTAL	**1,001**	**2,092**	**1,081**	**2,011**	**-80**	**81**	**1**	**61,023**	**61,484**	**0%**

***Note that the net change in contracts only refers to dual-choices (excludes new coverage and cancellations), therefore the net change in contracts added to the December counts will not add up to the January counts.*

Table 3: 2008 Dual Choice Statistics--Local Employees, Retirees, and Continuants

	ADDITIONS					DELETIONS					NET CHANGE					TOTAL NET CHANGE	DEC 2007 CONTRACTS*	JAN 2008 CONTRACTS	PERCENT CHANGE
	SGL	FML	MED SGL	MED FML 1	MED FML 2	SGL	FML	MED SGL	MED FML 1	MED FML 2	SGL	FML	MED SGL	MED FML 1	MED FML 2				(due to dual-choices)
ANTHEM BCBS NORTHWEST	1	17	0	0	0	3	8	0	0	0	-2	9	0	0	0	7	46	50	**15%**
ANTHEM BCBS SOUTHEAST	1	0	0	0	0	15	25	3	0	0	-14	-25	-3	0	0	-42	73	26	**-58%**
ARISE HEALTH PLAN	10	15	0	0	0	11	43	0	0	0	-1	-28	0	0	0	-29	108	79	**-27%**
DEAN HEALTH PLAN	67	155	0	0	1	62	127	4	2	1	5	28	-4	-2	0	27	3,946	4,057	**1%**
GHC-EAU CLAIRE	24	52	2	0	2	2	14	0	0	0	22	38	2	0	2	64	306	371	**21%**
GHC-SCW	11	21	0	1	0	14	12	0	0	0	-3	9	0	1	0	7	809	833	**1%**
GUNDERSEN LUTHERAN HEALTH PLAN	10	31	0	0	1	4	4	0	1	0	6	27	0	-1	1	33	474	510	**7%**
HEALTH TRADITION	11	26	0	0	0	9	16	0	0	1	2	10	0	0	-1	11	547	551	**2%**
HUMANA-EASTERN	1	0	7	1	5	28	61	1	0	1	-27	-61	6	1	4	-77	240	157	**-32%**
HUMANA-WESTERN	2	5	0	0	0	22	73	3	1	4	-20	-68	-3	-1	-4	-96	262	154	**-37%**
MEDICAL ASSOCIATES HEALTH PLAN	0	2	0	0	0	1	2	0	0	0	-1	0	0	0	0	-1	28	29	**-4%**
MERCYCARE HEALTH PLAN	12	29	0	0	0	44	186	0	2	0	-32	-157	0	-2	0	-191	355	173	**-54%**
NETWORK HEALTH PLAN	26	75	0	0	0	1	2	0	0	0	25	73	0	0	0	98	277	410	**35%**
PHYSICIANS PLUS MERITER & UW	10	19	0	0	1	130	454	2	2	1	-120	-435	-2	-2	0	-559	1,893	1,360	**-30%**
SECURITY HEALTH PLAN	0	0	0	0	0	8	16	0	0	0	-8	-16	0	0	0	-24	65	41	**-37%**
SMP (LOCAL)	4	3	0	0	0	0	0	0	0	0	4	3	0	0	0	7	13	20	**54%**
STANDARD - WAUKESHA (LOCAL)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	17	17	**0%**
STANDARD PLAN DANE (LOCAL)	1	2	0	0	1	2	0	0	0	0	-1	2	0	0	1	2	42	48	**5%**
STANDARD PLAN MILWAUKEE (LOCAL)	0	0	1	0	0	2	0	0	0	1	-2	0	1	0	-1	-2	97	98	**-2%**
STANDARD WISCONSIN (LOCAL)	1	1	2	0	3	5	2	0	0	1	-4	-1	2	0	2	-1	90	90	**-1%**
STANDARD WISCONSIN PPP	0	0	0	0	0	0	1	0	0	0	0	-1	0	0	0	-1	0	1	**NA**
UNITEDHEALTHCARE NE	3	13	0	0	0	21	30	1	0	0	-18	-17	-1	0	0	-36	606	587	**-6%**
UNITEDHEALTHCARE SE	63	110	1	0	1	7	13	3	0	3	56	97	-2	0	-2	149	1,491	1,687	**10%**
UNITY-COMMUNITY	133	524	2	4	1	8	20	0	1	0	125	504	2	3	1	635	1,098	1,774	**58%**
UNITY-UW HEALTH	14	35	0	1	0	11	13	0	0	0	3	22	0	1	0	26	616	657	**4%**
WPS PATIENT CHOICE PLAN 1	0	0	0	0	0	3	4	0	0	0	-3	-4	0	0	0	-7	8	1	**-88%**
TOTAL	**405**	**1,135**	**15**	**7**	**16**	**413**	**1,126**	**17**	**9**	**13**	**-8**	**9**	**-2**	**-2**	**3**	**0**	**13,507**	**13,781**	**0%**

**Note that the net change in contracts only refers to dual-choices (excludes new coverage and cancellations), therefore the net change in contracts added to the December counts will not add up to the January counts.*

Table 4: 2008 Dual Choice Statistics--Graduate Assistants and Continuants

HEALTH PLAN	ADDITIONS		DELETIONS		NET CHANGE		TOTAL NET CHANGE	DEC 2007 CONTRACTS*	JAN 2008 CONTRACTS	PERCENT CHANGE (due to dual-choices)
	SINGLE	FAMILY	SINGLE	FAMILY	SINGLE	FAMILY				
ANTHEM BCBS NORTHWEST	0	0	0	0	0	0	0	4	0	**0%**
ANTHEM BCBS SOUTHEAST	7	3	6	3	1	0	1	295	245	**0%**
ARISE HEALTH PLAN	0	0	0	1	0	-1	-1	5	3	**-20%**
DEAN HEALTH PLAN	4	3	9	5	-5	-2	-7	809	812	**-1%**
GHC-EAU CLAIRE	1	2	0	0	1	2	3	73	86	**4%**
GHC-SCW	18	13	20	10	-2	3	1	3,403	3,321	**0%**
GUNDERSEN LUTHERAN	0	0	0	0	0	0	0	26	37	**0%**
HEALTH TRADITION	1	0	0	0	1	0	1	62	39	**2%**
HUMANA-EASTERN	9	13	5	1	4	12	16	485	587	**3%**
HUMANA-WESTERN	0	0	2	5	-2	-5	-7	27	12	**-26%**
MEDICAL ASSOCIATES	0	0	0	0	0	0	0	11	8	**0%**
MERCYCARE	0	0	0	0	0	0	0	13	11	**0%**
NETWORK HEALTH PLAN	0	0	0	0	0	0	0	51	35	**0%**
PHYSICIANS PLUS MERITER & UW	6	8	11	2	-5	6	1	621	713	**0%**
SECURITY HEALTH PLAN	2	0	0	1	2	-1	1	64	70	**2%**
SMP	0	0	0	0	0	0	0	1	3	**0%**
STANDARD PLAN	5	5	30	5	-25	0	-25	249	252	**-10%**
UNITEDHEALTHCARE - NORTHEAST	0	0	0	0	0	0	0	31	40	**0%**
UNITEDHEALTHCARE SE	1	0			1	0	1	27	52	**4%**
UNITY-COMMUNITY	0	3			0	3	3	7	10	**43%**
UNITY-UW HEALTH	14	15	16	4	-2	11	9	1,653	1,789	**1%**
WPS PATIENT CHOICE PLAN 1	3	2	1	2	2	0	2	39	54	**5%**
WPS PATIENT CHOICE PLAN 2	0	1			0	1	1	11	20	**9%**
TOTAL	**71**	**68**	**100**	**39**	**-29**	**29**	**0**	**7,967**	**8,199**	**0%**

**Note that the net change in contracts only refers to dual-choices (excludes new coverage and cancellations), therefore the net change in contracts added to the December counts will not add up to the January counts.*

Table 5: 2008 Dual Choice Statistics--State Retirees and Continuants

	ADDITIONS					DELETIONS					NET CHANGE					TOTAL NET CHANGE	DEC 2007 CONTRACTS*	JAN 2008 CONTRACTS	PERCENT CHANGE
	SGL	FML	MED SGL	MED FML1	MED FML 2	SGL	FML	MED SGL	MED FML1	MED FML 2	SGL	FML	MED SGL	MED FML1	MED FML 2				(due to dual-choices)
ANTHEM BCBS NORTHWEST	2	2	0	3	0	5	6	9	4	9	-3	-4	-9	-1	-9	-26	217	187	**-12%**
ANTHEM BCBS SOUTHEAST	6	2	5	2	4	6	6	17	8	12	0	-4	-12	-6	-8	-30	280	255	**-11%**
ARISE HEALTH PLAN	8	8	0	2	1	2	4	1	3	2	6	4	-1	-1	-1	7	242	259	**3%**
DEAN HEALTH PLAN	7	4	6	4	4	20	15	33	8	23	-13	-11	-27	-4	-19	-74	4,276	4,267	**-2%**
GHC-EAU CLAIRE	59	51	95	55	97	1	2	9	6	7	58	49	86	49	90	332	566	950	**59%**
GHC-SCW	3	0	3	0	0	2	2	4	0	0	1	-2	-1	0	0	-2	550	577	**0%**
GUNDERSEN LUTHERAN HEALTH	0	5	5	1	1	2	2	0	0	0	-2	3	5	1	1	8	483	494	**2%**
HEALTH TRADITION	1	0	0	0	0	0	2	5	3	0	1	-2	-5	-3	0	-9	210	203	**-4%**
HUMANA-EASTERN	11	7	49	22	50	4	3	6	1	1	7	4	43	21	49	124	618	791	**20%**
HUMANA-WESTERN	2	0	13	6	10	62	55	119	59	132	-60	-55	-106	-53	-122	-396	588	192	**-67%**
MEDICAL ASSOCIATES HEALTH F	2	1	0	0	0	0	0	0	0	0	2	1	0	0	0	3	87	94	**3%**
MERCYCARE HEALTH PLAN	2	3	1	1	0	0	0	0	0	0	2	3	1	1	0	7	73	84	**10%**
NETWORK HEALTH PLAN	5	8	3	5	4	2	3	7	1	9	3	5	-4	4	-5	3	549	594	**1%**
PHYSICIANS PLUS MERITER & UV	10	4	9	3	3	3	6	9	3	9	7	-2	0	0	-6	-1	2,403	2,441	**0%**
SECURITY HEALTH PLAN	9	5	9	4	2	13	9	7	10	11	-4	-4	2	-6	-9	-21	531	561	**-4%**
SMP	1	1	0	2	0	5	4	0	4	0	-4	-3	0	-2	0	-9	39	21	**-23%**
STANDARD PLAN	18	9	59	17	87	10	6	18	5	10	8	3	41	12	77	141	7,697	7,737	**2%**
UNITEDHEALTHCARE NE	7	5	2	2	1	5	7	11	5	21	2	-2	-9	-3	-20	-32	787	778	**-4%**
UNITEDHEALTHCARE SE	4	5	3	2	2	3	0	11	11	7	1	5	-8	-9	-5	-16	95	88	**-17%**
UNITY-COMMUNITY	0	1	1	0	0	2	1	1	0	1	-2	0	0	0	-1	-3	67	65	**-4%**
UNITY-UW HEALTH	7	4	1	2	1	8	6	6	2	8	-1	-2	-5	0	-7	-15	1,604	1,655	**-1%**
WPS PATIENT CHOICE PLAN 1	3	0	2	0	0	0	0	0	0	0	3	0	2	0	0	5	14	25	**36%**
WPS PATIENT CHOICE PLAN 2	1	2	1	0	0	0	0	0	0	0	1	2	1	0	0	4	4	8	**100%**
TOTAL	**168**	**127**	**267**	**133**	**267**	**155**	**139**	**273**	**133**	**262**	**13**	**-12**	**-6**	**0**	**5**	**0**	**21,980**	**22,326**	**0%**

**Note that the net change in contracts only refers to dual-choices (excludes new coverage and cancellations), therefore the net change in contracts added to the December counts will not add up to the January counts.*

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CORRESPONDENCE MEMORANDUM

DATE: January 24, 2008

TO: Group Insurance Board

FROM: Sonya Sidky, Project Manager
Health Benefits and Insurance Plans

SUBJECT: HEDIS® and CAHPS® Performance in 2006

This informational piece does not require Board action.

Each year, the Board is presented with a summary of health plan quality data. The following report is an analysis of:

- The Healthcare Effectiveness Data and Information Set (HEDIS®) submitted by the participating Health Maintenance Organizations (HMOs) to the Department of Employee Trust Funds (ETF).
- The Consumer Assessment of Healthcare Providers and Systems (CAHPS®) data collected by ETF through Internet and mail surveys.
- The 2007 Disease Management Survey Results collected by ETF from all participating health plans.

How this Report is Structured

This report includes a brief summary of health plan performance on HEDIS®, CAHPS®, and the disease management survey. In-depth descriptions of these quality indicators and results for measures examined for this study are available in the attached report, *2006 Detailed HEDIS® and CAHPS® Results*. The report includes several appendixes, which display summary statistics and results by health plan.

HEDIS® Description

HEDIS®, the most widely used set of performance measures in the managed care industry, is developed and maintained by the National Committee for Quality Assurance (NCQA), a not-for-profit organization. The purpose of HEDIS® is to improve upon the quality of care provided by organized delivery systems by providing measures designed to increase accountability of managed care.

CAHPS® Description

The CAHPS® survey was developed collaboratively by several leading health care research organizations such as the Agency for Health Care Policy and Research (AHRQ), the Harvard Medical School, RAND, Research Triangle Institute and Westat. Each year, ETF contracts with a vendor to survey state employees and retirees about their experiences with their health plans.

Reviewed and approved by Tom Korpady, Division of Insurance Services.

_____ _____
Signature Date

Board	Mtg Date	Item #
GIB	02/12/2008	3

A New Tool for Assessing Quality

New this year is a discussion of ETF's efforts to make health plans more accountable for managing health care. This was achieved by asking health plans to respond to a disease management survey and answer questions about HEDIS® and CAHPS® deficiencies. Health plans that could demonstrate they were actively measuring and managing care for chronic conditions tended to have higher HEDIS® and CAHPS® scores. Although ETF is just beginning to examine how health plans manage care and track data, it is clear this approach adds an important tool to better understand why certain health plans perform better than others. Appendix #1 of the attached report includes a brief summary by health plan.

How HEDIS® and CAHPS® Results were Used

Once again, HEDIS® and CAHPS® results were used to give credit to high-performing HMO health plans during the negotiation process. The top performing health plans were GHC-SCW, Network Health Plan and GHC-Eau Claire. The poorest performing health plans were Anthem BCBS and Humana. Performance based on the quality composite system used in health plan negotiations was published in the *It's Your Choice* booklets. Health plan performance was noted by a four star rating system on overall quality, wellness and prevention, disease management, and customer service/claims processing. In 2006, 41 percent of respondents reported that they use the information published in the *It's Your Choice* booklets to make a health plan selection.

In addition, the health plans use the HEDIS® and CAHPS® results along with other reports from ETF for quality improvement purposes.

Overall Health Plan Performance

Our participating health plans continue to perform well on quality measures, when compared to health plans nationwide. Although there are some shifts in participating health plans on performance rankings, previously high performers continued to rate high and poor performers continued to perform poorly.

HEDIS®

Overall, participating HMOs continued to score higher on HEDIS® measures than HMOs nationwide for the 2006 measurement year. Participating HMOs performed better than the national average on measures such as Childhood Immunizations, Adolescent Immunizations, Colorectal Cancer Screenings, Breast Cancer Screenings, and Comprehensive Diabetes Care. We continue to note big differences in the relative performance of Wisconsin participating HMOs on their HEDIS® scores. For example GHC-SCW scored significantly above average on ten scores across seven measures and Anthem BCBS performed significantly below average on eight scores across five measures.

Although the HEDIS® scores of participating HMOs continue to be higher than that of HMOs nationwide, there is still significant room for improvement in several areas of care including appropriate use of antibiotics, cancer screening, and mental health. The most notable improvements in 2006 were with scores within the Childhood and Adolescent Immunization measures.

CAHPS®

Overall, member satisfaction with their **health plan** remained the same, while member satisfaction with their **health care** decreased. Interestingly enough, member satisfaction with their **primary doctors** and **specialists** increased. Respondents often commented that they

were very pleased with the care that they received from their primary doctor and specialists, but that they were frustrated with barriers to getting care, such as needing to schedule appointments months in advance to see their providers.

We continue to note big differences in member satisfaction levels with the best and worst performing health plans. For example, GHC-Eau Claire rated significantly better than the ETF average on eight of the ten measures examined. By contrast, Anthem BCBS Northwest, Anthem BCBS Southeast, and the State Maintenance Plan each rated significantly worse than the ETF average on six measures.

WISCONSIN DEPARTMENT OF EMPLOYEE TRUST FUNDS

HEDIS®

Health Care Quality Information
Based on Health Plan Performance

CAHPS®

Health Care Quality Information
From the Consumer Perspective

2006 Detailed HEDIS® and CAHPS® Results

Healthcare Effectiveness Data and Information Set (HEDIS®)

HEDIS®, the most widely used set of performance measures in the managed care industry, is developed and maintained by the National Committee for Quality Assurance (NCQA), a not-for-profit organization. The purpose of HEDIS® is to improve upon the quality of care provided by organized delivery systems by providing measures designed to increase accountability of managed care.

Definition of HEDIS® Measures and Scores Examined in this Report

HEDIS® 2007 (measurement year 2006) consists of 71 measures across 8 domains of care:

- Effectiveness of Care
- Access/Availability of Care
- Satisfaction with the Experience of Care (CAHPS®)
- Health Plan Stability
- Use of Services
- Cost of Care
- Informed Health Care Choices
- Health Plan Descriptive Information

For the purposes of this study, we focused on 30 measures across 3 domains—Effectiveness of Care, Access/Availability of Care, and Use of Services for a total of 70 scores. For most of the scores examined, a higher score is considered better. However, there are two exceptions:

- For the Poor HbA1c Control (>9.0%) for the Comprehensive Diabetes Care measure, a lower score is better because it indicates that fewer people with diabetes were poorly controlled.
- For Inappropriate Antibiotic Treatment for Adults with Acute Bronchitis, a lower score indicates that fewer people who should not receive antibiotics did in fact receive a prescription. Note that in order to be more consistent with other antibiotic misuse measures, NCQA has changed this measure so that a higher rate is better. The rate is now called "Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis", but is presented in this report in its original form in order to be consistent with how it was displayed in the Report Card Section of the 2008 *It's Your Choice* booklets.

Please see appendix #8 for a description of each measure analyzed in this report.

Methods for determining clinically significant differences

According to NCQA, when comparing differences among HMOs, the number of cases should be greater than 100 for each plan. Although NCQA indicates that HMOs should report numerators and denominators for measures in which the denominator is less than 30, the reported rate should not be calculated in these cases.

The reported rates for the 15 HMOs included in this report for the Effectiveness of Care, Access/Availability of Care, and Use of Services domains were compared according to NCQA guidelines. For measures in which an HMO has a denominator greater than 100, a difference of at least 10 percentage points between scores is needed to conclude that the difference is meaningful. For measures in which an HMO has a denominator between 30 to 99, a difference of at least 20 percentage points between scores is needed to conclude that the difference is meaningful.

Limitations

Although HEDIS® data is a valuable method of evaluating how well an HMO takes action to keep members healthy, there are some limitations that should be acknowledged when comparing the reported rates of multiple HMOs. For example, results can differ for the following reasons:

- Random Chance
- Different Population of Members
- Data Collection and Record keeping Issues

These limitations should be kept in mind when comparing the performance of HMOs. NCQA recommends that no measure be looked at in isolation. Rather, NCQA recommends to look for patterns in performance for multiple measures that address a particular issue, such as how well an HMO keeps members healthy or takes steps in implementing effective preventive medicine initiatives.

One limitation of only reporting clinically significant results, as defined in the previous section, is that as health plan scores improve over the years, the variability for measures decreases. This reduces the ability of clinic significance to distinguish performance differences between health plans, which may in fact be meaningful. For this reason, statistical significance is included in the calculation of the quality composite even though the results are not presented in this report.

HEDIS® data measures an HMO's entire block of Wisconsin business. NCQA strongly discourages HMOs from providing HEDIS® data that reflects the experience of particular employers because HEDIS® data is expensive and difficult to collect. Even large HMOs struggle to obtain an adequate sample for certain measures, such as treatment after a heart attack, due to limited events in their covered population.

HEDIS® Results

Individual HMOs Compared to State Average: Better than Average

The ETF HMOs are listed in order of number of measures for which they achieved a significantly better score than the average of all participating HMOs. A score is considered significantly better if it is 10 percentage points above the mean for a plan with a sample size of 100 or greater, or 20 percentage points above the mean for a plan with a sample size of at least 30 but less than 100. Not all HMOs were included in all of the measures (see Appendix #3), due to sample size issues. Therefore, it is important to keep in mind that smaller HMOs or HMOs that have a limited presence in Wisconsin do not have as much opportunity to either overachieve or underachieve.

GHC-SCW had 10 above average rates (and no below average rates)

- Adolescent Immunization Status/VZV
- Adolescent Immunization Status/Combination #2
- Appropriate Testing for Children With Pharyngitis
- Childhood Immunization Status/Combination #3
- Chlamydia Screening/ Chlamydia age 16-20
- Chlamydia Screening/ Chlamydia age 21-25
- Chlamydia Screening/ Chlamydia Combined Age Brackets
- Comprehensive Diabetes Care/ Eye Exam
- Inappropriate Antibiotic Treatment for Adults with Acute Bronchitis
- Well-Child Visits in the First 15 Months of Life (six or more visits)

Network Health Plan had 4 above average rates (and 1 below average rate)
- Adolescent Immunization Status/ Combination #2
- Adolescent Immunization Status/ VZV
- Use of Spirometry Testing in the Assessment and Diagnosis of COPD
- Well-Child Visits in the First 15 Months of Life (six or more visits)

GHC-Eau Claire had 4 above average rates (and 1 below average rate)
- Antidepressant Medication Management/Effective Acute Phase Treatment
- Antidepressant Medication Management/Effective Continuation Phase Treatment
- Call Timeliness
- Colorectal Cancer Screening

Security Health Plan had 4 above average rates (and no below average rates)
- Adolescent Immunization Status/Combination #2
- Antidepressant Medication Management/Effective Acute Phase Treatment
- Antidepressant Medication Management/Effective Continuation Phase Treatment
- Comprehensive Diabetes Care/Eye Exam

Gundersen Lutheran had 2 above average rates (and 2 below average rates)
- Childhood Immunization Status/Combination #3
- Inappropriate Antibiotic Treatment for Adults with Acute Bronchitis

Unity Health Plan had 2 above average rates (and no below average rates)
- Follow-Up After Hospitalization for Mental Illness/ 7-day follow-up
- Call Timeliness

Anthem BCBS had 1 above average rate (and 8 below average rates)
- Inappropriate Antibiotic Treatment for Adults with Acute Bronchitis

MercyCare Health Plan had 1 above average rates (and 2 below average rates)
- Adolescent Immunization Status/Combination #2

Physicians Plus had 1 above average rate (and 4 below average rates)
- Appropriate Testing for Children With Pharyngitis

UnitedHealthcare had 1 above average rate (and no below average rates)
- Follow-Up Care for Children Prescribed with Attention-Deficit/Hyperactivity Disorder: Continuation and Maintenance Phase

Arise Health Plan had no above average rates (and 1 below average rate)

Dean Health Plan had no above average rates (and 4 below average rates)

Health Tradition had no above average rates (and 6 below average rates)

Humana had no above average rates (and 3 below average rates)

Medical Associates had no above average rates (and 4 below average rates)

Individual HMOs Compared to State Average: Below Average Performance

The HMOs are listed in the order of the most rates with a below average score. A score is considered significantly below average if it is 10 percentage points below the mean for a plan with a sample size of 100 or greater or 20 percentage points below the mean for a plan with a sample size of at least 30 but less than 100. As with above average performance, it should be taken into consideration that the smaller HMOs that experienced sample size issues were excluded from some measures (see Appendix #3).

It is important to keep in mind that although an HMO may have scored below the average, it may have achieved the national average provided by NCQA. These cases are noted below. Measures, for which national averages are not available, are noted below as well.

Anthem had 8 below average rates (and one above average rate)

- Antidepressant Medication Management/Effective Continuation Phase Treatment
- Call Timeliness
- Childhood Immunization Status/Combination #3 **(met national average)**
- Colorectal Cancer Screening
- Comprehensive Diabetes Care/ Poor HbA1c Control >9.0%
- Comprehensive Diabetes Care/ Eye Exam
- Comprehensive Diabetes Care/ Blood Pressure Control <130/80 Hg **(national average not available)**
- Well-Child Visits in the First 15 Months of Life (six or more visits)

Health Tradition had 6 below average rates (and no above average rates)

- Adolescent Immunization Status/ VZV
- Adolescent Immunization Status/ Combination #2
- Childhood Immunization Status/Combination #2
- Childhood Immunization Status/Combination #3 **(met national average)**
- Childhood Immunization Status/ Pneumococcal Conjugate **(met national average)**
- Colorectal Cancer Screening

Dean Health Plan had 4 below average rates (and no above average rates)

- Adolescent Immunization Status/Combination #2
- Adolescent Immunization Status/VZV
- Timeliness of Prenatal Care **(met national average)**
- Well-Child Visits in the First 15 Months of Life (six or more visits)

Medical Associates had 4 below average rates (and no above average rates)

- Appropriate Treatment for Children With Upper Respiratory Infection
- Inappropriate Antibiotic Treatment for Adults with Acute Bronchitis
- Chlamydia Screening/ Chlamydia age 21-25
- Chlamydia Screening/ Chlamydia Combined Age Brackets

Physicians Plus had 4 below average rates (and 1 above average rate)

- Comprehensive Diabetes Care/ Eye Exam **(met national average)**
- Follow-Up Care for Children Prescribed with Attention-Deficit/Hyperactivity Disorder: Initiation Phase **(national average not available)**
- Follow-Up Care for Children Prescribed with Attention-Deficit/Hyperactivity Disorder: Continuation and Maintenance Phase **(national average not available)**
- Timeliness of Prenatal Care

Humana had 3 below average rates (and no above average rate)
- Comprehensive Diabetes Care/ Poor HbA1c Control >9.0%
- Comprehensive Diabetes Care/ Eye Exam **(met national average)**
- Use of Imaging Studies for Low Back Pain

Gundersen Lutheran had 2 below average rates (and 2 above average rates)
- Follow-Up After Hospitalization for Mental Illness/ 7-day follow-up
- Call Timeliness

MercyCare Health Plan had 2 below average rate (and 1 above average rate)
- Appropriate Testing for Children With Pharyngitis
- Call Timeliness

Arise Health Plan had 1 below average rate (and no above average rates)
- Appropriate Testing for Children with Pharyngitis

GHC-Eau Claire had 1 below average rate (and 4 above average rates)
- Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life

Network Health Plan had 1 below average rate (and 4 above average rates)
- Initiation of Alcohol and Other Drug Dependence Treatment

GHC-SCW had no below average rates (and 10 above average rates)

Security Health Plan had no below average rates (and 4 above average rates)

UnitedHealthcare had no below average rates (and 1 above average rate)

Unity Health Plan had no below average rates (and 2 above average rates)

Consumer Assessment of Healthcare Providers and Systems (CAHPS®)

The CAHPS® survey was developed collaboratively by several leading health care research organizations such as the Agency for Health Care Policy and Research (AHRQ), the Harvard Medical School, RAND, Research Triangle Institute and Westat. Each year, ETF contracts with a vendor to survey state employees and retirees about their experiences with their health plans.

Summary of CAHPS® Measurement Tools

In addition to collecting CAHPS® data and reporting it in the ETF report card, Morpace Inc., the CAHPS® survey vendor, also conducts additional analysis that determines what factors are "key drivers" of overall satisfaction with a health plan and with health care. Key drivers for each of the health plans were compared to the 2007 NCQA Quality Compass in order to determine the most appropriate action for the health plan. The Quality Compass consists of the HEDIS® data, including CAHPS® that health plans around the country submit to NCQA to seek accreditation.

Appendixes #5, #6, and #7 provide comparisons of individual health plans to the ETF and the 2007 NCQA Quality Compass. Appendix #4 provides an explanation of the data presented in appendix #5 and appendix #6. More specifically:

- Appendix #5 summarizes how participating health plans compared to the NCQA and ETF averages on how people rated health plan, health care, primary doctor and specialists.

- Appendix #6 displays detailed results for health plan performance as compared to NCQA and ETF averages on six composite scores: Claims Processing, Customer Service, Getting Care Needed, How Well Doctors Communicate, Getting Care Quickly, and Shared Decision Making.

- Appendix #7 displays health plan performance compared to the NCQA Quality Compass and the ETF average for the three specific areas that were found to be the most highly correlated with overall satisfaction levels for all ETF health plans combined. These areas are:
  - Handled claims correctly (r=.62)
  - Handled claims quickly (r=.62)
  - Got info/help needed from customer service (r=.57)
  - Ability to get care believed necessary (r=.56)
  - Customer service treated you with courtesy & respect (r=.52)

Areas that fall into the key driver category are further classified into actions health plans should take based on what percentile they fall into when comparing their score to the Quality Compass. Health plans that achieve the 75th percentile level should consider this an area of strength and should maintain their efforts. Health plans between the 50th and 75th percentiles should monitor their progress—they are not doing as well as the top health plans, but they are doing better than the majority of health plans. Health plans that score below the 50th percentile have an opportunity to improve their performance in that area.

- Appendix #4 displays the scores used for the composites detailed in appendix #7.

Note that it is possible for a health plan to receive a lower score as compared to the ETF average and rank higher against the 2006 Quality Composite. This is because for the overall ratings, the ETF methodology considers the total rating from 0 to 10 while the Quality Compass only considers the percentage of respondents who rate their health plan from 8 to 10.

For the calculations used by ETF for the health plan report card, the raw scores are adjusted for self-reported health status, education level and age. Studies have demonstrated that older respondents and respondents who report better health tend to rate their health care more favorably when compared to their counterparts, while more educated respondents tend to rate their health plan less favorably.

CAHPS® Results

Individual Health Plans Compared to State Average: Better than Average Performance
The participating health plans are listed in the order of the number of the four satisfaction rating questions and the six composite scores detailed in Appendix #5 and Appendix #6 that they score significantly above the ETF average.

GHC-Eau Claire had 6 above average scores (and no below average scores):
- How People Rated their Health Plan
- How People Rated their Health Care
- How People Rated their Primary Doctors
- Claims Processing composite
- Customer Service composite
- How Well Doctors Communicate composite

Medical Associates had 5 above average scores (and 1 below average score):
- How People Rated their Health Plan
- How People Rated their Health Care
- How People Rated their Primary Doctors
- Getting Care Needed composite
- How Well Doctors Communicate composite

Gundersen Lutheran had 4 above average scores (and no below average scores):
- How People Rated their Health Plan
- How People Rated their Health Care
- How People Rated their Primary Doctors
- Claims Processing composite

GHC-SCW had 3 above average scores (and no below average scores):
- How People Rated their Health Plan
- Claims Processing composite
- Customer Service composite

Network Health Plan had 3 above average scores (and 1 below average scores):
- How People Rated their Health Plan
- Claims Processing composite
- Customer Service composite

Unity-UW has 3 above average scores (and 2 below average scores):
- How People Rated their Health Plan
- Claims Processing composite
- Customer Service composite

Health Tradition had 3 above average scores (and no below average scores):
- How People Rated their Health Plan
- Claims Processing composite
- Getting Care Quickly composite

Humana-Western had 3 above average scores (and 3 below average scores):
- How People Rated their Health Care
- How People Rated their Specialists
- Getting Care Quickly composite

Unity-Community has 3 above average scores (and no below average scores):
- How People Rated their Health Plan
- Claims Processing composite
- Customer Service composite

Humana-Eastern has 1 above average score (and 3 below average scores):
- How People Rated their Specialists

Physicians Plus had 1 above average score (and 1 below average score):
- How People Rated their Health Plan

Arise Health Plan had no above average scores (and no below average scores)

Anthem BCBS Northwest had no above average scores (and 4 below average scores)

Anthem BCBS Southeast had no above average scores (and 4 below average scores)

Dean Health Plan had no above average scores (and 1 below average score)

MercyCare Health Plan had no above average scores (and 1 below average score).

UnitedHealthcare NE had no above average scores (and 3 below average scores).

UnitedHealthcare SE had no above average scores (and 1 below average score).

The Standard Plan had no above average scores (and 1 below average score).

The State Maintenance Plan had no above average scores (and 4 below average scores).

WPS Patients Choice had no above average scores (and 2 below average scores).

Individual Health Plans Compared to State Average: Worse than Average Performance

The participating health plans are listed in the order of the number of the four satisfaction rating questions and the six composite scores detailed in Appendix #5 and Appendix #6 that they score significantly below the ETF average. Scores that met the 2007 Quality Compass 50th percentile are noted below.

Anthem BCBS Northwest 4 below average scores (and no above average scores):
- How People Rated their Health Plan
- Claims Processing composite
- Customer Service composite (Quality Compass not available for this composite)
- Getting Care Quickly composite (Met Quality Compass 50th percentile)

Anthem BCBS Southeast had 4 below average scores (and no above average scores):
- How People Rated their Health Plan
- How People Rated their Health Care
- How People Rated their Primary Doctors
- Claims Processing composite

The State Maintenance Plan had 4 below average scores (and no above average scores):
- How People Rated their Health Plan
- Claims Processing composite
- Customer Service composite (Quality Compass not available for this composite)
- Getting Care Needed composite

Humana-Eastern had 3 below average scores (and 1 above average score):
- How People Rated their Health Plan
- Claims Processing composite
- Customer Service composite (Quality Compass not available for this composite)

Humana-Western had 3 below average scores (and 3 above average scores):
- How People Rated their Health Plan
- Claims Processing composite
- Customer Service composite (Quality Compass not available for this composite)

UnitedHealthcare NE had 3 below average scores (and no above average scores):
- How People Rated their Health Plan (Met Quality Compass 50th percentile)
- Claims Processing composite
- Customer Service composite (Quality Compass not available for this composite)

Unity-UW has 2 below average scores (and 3 above average scores):
- Getting Care Needed composite
- Getting Care Quickly composite

WPS Patient Choice had 2 below average scores (and no above average scores):
- How People Rated their Health Plan
- Claims Processing composite

Dean Health Plan has 1 below average score (and no above average scores):
- Getting Care Needed composite

Medical Associates had 1 below average score (and 5 above average scores):
- Shared Decision Making composite (Quality Compass not available for this composite)

MercyCare Health Plan had 1 below average score (and no above average scores):
- Customer Service composite (Quality Compass not available for this composite)

Network Health Plan had 1 below average score (and 3 above average scores):
- How People Rated their Primary Doctors (Met Quality Compass 50th percentile)

Physicians Plus had 1 below average score (and 1 above average score):
- Getting Care Quickly composite (Met Quality Compass 50th percentile)

UnitedHealthcare SE had 1 below average score (and no above average scores):
- Claims Processing composite

The Standard Plan had 1 below average score (and no above average scores):
- How Well Doctors Communicate composite (Met Quality Compass 90th percentile)

Arise Health Plan had no below average scores (and no above average scores).

GHC-Eau Claire *had no below average scores (and 6 above average scores).*

GHC-SCW had no below average scores (and 3 above average scores).

Gundersen Lutheran had no below average scores (and 4 above average scores).

Health Tradition had no below average scores (and 3 above average scores).

Unity-Community had no below average score (and 3 above average scores).

Conclusions

Overall HMOs in Wisconsin continue to perform better than HMOs across the country. However, there are significant differences in the performance of HMOs. HMOs such as GHC-SCW, Network Health Plan, GHC-Eau Claire and Security Health Plan scored high on several HEDIS® measures while an HMO such as Anthem BCBS scored below average across several important measures and had few high scores.

Certain health plans such as GHC-Eau Claire, Medical Associates, and Gundersen Lutheran stand out as having high CAHPS® scores, while other health plans such as Anthem BCBS and Humana continue to have areas of weakness, such as customer service and claims processing that need to be addressed. These findings are significant and point to areas in which improvement could be made to better serve Wisconsin state and local employees.

These findings, and the findings of future studies, must continue to be shared with consumers and addressed with the HMOs. In fact, according to NCQA, organizations that have their HEDIS® scores published typically score higher than organizations that do not have their scores published. Please see the appendixes for more detailed HEDIS® and CAHPS® results.

Summary of Appendixes

Appendix 1: Status of Managed Care by Health Plan. {This appendix provides a summary of ETF's efforts to make health plans accountable for managing care and a brief summary of the progress being made by each health plan.}

Appendix 2: ETF Participating Health Plan Commercial National Ranking. {This appendix shows how health plans performed in following national composite areas: Consumer Assessment, Prevention, and Treatment.}

Appendix 3: Measurement Year 2006 HEDIS®: HMO Performance on 70 scores. {This appendix summarizes the number of HEDIS® scores that each health plan met the national, performed significantly better than the ETF average, and performed significantly worse than the ETF average.}

Appendix 4: Description of Six Composite Scores and Morpace Inc. Key Driver Analysis. {This appendix lists the questions that are included in each of the six composite scores display in appendix #6. Definitions of each of the three recommended areas of action for health plans that are shown in appendix #7are defined.

Appendix 5: 2007 Overall Levels of Satisfaction by Health Plan. {This appendix shows health plan performance compared to the NCQA Quality Compass and the ETF average for overall satisfaction ratings with Health Plan, Health Care, Primary Doctor, and Specialists.}

Appendix 6: 2006 Performance in Six Areas of Care by Health Plan. {This appendix shows health plan performance compared to the NCQA Quality Compass and the ETF average for six composite areas: Getting Care Quickly, Shared Decision Making, How Well Doctors Communicate, Claims Processing, Customer Service, and Getting Care Needed.}

Appendix 7: 2006 Morpace Inc. Key Drivers of Satisfaction with Health Plan. {This appendix shows health plan performance compared to the NCQA Quality Compass and the ETF average on the questions that are most highly correlated with overall health plan satisfaction: handled claims in a timely manner, handled claims correctly, and getting help needed when called customer service, getting care needed, and treated with respect by customer service.}

Appendix 8: Description of 2007 HEDIS® Measures (measurement year 2006). {This appendix describes the 30 scores reported in this study in the Effectiveness of Care, Access and Availability of Care, and Use of Services domains.}

Appendix 9: Childhood Immunization Status: Pneumococcal Conjugate. {This appendix displays a bar chart with comparison of 2005 to 2006 health plan scores.}

Appendix 10: Adolescent Immunization Status: Chicken Pox. {This appendix displays a bar chart with comparison of 2005 to 2006 health plan scores.}

Appendix 11: Comparison of 2006 Participating HMO Averages to 2005 HMO Averages and to 2005 National Averages. {This appendix shows average comparisons for the 30 scores examined in this study.}

Appendix #1: Status of Managed Care by Health Plan

Starting in 2006, ETF made the decision to probe further into how health plans are managing care for the state population. This was achieved by requiring health plans to respond to a survey about their disease management efforts. ETF offered credit towards premium negotiations as an incentive for health plans to take the survey seriously. Unfortunately, the responses to the survey were not very helpful; most health plans failed to answer the questions posed by ETF. In 2007, the disease management survey was revised to be more specific and probing and ETF was more specific about what was expected from the health plans. The 2007 Disease Management Survey included five sections:

- Disease Management Program Description and Outcomes (Spinal Care, Coronary Artery Disease (CAD), Depression in People with Chronic Conditions, Diabetes, Hypertension)
- Disease Management Areas of Focus (Spinal Care, Coronary Artery Disease (CAD), and Depression in People with Chronic Conditions)
- Appropriate Use of Services (Emergency Department Utilization)
- Electronic Claims and Patient Data Integration and Management
- Health Plan Specific Questions (HEDIS® and CAHPS®)

ETF asked follow up questions based on initial responses as well as the following new categories: Efficiency in spending, mental health, commitment to public reporting, and inappropriate use of antibiotics.

One important theme that was addressed throughout the survey is how well health plans are incorporating pharmacy claims data into their disease measurement and management processes. Many health plans have not yet achieved the standard required by ETF.

Here are brief highlights by health plan:

Anthem BCBS continues to achieve low HEDIS® and CAHPS® scores and has not demonstrated that it is doing anything to manage the state's population. Anthem scored below participating health plans for scores in key HEDIS® measures including Comprehensive Diabetes Care and Colorectal Cancer Screening. Anthem BCBS members continue to express lower levels of satisfaction with claims processing and customer service than expressed by members of all participating health plans.

Arise Health Plan has improved its HEDIS® scores dramatically over the past five years. This is a case that appears to indicate improved disease management is correlated with higher HEDIS® scores. For the last several years, Arise Health Plan has improved its HEDIS® scores and therefore improved its ranking among other participating health plans. Although Arise Health Plan already start to see an improvement in measurement year 2003 HEDIS® score they had 14 scores out of 51 in which they performed significantly worse than the average or all participating health plans. In 2004, Arise Health Plan implemented disease management programs for diabetes, asthma, and coronary artery disease. They also addressed and improved their

HEDIS® data collection process. For measurement year 2004, the number of scores that they significantly underperformed compared to the average dropped to 7 out of 56. In 2005, they achieved a similar result, underperforming in 8 out of 57 scores. Most recently, they only had 1 score out of 70 in which they significantly underperformed the average. This improvement is in part due to ETF publishing HEDIS® starting in the year 2003. This publication highlighted Arise's poor performance and motivated Arise to implement disease management programs. Arise has made further gains managing its population and was able to demonstrate that it is in the process of developing a good spinal care program. Arise is also doing a good job tracking of emergency room utilization and incorporating pharmacy data into disease management.

Dean Health Plan, our health plan with by far the largest share of membership has been for years and continues to be an average performer and is deficient compared to other health plans in some areas of care such as adolescent immunizations. Although Dean has disease management programs including a good depression program, it appears that ETF members are not benefiting from those programs. Dean does a good job managing emergency room visits.

GHC-Eau Claire continues to improve even though it has been a top performing health plans for years. This once small health plan continues to gain ETF membership. It is one of the few health plans to demonstrate that it has excellent disease management programs although it still needs to work on developing a spinal care program. Despite its high commitment to managing care, GHC-Eau Claire has yet to incorporate Navitus pharmacy data into disease management.

GHC-SCW continues to perform well on HEDIS® and CAHPS® scores and once again achieved the highest score on ETF's quality composite. GHC is a high performing health plan in spite of the fact that it was unable to demonstrate having a developed chronic disease management program. GHC did a good job analyzing their emergency room utilization data and it has an excellent medical record system. There is some question about how GHC integrates pharmacy data into its disease management activities since it did not provide ETF requested data demonstrating that Navitus data is being integrated for disease management purposes.

Gundersen Lutheran continues to achieve high HEDIS® and CAHPS® scores. Once again, it achieved the highest CAHPS® score on the quality composite, demonstrating that this health plan is well liked by its members. Gundersen has established some good benchmarks for measuring emergency room usage and the treatment of spinal care and therefore is well positioned to make improvements in these areas.

Health Tradition has experienced a decline in its performance on HEDIS® measures relative to other participating health plans. For example, Health Tradition has not kept up with the other health plans in improving childhood and adolescent immunization rates. Health Tradition does seem to be well positioned to improve the quality of care provided to ETF members. Health Tradition was able to demonstrate that it does an excellent job tracking emergency room data and has a good emergency room program. Health Tradition also does a good job measuring spinal care utilization and integrating Navitus data into disease management.

Humana continues to have average HEDIS® score and continues to have problems in some areas of member satisfaction such as customer service and claims processing.

Humana was unable to demonstrate that it is addressing disease management for Wisconsin members. Its focus is more on national programs for quality improvement, which in some cases does not adequately address the population in Wisconsin.

Medical Associates continues to do pretty well with HEDIS®, although it does not excel in areas. It continues to be a well-liked health plan that achieves high CAHPS® scores. Medical Associates was able to demonstrate that it has an excellent hypertension program and diabetes registry. Medical Associates has demonstrated the ability to measure emergency room usage and spinal care data and therefore is well positioned to achieve improvements in efficiency in these areas. It is unclear whether or not Medical Associates is integrating Navitus claims into its disease management efforts.

MercyCare continues to get average HEDIS® scores and below average CAHPS® scores. MercyCare scored below average for customer service. It is difficult to determine what it is doing in to address disease management and data measurement efforts such as emergency room utilization and good spinal care, because it did not provide detailed responses to the disease management survey.

Network Health Plan continues to be a high performing health plan with high HEDIS® and CAHPS® scores. Network achieved the second highest score based on ETF's quality composite. Although it does not have many HEDIS® scores in which it performed 10 percentage points above the average score, Network consistently achieves high scores across several measures. Network is very strong in the area of data analysis, using the D2 Hawkeye claims analyzer. Network also does an excellent job in integrating Navitus data into its disease management claims system.

Physicians Plus has average HEDIS® scores that have declined somewhat over the last couple of years. Its CAHPS® scores are average, although members gave a high rating of their overall satisfaction with Physicians Plus. For the last couple of years, Physicians Plus has not sought NCQA accreditation and in 2007, Physicians Plus made the decision to not publicly report their data through the NCQA Quality Compass. Physicians Plus did not demonstrate that is has any disease management programs, although it is doing a good job of integrating Navitus data into disease management and analyzing drug utilization.

Security Health Plan continues to achieve high HEDIS® scores, although it did not demonstrate that it has well developed disease management programs. There are other health plans that are ahead of Security Health Plan, both in terms having higher HEDIS® scores and more developed programs to manage chronic conditions. Security does have a good program for managing perinatal depression and does a good job analyzing claims data. Security Health Plan was not included in the 2007 CAHPS® study but will be included in the 2008 study.

UnitedHealthcare appears to have adequate HEDIS® scores, however this is because the high scores from the northeastern section bring up the overall scores. These scores very likely overstate the quality performance that is achieved in the southeastern region. Member satisfaction with southeastern region was higher than for the northeastern region however. This finding is supported by open-ended comments in which respondents expressed satisfaction in the southeast region and frustration with change, particularly with customer service in the northeastern region. Members in both regions expressed lower levels of satisfaction with claims processing than members of

participating health plans on average. UnitedHealthcare failed to demonstrate that it is managing care in Wisconsin. It does not have a spinal care program, does not have a program for managing emergency room visits, and does not have any disease management registries. Furthermore, it appears that UnitedHealthcare is not integrating Navitus data into disease management.

Unity Health Insurance continues to maintain good HEDIS® scores and has demonstrated that it has good programs in place for managing chronic conditions and depression, but was unable to provide spinal care claims data. Unity does a good job integrating and analyzing Navitus data. Member satisfaction with both Unity-UW and Unity-Community is pretty high. Satisfaction levels with Unity-Community primary doctors and specialists increased significantly from the 2006 study to the 2007 study. Unity-UW experienced dissatisfaction with ease of getting an appointment with specialists, which is a finding that is supported by numerous open-ended comments from members who were frustrated that they needed to make appointments with specialists months ahead of time. Unity is aware of this issue and indicated that have taken steps to hire more specialists.

WPS demonstrated that it does a good job incorporating Navitus data into disease management and analyzing pharmacy data. WPS provided a good analysis of emergency room data and has a good emergency room program. WPS does not submit HEDIS® data for the Standard Plans or for the Patient Choice plans because they are not managed care plans, however the Standard Plan, SMP and the Patient Choice plans were included in the 2007 CAHPS® study. There were high levels of satisfaction with the Standard Plan, but SMP and the Patient Choice plans received below average scores for several questions, such as overall satisfaction with the health plan and getting care needed for SMP and customer service, and claims processing for the Patient Choice plans. SMP currently has a very small membership and has historically received lower CAHPS® scores than the other health plans. This may be in part be explained by dissatisfaction with the plan design and what is perceived as the lack of providers available through the health plan.

Appendix #2: ETF Participating Health Plan Commercial National Ranking

HEALTH PLAN	CONSUMER ASSESSMENT	PREVENTION	TREATMENT
Anthem Blue Cross and Blue Shield (Compcare) (Ranked 119th)	★★★	★★	★★★★
Dean Health Plan (Ranked 56th)	★★★★	★★★	★★★★
GHC South Central Wisconsin (Ranked 8th)	★★★	★★★★★	★★★★★
Group Health Cooperative of Eau Claire (Ranked 222nd) ***not accredited***[1]	★★★★★	★★★★★	★★★★★
Gundersen Lutheran Health Plan (Ranked 224th) ***not accredited***[1]	★★★	★★★★	★★★★
Humana Wisconsin Health Organization Insurance Corporation (Ranked 54th)	★★★	★★★★	★★★★
Medical Associates Health Plans (WI) (Ranked 88th)	★★★★	★★★	★★★
MercyCare Health Plans (Ranked 159th)	★★	★★★	★★★
Network Health Plan (Ranked 37th)	★★★	★★★★	★★★★★
Security health Plan (Ranked 49th)	★★★	★★★★	★★★★
UnitedHealthcare of Wisconsin (Ranked 112th)	★★	★★★	★★★★
Unity Health Plans (Ranked 44th)	★★★	★★★★	★★★★★
WPS Health Plan (Arise) (Ranked 70th)	★★★★	★★★★	★★★

The rating is based on a scale of one "star" to five "stars," with five being the highest. Note that data for Health Tradition and Physicians Plus is not available because these health plans do not report to NCQA.

Source: U.S News & World Report http://www.usnews.com/usnews/health/best-health-insurance/topplans.htm

Consumer Assessment
Getting care needed, getting care quickly, how well doctors communicate, high rating of personal doctor, high rating of specialists, high rating of care received, satisfaction with claims processing, and high rating of plan services.

Prevention
Well-child visits, children's access to care visits, early childhood immunizations, adolescent immunizations, timely prenatal care, timely postpartum care, breast cancer screening, cervical cancer screening, colorectal cancer screening, and chlamydia screening.

Treatment
- **Asthma--**medicating asthma appropriately.
- **Diabetes**--checking eyes, testing and controlling blood sugar, checking LDL cholesterol, and monitoring kidney disease.
- **Heart Disease**—giving beta blocker after heart attack, staying on beta blocker after a heart attack, controlling high blood pressure, advising smokers to quit and offering strategies and medications for quitting, LDL cholesterol screening and control.
- **Mental and Behavioral Health** --medicating management for people with acute depression appropriately; following up after hospitalization for mental illness; initiating and continuing treatment for alcoholism and substance abuse; following up after an ADHD diagnosis.
- **Other Treatment Measures**—medication for rheumatoid arthritis, monitoring of key long-term medications, spirometry testing for COPD, appropriate antibiotic use for children with URI, appropriate testing and care for children with pharyngitis, and appropriate antibiotic use for adults with acute bronchitis.

[1]Not all participating health plans seek NCQA accreditation and therefore would not have the opportunity to earn the 15 out of 100 points that make up the accreditation portion of the score used for ranking performance.

Appendix #3: Measurement Year 2006 HEDIS®: HMO Performance on 70 scores

	Met national average?[1]			Met ETF mean score?[2]			Comparison to ETF mean score[3]			
PLAN	**Yes**	**No**	**NA[4]**	**Yes**	**No**	**NA[4]**	**better**	**not different**	**worse**	**NA[4]**
Anthem BCBS	31	31	8	15	54	1	1	60	8	1
Arise Health Plan	42	16	12	33	32	5	0	64	1	5
Dean Health Plan	49	13	8	40	30	0	0	66	4	0
GHC-Eau Claire	41	13	16	42	19	9	4	56	1	9
GHC-SCW	59	1	10	60	7	3	10	57	0	3
Gundersen Lutheran	47	9	14	51	11	8	2	58	2	8
Health Tradition	32	23	15	24	38	8	0	56	6	8
Humana	50	10	10	36	31	3	0	64	3	3
Medical Associates	43	10	17	39	21	10	0	56	4	10
MercyCare Health Plan	43	12	15	38	24	8	1	59	2	8
Network Health Plan	51	11	8	56	13	1	4	64	1	1
Physicians Plus	52	10	8	47	23	0	1	65	4	0
Security Health Plan	50	11	9	51	17	2	4	64	0	2
UnitedHealthcare	48	14	8	32	38	0	1	69	0	0
Unity Health Insurance	57	5	8	55	15	0	2	68	0	0
TOTAL	**695**	**189**	**166**	**619**	**373**	**58**	**30**	**926**	**36**	**58**

[1]Met or came within a percentage point of meeting the national Quality Compass average, except for call abandonment rate which is defined as met if it is within a tenth of a percentage point.

[2]Met or came within a percentage point of meeting the average of ETF HMOs, except for call abandonment rate which is defined as met if it is within a tenth of a percentage point.

[3]Better or worse performance is defined as at least a 10-percentage point difference from the ETF mean score for plans with a denominator of 100 or greater and a 20-percentage point difference for plans with a denominator of 30 to 99.

[4]Scores are not available because the HMO has a denominator of less than 30. National averages are not available for eight measures.

Appendix #4: Description of Six Composite Scores and Morpace Inc. Key Driver Analysis

Each of the six composites includes scores on multiple survey questions:

1) Getting Needed Care
   - Getting the care, test, or treatment you needed through your health plan
   - Ease of getting appointments with specialists

2) Getting Care Quickly
   - Getting care as soon as you needed
   - Getting an appointment as soon as you needed

3) How Well Doctors Communicate
   - Doctor listening carefully to you
   - Doctor explaining things in a way you could understand
   - Doctor showing respect for what you had to say
   - Doctor spends enough time with you

4) Shared Decision Making
   - Doctor discussing the pros and cons for each choice of treatment or health care with you
   - Doctor asking you which choice was best for you

5) Customer Service
   - Finding or understanding information in written materials or Internet
   - Getting information or help from customer service
   - Courteous and respectful customer service staff
   - Ease of filling out forms for health plan

6) Claims Processing
   - Handling claims in a timely manner
   - Handling claims correctly

Dependent Variable
Individual questions within the composite categories are correlated with how people rated their overall satisfaction with their health plan. The percentage of respondents who ranking their health plan/health care from 8 to 10 (on a scale of 0 to 10) is compared to NCQA's Quality Compass. The health plan is ranked among health plans that reported to NCQA in 2007 and that allowed their data to be publicly reported.

Key Driver Analysis:

Health Plan Strength
Key driver of satisfaction and plan rates are at/above the 75th percentile when compared to Quality Compass 2007. Recommended action: Market and Maintain

Health Plan Opportunity
Key Driver of satisfaction but plan rates below the 50th percentile when compared to Quality Compass 2007. Recommended action: Investigate and Improve

Monitor
Key driver of satisfaction, but rates between the 50th and 75th percentile when compared to Quality Compass 2007. Recommended action: Monitor.

Appendix #5: 2006 Overall Levels of Satisfaction by Health Plan

	Q42. How people rate their Health Plan		Q12. How people rate their Health Care		Q21. How people rate their Primary Doctors		Q25. How people rate their Specialists	
Health Plan	**ETF**	**Percentile***	**ETF**	**Percentile***	**ETF**	**Percentile***	**ETF**	**Percentile***
Anthem BCBS Northwest	BELOW	25th to 49th	SAME	50th to 74th	SAME	90th or above	SAME	25th to 49th
Anthem BCBS Southeast	BELOW	25th to 49th	BELOW	10th to 24th	BELOW	Below 10th	SAME	Below 10th
Arise Health Plan	SAME	75th to 89th	SAME	90th or above	SAME	25th to 49th	SAME	50th to 74th
Dean Health Plan	SAME	90th or above	SAME	50th to 74th	SAME	75th to 89th	SAME	10th to 24th
GHC-Eau Claire	ABOVE	90th or above	ABOVE	90th or above	ABOVE	75th to 89th	SAME	75th to 89th
GHC-SCW	ABOVE	90th or above	SAME	50th to 74th	SAME	Below 10th	SAME	Below 10th
Gundersen Lutheran	ABOVE	90th or above	ABOVE	90th or above	ABOVE	90th or above	SAME	25th to 49th
Health Tradition	ABOVE	90th or above	SAME	90th or above	SAME	75th to 89th	SAME	10th to 24th
Humana-Eastern	BELOW	25th to 49th	SAME	25th to 49th	SAME	25th to 49th	ABOVE	50th to 74th
Humana-Western	BELOW	25th to 49th	ABOVE	90th or above	SAME	90th or above	ABOVE	90th or above
Medical Associates	ABOVE	90th or above	ABOVE	90th or above	ABOVE	90th or above	SAME	50th to 74th
MercyCare Health Plan	SAME	75th to 89th	SAME	50th to 74th	SAME	50th to 74th	SAME	10th to 24th
Network Health Plan	ABOVE	90th or above	SAME	50th to 74th	BELOW	50th to 74th	SAME	10th to 24th
Physicians Plus	ABOVE	90th or above	SAME	75th to 89th	SAME	50th to 74th	SAME	50th to 74th
Standard Plan	SAME	90th or above	SAME	90th or above	SAME	90th or above	SAME	90th or above
State Maintenance Plan	BELOW	Below 10th	SAME	10th to 24th	SAME	75th to 89th	SAME	10th to 24th
UnitedHealthcare NE	BELOW	50th to 74th	SAME	50th to 74th	SAME	25th to 49th	SAME	25th to 49th
UnitedHealthcare SE	SAME	50th to 74th	SAME	75th to 89th	SAME	90th or above	SAME	25th to 49th
Unity-Community	ABOVE	90th or above	SAME	50th to 74th	SAME	25th to 49th	SAME	50th to 74th
Unity-UW Health	ABOVE	90th or above	SAME	75th to 89th	SAME	50th to 74th	SAME	10th to 24th
WPS Patient Choice	BELOW	10th to 24th	SAME	25th to 49th	SAME	90th or above	SAME	Below 10th
*2007 Quality Compass ranking								

Appendix #6: 2006 Satisfaction with Six Areas of Care

	GETTING CARE QUICKLY		SHARED DECISION MAKING		HOW WELL DOCTORS COMMUNICATE		GETTING NEEDED CARE		CUSTOMER SERVICE		CLAIMS PROCESSING	
Health Plan	PERCENTILE*	ETF	PERCENTILE*	ETF	PERCENTILE*	ETF	PERCENTILE*	ETF	PERCENTILE*	ETF	PERCENTILE*	ETF
Anthem BCBS Northwest	50th to 74th	Below	NA	Same	50th to 74th	Same	50th to 74th	Same	NA	Below	10th to 24th	Below
Anthem BCBS Southeast	50th to 74th	Same	NA	Same	25th to 49th	Same	25th to 49th	Same	NA	Same	Below 10th	Below
Arise Health Plan	90th or above	Same	NA	Same	50th to 74th	Same	90th or above	Same	NA	Same	90th or above	Same
Dean Health Plan	75th to 89th	Same	NA	Same	50th to 74th	Same	25th to 49th	Below	NA	Same	25th to 49th	Same
GHC-Eau Claire	75th to 89th	Same	NA	Same	90th or above	Above	50th to 74th	Same	NA	Above	90th or above	Above
GHC-SCW	75th to 89th	Same	NA	Same	75th to 89th	Same	10th to 24th	Same	NA	Above	50th to 74th	Above
Gundersen Lutheran	75th to 89th	Same	NA	Same	90th or above	Same	75th to 89th	Same	NA	Same	75th to 89th	Above
Health Tradition	90th or above	Above	NA	Same	75th to 89th	Same	75th to 89th	Same	NA	Same	90th or above	Above
Humana-Eastern	75th to 89th	Same	NA	Same	50th to 74th	Same	25th to 49th	Same	NA	Below	10th to 24th	Below
Humana-Western	90th or above	Above	NA	Same	90th or above	Same	50th to 74th	Same	NA	Below	Below 10th	Below
Medical Associates	90th or above	Same	NA	Below	90th or above	Above	90th or above	Above	NA	Same	25th to 49th	Same
MercyCare Health Plan	50th to 74th	Same	NA	Same	25th to 49th	Same	25th to 49th	Same	NA	Below	50th to 74th	Same
Network Health Plan	50th to 74th	Same	NA	Same	25th to 49th	Same	50th to 74th	Same	NA	Above	75th to 89th	Above
Physicians Plus	50th to 74th	Below	NA	Same	50th to 74th	Same	25th to 49th	Same	NA	Same	50th to 74th	Same
Standard Plan	90th or above	Same	NA	Same	90th or above	Below	90th or above	Same	NA	Same	75th to 89th	Same
State Maintenance Plan	75th to 89th	Same	NA	Same	90th or above	Same	Below 10th	Below	NA	Below	25th to 49th	Below
UnitedHealthcare NE	90th or above	Same	NA	Same	75th to 89th	Same	50th to 74th	Same	NA	Below	10th to 24th	Below
UnitedHealthcare SE	75th to 89th	Same	NA	Same	90th or above	Same	50th to 74th	Same	NA	Same	10th to 24th	Below
Unity-Community	75th to 89th	Same	NA	Same	75th to 89th	Same	50th to 74th	Same	NA	Above	75th to 89th	Above
Unity-UW Health	10th to 24th	Below	NA	Same	50th to 74th	Same	25th to 49th	Below	NA	Above	75th to 89th	Above
WPS Patient Choice	90th or above	Same	NA	Same	90th or above	Same	50th to 74th	Same	NA	Same	Below 10th	Below
*2007 Quality Compass ranking												

Appendix #7: Morpace Inc. Key Drivers of Satisfaction with Health Plan

	Q41 - Handled claims correctly (r=.62)			Q40 - Handled claims quickly (r=.62)			Q35 - Got info/help needed from customer service (r=.57)			Q27 - Ability to get care believed necessary (r=.56)			Q36 - Customer service treated you with courtesy & respect (r=.52)		
Health Plan	**Action***	**ETF**	**Percentile****	**Action***	**ETF**	**Percentile****	**Action***	**ETF**	**Percentile****	**Action***	**ETF**	**Percentile****	**Action***	**ETF**	**Percentile****
Anthem BCBS Northwest	Opportunity	Below	10th to 24th	Opportunity	Below	Below 10th	Opportunity	Below	Below 10th	Monitor	Below	50th to 74th	NA	Below	NA
Anthem BCBS Southeast	Opportunity	Below	Below 10th	Opportunity	Below	Below 10th	Opportunity	Same	25th to 49th	Opportunity	Same	25th to 49th	NA	Same	NA
Arise Health Plan	Strength	Same	75th to 89th	Strength	Above	90th or above	Strength	Above	75th to 89th	Strength	Same	75th to 89th	NA	Same	NA
Dean Health Plan	Opportunity	Same	25th to 49th	Opportunity	Same	25th to 49th	Monitor	Same	50th to 74th	Monitor	Same	50th to 74th	NA	Same	NA
GHC-Eau Claire	Strength	Above	90th or above	Strength	Above	75th to 89th	Strength	Above	90th or above	Strength	Above	75th to 89th	NA	Above	NA
GHC-SCW	Monitor	Above	50th to 74th	Strength	Above	75th to 89th	Strength	Above	75th to 89th	Strength	Above	75th to 89th	NA	Above	NA
Gundersen Lutheran	Strength	Above	90th or above	Strength	Above	75th to 89th	Monitor	Same	50th to 74th	Strength	Above	90th or above	NA	Same	NA
Health Tradition	Strength	Above	90th or above	Strength	Above	90th or above	Monitor	Same	50th to 74th	Strength	Same	90th or above	NA	Same	NA
Humana Eastern	Opportunity	Below	10th to 24th	Opportunity	Same	10th to 24th	Opportunity	Below	Below 10th	Opportunity	Same	25th to 49th	NA	Below	NA
Humana Western	Opportunity	Below	Below 10th	Opportunity	Below	Below 10th	Opportunity	Below	Below 10th	Strength	Same	90th or above	NA	Below	NA
Medical Associates	Opportunity	Same	25th to 49th	Opportunity	Same	10th to 24th	Opportunity	Same	25th to 49th	Strength	Same	75th to 89th	NA	Same	NA
MercyCare Health Plan	Monitor	Same	50th to 74th	Opportunity	Same	25th to 49th	Opportunity	Below	10th to 24th	Opportunity	Same	25th to 49th	NA	Below	NA
Network Health Plan	Strength	Above	75th to 89th	Strength	Above	75th to 89th	Strength	Above	90th or above	Strength	Same	75th to 89th	NA	Above	NA
Physicians Plus	Strength	Same	75th to 89th	Monitor	Same	50th to 74th	Strength	Same	75th to 89th	Strength	Same	75th to 89th	NA	Above	NA
Standard Plan	Strength	Same	75th to 89th	Monitor	Same	50th to 74th	Monitor	Same	50th to 74th	Strength	Above	90th or above	NA	Same	NA
State Maintenance Plan	Opportunity	Below	25th to 49th	Opportunity	Same	25th to 49th	Opportunity	Below	25th to 49th	Opportunity	Below	Below 10th	NA	Same	NA
UnitedHealthcare NE	Opportunity	Below	10th to 24th	Opportunity	Below	10th to 24th	Opportunity	Below	10th to 24th	Monitor	Same	50th to 74th	NA	Below	NA
UnitedHealthcare SE	Opportunity	Same	10th to 24th	Opportunity	Below	Below 10th	Monitor	Same	50th to 74th	Strength	Same	75th to 89th	NA	Same	NA
Unity-Community	Monitor	Same	50th to 74th	Strength	Above	90th or above	Strength	Above	90th or above	Strength	Same	75th to 89th	NA	Same	NA
Unity-UW Health	Monitor	Above	50th to 74th	Strength	Above	75th to 89th	Strength	Above	90th or above	Strength	Same	75th to 89th	NA	Above	NA
WPS Patient Choice	Opportunity	Below	Below 10th	Opportunity	Same	Below 10th	Opportunity	Same	Below 10th	Opportunity	Same	10th to 24th	NA	Same	NA
*See appendix #4 for explanation of action categories															
**2007 Quality Compass ranking															

Appendix #8: Description of HEDIS® 2007 Measures (Measurement Year 2006)

The measures examined from the **Effectiveness of Care Domain** include:

- **Childhood Immunization Status**—the percentage of children that receive the appropriate immunizations by their second birthday
  - Four shots of DTaP (diphtheria-tetanus-pertussis)
  - IPV (injectable polio virus)
  - One dose of MMR (measles-mumps-rubella)
  - Three Hib (haemophilus influenza type B)
  - Three Hepatitis B
  - One VZV (chicken pox)
  - Combination #2—children who have received all the vaccines specified above
  - At least four pneumococcal conjugate vaccinations
  - Combination #3-- children who have received all the vaccines in Combination #2 and four pneumococcal conjugate vaccinations

- **Adolescent Immunization Status**—the percentage of 13 year-olds that received all of the appropriate immunizations:
  - MMR-2 (second dose of measles-mumps-rubella)
  - Three Hepatitis B vaccinations
  - VZV (chicken pox, if they have not already had the disease)
  - Combination #2—adolescents who received all the vaccines specified above

- **Appropriate Testing for Children With Pharyngitis**—the percentage of children 2–18 years of age, who were diagnosed with pharyngitis, prescribed an antibiotic and received a group A streptococcus (strep) test for the episode. This measure assesses the adequacy of clinical management of pharyngitis episodes for members who received an antibiotic prescription.

- **Appropriate Treatment for Children With Upper Respiratory Infection**–-the percentage of children 3 months to 18 years of age who were given a diagnosis of upper respiratory infection (URI) and were not dispensed an antibiotic prescription on or three days after the Episode Date. This process measure assesses if antibiotics were inappropriately prescribed for children with URI.

- **Inappropriate Antibiotic Treatment for Adults With Acute Bronchitis**—the percentage of healthy adults 18–64 years of age with a diagnosis of acute bronchitis who were dispensed an antibiotic prescription on or within three days after the Episode Date. This misuse measure assesses if antibiotics were inappropriately prescribed for healthy adults with acute bronchitis. A lower rate represents better performance.

- **Breast Cancer Screening**—the percentage of female members from age 40 - 69 who had at least one mammogram.
  - Women age 42-51
  - Women age 52-69
  - Total women age 40-69

- **Cervical Cancer Screening**—the percentage of women, age 24–64, who had at least one Pap test.

- **Colorectal Cancer Screening**—the percentage of adults 50–80 years of age who had appropriate screening for colorectal cancer. Appropriate screenings are defined by any one of the four criteria below:
  - fecal occult blood test (FOBT) during the measurement year
  - flexible sigmoidoscopy during the measurement year or the four years prior to the measurement year
  - double contrast barium enema (DCBE) during the measurement year or the four years prior to the measurement year. Clinical synonyms, including air contrast enema may also be used
  - colonoscopy during the measurement year or the nine years prior to the measurement year

- **Chlamydia Screening in Women**—assesses the percentage of sexually active women, age 16-25, who were screened for chlamydia at least once during the measurement year
  - Women age 16-20
  - Women age 21-25
  - Total women age 16-25

- **Controlling High Blood Pressure**—looks whether or not blood pressure was controlled (<140/90) for adults, age 18-85, who were diagnosed with hypertension.
  - Adults age 18-45
  - Adults age 46-85
  - Total adults age 18-85

- **Beta Blocker Treatment After a Heart Attack**—looks at one way of preventing a second heart attack—it estimates the number of members, ages 35 and older, who were discharged from the hospital after surviving a heart attack and subsequently received a prescription for a type of drug called a beta blocker (excluding those members who have a valid reason to not take the drug)

- **Persistence of Beta-Blocker Treatment After a Heart Attack (PBH)**—the percentage of members 35 years of age and older who were hospitalized and discharged alive and diagnosis of acute myocardial infarction (AMI) and who received persistent beta-blocker treatment for six months after discharge.

- **Cholesterol Management for Patients With Cardiovascular Conditions (CMC)**—the percentage of members 18–75 years of age who were discharged alive for acute myocardial infarction (AMI), coronary artery bypass graft (CABG) or percutaneous transluminal coronary angioplasty (PTCA), or who had a diagnosis of ischemic vascular disease (IVD), who had each of the following during the measurement year:

  - LDL-C screening performed
  - LDL-C control (<100 mg/dL)

- **Comprehensive Diabetes Care**—looks at how well a health plan cares for common and serious chronic diabetes in members age 18-75

- Glycohemoglobin (HbA1c) blood test
- Poorly controlled diabetes (HbA1c>9.0 percent)
- Good diabetes control (HbA1c<7.0 percent)
- LDL-C screening
- LDL-C level below 100 mg/dL
- Eye exam
- Kidney Disease Screening
- Blood pressure level <130/80 mm Hg
- Blood pressure level <140/90 mm Hg

- **Use of Appropriate Medications for People with Asthma**—evaluates whether members with persistent asthma are being prescribed medications acceptable as primary therapy for long-term control of asthma
  - Age 5-9
  - Age 10-17
  - Age 18-56
  - Combined ages 5-56

- **Use of Spirometry Testing in the Assessment and Diagnosis of COPD (SPR)—** looks at the percentage of members 40 years of age and older with a new diagnosis or newly active chronic obstructive pulmonary disease (COPD) who received appropriate spirometry testing to confirm the diagnosis.

- **Follow-up After Hospitalization for Mental Illness**—looks at the continuity of care for mental illness by estimating the percentage of members, age six or older, who were hospitalized for selected mental disorders and were subsequently seen on an outpatient basis by a mental health provider after their discharge
  - 30 day follow-up
  - 7 day follow-up

- **Antidepressant Medication Management**—looks at whether adults treated with drugs for depression are receiving good care
  - Optimal Practitioner Contacts for Medication Management—at least three follow-up office visits
  - Effective Acute Phase Treatment—three months
  - Effective Continuation Phase Treatment—six months

- **Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication (ADD)—**looks at percentage of children newly prescribed ADHD medication who have at least 3 follow-up care visits within a 10-month period, one of which is within 30 days of when the first ADHD medication was dispensed.
  - Initiation Phase
  - Continuation and Maintenance (C&M) Phase

- **Use of Imaging Studies for Low Back Pain--**assesses if imaging studies (plain x-ray, MRI, CT scan) are over utilized in the evaluation of patients with acute low back pain.

Measures examined from the **Access/Availability of Care** domain include:

- **Adults' Access to Preventive/Ambulatory Health Services**—indicates whether adult members are getting preventive and ambulatory services from their plan and looks at the percentage of members who have had a preventive or ambulatory visit
  - Age 20-44
  - Age 45-65
  - Age 65 and older

- **Initiation and Engagement of Alcohol and Other Drug Dependence Treatment**—this measure calculates two rates using the same population of members with Alcohol and Other Drug (AOD) dependence:
  - Initiation of AOD Dependence Treatment: The percentage of adults diagnosed with AOD dependence who initiate treatment through either:
    - an inpatient AOD admission, or
    - an outpatient service for AOD dependence and an additional AOD services within 14 days
  - Engagement of AOD Treatment is an intermediate step between initially accessing care (in the initiation treatment) and completing a full course of treatment. This measure is designed to assess the degree to which members engage in treatment with two additional AOD services within 30 days after initiation.

- **Children's Access to Primary Care Practitioners**—looks at visits to pediatricians, family physicians and other primary care providers as a way to assess general access to care for children
  - Age 12-24 months
  - Age 25 months-6 years
  - Age 7-11
  - Age 12-19

- **Prenatal and Postpartum Care**
  - Timeliness of prenatal care—the percentage of pregnant women who began prenatal care during the first 13 weeks of pregnancy or within 43 days of enrollment if a woman was more than 13 weeks pregnant when she enrolled
  - Postpartum care—the percentage of women who had live births and who had a postpartum visit between 21 days and 56 days after delivery.

Measures examined from the **Use of Services** domain include:

- **Adolescent Well-Care Visits**—looks at the use of regular check-ups by adolescents. It reports the percentage of adolescents 12-21 who had one or more well-care visits with a primary care provider or OB/GYN during the measurement year.

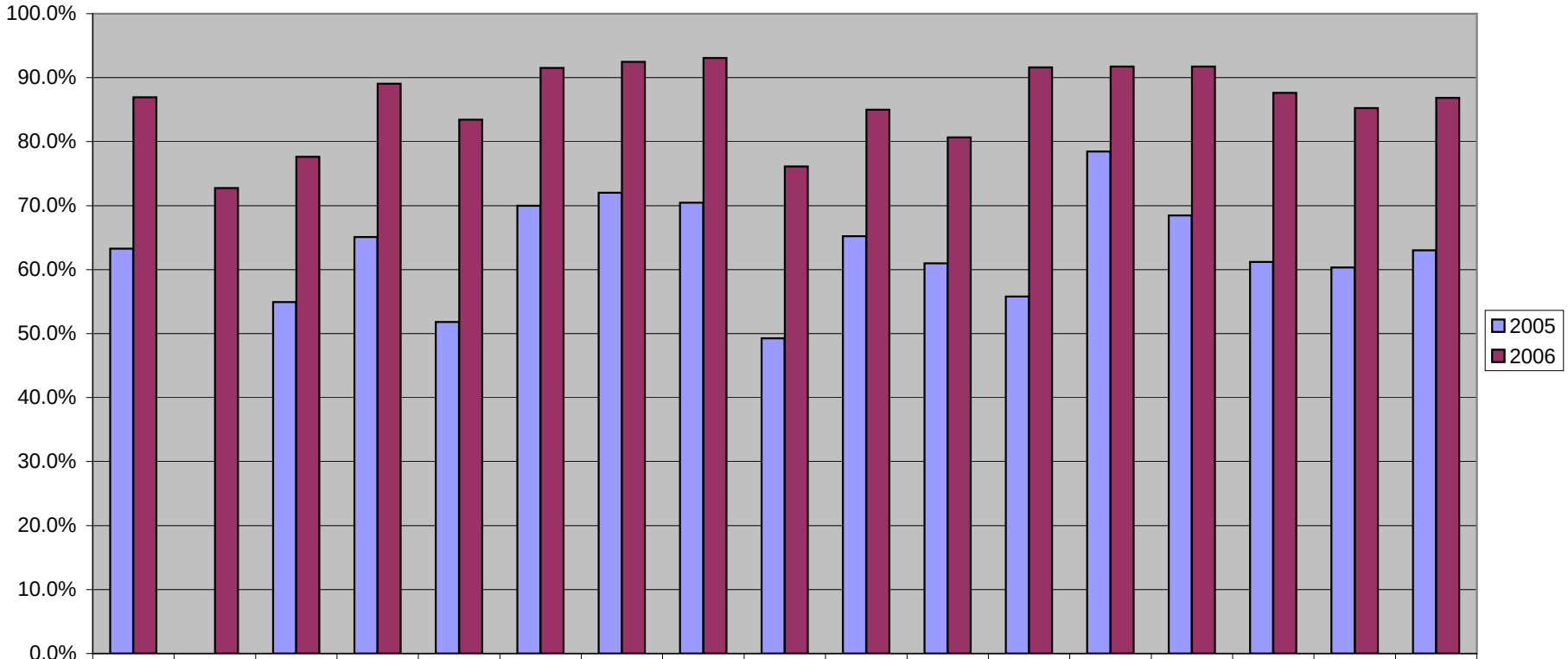
- **Call Answer Timeliness—** reports the percentage of calls received by member services call centers (during operating hours) during the measurement year that were answered by a live voice within 30 seconds.

- **Call Abandonment**—the percentage of calls received by member services call centers (during operating hours) during the measurement year that were abandoned by the caller before being answered by a live voice.

- **Well-Child Visits in the First 15 Months of Life**—looks at the adequacy of well-child care for infants. It estimates the percentage of children who had six or more visits by the time they turn 15 months of age**.**

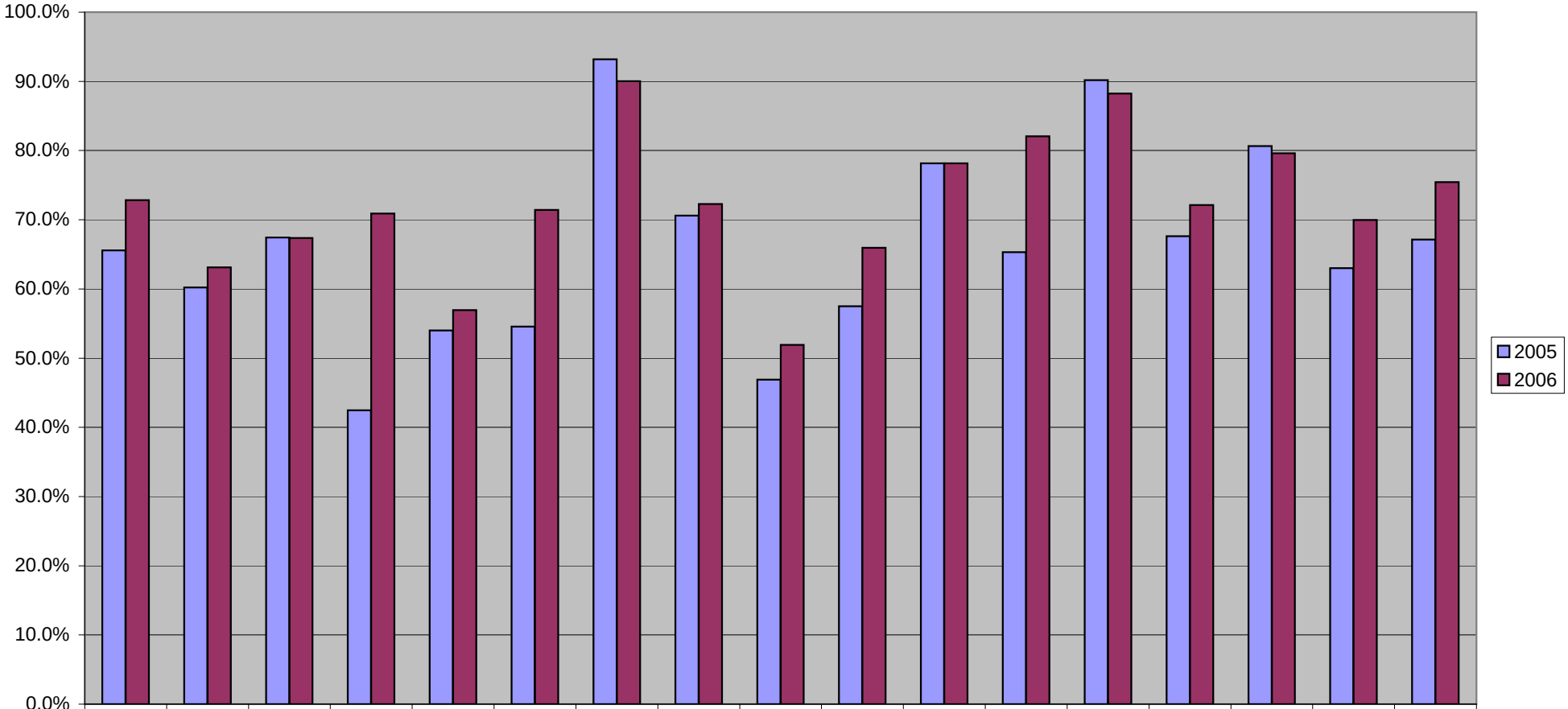
- **Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life**—looks at the use of routine check-ups by preschool and early school aged children who are 3, 4, 5, and 6 years old who received at least one well-child visit with a primary care practitioner during the measurement year.

Appendix #9: Childhood Immunization Status: Pneumococcal Conjugate



	ETF Plan Average	National Average	Anthem BCBS	Arise Health Plan	Dean Health Plan	GHC-Eau Claire	GHC-SCW	Gundersen Lutheran	Health Tradition	Humana	Medical Associates	MercyCare Health Plan	Network Health Plan	Physicians Plus	Security Health Plan	UnitedHealthcare	Unity Health Insurance
2005	63.3%	0.0%	54.9%	65.1%	51.8%	70.0%	72.0%	70.4%	49.3%	65.2%	61.0%	55.8%	78.5%	68.5%	61.2%	60.3%	63.0%
2006	86.9%	72.8%	77.6%	89.0%	83.5%	91.5%	92.5%	93.1%	76.1%	85.0%	80.7%	91.6%	91.7%	91.7%	87.6%	85.3%	86.9%

Appendix #10 Adolescent Immunization Status: Chicken Pox



	ETF Plan Average	National Average	Anthem BCBS	Arise Health Plan	Dean Health Plan	GHC-Eau Claire	GHC-SCW	Gundersen Lutheran	Health Tradition	Humana	Medical Associates	MercyCare Health Plan	Network Health Plan	Physicians Plus	Security Health Plan	UnitedHealth care	Unity Health Insurance
2005	65.6%	60.2%	67.4%	42.4%	54.0%	54.5%	93.2%	70.6%	46.9%	57.5%	78.2%	65.3%	90.2%	67.6%	80.6%	63.0%	67.2%
2006	72.8%	63.1%	67.4%	70.9%	56.9%	71.4%	90.0%	72.3%	51.9%	65.9%	78.2%	82.1%	88.2%	72.1%	79.6%	70.0%	75.4%

Appendix #11 Comparison of 2006 Participating HMO averages to 2005 HMO averages and 2006 National Averages

Domain	Measure	Score	2005 ETF Average	2006 ETF Average	2006 National Average	2006 ETF minus National Average	2006 ETF Average minus 2005 ETF Average	Not Trendable
Effectiveness of Care								
	Childhood Immunization Status	DTaP/DT	89.6%	91.4%	87.2%	4.2%	1.8%	
	Childhood Immunization Status	IPV	94.2%	94.8%	91.4%	3.4%	0.6%	
	Childhood Immunization Status	MMR	95.1%	95.8%	93.6%	2.2%	0.7%	
	Childhood Immunization Status	HiB	95.8%	95.5%	93.4%	2.1%	-0.3%	
	Childhood Immunization Status	Hepatitis B	93.6%	95.0%	91.0%	4.0%	1.4%	
	Childhood Immunization Status	VZV	91.5%	91.5%	90.9%	0.6%	0.0%	
	Childhood Immunization Status	Pneumococcal Conjugate	63.3%	86.9%	72.8%	14.1%	23.6%	
	Childhood Immunization Status	Combination #2	82.3%	85.0%	79.8%	5.2%	2.7%	
	Childhood Immunization Status	Combination #3	57.6%	79.5%	65.7%	13.8%	21.9%	
	Adolescent Immunization Status	MMR	84.6%	87.4%	78.8%	8.6%	2.8%	
	Adolescent Immunization Status	Hepatitis B	80.7%	83.5%	74.6%	8.9%	2.8%	
	Adolescent Immunization Status	VZV	65.6%	72.8%	63.1%	9.7%	7.2%	
	Adolescent Immunization Status	Combination #2	58.1%	65.8%	57.7%	8.1%	7.7%	
	Appropriate Treatment for Children With Upper Respiratory Infection	Appropriate Treatment for Children With Upper Respiratory Infection	88.7%	87.0%	82.8%	4.2%	-1.7%	
	Appropriate Testing for Children With Pharyngitis	Appropriate Testing for Children With Pharyngitis	76.4%	80.2%	72.7%	7.5%	3.8%	
	Inappropriate Antibiotic Treatment for Adults with Acute Bronchitis (AAB)	Received Antibiotic Prescription within 3 days	NA	71.0%	71.3%	-0.3%	First Year Reported	
	Colorectal Cancer Screening	Colorectal Cancer Screening	57.4%	60.5%	54.5%	6.0%	3.1%	
	Breast Cancer Screening	Breast Cancer Screening 52-69	77.7%	77.8%	72.0%	5.8%	NA	X
	Breast Cancer Screening	Breast Cancer Screening 42-51	NA	71.2%	NA	NA	NA	X
	Breast Cancer Screening	Breast Cancer Screening Total	NA	74.6%	68.9%	5.7%	NA	X
	Cervical Cancer Screening	Cervical Cancer Screening	84.5%	84.0%	81.0%	3.0%	-0.5%	
	Chlamydia Screening	Chlamydia age 16-20	37.5%	36.6%	36.2%	0.4%	-0.9%	
	Chlamydia Screening	Chlamydia age 21-25	34.6%	36.1%	38.0%	-1.9%	1.5%	
	Chlamydia Screening	Chlamydia Total	36.0%	36.3%	37.3%	-1.0%	0.3%	
	Controlling High Blood Pressure	Blood Pressure Measure 46-85	69.7%	63.8%	NA	NA	NA	X
	Controlling High Blood Pressure	Blood Pressure Measure 18-45	NA	65.1%	NA	NA	NA	X
	Controlling High Blood Pressure	Blood Pressure Measure Total	NA	64.0%	59.7%	NA	NA	X
	Beta Blocker Treatment After a Heart Attack	Treatment Measure	96.7%	97.8%	97.7%	0.1%	1.1%	
	Persistence of Beta-Blocker Treatment after a Heart Attack	Persistence of Beta-Blocker Treatment after a Heart Attack	69.0%	72.9%	72.5%	0.4%	3.9%	
	Cholesterol Management after Acute Cardiovascular Conditions	LDL-C Screening	NA	88.8%	87.5%	1.3%	NA	X
	Cholesterol Management after Acute Cardiovascular Conditions	LDL-C Level <100 mg/dL	NA	63.2%	56.6%	6.6%	NA	X
	Comprehensive Diabetes Care	HbA1c Testing	92.2%	92.0%	87.5%	4.5%	-0.2%	
	Comprehensive Diabetes Care	Poor HbA1c Control >9.0%	20.9%	20.6%	29.6%	-9.0%	-0.3%	
	Comprehensive Diabetes Care	Good HbA1c Control <7.0%	NA	44.3%	NA	NA	First Year Reported	
	Comprehensive Diabetes Care	Eye Exam	67.8%	68.6%	54.7%	13.9%	0.8%	
	Comprehensive Diabetes Care	LDL-C Screening	93.8%	84.3%	83.4%	0.9%	NA	X

Appendix #11 Comparison of 2006 Participating HMO averages to 2005 HMO averages and 2006 National Averages

Domain	Measure	Score	2005 ETF Average	2006 ETF Average	2006 National Average	2006 ETF minus National Average	2006 ETF Average minus 2005 ETF Average	Not Trendable
	Comprehensive Diabetes Care	LDL-C Level <100 mg/dL	51.3%	48.3%	43.0%	5.3%	-3.0%	
	Comprehensive Diabetes Care	Medical Attention for Nephropathy	63.2%	85.4%	79.7%	5.7%	NA	X
	Comprehensive Diabetes Care	Blood Pressure Control <130/80 Hg	NA	38.3%	NA	NA	First Year Measure	
	Comprehensive Diabetes Care	Blood Pressure Control <140/90 Hg	NA	68.4%	NA	NA	First Year Measure	
	Use of Appropriate Medications for People with Asthma	Asthma age 5-9	97.5%	97.2%	96.4%	0.8%	-0.3%	
	Use of Appropriate Medications for People with Asthma	Asthma age 10-17	92.0%	91.9%	92.9%	-1.0%	-0.1%	
	Use of Appropriate Medications for People with Asthma	Asthma age 18-56	90.4%	91.1%	90.3%	0.8%	0.7%	
	Use of Appropriate Medications for People with Asthma	Asthma Combined	91.3%	91.8%	91.6%	0.2%	0.5%	
	Use of Spirometry Testing in the Assessment and Diagnosis of COPD (SPR)	Appropriate Spirometry Testing	NA	37.9%	NA	NA	First Year Measure	
	Follow-Up After Hospitalization for Mental Illness	30-day follow-up	82.9%	83.2%	75.8%	7.4%	0.3%	
	Follow-Up After Hospitalization for Mental Illness	7-day follow-up	58.3%	61.0%	56.7%	4.3%	2.7%	
	Antidepressant Medication Management	Optimal Practicioner Contacts for Medication Management	22.0%	24.4%	20.3%	4.1%	2.4%	
	Antidepressant Medication Management	Effective Acute Phase Treatment	65.1%	65.4%	61.1%	4.3%	0.3%	
	Antidepressant Medication Management	Effective Continuation Phase Treatment	48.6%	49.9%	45.1%	4.8%	1.3%	
	Use of Imaging Studies for Low Back Pain	Use of Imaging Studies for Low Back Pain	76.6%	76.6%	73.9%	2.7%	0.0%	
	Follow-Up Care for Children Prescribed with Attention-Deficit/Hyperactivity Disorder	Initiation Phase	NA	30.4%	33.0%	-2.6%	First Year Reported	
	Follow-Up Care for Children Prescribed with Attention-Deficit/Hyperactivity Disorder	Continuation and Maintenance Phase	NA	27.1%	NA	NA	First Year Reported	
	Disease Modifying Anti-Rheumatic Drug Therapy in Rheumatoid Arthritis	At least one ambulatory prescription dispensed	NA	90.7%	84.8%	5.9%	First Year Reported	
Access/Availability of Care								
	Adults' Access to Preventive/Ambulatory Health Services	Access Age 20-44	94.4%	95.0%	93.1%	1.9%	0.6%	
	Adults' Access to Preventive/Ambulatory Health Services	Access Age 45-64	96.3%	96.4%	95.1%	1.3%	0.1%	
	Adults' Access to Preventive/Ambulatory Health Services	Access Age 65 and older	98.1%	98.6%	96.6%	2.0%	0.5%	
	Children's Access to Primary care Practitioners	Access 12-24 months	97.8%	97.9%	97.0%	0.9%	0.1%	
	Children's Access to Primary care Practitioners	Access 25 months-6 years	89.7%	89.5%	89.3%	0.2%	-0.2%	
	Children's Access to Primary care Practitioners	Access 7-11 years	86.9%	89.3%	89.2%	0.1%	2.4%	
	Children's Access to Primary care Practitioners	Access 12-19 years	87.1%	89.2%	86.6%	2.6%	2.1%	
	Prenatal and Postpartum Care	Timeliness of Prenatal Care	93.6%	90.7%	79.9%	10.8%	-2.9%	
	Prenatal and Postpartum Care	Postpartum Care	84.6%	83.9%	90.6%	-6.7%	-0.7%	
	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	Initiation of Alcohol and Other Drug Dependence Treatment (Total)	35.9%	39.4%	43.2%	-3.8%	3.5%	
	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	Engagement of Alcohol and Other Drug Dependence Treatment (Total)	12.5%	16.5%	13.8%	2.7%	4.0%	
	Call Timeliness	Call Timeliness	75.7%	77.7%	75.3%	2.4%	2.0%	
	Call Abandonment	Call Abandonment	3.5%	3.0%	3.0%	0.0%	-0.5%	
Use of Services								
	Well-Child Visits in the First 15 Months of Life	Well-Child Visits in the First 15 Months of Life (six or more visits)	72.1%	79.6%	72.9%	6.7%	7.5%	
	Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	64.8%	65.9%	66.7%	-0.8%	1.1%	
	Adolescent Well-Care Visits	Adolescent Well-Care Visits	35.5%	36.4%	40.3%	-3.9%	0.9%	

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CORRESPONDENCE MEMORANDUM

DATE: January 18, 2008

TO: Group Insurance Board

FROM: Bill Kox, Director, Health Benefits and Other Insurance Programs
Arlene Larson, Manager, Self-Insured Health Plans

SUBJECT: Third Party Audit of Navitus Health Solutions

The Department of Employee Trust Funds (ETF) retained CGI Technologies & Solutions Inc. (CGI), a subcontractor of Claim Technologies Incorporated, to conduct an audit of Navitus Health Solution's (Navitus) administration of the self-insured prescription drug program for calendar years 2004 and 2005. CGI has completed its audit and submits the attached reports, including an executive summary and the analysis of the audit. Navitus' response is also attached.

The CGI report and Navitus response letter is provided for the Board's information only. No action is required.

Overall, Navitus is performing very well. The audit covered 7,719,156 paid claims totaling $361,014,774 in 2004 and 2005. The audit found an observed accuracy rate between 99.92% and 99.93%. In its broadest measure, Navitus is at the top of the highest quartile when compared with other CGI clients.

CGI has validated accurate processing by Navitus of most processes, including the administration of rebates for the program. However, there are findings in a few areas where process improvements could be made. After an electronic audit of all claims, CGI found a maximum exposure amount between $251,910 and $295,536, due to unresolved discrepancies.

Navitus responded that it was pleased with the findings and is committed to improvement (see attached letter).

The following items reviewed findings related to duplicate claims, early prescription refills, and prescriptions filled for a gender where it is not indicated as a treatment. Staff has reports detailing the auditor's findings that are available to the Board upon request.

1. CGI found potential duplicate retail claims that appeared to be filled twice within four days. CGI found $120,978 from 3,510 claims, for which the Trust Fund was liable, that appeared to have been paid as duplicates. Navitus performed an analysis of claims processed during a representative month (May 2005) and determined that no reviewed claims had been paid as duplicates. Rather, they had been processed with an appropriate pharmacist override.

Reviewed and approved by Tom Korpady, Division of Insurance Services.

_____ _____
Signature Date

Board	Mtg Date	Item #
GIB	2/12/2008	3

Navitus states (see attached letter) that its practice for managing duplicate claims offers adequate protection against duplicate claims and at the same time allows the pharmacist to make appropriate clinical judgements that are within the scope of his/her practice. The auditor found that, in reviewing the representative sample, each claim was reviewed appropriately and no duplicates were found. Staff believes this is an indication that Navitus' process is appropriate.

In addition, analysis of the data by Navitus showed that some pharmacies were using this process to manage coordination of benefits (COB) for prescription drugs for some members who had two policies under the state. Navitus believes that this is not the most appropriate method for submitting COB information, and will contact these pharmacies.

2. During analysis of early prescription refills, CGI found that 10,015 retail and 104 mail order claims appeared to have been filled prior to established refill parameters, which could lead to situations where patients could stockpile prescription drugs. This can be an issue for those who are losing eligibility and therefore receiving prescription coverage inappropriately after their termination dates. The value of this finding was $111,551. This finding is similar to the duplicate claim finding, described above. It also is controlled by the pharmacist and allowed for override if determined to be appropriate for the patient. Navitus submitted screen prints of 374 sample retail claims to CGI for verification, and it was found that, as with duplicate claims, the override appears to have been appropriately managed by the pharmacist. As such, CGI accepted the documentation and eliminated the finding for the 374 claims. However, CGI did not remove the remainder of the finding without specific claim-by-claim documentation. Staff feels that the representative sample is sufficient and a complete review of these claims would not be necessary or cost effective. Staff will continue to discuss opportunities for improvement with Navitus.

3. CGI discovered non-matched gender prescriptions where members of one gender appeared to be receiving prescriptions that CGI notes should not be utilized by that gender. CGI identified 1,254 claims valued at $50,514 that appeared to be provided to a gender that was not indicated for its use. A sample of the top ten highest cost utilizers of either gender was sent to Navitus for review. Navitus did find errors and noted that it had incorporated system edits to review for gender-based prescriptions on November 16, 2005. In addition, Navitus will implement an edit for Proscar and consider additional edits for other prescriptions. Staff will work with Navitus to determine if additional gender edits would be advisable.

Other findings were for relatively small dollar amounts, approximately $15,000 or less. In addition, when comparing Navitus to other vendors, Navitus performed at a level of 99.95% or higher. These findings include:

- Duplicate claims where it appears drugs were dispensed within the same drug classification in an overlapping time frame.
- Excessive quantities appeared to have been dispensed, beyond utilization guidelines.
- Four specifically non-covered drugs were covered.
- Drug-seeking behavior occurred and was not controlled to CGI’s satisfaction.
- Drugs appeared to have been dispensed exceeding the package size.
- Invalid Drug Enforcement Administration (DEA) numbers were used by certain providers.

In many categories Navitus was ranked at 99.99%. These findings are described throughout the detail of the audit. Navitus noted in its response letter that several identified areas will be added to its internal auditing protocol for future review.

Staff feels that these findings will help Navitus continue to improve its documentation strategies. We plan to work with Navitus to determine what changes should be made to further enhance performance.

It should be noted the auditor's observed accuracy for claim payment rate was between 99.92% and 99.93%, exceeding Navitus' performance standard under the contract, which is 99.5%.

In summary, Navitus has performed very well and the maximum exposure following an electronic audit of all claims results in an observed error rate of approximately .07%. Staff will work with Navitus to determine cost-effective changes for those areas targeted for improvement.

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January 16, 2008

Arlene Larson
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Re: Response to CGI Technologies & Solutions Audit of ETF Claims for 2004 and 2005.

Dear Arlene,

Thank you for the opportunity to allow Navitus to comment on the summary of the audit findings provided by CGI.

We are very pleased to hear that the findings showed a 99.93%/99.2% level of plan payment accuracy.

We do have responses to the summary provided by CGI.

Categories: **Duplicate Mail/Duplicate Retail**
Early Refill Retail/Early Refill Mail,
Duplicate Therapy.

Duplicate Mail/Duplicate Retail
Early Refill Retail/Early Refill Mail

Navitus reviewed archived SXC claims for May and determined that the duplicate claims resulted from a pharmacist override. The pharmacist has the option to override any "SOFT REJECT." Definitions of "SOFT AND HARD REJECTS" are as follows:

Definitions:
A SOFT REJECT will reject a claim that has been submitted by the dispensing pharmacy. Once the pharmacist has reviewed the claim they can submit the claim a second time after entering a code indicating that they have reviewed the claim, and feel that it is appropriate to continue to fill the claim. The reason it is called a SOFT REJECT is because it can be manually overridden by the pharmacist at the pharmacy, after first being reviewed.

A HARD REJECT is one that cannot be overridden by the dispensing pharmacy, and the pharmacy must call Navitus and request that an authorization be entered before the claim will be allowed to be processed and paid. The Navitus claims processor uses many edits that check each claim as it is submitted. One of the checks is to determine if the claim submitted is a duplicate of a claim previously submitted. If the claims processor identifies the claim as a duplicate, based on the drug and strength, the system will reject the claim and message the pharmacy back stating that this is a duplicate prescription. This will be a SOFT REJECT if the duplicate prescription is being filled at the same pharmacy. If the duplicate prescription is being filled at a different pharmacy this would be considered a HARD REJECT and the pharmacy would have to call Navitus to get the claim to pay.

Navitus allows the pharmacy to use its professional judgment to fill or not to fill a duplicate prescription if they have record of both prescriptions being filled; and therefore, this is considered a SOFT REJECT the pharmacist can override themselves. When the duplicate prescription is being filled at a different pharmacy the dispensing pharmacy does not have all the information to make that professional judgment to fill or not to fill, and is required to call Navitus to discuss the situation prior to Navitus entering an auth to allow the claim to be paid.

Duplicate Therapy Screening checks to ensure a patient is not taking two or more medications from the same therapeutic class. This edit uses a table within the claims processing system that is developed by Medispan, a leading supplier of drug information, to include what would be considered a duplicate therapy situation. Currently, this edit is set up to SOFT REJECT. A SOFT REJECT will reject the claim the first time the pharmacy submits for payment, but allows the pharmacy to manually override this edit themselves on the second submission.

Response
In the initial discussions on system set-up, a decision was made by the Navitus Pharmacy and Therapeutics Committee, which is made up of pharmacists and physicians, to allow a SOFT REJECT, allowing pharmacists to make these types of decisions for members and to assist in providing as little disruption for members as possible.

The SOFT REJECT serves two purposes. By rejecting the claim initially; it requires the pharmacist to look at the type of rejection received. The second purpose it serves is, if the pharmacist deems the claim is appropriate, they have the ability to override the submission themselves. This does not require the pharmacy to contact Navitus to have an authorization added. This allows the pharmacist to make appropriate clinical judgments that are within his/her scope of practice.

The claims processor vendor only provides eighteen months worth of claims that show the entire claim transaction. Claims paid before the eighteen months are archived and it is cost prohibitive to extract all the daily extract files and remove only ETF members from the files. The Navitus data warehouse does not house the field that shows the override.

Navitus was able to review a total of 40 screen prints from 2005 claims showing the pharmacy rejects of “0000000003” or a “3.” **100% of the claims pulled showed a SOFT REJECT happened and that the claim was overridden by the pharmacist.**

Navitus is confident that 100% of the claims in the Duplicate Therapy and Early Refill categories were the result of a SOFT REJECT that was reviewed by the pharmacist and subsequently overridden by the pharmacist. Navitus would be happy to pull additional random claims if requested. Also, if the State decides to collect the amount shown on the spreadsheet, Navitus would like the opportunity to pull the claims at issue in order to show the SOFT REJECT.

Pharmacists may decide to override SOFT REJECTS for other reasons as well, some of which include:

1. Upon review of the claims, it was discovered that many of the Duplicate Retail/Mail claims listed on the spreadsheet are the result of coordination of benefits for members who have coverage under two policies with the State. If the first line of the duplicate claims shows a copayment amount and the second line shows "0," this means the second claim was sent in for Navitus to process as secondary coverage (and covers any copay amount remaining from the first claim submission). This is not typically a normal way of submitting COB and Navitus will work with those pharmacies to coordinate benefits in a more traditional manner.

2. Pharmacies may also override a soft reject when a prescriber rewrites a prescription for the tablet splitting program and a member tries to get a refill early. The new prescription is a higher dose (and half the number of tablets), which results in a different prescription number.

Intervention:

Navitus is exploring several options:

1. Turn off the ability for pharmacists to enter in an override, forcing pharmacists to call Navitus for each situation. This would greatly increase member disruption and the pharmacist's ability to make clinical judgments that are within their scope of practice.
2. Explore the option of being able to use the soft override in some situations but not others, or to be able to have several "override" codes to track why pharmacists are using the overrides. This is being explored with the new claims processing system.
3. In 2008, auditing Duplicate Prescriptions, Overrides, and Refill Too Soon will be added to Navitus' internal auditing process.

Duplicate Therapy

Navitus believes the Duplicate Therapy claims related to oral contraceptives (OC's), antihistamines, and narcotics were reasonable and appropriate. Patients often cannot tolerate specific OC's and are switched to another OC that contains a different combination of hormones. There are also some instances where members need more than one antihistamine to control symptoms of itching or rash. Also, prescribing two different narcotics is clinically appropriate and used often as step down therapy. This is when members use a more potent narcotic first until the pain level reduces at which time the member can use the less potent narcotic. It is also considered standard of care to use both a long acting narcotic in combination with a short acting narcotic for those times when members have break through pain.

Navitus determined that duplicate claims for these instances are reasonable and appropriate.

Quantity Dispensed Exceeds Standard Package Size

The drugs on the spreadsheet were reviewed by a Navitus pharmacist. His conclusions are:

- Nasal sprays – Navitus does not currently have quantity limits in place for nasal sprays. Our focus on quantity limits is around safety and preventing misuse or overuse. This is not an issue with nasal sprays.
- Micardis – The specific drug identifier (NDC) of Micardis comes in a bottle of 28. Since the drug benefit allows for 30 days supply and this drug is given once each day the pharmacist opens up another bottle and puts two tabs in the bottle of 28 to make a quantity of 30. This is reasonable and appropriate.
- Prempo – Prempro comes in a package size for a 28-day supply. In this case pharmacists are used to putting in a quantity of 30 so they are miskeying the quantity amount. They are keying in a quantity of 30 when in actuality a quantity of 28 was dispensed.

Intervention:
Navitus is currently evaluating quantity limits for oral inhalers, nasal sprays, topical creams and ointments, and eye drops. We will be evaluating quantity limits based on safety but also potential for misbilling on the part of the pharmacy. Also, in 2008, Quantity Limit/Days Supply and Quantity Limit, Package Size will be added to Navitus' internal auditing process.

Non-Matched Gender Male

Initially claims were checked to see if they were processed incorrectly under a spouse of the member. The member on Premarin and Medroxyprogesterone were processed incorrectly to the husband. This has been corrected.

The gender of the member on Prometrium and Estradiol is listed as "M" and the member's name is XXXXX. This was an eligibility issue and ETF was contacted to correct the member's gender code.

Zelnorm was approved by the U.S. Food and Drug Administration for the treatment of chronic idiopathic constipation in male and female patients less than 65 years of age on August 23, 2004. This is clinically appropriate treatment.

Danazol (Danocrine) is indicated for the prophylaxis of attacks of hereditary angioedema of a severe or life-threatening nature, in male and female patients. Because of this information, the treatment is clinically appropriate.

Navitus has been unsuccessful in contacting the provider for the member on Fareston. Studies have shown this medication is used off label for prostate cancer; however the medication profile does not indicate a diagnosis of prostate cancer. The last fill of this medication was on 8/25/05.

Navitus has also been unsuccessful in contacting the providers of the members on Arimidex and Femara. Neither of these members are currently on these prescriptions. It may be that these prescriptions were filled in error.

Intervention:
Age and gender edits were added as an edit on multiple products on November 16, 2005.

Non-Matched Gender Females

Initially claims were checked to see if they were processed incorrectly under a spouse of the member. It was determined they were processed correctly in that regard. Upon further investigation the following findings were concluded:

Androgel and Androderm are used in post-menopausal women to treat decreased libido. Many times these products are compounded which is an exclusion in "It's Your Benefit" which states, "Non-FDA approved prescriptions, including compounded estrogen, progesterone or testosterone products, except as authorized by the PBM." Androgel and Androderm are FDA approved products, but are not indicated for this use.

Uroxatral is in a group of drugs called alpha-adrenergic blockers. Uroxatral helps relax the muscles in the prostate, in males, and also relaxes the bladder neck in both males and females, making it easier to urinate. One of the members identified is using two other medications to help her urinate, and the other member has been changed to another alpha-adrenergic agent called doxazosin. This is again being used off-label.

Proscar is given in combination with oral contraceptives to treat female hair loss. This member is also taking estrogen and progesterone. This is a definite exclusion.

Intervention:
Age and gender edits were added as an edit on multiple products on November 16, 2005. Navitus will evaluate if there needs to be a gender edit placed on Androgel, Androderm and Uroxatral. A gender edit will be placed on Proscar.

Unofficial DEA for Controlled Substances Claims

In 2004 and 2005 Navitus did not require an official DEA# to process prescriptions. In late 2006 Navitus this became a requirement. Because an official DEA# was not previously required, pharmacists, who may not have known a prescriber's DEA#, could put in a dummy DEA# to get the prescription to adjudicate (if the claim was not for a narcotic). These claims are usually the result of prescriptions written by providers out of the area, emergency room providers, or pharmacists who do not take the time to get an official DEA#.

Intervention:
Navitus currently requires a DEA/NPI# to process prescriptions (implemented later part of 2006).

Excessive Quantities Dispensed

A Navitus pharmacist reviewed the claims on the spreadsheet. For member 10368761, per the call notes from a Navitus pharmacist: at that time,

"Discussed unusual narcotic regimen with his physician who indicated this is the narcotic regimen he prescribed. He will be on this regimen for at least the next year which includes Methyphenidate #90, hydromorphone #640, oxycodone #3600 per month. Having confirmed this is a valid regimen per his MD, will enter the appropriate authorization."

ETF was not contacted since this was related to a clinical determination made by the member's physician. If ETF would like to be notified of situations like this, Navitus would be happy to do so.

Please note: The Quantity listed is much higher than what was actually dispensed or charged due to incorrect entry of the Quantity by the pharmacist or pharmacy technician (usually these are "fat finger" errors). As you can see from the Quantity amounts listed 3028571 was listed instead of 30, etc.

Navitus does not automatically pay claims based on the Quantity amount. The Net Pay amount is appropriate for the Days Supply, not the Quantity indicated**. Navitus has logic built in to pay claims the lower of the Average Wholesale Price (AWP) or Maximum Allowable Cost (MAC) or Usual and Customary (U&C), so the claim would not pay if the Quantity entered was an error.**

Drugs Requiring PA - Restasis

Navitus has a prior authorization process in place that limits coverage of Restasis to providers who are optometrists or ophthalmologists. Once a provider fills out the form that is located on the Navitus Web site, the provider name is added to the claims processing system to generate auto-approvals for prescribing Restasis. This edit was added to the system on July 18, 2005 with an effective date of August 1, 2005. A list of provider names was provided**. Claims filled prior to August 1, 2005 did not require a prior authorization.**

Non-Covered Clarinex

Clarinex was appropriately set up in the system to reject. However, when Clarinex D and Clarinex Syrup came on the market, Navitus did not immediately add them to the list of medications to reject for coverage.

Intervention:

The formulary change process has evolved over time and Navitus now has a very detailed process to document all changes, including new formulations and dosage forms. In addition, we have changed how we build the formulary by eliminating the possibility of a change resulting in a product paying at the incorrect level. The change control process Navitus has in place today would not have allowed this situation to occur.

Non-Covered Clindamycin

The original set up in November of 2003 in the claims processing system included the coverage of 150 mg and 300 mg strengths. The intent was to cover only the 150 mg strength and not cover the 300 mg strength.

Intervention:

On January 12, 2004, the system set up was corrected to reject the 300 mg strength.

Non-Covered Prozac Liquid
Initially a decision was made to not cover Prozac liquid; however, it was set up in the system to be covered.

Intervention:
Upon review in early 2005, the decision was made to cover Prozac liquid since it is the only liquid formation.

Non-covered Sarafem
Sarafem was initially set up correctly to reject coverage. In July of 2004 Medispan reclassified the drug and it was then set up incorrectly to be covered.

Intervention:
The system was set up to reject coverage of Sarafem on September 23, 2004.

Drug Seeking Behavior Cases
Navitus Health Solutions implemented a Substance Abuse Monitoring Program in December of 2005 as a pilot program for the State of Wisconsin. The criteria set up were at a high level and only 11 members were flagged. A clinical review was done on each of the members to ensure that the findings were appropriate. Letters were then sent to the prescribers of the member notifying them of a potential problem with abuse.

The Substance Abuse Monitoring Program was again run in July and November of 2006 and May of 2007. Upon review of the pilot run, the criteria has been changed with successive runs to strengthen the targeting ability (identify more members who may have an issue with substance abuse).

All of the members identified on the spreadsheet would have been identified as having a potential problem if the current criteria of the program had been instituted in 2004 and 2005.

10166278	Member was identified in the May, 2007 process and letters mailed to prescribers.
10268973	Current review of claims shows member being treated appropriately with no excessive use.
10213188	Member was identified in the May, 2007 process and letters mailed to prescribers.
10107846	Member was identified in the May, 2007 process and letters mailed to prescribers.
10155033	Current review of claims shows member being treated appropriately with no excessive use.
10202835	Member was identified in the November, 2006 process. Current review of claims shows improvement made in use of narcotics.
10116397	Current review of claims indicates member is being treated by one main prescriber with no excessive overuse.
10339679	Member termed from coverage 3/31/07. Current review of claims shows member may be on a treatment plan for drug abuse.
10031029	Member was identified in the November, 2006 process. Review of claims shows member no longer has claims for narcotics.

10088713	Member was identified in the May, 2007 process and letters mailed to prescribers.
10344399	Current review of claims shows member appears to be on a pain contract.

Navitus has recommended that specific members be restricted to one pharmacy, but it was decided between ETF and Navitus that a second mailing would first be sent out to providers before members would be restricted to one pharmacy.

If ETF decides that they would like to have more information about these cases, Navitus would be happy to supply that information.

Again, thank you for the opportunity to participate in the audit and for sharing the results. It is great hearing that Navitus is administering the benefit for the participants of the State of Wisconsin Group Health Insurance Program at a high level of success.

Sincerely ,

Sue Hill

Sue Hill

CC: Bill Kox
Jeff Bogardus
Joseph Schauer

STATE OF WISCONSIN
Department of Employee Trust Funds
David A. Stella
SECRETARY

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CORRESPONDENCE MEMORANDUM

DATE: January 9, 2008

TO: Group Insurance Board

FROM: David H. Nispel
Deputy Chief Legal Counsel

SUBJECT: Approval of Scope Statement Regarding Proposed Amendment to Wis. Admin. Code s. ETF 11.11

The Board is asked to approve the attached scope statement.

The Department of Employee Trust Funds (Department) proposes to modify Wis. Admin. Code s. ETF 11.11, relating to the appointment of legal counsel to advise the boards attached to the Department while the boards consider a final decision pertaining to an appeal. Approval of the scope statement is the first step in promulgating an administrative rule. The final version of the proposed rule will be submitted to the boards in the spring of 2008.

The proposed amendment covered by the scope statement concerns appointment of legal counsel by the Employee Trust Funds Board, Wisconsin Retirement Board, Teachers Retirement Board, Group Insurance Board, and the Deferred Compensation Board. The amendment also relates to the nature of the legal representation provided to those boards during their consideration of a final decision pertaining to a pending appeal.

Currently, board staff arranges for legal counsel to advise the boards from one of three sources: 1) the Department of Justice, if the Department is a party to the appeal; 2) the Department's chief counsel, if the Department is not a party to the appeal; and 3) outside counsel, if neither the Department's chief counsel nor the Department of Justice is able to provide legal counsel. The current rule also prescribes a number of specific duties of the legal counsel.

The proposed amendment was prompted by the need to provide the boards with additional flexibility in the use of legal counsel. Under the proposed amendment covered by the scope statement, board staff may arrange for legal counsel for the boards as deemed necessary and in accordance with the statutory responsibilities of the Department of Justice to provide legal counsel. In addition, the proposed amendment would eliminate the itemized duties of the legal counsel contained in the current rule and simply provide that the legal counsel shall provide legal representation to the board.

The scope statement was modified to reflect the concerns expressed at the November board meeting regarding the statutory responsibilities of the Department of Justice under Wis. Stat. s. 40.03 (3). The retirement boards approved this scope statement in December 2007.

Reviewed and approved by Robert J. Conlin, Deputy Secretary.

_____ _____
Signature Date

Board	Mtg Date	Item #
GIB	02/12/2008	4

Statement of Scope of Proposed Rule
Department of Employee Trust Funds

The Department of Employee Trust Funds (department) gives notice pursuant to Wis. Stat. s. 227.135, that it proposes to modify an existing administrative rule, specifically Wis. Admin. Code s. ETF 11.11. The rule relates to legal counsel advising the boards that are attached to the department while a board considers a final decision pertaining to an appeal.

DESCRIPTION OF RULE

The proposed modifications concern appointment of legal counsel by the Employee Trust Funds Board, Wisconsin Retirement Board, Teachers Retirement Board, Group Insurance Board, and the Deferred Compensation Board and the nature of the legal representation provided to those boards during their consideration of a final decision pertaining to a pending appeal. The proposed rule does not change the responsibility of the Department of Justice to provide legal counsel pursuant to Wis. Stat. s. 40.03 (3).

POLICY ANALYSIS

Under current law (Wis. Stat. s. 40.03 (3)), the Department of Justice is required to furnish legal counsel and prosecute and defend all actions brought by or against the Employee Trust Funds Board, the Group Insurance Board, the department, or any employee of the department as a result of the performance of the department employee's duties. Under the current administrative rules, board staff arrange for legal counsel to advise the Employee Trust Funds Board, Wisconsin Retirement Board, Teachers Retirement Board, Group Insurance Board, and the Deferred Compensation Board from one of three sources: 1) the Department of Justice, if the department is a party to the appeal; 2) the department's chief counsel, if the department is not a party to the appeal; and 3) outside counsel, if neither the department's chief counsel nor the Department of Justice is able to provide legal counsel. The current rule also prescribes a number of specific duties of the legal counsel.

Under the proposed modifications, board staff may arrange for legal counsel for the boards as deemed necessary and in accordance with Wis. Stat. s. 40.03 (3). In addition, the proposed modifications will eliminate the specific duties of the legal counsel contained in the current rule and simply provide that the legal counsel shall provide legal representation to the board. The proposed modifications will provide the boards with additional flexibility in the use of legal counsel.

STATUTORY AUTHORITY

Wis. Stat. ss. 40.03 (2) (i) and 227.11 (2) (a) provide the authority for the proposed rule.

ESTIMATE OF AGENCY STAFF TIME TO DEVELOP RULE:

The Department estimates that state employees will spend 40 hours to develop this rule.

ENTITIES LIKELY TO BE AFFECTED BY THE PROPOSED RULE

The proposed modifications would affect the various boards attached to the department, the department itself, and the Department of Justice.

SUMMARY OF AND COMPARISON TO FEDERAL REGULATIONS

No specific federal regulation is implicated by this rulemaking. There is no impact on the provisions of the Internal Revenue Code regulating qualified pension plans. Similarly, there is no impact on Wis. Stat. s. 40.015, which requires that the Wisconsin Retirement System be maintained as a qualified plan.

I have reviewed this Statement of Scope and approve it for publication in the Administrative Register this _____ day of _____, 200__.

_____

David A. Stella, Secretary
Department of Employee Trust Funds

STATE OF WISCONSIN
Department of Employee Trust Funds

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CORRESPONDENCE MEMORANDUM

DATE: January 28, 2008

TO: Group Insurance Board

FROM: Liz Doss-Anderson, Ombudsperson, Quality Assurance Services Bureau
Christina Keeley, Ombudsperson, Quality Assurance Services Bureau
Linda Esser, Executive Staff Assistant, Quality Assurance Services Bureau

SUBJECT: Correspondence and Complaint Summary

This summary is provided for informational purposes and contains a listing of issues raised by participants relating to insurance benefits under the authority of the Group Insurance Board (GIB). The tables below include a summary of the following:

(1) correspondence received by the Department written to the Secretary or the GIB

(2) the number of written formal and informal (usually via telephone) complaints and inquiries handled by the ombudspersons in the Quality Assurance Services Bureau

The information in the attached tables is from August 1, 2007, through December 31, 2007.

Quality Assurance Services Bureau staff will be available at the Board meeting to address any questions you have regarding this report. Thank you.

Attachments

Reviewed and approved by Pam Henning, Administrator, Division of Management Services.

_____ _____
Signature Date

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Correspondence:

	Number
Health Insurance	
• Concern about access to providers in the Beech Street and National Preferred Provider Network.	**1**
• Suggested changes to uniform benefits.	**1**
• Complaints regarding tiering, pricing of health insurance plans and availability of clinics in northwest Wisconsin.	**8**
• Question regarding ability to enroll in group health insurance programs without pre-existing condition waiting period.	**1**
• Request for less expensive supplemental health insurance.	**1**
Pharmacy Benefits	
• Concern that a drug became available over-the-counter and therefore, was no longer covered by Navitus.	**1**
Disability Programs	
• Concern regarding repayment of disability benefits.	**1**
• Concern that employer did not notify employee of possible disability benefits.	**1**
TOTAL	**15**

Formal and Informal Complaints/Inquiries:

From August 1, 2007, through December 31, 2007, 240 members contacted the ombudspersons for assistance with benefit issues. The majority of these contacts involved health insurance and pharmacy benefits, including inquiries and requests for assistance regarding Medicare Part D. In addition, the ombudspersons assisted 139 members with general inquiries that are not reflected in the chart below. The following table summarizes the issues addressed.

	Number
Health Insurance	**189**
Most Common Issues: • *Enrollment and Eligibility (28%)* • *Billing/Claim Processing (23%)*	
Pharmacy Benefits/Medicare D	**34**
Most Common Issues: • *Billing/Claim Processing (24%)* • *Enrollment and Eligibility (15%)* • *Copayment Reduction (15%)*	
Disability Programs	**7**
Income Continuation Insurance	5
Disability Retirement (§ 40.63)	0
Duty Disability (§ 40.65)	1
Long-Term Disability Insurance	1
All Other Program Types (Life Insurance, ERA, EPIC, Dental, Spectera, WRS)*	**10**
Total	**240**

*It is not common to receive a large number of complaints regarding these programs. The availability of ombudsperson assistance in this area is not widely known and most of these programs are not under contract with ETF; rather, they are benefits that the Board simply approves to be offered through payroll deduction.

Key:

- *ERA: Employee Reimbursement Accounts. Optional pre-tax savings account for medical expenses and dependent care.*
- *EPIC: Optional supplemental benefit plan that provides coverage for dental, excess medical and accidental death and dismemberment.*
- *Spectera: Optional vision benefit*
- *WRS: Wisconsin Retirement System*

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CORRESPONDENCE MEMORANDUM

DATE: January 8, 2008

TO: Group Insurance Board

FROM: Sharon Walk
Board Liaison

SUBJECT: 2008 Meeting Dates (Revised)

At the request of the Group Insurance Board, the November 2008 meeting date has been changed. The new date is **November 11, 2008**.

Listed below are the 2008 meeting dates:

Tuesday, February 12, 2008
Tuesday, April 15, 2008
Tuesday, June 10, 2008
Tuesday, August 26, 2008
Tuesday, November 11, 2008

Also, as a reminder, the meetings will be held at the new location: Holiday Inn, 1109 Fourier Drive, Madison, WI. Attached you will find a map and directions to the hotel. As in the past, hotel reservations will be made for you if you have requested a room.

Please feel free to contact me at 267-2417 if you have any questions or concerns.

Reviewed and approved by Robert J. Conlin, Deputy Secretary.

_____ _____
Signature Date

Board	Mtg Date	Item #
GIB	02/12/2008	5

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CORRESPONDENCE MEMORANDUM

DATE: January 15, 2008

TO: Group Insurance Board

FROM: Joan Steele, Manager, Alternate Health Plans
Deb Roemer, Policy Analyst

SUBJECT: Participation in the Wisconsin Public Employers' Group Health Insurance Program and Income Continuation Insurance Plan

This memo is for the Board's information only. No action is required.

Annually, staff provides the Board with an update on local government employers that have either joined or terminated participation in the Wisconsin Public Employers' Group Health (WPEG) Insurance Program and the Income Continuation Insurance (ICI) plan during the prior calendar year.

The number of employers in the WPEG plan continues to grow, although they have been employers with relatively small employee counts. No large employer has joined the plan since the underwriting process was implemented in 2005 for employers with 100 or more employees in the Wisconsin Retirement System (WRS). Effective in 2008, the underwriting process applies to employers with 51 or more employees in the WRS. Employers are underwritten and assessed a surcharge when the risk is determined to be detrimental to the existing pool. At this time, no participating employers are being assessed a surcharge.

In 2007, eight large employers (five counties, two cities, and one school district) went through the underwriting process. All were determined to have poor risk and were placed in the category with the highest surcharge amount. Subsequently, none of the eight employers joined the WPEG plan. Staff believes the surcharge amounts to be reasonable, as the WPEG rates with the surcharge amount were comparable to the renewal rates the employers received from their existing insurance carrier.

The WPEG plan began to offer additional health program options at reduced premiums in 2005. The options include a Standard Plan that is a preferred provider plan (PPP) as an option to the classic fee-for-service Standard Plan, and a deductible option for both Uniform Benefits and the Standard Plan or the Standard PPP.

Table 1 on the next page provides a summary of resolutions filed by new and participating employers for coverage in 2007, under each of the new health program options.

Reviewed and approved by Tom Korpady, Division of Insurance Services.

_____ _____
Signature Date

Board	Mtg Date	Item #
GIB	2/12/2008	5

TABLE 1
PARTICIPATION IN WPEG PROGRAM OPTIONS FOR 2007

Description	Uniform Benefits & Classic Standard Plan	Uniform Benefits & Standard PPP	Deductible Uniform Benefits & Deductible Standard Plan	Deductible Uniform Benefits & Deductible Standard PPP
Employers Previously Enrolled in This Option	290	7	21	8
Employers That Joined WPEG Selecting This Option	12	4	1	2
Employers in WPEG That Switched to This Option	0	0	3	1
Total Employers Enrolled in This Option as of 12/31/07	302	11	25	11
Total Active Insured Employees	10,199	142	644	334

Eight employers have already passed resolutions to join the WPEG plan in 2008, with two selecting one of the new health program options. In addition, three employers already participating in the WPEG plan filed resolutions to switch to a new health program option in 2008.

Two employers terminated participation in the WPEG plan effective in 2007: City of Augusta and City of Phillips. In addition, the Town of Phelps had all employees cancel their coverage voluntarily and coverage was terminated after their enrollment in the program fell to zero, pursuant to section 3.2 of the contract. The Neenah-Menasha Sewerage Commission also had coverage terminated pursuant to section 3.2 when its only subscriber ended coverage due to retirement.

The local ICI plan continues to see some growth. As with the WPEG plan, the ICI plan tends to attract smaller employers. Four of the local employers joining the ICI plan for 2007 had only one employee. The largest local employer joining was Vilas County with 203 employees. One employer terminated participation in the ICI plan in 2007.

Table 2, below, provides a summary of the types of employers in the WPEG plan and the local ICI plan as of December 31, 2007.

TABLE 2
PARTICIPATION IN THE WPEG & LOCAL ICI PLANS AS OF 12/31/07

Category	WPEG Plan	ICI Plan
New Employers in Calendar Year 2007	19	10
New Employees in Calendar Year 2007	205	351
Employers Terminating in Calendar Year 2007	4	1
Employees Terminating in Calendar Year 2007	53	3
Participating Cities	64	40
Participating Villages	107	52
Participating School Districts	3	0
Participating Special Districts	99	63
Participating Towns	71	17
Participating Counties	8	9
Total Employers	349	180
Total Active Insured Employees	11,319	7243

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CORRESPONDENCE MEMORANDUM

DATE: January 1, 2008

TO: Group Insurance Board

FROM: Sharon Walk
Appeals Coordinator

SUBJECT: Pending Appeals

PENDING APPEALS BY BOARD						
As of:	ETF	GIB	WR	TR	DC	TOTAL
12/01/07	**9**	**11**	**6**	**1**	**0**	**27**
New Appeals (+)	+1	+2	0	0	0	+3
Final Decisions (-)	0	-2	0	0	0	-2
Appeals Withdrawn (-)	0	-1	0	0	0	-1
01/01/08	**10**	**10**	**6**	**1**	**0**	**27**
+/-	+1	-1	0	0	0	0

Reviewed and approved by Pamela Henning, Administrator, Division of Management Services.

_____ _____
Signature Date

Board	Mtg Date	Item #
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