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WPS HEALTH INSURANCE

State of Wisconsin

Section 1: State Employee Trust Funds

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

Executive Summary

Member / Demographic Data

Total enrollment was 13,957 as of January 2008, down from 14,489 members in January 2007. The reduction in membership was mainly due to HMO offerings being made available in Marinette, Pierce and Ashland Counties in January 2008.

The **Standard Plan** membership is much older than the normative distribution with 41.4% of membership over the age of 55 compared to the benchmark of 16.4%. 75.9% of the Standard Plan participants live within Wisconsin. Much of the Standard Plan population is located near larger metropolitan areas in Wisconsin with 25.4% of the population living in Dane County and 17.4% living in Milwaukee County.

The ages of the **SMP Plan** members by comparison are in line with the normative distribution. The SMP Plan membership is almost entirely within Wisconsin, with a majority of the population living in Marinette and Pierce Counties. Only 4.0% of the population lives outside of Wisconsin. In 2008 the SMP Plan will only be available in 9 counties down from the current 12 county region. As of January 2008, this change has resulted in a population reduction from the current 519 members to 161 members.

Claims Data

Summary

In 2007, the Standard Plan was 87.9% higher in overall PMPM claims costs than the SMP Plan. The Standard Plan's enrollment is generally in more expensive urban areas such as Milwaukee and Dane Counties, causing some of the differential. A bigger factor is the difference in demographics between the two plans, which by itself would be expected to raise the Standard Plan's costs another 26% above the SMP Plan. The final piece is simply the anti-selection that the Standard Plan is subject to vs. the other options available to the members. A broader provider panel is more attractive to members who utilize healthcare services and therefore value provider access, despite a larger premium contribution and the presence of modest cost sharing provisions within the benefit plan.

Standard Plan

The Standard Plan has seen an 8.3% increase in overall claim costs between 2006 and 2007, in line with independent trend estimates

The Standard Plan's costs were 47.9% above the benchmark in 2007, which is similar to the 2006 percentage of 45.6%. The variance to the benchmark is primarily a result of the anti-selection resulting from the dual choice open enrollment. Other contributing factors include the location of the Standard Plan's enrolled membership (the higher cost urban areas) and the rich benefit design (relative to the benchmark).

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

The Standard Plan has 36 members with claims over $100,000 for a total of $7,719,465 in claim costs. These 36 members represent 22.0% of total claims paid under the Standard Plan. The expected percent of claims over $100,000 for a group of this size is 6.0%, while the actual is 11.7%. The Standard Plan members pay 2.6% of their own medical claims as compared to the benchmark of 7.4%.

WPS paid 68.0% of submitted charges on behalf of the plan.

SMP Plan

For the SMP Plan, the year over year medical PMPM trend was -1.8%, influenced substantially by the change in membership. The SMP Plan was 0.5% above the benchmark for 2007. Facility outpatient services are higher than benchmark, but considering the small size, some variances are expected.

A review of claims by Major Diagnostic Category shows a few categories with significant deviations from the benchmark. However, with the low membership on the plan, the two large claims tend to drive overages related to those conditions.

The SMP Plan has 2 members with claims over $100,000 for a total of $466,192 in claim costs. These members represent 13.6% of total claims paid under the SMP Plan. The SMP Plan members pay almost nothing towards their own medical claims (in the form of cost sharing), unlike the members of most large groups who pay an average of about 7-8% of their medical claims.

WPS paid 73.3% of submitted charges on behalf of the plan.

Medicare

The Medicare Plus $1M Plan has seen stable results over the last 2 years. The year over year medical PMPM trend from 2006 to 2007 was 7.3%.

WPS paid 7.0% of submitted charges on behalf of the plan. 80.4% of the charges were paid by Medicare.

Provider Data

For the **Standard Plan**, the top 20 facilities provide 57.1% of the total facility charges for the plan. By far, the largest percent of claims and number of patients came from the University of Wisconsin hospital. 44.4% of professional charges are from the top 20 providers. The University of Wisconsin Medical Foundation is the leading professional provider. Like the facility charges a concentration of the top providers are from the Dane and Milwaukee Counties regions.

For the **SMP Plan**, the top 20 facilities provide 97.3% of the total facility charges for the plan. The largest percentage of paid claims is from Bay Area Medical Center in Marinette. The provider with the second highest amount of paid claims is the University of Wisconsin Hospital, though this was for only one claimant.

74.1% of the paid claims are from the top 20 professional providers. Bay Area / Bellin Health in Marinette was the largest provider, receiving 10.4% of the overall payments, followed by Aurora Medical in Oshkosh at 9.7%.

Benchmarks

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

Demographic benchmarks are based on calendar year 2007 data. For Medicare classes, demographic benchmarks are based on comparable WPS Medicare enrollment as appropriate.

Claim cost benchmarks are also based on calendar year 2007 data. To make the claim benchmarks more meaningful, they have been adjusted for demographic differences between the specific population profiled in each report and the population in the WPS benchmark. For example, an older population may be expected to have higher prescription drug costs but lower maternity costs. Unless otherwise specified, each claim based benchmark has had such an adjustment made, including not only PMPM costs but days/1000 and cost/day. The factors that go into each adjustment are unique to the particular claim-based statistic. Claim benchmarks are not adjusted, however, for plan benefit differences between the average represented in the WPS benchmark and the specific reported ETF class.

Monthly Membership

The Monthly Membership report in Exhibit 1-A shows monthly membership for the Standard, SMP and Medicare Plus $1M Plans from January 2006 through December 2007.

Enrollment on the **Standard Plan** averaged 4,329 members per month in 2006 compared to 3,901 members per month in 2007, a reduction of 10.0%. Monthly membership within each year stayed relatively stable with increases seen in September and October of each year.

SMP Plan enrollment averaged 8,162 members per month in 2006 compared to 533 members per month in 2007. This reduction is the result of a reduced service area in which the plan is available, dropping from 27 counties in 2006 to 12 counties in 2007.

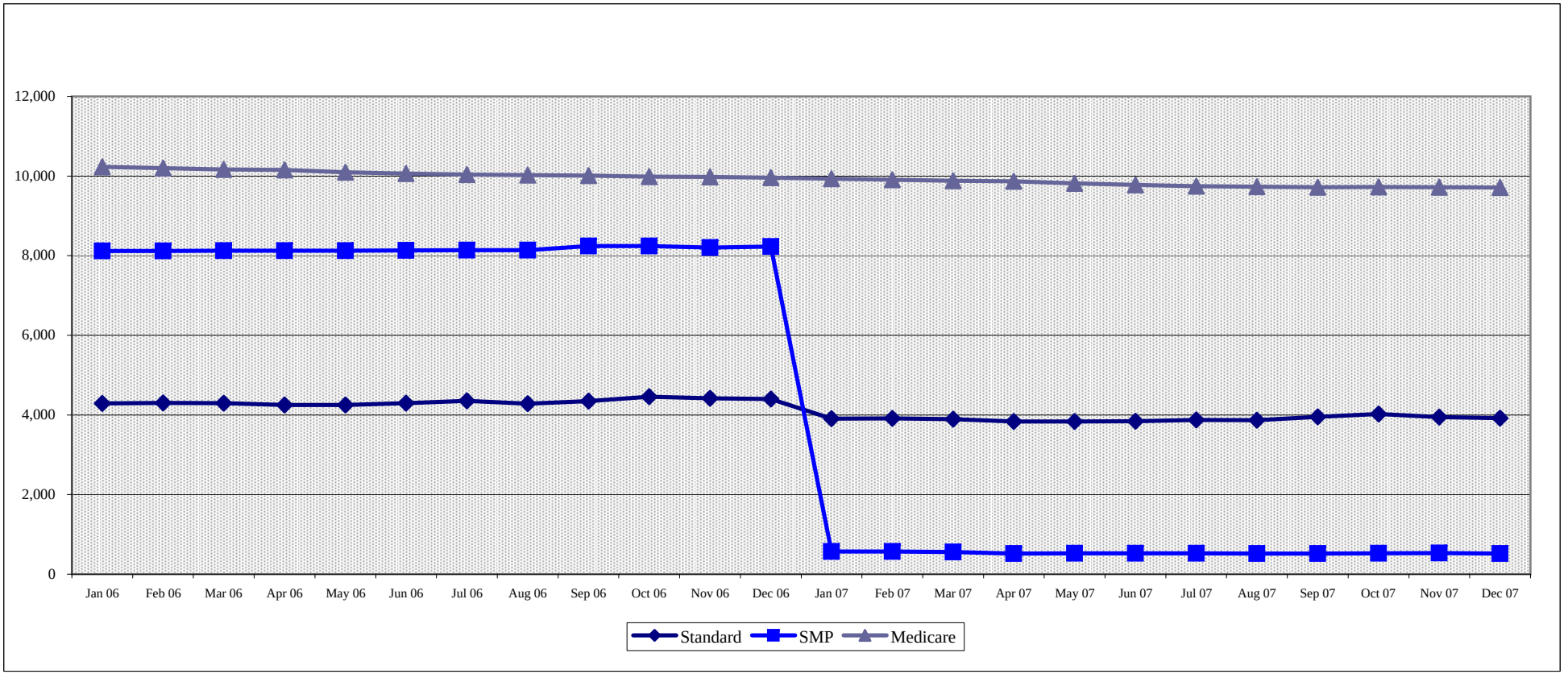
The **Medicare Plus $1M Plan** enrollment is experiencing a very gradual decline in membership. Between Jan 2006 and December 2007, enrollment dropped from 10,234 to 9,714, or a reduction of 5% over the course of the two years.

STATE EMPLOYEE TRUST FUNDS

Monthly Membership

January 2006 through December 2007

Exhibit 1-A



	EFFECTIVE MONTH																							
	Jan 06	Feb 06	Mar 06	Apr 06	May 06	Jun 06	Jul 06	Aug 06	Sep 06	Oct 06	Nov 06	Dec 06	Jan 07	Feb 07	Mar 07	Apr 07	May 07	Jun 07	Jul 07	Aug 07	Sep 07	Oct 07	Nov 07	Dec 07
Standard	4,292	4,303	4,293	4,248	4,249	4,294	4,354	4,285	4,348	4,456	4,420	4,400	3,905	3,916	3,896	3,836	3,835	3,842	3,875	3,868	3,952	4,021	3,948	3,922
SMP	8,118	8,122	8,125	8,126	8,128	8,132	8,138	8,137	8,241	8,245	8,203	8,226	569	568	560	519	527	524	524	520	521	522	531	519
Medicare	10,234	10,201	10,167	10,151	10,097	10,060	10,036	10,023	10,012	9,985	9,980	9,958	9,935	9,906	9,881	9,867	9,818	9,775	9,747	9,732	9,722	9,727	9,720	9,714

Enrollment by Plan

The Enrollment by Plan report shown in Exhibit 2-A shows the December 2007 membership for the Standard, SMP and Medicare Plus $1M Plans at the class level. For each class, member average age and gender distribution is shown. The age/gender factor is included as an index intended to represent expected plan cost based on the age and gender of each member, without regard to plan design, health, etc. The age/gender factor is not shown for the Medicare Plus $1M Plan, where coordination of benefits with Medicare has an overwhelming impact on plan cost.

The average age of the Standard Plan is 43.7 years, 6.2 years older than the 36.5 average age of the smaller SMP Plan. Based on the age/gender factors for December 2007, we would expect the demographics alone would cause the Standard Plan to be 26% higher in claim costs than the SMP Plan, everything else being equal.

Exhibit 2-A

STATE EMPLOYEE TRUST FUNDS
Enrollment by Plan
December 2007

Plan	Class	# of Members	Average Member Age	Member Gender Distribution Female	Member Age/ Gender Factor
Standard	Regular	2,816	42.8	53.5%	1.594
	Graduate Assistant (including GA continuation)	387	27.9	49.4%	0.924
	Continuation	20	35.0	35.0%	1.105
	Annuitants	699	56.1	68.4%	2.318
	Subtotal	**3,922**	**43.7**	**55.6%**	**1.655**
SMP	Regular	470	35.0	50.6%	1.235
	Graduate Assistant (including GA continuation)	4	33.3	50.0%	0.995
	Continuation	1	42.0	0.0%	0.912
	Annuitants	44	53.1	50.0%	2.176
	Subtotal	**519**	**36.5**	**50.5%**	**1.313**
Medicare Plus One Million	Single	4,549	80.2	72.6%	N/A
	One Over	245	69.8	10.6%	N/A
	Two Over	4,920	75.8	50.1%	N/A
	Subtotal	**9,714**	**77.7**	**59.6%**	**N/A**
ETF Grand Total		**14,155**	**66.8**	**58.2%**	**N/A**

Member Census Grids

The Member Census Grid breaks down the December 2007 membership into age and gender categories for the Standard, SMP and Medicare Plus $1M Plans. The Standard and SMP distributions are compared to a benchmark distribution based on WPS large group business as described in the Executive Summary. The benchmark distribution for the Medicare plan is based on WPS Medicare Supplement business.

Standard Plan

The Standard Plan membership in Exhibit 3-A shows the plan having a much older actual population than the normative distribution with 41.4% of membership over the age of 55 compared to the benchmark of 16.4%. The broad provider panel and out of state membership produce an upward bias on the average age. Older members tend to seek more medical care and tend to select a broader panel of providers for that care. Since the Standard Plan has a broader panel of providers, this causes the average age to be higher. Secondly, the Standard Plan is the only out of state offering. Therefore, all retirees who move out of state will select the Standard Plan, again contributing to a higher average age.

Also corresponding to the older than expected membership is the smaller than expected population of children with only 15.8% of the membership under the age of 20 compared to the benchmark of 29.7%. The Standard Plan also has a slightly higher than normal female population with 55.6% female, compared to the benchmark of 51.8%.

SMP Plan

The SMP Plan membership shown in Exhibit 3-B by comparison is in line with the normative distribution with only a slightly older population as compared to the benchmark. The SMP Plan distribution shows 52.3% of the population above age 40 compared to the benchmark of 43.4%. The SMP Plan has more males as a percentage when compared to the benchmark.

Medicare

The Medicare Plus $1M Plan membership is shown in Exhibit 3-C. The population over the age of 65 is distributed evenly, with most age bands containing about 20% of the population.

Exhibit 3-A

STATE EMPLOYEE TRUST FUNDS
Member Census Grid - Standard
December 2007

FEMALE			
Age Band	# of Members	% of Total	Benchmark
< 20	324	8.3%	14.4%
20 - 24	136	3.5%	3.7%
25 - 29	94	2.4%	3.5%
30 - 34	99	2.5%	3.3%
35 - 39	98	2.5%	3.9%
40 - 44	114	2.9%	4.5%
45 - 49	159	4.1%	5.0%
50 - 54	223	5.7%	5.0%
55 - 59	333	8.5%	4.3%
60 - 64	493	12.6%	2.7%
65 +	109	2.8%	1.5%
Total	**2,182**	**55.6%**	**51.8%**

MALE			
Age Band	# of Members	% of Total	Benchmark
< 20	295	7.5%	15.3%
20 - 24	135	3.4%	3.3%
25 - 29	113	2.9%	2.7%
30 - 34	73	1.9%	3.0%
35 - 39	82	2.1%	3.5%
40 - 44	90	2.3%	4.0%
45 - 49	103	2.6%	4.3%
50 - 54	161	4.1%	4.2%
55 - 59	196	5.0%	3.8%
60 - 64	339	8.6%	2.6%
65 +	153	3.9%	1.5%
Total	**1,740**	**44.4%**	**48.2%**

TOTAL			
Age Band	# of Members	% of Total	Benchmark
< 20	619	15.8%	29.7%
20 - 24	271	6.9%	7.0%
25 - 29	207	5.3%	6.2%
30 - 34	172	4.4%	6.3%
35 - 39	180	4.6%	7.4%
40 - 44	204	5.2%	8.5%
45 - 49	262	6.7%	9.3%
50 - 54	384	9.8%	9.2%
55 - 59	529	13.5%	8.1%
60 - 64	832	21.2%	5.3%
65 +	262	6.7%	3.0%
Total	**3,922**	**100.0%**	**100.0%**

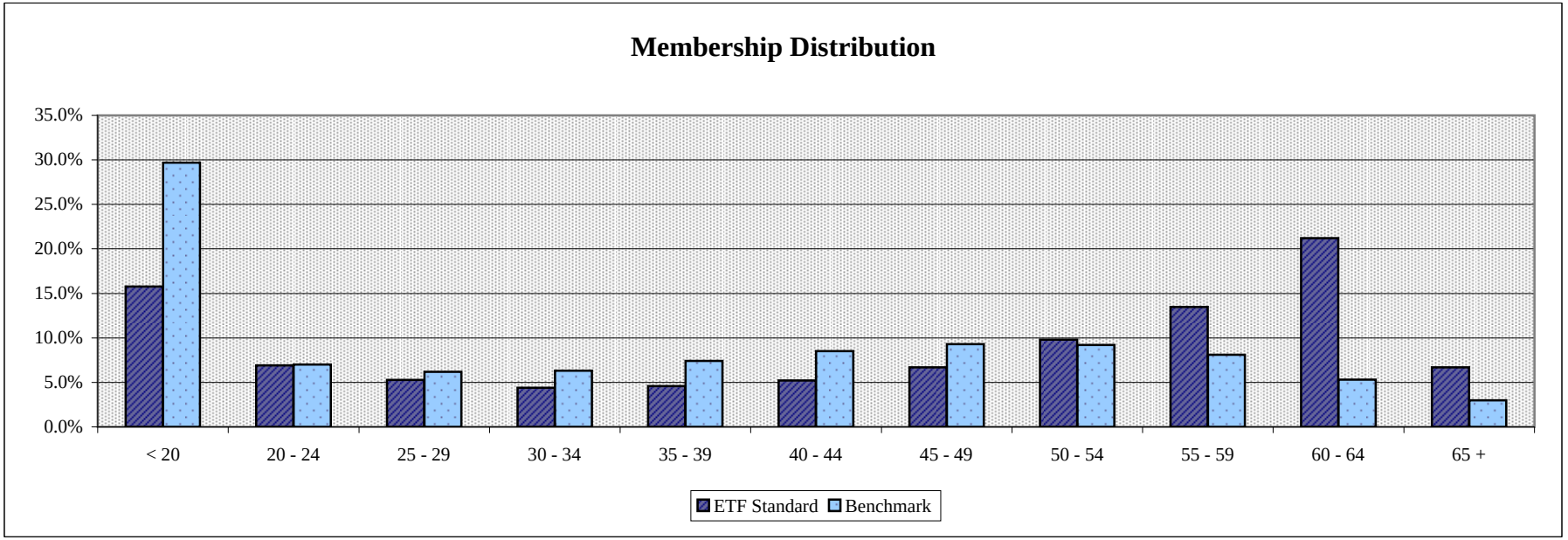


Exhibit 3-B

STATE EMPLOYEE TRUST FUNDS
Member Census Grid - SMP
December 2007

FEMALE			
Age Band	# of Members	% of Total	Benchmark
< 20	73	14.1%	14.4%
20 - 24	14	2.7%	3.7%
25 - 29	12	2.3%	3.5%
30 - 34	18	3.5%	3.3%
35 - 39	14	2.7%	3.9%
40 - 44	24	4.6%	4.5%
45 - 49	30	5.8%	5.0%
50 - 54	25	4.8%	5.0%
55 - 59	29	5.6%	4.3%
60 - 64	20	3.9%	2.7%
65 +	3	0.6%	1.5%
Total	**262**	**50.5%**	**51.8%**

MALE			
Age Band	# of Members	% of Total	Benchmark
< 20	65	12.5%	15.3%
20 - 24	13	2.5%	3.3%
25 - 29	9	1.7%	2.7%
30 - 34	10	1.9%	3.0%
35 - 39	20	3.9%	3.5%
40 - 44	22	4.2%	4.0%
45 - 49	26	5.0%	4.3%
50 - 54	30	5.8%	4.2%
55 - 59	30	5.8%	3.8%
60 - 64	29	5.6%	2.6%
65 +	3	0.6%	1.5%
Total	**257**	**49.5%**	**48.2%**

TOTAL			
Age Band	# of Members	% of Total	Benchmark
< 20	138	26.6%	29.7%
20 - 24	27	5.2%	7.0%
25 - 29	21	4.0%	6.2%
30 - 34	28	5.4%	6.3%
35 - 39	34	6.6%	7.4%
40 - 44	46	8.9%	8.5%
45 - 49	56	10.8%	9.3%
50 - 54	55	10.6%	9.2%
55 - 59	59	11.4%	8.1%
60 - 64	49	9.4%	5.3%
65 +	6	1.2%	3.0%
Total	**519**	**100.0%**	**100.0%**

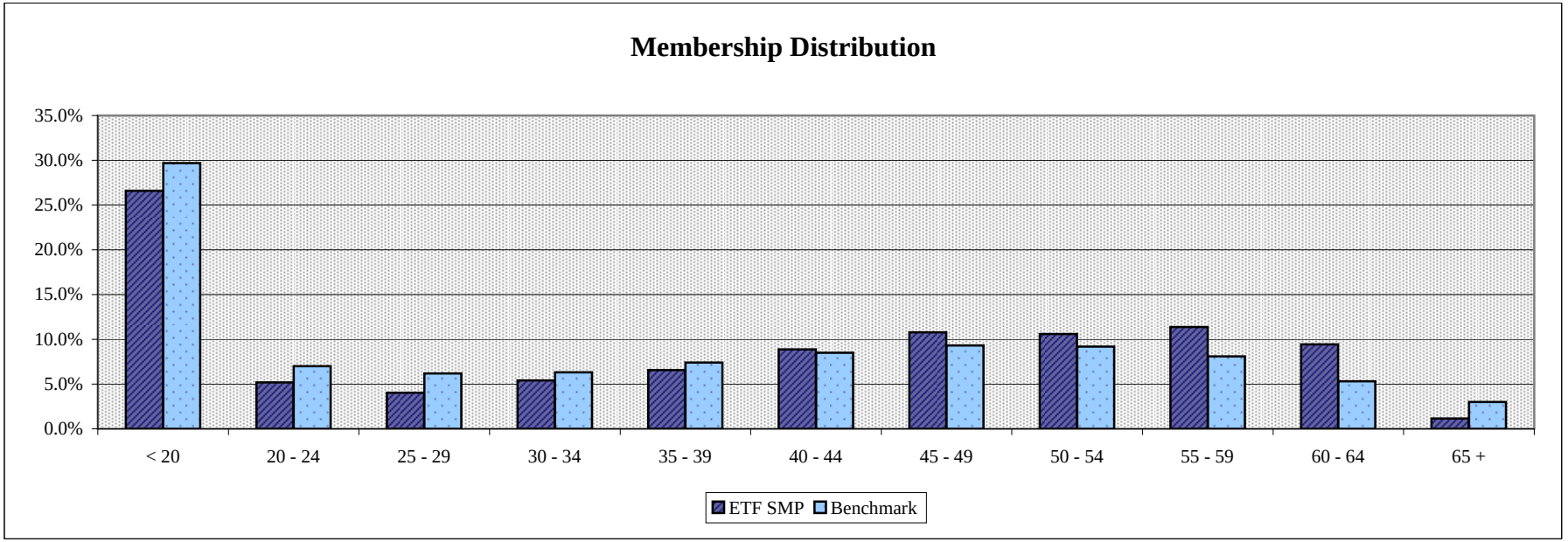


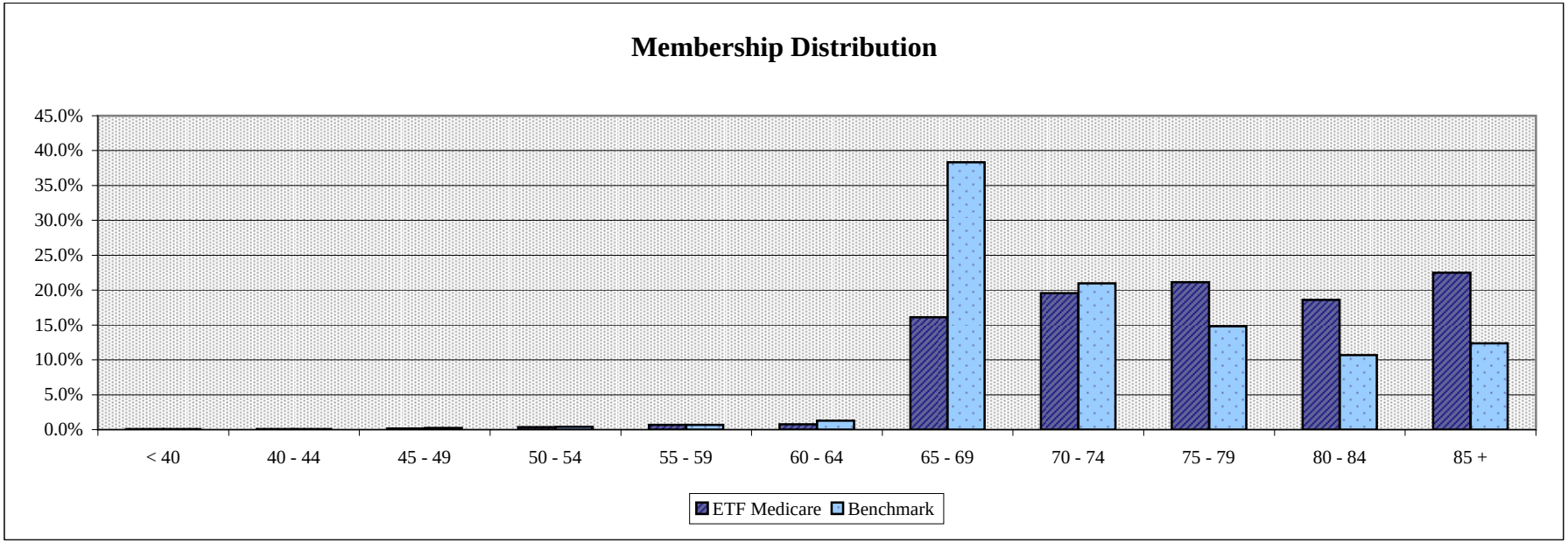
Exhibit 3-C

STATE EMPLOYEE TRUST FUNDS
Member Census Grid - Medicare Plus One Million
December 2007

FEMALE			
Age Band	# of Members	% of Total	Benchmark
< 40	3	0.0%	0.1%
40 - 44	2	0.0%	0.0%
45 - 49	12	0.1%	0.2%
50 - 54	25	0.3%	0.2%
55 - 59	51	0.5%	0.4%
60 - 64	47	0.5%	0.7%
65 - 69	938	9.7%	20.7%
70 - 74	1,047	10.8%	10.9%
75 - 79	1,127	11.6%	8.3%
80 - 84	1,059	10.9%	6.5%
85 +	1,481	15.2%	8.9%
Total	**5,792**	**59.6%**	**56.8%**

MALE			
Age Band	# of Members	% of Total	Benchmark
< 40	4	0.0%	0.0%
40 - 44	4	0.0%	0.0%
45 - 49	3	0.0%	0.1%
50 - 54	9	0.1%	0.2%
55 - 59	16	0.2%	0.3%
60 - 64	28	0.3%	0.6%
65 - 69	626	6.4%	17.7%
70 - 74	855	8.8%	10.1%
75 - 79	924	9.5%	6.5%
80 - 84	747	7.7%	4.2%
85 +	706	7.3%	3.5%
Total	**3,922**	**40.4%**	**43.2%**

TOTAL			
Age Band	# of Members	% of Total	Benchmark
< 40	7	0.1%	0.1%
40 - 44	6	0.1%	0.1%
45 - 49	15	0.2%	0.3%
50 - 54	34	0.4%	0.4%
55 - 59	67	0.7%	0.7%
60 - 64	75	0.8%	1.3%
65 - 69	1,564	16.1%	38.3%
70 - 74	1,902	19.6%	21.0%
75 - 79	2,051	21.1%	14.8%
80 - 84	1,806	18.6%	10.7%
85 +	2,187	22.5%	12.4%
Total	**9,714**	**100.0%**	**100.0%**



Wisconsin Enrollment

The Wisconsin Enrollment map in Exhibit 4-A visually shows how the membership for the Standard and SMP Plans are dispersed throughout Wisconsin. The map shows enrollment as of December 1, 2007. Each of the dots represents one address. Members of the SMP plan that appear to be living outside the available SMP county region are commonly dependent students. Exhibit 4-B shows the same information numerically.

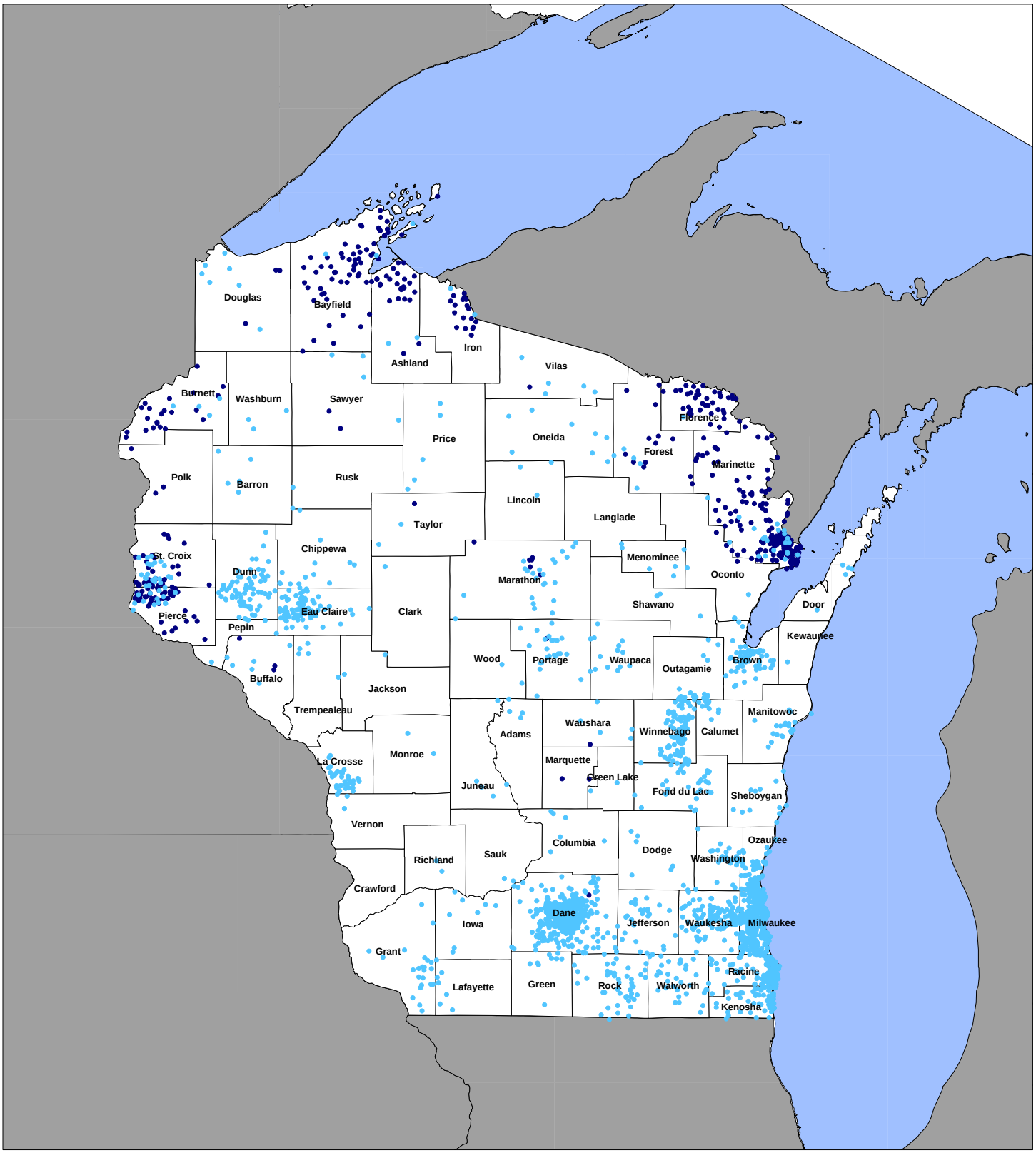
75.9% of the **Standard Plan** participants live within Wisconsin. Much of the Standard Plan population is located near larger metropolitan areas in Wisconsin with 25.4% of the population living in Dane County and 17.4% living in Milwaukee County.

The **SMP Plan** membership in comparison is almost entirely within Wisconsin. Of that population, the membership tends to reside in the more rural areas with a majority of the population on the northern fringes of the state. 52.0% of the SMP Plan participants live in 2 counties, Marinette and Pierce. In 2007 the SMP Plan region was reduced from 27 counties down to 12. In 2008, the SMP Plan region has been reduced by 3 more counties, removing Ashland, Marinette, and Pierce from the plan offering.

STATE EMPLOYEE TRUST FUNDS

Exhibit 4-A

Enrollment By County
December 2007



Standard

SMP

STATE EMPLOYEE TRUST FUNDS

Enrollment By County

December 2007

Exhibit 4-B

County	STANDARD # of Members	STANDARD % of Members	SMP # of Members	SMP % of Members
ADAMS	0	0.0%	0	0.0%
ASHLAND	3	0.1%	37	7.1%
BARRON	8	0.2%	0	0.0%
BAYFIELD	2	0.1%	50	9.6%
BROWN	56	1.4%	0	0.0%
BUFFALO	8	0.2%	2	0.4%
BURNETT	4	0.1%	23	4.4%
CALUMET	15	0.4%	0	0.0%
CHIPPEWA	9	0.2%	0	0.0%
CLARK	3	0.1%	0	0.0%
COLUMBIA	6	0.2%	0	0.0%
CRAWFORD	0	0.0%	0	0.0%
DANE	998	25.4%	1	0.2%
DODGE	7	0.2%	0	0.0%
DOOR	5	0.1%	0	0.0%
DOUGLAS	7	0.2%	4	0.8%
DUNN	76	1.9%	0	0.0%
EAU CLAIRE	89	2.3%	0	0.0%
FLORENCE	1	0.0%	36	6.9%
FOND DU LAC	29	0.7%	0	0.0%
FOREST	4	0.1%	15	2.9%
GRANT	28	0.7%	0	0.0%
GREEN	5	0.1%	0	0.0%
GREEN LAKE	6	0.2%	0	0.0%
IOWA	8	0.2%	0	0.0%
IRON	2	0.1%	18	3.5%
JACKSON	1	0.0%	0	0.0%
JEFFERSON	21	0.5%	0	0.0%
JUNEAU	4	0.1%	0	0.0%
KENOSHA	44	1.1%	0	0.0%
KEWAUNEE	1	0.0%	0	0.0%
LACROSSE	37	0.9%	0	0.0%
LAFAYETTE	1	0.0%	0	0.0%
LANGLADE	2	0.1%	0	0.0%
LINCOLN	3	0.1%	0	0.0%
MANITOWOC	21	0.5%	0	0.0%
MARATHON	21	0.5%	11	2.1%
MARINETTE	20	0.5%	200	38.5%
MARQUETTE	0	0.0%	3	0.6%
MENOMINEE	5	0.1%	0	0.0%
MILWAUKEE	681	17.4%	0	0.0%
MONROE	2	0.1%	0	0.0%
OCONTO	5	0.1%	0	0.0%
ONEIDA	9	0.2%	0	0.0%
OUTAGAMIE	19	0.5%	0	0.0%
OZAUKEE	66	1.7%	0	0.0%
PEPIN	2	0.1%	1	0.2%
PIERCE	23	0.6%	70	13.5%
POLK	0	0.0%	2	0.4%
PORTAGE	24	0.6%	1	0.2%
PRICE	5	0.1%	0	0.0%
RACINE	152	3.9%	4	0.8%
RICHLAND	2	0.1%	0	0.0%
ROCK	42	1.1%	0	0.0%
RUSK	0	0.0%	0	0.0%
SAUK	9	0.2%	0	0.0%
SAWYER	5	0.1%	2	0.4%
SHAWANO	3	0.1%	0	0.0%
SHEBOYGAN	13	0.3%	0	0.0%
ST CROIX	13	0.3%	15	2.9%
TAYLOR	1	0.0%	2	0.4%
TREMPEALEAU	3	0.1%	0	0.0%
VERNON	2	0.1%	0	0.0%
VILAS	5	0.1%	1	0.2%
WALWORTH	36	0.9%	0	0.0%
WASHBURN	2	0.1%	0	0.0%
WASHINGTON	29	0.7%	0	0.0%
WAUKESHA	129	3.3%	0	0.0%
WAUPACA	13	0.3%	0	0.0%
WAUSHARA	2	0.1%	0	0.0%
WINNEBAGO	111	2.8%	0	0.0%
WOOD	10	0.3%	0	0.0%
OUT OF STATE	944	24.1%	21	4.0%
Totals	**3,922**	**100.0%**	**519**	**100.0%**

Out of State Enrollment

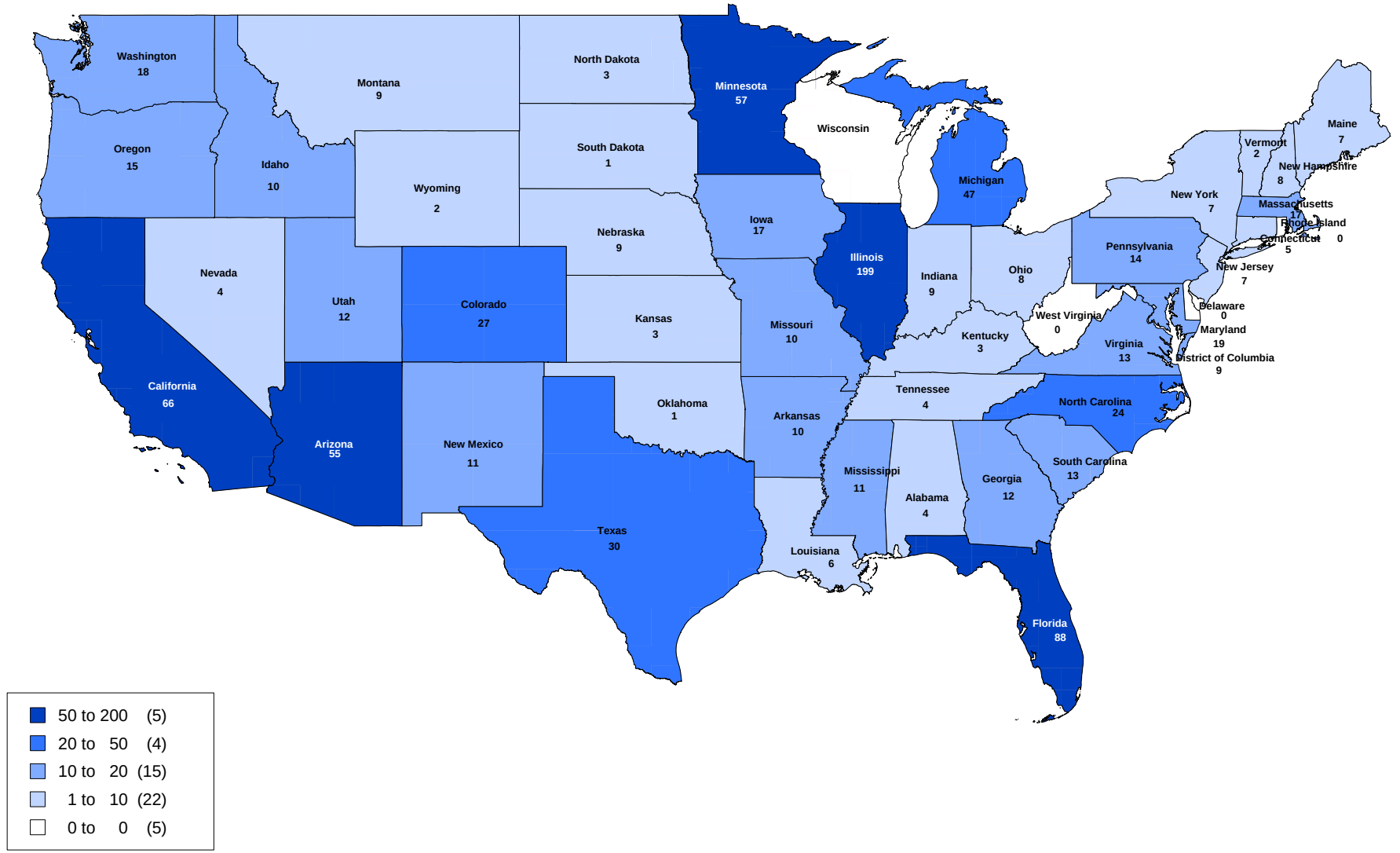
The United States Enrollment Map in Exhibit 5-A visually depicts how the enrollment in the Standard and SMP Plans are spread throughout the United States. The out of state enrollment is based on the member's address as of December 2007 and could change as members relocate. The map displays the number of Standard and SMP Plan members living in each state along with a shading scheme in which higher population areas are represented with increasingly darker shading. Exhibit 5-B shows the same information numerically.

The **Standard Plan** has 24.1% of the population living outside the state of Wisconsin with the membership dispersed over 46 states with an additional 55 members living internationally. 31.9% of the out of state enrollment lives along the Wisconsin border with the largest number of members living in Illinois (199 members or 21.1%). Another area of membership concentration is in typical retirement states with 25.2% of the out of state membership residing in Florida (88), California (66), Arizona (54) and Texas (30).

The **SMP Plan** in comparison has only 4.0% of the population living outside the state of Wisconsin. A majority of the out of state membership resides in Minnesota and Michigan. These individuals are likely employees living on the Wisconsin border. The SMP Plan does have some provider coverage in the states bordering Wisconsin however the plan does not have any non-emergency provider coverage in other states.

STATE EMPLOYEE TRUST FUNDS
Out of State Enrollment
December 2007

Exhibit 5-A



STATE EMPLOYEE TRUST FUNDS

Out of State Enrollment

December 2007

Exhibit 5-B

State	STANDARD # of Members	STANDARD % of Members	SMP # of Members	SMP % of Members
ALABAMA	4	0.4%	0	0.0%
ALASKA	0	0.0%	0	0.0%
ARIZONA	54	5.7%	1	4.8%
ARKANSAS	10	1.1%	0	0.0%
CALIFORNIA	66	7.0%	0	0.0%
COLORADO	27	2.9%	0	0.0%
CONNECTICUT	5	0.5%	0	0.0%
DELAWARE	0	0.0%	0	0.0%
FLORIDA	88	9.3%	0	0.0%
GEORGIA	12	1.3%	0	0.0%
HAWAII	3	0.3%	0	0.0%
IDAHO	10	1.1%	0	0.0%
ILLINOIS	199	21.1%	0	0.0%
INDIANA	9	1.0%	0	0.0%
IOWA	17	1.8%	0	0.0%
KANSAS	3	0.3%	0	0.0%
KENTUCKY	3	0.3%	0	0.0%
LOUISIANA	6	0.6%	0	0.0%
MAINE	7	0.7%	0	0.0%
MARYLAND	19	2.0%	0	0.0%
MASSACHUSETTS	17	1.8%	0	0.0%
MICHIGAN	30	3.2%	17	81.0%
MINNESOTA	55	5.8%	2	9.5%
MISSISSIPPI	11	1.2%	0	0.0%
MISSOURI	10	1.1%	0	0.0%
MONTANA	9	1.0%	0	0.0%
NEBRASKA	9	1.0%	0	0.0%
NEVADA	4	0.4%	0	0.0%
NEW HAMPSHIRE	8	0.8%	0	0.0%
NEW JERSEY	7	0.7%	0	0.0%
NEW MEXICO	11	1.2%	0	0.0%
NEW YORK	7	0.7%	0	0.0%
NORTH CAROLINA	24	2.5%	0	0.0%
NORTH DAKOTA	3	0.3%	0	0.0%
OHIO	8	0.8%	0	0.0%
OKLAHOMA	1	0.1%	0	0.0%
OREGON	15	1.6%	0	0.0%
PENNSYLVANIA	14	1.5%	0	0.0%
RHODE ISLAND	0	0.0%	0	0.0%
SOUTH CAROLINA	13	1.4%	0	0.0%
SOUTH DAKOTA	1	0.1%	0	0.0%
TENNESSEE	4	0.4%	0	0.0%
TEXAS	30	3.2%	0	0.0%
UTAH	12	1.3%	0	0.0%
VERMONT	2	0.2%	0	0.0%
VIRGINIA	13	1.4%	0	0.0%
WASHINGTON	18	1.9%	0	0.0%
WASHINGTON DC	9	1.0%	0	0.0%
WEST VIRGINIA	0	0.0%	0	0.0%
WYOMING	2	0.2%	0	0.0%
FOREIGN	55	5.8%	1	4.8%
Totals	**944**	**100.0%**	**21**	**100.0%**

Dual Choice Changes

The Dual Choice Enrollment Changes by Plan report in Exhibit 6-A shows the January 2008 enrollment reflecting changes that occurred during the Dual Choice Enrollment. The enrollment changes are numerical differences relative to December 2007. The change in Member / Age Gender shows how much plan costs changed between 2007 and 2008 due to demographic factors. The age/gender factor is not shown for the Medicare Plus $1M Plan, where coordination of benefits with Medicare has an overwhelming impact on plan cost.

Exhibit 6-A shows total enrollment for all plans was 13,957 members as of January 2008, which is down 198 members from the 14,155 members in the plan in December 2007. The reduction in membership was mainly due to the loss of members in the SMP Plan related to new HMO offerings in Ashland, Marinette, and Pierce counties. The Standard Plan also experienced the loss of 12 members during Dual Choice Enrollment. The Medicare Plus $1M membership actually increased by 172 individuals in January 2008. The positive change in age/gender factors for the Standard and SMP Plans means both got more expensive demographically in 2008 on a per member basis as a result of the membership loss and overall aging of the population.

Exhibit 6-A

STATE EMPLOYEE TRUST FUNDS
Dual Choice Enrollment Changes by Plan
December 2007 to January 2008

Plan	Class	January 2008 Membership	Change in Membership from December 2007	Change in Member Age/ Gender
Standard	Regular	2,806	-10	1.78%
	Graduate Assistant (including GA continuation)	372	-15	1.57%
	Continuation	29	9	-10.29%
	Annuitants	703	4	1.59%
	Subtotal	**3,910**	**-12**	**1.81%**
SMP	Regular	125	-345	-0.40%
	Graduate Assistant (including GA continuation)	3	-1	-8.72%
	Continuation	1	0	0.00%
	Annuitants	32	-12	1.79%
	Subtotal	**161**	**-358**	**8.04%**
Medicare Plus One Million	Single	4,599	50	N/A
	One Over	254	9	N/A
	Two Over	5,033	113	N/A
	Subtotal	**9,886**	**172**	**N/A**
ETF Grand Total		**13,957**	**-198**	**N/A**

Paid Per Member Per Month Costs

The Paid Medical and Drug PMPM report in Exhibit 7-A displays the average amount paid per member each month for the Standard, SMP and Medicare Plus $1M Plans incurred from January 2006 through December 2007. The PMPM costs for each plan represent medical and drug claims paid through the end of March 2008.

Standard Plan

The Standard Plan has seen an 8.3% increase in claim costs between 2006 and 2007. Independent trend estimates for medical claims for 2007 were 9-11% thus the Standard Plan ran slightly better than expected. The monthly spikes in claim costs are generally due to large claim activity that occurred in those months.

In 2007, the Standard plan was 87.9% higher in overall claims costs on a PMPM basis when compared to the SMP Plan. The Standard Plan's enrollment is generally in more expensive urban areas such as Milwaukee and Dane Counties. A bigger factor is the difference in demographics between the two plans, which by itself would be expected to raise the Standard Plan's costs another 26.0% above the SMP Plan. The small size of the SMP Plan compared to the larger Standard Plan, along with the dramatic reduction in SMP plan membership in 2007, adds to the variability of the results. The final piece is simply the anti-selection that the Standard Plan is subject to versus the other options available to the membership. Members who utilize healthcare services are generally willing to make a larger premium contribution and incur modest cost sharing provisions within the benefit plan in exchange for the broader panel of providers.

SMP Plan

The SMP Plan saw a dramatic drop in membership in 2007, therefore year over year trend numbers have less meaning. However, for informational purposes, the SMP plan saw a 1.8% decrease in claims costs between 2006 and 2007.

Medicare

The Medicare Plus $1M Plan has seen stable results over the last 2 years. We would expect this population to have stable results since Medicare is the primary payer and the plan has a large population. Seasonally, the medical only costs start out high during the first months of the year and then decline. When drug costs are added, the pattern is reversed and more resembles a typical non-Medicare plan. The

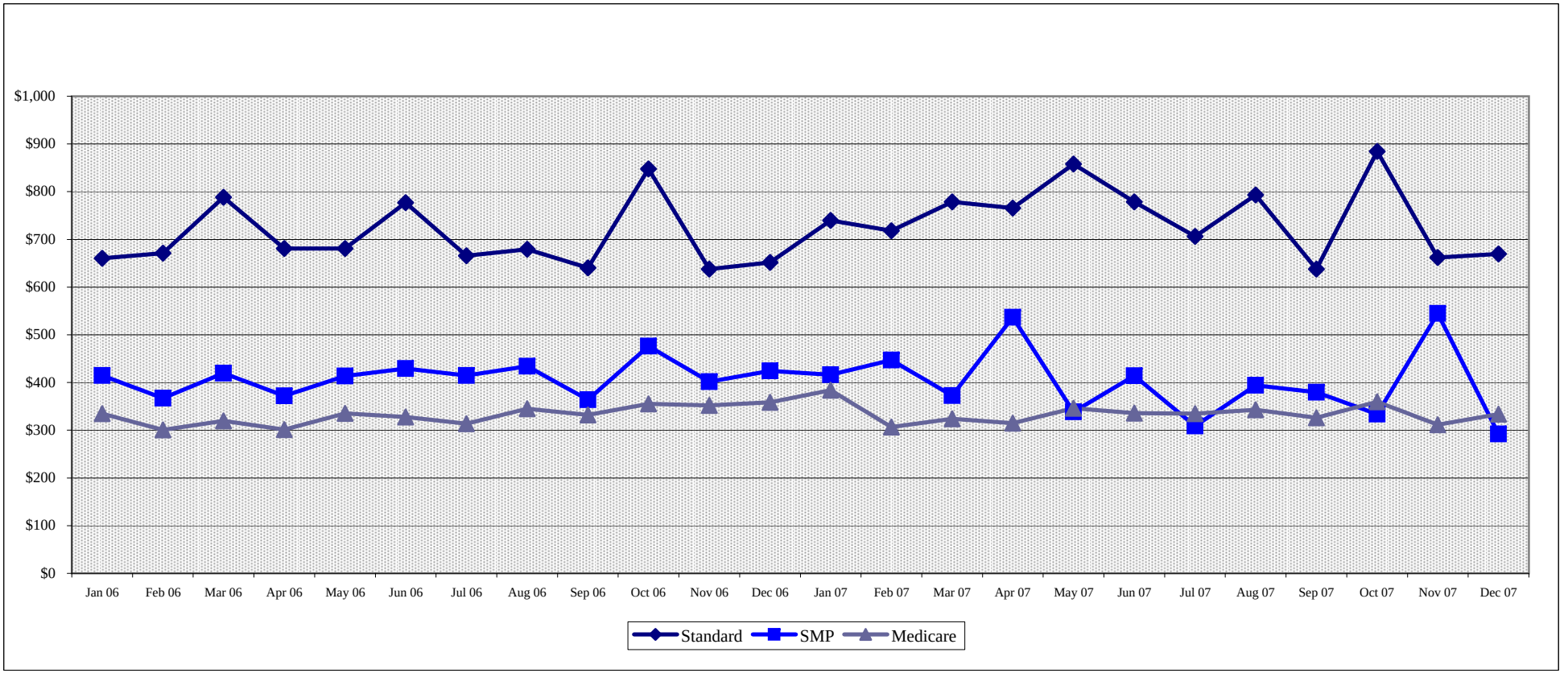
year over year medical PMPM trend from 2006 to 2007 was 7.3%, which is in line with WPS's Medicare supplement trend. We would naturally expect a small increase in the medical claims each year due to the benefit changes Medicare makes annually and medical cost trend.

STATE EMPLOYEE TRUST FUNDS

Paid Medical and Drug PMPM

Paid Through March 2008

Exhibit 7-A



	INCURRED MONTH																							
	Jan 06	Feb 06	Mar 06	Apr 06	May 06	Jun 06	Jul 06	Aug 06	Sep 06	Oct 06	Nov 06	Dec 06	Jan 07	Feb 07	Mar 07	Apr 07	May 07	Jun 07	Jul 07	Aug 07	Sep 07	Oct 07	Nov 07	Dec 07
Standard	$660.51	$671.30	$788.43	$681.14	$680.67	$776.77	$665.58	$679.08	$640.31	$847.55	$637.56	$651.68	$739.61	$718.09	$778.80	$765.89	$857.84	$778.54	$706.32	$793.33	$637.75	$884.60	$661.87	$669.57
SMP	$414.73	$366.98	$419.59	$371.77	$413.53	$429.38	$414.60	$434.01	$364.07	$476.49	$401.80	$424.47	$416.19	$447.31	$372.81	$536.77	$338.76	$414.05	$308.68	$394.17	$379.56	$333.79	$544.81	$292.13
Medicare	$334.68	$300.76	$319.88	$301.17	$335.05	$327.66	$313.65	$344.97	$332.17	$355.33	$352.21	$358.70	$383.87	$306.54	$323.96	$314.70	$345.95	$335.98	$334.99	$342.91	$326.34	$359.84	$311.74	$333.58

PMPM by Type of Service

The Total PMPM by Type of Service reports (8-A and 8-C) provide a breakdown of the PMPM by major type of service compared to the benchmark. The pie chart also provides an overview of the percentage of the PMPM each major type of service is contributing to the total PMPM plus a comparison to the benchmark. The actual PMPM costs are for claims incurred January 2007 – December 2007 and paid through the end of March 2008. The Paid PMPM by Type of Service reports (8-B, 8-D, and 8-E) show the same actual data, but compare 2006 to 2007.

Standard Plan

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

The bottom chart in Exhibit 8-A shows that the total PMPM cost is 47.9% above the benchmark. The inpatient facility PMPM cost is 53.0% above the benchmark and outpatient facility is 68.0% above the benchmark. The physician PMPM cost is 21.4% above the benchmark. The drug paid PMPM cost is 45.7% above the benchmark and roughly in line with the variance of the non-drug paid costs. Lastly the other services category is 87.6% over the norm. The largest contributor to this differential is the psychiatric/AODA benefit sub-category which is $22.47 above the norm. Every $1.00 PMPM represented in the graph is equivalent to $46,800 in annual plan costs for the Standard Plan.

Exhibit 8-B compares the Standard Plan's paid PMPM costs for 2006 vs. 2007, showing an 8.3% increase between the two years. Facility outpatient costs on a PMPM basis increased by 24.3% between the two years. The other services category actually decreased by 10.3%. The remaining categories increased near expected levels

SMP Plan

Exhibit 8-C shows the percentage breakdown by type of service for the SMP Plan is fairly close to the benchmark, with slightly more services falling into the facility outpatient category.

In total the SMP Plan is at the benchmark, with the plan being under in the facility inpatient, drug and other services categories. Facility outpatient is the biggest deviation from the benchmark, being 17.4% higher than our norms.

Exhibit 8-D compares the SMP Plan's paid PMPM costs for 2006 vs. 2007. Facility inpatient and facility outpatient costs increased by 23.5% and 34.8% while the rest of the categories were significantly lower in 2007. The total PMPM decreased by 1.8% in 2007. Due to the dramatic change in membership that occurred in 2007, we would expect this degree of variability.

Medicare

The Medicare Plus $1M Plan in Exhibit 8-E compares paid PMPM costs for 2006 vs. 2007. The medical segment of the paid PMPM cost accounts for only 38.3% of the payments made under the plan due to the impact of coordination of benefits with Medicare. In total the PMPM increased by 2% in 2007. Prescription drugs decreased by 1% while the medical categories experienced single digit increases, averaging 7.3%.

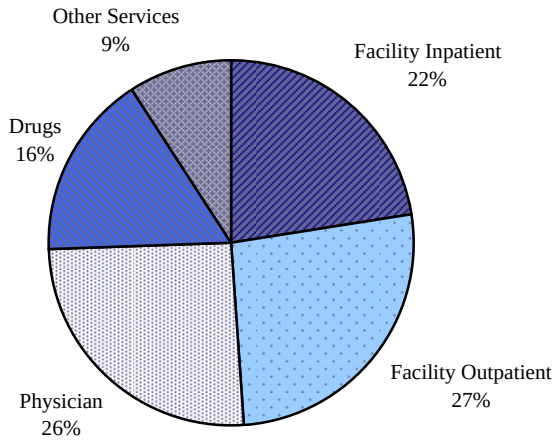
Exhibit 8-A

STATE EMPLOYEE TRUST FUNDS

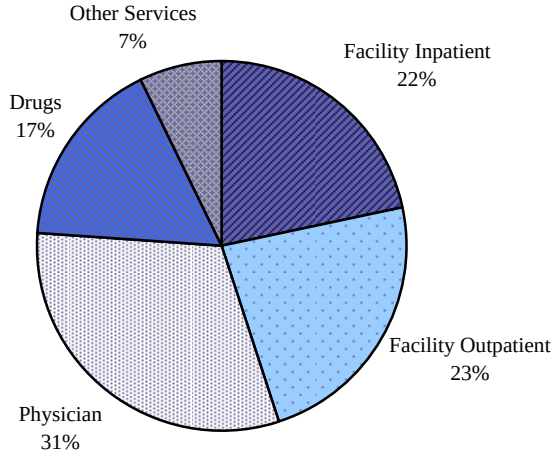
Total PMPM by Type of Service - Standard

Incurred January 2007 - December 2007 Paid Through March 2008

Actual PMPM



Benchmark PMPM



			Difference	
	Actual	Benchmark	$	%
Facility Inpatient	**$168.49**	**$110.14**	**$58.35**	**53.0%**
Facility Outpatient	**$197.08**	**$117.31**	**$79.77**	**68.0%**
Physician	**$192.35**	**$158.42**	**$33.93**	**21.4%**
Drugs	**$123.02**	**$84.44**	**$38.58**	**45.7%**
Other Services	**$68.28**	**$36.39**	**$31.89**	**87.6%**
Totals	**$749.22**	**$506.70**	**$242.52**	**47.9%**

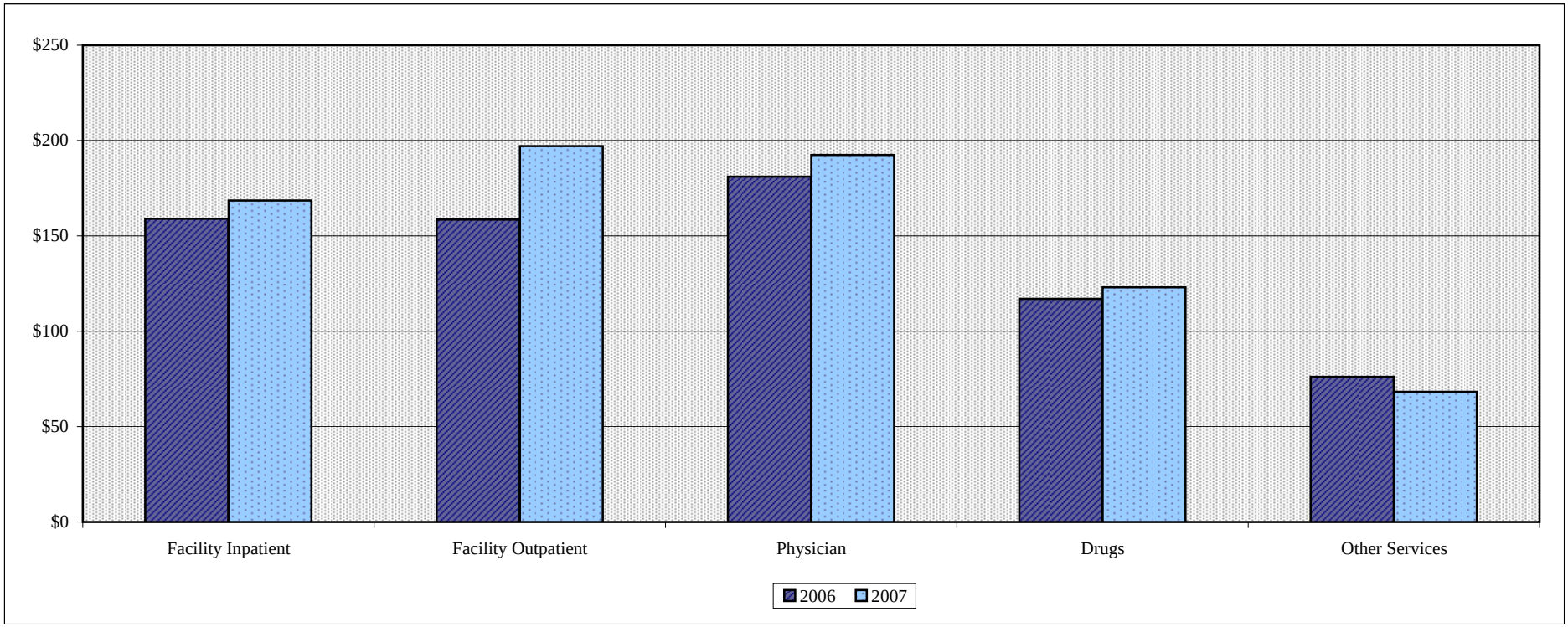
Note: Drug includes prescription and injectables

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

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

Exhibit 8-B

STATE EMPLOYEE TRUST FUNDS
Total PMPM by Type of Service - Standard
Comparison of 2007 to 2006



			Difference	
	2006 *	2007 **	$	%
Facility Inpatient	$158.97	$168.49	$9.52	6.0%
Facility Outpatient	$158.61	$197.08	$38.47	24.3%
Physician	$181.10	$192.35	$11.25	6.2%
Drugs	$116.99	$123.02	$6.03	5.2%
Other Services	$76.09	$68.28	-$7.81	-10.3%
Totals	$691.76	$749.22	$57.46	8.3%

Note: Drug includes prescription and injectables

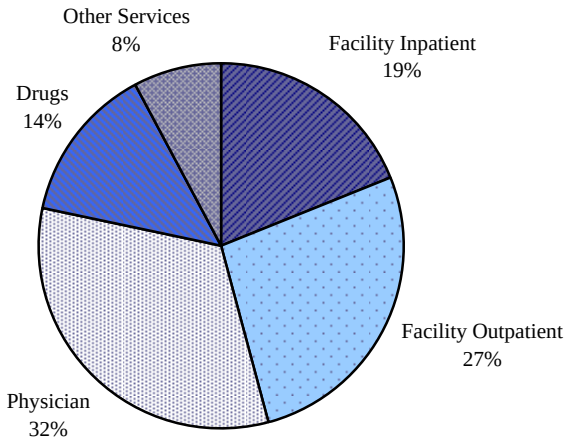
*** Each $1.00 paid PMPM = $52,016 in plan costs.**

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

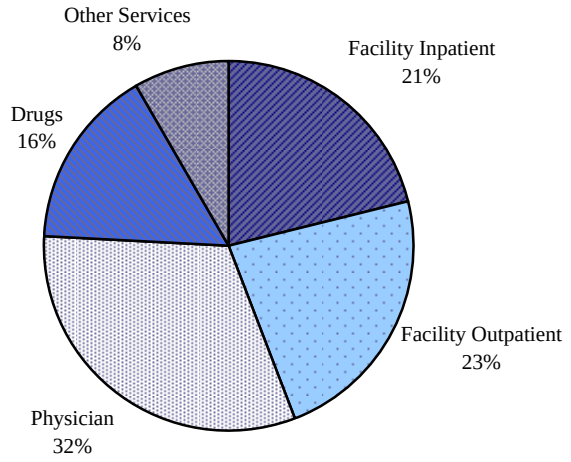
Exhibit 8-C

STATE EMPLOYEE TRUST FUNDS
Total PMPM by Type of Service - SMP
Incurred January 2007 - December 2007 Paid Through March 2008

Actual PMPM



Benchmark PMPM



			Difference	
	Actual	Benchmark	$	%
Facility Inpatient	**$75.07**	**$83.55**	**-$8.48**	**-10.1%**
Facility Outpatient	**$107.94**	**$91.92**	**$16.02**	**17.4%**
Physician	**$129.05**	**$125.21**	**$3.84**	**3.1%**
Drugs	**$55.67**	**$62.69**	**-$7.02**	**-11.2%**
Other Services	**$31.01**	**$33.24**	**-$2.23**	**-6.7%**
Totals	**$398.74**	**$396.61**	**$2.13**	**0.5%**

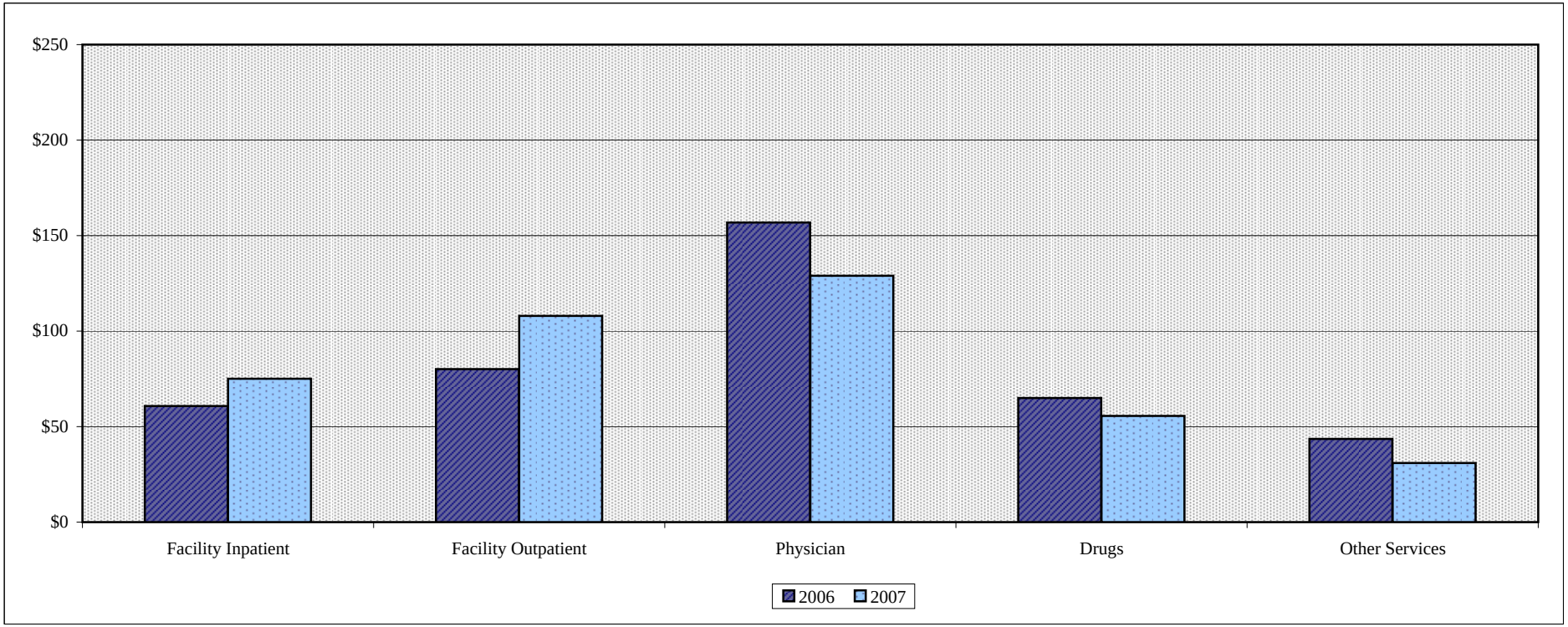
Note: Drug includes prescription and injectables

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

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

Exhibit 8-D

STATE EMPLOYEE TRUST FUNDS
Total PMPM by Type of Service - SMP
Comparison of 2007 to 2006



			Difference	
	2006 *	2007 **	$	%
Facility Inpatient	$60.79	$75.07	$14.28	23.5%
Facility Outpatient	$80.05	$107.94	$27.89	34.8%
Physician	$156.88	$129.05	-$27.83	-17.7%
Drugs	$64.99	$55.67	-$9.32	-14.3%
Other Services	$43.50	$31.01	-$12.49	-28.7%
Totals	$406.21	$398.74	-$7.47	-1.8%

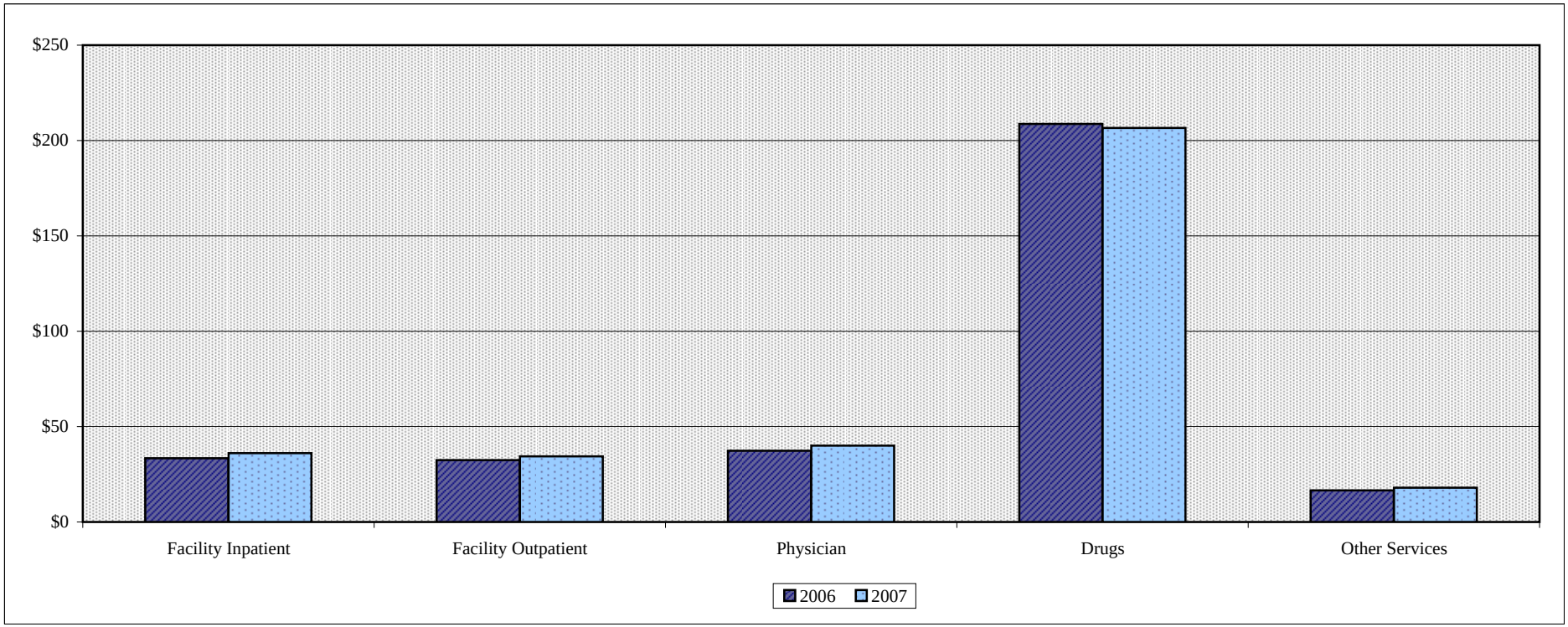
Note: Drug includes prescription and injectables

*** Each $1.00 paid PMPM = $97,961 in plan costs.**

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

Exhibit 8-E

STATE EMPLOYEE TRUST FUNDS
Total PMPM by Type of Service - Medicare Plus One Million
Comparison of 2007 to 2006



			Difference	
	2006 *	2007 **	$	%
Facility Inpatient	$33.47	$36.05	$2.58	7.7%
Facility Outpatient	$32.50	$34.43	$1.93	6.0%
Physician	$37.32	$40.09	$2.77	7.4%
Drugs	$208.72	$206.58	-$2.14	-1.0%
Other Services	$16.51	$17.92	$1.41	8.5%
Totals	$328.51	$335.07	$6.56	2.0%

Note: Drug includes prescription and injectables

*** Each $1.00 paid PMPM = $120,917 in plan costs.**

**** Each $1.00 paid PMPM = $117,541 in plan costs.**

Type of Service Detail

The Type of Service Detail report provides an overview of paid medical costs on a PMPM basis divided into 5 major service categories and further divided into 26 subcategories. The Actual PMPM costs are compared to the benchmark PMPM to help determine where the plan is experiencing higher than normal claim costs. The comparison to the benchmark is displayed as a PMPM difference and as a percentage difference. The Actual PMPM cost are for claims incurred January 2007 – December 2007 and paid through the end of March 2008.

Standard Plan

The Standard Plan in Exhibit 9-A was 47.9% above the benchmark in 2007. The variance to the benchmark is primarily a result of the anti-selection resulting from the dual choice open enrollment. Other contributing factors include the location of the Standard Plan's enrolled membership (the higher cost urban areas) and the rich benefit design. Since the percentage comparison can be deceiving, it is more important to look at the PMPM difference with $1.00 PMPM being equivalent to $46,800 in annual plan costs. Below are some areas that stand out relative to the benchmark and some analysis on what is driving the higher costs:

- Facility Inpatient – The majority of dollars are for surgical/medical services. Within surgical/medical, $10.05 PMPM is due to gastric bypass procedures not generally included in the norm. Another contributor to the overage is higher than expected large claim activity. For those claimants over $100,000, 48.1% of their claims fall into the inpatient facility category and drive a higher than expected PMPM. Also, psych/AODA services were 498.1% above the norm. In the psych/AODA category, $6.50 PMPM is due to a single large claimant.

- Facility Outpatient – Higher than expected costs in this category are reflective of the relative morbidity of the Standard Plan's population. Greater use of diagnostic services such as CT scans, MRIs and lab work has lead to cost variances versus the norm for outpatient radiology and pathology services. Costs in the other services category are 95.5% above the norm and 34.4% higher than last year. This difference is due to a significant change in the case mix of the high cost claimants who used more services such as chemotherapy. Psych/AODA services are still well above the norm but the PMPM has decreased from 2006 to 2007.

- Physician – The surgery category is $12.17 PMPM above the benchmark. Gastric bypass procedures have added $5.02 to the Paid PMPM cost. Costs for these procedures are not generally accounted for in the benchmark.

- Drug – The prescription drug and injectable costs are higher than the benchmark, however they are in line with the plan's performance overall. The injectable drug category warrants special attention into the future. Specialty drugs can have exceptionally high mark-ups when provided in a physician's office. Certain drugs are often less costly to the plan if provided through the PBM. Select drugs can be self-injected by the patient in their own home, which is often viewed positively by the member. Taking a proactive approach, contract/benefit language should be reviewed so specialty drugs can be most effectively managed in the future.

- Other services – The other services category is $31.89 above the benchmark. The major contributor to the variance is the Psychiatric /AODA cost which is $22.47 PMPM above the benchmark. The Standard Plan's benefit design in this sub-category is more comprehensive than the typical commercial plan, which is often limited to the Wisconsin state mandate.

SMP Plan

The SMP Plan in Exhibit 9-B by comparison is in line with the benchmark for 2007. For the plan $1.00 PMPM represented in the chart is equivalent to $6,392 in annual plan costs.

- Inpatient Facility – This category is running better than the benchmark. However, maternity costs are actually $4.93 higher than expected, driven by a slightly higher than expected incidence rate.

- Outpatient Facility –- On a dollar basis, the Surgical/Medical, Radiology, Psych/AODA, and Other categories are running well above the norm. High therapy and blood costs led to the overage in the outpatient-other category.

- Physician – This category is running close to expected. The Office Visit, Maternity and Other sub-categories are all well above the norm.

- Drug – The prescription drug PMPM cost is running 27.3% below the norm, while injectable drug costs are running 110.2% above the norm. Injectable drugs are high cost, low frequency events which warrant special attention. With the smaller SMP population, if someone requires these types of claims, one individual can drive the costs above the norm.

- Other Services – The Chiropractic sub-category is $1.37 above the norm which is a function of the region in which the SMP population resides. In the northern region, chiropractic care is more commonly used to treat back problems in comparison to other areas of the state. The other sub-category is $1.48 PMPM above the norm and appears to be driven by higher than expected costs for immunizations and hearing exams. Well baby exams are higher than expected with tends to be correlated with the higher maternity costs mentioned above.

Exhibit 9-A

STATE EMPLOYEE TRUST FUNDS

Type of Service Detail - Standard

Incurred January 2007 - December 2007 Paid Through March 2008

TYPE OF SERVICE	DETAIL	ACTUAL PMPM	BENCHMARK PMPM	DIFFERENCE $	DIFFERENCE %
FACILITY INPATIENT	SURGICAL/MEDICAL	$153.02	$102.99	$50.03	48.6%
	PSYCH/AODA	$9.51	$1.59	$7.92	498.1%
	MATERNITY	$3.52	$4.36	-$0.84	-19.3%
	OTHER	$2.44	$1.20	$1.24	103.3%
	Subtotal	**$168.49**	**$110.14**	**$58.35**	**53.0%**
FACILITY OUTPATIENT	SURGICAL/MEDICAL	$29.98	$22.01	$7.97	36.2%
	RADIOLOGY	$49.12	$33.05	$16.07	48.6%
	PATHOLOGY	$23.47	$13.16	$10.31	78.3%
	EMERGENCY ROOM	$5.84	$3.80	$2.04	53.7%
	PSYCH/AODA	$2.02	$0.96	$1.06	110.4%
	OTHER	$86.65	$44.33	$42.32	95.5%
	Subtotal	**$197.08**	**$117.31**	**$79.77**	**68.0%**
PHYSICIAN	OFFICE VISIT	$25.87	$20.37	$5.50	27.0%
	RADIOLOGY	$34.56	$29.96	$4.60	15.4%
	PATHOLOGY	$23.73	$18.76	$4.97	26.5%
	SURGERY	$61.03	$48.86	$12.17	24.9%
	ANESTHESIA	$10.96	$9.86	$1.10	11.2%
	MATERNITY	$1.32	$2.26	-$0.94	-41.6%
	OTHER	$34.88	$28.35	$6.53	23.0%
	Subtotal	**$192.35**	**$158.42**	**$33.93**	**21.4%**
DRUGS	PRESCRIPTIONS	$107.62	$74.57	$33.05	44.3%
	INJECTABLES	$15.40	$9.87	$5.53	56.0%
	Subtotal	**$123.02**	**$84.44**	**$38.58**	**45.7%**
OTHER SERVICES	PSYCH/AODA	$27.86	$5.39	$22.47	416.9%
	CHIROPRACTIC	$4.13	$3.30	$0.83	25.2%
	THERAPIES	$8.85	$3.74	$5.11	136.6%
	AMBULANCE	$1.96	$1.86	$0.10	5.4%
	WELL BABY EXAM	$0.32	$0.31	$0.01	3.2%
	DURABLE MEDICAL EQUIPMENT	$8.62	$5.55	$3.07	55.3%
	OTHER	$16.54	$16.24	$0.30	1.8%
	Subtotal	**$68.28**	**$36.39**	**$31.89**	**87.6%**
Grand Total		**$749.22**	**$506.70**	**$242.52**	**47.9%**

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

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

Exhibit 9-B

STATE EMPLOYEE TRUST FUNDS

Type of Service Detail - SMP

Incurred January 2007 - December 2007 Paid Through March 2008

TYPE OF SERVICE	DETAIL	ACTUAL PMPM	BENCHMARK PMPM	DIFFERENCE $	DIFFERENCE %
FACILITY INPATIENT	SURGICAL/MEDICAL	$64.44	$75.93	-$11.49	-15.1%
	PSYCH/AODA	$0.43	$1.61	-$1.18	-73.3%
	MATERNITY	$10.15	$5.22	$4.93	94.4%
	OTHER	$0.05	$0.79	-$0.74	-93.7%
	Subtotal	**$75.07**	**$83.55**	**-$8.48**	**-10.1%**
FACILITY OUTPATIENT	SURGICAL/MEDICAL	$20.43	$17.43	$3.00	17.2%
	RADIOLOGY	$28.21	$25.21	$3.00	11.9%
	PATHOLOGY	$11.28	$10.04	$1.24	12.4%
	EMERGENCY ROOM	$3.74	$3.45	$0.29	8.4%
	PSYCH/AODA	$3.50	$1.05	$2.45	233.3%
	OTHER	$40.78	$34.74	$6.04	17.4%
	Subtotal	**$107.94**	**$91.92**	**$16.02**	**17.4%**
PHYSICIAN	OFFICE VISIT	$18.35	$16.70	$1.65	9.9%
	RADIOLOGY	$19.39	$22.63	-$3.24	-14.3%
	PATHOLOGY	$15.90	$15.05	$0.85	5.6%
	SURGERY	$36.03	$37.93	-$1.90	-5.0%
	ANESTHESIA	$8.35	$7.77	$0.58	7.5%
	MATERNITY	$5.41	$2.69	$2.72	101.1%
	OTHER	$25.62	$22.44	$3.18	14.2%
	Subtotal	**$129.05**	**$125.21**	**$3.84**	**3.1%**
DRUGS	PRESCRIPTIONS	$40.26	$55.36	-$15.10	-27.3%
	INJECTABLES	$15.41	$7.33	$8.08	110.2%
	Subtotal	**$55.67**	**$62.69**	**-$7.02**	**-11.2%**
OTHER SERVICES	PSYCH/AODA	$2.02	$5.87	-$3.85	-65.6%
	CHIROPRACTIC	$4.36	$2.99	$1.37	45.8%
	THERAPIES	$3.38	$3.13	$0.25	8.0%
	AMBULANCE	$1.17	$1.45	-$0.28	-19.3%
	WELL BABY EXAM	$1.02	$0.79	$0.23	29.1%
	DURABLE MEDICAL EQUIPMENT	$2.88	$4.31	-$1.43	-33.2%
	OTHER	$16.18	$14.70	$1.48	10.1%
	Subtotal	**$31.01**	**$33.24**	**-$2.23**	**-6.7%**
Grand Total		**$398.74**	**$396.61**	**$2.13**	**0.5%**

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

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

Inpatient Utilization, Days/1000 and Average Length of Stay

The Inpatient Utilization report compares annual inpatient days per 1,000, admits per 1,000, average length of stay, cost per day, cost per admit, and inpatient PMPM cost to the benchmark for the 5 major inpatient service categories. Days/1000 is the annual average number of hospital days utilized by a population of 1,000 members which is calculated by taking (Total Days/Member Months)*12000. The Admits/1000 is the annual number of admits that occur within a typical population of 1,000 members which is calculated by taking (Total Admits/Member Months)*12000. The Days/1000 and Admits/1000 are calculations that allow a comparison of one population to another regardless of group size. Average Length of Stay (ALOS) shows the average length of hospitalization experienced for the entire group (Total Days/Total Admits). Cost per Day is an average of the cost per hospital day (Total Cost/Total Days). The cost per admit is an average of the cost per hospital admission (Total Cost/Total Admits). Lastly the inpatient PMPM is the per member per month cost incurred by the plan. Beyond the numerical comparison, a percentage has been included as observed in the pie charts, including a comparison to the benchmark.

Standard Plan

The totals for the Standard Plan in Exhibit 10-A exceed the benchmark totals for all statistics. The Medical category is below the benchmark in Days/1000, Admits/1000, and ALOS. In contrast, the Surgical category is above the benchmark in Days/1000 and Admits/1000. Contributing factors to the variance include gastric bypass procedures that are not generally accounted for in the benchmark as well as higher than expected large claim activity. For claimants with annual claims over $100,000, 25.9% of their claims fall into the surgical inpatient hospital category. The other inpatient services category appears higher than expected. This is due to the reporting of admits for skilled nursing facility stays being counted in the medical or surgical categories when a stay is continuous.

SMP

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

Exhibit 10-A

STATE EMPLOYEE TRUST FUNDS

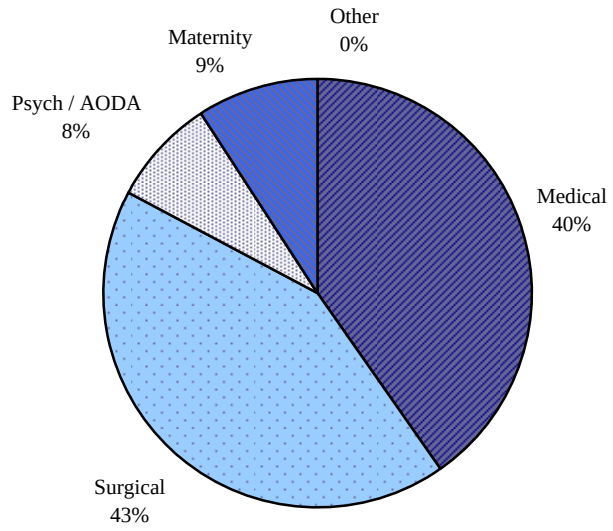
Inpatient Utilization - Standard

Incurred January 2007 - December 2007 Paid Through March 2008

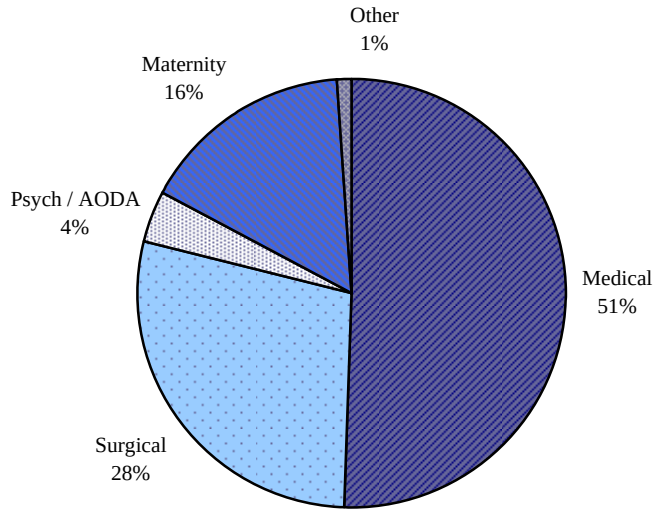
ACTUAL	Medical	Surgical	Psych / AODA	Maternity	Other	Total
Days/1000	155	179	36	22	63	455
Admits/1000	35	37	7	8	0	87
ALOS	4.38	4.86	5.26	2.55	247.00	5.18
Cost/Day	$3,787	$6,957	$3,134	$1,962	$463	$4,435
Cost/Admit	$16,603	$33,820	$16,483	$4,993	$114,296	$22,990
PMPM	$48.96	$104.07	$9.51	$3.52	$2.44	$168.50
% of Paid	29.06%	61.76%	5.64%	2.09%	1.45%	100.00%

BENCHMARK	Medical	Surgical	Psych / AODA	Maternity	Other	Total
Days/1000	187	108	19	32	55	401
Admits/1000	41	23	3	13	1	81
ALOS	4.56	4.70	6.33	2.46	55.00	4.95
Cost/Day	$2,998	$6,365	$1,024	$1,616	$286	$3,285
Cost/Admit	$13,541	$29,214	$5,700	$3,551	$15,031	$18,227
PMPM	$46.38	$56.61	$1.59	$4.36	$1.20	$110.14
% of Paid	42.11%	51.40%	1.44%	3.96%	1.09%	100.00%

% OF ADMITS FOR ACTUAL



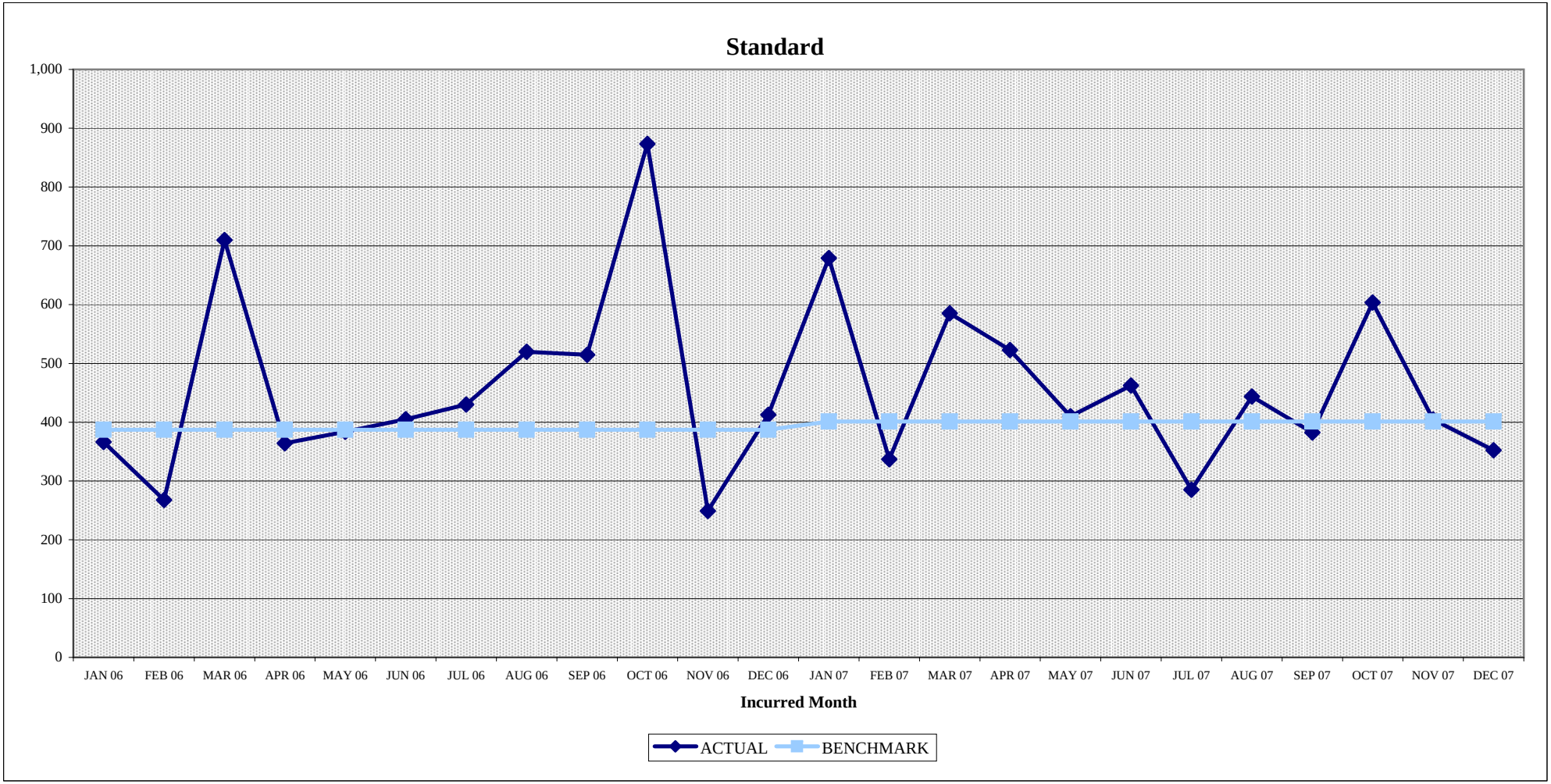
% OF ADMITS FOR BENCHMARK



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

Exhibit 10-B

STATE EMPLOYEE TRUST FUNDS
Monthly Inpatient Days/1000
Paid Through March 2008



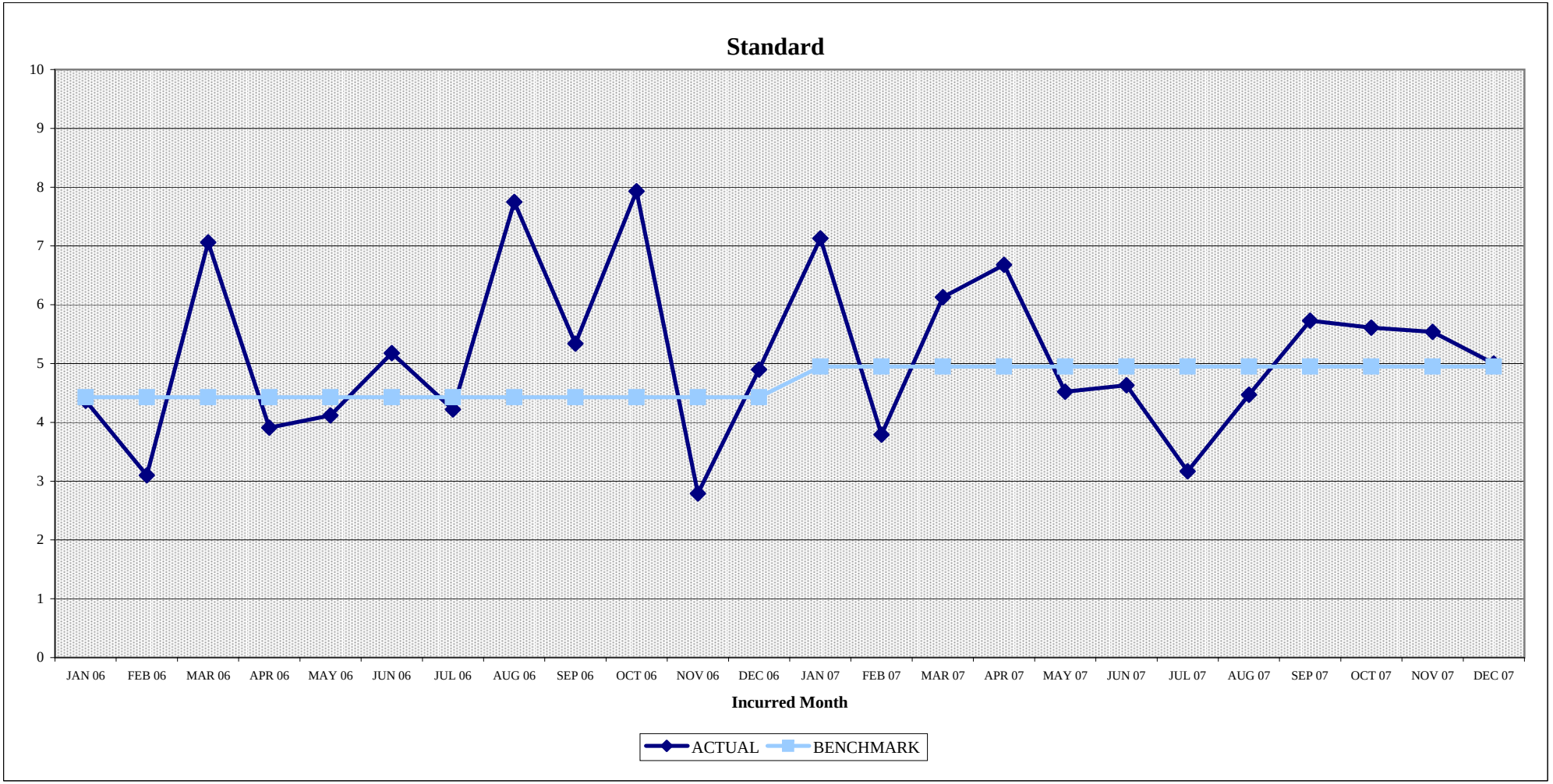
Note: Benchmark data has been age/sex adjusted to correspond to the population included in this exhibit

Exhibit 10-C

STATE EMPLOYEE TRUST FUNDS

Monthly Inpatient Average Length of Stay

Paid Through March 2008



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

Claim Costs by Major Diagnostic Categories (MDC)

The Claim Costs by Major Diagnostic Categories report divides medical claim costs into 25 mutually exclusive diagnostic categories. The category descriptions have been modified to incorporate simpler, more easily understood terms when compared to last years report. The diagnoses in each MDC correspond to a single organ system and, in general, are associated with a particular medical specialty. The actual PMPM cost by major diagnostic category is compared to the WPS benchmark PMPM. The Actual PMPM costs show calendar year results, comparing 2006 to 2007, each with three months run-out.

Prior exhibits have shown the **Standard Plan's** costs exceed the benchmark overall. Exhibit 11-A shows this deviation by MDC. Variation from the benchmark can be the result of many different factors. Since the benchmark is not adjusted for plan differences we can attribute some variation to non-standard benefits included in the Standard Plan. An example of this is gastric bypass procedures which contributed $16.73 PMPM to MDC 10. Without this non standard benefit, MDC 10 would actually be below the benchmark. We have discovered a membership trend where a high percentage of gastric bypass patients terminated from the plan after the procedure. For example in 2006, the plan had 25 gastric bypass patients. As of the writing of this report, only 5 were still active. For 2007, there were 27 patients, and now only 15 remain active in the plan. This anti-selection tends to increase the cost of the standard plan, and decrease the cost of the other non-WPS benefit offerings. More commentary regarding bariatric surgery, including discussion of the Center of Excellence approach is discussed in section 3.

Another instance of non-standard benefit variance is MDC 19 where the outpatient psychiatric benefit is adding over $13.00 PMPM of additional costs. Additional discussion regarding behavioral health management activities is included in section 3. Another reason for variances from the norm can be the case mix of large claim activity. This is what happened for MDC 17 where the 36 high cost patients accounted for $38.99 PMPM in this category. This change in case mix also leads to the large increase in MDC 17 between 2006 and 2007.

For the Standard Plan $1.00 PMPM in claim costs represented in the chart is equivalent to $46,800 annual in plan costs.

The **SMP Plan,** shown in Exhibit 11-B, is experiencing slightly higher than expected PMPM Cost overall. The large variance seen in MDC 16 and 17 are due to the conditions of the 2 high cost patients. Due to the decreasing size of the group, meaningful conclusions on other individual categories cannot be made. For the SMP Plan $1.00 PMPM in claim cost represented in the charts is equivalent to $6,392 in annual plan costs.

STATE EMPLOYEE TRUST FUNDS

Exhibit 11-A

Claim Costs by Major Diagnostic Categories - Standard

Comparison of 2007 to 2006

MDC CODE	MAJOR DIAGNOSTIC CATEGORY DESCRIPTION	2006 ACTUAL PMPM *	2007 ACTUAL PMPM **	BENCHMARK PMPM **	DIFFERENCE 2007 to 2006	DIFFERENCE 2007 to BENCHMARK
1	Nervous System Diseases and Disorders (D/D)	$43.60	$42.90	$24.60	-1.6%	74.4%
2	Eye D/D	$12.63	$17.07	$12.25	35.2%	39.4%
3	Ear, Nose, Mouth and Throat D/D	$21.83	$24.30	$16.91	11.3%	43.7%
4	Respiratory System D/D	$22.43	$24.33	$17.94	8.5%	35.7%
5	Circulatory System D/D	$61.36	$66.54	$57.34	8.4%	16.1%
6	Digestive System D/D	$65.00	$53.10	$41.05	-18.3%	29.4%
7	Liver, Gallbladder, Biliary Ducts and Pancreas D/D	$11.03	$13.33	$9.77	20.9%	36.5%
8	Muscles, Bones, and Connective Tissue D/D	$107.33	$106.20	$85.04	-1.1%	24.9%
9	Skin, Subcutaneous Tissue (fat and connective) and Breast D/D	$29.91	$40.53	$24.49	35.5%	65.5%
10	Endocrine, Nutritional and Metabolic D/D (included diagnoses related to obesity, diabetes and hormones)	$29.04	$34.77	$13.71	19.7%	153.7%
11	Kidney and Urinary Tract D/D	$20.72	$19.08	$16.76	-7.9%	13.8%
12	Male Reproductive System D/D	$4.15	$6.34	$4.97	52.8%	27.6%
13	Female Reproductive System D/D	$13.99	$10.78	$13.11	-22.9%	-17.7%
14	Pregnancy, Childbirth, and After Delivery Diagnoses	$5.32	$5.62	$8.09	5.6%	-30.5%
15	Newborns, and Newborns with Conditions Originating Shortly Before or After Birth	$1.39	$1.65	$3.86	18.7%	-57.2%
16	Blood and Blood Forming Organ D/D (including spleen) and Immune System Disorders	$8.95	$6.42	$3.82	-28.3%	68.3%
17	Bone Marrow D/D and Poorly Differentiated Cancers	$17.63	$46.67	$11.46	164.7%	307.4%
18	Infectious and Parasitic Diseases	$11.50	$3.05	$4.03	-73.5%	-24.3%
19	Behavioral Health Diagnoses	$37.31	$41.80	$9.28	12.0%	350.5%
20	Alcohol/Drug Use and Alcohol/Drug Induced Organic Mental Disorders	$1.10	$1.31	$1.25	19.1%	5.0%
21	Injuries, Poisoning and Toxic Effects of Drugs	$5.08	$6.55	$4.13	28.9%	58.5%
22	Burns	$0.03	$0.09	$0.21	200.0%	-57.4%
23	Other Miscellaneous Services Including Health Screenings, Medical Exams and Rehabilitation	$55.87	$65.56	$45.14	17.3%	45.2%
24	Multiple Significant Trauma	$0.00	$0.96	$1.19	0.0%	-19.6%
25	Human Immunodeficiency Virus Infections	$0.12	$0.10	$0.05	-16.7%	89.2%
0	Ungroupable	$0.74	$2.57	$1.71	247.3%	50.1%
	Total	**$588.06**	**$641.62**	**$432.13**	**9.1%**	**48.5%**

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

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

*** Each $1.00 paid PMPM = $52,016 in plan costs.**

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

Exhibit 11-B

STATE EMPLOYEE TRUST FUNDS
Claim Costs by Major Diagnostic Categories - SMP
Comparison of 2007 to 2006

MDC CODE	MAJOR DIAGNOSTIC CATEGORY DESCRIPTION	2006 ACTUAL PMPM *	2007 ACTUAL PMPM **	BENCHMARK PMPM **	DIFFERENCE 2007 to 2006	DIFFERENCE 2007 to BENCHMARK
1	Nervous System Diseases and Disorders (D/D)	$13.59	$10.52	$19.17	-22.6%	-45.1%
2	Eye D/D	$12.47	$5.09	$8.18	-59.2%	-37.8%
3	Ear, Nose, Mouth and Throat D/D	$18.63	$12.51	$16.52	-32.9%	-24.3%
4	Respiratory System D/D	$8.90	$11.05	$13.21	24.2%	-16.4%
5	Circulatory System D/D	$32.76	$34.17	$41.51	4.3%	-17.7%
6	Digestive System D/D	$34.19	$40.61	$33.57	18.8%	21.0%
7	Liver, Gallbladder, Biliary Ducts and Pancreas D/D	$6.37	$10.76	$7.98	68.9%	34.8%
8	Muscles, Bones, and Connective Tissue D/D	$71.66	$78.70	$63.27	9.8%	24.4%
9	Skin, Subcutaneous Tissue (fat and connective) and Breast D/D	$22.38	$12.76	$18.13	-43.0%	-29.6%
10	Endocrine, Nutritional and Metabolic D/D (included diagnoses related to obesity, diabetes and hormones)	$11.31	$5.91	$10.53	-47.7%	-43.9%
11	Kidney and Urinary Tract D/D	$11.02	$7.74	$12.11	-29.8%	-36.1%
12	Male Reproductive System D/D	$4.28	$5.94	$3.79	38.8%	56.6%
13	Female Reproductive System D/D	$18.70	$6.63	$11.23	-64.5%	-40.9%
14	Pregnancy, Childbirth, and After Delivery Diagnoses	$10.84	$15.53	$9.33	43.3%	66.5%
15	Newborns, and Newborns with Conditions Originating Shortly Before or After Birth	$7.35	$7.23	$5.28	-1.6%	36.8%
16	Blood and Blood Forming Organ D/D (including spleen) and Immune System Disorders	$2.95	$13.68	$2.96	363.7%	362.0%
17	Bone Marrow D/D and Poorly Differentiated Cancers	$8.62	$35.18	$8.48	308.1%	315.0%
18	Infectious and Parasitic Diseases	$2.45	$1.37	$3.51	-44.1%	-61.0%
19	Behavioral Health Diagnoses	$9.14	$6.48	$9.13	-29.1%	-29.0%
20	Alcohol/Drug Use and Alcohol/Drug Induced Organic Mental Disorders	$0.87	$0.91	$1.36	4.6%	-33.0%
21	Injuries, Poisoning and Toxic Effects of Drugs	$2.25	$2.59	$3.49	15.1%	-25.8%
22	Burns	$0.36	$0.06	$0.28	-83.3%	-78.9%
23	Other Miscellaneous Services Including Health Screenings, Medical Exams and Rehabilitation	$37.08	$32.61	$35.59	-12.1%	-8.4%
24	Multiple Significant Trauma	$0.00	$0.00	$1.14	0.0%	-100.0%
25	Human Immunodeficiency Virus Infections	$0.21	$0.00	$0.05	-100.0%	-100.0%
0	Ungroupable	$0.58	$0.46	$1.47	-20.7%	-68.7%
	Total	**$348.96**	**$358.49**	**$341.25**	**2.7%**	**5.1%**

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

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

*** Each $1.00 paid PMPM = $97,961 in plan costs.**

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

Top 20 Providers

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

Facility

The report for the **Standard Plan** in Exhibit 12-A shows that the top 20 facilities provide 57.1% of the total facility charges for the plan. By far, the largest percent of claims and number of patients came from the University of Wisconsin hospital. Second was Columbia St. Marys in Milwaukee. As expected, a concentration of the top 20 facility providers are located in the Dane and Milwaukee County areas where a majority of the Standard Plan population resides. Since the Standard Plan is available nationwide, however, we do see providers from various regions and states.

The report for the **SMP Plan** in Exhibit 12-B shows that the top 20 facilities provide 97.3% of the total facility charges for the plan. The largest percentage of paid claims is from Bay Area Medical Center in Marinette. The provider with the second highest amount of paid claims is the University of Wisconsin Hospital, though this was for only one claimant.

Professional

The **Standard Plan** shown in Exhibit 12-C received 44.4% of professional charges from the top 20 providers. Once again the University of Wisconsin Medical Foundation is the leading professional provider which corresponds to the top facility charges for the plan. Like the facility charges a concentration of the top providers are from the Dane and Milwaukee Counties regions.

The **SMP Plan** in Exhibit 12-D received 74.1% of the paid claims from the top 20 professional providers. Bay Area / Bellin Health in Marinette was the largest provider, receiving 10.4% of the overall payments, followed by Aurora Medical in Oshkosh at 9.7%. Like the facility charges we see a majority of the charges are received at regional facilities due to the HMO-type coverage and the limited service area. You can also see some services were received in Minnesota and Michigan since the SMP does have limited coverage in the states surrounding Wisconsin.

Exhibit 12-A

STATE EMPLOYEE TRUST FUNDS

Top 20 Facility Providers - Standard

Incurred January 2007 - December 2007 Paid Through March 2008

	Facility Provider	City	State	# of Unique Patients	Inpatient Paid Claims	Outpatient Paid Claims	Total Paid Claims	Paid %
1	UNIVERSITY WI HSP CL AUTHORITY	MADISON	WI	619	$782,146	$1,861,801	$2,643,947	15.5%
2	CSM COMMUNITY PHYSICIANS	MILWAUKEE	WI	221	$376,819	$507,608	$884,427	5.2%
3	FROEDTERT MEM LUTH HOSP	MILWAUKEE	WI	119	$442,994	$369,745	$812,739	4.8%
4	MERITER HOSPITAL INC	MADISON	WI	144	$384,204	$378,418	$762,622	4.5%
5	SOUTHWESTERN REGIONAL MEDICAL	TULSA	OK	1	$84,583	$364,176	$448,759	2.6%
6	ALL SAINTS ST MARYS MED CTR	RACINE	WI	85	$149,133	$272,683	$421,816	2.5%
7	WAUKESHA MEM HSP INC	WAUKESHA	WI	39	$306,549	$106,356	$412,905	2.4%
8	AURORA ST LUKES MEDICAL CTR	MILWAUKEE	WI	80	$178,015	$227,003	$405,018	2.4%
9	CLEVELAND CLINIC FOUNDATION	CLEVELAND	OH	3	$155,041	$226,246	$381,287	2.2%
10	AURORA SINAI SAMARTN MED CTR	MILWAUKEE	WI	32	$6,366	$341,950	$348,316	2.0%
11	FAIRVIEW UNIVERSITY MED CTR	MINNEAPOLIS	MN	14	$277,305	$53,837	$331,142	1.9%
12	LENOX HILL HOSP	NEW YORK	NY	1	$304,099	$0	$304,099	1.8%
13	SACRED HEART HOSP	EAU CLAIRE	WI	19	$232,964	$50,549	$283,513	1.7%
14	ST MARYS HOSP OZAUKEE	MEQUON	WI	49	$49,793	$156,910	$206,703	1.2%
15	ST MARYS HSP-ROCHESTER	ROCHESTER	MN	13	$129,797	$65,825	$195,622	1.1%
16	THOMAS JEFFERSON HOSPITAL	PHILADELPHIA	PA	2	$183,904	$4,471	$188,375	1.1%
17	ABBOTT NORTHWESTERN HOSPITAL	MINNEAPOLIS	MN	19	$157,902	$30,382	$188,284	1.1%
18	SAINT MICHAELS HOSP	STEVENS POINT	WI	18	$126,525	$61,319	$187,844	1.1%
19	LUTHER HOSPITAL	EAU CLAIRE	WI	32	$97,379	$86,885	$184,264	1.1%
20	TRIDENT MEDICAL CTR	CHARLESTON	SC	2	$119,999	$59,933	$179,932	1.1%
	Top 20 Total			**1,512**	**$4,545,517**	**$5,226,097**	**$9,771,614**	**57.1%**
	All Other Facility Charges			**1,663**	**$3,339,902**	**$3,997,221**	**$7,337,123**	**42.9%**
	Total Facility Charges			**3,175**	**$7,885,419**	**$9,223,318**	**$17,108,737**	**100.0%**

Exhibit 12-B

STATE EMPLOYEE TRUST FUNDS

Top 20 Facility Providers - SMP

Incurred January 2007 - December 2007 Paid Through March 2008

	Facility Provider	City	State	# of Unique Patients	Inpatient Paid Claims	Outpatient Paid Claims	Total Paid Claims	Paid %
1	BAY AREA MEDICAL CTR	MARINETTE	WI	95	$142,667	$235,293	$377,960	32.3%
2	UNIVERSITY WI HSP CL AUTHORITY	MADISON	WI	1	$65,142	$61,501	$126,643	10.8%
3	MEMORIAL MED CTR INC	ASHLAND	WI	31	$27,330	$94,529	$121,859	10.4%
4	ABBOTT NORTHWESTERN HOSPITAL	MINNEAPOLIS	MN	29	$21,166	$54,605	$75,771	6.5%
5	AURORA BAYCARE MED CTR	GREEN BAY	WI	6	$35,046	$38,908	$73,954	6.3%
6	DICKINSON COUNTY MEMORIAL HOSP	IRON MOUNTAIN	MI	32	$16,340	$53,020	$69,360	5.9%
7	ST MARYS MED CTR	DULUTH	MN	4	$31,795	$15,154	$46,949	4.0%
8	BURNETT MEDICAL CENTER INC	GRANTSBURG	WI	14	$0	$46,697	$46,697	4.0%
9	ST MARYS HSP-ROCHESTER	ROCHESTER	MN	1	$38,540	$0	$38,540	3.3%
10	BELLIN MEMORIAL HOSP	GREEN BAY	WI	5	$26,619	$7,780	$34,399	2.9%
11	ST JOSEPHS HOSPITAL	MARSHFIELD	WI	1	$33,436	$0	$33,436	2.9%
12	ST VINCENT HOSPITAL	GREEN BAY	WI	2	$22,986	$4,239	$27,225	2.3%
13	GRAND VIEW HOSP	IRONWOOD	MI	9	$0	$18,156	$18,156	1.6%
14	MARQUETTE GENERAL HOSPITAL INC	MARQUETTE	MI	3	$11,733	$2,119	$13,852	1.2%
15	IRON CO COMM HOSPITAL	IRON RIVER	MI	2	$2,709	$4,782	$7,491	0.6%
16	ROCHESTER METHODIST HOSPITAL	ROCHESTER	MN	1	$0	$7,114	$7,114	0.6%
17	ST MARYS HOSPITAL OF SUPERIOR	SUPERIOR	WI	1	$0	$5,771	$5,771	0.5%
18	ONTONAGON MEM HOSP	ONTONAGON	MI	2	$2,797	$2,356	$5,153	0.4%
19	SAINT MICHAELS HOSP	STEVENS POINT	WI	2	$1,202	$2,904	$4,106	0.4%
20	DIVINE SAVIOR HOSP	PORTAGE	WI	1	$0	$4,097	$4,097	0.4%
	Top 20 Total			**242**	**$479,508**	**$659,025**	**$1,138,533**	**97.3%**
	All Other Facility Charges			**37**	**$300**	**$31,032**	**$31,332**	**2.7%**
	Total Facility Charges			**279**	**$479,808**	**$690,057**	**$1,169,865**	**100.0%**

Exhibit 12-C

STATE EMPLOYEE TRUST FUNDS

Top 20 Professional Providers - Standard

Incurred January 2007 - December 2007 Paid Through March 2008

	Professional Provider	City	State	# of Unique Patients	Total Paid Claims	Paid %
1	UW MEDICAL FOUNDATION	MADISON	WI	806	$1,714,097	13.3%
2	MAYO CLINIC ROCHESTER	ROCHESTER	MN	77	$563,198	4.4%
3	MEDICAL COLLEGE OF WISCONSIN	MILWAUKEE	WI	215	$522,205	4.0%
4	DEAN MEDICAL CTR	MADISON	WI	272	$456,835	3.5%
5	MARSHFIELD CLINIC	MARSHFIELD	WI	90	$451,991	3.5%
6	AURORA MEDICAL GROUP OSHKOSH	OSHKOSH	WI	275	$399,545	3.1%
7	ADVANCED HEALTHCARE SC	MILWAUKEE	WI	179	$252,793	2.0%
8	MIDELFORT CLINIC MHS	EAU CLAIRE	WI	104	$218,480	1.7%
9	ONCOLOGY ALLIANCE SC	RACINE	WI	11	$210,635	1.6%
10	WHEATON FRANCISCAN MEDICAL GRP	RACINE	WI	120	$151,720	1.2%
11	CSM COMMUNITY PHYSICIANS	MILWAUKEE	WI	194	$145,857	1.1%
12	ASSOCIATED PHYSICIANS LLP	MADISON	WI	139	$111,378	0.9%
13	SAINT MICHAELS HOSP	STEVENS POINT	WI	37	$87,966	0.7%
14	GUNDERSEN CLINIC LTD	LA CROSSE	WI	34	$87,651	0.7%
15	BAYCARE CLINIC LLP	GREEN BAY	WI	26	$74,479	0.6%
16	MADISON PSYCH & PSYCH SVC	MADISON	WI	23	$67,428	0.5%
17	MADISON MEDICAL AFFILIATES INC	MEQUON	WI	78	$57,340	0.4%
18	RED CEDAR MEDICAL CTR	MENOMONIE	WI	49	$55,520	0.4%
19	AFFINITY MEDICAL GROUP	NEENAH	WI	51	$53,559	0.4%
20	MILWAUKEE RADIOLOGISTS LTD SC	MILWAUKEE	WI	94	$50,216	0.4%
	Top 20 Total			**2,874**	**$5,732,893**	**44.4%**
	All Other Professional Charges			**10,095**	**$7,185,431**	**55.6%**
	Total Professional Charges			**12,969**	**$12,918,324**	**100.0%**

Exhibit 12-D

STATE EMPLOYEE TRUST FUNDS

Top 20 Professional Providers - SMP

Incurred January 2007 - December 2007 Paid Through March 2008

	Professional Provider	City	State	# of Unique Patients	Total Paid Claims	Paid %
1	BAY AREA BELLIN HEALTH LLC	MARINETTE	WI	144	$116,092	10.4%
2	AURORA MEDICAL GROUP OSHKOSH	OSHKOSH	WI	48	$108,875	9.7%
3	DULUTH CLINIC LTD	DULUTH	MN	49	$108,132	9.6%
4	BAY AREA MEDICAL CTR	MARINETTE	WI	34	$83,668	7.5%
5	BAYCARE CLINIC LLP	GREEN BAY	WI	10	$65,543	5.8%
6	RIVER FALLS MEDICAL CLINIC	RIVER FALLS	WI	73	$50,389	4.5%
7	MINNESOTA ONCOLOGY HEMATOLOGY	MAPLEWOOD	MN	2	$46,861	4.2%
8	MARSHFIELD CLINIC	MARSHFIELD	WI	11	$38,253	3.4%
9	MAYO CLINIC ROCHESTER	ROCHESTER	MN	1	$35,591	3.2%
10	UNIVERSITY WI HSP CL AUTHORITY	MADISON	WI	1	$24,244	2.2%
11	GREEN BAY RADIOLOGY SC	GREEN BAY	WI	68	$21,374	1.9%
12	NARAYAN AMARNANI MD SC OUTREAC	MARINETTE	WI	14	$19,694	1.8%
13	BURNETT MEDICAL CENTER INC	GRANTSBURG	WI	15	$18,608	1.7%
14	UW MEDICAL FOUNDATION	MADISON	WI	2	$17,818	1.6%
15	NORTHERN LIGHTS CLINIC SC	MARINETTE	WI	19	$15,658	1.4%
16	IHC BAY AREA EMERGENCY PHYSICI	MARINETTE	WI	33	$14,153	1.3%
17	HENKE & RYAN PC	IRON MOUNTAIN	MI	5	$12,261	1.1%
18	MAINSTREET CLINIC SC	ASHLAND	WI	25	$11,799	1.1%
19	DICKINSON COUNTY MEMORIAL HOSP	IRON MOUNTAIN	MI	34	$11,720	1.0%
20	NEONATAL CONSULTANTS	GREEN BAY	WI	1	$10,791	1.0%
	Top 20 Total			**589**	**$831,524**	**74.1%**
	All Other Professional Charges			**569**	**$290,086**	**25.9%**
	Total Professional Charges			**1,158**	**$1,121,610**	**100.0%**

Out of Network Utilization

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

Facility

The **Standard Plan** out of network facility utilization was 6.5% of the total facility claims for the plan in 2007, slightly higher than last year's facility utilization number of 3.9%. The 2006 number was calculated using a slightly different methodology. 12 of the 20 out of network providers were from outside the state which is expected given 24.1% of the Standard Plan population lives outside the state of Wisconsin and are more likely to see an out of network provider depending on location.

Professional

The **Standard Plan** out of network professional utilization was 10.2% of the total professional claims for the plan in 2007. While last year's report showed better network utilization, (out of network claims were equal to 6.3% in 2006), last year's number was calculated via a different methodology. 19 of the top 20 professional providers practice in Wisconsin.

Exhibit 13-A

STATE EMPLOYEE TRUST FUNDS

Facility Out of Network Utilization - Standard

Incurred January 2007 - December 2007 Paid Through March 2008

	Facility Provider	City	State	# of Unique Patients	Inpatient Paid Claims	Outpatient Paid Claims	Total Paid Claims
1	TRIDENT MEDICAL CTR	CHARLESTON	SC	2	$119,998.75	$59,933.14	$179,931.89
2	SOUTHWESTERN REGIONAL MEDICAL	TULSA	OK	2	$0.00	$167,014.27	$167,014.27
3	SELECT SPECIALTY HOSPITAL	WEST ALLIS	WI	1	$148,782.33	$0.00	$148,782.33
4	LAKEVIEW REHABILITATION CTR	WATERFORD	WI	1	$145,490.37	$0.00	$145,490.37
5	SUMMIT SURGERY CTR	SANTA BARBARA	CA	1	$0.00	$44,171.00	$44,171.00
6	COPLEY MEM HOSP	AURORA	IL	1	$0.00	$28,787.12	$28,787.12
7	HENRY FORD HOME CARE	DETROIT	MI	1	$0.00	$27,322.32	$27,322.32
8	WISCONSIN RENAL CARE GRP	MILWAUKEE	WI	3	$0.00	$25,521.26	$25,521.26
9	MT CARMEL NEW ALBANY SURG	NEW ALBANY	OH	1	$24,995.76	$0.00	$24,995.76
10	YALE NEW HAVEN HOSPITAL	NEW HAVEN	CT	1	$21,358.57	$0.00	$21,358.57
11	HOPE HOSPICE	FORT MYERS	FL	1	$15,398.80	$0.00	$15,398.80
12	TRINITY HEALTHCARE	MILWAUKEE	WI	2	$15,271.39	$0.00	$15,271.39
13	CEDAR SPRINGS HEALH AND REHABI	CEDARBURG	WI	2	$13,736.98	$0.00	$13,736.98
14	MANORCARE HEALTH SVC	FOND DU LAC	WI	1	$11,927.50	$0.00	$11,927.50
15	MILW CO M/H COMPLEX	MILWAUKEE	WI	2	$10,322.00	$0.00	$10,322.00
16	MERCY MEMORIAL HEALTH CTR	OKLAHOMA CITY	OK	1	$8,283.33	$1,890.17	$10,173.50
17	MEMORIAL HOSP	COLORADO SPRINGS	CO	1	$0.00	$9,924.75	$9,924.75
18	900 NORTH MICHIGAN SURG CTR	CHICAGO	IL	1	$0.00	$9,718.40	$9,718.40
19	EVERGREEN RETIREMENT	OSHKOSH	WI	1	$9,281.80	$0.00	$9,281.80
20	SANTA BARBARA SURGERY CENTER	SANTA BARBARA	CA	1	$0.00	$9,231.30	$9,231.30
TOTAL				**27**	**$544,847.58**	**$383,513.73**	**$928,361.31**

Exhibit 13-B

STATE EMPLOYEE TRUST FUNDS

Professional Out of Network Utilization - Standard

Incurred January 2007 - December 2007 Paid Through March 2008

	Professional Provider	City	State	# of Unique Patients	Total Paid Claims
1	MADISON PSYCH & PSYCH SVC	MADISON	WI	23	$67,428.00
2	WISCONSIN RENAL CARE GRP	MILWAUKEE	WI	3	$46,617.52
3	WISCONSIN PSYCHOTHERAPY & HE	MADISON	WI	6	$40,587.75
4	WOMENS PSYCHIATRIC CENTER OF W	MADISON	WI	7	$39,820.50
5	RICHARD A FRANK MD SC	MILWAUKEE	WI	9	$35,690.22
6	NEWPORT PROFESSIONALS LTD	MEQUON	WI	5	$25,308.00
7	MEDICAL SUPPRT SRV INC	RACINE	WI	1	$20,541.27
8	ROBERT L WELKER PHD	GLENDALE	WI	4	$15,286.50
9	DOPSYCH SC	GREEN BAY	WI	2	$14,845.04
10	BELL AMBULANCE	MILWAUKEE	WI	9	$14,094.96
11	BETH ISRAEL HAND SURGERY CENTE	NEW YORK	NY	1	$13,695.00
12	COUNSELING ASSOCIATES MADISON	MADISON	WI	8	$13,322.37
13	RIVERHILL PSYCHIATRIC ASSOCIAT	MANITOWOC	WI	4	$13,281.32
14	MARCI M GITTLEMAN PHD	MADISON	WI	8	$12,307.50
15	GOODYEAR CHIROPRACTIC	GLENDALE	WI	4	$11,318.36
16	SILVER SPRING PSYCHIATRIC ASSO	MILWAUKEE	WI	5	$11,308.50
17	IKAR J KALOGJERA MD	WAUWATOSA	WI	6	$10,731.27
18	JAN C VAN SCHAIK MD	WHITEFISH BAY	WI	1	$10,692.00
19	EASTLAKE COUNSELING	MILWAUKEE	WI	5	$10,518.75
20	WISCONSIN EARLY AUTISM PROJECT	MADISON	WI	4	$10,201.63
	TOTAL			**115**	**$437,596.46**

High Cost Patients

The High Cost Patients report in Exhibit 14-A lists the plan members with claims over $100,000 for claims incurred January 2007 – December 2007 and paid through March 2008 for the Standard, SMP and Medicare Plus $1M Plans. The Primary Condition is the condition associated with the largest percentage of claim payments and therefore may not be representative of a patient's complete condition. The Care Management section shows the type of care management provided on each case. For a detailed description of care management processes please reference the Case Management Description on the next page.

In general, cancer diagnoses accounted for 40% of the high dollar cases and 49% of the total high dollar claims. Of the cancer claims, breast cancer was the most prevalent with six breast cancer patients out of the 17 total cancer patients. Two members in the high cost category had behavioral health diagnoses. All members with high dollar claims received intensive care management service.

The **Standard Plan** has 36 members with claims over $100,000 for a total of $7,719,465 in claim costs. Of these 36 members 20 are employees, 13 are spouses, and 3 are dependents. Another way to break down these members is that 22 are regular members, 13 are annuitants, and 1 is a graduate assistant. 26 of the members reside in state and 10 are out of state. These 36 members represent 22.0% of total claims paid under the Standard Plan. The expected percent of claims over $100,000 for a group of this size is 6.0%, whereas for the Standard Plan, they have 11.7% of claims over $100,000. Therefore, large claim activity is much higher than expected.

The **SMP Plan** has 2 members with claims over $100,000 for a total of $345,831 in claim costs. One of the members is an employee and the other is a spouse, while both are regular members. Both large claimants for the SMP Plan reside in Wisconsin. These 2 members represent 13.6% of total claims paid under the SMP Plan. .

The **Medicare Plus $1M Plan** has 4 members with claims over $100,000 for a total $466,192 in claim costs. Three members reside in Wisconsin and one resides out of state. One member is a foreign resident and claims were incurred at a foreign provider. There are limited opportunities for repricing of claims performed at foreign providers. For two of the other claimants, Medicare benefits were exhausted, and the state plan paid for the excess charges. The forth claimant labeled in this category recently changed from the Standard Plan to the Medicare Plus $1M Plan, so some of the claims were actually incurred while on the Standard Plan.

Case Management Descriptions

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

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

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

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

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

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

Exhibit 14-A

STATE EMPLOYEE TRUST FUNDS

High Cost Patients (over $100,000)

Incurred January 2007 - December 2007 Paid Through March 2008

	Patient Status	Plan	Care Management	Primary Condition	Total Paid
1	ACTIVE	STANDARD	Preauth, UM, CM	MYELOID LEUKEMIA	$569,049.29
2	CANCELLED	STANDARD	UM, CM	OVARIAN/COLON CANCER	$486,855.85
3	ACTIVE	STANDARD	Preauth, UM, CM	AORTIC ANEURYSM	$470,925.01
4	ACTIVE	STANDARD	UM, CM	HODGKINS DISEASE	$438,069.45
5	ACTIVE	STANDARD	UM, CM	STROKE	$415,843.18
6	CANCELLED	STANDARD	Preauth, UM, CM	BRAIN CANCER	$387,537.12
7	ACTIVE	STANDARD	UM, BH	BEHAVIORAL HEALTH	$348,459.76
8	CANCELLED	STANDARD	UM, CM	BREAST/LIVER CANCER	$286,609.48
9	CANCELLED	STANDARD	Preauth, UM, CM	EYE/LIVER CANCER	$258,618.75
10	CANCELLED	STANDARD	UM, CM	BREAST CANCER	$254,227.96
11	CANCELLED	STANDARD	Preauth, UM, CM	CHRONIC PANCREATITIS	$251,863.51
12	ACTIVE	STANDARD	Preauth, UM, CM	BREAST CANCER	$250,050.67
13	CANCELLED	SMP	Preauth, UM, CM	NON HODGKINS DISEASE	$242,995.81
14	ACTIVE	STANDARD	Preauth, UM	SPINAL STENOSIS/LUMBAR FUSION	$179,996.53
15	CANCELLED	STANDARD	Preauth,UM	SPINAL STENOSIS/LUMBAR FUSION	$177,940.70
16	CANCELLED	STANDARD	UM, CM	AORTIC ANEURYSM	$174,739.85
17	ACTIVE	STANDARD	UM, CM	CHRONIC RENAL FAILURE	$174,508.17
18	ACTIVE	STANDARD	UM, CM	HEART VALVE DEFECT	$170,858.00
19	CANCELLED	STANDARD	UM, CM	CHRONIC LEUKEMIA	$161,404.08
20	ACTIVE	STANDARD	UM, CM	PLASMA CELL CANCER	$158,642.11
21	CANCELLED	STANDARD	UM, CM	BACTERIAL PNEUMONIA	$153,896.72
22	ACTIVE	STANDARD	UM, DM	SPINAL STENOSIS/LUMBAR FUSION	$152,554.88
23	CANCELLED	STANDARD	UM	HEART VALVE DISORDER	$152,381.65
24	ACTIVE	STANDARD	UM, BH	KNEE REPLACEMENT	$146,258.11
25	ACTIVE	STANDARD	Preauth, UM, CM	CYSTIC FIBROSIS COMPLICATIONS	$143,558.18
26	ACTIVE	STANDARD	Preauth, UM, CM	TONSIL CANCER	$140,693.13
27	ACTIVE	MEDICARE PLUS ONE MILLION	DM	HEART FAILURE	$131,886.85
28	ACTIVE	STANDARD	Preauth, UM, CM	TRACHEA/LUNG CANCER	$126,402.18
29	ACTIVE	STANDARD	UM	CURVATURE OF SPINE/LUMBAR FUSION	$122,365.84
30	ACTIVE	MEDICARE PLUS ONE MILLION	Medical Review	CHRONIC PULMONARY HEART DISEASE	$121,315.02
31	ACTIVE	STANDARD	Preauth, UM, BH	BEHAVIORAL HEALTH	$121,174.63
32	ACTIVE	STANDARD	Preauth,UM, BH, CM	BREAST CANCER	$109,617.45

Preauth = Preauthorization UM = Utilization Management CM = Case Management DM = Disease Management BH = Behavioral Health

Exhibit 14-A

STATE EMPLOYEE TRUST FUNDS

High Cost Patients (over $100,000)

Incurred January 2007 - December 2007 Paid Through March 2008

	Patient Status	Plan	Care Management	Primary Condition	Total Paid
33	ACTIVE	STANDARD	Preauth, UM, CM	INFLAM/TOXIC NEUROPATHY	$109,211.53
34	ACTIVE	STANDARD	Preauth, UM, CM	RECTUM/ANUS CANCER	$108,666.45
35	CANCELLED	MEDICARE PLUS ONE MILLION	UM, CM	STROKE	$108,220.39
36	ACTIVE	STANDARD	UM, CM	ESSENTIAL HYPERTENSION	$107,703.02
37	ACTIVE	STANDARD	CM	BREAST CANCER	$105,860.71
38	ACTIVE	MEDICARE PLUS ONE MILLION	UM	ENCEPHALOPATHY, RESPIRATORY FAILURE	$104,770.08
39	CANCELLED	SMP	UM, CM	KNEE REPLACEMENT	$102,834.80
40	ACTIVE	STANDARD	Preauth, UM, CM	INFANTILE CEREBRAL PALSY	$102,177.97
41	ACTIVE	STANDARD	Preauth, UM	BREAST CANCER	$100,466.34
42	ACTIVE	STANDARD	UM	SEVERE INTESTINAL INFLAMMATION	$100,276.87
Total					**$8,531,488.08**

Preauth = Preauthorization UM = Utilization Management CM = Case Management DM = Disease Management BH = Behavioral Health

Note: Total paid includes medical and drug data

Note: Descriptions of the Care Management functions may be found in Section 3 pages 1a and 1b

Medical and Drug Cost Sharing

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

The **Standard Plan** members pay about 2.6% of their own medical claims as compared to the benchmark of 7.4%. The prescription drug cost share is slightly closer to our normative benchmark with the Standard Plan around 16.0% and the benchmark at 19.6%.

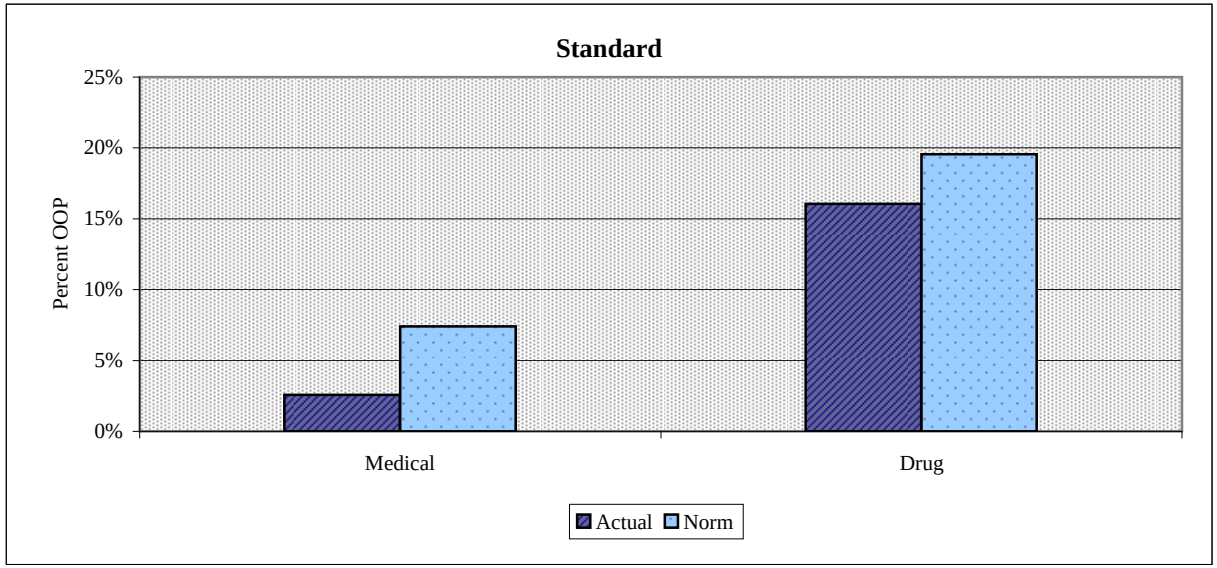
The **SMP Plan** members by comparison pay almost nothing towards their own medical claims (in the form of cost sharing), unlike the members of most large groups who pay an average of about 8.3% of their medical claims. The SMP cost share for prescription drugs is just over 17% compared to the benchmark of 19.5%. Even though the Standard and SMP Plans have the same prescription drug benefit, they have slightly different drug utilization profiles, which is the result of each plan's unique blend of treated conditions.

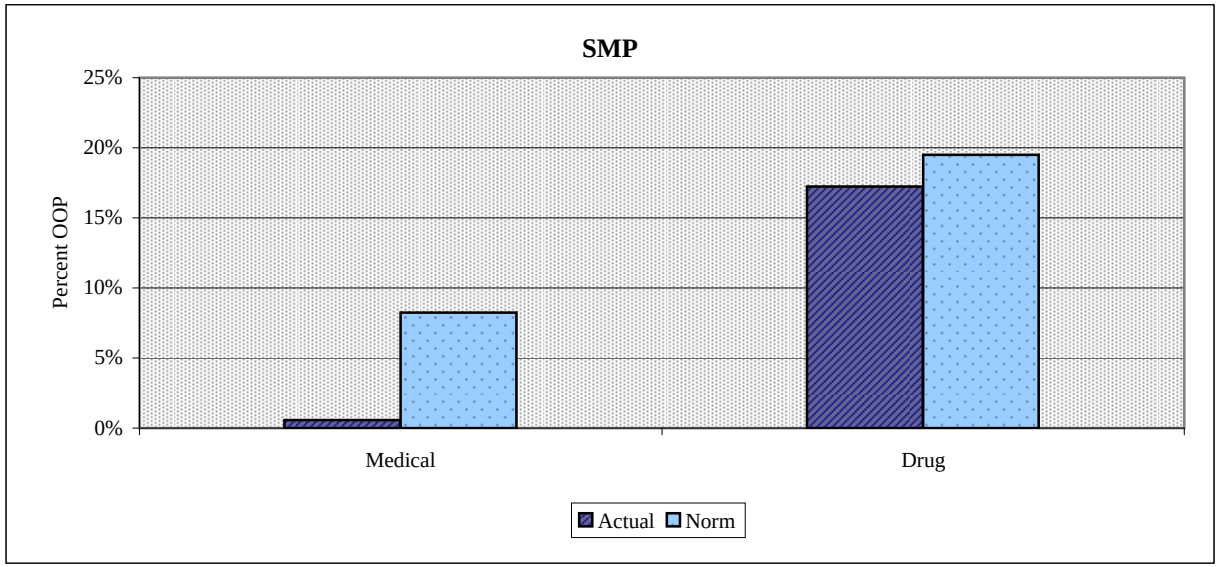
Exhibit 15-A

STATE EMPLOYEE TRUST FUNDS

Medical and Drug Cost Sharing

Incurred January 2007 - December 2007 Paid Through March 2008





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

Medical and Drug Out of Pocket by Member

The Medical and Drug Out of Pocket by Member bar graph shown in Exhibit 16-A divides members with out of pocket cost sharing into categories based on the annual amount of out of pocket costs they paid in 2007. The annual out of pocket for each member includes medical and prescription drug costs.

The **Standard Plan** has a large disparity between the members as far as out of pocket costs. A good portion of members pay between $100 and $200 out of pocket annually. There are also almost 800 members in the $500 to $999 range but it is important to note the range for this category is larger than the previous categories. Lastly, there are over 400 members who pay over $1000 out of pocket annually.

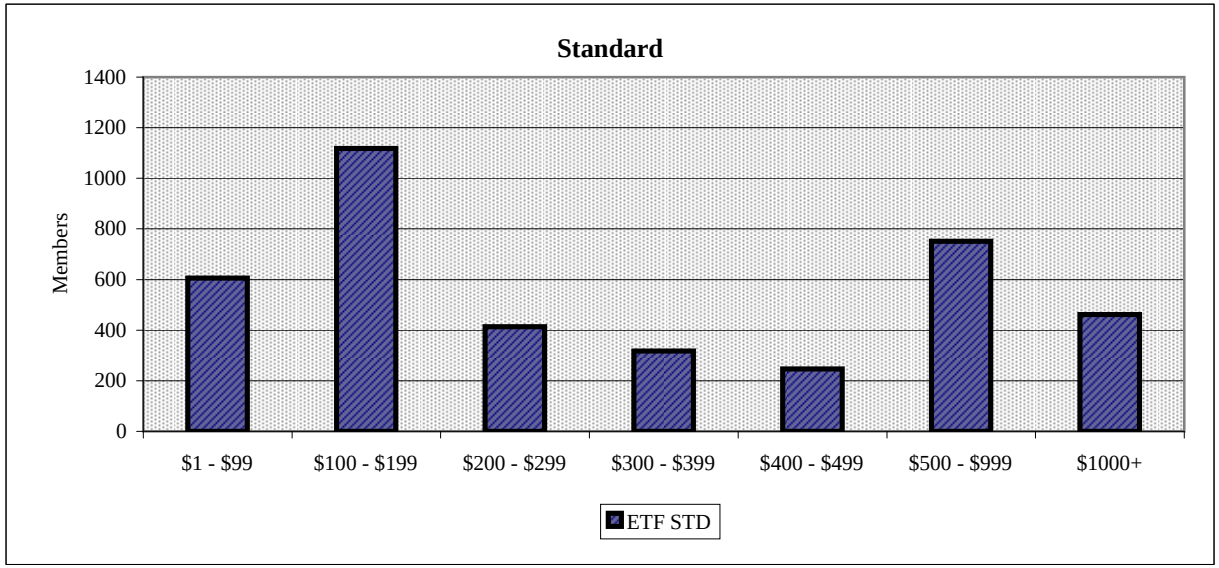
The **SMP Plan** by comparison has a large number of all members paying between $1and $99 in cost sharing. Most of the cost sharing comes from prescription drug copays.

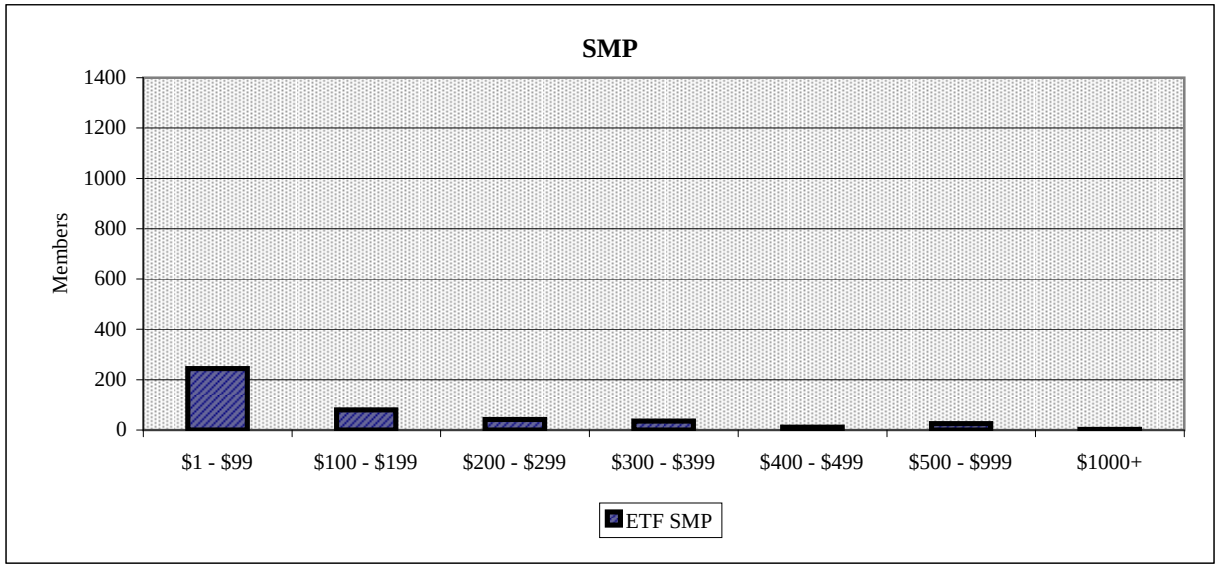
Exhibit 16-A

STATE EMPLOYEE TRUST FUNDS

Medical and Drug Out of Pocket by Member

Incurred January 2007 - December 2007 Paid Through March 2008





Medical Claim Savings Analysis

The Medical Claim Saving Analysis in Exhibit 17-A takes the charges submitted on behalf of the ETF members and details the savings that take place before the final payments are made to the providers. The submitted charges represent medical claims only. The charges are split between the Standard, SMP and Medicare Plus $1M Plans for claims incurred January 2007 through December 2007 and paid through the end of March 2008. Exhibit 17-B provides a summary of the savings by plan along with a pie chart that provides the percentage of savings in each category combining all plans.

For the **Standard Plan**, WPS paid 68.0% of submitted charges on behalf of the plan. Of the 32.0% savings, 18.0% came from pricing cutbacks from the network providers. Another 7.9% of savings was received from the rejection of duplicate charges or charges that were not eligible. Another 3.4% of savings was received by rejection of non-covered services. The Standard Plan also had 1.8% of charges paid by the members with deductibles, coinsurance and copays. The savings due to third party liability is small at this time but these types of recoveries can be long term and may take several years to be completed.

For the **SMP Plan**, WPS paid 73.3% of submitted charges on behalf of the plan. Of the 26.7% savings, 13.8% was saved on claims rejected for duplicate submission, non-eligible claims, and services not covered by the plan. Another 10.9% was received from pricing cutbacks from network providers. In comparison to the Standard Plan, the SMP Plan members contributed only 0.4% in out-of-pocket costs. The SMP Plan does have some out-of-pocket costs in the form of ER Copays and coinsurance on DME and Outpatient Psychiatric Visits. The total seen in the copayment segment is not just ER copays but also encompasses coinsurance amounts that do not apply to the annual out-of-pocket maximum for a member.

For the **Medicare Plus $1M Plan**, WPS paid 7.0% of submitted charges on behalf of the plan. Payments made by Medicare have an overwhelming impact on savings by accounting for 80.4% of the submitted charges. The second highest savings, 11.7%, came from the rejection of duplicate or non-eligible charges. This percentage has decreased from 17.3% in 2006. The decrease is the result of a WPS Claims Department provider education initiative regarding optimal methods of claim submission.

As seen in the pie chart in Exhibit 17-B, the total payment made by WPS for all plan types in 2006 was 17.8% of submitted charges. With the Medicare population's impact, 66.4% of the savings was provided by Medicare, followed by 11.0% in rejections for duplicates and non-eligible services and 3.1% in pricing cutback.

Exhibit 17-A

STATE EMPLOYEE TRUST FUNDS

Medical Claim Savings Analysis

Incurred January 2007 - December 2007 Paid Through March 2008

Category	STANDARD		SMP		MEDICARE PLUS ONE MILLION	
	$ Amount	% of Total	$ Amount	% of Total	$ Amount	% of Total
Submitted Charges	**$44,132,114.12**	**100.0%**	**$3,124,686.06**	**100.0%**	**$222,261,502.13**	**100.0%**
Duplicates/Not Eligible	**$3,480,386.69**	**7.9%**	**$168,402.61**	**5.4%**	**$25,894,610.62**	**11.7%**
Pricing Cutbacks	**$7,956,120.61**	**18.0%**	**$340,529.85**	**10.9%**		
Out-of-Pocket						
Deductible	$504,241.08	1.1%	$0.00	0.0%	$0.00	0.0%
Coinsurance	$286,282.68	0.6%	$1,954.86	0.1%	$61,952.83	0.0%
Copayments	$300.00	0.0%	$11,317.20	0.4%	$499.00	0.0%
Total	**$790,823.76**	**1.8%**	**$13,272.06**	**0.4%**	**$62,451.83**	**0.0%**
Not Covered						
Medical Necessity	$214,787.33	0.5%	$14,142.66	0.5%	$29,178.96	0.0%
Inappropriate Provider	$35,455.31	0.1%	$0.00	0.0%	$5,901.70	0.0%
Benefit Maximum	$99,461.50	0.2%	$6,630.40	0.2%	$507,651.34	0.2%
Experimental/Fertility	$70,017.37	0.2%	$117.00	0.0%	$21,147.00	0.0%
Dental	$32,482.45	0.1%	$2,760.00	0.1%	$17,404.06	0.0%
Custodial	$41.56	0.0%	$0.00	0.0%	$519,621.54	0.2%
Code Review	$543,159.64	1.2%	$56,989.04	1.8%	$70,988.32	0.0%
Contact Lens/Hearing Aid	$21,193.42	0.0%	$3,333.88	0.1%	$95,939.26	0.0%
Drugs	$0.00	0.0%	$0.00	0.0%	$35,455.16	0.0%
No Referral	$0.00	0.0%	$142,368.22	4.6%	$0.00	0.0%
All Other	$482,669.44	1.1%	$36,152.53	1.2%	$606,631.44	0.3%
Total	**$1,499,268.02**	**3.4%**	**$262,493.73**	**8.4%**	**$1,909,918.78**	**0.9%**
Third Party Liability						
Workers Compensation	$19,889.39	0.0%	$30,280.97	1.0%	$65,272.53	0.0%
Subrogation	$10,873.71	0.0%	$0.00	0.0%	$11,933.17	0.0%
Coordination of Benefits	$157,978.60	0.4%	$18,231.62	0.6%	$5,982.83	0.0%
Total	**$188,741.70**	**0.4%**	**$48,512.59**	**1.6%**	**$83,188.53**	**0.0%**
Medicare	**$188,766.74**	**0.4%**	**$0.00**	**0.0%**	**$178,690,890.89**	**80.4%**
Payments	**$30,028,006.60**	**68.0%**	**$2,291,475.22**	**73.3%**	**$15,620,441.48**	**7.0%**

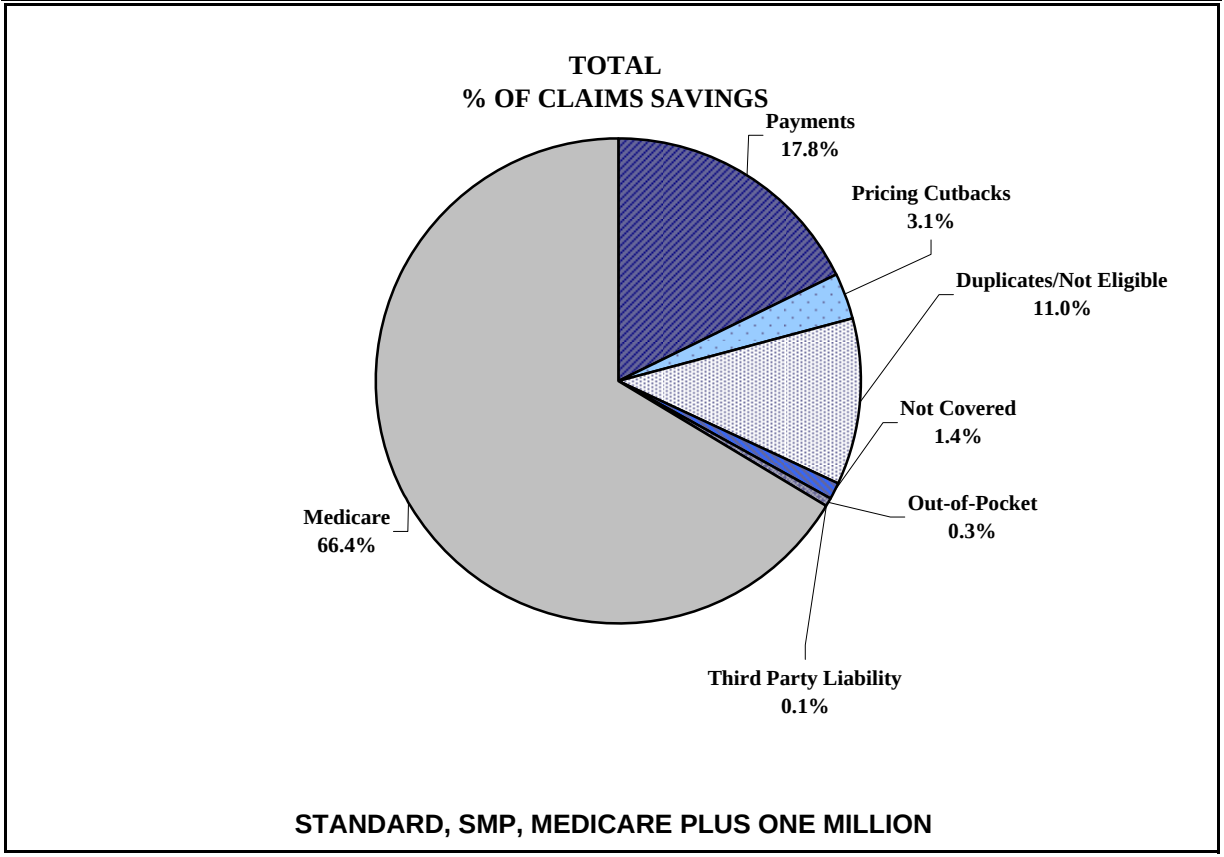
Exhibit 17-B

STATE EMPLOYEE TRUST FUNDS

Medical Claim Savings Analysis Summary

Incurred January 2007 - December 2007 Paid Through March 2008

	STANDARD		SMP		MEDICARE PLUS ONE MILLION	
	$ Amount	% of Total	$ Amount	% of Total	$ Amount	% of Total
Payments	$30,028,006.60	68.0%	$2,291,475.22	73.3%	$15,620,441.48	7.0%
Pricing Cutbacks	$7,956,120.61	18.0%	$340,529.85	10.9%		
Duplicates/Not Eligible	$3,480,386.69	7.9%	$168,402.61	5.4%	$25,894,610.62	11.7%
Not Covered	$1,499,268.02	3.4%	$262,493.73	8.4%	$1,909,918.78	0.9%
Out-of-Pocket	$790,823.76	1.8%	$13,272.06	0.4%	$62,451.83	0.0%
Third Party Liability	$188,741.70	0.4%	$48,512.59	1.6%	$83,188.53	0.0%
Medicare	$188,766.74	0.4%	$0.00	0.0%	$178,690,890.89	80.4%



WPS HEALTH INSURANCE

State of Wisconsin

Section 2: Wisconsin Public Employers

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

Wisconsin Public Employers

Executive Summary

Member / Demographic Data

Total enrollment was 404 members as of January 2008, up 6 from the 398 members in the plan in December 2007. Membership remained quite stable despite the SMP region reduction from 12 counties to 9 as of January 2008.

The **Standard Plan** membership is much older than the normative distribution with 71.6% of membership over the age of 50 compared to the benchmark of 25.6%. 67.9% of the Standard Plan participants live within Wisconsin.

The ages of the **SMP Plan** members by comparison are younger than our benchmark. The SMP Plan membership is entirely within Wisconsin and in the more rural areas with a majority of the population in the northern fringe of Wisconsin. For the SMP Plan all of the membership is within Marinette County. As of January 2008, the SMP plan is no longer available in Marinette County, and in total will be available in only 9 counties.

Claims Data

Standard Plan

The Standard Plan has seen a 23.2% decrease in medical claim costs between 2006 and 2007. The Standard Plan was 3.9% below the benchmark in 2007. The small population of the Standard Plan results in large variances in claim costs from year to year which happened to be better than expected in 2007.

The Standard Plan did not have any members exceed $100,000 in claim costs. The Standard Plan members pay 6.0% of their own medical claims as compared to the benchmark of 6.7%.

WPS paid 76.2% of submitted charges on behalf of the plan.

SMP Plan

For the SMP Plan, the year over year medical PMPM trend was 5.0%. The SMP Plan was 22.1% above the benchmark in 2007. The small population of the SMP Plan results in large variances in claim cost from year to year.

The SMP Plan did not have any members exceed $100,000 in claim costs. The SMP Plan members pay 1% towards their own medical claims (in the form of cost sharing), unlike the members of most large groups who pay an average of about 9.3% of their medical claims.

WPS paid 73.1% of submitted charges on behalf of the plan.

Medicare Carve-out Plan

The Medicare Carve-out Plan has seen stable results over the last 2 years. The year over year medical PMPM trend from 2006 to 2007 was 3.6%.

WPS paid 5.6% of submitted charges on behalf of the plan. 76.7% of the charges were paid by Medicare.

Provider Data

For the **Standard Plan**, the top 20 facilities provide 91.6% of the total facility charges for the plan. 52.7% of professional charges are from the top 20 providers.

For the **SMP Plan**, the top 7 facilities provide 100.0% of the total facility charges for the plan. 88.6% of the paid claims are from the top 20 professional providers. Dickinson County Memorial Hospital in Iron Mountain, Michigan was the largest provider of Facility and Professional services.

Benchmarks

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

Demographic benchmarks are based on calendar year 2007 data. For Medicare classes, demographic benchmarks are based on comparable WPS Medicare enrollment as appropriate.

Claim cost benchmarks are also based on calendar year 2007 data. To make the claim benchmarks more meaningful, they have been adjusted for demographic differences between the specific population profiled in each report and the population in the WPS benchmark. For example, an older population may be expected to have higher prescription drug costs but lower maternity costs. Unless otherwise specified, each claim based benchmark has had such an adjustment made, including not only PMPM costs but days/1000 and cost/day. The factors that go into each adjustment are unique to the particular claim-based statistic. Claim benchmarks are not adjusted, however, for plan benefit differences between the average represented in the WPS benchmark and the specific reported ETF class.

Wisconsin Public Employers

Group Demographics

Monthly Membership

The Monthly Membership report in Exhibit 1-B shows monthly membership and incurred claims for the Standard, SMP and Medicare Carve-out plans from January 2006 through December 2007

Enrollment on the **Standard Plan** averaged 106 members per month in 2006 and decreased to an average of 68 in 2007. The membership over the course of the year remained fairly stable with increases beginning in September of each year.

SMP Plan enrollment averaged 201 members per month in 2006 and decreased to an average of 44 per month in 2007. This reduction is the result of a reduced service area in which the plan is available, dropping from 27 counties in 2006 to 12 counties in 2007. The membership remained very stable within each year with very little seasonal fluctuation

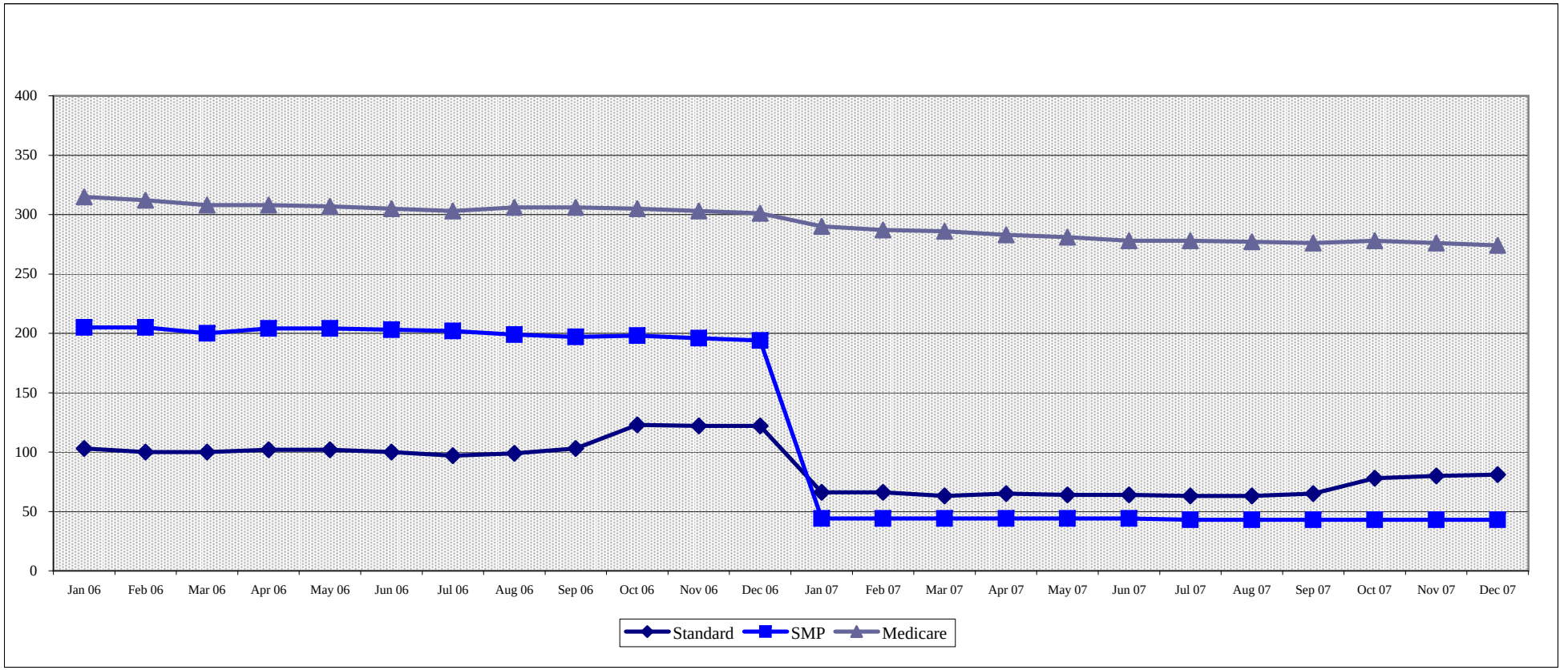
The **Medicare Carve-out Plan** enrollment averaged 307 members per month in 2006 and decreased to 280 members per month in 2007. The membership declined gradually over the course of the two years, beginning with 315 members in January 2006 and ending at 274 in December of 2007, a 13% reduction in membership during the 2 years.

WISCONSIN PUBLIC EMPLOYERS

Monthly Membership

January 2006 through December 2007

Exhibit 1-B



	EFFECTIVE MONTH																							
	Jan 06	Feb 06	Mar 06	Apr 06	May 06	Jun 06	Jul 06	Aug 06	Sep 06	Oct 06	Nov 06	Dec 06	Jan 07	Feb 07	Mar 07	Apr 07	May 07	Jun 07	Jul 07	Aug 07	Sep 07	Oct 07	Nov 07	Dec 07
Standard	103	100	100	102	102	100	97	99	103	123	122	122	66	66	63	65	64	64	63	63	65	78	80	81
SMP	205	205	200	204	204	203	202	199	197	198	196	194	44	44	44	44	44	44	43	43	43	43	43	43
Medicare	315	312	308	308	307	305	303	306	306	305	303	301	290	287	286	283	281	278	278	277	276	278	276	274

Enrollment by Plan

The Enrollment by Plan report shown in Exhibit 2-B shows the December 2007 membership for the Standard, SMP and Medicare Plus $1M Plans at the class level. For each class, member average age and gender distribution is shown. The age/gender factor is included as an index intended to represent expected plan cost based on the age and gender of each member, without regard to plan design, health, etc. The age/gender factor is not shown for the Medicare Carve-out Plan, where coordination of benefits with Medicare has an overwhelming impact on plan cost.

Exhibit 2-B

WISCONSIN PUBLIC EMPLOYERS
Enrollment by Plan
December 2007

Plan	Class	# of Members	Average Member Age	Member Gender Distribution Female	Member Age/ Gender Factor
Classic Standard	Milwaukee	18	55.7	55.6%	2.197
	Waukesha	1	52.0	0.0%	1.594
	Dane	10	47.6	50.0%	1.883
	Rest of State	32	50.3	50.0%	1.905
	Annuitants	10	59.5	70.0%	2.435
	Continuation	0	0.0	0.0%	0.000
	Medicare	273	75.7	58.2%	N/A
	Subtotal	**344**	**70.9**	**57.3%**	**2.046**
Deductible Classic Standard	Milwaukee	0	0.0	0.0%	0.000
	Waukesha	0	0.0	0.0%	0.000
	Dane	0	0.0	0.0%	0.000
	Rest of State	3	34.0	33.3%	0.946
	Annuitants	0	0.0	0.0%	0.000
	Continuation	0	0.0	0.0%	0.000
	Medicare	1	72.0	100.0%	N/A
	Subtotal	**4**	**43.5**	**50.0%**	**0.946**
Standard Preferred	Milwaukee	0	0.0	0.0%	0.000
	Waukesha	0	0.0	0.0%	0.000
	Dane	0	0.0	0.0%	0.000
	Rest of State	3	55.3	66.7%	2.058
	Annuitants	0	0.0	0.0%	0.000
	Continuation	0	0.0	0.0%	0.000
	Medicare	0	0.0	0.0%	N/A
	Subtotal	**3**	**55.3**	**66.7%**	**2.058**
Deductible Standard Preferred	Milwaukee	0	0.0	0.0%	0.000
	Waukesha	0	0.0	0.0%	0.000
	Dane	0	0.0	0.0%	0.000
	Rest of State	4	33.8	50.0%	1.277
	Annuitants	0	0.0	0.0%	0.000
	Continuation	0	0.0	0.0%	0.000
	Medicare	0	0.0	0.0%	N/A
	Subtotal	**4**	**33.8**	**50.0%**	**1.277**
SMP	Local	43	32.5	44.2%	1.046
	Annuitants	0	0.0	0.0%	0.000
	Continuation	0	0.0	0.0%	0.000
	Subtotal	**43**	**32.5**	**44.2%**	**1.046**
Deductible SMP	Local	0	0.0	0.0%	0.000
	Annuitants	0	0.0	0.0%	0.000
	Continuation	0	0.0	0.0%	0.000
	Subtotal	**0**	**0.0**	**0.0%**	**0.000**
WPE Grand Total		**398**	**66.0**	**55.8%**	**N/A**

Member Census Grids

The Member Census Grid breaks down the December 2007 membership into age and gender categories for the Standard, SMP and Medicare Carve-out Plans. The Standard and SMP distributions are compared to a benchmark distribution based on WPS large group business as described in the Executive Summary. The benchmark distribution for the Medicare Carve-out Plan is based on WPS Medicare Carve-out business.

Standard Plan

The Standard Plan membership shown in Exhibit 3-D appears to be much older than the normative distribution with 71.6% of membership over the age of 50 compared to the benchmark of 25.6%. Older members tend to seek more medical care and tend to select a broader panel of providers for that care. Since the Standard Plan has a broader panel of providers, this causes the average age to be higher.

Also contributing to the older than expected membership is the smaller than expected population of children with only 7.4% of the membership under the age of 20 compared to the benchmark of 29.7%. The Standard Plan also has a slightly higher than normal population of females with 53.1% female as compared to the benchmark of 51.8%.

SMP Plan

The SMP Plan membership shown in Exhibit 3-E by comparison is on average younger than our benchmark. The SMP distribution is significantly lower than the benchmark at ages 55 and older.

Medicare Carve-out Plan

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

Exhibit 3-D

WISCONSIN PUBLIC EMPLOYERS
Member Census Grid - Standard
December 2007

FEMALE			
Age Band	# of Members	% of Total	Benchmark
< 20	1	1.2%	14.4%
20 - 24	1	1.2%	3.7%
25 - 29	1	1.2%	3.5%
30 - 34	2	2.5%	3.3%
35 - 39	1	1.2%	3.9%
40 - 44	0	0.0%	4.5%
45 - 49	6	7.4%	5.0%
50 - 54	11	13.6%	5.0%
55 - 59	8	9.9%	4.3%
60 - 64	11	13.6%	2.7%
65 +	1	1.2%	1.5%
Total	**43**	**53.1%**	**51.8%**

MALE			
Age Band	# of Members	% of Total	Benchmark
< 20	5	6.2%	15.3%
20 - 24	0	0.0%	3.3%
25 - 29	0	0.0%	2.7%
30 - 34	1	1.2%	3.0%
35 - 39	0	0.0%	3.5%
40 - 44	5	6.2%	4.0%
45 - 49	0	0.0%	4.3%
50 - 54	3	3.7%	4.2%
55 - 59	10	12.3%	3.8%
60 - 64	11	13.6%	2.6%
65 +	3	3.7%	1.5%
Total	**38**	**46.9%**	**48.2%**

TOTAL			
Age Band	# of Members	% of Total	Benchmark
< 20	6	7.4%	29.7%
20 - 24	1	1.2%	7.0%
25 - 29	1	1.2%	6.2%
30 - 34	3	3.7%	6.3%
35 - 39	1	1.2%	7.4%
40 - 44	5	6.2%	8.5%
45 - 49	6	7.4%	9.3%
50 - 54	14	17.3%	9.2%
55 - 59	18	22.2%	8.1%
60 - 64	22	27.2%	5.3%
65 +	4	4.9%	3.0%
Total	**81**	**100.0%**	**100.0%**

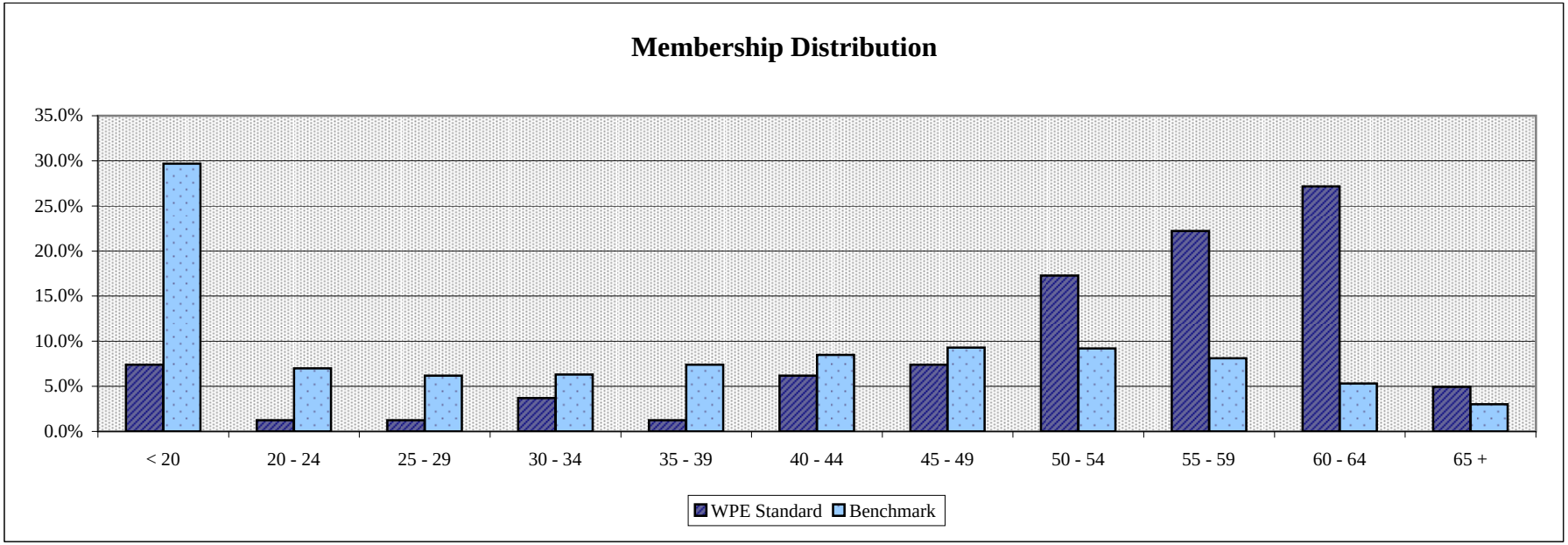


Exhibit 3-E

WISCONSIN PUBLIC EMPLOYERS
Member Census Grid - SMP
December 2007

FEMALE			
Age Band	# of Members	% of Total	Benchmark
< 20	4	9.3%	14.4%
20 - 24	3	7.0%	3.7%
25 - 29	0	0.0%	3.5%
30 - 34	1	2.3%	3.3%
35 - 39	4	9.3%	3.9%
40 - 44	0	0.0%	4.5%
45 - 49	4	9.3%	5.0%
50 - 54	1	2.3%	5.0%
55 - 59	2	4.7%	4.3%
60 - 64	0	0.0%	2.7%
65 +	0	0.0%	1.5%
Total	**19**	**44.2%**	**51.8%**

MALE			
Age Band	# of Members	% of Total	Benchmark
< 20	9	20.9%	15.3%
20 - 24	2	4.7%	3.3%
25 - 29	0	0.0%	2.7%
30 - 34	1	2.3%	3.0%
35 - 39	1	2.3%	3.5%
40 - 44	4	9.3%	4.0%
45 - 49	2	4.7%	4.3%
50 - 54	4	9.3%	4.2%
55 - 59	0	0.0%	3.8%
60 - 64	1	2.3%	2.6%
65 +	0	0.0%	1.5%
Total	**24**	**55.8%**	**48.2%**

TOTAL			
Age Band	# of Members	% of Total	Benchmark
< 20	13	30.2%	29.7%
20 - 24	5	11.6%	7.0%
25 - 29	0	0.0%	6.2%
30 - 34	2	4.7%	6.3%
35 - 39	5	11.6%	7.4%
40 - 44	4	9.3%	8.5%
45 - 49	6	14.0%	9.3%
50 - 54	5	11.6%	9.2%
55 - 59	2	4.7%	8.1%
60 - 64	1	2.3%	5.3%
65 +	0	0.0%	3.0%
Total	**43**	**100.0%**	**100.0%**

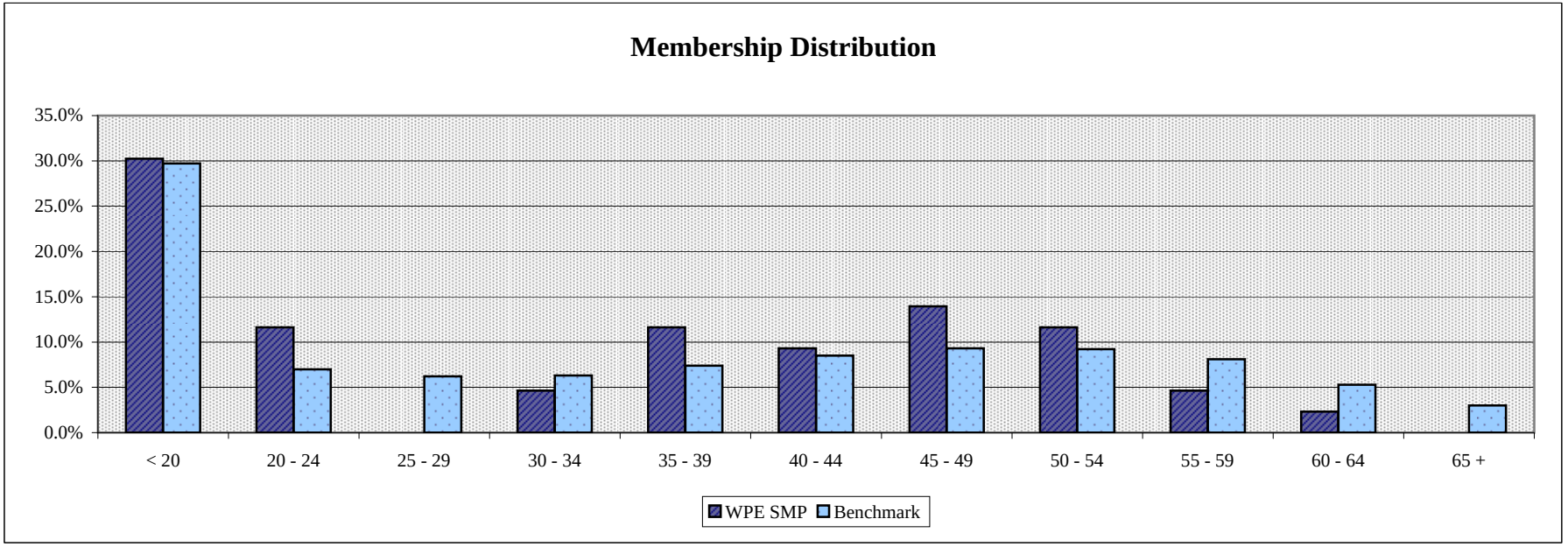


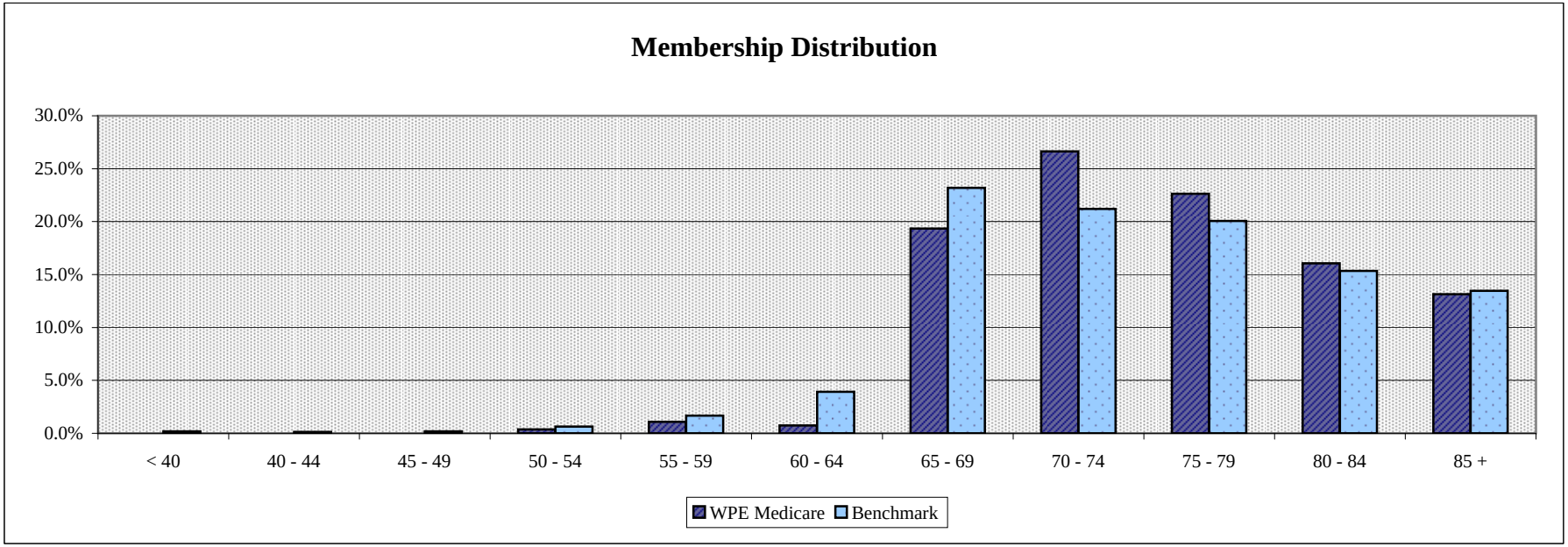
Exhibit 3-F

WISCONSIN PUBLIC EMPLOYERS
Member Census Grid - Medicare
December 2007

FEMALE			
Age Band	# of Members	% of Total	Benchmark
< 40	0	0.0%	0.1%
40 - 44	0	0.0%	0.1%
45 - 49	0	0.0%	0.1%
50 - 54	1	0.4%	0.4%
55 - 59	3	1.1%	1.0%
60 - 64	2	0.7%	2.4%
65 - 69	29	10.6%	13.4%
70 - 74	42	15.3%	12.1%
75 - 79	36	13.1%	11.8%
80 - 84	23	8.4%	9.9%
85 +	24	8.8%	9.9%
Total	**160**	**58.4%**	**61.1%**

MALE			
Age Band	# of Members	% of Total	Benchmark
< 40	0	0.0%	0.1%
40 - 44	0	0.0%	0.1%
45 - 49	0	0.0%	0.1%
50 - 54	0	0.0%	0.3%
55 - 59	0	0.0%	0.7%
60 - 64	0	0.0%	1.5%
65 - 69	24	8.8%	9.8%
70 - 74	31	11.3%	9.1%
75 - 79	26	9.5%	8.2%
80 - 84	21	7.7%	5.5%
85 +	12	4.4%	3.6%
Total	**114**	**41.6%**	**38.9%**

TOTAL			
Age Band	# of Members	% of Total	Benchmark
< 40	0	0.0%	0.2%
40 - 44	0	0.0%	0.1%
45 - 49	0	0.0%	0.2%
50 - 54	1	0.4%	0.6%
55 - 59	3	1.1%	1.7%
60 - 64	2	0.7%	3.9%
65 - 69	53	19.3%	23.2%
70 - 74	73	26.6%	21.2%
75 - 79	62	22.6%	20.1%
80 - 84	44	16.1%	15.4%
85 +	36	13.1%	13.5%
Total	**274**	**100.0%**	**100.0%**



Wisconsin Enrollment

The Wisconsin Enrollment map in Exhibit 4-C visually shows how the membership for the Standard and SMP plans are dispersed throughout Wisconsin. The map shows enrollment as of December 1, 2007. Each of the dots represents one address. Exhibit 4-D shows the same information numerically.

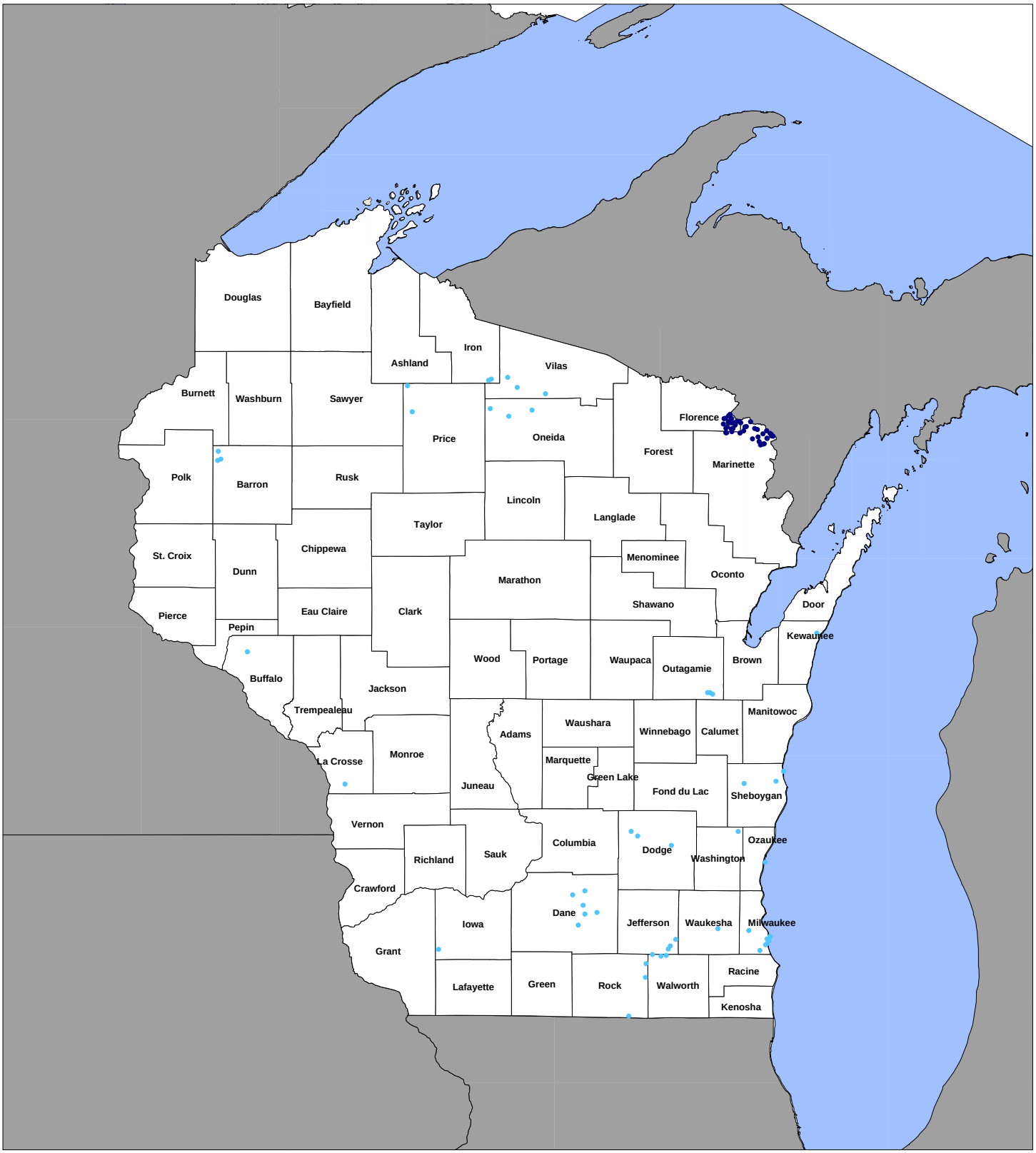
67.9% of the **Standard Plan** participants live within Wisconsin. The Standard Plan population is spread out among 21 counties in Wisconsin with 9.9% of the population living in Milwaukee County, 7.4% in Dane County, and 4.9% each in Jefferson, Price, Vilas and Walworth Counties.

The **SMP Plan** membership in comparison is entirely within Marinette County. You may notice on exhibit 4-C that some of the membership looks to be in Florence County. This is due to a few zip codes that overlap county lines. In 2007 the SMP Plan was only available in 12 counties down from 27 county region 2006. As of January 2008, the SMP plan is no longer available in Marinette County, and in total will be available in only 9 counties.

WISCONSIN PUBLIC EMPLOYERS

Exhibit 4-C

Enrollment By County
December 2007



Standard

SMP

WISCONSIN PUBLIC EMPLOYERS

Enrollment By County

December 2007

Exhibit 4-D

County	STANDARD # of Members	STANDARD % of Members	SMP # of Members	SMP % of Members
ADAMS	0	0.0%	0	0.0%
ASHLAND	0	0.0%	0	0.0%
BARRON	3	3.7%	0	0.0%
BAYFIELD	0	0.0%	0	0.0%
BROWN	0	0.0%	0	0.0%
BUFFALO	0	0.0%	0	0.0%
BURNETT	0	0.0%	0	0.0%
CALUMET	0	0.0%	0	0.0%
CHIPPEWA	0	0.0%	0	0.0%
CLARK	0	0.0%	0	0.0%
COLUMBIA	0	0.0%	0	0.0%
CRAWFORD	0	0.0%	0	0.0%
DANE	6	7.4%	0	0.0%
DODGE	3	3.7%	0	0.0%
DOOR	0	0.0%	0	0.0%
DOUGLAS	0	0.0%	0	0.0%
DUNN	0	0.0%	0	0.0%
EAU CLAIRE	0	0.0%	0	0.0%
FLORENCE	0	0.0%	0	0.0%
FOND DU LAC	0	0.0%	0	0.0%
FOREST	0	0.0%	0	0.0%
GRANT	1	1.2%	0	0.0%
GREEN	0	0.0%	0	0.0%
GREEN LAKE	0	0.0%	0	0.0%
IOWA	0	0.0%	0	0.0%
IRON	0	0.0%	0	0.0%
JACKSON	0	0.0%	0	0.0%
JEFFERSON	4	4.9%	0	0.0%
JUNEAU	0	0.0%	0	0.0%
KENOSHA	0	0.0%	0	0.0%
KEWAUNEE	1	1.2%	0	0.0%
LACROSSE	1	1.2%	0	0.0%
LAFAYETTE	0	0.0%	0	0.0%
LANGLADE	0	0.0%	0	0.0%
LINCOLN	0	0.0%	0	0.0%
MANITOWOC	0	0.0%	0	0.0%
MARATHON	0	0.0%	0	0.0%
MARINETTE	0	0.0%	43	100.0%
MARQUETTE	0	0.0%	0	0.0%
MENOMINEE	0	0.0%	0	0.0%
MILWAUKEE	8	9.9%	0	0.0%
MONROE	0	0.0%	0	0.0%
OCONTO	0	0.0%	0	0.0%
ONEIDA	2	2.5%	0	0.0%
OUTAGAMIE	3	3.7%	0	0.0%
OZAUKEE	1	1.2%	0	0.0%
PEPIN	1	1.2%	0	0.0%
PIERCE	0	0.0%	0	0.0%
POLK	0	0.0%	0	0.0%
PORTAGE	0	0.0%	0	0.0%
PRICE	4	4.9%	0	0.0%
RACINE	0	0.0%	0	0.0%
RICHLAND	0	0.0%	0	0.0%
ROCK	1	1.2%	0	0.0%
RUSK	0	0.0%	0	0.0%
SAUK	0	0.0%	0	0.0%
SAWYER	0	0.0%	0	0.0%
SHAWANO	2	2.5%	0	0.0%
SHEBOYGAN	3	3.7%	0	0.0%
ST CROIX	0	0.0%	0	0.0%
TAYLOR	0	0.0%	0	0.0%
TREMPEALEAU	1	1.2%	0	0.0%
VERNON	0	0.0%	0	0.0%
VILAS	4	4.9%	0	0.0%
WALWORTH	4	4.9%	0	0.0%
WASHBURN	0	0.0%	0	0.0%
WASHINGTON	1	1.2%	0	0.0%
WAUKESHA	1	1.2%	0	0.0%
WAUPACA	0	0.0%	0	0.0%
WAUSHARA	0	0.0%	0	0.0%
WINNEBAGO	0	0.0%	0	0.0%
WOOD	0	0.0%	0	0.0%
OUT OF STATE	26	32.1%	0	0.0%
Totals	**81**	**100.0%**	**43**	**100.0%**

Out of State Enrollment

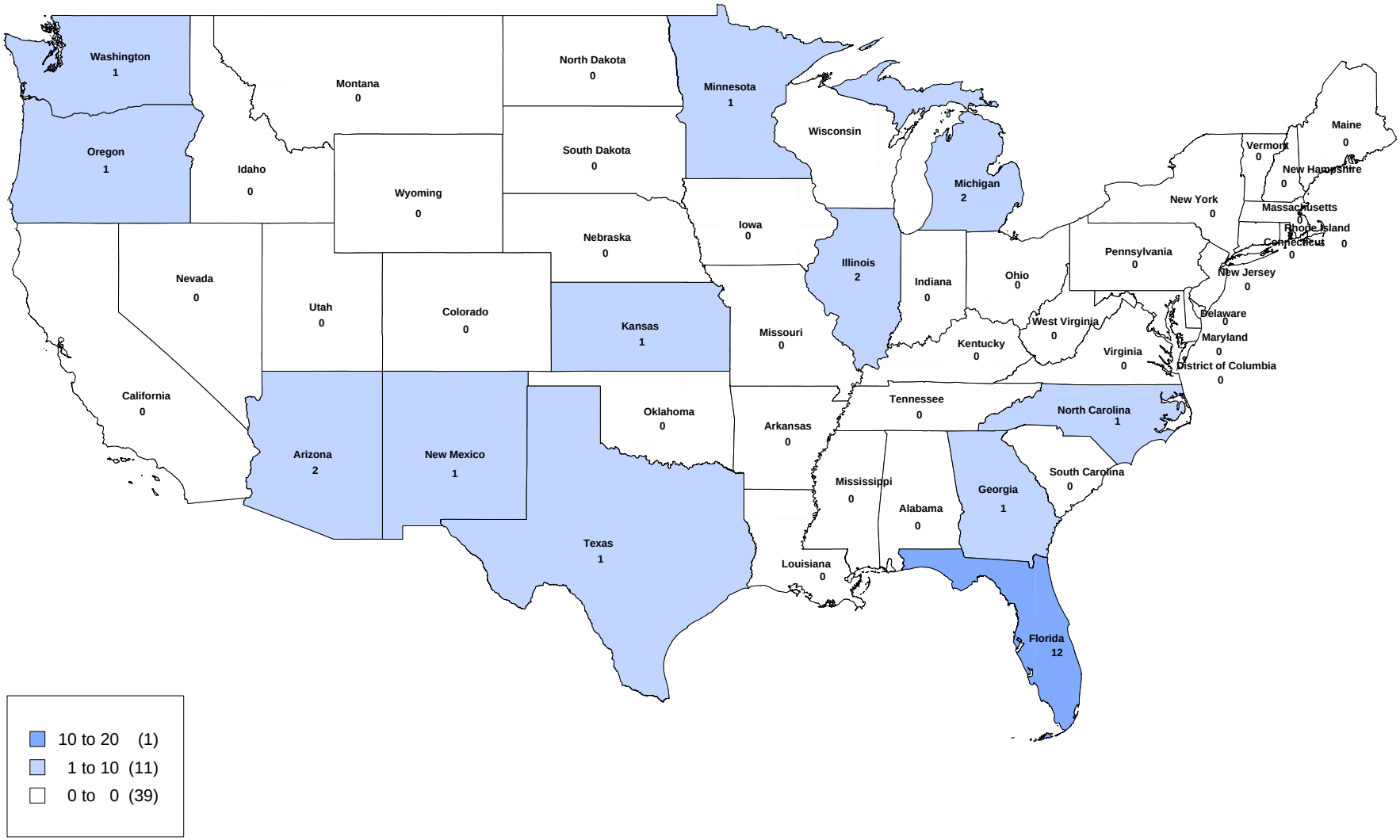
The United States Enrollment Map in Exhibit 5-C visually depicts how the enrollment in the Standard and SMP plans are spread throughout the United States. The out of state enrollment is based on the member's address as of December 1, 2007 and could change as members relocate. The map displays the number of Standard and SMP plan members living in each state along with a shading scheme in which higher population areas are represented with increasingly darker shading. Exhibit 5-D shows the same information numerically.

The **Standard Plan** has 32.1% of the population living outside the state of Wisconsin with the membership dispersed over 12 states. 69.2% of the out of state membership lives in the sunbelt.

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

WISCONSIN PUBLIC EMPLOYERS
Out of State Enrollment
December 2007

Exhibit 5-C



WISCONSIN PUBLIC EMPLOYERS

Exhibit 5-D

Out of State Enrollment

December 2007

State	STANDARD # of Members	STANDARD % of Members	SMP # of Members	SMP % of Members
ALABAMA	0	0.0%	0	0.0%
ALASKA	0	0.0%	0	0.0%
ARIZONA	2	7.7%	0	0.0%
ARKANSAS	0	0.0%	0	0.0%
CALIFORNIA	0	0.0%	0	0.0%
COLORADO	0	0.0%	0	0.0%
CONNECTICUT	0	0.0%	0	0.0%
DELAWARE	0	0.0%	0	0.0%
FLORIDA	12	46.2%	0	0.0%
GEORGIA	1	3.8%	0	0.0%
HAWAII	0	0.0%	0	0.0%
IDAHO	0	0.0%	0	0.0%
ILLINOIS	2	7.7%	0	0.0%
INDIANA	0	0.0%	0	0.0%
IOWA	0	0.0%	0	0.0%
KANSAS	1	3.8%	0	0.0%
KENTUCKY	0	0.0%	0	0.0%
LOUISIANA	0	0.0%	0	0.0%
MAINE	0	0.0%	0	0.0%
MARYLAND	0	0.0%	0	0.0%
MASSACHUSETTS	0	0.0%	0	0.0%
MICHIGAN	2	7.7%	0	0.0%
MINNESOTA	1	3.8%	0	0.0%
MISSISSIPPI	0	0.0%	0	0.0%
MISSOURI	0	0.0%	0	0.0%
MONTANA	0	0.0%	0	0.0%
NEBRASKA	0	0.0%	0	0.0%
NEVADA	0	0.0%	0	0.0%
NEW HAMPSHIRE	0	0.0%	0	0.0%
NEW JERSEY	0	0.0%	0	0.0%
NEW MEXICO	1	3.8%	0	0.0%
NEW YORK	0	0.0%	0	0.0%
NORTH CAROLINA	1	3.8%	0	0.0%
NORTH DAKOTA	0	0.0%	0	0.0%
OHIO	0	0.0%	0	0.0%
OKLAHOMA	0	0.0%	0	0.0%
OREGON	1	3.8%	0	0.0%
PENNSYLVANIA	0	0.0%	0	0.0%
RHODE ISLAND	0	0.0%	0	0.0%
SOUTH CAROLINA	0	0.0%	0	0.0%
SOUTH DAKOTA	0	0.0%	0	0.0%
TENNESSEE	0	0.0%	0	0.0%
TEXAS	1	3.8%	0	0.0%
UTAH	0	0.0%	0	0.0%
VERMONT	0	0.0%	0	0.0%
VIRGINIA	0	0.0%	0	0.0%
WASHINGTON	1	3.8%	0	0.0%
WASHINGTON DC	0	0.0%	0	0.0%
WEST VIRGINIA	0	0.0%	0	0.0%
WYOMING	0	0.0%	0	0.0%
FOREIGN	0	0.0%	0	0.0%
Totals	**26**	**100.0%**	**0**	**0.0%**

Dual Choice Changes

The Dual Choice Enrollment Changes by Plan report in Exhibit 6-B shows the January 2008 enrollment reflecting changes that occurred during the Dual Choice Enrollment. The enrollment changes are numerical differences relative to December 2007. The change in Member / Age Gender show how much plan costs changed between 2007 and 2008 due to demographic factors. The age/gender factor is not shown for the Medicare Carve-out Plan, where coordination of benefits with Medicare has an overwhelming impact on plan cost.

Exhibit 6-B

WISCONSIN PUBLIC EMPLOYERS
Dual Choice Enrollment Changes by Plan
December 2007 to January 2008

Plan	Class	January 2008 Membership	Change in Membership from December 2007	Change in Member Age/ Gender
Classic Standard	Milwaukee	16	-2	3.80%
	Waukesha	1	0	0.00%
	Dane	13	3	-2.92%
	Rest of State	31	-1	-2.01%
	Annuitants	10	0	2.71%
	Continuation	0	0	0.00%
	Medicare	278	5	N/A
	Subtotal	**349**	**5**	**-0.38%**
Deductible Classic Standard	Milwaukee	0	0	0.00%
	Waukesha	0	0	0.00%
	Dane	0	0	0.00%
	Rest of State	0	-3	-100.00%
	Annuitants	0	0	0.00%
	Continuation	0	0	0.00%
	Medicare	1	0	N/A
	Subtotal	**1**	**-3**	**-100.00%**
Standard Preferred	Milwaukee	0	0	0.00%
	Waukesha	0	0	0.00%
	Dane	0	0	0.00%
	Rest of State	0	-3	-100.00%
	Annuitants	0	0	0.00%
	Continuation	0	0	0.00%
	Medicare	0	0	N/A
	Subtotal	**0**	**-3**	**-100.00%**
Deductible Standard Preferred	Milwaukee	0	0	0.00%
	Waukesha	0	0	0.00%
	Dane	0	0	0.00%
	Rest of State	4	0	0.00%
	Annuitants	0	0	0.00%
	Continuation	0	0	0.00%
	Medicare	0	0	N/A
	Subtotal	**4**	**0**	**0.00%**
SMP	Local	50	7	20.99%
	Annuitants	0	0	0.00%
	Continuation	0	0	0.00%
	Subtotal	**50**	**7**	**20.99%**
Deductible SMP	Local	0	0	0.00%
	Annuitants	0	0	0.00%
	Continuation	0	0	0.00%
	Subtotal	**0**	**0**	**0.00%**
WPE Grand Total		**404**	**6**	**N/A**

Paid Per Member Per Month Costs

The Paid Medical and Drug PMPM report in Exhibit 7-B displays the average amount paid per member each month for the Standard, SMP and Medicare Carve-out plans incurred from January 2006 through December 2007. The PMPM costs for each plan represent medical and drug claims paid through the end of March 2008.

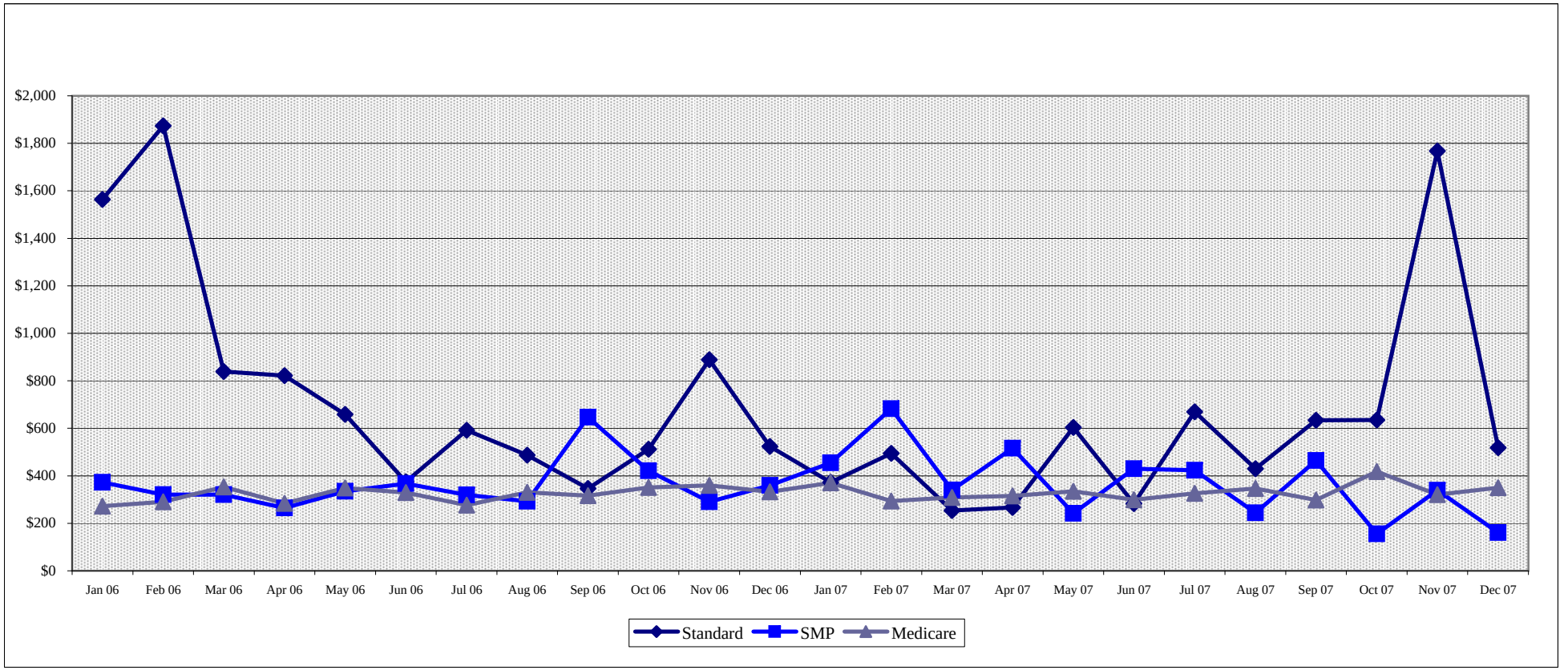
The **Standard Plan** has seen a 23.2% reduction in total paid claim costs between 2006 and 2007. While independent trend estimates for medical claims for 2007 were 9-11%, the plan performed much better than anticipated. The standard plan had zero individualss with annual claims over $100,000. That fact has contributed to the favorable year over year claim results. The small population of the Standard Plan naturally leads to instability in the monthly claim results, as the larger spikes in claims are generally due to large claim activity that occurred in those months.

The **SMP Plan** has seen an increase in claims over the last year. The small number of members enrolled on the plan result in claim cost variance from month to month and year to year. The total paid PMPM trended up 5.0% from 2006 to 2007 which is still below trend estimates for 2007.

The **Medicare Carve-out Plan** has seen stable results over the last 2 years. We would expect this population to have stable results since Medicare is the primary payer. The year over year PMPM trend from 2006 to 2007 was 3.6%. We would naturally expect an increase in the medical claims each year due to the benefit changes Medicare makes annually and medical cost trend.

Exhibit 7-B

WISCONSIN PUBLIC EMPLOYERS
Paid Medical and Drug PMPM
Paid Through March 2008



	INCURRED MONTH																							
	Jan 06	Feb 06	Mar 06	Apr 06	May 06	Jun 06	Jul 06	Aug 06	Sep 06	Oct 06	Nov 06	Dec 06	Jan 07	Feb 07	Mar 07	Apr 07	May 07	Jun 07	Jul 07	Aug 07	Sep 07	Oct 07	Nov 07	Dec 07
Standard	$1,564.21	$1,873.31	$839.09	$822.10	$658.63	$374.33	$592.17	$487.43	$346.42	$512.41	$889.30	$523.94	$372.48	$494.97	$253.57	$266.36	$603.44	$283.29	$669.92	$429.52	$634.25	$635.14	$1,767.86	$518.39
SMP	$372.50	$320.74	$320.77	$264.36	$334.95	$367.17	$319.78	$292.80	$646.81	$421.57	$290.25	$359.79	$454.21	$682.48	$339.92	$516.63	$242.01	$429.57	$423.24	$243.64	$464.57	$155.66	$339.30	$161.04
Medicare	$272.45	$290.07	$352.95	$283.58	$349.01	$329.12	$276.86	$330.61	$316.54	$351.09	$359.22	$332.67	$369.90	$293.33	$309.01	$315.66	$334.46	$299.53	$326.66	$346.90	$297.74	$418.40	$320.88	$350.15

PMPM by Type of Service

The Total PMPM by Type of Service reports (8-F and 8-H) provide a breakdown of the PMPM by major type of service compared to the benchmark. The pie chart also provides an overview of the percentage of the PMPM each major type of service is contributing to the total PMPM plus a comparison to the benchmark. The total PMPM cost are for claims incurred January 2006 – December 2007 and paid through the end of March 2008. Exhibits 8-G and 8-I show the same actual data, but compare 2006 to 2007.

Standard Plan

The Standard Plan in Exhibit 8-F shows that the percentage breakdown by major type of service is similar to the benchmark. The facility outpatient costs make up a larger percent of the total costs while the physician costs make up less. The total PMPM cost is 3.9% below the benchmark. The inpatient facility PMPM cost is 6.9% below the benchmark and outpatient facility is 6.6% above the benchmark. The Standard Plan did not experience high cost claim activity which is directly correlated with inpatient charges. The physician PMPM cost is 7.3% below the benchmark. The drug paid PMPM cost is 12.0% below the benchmark. Lastly the other services category is 6.7% over the norm. Every $1.00 PMPM represented in the graph is equivalent to $818 in annual plan costs for the Standard plan.

Exhibit 8-G shows how claims on the Standard Plan on a PMPM basis have dropped from 2006 to 2007. Medical Claims dropped by 10.2%, most notably Facility Inpatient is down 32.9%.

SMP Plan

Exhibit 8-H shows the percentage breakdown by type of service for the SMP Plan is significantly different than the benchmark. Facility Outpatient claims comprise a much larger percentage of the total plan costs than would be expected. In total, the SMP plan is 22.1% above the benchmark. The driver of that variance is facility outpatient claims which are 133.9% higher than the benchmark. Inpatient facility PMPM cost is 39.7% below the norm and other services is 46.9% below the norm. The drug PMPM is in line with the norm, being only 1.6% lower.

Exhibit 8-I shows the SMP Plan's paid PMPM costs by type of service, comparing 2006 to 2007. Claim costs have increased 5.0% on average between the two years, which is lower than expected. However, facility inpatient claims increased by 113.8%, while all other categories decreased by over 20%.

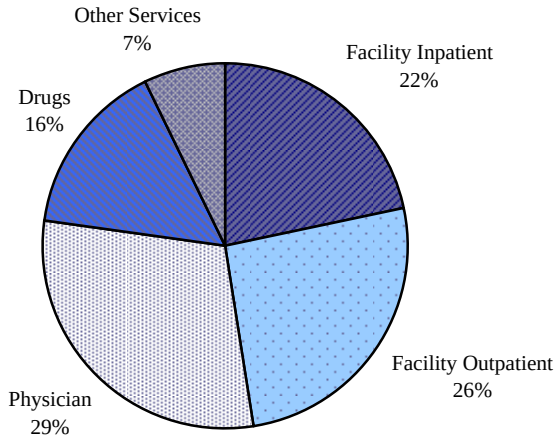
Exhibit 8-F

WISCONSIN PUBLIC EMPLOYERS

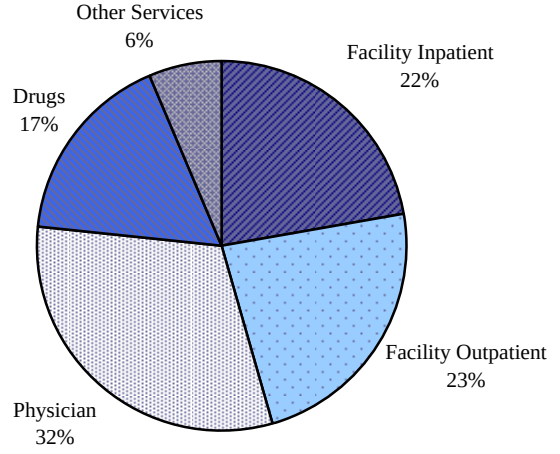
Total PMPM by Type of Service - Standard

Incurred January 2007 - December 2007 Paid Through March 2008

Actual PMPM



Benchmark PMPM



			Difference	
	Actual	Benchmark	$	%
Facility Inpatient	**$129.91**	**$139.48**	**-$9.57**	**-6.9%**
Facility Outpatient	**$154.53**	**$144.97**	**$9.56**	**6.6%**
Physician	**$179.49**	**$193.55**	**-$14.06**	**-7.3%**
Drugs	**$93.15**	**$105.87**	**-$12.72**	**-12.0%**
Other Services	**$42.85**	**$40.16**	**$2.69**	**6.7%**
Totals	**$599.93**	**$624.03**	**-$24.10**	**-3.9%**

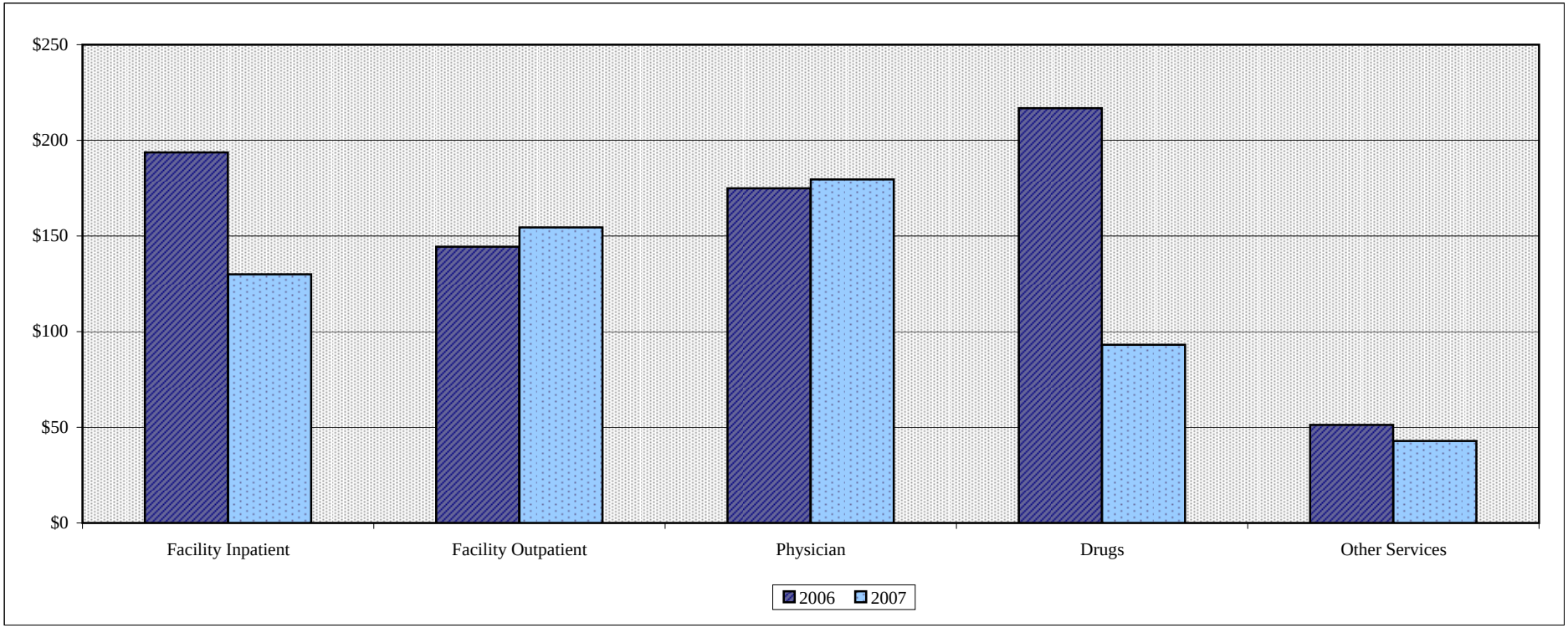
Note: Drug includes prescription and injectables

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

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

Exhibit 8-G

WISCONSIN PUBLIC EMPLOYERS
Total PMPM by Type of Service - Standard
Comparison of 2007 to 2006



	2006 *	2007 **	Difference $	Difference %
Facility Inpatient	$193.63	$129.91	-$63.72	-32.9%
Facility Outpatient	$144.45	$154.53	$10.08	7.0%
Physician	$174.92	$179.49	$4.57	2.6%
Drugs	$216.78	$93.15	-$123.63	-57.0%
Other Services	$51.31	$42.85	-$8.46	-16.5%
Totals	$781.09	$599.93	-$181.16	-23.2%

Note: Drug includes prescription and injectables

*** Each $1.00 paid PMPM = $1,273 in plan costs.**

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

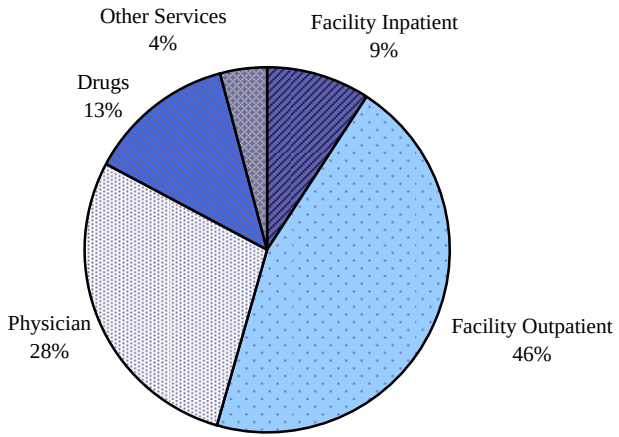
Exhibit 8-H

WISCONSIN PUBLIC EMPLOYERS

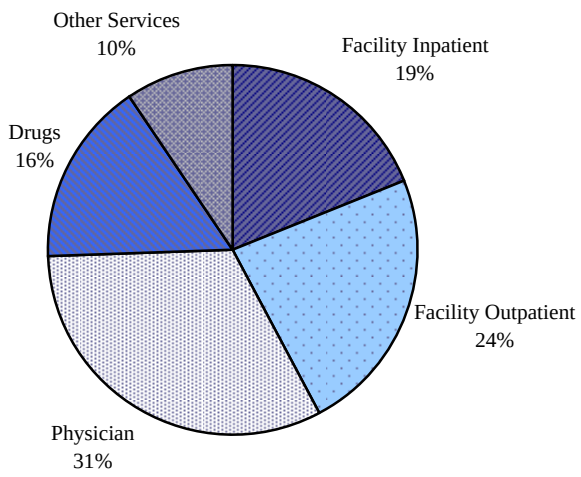
Total PMPM by Type of Service - SMP

Incurred January 2007 - December 2007 Paid Through March 2008

Actual PMPM



Benchmark PMPM



			Difference	
	Actual	Benchmark	$	%
Facility Inpatient	**$34.48**	**$57.14**	**-$22.66**	**-39.7%**
Facility Outpatient	**$167.76**	**$71.72**	**$96.04**	**133.9%**
Physician	**$105.88**	**$97.53**	**$8.35**	**8.6%**
Drugs	**$48.26**	**$49.02**	**-$0.76**	**-1.6%**
Other Services	**$15.47**	**$29.13**	**-$13.66**	**-46.9%**
Totals	**$371.85**	**$304.54**	**$67.31**	**22.1%**

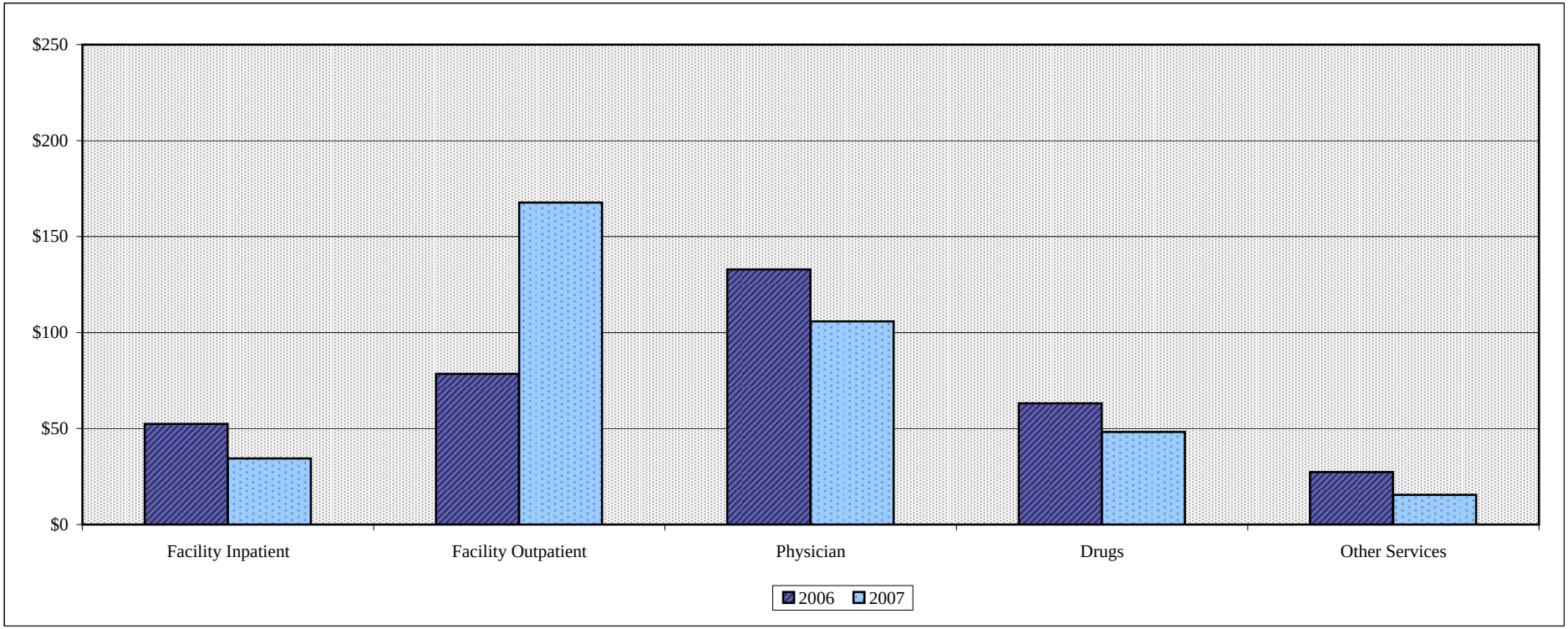
Note: Drug includes prescription and injectables

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

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

Exhibit 8-I

WISCONSIN PUBLIC EMPLOYERS
Total PMPM by Type of Service - SMP
Comparison of 2007 to 2006



			Difference	
	2006 *	2007 **	$	%
Facility Inpatient	$52.38	$34.48	-$17.90	-34.2%
Facility Outpatient	$78.45	$167.76	$89.31	113.8%
Physician	$132.91	$105.88	-$27.03	-20.3%
Drugs	$63.22	$48.26	-$14.96	-23.7%
Other Services	$27.28	$15.47	-$11.81	-43.3%
Totals	$354.24	$371.85	$17.61	5.0%

Note: Drug includes prescription and injectables

*** Each $1.00 paid PMPM = $2,407 in plan costs.**

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

Type of Service Detail

The Type of Service Detail report provides an overview of paid medical costs on a PMPM basis divided into 5 major service categories and further divided into 26 subcategories. The Actual PMPM costs are compared to the Benchmark PMPM to help determine where the plan is experiencing higher than normal claim costs. The comparison to the Benchmark is displayed as a PMPM difference and as a percentage difference. The Actual PMPM cost are for claims incurred January 2007 – December 2007 and paid through the end of March 2008.

Standard Plan

The Standard Plan in Exhibit 9-C was 3.9% below the benchmark in 2007. Due to the very small size of this group, the health conditions of a few members can have a significant impact on individual sub-categories. Therefore, meaningful conclusions cannot always be made. Since the percentage comparison can be deceiving, it is more important to look at the PMPM difference with $1.00 PMPM being equivalent to $818 in annual plan costs. Below are some areas that stand out relative to the benchmark and some analysis on what is driving the higher costs.

- Facility Inpatient – The majority of dollars here are for surgical/medical services. The lower than expected results in this category are directly correlated to the lack of high cost patients.

- Outpatient Facility – The surgical/medical sub-category is 88.2% above the norm. This overage is most like driven by the health conditions of this small population.

- Physician – The maternity sub-category is running 67.9% above the norm. Given the small population, a small number of pregnancies could skew this number. Surgery and Anesthesia sub-categories are also running well above the norm. Claim costs for these two services are highly correlated.

- Drug – The prescription drug costs are in line with the benchmark while injectible drugs are well below the benchmark.

- Other services – The other services category is $2.69 PMPM above the benchmark. The major contributor to the variance is the Psych/AODA sub-category which is $11.97 PMPM above the benchmark. In 2007, over 23% of the plan members utilized this benefit.

SMP Plan

The SMP Plan in Exhibit 9-D by comparison is 22.1% above the benchmark for 2007. Due to the very small size of this group, the health conditions of a few members can have a significant impact on individual sub-categories. Therefore, meaningful conclusions cannot always be made. For the plan $1.00 PMPM represented in the chart is equivalent to $522 in annual plan costs.

- Inpatient Facility - All of dollars here are for surgical/medical services. The lower than expected results in this category are directly correlated to the lack of high cost patients.

- Outpatient Facility – This category is 133.9% above the benchmark. This overage is most like driven by the health conditions of this small population.

- Physician – The Surgery and Anesthesia sub-categories are running well above the norm. Claim costs for these two services are highly correlated.

- Drug – The prescription drug PMPM cost is running 8.4% above the norm and the injectable drug costs are running 76.8% below norm. Overall the drug cost is lower than the total plan performance for 2007.

- Other Services – The Chiropractic sub-category is $4.51 PMPM above the norm which is a function of the region in which the SMP population resides. In the northern region, chiropractic care is more commonly used to treat back problems in comparison to other areas of the state.

Exhibit 9-C

WISCONSIN PUBLIC EMPLOYERS

Type of Service Detail - Standard

Incurred January 2007 - December 2007 Paid Through March 2008

TYPE OF SERVICE	DETAIL	ACTUAL PMPM	BENCHMARK PMPM	DIFFERENCE $	DIFFERENCE %
FACILITY INPATIENT	SURGICAL/MEDICAL	$129.46	$135.36	-$5.90	-4.4%
	PSYCH/AODA	$0.00	$1.53	-$1.53	-100.0%
	MATERNITY	$0.00	$1.07	-$1.07	-100.0%
	OTHER	$0.45	$1.52	-$1.07	-70.4%
	Subtotal	**$129.91**	**$139.48**	**-$9.57**	**-6.9%**
FACILITY OUTPATIENT	SURGICAL/MEDICAL	$50.89	$27.04	$23.85	88.2%
	RADIOLOGY	$36.68	$41.51	-$4.83	-11.6%
	PATHOLOGY	$14.65	$16.53	-$1.88	-11.4%
	EMERGENCY ROOM	$3.92	$4.06	-$0.14	-3.4%
	PSYCH/AODA	$0.00	$0.92	-$0.92	-100.0%
	OTHER	$48.39	$54.91	-$6.52	-11.9%
	Subtotal	**$154.53**	**$144.97**	**$9.56**	**6.6%**
PHYSICIAN	OFFICE VISIT	$15.71	$24.25	-$8.54	-35.2%
	RADIOLOGY	$27.13	$37.05	-$9.92	-26.8%
	PATHOLOGY	$21.81	$22.94	-$1.13	-4.9%
	SURGERY	$75.51	$61.42	$14.09	22.9%
	ANESTHESIA	$15.40	$12.07	$3.33	27.6%
	MATERNITY	$0.89	$0.53	$0.36	67.9%
	OTHER	$23.04	$35.29	-$12.25	-34.7%
	Subtotal	**$179.49**	**$193.55**	**-$14.06**	**-7.3%**
DRUGS	PRESCRIPTIONS	$92.85	$93.49	-$0.64	-0.7%
	INJECTABLES	$0.30	$12.38	-$12.08	-97.6%
	Subtotal	**$93.15**	**$105.87**	**-$12.72**	**-12.0%**
OTHER SERVICES	PSYCH/AODA	$17.10	$5.13	$11.97	233.3%
	CHIROPRACTIC	$6.50	$3.83	$2.67	69.7%
	THERAPIES	$3.77	$4.41	-$0.64	-14.5%
	AMBULANCE	$0.00	$2.21	-$2.21	-100.0%
	WELL BABY EXAM	$0.00	$0.04	-$0.04	-100.0%
	DURABLE MEDICAL EQUIPMENT	$1.98	$6.80	-$4.82	-70.9%
	OTHER	$13.50	$17.74	-$4.24	-23.9%
	Subtotal	**$42.85**	**$40.16**	**$2.69**	**6.7%**
Grand Total		**$599.93**	**$624.03**	**-$24.10**	**-3.9%**

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

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

Exhibit 9-D

WISCONSIN PUBLIC EMPLOYERS

Type of Service Detail - SMP

Incurred January 2007 - December 2007 Paid Through March 2008

TYPE OF SERVICE	DETAIL	ACTUAL PMPM	BENCHMARK PMPM	DIFFERENCE $	DIFFERENCE %
FACILITY INPATIENT	SURGICAL/MEDICAL	$34.48	$50.54	-$16.06	-31.8%
	PSYCH/AODA	$0.00	$1.80	-$1.80	-100.0%
	MATERNITY	$0.00	$4.27	-$4.27	-100.0%
	OTHER	$0.00	$0.53	-$0.53	-100.0%
	Subtotal	**$34.48**	**$57.14**	**-$22.66**	**-39.7%**
FACILITY OUTPATIENT	SURGICAL/MEDICAL	$32.37	$13.96	$18.41	131.9%
	RADIOLOGY	$55.80	$19.19	$36.61	190.8%
	PATHOLOGY	$26.85	$7.65	$19.20	251.0%
	EMERGENCY ROOM	$11.91	$3.11	$8.80	283.0%
	PSYCH/AODA	$0.70	$1.16	-$0.46	-39.7%
	OTHER	$40.13	$26.65	$13.48	50.6%
	Subtotal	**$167.76**	**$71.72**	**$96.04**	**133.9%**
PHYSICIAN	OFFICE VISIT	$14.17	$13.49	$0.68	5.0%
	RADIOLOGY	$12.37	$17.45	-$5.08	-29.1%
	PATHOLOGY	$3.61	$12.13	-$8.52	-70.2%
	SURGERY	$50.29	$29.46	$20.83	70.7%
	ANESTHESIA	$10.75	$5.99	$4.76	79.5%
	MATERNITY	$0.00	$2.23	-$2.23	-100.0%
	OTHER	$14.69	$16.78	-$2.09	-12.5%
	Subtotal	**$105.88**	**$97.53**	**$8.35**	**8.6%**
DRUGS	PRESCRIPTIONS	$46.93	$43.29	$3.64	8.4%
	INJECTABLES	$1.33	$5.73	-$4.40	-76.8%
	Subtotal	**$48.26**	**$49.02**	**-$0.76**	**-1.6%**
OTHER SERVICES	PSYCH/AODA	$0.00	$6.52	-$6.52	-100.0%
	CHIROPRACTIC	$7.26	$2.75	$4.51	164.0%
	THERAPIES	$0.00	$2.75	-$2.75	-100.0%
	AMBULANCE	$3.41	$1.16	$2.25	194.0%
	WELL BABY EXAM	$0.00	$0.00	$0.00	0.0%
	DURABLE MEDICAL EQUIPMENT	$0.00	$3.44	-$3.44	-100.0%
	OTHER	$4.80	$12.51	-$7.71	-61.6%
	Subtotal	**$15.47**	**$29.13**	**-$13.66**	**-46.9%**
Grand Total		**$371.85**	**$304.54**	**$67.31**	**22.1%**

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

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

Inpatient Utilization, Days/1000 and Average Length of Stay

The Inpatient Utilization report compares annual inpatient days per 1,000, admits per 1,000, average length of stay, cost per day, cost per admit, and inpatient PMPM cost to the benchmark for the 5 major inpatient service categories. Days/1000 is the annual average number of hospital days utilized by a population of 1,000 members which is calculated by taking (Total Days/Member Months)*12000. The Admits/1000 is the annual number of admits that occur within a typical population of 1,000 members which is calculated by taking (Total Admits/Member Months)*12000. The Days/1000 and Admits/1000 are calculations that allow a comparison of one population to another regardless of group size. Average Length of Stay (ALOS) shows the average length of hospitalization experienced for the entire group (Total Days/Total Admits). Cost per Day is an average of the cost per hospital day (Total Cost/Total Days). The cost per admit is an average of the cost per hospital admission (Total Cost/Total Admits). Lastly the inpatient PMPM is the per member per month cost incurred by the plan. Beyond the numerical comparison, a percentage has been included as observed in the pie charts, including a comparison to the benchmark.

Standard Plan

The totals for the Standard Plan in Exhibit 10-D are below the benchmark in most inpatient statistics. Due to the small size of this group the inpatient claim results are highly volatile from year to year and accurate predictions of future trends cannot be made. This year the group did not have any members with annual claims over $100,000 and thus experienced lower than expected inpatient costs. Of the costs that were incurred 88.5% were in the surgical sub-category.

SMP

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

Exhibit 10-D

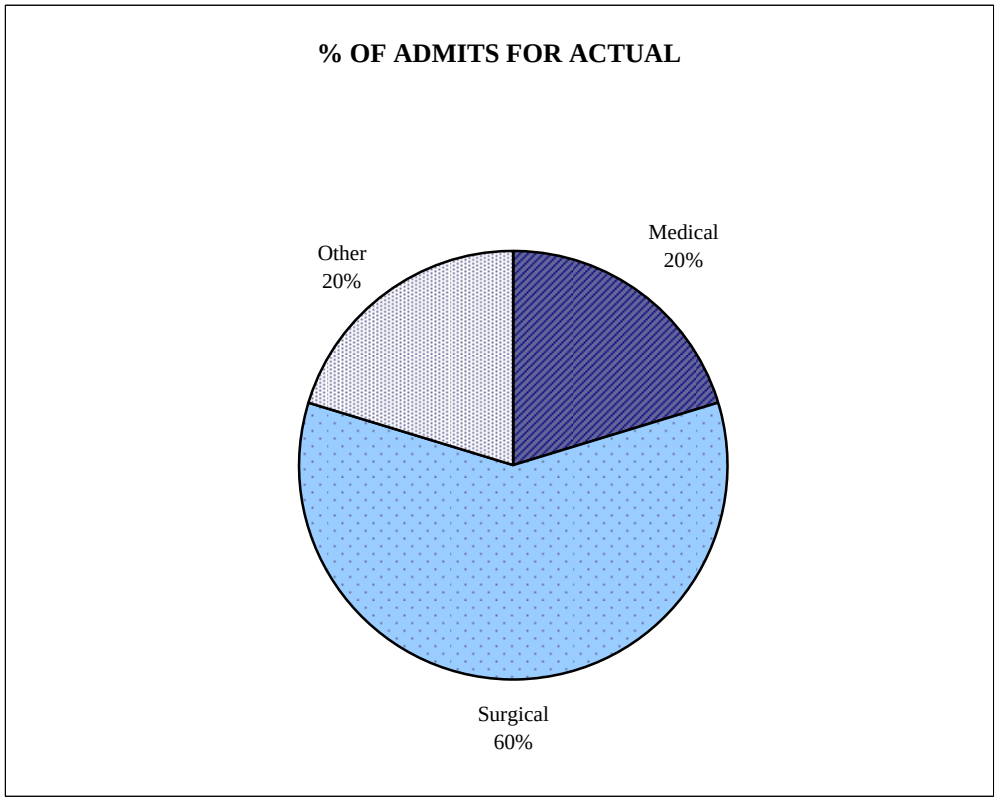
WISCONSIN PUBLIC EMPLOYERS

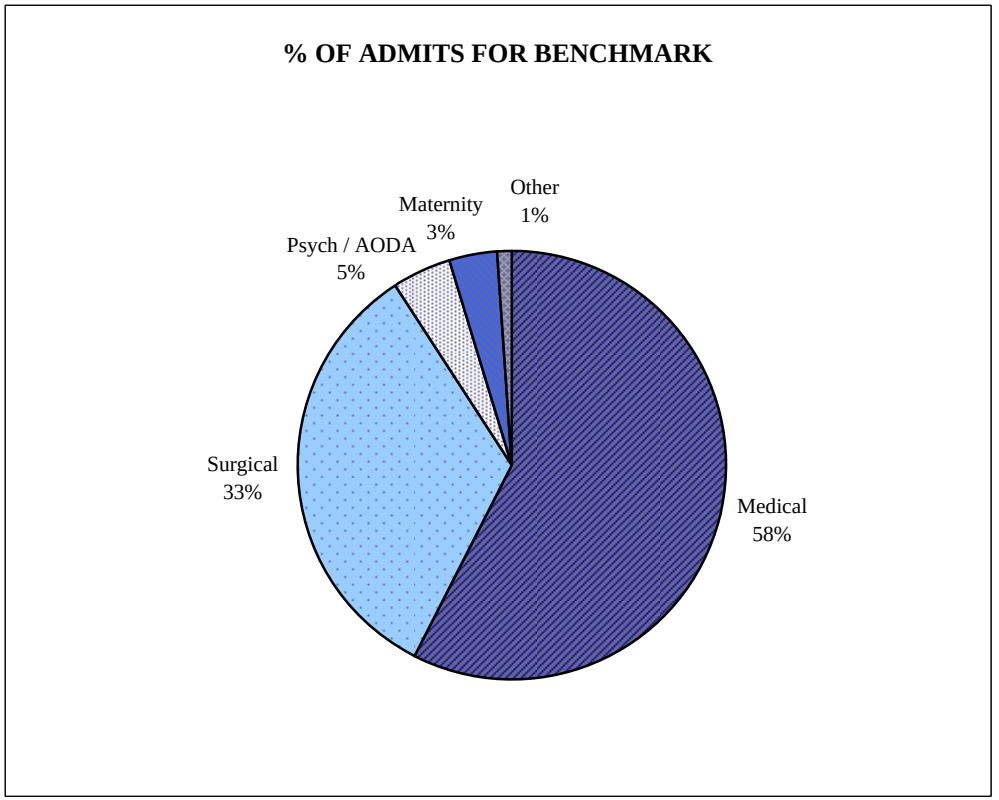
Inpatient Utilization - Standard

Incurred January 2007 - December 2007 Paid Through March 2008

ACTUAL	Medical	Surgical	Psych / AODA	Maternity	Other	Total
Days/1000	29	176	0	0	132	337
Admits/1000	15	44	0	0	15	74
ALOS	2.00	4.00	0.00	0.00	9.00	4.60
Cost/Day	$5,940	$7,835	$0	$0	$41	$4,620
Cost/Admit	$11,880	$31,338	$0	$0	$372	$21,254
PMPM	$14.52	$114.93	$0.00	$0.00	$0.45	$129.90
% of Paid	11.18%	88.48%	0.00%	0.00%	0.35%	100.00%

BENCHMARK	Medical	Surgical	Psych / AODA	Maternity	Other	Total
Days/1000	242	139	18	7	69	475
Admits/1000	50	29	4	3	1	87
ALOS	4.84	4.79	4.50	2.33	69.00	5.46
Cost/Day	$3,140	$6,667	$1,024	$1,616	$286	$3,576
Cost/Admit	$15,620	$33,701	$5,433	$2,843	$17,060	$23,241
PMPM	$60.95	$74.41	$1.53	$1.07	$1.52	$139.48
% of Paid	43.70%	53.35%	1.10%	0.77%	1.09%	100.00%

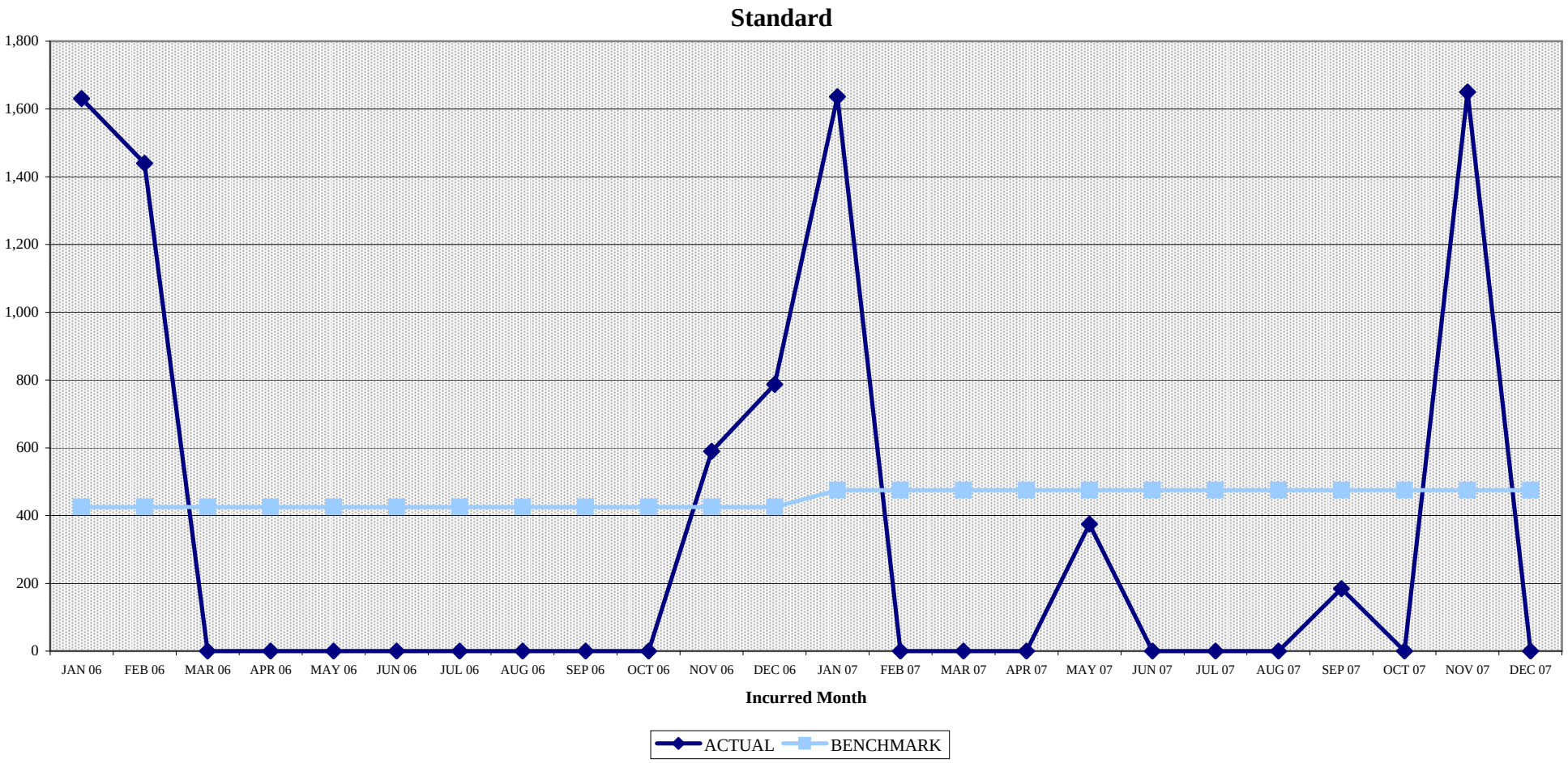




Note: Benchmark data has been age/sex adjusted to correspond to the population included in this exhibit

Exhibit 10-E

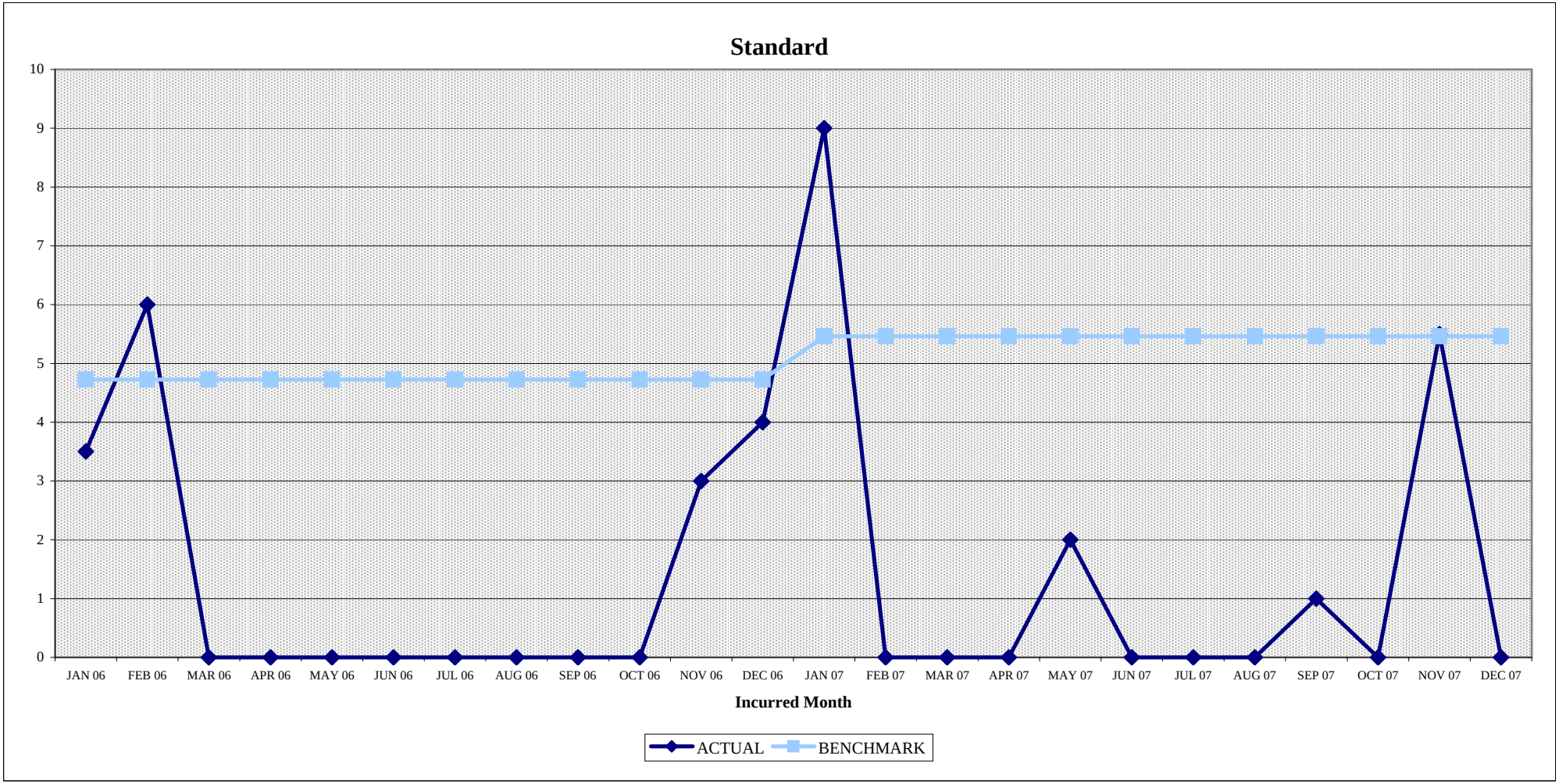
WISCONSIN PUBLIC EMPLOYERS
Monthly Inpatient Days/1000
Paid Through March 2008



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

Exhibit 10-F

WISCONSIN PUBLIC EMPLOYERS
Monthly Inpatient Average Length of Stay
Paid Through March 2008



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

Claim Costs by Major Diagnostic Categories (MDC)

The Claim Costs by Major Diagnostic Categories report divides medical claim costs into 25 mutually exclusive diagnostic categories. The category descriptions have been modified to incorporate simpler, more easily understood terms when compared to last years report. The diagnoses in each MDC correspond to a single organ system and, in general, are associated with a particular medical specialty. The actual PMPM cost by major diagnostic category is compared to the WPS benchmark PMPM. The Actual PMPM costs show calendar year results, comparing 2006 to 2007, each with three months run-out.

Prior exhibits have shown the **Standard Plan** is slightly below the benchmark overall. Exhibits 11-C show this deviation by MDC. Due to the small size of this group, the splitting of claims into small categories is highly volatile which is can be seen in large positive and negative comparisons. The individual health conditions of each member can affect a single sub-category. Therefore, this graph is for informational purposes only and we cannot make any recommendations based on the data presented. For the Standard Plan $1.00 PMPM in claim cost represented in the charts is equivalent to $818 in annual plan costs.

The **SMP Plan,** shown in Exhibits 11-D is experiencing higher than expected PMPM Cost overall. Once again the small size of this segment is creating large volatility in the results of individual categories which is seen in the large positive and negative comparisons. Therefore, this graph is for informational purposes only and we cannot make any recommendations based on the data presented. For the SMP plan $1.00 PMPM in claim cost represented in the charts is equivalent to $522 in annual plan costs.

Exhibit 11-C

WISCONSIN PUBLIC EMPLOYERS

Claim Costs by Major Diagnostic Categories - Standard

Comparison of 2007 to 2006

MDC CODE	MAJOR DIAGNOSTIC CATEGORY DESCRIPTION	2006 ACTUAL PMPM *	2007 ACTUAL PMPM **	BENCHMARK PMPM **	DIFFERENCE 2007 to 2006	DIFFERENCE 2007 to BENCHMARK
1	Nervous System Diseases and Disorders (D/D)	$22.63	$20.04	$31.05	-11.4%	-35.5%
2	Eye D/D	$6.28	$11.30	$16.31	79.9%	-30.7%
3	Ear, Nose, Mouth and Throat D/D	$11.73	$5.43	$17.10	-53.7%	-68.2%
4	Respiratory System D/D	$44.74	$1.76	$22.58	-96.1%	-92.2%
5	Circulatory System D/D	$104.48	$41.69	$81.51	-60.1%	-48.9%
6	Digestive System D/D	$43.28	$48.23	$50.05	11.4%	-3.6%
7	Liver, Gallbladder, Biliary Ducts and Pancreas D/D	$11.94	$4.16	$12.84	-65.2%	-67.6%
8	Muscles, Bones, and Connective Tissue D/D	$160.16	$222.59	$107.17	39.0%	107.7%
9	Skin, Subcutaneous Tissue (fat and connective) and Breast D/D	$161.97	$19.82	$29.22	-87.8%	-32.2%
10	Endocrine, Nutritional and Metabolic D/D (included diagnoses related to obesity, diabetes and hormones)	$44.21	$11.45	$17.13	-74.1%	-33.2%
11	Kidney and Urinary Tract D/D	$7.89	$2.99	$22.44	-62.1%	-86.7%
12	Male Reproductive System D/D	$2.52	$3.21	$7.92	27.4%	-59.5%
13	Female Reproductive System D/D	$5.27	$23.27	$14.01	341.6%	66.1%
14	Pregnancy, Childbirth, and After Delivery Diagnoses	$0.00	$9.55	$1.95	0.0%	390.2%
15	Newborns, and Newborns with Conditions Originating Shortly Before or After Birth	$0.00	$0.00	$1.41	0.0%	-100.0%
16	Blood and Blood Forming Organ D/D (including spleen) and Immune System Disorders	$2.81	$5.19	$4.59	84.7%	13.1%
17	Bone Marrow D/D and Poorly Differentiated Cancers	$3.05	$0.35	$14.62	-88.5%	-97.6%
18	Infectious and Parasitic Diseases	$0.78	$0.20	$5.43	-74.4%	-96.3%
19	Behavioral Health Diagnoses	$9.57	$15.45	$8.95	61.4%	72.6%
20	Alcohol/Drug Use and Alcohol/Drug Induced Organic Mental Disorders	$0.07	$2.07	$1.34	2857.1%	54.3%
21	Injuries, Poisoning and Toxic Effects of Drugs	$0.55	$0.03	$5.12	-94.5%	-99.4%
22	Burns	$0.09	$0.00	$0.10	-100.0%	-100.0%
23	Other Miscellaneous Services Including Health Screenings, Medical Exams and Rehabilitation	$29.51	$57.96	$53.77	96.4%	7.8%
24	Multiple Significant Trauma	$0.00	$0.00	$1.78	0.0%	-100.0%
25	Human Immunodeficiency Virus Infections	$0.00	$0.00	$0.05	0.0%	-100.0%
0	Ungroupable	$0.04	$0.32	$2.10	700.0%	-84.7%
	Total	**$673.57**	**$507.06**	**$530.54**	**-24.7%**	**-4.4%**

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

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

*** Each $1.00 paid PMPM = $1,273 in plan costs.**

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

Exhibit 11-D

WISCONSIN PUBLIC EMPLOYERS
Claim Costs by Major Diagnostic Categories - SMP
Comparison of 2007 to 2006

MDC CODE	MAJOR DIAGNOSTIC CATEGORY DESCRIPTION	2006 ACTUAL PMPM *	2007 ACTUAL PMPM **	BENCHMARK PMPM **	DIFFERENCE 2007 to 2006	DIFFERENCE 2007 to BENCHMARK
1	Nervous System Diseases and Disorders (D/D)	$6.84	$1.89	$14.09	-72.4%	-86.6%
2	Eye D/D	$4.25	$1.57	$4.80	-63.1%	-67.3%
3	Ear, Nose, Mouth and Throat D/D	$20.73	$7.60	$16.34	-63.3%	-53.5%
4	Respiratory System D/D	$10.94	$20.09	$9.28	83.6%	116.5%
5	Circulatory System D/D	$52.31	$41.65	$25.91	-20.4%	60.7%
6	Digestive System D/D	$26.26	$43.58	$26.70	66.0%	63.3%
7	Liver, Gallbladder, Biliary Ducts and Pancreas D/D	$0.00	$12.37	$5.94	0.0%	108.4%
8	Muscles, Bones, and Connective Tissue D/D	$51.82	$70.16	$44.70	35.4%	57.0%
9	Skin, Subcutaneous Tissue (fat and connective) and Breast D/D	$9.78	$6.71	$13.07	-31.4%	-48.7%
10	Endocrine, Nutritional and Metabolic D/D (included diagnoses related to obesity, diabetes and hormones)	$13.84	$16.47	$7.79	19.0%	111.3%
11	Kidney and Urinary Tract D/D	$12.13	$30.59	$8.01	152.2%	282.0%
12	Male Reproductive System D/D	$0.57	$0.42	$2.16	-26.3%	-80.6%
13	Female Reproductive System D/D	$31.21	$48.73	$9.39	56.1%	419.1%
14	Pregnancy, Childbirth, and After Delivery Diagnoses	$6.48	$0.00	$11.55	-100.0%	-100.0%
15	Newborns, and Newborns with Conditions Originating Shortly Before or After Birth	$0.42	$0.00	$7.06	-100.0%	-100.0%
16	Blood and Blood Forming Organ D/D (including spleen) and Immune System Disorders	$0.42	$8.12	$2.19	1833.3%	270.7%
17	Bone Marrow D/D and Poorly Differentiated Cancers	$1.52	$0.00	$6.02	-100.0%	-100.0%
18	Infectious and Parasitic Diseases	$0.71	$1.79	$2.64	152.1%	-32.2%
19	Behavioral Health Diagnoses	$12.87	$0.96	$9.06	-92.5%	-89.4%
20	Alcohol/Drug Use and Alcohol/Drug Induced Organic Mental Disorders	$0.00	$0.00	$1.38	0.0%	-100.0%
21	Injuries, Poisoning and Toxic Effects of Drugs	$1.12	$0.91	$2.76	-18.8%	-67.0%
22	Burns	$0.00	$0.00	$0.37	0.0%	-100.0%
23	Other Miscellaneous Services Including Health Screenings, Medical Exams and Rehabilitation	$26.10	$9.83	$27.87	-62.3%	-64.7%
24	Multiple Significant Trauma	$0.00	$0.00	$0.90	0.0%	-100.0%
25	Human Immunodeficiency Virus Infections	$0.00	$0.00	$0.04	0.0%	-100.0%
0	Ungroupable	$1.01	$1.50	$1.23	48.5%	21.7%
	Total	**$291.33**	**$324.94**	**$261.25**	**11.5%**	**24.4%**

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

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

*** Each $1.00 paid PMPM = $2,407 in plan costs.**

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

Top 20 Providers

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

Facility

The report for the **Standard Plan** in Exhibit 12-E shows that the top 20 facilities provide 91.6% of the total facility charges for the plan. The largest percent of claims came from St Francis Hospital in Milwaukee. The second largest percent of claims came from Lakeview Memorial Hospital in Stillwater, Minnesota. You will note that most of the hospitals in the top 20 treated only one patient. Since the Standard Plan is available nationwide, we see providers from various regions and states.

The report for the **SMP Plan** in Exhibit 12-F shows that the top 7 facilities provide 100% of the total facility charges for the plan. The vast majority of claims came from Dickinson County Memorial Hospital in Iron Mountain, Michigan. This hospital also saw the most patients with 26. Due to the HMO type coverage and limited plan area of the SMP plan we would expect to see a majority of services received at a finite number of hospitals within the SMP region.

Professional

The **Standard Plan** shown in Exhibit 12-G received 52.7% of professional charges from the top 20 providers. The top professional provider is Kagan Jugan Associates in Fort Myers, Florida. Once again most providers in the top 20 only treated one patient. The top Wisconsin provider by paid claims and number of patients treated was the UW Medical Foundation in Madison.

The **SMP Plan** in Exhibit 12-H received 88.6% of the paid claims from the top 20 professional providers. Dickinson Memorial Hospital was again the top provider in both paid dollars and patients treated. You will note that most of the services were provided in Iron Mountain, Michigan.

Exhibit 12-E

WISCONSIN PUBLIC EMPLOYERS

Top 20 Facility Providers - Standard

Incurred January 2007 - December 2007 Paid Through March 2008

	Facility Provider	City	State	# of Unique Patients	Inpatient Paid Claims	Outpatient Paid Claims	Total Paid Claims	Paid %
1	ST FRANCIS HOSPITAL	MILWAUKEE	WI	1	$41,570	$1,001	$42,571	18.3%
2	LAKEVIEW MEMORIAL HOSPITAL	STILLWATER	MN	1	$25,467	$0	$25,467	10.9%
3	SAINT JOSEPH HEALTH CTR	KANSAS CITY	MO	1	$11,143	$4,731	$15,874	6.8%
4	WHEATON FRANCISCAN HEALTHCARE	MILWAUKEE	WI	1	$15,835	$0	$15,835	6.8%
5	MERITER HOSPITAL INC	MADISON	WI	3	$11,880	$3,488	$15,368	6.6%
6	PHYSICIANS SURG CTR	FORT MYERS	FL	1	$0	$12,794	$12,794	5.5%
7	AURORA MEDICAL CTR HARTFORD	HARTFORD	WI	1	$0	$12,042	$12,042	5.2%
8	COLUMBIA ST MARYS HOSPITAL COL	MILWAUKEE	WI	1	$0	$9,759	$9,759	4.2%
9	FOND DU LAC SURGERY CTR	FOND DU LAC	WI	1	$0	$9,707	$9,707	4.2%
10	CUMBERLAND MEMORIAL HOSPITAL	CUMBERLAND	WI	3	$0	$8,471	$8,471	3.6%
11	AURORA ST LUKES MEDICAL CTR	MILWAUKEE	WI	4	$0	$7,463	$7,463	3.2%
12	MURRAY-CALLOWY CTY HSP	MURRAY	KY	1	$0	$5,889	$5,889	2.5%
13	UNIVERSITY WI HSP CL AUTHORITY	MADISON	WI	4	$0	$5,342	$5,342	2.3%
14	UPLAND HILLS HEALTH	DODGEVILLE	WI	1	$0	$5,314	$5,314	2.3%
15	OAKLEAF SURGICAL HOSPITAL	EAU CLAIRE	WI	1	$0	$4,184	$4,184	1.8%
16	ST FRANCIS HOSP INC	COLUMBUS	GA	1	$0	$4,157	$4,157	1.8%
17	SARASOTA MEM HOSP	SARASOTA	FL	3	$0	$4,027	$4,027	1.7%
18	ASSOCIATED EYE CARE AMBUL	STILLWATER	MN	1	$0	$3,147	$3,147	1.4%
19	LAKEVIEW MED CTR	RICE LAKE	WI	1	$0	$2,996	$2,996	1.3%
20	LEESBURG REG MED CTR	LEESBURG	FL	1	$0	$2,641	$2,641	1.1%
	Top 20 Total			**32**	**$105,895**	**$107,153**	**$213,048**	**91.6%**
	All Other Facility Charges			**29**	**$372**	**$19,260**	**$19,632**	**8.4%**
	Total Facility Charges			**61**	**$106,267**	**$126,413**	**$232,680**	**100.0%**

Exhibit 12-F

WISCONSIN PUBLIC EMPLOYERS

Top 20 Facility Providers - SMP

Incurred January 2007 - December 2007 Paid Through March 2008

	Facility Provider	City	State	# of Unique Patients	Inpatient Paid Claims	Outpatient Paid Claims	Total Paid Claims	Paid %
1	DICKINSON COUNTY MEMORIAL HOSP	IRON MOUNTAIN	MI	26	$18,001	$68,798	$86,799	82.2%
2	AURORA MEDICAL GROUP OSHKOSH	OSHKOSH	WI	1	$0	$7,365	$7,365	7.0%
3	BELLIN MEMORIAL HOSP	GREEN BAY	WI	1	$0	$6,010	$6,010	5.7%
4	FRANCISCAN SKEMP MEDICAL CENTE	LA CROSSE	WI	1	$0	$2,293	$2,293	2.2%
5	NIAGARA HEALTH CTR	NIAGARA	WI	1	$0	$1,190	$1,190	1.1%
6	MARQUETTE MEDICAL CL	KINGSFORD	MI	3	$0	$1,004	$1,004	1.0%
7	ST VINCENT HOSPITAL	GREEN BAY	WI	2	$0	$909	$909	0.9%
	Top 7 Total			**35**	**$18,001**	**$87,569**	**$105,570**	**100.0%**
	All Other Facility Charges			**0**	**$0**	**$0**	**$0**	**0.0%**
	Total Facility Charges			**35**	**$18,001**	**$87,569**	**$105,570**	**100.0%**

Exhibit 12-G

WISCONSIN PUBLIC EMPLOYERS

Top 20 Professional Providers - Standard

Incurred January 2007 - December 2007 Paid Through March 2008

	Professional Provider	City	State	# of Unique Patients	Total Paid Claims	Paid %
1	KAGAN JUGAN ASSOCIATES PA	FORT MYERS	FL	1	$10,955	6.0%
2	UW MEDICAL FOUNDATION	MADISON	WI	7	$10,548	5.8%
3	SPORTS MEDICINE & ORTHOPEDIC	MILWAUKEE	WI	1	$9,958	5.5%
4	DEAN MEDICAL CTR	MADISON	WI	3	$7,642	4.2%
5	ST CROIX ORTHOPAEDICS PA	STILLWATER	MN	1	$7,309	4.0%
6	LAKEFRONT WELLNESS CENTER SC	PEWAUKEE	WI	4	$6,269	3.4%
7	FLORIDA HEART & VASCULAR CTR	LEESBURG	FL	1	$5,312	2.9%
8	AURORA MEDICAL GROUP OSHKOSH	OSHKOSH	WI	4	$4,729	2.6%
9	CLEARVIEW MEDICAL IMAGING LLC	MILWAUKEE	WI	1	$4,665	2.6%
10	INTERVENTIONAL PAIN SPECIALIST	RICE LAKE	WI	1	$3,967	2.2%
11	ASSOCIATED EYE CARE	STILLWATER	MN	1	$3,443	1.9%
12	BARRY K GIMBEL MD SC	MILWAUKEE	WI	1	$2,862	1.6%
13	FAMILY FOOT CLINIC SC	FOND DU LAC	WI	1	$2,647	1.5%
14	MIDWEST ANESTHESIA CONSULTANTS	MILWAUKEE	WI	1	$2,419	1.3%
15	MEDICAL COLLEGE OF WISCONSIN	MILWAUKEE	WI	3	$2,299	1.3%
16	CARONDELET SPECIALTY CARE NETW	KANSAS CITY	MO	1	$2,264	1.2%
17	PLASTIC SURGERY CLINIC	EAU CLAIRE	WI	1	$2,246	1.2%
18	JULIE CHICKS MD SC	CEDARBURG	WI	1	$2,187	1.2%
19	CUMBERLAND CLINIC SC	CUMBERLAND	WI	3	$2,176	1.2%
20	M M PHYSICAL THERAPY LLC	S MILWAUKEE	WI	1	$2,127	1.2%
	Top 20 Total			**38**	**$96,024**	**52.7%**
	All Other Professional Charges			**231**	**$86,089**	**47.3%**
	Total Professional Charges			**269**	**$182,113**	**100.0%**

Exhibit 12-H

WISCONSIN PUBLIC EMPLOYERS

Top 20 Professional Providers - SMP

Incurred January 2007 - December 2007 Paid Through March 2008

	Professional Provider	City	State	# of Unique Patients	Total Paid Claims	Paid %
1	DICKINSON COUNTY MEMORIAL HOSP	IRON MOUNTAIN	MI	16	$7,926	12.4%
2	BAYCARE CLINIC LLP	MARINETTE	WI	1	$7,634	11.9%
3	BENISHEK CECCONI AND TERRIAN	IRON MOUNTAIN	MI	4	$7,510	11.7%
4	JOHN M COOK MD PC	IRON MOUNTAIN	MI	4	$4,593	7.2%
5	UROLOGY ASSOC OF GREEN BAY SC	GREEN BAY	WI	3	$4,560	7.1%
6	RADIOLOGY ASSOC IRON MTN	IRON MOUNTAIN	MI	16	$3,888	6.1%
7	NORTHERN MICHIGAN ANESTHESIA	IRON MOUNTAIN	MI	3	$3,835	6.0%
8	MARQUETTE MEDICAL CL	KINGSFORD	MI	7	$2,136	3.3%
9	BEGRES CHIROPRACTIC	IRON MOUNTAIN	MI	9	$2,126	3.3%
10	WISCONSIN MICHIGAN PHYSICIANS	NIAGARA	WI	1	$1,872	2.9%
11	BEACON AMBULANCE SVC	HURLEY	WI	1	$1,778	2.8%
12	NIAGARA CHIROPRACTIC	NIAGARA	WI	3	$1,458	2.3%
13	JAMES A BATTI MD	IRON MOUNTAIN	MI	10	$1,210	1.9%
14	AURORA MEDICAL GROUP OSHKOSH	OSHKOSH	WI	1	$1,137	1.8%
15	NORTHWOODS IMAGING ASSOC	IRON MOUNTAIN	MI	2	$1,099	1.7%
16	STEVEN HUNT	IRON MOUNTAIN	MI	1	$970	1.5%
17	HOSPITAL DIAGNOSTIC SVC	GREEN BAY	WI	1	$922	1.4%
18	JOHN H BARSCH MD	IRON MOUNTAIN	MI	1	$713	1.1%
19	MEDCO WACHOVIA	COLUMBUS	OH	1	$696	1.1%
20	MI-WI FAMILY PRACTICE ASSOC PC	IRON MOUNTAIN	MI	2	$668	1.0%
	Top 20 Total			**87**	**$56,731**	**88.6%**
	All Other Professional Charges			**29**	**$7,310**	**11.4%**
	Total Professional Charges			**116**	**$64,041**	**100.0%**

High Cost Patients

There are no high cost claimants, defined as members who have more than $100,000 in claims in the most recent 12 month period, on the WPE plan.

Medical and Drug Cost Sharing

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

The **Standard Plan** members pay about 6.0% of their own medical claims as compared to the benchmark of 6.7%. The prescription drug cost share is above our normative benchmark with the Standard Plan around 21.8% and the benchmark at 19.0%.

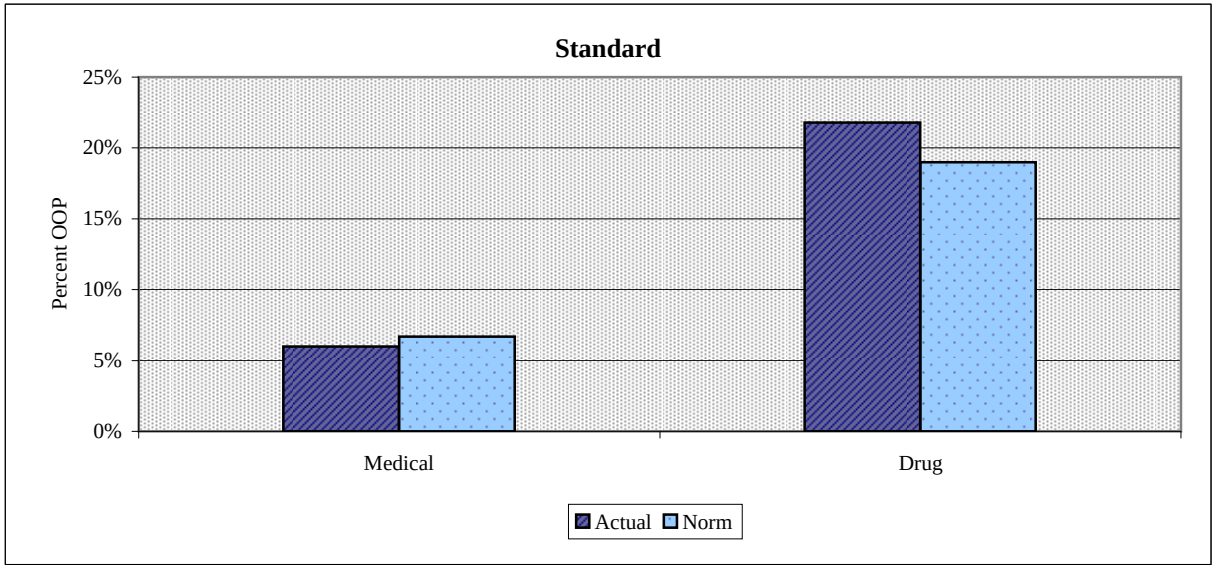
The **SMP Plan** members by comparison pay a smaller amount towards their own medical claims (in the form of cost sharing). Unlike the members of most large groups who pay an average of about 9.3% of their medical claims, SMP Plan members pay 1.0%. The SMP cost share for prescription drugs is just below the benchmark of 19.5%. Even though the Standard and SMP plans have the same prescription drug benefit, they have slightly different drug utilization profiles, the result of each plan's unique blend of treated conditions.

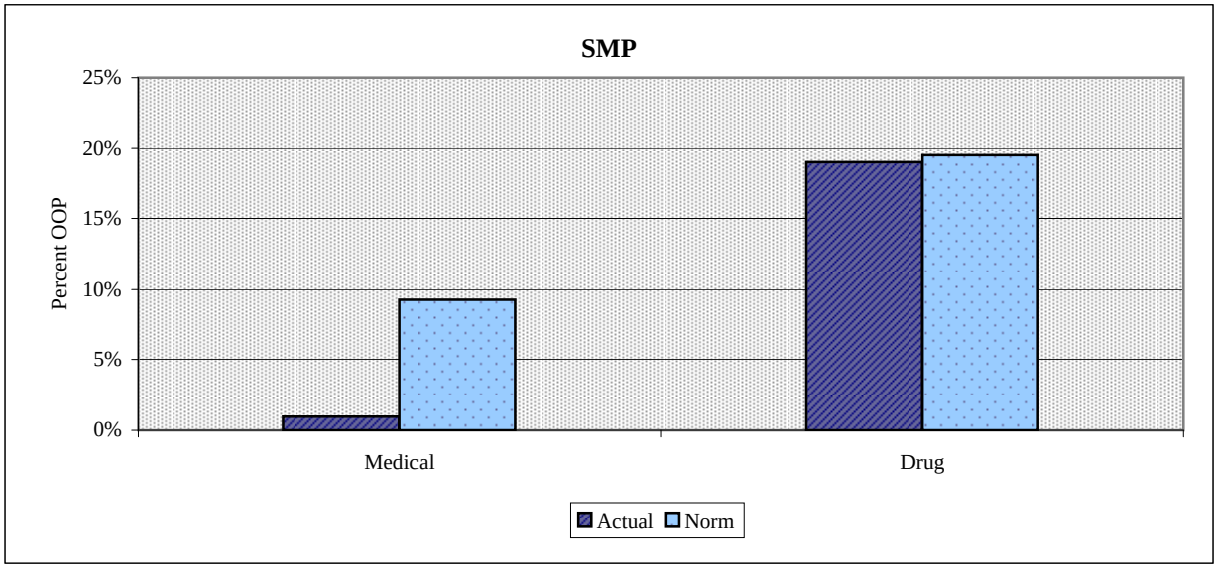
Exhibit 15-B

WISCONSIN PUBLIC EMPLOYERS

Medical and Drug Cost Sharing

Incurred January 2007 - December 2007 Paid Through March 2008





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

Medical and Drug Out of Pocket by Member

The Medical and Drug Out of Pocket by Member bar graph shown in Exhibit 16-B divides members with out of pocket cost sharing into categories based on the annual amount of out of pocket costs they paid in 2007. The annual out of pocket for each member includes medical and prescription drug costs.

The **Standard Plan** has a large disparity between the members as far as out of pocket costs. The distribution of out of pocket costs are fairly evenly distributed across the different categories, however there appears to be a bias towards the higher out of pocket costs. There are just over 16 members who pay over $1000 out of pocket annually. Also, there are over 15 members in the $500 to $999 range but it is important to note the range for this category is larger than the previous categories.

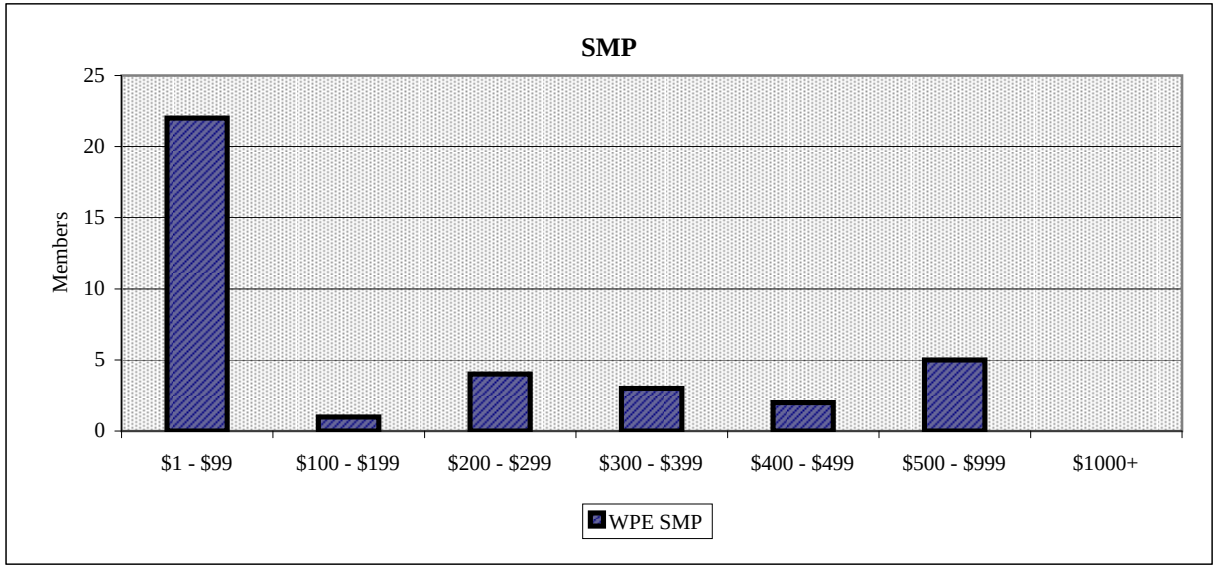
The **SMP Plan** by comparison has a large number of members paying between $1and $99 in cost sharing. Most of the cost sharing comes from prescription drug copays.

Exhibit 16-B

WISCONSIN PUBLIC EMPLOYERS

Medical and Drug Out of Pocket by Member

Incurred January 2007 - December 2007 Paid Through March 2008



Medical Claim Savings Analysis

The Medical Claim Saving Analysis in Exhibit 17-C takes the charges submitted on behalf of the ETF members and details the savings that take place before the final payments are made to the providers. The submitted charges represent medical claims only. The charges are split between the Standard, SMP and Medicare Carve-out plans for claims incurred January 2007 through December 2007 and paid through the end of March 2008. Exhibit 17-D provides a summary of the savings by plan along with a pie chart that provides the percentage of savings in each category combining all plans.

For the **Standard Plan**, WPS paid 76.2% of submitted charges on behalf of the plan. Of the 23.8% savings, 10.3% came from pricing cutbacks from the network providers. Another 3.7% was saved on claims rejected for duplicate submission, non-eligible claims, and services not covered by the plan. The Standard Plan also had 4.9% of charges paid by the members with deductibles, coinsurance and copays. The savings due to third party liability is small at this time but these types of recoveries can be long term and may take several years to be completed.

For the **SMP Plan**, WPS paid 73.1% of submitted charges on behalf of the plan. Of the 26.9% savings, 9.8% was received from pricing cutbacks from network providers. Another 7.2% was saved on claims rejected for duplicate submission, non-eligible claims, and services not covered by the plan. In comparison to the Standard Plan, the SMP plan members contributed only 0.7% in out-of-pocket costs. The SMP plan does have some out-of-pocket costs in the form of ER Copays, coinsurance on DME and Outpatient Psychiatric Visits. The total seen in the copayment segment is not just ER copays but also encompasses coinsurance amounts that do not apply to the annual out-of-pocket maximum for a member.

For the **Medicare Carve-out Plan**, WPS paid 5.6% of submitted charges on behalf of the plan. Payments made by Medicare have an overwhelming impact on savings by accounting for 76.7% of the submitted charges. The second highest savings percentage, 13.8%, came from the rejection of duplicate or non-eligible charges. This percentage has decreased from 17.4% in 2006. The decrease is the result of a WPS Claims Department provider education initiative regarding optimal methods of claim submission.

As seen in the pie chart in Exhibit 16-D, the total payment made by WPS for all plan types in 2006 was 11.4% of submitted charges. With the Medicare population's impact, 70.2% of the savings was provided by Medicare, followed by 13.0% in rejections for duplicates and non-eligible services.

Exhibit 17-C

WISCONSIN PUBLIC EMPLOYERS
Medical Claim Savings Analysis
Incurred January 2007 - December 2007 Paid Through March 2008

Category	STANDARD		SMP		MEDICARE	
	$ Amount	% of Total	$ Amount	% of Total	$ Amount	% of Total
Submitted Charges	**$544,613.56**	**100.0%**	**$232,015.29**	**100.0%**	**$8,442,023.28**	**100.0%**
Duplicates/Not Eligible	**$19,986.21**	**3.7%**	**$16,604.03**	**7.2%**	**$1,160,977.75**	**13.8%**
Pricing Cutbacks	**$56,135.80**	**10.3%**	**$22,697.74**	**9.8%**		
Out-of-Pocket						
Deductible	$14,428.56	2.6%	$931.72	0.4%	$40,783.92	0.5%
Coinsurance	$10,819.17	2.0%	$694.40	0.3%	$80,500.90	1.0%
Copayments	$1,223.50	0.2%	$47.62	0.0%	$1,268.26	0.0%
Total	**$26,471.23**	**4.9%**	**$1,673.74**	**0.7%**	**$122,553.08**	**1.5%**
Not Covered						
Medical Necessity	$2,973.31	0.5%	$0.00	0.0%	$1,582.52	0.0%
Inappropriate Provider	$0.00	0.0%	$0.00	0.0%	$523.00	0.0%
Benefit Maximum	$1,087.68	0.2%	$2,360.00	1.0%	$52,504.55	0.6%
Experimental/Fertility	$582.00	0.1%	$0.00	0.0%	$369.00	0.0%
Dental	$468.00	0.1%	$0.00	0.0%	$510.00	0.0%
Custodial	$0.00	0.0%	$0.00	0.0%	$45,980.00	0.5%
Code Review	$16,354.00	3.0%	$1,856.80	0.8%	$2,020.83	0.0%
Contact Lens/Hearing Aid	$133.96	0.0%	$0.00	0.0%	$1,361.29	0.0%
Drugs	$0.00	0.0%	$0.00	0.0%	$0.00	0.0%
No Referral	$0.00	0.0%	$13,232.83	5.7%	$0.00	0.0%
All Other	$1,341.43	0.2%	$3,267.27	1.4%	$107,391.19	1.3%
Total	**$22,940.38**	**4.2%**	**$20,716.90**	**8.9%**	**$212,242.38**	**2.5%**
Third Party Liability						
Workers Compensation	$0.00	0.0%	$225.00	0.1%	$3,458.88	0.0%
Subrogation	$0.00	0.0%	$0.00	0.0%	$0.00	0.0%
Coordination of Benefits	$406.41	0.1%	$482.82	0.2%	$0.00	0.0%
Total	**$406.41**	**0.1%**	**$707.82**	**0.3%**	**$3,458.88**	**0.0%**
Medicare	**$3,756.38**	**0.7%**	**$0.00**	**0.0%**	**$6,472,217.57**	**76.7%**
Payments	**$414,917.15**	**76.2%**	**$169,615.06**	**73.1%**	**$470,573.62**	**5.6%**

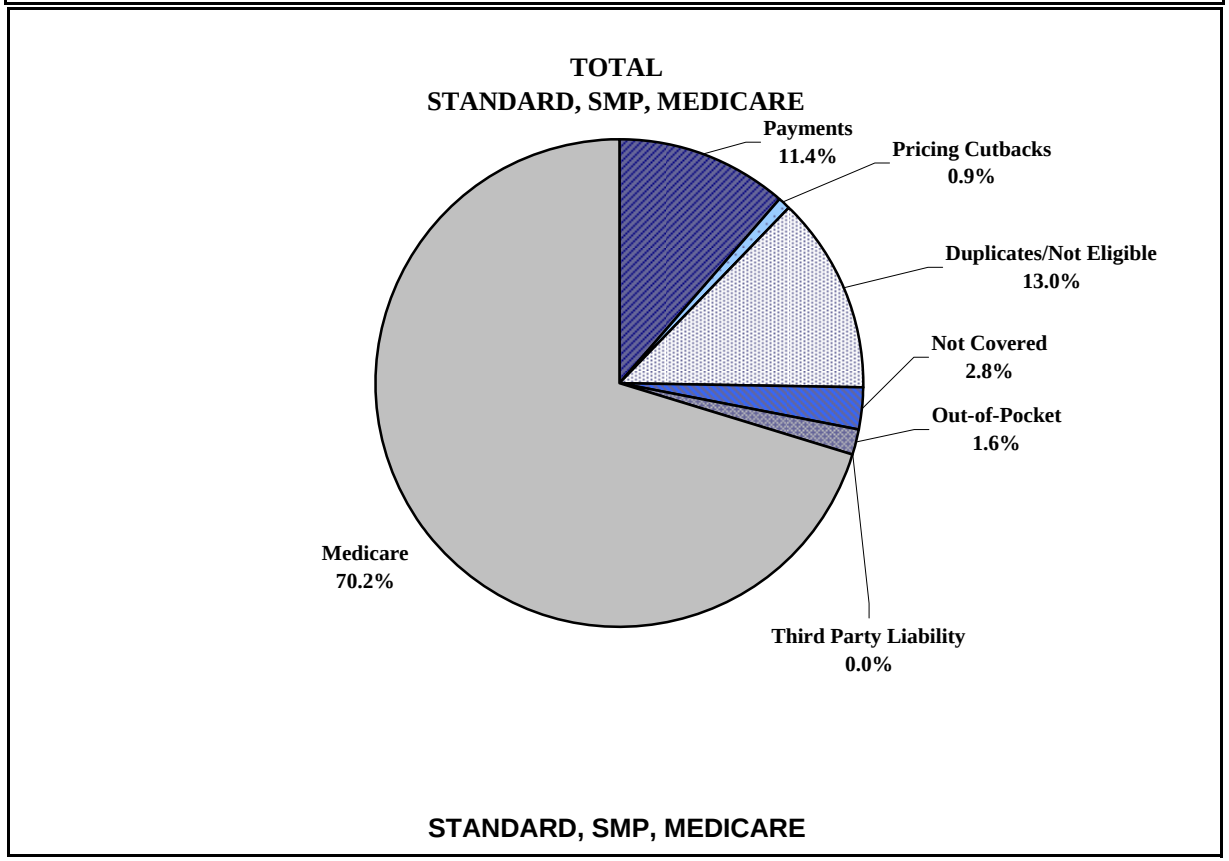
Exhibit 17-D

WISCONSIN PUBLIC EMPLOYERS

Medical Claim Savings Analysis Summary

Incurred January 2007 - December 2007 Paid Through March 2008

	STANDARD		SMP		MEDICARE	
	$ Amount	% of Total	$ Amount	% of Total	$ Amount	% of Total
Payments	$414,917.15	76.2%	$169,615.06	73.1%	$470,573.62	5.6%
Pricing Cutbacks	$56,135.80	10.3%	$22,697.74	9.8%		
Duplicates/Not Eligible	$19,986.21	3.7%	$16,604.03	7.2%	$1,160,977.75	13.8%
Not Covered	$22,940.38	4.2%	$20,716.90	8.9%	$212,242.38	2.5%
Out-of-Pocket	$26,471.23	4.9%	$1,673.74	0.7%	$122,553.08	1.5%
Third Party Liability	$406.41	0.1%	$707.82	0.3%	$3,458.88	0.0%
Medicare	$3,756.38	0.7%	$0.00	0.0%	$6,472,217.57	76.7%



WPS HEALTH INSURANCE

State of Wisconsin

Section 3: Integrated Care Management

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

State Employee Trust Funds

Executive Summary

- Costs compared to benchmarks are high (PMPM) in three diagnostic categories including cancer, behavioral health, and obesity.

- Bariatric Surgery costs continue to contribute to a high PMPM in the obesity category, but no cases were in the high dollar report.

- Mammography screening rates are above the national average.

- Cervical cancer rates are below the national average, but the optional exclusion for members with a hysterectomy was not taken and the denominator maybe inflated.

- There are 42 ETF members with claims over $100K.
  - Care Management services were provided to 100% of these high dollar members
  - Cancer accounted for 40% of these high dollar cases

- 86 members were opened to Chronic Condition Management in 2007.
  - 60% had cardiac (including hypertension) diagnoses
  - 37% were members with diabetes

- Clinical Quality measures for Diabetic Care were below the National average. There is an opportunity to engage more members with diabetes in chronic condition management in 2008.

- Care Management savings for Utilization Management, Outpatient Prior Authorization, Case Management, and Medical Review was $2.3 million, a 12 % increase over 2006.

- Comprehensive WPS Wellness program was launched in 2008, including numerous free health resources for consumer education.

Integrated Care Management: The Paradigm has changed

- **Coordination of services across the healthcare continuum from healthy to "sick"**

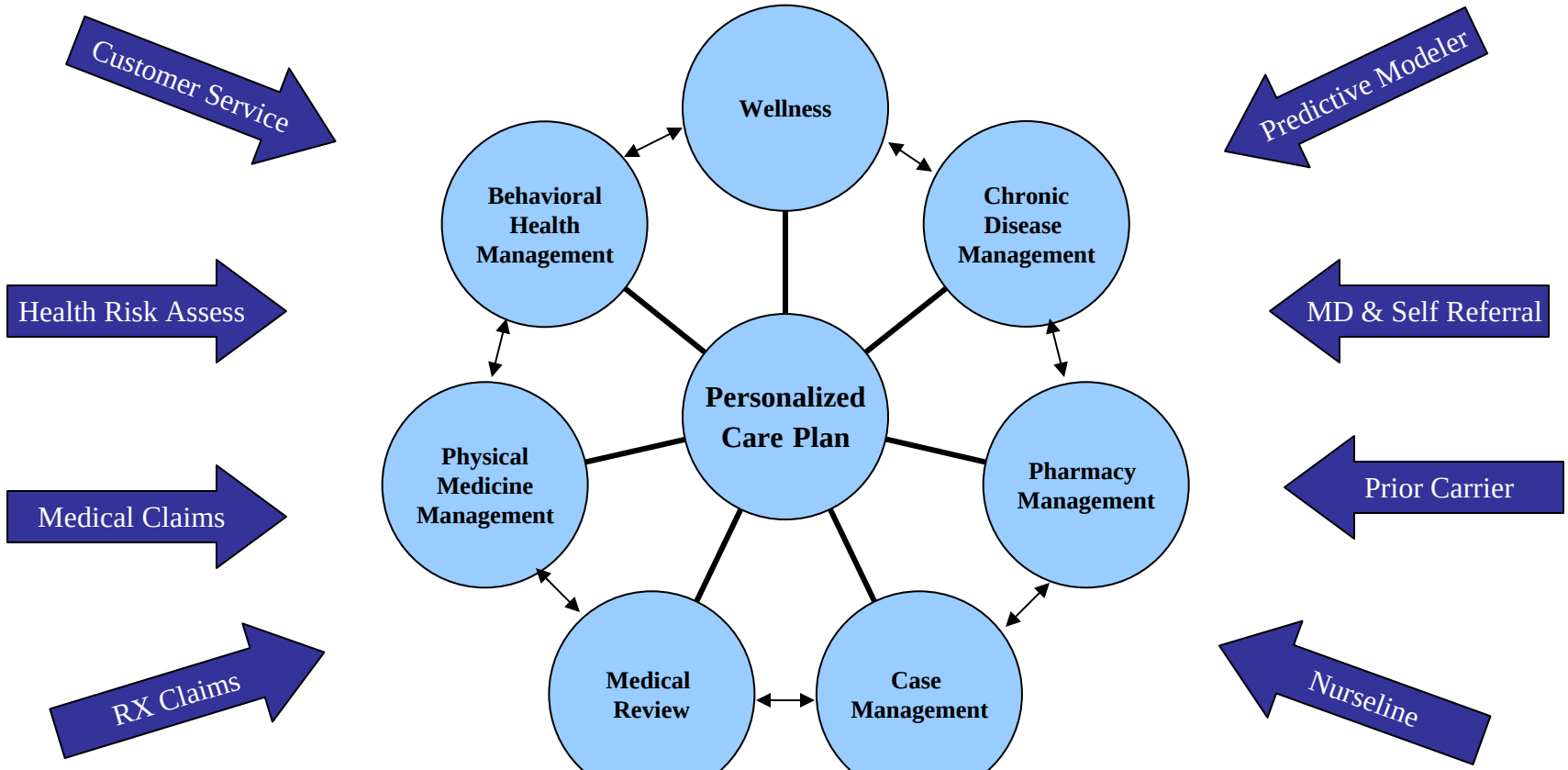
  - Wellness and Lifestyle Management – Wellness Coaches
  - Chronic Condition and Targeted Health Conditions – Chronic Condition Managers
  - Acute Episode, Complex and High Dollar Cases – Case Managers

- **Philosophy and Goals**

  - Empower members as consumers of care
  - Improve health care outcomes with efficient cost effective delivery of care
  - Member focused and quality-oriented interventions

Exhibit 1

Integrated Care Management



Obesity and Bariatric Surgery

- PMPM costs were high compared to the benchmark.
- No obesity related diagnoses were found in the high dollar claims report in 2007.
- The report that follows provides information about Bariatric Surgery Centers including 2007 cost differences between Bariatric Centers of Excellence and non-Centers of Excellence.

ETF Bariatric Procedures

ETF Bariatric Surgery History

In 2006 and 2007, ETF covered bariatric surgery for members in the WPS Standard Plan who met the medical necessity criteria in the WPS Bariatric Surgery Medical Policy. The Lap Band technique was not covered during 2006, but this coverage was added in 2007. Criteria for coverage of the Lap Band procedures are the same as the criteria for other bariatric procedures.

In 2007, based on concern about the variation in the cost of bariatric surgery and related complications, ETF asked WPS to create a Center of Excellence approach for Bariatric surgeries. The ETF Bariatric programs (hospital and surgeon combinations) are certified by CMS and the America Society of Bariatric Surgeons as a Center of Excellence (COE).

In response, WPS contracted in 2008 with the following programs that meet the COE criteria:

Aspirus Wausau Hospital, Wausau, WI
Bellin Health, Green Bay, WI
Columbia-St. Mary's, Milwaukee, WI
Elmbrook Memorial Hospital, Brookfield, WI
Froedtert Memorial Hospital, Milwaukee, WI
Gundersen Lutheran Medical Center, LaCrosse, WI
Meriter Hospital, Madison, WI (as part of UW designation - same surgeons)
Theda Clark Medical Center, Neenah, WI
University of Wisconsin Hospital, Madison, WI

ETF Bariatric Procedure Data

The following data summarizes and compares case costs using the Center of Excellence (COE) approach and Paid per Member per Month (PMPM) procedure costs. A comparison to a WPS book of business is also provided.

Although the numbers are small, it appears there maybe an economic advantage for ETF to continue pursuing a bariatric procedure center of excellence approach. ETF's PMPM is greater than WPS's book of business PMPM, and contributing factors are discussed.

Exhibit 2

STATE EMPLOYEE TRUST FUNDS
Bariatric Cost Per Case and PMPM
Incurred January 2007 - December 2007 Paid Through March 2008

	INPATIENT Bariatric Procedures		OUTPATIENT Bariatric Procedures	
	ETF	**WPS**	**ETF**	**WPS**
Center of Excellence				
Cost/Case (# of cases)	$30,172 (13)	$35,566 (18)	$14,578 (2)*	$21,258 (3)**
LOS	1.62	2.28	N/A	N/A
Non-Center of Excellence				
Cost/Case (#of cases)	$37,261 (9)	$33,230 (33)	$23,980 (4)	$14,960 (9)***
LOS	2.22	3.12	N/A	N/A
Combined Cost/Case (total # of cases)	$33,072 (22)	$34,054 (51)	$20,846 (6)	$16,535 (12)
Average LOS	1.86	2.82	N/A	N/A
Total Member Months	46,800	512,970	46,800	512,970
Incidence (patients/1000)	5.64	1.19	1.28	0.28
Total PMPM	$15.55	$3.39	$2.66	$0.39

Note: Costs calculated based on allowed amount.

Note: Book of WPS members with bariatric surgery benefit excludes ETF members. Costs did not include two outlier cases.

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

**** All procedures performed in hospital outpatient setting.**

***** Several surgeries performed at surgical centers.**

ETF Bariatric Procedures

Summary

- ETF's 2007 inpatient cost per case was almost 20% less at a COE when compared to a non-COE facility, and clearly demonstrates the economic advantage of a COE approach to bariatric surgery.

- ETF's 2007 outpatient cost per case was almost 40% less at a COE when compared to a non-COE. However outpatient data is limited to six cases and one of the COE procedures was a lap band revision (five members with six outpatient procedures).

- Cost per case for outpatient procedures is impacted by the treatment setting. Outpatient cost per case is less at surgical centers when compared to hospital based outpatient procedures, and provides ETF an opportunity for savings when lap band procedures are performed at surgical centers. These savings are driven by lower facility costs at surgical centers.

- ETF's 2007 PMPM is greater than the book of WPS members with a bariatric surgery benefit. Factors influencing these higher costs include:

    - 2007 ETF total incidence rate of 6.92 for bariatric surgery is almost five times the WPS book of business total incidence rate of 1.47 for bariatric surgery.
    - Fewer ETF members to allocate costs when compared to book of WPS business.
    - ETF members may use the WPS plan exclusively for bariatric procedures resulting in adverse selection. Many ETF members dis-enroll from the WPS plan at the end of the year following their bariatric procedure. During 2006, twenty five ETF members had bariatric surgery and 80% (20/25) termed with WPS by January 1, 2008. For 2007, twenty seven ETF members had twenty eight bariatric procedures and 41% (11/27) termed with WPS as of January 1, 2008.

Conditions Managed for High Cost Cases

- Behavioral health (MDC 19) PMPM was high compared to the benchmark.
- Inpatient behavioral health admissions appear to be responsible for this difference, and two members with Behavioral Health diagnoses accounted for 5% of the total high cots members (over $100,000).
- Cancer accounted for 40% (17/42) of high dollar cases and 49% of total high dollar claims.
- Breast cancer was the most prevalent type of cancer, accounting for 35% (6/17) of high dollar cancer diagnoses.
- All members with high dollar claims received intensive care management services.

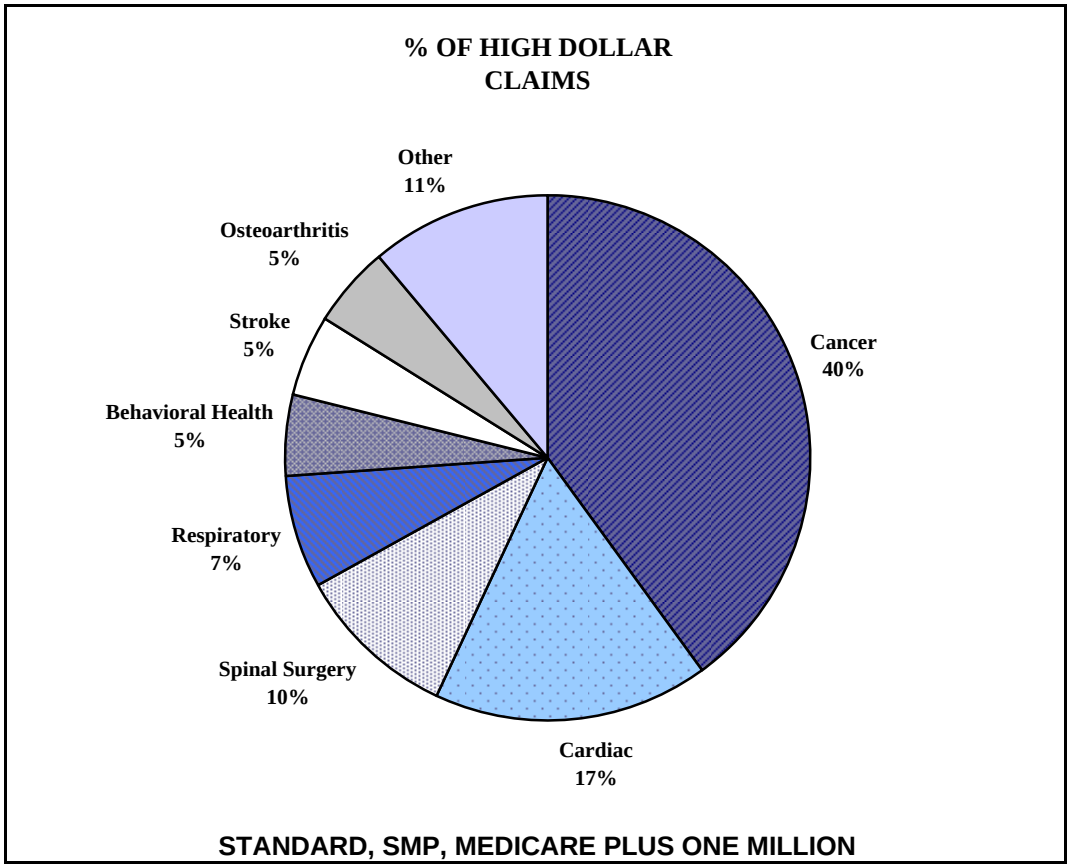
Exhibit 3

STATE EMPLOYEE TRUST FUNDS

Claims by Diagnosis

Incurred January 2007 - December 2007 Paid Through March 2008

Diagnosis	% of High Dollar Claims	% of Total Claims
Cancer	40.0%	49.0%
Cardiac	17.0%	16.0%
Spinal Surgery	10.0%	7.0%
Respiratory	7.0%	5.0%
Behavioral Health	5.0%	6.0%
Stroke	5.0%	6.0%
Osteoarthritis	5.0%	3.0%
Other	11.0%	8.0%



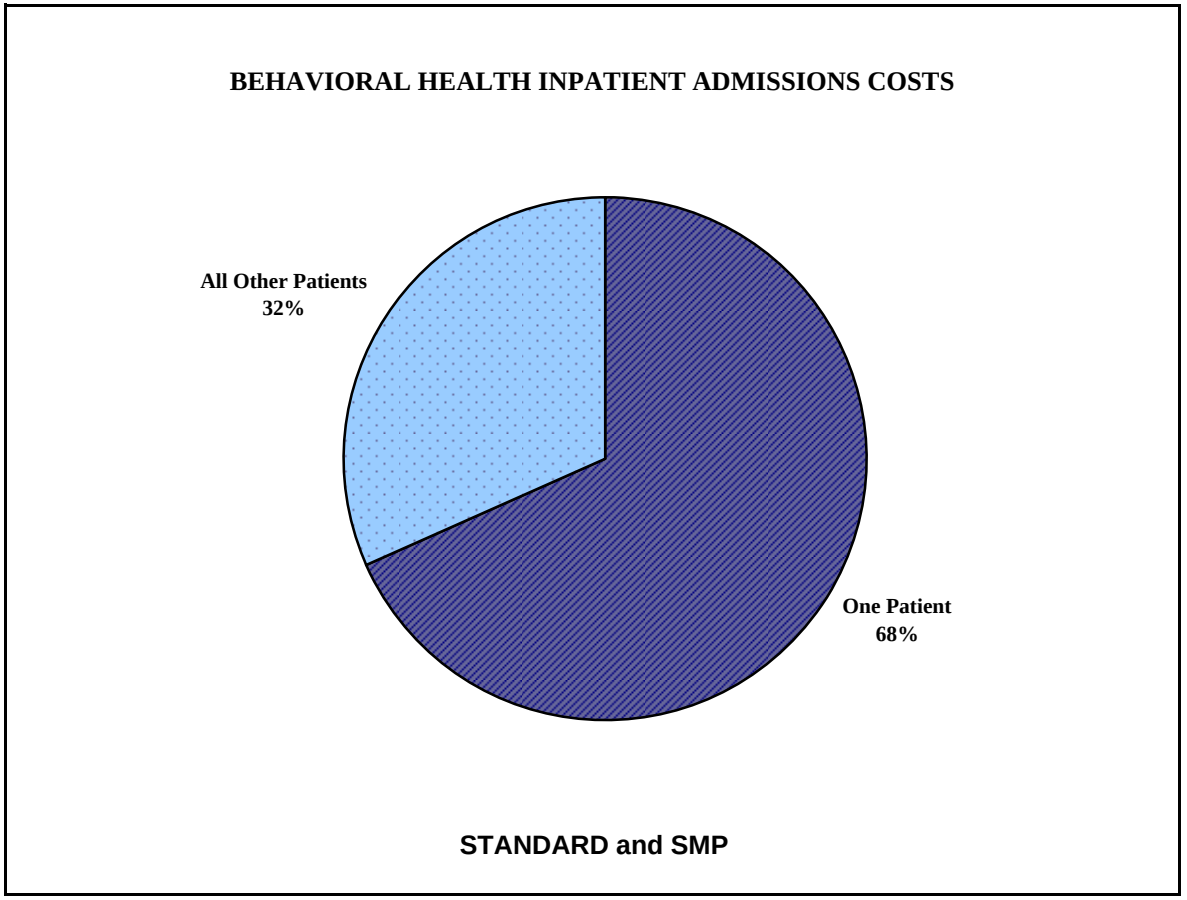
Behavioral Health Findings

- **Behavioral Health Management** provides both inpatient as well as outpatient reviews which are performed by individuals specifically licensed in the behavioral health field. All managed care services, including utilization management, case management, disease (chronic condition) management, and pre-authorization are performed by this team.
- Only 22 behavioral health inpatients admissions for ETF members in 2007.
- Behavioral health admissions represented 1% of total paid claims and 6% of high dollar claims (over $100K).
- One admission was 68% of inpatient behavioral health claims. This outlier admission occurred in early Q2; all days certified by MD psychiatric physician advisor; member case managed by one of our licensed clinical social workers. Member had an additional 45 day stay in Q4; claim recently received and not processed yet. Anticipate ongoing care and possible high costs for this member.
- Increase in PMPM cost for behavioral health was primarily due to this one outlier case.

Exhibit 4

STATE EMPLOYEE TRUST FUNDS
Behavioral Health Inpatient Admissions
Calendar Year 2007

	Paid Claims
One Patient	$304,000
All Other Patients	$141,000



Care Management Services

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

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

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

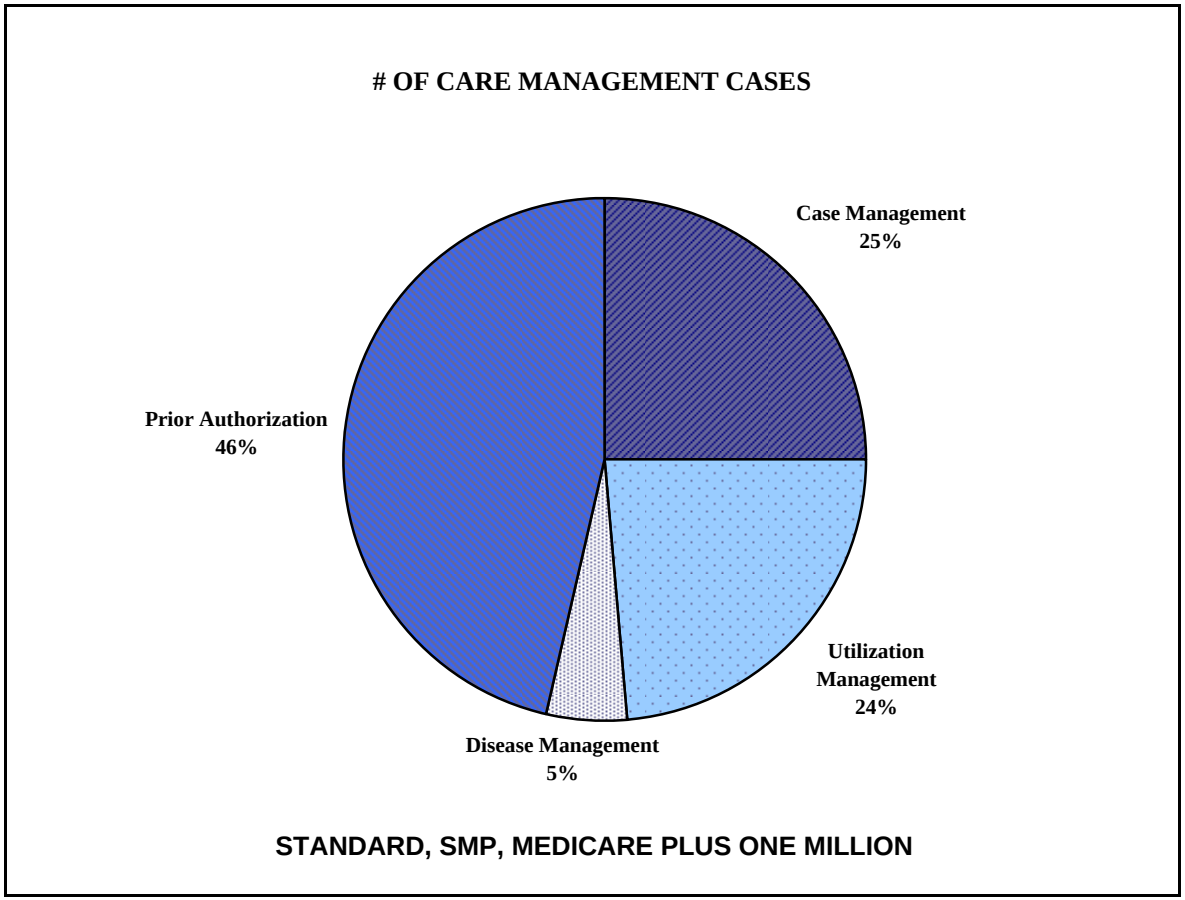
Preauthorization is the review of specific outpatient services, including surgical services, diagnostic services, and referral, and determination that these services meet the criteria for medical necessity under the member's benefit plan.

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

Exhibit 5

STATE EMPLOYEE TRUST FUNDS
Care Management Summary
Calendar Year 2007

Care Management Category	# of Cases
Case Management	430
Utilization Management	405
Disease Management	86
Prior Authorization	797



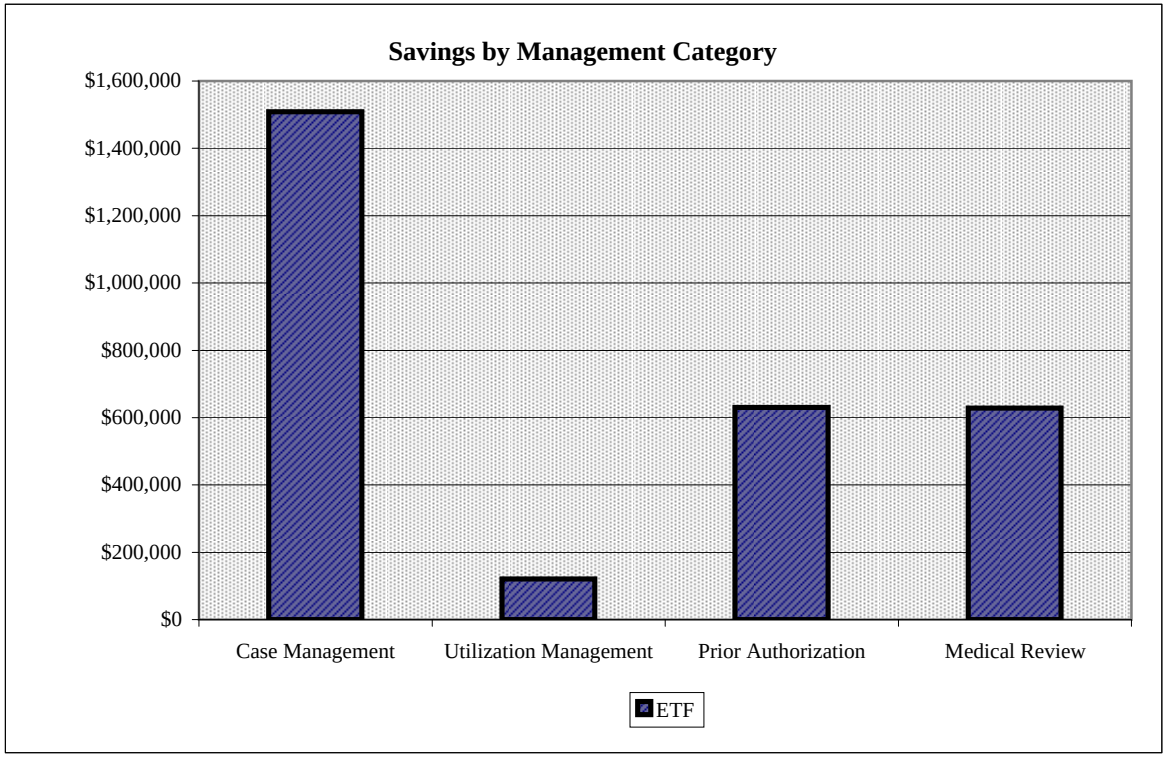
Care Management Savings

- In 2007, WPS Care Management saved ETF almost $2.3 million dollars, an increase of 12% compared to 2006.
- Savings are based on avoided hospital days, avoided/denied services, or negotiated rate reductions.
- Only hard savings are included – projected future (soft savings) from Chronic Condition (Disease) Management are not calculated.
- Not all Case Management results in dollar savings based on the above definition. Many cases are followed so that the most cost effective care possible is provided – for example a potential transplant case that is kept open for several months.

Exhibit 6

STATE EMPLOYEE TRUST FUNDS
Care Management Savings
Calendar Year 2007

Care Management Category	Savings
Case Management	$1,508,880
Utilization Management	$120,329
Prior Authorization	$630,748
Medical Review	$628,403



Health Status Measures – HSM

Health Status Measures (HSM) are a predictor of members at risk for additional care and related costs. Our predictive modeling tool helps improve the effectiveness and productivity of our case and disease managers by identifying at-risk members before their conditions and costs escalate. This enables us to enroll members in Case and Chronic Condition Management programs at a much earlier stage.

The software uses multiple technologies, including severity indices. One of these indices, Burden of Illness (BOI), ranks members based on severity and complications. These scores are categorized into HSM's. Members with high scores of 7 to 10 are identified and screened for chronic condition management. Those with low HSM scores are provided self management guides via quarterly mailing.

Exhibit 7

STATE EMPLOYEE TRUST FUNDS

HSM Table

Calendar Year 2007

HSM Severity Score	Members with			
	Asthma	Diabetes	Hypertension	Heart Disease
10	2	3	2	2
9	2	3	1	1
8	2	6	8	4
7	4	6	9	2
6	3	7	9	3
5	14	25	48	12
4	27	55	105	16
3	32	34	141	14
2	38	38	134	13
1	55	51	139	12
Total	**179**	**228**	**596**	**79**

Chronic Condition (Disease) Management

The Chronic Conditions managed for ETF are: Asthma, Congestive Heart Failure, Coronary Artery Disease (which includes Hypertension and High Cholesterol), Diabetes, Neonatal, Alcohol & Drug Abuse, & Depression. (Note: Members enrolled in the Great Beginnings High Risk Prenatal program were managed under Case Management in 2007).

New in 2008, is our opt-out program. Members identified for case or disease management are offered the opportunity to participate in our program and must decline either verbally or in writing if they chose not to participate.

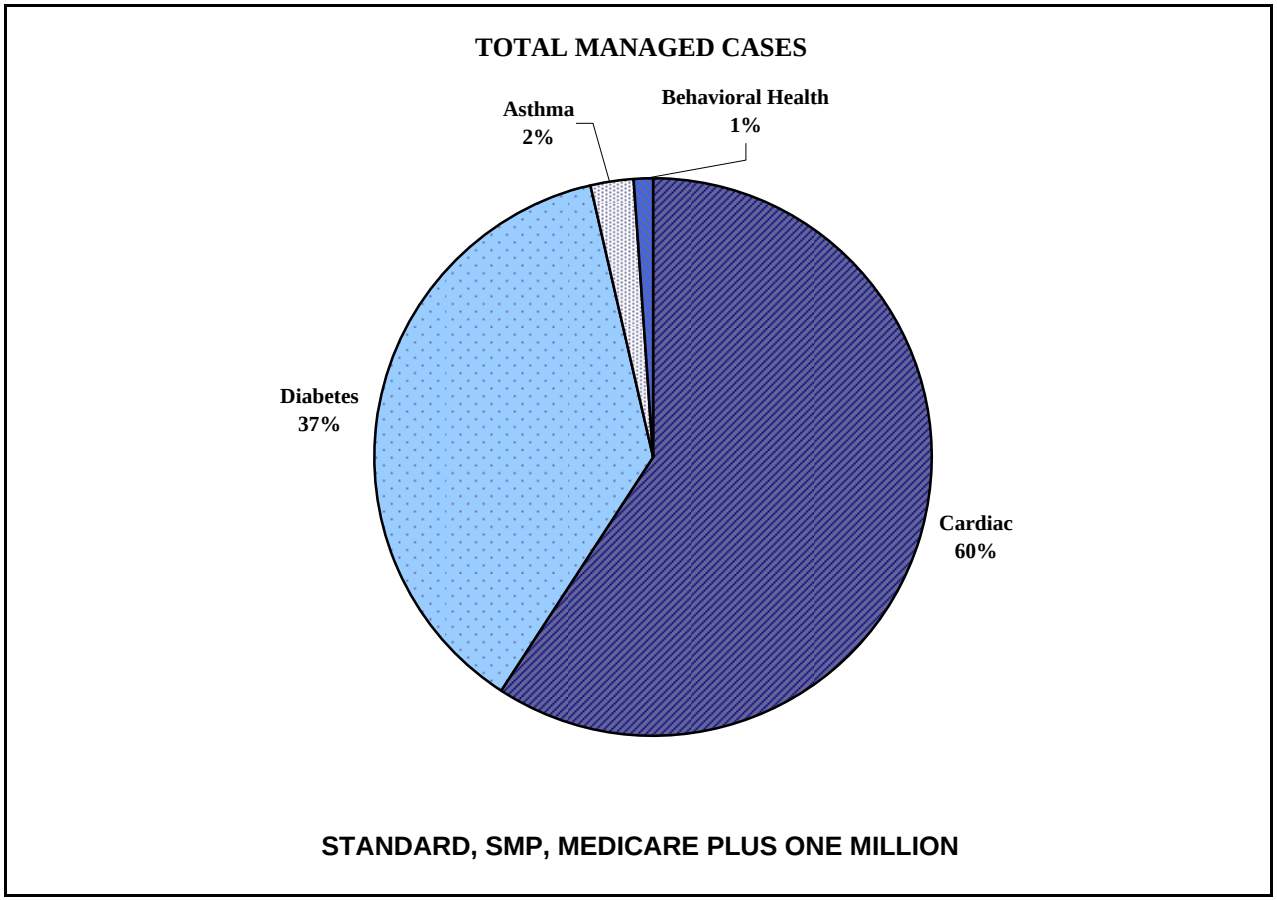
The Chronic Condition Management process starts with an introductory letter followed by two phone contacts. If member has no listed phone number, a second letter is sent. If no response from the member to opt-out, they are transferred to our mailing queue and receive disease specific information on a quarterly basis.

In 2007, ETF members with cardiac and diabetic conditions received the majority of our chronic condition management services.

Exhibit 8

STATE EMPLOYEE TRUST FUNDS
Chronic Conditions - Managed Cases
Calendar Year 2007

Chronic Conditions	Open Cases	Closed Cases	Total Cases
Cardiac	21	30	51
Diabetes	10	22	32
Asthma	0	2	2
Behavioral Health	0	1	1



Quality Measures for Chronic Conditions and Health Screening

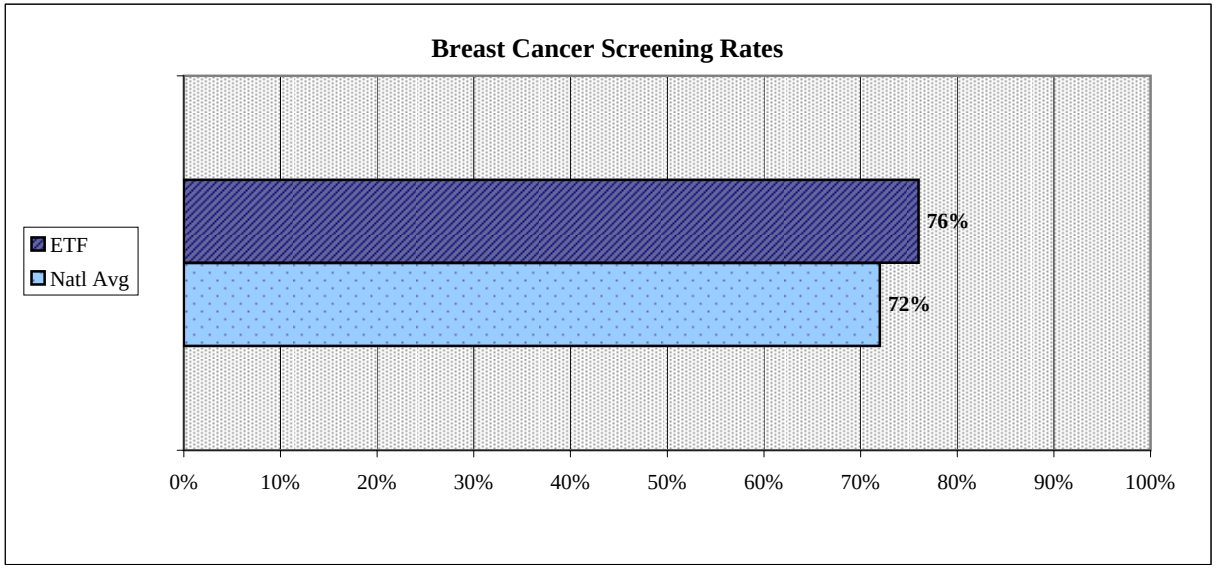
- Performance measures provide information about a provider's quality of clinical care. New for 2007 were a limited number of quality measures for preventive health screening and chronic condition management.
- The breast cancer screening rate for women ages 52 to 69 who received a mammogram within the past two years (2006-2007) was above the national average.
- Screening rate for cervical cancer for women ages 21 to 64 who received a Pap test within the past two years (2006-2007) was below the national average; however the optional exclusion for women who had a hysterectomy was not taken, and the denominator maybe overstated.
- Quality measures for ETF's diabetic population included rates for HbA1c and LDL-C testing in 2007. These screening rates were below the national average, and provide an opportunity for improving the effectiveness of care for diabetic members.
- Opportunities to provide quality measures is currently limited, but additional quality measures for chronic conditions and preventive health screening will be available for 2008 data. A partial listing of these quality measures is included.

Exhibit 9-A

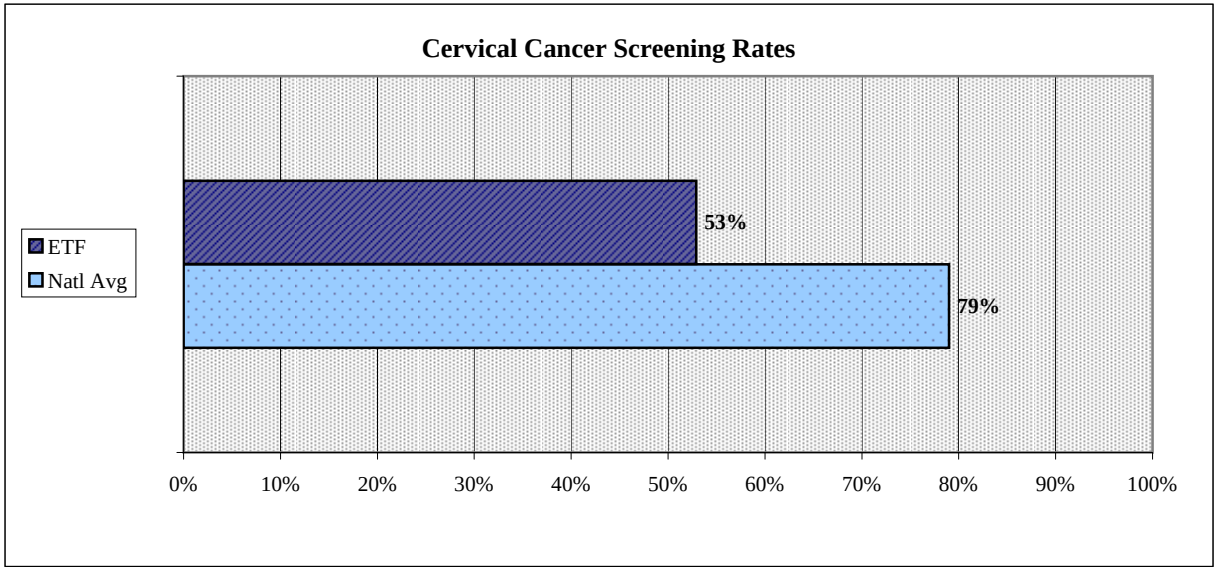
STATE EMPLOYEE TRUST FUNDS

Screening Rates

Calendar Years 2006 and 2007



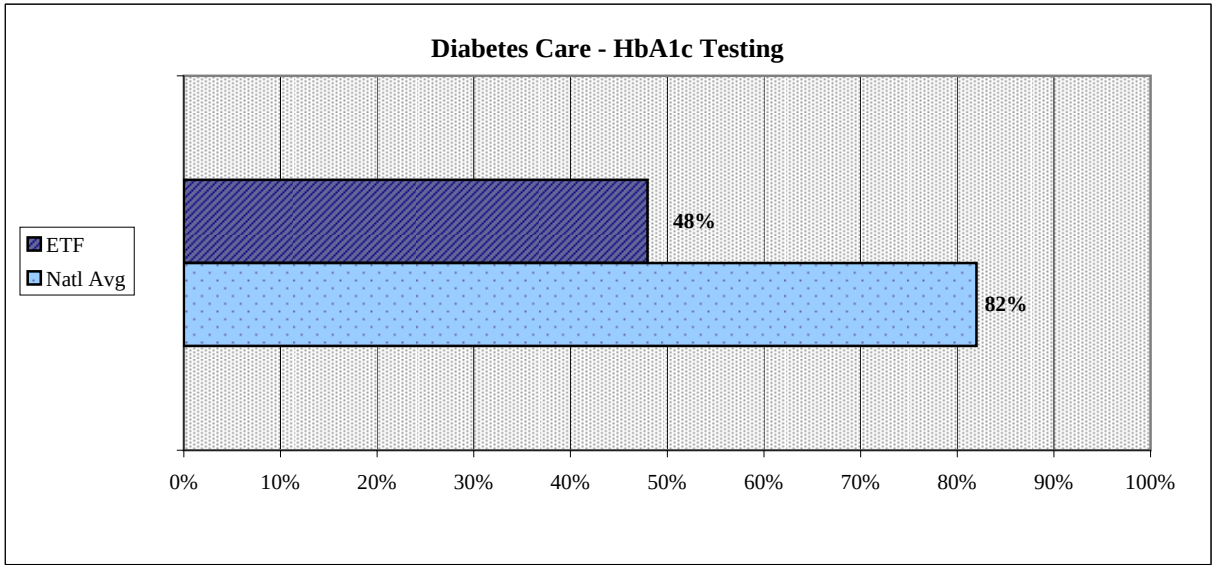
*** Percentage of Women Ages 52-69 with a Mammogram in 2006 or 2007**



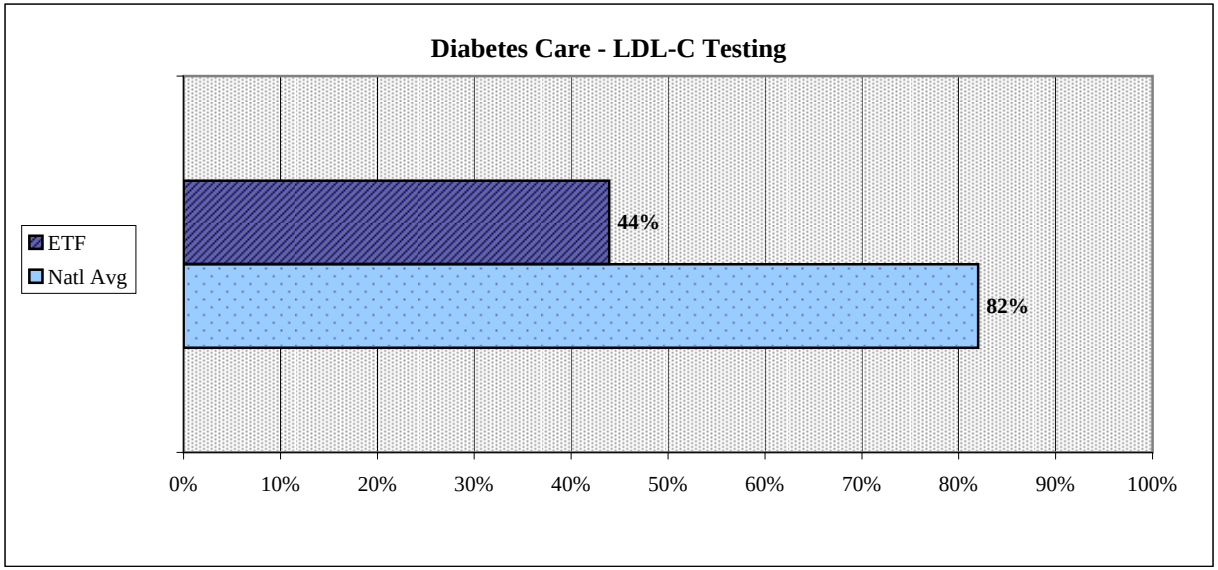
*** Percentage of Women Ages 21-64 with a Pap Test in 2006 or 2007**

Exhibit 9-B

STATE EMPLOYEE TRUST FUNDS
Diabetes Measures
Calendar Year 2007



*** Percentage of Diabetics ages 18-75 with a HbA1c Test in 2007**



*** Percentage of Diabetics ages 18-75 with an LDL-C Test in 2007**

Available Quality Measures (Partial Listing)

Asthma Care Management:

- Members 5-40 years old with an office visit for asthma care in the last 12 reported months (or 6 months).
- Members with presumed persistent asthma.
- Members with presumed persistent asthma using an inhaled corticosteroid or acceptable alternative.
- Members exhibiting problematic asthma control who had a specialty consult in last 12 months.
- Members taking theophylline with annual serum theophylline level test.
- Members using a long-acting beta2-agonist inhaler in combination with an inhaled corticosteroid.
- Members compliant with theophylline (compliance >= 70%).
- Members compliant with leukotriene modifier (compliance >= 70%).

Cardiovascular Care Management:

- CAD Members hospitalized with acute myocardial infarction taking a beta-blocker at admission or within 7 days of discharge.
- CAD Members with prior myocardial infarction prescribed beta blocker during measurement year.
- CAD Members with myocardial infarction in the past currently on beta blockers.
- CAD Members with an LDL cholesterol test in the report period.
- CHF Members prescribed ACE-inhibitor or angiotensin II receptor antagonist treatment during measurement year.
- CHF Members currently taking an ACE-inhibitor or acceptable alternative.
- CHF Members prescribed beta-blocker therapy during measurement year.
- CHF Members currently taking a beta-blocker.

Note: Quality measures available first quarter 2009, for 2008 data.

Care Management Satisfaction

Satisfaction Rating: 97%

Satisfaction Survey Comments:

- This was an excellent, highly professional, and personally friendly service - much appreciated!
- Carla was the most professional, compassionate, knowledgeable, yet always an advocate for the best possible solution for my care within the insurance guidelines. She is a true gem.
- I was very impressed that this service is provided and with the quality and personal attention provided.
- Our care manager, Rhonda, was extremely professional and proficient. She went out of her way to help us through this stressful time.
- What a wonderful service your insurance company provides! Rosalynn was my biggest cheerleader and is one of the reasons I made such wonderful progress. Rosalynn also provided me with pamphlets and reading material to maintain a healthy heart. I have never had an insurance company that followed my care postop. All I can say is that it is a great program to provide for those you insure. My thanks!
- Ann was outstanding! She was an amazing support! She called to check on me often, I truly appreciated her guidance and support. Wonderful program!!
- Virgie, I cannot thank you enough, you saved my life. I want to thank you in greater detail when I can.

Wellness and Prevention Programs

Included in the WPS Integrated Care Management programs is a Comprehensive Wellness initiative that was launched in 2008.

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

A ***free online health encyclopedia*** from Healthwise. The Healthwise® Knowledgebase contains more than 3,200 evidence-based topics on health conditions, medical tests and procedures, medications, and everyday health and wellness issues.

HealthSense Rewards™, a WPS program that provides discounted access to a variety of health clubs, weight-management centers, and other wellness resources.

Health and Wellness Newsletter (PDF versions or disc) are on a bi-monthly basis ***available through the WPS Member Health Center portal***.

Health and Wellness Community Resource Guide (PDF versions or disc) that refers ETF employees to approximately 200 local organizations, helping you to further enhance your worksite wellness program.

Weekly / Monthly email Wellness Tips (available on disc or word document) specific to ETF needs (Nutrition and Weight Management, General Wellness and/or Physical Activity)***.***

Wellness Services available at cost:

Health Risk Appraisal
This is available on-line or in paper format. Administered by WPS Wellness staff and provided through Staywell. WPS Staff will present the results in an aggregate form as well as individually to the employees during a 10-15 minute coaching session. ***This is offered for an additional fee based on whether it is online or paper.***

Biometric Screening ***This service is billed at cost and arranged through local providers.***

Wellness Coaching Sessions
Telephonic and on-line wellness coaching sessions can be purchased for an additional fee.