AGENDA AND NOTICE OF MEETING

State of Wisconsin
Group Insurance Board Meeting
Tuesday, February 17, 2009
9:30 a.m.

Holiday Inn
1109 Fourier Drive
Madison, Wisconsin

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

Times shown are estimates only.
Denotes action item.

Time	Action	No.	Item
9:30 a.m.	✓	1.	**Consideration of Minutes of November 11, 2008, Meeting**
9:35 a.m.	✓	2.	**Election of Officers**
9:40 a.m.	✓	3.	**Health Insurance** ➢ Guidelines/Uniform Benefits Timeline & Discussion ➢ Cost and Quality Project Update ➢ Dual-Choice Enrollment Statistics ➢ Report on Health Plan Employer Data and Information Set (HEDIS®) and Consumer Assessment of Health Plans Survey (CAHPS®) ➢ Standard Plan Audit ➢ Consideration of Proposal to Develop Prescription Drug Plan (PDP) ➢ Enrollment Validation Payment (EVP) Project
10:30 a.m.	✓	4.	**Income Continuation Insurance (ICI)** ➢ Consideration of Proposed Change to the ICI Plan on Determining Monthly Earnings
10:40 a.m.	✓	5.	**Life Insurance** ➢ Actuary's Determination of Other Post-Employment Benefits (OPEB) Liability and Related Contract Modifications
10:50 a.m.	✓	6.	**Consideration of Payroll Deduction Authorization for Legal Services Plan**
11:00 a.m.		7.	**Miscellaneous** ➢ Legislative Update ➢ Budget Update ➢ 2009 Meeting Date Card ➢ Correspondence and Complaint Summary ➢ Local Employers Joining or Leaving the Wisconsin Group Health and Income Continuation Insurance Programs as of 12/31/2008 ➢ Pending Appeals Status Report ➢ Future Items for Discussion

11:15 a.m. 8. Adjournment

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

MINUTES OF MEETING

STATE OF WISCONSIN
GROUP INSURANCE BOARD

Tuesday, November 11, 2008

Holiday Inn
1109 Fourier Drive
Madison, Wisconsin

BOARD PRESENT:
Cindy O'Donnell, Vice-Chair
Esther Olson, Secretary
Robert Baird
Janis Doleschal
Jennifer Donnelly
Eileen Mallow
Gary Sherman

BOARD ABSENT:
Stephen Frankel, Chair
Martin Beil
David Schmiedicke

PARTICIPATING ETF STAFF:
Dave Stella, Secretary
Bob Conlin, Deputy Secretary
Tom Korpady, Administrator, Division of Insurance Services
Sharon Walk, Group Insurance Board Liaison
Rob Weber, Chief Legal Counsel

OTHERS PRESENT:
Kathryn Beals, Dean Health Plan
Marcia Blumer, Division of Insurance Services
Penny Bound, Dean Health Plan
Andrea Darling, United Health Care
Liz Doss-Anderson, Division of Management Services
Elizabeth Dye, Group Health Cooperative
Lisa Ellinger, Division of Insurance Services
Kjirsten Elsner, Minnesota Life Insurance Company
Ralph Epifanio, Anthem Blue Cross Blue Shield
Colleen Evans-Carter, Compcare Blue
Cindy Gilles, Division of Management Services
David Grunke, Wisconsin Physicians Service Insurance Corporation
Ross Hampton, Wisconsin Education Association Trust
Carrie Helms, Network Health Plan
Kathy Ikeman, Unity Health Insurance
Sari King, Division of Retirement Services
Bill Kox, Director, Health Benefits and Insurance Plans Bureau
Jon Kranz, Office of Internal Audit and Budget
Bill Kumpf, Senior Care Insurance
Arlene Larson, Division of Insurance Services
Greg Nelson, Wisconsin Physicians Service Insurance Corporation

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Paul Ostrowski, Office of State Employment Relations
Tom Pabich, Navitus
Ryan Pelz, Mercy Care
Paul Perkins, Group Health Cooperative
Chris Schmelzer, Minnesota Life Insurance Company
Ron Sebranek, Physicians Plus Insurance Corporation
Terry Seligman, Navitus
Mel Sensenbrenner, State Engineers Association
Sonya Sidky, Division of Insurance Services
Joan Steele, Division of Insurance Services
Jill Thomas, Office of State Employment Relations
John Verberkmoes, American Federation of Teachers-Wisconsin
Betty Wittmann, Division of Insurance Services

Cindy O'Donnell, Vice-Chair, Group Insurance Board (Board), called the meeting to order at 9:30 a.m.

ANNOUNCEMENTS

Update on Rhonda Dunn Dave Stella, Secretary, shared with Board members that Rhonda Dunn remained in the hospital and that he will send updates as they become available.

Indroduction of New Staff Member Tom Korpady, Administrator, Division of Insurance Services, introduced Cindy Gilles. Cindy will assist with the Group Insurance Board meetings and is the new Board Liaison for the Retirement boards.

CONSIDERATION OF MINUTES OF AUGUST 26, 2008, MEETING

MOTION: Ms. Mallow moved approval of the minutes of the August 26, 2008, meeting as submitted by the Board Liaison. Ms. Olson seconded the motion, which passed without objection on a voice vote.

CONSIDERATION OF SURVIVING INSURED DEPENDENT RULE

Rob Weber, Chief Legal Counsel, discussed the final draft report on the "Surviving Insured Dependent Rule (Clearinghouse Rule #08-079)" with the Board. This rule will repeal and recreate Wis. Admin. Code § ETF 40.01. Under the current law, surviving insured dependents have up to 90 days after the death of the insured employee (or annuitant) to apply to continue their health insurance coverage. After the Department sends out the standard packet of materials relating to death benefits, a surviving dependent will have 30 days to apply for health insurance coverage. This exception will address both customer service and Department work-load issues by reducing or eliminating interruptions in coverage for surviving dependents.

MOTION: Ms. Olson moved approval of the final draft of the Surviving Insured Dependent Rule for submission to the Legislature. Ms. Mallow seconded the motion, which passed without objection on a voice vote.

GATEWAY VENTURES, INC., PRE-PAID LEGAL SERVICES PROPOSAL

Mr. Korpady informed the Board that Martin Beil was unable to attend this meeting and that he asked that the Board delay consideration of this item until the next meeting.

MOTION: Ms. Donnelly moved to delay consideration of the Pre-Paid Legal Services Proposal until the next Board meeting. Ms. Olson seconded the motion, which passed without objection on a voice vote.

MISCELLANEOUS

Budget Update Bob Conlin, Deputy Secretary, provided an update on the FY 2009-2011 Department biennial budget proposal. He reviewed the October 28, 2008, memo written by Jon Kranz, Director, Office of Internal Audit and Budget. Items that affect the Group Insurance Board include:

- Flexibility to modify Uniform Benefits for inclusion of wellness incentives without having to reduce other benefits;
- Increased authority to contract for data collection and analysis services;
- Removal of the requirement for state agencies to obtain approval for optional employee-pay-all-benefits; and
- Flexibility to allow the Board to determine long-term care benefits.

The Board discussed the Department's budget proposal.

Dual-Choice Update Mr. Korpady updated the Board on the Department's efforts to inform members about the changes in the health insurance program, especially those located in western Wisconsin, both prior to and during the Dual-Choice period

Items for Future Discussion Mr. Korpady thanked the Board members for attending today's meeting and discussed the fact that the agenda was very short. He asked the Board if they would like to consider holding meetings that have limited agendas via Teleconference. The Board members indicated that, as long as there are no appeals and nothing controversial to discuss, they would have no objection to conducting the meeting via teleconference.

Mr. Korpady referred members to the informational reports in their binders.

ADJOURNMENT

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

The Board adjourned at 10:03 a.m.

Dated Approved: ___________________________

Signed: __________________________________
Esther Olson, Secretary
Group Insurance Board

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

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CORRESPONDENCE MEMORANDUM

DATE: January 30, 2009

TO: Group Insurance Board

FROM: Sharon Walk
Board Liaison

SUBJECT: Election of Officers

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

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

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

Enclosure/Roster

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

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Signature Date

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GROUP INSURANCE BOARD

MEMBERSHIP ROSTER

MEMBER NAME	TERM BEGAN	TERM EXPIRES	MEMBERSHIP REQUIREMENTS
Baird Robert	05/07/2007 (5/03-5/07)	05/01/2009	§ 15.165 (2) 2-year term Appointed by Governor. Insured participant who is an employee of a local unit of government.
Beil Martin	05/08/2007 (10/83-5/07)	05/01/2009	§ 15.165 (2) 2-year term Appointed by Governor. Insured participant in WRS who is not a teacher.
Vacant			§ 15.165 (2). 2-year term Appointed by Governor. Chief executive or member of the governing body of a local unit of government that is a participating employer in the WRS.
Doleschal Janis	05/08/2007 (5/05-5/07)	05/01/2009	§ 15.165 (2) 2-year term Appointed by Governor. Insured participant in WRS who is a retired employee.
Donnelly Jennifer	03/21/07	Ex Officio	§ 15.165 (2). Ex Officio Director of the Office of State Employment Relations or his/her designee.
Frankel Steve (C)	05/08/2007 (7/88-5/07)	05/01/2009	§ 15.165 (2). 2-year term Appointed by Governor. No membership requirement.
Mallow Eileen	09/18/2006	Ex Officio	§ 15.165 (2) Ex Officio Commissioner of Insurance or his/her designee.
O'Donnell Cindy (V)	10/12/2005	Ex Officio	§ 15.165 (2) Ex Officio Attorney General or his/her designee.
Olson Esther (S)	05/09/2007 (5/01-5/07)	05/01/2009	§ 15.165 (2). 2-year term Appointed by Governor. Insured participant in WRS who is a teacher.
Schmiedicke David	11/14/2003	Ex Officio	§ 15.165 (2) Ex Officio Secretary of Dept. of Administration or his/her designee.
Sherman Gary	1/24/2005	Ex Officio	§ 15.165 (2) Ex Officio Governor or his/her designee.

(C) – Chair (V) – Vice-Chair (S) – Secretary

MAILINGS FOR BOARD MEMBERS SHOULD BE SENT TO:

Group Insurance Board
c/o Board Liaison
Department of Employee Trust Funds
PO Box 7931
Madison WI 53707-7931
Phone (608) 267-2417

STATE OF WISCONSIN
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CORRESPONDENCE MEMORANDUM

DATE: January 23, 2009

TO: Group Insurance Board

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

SUBJECT: GUIDELINES/Uniform Benefits – Timeline and Discussion Regarding Contract Changes and Clarifications for Year 2010

This memo is informational only. No Board action is necessary.

In the past, a staff discussion group has developed recommendations for changes to the GUIDELINES and Uniform Benefits for the next contract year. Recently, Board members or their designated staff have also participated. Should the Board wish to continue this process for contract year 2010, we are providing the following information on the expected issues and timelines for the development of the GUIDELINES.

The anticipated timeline for the 2010 contract is as follows:

- With the input of the Board's actuary, staff establishes preliminary recommendations for changes/clarifications for the 2010 contract year. The health plans have been asked to identify any issues that warrant clarification in the GUIDELINES or Uniform Benefits by February 2.

- On or about February 24, an Employee Trust Funds (ETF) staff discussion group will meet to identify issues to be included in the first draft of the GUIDELINES.

- On or about February 27, ETF will send health plans a draft of the 2010 GUIDELINES/ Administrative Provisions and Uniform Benefits. Health plans will have until March 5 to return their comments on the draft.

- On or about March 10, the discussion group will meet to finalize recommendations to the Board. The discussion group's deadline for finalizing its recommendations is March 20.

- The recommendations are set for approval at the Board's April 14 meeting.

The following briefly summarizes several issues for the 2010 contract that may be reviewed during this process. Participants, health plans or staff members have raised these issues over the course of the past year. We also welcome any comments or suggestions from the Board.

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

_______________________________________ ____________
Signature Date

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

Possible Changes to Administration:

- Potential modifications may be required if the Voluntary Data Sharing Agreement (VDSA) for a Medicare prescription drug plan (PDP) is adopted.
- Consider incorporating Federal Centers for Medicare and Medicaid Services policy that went into effect in October 2008, in which payments are withheld from hospitals for care associated with treating certain infections and medical errors.
- Modify language describing the calculation of the Medicare-reduced rate. Some health plan rates could be lower based on experience. The challenge in the past has been attaching credibility to the experience, and we continue to work with the Board's actuary to address this.

Possible Changes to Eligibility/Enrollment:

- Potential modifications may be required following an Administrative Rule change for surviving dependents to continue coverage.
- Clarify that the addition of a dependent due to a National Medical Support Notice or establishment of paternity will create an opportunity to switch health plans.
- Consider requiring that the application to add an eligible dependent be filed in a timely fashion. Currently, all eligible dependents are covered when family coverage is in effect, regardless of when the application is filed to add a newly eligible dependent. Now, ETF has the administrative capabilities to require subscribers to complete an application within the time period as defined by law.

Possible Changes to the Local Contract:

- Tighten the 65% participation waiver allowances for new groups joining the health insurance program when in conflict with group underwriting requirements.
- Review the percentage range of savings for the deductible option rate.

Possible Changes to Benefits:

- Update as needed due to Federal Mental Health Parity that includes treatment for alcohol and other drug abuse (AODA).
- Update as needed to make benefits covered if mandates are passed before the bidding process is complete.
- Consider the following benefit additions:
  - Providing coverage for dental implants
  - Providing coverage for bariatric surgery
  - Providing coverage for acupuncture
  - Removing the exclusion for treatment of flexible flat feet
- Suggestions for ways to free up dollars if needed to offset benefit additions:
  - Increase copayment for emergency room visits
  - Increase copayment for prescriptions

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CORRESPONDENCE MEMORANDUM

DATE: January 28, 2009

TO: Group Insurance Board

FROM: Sonya Sidky, Project Manager
Division of Insurance Services

SUBJECT: 2009 Dual-Choice Enrollment Results

This report is for information only. No Board action is required.

This memo highlights and explains major shifts in participant enrollment during the 2009 Dual-Choice enrollment period. Attached are various 2009 Dual-Choice statistical charts for total contracts, active state employees, state retirees and continuants, graduate assistants and continuants, and local employees, retirees and continuants. These charts provide December 2008 and January 2009 contract counts and the number of Dual-Choice applications that were filed, by health plan. The number of contracts gained or lost by health plan is broken down by coverage type (single and family). The percentage change in total contracts for each plan is included.

Summary of Changes in Health Plans

The change in contract counts from December 2008 to January 2009 is largely a result of subscribers changing health plans during the Dual-Choice enrollment period. However these numbers also reflect other changes, such as health insurance cancellations and new coverage. Note that this year there were fewer changes in health plans made than any other year in recent history. This may largely be due to the trend for health plans to expand their provider network offerings to stay competitive with other health plans and retain their membership and at the same time maintain contracts with existing providers. Members have less reason to switch health plans than in the past because they are able to continue accessing their providers through their current health plan at relatively the same cost, since there were no tiering changes for 2009. The main geographic area in which members had a reason to switch health plans in order to gain access to more providers is in the western part of the state. For example, SMP added providers along the Minnesota and Michigan borders and the adjacent counties in Wisconsin. Another example is that Health Tradition expanded into the region by adding Luther Midelfort and Red Cedar Medical Center systems for 2009 and gaining contracts from GHC-Eau Claire. Each year contracts shift between health plans in the local program due to changes in which health plan is the low-cost health plan in the county.

Dual Choice Applications Submitted for 2009

There were 42% fewer Dual-Choice applications submitted for 2009 (3,362) than there were for 2008 (5,772). Approximately 3,362 applications were submitted during the Dual-Choice enrollment period, of which 2,824 switched health plans and 711 switched coverage types. Of the 711 family type changes, 538 remained in the same health plan.

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

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Signature Date

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The breakdown of applications submitted by employee type is as follows:

Active state employees accounted for 59.2% (1,991) of the applications.
State retirees and continuants accounted for 15.8% (531) of the applications.
Local employees, retirees and continuants accounted for 20.4% (686) of the applications.
Graduate assistants and continuants accounted for 4.6% (154) of the applications.

Another 420 policy holders that did not submit a Dual Choice application were automatically switched from the WPS Patient Choice plans into WPS Metro Choice.

CHANGES IN HEALTH PLANS

- Anthem has developed a new network in Northeast Wisconsin available in Brown, Fond du Lac, Manitowoc, Marinette, Outagamie, Shawano, Sheboygan, Waupaca and Waushara Counties. Anthem has additional providers in Calumet, Door, Kewaunee, Oconto and Winnebago Counties.

- WPS Patient Choice Plans 1 and 2 have combined and are now called WPS Metro Choice. Members enrolled in either of these plans were automatically enrolled in WPS Metro Choice unless a Dual-Choice application was submitted. WPS Metro Choice is a Tier 1 preferred provider plan.

FAMILY TYPE CHANGES AND HEALTH INSURANCE CANCELLATIONS

Of the 3,362 Dual-Choice applications filed, 711 (21%) included coverage level changes. There were more subscribers who increased their level of coverage from single to family (416) than there were subscribers who decreased coverage from family to single (283). There were 361 subscribers who decided to cancel their health insurance coverage effective 12/31/2008.

HEALTH MAINTENANCE ORGANIZATIONS (HMO) CONTRACTS GAINED AND LOST

HMOs that gained the greatest number of contracts include:

- Health Tradition had a net increase of 395 contracts (18.9%). The majority of the contracts were gained from GHC-Eau Claire (358). Health Tradition added the Luther Midelfort and Red Cedar Medical Center systems for 2009 and expanded into Barron, Chippewa, and Eau Claire Counties as a qualified health plan and into Dunn, Sauk, and St.Croix Counties as a non-qualified health plan.

- The State Maintenance Plan (SMP) had a net increase of 168 contracts (204.9%) increase. The majority of the contracts were gained from the Standard Plans (87) and Humana Western (52). Members in the Western area of the state voiced concern that they did not have a tier 1 option with enough providers along the western border and into Minnesota and Michigan. Staff responded by working with WPS to expand the SMP network in the region. For 2009, SMP was newly added to Crawford and Pierce Counties.

- Humana Eastern had a net increase of 161 contracts (2.0%).

- Unity UW Health had a net increase of 116 contracts (0.9%).

HMOs that lost the greatest number of contracts include:

- GHC-Eau Claire had a net decrease of 327 contracts (5.8%). The majority of contracts that were lost switched to Health Tradition (358).

- The Standard Plans had a net decrease of 242 contracts (2.5%). The majority of contracts that were lost switched to SMP (87) and Humana Eastern (47).

- Anthem BCBS Northwest had a net decrease of 145 contracts (32.4%). The majority of contracts that were lost switched to GHC-Eau Claire (55), Humana Western (44), and SMP (29).

CONTRACT SHIFTS BETWEEN HEALTH PLANS

Of the 2,824 contract shifts between plans, the major shifts were as follows:

- 358 switched from GHC-Eau Claire to Health Tradition (169 are locals; 98 are active state contracts; and 91 are retiree and continuant contracts).

- 87 switched from the Standard Plan to SMP (83 are active state contracts).

- 86 switched from Dean to Unity-UW Health (69 are active state contracts).

- 85 switched from Anthem BCBS Southeast to Humana Eastern (76 are active state contracts).

- 66 switched from GHC-SCW to Unity-UW Health (39 are active state contracts; 21 are graduate assistant contracts).

- 66 switched from Physicians Plus to Unity-UW Health (41 are active state contracts).

- 62 switched from Unity-UW Health to Physician's Plus (46 are active state contracts).

- 61 switched from Physicians Plus to Dean Health Plan (36 are local contracts and 21 are active state contracts).

- 55 switched from Anthem BCBS Northwest to GHC-Eau Claire (33 are active state contracts and 15 are retiree contracts).

- 54 switched from Dean Health Plan to Physicians Plus (39 are active state contracts).

Attachments:

Table 1: 2009 Dual-Choice Statistics All Contracts: New Coverage, Old Coverage and Net Change in Contracts by Health Plan

Table 2: 2009 Dual-Choice Statistics—Active State Employees

Table 3: 2009 Dual-Choice Statistics—Local Employees, Retirees and Continuants

Table 4: 2009 Dual-Choice Statistics—Graduate Assistants and Continuants

Table 5: 2009 Dual-Choice Statistics—State Retirees and Continuants

Table 1: 2009 Dual-Choice Statistics All Contracts: New Coverage, Old Coverage and Net Change in Contracts by Health Plan

NEW COVERAGE	SINGLE	FAMILY	GRAD SINGLE	GRAD FAMILY	MED SINGLE	MED FAMILY 1	MED FAMILY 2	Total
ANTHEM BCBS NORTHEAST	11	18	0	0	1	0	0	**30**
ANTHEM BCBS NORTHWEST	3	1	0	0	1	1	0	**6**
ANTHEM BCBS SOUTHEAST	23	45	3	2	2	1	0	**76**
ARISE HEALTH PLAN	17	51	0	0	1	2	0	**71**
DEAN HEALTH PLAN	142	209	5	8	3	7	1	**375**
GHC EAU CLAIRE	51	96	0	1	6	3	4	**161**
GHC-SCW	44	67	30	22	1	0	1	**165**
GUNDERSEN LUTHERAN	28	46	2	0	1	1	0	**78**
HEALTH TRADITION	117	277	1	0	6	14	30	**445**
HUMANA EASTERN	94	179	6	6	15	5	12	**317**
HUMANA WESTERN	18	53	0	0	5	2	2	**80**
MEDICAL ASSOCIATES HEALTH PLAN	6	17	0	0	1	0	0	**24**
MERCYCARE HEALTH PLAN	6	11	0	0	0	0	1	**18**
NETWORK HEALTH PLAN	37	56	0	0	2	0	1	**96**
PHYSICIANS PLUS	67	112	4	7	9	7	6	**212**
SECURITY HEALTH PLAN	25	52	0	0	13	10	17	**117**
SMP	45	127	3	0	0	1	0	**176**
SMP (LOCAL)	1	2	0	0	0	0	0	**3**
STANDARD PLAN	47	32	2	3	46	14	57	**201**
STANDARD PLAN DANE (LOCAL)	2	0	0	0	0	0	1	**3**
STANDARD PLAN MILWAUKEE (LOCAL)	1	0	0	0	0	0	0	**1**
STANDARD WISCONSIN (LOCAL)	0	1	0	0	0	0	1	**2**
STANDARD - WAUKESHA (LOCAL)	0	0	0	0	0	0	0	**0**
STANDARD WISCONSIN PPP	0	0	0	0	0	0	0	**0**
UNITEDHEALTHCARE NE	30	49	0	1	0	2	0	**82**
UNITEDHEALTHCARE SE	40	92	0	1	6	4	0	**143**
UNITY COMMUNITY	21	86	0	2	2	3	1	**115**
UNITY UW HEALTH	107	162	20	19	9	2	3	**322**
WPS METRO CHOICE	10	26	3	2	2	0	0	**43**
TOTAL CONTRACTS GAINED	**993**	**1867**	**79**	**74**	**132**	**79**	**138**	**3362**

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

Table 1: 2009 Dual-Choice Statistics All Contracts: New Coverage, Old Coverage and Net Change in Contracts by Health Plan

OLD COVERAGE	SINGLE	FAMILY	GRAD SINGLE	GRAD FAMILY	MED SINGLE	MED FAMILY 1	MED FAMILY 2	Total
ANTHEM BCBS NORTHEAST	0	0	0	0	0	0	0	**0**
ANTHEM BCBS NORTHWEST	25	99	0	0	13	4	10	**151**
ANTHEM BCBS SOUTHEAST	43	91	6	1	4	5	2	**152**
ARISE HEALTH PLAN	10	12	0	0	4	0	3	**29**
DEAN HEALTH PLAN	157	235	17	6	14	5	3	**437**
GHC EAU CLAIRE	123	272	1	0	18	25	49	**488**
GHC-SCW	64	61	34	14	1	1	1	**176**
GUNDERSEN LUTHERAN	23	55	0	0	4	1	0	**83**
HEALTH TRADITION	14	35	0	0	0	0	1	**50**
HUMANA EASTERN	55	81	3	1	12	2	2	**156**
HUMANA WESTERN	26	86	0	0	6	2	6	**126**
MEDICAL ASSOCIATES HEALTH PLAN	5	3	0	0	0	0	1	**9**
MERCYCARE HEALTH PLAN	14	20	0	1	0	0	0	**35**
NETWORK HEALTH PLAN	37	65	0	0	3	4	5	**114**
PHYSICIANS PLUS MERITER & UW	75	134	10	2	14	2	10	**247**
SECURITY HEALTH PLAN	29	37	0	0	7	2	6	**81**
SMP	2	9	0	0	0	0	0	**11**
SMP (LOCAL)	0	0	0	0	0	0	0	**0**
STANDARD PLAN	187	172	30	4	16	7	6	**422**
STANDARD PLAN DANE (LOCAL)	5	1	0	0	0	0	0	**6**
STANDARD PLAN MILWAUKEE (LOCAL)	0	1	0	0	0	0	0	**1**
STANDARD WISCONSIN (LOCAL)	14	0	0	0	0	0	0	**14**
STANDARD - WAUKESHA (LOCAL)	2	0	0	0	0	0	0	**2**
STANDARD WISCONSIN PPP	4	0	0	0	0	0	0	**4**
UNITEDHEALTHCARE NE	36	91	1	0	12	1	11	**152**
UNITEDHEALTHCARE SE	21	38	1	0	9	4	2	**75**
UNITY COMMUNITY	18	55	0	1	2	1	1	**78**
UNITY UW HEALTH	67	97	15	6	6	10	5	**206**
WPS METRO CHOICE	28	39	0	0	0	0	0	**57**
TOTAL CONTRACTS LOST	**1074**	**1789**	**118**	**36**	**145**	**76**	**124**	**3362**

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

Table 1: 2009 Dual-Choice Statistics All Contracts: New Coverage, Old Coverage and Net Change in Contracts by Health Plan

NET CHANGE	SINGLE	FAMILY	GRAD SINGLE	GRAD FAMILY	MED SINGLE	MED FAMILY 1	MED FAMILY 2	Total Gained	DEC 2008 CONTRACTS*	JAN 2009 CONTRACTS
ANTHEM BCBS NORTHEAST	11	18	0	0	1	0	0	**30**	0	36
ANTHEM BCBS NORTHWEST	-22	-98	0	0	-12	-3	-10	**-145**	448	287
ANTHEM BCBS SOUTHEAST	-20	-46	-3	1	-2	-4	-2	**-76**	2398	2325
ARISE HEALTH PLAN	7	39	0	0	-3	2	-3	**42**	887	936
DEAN HEALTH PLAN	-15	-26	-12	2	-11	2	-2	**-62**	22879	23118
GHC EAU CLAIRE	-72	-176	-1	1	-12	-22	-45	**-327**	5606	5269
GHC-SCW	-20	6	-4	8	0	-1	0	**-11**	8474	8461
GUNDERSEN LUTHERAN	5	-9	2	0	-3	0	0	**-5**	2525	2535
HEALTH TRADITION	103	242	1	0	6	14	29	**395**	2091	2509
HUMANA EASTERN	39	98	3	5	3	3	10	**161**	7964	8142
HUMANA WESTERN	-8	-33	0	0	-1	0	-4	**-46**	902	789
MEDICAL ASSOCIATES HEALTH PLAN	1	14	0	0	1	0	-1	**15**	487	505
MERCYCARE HEALTH PLAN	-8	-9	0	-1	0	0	1	**-17**	706	697
NETWORK HEALTH PLAN	0	-9	0	0	-1	-4	-4	**-18**	4852	4832
PHYSICIANS PLUS MERITER & UW	-8	-22	-6	5	-5	5	-4	**-35**	11157	11160
SECURITY HEALTH PLAN	-4	15	0	0	6	8	11	**36**	3608	3652
SMP	43	118	3	0	0	1	0	**165**	64	230
SMP (LOCAL)	0	0	0	0	0	0	0	**3**	18	20
STANDARD PLAN	-186	-170	-30	-4	-16	-7	-6	**-419**	9154	8920
STANDARD PLAN DANE (LOCAL)	42	31	2	3	46	14	57	**195**	45	43
STANDARD PLAN MILWAUKEE (LOCAL)	2	-1	0	0	0	0	1	**2**	90	90
STANDARD WISCONSIN (LOCAL)	-13	0	0	0	0	0	0	**-13**	99	89
STANDARD - WAUKESHA (LOCAL)	0	0	0	0	0	0	0	**0**	17	15
STANDARD WISCONSIN PPP	-4	1	0	0	0	0	1	**-2**	5	1
UNITEDHEALTHCARE NE	-6	-42	-1	1	-12	1	-11	**-70**	4668	4600
UNITEDHEALTHCARE SE	19	54	-1	1	-3	0	-2	**68**	2808	2927
UNITY COMMUNITY	3	31	0	1	0	2	0	**37**	2458	2740
UNITY UW HEALTH	40	65	5	13	3	-8	-2	**116**	13338	13495
WPS METRO CHOICE	-18	-13	3	2	2	0	0	**-14**	497	482
TOTAL NET CHANGE	**-81**	**78**	**-39**	**38**	**-13**	**3**	**14**	**0**	108245	108905

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

Table 2: 2009 Dual-Choice Statistics--Active State Employees

HEALTH PLAN	ADDITIONS		DELETIONS		NET CHANGE		TOTAL NET CHANGE	DEC 2008 CONTRACTS*	JAN 2009 CONTRACTS	PERCENT CHANGE (due to dual choices)
	SINGLE	FAMILY	SINGLE	FAMILY	SINGLE	FAMILY				
ANTHEM BCBS NORTHEAST	11	17	0	0	11	17	28	0	34	**NA**
ANTHEM BCBS NORTHWEST	3	0	14	87	-11	-87	-98	223	126	**-44%**
ANTHEM BCBS SOUTHEAST	20	45	36	81	-16	-36	-52	1905	1854	**-3%**
ARISE HEALTH PLAN	10	44	6	9	4	35	39	539	582	**7%**
DEAN HEALTH PLAN	97	118	126	176	-29	-58	-87	13718	13627	**-1%**
GHC EAU CLAIRE	35	77	43	108	-8	-31	-39	4098	4054	**-1%**
GHC-SCW	34	36	50	43	-16	-7	-23	3821	3799	**-1%**
GUNDERSEN LUTHERAN	13	30	7	14	6	16	22	1375	1402	**2%**
HEALTH TRADITION	33	87	10	26	23	61	84	1228	1318	**7%**
HUMANA EASTERN	90	178	42	68	48	110	158	6372	6539	**2%**
HUMANA WESTERN	14	48	19	60	-5	-12	-17	587	568	**-3%**
MEDICAL ASSOCIATES	3	9	5	2	-2	7	5	360	367	**1%**
MERCYCARE HEALTH PLAN	3	4	8	12	-5	-8	-13	442	427	**-3%**
NETWORK HEALTH PLAN	27	42	22	53	5	-11	-6	3757	3743	**0%**
PHYSICIANS PLUS	51	91	45	71	6	20	26	6437	6476	**0%**
SECURITY HEALTH PLAN	15	45	19	31	-4	14	10	2917	2927	**0%**
SMP	40	124	1	7	39	117	156	48	205	**325%**
STANDARD PLAN	41	29	169	167	-128	-138	-266	1445	1154	**-18%**
UNITEDHEALTHCARE NE	17	35	27	77	-10	-42	-52	3271	3219	**-2%**
UNITEDHEALTHCARE SE	15	52	14	25	1	27	28	887	925	**3%**
UNITY COMMUNITY	7	36	8	14	-1	22	21	541	570	**4%**
UNITY UW HEALTH	93	136	52	83	41	53	94	9141	9249	**1%**
WPS METRO CHOICE	10	26	17	37	-7	-11	-18	380	357	**-5%**
TOTAL	**682**	**1309**	**740**	**1251**	**-58**	**58**	**0**	**63492**	**63522**	**0%**

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

Table 3: 2009 Dual Choice Statistics--Local Employees, Retirees, and Continuants

	ADDITIONS					DELETIONS					NET CHANGE					TOTAL NET CHANGE	DEC 2008 CONTRACTS*	JAN 2009 CONTRACTS	PERCENT CHANGE
	SGL	FML	MED SGL	MED FML 1	MED FML 2	SGL	FML	MED SGL	MED FML 1	MED FML 2	SGL	FML	MED SGL	MED FML 1	MED FML 2				(due to dual choices)
ANTHEM BCBS NORTHWEST	0	1	0	0	0	2	8	0	0	0	-2	-7	0	0	0	-9	47	23	**-39%**
ANTHEM BCBS SOUTHEAST	1	0	0	0	0	3	9	1	2	0	-2	-9	-1	-2	0	-14	28	13	**-108%**
ARISE HEALTH PLAN	2	2	0	0	0	2	1	0	0	0	0	1	0	0	0	1	81	84	**1%**
DEAN HEALTH PLAN	37	86	0	1	0	23	49	1	2	1	14	37	-1	-1	-1	48	4054	4420	**1%**
GHC EAU CLAIRE	2	13	0	0	0	51	125	1	0	1	-49	-112	-1	0	-1	-163	384	211	**-77%**
GHC-SCW	8	29	0	0	0	12	15	0	0	0	-4	14	0	0	0	10	857	866	**1%**
GUNDERSEN LUTHERAN	10	12	0	0	0	15	40	1	0	0	-5	-28	-1	0	0	-34	612	583	**-6%**
HEALTH TRADITION	61	164	2	0	1	4	8	0	0	0	57	156	2	0	1	216	627	859	**25%**
HUMANA EASTERN	0	0	2	0	0	7	9	0	1	0	-7	-9	2	-1	0	-15	149	133	**-11%**
HUMANA WESTERN	1	2	0	0	0	6	25	0	0	0	-5	-23	0	0	0	-28	135	41	**-68%**
MEDICAL ASSOCIATES	2	8	1	0	0	0	1	0	0	0	2	7	1	0	0	10	27	37	**27%**
MERCYCARE HEALTH PLAN	2	6	0	0	0	4	8	0	0	0	-2	-2	0	0	0	-4	174	180	**-2%**
NETWORK HEALTH PLAN	6	12	0	0	0	9	11	0	0	0	-3	1	0	0	0	-2	440	442	**0%**
PHYSICIANS PLUS	8	15	1	2	0	21	61	2	1	1	-13	-46	-1	1	-1	-60	1354	1303	**-5%**
SECURITY HEALTH PLAN	0	1	0	0	0	2	0	0	0	0	-2	1	0	0	0	-1	17	16	**-6%**
SMP (LOCAL)	1	2	0	0	0	0	0	0	0	0	1	2	0	0	0	3	18	20	**15%**
STANDARD - WAUKESHA (LOCAL)	0	0	0	0	0	2	0	0	0	0	0	0	0	0	0	0	17	15	**0%**
STANDARD PLAN DANE (LOCAL)	2	0	0	0	1	5	1	0	0	0	-3	-1	0	0	1	-3	45	43	**-7%**
STANDARD PLAN MILWAUKEE (LOCAL)	1	0	0	0	0	0	1	0	0	0	1	-1	0	0	0	0	90	90	**0%**
STANDARD WISCONSIN (LOCAL)	0	1	0	0	1	14	0	0	0	0	-14	1	0	0	1	-12	99	89	**-13%**
STANDARD WISCONSIN PPP	0	0	0	0	0	4	0	0	0	0	-4	0	0	0	0	-4	5	1	**-400%**
UNITEDHEALTHCARE NE	9	11	0	0	0	7	10	0	0	0	2	1	0	0	0	3	571	575	**1%**
UNITEDHEALTHCARE SE	14	35	1	3	0	7	12	2	0	0	7	23	-1	3	0	32	1726	1797	**2%**
UNITY COMMUNITY	14	50	1	2	1	10	41	1	1	0	4	9	0	1	1	15	1832	2083	**1%**
UNITY UW HEALTH	10	22	2	1	0	8	10	2	1	0	2	12	0	0	0	14	666	687	**2%**
WPS METRO CHOICE	0	0	0	0	0	0	1	0	0	0	0	-1	0	0	0	-1	2	1	**-100%**
TOTAL	**191**	**472**	**10**	**9**	**4**	**218**	**446**	**11**	**8**	**3**	**-27**	**26**	**-1**	**1**	**1**	**0**	**14057**	**14612**	**0%**

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

Table 4: 2009 Dual Choice Statistics--Graduate Assistants and Continuants

HEALTH PLAN	ADDITIONS		DELETIONS		NET CHANGE		TOTAL NET CHANGE	DEC 2008 CONTRACTS*	JAN 2009 CONTRACTS	PERCENT CHANGE (due to dual choices)
	SINGLE	FAMILY	SINGLE	FAMILY	SINGLE	FAMILY				
ANTHEM BCBS NORTHWEST	0	0	0	0	0	0	0	2	1	**0%**
ANTHEM BCBS SOUTHEAST	3	2	6	1	-3	1	-2	208	207	**-1%**
ARISE HEALTH PLAN	0	0	0	0	0	0	0	6	6	**0%**
DEAN HEALTH PLAN	5	8	17	6	-12	2	-10	789	772	**-1%**
GHC EAU CLAIRE	0	1	1	0	-1	1	0	104	104	**0%**
GHC-SCW	30	22	34	14	-4	8	4	3169	3162	**0%**
GUNDERSEN LUTHERAN	2	0	0	0	0	0	0	42	45	**0%**
HEALTH TRADITION	1	0	0	0	1	0	1	30	33	**3%**
HUMANA EASTERN	6	6	3	1	3	5	8	586	594	**1%**
HUMANA WESTERN	0	0	0	0	0	0	0	7	7	**0%**
MEDICAL ASSOCIATES	0	0	0	0	0	0	0	12	12	**0%**
MERCYCARE	0	0	0	1	0	0	0	8	7	**0%**
NETWORK HEALTH PLAN	0	0	0	0	0	0	0	35	36	**0%**
PHYSICIANS PLUS	4	7	10	2	-6	5	-1	828	826	**0%**
SECURITY HEALTH PLAN	0	0	0	0	0	0	0	67	69	**0%**
SMP	3	0	0	0	0	0	0	0	3	**NA**
STANDARD PLAN	2	3	30	4	-28	-1	-29	269	240	**-11%**
UNITEDHEALTHCARE - NORTHEAST	0	1	1	0	0	0	0	37	37	**0%**
UNITEDHEALTHCARE SE	0	1	1	0	-1	1	0	104	104	**0%**
UNITY COMMUNITY	0	2	0	1	0	1	1	18	19	**6%**
UNITY UW HEALTH	20	19	15	6	5	13	18	1800	1815	**1%**
WPS METRO CHOICE	3	2	0	0	3	2	5	78	83	**6%**
TOTAL	**79**	**74**	**118**	**36**	**-39**	**38**	**-1**	**8199**	**8182**	**0%**

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

Table 5: 2009 Dual Choice Statistics--State Retirees and Continuants

	ADDITIONS					DELETIONS					NET CHANGE					TOTAL NET CHANGE	DEC 2008 CONTRACTS*	JAN 2009 CONTRACTS	PERCENT CHANGE
	SGL	FML	MED SGL	MED FML1	MED FML 2	SGL	FML	MED SGL	MED FML1	MED FML 2	SGL	FML	MED SGL	MED FML1	MED FML 2				(due to dual choices)
ANTHEM BCBS NORTHEAST	0	1	1	0	0	0	0	0	0	0	0	1	1	0	0	2	0	2	**NA**
ANTHEM BCBS NORTHWEST	0	0	1	1	0	9	4	13	4	10	-9	-4	-12	-3	-10	-38	176	137	**-22%**
ANTHEM BCBS SOUTHEAST	2	0	2	1	0	4	1	3	3	2	-2	-1	-1	-2	-2	-8	257	251	**-3%**
ARISE HEALTH PLAN	5	5	1	2	0	2	2	4	0	3	3	3	-3	2	-3	2	261	264	**1%**
DEAN HEALTH PLAN	8	5	3	6	1	8	10	13	3	2	0	-5	-10	3	-1	-13	4318	4299	**0%**
GHC EAU CLAIRE	14	6	6	3	4	29	39	17	25	48	-15	-33	-11	-22	-44	-125	1020	900	**-12%**
GHC-SCW	2	2	1	0	1	2	3	1	1	1	0	-1	0	-1	0	-2	627	634	**0%**
GUNDERSEN LUTHERAN	5	4	1	1	0	1	1	3	1	0	4	3	-2	0	0	5	496	505	**1%**
HEALTH TRADITION	23	26	4	14	29	0	1	0	0	1	23	25	4	14	28	94	206	299	**46%**
HUMANA EASTERN	4	1	13	5	12	6	4	12	1	2	-2	-3	1	4	10	10	857	876	**1%**
HUMANA WESTERN	3	3	5	2	2	1	1	6	2	6	2	2	-1	0	-4	-1	173	173	**-1%**
MEDICAL ASSOCIATES	1	0	0	0	0	0	0	0	0	1	1	0	0	0	-1	0	88	89	**0%**
MERCYCARE HEALTH PLAN	1	1	0	0	1	2	0	0	0	0	-1	1	0	0	1	1	82	83	**1%**
NETWORK HEALTH PLAN	4	2	2	0	1	6	1	3	4	5	-2	1	-1	-4	-4	-10	620	611	**-2%**
PHYSICIANS PLUS	8	6	8	5	6	9	2	12	1	9	-1	4	-4	4	-3	0	2538	2555	**0%**
SECURITY HEALTH PLAN	10	6	13	10	17	8	6	7	2	6	2	0	6	8	11	27	607	640	**4%**
SMP	5	3	0	1	0	1	2	0	0	0	4	1	0	1	0	6	16	22	**38%**
STANDARD PLAN	6	3	46	14	57	18	5	16	7	6	-12	-2	30	7	51	74	7440	7526	**1%**
UNITEDHEALTHCARE NE	4	3	0	2	0	2	4	12	1	11	2	-1	-12	1	-11	-21	789	769	**-3%**
UNITEDHEALTHCARE SE	11	5	5	1	0	0	1	7	4	2	11	4	-2	-3	-2	8	91	101	**9%**
UNITY COMMUNITY	0	0	1	1	0	0	0	1	0	1	0	0	0	1	-1	0	67	68	**0%**
UNITY UW HEALTH	4	4	7	1	3	7	4	4	9	5	-3	0	3	-8	-2	-10	1731	1744	**-1%**
WPS METRO CHOICE	0	0	2	0	0	1	1	0	0	0	-1	-1	2	0	0	0	37	41	**0%**
TOTAL	**120**	**86**	**122**	**70**	**134**	**116**	**92**	**134**	**68**	**121**	**4**	**-6**	**-12**	**2**	**13**	**1**	**22497**	**22589**	**0%**

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

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CORRESPONDENCE MEMORANDUM

DATE: February 2, 2009

TO: Group Insurance Board

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

SUBJECT: HEDIS® and CAHPS® Performance in 2007

This is for informational purposes and does not require Board action.

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

- The Healthcare Effectiveness Data and Information Set (HEDIS®) submitted by the participating Health Maintenance Organizations (HMOs) to the Department of Employee Trust Funds (ETF).
- The Consumer Assessment of Healthcare Providers and Systems (CAHPS®) data collected by ETF through Internet and mail surveys.
- The 2008 Disease Management Survey Results collected by ETF from all participating health plans.

How this Report is Structured

This report includes a brief summary of health plan performance on HEDIS®, CAHPS®, and the disease management survey. In-depth descriptions of HEDIS and CAHPS results for measures examined for this study are available in the attached report, *2007 Detailed HEDIS® and CAHPS® Results*. The report includes several appendixes, which display summary statistics and results by health plan.

HEDIS® Description

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

CAHPS® Description

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

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

_______________________________ ___________
Signature Date

Board	Mtg Date	Item #
GIB	02/17/2009	3

How HEDIS® and CAHPS® Results were Used

Once again, HEDIS® and CAHPS® results were used to give credit to high-performing HMO plans during the negotiation process. The top-performing health plans were GHC-SCW, Network Health Plan and GHC-Eau Claire. The poorest-performing health plans were Anthem BCBS and Humana. Performance based on the quality composite system used in health plan negotiations was published in the *It's Your Choice* booklets. Health plan performance was noted by a four star rating system on overall quality, wellness and prevention, behavioral health, disease management, and customer satisfaction and experiences. In 2007, 42 percent of respondents reported that they use the information published in the *It's Your Choice* booklets to make a health plan selection.

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

Overall Health Plan Performance

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

HEDIS®

Overall, participating HMOs continued to score higher on HEDIS® measures than HMOs nationwide for the 2007 measurement year. Participating HMOs performed better than the national average on measures such as Childhood Immunizations, Colorectal Cancer Screenings, Breast Cancer Screenings, Comprehensive Diabetes Care, Follow-up after Hospitalization for Mental Illness, and Timeliness of Prenatal and Postpartum Care. We continue to note big differences in the relative performance of Wisconsin participating HMOs on their HEDIS® scores. For example, GHC-SCW scored significantly above average on eleven scores across seven measures and Humana performed significantly below average on nine scores across six measures.

Although the HEDIS® scores of participating HMOs continue to be higher than that of HMOs nationwide, there is still significant room for improvement in several areas of care including appropriate use of antibiotics, cancer screenings, and mental health. On average, the performance of participating HMOs remained about the same in 2007 as it was in 2006. Specific health plan results are detailed in the attached report.

CAHPS®

Overall, member satisfaction with their health plan, their health care, their primary doctors and their specialists remained about the same from 2006 to 2007. However individual health plans had significant increases or decreases in satisfaction levels. Arise Health Plan and Dean Health Plan had significant increases in satisfaction levels with the health plan and Arise, Dean and Gundersen Lutheran had significant increases in satisfaction with health care. Health Tradition and Humana Eastern achieved significant increases in satisfaction levels with primary doctors and Medical Associates achieved a significant increase in satisfaction levels with specialists.

Humana Western received significantly lower levels of satisfaction in each of these categories. This was mainly caused by the provider network changes in Minnesota and Western Wisconsin. Several members expressed dissatisfaction with no longer being able to see providers from the

Mayo Clinic. Humana Western Medicare respondents were not affected by the provider changes and did not report decreases in satisfaction levels.

The State Maintenance Plan and Unity Community experienced significantly lower levels of satisfaction with specialists.

In addition to the four questions rating the health plan, health care, primary doctors, and specialists, six composite areas were examined in this study:

- Getting Care Quickly
- Shared Decision Making
- How Well Doctors Communicate
- Claims Processing
- Customer Service
- Getting Needed Care

We continue to note big differences in member satisfaction levels with the best- and worst-performing health plans. For example, Medical Associates rated significantly better than the ETF average on nine of the ten measures examined. By contrast, Humana Western rated significantly worse than the ETF average on eight measures.

2008 Disease Management Survey

In 2007, staff developed a comprehensive disease management survey to assess what health plans were doing to provide quality care and contain costs, with a focus on disease management programs, appropriate use of services and electronic medical records. The survey results revealed that the health plans had very different abilities to deliver and measure quality of care. One such area in which there seems to be a high level of variance in managing care is in treating lower back pain. In consultation with medical consultant, Dr. John Hansen and Deloitte Consulting, staff is pursuing an initiative to work with health plans on quality of care and cost containment in the area of lower back pain. We believe this is an area in which there is considerable variability in health plan performance and for which we have HEDIS data available to compare health plan performance. Currently a workgroup of medical directors from a representative group of health plans is being convened to assist with a quality improvement initiative and developing a methodology for measuring cost and performance in this area.

In addition, staff will work with Dr. Hansen as time permits on emergency department usage and the appropriate use of antibiotics. Findings from the disease management survey reveal an opportunity to work on these areas together as well. Several health plans listed bronchitis as one of the top five diagnoses for emergency room visits. It is known that a substantial portion of antibiotic prescribing is related to a bronchitis diagnosis in the emergency room and that in many cases it is inappropriate. According to the Center for Disease Control (CDC), 80 percent of all prescriptions given to adults with acute respiratory infection are unnecessary. To begin investigating this area further, ETF will add a section on the 2009 CAHPS survey that addresses member experiences with the appropriate use of antibiotics.

ETF staff, in consultation with Dr Hansen will focus on other areas of care as resources permit. ETF will review the past two years of comprehensive responses from the health plans and will look at refining the disease management survey with the goal of receiving more specific and uniform types of responses.

HEDIS®

Health Care Quality Information
Based on Health Plan Performance

CAHPS®

Health Care Quality Information
From the Consumer Perspective

2007 Detailed HEDIS® and CAHPS® Results

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Healthcare Effectiveness Data and Information Set (HEDIS) .... page 2

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Consumer Assessment of Healthcare Providers and Systems (CAHPS) ....page 7

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HEDIS® is a registered trademark of the National Committee for Quality Assurance.
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INTRODUCTION

This report displays detailed HEDIS and CAHPS results from data collected in 2008 for measured year 2007. The report includes comparisons to the average of participating health plans as well as to national benchmarks. This report also provides detail on trending information for HEDIS and CAHPS results. Each year ETF creates a quality composite based on HEDIS and CAHPS results that are used during health plan negotiations to give credit to high performing health plans. The results of this analysis are also published in the *It's Your Choice* booklet report card section (see appendix #1) as an overall composite and for the following specific areas:

- Wellness and Prevention
- Behavioral Health
- Disease Management
- Consumer Satisfaction and Experiences

In addition to the analysis provided in this report, please see appendix #2 to view the performance of participating health plans based on the National Committee for Quality Assurance (NCQA) composite areas:

- Consumer Assessment
- Prevention
- Treatment

Healthcare Effectiveness Data and Information Set (HEDIS®)

Definition of HEDIS Measures and Scores Examined in this Report

HEDIS 2008 (measurement year 2007) consists of 70 measures across 8 domains of care:

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

For the purposes of this study, we focused on 30 measures across 3 domains—Effectiveness of Care, Access/Availability of Care, and Use of Services for a total of 69 scores. For most of the scores examined, a higher score is considered better. However, there is an exception:

- For the Poor HbA1c Control (>9.0%) for the Comprehensive Diabetes Care measure, a lower score is better because it indicates that fewer people with diabetes were poorly controlled.

Please see appendix #3 for a description of each measure analyzed in this report.

Methods for determining clinically significant differences

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

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

Limitations

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

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

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

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

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

HEDIS Results

Individual HMOs Compared to State Average: Better than Average

The ETF HMOs are listed in order of number of measures for which they achieved a significantly better score than the average of all participating HMOs. A score is considered significantly better if it is 10 percentage points above the mean for a plan with a sample size of 100 or greater, or 20 percentage points above the mean for a plan with a sample size of at least 30 but less than 100. Not all HMOs were included in all of the measures (see Appendix #4), due to sample size issues. Therefore, it is important to keep in mind that smaller HMOs or HMOs that have a limited presence in Wisconsin do not have as much opportunity to either overachieve or underachieve. See appendix #5 for a comparison of the average or participating health plan performance to the previous year and to the national averages.

GHC-SCW had 11 above average rates (and no below average rates)

- Appropriate Testing for Children With Pharyngitis
- Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis/Antibiotic Prescription not dispensed within 3 days
- Chlamydia Screening/ Chlamydia age 16-20
- Chlamydia Screening/ Chlamydia age 21-25
- Chlamydia Screening/ Chlamydia Combined Age Brackets
- Comprehensive Diabetes Care/ Eye Exam
- Annual Monitoring for Patients on Persistent Medications/ Anticonvulsants
- Initiation of Alcohol and Other Drug Dependence Treatment
- Engagement of Alcohol and Other Drug Dependence Treatment
- Well-Child Visits in the First 15 Months of Life (six or more visits)
- Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life

Network Health Plan had 4 above average rates (and 1 below average rate)

- Annual Monitoring for Patients on Persistent Medications/ Anticonvulsants
- Antidepressant Medication Management/ Optimal Practicioner Contacts for Medication Management
- Comprehensive Diabetes Care/Eye Exam
- Well-Child Visits in the First 15 Months of Life (six or more visits)

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

- Antidepressant Medication Management/Effective Acute Phase Treatment
- Antidepressant Medication Management/Effective Continuation Phase Treatment
- Call Timeliness
- Well-Child Visits in the First 15 Months of Life (six or more visits)

Physicians Plus had 3 above average rates (and 4 below average rates)

- Appropriate Testing for Children With Pharyngitis
- Call Timeliness
- Well-Child Visits in the First 15 Months of Life (six or more visits)

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

- Call Timeliness
- Well-Child Visits in the First 15 Months of Life (six or more visits)

GHC-Eau Claire had 2 above average rates (and no below average rates)

- Call Timeliness
- Comprehensive Diabetes Care/ Blood Pressure Control <130/80 Hg

Gundersen Lutheran had 1 above average rate (and 3 below average rates)

- Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis/Antibiotic Prescription not dispensed within 3 days

Humana had 2 above average rates (and 9 below average rates)

- Annual Monitoring for Patients on Persistent Medications/ Digoxins
- Initiation of Alcohol and Other Drug Dependence Treatment

Anthem BCBS had 1 above average rate (and 7 below average rates)
- Engagement of Alcohol and Other Drug Dependence Treatment

Dean Health Plan had 1 above average rate (and 1 below average rate)
- Pharmacotherapy Management of COPD Exacerbation/ Dispensed a systemic corticosteroid within 14 days of the event

MercyCare Health Plan had 1 above average rate (and 3 below average rates)
- Call Abandonment

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

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

Medical Associates had no above average rates (and 1 below average rate)

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

Individual HMOs Compared to State Average: Below Average Performance

The HMOs are listed in the order of the most rates with a below average score. A score is considered significantly below average if it is 10 percentage points below the mean for a plan with a sample size of 100 or greater or 20 percentage points below the mean for a plan with a sample size of at least 30 but less than 100. As with above average performance, it should be taken into consideration that the smaller HMOs that experienced sample size issues were excluded from some measures (see Appendix #4).

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

Humana had 9 below average rates (and 2 above average rate)
- Annual Monitoring for Patients on Persistent Medications/Anticonvulsants
- Engagement of Alcohol and Other Drug Dependence Treatment
- Comprehensive Diabetes Care/ Poor HbA1c Control >9.0% **(met national average)**
- Comprehensive Diabetes Care/ Blood Pressure Control <140/90 Hg **(met national average)**
- Persistence of Beta-Blocker Treatment after a Heart Attack
- Pharmacotherapy Management of COPD Exacerbation/Dispensed a systemic corticosteroid within 14 days of the event
- Pharmacotherapy Management of COPD Exacerbation/Dispensed a bronchodilator within 30 days of the event
- Well-Child Visits in the First 15 Months of Life (six or more visits)
- Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life

Anthem had 7 below average rates (and one above average rate)
- Antidepressant Medication Management/Effective Acute Phase Treatment
- Antidepressant Medication Management/Effective Continuation Phase Treatment
- Call Timeliness
- Colorectal Cancer Screening
- Comprehensive Diabetes Care/ Eye Exam **(met national average)**
- Disease Modifying Anti-Rheumatic Drug Therapy in Rheumatoid Arthritis/ At least one ambulatory prescription dispensed
- Well-Child Visits in the First 15 Months of Life (six or more visits)

Physicians Plus had 4 below average rates (and 3 above average rates)
- Annual Monitoring for Patients on Persistent Medications/ Digoxin
- Comprehensive Diabetes Care/ Eye Exam **(met national average)**
- Controlling High Blood Pressure/ Total 18-85
- Timeliness of Prenatal Care

Gundersen Lutheran had 3 below average rates (and 1 above average rate)
- Initiation of Alcohol and Other Drug Dependence Treatment
- Call Timeliness
- Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life

MercyCare Health Plan had 3 below average rates (and 1 above average rate)
- Call Timeliness
- Cholesterol Management for Patients With Cardiovascular Conditions/LDL-C Level <100 mg/dL **(met national average)**
- Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life

UnitedHealthcare had 3 below average rates (and no above average rates)
- Comprehensive Diabetes Care/ Eye Exam **(met national average)**
- Comprehensive Diabetes Care/ Blood Pressure Control <130/80 Hg **(met national average)**
- Comprehensive Diabetes Care/ Blood Pressure Control <140/90 Hg **(met national average)**

Arise Health Plan had 2 below average rates (and no above average rates)
- Appropriate Testing for Children with Pharyngitis
- Call Timeliness

Health Tradition had 1 below average rate (and no above average rates)
- Follow-Up After Hospitalization for Mental Illness/ 7-day follow-up

Dean Health Plan had 1 below average rate (and 1 above average rate)
- Follow-Up Care for Children Prescribed with Attention-Deficit/Hyperactivity Disorder--Continuation and Maintenance Phase **(met national average)**

Medical Associates had 1 below average rate (and no above average rates)
- Appropriate Treatment for Children With Upper Respiratory Infection

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

GHC-Eau Claire had no below average rates (and 2 above average rates)

GHC-SCW had no below average rates (and 11 above average rates)

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

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

Consumer Assessment of Healthcare Providers and Systems (CAHPS®)

Summary of CAHPS Measurement Tools

In addition to collecting CAHPS data and reporting it in the report card in the *It's Your Choice* booklets, Morpace Inc. (the CAHPS survey vendor) also conducts additional analysis that determines what factors are "key drivers" of overall satisfaction with a health plan and with health care (see appendix #6). Key drivers for each of the health plans were compared to the 2008 NCQA Quality Compass in order to determine the most appropriate action for the health plan. The Quality Compass consists of the HEDIS data, including CAHPS, that health plans around the country submit to NCQA to seek accreditation.

Appendixes #7, #8, and #9 provide comparisons of individual health plans to the ETF and the 2008 NCQA Quality Compass. More specifically:

- Appendix #7 summarizes how participating health plans compared to the NCQA and ETF averages on how people rated their health plan, health care, primary doctor and specialists.

- Appendix #8 displays detailed results for health plan performance as compared to NCQA and ETF averages on six composite scores: Claims Processing, Customer Service, Getting Needed Care, How Well Doctors Communicate, Getting Care Quickly, and Shared Decision Making.

- Appendix #9 displays health plan performance compared to the NCQA Quality Compass and the ETF average for the three specific areas that were found to be the most highly correlated with overall satisfaction levels for all ETF health plans combined. These areas are:
  - Handled claims correctly (r=.59)
  - Handled claims quickly (r=.59)
  - Got info/help needed from customer service (r=.59)
  - Customer service treated you with courtesy & respect (r=.56)
  - Ability to get care believed necessary (r=.54)

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

Note that it is possible for a health plan to receive a lower score as compared to the ETF average and rank higher against the 2008 Quality Composite. This is because for the overall ratings, the ETF methodology considers the total rating from 0 to 10 while the Quality Compass only considers the percentage of respondents who rate their health plan from 8 to 10.

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

For historical trend information from 2006 through 2008 on health plan, health care, primary doctor, and specialists ratings, please refer to appendix #10.

CAHPS Results

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

The participating health plans are listed in the order of the number of the four satisfaction rating questions and the six composite scores detailed in Appendix #7 and Appendix #8 that they score significantly above the ETF average.

Medical Associates had 9 above average scores (and no below average scores):

- How People Rated their Health Plan
- How People Rated their Health Care
- How People Rated their Primary Doctors
- How People Rated their Specialists
- Claims Processing composite
- Customer Service composite
- Getting Needed Care composite
- How Well Doctors Communicate composite
- Shared Decision Making composite

Health Tradition had 8 above average scores (and no below average scores):

- How People Rated their Health Plan
- How People Rated their Health Care
- How People Rated their Primary Doctors
- Claims Processing composite
- Customer Service composite
- Getting Needed Care composite
- Getting Care Quickly composite
- How Well Doctors Communicate composite

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

- How People Rated their Health Plan
- How People Rated their Primary Doctors
- How People Rated their Specialists
- Claims Processing composite
- Customer Service composite
- Getting Needed Care composite

Gundersen Lutheran had 5 above average scores (and no below average scores):
- How People Rated their Health Plan
- How People Rated their Health Care
- How People Rated their Primary Doctors
- Claims Processing composite
- How Well Doctors Communicate composite

Arise Health Plan had 4 above average scores (and no below average scores):
- How People Rated their Health Plan
- How People Rated their Health Care
- Claims Processing composite
- Getting Care Needed composite

GHC-SCW had 4 above average scores (and no below average scores):
- How People Rated their Health Plan
- How People Rated their Health Care
- Claims Processing composite
- Customer Service composite

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

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

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

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

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

UnitedHealthcare SE had 2 above average scores (and no below average scores):
- Getting Needed Care composite
- Getting Care Quickly composite

The Standard Plan had 1 above average score (and no below average scores):
- How People Rated their Health Plan

UnitedHealthcare NE had 1 above average score (and 2 below average scores):
- Getting Needed Care composite

Anthem BCBS Northwest had no above average scores (and 3 below average scores).

Anthem BCBS Southeast had no above average scores (and 5 below average scores).

Humana-Western had no above average scores (and 8 below average scores).

Humana-Eastern had no above average scores (and 2 below average scores).

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

The State Maintenance Plan had no above average scores (and 6 below average scores).

WPS Patients Choice had no above average scores (and 1 below average score).

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

The participating health plans are listed in the order of the number of the four satisfaction rating questions and the six composite scores detailed in Appendix #7 and Appendix #8 that they score significantly below the ETF average. Scores that met the 2008 Quality Compass 50th percentile are noted below.

Humana-Western had 8 below average scores (and no above average scores):
- How People Rated their Health Plan
- How People Rated their Health Care
- How People Rated their Primary Doctors
- Claims Processing composite
- Customer Service composite
- Getting Needed Care composite
- How Well Doctors Communicate composite (Met Quality Compass 50th percentile)
- Shared Decision Making composite

Anthem BCBS Southeast had 5 below average scores (and no above average scores):
- How People Rated their Health Care
- How People Rated their Primary Doctors
- Claims Processing composite
- Customer Service composite
- How Well Doctors Communicate composite

The State Maintenance Plan had 6 below average scores (and no above average scores):
- How People Rated their Health Plan
- How People Rated their Health Care
- How People Rated their Primary Doctors
- How People Rated their Specialists
- Claims Processing composite
- Getting Needed Care composite

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

Humana-Eastern had 2 below average scores (and no above average scores):
- Claims Processing composite
- Customer Service composite

UnitedHealthcare NE had 2 below average scores (and 1 above average score):
- Claims Processing composite
- Customer Service composite

Network Health Plan had 2 below average scores (and 3 above average scores):
- How People Rated their Primary Doctors
- How Well Doctors Communicate composite

Unity-UW had 1 below average score (and 3 above average scores).
- Getting Care Quickly composite

WPS Patient Choice had 1 below average score (and no above average scores).
- Claims Processing composite

MercyCare Health Plan had 1 below average score (and no above average scores).
- Getting Care Quickly composite

Unity-Community had 1 below average score (and 3 above average scores).
- How People Rated their Specialists

Arise Health Plan had no below average scores (and 4 above average scores).

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

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

GHC-SCW had no below average scores (and 4 above average scores).

Gundersen Lutheran had no below average scores (and 5 above average scores).

Health Tradition had no below average scores (and 8 above average scores).

Medical Associates had no below average scores (and 9 above average scores).

Physicians Plus had no below average scores (and 2 above average scores).

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

UnitedHealthcare SE had no below average scores (and 2 above average scores).

Conclusions

Overall HMOs in Wisconsin continue to perform better than HMOs across the country. The average performance of participating HMOs did not change much from the previous year for HEDIS or CAHPS measures. However, individual health plans changed their performance from the previous year and there continues to be a great difference in the scores of the best and worst performing HMOs.

GHC-SCW stands out as a health plan that performs significantly better on a number of HEDIS measures, while Humana and Anthem have performed much worse on HEDIS than the other participating health plans.

Certain health plans such as Medical Associates, Health Tradition, GHC-Eau Claire, and Gundersen Lutheran stand out as having high CAHPS scores, while other health plans such as Humana and Anthem continue to have areas of weakness, such as customer service and claims processing, that really need to be addressed. Currently internal staff is working with Anthem to address long-standing customer service problems. These findings are significant and point to areas in which improvement could be made to better serve Wisconsin state and local employees.

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

Summary of Appendixes

Appendix 1: Quality Composite (page E-5 and E-6 in report card in the *It's Your Choice* booklets). This appendix displays the results of a composite ETF staff calculates based on HEDIS and CAHPS results that is used during health plan negotiations to give credit to high performing health plans. An overall composite score as well as a composite for Wellness and Prevention, Behavioral Health, Disease Management, and Consumer Satisfaction and Experiences are published in the report card section of the *It's Your Choice* booklets.

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

Appendix 3: Description of 2008 HEDIS Measures (measurement year 2007). This appendix describes the 69 scores reported in this study in the Effectiveness of Care, Access and Availability of Care, and Use of Services domains.

Appendix 4: Measurement Year 2007 HEDIS: HMO Performance on 69 scores. This appendix summarizes the number of HEDIS scores that each health plan met the national average, performed significantly better than the ETF average, and performed significantly worse than the ETF average.

Appendix 5: Comparison of 2007 Participating HMO Averages to 2006 HMO Averages and to 2007 National Averages. This appendix shows average comparisons for the 69 scores examined in this study.

Appendix 6: 2008 Description of Six Composite Scores and Morpace Inc. Key Driver Analysis. This appendix lists the questions that are included in each of the six composite scores display in appendix #8. Definitions of each of the three recommended areas of action for health plans that are shown in appendix #9 are defined.

Appendix 7: 2008 Overall Levels of Satisfaction by Health Plan. This appendix shows health plan performance compared to the NCQA Quality Compass and the ETF average for overall satisfaction ratings with Health Plan, Health Care, Primary Doctor, and Specialists.

Appendix 8: 2008 Performance in Six Areas of Care by Health Plan. This appendix shows health plan performance compared to the NCQA Quality Compass and the ETF average for six composite areas: Getting Care Quickly, Shared Decision Making, How Well Doctors Communicate, Getting Needed Care, Claims Processing, and Customer Service.

Appendix 9: 2008 Morpace Inc. Key Drivers of Satisfaction with Health Plan. This appendix shows health plan performance compared to the NCQA Quality Compass and the ETF average on the questions that are most highly correlated with overall health plan satisfaction: handled claims in a timely manner, handled claims correctly, and getting help needed when called customer service, getting care needed, and treated with respect by customer service.

Appendix 10: Historical Trending for CAHPS (page E-13 in report card in *It's Your Choice* booklets). This appendix displays the average score for each of the rating questions (Health Plan, Health Care, Primary Doctor, and Specialists) and whether or not there was a statistically significant change in satisfaction levels from one year to the next.

Appendix #1: 2009 Health Plan Quality Comparison

HEALTH PLAN	Overall Quality Score	Wellness and Prevention Score	Behavioral Health Score	Disease Management Score	Consumer Satisfaction and Experiences Score
Anthem BCBS Northwest	★	★	★	★	★
Anthem BCBS Southeast	★	★	★	★	★
Arise Health Plan	★★★	★★	★★★	★★★	★★★
Dean Health Plan	★★★	★★	★★★	★★★	★★★
GHC Eau Claire	★★★	★★★	★★	★★★★	★★★
GHC-SCW	★★★★	★★★★	★★★	★★★	★★★
Gundersen Lutheran	★★★	★★★★	★★	★★★	★★★
Health Tradition	★★★	★★	★	★★★	★★★★
Humana Eastern	★	★★	★★	★	★
Humana Western	★	★★	★★	★	★
Medical Associates	★★★	★★★	★	★★★★	★★★★
MercyCare Health Plan	★★	★★	★★	★★	★★
Network Health Plan	★★★★	★★★	★★★	★★★★	★★★
Physicians Plus	★★	★★★	★★★★	★★	★★★
Security Health Plan	★★★	★★★	★★★★	★★★★	★★★
UnitedHealthcare NE	★	★★	★★	★	★
UnitedHealthcare SE	★★	★★	★★	★	★★
Unity Community	★★★	★★★★	★★★	★★★	★★★
Unity UW Health	★★★	★★★★	★★★★	★★★	★★★

★★★★	**Score is one standard deviation or more above the mean**
★★★	**Score is above the mean by less than one standard deviation**
★★	**Score is below the mean by less than one standard deviation**
★	**Score is one standard deviation or more below the mean**

Overall Quality Score

The overall score is based on a comprehensive set of HEDIS® and CAHPS® measures that address many domains of care. All the measures that are included in the four areas of focus described below are included in the overall quality score. The performance of each health plan is compared to the average performance of all health plans available in 2008, except for WPS Metro Choice, the Standard Plan, and the State Maintenance Plan (SMP).

If the composite score for a health plan is one standard deviation or more above the mean composite score, than the health plan's performance is noted with four stars. Composite scores that are above the mean by less than one standard deviation are noted with three stars and composite scores that are below the mean by less than one standard deviation are noted with two stars. If the composite score for a health plan is one standard deviation or more below the mean composite score, then the health plan's performance is noted with one star. One standard deviation is on average, how much each score varies from a set of scores. Note that there may be meaningful differences in the performance on individual measures that were not noted as statistically above or below the average score. Detailed results of health plans available to members in 2008 are published in CAHPS®(page E-8 through page E-30) and HEDIS® (page E33 through page E-44) report cards.

Wellness and Prevention Score

This composite includes HEDIS® measures such as childhood immunizations, well child visits, prenatal and postpartum care, and appropriate use of antibiotics for children and adults, and breast, cervical and colorectal cancer screenings. This composite also includes survey questions that ask members about wellness information provided by their doctor and whether or not their doctor asked them about tobacco usage, their exercise habits and diet habits.

Behavioral Health

This composite includes HEDIS® measures for the treatment of depression and follow up after a hospitalization for mental illness. This composite also includes a survey question on whether or not members could obtain needed treatment or counseling for a personal or family problem.

Disease Management Score

This composite includes HEDIS® measures that address treatment and screenings for members with acute cardiovascular conditions, hypertension, diabetes, chronic obstructive pulmonary disease, and asthma. This composite also includes a measure that address monitoring of members who are on persistent medications of interest.

Consumer Satisfaction and Experiences Score

This composite includes CAHPS® scores that measure member satisfaction with their health plan and the health care they receive as well as their experiences with getting needed care, getting care quickly, health plan customer service and how their claims were processed.

Appendix #2: ETF Participating Health Plan Commercial National Ranking

HEALTH PLAN	CONSUMER ASSESSMENT	PREVENTION	TREATMENT
Anthem Blue Cross and Blue Shield (Compcare) (Ranked 187th)	★★	★★	★★★
Dean Health Plan (Ranked 40th)	★★★★	★★★★	★★★★★
GHC South Central Wisconsin (Ranked 8th)	★★★	★★★★★	★★★★★
Group Health Cooperative of Eau Claire (Ranked 217th) ***not accredited***[1]	★★★★★	★★★★	★★★★
Gundersen Lutheran Health Plan (Ranked 218th) ***not accredited***[1]	★★★★	★★★★	★★★★
Humana Wisconsin Health Organization Insurance Corporation (Ranked 122nd)	★★	★★★	★★★
Medical Associates Health Plans (WI) (Ranked 66th)	★★★★	★★★	★★★★
MercyCare Health Plans (Ranked 131st)	★★	★★★	★★★★
Network Health Plan (Ranked 31st)	★★★	★★★★	★★★★★
Security health Plan (Ranked 19th)	★★★★	★★★★	★★★★★
UnitedHealthcare of Wisconsin (Ranked 114th)	★★	★★★	★★★★
Unity Health Plans (Ranked 24th)	★★★★	★★★★	★★★★★
WPS Health Plan (Arise) (Ranked 68th)	★★★	★★★	★★★★

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

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

Consumer Assessment
Getting needed care, satisfaction with physicians, and satisfaction with health plan services.

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

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

For more information on measures included in this study please refer to U.S. News & World Report "Best Health Plan Glossary": http://health.usnews.com/articles/health/health-plans/2008/11/07/2009-best-health-plans-glossary.html

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

Appendix #3: Description of HEDIS® 2008 Measures (Measurement Year 2007)

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

- **Annual Monitoring for Patients on Persistent Medications**--the percentage of members 18 years and older on persistent medications who received annual monitoring for the drugs of interest, reported as a combined rate and four separate rates:
  - Annual Monitoring for Members on ACE Inhibitors or ARB
  - Annual Monitoring for Members on Digoxin
  - Annual Monitoring for Members on Diuretic
  - Annual Monitoring for Members on Anticonvulsants
  - Total Rate—the sum of the numerators divided by the sum of the denominators of the four rates above

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

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

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

- **Avoidance of Antibiotic Treatment for Adults with Acute Bronchitis**--the percentage of healthy adults 18–64 years of age with a diagnosis of acute bronchitis who were **not** given an antibiotic prescription on or within three days after the Episode Date. This misuse measure assesses if an inappropriate prescription of antibiotics was avoided for healthy adults with acute bronchitis.

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

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

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

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

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

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

- **Cholesterol Management for Patients With Cardiovascular Conditions**--the percentage of members 18–75 years of age who were discharged alive for acute myocardial infarction (AMI), coronary artery bypass graft (CABG) or percutaneous transluminal coronary angioplasty (PTCA), or who had a diagnosis of ischemic vascular disease (IVD), who had each of the following during the measurement year:
  - LDL-C screening performed
  - LDL-C control (<100 mg/dL)

- **Comprehensive Diabetes Care**--looks at how well a health plan cares for common and serious chronic diabetes in members age 18-75 on the following scores:
  - Glycohemoglobin (HbA1c) blood test
  - Poorly controlled diabetes (HbA1c>9.0 percent)
  - LDL-C screening
  - LDL-C level below 100 mg/dL
  - Eye exam
  - Kidney Disease Screening
  - Blood pressure level <130/80 mm Hg
  - Blood pressure level <140/90 mm Hg

- **Disease Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis**--assesses whether patients diagnosed with rheumatoid arthritis have been prescribed a disease-modifying anti-rheumatic drug.

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

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

- **Persistence of Beta-Blocker Treatment after a Heart Attack (PBH)--**the percentage of members 18 years of age and older who were hospitalized and discharged alive and diagnosis of acute myocardial infarction (AMI) and who received persistent beta-blocker treatment for six months after discharge.

- **Pharmacotherapy of COPD Exacerbation--**assesses the percentage of COPD exacerbations for 40 years of age and older who had an acute inpatient discharge or emergency department (ED) encounter:
  - Dispensed a systemic corticosteroid within 14 days of the event
  - Dispensed a bronchodilator within 30 days of the event

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Appendix #4: Measurement Year 2007 HEDIS®: HMO Performance on 69 scores

	Met national average?[1]			Met ETF mean score?[2]			Comparison to ETF mean score[3]			
PLAN	**Yes**	**No**	**NA[4]**	**Yes**	**No**	**NA[4]**	**better**	**not different**	**worse**	**NA[4]**
Anthem BCBS	44	21	4	9	56	4	1	57	7	4
Arise Health Plan	53	9	7	37	25	7	0	60	2	7
Dean Health Plan	65	4	0	57	12	0	1	67	1	0
GHC-Eau Claire	48	14	7	42	20	7	2	60	0	7
GHC-SCW	63	5	1	58	10	1	11	57	0	1
Gundersen Lutheran	51	12	6	44	19	6	1	59	3	6
Health Tradition	47	13	9	31	29	9	0	59	1	9
Humana	48	15	6	33	32	4	2	54	9	4
Medical Associates	47	14	8	37	24	8	0	60	1	8
MercyCare Health Plan	53	8	8	37	24	8	1	57	3	8
Network Health Plan	60	6	3	56	10	3	4	61	1	3
Physicians Plus	51	13	5	37	27	5	3	57	4	5
Security Health Plan	57	10	2	47	20	2	4	63	0	2
UnitedHealthcare	62	7	0	30	39	0	0	66	3	0
Unity Health Insurance	62	7	0	51	18	0	2	67	0	0
TOTAL	**811**	**158**	**66**	**606**	**365**	**64**	**32**	**904**	**35**	**64**

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

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

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

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

Appendix #5 Comparison of 2007 Participating HMO averages to 2006 HMO averages and 2007 National Averages

Domain	Measure	Score	2006 ETF Average	2007 ETF Average	2007 National Average	2007 ETF minus 2007 National Average	2007 ETF Average minus 2006 ETF Average
Effectiveness of Care							
	Childhood Immunization Status	DTaP/DT	91.4%	91.4%	73.1%	18.2%	0.0%
	Childhood Immunization Status	IPV	94.8%	95.1%	77.9%	17.2%	0.3%
	Childhood Immunization Status	MMR	95.8%	95.8%	88.2%	7.6%	0.0%
	Childhood Immunization Status	HiB	95.5%	94.9%	80.9%	14.0%	-0.6%
	Childhood Immunization Status	Hepatitis B	95.0%	94.3%	74.6%	19.7%	-0.7%
	Childhood Immunization Status	VZV	91.5%	93.4%	86.5%	7.0%	1.9%
	Childhood Immunization Status	Pneumococcal Conjugate	86.9%	90.3%	70.9%	19.4%	3.4%
	Childhood Immunization Status	Combination #2	85.0%	85.8%	66.9%	18.9%	0.8%
	Childhood Immunization Status	Combination #3	79.5%	82.7%	62.3%	20.4%	3.2%
	Appropriate Treatment for Children With Upper Respiratory Infection	Appropriate Treatment for Children With Upper Respiratory Infection	87.0%	88.1%	83.3%	4.8%	1.1%
	Appropriate Testing for Children With Pharyngitis	Appropriate Testing for Children With Pharyngitis	80.2%	80.6%	74.2%	6.4%	0.4%
	Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	Antibiotic Prescription not dispensed within 3 days	29.0%	27.1%	27.0%	0.1%	-1.9%
	Colorectal Cancer Screening	Colorectal Cancer Screening	60.5%	61.4%	51.3%	10.1%	0.9%
	Breast Cancer Screening	Breast Cancer Screening 52-69	77.8%	77.7%	69.8%	7.9%	-0.1%
	Breast Cancer Screening	Breast Cancer Screening 42-51	71.2%	72.5%	64.5%	7.9%	1.3%
	Breast Cancer Screening	Breast Cancer Screening Total	74.6%	75.2%	67.3%	7.9%	0.6%
	Cervical Cancer Screening	Cervical Cancer Screening	84.0%	84.9%	78.4%	6.5%	0.9%
	Chlamydia Screening	Chlamydia age 16-20	36.6%	35.1%	34.8%	0.3%	-1.5%
	Chlamydia Screening	Chlamydia age 21-25	36.1%	37.2%	37.5%	-0.3%	1.1%
	Chlamydia Screening	Chlamydia Total	36.3%	36.1%	36.4%	-0.3%	-0.2%
	Controlling High Blood Pressure	Blood Pressure Measure 18-85	64.0%	65.9%	62.2%	3.7%	1.9%
	Persistence of Beta-Blocker Treatment after a Heart Attack	Persistence of Beta-Blocker Treatment after a Heart Attack	72.9%	75.9%	68.3%	7.6%	3.0%
	Cholesterol Management after Acute Cardiovascular Conditions	LDL-C Screening	88.8%	90.2%	82.7%	7.5%	1.4%
	Cholesterol Management after Acute Cardiovascular Conditions	LDL-C Level <100 mg/dL	63.2%	68.4%	47.8%	20.5%	5.2%
	Comprehensive Diabetes Care	HbA1c Testing	92.0%	92.5%	83.2%	9.4%	0.5%
	Comprehensive Diabetes Care	Poor HbA1c Control >9.0%	20.6%	20.5%	43.4%	-22.9%	-0.1%
	Comprehensive Diabetes Care	Eye Exam	68.6%	65.9%	46.9%	19.0%	-2.7%
	Comprehensive Diabetes Care	LDL-C Screening	84.3%	85.2%	79.5%	5.7%	0.9%
	Comprehensive Diabetes Care	LDL-C Level <100 mg/dL	48.3%	50.9%	35.0%	15.8%	2.6%
	Comprehensive Diabetes Care	Medical Attention for Nephropathy	85.4%	86.1%	74.1%	11.9%	0.7%
	Comprehensive Diabetes Care	Blood Pressure Control <130/80 Hg	38.3%	40.1%	28.5%	11.6%	1.8%
	Comprehensive Diabetes Care	Blood Pressure Control <140/90 Hg	68.4%	69.8%	56.8%	13.0%	1.4%
	Use of Appropriate Medications for People with Asthma	Asthma age 5-9	97.2%	97.6%	97.1%	0.5%	0.4%
	Use of Appropriate Medications for People with Asthma	Asthma age 10-17	91.9%	94.4%	94.3%	0.1%	2.5%
	Use of Appropriate Medications for People with Asthma	Asthma age 18-56	91.1%	92.8%	91.2%	1.6%	1.7%
	Use of Appropriate Medications for People with Asthma	Asthma Combined	91.8%	93.6%	92.5%	1.1%	1.8%
	Use of Spirometry Testing in the Assessment and Diagnosis of COPD	Appropriate Spirometry Testing	37.9%	36.1%	34.9%	1.2%	-1.8%
	Pharmacotherapy Management of COPD Exacerbation	Dispensed a systemic corticosteroid within 14 days of the event	NA	45.3%	NA	NA	NA
	Pharmacotherapy Management of COPD Exacerbation	Dispensed a bronchodilator within 30 days of the event	NA	69.2%	NA	NA	NA

Appendix #5 Comparison of 2007 Participating HMO averages to 2006 HMO averages and 2007 National Averages

Domain	Measure	Score	2006 ETF Average	2007 ETF Average	2007 National Average	2007 ETF minus 2007 National Average	2007 ETF Average minus 2006 ETF Average
Effectiveness of Care							
	Follow-Up After Hospitalization for Mental Illness	30-day follow-up	83.2%	83.4%	69.6%	13.9%	0.2%
	Follow-Up After Hospitalization for Mental Illness	7-day follow-up	61.0%	61.9%	49.9%	12.0%	0.9%
	Antidepressant Medication Management	Optimal Practicioner Contacts for Medication Management	24.4%	21.3%	17.7%	3.6%	-3.1%
	Antidepressant Medication Management	Effective Acute Phase Treatment	65.4%	66.3%	63.2%	3.1%	0.9%
	Antidepressant Medication Management	Effective Continuation Phase Treatment	49.9%	49.6%	46.7%	2.9%	-0.3%
	Use of Imaging Studies for Low Back Pain	Use of Imaging Studies for Low Back Pain	76.6%	76.9%	74.1%	2.8%	0.3%
	Follow-Up Care for Children Prescribed with Attention-Deficit/Hyperactivity Disorder	Initiation Phase	30.4%	36.6%	33.0%	3.7%	6.2%
	Follow-Up Care for Children Prescribed with Attention-Deficit/Hyperactivity Disorder	Continuation and Maintenance Phase	27.1%	49.2%	36.9%	12.2%	22.1%
	Disease Modifying Anti-Rheumatic Drug Therapy in Rheumatoid Arthritis	At least one ambulatory prescription dispensed	90.7%	90.9%	82.7%	8.2%	0.2%
	Annual Monitoring for Patients on Persistent Medications	Annual monitoring for members on angiotensin converting enzyme (ACE) inhibitors or angiotensin receptor blockers (ARB	NA	74.4%	76.6%	-2.1%	NA
	Annual Monitoring for Patients on Persistent Medications	Annual monitoring for members on digoxin	NA	73.8%	78.0%	-4.3%	NA
	Annual Monitoring for Patients on Persistent Medications	Annual monitoring for members on diuretics	NA	74.3%	76.1%	-1.8%	NA
	Annual Monitoring for Patients on Persistent Medications	Annual monitoring for members on anticonvulsants	NA	56.9%	58.3%	-1.4%	NA
	Annual Monitoring for Patients on Persistent Medications	Total rate (the sum of the five numerators divided by the sum of the five denominators)	NA	73.8%	75.9%	-2.1%	NA
Access/Availability of Care							
	Adults' Access to Preventive/Ambulatory Health Services	Access Age 20-44	95.0%	94.9%	92.3%	2.6%	-0.1%
	Adults' Access to Preventive/Ambulatory Health Services	Access Age 45-64	96.4%	96.5%	94.6%	1.9%	0.1%
	Adults' Access to Preventive/Ambulatory Health Services	Access Age 65 and older	98.6%	98.6%	95.8%	2.8%	0.0%
	Children's Access to Primary care Practitioners	Access 12-24 months	97.9%	98.4%	95.6%	2.8%	0.5%
	Children's Access to Primary care Practitioners	Access 25 months-6 years	89.5%	90.1%	88.2%	1.9%	0.6%
	Children's Access to Primary care Practitioners	Access 7-11 years	89.3%	89.0%	88.4%	0.6%	-0.3%
	Children's Access to Primary care Practitioners	Access 12-19 years	89.2%	88.5%	85.5%	3.0%	-0.7%
	Prenatal and Postpartum Care	Timeliness of Prenatal Care	90.7%	92.0%	77.5%	14.5%	1.3%
	Prenatal and Postpartum Care	Postpartum Care	83.9%	85.1%	69.0%	16.1%	1.2%
	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	Initiation of Alcohol and Other Drug Dependence Treatment	39.4%	41.0%	45.1%	-4.1%	1.6%
	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	Engagement of Alcohol and Other Drug Dependence Treatment	16.5%	16.7%	15.2%	1.5%	0.2%
	Call Timeliness	Call Timeliness	77.7%	78.0%	77.6%	0.4%	0.3%
	Call Abandonment	Call Abandonment	3.0%	4.2%	2.3%	1.9%	1.2%
Use of Services							
	Well-Child Visits in the First 15 Months of Life	Well-Child Visits in the First 15 Months of Life (six or more visits)	79.6%	75.3%	69.0%	6.3%	-4.3%
	Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	65.9%	66.3%	65.0%	1.2%	0.4%
	Adolescent Well-Care Visits	Adolescent Well-Care Visits	36.4%	37.9%	39.0%	-1.1%	1.5%

Appendix #6: 2008 Description of Six Composite Scores and Morpace Inc. Key Driver Analysis

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

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

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

3) **How Well Doctors Communicate**
    - Explain things in a way you could understand
    - Listen carefully to you
    - Show respect for what you had to say
    - Spend enough time with you

4) **Shared Decision Making**
    - Doctor talked about pros/cons of each choice
    - Doctor asked which choice was best for you

5) **Customer Service**
    - Got information or help needed
    - Treated you with courtesy and respect

6) **Claims Processing**
    - Health plan handled claims quickly
    - Health plan handled claims correctly

Dependent Variable
Individual questions within the composite categories are correlated with how people rated their overall satisfaction with their health plan. The percentage of respondents ranking their health plan/health care from 8 to 10 (on a scale of 0 to 10) is compared to NCQA's Quality Compass. The health plan is ranked among health plans that reported to NCQA in 2008 (measured year 2007) and that allowed their data to be publicly reported.

Key Driver Analysis:

Health Plan Strength
Key driver of satisfaction and plan rates are at/above the 75th percentile when compared to Quality Compass 2008. Recommended action: Market and Maintain.

Monitor
Key driver of satisfaction, but rates between the 50th and 75th percentile when compared to Quality Compass 2008. Recommended action: Monitor.

Health Plan Opportunity
Key Driver of satisfaction but plan rates below the 50th percentile when compared to Quality Compass 2008. Recommended action: Investigate and Improve.

Appendix #7: 2008 Overall Levels of Satisfaction by Health Plan

	Q12. How people rate their Health Care		Q21. How people rate their Primary Doctors		Q25. How people rate their Specialists		Q42. How people rate their Health Plan	
Health Plan	**ETF**	**Percentile***	**ETF**	**Percentile***	**ETF**	**Percentile***	**ETF**	**Percentile***
Anthem BCBS Northwest	↔	90th	↔	90th	↔	90th	↓	10th
Anthem BCBS Southeast	↓	25th	↓	10th	↔	10th	↔	50th
Arise Health Plan	↑	90th	↔	90th	↔	50th	↑	90th
Dean Health Plan	↔	90th	↔	90th	↔	50th	↑	90th
GHC-Eau Claire	↔	90th	↑	90th	↑	75th	↑	90th
GHC-SCW	↑	90th	↔	25th	↔	10th	↑	90th
Gundersen Lutheran	↑	90th	↑	90th	↔	50th	↑	90th
Health Tradition	↑	90th	↑	90th	↔	25th	↑	90th
Humana-Eastern	↔	50th	↔	90th	↔	25th	↔	50th
Humana-Western	↓	Below 10th	↓	25th	↔	25th	↓	Below 10th
Medical Associates	↑	90th	↑	90th	↑	90th	↑	90th
MercyCare Health Plan	↔	50th	↔	25th	↔	25th	↔	75th
Network Health Plan	↔	50th	↓	10th	↔	75th	↑	90th
Physicians Plus	↔	90th	↔	75th	↔	50th	↑	90th
Security Health Plan	↔	75th	↔	75th	↔	50th	↑	90th
Standard Plan	↔	90th	↔	90th	↔	75th	↑	90th
State Maintenance Plan	↓	Below 10th	↓	10th	↓	Below 10th	↓	Below 10th
UnitedHealthcare NE	↔	75th	↔	50th	↔	25th	↔	75th
UnitedHealthcare SE	↔	50th	↔	25th	↔	50th	↔	75th
Unity-Community	↔	75th	↔	25th	↓	Below 10th	↑	90th
Unity-UW Health	↔	75th	↔	50th	↔	25th	↑	90th
WPS Metro Choice	↔	90th	↔	90th	↔	Below 10th	↔	50th

***2008 Quality Compass ranking**
Below 10th = Below 10th
10th = 10th to 24th
25th = 25th to 49th
50th = 50th to 74th
75th = 75th to 89th
90th = 90th or Above

Appendix #8: 2008 Satisfaction with Six Areas of Care

	GETTING CARE QUICKLY		SHARED DECISION MAKING		HOW WELL DOCTORS COMMUNICATE		GETTING NEEDED CARE		CUSTOMER SERVICE		CLAIMS PROCESSING	
Health Plan	ETF	PERCENTILE*	ETF	PERCENTILE*	ETF	PERCENTILE*	ETF	PERCENTILE*	ETF	PERCENTILE*	ETF	PERCENTILE*
Anthem BCBS Northwest	↔	90th	↔	10th	↔	50th	↔	75th	↓	Below 10th	↓	Below 10th
Anthem BCBS Southeast	↔	50th	↔	Below 10th	↓	10th	↔	50th	↓	Below 10th	↓	10th
Arise Health Plan	↔	90th	↔	50th	↔	90th	↑	90th	↔	50th	↑	75th
Dean Health Plan	↔	90th	↔	25th	↔	90th	↔	50th	↑	75th	↑	75th
GHC-Eau Claire	↔	90th	↔	50th	↔	90th	↑	90th	↑	90th	↑	75th
GHC-SCW	↔	50th	↔	25th	↔	90th	↔	Below 10th	↑	75th	↑	50th
Gundersen Lutheran	↔	90th	↔	10th	↑	90th	↔	90th	↔	75th	↑	90th
Health Tradition	↑	90th	↔	25th	↑	90th	↑	90th	↑	90th	↑	75th
Humana-Eastern	↔	50th	↔	10th	↔	50th	↔	25th	↓	10th	↓	10th
Humana-Western	↔	50th	↓	Below 10th	↓	50th	↓	Below 10th	↓	Below 10th	↓	Below 10th
Medical Associates	↔	90th	↑	90th	↑	90th	↑	90th	↑	90th	↑	90th
MercyCare Health Plan	↓	50th	↔	25th	↔	90th	↔	25th	↔	50th	↔	25th
Network Health Plan	↔	25th	↔	10th	↓	25th	↔	50th	↑	90th	↑	90th
Physicians Plus	↔	75th	↔	25th	↔	75th	↔	25th	↔	75th	↑	75th
Security Health Plan	↔	90th	↓	Below 10th	↔	90th	↑	75th	↔	90th	↑	90th
Standard Plan	↔	90th	↔	75th	↔	90th	↔	90th	↔	90th	↔	90th
State Maintenance Plan	↔	90th	↔	25th	↔	50th	↓	Below 10th	↔	75th	↓	Below 10th
UnitedHealthcare NE	↔	90th	↔	Below 10th	↔	50th	↑	90th	↓	10th	↓	25th
UnitedHealthcare SE	↑	90th	↔	Below 10th	↔	90th	↑	90th	↔	10th	↔	10th
Unity-Community	↔	90th	↔	25th	↔	90th	↔	25th	↑	90th	↑	75th
Unity-UW Health	↓	10th	↔	25th	↔	75th	↔	10th	↑	75th	↑	90th
WPS Metro Choice	↔	90th	↔	25th	↔	50th	↔	10th	↔	25th	↓	10th

***2008 Quality Compass ranking**
Below 10th = Below 10th
10th = 10th to 24th
25th = 25th to 49th
50th = 50th to 74th
75th = 75th to 89th
90th = 90th or Above

Appendix #9: 2008 Morpace Inc. Key Drivers of Satisfaction with Health Plan

	Q35 - Got info/help needed from customer service (r=.59)			Q40 - Handled claims quickly (r=.59)			Q41 - Handled claims correctly (r=.59)			Q36 - Customer service treated you with courtesy & respect (r=.56)			Q27 - Ability to get care believed necessary (r=.54)		
Health Plan	**ETF**	**Percentile***	**Action****	**ETF**	**Percentile***	**Action****	**ETF**	**Percentile***	**Action****	**ETF**	**Percentile***	**Action****	**ETF**	**Percentile***	**Action****
Anthem BCBS Northwest	↓	Below 10th	O	↓	Below 10th	O	↓	Below 10th	O	↓	Below 10th	O	↔	25th	O
Anthem BCBS Southeast	↓	10th	O	↔	Below 10th	O	↔	25th	O	↓	Below 10th	O	↔	50th	M
Arise Health Plan	↑	75th	S	↔	75th	S	↑	75th	S	↔	50th	M	↑	90th	S
Dean Health Plan	↑	90th	S	↔	50th	M	↑	75th	S	↑	50th	M	↔	50th	M
GHC-Eau Claire	↑	90th	S	↑	75th	S	↑	75th	S	↑	90th	S	↑	90th	S
GHC-SCW	↑	90th	S	↑	50th	M	↑	50th	M	↔	50th	M	↔	50th	M
Gundersen Lutheran	↔	50th	M	↑	90th	S	↑	90th	S	↔	90th	S	↔	90th	S
Health Tradition	↑	75th	S	↑	75th	S	↑	75th	S	↔	90th	S	↑	75th	S
Humana Eastern	↓	10th	O	↓	Below 10th	O	↓	10th	O	↓	25th	O	↔	25th	O
Humana Western	↓	Below 10th	O	↓	Below 10th	O	↓	Below 10th	O	↓	Below 10th	O	↓	Below 10th	O
Medical Associates	↑	90th	S	↔	90th	S	↑	75th	S	↑	90th	S	↑	90th	S
MercyCare Health Plan	↔	50th	M	↔	25th	O	↔	25th	O	↔	50th	M	↔	50th	M
Network Health Plan	↑	90th	S	↑	90th	S	↑	90th	S	↑	90th	S	↔	50th	M
Physicians Plus	↔	75th	S	↑	50th	M	↑	75th	S	↔	75th	S	↔	50th	M
Security Health Plan	↑	90th	S	↑	90th	S	↔	75th	S	↔	90th	S	↑	90th	S
Standard Plan	↑	90th	S	↔	75th	S	↑	90th	S	↑	90th	S	↔	90th	S
State Maintenance Plan	↔	50th	M	↓	Below 10th	O	↓	Below 10th	O	↔	90th	S	↓	Below 10th	O
UnitedHealthcare NE	↓	Below 10th	O	↓	25th	O	↔	50th	M	↓	10th	O	↑	90th	S
UnitedHealthcare SE	↔	Below 10th	O	↔	10th	O	↔	10th	O	↔	25th	O	↑	90th	S
Unity-Community	↑	90th	S	↔	75th	S	↑	90th	S	↑	90th	S	↔	90th	S
Unity-UW Health	↑	75th	S	↑	75th	S	↑	90th	S	↑	75th	S	↔	50th	M
WPS Metro Choice	↔	25th	O	↔	10th	O	↓	10th	O	↔	50th	M	↔	25th	O

***2008 Quality Compass ranking**
Below 10th = Below 10th
10th = 10th to 24th
25th = 25th to 49th
50th = 50th to 74th
75th = 75th to 89th
90th = 90th or Above

**S=Stregnth
**M=Monitor
**O=Opportunity

Appendix #10: CAHPS Historical Trending Summary

Health Plan	How people rated their HEALTH PLAN			How people rated their HEALTH CARE			How people rated their PRIMARY DOCTOR			How people rated their SPECIALISTS		
Year	**2006**	**2007**	**2008**	**2006**	**2007**	**2008**	**2006**	**2007**	**2008**	**2006**	**2007**	**2008**
Average—All Health Plans	8.06	8.03	8.06	8.47	**8.30↓**	8.34	8.36	**8.64↑**	8.66	8.34	**8.42↑**	8.48
Anthem BCBS Northwest	NA	7.35	7.08	NA	8.26	8.40	NA	8.70	8.86	NA	8.44	8.70
Anthem BCBS Southeast	7.58	7.49	7.63	8.33	**7.83↓**	7.95	8.20	8.30	8.28	8.27	8.09	8.24
Arise Health Plan	8.27	8.07	**8.42↑**	8.65	**8.43↓**	**8.62↑**	8.42	8.61	8.76	8.40	8.56	8.55
Dean Health Plan	8.34	**8.12↓**	**8.35↑**	8.50	**8.21↓**	**8.45↑**	8.39	**8.69↑**	8.79	8.37	8.35	8.50
GHC Eau Claire	8.51	8.43	8.48	8.60	8.52	8.43	8.55	**8.85↑**	8.84	8.27	8.57	8.70
GHC-SCW	8.22	8.28	8.23	8.30	8.29	8.32	8.16	8.33	8.50	8.18	8.12	8.31
Gundersen Lutheran	8.48	8.51	8.58	8.77	**8.55↓**	**8.75↑**	8.69	**8.93↑**	9.08	8.62	8.45	8.67
Health Tradition	8.35	8.26	8.38	8.51	8.41	8.51	8.52	8.71	**8.92↑**	8.22	8.13	8.41
Humana Eastern	7.64	7.60	7.66	8.32	**8.08↓**	8.21	8.25	8.49	**8.69↑**	8.18	**8.51↑**	8.25
Humana Western	7.76	7.59	**5.75↓**	8.61	8.51	**7.54↓**	8.58	**8.80↑**	**8.50↓**	8.52	8.78	**8.31↓**
Medical Associates	8.60	8.45	8.49	8.77	8.58	8.73	8.72	**9.05↑**	9.20	8.59	8.48	**8.92↑**
MercyCare Health Plan	7.85	7.89	8.05	8.24	8.09	8.19	8.26	8.47	8.49	8.01	8.26	8.35
Network Health Plan	8.32	8.30	8.32	8.39	8.20	8.19	8.13	**8.42↑**	8.41	8.37	8.45	8.58
Physicians Plus	8.44	8.32	8.33	8.54	8.33	8.45	8.34	8.57	8.60	8.55	8.43	8.56
Security Health Plan	NA	NA	8.22	NA	NA	8.31	NA	NA	8.57	NA	NA	8.51
Standard Plan	8.45	8.39	8.58	8.76	**8.56↓**	8.65	8.59	**8.90↑**	8.91	8.63	8.85	8.83
State Maintenance Plan	6.98	6.98	6.35	8.07	7.94	7.63	8.14	**8.63↑**	8.17	8.00	8.23	**7.29↓**
UnitedHealthcare NE	7.46	7.69	7.85	8.39	8.23	8.27	8.25	**8.62↑**	8.54	8.33	8.20	8.37
UnitedHealthcare SE	NA	7.78	7.78	NA	8.31	8.19	NA	8.79	8.59	NA	8.30	8.54
Unity Community	7.97	8.24	8.27	8.31	8.34	8.29	8.22	**8.68↑**	8.44	7.82	**8.45↑**	**7.99↓**
Unity UW Health	8.37	8.19	8.20	8.58	**8.31↓**	8.31	8.34	8.47	8.54	8.45	8.40	8.32
WPS Metro Choice	NA	7.23	7.58	NA	8.07	8.28	NA	8.69	8.8	NA	8.08	8.29

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

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CORRESPONDENCE MEMORANDUM

DATE: January 29, 2009

TO: Group Insurance Board

FROM: Arlene Larson, Manager, Self-Insured Health Plans

SUBJECT: Third Party Audit of WPS Health Insurance

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

The Department of Employee Trust Funds (ETF) retained Claim Technologies Incorporated (CTI) to conduct an audit of the WPS Health Insurance (WPS) administration of the self-insured plans for the calendar years 2006 and 2007. CTI has completed its audit and is submitting the attached Executive Summary report. The response from WPS is also attached. Additional detailed reports developed by CTI are available to the Board upon request.

Overall, WPS is performing well and the audit did not reveal any areas of substantial concern. In its broadest measure, WPS is performing in the top half of the approximately 100 plans CTI has audited (see page 4 of the Executive Summary) on 11 of 12 measures, for both the Medicare and non-Medicare populations. However, in one of the measures, (documentation accuracy - financial for the Medicare Plus $1,000,000 plan) WPS performed below average. WPS performed worse in 2006 but its performance improved significantly in 2007.

CTI has identified areas of opportunity for improvement in processes that could result in financial savings and/or improved customer service. WPS responded that, while in general it agrees with CTI's findings, WPS nevertheless questions certain findings due to past practice and interpretation by ETF. Staff will follow up with WPS to assure that all identified issues are addressed. In areas where the contract needs to be strengthened or clarified to reflect issues identified by the audit, staff will proceed in this direction. The major findings consist of:

1. CTI found an area for improvement regarding claims that were paid after member termination date. The problem was that claims were not recouped for seven retroactively-terminated individuals. This involved $24,577 worth of claims. ETF sends WPS enrollment changes electronically, after entering information received from the employer or member. At times, termination information is received by ETF quite some time after the event. When this occurs, claims may be paid that subsequently need to be recovered. The contract requires that WPS make diligent efforts to recover overpayments over $50, as trying to recover payments of less than $50 is not cost effective. As a result of this finding, WPS has altered its recovery procedures and is attempting to recover these dollars, as required in the contract. WPS is also instituting monthly reporting on the types of recoveries. **Staff agrees with CTI that this is an error. Staff will assure that the recovery of claims paid after termination is pursued for identified members and any future affected members.**

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

______________________________ ____________
Signature Date

Board	Mtg Date	Item #
GIB	02/17/2009	3

2. Miscellaneous Policy Provisions: CTI found several items with relatively low dollar amounts, usually under $10,000, that may have been paid in error. These include claims CTI considers experimental, or items typically denied by health plans, such as massage therapy and automated lab charges. WPS concurs with some findings, but disputes others and stated it consulted with ETF in these cases. **However, ETF staff does not agree with WPS in all cases, but will work with WPS to determine if any identified claim issues will require recovery and if any contract language should be clarified.**
3. CTI reviewed all claims paid in order to find duplicate payments. CTI needed certain data elements in the claims information to conduct this review, but WPS could not provide it. CTI identified 439 Standard Plan/SMP and 148 Medicare Plus $1,000,000 members with potential duplicate payments. WPS tested 267 of these members and discovered three cases with errors, resulting in overpayments totaling $1,045. The other cases were not duplicates. CTI agreed with the review but recommends a follow-up screening of the information to validate that WPS is denying duplicate submissions. **Staff feels that WPS is adequately managing duplicate submissions. However, WPS data compilation needs to be adjusted to include elements necessary to ease review during the next audit cycle, and the dollars paid in error need to be recouped. Staff will work with WPS to prepare the data for subsequent audits.**
4. Potential Fraud and Abuse: CTI found that WPS did not have protocols in place to review claims that were billed fraudulently for nerve conduction studies when submitted without a coinciding needle electromyogram (EMG). WPS agreed with CTI and has since adjusted claim workflows to send such claims to medical review to determine if the services are medically necessary and have been billed appropriately. **Staff feels that this issue is resolved adequately.**
5. CTI compared performance of six measures for accuracy in claim payment to 100 other plans CTI has audited. CTI found that under the Standard Plan/SMP programs, WPS performed well in all measures. They further found that under the Medicare Plus $1,000,000 plan, WPS performed well in five of the six measures. WPS agrees with the results and notes that in the measure where they did not perform well, financial documentation accuracy, the poor performance occurred in 2006 and was corrected in 2007. **Staff concurs with the assessment.**
6. CTI used the audit results to calculate the performance of WPS in accordance with the performance guarantee definitions found in the contract. The results presented by CTI differ from those reported by WPS. WPS states that this is due to three claims for self-administered drugs. WPS disagrees with CTI's interpretation of the benefit and states that without these errors, the results would show that WPS met or exceeded all but one of the performance measures. **Staff will review the contract language on self-administered drugs to determine if changes should be made.**
   - ♦ WPS self-reports the level of achievement for all performance guarantees. In 2007, WPS reported that it did not achieve one standard and subsequently paid applicable penalties.
7. CTI recommends the formation of a Quality Team to oversee follow-up activities. **Staff will work with WPS to follow up on audit issues and provide the Board with a progress report as needed.**

Please contact me at 608-264-6624 if you have any questions.

January 20, 2009

Ms. Arlene Larson
Manager, Self Insured Health Plans
State of Wisconsin Department of Employee Trust Funds
P.O. Box 7931
Madison, WI 53707-7931

RE: Wisconsin Physicians Service Insurance Corporation 2006 and 2007 State of Wisconsin Department of Employee Trust Funds (ETF) health insurance audit performed by Claims Technologies Incorporated (CTI)

Dear Ms. Larson,

This letter represents Wisconsin Physicians Service Insurance Corporation (WPS) response to the Claims Technologies Incorporated (CTI) Executive Summary of Claims Administration Audit Finding for the auditing period of January 1, 2006 to December 31, 2007. We appreciate the opportunity to engage in and respond to CTI's audit observations, findings and statistics.

AUDIT FINDINGS/OPPORTUNITIES FOR SAVINGS AND IMPROVEMENT

- **Claims Paid After Termination** – WPS is in the process of attempting to recoup the $24,577 paid on the seven terminated employees identified by CTI.

  In addition, effective January 1, 2009 software enhancements were implemented to improve timely and successful recoupment of claim overpayments due to the retroactive termination of ETF employees. WPS will provide ETF with a monthly status report of retro termination refund requests beginning in February 2009.

  WPS will discuss with ETF whether ETF wants WPS to pursue the member if the collection efforts with the provider are unsuccessful.

- **Miscellaneous Policy Provision Errors** – WPS has reviewed the variety of errors occurring on an infrequent basis with ETF and CTI and completed an analysis of each cited error. ETF and WPS mutually agreed upon the manner in which the claims were processed.

  CTI: Potential overpayment of Automated Labs.

  WPS concurred with the reviewer on the two tested cases totaling $12.00 with CPT codes 82272 and 81000. Shortly after this finding was reported to WPS, we modified our benefit system to reject procedure codes 82272 and 81000 when billed with modifier 26.

Corporate Address—1717 W. Broadway • P. O. Box 8190 • Madison, WI 53708 • (608) 221-4711

We believe this action will address the finding noted by the reviewer in conjunction with the automated code editing system to verify appropriateness of provider coding on submitted claims.

WPS does not agree with the basis for 100 of the remaining 146 untested cases, as the lab codes identified by CTI are not defined as "automated" in the Current Procedural Terminology (CPT) manual by the American Medical Association. Nor do the Centers for Medicare & Medicaid Services (CMS) Resource–based Relative Value Scale (RBRVS) payment policies support paying them as an automated lab.

CTI: Potential overpayment for Experimental and Investigational Services.

CTI identified 12 cases of procedures paid with CPT codes that denote them as experimental/ investigational in nature that were not approved by preauthorization, medical review or case management.

As a result of the CTI finding, claims with the identified CPT codes will now be reviewed by our Medical Affairs department for a medical necessity determination for the Standard and SMP ETF plans.

CTI: WPS is covering massage therapy as there is no specific exclusion in the Plan.

WPS concurred with the reviewer that there is no specific exclusion for massage therapy in the ETF Standard and SMP Plans or Medicare Plus $1,000,000 plans. Massage Therapy (CPT 97124) which is designed to restore muscle function, reduce edema, improve joint motion, or relieve muscle spasm, may be medically necessary as adjunctive treatment to another therapeutic procedure on the same day.

Upon review of the BCBS historical claims data provided by ETF, BCBS was also processing massage therapy as a payable benefit under all ETF plans. In addition, two other carriers, Aetna and United Health Care, have medical guidelines substantiating coverage for massage therapy when medically necessary and performed by a provider practicing within the scope of their license. Preferred providers who can perform these services within the scope of their license would be physical therapists and chiropractors. WPS also considers this code for payment based upon medical necessity when services are provided within the scope of the provider's license.

If it is ETF's intent to exclude massage therapy services, WPS can add an exclusion for massage therapy services to both plans and update the WPS benefit system to reject this service upon written request from ETF.

- **Duplicate Payments**

WPS concurred with the reviewer that CTI's ESAS screening for duplicates produced false positives.

- **Potential Fraud and Abuse**

  As a result of the CTI finding, WPS has updated the claim processing workflows effective August 4, 2008 to include sending nerve conduction studies billed without an associated needle electromyography (EMG) to our Medical Review department for the purpose of determining whether the services are medically necessary.

PERFORMANCE BENCHMARKING OF WPS

Overall, WPS is performing very well. CTI validated WPS' claim administration performance for ETF's combined plans to be in either the highest (best) performance quartile or above average performance, with one exception. Documentation Accuracy - Financial evaluates how well we investigate claims before payment. For the Medicare Plus $1,000,000 plan in 2006, WPS fell below the median level of performance. However, WPS' performance in this category moved into the highest (best) performance quartile in 2007 at 100%.

WPS PERFORMANCE GUARANTEES

The variances reported in the CTI "WPS Performance Guarantee Year 2007" table using the CTI extrapolated formulas is due to the same finding (cited for audit numbers 2110, 2135, and 2145); namely, the processing of self-administered drugs which WPS is not in agreement with.

CTI's position is that WPS paid for non-covered services because the Outline of Coverage included in the Summary of Plan Descriptions for 2006 and 2007 implies that self-administered drugs are not covered. However, the Medicare Plus $1,000,000 Master Plan Document does not support excluding self-administered drugs in an outpatient hospital setting. WPS's responsibility, as administrator, is to pay benefits as stipulated by the signed Master Plan Document.

In the absence of these 3 claims CTI's results for Payment Accuracy would be 98.1% and for Processing Accuracy would be 98.6%; both of which are above the performance guarantee standard of 97%. Due to the difference in audit methodology between CTI and WPS, specifically the claim frequency and dollars per stratum, WPS is unable to recalculate CTI's Financial Accuracy rate when removing the self-administered drug claims.

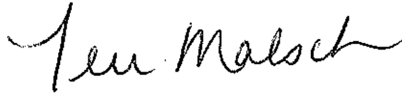
If it is ETF's intent to exclude self-administered drugs in an outpatient hospital setting, an exclusion can be added to the Master Plan Document and the WPS benefit system will be set to reject self-administered drugs in an outpatient hospital setting upon written request from ETF.

RECOVERY AND IMPROVEMENT OPPORTUNITIES NEXT STEPS RECOMMENDATIONS

In summary, WPS has performed well as documented in the CTI Executive Summary of Claims Administration Audit Findings. Additionally, WPS was given high marks by CTI for our thorough and responsive performance during the audit process.

WPS would be pleased to meet with CTI and ETF with an agenda focusing on these audit findings and process improvement ideas. WPS will follow up with ETF on any open items. Please feel free to contact me at (608)221-5086, if you have any questions.

Sincerely,



Teri Malsch
Vice President, Claims Operations

EXECUTIVE SUMMARY OF CLAIMS ADMINISTRATION AUDIT FINDINGS

For the

State of Wisconsin, Department of Employee Trust Funds

Standard and SMP Plans

Medicare Plus $1,000,000 Plan

Administered by:

Wisconsin Physician Service Insurance Corporation

Audit Period: 01/01/06 – 12/31/07

Presented by:

Claim Technologies Incorporated
January 14, 2008

STRICTLY PRIVATE AND CONFIDENTIAL
NOT TO BE REPRODUCED

SUMMARY OF CLAIMS ADMINISTRATION AUDIT FINDINGS

The State of Wisconsin Employee Trust Fund (ETF) engaged Claim Technologies Incorporated (CTI) to perform Comprehensive Audits of the claims administration of ETF's self-funded medical benefit plans administered by WPS Health Insurance (WPS). An independent claim administration audit firm, CTI performed the audits in the second quarter of 2008. The purpose of the audits was to assess the quality of claims administration being provided by WPS. The audits covered claims processed during the period of January 1, 2006 through December 31, 2007. Using data provided by WPS, CTI analyzed $28,805,636 in claims payments made by the Medicare Plus $1,000,000 plan and $96,468,383 in claims payments made by the State Maintenance Plan (SMP) and Standard plans. Overall the results of the audits indicate that for the audit period WPS' claim administration accuracy and proficiency was good. Areas for improvement were identified and have been discussed with WPS and authorized representatives of the ETF.

Audit Approach

The CTI Audit System is designed to measure and facilitate continuous quality improvement in the processes of claim administration. This Audit System views administrative processes through the lens of CTI's Electronic Screening and Analysis System (ESAS®) and statistically through a Statistical Sample Field Audit.

The following table shows the specific benefits of each of the two techniques used by CTI in its Audit System.

ESAS®	Field Audit
Electronic Screening and Analysis of 100% of Paid Claims Data	Stratified Sample of Paid Claims **Confidence Level 95% (+/- 3%)**
Benefits include: • **Focus In Known High Control Risk Categories** • **Identify Potential Overpayments For Recovery**	**Sample designed to:** • **Benchmark Performance** • **Quantify Financial Impact** • **Prioritize Issues**

AUDIT FINDINGS/OPPORTUNITIES FOR SAVINGS AND IMPROVEMENT

The areas demonstrated by ESAS® to have opportunity for improvement in WPS' claim administration processes that would represent financial savings or improved customer service for ETF are summarized as follows.

- **Claims Paid After Termination** – Eligibility information, including termination dates, are sent to WPS from ETF electronically. Eligibility changes, additions and terminations are sent daily and enrollment records are reconciled with ETF monthly.

  Through ESAS® CTI identified seven cases of claims being paid after the employee's coverage termination date; ESAS® confirmed the amount to have been paid on these seven terminated employees was $24,577. WPS responded to our questions regarding why these claims remained paid after the termination date saying that WPS does not attempt collection on claims paid after the termination date when the termination information from ETF is delayed. As a result of this audit WPS stated that it would proceed with attempts to recover these overpayments, and that it

would revise its policy regarding recovering overpayments caused by retroactive terminations made by the ETF.

- **Miscellaneous Policy Provision Errors** – ESAS® determined that a variety of errors caused by incorrect application of the ETF Plans' limitations and exclusions were occurring on an infrequent basis resulting in a combination of over- and under- payments. Payment errors were identified and confirmed in the amount of $19,977 and an additional potential exposure of $70,146 was identified by CTI's ESAS® system. CTI recommends discussion with WPS and potentially further causal analysis by WPS into the errors to determine if opportunities exist for further reducing errors. Because of the wide variety of issues observed, ETF should confirm through follow-up audits that corrective measures by WPS have been successful.

- **Duplicate Payments** – CTI was not able to fully use its ESAS® system to test WPS' system capability for identifying and denying duplicate claim submissions. CTI's efforts to use ESAS® to quantify the impact of payment of duplicate claims were thwarted due to lack of information in the claim data received from WPS such as CPT code modifiers. CTI would recommend a follow-up electronic screening audit using complete claim information to validate for ETF that WPS' is performing well with respect to identifying and denying duplicate submissions.

- **Potential Fraud and Abuse** – CTI determined through ESAS® that WPS does not have a protocol in place for identifying nerve conduction studies without an accompanying needle EMG and with no evidence of medical necessity. This is a new pattern of abuse by providers in billing for a study in isolation that is not conclusive without completing a companion procedure (per the American Association of Neuromuscular and Electrodiagnostic Medicine). Through testing, 2 potential overpayments totaling $2,175 were identified for nerve conduction studies without an accompanying needle EMG and with no evidence of medical necessity; additionally $58,878 was identified to have been paid on 63 other cases. As a result of this audit WPS has advised that it is in the process of establishing criteria for review of nerve conduction studies performed without an accompanying needle EMG and/ or with insufficient evidence of medical necessity.

PERFORMANCE BENCHMARKING OF WPS

CTI's protocols for conducting its Statistical Sample Field Audits enables it to compare claim administration process performance between administrators and plans to Benchmarks that it has created and maintains. The following table demonstrates that in five of the six measures used by CTI to facilitate meaningful comparison WPS' accuracy in administering the Medicare Plus $1,000,000 plan is good when compared to approximately one hundred other plans most recently audited by CTI. WPS' performance was good in all six measures for the SMP and Standard plans.

PERFORMANCE MEASURES	PERFORMANCE BY QUARTILES			
✓ = Medicare Plus $1,000,000 ● = Standard and SMP Plans	1st (Lowest)	2nd	3rd	4th (Highest)
Documentation Accuracy – Financial compares the number of dollars processed with documentation adequate to substantiate payment or denial to the total number of dollars processed in the Audit Sample.		✓		●
Documentation Accuracy – Frequency compares the number of claims processed with documentation adequate to substantiate			✓	

payment or denial to the total number of claims processed in the Audit Sample.				●
Financial Accuracy compares the total correct claim payments that were made to the total dollars of correct claim payments that should have been made for the Audit Sample. The formula for this measure is: Total correct payments (claims paid in the sample minus overpayments plus underpayments) minus the absolute variance (overpayments plus underpayments), divided by total correct payments.			●	✓
Accurate Payment Frequency compares the number of bills paid correctly to the total number of bills paid for the Audit Sample.			● ✓	
Adjudication Proficiency compares the number of correct adjudication decisions made to the total number of adjudication decisions required for the claims in the Audit Sample			✓	●
Accurate Processing Frequency compares the number of bills processed without errors to the total number of bills processed in the Audit Sample.			✓	●

WPS PERFORMANCE GUARANTEES

The ETF has performance standards in place in its Administrative Agreement with WPS. In the two tables below CTI shows its Statistical Sample Field Audits' results side by side with WPS' reported audit results for the same year. This is done to allow comparison of CTI's Statistical Sample Field Audit outcomes using its operational definitions against WPS' audit outcomes using its operational definitions. This comparison enables discussion about the differences in operational definitions and methodology for construction of audit samples. Differences in audit outcomes also will result from different audit techniques and standards for what constitutes an "error".

WPS Performance Guarantees Year 2006

Performance Measure	WPS Guarantee	WPS Reported Performance Whole Group 2006	Performance Using CTI Formula 2006
Financial Accuracy	99%	99.3%	99.9%
Payment Accuracy	97%	97.2%	99.5%
Processing Accuracy	97%	97.2%	98.1%
Turnaround Time	95% paid within 30 days of receipt	99% of claims were paid within 30 days of receipt	5 days

WPS Performance Guarantees Year 2007

Performance Measure	WPS Guarantee	WPS Reported Performance Whole Group 2007	Performance Using CTI Formula 2007
Financial Accuracy	99%	99.5%	98.8%
Payment Accuracy	97%	97.1%	96.7%
Processing Accuracy	97%	96.8%	94.8%
Turnaround Time	95% paid within 30 days of receipt	99% of claims were paid within 30 days of receipt	8 days

Additional areas of review performed during the audit are:

- **Telephone Inquiries**: WPS reported its abandoned call rate as .8% in 2006 and .675% in 2007, well within the expected time frame of 3%.

- **Written Inquires**: WPS reported its resolved inquiries rate as 2 business days in 2006 and as 3 business days in 2007, well within the expected time frame of 12 business days.

- **Enrollment File Updates**: WPS reported its rate of enrollment file updates as one business day for daily maintenance files and 2 business days for manual entry files in 2006 and 0 business days for daily maintenance files and one business day for manual entry files in 2007, within the expected time frame of one business day for daily maintenance files and 2 business days for manual entry files.

- **ID Card Issuance**: WPS reported its ID card issuance rate as 2 business days in 2006 and as 2 business days in 2007, well within the expected time frame of 5 business days.

RECOVERY AND IMPROVEMENT OPPORTUNITIES NEXT STEPS RECOMMENDATIONS

In prioritized order, opportunities for improvement (as previously described in this report) should be analyzed and action plans agreed upon and implemented. To ensure that the ETF has input and control over the improvement actions taken CTI recommends two steps:

- the implementation of a Quality Team, and
- follow-up sequential comprehensive audits

Building on the database established for each plan in the 2006 and 2007 Audits, CTI proposes follow-up Comprehensive Audits for all ETF Plans covering the 12-month period from January 1, 2008 through December 31, 2008. The results would be used by ETF to monitor ongoing performance and to assess performance penalties for the year ending December 31, 2008.

We have considered it a privilege to have worked for and with ETF's staff in these important endeavors and would welcome any opportunity to assist you in achieving your future objectives. Thank you again for selecting CTI to assist you in these important endeavors.

Sincerely,

Patricia C. Gagne, FLMI
Vice President

Kelly Barnett, HIA
Account Executive

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Department of Employee Trust Funds
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CORRESPONDENCE MEMORANDUM

DATE: January 29, 2009

TO: Group Insurance Board

FROM: Jeff Bogardus, Manager, Pharmacy benefit Programs

SUBJECT: Employer Group Direct Contract Medicare Part D Prescription Drug Plan for Medicare Eligible State Retirees

This memo is for informational purposes only. No Board action is necessary at this time.

This memo is to advise the Board of the staff's investigation into contracting directly with the Centers for Medicare and Medicaid Services (CMS) in order to provide a Medicare Part D Prescription Drug Plan (PDP) to more than 23,000 Medicare-covered State retirees and dependents. A Medicare Part D PDP would replace the subsidy the State Group Health Insurance Program currently receives from CMS under the Retiree Drug Subsidy (RDS) program.

Background

Since 2006 the State Group Health Insurance Program has participated in the RDS program. This Federal subsidy pays for 28% of the cost of Medicare Part D eligible retirees' pharmacy claims that fall between the cost thresholds and cost limits established by CMS annually (currently $295.00 and $6,000.00 respectively, for 2009). The RDS program has provided our program more than $10 million of Federal subsidy annually since its inception in 2006.

When Medicare prescription drug options were initially reviewed in 2005, it was determined that the cost savings from the RDS program were comparable to the cost savings attainable through an employer group PDP. Other factors that affected the decision to participate in the RDS program in 2006 included the administrative simplicity of the RDS program, as well as uncertainties and start-up costs related to designing a stand alone PDP.

Discussion

After discussions with Deloitte and Navitus, and conference calls with CMS, staff developed the following list of advantages and disadvantages of implementing a PDP.

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

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Signature Date

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PDP Advantages

- Additional Savings to the State Group Health Insurance Program
  Deloitte's financial modeling indicates the potential for additional annual savings of between $1 million and $2 million in 2010 if the option of a direct contract PDP is adopted, in place of the RDS program. Depending on the payment risk scores CMS uses to evaluate our population, the savings could vary in either direction. Deloitte is performing additional research to determine the accuracy of the modeling and staff is working to obtain better payment risk score information from CMS.

- Depletion of the GASB liability
  Current Governmental Accounting Standards Board (GASB) rules provide that the amount our program receives in RDS subsidy constitutes a GASB liability. The adoption of an employer group direct contract PDP option would essentially dissolve the estimated $500 million GASB liability associated with the subsidy from the RDS program.

- Employer Group Waivers
  CMS has the authority to waive certain requirements placed on commercial Part D plans to facilitate the offering of Part D plans by employers or employer funds to their retirees. In practice, this should significantly decrease the costs associated with implementing a PDP. In applying waivers, CMS considers a number of important goals, including:
    - Providing group plan sponsors with maximum flexibility and minimum administrative burden with regard to requirements that would hinder the design of, the offering of, or the enrollment in, Part D plans offered to their retirees so they will keep offering --- and retirees can retain -- high quality retiree prescription drug coverage; and
    - Considering the appropriate protections that Medicare enrollees may expect when enrolling in a Part D plan.

  CMS currently approves waivers that apply to specific requirement areas, which include, but are not limited to, the drug formulary, marketing/informational materials and enrollment requirements. CMS will also consider additional waiver requests relating to specific requirements on a case-by-case basis.

PDP Disadvantages

- Increased Pharmacy Benefit Management Administration Costs
  Implementing an employer group PDP will require Navitus to perform additional administrative functions for the State. Staff is awaiting a cost estimate from Navitus, based on the division of administrative responsibilities that has been developed with staff.

- Administrative Complexity
  The RDS program is relatively simpler to administer than an employer group PDP. New guidance from CMS that affects commercial Part D plans is published on nearly a daily basis. The waivers, as mentioned above, should mitigate the process of analyzing the CMS guidance, but additional information technology and staff time will be required. In addition, while the PBM may handle a great deal of the PDP administration, the State is ultimately responsible for the plan and additional oversight of the PBM will be required.

Following are key dates that apply to the PDP application and contracting process:

November 18, 2008.........The "Notice of Intent to Apply for 2010" was submitted to CMS by staff. A pending PDP sponsor contract number was issued.

December 12, 2008.........Request for staff to access CMS's Health Plan Management System (HPMS) was submitted to CMS.

February 26, 2009...........Deadline for staff to submit the "2010 Employer Group Direct Contract PDP Application" to CMS.

Mid-March, 2009 ....Staff may receive notice from CMS regarding any deficiencies found in the application.

Late-April, 2009...............Staff will receive notice from CMS regarding its intent to deny or approve the application.

April 20, 2009 ....Deadline for staff to submit the 2010 formulary, developed by Navitus, to CMS.

June 8, 2009....................Marketing/informational materials must be submitted to CMS for review and approval.

Summer 2009..................Staff will perform system testing with CMS to ensure accurate data transfers.

August 25, 2009 ....Deadline for staff to receive approval from the Board to implement a Direct Contract Employer Group PDP and execute a contract with CMS for 2010.

Early-September 2009.....Contract with CMS is executed.

Summary

Staff will proceed with the application process while details of the administration of the plan are worked out and more definitive financial information is sought. It should be noted that the Board is not ultimately committed to adopting a PDP plan until a contract has been executed with CMS. In addition, the PDP application can be withdrawn by staff at anytime during the process, before the contract is executed. Should the investigation of the direct contract PDP prove that it is the preferred option, the Board and staff will have an opportunity in August 2009 to make a final decision whether to implement the program and execute the contract with CMS. If for some reason CMS denies the application for a direct contract PDP, there will be ample time to apply for participation in the RDS program for the 2010 plan year.

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CORRESPONDENCE MEMORANDUM

DATE: January 21, 2009

TO: Group Insurance Board

FROM: Michelle Baxter, Director
Insurance Administration Bureau, Division of Insurance Services

SUBJECT: Health Insurance Enrollment, Validation, and Payment (EVP) Project

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

In 2008, an internal planning team developed a plan to improve and update the current Health Insurance and Complaint System (HICS) and related processes. HICS is the "system of record" for our members and supports the data related to our health insurance enrollment, premium payments, and complaints. The main focus of the project is to improve customer service by providing online services for members and employers, ensure that participants eligible for medical and pharmacy benefits are receiving those benefits, eliminate duplication of work, and ensure continued compliance with the Health Insurance Portability and Accountability Act (HIPAA).

HICS data provides enrollment information electronically to participating health plans, drug benefit payments of nearly $200 million annually, and secures the retiree drug subsidy from the Centers for Medicare and Medicaid Services (CMS) of approximately $10 million per year. Although, the current system adequately performs the required processes, it is not integrated with other ETF systems and still requires manual processing of various paper documents and reports.

The new EVP project will improve the timeliness and accuracy of premium payments, reduce administrative efforts, and replace the current manual processing of paper documents and reports. Members and employers will be provided online access to enroll, change and validate health insurance information electronically, ensuring accurate premium collection and payment to participating health plans. With the introduction of the online coverage reporting system, we will also look to transition to a one month advance deduction cycle versus the current two month advance deduction cycle. The project will be completed in multiple phases during 2009 and 2010.

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

_______________________________________ ___________
Signature Date

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CORRESPONDENCE MEMORANDUM

DATE: February 4, 2009

TO: Group Insurance Board

FROM: Diane Poole, Director, Disability Programs Bureau

SUBJECT: Income Continuation Insurance (ICI) Monthly Earnings Calculation

ACTION REQUESTED

Staff recommends the Board approve State and Local ICI plan changes to correct an unintended consequence of changes made in 2006 that negatively affected employees who work overtime on a regular basis.

Background

On August 29, 2006, the Board approved ICI Plan changes to have premiums and benefits based on the prior calendar year's earnings and to estimate (project) earnings when there is a permanent change to an employee's salary. An unintended result was that regular overtime earnings were excluded when an individual received a salary increase and earnings were estimated. Overtime is not guaranteed and, therefore, is not considered part of the base salary. See example below. In addition, this forced employers to continually project salaries for premiums for large numbers of employees.

<u>Example – Mr. Smith</u>

Year	Earnings
2008	$57,802
2007	$97,919
2006	$81,733
2005	$90,750

Mr. Smith goes out on an ICI disability on 3/15/08. His disability benefit is based on his prior year's earnings ($97,919 which includes overtime). Mr. Smith returns to work on 6/13/2008. He has a pay increase on 10/15/2008 which caused his premiums and benefits to be based on a projected salary ($45,000 - which does not include overtime). He also loses supplemental ICI coverage (as his earnings are under $64,000). He does not receive an annual adjustment in 2009 as his projection has not been in effect for 12 months. Mr. Smith again goes out on an ICI disability on 11/15/09. His disability benefit is now based on his projection of $45,000 (not changed until the annual adjustment on 2/1/2010) even though he

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

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Signature Date

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may have already earned more than that in 2009.

To correct this, staff recommends using an estimated salary only for new hires or when an employee's percentage of appointment changes (i.e., full-time to part-time). In addition, staff recommends other language changes that would resolve inequities for individuals who unsuccessfully attempt to return to work.

The following is a brief description of the proposed language changes. New language is shaded and underscored. Language to be deleted is ~~stricken~~. If approved by the Board, changes to Sections 2.05, 2.10, and 2.11 would be effective February 1, 2010 for the State ICI Plan and March 1, 2010 for the Local ICI Plan. Changes to Section 2.165 would be effective April 1, 2009 for both State and Local ICI Plans.

Section	Clarification	Language Change
State & Local ICI Plan Language *Article II*	For Premiums, earnings are estimated (projected) for new hires or when an employee's percentage of appointment changes. Premiums remain the same upon return to employment from an authorized leave and are only changed after the employee has worked one full calendar year or has a permanent change in appointment. This assures that premiums are more closely aligned with benefits.	2.05 CONTINUATION OF COVERAGE DURING PERIODS OF AUTHORIZED LEAVE (Local) (4) The gross premium shall remain the same throughout the period of authorized leave. Upon the EMPLOYEE's return to employment, the premium shall be ~~adjusted if there has been an annual premium or salary adjustment in the interim.~~ reinstated at the rate category which was in effect prior to the date of the authorized leave until the EMPLOYEE has worked one full calendar year after which the premium shall be adjusted at the time of the annual adjustment (March 1) or if there has been a permanent change in the EMPLOYEE's percentage of appointment (whichever is earlier). 2.05 CONTINUATION OF COVERAGE DURING PERIODS OF AUTHORIZED LEAVE (State) (4) The first three (3) months of authorized leave qualify for EMPLOYER contribution. For subsequent months, the EMPLOYEE must pay the gross premium including the amount normally considered state contribution. The gross premium shall remain the same throughout the period of leave. Upon the EMPLOYEE's return to employment, the premium shall be ~~adjusted if there has been an annual premium or salary adjustment in the interim.~~ reinstated at the rate category which was in effect prior to the date of the authorized leave until the EMPLOYEE has worked one full calendar year after which the premium shall be adjusted at the time of the annual adjustment (February 1) or if there has been a permanent change in the EMPLOYEE's percentage of appointment (whichever is earlier).. 2.10 EMPLOYER CONTRIBUTIONS (State Only) (3) When an EMPLOYEE returns to employment after a period of authorized leave ~~disability during which accumulated sick leave hours were diminished or exhausted~~, the State contribution toward premium shall be reinstated at the rate category which was in effect prior to the date the disability began until the EMPLOYEE has worked one full calendar year after which the premium shall be adjusted at the time of the annual adjustment (February 1) or if there has been a permanent change in the EMPLOYEE's percentage of appointment (whichever is earlier). . ~~However, the gross premium shall be established pursuant to Table I, IV and IV-A.~~

		2.11 EMPLOYEE CONTRIBUTIONS (State & Local) 2(a) ~~If the prior year earnings represent an interruption extending three (3) consecutive months or more, or~~ If the EMPLOYEE is newly hired or if there is a permanent change in the EMPLOYEE's percentage of appointment, the EMPLOYER shall estimate the base salary earnings to be received during the ensuing twelve (12) months rounded to the next higher thousand and divided by twelve (12) and that projection shall be the basis for establishing average monthly earnings until coverage has been in effect for a full calendar year. ~~2(b) A new projection shall be made when there is a permanent change in the EMPLOYEE's salary (excluding annual adjustments).~~
	For Benefits, earnings are determined at the time of disability (prevents people from delaying filing a claim until they receive a higher salary). Earnings projections are no longer required if there is a 3-month break in service. Earnings shall be projected for new hires and when there is a permanent change in percentage of appointment. Earnings may be projected when only the rate of pay changes. Individuals attempting to return to work, but are unsuccessful, are no longer penalized by having the second disability based on a year with smaller earnings (the year in which the first break in service occurred).	2.165 EARNINGS DEFINED FOR DETERMINATION OF BENEFIT PAYMENTS (State & Local) (1) The average monthly earnings in effect on the first date of disability shall be the total earnings paid to the insured EMPLOYEE by the EMPLOYER during the previous calendar year as reported to the Wisconsin Retirement System, rounded to the next higher thousand and divided by twelve (12). (a) ~~If the prior year earnings represent an interruption extending three (3) consecutive months or more, or~~ If the EMPLOYEE is newly hired, the EMPLOYER shall estimate the base salary earnings to be received during the ensuing twelve (12) months rounded to the next higher thousand and divided by twelve (12) and that projection shall be the basis for establishing average monthly earnings until coverage has been in effect for a full calendar year. (b) A new projection shall be made when there is a permanent change in the EMPLOYEE's percentage of appointment ~~salary (excluding~~

		~~annual adjustments~~. <u>Projections shall be made based on the new rate of pay.</u> (c) <u>If the EMPLOYEE has a permanent change in their rate of pay AND has no change in their percentage appointment, then a new projection may be made based on the new rate of pay OR 2.165(1) whichever is higher.</u> (d) <u>If the EMPLOYEE returns to employment after a period of disability or authorized leave, then goes out on a new disability as defined by 2.17, earnings shall be the same as the prior disability/authorized leave or based 2.165 (1), whichever is higher.</u>

Disability staff will be available at the Board meeting to respond to any questions or concerns.

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CORRESPONDENCE MEMORANDUM

DATE: January 27, 2009

TO: Group Insurance Board

FROM: Robert Willett, CPA
Chief Trust Financial Officer

SUBJECT: Post-Retirement Life Insurance Actuarial Valuation

This report is provided for your information only. No action is required.

Governmental Accounting Standards Board (GASB) Statement 43, *Financial Reporting for Postemployment Benefit Plans Other Than Pension Plans*, established new accounting and financial reporting standards for benefits paid to employees after their working careers. These benefits are commonly referred to as Other Post-Employment Benefits, or “OPEBs”. The standard establishes uniform practices for measuring the value of benefits being promised to current employees that will be paid out after the employee retires. While these standards were primarily intended for retiree health insurance plans, they also apply to our retiree life insurance plan.

The greatest challenge in applying these new standards to our life insurance plan was the requirement that post-employment benefits be reported separately from active employee benefits. Our plan provides life insurance coverage to employees during their working careers and continues that coverage after retirement, for the life of the participant. We manage this lifetime coverage as a single benefit plan. Under the OPEB standards, we must report it as two plans; an active employee plan, and a retiree plan.

One of the new OPEB requirements is for an actuarial valuation of the retiree plan, to be conducted at least biennially, using standardized methods and assumptions defined by GASB. While Minnesota Life Insurance Company (MLIC) prepares an annual actuarial valuation of the plan, their valuation is of the combined active/retiree plan, and is conducted using methods and assumptions appropriate for funding the plan, and not the rigid standards required by GASB. For this reason, MLIC contracted with Deloitte Consulting, the Board’s consulting actuary, to perform an OPEB valuation of the retiree life insurance plan.

Accompanying this memo is the report from the January 1, 2008 actuarial valuation of the retiree life insurance plan.

Attachment

Reviewed and approved by Jon Kranz, Director, Office of Budget and Trust Finance.

______________________________ ____________
Signature Date

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State of Wisconsin Postretirement Life Insurance Plan

January 1, 2008
Actuarial Valuation

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November 2008

ACTUARIAL VALUATION CERTIFICATION

This report presents results of the actuarial valuation of the State of Wisconsin Postretirement Life Insurance Plan ("the Plan") as of January 1, 2008.

Minnesota Life provided the participant data, financial information and plan descriptions used in this valuation. The actuary has checked the data for reasonableness, but has not independently audited the data. Estimates were made where data was missing or unavailable. The actuary has no reason to believe the data is not complete and accurate, and knows of no further information that is essential to the preparation of the actuarial valuation.

Actuarial information under Government Accounting Standards Board Statement No. 43 (GASB 43) is for purposes of fulfilling plan financial accounting requirements. The results have been made on a basis consistent with GASB 43 and are based upon assumptions prescribed by the State of Wisconsin. Determinations for purposes other than meeting plan financial accounting requirements may be significantly different from the results reported herein.

In our opinion, all costs, liabilities, rates of interest, and other factors under the Plan have been determined on the basis of actuarial assumptions and methods that are each reasonable (or consistent with authoritative guidance), taking into account the experience of the Plan and future expectations and that, when combined, represent our best estimate of anticipated experience under the Plan.

Future actuarial measurements may differ significantly from the current measurements presented in this report due to such factors as the following: plan experience differing from that anticipated by the economic or demographic assumptions; changes in economic or demographic assumptions; increases or decreases expected as part of the natural operations of the methodology used for these measurements (such as the end of an amortization period or additional cost or contribution requirements based on the plan's funded status); and changes in plan provisions or applicable law.

Our scope did not include analyzing the potential range of such future measurements, and we did not perform that analysis.

The undersigned with actuarial credentials collectively meet the Qualification Standards of the American Academy of Actuaries to render the actuarial opinions contained herein.

Any tax advice included in this written communication was not intended or written to be used, and it cannot be used by the taxpayer, for the purpose of avoiding any penalties that may be imposed by any governmental taxing authority or agency.

Deloitte Consulting LLP

Michael de Leon, EA, FCA, MAAA **Senior Manager**	**David Pitts, EA, FSA, MAAA** **Manager**

State of Wisconsin
Postretirement Life Insurance Plan
January 1, 2008
Actuarial Valuation

Section I - Background and Comments

The Governmental Accounting Standards Board released the Statement of Governmental Accounting Standards No. 43 ("GASB 43") and No. 45 ("GASB 45") in 2004. These statements require trusts (GASB 43) and employers (GASB 45) to accrue the cost of Postretirement Welfare Plans while employees who will receive these benefits are providing services to the employer. The State of Wisconsin was a phase 1 entity for implementation of GASB 43 and was therefore required to adopt GASB 43 for the financial period beginning January 1, 2006. The purpose of this report is to provide the information required under GASB 43 to be disclosed on the State of Wisconsin's financial statements for the financial period ending December 31, 2008.

The State of Wisconsin provides postretirement life insurance coverage to retired participants over the age of 65 at no cost to the employees. There have been no plan changes since our January 1, 2006 actuarial valuation. The substantive plan benefits are described in Section X of this report.

Funding Policy

Employers are required to pay the following contributions for active members to provide them with Basic Coverage after age 65 under the Postretirement Life Insurance Plan:

- State: 28% of the Employee Premiums
- Local: 40% of the Employee Premiums for 50% post-retirement coverage (or, 20% for 25% postretirement coverage)

These contributions are different from the Annual Required Contributions determined under GASB 43.

Assets

The assets for this plan are held in the Premium Deposit Fund and the Contingent Liability Reserve. The total assets in these two funds as of January 1, 2006 were reduced by an initial reserve estimate for pre-retirement death benefits because those benefits are not part of this Postretirement Life Insurance Plan. The net assets under this plan after January 1, 2006 were based on the January 1, 2006 net assets adjusted for annual cash flows (benefits paid, expenses, premium taxes, etc.) and a proportional share of the investment earnings on the Premium Deposit Fund and Contingent Liability Reserve.

Assumptions

Where applicable, the assumptions used in this actuarial valuation were based on the assumptions used for the WRS actuarial valuation as of December 31, 2007. Some additional or differing assumptions were required to handle issues unique to the plan. The actuarial methods and assumptions are described in Section IX of this report.

Since our January 1, 2006 actuarial valuation, the following assumptions were changed: rates of salary increases, mortality rates, disability rates, withdrawal rates, and retirement rates. These changes increased the Actuarial Accrued Liability for the State plan by $1.8 million and decreased the Actuarial Accrued Liability for the Local plan by $2.2 million. The assumption changes affected the State and Local liabilities differently because the assumed mortality rates for Local members have been reduced since our prior valuation but the mortality rates for State members have not changed. The lower mortality rates for Local members more than offset the increase in liabilities from the other assumption changes made. The assumed mortality rates were provided by Minnesota Life and were used in their actuarial valuation for the policy year ended December 31, 2007.

Actuarial Experience

During 2006, the market value of assets experienced an estimated investment return of 5.71% for the State plan and 5.56% for the Local plan. During 2007, the market value of assets experienced an estimated investment return of 5.81% for the State plan and 5.71% for the Local plan. Compared to the investment return assumption of 6.00%, there were market value losses of $6.6 million for 2006 and 2007 combined for the State plan and $1.4 million for the Local plan.

The State plan experienced a liability gain of $2.8 million in 2006 and 2007 combined, primarily due to salary increases less than expected. The Local plan experienced a liability gain of $5.6 million in 2006 and 2007 combined, also primarily due to salary increases less than expected. These gains were offset by new entrants to the plans.

State of Wisconsin
Postretirement Life Insurance Plan
January 1, 2008
Actuarial Valuation

Section II – Summary of Actuarial Valuation Results

Presented below are the January 1, 2008 actuarial valuation results for the State of Wisconsin Postretirement Life Insurance Plan. January 1, 2006 actuarial valuation results are shown for comparison. Dollar amounts are in thousands.

	State	
	1/1/2006	1/1/2008
a. Actuarial Accrued Liability		
Actives	$ 162,989	$ 182,459
Disableds	3,409	4,052
Pre-65 Annuitants	40,965	47,024
Post-65 Retirees	129,978	148,857
Total	$ 337,341	$ 382,392
b. Market Value of Assets	$ 314,116	$ 329,822
c. Unfunded Actuarial Accrued Liability (UAAL), (a) – (b)	$ 23,225	$ 52,570
d. Funded ratio (b / a)	93.1%	86.3%
e. UAAL as a percentage of covered payroll (c / h.2)	0.9%	1.9%
f. Normal Cost	$ 10,536	$ 10,657
g. Discount rate	6.00%	6.00%
h. Census data used		
1. Count of Covered Participants		
- Actives	49,126	49,933
- Disableds	1,025	1,135
- Pre-65 Annuitants	5,889	6,393
- Post-65 Retirees	13,717	14,727
- Total	69,757	72,188
2. Covered payroll*	$ 2,506,437	$ 2,699,508
3. Expected benefit payments	$ 8,483	$ 9,889

* Active participant payroll projected based on actual pay for preceding year.

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Section II – Summary of Actuarial Valuation Results (cont.)

		Local	
		1/1/2006	1/1/2008
a.	Actuarial Accrued Liability		
	Actives	$ 101,342	$ 110,912
	Disableds	2,500	2,761
	Pre-65 Annuitants	31,007	36,729
	Post-65 Retirees	71,248	83,042
	Total	$ 206,097	$ 233,444
b.	Market Value of Assets	$ 195,632	$ 211,950
c.	Unfunded Actuarial Accrued Liability (UAAL), (a) – (b)	$ 10,465	$ 21,494
d.	Funded ratio (b / a)	94.9%	90.8%
e.	UAAL as a percentage of covered payroll (c / h.2)	0.3%	0.6%
f.	Normal Cost	$ 9,005	$ 9,420
g.	Discount rate	6.00%	6.00%
h.	Census data used		
	1. Count of Covered Participants		
	- Actives	75,013	76,448
	- Disableds	1,113	1,172
	- Pre-65 Annuitants	8,054	9,003
	- Post-65 Retirees	18,414	19,921
	- Total	102,594	106,544
	2. Covered payroll*	$ 3,310,064	$ 3,556,913
	3. Expected benefit payments	$ 5,338	$ 6,064

* Active participant payroll projected based on actual pay for preceding year.

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Section II – Summary of Actuarial Valuation Results (cont.)

		Total	
		1/1/2006	1/1/2008
a.	Actuarial Accrued Liability		
	Actives	$ 264,331	$ 293,371
	Disableds	5,909	6,813
	Pre-65 Annuitants	71,972	83,753
	Post-65 Retirees	201,226	231,899
	Total	$ 543,438	$ 615,836
b.	Market Value of Assets	$ 509,748	$ 541,772
c.	Unfunded Actuarial Accrued Liability (UAAL), (a) – (b)	$ 33,690	$ 74,064
d.	Funded ratio (b / a)	93.8%	88.0%
e.	UAAL as a percentage of covered payroll (c / h.2)	0.6%	1.2%
f.	Normal Cost	$ 19,541	$ 20,077
g.	Discount rate	6.00%	6.00%
h.	Census data used		
	1. Count of Covered Participants		
	- Actives	124,139	126,381
	- Disableds	2,138	2,307
	- Pre-65 Annuitants	13,943	15,396
	- Post-65 Retirees	32,131	34,648
	- Total	172,351	178,732
	2. Covered payroll*	$ 5,816,501	$ 6,256,421
	3. Expected benefit payments	$ 13,821	$ 15,953

* Active participant payroll projected based on actual pay for preceding year.

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Section III – Changes in Net Assets Available to Pay Benefits

Presented below are the changes in the net assets available to pay benefits from January 1, 2006 to January 1, 2007. Dollar amounts are in thousands.

		State	Local	Total
a.	Net Assets as of January 1, 2006*	$ 309,565	$ 195,632	$ 505,197
b.	Contributions	$ 1,235	$ 2,096	$ 3,331
c.	Benefits Paid			
	Employee Basic Plan Death Benefits	$ 8,480	$ 4,551	$ 13,031
	Withdrawals for Health/LTC Premiums	538	-	538
	Subtotal	$ 9,018	$ 4,551	$ 13,569
d.	Plan Expenses			
	Minnesota Life Expenses	$ 129	$ 148	$ 277
	State Premium Taxes	176	96	272
	Subtotal	$ 305	$ 244	$ 549
e.	Investment Income			
	Premium Deposit Fund	$ 16,074	$ 6,879	$ 22,953
	Contingent Liability Reserve	1,682	4,181	5,863
	Subtotal	$ 17,756	$ 11,060	$ 28,816
f.	Net Assets as of January 1, 2007 (a) + (b) – (c) – (d) + (e)	$ 319,233	$ 203,993	$ 523,226
	Estimated Investment Return	5.71%	5.56%	

* The net assets as of January 1, 2006 for the State plan were revised since our January 1, 2006 valuation due to a change to the pre-retirement reserve.

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Section III – Changes in Net Assets Available to Pay Benefits (cont.)

Presented below are the changes in the net assets available to pay benefits from January 1, 2007 to January 1, 2008. Dollar amounts are in thousands.

		State	Local	Total
a.	Net Assets as of January 1, 2007	$ 319,233	$ 203,993	$ 523,226
b.	Contributions	$ 1,314	$ 1,733	$ 3,047
c.	Benefits Paid			
	Employee Basic Plan Death Benefits	$ 8,775	$ 5,308	$ 14,083
	Withdrawals for Health/LTC Premiums	263	19	282
	Subtotal	$ 9,038	$ 5,327	$ 14,365
d.	Plan Expenses			
	Minnesota Life Expenses	$ 136	$ 169	$ 305
	State Premium Taxes	182	112	294
	Subtotal	$ 318	$ 281	$ 599
e.	Interest			
	Premium Deposit Fund	$ 17,326	$ 7,507	$ 24,833
	Contingent Liability Reserve	1,305	4,325	5,630
	Subtotal	$ 18,631	$ 11,832	$ 30,463
f.	Net Assets as of January 1, 2008 (a) + (b) – (c) – (d) + (e)	$ 329,822	$ 211,950	$ 541,772
	Estimated Investment Return	5.81%	5.71%	

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Section IV – Development of Unfunded Actuarial Accrued Liability

Presented below is the development of the Unfunded Actuarial Accrued Liability as of January 1, 2008, which is the excess of the Actuarial Accrued Liability over the net assets available to pay benefits. Dollar amounts are in thousands.

		State	Local	Total
a.	Present Value of Future Benefits			
	Actives	$ 291,825	$ 208,913	$ 500,738
	Disableds	4,052	2,761	6,813
	Pre-65 Annuitants	47,024	36,729	83,753
	Post-65 Retirees	148,857	83,042	231,899
	Subtotal	$ 491,758	$ 331,445	$ 823,203
b.	Present Value of Future Normal Costs	$ 109,366	$ 98,001	$ 207,367
c.	Actuarial Accrued Liability (a) – (b)	$ 382,392	$ 233,444	$ 615,836
d.	Assets	$ 329,822	$ 211,950	$ 541,772
e.	Unfunded Accrued Actuarial Liability as of January 1, 2008, (c) – (d)	$ 52,570	$ 21,494	$ 74,064

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Section V – Actuarial Experience

Actuarial gains and losses arise from experience different from that assumed, changes in actuarial assumptions and methods, and changes in plan provisions. The following summarizes the changes in the Unfunded Actuarial Accrued Liability due to these sources from January 1, 2006 to January 1, 2008. Dollar amounts are in thousands.

		State	Local	Total
a.	Unfunded Actuarial Accrued Liability as of January 1, 2006	$ 23,225	$ 10,465	$ 33,690
b.	Normal Cost for 2006	10,536	9,005	19,541
c.	Employer Contributions	(1,235)	(2,096)	(3,331)
d.	Interest at 6.00%	2,026	1,169	3,195
e.	Expected Unfunded Actuarial Accrued Liability as of January 1, 2007: (a) + (b) + (c) + (d)	$ 34,552	$ 18,543	$ 53,095
f.	Normal Cost for 2007	10,968	9,375	20,343
g.	Employer Contributions	(1,314)	(1,733)	(3,047)
h	Interest at 6.00%	2,731	1,675	4,406
i.	Assumption Changes:	1,814	(2,175)	(361)
j.	Expected Unfunded Actuarial Accrued Liability as of January 1, 2008 after changes: (e) + (f) + (g) + (h) + (i)	$ 48,751	$ 25,685	$ 74,436
k.	Unfunded Actuarial Accrued Liability as of January 1, 2008	$ 52,570	$ 21,494	$ 74,064
l.	Experience (Gain)/Loss: (k) – (j)	$ 3,819	$ (4,191)	$ (372)
m.	Experience (Gain)/Loss Sources:			
	Demographic (Gain)/Loss	$ (2,767)	$ (5,552)	$ (8,319)
	Asset (Gain)/Loss	6,586	1,361	7,947
		$ 3,819	$ (4,191)	$ (372)

Section VI – Determination of Annual Required Contribution

GASB 43 requires the disclosure of the annual OPEB cost. A component of the annual OPEB cost is the Annual Required Contribution. The following is a brief explanation of the components of the Annual Required Contribution:

- **Normal Cost:** The portion of the total present value of benefits attributed to employee service during the current fiscal year.

- **Amortization Payments:** closed, 30-year level percent of pay amortization of the initial Unfunded Actuarial Accrued Liability ("UAAL"), and closed 15-year percent of pay amortizations of any future gains and losses including contribution deficiencies or excesses.

Presented below is an illustration of the Annual Required Contribution for the fiscal year ending December 31, 2008. Dollar amounts are in thousands.

Annual Required Contribution for Fiscal Year Ending December 31, 2008

		State	Local	Total
a.	Normal Cost	$ 10,657	$ 9,420	$ 20,077
b.	Amortization Payment	3,292	1,331	4,623
c.	Interest to End of Year	837	645	1,482
d.	Annual Required Contribution (a) + (b) + (c)	$ 14,786	$ 11,396	$ 26,182

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Section VI – Determination of Annual Required Contribution (continued)

State

Schedule of Amortization Payments
(000's)

	Date Established	Initial Amount	Initial Years	Remaining Years	1/1/2008 Balance	Amortization
Initial UAAL	1/1/2006	$ 23,225	30	28	$ 23,882	$ 1,077
Contribution Deficiency	1/1/2007	10,987	15	14	10,767	863
Assumption Changes and Experience (Gain)/Loss	1/1/2008	5,633	15	15	5,633	425
Contribution Deficiency	1/1/2008	12,288	15	15	12,288	927
Total					$ 52,570	$ 3,292

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Section VI – Determination of Annual Required Contribution (continued)

Local

Schedule of Amortization Payments
(000's)

	Date Established	Initial Amount	Initial Years	Remaining Years	1/1/2008 Balance	Amortization
Initial UAAL	1/1/2006	$ 10,465	30	28	$ 10,761	$ 486
Contribution Deficiency	1/1/2007	7,925	15	14	7,767	622
Assumption Changes and Experience (Gain)/Loss	1/1/2008	(6,366)	15	15	(6,366)	(481)
Contribution Deficiency	1/1/2008	9,332	15	15	9,332	704
Total					$ 21,494	$ 1,331

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Section VII - Disclosure Information Pursuant to Statement No. 43 of the Governmental Accounting Standards Board

Governmental Accounting Standards Board ("GASB") Statement No. 43 requires disclosure of notes to the financial statements and supplementary information that includes information shown in two schedules, the Schedule of Funding Progress and the Schedule of Employer Contributions. Table A shows the Schedule of Funding Progress. Table B shows the Schedule of Employer Contributions.

Table A
GASB No. 43 Schedule of Funding Progress
(000's)

State

Actuarial Valuation Date	Actuarial Value of Assets (a)	Actuarial Accrued Liability (AAL) (b)	Unfunded Actuarial Accrued Liability (UAAL) (b - a)	Funded Ratio (a/b)	Covered Payroll (c)	UAAL as a Percentage of Covered Payroll [(b- a)/ (c)]
January 1, 2006	$ 314,116	$ 337,341	$ 23,225	93.1%	$ 2,506,437	0.9%
January 1, 2008	329,822	382,392	52,570	86.3	2,699,508	1.9

Local

Actuarial Valuation Date	Actuarial Value of Assets (a)	Actuarial Accrued Liability (AAL) (b)	Unfunded Actuarial Accrued Liability (UAAL) (b - a)	Funded Ratio (a/b)	Covered Payroll (c)	UAAL as a Percentage of Covered Payroll [(b- a)/ (c)]
January 1, 2006	$ 195,632	$ 206,097	$ 10,465	94.9%	$ 3,310,064	0.3%
January 1, 2008	211,950	233,444	21,494	90.8	3,556,913	0.6

Section VII - Disclosure Information Pursuant to Statement No. 43 of the Governmental Accounting Standards Board (continued)

Table B
GASB No. 43 Schedule of Employer Contributions
(000's)

State

Year Ended	Annual Required Contribution	Employer Contribution	Percentage Contributed
December 31, 2006	$ 12,222	$ 1,235	10.1%
December 31, 2007	13,602	1,314	9.7
December 31, 2008	14,786		

Local

Year Ended	Annual Required Contribution	Employer Contribution	Percentage Contributed
December 31, 2006	$ 10,020	$ 2,096	20.9%
December 31, 2007	11,065	1,733	15.7
December 31, 2008	11,396		

Section VIII – 10-Year Projection of Employer Benefit Payments

Presented below are the projected employer benefit payments for the next ten years based on the current plan design. These projected benefit payments are based on the actuarial assumptions shown in Section IX. If actual experience differs from that expected by the actuarial assumptions, the actual employer benefit payments will vary from those presented below. Dollar amounts are in thousands.

Year	State	Local	Total
2008	$ 9,889	$ 6,064	$ 15,953
2009	10,607	6,378	16,985
2010	11,445	6,809	18,254
2011	12,308	7,323	19,631
2012	13,414	8,110	21,524
2013	14,528	8,853	23,381
2014	15,739	9,615	25,354
2015	17,056	10,434	27,490
2016	18,448	11,366	29,814
2017	19,958	12,399	32,357

Section IX - Summary of Actuarial Methods and Assumptions

Actuarial Cost Method

The Actuarial Cost Method used in this valuation to determine the Actuarial Accrued Liability and the Annual Required Contribution (ARC) is the Entry Age Normal method. This method is one of the family of projected benefit cost methods and one of the GASB 43 approved methods.

An estimate of the projected benefit payable at retirement is initially required to determine costs and liabilities under this method. The normal cost is the sum of the annual contributions required for each participant from his entry date to his assumed retirement date so that the accumulated contributions at retirement is equal to the liability for the projected benefit. The projected benefits are based on estimates of future years of service. The normal cost is developed as a level percent of covered pay.

The present value of future benefits is equal to the value of the projected benefit payable at retirement discounted back to the participant's current age. Discounts include such items as interest and mortality. The present value of future normal cost contributions is equal to the discounted value of the normal costs payable from the member's current age to retirement age.

The difference between the present value of future benefits and the present value of future normal cost contributions represents the actuarial liability at the participant's current age. The Actuarial Accrued Liability for participants currently eligible for retirement and participants currently receiving payments is calculated as the actuarial present value of future benefits expected to be paid. No normal cost is payable for these participants.

Assets

The assets for this plan are held in the Premium Deposit Fund and the Contingent Liability Reserve. The total assets in these two funds as of January 1, 2006 were reduced by an initial reserve estimate for pre-retirement death benefits because those benefits are not part of this Postretirement Life Insurance Plan. The net assets under this plan after January 1, 2006 were based on the January 1, 2006 net assets adjusted for annual cash flows (benefits paid, expenses, premium taxes, etc.) and a proportional share of the investment earnings on the Premium Deposit Fund and Contingent Liability Reserve.

Amortization of Unfunded Accrued Actuarial Liability

The Unfunded Accrued Actuarial Liability (UAAL) is the excess of the Accrued Actuarial Liability over the Assets. This excess will be amortized in the following ways:

- 30-year, level percent of pay, closed amortization period for the initial UAAL; and
- 15-year, level percent of pay, closed amortization periods for future gains and losses.

Section IX - Summary of Actuarial Methods and Assumptions (continued)

Discount Rate: 6.0%, net of expenses

Mortality: Unisex rates of mortality developed by Minnesota Life based on actual plan experience from 2004 to 2006. Sample rates of mortality are as follows:

Age	State	Local
25	0.0218%	0.0246%
35	0.0405	0.0457
45	0.1074	0.1210
55	0.3207	0.3617
65	0.9013	1.0164
75	2.6270	2.9624
85	7.7475	8.7364

Withdrawal: Percent of employees expected to terminate each year within the first 10 years of employment are as follows:

Service	State	Local
0	19.5%	15.8%
1	14.4	11.2
2	11.1	8.0
3	9.3	6.5
4	7.6	5.3
5	6.6	4.5
6	5.7	3.9
7	5.0	3.5
8	4.5	3.2
9	4.0	2.9

Percent of employees expected to terminate each year after the first 10 years of employment are as follows:

Age	State	Local
25	4.0%	2.9%
30	3.9	2.7
35	3.7	2.2
40	3.2	1.8
45	2.5	1.5
50	1.8	1.3
55	1.5	1.3
60	1.5	1.3

These are ‘blended’ rates based on the assumptions used in the Wisconsin Retirement System (WRS) actuarial valuation as of December 31, 2007. The blending methodology is described below.

Section IX - Summary of Actuarial Methods and Assumptions (continued)

Disability: Percent of employees expected to become disabled each year are as follows:

Age	State	Local
20	0.01%	0.01%
25	0.01	0.01
30	0.02	0.02
35	0.03	0.02
40	0.05	0.04
45	0.07	0.08
50	0.13	0.16
55	0.37	0.41
60	0.60	0.67

These are ‘blended’ rates based on the assumptions used in the Wisconsin Retirement System (WRS) actuarial valuation as of December 31, 2007. The blending methodology is described below.

Disabled members were valued using the same mortality table that was used to value healthy lives.

Salary Increases: Assumed annual rates of salary increase are as follows:

Service	State	Local
1	7.7%	8.7%
2	7.7	8.7
3	7.5	8.3
4	7.3	7.9
5	7.0	7.6
10	6.3	6.3
15	5.9	5.5
20	5.6	5.1
25	5.2	4.8
30	5.0	4.6

These are ‘blended’ rates based on the assumptions used in the Wisconsin Retirement System (WRS) actuarial valuation as of December 31, 2007. The blending methodology is described below.

Payroll Growth: 4.1% annually

Section IX - Summary of Actuarial Methods and Assumptions (continued)

Retirement: Percent of employees expected to retire each year are as follows.
Eligible for WRS Normal Retirement benefit:

Age	State	Local
50 to 56	0%	0%
57	19	27
58	18	26
59	18	25
60	18	25
61	21	26
62	26	35
63	26	34
64	22	25
65	23	27
66	23	25
67	17	18
68	16	15
69	16	16
70	23	23
71	23	23
72	23	23
73	23	23
74	23	23
75	100	100

Eligible for WRS Early Retirement benefit:

Age	State	Local
55	7%	10%
56	7	10
57	5	9
58	6	10
59	7	9
60	9	12
61	8	12
62	15	21
63	16	20
64	14	15

These are 'blended' rates based on the assumptions used in the Wisconsin Retirement System (WRS) actuarial valuation as of December 31, 2007. The blending methodology is described below.

Section IX - Summary of Actuarial Methods and Assumptions (continued)

Continuation of Premiums after Termination: All members who terminate before age 65 are assumed to continue paying premiums until age 65.

Members Included: Current members only; we did not include new hires or non-participants who may enroll later with Evidence of Insurability.

Expenses: None included.

Future Service: All members earn a full year of service in each calendar year.

Assumption Blending: Many assumptions were based on the Wisconsin Retirement System (WRS) actuarial valuation as of December 31, 2007. However, some WRS assumptions depend on gender and "actuary group" (Public Schools, Protective, General, etc.), which were not provided in the data. To implement the WRS assumptions, we blended the WRS rates by actuary group and gender into one set for State and one set for Local.

Blending was based on member counts and average pay provided in the CAFR as of December 31, 2005. For simplicity, we excluded 'Protective w/o Social Security' and 'Executive & Elected' from the actuary group blending (only 4,163 members or 1.6%). Also, Normal Retirement before age 57 was ignored for Protective.

Rates were first blended by actuary group as follows:

	General	Teachers	Protective w/Soc Sec	Total
Count	137,959	101,845	19,155	258,959
Avg. Pay	$33,222	$48,009	$47,518	
Total Pay	$4,583 M	$4,889 M	$910 M	$10,383 M
Blend %	44.1%	47.1%	8.8%	100.0%

Then, the resulting male/female rates were blended by count:

	Male	Female	Total
Count	100,322	162,800	263,122
Blend %	38.1%	61.9%	100.0%

Normal Retirement before age 57 was ignored for Protective.

Section X - Summary of Substantive Plan Provisions

Enrollment Eligibility: Generally, members may enroll during a 30-day enrollment period once they satisfy a six-month waiting period. They may enroll after the initial 30-day enrollment period with evidence of insurability. Members under evidence of insurability enrollment must enroll in group life insurance coverage before age 55 to be eligible for Basic or Supplemental coverage.

Retirement Eligibility: At retirement, the member must satisfy one of the following –

- WRS coverage prior to January 1, 1990, or
- at least one month of group life insurance coverage in each of 5 calendar years after 1989

and one of the following –

- eligible for an immediate WRS benefit, or
- at least 20 years from their WRS creditable service as of 1/1/90 plus their years of group life insurance coverage after 1989, or
- at least 20 years on the payroll of their last employer.

In addition, terminating members and retirees must continue to pay the Employee Premiums until age 65 (age 70 if active).

Basic Coverage Benefits: After retirement, Basic coverage is continued for life in these amounts of the insurance in force before retirement:

State:

Age	Percent of Basic Coverage Continuing
Before age 65	100%
While age 65	75
While age 66 and later	50

Local:

Age	Percent of Basic Coverage Continuing
Before age 65	100%
While age 65	75
While age 66	50
While age 67 and later	25*

*Local employers may elect to increase this to 50%

Supplemental Coverage Benefits: After retirement, Supplemental coverage may be continued until age 65 at 100% of the amount of the insurance in force before retirement at the employee's expense (this benefit is not included in the valuation as it is entirely employee paid).

Section X - Summary of Substantive Plan Provisions (continued)

Additional Coverage: After retirement, Additional coverage may be continued until age 65 at 100% of the amount of the insurance in force before retirement at the employee's expense (this benefit is not included in the valuation as it is entirely employee paid).

Spouse & Dependent Coverage After retirement, the coverage is terminated and not included in the Postretirement Life Insurance Plan.

Employee Premiums: The employee must pay these monthly premiums per $1,000 of insurance until age 65 (age 70 if active):

State:

Attained Age	Basic	Supplemental
Under 30	$0.05	$0.05
30-34	0.05	0.05
35-39	0.05	0.05
40-44	0.07	0.07
45-49	0.11	0.11
50-54	0.18	0.18
55-59	0.28	0.28
60-64	0.38	0.38
65-69	0.50	0.50

Local:

Attained Age	Basic	Supplemental
Under 30	$0.05	$0.05
30-34	0.06	0.06
35-39	0.07	0.07
40-44	0.09	0.09
45-49	0.15	0.15
50-54	0.29	0.29
55-59	0.47	0.47
60-64	0.53	0.53
65-69	0.60	0.60

Disabled members under age 70 receive a waiver-of-premium benefit

Employer Premiums: The employer must pay these premiums until the member's retirement:

State:

- 63% of the Employee Premiums for Basic coverage
  - 35% is paid to fund pre-retirement coverage
  - 28% is paid to fund post-65 retiree coverage
- 35% of the Employee Premiums for Supplemental coverage

Local:

- 40% of Employee Premiums if 50% post-65 retiree Basic coverage
- 20% of Employee Premiums if 25% post-65 retiree Basic coverage
- No Employer contribution required for Supplemental Coverage

Section XI - Summary of Participant Demographic Information

The participant data used in the valuation was provided by Minnesota Life as of January 1, 2008. While the participant data was checked for reasonableness, the data was not audited, and the valuation results presented in this report are dependent upon the accuracy of the participant data provided. The table below presents a summary of the basic participant information for the active and inactive participants covered under the terms of the Plan.

		State	Local	Total
a.	Active participants			
	Count	49,933	76,448	126,381
	Average Age	46.6	45.7	46.1
	Average Service	12.4	9.8	10.8
	Average Pay	$50,990	$43,731	$46,599
b.	Disabled participants			
	Count	1,135	1,172	2,307
	Average Age	55.3	56.4	55.9
	Average Current Insurance	$34,930	$37,024	$35,994
c.	Pre-65 annuitants			
	Count	6,393	9,003	15,396
	Average Age	60.8	60.6	60.7
	Average Current Insurance	$54,691	$51,463	$52,803
d.	Post-65 retirees			
	Count	14,727	19,921	34,648
	Average Age	75.3	75.0	75.1
	Average Current Insurance	$21,745	$10,507	$15,284

Section XI - Summary of Participant Demographic Information (continued)

Distribution by Age, Service and Average Pay – Actives – State

	0-4 Years		5-9 Years		10-14 Years		15-19 Years		20-24 Years		25 -29 Years		30 Years +		All Years	
Age Group	Count	Avg. Pay	Count	Avg. Pay	Count	Avg. Pay	Count	Avg. Pay	Count	Avg. Pay	Count	Avg. Pay	Count	Avg. Pay	Count	Avg. Pay
0-19	19	$26,105	0	$0	0	$0	0	$0	0	$0	0	$0	0	$0	19	$26,105
20-24	866	31,453	18	31,444	0	0	0	0	0	0	0	0	0	0	884	31,452
25-29	2,442	37,697	681	38,871	9	40,778	0	0	0	0	0	0	0	0	3,132	37,961
30-34	2,334	43,275	1,706	42,932	334	42,243	2	48,000	0	0	0	0	0	0	4,376	43,065
35-39	2,388	48,117	1,905	46,507	1,250	46,338	230	47,457	2	41,000	0	0	0	0	5,775	47,172
40-44	1,218	42,760	2,668	52,283	1,413	51,087	834	52,344	185	51,070	3	44,333	0	0	6,321	50,150
45-49	1,255	42,641	1,749	46,559	2,445	57,743	1,271	55,303	768	52,522	440	47,889	28	42,429	7,956	51,410
50-54	1,047	44,380	1,548	46,052	1,392	51,268	2,298	62,998	1,106	57,294	1,106	55,095	574	49,209	9,071	53,626
55-59	696	46,287	1,179	47,684	1,085	52,942	976	56,897	1,824	68,248	1,041	59,823	1,135	55,695	7,936	56,878
60-64	249	44,076	487	45,396	498	49,661	488	56,434	363	58,284	960	77,024	532	64,758	3,577	60,080
65 & Up	34	33,853	85	45,812	120	52,983	94	61,213	66	60,318	66	53,364	421	82,216	886	66,900
Total	**12,548**	**$42,405**	**12,026**	**$46,841**	**8,546**	**$52,149**	**6,193**	**$57,896**	**4,314**	**$60,931**	**3,616**	**$61,361**	**2,690**	**$60,116**	**49,933**	**$50,990**

Distribution by Age, Service and Average Pay – Actives – Local

	0-4 Years		5-9 Years		10-14 Years		15-19 Years		20-24 Years		25 -29 Years		30 Years +		All Years	
Age Group	Count	Avg. Pay	Count	Avg. Pay	Count	Avg. Pay	Count	Avg. Pay	Count	Avg. Pay	Count	Avg. Pay	Count	Avg. Pay	Count	Avg. Pay
0-19	24	$12,375	0	$0	0	$0	0	$0	0	$0	0	$0	0	$0	24	$12,375
20-24	1,068	27,703	15	29,867	0	0	0	0	0	0	0	0	0	0	1,083	27,733
25-29	4,607	35,415	796	41,897	7	31,857	0	0	0	0	0	0	0	0	5,410	36,364
30-34	3,393	38,369	3,460	45,411	368	47,351	4	39,750	0	0	0	0	0	0	7,225	42,200
35-39	3,074	37,559	3,319	46,266	2,413	50,903	438	49,594	3	33,667	0	0	0	0	9,247	44,735
40-44	2,970	35,506	3,178	43,634	2,281	49,331	2,092	53,812	383	49,509	0	0	0	0	10,904	44,771
45-49	2,908	34,870	3,448	41,221	3,324	47,023	2,206	50,874	1,191	54,917	9	76,333	0	0	13,086	44,181
50-54	2,309	37,792	2,804	40,801	2,871	46,185	4,386	51,120	1,262	52,258	29	65,207	10	65,600	13,671	45,862
55-59	1,524	38,663	2,006	40,914	1,911	46,248	2,276	47,954	2,766	52,094	26	75,154	57	67,807	10,566	46,226
60-64	635	35,504	816	39,107	758	43,636	739	41,422	687	47,261	729	50,623	16	86,813	4,380	43,129
65 & Up	152	20,743	205	29,727	161	30,354	148	35,176	56	37,679	57	45,439	73	38,397	852	31,506
Total	**22,664**	**$36,067**	**20,047**	**$42,887**	**14,094**	**$47,413**	**12,289**	**$50,114**	**6,348**	**$51,841**	**850**	**$51,795**	**156**	**$55,853**	**76,448**	**$43,731**

Section XI - Summary of Participant Demographic Information (continued)

Distribution by Age and Average Current Insurance – Inactives (Disableds, Annuitants, Retirees) – State

Age Group	Count	Average Current Insurance
Under 50	221	$ 37,136
50-54	387	41,289
55-59	2,105	52,429
60-64	4,288	52,697
65-69	4,470	31,610
70-74	3,613	22,837
75-79	3,078	20,236
80-84	2,168	17,618
85-89	1,271	14,193
90 &Up	654	10,200
Total	22,255	$ 31,881

Distribution by Age and Average Current Insurance – Inactives (Disableds, Annuitants, Retirees) – Local

Age Group	Count	Average Current Insurance
Under 50	176	$ 36,284
50-54	456	50,410
55-59	3,098	53,162
60-64	5,743	49,021
65-69	6,215	21,433
70-74	5,340	9,126
75-79	4,021	7,584
80-84	2,572	6,449
85-89	1,494	5,247
90 &Up	981	3,639
Total	30,096	$ 23,791

STATE OF WISCONSIN
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CORRESPONDENCE MEMORANDUM

DATE: January 26, 2009

TO: Group Insurance Board

FROM: Marcia Blumer, Program Manager
Wisconsin Public Employers Group Life Insurance Program

SUBJECT: Reporting Changes due to Governmental Accounting Standards Board (GASB) Requirements

Recommendation

Staff supports the recommendations of Minnesota Life Insurance Company (MLIC) with regard to changes to the administrative agreement and annual reporting to comply with GASB standards.

New GASB rules require that the full cost of retiree benefits earned by individuals while employed must be accrued while they are employed and that the benefit plan must account for any accrued unfunded liability. GASB, which dictates the financial reporting requirements for governments, issued GASB Statement 43, which specifies the annual financial disclosure requirements for reporting the funding status of employee benefit programs.

These GASB requirements have necessitated changes to the Wisconsin Public Employers Group Life Insurance Program administrative agreement between the Group Insurance Board and MLIC. Historically, the plan experience of insured retirees who are under age 65 has been included with the active employee experience. The new rules require that the experience of all retirees, both those under age 65 and those over age 65, be accounted for as one group, separate from active employees. To accommodate this, the experience calculations will be split between active employees and all retirees so that the risk characteristics are appropriately reflected and reserves allocated to properly fund benefits. This will result in a change to the stop loss and risk charges, as well as to the reserve funding.

The attached letter from Robert Olafson and Paul Rudeen of MLIC outlines the recommended changes in the experience calculation and the reserve funding to comply with the GASB rules. Although different methodology and assumptions will be applied when preparing the annual policy year financial experience report, the underlying plan funding will not change. These changes will be reflected in the 2008 policy year financial report that will be presented to the Board at the August 2009 meeting.

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

______________________________ __________
Signature Date

Board	Mtg Date	Item #
GIB	02/17/2009	5

Minnesota Life Insurance Company
A Securian Company
400 Robert Street North
St. Paul, MN 55101-2098
651.665.3500 Tel

MINNESOTA LIFE

January 27, 2009

Bob Willett
Chief Trust Financial Officer
Department of Employee Trust Funds
801 West Badger Road
Madison, WI 53713-2526

RE: REPORTING CHANGES DUE TO GASB REQUIREMENTS

Dear Bob:

Due to GASB requirements, beginning with the 2008 policy year, the State of Wisconsin experience calculation will be split between actives and retirees. The active employee plan financial report includes pre-retirement insurance for currently active employees, and the spouses and dependents of such employees. The retiree plan financial report includes: (1) all retirees age 65 and over who receive a life insurance benefit with no further premium payments, (2) all retirees under age 65 who receive a life insurance benefit based on continued premium payments, and (3) all funding contributions by the State toward future post-retirement life insurance for currently active employees.

The following items are changes in methodology and assumptions under the new policy year financial experience report format for the State of Wisconsin. The same changes apply to the Local Government plan except as noted in the "Local Government Differences" section of this letter.

Stop Loss and Risk Charge

When the plan is split, the resulting active and retiree blocks have different risk characteristics than the combined block due to the relative size difference and the nature of active mortality compared to retiree mortality. Because of these differences, new stop loss limits have been established for the two blocks. The current stop loss limit for the combined plan is 125% of expected claims. The proposed active limit is 140% of expected claims, while the proposed retiree limit is 120% of expected claims.

These limits were determined so that the probability of exceeding the stop loss limit for each block on its own is similar to the probability for the combined plan under the current basis. This results in the total stop loss limits of the split plans being greater than the current stop loss limit of the combined plan, due to the increased risk of the split plans relative to the combined plan. This approach enables the plan to have a total risk charge similar to the current risk charge.

The risk reserve and risk charge were split between the two plans based on the expected amount of claims in excess of the stop loss limit when the limit is exceeded. This results in a change to the percent

of premium used to calculate the risk charge for the active plan. In addition, due to the need for a risk charge on the retirees, we have established a charge based on a rate per thousand of volume for the retirees.

Disability Claims

All disability claims will be included in the active experience calculation. The rationale for this is that, while it is technically possible for someone to be on disability and qualify as an annuitant, the onset of the disability would have to occur while the insured individual is on active status. Any later financial charges or credits related to the disabled life are continuations of the active claim. In addition, if the disabled individual recovers before disability benefit termination at age 65, that individual would return to active status. Treating disability claims in this manner also simplifies the experience calculation.

Active Reserves

For tax purposes there will be two reserves established for the active plan – a stabilization reserve and a premium deposit fund (PDF). The initial balance of the active PDF will be 50% of the prior year's premium. The initial PDF balance for retirees will be the current combined PDF balance reduced by the amount established as the initial PDF balance for the actives. The initial stabilization reserve balance will be $0.

Contributions due to good experience on the active plan will be deposited into the stabilization reserve. Withdrawals due to poor experience will be taken first from the stabilization reserve. If the stabilization reserve is depleted, further required withdrawals will be taken from the PDF. This priority order for withdrawals provides the most favorable state premium tax treatment to the plan.

Post-Retirement Valuation

The total calculated value of liabilities in the post-retirement valuation is different from that in the current combined calculation. This is due to the removal of the pre-retirement portion of the active employees' liability. The post-retirement portion of the active employees' liability remains in the stated liabilities for the retiree plan.

State Contributions

State contributions will be split between the active and retiree reports based on the implied pricing allocations. The contribution to the active plan will be 56% of the total State contribution. The contribution to the retiree plan will be 44% of the total State contribution.

Treatment of Active Employer Contributions in the Experience Calculation

Under the prior methodology, all State contributions were deposited directly into the premium deposit fund. In order to simplify the experience calculation, we will not deposit the State contributions for the active plan into the premium deposit fund. State contributions for this plan will be included in the premium used in the calculation.

Annutant Calculation Separate from Post-Age 65 Calculation

The annuitant calculation within the retiree calculation remains separate from the post-age 65 calculation. This is to retain the ability to easily assess annuitant pricing adequacy.

The post-age 65 retiree calculation will be performed in a similar manner to the current calculation.

Spouse and Dependent Coverage

There will not be a spouse and dependent section of the retiree report due to spouse and dependent coverage terminating upon retirement.

State Internal Administration Expense

The state internal administration expense will be allocated to the active and retiree experience according to ETF's instructions.

Actuarial Service Charge

Actuarial service charges will be allocated to whichever plan receives the benefit of the service.

Local Government Differences

The following items differ for the Local Government plan from the descriptions above:

Stop Loss and Risk Charge – For the Local plan, the new stop loss limits are 135% of expected claims for the active plan, and 125% of expected claims for the retiree plan.

State Contributions – This section does not apply to the Local plan since local governments do not subsidize active premiums.

Treatment of Active Employer Contributions in the Experience Calculation - This section does not apply to the Local plan since local governments do not subsidize active premiums.

If you have any questions or would like to discuss any of these proposed changes, please let us know.

Sincerely,

Robert M. Olafson, FSA
Senior Vice President
Group Insurance Division

Paul Rudeen, FSA
Second Vice President and Actuary
Group Insurance Division

STATE OF WISCONSIN
Department of Employee Trust Funds
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CORRESPONDENCE MEMORANDUM

DATE: January 28, 2009

TO: Group Insurance Board

FROM: Sharon Walk
Board Liaison

SUBJECT: Gateway Ventures, Inc., Pre-Paid Legal Services Proposal

For agenda item #6, Consideration of Legal Services Payroll Deduction

At its November 11, 2008, Group Insurance Board (Board) meeting, the Board moved to delay consideration of the Gateway Ventures, Inc., Pre-Paid Legal Services Proposal until the next Board meeting. This is to advise you that consideration of this proposal has been added to the agenda of the February 17, 2009, meeting.

Attached is a copy of the October 29, 2008, memo from the Department that you received for the November meeting. At that time, you also received informational materials from Gateway Ventures that you were asked to retain and bring to the February Board meeting. If you no longer have the informational packet, please contact me at (608) 267-2417.

Staff from the Department will be available at the February meeting to answer any questions you may have.

Attachment

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

_____________________________________ __________
Signature Date

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STATE OF WISCONSIN
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CORRESPONDENCE MEMORANDUM

DATE: October 29, 2008

TO: Group Insurance Board

FROM: Betty Wittmann, Manager
Optional Insurance Plans and Audits

SUBJECT: Gateway Ventures, Inc, Pre-Paid Legal Services Proposal

Recommendation

Staff recommends that the Board not approve Gateway Ventures, Inc.'s request to offer Pre-Paid Legal Services through Pre-Paid Legal Casualty, Inc. (PPLC) for payroll deduction as it does not meet the Board's loss ratio requirements.

Background

Under authority granted to the Group Insurance Board (Board) by Wis. Stats. § 40.03(6)(b) and pursuant to Wis. Stats. § 20.921 (1)(a) 3, and Wis. Admin. Code § ETF10.20, the Board may authorize optional group insurance for payroll deduction where employees pay the entire premiums for such plans. Such proposals are reviewed under the Board's Guidelines for Optional Group Insurance Plans Seeking Group Insurance Board Approval for Payroll Deduction Authorization. An analysis by Deloitte, the Board's Consulting Actuary, is attached.

PPLC and its parent company, Pre-Paid Legal Services (PPL), are domiciled in the state of Oklahoma. In 1988, PPLC was licensed as a property and casualty insurer in the state of Wisconsin under Chapter 618 of the Wisconsin Statutes and is regulated by the commissioner of insurance according to Wis. Admin. Code § Ins 22.01(1).

Gateway Ventures Inc., an Independent Marketing Associate of PPL will market the PPLC policy and utilizing licensed insurance agents to sell policies. The PPLC plan indicates that for a membership fee of $14.75 per month, it would make available certain preventative legal services, motor vehicle defense services, trial defense services, will preparation services, IRS audit services and a 25% discount off other legal services. PPLC also offers a legal shield rider that provides 24-hour access to a toll-free number for attorney assistance if the member is arrested or detained. The cost for the rider is an additional $1.00 per month. The proposed premium rates would be guaranteed for three years.

Discussion

Staff is recommending against approval of the proposal due to its failure to meet the Board's loss ratio requirement. Specifically, the Board requires that at least 75% of the total premium collected be used to pay provider's claims under the policy. The Board developed this requirement to ensure that proposed plans offer good value to our participants, while retaining a

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

______________________________ ____________
Signature Date

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reasonable portion of the premium to cover administration cost and profit. A loss ratio below 75% will not normally be eligible for consideration unless the higher retention ratio is justified.

Gateway has asked for an exception to the 75% loss ratio and proposes a 42% loss ratio. In their view, the plan offers value in excess of the capitated payments (claims). In addition, Gateway cites the Loss Ratio Work Group Paper of the American Academy of Actuaries (AAA). However, Deloitte indicates the capitated rate structure is an accurate, fair-market value of the services, and an accurate representation of the value of the plan. Further Deloitte reviewed the findings of the AAA Loss Ratio Work Group Paper and does not believe it supports a 42% loss ratio.

Deloitte's loss ratio development analysis, beginning on page 3 of the attached memo, calculated an actual historical loss ratio of 31% based on PPLC's earned premiums and incurred claims (i.e. capitated payments) as presented in the 2007 annual statement (Exhibit G). As a result a very high portion of the premiums are retained for profit, agent commissions, and administrative expenses. In comparison with other employee benefit plans, Deloitte determined these commission expenses and profit margins to be significantly greater than industry norms.

Concerning the benefits of the plan, it appears they are geared towards providing initial consultations with an attorney, document review (under 10 pages), and basic will preparation service. The will preparation is based on a questionnaire (no meeting) and does not include execution of the will or storage and if the member would like to have it executed or stored they would need to utilize the 25% discount. The representation offered under the membership fee applies to non-felony and uncontested matters such as adoption (no guardianship proceedings), legal separation, or divorce where net marital assets are under $100,000 and/or involve division of retirement assets.

Staff reviewed the benefits provisions, exclusions, and limitations in the membership and was not able to determine the value of these benefits since no claims or quantifiable information was provided. This will also make annual reporting a challenge, as PPLC has stated that it can only report enrollment, provider inquiries, and financial information. Since this product is offered to employees on a capitated basis and the services are legal in nature, utilization statistics are not available.

Conclusion

Based on the review by staff and the Board's actuary, we do not recommend accepting the Gateway Ventures, Inc. pre-paid legal services proposal. While the policy provides some access to legal services, the exclusions and limitations are extensive. In addition, the premium is used to provide a substantial agent commission and profit and does not satisfy the Board's 75% loss ratio or any reasonable extension of it.

Staff will be available at the meeting to answer any questions you may have regarding this matter.

STATE OF WISCONSIN
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CORRESPONDENCE MEMORANDUM

DATE: January 29, 2009

TO: Group Insurance Board

FROM: Liz Doss-Anderson, Ombudsperson
Vickie Baker, Ombudsperson
Christina Keeley, Ombudsperson
Sharon Walk, Executive Staff Assistant

SUBJECT: Correspondence and Complaint Summary

This is for information only. No Board action is required.

This memo lists issues raised by participants relating to insurance benefits under the authority of the Group Insurance Board (GIB). The tables below include a summary of the following for the period of October 1, 2008, through December 31, 2008:

(1) Correspondence received by the Department addressed to the Secretary or the GIB;

(2) The number of requests for information and assistance made to the ombudspersons in the Office of Quality Assurance.

Staff will be available at the Board meeting to address any questions you have regarding this report.

Correspondence:

	Number
Health Insurance	
• Concern about the rising cost of health insurance	**1**
• Complaint regarding the contribution rate for out-of-state employees	**1**
• Complaint regarding processing of health insurance change from family to single coverage	**1**
• Request from participant to include in Uniform Benefits coverage for the treatment of flexible flat feet	**1**
• Question asking why health insurance premiums are higher in northwestern Wisconsin compared to central Wisconsin	**1**
• Complaint about health insurance coverage in western Wisconsin	**1**
• Complaint regarding denial of coverage of shingles vaccination in 2008	**1**

Reviewed and approved by Matt Stohr, Director, Office of Legislative Affairs, Communications and Quality Assurance.

____________________________ __________
Signature Date

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Pharmacy Benefits	
• Question regarding denied prescription	**1**
• Inquiry about reimbursement for a 12-month supply of prescription drugs.	**1**
TOTAL	**9**

Contacts to Ombudspersons:
From October 1, 2008, through December 31, 2008, 303 members contacted the ombudspersons for assistance with benefit issues. The majority of these contacts involved health insurance and pharmacy benefits, which includes Medicare Part D.

Recurring issues that staff identified during this period include:

- Participants unable to obtain the shingles vaccine as a covered service, unsuccessful in receiving reimbursement for the vaccine, or being provided incorrect coverage information by their health plan or PBM.

- Participants experiencing enrollment and eligibility problems - *Most of these were related to coverage of dependents, questions regarding late Dual-Choice application process and/or the Dual-Choice rescind process. This also included working collaboratively with health plans, PBM and other ETF staff to resolve eligibility issues immediately, to allow members to obtain necessary covered prescriptions.*

- Participants for whom a claim or deductible/copayment discrepancy occurred between health plan or PBM and the participant's provider – *Ombudspersons routinely assist members when their claims have been denied, excess copayment is applied or when provider billing errors occur.*

- Participants requiring assistance with the student dependent or disabled dependent verification process (which determines continued dependent eligibility for health insurance) or who have concerns about how plan changes may affect their dependent's health insurance coverage.

- Participants in need of assistance with new or continuing Medicare coordination of benefits or enrollment problems (which result in neither insurer paying claims until the primary versus secondary payer problem is resolved) - O*mbudspersons regularly work with Medicare, health plans, and advocacy organizations on behalf of members to expedite resolution of these problems.*

- Participants with COBRA or other continuation of health insurance coverage problems.

- Participants who do not fully understand their coverage or reasons for denials - *Ombudspersons regularly work with participants to help them better understand the characteristics of ETF-administered benefit programs*.

The following tables summarize the method of contact and program areas involved compared with the same period in 2007.

Total Contacts	2008	2007
October	153	107
November	65	76
December	85	80
Total	303	263

Method of Contact	Jan-Dec 2008	Jan-Dec 2007
Telephone	1,028	N/A
E-mail/Contact Us Internet Page	203	N/A
US Mail	76	N/A
Walk-In	24	N/A

Number of Contacts by Program	Jan-Dec 2008	Jan-Dec 2007
Health Insurance-HMOs	714	370
Health Insurance-Self Funded	268	195
Pharmacy Benefits	198	92
Non-WRS Programs (DentalBlue)	43	25
Disability/Income Continuation Insurance	24	18
All other program types* (Life Insurance, ERA, EPIC, Spectera, WRS/ASLCC and WDC)	84	37

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

Key:

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

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CORRESPONDENCE MEMORANDUM

DATE: January 15, 2009

TO: Group Insurance Board

FROM: Michelle Baxter, Director
Insurance Administration Bureau, Division of Insurance Services

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

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

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

The WPEG plan has experienced continued growth in the number of participating employers, primarily by adding smaller employers. No large employer has joined the plan since 2005, when the underwriting process was implemented for employers with 51 or more employees in the Wisconsin Retirement System (WRS). Effective in 2009, the underwriting process applies to all WRS employers. Employers are underwritten and assessed a surcharge when the risk is determined to be detrimental to the existing pool.

In 2008, nine employers (one county, three cities, one town, one village and three special districts) completed the underwriting process. Seven employers were determined to have poor risk and were placed in the category with the highest surcharge amount. Three entities became effective during 2008, five will become effective in 2009, and one rescinded their application. Staff believes the surcharge amounts to be reasonable, as the WPEG rates with the surcharge amount were comparable to the renewal rates the employers received from their existing insurance carrier.

Effective in 2005, the WPEG plan began to offer additional health program options at reduced premiums. The options include a Standard Plan that is a preferred provider plan (PPP) as an option to the classic fee-for-service Standard Plan, and a deductible option for both Uniform Benefits and the Standard Plan or the Standard PPP. Table 1 on the next page provides a summary of resolutions filed by new and participating employers for coverage in 2008 under each of the new health program options.

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

_______________________________ __________
Signature Date

Board	Mtg Date	Item #
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TABLE 1
PARTICIPATION IN WPEG PROGRAM OPTIONS FOR 2008

Description	Uniform Benefits & Classic Standard Plan	Uniform Benefits & Standard PPP	Deductible Uniform Benefits & Deductible Standard Plan	Deductible Uniform Benefits & Deductible Standard PPP
Employers Previously Enrolled in This Option	299	11	23	11
Employers That Joined WPEG Selecting This Option	10	4	0	1
Employers in WPEG That Switched to This Option	0	0	3	0
Total Employers Enrolled in This Option as of 12/31/08	309	15	26	12
Total Active Insured Employees	10,346	156	853	334

Six employers have passed resolutions to join the WPEG plan in 2009. In addition, five employers already participating in the WPEG plan filed resolutions to switch to a new health program option in 2009.

Two employers terminated participation in the WPEG plan effective in 2008: the City of Hudson and the Town of Hull.

The local ICI plan continues to see some growth. As with the WPEG plan, the ICI plan tends to attract smaller employers. Four of the local employers joining the ICI plan for 2008 had only two employees. The largest local employer joining was the City of Rice Lake with 97 employees. No employer terminated participation in the ICI plan in 2008.

Table 2, below, provides a summary of the types of employers in the WPEG plan and the local ICI plan as of December 31, 2008.

TABLE 2
PARTICIPATION IN THE WPEG & LOCAL ICI PLANS AS OF 12/31/08

Category	WPEG Plan	ICI Plan
New Employers in CY2008	17	8
New Employees in CY2008	217	123
Employers Terminating in CY2008	2	0
Employees Terminating in CY 2008	770	0
Participating Cities	65	40
Participating Villages	113	52
Participating School Districts	5	0
Participating Special Districts	102	65
Participating Towns	74	21
Participating Counties	8	9
Total Employers	367	187
Total Active Insured Employees	11,689	7366

STATE OF WISCONSIN
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CORRESPONDENCE MEMORANDUM

DATE: January 21, 2009

TO: Group Insurance Board

FROM: Sharon Walk
Appeals Coordinator

SUBJECT: Pending Appeals

<u>This memo is provided for informational purposes only. No Board action is necessary.</u>

This memo shows the appeals that were filed in 2008, with a breakdown showing the type of appeals currently pending.

For the period January 1, 2008, to December 31, 2008, 55 new appeals were filed. During that same period, 44 appeal cases were closed (37 were withdrawn and the remaining 7 were closed when a final decision was issued).

There are currently 38 pending appeals, which can be divided into the following categories:

GI Board (10)
- Long-Term Disability Insurance Denial 6
- Health Insurance Coverage 4

ETF Board (17)
- Participation or Category of Employment.......................... 11
- Annuity Option or Start Date... 2
- Beneficiary 2
- Cancellation of WRS Separation Benefit 2

WR Board (11)
- Section 40.63 Disability Denial 6
- Section 40.65 Disability Calculation................................... 5

There are no pending appeals that have been filed by groups of participants.

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

_______________________________ ____________
Signature Date

Board	Mtg Date	Item #
GIB	02/17/2009	7

The chart below shows the appeals pending as of January 1, from 2003 to 2009.

PENDING APPEALS BY BOARD						
As of:	**ETF**	**GIB**	**WR**	**TR**	**DC**	**TOTAL**
01/01/03	73	39	45	8	0	165
01/01/04	66	28	26	8	0	128
01/01/05	54	22	26	2	0	104
01/01/06	49	19	14	0	0	82
01/01/07	14	10	10	1	1	36
01/01/08	10	10	6	1	0	27
01/01/09	17	10	11	0	0	38

Staff will be available at the February 17, 2009, meeting to answer any questions you may have.