

Health Insurance Shared Services Analysis

Project Report Submitted To:
Joint Commission On Shared Services Initiatives
April 10, 2013

Compiled By:



Eau Claire County
721 Oxford Avenue
Eau Claire, WI 54703



Eau Claire Area School District
500 Main Street
Eau Claire, WI 54701



City of Eau Claire
203 S. Farwell Street
Eau Claire, WI 54701

TABLE OF CONTENTS

I.	Introduction	1
II.	Executive Summary	3
III.	Defining the Current State of Health Insurance	6
A.	Current Programs.	6
1.	Current Insurance Companies	6
2.	Renewal Dates	6
3.	Demographics	6
4.	Benefits Comparison (Coverage Analysis)	8
5.	Analysis of Expenses Within the Deductible.	9
6.	Out of Pocket Employee Paid Expenses.	10
7.	Wellness Program Plan Designs	11
8.	Premium Rates	14
9.	Premium Rate Increase History	15
10.	Total Annual Cost to Provide Health Insurance	16
11.	Claims Data – Where Does the Money Go?	16
B.	Medical Cost and Health Insurance Trends.	17
C.	Regional Medical Cost Analysis	20
D.	Access to Accurate Pricing and Cost Information	25
E.	Quality of Health Care in the Chippewa Valley	26
F.	Availability of Insurance Companies – Region and State.	27
G.	Insurance Company Administrative Cost Analysis	28
H.	History of Combined Public Sector Health Insurance Purchasing Efforts	29
I.	Impact of Federal Legislation	30
J.	Description of Regional Medical Facilities and Services	33
IV.	Prioritization of Collaborative Opportunities	34
V.	Collaborative Opportunities and Barriers	36
VI.	Conclusion	45
	Works Cited.	46
	Appendix Table of Contents	47

I. Introduction

I. INTRODUCTION

A Report to the Joint Commission on Shared Services Initiatives

Health insurance is expensive and, for most employers, the fastest growing expense. This is also true for public entities like the Eau Claire Area School District (ECASD), City of Eau Claire and Eau Claire County. These entities spend a combined \$46 million each year on health insurance. Furthermore, this expense is consistently, year after year, rising much faster than inflation and sources of revenue. This report, commissioned by the Joint Commission on Shared Services Initiatives, reviews the current state of health insurance for these three public entities. It also explores possible ways the entities may better impact and control the cost of health care by working together, versus standing alone.

The Joint Commission on Shared Services Initiatives was created to provide visionary leadership in the delivery of collaborative public services by identifying opportunities and challenges, engaging the multiple constituencies, and developing strategies to support collaboration in areas of common interest among the governmental bodies. The Commission makes recommendations to the School Board, City Council and County Board for approval of concepts and strategies for implementation.

The Commission consists of three School Board members, three City Council members and three County Board members.

Current members of the Commission are:

Eau Claire Area School District

Carol Craig
Brent Wogahn
Kathryn Duax

City of Eau Claire

David Duax
Jackie Pavelski
Kerry Kincaid

Eau Claire County

Colleen Bates
Gregg Moore
Gerald Wilkie

Priority Partnership Opportunities (Projects) that have been identified by the Joint Commission on Joint Services Initiatives include:

- Combine information technology & communications technology functions
- Share administrative functions
- Include the school district in joint purchasing program
- Joint health care insurance program
- Combine land record systems including GIS
- Share administrative space and facilities

This report is a review of the current health insurance and wellness plan for each entity, and an exploration of the options for combining the plans. The goal is to improve the health insurance buying power and experience rating of the group to produce healthier and more engaged consumers of health care. Team Members that produced this report include:

Kay Marks, Executive Director of Human Resources, Eau Claire Area School District
Daniel Van De Water, Executive Director of Business Services, Eau Claire Area School District
Dale Peters, Director of Human Resources, City of Eau Claire
Frank Draxler, Director of Purchasing, City & County of Eau Claire
Scott Rasmussen, Director of Finance, Eau Claire County
Heather Baker, Director of Human Resources, Eau Claire County
Carrie Riepl, Human Resources Secretary, City of Eau Claire

II. Executive Summary

II. EXECUTIVE SUMMARY

Health insurance is the fastest growing line item in the budget of any business that offers health insurance to its employees. A public sector employer is no different. In fact, in this age of decreasing revenue and increased demand for services, failure to control health insurance costs can result in layoffs and reductions in services. This report focused on exploring ways that public entities in the Chippewa Valley, principally the Eau Claire Area School District, City of Eau Claire and Eau Claire County, can work together to lower the cost of providing health insurance to their employees. Although the report was completed specifically with regard to these three public entities, the recommendations and resulting collaborations are made with the flexibility and understanding that other units of local government may want to participate as well.

Report Philosophy

The price of an employer's health insurance premium is really quite simple. It is a function of the medical claims (cost of each medical procedure, number of medical procedures and cost of prescriptions), the cost to administer the claims, the cost of catastrophic or large loss protection and the profits of the insurance company. By far, the largest component of any health insurance premium is the employer's claims experience. The authors of this report believe strongly that the way to impact the cost of claims and consequently the cost of health insurance is to:

1. Have healthy employees.
2. Have employees establish relationships with primary doctors that encourage wellness and preventive screenings.
3. Have easy access to high quality care for employees with chronic conditions and have these conditions actively managed.
4. Have employees actively engaged in understanding the price and quality of the medical services they receive.
5. Continue to require that employees have a reasonable financial interest concerning their health insurance costs and options.

Report Methodology

This report was divided into three primary sections:

- Understanding the current state of health care in the Chippewa Valley. Prior to answering any question, it is important to know the problem or situation that is to be addressed. Health care and the purchase of health insurance for employees is complex, with many players that have a strong financial interest, sometimes in maintaining the status quo. This report attempts to carefully describe the quality, cost, and availability of health care and insurance services to local employers. It also carefully describes the health insurance and wellness plans offered by each of the three public entities in order to be able to make “apples to apples” comparisons of the plans and identify features of the plans that are successful.
- Exploring opportunities for future collaboration. This section of the report focuses on ways that the public sector, working together, can leverage their significant resources together to influence the quality and cost of health services offered to their employees.
- Developing recommendations and priorities. There is no quick or easy solution for controlling health insurance costs. This section of the report takes the information and ideas gathered in the development of the report and presents recommendations or a “road map” for how the three entities can move forward together in a collaborative manner to positively impact the cost of the health insurance that is provided to their employees.

Summary of Findings

- Medical procedures and drugs are expensive.
- The cost of medical procedures and drugs (medical CPI) is rising significantly faster than the price of general consumer goods and personal income (CPI).
- The rate of increase in the cost of medical procedures in the Chippewa Valley is higher than the state and national medical CPI.
- All area hospitals routinely have higher net operating income and total net income than the average for hospitals in the state of Wisconsin.
- There is high variability in the cost of procedures from facility to facility.
- It is very difficult to obtain an accurate price quote for specific procedures from a medical facility or clinic.

- The price or cost of a procedure is not based upon the outcome of the procedure.
- The Chippewa Valley generally enjoys high quality and broad access to specialty medical care.
- Wellness programs can positively impact the utilization of medical services and cost of claims.
- The current purchasing practices of each entity present challenges for having all three entities covered by the same insurance company.
- Combined, the School District, City and County spend more than \$46 million every year on health insurance.
- Consistent, complete and “apples to apples” claims data is difficult to obtain from different insurance companies.
- Complete paid claims data can be difficult to obtain in usable formats.
- Historically, health insurance premium increases have not been stable or predictable, which can provide large variances in entity budgets.
- In order for employees to embrace recommendations for engaging price and quality discussions with the medical community, the employer must spend the time and energy necessary to educate them on the challenges associated with the costs of health care.
- When comparing insurance rates at renewal, it is difficult to understand the pricing formulas and methodology.

III. Defining the Current State of Health Insurance

III. DEFINING THE CURRENT STATE OF HEALTH INSURANCE

This section of the report focuses on defining and outlining the health insurance plans and associated costs for the insurance plans that are provided for the employees and retirees of the Eau Claire Area School District, City of Eau Claire and Eau Claire County.

A. Current Programs

1. Current Insurance Companies

- Eau Claire Area School District - Group Health Cooperative of Eau Claire (note: effective July 1, 2013 the School District will be changing insurance companies to Security Health Plan).
- City of Eau Claire - Group Health Cooperative of Eau Claire.
- Eau Claire County - Wisconsin Counties Associations (WCA) Group Health Trust.

2. Renewal Dates

The School District and City both have health insurance annual renewals in July, while the County has annual renewal in January.

Entity	Health Insurance Company	Renewal Date	Years With Company
ECASD	Group Health Cooperative of Eau Claire	July 1 st	1975 to 2005, 2009 to 2013
City of Eau Claire	Group Health Cooperative of Eau Claire	July 1 st	1975 to 2002, 2007 to Present
Eau Claire County	WCA Group Health Trust	January 1 st	1975 to 1990 2005 to Present

3. Demographics

All three of the entities offer health insurance to their employees, retirees and their dependents. The definition of employees eligible for insurance varies between the entities, but is generally limited to employees that have regular hours and schedules. Seasonal, temporary and employees with limited hours are generally not eligible for health insurance.

Combined, the three entities have over 6,000 lives insured. This is statistically significant for the calculation and projection of loss and claims information. Generally speaking, groups smaller than 4,000 are not large enough to have predictable loss information or have influence in the market place.

HEALTH INSURANCE CENSUS DATA

ECASD as of December 2012

	Active	Retiree	Total
Employees	1072	349	1421
Dependents	2072	247	2319
Total Insured Lives	3144	596	3740

Family Plans	550	28	578
Limited Family Plans	281	171	452
Single Plans	241	150	391
	1072	349	1421

Number of Active Eligible Employees: 1432

City of Eau Claire as of December 2012*

	Active	Retiree	Total
Employees	430	143	573
Dependents	779	51	830
Total Insured Lives	1209	194	1403

Family Plans	221	3	224
Limited Family Plans	130	47	177
Single Plans	79	93	172
	430	143	573

Number of Active Eligible Employees: 503

* Does not include Library, Health or Housing

Eau Claire County as of December 2012

	Active	Retiree	Total
Employees	404	90	494
Dependents	725	38	763
Total Insured Lives	1129	128	1257

Family Plans	175	1	176
Limited Family Plans	124	36	160
Single Plans	105	53	158
	404	90*	494

Number of Active Eligible Employees: 420

* County retirees pay 100% of the cost.

Combined Totals as of December 2012

	Active	Retiree	Total
Employees	1906	582	2488
Dependents	3576	336	3912
Total Insured Lives	5482	918	6400

Family Plans	946	32	978
Limited Family Plans	535	254	789
Single Plans	425	296	721
	1906	582	2488

4. Benefits Comparison (Coverage Analysis)

Benefits and plan design for each of the three entities are fairly similar. Each has a “high deductible” policy, although there are differences in how the deductible is funded, handled or reimbursed between the entities. This issue will be discussed more later in the report. Copays, covered procedures and drug copays are similar for all three entities. The School District and City present greater steerage to generic drugs with their zero dollar copay. The County is the only entity to have a coinsurance clause which requires the participant to pay 10% of every covered item up to a maximum of \$200 per single policy and \$400 per family policy.

	ECASD**	City of Eau Claire	Eau Claire County
Insurance Company Network	GHC HMO	GHC HMO	WCA EPO
Deductible from Insurance Company	\$1,500 / \$3,000	\$1,650 / \$3,300	\$1,250 / \$2,500
Amount of Deductible funded by employer to HSA/HRA	\$1,000 / \$2,000	N/A	\$1,000 / \$2,000
Max deductible reimbursement of actual claims	N/A	\$1,650 / \$3,300	N/A
Coinsurance In-Network	100%	100%	90%
Coinsurance Out-of-Pocket Max	N/A	N/A	\$200 / \$400
Maximum Out-of-Pocket includes Deductible and Coinsurance; copays do not apply to this maximum	\$500 / \$1,000	\$1,650 / \$3,300*	\$450 / \$900
Lifetime Maximum	Unlimited	Unlimited	Unlimited
Office Visits In-Network	\$18 Copay	\$27.50 Copay	\$25 Copay
Urgent Care Visits	\$28 Copay	\$37.50 Copay	\$25 Copay
Routine/Preventive Care	100% Covered	100% Covered	100% Covered
Inpatient Hospital Services	Ded, 100% Coins	Ded, 100% Coins	Ded, 90% Coins
Outpatient Hospital Services	Ded, 100% Coins	Ded, 100% Coins	Ded, 90% Coins
Emergency Room	\$100 Copay	\$150 Copay	\$100 Copay
Prescription Drugs - Participating Pharmacy	<i>31-Day Supply</i>	<i>31-Day Supply</i>	<i>31-Day Supply</i>
Formulary Generic	\$0	\$0	\$10
Formulary Brand Name	\$25	\$30	\$25
Non-Formulary	50% (Max \$75 per Fill)	50% (Max \$80 per Fill)	\$50

*Employee payment of claims if they do not meet certain wellness requirements.

** Most popular plan of six offered to ECASD employees.

See Appendix A for additional health insurance plan information for each entity.

5. Analysis of Expenses Within the Deductible

The School District, City and County each offer “high deductible” health insurance plans to their employees and their families. However, each has structured the way they fund and/or pay claims within the deductible layer differently.

Eau Claire Area School District

The School District has a deductible of \$1,500 for a single plan and \$3,000 for a limited family or family plan which is tied to a Health Savings Account (HSA). The School District provides a contribution to the HSA in the amount of \$1,000 for a single plan and \$2,000 for a limited family or family plan. Cash balances in the HSA rollover to cover medical expenses in future years. The employee out of pocket deductible exposure is \$500 for a single plan and \$1,000 for a limited family or family plan.

City of Eau Claire

The City of Eau Claire uses a Health Reimbursement Account (HRA) to reimburse the actual claim costs incurred by the employees within the deductible layer. This reimbursement is directly tied to the employee and their spouse completing certain wellness requirements. If the employee and their spouse meet all of the wellness requirements, the City will reimburse all claims within the deductible. Failure to complete all of the wellness requirements can result in the employee paying the full amount for all claims within the deductible layer. The deductible is \$1,650 for a single plan and \$3,300 for a limited family or family plan. There is no rollover or savings component to this program.

Eau Claire County

Eau Claire County has a deductible of \$1,250 for a single plan and \$2,500 for a limited family or family plan which is tied to a Health Savings Account (HSA). The County provides a contribution to the HSA in the amount of \$1,000 for a single plan and \$2,000 for a limited family or family plan. Cash balances in the HSA rollover to cover medical expenses in future years. The employee out of pocket deductible exposure is \$250 for a single plan and \$500 for a limited family or family plan (does not include co-insurance cost). Failure to comply with the wellness requirements increases the employee’s cost - \$600 for a single plan and \$1,200 for a limited family or family plan per year.

Below is a comparison of the amounts paid within the deductible by each entity.

Entity	Employee Deductible	Total Deductible Exposure	Total Paid Claims	Employer Payment or HSA Funding	Percentage of Exposure Paid
ECASD	\$1500/\$3000	\$2,953,500	\$1,362,353	\$1,993,800	67.5%
City of Eau Claire	\$1650/\$3300	\$1,607,100	\$690,764	\$690,764	43.0%
Eau Claire County	\$1250/\$2500	\$878,750	\$468,439	\$234,561	80.0%

6. Out of Pocket Employee Paid Expenses

Each of the plans offered by the three entities has out of pocket copays and coinsurance that are paid by the employees and their families. The table below notes the amounts paid.

ECASD Out of Pocket Utilization for 2011/2012 policy year

Copays	\$539,059
Coinsurance	\$79,091

City of Eau Claire Out of Pocket Utilization for 2011/2012 policy year

Copays	\$385,259
Coinsurance	\$3,701

Eau Claire County Out of Pocket Utilization for 2012

Copays	\$633,959
Coinsurance	\$119,594

7. Wellness Program Plan Designs

Eau Claire Area School District Wellness Program

The Eau Claire Area School District's Health Promotion program is designed to support employees, retirees and covered spouses in the pursuit of healthier lifestyle choices and, through education, empower them to make informed decisions about their health care. These changes can improve the overall quality of life for employees, retirees and their families and, in the process, control future health care costs.

To obtain or maintain the reduced premium for the next benefit year, all employees, retirees and covered spouses must complete each of the three steps of the program within 90 days of their effective date. If employees, retirees and covered spouses do not complete the following steps within the specified time period, the right to the reduced premium for the plan year is forfeited. These steps are:

- Step 1: Know your numbers. Employees, retirees, and covered spouses each participate in a biometric screening evaluation. This includes height, weight, blood pressure and body mass index. Results remain strictly confidential.
- Step 2: Know your risks. Employees, retirees, and covered spouses complete an online health risk assessment at group-health.com. The assessment takes approximately 15 minutes.
- Step 3: Know your health. Employees, retirees, and covered spouses meet with one of Group Health Cooperative's Health Promotion Coaches to review the results of steps 1 and 2.

As an additional incentive for the 2012-13 plan year, ECASD employees, retirees and covered spouses can earn \$50 in Eau Claire Chamber gift certificates by having a preventive screening form signed by the physician at the annual preventive care visit between July 1, 2012 and June 30, 2013. This form indicates that age and gender appropriate preventive medical screenings are up-to-date and must be turned in to Group Health Cooperative. Once the form is received by Group Health Cooperative, the gift certificates are mailed.

City of Eau Claire Wellness Program

The City of Eau Claire’s Wellness Program strives to improve the overall quality of life for its employees, retirees and spouses, in addition to helping control health care costs. The wellness committee, in partnership with its health insurance carrier, Group Health Cooperative, helps employees adopt and maintain healthy habits through financial incentives, education and by providing the tools and programs to engage employees and their families in taking an active part in their overall health.

The core of the City’s wellness plan centers on each employee and spouse achieving four wellness outcomes. Reimbursement of medical expenses within the deductible layer is tied to each wellness outcome. These outcomes are:

- Coach meetings:
 - A mid-year follow-up phone call
 - Health promotion appointment (biometrics, health risk assessment and health promotion plan).
- Medical preventive screening - an appointment with a primary physician and certification that the patient has completed all recommended preventive screenings.
- Tobacco free validation.
- Body mass index/body fat and blood pressure:
 - BMI of 27 or less OR weight loss of three percent of body weight
 - Blood pressure < 140/90.

Financial reimbursement of actual, incurred claims within the deductible layer (\$1,650/single and \$3,300 /family) is outlined in the table below.

Single Plan	Family Plan		Requirements
	Subscriber	Spouse	
25%	12.5%	12.5%	Health Promotion appointments and HRA
25%	12.5%	12.5%	Complete a preventive care screening
25%	12.5%	12.5%	Tobacco free
25%	12.5%	12.5%	Meet BMI/body fat percentage and blood pressure requirements
100%	50%	50%	Total Deductible Credit

The City, in partnership with the YMCA, WeightWatchers and others, provides programs throughout the year to help employees and their spouses achieve these goals, including: weight loss - WeightWatchers, weight loss challenges; physical activity - yoga, boot camp, indoor cycling; educational - “The 8 Habits That Will Change Your Life”; as well as a variety of other activities.

Eau Claire County Wellness Program

The Eau Claire County Wellness Program is managed by an employee committee and designed to meet employee needs as identified in employee surveys and by its health insurance carrier, WCA Group Health Trust, through incentivizing healthy behavior. Employees and spouses who have annual physical exams and comply with case management reviews qualify for reduced health insurance premiums, currently \$50 less/month for single plans and \$100 less/month for family plans plus \$25/person in Chamber Bucks. Employees can join teams and participate in an annual wellness activity challenge to earn Chamber Bucks and Scholarship Bucks, with employees being reimbursed for half of the cost of these activities which include exercise classes such as pilates, zumba and yoga offered at the courthouse or within the community, and other activities such as the YMCA Boot Camp. Reimbursement is also received for weight loss classes, such as WeightWatchers and HMR (Mayo Health System’s weight loss plan), and for participating in smoking cessation classes. Health club memberships are reimbursed up to \$100/employee and spouse annually directly by WCA Group Health Trust.

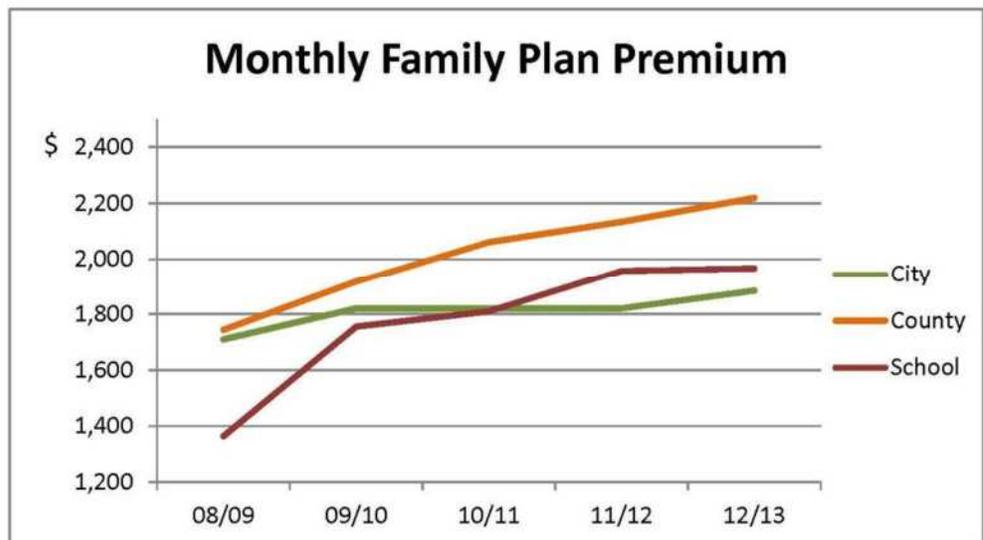
The committee also coordinates many other activities throughout the year. These activities include: lunch and learn sessions which are held periodically to encourage healthy eating, increased physical activity, stress reduction and other relevant topics; an on-site Wellness Fair is held every other year; the Great American Smokeout is celebrated; employees are encouraged to participate in community activities such as Relay for Life, American Heart Walk, Juvenile Diabetes Walk and Alzheimers Walk; and the opportunity for on-site massages.

As part of the courthouse remodeling project, an employee fitness room will be opened on the third floor by the end of March. It will contain two exercise bikes, an elliptical trainer, a treadmill, a weight trainer, kettle balls and exercise mats. Funding for the fitness room and all of the incentives is provided through grants from WCA Group Health Trust.

8. Premium Rates

All three entities offer single and family plan coverage to their employees. Family is defined as a legal couple and any number of children. The School District and City offer a limited family plan which is an employee and their spouse or an employee and any number of children. The County offers a limited family plan which is offered to an employee and their spouse or an employee and a child.

FROM	TO	EMPLOYEE	LIMITED FAMILY	EMPLOYEE PLUS 1	FAMILY
ECASD Active Option 1 with Wellness - HMO					
7/1/2012	6/30/2013	\$759	\$1,589	n/a	\$1,966
7/1/2011	6/30/2012	\$756	\$1,582	n/a	\$1,958
7/1/2010	6/30/2011	\$698	\$1,462	n/a	\$1,809
7/1/2009	6/30/2010	\$677	\$1,418	n/a	\$1,754
7/1/2008	6/30/2009	\$524	\$1,069	n/a	\$1,363
7/1/2007	6/30/2008	\$570	\$1,163	n/a	\$1,483
City of EC HMO Option – Actives					
7/1/2012	6/30/2013	\$727	\$1,522	n/a	\$1,884
7/1/2011	6/30/2012	\$703	\$1,471	n/a	\$1,820
7/1/2010	6/30/2011	\$703	\$1,471	n/a	\$1,820
7/1/2009	6/30/2010	\$703	\$1,471	n/a	\$1,820
7/1/2008	6/30/2009	\$660	\$1,381	n/a	\$1,709
7/1/2007	6/30/2008	\$611	\$1,279	n/a	\$1,582
Eau Claire County HMO Option – Actives					
1/1/2013	12/31/2013	\$707	n/a	\$1,413	\$2,218
1/1/2012	12/31/2012	\$681	n/a	\$1,359	\$2,133
1/1/2011	12/31/2011	\$657	n/a	\$1,313	\$2,061
1/1/2010	12/31/2010	\$612	n/a	\$1,221	\$1,917
1/1/2009	12/31/2009	\$505	n/a	\$1,110	\$1,743
1/1/2008	12/31/2008	\$505	n/a	\$1,009	\$1,585



9. Premium Rate Increase History

Premiums rate increases, expressed as a percentage, are noted in the table below. It is not uncommon for insurance premiums to double or triple from one year to the next. This variability and unpredictability makes budgeting for health insurance a challenge and can produce large year-end variances, both positive and negative.

ECASD		
Year	Increase	
2012	0.42%	With Health Promotions (No Health Promotions 1.8% increase)
2011	8.25%	With Health Promotions (No Health Promotions 9% increase)
2010	3%	With Health Promotions (No Health Promotions 3.1% increase) With Benefit Changes
2009	28.7%	

Four year average increase of 10.1%

City of Eau Claire		
Year	Increase	
2012	3.5%	With Benefit Changes
2011	0%	With Benefit Changes
2010	0%	With Benefit Changes
2009	6.5%	

Four year average increase of 2.5%.

Eau Claire County		
Year	Increase	
2013	4%	With Benefit Changes
2012	3.5%	With Benefit Changes
2011	7.5%	With Benefit Changes
2010	10%	With Benefit Changes

Four year average increase of 6.25%.

10. Total Annual Cost to Provide Health Insurance

Health insurance is a substantial budget item for each of the three public entities. Between premiums paid to insurance companies and funding/reimbursements to health savings accounts, the three entities pay more than \$46 million per budget year.

2012

	Employer Premium Paid	Employee Premiums Paid	Reimbursements or Employer HSA/HRA Funding	Total
ECASD	\$22,773,508	\$3,072,244	\$1,993,800	\$27,839,552
City of Eau Claire	\$8,625,660	\$1,045,182	\$690,764	\$10,361,606
Eau Claire County*	\$6,486,952	\$884,584	\$703,000	\$8,074,536
Total	\$37,886,120	\$5,002,010	\$3,387,564	\$46,275,694

* Does not include retirees, as County does not pay for retiree health insurance.

11. Claims Data – Where Does the Money Go?

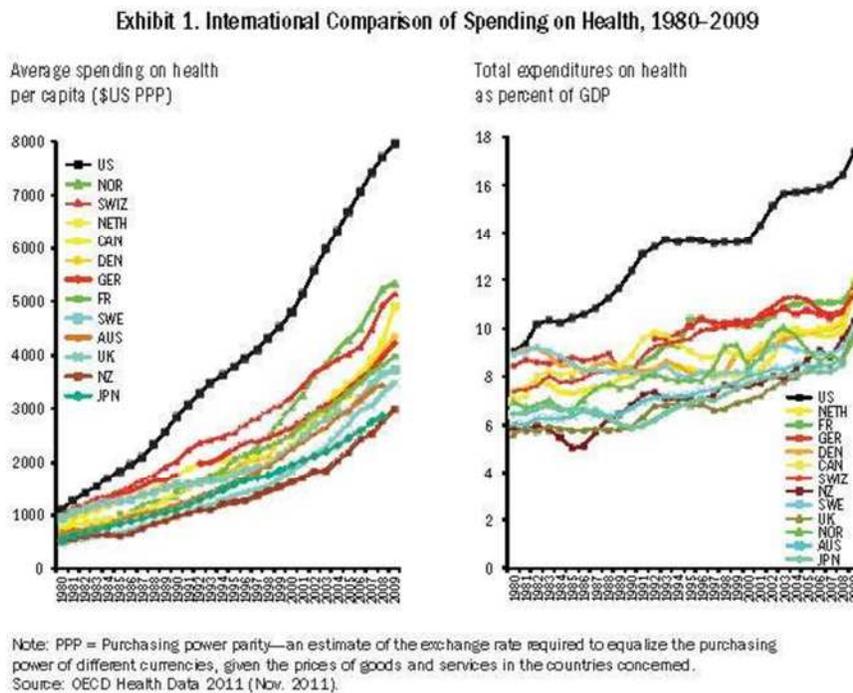
Paid loss data was collected from the insurance company of each entity. Reporting formats were not consistent. For categories that were consistent, the dollars paid have been presented below. It should be noted that these are not the total claims paid. Accurate paid claims data by type of service and insurance company is important the entities are to fully understand how their dollars are being spent. This type of data is especially important if the entities collectively want to impact the cost of medical procedures. The data below provides some insight on how some of the health care dollars are spent.

Examples of 2011 Actual Paid Claims

TYPE OF SERVICE	EASD	City	County	Total
Speech Therapy	\$8,964	\$3,722	\$565	\$13,251
Occupational Therapy	\$26,248	\$18,839	\$12,862	\$57,949
Chiropractic	\$53,475	\$20,175	\$13,808	\$87,459
Oral Surgery	\$50,223	\$48,326	\$10,640	\$109,190
Nursing Home	\$45,106	\$42,341	\$71,923	\$159,370
Ambulance Services	\$78,396	\$77,060	\$46,947	\$202,404
Durable Medical equipment	\$132,857	\$102,756	\$45,627	\$281,240
Physical Therapy	\$326,522	\$152,560	\$47,090	\$526,171
Inpatient Surgery	\$635,823	\$207,340	\$249,162	\$1,092,326
Anesthesia	\$628,803	\$304,035	\$254,742	\$1,187,581
Primary Physician Services	\$673,218	\$396,776	\$316,694	\$1,386,688
Emergency Room	\$1,085,403	\$502,717	\$227,552	\$1,815,672
Outpatient Hospitalization	\$1,630,060	\$922,980	\$359,735	\$2,912,774
Outpatient Services Surgery	\$2,193,569	\$1,060,610	\$669,592	\$3,923,771
Pharmacy	\$2,220,487	\$1,292,291	\$1,156,494	\$4,669,273
Inpatient Hospital/Inpatient Home	\$4,171,616	\$1,930,955	\$1,348,523	\$7,451,093
Total	\$13,960,770	\$7,083,483	\$4,831,956	\$25,876,212

B. Medical Cost and Health Insurance Trends

Most people are keenly aware that the cost of health insurance is escalating at a rate higher than general inflation and personal incomes. Unfortunately, the cost of health care spending in the United States is rising faster than any other country in the world on a per capita and percent of GDP basis. The cost of providing health care is not only a problem for employers in the Chippewa Valley, but is a national problem. If businesses and governments are to remain competitive and productive on a local, regional, national and international level, they must find a way to control the cost. The rate of increase in the cost of health care is not sustainable locally or nationally.



(Squires 2). See Appendix B for complete article.

Unfortunately, Wisconsin, and more specifically northwestern Wisconsin, has some of the highest health care costs. One study, *Wisconsin Health Insurance Cost Rankings 2013*, came to the following conclusions:

- Wisconsin health insurance rates have nearly doubled since 2000, increasing 193% for similar benefit packages, with regional rates of inflation varying between a low of 149% and a high of 324%. (According to the Department of Labor website, the All item U.S. CPI for the same time period was 32.5%, while national medical services CPI was 55.8%)
- The report found there was no correlation between quality and health insurance costs.
- The report found there is a strong correlation between type of insurance and quality, with national for-profit companies having below average to poor quality and regional non-profit provider-driven networks offering the highest quality plans.
- The Greater Milwaukee Business Foundation on Health Inc. study (December 2012) also found that Southeast Wisconsin health care premiums in 2011 were \$666 per year higher than the Midwest average, and \$528 per year higher than the national average.
- American Hospital Association data shows that the Wisconsin hospital operating margins are 62% above the national average. (and as you will see in the next section of the report, Eau Claire hospitals have consistently higher operating margins than the state average).
- A 2005 U.S Government Accountability Office (GAO) study found that out of 319 metro areas, eight of the top ten cities in the nation for physician costs, and two of the top ten cities for hospital costs are in Wisconsin.
- Frequently, the medical community will state that the reason costs are escalating so quickly is that reduced reimbursements from Medicare and Medicaid are causing a cost shift to commercial insurance. This study, however, reinforces the conclusion of previous research by the GAO that cost shifting from Medicaid and Medicare does not appear to be a major factor in health insurance cost variations. It goes on to say, “if cost shifting were a controlling variable, one would expect to see the highest health insurance costs in metro areas and regions of the state with much higher than average Medicaid utilization, poverty rates, or proportions of individuals without health insurance. Yet the fact that North Central, West Central and Northwestern Wisconsin have costs comparable to Southeast Wisconsin does not fit this pattern. The retrospective data in this report makes this case even stronger, as the gap between Medicare and Medicaid reimbursements and medical inflation has widened this decade.”

(Kraig). See Appendix C for complete study.

**Wisconsin Metro Area Cost Ranking
2013**

(Single Monthly Premium)

1. Milwaukee	\$767.12
Racine*	
2. Eau Claire	\$761.78
3. La Crosse	\$754.78
4. Wausau	\$747.73
Marshfield*	
Stevens Point*	
Wisconsin Rapids*	
5. Rhinelander	\$743.35
6. Twin Cities Metro (WI)	\$742.96
7. Superior	\$742.47
8. Kenosha	\$742.33
9. Green Bay	\$720.27
Appleton*	
Manitowoc*	
Oshkosh*	
Sheboygan*	
10. Fond du Lac	\$707.88
11. Dubuque Area (WI)	\$705.38
11. Janesville	\$701.44
Beloit*	
12. Madison	\$616.38
State Average	\$714.39

* Indicates Tie

**Wisconsin Metro Area Health Insurance
Cost Disparities with Madison**

(Single Monthly Premium)

Milwaukee	24%
Eau Claire*	
Racine*	
La Crosse	22%
Wausau	21%
Stevens Point*	
Wisconsin Rapids*	
Marshfield*	
Twin Cities Area (WI)*	
Rhinelander	
Superior	20%
Kenosha*	
Green Bay	17%
Appleton*	
Oshkosh*	
Manitowoc*	
Sheboygan*	
Fond du Lac	15%
Janesville	14%
Beloit*	
Dubuque Area (WI)*	
Madison	0%
State Average	16%

* Indicates Tie

(Kraig 11-12).

C. Regional Medical Cost Analysis

Net Profit Analysis by Hospital

Financial information for all hospitals in the state is available through the Wisconsin Hospital Association. Data for regional hospitals was researched for 2009, 2010 and 2011 (most current year data available). In two of the three years studied (2009 & 2011), OakLeaf Surgical Hospital was the most profitable hospital in the State of Wisconsin. Statewide, hospitals made an average net profit between 8 and 9% for each of the three years studied. All area hospitals consistently achieved net income percentages at or above the state average.

Net Income from Operations as a %:

Hospital	2009	2010	2011
OakLeaf Surgical Hospital	31.2	34.4	31.8
Sacred Heart Hospital	11.6	12.4	8.7
St. Joseph's Hospital Chippewa Falls	12.1	11.1	8.4
Mayo Clinic Health System Eau Claire	16.2	15.6	14.1
State average for net income from operations	7.8	7.7	7.4

Total Hospital Net Income as a %:

Hospital	2009	2010	2011
OakLeaf Surgical Hospital	31.2	34.4	31.8
Sacred Heart Hospital	4.0	17.6	20.8
St. Joseph's Hospital Chippewa Falls	7.8	14.8	17.3
Mayo Clinic Health System Eau Claire	16.7	18.7	15.2
State average for hospital net income	8.3	8.5	8.7

(Wisconsin Hospital Association).

In 2010 the statewide average profit for all hospitals was 8.4%. As previously indicated, all four area hospitals had net income at or above the state average. In 2011 this represented \$117,987,821 of net income. Net income for these four local hospitals exceeded the state average of 8.7% by \$68,830,862 in 2011. Stated another way, this is \$69 million of net income or “profit” above the state average collected by these hospitals from the employers and other payers of medical services in the Eau Claire area.

2010

Health Care Provider	Total Net Income	Amount That Exceeds State Average of 8.4%
OakLeaf Surgical Hospital	\$13,280,484	\$10,043,111
Sacred Heart Hospital	\$47,615,423	\$28,232,386
St. Joseph's Hospital Chippewa Falls	\$35,794,262	\$20,012,035
Mayo Clinic Health System Eau Claire	\$9,780,379	\$4,613,396
Total	\$106,470,548	\$62,900,928

2011

Health Care Provider	Total Net Income	Amount That Exceeds State Average of 8.7%
OakLeaf Surgical Hospital	\$12,803,909	\$9,308,204
Sacred Heart Hospital	\$50,556,521	\$32,612,670
St. Joseph's Hospital Chippewa Falls	\$13,146,106	\$7,376,935
Mayo Clinic Health System Eau Claire	\$41,481,285	\$19,533,053
Total	\$117,987,821	\$68,830,862

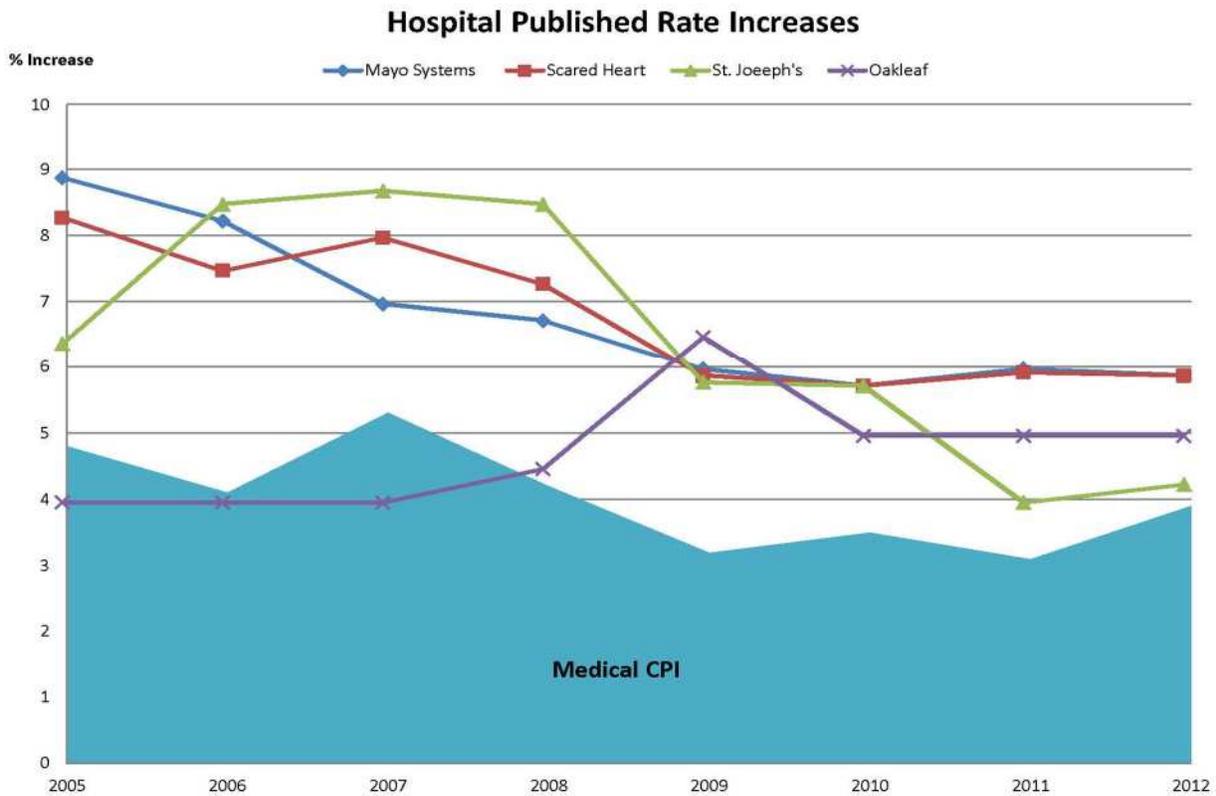
(Wisconsin Hospital Association).

Data from the Wisconsin Hospital Association also compares the net revenues for inpatient and outpatient revenues compared to their peer group. For outpatient procedures, all four area hospitals had net revenues at or above their peer group. Most had net revenues above their peer group ranging from 12 to 40 percent. OakLeaf, in 2010, had net revenues for outpatient services of 608% above its peer group. A peer group is hospitals that are grouped together by the Wisconsin Hospital Association by volume. See Appendix D for details.

Median charges for procedures vary greatly between health care providers:

Health Care Provider	Inpatient Hip Replacement	Inpatient Tonsil & Adenoid Procedures	Outpatient Removal of Medial & Lateral Cartilage Knee Scope	Outpatient Insertion of Drainage Tube Eardrum	Outpatient Repair Great Toe Bunion Foot Surgery
Marshfield Clinic	No data	No data	\$8,052	\$4,582	\$3,962
Mayo Clinic	\$36,161	No data	\$7,728	\$3,061	\$6,805
St. Josephs Hospital	\$49,994	No data	\$13,029	\$7,274	No data
OakLeaf Surgical Center	\$32,908	\$5,945	\$7,875	\$3,823	\$10,970
Sacred Heart Hospital	\$40,822	\$22,486	\$6,430	No data	No data
All WI Hospitals Median	\$39,362	\$12,699	\$7,579	\$3,076	\$7,882

(Wisconsin Hospital Association).



(United States Department of Labor and Wisconsin Hospital Association).

Net Profit and Billed Rate Analysis for Medical Clinics

Information on the revenues, expenses and profitability of clinics could not be located and are not currently required to be reported to the State Office of the Insurance Commissioner. However, for comparison purposes, the billed charges for several common services were compared, as well as the increase in billing rates, for these procedures for the past three years. Like the charges for hospital procedures, the price for clinic procedures can vary greatly between providers. Generally the price increase for these procedures outpaced general cost increases and medical inflation.

Immunization Administration

Health Care Provider	Average 2012 Bill	% Increase 2009-2012	Average Annual Increase
Family Health Associates	\$45	n/a	n/a
Eau Claire Medical Clinic	\$43	41%	13.7%
OakLeaf Pediatrics Clinic	\$42	16%	5.3%
Pine Grove Family Practice	\$41	24%	8.0%
MCHS Eau Claire Luther Campus*	\$40	42%	14%
Essentia Health Duluth	\$38	65%	21.7%
Marshfield Eau Claire Center	\$32	17%	5.7%
MCHS Eau Claire Clairemont*	\$27	13%	4.3%

Venous Blood Draw

Health Care Provider	Average 2012 Bill	% Increase 2009-2012	Average Annual Increase
Pine Grove Family Practice	\$41	25%	8.3%
MCHS Eau Claire Luther Campus*	\$30	0%	0%
MCHS Eau Claire Clairemont*	\$30	20%	6.7%
Family Health Associates	\$27	n/a	n/a
Marshfield Eau Claire Center	\$27	10%	3.3%
Eau Claire Medical Clinic	\$22	-1%	-0.3%
Essentia Health Duluth	\$19	1%	0.3%
UW Health Eau Claire	\$16	-11%	-3.7%

*MCHS = Mayo Clinic Health System

Basic Office or Other Outpatient Visit

Health Care Provider	Average 2012 Bill	% Increase 2009-2012	Average Annual Increase
Pine Grove Family Practice	\$175	24%	8.0%
MCHS Eau Claire Luther Campus	\$136	31%	10.3%
OakLeaf Pediatrics Clinic	\$135	17%	5.7%
MCHS Eau Claire Clairemont	\$129	12%	4.0%
Marshfield Eau Claire Center	\$127	18%	6.0%
Eau Claire Medical Clinic	\$126	17%	5.7%
Essentia Health Duluth	\$125	16%	5.3%
Family Health Associates	\$121	n/a	n/a

Specialty Office or Other Outpatient Visit

Health Care Provider	Average 2012 Bill	% Increase 2009-2012	Average Annual Increase
Pine Grove Family Practice	\$222	20%	6.7%
Marshfield Eau Claire Center	\$200	21%	7.0%
OakLeaf Pediatrics Clinic	\$197	15%	5.0%
MCHS Eau Claire Luther Campus*	\$193	17%	5.7%
MCHS Eau Claire Clairemont*	\$192	14%	4.7%
Eau Claire Medical Clinic	\$180	16%	5.3%
Family Health Associates	\$180	n/a	n/a
Essentia Health Duluth	\$169	-2%	-0.7%

*MCHS = Mayo Clinic Health System

(Group Health Cooperative).

D. Access to Accurate Pricing and Cost Information

When people engage the services of an auto mechanic, contractor, veterinarian or any other non-medical service provider, they engage in a conversation over the price and quality of the service they are about to receive. That is not the case with health care. Employer-paid and government-provided health insurance has insulated people, as consumers, from the cost/quality discussion. People are not accustomed to asking for or receiving cost information for the medical services they use.

This was recently documented in a study conducted by Jaime A. Rosenthal, Xin Lu, MS, Peter Cram, MD, MBA, and published by JAMA Internal Medicine online on February 11, 2013. In this study the researchers contacted two hospitals from each state and the 20 top-ranked orthopedic hospitals according to *US News and World Report*. Each hospital was asked for the lowest complete bundled price for an elective hip replacement for the author's 62 year old mother. The results: less than 20% of the hospitals contacted could provide one "bundled price." If researchers contacted the hospital and doctor directly, they were able to calculate a total cost 60% of the time. Prices ranged from \$11,100 to \$126,000. Furthermore, the prices did not correlate with quality. To quote the study:

Our calls to hospitals were often greeted by uncertainty and confusion by the hospital representatives about how to assist us. We were frequently transferred between departments, asked to leave messages that were rarely returned, and told that prices could not be estimated without an office visit.

(Rosenthal, Lu, Cram).

One way to control the cost of health care is to have the users of health care inquire about the cost of the services they receive. Incorporating plan designs that encourage employees and their families to engage in the cost discussion with the medical community is one way to encourage competition for price and quality between health care providers.

E. Quality of Health Care in the Chippewa Valley

By most measures, the quality of health care in the Chippewa Valley is very high, with services delivered by several large medical facilities with the support and resources of nationally recognized health care providers. One firm, HealthInsight (www.healthinsight.org/internal/hospitalperformancerankings), provides hospital quality rankings based upon 19 measures representing four clinical topic areas: heart attack, heart failure, pneumonia and surgical care. All four area hospitals score well for quality on the HealthInsight website as noted below. Medicare also provides quality rankings (www.medicare.gov/hospitalcompare). With the Medicare quality rankings, all four area hospitals are average or above average.

The rankings displayed for each hospital are presented as percentiles. A ranking in the 100th percentile does not necessarily mean that hospitals in that percentile achieved perfect rates on all their measures. It indicates that their rates were better than all other hospitals except for those who are also in the 100th percentile. Similarly, a hospital with a rank in the 50th percentile did not achieve an average of 50% on their performance measures. They performed better than 50% of all the hospitals in the country.

1ST QUARTER 2012 PERFORMANCE RANKING

Hospital	National Ranking	Overall Performance Rate
Mayo Clinic Health System Eau Claire Hospital	84 th	99
OakLeaf Surgical Hospital	81 st	99
Sacred Heart Hospital	29 th	95
St. Joseph's Hospital	42 nd	96

(HealthInsight). See Appendix E for complete charts, rankings, and explanation of percentiles and criteria used.

F. Availability of Insurance Companies – Region and State

Generally speaking, availability or access to insurance companies is not an issue for employers in the Chippewa Valley. There are over 250 insurance companies that sell group accident and health insurance in the State of Wisconsin. However, 25 companies generate 85% of the premiums written (Wisconsin Office of the Commissioner of Insurance). See Appendix F for complete list of insurers.

Seven managed care health insurance companies sell health insurance in Eau Claire County. They are:

- Compcare Health Services Ins. Corp.
- Group Health Cooperative of Eau Claire
- Health Tradition Health Plan f/k/a Greater La Crosse Health Plan, Inc.
- Humana Wisconsin Health Org. Ins. Corp.
- Managed Health Services Ins. Corp.
- Partnership Health Plan, Inc.
- Security Health Plan of WI, Inc.

Note: WCA Group Health Trust is considered a “trust,” not an insurance company or cooperative.

G. Insurance Company Administrative Cost Analysis

Based upon a review of the comparison of administration ratios, the administration fees charged by the current health insurance firms are lower than most all others in Wisconsin (see chart). Group Health Cooperative is about 8% and Group Health Trust is about 7%. Both are substantially lower than other firms and it is unlikely that this can be lower in the future.

Comparison of Administrative Loss Ratios of Wisconsin Health Insurance Companies

Company	Exam Year	Premium Income	Admin Expenses	Admin %	Plan Business Type
Care Wisconsin Health Plan	2010	\$73,487,675	\$15,849,881	21.6%	Medicaid
WPS Ins Corp	2006	\$470,623,748	\$98,767,619	21.0%	Commercial/Medicare
Community Care Health Plan	2008	\$72,522,998	\$12,561,133	17.3%	Medicaid
Abri Health Plan	2008	\$34,863,722	\$5,880,672	16.9%	Medicaid
Independent Care Health Plan	2010	\$141,698,483	\$20,136,181	14.2%	Medicaid
Compcare Health Services Ins Corp	2009	\$473,289,547	\$63,091,773	13.3%	Commercial/Medicare
Managed Health Serv Ins Corp	2009	\$245,809,204	\$32,203,838	13.1%	Medicaid
Humana WI Health Org. IC	2010	\$176,843,655	\$20,728,343	11.7%	Commercial/Medicare
Partnership Health Plan	2010	\$114,779,012	\$13,024,791	11.3%	Medicaid
United Healthcare of WI, Inc	2007	\$683,864,854	\$72,777,232	10.6%	Commercial/Medicaid 70/30
GHC of South Central WI	2010	\$257,116,763	\$25,801,132	10.0%	Commercial/Medicaid 95/5
Blue Cross Blue Shield of WI	2009	\$867,996,809	\$84,740,899	9.8%	Commercial/Medicare
GHC of Eau Claire	2010	\$286,538,269	\$27,167,892	9.5%	Commercial/Medicaid 50/50
WEA Ins Corp. ⁴	2006	\$926,943,215	\$82,490,340	8.9%	Commercial
	Total	\$4,826,377,954	\$575,221,726	11.9%	
	Total w/o WEA	\$3,899,434,739	\$492,731,386	12.6%	
			Avg of Plan %'s	13.9%	

Notes:

1. Financial statistics are taken from most recent OCI Financial Exam Report to ensure consistency.
2. Provider sponsored plans were not included due to the blending of admin costs between health care provider parent and health plan.
3. Business mix is noted because admin % tends to be lower for commercial and Medicare plans than Medicaid plans due to the level of overall premium in each.
4. WEA Ins Corp was included despite significant difference in business model and lack of commercial availability.
5. Total represents approx. 50% of Wisconsin insurance market.
6. GHC EC's admin percentage is about 8% for commercial and 11.5% for Medicaid

(Wisconsin Office of the Commissioner of Insurance).

H. History of Combined Public Sector Health Insurance Purchasing Efforts

For many years the School District, City and County have discussed the advantages of collaborating and bidding out health insurance in order to obtain a discounted cost due to the larger number of employees (insured lives). About 12 years ago the attempt was made, a bid was sent out for health insurance BOTH as separate entities and as a combined cooperative unit. At the time two local health insurance companies provided pricing. One insurance company offered lower pricing if all three entities had one combined plan; however, the other insurance company increased the rates if all were combined. Due to the higher costs, the entities could not move forward with a cooperative purchase for health insurance. However, the School District and City for several years were offered 5% discounts on their premiums if they purchased HMO coverage from the same insurance company, which they did for several years.

Success has been achieved in the cooperative efforts between the School District, City and County in the comparing and sharing of information such as plan costs, design coverage, HRA and large deductible plans, percentage paid by employees vs. employers, copays and health and wellness programs. Sharing this information has allowed each entity to better understand what changes are working and the intent of changes. This sharing of information has helped the entities encourage staff to support changes.

I. Impact of Federal Legislation

Impact of the Affordable Care Act

On March 23, 2010, President Obama signed the Affordable Care Act (ACA) into law. The law sets in motion comprehensive health care and health insurance reforms that will be implemented over time with most changes taking place by 2014. The general goals of the legislation are to:

- Expand the population that receives health care coverage through either publicly-funded programs (Medicare/Medicaid), private insurance companies or self-funded employer plans.
- Improve access to health care.
- Improve the quality of health care.
- Provide appropriate care and achieve optimal results.
- Decrease the cost of health care.

The Affordable Care Act will have implications for:

- Insurance industry.
- Health care provider industry.
- Medicare/Medicaid.
- Individuals.
- Small businesses.
- Large businesses.

Affordable Care Act 2010 through 2013

- Extension of health insurance coverage and corresponding income tax exclusion to employer-provided coverage of adult dependent children under age 27 effective March 23, 2010.
- Group health plan requirements effective for plan years beginning after September 22, 2010 (limited application for grandfathered plans):
 - Prohibition against preexisting condition exclusions for enrollees under age 19.
 - Prohibition against lifetime limits and annual limits.
 - Prohibition against rescissions.
 - Requirements for coverage of specified preventive health services.
 - Prohibition against discrimination under insured plans based on salary.

- Required rebates of excessive revenues from insurers of group or individual health plans (including grandfathered plans) to enrollees (not applicable to self-insured group health plans).
- Required internal and external appeals processes.
- Prohibition against reimbursements from HRAs, FSAs, HSAs and Archer MSAs for over-the counter drugs after 2010.
- Form W-2 reporting of cost of employer-sponsored health coverage after 2011.
- Requirement to provide summaries of benefits and coverage (“SBC”) developed by Health and Human Services after September 23, 2012.
- \$2,500 cap on contributions to health FSAs after 2012.
- Increase in Medicare tax on employees and self-employed individuals with high incomes (but not employers) and new Medicare tax on individuals, estates and trusts with high investment income effective after 2012. Effective January 1, 2013, Medicare tax is increased from 1.45% to 2.35% on wages over \$200,000 for individuals/\$250,000 for couples filing jointly.

What happens in 2014?

- Insurance exchanges:
 - Marketplace for individuals and small employers to shop for health insurance coverage.
 - Must be established by each state, or federal government will do so.
 - Provide coverage to individuals and small businesses.
 - Four levels of coverage: bronze, silver, gold, platinum.
 - See www.exchange.utah.gov for an example.
 - Wisconsin will not establish a state exchange.
- Individual health insurance mandates:
 - “Applicable individuals” must maintain “minimum essential coverage” for themselves and dependents or pay a “shared responsibility penalty” (for an individual equals the greater of \$695 per year or 2.5% of household income over tax-filing threshold, with phase-in beginning in 2014).
 - Exemptions for:
 - Low income individuals/families (income below tax-filing threshold).
 - Direct premium of the bronze plan exceeds 8% of household income.
 - Individuals who qualify for a religious exemption.
 - Non-citizens who are not lawfully present in U.S.
 - Convicted prisoners.
 - Members of Indian tribes.

- Premium credits and subsidies may be available to individuals purchasing coverage on the exchange if household income does not exceed 400% of the Federal Poverty Level (FPL).
 - 400% of the FPL for a family of four in Wisconsin for 2013 would be \$94,200.
 - However, premium credits/subsidies are not available for insurance purchased on the exchange if the individual's employer offers minimum essential coverage that is minimum value and affordable.
 - Minimum essential coverage.
 - Minimum value coverage - plan share of the total allowed costs is 60% or more.
 - Affordable coverage - employee's share of the premium for self-only coverage for the lowest cost option offering minimum value coverage does not exceed 9.5% of household income.

Effects of Availability of Exchanges on Employer Benefits for 2014 and Beyond

- Employers are not required to provide health insurance coverage to employees under current law.
- Employers provide health insurance for a number of reasons:
 - Maintain a healthy workforce.
 - Tax-free form of compensation to employees.
 - Difficult for certain employees to obtain individual coverage.
- Availability of the exchanges to employees (with no preexisting condition exclusions, risk pooling, and guaranteed issue) might change the calculus.

Other Requirements of the Affordable Care Act for 2014 and Beyond

- Group health plan requirements effective for plan years beginning after 2013:
 - Prohibition against preexisting condition exclusions for enrollees over age 18.
 - Prohibition against new hire enrollment waiting periods that exceed 90 days.
- Requirement of employers subject to the Fair Labor Standards Act ("FLSA") to inform employees of the existence of the exchanges effective in late 2013.
- Wellness program changes beginning after 2013.
- Automatic enrollment - employers with more than 200 full-time employees (not effective until regulations issued).
- Excise tax on high-cost employer-sponsored health coverage ("Cadillac plan tax") - 2018.

(Beaudry et al).

J. Description of Regional Medical Facilities and Services

Major Area Community Health Care Systems:

Mayo Clinic Health Systems - Eau Claire

A 304-bed general/intensive care facility, Mayo Clinic Health System is a regional center for cardiology and cardiac surgery, neurosurgery and orthopedics; is verified as a Level II Trauma Center and a Primary Stroke Center; and is served by the Mayo One emergency medical helicopter. Mayo Clinic Health System is a multi-specialty center with a 247-member physician staff providing primary, surgical and specialty care. It is based in Eau Claire, and its regional locations include Mayo Clinic Health System Chippewa Valley, Northland and Oakridge.

Sacred Heart Hospital - Hospital Sisters Health System

Sacred Heart is a full service progressive and rapidly growing hospital. The medical staff consists of approximately 200 independent, Marshfield Clinic and OakLeaf Medical Network physicians with privileges to practice there. A 344-bed facility, Sacred Heart Hospital provides exceptional patient experiences in the following areas: Neurosurgery, Cardiology, Critical Care/Trauma, Cancer Care, Surgery, Orthopedics, Rehabilitation, and Women's Health.

Marshfield Clinic

With 730 physicians representing 84 medical specialties and subspecialties, and 6,000 employees system-wide, Marshfield Clinic is a private group medical practice with more than 40 locations in 31 western, central and northern Wisconsin communities. Since Marshfield Clinic is one of the nation's top medical and clinical research organizations, patients have access to clinical research trials and other research programs close to home. Marshfield Clinic physicians at 12 locations in the Chippewa Valley offer care in almost 40 specialty areas, including the Regional Cancer Center in Eau Claire.

OakLeaf Surgical Hospital

OakLeaf Surgical Hospital is the newest hospital in Eau Claire. Formerly an outpatient surgery center, OakLeaf provides state-of-the-art surgical capability with high quality, experienced staff. The hospital accommodates most inpatient and outpatient elective surgical procedures. The surgical hospital features 10 deluxe private hospital suites in an environment designed to reflect a residential atmosphere featuring an on-site chef and a professional medical staff.

(Eau Claire Area Economic Development Corporation).

IV. Prioritization of Collaborative Opportunities

IV. PRIORITIZATION OF COLLABORATIVE OPPORTUNITIES

The authors of this report offer the following prioritization of the suggested collaborative opportunities.

With Separate Insurance Companies

1. Present this report and recommendations to the Boards/Council, employees, and management of each entity.
2. Require insurance companies to supply timely and accurate claims data.
3. Reinforce the commitment of each entity to quarterly meetings of staff to discuss matters relating to health insurance and the implementation of the recommendations from this report.
4. Explore ways to consolidate all three public entities with one health insurance company and/or form a public sector health insurance pool or consortium.
5. Study the feasibility of a public employee clinic to provide primary care.
6. Standardize the benefits structure between the three entities.
7. Review policies that encourage employees to take available insurance from other sources.

With All Three Entities With One Insurance Company

1. Solicit bids for specific procedures and modify plan design to encourage use of lower cost contracted health care provider.
2. Develop payment methods that reward outcomes instead of frequency.
3. Support and encourage requirements that hospitals and clinics provide accurate and timely information on the quality and outcomes of the procedures performed.

4. Develop plan designs that encourage users of the health care system to understand the cost and quality of the services purchased.
5. Develop programs that encourage the use of a “medical home” and a primary doctor.
6. Establish wellness programs that measurably improve the health of employees and their families. Wellness programs should produce tangible, measurable results based on measurable outcomes.
7. Establish programs that encourage better medical consumerism.
8. Medical tourism.
9. Encourage and support alternative (non-traditional) approaches and methods to addressing medical conditions.
10. Narrow access to a particular network of physicians.

V. Collaborative Opportunities and Barriers

V. COLLABORATIVE OPPORTUNITIES AND BARRIERS

As separate and independent entities, there is only so much that any one of the three entities studied can do alone to impact the cost of health care. However, working together, there are economies of scale that can be leveraged to the advantage of each entity and their employees that would improve the cost, while maintaining or possibly improving the quality of medical care received. As of July 1, 2013, each of the three entities will be insured by separate insurance companies. Many, if not most of the efficiencies that could be obtained, require that all three entities be able to speak with one coordinated voice to the medical community. However, until such time as all three entities are with one insurance company, there are certain options that should be explored. The opportunities below are broken into two broad sections: 1) those items that should be explored while the entities are with separate insurance companies; and 2) those items that may be explored if the entities are all with the same insurance company.

Collaborative Opportunities With Separate Insurance Companies

1. Description: Present this report and recommendations to the Boards/Council, employees, and management of each entity.

Benefits to be Realized: Education and understanding of the challenges and concerns with health insurance is key to the ability to implement change. If the entities, at all levels, do not understand the problem to be solved, they will be unable to participate in finding solutions.

Commission Action: Support for the concept of presenting this report to the Boards/Council, employees and management of each entity.

Staff Action: Schedule and present the report.

Timeline: Summer of 2013.

2. Require insurance companies to supply timely, complete and consistent claims data.

Description: One of the most important elements in controlling health insurance costs is being able to obtain and understand actual paid claims data. Historically it has been challenging to obtain this data from health insurance companies.

Benefits to be Realized: Understanding where and how the health dollars are spent allows for the development of programs and negotiation with insurance companies that can effectively impact the cost of health care. Without this data it is difficult to have a meaningful impact.

Barriers to Implementation: Cooperation from insurance companies. Historically there have been minimal to no negative consequences to an insurance company that is unwilling to share meaningful, timely and accurate loss data.

Implementation Strategy: Require each of the insurance companies to provide data in a format that is developed by the public entity's staff. This requirement would be written into the contracts. Failure to provide the data would be grounds for withholding premium or it to be determined a non-responsive proposal.

Commission Action: Support this concept.

Staff Action: Develop a standard reporting format and insert reporting requirements into the health insurance contracts.

Timeline: Summer 2013 - develop reporting format. Upon renewal, insert a contract requirement to supply requested loss run data.

3. Reinforce the commitment of each entity to quarterly meetings of staff to discuss matters relating to health insurance and implement the recommendations from this report.

4. Explore ways to consolidate all public entities with one health insurance company.

Description: The School District, City and County would each utilize the same health insurance company.

Benefits to be Realized: If all three entities are with the same health insurance company, it is significantly easier to speak as “one voice” when negotiating with the medical community. Combined, the public sector spent \$46 million on medical services in the Eau Claire community in 2012. Separated, each entity’s financial influence is not large enough to have a significant or meaningful impact on the cost or delivery methods of medical services in the Chippewa Valley.

Barriers to Implementation: The largest barrier to consolidating all three public entities with one insurance company is the inability to look beyond the cost for the next year. As long as the entities chase the “low bid” on an annual basis, it will be very difficult to consolidate with one carrier.

Implementation Strategy: Health insurance premiums are the function of claims, administration costs, discounts and networks, large claim protection (stop loss insurance) and insurance company profits or contributions to surplus. By far the largest and most variable of these factors is the claims loss. The cost of claims is what drives the premiums. Over the long run, insurance premiums are simply claims plus the insurance company’s overhead. Instead of chasing the lowest premium, the entities should select a multi-year insurance company based upon their overhead costs and ability to negotiate and impact the cost of claims. Premiums should then be tied to the annual change in the claims experience.

Commission Action: Support the concept of exploring alternate purchasing methods for procuring health insurance.

Staff Action:

- Develop a standard format to evaluate the overhead of an insurance company’s proposal.
- Develop a standard format for evaluating and projecting the cost of future claims using historical data.
- Develop a standard multi-year agreement that accounts and adjusts for the variability of claims absorbed by the insurance company and provides fiscal year stability for the public entity.

Timeline: Fall 2013.

5. Form a public sector health insurance pool or consortium.

Description: In the 1980's, following crisis in the property and casualty insurance marketplace, it became very difficult for municipalities and school districts to obtain affordable health insurance. Local governments took matters into their own hands and formed risk-sharing pools that were sanctioned by state law. Forming an Eau Claire public sector health insurance pool or consortium would involve forming a legal entity that administers the claims for all three entities.

Benefits to be Realized: This approach would allow the public sector to have more control over the administrative cost of health insurance. It would also provide them with more control and input into the design of plans and programs that would better engage their employees with the health insurance procedures they receive.

Barriers to Implementation: This is a long-term strategy that would take several years (and some expense) to study. Issues like regulatory approval, form of governance and fair allocation of costs and capitalization are big challenges to overcome. However, there is a way to "walk before we run." This would involve all three entities joining together as a subsidiary of an insurance company that is already licensed and regulated in the State of Wisconsin.

Implementation Strategy: Commission a feasibility study that would outline the legal and administrative requirements to form a public entity health insurance company. An alternative intermediary option would be to explore the possibility of developing a public sector subsidiary of an established insurance company or insurance company.

Commission Action: Support the concept of a feasibility study to form a public sector self-insurance pool or, in the alternative, become a public sector subsidiary of an already existing pool, cooperative or trust.

Staff Action: Bring forward a feasibility proposal.

Timeline: Present the proposal in the 2014 budgets for each entity.

6. Develop a public employee clinic to provide primary care.

Description: This concept involves operating a “bricks and mortar” facility to provide primary care to public employees and their families. Co-pays would be waived for those that participate. The facility would be staffed with a primary physician, nurse and lab personnel. Basic exams and lab tests would be provided with 20 to 30 minute office visits. Some facilities of this type also provide x-rays.

Benefits to be Realized: Lower cost primary care. With 20 to 30 minute office visits, chronic disease costs should be reduced.

Barriers to Implementation: Initial capital expense and ongoing operating expense. There may also be initial reluctance by employees to use the clinic. However, experience in other communities demonstrates that this concern is quickly overcome once the quality service and low cost to the employee is experienced and spread by word of mouth.

Implementation Strategy: Conduct a feasibility study. If the results are positive, enter into an intergovernmental agreement and solicit proposals.

Commission Action: Support the concept and feasibility study of providing a publicly owned and operated primary clinic.

Staff Action: Bring forward a proposal for a feasibility study.

Timeline: Fall 2013.

7. Standardize the benefits structure between the three entities.

Description: Move to a standard benefits design for all three entities.

Benefits to be Realized: A standard benefit design makes it easier to provide “apples to apples” comparisons of claims experience. It would also lower the cost of administration, as three separate benefits plan booklets would be consolidated into one.

Barriers to Implementation: For items like copays and covered procedures, this would require the administration of each of the entities to recommend a common plan design. Changing the methods for reimbursement within the high deductibles would be more challenging, because of the potentially significant cost to either the employer or employees depending upon the recommended changes.

Implementation Strategy: The three entities should agree upon a standard benefit plan and move toward the standard plan in subsequent renewals. However, it should be noted that this is a long-term strategy that does not have a high priority or a big effect on the ability to impact the cost of health insurance.

Commission Action: Support the concept of standardizing benefits.

Staff Action: Develop model benefit plan structures.

Timeline: Ongoing.

8. Review policies that encourage employees to take available health insurance from other sources.

Description: The City of Eau Claire and Eau Claire County both have programs that pay employees to take health insurance coverage from their spouse's employer. Another option would be to dis-incentivize this practice by making the employee pay a premium surcharge if they did not take their spouse's available coverage. This option has been implemented by some private sector businesses. Conversely, by incentivizing the payment at a higher level, more employees may elect their spouse's plan.

Benefits to be Realized: Savings from the elimination of payment in-lieu-of health insurance programs or a reduction in insurance premiums from having fewer employees on the plan.

Barriers to Implementation: Eliminating the incentive would be a direct reduction in pay for some employees, and an additional charge for those employees opting not to join their spouse's plan. Increasing the incentive may not force any employees to switch to their spouse's plan, and therefore, may just increase the total cost paid out for the incentive.

Implementation Strategy: This should be handled through the budget process for each entity.

Commission Action: None. Just be aware of the concept if it is brought forward by the administration.

Staff Action: As appropriate, bring forward a proposal within the administrative structures for each entity.

Timeline: None.

Collaborative Opportunities With All Three Entities With One Carrier or Administrator

Any one of the following recommendations can and should be pursued by each entity independently. However, the real impact, benefit and influence will only be realized when all three entities work together to approach these concepts.

1. Solicit bids for specific health care procedures and modify plan design to encourage the use of lower cost contracted health care providers.

Description: This would involve “carving” out specific procedures from the health plans and negotiating set pricing with a specific health care provider to offer this service to public sector employees and their families. Reimbursement for the specific procedures would be set at the negotiated level. Employees and their families that wish to obtain the service at other health care providers are free to do so, but would be required to pay any price difference out of pocket.

Benefits to be Realized: With the volume of the entities, they should be able to obtain favorable pricing for employees and their families. This approach also encourages employees and their families that want to use alternate service providers to engage in a discussion over the cost of the procedure.

Barriers to Implementation: This approach could only be applied to a limited number of elective, non-emergency procedures. Procedures like MRIs, colonoscopies, lab tests and orthopedic procedures might be good opportunities to explore. Employees would have to be educated about the value of this approach and be willing to engage in the cost discussion with other health care providers.

Implementation Strategy: Select a procedure based upon utilization and cost data. Through a competitive bidding process, select a low cost, quality vendor and carve this procedure out from the health plan. Reimbursement would be set at this rate.

2. Develop payment methods that reward outcomes instead of frequency. The current medical system pays health care providers on a “per unit” basis, regardless of the outcome of the procedure. If you are readmitted post-surgery for an infection or complication, the hospital and doctor receive more revenue. Another approach would be to pay a “fixed cost” for certain procedures and have the price “guarantee” specific outcomes. Where this has been tried (see Geisinger clinic) the result is lower infection, mortality, complication and re-admittance rates combined with lower costs and faster recovery times for the patient.

3. Support and encourage a requirement that hospitals and clinics provide accurate and timely information on the quality and outcome of the procedures performed. Until there is transparency in the price and quality of the services received, it will continue to be very difficult to have consumers of health care make educated medical decisions.
4. Develop plan designs that encourage users of the health care system to understand the cost and quality of the services purchased.

Description: This approach is similar to option one, except that the rates are developed by the insurance company and integrated into the health plan design. The insurance company would work with one or two substantial health care provider groups to develop and incrementally improve the reimbursement structure. Rather than simply providing discounts or provider established rates (the current system), procedure rates would be based upon outcome measures of quality and actual costs to deliver the service. Like option seven, reimbursement in the plan design would be limited to the amounts negotiated with key health care providers. Employees and their family members that desire to have a procedure completed at an alternate, higher priced facility would be responsible for paying the difference in price.

Benefits to be Realized: Lower costs, higher quality and users of the medical system that are better informed of the cost and quality of procedures they receive.

Barriers to Implementation: Plan designs of this nature would have to be approved by the Office of the Insurance Commissioner. Employees would have to be educated about the value of this approach and be willing to engage in the cost discussion with other health care providers.

Implementation Strategy: Work with an insurance company that is willing to embrace this type of approach.

5. Develop programs that encourage the use of a “medical home” and primary doctor. Regular, primary care with a focus on prevention is key to preventing chronic and severe health conditions. Plan designs should encourage employees and their families to establish and maintain a regular relationship with a primary physician. This type of program also helps to earlier identify and better manage chronic health conditions. Chronic conditions, when ignored, produce a lower quality of life (less productive employee) and higher medical costs. Working in conjunction with the “medical home,” the insurance company can develop tools that assist employees and their families with the management of their health – i.e. reminders, resources, follow-up, medication management, etc.

6. Establish wellness programs that measurably improve the health of employees and their families. Wellness programs should produce tangible, measurable results based on measurable outcomes.
7. Establish programs that encourage better medical consumerism. Several studies have demonstrated that individuals, when discussing a medical condition with a doctor, do not fully understand the information that is being provided by the physician. Educating employees and their families on ways to better access their health care providers results in:
 - Better understanding of medical screenings.
 - A reduction in medical mistakes.
 - Better management of medications.
 - Proper pre and post-operative care.
8. Medical tourism. Around the world there are highly rated facilities that perform surgeries and procedures for a significantly lower cost with equal or better outcomes. Medical tourism would provide a direct financial incentive for a patient (and his or her caregivers) to explore the possibility of having certain elective procedures, covered by the health insurance plan design, completed in another country.
9. Encourage and support alternative (non-traditional) approaches and methods to addressing medical conditions. Not every condition is best treated by traditional medicine. Current plan designs do not support many alternative, non-traditional treatments. The challenge is that many non-traditional approaches do not have proven outcomes. However, if lower cost treatments that have proven outcomes can be provided, this option should be explored.
10. Narrow access to a particular network of physicians. People like choice, especially when it comes to health care. However, lower costs can be obtained by getting “volume discounts” when an entire employee group is steered to one network of health care providers through plan design.

VI. Conclusion

VI. CONCLUSION

How to provide and pay for health care is one of the biggest challenges facing employers and governments today. Public entities face the same challenges as private employers to provide health insurance in order to attract and retain competent, motivated employees. This study has shown that employers in the Chippewa Valley have access to a wide variety of quality health care services. However, the costs for these medical services remain high by state and national standards. The three public entities in this report combined represent 6,400 insured lives and spend more than \$46 million on health care each year. These numbers should be used to enter into a conversation with the medical community. Health care delivery systems have to change, as the current cost of delivery is not sustainable. There is an opportunity in the Chippewa Valley to explore new approaches to medical service delivery. There is no reason why these three public entities should not be an example of how, by working together on some of the approaches outlined in this report, employers and the medical community can produce an alternate delivery system that is sustainable while maintaining quality health care.

Works Cited

WORKS CITED

	Page
Beaudry, Rae Anne & Mongoven, Dan (The Horton Group, Waukesha WI); Conway, Catherine & McDonald, Timothy (von Briesen & Roper, Milwaukee, WI). <i>WPELRA Health Care Reform Summit</i> . Presentation. March 4, 2013.	32
Eau Claire Area Economic Development Corporation. www.eauclaire-wi.com . Web. March 2013.	33
Group Health Cooperative of Eau Claire. <i>Actual Billed Claims Data</i> . Print. 2012.	23, 24
HealthInsight. www.healthinsight.org . Web. March 2013.	26
Kraig, Robert. <i>Wisconsin Health Insurance Cost Rankings 2013</i> . Print. December 19, 2012.	18, 19
Rosenthal, Jaime; Lue, Xin; Cram, Peter. “Availability of Consumer Prices From US Hospitals for a Common Surgical Procedure.” <i>JAMA</i> . Print. February 11, 2013.	25
Squires, David. “Explaining High Health Care Spending in the United States: An International Comparison of Supply, Utilization, Price and Quality.” <i>The Commonwealth Fund</i> . Print. May 2012.	17
United States Department of Labor. www.dol.gov . Web. February 2013.	22
Wisconsin Hospital Association. www.dol.gov . Web. March 2013.	20, 21, 22
Wisconsin Office of the Commissioner of Insurance. www.oci.wi.gov . Web. March 2013.	27, 28

Appendix

Table of Contents

APPENDIX TABLE OF CONTENTS

Appendix	Description	Page
A	Health Insurance Open Enrollment Documents for Eau Claire Area School District and City of Eau Claire, & Partial Health Insurance Plan Document for Eau Claire County	48
B	“Explaining High Health Care Spending in the United States: An International Comparison of Supply, Utilization, Price and Quality,” <i>The Commonwealth Fund</i> , David Squires	92
C	<i>Wisconsin Health Insurance Cost Rankings 2013</i> , Robert Kraig	106
D	Wisconsin Hospital Association 2010 and 2011 Net Revenues for Hospitals	121
E	HealthInsight Hospital Rankings and Explanation of Rankings	122
F	2011 Wisconsin Market Shares for Group Accident and Health Insurance Companies, Wisconsin Office of the Commissioner of Insurance	139

Appendix A

Health Insurance Open Enrollment
Booklets/Plan Documents

welcome

eau claire area school district employees

The following information is available to provide you with the details of your health plan with Group Health Cooperative of Eau Claire. If you have questions about your health plan or if there is anything we can do to help, please call Member Services at (715) 552-4300 or toll-free at (888) 203-7770.

- [View our Provider Directory \(/Directories/Providers.aspx\)](/Directories/Providers.aspx)
- [2012-13 Health Plan Options \(/docs/Members/ECASD/2012-ECASD-Benefit-Outline-Options.pdf\)](/docs/Members/ECASD/2012-ECASD-Benefit-Outline-Options.pdf)
- [Preventive Screening Form \(/docs/Members/ECASD/PreventiveScreening_ECASD.pdf\)](/docs/Members/ECASD/PreventiveScreening_ECASD.pdf)
- [Frequently Asked Questions \(/docs/Members/ECASD/2012-ECASD-HP-Program-FAQs.pdf\)](/docs/Members/ECASD/2012-ECASD-HP-Program-FAQs.pdf)

follow up phone appointments

Group Health Cooperative will be offering optional 15 minute follow up phone appointments December 2012 through February 2013. This is an opportunity to speak with a Health Promotion Coach to review the goals you set during your onsite appointments.

The Health Promotion Coaches are here to talk through your accomplishments and challenges. Click the button below or call (715) 552-4300 or (888) 203-7770 to schedule you appointment today!



your health promotion program benefits

As part of the Eau Claire Area School District's (ECASD) commitment to improving the overall quality of life for its employees, the Group Health Cooperative of Eau Claire Health Promotion program benefit will continue as part of the 2012/13 plan. There have been several requirement changes this year, so please be sure to read all of the information on this page.

To obtain or maintain the reduced premium, all current employees and covered spouses needed to complete each of the three steps of the program by **Wednesday, October 31st**. Employees who achieved the discounted rate for participating in the Health Promotion benefit for 2011 will remain at the discounted rate. Employees who did not complete the requirements of the Health Promotion program benefit for 2011 will remain at the non-discounted rate until the 1st of the month following the completion of all three steps. **All new employees** and covered spouses must complete the three steps of the program within 90 days of their effective date in order to obtain the reduced premium.

Click [here \(http://www.genbook.com/bookings/slot/reservation/30054427/54775006/54037416/1335848400000?bookingContactId=353802400\)](http://www.genbook.com/bookings/slot/reservation/30054427/54775006/54037416/1335848400000?bookingContactId=353802400) to schedule your 30 minute appointment at the Cooperative administrative office online or please call (715) 552-4300 or (888) 202-7770 to schedule with member services.

To earn \$50 in Eau Claire Chamber gift certificates, ECASD employees and their covered spouses will need to have their primary care provider sign the preventive screenings form between July 1, 2012 and June 30, 2013, which indicates that you are up-to-date on your age and gender appropriate preventive medical screenings. See our [Frequently Asked Questions \(/docs/Members/ECASD/2012-HP-Program-FAQs.pdf\)](/docs/Members/ECASD/2012-HP-Program-FAQs.pdf) for more detail on this requirement.

regular checkups

Regular checkups, preventive screening tests and immunizations are among the most important things you can do for yourself. Work in partnership with your primary care provider to decide which screenings and immunizations are appropriate based on your personal health profile.

Your provider will need to sign the preventive medical [screening form](#) (/docs/Members/ECASD/PreventiveScreening_ECASD.pdf). Simply mail completed forms to:

Group Health Cooperative of Eau Claire

Attn: Health Promotion Department / ECASD
2503 N. Hillcrest Parkway
Altoona, WI 54720

You may also fax your completed preventive screenings forms to (715) 552-3500. Once your signed preventive screenings form has been received, your Eau Claire Chamber gift certificates will be mailed to you within 2-4 weeks.

step 1

know your numbers

In Step 1, ECASD employees and spouses each complete a biometric screening evaluation. This will take approximately 5 minutes. These screenings will include:

- Height
- Weight
- Body mass index
- Body fat percentage
- Blood pressure

step 2

know your risks

In Step 2, ECASD employees and spouses each complete an online health risk assessment. This will take approximately 10-15 minutes. Be sure to have your biometric numbers from Step 1 handy. If you have your cholesterol numbers available from recent lab work, you can enter them in to make the HRA more accurate. [Take the Online Health Risk Assessment \(/Members/HealthRiskAssessment.aspx\)](#)

If you complete Step 1 at your school in May, we encourage you to do the online HRA as soon as possible.

step 3

know your health

In the last step, ECASD employees and spouses meet individually with a Cooperative Health Promotion Coach to review the results of Steps 1 and 2. This will take approximately 15 minutes.

Your employer's health promotion program is an optional program administered by Group Health Cooperative of Eau Claire for the benefit of your health and wellness. Your employer may or may not offer incentives to you for participating in the program. If you choose to participate, please understand that we expect that you will participate in good faith and work with the Cooperative's staff in a professional and respectful manner. Good faith participation does not mean that you must accomplish all of your goals; it means that your level of participation reflects effort and true commitment to improving your health and well-being by setting health-related goals, demonstrating progress toward those goals, and sharing accurate information with our Health Promotion staff. Continued participation in the program is subject to review by the Cooperative. If the Cooperative determines that your participation is not in good faith, or you are physically or verbally abusive or threatening to our staff, we may terminate your participation in any session or the program as a whole at the Cooperative's discretion. If your participation is terminated, the Cooperative will notify your employer that your participation has terminated and the reason for the termination, subject to applicable law regarding the protection of health information.



Plan A

Lifetime Maximum	Unlimited
Deductible	\$1,500 Single /\$3,000 Family
Health Reimbursement Account (Employer Funded Deductible)	\$1,000 Single /\$2,000 Family
Health Promotion Package	Refer to Health Promotion Proposal Section
Coinsurance	100%
Coinsurance Out-of-Pocket Limit	N/A
Emergency Services (waived if admitted)	100% after \$100 copay
Ambulance	100% after deductible
Surgical Services	100% after deductible
Office Visits: Primary Care, Chiropractic, Maternity	100% after \$18 copay Maternity limited to 1 copay
Physical, Speech, Occupational Therapy	100% after \$18 copay
Preventive Care Office Visits	100% to no annual maximum (Health Care Reform Preventive Included)
Specialist Care Office Visits	100% after \$18 copay
Urgent Care Office Visits	100% after \$28 copay
Immunizations	100%
Lab & X-Ray (in clinic setting)	100%
Optical Exams (one routine exam per plan year)	100%
Home Health Care	100% after \$18 copay
Hospice Care	100% after deductible
Oral Surgery	100% after deductible
Organ Transplant Service	100% after deductible
Kidney Disease Treatment	100% after deductible
Hospital Inpatient Services	100% after deductible
Hospital Outpatient - Surgery or Surgi-Center	100% after deductible
Hospital Outpatient - Diagnostic Services	100% after deductible
Non-Inpatient Imaging Services	100% after deductible
Skilled Nursing Facilities/Services (30 day limit)	100% after deductible
Mental Health/AODA	
Inpatient Services	100% after deductible
Outpatient Services	100% after \$18 copay
Transitional Services	100% after \$18 copay
Prescription Drugs Limited to a 31-day supply per drug/refill (100-day supply if the drug is on the maintenance list)	\$0 Generic \$25 Brand 50% Non-Formulary Drugs to a maximum of \$75 per fill. Diabetic supplies paid at 100%, must be received from a GHC network pharmacy.
Durable Medical Equipment	100% after deductible
Prosthetics	100% after deductible
TMJ Services (non-surgical max \$1,250)	
Office Visits	100% after \$18 copay
Appliances & Therapy	100% after deductible
Dependency Criteria	26: to end of month
Network*	Standard GHC Network

* Provider Network Note: Mayo Clinic, St. Mary's and Methodist Hospital in Rochester, Minnesota are available to GHC members only after receiving a prior event authorization by the health plan. This provision does not apply to Mayo Clinic affiliated providers in Wisconsin.

	Plan B
Lifetime Maximum	Unlimited
Deductible	\$3,000 Single /\$6,000 Family
Health Reimbursement Account (Employer Funded Deductible)	\$1,000 Single /\$2,000 Family
Health Promotion Package	Refer to Health Promotion Proposal Section
Coinsurance	100%
Coinsurance Out-of-Pocket Limit	n/a
Emergency Services (waived if admitted)	100% after \$100 copay
Ambulance	100% after deductible
Surgical Services	100% after deductible
Office Visits: Primary Care, Chiropractic, Maternity	100% after \$18 copay
Physical, Speech, Occupational Therapy	100% after \$18 copay
Preventive Care Office Visits	100% to no annual maximum (Health Care Reform Preventive Included)
Specialist Care Office Visits	100% after \$18 copay
Urgent Care Office Visits	100% after \$28 copay
Immunizations	100%
Lab & X-Ray (in clinic setting)	100%
Optical Exams (one routine exam per plan year)	100%
Home Health Care	100% after \$18 copay
Hospice Care	100% after deductible
Oral Surgery	100% after deductible
Organ Transplant Service	100% after deductible
Kidney Disease Treatment	100% after deductible
Hospital Inpatient Services	100% after deductible
Hospital Outpatient - Surgery or Surgi-Center	100% after deductible
Hospital Outpatient - Diagnostic Services	100% after deductible
Non-Inpatient Imaging Services	100% after deductible
Skilled Nursing Facilities/Services (30 day limit)	100% after deductible
Mental Health/AODA	
Inpatient Services	100% after deductible
Outpatient Services	100% after \$18 copay
Transitional Services	100% after \$18 copay
Prescription Drugs Limited to a 31-day supply per drug/refill (100-day supply if the drug is on the maintenance list)	\$0 Generic \$25 Brand 50% Non-Formulary Drugs to a maximum of \$75 per fill. Diabetic supplies paid at 100%, must be received from a GHC
Durable Medical Equipment	100% after deductible
Prosthetics	100% after deductible
TMJ Services (non-surgical max \$1,250)	
Office Visits	100% after \$18 copay
Appliances & Therapy	100% after deductible
Dependency Criteria	26: to end of month
Network*	Standard GHC Network

* Provider Network Note: Mayo Clinic, St. Mary's and Methodist Hospital in Rochester, Minnesota are available to GHC members only after receiving a prior event authorization by the health plan. This provision does not apply to Mayo Clinic affiliated providers in Wisconsin.



Plan C

In-Network

Out-of-Network

Lifetime Maximum	Unlimited	Unlimited
Deductible	\$1,500 Single /\$3,000 Family	
Health Reimbursement Account (Employer Funded Deductible)	\$1,000 Single /\$2,000 Family	
Health Promotion Package	Refer to Health Promotion Proposal Section	
Coinsurance	90%	70%
Coinsurance Out-of-Pocket Limit	\$1,000/\$2,000	\$1,000/\$2,000
Emergency Services (waived if admitted)	100% after \$100 copay	100% after \$100 copay
Ambulance	90% after deductible	70% after deductible
Surgical Services	90% after deductible	70% after deductible
Office Visits: Primary Care, Chiropractic, Maternity	100% after \$18 copay Maternity limited to 1 copay	70% after deductible
Physical, Speech, Occupational Therapy	100% after \$18 copay	70% after deductible
Preventive Care Office Visits	100% to no annual maximum (Health Care Reform Preventive Included)	70% after deductible
Specialist Care Office Visits	100% after \$18 copay	70% after deductible
Urgent Care Office Visits	100% after \$28 copay	100% after \$28 copay
Immunizations	100%	70% after deductible
Lab & X-Ray (in clinic setting)	100%	70% after deductible
Optical Exams (one routine exam per plan year)	100%	70% after deductible
Home Health Care	100% after \$18 copay	70% after deductible
Hospice Care	90% after deductible	70% after deductible
Oral Surgery	90% after deductible	70% after deductible
Organ Transplant Service	90% after deductible	70% after deductible
Kidney Disease Treatment	90% after deductible	70% after deductible
Hospital Inpatient Services	90% after deductible	70% after deductible
Hospital Outpatient - Surgery or Surgi-Center	90% after deductible	70% after deductible
Hospital Outpatient - Diagnostic Services	90% after deductible	70% after deductible
Non-Inpatient Imaging Services	90% after deductible	70% after deductible
Skilled Nursing Facilities/Services (30 day limit)	90% after deductible	70% after deductible
Mental Health/AODA		
Inpatient Services	90% after deductible	70% after deductible
Outpatient Services	100% after \$18 copay	70% after deductible
Transitional Services	100% after \$18 copay	70% after deductible
Prescription Drugs Limited to a 31-day supply per drug/refill (100-day supply if the drug is on the maintenance list)	\$0 Generic \$25 Brand 50% Non-Formulary Drugs to a maximum of \$75 per fill. Diabetic supplies paid at 100%, must be received from a GHC network pharmacy.	
Durable Medical Equipment	90% after deductible	70% after deductible
Prosthetics	90% after deductible	70% after deductible
TMJ Services (non-surgical max \$1,250)		
Office Visits	100% after \$18 copay	70% after deductible
Appliances & Therapy	90% after deductible	70% after deductible
Dependency Criteria	26: to end of month	
Network*	Standard GHC Network	Non-Contracted Licensed Providers. UCR Applies.

* Provider Network Note: Mayo Clinic, St. Mary's and Methodist Hospital in Rochester, Minnesota are available to GHC members only after receiving a prior event authorization by the health plan. This provision does not apply to Mayo Clinic affiliated providers in Wisconsin.

** The amount you pay towards the in-network coinsurance will only apply toward the in-network benefit levels, and the amounts you pay toward the out-of-network coinsurance will only apply toward the out-of-network benefit levels. In other words, the in-network and out-of-network coinsurance maximums are completely separate and cannot be combined. The deductible is a combined deductible for both in and out-of-network.



Preventive Screening

Medical: Eau Claire Area School District

Getting regular check ups, preventive screening tests, and immunizations are among the most important things you can do for yourself. Work in partnership with your primary care provider to decide which screenings and immunizations are appropriate based on your personal health profile. Please have your primary care provider sign this form to indicate you are up-to-date on your preventive screenings. Screening forms need to be dated sometime between July 1, 2012 and June 30, 2013

Member Signature: _____ Date: _____

Print Member Name: _____ DOB: _____ Member ID: _____

Physician Signature: _____ Date: _____

Print Physician Name: _____

Select Specialty Type: Family Practice Internal Medicine OB/GYN

Mail to: Group Health Cooperative | Attn: Health Promotion/ECASD | 2503 N. Hillcrest Parkway | Altoona, WI 54720
Fax attention to Health Promotion: (715) 552-3500 or (715) 552-7202



Preventive Screening

Medical: Eau Claire Area School District

Getting regular check ups, preventive screening tests, and immunizations are among the most important things you can do for yourself. Work in partnership with your primary care provider to decide which screenings and immunizations are appropriate based on your personal health profile. Please have your primary care provider sign this form to indicate you are up-to-date on your preventive screenings. Screening forms need to be dated sometime between July 1, 2012 and June 30, 2013

Member Signature: _____ Date: _____

Print Member Name: _____ DOB: _____ Member ID: _____

Physician Signature: _____ Date: _____

Print Physician Name: _____

Select Specialty Type: Family Practice Internal Medicine OB/GYN

Mail to: Group Health Cooperative | Attn: Health Promotion/ECASD | 2503 N. Hillcrest Parkway | Altoona, WI 54720
Fax attention to Health Promotion: (715) 552-3500 or (715) 552-7202



Frequently Asked Questions: 2012/13 ECASD Health Promotion Program

Who qualifies as a primary care provider?

Primary care is the term for the health services by providers who act as the principal point of consultation for patients within a health care system. This includes internal medicine and family medicine providers. Additionally while we encourage all of our members to have one of the two specialties for their primary care provider, we will also permit OB/GYN's in this category.

Who must sign the medical preventive screening form?

The form must be signed by a primary care provider. Primary care is the term for the health services rendered by providers who act as the principal point of consultation for patients within a health care system. This includes Internal Medicine, Family Medicine and OB/GYN.

I called to make an appointment with my primary care provider, and there are no openings available until after the June 30, 2013 program deadline. Will I still earn the \$50 in Eau Claire Chamber gift certificates?

No, it is your responsibility to get the appointment completed by June 30, 2013.

However, if you already had an appointment scheduled before June 30, 2013 and your provider had a conflict resulting in a rescheduled appointment, please call Group Health Cooperative's Health Promotion Manager to discuss.

I forgot to bring my preventive screening form in with me when I saw my primary care provider. Now what?

You will need to speak with your primary care clinic to determine the best way for your provider to sign your form.

I misplaced my preventive screenings form. Where can I find another copy?

You can obtain the preventive screenings form from any of the following sources:

- Visit group-health.com and click on the ECASD logo
- Contact Group Health Cooperative's Member Services at (715) 552-4300 or (888) 203-7770

I had my annual physical before July 1, 2012; do I need to get another one sometime between July 1, 2012 and June 30, 2013?

If your primary care provider wants to see you annually, then yes, to meet the requirement you need to get your physical completed and return the Preventive Screening Form between July 1, 2012 and June 30, 2013.

If your primary care provider doesn't need to see you annually, you will need to contact your provider to explain that your employer has a Health Promotion program and you need to have the Preventive Screening Form completed. It must be signed and dated between July 1, 2012 and June 30, 2013.

I'm required to get a physical for my CDL license. Does that meet this requirement?

Yes, as long as the examination is done by a physician, nurse practitioner or physicians assistant in the Internal Medicine or Family Medicine department

2012 Open Enrollment

*Information for City of Eau Claire
Employees and Retirees*



GROUPHEALTH
COOPERATIVE of Eau Claire

A personal touch. A proven choice.®

group-health.com

A Partner in Health Care

Dear City of Eau Claire Member,

Thank you for the opportunity for Group Health Cooperative of Eau Claire to serve you over this past year! As the only member-governed health plan in Western Wisconsin, the Cooperative is committed to partnering with you in optimizing your health care. For over 30 years, the Cooperative has made service to our members our primary focus and it continues to be at the core of everything we do.

We understand that health care decisions can be overwhelming. The information included in this booklet is intended to help you make an informed choice regarding your health care coverage for the 2012 plan year.

Health Promotion Program Summary.....	2
Health Promotion Program Details.....	3
Health Promotion Program Checklist.....	5
Preventive Screening Form.....	7
Tobacco Free Validation Form	9
Frequently Asked Questions.....	11
Benefit Plan Outline: \$1,650/ \$3,300 HMO: Active and Under Age 65 Retirees.....	14
Benefit Plan Outline: \$1,650/ \$3,300 POS: Active and Under Age 65 Retirees.....	15
Benefit Plan Outline: Zero Deductible HMO: Retirees Age 65 and Over.....	16
Benefit Plan Outline: Zero Deductible POS: Retirees Age 65 and Over.....	17

IMPORTANT: If you need to make changes to your benefit plan or add/delete dependents, please contact the City of Eau Claire's Human Resources department to complete a Cooperative Change Form. They will provide you with the necessary materials. If you do not make changes, you may continue to use your existing member ID card.

Please be sure to review the details of this year's Health Promotion program on page 2, as some requirements have changed.

As part of the Cooperative's ongoing commitment to environmentally-friendly printing practices, we encourage our members to visit group-health.com for the most up-to-date listing of health care providers in the Cooperative network.

Our goal is to continue to be your partner in your health care and to help you navigate whatever issues may arise. If you have questions about the open enrollment process or if there is anything we can do to help, please call Member Services at (715) 552-4300, toll-free at (888) 203-7770 or visit group-health.com.

Sincerely,



Peter Farrow
General Manager and CEO

Health Promotion Program Summary

The City of Eau Claire is once again partnering with Group Health Cooperative of Eau Claire to help improve the overall quality of life for their employees. A Health Promotion program has been outlined to help employees and their covered spouses achieve a healthy lifestyle.

Participation in the program is voluntary. However, a discounted deductible and reduction in premium will be credited to those who achieve the outlined requirements of the program. Please review these requirements outlined below.

Requirements to earn the discounted deductible

Single Plan	Family Plan		Requirements
	Subscriber	Spouse	
25%	12.5%	12.5%	Complete a follow-up phone call and Health Promotion appointment with a Health Promotion Coach
25%	12.5%	12.5%	Complete a preventive care screening
25%	12.5%	12.5%	Complete a tobacco free validation form
25%	12.5%	12.5%	Meet BMI/body fat percentage and blood pressure requirements
100%	50%	50%	Total Deductible Credit
	100%		

Requirements to earn the reduced premium

- Complete a follow-up phone call with a Health Promotion Coach
- Complete a Health Promotion appointment with a Health Promotion Coach
- Complete two of the following activities:
 - o Preventive care screening
 - o Tobacco free validation form
 - o BMI/body fat percentage and blood pressure requirements

By completing all requirements outlined above by June 28, 2013, employees and their covered spouses can receive both the deductible credit and the reduced premium for the 2013 plan year. However, if one or more of the requirements are not completed, the participant may not receive both. Below are a couple of program completion examples for your reference.

- An employee with a single plan does not meet BMI/body fat percentage and blood pressure requirements and does not complete the tobacco free validation form. The employee will receive a 50 percent credit toward the deductible but will not receive the reduced premium.
- An employee with a family plan completes all requirements, but their covered spouse does not complete the tobacco free validation form. The employee and their covered spouse will receive 87.5 percent credit toward the deductible and the reduced premium.

If it is unreasonably difficult due to a medical condition for an employee or their covered spouse to meet the requirements under the program, or if it is medically inadvisable for the employee or their covered spouse to attempt to meet the requirements of the program, please contact Group Health Cooperative's Health Promotion Manager at (715) 552-4300 or toll free at (888) 203-7770. An alternative solution for reward qualification will be determined.



Health Promotion Program Details

Below is an overview of the 2012 City of Eau Claire Health Promotion program. For questions on these requirements, please contact Roxanne Hinrichs at (715) 839-4887.

City of Eau Claire employees are responsible for communicating the Health Promotion program guidelines and requirements to their covered spouse if they choose to participate.

Health Promotion Phone Follow-up and Appointment

Phone follow-up appointments are an opportunity for program participants to speak with a Health Promotion Coach to discuss the progress of their Health Promotion Plan. The Coaches will discuss the participant's progress and adjust their plan if needed. Phone follow-up appointments will be held from November 2012 through January 2013. Details on these appointments will be communicated at a later date.

Health Promotion appointments are an opportunity for participants to meet individually with a Health Promotion Coach to discuss personal health goals. At the appointment, participants will complete a biometrics screening, online Health Risk Assessment (HRA) and Health Promotion plan.

Biometrics: This screening includes height, weight, blood pressure, body mass index (BMI), and body fat percentage.

Online HRA: The online HRA will calculate your health age, identify your health risks, and provide personalized ways for you to make healthier life choices. It is recommended that you complete the online HRA at least **24 hours before** your Health Promotion appointment. However, if you are unable to do so, you may also complete the online HRA during your Health Promotion appointment.

Health Promotion Plan: The results of your biometrics and online HRA will be discussed with a Health Promotion Coach. These results will help customize the Health Promotion Plan to your specific health and wellness goals.

Health Promotion appointments for this plan year's program will be available April 2, 2013 through June 28, 2013 at both the **Group Health Cooperative administrative office** and the **City of Eau Claire locations**. Details on these appointments will be communicated at a later date.

Preventive Screening Forms

Getting regular checkups, preventive screening tests and immunizations are among the most important things you can do. Work with your primary care provider to decide which screenings and immunizations are appropriate for you.

Participants must have their primary care provider sign the Preventive Medical Screening Form to indicate they are up-to-date on their age and gender appropriate preventive screenings. Please submit this form to Group Health Cooperative's Health Promotion department with a postmark date no later than June 28, 2013. **The form is located on page 7 of this booklet and online at group-health.com.**

Tobacco Free Validation

Participants must certify that they are tobacco free by completing the **tobacco free validation form found on page 9 of this booklet** and online at group-health.com. See the Frequently Asked Questions on page 11 to verify what qualifies as tobacco free. Please submit this form to Group Health Cooperative's Health Promotion department with a postmark date no later than June 28, 2013.

Preventive screening and tobacco free validation forms can be mailed to:

Group Health Cooperative of Eau Claire | Attn: Health Promotion | 2503 N Hillcrest Pkwy | Altoona, WI 54720

Or faxed attention to Health Promotion:

(715) 552-3500 or (715) 552-7202

BMI/Body Fat Percentage and Blood Pressure Requirement

By the last Health Promotion appointment a BMI of 27 or less OR a body fat percentage in the recommended range based on age and gender must be achieved. **However**, participants can also meet this requirement by lowering their body weight by 3 percent or more by the final Health Promotion appointment, which will be held between April and June of 2013.

In addition, a blood pressure of less than 140/90 with or without medication, must be achieved by the participant's last Health Promotion appointment. If the participant's blood pressure is elevated at their Health Promotion appointment, there will be opportunities for additional blood pressure checks. Details on these additional opportunities will be communicated at a later date.

What is body mass index (BMI)?

BMI is an internationally used index to show the body condition by checking the balance between the height and weight. The BMI number does not consider if weight comes from fat or from muscle. The BMI chart on the right can be helpful to see if you are in a healthy range.

What is body fat percentage?

Body fat percentage is the amount of fat that makes up an individual's total body weight (see chart on the right).

What is blood pressure?

Blood pressure is the pressure of the blood against the walls of the arteries. Blood pressure results from two forces. The heart creates one as it pumps blood into the arteries and through the circulatory system. The other is the force of the arteries as they resist the blood flow.

What do blood pressure numbers indicate?

The first (systolic) number represents the pressure while the heart contracts to pump blood to the body. The second (diastolic) number represents the pressure when the heart relaxes between beats. Any blood pressure above normal should be discussed with your primary care provider.

Blood Pressure Chart

Systolic	Diastolic	Level
210	120	Stage 4 High Blood Pressure
180	110	Stage 3 High Blood Pressure
160	100	Stage 2 High Blood Pressure
140	90	Stage 1 High Blood Pressure
130	85	High Blood Pressure
120	80	Normal Blood Pressure
110	75	Low Normal
90	60	Borderline Low



BMI Chart

WEIGHT	95	100	105	110	115	120	125	130	135	140	145	150	155	160	165	170	175	180	185	190	195	200	205	210	215	220	225	230	235	240	245
5'0"	19	20	21	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48
5'1"	18	19	20	21	22	23	24	25	26	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	43	44	45	46
5'2"	17	18	19	20	21	22	23	24	25	26	27	27	28	29	30	31	32	33	34	35	36	37	37	38	39	40	41	42	43	44	45
5'3"	17	18	19	19	20	21	22	23	24	25	26	27	27	28	29	30	31	32	33	34	35	35	36	37	38	39	40	41	42	43	43
5'4"	16	17	18	19	20	21	21	22	23	24	25	26	27	27	28	29	30	31	32	33	33	34	35	36	37	38	39	39	40	41	42
5'5"	16	17	17	18	19	20	21	22	22	23	24	25	26	27	27	28	29	30	31	32	32	33	34	35	36	37	37	38	39	40	41
5'6"	15	16	17	18	19	19	20	21	22	23	23	24	25	26	27	27	28	29	30	31	31	32	33	34	35	36	36	37	38	39	40
5'7"	15	16	16	17	18	19	20	21	22	23	23	24	25	26	27	27	28	29	30	31	31	32	33	34	34	35	36	37	38	38	
5'8"	14	15	16	17	17	18	19	20	21	21	22	23	24	24	25	26	27	27	28	29	30	30	31	32	33	33	34	35	36	36	37
5'9"	14	15	16	16	17	18	18	19	20	21	21	22	23	24	24	25	26	27	27	28	29	30	30	31	32	32	33	34	35	35	36
5'10"	14	14	15	16	16	17	18	19	19	20	21	22	22	23	24	24	25	26	27	27	28	29	29	30	31	32	32	33	34	34	35
5'11"	13	14	15	15	16	17	17	18	19	20	20	21	22	22	23	24	24	25	26	26	27	28	29	29	30	31	31	32	33	33	34
6'0"	13	14	14	15	16	16	17	18	18	19	20	21	22	22	23	24	24	25	26	26	27	28	28	29	30	31	31	32	33	33	34
6'1"	13	13	14	15	15	16	16	17	18	18	19	20	20	21	22	22	23	24	24	25	26	26	27	28	28	29	30	30	31	32	32
6'2"	12	13	13	14	15	15	16	17	17	18	19	19	20	21	22	22	23	24	24	25	26	26	27	28	28	29	30	30	31	31	31
6'3"	12	12	13	14	14	15	16	16	17	17	18	19	19	20	21	21	22	22	23	24	24	25	26	26	27	27	28	29	29	30	31
6'4"	12	12	13	13	14	15	15	16	16	17	18	18	19	19	20	21	21	22	23	23	24	24	25	26	26	27	27	28	29	29	30

HEIGHT Under healthy weight: BMI <18.5 Healthy weight: BMI 18.5-24.9 Overweight: BMI 25-29.9 Overweight: BMI 25-29.9

Body Fat Percentage Chart

		Age	Low	Recommended	High	Very High
Body Fat Percentage	Female	20-39	5.0-20.9	21.0-32.9	33.0-38.9	≥39.0
		40-59	5.0-22.9	23.0-33.9	34.0-39.9	≥40.0
		60-79	5.0-23.9	24.0-35.9	36.0-41.9	≥42.0
	Male	20-39	5.0 - 7.9	8.0 - 19.9	20.0-24.9	≥25.0
		40-59	5.0-10.9	11.0-21.9	22.0-27.9	≥28.0
		60-79	5.0-12.9	13.0-24.9	25.0-29.9	≥30.0

Health Promotion Program Checklist

To help you more easily track your progress through the 2012 City of Eau Claire Health Promotion program, this checklist has been included for your personal use.

	<u>Employee/Retiree</u>	<u>Covered Spouse</u>
Medical preventive screening form submitted	Date: _____	Date: _____
Tobacco-free validation form submitted	Date: _____	Date: _____
Health Promotion appointment with a Health Promotion Coach	Date: _____	Date: _____
Phone follow-up appointment with a Health Promotion Coach	Date: _____	Date: _____

Preventive Screening

Medical: City of Eau Claire



Getting regular check ups, preventive screening tests, and immunizations are among the most important things you can do for yourself. Work in partnership with your primary care provider to decide which screenings and immunizations are appropriate based on your personal health profile. Please have your primary care provider sign this form to indicate you are up-to-date on your preventive screenings. **Screening forms need to be dated sometime between July 1, 2012 and June 30, 2013.**

Member Signature: _____ Date: _____

Print Member Name: _____ DOB: _____ GHC ID: _____

Physician Signature: _____ Date: _____

Print Physician Name: _____

Select Specialty Type: Family Practice Internal Medicine OB/GYN

Mail to: Group Health Cooperative | Attn: Health Promotion/COEC | 2503 N. Hillcrest Parkway | Altoona, WI 54720
Fax attention to Health Promotion: (715) 552-3500 or (715) 552-7202

Preventive Screening

Medical: City of Eau Claire



Getting regular check ups, preventive screening tests, and immunizations are among the most important things you can do for yourself. Work in partnership with your primary care provider to decide which screenings and immunizations are appropriate based on your personal health profile. Please have your primary care provider sign this form to indicate you are up-to-date on your preventive screenings. **Screening forms need to be dated sometime between July 1, 2012 and June 30, 2013.**

Member Signature: _____ Date: _____

Print Member Name: _____ DOB: _____ GHC ID: _____

Physician Signature: _____ Date: _____

Print Physician Name: _____

Select Specialty Type: Family Practice Internal Medicine OB/GYN

Mail to: Group Health Cooperative | Attn: Health Promotion/COEC | 2503 N. Hillcrest Parkway | Altoona, WI 54720
Fax attention to Health Promotion: (715) 552-3500 or (715) 552-7202

Tobacco Free Validation Form

Participant Name: _____

Member ID: _____

To be eligible for the City of Eau Claire's Health Promotion program this tobacco free validation form must be completed and submitted to Group Health Cooperative's Health Promotion department with a postmark date no later than June 28, 2013.

Individuals currently using tobacco products must be tobacco free for at least three months prior to June 28, 2013 to qualify for this requirement. For information on tobacco cessation programs in our area, visit group-health.com.

Participant

I, _____, agree that I do not use tobacco or any tobacco-related products and have been tobacco free for at least three months prior to the date below and therefore am eligible to participate and earn the reward if I fulfill this requirement in addition to the others outlined in the 2012/13 open enrollment handbook. I further agree that if I am no longer tobacco free I will immediately notify Group Health Cooperative's Health Promotion department and understand that I will not be eligible for this portion of the 2013/14 plan year reward.

By signing below, I certify the above information is true and correct to the best of my knowledge and understand that any misstatement constitutes fraud and may be sufficient cause for the City of Eau Claire to financially recover the reward.

Signature _____

Date _____

Mail to: Group Health Cooperative | Attn: Health Promotion/COEC | 2503 N. Hillcrest Parkway | Altoona, WI 54720
Fax attention to Health Promotion: (715) 552-3500 or (715) 552-7202

Tobacco Free Validation Form

Participant Name: _____

Member ID: _____

To be eligible for the City of Eau Claire's Health Promotion program this tobacco free validation form must be completed and submitted to Group Health Cooperative's Health Promotion department with a postmark date no later than June 28, 2013.

Individuals currently using tobacco products must be tobacco free for at least three months prior to June 28, 2013 to qualify for this requirement. For information on tobacco cessation programs in our area, visit group-health.com.

Participant

I, _____, agree that I do not use tobacco or any tobacco-related products and have been tobacco free for at least three months prior to the date below and therefore am eligible to participate and earn the reward if I fulfill this requirement in addition to the others outlined in the 2012/13 open enrollment handbook. I further agree that if I am no longer tobacco free I will immediately notify Group Health Cooperative's Health Promotion department and understand that I will not be eligible for this portion of the 2013/14 plan year reward.

By signing below, I certify the above information is true and correct to the best of my knowledge and understand that any misstatement constitutes fraud and may be sufficient cause for the City of Eau Claire to financially recover the reward.

Signature _____

Date _____

Mail to: Group Health Cooperative | Attn: Health Promotion/COEC | 2503 N. Hillcrest Parkway | Altoona, WI 54720
Fax attention to Health Promotion: (715) 552-3500 or (715) 552-7202



Frequently Asked Questions

General

Q: Why did the City of Eau Claire change the Health Promotion program this year?

A: According to the feedback from last year's Health Promotion program, many felt the required record keeping was burdensome and time consuming. As the City of Eau Claire continues to pursue proactive approaches to maintain health care costs, outcome based programs serve as the next step in the program's evolution.

Q: How did the City of Eau Claire decide to include the program requirements it did?

A: Two of the major lifestyle behaviors that are affecting employee health and driving up health care costs are obesity and smoking. By including goals around these behaviors and providing individuals with the necessary tools, resources and culture to make positive changes, we believe we can assist and motivate those individuals who are ready to begin that change process. The Preventive Screening requirement has also been included as an effective way to stay vigilant on your personal health status. Some diseases such as high blood pressure and some cancers may not have symptoms in the early states. Exams performed at annual preventive care visits can help detect these.

Q: If I elect to voluntarily participate in this program, will Group Health Cooperative respect my privacy rights?

A: Yes. Group Health Cooperative keeps all protected health information confidential. The Cooperative's privacy responsibilities include but are not limited to protecting the privacy of protected health information created or received about you, providing you with a Privacy Notice that indicates Group Health Cooperative of Eau Claire's privacy policies and the legal duty for those policies, using and sharing protected health information as outlined in the Privacy Notice as well as notifying you when information within the Privacy Notice changes.

Q: Where can I find the Privacy Notice?

A: The Privacy Notice can be found at group-health.com. If you have any question on this notice, please call us at (715) 552-4300 or toll free at (888) 203-7770.

Q: What if I am medically unable to meet one or more of the requirements?

A: If it is unreasonably difficult for an individual, due to a health factor, to meet the requirements, or it is medically inadvisable for an individual to attempt to meet the requirements, you will be provided with a reasonable alternative or the requirement may be waived in entirety. For additional information, contact Barb Powers, Health Promotion Manager at (715) 552-4300 or toll free at (888) 203-7770.

Q: How can I verify that Group Health Cooperative has received the required forms and that I have received credit?

A: You can verify this information 48 hours after submission by contacting Group Health Cooperative's Member Services at (715) 552-4300 or toll free at (888) 203-7770.

Health Risk Assessment (HRA)

Q: Can I take my HRA before I come in for my appointment? If so, do I need to print off a hard copy and bring it with me?

A: Yes. You can take your HRA online before you come in for your appointment. However, you do not need to bring in a hard copy, as the Health Promotion Coach will provide you with one.

Preventive Screening

Q: Why did I receive a bill when I went in for my annual physical that is supposed to be covered at 100%?

A: Dependent on the circumstances surrounding the preventive care visit, you may be billed for several reasons. The reasons may include, but are not limited to:

- The services billed were not coded as preventive care
- The services billed are not a covered benefit
- The services billed are for a medical condition and are not considered preventive

To view a list of services covered under a preventive care visit, visit Healthcare.gov. If you have questions regarding a current billing or future preventive care visits please contact Group Health Cooperative's Member Services at (715) 552-4300 or toll free at (888) 203-7770.

Q: I had my physical before July 1, 2012; do I need to get another one sometime between July 1, 2012 and June 28, 2013?

A: If your primary care provider wants to see you annually, then yes. To meet the requirement you need to get your physical completed. Your Preventive Screening Form must be dated sometime between July 1, 2012 and June 28, 2013.

Q: I had my physical before July 1, 2012 and my primary care provider told me I didn't have to come back for two years. Now what do I do?

A: Contact your primary care provider and explain that your employer has a Health Promotion program and you need to have the Preventive Screening Form completed. It must be signed and dated between July 1, 2012 and June 28, 2013.

Non-tobacco Use

Q: Why does the Health Promotion program focus on tobacco?

A: The City of Eau Claire is focusing on tobacco because according to the National Institute on Drug Abuse:

- Smoking harms nearly every organ in the body. It's been linked to cataracts and pneumonia, and it accounts for about one-third of all cancer deaths. The overall rates of death from cancer are twice as high among smokers as among nonsmokers.
- Smoking has been linked to about 90 percent of all cases of lung cancer and is associated with many other cancers and lung diseases. It's also been well documented that smoking substantially increases the risk of heart disease, including stroke, heart attack, vascular disease and aneurysms.
- All tobacco, including smokeless tobacco, contains nicotine, which is addictive. The amount of nicotine absorbed from smokeless tobacco is 3-4 times greater than that delivered by a cigarette, and while nicotine is absorbed more slowly from smokeless tobacco, more nicotine per dose is absorbed and stays in the bloodstream longer.
- Chewing tobacco and snuff contain 28 carcinogens (cancer-causing agents). Smokeless tobacco increases the risk for cancer of the oral cavity, which can include cancer of the lip, tongue, cheeks, gums, and the floor and roof of the mouth. Other effects include oral leukoplakia (white mouth lesions that can become cancerous), gum disease, and gum recession (when the gum pulls away from the teeth).

Q: How does the Health Promotion program define tobacco free?

A: Being tobacco free means a person has not used tobacco products in the past three months. Tobacco products include cigars, cigarettes, electronic cigarettes, chewing tobacco, pipe tobacco or any other tobacco product.

Q: Are electronic cigarettes included as tobacco use?

A: Yes. They may contain tobacco, or they may contain nicotine, which is derived from tobacco.

The health effects of using electronic cigarettes are currently unknown. Several studies regarding the long-term health effects of nicotine vapor both inhaled directly and secondhand are currently in progress. The FDA will be developing regulations on electronic cigarettes as tobacco products under the Family Smoking Prevention and Tobacco Control Act.



Q: I use the nicotine patch; does that count as tobacco use?

A: No. Nicotine replacement therapy, such as the nicotine patch or nicotine gum, does not count as tobacco use.

Q: Is nicotine replacement therapy a covered benefit?

A: A number of FDA-approved smoking cessation aids are available for tobacco users, depending on their dependence on nicotine. To learn if a nicotine replacement therapy product is a covered benefit, please contact Group Health Cooperative's Member Services at (715) 552-4300 or toll free at (888) 203-7770.

Q: What if an employee or covered spouse validate they are not tobacco users when, in fact, they are?

A: When you validate your tobacco free status, you attest that you are telling the truth. If it is later discovered that you made a false statement, you may be responsible for a portion of your deductible credit. Employees may be subject to disciplinary action by the City of Eau Claire.

BMI/Body Fat and Blood Pressure Requirements

Q. Why are both BMI and body fat percentage being measured at the appointment?

A. We understand that BMI does not take into account body composition. In recognition of these differences, we are also taking into consideration the recommended body fat percentage range.

Q: Is my body fat percentage results influenced by my degree of hydration?

A: The Omron Fat Loss Monitor works by sending an extremely low-level electrical current through your body to determine the amount of fat tissue. The reading can be influenced by your hydration status. That is why it is recommended to use the monitor when you are normally hydrated. Avoid the following situations prior to your Health Promotion appointment, as they may cause difference in your measured body fat percentage.

- Drinking a large amount of water or after a meal (1 to 2 hours)
- Drinking alcohol
- Showering, bathing or spending time in a sauna
- Exercising

Q: Can I do another reading prior to the Health Promotion appointments in April-June of 2013?

A: Yes. Group Health Cooperative Health Promotion Coaches will be at City of Eau Claire locations October 2012 and February 2013. Availability will be on a first come first serve basis, and you will not have to schedule an appointment in advance. Details on these visits will be communicated at a later date.

Q: Is this device accurate for post-menopausal women?

A: For post-menopausal women, the body fat percentage measured by the Omron may significantly differ from the actual body fat percentage due to consistently changing amounts of water and tissue density within their bodies. That is one of the reasons we have provided the BMI or the 3% drop in body weight as alternatives for this requirement.

Q: I weigh less on my scale at home/doctor's office. Can I use the weight from that scale?

A: No. The City of Eau Claire recently purchased the same brand and model scales that Group Health Cooperative will be using. If you are wanting to check your weight more frequently, please visit one of the onsite locations: City Hall, Central Maintenance, Parks or Police Department. There will be variability between scales used in other situations outside of the Health Promotion program. However, your progress will be accurately captured from appointment to appointment using Group Health Cooperative's scales.

Q: Why does the Health Promotion program focus on blood pressure?

A: The City of Eau Claire is focusing on blood pressure because about one out of three U.S. adults (31.3 percent) has high blood pressure. High blood pressure increases the risk of heart disease and stroke and is known to be a 'silent killer' because high blood pressure has no signs or symptoms. This is why screening is important.

Q: I'm on medication for high blood pressure, does this affect my ability to meet the blood pressure requirement?

A: No. You are still qualified for the incentive. The fact that it is below 140/90 due to medication does not affect your ability to meet the blood pressure requirement. You are already taking preventive measures to keep your blood pressure within the recommended range, even with the assistance of medication.

\$1,650/ \$3,300 HMO

Active and Under Age 65 Retirees

 GROUPHEALTH <small>COOPERATIVE of Eau Claire</small>	2012 HMO Option Active and Under Age 65 Retirees
Lifetime Maximum	Unlimited
Deductible	\$1,650 Single /\$3,300 Family
Health Reimbursement Account (City Funded Deductible) <small>Deductible reimbursement amount is determined based on employee/spouse participation within the wellness program.</small>	\$1,650 Single /\$3,300 Family
Health Promotion Package	Refer to Health Promotion Proposal Section
Coinsurance	100%
Coinsurance Out-of-Pocket Limit	Not applicable
Maximum Out-of-Pocket Limit <small>Includes deductible and coinsurance; copays do not apply to this maximum.</small>	\$1,650 Single /\$3,300 Family (Deductible Reimbursement may reduce this amount)
Emergency Services (waived if admitted)	100% after \$150 copay
Ambulance	100% after deductible
Office Visits: Primary Care, Chiropractic, Maternity	100% after \$27.50 copay Maternity limited to 1 copay
Physical, Speech, Occupational Therapy	100% after \$27.50 copay
Preventive Care Office Visits	100% to no annual maximum
Specialist Care Office Visits	100% after \$27.50 copay
Urgent Care Office Visits	100% after \$37.50 copay
Immunizations	100%
Lab & X-Ray (in clinic setting)	100%
Optical Exams (one routine exam per plan year)	100%
Home Health Care	100% after \$27.50 copay
Hospice Care	100% after deductible
Oral Surgery	100% after deductible
Hospital Inpatient Services	100% after deductible
Inpatient and Outpatient Surgery (Non-Emergency)	100% after deductible and \$250 Copay (Copay waived if surgery discussed with GHC Health Management 5 business days prior to event)
Hospital Outpatient - Diagnostic Services	100% after deductible
Non-Inpatient Imaging Services Copayment is per scan	100% after \$150 copay (Maximum 2 copays per visit) <small>Including the following whether performed in a hospital or clinic setting: MRA, MRI, PET and CAT scans.</small>
Skilled Nursing Facilities/Services (30 day limit)	100% after deductible
Mental Health/AODA Inpatient Services	100%, not subject to deductible
Mental Health/AODA Outpatient Services	100%, not subject to deductible
Mental Health/AODA Transitional Services	100%, not subject to deductible
Prescription Drugs Limited to a 31-day supply per drug/refill (100-day supply if the drug is on the maintenance list)	\$0 Generic / \$30 Brand / 50% Non-Formulary Drugs to a maximum of \$80 per fill. Diabetic supplies paid at 100%, must be received from a Network Pharmacy.
Durable Medical Equipment	100% after \$27.50 copay
Prosthetics	100% after deductible <small>Covered Services are limited to \$50,000 per member per lifetime. This limit does not apply; however, to prosthetics used as a result of a mastectomy.</small>
TMJ Services (non-surgical max \$1,250) Office Visits Appliances & Therapy	100% after \$27.50 copay 100% after deductible
Dependency Criteria	To age 26: to end of month
Network*	Standard GHC Network

* Provider Network Note: Mayo Clinic, St. Mary's and Methodist Hospital in Rochester, Minnesota are available to GHC members only after receiving a prior event authorization by the health plan. This provision does not apply to Mayo Clinic affiliated providers in Wisconsin.



(715) 552-4300 or (888) 203-7770

\$1,650 / \$3,300 POS

Active and Under Age 65 Retirees

	2012 Point of Service Option Active and Under Age 65 Retirees	
	In-Network	Out-of-Network
Lifetime Maximum	Unlimited	
Deductible	\$1,650 Single /\$3,300 Family	
Health Reimbursement Account (City Funded Deductible) <small>Deductible reimbursement amount is determined based on employee/spouse participation within the wellness program.</small>	\$1,650 Single /\$3,300 Family	
Health Promotion Package	Refer to Health Promotion Proposal Section	
Coinsurance	90%	70%
Coinsurance Out-of-Pocket Limit	\$1,000/\$2,000	\$1,000/\$2,000
Maximum Out-of-Pocket Limit <small>Includes deductible and coinsurance; copays do not apply to this maximum.</small>	\$2,650 Single /\$5,300 Family (Deductible Reimbursement will reduce this amount)	\$2,650 Single /\$5,300 Family (Deductible Reimbursement may reduce this amount)
Emergency Services (waived if admitted)	100% after \$150 copay	100% after \$150 copay
Ambulance	90% after deductible	70% after deductible
Office Visits: Primary Care, Chiropractic, Maternity	100% after \$27.50 copay Maternity limited to 1 copay	70% after deductible
Physical, Speech, Occupational Therapy (limited to a combined maximum of 40 visits per plan year.)	100% after \$27.50 copay	70% after deductible
Preventive Care Office Visits	100%	70% after deductible
Specialist Care Office Visits	100% after \$27.50 copay	70% after deductible
Urgent Care Office Visits	100% after \$37.50 copay	100% after \$37.50 copay
Immunizations	100%	70% after deductible
Lab & X-Ray (in clinic setting)	100%	70% after deductible
Optical Exams (one routine exam per plan year)	100%	70% after deductible
Home Health Care	100% after \$27.50 copay	70% after deductible
Hospice Care	90% after deductible	70% after deductible
Oral Surgery	90% after deductible	70% after deductible
Hospital Inpatient Services	90% after deductible	70% after deductible
Inpatient and Outpatient Surgery (Non-Emergency)	90% after deductible and \$250 Copay (Copay waived if surgery discussed with GHC Health Management 5 business days prior to event)	70% after deductible and \$250 Copay (Copay waived if surgery discussed with GHC Health Management 5 business days prior to event)
Hospital Outpatient - Diagnostic Services	90% after deductible	70% after deductible
Non-Inpatient Imaging Services <small>Copayment is per scan</small>	100% after \$150 copay (Maximum 2 copays per visit) <small>Including the following whether performed in a hospital or clinic setting: MRA, MRI, PET and CAT scans.</small>	70% after deductible
Skilled Nursing Facilities/Services (30 day limit)	90% after deductible	70% after deductible
Mental Health/AODA Inpatient Services	100%, not subject to deductible	90%, not subject to deductible
Mental Health/AODA Outpatient Services	100%, not subject to deductible	90%, not subject to deductible
Mental Health/AODA Transitional Services	100%, not subject to deductible	90%, not subject to deductible
Prescription Drugs <small>Limited to a 31-day supply per drug/refill (100-day supply if the drug is on the maintenance list)</small>	\$0 Generic / \$30 Brand / 50% Non-Formulary Drugs to a maximum of \$80 per fill. Diabetic supplies paid at 100%, must be received from a Network Pharmacy.	
Durable Medical Equipment	100% after \$27.50 copay	70% after deductible
Prosthetics	90% after deductible <small>Covered Services are limited to \$50,000 per member per lifetime. This limit does not apply; however, to prosthetics used as a result of a mastectomy.</small>	70% after deductible <small>Covered Services are limited to \$50,000 per member per lifetime. This limit does not apply; however, to prosthetics used as a result of a mastectomy.</small>
TMJ Services (non-surgical max \$1,250) Office Visits Appliances & Therapy	100% after \$27.50 copay 90% after deductible	70% after deductible 70% after deductible
Dependency Criteria	To age 26: to end of month	
Network*	Standard GHC Network	Non-Contracted Licensed Providers. UCR Applies.
<p>* Provider Network Note: Mayo Clinic, St. Mary's and Methodist Hospital in Rochester, Minnesota are available to GHC members only after receiving a prior event authorization by the health plan. This provision does not apply to Mayo Clinic affiliated providers in Wisconsin.</p> <p>** The amount you pay towards the in-network coinsurance will only apply toward the in-network benefit levels, and the amounts you pay toward the out-of-network coinsurance will only apply toward the out-of-network benefit levels. In other words, the in-network and out-of-network coinsurance maximums are completely separate and cannot be combined. The deductible is a combined deductible for both in and out-of-network.</p>		

Zero Deductible HMO

Retirees Age 65 and Over

	2012 HMO Option Retirees Over Age 65
Lifetime Maximum	Unlimited
Deductible	\$0 Single /\$0 Family
Coinsurance	100%
Coinsurance Out-of-Pocket Limit	Not applicable
Maximum Out-of-Pocket Limit <small>Includes deductible and coinsurance; copays do not apply to this maximum.</small>	\$0 Single / \$0 Family
Emergency Services (waived if admitted)	100% after \$150 copay
Ambulance	100% after deductible
Office Visits: Primary Care, Chiropractic, Maternity	100% after \$27.50 copay Maternity limited to 1 copay
Physical, Speech, Occupational Therapy <small>(limited to a combined maximum of 40 visits per plan year.)</small>	100% after \$27.50 copay
Preventive Care Office Visits	100% to no annual maximum
Specialist Care Office Visits	100% after \$27.50 copay
Urgent Care Office Visits	100% after \$37.50 copay
Immunizations	100%
Lab & X-Ray (in clinic setting)	100%
Optical Exams (one routine exam per plan year)	100%
Home Health Care	100% after \$27.50 copay
Hospice Care	100% after deductible
Oral Surgery	100% after deductible
Organ Transplant Service	100% after deductible
Kidney Disease Treatment	100% after deductible
Hospital Inpatient Services	100% after deductible
Inpatient and Outpatient Surgery (Non-Emergency)	100% after deductible and \$250 Copay (Copay waived if surgery discussed with GHC Health Management 5 business days prior to event)
Hospital Outpatient - Diagnostic Services	100% after deductible
Non-Inpatient Imaging Services <small>Copayment is per scan</small>	100% after \$150 copay (Maximum 2 copays per visit) <small>Including the following whether performed in a hospital or clinic setting: MRA, MRI, PET and CAT scans.</small>
Skilled Nursing Facilities/Services (30 day limit)	100% after deductible
Mental Health/AODA Inpatient Services	100%, not subject to deductible
Mental Health/AODA Outpatient Services	100%, not subject to deductible
Mental Health/AODA Transitional Services	100%, not subject to deductible
Prescription Drugs <small>Limited to a 31-day supply per drug/refill (100-day supply if the drug is on the maintenance list)</small>	\$0 Generic / \$30 Brand / 50% Non-Formulary Drugs to a maximum of \$80 per fill. Diabetic supplies paid at 100%, must be received from a Network Pharmacy.
Durable Medical Equipment	100% after \$27.50 copay
Prosthetics	100% after deductible <small>Covered Services are limited to \$50,000 per member per lifetime. This limit does not apply; however, to prosthetics used as a result of a mastectomy.</small>
TMJ Services (non-surgical max \$1,250) Office Visits Appliances & Therapy	100% after \$27.50 copay 100% after deductible
Dependency Criteria	To age 26: to end of month
Network*	Standard GHC Network

* Provider Network Note: Mayo Clinic, St. Mary's and Methodist Hospital in Rochester, Minnesota are available to GHC members only after receiving a prior event authorization by the health plan. This provision does not apply to Mayo Clinic affiliated providers in Wisconsin.



Zero Deductible POS

Retirees Age 65 and Over

 GROUPHEALTH <small>COOPERATIVE of Eau Claire</small>	2012 Point of Service Option	
	Retirees Over Age 65	
	In-Network	Out-of-Network
Lifetime Maximum	Unlimited	
Deductible	\$0 Single /\$0 Family	
Coinsurance	90%	70%
Coinsurance Out-of-Pocket Limit	\$1,000/\$2,000	\$1,000/\$2,000
Maximum Out-of-Pocket Limit <small>Includes deductible and coinsurance; copays do not apply to this maximum.</small>	\$1,000 Single / \$2,000 Family	\$1,000 Single / \$2,000 Family
Emergency Services (waived if admitted)	100% after \$150 copay	100% after \$150 copay
Ambulance	90% after deductible	70% after deductible
Office Visits: Primary Care, Chiropractic, Maternity	100% after \$27.50 copay Maternity limited to 1 copay	70% after deductible
Physical, Speech, Occupational Therapy <small>(limited to a combined maximum of 40 visits per plan year.)</small>	100% after \$27.50 copay	70% after deductible
Preventive Care Office Visits	100% to no annual maximum	70% after deductible
Specialist Care Office Visits	100% after \$27.50 copay	70% after deductible
Urgent Care Office Visits	100% after \$37.50 copay	100% after \$37.50 copay
Immunizations	100%	70% after deductible
Lab & X-Ray (in clinic setting)	100%	70% after deductible
Optical Exams (one routine exam per plan year)	100%	70% after deductible
Home Health Care	100% after \$27.50 copay	70% after deductible
Hospice Care	90% after deductible	70% after deductible
Oral Surgery	90% after deductible	70% after deductible
Organ Transplant Service	90% after deductible	70% after deductible
Kidney Disease Treatment	90% after deductible	70% after deductible
Hospital Inpatient Services	90% after deductible	70% after deductible
Inpatient and Outpatient Surgery (Non-Emergency)	90% after deductible and \$250 Copay (Copay waived if surgery discussed with GHC Health Management 5 business days prior to event)	70% after deductible and \$250 Copay (Copay waived if surgery discussed with GHC Health Management 5 business days prior to event)
Hospital Outpatient - Diagnostic Services	90% after deductible	70% after deductible
Non-Inpatient Imaging Services <small>Copayment is per scan</small>	100% after \$150 copay (Maximum 2 copays per visit) <small>Including the following whether performed in a hospital or clinic setting: MRA, MRI, PET and CAT scans.</small>	70% after deductible
Skilled Nursing Facilities/Services (30 day limit)	90% after deductible	70% after deductible
Mental Health/AODA Inpatient Services	100%, not subject to deductible	90%, not subject to deductible
Mental Health/AODA Outpatient Services	100%, not subject to deductible	90%, not subject to deductible
Mental Health/AODA Transitional Services	100%, not subject to deductible	90%, not subject to deductible
Prescription Drugs <small>Limited to a 31-day supply per drug/refill (100-day supply if the drug is on the maintenance list)</small>	\$0 Generic / \$30 Brand / 50% Non-Formulary Drugs to a maximum of \$80 per fill. Diabetic supplies paid at 100%, must be received from a Network Pharmacy.	
Durable Medical Equipment	100% after \$27.50 copay	70% after deductible
Prosthetics	90% after deductible <small>Covered Services are limited to \$50,000 per member per lifetime. This limit does not apply; however, to prosthetics used as a result of a mastectomy.</small>	70% after deductible <small>Covered Services are limited to \$50,000 per member per lifetime. This limit does not apply; however, to prosthetics used as a result of a mastectomy.</small>
TMJ Services (non-surgical max \$1,250) Office Visits Appliances & Therapy	100% after \$27.50 copay 90% after deductible	70% after deductible 70% after deductible
Dependency Criteria	To age 26: to end of month	
Network*	Standard GHC Network	Non-Contracted Licensed Providers. UCR Applies.
<p>* Provider Network Note: Mayo Clinic, St. Mary's and Methodist Hospital in Rochester, Minnesota are available to GHC members only after receiving a prior event authorization by the health plan. This provision does not apply to Mayo Clinic affiliated providers in Wisconsin.</p> <p>** The amount you pay towards the in-network coinsurance will only apply toward the in-network benefit levels, and the amounts you pay toward the out-of-network coinsurance will only apply toward the out-of-network benefit levels. In other words, the in-network and out-of-network coinsurance maximums are completely separate and cannot be combined. The deductible is a combined deductible for both in and out-of-network.</p>		



GROUPHEALTH
COOPERATIVE of Eau Claire

PO Box 3217
Eau Claire, WI 54702-3217
(715) 552-4300 • (888) 203-7770

group-health.com

GHC12034
©2012 Group Health Cooperative of Eau Claire



**WCA Group Health
Trust Eau Claire
County
Medical Benefit Plan (EPO)**

Group Number: WCA0018
Revised: January 1, 2011

SUMMARY PLAN DESCRIPTION

EMPLOYEE MEDICAL PLAN FOR

WCA GROUP HEALTH TRUST
EAU CLAIRE COUNTY
(EPO PLAN)

GROUP NUMBER: WCA0018

Underwritten By:
WCA Group Health Trust
22 East Mifflin Street Suite 900
Madison, Wisconsin
(866) 404-2700 (toll-free)

Effective Date: January 1, 2011

Authorized County Representative

Authorized Representative,
WCA Group Health Trust

Title

Title

Date

Date

SIGNED

TABLE OF CONTENTS

SECTION 1 MEDICAL BENEFITS

PAYMENT OF COVERED EXPENSES	1-1
AN IMPORTANT MESSAGE ABOUT YOUR PLAN	1-2
CERTIFICATION PROCEDURES	1-2
PENALTY FOR NOT OBTAINING CERTIFICATION	1-2
MEDICAL BILL REVIEW	1-2
SCHEDULE OF BENEFITS	1-3
MEDICAL BILL REVIEW: MEDICAL BENEFITS	1-3 1-3
MEDICAL BENEFITS	1-15
DEDUCTIBLE AND COINSURANCE INFORMATION	1-15
MEDICAL COVERED EXPENSES	1-16
INPATIENT HOSPITAL BENEFITS	1-16
QUALIFIED PRACTITIONER BENEFITS	1-16
ORAL SURGERY	1-17
WELLNESS BENEFIT	1-17
OUTPATIENT HOSPITAL BENEFIT	1-19
URGENT CARE CENTER BENEFIT	1-19
AMBULATORY SURGICAL CENTER/FREE STANDING SURGICAL FACILITY	1-19
X-RAY AND LABORATORY TESTS	1-19
AMBULANCE SERVICE BENEFIT	1-20
PREGNANCY BENEFIT	1-20
NEWBORN BENEFITS	1-20
BIRTHING CENTER BENEFIT	1-21
HOME HEALTH CARE BENEFIT	1-21
CONVALESCENT NURSING HOME BENEFIT	1-22
HOSPICE CARE BENEFIT	1-22
HUMAN ORGAN AND TISSUE TRANSPLANTS	1-23
KIDNEY DISEASE BENEFIT	1-24
PSYCHOLOGICAL DISORDERS, CHEMICAL DEPENDENCE AND ALCOHOLISM BENEFIT	1-24 1-24
OTHER COVERED EXPENSES	1-26
MEDICAL LIMITATIONS AND EXCLUSIONS	1-32
ALTERNATIVE TREATMENTS	1-32
DENTAL	1-32
DRUGS	1-32
EXPERIMENTAL OR UNPROVEN SERVICES	1-32
PHYSICAL APPEARANCE	1-33
PROVIDERS	1-33
REPRODUCTION	1-33
ROUTINE AND GENERAL HEALTH	1-34
SERVICES UNDER ANOTHER PLAN	1-34

OTHER	1-35
PRESCRIPTION DRUG CARD	1-37
<u>SECTION 2</u> <u>DEFINITIONS</u>	
<hr/>	
DEFINITIONS	2-1
<u>SECTION 3</u> <u>ELIGIBILITY</u>	
<hr/>	
ELIGIBILITY AND EFFECTIVE DATE OF COVERAGE	3-1
ANNUAL ENROLLMENT	3-1
EMPLOYEE ELIGIBILITY	3-1
EMPLOYEE EFFECTIVE DATE OF COVERAGE	3-1
DEPENDENT ELIGIBILITY	3-2
DEPENDENT EFFECTIVE DATE OF COVERAGE	3-2
ANNUAL ENROLLMENT PERIOD	3-3
RETIREE COVERAGE	3-4
SPECIAL ENROLLMENT RIGHTS	3-4
MEDICAID/STATE CHILD HEALTH PLAN	3-5
SPOUSAL TRANSFER PROVISION	3-6
BENEFIT CHANGES	3-6
SPECIAL PROVISIONS FOR NOT BEING ACTIVELY AT WORK	3-6
TERMINATION OF COVERAGE	3-7
FAMILY AND MEDICAL LEAVE ACT (FMLA)	3-8
EMPLOYEE ELIGIBILITY	3-8
TYPES OF LEAVE	3-8
REINSTATEMENT OF COVERAGE UPON RETURN TO WORK	3-9
DEFINITIONS	3-9
UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT (USERRA)	3-11
CONTINUATION OF COVERAGE DURING MILITARY LEAVE	3-11
REINSTATEMENT OF COVERAGE FOLLOWING MILITARY LEAVE	3-11
CONTINUATION OF BENEFITS	3-13
THE CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT (COBRA)	3-13
AMERICAN RECOVERY AND REINVESTMENT ACT	3-17
ELIGIBLE INDIVIDUALS	3-17
AMOUNT AND LENGTH OF SUBSIDY	3-18
ELECTING THE SUBSIDY	3-19
ELECTING DIFFERENT COVERAGE	3-19
INDIVIDUAL MEDICAL CONVERSION PRIVILEGE	3-20

SECTION 4 GENERAL PLAN INFORMATION

COORDINATION OF BENEFITS	4-1
RECOVERY RIGHTS	4-4
GENERAL RECOVERY RIGHTS PROVISIONS	4-4
GENERAL PROVISIONS	4-6
ALTERNATE RECIPIENTS	4-6
AMENDMENTS TO OR TERMINATION OF THE PLAN	4-6
ASSIGNMENT	4-6
CLERICAL ERROR	4-6
CONFORMITY WITH APPLICABLE LAWS	4-6
CONTRIBUTIONS TO THE PLAN	4-7
COOPERATION	4-7
FAILURE TO ENFORCE PLAN PROVISIONS	4-7
FREE CHOICE OF PROVIDER	4-7
HEALTH INSURANCE PORTABILITY & ACCOUNTABILITY ACT	4-7
LEGAL ACTIONS	4-7
PAYMENT OF CLAIMS	4-7
PHYSICAL EXAMINATION	4-8
PRIVACY OF PROTECTED HEALTH INFORMATION	4-8
PROOF OF LOSS	4-10
PROTECTION AGAINST CREDITORS	4-11
REPRESENTATIONS	4-11
RIGHT TO NECESSARY INFORMATION	4-11
SECURITY	4-11
TERMINATION OF THE PLAN	4-11
TIME OF CLAIM DETERMINATION	4-12
CLAIM APPEAL PROCEDURE	4-13
FIRST LEVEL OF APPEAL	4-13
SECOND LEVEL OF APPEAL	4-13
FEDERAL EXTERNAL REVIEW PROGRAM	4-14

SECTION 1 MEDICAL BENEFITS

PAYMENT OF COVERED EXPENSES

The Plan will pay for Your Covered Expenses to the extent provided in the Plan for the benefits selected by the Covered Employee, subject to deductibles, copayments, maximums, and all other terms, provisions, limitations, conditions and exclusions of the Plan. Capitalized words and phrases are defined in Section 2 – Definitions.

AN IMPORTANT MESSAGE ABOUT YOUR PLAN

CERTIFICATION PROCEDURES

The Utilization Management company (UM) shown on Your ID card will handle the certification requirements of Your Plan. You should call UM as soon as possible to receive proper certification. The UM toll-free number is on the back of Your ID card. For additional information, call UM.

Non-Emergency Qualified Treatment Facility Inpatient Admissions: You must notify UM at least 48 hours in advance of any Non-Emergency inpatient admission to a Qualified Treatment Facility.

Emergency Inpatient Admissions: You must notify UM within 48 hours or the first business day after any Emergency inpatient admission to a Qualified Treatment Facility.

Inpatient stays resulting from the birth of a child do not need to be certified unless the stay, for the mother or the child, exceeds 48 hours after a vaginal delivery or 96 hours after a cesarean section delivery. Admissions that exceed these time limits must be certified by UM as stated above.

Certification by UM is not a guarantee of coverage.

PENALTY FOR NOT OBTAINING CERTIFICATION

EPO Facility: No penalty will be applied if You use an EPO facility.

Non-EPO Facility: If Your admission is not certified, Your benefits for Covered Expenses will be reduced by 50%, to a maximum penalty of \$250 per occurrence. The penalty may be taken from any charges relating to Your admission. The penalty is not applied to the out-of-pocket limit.

MEDICAL BILL REVIEW

You should carefully review Your bill for any service. If You find any errors such as:

1. Treatment that is billed, but was not received;
2. Incorrect arithmetic;
3. Drugs or supplies that were not received;

You should report them to the provider of service and request a corrected itemized billing. You should then submit copies of the original bill, with the errors circled, and the corrected bill to the Claim Administrator. This serves as proof that the provider of service agreed to the corrections. **If You are correct, You will receive 50% of the errors in the bill, but not more than \$500 paid per bill.**

NOTE: UMR, Inc. is the Plan’s Claims Administrator. UMR, Inc. provides clerical and claim processing services to the Plan. UMR, Inc. is not financially responsible for the funding or payment of claims processed under the Plan, nor is UMR, Inc. a fiduciary to this Plan.

SCHEDULE OF BENEFITS

MEDICAL BILL REVIEW:

If You discover a billing error, report it to the Plan. As a reward, You will receive 50% of the error, but not more than **\$500 paid per bill**.

MEDICAL BENEFITS

Plan Lifetime Maximum: Unlimited

IMPORTANT: You must use an EPO provider. Services from Non-EPO providers are not covered, except as shown under EPO Benefit Provisions. EPO providers are providers in the HealthEOS Network.

MEDICAL BENEFITS	PLAN PAYS	YOU PAY	BENEFIT SUMMARY	TEXT PAGE
Deductible per Calendar Year Individual Family	\$0 \$0	\$1,250 \$2,500	The amount You must pay each year before the Plan will begin paying any benefits. The family maximum is on an aggregate dollar basis.	1-15
Individual Coinsurance per Calendar Year EPO Non-EPO	90% 0%	10% 100%	EPO Providers: After the deductible is met, the Plan pays 90% of EPO Covered Expenses, subject to any maximums and copays. Non-EPO Providers: Services from Non-EPO providers are not covered, except as stated under the EPO Benefit Provision.	1-15
Out-of-Pocket Limit per Calendar Year Individual Family		\$1,450 \$2,900	Represents the total paid by You for the deductible and coinsurance. After which the Plan pays 100% of Covered Expenses subject to any maximums. The family maximum is on an aggregate dollar basis. The copays do not apply to the out-of-pocket limit.	1-15

MEDICAL BENEFITS	PLAN PAYS	YOU PAY	BENEFIT SUMMARY	TEXT PAGE
<p>The deductible and coinsurance limits shown above apply to all Covered Expenses unless stated otherwise below.</p> <p>EPO Benefit Provision Services from Non-EPO providers are <u>not</u> covered. They will only be covered if: :</p> <ol style="list-style-type: none"> 1. An EPO provider refers You to a Non-EPO provider for required medical services. (A referral is not required for inpatient Hospital services if You are admitted to the Hospital directly from the Emergency Room. 2. You require Emergency medical care. 3. You receive treatment that is a Covered Expense from an EPO provider and as a result of that treatment, a Covered Expense is incurred from a Non-EPO provider that is a: pathologist; anesthesiologist; cardiologist; radiologist or Emergency Room physician. <p>Continuity of Care: If, while You are covered under this Plan, Your provider ceases to be an EPO provider for this Plan, the Plan will pay EPO benefits for Covered Expenses provided to You by that provider, regardless of whether that provider is an EPO provider at the time the services were provided to You. This provision will apply if Your provider was listed as an EPO provider in the EPO provider directory that was given to You at the time of Your enrollment in this Plan or at Your most-recent renewal under the Plan, whichever occurs later.</p>				

COVERED EXPENSES	PAYABLE AT	BENEFIT SUMMARY	TEXT PAGE
Inpatient Hospital Benefit	EPO: Deductible/ 90% to the coinsurance limit Non-EPO: Not Covered	Semi-private room and board, intensive care or coronary care and miscellaneous charges.	1-16
Qualified Practitioner Office Services Benefit	EPO: \$25 copay per visit, then deductible/90% to coinsurance limit Non-EPO: Not Covered	EPO: This copay does not apply to the out-of-pocket limit. This copay applies to the office visit charge only. Other Covered Expenses performed in the office are subject to the deductible and coinsurance.	1-16

COVERED EXPENSES	PAYABLE AT	BENEFIT SUMMARY	TEXT PAGE
Qualified Practitioner Benefits	EPO: Deductible/ 90% to coinsurance limit Non-EPO: Not Covered	Inpatient and outpatient Hospital visits, surgery and anesthesia.	1-16
Oral Surgery	EPO: Deductible/ 90% to coinsurance limit Non-EPO: Not Covered	Refer to list of covered oral surgeries in text. The Office Visit copay does not apply to this benefit.	1-17
Wellness Benefit	EPO: 100%, deductible and coinsurance waived Non-EPO: Not Covered Routine Immunizations: 100%, deductible and coinsurance waived (for EPO and Non-EPO providers).	Benefits include routine physical exams, well child exams, routine x-ray and laboratory tests, routine immunizations and routine hearing tests <u>Refer to the text for details and limits.</u> X-rays and Lab Tests: All covered x-rays and lab tests, whether routine or with a diagnosis, performed in conjunction with a Wellness exam, are payable the same as the Wellness Benefit. Mammograms, Pap Smears, Pelvic Exams, Prostate Tests and Endoscopic Surgeries (e.g. colonoscopies): Payable as shown under the Other Covered Expenses. The Office Visit copay does not apply to this benefit.	1-17
Outpatient Hospital Benefit	EPO: Deductible/ 90% to the coinsurance limit Non-EPO: Not Covered		1-19

COVERED EXPENSES	PAYABLE AT	BENEFIT SUMMARY	TEXT PAGE
Emergency Room Benefit	<p>EPO: \$100 copay per visit, then deductible/90% to coinsurance limit</p> <p>Non-EPO: \$100 copay per visit, then deductible/90% to coinsurance limit</p>	<p>This copay does not apply to the out-of-pocket limit.</p> <p>This copay is waived if You are admitted to the Hospital from the Emergency Room.</p> <p>This benefit includes Emergency room physician charges and other services provided in the Emergency room.</p> <p>Emergency room treatment is limited to Emergencies, as defined in this Plan.</p>	1-19
Urgent Care Center Benefits	<p>EPO: \$25 copay per visit, then deductible/90% to coinsurance limit</p> <p>Non-EPO: Not Covered</p>	<p>This copay does not apply to the out-of-pocket limit.</p> <p>Services provided by an Urgent Care Center or Walk-In Clinic. Benefits include all Covered Expenses performed during the visit.</p>	1-19
Ambulatory Surgical Center	<p>EPO: Deductible/90% to coinsurance limit</p> <p>Non-EPO: Not Covered</p>		1-19
X-ray and Laboratory Tests	<p>EPO: Deductible/90% to coinsurance limit</p> <p>Non-EPO: Not Covered</p>	<p>Dental x-rays limited to covered oral surgery or Injury.</p> <p>All covered x-rays and lab tests, whether routine or with a diagnosis, performed in conjunction with a Wellness exam, are payable the same as the Wellness Benefit.</p>	1-19
Ambulance Service Benefit	<p>Deductible/90% to the coinsurance limit (for EPO and Non-EPO)</p>	<p>Limited to appropriate transport to the nearest facility equipped to treat the Sickness or Injury.</p>	1-20

COVERED EXPENSES	PAYABLE AT	BENEFIT SUMMARY	TEXT PAGE
Pregnancy Benefit	EPO: Deductible/ 90% to coinsurance limit Non-EPO: Not Covered	Covered for Employee, spouse and Dependent daughter.	1-20
Newborn Benefits	EPO: Deductible/ 90% to coinsurance limit Non-EPO: Not Covered	See "Section 3 – Eligibility" for important information on Dependent Coverage.	1-20
Birthing Center Benefit	EPO: Deductible/ 90% to coinsurance limit Non-EPO: Not Covered		1-21
Home Health Care Benefit	EPO: Deductible/ 90% to coinsurance limit Non-EPO: Not Covered	When Home Health Care is in lieu of a covered Confinement in a Hospital or Convalescent Nursing Home.	1-21
Convalescent Nursing Home Benefit	EPO: Deductible/ 90% to coinsurance limit Non-EPO: Not Covered	Limited to 120 days per Calendar Year.	1-22
Hospice Care Benefit	EPO: Deductible/ 90% to coinsurance limit Non-EPO: Not Covered	Hospice Care must be in lieu of a covered Confinement in a Hospital or Convalescent Nursing Home.	1-22

COVERED EXPENSES	PAYABLE AT	BENEFIT SUMMARY	TEXT PAGE
Human Organ and Tissue Transplants	EPO: Deductible/ 90% to coinsurance limit Non-EPO: Not Covered	Refer to the list of covered transplants in the text. Procurement: Limited to \$10,000 paid per organ. Limited to one transplant per organ while You are covered under this Plan. Note: Kidney transplants are not payable under this benefit. (Refer to the Kidney Disease Benefit for kidney transplants.)	1-23
Kidney Disease Benefit	EPO: Deductible/ 90% to coinsurance limit Non-EPO: Not Covered	Includes dialysis treatment and kidney transplants expenses for both the recipient and the donor.	1-24
Psychological Disorders, Chemical Dependence and Alcoholism Benefit	Paid the same as any other Sickness or Injury		1-24
Other Covered Expenses	EPO: Deductible/ 90% to coinsurance limit Non-EPO: Not Covered		1-26
Chiropractic Care	EPO: \$25 copay per visit, then deductible/90% to coinsurance limit Non-EPO: Not Covered	EPO: This copay does not apply to the out-of-pocket limit. Routine or maintenance care is not covered.	1-26

COVERED EXPENSES	PAYABLE AT	BENEFIT SUMMARY	TEXT PAGE
Physical, Speech, Occupational and Respiratory Therapy	<p>EPO: \$25 copay per visit, then deductible/90% to coinsurance limit</p> <p>Non-EPO: Not Covered</p>	<p>EPO: This copay does not apply to the out-of-pocket limit.</p> <p>Limited to a combined maximum of 50 visits per Calendar Year. (This limit does not apply to respiratory therapy.)</p> <p>Additional visits may be payable if they are pre-authorized.</p>	1-26
Outpatient Cardiac Rehabilitation	<p>EPO: Deductible/90% to coinsurance limit</p> <p>Non-EPO: Not Covered</p>	Refer to the text for details.	1-26
TMJ Benefit	<p>EPO: Deductible/90% to coinsurance limit</p> <p>Non-EPO: Not Covered</p>	<p>Covers surgical, non-surgical and diagnostic treatment.</p> <p>Diagnostic and Non-Surgical: Limited to a combined maximum of \$1,250 <u>in charges</u> per Calendar Year.</p>	1-27

COVERED EXPENSES	PAYABLE AT	BENEFIT SUMMARY	TEXT PAGE
Mammograms, Pap Smears and Pelvic Exams	<p>1st each Calendar Year: EPO: 100%, deductible and coinsurance waived</p> <p>Non-EPO: Not Covered</p> <p>Additional in the same Calendar Year: <u>Routine:</u> EPO: 100%, deductible and coinsurance waived.</p> <p>Non-EPO: Not Covered</p> <p><u>Non-Routine</u> EPO: Deductible/ 90% to coinsurance limit</p> <p>Non-EPO: Not Covered</p>	<p>Includes routine and those related to a Sickness or Injury.</p> <p>Mammograms: Includes digital mammography.</p> <p>For any covered female person.</p> <p>Includes charges for the related office visit.</p>	1-27

COVERED EXPENSES	PAYABLE AT	BENEFIT SUMMARY	TEXT PAGE
Prostate Tests	<p>1st each Calendar Year: EPO: 100%, deductible and coinsurance waived</p> <p>Non-EPO: Not Covered</p> <p>Additional in the same Calendar Year: <u>Routine:</u> EPO: 100%, deductible and coinsurance waived.</p> <p>Non-EPO: Not Covered</p> <p><u>Non-Routine</u> EPO: Deductible/ 90% to coinsurance limit</p> <p>Non-EPO: Not Covered</p>	<p>Includes routine tests and those related to a Sickness or Injury.</p> <p>For any covered male person.</p> <p>Includes charges for the related office visit</p>	1-27
Endoscopic Surgeries (e.g.. Colonoscopies)	<p><u>Routine:</u> EPO: 100%, deductible and coinsurance waived.</p> <p>Non-EPO: Not Covered</p> <p><u>Non-Routine</u> EPO: Deductible/ 90% to coinsurance limit</p> <p>Non-EPO: Not Covered</p>	<p>Includes routine, those related to a Sickness or Injury and those required due to family history.</p> <p>For any Covered Person.</p>	1-27

COVERED EXPENSES	PAYABLE AT	BENEFIT SUMMARY	TEXT PAGE
Eye Exams	<p>1st each Calendar Year: 100%, deductible and coinsurance waived (for EPO and Non-EPO)</p> <p>Additional Exams in the Same Calendar Year: EPO: Deductible/90% to coinsurance limit</p> <p>Non-EPO: Not Covered.</p>	<p>Includes routine exams and those related to a Sickness or Injury.</p> <p><u>Routine Eye Exams:</u> Limited to one per Calendar Year.</p>	1-28
Pain Management	<p>EPO: \$25 copay per visit, then deductible/90% to coinsurance limit</p> <p>Non-EPO: Not Covered</p>	<p>EPO: This copay does not apply to the out-of-pocket limit.</p> <p>Limited to four shots per Calendar Year.</p>	1-28
High Risk Weight Management Program (HMR)	Deductible/50% to coinsurance limit	<p>Limited to \$500 <u>in charges</u> per Lifetime.</p> <p>Limited to treatment from the Midelfort Clinic High Risk Weight Management Program only.</p> <p>You must be referred to the program by an EPO Qualified Practitioner.</p> <p>Prior approval from the Plan is required.</p> <p>Refer to the text for more information.</p> <p>The Office Visit copay does not apply to this benefit.</p>	1-28

COVERED EXPENSES	PAYABLE AT	BENEFIT SUMMARY	TEXT PAGE
Preventive Dental Care	100%, deductible and coinsurance waived (for EPO and Non-EPO)	<p>Limited to one visit per Calendar Year.</p> <p>Covered for Dependent children age 11 and under only.</p> <p>Covers routine oral exams, cleanings, bitewing x-rays and topical fluoride treatments only.</p> <p>The Office Visit copay does not apply to this benefit.</p>	1-28
Health Club and Fitness Programs	100%, deductible and coinsurance waived	<p>This benefit applies to Covered Employees and covered Dependent spouses only. It does not apply to Dependent children.</p> <p>Limited to \$100 paid per Covered Employee and \$100 paid per covered Dependent spouse per Calendar Year.</p> <p>Charges must be incurred at a licensed facility such as, but not limited to, the YMCA, the YWCA and Curves.</p>	1-29
Midelfort Clinic Express Care Facility (South Point location)	Deductible/90% to coinsurance limit	The Office Visit copay does not apply to this benefit.	1-29
Limitations and Exclusions	Not Payable	List of exclusions that apply to all Covered Expenses. A service that is normally covered or Medically Necessary may be excluded when provided with an excluded item.	1-32

COVERED EXPENSES	PAYABLE AT	BENEFIT SUMMARY	TEXT PAGE
Prescription Drug Card	100%, after copay Copays apply per drug/refill.	<p>Retail (34-day supply) Generic: \$10 copay Formulary Brand: \$25 copay Non-Formulary Brand: \$50 copay</p> <p>Retail (90-day supply) Generic: \$25 copay Formulary Brand: \$62.50 copay Non-Formulary Brand: \$125 copay</p> <p>Mail Order (90-day supply) Generic: \$25 copay Formulary Brand: \$62.50 copay Non-Formulary Brand: \$125 copay</p> <p>Insulin and Diabetic Supplies: The copays do not apply.</p> <p>If You choose a Non-Formulary drug when a generic equivalent is available, You will have to pay the difference between the cost of the generic drug and the Non-Formulary drug, in addition to the Non-Formulary copay.</p>	1-37

Appendix B

“Explaining High Health Care
Spending in the United States: An
International Comparison of Supply,
Utilization, Price and Quality”



MAY 2012

Issues in International Health Policy

Explaining High Health Care Spending in the United States: An International Comparison of Supply, Utilization, Prices, and Quality

DAVID A. SQUIRES
THE COMMONWEALTH FUND

ABSTRACT: This analysis uses data from the Organization for Economic Cooperation and Development and other sources to compare health care spending, supply, utilization, prices, and quality in 13 industrialized countries: Australia, Canada, Denmark, France, Germany, Japan, the Netherlands, New Zealand, Norway, Sweden, Switzerland, the United Kingdom, and the United States. The U.S. spends far more on health care than any other country. However this high spending cannot be attributed to higher income, an older population, or greater supply or utilization of hospitals and doctors. Instead, the findings suggest the higher spending is more likely due to higher prices and perhaps more readily accessible technology and greater obesity. Health care quality in the U.S. varies and is not notably superior to the far less expensive systems in the other study countries. Of the countries studied, Japan has the lowest health spending, which it achieves primarily through aggressive price regulation.

★ ★ ★ ★ ★

INTRODUCTION

Health care spending is a key component of any industrialized country's economy. It provides a major source of employment, often for highly skilled workers and in rural areas without other significant industries. In addition, the development of drugs and medical technologies can lead to breakthrough products, innovation hubs, and new markets. Most important, health spending satisfies fundamental individual and social demands for services that bring improved health, greater productivity, and longer lives.

Compared with most other sectors of the economy, a large share of health care is publicly funded. In all industrialized countries, with the exception of the United States, health care affordability is ensured through universal insurance-based or tax-financed systems.¹ In the U.S., public funds contribute to health care through

The mission of The Commonwealth Fund is to promote a high performance health care system. The Fund carries out this mandate by supporting independent research on health care issues and making grants to improve health care practice and policy. Support for this research was provided by The Commonwealth Fund. The views presented here are those of the author and not necessarily those of The Commonwealth Fund or its directors, officers, or staff.

For more information about this study, please contact:

David A. Squires, M.A.
Senior Research Associate
International Program in Health Policy
and Innovation
The Commonwealth Fund
ds@cmwf.org

To learn more about new publications when they become available, visit the Fund's Web site and register to receive e-mail alerts.

Commonwealth Fund pub. 1595
Vol. 10

insurance programs like Medicare and Medicaid, as well as through tax policy that supports employer-sponsored health insurance, delivery systems like the Veterans Health Administration, and research by the National Institutes of Health. Because of the significant public sector stake in health care, ensuring we receive value for this investment is a compelling social concern.

This study updates previous cross-national studies sponsored by The Commonwealth Fund using health data from the Organization for Economic Cooperation and Development (see [Methods](#)).^{2,3} It compares health care spending, supply, utilization, prices, and quality in 13 industrialized countries: Australia, Canada, Denmark, France, Germany, Japan, the Netherlands, New Zealand, Norway, Sweden, Switzerland, the U.K., and the U.S. The analysis finds that the U.S. spends more than all other countries on health care, but this higher spending cannot be attributed to higher income, an aging population, or greater supply or utilization of hospitals and doctors. Instead, it is more likely that higher spending is largely due to higher prices and perhaps more readily accessible technology and greater obesity. Despite being

more expensive, the quality of health care in the U.S. appears to be variable, with better-than-average cancer survival rates, middling in-hospital mortality rates for heart attacks and stroke, and the worst rates of presumably preventable deaths due to asthma and amputations due to diabetes compared with the other study countries. In contrast, Japan, which has the lowest health spending among these countries, controls costs primarily through aggressive price regulation—demonstrating the powerful correlation between health care prices and total spending.

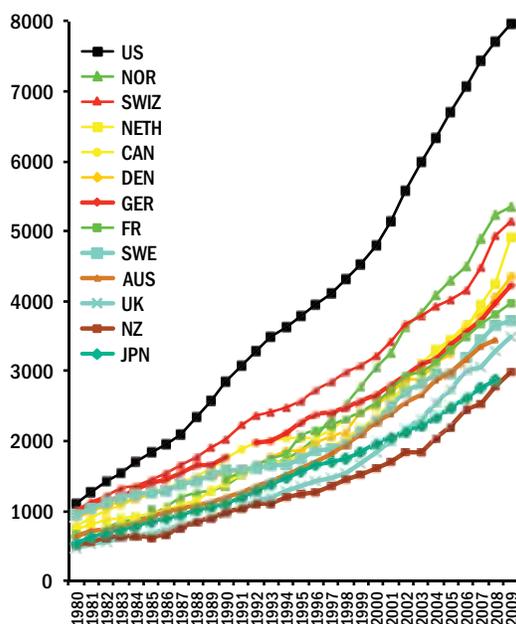
KEY FINDINGS

Health Care Spending in the U.S. Is Far Greater Than in Other Industrialized Countries

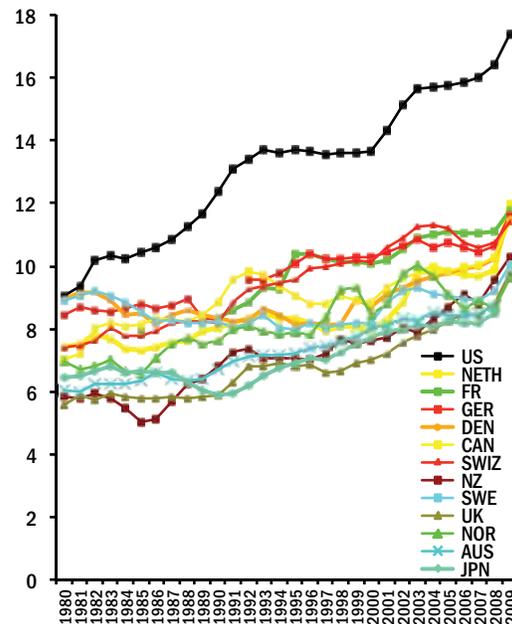
As previous studies have shown, health care spending in the U.S. dwarfs that found in any other industrialized country. In 2009, U.S. spending reached nearly \$8,000 per capita. The other study countries spent between one-third (Japan and New Zealand) and two-thirds (Switzerland and Norway) as much (Exhibits 1 and 2).⁴

Exhibit 1. International Comparison of Spending on Health, 1980–2009

Average spending on health per capita (\$US PPP)



Total expenditures on health as percent of GDP



Note: PPP = Purchasing power parity—an estimate of the exchange rate required to equalize the purchasing power of different currencies, given the prices of goods and services in the countries concerned.

Source: OECD Health Data 2011 (Nov. 2011).

Exhibit 2. Health Spending in Select OECD Countries, 2009

	Population (millions)	GDP per capita ^b	Total health spending		Health spending, by source of financing		
			Per capita ^b	% GDP	Public	Private	Out-of-pocket
Australia	22.0	\$39,924	\$3,445 ^a	8.7% ^a	\$2,342 ^a	\$476 ^a	\$627 ^a
Canada	33.4	\$38,230	\$4,363	11.4%	\$3,081	\$646	\$636
Denmark	5.5	\$37,706	\$4,348	11.5%	—	—	—
France	62.6	\$33,763	\$3,978	11.8%	\$3,100	\$587	\$291
Germany	81.9	\$36,328	\$4,218	11.6%	\$3,242	\$424	\$552
Japan	127.5	\$32,431	\$2,878 ^a	8.5% ^a	\$2,325 ^a	\$99 ^a	\$454 ^a
Netherlands	16.4	\$41,085	\$4,914	12.0%	—	—	—
New Zealand	4.3	\$28,985	\$2,983	10.3%	\$2,400	\$184	\$399
Norway	4.8	\$55,730	\$5,352	9.6%	\$4,501	\$43	\$808
Sweden	9.3	\$37,155	\$3,722	10.0%	\$3,033	\$69	\$620
Switzerland	7.7	\$45,150	\$5,144	11.4%	\$3,072	\$504	\$1,568
United Kingdom	60.9	\$35,656	\$3,487	9.8%	\$2,935	\$188	\$364
United States	306.7	\$45,797	\$7,960	17.4%	\$3,795	\$3,189	\$976
OECD Median	10.7	\$33,434	\$3,182	9.5%	\$2,400	\$193	\$559

^a 2008.

^b Adjusted for differences in cost of living.

Source: OECD Health Data 2011 (Nov. 2011).

Accounting for differences in national income, the U.S. still far outspent the other countries, dedicating more than 17 percent of its gross domestic product (GDP) to health care compared with 12 percent or less in all other countries. These figures reflect health spending inflation that has rapidly surpassed GDP in recent decades.

While there is a positive correlation between health spending and per capita income in the 34 member countries in the Organization for Economic Cooperation and Development (OECD), the higher spending observed in the U.S. does not seem primarily attributable to greater income. In the wealthiest of the study countries, Norway, health spending accounts for only 9.6 percent of GDP—nearly 8 percentage points less than in the U.S. (Exhibit 2). Based on national income and health spending in other OECD countries, a linear regression would predict that U.S. health spending would be \$4,849 per capita or 11 percent of GDP—far less than is actually observed.⁵

Public spending in the U.S. accounted for almost half of all health spending in 2009, whereas in other countries it accounted for between 60 percent (Switzerland) and 84 percent (Norway and the U.K.) However, in terms of spending per capita, only Norway

(\$4,501) had higher public health care spending than the U.S. (\$3,795). In fact, public per capita spending in the U.S. exceeded total per capita health spending in Sweden, the U.K., Australia, New Zealand, and Japan.

U.S. Has Smaller Elderly Population and Fewer Smokers, But Higher Obesity Rates

One potential explanation for the high level of U.S. health care spending is to attribute it to the aging population, as the baby boom generation enters retirement age with correspondingly greater health care needs. However, this theory does not appear to be borne out. While the population is growing older, the U.S. has a relatively young population compared with the other study countries (Exhibit 3). Only 13 percent of the U.S. population was older than 65 in 2009, compared with the OECD median of nearly 16 percent. New Zealand was the only study country with a smaller elderly population than the U.S., whereas more than one-fifth of the populations of Germany and Japan were over 65. Moreover, the proportion of the U.S. population over age 65 has grown relatively slowly in recent years, rising only 0.5 percent since 1999, suggesting that an aging demographic has not been a primary driver of health spending increases over the past decade.

Exhibit 3. Determinants of Health in Select OECD Countries, 2009

	Percent of population over age 65		Tobacco consumption (% population age 15+ who are daily smokers)		Obesity (% population with BMI ≥ 30)	
	1999	2009	1999	2009	1999	2009
Australia	12.3%	13.3%	22.1% ^e	16.6% ^b	21.7%	24.6% ^b
Canada	12.5%	13.9%	23.8% ^e	16.2%	13.6% ^{c,d}	24.2% ^a
Denmark	14.9%	16.1%	31.0%	19.0%	—	—
France	15.9%	16.7%	28.0%	26.2% ^a	8.2% ^{c,d}	11.2% ^{a,c}
Germany	16.1%	20.5%	24.7%	21.9%	11.5% ^c	14.7% ^c
Japan	16.7%	22.7%	33.6%	24.9%	2.8%	3.9%
Netherlands	13.5%	15.2%	27.8%	28.0%	8.7% ^c	11.8% ^c
New Zealand	11.7%	12.8%	26.0%	18.1% ^b	18.8% ^e	26.5% ^b
Norway	15.4%	14.8%	32.0%	21.0%	6% ^{d,c}	10.0% ^{a,c}
Sweden	17.3%	17.9%	19.3%	14.3%	8.1% ^c	11.2% ^c
Switzerland	15.2%	17.2%	28.9% ^f	20.4% ^b	6.8% ^{c,e}	8.1% ^{b,c}
United Kingdom	15.8%	15.8%	27.0% ^e	21.5%	20.0%	23.0%
United States	12.5%	13.0%	19.2%	16.1%	30.5% ^f	33.8% ^a
OECD Median	14.5%	15.8%	26.0%	21.5%	—	—

Note: BMI = body mass index.

^a 2008.

^b 2007.

^c Self-reported data as opposed to directly measured; tends to underestimate.

^d 1998.

^e 1997.

^f 2000.

Source: OECD Health Data 2011 (Nov. 2011).

Lifestyle and behavior are also major determinants of health, which in turn have an impact on health care needs and spending. The OECD reports on several health-related lifestyle and behavioral indicators, including tobacco consumption and obesity. Adults in the U.S. were the least likely to be daily smokers than in all of the study countries except for Sweden. In 2009, 16 percent of U.S. adults were daily smokers compared with the OECD median of 21.5 percent (Exhibit 3). In Japan, France, and the Netherlands, one-quarter or more of the population over age 15 are smokers. Over the past decade, smoking rates have declined in all countries except the Netherlands.

The story is very different for obesity, which is defined as having a body mass index (BMI) equal to or greater than 30. One-third of the U.S. population is obese—higher than the proportion in any OECD country. However, in many countries only self-reported data (rather than direct measurements) are available,

which tend to underestimate obesity. Notably, more than one-fifth of the population is also obese in several study countries, including New Zealand (27%), where the prevalence jumped by nearly 8 percentage points over the past decade compared with only 3 percentage points in the U.S. (Exhibit 3).

Higher rates of obesity undoubtedly inflate health spending; one study estimates the medical costs attributable to obesity in the U.S. reached almost 10 percent of all medical spending in 2008.⁶ However, the younger population and lower rates of smoking likely have an opposite effect, reducing U.S. health care spending relative to most other countries.

U.S. Has Below-Average Supply and Utilization of Physicians, Hospitals Beds

Another commonly assumed explanation for higher U.S. health care spending is that the utilization or supply of health care services in the U.S. must be greater than in

other countries. OECD data suggest, however, that this assumption is unfounded, at least when it comes to physician and hospital services. There were 2.4 physicians per 1,000 population in the U.S. in 2009, fewer than in all other study countries except Japan. Likewise, patients had fewer doctor consultations in the U.S. (3.9 per capita) than in any other country except Sweden (Exhibit 4).

Hospital supply and use showed similar trends, with the U.S. having fewer hospital beds (2.7 per 1,000 population), shorter lengths of stay for acute care (5.4 days), and fewer discharges (131 per 1,000 population) than the OECD median (Exhibit 4). Exhibit 5, however, shows that hospital stays in the U.S. were far more expensive than in the other study countries, exceeding \$18,000 per discharge compared with less than \$10,000 in Sweden, Australia, New Zealand, France, and Germany. This could indicate that U.S. hospital stays tend to be more resource-intensive than in other countries or that the prices for hospital services are higher.

Prices for Drugs, Office Visits, and Procedures Are Highest in the U.S.

Exhibit 6 shows prices for selected health services and products to be higher in the U.S.—far higher, in some cases—than in the other study countries. According to an analysis by Gerard Anderson of IMS Health data, U.S. prices for the 30 most-commonly prescribed drugs are one-third higher than in Canada and Germany, and more than double the prices in Australia, France, Netherlands, New Zealand, and the U.K. (Exhibit 6).⁷ Notably, prices for generic drugs are lower in the U.S. than in these other countries, whereas prices for brand-name drugs are much higher.

Spending on physician services is an even larger component of total health spending than pharmaceuticals. In an analysis published in *Health Affairs* in 2011, Miriam Laugesen and Sherry Glied found U.S. primary care physicians generally receive higher fees for office visits and orthopedic physicians receive higher fees for hip replacements than in Australia, Canada,

Exhibit 4. Supply and Utilization of Doctors and Hospitals in Select OECD Countries, 2009

	Physician supply and use		Hospital supply and use		
	Practicing physicians per 1,000 population	Doctor consultations per capita	Acute care hospital beds per 1,000 population	Average length of stay for acute care (days)	Hospital discharges per 1,000 population
Australia	3.0 ^a	6.5	—	5.9 ^a	162 ^a
Canada	—	5.5 ^a	1.8 ^a	7.7 ^a	84 ^a
Denmark	3.4 ^a	4.6	2.9	—	170
France	—	6.9	3.5	5.2	263
Germany	3.6	8.2	5.7	7.5	237
Japan	2.2 ^a	13.2 ^a	— ^d	— ^d	— ^d
Netherlands	—	5.7	3.1	5.6	117
New Zealand	2.6	4.3 ^b	—	5.9 ^a	142 ^a
Norway	4.0	—	2.4	4.6	177
Sweden	3.7 ^a	2.9	2.0	4.5	166
Switzerland	3.8	4.0 ^b	3.3	7.5	168
United Kingdom	2.7	5.0	2.7	6.8	138
United States	2.4	3.9 ^a	2.7 ^b	5.4	131 ^a
OECD Median	3.0	6.3	3.2	5.9	160

^a 2008.

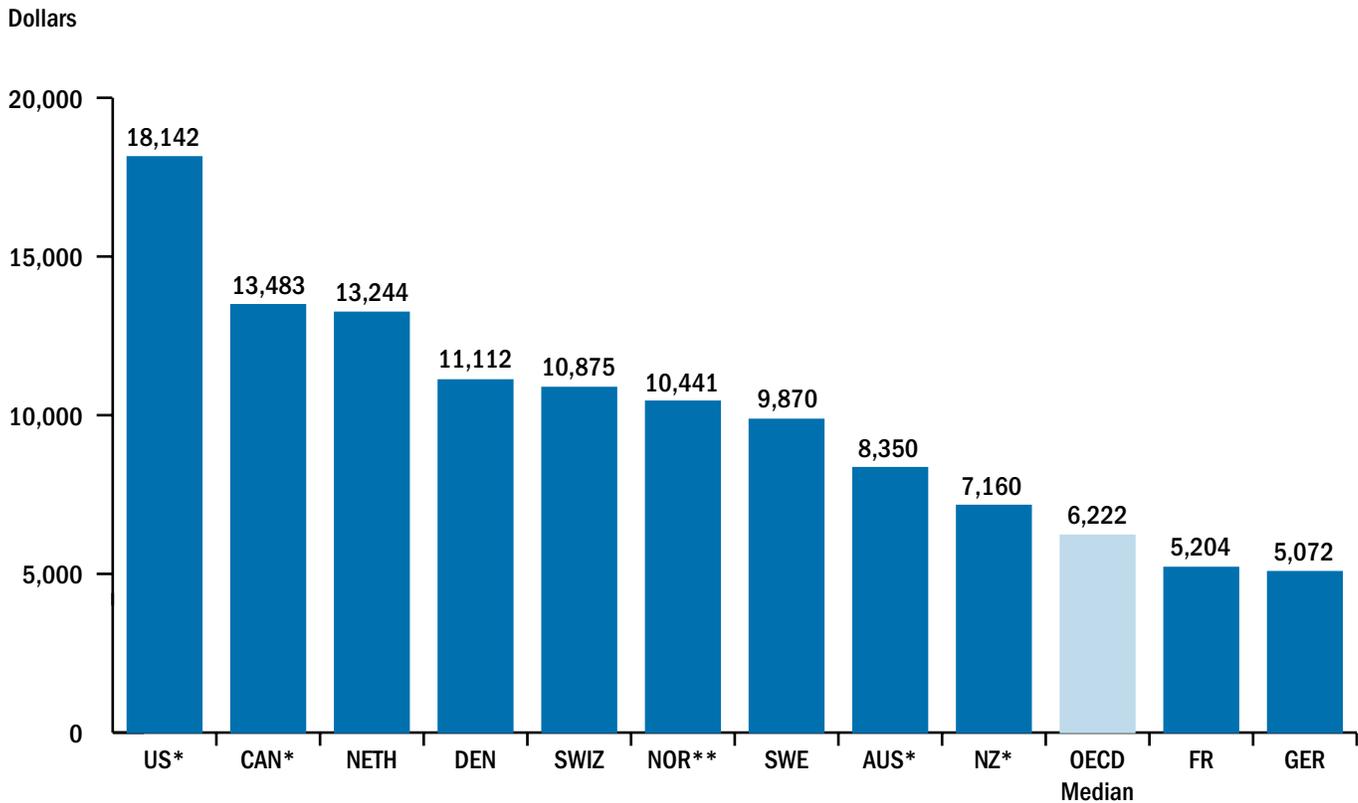
^b 2007.

^c Adjusted for differences in cost of living.

^d A significant amount of hospital care is dedicated to long-term care in Japan, making cross-national comparison difficult.

Source: OECD Health Data 2011 (Nov. 2011).

Exhibit 5. Hospital Spending per Discharge, 2009
Adjusted for Differences in Cost of Living



* 2008.

** 2007.

Source: OECD Health Data 2011 (Nov. 2011).

Exhibit 6. Drug Prices and Physician Fees in Select OECD Countries

	Prices for 30 most commonly prescribed drugs, 2006-07 (U.S. set at 1.00) ^a			Primary care physician fee for office visits, 2008 ^{b,c}		Orthopedic physician fee for hip replacements, 2008 ^{b,c}	
	Brand name	Generic	Overall	Public payer	Private payer	Public payer	Private payer
Australia	0.40	2.57	0.49	\$34	\$45	\$1,046	\$1,943
Canada	0.64	1.78	0.77	\$59	—	\$652	—
France	0.32	2.85	0.44	\$32	\$34	\$674	\$1,340
Germany	0.43	3.99	0.76	\$46	\$104	\$1,251	—
Netherlands	0.39	1.96	0.45	—	—	—	—
New Zealand	0.33	0.90	0.34	—	—	—	—
Switzerland	0.51	3.11	0.63	—	—	—	—
United Kingdom	0.46	1.75	0.51	\$66	\$129	\$1,181	\$2,160
United States	1.00	1.00	1.00	\$60	\$133	\$1,634	\$3,996
Median (countries shown)	0.43	1.96	0.51	\$53	\$104	\$1,114	\$2,052

^a Source: Analysis by G. Anderson of IMS Health data.

^b Adjusted for differences in cost of living.

^c Source: M.J. Laugesen and S.A. Glied, "Higher Fees Paid to U.S. Physicians Drive Higher Spending for Physician Services Compared to Other Countries," *Health Affairs*, Sept. 2011 30(9):1647-56.

France, Germany, and the U.K. (Exhibit 6).⁸ This was true whether the payers were public or private, though in every country private payers paid higher fees than public payers (where data was available). Not surprising, Laugesen and Glied also found that U.S. primary care doctors (\$186,582) and particularly orthopedic doctors (\$442,450) earned greater income than in the other five countries (Exhibit 7).

Use of Expensive Medical Technology More Common in the U.S.

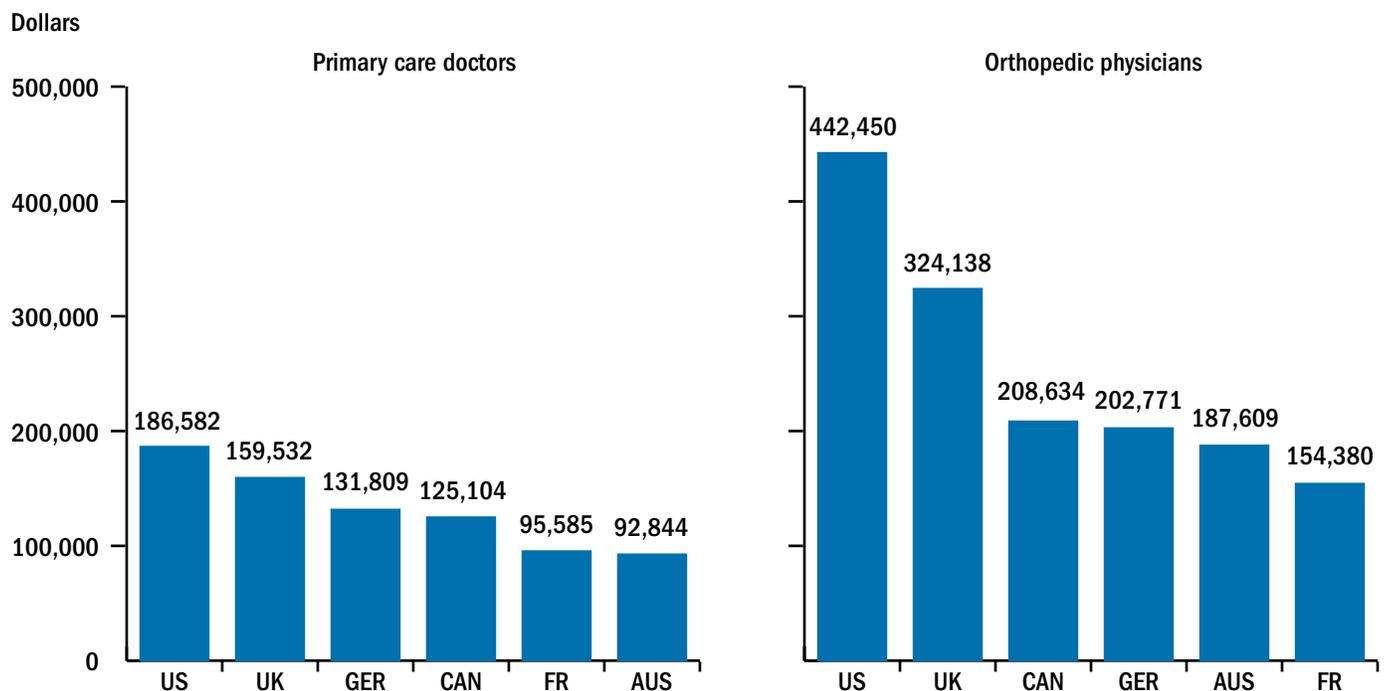
The final potential explanation for high U.S. health spending considered in this study is greater use of more expensive medical technology than other countries. The OECD tracks the volume of several types of procedures, including hip and knee replacements—two generally elective procedures that involve expensive medical devices. In 2009, the U.S., along with Germany, performed the most knee replacements (213 per 100,000 population) among the study countries, and 75 percent more knee replacements than the OECD median (122

per 100,000 population). However, the U.S. performed barely more hip replacements than the OECD median, and significantly less than several of the other study countries (Exhibit 8).

The OECD also tracks the supply and utilization of several types of diagnostic imaging devices—important and often costly technologies. Relative to the other study countries where data were available, there were an above-average number of magnetic resonance imaging (MRI) machines (25.9 per million population), computed tomography (CT) scanners (34.3 per million), positron emission tomography (PET) scanners (3.1 per million), and mammographs (40.2 per million) in the U.S. in 2009 (Exhibit 9). Utilization of imaging was also highest in the U.S., with 91.2 MRI exams and 227.9 CT exams per 1,000 population. MRI and CT devices were most prevalent in Japan, though no utilization data were available for that country.

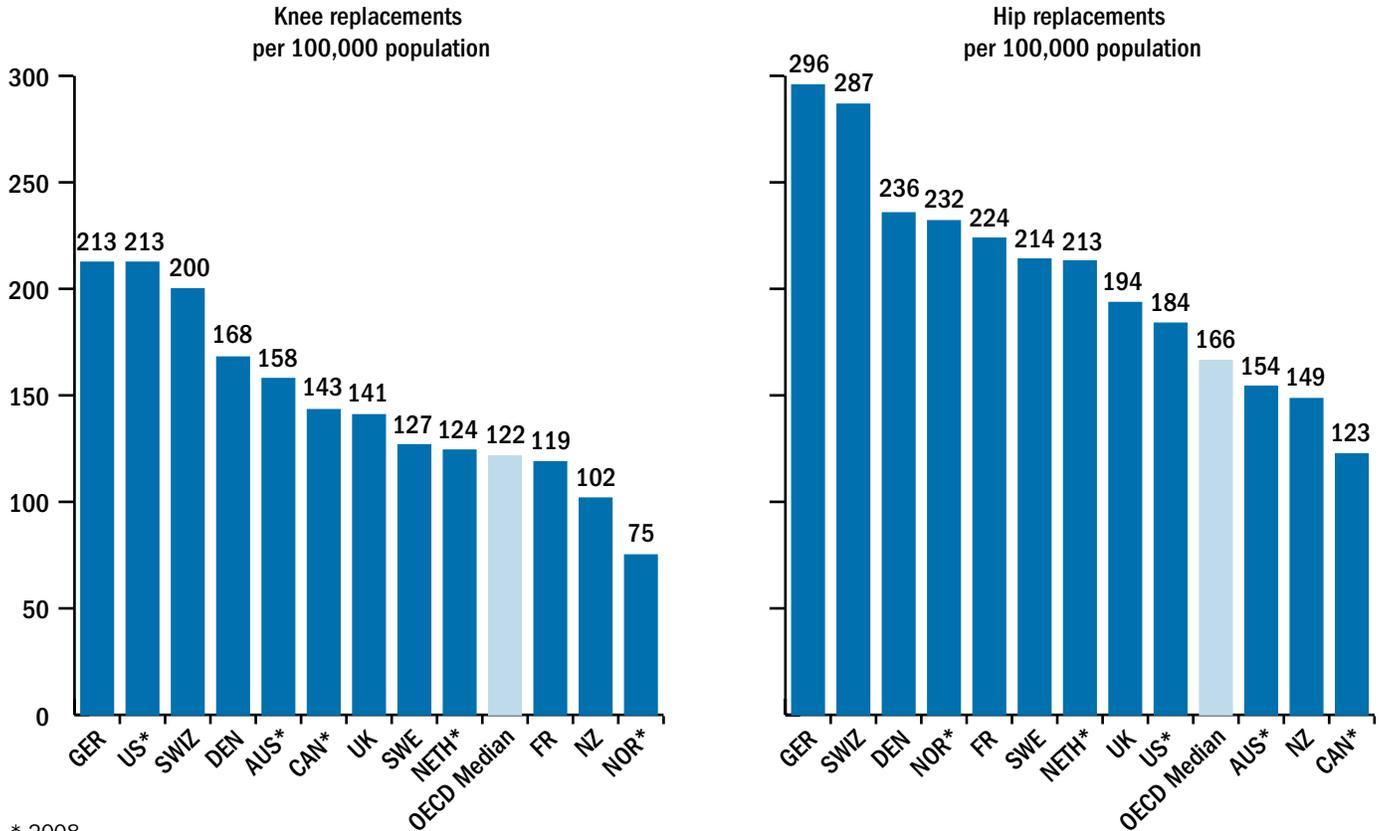
The International Federation of Health Plans—a membership organization of health insurance companies from over 30 countries—issues an annual report tracking

Exhibit 7. Physician Incomes, 2008
Adjusted for Differences in Cost of Living



Source: M. J. Laugesen and S. A. Glied, “Higher Fees Paid to U.S. Physicians Drive Higher Spending for Physician Services Compared to Other Countries,” *Health Affairs*, Sept. 2011 30(9):1647–56.

Exhibit 8. Volume of Knee and Hip Replacements, 2009



* 2008.

** 2007.

Source: OECD Health Data 2011 (Nov. 2011).

Exhibit 9. Diagnostic Imaging in Select OECD Countries

	MRI machines			CT scanners			PET scanners	Mammographs
	Devices per million pop., 2009 ^c	Exams per 1,000 pop., 2009 ^c	MRI scan fees, 2011 ^d	Devices per million pop., 2009 ^c	Exams per 1,000 pop., 2009 ^c	CT scan (head) fees, 2011 ^d	Devices per million pop., 2009 ^c	Devices per million pop., 2009 ^c
Australia	5.9	23.3	—	38.7	93.9	—	1.1	24.3
Canada	8.0	43.0	—	13.9	125.4	\$122 ^e	1.1	—
Denmark	15.4	37.8 ^a	—	23.7	83.8 ^a	—	5.6	17.0
France	6.5	55.2	\$281	11.1	138.7	\$141	0.9	—
Germany	—	—	\$599	—	—	\$272	—	—
Japan	43.1 ^a	—	—	97.3 ^a	—	—	3.7 ^a	29.7 ^a
Netherlands	11.0	43.9	—	11.3	65.7	—	4.5	—
New Zealand	9.7	—	—	14.6	—	—	0.5	26.4
Switzerland	—	—	\$903	32.8	—	\$319	3.0	33.2
United Kingdom	5.6 ^a	—	—	7.4 ^a	—	—	—	9.0
United States	25.9 ^b	91.2 ^b	\$1,080 ^f	34.3 ^b	227.9 ^b	\$510 ^f	3.1 ^a	40.2 ^a
Median (countries shown)	8.9	43.0	—	15.1	122.8	—	1.1	17.3

^a 2008.^b 2007.^c Source: OECD Health Data 2011 (Nov. 2011).^d Source: International Federation of Health Plans, 2011 Comparative Price Report: Medical and Hospital Fees by Country (London: IFHP, 2011).^e Nova Scotia only.^f U.S. commercial average.

health care prices around the world.⁹ Data from their 2011 report indicate that the U.S. commercial average diagnostic imaging fees (\$1,080 for an MRI and \$510 for a CT exam) are far higher than what is charged in almost all of the other countries (Exhibit 9). This combination of pervasive medical technology and high prices showcases two potent drivers of U.S. health spending, and a possible explanation for the outsized share of resources we dedicate to health care relative to the rest of the world.

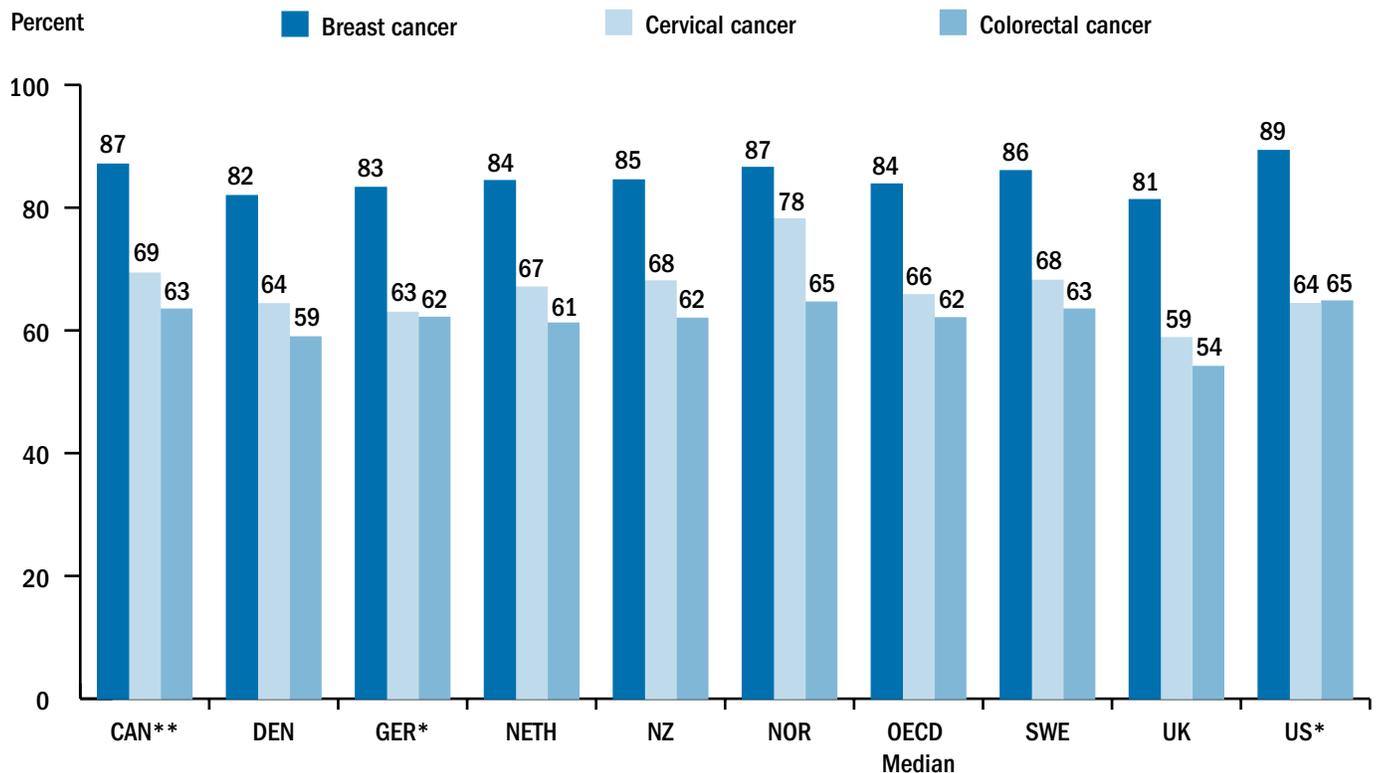
Despite High Health Care Spending, Quality Indicators Show Variable Performance in the U.S.

An array of health care quality indicators included in the 2011 OECD Health Data database provides insight into the performance of each country’s health care system. The findings make clear that, despite high costs, quality in the U.S. health care system is variable and not notably superior to the far less expensive systems in the other study countries.

Exhibit 10 shows the five-year survival rates for breast, cervical, and colorectal cancers. The U.S. had the highest survival rates among the study countries for breast cancer (89%) and, along with Norway, for colorectal cancer (65%). However, at 64 percent, the survival rate for cervical cancer in the U.S. was worse than the OECD median (66%), and well below the 78 percent survival rate in Norway—indicating significant room for improvement. Notably, the U.K. had the lowest survival rates for all three forms of cancer.

Exhibit 11 shows rates of potentially preventable mortality due to asthma (for those between ages 5 and 39) and lower-extremity amputations due to diabetes per 100,000 population. On both measures, the U.S. had among the highest rates, suggesting a failure to effectively manage these chronic conditions that make up an increasing share of the disease burden.¹⁰ Exhibit 11 also shows rates of in-hospital fatality rates—that is, the ratio of in-hospital deaths among people admitted with a particular condition—within 30 days of admission for

Exhibit 10. Five-Year Survival Rate for Select Cancers, 2004–2009



Note: Breast and cervical cancer rates are age-standardized; colorectal cancer rates are age–sex standardized.

* 2003–08.

** 2002–07.

Source: OECD Health Data 2011 (Nov. 2011).

Exhibit 11. Quality Indicators in Select OECD Countries, 2009

	Asthma mortality among ages 5 to 39 per 100,000 population	Diabetes lower extremity amputations per 100,000 population	In-hospital fatality rate within 30 days of admission per 100 patients ^c		
			Acute myocardial infarction	Ischemic stroke	Hemorrhagic stroke
Australia	0.13	11.0	3.2	5.7	17.2
Canada	0.17 ^b	9.5	3.9	6.3	20.6
Denmark	0.08	18.1	2.3	2.6	16.4
France	—	12.6 ^b	—	—	—
Germany	0.17 ^b	33.7	6.8	4.0	13.8
Japan	—	—	9.7 ^a	1.8 ^a	9.7 ^a
Netherlands	0.09 ^a	12.0 ^b	5.3 ^b	5.7 ^b	22.5 ^b
New Zealand	0.43 ^b	7.0	3.2	5.4	21.1
Norway	0.27	9.9	2.6	2.8	11.6
Sweden	0.01 ^a	5.7	2.9 ^b	3.9 ^b	12.8
Switzerland	—	7.4 ^a	4.5 ^a	—	14.8 ^a
United Kingdom	0.27	4.8	5.2	6.8	19.3
United States	0.40 ^b	32.9 ^a	4.3 ^a	3.0 ^a	21.0 ^a
OECD Median	0.09	9.9	4.6	4.9	19.3

Note: Rates are age–sex standardized.

^a 2008.

^b 2007.

^c Figures do not account for death that occurs outside of the hospital, possibly influencing the ranking for countries, such as the U.S., that have shorter lengths of stay.

Source: OECD Health Data 2011 (Nov. 2011).

acute myocardial infarctions and ischemic and hemorrhagic stroke.¹¹ U.S. performance on these measures was middling: the fatality rate for acute myocardial infarctions was roughly average in the U.S. (4.3 deaths per 100 patients) compared with the study countries, the rate for ischemic stroke (3.0 deaths per 100 patients) was somewhat better than average, and the rate for hemorrhagic stroke (21.0 deaths per 100 patients) was somewhat worse than average.

DISCUSSION

U.S. health care spending, which reached nearly \$8,000 per person annually in 2009, has outpaced GDP growth for the past several decades and far exceeds spending in any other country. The analysis in this brief suggests that this spending cannot be attributed to higher income, an aging population, or greater supply or utilization of hospitals and doctors. Instead, it is more likely that higher spending is largely due to higher prices and perhaps

because of more readily accessible technology and greater rates of obesity. Despite being more expensive, the quality of health care in the U.S. does not appear to be notably superior to other industrialized countries.

Such an expensive health system creates an enormous financial strain and can pose a barrier to accessing care. For many U.S. households, health care has become increasingly unaffordable. In 2010, four of 10 adults went without care because of costs and the number of either uninsured or “underinsured” (i.e., people with health coverage that does not adequately protect them from high medical expenses) increased to more than 80 million.¹² A 2007 survey in five states found that difficulty paying medical bills contributed to 62 percent of all bankruptcies, up 50 percent from 2001.¹³ For the average worker with employer-based health insurance, growth in premiums and cost-sharing has largely erased wage gains over the past decade.¹⁴

Rising health care spending has a profound effect on public budgets as well. Federal spending on Medicare and Medicaid increased from 1 percent to 5 percent of GDP between 1970 and 2009, and is projected to reach 12 percent by 2050.¹⁵ The Congressional Budget Office has identified it as the primary cause of projected federal budget deficits.¹⁶ Medicaid spending also impacts state budgets, increasing faster than and potentially crowding out other socially desirable budget items, such as education and infrastructure.

While all the countries in this study struggle in one way or another with health care costs, financing the U.S. health system requires a unique commitment of resources. Were the U.S. to spend the same share of GDP on health care as the Netherlands—the country spending the next-largest share of GDP—savings for the nation as a whole would have been \$750 billion in 2009 alone. Were the U.S. to spend the same share of GDP as Japan, savings would have totaled \$1.25 trillion—an amount larger than the U.S. defense budget.

As the lowest-spending nation in this study, Japan offers an interesting contrast to the U.S. In some ways, the two countries' health systems share similar features. Japan operates a fee-for-service system, characterized by unrestricted access to specialists and hospitals.¹⁷ Advanced medical technology also appears to be widely available, with Japan having the most CT scanners and MRI machines among the countries in this study. Yet health spending in Japan as a share of GDP has increased by only 2 percentage points in the past three decades, compared with an increase of more than 8 percentage points in the U.S. over the same period.

Notably, the Japanese do not restrain spending by restricting access; rather, they do so by aggressively regulating health care prices.¹⁸ Every two years, a panel of experts uses volume projections to revise the national fee schedule, which determines the maximum prices for

nearly all health services, to keep total health spending growth within a target set by the central government. Providers' profitability is also monitored, and when certain categories of providers (e.g., acute care hospitals or ambulatory specialists) demonstrate significantly greater profitability than the average, prices for their services are reduced. Despite such overt price controls, the results are hard to dispute—the Japanese enjoy the longest life expectancy in the world.

In the U.S., private payers individually negotiate prices with health care providers, in a process characterized by administrative complexity and a lack of transparency. For example, hospitals often charge different payers widely varying prices that are, on average, far below those listed on hospitals' official price lists.¹⁹ The economist Uwe Reinhardt and others have argued that such price discrimination is not in the public interest, and that an all-payer system—as in Japan, Germany, and several other nations—would be more equitable, efficient, and potentially effective at reining in spending growth.²⁰ Such a system is not completely foreign to the U.S. The state of Maryland has operated an all-payer system for hospitals since 1977, and has seen costs per admission rise slower than the national average.²¹

Inevitably, efforts to control health care spending involve trade-offs, and many such efforts—whether restricting access or regulating prices—come with a cost. Lower drug prices may lead to less research and development and, consequently, fewer pharmaceutical breakthroughs. Lower provider incomes could reduce the quality of applicants choosing a career in medicine. These drawbacks need to be measured against the opportunity costs of health care crowding out other forms of public investment, and of vulnerable household budgets being exposed to the most expensive health care system in the world.

METHODS

The Organization for Economic Cooperation and Development (OECD) annually tracks and reports on more than 1,200 health system measures across 34 industrialized countries, ranging from population health status and non-medical determinants of health to health care resources and utilization. This analysis examined 2011 OECD health data for 13 countries: Australia, Canada, Denmark, France, Germany, Japan, Netherlands, New Zealand, Norway, Sweden, Switzerland, the United Kingdom, and the United States. This brief presents data for the year 2009 or, where not available, 2008 or 2007. The median for all OECD countries is also included in Exhibits 2, 3, 4, 5, 8, 10 and 11; for Exhibits 6 and 9, the median is included for only the countries shown, because of incompleteness of data. All currency amounts are listed in U.S. dollars (USD) and adjusted for national differences in cost of living.

Data are also included from an analysis by Gerard Anderson of IMS Health data on pharmaceutical prices; an analysis by Miriam Laugesen and Sherry Glied on physician fees and income, originally published in *Health Affairs*; and the International Federation of Health Plans on the cost of diagnostic tests.

NOTES

- ¹ S. Thomson, R. Osborn, D. A. Squires, and S. J. Reed, *International Profiles of Health Care Systems, 2011* (New York: The Commonwealth Fund, Nov. 2011).
- ² Organization for Economic Cooperation and Development, *OECD Health Data 2011* (Paris: OECD, Nov. 2011).
- ³ D. A. Squires, *The U.S. Health System in Perspective: A Comparison of Twelve Industrialized Nations* (New York: The Commonwealth Fund, July 2011); G. F. Anderson and D. A. Squires, *Measuring the U.S. Health Care System: A Cross-National Comparison* (New York: The Commonwealth Fund, June 2010); G. F. Anderson and B. K. Frogner, "Health Spending in OECD Countries: Obtaining Value per Dollar," *Health Affairs*, Nov./Dec. 2008 27(6):1718–27; G. F. Anderson, B. K. Frogner, and U. E. Reinhardt, "Health Spending in OECD Countries in 2004: An Update," *Health Affairs*, Sept./Oct. 2007 26(5):1481–89; G. F. Anderson, P. S. Hussey, B. K. Frogner et al., "Health Spending in the United States and the Rest of the Industrialized World," *Health Affairs*, July/Aug. 2005 24(4):903–14; U. E. Reinhardt, P. S. Hussey, and G. F. Anderson, "U.S. Health Care Spending in an International Context," *Health Affairs*, May/June 2004 23(3):10–25; G. F. Anderson, U. E. Reinhardt, P. S. Hussey et al., "It's the Prices, Stupid: Why the United States Is So Different from Other Countries," *Health Affairs*, May/June 2003 22(3):89–105; U. E. Reinhardt, P. S. Hussey, and G. F. Anderson, "Cross-National Comparisons of Health Systems Using OECD Data, 1999," *Health Affairs*, May/June 2002 21(3):169–81; G. F. Anderson and P. S. Hussey, "Comparing Health System Performance in OECD Countries," *Health Affairs*, May/June 2001 20(3):219–32; G. F. Anderson, J. Hurst, P. S. Hussey et al., "Health Spending and Outcomes: Trends in OECD Countries, 1960–1998," *Health Affairs*, May/June 2000 19(3):150–57; and G. F. Anderson and J. P. Poullier, "Health Spending, Access, and Outcomes: Trends in Industrialized Countries," *Health Affairs*, May/June 1999 18(3):178–92.

- ⁴ All dollar amounts are adjusted for differences in the cost of living between countries.
- ⁵ Regression includes all OECD countries, except Luxembourg. For health spending per capita: coefficient = 0.125 and intercept = -876. For health spending as a percentage of GDP: coefficient = 0.000121 and intercept = 5.589. Similar analysis in Anderson and Frogner, “Health Spending in OECD Countries,” 2008.
- ⁶ E. A. Finkelstein, J. G. Trogon, J. W. Cohen et al., “Annual Medical Spending Attributable to Obesity: Payer- and Service-Specific Estimates,” *Health Affairs*, Sept./Oct. 2009 28(5):w822–w831.
- ⁷ G. F. Anderson and P. Markovich, *Multinational Comparisons of Health Systems Data, 2010* (New York: The Commonwealth Fund, July 2011).
- ⁸ M. J. Laugesen and S. A. Glied, “Higher Fees Paid to U.S. Physicians Drive Higher Spending for Physician Services Compared to Other Countries,” *Health Affairs*, Sept. 2011 30(9):1647–56.
- ⁹ International Federation of Health Plans, *2011 Comparative Price Report: Medical and Hospital Fees by Country* (London: IFHP, 2011), available at http://www.ifhp.com/documents/2011iFHPPriceReportGraphs_version3.pdf.
- ¹⁰ Centers for Disease Control and Prevention, Chronic Diseases and Health Promotion.
- ¹¹ This measure does not account for deaths that occur outside the hospital to which the patient was admitted, meaning rates may be influenced by referral patterns and hospital lengths of stay.
- ¹² Underinsured adults are those between ages 19 and 64 with: family out-of-pocket medical care expenses (not including premiums) that are 10 percent or more of income; among low-income adults (i.e., incomes below 200 percent of the federal poverty level), medical expenses that are 5 percent or more of income; or per-person deductibles that are 5 percent or more of income. See C. Schoen, M. M. Doty, R. H. Robertson, and S. R. Collins, “Affordable Care Act Reforms Could Reduce the Number of Underinsured U.S. Adults by 70 Percent,” *Health Affairs*, Sept. 2011 30(9):1762–71.
- ¹³ D. U. Himmelstein, D. Thorne, E. Warren et al., “Medical Bankruptcy in the United States, 2007: Results of a National Study,” *American Journal of Medicine*, Aug. 2009 122(8):741–46.
- ¹⁴ D. I. Auerbach and A. L. Kellermann, “A Decade of Health Care Cost Growth Has Wiped Out Real Income Gains for an Average U.S. Family,” *Health Affairs*, Sept. 2011 30(9):1630–36.
- ¹⁵ M. E. Chernew, K. Baicker, and J. Hsu, “The Specter of Financial Armageddon—Health Care and Federal Debt in the United States,” *New England Journal of Medicine*, April 1, 2010 362(13):1166–68.
- ¹⁶ Letter from Douglas W. Elmendorf, Director, Congressional Budget Office to Kent Conrad, Chairman, Senate Committee on the Budget, June 16, 2009, <http://www.cbo.gov/sites/default/files/cbofiles/ftpdocs/103xx/doc10311/06-16-healthreformandfederalbudget.pdf>.
- ¹⁷ D. A. Squires, “The Japanese Health Care System,” in: Thomson, Osborn, Squires, and Reed, *International Profiles of Health Care Systems*, 2011.
- ¹⁸ N. Ikegami and J. C. Campbell, “Japan’s Health Care System: Containing Costs and Attempting Reform,” *Health Affairs*, May/June 2004 23(3):26–36.
- ¹⁹ U. E. Reinhardt, “The Pricing of U.S. Hospital Services: Chaos Behind a Veil of Secrecy,” *Health Affairs*, Jan./Feb. 2006 25(1):57–69.
- ²⁰ U. E. Reinhardt, “The Many Different Prices Paid to Providers and the Flawed Theory of Cost Shifting: Is It Time for a More Rational All-Payer System?” *Health Affairs*, Nov. 2011 30(11):2125–33.
- ²¹ R. Murray, “Setting Hospital Rates to Control Costs and Boost Quality: The Maryland Experience,” *Health Affairs*, Sept./Oct. 2009 28(5):1395–405.

ABOUT THE AUTHOR

David A. Squires, M.A., is senior research associate for the International Program in Health Policy and Innovation at The Commonwealth Fund. He is responsible for research support for the Fund's annual international health policy surveys; researching and tracking health care policy developments in industrialized countries; preparing presentations; monitoring the research projects of the current class of Harkness Fellows; and tracking the impact of the fellows' projects and publications on U.S. and home country policy. Squires joined the Fund in September 2008, having worked for Abt Associates, Inc., as associate analyst in domestic health for the previous two years. Squires graduated magna cum laude with a B.A. in English and minors in economics and philosophy from Bates College. He holds a master's degree in bioethics from New York University.

ACKNOWLEDGMENTS

The author would like to thank Robin Osborn, Cathy Schoen, and Tony Shih for their contributions to this brief.

Editorial support was provided by Deborah Lorber.



Appendix C

Wisconsin Health Insurance Cost Rankings 2013

EMBARGOED UNTIL 9:30 AM Wednesday December 19, 2012



Wisconsin Health Insurance Cost Rankings 2013

Robert Kraig, Ph.D.
Citizen Action of Wisconsin

Release Date: December 19, 2012

Executive Summary

This is the 7th annual report on Wisconsin regional health insurance costs.

This report comes at a crucial time in the health care reform debate, as Wisconsin and the nation prepare for full implementation of the Affordable Care Act. The 2013 Wisconsin Health Insurance Cost Ranking Report sheds light on how health insurance hyperinflation is impacting the major regions of the state, and therefore provides valuable insights for policymakers seeking to use the Affordable Care Act to reform the health insurance market. The findings have especially important implications for the development of competitive health insurance marketplaces (health insurance exchanges), which in Wisconsin will be developed by the federal government during 2013 for implantation on January 1, 2014.

Although there has been a great deal of attention to higher than average health insurance costs in Wisconsin, and especially in the Milwaukee area, until we began this annual report there was very little analysis of relative cost between the regions of the state. Since its inception in 2006, the annual Wisconsin Health Insurance Cost Ranking report has received a great deal of attention across the state because it provides such a measure. The report has consistently shown that although costs are high across Wisconsin, that some regions of the state pay thousands of dollars more for health insurance than others. These regional disparities have critical public policy implications.

Beginning with the 2009 report, the annual Wisconsin Health Insurance Cost Ranking was enhanced with retrospective data which makes it possible to measure the rate of health care inflation in each metro area since 2000.

A new enhancement added for 2010 was quality ratings of the health care plans available in each metro area of Wisconsin. This information makes it possible to examine the relationship between health insurance costs and the quality of insurance that is provided, as measured by key benchmarks such as consumer satisfaction, preventative care, disease management, mental health, and responsiveness to consumers.

Although this is the third Wisconsin Insurance Cost Ranking report since the passage of the Affordable Care Act, it is too early for national health care reform to have had any significant affect on the health insurance rates measured in this report. This report draws on data from the large group health insurance market (not the individual and small group markets). The new insurance regulations that went into effect in 2010 and 2011 have little impact on large group health insurance coverage because most of the requirements are already met. The significant impacts of the Affordable Care Act on health insurance rates will begin to take place beginning in 2014, when the federal health insurance exchanges for the small group and the individual market begin operation in Wisconsin.

This annual report is made possible in part by the generous support of the Nathan Cummings Foundation, Brico Fund, Families USA Foundation, and individual supporters throughout Wisconsin.

Key Findings in 2013 Report (See ranking charts pp. 11-13)

1. There continue to be wide cost variations between higher and lower cost areas of the state. There is a 24% variation between the highest cost major metro area (Milwaukee and Racine) and the lowest cost metro area (Madison), which amounts to a \$1,809 difference for a single policy each year (see Chart 1, p. 11, Chart 3, p. 12). Although this variation is still extremely high, it declined by 8% in a single year because Madison had the highest 1 year health insurance inflation in the state.
2. Madison had 8% health insurance rate inflation in 2012-13, double the state average, although Madison remains the lowest cost area (See Chart 4, p. 12). This inflationary burst may reflect alarming changes in patterns of competition in the Madison health care market. (This is elaborated in the discussion section of the report).
3. Wisconsin health insurance rates have nearly doubled since 2000, increasing 193% for a similar benefit package, with regional rates of inflation varying between a low of 149% in Madison to 324% in Green Bay and 217% in Appleton and Oshkosh (See Chart 2, p. 11).
4. The rate of health insurance inflation has differed greatly between regions since the beginning of the new century, with Green Bay, the Fox Valley, and Milwaukee suffering the worst hyperinflation. As a result, the geographic distribution of health insurance costs in Wisconsin has shifted substantially since the current health care cost run up began a decade ago. In 2000, Northeast Wisconsin was the lowest cost area, but has suffered from much higher than average health insurance inflation this decade. In this year's report, for only the second time, Green Bay and the Fox Valley have health insurance costs above the state average. Over the past decade Green Bay has had the highest rate of health care inflation of any major metro area in the state, followed by Appleton, Oshkosh, and Milwaukee. In 2000, Madison was in the middle of the pack but is now by far the lowest cost metro area. (See Chart 2, p. 11, Chart 3, p. 12).
5. This report finds that there is no correlation between quality and health insurance costs, with some of the low cost areas of the state having higher quality insurance plans and some higher costs areas having lower quality. In fact, in this year's report there is an inverse correlation between cost and quality. Madison, the lowest cost area, is the highest in quality, while Milwaukee and Racine are the highest cost areas but have the lowest quality.
6. There is a strong correlation between type of insurance and quality, with the national for-profit companies having below average to poor quality and the regional non-profit provider-driven networks offering the highest quality plans. Metro areas with a preponderance of for-profit insurance, such as Milwaukee, Racine, and Kenosha, have much lower quality while areas with non-profit provider driven networks have the highest quality. Areas like Green Bay and the Fox Valley which have a mix of for-profit and non-profit plans are middling in quality (See Chart 5 and Chart 6, p. 13).
7. For the first time in the history of the report, Milwaukee and Racine had the highest health insurance costs. However, the regions with the highest costs have remained relatively constant over the past seven years. Southeastern, Northwestern, West Central, and North Central Wisconsin continue to be high cost regions. The highest cost

metro areas in 2013 are Milwaukee, Racine, Eau Claire, La Crosse, and the region centering around Wausau. (See Chart 1, p. 11).

Introduction

Although health insurance hyperinflation is a national phenomenon, there is a substantial research indicating that the problem is even worse in Wisconsin.

- A December 2012 Commonwealth Fund study found that family health insurance premiums in Wisconsin increased by 62% from 2003-2011 for a declining quality of coverage that shifts more costs onto employees. In Wisconsin deductibles increased by 159% for single plans and 158% for family plans, and premiums as a proportion of median income increased from 14.9% to 20.4% over the same time period.¹
- A December 2012 Study by the Greater Milwaukee Business Foundation on Health Inc. found that physician fees in Southeast Wisconsin in 2011 were 20-25% above the Midwest average.²
- The Greater Milwaukee Business Foundation on Health Inc. study (December 2012) also found that Southeast Wisconsin health care premiums in 2011 were \$666 per year higher than the Midwest average, and \$528 per year higher than the national average.³
- American Hospital Association data shows that Wisconsin hospital operating margins are 62% above the national average.⁴
- According to a Families USA Report co-released by Citizen Action of Wisconsin, Wisconsin health insurance premiums have risen 4.8 times faster than wages since 2000.⁵
- A 2005 U.S. Government Accountability Office (GAO) Study found that out of 319 metro areas, 8 of the top 10 cities in the nation for physician costs, and 2 of the top 10 cities for hospital costs, are in Wisconsin.⁶
- According to a 2006 Greater Milwaukee Business Foundation on Health study, specialists in Milwaukee charge 30-40% more for the same procedures as their counterparts in Cincinnati, St. Louis, and Kansas City.⁷
- A 2004 GAO Study found Milwaukee metro area health care costs are 27% above the national average.⁸

Health insurance hyperinflation is placing severe stress on Wisconsin's employer-based health insurance system. Laura Dresser, Joel Rogers, and Edo Navot in *The State of Working Wisconsin* (September 2010) document the precipitous decline of employment-based health insurance coverage in Wisconsin. In 1979, 73% of Wisconsin workers had health insurance through their jobs, but by 2007 the share had dropped to 56%.⁹ This trend is growing worse during the Great Recession. According to the Kaiser Family Foundation in 2011 only 49.3% of Wisconsin employers now offer health coverage.¹⁰ In addition the Wisconsin Council on Children and Families reported that 166,000 Wisconsinites have lost their employer-based health insurance during the recession.¹¹

The most current and reliable national research shows that most of this decline in employer-based coverage has occurred during this decade, primarily among employers with less than fifty workers (a group that will have access to a new health insurance exchange in 2014). According to Kaiser Family Foundation, while 95.7% of large Wisconsin employers offer health coverage to their employees, only 32.5% of Wisconsin small employers offer coverage. A decade ago,

nearly 60% of Wisconsin small employers offered coverage.¹² The highly respected Kaiser/HRET 2011 survey (September, 2011) concludes that high health insurance costs are the primary reason employers do not offer coverage.¹³

It is widely recognized that spiraling health insurance costs are endangering access to affordable health care for a rising share of the population, and increasingly discouraging the underinsured from seeking needed preventive care or chronic disease management. In addition, there are many who are concerned that Wisconsin's relatively high health insurance costs are damaging the state's ability to create and attract family supporting jobs by making job creation much more expensive.

The Wisconsin Health Insurance Cost Ranking Report was the first to demonstrate substantial and consistent regional variations in the cost of health insurance in Wisconsin. The first six reports showed that there are indeed substantial and persistent geographic differences in Wisconsin's health insurance costs. As a result of these persistent patterns, some regions of the state may have a competitive advantage over others. In addition, if some regions are having more success in containing health insurance costs, they may present useful lessons for the rest of the state, especially as Wisconsin enters into the full implementation phase of health insurance exchanges under the Affordable Care Act.

The 7th annual Wisconsin Health Insurance Cost Ranking report is much more than a snapshot of current health insurance rates. This historic inflation and quality data in the report makes it possible to examine the relationship between health insurance costs and the quality of insurance that is provided, as measured by key benchmarks such as consumer satisfaction, preventative care, disease management, mental health, and responsiveness to consumers.

Methodology

This analysis compares relative health insurance costs across regions and metropolitan areas of Wisconsin by analyzing the 2000-2013 rates paid by the State of Wisconsin's Group Health Insurance Program (GHIP) for state employees, a model program administered by the Wisconsin Department of Employee Trust Funds (ETF). The program covers over 194,000 individuals, including state employees, state retirees, some local government employees and retirees, and their immediate families and dependents.¹⁴ There are 25 participating private health insurance plans in the program covering all of the state's 72 counties.

The GHIP's uniquely competitive bidding process, geographic breadth, and uniform benefits package make it a useful surrogate for regional and metropolitan private health insurance markets. In 2003, the State of Wisconsin switched to a three-tiered bidding process, which requires members who select higher cost Tier 2 and Tier 3 plans to pay substantially higher premiums. Plans in all three tiers provide uniform benefits, with plans which score higher on several quality indicators receiving extra credits in the scoring process. As the boundaries between the tiers are not set in advance of the process, insurers have a strong incentive to bid as low as possible. Tier 2 and Tier 3 plans attract far fewer participants during the annual open enrollment process due to the higher premiums charged to enrollees. As the tiered system creates a powerful incentive to make the lowest responsible bid, the rates that GHIP is able to obtain through this annual process is a barometer of the private health insurance market in each region. In addition, as the program requires a uniform benefits package across all 24 participating health plans, it offers a rare opportunity to compare relative costs for the same bundle of services.

This methodology was first used in the 2007 Wisconsin Health Insurance Cost Ranking report (released in late 2006). The methodology is comparable to that used by the GAO's 2005 national study of variations in physician rates between metropolitan areas. Previously, there had been a great deal of research into geographic differences in health care utilization, but very little into geographic cost differentials. The GAO study analyzed regional cost variations accrued by the Federal Employee Health Benefits Program (FEHBP). FEHBP is the largest private health insurance program in the country, with over 8 million enrollees.¹⁵

One of the criticisms of the GAO study is that because it looked at retrospective FEHBP Preferred Provider Organization (PPO) claims data, its results may have been out of date. The following analysis of GHIP, like the 2007, 2008, 2009, 2010, 2011, and 2012 reports, does not have the same weakness, as it examines 2013 insurance rates rather than retrospective cost reports. On the other hand, because it examined actual claims, the GAO study was able to break down its analysis into various cost centers, something that cannot be presently done with aggregate GHIP rates.

In addition to examining the 2013 rates for GHIP, this report looks retrospectively at rates back to 2000. This permits an analysis of the relative rate of health insurance inflation in every metro area of Wisconsin. As the data allows a measure of the cost of competitive regional rates for a relatively uniform benefit over time, it offers a unique window into the rising cost of health insurance in Wisconsin.

Wisconsin Department of Employee Trust Funds (ETF) publishes a quality report card for all insurance plans that participate in GHIP. The measures rank health plans based on Wellness and Prevention Services, Behavioral and Mental Health, Disease Management, and Consumer Satisfaction and Experiences. Out of these 4 measures, ETF created an overall quality score. This data set permits a comparison of the cost and quality of health insurance plans available in each metro area of the state.¹⁶

Finally, beginning in 2012 the quality of the coverage offered to employees participating in GHIP was reduced. This means that the substantial decade long inflation rates reported here are for a reduced level of benefit, meaning the rate would be even higher if the same benefit was provided in 2013 as in 2000.

The data presented in this analysis is descriptive rather than predictive.

Results

Wisconsin 2013 health insurance rates reflect wide cost variations between the metro areas of the state for the same health insurance benefits package. The range of cost differential is 24% between the highest and lowest cost major metro areas. As it did the last seven years, this report finds that costs are highest in Northwestern, North Central, and West Central Wisconsin, as well as the Southeastern portion of the state. The highest cost metro area, Milwaukee, Racine, and Eau Claire, are 24% higher than Madison, the lowest cost metro area. La Crosse is 22% above Madison and Wausau is 21% higher. The percentage gap between Milwaukee and Madison translates in dollar terms into a \$1,809 difference for a single policy each year (See charts pp. 11-13).

The retrospective data used in this report permits an analysis of the differential impact of health insurance inflation in different metro areas of the state. The data shows that the health insurance hyperinflation that began in 2000 has changed the regional distribution of health insurance costs in Wisconsin. Whereas the highest cost and lowest cost areas have been relatively stable over the past four years (although the order at the top change from year to year), there have been substantial changes since 2000.

First, Wisconsin health insurance rates have nearly doubled since 2000, increasing 193% for a similar benefit package, with regional rates of inflation varying between a low of 149% in Madison to 324% in Green Bay and 217% in Appleton and Oshkosh (See Chart 2, p. 11).

Second, Northeast Wisconsin has suffered the most severe health insurance inflation since the beginning of the 21st Century. In 2000 the lowest cost region was not South Central Wisconsin but Northeast Wisconsin. While the Northeast is not one of the highest cost regions in 2013, it has been catching up to the highest cost regions of the state, and for the second consecutive year of this report is above the state average. As a consequence, Green Bay, Appleton, and Oshkosh have suffered the highest relative rates of health insurance inflation this decade, while Madison has had by far the lowest rate of health insurance inflation. This more moderate health insurance inflation in Madison has firmly established it as the lowest cost metro area over the past decade (See Chart 2, p. 11).

Second, Madison had 8% health insurance rate inflation in 2012-13, double the state average, although Madison remains the lowest cost area of the state (See Chart 4, p. 12). This inflationary burst may reflect alarming changes in patterns of competition in the Madison health care market. (This is discussed further in the next section of the report).

Third, there is not a strong correlation between health insurance costs and quality. In fact, this year there is an inverse correlation between cost and quality. Southeast Wisconsin has the lowest quality health plans, as measured by quality measures and consumer satisfaction, but has the highest rates. Madison is at the top in these same quality measures, despite being by far the lowest cost area of the state. On the other hand, higher cost areas such as North Central, West Central, and Northwestern Wisconsin are somewhat compensated with relatively higher quality insurance plans.

Fourth, there is a very strong correlation between quality rating and type of health plan. The large national for-profit health insurance companies (Humana, United HealthCare, and Anthem Blue Cross, which is owned by Wellpoint) measure average to poor in quality while the regional non-profit plans are almost all are above average or high in quality. It is the predominance of national for-profit insurance companies in Milwaukee, Kenosha, and Racine that drives down the average quality of the available insurance options (See Charts 5 and 6, p. 13).

Discussion

Large regional variations in health insurance costs raise critical public policy questions. Although the data presented here is not sufficient to ascribe causation, it does reinforce several significant conclusions reached in other recent studies, and the previous seven years of this report. The findings about differential health insurance inflation in Wisconsin provide valuable lessons for the implementation of the Affordable Care Act in Wisconsin, especially Wisconsin's health insurance exchanges which will be built in 2013 and launched January 1, 2014.

First, as has been suggested in the previous years of this report, the relatively lower cost of health insurance in the Madison area suggests the possibility that greater buying power, when combined with a competitive bidding process, may leverage lower costs. This is highly significant for the debate over national health care reform, where the creation of greater buying power through health insurance exchanges is a major feature of the Affordable Care Act.¹⁷ The extent to which the Affordable Care Act can transform the health insurance marketplace throughout Wisconsin to parallel Madison depends heavily on how it is implemented by the federal government (now that Wisconsin has given up the option to build its own health exchanges).

The finding in this study that Madison's cost advantage has only emerged during the health insurance hyperinflation that began in 2000 suggests that buying power and competitive bidding may have become more important over the last decade. The Group Health Insurance Program has by far the most bargaining leverage in Dane County, where over 81,576 of its 194,192 members reside. This of course was also the case at the beginning of the decade. What has changed is the competitive bidding process that was added in 2003, combined with a larger pool. This bidding process began combining both cost and quality measures in 2009. Relatively lower health insurance costs in the Madison area lend empirical support to the value of a competitive bidding process that covers a large number of participants and includes both cost and quality as a mechanism to contain health insurance inflation. All of these features could be built into Wisconsin's health insurance exchanges over time.

Second, the quality measures in this year's report, when overlaid with cost trends, are highly significant for the health care reform debate. This report continues to find, as it has the last three years, that there is no clear correlation between the cost of health insurance plans and overall quality. In fact, Southeastern Wisconsin, which has low quality plans, is the highest cost region while the lowest cost area (Madison) has the highest quality plans.

The report does find a strong correlation between quality and type of health plan, with the national for-profit insurance companies offering generally lower quality plans, and non-profit provider networks offering the highest quality plans. This strongly suggests that if Wisconsin's competitive health insurance marketplace under the Affordable Care Act, once established, offers only national for-profit insurance plans, it would deliver much lower quality and higher cost insurance than an exchange that offered a full range of options. This finding is also reinforced by additional research conducted in 2008 by Citizen Action of Wisconsin which found that the large for-profit insurance companies in Wisconsin spend much less on medical care than the regional non-profit plans.¹⁸

Third, new in this year's report is a one year spike in health insurance inflation in Madison (8%), double the state average. Although it is too early to establish this as a permanent trend, it is possible that this reflects detrimental changes in the patterns of competition between the major health systems in the Madison area that may accelerate health insurance inflation over time. As business journalist Mike Ivey documented in a well researched story in the *Capital Times* in September of 2012, Madison's health systems have engaged in a building boom of fancy new buildings and specialty services as cut throat competition for patients has intensified. In the health insurance market, building new unnecessary capacity increases costs which are passed to health insurance rate payers.¹⁹ In addition, health care reporter David Wahlberg revealed last year that Madison health system CEO compensation packages are well above the national average.²⁰ Given the one-year spike in insurance rates, it will be important to monitor whether

destructive competition based on amenities (as opposed to quality and price) is beginning to cause Madison to lose its price advantage over the rest of the state.

Fourth, as it has in previous years, this analysis reinforces the conclusion of previous research by the GAO that cost shifting from Medicaid and Medicare does not appear to be a major factor in health insurance cost variations.²¹ If cost shifting were a controlling variable, one would expect to see the highest health insurance costs in metro areas and regions of the state with much higher than average Medicaid utilization, poverty rates, or proportions of individuals without health insurance. Yet the fact that North Central, West Central and Northwestern Wisconsin have costs comparable to Southeast Wisconsin does not fit this pattern. The retrospective data in this report makes this case even stronger, as the gap between Medicare and Medicaid reimbursements and medical inflation has widened this decade.

Fifth, the data in this report continues to reinforce the conclusion reached by GAO and the Milwaukee Business Foundation for Health that the geographic distribution of health insurance costs reflects the structure of competition within regional health care markets, and especially that the market predominance of large health systems is a dominant health insurance cost driver. The regional cost variations reflected in this analysis correspond to the regional footprints of the major health systems in Southeastern, West Central, North Central, and Northwestern Wisconsin. The high rate of insurance inflation in the Northeast part of the state may reflect the expansion of Southeastern Wisconsin health systems into the region during this decade. Madison, which has the most competitive health care provider market, still has by far the lowest health insurance rates despite its higher inflation rate over the past year.²² But if the structure of competition in Madison is changing in a way that deemphasizes competition over price and efficiency, as the inflation numbers this year suggest, then Madison may be beginning to lose its advantage.

CHARTS

Chart 1: Wisconsin Metro Area Cost Ranking 2013

Single Monthly Premium

1. Milwaukee Racine*	\$767.12
2. Eau Claire	\$761.78
3. La Crosse	\$754.78
4. Wausau Marshfield* Stevens Point* Wisconsin Rapids*	\$747.73
5. Rhinelander	\$743.35
6. Twin Cities Metro (WI)	\$742.96
7. Superior	\$742.47
8. Kenosha	\$742.33
9. Green Bay Appleton* Manitowoc* Oshkosh* Sheboygan*	\$720.27
10. Fond du Lac	\$707.88
11. Dubuque Area (WI)	\$705.38
11. Janesville Beloit*	\$701.44
12. Madison	\$616.38
State Average	\$714.39

* Indicates Tie

Chart 2: Wisconsin Metro Area Health Insurance Inflation 2000-2013

Single Monthly Premium

Green Bay	324%
Appleton Oshkosh	217%
Milwaukee	208%
Racine Stevens Point*	206%
La Crosse	204%
Wisconsin Rapids Marshfield*	199%
Sheboygan Manitowoc* Fond du Lac*	196%
Wausau	192%
Kenosha Rhinelander*	190%
Eau Claire	188%
Janesville/Beloit	181%
Superior Twin Cities Metro (WI)*	178%
Madison	149%
State Average	193%

* Indicates Tie

**Chart 3: Wisconsin Metro Area
Health Insurance Cost
Disparities with Madison**

Single Monthly Premium

Milwaukee	24%
Eau Claire*	
Racine*	
La Crosse	22%
Wausau	21%
Stevens Point*	
Wisconsin Rapids*	
Marshfield*	
Twin Cities Area (WI)*	
Rhineland	
Superior	20%
Kenosha*	
Green Bay*	17%
Appleton*	
Oshkosh*	
Manitowoc*	
Sheboygan*	
Fond du Lac	15%
Janesville	14%
Beloit*	
Dubuque Area (WI)*	
Madison	0%
State Average	16%

* Indicates Tie

**Chart 4: Wisconsin Metro Area
Health Insurance Inflation
2012-2013**

Single Monthly Premium

Madison	8%
Dubuque Area (WI)	7%
Milwaukee	5%
Racine*	
Green Bay	4%
Appleton*	
Oshkosh*	
Sheboygan*	
Manitowoc*	
Janesville*	
Beloit*	
Rhineland	3%
Wausau	2%
Kenosha*	
Stevens Point*	
Wisconsin Rapids*	
Marshfield*	
Twin Cities Metro (WI)	1%
La Crosse	0%
Superior*	
State Average	4%

* Indicates Tie

Chart 5: 2013 Wisconsin Metro Area Health Insurance Plan Quality (4 Star Scale)

1. Madison	3.25 Stars
2. La Crosse Dubuque Area (WI)* Rhineland*	3.0 Stars
3. Superior	2.4 Stars
4. Eau Claire	2.25 Stars
5. Janesville Beloit*	2.1% Stars
6. Wausau Twin Cities Metro* Fond du Lac* Stevens Point* Marshfield* Wisconsin Rapids*	2 Stars
7. Green Bay Appleton* Oshkosh* Manitowoc* Sheboygan*	1.8 Stars
8. Milwaukee Racine* Kenosha*	1.5 Stars

* Indicates Tie

Chart 6: Health Insurance Plan Quality 2013 (4 Star Scale)

1. Group Health Coop. SC	4 Stars
2. Arise Health Plan Group Health Coop. EC* Gundersen Lutheran* Medical Associates* Health Tradition* Network Health Plan* Security Health Plan* Physicians Plus* Unity Community* Unity UW Health* Dean Health Plan* Health Partners* MercyCare Health Plans*	3 Stars
3. Anthem BCBS United HealthCare Southeast*	2 Stars
4. Humana UnitedHealthCare Northeast* WEA Trust PPO East*	1 Star

* Indicates Tie

Source: Wisconsin Department of Employee Trust Funds



www.citizenactionwi.org

Citation for this Report: Robert Kraig, “Wisconsin Health Insurance Cost Rankings 2013,” Citizen Action of Wisconsin, December 19, 2012.

About the Author: Robert Kraig is the Executive Director of Citizen Action of Wisconsin. In 2009 he was awarded the Health Care Consumer Advocate of the Year Award by Families USA, the leading national voice for health care consumers. Kraig holds a Ph.D. from the University of Wisconsin-Madison, an M.A. from the University of Georgia, and a B.A. from the University of Pittsburgh.

Acknowledgements: This report was made possible in part by the generous support of the Nathan Cummings Foundation, Brico Fund, Families USA Foundation, and individual supporters throughout Wisconsin. The author also wishes to thank David Riemer and Laura Dresser for the methodological assistance with the first report in 2006.

Endnotes

¹ Cathy Schoen, Jacob Lippa, Sara Collins, and David Radley, “Realizing Health Care Reform’s Potential: State Trends in Premiums and Deductibles, 2003-2011,” Commonwealth Fund, December, 2012, pp. 21, 25, 29. <http://www.commonwealthfund.org/Publications/Issue-Briefs/2012/Dec/State-Trends-in-Premiums-and-Deductibles.aspx>

² Greater Milwaukee Business Foundation on Health Inc, “Study of 2011 Southeast Wisconsin Community HealthCare Premium Costs,” December 4, 2012, p. 19. The study was conducted by Mercer, a benefits consulting company, and Milliman, an actuarial and consulting firm. <http://www.gmbfh.org/documents/20121204GMBFH4MidwestPremiumComparisonReport.pdf>
Also see Rich Kirchen, “Area Insurance Payments to Doctors Remain Higher than Midwest Average,” *Milwaukee Business Journal*, December 11, 2012.

³ Greater Milwaukee Business Foundation on Health Inc, “Study of 2011 Southeast Wisconsin Community HealthCare Premium Costs,” December 4, 2012, p. 14. <http://www.gmbfh.org/documents/20121204GMBFH4MidwestPremiumComparisonReport.pdf>
Also see Guy Bolton, “Health Care Cost Increases Slow, But Still Higher than Midwest,” *Milwaukee Journal Sentinel*, December 4, 2012.

⁴ Harold Cohn, *More than a Decade of Quality, Efficiency, and Value Improvements in Michigan Hospitals, 2009 Update* (Harold Cohn, Inc, Health Care Consulting, November 2009), 20.

⁵ “Premiums versus Paychecks: A Growing Burden for Wisconsin’s Workers,” Families USA Report co-released by Citizen Action of Wisconsin (September 2008), 1,

<http://citizenactionwi.org/images/stories/Reports/wi%20premiums%20vs%20pay%20final%20updateemb.pdf> . Also see Ellyn Ferguson, “Rising Health Insurance Costs Outpace Income: Report,” *Appleton Post Crescent*, September 22, 2008.

⁶ US Government Accountability Office, *Federal Employee Health Benefits Program, Competition and Other Factors Linked to Wide Variation in Health Care Prices*, August 2005, 14.

⁷ Merton D. Finkler and Wayne Wendling, *The Physician Marketplace—A Comparison of Central USA Metropolitan Areas*, Greater Milwaukee Business Foundation on Health, September 21, 2006.

⁸ U.S. Government Accountability Office, *Milwaukee Health Care Spending Compared to Other Metropolitan Areas*, August 2004.

⁹ Laura Dresser , Joel Rogers, and Edo Navot, *The State of Working Wisconsin 2010*, Center on Wisconsin Strategy, September, 2010, 19.

¹⁰ Kaiser Family Foundation, StateHealthFacts.org, <http://www.statehealthfacts.org/profileind.jsp?ind=175&cat=3&rgn=51&cmprgn=1> (Accessed December 18, 2012)

¹¹ Wisconsin Council on Children and Families, Wiskids Blogspot, September 13, 2011, <http://wiskids.blogspot.com/2011/09/census-data-shows-badgercare-has-filled.html>

¹² Kaiser Family Foundation, StateHealthFacts.org <http://www.statehealthfacts.org/profileind.jsp?ind=176&cat=3&rgn=51&cmprgn=1> (Accessed December 18, 2012).

¹³ Kaiser Family Foundation and Health Research & Educational Trust, *Employee Health Benefits 2011* (September 2011), <http://ehbs.kff.org/pdf/2011/8225.pdf>

¹⁴ Data from Wisconsin Department of Employee Trust Funds, February, 2006.

¹⁵ US Government Accountability Office, *Federal Employee Health Benefits Program, Competition and Other Factors Linked to Wide Variation in Health Care Prices*, 6.

¹⁶ Wisconsin Department of Employee Trust Funds, “Health Plan Report Card,” Fall 2012, in *It’s Your Choice: 2012 Decision Guide*, pp. 69-75 http://etf.wi.gov/publications/dc_content/dc_2012/State_DG.pdf

¹⁷ The finding of the last three Wisconsin Health Insurance Cost Ranking studies which show that Madison has lower health insurance costs has entered the national debate. See John Reichard, “The Exchange Equation: Avoiding a Death Spiral with a Balancing of Risks,” *CQ Health Beat News* (December 18, 2009).

¹⁸ Darcy Haber and Robert Kraig, “A Heavy Burden: The Hidden Cost of Health Insurance in Wisconsin,” Citizen Action of Wisconsin, October 2008, <http://citizenactionwi.org/images/stories/Reports/citizen%20action%20wisconsin%20insurance%20report%20final.pdf>

¹⁹ Mike Ivey, “Healthy Competition? Critics Say Consumers Lose as Providers Build, Bicker,” *Capital Times*, September 12, 2012. http://host.madison.com/business/biz_beat/healthy-competition-critics-say-consumers-lose-as-providers-build-bicker/article_46adbc46-01c9-11e2-821c-0019bb2963f4.html#ixzz2FLZRiLNk

²⁰ David Wahlberg, “Pay to Top Area Health Care Executives Exceeds National Average,” *Wisconsin State Journal*, August 28, 2011, http://host.madison.com/news/local/health_med_fit/pay-to-top-area-health-care-executives-exceeds-national-average/article_c9e10fae-d174-11e0-93ad-001cc4c002e0.html

²¹ GAO, *Federal Employee Health Benefits Program*, 9-10, 18.

²² GAO, *Federal Employee Health Benefits Program*, 4, 8, 18. Also see Kieffer and Slipher, *Factors Contributing to Higher Hospital Inpatient Payment Levels in Milwaukee*, Greater Milwaukee Business Foundation on Health, April 26, 2006.

Appendix D

Wisconsin Hospital Association 2010 and
2011 Net Revenues for Hospitals

Data from the Wisconsin Hospital Association also compares the net revenues for inpatient and outpatient revenue compared to their peer group. A peer group is hospitals that are grouped together by the Wisconsin Hospital Association by volume. The tables below represent the revenues, as a percentage, that each hospital received for inpatient and outpatient services in 2010 and 2011.

Inpatient net revenue as a % per discharge compared to Peer Group:

Health Care Provider	2010	2011
Oak Leaf Surgical Hospital	53	29
Mayo Clinic Health System Eau Claire	-5	14
St. Joseph's Hospital Chippewa Falls	-33	-22
Sacred Heart Hospital	5	23

Outpatient net revenue per visit compared to Peer Group

Health Care Provider	2010	2011
Oak Leaf Surgical Hospital	608	444
Mayo Clinic Health System Eau Claire	40	34
St. Joseph's Hospital Chippewa Falls	12	0
Sacred Heart Hospital	23	22

(Wisconsin Hospital Association).

Appendix E

HealthInsight Hospital Rankings &
Explanation of Rankings

National Rankings for Hospitals

Please select your state's initials and press the **Show Results** button.

Select your State by initial:

Show Results

These data have limitations that people should be aware of when interpreting the data. [Click here for more information.](#)

The hospital rankings are computed using publicly reported data downloaded from the Centers for Medicare & Medicaid Services ([CMS Hospital Compare website](#)) (last accessed 12/18/2012¹).



Quality Measures

The Hospital Compare data set contains hospital-specific performance on process of care quality measures for over 4,500 hospitals nationwide². The quality measures show how often hospitals give recommended treatments that are known to get the best results for patients. The quality measures used to compute the rankings are drawn from four clinical topic areas: heart attack; heart failure; pneumonia; and surgical care. Information about these treatments is taken from patients' records. Hospitals voluntarily report their data, and some hospitals may not provide data for some topics or measures. For each measure the denominator is the number of eligible cases, and the numerator is the number of eligible cases where the recommended care was provided.

The hospital ranks presented here are determined by first calculating the overall performance rate for each hospital by summing the numerators and denominators over all topics for all measures in the measure set and reported for the facility. We rank hospital performance on this overall rate and then convert the ranks to percentiles.

Hospitals' performance on the quality measures has improved dramatically over time, with the result that for a number of measures the great majority of hospitals are achieving perfect or near perfect performance. Including these 'topped out' measures in the set of measures used to rank hospitals has the effect of obscuring the real performance differences between hospitals, and results in a situation where very small differences in overall performance on the quality measures produce large differences in hospitals' ranks. Therefore, we exclude nine topped out measures,

which we define as measures for which 50% or more of the hospitals have a performance rate of 100%, from our measure set.

Our hospital rankings are based on the set of 19 remaining quality measures, representing four clinical topic areas: heart attack; heart failure; pneumonia; and surgical care. We do not exclude any hospitals or measures based on the number of cases in the denominator. This means that for some hospitals the rankings are based on only a few eligible cases; and the rankings for these facilities should be interpreted cautiously.



HCAHPS

The HCAHPS (Hospital Consumer Assessment of Healthcare Providers and Systems) is a national, standardized survey of patients' perspectives of hospital care. The survey asks a random sample of discharged patients 27 questions about their recent hospital stay. For each participating hospital results on 10 measures (six summary measures, two individual survey items and two global ratings) are publically reported on the [Hospital Compare website](#)³.

The national rankings presented here are based on the percentage of survey respondents who give the most favorable response for each of these measures. For each hospital these 10 response rates are averaged to get the mean most favorable response rate, hospitals are ranked based on this mean and then the ranks are converted to percentiles.⁴



Mortality and Readmission Measures

The Hospital Compare data set contains hospital-specific 30-day risk-standardized mortality and readmission measures for patients hospitalized for heart attack, heart failure, and pneumonia. These measures are produced from Medicare claims and enrollment data using statistical techniques that adjust for patient-specific characteristics and differences between hospitals in patient populations. The three mortality models estimate hospital-specific, risk-standardized, all-cause 30-day mortality rates for patients hospitalized with a principal diagnosis of heart attack, heart failure, and pneumonia. All-cause mortality is defined as death from any cause within 30

days, regardless of whether the patient dies while still in the hospital or after discharge. The three readmission models estimate hospital-specific, risk-standardized, all-cause 30-day readmission rates for patients discharged alive to a non-acute care setting with a principal diagnosis of heart attack, heart failure, and pneumonia. The mortality and readmission measures are based on three years of data.

The star ratings for mortality and readmissions presented here are based on hospitals' performance for each of the three conditions. The ratings are calculated by assigning hospitals a score for each condition, based on which quartile they fall in. Hospitals in the first quartile have the lowest risk-standardized rates and are assigned a score of 3; hospitals in the second quartile are assigned a score of 2; hospitals in the third quartile are assigned a score of 1; and hospitals in the fourth quartile, which have the highest risk-standardized rates, are assigned a score of 0. These ratings are averaged over the three conditions and the average scores are rounded to the nearest 0.5 and converted to stars.

¹ This currently includes data from the time period 4/1/2011 to 3/31/2012 for the Quality Measures and HCAHPS and 7/1/2008 to 6/30/2011 for 30-day mortality and readmissions. To obtain a copy of the database, go to: [Hospital Compare](#) and click on "Download the Hospital Compare database".

² These Quality Measures are (* indicates topped out measures excluded from our analysis):

Heart Attack (Acute Myocardial Infarction or AMI)

- Fibrinolytic medication within 30 minutes of arrival
- Statin prescribed at discharge
- Percutaneous coronary intervention (PCI) within 90 minutes of arrival
- *Aspirin at arrival
- *Aspirin at discharge
- *ACEI or ARB for left ventricular systolic dysfunction
- *Beta Blocker at discharge
- *Smoking cessation advice/counseling

Heart Failure

- Assessment of Left Ventricular Function
- ACE Inhibitor for Left Ventricular Systolic Dysfunction
- Discharge instructions
- *Smoking cessation advice/counseling

Pneumonia

- Initial Antibiotic Timing
- Appropriate antibiotic for immunocompromised patients
- Blood culture before first dose of antibiotics
- Pneumococcal Vaccination
- Influenza vaccination (seasonal)
- *Smoking cessation advice/counseling

Surgical Infection Prevention

- Preventative antibiotics one hour before incision
 - Preventative antibiotics stopped within 24 hours after surgery
 - Appropriate preventative antibiotics
 - Cardiac surgery patients with controlled blood glucose post surgery
 - Patients on a Beta Blocker prior to arrival who received a Beta Blocker during the perioperative period
 - Surgery patients whose urinary catheters were removed on the first or second day after surgery
 - Treatment to prevent blood clots within 24 hours before or after selected surgeries
 - Doctors ordered treatments to prevent blood clots for certain types of surgeries
 - *Appropriate hair removal
 - *Surgery patients with perioperative temperature management
-
- How often did nurses communicate well with patients? (Sometimes or Never; Usually; **Always**)
 - How often did doctors communicate well with patients? (Sometimes or Never; Usually; **Always**)
 - How often did patients receive help quickly from hospital staff? (Sometimes or Never; Usually; **Always**)
 - How often was the patient's pain well controlled (Sometimes or Never; Usually; **Always**)
 - How often did staff explain about medicines before giving them to patients? (Sometimes or Never; Usually; **Always**)
 - Were patients given information about what to do during their recovery at home (No; **Yes**)
 - How often were the patients' rooms and bathrooms kept clean? (Sometimes or Never; Usually; **Always**)
 - How often was the area around the patient's rooms kept quiet at night? (Sometimes or Never; Usually; **Always**)
 - How do patients rate the hospital overall? [on a scale of 1-10: 6 or lower (low); 7 or 8 (medium); **9 or 10 (high)**]
 - Would patients recommend the hospital to friends or family? (No, Probably; **Definitely**)

⁴For more details on hospital participation, the Quality Measures, and HCAHPS go to: [Hospital Compare](#)

Quality Measures for Hospitals

The hospital quality measures come from data collected and submitted by hospitals to the QIO Clinical Warehouse. Below is a list of the 19 measures used to calculate the hospital rankings. All are process measures with higher percentages indicating better performance.

Process Measure	Definition
AMI	
Percent of Heart Attack Patients Given Fibrinolytic Medication Within 30 Minutes Of Arrival	Blood clots can cause heart attacks. Doctors may give this medicine, or perform a procedure to open the blockage, and in some cases, may do both.
Percent of Heart Attack Patients Given PCI Within 90 Minutes Of Arrival	The procedures called Percutaneous Coronary Interventions (PCI) are among those that are the most effective for opening blocked blood vessels that cause heart attacks. Doctors may perform PCI, or give medicine to open the blockage, and in some cases, may do both.
Percent of Heart Attack Patients Given a Prescription for a Statin at Discharge	Statins are drugs used to lower cholesterol. Cholesterol is a fat that your body needs to work properly but cholesterol levels that are too high can increase your chance of getting heart disease, stroke, and other problems. For patients who had a heart attack and have high cholesterol, taking Statins can lower the chance that they will have another heart attack or die.
Heart Failure	
Percent of Patients Given ACE Inhibitor or ARB for Left Ventricular Systolic Dysfunction (LVSD)	ACE (angiotensin converting enzyme) inhibitors and ARBs (angiotensin receptor blockers) are medicines used to treat heart attacks, heart failure, or a decreased function of the heart.
Percent of Patients Given Assessment of Left Ventricular Function (LVF)	An LVF assessment checks how the left chamber of the heart is pumping.
Percent of Heart Failure Patients Given Discharge Instructions	The staff at the hospital should provide you with information to help you manage your heart failure symptoms when you are discharged.
Pneumonia	
Percent of Patients Assessed and Given Pneumococcal Vaccination	A pneumonia (pneumococcal) shot can help prevent pneumonia in the future, even for patients who have been hospitalized for pneumonia.
Percent of Pneumonia Patients Assessed and Given Influenza Vaccination	An influenza shot can help prevent Influenza in the future, even for patients who have been hospitalized for pneumonia.
Percent of Patients Given Initial Antibiotic(s) within 6 Hours After Arrival	Timely use of antibiotics can improve the treatment of pneumonia caused by bacteria.

Percent of Pneumonia Patients Given the Most Appropriate Initial Antibiotic(s) Antibiotics are medicines that treat infection, and each one is different. Hospitals should choose the antibiotics that best treat the infection type for each pneumonia patient.

Percent of Pneumonia Patients Whose Initial Emergency Room Blood Culture Was Performed Prior To The Administration Of The First Hospital Dose Of Antibiotics A blood culture tells what kind of medicine will work best to treat your pneumonia.

Surgical Infection and Blood Clot Prevention

Percent of Surgery Patients Who Received Preventative Antibiotic(s) One Hour Before Incision Getting an antibiotic within one hour before surgery reduces the risk of wound infections. Hospitals should check to make sure surgery patients get antibiotics at the right time.

Percent of Surgery Patients Who Received the Appropriate Preventative Antibiotic(s) for Their Surgery Certain antibiotics are recommended to help prevent wound infection for particular types of surgery.

Percent of Surgery Patients Whose Preventative Antibiotic(s) are Stopped Within 24 hours After Surgery It is important for hospitals to stop giving preventative antibiotics within 24 hours after surgery to avoid side effects and other problems associated with antibiotic use. For certain surgeries, however, antibiotics may be needed for a longer time.

Percent of Heart Surgery Patients Whose Blood Sugar is Kept Under Good Control in the Days Right After Surgery Even if heart surgery patients do not have diabetes, keeping their blood sugar under good control after surgery lowers the risk of infection and other problems. "Under good control" means their blood sugar should be 200 mg/dL or less when checked first thing in the morning.

Percent of Surgery Patients Who Were Taking Heart Drugs Called Beta Blockers Before Coming to the Hospital, Who Were Kept on the Beta Blockers During the Period Just Before and After Their Surgery Many people who have heart problems or are at risk for heart problems take drugs called beta blockers to reduce the risk of future heart problems. This measure shows whether surgery patients who were already taking beta blockers before coming to the hospital were given beta blockers during the time period just before and after their surgery.

Percent of Surgery Patients Whose Urinary Catheters Were Removed on the First or Second Day After Surgery Surgery patients can develop infections when urinary catheters are left in place too long after surgery. Research shows that most surgery patients should have their urinary catheters removed within 2 days following surgery to help prevent infection.

Percent of Surgery Patients Who Received Treatment To Prevent Blood Clots Within 24 Hours Before or After This measure tells how often surgery patients received treatment to prevent blood clots within 24 hours before or after certain surgeries

Selected Surgeries to Prevent Blood Clots

Percent of Surgery Patients Whose Doctors Ordered Treatments to Prevent Blood Clots (Venous Thromboembolism) For Certain Types of Surgeries

This measure tells how often surgery patients' doctors ordered treatment to prevent blood clots from forming in the veins after certain surgeries

National Rankings for Hospitals For Wisconsin ¹

Copyright© HealthInsight 2012

Hospital	City	AMI - Performance Rate (%)	Heart Failure - Performance Rate (%)	Pneumonia - Performance Rate (%)	SCIP - Performance Rate (%)	National Ranking (percentile)	Mean Most Favorable Response Rate (HCAHPS)	National Ranking (percentile) (HCAHPS)	Readmission Rating	Mortality Rating
GOOD SAMARITAN HLTH CTR	MERRILL	*	100	100	100	99th	71	52nd		
TOMAH MEM HSPTL	TOMAH	*	100	100	*	99th	79	92nd		
ST CLARE'S HOSPITAL OF WESTON INC	WESTON	100	100	99	99	96th	74	70th		
AURORA SHEBOYGAN MEM MED CTR	SHEBOYGAN	96	98	99	100	95th	73	67th		
AURORA MED CTR OSHKOSH	OSHKOSH	98	97	100	100	94th	74	72nd		
MAYO CLINIC HEALTH SYSTEM - RED CEDAR INC	MENOMONIE	*	99	100	99	93rd	79	90th		
MIDWEST ORTHOPEDIC SPECIALTY HOSPITAL LLC	FRANKLIN	*	*	*	99	92nd	88	99th		
ST CLARE HSPTL HLTH SVCS	BARABOO	*	100	100	99	92nd	75	78th		
AURORA MEDICAL CENTER	GRAFTON	98	98	97	99	91st	77	86th		
ORTHOPAEDIC HSPTL OF WI	GLENDALE	*	*	*	99	90th	86	99th		
MINISTRY ST MICHAELS HOSPITAL OF STEVENS POINT	STEVENS POINT	*	98	99	99	90th	72	55th		
AURORA MEDICAL CENTER	SUMMIT	97	97	99	99	89th	78	89th		
AURORA MED CENTER- WASHINGTON COUNTY	HARTFORD	100	99	99	99	89th	71	50th		
SAUK PRAIRIE MEM HSPTL	PRAIRIE DU SAC	*	95	95	99	88th	82	95th		
LAKEVIEW MED CENTER	RICE LAKE	*	99	100	99	87th	77	87th		
AURORA BAYCARE MED CTR	GREEN BAY	100	96	97	99	85th	76	83rd		
AURORA MEMORIAL HSPTL BURLINGTON	BURLINGTON	100	98	98	99	85th	70	41st		
MAYO CLINIC HEALTH SYSTEM EAU	EAU CLAIRE	100	99	97	99	84th	77	87th		

CLAIRE HOSPITAL											
ST ELIZABETH HSPTL	APPLETON	100	100	100	98	84th	74	70th			
MILWAUKEE VA MEDICAL CENTER	MILWAUKEE	*	99	100	98	83rd	*	*			
MINISTRY EAGLE RIVER MEM HSPTL	EAGLE RIVER	*	100	98	*	82nd	77	87th			
RIVER FALLS AREA HSPTL	RIVER FALLS	*	100	95	99	81st	79	91st			
OAK LEAF SURGCL HSPTL	EAU CLAIRE	*	*	*	99	81st	89	99th			
MERCY WALWORTH HOSPITAL & MEDICAL CENTER	LAKE GENEVA	*	100	100	98	80th	*	*			
WHEATON FRANCISCAN HEALTHCARE- ALL SAINTS	RACINE	99	98	98	98	78th	68	25th			
MERCY MED CTR OF OSHKOSH	OSHKOSH	99	98	97	99	78th	75	77th			
AURORA WEST ALLIS MEDICAL CENTER	WEST ALLIS	91	97	98	99	76th	70	41st			
HOWARD YOUNG MED CTR	WOODRUFF	*	100	97	98	76th	69	31st			
MINISTRY ST MARYS HOSPITAL	RHINELANDER	*	100	100	98	76th	72	56th			
CALUMET MEDICAL CTR	CHILTON	*	100	100	98	75th	80	92nd			
UNITED HSPTL SYS	KENOSHA	97	96	98	99	75th	71	47th			
MADISON VA MEDICAL CENTER	MADISON	*	98	98	98	74th	*	*			
VERNON MEM HSPTL	VIROQUA	*	82	94	99	72nd	81	94th			
ST MARY'S HOSPITAL	MADISON	99	99	98	98	72nd	78	87th			
MINISTRY SAINT JOSEPH'S HOSPITAL	MARSHFIELD	99	100	99	98	72nd	69	32nd			
AURORA MED CTR KENOSHA	KENOSHA	*	93	98	98	71st	70	44th			
AURORA MED CTR MANITOWOC CTY	TWO RIVERS	94	95	100	98	70th	77	85th			
RIVERVIEW HSPTL ASSOC	WISCONSIN RAPIDS	*	97	98	98	70th	77	85th			
MAYO CLINIC HLTH SYSTM FRANCISCAN HLTHCARE- SPARTA	SPARTA	*	*	98	*	68th	78	87th			
MAYO CLINIC											

HLTH SYSTEM-FRANCISCAN MED CTR INC	LA CROSSE	99	92	96	98	66th	73	67th		
HOLY FAMILY MEMORIAL INC	MANITOWOC	86	95	98	98	63rd	71	50th		
AURORA LAKELAND MED CTR	ELKHORN	*	86	99	99	63rd	67	20th		
AURORA ST LUKES MEDICAL CENTER	MILWAUKEE	99	96	99	98	62nd	69	35th		
THE MONROE CLINIC	MONROE	*	100	96	98	62nd	76	82nd		
WAUPUN MEM HSPTL	WAUPUN	*	90	99	98	61st	78	87th		
MAYO CLINIC HEALTH SYSTEM-CHIPPEWA VALLEY INC	BLOOMER	*	100	96	*	60th	78	88th		
MEMORIAL HSPTL LAFAYETTE CTY	DARLINGTON	*	*	94	99	60th	82	95th		
COMMUNITY MEMORIAL HSPTL	MENOMONEE FALLS	96	97	100	97	60th	72	58th		
UNIVERSITY OF WI HOSPITALS & CLINICS AUTHORITY	MADISON	99	97	94	98	59th	73	62nd		
BELLIN MEMORIAL HSPTL	GREEN BAY	99	97	98	97	57th	78	89th		
WHEATON FRANCISCAN INC- ST JOSEPH	MILWAUKEE	96	97	99	97	54th	72	56th		
ST AGNES HSPTL	FOND DU LAC	99	95	97	97	54th	70	43rd		
THEDA CLARK MED CTR	NEENAH	99	96	95	97	54th	69	35th		
STOUGHTON HOSPITAL	STOUGHTON	*	91	97	98	53rd	79	91st		
FROEDTERT MEM LUTHERAN HSPTL	MILWAUKEE	99	99	98	97	53rd	75	77th		
ST JOSEPHS COM HSPTL WEST BEND	WEST BEND	*	88	98	98	53rd	74	74th		
MEMORIAL HEALTH CTR	MEDFORD	*	100	98	96	52nd	77	84th		
BERLIN MEMORIAL HOSPITAL	BERLIN	*	95	94	97	51st	74	68th		
REEDSBURG AREA MED CTR	REEDSBURG	*	92	95	99	51st	75	76th		
OUR LADY OF VICTORY HSPTL	STANLEY	*	97	97	*	51st	83	96th		
OCONOMOWOC MEM HSPTL	OCONOMOWOC	94	97	98	97	51st	79	91st		
WAUKESHA										

MEMORIAL HOSPITAL	WAUKESHA	98	95	98	97	51st	76	83rd		
ST NICHOLAS HOSPITAL	SHEBOYGAN	72	89	96	98	48th	66	14th		
MAYO CLINIC HEALTH SYSTEM - NORTHLAND INC	BARRON	*	98	100	95	46th	75	78th		
APPLETON MED CTR	APPLETON	99	96	98	96	45th	72	58th		
ST CROIX REG MED CTR	SAINT CROIX FALLS	*	95	92	98	44th	76	82nd		
MAYO CLINIC HEALTH SYSTEM- OAKRIDGE INC	OSSEO	*	*	96	*	44th	77	86th		
COLUMBIA ST MARY'S HOSPITAL MILWAUKEE	MILWAUKEE	92	99	97	96	43rd	70	40th		
ST JOSEPHS HSPTL	CHIPPEWA FALLS	*	82	93	98	42nd	74	72nd		
NEW LONDON FAMILY MED CTR	NEW LONDON	*	*	96	*	41st	65	10th		
UPLAND HILLS HLTH	DODGEVILLE	*	*	97	96	40th	81	94th		
ST MARYS HSPTL MED CTR	GREEN BAY	97	94	97	96	38th	71	52nd		
MERITER HSPTL	MADISON	95	96	91	97	38th	74	73rd		
BEAVER DAM COM HSPTL	BEAVER DAM	80	88	95	97	38th	71	51st		
ST VINCENT HSPTL	GREEN BAY	92	89	99	97	38th	73	62nd		
WHEATON FRANCISCAN HEALTHCARE- FRANKLIN INC	FRANKLIN	*	98	99	92	37th	82	95th		
WHEATON FRANCISCAN HEALTHCARE- ST FRANCIS	MILWAUKEE	91	95	100	95	37th	68	27th		
ASPIRUS WAUSAU HOSPITAL	WAUSAU	98	93	95	96	36th	72	57th		
COLUMBIA ST MARY'S HOSPITAL OZAUKEE INC	MEQUON	91	93	97	96	35th	68	23rd		
COMMUNITY MEM HSPTL	OCONTO FALLS	*	95	97	95	34th	71	47th		
ST JOSEPHS HLTH SVCS	HILLSBORO	*	88	88	100	33rd	78	88th		
BLACK RIVER MEM HSPTL	BLACK RIVER FALLS	*	99	94	95	32nd	83	96th		
GUNDERSEN LUTH MED CTR	LA CROSSE	99	98	96	94	31st	73	67th		
MERCY HLTH SYS CORP	JANESVILLE	97	90	97	96	31st	67	17th		
MINISTRY DOOR COUNTY	STURGEON									

MEDICAL CENTER	BAY	*	89	95	96	30th	81	94th		
PRAIRIE DU CHIEN MEM HSPTL	PRAIRIE DU CHIEN	*	86	93	97	29th	80	92nd		
BELOIT MEM HSPTL	BELOIT	87	94	97	95	29th	71	50th		
SACRED HEART HSPTL: EAU CLAIRE	EAU CLAIRE	96	95	96	95	29th	74	74th		
UW HLTH PARTNERS - WATERTOWN REGIONAL MEDICAL CTR	WATERTOWN	100	87	98	95	28th	73	64th		
FORT HEALTHCARE	FORT ATKINSON	*	89	95	95	28th	71	51st		
HUDSON HOSPITAL	HUDSON	*	95	92	100	27th	77	86th		
SHAWANO MED CTR	SHAWANO	*	81	98	97	26th	70	42nd		
SPOONER HEALTH SYS	SPOONER	*	86	100	*	26th	76	82nd		
BAY AREA MED CTR	MARINETTE	94	94	92	94	25th	68	23rd		
DIVINE SAVIOR HLTHCARE	PORTAGE	*	85	94	95	23rd	69	29th		
RICHLAND HSPTL	RICHLAND CENTER	*	88	84	96	22nd	78	88th		
CUMBERLAND MEMORIAL HOSPITAL	CUMBERLAND	*	*	93	*	20th	78	89th		
RIVERSIDE MEDICAL CENTER	WAUPACA	*	90	95	*	20th	72	56th		
MILE BLUFF MEDICAL CENTER INC	MAUSTON	*	78	90	94	18th	69	30th		
SOUTHWEST HEALTH CENTER INC	PLATTEVILLE	*	85	96	*	15th	76	80th		
LANGLADE HOSPITAL	ANTIGO	*	98	100	86	14th	73	66th		
WILD ROSE COM MEM HOSPITAL INC	WILD ROSE	*	89	90	*	14th	75	79th		
BURNETT MED CTR	GRANTSBURG	*	78	96	93	13th	76	82nd		
ST MARYS HSPTL SUPERIOR	SUPERIOR	*	90	88	*	13th	*	*		
HAYWARD AREA MEMORIAL HOSPITAL	HAYWARD	*	88	89	*	12th	76	83rd		
RIPON MED CTR	RIPON	*	83	92	*	12th	70	40th		
MEMORIAL MED CTR	ASHLAND	60	85	96	86	11th	74	69th		
BALDWIN AREA MED CTR	BALDWIN	*	73	90	94	11th	*	*		
WESTFIELDS HOSPITAL	NEW RICHMOND	*	84	82	89	10th	74	73rd		

COLUMBUS COM HSPTL	COLUMBUS	*	61	83	88	8th	74	74th		
GRANT REG HLTH CTR	LANCASTER	*	92	100	82	8th	80	92nd		
LADD MEMORIAL HOSPITAL INC	OSCEOLA	*	*	*	81	7th	79	91st		
RUSK COUNTY MEM HSPTL	LADYSMITH	*	92	77	*	6th	*	*		
MOUNDVIEW MEM HSPTL AND CLINICS	FRIENDSHIP	*	77	*	*	5th	73	63rd		
MEMORIAL MEDICAL CTR	NEILLSVILLE	*	71	*	*	4th	76	80th		
BOSCOBEL AREA HEALTH CARE	BOSCOBEL	*	64	*	*	2nd	77	87th		
TRI COUNTY MEM HSPTL	WHITEHALL	*	5	97	*	1st	*	*		
BELLIN HEALTH OCONTO HOSPITAL	OCONTO	*	*	*	*	*	*	*		
INDIANHEAD MED CTR	SHELL LAKE	*	*	*	*	*	*	*		
FLAMBEAU HSPTL	PARK FALLS	*	*	*	*	*	81	94th		
EDGERTON HOSPITAL AND HEALTH SERVICES	EDGERTON	*	*	*	*	*	75	79th		
SACRED HEART HSPTL; TOMAHAWK	TOMAHAWK	*	*	*	*	*	85	98th		
AMERY REG MED CTR	AMERY	*	*	*	*	*	*	*		
CHIPPEWA VALLEY HSPTL	DURAND	*	*	*	*	*	*	*	*	*
ST MARY'S JANESVILLE HOSPITAL	JANESVILLE	*	*	*	*	*	*	*	*	*
COLUMBIA CENTER	MEQUON	*	*	*	*	*	82	95th		
TOMAH VA MEDICAL CENTER	TOMAH	*	*	*	*	*	*	*		

¹For all hospitals reporting during 2nd quarter through 1st quarter 2011 (4/1/2011 - 3/31/2012)

*Hospital did not have sufficient case volume to report and was not included in the analysis.

Disclaimer: The rankings displayed on this web site are presented as percentiles. A ranking in the 100th percentile does not necessarily mean that hospitals in that percentile achieved perfect rates on all their measures. It indicates that their rates were better than all other hospitals except for those who are also in the 100th percentile. Similarly, a hospital with a rank in the 50th percentile did not achieve an average of 50% on their performance measures. They performed better than 50% of all the hospitals in the country.

Hospital Historical Data

Copyright© HealthInsight 2012

Hospital																						
MAYO CLINIC HEALTH SYSTEM EAU CLAIRE HOSPITAL	2006 Q4	2007 Q1	2007 Q2	2007 Q3	2007 Q4	2008 Q1	2008 Q2	2008 Q3	2008 Q4	2009 Q1	2009 Q2	2009 Q3	2009 Q4	2010 Q1	2010 Q2	2010 Q3	2010 Q4	2011 Q1	2011 Q2	2011 Q3	2011 Q4	2012 Q1
National Ranking	99th	99th	99th	98th	97th	96th	93rd	91st	89th	90th	94th	94th	95th	94th	92nd	92nd	90th	89th	87th	86th	87th	84th
Overall Performance Rate	98	97	97	97	97	97	97	97	97	97	98	98	99	99	98	99	98	99	98	98	99	99

* Indicates a missing value for that quarter



Dynamic Flash charting solution provided by BlackBoxChart.com©

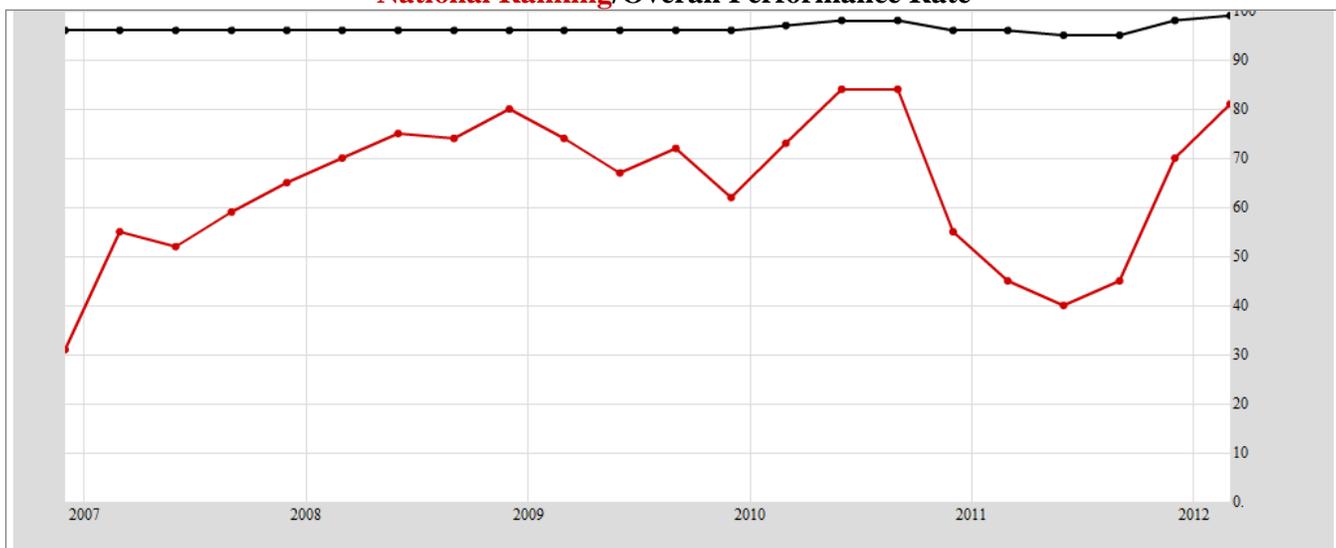
Hospital Historical Data

Copyright© HealthInsight 2012

Hospital																						
OAK LEAF SURGCL HSPTL	2006 Q4	2007 Q1	2007 Q2	2007 Q3	2007 Q4	2008 Q1	2008 Q2	2008 Q3	2008 Q4	2009 Q1	2009 Q2	2009 Q3	2009 Q4	2010 Q1	2010 Q2	2010 Q3	2010 Q4	2011 Q1	2011 Q2	2011 Q3	2011 Q4	2012 Q1
National Ranking	31st	55th	52nd	59th	65th	70th	75th	74th	80th	74th	67th	72nd	62nd	73rd	84th	84th	55th	45th	40th	45th	70th	81st
Overall Performance Rate	80	87	87	89	91	92	94	95	96	95	95	96	96	97	98	98	96	96	95	95	98	99

* Indicates a missing value for that quarter

National Ranking/Overall Performance Rate



Legend:

Red: National Ranking
Black: Overall Performance Rate

Dynamic Flash charting solution provided by BlackBoxChart.com©

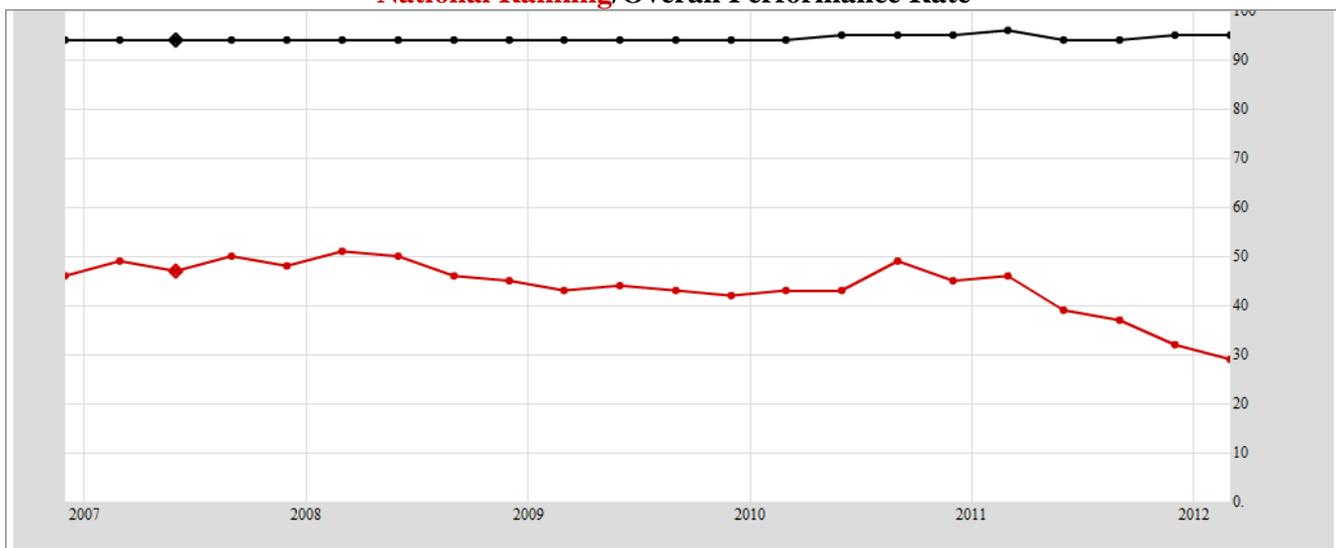
Hospital Historical Data

Copyright© HealthInsight 2012

Hospital																						
SACRED HEART HSPRTL: EAU CLAIRE	2006 Q4	2007 Q1	2007 Q2	2007 Q3	2007 Q4	2008 Q1	2008 Q2	2008 Q3	2008 Q4	2009 Q1	2009 Q2	2009 Q3	2009 Q4	2010 Q1	2010 Q2	2010 Q3	2010 Q4	2011 Q1	2011 Q2	2011 Q3	2011 Q4	2012 Q1
National Ranking	46th	49th	47th	50th	48th	51st	50th	46th	45th	43rd	44th	43rd	42nd	43rd	43rd	49th	45th	46th	39th	37th	32nd	29th
Overall Performance Rate	84	86	86	87	88	90	91	91	92	92	93	93	94	94	95	95	95	96	94	94	95	95

* Indicates a missing value for that quarter

National Ranking/Overall Performance Rate



Legend:

Red: National Ranking
Black: Overall Performance Rate

Dynamic Flash charting solution provided by BlackBoxChart.com®

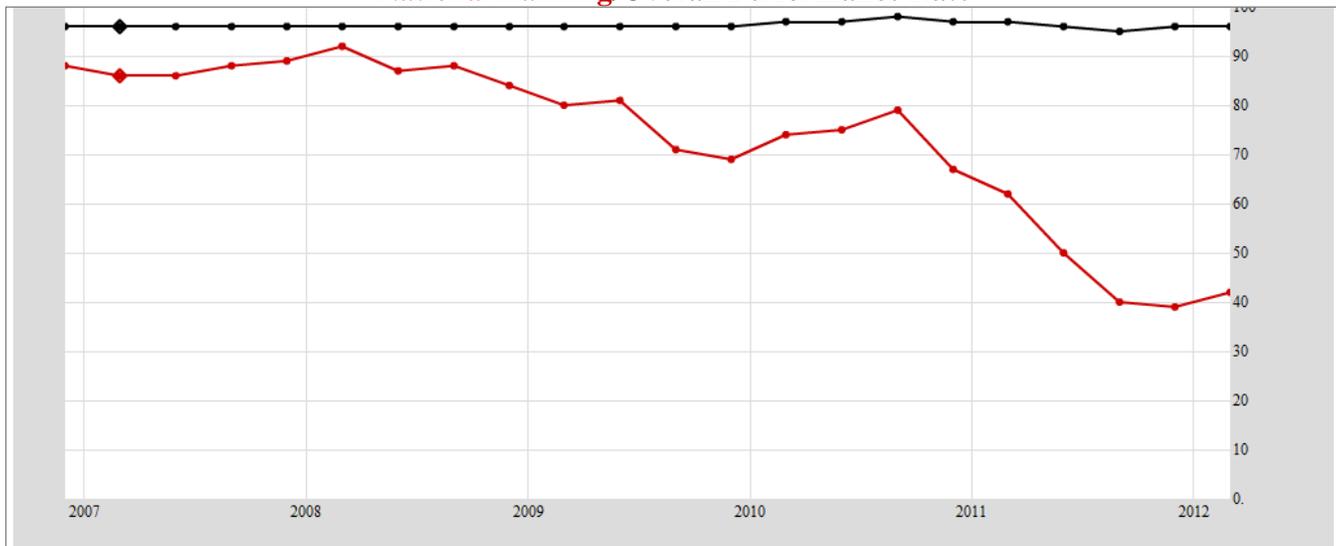
Hospital Historical Data

Copyright© HealthInsight 2012

Hospital																						
ST JOSEPHS HSPTL	2006 Q4	2007 Q1	2007 Q2	2007 Q3	2007 Q4	2008 Q1	2008 Q2	2008 Q3	2008 Q4	2009 Q1	2009 Q2	2009 Q3	2009 Q4	2010 Q1	2010 Q2	2010 Q3	2010 Q4	2011 Q1	2011 Q2	2011 Q3	2011 Q4	2012 Q1
National Ranking	88th	86th	86th	88th	89th	92nd	87th	88th	84th	80th	81st	71st	69th	74th	75th	79th	67th	62nd	50th	40th	39th	42nd
Overall Performance Rate	92	92	93	94	94	96	96	96	96	96	97	96	96	97	97	98	97	97	96	95	96	96

* Indicates a missing value for that quarter

National Ranking/Overall Performance Rate



Legend:

Red: National Ranking
 Black: Overall Performance Rate

Dynamic Flash charting solution provided by BlackBoxChart.com©

Appendix F

2011 Wisconsin Market Shares for Group
Accident and Health Insurance Companies

GROUP ACCIDENT & HEALTH

	INSURER	% OF MARKET	PREMIUMS WRITTEN	PREMIUMS EARNED	LOSSES INCURRED
1	UNITEDHEALTHCARE INS CO	11.3	1,170,003,651	1,169,215,999	899,209,637
2	UNITEDHEALTHCARE OF WI INC	8.1	836,736,572	835,098,864	746,294,768
3	DEAN HEALTH PLAN INC	8.0	826,537,930	826,537,930	776,184,988
4	WEA INS CORP	7.5	770,287,256	770,287,256	702,551,230
5	SECURITY HEALTH PLAN OF WI INC	5.5	565,413,259	565,413,259	542,905,427
6	PHYSICIANS PLUS INS CORP	4.3	440,285,871	439,569,055	423,510,003
7	BLUE CROSS BLUE SHIELD OF WI	4.2	437,661,724	425,846,512	387,414,190
8	NETWORK HEALTH PLAN	4.1	418,607,982	418,607,982	363,278,663
9	UNITY HEALTH PLANS INS CORP	3.8	397,379,621	397,379,622	361,135,795
10	COMPCARE HEALTH SERVICES INS CORP	3.4	349,094,557	349,128,737	267,725,285
11	HUMANA INS CO	3.2	334,972,569	330,426,377	268,989,127
12	WISCONSIN PHYSICIANS SERVICE INS CORP	2.7	278,959,626	279,297,464	250,034,977
13	GROUP HEALTH COOP OF SOUTH CENTRAL WI	2.6	269,109,089	267,230,386	244,352,398
14	GUNDERSEN LUTHERAN HEALTH PLAN INC	2.5	255,886,263	255,199,049	238,691,156
15	GROUP HEALTH COOP OF EAU CLAIRE	2.3	235,834,620	254,807,843	227,962,230
16	HUMANA WISCONSIN HEALTH ORGANIZATION INS CORP	1.9	201,112,319	201,052,374	173,246,326
17	HEALTH TRADITION HEALTH PLAN	1.3	135,712,959	135,712,959	124,204,595
18	DELTA DENTAL OF WI INC	1.3	129,600,749	132,402,584	108,418,922
19	MOLINA HEALTHCARE OF WI INC	1.2	124,227,264	124,227,264	111,248,797
20	HEALTHPARTNERS INS CO	1.1	116,626,000	116,626,000	97,807,000
21	MERCYCARE HMO INC	1.1	113,338,600	106,479,263	106,066,142
22	MANAGED HEALTH SERVICES INS CORP	1.1	112,881,765	112,881,765	184,473,227
23	PARTNERSHIP HEALTH PLAN INC	1.0	104,333,390	104,333,389	95,375,828
24	CHILDRENS COMMUNITY HEALTH PLAN INC	0.9	97,079,386	97,079,386	94,348,074
25	WPS HEALTH PLAN INC	0.9	91,561,405	91,561,405	76,781,297
26	COMMUNITY CARE HEALTH PLAN INC	0.9	88,342,025	88,129,323	79,284,124
27	SUN LIFE ASSUR CO OF CN	0.7	75,418,970	76,080,634	54,782,209
28	GOLDEN RULE INS CO	0.7	68,595,004	68,532,161	50,176,029
29	AETNA LIFE INS CO	0.6	63,053,212	61,738,159	60,066,849
30	MEDICA INS CO	0.6	58,913,530	58,913,529	66,951,335
31	UNUM LIFE INS CO OF AMER	0.6	57,969,574	57,934,378	37,642,175
32	HARTFORD LIFE & ACCIDENT INS CO	0.5	53,117,742	52,768,743	41,731,867
33	TIME INS CO	0.5	52,440,770	50,322,562	38,008,036
34	ANTHEM INS COS INC	0.4	43,756,959	35,126,218	32,180,409
35	TRILOGY HEALTH INS INC	0.4	43,518,099	43,518,099	36,393,528
36	METROPOLITAN LIFE INS CO	0.4	42,487,719	41,621,289	34,995,025
37	PRINCIPAL LIFE INS CO	0.4	36,517,533	36,931,911	27,165,713
38	FEDERATED MUTUAL INS CO	0.3	34,157,781	34,157,781	31,973,231
39	RELIASTAR LIFE INS CO	0.3	31,812,636	31,426,824	24,708,034
40	CONNECTICUT GENERAL LIFE INS CO	0.3	31,802,802	30,575,508	27,104,024
41	MEDICAL ASSOC CLINIC HEALTH PLAN OF WI THE	0.3	31,468,040	31,273,065	28,564,892
42	LINCOLN NATIONAL LIFE INS CO THE	0.3	28,478,352	28,545,631	22,077,407
43	HCC LIFE INS CO	0.3	28,249,798	28,236,635	17,047,535
44	SILVERSCRIPT INS CO	0.2	25,498,464	4,046,854	3,575,960
45	NATIONAL UNION FIRE INS CO OF PITTSBURGH	0.2	22,264,674	22,278,911	13,293,042
46	ALL SAVERS INS CO	0.2	21,436,644	20,724,208	13,101,862
47	HUMANADENTAL INS CO	0.2	20,683,268	20,395,736	14,176,090
48	AMERITAS LIFE INS CORP	0.2	20,540,119	20,653,163	15,861,960
49	AMERICAN REPUBLIC INS CO	0.2	19,961,541	20,354,966	14,888,277
50	CARE PLUS DENTAL PLANS INC	0.2	18,657,293	18,657,293	18,307,264
51	LIFE INS CO OF NORTH AMER	0.2	16,819,172	16,819,167	14,568,639
52	JOHN ALDEN LIFE INS CO	0.2	16,531,870	16,259,769	12,608,160
53	UNION SECURITY INS CO	0.2	16,482,895	16,509,937	10,210,177
54	COMPANION LIFE INS CO	0.2	16,165,359	16,157,541	12,035,568
55	HM LIFE INS CO	0.1	14,964,299	15,120,778	7,633,256
56	GUARDIAN LIFE INS CO OF AMER THE	0.1	14,834,477	14,838,519	10,028,286
57	MONUMENTAL LIFE INS CO	0.1	14,186,284	13,952,468	7,583,650
58	STANDARD INS CO	0.1	13,870,061	11,793,604	9,277,284
59	RELIANCE STANDARD LIFE INS CO	0.1	13,748,942	13,806,903	7,501,595
60	QBE INS CORP	0.1	13,659,757	13,627,915	10,918,245

GROUP ACCIDENT & HEALTH

	INSURER	% OF MARKET	PREMIUMS WRITTEN	PREMIUMS EARNED	LOSSES INCURRED
61	MADISON NATIONAL LIFE INS CO INC	0.1	13,573,630	13,300,561	6,066,848
62	PRUDENTIAL INS CO OF AMER THE	0.1	13,474,711	13,291,536	9,748,268
63	EPIC LIFE INS CO THE	0.1	13,229,087	13,742,516	9,623,721
64	WISCONSIN VISION SERVICE PLAN INC	0.1	11,842,629	11,842,629	10,072,705
65	DEAN HEALTH INS INC	0.1	10,997,614	10,997,614	10,180,453
66	TRUSTMARK LIFE INS CO	0.1	10,480,871	10,209,416	10,271,439
67	GERBER LIFE INS CO	0.1	10,026,106	10,180,938	3,959,999
68	VISION INS PLAN OF AMER INC	0.1	8,966,396	0	5,432,211
69	SYMETRA LIFE INS CO	0.1	8,957,686	9,018,342	8,839,156
70	ZURICH AMERICAN INS CO	0.1	8,563,872	8,770,963	6,429,048
71	MEGA LIFE & HEALTH INS CO THE	0.1	7,069,962	7,243,253	4,860,665
72	NEW YORK LIFE INS CO	0.1	6,779,606	6,867,552	6,386,882
73	KANAWHA INS CO	0.1	6,653,160	6,743,500	5,574,020
74	US FIRE INS CO	0.1	6,635,356	6,635,356	3,884,073
75	FIDELITY SECURITY LIFE INS CO	0.1	6,566,126	6,570,376	5,336,351
76	UNITED OF OMAHA LIFE INS CO	0.1	6,352,787	6,222,621	3,360,746
77	BERKLEY LIFE & HEALTH INS CO	0.1	6,264,839	6,765,150	126,756
78	LIBERTY LIFE ASSUR CO OF BOSTON	0.1	6,130,083	6,663,294	5,377,057
79	PAN AMERICAN LIFE INS CO	0.1	6,111,568	6,282,441	5,066,812
80	NATIONAL GUARDIAN LIFE INS CO	0.1	5,922,119	5,953,300	4,400,579
81	NETWORK HEALTH INS CORP	0.1	5,858,542	5,858,542	5,707,321
82	STANDARD SECURITY LIFE INS CO OF NY	0.1	5,602,752	5,528,227	4,601,275
83	STATE FARM MUTUAL AUTOMOBILE INS CO	0.0	4,834,346	4,834,346	6,042,202
84	CUNA MUTUAL INS SOCIETY	0.0	4,785,996	4,788,812	4,402,528
85	UNITED AMERICAN INS CO	0.0	4,699,967	4,662,014	3,533,589
86	AMERICAN FIDELITY ASSUR CO	0.0	4,575,970	4,493,435	4,873,322
87	WYSSTA INS CO INC	0.0	4,423,809	4,423,809	3,195,646
88	AMERICAN HERITAGE LIFE INS CO	0.0	4,328,998	4,355,940	1,427,465
89	NORTHWESTERN MUTUAL LIFE INS CO THE	0.0	4,265,103	4,436,178	6,242,453
90	PEKIN LIFE INS CO	0.0	4,158,684	4,165,485	2,673,085
91	ACE AMERICAN INS CO	0.0	4,148,231	4,334,290	2,186,793
92	BCS INS CO	0.0	4,019,296	4,021,218	3,336,381
93	AMERICAN UNITED LIFE INS CO	0.0	3,962,395	3,993,266	2,918,050
94	AMERICAN MEDICAL SECURITY LIFE INS CO	0.0	3,700,954	3,723,176	3,357,223
95	UNIMERICA INS CO	0.0	3,677,158	3,708,509	1,637,164
96	WORLD INS CO	0.0	3,400,798	3,453,034	2,693,287
97	ANTHEM LIFE INS CO	0.0	3,285,982	3,524,648	1,637,085
98	DIRECT DENTAL SERVICE PLAN INC	0.0	3,279,785	3,279,785	2,886,211
99	STONEBRIDGE LIFE INS CO	0.0	3,265,169	3,266,350	740,258
100	FORT DEARBORN LIFE INS CO	0.0	3,209,468	3,209,468	3,522,848
101	MII LIFE INC	0.0	3,197,229	3,197,229	2,100,966
102	MIDWEST NATIONAL LIFE INS CO OF TN	0.0	3,164,013	3,211,924	2,063,325
103	BANKERS LIFE & CSLTY CO	0.0	3,124,727	3,186,169	2,439,433
104	AMERICAN DENTAL PLAN OF WI INC	0.0	3,049,744	3,049,744	2,617,343
105	NATIONAL INS CO OF WI INC	0.0	2,828,577	2,828,577	2,217,489
106	DENTAL COM INS PLAN	0.0	2,766,983	2,766,983	2,490,285
107	EXPRESS SCRIPTS INS CO	0.0	2,761,386	2,761,386	2,733,265
108	DENTEGRA INS CO	0.0	2,671,621	2,616,154	1,776,510
109	US LIFE INS CO IN THE CITY OF NY THE	0.0	2,666,786	3,655,882	1,782,569
110	JOHN HANCOCK LIFE INS CO USA	0.0	2,616,340	2,622,431	841,406
111	SECURITY LIFE INS CO OF AMER	0.0	2,560,909	2,494,326	1,643,990
112	TRANSAMERICA LIFE INS CO	0.0	2,468,695	2,490,466	1,619,144
113	PERICO LIFE INS CO	0.0	2,381,312	2,381,279	1,663,180
114	SUN LIFE & HEALTH INS CO (US)	0.0	2,309,340	2,310,005	1,115,995
115	COLUMBIAN LIFE INS CO	0.0	2,116,483	2,286,180	1,627,134
116	CONTINENTAL AMERICAN INS CO	0.0	2,095,307	2,285,579	990,005
117	MINNESOTA LIFE INS CO	0.0	1,907,971	2,061,828	776,452
118	COMBINED INS CO OF AMER	0.0	1,836,675	1,836,528	1,372,329
119	CONTINENTAL CASUALTY CO	0.0	1,769,248	-213,920	1,317,635
120	AMERICAN FAMILY MUTUAL INS CO	0.0	1,751,730	1,751,730	1,710,597

GROUP ACCIDENT & HEALTH

	INSURER	% OF MARKET	PREMIUMS WRITTEN	PREMIUMS EARNED	LOSSES INCURRED
121	KANSAS CITY LIFE INS CO	0.0	1,629,132	1,637,220	1,151,926
122	TRUSTMARK INS CO	0.0	1,574,035	1,571,611	1,111,635
123	UNION LABOR LIFE INS CO THE	0.0	1,387,834	1,372,456	105,873
124	GENWORTH LIFE INS CO	0.0	1,326,970	1,272,634	930,488
125	NIPPON LIFE INS CO OF AMER	0.0	1,322,820	1,433,433	1,066,958
126	HARTFORD LIFE INS CO	0.0	1,299,994	1,281,455	1,017,037
127	STERLING LIFE INS CO	0.0	1,262,709	1,378,655	1,035,891
128	CIGNA HEALTH & LIFE INS CO	0.0	1,217,028	1,216,824	915,407
129	NATIONWIDE LIFE INS CO	0.0	1,213,069	1,201,963	1,041,990
130	IMPERIUM INS CO	0.0	1,198,161	1,198,161	172,840
131	AAA LIFE INS CO	0.0	1,170,328	1,205,485	256,920
132	AMERICAN MEDICAL & LIFE INS CO	0.0	1,167,415	1,167,415	406,448
133	MUTUAL OF OMAHA INS CO	0.0	1,059,113	1,069,248	828,422
134	SENTRY INS A MUTUAL CO	0.0	1,048,473	-175,084	1,790,066
135	LONDON LIFE REINS CO	0.0	1,010,933	1,010,933	466,564
136	FIDELITY LIFE ASSN A LEGAL RESERVE LIFE INS CO	0.0	1,010,254	1,010,255	1,351,404
137	SENTRY LIFE INS CO	0.0	986,466	769,391	3,297,827
138	GREAT WEST LIFE & ANNUITY INS CO	0.0	785,992	559,380	617,246
139	AMERICAN GENERAL LIFE INS CO OF DE	0.0	776,391	834,769	1,438,958
140	PHYSICIANS MUTUAL INS CO	0.0	754,282	718,476	404,319
141	EVEREST REINSURANCE CO	0.0	741,612	741,612	642,783
142	AMERICAN NATIONAL LIFE INS CO OF TX	0.0	731,699	737,598	698,042
143	FEDERAL INS CO	0.0	724,420	1,758,047	1,086,092
144	STARR INDEMNITY & LIABILITY CO	0.0	687,402	969,950	509,422
145	GUARANTEE TRUST LIFE INS CO	0.0	682,671	689,062	201,086
146	MERCYCARE INS CO	0.0	677,105	669,443	722,992
147	AMEX ASSURANCE CO	0.0	524,293	526,896	51,496
148	MARKEL INS CO	0.0	505,757	505,681	267,876
149	SEARS LIFE INS CO	0.0	491,827	406,469	68,662
150	ONEBEACON AMERICA INS CO	0.0	483,982	519,577	249,404
151	LIBERTY LIFE INS CO	0.0	446,656	683,154	233,939
152	AMERICAN GENERAL ASSUR CO	0.0	431,432	309,970	146,185
153	ALLSTATE LIFE INS CO	0.0	420,858	425,704	855,298
154	FIRST HEALTH LIFE & HEALTH INS CO	0.0	408,951	224,501	-29,088
155	US SPECIALTY INS CO	0.0	404,273	413,803	220,324
156	CHESAPEAKE LIFE INS CO THE	0.0	402,136	412,544	182,061
157	AMERICAN FAMILY LIFE ASSURNC CO OF COLUMBUS	0.0	354,388	376,313	179,506
158	WESTERN RESERVE LIFE ASSUR CO OF OH	0.0	352,865	352,865	159,178
159	PAUL REVERE LIFE INS CO THE	0.0	350,937	351,698	202,446
160	STARNET INS CO	0.0	328,809	383,471	65,937
161	INDEPENDENCE AMERICAN INS CO	0.0	306,150	306,150	76,562
162	AMERICAN INCOME LIFE INS CO	0.0	305,324	303,867	231,866
163	UNICARE LIFE & HEALTH INS CO	0.0	299,197	270,944	195,463
164	BALBOA LIFE INS CO	0.0	286,229	286,229	63,627
165	AMALGAMATED LIFE INS CO	0.0	278,320	278,320	16,622
166	WESTPORT INS CORP	0.0	273,787	273,787	1,552,971
167	MEDCO CONTAINMENT LIFE INS CO	0.0	243,541	243,541	155,564
168	COVENTRY HEALTH & LIFE INS CO	0.0	242,167	242,167	-227,112
169	CAPITOL INDEMNITY CORP	0.0	237,634	226,746	97,374
170	WASHINGTON NATIONAL INS CO	0.0	213,903	215,044	51,710
171	STARMOUNT LIFE INS CO	0.0	205,311	214,785	222,444
172	MIDWEST SECURITY LIFE INS CO	0.0	197,922	113,662	-760,862
173	RELIASTAR LIFE INS CO OF NY	0.0	192,819	192,502	0
174	ILLINOIS MUTUAL LIFE INS CO	0.0	179,554	177,616	66,719
175	CELTIC INS CO	0.0	142,424	136,549	28,178
176	SECURIAN LIFE INS CO	0.0	140,433	140,266	85,101
177	BROKERS NATIONAL LIFE ASSUR CO	0.0	139,305	139,412	121,125
178	UNION FIDELITY LIFE INS CO	0.0	114,562	112,860	32,537
179	COLONIAL LIFE & ACCIDENT INS CO	0.0	104,268	104,265	64,515
180	MUTUAL OF AMER LIFE INS CO	0.0	101,247	101,247	112,807

GROUP ACCIDENT & HEALTH

	INSURER	% OF MARKET	PREMIUMS WRITTEN	PREMIUMS EARNED	LOSSES INCURRED
181	NORTH AMERICAN INS CO	0.0	97,151	99,829	48,887
182	UNITED CONCORDIA INS CO	0.0	95,708	95,708	75,450
183	BOSTON MUTUAL LIFE INS CO	0.0	89,915	89,459	71,667
184	TRANSAMERICA FINANCIAL LIFE INS CO	0.0	87,094	89,888	2,015
185	GREAT WEST LIFE ASSUR CO THE	0.0	82,286	82,286	469
186	GREAT AMERICAN LIFE INS CO	0.0	69,199	68,920	531
187	4 EVER LIFE INS CO	0.0	67,923	68,278	18,746
188	AMERICAN BANKERS LIFE ASSUR CO OF FL	0.0	65,502	65,843	-660
189	GREAT AMERICAN INS CO	0.0	63,959	85,575	-6,927
190	OXFORD LIFE INS CO	0.0	51,274	50,486	48,873
191	STANDARD LIFE & ACCIDENT INS CO	0.0	49,380	54,728	9,201
192	CENTRAL UNITED LIFE INS CO	0.0	46,672	49,059	1,591
193	VISION CARE NETWORK INS CORP	0.0	46,387	46,387	0
194	FARM BUREAU LIFE INS CO	0.0	45,222	37,774	40,611
195	AMERICAN PUBLIC LIFE INS CO	0.0	43,475	43,314	17,160
196	AEGIS SECURITY INS CO	0.0	42,060	36,887	7,702
197	EYE CARE OF WI INS INC	0.0	39,801	39,801	17,007
198	JOHN HANCOCK LIFE & HEALTH INS CO	0.0	39,125	36,095	0
199	HARLEYSVILLE LIFE INS CO	0.0	37,559	37,701	0
200	AMERICAN ALTERNATIVE INS CORP	0.0	37,537	37,537	26,153
201	MEDAMERICA INS CO	0.0	37,288	40,902	33,263
202	USABLE LIFE	0.0	33,673	33,673	33,992
203	REASSURE AMERICA LIFE INS CO	0.0	33,411	45,566	0
204	COUNTRY LIFE INS CO	0.0	33,058	33,081	4,150
205	PRESIDENTIAL LIFE INS CO	0.0	30,142	30,142	24,890
206	AXIS INS CO	0.0	29,831	14,638	5,757
207	GREAT NORTHERN INS CO	0.0	29,613	17,128	2,760
208	OLD REPUBLIC LIFE INS CO	0.0	28,092	28,092	-49,387
209	AMERICAN BANKERS INS CO OF FL	0.0	20,677	20,890	-8,921
210	AUTO CLUB LIFE INS CO	0.0	19,011	19,195	-389
211	SECURITY MUTUAL LIFE INS CO OF NY	0.0	17,890	17,790	18,535
212	METLIFE INS CO OF CT	0.0	17,704	15,712	49,815
213	COMMERCIAL TRAVELERS MUTUAL INS CO	0.0	16,957	17,398	0
214	LAFAYETTE LIFE INS CO THE	0.0	14,366	14,366	76,962
215	PROVIDENT LIFE & ACCIDENT INS CO	0.0	13,184	3,498	309,387
216	GREAT SOUTHERN LIFE INS CO	0.0	11,706	11,705	0
217	NATIONAL BENEFIT LIFE INS CO	0.0	10,959	10,966	1,774
218	SHENANDOAH LIFE INS CO	0.0	10,880	10,880	152,321
219	UNITED TEACHER ASSOCIATES INS CO	0.0	10,466	10,700	752
220	RIVERSOURCE LIFE INS CO	0.0	9,484	9,464	635
221	MONY LIFE INS CO	0.0	8,465	8,558	0
222	RESERVE NATIONAL INS CO	0.0	8,422	0	0
223	LINCOLN LIFE & ANNUITY CO OF NY	0.0	8,068	8,171	9,346
224	BALTIMORE LIFE INS CO THE	0.0	7,542	7,542	6,566
225	USAA LIFE INS CO	0.0	6,853	6,880	0
226	NATIONWIDE MUTUAL INS CO	0.0	6,564	6,563	273,065
227	CENTRAL STATES INDEMNITY CO OF OMAHA	0.0	6,513	6,654	-4,516
228	AMERICAN HEALTH & LIFE INS CO	0.0	5,421	5,502	-840
229	PRIMERICA LIFE INS CO	0.0	3,998	4,183	483
230	STONEBRIDGE CASUALTY INS CO	0.0	3,749	3,746	232
231	GOVERNMENT PERSONNEL MUT LIFE INS CO	0.0	3,702	3,780	3,832
232	RENAISSANCE LIFE & HEALTH INS CO OF AMER	0.0	3,544	3,544	4,305
233	CANADA LIFE ASSURNC CO THE	0.0	3,504	3,158	182,303
234	CENTRAL STATES HEALTH & LIFE CO OF OMAHA	0.0	3,036	10,012	18,141
235	NATIONAL CASUALTY CO	0.0	3,016	3,667	60
236	ALLIANZ LIFE INS CO OF NORTH AMER	0.0	2,590	3,455	1,211
237	SENIOR HEALTH INS CO OF PA	0.0	1,889	2,296	41
238	FAMILY HERITAGE LIFE INS CO OF AMER	0.0	1,578	1,504	0
239	AMERICAN GENERAL LIFE INS CO	0.0	1,494	1,494	0
240	COLORADO BANKERS LIFE INS CO	0.0	1,197	1,170	285

GROUP ACCIDENT & HEALTH

	INSURER	% OF MARKET	PREMIUMS WRITTEN	PREMIUMS EARNED	LOSSES INCURRED
241	FIRST ALLMERICA FINANCIAL LIFE INS CO	0.0	1,097	991	446
242	UNITED LIFE INS CO	0.0	1,035	1,035	0
243	21ST CENTURY PREMIER INS CO	0.0	946	1,054	1,501
244	SAFEHEALTH LIFE INS CO	0.0	878	882	230
245	MOMENTUM INS PLANS INC	0.0	695	695	91
246	HOUSEHOLD LIFE INS CO	0.0	394	394	0
247	HORACE MANN LIFE INS CO	0.0	346	327	388
248	UNIFIED LIFE INS CO	0.0	264	256	69
249	GARDEN STATE LIFE INS CO	0.0	253	393	0
250	IDS PROPERTY CSLTY INS CO	0.0	137	129	0
251	COLONIAL PENN LIFE INS CO	0.0	130	162	59
252	WILTON REASSURANCE LIFE CO OF NY	0.0	91	91	0
253	MEMBERS LIFE INS CO	0.0	44	44	0
254	BALBOA INS CO	0.0	6	6	332
255	NEW HAMPSHIRE INS CO	0.0	0	913	0
256	AMERICAN HOME ASSUR CO	0.0	0	6	240
257	INSURANCE COMPANY OF NORTH AMER	0.0	0	0	148,182
258	HEALTH NET LIFE INS CO	0.0	0	0	60,236
259	AXA EQUITABLE LIFE INS CO	0.0	0	0	59,252
260	TEACHERS INS & ANNUITY ASSN OF AMER	0.0	0	0	51,161
261	PHOENIX LIFE INS CO	0.0	0	0	21,862
262	MONARCH LIFE INS CO	0.0	0	0	7,994
263	CONSECO LIFE INS CO	0.0	0	0	3,847
264	IA AMERICAN LIFE INS CO	0.0	0	0	2,083
265	PROTECTIVE LIFE INS CO	0.0	0	0	2,045
266	GENWORTH LIFE & ANNUITY INS CO	0.0	0	0	1,886
267	INSURANCE COMPANY OF STATE OF PA THE	0.0	0	0	1,522
268	CENTRAL RESERVE LIFE INS CO	0.0	0	0	1,474
269	EMPIRE FIRE & MARINE INS CO	0.0	0	0	2
270	FAIRFIELD INS CO	0.0	0	0	-74
271	CONTINENTAL GENERAL INS CO	0.0	0	0	-97
272	AMERICAN ZURICH INS CO	0.0	0	0	-257
273	CLARENDON NATIONAL INS CO	0.0	0	0	-1,876
274	EMPLOYERS INS CO OF WAUSAU	0.0	0	0	-4,468
275	TIG INS CO	0.0	0	0	-37,019
276	UNION CENTRAL LIFE INS CO THE	0.0	0	0	-47,820
277	MEDICA HEALTH PLANS OF WI	0.0	0	0	-56,077
278	TRAVELERS INDEMNITY CO OF CT THE	0.0	0	0	-142,702
279	UNITED WISCONSIN INS CO	0.0	0	0	-2,155,786
280	ILLINOIS NATIONAL INS CO	0.0	0	-1	0
281	5 STAR LIFE INS CO	0.0	0	-27	0
282	NATIONAL HEALTH INS CO	0.0	-54	-54	-61,318
283	CONTINENTAL LIFE INS CO OF BRENTWOOD TN	0.0	-625	-634	-66
284	WISCONSIN AUTO & TRUCK DEALERS INS CORP	0.0	-3,586	-3,586	-137,661
	TOTAL WISCONSIN OPERATIONS	100.0	10,331,053,165	10,278,164,569	9,033,700,884