State of Arizona

Arizona Department of Administration
Benefit Services Division

2011 Annual Report
Benefit Options

January 1, 2011 through December 31, 2011

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Choice Value Health

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FOREWORD

Benefit Options is the program name for the benefits offered to State of Arizona employees and retirees. This report was prepared to give a broad overview of Benefit Options.

The information provided in the report was gathered from contracted vendors participating in the Benefit Options insurance programs. This report was compiled to meet the requirements of A.R.S. §38-652 (G) and A.R.S. §38-658 (B).

The data shown is presented for the period January 1, 2011 through December 31, 2011. The active and retiree plans were concurrent for this period.

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Report Background

This document has been assembled to report the financial status of the Employee Health Insurance Trust Fund pursuant to A.R.S. §38-652 (G), which reads:

> G. The department of administration shall annually report the financial status of the trust account to officers and employees who have paid premiums under one of the insurance plans from which monies were received for deposit in the trust account since the inception of the health and accident coverage program or since submission of the last such report, whichever is later.

The Benefit Options program is accounted for in two different funds. The Special Employee Health Fund, also known as fund 3015 or the Health Insurance Trust Fund (HITF), encompasses the medical and dental programs and the appropriated expenditures for ADOA Benefit Services operations. The ERE/Benefits Administration Fund or fund 3035, is primarily a "pass through" fund for other benefits including vision, disability insurance, life insurance and flexible spending accounts.

The benefits offered through the program fall into one of two types — self-funded or fully-insured. The health benefit plan is self-funded; whereas the dental plans, vision plan, disability insurance, and life insurance plans are fully-insured.

The State's self-funded medical plan began on October 1, 2004, and consists of a carved out pharmacy plan with integrated or nonintegrated options for the medical plan. The integrated option combines the functions of; claims review and payment, network access, and utilization review and utilization management (URUM), and case management and disease management. The non-integrated option is similar, but the URUM function is carved out to a separate contracted vendor.

Schedules of premiums received and accounted for in fund 3015; incurred and paid medical/drug claims; expenses related to the medical and dental plans; and distribution by enrollment are included within this Annual Report. A summary of premiums collected and paid for life insurance, vision insurance and flexible spending accounts has also been included for fund 3035. The Cash Flow Reconciliation charts for the two funds can be found in Appendix A. The difference in the values presented in Appendix A and the Health Insurance Trust Fund (HITF) Summary on page 4 is a result of the difference between when premiums and/or services are incurred and when they are paid. Appendix A was prepared on a cash basis, where as, the HITF Summary was prepared on an accrued and paid basis.

All data provided herein is for the Plan Year 2011 (January 1, 2011 – December 31, 2011).

Executive Summary

During the 2011 Plan Year, the Benefit Services Division (BSD) Health Plan offered a comprehensive insurance package to over 128 thousand members consisting of active State and University employees, retirees, and their qualified dependents. The benefits include medical, pharmaceutical, dental, flexible spending, vision, wellness, life, and disability insurance.

Premiums
Based on the 2011 Contribution Strategy, the total premiums expected were $810 million with total expenses for the plan of $702 million, resulting in an expected net operational gain of $108 million.

Medical Expenses
Medical claims expenses accounted for $455 million of the total health plan cost during 2011. The average cost to insure each member was $5,065.50.

- Average active member cost was $4,795.78
- Average retiree cost was $8,452.79

The leading diagnosis category when analyzed by cost was the musculoskeletal system, accounting for $56 million or just over 12% of total claims paid.

Medical Utilization
Claims showed members are seeking the care of a physician or specialist for the majority of their medical needs. There were 192 emergency room visits, 194 urgent care visits, and 4,270 physician visits per 1,000 members on the plan indicating appropriate care.

Pharmacy Expenses
Total pharmacy expense was $115 million. The five most expensive drug classes are maintenance drugs used to control and prevent chronic diseases. Diabetes drugs were the highest cost with 11 million dollars or 15% of the total pharmacy expenses.

Pharmacy Utilization
A reported 1.5 million prescriptions were filled during the 2011 plan year.

- Retirees filled an average of 25.1 prescriptions per year
- Active members averaged 10.4 per year

Performance Measures
Financial guarantees are in place to manage the performance of the contacted Health Plan vendors. Penalties collected for the prior plan year totaled over $201,000.

Review
The 2011 Plan Year demonstrated a balance of expenses and premiums that allowed the State to offer members comprehensive and affordable insurance coverage. The State effectively controlled the rise in health care costs through quality benefit design, administrative oversight, strategic planning and auditing, and effective contract management. Detailed evidence of the State's Health Plan accomplishments can be reviewed herein.

Health Insurance Trust Fund Summary

Table 1 provides a summary of receipts, expenses, and enrollment incurred during the 2011 Plan Year and paid through March 2012.

ADOA Benefit Options refers to the self-funded medical program and includes Aetna, Blue Cross Blue Shield of Arizona administered by AmeriBen, CIGNA, and United Healthcare networks. UHC Secure Horizons, BCBS (NAU), and all dental plans are fully-insured.

State and University employees and retirees choose coverage from one of the self-funded networks. However, Blue Cross Blue Shield is a fully-insured option available only to NAU employees and NAU retirees. UHC Secure Horizons is a fully-insured option that was available to Medicare-eligible retirees until the contract terminated December 31, 2009.

Table 1: Health Insurance Trust Fund Summary

	2011	2009-2010*
Receipts (accrual basis)		
ADOA Benefit Options	$733,523,433.75	$664,852,966.76
UHC Secure Horizons		$1,839,423.23
BCBS (NAU)	$34,511,692.27	$30,718,640.22
Dental	$42,927,763.06	$42,061,539.64
Total	$810,962,889.08	$739,472,569.85
Expenses		
Medical Claims (accrual basis)	$455,227,059.25	$442,328,374.53
Drug Claims (accrual basis)	$115,534,293.24	$104,245,794.65
Medicare Part D Subsidy	($2,651,407.78)	($1,249,718.22)
Rebates & Recoveries	($10,606,711.75)	($12,994,653.98)
Reserve for Unreported Claims	$38,007,320.98	$36,270,926.71
Secure Horizons expense		$2,260,433.67
BCBS Payments	$34,320,311.68	$30,714,058.44
Administration Fees	$27,016,754.23	$29,092,947.64
Stop-Loss Premiums		$6,470,888.20
Appropriated Expenses	$4,190,980.95	$3,846,184.78
Dental Costs	$41,767,766.83	$40,848,735.78
Total	$702,806,367.63	$681,833,972.20
Difference	$108,156,521.45	$57,638,597.65

**The data is for the incurred period October 2009 through September 2010 and paid through December 2010.*

The Medicare Part D Subsidy is available to employers who provide a qualified pharmacy plan to Medicare-eligible retirees. Rebates & Recoveries consist of rebates paid by drug manufacturers, performance penalties assessed to contractors for not achieving performance guarantees, overpayment recoveries, and stop-loss reinsurance payments. Reserve (IBNR) is the amount of money that must be held in reserve for the purpose of paying claims that have been incurred but have not been reported. Stop-loss is a "-catastrophic claim-" reinsurance program that covers individual medical/drug plan expenses over $500 thousand with a lifetime maximum of $2 million.

Enrollment in Benefit Options Medical Plans

The Benefit Options group medical plan is available to the following:

- Eligible State employees and University staff, officers, and elected officials
- State retirees receiving pension benefits through any of the State retirement systems
- State employees or University staff accepted for long-term disability benefits
- employees of participating political subdivisions
- State employees or University staff eligible for COBRA benefits

There are three medical plans offered to active participants under Benefit Options. They are the Exclusive Provider Organization (EPO), the Preferred Provider Organization (PPO), and the Health Savings Account Option (HSA).

The EPO Plan
If the employee chooses the EPO plan under Benefit Options, services must be obtained from a Network provider. Out-of-Network services are only covered in emergency situations. Under the EPO plan, the employee will pay the monthly premium and any required copay at the time of service. The EPO plan is available with all four Networks: Aetna, Blue Cross Blue Shield of Arizona Network administered by AmeriBen, CIGNA, and UnitedHealthcare.

The PPO Plan
If the employee chooses the PPO plan under Benefit Options, services can be provided in-Network or out-of-Network, but there will be higher costs for out-of-Network services. Additionally, there is an in-Network and out-of-Network deductible that must be met. Under the PPO plan, the employee will pay the monthly premium and any required copay or coinsurance (percent of the cost) at the time of service. The PPO plan is available with Aetna, Blue Cross Blue Shield of Arizona Network administered by AmeriBen, and UnitedHealthcare.

The High Deductible Health Plan (HSA Option)
If the employee chooses to enroll in the High Deductible Health Plan (HSA Option), the employee will be eligible to open a Health Savings Account (HSA), which is a special type of account that allows tax-free contributions, earnings, and healthcare-related withdrawals.

If the HSA Option is chosen, the employee can use in-Network and out-of-Network providers. Members pay the copay and/or coinsurance after the deductible is met.

The premiums for the HSA Option are lower, qualified preventative services are free, and members pay coinsurance and/or copays.

The table on page 5 shows how enrollment was distributed between networks and between active, retired, university, and COBRA members.

Table 2: Average Monthly Enrollment					
		2011		2009-2010*	
Network	Plan Type	Subscribers	Members **	Subscribers	Members **
AETNA					
Active	EPO	1,273	2,865	1,037	2,338
Retiree	EPO	261	342	278	354
University	EPO	1,230	2,246	981	1,767
COBRA	EPO	20	30	21	32
Active	PPO	81	146	75	123
Retiree	PPO	51	62	72	90
University	PPO	142	231	116	191
COBRA	PPO	0	1	2	3
Active	HSAO	146	285	109	194
Retiree	HSAO	-	-	-	-
University	HSAO	194	347	136	256
COBRA	HSAO	1	1	3	5
AmeriBen					
Active	EPO	5,839	14,441	5,528	13,516
Retiree	EPO	1,098	1,443	1,104	1,459
University	EPO	1,705	3,558	1,524	3,161
COBRA	EPO	35	47	60	88
Active	PPO	240	428	205	360
Retiree	PPO	147	181	220	267
University	PPO	256	468	250	460
COBRA	PPO	3	4	7	11
CIGNA					
Active	EPO	2,942	6,913	2,688	6,398
Retiree	EPO	624	803	688	900
University	EPO	1,134	2,283	1,127	2,209
COBRA	EPO	9	11	25	37
UnitedHealthcare					
Active	EPO	22,059	51,942	23,337	53,633
Retiree	EPO	4,735	6,126	4,838	6,318
University	EPO	11,683	25,938	12,340	26,505
COBRA	EPO	158	206	402	588
Active	PPO	520	948	645	1,145
Retiree	PPO	131	168	178	233
University	PPO	630	1,165	761	1,429
COBRA	PPO	10	12	26	39
Blue Cross Blue Shield					
NAU only	PPO	2,821	4,391	2,809	2,961
SecureHorizons					
Medicare only	HMO	-	-	2,223	2,890
Total		60,177	128,029	63,814	129,959

** The data is for the incurred period October 2009 through September 2010.*
***UHC Secure Horizons plan was not offered during the 2011 Plan Year.*

Medical Premiums

The tables below summarize medical rates by pay period for active and retired members.

Table 3: Pay Period Medical Premiums (26 pay periods)*					
Plan	**Tier**	**Employee Premium**	**State Premium**	**Total Premium**	**Agency HSA Contribution**
EPO (Aetna, BCBSAZ/AmeriBen**, CIGNA, UnitedHealthcare)	Emp only	$18.46	$253.85	$272.31	-
	Emp+adult	$54.92	$522.92	$577.84	-
	Emp+child	$46.62	$497.54	$544.16	-
	Family	$102.00	$648.46	$750.46	-
PPO (Aetna, BCBSAZ/AmeriBen**, UnitedHealthcare)	Emp only	$71.54	$342.00	$413.54	-
	Emp+adult	$161.54	$695.08	$856.62	-
	Emp+child	$152.77	$667.85	$820.62	-
	Family	$224.31	$890.31	$1,114.62	-
HSA (Aetna)	Emp only	$12.00	$232.15	$244.15	$27.70
	Emp+adult	$47.08	$466.15	$513.23	$55.39
	Emp+child	$37.38	$450.92	$488.30	$55.39
	Family	$89.08	$583.85	$672.93	$55.39

Table 4: Medical Premiums (Without Medicare)		
	Tier	**Premium Payment**
EPO (Aetna, BCBSAZ/AmeriBen**, CIGNA,	Retiree only	$593
	Retiree +1	$1,387
	Family	$1,869
PPO (Aetna, BCBSAZ/AmeriBen**, UnitedHealthcare)	Retiree only	$943
	Retiree +1	$2,219
	Family	$3,074

Table 5: Monthly Medical Premiums (With Medicare)		
	Tier	**Premium Payment**
EPO (Aetna, BCBSAZ/AmeriBen**, CIGNA, UnitedHealthcare)	Retiree only	$442
	Retiree +1 (Both Medicare)	$878
	Retiree +1 (One Medicare)	$1,024
	Family (Two Medicare)	$1,166
PPO (Aetna, BCBSAZ/AmeriBen**, UnitedHealthcare)	Retiree only	$789
	Retiree +1 (Both Medicare)	$1,576
	Retiree +1 (One Medicare)	$1,740
	Family (Two Medicare)	$1,980

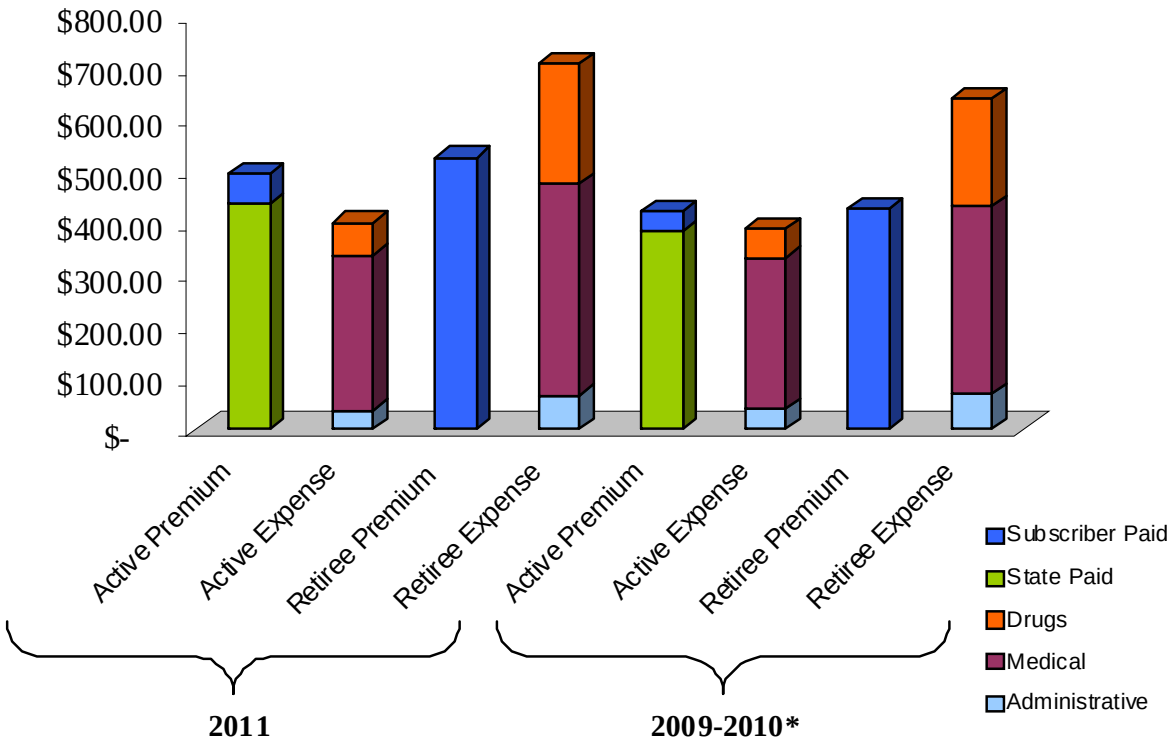
**University of Arizona has 24 pay period deductions; please refer to your Human Resources website for more information.*

***Blue Cross Blue Shield of Arizona Network administered by AmeriBen.*

Expenses vs. Premiums for Active and Retired Members

The figure below shows how the average monthly premiums compared to the average monthly cost for active and retired members.

Figure 1: Average Monthly Premiums and Expenses per Member



** The data is for the incurred period October 2009 through September 2010.*

ADOA developed an employee/employer cost strategy that provided affordable health insurance to all State and University employees. The EPO plan was offered to employees for an employee contribution of $39 for single, $97 for employee plus adult, $79 for employee plus child, and $178 for family coverage. Monthly premiums were determined from actual experience and the true cost of the coverage.

The 2011 contribution strategy for the self-insured medical plan resulted in employees paying 11% of the average monthly total premium, while the State paid the remaining 89%. The contribution strategy for the dental plans resulted in employees paying 85% of the average monthly total premium, while the State paid the remaining 15%.

Pursuant to A.R.S. §38.651.01(B.), retiree and active medical expenses shall be grouped together to "obtain health and accident coverage at favorable rates." This requirement results in retiree premium rates lower than what their experience would otherwise dictate.

Expenses for Benefit Options Self-Funded Plans

The tables below show the distribution of the self-funded expenses. Table 6 shows the expenses distributed between active/retiree and EPO/PPO members. The average annual cost to insure each type of subscriber/member is also provided.

Table 6: Self-funded Expenses by Active, Retiree, EPO, and PPO Subscribers and Members

Expenses	Overall	Active	Retiree	EPO	PPO	HSAO
Medical Claims (accrual basis)	$455,227,059	$410,610,823	$44,616,236	$434,664,778	$19,859,588	$702,693
Drug Claims (accrual basis)	$115,534,293	$87,652,031	$27,882,262	$106,481,018	$9,000,169	$53,105
Medicare Part D Subsidy	($2,651,408)		($2,651,408)	($2,527,836)	($123,571)	
ERRP Reimbursement	($429,413)	($374,869)	($33,567)	($327,021)	($14,941)	($529)
Rebates & Recoveries	($10,606,712)	($9,259,440)	($1,347,272)	($10,056,353)	($536,314)	($14,045)
Reserve (IBNR)	$38,007,321	$33,179,605	$4,827,716	$36,035,204	$1,921,788	$50,329
Administration Fees	$27,016,754	$23,697,480	$3,319,274	$25,815,127	$1,040,727	$160,900
Stop-Loss Premiums	$0	$0	$0	$0	$0	$0
Appropriated Expenses	$4,190,981	$3,676,078	$514,903	$4,004,578	$161,443	$24,960
Total	$626,288,876	$549,181,709	$77,128,144	$594,089,496	$31,308,889	$977,414
Enrollment in self-funded plans						
Subscribers	$57,355	$50,309	$7,047	$54,804	$2,209	$342
Members	$123,638	$114,513	$9,125	$119,193	$3,812	$632
Annual cost						
Per subscriber	$10,919	$10,916	$10,945	$10,840	$14,171	$2,861
Per member	$5,066	$4,796	$8,453	$4,984	$8,213	$1,546

Table 7 below shows the distribution of expenses by benefit plan.

Table 7: Self-funded Expenses by Benefit Plan

Expenses (in dollars)	Overall	Active/ EPO	Active/ PPO	Active/ HSAO	Retiree/ EPO	Retiree/ PPO
Medical Claims (accrual basis)	$455,227,059	$391,642,686	$18,265,444	$702,693	$43,022,092	$1,594,144
Drug Claims (accrual basis)	$115,534,293	$80,190,719	$7,408,207	$53,105	$26,290,300	$1,591,962
Medicare Part D Subsidy	($2,651,408)				($2,532,053)	($119,355)
ERRP Reimbursement	($429,413)	($354,985)	($13,742)	($529)	($32,368)	($1,199)
Rebates & Recoveries	($10,606,712)	($8,768,290)	($477,105)	($14,045)	($1,288,063)	($59,209)
Reserve (IBNR)	$38,007,321	$31,419,653	$1,709,623	$50,329	$4,615,551	$212,165
Administration Fees	$27,016,754	$22,650,551	$886,029	$160,900	$3,164,576	$154,698
Stop-Loss Premiums	$0	$0	$0	$0	$0	$0
Appropriated Expenses	$4,190,981	$3,513,673	$137,446	$24,960	$490,906	$23,998
Total	$626,288,876	$520,294,007	$27,915,902	$977,414	$73,730,941	$3,397,203
Enrollment in self-funded plans						
Subscribers	$57,355	$48,086	$1,881	$342	$6,718	$328
Members	$123,638	$110,479	$3,402	$632	$8,714	$411
Annual cost						
Per subscriber	$10,919	$10,820	$14,841	$2,861	$10,975	$10,344
Per member	$5,066	$4,709	$8,207	$1,546	$8,461	$8,271

Medical Expenses Associated with Medical Diagnoses

The table below shows how medical expenses were distributed among different diagnoses. More dollars are spent on treating conditions related to the musculoskeletal system than on any other diagnosis.

Table 8: Medical Expenses by Diagnosis – Actives & Retirees

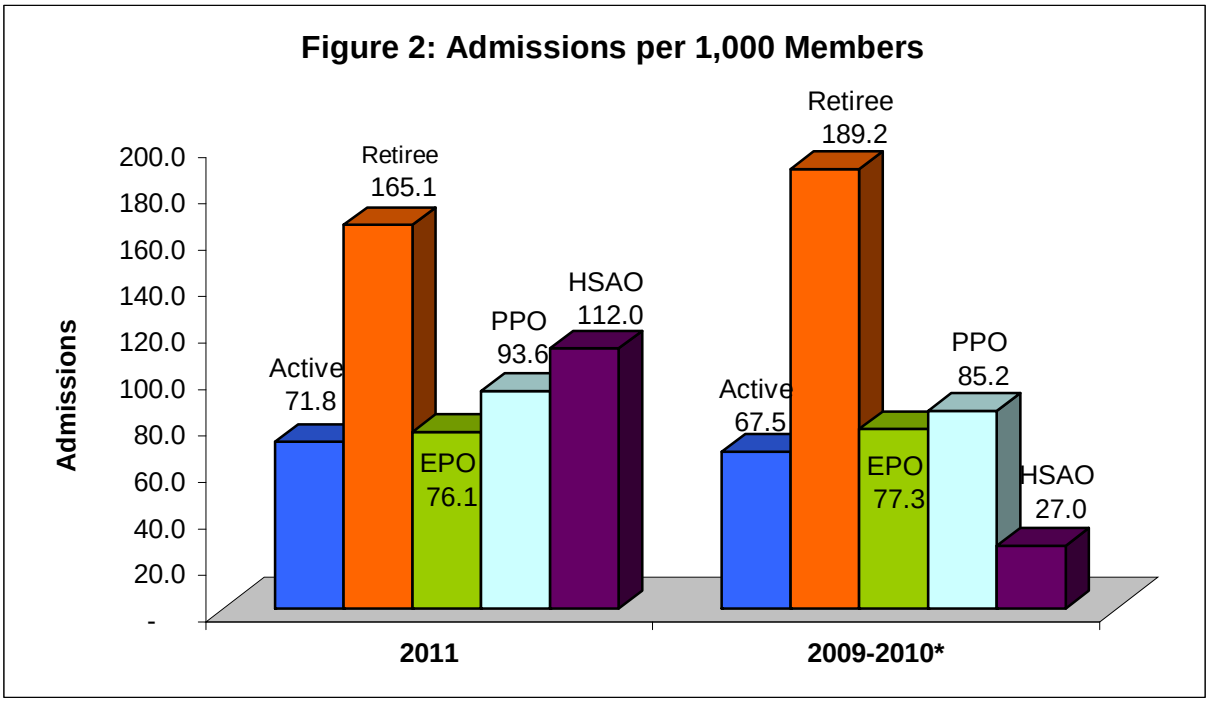
	2011			2009-2010*		
	Actives	Retirees	All members	Actives	Retirees	All members
Diagnosis	**% of Total**	**% of Total**	**% of Total**	**% of Total**	**% of Total**	**% of Total**
Musculoskeletal System and Connective Tissue	12.25%	14.23%	12.31%	12.65%	14.57%	12.83%
Supplementary Classification of Factors Influencing Health Status and Contact With Health Service	10.23%	9.73%	10.21%	10.16%	8.38%	9.99%
Neoplasms	9.88%	17.39%	10.09%	8.22%	12.73%	8.64%
Symptoms, Signs, and Ill-Defined Conditions	9.69%	7.92%	9.64%	9.92%	8.16%	9.75%
Circulatory System	7.89%	8.28%	7.90%	8.05%	13.47%	8.56%
Injury and Poisoning	7.65%	5.70%	7.60%	9.44%	6.14%	9.13%
Digestive System	6.95%	5.69%	6.92%	7.32%	5.34%	7.14%
Genitourinary System	6.85%	8.55%	6.90%	7.32%	9.78%	7.55%
Nervous System and Sense Organs	6.39%	9.36%	6.48%	5.63%	7.95%	5.85%
Respiratory System	4.90%	3.77%	4.87%	4.92%	4.40%	4.87%
Pregnancy, Childbirth, and The Puerperium	4.26%	0.00%	4.14%	4.37%	0.02%	3.96%
Endocrine, Nutritional and Metabolic Diseases, and Immunity Disorders	3.77%	3.97%	3.78%	3.51%	3.56%	3.52%
Mental Disorders	2.55%	1.36%	2.52%	2.30%	1.46%	2.22%
Infectious and Parasitic Diseases	2.24%	1.91%	2.23%	1.90%	1.22%	1.84%
Skin and Subcutaneous Tissue	1.59%	1.24%	1.58%	1.53%	1.65%	1.54%
Congenital Anomalies	1.52%	0.14%	1.48%	1.49%	0.20%	1.37%
Blood and Blood-Forming Organs	0.99%	0.77%	0.99%	0.92%	0.96%	0.93%
Certain Conditions Originating In The Perinatal Period	0.38%	0.00%	0.37%	0.35%	0.00%	0.32%
Supplementary Classification Of External Causes of Injury and Poisoning	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Grand Total	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%

** The data is for the incurred period October 2009 through September 2010.*

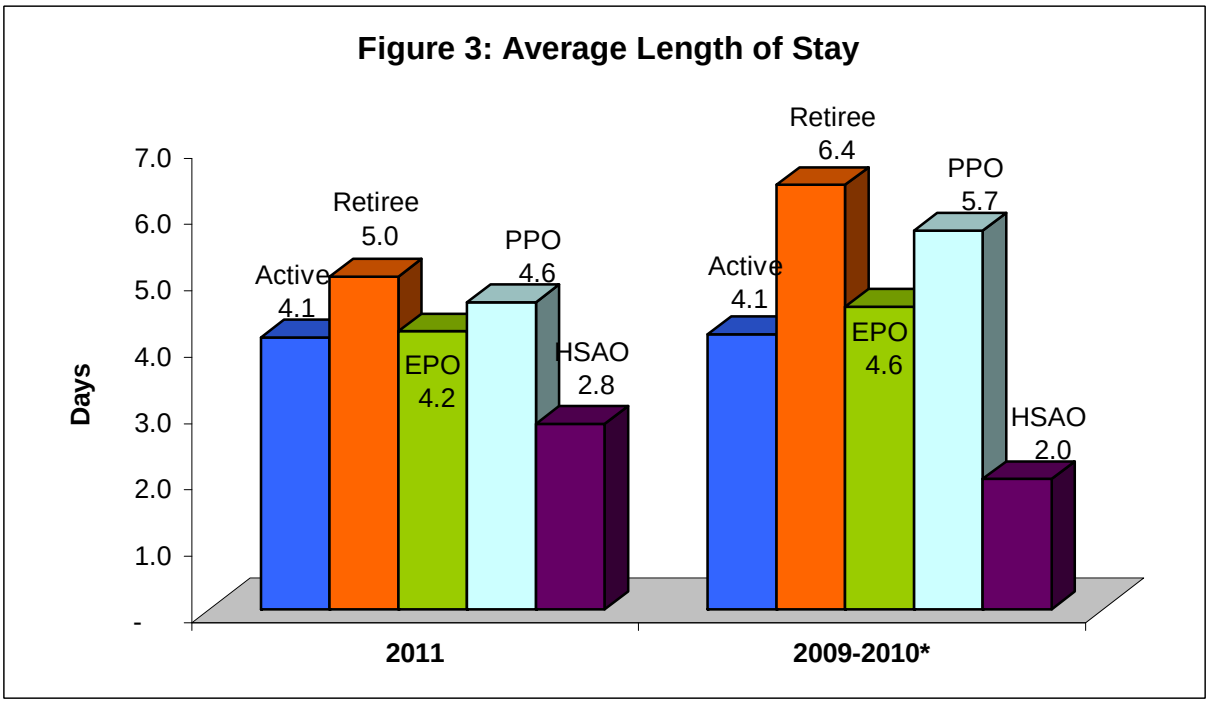
Note: Some statistics may vary slightly from previous annual reports due to the late receipt of program data following the completion of the previous annual report. In no case does the variation represent a substantive change in trend or comparative values.

Hospital Care

Inpatient hospital care represents a significant portion of total medical expenses: 36% for active members and 33% for retired members. The figures below show a comparison of hospital admissions and the average length of stay for active and retired members and EPO, PPO, and HSA members.



** The data is for the incurred period October 2009 through September 2010*

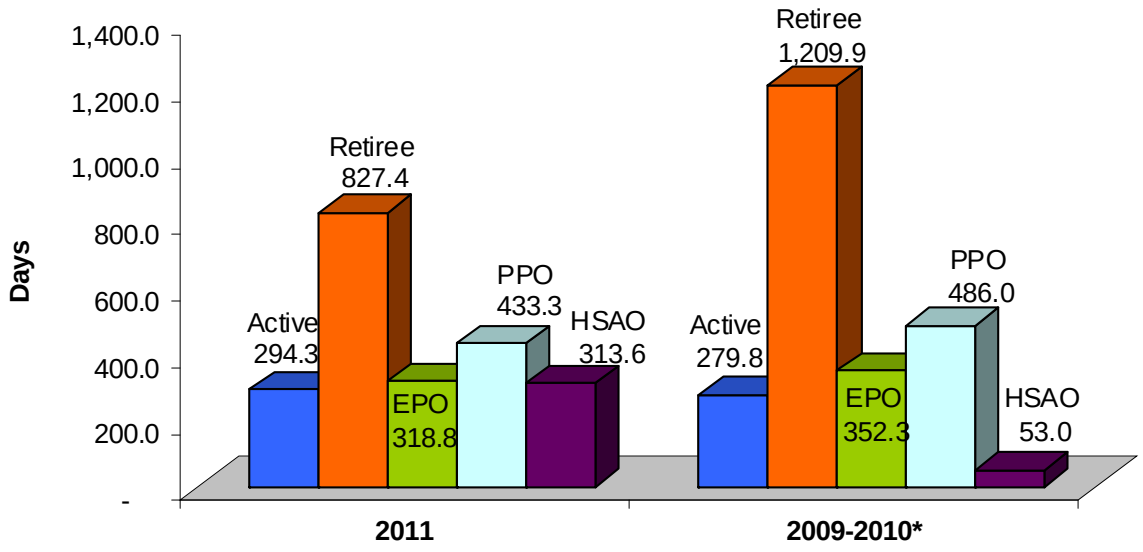


** The data is for the incurred period October 2009 through September 2010*
Note: Mental health, substance abuse, and maternity admissions are included.

Hospital Care (continued)

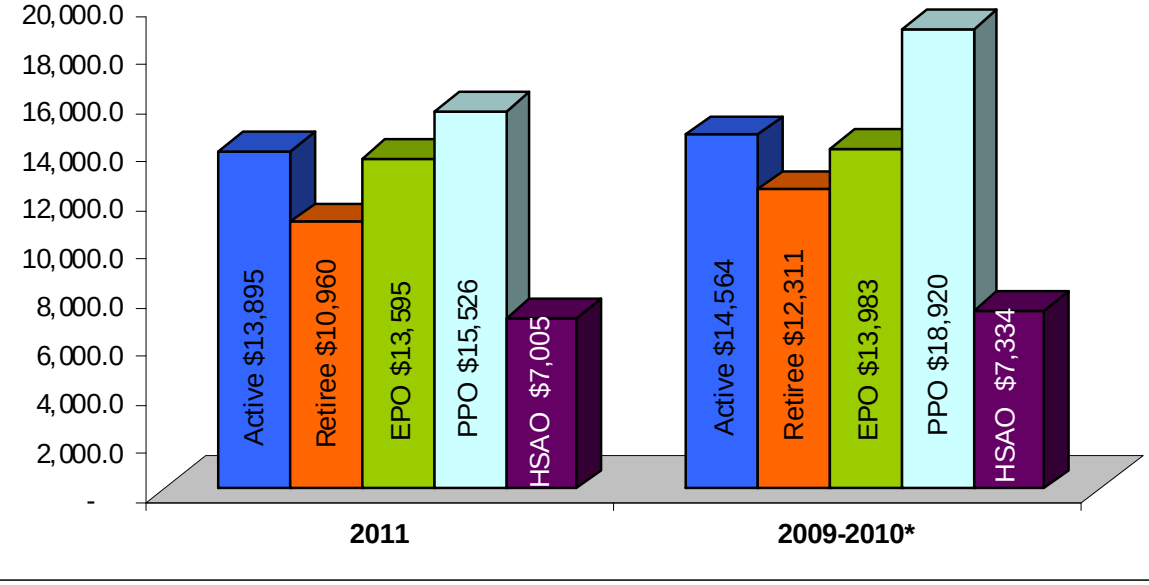
The figures below show how active/retired members and EPO/PPO/HSAO members compared statistically in number of hospital days and average cost per admission. As a group, retirees spent 2.8 times as many days in the hospital as active members. Also, PPO members spent 1.3 times as many days in the hospital as EPO members. On average, PPO members cost per admission was $1,930 higher than EPO members.

Figure 4: Days per 1,000 Members



**The data is for the incurred period October 2009 through September 2010.*

Figure 5: Average Cost per Admission



**The data is for the incurred period October 2009 through September 2010.*
Note: Mental health, substance abuse, and maternity admissions are included.

Emergency Room Visits

During Plan Year 2011, there were approximately 193 emergency room visits per 1,000 members of the self-funded plan. The average plan cost per emergency room visit was $1,139.26. This cost is indicative of proper utilization of emergency room visits. These figures include facility claims and professional fees.

Urgent Care Visits

During Plan Year 2011, there were approximately 194 urgent care visits per 1,000 members of the self-funded plan. The average plan cost per urgent care visit was $98.43.

Physician Visits

During Plan Year 2011, there were approximately 4,270 physician visits per 1,000 members (or each member of the self-funded plan visited a physician approximately 4.3 times). The average plan cost per office visit cost was $95.66.

Figures 6 and 7 show how total active and retiree medical expenses were distributed by type of care. 2.25% of medical expenses for active employees were spent for emergency room care while 1.25% of medical expenses for retired members were spent for emergency room care.

Figure 6: Active Employee Medical Expense by Place of Service

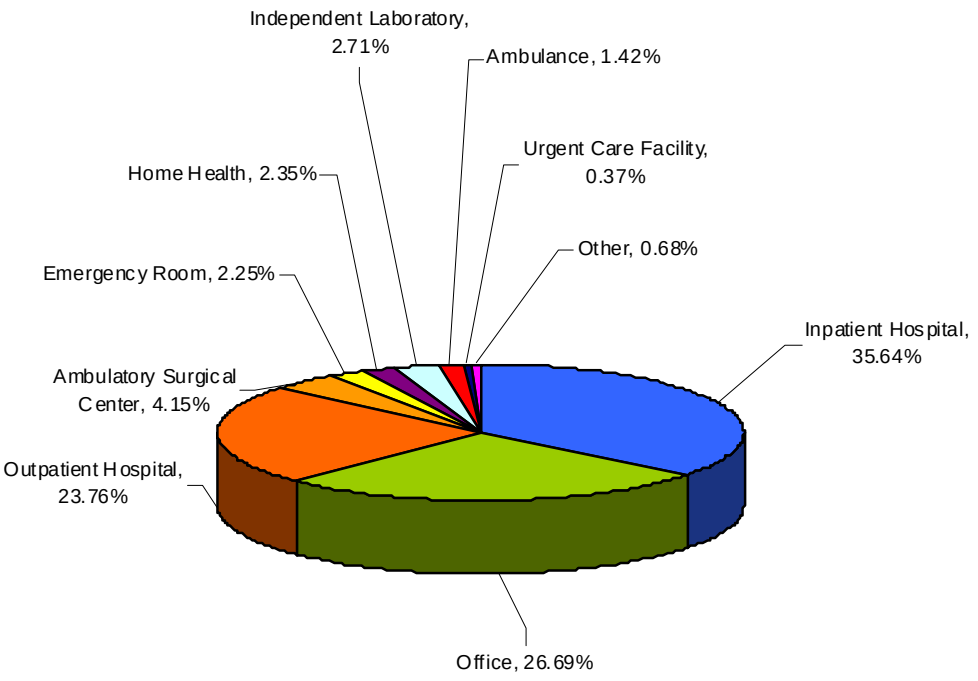
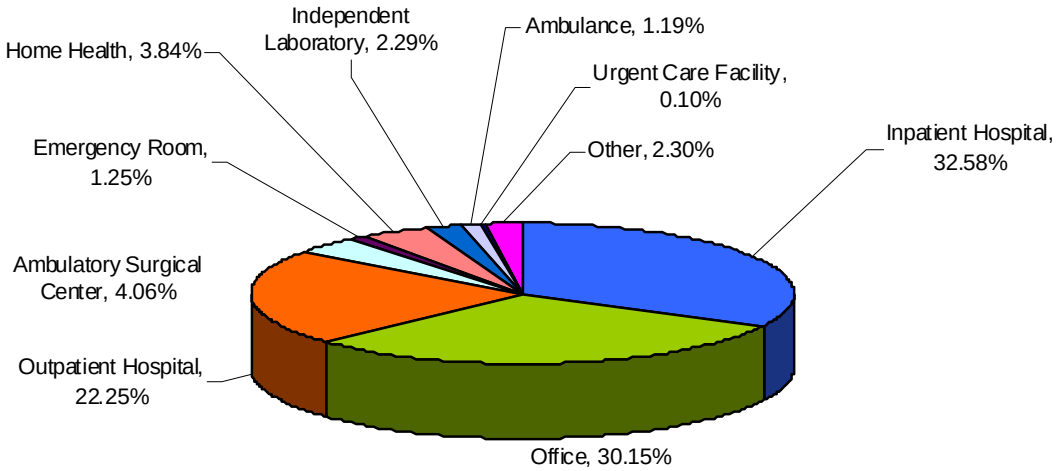
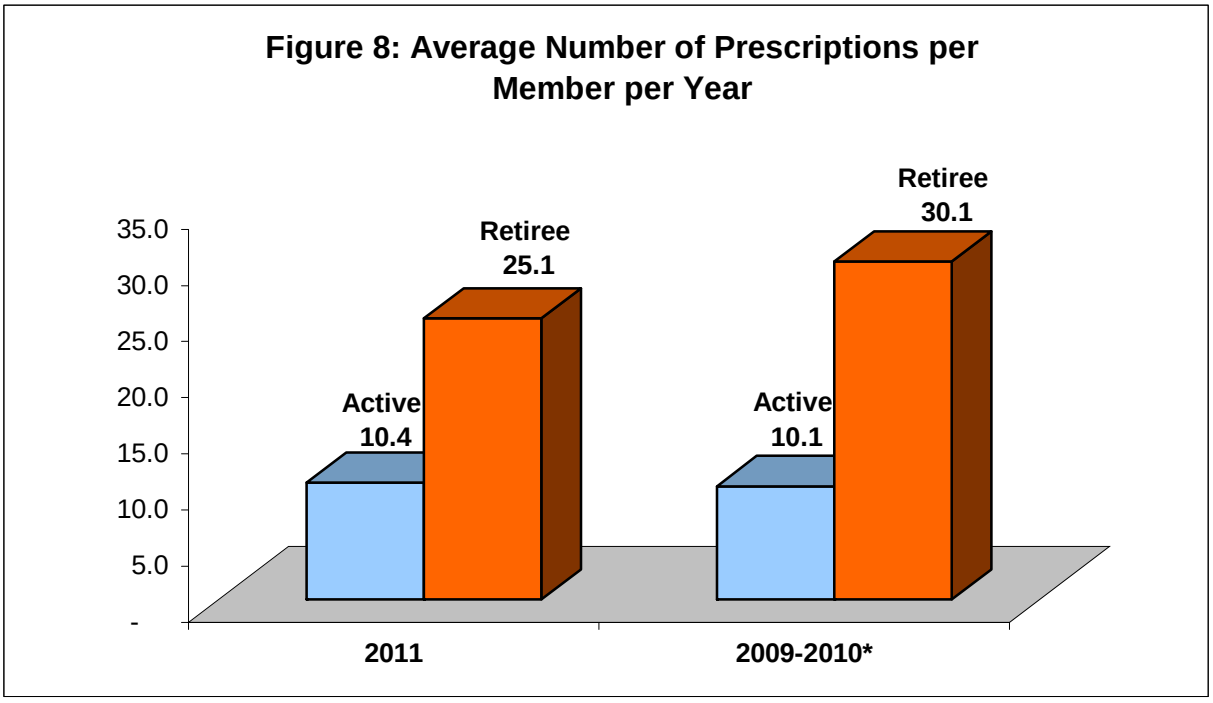


Figure 7: Retiree Medical Expense by Place of Service



Annual Prescription Use

The figure below compares the average number of prescriptions filled last plan year by active and retired members.



**The data is for the incurred period October 2009 through September 2010.*

Generic and Name-Brand Prescription Use

The table below shows how total pharmacy expenses were distributed among generic, preferred, and non-preferred types of drugs.

Table 9: Claim Distribution for 3-tier Formulary				
	2011		2009-2010*	
	Total Prescriptions	Percent	Total Prescriptions	Percent
Tier 1 Generic ($10 copay)	1,058,605	72.1%	980,591	68.0%
Tier 2-Preferred ($20 copay)	302,013	20.6%	361,208	25.0%
Tier 3-Non-Preferred ($40 copay)	107,477	7.3%	101,173	7.0%
Total	1,468,096	100.0%	1,442,972	100.0%

**The data is for the incurred period October 2009 through September 2010.*

Prescription Use by Therapeutic Class

The table below shows the ten most utilized classes of drugs according to total expense. More dollars were spent on "Diabetes", than on any other therapeutic class.

Table 10: Top Therapeutic Classes by Total Expense				
	2011		2009-2010*	
Therapeutic Class	Total Cost	Percent	Total Cost	Percent
Diabetes	$11,135,835	15.17%	$9,602,335	8.70%
Cardiovascular Disease - Lipid	$11,067,035	15.08%	$10,065,596	9.10%
Behavioral Health - Other	$8,742,497	11.91%	$7,078,441	6.40%
Asthma	$8,291,055	11.30%	$7,705,106	7.00%
Inflammatory Disease	$7,446,035	10.15%	$6,527,936	5.90%
Behavioral Health - Antidepressants	$6,327,975	8.62%	$7,431,696	6.70%
Infectious Disease - Viral	$5,377,764	7.33%	$5,214,141	4.70%
Pain Management - Analgesics	$5,168,510	7.04%	$5,965,851	5.40%
Upper Gastrointestinal Disorders - Ulcer	$4,947,846	6.74%	$5,549,570	5.00%
Cardiovascular Disease - Hypertension	$4,884,327	6.66%	$5,450,331	4.90%
Anticonvulsants				
Total	$73,388,879	100.00%	$70,591,003	63.80%

**The data is for the incurred period October 2009 through September 2010.*

Prescription Use by Type of Drug

The table below shows the ten most utilized drugs according to total expense. Lipitor, a cholesterol controlling medication, is the leading prescription for the plan year.

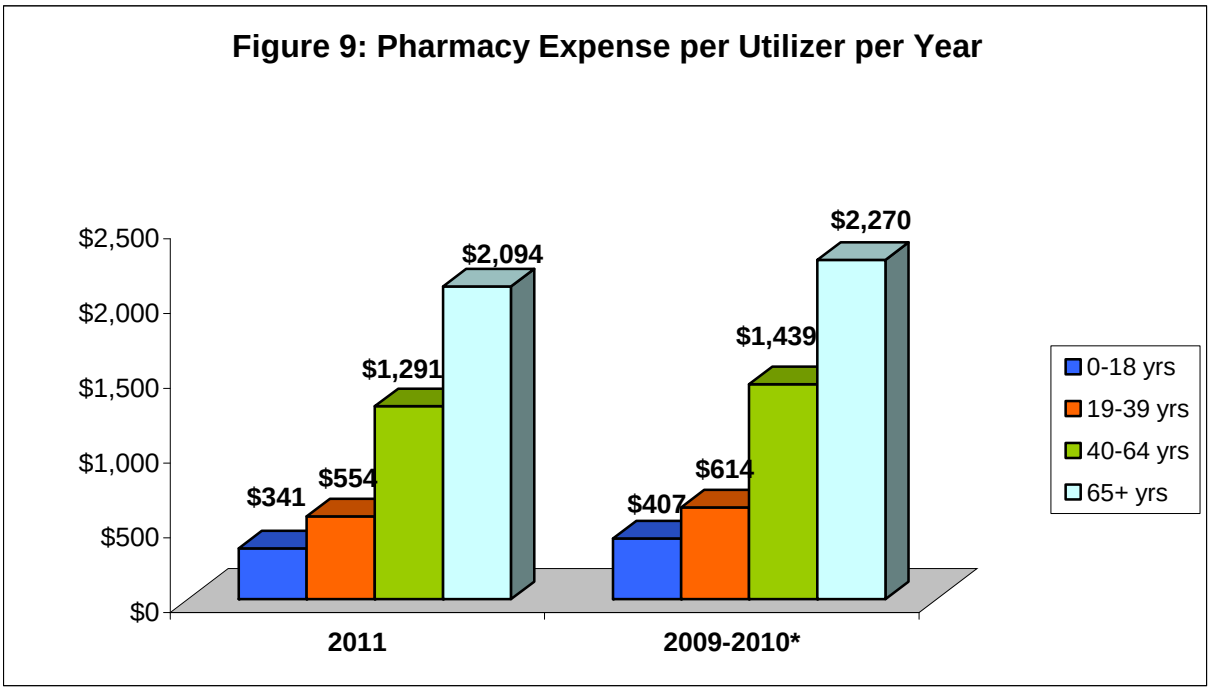
Table 11: Top Ten Drugs by Total Expense

2011			2009-2010*		
Drug Name	**Total Gross Cost**	**Percent**	**Drug Name**	**Total Gross Cost**	**Percent**
Lipitor	$3,945,794	3.42%	Lipitor	$3,440,283	3.30%
Crestor	$2,753,127	2.38%	Enbrel	$2,289,241	2.20%
Humira	$2,664,647	2.31%	Advair diskus	$2,063,084	1.98%
Singulair	$2,494,553	2.16%	Humira	$2,062,801	1.98%
Enbrel	$2,220,952	1.92%	Crestor	$2,000,769	1.92%
Cymbalta	$2,093,297	1.81%	Singulair	$1,921,456	1.84%
Plavix	$2,073,300	1.79%	Plavix	$1,769,859	1.70%
Carbaglu	$1,877,138	1.62%	Cymbalta	$1,663,635	1.60%
Copaxone	$1,789,746	1.55%	Actos	$1,566,236	1.50%
Lexapro	$1,666,472	1.44%	Oxycontin	$1,461,868	1.40%
Total	$23,579,026	20.41%	Total	$20,239,230	19.41%

**The data is for the incurred period October 2009 through September 2010.*

Annual Pharmacy Expenses by Age

The figure below shows how pharmacy expenses increase with age among plan members.



**The data is for the incurred period October 2009 through September 2010.*

Note: Some statistics may vary slightly from previous annual reports due to the late receipt of program data following the completion of the previous annual report. In no case does the variation represent a substantive change in trend or comparative values.

Benefit Options Fully-Funded Dental Plans

Benefit Options offers two different dental plan types: a Prepaid Plan provided by Total Dental Administrators and an Indemnity Plan provided by Delta Dental.

Prepaid Plan – Total Dental Administrators (TDA)

Key components of Prepaid Plan include:

- See a Participating Dental Provider (PDP) to provide and coordinate all dental care
- No annual deductible or maximums ($200.00 maximum reimbursement for non-contracted emergency services) under Total Dental Administrators
- No claim forms (except for emergency services)

Indemnity/PPO Plan – Delta Dental

Key components of Indemnity/PPO Plan include:

- May see any dentist. Deductible and/or out-of-pocket payments apply
- A maximum benefit of $2,000 per person per plan year for dental services
- $1,500 per person lifetime for orthodontia
- May need to submit a claim form for eligible expenses to be paid
- Benefits may be based on reasonable and customary charges

The following table show how active employee and retiree dental enrollments were distributed among plans.

Table 12. Average Monthly Enrollment

	Delta	TDA	TOTAL
Actives	34,088	16,179	50,267
Retirees	10,479	2,184	12,662

Dental Rates

The table below summarizes monthly dental rates for active and retired members.

Table 13: Summary of Monthly Dental Rates									
Active Employees	**Single Coverage**			**Employee +One Coverage**			**Family Coverage**		
	Employee	State	Total	Employee	State	Total	Employee	State	Total
Delta Dental	$30.98	$4.96	$35.94	$70.87	$9.92	$80.79	$123.12	$13.70	$136.82
Total Dental Admin.	$5.00	$4.96	$9.96	$9.00	$9.92	$18.92	$14.00	$13.70	$27.70
Retirees	**Single Coverage**			**Employee +One Coverage**			**Family Coverage**		
Delta Dental	$35.94			$80.79			$136.82		
Total Dental Admin.	$9.96			$18.92			$27.70		

Wellness

Worksite wellness services are available to State employees as part of the employer benefits through the Benefit Options Program. Employees have access to preventive health screenings, annual flu vaccines and Employee Assistance Program (EAP) benefits.

The table below shows the total utilization of the health screening benefit during the 2011 Plan Year and the number of at-risk employees referred to follow up care.

Table 14: Plan Year 2011 Screenings

	Events	Participants***	Referrals
Mini Health Screening*	79	2,994	499
Osteoporosis Screening**		1,308	12
Prostate Specific Antigen (PSA)**		273	20
Facial Skin Analysis**		1,769	N/A
Mobile Onsite Mammography	63	1,168	33
Prostate Onsite Projects	23	517	63
Total	165	8,029	627

** The basic Mini Health Screening includes; full lipid panel, fasting blood glucose, blood pressure, BMI, and body composition.*
*** Optional tests offered as a package with the basic Mini Health Screening.*
**** Participants are not unique.*

The table below shows the total utilization for the 2011 Annual Flu Vaccine Program held October through December. Wellness provided a total of 14,039 vaccines. Employees had access to the flu vaccine at a total of 477 locations, and 89% of members received shots at a worksite clinic.

Table 15: Plan Year 2011 Flu Vaccines

	Locations	Participants
State Agency Worksite	178	7,668
University Worksite	38	3,108
Combined Worksite (Wesley Bolin)	6	1,690
Open Enrollment Clinics	4	163
Public Clinics	251	1,410
Total	477	14,039

The table below shows the utilization for the Employee Assistance Program (EAP) and support services offered to agencies covered under the Arizona Department of Administration. EAP counseling and FamilySource consultation are the two most utilized services both telephonically and online.

Table 16: Plan Year 2011 EAP Utilization

	Eligible Population	Users	Utilization Rate
Live Telephonic Access		1153	5.5%
EAP		894	4.3%
FamilySource		54	0.3%
FinancialConnect		42	0.2%
LegalConnect		163	0.8%
Online Access		3637	17.5%
EAP		568	2.7%
FamilySource		1025	4.9%
FinancialConnect		443	2.1%
GlobalConnect		6	0.0%
Health & Wellness		712	3.4%
LegalConnect		883	4.2%
Critical Incident Stress Debriefing		19	0.1%
Trainings		68	0.3%
Overall Utilization	20,807	4,877	23.4%

A three year Wellness strategic plan was put into place midway through 2011 to enhance the services offered to Benefit Options members. The major strategic plan achievements for the 2011 Plan Year included wellness rebrand and revised communications, improved integration with health plan vendors, assignment of quarterly health topics, and the implementation of health management educational series.

During the third and fourth quarters wellness targeted heart disease and diabetes and organized 18 health management classes, 16 weight management and, 2 cholesterol management series. A total of 353 participants utilized the new health management series and lost on average 11 pounds.

Life, Disability, Vision Insurance and Flexible Spending Accounts Premiums

The table below shows the amount of premiums collected and paid for life insurance, disability insurance, vision insurance, and flexible spending accounts (FSA).

Table 17: Summary of Earned Premiums

	2011		2009-2010*	
Vendor	**Collected**	**Paid**	**Collected**	**Paid**
Hartford**				
Basic Life	$1,380,353	$1,391,396	$2,353,728	
Supp Life	$11,251,701	$11,249,172	$11,569,012	
Dep Life	$2,537,922	$2,537,759	$2,635,373	
STD	$7,505,119	$7,504,655	$7,538,133	
LTD	$2,830,391	$2,829,702	$2,744,220	
Total	$25,505,485	$25,512,684	$26,840,466	$23,930,135
Avesis - Vision**	$4,703,866	$4,689,082		$4,728,106
ASI - FSA	$4,576,280	$4,876,516		$5,861,366
Total	$34,785,632	$35,078,282		$36,765,607

**Per contract, vendors paid 55 days in arrears.*

Health Insurance Vendor Performance Standards

Pursuant to A.R.S. § 38-658(B), the Arizona Department of Administration (ADOA) shall "...report to the Joint Legislative Budget Committee at least semiannually on the performance standards for health plans, including indemnity health insurance, hospital and medical service plans, dental plans, and health maintenance organizations."

Among the terms of the self-funded health insurance contracts are a number of ADOA-negotiated performance measures with specific financial guarantees tied to the contracted performance of the vendors providing various services for the health plans. If a vendor fails to meet any of the measures within the specified performance range, a percentage of the annual administrative fee is withheld by ADOA as performance penalties. This percentage is allocated among the more critical measures of the contract.

The following is a report of the performance penalties incurred by health plan vendors not meeting agreed upon performance standards during the year starting January 01, 2011, ending December 31, 2011. In each case below, the final member satisfaction survey and the Benefit Services Division Vendor Survey for FY 2011 may result in additional penalties.

A. UnitedHealthcare (Claims Administrator) – penalties to date of $48,105.65, equaling .33% of the administrative fee and .50% of the vendor's medical management fee.

Measure	Percent of Fees at Risk	Total Percent Assessed Vendor (Based on Missed Measure)
Written appeals resolved in 15 calendar days after receipt of participant's request for review in the case of pre-service claims.	0.25%	• 0.10%: Which equals 5 months missed out of 12 months measured. • **Corrective Action:** Feedback and coaching was provided to the team member who misdirected or caused delay in appeal processing.
97% of all fully documented claims received will be completely processed within 10 calendar days after they are received.	0.75%	• 0.06%: Which equals 1 month missed out of 12 months measured. • **Corrective Action:** During the month of May overall claim receipts were higher than anticipated. As a result, turn around times increased causing claims to flow to transaction claim queues later in the cycle than normal resulting a claims processing metric of 96.76% against the goal of 97% at the end of the month. We have made appropriate adjustments to our cycle so claims will not be delayed in our queues when we have heightened claims in the future. In addition, we are currently back on track and currently sitting at a 98.17% turn around time in 10 days.
99.3% of claims dollars submitted for payment will be accurately processed and paid.	2%	• 0.17%: Which equals 1 month missed out of 12 months measured. • **Corrective Action:** The measure was missed due to two errors during the month of February resulting in a metric of 99.06% against the goal of 99.3%: o The first was due to a copay error made by a processor. This person has been coached on their mistake. o The second error was due to the wrong provider suffix paid. The processor had a revenue code on the claim and should have changed the suffix from physician to facility. This processor has also been coached.
90% of DM members identified will receive follow-up outreach and assessments according to the program specifications.	2%	• 0.50%: Which equals 1 quarter missed out of 4 quarters measured. • **Corrective Action**: This metric was missed for Q1 2011. This metric was missed due to the timing of our mailing since they go out 3 times a year. Mailings do not go out for Q1, this caused the metric to drop.

B. AmeriBen (Claims Administrator) – penalties to date of $19,443.92, equaling 0.64% of the vendor's administrative fee.

Measure	Percent of Fees at Risk	Total Percent Assessed Vendor (Based on Missed Measure)
Written appeals resolved in 45 calendar days after receipt of participant's request for review in the case of post-service claims.	0.50%	• 0.04%: Which equals 1 month missed out of 12 months measured. • **Corrective Action:** AmeriBen created an appeal open log reports that are monitored daily by the Appeals Supervisor. Logs exceeding 25 days are reviewed by the Manager of Customer and Network Relations.
Contractor will process 98% or more of enrollments within 1 calendar day of receipt of the file load. This standard will not apply during the open enrollment or option selection period.	1.25%	• 0.10%: Which equals 1 month missed out of 12 months measured. • **Corrective Action:** To ensure 100% of enrollments are processed within 1 calendar day receipt of the file load, AmeriBen established a backup plan in the event that the primary ADOA Eligibility Specialist is unavailable due to scheduled or unscheduled absence.
ID card release report noting number of ID cards required and number released each day for new hire enrollments.	0.25%	• 0.13%: Which equals 2 quarters missed out of 4 quarters measured. • **Corrective Action**: All ID card files will continue to be reviewed by the Account Management Team prior to release to the print vendor to minimize any print delays.
97% of all fully documented claims received will be completely processed within 10 calendar days after they are received.	0.75%	• 0.06%: Which equals 1 month missed out of 12 months measured. • **Corrective Action:** AmeriBen identified that claims were worked in the maintenance queue without priority. AmeriBen implemented the following action items: o A daily report has been prepared, which identifies explicitly each of the ADOA claim extracts. o The Provider Relations Team Lead receives and reviews the report daily, assigning ADOA files. o Transmit claim files with 'ADOA' in the file name standard, to ensure visibility to ADOA files with or without reporting/monitoring of extracts.

C. Cigna (Claims Administrator) – penalties to date of $16,642.82, equaling .86% of the vendor's administrative fee.

Measure	Percent of Fees at Risk	Total Percent Assessed Vendor (Based on Missed Measure)
Average Speed to Answer <30 seconds.	0.50%	• 0.08%: Which equals 2 months missed out of 12 months measured. • **Corrective Action:** Increased Call Handle Time: Average call handle time increased more than expected (almost 10%) as we increased agent focus on staying on the phone with the customers to fully resolve their issues. In order to truly "take the customer out of the middle", our agents began to conference in the 3rd parties and providers with the customer on the line instead of just giving them an 800# or directing them to contact their providers. We expected an increase to handle time, but our estimates fell short. • Staffing levels: Staffing levels dropped slightly below plan due to agent attrition and call volumes. Planned staffing increases (hiring plan) and will continued to increase by more than 280 agents in 2011. Note call ASA is based on 24/7 members services availability, not just dedicated team results.
First Call Resolution 90% or greater.	0.50%	• 0.04%: Which equals 1 month missed out of 12 months measured. • **Corrective Action:** Cigna implemented 2 hours of Open Call time per Customer Service Associate per week. This initiative allows the CSA's time off phones to follow up on outstanding issues and make customer contacts timely.
Monthly appeal statistic reports.	0%	• 0.0%: Which equals 2 months missed out of 12 months measured. • **Corrective Action**: Reporting measure only no corrective action requested.
Written appeals resolved in 45 calendar days after receipt of participant's request for review in the case of post-service claims.	0.33%	• 0.11%: Which equals 4 months missed out of 12 months measured. • **Corrective Action:** Supervisor provided additional training and check daily appeal reports to ensure that days are being tracked more closely. Processor has been given additional training and Supervisor will work closely with the processor on an ongoing basis.

Continued C. Cigna (Claims Administrator)

Measure	Percent of Fees at Risk	Total Percent Assessed Vendor (Based on Missed Measure)
Contractor will deliver quarterly reports to the ADOA within 45 calendar days from the end of the quarter.	0.25%	• 0.11%: Which equals 4 months missed out of 12 months measured. • **Corrective Action:** Account Manager was using 55 day delivery rule for in person meetings in error. • Account Manager is aware that reports to be delivered via email 45 days after close of quarter and 55 days for in-person meeting. Calendar alerts and reminders set up so that all required reports will be received from reporting areas in advance of each quarterly deadline. Supervisor provided additional training and check daily appeal reports to ensure that days are being tracked more closely.
97% of all fully documented claims received will be completely processed within 14 calendar days after they are received. Will be calculated by counting the number of days from the day the claim is received.	0.75%	• 0.11%: Which equals 4 month missed out of 12 months measured. • **Corrective Action:** Jan – Apr claim payment delays due to claim diverts for Health Care Reform required Audits. Further impacted as first in is first out rule once the hold was released. • Better planning and staffing for any known HCR audits that will need to take place in the future. • In the last quarter of the year, team placed additional focus on aging claims and pended claims so that they could be paid by year's end, which impacted monthly time to process, but we followed up on all claims to ensure all claims were paid. • Will ensure appropriate staff for 2012 year end focus on aging and pended claims and ensure the training and skill set is appropriate.
Network Management-Change to Primary Provider Count.	0%	• 0.0%: Which equals 1 month missed out of 12 months measured. • **Corrective Action:** Reporting measure only no corrective action requested.
Contractor will provide a detailed provider report which identifies providers by TIN number.	0%	• 0.0%: Which equals 1 month missed out of 12 months measured. • **Corrective Action:** Reporting measure only no corrective action requested.

D. Aetna (Claims Administrator) – penalties to date of $9,455.55, equaling .63% of the vendor's administrative fee.

Measure	Percent of Fees at Risk	Total Percent Assessed Vendor (Based on Missed Measure)
Abandonment Rate 3% or less.	1%	• 0.08%: Which equals 1 month missed out of 12 months measured. • **Corrective Action:** Higher than expected call volume occurred within the ADOA designated Member Services Team due to open enrollment calls. Call routing volume adjustments were made subsequently the target was met in December.
Average Speed to Answer <30 seconds.	1%	• 0.08%: Which equals 1 month missed out of 12 months measured. • **Corrective Action:** Higher than expected call volume occurred within the ADOA designated Member Services Team due to open enrollment calls. Call routing volume adjustments were made subsequently the target was met in December.
97% Telephone Call Quality.	1%	• 0.17%: Which equals 2 months missed out of 12 months measured. • **Corrective Action:** Feedback and coaching was provided to the team member identified as causing the error.
Contractor will resolve 95% or more of all "normal" correspondence within 15 calendar days of receipt. Normal correspondence is defined as: plan descriptive materials requests; and premium and/or coverage verification.	1%	• 0.17%: Which equals 2 month missed out of 12 months measured. • **Corrective Action:** (December) Aetna identified correspondence tasks that were internally mis-routed causing a delay in reaching the Correspondence Team for handling. The Correspondence Team worked the tasks as quickly as possible once identified. Feedback and coaching was provided to the team member that caused the delay. • **Corrective Action:** (November) Written Correspondence Rate - There was one correspondence task that was opened in error by a Member Services Representative in which the Representative failed to follow correct handling workflow. This caused this guarantee to be missed. The Member Representative involved has been re-educated on the correct workflow and a reminder has been sent to the Member Services Team.
92% of all fully documented claims received will be completely processed within 12 calendar days after they are received.	0.50%	• 0.08%: Which equals 1 month missed out of 12 months measured. • **Corrective Action:** The PG was missed due to larger than expected claim inventory and the TAT was missed in the first week of January. ADOA Claim Team resources were focused on reducing the inventory and was able to recover the plan TAT guarantee for the month of February.

E. ASIFLEX (Flexible Spending) - penalties to date of $510.92, equaling .50% of the vendor's fee at risk.

Measure	Percent of Fees at Risk	Total Percent Assessed Vendor (Based on Missed Measure)
95% of claims will be processed within two working days.	1%	• 0.25%: Which equals 1 quarter missed out of 4 quarters measured. • **Corrective Action:** ASIFLEX hired 17 additional claims/customer service representatives to address the increase in claims in the first quarter.
100% of claims will be processed within five working days.	1%	• 0.25%: Which equals 1 quarter missed out of 4 quarters measured. • **Corrective Action:** ASIFLEX hired 17 additional claims/customer service representatives to address the increase in claims in the first quarter.

F. Avesis (Vision) - penalties to date of $3,500, equaling 1.05% of the vendor's fee at risk.

Measure	Fees at Risk	Total Percent Assessed Vendor (Based on Missed Measure)
Monthly reports provided within 30 calendar days after the close of month.	$12,000.00	• $1,000: Which equals 1 month missed out of 12 months measured. • **Corrective Action:** As a result of Avesis' performance falling outside of the monthly reporting requirement of 30 calendar days after the close of the month for the February 2011 monthly report, Avesis has crossed trained additional staff to ensure that the monthly reports are provided within 30 calendar days.
90% of all calls requesting a member services representative will be answered in 30 seconds or less.	$30,000	• $2,500: Which equals 1 month missed out of 12 months measured. • **Corrective Action:** As a result of Avesis' performance falling below the requirement for the month of December 2011 additional resources were put in place to support unexpected spikes in call volume. Additional staff was added to ensure coverage during spike times. Contingent staff has also been identified to assist during spikes in call volume.

G. MedImpact - penalties to date of $13,750.00, equaling 2.63% of the vendor's fee at risk.

Measure	Fees at Risk	Total Percent Assessed Vendor (Based on Missed Measure)
99% Percent of time internal on-line system available.	$5,000.00	• $1,250.00: Which equals 1 quarter missed out of 1 quarter measured. • **Corrective Action:** MedImpact will ensure improvements have been made since 2Q11. MedImpact commits to periodic system improvements and updates in order to reach the 99.9% mark for this item.
3 Business Days Number of days for a response to a written inquiry.	$50,000.00	• $12,500.00: Which equals 1 quarter missed out of 4 quarters measured. • **Corrective Action**: MedImpact completed review of timely responses to all ADOA inquiries, and will make a concerted effort to respond quickly and effectively to meet the target.

Successfully Met Performance Guarantees

Table 18: Successful Performance Guarantees		
Vendor	**At risk**	**Guarantees Met**
UHC	18.55% Total Administration Fee 25% Medical Management Fee	Customer Service, Appeals (met 79 out of 84 targets), Open Enrollment, Claims Adjudication (met 57 out of 60 targets), Administration, Account Management Meeting, Network Management, Medical Management, Case Management, Disease Management (met 9 out of 10 targets), and Nurse Line.
AmeriBen	15% Total Administration Fee	Customer Service, Appeals (met 26 out of35 measures), Open Enrollment, Claims Adjudication (met 71 of the 72 targets), Administration (met 29 of the 32 targets), Account Management Meeting (met 3 out of the 4 targets), Reports (met 16 out of17 targets), & Finance Accounting.
Cigna	15.20% Total Administration Fee 25% Medical Management Fee	Customer Service (met 81 out of 84 targets), Appeals (met 42 out of 48 targets), Open Enrollment, Claims Adjudication (met 52 out of 60 targets), Account Management Meeting, Administration , Reports (met 25 out of 29 targets), Network Management (met 20 out of 24 targets), Finance Accounting, and Case Management.
Aetna	23% Total Administration Fee 20% Medical Management Fee	Customer Service (met 65 out of 73 targets), Appeals, Open Enrollment, Claims Adjudication (met 72 out of 73 targets), Administration, Account Management Meeting, Reports, Network Management & Nurse Line (met 1 out of 3 targets).
American Health Holding	Total Administration Fee 1.95% Case Management Fee 1.87% Disease Management Fee 1.25% Nurse Line Fee 1.25%	Implementation, Utilization Management, Case Management, Disease Management, Reporting, Systems, Nurse & Other Call Center Activity.
MedImpact	$522,500.00 Total Fees at Risk	Data & Eligibility Requirements, Claims, Customer Services, Account Services, Reports, Network Access, Network Pharmacy Management, Mail Order Service, Retail Paper Claims Processing Time, Network Pharmacy POS Compliance.

Continued Table 18: Successful Performance Guarantees

Vendor	At risk	Guarantees Met
Delta Dental	1.25% Total Administration Fee	Reporting, Network Management, Claims Administration, Appeals, Satisfaction, and Quality of Service and Responsiveness to Members.
TDA	1% Total Administration Fee	Reporting, Network Management, Appeals, Satisfaction, Quality of Service & Responsiveness to Members.
Hartford	10% Total Administration Fee	Open Enrollment, Report Timeliness, Quality of Service and Responsiveness to Members, Appeals/Grievance, Claims Administration, Claimant Notification, and Financial Payment Accuracy.
Avesis	$332,000.00 Total Fees at Risk	Implementation, Reporting (met 16 out the 17 targets), Networking, Claims, Appeals, and Call Center (met 35 out of the 36 targets).
ASIFlex	5% Total Administration Fee	Claims Turnaround (met 6 out of 8 targets), Claims Adjudication Financial Accuracy, Web Availability, and Phone Response Time.
ComPysch	20% Total Administration Fee	Implementation, Account Management, Customer Service, Reporting, Program Administration, and Surveys.

Audit Services

The Benefit Services Division (BSD) Audit Services Unit provides assurances that add value and improve the operations of the BSD. Audit Services performs systematic evaluations of contract compliance, operational controls, risk management, and the implementation of best practices to support BSD objectives.

During the 2011 plan year, BSD Audit Services completed audits to ensure the health plan vendors appropriately provided contracted services. The audit schedule for the plan year was developed using a combination of contract elements and risk analysis. Individual audit objectives were developed with the consideration of dollar value, complexity of operations, changes in personnel or operations, loss exposure, and previous audit results. Audits were completed in, but were not limited to the following four functional areas:

Functional Area	Audit Methodology
Vendor operating transactions	Statement on Standards for Attestation Engagements No. 16 Audits ("SSAE 16")
Vendor internal operating standards	Quality Management Review ("QMR")
Vendor execution of benefit design	Plan Allowance/Exclusion Audit ("A&E")
ADOA accuracy of shared data	Dependent eligibility audit

All of the health plan's contracted vendors that pay claims are required to provide BSD a copy of an independently assessed operational audit (SSAE 16) annually. SSAE 16 audits evaluate the internal control of the vendor's processing systems utilized to process claims and identify deficiencies to be addressed. Audit services reviewed the SSAE 16 reports provided by each of the vendor's external auditors. There were no instances of significant operating failure noted and no corrective action was required.

QMRs ensure the vendor's internal audit teams were effectively measuring operating standards, identifying and correcting errors, and providing sufficient training for claims processing, customer service, and clinical reviews. QMR results indicated that vendors were either meeting or exceeding internal standards and that claims processors were appropriately trained. A&E Audits ensure that the vendor's systems were set up correctly to service the health plan's benefit design. A&E Audit findings for the plan year indicated that plan limitations and restrictions were processed accurately with few exceptions and members received the benefits allowed to them as defined in the plan description.

A dependent eligibility audit was also performed on the health plan's membership. The results of the eligibility audit indicated that only eligible individuals were enrolled in the plan and receiving benefits. Additionally, dependent eligibility is effectively monitored to minimize the risk of claims paid on behalf of ineligible dependents.

In addition to the regularly scheduled audits, reviews, and evaluations listed above, Audit Services performed operational standards testing related to vendor performance guarantees, quality management standards, and reporting structure for each of the contracted vendors.

Glossary of Terms

Active member – an employee, other than one excluded by the Arizona Administrative Code, who works for the State of Arizona or a State University and is enrolled in one of the health plan options offered by the State. Also referred to as "Actives."

Administrative fees – fees paid to third-party vendors for plan administration, network rental, transplant network access fees, shared savings for negotiated discounted rates with other providers, COBRA administration, direct pay billing, additional reporting billing, State fees (MA and NY), and bank reconciliation fees.

Case management – a collaborative process that facilitates recommended treatment plans to ensure that appropriate medical care is provided to disabled, ill, or injured individuals.

Claim – a provider's demand upon the payer for payment for medical services or products.

Claim appeal – a request for a review of the denial of coverage for a specific medical procedure contemplated or performed.

COBRA Consolidated Omnibus Budget Reconciliation Act of 1985 – a federal law that requires an employer to allow eligible employees, retirees, and their dependents to continue their health coverage after they have terminated their employment or are no longer eligible for the health plan - COBRA enrollees must pay the total contribution, in addition to an administrative fee of 2%.

Contribution strategy – a premium structure that includes both the employer's financial contribution and the employee's financial contribution towards the total plan cost.

Copayment – a form of medical cost sharing in the health plan that requires the member to pay a fixed dollar amount for a medical service or prescription.

Deductible – a fixed dollar amount during the plan year that a member pays before the health plan starts to make payments for covered medical services.

Dependent – an unmarried child of the employee or spouse who meets the conditions established by the relevant plan description.

DHMO/PrePaid Dental – a dental plan that offers members dental services with no annual maximums, no claim forms, and services are based on a discounted rate. Total Dental is the prepaid dental vendor.

Disease management – a comprehensive, ongoing, and coordinated approach to achieving desired outcomes for a population of patients - These outcomes include improving members' clinical condition and quality of life as well as reducing unnecessary healthcare costs. These objectives require rigorous, protocol-based, clinical management in conjunction with intensive patient education, coaching, and monitoring.

Eligibility appeal – a request for a review of the denial of coverage relating to a claimant's entitlement to benefits under a plan.

Employee – a person, other than one excluded by the Arizona Administrative Code, who works for the State of Arizona or a State University.

Exclusive Provider Organization (EPO) – an exclusive provider organization or network - Enrollees are limited to use only those providers on the exclusive list. Any exceptions require prior authorization.

Flexible spending account (FSA) – an account that can be set up through the State's Benefit Options program – An FSA allows an employee to set aside a portion of his/her earnings to pay for qualified medical and dependent care expenses. Money deducted from an employee's pay into an FSA is not subject to payroll taxes.

Formulary – a list of preferred medications covered by the health plan - The list contains generic and name brand drugs. The most cost-effective name brand drugs are placed in the "preferred" category and all other name brand drugs are placed in the "non-preferred" category.

Fully-Insured – an insurance model wherein Benefit Options collects premiums and transfers the premiums to commercial insurers who take the risk of revenue to expense.

Health Savings Account Option (HSAO) – an account that allows individuals to pay for current health expenses and save for future health expenses on a tax-free basis. Only certain plans are HSA-eligible.

Indemnity/PPO – a dental plan that offers members choice to visit any dentist with an in-network and out-of-network co-insurance structure. There is a maximum annual benefit of $2,000 per member per year for dental services. The vendor for the PPO plan is Delta Dental.

Integrated – health plan operations that are provided by one entity - These operations include: claims processing and payment, a network of medical providers, utilization management, case management, and disease management services.

Medicare – the federal health insurance program provided to those who are age 65 and older or those with disabilities who are eligible for Social Security benefits - Medicare has four parts: Part A, which covers hospitalization; Part B, which covers physicians and medical providers; Part C, which expands the availability of managed care arrangements for Medicare recipients; and, Part D, which provides a prescription drug benefit. Retirees signing up for ADOA insurance should enroll in Parts A and B, but not C or D.

Member – a health plan participant - This individual can be an employee, retiree, spouse or dependent.

Network – an organization that contracts with providers (hospitals, physicians, and other health care professionals) to provide health care services - Contract terms include agreed upon fee arrangements for services and performance standards.

Non-integrated – health plan operations that are provided by multiple entities - These operations include claims processing and payments, a network of medical providers, and disease management services.

Payer – the entity responsible for paying a claim.

Pharmacy benefit manager – an organization that provides a pharmacy network, processes and pays for all pharmacy claims, and negotiates discounts on medicines directly from the pharmaceutical manufacturers - These discounts are passed to the employer payer in the form of rebates and reduced costs in the formulary.

Plan year – the period January 1 through December 31.

Preferred Provider Organization (PPO) – an organization that offers a broad selection of providers and the ability to choose a non-PPO provider as well - This non-PPO provider requires greater copay from the enrollee and a deductible to be paid.

Premium – agreed upon fees paid for medical insurance coverage - Premiums are paid by both the employer and the health plan member.

Retiree – a former State or State University employee, officer or elected official who is retired under a State-sponsored retirement plan - For analytical purposes, this term encompasses both actual retirees and their dependents.

Self-funded – insurance program wherein Benefit Options collects premiums, pays claims, and assumes the risk of revenues to expenses.

Self-insured – a plan that is funded by the employer who is financially responsible for all medical claims and administrative expenses.

Spouse – one legally married—as defined by the Arizona Revised Statutes—to an employee or a retiree.

Stop-loss – a form of insurance for self-insured employers that limits the amount the employer as primary insurer will pay for medical expenses.

Subscriber – employee, officer, elected official, or retiree who is eligible and enrolls in the health plan.

Third party administrator – an organization that handles all administrative functions of a health plan, including: processing and paying medical claims, compiling and producing management reports, and providing customer service.
Utilization management – a process whereby an insurer evaluates the quantity (duration) and quality (level) of the delivery of medical services.

Utilization review – a process whereby an insurer evaluates the appropriateness, necessity, and cost of services provided.

Utilizer – a member who receives a specific service.

Appendix A

The HITF Fund-3015 established under A.R.S. 38-654-A is used to pay medical claims, dental premiums, and administrative and operating costs of the Wellness Program and the Benefits Services Division.

Table A: 3015 Fund Plan Year 01/1/2011 - 12/31/2011

BEGINNING CASH PER AFIS				**$ 189,162,971.16**
REVENUE				**$ 801,029,668.34**
EXPENDITURES				**$ 720,822,356.42**
VENDOR	ADMIN FEES	PERF PENALTIES		
AHH UR/UM	$ 1,023,116.40	$ 1,556.77		
AETNA	$ 2,150,991.12	$ 13,835.66		
CIGNA	$ 2,142,910.89	$ 13,724.52		
UHC	$ 22,849,050.42	$ 146,937.80		
AMERIBEN	$ 3,321,299.14	$ 9,822.91		
MEDIMPACT	$ 1,015,992.25	$ 6,250.00		
OTHER FEES**	$ 241,035.25			
AG COLLECTION FEES	$ 321.99			
NET ADMIN FEES^	**$ 32,744,717.46**	**$ 192,127.66**	**$ 32,552,589.80**	
	MEDICAL CLAIMS	RECOVERIES*		
HARRINGTON	$ 111,772.98	$ 3,370,051.61		
AETNA	$ 23,397,906.52	$ 2,480.62		
CIGNA	$ 39,771,480.75	$ -		
UHC	$ 322,424,880.35	$ 77,972.29		
AMERIBEN	$ 83,644,333.28	$ 789,320.23		
WHI		$ 14,044.99		
MEDIMPACT	$ 110,799,552.44	$ 6,075,443.64		
ERRP REIMBURSEMENT		$ 429,413.25		
RDS SUBSIDY		$ 2,651,407.78		
OTHER WELLNESS	$ 750,543.77			
NET MEDICAL CLAIMS	**$ 580,900,470.09**	**$ 13,410,134.41**	**$ 567,490,335.68**	
	STOP LOSS PREM	CLAIM REIMB		
SYMETRA	$ 280,305.60	$ 85,270.71	**$ 195,034.89**	
SELF INSURED EXPENDITURES			***$ 600,237,960.37***	
	FULL SVC PREM			
BCBS (NAU ONLY)	$ 34,376,006.00		**$ 34,376,006.00**	
	DENTAL PREM	PERF PENALTIES		
DELTA	$37,908,686.44	$ -		
TDA	$3,782,278.06	$ 9,355.40		
NET DENTAL PREM	$ 41,690,964.50	$ 9,355.40	**$ 41,681,609.10**	
FULLY INSURED EXPENDITURES			***$ 76,057,615.10***	
HITF OPERATING EXP	$ 4,190,980.95		**$ 4,190,980.95**	
FUND TRANSFERS OUT	$ 40,335,800.00		**$ 40,335,800.00**	
TOTAL EXPENDITURES	**$ 734,519,244.60**			
TOTAL RECOVERIES*		**$ 13,696,888.18**		
NET EXPENDITURES			**$ 720,822,356.42**	
ENDING CASH BALANCE PER AFIS				**$ 269,370,283.08**

*Recoveries include Medicare Part D Retiree Drug Subsidy reimbursement, prescription drug rebates, stop loss claim reimbursements, overpayment recoveries (including stop payments and voids), subrogation recoveries, etc.
**Other fees include HSA Administration, NYHCR, MA, and legal fees.
^Vendor administrative fees and fully insured premiums are paid 55 days in arrears per contract.

Fund 3035 is established under A.R.S. 38-651.05. to pay premiums for other insurance products offered to State employees including Vision, Flexible Spending, Supplemental and Dependent Life, Short Term Disability, Non-ASRS Long Term Disability, and Basic Life insurance.

Table B: 3035 Fund Plan Year 01/1/2011 - 12/31/2011

BEGINNING CASH PER AFIS			**$**	**4,284,020.85**
REVENUE			**$**	**34,787,566.22**
VENDOR	INSURANCE	AMOUNT		
HARTFORD	BASIC LIFE	$ 1,380,352.52		
	SUPP LIFE	$ 11,251,700.51		
	DEP LIFE	$ 2,537,921.75		
	STD	$ 7,505,118.63		
	LTD	$ 2,830,391.11		
TOTAL HARTFORD		$ 25,505,484.52		
AVESIS	VISION	$ 4,703,866.15		
ASI	AMRA	$ 3,443,290.79		
	DCRA	$ 1,132,989.39		
TOTAL FLEX SPENDING		$ 4,576,280.18		
PAYROLL CLEARING		$ 1,935.37		
TOTAL REVENUE		$ 34,787,566.22		
EXPENDITURES			**$**	**34,648,429.04**
VENDOR	INSURANCE	AMOUNT		
HARTFORD	BASIC LIFE	$ 1,394,221.27		
	SUPP LIFE	$ 11,260,169.68		
	DEP LIFE	$ 2,546,554.91		
	STD	$ 7,478,916.02		
	LTD	$ 2,827,526.09		
TOTAL HARTFORD		$ 25,507,387.97		
AVESIS	VISION	$ 4,687,702.45		
ASI	AMRA	$ 3,243,924.24		
	DCRA	$ 1,110,217.00		
	ADMIN FEES	$ 97,097.38		
TOTAL FLEX SPENDING		$ 4,451,238.62		
GAO AFIS COST		$ 2,100.00		
TOTAL EXPENDITURES		$ 34,648,429.04		
ENDING CASH BALANCE PER AFIS			**$**	**4,423,158.03**

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