Benefit Options
Choice Value Health

2012 Annual Report
Health Insurance Trust Fund

Arizona Department of Administration
Human Resources Division – Benefit Services

Janice K. Brewer
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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. 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, 2012 through December 31, 2012. The active and retiree plans were concurrent for this period.

The 2012 annual report reflects a method change in the statistical reporting. In prior years, many of the reported statistics were weighted averages (by enrollment) of vendor report data. Often, the results of the weighted average approach could not be reproduced independently by ADOA staff. In addition, the vendors' reporting methodology is proprietary, confidential, and subject to change without notice to ADOA. In contrast, for this report ADOA has internally developed a more consistent statistical model. ADOA's model is based on generally accepted actuarial principles and standards, including *Milliman Health Cost Guidelines Commercial Rating Structures, July 1, 2012*. As a result, Plan Year 2011 figures and values may differ from the 2011 Annual Report.

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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. For 2012, the health benefit plan was self-funded; whereas the dental plans, vision plan, disability insurance, and life insurance plans were fully-insured.

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

Schedules of premiums received and accounted for in fund 3015, distribution by enrollment, incurred and paid medical/drug claims, and expenses related to the medical and dental plans are included within this Annual Report. A summary of premiums collected and paid for life insurance, disability insurance, vision insurance and flexible spending accounts has also been included for fund 3035.

All data provided herein is for the Plan Year 2012 (January 1, 2012 – December 31, 2012).

Executive Summary

During the 2012 Plan Year, the Benefit Options program offered a comprehensive insurance package to over 128,000 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.

Based on the 2012 contribution strategy, the total health and dental premiums collected was $734 million with total plan expenses of $726 million, resulting in a net operational gain of $7 million.

Health Plan

- The average cost to insure each member was $5,061
  - Average active member cost was $4,789
  - Average retiree cost was $8,503
- Medical claims expense was $481 million of total health plan cost for 2012
  - The leading diagnosis category by cost was the musculoskeletal system
    - Just over 12% of total medical claims cost
  - Claims showed members are seeking the care of a physician or specialist for the majority of their medical needs indicating appropriate care
    - 169 emergency room visits per 1,000 members
    - 183 urgent care visits per 1,000 members
    - 3,960 physician visits per 1,000 members
- Pharmacy claims expense was $118 million of total health plan cost for 2012
  - The leading therapeutic drug class by cost was Diabetes
    - 10% of total pharmacy claims cost
  - 1.4 million prescriptions were filled during the 2012 plan year
    - Retirees filled an average of 31.5 prescriptions per year
    - Active members averaged 10 per year

Wellness Program

- Administered over 13,500 flu vaccines through 405 worksite or public events
- Administered over 4,500 screenings through 162 worksite events
  - 614 referrals to physicians for various health issues

Performance Measures

Financial guarantees are in place to manage the performance of the contracted vendors. Penalties collected in 2012 for the 2011 plan year, from vendors failing to meet agreed upon performance measures, totaled over $315,000.

Review

The 2012 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 is a cash statement of receipts received and expenses paid during 2012 for the 2012 Plan Year and as well as prior plan years.

ADOA Benefit Options is the self-funded medical program and includes Aetna, Blue Cross Blue Shield of Arizona administered by AmeriBen, CIGNA, and United Healthcare networks. State and University employees and retirees choose coverage from one of the self-funded networks. BCBS (NAU) is a fully-insured option available only to NAU employees and NAU retirees.

The Medicare Part D Retiree Drug Subsidy is available to employers who provide a qualified pharmacy plan to Medicare-eligible retirees.

The Early Retiree Reinsurance Program was instituted by the Affordable Care Act as an incentive for employers to continue health coverage for early retirees. The 2012 expense is reimbursement for an overpayment received in the prior year.

Health Insurance Trust Fund Summary	
	Plan Year 2012
Prior Balance December 31, 2011	$269,370,283.08
Revenues	
ADOA Benefit Options	722,898,333.62
BCBS (NAU)	33,156,089.92
Premium Holiday	(64,745,409.79)
Dental	42,826,230.60
Other Revenue	38,044.67
Total Revenues	$734,173,289.02
Expenditures	
Medical Claims	481,280,557.17
Drug Claims	117,870,604.80
Medicare Part D Retiree Drug Subsidy	(4,405,890.98)
Early Retiree Reinsurance Program	148,531.10
BCBS Payments	32,453,351.76
Administrative Fees	23,806,885.86
Dental Costs	41,967,782.10
Appropriated Expenses	3,533,327.41
General Fund Transfers	29,986,000.00
Total Expenditures	$726,641,149.22
Fund Balance December 31, 2012	$276,902,422.88
Reserves	
IBNR Liability	90,800,000.00
Contingency Reserve	90,800,000.00
Total Reserves	$181,600,000.00
Unrestricted Balance December 31,2012	$ 95,302,422.88

Table 1: Health Insurance Trust Fund Summary

Reserves are monies set aside for the purpose of paying claims that have been Incurred But Not Reported (IBNR) and a Contingency Reserve to cover any insufficiencies that may develop, such as actual medical trend exceeding assumed medical trend in rate setting, shifts in plan membership, unexpected catastrophic claims, and changes in provider reimbursement rates that may occur in a given plan year.

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 (HSAO).

The EPO Plan

If a member 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. Members selecting the EPO plan choose from four networks: Aetna, Blue Cross Blue Shield of Arizona administered by AmeriBen*, CIGNA, and UnitedHealthcare.

The PPO Plan

If a member 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. Members selecting the PPO plan choose from Aetna, Blue Cross Blue Shield of Arizona administered by AmeriBen*, and UnitedHealthcare.

The HSAO Plan

The HSAO plan is a high deductible health plan only available with the Aetna network and is only available to active employees. If the employee chooses to enroll in the HSAO, 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 employee opens the Aetna associated qualifying HSA, the state makes a bi-weekly deposit to the account.

If the HSAO plan 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, except for qualified preventative services, which are covered without a copay or coinsurance.

**Blue Cross Blue Shield of Arizona Network administered by AmeriBen. Blue Cross Blue Shield of Arizona, an independent licensee of the Blue Cross Blue Shield Association, provides Network access only and does not provide administrative or claims payment services and does not assume any financial risk or obligation with respect to claims. AmeriBen has assumed all liability for claims payment. No Network access is available from Blue Cross Blue Shield Plans outside of Arizona.*

Table 2 below shows how enrollment was distributed by plan and network between active, retired, university, and COBRA members.

Average Monthly Enrollment by Plan & Network					
		2012		2,011	
Network	Plan Type	Subscribers	Members	Subscribers	Members
AETNA					
Active	EPO	1,451	3,306	1,273	2,865
Retiree	EPO	260	344	261	342
University	EPO	1,392	2,573	1,230	2,246
COBRA	EPO	13	19	20	30
Active	PPO	89	161	81	146
Retiree	PPO	46	54	51	62
University	PPO	140	235	142	231
COBRA	PPO	0	0	0	1
Active	HSAO	196	369	146	285
Retiree	HSAO	-	-	-	-
University	HSAO	242	423	194	347
COBRA	HSAO	1	1	1	1
AmeriBen*					
Active	EPO	6,112	15,138	5,839	14,441
Retiree	EPO	1,105	1,451	1,098	1,443
University	EPO	1,889	3,998	1,705	3,558
COBRA	EPO	23	33	35	47
Active	PPO	267	476	240	428
Retiree	PPO	126	153	147	181
University	PPO	267	479	256	468
COBRA	PPO	3	5	3	4
CIGNA					
Active	EPO	2,929	6,964	2,942	6,913
Retiree	EPO	605	774	624	803
University	EPO	1,101	2,256	1,134	2,283
COBRA	EPO	6	8	9	11
UnitedHealthcare					
Active	EPO	21,148	50,452	22,059	51,942
Retiree	EPO	4,718	6,084	4,735	6,126
University	EPO	11,034	24,798	11,683	25,938
COBRA	EPO	104	141	158	206
Active	PPO	509	932	520	948
Retiree	PPO	113	144	131	168
University	PPO	592	1,134	630	1,165
COBRA	PPO	6	6	10	12
Blue Cross Blue Shield**					
NAU only	PPO	2,770	4,304	2,821	4,391
Total		59,258	127,213	60,177	128,029

Table 2: Average Medical Enrollment by Plan & Network

**AmeriBen administering the Blue Cross Blue Shield of Arizona Network for the self-funded Benefit Options program. **Blue Cross Blue Shield fully insured plan only available to NAU employees and NAU retirees.*

Medical Premiums

Table 3 below lists the medical premium by plan and coverage tier per pay period for active members.

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

Table 3: Active Medical Premiums by Pay Period
**University of Arizona has 24 pay period deductions.*

Table 4 lists the monthly medical premium by plan and coverage tier for retirees not enrolled in Medicare and for retirees where the retiree or one or more family members are enrolled in Medicare.

Monthly Retiree Medical Premiums				
	Without Medicare		**With Medicare**	
Plan	**Tier**	**Premium**	**Tier**	**Premium**
EPO	Retiree only	$593	Retiree only	$442
	Retiree +1	$1,387	Retiree +1 (Both Medicare)	$878
			Retiree +1 (One Medicare)	$1,024
	Family	$1,869	Family (Two Medicare)	$1,166
PPO	Retiree only	$943	Retiree only	$789
	Retiree +1	$2,219	Retiree +1 (Both Medicare)	$1,576
			Retiree +1 (One Medicare)	$1,740
	Family	$3,074	Family (Two Medicare)	$1,980

Table 4: Monthly Retiree Medical Premiums

Premiums vs. Expenses for Active and Retired Members

The 2012 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%.

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

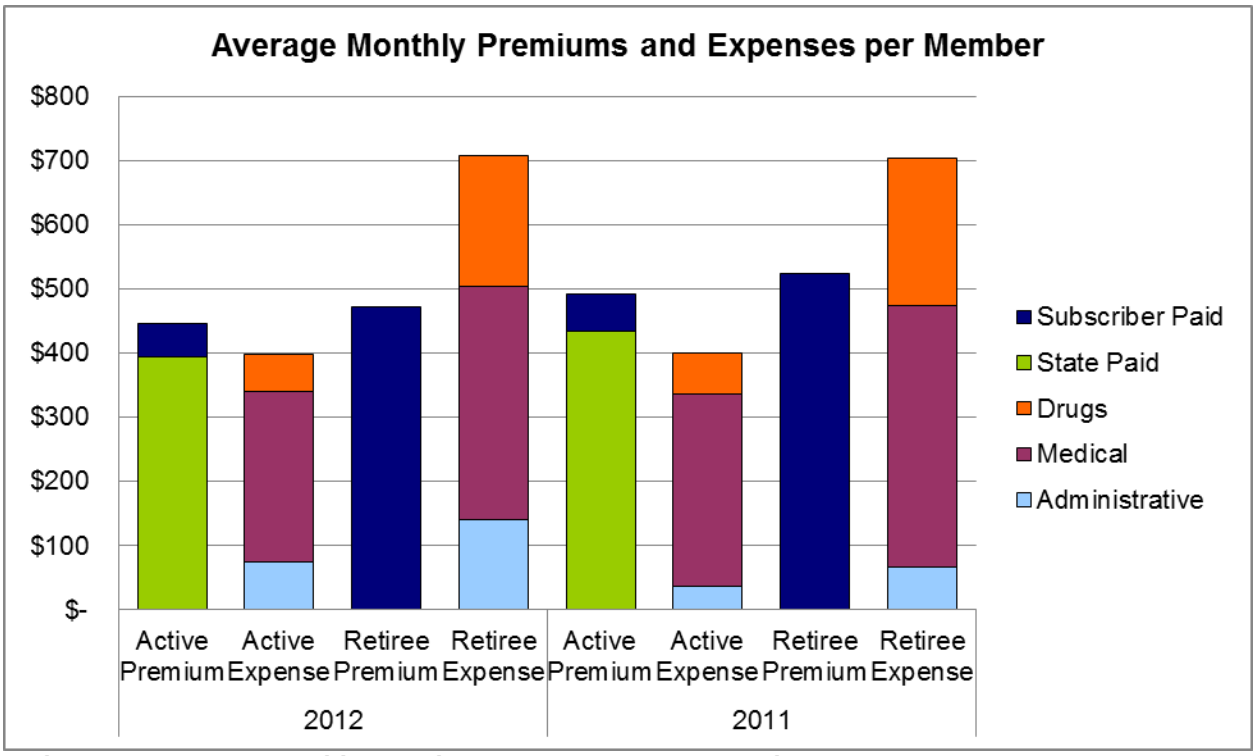

Figure 1: Average Monthly Premiums & Expenses per Member
**2012 Premiums are net of the legislatively mandated Premium Holiday*

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 premiums lower and active premiums higher than what their experience would otherwise dictate.

Expenses for Benefit Options Self-Funded Plans

The tables below show the distribution of claims and expenses incurred in Plan Year 2012, and the average annual cost to insure each type of subscriber/member.

Self-funded Expenses by Active, Retiree, and Plan						
Expenses	**Overall**	**Active**	**Retiree**	**EPO**	**PPO**	**HSAO**
Medical Claims	402,794,859	363,367,688	39,427,171	385,953,442	15,936,799	904,618
Drug Claims	113,569,696	86,119,182	27,450,515	105,862,924	7,621,485	85,288
Medicare Part D Subsidy	(4,405,891)		(4,405,891)	(4,190,016)	(215,875)	
ERRP Reimbursement	148,531	133,992	14,539	142,321	5,877	334
Rebates & Recoveries	(8,217,459)	(7,153,163)	(1,064,296)	(7,826,797)	(374,908)	(15,753)
Administration Fees	23,806,886	20,916,400	2,890,486	22,337,900	894,344	574,643
Appropriated Expenses	3,533,327	3,097,135	436,193	3,370,932	134,962	27,433
Total Expenses	531,229,950	466,481,233	64,748,717	505,650,705	24,002,684	1,576,562
IBNR Liability	90,800,000	79,039,910	11,760,090	86,483,330	4,142,601	174,070
Total	$622,029,950	$545,521,143	$76,508,807	$592,134,034	$28,145,284	$1,750,631
Enrollment in self-funded plans						
Subscribers	56,488	49,515	6,974	53,892	2,158	439
Members	122,909	113,905	9,004	118,339	3,777	793
Annual cost						
Per subscriber	$ 11,012	$ 11,017	$ 10,971	$ 10,987	$ 13,044	$ 3,992
Per member	$ 5,061	$ 4,789	$ 8,497	$ 5,004	$ 7,451	$ 2,208

Table 5: Self-funded Expenses by Active, Retiree, & Plan

Self-funded Expenses by Plan for Active & Retiree						
Expenses (in dollars)	**Overall**	**Active EPO**	**Active PPO**	**Active HSAO**	**Retiree EPO**	**Retiree PPO**
Medical Claims	402,794,859	348,166,276	14,296,794	904,618	37,787,166	1,640,006
Drug Claims	113,569,696	79,757,399	6,276,495	85,288	26,105,525	1,344,990
Medicare Part D Subsidy	(4,405,891)				(4,190,016)	(215,875)
ERRP Reimbursement	148,531	128,387	5,272	334	13,934	605
Rebates & Recoveries	(8,217,459)	(6,810,005)	(327,405)	(15,753)	(1,016,792)	(47,503)
Administration Fees	23,806,886	19,565,545	776,212	574,643	2,772,355	118,131
Appropriated Expenses	3,533,327	2,952,566	117,135	27,433	418,366	17,827
Total Expenses	531,229,950	443,760,168	21,144,504	1,576,562	61,890,537	2,858,180
IBNR Liability	90,800,000	75,248,135	3,617,705	174,070	11,235,195	524,896
Total	$622,029,950	$519,008,302	$24,762,209	$ 1,750,631	$73,125,732	$3,383,075
Enrollment in self-funded plans						
Subscribers	56,488	47,203	1,873	439	6,689	285
Members	122,909	109,686	3,426	793	8,653	351
Annual cost						
Per subscriber	$ 11,012	$ 10,995	$ 13,223	$ 3,992	$ 10,933	$ 11,870
Per member	$ 5,061	$ 4,732	$ 7,227	$ 2,208	$ 8,451	$ 9,634

Table 6: Self-funded Expenses by Plan for Actives & Retirees

Medical Expenses Associated with Medical Diagnoses

Table 7 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.

Medical Expenses by Diagnosis for Actives & Retirees						
	2012			2011		
	All members	Actives	Retirees	All members	Actives	Retirees
Diagnosis	% of Total	% of Total	% of Total	% of Total	% of Total	% of Total
Musculoskeletal System and Connective Tissue	12.08%	12.07%	12.17%	12.31%	12.25%	14.23%
Supplementary Classification of Factors Influencing Health Status and Contact With Health Service	10.04%	10.20%	8.57%	10.21%	10.23%	9.73%
Neoplasms	9.86%	9.20%	15.97%	10.09%	9.88%	17.39%
Symptoms, Signs, and Ill-Defined Conditions	9.38%	9.64%	6.96%	9.64%	9.69%	7.92%
Injury and Poisoning	7.52%	7.20%	10.51%	7.60%	7.65%	5.70%
Circulatory System	8.72%	9.00%	6.12%	7.90%	7.89%	8.28%
Nervous System and Sense Organs	6.93%	7.16%	4.83%	6.48%	6.39%	9.36%
Digestive System	5.99%	5.83%	7.42%	6.92%	6.95%	5.69%
Genitourinary System	7.06%	6.58%	11.46%	6.90%	6.85%	8.55%
Respiratory System	5.08%	5.09%	4.97%	4.87%	4.90%	3.77%
Pregnancy, Childbirth, and The Puerperium	4.30%	4.76%	0.07%	4.14%	4.26%	0.00%
Endocrine, Nutritional and Metabolic Diseases, and Immunity Disorders	4.21%	4.12%	5.09%	3.78%	3.77%	3.97%
Mental Disorders	2.73%	2.86%	1.50%	2.52%	2.55%	1.36%
Infectious and Parasitic Diseases	2.27%	2.30%	1.98%	2.23%	2.24%	1.91%
Skin and Subcutaneous Tissue	1.52%	1.54%	1.34%	1.58%	1.59%	1.24%
Congenital Anomalies	1.04%	1.12%	0.28%	1.48%	1.52%	0.14%
Blood and Blood-Forming Organs	0.87%	0.88%	0.76%	0.99%	0.99%	0.77%
Certain Conditions Originating In The Perinatal Period	0.41%	0.45%	0.00%	0.37%	0.38%	0.00%
Supplementary Classification Of External Causes of Injury and Poisoning	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Total	100.00%	100.00 %	100.00%	100.00%	100.00 %	100.00%

Table 7: Medical Expenses by Diagnosis for Actives & Retirees

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: 34% for active members and 31% 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 HSAO members.

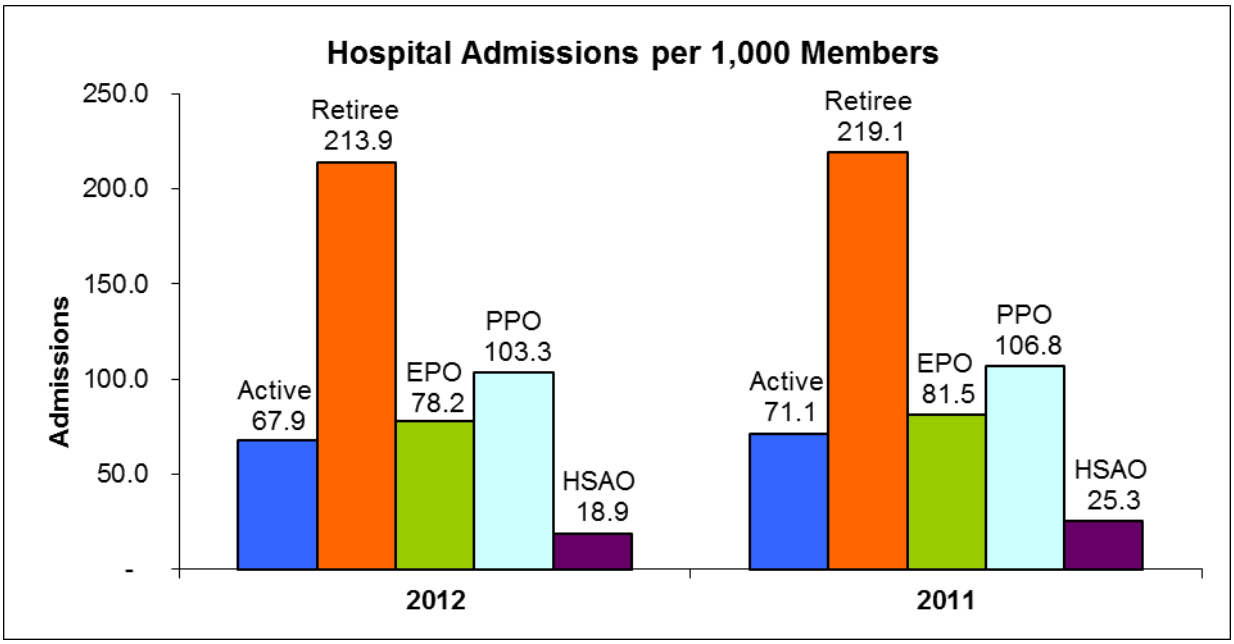

Figure 2: Hospital Admissions per 1,000 Members

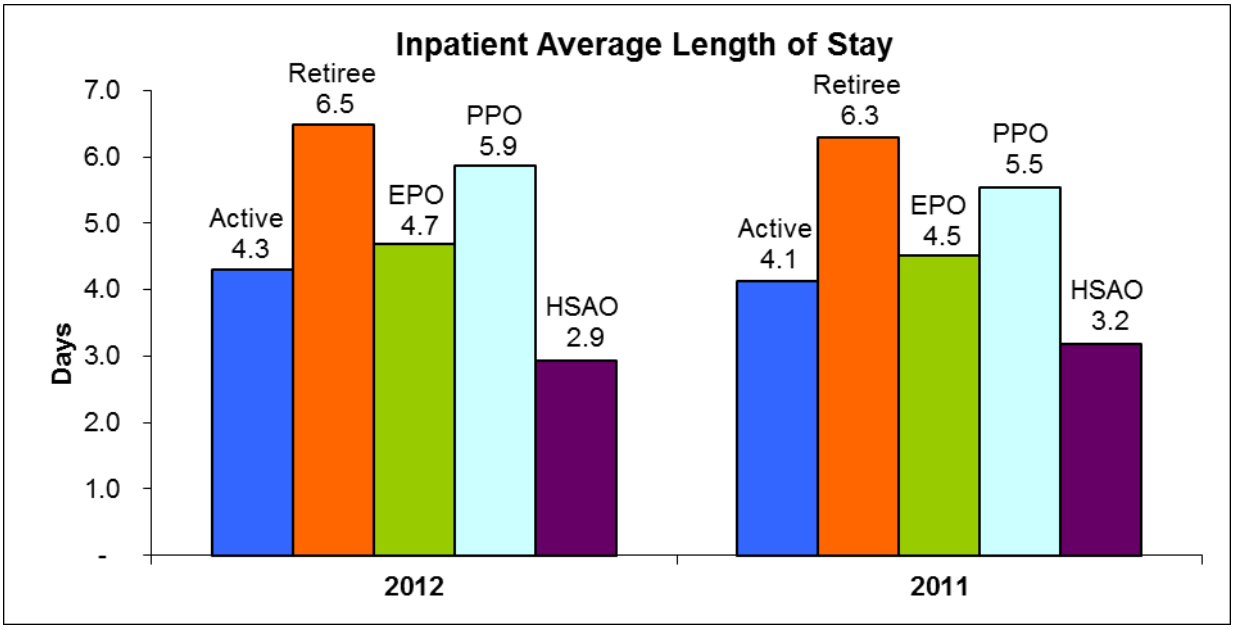

Figure 3: Inpatient Average Length of Stay

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 4.8 times as many days in the hospital as active members. While the plan pays less for Medicare enrolled retiree admissions than for active admissions, the total cost of retiree admissions is 2.1 times higher than the cost of active admissions when all sources of insurance are considered.

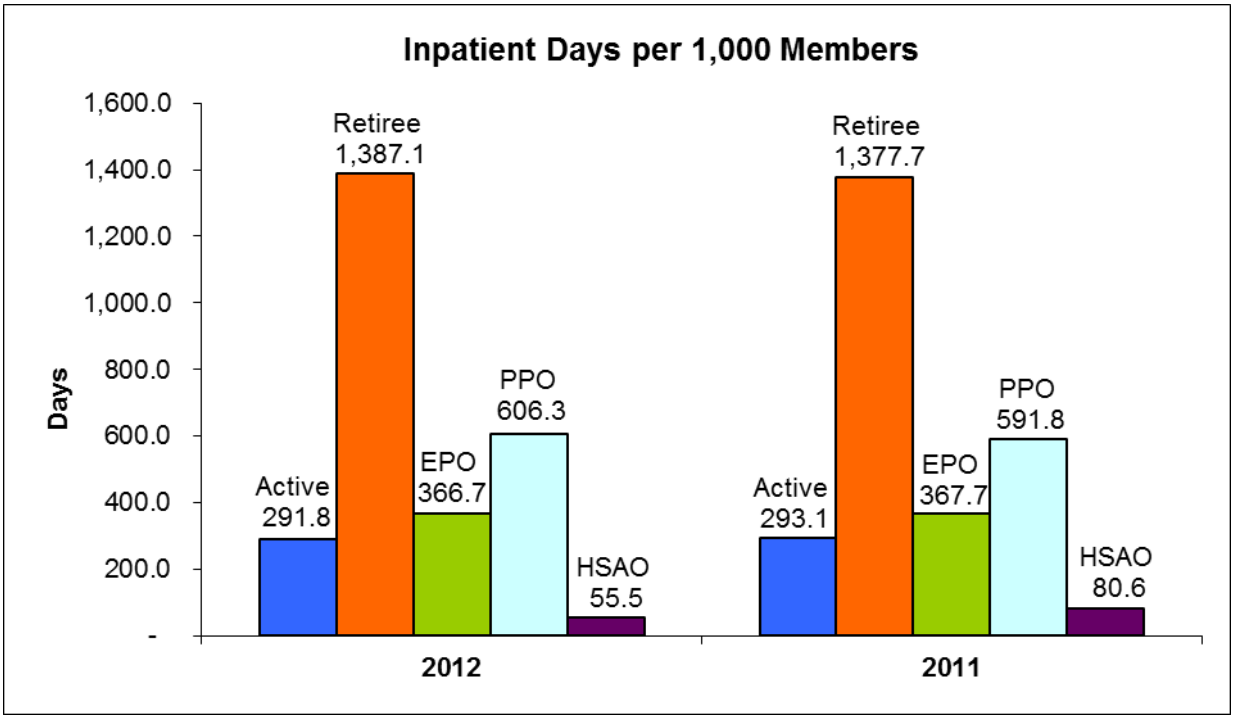

Figure 4: Inpatient Days per 1,000 Members

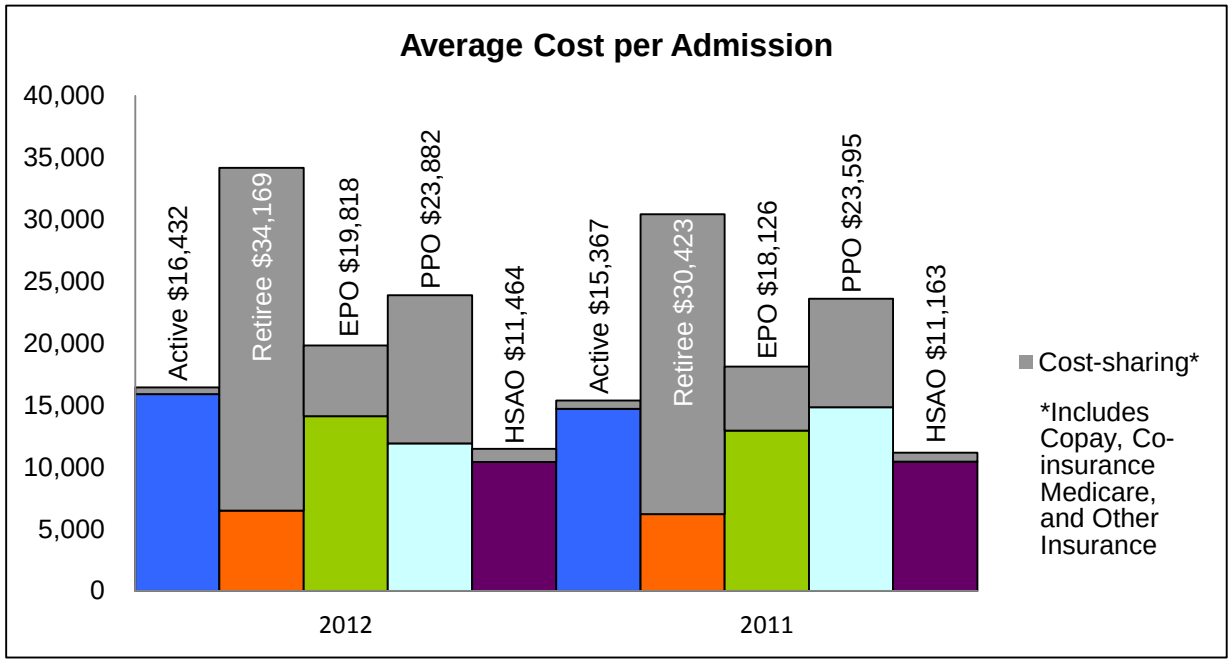

Figure 5: Average Cost per Admission

Emergency Room Visits

During Plan Year 2012, there were approximately 169 emergency room visits per 1,000 members of the self-funded plan. The average plan cost per emergency room visit was $1,246. 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 2012, there were approximately 183 urgent care visits per 1,000 members of the self-funded plan. The average plan cost per urgent care visit was $80.54.

Physician Visits

During Plan Year 2012, there were approximately 3,960 physician visits per 1,000 members (or each member of the self-funded plan visited a physician approximately 4 times). The average plan cost per office visit cost was $97.21

Figures 6 and 7 show how total active and retiree medical expenses were distributed by type of care. Emergency room care for active employees was 4.44% of medical expenses, compared to 1.98% of medical expenses for retired members.

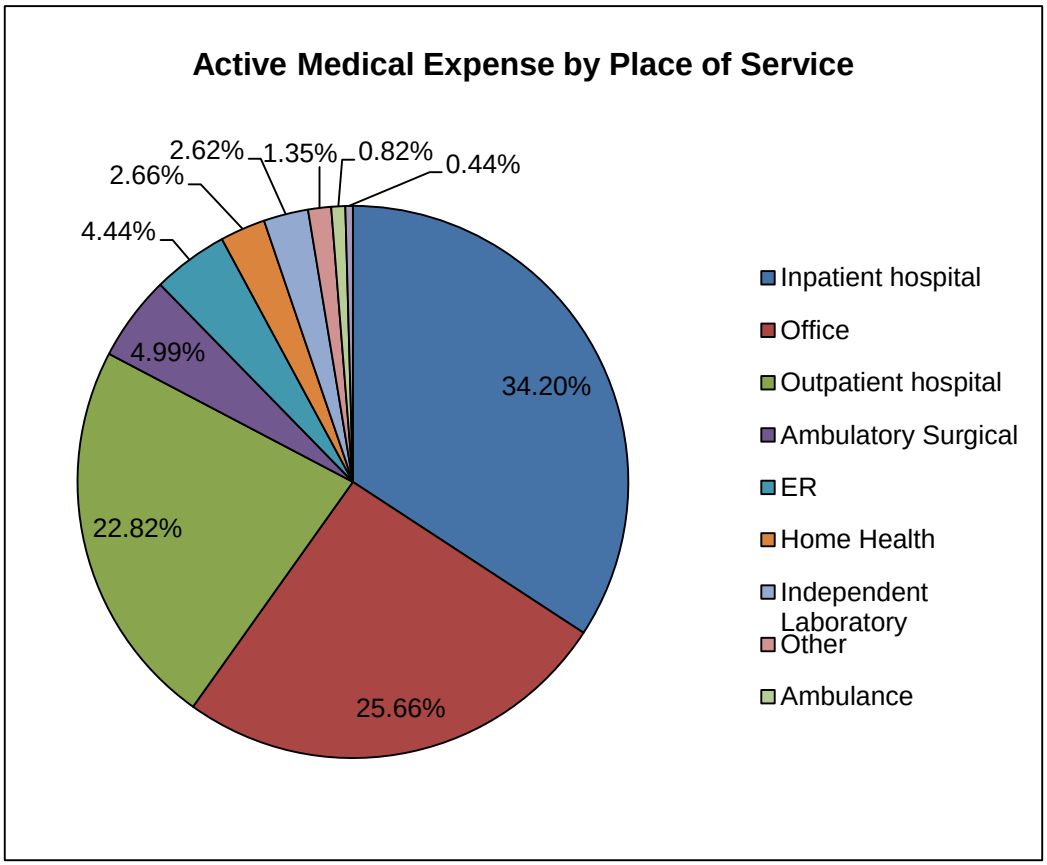

Figure 6: Active Medical Expense by Place of Service

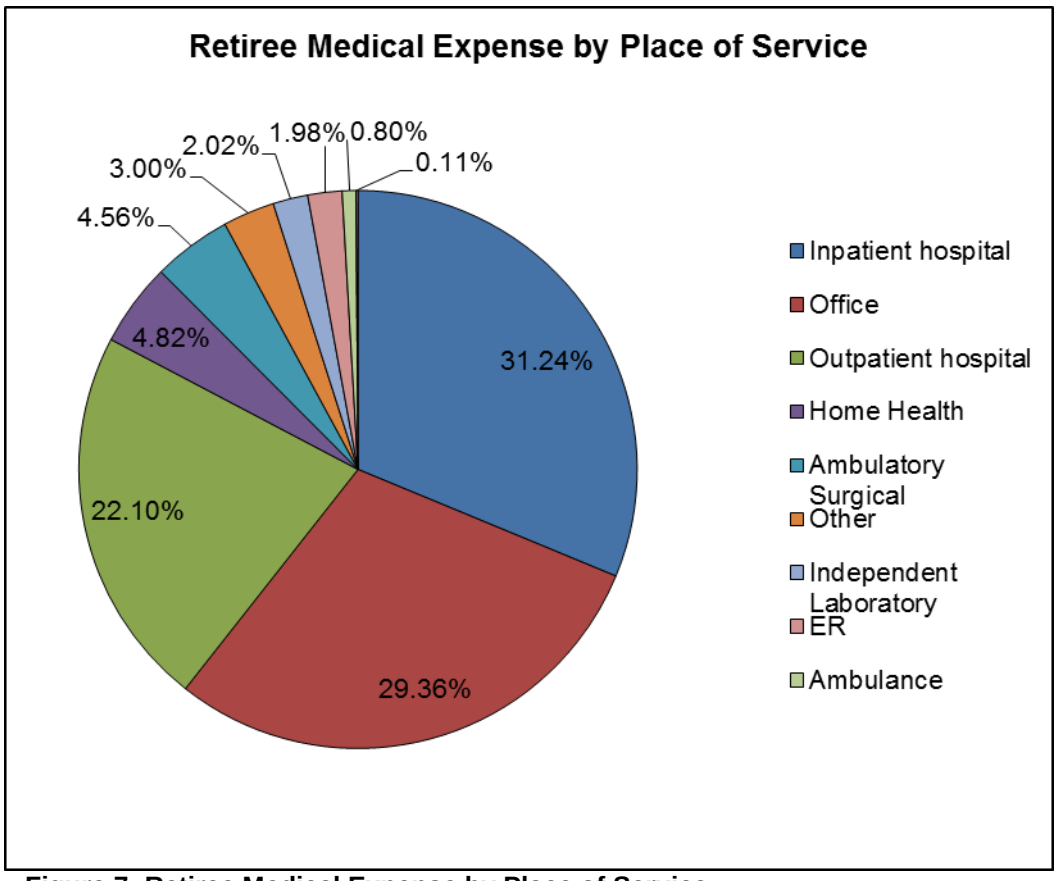

Figure 7: Retiree Medical Expense by Place of Service

Annual Prescription Use

Figure 8 compares the average number of prescriptions filled by active and retired members for plan years 2012 and 2011.

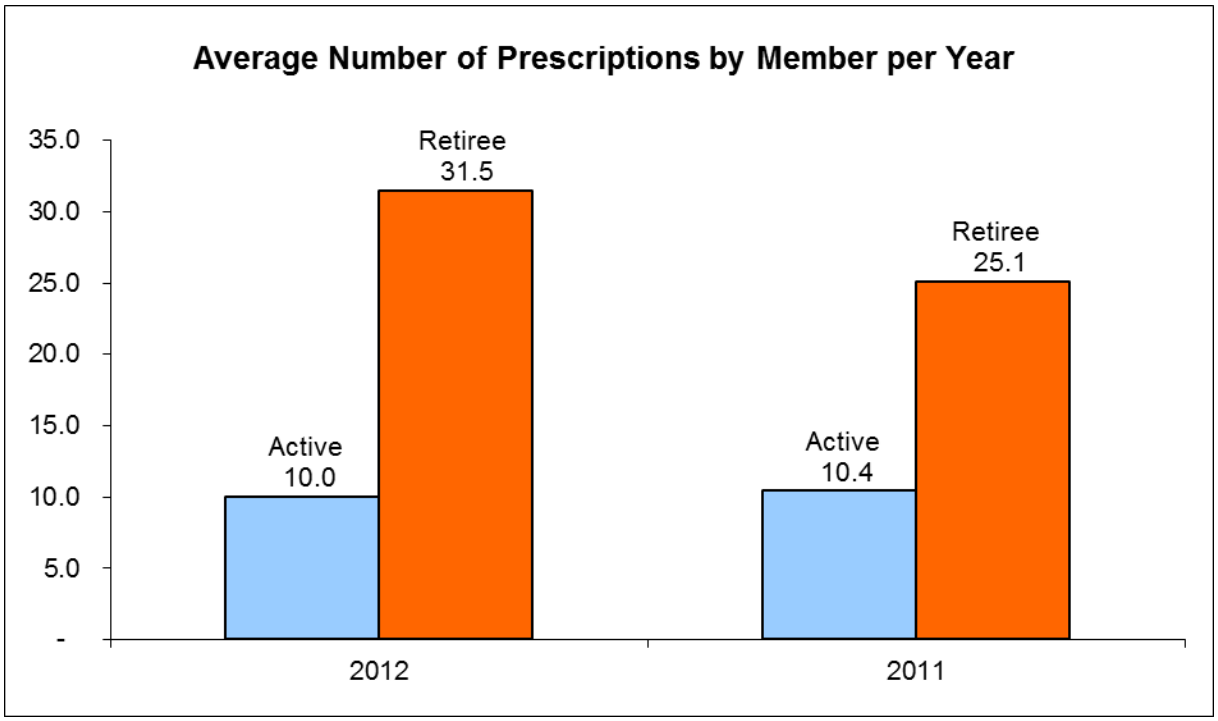

Figure 8: Average Number of Prescriptions per Year

Figure 9 compares pharmacy expense per utilizer by age for plan years 2012 and 2011.

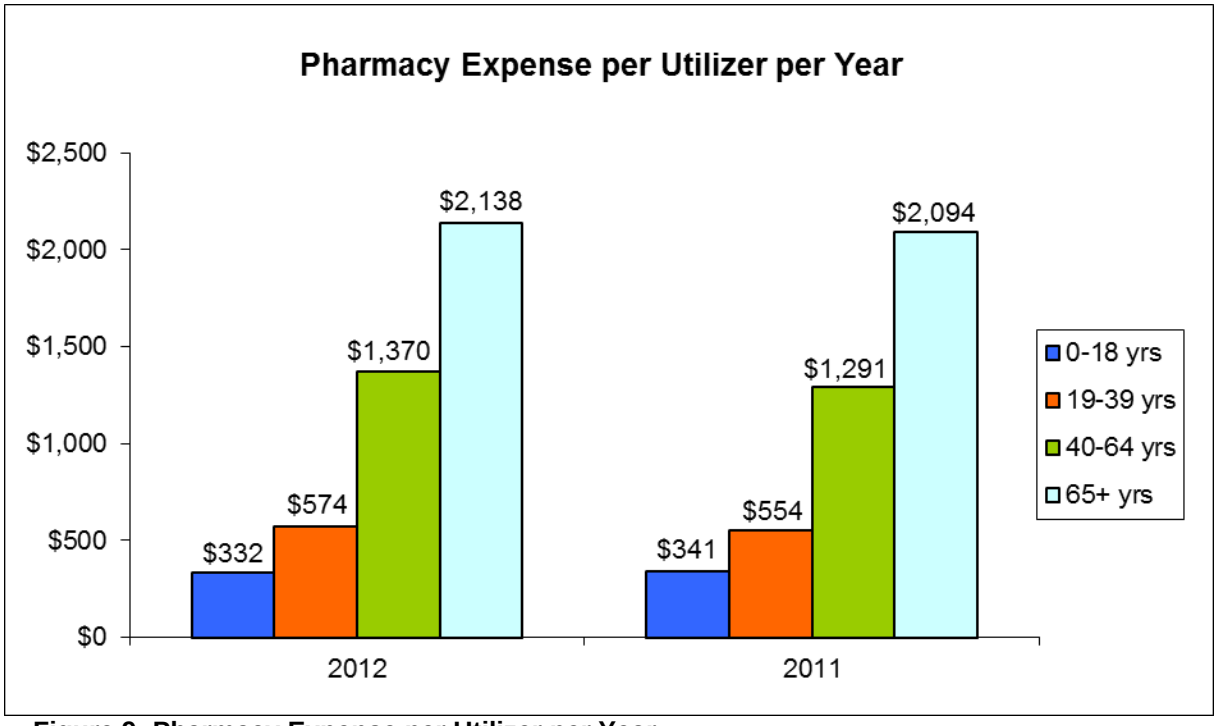

Figure 9: Pharmacy Expense per Utilizer per Year

Generic and Name-Brand Prescription Use

Table 8 shows how total pharmacy expenses were distributed among generic, preferred, and non-preferred types of drugs.

Total Prescriptions by Tier				
	2012		2011	
	Prescriptions	Percent	Prescriptions	Percent
Tier 1 Generic ($10 copay)	1,074,935	75.5%	1,058,605	72.1%
Tier 2-Preferred ($20 copay)	284,675	20.0%	302,013	20.6%
Tier 3-Non-Preferred ($40 copay)	63,688	4.5%	107,477	7.3%
Total	1,423,298	100.0%	1,468,096	100.0%

Table 8: Total Prescriptions by Tier

Prescription Use by Therapeutic Class

Table 9 shows the ten most utilized classes of drugs according to total expense. More dollars were spent on "Diabetes" than on any other therapeutic class.

Pharmacy Top Therapeutic Classes by Plan Paid				
	2012		2011	
Therapeutic class	Plan Paid	Percent	Plan Paid	Percent
Diabetes	12,099,557	10.00%	11,096,187	9.53%
Cardiovascular Disease - Lipid	9,416,313	7.78%	11,044,000	9.48%
Behavioral Health - Other	8,897,548	7.40%	8,732,785	7.50%
Inflammatory Disease	8,197,472	6.78%	7,426,270	6.38%
Asthma	7,677,516	6.35%	8,264,688	7.10%
Infectious Disease - Viral	6,476,226	5.35%	5,372,585	4.61%
Behavioral Health - Antidepressants	6,236,733	5.16%	6,304,133	5.41%
Pain Management - Analgesics	5,710,999	4.72%	5,149,968	4.42%
Neurological Disease - Miscellaneous	5,456,252	4.51%		
Cardiovascular Disease - Hypertension	5,412,245	4.47%	4,873,118	4.18%
Upper Gastrointestinal Disorders - Ulcer			4,952,566	4.25%
Total	$ 75,580,861	62.52%	$ 73,216,300	62.86%

Table 9: Pharmacy Top Therapeutic Classes by Plan Paid

Prescription Use by Type of Drug

Table 10 shows the ten most utilized drugs according to total expense. Humira is the leading prescription for the plan year.

Top Ten Drugs by Total Plan Paid					
2012			2011		
Drug Name	**Plan Paid**	**Percent**	**Drug Name**	**Plan Paid**	**Percent**
Humira	3,276,990	2.71%	Lipitor	3,960,962	3.40%
Crestor	3,067,585	2.54%	Crestor	2,778,828	2.39%
Cymbalta	2,626,269	2.17%	Humira	2,697,286	2.32%
Enbrel	2,415,040	2.00%	Singulair	2,520,425	2.16%
Copaxone	2,316,883	1.92%	Enbrel	2,278,946	1.96%
Carbaglu	1,821,311	1.51%	Cymbalta	2,116,590	1.82%
Singulair	1,740,462	1.44%	Plavix	2,079,448	1.79%
Atorvastatin Calcium	1,695,500	1.40%	Carbaglu	1,877,138	1.61%
Oxycontin	1,646,261	1.36%	Copaxone	1,789,746	1.54%
Abilify	1,565,730	1.29%	Advair Diskus	1,713,935	1.47%
Total	$ 22,172,031	18.33%	Total	$ 23,813,305	20.44%

Table 10: Top Ten Drugs by Total Plan Paid

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

Table 11 shows how active employee and retiree dental enrollments were distributed among plans.

Average Dental Enrollment by Plan			
	Delta	**TDA**	**Total**
Actives	33,643	15,783	49,426
Retirees	11,152	2,256	13,408

Table 11: Average Dental Enrollment by Plan

Dental Rates

Table 12 summarizes monthly dental rates for active and retired members.

Monthly Dental Premiums									
Actives	**Single Coverage**			**Employee + One Coverage**			**Family Coverage**		
	Employee	State	Total	Employee	State	Total	Employee	State	Total
Delta	$30.98	$4.96	$35.94	$70.87	$9.92	$80.79	$123.12	$13.70	$136.82
TDA	$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	$35.94			$80.79			$136.82		
TDA	$9.96			$18.92			$27.70		

Table 12: Monthly Dental Premiums

Wellness

Wellness services are available to State employees, retirees and covered dependents as part of the Benefit Options Health Plan benefits package. Members have access to preventive health screenings, health management courses, annual flu vaccines and Employee Assistance Program (EAP) benefits.

Table 13 shows the total utilization of the health screening benefit during the 2012 Plan Year and the number of at-risk employees referred to follow-up care.

Plan Year 2012 Wellness Screenings			
	Events	**Participant**	**Referrals**
Mini Health Screening*	65	2,692	497
Osteoporosis Screening**		1,027	13
Prostate Specific Antigen (PSA)**		167	7
Facial Skin Analysis**		1,796	N/A
Mobile Onsite Mammography	67	1,311	34
Prostate Onsite Projects	30	558	63
Total	162	7,551	614

Table 13: Plan Year 2012 Wellness Screenings

** 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.*

Table 14 shows the total utilization for the 2012 Annual Flu Vaccine Program held October through December. Wellness provided a total of 13,589 vaccines. Of the 13,589 members who participated in the Flu Vaccine Program, 11,638 were active employees. Members had access to the flu vaccine at a total of 405 locations, and 89.5% of members who received a flu vaccine, did so at a worksite clinic.

Plan Year 2012 Flu Vaccines		
	Locations	**Participants**
State Agency Worksite	189	7,563
University Worksite	30	3,007
Combined Worksite (Wesley Bolin)	5	1,603
Open Enrollment Clinics	5	297
Public Clinics	176	1,119
Total	405	13,589

Table 14: Plan Year 2012 Flu Vaccines

Table 15, on page 21, 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 LegalConnect consultation were the two most utilized services via live telephonic access. LegalConnect utilization increased 96% in 2012 and replaced FamilySource consultation as the second leading reason employees sought support through EAP. Total utilization for 2012 increased by 50% over 2012 statistics. As part of the Stress and Pain Quarterly Health Target, Benefit Options Wellness held an EAP training campaign which increased participation from 129 in 2011 to 403 in 2012.

Plan Year 2012 Employee Assistance Program Utilization			
	Eligible Population	**Users**	**Utilization Rate**
Live Telephonic Access		1,855	8.4%
EAP		1,378	6.2%
FamilySource		97	0.4%
FinancialConnect		60	0.3%
LegalConnect		320	1.4%
Online Access		4,767	21.6%
EAP		742	3.4%
FamilySource		1,293	5.8%
FinancialConnect		423	1.9%
GlobalConnect		14	0.1%
Health & Wellness		941	4.3%
LegalConnect		1,354	6.1%
Critical Incident Stress Debriefing		191	0.9%
Trainings		403	1.8%
Overall Utilization	22,113	7,216	32.6%

Table 15: Plan Year 2012 Employee Assistance Program Utilization

In addition to health screenings, vaccines, and EAP, the Wellness strategic plan for 2012 provided employees with Health Management Courses to support the four Quarterly Health Targets: Men's and Women's Preventive Health, Stress and Pain, Hypertension, and Diabetes. Table 16 shows the class series held during the Plan Year and total participation.

Plan Year 2012 Health Management Courses		
	Classes	**Participants**
Cholesterol (5 weeks)	1	21
Diabetes Management (10 weeks)	2	42
Weight Management (12 weeks)	5	138
Fitness (4 weeks)	2	41
Nutrition (4 weeks)	7	162
Hypertension (5 weeks)	2	44
Stress Management (5 weeks)	6	140
Total	25	588

Table 16: Plan Year 2012 Health Management Courses

The Wellness Strategic Plan continues to progress as scheduled. Wellness achievements for the 2012 Plan Year include: increased wellness participation, health plan vendor integration, and the early development efforts on the utilization database.

Life, Disability, Vision Insurance and Flexible Spending Accounts Premiums

Fund 3035, ERE/Benefits Administration, is used to pay insurance premiums and to administer state employee benefit plans other than health and dental. Vision, Flexible Spending, Supplemental and Dependent Life and Short Term Disability are funded solely by employee premiums. Basic Life Insurance and Non-ASRS Long Term Disability is funded solely by employer premiums. Fund 3035 is primarily a pass-through fund with collections funding the insurance vendor premium payments.

ERE/Benefits Administration Fund Summary

				Plan Year 2012
Prior Balance December 31, 2011				**$ 4,423,158.03**
Revenues				**$ 34,279,428.53**
Insurance Product	**Amount**			
Basic Life	1,353,409.79			
Supplemental Life	11,096,878.37			
Dependent Life	2,456,410.36			
Short Term Disability	7,304,459.75			
Long Term Disability	2,842,811.96			
Total Life & Disability	25,053,970.23			
Vision	4,759,227.74			
Health Care FSA	3,423,278.99			
Dependent Care FSA	1,042,951.57			
Total Flex Spending	4,466,230.56			
Total Revenues	34,279,428.53			
Expenditures				**$ 35,291,675.41**
Insurance Product	**Amount**	**Penalties**		
Basic Life	1,358,782.58			
Supplemental Life	11,440,705.25			
Dependent Life	2,539,468.60			
Short Term Disability	7,591,336.28			
Long Term Disability	2,947,209.32			
Total Life & Disability*	25,877,502.03	-		
Vision*	4,891,125.39	(3,500.00)		
Health Care FSA	3,367,956.56			
Dependent Care FSA	1,009,496.35			
Administrative Fees*	147,506.00	(510.92)		
Total Flex Spending	4,524,958.91	(510.92)		
GAO AFIS Cost	2,100.00			
Total Expenditures	35,295,686.33	(4,010.92)	35,291,675.41	
Ending Balance December 31, 2012				**$ 3,410,911.15**

Table 17: ERE/Benefits Administration Fund Summary

**Vendor administrative fees and fully insured premiums are paid 55 days in arrears per contract.*

Vendor Performance Standards

Pursuant to A.R.S. § 38-658(B) “On or before October 1 of each year, the director of the Department of Administration shall report to the Joint Legislative Budget Committee 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, and other contracts for the Benefit Options program, are a number of ADOA-negotiated performance measures with specific financial guarantees tied to the performance of the contracted vendors providing various services for the program. If a vendor fails to meet any of the measures within the specified performance range, the vendor is required to submit a Corrective Action Plan detailing why the measure was missed and actions taken to address the issue and improve performance to meet the standard of the measure. A percentage of the vendor’s annual payment is withheld by ADOA as a performance penalty per terms of the vendor contract. This percentage is allocated among the more critical measures of the contract.

The following is a report of the agreed upon performance standards both met and missed by contracted vendors during the 2012 plan year. In each case, performance penalties for measures missed will be assessed per the terms of the vendor contract.

Aetna		
Successfully Met Performance Measures		
Fees At Risk		**Performance Measure**
23.00% of Total Administrative Fee		Customer Service - 53 of 61 targets Appeals – met 34 of 36 targets Reporting – met 16 of 18 targets Claims Adjudication - met 55 of 60 targets Open Enrollment, Administration, Survey & Medicare Administration – met all 34 targets
20.00% Medical Management Fee		Nurse Line – met 2 of 3 targets Medical Management, Case Management & Disease Management - met all 17 targets
Performance Measures Not Met		
Total Percent Assessed Based on Reporting Frequency	**Percent of Fees at Risk**	**Performance Measure**
Missed 1 month of 12 months measured = 0.08%	1.00%	Customer Service: call abandonment rate 3% or less.
Missed 3 months of 12 months measured = 0.25%	1.00%	Customer Service: average speed to answer call <30 seconds.
Missed 1 month of 12 months measured = 0.08%	1.00%	Customer Service: 97% telephone call quality.
Missed 3 months of 12 months measured = 0.25%	1.00%	Customer Service: 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.
Missed 2 months of 12 months measured = 0.17%	0.33%	Appeals: written appeals resolved in 15 calendar days after receipt of participant's request for review in the case of pre-service claims.
Missed 1 quarter of 4 quarters = 0.25%	1.00%	Reporting: Contractor will deliver quarterly reports to the ADOA within 45 calendar days from the end of the quarter.
Missed 1 month of 12 months measured = 0.08%	1.00%	Reporting: Contractor will deliver monthly reports to the ADOA within 30 calendar days from the end of the month.
Missed 3 months of 12 months measured = 0.25%	1.00%	Claims Adjudication: 98.2% of claims dollars submitted for payment will be accurately processed and paid.
Missed 2 months of 12 months measured = 0.17%	1.00%	Claims Adjudication: 96% of all claims will be processed accurately.
Missed annual measurement	0.00%	Nurse Line: 90% of all calls appropriately triaged (self-reported by vendor).

Vendor Performance Measures 1: Aetna

Cigna		
Successfully Met Performance Measures		
Fees At Risk		**Performance Measure**
15.20% of Total Administrative Fee		Customer Service - met 70 of 72 targets Claims Adjudication - met 49 of 60 targets Appeals, Open Enrollment, Administration, Reporting, Survey & Medicare Administration - met all 99 targets
27.00% Medical Management Fee		Medical Management - met 15 of 16 targets Case Management, Disease Management & Nurse Line - met all 32 targets
Performance Measures Not Met		
Total Percent Assessed Based on Reporting Frequency	**Percent of Fees at Risk**	**Performance Measure**
Missed 2 months of 12 months measured = 0.08%	0.50%	Customer Service: call abandonment rate 3% or less.
Missed 6 months of 12 months measured = 0.38%	0.75%	Claims Adjudication: 97% of all fully documented claims received will be completely processed within 14 calendar days after they are received.
Missed 1 month of 12 months measured = 0.17%	2.00%	Claims Adjudication: 99% of claims dollars submitted for payment will be accurately processed and paid.
Missed 4 months of 12 months measured = 0.17%	0.50%	Claims Adjudication: 97% of all claims will be process accurately. Accurate processing includes payment amount; communication to claimant or provider; data entry errors affecting current or future benefit determinations and management reports.
Missed 1 quarter of 4 quarters = 0.50%	2.00%	Medical Management: Contractor to provide a quarterly report demonstrating that HIPAA compliance standards have been met.

Vendor Performance Measures 2: Cigna

United HealthCare		
Successfully Met Performance Measures		
Fees At Risk		**Performance Measure**
18.55% of Total Administrative Fee		Customer Service - met 59 of 60 targets Appeals - met 45 of 48 targets Reporting - met 28 of 29 targets Claims Adjudication - met 56 of 60 targets Open Enrollment, Administration, Survey & Medicare Administration - met all 41 targets
25.00% Medical Management Fee		Medical Management - met 12 of 13 targets Case Management, Disease Management & Nurse Line - met all 38 targets
Performance Measures Not Met		
Total Percent Assessed Based on Reporting Frequency	**Percent of Fees at Risk**	**Performance Measure**
Missed 1 month of 12 months measured = 0.04%	0.50%	Customer Service: average speed to answer call <30 seconds.
Missed 3 months of 12 months measured = 0.06%	0.25%	Appeals: written appeals resolved in 15 calendar days after receipt of participant's request for review in the case of pre-service claims.
Missed 1 quarter of 4 quarters = 0.13%	0.50%	Reporting: Contractor will deliver quarterly reports to the ADOA within 45 calendar days from the end of the quarter.
Missed 2 months of 12 months measured = 0.13%	0.75%	Claims Adjudication: 97% of all fully documented claims received will be completely processed within 10 calendar days after they are received.
Missed 1 month of 12 months measured = 0.17%	2.00%	Claims Adjudication: 99.3% of claims dollars submitted for payment will be accurately processed and paid.
Missed 1 month of 12 months measured = 0.08%	1.00%	Claims Adjudication: 97% of all claims will be process accurately. Accurate processing includes payment amount; communication to claimant or provider; data entry errors affecting current or future benefit determinations and management reports.
Missed 1 quarter of 4 quarters = 0.50%	2.00%	Medical Management: Contractor to provide a quarterly report demonstrating that HIPAA compliance standards have been met.

Vendor Performance Measures 3: United HealthCare

AmeriBen		
Successfully Met Performance Measures		
Fees At Risk		**Performance Measure**
14.00% of Total Administrative Fee		Administration – met 31 out of 32 targets Claims Adjudication – met 59 out of 60 targets Customer Service, Appeals, Open Enrollment, Reporting, Survey & Medicare Administration – met all 151 targets
Performance Measures Not Met		
Total Percent Assessed Based on Reporting Frequency	**Percent of Fees at Risk**	**Performance Measure**
Missed 1 month out of 12 months measured = 0.04%	0.50%	Administration: Contractor will mail appropriate plan descriptive material to participants within 2 calendar days of receiving a request.
Missed 1 month out of 12 months measured = 0.06%	0.75%	Claims Adjudication: Processing of a claim will be completed when it has been approved for payment, denied or pended with a request for further information. 97% of all fully documented claims received will be completely processed within 10 calendar days after they are received.

Vendor Performance Measures 4: AmeriBen

American Health Holding		
Successfully Met Performance Measures		
Fees At Risk		**Performance Measure**
21.00% of Total Administrative Fee		Implementation, Reporting, Systems & Survey - met all 46 targets
30.00% Medical Management Fee		Utilization Management, Case Management, Disease Management & Nurse Line - met all 48 targets
Performance Measures Not Met		
Total Percent Assessed Based on Reporting Frequency	**Percent of Fees at Risk**	**Performance Measure**
		No measures missed.

Vendor Performance Measures 5: American Health Holding

MedImpact		
Successfully Met Performance Measures		
Fees At Risk		**Performance Measure**
Fixed Amounts Totaling $1,520,000		Network Management, Eligibility, Claims/Paper, Claims/Mail Order, Customer Service, Survey, Account Management, Implementation, Reporting & Generic Substitution/Utilization - met all 96 targets
Performance Measures Not Met		
Total Amount Assessed Based on Reporting Frequency	**Fees at Risk**	**Performance Measure**
$200,000	$200,000	Account Management: PBM guarantees a satisfaction rating of at least 90% on a scale from 0 - 100% based upon a mutually agreed methodology.

Vendor Performance Measures 6: MedImpact

Delta Dental		
Successfully Met Performance Measures		
Fees At Risk		**Performance Measure**
1.25% of Total Premiums Paid		Implementation, Report Timeliness, Account Management, Network Management, Satisfaction, Appeals & Quality of Service - met all 159 targets
Performance Measures Not Met		
Total Percent Assessed Based on Reporting Frequency	**Percent of Fees at Risk**	**Performance Measure**
		No measures missed.

Vendor Performance Measures 7: Delta Dental

Total Dental Administrators		
Successfully Met Performance Measures		
Fees At Risk		**Performance Measure**
3.25% of Total Premiums Paid		Implementation, Report Timeliness, Network Management, Appeals & Quality of Service - met all 130 targets
Performance Measures Not Met		
Total Percent Assessed Based on Reporting Frequency	**Percent of Fees at Risk**	**Performance Measure**
Missed 1 of 1 annual measure = 0.25%	0.25%	Satisfaction: no less than 80% overall member satisfaction on annual survey.

Vendor Performance Measures 8: Total Dental Administrators

ComPsych		
Successfully Met Performance Measures		
Fees At Risk		**Performance Measure**
17.00% of Total Administrative Fee		Account Management/Customer Service Administration, Reporting, Program Administration & Survey – met all 36 targets
Performance Measures Not Met		
Total Percent Assessed Based on Reporting Frequency	**Percent of Fees at Risk**	**Performance Measure**
		No measures missed.

Vendor Performance Measures 9: ComPsych

Avesis		
Successfully Met Performance Measures		
Fees At Risk		**Performance Measure**
Fixed Amounts Totaling $313,000		Call Center - met 35 of 36 targets Implementation/Member Communication, Reporting, Network Management, Claims Administration, Appeals & Survey - met all 84 targets
Performance Measures Not Met		
Total Amount Assessed Based on Reporting Frequency	**Fees at Risk**	**Performance Measure**
Missed 1 month out of 12 months measured = $2,500	$30,000	Call Center: 90% of all calls requesting a member services representative will be answered in 30 seconds or less.

Vendor Performance Measures 10: Avesis

Application Software Inc.		
Successfully Met Performance Measures		
Fees At Risk		**Performance Measure**
5.00% of Total Administrative Fees		Claims Adjudication – met 6 of 8 targets Claims Financial, Web Availability & Phone Response Time – met all 9 targets
Performance Measures Not Met		
Total Percent Assessed Based on Reporting Frequency	**Percent of Fees at Risk**	**Performance Measure**
Missed 1 quarter of 4 quarters measured = 0.25%	1.00%	Claims Adjudication: 95% of claims will be processed within two working days.
Missed 1 quarter of 4 quarters measured = 0.25%	1.00%	Claims Adjudication: 100% of claims will be processed within five working days.

Vendor Performance Measures 11: Application Software Inc.

The Hartford		
Successfully Met Performance Measures		
Fees At Risk		**Performance Measure**
7.28% of Total Premiums Paid		Implementation, Quality of Service, Appeals, Claimant Notification, Financial Payment & Report Timeliness - met all 101 targets
1.25% of Total STD Premiums Paid		Short Term Disability Processing – met all 36 targets
0.50% of Total LTD Premiums Paid		Long Term Disability Processing – met all 2 targets
1.00% of Total Life Premiums Paid		Life Claims Processing – met all 13 targets
Performance Measures Not Met		
Total Percent Assessed Based on Reporting Frequency	**Percent of Fees at Risk**	**Performance Measure**
Missed 1 month of 12 months measured = 0.04%	0.50%	Quality of Service and Responsiveness to Members-Telephonic: Abandonment Rate <3%

Vendor Performance Measures 12: The Hartford

Audit Services

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

During the 2012 plan year, thirty-two (32) audit projects were completed 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. The 32 audit projects resulted in 26 recommendations, 12 of which were fully implemented by the end of the year, and $219,312 of recoverable savings.

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. Table 18 is a summary of the functional areas in which audits were completed, and the corresponding audit methodology.

Audit Services Summary	
Functional Area	**Audit Methodology**
Vendor operating transactions	Statement on Standards for Attestation Engagements No. 16 Audits (“SSAE 16”) Evaluation of external audit results
Vendor internal operating standards	Quality Management Review (“QMR”)
Vendor execution of benefit design and contract elements	Plan Allowances/Exclusions (“A&E”) Plan Authorizations Claims adjudication compliance Inquiries (i.e., research, plan coverage design, etc.)
ADOA accuracy of shared data	Dependent Eligibility Audit (DEA)

Table 18: Audit Services Summary

Vendor Operating Transactions

Each of the health plans’ contracted vendors that pay claims are required to provide a copy of a SSAE 16, which is an independently assessed operational annual audit. SSAE 16 audits evaluate the internal control of the vendor’s processing systems utilized to adjudicate claims and identify deficiencies. 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. In addition, audits performed by external or third party vendors are evaluated and considered for the development of the audit schedule when there is significant impact on the health plan and contract compliance (i.e. large medical and/or pharmacy claims audit).

Vendor Internal Operating Standards

QMRs are conducted to ensure the vendor’s internal audit teams are effectively measuring established operating standards, identifying and correcting errors, and providing sufficient training for claims processing, customer service, and clinical reviews. QMR results indicated that vendors had adequate operating controls and re-trained staff as issues were identified.

Vendor Execution of Benefit Design and Contract Elements

Plan Implementation audits are completed annually for new, deleted, or revised plan design elements. Implementation audits are designed to measure compliance with new and/or revised plan elements as they are executed at the start of a new plan year. Plan elements may include revisions to language in the plan document, vendor system edits (claim adjudication), plan allowances/limitations, internal controls, etc. Audit results indicated that, in some cases, routine physicals were not adjudicated properly and a recoverable savings of $2,013.92 was identified.

Plan allowance/exception (A&E) audits are designed to evaluate whether the contracted vendors' system were set up correctly in compliance with the health plan's benefit design. A&E audit findings for the plan year indicated that plan limitations and restrictions were processed accurately and members received the benefits allowed to them as defined in the plan description with the exception of two coverage elements. Medical foods allowance and excluded erectile dysfunction and sexual dysfunction treatment were erroneously adjudicated. As a result of the Medical Foods audit, an impact report identified $108,390.28 in recoverable savings. The Erectile Dysfunction and Sexual Dysfunction audit identified $2,505.76 of recoverable savings.

Plan authorization reviews are conducted to ensure contracted vendors implement operational changes, language revisions, and claim payment exceptions in an accurate and timely manner. A plan authorization is an agreement to revise a process or operating standard and may be initiated by either a contracted vendor or ADOA. Results indicated that plan authorizations were correctly implemented and no corrective action was required.

Claims adjudication compliance audits are performed to evaluate the contracted vendors' adherence to regulatory guidelines, current operating standards, contractual elements, vendor performance, and/or plan authorization documents. During the 2012 plan year, the End-Stage Renal Disease (ESRD) Audit was conducted to evaluate the medical vendors' accuracy of primary and secondary payer status. The audit identified $106,402.35 of recoverable savings.

ADOA Accuracy of Shared Data

Dependent Eligibility audits are performed annually on the health plan's membership. The eligibility audits provide assurance that dependent eligibility is monitored effectively and the risk of claims paid on behalf of ineligible dependents is minimized. 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.

Appendix

Table A: Special Employee Health Fund Cash Statement

					Plan Year 2012
Prior Balance December 31, 2011				$	269,370,283.08
Revenues				$	734,173,289.02
Source	Premiums	Reductions****			
ADOA Health Plan (EE)	130,271,277.16	(11,371,655.64)			
ADOA Health Plan (ER)	592,627,056.45	(51,170,309.00)			
BCBS NAU Plan (EE)	6,416,104.92	(261,221.72)			
BCBS NAU Plan (ER)	26,739,985.00	(1,942,223.42)			
Dental Plan (EE)	35,781,551.65				
Dental Plan (ER)	7,044,678.95				
Other Revenue	38,044.67				
Net Revenue	798,918,698.81	(64,745,409.79)	734,173,289.02		
Expenditures				$	759,094,500.98
Vendor	Admin Fees	Penalties			
AHH Medical Management	1,090,544.60	0.00			
Aetna	2,695,582.19	(9,455.55)			
Cigna	1,486,196.73	(16,642.82)			
UnitedHealthcare	13,715,733.06	(51,833.96)			
AmeriBen	3,634,648.57	(10,127.04)			
MedImpact	1,090,371.80	(213,750.00)			
Other Fees**	395,234.56				
AG Collection Fees	383.72				
Net Administrative Fees***	24,108,695.23	(301,809.37)	23,806,885.86		
	Medical Claims	Recoveries*			
Harrington	26,511.05	(565,788.70)			
Aetna	25,384,986.47	(2,934.10)			
Cigna	40,910,988.47	(7,129.11)			
UnitedHealthcare	329,362,371.93	(133,567.27)			
AmeriBen	86,281,174.31	(600,163.49)			
MedImpact	124,778,480.82	(6,907,876.02)			
Early Retiree Reinsurance Program		148,531.10			
Medicare Part D Retiree Drug Subsidy		(4,405,890.98)			
Other Wellness	624,107.61				
Net Medical Claims	607,368,620.66	(12,474,818.57)	594,893,802.09		
Self-Insured Expenditures			*618,700,687.95*		
	Fully Insured Premium	Penalties			
BCBS (NAU Only)	32,453,351.76				
Delta Dental	38,271,083.62	0.00			
Total Dental Administrators	3,706,197.40	(9,498.92)			
*Fully Insured Expenditures****	*74,430,632.78*	*(9,498.92)*	*74,421,133.86*		
HITF Operating	3,533,327.41		3,533,327.41		
Fund Transfers Out	29,986,000.00		29,986,000.00		
NET EXPENDITURES	739,427,276.08	(12,786,126.86)	759,094,500.98		
Fund Balance December 31, 2012				$	276,902,422.88
IBNR Liability				$	90,800,000.00
Contigency Reserve				$	90,800,000.00
Unreserved Cash Balance As Of December 31, 2012				$	95,302,422.88

**Recoveries include prescription drug rebates, overpayment recoveries (including stop payments and voids), subrogation recoveries, etc. **Other Fees include HSA Administration, surcharges by other states (MA, MI, NYHCR), and legal fees. ***Vendor administrative fees and fully insured premiums are paid 55 days in arrears per contract. ****Legislatively mandated premium holiday.*

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 Active Employees or "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, MI 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/Pre-Paid Dental – a dental plan that offers members dental services with no annual maximums, no claim forms, and services 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 – is 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 – is 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 – defined as the period of January 1 through December 31 of a given year.

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 – is 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 – is 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.

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