**Arizona Department of Administration**
Benefit Services Division

# 2014
# Annual Report
## Health Insurance Trust Fund

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Benefit Options
Choice Value Health

## FOREWORD

Benefit Options is the program name for the benefits offered to State of Arizona ("State") employees and retirees by the Arizona Department of Administration ("ADOA"). This report provides a broad overview of the Benefit Options program, and meets 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, 2014 through December 31, 2014. The active and retiree plans were concurrent for this period.

For this report, ADOA internally developed a consistent statistical model based on generally accepted actuarial principles and standards, including *Milliman Health Cost Guidelines Commercial Rating Structures, July 1, 2013*.

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# Report Background

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

> 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 Division. The ERE/Benefits Administration Fund, or Fund 3035, is primarily a "pass through" fund for other benefits including vision, life, and disability insurance, and flexible spending accounts.

The benefits offered through the program fall into one of two types — self-funded or fully-insured. For 2014, the health benefit plan and the dental PPO plan were self-funded, whereas the dental HMO plan, vision plan, life, and disability insurance plans were fully-insured.

The State's self-funded medical plan began on October 1, 2004, and consists of both integrated and non-integrated 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.

The State's self-funded dental PPO plan began on January 1, 2013.

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. Also included is a summary of premiums collected and paid for life insurance, disability insurance, vision insurance, and flexible spending accounts for Fund 3035.

All data provided herein is for Plan Year (PY) 2014 (January 1, 2014 – December 31, 2014).

# Executive Summary

During PY 2014, ADOA offered a comprehensive insurance package through Benefit Options to over 129,000 members consisting of active state and university employees, retirees, and their qualified dependents. The benefits offered in the package include medical, pharmaceutical, dental, flexible spending, vision, wellness, life, and disability insurance.

Based on the 2014 contribution strategy, the sum of health and dental premiums collected was $839 million with total plan expenses of $815 million, resulting in a net operational gain of $24 million.

**Health Plan**

- The average plan cost to insure each member was $5,776
  - Average active member cost was $5,527
  - Average retiree cost was $9,078
- The medical claims expense was $518 million of total health plan costs for 2014
  - The leading diagnosis category by cost was the musculoskeletal system
    - Just under 13% of the total medical claims cost
  - Claims showed members are seeking care from physicians or specialists for the majority of their medical needs, indicating appropriate care
    - 4,395 physician visits per 1,000 members
    - 216 urgent care visits per 1,000 members
    - 169 emergency room visits per 1,000 members
- The pharmacy claims expense was $142 million of total health plan costs for 2014
  - The leading therapeutic drug class by cost was diabetes
    - 19% of the total pharmacy claims cost
  - 1.4 million prescriptions were filled during PY 2014
    - Retirees filled an average of 31 prescriptions per year
    - Active members averaged 10 per year

**Wellness Program**

- Administered over 14,092 flu vaccines through 623 worksite or public events
- Administered over 5,196 screenings through 133 worksite events resulting in 179 referrals to physicians for various health issues

**Performance Measures**

Financial guarantees are in place to manage the performance of the contracted vendors. Most vendors met the majority or all of the agreed-upon performance measures. However, estimated penalties of $210,971 will be collected in 2015 from a few vendors failing to meet agreed upon PY 2014 performance targets in customer service, claims processing, appeals, reporting, survey, and network management.

**Review**

The PY 2014 ratio of expenses to premiums of 95% indicates that the ADOA effectively controlled the rise in health care costs through quality benefit design, administrative oversight, strategic planning, auditing, and effective contract management. Detailed evidence of ADOA's accomplishments can be reviewed herein.

# Health Insurance Trust Fund Summary

Table 1 is a cash statement of receipts received and expenses paid during 2014 for PY 2014 and prior plan years.

ADOA Health Plan is the self-funded medical program and includes Aetna, Blue Cross Blue Shield of Arizona administered by AmeriBen, Cigna, and UnitedHealthcare 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.

Effective January 1, 2014, all Medicare eligible participants covered under the State of Arizona Benefit Options Program were transitioned from the Medicare Part D Retiree Drug Subsidy program to a Medicare Employer Group Prescription Drug Plan (EGWP), a prescription drug plan that combines a standard Medicare Part D plan with additional prescription drug coverage provided by Benefit Options. The EGWP program achieved an estimated plan savings of $8,972,015.

Reserves are monies set aside for the purpose of paying claims that have been incurred but not reported (IBNR) and for 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.

| Health Insurance Trust Fund Summary | |
|---|---|
| | **Plan Year 2014** |
| **Prior Balance December 31, 2013** | $283,197,937.22 |
| | |
| **Revenues** | |
| ADOA Benefit Options | 760,164,923.28 |
| BCBS (NAU) | 36,494,817.60 |
| ADOA Dental Plan | 38,997,026.34 |
| PrePaid Dental Plan | 3,633,339.63 |
| Other Revenue | 94,631.14 |
| **Total Revenues** | $839,384,737.99 |
| | |
| **Expenditures** | |
| Administrative Fees | 28,442,857.00 |
| Medical Claims | 517,727,939.38 |
| Drug Claims | 141,741,409.41 |
| Dental Claims | 35,582,110.23 |
| Medicare Part D Retiree Drug Subsidy | (6,388,752.30) |
| BCBS (NAU) Premiums | 36,277,339.11 |
| Dental Premiums | 3,638,583.98 |
| Appropriated Expenses | 4,048,311.19 |
| **Total Expenditures** | $761,069,798.00 |
| | |
| Interfund Transfers^ | 53,900,000.00 |
| Federal Participation Reimbursement | - |
| | |
| Fund Balance December 31, 2014 | $307,612,877.21 |
| | |
| **Reserves** | |
| IBNR Liability (Medical & Dental) | $113,000,000 |
| Contigency Reserve (Medical & Dental) | $113,000,000 |
| **Total Reserves** | $226,000,000.00 |
| | |
| **Unrestricted Balance December 31,2014** | $ 81,612,877.21 |

Table 1: Health Insurance Trust Fund Summary

*^Interfund transfers from HITF to other State operating funds. Future transfers include $8.3 million pursuant to Laws 2014, Ch. 18 (HB2703) – 2014-2015 for fiscal year 2015.*

# Medical Plan Enrollment

The ADOA 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; and
- State employees or university staff eligible for COBRA benefits.

The three types of medical plans offered to eligible participants 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, services must be obtained from a network provider. Out-of-network services are only covered in emergency situations. Under the EPO plan, the employee pays the monthly premium and any required copay at the time of service. Members selecting the EPO plan may choose from four networks: Aetna, Blue Cross Blue Shield of Arizona administered by AmeriBen*, Cigna, or UnitedHealthcare.

**The PPO Plan**
If a member chooses the PPO plan, services can be provided in-network or out-of-network, but there are 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 may choose from Aetna, Blue Cross Blue Shield of Arizona administered by AmeriBen*, or UnitedHealthcare.

**The HSAO Plan**
The HSAO plan is a high deductible health plan only available to active employees through the Aetna network. If an employee enrolls in the HSAO, the employee is 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.

When enrolled in the HSAO plan, members can use in-network and out-of-network providers. Members pay the copay and/or coinsurance after the deductible is met, except for qualified preventive services that 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 shows how enrollment was distributed by plan and network between active, retired, university, and COBRA members.

| Average Monthly Medical Enrollment by Plan & Network | | | | | |
|---|---|---|---|---|---|
| | | 2014 | | 2013 | |
| Network | Plan Type | Subscribers | Members | Subscribers | Members |
| AETNA | | | | | |
| Active | EPO | 1,796 | 4,080 | 1,595 | 3,639 |
| Retiree | EPO | 245 | 323 | 247 | 327 |
| University | EPO | 1,940 | 3,588 | 1,639 | 3,000 |
| COBRA | EPO | 9 | 11 | 21 | 25 |
| Active | PPO | 127 | 221 | 96 | 176 |
| Retiree | PPO | 34 | 41 | 41 | 50 |
| University | PPO | 214 | 399 | 182 | 328 |
| COBRA | PPO | 0 | 0 | 0 | 0 |
| Active | HSAO | 332 | 664 | 250 | 487 |
| Retiree | HSAO | - | - | - | - |
| University | HSAO | 416 | 762 | 317 | 566 |
| COBRA | HSAO | 2 | 2 | 1 | 1 |
| AmeriBen* | | | | | |
| Active | EPO | 7,067 | 17,512 | 6,513 | 16,122 |
| Retiree | EPO | 1,123 | 1,511 | 1,125 | 1,488 |
| University | EPO | 2,465 | 5,168 | 2,185 | 4,626 |
| COBRA | EPO | 36 | 46 | 35 | 41 |
| Active | PPO | 420 | 776 | 310 | 570 |
| Retiree | PPO | 95 | 110 | 103 | 122 |
| University | PPO | 360 | 662 | 300 | 539 |
| COBRA | PPO | 1 | 1 | 4 | 7 |
| CIGNA | | | | | |
| Active | EPO | 3,208 | 7,776 | 3,009 | 7,228 |
| Retiree | EPO | 593 | 762 | 589 | 764 |
| University | EPO | 1,261 | 2,613 | 1,160 | 2,361 |
| COBRA | EPO | 11 | 14 | 14 | 17 |
| UnitedHealthcare | | | | | |
| Active | EPO | 20,264 | 48,949 | 20,557 | 49,366 |
| Retiree | EPO | 4,815 | 6,184 | 4,771 | 6,109 |
| University | EPO | 10,818 | 24,515 | 10,847 | 24,508 |
| COBRA | EPO | 80 | 111 | 114 | 145 |
| Active | PPO | 561 | 1,044 | 516 | 943 |
| Retiree | PPO | 98 | 122 | 108 | 136 |
| University | PPO | 650 | 1,279 | 602 | 1,153 |
| COBRA | PPO | 3 | 4 | 4 | 4 |
| Blue Cross Blue Shield** | | | | | |
| NAU only | PPO | 3,054 | 5,631 | 2,877 | 5,311 |
| Total | | 62,098 | 134,881 | 60,131 | 130,156 |

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

| Active Medical Premiums per 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 both retirees not enrolled in Medicare and for those retirees who are enrolled in Medicare, or have at least one family member 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**

## Medical Premium vs. Plan Cost

The 2014 contribution strategy for the self-insured medical plan resulted in employees paying 12% of the average monthly total premium, while the State paid the remaining 88%.

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

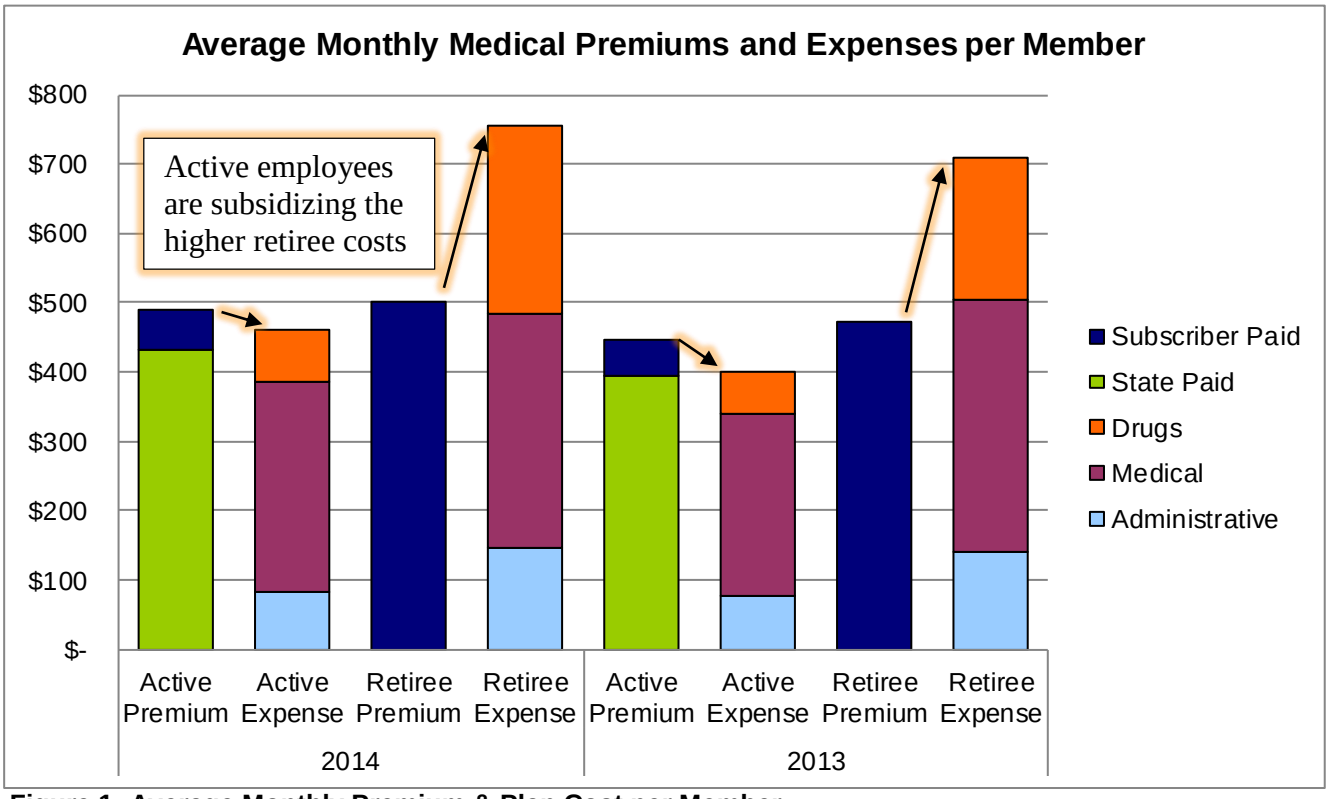


**Figure 1: Average Monthly Premium & Plan Cost per Member**

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

## Expenses for Self-Funded Medical Plans

The tables below show the distribution of claims and expenses incurred in PY 2014, and the average annual cost to insure each type of subscriber/member.

| Self-funded Incurred Medical Expenses by Active, Retiree, and Plan | | | | | | |
|---|---|---|---|---|---|---|
| **Expenses** | **Overall** | **Active** | **Retiree** | **EPO** | **PPO** | **HSAO** |
| Medical Claims | $475,471,153 | $438,561,075 | $36,910,078 | $450,817,762 | $22,450,756 | $2,202,635 |
| Drug Claims | $148,993,748 | $112,422,072 | $36,571,676 | $139,442,067 | $9,159,785 | $391,896 |
| Medicare Part D Subsidy | ($6,388,752) | $0 | ($6,388,752) | ($6,175,461) | ($213,291) | $0 |
| ERRP Reimbursement | $0 | $0 | $0 | $0 | $0 | $0 |
| Rebates & Recoveries | ($7,189,809) | ($6,343,773) | ($846,036) | ($6,795,987) | ($363,950) | ($29,872) |
| Administration Fees | $26,825,466 | $23,690,607 | $3,134,859 | $24,949,907 | $1,147,135 | $728,423 |
| Appropriated Expenses | $3,837,747 | $3,382,597 | $455,150 | $3,622,473 | $166,552 | $48,722 |
| Total Expenses | $641,549,553 | $571,712,577 | $69,836,975 | $605,860,762 | $32,346,987 | $3,341,804 |
| IBNR Liability | $104,900,000 | $92,556,254 | $12,343,746 | $99,154,101 | $5,310,059 | $435,839 |
| Total | $746,449,553 | $664,268,832 | $82,180,721 | $705,014,863 | $37,657,047 | $3,777,643 |
| **Enrollment in self-funded plans** | | | | | | |
| Subscribers | 59,044 | 52,041 | 7,003 | 55,732 | 2,562 | 750 |
| Members | 129,250 | 120,197 | 9,053 | 123,164 | 4,657 | 1,428 |
| **Annual cost** | | | | | | |
| Per subscriber | $12,642 | $12,764 | $11,736 | $12,650 | $14,696 | $5,040 |
| Per member | $5,775 | $5,527 | $9,078 | $5,724 | $8,086 | $2,645 |

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

| Self-funded Incurred Medical Expenses by Plan for Active & Retiree | | | | | | |
|---|---|---|---|---|---|---|
| **Expenses (in dollars)** | **Overall** | **Active EPO** | **Active PPO** | **Active HSAO** | **Retiree EPO** | **Retiree PPO** |
| Medical Claims | $475,471,153 | $414,932,189 | $21,426,251 | $2,202,635 | $35,885,573 | $1,024,505 |
| Drug Claims | $148,993,748 | $104,091,353 | $7,938,823 | $391,896 | $35,350,714 | $1,220,962 |
| Medicare Part D Subsidy | ($6,388,752) | $0 | $0 | | ($6,175,461) | ($213,291) |
| ERRP Reimbursement | $0 | $0 | $0 | $0 | $0 | $0 |
| Rebates & Recoveries | ($7,189,809) | ($5,975,805) | ($338,096) | ($29,872) | ($820,183) | ($25,853) |
| Administration Fees | $26,825,466 | $21,916,484 | $1,045,699 | $728,423 | $3,033,423 | $101,436 |
| Appropriated Expenses | $3,837,747 | $3,182,051 | $151,825 | $48,722 | $440,422 | $14,728 |
| Total Expenses | $641,549,553 | $538,146,272 | $30,224,501 | $3,341,804 | $67,714,489 | $2,122,486 |
| IBNR Liability | $104,900,000 | $87,187,558 | $4,932,857 | $435,839 | $11,966,544 | $377,202 |
| Total | $746,449,553 | $625,333,830 | $35,157,359 | $3,777,643 | $79,681,033 | $2,499,688 |
| **Enrollment in self-funded plans** | | | | | | |
| Subscribers | 59,044 | 48,956 | 2,336 | 750 | 6,776 | 227 |
| Members | 129,250 | 114,384 | 4,385 | 1,428 | 8,780 | 273 |
| **Annual cost** | | | | | | |
| Per subscriber | $12,642 | $12,773 | $15,051 | $5,040 | $11,759 | $11,032 |
| Per member | $5,775 | $5,467 | $8,018 | $2,645 | $9,075 | $9,170 |

**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 were spent treating conditions related to the musculoskeletal system than any other diagnosis.

| Medical Expenses by Diagnosis for Actives & Retirees | | | | | | |
|---|---|---|---|---|---|---|
| | 2014 | | | 2013 | | |
| Diagnosis | All members % of Total | Actives % of Total | Retirees % of Total | All members % of Total | Actives % of Total | Retirees % of Total |
| Musculoskeletal System/Connective Tissue | 12.98% | 12.80% | 15.04% | 13.28% | 13.28% | 13.28% |
| Health Status and Contact with Health Service | 11.22% | 11.35% | 9.71% | 11.03% | 11.03% | 11.03% |
| Symptoms, Signs, and Ill-defined | 9.42% | 9.51% | 8.33% | 9.47% | 9.47% | 9.47% |
| Neoplasms | 8.99% | 8.50% | 14.54% | 9.96% | 9.96% | 9.96% |
| Injury and Poisoning | 7.87% | 8.11% | 5.20% | 8.78% | 8.78% | 8.78% |
| Digestive System | 7.30% | 7.38% | 6.39% | 6.80% | 6.80% | 6.80% |
| Circulatory System | 7.20% | 6.98% | 9.75% | 6.85% | 6.85% | 6.85% |
| Nervous System and Sense Organs | 6.32% | 5.98% | 10.15% | 5.83% | 5.83% | 5.83% |
| Genitourinary System | 6.21% | 6.22% | 6.12% | 6.11% | 6.11% | 6.11% |
| Pregnancy, Childbirth, and the Puerperium | 4.79% | 5.21% | 0.04% | 4.50% | 4.50% | 4.50% |
| Respiratory System | 4.27% | 4.38% | 2.97% | 4.85% | 4.85% | 4.85% |
| Endocrine System | 4.12% | 4.13% | 4.01% | 3.99% | 3.99% | 3.99% |
| Mental Disorders | 2.92% | 3.05% | 1.39% | 2.73% | 2.73% | 2.73% |
| Infectious and Parasitic Diseases | 2.66% | 2.65% | 2.80% | 2.07% | 2.07% | 2.07% |
| Skin and Subcutaneous Tissue | 1.52% | 1.48% | 1.93% | 1.44% | 1.44% | 1.44% |
| Congenital Anomalies | 1.09% | 1.14% | 0.57% | 0.86% | 0.86% | 0.86% |
| Blood and Blood-Forming Organs | 0.77% | 0.74% | 1.04% | 0.88% | 0.88% | 0.88% |
| Conditions in the Perinatal Period | 0.36% | 0.39% | 0.00% | 0.59% | 0.59% | 0.59% |
| 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 30% 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.

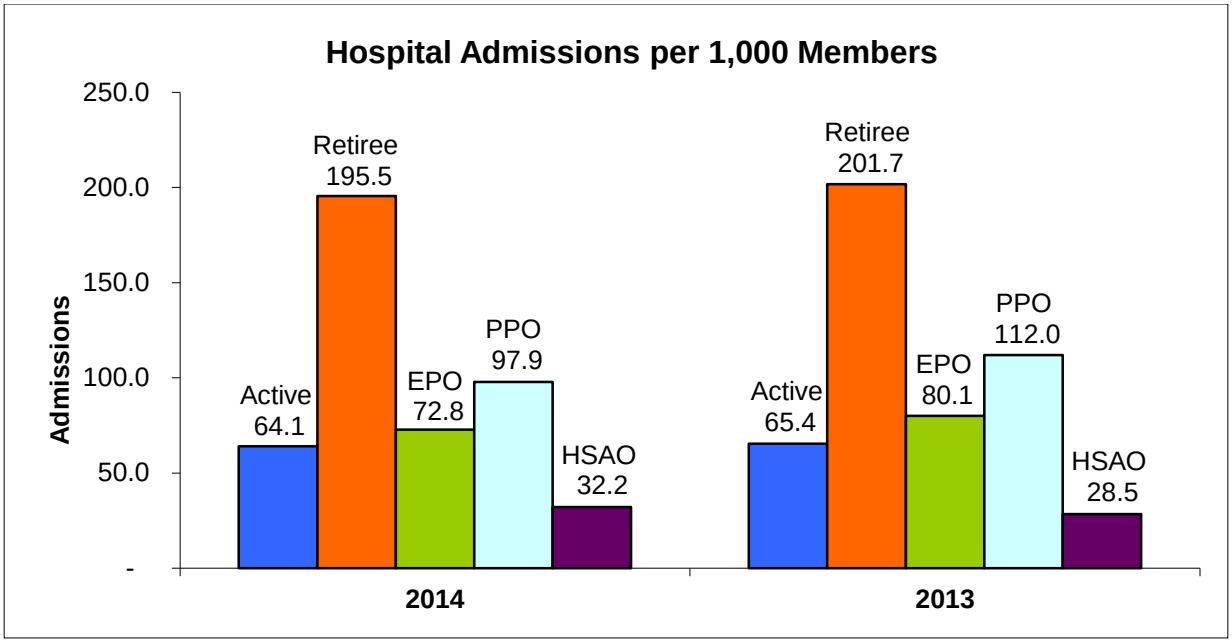


**Figure 2: Hospital Admissions per 1,000 Members**

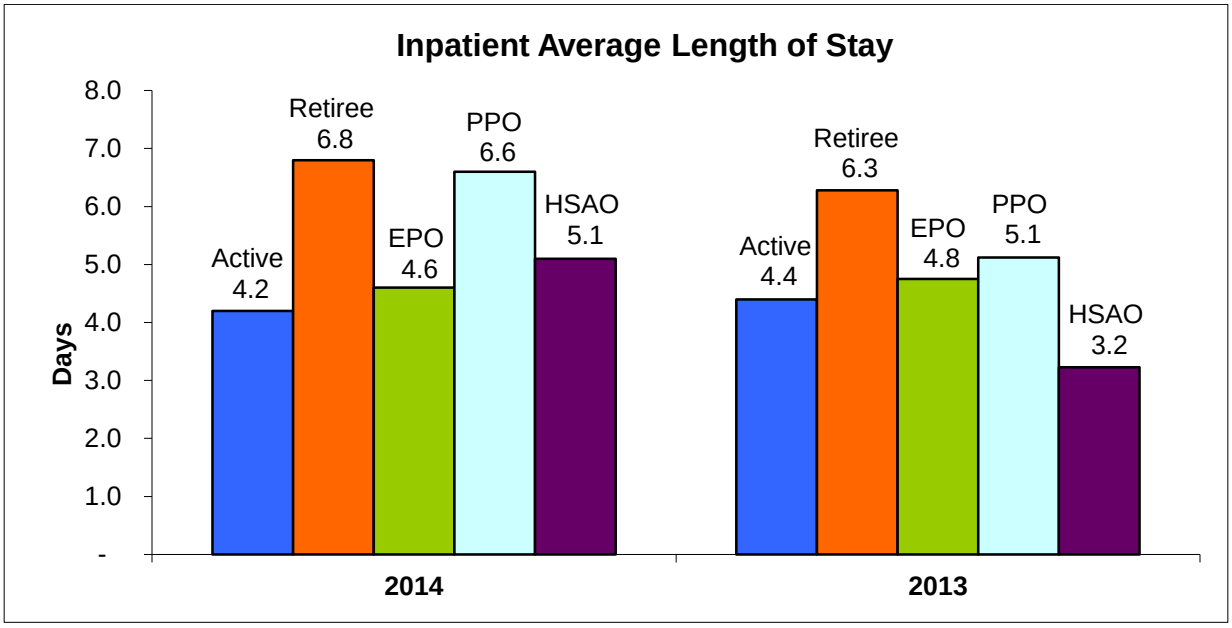


**Figure 3: Inpatient Average Length of Stay**

*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 4.9 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 2.0 times higher than the cost of active admissions when all sources of insurance are considered.

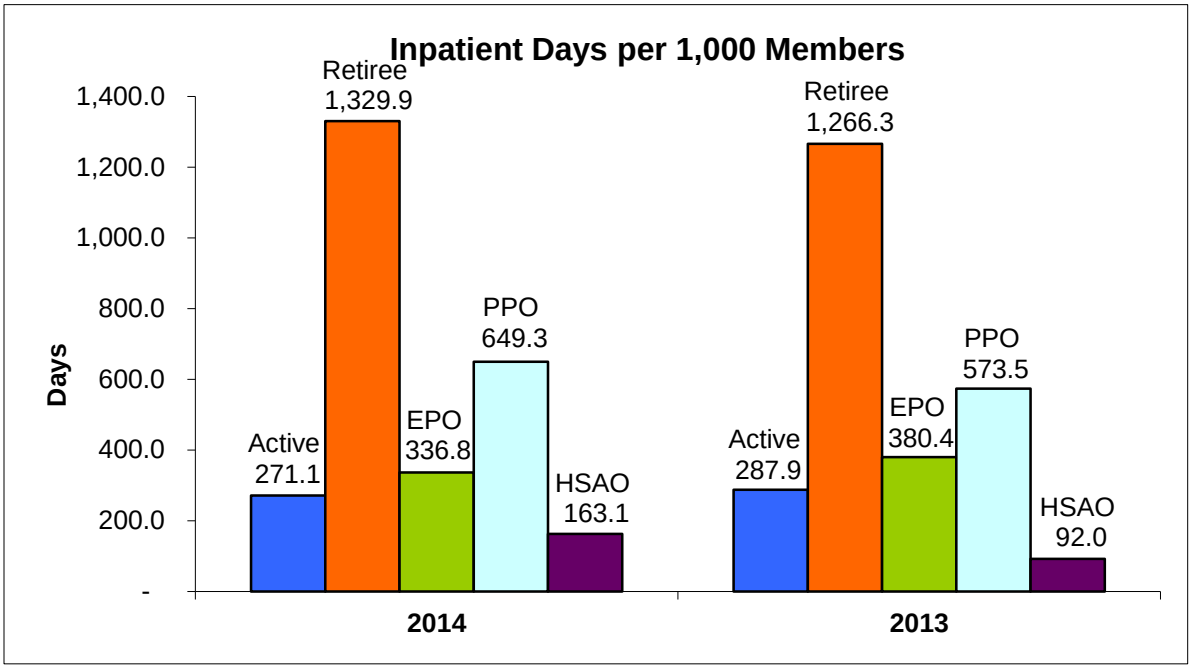


**Figure 4: Inpatient Days per 1,000 Members**

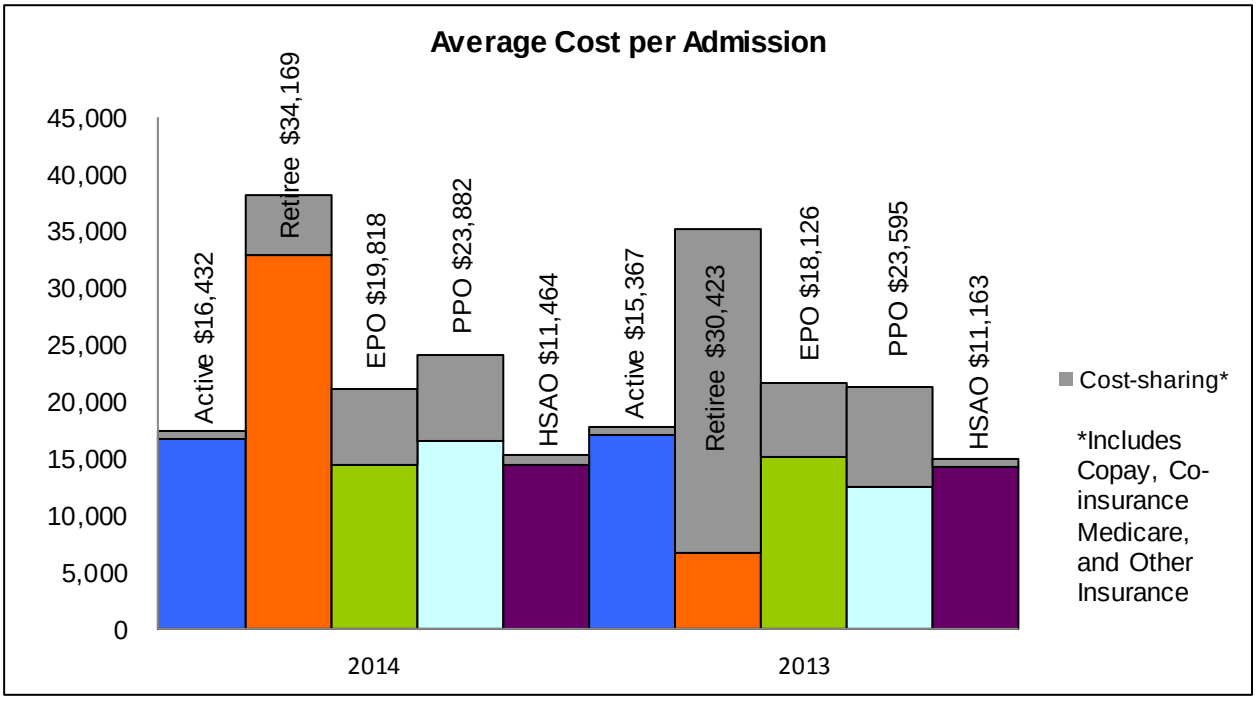


**Figure 5: Average Cost per Admission**

## Emergency Room Visits

During PY 2014, 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 $1,455. This cost is indicative of proper utilization of emergency room visits. These figures include facility claims and professional fees.

## Urgent Care Visits

During PY 2014, there were approximately 216 urgent care visits per 1,000 members of the self-funded plan. The average plan cost per urgent care visit was $100.

## Physician Visits

During PY 2014, there were approximately 4,395 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 $91.

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 5.3% of medical expenses, compared to 2.5% of medical expenses for retired members.

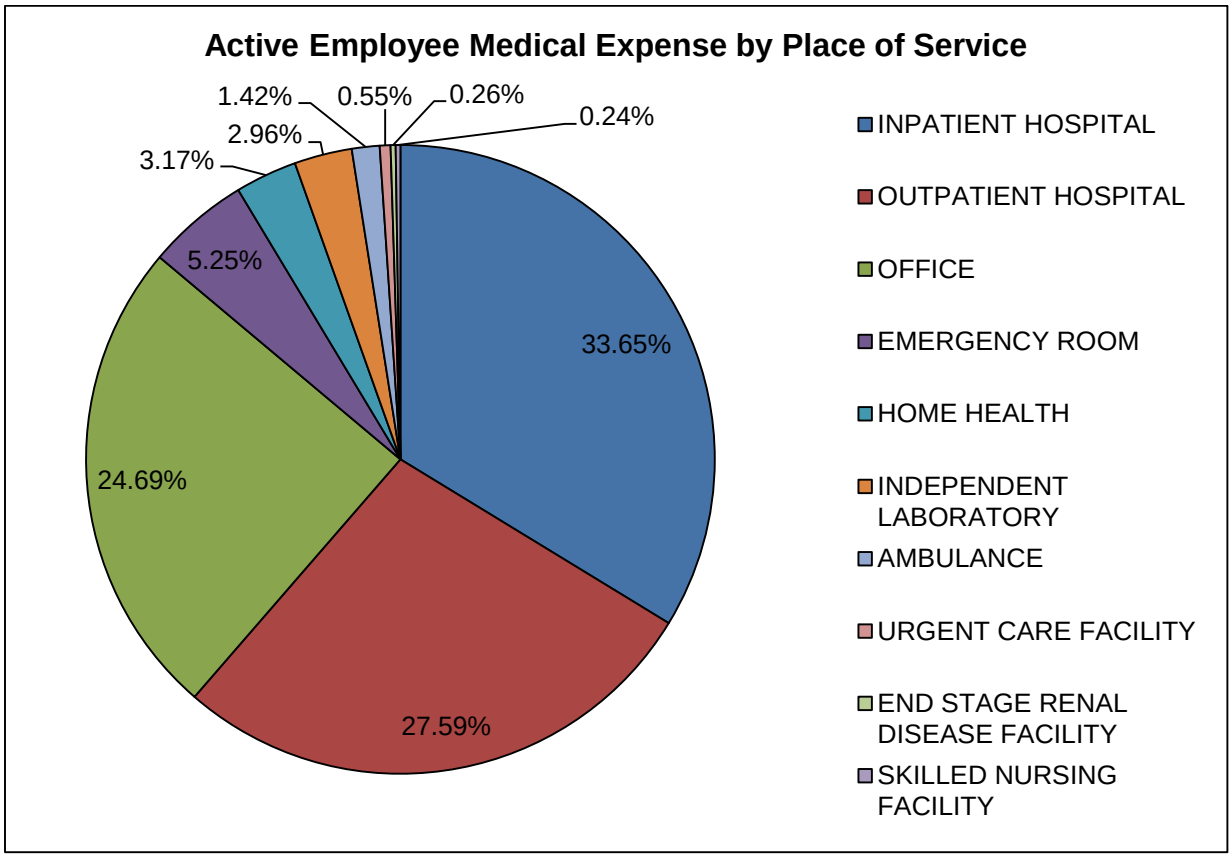


**Figure 6: Active Medical Expense by Place of Service**

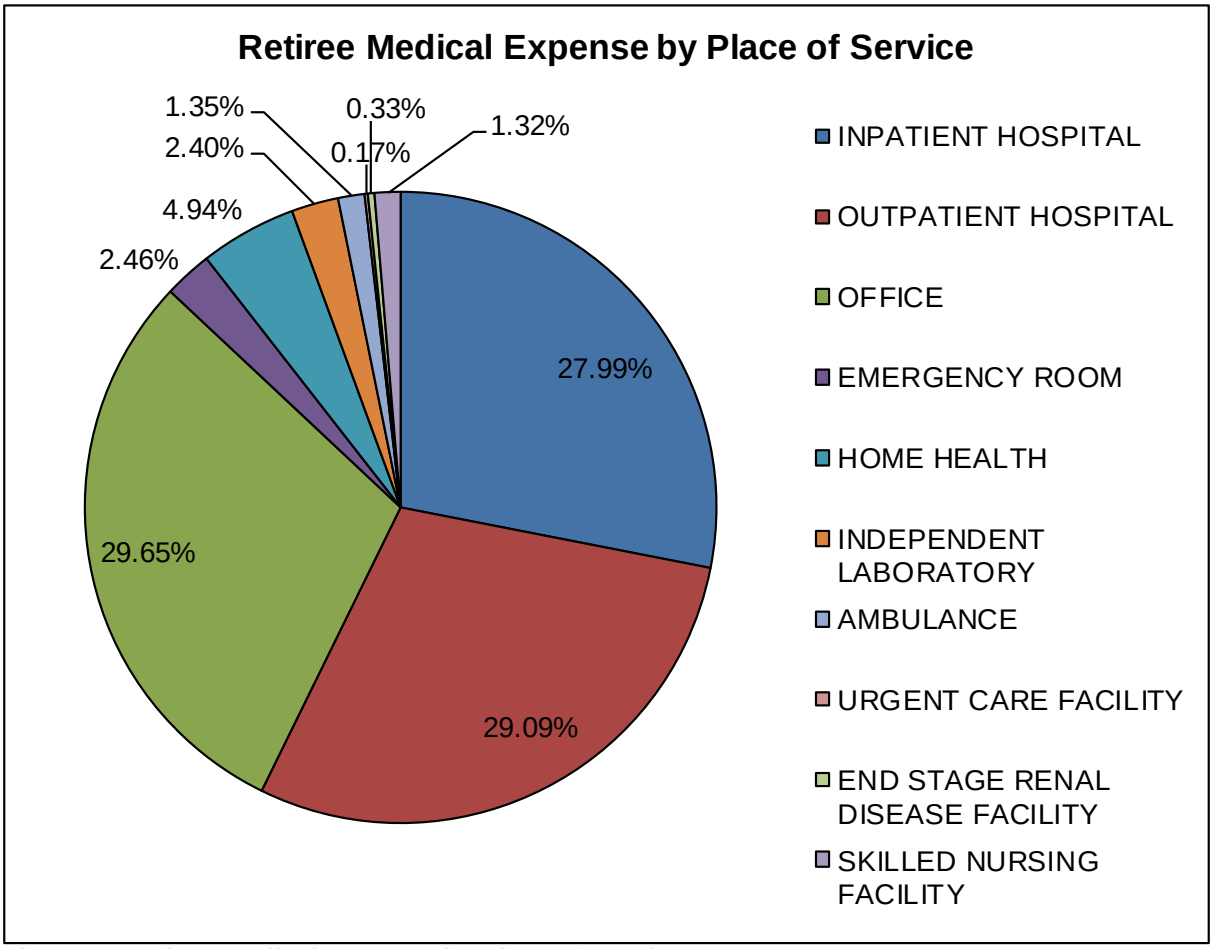


**Figure 7: Retiree Medical Expense by Place of Service**

## Annual Prescription Use

Figure 8 compares the average number of prescriptions filled by active and retired members for PY 2014 and PY 2013.

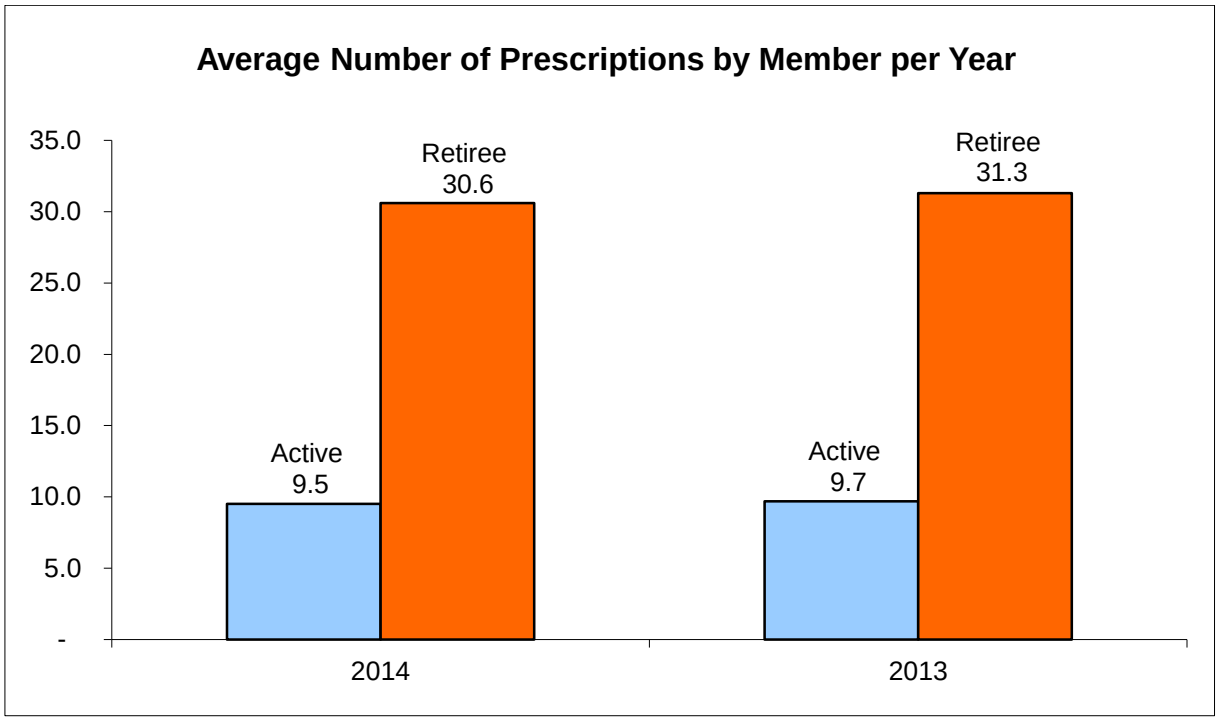


**Figure 8: Average Number of Prescriptions per Year**

Figure 9 compares pharmacy expense per utilizer by age for PY 2014 and PY 2013.

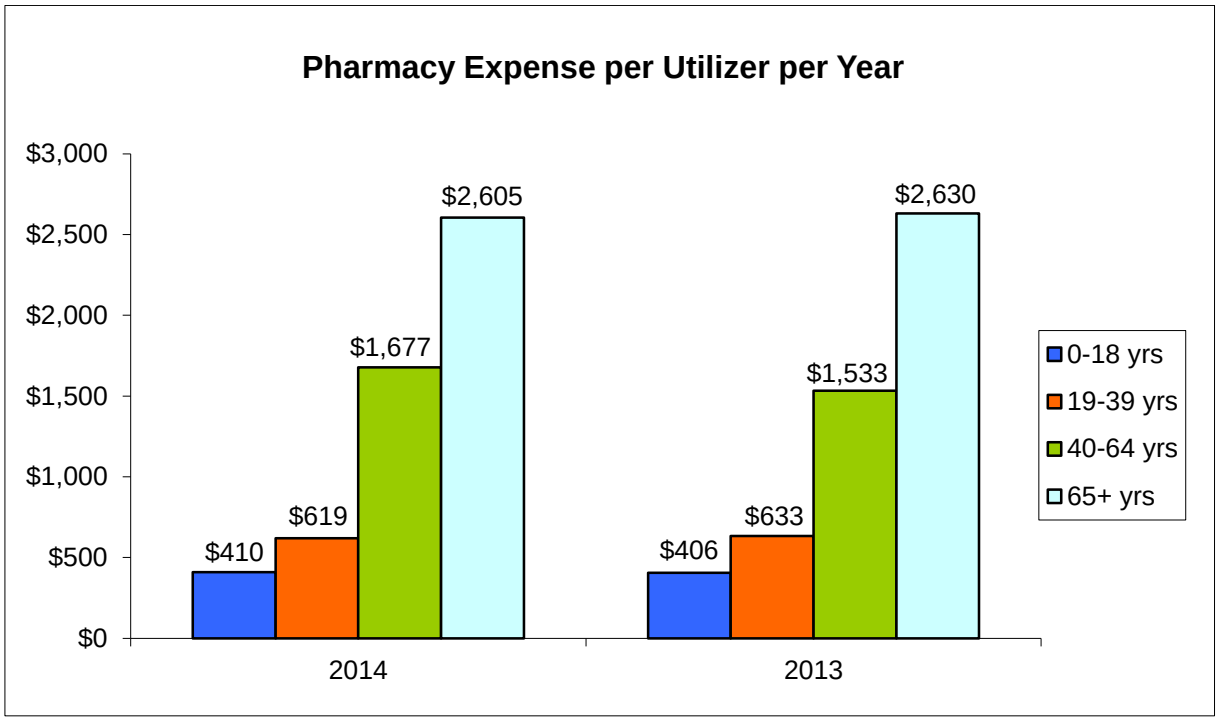


**Figure 9: Pharmacy Expense per Utilizer per Year**

## Generic and Brand-Name Prescription Use

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

| Claim Distribution for 3-tier Formulary | | | | |
|---|---|---|---|---|
| | 2014 | | 2013 | |
| | Prescriptions | Percent | Prescriptions | Percent |
| Tier 1 Generic ($10 copay) | 1,165,075 | 82.2% | 1,121,620 | 79.5% |
| Tier 2-Preferred ($20 copay) | 198,121 | 14.0% | 224,623 | 15.9% |
| Tier 3-Non-Preferred ($40 copay) | 53,355 | 3.8% | 64,087 | 4.5% |
| Total | 1,416,551 | 100.0% | 1,410,330 | 100.0% |

**Table 8: Total Prescriptions by Tier**

## Prescription Use by Therapeutic Class

Table 9 shows the 10 most utilized classes of drugs according to total expense. More dollars were spent on diabetes than any other therapeutic class.

| Top Therapeutic Classes by Total Plan Paid | | | | |
|---|---|---|---|---|
| | 2014 | | 2013 | |
| Therapeutic class | Plan Paid | Percent | Plan Paid | Percent |
| DIABETES | $17,040,732 | 19.19% | $13,806,575 | 19.63% |
| INFLAMMATORY DISEASE | $14,314,170 | 16.12% | $10,092,103 | 14.35% |
| INFECTIOUS DISEASE - VIRAL | $11,365,754 | 12.80% | $5,568,802 | 7.92% |
| NEOPLASTIC DISEASE | $7,796,848 | 8.78% | $6,196,750 | 8.81% |
| ASTHMA | $7,752,298 | 8.73% | $6,704,709 | 9.53% |
| NEUROLOGICAL DISEASE - MISCELLANEOUS | $7,277,496 | 8.20% | $6,008,536 | 8.54% |
| PAIN MANAGEMENT - ANALGESICS | $7,143,101 | 8.04% | $6,045,038 | 8.60% |
| CARDIOVASCULAR DISEASE - LIPID IRREGULARITY | $6,265,064 | 7.06% | $6,877,395 | 9.78% |
| CARDIOVASCULAR DISEASE - HYPERTENSION | $6,094,082 | 6.86% | $5,492,258 | 7.81% |
| ENDOCRINE DISORDER - OTHER | $3,747,975 | 4.22% | $3,526,859 | 5.02% |
| Total | $ 88,797,520 | 100.00% | $ 70,319,024 | 100.00% |

**Table 9: Pharmacy Top Therapeutic Classes by Plan Paid**

## Prescription Use by Type of Drug

Table 10 shows the 10 most utilized drugs according to total expense. Humira is the leading prescription by cost for PY 2014.

| Top Ten Drugs by Total Plan Paid | | | | | |
|---|---|---|---|---|---|
| 2014 | | | 2013 | | |
| Drug Name | Plan Paid | Percent | Drug Name | Plan Paid | Percent |
| HUMIRA | $5,616,210 | 3.79% | HUMIRA | $4,355,633 | 3.46% |
| SOVALDI | $4,296,538 | 2.90% | ENBREL | $2,543,042 | 2.02% |
| ENBREL | $3,337,881 | 2.25% | COPAXONE | $2,282,720 | 1.81% |
| COPAXONE | $2,572,100 | 1.73% | CRESTOR | $2,074,012 | 1.65% |
| LANTUS SOLOSTAR | $2,420,070 | 1.63% | LANTUS SOLOSTAR | $1,633,147 | 1.30% |
| CRESTOR | $2,249,497 | 1.52% | OXYCONTIN | $1,596,022 | 1.27% |
| LANTUS | $1,900,561 | 1.28% | REVLIMID | $1,418,124 | 1.13% |
| HUMALOG | $1,731,102 | 1.17% | HUMALOG | $1,393,032 | 1.11% |
| TECFIDERA | $1,666,676 | 1.12% | LANTUS | $1,336,092 | 1.06% |
| REVLIMID | $1,583,604 | 1.07% | JANUVIA | $1,241,683 | 0.99% |
| Total | $ 27,374,239 | 18.46% | Total | $ 19,873,506 | 15.77% |

**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.*

# Dental Plan Enrollment

ADOA Benefit Options offers two different types of dental plans: a fully-insured dental health maintenance organization (DHMO) plan provided by Total Dental Administrators and a self-funded dental preferred provider organization (DPPO) plan administered by Delta Dental.

**DHMO Plan – Total Dental Administrators (TDA)**
Key components of DHMO plan include:

- See a participating dental provider (PDP) to provide and coordinate all dental care;
- No annual deductible or maximums ($200 maximum reimbursement for non-contracted emergency services);
- $1,500 per person lifetime for orthodontia; and
- No claim forms (except for emergency services).

**DPPO Plan – Delta Dental**
Key components of the self-funded DPPO plan include:

- Members 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; and
- Benefits may be based on reasonable and customary charges.

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

| Average Monthly Dental Enrollment by Plan | | | | | |
|---|---|---|---|---|---|
| | | 2014 | | 2013 | |
| Network | Plan Type | Subscribers | Members | Subscribers | Members |
| Delta Dental | | | | | |
| Active | DPPO | 21,949 | 51,006 | 21,159 | 48,943 |
| Retiree | DPPO | 12,212 | 19,132 | 11,215 | 17,386 |
| University | DPPO | 14,084 | 27,812 | 13,405 | 27,514 |
| COBRA | DPPO | 162 | 231 | 179 | 241 |
| Total Dental Administrators | | | | | |
| Active | DHMO | 10,057 | 24,213 | 9,708 | 23,740 |
| Retiree | DHMO | 2,152 | 3,295 | 2,104 | 3,203 |
| University | DHMO | 5,585 | 11,620 | 5,122 | 11,063 |
| COBRA | DHMO | 65 | 95 | 68 | 99 |
| Total | | 66,265 | 137,403 | 62,960 | 132,189 |

**Table 11: Average Dental Enrollment by Plan**

# Dental Premiums

Table 12 shows the active employee dental premiums per pay period.

| Active Dental Premiums per Pay Period (26 pay periods)* | | | | |
|---|---|---|---|---|
| **Plan** | **Tier** | **Employee Premium** | **State Premium** | **Total Premium** |
| **DPPO** | Employee only | $14.30 | $2.29 | $16.59 |
| | Employee + adult | $30.33 | $4.58 | $34.91 |
| | Employee + child | $23.34 | $4.58 | $27.92 |
| | Family | $48.26 | $6.32 | $54.58 |
| **DHMO** | Employee only | $1.86 | $2.29 | $4.15 |
| | Employee + adult | $3.72 | $4.58 | $8.30 |
| | Employee + child | $3.50 | $4.58 | $8.08 |
| | Family | $6.12 | $6.32 | $12.44 |

**Table 12: Active Dental Premiums**

**University of Arizona has 24 pay period deductions.*

Table 13 shows the retiree monthly dental premiums.

| Retiree Monthly Dental Premiums | | |
|---|---|---|
| **Plan** | **Tier** | **Premium** |
| **DPPO** | Employee only | $35.94 |
| | Employee + adult | $75.63 |
| | Employee + child | $60.48 |
| | Family | $118.26 |
| **DHMO** | Employee only | $8.99 |
| | Employee + adult | $17.98 |
| | Employee + child | $17.51 |
| | Family | $26.97 |

**Table 13: Retiree Dental Premiums**

# Dental Premium vs. Plan Cost

The 2014 contribution strategy for the dental plans resulted in employees paying 84% of the average monthly total premium, and the State paying the remaining 16%.

Figure 10, on the following page, shows how the average monthly premiums compared to the average monthly cost for active and retired members.

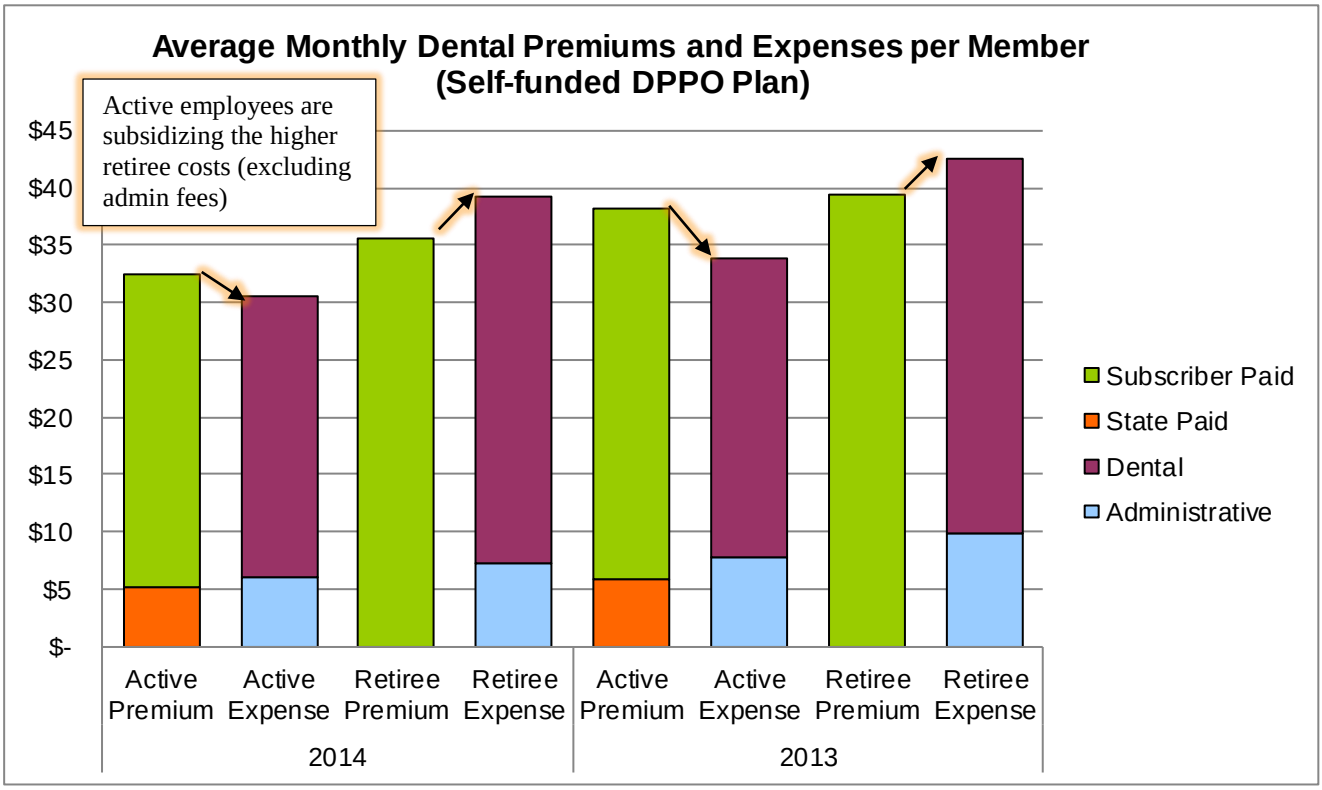


**Figure 10: Average Dental Premiums & Expenses per Member**

## Expenses for Self-funded Dental Plan

The table below shows the distribution of dental claims and expenses incurred in PY 2014, and the average annual cost to insure each type of subscriber/member.

| 2014 Self-funded Dental Incurred Expenses by Active, Retiree | | | |
|---|---|---|---|
| **Expenses** | **Overall** | **Active** | **Retiree** |
| Dental Claims | $30,644,067 | $23,303,297 | $7,340,770 |
| Rebates & Recoveries | $0 | $0 | $0 |
| Administration Fees | $1,617,391 | $1,302,221 | $315,170 |
| Appropriated Expenses | $210,564 | $169,533 | $41,031 |
| Total Expenses | $32,472,022 | $24,775,051 | $7,696,971 |
| IBNR Liability | $5,600,000 | $4,273,000 | $1,327,000 |
| Total | $38,072,022 | $29,048,051 | $9,023,971 |
| **Enrollment in self-funded plans** | | | |
| Subscribers | 48,407 | 36,195 | 12,212 |
| Members | 98,180 | 79,048 | 19,132 |
| **Annual cost** | | | |
| Per subscriber | $786 | $803 | $739 |
| Per member | $388 | $367 | $472 |

**Table 14: Self-funded Dental Expenses by Active & Retiree**

# Wellness

Benefit Options Wellness provides services 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 and health education courses, annual flu vaccines, online stress management seminars, and Employee Assistance Program (EAP) benefits.

The Health Impact Program (HIP) is an incentive based employee wellness program for eligible State of Arizona employees, effective October 1, 2014 to September 30, 2015. Employees who successfully complete the program by engaging in a variety of wellness activities while accumulating and logging progress toward an end goal of 500 points, may be eligible to receive up to $200 at the conclusion of the program period. The mission of HIP is to promote prevention as the first line of defense against chronic disease and encourage employees to participate in disease management so they can manage pre-existing conditions and enjoy greater total health and well-being.

The table below shows the total utilization of health screening benefits during the PY 2014 and the number of at-risk employees referred to follow-up care.

| Plan Year 2014 Screenings | | | |
|---|---|---|---|
| | **Events** | **Participant** | **Referrals** |
| **Mini Health Screening*** | 50 | 1,764 | |
| Osteoporosis Screening** | | 598 | 116 |
| Prostate Specific Antigen (PSA)** | | 125 | 5 |
| Facial Skin Analysis** | | 1,139 | |
| **Mobile Onsite Mammography** | 59 | 1,175 | 31 |
| **Prostate Onsite Projects** | 24 | 395 | 27 |
| Total | 133 | 5,196 | 179 |

* 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 15: Plan Year Screenings**

The table below shows the total utilization for the 2014 Annual Flu Vaccine Program held September 1, through December 31, 2014. Wellness provided a total of 14,092 vaccines to benefits eligible employees and dependents, as well as retirees covered under Benefit Options, an increase of 10.4% when compared to the 2013 Program. Members had access to the flu vaccine at a total of 623 locations throughout the state. A total of 87.2% of members who received a flu vaccine did so at a worksite clinic.

| Plan Year 2014 Flu Vaccines | | |
|---|---|---|
| | **Locations** | **Participants** |
| State Agency Worksite | 206 | 10,543 |
| University Worksite | 15 | 240 |
| Combined Worksite (Wesley Bolin) | 4 | 1,503 |
| Open Enrollment Clinics | 8 | 595 |
| Public Clinics | 390 | 1,211 |
| Total | 623 | 14,092 |

**Table 16: Plan Year Flu Vaccines**

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. Total utilization for 2014 reached over 32%, showing sustained high usage especially when compared to the 16% national standard for government entities. ADOA covered agencies continue to show utilization higher than our EAP vendor's Book of Business, and has seen a consistent increase in the past five years from 12% in 2009 to 19% in 2014.

In addition, ADOA added the Department of Corrections (9,129 eligible users) and the Department of Transportation (4,078 eligible users) to its EAP contract effective July 1 and December 1, respectively.

| Plan Year 2014 EAP Utilization | | | |
|---|---|---|---|
| | **Eligible Population** | **Users** | **Utilization Rate** |
| **Live Telephonic Access** | | 2,364 | 7.9% |
| EAP | | 1,805 | 6.0% |
| FamilySource | | 135 | 0.5% |
| FinancialConnect | | 75 | 0.3% |
| LegalConnect | | 349 | 1.2% |
| **Online Access** | | 6,422 | 21.4% |
| EAP | | 1,349 | 4.5% |
| FamilySource | | 1,500 | 5.0% |
| FinancialConnect | | 508 | 1.7% |
| GlobalConnect | | 4 | 0.0% |
| Health & Wellness | | 634 | 2.1% |
| LegalConnect | | 2,427 | 8.1% |
| **Critical Incident Stress Debriefing** | | 247 | 0.8% |
| **Trainings** | | 602 | 2.0% |
| Overall Utilization | 29,941 | 9,635 | 32.2% |

**Table 17: Plan Year EAP Utilization**

In addition to health screenings, vaccines, and EAP services, the Wellness strategic plan for 2014 provided employees with access to online mindfulness and stress reduction opportunities through eMindful, Inc. Feedback of eMindful and its programming was positive and this service was expanded and offered statewide beginning in January 2015.

| Plan Year 2014 Online Courses | | |
|---|---|---|
| | **Classes** | **Participants** |
| Midfulness at Work 1-hr online | 24 | 777 |
| Total | 24 | 777 |

**Table 18: Plan Year Online Courses**

# Life, Disability, Vision Insurance, and Flexible Spending Accounts Premiums

Fund 3035, ERE/Benefits Administration, is used to pay Fully Insured insurance premiums and administer State employee benefit plans other than health and dental. Vision, supplemental, dependent, and short-term disability insurance, and flexible spending are funded solely by employee premiums. Basic life and non-ASRS long-term disability insurance are 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 2014 |
|---|---|---|---|---|
| **Prior Balance December 31, 2013** | | | | **$3,731,803** |
| **Revenues** | | | | **$36,019,201** |
| **Insurance Product** | **Amount** | | | |
| Basic Life | $1,445,716 | | | |
| Supplemental Life | $11,263,512 | | | |
| Dependent Life | $2,618,809 | | | |
| Short Term Disability | $7,918,587 | | | |
| Long Term Disability | $2,994,342 | | | |
| Total Life & Disability | $26,240,966 | | | |
| Vision | $5,246,550 | | | |
| Health Care FSA | $3,293,428 | | | |
| Dependent Care FSA | $1,238,258 | | | |
| Total Flex Spending | $4,531,686 | | | |
| **Total Revenues** | $36,019,201 | | | |
| **Expenditures** | | | | **$35,986,358** |
| **Insurance Product** | **Amount** | **Penalties** | | |
| Basic Life | $1,447,400 | | | |
| Supplemental Life | $11,251,970 | | | |
| Dependent Life | $2,618,999 | | | |
| Short Term Disability | $7,904,596 | | | |
| Long Term Disability | $2,982,979 | ($12,568) | | |
| Total Life & Disability* | $26,205,944 | ($12,568) | | |
| Vision* | $5,234,319 | ($417) | | |
| Health Care FSA | $3,232,316 | | | |
| Dependent Care FSA | $1,218,866 | | | |
| Administrative Fees* | $108,053 | ($2,256) | | |
| Total Flex Spending | $4,559,235 | ($2,256) | | |
| GAO AFIS Cost | $2,100 | | | |
| **Total Expenditures** | $36,001,599 | ($15,241) | $35,986,358 | |
| **Ending Balance December 31, 2014** | | | | **$3,764,646** |

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

**Table 19: ERE/Benefits Administration Fund Summary**

# 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 vendor performance of the contracted services. 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 any actions taken to address the issue and improve performance to meet the standard of the measure. A percentage of the vendor’s annual payment, or previously agreed upon amount, is then withheld by ADOA as a performance penalty per the terms of the vendor contract.

The following is a report of the agreed-upon performance standards both met and missed by contracted vendors during PY 2014. In each case, performance penalties for measures missed are assessed per the terms of the individual vendor contract.

**Vendor Performance Measures 1: Aetna**

| Aetna | | |
|---|---|---|
| **Successfully Met Performance Measures** | | |
| **Fees At Risk** | | **Performance Measure** |
| 23.00% of Total Administrative Fee | | Customer Service - 70 of 84 targets met<br>Claims - 71 of 72 targets met<br>Appeals - 41 of 48 targets met<br>Reporting – 27 of 29 targets met<br>Network Management – 22 of 24 targets met<br>Open Enrollment, Administration, Medicare Administration, & Surveys – 32 of 34 targets met |
| 3.00% of Medical Management Fee | | Medical Management – 4 of 6 targets met, pending results on 2 targets<br>Survey – 0 of 1 target met |
| 3.50% of Case Management Fee | | Case Management – 4 of 5 targets met, pending results on 1 target |
| 13.50% of Disease Management Fee | | Disease Management – 8 of 21 targets met, pending results on 9 targets |
| 0% of Nurse Line Fee | | Nurse Line Call Center – 2 of 3 targets met |
| 15.00% of HSA Program Administration Fee | | Administration – All 37 targets met |
| **Performance Measures Not Met** | | |
| **Percent of Fees at Risk** | **Total Percent Assessed Based on Reporting Frequency** | **Performance Measure** |
| 1.00% | Missed 1 month of 12 months measured = 0.08% | Customer Service – Phone Line: Call abandonment rate is ≤ 3% |
| 1.00% | Missed 2 months of 12 months measured = 0.16% | Customer Service – Phone Line: All phone calls will be answered in < 30 seconds |
| 1.00% | Missed 3 months of 12 months measured = 0.25% | Customer Service – Phone Line: First call resolution is 90% or greater |
| 1.00% | Missed 6 months of 12 months measured = 0.50% | Customer Service – Phone Line: 97% or greater telephone call quality |
| 1.00% | Missed 2 months of 12 months measured = 0.16% | Customer Service – Written Correspondence: At least 95% of written inquiries are resolved within 15 calendar days of receipt |
| 0.00% | Missed 1 month of 12 months measured = 0.00% | Appeals – Reporting: Monthly reports are delivered to ADOA within 30 days of the end of the month |
| 0.33% | Missed 2 months of 12 months measured = 0.06% | Appeals – Pre-Service: At least 95% of written pre-service appeals are resolved within 15 calendar days of receipt |
| 0.34% | Missed 4 months of 12 months measured = 0.11% | Appeals – Post-Service: At least 95% of written pre-service appeals are resolved within 15 calendar days of receipt. |
| 1.00% | Missed 1 quarter of 4 quarters measured = 0.25% | Reporting – Quarterly: Quarterly reports are submitted to ADOA within 45 calendar days of the end of each quarter |
| 1.00% | Missed 1 month of 12 months measured = 0.08% | Reporting – Monthly: Monthly reports are submitted to ADOA within 30 calendar days of the end of each month |
| 0.50% | Missed 1 month of 12 months measured = 0.04% | Claims – Processing Turnaround Time: At least 98% of all fully-documented claims will be processed within 30 calendar days of receipt |
| 1.00% | Missed annual measurement = 1.00% | Survey - Member Satisfaction 90% or greater |

| | | |
|---|---|---|
| 1.00% | Missed 1 quarter of 4 quarters measured = 0.25% | Account Management – Status Report Meeting: Status meetings are to be conducted with ADOA within 55 calendar days of the end of the quarter |
| 0.00% | Missed 1 month of 12 months measured = 0.00% | Network Management – Change to Primary Provider Count: The monthly report of changes to provider counts is to be submitted to ADOA within 30 days of the end of the month |
| 0.00% | Missed 1 month of 12 months measured = 0.00% | Network Management – Primary Care Provider Count Turnover: The monthly provider count turnover report is to be submitted to ADOA within 30 days of the end of the month |
| 0.50% | Missed annual measurement = 0.50% | Survey – Medical Management member satisfaction 85% or greater |
| 0.75% | Missed 1 semi-annual measurement = 0.375% | Disease Management – CHF: Members using Angiotensin-converting enzyme / angiotensin receptor blockers (ACE/ARB) in the past 12 months, up to a 75% target. |
| 0.75% | Missed 1 semi-annual measurement = 0.375% | Disease Management – Diabetes: Members receiving an HBA1c test in the past 12 months up to a 75% target |
| 0.75% | Missed 1 semi-annual measurement = 0.375% | Disease Management - CAD/PAD: Members are using lipid-lowering drugs in the past 12 months up to a 70% target |
| 0.75% | Missed 1 semi-annual measurement = 0.375% | Disease Management – CAD/PAD: Members have had their cholesterol monitored in the past 12 months up to a 75% target |
| 0.00% | Missed annual measurement = 0.00% | Nurse Line Call Center – Calls Triaged: At least 90% of all calls appropriately triaged |

**Vendor Performance Measures 2: Cigna**

| Cigna | | |
|---|---|---|
| **Successfully Met Performance Measures** | | |
| **Fees At Risk** | | **Performance Measure** |
| 15.20% of Total Administrative Fee | | Appeals – 39 of 48 targets met<br>Reporting – 27 of 29 targets met<br>Claims - 58 of 60 targets met<br>Surveys – 1 of 2 targets met<br>Network Management – 22 of 24 targets met<br>Customer Service, Open Enrollment, Administration, Medicare Administration - All 128 targets met |
| 7.00% of Medical Management Fee | | Medical Management – All 16 targets met |
| 8.00% of Case Management Fee | | Case Management – All 12 targets met |
| 7.00% of Disease Management Fee | | Disease Management – 16 of 24 targets met, pending results on 8 targets |
| 5.00% of Nurse Line Fee | | Nurse Line – All 12 targets met |
| **Performance Measures Not Met** | | |
| **Percent of Fees at Risk** | **Total Percent Assessed Based on Reporting Frequency** | **Performance Measure** |
| 0.00% | Missed 1 month of 12 months measured = 0.00% | Appeals – Reporting: Monthly appeal reports are submitted to ADOA within 30 calendar days of the end of the month |
| 0.33% | Missed 3 months of 12 months measured = 0.08% | Appeals – Pre-Service: 100% of written appeals are resolved within 15 calendar days of receipt |
| 0.33% | Missed 5 months of 12 months measured = 0.14% | Appeals – Post-Service: 100% of written appeals are resolved within 45 calendar days of receipt |
| 0.25% | Missed 1 quarter of 4 quarters measured = 0.06% | Reporting – Quarterly: Quarterly reports are submitted to ADOA within 45 calendar days of the end of each quarter |
| 0.25% | Missed 1 month of 12 months measured = 0.02% | Reporting – Monthly: Monthly reports are submitted to ADOA within 30 calendar days of the end of each month |
| 0.75% | Missed 1 month of 12 months measured = 0.06% | Claims – Processing Turnaround Time: At least 97% of all fully-documented claims will be processed within 14 calendar days of receipt |
| 0.50% | Missed 1 month of 12 months measured = 0.04% | Claims – Processing Accuracy: At least 97% of claims will be processed accurately |
| 0.50% | Missed annual measurement = .50% | Survey - Account Management 95% or greater |
| 0.00% | Missed 1 month of 12 months measured = 0.00% | Network Management – Change to Primary Provider Count: The monthly report of changes to provider counts is to be submitted to ADOA within 30 days of the end of the month |
| 0.00% | Missed 1 month of 12 months measured = 0.00% | Network Management – Primary Care Provider Count Turnover: The monthly provider count turnover report is to be submitted to ADOA within 30 days of the end of the month |

**Vendor Performance Measures 3: UnitedHealthcare**

| UnitedHealthcare | | |
|---|---|---|
| **Successfully Met Performance Measures** | | |
| **Fees At Risk** | | **Performance Measure** |
| 18.55% of Total Administrative Fee | | Customer Service – 71 of 72 targets met<br>Claims - 58 of 60 targets met<br>Reporting – 17 of 18 targets met<br>Surveys – 2 of 2 targets met<br>Network Management – All 24 targets met<br>Appeals, Open Enrollment, Administration, Medicare Administration - All 88 targets met |
| 5.00% of Medical Management Fee | | Medical Management – All 9 targets met |
| 10.00% of Case Management Fee | | Case Management – All 20 targets met |
| 5.00% of Disease Management Fee | | Disease Management – All 22 targets met |
| 5.00% of Nurse Line Fee | | Nurse Line - All 12 targets met. |
| **Performance Measures Not Met** | | |
| **Percent of Fees at Risk** | **Total Percent Assessed Based on Reporting Frequency** | **Performance Measure** |
| 0.50% | Missed 1 month of 12 months measured = 0.04% | Customer Service – Phone Line: All phone calls will be answered in < 30 seconds |
| 0.50% | Missed 1 month of 12 months measured = 0.04% | Reporting – Monthly: Monthly reports are submitted to ADOA within 30 calendar days of the end of each month |
| 0.75% | Missed 1 month of 12 months measured = 0.06% | Claims – Processing Turnaround Time: At least 97% of all fully-documented claims will be processed within 14 calendar days of receipt |
| 1.00% | Missed 1 month of 12 months measured = 0.08% | Claims – Processing Accuracy: At least 97% of claims will be processed accurately |

**Vendor Performance Measures 4: AmeriBen**

| AmeriBen | | |
|---|---|---|
| **Successfully Met Performance Measures** | | |
| **Fees At Risk** | | **Performance Measure** |
| 15.00% of Total Administrative Fee | | Appeals – 47 of 48 targets met<br>Customer Service – 79 of 84 targets met<br>Claims – 58 of 60 targets met<br>Network Management – All 24 targets met<br>Surveys – 2 of 2 targets met<br>Administration, Open Enrollment, Reporting, Medicare Administration – All 62 targets met. |
| **Performance Measures Not Met** | | |
| **Percent of Fees at Risk** | **Total Percent Assessed Based on Reporting Frequency** | **Performance Measure** |
| 0.75% | Missed 1 month out of 12 months measured = 0.06% | Customer Service – Phone Line: All phone calls will be answered in < 30 seconds |
| 0.30% | Missed 3 months out of 12 months measured = 0.08% | Customer Service – Phone Line: First call resolution will be 90% or greater |

| | | |
|---|---|---|
| 0.10% | Missed 1 month out of 12 months measured = 0.01% | Customer Service – Written Correspondence: All correspondence (inquiries and requests) will be acknowledged within 2 working days of receipt and 95% or more will be resolved within 30 calendar days of receipt |
| 0.50% | Missed 1 month out of 12 months measured = 0.04% | Appeals – Post-Service: 100% of written appeals are resolved within 45 calendar days of receipt |
| 0.75% | Missed 2 months out of 12 months measured = 0.16% | Claims – Processing Turnaround Time: At least 97% of all fully-documented claims will be processed within 10 calendar days of receipt |

**Vendor Performance Measures 5: American Health Holding**

| American Health Holding | | |
|---|---|---|
| **Successfully Met Performance Measures** | | |
| **Fees At Risk** | | **Performance Measure** |
| 21.00% of Total Administrative Fee | | Surveys – 2 of 2 targets met Administration, Implementation, Reporting, Systems- All 46 targets met |
| 5.00% of Disease Management Fee | | Disease Management – 15 of 16 targets met |
| 10.00% of Case Management Fee | | Case Management – All 16 targets met |
| 10.00% of Preadmission Certification Fee | | Utilization Management –1 of 1 target met |
| 5.00% of Nurse Line Fee | | Nurse Line - 9 of 12 targets met |
| **Performance Measures Not Met** | | |
| **Percent of Fees at Risk** | **Total Percent Assessed Based on Reporting Frequency** | **Performance Measure** |
| 1.68% | Missed 1 quarter out of 4 quarters measured = 0.42% | Disease Management -Initial Outreach at Identification: Call will be placed to at least 90% of members who have been identified for disease management within 14 calendar days of identification |
| 1.67% | Missed 3 quarters out of 4 quarters measured = 1.25% | Nurse/Other Call Center - Call Abandonment: Less than 5% call abandonment rate |

**Vendor Performance Measures 6: MedImpact**

| MedImpact | | |
|---|---|---|
| **Successfully Met Performance Measures** | | |
| **Fees At Risk** | | **Performance Measure** |
| Fixed AmountsTotaling $1,500,000 | | Surveys – 2 of 2 targets met Network Management, Eligibility, Claims (Paper), Claims (Mail Order), Customer Service, Surveys, Account Management, Implementation, Reporting, Generic Substitution/Utilization, CMS - All 214 targets met |
| **Performance Measures Not Met** | | |
| **Fees At Risk** | **Total Amount Assessed Based on Reporting Frequency** | **Performance Measure** |
| | | No targets missed |

**Vendor Performance Measures 7: Delta Dental**

| Delta Dental | | |
|---|---|---|
| **Successfully Met Performance Measures** | | |
| **Fees At Risk** | | **Performance Measure** |
| 28.92% of Total Administrative Fee | | Surveys – 2 of 2 targets met<br>Account Management, Administration, Appeals, Claims, Customer Service, Open Enrollment, Network Management, Reporting – All 256 targets met |
| Fixed Amounts Totaling $50,000 | | Implementation – All 4 targets met |
| **Performance Measures Not Met** | | |
| **Percent of Fees At Risk** | **Total Amount Assessed Based on Reporting Frequency** | **Performance Measure** |
| | | No targets missed |

**Vendor Performance Measures 8: Total Dental Administrators**

| Total Dental Administrators | | |
|---|---|---|
| **Successfully Met Performance Measures** | | |
| **Fees At Risk** | | **Performance Measure** |
| 15.50% of Total Premiums Paid | | Survey – 1 of 1 target met<br>Account Management, Administration, Appeals, Customer Service, Implementation, Open Enrollment, Network Management, & Reporting – All 135 targets met |
| **Performance Measures Not Met** | | |
| **Percent of Fees At Risk** | **Total Amount Assessed Based on Reporting Frequency** | **Performance Measure** |
| | | No targets missed |

**Vendor Performance Measures 9: ComPsych**

| ComPsych | | |
|---|---|---|
| **Successfully Met Performance Measures** | | |
| **Fees At Risk** | | **Performance Measure** |
| 17.00% of Total Administrative Fee | | Customer Service, Reporting, Program Administration, Surveys – All 38 targets met |
| **Performance Measures Not Met** | | |
| **Percent of Fees at Risk** | **Total Percent Assessed Based on Reporting Frequency** | **Performance Measure** |
| | | No targets missed |

**Vendor Performance Measures 10: Avesis**

| Avesis | | |
|---|---|---|
| **Successfully Met Performance Measures** | | |
| **Fees At Risk** | | **Performance Measure** |
| Fixed Amounts Totaling $84,333.32 | | Surveys – 2 of 2 targets met<br>Implementation, Reporting, Network Management, Claims Administration, Appeals,Call Center - All 113 targets met |
| **Performance Measures Not Met** | | |
| **Fees At Risk** | **Total Amount Assessed Based on Reporting Frequency** | **Performance Measure** |
| | | No targets missed |

**Vendor Performance Measures 11: Application Software Inc.**

| Application Software Inc. (ASI) | | |
|---|---|---|
| **Successfully Met Performance Measures** | | |
| **Fees At Risk** | | **Performance Measure** |
| 33.10% of Total Administrative Fees | | Customer Service – 15 of 16 measures met<br>Reporting – 4 of 5 measures met, pending result of 1 target<br>Program Administration – 7 of 8 targets met<br>Claims –14 of 16 targets met<br>Implementation – All 4 targets met |
| **Performance Measures Not Met** | | |
| **Percent of Fees at Risk** | **Total Percent Assessed Based on Reporting Frequency** | **Performance Measure** |
| 2.00% | Missed 1 quarter of 4 quarters measured = 0.50% | Customer Service – Account Management: All account issues will be responded to within 1 business day |
| 2.50% | Missed 1 quarter of 4 quarters measured = 0.63% | Claims – Eligibility File Load: Daily eligibility files will be loaded and reconciled within 24 hours of receipt |
| 2.50% | Missed 2 quarters of 4 quarters measured = 1.25% | Claims – Processing: All fully-documented claims will be processed within 2 business days of receipt |

**Vendor Performance Measures 12: The Hartford**

| The Hartford | | |
|---|---|---|
| **Successfully Met Performance Measures** | | |
| **Fees At Risk** | | **Performance Measure** |
| 6.28% of Total Premiums Paid | | Surveys – 3 of 3 targets met<br>Implementation/Open Enrollment, Quality of Service, Appeals. Claims, Reporting – All 89 targets met |
| 1.25% of Total STD Premiums Paid | | Short-Term Disability Processing – All 36 targets met |
| 0.50% of Total LTD Premiums Paid | | Long-Term Disability Processing – All 2 targets met |
| 1.00% of Total Life Premiums Paid | | Life Insurance Claims Processing – All 13 targets met |
| **Performance Measures Not Met** | | |
| **Percent of Fees at Risk** | **Total Percent Assessed Based on Reporting Frequency** | **Performance Measure** |
| | | No targets missed |

# Audit Services

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

During the 2014 plan year, twenty-five (25) 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. An overview of the completed project results for the PY 2014 is shown below including recommendations made, implemented recommendations*, identified savings, and health plan recovery dollars.

| Recommendations | Implemented Recommendations* | Identified Savings | Recovery Dollars | Pending Recovery** |
|---|---|---|---|---|
| 30 | 4 | $22,741.24 | $0 | $21,588.65 |

* Implementation of recommendations may vary based on the completion of all corrective action plan directives. In many cases, directives may still be in progress and may roll over to the new plan year.

** Recovery may vary based on pending corrective action plans and/or claims reprocessing/adjustments

**Table 20: Plan Year Audit Results**

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, but were not limited to the following functional areas:

| Audit Services Summary | |
|---|---|
| **Functional Area** | **Audit Methodology** |
| Vendor operating transactions | Statement on Standards for Attestation Engagements No. 16 Audits (SSAE 16)<br>Evaluation of external audit results |
| Vendor execution of benefit design and contract elements | Plan Implementations and Claims Readiness<br>Plan Allowances/Exclusions (A&E)<br>Plan Authorizations review<br>Claims adjudication compliance<br>Inquiries (i.e. research, plan coverage design, etc.) |
| ADOA accuracy of shared data | Dependent Eligibility Audit (DEA) |
| Audit program improvement initiatives | Performance Guarantees<br>Plan Authorizations<br>Administrative functions and program-specific improvements |

**Table 21: Audit Services Summary**

**Vendor Operating Transactions**
All health plan 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 controls of the vendor's systems utilized to process 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 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 plan document language, vendor system edits (claim adjudication), plan allowances/limitations, internal controls, etc. Audit results indicated that in some cases, foot orthotics and rehab/sub-acute copays were not adjudicated properly; a savings of $2,032 was identified and will be recovered.

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. A follow up audit was performed for Biofeedback; $474.62 was identified as paid in error and is pending recovery. Additionally, a follow up to the 2012 Erectile Dysfunction and Sexual Disorder Audit identified claim adjudication errors with $19,082 in 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, healthcare industry standards, current operating standards, contractual elements, vendor performance, and/or plan authorization documents. During PY 2014, a Claims Readiness review was begun to test vendors' preparedness to adjudicate claims for PY 2015.

Various internal inquiries were researched and completed to support the functions of the Benefit Services Division. A response to an inquiry can be informal and/or open a formal audit based on significant findings of the evaluation. An exception-based audit is an evaluation response to a customer complaint or an identified process failure. Exceptions are generally categorized as operational weakness or claims payment errors. In both instances, audits are developed with a very limited scope to specifically

address the identified exception. There were no exception-based audits performed during PY 2014.

**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 PY 2014 eligibility audit indicated that 2 ineligible dependents were enrolled in the plan with 1 erroneously receiving benefits of $1,153 due to unreported qualified life events.

**Audit Program Improvement Initiatives**
In addition to the regularly scheduled audits, reviews, and evaluations listed above, Audit Services performed operational standards testing related to vendor performance guarantees and plan authorizations for each of the contracted vendors.

Audit Services continues to strive towards improvement and efficiency; the focus during PY 2014 was to streamline administrative functions to improve audit program initiatives.

# Appendix

**Table A: Special Employee Health Fund Cash Statement**

| | | | | Plan Year 2014 |
|---|---|---|---|---|
| **Prior Balance December 31, 2013** | | | | $283,197,937 |
| **Revenues** | | | | $839,384,738 |
| Source | Premiums | Reductions | | |
| ADOA Health Plan (EE) | $136,233,719 | | | |
| ADOA Health Plan (ER) | $623,931,204 | | | |
| BCBS NAU Plan (EE) | $6,885,091 | | | |
| BCBS NAU Plan (ER) | $29,609,727 | | | |
| ADOA Dental Plan (EE) | $34,080,405 | | | |
| ADOA Dental Plan (ER) | $4,916,622 | | | |
| PrePaid Dental Plan (EE) | $1,877,532 | | | |
| PrePaid Dental Plan (ER) | $1,755,807 | | | |
| Other Revenue | $94,631 | | | |
| Net Revenue | $839,384,738 | $0 | $839,384,738 | |
| **Expenditures** | | | | $814,969,798 |
| Vendor | Admin Fees | Penalties | | |
| AHH Medical Management | $1,315,148 | $0 | | |
| Aetna | $2,820,131 | ($67,528) | | |
| Cigna | $2,297,554 | ($5,587) | | |
| UnitedHealthcare | $13,609,288 | ($16,980) | | |
| AmeriBen | $4,576,667 | ($3,916) | | |
| MedImpact | $1,533,736 | $0 | | |
| Delta Dental | $1,617,391 | $0 | | |
| Other Fees** | $837,581 | $ (71,731.53) | | |
| AG Collection Fees | $1,104 | $0 | | |
| Net Administrative Fees*** | $28,608,600 | ($165,743) | $28,442,857 | |
| | Claims | Recoveries* | | |
| Harrington | $0 | ($20,463) | | |
| Aetna | $31,937,130 | $0 | | |
| Cigna | $44,158,783 | ($8,867) | | |
| UnitedHealthcare | $329,114,776 | ($18,255) | | |
| AmeriBen | $112,504,895 | ($488,782) | | |
| Other Wellness | $548,723 | $0 | | |
| MedImpact | $148,295,605 | ($6,554,196) | | |
| Delta Dental | $35,681,356 | ($99,246) | | |
| Medicare Part D Retiree Drug Subsidy | $0 | ($6,388,752) | | |
| Early Retiree Reinsurance Program | $0 | $0 | | |
| Net Claims | $702,241,268 | ($13,578,562) | $688,662,707 | |
| *Self-Insured Expenditures* | | | *$717,105,564* | |
| | Premiums | Penalties | | |
| BCBS (NAU Only) | $ 36,277,339.11 | $0 | | |
| Delta Dental | $0 | $0 | | |
| Total Dental Administrators | $ 3,638,583.98 | $0 | | |
| *Fully Insured Expenditures**** | *$39,915,923* | *$0* | *$39,915,923* | |
| HITF Operating | $ 4,048,311.19 | | $4,048,311 | |
| Fund Transfers Out^ | $ 53,900,000.00 | | $53,900,000 | |
| Federal Participation Reimbursement | $0 | | $0 | |
| NET EXPENDITURES AND TRANSFERS | $828,714,102 | ($13,744,304) | $814,969,798 | |
| **Fund Balance December 31, 2014** | | | | $307,612,877 |
| **IBNR Liability (Medical & Dental)** | | | | $113,000,000 |
| **Contigency Reserve (Medical & Dental)** | | | | $113,000,000 |
| **Unrestricted Cash Balance As Of December 31, 2014** | | | | $81,612,877 |

*Recoveries include Medicare Part D Retiree Drug Subsidy reimbursement, prescription drug rebates, overpayment recoveries

**Other Fees include HSA Administration, surcharges by other states (MA, MI, NYHCR), ACA taxes/fees and legal fees.

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

^ Interfund transfers from HITF to other State operating funds. Future transfers include $8.3 million pursuant to laws 2014, Ch. 18 (HB2703) - 2014-2015 for fiscal year 2015

# Glossary of Terms

**Active member(s)** – An employee and their eligible dependents, as defined in the Arizona Administrative Code, who are 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, 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 by an insured member 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 that a member pays during the plan year, before the health plan starts to make payments for covered medical services.

**Dependent** – An unmarried child or a spouse of the employee 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 or claim forms, and services based on a discounted rate. Total Dental is the current prepaid dental vendor.

**DPPO** – A dental plan, with an in-network and out-of-network coinsurance structure, that allows members to visit any dentist. There is an annual deductible, and maximum annual benefit of $2,000 per member per year for dental services. The current administrator for the DPPO plan is Delta Dental.

**Disease management** – A comprehensive, ongoing, and coordinated approach to achieving desired outcomes for a population of patients. These outcomes include improving members' clinical conditions and qualities 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** – The process for a member to request a review of a health plan decision regarding a claimant's qualifications for, or entitlement to, benefits under a plan.

**Employee** – As defined in the Arizona Administrative Code who works for the State of Arizona or a State university.

**Employee Group Waiver Program (EGWP)** – An employer group Medicare Prescription D drug plan.

**Exclusive Provider Organization (EPO)** – A health plan designed with an exclusive provider organization or network. Enrollees are limited to access in-network providers and are subject to co-pays. 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 and put 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 brand-name drugs. The most cost-effective brand-name drugs are placed in the "preferred" category and all other brand-name drugs are placed in the "non-preferred" category.

**Fully-insured** – An insurance model wherein a commercial insurer collects premiums, pays claims for services, and takes the risk of revenue to expense. Benefit Options may collect the premiums for transfer to the commercial insurer.

**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.

**Integrated** – A health plan operation administered by one entity. Such 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 must 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 to members. Contract terms include agreed upon fee arrangements for services and performance standards.

**Non-integrated** – A health plan with operations administered 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 (PBM)** – 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 (PY)** – Defined as the period of January 1 through December 31 of a given year.

**Preferred Provider Organization (PPO)** – A health plan designed with a preferred provider organization or network. Enrollees have access to in-network and out-of-network providers, and are subject to co-pays, or co-insurance, and annual deductibles. Out-of-network providers require greater co-pays.

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

**Retiree** – A former State of Arizona employee, State university employee, officer, or elected official who is retired under a State-sponsored retirement plan. For reporting purposes, this term encompasses both actual retirees and their dependents.

**Self-funded** – An 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** – A dependent legally married to an employee or a retiree, as defined by the Arizona Revised Statutes.

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

**Subscriber –** An 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 claims, compiling and producing management reports, and providing customer service.

**Utilization management** – The evaluation of appropriateness and efficiency of health care services procedures and facilities according to established criteria or guidelines and under the provisions of an applicable health benefits plan.

**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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