

Douglas A. Ducey
Governor



Craig C. Brown
Director

ARIZONA DEPARTMENT OF ADMINISTRATION

OFFICE OF THE DIRECTOR

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June 27, 2016

The Honorable Douglas A. Ducey, Governor, State of Arizona
The Honorable Andy Biggs, President, Arizona State Senate
The Honorable David M. Gowan Sr., Speaker, House of Representatives
1700 West Washington Street
Phoenix, AZ 85007

Dear Governor Ducey, President Biggs, and Speaker Gowan:

Pursuant to A.R.S. § 38-652 (G) and A.R.S. § 38-658 (B), we are pleased to present the *2015 Annual Report for the Health Insurance Trust Fund*, including a report on the performance standards for the health and dental plans.

Sincerely,

Craig C. Brown
Director

- c: Richard Stavneak, Director, Joint Legislative Budget Committee
- Rebecca Perrera, Joint Legislative Budget Committee Staff
- Lorenzo Romero, Director, Office of Strategic Planning and Budgeting
- Chris Olvey, Budget Analyst, Office of Strategic Planning and Budgeting
- Paul Shannon, ADOA Assistant Director Budget and Resource Planning
- Marie Isaacson, Benefit Services Director
- Joan Clark, State Librarian and Director, Arizona Department of Library and Archives

Arizona Department of Administration
Benefit Services Division

2015

Annual Report

Health Insurance Trust Fund



Doug Ducey
Governor

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Director

FOREWARD

The Arizona Department of Administration (“ADOA”) offers health, dental, life, and disability insurance as well as medical and dependent care flexible spending accounts to the State of Arizona (“State”) employees and Retirees. These combined group of benefits offered is referred to as Benefit Options. This report provides a broad overview of the Benefit Options program, and meets the requirements of the A.R.S. §38-652 (G) and A.R.S. §38-658 (B).

The data shown is presented for the period January 1, 2015 through December 31, 2015. The Active and Retiree plans were concurrent for this period.

Any questions relating to the contents of this report should be addressed to:

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Benefit Services Division
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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 Annual Report also reports the performance standards for the health plans pursuant to A.R.S. §38-658 (B), which reads:

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 of health plans, including indemnity health insurance, hospital and medical service plans, dental plans and health maintenance organizations.

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

The benefits offered are either self-insured or fully-insured. For 2015, the medical and dental PPO plans were self-insured, whereas the dental HMO, vision, life and disability insurance plans were fully-insured.

The State’s self-insured medical plan began on October 1, 2004. The State contracts with the medical and pharmacy vendors to provide network access and related discounts, claim adjudication and payment, and medical management including utilization management, case management and disease management. The State is responsible for the full cost of all claims and programs offered by the vendors.

The State’s self-insured dental PPO began on January 1, 2013.

Schedules of premiums received and accounted for in Fund 3015, distributions by enrollments, 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 the life insurance, disability insurance vision insurance, and flexible spending accounts for Fund 3035.

All data provided herein is for Plan Year (“PY”) 2015 running January 1, 2015 through December 31, 2015.

Please 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.

Executive Summary

During PY 2015, ADOA offered a comprehensive insurance package through Benefit Options to over 133,000 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, employee assistance program (EAP), life and disability insurance.

For PY 2015 the sum of health and dental premiums collected was \$869M with total plan expenses and transfers of \$808M, resulting in a net operational gain of \$61M.

Health Plan

- The average plan cost to insure each member was \$5,507
 - Average Active member cost was \$5,295; average Retiree member cost was \$8,398
- The medical claims expense was \$464M
 - The leading diagnosis category by cost remains to be musculoskeletal system at 12% of total medical spend
 - Claims indicate that members are seeking appropriate level of care by seeking majority of care from physicians or specialists
 - 4,331 physician visits per 1,000 members (slightly lower than prior years)
 - 261 urgent care visits per 1,000 members (slightly up from prior years)
 - 166 emergency room visits per 1,000 members (in line with prior years)
- The pharmacy claims expense was \$167M
 - The leading therapeutic drug class by cost was diabetes at 13% of total pharmaceutical spend
 - Over 1.4M prescriptions were filled in PY 2015
 - Actives filled an average of 9 prescriptions per year while Retirees filled an average of 30

Wellness Program

- Administered over 13,585 flu vaccines through 429 worksite or public events
- Administered over 8,356 screenings through 151 worksite events resulting in 386 referrals to physicians for various health issues, a huge increase over the prior year
- Paid out over \$362k in incentive pay to 1,810 members participating in the HIP program

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 approximately \$581,197 will be collected in 2016 from vendors failing to meet agreed upon PY 2015 performance targets in customer service, claims processing, appeals, reporting, survey, and network management.

Review

The PY 2015 ratio of expenses to premiums of 93% indicates that ADOA has effectively managed 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

The table to the right is a cash statement of receipts received and expenses paid during PY 2015 that relate to PY 2015 as well as prior plan years.

ADOA Health Plan is the self-insured medical program and includes Aetna, Blue Cross Blue Shield (“BCBS”) of Arizona, Cigna, and UnitedHealthcare (UHC) networks. State and university Active employees and Retirees choose coverage from one of the self-insured networks. BCBS NAU is a fully-insured option available only to NAU Active employees and Retirees.

Effective January 1, 2014, all Medicare eligible participants covered under the State of Arizona Benefit Services Division health plans were transitioned from the Medicare Part D Drug Subsidy program to a Medicare Employer Group Prescription Drug Plan (“EGWP”). The EGWP program is a prescription drug plan that combines a standard Medicare Part D plan with additional prescription drug coverage provided by the Benefit Services Division health plan. The EGWP program achieved savings of \$4.9M in PY 2015. An additional \$8.6M was received in PY2015 related to PY2013 and PY2014 RDS program.

	Plan Year 2015
Prior Balance December 31, 2014	<u>\$307,612,877</u>
Revenues	
ADOA Benefit Options	\$784,353,422
BCBS (NAU)	40,026,269
ADOA Dental Plan	41,160,693
PrePaid Dental Plan	3,706,206
Other Revenue	121,069
Total Revenues	<u>\$869,367,659</u>
Expenditures	
Administrative Fees	\$35,233,709
Medical Claims	547,389,541
Drug Claims	144,045,981
Dental Claims	36,842,067
Medicare Part D Retiree Drug Subsidy	(13,470,703)
BCBS (NAU) Premiums	41,243,680
Fully Insured Dental Premiums	3,782,270
Appropriated Expenses	4,557,595
Interfund Transfers [^]	-
Federal Participation Reimbursement	8,302,800
Total Expenditures and Transfers	<u>\$807,926,941</u>
Fund Balance December 31, 2015	<u>\$369,053,596</u>
Reserves	
IBNR Liability (Medical & Dental)	\$94,891,000
Contingency Reserve (Medical & Dental)	94,891,000
Total Reserves	<u>\$189,782,000</u>
Unrestricted Balance December 31, 2014	<u>\$179,271,596</u>

[^] Interfund transfers from HITF to other State Operating funds

Figure 1: Health Insurance Trust Fund Summary

Benefit Services Division holds reserves for the purpose of paying claims that have been incurred but not reported (“IBNR”) and for a contingency to cover any insufficiencies that may develop, such as actual medical trend exceeding assumed medical trend during rate setting,

unplanned shifts in plan membership, unexpected catastrophic claims, and changes in provider reimbursement rates that may occur in a given plan year.

Medical Plan Enrollment

Benefits Services Division offers medical coverage to the following employees and their dependents:

- 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

The three types of medical plans offered to eligible participants are the Exclusive Provider Organization (EPO), the Preferred Provider Organization (PPO) and the High Deductible Health Plan (HDHP) with Health Savings Account (HSA).

The EPO Plan

Within the EPO plan, services must be obtained from an in-network provider; out-of-network services are only covered in emergency situations. The employee pays the monthly premium and any required copay at the time of service. Employees who select the EPO plan may choose from four networks: Aetna, BCBS of Arizona, Cigna or UHC.

The PPO Plan

Within the PPO plan, services may be obtained from an in- or out-of-network provider. There is a separate in- and out-of-network deductible that must be met before copays or coinsurance (percent of the cost) are allowed. The employee pays the monthly premium and at the time of service pays 100% of the allowed amount of service until the deductible is met. After the deductible is met, the employee pays copays if the provider is in-network and co-insurance if the provider is out-of-network until the out of pocket maximum (OOP) is met. Once the OOP is met the plan pays 100% of services for the remaining plan year, with a few exceptions, e.g. pharmacy copays. Employees who select the PPO plan may choose from four networks: Aetna, BCBS of Arizona, Cigna or UHC. Employees at NAU also have the option of participating in their fully-insured BCBS NAU plan.

The HDHP with HSA Plan

Within the HDHP, services may be obtained from both in- and out-of-network providers. There is a separate in- and out-of-network deductible that must be met before coinsurance is allowed. The employee pays the monthly premium and at the time of service pays 100% of the allowed amount of service (except for qualified preventative services that are covered 100% by the plan) until the deductible is met. After the deductible is met, the employee pays co-insurance up to the out of pocket maximum at which time the plan pays 100% of any additional costs for the year.

Employees who enroll in the HDHP and are under the age of 65 are eligible to open an HSA. This account allows employees to make pre-tax contributions into the account and withdraw the monies to pay for healthcare related expenses. When the employee opens the HSA with the State HDHP, the State makes bi-weekly deposits to the account.

The HDHP is only available to Active employees and under the Aetna network.

The figure below shows how enrollment was distributed by plan and network between active, retired, university, and COBRA members. The subscriber references the employee and the member references the employee plus dependents.

		2015		2014	
Network	Plan Type	Subscribers	Members	Subscribers	Members
Active	EPO	1,947	4,407	1,796	4,080
Retiree	EPO	247	318	245	323
University	EPO	2,161	4,109	1,940	3,588
COBRA	EPO	11	14	9	11
Active	PPO	158	253	127	221
Retiree	PPO	30	38	34	41
University	PPO	239	458	214	399
COBRA	PPO	1	1	0	0
Active	HDHP	409	830	332	664
Retiree	HDHP	0	0	0	0
University	HDHP	560	1,067	416	762
COBRA	HDHP	2	5	2	2
Total AETNA		5,765	11,500	5,115	10,091
Active	EPO	7,337	18,276	7,067	17,512
Retiree	EPO	1,149	1,549	1,123	1,511
University	EPO	2,967	6,243	2,465	5,168
COBRA	EPO	32	43	36	46
Active	PPO	545	1,108	420	776
Retiree	PPO	65	79	95	110
University	PPO	490	907	360	662
COBRA	PPO	3	4	1	1
Total Blue Cross Blue Shield AZ		12,588	28,209	11,567	25,786
Active	EPO	3,229	7,862	3,208	7,776
Retiree	EPO	588	767	593	762
University	EPO	1,368	2,957	1,261	2,613
COBRA	EPO	20	26	11	14
Total CIGNA		5,205	11,612	5,073	11,165
Active	EPO	19,704	47,698	20,264	48,949
Retiree	EPO	4,789	6,224	4,815	6,184
University	EPO	10,736	24,623	10,818	24,515
COBRA	EPO	81	115	80	111
Active	PPO	748	1,479	561	1,044
Retiree	PPO	97	119	98	122
University	PPO	789	1,637	650	1,279
COBRA	PPO	3	3	3	4
Total UnitedHealthcare		36,947	81,898	37,289	82,208
NAU only*	PPO	3,100	5,722	3,054	5,631
Total Blue Cross Blue Shield NAU		3,100	5,722	3,054	5,631
Total		63,605	138,941	62,098	134,881

Figure 2: Average Monthly Enrollment by Plan & Network

Medical Premiums

The below tables show the medical premium by plan and coverage tier per pay period for Active employees and Retirees. Retirees have two different tier structures: 1) those who are not enrolled in Medicare and have no dependents enrolled in Medicare and 2) those who either are enrolled in Medicare themselves or have a dependent who is enrolled in Medicare.

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	\$497.53	\$544.15	-
	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	-
HDHP	Employee only	\$12.00	\$232.15	\$244.15	\$27.69
	Employee + adult	\$47.08	\$466.15	\$513.23	\$55.38
	Employee + child	\$37.38	\$450.93	\$488.31	\$55.38
	Family	\$89.08	\$853.84	\$942.92	\$55.38

* University of Arizona has 24 pay period deductions

Figure 3: Active Employee Medical Premiums

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

Figure 4: Retiree Medical Premiums

Medical Premium vs. Plan Cost

The 2015 contribution strategy for the self-insured medical plan resulted in employees paying 12% of the average monthly 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 employees and Retirees and their dependents (Active and Retiree members). 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.

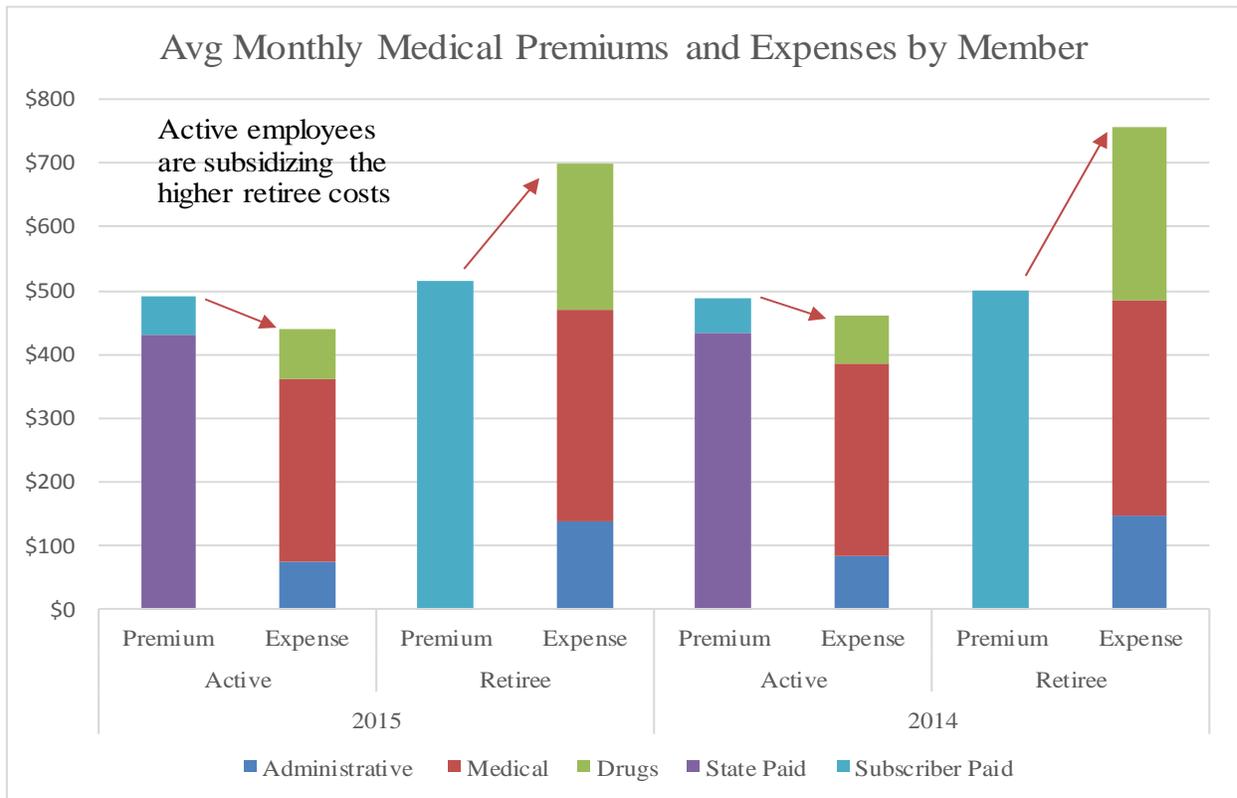


Figure 5: Average Monthly Medical Premium vs Expense

Expenses for Self-Insured Medical Plans

The figures below show the distribution of claims and expenses incurred in PY 2015 and the average annual cost to insure each type of subscriber/member.

2015 Incurred and Paid Self-funded Medical Expenses by Active, Retiree, and Plan						
Expenses	Overall	Active	Retiree	EPO	PPO	HDHP
Medical Claims	\$464,179,973	\$428,104,088	\$36,075,886	\$435,118,482	\$26,323,533	\$2,737,958
Drug Claims	\$166,770,139	\$126,708,705	\$40,061,434	\$153,084,826	\$13,034,082	\$651,231
Medicare Part D Subsidy	(\$13,470,703)	\$0	(\$13,470,703)	(\$12,413,760)	(\$1,056,943)	\$0
Rebates & Recoveries	(\$12,054,920)	(\$10,600,242)	(\$1,454,678)	(\$11,238,200)	(\$751,966)	(\$64,754)
Administration Fees	\$33,640,811	\$29,866,251	\$3,774,560	\$30,546,572	\$1,716,842	\$1,377,396
Appropriated Expenses	\$4,323,832	\$3,826,097	\$497,736	\$4,028,049	\$226,393	\$69,390
Total Expenses	\$643,389,133	\$577,904,898	\$65,484,235	\$599,125,970	\$39,491,941	\$4,771,222
IBNR Liability	\$90,225,000	\$79,337,468	\$10,887,532	\$84,112,266	\$5,628,085	\$484,649
Total	\$733,614,133	\$657,242,366	\$76,371,767	\$683,238,236	\$45,120,026	\$5,255,871
Enrollment in self-funded plans						
Subscribers	60,505	53,540	6,965	56,366	3,168	971
Members	133,219	124,125	9,094	125,231	6,086	1,902
Annual cost						
Per subscriber	\$12,125	\$12,276	\$10,965	\$12,121	\$14,242	\$5,413
Per member	\$5,507	\$5,295	\$8,398	\$5,456	\$7,414	\$2,763

Figure 6: Self-Insured Expenses by Active, Retiree, and Plan

2015 Incurred and Paid Self-funded Medical Expenses by Plan for Active & Retiree						
Expenses (in dollars)	Overall	Active	Active	Active	Retiree	Retiree
		EPO	PPO	HDHP	EPO	PPO
Medical Claims	\$464,179,973	\$399,724,203	\$25,641,926	\$2,737,958	\$35,394,279	\$681,607
Drug Claims	\$166,770,139	\$114,328,903	\$11,728,571	\$651,231	\$38,755,923	\$1,305,511
Medicare Part D Subsidy	(\$13,470,703)	\$0	\$0	\$0	(\$12,413,760)	(\$1,056,943)
Rebates & Recoveries	(\$12,054,920)	(\$9,821,488)	(\$714,000)	(\$64,754)	(\$1,416,712)	(\$37,966)
Administration Fees	\$33,640,811	\$27,251,732	\$1,635,335	\$926,424	\$3,721,815	\$105,505
Appropriated Expenses	\$4,323,832	\$3,544,035	\$212,672	\$69,390	\$484,015	\$13,721
Total Expenses	\$643,389,133	\$535,027,385	\$38,504,504	\$4,320,249	\$64,525,560	\$1,011,435
IBNR Liability	\$90,225,000	\$73,508,889	\$5,343,930	\$484,649	\$10,603,377	\$284,155
Total	\$733,614,133	\$608,536,274	\$43,848,434	\$4,804,898	\$75,128,937	\$1,295,590
Enrollment in self-funded plans						
Subscribers	60,505	49,593	2,976	971	6,773	192
Members	133,219	116,373	5,850	1,902	8,858	236
Annual cost						
Per subscriber	\$12,125	\$12,271	\$14,734	\$4,948	\$11,092	\$6,748
Per member	\$5,507	\$5,229	\$7,495	\$2,526	\$8,481	\$5,490

Figure 7: Self-Insured Expenses by Plan for Actives and Retirees

Medical Expenses Associated with Medical Diagnoses

The tables below show the trend in cost by diagnosis for Actives and Retirees. For Actives, the first five categories make up approximately 50% (\$248M) of the total 2015 medical spend and have increased by 14% (\$30M) since 2012.

For Retirees, spending has actually decreased over the years by 13% (\$6M) partly due to the shifting of the Retiree population from pre-Medicare to Medicare. The top five categories make up approximately 60% (\$23M) of total 2015 spend and have decreased by 10% (\$2.4M) since 2012. Digestive systems issues appear to have the biggest percentage increase in the higher spend areas over the years while musculoskeletal has biggest dollar increase. This reduction in spend is decreasing the amount that the Active employees must subsidize the Retiree premiums.

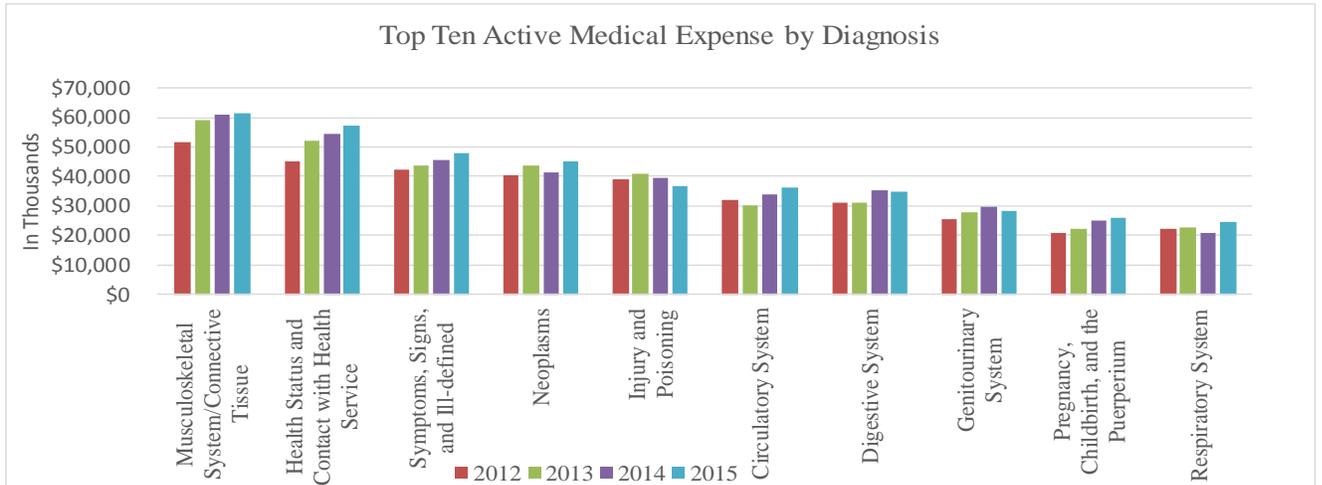


Figure 8: Top Ten Active Medical Expense by Diagnosis

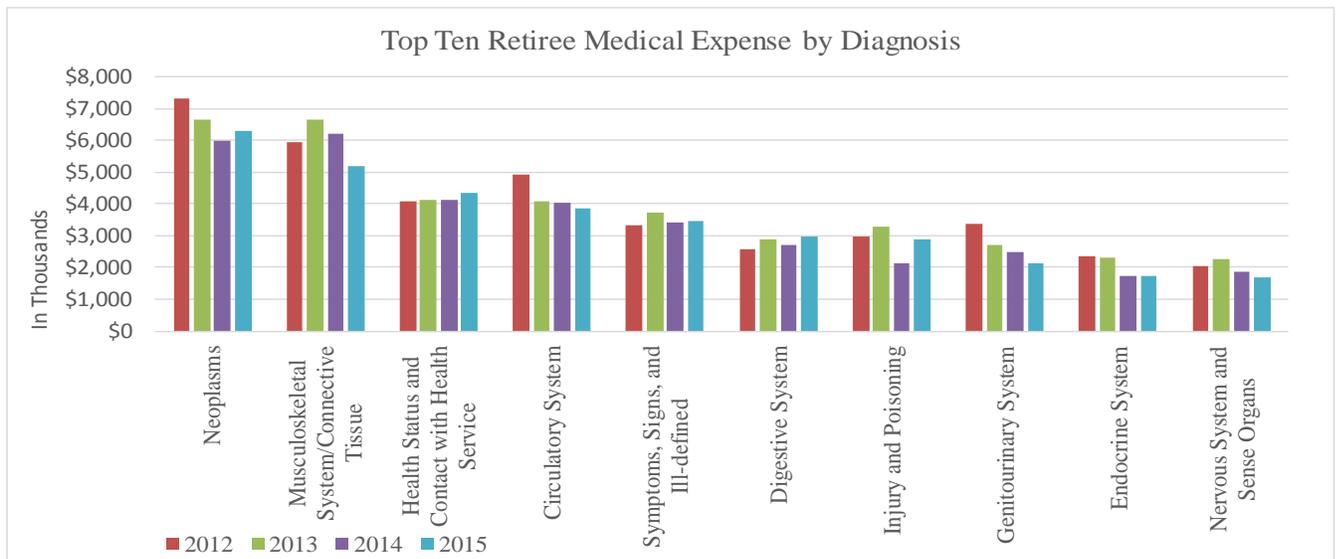


Figure 9: Top Ten Retiree Medical Expense by Diagnosis

Hospital Care

Inpatient hospital care represents a significant portion of total medical expenses. The tables below show the Hospital Admissions per 1,000 members and average length of stay. Retirees are admitted more often and longer than active employees which is in line with their higher overall costs. When comparing plans, PPO members are admitted more often than EPO members which are admitted more often than HDHP members. This is all in line with the average costs of these members in each plan. The length of stay is similar between the EPO and PPO, however, the active employees in the HDHP tend to have a shorter length of stay.

The positive is it appears that the number of hospital admissions are trending downwards and the length of stay is remaining consistent.

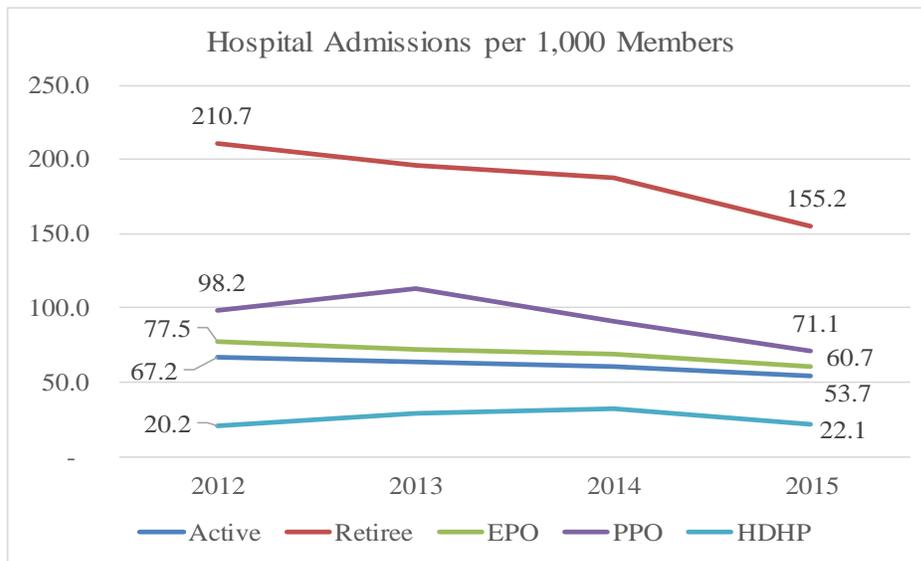


Figure 10: Hospital Admissions per 1,000 Members

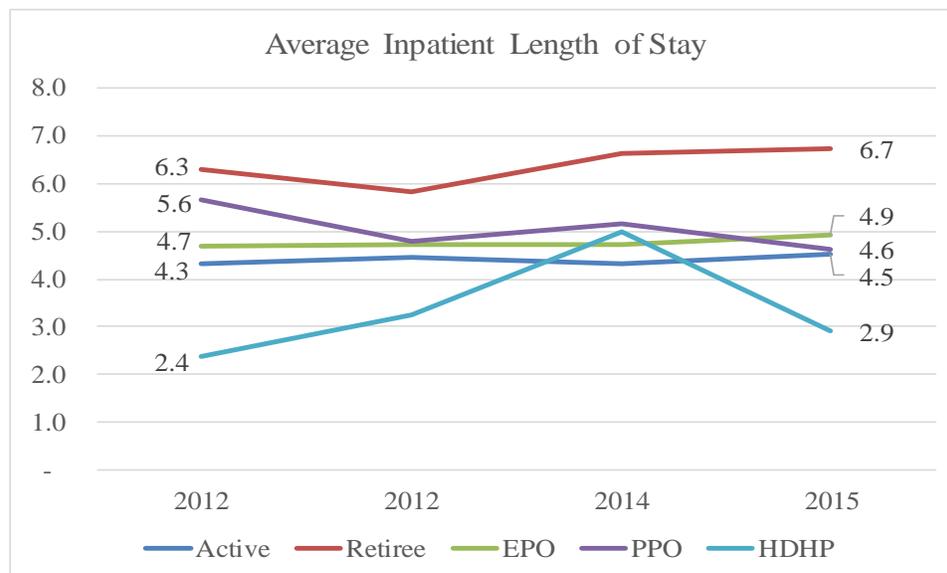
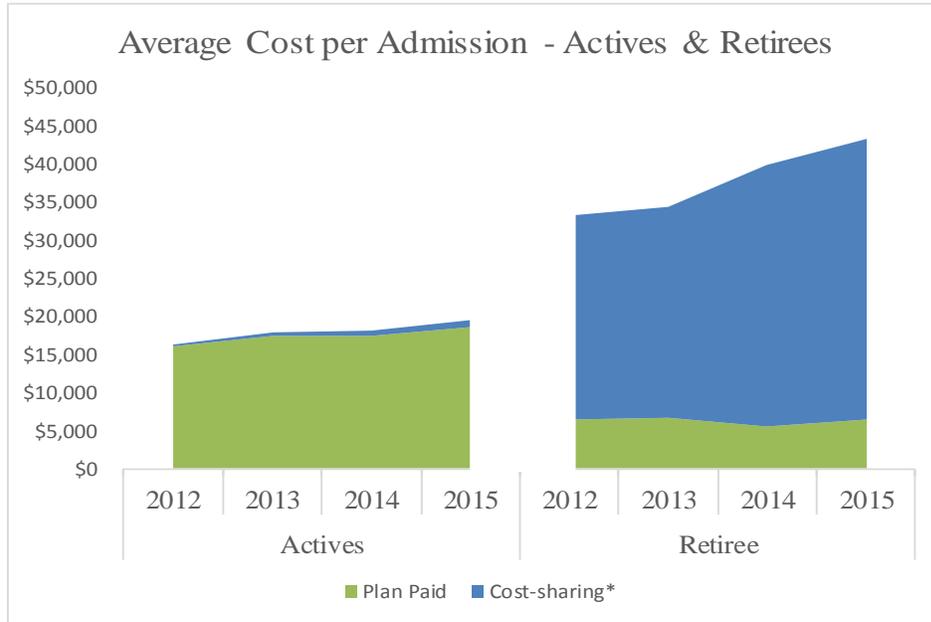


Figure 11: Average Inpatient Length of Stay

The tables below represent the cost share of the inpatient stays.

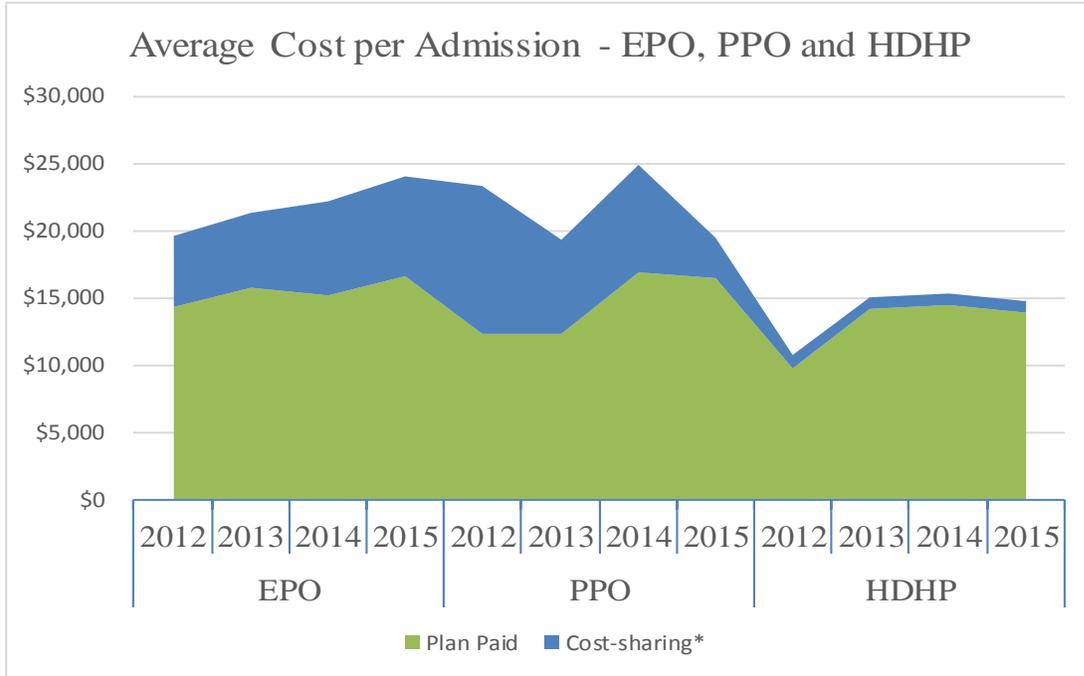
As shown in the graph below, Retirees cost more than twice as much as Actives. However, there is greater cost sharing with the Retirees because approximately two-thirds of Retirees have Medicare paying as primary for their claims. Overall, the Plan paid approximately 96% (\$18.8M of \$19.5M total) of Active in-patient costs and 15% (\$6.5M of \$43.5M total) of Retiree in-patient costs during 2015 which has been trending slightly downward over the last three years from 99% and 20%, respectively.



* Includes copay, co-insurance, Medicare, and other insurance

Figure 12: Average Cost per Admission - Active & Retiree

When looking at the cost by plan, there is greater cost share for the EPO and PPO than the HDHP due to Retirees in the EPO and PPO plans utilizing Medicare as the primary payer and not eligible for the HDHP. Overall, the Plan paid approximately 70% (\$16.6M of \$24M total) of EPO, 84% (\$16.4M of \$19.5M total) of PPO and 94% (\$13.9M of \$14.8M total) of HDHP inpatient costs during 2015 which is consistent with the prior three years except for the PPO plan. Historically, the Plan has paid approximately 53%-68% of the total cost for the PPO, however in 2015 the Plan paid 84% which was driven by an increase in out of network claims.



* Includes copay, co-insurance, Medicare, and other insurance

Figure 13: Average Cost per Admission - EPO, PPO, & HDHP

Place of Service

The figures below show the total cost by place of care for Active and Retirees over the past four years. Overall membership increased which resulted in an expected overall increase in costs. However, it is positive to see the inpatient hospital costs decreasing for both Actives and Retirees.

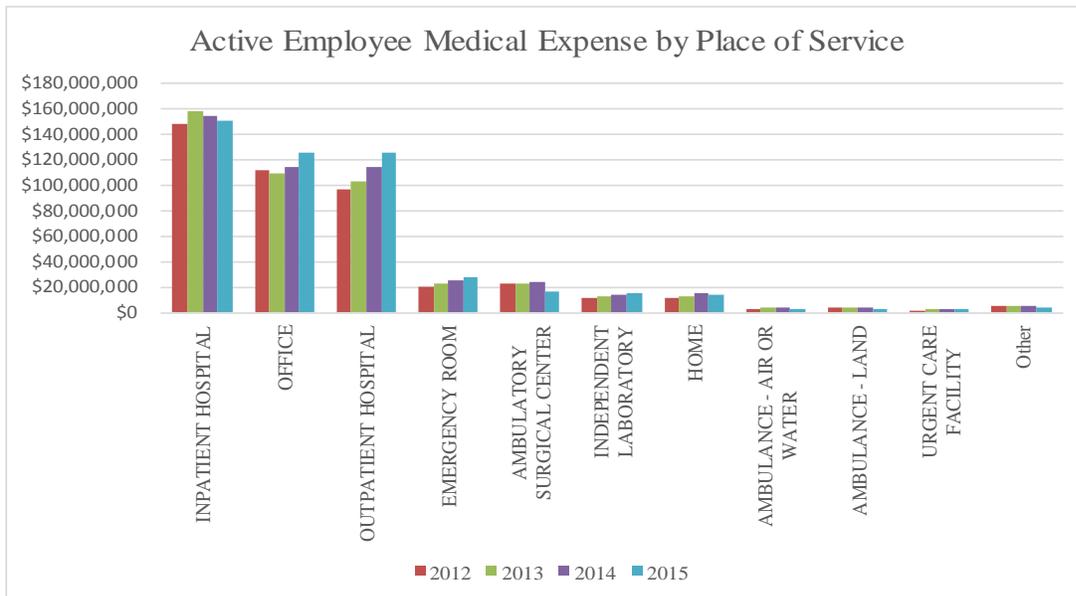


Figure 14: Medical Expense by Place of Service – Actives

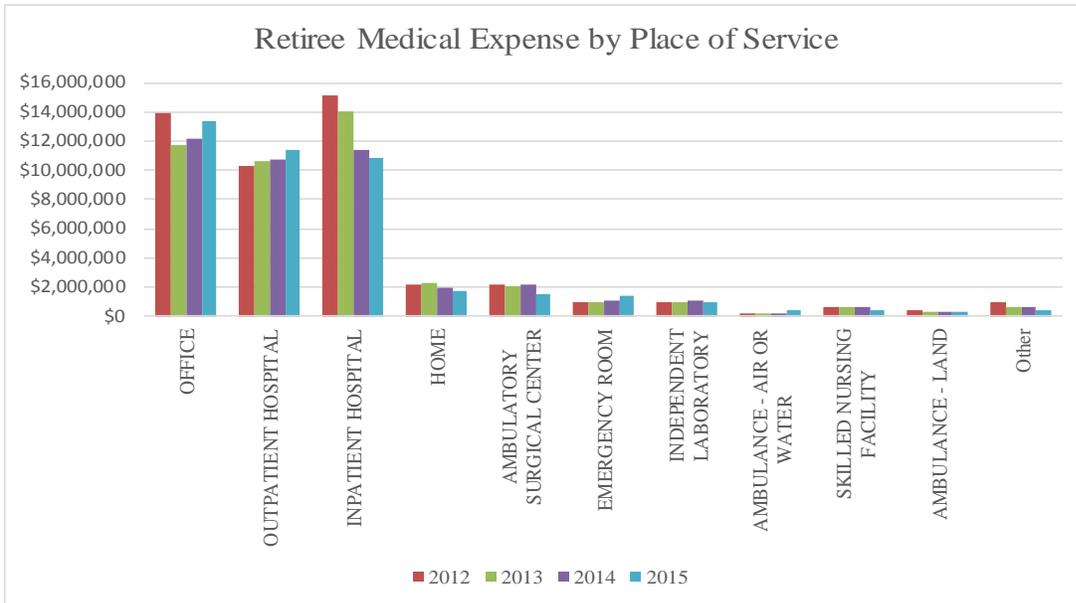


Figure 15: Medical Expense by Place of Service - Retirees

Emergency

During PY 2015 there were approximately 166 emergency room visits per 1,000 members of the self-funded plan. The average plan cost per visit was \$1,378 (inclusive of both facility and professional costs). This is consistent with the prior four years ranging between 160 and 166 in utilization and between \$1,348 and \$1,378 in costs.

Urgent Care Visits

During PY 2015 there were approximately 261 urgent care visits per 1,000 members of the self-funded plan. The average plan costs per urgent care visit was \$83. Utilization has increased from 203 in 2012, to 230 in 2013 and 240 in 2014. Costs have increased slightly from \$79 to \$83 over the last four years.

Physician Visits

During PY 2015 there were approximately 4,331 physician visits per 1,000 members of the self-funded plan (or each member of the plan visited a physician's office approximately four times on average). The average plan costs per office visit was \$109. Utilization is slightly lower than the prior four years ranging which ranged from 4,336 to 4,404. Costs have increased over the last four years from \$102 in 2012, to \$104 in 2013 and \$106 in 2014.

Annual Prescription Use

The table below show the average number of prescriptions filled by Active and Retiree members, including those that did not utilize the pharmacy benefit at all during the year. This shows a

positive downward trend meaning as new people are coming on the plan, they are utilizing the pharmacy benefit at a lower rate than those already on the plan.

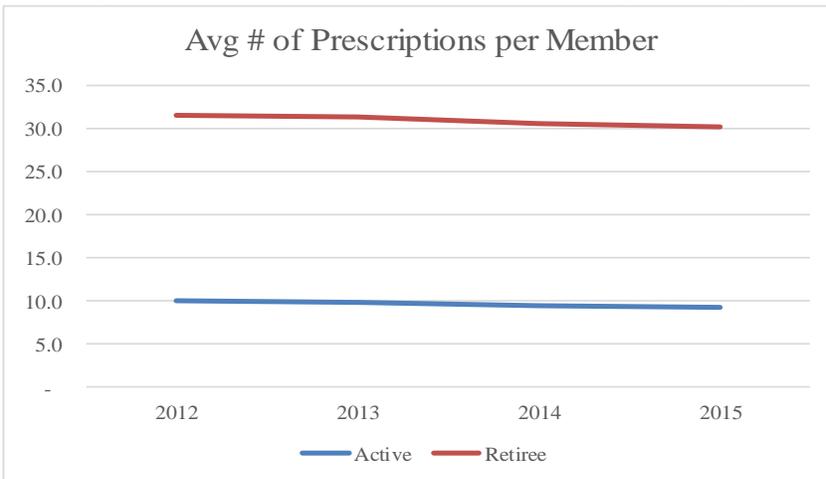


Figure 16: Average # of Prescriptions by Member

When looking at the utilization of the pharmacy benefit, it shows those utilizing the pharmacy benefit are overall maintaining or even slightly decreasing the number of prescriptions filled but the cost per utilizing member steadily increasing. This indicates an increasing overall cost in the pharmacy benefit.

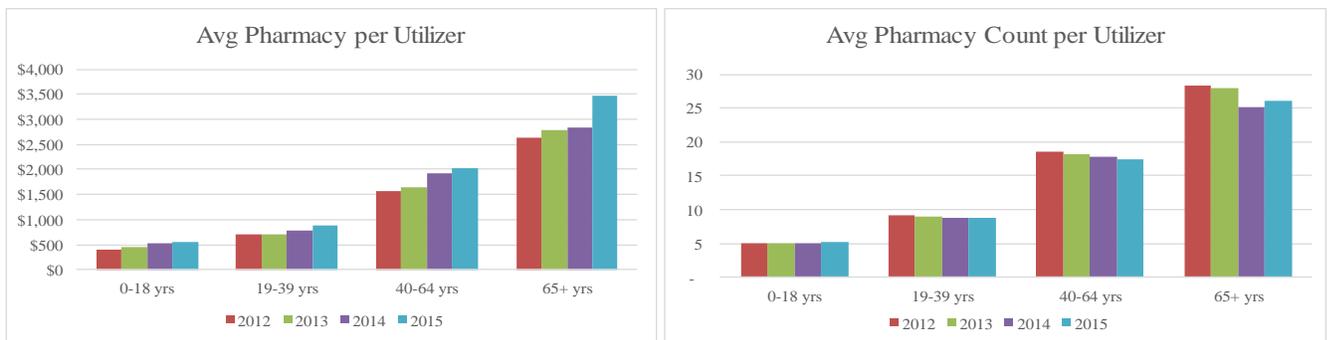


Figure 17: Pharmacy Cost and Count by Utilizer

Generic and Brand-Name Prescription Utilization

The table below shows a positive trend in the utilization of the lower cost drugs. Generic drugs tend to have the lower overall cost to the plan, preferred have a higher cost to the plan and non-preferred tend to have the highest cost to the plan. The trend shown below indicates a slight increase in the utilization of the generic drugs with a slight decrease in preferred drugs and that generic drugs make up an increasing amount of total drugs (just under 80% in 2015).

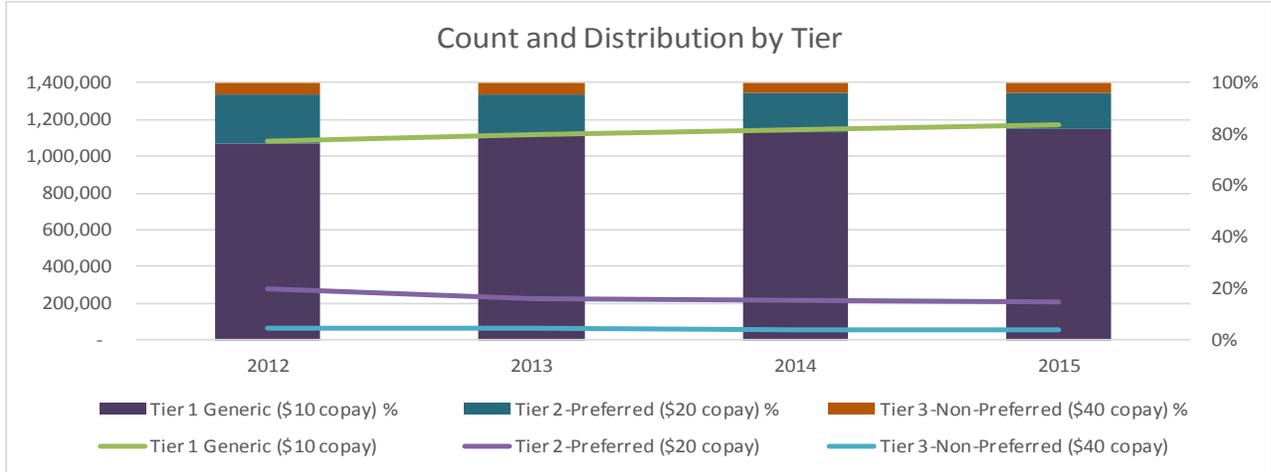


Figure 18: Pharmacy Count and Distribution by Tier

Prescription Use by Therapeutic Class

The graph below shows spend by therapeutic class by year. In almost all of the top 10 classes, expenses have increased which is driving the overall increase in pharmaceutical spend. The top 10 classes make up approximately 60% (\$99.6M) of the total spend (\$166.8M) in 2015 which is slightly up from the prior years (ranging from 53%-56% in prior years). Diabetes and inflammatory disease continue to be the highest cost drivers.

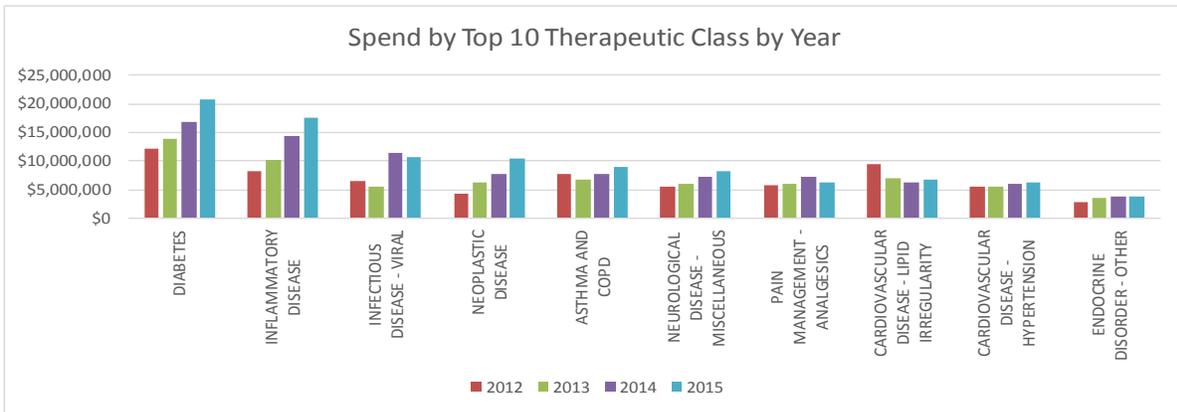


Figure 19: Spend by Top 10 Therapeutic Class by Year

Prescription Use by Type of Drug

The graph below shows spend by drug by year. In almost all of the top 10 drugs, expenses have increased which is driving the overall increase in pharmaceutical spend. The top 10 drugs make up approximately 20% (\$31.4M) of the total spend (\$166.8M) in 2015 which is up from the prior years of 13%. The top two drugs in 2015 (Humira Pen and Enbrel) are anti-inflammatory drugs

and Harvoni was a new drug introduced late in 2014 related to the treatment of Hepatitis C virus. The top three drugs make up almost half (\$14.5M) of total spend for the top 10 drugs.

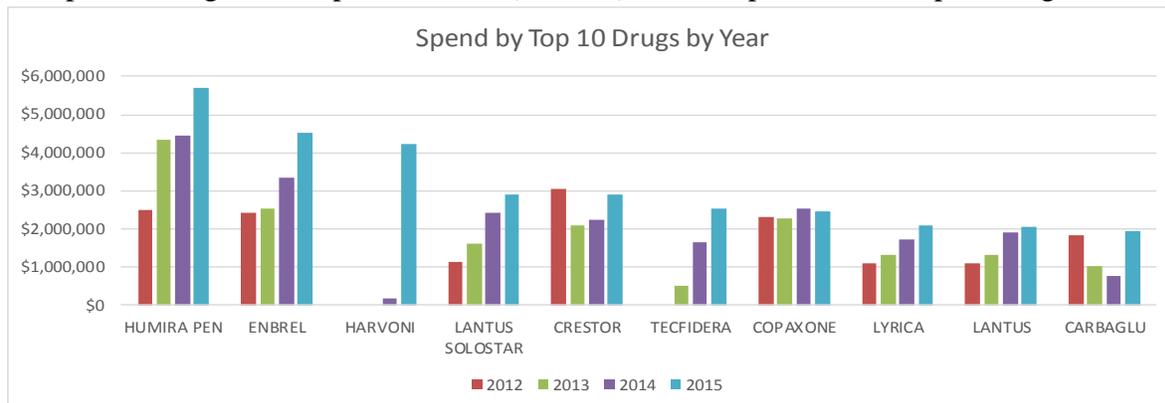


Figure 20: Spend by Top 10 Drugs by Year

Dental Plan Enrollment

Benefits Services Division offers two different types of dental plans: a fully-insured Dental Health Maintenance Organization (DHMO) plan administered by Total Dental Administrators and a self-insured Dental Preferred Provider Organization (DPPO) plan administered by Delta Dental.

DHMO Plan

Within the DHMO plan, services must be obtained from a participating dental provider (PDP). There is no annual deductible or out of pocket maximum. The plan coverage maximums include a \$200 maximum reimbursement for non-PDP emergency services and a \$1,500 per person lifetime maximum for orthodontia. This plan is administered by Total Dental Administrators.

DPPO Plan

Within the DPPO plan, services may be obtained from any dentist and deductibles and out of pocket maximum apply. Benefits may be based on reasonable and customary charges. The plan coverage maximums include a \$2,000 maximum per person per year and a \$1,500 per person lifetime maximum for orthodontia. This plan is administered by Delta Dental.

The figure below shows how enrollment was distributed by plan and network between active, retired, university, and COBRA members. The subscriber references the employee and the member references the employee plus dependents.

Average Monthly Dental Enrollment by Plan					
		2015		2014	
Network	Plan Type	Subscribers	Members	Subscribers	Members
Active	DPPO	22,478	52,508	21,949	51,006
Retiree	DPPO	13,267	20,910	12,212	19,132
University	DPPO	14,967	31,226	14,084	27,812
COBRA	DPPO	174	243	162	231
Total Delta Dental		50,885	104,887	48,407	98,181
Active	EPO	10,095	24,061	10,057	24,213
Retiree	EPO	2,258	3,437	2,152	3,295
University	EPO	5,979	12,578	5,585	11,620
COBRA	EPO	73	102	65	95
Total Dental Administrators		18,405	40,178	17,859	39,223
Total		69,290	145,065	66,266	137,404

Figure 21: Average Dental Enrollment by Plan

Dental Premiums

The below tables show the dental premiums by plan and coverage tier per pay period for Active employees and Retirees.

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

*University of Arizona has 24 pay period deductions

Figure 22: Active 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	\$17.99
	Employee + child	\$17.51
	Family	\$26.97

Figure 23: Retiree Dental Premiums

Dental Premium vs. Plan Cost

The 2015 contribution strategy for the self-insured dental plan resulted in employees paying 86% of the average monthly premium while the state paid the remaining 14%. The figure below shows how the average monthly premium compared to the average monthly plan cost for Active employees and Retirees and their dependents (Active and Retiree members).

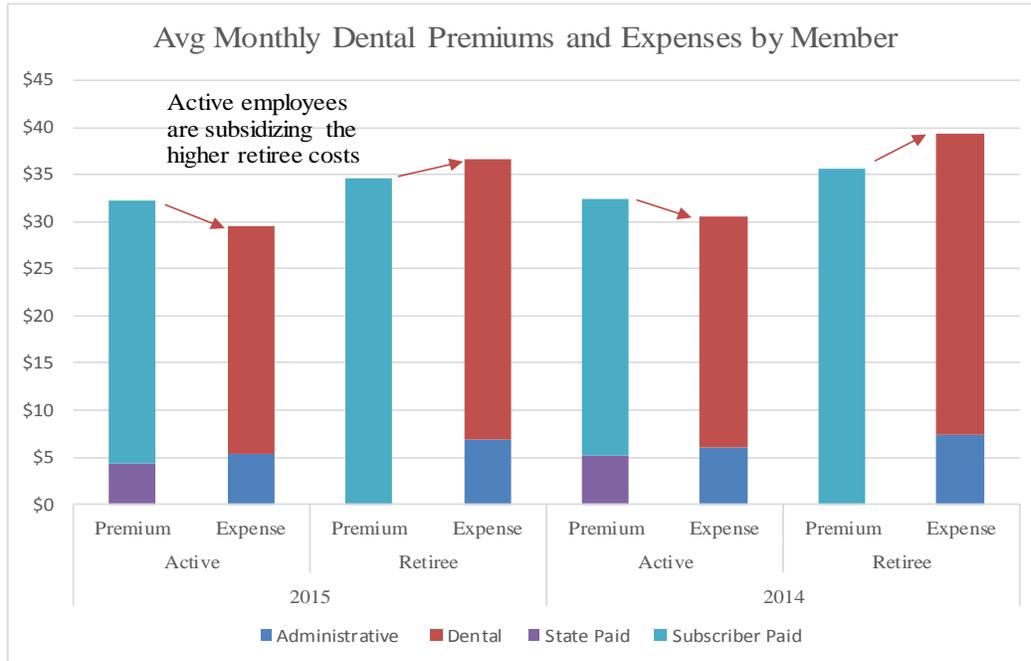


Figure 24: Average Dental Premiums and Expenses per Member

Expenses for Self-Insured Dental Plan

The figure below show the distribution of claims and expenses incurred in PY 2015 and the average annual cost to insure each type of subscriber/member.

2015 Self-Insured Dental Expenses by Active, Retiree			
Expenses	Overall	Active	Retiree
Dental Claims	\$32,044,961	\$24,550,209	\$7,494,752
Rebates & Recoveries	(\$71,437)	(\$54,729)	(\$16,708)
Administration Fees	\$1,699,629	\$1,256,487	\$443,142
Appropriated Expenses	\$659,621	\$487,639	\$171,982
Total Expenses	\$34,332,775	\$26,239,606	\$8,093,168
IBNR Liability	\$4,666,000	\$3,574,705	\$1,091,295
Total	\$38,998,775	\$29,814,311	\$9,184,464
Enrollment in self-funded plans			
Subscribers	50,885	37,618	13,267
Members	104,887	83,977	20,910
Annual cost			
Per subscriber	\$766	\$793	\$692
Per member	\$372	\$355	\$439

Figure 25: Self-Insured Dental Expenses by Active and Retiree

Wellness

Benefits Services Division provides wellness services to State employees. Members have access to preventive health screenings, health management and health education courses, annual flu vaccines, online lifestyle management programs, onsite seminars, and Employee Assistance Program (EAP) benefits.

The Health Impact Program (HIP) offers an incentive based employee wellness program for benefits eligible State of Arizona employees, and was launched October 1, 2014 through September 30, 2015. 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.

Employees who successfully completed the program by engaging in a variety of wellness activities while accumulating and logging progress towards an end goal of 500 points, were eligible to receive up to \$200 at the conclusion of the program period.

Engagement

The 2015 baseline data graph below shows that of the 53,102 total eligible employees 7,955 (15%) employees registered on the Mayo Clinic Healthy Living website. Of the total registered, 5,487 employees completed the online Healthy Assessment, which is a 69% completion rate.

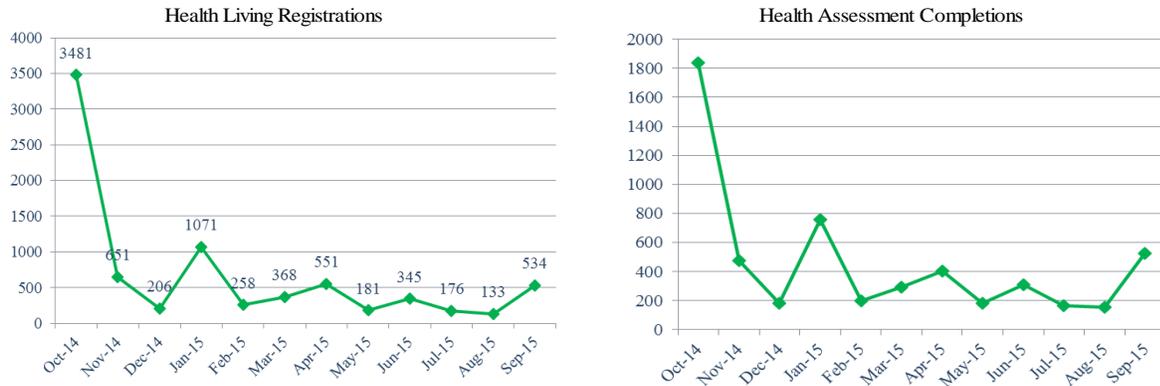


Figure 26: Healthy Living Registrations and Completions

Screening Utilization

The table below shows the total utilization of health screening benefits during the PY 2015 and the number of at-risk employees referred to follow-up care.

	Events	Participant	Referrals
Mini Health Screening*	57	3,524	
Osteoporosis Screening**		1,481	267
Prostate Specific Antigen (PSA)**		235	13
Facial Skin Analysis**		1,139	
Mobile Onsite Mammography	73	1,375	33
Prostate Onsite Project	21	602	73
Total	151	8,356	386

* 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.

Figure 27: Plan Year 2015 Screenings

The table below shows the total utilization for the 2015 Annual Flu Vaccine Program held September 1st through December 31, 2015. A total of 13,585 vaccines were given to benefits eligible employees and dependents, as well as Retirees. Members had access to the flu vaccine at 429 locations throughout the state. 91% of members who received a flu vaccine did so at a worksite clinic.

	Locations	Participants
State Agency Worksite	201	8,579
University Worksite	22	2,294
Combined Worksite (Wesley Bolin)	4	901
Open Enrollment Clinics	8	600
Public Clinics	194	1,211
Total	429	13,585

Figure 28: Flu Vaccines

Incentives

The graph below shows the distribution of points of program participants. 5,750 (72%) of registered participants logged points. 1,810 (85%) of the 2128 logging 500 points actually earned the incentive, for an estimated payout of \$362,400. (23% of total registered).

Distribution of Points Earned

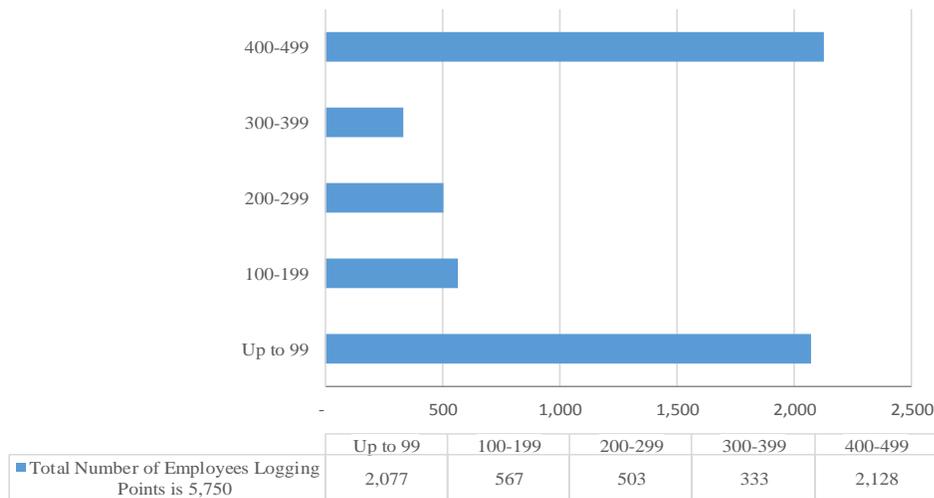


Figure 29: Distribution of Points

By providing the Health Impact Program (HIP) Framework and incentive component, the year over year participation metrics showed an increase in employee engagement in preventive services, screening, and educational activities.

Employee Assistance Program

The table below shows the utilization for the Employee Assistance Program (EAP) and support services offered to agencies covered under the Benefits Services Division. Total utilization for 2015 reached over 29%, showing sustained high usage especially when compared to the 18% national standard for government entities. Benefit Services Division covered agencies continue to show utilization higher than our EAP vendor's Book of Business.

This year the Department of Child Safety and the Department of Economic Security were separated to provide direct access for services and the Department of Education will be added to the Benefit Services Division program effective January 2016.

	Eligible Population	Users	Utilization Rate
EAP		2,301	6.1%
FamilySource		137	0.4%
FinancialConnect		101	0.3%
LegalConnect		405	1.1%
Total Live Telephonic Access		2,944	7.8%
EAP		1,149	3.1%
FamilySource		1,577	4.2%
FinancialConnect		632	1.7%
GlobalConnect		2	0.0%
Health & Wellness		469	1.2%
LegalConnect		2,013	5.3%
Total Online Access		5,842	15.5%
Critical Incident Stress Debriefing		265	0.7%
Trainings		1,878	5.0%
Overall Utilization	37,633	10,929	29.0%

Figure 30: EAP Utilization

In addition to health screenings, vaccines, and EAP services, the strategic plan for 2015 continued to provide employees with access to online mindfulness and stress reduction by enhancing the number of sessions through eMindful, Inc. Participation significantly increased by 74% from 2014.

	Classes	Participants
Mindfulness at Work 1-hr online	24	3,096
Total	24	3096

Figure 31: Online Course Participation

Life, Disability, Vision Insurance and Flexible Spending Accounts

Fund 3035, ERE/Benefits Administration, is used to pay Fully Insured premiums and administer State employees benefit plans other than health and dental. These include basic, supplemental, and dependent life insurance, short-term and non-ASRS long term disability insurance, vision insurance, and medical and dependent care flexible spending accounts. Basic life and non-ASRS long term disability insurance is funded solely by State agency premiums (employer premiums) while all others are funded solely be employee premiums. Fund 3035 is primarily a pass-through fund with collections funding the premiums payments.

The table below is a cash statement of receipts received and expenses paid during PY 2015 that related to PY 2015 as well as prior.

			<u>Plan Year 2015</u>
Prior Balance December 31, 2014			<u>\$3,764,646</u>
Revenues			
Insurance Product	Amount		
Basic Life	\$1,130,809		
Supplemental Life	10,501,382		
Dependent Life	2,790,551		
Short Term Disability	7,298,537		
Long Term Disability	3,506,053		
Total Life & Disability			<u>\$25,227,334</u>
Vision			<u>\$5,177,395</u>
Health Care FSA	\$3,795,671		
Dependent Care FSA	1,452,170		
Total Flex Spending			<u>\$5,247,842</u>
Total Revenues			<u>\$35,652,570</u>
Expenditures			
Insurance Product	Amount	Penalties	
Basic Life	1,165,271.64	-	
Supplemental Life	10,583,970.79	-	
Dependent Life	2,782,272.12	-	
Short Term Disability	7,363,666.73	-	
Long Term Disability	3,498,136.20	-	
Total Life & Disability*			<u>\$25,393,317</u>
Vision*	5,193,830.06	-	<u>\$5,193,830</u>
Health Care FSA	3,403,900.90		
Dependent Care FSA	1,323,214.02		
Administrative Fees*	130,208.53		
Total Flex Spending			<u>\$4,857,323</u>
GAO AFIS Cost	5,109.95		<u>\$5,110</u>
Total Expenditures	<u>\$35,449,581</u>	<u>\$0</u>	<u>\$35,449,581</u>
Ending Balance December 31, 2015			<u>\$3,967,635</u>

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

Figure 32: ERE/Benefits Administration Fund 3035 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-insured health insurance contracts and other contracts the Benefit Services Division administers 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. 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 PY 2015. In each case, performance penalties for measures missed are assessed per the terms of the individual vendor contract. As some performance metrics are yet to be finalized, the estimated performance penalty paid to Benefit Services Division related to PY 2015 was \$581,198.

Aetna

Performance Measures	
Performance Measure	Fees At Risk
Total Performance Measures = 192 Targets successfully met = 162 Targets missed resulting in penalties = 28 Targets Pending = 2	Approximately \$24,559

Performance Measures Not Met		
Performance Measure	Fees At Risk	Total % Assessed
Customer Service – Phone Line: Call abandonment rate is \leq 3%; average speed to answer for all phone calls is 30 seconds or less	1.00% of Total Administrative Fee	Missed 1 of 12 months measured = 0.08%
Appeals – At least 95% of urgent pre-service appeals are resolved within 15 calendar days of receipt; post-service appeals resolved within 30 days.	0.50% of Total Administrative Fee	Missed 11 of 12 months measured = 0.45%

Claims – Processing Turnaround Time: At least 98% of all fully-documented claims will be processed within 30 calendar days of receipt	0.50% of Total Administrative Fee	Missed 2 of 12 months measured = 0.08%
Claims – Financial Accuracy: At least 98% of claims submitted for payment will be accurately processed and paid	2.00% of Total Administrative Fee	Missed 1 of 12 months measured = 0.16%
HSA Administration – Quality Member Phone Services: Call abandonment rate is ≤ 3%; average speed to answer for all phone calls is 30 seconds or less	3.00% of HSA Fees	Missed 1 of 12 months measured = 0.25%
Case Management and Disease Management Customer Service – Quality nurse line phone services: Call abandonment rate is ≤ 3%; average speed to answer for all phone calls will 30 seconds or less; and 90% of all calls must be appropriately triaged	1.00% of Total Administrative Fee	Missed 12 of 12 months measured = 1.00%

Cigna

Performance Measures	
Performance Measure	Fees At Risk
Total Performance Measures = 200 Targets successfully met = 162 Targets missed resulting in penalties = 12 Targets Pending = 6	Approximately \$40,825

Performance Measures Not Met		
Performance Measure	Fees At Risk	Total % Assessed
Implementation - Successful implementation of contract with ID cards distributed within 10 days of receiving eligibility; Claim system configured 30 days prior to January 1; Customer service center and website set up and tested 45 days prior to Open Enrollment	2.00% of Total Administrative Fee	Missed 1 of 1 year measured = 2.00%
Appeals - Accurate and timely response to member request for review; urgent appeals resolved within three (3) business days of request, pre-service resolved within 15 calendar days of request and post-service resolved within 30 calendar days of request	0.75% of Total Administrative Fee	Missed 5 of 12 months measured = 0.31%
Customer Service Nurse Line - Cigna will	0.66% of Total	Missed 2 of 12 months

provide Nurse Line phone service to members with no more than 3% abandonment rate, an average speed to answer of 30 seconds or less, and 90% of all calls must be appropriately triaged	Administrative Fee	measured = 0.11%
Claims – Processing Accuracy: At least 99% of claims will be processed accurately	1.34% of Total Administrative Fee	Missed 4 of 12 months measured = 0.44%

UnitedHealthcare

Performance Measures	
Performance Measure	Fees At Risk
Total Performance Measures = 200 Targets successfully met = 162 Targets missed resulting in penalties = 7 Targets Pending = 6	Approximately \$29,191

Performance Measures Not Met		
Performance Measure	Fees At Risk	Total % Assessed
Customer Service - UHC will provide phone service to members with no more than 3% abandonment rates and average speed to answer of 30 seconds or less	1.00% of Total Administrative Fee	Missed 2 of 12 months measured = 0.16%
Case Management and Disease Management - Phone Line: Call abandonment rate is \leq 3%; average speed to answer for all phone calls will 30 seconds or less	0.50% of Total Administrative Fee	Missed 2 of 12 months measured = 0.08%
Case Management – Pre-Admission Counseling: 95% of Surgical admissions within 3 business days’ notice for: Musculoskeletal Conditions: Back Pain, Joint Replacement for Knee or hip; Women’s Health: Breast Cancer, Uterine Conditions; Heart Surgery: Angioplasty or Bypass Surgery; Men’s Health: Prostate Surgery admissions will receive preadmission outreach and counseling prior to admission date	0.50% of Total Administrative Fee	Missed 2 of 4 quarters measured = 0.25%
Case Managementnt – 90% of members will be screened for outreach within 14 calendar days after identification by predictive modeling	0.50% of Total Administrative Fee	Missed 1 of 4 quarters measured = 0.12%

Blue Cross Blue Shield (BCBS) of Arizona

Performance Measures	
Performance Measure	Fees At Risk
Total Performance Measures = 200 Targets successfully met = 189 Targets missed resulting in penalties = 9 Targets Pending = 6	Approximately \$86,934

Performance Measures Not Met		
Performance Measure	Fees At Risk	Total % Assessed
Implementation - Successful implementation of contract with ID cards distributed within 10 days of receiving eligibility; Claim system configured 30 days prior to January 1; Customer service center and website set up and tested 45 days prior to Open Enrollment	2.00% of Total Administrative Fee	Missed 1 of 1 year measured = 2.00%
Claims - At least 99% of all fully documented claims will be processed within 30 calendar days of receipt	2.00% of Total Administrative Fee	Missed 1 of 12 months measured = 0.16%
Case Management/Disease Management Customer Service - BCBS will provide Nurse Line (demand management) phone service to members with no more than 3% abandonment rate, an average speed to answer of 30 seconds or less	1.00% of Total Administrative Fee	Missed 6 of 12 months measured = 0.50%
Case Management - At least 95% of select surgical inpatient admissions will receive outreach prior to the admission date	1.00% of Total Administrative Fee	Missed 1 of 4 quarters measured = 0.25%

MedImpact

Performance Measures	
Performance Measure	Fees At Risk
Total Performance Measures = 113 Targets successfully met = 113	No penalties

Performance Measures Not Met		
Performance Measure	Fees At Risk	Total % Assessed
No targets missed		

Delta Dental

Performance Measures	
Performance Measure	Fees At Risk
Total Performance Measures = 262 Targets successfully met = 261 Targets Pending = 1	No penalties

Performance Measures Not Met		
Performance Measure	Fees At Risk	Total % Assessed
No targets missed		

Total Dental Administrators

Performance Measures	
Performance Measure	Fees At Risk
Total Performance Measures = 136 Targets successfully met = 135 Targets missed resulting in penalties = 1 Targets Pending = 6	Approximately \$9,412

Performance Measures Not Met		
Performance Measure	Fees At Risk	Total % Assessed
ADOA will perform satisfaction survey of plan at least annually. At least 80% overall member satisfaction on annual survey.	2.00% of Total Administrative Fee	Missed 1 of 1 year measured = 2.00%

Compsych

Performance Measures	
Performance Measure	Fees At Risk
Total Performance Measures = 38 Targets successfully met = 37 Targets missed resulting in penalties = 1	Approximately \$2,044

Performance Measures Not Met		
Performance Measure	Fees At Risk	Total % Assessed
Less than 3% of calls abandoned. This is a Customer Service metric for the Guidance Resources Unit only.	3.00% of Total Administrative Fee	Missed 2 of 4 quarters measured = 1.50%

Avesis

Performance Measures	
Performance Measure	Fees At Risk
Total Performance Measures = 182 Targets successfully met = 175 Targets missed resulting in penalties = 7	Approximately \$77,658

Performance Measures Not Met		
Performance Measure	Fees At Risk	Total % Assessed
Claims - 97% of clean claims shall be processed (paid or denied) within ten calendar days of receipt of claim. Clean claims are defined as requiring no intervention to process.	1.00% of Total Premiums Paid	Missed 3 of 12 months measured = 0.25%
Customer Service - 90% of phone calls requesting a member services representative will be answered in 30 seconds or less	1.00% of Total Premiums Paid	Missed 3 of 12 months measured = 0.25%
Account Management - Avesis will provide sufficient staffing levels and expertise to appropriately support the State's contract. This shall be determined by a yearly survey of State Management staff with an average of 90% of Management Staff satisfied with the staff.	1.00% of Total Premiums Paid	Missed 1 of 1 year measured = 1.00%

Application Software, Inc. ("ASI")

Performance Measures	
Performance Measure	Fees At Risk
Total Performance Measures = 49 Targets successfully met = 35 Targets missed resulting in penalties = 14	Approximately \$9,170

Performance Measures Not Met		
Performance Measure	Fees At Risk	Total % Assessed
Account Management/Customer Service - At least 80% of calls will be answered within 30 seconds or less.	2.00% of Total Administrative Fees	Missed 3 of 4 quarters measured = 1.50%
Account Management/Customer Service - No more than 3% of calls abandoned.	2.00% of Total Administrative Fees	Missed 3 of 4 quarters measured = 1.50%
Account Management/Customer Service - ASIFlex will respond to account issues within 1 business day.	2.00% of Total Administrative Fees	Missed 2 of 4 quarters measured = 1.00%
Program/Claim Administration -All fully documented claims received will be processed within 2 business days.	2.50% of Total Administrative Fees	Missed 4 of 4 quarters measured = 2.50%
Account Management/Customer Service - ASIFlex will respond to all written inquiries/ correspondence within 3 business days.	2.00% of Total Administrative Fees	Missed 1 of 4 quarters measured = 0.50%
Report Delivery - Quarterly reports with supporting documentation will be delivered to ADOA within 45 days following end of each quarter.	.05% of Total Administrative Fees	Missed 1 of 4 quarters measured = 0.0125%

The Hartford

Performance Measures	
Performance Measure	Fees At Risk
Total Performance Measures = 129 Targets successfully met = 125 Targets missed resulting in penalties = 4, the survey penalty was waived per agreement with The Hartford	Approximately \$323,796

Performance Measures Not Met		
Performance Measure	Fees At Risk	Total % Assessed
STD Claims - At least ninety-five percent (95%) of all fully documented STD claims shall be processed within five (5) business days of receipt.	.5% of Total Administrative Fees	Missed 1 of 12 months measured = 0.25%
Account Management/Customer Service - Hartford shall obtain at least a ninety percent (90%) satisfaction rate on its STD claims processing service in the annual member satisfaction survey conducted by ADOA.	1.00% of Total Administrative Fees	Missed 1 of 1 year measured = 1.00%
Account Management - The overall rating of the survey shall indicate a ninety percent (90%) satisfaction rate by Account Management of Hartford's services.	1.20% of Total Administrative Fees	Missed 1 of 1 year measured = 1.20%
Reporting - Agreed upon reporting packages (identified on the Report Index) shall be submitted within stated timeframes.	.5% of Total Administrative Fees	Missed 1 of 12 months measured = 0.04% - Penalty waived for 2015

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 PY 2015, eight 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 PY 2015 is shown below including recommendations made, implemented recommendations*, identified savings, and health plan recovery dollars.

Recommendations	Implemented Recommendations*	Identified Savings	Recovery Dollars	Pending Recovery
14	11	\$37,836	\$1,647	\$0

* 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.

Figure 33: Audit Recommendation Summary

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:

Functional Area	Audit Methodology
Vendor operating transactions	Evaluation of external audit results of Statement on Standards for Attestation Engagements No. 16 Audits (SSAE 16)
Vendor execution of benefit design and contract elements	Plan Implementations and Claims Readiness Claims adjudication compliance Inquiries (i.e. research, plan coverage design, etc.)
ADOA accuracy of shared data	Dependent Eligibility Audits (DEA) Health Impact Program (HIP)
Audit program improvement initiatives	Performance Guarantees Administrative functions and program-specific

Figure 34: Audit Functional Area and Methodology

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 the on the health plan and contract compliance (i.e. large medical and/or pharmacy claims audit).

The outcomes of contracted medical vendors' external claim audits were reviewed to determine at risk areas for the health plan to conduct future audits. Member copay adjudication was noted for further review.

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, chiropractic care services, nutritional evaluations, infertility, and compression garments were not adjudicated properly; a savings of \$630 was identified and \$1,647 was recovered.

Plan allowance/exception audits are designed to evaluate whether the contracted vendors' system(s) were set up correctly in compliance with the health plan's benefit design. There were no plan allowance/exception audits performed during PY 2015.

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 2015, a Claims Readiness review (began in 2014) was completed. The review tested vendors' preparedness to adjudicate claims for PY 2015.

Various internal inquiries were researched and completed to support the functions of Benefit Services. 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 2015

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 10 ineligible dependents were enrolled in the plan. Three dependents erroneously received total benefits of \$16,980 due to unreported qualified life events. Additionally, appropriate documentation was not received for 3 dependents resulting in the erroneous payment of benefits totaling \$20,225. A total of \$37,205 in benefits were paid in error.

Audit Services supported the Health Impact Program (HIP) initiative by verifying data and providing data reporting for the 2,128 employees who indicated completion of the program. Of the 1,810 employees deemed eligible to receive the incentive, 1,033 had 100% of points verified and the remaining 777 had 75% of total points verified. The remaining 318 members who indicated completion were either unable to provide documentation or terminated employment. The PY 2015 HIP was initiated October 1, 2014 to create an employee incentive program designed to encourage employee healthy living. To participate, employees registered via the Mayo Healthy Living Online Portal, where they were able to report the completion of various health and wellness activities, each worth a pre-determined number of points. Employees who logged 500 points or greater became eligible to receive the \$200 incentive.

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 for each of the contracted vendors. The responsibility for the review of the performance guarantees was transferred to Plan Administration.

Audit Services continues to strive towards improvement and efficiency; the focus during PY 2015 was to streamline administrative functions to improve audit program initiatives.

Appendix

		Plan Year 2015	
Prior Balance December 31, 2014		\$307,612,877	
Revenues			
	Source	Premiums	
	ADOA Health Plan (EE)	\$134,682,534	
	ADOA Health Plan (ER)	649,670,888	
	BCBS NAU Plan (EE)	7,922,748	
	BCBS NAU Plan (ER)	32,103,521	
	ADOA Dental Plan (EE)	31,965,382	
	ADOA Dental Plan (ER)	9,195,311	
	PrePaid Dental Plan (EE)	1,743,005	
	PrePaid Dental Plan (ER)	1,963,201	
	Other Revenue	121,069	
Net Revenue		\$869,367,659	\$869,367,659
Expenditures			
	Vendor	Admin Fees	Penalties
	AHH Medical Management	\$180,100	(\$3,768)
	Aetna	2,730,220	-
	Cigna	2,161,068	-
	UnitedHealthcare	13,562,925	(19,359)
	Blue Cross Blue Sheild AZ	3,788,330	-
	AmeriBen	2,188,603	(12,168)
	MedImpact	1,056,580	-
	Delta Dental	1,699,629	(71,437)
	HIP Payout	382,262	-
	ACA Related Taxes/Fees	6,722,832	-
	HSA Funding (EE and ER)	851,180	-
	AG Collection Fees	16,713	-
	Net Administrative Fees***	\$35,340,440	(\$106,732)
			\$35,233,709
		Claims	Recoveries*
	Aetna	\$38,471,401	\$0
	Cigna	48,647,804	-
	UnitedHealthcare	347,422,989	(196,029)
	AmeriBen	23,539,154	(227,206)
	Blue Cross Blue Sheild AZ	89,060,148	-
	MedImpact	155,631,224	(11,585,243)
	Medicare Part D Retiree Drug Subsid;	-	(13,470,703)
	Other Medical**	-	(11,148)
	Delta Dental	36,842,067	-
	Other Wellness	682,428	-
	Net Claims	\$740,297,214	(\$25,490,328)
			\$714,806,887
Self-Insured Expenditures		\$775,637,654	(\$25,597,059)
			\$750,040,595
		Premiums	Penalties
	BCBS (NAU Only)	\$41,243,680	\$0
	Total Dental Administrators	3,782,270	-
Fully Insured Expenditures***		\$45,025,950	\$0
			\$45,025,950
	HITF Operating	\$4,557,595	\$0
	Fund Transfers Out^	-	-
	Federal Participation Reimbursement	\$8,302,800	-
Operating Expenses and Transfers		\$12,860,395	\$0
			\$12,860,395
Net Expenditures and Transfers		\$833,524,000	(\$25,597,059)
			\$807,926,941
Fund Balance December 31, 2015			\$369,053,596
	IBNR Liability (Medical & Dental)		\$94,891,000
	Contingency Reserve (Medical & Dental)		\$94,891,000
Unrestricted Cash Balance As Of December 31, 2015			\$179,271,596

*Recoveries include Medicare Part D Retiree Drug Subsidy reimbursement, prescription drug rebates, overpayment recoveries (including stop payments and voids), subrogation recoveries, workers compensation recoveries from Risk

**Other Medical includes recoveries from Risk Management for Worker Comp claims, UMR and Harrington

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

^ Interfund transfers from HITF to other State operating funds.

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 premium, 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.

High Deductible Health Plan (HDHP) – A health plan designed with an open access provider organization or network. Enrollees have access to in-network and out-of-network providers, and are subject to co-insurance and higher annual deductibles than traditional plans. Out-of-network providers require greater co-insurance.

Health Savings Account (HSA) – An account that allows individuals to pay for current health expenses and save for future health expenses on a tax-free basis. Only high deductive health 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.

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.