Douglas A. Ducey
Governor

Andy Tobin
Director

ARIZONA DEPARTMENT OF ADMINISTRATION

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July 25, 2019

The Honorable Douglas A. Ducey, Governor, State of Arizona
The Honorable Karen Fann, President, Arizona State Senate
The Honorable Russell Bowers, Speaker, House of Representatives
1700 West Washington Street
Phoenix, Arizona 85007

Dear Governor Ducey, President Fann, and Speaker Bowers:

Pursuant to A.R.S. § 38-652 (G) and A.R.S. § 38-658 (B), we are pleased to present the *2018 Annual Report for the Health Insurance Trust Fund*, including a report on the performance standards for the health and dental plans.

Sincerely,

Andy Tobin
Director

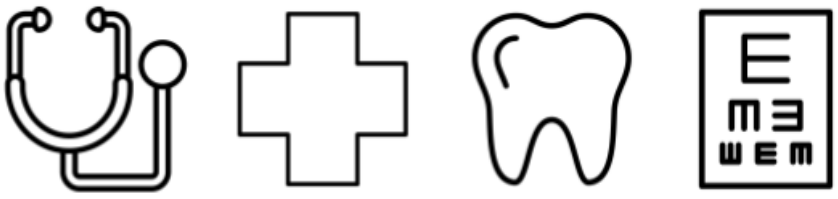
cc: Richard Stavneak, Director, Joint Legislative Budget Committee
Rebecca Perrera, Staff, Joint Legislative Budget Committee
Matthew Gress, Director, Office of Strategic Planning and Budgeting
Jacob Wingate, Budget Analyst, Office of Strategic Planning and Budgeting
Derik Leavitt, Assistant Director, ADOA Budget and Resource Planning
Katie Hobbs, State Librarian and Director, Arizona Department of Library and Archives
Paul Shannon, Assistant Director, ADOA Benefit Services Division

ARIZONA
DEPARTMENT OF ADMINISTRATION
BENEFITS

Health Insurance Trust Fund

ANNUAL REPORT

2018



FOREWORD

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") Active employees, COBRA members, and Retirees. This 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, 2018 through December 31, 2018. 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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Telephone: 602-542-500

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Report Background

This document reports the financial status of the Employee Health Insurance Trust Fund (HITF) 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 Insurance Fund, also known as Fund 3015 or the Health Insurance Trust Fund encompasses the medical and dental programs and the appropriated expenditures for the Arizona Department of Administration (ADOA), Benefit Services Division operations. The Employee Related Expenditures (ERE)/Benefits Administration Fund, or 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 plan year 2018, all medical, except for the Northern Arizona University (NAU) Blue Cross Blue Shield of Arizona (BCBS) fully- insured plan and Dental Preferred Provider Organizations (PPO) plans were self-insured, whereas the Dental Health Maintenance Organization (HMO), vision, life and disability insurance plans were fully-insured.

The State's medical plan became self-insured on October 1, 2004. The current set of contracts runs from July 15, 2014 through December 31, 2019 with an extension granted through December 31, 2020. 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") 2018 running January 1, 2018 through December 31, 2018.

Please note: statistics will vary from previous annual reports due to the late receipt of program data following the completion of the previous annual report. Further, the Benefit Services Division has moved to using a new data-mining platform called MedInsight to extract data, which further explains some of the variances in reported statistics. In no case does the variation represent a substantive change in trend. Last, some schedules represent a hybrid of cash and incurred accounting methods.

Executive Summary

During PY 2018, ADOA offered a comprehensive insurance package through Benefit Options to approximately 137,700 members consisting of Active State and University employees, COBRA members, Retirees and their qualified dependents. This figure excludes the 5,800 members that are served through the NAU BCBS fully-insured program. The benefits offered in the package include medical, pharmaceutical, dental, flexible spending, vision, wellness, an employee assistance program (EAP), life, and disability insurance.

During PY 2018, the sum of health and dental premiums collected was $880.2M with total plan expenses, including transfers, of $921.6M. Reported expenses include claims incurred in 2018 and prior plan years paid in PY 2018 as well as transfers out to other State funds (Figure 1).

Claims figures, referred to below, apply to 2018 incurred claims only, regardless of paid dates. Any figure that includes administrative and operating costs is a hybrid of two accounting methods as the administrative and operating costs are recorded on a cash basis while the claims costs are retrieved on an incurred basis from the MedInsight claims system.

Health Plan

- The average annual plan expense, including claims, administrative costs, and fees per member was $5,940.
- Average Active member expense was $5,780; average Retiree member expense was $8,180.
- The PY 2018 medical claims expenses totaled $618.1M, excluding Incurred But Not Reported (IBNR) liability (Figures 7 and 8). This figure was retrieved from the MedInsight claims system using incurred claim dates between January 01, 2018 and December 31, 2018. This differs from the $635.2M number in Figure 1 which represents medical claims expenses paid out of the Arizona Financial Information System (AFIS) during PY 2018 regardless of incurred dates (cash basis accounting). Therefore the $635.2M figure includes claims with incurred dates paid between January 01, 2018 and December 31, 2018 (PY 2018 claims) as well as claims submitted to ADOA for reimbursement with incurred dates prior to PY 2018. The AFIS figure also includes any other claims expenditure related transactions such as adjustments and corrections for

overpayments, coding errors, subrogation transactions, pharmacy rebates submitted by the medical vendors, Wellness expenses such as flu shots and screening costs.

- In terms of total spent, the Health Status and Contact with Health Service group takes the lead at almost 13% of total spent. However, this is not considered a single major diagnostic group by medical and health professionals. Rather, this category represents a roll up of claims with specific diagnoses codes covering regular primary care physician visits, including OB/GYN, preventative services such as wellness (well-baby and well-child visits, routine vaccinations, screenings and tests) and other specialist visits. Therefore the actual single leading diagnosis group by total spend is the Musculoskeletal System and Connective Tissue category at 12.2% of total medical spend.
- The fact that the top medical spent is occurring in the Health Status and Contact with Health Service group (primary care) indicates that members are seeking appropriate levels of care by seeking the majority of care from physicians or specialists. The Health Affairs journal, the leading journal on health policy thought on health reform, health care costs and health systems innovation, has published a study in May 2010 called "Primary Care and Why It matters For U. S. Health System Reform." In this study, the authors Rober L. Phillips and Andrew W. Bazemore, quote that the United States primary care spent represents 10-12% of total healthcare spending. The 13% figure attributed to primary care spent on our plan compares favorably to this study.
- 3,763 physician visits per 1,000 members (notably lower than prior year).
- 171 urgent care visits per 1,000 members (slightly higher than prior year).
- 189 emergency room visits per 1,000 members (slightly lower than prior year).
- The PY 2018 pharmacy claims expense was $188.5M (Figure 7 and 8). This differs from the $183.9M number in Figure 1 that represents pharmacy claims expenses paid out of AFIS during PY 2018. This figure represent claims with incurred dates PY 2018 and prior and excludes the Retiree drug subsidy. Further, this figure also includes any other expenditure related transactions, including refunds, rebates, adjustments, and corrections. Medicare Part B Retiree Drug subsidies are not included in this figure.
- The leading therapeutic drug class by cost was anti-diabetics at close to 14% of total pharmaceutical spend.
- Over 1.3 million prescriptions were filled in PY 2018.
- Active employees filled an average of 8.5 prescriptions per year while Retirees filled an average of 27.1.

Wellness Program

- Administered over 15,559 flu vaccines through 400 worksite or public events.
- Administered over 10,788 screenings through 240 statewide worksite events resulting in 686 referrals to physicians for various health issues. This represents a slight increase in referrals over the prior year, with the majority of referrals coming from Diabetes screening.
- Incentives covering 4,353 employees participating in the HIP program during PY 2018 were paid out during the spring of calendar year 2019. The incentives total to $870K representing a 51% increase over the PY 2017 incurred figure paid out in PY 2018.

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 $165K will be collected in calendar year 2019 from vendors failing to meet agreed upon PY 2018 performance targets in customer service, claims processing, appeals, reporting, surveys, and network management. During calendar year 2018, $725K of performance penalties were collected related to the PY 2017 and PY 2016 performance period.

Health Insurance Trust Fund Review and Summary

Total PY 2018 expenses, including 2018 and prior PY claims, were covered by revenues collected during 2018 and the unrestricted reserve from prior years.

The Health Insurance Trust Fund Summary (Figure 1) is a cash statement of receipts received and expenses paid during PY 2018 that relate to PY 2018 as well as prior plan years.

ADOA Health Plan is the self-insured medical program and includes Aetna Life Insurance Company (Aetna), Blue Cross Blue Shield of Arizona (BCBS), Cigna Health and Life Insurance Company (Cigna), and United HealthCare Services, Inc. (UHC) networks. State and University Active employees and Retirees choose coverage from one of the self-insured networks.

NAU Active and COBRA members have an additional option to participate in the fully-insured BCBS NAU plan. The plan is managed by the university and the ADOA serves as a pass-through entity between NAU and BCBS. Practically speaking, premiums collected by NAU are passed on to ADOA every month. Those premiums are then submitted to BCBS via paying the monthly premium invoice.

Rates for the 07/01/2018 – 12/31/2018 time period are provided below for comparison between the self-insured PPO plan and fully-insured BCBS PPO plan:

Active Medical Premiums per Pay Period (26 pay periods)*				
Plan	**Tier**	**Employee Premium**	**State Premium**	**Total Premium**
State of AZ Self-Insured PPO (Aetna, BCBS, UHC)	Employee only	$51.78	$271.94	$323.72
	Employee + adult	$109.15	$575.01	$684.16
	Employee + child	$73.11	$384.80	$457.91
	Family	$127.43	$670.85	$798.28
NAU BCBS Fully-Insured PPO	Employee only	$36.23	$278.83	$315.06
	Employee + adult	$100.57	$561.06	$661.63
	Employee + child	$76.62	$427.47	$504.09
	Family	$172.87	$803.82	$976.69

For additional information regarding differences between the two PPO plans, please visit the NAU Human Resources website.

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 Part D Employer Group Waiver 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 $15.1M in PY 2018. The savings relate to PY 2018 and prior. The

pharmacy benefits management for all members services are provided by MedImpact Healthcare Systems Inc. The pharmacy offers a three-tier formulary for a 31-day supply of medication, with a $15 copay for generic drugs, $40 copay for preferred brands, and a $60 copay for non-preferred brands.

ADOA dental plan services were provided by two vendors during PY 2018: Delta Dental Plan of Arizona (Delta Dental) and Cigna Health and Life Insurance Company (Cigna Dental).

Benefit Services Division holds reserves for paying claims that have been incurred but not reported (IBNR) and for a contingency to cover any insufficiencies that may develop, such as an actual medical trend exceeding the projected medical trend, unplanned shifts in plan membership, unexpected catastrophic claims, and changes in provider reimbursement rates that may occur during each plan year. At the end of PY 2018, ADOA was short $62.6M (unrestricted balance) of the desired total reserve amount of $172.5M.

Special Employee Health Trust Fund Summary	
Plan Year 2018	
Beginning Fund Balance January 01, 2018	**$151,250,435**
Revenues	
ADOA Benefit Options	$791,973,181
BCBS (NAU)	42,470,050
ADOA Dental Plan	42,142,836
PrePaid Dental Plan	3,587,010
Other Revenue	65,976
Total Revenues	**$880,239,052**
Expenditures	
Administrative Fees	$29,020,405
Medical Claims	635,233,638
Drug Claims	183,929,818
Dental Claims	37,553,248
Medicare Part D Retiree Drug Subsidy	(15,063,564)
BCBS (NAU) Premiums	42,241,687
Fully Insured Dental Premiums	3,688,937
Appropriated Expenses	4,934,591
Administrative/Cash Adjustments	40,233
Fund Transfers Out *	990
Total Expenditures and Transfers	**$921,579,983**
Ending Fund Balance December 31, 2018	**$109,909,504**
Reserves	
IBNR Liability (Medical & Dental)	$86,257,000
Contigency Reserve (Medical & Dental)	86,257,000
Total Reserves	**$172,514,000**
Unrestricted Balance December 31,2018	**($62,604,496)**

* Fund transfers from HITF to other State funds.

Figure 1: Health Insurance Trust Fund Summary

Medical Plan Enrollment

Benefit 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
- State employees or university staff, including dependents, 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 emergencies. 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, Cigna, or UHC.

The PPO Plan
Within the PPO plan, services may be obtained from an in- or out-of-network provider. There are separate in- and out-of-network deductibles 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 the service until the deductible is met. After the deductible is met, the employee pays copays if the provider is in-network and coinsurance 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 three networks: Aetna, BCBS, 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. Separate in- and out-of-network deductibles 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 deductibles are met. After the deductibles are met, the employee pays coinsurance 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 a HSA. This account allows employees to make pre-tax contributions into the account and withdraw the monies to pay for qualified medical expenses. When the employee opens the HSA with the State HDHP, the State also contributes bi-weekly to the account. The annual amount that the State

contributes towards the HSA is $720 for employee/single tier only and $1,440 for all other tiers. Employee contributions to the HSA is not mandatory. The HDHP is only available to Active employees and only under the Aetna network.

Figure 2 below, shows enrollment distribution 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 Medical Enrollment by Plan & Network					
		2018		2017	
Network	Plan Type	Subscribers	Members	Subscribers	Members
Active	EPO	1,842	4,065	2,017	4,471
Retiree	EPO	245	320	251	331
University	EPO	2,187	4,258	2,155	4,244
COBRA	EPO	19	33	13	23
Active	PPO	361	853	278	548
Retiree	PPO	23	27	27	31
University	PPO	427	939	354	739
COBRA	PPO	4	7	3	6
Active	HDHP	1,642	3,834	578	1,268
Retiree	HDHP	0	0	0	0
University	HDHP	1,172	2,511	783	1,570
COBRA	HDHP	17	33	14	22
Total AETNA		**7,939**	**16,880**	**6,473**	**13,253**
Active	EPO	7,636	18,668	7,791	19,351
Retiree	EPO	1,190	1,611	1,237	1,688
University	EPO	4,158	8,680	3,736	7,889
COBRA	EPO	46	73	56	97
Active	PPO	1,493	3,625	1,167	2,727
Retiree	PPO	74	93	67	85
University	PPO	1,249	2,945	915	1,985
COBRA	PPO	22	43	22	47
Total Blue Cross Blue Shield AZ		**15,868**	**35,738**	**14,991**	**33,869**
Active	EPO	2,821	6,883	2,959	7,342
Retiree	EPO	564	752	605	798
University	EPO	1,420	3,058	1,389	3,004
COBRA	EPO	16	21	19	28
Total CIGNA		**4,821**	**10,714**	**4,972**	**11,172**
Active	EPO	16,240	39,637	17,659	43,252
Retiree	EPO	4,727	6,231	4,989	6,532
University	EPO	9,622	22,021	9,975	22,930
COBRA	EPO	83	129	99	156
Active	PPO	1,428	3,472	1,179	2,672
Retiree	PPO	96	126	93	114
University	PPO	1,208	2,717	984	2,130
COBRA	PPO	19	29	17	24
Total UnitedHealthcare		**33,422**	**74,362**	**34,995**	**77,810**
NAU only*	PPO	2,809	5,807	2,958	5,466
Total Blue Cross Blue Shield NAU		**2,809**	**5,807**	**2,958**	**5,466**
Total		**64,859**	**143,501**	**64,389**	**141,570**

Figure 2: Average Monthly Enrollment by Plan and Network

Medical Premiums

The tables below 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.

During the First Regular Session of the Fifty-third Legislature, a one-time infusion of $25M of General Fund was appropriated for the Active employer contribution rate in fiscal year (FY) 2018. This resulted in a 12.62% increase to the State (employer) portion of the medical premium. The rates for the first and second halves of PY 2018 are represented below. This increase did not apply to Retiree medical premiums. This one-time infusion expired at the end of FY 2018 and was replaced by another one-time infusion of 5.4% (as compared to FY 2017 active employer premium rate contribution) which is projected to bring in $31.2M, of which $15.6M falls into PY 2018.

Active rates effective 01/01/2018 through 06/30/2018 (last two quarters of FY 2018):

Active Medical Premiums per Pay Period (26 pay periods)*					
Plan	**Tier**	**Employee Premium**	**State Premium**	**Total Premium**	**State HSA Contribution**
EPO	Employee only	$20.31	$285.88	$306.19	-
	Employee + adult	$60.42	$587.38	$647.80	-
	Employee + child	$51.28	$381.54	$432.82	-
	Family	$112.20	$643.54	$755.74	-
PPO	Employee only	$51.78	$290.58	$342.36	-
	Employee + adult	$109.15	$614.42	$723.57	-
	Employee + child	$73.11	$411.15	$484.26	-
	Family	$127.43	$716.81	$844.24	-
HDHP	Employee only	$10.15	$193.38	$203.53	$27.69
	Employee + adult	$30.46	$400.77	$431.23	$55.38
	Employee + child	$25.89	$262.00	$287.89	$55.38
	Family	$56.35	$446.50	$502.85	$55.38

* University of Arizona has 24 pay period deductions

Figure 3: Active Medical Premiums per Pay Periods (26 pay periods) for 01/01/2018 through 06/30/2018

Active rates effective 07/01/2018 through 12/31/2018 (first two quarters of FY 2019):

Active Medical Premiums per Pay Period (26 pay periods)*					
Plan	Tier	Employee Premium	State Premium	Total Premium	State HSA Contribution
EPO	Employee only	$20.31	$267.56	$287.87	-
	Employee + adult	$60.42	$549.72	$610.14	-
	Employee + child	$51.28	$357.07	$408.35	-
	Family	$112.20	$602.26	$714.46	-
PPO	Employee only	$51.78	$271.94	$323.72	-
	Employee + adult	$109.15	$575.01	$684.16	-
	Employee + child	$73.11	$384.80	$457.91	-
	Family	$127.43	$670.85	$798.28	-
HDHP	Employee only	$10.15	$180.97	$191.12	$27.69
	Employee + adult	$30.46	$375.07	$405.53	$55.38
	Employee + child	$25.89	$245.18	$271.07	$55.38
	Family	$56.35	$417.88	$474.23	$55.38

* University of Arizona has 24 pay period deductions

Figure 4: Active Medical Premiums per Pay Period (26 pay periods) for 07/01/2018 through 12/31/2018

The PY 2018 Retiree premium rates increased 3% when compared to PY 2017 rates:

Retiree rates effective 01/01/2018 through 12/31/2018:

Monthly Retiree Medical Premiums				
	Without Medicare		With Medicare	
Plan	Tier	Premium	Tier	Premium
EPO	Retiree only	$652	Retiree only	$486
	Retiree +1	$1,526	Retiree +1 (Both Medicare)	$966
			Retiree +1 (One Medicare)	$1,126
	Family	$2,056	Family (Two Medicare)	$1,283
PPO	Retiree only	$908	Retiree only	$868
	Retiree +1	$2,210	Retiree +1 (Both Medicare)	$1,734
			Retiree +1 (One Medicare)	$1,914
	Family	$2,417	Family (Two Medicare)	$2,178

Figure 5: Monthly Retiree Medical Premiums

Medical Premium vs. Plan Cost

The PY 2018 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%. This ratio remains mostly unchanged from PY 2017 despite one-time increases to the employer portion of premiums. The overall premium revenue collected in PY 2018 was not sufficient to cover expenses in PY 2018 and the fund was not structurally balanced. The fund had a sufficient carry-over balance from prior years to cover all expenses in the fund in PY 2018, but not enough to cover the desired reserves of two times the IBNR.

The one-time employer premium FY 2018 infusion of 12.6%, effective in July 2017, generated an additional $38.2M of revenue to the HITF in PY 2018 (close to $76.4M annually by end of June 2018). This one-time infusion was rolled back and replaced by a new one-time FY 2019 infusion of 5.4%. This infusion is projected to bring in a total of $31.2M of which $15.6M took place in PY 2018. While this additional revenue improved the cash balance of the fund, it did not address the underlying structural shortfall for PY 2018. As mentioned previously, at the end of PY 2018, ADOA was short $62.6M (unrestricted balance) of the desired total reserve amount of $172.5M. Thus, additional premium and other plan changes were necessary for PY 2019.

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.

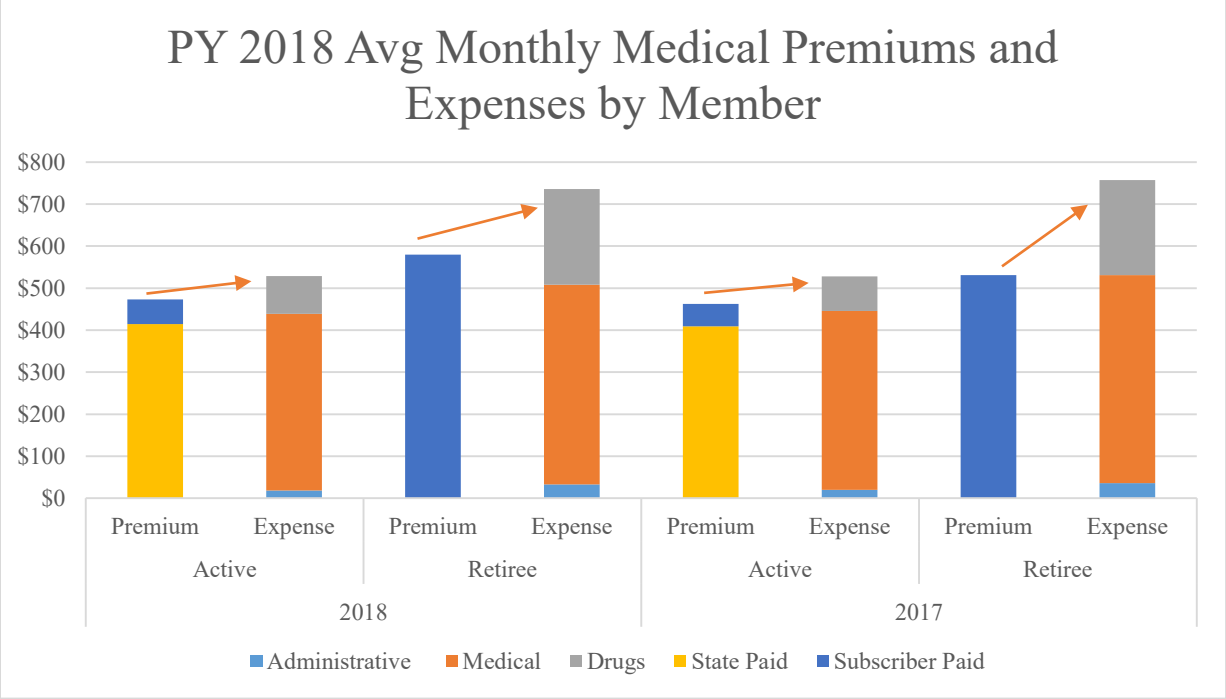


Figure 6: Average Monthly Medical Premiums and Expenses by Member

Expenses for Self-Insured Medical Plans

The figures below show the distribution of PY 2018 incurred claims (paid in PY 2018 through March of 2019) and other expenses paid/processed in PY 2018, and the average annual cost to insure each type of subscriber/member.

2018 Incurred and Paid Self-funded Medical Expenses by Active, Retiree, and Plan						
Expenses	**Overall**	**Active**	**Retiree**	**EPO**	**PPO**	**HDHP**
Medical Claims	$618,059,334	$571,874,446	$46,184,888	$528,251,434	$77,784,474	$12,023,426
Drug Claims	$188,500,460	$146,052,887	$42,447,573	$162,123,467	$23,303,301	$3,073,692
Medicare Part D Subsidy	($15,063,564)	$0	($15,063,564)	($13,170,468)	($1,893,097)	$0
Rebates & Recoveries	($12,004,717)	($9,301,428)	($2,703,288)	($10,324,889)	($1,484,079)	($195,749)
Administration Fees	$27,758,333	$24,676,364	$3,081,969	$23,527,098	$2,852,890	$1,378,345
Operating Expenses & Adj.	$4,753,042	$4,223,078	$529,964	$4,045,634	$490,573	$216,836
Total Expenses	$812,002,889	$737,525,347	$74,477,541	$694,452,277	$101,054,062	$16,496,549
IBNR Liability	$6,101,328	$5,645,402	$455,926	$5,214,767	$767,869	$118,692
Total	$818,104,217	$743,170,750	$74,933,467	$699,667,044	$101,821,931	$16,615,242
Enrollment in self-funded plans						
Subscribers	62,050	55,132	6,919	52,815	6,404	2,831
Members	137,694	128,534	9,160	116,440	14,876	6,378
Annual cost						
Per subscriber	$13,185	$13,480	$10,831	$13,248	$15,899	$5,870
Per member	$5,941	$5,782	$8,181	$6,009	$6,845	$2,605

Figure 7: 2017 Incurred and Paid Self-funded Medical Expenses by Active, Retire, and Plan

2018 Incurred and Paid Self-funded Medical Expenses by Plan for Active & Retiree						
		Active	**Active**	**Active**	**Retiree**	**Retiree**
Expenses (in dollars)	**Overall**	**EPO**	**PPO**	**HDHP**	**EPO**	**PPO**
Medical Claims	$618,059,334	$483,686,477	$76,164,543	$12,023,426	$44,564,957	$1,619,931
Drug Claims	$188,500,460	$121,725,028	$21,254,168	$3,073,692	$40,398,439	$2,049,133
Medicare Part D Subsidy	($15,063,564)	$0	$0	$0	($13,170,468)	($1,893,097)
Rebates & Recoveries	($12,004,717)	($7,752,100)	($1,353,579)	($195,749)	($2,572,789)	($130,500)
Administration Fees	$27,758,333	$20,531,215	$2,766,804	$1,378,345	$2,995,883	$86,086
Operating Expenses & Adj.	$4,753,042	$3,530,473	$475,770	$216,836	$515,161	$14,803
Total Expenses	$812,002,889	$621,721,093	$99,307,705	$16,496,549	$72,731,185	$1,746,357
IBNR Liability	$6,101,328	$4,774,833	$751,877	$118,692	$439,934	$15,992
Total	$818,104,217	$626,495,925	$100,059,583	$16,615,242	$73,171,119	$1,762,348
Enrollment in self-funded plans						
Subscribers	62,050	46,090	6,211	2,831	6,725	193
Members	137,491	107,456	14,566	6,309	8,914	246
Annual cost						
Per subscriber	$13,185	$13,593	$16,110	$5,870	$10,880	$9,120
Per member	$5,950	$5,830	$6,869	$2,634	$8,209	$7,164

Figure 8: 2017 Incurred and Paid Self-funded Medical Expenses by Plan for Active, Retiree

Medical Expenses Associated with Medical Diagnoses

The tables below show the trend in cost by diagnosis for Actives and Retirees. For Actives, the first ten categories make up approximately 78.3% ($448M) of the total PY 2018 medical spend. The top ten medical categories total spend for Actives have decreased by 1.6% (negative $7.1M) over PY 2017. Health Status and Contact with Health Service diagnosis group has experienced the largest percentage growth as well as spend growth for the Active population in PY 2018 over PY 2017 with 10.3% increase with a total growth in spend of $7.1M ($68.6M to $75.7M). Health Status and Contact with Health Service diagnosis group covers regular primary care physician visits, including OB/GYN, preventative services such as wellness (well-baby and well-child visits, routine vaccinations, screenings and tests) and certain specialist visits. Symptoms, Signs, and Ill-defined medical diagnosis group has experienced the largest percentage drop as well as spend drop from PY 2017 to PY 2018 of 11.4%, or negative $5.6M (from $49.5M to $43.9M).

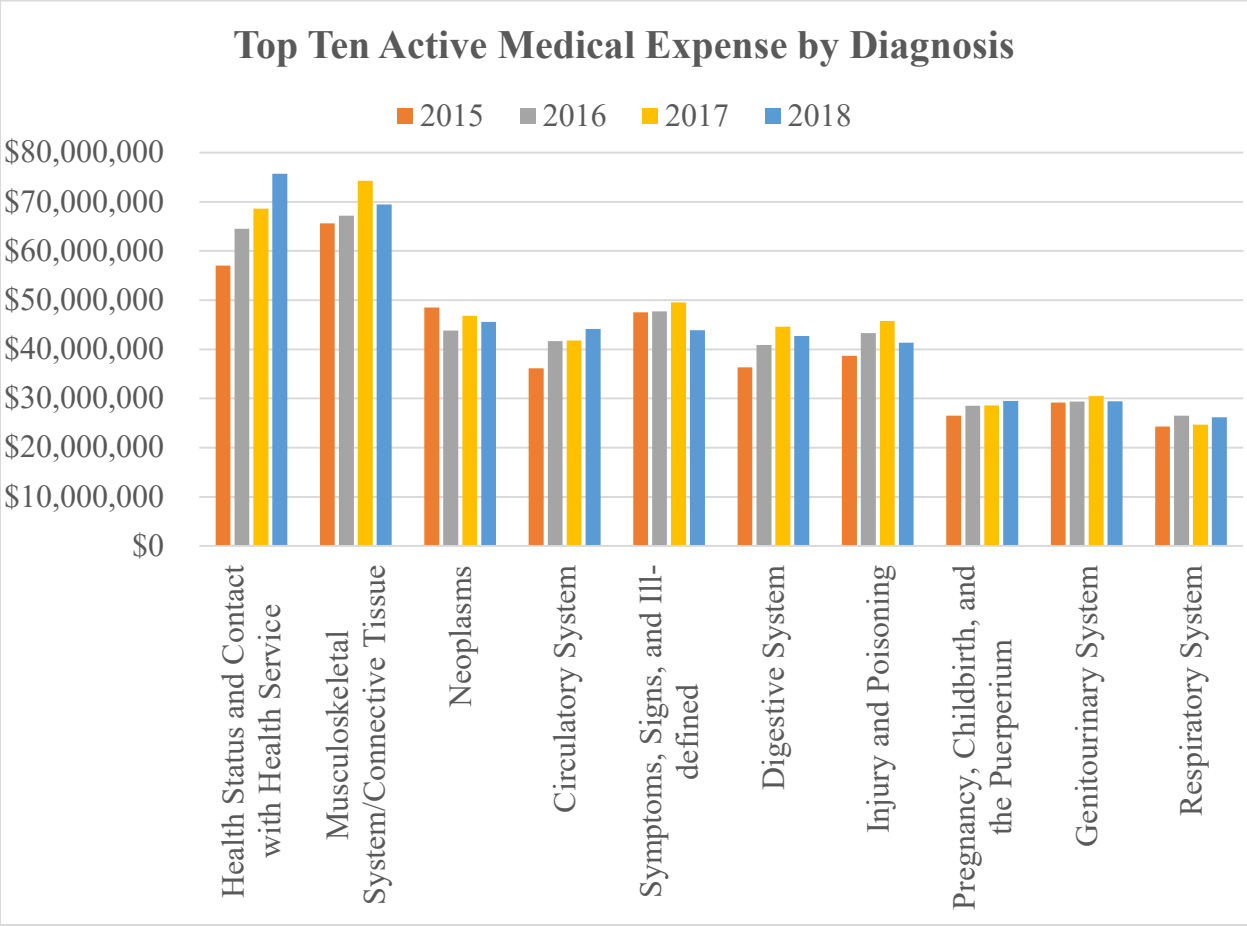


Figure 9: Top Ten Active Medical Expense by Diagnosis

For Retirees, spending on the top ten categories has decreased in PY 2018 over PY 2017 by 9.7% ($4.1M). The top ten categories make up approximately 81.6% ($37.7M) of the total PY 2018 Retiree medical spend. The Musculoskeletal System/Connective Tissue treatment group continues as the largest spend category for both the Active and Retiree populations. The highest percentage growth for the Retiree population was observed in the Circulatory System diagnosis group with 16.3% increase in expenditures PY 2018 over PY 2017. The largest spend increase of $810K (from $5M to $5.8M) occurred in the same diagnosis group. The largest percentage decrease of 31.9% was observed in the Health Status and Contact with Health Service diagnosis group. In addition, this group also had the largest spend decrease of $2M in PY 2018 as compared to PY 2017. The overall large spend decrease was caused, in part, by the drop in retiree enrollment in PY 2018 over PY 2017 and partially due to increases in PY 2018 copays that shifted costs from the plan to the member. Further, plan spend also decreased due to the decreases in utilization across most medical diagnoses.

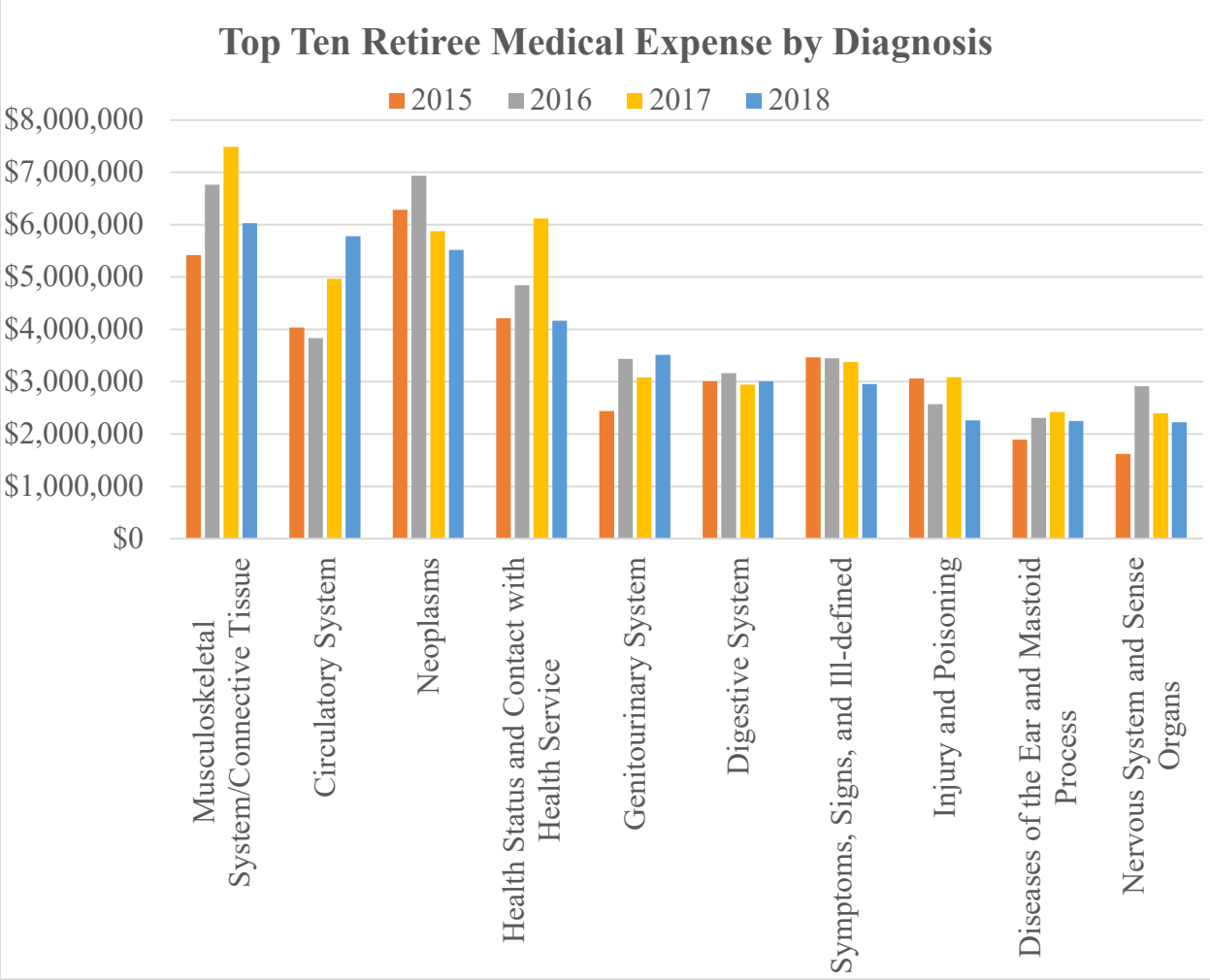


Figure 10: Top Ten Retiree Medical Expense by Diagnosis

Inpatient Hospital Care

Inpatient hospital care represents a significant portion of total medical expenses. Inpatient hospital care includes the cost of hospitalizations, skilled nursing facilities, and hospice. The tables below show the Hospital Admissions per 1,000 members and average length of stay. The Retiree population was, on average, admitted more times per member and for longer hospital stays than the Active population. When comparing plans, PPO members are admitted more often than EPO members, which are admitted more often than HDHP members are. This is in line with the average costs of these members in each plan. The length of stay has historically been similar between the EPO and PPO, while the Active employees in the HDHP tend to have a shorter length of stay. However, there has been a significant pick up in the length of stay for the HDHP population in PY 2018 that could be partially explained by more individuals signing up for the HDHP plan than ever before.

The number of hospital admissions for all populations is holding steady; however, the length of stay has seen a small, yet notable, increase for both the Active and Retiree populations in PY 2018 when compared to PY 2017. The number of hospital admissions for Retirees has decreased marginally while the hospital admissions for the Active population remained unchanged; a positive development.

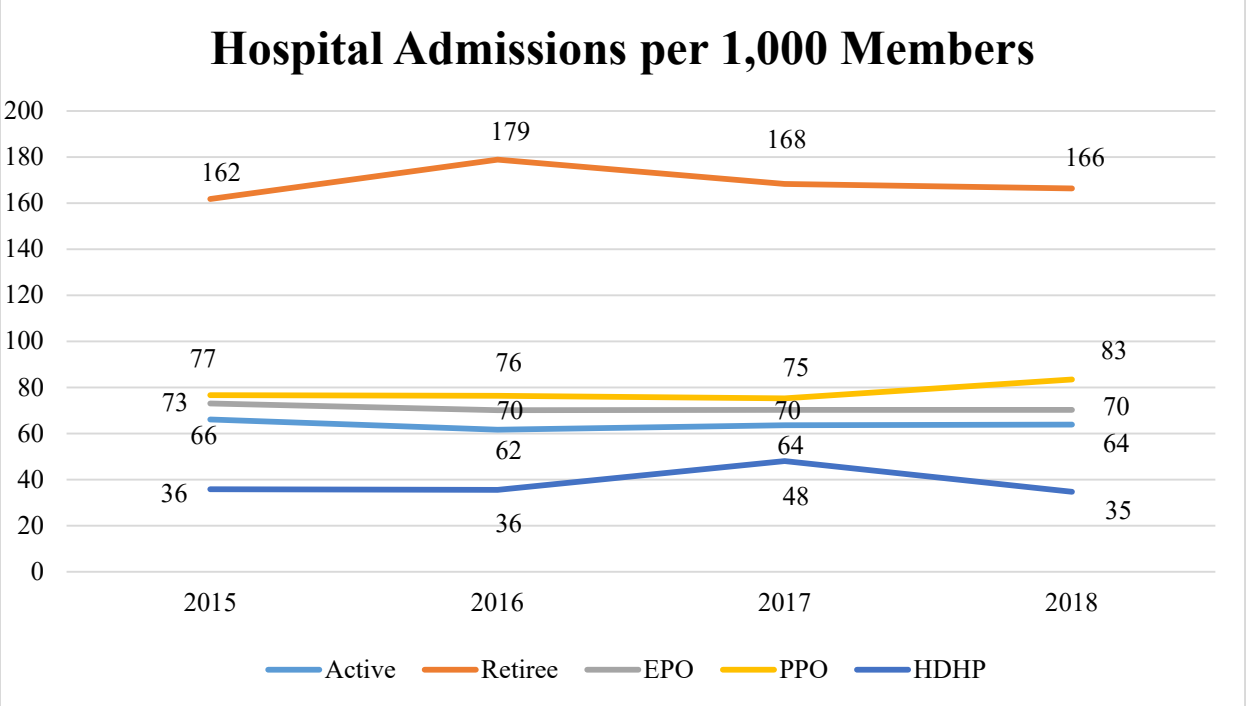


Figure 11: Hospital Admissions per 1,000 Members

The average inpatient length of stay for Active and Retiree populations has increased slightly for PY 2018 over PY 2017 and it is the highest it has been in the last four years. It ranged from 4.8 days in PY 2015 to 5.1 in PY 2018. It remains to be seen if this trend will hold in PY 2019. The Retiree population tends to have a significantly higher average inpatient length of stay than the Active population as older members tend to be diagnosed with more serious conditions that require longer treatment and thus longer hospital stays.

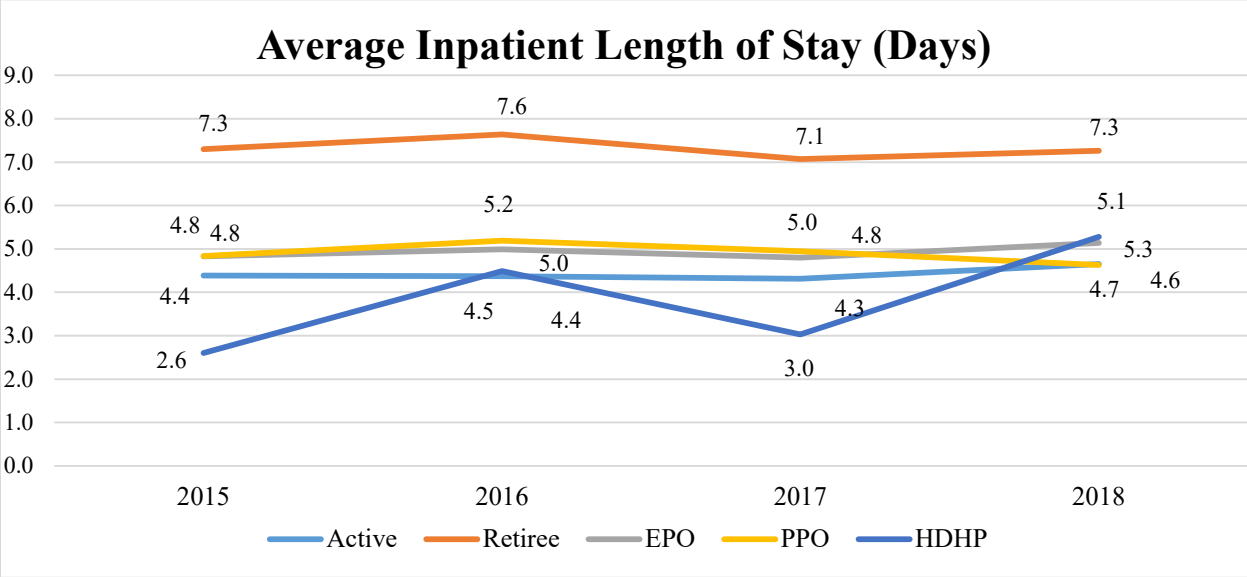
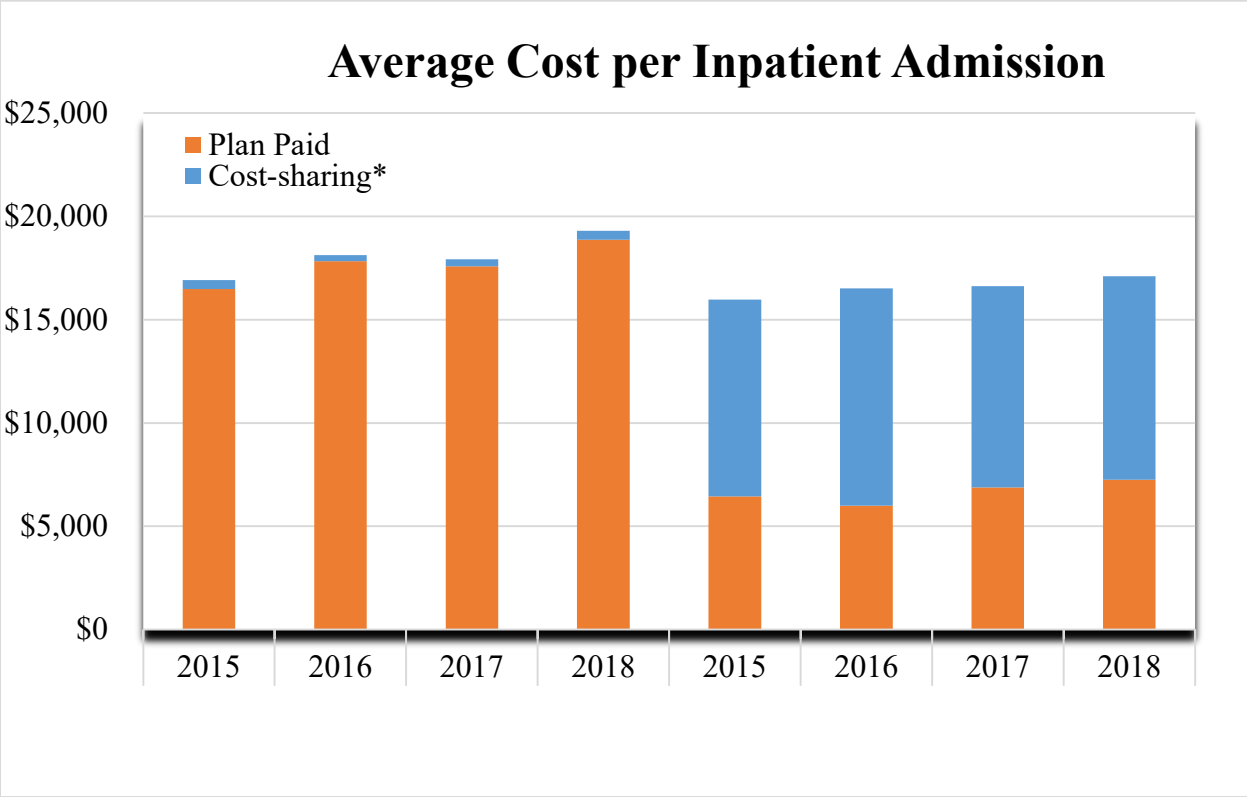


Figure 12: Average Inpatient Length of Stay

There is greater inpatient admission cost sharing with the Retirees because approximately two-thirds of Retirees have Medicare paying as primary for their claims. Overall, the Plan paid approximately 97.8% ($149.8M of $153.2M total) of Active inpatient costs and 42.4% ($11.3M of $26.7M total) of Retiree inpatient costs during PY 2018. This cost sharing experience has been nearly the same over the last four years for Active members, averaging 97.9%. For Retirees, the average cost share over the last four years is 40.1% and ranges between 36.3% in PY 2016 and 42.4% in PY 2018. The chart also indicates that the Retirees average cost per admission runs slightly less than for Actives. The cost per admission does include the cost of skilled nursing facilities, which Retirees use more frequently than Actives. This drives the cost per admission down since skilled nurse facility care is less expensive than traditional hospital stays. Often, retirees also require additional medical care following hospital admission, resulting in more frequent visits and therefore they overall are higher on a per member per month basis.



* Includes copay, coinsurance, Medicare, and other insurance

Figure 13: Average Cost per Inpatient Admission - Actives and Retirees

The average Per Member Per Month (PMPM) per hospital admission costs are displayed below. The PMPM cost is simply calculated by taking the total annual cost of all hospital admissions divided by the average medical membership and then divided by twelve (months). The chart indicates increasing PMPM costs for both Active and Retiree populations.

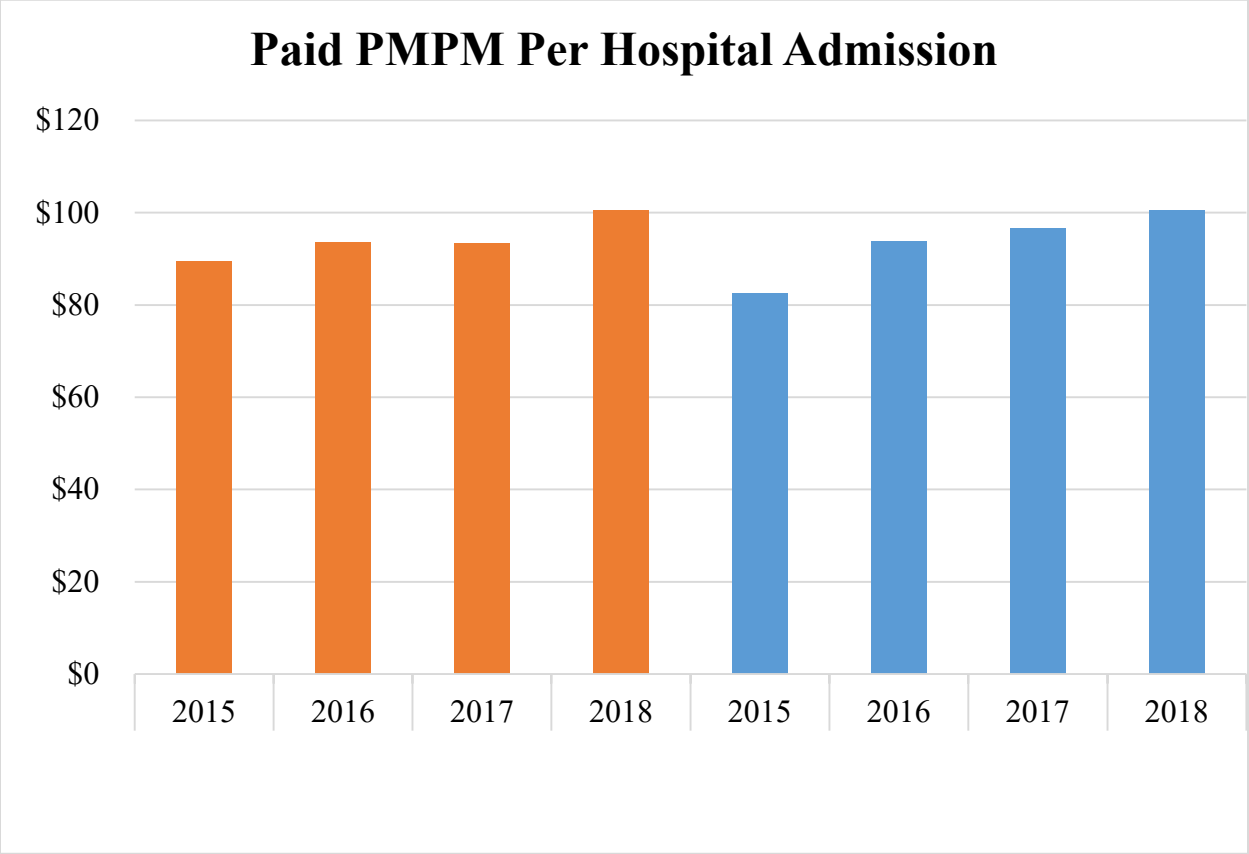
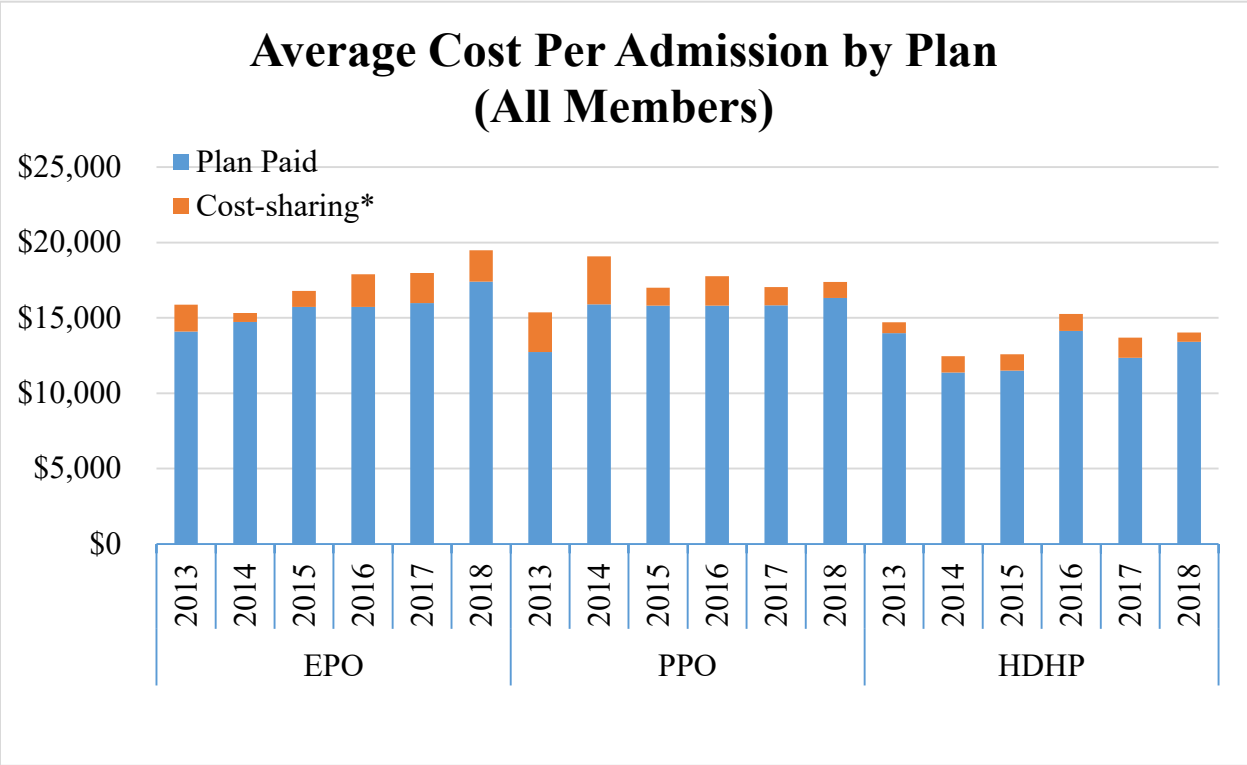


Figure 14: Plan Paid PMPM per Hospital Admission – Active and Retiree

Referencing the total cost share per admission by plan chart, below, greater average costs per admission costs were realized in the EPO and PPO plan than in the HDHP plan. This is partly due to Retirees not being eligible for the HDHP. During PY 2018, the Plan paid approximately 89% ($149.9M of $167.9M total) of EPO, 93% ($11.8 M of $12.6 M total) of PPO, and 96% ($1.1M of $1.2M total) of HDHP inpatient costs during PY 2018.



* Includes copay, coinsurance, Medicare, and other insurance

Figure 15: Average Cost per Admission – EPO, PPO, and HDHP

Place of Service

The figures below show the total cost by place of service for Active and Retirees over the past four years. The Inpatient setting continues to be the highest cost driver for the Active population while the Outpatient setting is the top place of service for the Retiree population with Inpatient setting close behind. Pharmacy costs, if they were to be included as one of the categories, would fall into one of the top three places of service for both the Active and Retiree populations.

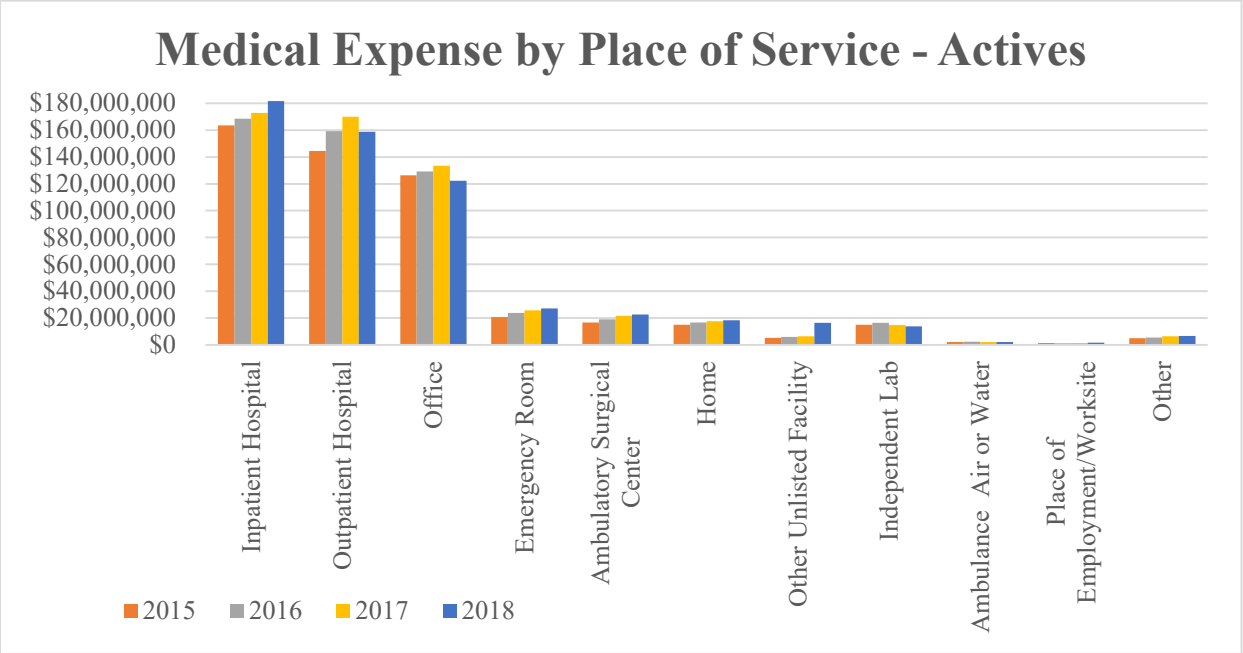


Figure 16: Medical Expense by Place of Service – Actives

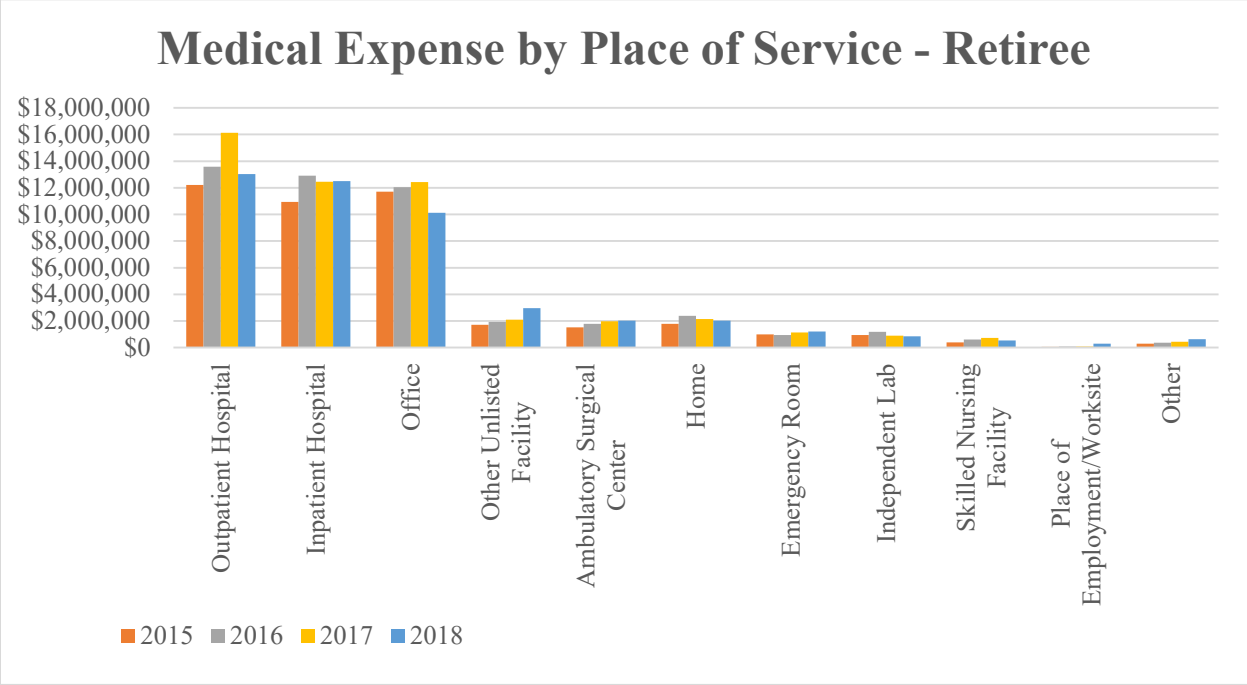


Figure 17: Medical Expense by Place of Service – Retirees

Emergency Services

During PY 2018, there were approximately 189 emergency room visits per 1,000 members of the self-funded plan.

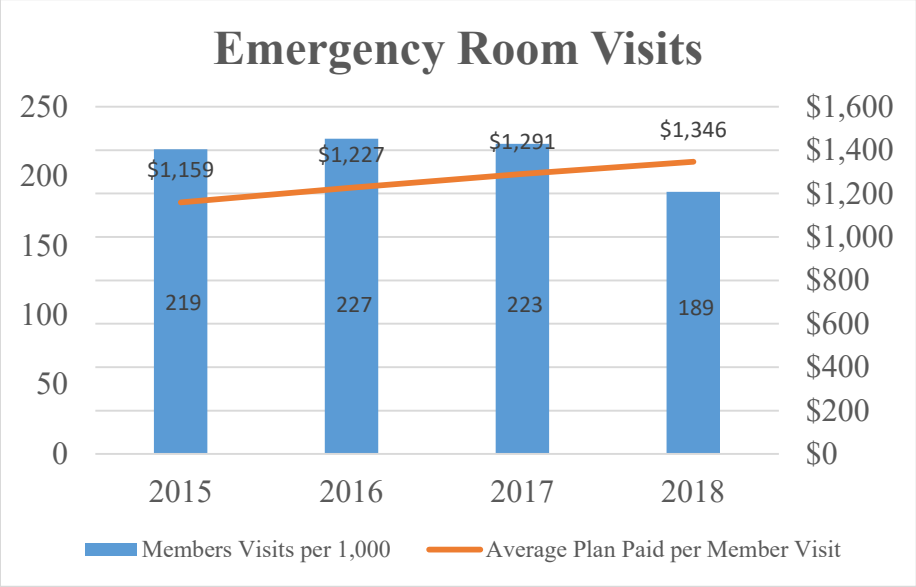


Figure 18: Emergency Room Visits

This represents a notable decrease over the PY 2017 number of member visits per 1,000, which was 223. The average plan cost per visit was $1,346 (inclusive of both facility and professional costs), higher than in the previous three years where the average plan paid per member visits ranged between $1,159 and $1,291 in costs. To drive down the non-emergent utilization of emergency rooms, the Benefit Services Division has implemented several initiatives in PY 2018. Specifically – members were awarded Health Incentive Plan (HIP) points for downloading Doctor on Demand, a telemedicine application, and had the chance to participate in a prize drawing for a Fitbit Flex. The decrease in emergency room visits can be directly attributed to increased telemedicine utilization. In addition, the increased emergency room copays have further driven the decrease in utilization of emergency room services, steering members to utilize alternative and less costly service such as convenience care/walk-in clinics, urgent care, virtual visits, and primary physician offices.

Urgent Care Visits

During PY 2018, there were approximately 171 urgent care visits per 1,000 members of the self-funded plan, which represents a significant drop over the previous three years.

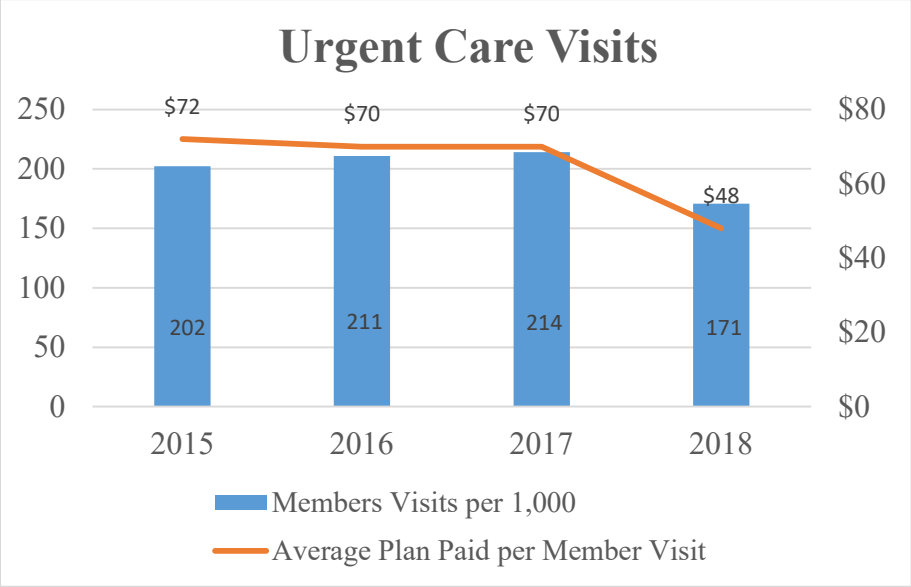


Figure 19: Urgent Care Visits

The average of the previous three plan years was 209 urgent care visits per 1,000 members while the average for PY 2018 was 171. The average plan costs per urgent care visit was $48 in PY 2018. That is a notable drop over the previous three years whose average has held steady around $70 per visit. The copays on urgent care visits increased from $40 to $75 per visit in PY 2018. The copay increases had a major downward effect on member utilization of services, as well as on the average cost of urgent care visits. The higher copays resulted in higher employee cost share while decreasing the costs to the plan.

Physician Visits

During PY 2018, there were approximately 3,763 physician visits per 1,000 members of the self-funded plan, or each member of the plan visited a physician's office close to four times a year on average.

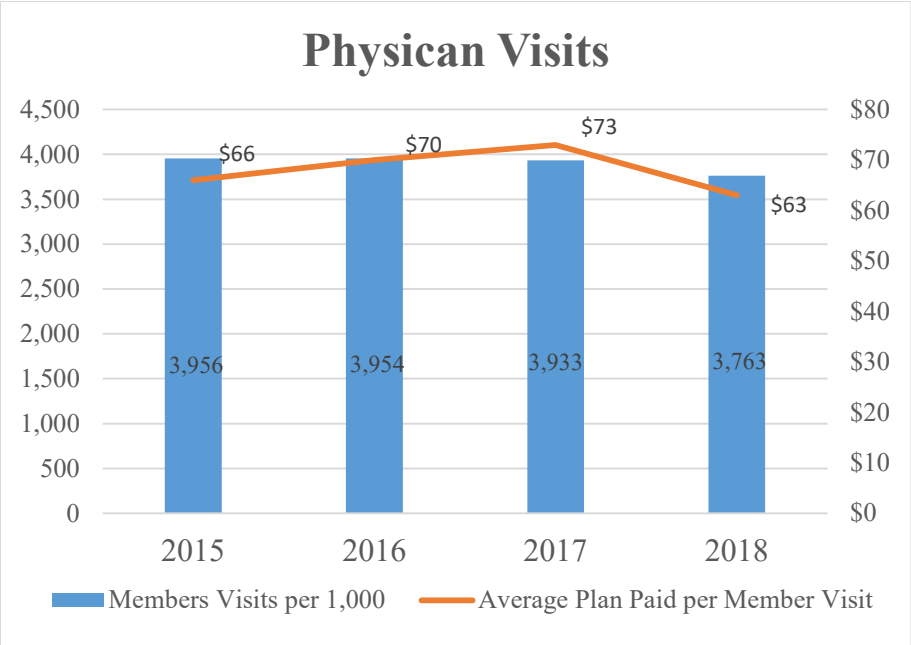


Figure 20: Physician Visits

Utilization in PY 2018 was lower than in the prior three years where it ranged between 3,933 in PY 2017 and 3,956 in PY 2015. ADOA is having difficulties understanding this new trend as preventative care visits were covered at no costs in PY 2018 and thus is closely monitoring the situation. The average plan costs per office visit in PY 2018 was $63, the lowest of the past four years with PY 2017 being the highest at $73.

Annual Prescription Use

The table below shows the average number of prescriptions filled by active and retiree members and by total of all members, including those that did not utilize the pharmacy benefit at all during the year. The retirees fill prescriptions on average three times the amount of prescriptions than the actives. The chart shows a downward trend for both the active and the retiree populations PY 2018 over PY 2017 and PY 2017 over PY 2016. The notable decrease in the utilization of drugs for PY 2018 over PY 2017 can be attributed to increased copays that went into effect in PY 2018 as well as to lower retiree membership when compared to PY 2017.

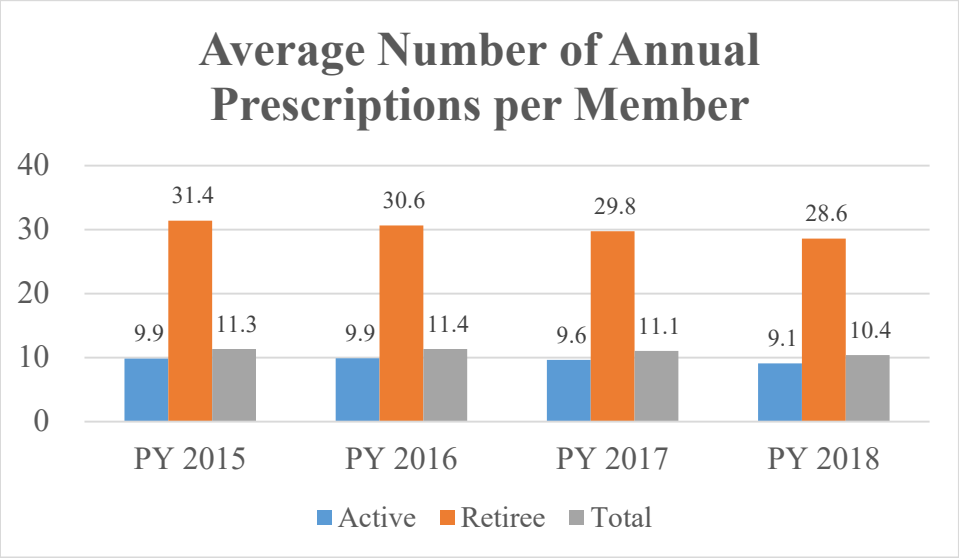


Figure 21: Average Number of Prescriptions per Member

The cost of an average prescription refill is higher for the retiree group than for actives. The cost of each refill has been increasing rapidly for both the active and retiree populations over the last four years. ADOA research has found that there has been no significant increase in research and development activities over the last several years. The main takeaway from the research is that increases in prices of brand-name drugs were largely driven by year-over-year price increases of drugs that were already on the market. The drug price increases were the result of lack of competition (many name-brand medications are protected against generic competitors due to patents), mergers and acquisitions in the pharmaceuticals industry, and only partially due to high costs of newly developed specialty drugs. According Health Affairs magazine study published in January 2019, older name-brand drug prices increased close to 9% annually, far exceeding inflation rates. Interestingly, even prices of generic drugs have risen between 4% - 7% in the analysis.

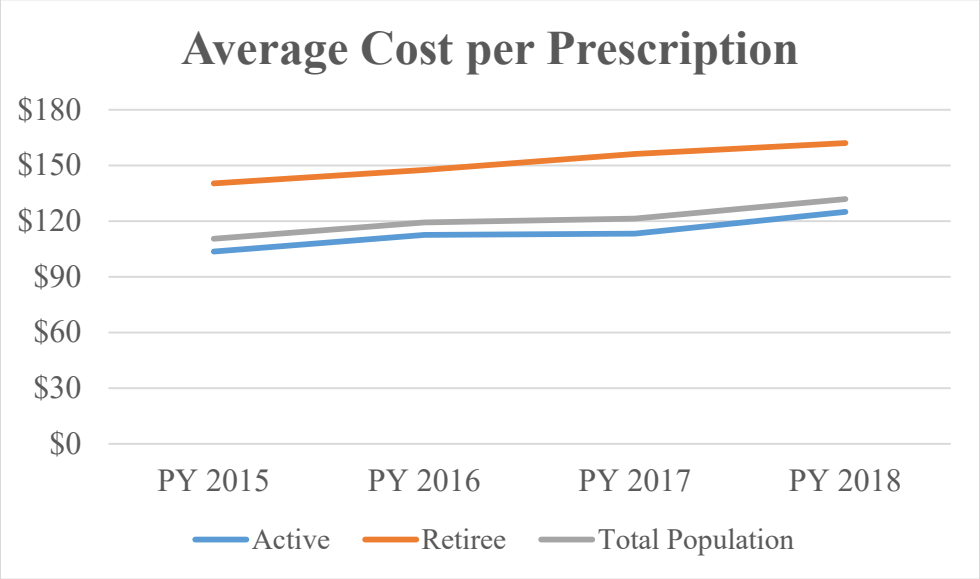


Figure 22: Average Cost per Prescription

While the average number of prescriptions per member per year has been decreasing over the last few years, the annual cost per utilizing member is mostly steadily increasing. This indicates an increasing overall cost in the pharmacy benefit.

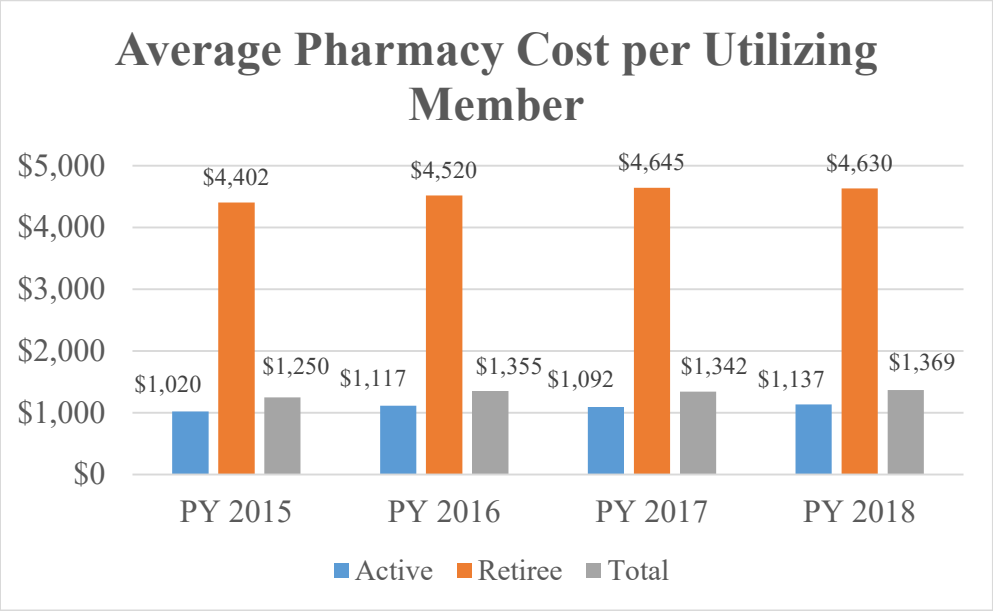


Figure 23: Average Pharmacy Cost per Utilizer

Generic and Brand-name Prescription Utilization

The table below shows a positive trend in the utilization of lower cost drugs up until PY 2017. However, in PY 2018 there has been an uptick in the utilization of tier 2 and tier 3 drugs. Generic (Tier 1) drugs tend to have the lower overall cost to the plan, preferred name-brand drugs (Tier 2) have a higher cost to the plan, and non-preferred brand name drugs (Tier 3) tend to have the highest cost to the plan.

MedImpact is the name of the drug provider for all of our medical plans. MedImpact works with a committee of doctors and pharmacists to compile the Plan's formulary which is essentially a list of medications itemized by the three drug tiers. The "Benefit Options Formulary" is the name of our Plan's formulary and its goal is to provide the most clinically effective drugs at the lowest cost.

A generic drug is a drug that is comparable to a brand name/reference listed drug product in dosage form, strength, route of administration, quality and performance characteristics, and intended use. Generic drugs are usually referred to by its chemical name and are made available on the market when a patent protection on the brand name drug expires. The major difference between a generic drug and brand name drug is the price. It is important to note that generic drugs are just as safe and effective as name brand drugs.

The non-preferred brand name drugs are name brand drugs that cost significantly more than preferred name-brand drugs and therefore require higher co-pays. Further information regarding the full formulary, please visit https://benefitoptions.az.gov/employees/pharmacy.

Although not readily apparent from the chart, the overall number of written prescriptions decreased PY 2017 over PY 2016 and then again in PY 2018 over PY 2017. In fact, the total number of prescriptions/scripts was lowest in PY 2018 when examining usage over the last four years.

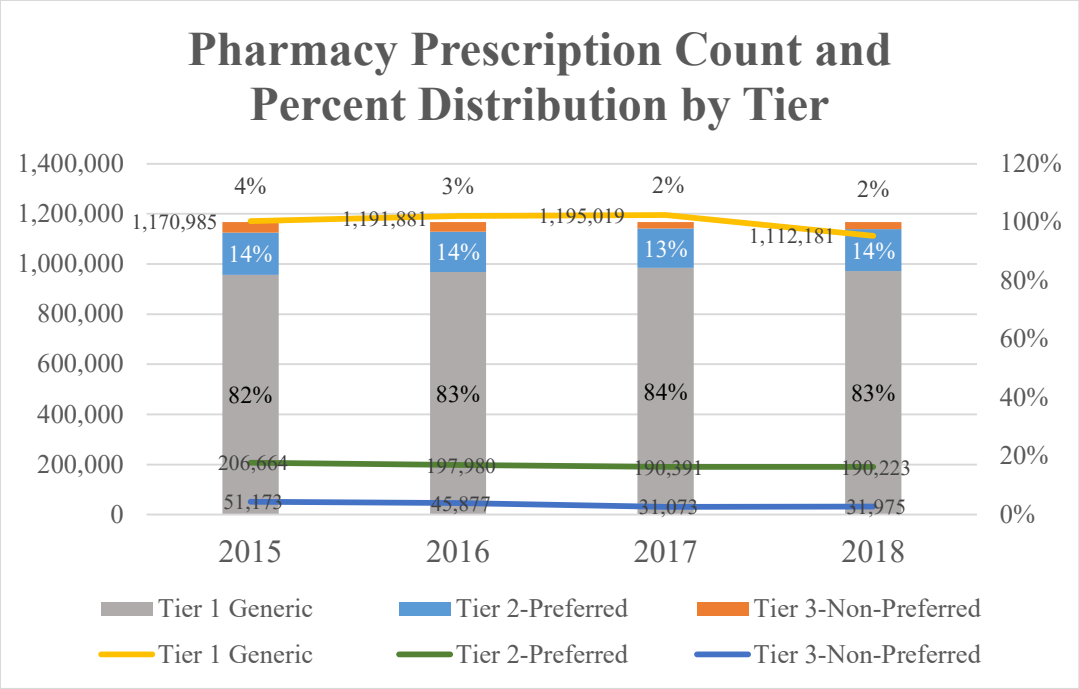


Figure 24: Pharmacy Count and Distribution by Tier

Prescription Spend by Therapeutic Class

The following graph shows spend by therapeutic class by year. The expenditures on the top ten therapeutic classes have steadily been increasing over the last four years in line with total pharmacy spent. The top ten therapeutic classes comprise 62% ($120.5M out of $188.5M) of total pharmacy spent in PY 2018. In PY 2018, the plan has seen the hematological agents class making it into the top ten therapeutic classes by spent, while displacing the ADHD/anti-narcolepsy/anti-obesity therapeutic class. In six out of the top ten classes, expenses have increased PY 2018 over PY 2017. Diabetes and inflammatory disease continue be the highest therapeutic class cost driver. Even though the top ten therapeutic classes have seen an increase, the remaining drug classes have seen slight decreases or minor increases, which explains the relatively small increase in total pharmacy spent PY 2018 over PY 2017.

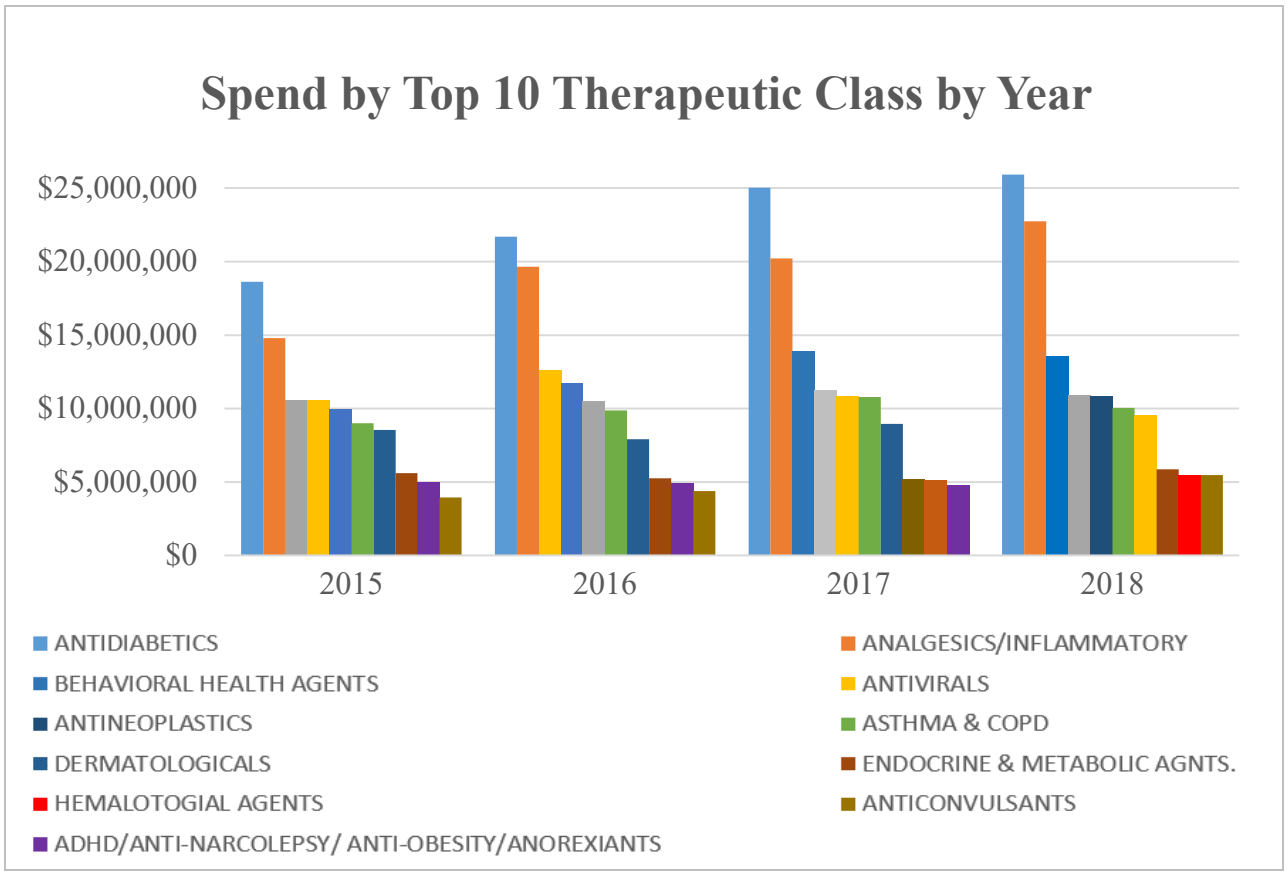


Figure 25: Prescription Spend by Top 10 Therapeutic Class by Year

Prescription Spend by Type of Drug

The graph below shows spend for top ten drugs by year. In almost all of the top ten drugs, expenses have increased. The top ten drugs make up approximately 19.4% ($36.5M) of the total PY 2018 spent, which is slightly up from the prior year of 16.2%. The top two drugs in PY 2018 are the Humira Pen, a drug to treat inflammation, and Revlimid, which is prescribed to treat certain cancers. Trulicity, a diabetes drug, and Truvada, an antiviral prescribed to help reduce the risk of getting HIV-1 through sex, or reduce the amount of virus in an already infected patient, made it into top ten prescriptions in PY 2018. Januvia, an antidiabetic, and Copaxone, a multiple sclerosis drug, are no longer on the top ten list.

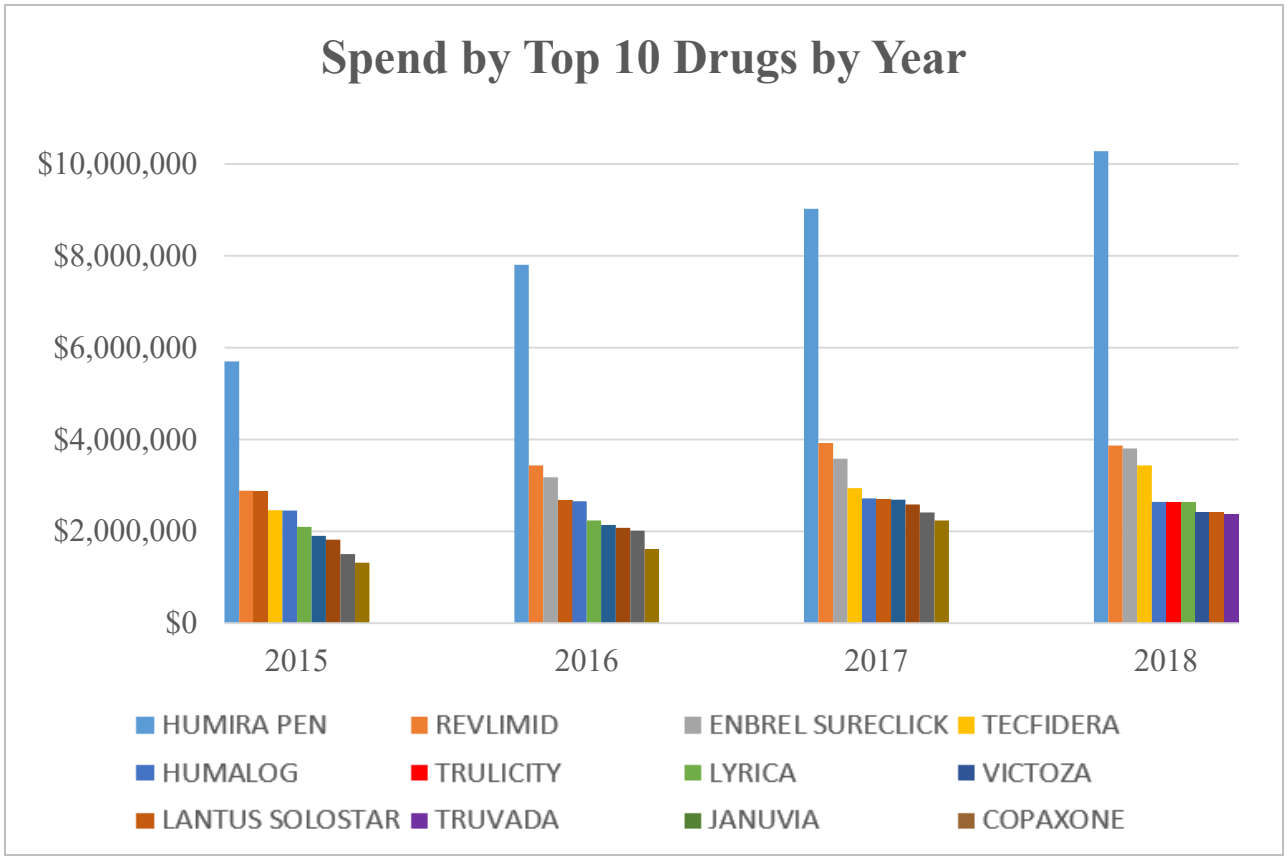


Figure 26: Spend by Top 10 Drugs by Year

Dental Plan Enrollment

In PY 2018, Benefit Services Division offered two different types of dental plans: a fully insured Dental Health Maintenance Organization (DHMO) plan administered by Cigna Dental and a self-insured Dental Preferred Provider Organization (DPPO) plan administered by Delta Dental. Cigna Dental became the fully-insured DHMO vendor in PY 2018, replacing Total Dental Administrators (TDA).

DHMO Plan
Within the DHMO plan, services must be obtained from a participating dental provider (PDP). There are no annual deductibles or out of pocket maximums. The plan coverage maximums include a $200 maximum reimbursement for non-PDP emergency services, $50 for emergency services less member cost share for the service.

DPPO Plan
Within the DPPO plan, services may be obtained from any dentist and deductibles and out-of-pocket maximums 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. Delta Dental administers this plan. 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.

In PY 2018, the total dental enrollment increased slightly by about 0.5%. We are seeing a significant movement from the Delta Dental plan to the Cigna Dental, most likely due to the difference in pricing between the two plans.

Average Monthly Dental Enrollment by Plan					
		2018		2017	
Network	Plan Type	Subscribers	Members	Subscribers	Members
Active	DPPO	20,415	48,596	22,224	52,866
Retiree	DPPO	14,676	23,256	15,009	23,768
University	DPPO	16,535	34,916	15,465	33,420
COBRA	DPPO	191	297	205	308
Total Delta Dental		**51,817**	**107,065**	**52,902**	**110,361**
Active	DHMO	11,403	27,192	9,686	22,658
Retiree	DHMO	2,348	3,594	2,485	3,797
University	DHMO	5,967	12,586	6,216	12,976
COBRA	DHMO	74	127	69	121
Total Cigna Dental		**19,792**	**43,500**	**18,456**	**39,552**
Total		**71,609**	**150,564**	**71,358**	**149,913**

Figure 27: Average Monthly 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	$1.64	$2.29	$3.93
	Employee + adult	$3.29	$4.58	$7.87
	Employee + child	$3.08	$4.58	$7.66
	Family	$5.46	$6.32	$11.78

Figure 28: Active Dental Premiums per Pay Period (26 pay periods)

Retiree Monthly Dental Premiums		
Plan	**Tier**	**Premium**
DPPO (Delta Dental)	Employee only	$35.94
	Employee + adult	$75.63
	Employee + child	$60.48
	Family	$118.26
DHMO (Cigna Dental)	Employee only	$8.52
	Employee + adult	$17.04
	Employee + child	$16.59
	Family	$25.54

Figure 29: Retiree Monthly Dental Premiums

Dental Premium vs. Plan Cost

Cigna Dental replaced Total Dental Administrators (TDA) as the DHMO plan in PY 2018. Cigna Dental's premiums in PY 2018 were lower than TDA's in PY 2017 while offering broader range of services at comparable or lower costs. The Active members on the DPPO plan are paying 88% of the average monthly premium while the state paid the remaining 12%. The figure below shows how the average monthly premium compares to the average monthly plan cost for Active employees and Retirees and their dependents (Active and Retiree members) in the DPPO plan.

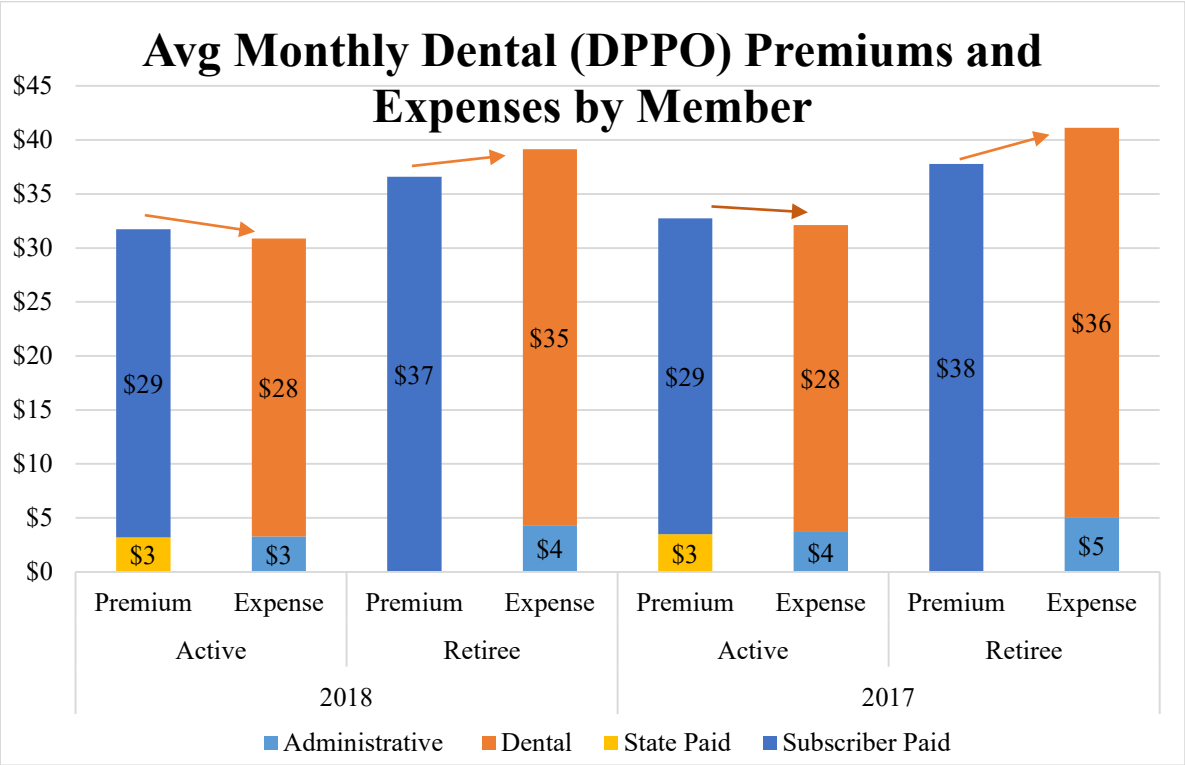


Figure 30: Average Monthly Dental Premiums and Expenses by Member

Expenses for Self-Insured Dental Plan

The figure below show the distribution of claims and expenses incurred in PY 2018 and the average annual cost to insure each type of subscriber/member.

2018 Self-Insured Dental Expenses by Active, Retiree			
Expenses	**Overall**	**Active**	**Retiree**
Dental Claims	37,462,721	$27,748,068	$9,714,653
Rebates & Recoveries	$0	$0	$0
Administration Fees	$1,262,072	$904,619	$357,453
Operating Expenses & Adj.	$221,782	$158,967	$62,815
Total Expenses	**$38,946,575**	**$28,811,655**	**$10,134,920**
IBNR Liability	$3,039,000	$2,250,941	$788,059
Total	**$41,985,575**	**$31,062,596**	**$10,922,979**
Enrollment in self-funded plans			
Subscribers	51,817	37,141	14,676
Members	107,065	83,809	23,256
Annual cost			
Per subscriber	$810	$836	$744
Per member	$392	$371	$470

Figure 31: Self-Insured Dental Expenses by Active and Retiree

Wellness

Benefit Services Division provides wellness programs and services to Active State employees. Members have access to preventive health screenings, health management and health education webinars and courses, annual flu vaccines, online lifestyle management programs, onsite seminars, activity challenges 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. For PY 2018, the program ran between January and December of 2018. The program launched a new web portal to allow employees to engage in preventive services and healthy activities throughout the full year. The mission of the HIP is to promote prevention for early detection and defense against chronic disease thereby encouraging employees to engage in health management programs to reduce risks, change behaviors that lead to healthy outcomes, and to foster 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 a $200 incentive payout which was paid out in the spring of 2019.

Engagement and Incentives

The PY 2018 chart below shows that of the 55 thousand eligible members, there were 2,981 new employees enrolled in 2018 in addition to the 10,970 employees enrolled in 2017, totaling 13,951 or 25% of the eligible population. Of those that enrolled in the HIP program, 6,889 completed the online Health Assessment, which translates to a 49% completion rate.

The number of enrolled participants that actively logged points was 8,799 (or 63%). Out of the 5,542 participants logging 500 points, 4,353 were validated and earned the $200 incentive for an estimated payout of $871k (31% of total enrolled). This represents an increase of 51% over PY 2017. Of total eligible employees, 7.9% earned the incentive.

By providing the HIP incentive component, the year over year participation metrics showed an increase in employee engagement and in overall active participation in preventive services, screening referrals, health assessment completion, and educational/behavior change and challenge activities.

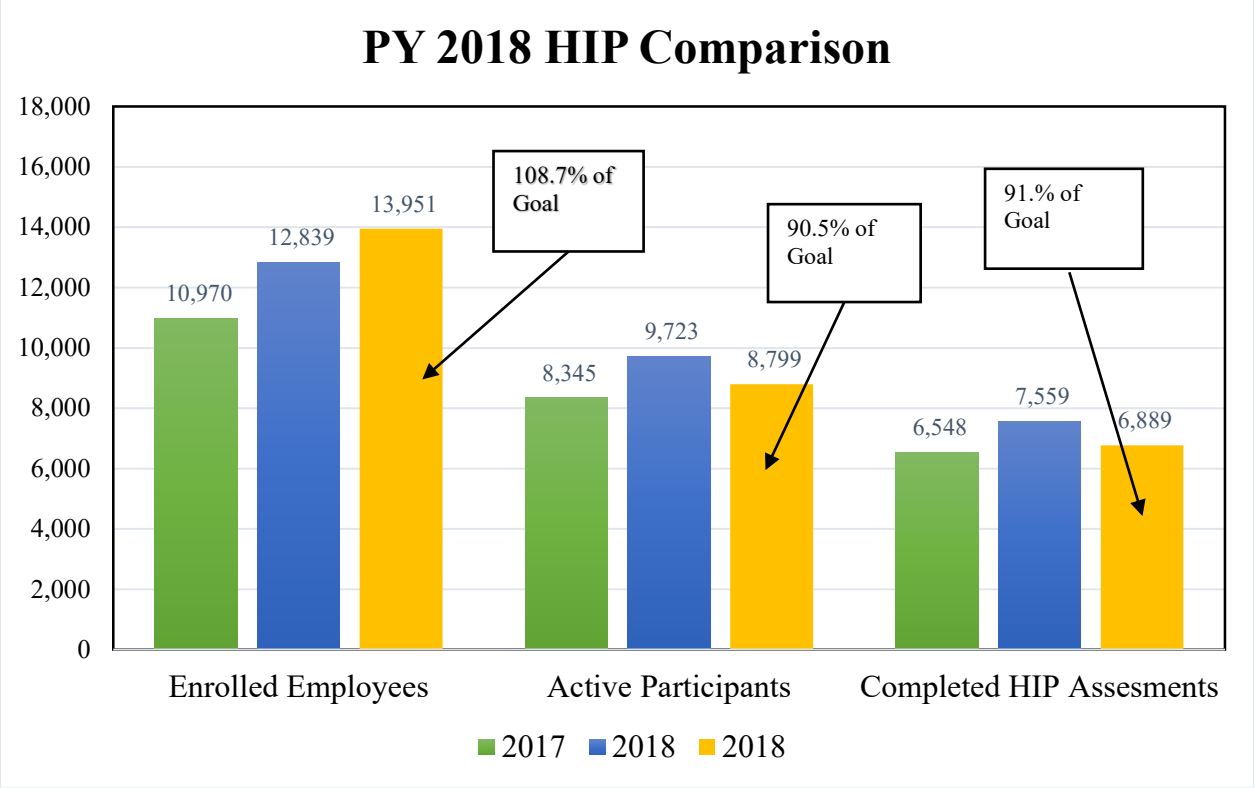


Figure 32: HIP Participation Comparison

Screening Utilization

The table below depicts the total utilization of core health screening benefits during PY 2018. The number of at-risk employees referred to follow-up care slightly increased by nine over PY 2017 ending with 686 referrals in PY 2018. For the first time, ADOA collaborated with the Arizona State University College of Health Solutions - Speech and Hearing Clinic to offer hearing screening at five agency locations with 600 participants.

PY 2018 Screenings			
	Events	**Participants**	**Referrals**
Mini Health Screening*	123	4,596	
Osteoporosis Screening**		1,739	361
Prostate Specific Antigen (PSA)**		581	30
Hemoglobin A1C **		1,930	249
Hearing Sreenings	5	600	0
Mobile Onsite Mammography	63	942	13
Prostate Onsite Projects	49	400	**33**
Total	**240**	**10,788**	**686**

*The base Mini Health Screening includes: fill lipid panel, fasting blood glucose, blood pressure, BMI, and body composition measurements.

** Additional tests offered as a package with the basic Mini Health Screening for those meeting specific age requirements.

Figure 33: Screening Utilization

The table below shows the total utilization for the PY 2018 State Wellness Annual Flu Vaccine Program held September 1, 2018 through December 31, 2018. 15,559 vaccines were administered to Active and Retiree members at 400 events held at various locations throughout the state. Close to 95% of members who received a flu vaccine, did so at a worksite or open enrollment clinic. The plan costs of the PY 2018 State Wellness Annual Flu Vaccine Program totaled $370K, which comes out to an average of $25 per participant. To contrast, 32,775 members and their dependents received flu vaccines through the medical plans in PY 2018 at a cost of $704K at an average cost of $22 per participant.

PY 2018 Flu Vaccines		
	Locations	**Participants**
State Agency Worksite	184	7,149
University Worksite	28	5,763
Combined Worksite (Wesley Bolin)	3	902
Open Enrollment Clinics	10	953
Public Clinics	175	792
Total	**400**	**15,559**

Figure 34: Flu Vaccines

As per Passport Health USA (see link below), each year 5% to 20% of the U.S. population gets the flu. Adults 18-64 years of age accounted for almost 60% of reported flu hospitalizations. The result is lost employee productivity, an increase in absenteeism, and costly medical bills. Per the Passport Health USA portal calculator, the estimated medical savings are $3.2M. Taking into account the cost of administering the flu vaccines program of $467K and vaccines paid via medical vendors $705K, the estimated medical net cost avoidance is $2M or an ROI close to 3:1 (https://www.passporthealthusa.com/employer-solutions/flu-roi-calculator/).
This calculation does not include the cost of absenteeism.

Employee Assistance Program

The table below shows the utilization for the Employee Assistance Program (EAP) and support services offered to agencies covered under the Benefit Services Division. The provider of EAP services is ComPsych, Inc., world's largest provider of employee assistance programs servicing more than 45 thousand organizations and 100M individuals. The total EAP utilization rate for PY 2018 reached 40.1%, constituting an increase over PY 2017 utilization level of 37.2%. Utilization is indicating sustained high usage especially when compared to the 24% national standard for government entities. Moreover, Benefit Services Division covered agencies also continue to show utilization higher than ComPsych's Book of Business. The PY 2018 contract increased the number of visits from 6 - 12 per issue, per person/year. It also increased the hours available for employee visits for those impacted by trauma or Post Traumatic Stress Disorder (PTSD).

PY 2018 EAP Utilization			
	Eligible Population	**Users**	**Utilization Rate**
Live Telephonic Access		**3,251**	
EAP		2,637	
FamilySource		121	
FinancialConnect		116	
LegalConnect		377	
Online Access		**9,328**	
EAP		2,265	
FamilySource		2,359	
FinancialConnect		1,018	
GlobalConnect		10	
Health & Wellness		836	
LegalConnect		2,840	
Critical Incident Stress Debriefing		**326**	
Trainings		**2,007**	
Overall Utilization	**37,153**	**14,912**	**40.1%**

Figure 35: EAP Utilization

In addition to health screenings, vaccines, and EAP services, the strategic plan for PY 2018 continued to provide employees with increased access to online mindfulness and stress reduction by enhancing the options for participation in the sessions also through ComPsych, Inc.

PY 2018 Webinars through ComPsych		
	Classes	**Participants**
1-hr Webinars	15	1,851

Figure 36: Online Webinar 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 2018 for 2018 incurred revenues and expenditures as well as for prior plan years. In PY 2018, the life and disability insurance services were provided by Hartford Life and Accident Insurance Company, while vision benefits were offered through Avesis Third Party Administrators, Inc. (Avesis) and dependent and flexible spending account services through Application Software, Inc. (ASIFlex). The fund's ending cash balance is significantly lower when compared to PY 2017 due to a $2.5M fund sweep completed during PY 2018.

FUND 3035 CASH RECONCILIATION

ERE/Benefits Administration Fund Summary				
				Plan Year 2018
Beginning Fund Balance January 01, 2018				**$4,189,161**
Revenues				
Insurance Product	**Amount**			
Basic Life	$1,177,607			
Supplemental Life	8,088,295			
Dependent Life	2,840,744			
Short Term Disability	4,692,683			
Long Term Disability	3,528,778			
Total Life & Disability			**$20,328,107**	
Vision	5,548,978		**5,548,978**	
Health Care FSA	$5,500,939			
Dependent Care FSA	1,888,604			
Total Flex Spending			**$7,389,544**	
Total Revenues				**$33,266,629**
Expenditures				
Insurance Product	**Amount**	**Penalties**		
Basic Life	$1,185,585	(3,257)		
Supplemental Life	8,305,222	(29,825)		
Dependent Life	2,847,632	(7,844)		
Short Term Disability	4,686,155	(13,122)		
Long Term Disability	3,561,330	(10,111)		
Other Operating Costs	879	-		
Total Life & Disability*			**$20,522,644**	
Vision*	5,576,962	(53,848)	**$5,523,114**	
Health Care FSA	5,029,830	-		
Dependent Care FSA	1,777,027	-		
Administrative Fees*	209,213	-		
Other Operating Costs	351	-		
Total Flex Spending			**$7,016,421**	
Fund Sweep	$2,500,000		**$2,500,000**	
Total Expenditures	**$35,680,185**	**(118,006)**		**$35,562,179**
Ending Fund Balance December 31, 2018				**$1,893,610**

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

Figure 37: 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 several 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 2018. 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 2018 will be approximately $165,100. Those performance measure penalties will be processed during PY 2019.

Aetna

Performance Measures	
Performance Measure	Fees At Risk
Total Performance Measures = 190 Targets successfully met = 179 Targets missed resulting in penalties = 11 Targets Pending = 1	Approximately $24,454

Performance Measures Not Met		
Performance Measure	Fees At Risk	Total % Assessed
Appeals – At least 95% of urgent pre-service appeals are resolved within 15 calendar days of receipt; post-service appeals resolved within 30 days.	1.50% of Total Administrative Fee	Missed 1 of 12 months measured = 0.125%
Claims – Processing Turnaround Time: At least 98% of all fully-documented claims will be processed within 30 calendar days of receipt	1.00% of Total Administrative Fee	Missed 3 of 12 months measured = 0.24%
Claims – Processing Accuracy: At least 98% of claims will be processed accurately	1.00% of Total Administrative Fee	Missed 1 of 12 months measured = 0.08%

Performance Measures Not Met		
Performance Measure	Fees At Risk	Total % Assessed
Customer Service – Quality Member Phone Services: Aetna will provide phone service to members with no more than 3% abandonment rates and average speed to answer of 30 seconds or less.	1.50% of Total Administrative Fee	Missed 4 of 12 annual measurement = .5%
Reporting – Timeliness: Agreed upon reporting packages must be submitted within stated timeframes.	1.00% of Total Administrative Fee	Missed 1 of 12 annual measurement = .083%
Case Management and Disease Management – Quality Nurse Phone Line: Aetna will provide Nurse Line phone service to members with no more than 5% abandonment rate and an average speed to answer of 45 seconds or less.	1.00% of CM/DM Administrative Fee	Missed 1 of 12 annual measurement = .083%

Figure 38: Performance Measures – Aetna

Cigna

Performance Measures	
Performance Measure	Fees At Risk
Total Performance Measures = 200 Targets successfully met = 181 Targets missed resulting in penalties = 12 Targets Pending = 4	Approximately $12,938

Performance Measures Not Met		
Performance Measure	Fees At Risk	Total % Assessed
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 = 0.3125%
Claims – Processing Accuracy: At least 99% of claims will be processed accurately	1.34% of Total Administrative Fee	Missed 5 of 12 months measured = 0.335%
Reporting – Timely Reporting: Agreed upon reporting packages (identified on the Report Index) must be submitted within stated timeframes.	1% of Total Administrative Fee	Missed 2 of 12 months measured = 0.16%

Figure 39: Performance Measures – Cigna

UnitedHealthcare

Performance Measures	
Performance Measure	Fees At Risk
Total Performance Measures = 200 Targets successfully met = 191 Targets missed resulting in penalties = 2 Targets Pending = 5	Approximately $8,424

Performance Measures Not Met		
Performance Measure	Fees At Risk	Total % Assessed
Claims – Overall Accuracy Rate: At least 99% of all claims will be processed accurately	.50% of Total Administrative Fee	Missed 1 of 12 months measured = 0.041%
Customer Service – 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.	50% of Total Administrative Fee	Missed 1 of 12 months measured = 0.041%

Figure 40: Performance Measures – UnitedHealthcare

Blue Cross Blue Shield (BCBS) of Arizona

Performance Measures	
Performance Measure	Fees At Risk
Total Performance Measures = 200 Targets successfully met = 187 Targets missed resulting in penalties = 8 Targets Pending = 5	Approximately $21,295

Performance Measures Not Met		
Performance Measure	Fees At Risk	Total % Assessed
Financial Accuracy (Dollar Value) – Processing accuracy: At least 98% of claims dollars submitted for payment will be accurately processed and paid (financial accuracy will be based on an audit sample of ADOA specific claims).	1.00% of Total Administrative Fee	Missed 1 of 12 measured = 0.083%
Claims – Processing accuracy: At least 99% of all claims will be processed accurately	1.00% of Total Administrative Fee	Missed 4 of 12 measured = 0.33%
Reporting - Timeliness: Agreed upon reporting packages (identified on the Report Index) must be submitted within stated timeframes.	.50% of Total Administrative Fee	Missed 1 of 12 measured = 0.0416%

Case Management and Disease Management – Quality Nurse Line Phone Services: 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 CM/DM Administrative Fee	Missed 2 of 12 measured = 0.166%

Figure 41: Performance Measures – Blue Cross Blue Shield of Arizona

MedImpact

Performance Measures	
Performance Measure	Fees At Risk
Total Performance Measures = 109 Targets successfully met = 107 Targets missed resulting in penalties = 2 Targets Pending =1	Approximately $13,250

Performance Measures Not Met		
Performance Measure	Fees At Risk	Total % Assessed
Network – Mail Order and Specialty Audits: All Mail Order and Specialty pharmacies with a claims count greater than 100 claims per month will be audited at least 1x/year.	$7,000 annual amount at risk	Missed 1 of 1 annual measurement = $7,000
Generic Substitution / Utilization – Utilization Increase: Guaranteed percentage increase in generic utilization on a plan year basis. At least 1.0% annual increase in generic utilization.	$25,000 quarterly	Missed 1 of 4 quarterly measurements = $6,250

Figure 42: Performance Measures – MedImpact

Delta Dental

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

Performance Measures Not Met		
Performance Measure	Fees At Risk	Total % Assessed
N/A	N/A	N/A

Figure 43: Performance Measures – Delta Dental

Cigna Dental

Performance Measures	
Performance Measure	Fees At Risk
Total Performance Measures = 120 Targets successfully met = 120	No penalties

Performance Measures Not Met		
Performance Measure	Fees At Risk	Total % Assessed
N/A	N/A	N/A

Figure 44: Performance Measures – Cigna Dental

ComPsych

Performance Measures	
Performance Measure	Fees At Risk
Total Performance Measures = 39 Targets successfully met = 38 Targets missed resulting in penalties = 4	Approximately $10,728

Performance Measures Not Met		
Performance Measure	Fees At Risk	Total % Assessed
Account Management/Customer Service-Abandonment Rate: Less than 3% of calls abandoned. This is a Customer Service metric for the Guidance Resources Unit (GRU) only.	3.00% of Total Administrative Fee	Missed 3 of 4 quarterly measured= 2.25%
Surveys – Member Satisfaction: At least 90% of those responding to the survey indicate a level of satisfaction on the Member Survey	2.00% of Total Administrative Fee	Missed 3 of 4 quarterly measured = 2.25%

Figure 45: Performance Measures – ComPsych

Telligen

Performance Measures	
Performance Measure	Fees At Risk
Total Performance Measures = 50 Targets successfully met = 50 Targets missed resulting in penalties = 0	No penalties

Performance Measures Not Met		
Performance Measure	Fees At Risk	Total % Assessed
N/A	N/A	N/A

Figure 46: Performance Measures – Telligen

Avesis

Performance Measures	
Performance Measure	Fees At Risk
Total Performance Measures = 182 Targets successfully met = 177 Targets missed resulting in penalties = 5	Approximately $73,986

Performance Measures Not Met		
Performance Measure	Fees At Risk	Total % Assessed
Account Management - Satisfaction Survey: 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 Administrative Fee	Missed 1 of 1 annual measurement = 1.00%
Customer Service - Answer Time: 90% of phone calls requesting a member services representative will be answered in 30 seconds or less.	1.00% of Total Administrative Fee	Missed 4 of 12 measured = 0.33%

Figure 47: Performance Measures – Avesis

Application Software, Inc. - ASI

Performance Measures	
Performance Measure	Fees At Risk
Total Performance Measures = 49 Targets successfully met = 49	No penalties

Performance Measures Not Met		
Performance Measure	Fees At Risk	Total % Assessed
N/A	N/A	N/A

Figure 48: Performance Measures – ASI

The Hartford

Performance Measures	
Performance Measure	Fees At Risk
Total Performance Measures = 141 Targets successfully met = 141	No penalties

Performance Measures Not Met		
Performance Measure	Fees At Risk	Total % Assessed
N/A	N/A	N/A

Figure 49: Performance Measures – The Hartford

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 2018, four 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 2018 plan year is shown below including recommendations made, implemented recommendations, identified savings, and health plan recovery dollars. Two completed audit projects for the 2018 plan year identified no exceptions or dollars for recovery, and three recommendations to be implemented. Two very complex audits that began in PY 2017 were completed in PY 2018. These audits identified 103 claim exceptions, a total of $1,660 in savings to the plan, and 30 recommendations.

The reporting year for implementation of recommendations and health plan recoveries for completed audits will vary based on the vendor's completion date of all corrective action plan directives. The directives include vendor impact reports to determine pending recovery dollars (amounts will be greater than savings identified during the audit because of audit scope period limitations). In many cases, directives are still in progress and may roll over to a new plan year. Recoveries are based on the completion of a corrective action plan that includes impact reports to identify affected claims and dollar error amounts, claims reprocessing/adjustments, and/or payments directly from the vendor.

Recommendations	Implemented Recommendations	Identified Savings	Recovery Dollars	Pending Recovery
33	3	$1,660	Unknown	Unknown

Figure 50: Audit Recommendation Implementation and Recoveries 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 and other projects were completed, and were not limited to the following functional areas:

Functional Area	Audit Methodology
Vendor operating transactions and controls	Statement on Standards for Attestation Engagements No. 16 Audits (SSAE 16) Evaluation of external audit results
Vendor execution of benefit design and contract elements	Medicare coordination of benefits compliance Plan deductibles Claims adjudication compliance Inquiries (e.g. research, plan coverage design, etc.)
ADOA accuracy of shared data	Dependent Eligibility Audits (DEA)
Audit program improvement initiatives	Administrative functions and program-specific improvements

Figure 51: 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 or semi-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 by Audit Services. 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.

Vendor Execution of Benefit Design and Contract Elements
The Medicare Coordination of Benefits audit was large in scope and designed to evaluate many components of vendor contract compliance with the health plan and Medicare standards:

- Plan allowances and exceptions to evaluate the contracted vendors' systems set up for correctness and compliance with the health plan's benefit design
- The accuracy of plan limitations and restrictions to determine that members received the benefits allowed to them as defined in the plan description
- Claims adjudication compliance to evaluate the contracted vendors' adherence to regulatory guidelines, healthcare industry standards, current operating standards, contractual elements, vendor performance and/or plan authorization documents
- Claims adjudication to determine the appropriate application of the plan and Medicare deductibles, Medicare primary and plan secondary payments, and member coinsurance and co-payments

The 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, however, the co-payment for ten claims was incorrectly applied. Other claim errors were found based on several factors: system set up errors, incorrect Medicare allowed and paid amounts in comparison to Medicare Explanation of Benefits documents, and data fields that were not calculated as required or incorrectly merged prior to the vendor's electronic claim file submissions to Benefit Services Division.

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 address, specifically, the identified exception. There were no additional exception-based audits performed during the 2018 plan year.

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 no ineligible dependents were enrolled in the plan. Dependents of all

subscribers who left State service, turned 26 years old, or obtained other insurance, had benefits timely and appropriately terminated.

Audit Program Improvement Initiatives

In addition to the regularly scheduled audits, reviews, and evaluations listed above, Audit Services continued assisting in the performance of user acceptance testing of a recently implemented claims data warehouse tool. Claims paid on behalf of the health plan members are loaded into the MedInsight data warehouse tool. The tool provides standard health plan reporting in addition to a query tool that is user friendly. Claims data is easily extracted based on selected parameters to accommodate audit objectives and scope.

Audit Services continues to strive towards improvement and efficiency; the focus during the 2018 plan year was to streamline administrative functions to improve audit program initiatives.

Appendix

Special Employee Health Fund Cash Statement

Special Employee Health Fund Cash Statement

Plan Year 2018				
Beginning Fund Balance January 01, 2018				**$151,250,435**
Revenues				
Source	**Premiums**			
ADOA Health Plan (EE)	$144,085,167			
ADOA Health Plan (ER)	647,888,014			
BCBS NAU Plan (EE)	9,254,252			
BCBS NAU Plan (ER)	33,215,798			
ADOA Dental Plan (EE)	28,713,813			
ADOA Dental Plan (ER)	13,429,022			
PrePaid Dental Plan (EE)	1,466,497			
PrePaid Dental Plan (ER)	2,120,513			
Other Revenue	65,976			
Net Revenue	**$880,239,052**			**$880,239,052**
Expenditures				
Vendor	**Admin Fees & Other Ins. Related Charges**	**Penalties**		
Aetna	3,737,057	(53,884)		
Blue Cross Blue Sheild AZ	7,141,160	(99,479)		
Cigna	2,642,049	-		
UnitedHealthcare	12,445,716	(30,675)		
MedImpact	1,656,597	(541,338)		
HSA Funding (EE and ER)	19,943	-		
Delta Dental	1,262,072	-		
HIP Payout	564,008	-		
ACA Related Taxes/Fees	258,648	-		
AG Collection Fees	18,531	-		
Net Administrative Fees*	29,745,781	(725,376)	29,020,405	
	Claims	**Recoveries****		
Aetna	57,327,985	-		
AmeriBen	-	(651,624)		
Blue Cross Blue Shield AZ	160,549,961	(654,391)		
Cigna	50,431,902	(636)		
UnitedHealthcare	367,805,471	(375,999)		
MedImpact	161,188,484	(10,322,066)		
Medicare Part D Retiree Drug Subsidy	33,063,400	(15,063,564)		
Delta Dental	37,553,248	-		
Other Wellness	800,970	-		
Net Claims	868,721,421	(27,068,281)	841,653,140	
Self-Insured Expenditures	**898,467,202**	**(27,793,656)**	**$870,673,545**	
	Premiums	**Penalties**		
BCBS (NAU Only)	42,241,687	-		
Cigna Dental, Total Dental Administrators	3,757,432	(68,495)		
Fully Insured Expenditures	**45,999,119**	**(68,495)**	**45,930,624**	
HITF Operating	$4,934,591	-		
Fund Transfers Out***	990	-		
Administrative/Cash Adjustments	40,233	-		
Operating Expenes and Transfers	**$4,975,814**	**$0**	**$4,975,814**	
Net Expenditures and Transfers	**$949,442,134**	**($27,862,151)**		**$921,579,983**
Ending Fund Balance December 31, 2018				**$109,909,504**
IBNR Liability (Medical & Dental)				$86,257,000
Contingency Reserve (Medical & Dental)				$86,257,000
Unrestricted Cash Balance As Of December 31, 2018				**($62,604,496)**

* Vendor administrative fees and fully insured premiums are paid 55 days in arrears per contract.
** Recoveries include Medicare Part D Retiree Drug Subsidy reimbursement, prescription drug rebates, overpayment recoveries (including stop payments and voids), claims audit recoveries and subrogation recoveries.
*** Fund transfers from HITF to other State funds.

Figure 52: Special Employee Health Fund Cash Statement

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.

Brand-name drug - Prescription drugs are drugs that marketed with a specific brand name by the company that manufactures it, usually the company which develops and patents it. When patents run out, generic versions of many popular drugs are marketed at lower cost by other companies. Under our Plan, these drugs can also be referred to as Tier 2 drugs.

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 – A child or a spouse of the employee who meets the conditions established by the relevant plan description.

Dental Health Maintenance Organization (DHMO) – A dental plan that offers members dental services with no annual maximums or claim forms, and services based on a discounted rate. Cigna Dental was the PY 2018 DHMO dental vendor.

Dental Preferred Provider Organization (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, a person who works for the State of Arizona or a State university.

Employer 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.

Generic Drug –A drug product that is comparable to a brand/reference listed drug product in dosage form, strength, method of administration, quality and performance characteristics, and intended use. The major difference between a generic drug and brand name drug is the price. Most generic drugs cost on average 70% to 90% less than brand name drug. Generic drugs are oftentimes sold under the chemical name of a drug. Under our Plan, generic drugs can also be referred as Tier 1 drugs.

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 coinsurance and higher annual deductibles than traditional plans. Out-of-network providers require greater coinsurance.

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 deductible health plans are HSA-eligible.

Inpatient admissions per 1,000 members – The number of hospital admissions for every 1,000 members. An admission can be more than one day.

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 eligible employee, Retiree, spouse, or dependent.

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

Per Member Per Month (PMPM) – Refers to the average cost per member per month. The PMPM is calculated by dividing the total paid claims for a particular month by the number of members covered that month or alternatively, by taking the total annual costs divided by average monthly membership divided by twelve (months).

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 copayments, or coinsurance, and annual deductibles. Out-of-network providers require greater copays.

Premium – The agreed-upon fees paid for medical insurance coverage. Both the employer and the health plan member pay premiums.

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.