



State of Arizona

# 2006 Annual Check-Up Benefit Options Annual Report

The State of AZ/AA/EOE/ADA Reasonable Accommodation Employer

© Copyright 2006 ADOA, State of Arizona. All Rights Reserved.

**Janet Napolitano**  
Governor

**Benefit Options**  
Choice. Value. Health.

**William Bell**  
Director, Department of Administration

## FORWARD

Benefit Options is the name for the various insurance benefits offered to Arizona State employees by the State of Arizona. This report was prepared to give a broad overview of Benefit Options.

The data shown in the report were gathered from contractors participating in the Benefit Options insurance programs. This report was compiled to meet the requirements of A.R.S. § 38-652 (G).

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

Benefit Options  
Department of Administration  
100 N. 15<sup>th</sup> Avenue  
Suite 103  
Phoenix, Arizona 85007

Telephone: 602-542-4788

Fax: 602-542-4048

GLOSSARY OF TERMS .....	1
BACKGROUND.....	4
Contribution Strategy .....	5
HEALTH BENEFITS PROGRAM AND ENROLLMENT .....	8
Program Structure .....	8
ADOA Benefits Options Operations Diagram .....	9
Integrated Option .....	10
Integrated Structure:.....	10
Non-Integrated Option .....	11
Non-Integrated Structure.....	11
DEMOGRAPHICS OF ENROLLED HEALTH PLAN MEMBERS .....	12
Total Statewide Enrollment .....	12
Membership by Health Plan .....	12
Family Coverage Status .....	12
Gender Status .....	12
Health Plan Membership Enrollment by Network.....	13
Age and Salary Distribution of Enrolled State Employees .....	15
Health Plan Demographics .....	16
Dependents per Employee By Plan .....	17
PLAN YEAR CLAIMS AND COST INFORMATION .....	19
Total Paid Claims.....	19
Total Net Health Plan Costs.....	20
Per Capita Costs - Members vs. Retirees.....	22
Claim Appeals.....	23
Eligibility Appeals.....	23
Paid Claims by Type of Service - Top 5.....	24
State and University Employees .....	24
Retirees.....	25
Hospitalizations.....	26
Annualized Number of Admits per 1000.....	26
Average Length of Stay.....	26
Annualized Hospital Days per 1000 .....	27
Average Paid per Day in Hospital .....	27
Per Member per Month Cost .....	28
Emergency Room Visits.....	29
Emergency Room Visits by Diagnosis.....	29
Paid Claims by Top 5 Diagnoses.....	30
State and University Employees .....	30
Retirees.....	31
Pharmacy Utilization and Costs .....	31
Pharmacy Utilization and Costs .....	32
Average Pharmacy Claims Costs:.....	32
Number of Prescriptions Filled: .....	32
Number of prescriptions per eligible and utilizing members: .....	32
Utilization demographics: .....	32
Top 10 Drugs by Frequency of Usage and Cost.....	33

Utilization by Formulary Tier .....	35
Specialty Drug Utilization and Cost.....	35
DENTAL PLANS .....	36
Prepaid Plans - Employers Dental Services (EDS) and Assurant.....	36
Indemnity/PPO Plans - Delta Dental and MetLife Dental.....	36
Demographics of Enrolled Dental Plan Members .....	36
Total Statewide Dental Enrollment .....	37
Membership by Dental Plan .....	37
Family Coverage Status .....	37
Dental Plan Membership by Network.....	38
State and University Dental Rates .....	39
Retiree Dental Rates.....	39
DEMOGRAPHICS OF ENROLLED VISION PLAN MEMBERS .....	40
Total Statewide Vision Enrollment .....	40
Family Coverage Status.....	40
Short-Term Disability .....	41
Average Number of Claims per Month.....	41
Number of Claims 2006 Plan Year .....	41

## GLOSSARY OF TERMS

The following terminology will be used in this report:

Administrative Fees -- Fee paid to third 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, MA and NY surcharges, bank reconciliation fees.

Case Management -- A process whereby aligns treatments to a patient's needs to achieve the optimal outcome at the minimal cost.

Claim -- A provider's demand upon the payer for payment for medical services or products.

Claim Appeal -- A request for a review of the denial of coverage for a specific medical procedure contemplated or performed.

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

Contribution Strategy -- A premium structure that includes both the employer's financial contribution and the employee's financial contribution towards the total plan cost.

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

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

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

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

Eligibility Appeal -- A request for a review of the denial of coverage relating to a claimant's entitlement to benefits under a plan.

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

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

Formulary -- A list of preferred medications covered by the health plan. The list contains generic and name brand drugs. The most cost-effective name brand drugs are placed in the “preferred” category and all other name brand drugs are placed in the “non-preferred” category. Prescription copays are tiered by generic, preferred, and non-preferred medications.

Fully-Insured -- A plan that is funded entirely with a premium paid to an insurance company. The employer paying the premium assumes only the risk of paying the premium. The insurance company assumes all financial and legal risk to provide medical services covered under the plan.

Health Maintenance Organization (HMO) -- A health care system that assumes the financial risks associated with providing comprehensive medical services to enrolled members in return for a fixed, prepaid premium. An HMO involves restrictions, such as prior authorization for specific medical procedures; often, primary care physician must refer a member to medical specialists. All medical care must be received by contracted medical providers.

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

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

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

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

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

Payer -- The entity responsible for paying a claim.

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

Plan Year -- The Benefit Options plan year runs from October 1 through September 30 for employees and dependents. The plan year for retirees and their dependents runs from January 1 through December 31. Unless otherwise noted, all references to yearly or annual calculations will conform to this time frame.

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

Point-of-Service (POS) -- A POS plan is an "HMO/PPO" hybrid and operates as an HMO plan for in-network medical services but operates as a PPO plan when the member goes outside of the network for services.

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

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

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

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

Stop-Loss -- A form of insurance for self-insured employers that limits the amount the employer primary insurer will pay for medical expenses.

Third Party Administrator -- An organization that handles all administrative functions of a health plan, including: processing and paying medical claims, compiling and producing management reports, and providing customer service. .

Utilization Management -- A process whereby an insurer evaluates the quantity (duration) and quality (level) of the delivery of medical services.

Utilization Review -- A process whereby an insurer evaluates the appropriateness, necessity, and cost of the delivery of medical services.

## BACKGROUND

The State's Benefits Options programs fall into two major categories. The first of these provides medical and pharmaceutical benefits; the second is comprised of various health benefits programs: including dental, vision, disability, life insurance programs, as well as a medical savings account plan.

The health benefit programs, except for the medical savings plan, are fully insured. The medical and pharmaceutical programs fall into one of two types—fully insured and self-funded.

The new group employee health medical plan began on October 1, 2004. As a part of the design, two distinct options were created: the “integrated” and “non-integrated” options. The differences between these options are discussed below:

- **The Integrated Option:** Currently, UnitedHealthcare (UHC) provides this integrated option. UHC combines the functions of claims review and payment, contracting and administering a network of medical providers, utilization review, and disease management, all in one contract with the State of Arizona.
- **The Non-Integrated Option:** Under this model, the basic functions of the plan are contracted out to numerous service providers. The Non-Integrated Option allows the State greater flexibility in contracting since service providers can be replaced, if necessary, without radically affecting the Benefits Options members.

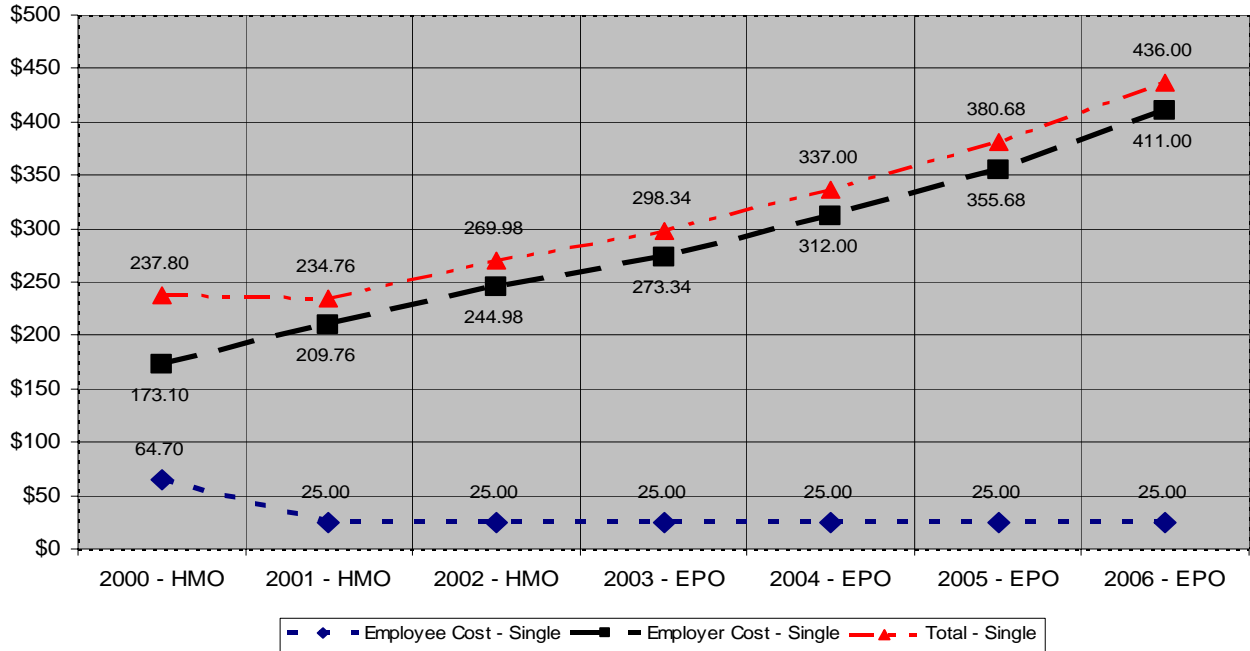
### Contribution Strategy

In 2001, ADOA developed a contribution strategy that provided affordable health insurance to all State and University employees. The HMO plan was offered to employees for \$25 single coverage and \$125 family coverage. This rate was set at a flat rate, while the POS and PPO monthly premiums were determined from actual experience and the true cost of the coverage.

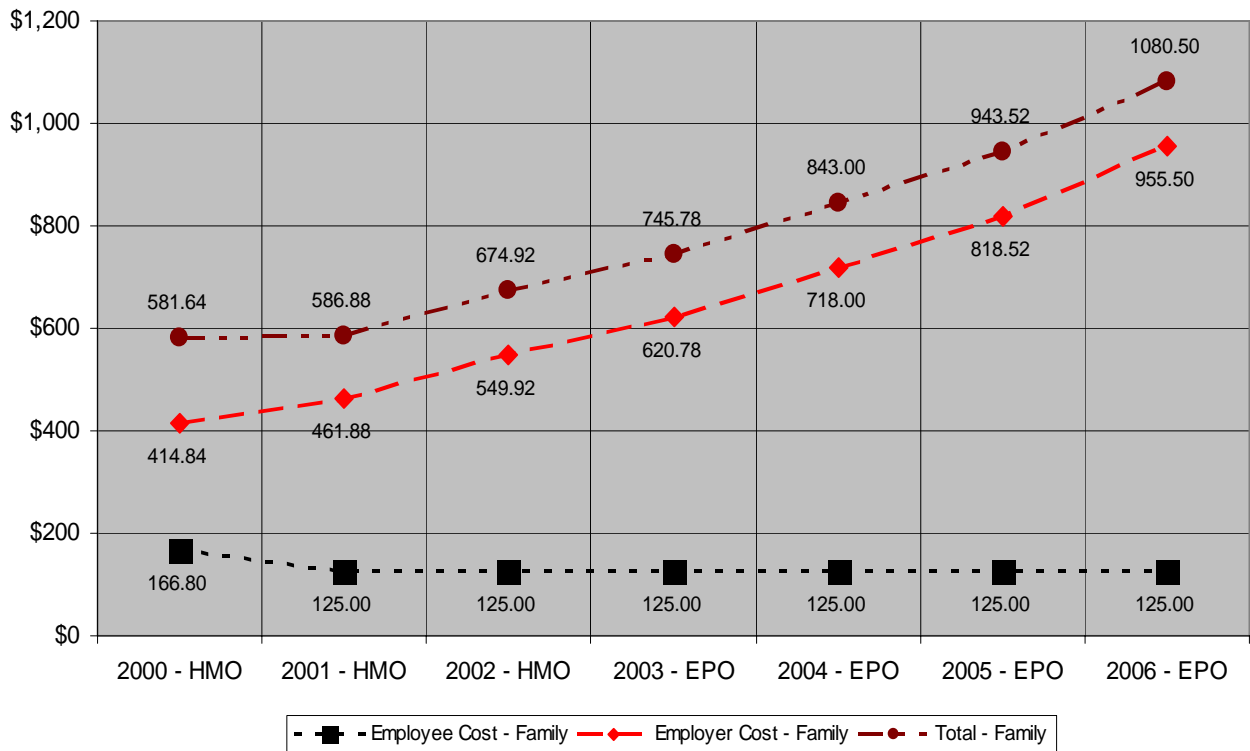
The 2006 contribution strategy allowed employees to pay only 14% of the total premium, while the State absorbed the remaining 86%.

**On October 1, 2004, ADOA implemented the self-funded medical plans. The implementation of the self-funded plans was approved as a means to manage escalating health care costs. The self-funded plans have shown sufficient management of costs resulting in no increases to employee contributions. The state absorbed the 14% increase during the 2004 plan year and the subsequent 16% increase for the 2005 plan year.**

## Monthly Premiums for Medical Insurance - Single Coverage



## Monthly Premiums for Medical Insurance - Family Coverage



## Program Goals

The self-insurance model enables the State to maximize the value of health medical benefits to its members through improved choices and program design.

- **Improve Provider Choice**

Members have more providers in more networks available to them. Members can choose an HMO-like managed care plan called an Exclusive Provider Organization (EPO) plan or Preferred Provider Organization (PPO) plan. Additionally, members can choose among multiple vendors and benefit administration approaches.
- **Improve Program Design**

The State maintains and analyzes utilization data, which supports program design. Program changes are implemented to improve program efficiency, reduce inappropriate healthcare utilization, and enhance benefits offered to members.
- **Improve Long Term Health**

Wellness and disease management programs are now incorporated within the health plan to focus on preventative measures and overall wellness initiatives. These programs improve the long term health and welfare of all members.

## HEALTH BENEFITS PROGRAM AND ENROLLMENT

The new Benefit Options program began on October 1, 2004. This program offered both an integrated and non-integrated option, as well as an HMO-like plan called an Exclusive Provider Organization (EPO) and a Preferred Provider Organization (PPO) plan.

Approximately 64,500 employees, retirees, COBRA participants, and long-term disability members were enrolled in the new plan. This was an increase of over 1,300 new members, versus the 58,666 previously enrolled in the prior fully-insured plan.

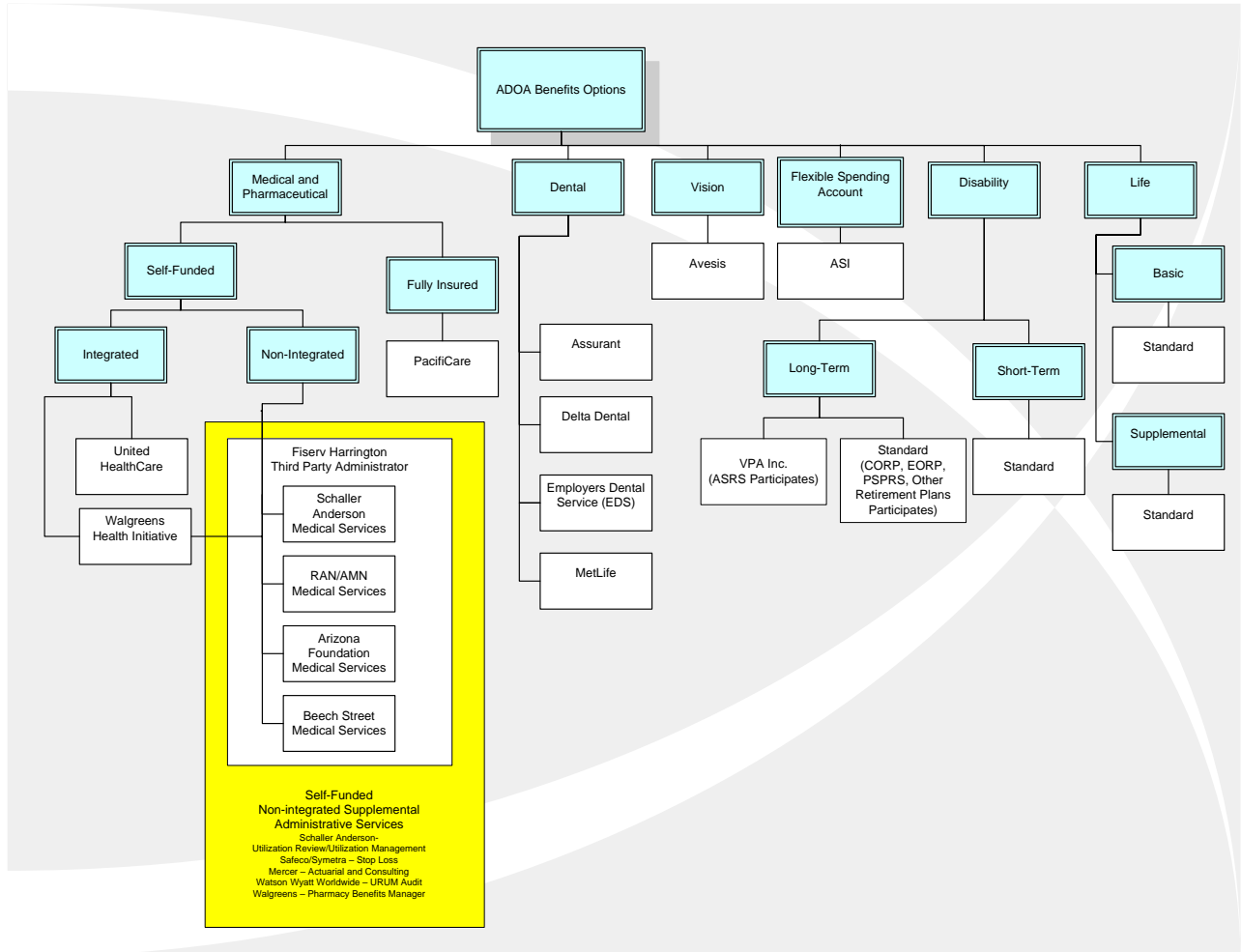
**87% of employees and retirees reported they were satisfied with the 2006 Open Enrollment process.**

### Program Structure

In order to best meet the needs of the State employees and retirees, both integrated and non-integrated options were developed to deliver health medical care services for the program. Both of these plans offer:

<u>Claims Payment</u>	The ability to receive, process, and pay medical and pharmacy claims.
<u>Medical Network</u>	A statewide network of hospitals, medical professionals, and ancillary services such as x-rays, laboratories, and physical therapy.
<u>Pharmacy</u>	Access to a statewide network of pharmacies, as well as the capacity to distribute specialty drugs that require special handling or injections.
<u>Disease Management / Utilization Management</u>	Management of diseases using medical professionals to work with patients. This function also analyzes data to develop benefit enhancements and wellness initiatives to prevent or reduce the impact of future illness and disease.
<u>Stop Loss Insurance</u>	Reinsurance providing partial coverage for medical claims above \$500,000.

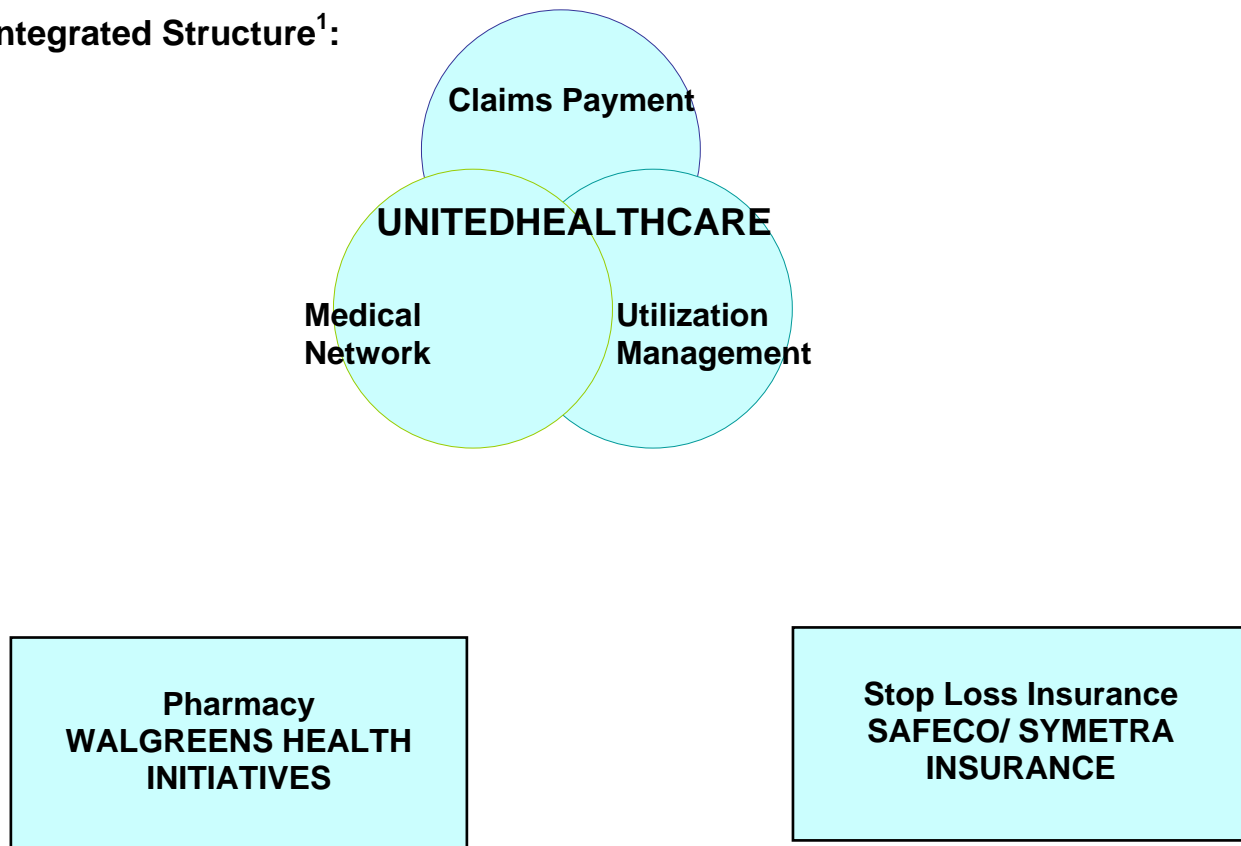
## ADOA Benefits Options Operations Diagram



## **Integrated Option**

UnitedHealthcare is offered as an integrated option. This option provides claims payment, medical network and disease management services through UnitedHealthcare. Pharmacy benefits are provided through Walgreens Health Initiatives and Stop Loss insurance is provided through Safeco/Symetra Insurance:

### **Integrated Structure<sup>1</sup>:**



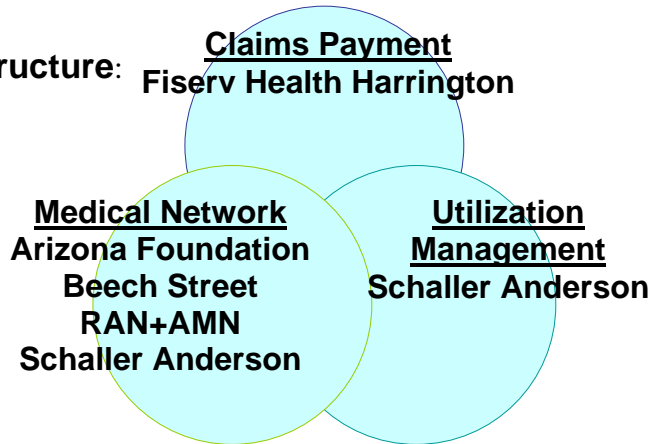
<sup>1</sup> PacifiCare Secure Horizons is also contracted under the integrated option. This Medicare Advantage plan does is fully insured (i.e., is not part of the State's self-insurance model) and is only offered to retirees who are Medicare Eligible.

### Non-Integrated Option

The non-integrated option offers all of the medical plan services under separate contracts. Since some companies specialize in specific services, this option offers “best in class” contract providers. This option also provides flexibility should one of the providers not perform to the State’s expectation. A new contractor can be put in place without impacting the other providers or necessitate an Open Enrollment for employees and retirees. The following contract providers provide services under the non-integrated option:

- Third Party Claims Payment      Fiserv Health Harrington
- Medical Networks                    Arizona Foundation  
   Beech Street  
   RAN+AMN  
   Schaller Anderson Healthcare
- Disease Management                Schaller Anderson Healthcare
- Pharmacy                                Walgreens Health Initiatives
- Stop Loss Insurance                  Safeco/Symetra Insurance

**Non-Integrated Structure:**



**Pharmacy**  
**WALGREENS HEALTH**  
**INITIATIVES**

**Stop Loss Insurance**  
**SAFECO/ SYMETRA**  
**INSURANCE**

**To provide additional flexibility for employees and retirees, both the integrated and non-integrated options offer open access to specialists. Members do not need referrals to see contracted specialist.**

## DEMOGRAPHICS OF ENROLLED HEALTH PLAN MEMBERS

### Demographics of Enrolled Health Plan Members<sup>2</sup>

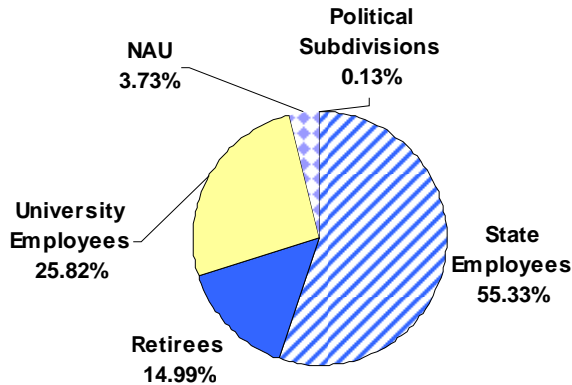
The Benefit Options group medical plan is available to all:

- Eligible State or State University employees;
- Retirees receiving pension benefits through any of the State Retirement Systems;
- State or State University employees accepted for long-term disability benefits;
- Employees of participating political subdivisions of the State of Arizona, or
- State or University employees eligible for COBRA benefits.

### Total Statewide Enrollment

State Employees	35,675	55.33%
University Employees	16,650	25.82%
Retirees	9,665	14.99%
NAU <sup>3</sup>	2,403	3.73%
Political Subdivisions	84	.13%

Total Statewide Enrollment



### Membership by Health Plan

Exclusive Provider Organization (EPO)	60,424	93.71%
Preferred Provider Organization (PPO)	4,053	6.29%

### Family Coverage Status<sup>4</sup>

Enrolled Single	45.7%
Enrolled Family	54.3%

### Gender Status<sup>5</sup>

Enrolled Females	54.7%
Enrolled Males	45.3%

<sup>2</sup> Enrollment and demographic data as of September 30, 2006.

<sup>3</sup> The BlueCross BlueShield plan is administered by Northern Arizona University.

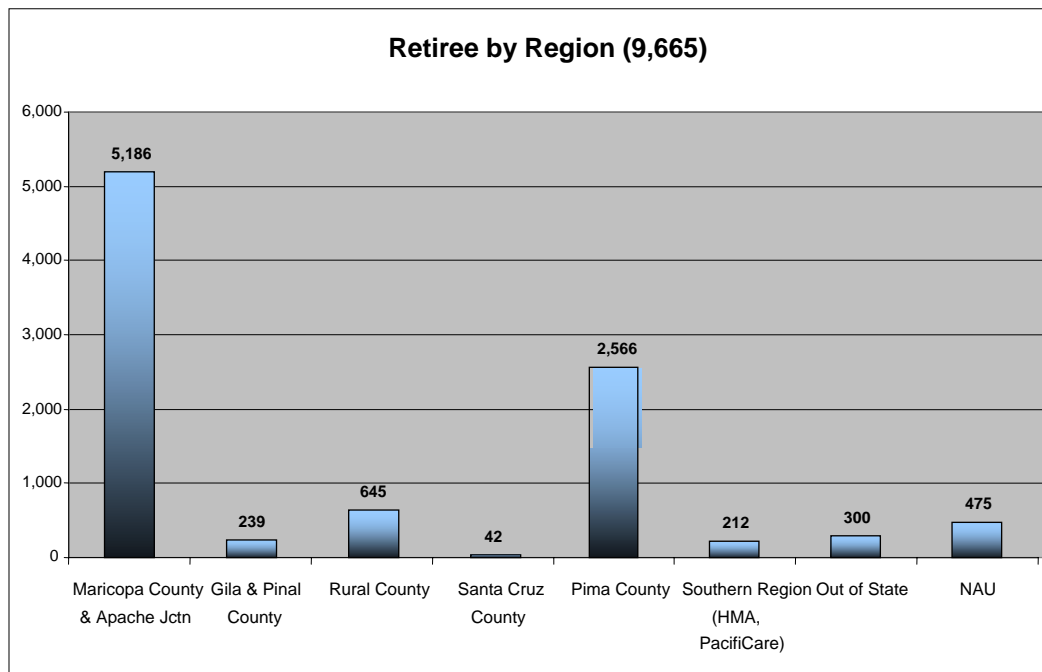
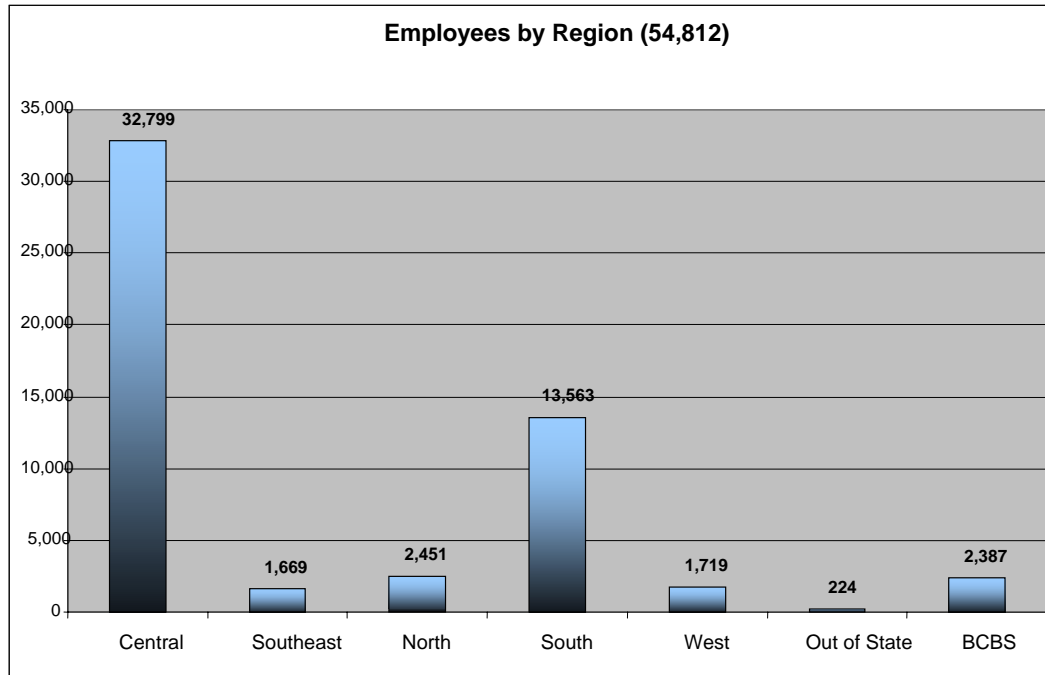
<sup>4</sup> State employee and University employee enrollment only.

<sup>5</sup> State employee enrollment only- ADOA does not receive this information from the Universities.



## Employees by Region

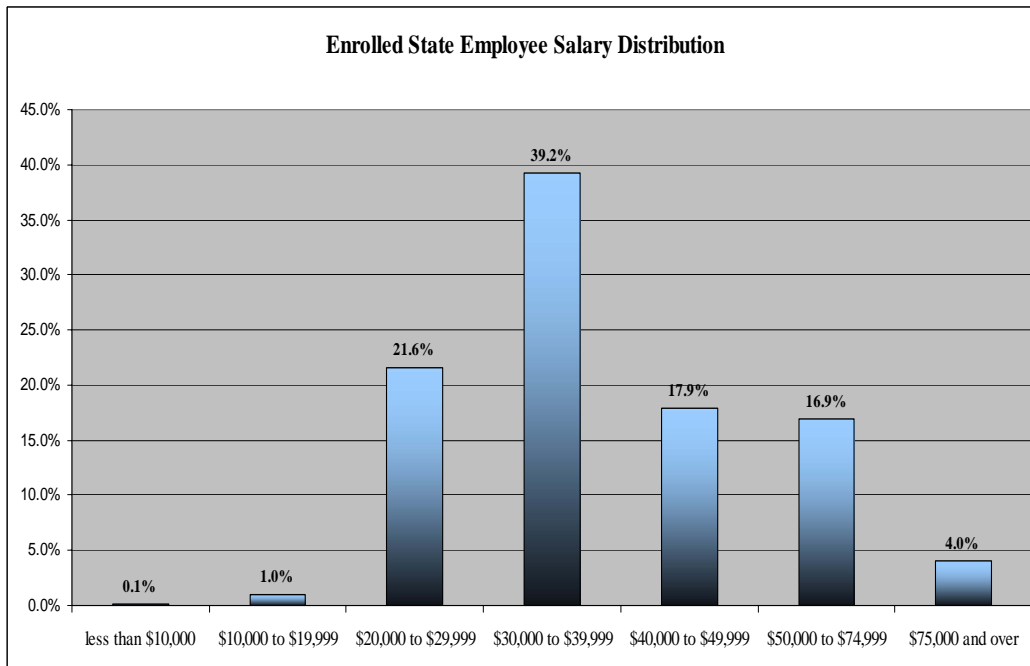
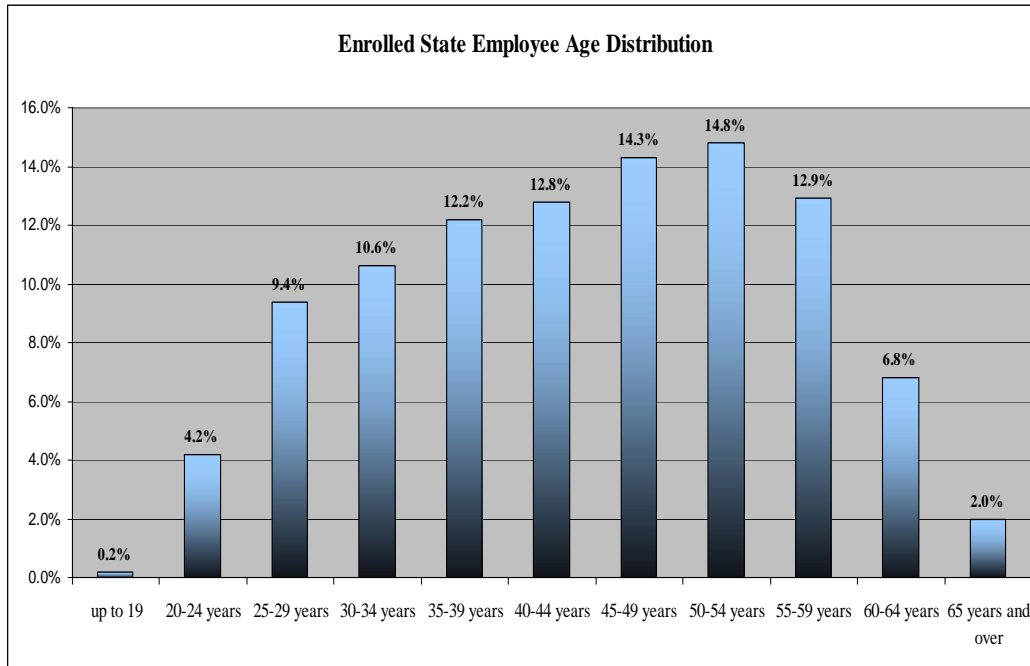
The tables below reflect the enrolled Active membership of employees<sup>8</sup> and retirees based on region:



<sup>8</sup> ADOA does not maintain this information for University employees.

## Age and Salary Distribution of Enrolled State Employees

Age and Salary Distribution of Enrolled State Employees<sup>9</sup>. The below tables reflect enrolled State employees by age and salary:



<sup>9</sup> ADOA does not maintain this information for University employees.

## Health Plan Demographics

The tables below reflect the gender and average age of enrolled members and their dependents within the health medical plans. The table below outlines the health medical plan population based on enrollment as of 09/30/06:

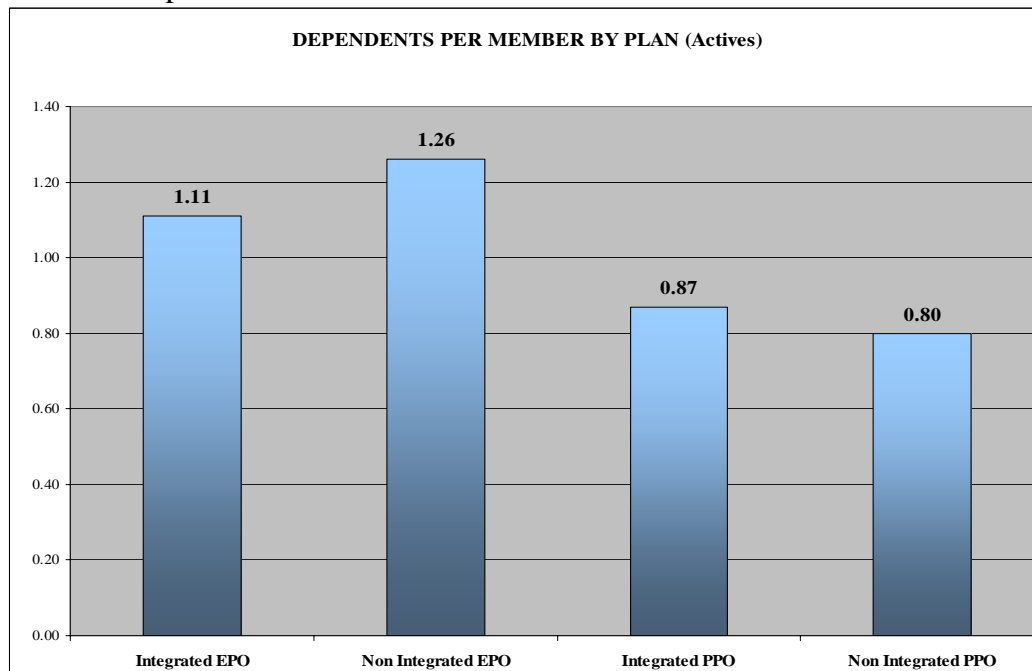
	Number of Primary Members Enrolled	Average Age	Dependent Average Age
<b>EPO PLANS</b>			
Male Employee	23,118	44.4	23.3
Female Employee	28,248	44.5	23.4
Male Retiree	4,318	60.1	49.0
Female Retiree	4,740	61.8	57.0
<b>Total</b>	<b>60,424</b>		

<b>PPO PLANS</b>			
Male Employee	1,659	50.4	30.5
Female Employee	1,786	50.0	30.4
Male Retiree	273	62.1	54.2
Female Retiree	335	62.5	55.5
<b>Total</b>	<b>4,053</b>		

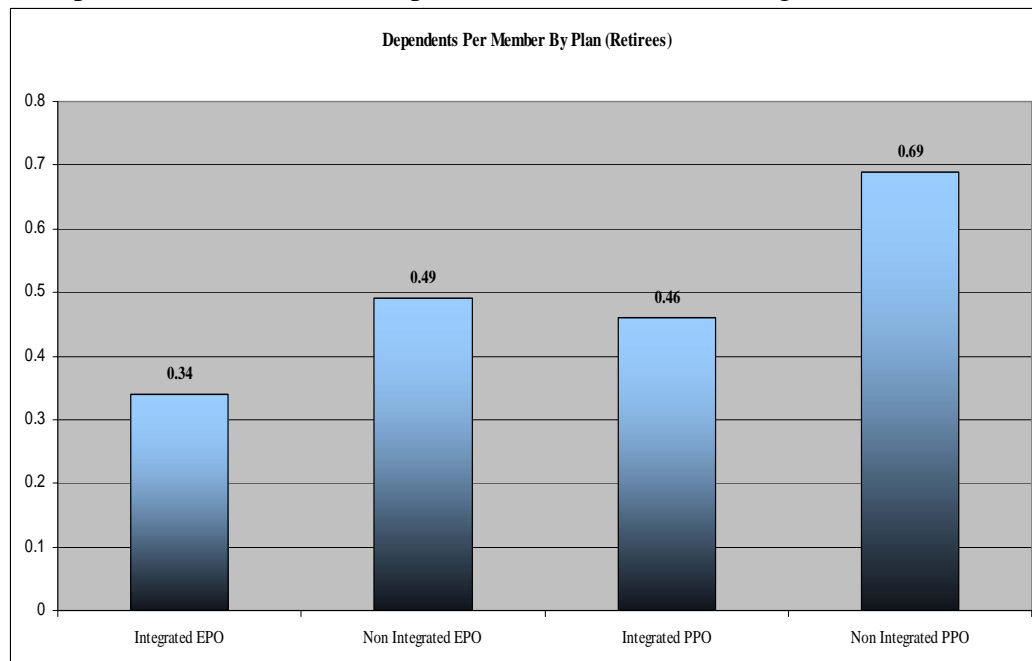
- Fewer than 50% of the male retirees enrolled in both either the EPO and PPO plans cover dependents.
- The PPO plans have older enrolled members than the EPO plans.

## Dependents per Employee By Plan

The chart below illustrates the ratio of covered dependents<sup>10</sup> per enrolled employee member. On average, for every member enrolled in the EPO plans, there were 1.18 dependents who were covered, with the integrated plan attracting slightly larger families. On average, for each member who enrolled in the PPO plans, there were 0.82 dependents that were also enrolled.



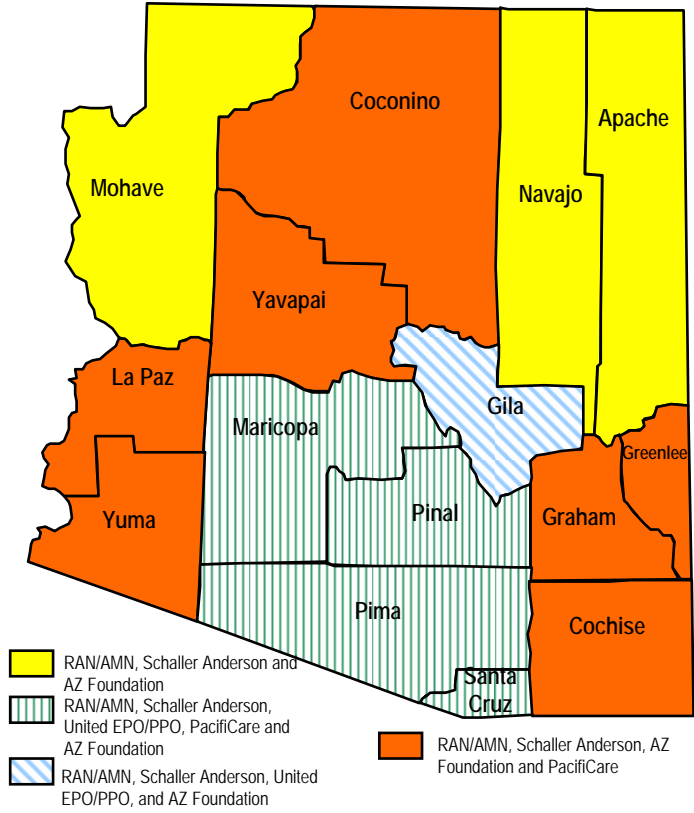
On average, retirees (below) enrolled about half the rate of dependents as employees (above), and the trend of higher dependent ratios in the EPO plans did not hold true among the enrolled retiree population.



<sup>10</sup> Dependents include spouse and any children under age 19 (or under age 25 if attending school full time).

## Network Statistics<sup>11</sup>

The following chart reflects the number of contracted physicians in each network by region (data compiled as of September, 2006):



County	UHC	Schaller	RAN	AZ Foundation	PacifiCare
Apache	n/a	n/a	83	32	n/a
Cochise	n/a	199	237	198	74
Coconino	n/a	144	321	237	96
Gila	29	72	98	77	n/a
Graham	n/a	70	44	84	27
Greenlee	n/a	8	11	20	6
La Paz	n/a	9	30	32	7
Maricopa	5417	5842	5079	7134	3579
Mohave	n/a	n/a	402	272	n/a
Navajo	n/a	n/a	197	105	n/a
Pima	1785	1764	1741	1859	1474
Pinal	254	265	269	241	138
Santa Cruz	93	54	68	68	26
Yavapai	n/a	161	415	345	106
Yuma	n/a	200	244	250	55

<sup>11</sup> Beech Street provides a nationwide network for out-of-state employees and retirees. Beech Street was not included in this analysis.

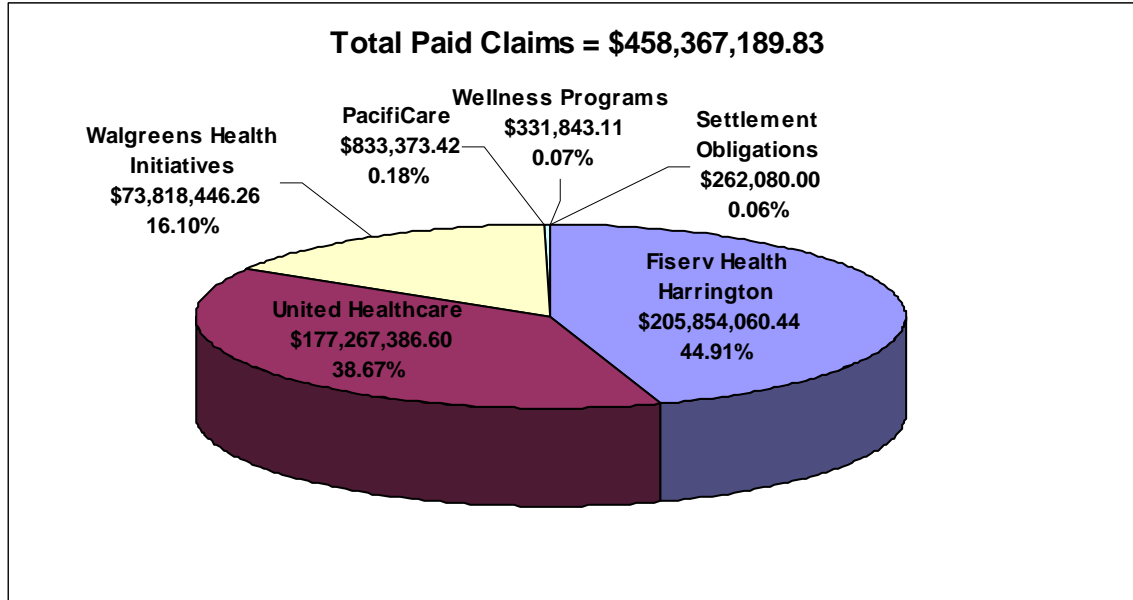
## PLAN YEAR CLAIMS AND COST INFORMATION

With the transition to self-insurance<sup>12</sup>, the State now owns all health medical plan data and is able to evaluate the true cost and usage of health medical care for all members.

### Total Paid Claims

The table below outlines the total paid claims for all health medical plan members<sup>13</sup> for the period 10/01/05 through 09/30/06:

Claim Payer/Use	Dollars Paid
Fiserv Health Harrington <sup>14</sup>	\$205,854,060.44
United Healthcare	177,267,386.60
Walgreens Health Initiatives	73,818,446.26
PacifiCare	833,373.42
Wellness Programs	331,843.11
Settlement Obligations	262,080.00
<b>TOTAL PAID CLAIMS</b>	<b>\$458,367,189.83</b>



<sup>12</sup> Self-insurance began 10/01/2004.

<sup>13</sup> Although retirees enrolled in PacifiCare are covered under a fully-insured basis, non-Medicare eligible family members are covered on a self-funded basis.

<sup>14</sup> Fiserv Health Harrington processes claims of four (4) provider networks: AZ Foundation, Beech Street, RAN+AMN, and Schaller Anderson.

## Total Net Health Plan Costs

The following chart shows the total costs for the Benefit Options health medical plan:

Category	Gross Total		Net Total
<i>Administrative Fees</i>		<i>Performance Penalties</i>	
Arizona Foundation for Medical Care	\$ 104,092.45		
Beech Street Health Management Associates & Rural Arizona Network	18,693.00		
	316,544.96	\$ (19,183.42)	
Schaller Network	1,038,796.95	(34,099.45)	
Utilization Review / Utilization Management	3,793,652.17	(167,788.07)	
Harrington	5,423,275.90	(362,787.93)	
PacifiCare	61,223.90		
UnitedHealthcare	10,180,577.97	(281,000.00)	
Walgreens	10,116.23	(87,907.65)	
Attorney General	31,434.23		
<b>Total Administrative Fees</b>	<b>\$20,978,407.76</b>	<b>\$ (952,766.52)</b>	<b>\$ 20,025,641.24</b>
<i>Stop Loss Insurance</i>			
Symetra	\$ 2,697,227.52		\$ 2,697,227.52
<b>Total Stop Loss Insurance</b>	<b>\$ 2,697,227.52</b>		<b>\$ 2,697,227.52</b>
<i>Full Service Insurance Premiums</i>			
Blue Cross Blue Shield	\$28,244,616.61		
PacifiCare	5,017,165.87		
<b>Total Full Service Insurance Premiums</b>	<b>\$33,261,782.48</b>		<b>\$ 33,261,782.48</b>
<i>Dental Premiums</i>			
Delta	\$31,127,973.96		
MetLife	5,422,862.23		
Assurant	1,531,300.17		
EDS	1,709,608.14		
<b>Total Dental Premiums</b>	<b>\$39,791,744.50</b>		<b>\$ 39,791,744.50</b>

# Benefit Options 2006 Annual Report



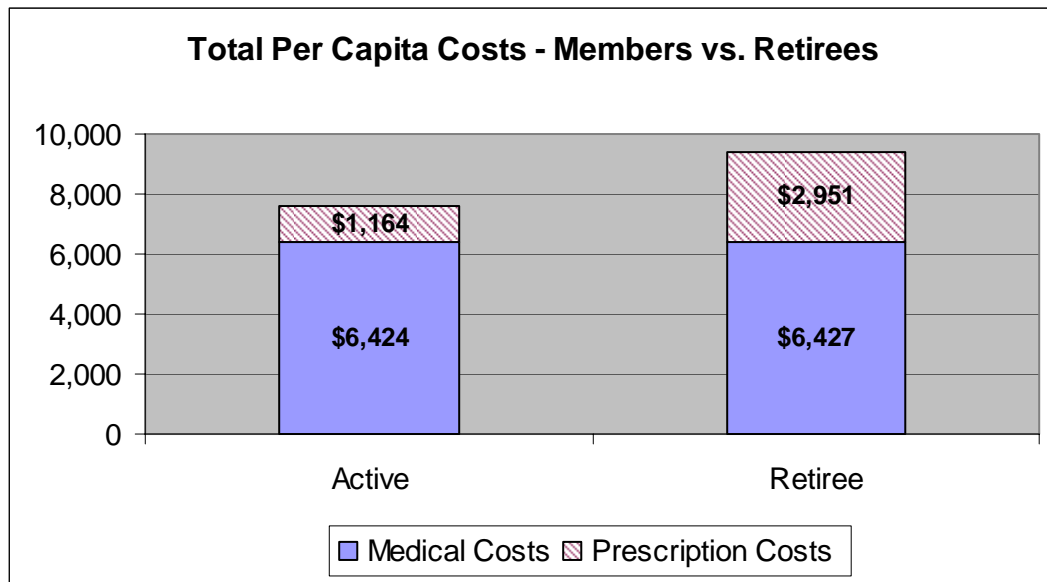
Category	Gross Total		Net Total
<i>Medical Claims</i>	<i>Amount</i>	<i>Recoveries<sup>15</sup></i>	
Harrington	\$210,681,354.48	\$ (4,827,294.04)	
UnitedHealthcare	177,859,789.92	(592,403.32)	
PacifiCare	833,373.42		
Walgreens	80,204,685.18	(6,386,238.92)	
Settlement Obligations	262,080.00		
Wellness Programs	331,843.11		
<b>Total Medical Claims</b>	<b>\$470,173,126.11</b>	<b>\$ (11,805,936.28)</b>	<b>\$458,367,189.83</b>
<i>Appropriated Expenditures</i>			
<b>Benefits Options Operations budget</b>	<b>\$ 3,959,581.90</b>		<b>\$ 3,959,581.90</b>
<b>Total HITF Expenditures</b>	<b>\$ 3,959,581.90</b>		<b>\$ 3,959,581.90</b>
<b>Total Expenditures</b>	<b>\$570,861,870.27</b>	<b>\$ (12,758,702.80)</b>	<b>\$558,103,167.47</b>

- During the plan year of 10/01/05-09/30/06, approximately \$20 million in administrative fees were paid to the contracted vendors.
- The Benefits Office is appropriated approximately \$4 million for personnel and management of the State's benefit plans.

<sup>15</sup> Recoveries include pharmaceutical rebates, overpayment recoveries, stop loss recoveries, stop payments, voids, etc.

**Per Capita Costs - Members vs. Retirees**

The below table shows actual per capita expenditures<sup>16</sup> for plan year 10/1/05-09/30/06 comparing costs between employees<sup>17</sup> and retirees:

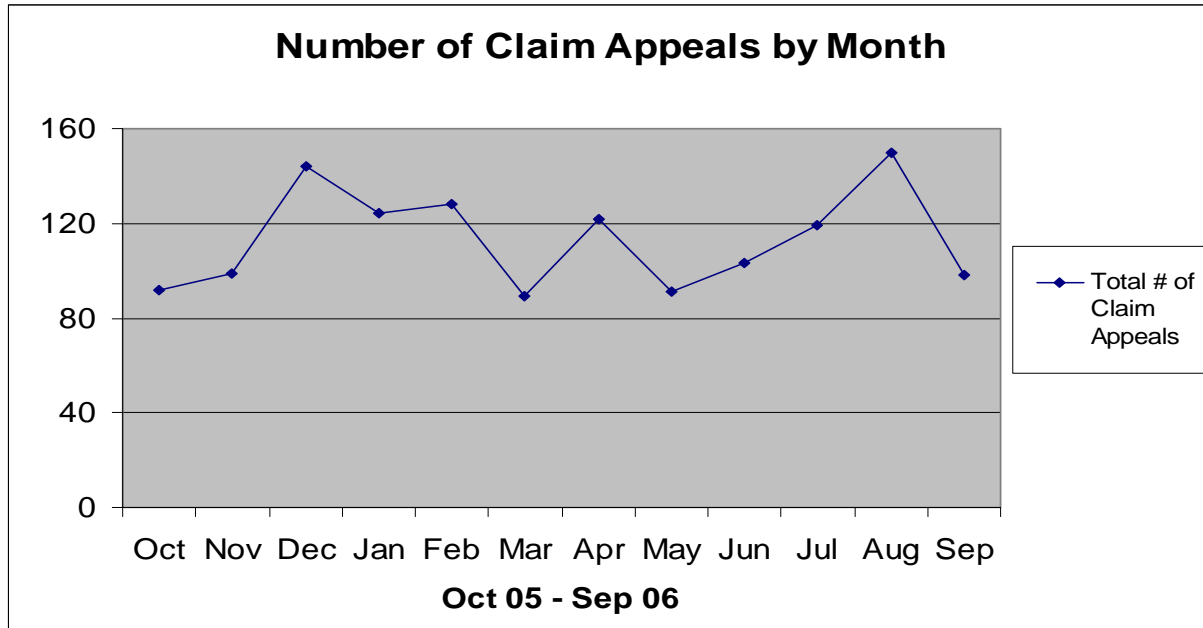


<sup>16</sup> Costs are reflected on a per enrolled member basis—this includes the employee/retiree and any covered family members.

<sup>17</sup> Information includes State employees and University employees.

## Claim Appeals

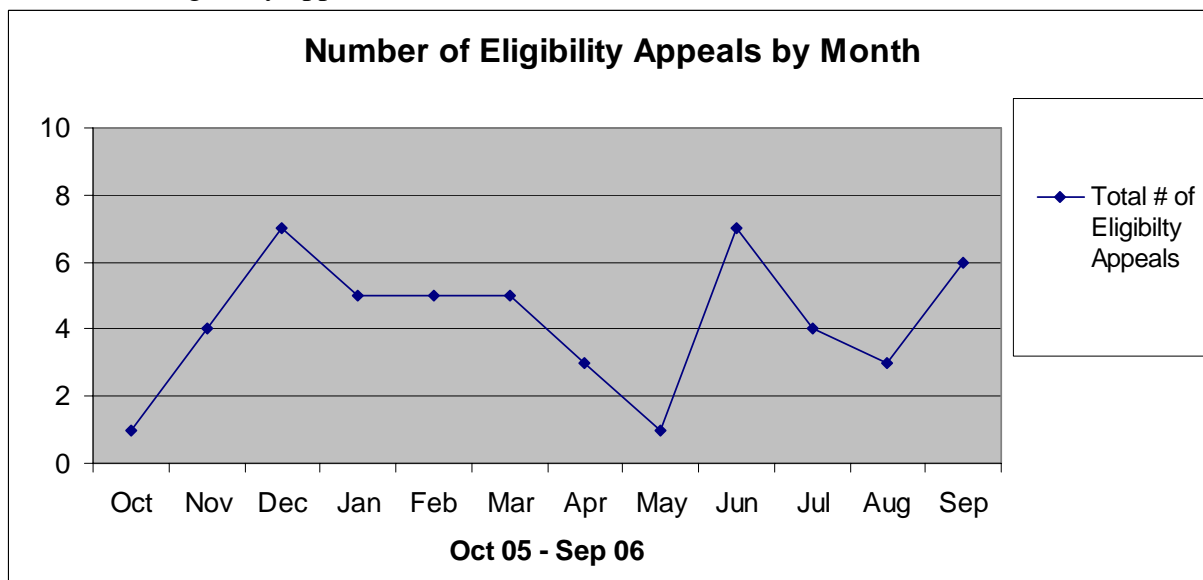
During the 10/01/05-09/30/06 plan year, Fiserv Health Harrington and UnitedHealthcare collectively received 1,359 claim appeals.



- Fiserv Health Harrington received 814 claim appeals.
- UnitedHealthcare received 545 claim appeals.

## Eligibility Appeals

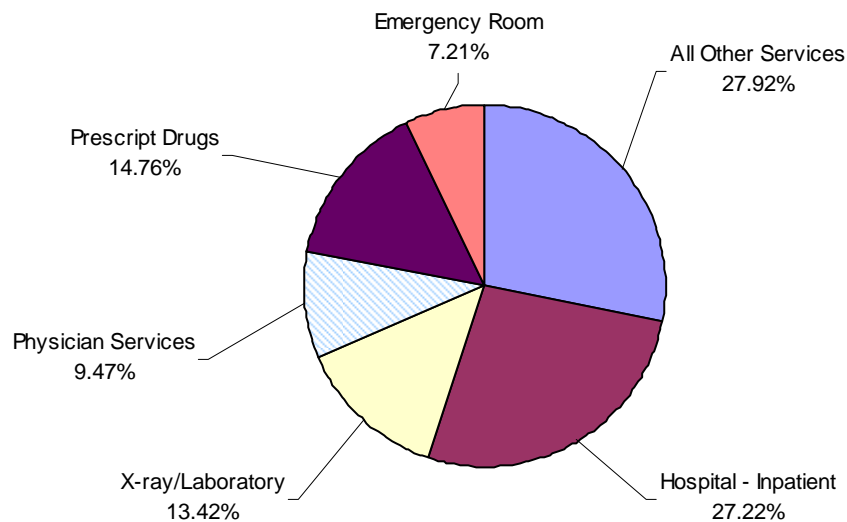
During the 10/01/05-09/30/06 plan year, Fiserv Health Harrington and UnitedHealthcare collectively received 51 eligibility appeals.



**Paid Claims by Type of Service - Top 5**

The tables below outline the top 5 total paid expenditures for the plan year 10/1/05-09/30/06 by type of service for both employees and retirees:

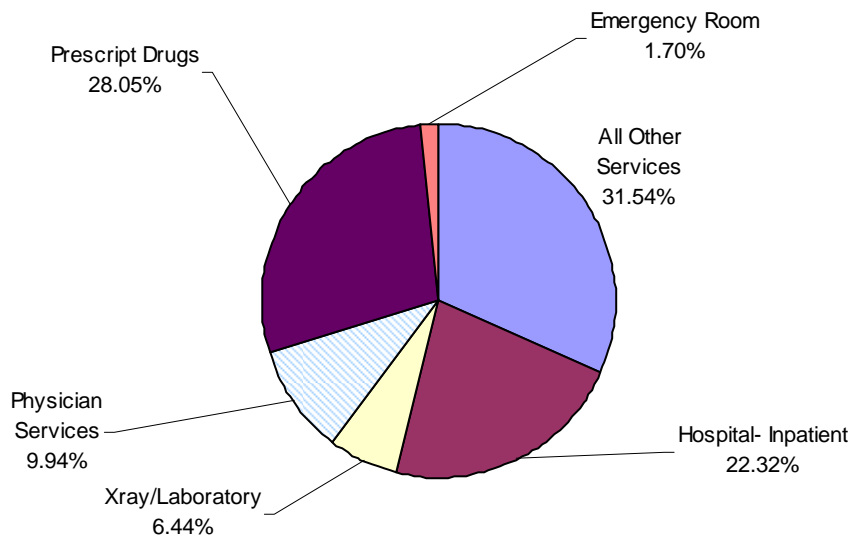
**State and University Employees**



<b>Type of Service</b>	<b>Paid Claims</b>	<b>% of Total Claims</b>
Hospital - Inpatient	\$114,180,866	27.22%
X-ray/Laboratory	\$56,309,193	13.42%
Physician Services	\$39,716,528	9.47%
Prescript Drugs	\$61,937,099	14.76%
Emergency Room	\$30,267,370	7.21%
All Other Services	\$117,122,626	27.92%
<b>Total</b>	<b>\$419,533,682</b>	<b>100.00%</b>

**Retirees**

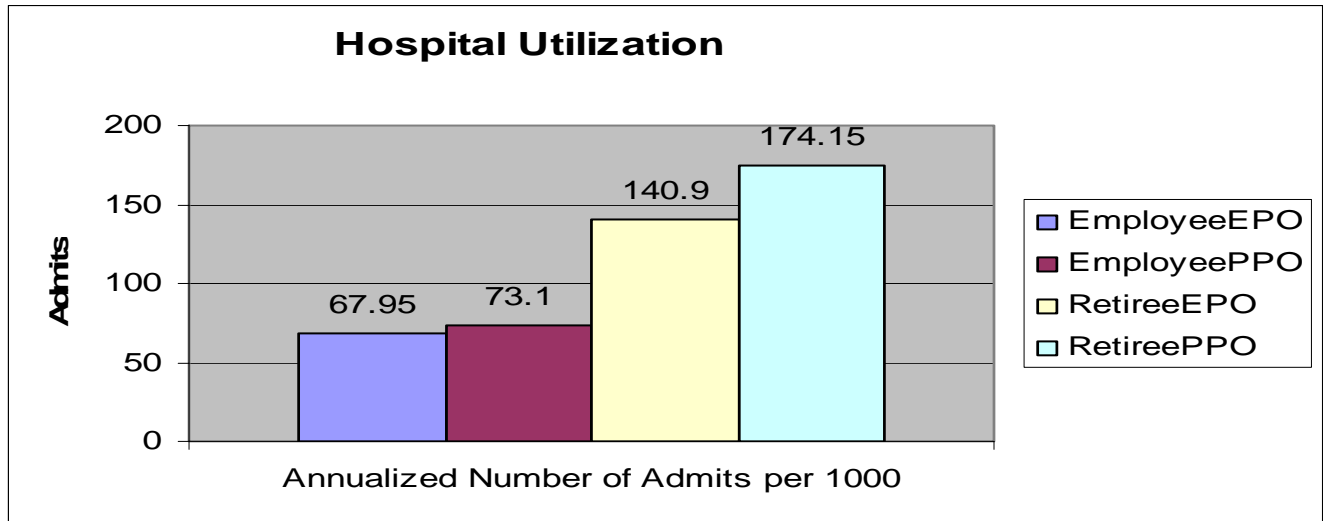
**Although Fiserv Health Harrington incurred higher costs with inpatient hospitalizations, UnitedHealthcare incurred higher costs for outpatient facilities.**



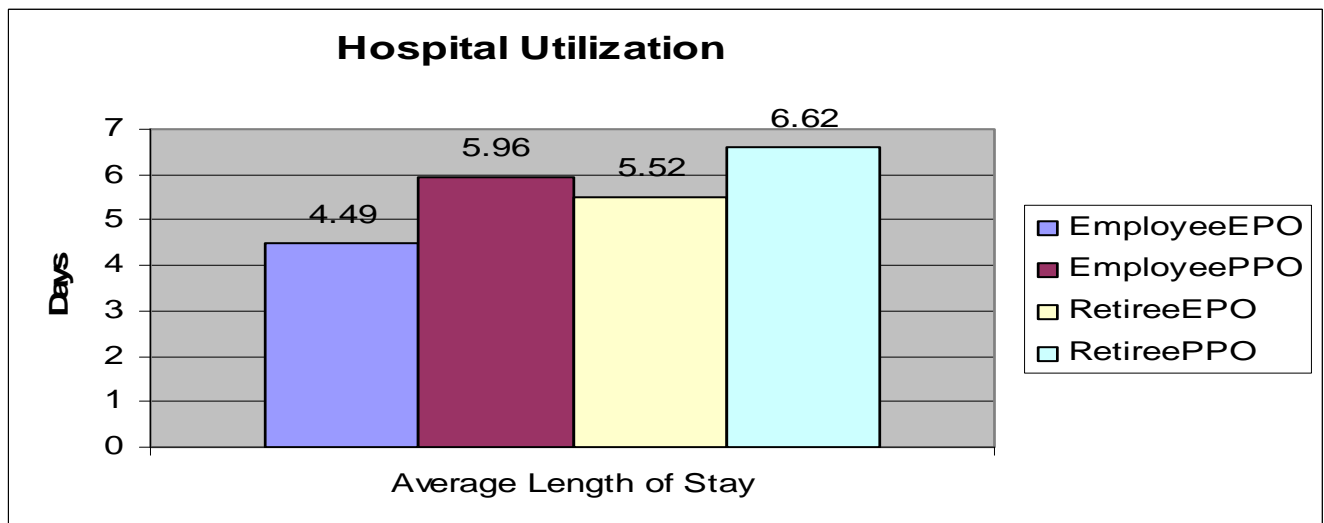
<i>Type of Service</i>	<i>Paid Claims</i>	<i>% of Total Claims</i>
Hospital - Inpatient	\$14,665,901	22.32%
X-ray/Laboratory	\$4,232,372	6.44%
Physician Services	\$6,529,425	9.94%
Prescript Drugs	\$18,428,556	28.05%
Emergency Room	\$1,119,626	1.70%
All Other Services	\$20,723,409	31.54%
<b>Total</b>	<b>\$65,699,289</b>	<b>100.00%</b>

## Hospitalizations

### Annualized Number of Admits per 1000<sup>18</sup>



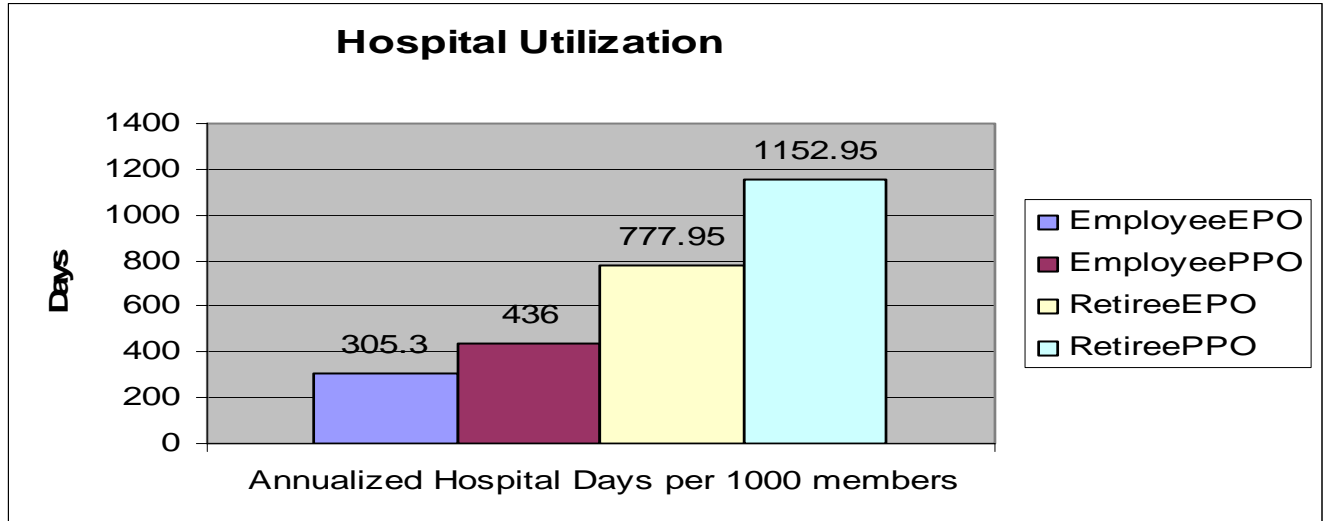
### Average Length of Stay



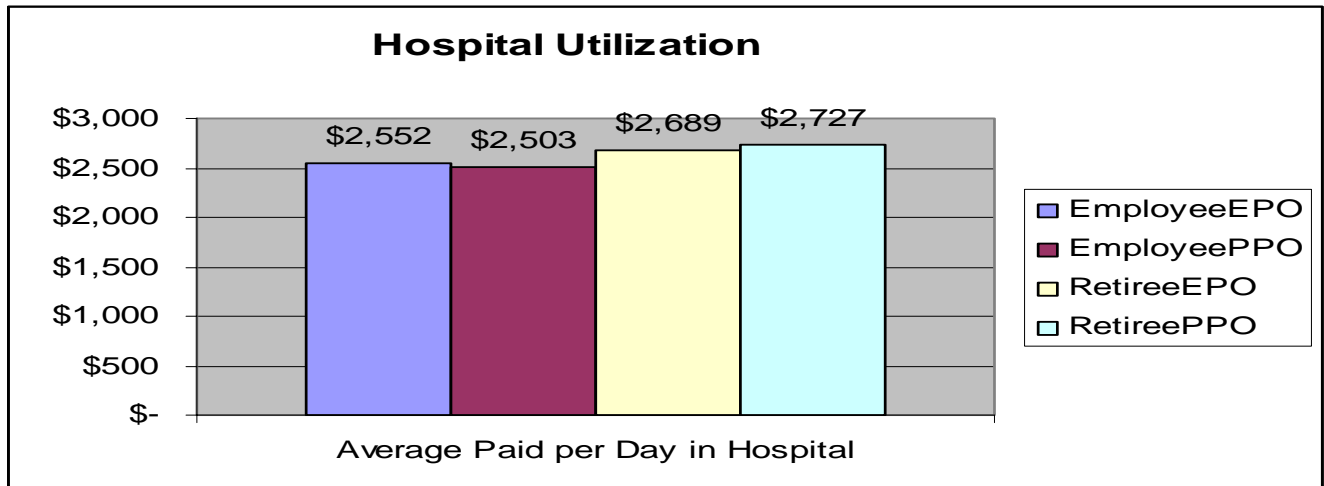
<sup>18</sup> Fiserv Health Harrington Executive Summary: 2005-2006 Plan Year 4th Quarter and UnitedHealthcare 2006 Annual Report data sheet.

**Hospitalizations (continued)**

**Annualized Hospital Days per 1000**

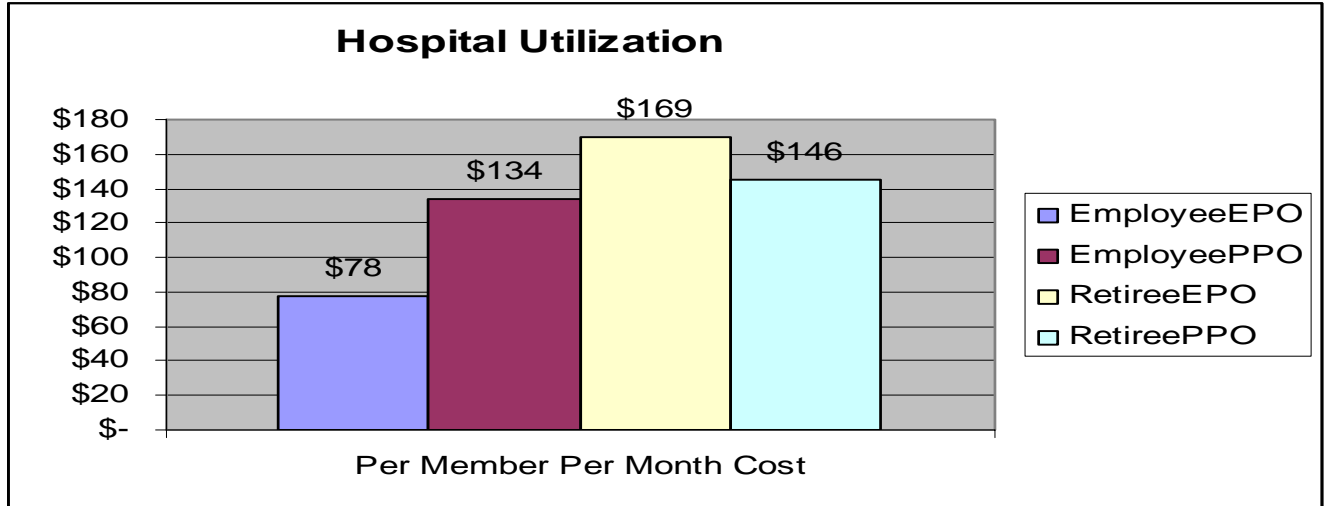


**Average Paid per Day in Hospital**



**Hospitalizations (continued)**

**Per Member per Month Cost**



## Emergency Room Visits

	<i>Total Emergency Room Visits</i>	<i>Total Costs</i>	<i>Average Per Visit</i>
Actives, Retirees and Dependents	25,283	\$31,386,946	\$ 604.46

## Emergency Room Visits by Diagnosis

The Top 5 conditions diagnosed at the emergency room according to volume of occurrences:

### *Top 5 Conditions*

1. Respiratory System and Symptoms
2. Back Disorders
3. General Symptoms, Illnesses
4. Head and Neck Pain and Symptoms
5. Acute Pharyngitis

According to the 2004 National Hospital Ambulatory Medical Care Survey (NHAMCS), the top 5 conditions presented nationally to an emergency room (according to volume of occurrence) are:

- General symptoms (such as fever, fatigue, and pain)
- Musculoskeletal symptoms
- Digestive symptoms
- Respiratory symptoms
- Nervous system (excluding sense organs)

Given the top list of conditions listed by both Fiserv Health Harrington and UnitedHealthcare, it appears utilization of emergency rooms by Benefit Option health plan members is consistent with the national norms.

## Physician Visits

The table below outlines total physicians office visits for the period 10/1/05-09/30/06<sup>19</sup>:

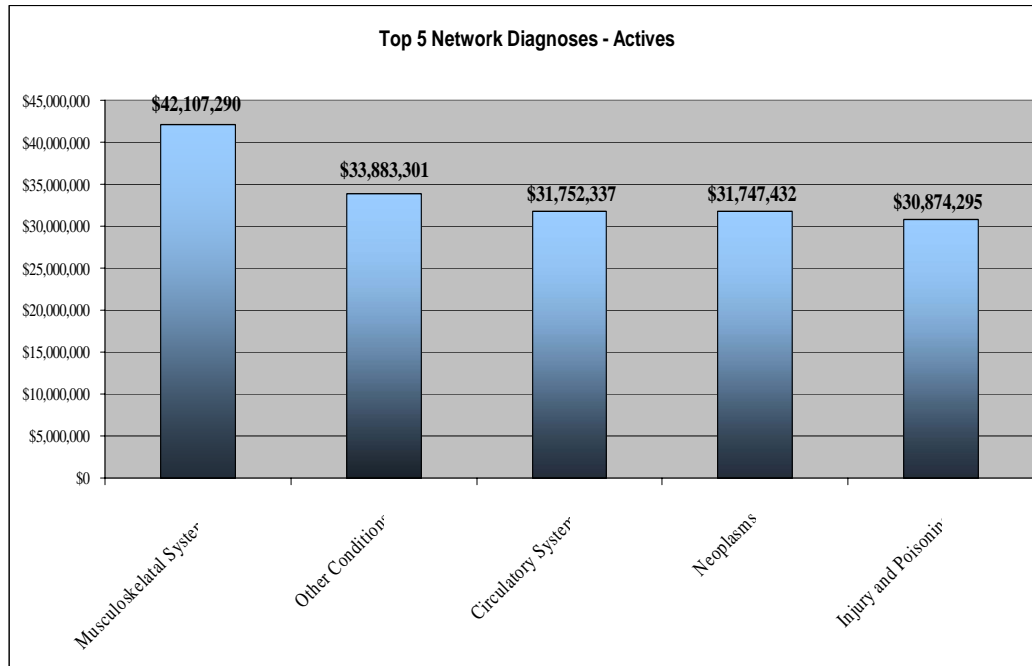
	<i>Total Physician Visits</i>	<i>Total Costs</i>	<i>Average Per Visit</i>
Actives, Retirees and Dependents	362,725	\$ 46,245,953	\$ 66.48

<sup>19</sup> Includes all physicians on an outpatient basis only; these numbers do not include inpatient hospitalizations.

## Paid Claims by Top 5 Diagnoses

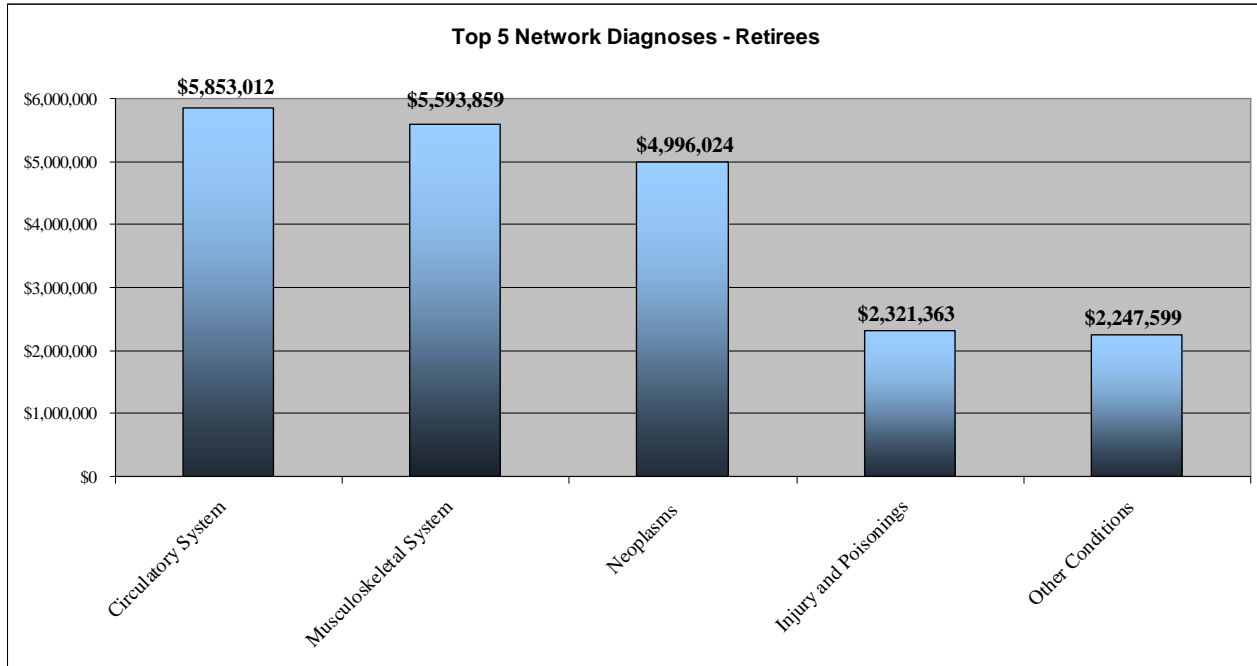
Due to differences in enrollment between the health medical plans, top conditions may vary between UnitedHealthcare and the networks covered by Fiserv Health Harrington<sup>20</sup>:

### State and University Employees



<sup>20</sup> Data source - Top 5 Diagnosis\_2006.xls.  
ADOA Benefit Options

## Retirees



**Overall, back disorders account for the highest number of services (149,933) and the highest cost for any medical diagnosis (\$47,701,149) for both employees and retirees during the 10/1/05-09/30/06 plan year.**

## Pharmacy Utilization and Costs

The following tables<sup>21</sup> outline the total cost for prescriptions during the 10/1/05-09/30/06 plan year:

	Total Cost	Member Costs <sup>22</sup>	State Cost
Prescriptions Filled at a Retail Store	\$80,519,624	\$20,616,234	\$59,903,390
Mail Order	\$25,043,054	\$ 4,580,789	\$20,462,265
<b>TOTAL</b>	<b>\$105,562,679</b>	<b>\$25,197,023</b>	<b>\$80,365,655</b>

### Average Pharmacy Claims Costs:

	Total Cost	Member Costs <sup>23</sup>	State Cost
Prescriptions Filled at a Retail Store	\$ 60.98	\$15.61	\$ 45.37
Mail Order	\$180.90	\$33.09	\$147.81
<b>OVERALL AVERAGE</b>	<b>\$ 69.67</b>	<b>\$16.78</b>	<b>\$ 52.98</b>

- The Walgreens Health Initiatives program allows for three months of medication for two co-pays; therefore, the average for mail order is higher to reflect the multiple months.

### Number of Prescriptions Filled:

	Number of Prescriptions Filled	Percentage
Prescriptions Filled at Retail Store	1,320,445	90.5%
Mail Order	138,436	9.5%
<b>TOTAL</b>	<b>1,458,881</b>	<b>100.0%</b>

### Number of prescriptions per eligible and utilizing members:

	Claims Per Eligible Member	Claims Per Utilizing Member
Prescriptions Filled at a Retail Store	10.70	15.51
Mail Order	1.12	32.28
<b>OVERALL AVERAGE</b>	<b>11.82</b>	<b>17.13</b>

### Utilization demographics:

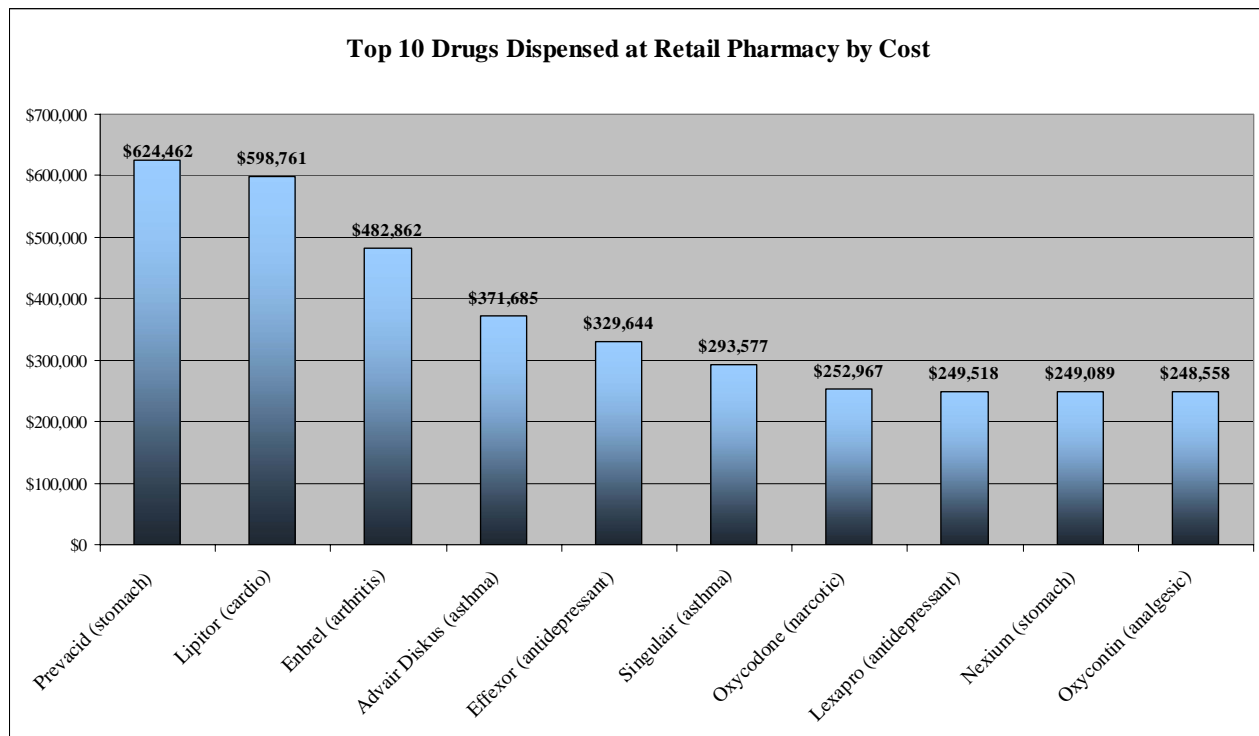
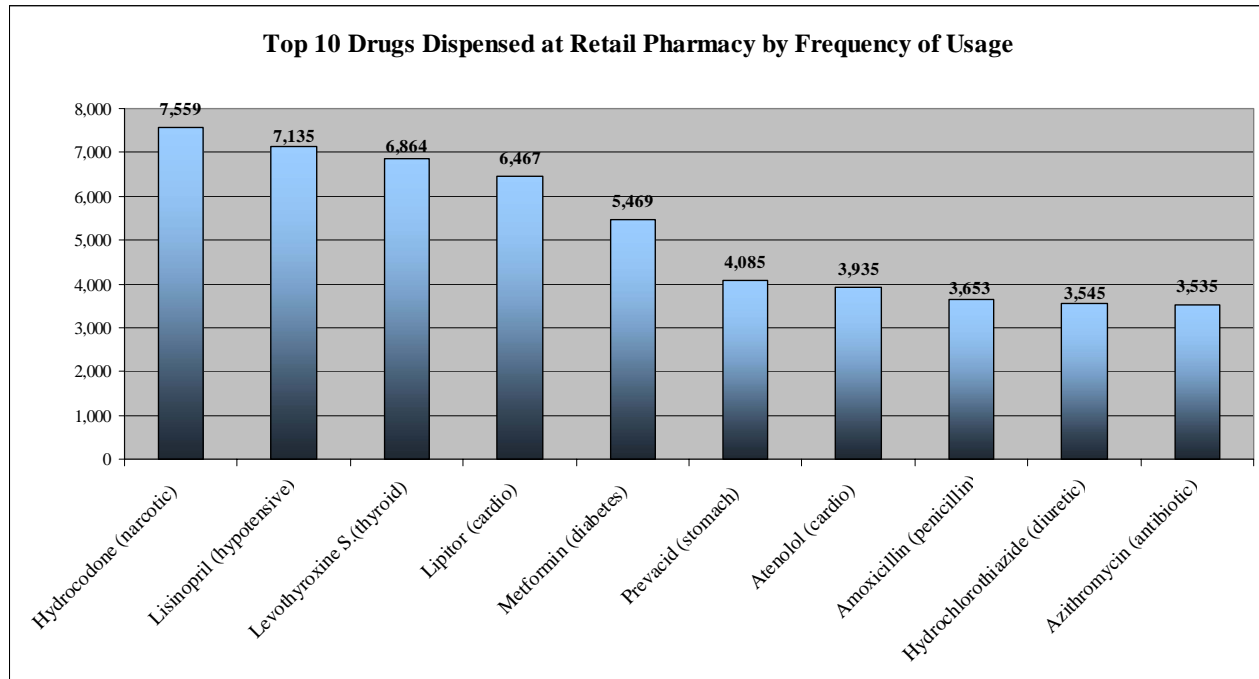
	Average Member Age	Average Days Supply
Prescriptions Filled at a Retail Store	48.1	24.8
Mail Order	57.6	87.4

<sup>21</sup> WHI 2006 4th Qtr. Quarterly Trend Report.

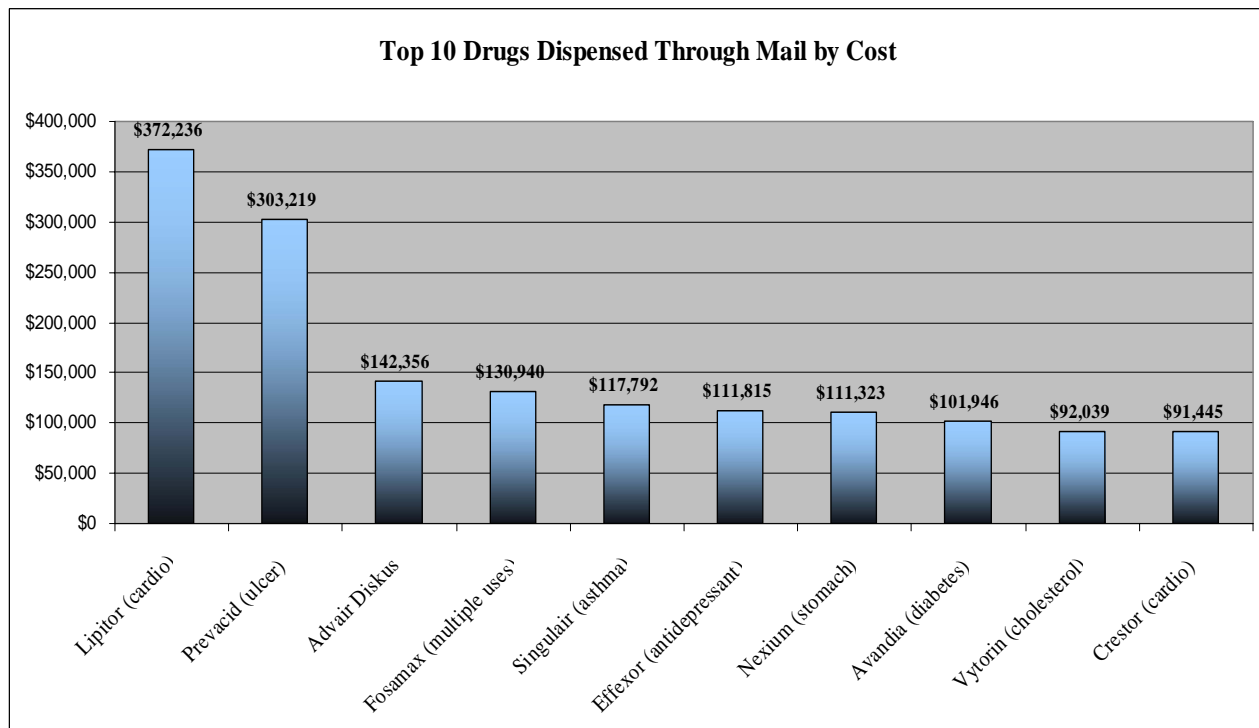
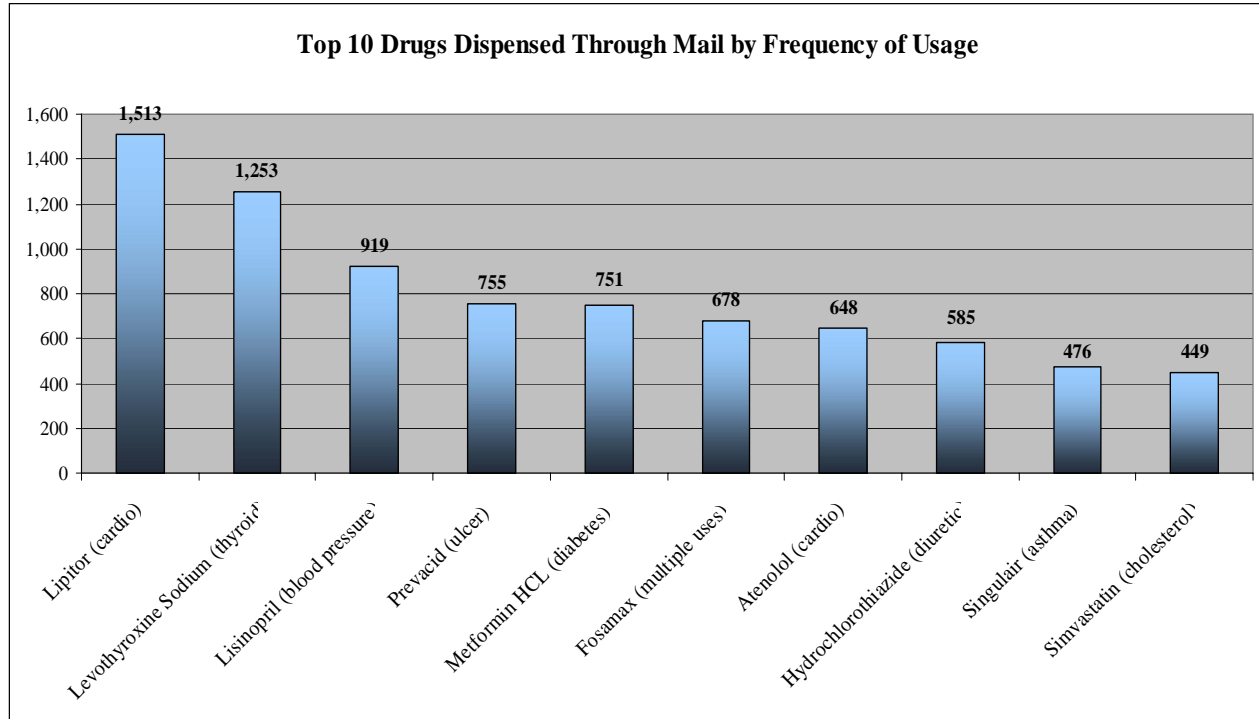
<sup>22</sup> These costs reflect the co-payments made by all health plan members for prescription drugs. The State has a three-tier co-payment structure. For retail sales, copays of \$10 for generic drugs, \$20 for preferred drugs, and \$40 for non-preferred drugs apply. For mail order sales, copays of \$10 for generic drugs, \$20 for preferred drugs, and \$40 for non-preferred drugs apply.

<sup>23</sup> WHI 2006 4th Qtr. Quarterly Trend Report – pg. 7.

## Top 10 Drugs by Frequency of Usage and Cost



**Top 10 Drugs by Frequency of Usage and Cost (continued)**



## Utilization by Formulary Tier

The State has implemented a three-tier formulary:

1st Tier: Generic medications.

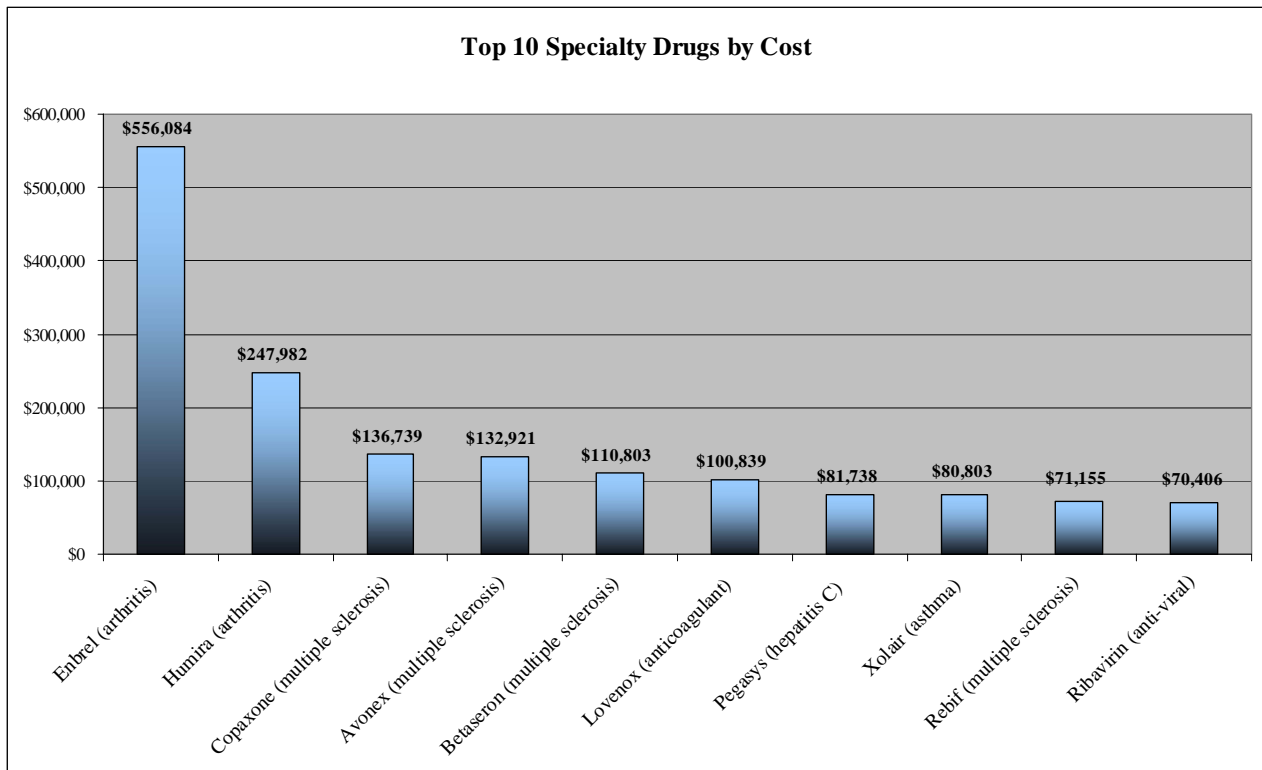
2nd Tier: Preferred medications--these are brand name medications that have the highest discounts.

3rd Tier: Non-Preferred drugs--these are brand name medications with lower or no discounts.

	Generic	Preferred	Non-Preferred
Prescriptions Filled at a Retail Store	58.6%	32.9%	8.5%
Mail Order	47.1%	43.7%	9.2%
<b>TOTAL</b>	<b>57.5%</b>	<b>33.9%</b>	<b>8.6%</b>

## Specialty Drug Utilization and Cost

The State has also implemented a specialty drug program. Specialty drugs are medications that are injected, have special handling requirements such as refrigeration, or are very costly and should be monitored.



**Specialty drugs account for 7.2% of all prescriptions filled in the Benefit Options program, however, these drugs account for 22.2% of the total pharmacy costs within the plan.**

## **DENTAL PLANS**

### **Prepaid Plans - Employers Dental Services (EDS) and Assurant**

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

### **Indemnity/PPO Plans - Delta Dental and MetLife Dental**

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

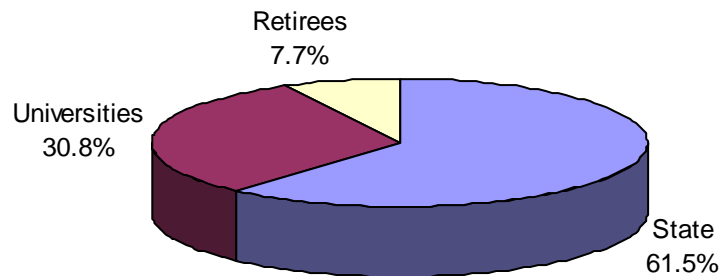
### **Demographics of Enrolled Dental Plan Members**

The Benefit Options group dental plan is available to all:

- Eligible State employees;
- Eligible State University employees;
- Retirees receiving pension benefits through any of the State Retirement Systems;
- State or State University employees accepted for long-term disability benefits;
- Employees of participating political subdivisions of the State of Arizona, or
- State or University employees eligible for COBRA benefits.

**Total Statewide Dental Enrollment<sup>24</sup>**

State Employees	35,560	55.5%
University Employees	18,823	29.4%
Retirees	9,672	15.1%



**Membership by Dental Plan**

Indemnity/PPO Plans	49,796	77.7%
Prepaid Plans	14,259	22.3%

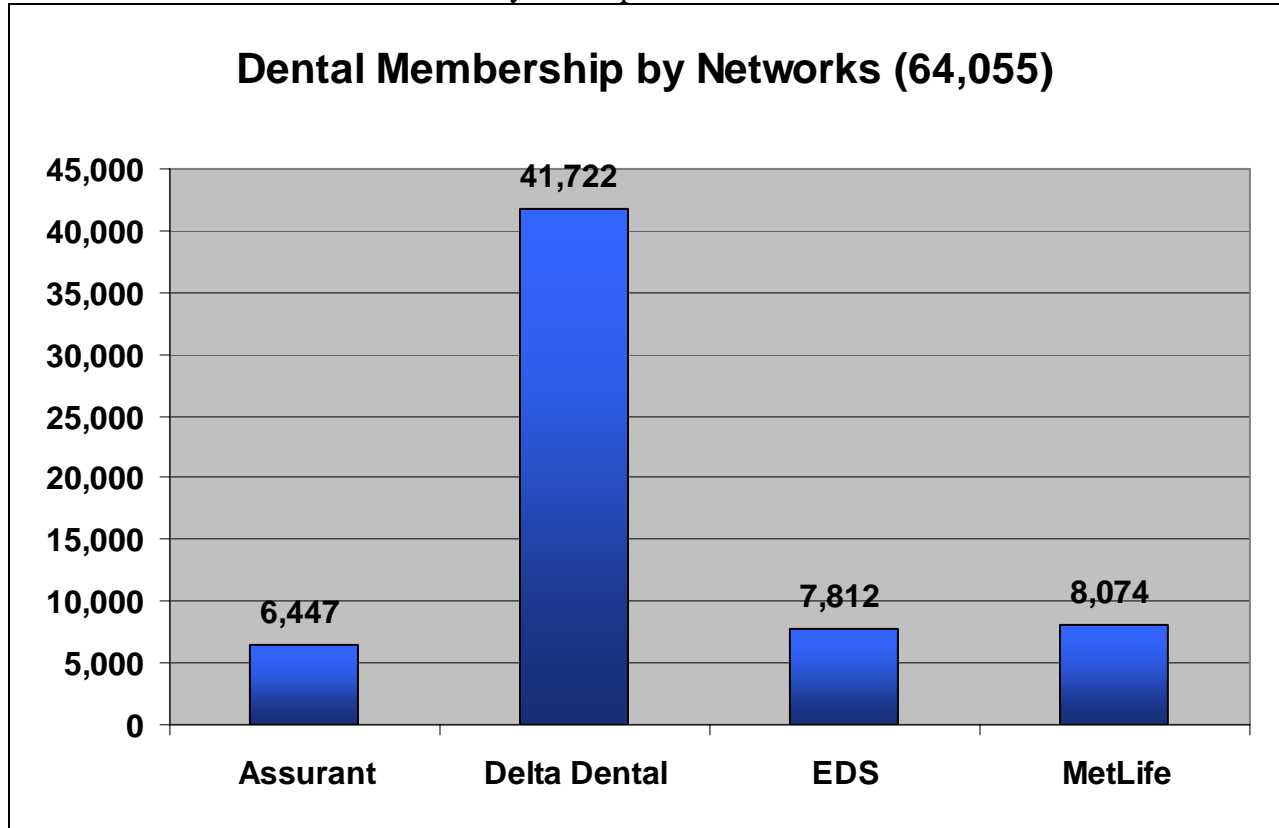
**Family Coverage Status**

Enrolled Single	31,107	48.6%
Enrolled Family	32,948	51.4%

<sup>24</sup> Enrollment and demographic data as of September 30, 2006.

### Dental Plan Membership by Network

The table below illustrates enrollment by dental plan network:



From the options available, members may select the dental plan that best meets their needs and circumstances.

Members may participate in one of the following plans:

• Assurant	Statewide
• Delta Dental	Statewide, Out-of-state
• Employee Dental Service	Statewide
• MetLife	Statewide, Out-of-state

## State and University Dental Rates

	Single Coverage			Family Coverage		
	Employee Rate	State Rate	Total Rate	Employee Rate	State Rate	Total Rate
Assurant	\$4.68	\$6.18	\$10.86	\$18.02	\$11.50	\$29.52
Employers Dental Services (EDS)	\$4.02	\$6.18	\$10.20	\$18.16	\$11.50	\$29.66
MetLife Dental	\$12.90	\$15.40	\$28.30	\$45.00	\$43.50	\$88.50
Delta Dental	\$14.56	\$17.29	\$32.44	\$54.14	\$49.81	\$105.89

## Retiree Dental Rates

Retiree dental rates will increase for Delta Dental only in January 2007. The increase is the same \$1.89 for single coverage and \$6.31 for family coverage presented in the Active employee which is paid by the State.

RETIREE DENTAL PREMIUMS <sup>25</sup>						
	2006 Plan Year	2007 Plan Year		2006 Plan Year	2007 Plan Year	
	Single		Variance	Family		Variance
Assurant Dental	\$10.86	\$10.86	\$0.00	\$29.53	\$29.53	\$0.00
Employers Dental Service	\$10.20	\$10.20	\$0.00	\$29.66	\$29.66	\$0.00
Delta Dental	\$30.55	\$32.44	\$1.89	\$99.58	\$105.89	\$6.31
MetLife Dental	\$28.30	\$28.30	\$0.00	\$88.50	\$88.50	\$0.00

<sup>25</sup> These rates include a \$1.00 communication fee.

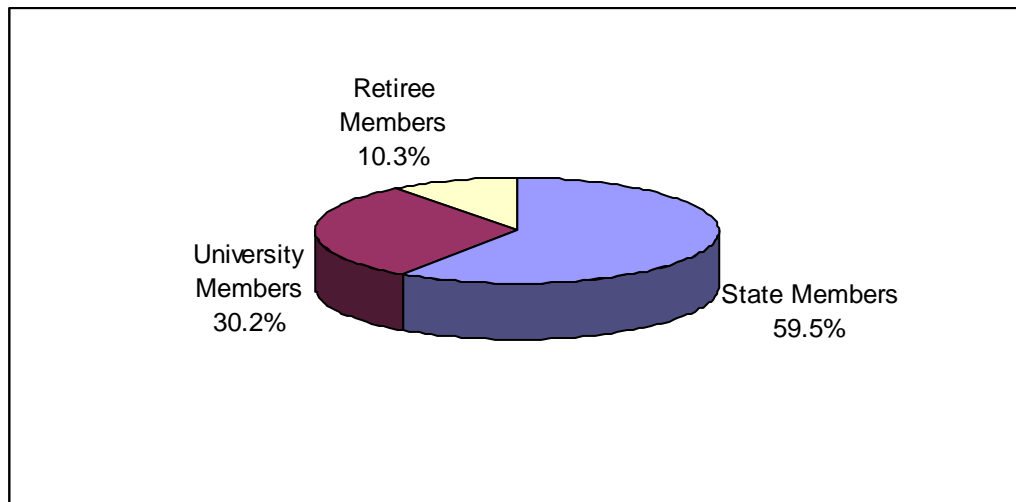
## DEMOGRAPHICS OF ENROLLED VISION PLAN MEMBERS

The Benefit Options group vision plan is available to all:

- Eligible State employees;
- Eligible State University employees;
- Retirees receiving pension benefits through any of the State Retirement Systems;
- State or State University employees accepted for long-term disability benefits;
- Employees of participating political subdivisions of the State of Arizona, or
- State or University employees eligible for COBRA benefits.

### Total Statewide Vision Enrollment

State Employees	23,687	59.5%
University Employees	11,889	30.2%
Retirees	2,968	10.3%



### Family Coverage Status

Enrolled Single	20,655	54%
Enrolled Family	17,889	46%

Members may participate in the following plan:

- Avesis Statewide, Out-of-state

## Short-Term Disability

The Benefit Options group vision plan is available to all:

- Eligible State employees or
- Eligible State University employees.

## Average Number of Claims per Month

Approved	Denied	Closed	Paid
109	23	132	998

## Number of Claims 2006 Plan Year

Number of Claims 2006 <sup>26</sup>	Approved	Denied	Closed	Paid	Amount issued
	982	209	1,189	8,985	\$5,026,117.61

<sup>26</sup> Data from January 1 to November 30, 2006 (missing February and April 2006 data).