Arizona
HUMAN RESOURCES

2005 Annual Report

Benefit Options Health Plan

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Governor

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Benefit Options
Choice. Value. Health.

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GLOSSARY OF TERMS

Claim Demand for payment to the claims payor for medical services.

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. Members must pay the full cost of the premium.

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

Copayment A form of medical cost sharing in the health plan that requires the member to pay a fixed dollar amount when a medical service is received before a copayment applies.

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.

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

Exclusive Provider Organization (EPO) Similar to a preferred provider organization plan, an EPO is a more restrictive type of plan under which members must use providers from the specified network of physicians and hospitals to receive coverage. There is no coverage for care received from a non-network provider except in an emergency situation.

Formulary A list of 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 divided by generic, preferred, and non-preferred medications.

Fully-Insured A plan that is funded entirely with a premium 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 both the financial risks associated with providing comprehensive medical services to enrolled members, usually in return for a fixed, prepaid premium. An HMO plan requires additional restrictions, such as prior authorization for specific medical procedures and a 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 processes and payments; a medical network of medical providers; and disease management services.

Medicare The federal health insurance program provided to members who are age 65 and older or members with disabilities who are eligible for Social Security benefits. Medicare has three parts: Part A, which covers hospitalization; Part B, which covers physicians and medical providers; and Part C, which expands the availability of managed care arrangements for Medicare recipients.

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

Network An organization who contracts with a group of providers (physicians, hospitals, and other health care professionals) to provide health care services. These contracts 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 processes and payments; a medical network of medical providers; and disease management services.

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 in the form of rebates and reduced costs in the formulary.

Plan Year The Benefits Options plan year operated from October 1, 2004 through September 30, 2005. Unless otherwise noted, all references to yearly or annual calculations will conform to this time frame.

Premium Agreed upon fees paid for coverage of medical benefits for a defined benefit period. 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) A PPO plan is a less managed plan that has all of the features of an HMO plan, however, allows members to go outside of the network for medical services. A PPO also requires annual deductibles and copayment for services.

Self-Insured A plan that is funded by the employer and is financially responsible for all medical claims and administrative expenses. The employer also assumes all liability for health plan appeals and litigation.

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

Third Party Administrator An organization that handles all administrative functions of a health plan, including the receipt and processing of all medical claims; payment of claims; compiles data and reports; and provides customer service support through a call center, correspondence, or the internet.

INTRODUCTION

HISTORY AND BACKGROUND

In 1971, the Arizona State Legislature created ARS§ 38-651. This statute authorized the Arizona Department of Administration (ADOA) to offer group health insurance as a benefit to all State and University employees. Prior to 1971, only the Agencies and Universities that could afford to pay for health insurance were able to offer this benefit to their employees. With the implementation of ARS§ 38-651, all State and University employees were offered health insurance coverage. In 1976, State and University retirees were added to the program.

In 1982, ADOA offered its first Health Maintenance Organization (HMO) plan to the program. Throughout the next 18 years, employees and retirees were able to choose from several fully-insured plans, including HMO plans, Point of Service (POS) plans, and Preferred Provider Organization (PPO) plans. Due to changes in the health care industry, the State transitioned to one statewide insurance carrier in 2001.

CONTRIBUTION STRATEGY

With the transition to the sole contract 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 2001 contribution strategy allowed employees to pay only 23% of the total premium, while the State absorbed the remaining 77%.

Over the 5 years between 2001 and 2006, State and University employees enrolled in the HMO plan (or EPO plan under self-insurance) have not experienced an increase in their monthly premiums. Employees enrolled in the non-HMO plans have not experienced an increase for 3 years (2003 through 2006).

Due to continued rising premiums, on average, the State now contributes over 84% of the total premiums for health insurance.

NEED FOR CHANGE

Due to the continued rising cost of healthcare, ADOA began exploring its option to rein in the cost of its health benefit program. All potential alternatives were explored and, after significant research, self-insurance was determined to be the best option to control spiraling costs and provide more choice for State employees, retirees, and their families.

In 2002, the Arizona Department of Administration began to develop a self-funded model for the employee group health program. After considerable research of best practices in other states and two years of program development, the Joint Legislative Budget Committee gave a favorable review of the new health plan on May 25, 2004.

PROGRAM GOALS

With the transition to self-insurance, the State will have the ability to maximize the value of health benefits to State employees and retirees through improved choice and improved program design. Focusing on this mission allowed the State to achieve the following goals:

- Improve Provider Choice — Employees, retirees and their families will have more providers available to them statewide among multiple networks. Members are also able to choose an HMO-like managed care plan called an Exclusive Provider Organization (EPO)[1] plan or Preferred Provider Organization (PPO) plan. In addition, members have substantially improved administrative choice and are able to choose among multiple vendors and benefit administration approaches.

- Improve Program Design — The State now has access to all utilization data. Therefore program decisions will now be made based on data analysis. This ensures that program changes are implemented to improve program efficiency, reduce inappropriate healthcare utilization, and enhance benefits offered to employees and retirees.

- 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. Disease management programs include Asthma, Congestive Heart Failure, Diabetes, and Perinatal Care. With the implementation of self-insurance, more employees and retirees are enrolled in the disease management programs than under the prior fully-funded health plan. Retirees are now included in wellness initiatves, including free flu shots and health screenings (skin cancer, cholesterol, etc.) With the expansion of disease management and wellness, the State can anticipate a positive impact to improve the long term health and welfare of all health plan members.

[1] Since a self-funded medical plan is not under the jurisdiction of the Arizona Department of Insurance, a managed care plan cannot be called an HMO (health maintenance organization). An EPO plan is the equivalent to an HMO under a self-funded program.

PROGRAM STRUCTURE

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 60,000 employees, retirees, COBRA participants, and long-term disability members enrolled in the new plan. This is an increase of over 1,300 new members, versus the 58,666 previously enrolled in the prior fully-insured plan.

Over 86% of employees and retirees reported they were satisfied with the Open Enrollment process and the transition to self-insurance.

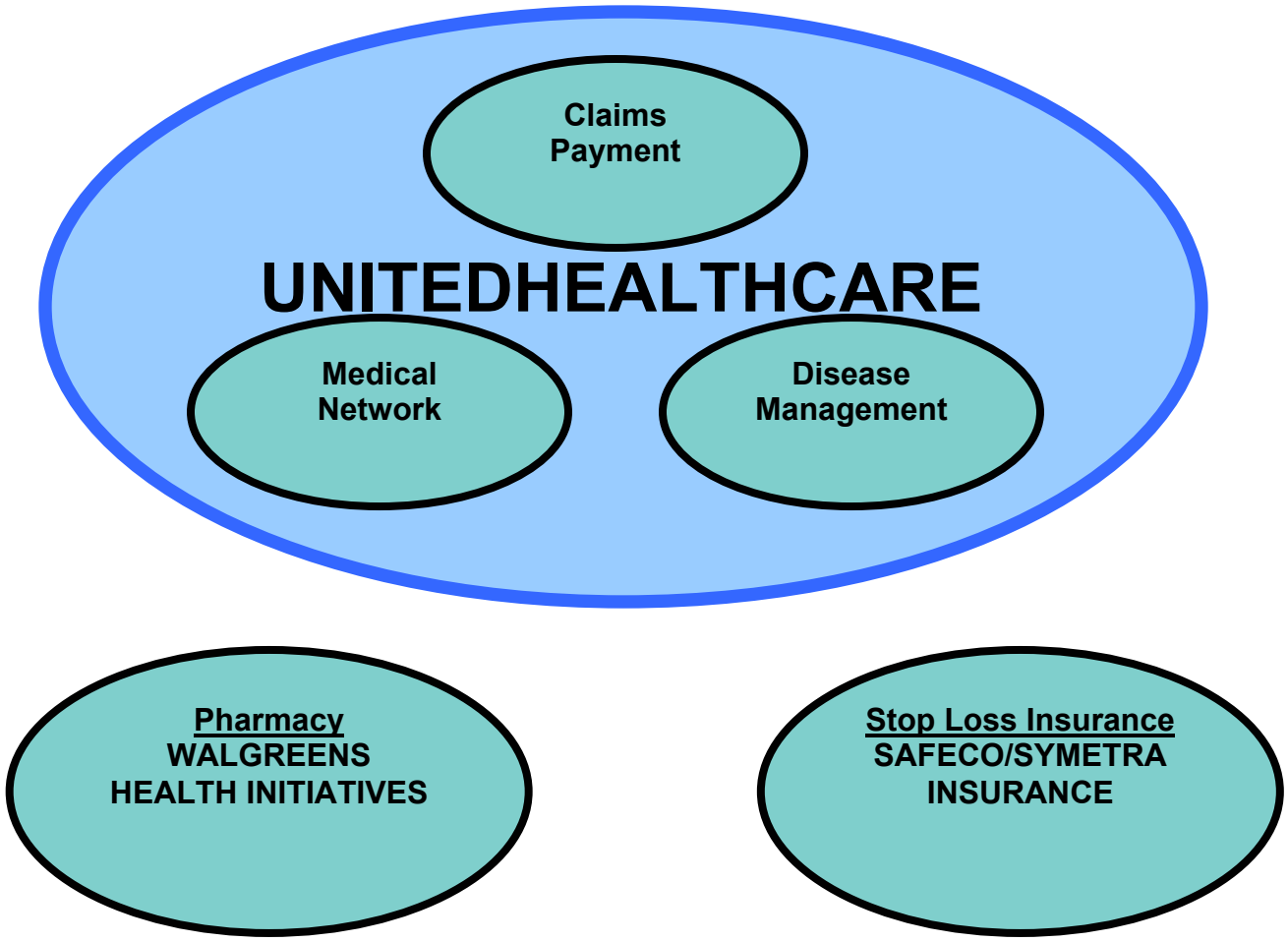
PROGRAM STRUCTURE

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

- Claims Payment — The ability to receive, process, and pay medical and pharmacy claims.
- Medical Network — A statewide network of hospitals, medical professionals, and ancillary services such as x-rays, laboratories, and physical therapy.
- Pharmacy — Access to a statewide network of pharmacies, as well as the ability to distribute specialty drugs that require special handling or injections.
- Disease Management — 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.
- Stop Loss Insurance — This insurance provides coverage for expensive medical claims above $500,000.

INTEGRATED OPTION[2]

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:

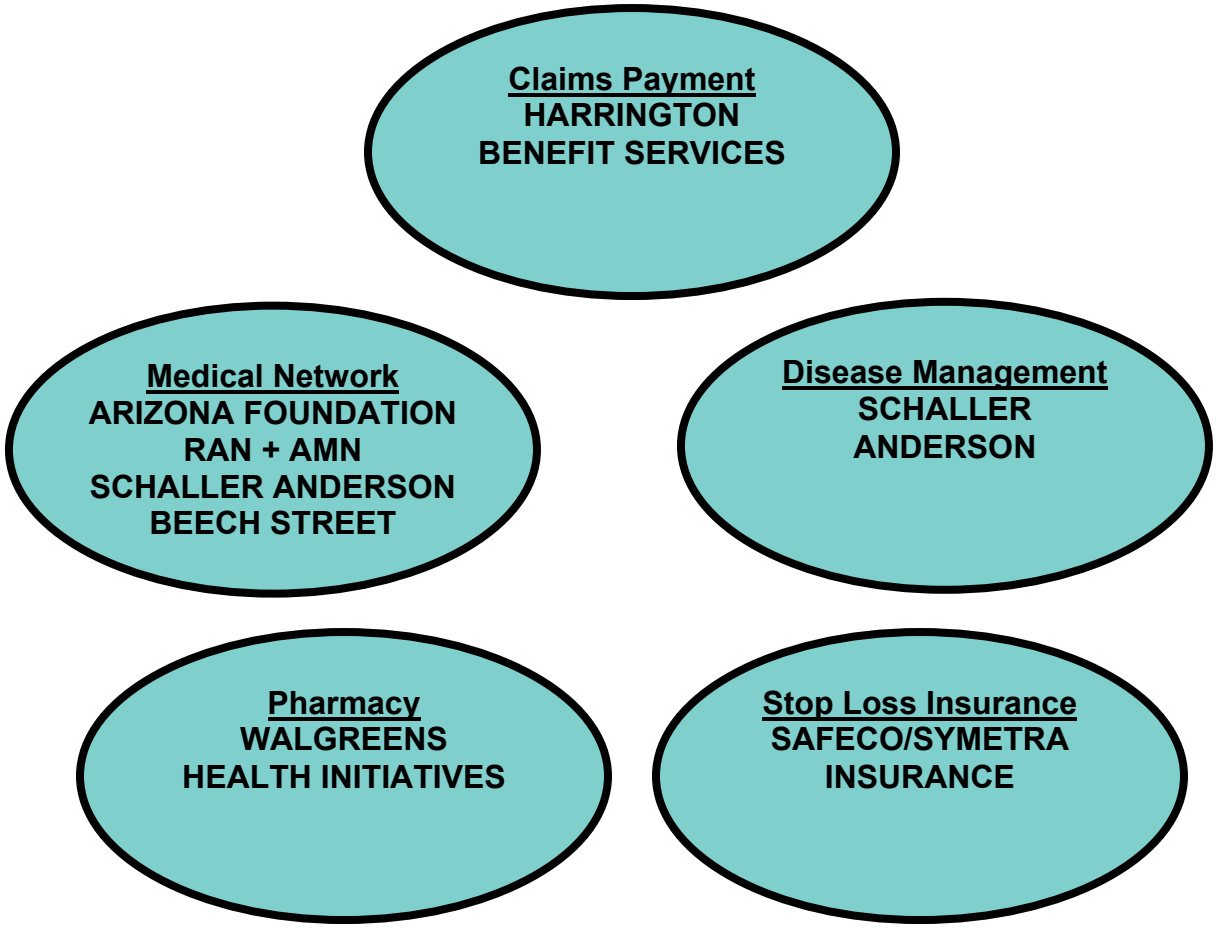


[2] PacifiCare Secure Horizons is also contracted under the integrated option. This is a fully-insured Medicare Advantage plan and is only offered to retirees who are Medicare Eligible.

NON-INTEGRATED OPTION

The non-integrated option offers all of the health plan services under separate contracts. Because 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 — Harrington Benefit Services
- 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



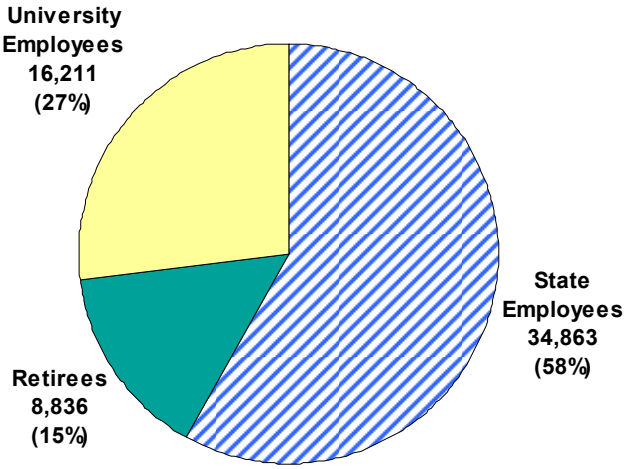
To provide additional flexibility for employees and retirees, both the integrated and non-integrated options offer open access to specialists. Members do not need referrals from their primary care provider to see a contracted specialist.

ENROLLMENT

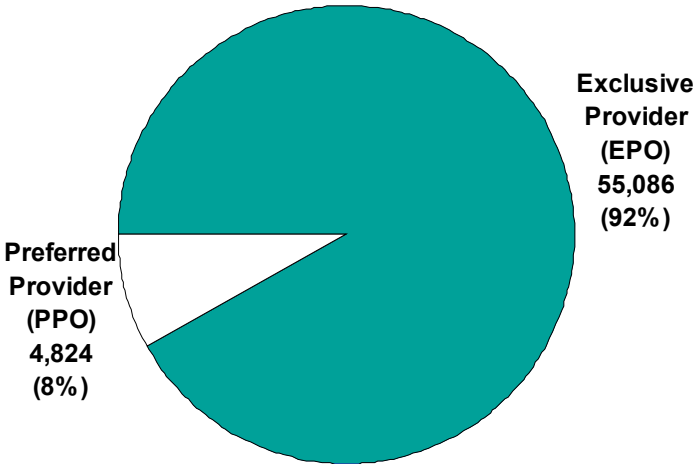
The Benefit Options group health plan is available to all…

- Full-time State employees;
- Full-time University employees;
- Retirees receiving pension benefits through any of the four State Retirement Systems;
- State or University employees accepted for long-term disability benefits; or
- State or University employees eligible for COBRA benefits.

TOTAL STATEWIDE ENROLLMENT[3] (59,910)

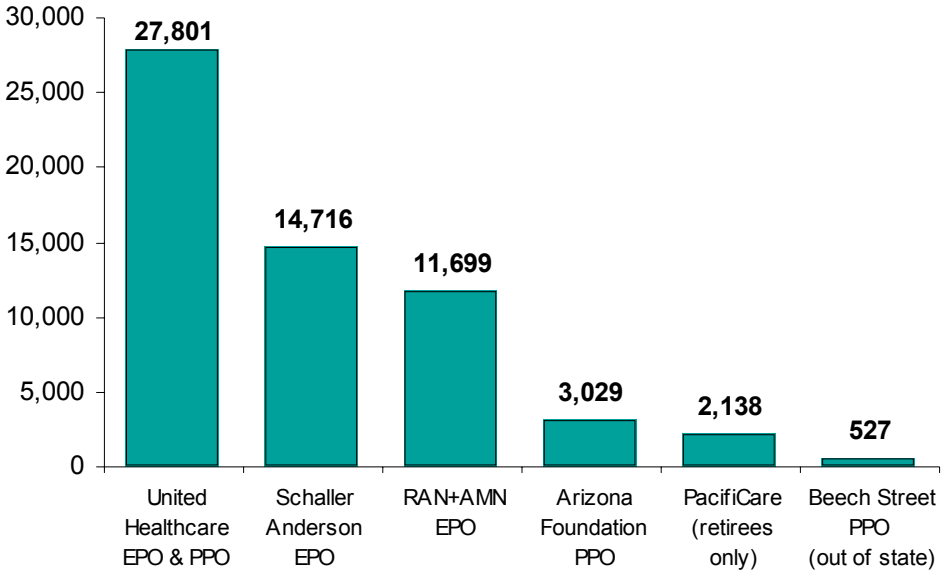


MEMBERSHIP BY HEALTH PLAN (59,910)



[3] Enrollment and demographic data as of February 28, 2005, reflecting the plan year 10/1/04-09/30/05.

MEMBERSHIP BY NETWORK (Total Membership 59,910) [4]



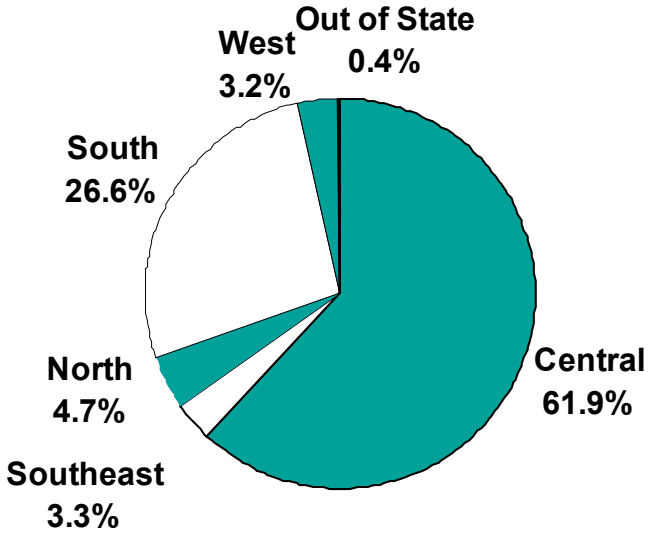
- Arizona Foundation PPO plan is offered statewide to all employees and retirees.
- Beech Street PPO plan is offered to out-of-state employees and retirees.
- PacifiCare is only offered to Medicare-eligible retirees.
- RAN+AMN EPO plan is offered statewide to all employees and retirees.
- Schaller Anderson Healthcare EPO plan is offered to employees and retirees in Maricopa, Pinal, Gila, Pima, and Santa Cruz Counties[5].
- UnitedHealthcare EPO and PPO plans are offered to employees and retirees in Maricopa, Pinal, Gila, Pima, and Santa Cruz Counties.

The availability of multiple networks has enabled the State to achieve its goal of improving provider choice for all employees and retirees statewide. For example, members are now able to select from four different networks in the urban areas and two networks in the rural areas. The total number of physicians available in the health plan continues to grow by 0.5% each month.

[4] United Healthcare membership reflects members enrolled in both the EPO plan and PPO plan. No other networks offer both an EPO and PPO option.
[5] Schaller Anderson was expanded statewide effective October 1, 2005.

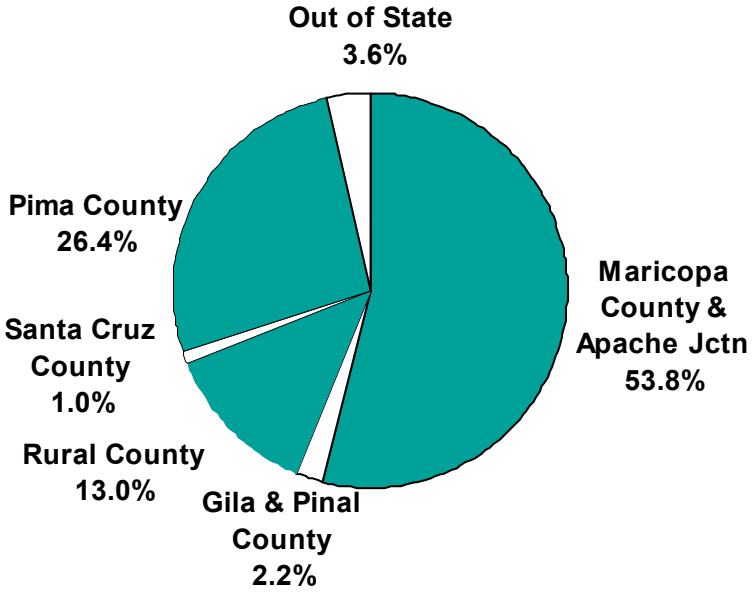
MEMBERSHIP BY REGION

The first chart illustrates the enrolled membership of state and university employees based on geographic region (total membership is 51,074).



Central = Maricopa, Gila, and Pinal Counties
Southeast = Graham, Greenlee, and Cochise Counties
North = Yavapai, Coconino, Navajo, and Apache Counties
South = Pima and Santa Cruz Counties
West = Mohave, La Paz, and Yuma Counties

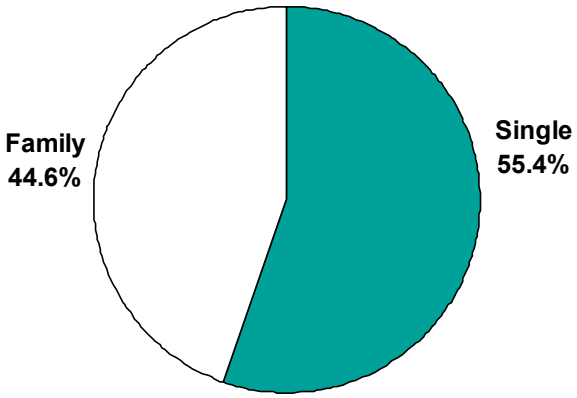
The chart below illustrates the enrolled membership of retirees based on geographic region (total membership is 8,836).



DEMOGRAPHICS

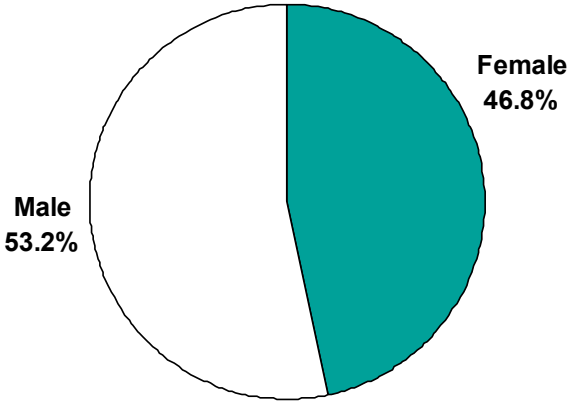
FAMILY COVERAGE STATUS[6]

The majority of enrolled members have elected single coverage instead of family coverage.



GENDER STATUS[7]

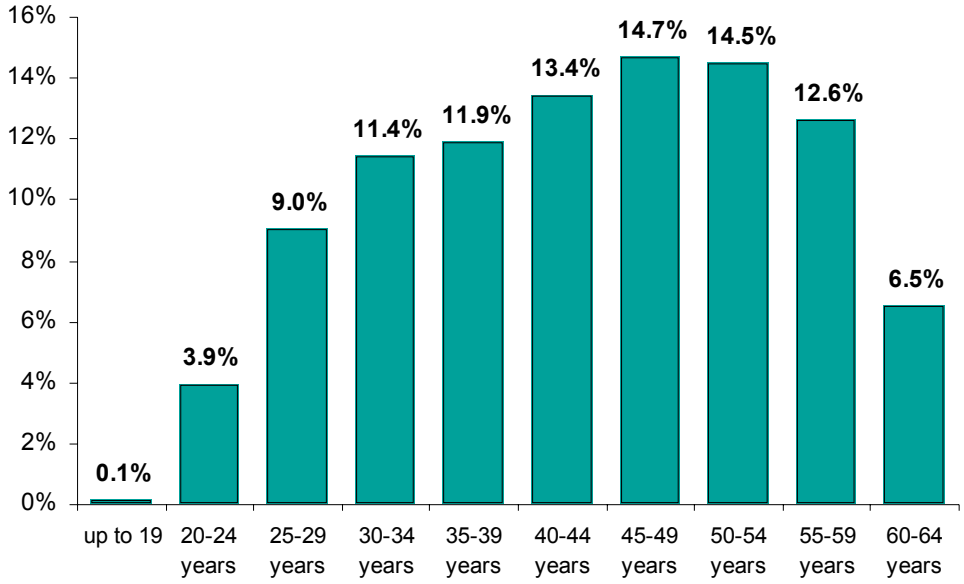
The majority of enrolled members are male.



[6] State employee and University employee enrollment only.
[7] State employee enrollment only- ADOA does not receive this information from the Universities.

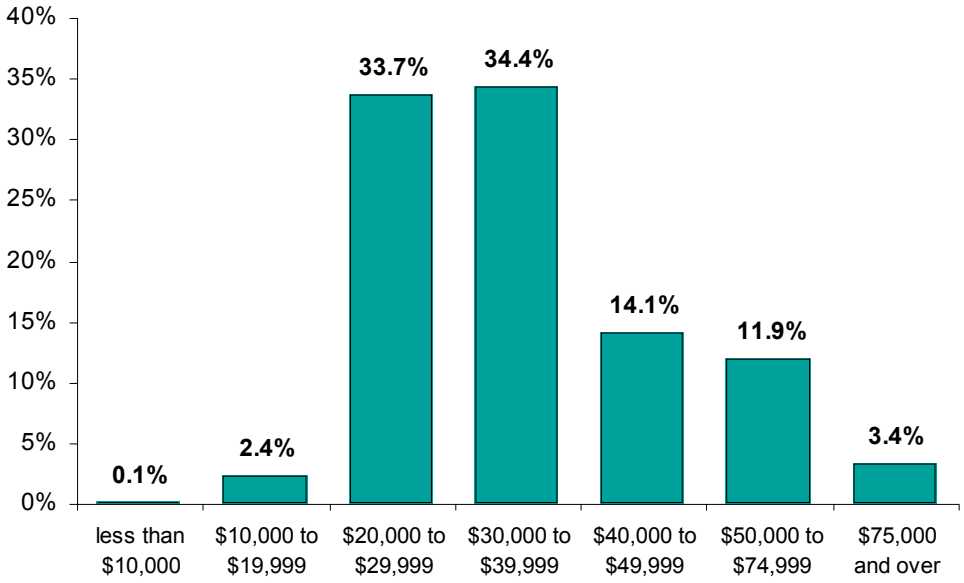
AGE DISTRIBUTION OF ENROLLED STATE EMPLOYEES[8]

The chart below illustrates the distribution of enrolled State employees by age.



SALARY DISTRIBUTION OF ENROLLED STATE EMPLOYEES

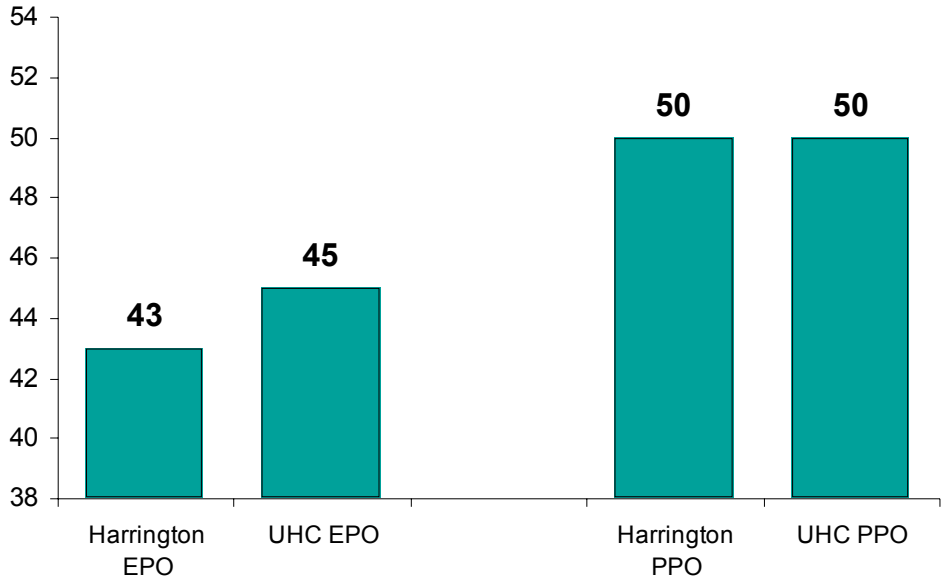
The chart below illustrates the distribution of enrolled State employees by salary.



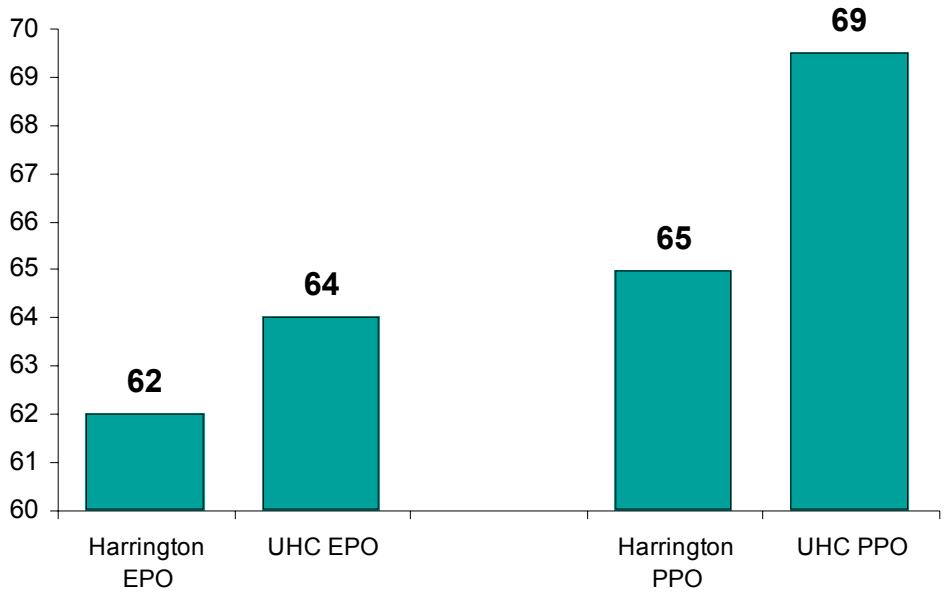
[8] ADOA does not maintain this information for University employees

AVERAGE AGE BY PLAN

The chart below illustrates that the PPO plan attracted older employees than the EPO plan.

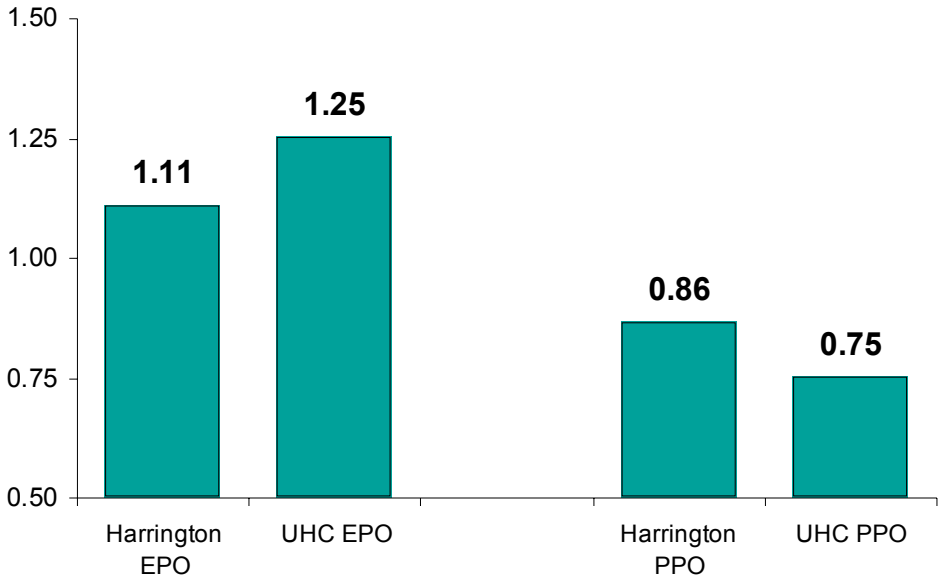


The same trend is true among the enrolled retiree population; older members selected the UHC plan, while younger retirees selected the Harrington plan.

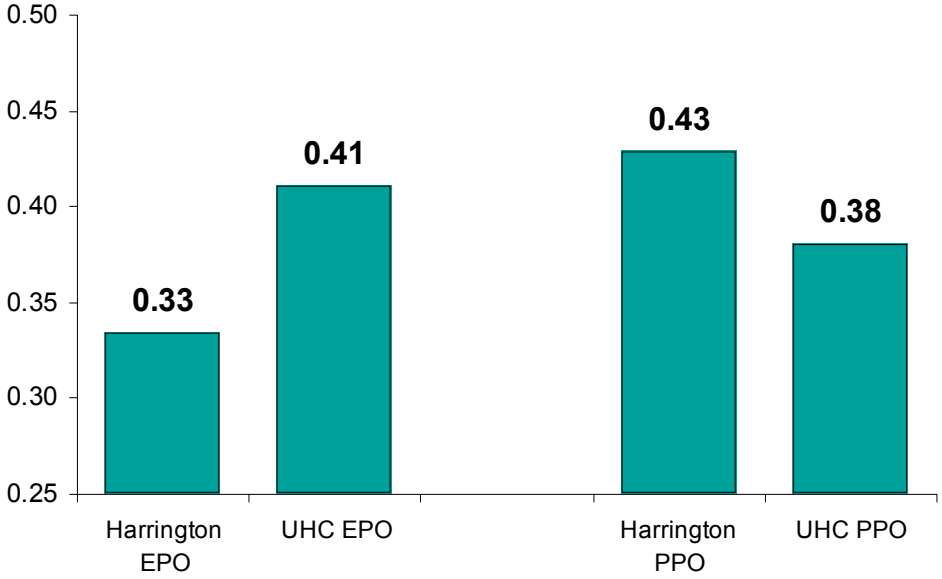


DEPENDENTS PER MEMBER BY PLAN[9]

The chart below illustrates the ratio of covered dependents per enrolled employee member. On average, for every member enrolled in the EPO plans, there were 1.18 dependents that were covered, with UHC attracting slightly larger families. On average, for each member that 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.

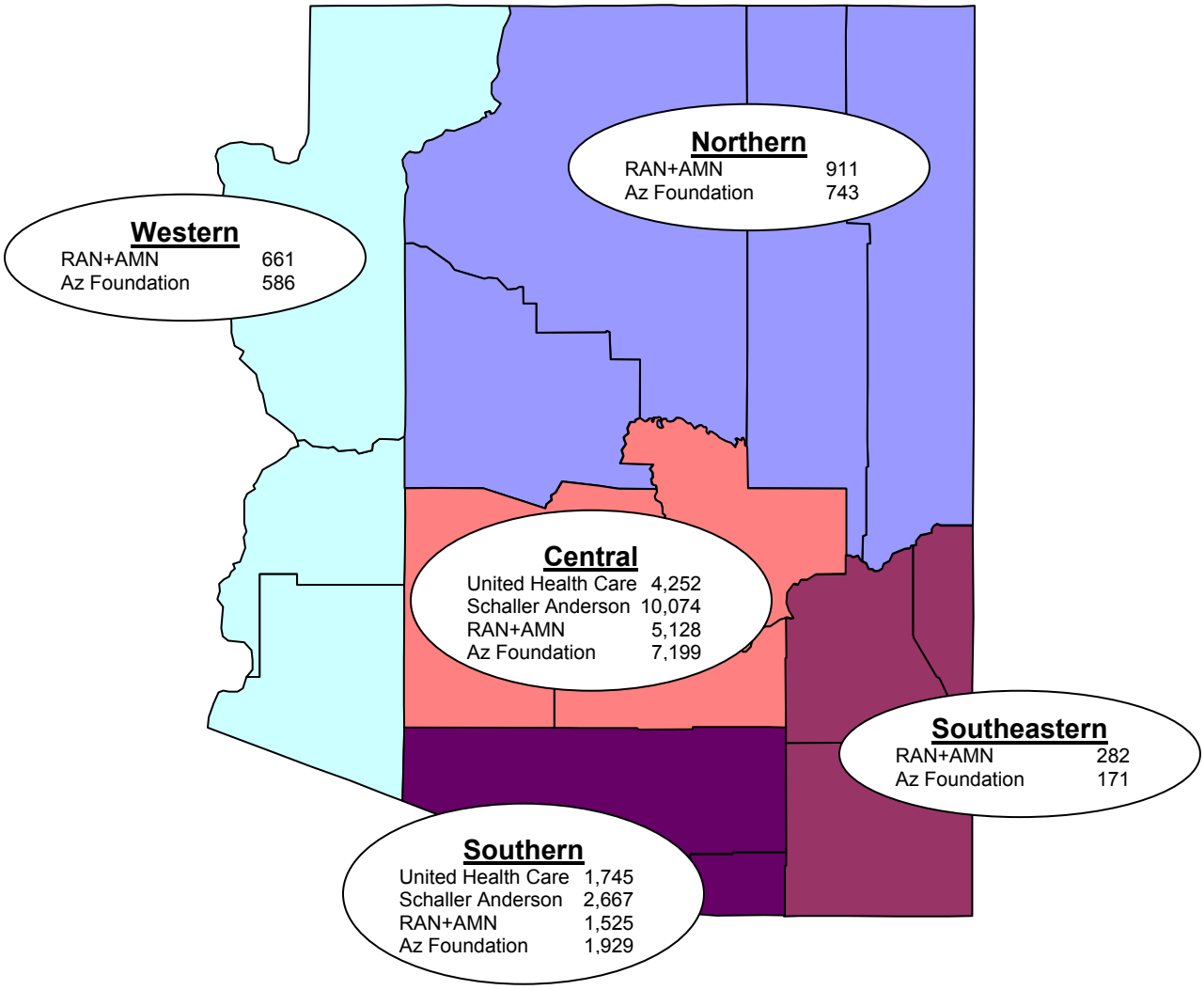


[9] Dependents include spouse and any children under age 18 (or under age 24 if attending school full time).

CONTRACTED PHYSICIANS

NETWORK STATISTICS[10]

The following illustration reflects the number of contracted physicians in each network by region (data compiled as of July, 2005):



[10] Beech Street provides a nationwide network for out-of-state employees and retirees. Beech Street was not included in this analysis.

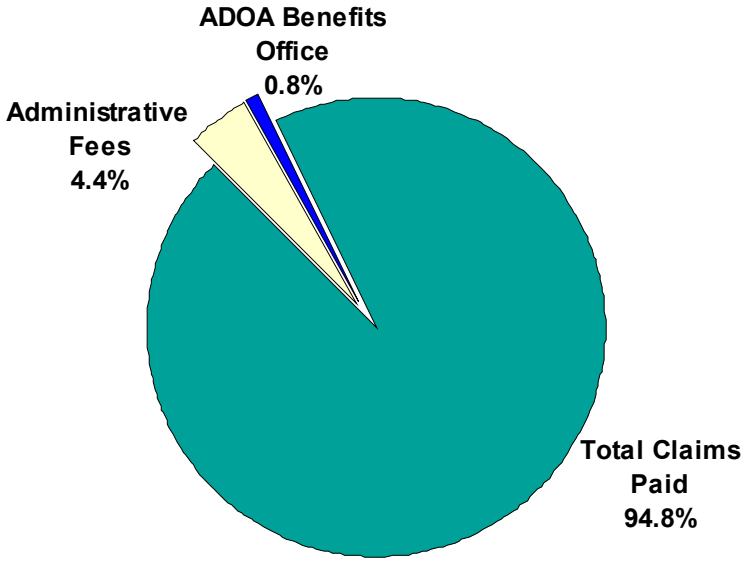
CLAIMS & COSTS

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

Evaluation of financial and utilization data will enable the State to achieve its goal of improved plan design, because program gaps and inefficiencies can now be identified. Program modifications and changes can be made to improve financial efficiency, impact inappropriate health care utilization, and specifically target the needs of health plan members.

TOTAL HEALTH PLAN COSTS

The following chart illustrates the total costs for the Benefit Options health plan, and the small percentage of costs that are attributed to administrative expenses.

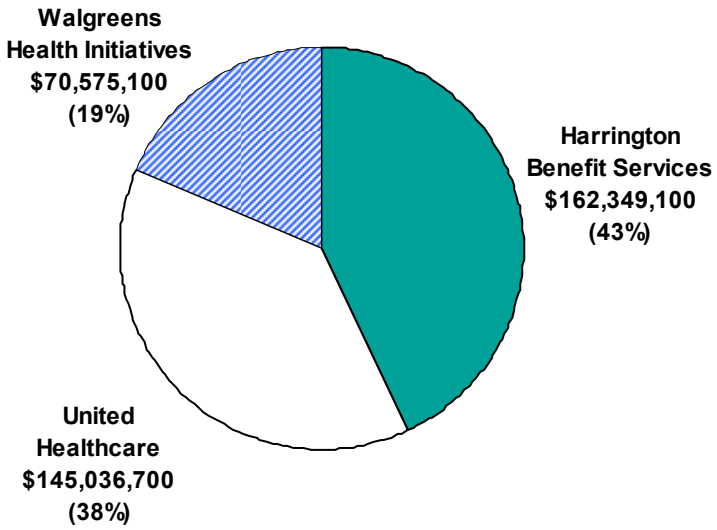


- During the last plan year, $17.7 million in administrative fees were paid to the contracted vendors.
- The ADOA Benefits Office is appropriated $3.2 million for personnel and management of the State's benefit plans[11].

[11] The Benefits staff performs tasks on all benefits, therefore, the appropriated amount includes administration of non-health benefits including, dental, vision, life, and disability insurance.

TOTAL PAID CLAIMS

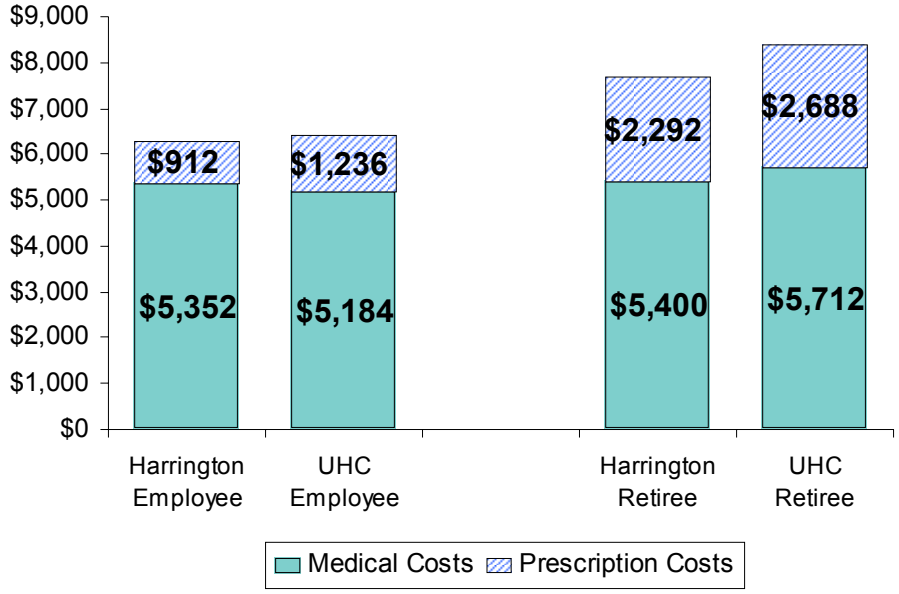
The chart below outlines the total paid claims for all health plan members[12] for the past plan year. The total amount of paid claims was $377,960,900.



[12] Although retirees enrolled in PacifiCare are covered under a fully-insured basis, non-Medicare eligible family members are covered on a self-funded basis. The State paid $748,000.00 in medical claims for family members during the 10/1/04-09/30/05 plan year.

PER CAPITA COSTS - EMPLOYEES VS. RETIREES

The below chart shows actual per capita expenditures[13] for the past plan year comparing costs between employees[14] and retirees. Retirees have higher per capita costs, regardless of which plan was selected. Most of the difference between employees and retirees can be attributed to prescription costs.



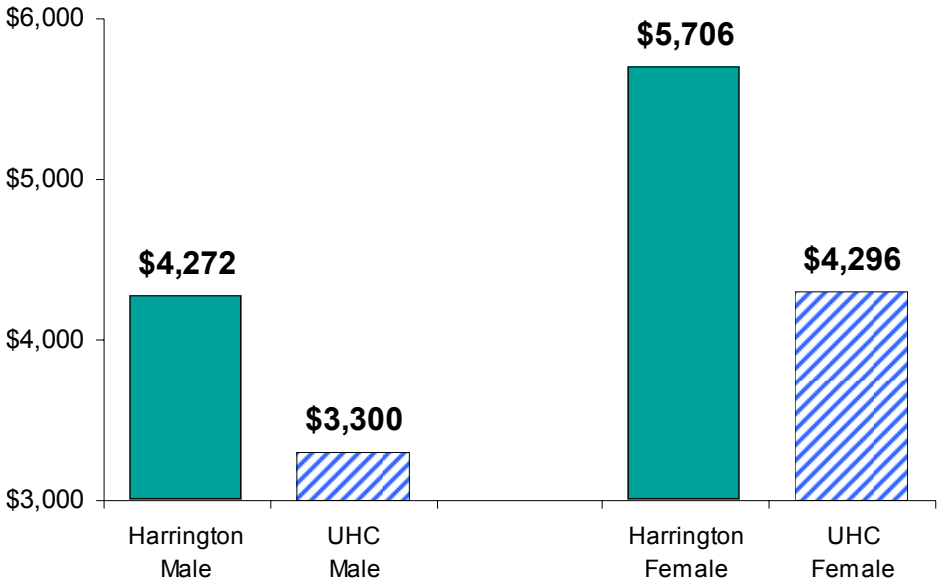
The Office of the Actuary for Centers for Medicare & Medicaid Services had projected the national health expenditures on a per capita basis for 2004 would be $6,040. Without adjusting for risk factors, the per capita costs for the Benefit Options health plan are slightly higher than the national average.

[13] Costs are reflected on a per enrolled member basis- this includes the employee/retiree and any covered family members.

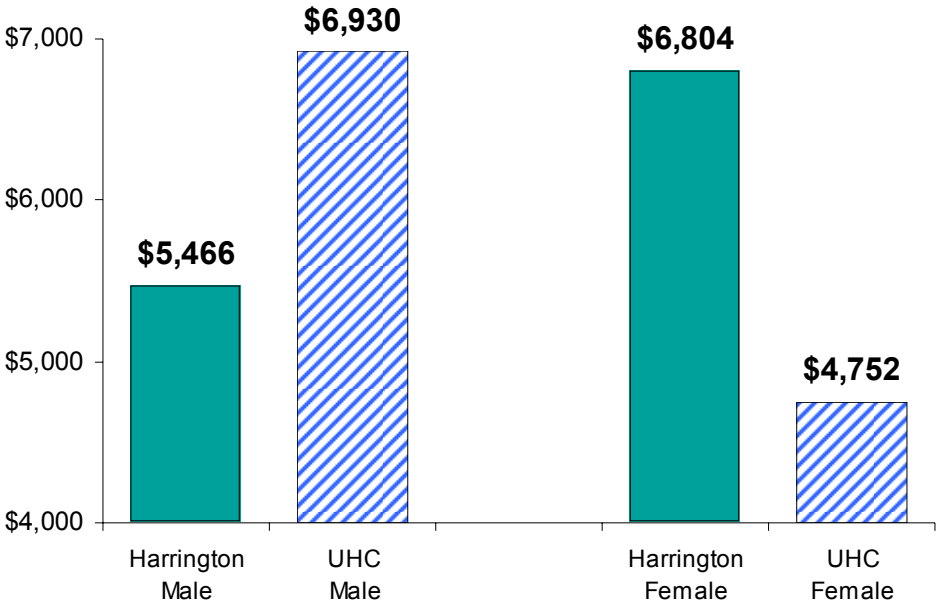
[14] Information includes State employees and University employees.

PER CAPITA COSTS- MALES VS. FEMALES

The chart below reflects per capita expenditures for enrolled employees for the past plan year. Expenditures on a per capita basis were higher for female employees and for employees enrolled in the Harrington plans.



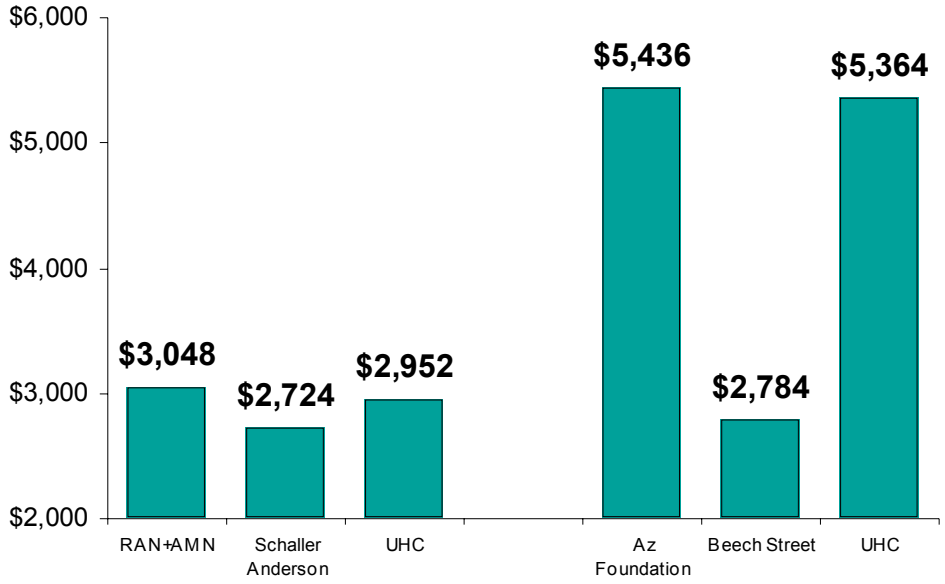
Retirees (below) had higher per capita expenditures than employees (above), although the differences between male and females was not consistent across plan types.



Variations in cost between the plans covered by Harrington Benefits and UnitedHealthcare may reflect differences in medical expenditures between urban and rural areas of the state. UnitedHealthcare is only offered in the urban areas of the state. The plans covered by Harrington Benefits are offered statewide.

PER CAPITA COSTS- EMPLOYEES BY NETWORK AND ENROLLMENT

The chart below shows total per capita healthcare costs for State and University employees by network and plan for 10/1/04-08/30/05[15]:



In the EPO plans, Schaller Anderson has the lowest per capita costs and RAN+AMN members have the highest. In the PPO plans, Beech Street has the lowest per capita costs, while Arizona Foundation has the highest.

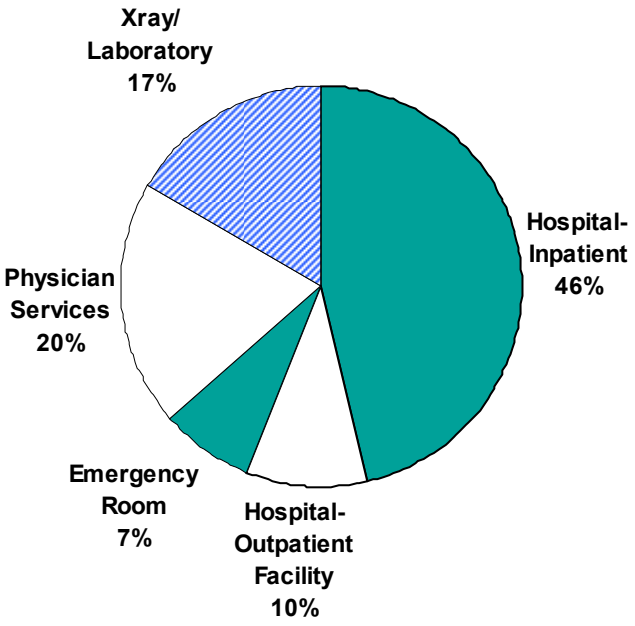
Variations in cost between the plans covered by Harrington Benefits and UnitedHealthcare may reflect differences in medical expenditures between urban and rural areas of the state. UnitedHealthcare is only offered in the urban areas of the state. The plans covered by Harrington Benefits are offered statewide

[15] Total costs include medical and prescription costs. Costs are reflected on a per enrolled member basis- enrolled employee/retiree to include covered family members. This data is provided by Mercer HumanResource Consulting.

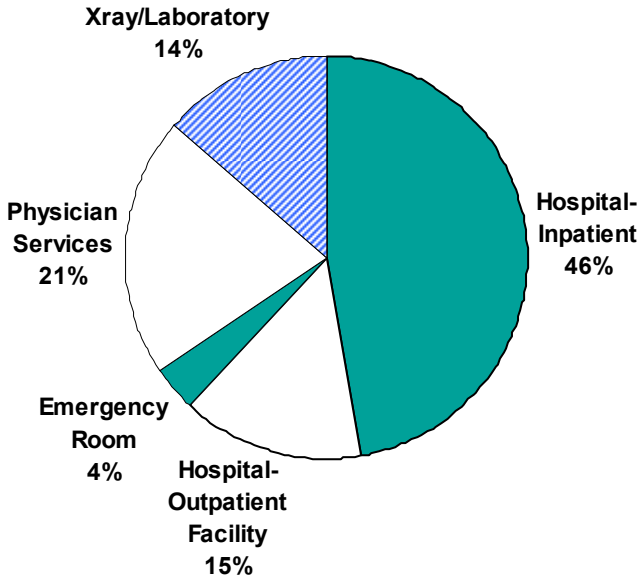
TYPES OF SERVICE

PAID CLAIMS BY TYPE OF SERVICE- TOP 5

The chart below illustrates the top 5 total paid expenditures for the past plan year by type of service for state and university employees. The largest expenditures were for inpatient hospitalizations, followed by physician services.



The chart below illustrates the top 5 total paid expenditures for the past plan year by type of service for the retiree population. Relative distribution was similar to the employees, except for higher expenditures for outpatient hospital visits, and lower emergency room expenditures[16].



HOSPITALIZATIONS

Inpatient hospital care accounts for the highest expenditures in overall health plan costs. Therefore, it is important to look at the utilization of hospitalizations:

State and University Employees

	Number of Admits per 1000	Average Length of Stay	Avg. Hospital Days per 1000	Avg. Paid per Day in Hospital	Per Member Per Month Cost
Harrington Benefit Services	49.8	4.50 days	224	$2,996	$55.93
UnitedHealthcare	75.0	4.12 days	309	$2,191	$56.42

Retirees

	Number of Admits per 1000	Average Length of Stay	Avg. Hospital Days per 1000	Avg. Paid per Day in Hospital	Per Member Per Month Cost
Harrington Benefit Services	107.2	5.30 days	559	$3,188	$159.13
UnitedHealthcare did not provide this information for all retirees.					

- Although State and University members enrolled in the UnitedHealthcare plans had higher hospital admissions, the average cost per hospitalization was lower than members enrolled with the Harrington plans.

[16] UnitedHealthcare did not report figures for Medicare-eligible retirees for emergency room services. These costs are underreported.

EMERGENCY ROOM VISITS

Evaluation of emergency room encounter data will provide an opportunity for the State to review the types of conditions presented and possibly reduce potential unnecessary visits through improved medical management and urgent care utilization:

	Total ER Visits	Total Costs	Avg. Per Visit
Harrington Benefits			
Employees and Dependents	11,976	$11,324,422	$945
Retirees and Dependents	15,803	$ 2,796,430	$176
UnitedHealthcare			
Employees and Dependents	16,062	$6,654,201	$414
UnitedHealthcare was unable to provide this information for all retirees.			

- Although employees and dependents enrolled with the Harrington Benefit plans have fewer total emergency room visits, total costs are higher than employees and dependents enrolled with UnitedHealthcare.

According to the 2003 National Hospital Ambulatory Medical Care Survey (NHAMCS), approximately 39 emergency room visits occurred per 100 persons. It appears the Benefit Options health plan membership has lower utilization of emergency rooms at 27 per 100 covered lives than the national average.

EMERGENCY ROOM VISITS BY DIAGNOSIS

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

Harrington Benefits	***UnitedHealthcare***
1. Respiratory System and Symptoms	1. Respiratory System and Symptoms
2. Abdominal Pain (including pelvis)	2. Ear Infections
3. General Symptoms, Illnesses	3. Acute Pharyngitis (sore throat)
4. Head and Neck Pain and Symptoms	4. Urinary Tract/Kidney Symptoms
5. Urinary Tract/Kidney Symptoms	5. Chest Pain

According to the 2003 National Hospital Ambulatory Medical Care Survey (NHAMCS), the top 5 conditions presented nationally to an emergency room (according to volume of occurrence) are:

- **Stomach pain**
- **Chest pain**
- **Fever**
- **Cough**
- **Headaches**

It appears utilization of emergency rooms by Benefit Options health plan members are consistent with national norms.

PHYSICIAN VISITS[17]

The table below outlines total physicians office visits[18] for the plan year:

	Total Physician Visits	Total Costs	Ave. Per Visit
Harrington Benefits			
Employees and Dependents	240,645	$40,912,235	$170
Retirees and Dependents	40,500	$ 5,559,738	$137
UnitedHealthcare			
Employees and Dependents	309,777	$37,938,286	$122
UnitedHealthcare was unable to report this information for all retirees.			

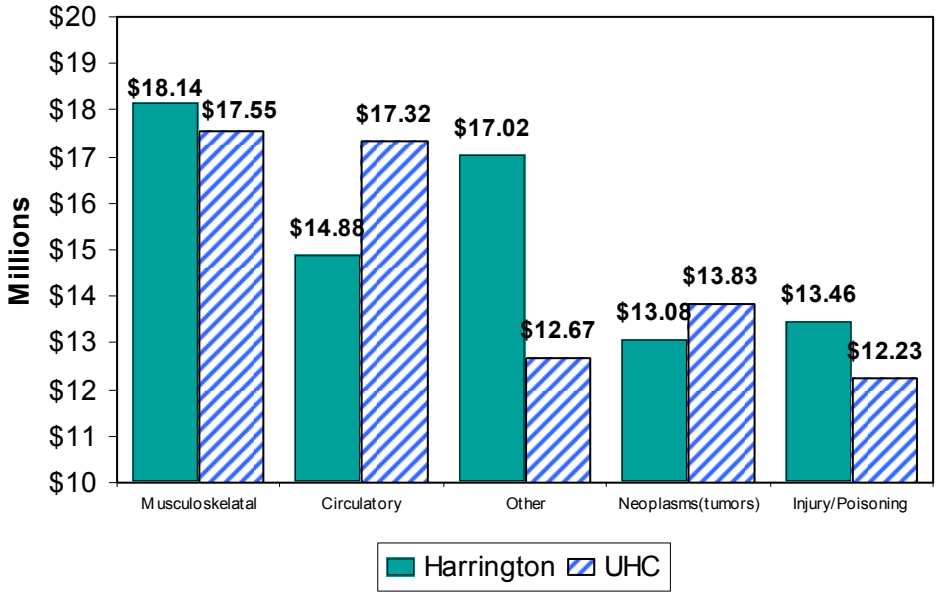
- Employees and dependents enrolled in UnitedHealthcare attended more physician office visits than employees and dependents enrolled in the Harrington Benefit plans; however, the average paid per office visit was lower for UnitedHealthcare members.

According to the 2003 National Hospital Ambulatory Medical Care Survey (NHAMCS), approximately 317 physician visits occurred nationally per 100 persons. Therefore, it appears the Benefit Options health plan membership has higher utilization of physician office visits at 438 visits per 100 covered lives than the national average.

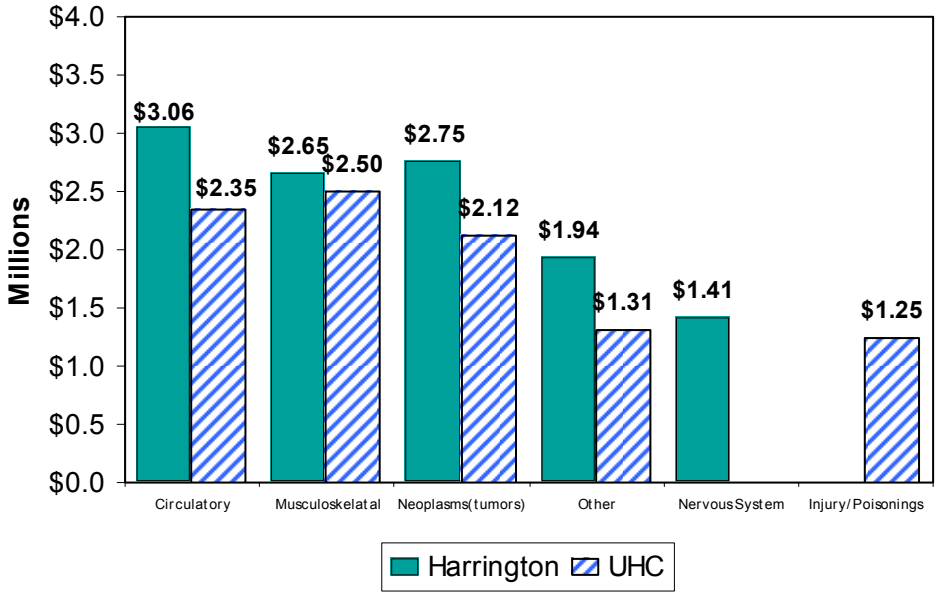
[17] http://www.cdc.gov/nchs/data/ad/ad346.pdf
[18] Includes all physicians on an outpatient basis only; these numbers do not include inpatient hospitalizations.

PAID CLAIMS BY TOP 5 DIAGNOSES

Musculoskeletal diagnoses accounted for the largest expenditures among state and university members.



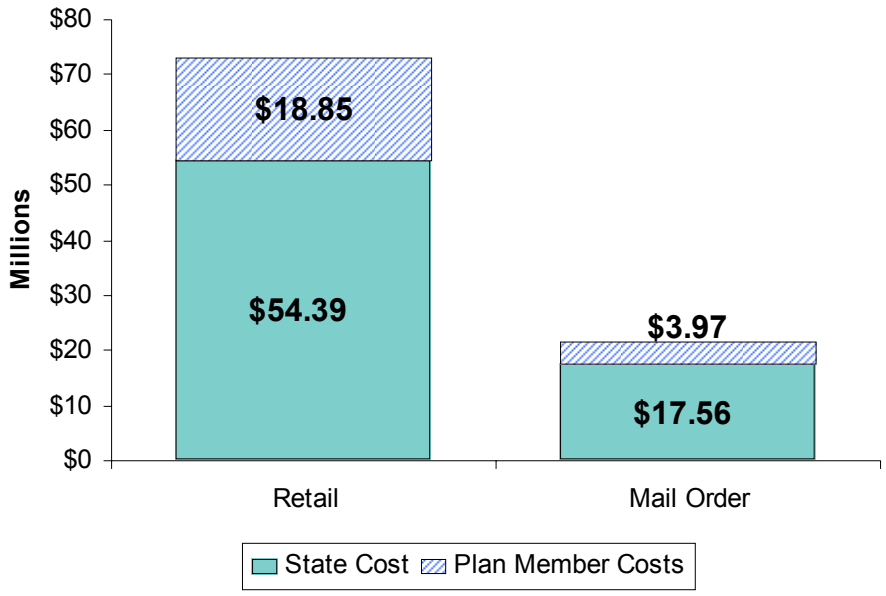
Circulatory disorders accounted for the largest expenditures among the retiree population.



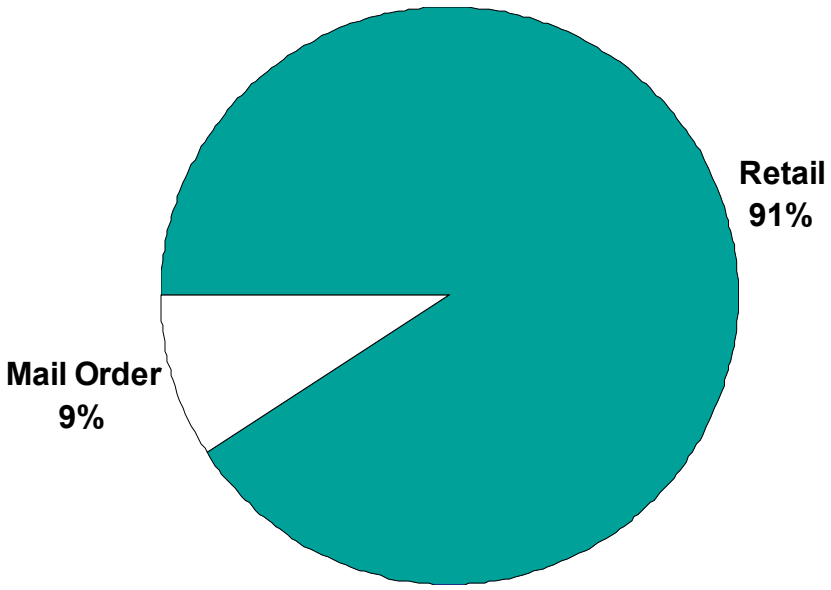
Overall, back disorders account for the highest number of services (162,882) and the highest cost for any medical diagnosis ($11,258,830) for both employees and retirees during the past plan year.

PHARMACY UTILIZATION

The following chart illustrates the total cost for prescriptions during the past plan year, and compares prescriptions filled at a retail store compared with prescriptions filled through mail order. On average, the state pays for slightly more than 75% of the cost of medications.



The chart below shows the number of prescriptions filled at a retail store compared with the number of prescriptions filled through mail order.



Number of prescriptions per eligible and utilizing members:

	Claims Per Eligible Member	Claims Per Utilizing Member
Prescriptions Filled at a Retail Store	10.07	20.49
Mail Order	1.01	12.74
OVERALL AVERAGE	**11.08**	**21.24**

Utilization demographics:

	Average Member Age	Average Days Supply
Prescriptions Filled at a Retail Store	48.1	24.7
Mail Order	57.3	87.3

TOP 10 DRUGS BY FREQUENCY OF USAGE AND COST

Top 10 Drugs Dispensed at Retail Pharmacy by Frequency of Usage	
Hydrocodone (narcotic)	7,340
Lipitor (cardio)	6,463
Levothyroxine S. (thyroid)	6,406
Lisinopril (hypotensive)	6,075
Metformin (diabetes)	5,074
Atenolol (cardio)	4,063
Prevacid (stomach)	3,783
Albuterol (bronchial)	3,539
Zoloft (antidepressant)	3,418
Amoxicillin (antibiotic)	3,208

Top 10 Drugs Dispensed at Retail Pharmacy by Cost	
Lipitor (cardio)	$570,102
Prevacid (stomach)	$546,054
Enbrel (arthritis)	$398,758
Advair Diskus (asthma)	$355,690
Oxycodone (narcotic)	$346,972
Effexor (antidepressant)	$339,435
Zoloft (antidepressant)	$311,080
Singulair (asthma)	$242,534
Oxycontin (narcotic)	$235,406
Zocor (cholesterol)	$228,447

Top 10 Drugs Dispensed by Mail by Frequency of Usage	
Lipitor (cardio)	1,547
Levothyroxine S. (thyroid)	1,158
Fosamax (multiple uses)	846
Lisinopril (hypotensive)	836
Prevacid (stomach)	716
Atenolol (cardio)	659
Metformin (diabetes)	648
Hydrochlorothiazide (diuretic)	518
Zocor (cholesterol)	466
Triamterene w/ HCTZ (diuretic)	429

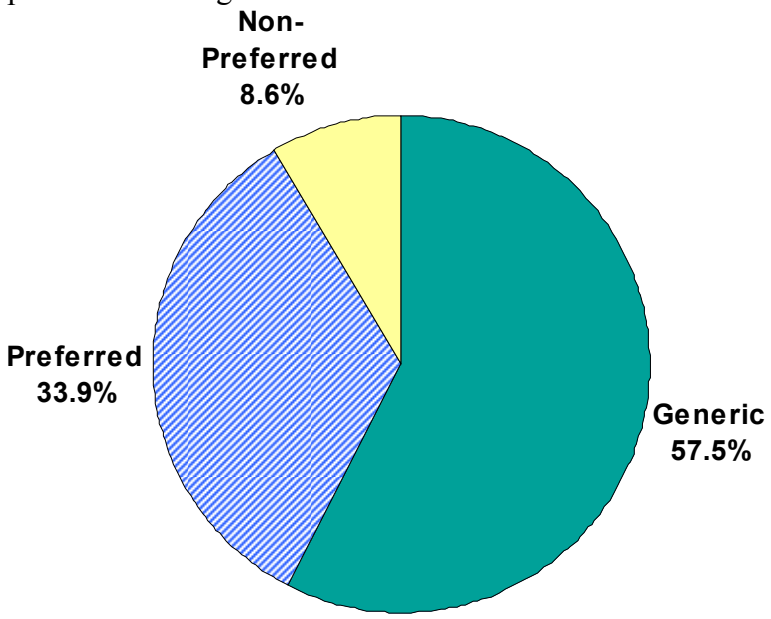
Top 10 Drugs Dispensed by Mail by Cost	
Lipitor (cardio)	$363,842
Prevacid (stomach)	$273,012
Zocor (cholesterol)	$156,111
Fosamax (multiple uses)	$155,231
Advair Diskus (asthma)	$122,930
Enbrel (arthritis)	$106,452
Effexor (antidepressant)	$105,206
Singulair (asthma)	$98,804
Zoloft (antidepressant)	$94,656
Avandia (diabetes)	$92,521

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.

Most of the prescriptions filled are generic medications.



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.

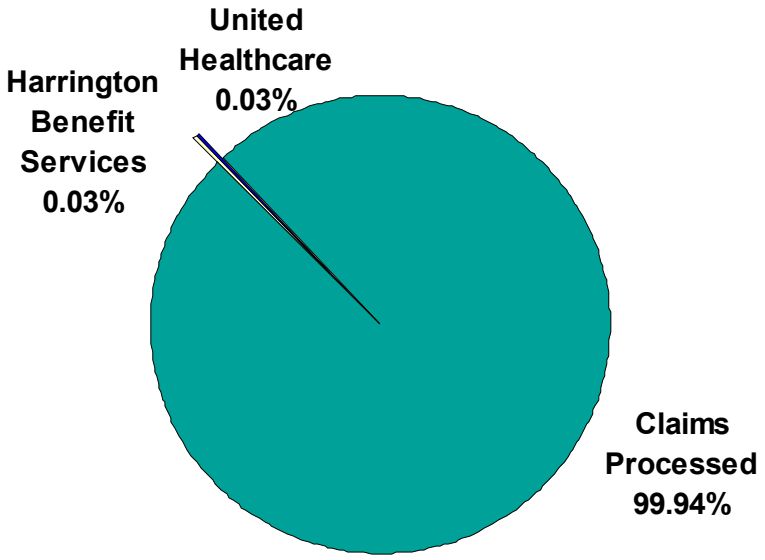
Top 10 Specialty Drugs by Cost	
Enbrel (arthritis)	$505,210
Humira (arthritis)	$200,516
Avonex (multiple sclerosis)	$129,997
Betaseron (multiple sclerosis)	$116,513
Pegasys (hepatitis C)	$97,314
Xolair (asthma)	$89,569
Copaxone (multiple sclerosis)	$87,052
Lovenox (anticoagulant)	$78,954
Neupogen (blood pressure)	$72,267
Copegus (hepatitis C)	$71,847

Specialty drugs account for 7% of all prescriptions filled in the Benefit Options program, however, these drugs account for 26% of the total pharmacy costs.

HEALTH PLAN APPEALS

During the past plan year, both Harrington Benefit Services and UnitedHealthcare received 961 appeals. This represents less than 0.06% of the total number of claims processed.

- Harrington Benefit Services received 491 appeals.
- UnitedHealthcare received 470 appeals.



PERSONAL HEALTH ASSESSMENT

An online Personal Health Assessment survey was conducted 10/3/05 through 10/31/05 by Walgreens Health Initiatives and Quest Diagnostics. This survey was available to all State and University employees and asked questions regarding their general health status and lifestyle choices.

Responses from this survey will assist the Benefit Options program in its goal to focus on preventative measures and overall wellness initiatives. The results of this survey will enable the Benefit Options program to target specific programs addressing the risks and issues identified by the survey.

DEMOGRAPHIC INFORMATION OF SURVEY PARTICIPANTS

Of the approximately 43,699 enrolled State and University employees, only 7,547 or 14.8%, of the employee population participated in the survey. The table below outlines the demographics of these survey participants. This information is important, since certain demographic groups have higher risk for various conditions such as diabetes, hypertension, or bone loss. The table compares the State participant results against the Quest database average of other employers who have utilized the same survey:

	State Survey Results	Quest Database Average
Participation Rate	14.8%	N/A
Male Participants	33%	45.4%
Female Participants	67%	54.6%
Average Age of Participants	44	44.3
African American Participants	3.4%	2.5%
American Indians Participants	1.7%	0.5%
Asian Participants	3.3%	2.9%
Caucasian Participants	73%	89%
Hispanic Participants	15.5%	3.1%
Multi-Ethnic Participants	1.9%	0.9%
High School graduates or less	10.3%	15.4%
Participants with some College	36.3%	30.1%
Participants who are College graduates	29.3%	35.1%
Participants with Post Graduate degree	24.1%	19.1%

The top 10 medical conditions reported by the survey participants:

Top 10 Medical Condition	State Survey Results	Quest Database Average
Allergies	29.1%	30.2%
Hypertension	16.5%	13.8%
Arthritis	11.6%	9.5%
Asthma	10.2%	8.3%
Migraines	9.9%	10.0%
Sciatica/pinched nerve in back	6.0%	5.7%
Diabetes Type 2	5.6%	2.9%
Osteoporosis	5.0%	1.9%
Cancer	2.2%	3.0%
Angina or Chest Pain	1.4%	1.6%

Risk Factor Analysis

Based on survey responses, the following risk factors have been identified and compared to the Quest database average:

Cholesterol

	State Percent At Risk	Database Average
Cholesterol of 200 to 239	19.75%	22.8%
Cholesterol of 240 or greater	4.4%	5.6%
Exercise less than 4 times/week	75.3%	74.8%
Consume more than 2 fat servings/day	20.1%	18.7%

- Desirable cholesterol level should be 200 or below. 75.85% of respondents either did not know their cholesterol level or their level was 200 and lower.
- Cholesterol levels at 200 to 239 are considered borderline high risk.
- Cholesterol levels above 240 are considered high risk. These individuals have twice the risk of developing coronary artery disease.

According to the American Heart Association, 20% of the population has high blood cholesterol levels.

Depression

	State Percent At Risk	Database Average
Feelings of hopelessness or guilt	15.0%	9.4%
Loss of appetite, weight gain/loss	23.3%	14.6%
Decreased energy/fatigue	40.5%	27.6%
Persistent sadness	15.8%	10.0%
Insomnia/oversleeping	28.2%	13.8%
Difficulty concentrating/decisions	20.2%	13.8%
Lack of interest in enjoyable activities	21.1%	13.9%
Persistent or troublesome anxiety	17.9%	12.7%

- It appears the State survey respondents have a higher risk for depression than the Quest database average.

Diabetes

	State Percent At Risk	Database Average
Diabetes Type 1	1.2%	0.8%
Receiving Treatment	1.0%	0.8%
Diabetes Type 2	5.6%	2.9%
Receiving Treatment	5.2%	2.6%
At-risk for Prediabetes	40.5%	28.8%

- It appears the State survey respondents have a higher risk for diabetes and developing diabetes than the Quest database average.

Nutrition

	State Percent At Risk	Database Average
< 5 fruits/vegetables per day	87.8%	86.9%
< 6 servings of fiber per day	0%	94.7%
> 2 servings of fat per day	20.1%	18.7%

- 93% of the State respondents report poor nutrition.

Stress

	State Percent At Risk	Database Average
Problem with stress	78.0%	67.7%
Stress affects health	50.3%	36.9%
Problem with friend/coworker/boss	23.5%	16.4%
Death of a loved one	18.1%	15.3%
Depression	21.0%	13.8%
Divorce/separation	5.9%	4.9%
Finances	33.7%	21.7%
Job loss/fear of job loss	10.7%	7.0%
Job stress	49.9%	39.8%
Moving/relocation	17.0%	12.0%
Violence	3.1%	1.4%
Family/relationships	28.4%	21.5%
Your health	23.7%	13.4%
Doesn't use stress reducing techniques	67.4%	67.9%

- 94.2% of the State respondents are at elevated risk for stress-related disorders.

Tobacco Use

	State Percent At Risk	Database Average
Participants who use cigarettes	13.9%	11.1%
Participants who use cigars/pipes	0.7%	0.6%
Participants who use chew tobacco	0.8%	1.1%
Participants who are ex-tobacco users for less than 1 year	1.4%	27.2%
Participants who attempted to quit but were unsuccessful	78%	39%

- 16.2% of the State respondents are at high risk for tobacco-related diseases.