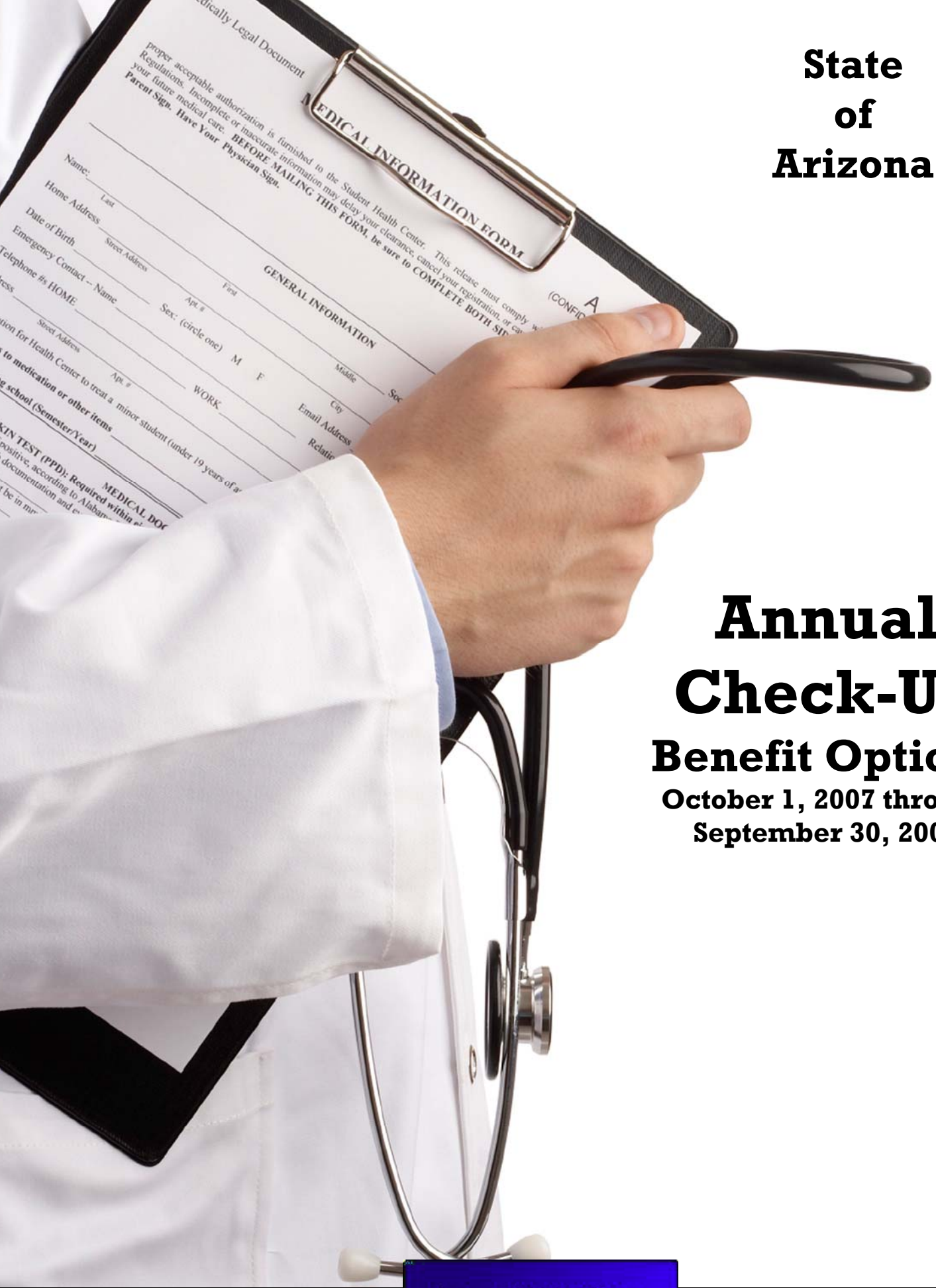


State
of
Arizona

Annual Check-Up

Benefit Options

October 1, 2007 through
September 30, 2008

Janice K. Brewer
Governor

Benefit Options
Choice. Value. Health.

William Bell
Director
Arizona 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 information provided in the report was 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) and A.R.S. §38-658 (B).

The data shown is presented for the period October 1, 2007 through September 30, 2008. The active Plan Year runs October 1, 2007 through September 30, 2008. However, all retiree statistics herein are adjusted to reflect that same period, despite the fact that the retiree Plan Year runs January 1 to December 31.

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

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

Telephone: 602-542-5008
Fax: 602-542-4048

Contents

Executive Summary

The purpose of this document is to report the financial status of the Employee Health Insurance Trust Fund pursuant to A.R.S. §38-652 (G), which reads:

> G. 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 State's Benefit Options programs fall into two major categories. The first of these provides medical and pharmaceutical benefits; the second is comprised of various health benefit programs including dental, vision, disability insurance, life insurance and a flexible spending account plan.

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

The self-funded 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 Benefit Options members.

Schedules of premiums received, incurred and paid medical/drug claims, and expenses related to the self-funded plans are included within this document. Also included is information regarding enrollment and the distribution of self-funded medical and pharmacy expenses.

Although not related to the Health Insurance Trust Fund, a summary of premiums collected and paid for life insurance, vision insurance and flexible spending accounts has also been included.

All data provided herein is for the active employee Plan Year 2007-2008 (October 1, 2007 – September 30, 2008). Except where noted, data related to the fully-funded Blue Cross Blue Shield and Secure Horizons plans is excluded.

Glossary of Terms

The following terminology will be used in this report:

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 and NY), and bank reconciliation fees.

Case management – a collaborative process that facilitates recommended treatment plans to ensure that appropriate medical care is provided to disabled, ill or injured individuals.

Claim – a provider's demand upon the payer for payment for medical services or products.

Claim appeal – a request 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 exclusive provider organization or network - Enrollees are limited to use only those providers on the exclusive list. 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 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 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.

Fully-funded – an insurance model wherein Benefit Options collects premiums and transfers the premiums to commercial insurers who take the risk of revenue to expense.

Integrated – health plan operations that are provided by one entity - These 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 should enroll in Parts A and B, but not C or D.

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

Network – an organization that contracts with providers (hospitals, physicians, and other health care professionals) to provide health care services - 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 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 period October 1 through September 30 for employees; January 1 through December 31 for retirees.

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 greater copay from the enrollee and a deductible to be paid.

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

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

Self-funded – 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 – 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 as primary insurer will pay for medical expenses.

Subscriber – 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 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 services provided.

Utilizer – a member who receives a specific service.

Health Insurance Trust Fund Summary

Table 1 provides a summary of receipts, expenses, and enrollment.

UMR, formerly FISERV Health or Harrington, is the claims payer for the non-integrated network of services. These include the Arizona Foundation, Beech Street, RAN+AMN, and Schaller Anderson networks. UHC refers to the UnitedHealthcare network. Both the UMR and UHC programs are self-funded. Secure Horizons, Blue Cross Blue Shield (BCBS), and all dental programs are fully-funded.

In general, state, university, and political subdivision employees and retirees choose from one of the self-funded networks. However, Secure Horizons is the only fully-funded option available to Medicare-eligible retirees and Blue Cross Blue Shield is the only fully-funded option available to NAU employees and retirees.

Table 1: Health Insurance Trust Fund Summary

	2007-2008	2006-2007
Premium (accrual basis, in dollars)		
UMR, UHC	622,865,513	579,995,347
Secure Horizons	8,536,011	8,122,332
BCBS	33,707,464	32,398,069
Dental	49,186,542	44,296,625
Total	714,295,530	664,812,373
Expenses (in dollars)		
Medical Claims (accrual basis)	467,414,597	420,133,173
Drug Claims (accrual basis)	104,369,240	91,414,992
Medicare Part D Subsidy	(2,483,125)	(1,747,224)
Rebates & Recoveries	(14,851,232)	(10,629,727)
Reserves for future benefits	38,559,679	39,912,651
Secure Horizons expense	7,719,357	7,961,816
BCBS Payments	33,713,166	32,398,069
Administration Fees	24,455,648	22,353,777
Stop-Loss Premiums	3,578,650	3,439,590
Appropriated Expenses	4,830,477	4,205,835
Dental Costs	48,878,502	44,296,625
Total	716,184,958	653,739,577
Difference	(1,889,429)	11,072,796
Enrollment		
Subscribers	66,993	66,490
Members	133,099	131,496

The Medicare Part D Subsidy is paid to employers who provide pharmacy insurance to Medicare-eligible retirees. Rebates & Recoveries consist of rebates paid by drug manufacturers and stop-loss payments. Reserve (IBNR) is the amount of money that must be "reserved" for the purpose of paying claims that have been incurred but have not been reported. Stop-loss is a "catastrophic claim" reinsurance program that covers individual medical/drug plan expenses over $500,000 with a lifetime maximum of $2 million.

Enrollment in Benefit Options Medical Plans

The Benefit Options group medical plan is available to all:

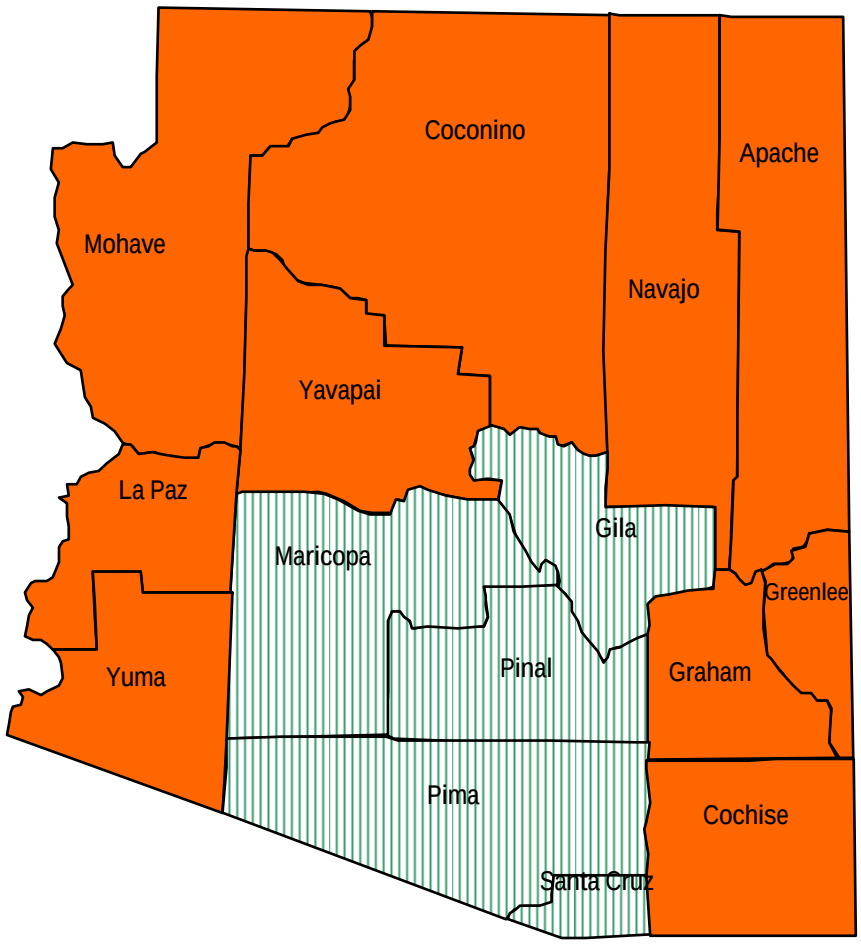
- eligible state and university employees, officers, and elected officials
- state retirees receiving pension benefits through any of the state retirement systems
- state or university employees accepted for long-term disability benefits
- employees of participating political subdivisions
- state or university employees eligible for COBRA benefits

The Table below shows how enrollment was distributed between networks and between active, retired, and university members. Network availability varies by region. The following pages show the networks available in each county.

Table 2: Average Monthly Enrollment

		2007-2008		2006-2007	
Network	**Plan Type**	**Subscribers**	**Members**	**Subscribers**	**Members**
AFMC					
Active	PPO	522	990	584	1,052
Retiree	PPO	584	788	735	1,000
University	PPO	469	874	561	1,038
Beech Street					
Active	PPO	130	380	121	357
Retiree	PPO	259	310	290	351
University	PPO	105	203	97	182
RAN+AMN					
Active	EPO	7,469	17,943	7,841	18,709
Retiree	EPO	876	1,144	928	1,233
University	EPO	1,968	3,664	2,304	4,177
Schaller Anderson					
Active	EPO	8,282	18,328	9,108	19,840
Retiree	EPO	1,350	1,731	1,312	1,701
University	EPO	3,650	7,363	3,962	7,793
UnitedHealthcare					
Active	EPO	20,248	45,739	18,575	41,696
Retiree	EPO	3,561	4,830	3,503	4,821
University	EPO	10,527	22,465	9,753	21,029
Active	PPO	854	1,590	700	1,834
Retiree	PPO	191	250	203	268
University	PPO	830	1,530	658	1,211
Blue Cross Blue Shield					
NAU only	PPO	2,854	not available	2,860	not available
SecureHorizons					
Medicare only	HMO	2,225	2,892	2,318	3,034
Political Subdivisions	EPO/ PPO	39	85	77	175
Total		66,993	133,099	66,490	131,496

Networks for Active Employees and Non-Medicare-Eligible Retirees

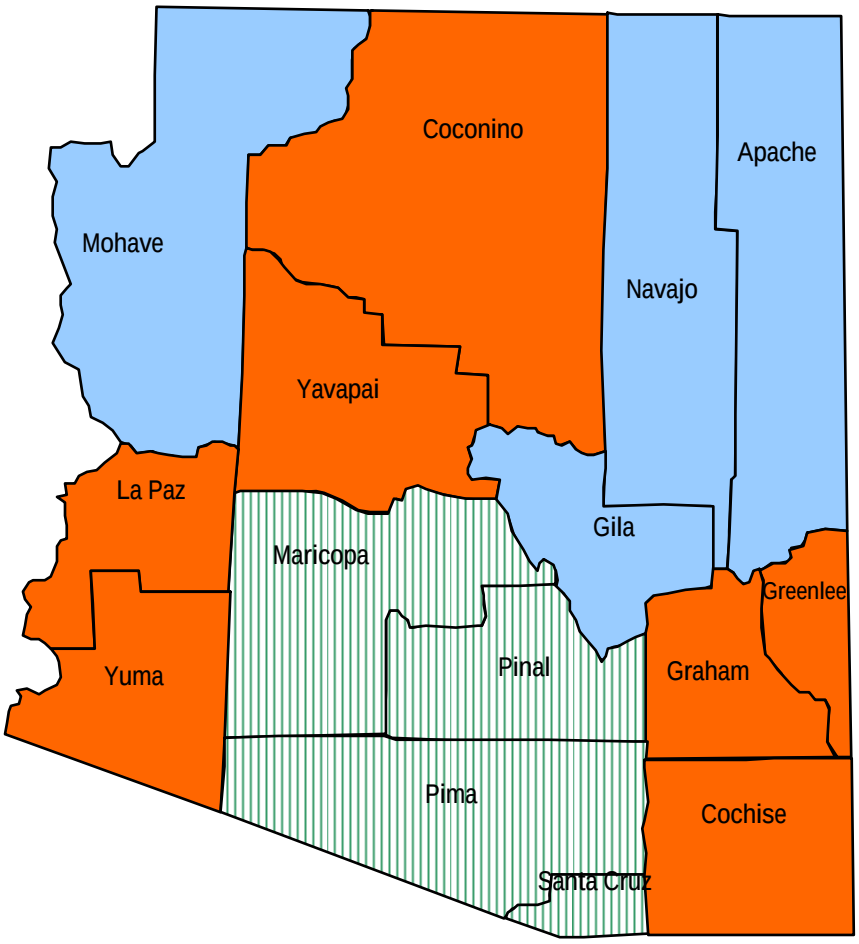


RAN+AMN EPO, Schaller Anderson EPO, United EPO/PPO, AZ Foundation PPO

RAN+AMN EPO, Schaller Anderson EPO, AZ Foundation PPO

Out of State: Beech Street PPO
NAU employees/retirees: Blue Cross Blue Shield PPO

Networks for Medicare-Eligible Retirees



RAN+AMN EPO, Schaller Anderson EPO, United EPO/PPO, AZ Foundation PPO, Secure Horizons High/Low option

RAN+AMN EPO, Schaller Anderson EPO, AZ Foundation PPO, Secure Horizons High/Low Option

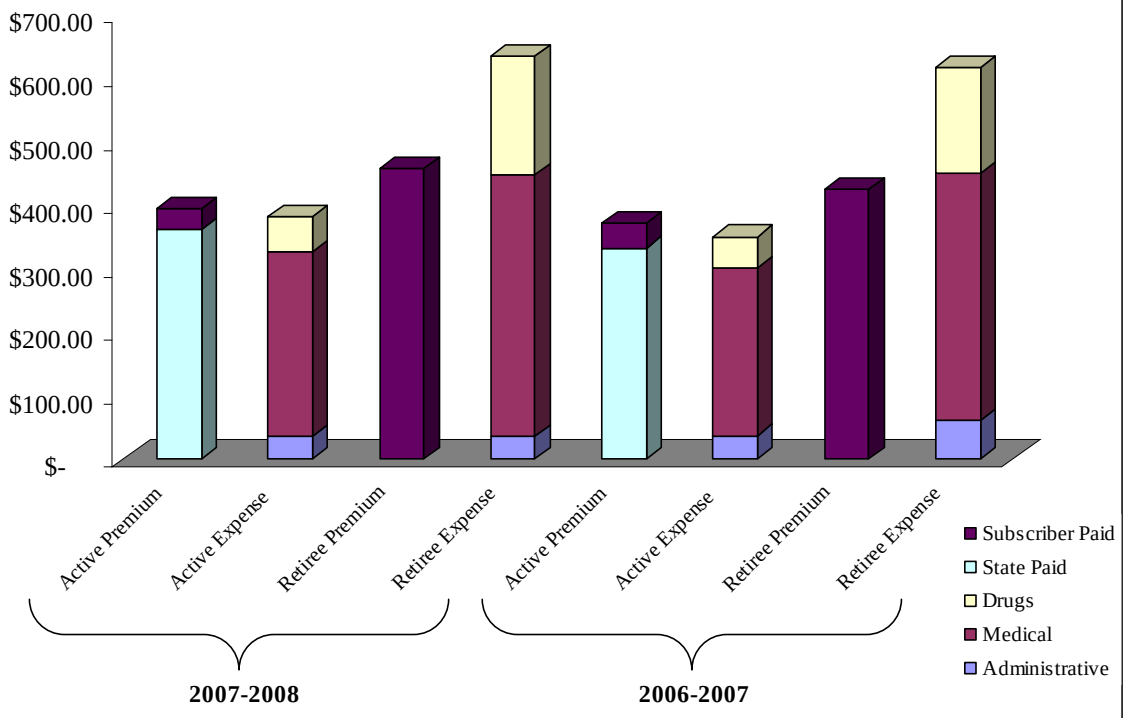
AZ Foundation PPO

Out of State: Beech Street PPO
NAU retirees: Blue Cross Blue Shield PPO

Expenses vs. Premiums for Active and Retired Members

The Figure below shows how the average monthly premiums compared to the average monthly cost for active and retired members.

Figure 1: Average Monthly Premiums and Expenses per Member



ADOA developed a contribution strategy that provided affordable health insurance to all state and university employees. The EPO plan was offered to employees for $25 for single coverage, $50 for employee plus one, and $125 for family coverage. PPO monthly premiums were determined from actual experience and the true cost of the coverage.

The 2008 contribution strategy allowed employees to pay only 8% coverage of the total premium, while the State absorbed the remaining 92%.

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 retiree premium rates lower than what their experience would otherwise dictate.

Expenses for Benefit Options Self-Funded Plans

The Tables below show how self-funded plan expenses were distributed between active/retired and EPO/PPO members. The average annual cost to insure each type of subscriber/member is also provided.

Table 3: Self-Funded Expenses by Active, Retiree, EPO, and PPO Subscribers and Members					
Expenses (in dollars)	**Overall**	**Active**	**Retiree**	**EPO**	**PPO**
Medical Claims (accrual basis)	467,414,597	422,478,255	44,936,342	434,731,525	32,683,072
Drug Claims (accrual basis)	104,369,240	81,659,753	22,709,487	92,637,345	11,731,895
Medicare Part D Subsidy	(2,483,125)		(2,483,125)	(1,856,872)	(626,254)
Rebates & Recoveries	(14,851,232)	(13,215,088)	(1,636,145)	(13,905,190)	(946,042)
Reserve (IBNR)	38,559,679	34,311,600	4,248,079	36,103,379	2,456,300
Administration Fees	24,455,648	21,761,395	2,694,253	22,897,792	1,557,856
Stop-Loss Premiums	3,578,650	3,184,394	394,256	3,350,685	227,965
Appropriated Expenses	4,830,477	4,298,308	532,169	4,522,770	307,707
Total	625,873,933	554,478,618	71,395,316	578,481,434	47,392,499
Enrollment in self-funded plans					
Subscribers	61,914	55,093	6,821	57,970	3,944
Members	130,207	121,154	9,053	123,292	6,915
Annual cost (in dollars)					
Per subscriber	10,109	10,064	10,467	9,979	12,016
Per member	4,807	4,577	7,886	4,692	6,854

Table 4: Self-funded Expenses by Active, Retiree, EPO, and PPO Subscribers and Members					
Expenses (in dollars)	**Overall**	**Active/ EPO**	**Active/ PPO**	**Retiree/ EPO**	**Retiree/ PPO**
Medical Claims (accrual basis)	467,414,597	395,694,168	26,784,088	39,037,358	5,898,984
Drug Claims (accrual basis)	104,369,240	74,753,199	6,906,554	17,884,146	4,825,341
Medicare Part D Subsidy	(2,483,125)			(1,856,872)	(626,254)
Rebates & Recoveries	(14,851,232)	(12,517,070)	(698,018)	(1,388,120)	(248,024)
Reserve (IBNR)	38,559,679	32,499,269	1,812,331	3,604,110	643,969
Administration Fees	24,455,648	20,611,963	1,149,432	2,285,829	408,424
Stop-Loss Premiums	3,578,650	3,016,195	168,199	334,491	59,766
Appropriated Expenses	4,830,477	4,071,273	227,036	451,497	80,672
Total	625,873,933	518,128,996	36,349,622	60,352,438	11,042,878
Enrollment in self-funded plans					
Subscribers	61,914	52,183	2,910	5,787	1,034
Members	130,207	115,587	5,567	7,705	1,348
Annual cost (in dollars)					
Per subscriber	10,109	9,929	12,491	10,429	10,680
Per member	4,807	4,483	6,529	7,833	8,192

Medical Expenses Associated with Medical Diagnoses

The Table below shows how medical expenses were distributed among different diagnoses. More dollars are spent on treating conditions related to the musculoskeletal system than on any other type of disorder.

Table 5: Medical Expenses by Diagnosis – Actives & Retirees

	2007-2008			2006-2007		
Diagnosis	**Actives % of Total**	**Retirees % of Total**	**All members % of Total**	**Actives % of Total**	**Retirees % of Total**	**All members % of Total**
Musculoskeletal System	13.20%	12.89%	13.17%	12.79%	14.60%	12.98%
Ill-defined[1]	10.69%	8.25%	10.46%	10.85%	8.11%	10.56%
Health Status (lab tests, etc.)	9.78%	7.21%	9.53%	9.11%	6.20%	8.80%
Neoplasm (tumors)	8.65%	14.39%	9.20%	9.33%	14.59%	9.88%
Circulatory System	8.22%	13.76%	8.75%	7.94%	12.58%	8.43%
Injury/Poisoning	8.75%	7.87%	8.66%	9.55%	6.87%	9.27%
Genitourinary System	7.09%	7.21%	7.11%	6.76%	7.38%	6.82%
Digestive System	6.86%	6.66%	6.84%	7.15%	6.83%	7.12%
Nervous System	5.20%	6.50%	5.33%	4.99%	7.21%	5.23%
Respiratory System	5.18%	4.40%	5.11%	4.94%	5.57%	5.00%
Pregnancy/Childbirth Complications	4.33%	0.03%	3.91%	4.67%	0.01%	4.18%
Endocrine System	3.36%	2.98%	3.33%	3.26%	2.73%	3.20%
Mental Health	2.26%	1.54%	2.19%	2.43%	1.87%	2.37%
Infectious/Parasitic	1.65%	3.51%	1.83%	2.03%	2.42%	2.07%
Skin and Subcutaneous Tissue	1.68%	1.65%	1.68%	1.82%	1.49%	1.79%
Congenital Anomalies	1.31%	0.08%	1.19%	1.08%	0.58%	1.03%
Conditions in the Perinatal Period	1.04%	0.00%	0.94%	0.54%	0.00%	0.48%
Blood and Blood Forming Organs	0.74%	1.08%	0.77%	0.75%	0.96%	0.77%
External Causes of Injury/Poisoning	0.00%	0.00%	0.00%	0.01%	0.00%	0.01%
Grand Total	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%

Note: Some statistics may vary slightly from previous annual reports due to the late receipt of program data following the completion of the previous annual report. In no case does the variation represent a substantive change in trend or comparative values.

[1]The ill-defined category is a technical term including symptoms, laboratory results and disorders which cannot be categorized elsewhere. Examples of ill-defined diagnoses are: adult convulsions not related to epilepsy, laboratory analysis of blood with findings not related to cellular abnormality, and senility associated with old age.

Hospital Care

The Figures below show how active/retired members and EPO/PPO members compared in terms of their number of admissions and their average lengths of stay. Inpatient hospital care represents a significant portion of total medical expenses: 36% and 38% for active and retired members, respectively.

Figure 2: Admissions per 1,000 Members

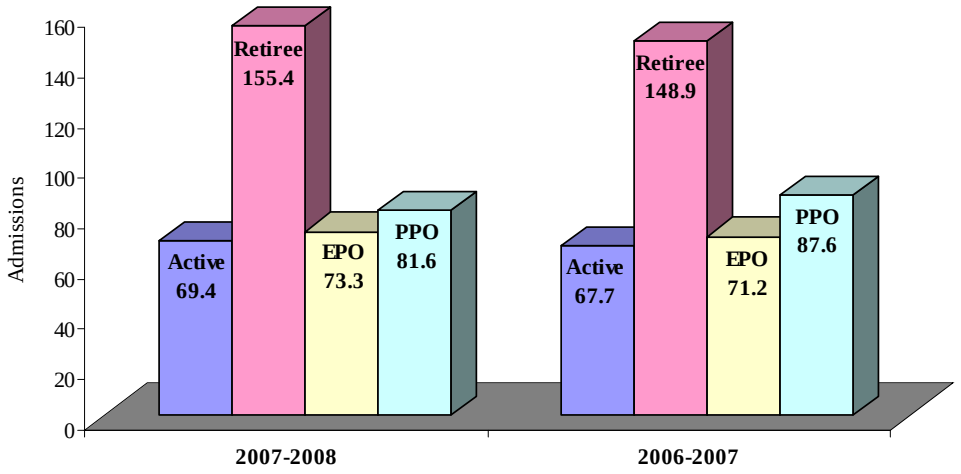
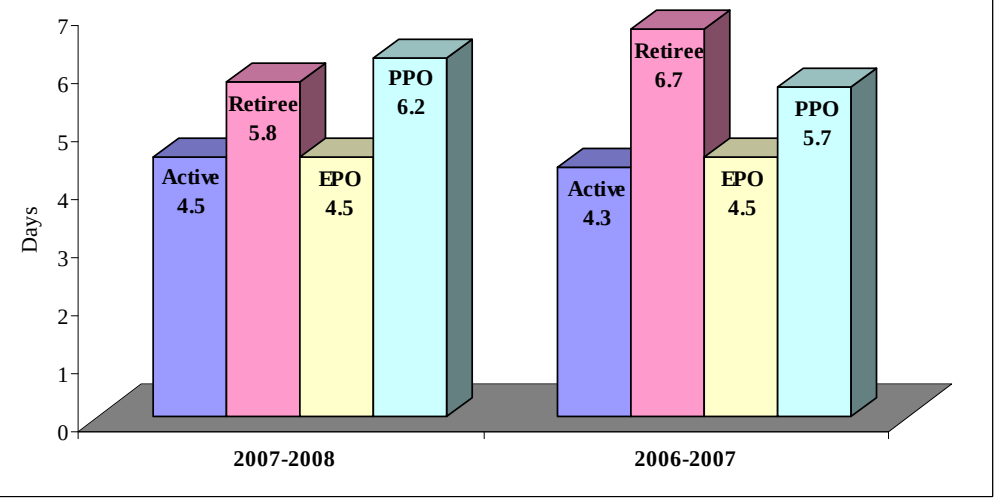


Figure 3: Average Length of Stay



Note: Mental health, substance abuse, and maternity admissions are included.

Hospital Care (continued)

The Figures below show how active/retired members and EPO/PPO members compared with regards to their collective number of hospital days and average cost per admission. As a group, retirees spent 3 times as many days in the hospital as active members. Also, PPO members spent 1.5 times as many days in the hospital as EPO members. On average, PPO members cost per admission was $4,623 higher than EPO members.

Figure 4: Days per 1,000 Members

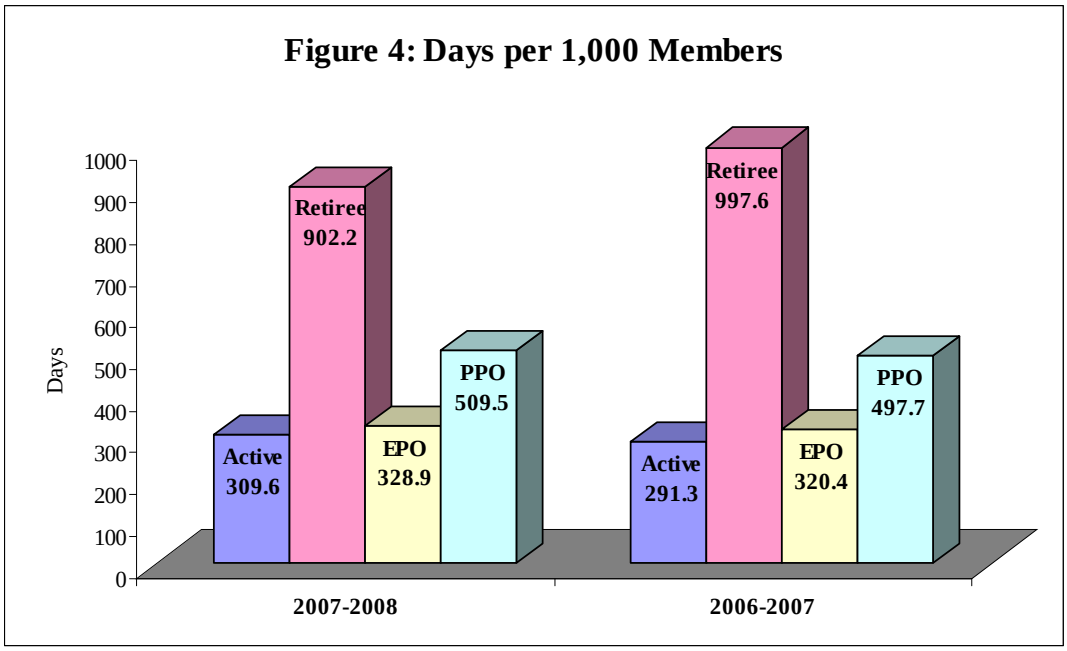
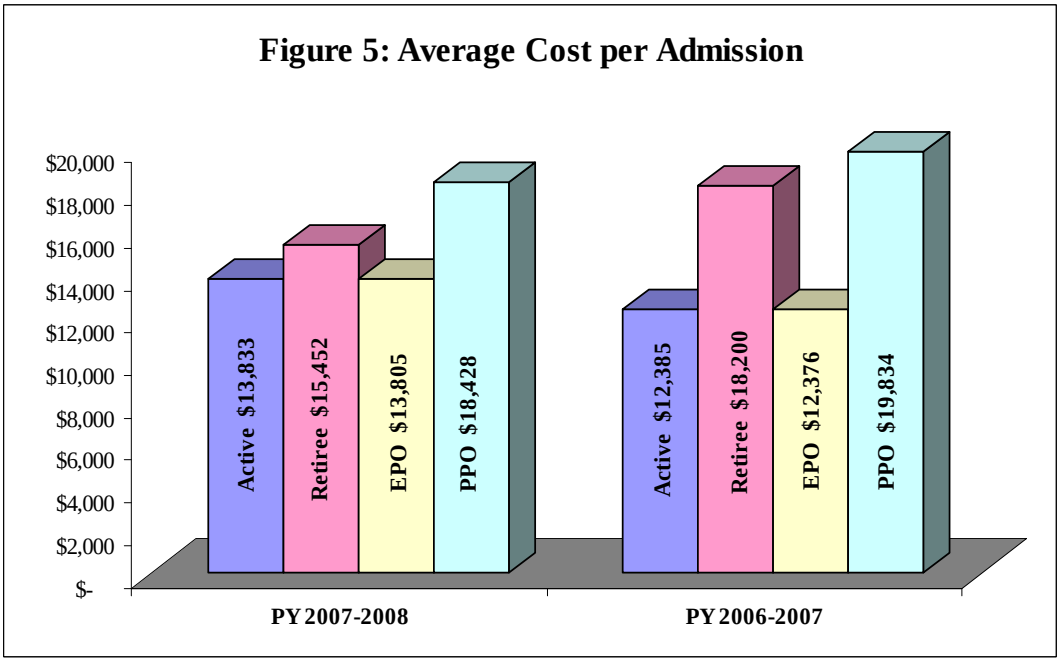


Figure 5: Average Cost per Admission



Note: Mental health, substance abuse, and maternity admissions are included.

Emergency Room Visits

During Plan Year 2007-2008, there were approximately 204.9 emergency room visits per 1,000 members of the self-funded plan. Each emergency room visit cost the plan $1,261.95 on average. These figures include facility claims and exclude professional fees.

Physician Visits

During Plan Year 2007-2008, each member of the self-funded plan visited a physician approximately 3.5 times or 3,500 visits per 1,000 members. Each office visit cost the plan $83.54 on average.

Urgent Care Visits

During Plan Year 2007-2008, there were approximately 97.9 urgent care visits per 1,000 members of the self-funded plan. Each urgent care visit cost the plan $227.18 on average.

The following Figures compare how total active and retiree medical expenses were distributed by type of care. 4% of medical expenses for active employees were spent for emergency room care while 4% of medical expenses for retired members were spent for home care.

Figure 6: Active Employee Medical Expense by Place of Service

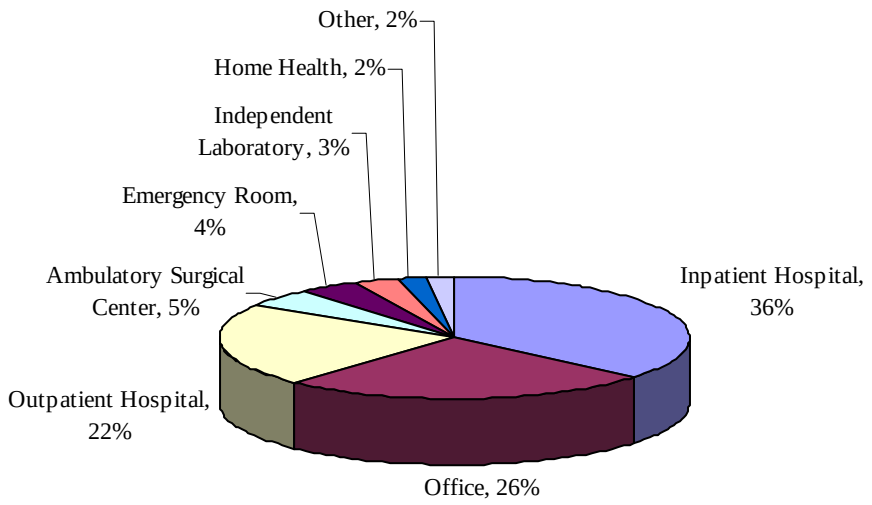
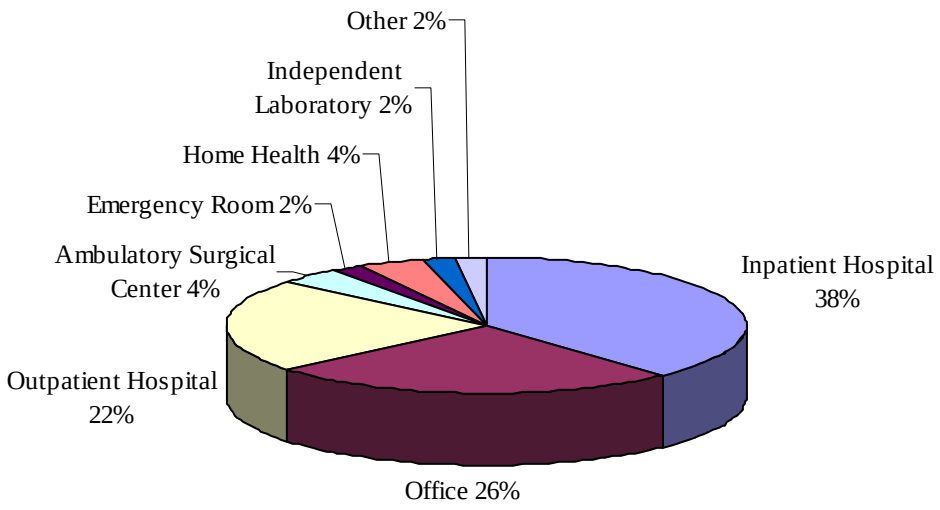


Figure 7: Retiree Medical Expenses by Place of Service



Generic and Name-Brand Prescription Use

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

Table 6: Claim Distribution for 3-Tier Formulary	2007-2008		2006-2007	
	Total Prescriptions	Percent	Total Prescriptions	Percent
Tier 1 Generic ($10 copay)	996,785	64.0%	939,708	61.3%
Tier 2-Preferred ($20 copay)	443,881	28.5%	469,088	30.6%
Tier 3-Non-Preferred ($40 copay)	116,811	7.5%	124,170	8.1%
Total	$1,557,477	100.0%	$1,532,966	100.0%

Prescription Use by Therapeutic Class

The Table below shows the top ten most used classes of drugs according to total expense. More dollars were spent on antihyperlipidemics (cholesterol-lowering drugs), than on any other therapeutic class.

Table 7: Top Therapeutic Classes by Total Expense				
	2007-2008		2006-2007	
Therapeutic class	Total Cost	Percent	Total Cost	Percent
antihyperlipidemics	11,419,509	10.94%	10,808,276	9.22%
antidepressants	8,907,603	8.53%	8,601,033	7.34%
ulcer medications	8,624,570	8.26%	8,203,568	7.00%
antidiabetics	7,821,290	7.49%	6,602,123	5.63%
antihypertensives	7,807,175	7.48%	7,945,493	6.78%
antiasthmatic/bronchodilator agents	7,627,217	7.31%	7,310,141	6.24%
analgesics – opioids	6,406,891	6.14%	5,798,144	4.95%
analgesics – anti-inflammatory	5,458,343	5.23%	4,709,545	4.02%
anticonvulsants	5,223,988	5.01%	4,156,683	3.55%
antivirals	4,429,641	4.24%	4,510,848	3.85%
Total	$73,726,227	70.64%	$68,645,854	58.58%

Prescription Use by Type of Drug

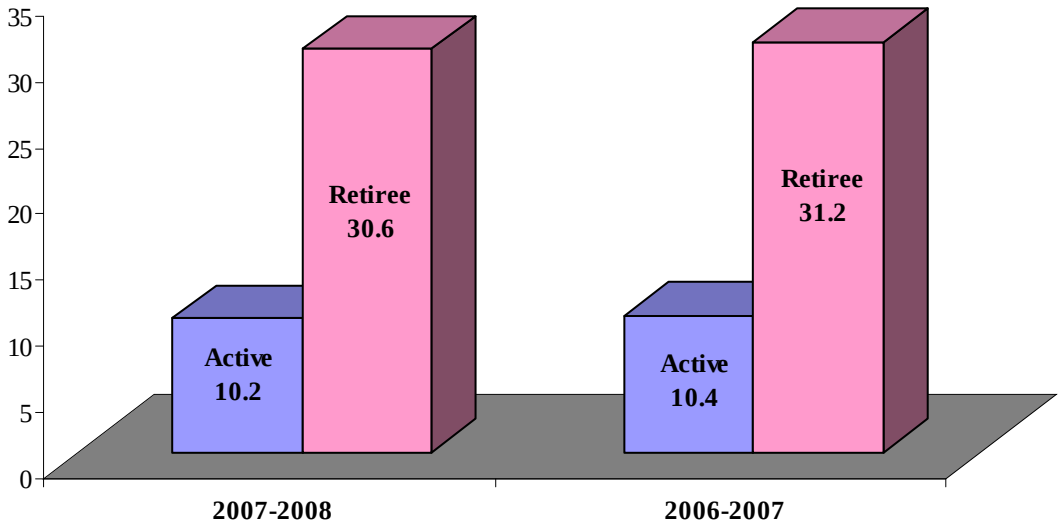
The Table below shows the top ten most used drugs according to total expense. Prevacid exceeded last year's top drug, Lipitor, during Plan Year 2007-2008.

Table 8: Top 10 Drugs by Total Expense		2007-2008		2006-2007	
Drug Name	**Therapeutic Class**	**Total Cost**	**Percent**	**Total Cost**	**Percent**
Prevacid	anti-ulcer/gastrointestinal	4,206,817	4.03%	3,806,801	3.26%
Lipitor	antihyperlipidemics	4,103,694	3.93%	3,983,758	3.41%
Enbrel	antiarthritics	2,413,952	2.31%	2,121,802	1.82%
Advair diskus	bronchial dilators	2,339,819	2.24%	2,323,748	1.99%
Effexor XR	psychostimulants-antidepressants	2,302,871	2.21%	2,000,796	1.71%
Singulair	bronchial dilators	1,999,700	1.92%	1,911,904	1.64%
Crestor	antihyperlipidemics	1,680,772	1.61%	1,344,940	1.15%
Lexapro	psychostimulants-antidepressants	1,645,187	1.58%	1,436,242	1.23%
Actos	actidiabetics	1,617,819	1.55%	1,371,731	1.17%
Vytorin	antihyperlipidemics	1,595,744	1.53%	1,575,980	1.35%
	Total	$23,906,375	22.91%	$21,877,702	18.72%

Annual Prescription Use

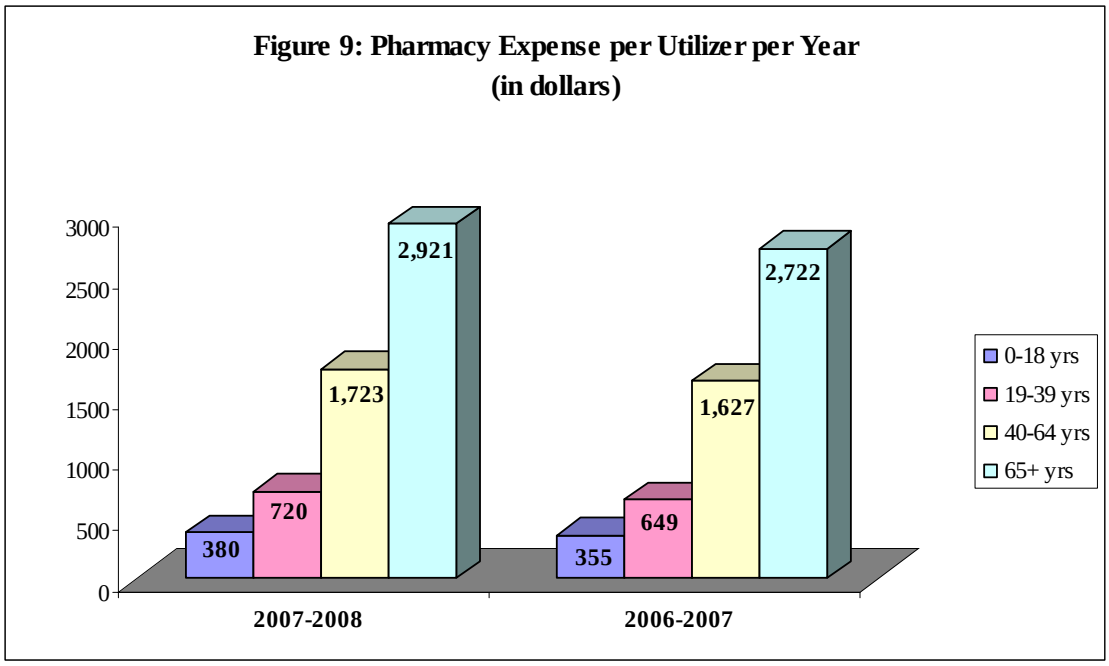
The Figure below compares the average number of prescriptions filled last plan year by active and retired members.

Figure 8: Average Number of Prescriptions per Member per Year



Annual Pharmacy Expenses by Age

The Figure below shows how pharmacy expenses increase with age among plan members.



Note: Some statistics may vary slightly from previous annual reports due to the late receipt of program data following the completion of the previous annual report. In no case does the variation represent a substantive change in trend or comparative values.

Benefit Options Dental Plans

Prepaid Plans – Employers Dental Services 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 Employers Dental Services and Assurant.
- No claim forms (except for emergency services under Employers Dental Services).

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 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.

The following Figures show how active employee and retiree dental enrollments were distributed among plans.

Figure 10: Active Employee Dental Enrollment

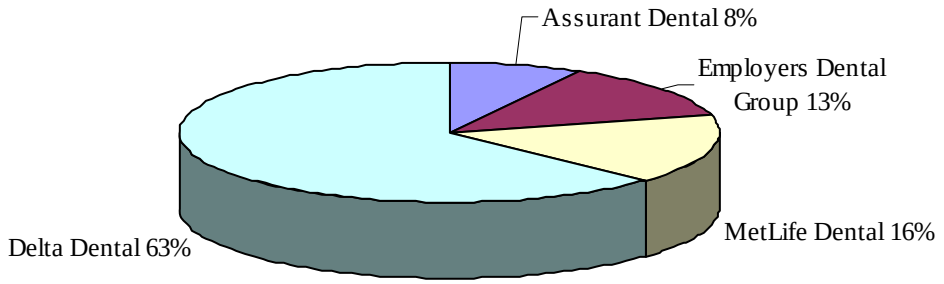
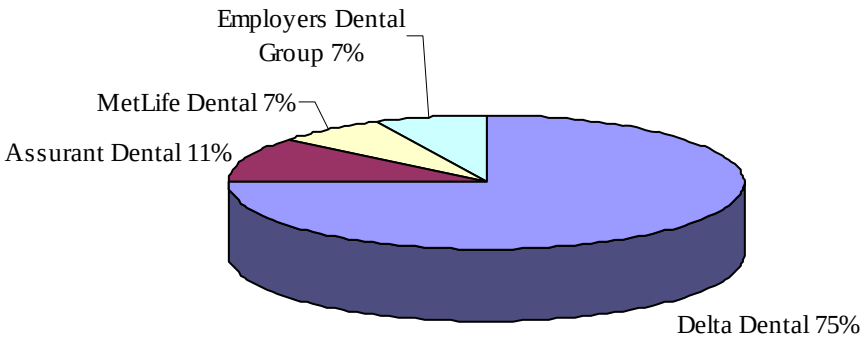


Figure 11: Retiree Dental Enrollment



Dental Rates

The Table below summarizes monthly dental rates for active and retired members.

Table 9: Summary of Monthly Dental Rates for 2007-2008

Active Employees	Single Coverage			Family Coverage		
	Employee	State	Total	Employee	State	Total
Assurant Dental	4.68	6.18	10.86	18.02	11.50	29.52
Delta Dental	14.56	19.82	34.38	54.14	55.90	110.04
Employers Dental Group	4.02	6.18	10.20	18.16	11.50	29.66
MetLife Dental	12.90	20.59	33.49	45.00	60.14	105.14
Retirees[1]	Single Coverage			Family Coverage		
Assurant Dental		10.86			29.52	
Delta Dental		34.38			110.04	
Employers Dental Group		10.20			29.66	
MetLife Dental		33.49			105.14	

[1]Effective January 1, 2008

Life, Disability, Vision Insurance and Flexible Spending Accounts Premiums

The Table below shows the amount of premiums collected and paid for life insurance, disability insurance, vision insurance and flexible spending accounts (FSA).

Table 10: Summary of Premiums

	2007-2008		2006-2007	
Vendor	**Collected**	**Paid**	**Collected**	**Paid**
Standard				
Basic Life	$2,601,679		$2,370,063	
Supp Life	10,198,944		9,153,730	
Dep Life	1,614,299		1,428,241	
STD	10,114,116		8,947,462	
LTD	4,455,294		4,064,335	
Total		$28,787,110		$25,963,831
Avesis - Vision		$5,561,668		$5,145,120
ASI - FSA		$5,328,689		$5,198,879
Total		$39,677,467		$36,307,830

Health Insurance Vendor Performance Standards

Pursuant to A.R.S. § 38-658(B), the Arizona Department of Administration (ADOA) shall "...report to the Joint Legislative Budget Committee at least semiannually on the performance standards for health plans, including indemnity health insurance, hospital and medical service plans, dental plans and health maintenance organizations."

Among the terms of the self-funded health insurance contracts are a number of ADOA-negotiated performance measures with specific financial guarantees tied to the contracted performance of the vendors providing various services for the health plans. If a vendor fails to meet any of the measures within the specified performance range, a percentage of the annual administrative fee is withheld by ADOA as liquidated damages. This percentage is allocated among the more critical measures of the contract.

The following is a report of the penalties incurred by health plan vendors for their non-performance during the Plan Year ending September 30, 2008. The details of each assessment are set forth in the exhibit specified by the same letter that identifies the vendor below. In each case below, the final member satisfaction survey and the Benefit Services Division Vendor Survey for FY 2007-2008, may result in additional penalties.

A. **UMR (Claims Administrator)** – penalties to date of $2,438.65, equaling 0.8% of the vendor's annual administrative fee

MEASURE	Annual Percent of Fees at Risk	Total Percent Assessed Vendor (BASED ON MISSED MEASURE)
Written appeals resolved within 45 calendar days after receipt of participant's request for review in the case of Post-Service claims.	0.33%	• 0.08%: WHICH EQUALS 3 MONTHS MISSED OUT OF 12 MONTHS MEASURED • Corrective Action: UMR provided reinforcement training to their processing staff.

Health Insurance Vendor Performance Standards (continued)

B. ASI Flex – penalties to date of $1352.10, equaling 1% of the vendor's annual administrative fee

MEASURE	Annual Percent of Fees at Risk	Total Percent Assessed Vendor (BASED ON MISSED MEASURE)
95% of claims will be processed within two working days	1%	• 0.50%: WHICH EQUALS 2 QUARTERS MISSED OUT OF 12 MONTHS MEASURED • Corrective Action: ASI has hired approximately 10 new claims processors. ASI anticipated that the extra man hours will improve turn around time significantly. Subsequently, ASI met the measure for the 3rd & 4th quarters.
98% of dollars will be paid accurately	1%	• 0.50%: WHICH EQUALS 2 QUARTERS MISSED OUT OF 12 MONTHS MEASURED • Corrective Action: The Customer Service Manager initiated retraining on claims processing accuracy. Subsequently, ASI met the measure for the 4th quarter.

C. Schaller Anderson (Utilization Review / Utilization Management) – penalties to date of $2,915.93, equaling 0.249% of the vendor's annual administrative fee

MEASURE	Annual Percent of Fees at Risk	Total Percent Assessed Vendor (BASED ON MISSED MEASURE)
Percent of calls answered in 30 seconds or less	1%	• 0.249%: WHICH EQUALS 3 MONTHS MISSED OUT OF THE 4 MONTHS MEASURED.

Health Insurance Vendor Performance Standards (continued)

D. Walgreens Health Initiative (Pharmacy Management) - penalties to date of $40,750.00, equaling 27.14% of the vendor's annual administrative fee

MEASURE	Annual Percent of Fees at Risk (Max $600K)	Total Percent Assessed Vendor (BASED ON MISSED MEASURE)
Average speed to answer for all calls made to the WHI Member Service Center	28%	• 13.99%: WHICH EQUALS 6 MONTHS MISSED OUT OF 12 MONTHS MEASURED • Corrective Action: WHI will report the results using an updated metric definition. Subsequently, WHI met the measure for the remainder of the year.
First call resolution	10%	• 2.5%: WHICH EQUALS 1 QUARTER MISSED OUT OF 4 QUARTERS MEASURED • Corrective Action: No action taken. Measurements were met for the rest of the year.
Standard management monthly reports series available on FTP site within 15 days of month end	8%	• 4.65%: WHICH EQUALS 7 MONTHS MISSED OUT OF 12 MONTHS MEASURED • Corrective Action: WHI implemented system enhancements.
Percent of transactions within three (3) seconds	8%	• 6%: WHICH EQUALS 3 QUARTERS MISSED OUT OF 4 QUARTERS MEASURED • Corrective Action: To improve performance and response time, WHI has been implementing several database enhancements.

E. Strategic Health Development Corporation (Utilization Review / Utilization Management) - penalties to date of $7,496.49, equaling 0.42% of the vendor's annual administrative fee

MEASURE	Annual Percent of Fees at Risk	Total Percent Assessed Vendor (BASED ON MISSED MEASURE)
95% of data file exchanges and reconciliation reports on time as established during implementation.	1.66%	• 0.42%: WHICH EQUALS 1 QUARTER MISSED OUT OF 3 QUARTERS MEASURED • Corrective Action: Due to numerous issues that were identified involving differing data at implementation the file exchange measure was not met. Subsequent to the resolution of the initial issues, all transmissions were made as scheduled.

F. Successfully Met Performance Guarantees

Table 11: Successful Performance Guarantees

Vendor	At risk	Guarantees Met
UMR	13%	Appeals (met 9 out of 12 measures), Call Center, Eligibility Administration, Claims Statistics
UnitedHealthcare	$2,704,401.00	Appeals, Telephone Service, Claims Statistics, Eligibility Administration, Network Management, Care Coordination Guarantees
Schaller Anderson URUM	6.32%	Disease Management, Customer Service (met 13 out of 16 measures)
Strategic Health Development Corporation	Total Administration Fee 7.8% Case Management Fee 7.5% Disease Management Fee 5% Nurseline Fee 5%	Implementation, Utilization Management, Case Management, Disease Management, Reporting (met 2 out of 3 measures), Systems, Nurse & Call Center
Walgreens Health Initiatives	$600,000.00	Data & Eligibility Requirements, Claims, Customer Services (met 21 of 28 measures), Account Services, Reports (met 21 out of 28 measures), Network Access, Network Pharmacy Management, Mail Order Service, Retail Paper Claims Processing Time, Network Pharmacy POS Compliance (met 15 out of 24 measures)
ASI Flex	4%	Claims Turnaround (3/4 of measure), Claims Adjudication Financial Accuracy (1/2 of measure), Web Availability, Phone Response Time
Schaller Anderson Network	5%	Program Management, Network Management
Arizona Foundation	1%	Program Management
RAN+AMN	1%	Program Management
The Standard Short Term Disability	5%	Telephone Service, Processing Timeline, Check Issuance Timeline, Processing Accuracy, Financial Accuracy, Appeals Timeline, Reports