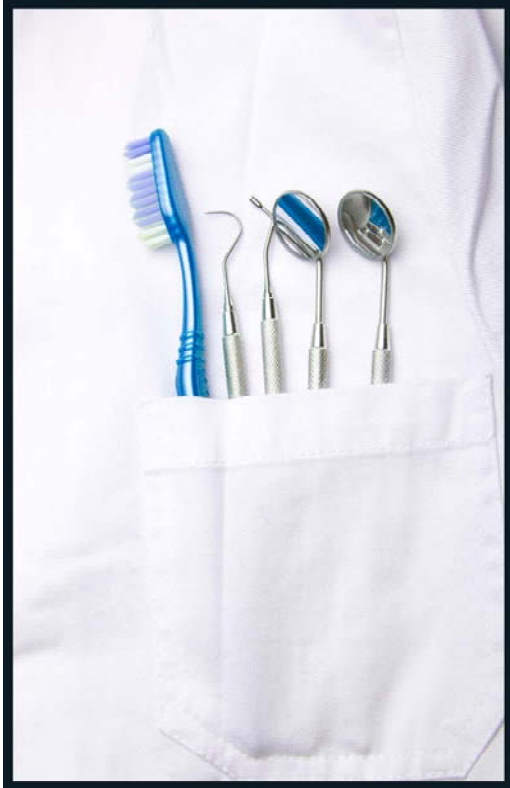
State of Arizona

Arizona Department of Administration
Benefit Services Division

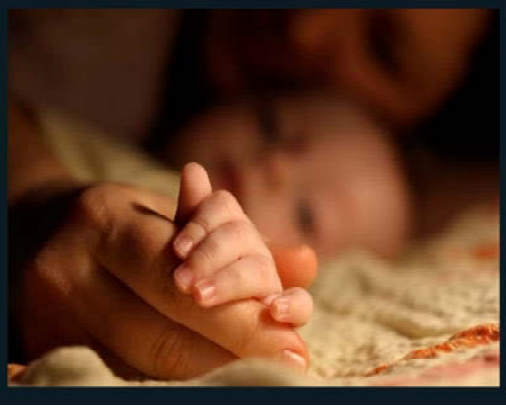
Benefit Options
Choice. Value. Health.



Annual Check-Up

Benefit Options

October 1, 2008 through September 30, 2009



Janice K. Brewer
Governor

David Raber
Interim 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, 2008 through September 30, 2009. The active Plan Year runs October 1, 2008 through September 30, 2009. 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.

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Report Background

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

The State's 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 integrated option combines the functions of claims review and payment, network administration, utilization review, and disease management, while the non-integrated option contracts multiple services providers for each function.

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. The Cash Flow Reconciliation charts for the two funds used by Benefit Options (3015 and 3035) can be found in Appendix A. There may be disparities in the values presented in Appendix A and the Health Insurance Trust Fund (HITF) Summary on page 4 as a result of timing differences between when services are rendered and when the services are paid. Appendix A was prepared on a paid basis, where as, the HITF Summary was prepared on accrual or incurred and paid basis.

All data provided herein is for the active employee Plan Year 2008-2009 (October 1, 2008 – September 30, 2009). Except where indicated, data related to the fully-insured Blue Cross Blue Shield and Secure Horizons plans is excluded.

Notable administrative changes for Plan Year 2008-2009 include; the removal of coverage for political subdivisions, new dental insurance contracts, the inclusion of a +1 tier under dental coverage, and the removal of Schaller Anderson as a medical network.

Executive Summary

During the Plan Year 2008-2009 the State Health Plan offered a comprehensive insurance package to over 130,000 members. Through the Health Insurance Trust Fund the State provided benefits to active state and university employees, retirees, and their qualified dependents. The benefit options include; medical, pharmaceutical, dental, flexible spending, life, and disability insurances.

To ensure the efficiency and effectiveness of the State Health Plan, during 2008-2009 BSD Audit Services developed a multi-directional audit plan which includes; contract compliance auditing, quality management reviews, process improvement, and plan design evaluation. Audits scheduled and completed this plan year consist of; dependent eligibility, chiropractic and osteopathic plan allowance, preventive care plan allowance, pharmaceutical benefit manager compliance audit among others. The audit plan has been strategically developed to identify potential loss and facilitate corrective action, further protecting the State and offering additional stability to insured members.

For the 2008-2009 Plan Year, the annual total expense calculated under for the plan was $757,347,735, and the total amount collected in premiums equaled $717,332,341, resulting in an expected net operational loss of $40,015,394. The net loss coupled with the 2008 Contribution Strategy placed 10% of the total premium on employees, while the State agencies absorbed the remaining 90%. This cost sharing method successfully made for a full, affordable bundle of insurance services for members.

The analysis of expenses for Plan Year 2008-2009 showed that the average cost to insure each member this year was $5,178. However, when divided by the type of subscriber; the active members average cost was $5,096 compared to the average retiree cost of $8,150. This difference in average cost between active and retiree members is a common trend. There is a direct relationship between the age of an insured member and their cost for health care. As the age of the State's insured members' increases it is expected there will be a resultant increase in costs.

Medical claims expenses alone accounted for $500,098,992 of the total cost the health plan during 2008-2009. When broken down by cost per diagnosis the notable leading diagnoses include; musculoskeletal system (muscles and joints), Neoplasms (cancers), and the circulatory system. More dollars were spent on musculoskeletal system medical expenses than on any other diagnosis with $64,462,760 or 12.89% of claims paid.

The examination of the hospital care reveals that inpatient care represents a significant portion of the total medical expenses: 30% and 35% for active and retired members respectively. Other considerable statistics show the type of medical care visits members are utilizing. Per 1,000 members covered under the self-insured plan there were 251.4 emergency room, 4,270 physician, and 224.7 urgent care visits, which indicates members are seeking the care of a physician or specialist for the majority of their medical needs.

Executive Summary (continued)

The annual cost of prescription drug claims for 2008-2009 totaled $114,299,093 and a reported 1.5 million prescriptions were filled. The top five most expensive drugs classes could be described as maintenance drugs used to control and prevent chronic diseases. Cholesterol-lowering drugs were the leading drug topping the list with 12 million dollars or 10.76%. Others were anitdepressants, ulcer medications, antidiabetics, and blood pressure controlling prescriptions. In fact, the most prescribed drug according to total expense is Prevacid. Prevacid is typically prescribed for treating and preventing stomach and intestinal ulcers, and remains as the leading prescription since the 2007-2008 plan year.

Retirees on the State health plan filled an average of 30.4 prescriptions per year, while actives fill only 10.6 per year. Similar to the medical cost per member, the pharmaceutical expense per utilizer increases as the population of members age increases. The analysis of data shows that the 40-64 year old members cost $1,840 compared to the cost of the 65+ members who cost $3,060 a year. As a result the smaller population of covered retirees attributes the majority of prescription health insurance expenses.

In addition to managing the volume statistics and expenses on the Health Plan, the State negotiates performance measures with specific financial guarantees. These financial guarantees are tied to the contracted performance of the vendors providing services. If a vendor fails to meet any of the measures, a percentage of the annual administrative fee is withheld by ADOA as liquidated damages. Over the 2008-2009 Plan Year the total collected penalties was $94,068.48 compared to the prior year's $123,602.28, which indicated the vendors' performance improved during the 2008-2009 Plan Year.

In review, the 2008-2009 Plan Year demonstrated a balance of expenses and premiums that allowed the State to offer members comprehensive and affordable insurance coverage. The State effectively controlled the rise in health care costs through quality benefit design, administrative oversight, strategic audit planning and efficient contracts management. Detailed evidence of the State's Health Plan accomplishment can be reviewed herein.

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, and RAN+AMN 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-insured.

Table 1: Health Insurance Trust Fund Summary

	2008-2009	2007-2008
Receipts (accrual basis)		
UMR, UHC	627,294,082	622,865,513
Secure Horizons	8,434,781	8,536,011
BCBS	34,272,496	33,707,464
Dental	47,330,983	49,186,542
Total	717,332,341	714,295,530
Expenses		
Medical Claims (accrual basis)	500,098,992	467,414,597
Drug Claims (accrual basis)	114,299,093	104,369,240
Medicare Part D Subsidy	(2,518,939)	(2,483,125)
Rebates & Recoveries	(16,688,279)	(14,851,232)
Reserves for future benefits	41,255,326	38,559,679
Secure Horizons expense	7,687,528	7,719,357
BCBS Payments	34,342,197	33,713,166
Administration Fees	23,750,954	24,455,648
Stop-Loss Premiums	3,509,198	3,578,650
Appropriated Expenses	4,342,510	4,830,477
Dental Costs	47,269,155	48,878,502
Total	757,347,735	716,184,958
Difference	(40,015,394)	(1,889,429)
Enrollment		
Subscribers	65,557	66,993
Members	134,918	133,099

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

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.

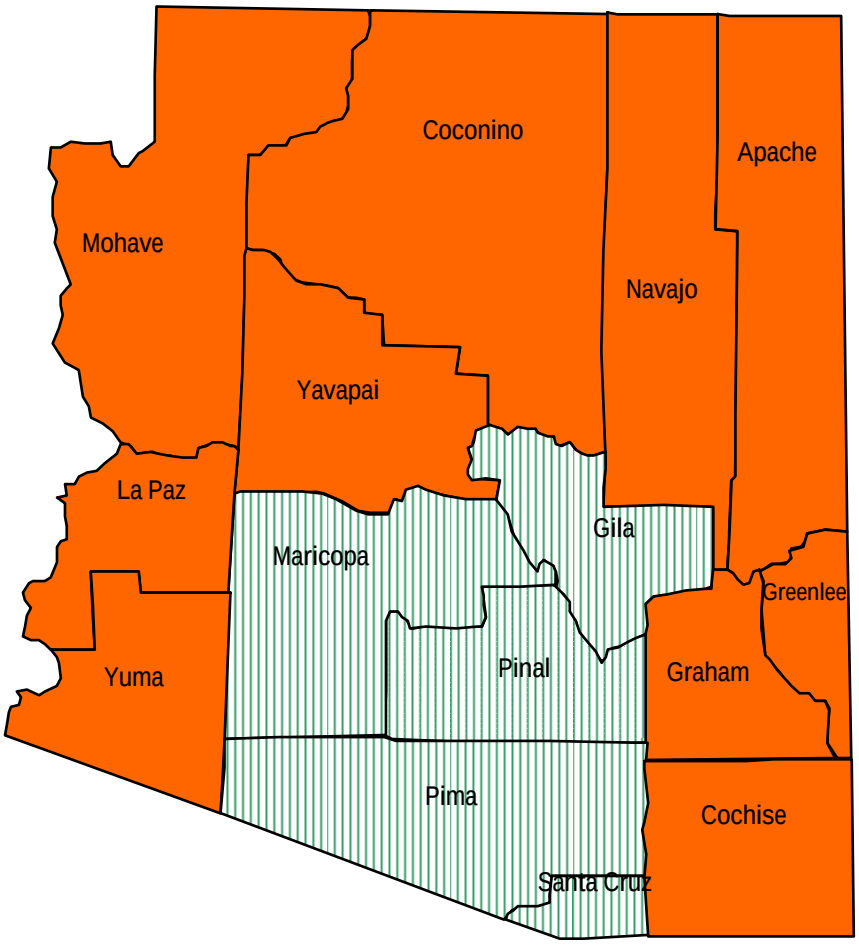
Table 2: Average Monthly Enrollment

		2008-2009		2007-2008	
Network	**Plan Type**	**Subscribers**	**Members**	**Subscribers**	**Members**
AFMC					
Active	PPO	494	945	522	990
Retiree	PPO	453	599	584	788
University	PPO	444	849	469	874
Beech Street					
Active	PPO	127	386	130	380
Retiree	PPO	235	280	259	310
University	PPO	114	222	105	203
RAN+AMN					
Active	EPO	8,888	21,755	7,469	17,943
Retiree	EPO	1,386	1,808	876	1,144
University	EPO	2,927	5,775	1,968	3,664
Schaller Anderson *					
Active	EPO	-	-	8,282	18,328
Retiree	EPO	-	-	1,350	1,731
University	EPO	-	-	3,650	7,363
UnitedHealthcare					
Active	EPO	25,726	58,660	20,248	45,739
Retiree	EPO	4,531	5,982	3,561	4,830
University	EPO	13,051	27,894	10,527	22,465
Active	PPO	920	1,699	854	1,590
Retiree	PPO	193	253	191	250
University	PPO	984	1,909	830	1,530
Blue Cross Blue Shield					
NAU only	PPO	2,859	3,016	2,854	NA
SecureHorizons					
Medicare only	HMO	2,225	2,886	2,225	2,892
Political Subdivisions	EPO/ PPO	-	-	39	85
Total		65,557	134,918	66,993	133,099

* Note: Schaller Anderson was no longer a Medical Network offering during the 2008-2009 Plan Year beginning 10/1/2008.

Network availability varies by region. The following pages show the networks available in each county.

Networks for Active Employees and Non-Medicare-Eligible Retirees

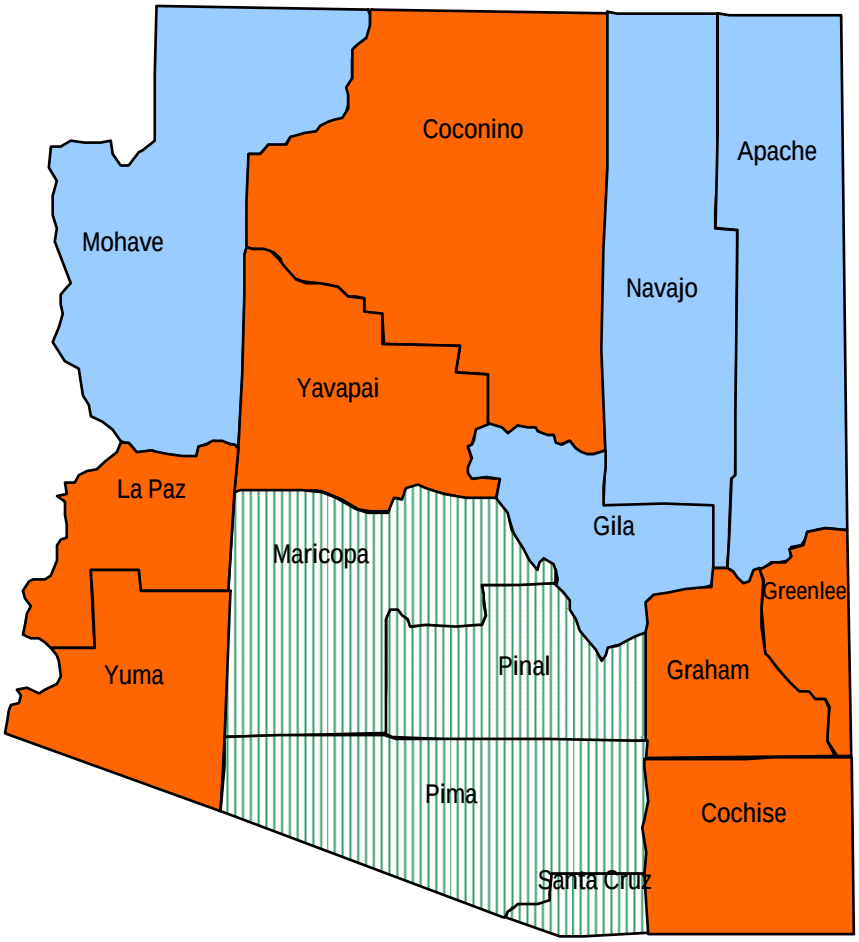


RAN+AMN EPO, United EPO/PPO, AZ Foundation PPO

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

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

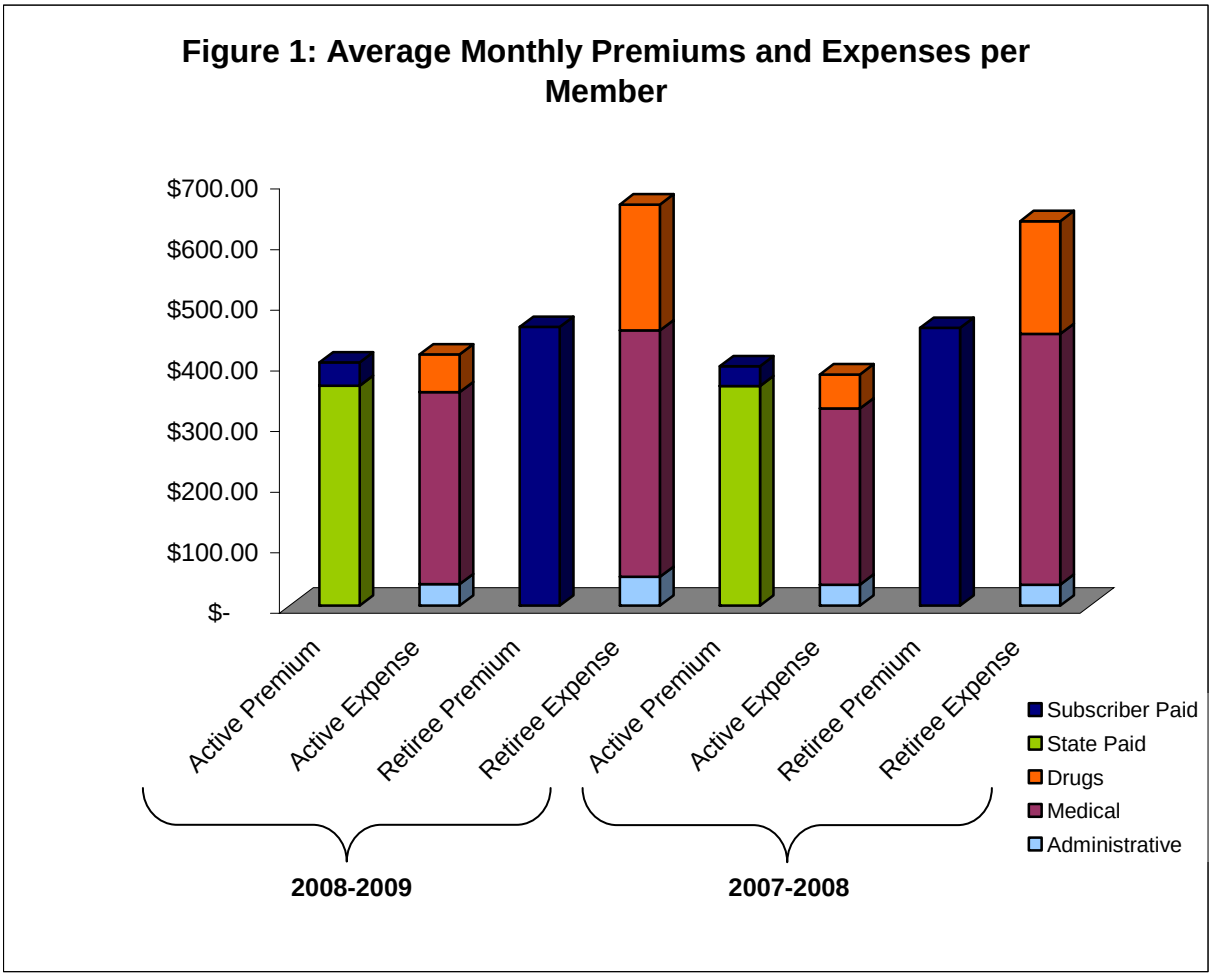
AZ Foundation PPO

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 single coverage, employee plus one, and family coverage at the cost of $30, $60, and $150. PPO monthly premiums were determined from actual experience and the true cost of the coverage.

The 2008-2009 contribution strategy allowed employees to pay only 10% of the total premium, while the State absorbed the remaining 90%.

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 the distribution of the self-funded expenses. Table 3 shows the expenses distributed between active/retiree 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		**Overall**	**Active**	**Retiree**	**EPO**	**PPO**
Medical Claims (accrual basis)		500,098,992	456,578,108	43,520,884	462,213,646	37,885,345
Drug Claims (accrual basis)		114,299,093	89,537,556	24,761,538	101,958,881	12,340,213
Medicare Part D Subsidy		(2,518,939)		(2,518,939)	(2,091,314)	(427,626)
Rebates & Recoveries		(16,688,279)	(14,812,286)	(1,875,993)	(15,594,364)	(1,093,915)
Reserve (IBNR)		41,255,326	37,665,100	3,590,226	38,130,000	3,125,326
Administration Fees		23,750,954	21,081,019	2,669,935	22,194,081	1,556,873
Stop-Loss Premiums		3,509,198	3,114,716	394,482	3,279,171	230,028
Appropriated Expenses		4,342,510	4,042,207	300,303	4,102,120	240,390
Total	$	668,048,856	597,206,420	70,842,436	614,192,221	53,856,634
Enrollment in self-funded plans						
Subscribers		60,473	53,675	6,798	56,509	3,964
Members		129,016	120,094	8,922	121,874	7,142
Annual cost						
Per Subscriber	$	11,047	11,126	10,421	10,869	13,586
Per Member	$	5,178	4,973	7,940	5,040	7,541

Table 4 below shows the distribution of expenses by benefit plan.

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)		500,098,992	423,775,128	32,802,980	38,438,518	5,082,366
Drug Claims (accrual basis)		114,299,093	81,400,965	8,136,591	20,557,916	4,203,622
Medicare Part D Subsidy		(2,518,939)			(2,091,314)	(427,626)
Rebates & Recoveries		(16,688,279)	(13,961,494)	(850,792)	(1,632,870)	(243,123)
Reserve (IBNR)		41,255,326	34,959,041	2,706,059	3,170,959	419,266
Administration Fees		23,750,954	19,870,161	1,210,858	2,323,920	346,015
Stop-Loss Premiums		3,509,198	2,935,812	178,904	343,359	51,124
Appropriated Expenses		4,342,510	3,839,918	202,289	262,201	38,102
Total	$	668,048,856	552,819,532	44,386,888	61,372,689	9,469,746
Enrollment in self-funded plans						
Subscribers		60,473	50,592	3,083	5,917	881
Members		129,016	114,084	6,010	7,790	1,132
Annual cost						
Per Subscriber	$	11,047	10,927	14,397	10,372	10,749
Per Member	$	5,178	4,846	7,386	7,878	8,366

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

	2008-2009			2007-2008		
	Actives	Retirees	All	Actives	Retirees	All
Diagnosis	**% of Total**	**% of Total**	**% of Total**	**% of Total**	**% of Total**	**% of Total**
Musculoskeletal System	12.90%	12.70%	12.89%	13.20%	12.89%	13.17%
Ill-defined[1]	10.29%	8.63%	10.15%	10.69%	8.25%	10.46%
Health Status (lab tests, etc.)	9.45%	7.39%	9.27%	9.78%	7.21%	9.53%
Neoplasm (tumors)	8.58%	14.35%	9.08%	8.65%	14.39%	9.20%
Circulatory System	8.58%	6.20%	8.38%	8.22%	13.76%	8.75%
Injury/Poisoning	7.86%	12.17%	8.23%	8.75%	7.87%	8.66%
Genitourinary System	7.86%	8.80%	7.94%	7.09%	7.21%	7.11%
Digestive System	7.60%	7.40%	7.59%	6.86%	6.66%	6.84%
Nervous System	5.16%	6.16%	5.24%	5.20%	6.50%	5.33%
Respiratory System	5.16%	5.14%	5.16%	5.18%	4.40%	5.11%
Pregnancy/Childbirth	4.27%	0.02%	3.91%	4.33%	0.03%	3.91%
Endocrine System	3.58%	3.94%	3.61%	3.36%	2.98%	3.33%
Mental Health	2.50%	1.36%	2.40%	2.26%	1.54%	2.19%
Infectious/Parasitic	1.89%	1.44%	1.85%	1.65%	3.51%	1.83%
Skin and Subcutaneous Tissue	1.53%	2.20%	1.59%	1.68%	1.65%	1.68%
Congenital Anomalies	1.23%	0.65%	1.18%	1.31%	0.08%	1.19%
Conditions in the Perinatal Period	0.85%	1.45%	0.91%	1.04%	0.00%	0.94%
Blood and Blood Forming Organs	0.70%	0.00%	0.64%	0.74%	1.08%	0.77%
Injury/Poisoning	0.01%	0.00%	0.01%	0.00%	0.00%	0.00%
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

Inpatient hospital care represents a significant portion of total medical expenses: 35% and 30% for active and retired members, respectively. The figures below show how active/retired members and EPO/PPO members' hospital admissions compared based on the number of admissions and the average length of stay.

Figure 2: Admissions per 1,000 Members

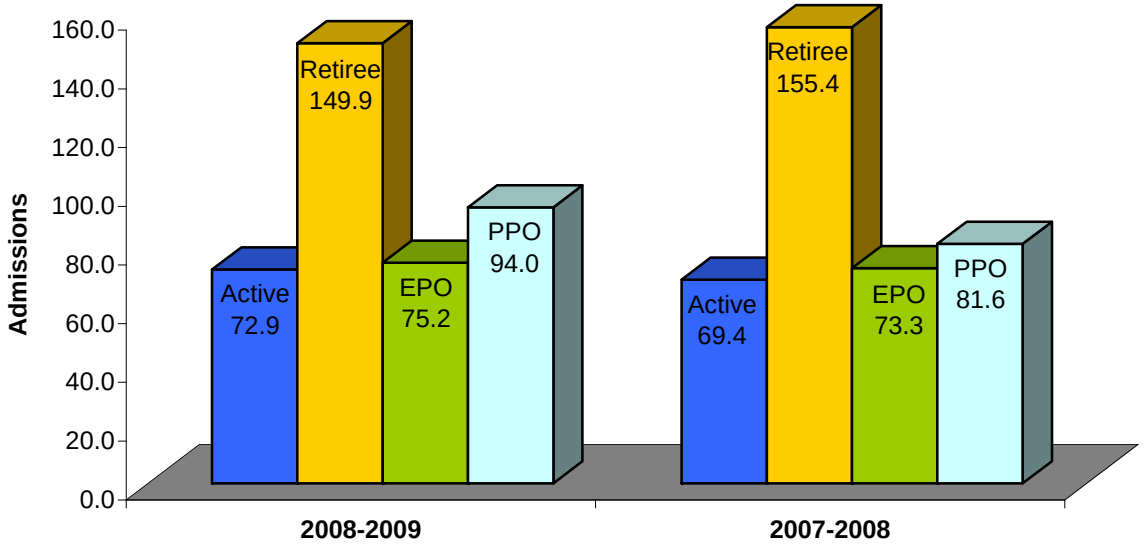
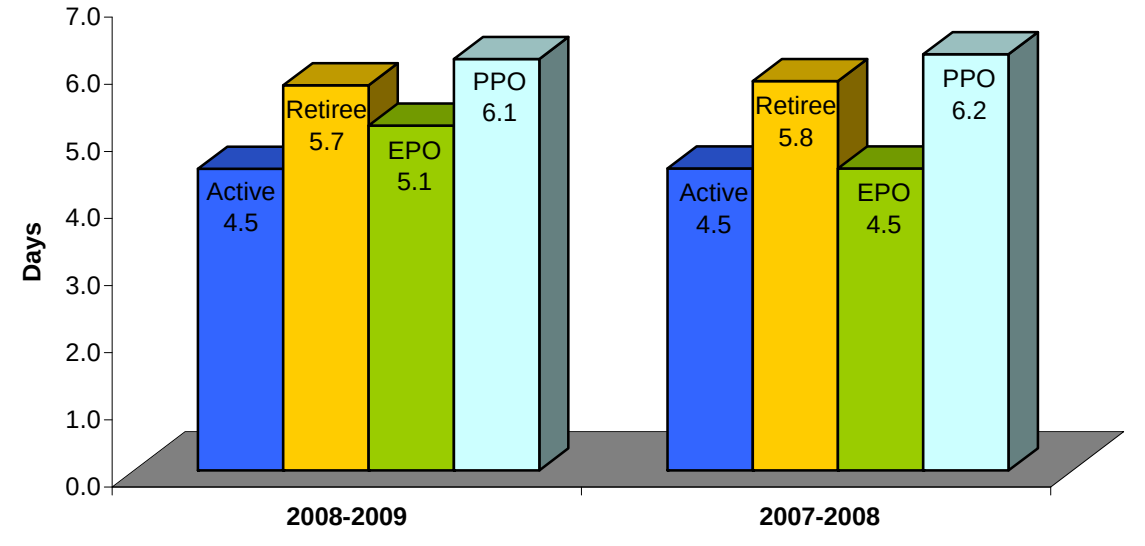


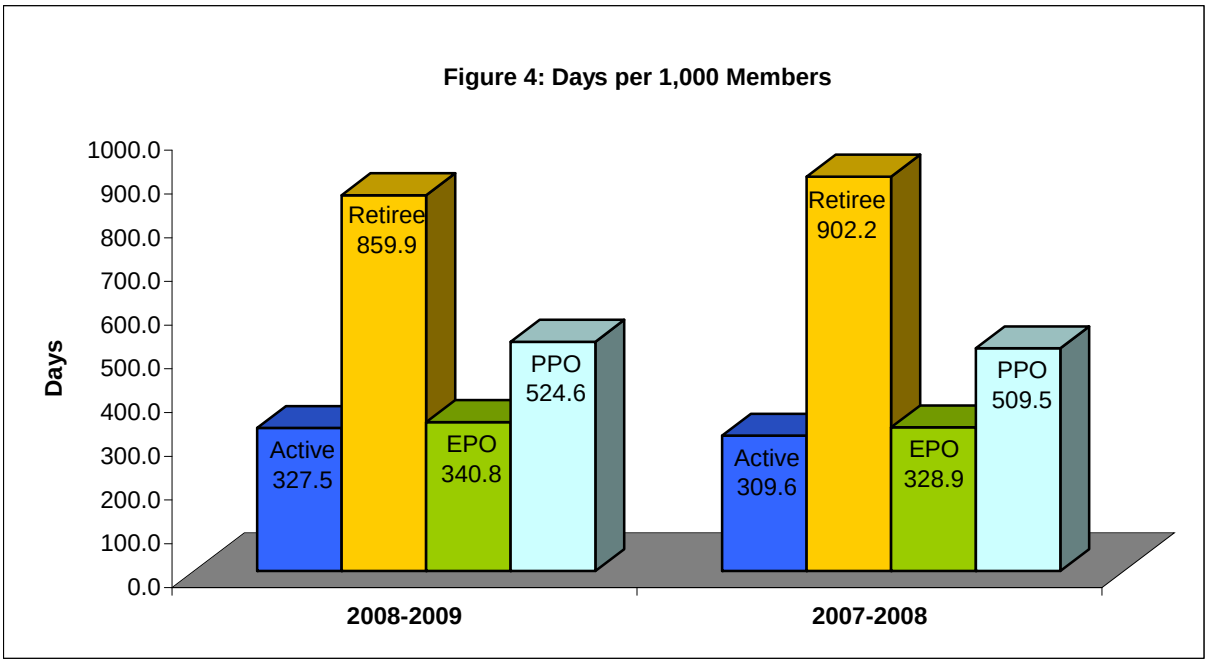
Figure 3: Average Length of Stay

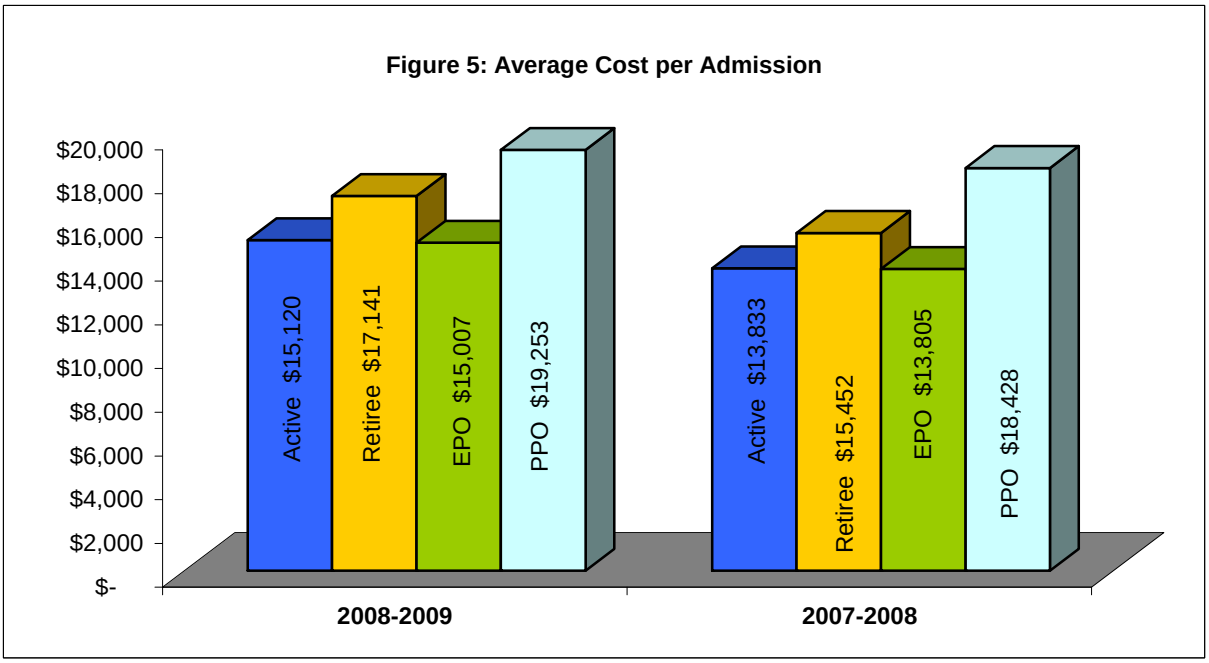


Note: Mental health, substance abuse, and maternity admissions are included.

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 2.6 times as many days in the hospital as EPO members. On average, PPO members cost per admission was $4,246 higher than EPO members.





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

Emergency Room Visits

During Plan Year 2008-2009, there were approximately 251.4 emergency room visits per 1,000 members of the self-funded plan. The average plan cost per emergency room visit was $738.92. These figures include facility claims and professional fees.

Physician Visits

During Plan Year 2008-2009, each member of the self-funded plan visited a physician approximately 4.3 times or 4,270 visits per 1,000 members. The average plan cost per office visit cost was $83.87.

Urgent Care Visits

During Plan Year 2008-2009, there were approximately 224.7 urgent care visits per 1,000 members of the self-funded plan. The average plan cost per urgent care visit was $108.47.

Figures 6 and 7 below show how total active and retiree medical expenses were distributed by type of care. 3% of medical expenses for active employees were spent for emergency room care while 5% of medical expenses for retired members were spent for home care.

Figure 6: Active Employee Medical Expense by Place of Service

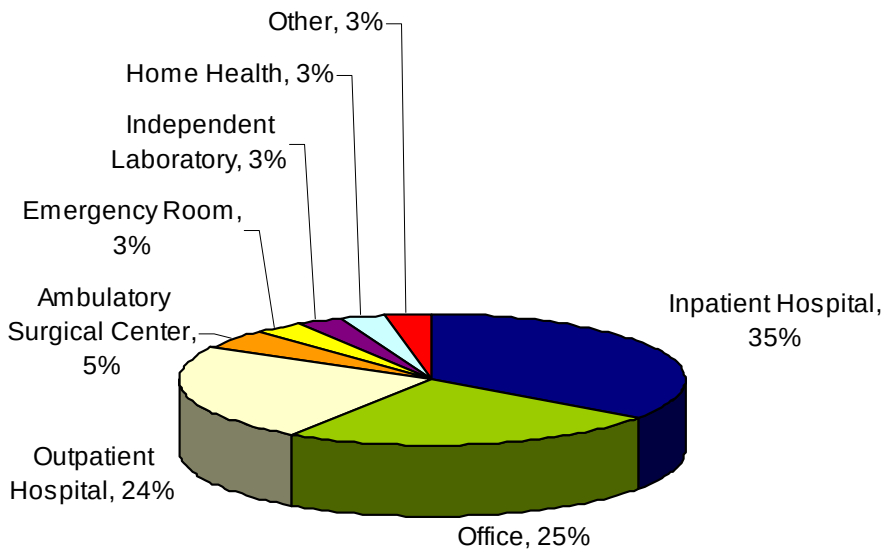
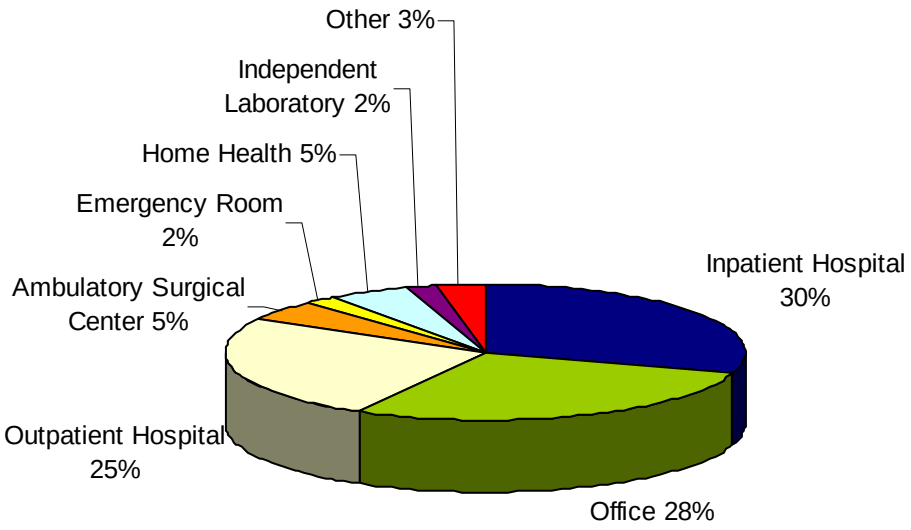


Figure 7: Retiree Medical Expenses by Place of Service



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				
	2008-2009		2007-2008	
	Total Prescriptions	Percent	Total Prescriptions	Percent
Tier 1 Generic ($10 copay)	974,094	63.5%	996,785	64.0%
Tier 2-Preferred ($20 copay)	476,648	31.1%	443,881	28.5%
Tier 3-Non-Preferred ($40 copay	83,455	5.4%	116,811	7.5%
Total	1,534,197	100.0%	1,557,477	100.0%

Prescription Use by Therapeutic Class

The table below shows the ten most utilized 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				
	2008-2009		2007-2008	
Therapeutic class	Total Cost	Percent	Total Cost	Percent
Antihyperlipidemics	12,303,047	10.76%	11,419,509	10.94%
Antidepressants	9,158,047	8.01%	8,907,603	8.53%
Ulcer medications	9,023,718	7.89%	8,624,570	8.26%
Antidiabetics	8,709,123	7.62%	7,821,290	7.49%
Antihypertensives	8,063,741	7.05%	7,807,175	7.48%
Antiasthmatic/bronchodilator agents	7,053,179	6.17%	7,627,217	7.31%
Analgesics – opioids	6,081,523	5.32%	6,406,891	6.14%
Analgesics – anti-inflammatory	5,605,012	4.90%	5,458,343	5.23%
Anticonvulsants	5,074,361	4.44%	5,223,988	5.01%
Antivirals	4,882,905	4.27%	4,429,641	4.24%
Total	$75,954,656	66.45%	$73,726,227	70.64%

Prescription Use by Type of Drug

The table below shows the ten most utilized drugs according to total expense. Prevacid remains as the leading prescription since last Plan Year 2007-2008.

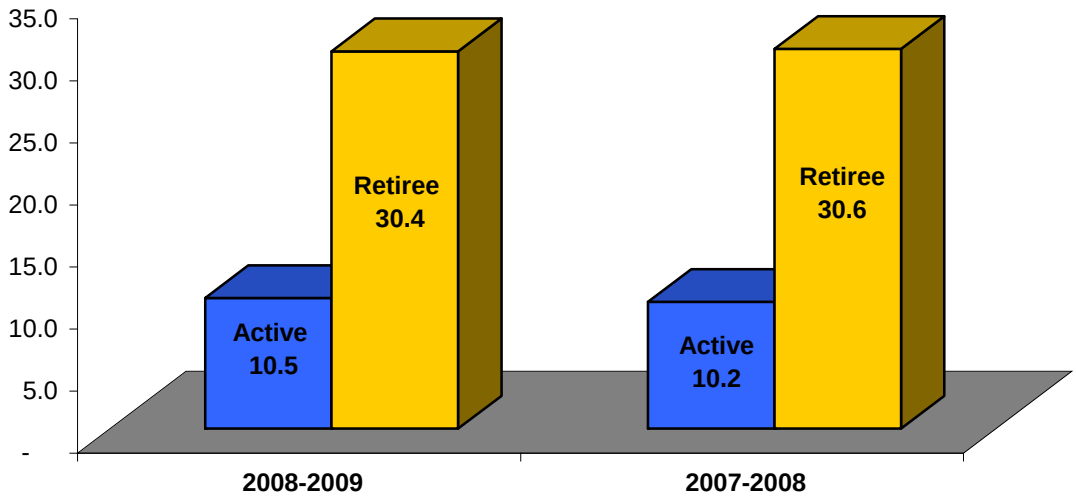
Table 8: Top ten drugs by total expense

2008-2009			2007-2008		
Drug Name	**Total Gross Cost**	**Percent**	**Drug Name**	**Total Gross Cost**	**Percent**
Prevacid	4,561,623	3.99%	Prevacid	4,206,817	4.03%
Lipitor	4,272,540	3.74%	Lipitor	4,103,694	3.93%
Enbrel	2,547,216	2.23%	Enbrel	2,413,952	2.31%
Oxycontin	2,363,851	2.07%	Advair diskus	2,339,819	2.24%
Crestor	2,311,852	2.02%	Effexor XR	2,302,871	2.21%
Effexor XR	2,212,614	1.94%	Singulair	1,999,700	1.92%
Advair diskus	2,160,881	1.89%	Crestor	1,680,772	1.61%
Singulair	2,102,215	1.84%	Lexapro	1,645,187	1.58%
Humira	2,036,027	1.78%	Actos	1,617,819	1.55%
Plavix	1,832,702	1.60%	Vytorin	1,595,744	1.53%
Total	$26,401,521	23.10%		$23,906,375	22.91%

Annual Prescription Use

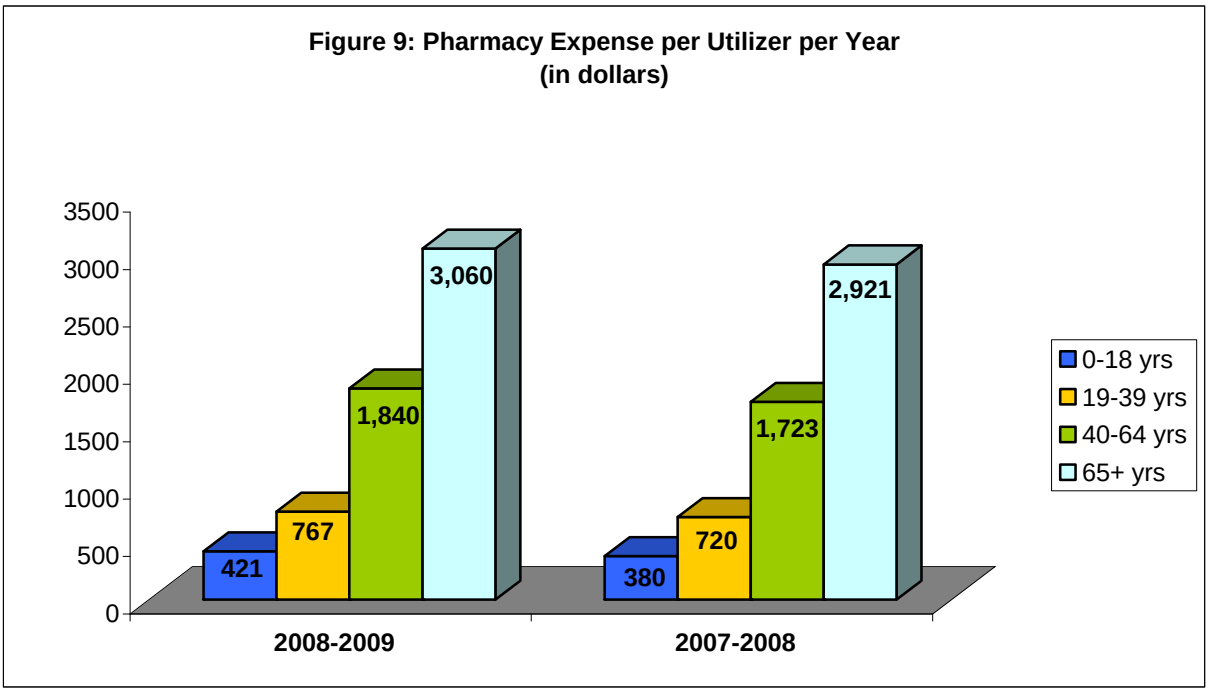
The figure below compares the average number of prescriptions filled last plan year by active and retired members.

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 Plan – Total Dental Administrators (TDA)

- 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 Total Dental Administrators.
- No claim forms (except for emergency services).

Indemnity/PPO Plan – Delta 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

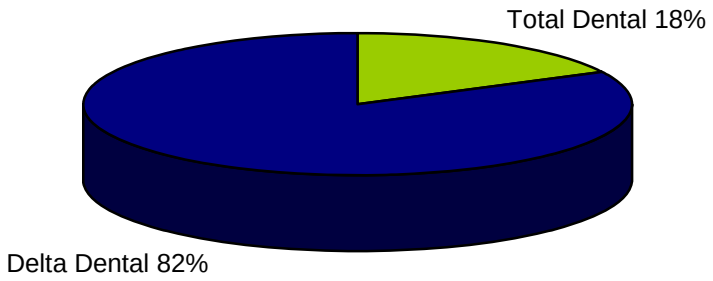
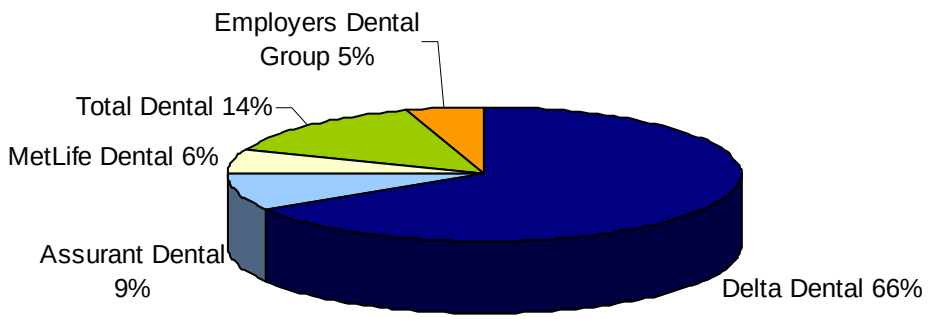


Figure 11: Retiree Dental Enrollment



Note: Between 10/1/2008 through 12/31/2009 retirees were enrolled in the Employers Dental Group, MetLife, and Assurant plans. Effective 1/1/2009 retirees were offered Delta Dental and Total Dental Administrators. Employers Dental Group, MelLife, and Assurant were not longer available.

Dental Rates

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

Table 9: Summary of Monthly Dental Rates

Active Employees	Single Coverage			Employee +One Coverage			Family Coverage		
	Employee	State	Total	Employee	State	Total	Employee	State	Total
Delta Dental	$16.00	$17.00	$33.00	$37.00	$37.00	$74.00	$63.00	$62.00	$125.00
Total Dental Admin.	$5.00	$5.00	$10.00	$9.00	$10.00	$19.00	$14.00	$14.00	$28.00

Retirees[1]	Single Coverage	Employee +One Coverage	Family Coverage
Delta Dental	$32.98	$74.01	$125.29
Total Dental Admin.	$9.96	$18.92	$27.70

[1]Effective January 1, 2009

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 Earned Premiums				
	2008-2009		2007-2008	
Vendor	**Collected**	**Paid**	**Collected**	**Paid**
Standard				
Basic Life	$ 2,533,453.45		$ 2,601,678.82	
Supp Life	$ 10,796,632.49		$ 10,198,943.64	
Dep Life	$ 1,652,663.50		$ 1,614,298.64	
STD	$ 10,073,067.22		$ 10,114,115.83	
LTD	$ 4,472,699.29		$ 4,455,294.13	
Total	**$ 29,528,515.95**	**$29,533,536**	**$ 28,984,331.06**	**$28,787,110**
Avesis - Vision		**$5,676,977**		**$5,561,668**
ASI - FSA		**$5,687,416**		**$5,328,689**
Total		**$40,897,929**		**$39,677,467**

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.

Over the 2008-2009 Plan Year the total collected penalties was $94,068.48 compared to the prior year's $123,602.28, which indicated the vendors' performance improved during the 2008-2009 Plan Year.

The following is a report of the penalties incurred by health plan vendors for their non-performance during the Plan Year ending September 30, 2009. 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 2008-2009, may result in additional penalties.

A. UnitedHealthcare (Claims Administrator) – penalties to date of $85,791.75, equaling 1.45% of the vendor's annual administrative fee.

MEASURE	Annual Percent of Fees at Risk	Total Percent Assessed Vendor (BASED ON MISSED MEASURE)
Time to Pay - Percent of claims paid in 10 business days	3%	• 1.20%*: WHICH EQUALS 1 QUARTERS MISSED OUT OF 4 QUARTERS MEASURED • Corrective Action: UHC implemented quality controls subsequently; UHC met the measure for the rest of the year. *Penalty calculated on gradient scale.
Admission Counseling: Outreach Contact - When notified 5 business days prior to an admission the care counselor will make no fewer than 3 attempts to reach 95% of participants by telephone prior to inpatient admit	.25%	• .25% WHICH EQUALS 2 QUARTERS MISSED OUT OF 4 QUARTERS MEASURED • Corrective Action: UHC provided reinforcement training to their processing staff.

Health Insurance Vendor Performance Standards (continued)

B. UMR (Claims Administrator) – penalties to date of $1715.63, equaling 0.08% 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.

C. ASI Flex – penalties to date of $661.32, equaling .50% of the vendor's annual administrative fee

MEASURE	Annual Percent of Fees at Risk	Total Percent Assessed Vendor (BASED ON MISSED MEASURE)
100% of claims will be processed within five working days	1%	• 0.25%: WHICH EQUALS 1 QUARTERS MISSED OUT OF 4 QUARTERS MEASURED • Corrective Action: ASI is implementing a new standard for claim processing and has created a tangible system of repercussions whereby claim processors that make egregious mistakes are subject to corrective action.
98% of dollars will be paid accurately	1%	• 0.25%: WHICH EQUALS 1 QUARTERS MISSED OUT OF 4 QUARTERS MEASURED • Corrective Action: The Customer Service Manager initiated retraining on claims processing accuracy.

D. Walgreens Health Initiative (Pharmacy Management) - penalties to date of $5000.00, equaling 0.83% of the vendor's total amount at risk $600,000.00.

MEASURE	Annual Percent of Fees at Risk (Max $600K)	Total Percent Assessed Vendor (BASED ON MISSED MEASURE)
Percent of transactions within three (3) seconds	2%	• 0.83%: WHICH EQUALS 2 QUARTERS MISSED OUT OF 4 QUARTERS MEASURED • Corrective Action: The measure was updated effective 02/01/09 to report as client specific as a result the measure was subsequently met for the last two quarters.

E. Delta Dental - penalties to date of $899.78, equaling 0.002% of the vendor's annual administrative fee

MEASURE	Annual Percent of Fees at Risk	Total Percent Assessed Vendor (BASED ON MISSED MEASURE)
90% of all calls requesting a member services representative will be answered in 30 seconds or less	.31%	• 0.002%: WHICH EQUALS 1 MONTH MISSED OUT OF 12 MONTHS MEASURED Corrective Action: Implemented system updates to stabilize phone system performance.

G. Successfully Met Performance Guarantees

Table 11: Successful Performance Guarantees

Vendor	At risk	Guarantees Met
UMR	15.67%	Appeals (met 11 out of 12 measures), Call Center, Eligibility Administration, Claims Statistics
UnitedHealthcare	$3,587,670.00	Appeals, Telephone Service, Claims Statistics (met 3 out of 4 measures), Eligibility Administration, Network Management, Care Coordination Guarantees (met 8 out of 9 measures)
Strategic Health Development Corporation	Total Admin Fee 7.8% Case Mgmt Fee 7.5% Disease Mgmt Fee 5% Nurseline Fee 5%	Utilization Management, Case Management, Disease Management, Reporting, Systems, Nurse & Other Call Center Activity
Walgreens Health Initiatives	$600,000.00	Data & Eligibility Requirements, Claims, Customer Services, Account Services, Reports, Network Access, Network Pharmacy Management, Mail Order Service, Retail Paper Claims Processing Time, Network Pharmacy POS Compliance (met 14 out of 16 measures)
ASI Flex	5%	Claims Turnaround (3/4 of measure), Claims Adjudication Financial Accuracy (3/4 of measure), Web Availability, Phone Response Time
Arizona Foundation	1%	Program Management
RAN+AMN	1%	Program Management
The Standard Short Term Disability	5%	Telephone Service , Processing Timeline (3/4 of measure), Check Issuance Timeline, Processing Accuracy, Financial Accuracy, Appeals Timeline, Reports
The Standard Life	5%	Telephone Service (3/4 of measure), Processing Timeline, Processing Accuracy, Financial Accuracy, Reports
The Standard Long Term Disability	5%	Telephone Service, Processing Timeline, Processing Accuracy, Financial Accuracy, Reports
Delta Dental	5%	Reporting, Network Management, Appeals, Claims Administration (met 35 out of 36 measures) Quality of Service and Responsiveness to Members
TDA	3%	Reporting, Network Management, Appeals, Claims Administration, Quality of Services, Claims Administration, Quality of Service and Responsiveness to Members

Glossary of Terms

Active member – an employee, other than one excluded by the Arizona Administrative Code, who works for the State of Arizona or a State University and is enrolled in one of the health plan options offered by the State. Also referred to as "Actives."

Administrative fees – fees paid to third-party vendors for plan administration, network rental, transplant network access fees, shared savings for negotiated discounted rates with other providers, COBRA administration, direct pay billing, additional reporting billing, state fees (MA 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-Insured – 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.

Appendix A

Table A: 3015 FUND PLAN YEAR 10/1/2008 - 9/30/2009

BEGINNING CASH PER AFIS					**$**	**115,737,519.48**
REVENUE					**$**	**692,617,307.43**
EXPENDITURES					**$**	**749,812,060.81**
VENDOR	ADMIN FEES	PERF PENALTIES				
AZ FOUNDATION	$ 71,559.60					
BEECH STREET	$ 17,668.62					
HMA	$ 389,343.94	$ 16,638.19				
SCHALLER NETWORK	$ 60,362.64					
SCHALLER UR/UM		$ 56,811.82				
STRATEGIC URUM	$ 1,731,032.45	$ 12,936.11				
HARRINGTON	$ 3,063,935.75	$ 74,943.32				
UHC	$ 17,652,290.78					
WHI	$ 962,495.33	$ 40,750.00				
ATTORNEY GENERAL	$ 4,507.11					
NET ADMIN FEES	**$ 23,953,196.22**	**$ 202,079.44**		**$**	**23,751,116.78**	
	MEDICAL CLAIMS	RECOVERIES				
HARRINGTON	$ 197,514,724.33	$ 2,253,920.82				
UHC	$ 333,317,458.32	$ 115,028.93				
PACIFICARE	$ 2,254.52					
WHI	$ 115,936,887.19	$ 8,358,506.30				
RDS SUBSIDY		$ 2,518,939.33				
OTHER WELLNESS	$ 709,415.40					
NET MEDICAL CLAIMS	**$ 647,480,739.76**	**$ 13,246,395.38**		**$**	**634,234,344.38**	
	STOP LOSS PREM	CLAIM REIMB				
SYMETRA	$ 3,509,198.40	$ 5,744,072.39		**$**	**(2,234,873.99)**	
SELF INSURED EXPENDITURES				***$***	***655,750,587.17***	
	FULL SVC PREM					
BCBS	$ 34,342,196.56					
PACIFICARE	$ 7,687,528.03					
TOTAL FS INS PREMS	$ 42,029,724.59	$ -		**$**	**42,029,724.59**	
	DENTAL PREM	PERF PENALTIES				
DELTA	$44,036,101.06					
METLIFE	$838,702.13					
FORTIS	$190,049.89	$ 14,671.07				
EDS	$182,079.75					
TDA	$2,036,893.26					
NET DENTAL PREM	$ 47,283,826.09	$ 14,671.07		**$**	**47,269,155.02**	
HITF APPROP EXP	$ 4,762,594.03			**$**	**4,762,594.03**	
TOTAL EXPENDITURES	**$ 769,019,279.09**					
TOTAL RECOVERIES*		**$ 19,207,218.28**				
NET EXPENDITURES				**$**	**749,812,060.81**	
ENDING CASH BALANCE PER AFIS					**$**	**58,542,766.10**

The HITF Fund-3015 established under A.R.S. 38-654-A is used to pay medical claims, dental premiums, and administrative and operating costs of the Wellness Program and the Benefits Services Division.

Appendix A

Table B: 3035 FUND PLAN YEAR 10/1/2008 - 9/30/2009

BEGINNING CASH PER AFIS				**$ 4,028,940.95**
REVENUE				**$ 41,002,530.08**
	VENDOR	INSURANCE	AMOUNT	
	STANDARD	BASIC LIFE	$ 2,533,453.45	
		SUPP LIFE	$ 10,796,632.49	
		DEP LIFE	$ 1,652,663.50	
		STD	$ 10,073,067.22	
		LTD	$ 4,472,699.29	
	TOTAL STANDARD		**$ 29,528,515.95**	
	AVESIS	VISION	**$ 5,702,630.22**	
	ASI	AMRA	$ 4,309,639.15	
		DCRA	$ 1,461,744.76	
	TOTAL FLEX SPENDING		**$ 5,771,383.91**	
	PAYROLL CLEARING		$ (0.00)	
TOTAL REVENUE			**$ 41,002,530.08**	
EXPENDITURES				**$ 40,897,928.92**
	VENDOR	INSURANCE	AMOUNT	
	STANDARD	BASIC LIFE	$ 2,538,716.74	
		SUPP LIFE	$ 10,772,512.88	
		DEP LIFE	$ 1,652,507.23	
		STD	$ 10,092,134.73	
		LTD	$ 4,477,664.11	
	TOTAL STANDARD		**$ 29,533,535.69**	
	AVESIS	VISION	**$ 5,676,977.43**	
	ASI	AMRA	$ 4,137,460.67	
		DCRA	$ 1,417,363.23	
		ADMIN FEES	$ 132,591.90	
	TOTAL FLEX SPENDING		**$ 5,687,415.80**	
	GAO AFIS COST			
TOTAL EXPENDITURES			**$ 40,897,928.92**	
ENDING CASH BALANCE PER AFIS				**$ 4,133,542.11**

Fund 3035 is established under A.R.S. 38-651.05. to pay premiums for other insurance products offered to State employees including Vision, Flexible Spending, Supplemental and Dependent Life, Short Term Disability, Non-ASRS Long Term Disability, and Basic Life insurance.

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