State of Arizona

Arizona Department of Administration

Benefit Services Division

Benefit Options

Choice. Value. Health.

Annual Report

Benefit Options Addendum

October 1, 2010 through December 31, 2010

Janice K. Brewer
Governor

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FOREWORD

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

The information provided in the report was gathered from contracted vendors 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, 2010 through December 31, 2010.

This report is an addendum to the Annual Report published for the October 1, 2009 through September 30, 2010. This report reflects data required to be reported as a result of the change in the plan year. The plan year now begins January 1 of each calendar year.

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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 Benefit Options program is accounted for in two different funds. The Special Employee Health Fund, also known as fund 3015 or the Health Insurance Trust Fund (HITF), encompasses the medical and dental programs and the appropriated expenditures for ADOA Benefit Services operations. The ERE/Benefits Administration Fund, fund 3035, is primarily a "pass through" fund for other benefits including vision, disability insurance, life insurance and flexible spending accounts.

The benefits offered through the program fall into one of two types — self-funded and fully-insured. The health benefit plan is self-funded; whereas the dental plans, vision plan, disability insurance, and life insurance plans are fully insured.

The State's self-funded medical plan began on October 1, 2004, and consists of a carved out pharmacy plan with two options for the medical plan, integrated or non-integrated. The integrated option combines the functions of claims review and payment, network access, and utilization review and utilization management (URUM) which includes case management and disease management. The non-integrated option is similar, but the URUM function is carved out to a separate contract.

Schedules of premiums received; incurred and paid medical/drug claims; expenses related to the medical and dental plans; and distribution by enrollment are included within this document as accounted for in fund 3015. A summary of premiums collected and paid for life insurance, vision insurance and flexible spending accounts has also been included for fund 3035. The Cash Flow Reconciliation charts for the two funds can be found in Appendix A. The difference in the values presented in Appendix A and the Health Insurance Trust Fund (HITF) Summary on page 4 is a result of timing difference between when premiums and/or services are incurred and when they are paid. Appendix A was prepared on a cash basis, where as, the HITF Summary was prepared on an accrued and paid basis.

All data provided herein is for the period October 1, 2010 through December 31, 2010.

Executive Summary

The passing of Health Care Reform by the Federal Government initiated a review of the plan year cycle. It was determined that the plan year should be moved to a calendar year for tax reporting purposes effective January 1, 2011. In order to effect a smooth transition to the new plan year, a mini-plan year was offered from October 1, 2010 through December 31, 2010, with no change in premium structure or contribution strategy from the ending 2009-2010 plan year. Due to this uncommon event and its unique characteristics, there are no similar reporting periods to which a comparison may be performed. Therefore, there is no comparative data presented in this report.

During the reporting period, October 1, 2010 through December 31, 2010, the Benefit Services Division (BSD) Health Plan offered a comprehensive insurance package to over 128,000 members consisting of active State employees, University staff, retirees, and their qualified dependents. The benefit options include; medical, pharmaceutical, dental, flexible spending, vision, life, and disability insurance.

To ensure the efficiency and effectiveness of the State Health Plan, BSD Audit Services maintained 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, vendor operating transactions, vendor internal operating standards, and vendor execution of benefit design. The audit plan has been strategically developed to identify potential loss and facilitate corrective action, in continuing efforts to improve plan performance and cost effectiveness.

For the reporting period, the total premiums expected were $193,928,037 with expected total expenses for the plan of $191,367,466, resulting in an expected net operational gain of $2,560,570.

The 2009-2010 contribution strategy for medical resulted in employees paying 10.61% of the average monthly total premium, while the State paid the remaining 89.39%. However, the contribution strategy for dental resulted in employees paying 84.21% of the average monthly total premium, while the State paid the remaining 15.79%. Retirees are fully responsible for payment of their premiums, but typically receive a subsidy through the respective retirement system to offset a portion of the cost. COBRA is offered to termed employees at 102% of the total premium. However, if qualified under the American Recovery and Reinvestment Act (ARRA), a COBRA member would pay only 35% of the total COBRA premium with the remaining 65% COBRA Premium Assistance portion to be collected through a reduction of employer paid payroll taxes.

The analysis of expenses for the reporting period indicated the average cost to insure each member was $5,554. However, when analyzed by type of subscriber; the active members average cost was $5,360 compared to the average retiree cost of $7,821. This difference in average cost between active and retired members is a common trend. There is a direct relationship between the age of an insured member and their cost for health care. Senior members usually require an increased amount of medical care, including additional pharmaceuticals, to maintain their quality of life.

Medical claims expenses accounted for $104,881,454 of the total cost the health plan during the reporting period. When analyzed by cost, the five leading diagnosis categories are: musculoskeletal system (muscles and joints), circulatory system (heart), neoplasm (cancers), genitourinary system (kidneys and reproductive organs), and digestive system. Musculoskeletal system was the leading category with $13,143,046 or 12.53% of total claims paid.

Examination of hospital care reveals that inpatient care represents a significant portion of the total medical expenses: 36.63% and 31.39% for active and retired members respectively. Analysis by the type of medical care visit reveals there were 157 emergency room, 135 urgent care, and 3,960 physician visits per 1,000 members covered under the self-insured plan; which indicates members are seeking the care of a physician or specialist for the majority of their medical needs.

The cost of prescription drug claims for the period totaled $27,635,461 and a reported 386,030 prescriptions were filled. The top five most expensive drugs classes are described as maintenance drugs used to control and prevent chronic diseases. Diabetes drugs lead the list with 2.59 million dollars or 9.21% of total pharmacy costs. Other leading categories were cardiovascular disease, asthma, behavioral health, and inflammatory disease. The most prescribed drug according to total expense is Lipitor, typically prescribed for treating and preventing high cholesterol.

Retirees on the State health plan filled an average of 14.2 prescriptions for the period, while active members averaged 8.2. Similar to medical cost per member, the pharmaceutical expense per member increases as the members age increases. Analysis indicates that the 40-64 age group annual prescription drug cost is $877 per member compared to the 65+ age group cost of $1,448 per member. As a result the smaller population of insured retirees attributes the majority of prescription expenses.

In addition to managing the volume statistics and expenses of the Program, the State manages 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 performance penalties. During the October 1, 2010 through December 31, 2011, ADOA collected penalties totaling $5,000 for the previous Plan Year. An assessment of vendor performance for the October 1, 2010 through December 31, 2010 period is provided in the Health Insurance Vendor Performance Standards section of this report.

In review, the October 1, 2010 through December 31, 2010, period continued to demonstrate 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 planning and auditing, and effective contract 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 incurred during the October 1, 2010 through December 31, 2010 Mini-Plan Year and paid through March 2011.

ADOA Benefit Options refers to the self-funded medical program and includes Aetna, Blue Cross Blue Shield of Arizona administered by AmeriBen, CIGNA, and United Healthcare networks. BCBS (NAU), and all dental plans are fully-insured.

State and University employees and retirees choose coverage from one of the self-funded networks. However, Blue Cross Blue Shield is a fully-insured option available only to NAU employees and NAU retirees. The Medicare Part D Subsidy is available to employers who provide a qualified pharmacy plan to Medicare-eligible retirees. Rebates & Recoveries consist of rebates paid by drug manufacturers, performance penalties assessed to contractors for not achieving performance guarantees, overpayment recoveries and stop-loss reinsurance payments. Reserve (IBNR) is the amount of money that must be held in reserve 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.

Table 1: Health Insurance Trust Fund Summary

	October 1, 2010 - December 31, 2010
Receipts (accrual basis)	
ADOA Benefit Options	174,545,324
BCBS (NAU)	8,462,079
Dental	10,920,634
Total	193,928,037
Expenses	
Medical Claims (accrual basis)	104,881,454
Drug Claims (accrual basis)	27,635,461
ERRP Reimbursement	(2,456,920)
Medicare Part D Subsidy*	-
Rebates & Recoveries	(2,851,784)
Reserves for future benefits	36,130,740
BCBS Payments	8,569,657
Administration Fees	7,682,583
Stop-Loss Premiums	839,462
Appropriated Expenses	1,107,953
Dental Costs	10,086,030
Total	191,624,636
Difference	2,303,401
Enrollment	
Subscribers	61,033
Members	128,983

*No Medicare Part D subsidy was received during the reporting period.

Enrollment in Benefit Options Medical Plans

The Benefit Options group medical plan is available to all:

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

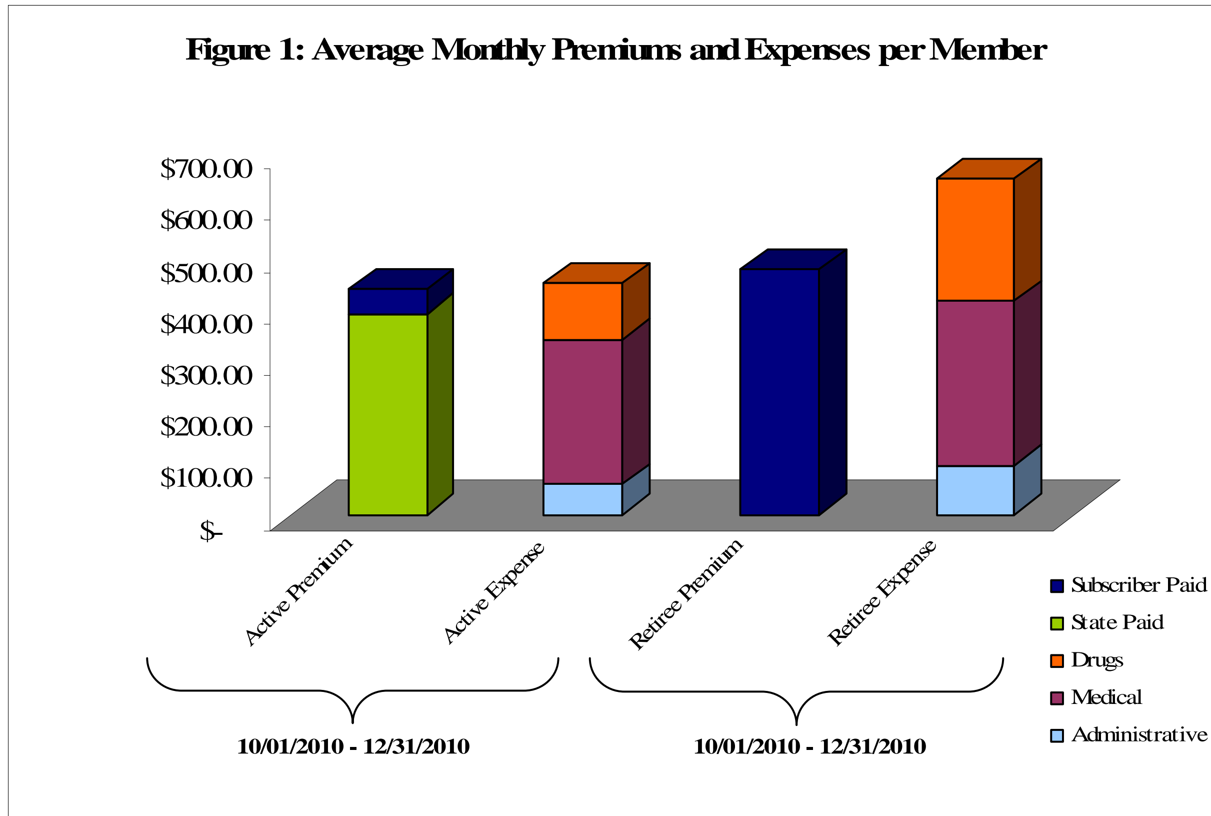
		October 1, 2010 - December 31, 2010	
Network	**Plan Type**	**Subscribers**	**Members ***
AETNA			
Active	EPO	1160	2622
Retiree	EPO	284	360
University	EPO	1164	2097
COBRA	EPO	23	34
Active	PPO	90	152
Retiree	PPO	67	82
University	PPO	145	240
COBRA	PPO	0	0
Active	HSAO	121	218
Retiree	HSAO	-	-
University	HSAO	171	316
COBRA	HSAO	4	5
AmeriBen			
Active	EPO	5573	13789
Retiree	EPO	1145	1525
University	EPO	1616	3352
COBRA	EPO	62	88
Active	PPO	222	398
Retiree	PPO	202	245
University	PPO	281	531
COBRA	PPO	6	6
CIGNA			
Active	EPO	2823	6740
Retiree	EPO	701	914
University	EPO	1174	2331
COBRA	EPO	19	23

Continuation Table 2: Average Monthly Enrollment			
		October 1, 2010 - December 31, 2010	
Network	**Plan Type**	**Subscribers**	**Members ***
UnitedHealthcare			
Active	EPO	**22311**	**52289**
Retiree	EPO	**4955**	**6464**
University	EPO	**12017**	**26427**
COBRA	EPO	**288**	**382**
Active	PPO	**609**	**1102**
Retiree	PPO	**171**	**222**
University	PPO	**748**	**1421**
COBRA	PPO	**17**	**22**
Blue Cross Blue Shield			
NAU only	PPO	**2864**	**4585**
Total		**61033**	**128983**

** NAU and COBRA dependent is an estimated number based on*

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.



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 adult, employee plus child, and family coverage at the cost of $39, $97, $79 and $178. PPO monthly premiums were determined from actual experience and the true cost of the coverage.

The 2009-2010 contribution strategy for medical resulted in employees paying 10.61% of the average monthly total premium, while the State paid the remaining 89.39%. The contribution strategy for dental resulted in employees paying 84.21% of the average monthly total premium, while the State paid the remaining 15.79%.

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	HSAO
Medical Claims (accrual basis)		104,881,454	95,499,699	9,381,755	99,357,245	5,443,057	81,152
Drug Claims (accrual basis)		27,635,461	20,692,552	6,942,908	25,566,670	2,039,636	29,154
ERRP Reimbursement		(2,456,920)		(2,456,920)	(2,300,407)	(156,513)	
Medicare Part D Subsidy+		0		0	0	0	
Rebates & Recoveries		(2,828,390)	(2,479,963)	(348,427)	(2,666,328)	(159,708)	(2,354)
Reserve (IBNR)		36,130,740	31,679,820	4,450,920	34,060,508	2,040,157	30,075
Administration Fees		7,425,414	6,464,798	960,616	7,061,141	326,489	37,785
Stop-Loss Premiums		839,462	730,862	108,600	798,280	36,910	4,272
Appropriated Expenses		1,107,953	964,619	143,334	1,053,600	48,716	5,638
Total	$	172,735,174	153,552,387	19,182,787	162,930,709	9,618,744	185,721
Enrollment in self-funded plans							
Subscribers		58,170	50,644	7,525	55,316	2,558	296
Members		124,398	114,587	9,811	119,437	4,422	540
Annualized cost							
Per subscriber	$	11,878	12,128	10,196	11,782	15,043	2,510
Per member	$	5,554	5,360	7,821	5,457	8,701	1,377

*The data is for the incurred period October 1, 2010 through December 31, 2010.
+No Medicare Part D subsidy was received during the reporting period.

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	Active/HSAO	Retiree/ EPO	Retiree/ PPO
Medical Claims (accrual basis)		104,881,454	90,591,874	4,826,672	81,152	8,765,371	616,385
Drug Claims (accrual basis)		27,635,461	19,105,914	1,557,484	29,154	6,460,756	482,152
ERRP Reimbursement		(2,456,920)				(2,300,407)	(156,512.96)
Medicare Part D Subsidy+		0				0	0
Rebates & Recoveries		(2,828,390)	(2,341,347)	(136,261)	(2,354)	(324,981)	(23,447)
Reserve (IBNR)		36,130,740	29,909,104	1,740,640	30,075	4,151,404	299,516
Administration Fees		7,425,414	6,156,691	270,322	37,785	904,450	56,166
Stop-Loss Premiums		839,462	696,030	30,561	4,272	102,250	6,350
Appropriated Expenses		1,107,953	918,646	40,335	5,638	134,954	8,381
Total	$	172,735,174	145,036,912	8,329,754	185,721	17,893,797	1,288,990
Enrollment in self-funded plans							
Subscribers		58,170	48,231	2,118	296	7,085	440
Members		124,398	110,174	3,873	540	9,263	549
Annualized cost							
Per subscriber	$	11,878	12,029	15,734	2,510	10,102	11,718
Per member	$	5,554	5,266	8,603	1,377	7,727	9,397

*The data is for the incurred period October 1, 2010 through December 31, 2010.
+No Medicare Part D subsidy was received during the reporting period.

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

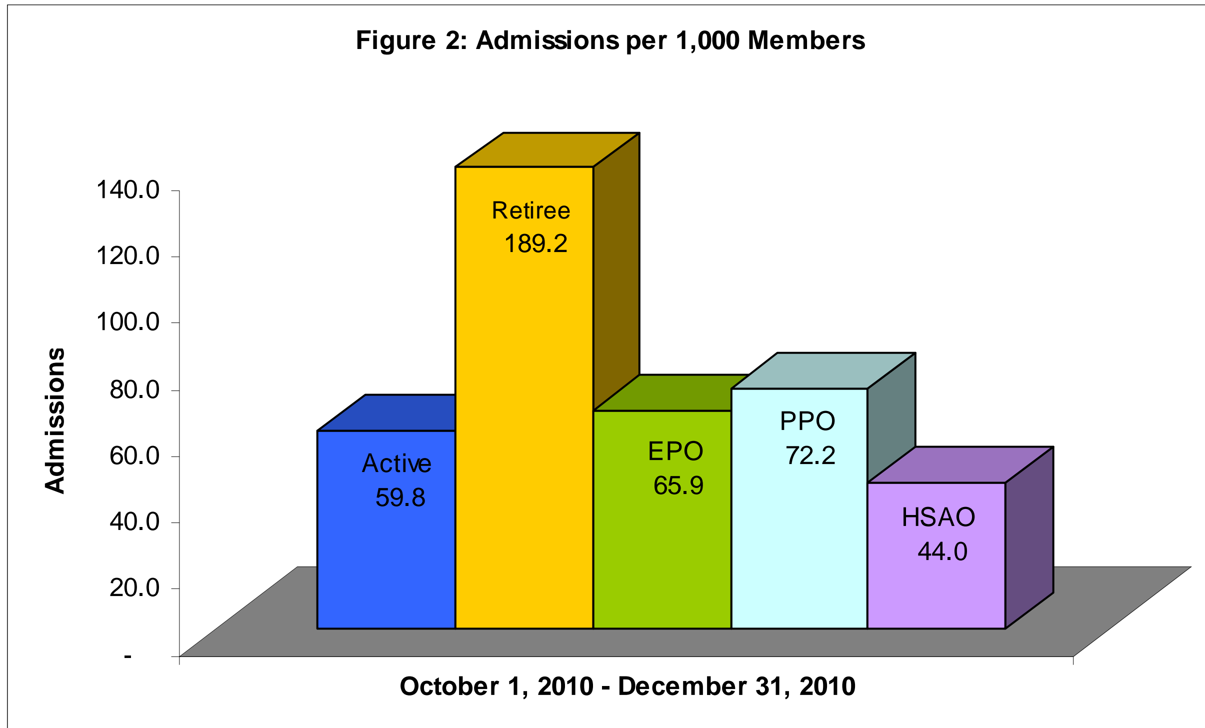
	October 1, 2010 - December 31, 2010		
	Actives	Retirees	All members
Diagnosis	% of Total	% of Total	% of Total
Musculoskeletal System	12.44%	13.46%	12.53%
Health Status (lab tests, etc.)	10.66%	9.27%	10.54%
Ill-defined[1]	9.52%	7.81%	9.37%
Circulatory System	9.25%	10.49%	9.36%
Neoplasm (tumors)	8.97%	12.68%	9.30%
Genitourinary System	7.67%	10.10%	7.89%
Digestive System	7.11%	8.17%	7.20%
Injury/Poisoning	7.25%	6.59%	7.19%
Nervous System	5.06%	8.90%	5.41%
Respiratory System	5.12%	3.43%	4.97%
Endocrine	4.30%	3.63%	4.24%
Pregnancy/Childbirth Complications	4.14%	0.01%	3.77%
Mental Health	2.51%	1.11%	2.39%
Infectious/Parasitic	2.19%	1.05%	2.09%
Skin and Subcutaneous Tissue	1.68%	2.14%	1.72%
Blood and Blood Forming Organs	1.09%	1.00%	1.09%
Congenital Anomalies	0.74%	0.16%	0.69%
Conditions in the Perinatal Period	0.30%	0.00%	0.27%
External Causes of Injury/Poisoning	0.00%	0.00%	0.00%
Grand Total	100.00%	100.00%	100.00%

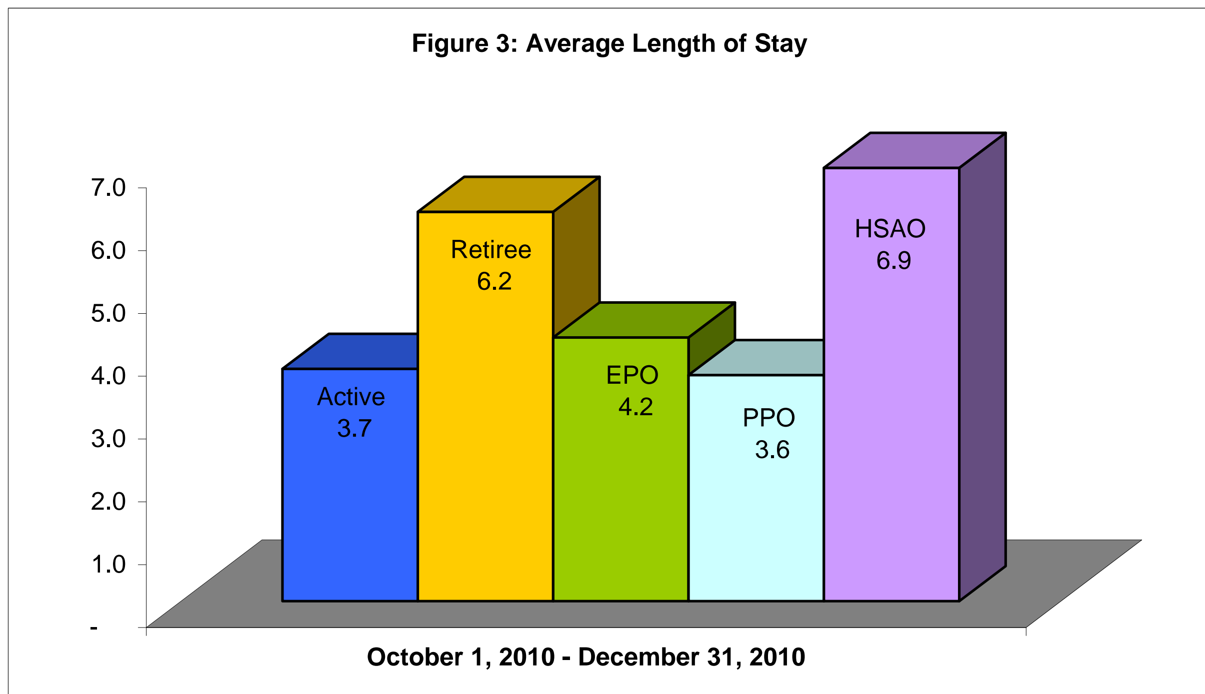
Note: Some statistics may vary slightly from previous annual reports due to the late receipt of program data following the completion of the previous annual report. In no case does the variation represent a substantive change in trend or comparative values.

[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, and laboratory analysis of blood with findings not related to cellular abnormality.

Hospital Care

Inpatient hospital care represents a significant portion of total medical expenses: 36.63% and 31.39% for active and retired members, respectively. The figures below show how active/retired members and EPO/PPO/HSAO members' hospital admissions compared based on the number of admissions and the average length of stay.

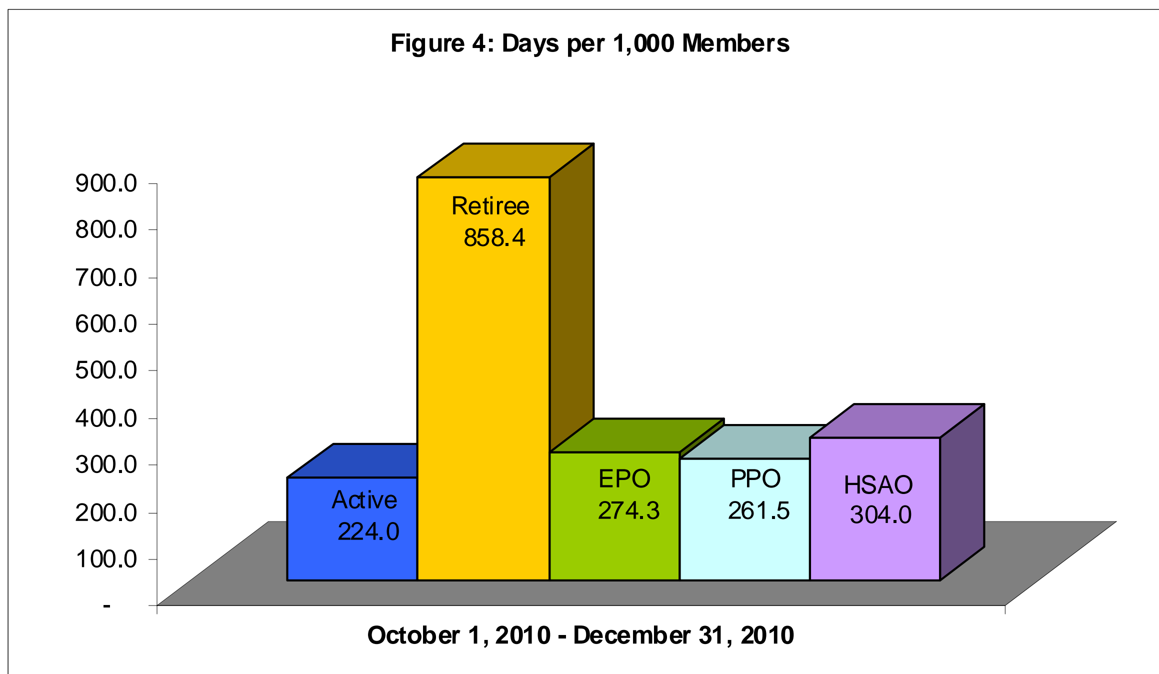


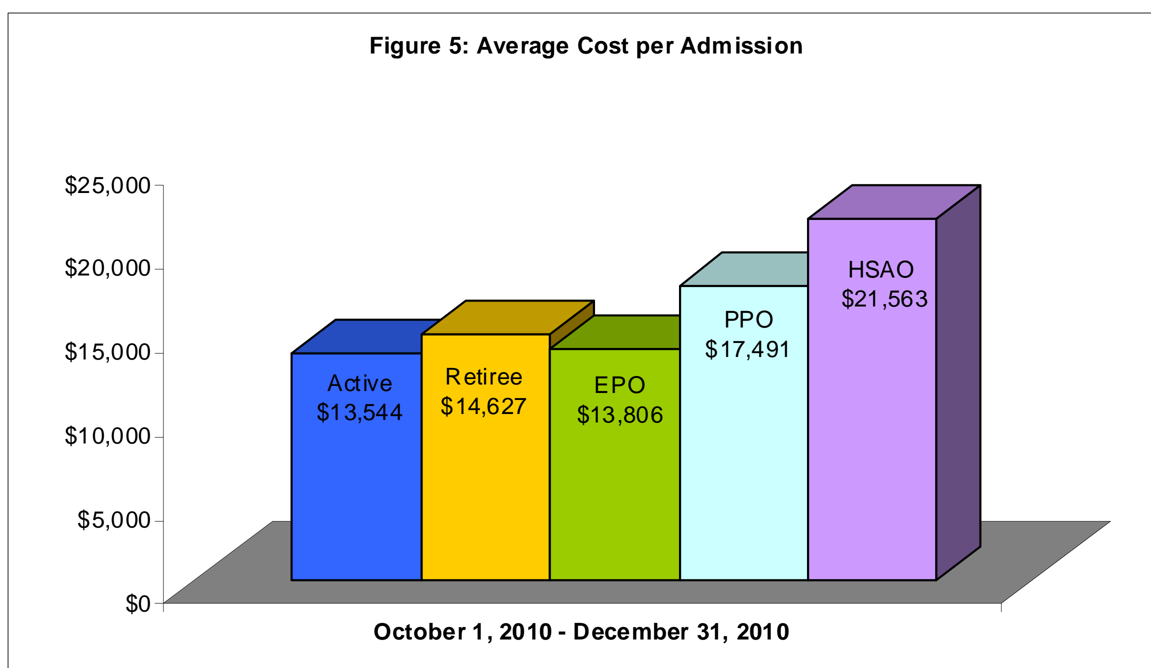


Note: Mental health, substance abuse, and maternity admissions are included.

Hospital Care (continued)

The figures below show how active/retired members and EPO/PPO/HSAO members compared statistically in collective number of hospital days and average cost per admission. As a group, retirees spent 4 times as many days in the hospital as active members. Also, PPO members spent about the same days in the hospital as EPO members. On average, PPO members cost per admission was $3,685 higher than EPO members.





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

Emergency Room Visits

During the reporting period, October 1, 2010 through December 31, 2010, there were approximately 157 emergency room visits per 1,000 members of the self-funded plan. The average plan cost per emergency room visit was $1,288. These figures include facility claims and professional fees.

Urgent Care Visits

During the reporting period, there were approximately 135 urgent care visits per 1,000 members of the self-funded plan. The average plan cost per urgent care visit was $90.00.

Physician Visits

During the reporting period, there were approximately 3,960 physician visits per 1,000 members (or each member of the self-funded plan visited a physician approximately 4.0 times). The average plan cost per office visit cost was $94.88.

Figure 6 indicates total active medical expense distribution by type of care.

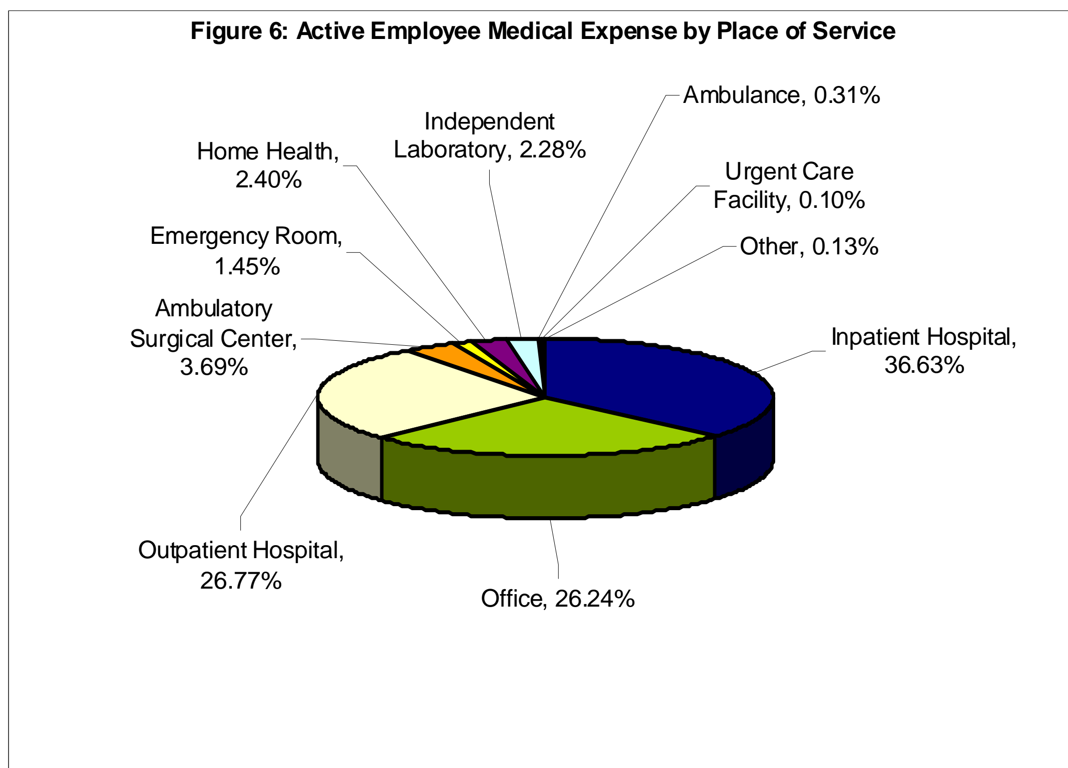
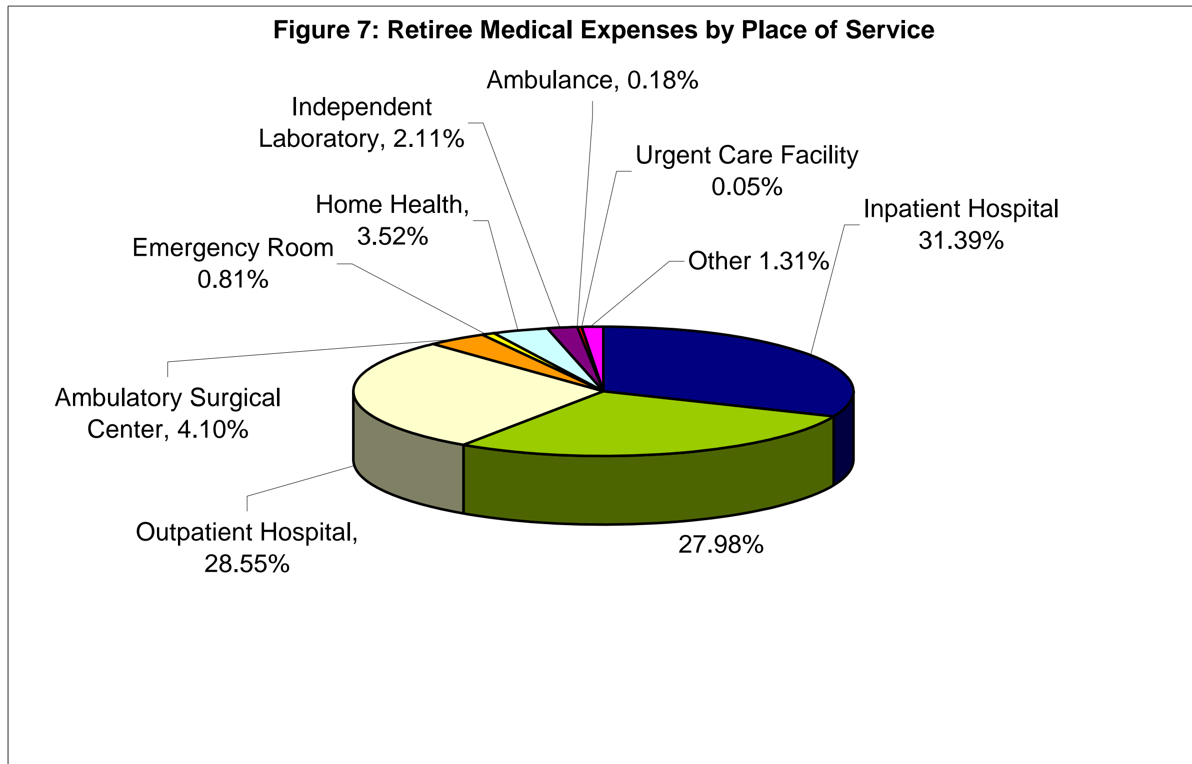


Figure 7 indicates total retiree medical expense distribution by type of care



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		
	October 1, 2010 - December 31, 2010	
	Total Prescriptions	Percent
Tier 1 Generic ($10 copay)	271,486	70.3%
Tier 2-Preferred ($20 copay)	87,666	22.7%
Tier 3-Non-Preferred ($40 copay)	26,878	7.0%
Total	386,030	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 "Diabetes", than on any other therapeutic class.

Table 7: Top therapeutic classes by total expense		
	October 1, 2010 - December 31, 2010	
Therapeutic class	**Total Cost**	**Percent**
Diabetes	$2,590,669	9.21%
Cardiovascular Disease - Lipid	$2,559,882	9.10%
Asthma	$2,033,343	7.23%
Behavioral Health - Other	$1,986,620	7.06%
Behavioral Health - Antidepressants	$1,782,699	6.34%
Inflammatory Disease	$1,759,314	6.25%
Pain Management - Analgesics	$1,337,032	4.75%
Upper Gastrointestinal Disorders - Ulcer	$1,263,443	4.49%
Cardiovascular Disease - Hypertension	$1,256,622	4.47%
Infectious Disease - Viral	$1,157,978	4.12%
Total	$17,727,602	63.00%

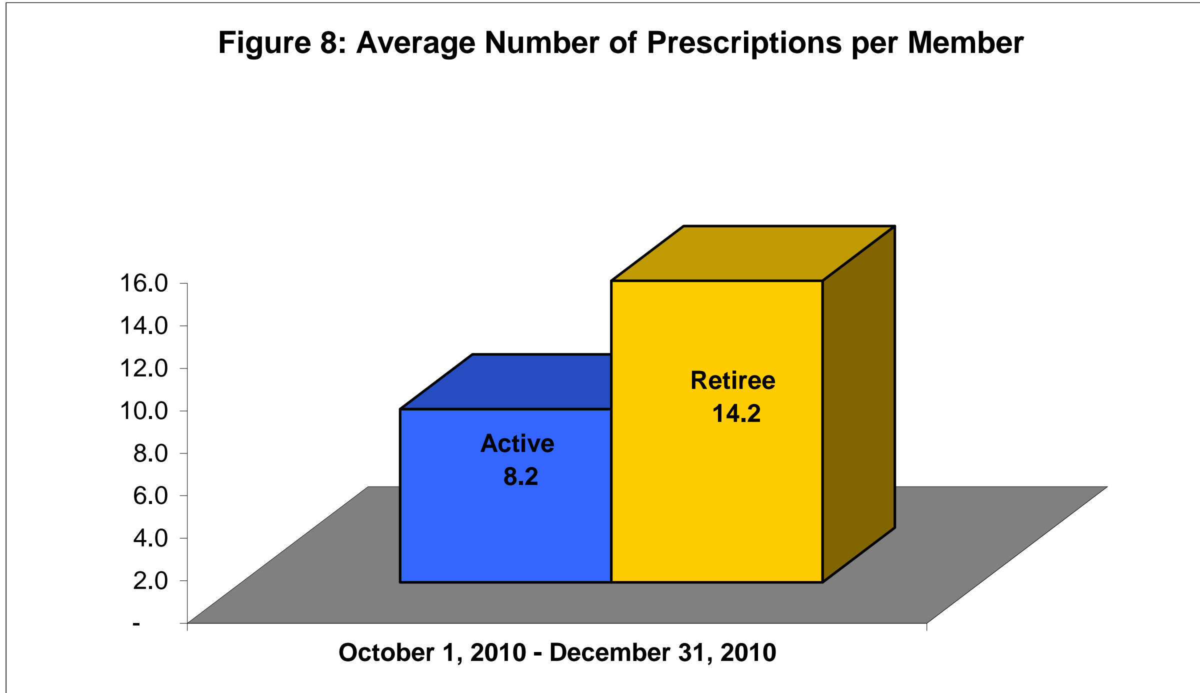
Prescription Use by Type of Drug

The table below shows the ten most utilized drugs according to total expense. Lipitor, a cholesterol controlling medication, is the leading prescription for the plan year.

Table 8: Top ten drugs by total expense		
	October 1, 2010 - December 31, 2010	
Drug Name	**Total Gross Cost**	**Percent**
Lipitor	939,637	3.34%
Humira	644,614	2.29%
Crestor	608,878	2.16%
Singulair	555,555	1.97%
Enbrel	551,340	1.96%
Advair diskus	539,332	1.92%
Plavix	515,358	1.83%
Cymbalta	491,188	1.75%
Actos	441,690	1.57%
Copaxone	430,075	1.53%
Total	$5,717,667	20.32%

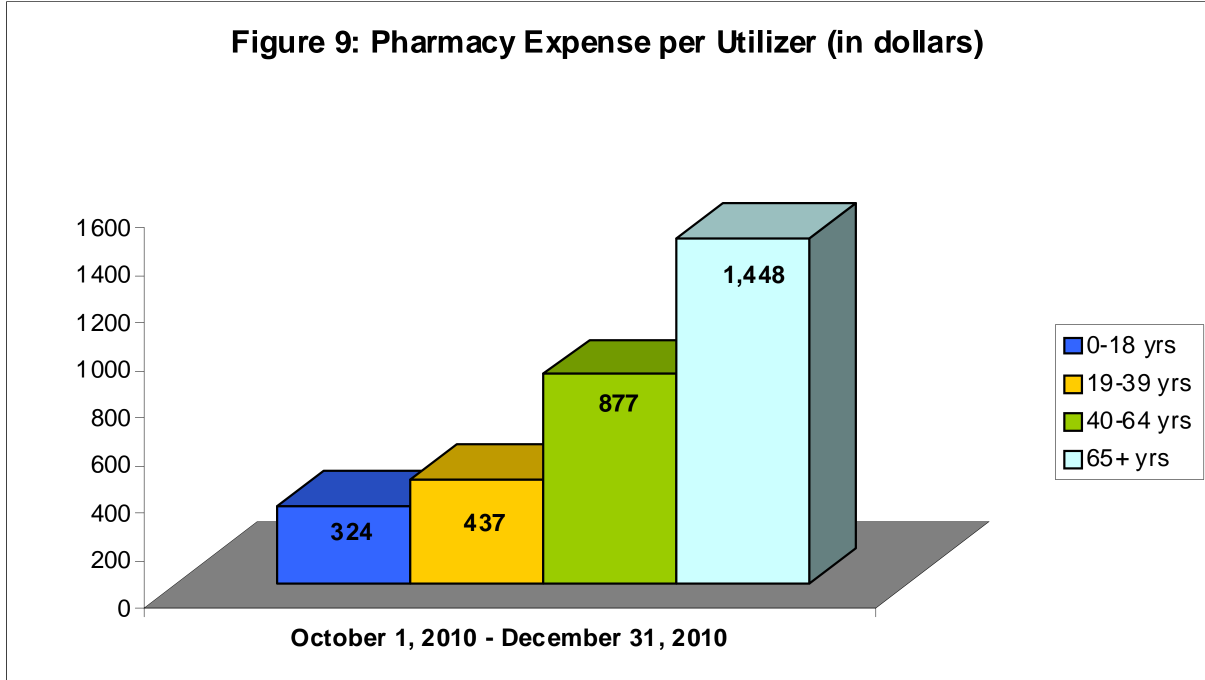
Annual Prescription Use

The figure below compares the average number of prescriptions filled during the reporting period by active and retired members.



Annual Pharmacy Expenses by Age

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



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 Premier

- 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.

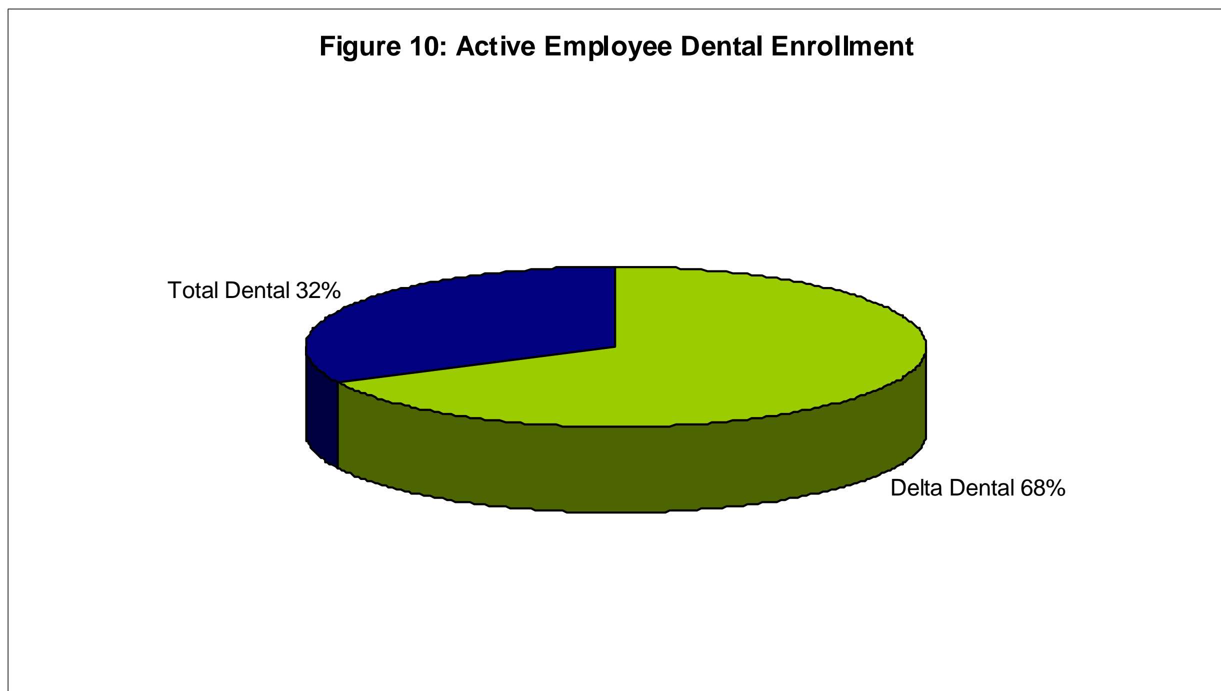
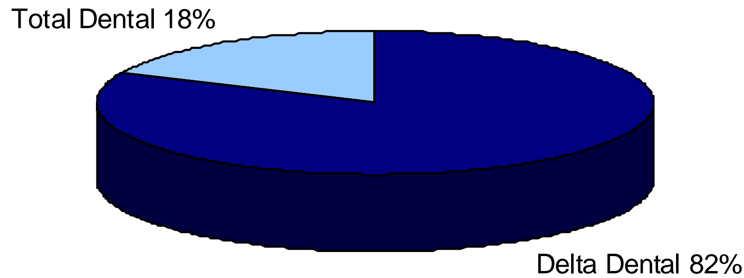


Figure 11: Retiree Dental Enrollment



Dental Rates

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

Table 9: Summary of Monthly Dental Rates

Active Employees	Single Coverage			Employee +One Coverage			Family Coverage		
	Employee	State	Total	Employee	State	Total	Employee	State	Total
Delta Dental	$29.86	$4.96	$34.82	$67.93	$9.92	$77.85	$118.12	$13.70	$131.82
Total Dental Admin.	$5.00	$4.96	$9.96	$9.00	$9.92	$18.92	$14.00	$13.70	$27.70

Retirees	Single Coverage	Employee +One Coverage	Family Coverage
Delta Dental	$34.82	$77.85	$131.82
Total Dental Admin.	$9.96	$18.92	$27.70

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		
	October 1, 2010 - December 31, 2010	
Vendor	Collected	Paid
Hartford*^		
Basic Life	$ (597,717.31)	
Supp Life	$ 2,883,848.62	
Dep Life	$ 673,778.17	
STD	$ 1,956,956.86	
LTD	$ 772,247.83	
Total	$ 5,689,114.17	$ 5,855,242.50
Other*		
Basic Life	$ -	
STD	$ (23.65)	
LTD	$ 890.94	
Total	$ 867.29	$ 5,000.00
Avesis* - Vision		$ 1,076,448.88
ASI - FSA		$ 1,003,349.90
Total		$ 7,940,041.28

* Per contract, vendors paid 55 days in arrears.
^ Collected amounts for Standard are residual collections due to timing of receipts from universities and members in leave without pay status.

Health Insurance Vendor Performance Standard

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 performance penalties. This percentage is allocated among the more critical measures of the contract.

The following is a report of the performance penalties incurred by health plan vendors for their non-performance during the Mini Plan Year starting October 1, 2010 ending December 31, 2010. The details of each assessment are set forth in the exhibit specified by the same letter that identifies the vendor below.

A. **UHC (Claims Administrator)** – penalties to date of $3,187.47, equaling .03% of the vendor's administrative fee.

MEASURE	Percent of Fees at Risk	Total Percent Assessed Vendor (BASED ON MISSED MEASURE)
Average Speed to Answer <30 seconds	.50%	• 0.03%: WHICH EQUALS 1 MONTH MISSED OUT OF 3 MONTHS MEASURED • Corrective Action: This metric was missed on the last day of the month when we had significant fluctuations in call volume and unanticipated staff out of the office. The site director of our dedicated team provided more security in coverage to prevent this from happening in the future. We confirmed this was isolated and not indicative of overall poor performance.

B. **AmeriBen (Claims Administrator)** – penalties to date of $449.27, equaling 0.06% of the vendor's administrative fee.

MEASURE	Percent of Fees at Risk	Total Percent Assessed Vendor (BASED ON MISSED MEASURE)
Written appeals resolved in 45 calendar days after	0.13%	• 0. 04%: WHICH EQUALS 1 MONTH MISSED OUT OF 3 MONTHS MEASURED

B. **AmeriBen (Claims Administrator)** continued

receipt of participant's request for review in the case of post-service claims.		• Corrective Action: The appeal target was missed due to contracting with a new external review vendor. The contract has been finalized so no further action is necessary.
Contractor will deliver its monthly reports to the ADOA within 30 calendar days from the end of the month.	0.06%	• 0. 02%: WHICH EQUALS 1 MONTH MISSED OUT OF 3 MONTHS MEASURED • Corrective Action: Clerical error resulted in late transmission of this data to the ADOA as required. To prevent future late reporting, an internal team has been established to monitor and ensure all information is compiled in advance of the due date. A notification will be sent to the Account Manager upon completion of the reporting, the Account Manager will document transmission of reports to ADOA.
Contractor will provide a detailed provider report which identifies providers by TIN number.	0%	• 0%: WHICH EQUALS 1 MONTH MISSED OUT OF 3 MONTHS MEASURED • Corrective Action: AmeriBen's Internal Audit Specialist will confirm the transmission on or before the due date.
Contractor will provide a detailed provider report which identifies providers by TIN number.	0%	• 0%: WHICH EQUALS 1 MONTH MISSED OUT OF 3 MONTHS MEASURED • Corrective Action: AmeriBen's Internal Audit Specialist will confirm the transmission on or before the due date.

C. Cigna (Claims Administrator) – penalties to date of $643.22, equaling .14% of the vendor's administrative fee.

MEASURE	Percent of Fees at Risk	Total Percent Assessed Vendor (BASED ON MISSED MEASURE)
Written appeals resolved in 15 calendar days after receipt of participant's request for review in the case of pre-service claims.	.08%	• 0. 02%: WHICH EQUALS 1 MONTH MISSED OUT OF 3 MONTHS MEASURED • Corrective Action: 1 claim out of the 2 pre-service appeals was missed due to the appeal being for medical necessity determination; a delayed response from the provider cause

C. Cigna (Claims Administrator) continued

		the target to be missed.
Written appeals resolved in 45 calendar days after receipt of participant's request for review in the case of post-service claims.	.08%	• 0.02%: WHICH EQUALS 1 MONTH MISSED OUT OF 3 MONTHS MEASURED • Corrective Action: The system issue was identified and resolved.
Contractor will deliver its monthly reports to the ADOA within 30 calendar days from the end of the month.	0.06%	• 0.02%: WHICH EQUALS 1 MONTH MISSED OUT OF 3 MONTHS MEASURED • Corrective Action: Follow up communication has been provided to the reporting unit to meet all future reporting targets.
97% of all fully documented claims received will be completely processed within 14 calendar days after they are received. Will be calculated by counting the number of days from the day the claim is received.	0.18%	• 0.06%: WHICH EQUALS 1 MONTH MISSED OUT OF 3 MONTHS MEASURED • Cigna identified system issues that caused a backlog for claim processing. The system issues where resolved and the target was met for the remaining reporting period.
Network Management- Change to Primary Provider Count. Contractor will provide a detailed provider report which identifies providers by TIN number	0%	• .0%: WHICH EQUALS 1 MONTH MISSED OUT OF 3 MONTHS MEASURED • Corrective Action: Follow up communication has been provided to the reporting unit to meet all future reporting targets.
Network Management- Primary Care Provider Count Turnover. Contractor will provide a detailed provider report which identifies providers by TIN number.	0%	• .0%: WHICH EQUALS 1 MONTH MISSED OUT OF 3 MONTHS MEASURED • Corrective Action: Follow up communication has been provided to the reporting unit to meet all future reporting targets.

D. Aetna (Claims Administrator) – penalties to date of $2,266.76, equaling .67% of the vendor's administrative fee.

MEASURE	Percent of Fees at Risk	Total Percent Assessed Vendor (BASED ON MISSED MEASURE)
First Call Resolution 90% or greater	.19%	• .33%: WHICH EQUALS 1 MONTH MISSED OUT OF 3 MONTHS MEASURED • Corrective Action: Aetna completed additional training to ensure proper handling of calls when a transfer is necessary.
97% Telephone Call Quality	.19%	• .33%: WHICH EQUALS 1 MONTH MISSED OUT OF 3 MONTHS MEASURED • Corrective Action: Aetna provided re-education to ensure customer service representatives follow internal processes.

E. ASI (Flexible Spending) - penalties to date of $26.67, equaling .25% of the vendor's fee at risk.

MEASURE	Percent of Fees at Risk	Total Percent Assessed Vendor (BASED ON MISSED MEASURE)
100% of claims will be processed within five working days	.25%	• 0.25%: WHICH EQUALS 1 QUARTER MISSED OUT OF 1 QUARTERS MEASURED • Corrective Action: ASI has identified two issues which caused the target to be missed and has implemented the following action items: o ASIFlex is currently updating the website to include in the instructions regarding faxed claims that participants should fax claim forms separately and only for their account. o ASIFlex has modified our practice of contacting the

E. ASI (Flexible Spending) continued

		employer first regarding enrollment issues. ASIFlex now initially denies the claim for not enrolled and then contact is made with the employer.

F. American Health Holding - penalties to date of $1,005.30, equaling 1.03% of the vendor's fee at risk.

MEASURE	Percent of Fees at Risk	Total Percent Assessed Vendor (BASED ON MISSED MEASURE)
95% of identified members will be screened within 7 business days	.62%	• 0.62%: WHICH EQUALS 1 QUARTER MISSED OUT OF 1 QUARTERS MEASURED • Corrective Action: AHH updated reporting requirement to insure compliance with measurement.
95% of cases are identified and appropriately triaged	.41%	• 0.41%: WHICH EQUALS 1 QUARTER MISSED OUT OF 1 QUARTERS MEASURED • Corrective Action: AHH updated reporting requirement to insure compliance with measurement.

H. Successfully Met Performance Guarantees

Table 11: Successful Performance Guarantees

Vendor	At risk	Guarantees Met
UHC	18.55% Total Administration Fee 25% Medical Management Fee	Customer Service (met 17 out of 18 targets), Appeals, Claims Adjudication, Administration, Account Management Meeting, Network Management, Medical Management, Case Management, Disease Management, Nurse Line, Account Management Survey,& Member Satisfaction Survey.
AmeriBen	15% Total Administration Fee	Customer Service, Appeals (met 11 out of 12 measures), Claims Adjudication, Administration, Account Management Meeting, Reports (met 7 out of 8 measures), Finance Accounting, Member Satisfaction Survey, & Network Management (met 4 out of 6 measures).

H. Successfully Met Performance Guarantees continued

Cigna	6.5% Total Administration Fee 6.75% Medical Management Fee	Customer Service (met 13 out of 14 targets), Appeals (met 10 out of 12 targets), Claims Adjudication (met 66 out of 72 targets), Account Management Meeting, Administration, Reports (met 2 out of 3 targets), Finance Accounting, Network Management (met 4 out of 6 targets), Medical Management, Case Management, Disease Management, Member Satisfaction Survey, & Nurse Line.
Aetna	4.5% Total Administration Fee 4% Medical Management	Customer Service (met 19 out of 21 targets), Appeals, Claims Adjudication, Administration, Account Management Meeting, Annual Member Satisfaction Survey, Reports, Network Management, Medical Management HIPPA Compliance, Case Management, & Nurse Line.
American Health Holding	Total Administration Fee 1.95% Case Management Fee 1.87% Disease Management Fee 1.25% Nurse line Fee 1.25%	Utilization Management, Case Management, Disease Management, Reporting, Systems, Nurse & Other Call Center Activity.
MedImpact	$522,500.00 Total Fees at Risk	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.
Delta Dental	1.25% Total Administration Fee	Reporting, Network Management, Claims Administration, Appeals, Satisfaction, & Quality of Service and Responsiveness to Members.
TDA	1% Total Administration Fee	Reporting, Network Management, Appeals, Satisfaction, Quality of Service & Responsiveness to Members.
Hartford	10% Total Administration Fee	Report Timeliness, Quality of Service and Responsiveness to Members, Appeals/Grievance, Claims Administration, & Survey Customer Satisfaction.
Avesis	$77,250.00 Total Fees at Risk	Implementation, Reporting, Networking, Claims, Appeals, & Call.
ASI Flex	5% Total Administration Fee	Claims Turnaround (met 7 out of 8 targets), Claims Adjudication Financial Accuracy, Web Availability, & Phone Response Time.

Audit Services

The Benefit Services Division (BSD) Audit Services Unit provides assurances that add value and improve the operations of the BSD. Audit Services performs systematic evaluations of contract compliance, operational controls, risk management, and the implementation of best practices to support BSD objectives.

During the reporting period BSD Audit Services completed various types of audits to ensure that the health plan's vendors appropriately provided contracted services. The audit schedule for the plan year was developed using a combination of contract elements and risk analysis. Individual audit objectives were developed with the consideration of dollar value, complexity of operations, changes in personnel or operations, loss exposure, and previous audit results. Audits were completed, but were not limited to the following four functional areas:

Functional Area	Audit Methodology
Vendor operating transactions	Statement on Auditing Standard No. 70 ("SAS 70")
Vendor internal operating standards	Quality Management Review ("QMR")
Vendor execution of benefit design	Plan Allowance/Exclusion Audit ("A & E")
ADOA Accuracy of shared data	Dependent eligibility audit

All of the health plans contracted vendors that pay claims are required to provide a third-party assessed operational audit (SAS 70) annually. SAS 70 audits evaluate operational process of the vendor's transactions and determine if identified deficiencies were appropriately addressed. Audit services reviewed the SAS 70 reports provided by each of the vendor's external auditors. There were no instances of significant operating failure noted and no corrective action was required.

QMRs ensure the vendor's internal audit teams were effectively measuring operating standards, identifying and correcting errors and providing sufficient training for claims processing, customer service, and clinical reviews. QMR results indicated that vendors were either meeting or exceeding internal standards and that claims processors were appropriately trained.

A & E Audits ensure that the vendor's systems were set up correctly to service the health plan's benefit design. A & E Audit findings for the plan year, indicated that plan limitations and restrictions were processed accurately with few exceptions and members received the benefits allowed to them as defined in the plan description.

A dependant eligibility audit was also performed on the health plan's membership. The results of the eligibility audit indicated that only eligible individuals were enrolled in the plan and receiving benefits. Additionally, dependent eligibility is effectively monitored to minimize the risk of claims paid on behalf of ineligible dependents.

In addition to the audits, reviews and evaluations list above, Audit Services performed operational standards testing related to vendor performance guarantees, quality management standards, and reporting structure for each of the newly implemented medical vendors.

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.

Health Savings Account Option (HSAO) – An account that allows individuals to pay for current health expenses and save for future health expenses on a tax-free basis. Only certain plans are HSA-eligible.

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.

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 2009-2010 ADDENDUM 10/1/2010 - 12/31/2010				
BEGINNING CASH PER AFIS				**$ 151,586,438.05**
REVENUE				**$ 195,898,775.31**
EXPENDITURES				**$ 158,322,242.20**
VENDOR	ADMIN FEES	PERF PENALTIES		
HARRINGTON	$ 396.25	$ -		
AHH UR/UM	$ 249,053.85	$ -		
AETNA	$ 379,601.42	$ -		
CIGNA	$ 840,310.72	$ -		
UHC	$ 2,885,990.23	$ -		
AMERIBEN	$ 795,550.59	$ -		
WHI	$ -	$ 5,000.00		
MEDIMPACT	$ 310,296.75	$ -		
OTHER FEES**	$ 52,890.51			
ATTORNEY GENERAL	$ 178.50			
NET ADMIN FEES^	**$ 5,514,268.82**	**$ 5,000.00**	**$ 5,509,268.82**	
	MEDICAL CLAIMS	RECOVERIES*		
HARRINGTON	$ 1,064.79	$ 643,448.15		
AETNA	$ 4,356,826.62	$ -		
CIGNA	$ 7,817,286.05	$ -		
UHC	$ 74,569,190.18	$ -		
AMERIBEN	$ 21,336,207.83	$ 130,330.27		
WHI	$ -	$ 448,682.62		
MEDIMPACT	$ 29,518,574.39	$ 1,624,323.15		
ERRP REIMBURSEMENT		$ 2,456,920.42		
RDS SUBSIDY		$ -		
OTHER WELLNESS	$ 14,619.00			
NET MEDICAL CLAIMS	**$ 137,613,768.86**	**$ 5,303,704.61**	**$ 132,310,064.25**	
	STOP LOSS PREM	CLAIM REIMB		
SYMETRA	$ 3,916,669.00	$ 3,168,251.89	**$ 748,417.11**	
SELF INSURED EXPENDITURES			***$ 138,567,750.18***	
	FULL SVC PREM			
BCBS	$ 8,569,657.03			
OTHER (COLONIAL)	$ 41.28			
TOTAL FS INS PREMS^	$ 8,569,698.31	$ -	**$ 8,569,698.31**	
	DENTAL PREM	PERF PENALTIES		
DELTA	$9,130,516.14	$ -		
TDA	$946,324.22	$ -		
NET DENTAL PREM	$ 10,076,840.36	$ -	**$ 10,076,840.36**	
HITF APPROP EXP	$ 1,107,953.35		**$ 1,107,953.35**	
TOTAL EXPENDITURES	**$ 166,799,198.70**			
TOTAL RECOVERIES*		**$ 8,476,956.50**		
NET EXPENDITURES			**$ 158,322,242.20**	
ENDING CASH BALANCE PER AFIS				**$ 189,162,971.16**

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.
*Recoveries include Medicare Part D Retiree Drug Subsidy reimbursement, prescription drug rebates, stop loss claim reimbursements, overpayment recoveries (including stop payments and voids), subrogation recoveries, etc.
**Other fees include HSA Administration, NYHCR, MA, and legal fees.
^Vendor administrative fees and fully insured premiums are paid 55 days in arrears per contract.

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.

Table B: 3035 FUND PLAN YEAR 20009-2010 ADDENDUM 10/1/2010 - 12/31/2010					
BEGINNING CASH PER AFIS				**$**	**4,697,559.87**
REVENUE				**$**	**7,526,502.26**
	VENDOR	INSURANCE	AMOUNT		
	HARTFORD	BASIC LIFE	$ (597,717.31)		
		SUPP LIFE	$ 2,883,848.62		
		DEP LIFE	$ 673,778.17		
		STD	$ 1,956,956.86		
		LTD	$ 772,247.83		
	TOTAL HARTFORD		$ 5,689,114.17		
	OTHER	BASIC LIFE	$ -		
		STD	$ (23.65)		
		LTD	$ 890.94		
	TOTAL OTHER		$ 867.29		
	AVESIS	VISION	$ 1,220,951.53		
	ASI	AMRA	$ 430,825.21		
		DCRA	$ 184,744.06		
	TOTAL FLEX SPENDING		$ 615,569.27		
	PAYROLL CLEARING		$ (0.00)		
TOTAL REVENUE			$ 7,526,502.26		
EXPENDITURES				**$**	**7,940,041.28**
	VENDOR	INSURANCE	AMOUNT		
	HARTFORD	BASIC LIFE	$ 341,194.45		
		SUPP LIFE	$ 2,558,472.55		
		DEP LIFE	$ 591,186.72		
		STD	$ 1,705,761.74		
		LTD	$ 658,627.04		
	TOTAL HARTFORD		$ 5,855,242.50		
	OTHER	BASIC LIFE	$ 5,000.00		
		STD	$ -		
		LTD	$ -		
	TOTAL OTHER		$ 5,000.00		
	AVESIS	VISION	$ 1,076,448.88		
	ASI	AMRA	$ 780,768.22		
		DCRA	$ 205,196.68		
		ADMIN FEES	$ 17,385.00		
	TOTAL FLEX SPENDING		$ 1,003,349.90		
	GAO AFIS COST		$ -		
TOTAL EXPENDITURES			$ 7,940,041.28		
ENDING CASH BALANCE PER AFIS				**$**	**4,284,020.85**

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