State of Arizona

Arizona Department of Administration
Benefit Services Division

Benefit Options
Choice. Value. Health.

Annual Report

Benefit Options

October 1, 2009 through
September 30, 2010

Janice K. Brewer
Governor

Scott A. Smith
Director
Arizona Department of Administration

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, 2009 through September 30, 2010. The active and retiree plans were concurrent for this period.

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

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

Telephone: 602-542-5008
Fax: 602-542-4744

Contents

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 Plan Year 2009-2010 (October 1, 2009 – September 30, 2010). Notable administrative changes for Plan Year 2009-2010 include; new medical, pharmacy, short term and long term disability, and life insurance contracts; a new Health Savings Account Option (HSAO); the inclusion of a fourth premium tier option under medical coverage; and termination of the UHC Secure Horizons contract effective December 31, 2009. The medical contracts require a nation-wide network giving members greater choice and access to providers in their local area.

Executive Summary

During Plan Year 2009-2010, the Benefit Services Division (BSD) Health Plan offered a comprehensive insurance package to over 129,900 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 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, 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 2009-2010 Plan Year, the total premiums expected were $739,472,570 with total expenses for the plan of $681,833,972, resulting in an expected net operational gain of $57,638,598.

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 terminated 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 Plan Year 2009-2010 indicated the average cost to insure each member was $4,899. However, when analyzed by type of subscriber; the active members average cost was $4,667 compared to the average retiree cost of $7,666. 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 $442,328,375 of the total cost the health plan during 2009-2010. When analyzed by cost, the five leading diagnosis categories are: musculoskeletal system (muscles and joints), injury and poisoning (accident), neoplasm (cancers), circulatory system (heart), and genitourinary system (kidneys and reproductive organs). Musculoskeletal system was the leading category with $57,502,689 or 13.00% of total claims paid.

Examination of hospital care reveals that inpatient care represents a significant portion of the total medical expenses: 34% and 35% for active and retired members

respectively. Analysis by the type of medical care visit reveals there were 180 emergency room, 150 urgent care, and 4,270 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 annual cost of prescription drug claims for 2009-2010 totaled $104,245,795 and a reported 1.4 million prescriptions were filled. The top five most expensive drugs classes are described as maintenance drugs used to control and prevent chronic diseases. Cholesterol-lowering drugs lead the list with 10 million dollars or 10.76% of total pharmacy costs. In fact, the most prescribed drug according to total expense is Lipitor, typically prescribed for treating and preventing high cholesterol. Other leading categories were diabetes, asthma, behavioral health (anti-depressants), and inflammatory disease.

Retirees on the State health plan filled an average of 30 prescriptions per year, while active members averaged 10 per year. 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 $1,439 per member compared to the 65+ age group cost of $2,270 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 2009-2010 Plan Year, ADOA collected penalties totaling $110,901.88 for the prior plan year. An assessment of vendor performance for the 2009-2010 Plan Year is provided in the Health Insurance Vendor Performance Standards section of this report.

In review, the 2009-2010 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 planning and auditing, and effective contract management. Detailed evidence of the State's Health Plan accomplishment can be reviewed herein.

The passing of the new 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 and a mini-plan year was offered from October 1, 2010 through December 31, 2010. An amendment covering the period of October 1, 2010 through December 31, 2010, will be provided in April 2011.

Health Insurance Trust Fund Summary

Table 1 provides a summary of receipts, expenses, and enrollment incurred during the 2009-2010 Plan Year and paid through December 2010.

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. UHC Secure Horizons, 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. UHC Secure Horizons is a fully-insured option that was available to Medicare-eligible retirees until the contract terminated December 31, 2009.

Table 1: Health Insurance Trust Fund Summary*

	2009-2010	2008-2009
Receipts (accrual basis)		
ADOA Benefit Options	664,852,967	627,294,082
UHC Secure Horizons	1,839,423	8,434,781
BCBS (NAU)	30,718,640	34,272,496
Dental	42,061,540	47,330,983
Total	739,472,570	717,332,341
Expenses		
Medical Claims (accrual basis)	442,328,375	500,098,992
Drug Claims (accrual basis)	104,245,795	114,299,093
Medicare Part D Subsidy	(1,249,718)	(2,518,939)
Rebates & Recoveries	(12,994,654)	(16,688,279)
Reserves for future benefits	36,270,927	41,255,326
Secure Horizons expense	2,260,434	7,687,528
BCBS Payments	30,714,058	34,342,197
Administration Fees	29,092,948	23,750,954
Stop-Loss Premiums	6,470,888	3,509,198
Appropriated Expenses	3,846,185	4,342,510
Dental Costs	40,848,736	47,269,155
Total	681,833,972	757,347,735
Difference	57,638,598	(40,015,394)
Enrollment		
Subscribers	63,814	65,557
Members	129,959	134,918

*The data is for the incurred period October 2009 through September 2010 and paid through December 2010.

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.

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

		2009-2010		2008-2009	
Network	**Plan Type**	**Subscribers**	**Members ****	**Subscribers**	**Members ****
AETNA					
Active	EPO	**1037**	**2338**	-	-
Retiree	EPO	**278**	**354**	-	-
University	EPO	**981**	**1767**	-	-
COBRA	EPO	**21**	**32**		
Active	PPO	**75**	**123**	-	-
Retiree	PPO	**72**	**90**	-	-
University	PPO	**116**	**191**	-	-
COBRA	PPO	**2**	**3**		
Active	HSAO	**109**	**194**	-	-
Retiree	HSAO	-	-	-	-
University	HSAO	**136**	**256**	-	-
COBRA	HSAO	**3**	**5**	-	-
AmeriBen/BCBC of AZ					
Active	EPO	**5528**	**13516**	-	-
Retiree	EPO	**1104**	**1459**	-	-
University	EPO	**1524**	**3161**	-	-
COBRA	EPO	**60**	**88**		
Active	PPO	**205**	**360**	-	-
Retiree	PPO	**220**	**267**	-	-
University	PPO	**250**	**460**	-	-
COBRA	PPO	**7**	**11**	-	-
AZ Foundation*					
Active	PPO	-	-	494	945
Retiree	PPO	-	-	453	599
University	PPO	-	-	444	849
Beech Street*					
Active	PPO	-	-	127	386
Retiree	PPO	-	-	235	280
University	PPO	-	-	114	222

Continues on next page

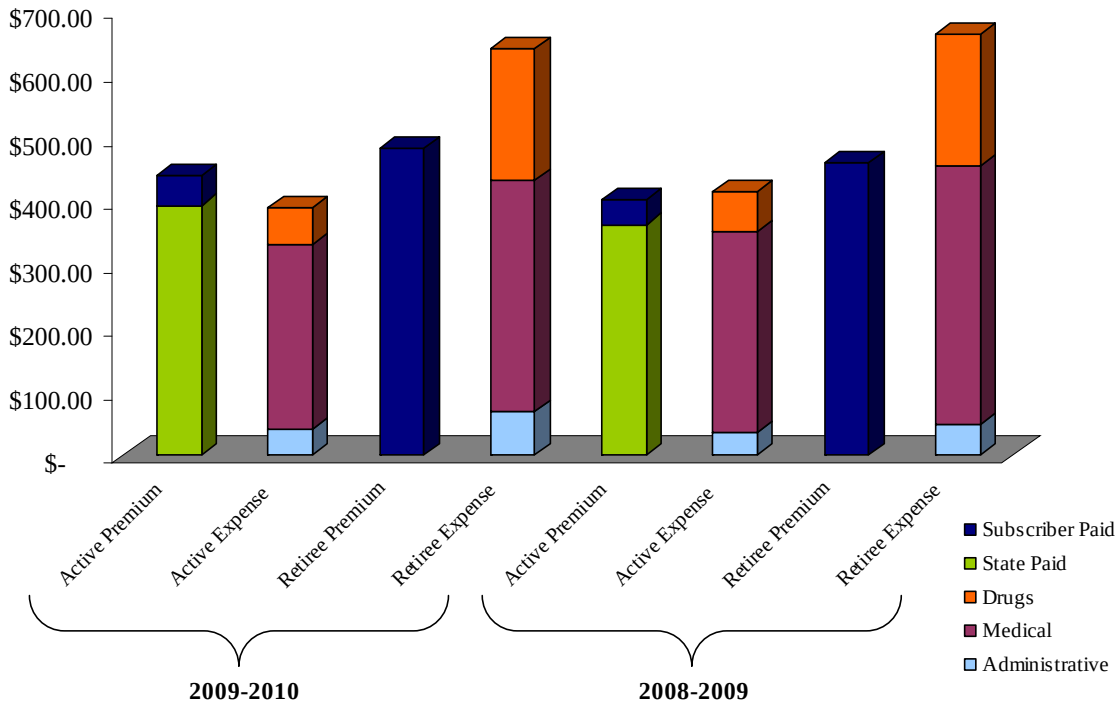
Continuation Table 2: Average Monthly Enrollment					
		2009-2010		2008-2009	
Network	**Plan Type**	**Subscribers**	**Members ****	**Subscribers**	**Members ****
CIGNA					
Active	EPO	**2688**	**6398**	-	-
Retiree	EPO	**688**	**900**	-	-
University	EPO	**1127**	**2209**	-	-
COBRA	EPO	**25**	**37**	-	-
RAN+AMN					
Active	EPO	-	-	8888	21755
Retiree	EPO	-	-	1386	1808
University	EPO	-	-	2927	5775
UnitedHealthcare					
Active	EPO	**23337**	**53633**	25726	58660
Retiree	EPO	**4838**	**6318**	4531	5982
University	EPO	**12340**	**26505**	13051	27894
COBRA	EPO	**402**	**588**	-	-
Active	PPO	**645**	**1145**	920	1699
Retiree	PPO	**178**	**233**	193	253
University	PPO	**761**	**1429**	984	1909
COBRA	PPO	**26**	**39**	-	-
Blue Cross Blue Shield					
NAU only	PPO	**2809**	**2961**	2859	3016
SecureHorizons *					
Medicare only	HMO	**2223**	**2890**	2225	2886
Political Subdivisions	EPO/ PPO	-	-	-	-
Total		**63814**	**129959**	**65557**	**134918**

*AZ Foundation, Beech Street, and RAN+AMN medical networks were not offered during the 2009-2010 Plan Year.

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 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)		442,328,375	400,260,956	42,067,419	419,204,308	22,608,425	515,642
Drug Claims (accrual basis)		104,245,795	79,116,099	25,129,696	96,923,304	7,264,520	57,970
Medicare Part D Subsidy		(1,249,718)		(1,249,718)	(1,170,108)	(79,611)	
Rebates & Recoveries		(12,971,260)	(11,376,543)	(1,594,717)	(12,248,704)	(708,943)	(13,613)
Reserve (IBNR)		36,270,927	31,811,694	4,459,233	34,250,478	1,982,383	38,065
Administration Fees		29,092,948	25,441,420	3,651,528	27,704,694	1,265,513	122,740
Stop-Loss Premiums		6,470,888	5,658,711	812,177	6,162,111	281,477	27,300
Appropriated Expenses		3,846,185	3,363,441	482,744	3,662,653	167,305	16,227
Total	$	608,034,139	534,275,777	73,758,362	574,488,737	32,781,070	764,332
Enrollment in self-funded plans							
Subscribers		58,783	51,405	7,378	55,978	2,557	248
Members		124,109	114,488	9,621	119,303	4,351	455
Annual cost							
Per subscriber	$	10,344	10,393	9,997	10,263	12,820	3,082
Per member	$	4,899	4,667	7,666	4,815	7,534	1,680

*The data is for the incurred period October 2009 through September 2010 and paid through December 2010.

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)		442,328,375	379,577,409	20,167,905	515,642	39,626,900	2,440,519
Drug Claims (accrual basis)		104,245,795	73,814,606	5,243,522	57,970	23,108,698	2,020,998
Medicare Part D Subsidy		(1,249,718)				(1,170,108)	(79,610.68)
Rebates & Recoveries		(12,971,260)	(10,759,867)	(603,062)	(13,613)	(1,488,837)	(105,880)
Reserve (IBNR)		36,270,927	30,087,314	1,686,315	38,065	4,163,165	296,068
Administration Fees		27,352,957	22,833,296	971,125	115,400	3,214,437	218,701
Stop-Loss Premiums		6,470,888	5,401,672	229,739	27,300	760,439	51,738
Appropriated Expenses		3,846,185	3,210,661	136,553	16,227	451,992	30,752
Total	$	606,294,148	504,165,090	27,832,096	756,991	68,666,685	4,873,286
Enrollment in self-funded plans							
Subscribers		58,783	49,070	2,087	248	6,908	470
Members		124,109	110,272	3,761	455	9,031	590
Annual cost							
Per subscriber	$	10,314	10,274	13,336	3,052	9,940	10,369
Per member	$	4,885	4,572	7,400	1,664	7,603	8,260

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

	2009-2010			2008-2009		
	Actives	Retirees	All members	Actives	Retirees	All members
Diagnosis	**% of Total**	**% of Total**	**% of Total**	**% of Total**	**% of Total**	**% of Total**
Musculoskeletal System	12.75%	15.41%	13.00%	12.90%	12.70%	12.89%
Health Status (lab tests, etc.)	9.99%	8.03%	9.80%	0.01%	0.00%	0.01%
Ill-defined1	9.77%	8.26%	9.63%	10.29%	8.63%	10.15%
Injury/Poisoning	9.32%	5.85%	8.99%	7.86%	12.17%	8.23%
Neoplasm (tumors)	8.45%	12.76%	8.86%	8.58%	14.35%	9.08%
Circulatory System	8.07%	12.93%	8.52%	8.58%	6.20%	8.38%
Genitourinary System	7.47%	9.73%	7.68%	7.86%	8.80%	7.94%
Digestive System	7.32%	5.51%	7.15%	7.60%	7.40%	7.59%
Nervous System	5.67%	8.00%	5.89%	5.16%	6.16%	5.24%
Respiratory System	4.94%	4.41%	4.89%	5.16%	5.14%	5.16%
Pregnancy/Childbirth Complications	4.43%	0.03%	4.02%	4.27%	0.02%	3.91%
Endocrine	3.55%	3.38%	3.53%	3.58%	3.94%	3.61%
Mental Health	2.42%	1.64%	2.35%	2.50%	1.36%	2.40%
Infectious/Parasitic	1.94%	1.18%	1.87%	1.89%	1.44%	1.85%
Skin and Subcutaneous Tissue	1.56%	1.71%	1.57%	1.53%	2.20%	1.59%
Congenital Anomalies	1.04%	0.22%	0.96%	1.23%	0.65%	1.18%
Blood and Blood Forming Organs	0.95%	0.95%	0.95%	0.70%	0.00%	0.64%
Conditions in the Perinatal Period	0.37%	0.00%	0.33%	0.85%	1.45%	0.91%
External Causes of Injury/Poisoning	0.00%	0.00%	0.00%	9.45%	7.39%	9.27%
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, 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: 34% and 35% 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.

Figure 2: Admissions per 1,000 Members

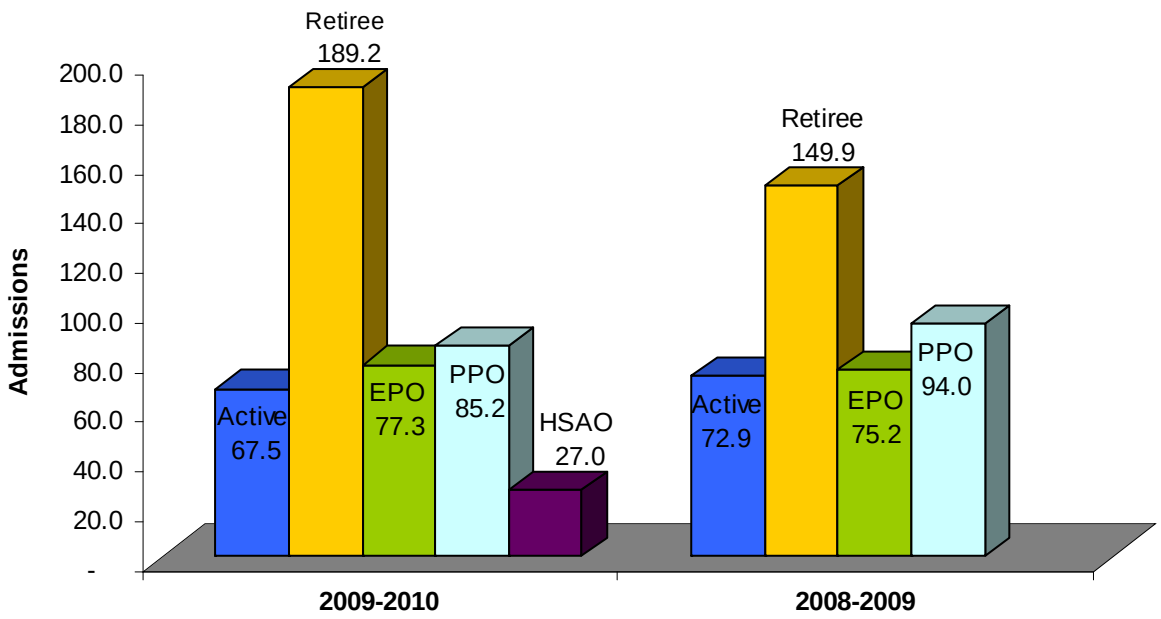
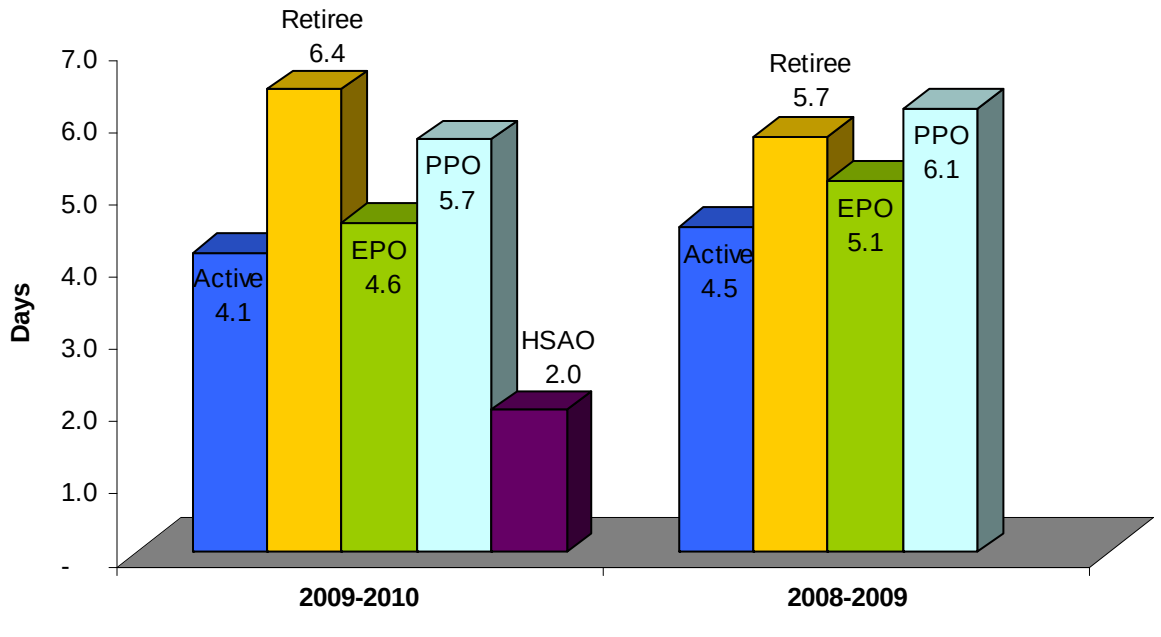


Figure 3: Average Length of Stay



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

Hospital Care (continued)

The figures below show how active/retired members and EPO/PPO/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 1.7 times as many days in the hospital as EPO members. On average, PPO members cost per admission was $4,937 higher than EPO members.

Figure 4: Days per 1,000 Members

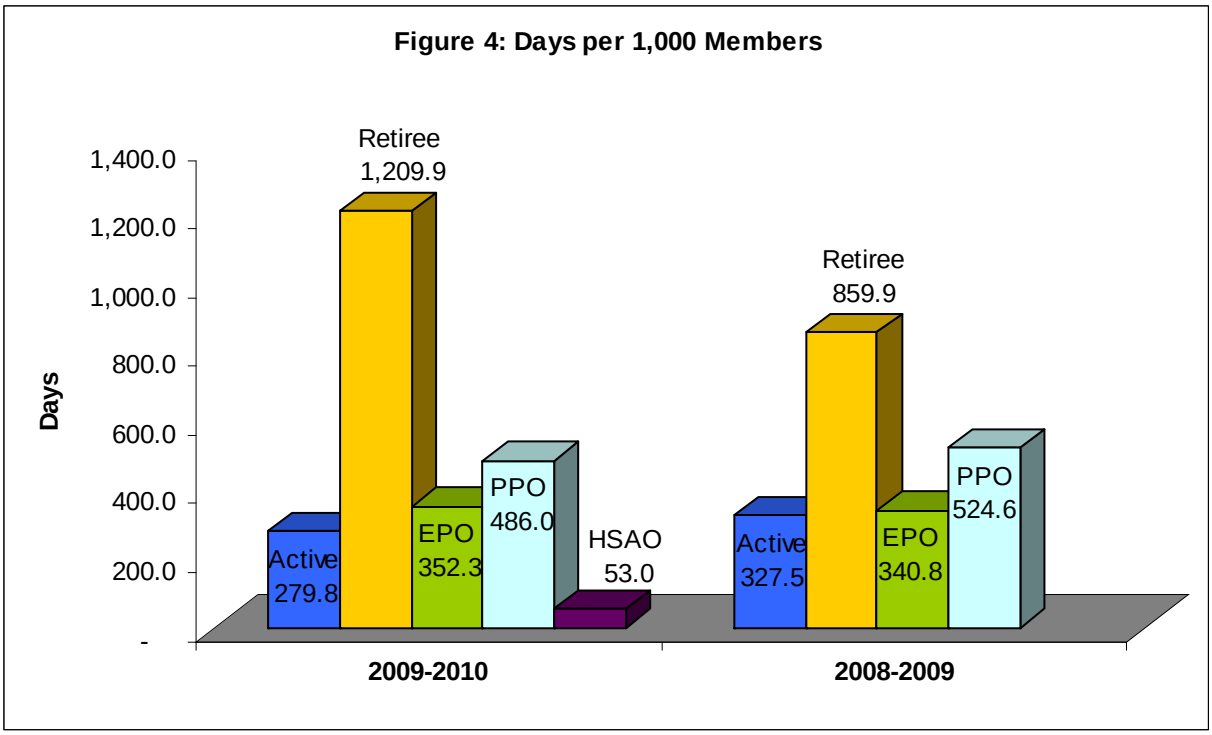
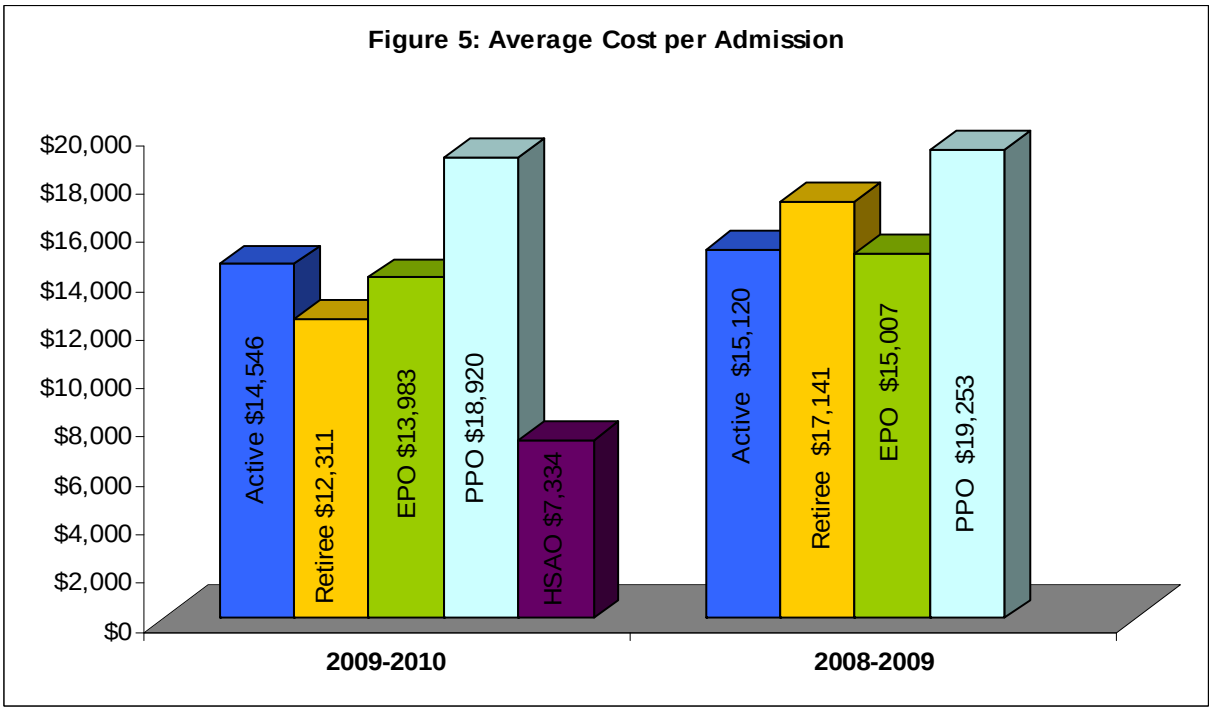


Figure 5: Average Cost per Admission



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

Emergency Room Visits

During Plan Year 2009-2010, there were approximately 180 emergency room visits per 1,000 members of the self-funded plan. The average plan cost per emergency room visit was $932.04. These figures include facility claims and professional fees.

Urgent Care Visits

During Plan Year 2009-2010, there were approximately 150 urgent care visits per 1,000 members of the self-funded plan. The average plan cost per urgent care visit was $101.00.

Physician Visits

During Plan Year 2009-2010, there were approximately 4,270 physician visits per 1,000 members (or each member of the self-funded plan visited a physician approximately 4.3 times). The average plan cost per office visit cost was $94.86.

Figures 6 and 7 show how total active and retiree medical expenses were distributed by type of care. 7.80% of medical expenses for active employees were spent for emergency room care while 6.33% of medical expenses for retired members were spent for home care.

Figure 6: Active Employee Medical Expense by Place of Service

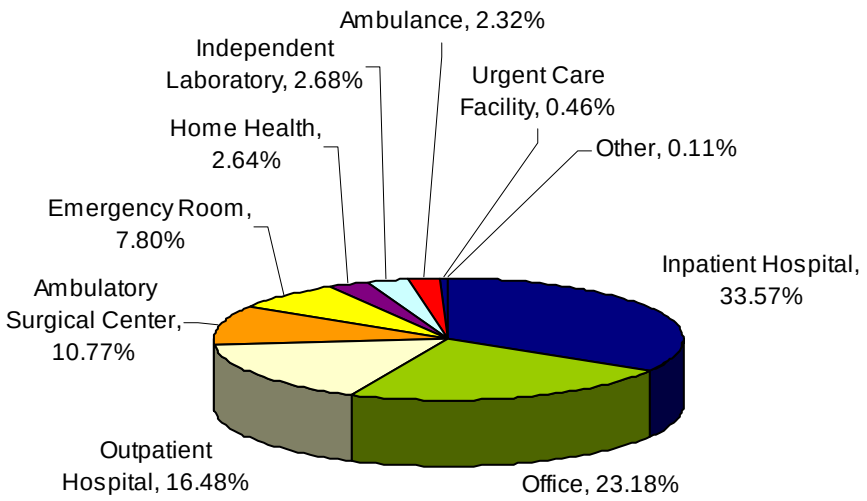
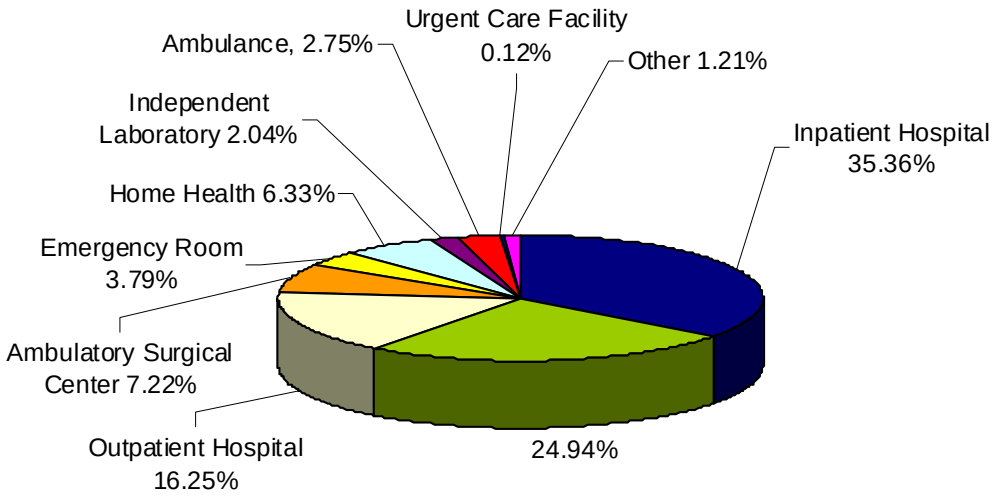


Figure 7: Retiree Medical Expenses by Place of Service



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				
	2009-2010		2008-2009	
	Total Prescriptions	Percent	Total Prescriptions	Percent
Tier 1 Generic ($10 copay)	980,591	68.0%	974,094	63.5%
Tier 2-Preferred ($20 copay)	361,208	25.0%	476,648	31.1%
Tier 3-Non-Preferred ($40 copay)	101,173	7.0%	83,455	5.4%
Total	1,442,972	100.0%	1,534,197	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 "Cardiovascular Disease – Lipid", than on any other therapeutic class.

Table 7: Top therapeutic classes by total expense				
	2009-2010		2008-2009	
Therapeutic class	Total Cost	Percent	Total Cost	Percent
Cardiovascular Disease - Lipid	$10,065,596	9.10%	12,303,047	10.76%
Diabetes	$9,602,335	8.70%	8,709,123	7.62%
Asthma	$7,705,106	7.00%	7,053,179	6.17%
Behavioral Health - Antidepressants	$7,431,696	6.70%	9,158,047	8.01%
Behavioral Health - Other	$7,078,441	6.40%	-	-
Inflammatory Disease	$6,527,936	5.90%	5,605,012	4.90%
Pain Management - Analgesics	$5,965,851	5.40%	6,081,523	5.32%
Upper Gastrointestinal Disorders - Ulcer	$5,549,570	5.00%	9,023,718	7.89%
Cardiovascular Disease - Hypertension	$5,450,331	4.90%	8,063,741	7.05%
Infectious Disease - Viral	$5,214,141	4.70%	4,882,905	4.27%
Anticonvulsants	-	-	5,074,361	4.44%
Total	$70,591,003	63.80%	$75,954,656	66.45%

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.

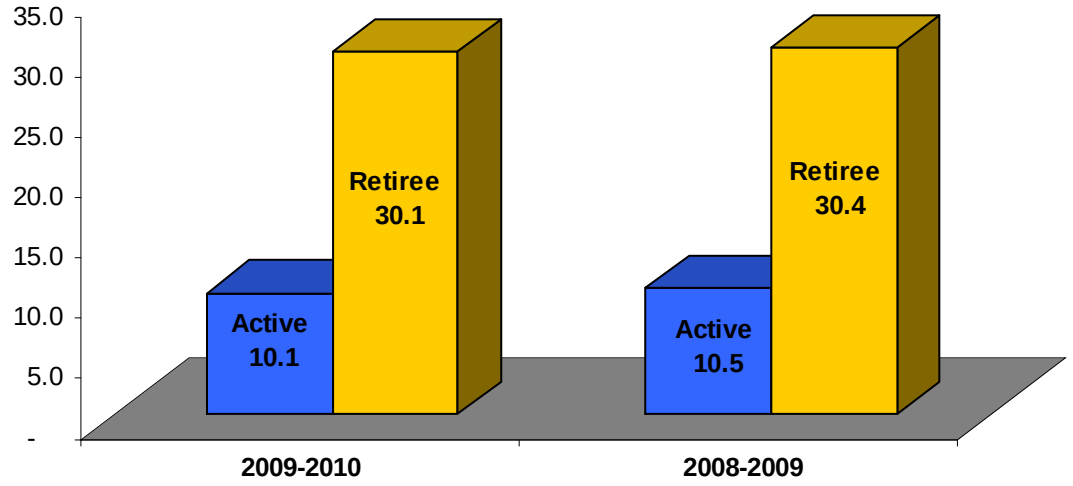
Table 8: Top ten drugs by total expense

	2009-2010			2008-2009	
Drug Name	**Total Gross Cost**	**Percent**	**Drug Name**	**Total Gross Cost**	**Percent**
Lipitor	3,440,283	3.30%	Prevacid	4,561,623	3.99%
Enbrel	2,289,241	2.20%	Lipitor	4,272,540	3.74%
Advair diskus	2,063,084	1.98%	Enbrel	2,547,216	2.23%
Humira	2,062,801	1.98%	Oxycontin	2,363,851	2.07%
Crestor	2,000,769	1.92%	Crestor	2,311,852	2.02%
Singulair	1,921,456	1.84%	Effexor XR	2,212,614	1.94%
Plavix	1,769,859	1.70%	Advair diskus	2,160,881	1.89%
Cymbalta	1,663,635	1.60%	Singulair	2,102,215	1.84%
Actos	1,566,236	1.50%	Humira	2,036,027	1.78%
Oxycontin	1,461,868	1.40%	Plavix	1,832,702	1.60%
Total	$20,239,230	19.41%	Total	$26,401,521	23.10%

Annual Prescription Use

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

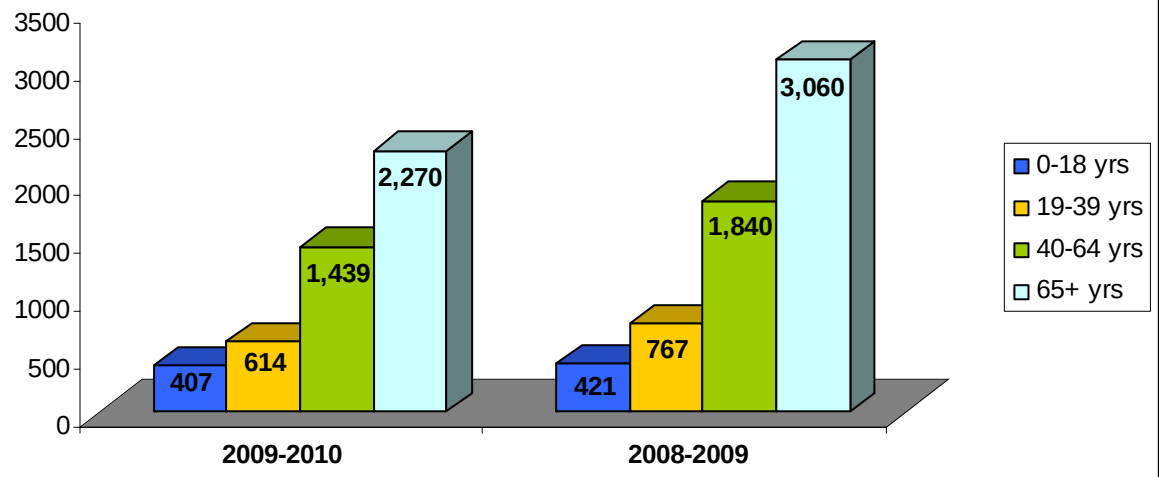
Figure 8: Average Number of Prescriptions per Member per Year



Annual Pharmacy Expenses by Age

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

Figure 9: Pharmacy Expense per Utilizer per Year (in dollars)



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

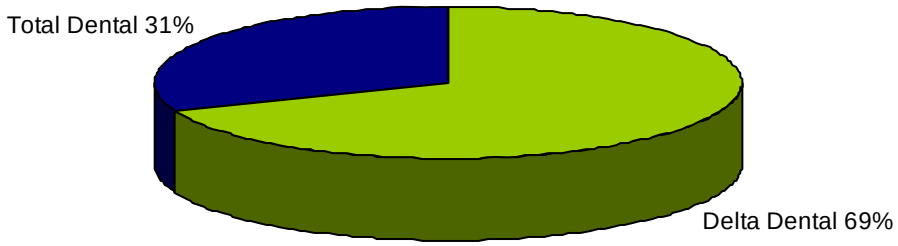
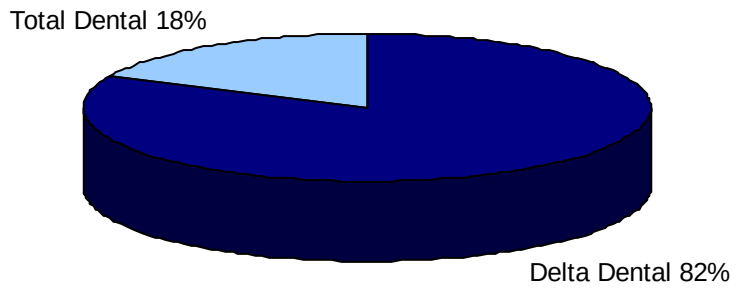


Figure 11: Retiree Dental Enrollment



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

	2009-2010		2008-2009	
Vendor	**Collected**	**Paid**	**Collected**	**Paid**
Standard*^				
Basic Life	$1,538		$2,533,453	
Supp Life	$2,438		$10,796,632	
Dep Life	$463		$1,652,664	
STD	$2,927		$10,073,067	
LTD	$4,961		$4,472,699	
Total	$12,328	$2,246,000	$29,528,516	$29,533,536
Hartford*				
Basic Life	$2,353,728			
Supp Life	$11,569,012			
Dep Life	$2,635,373			
STD	$7,538,133			
LTD	$2,744,220			
Total	$26,840,466	$23,930,135		
Avesis* - Vision		$4,728,106		$5,676,977
ASI - FSA		$5,861,366		$5,687,416
Total		$36,765,607		$40,897,929

* 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 Plan Year ending September 30, 2010. 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 2009-2010, may result in additional penalties.

A. **UHC (Claims Administrator)** – penalties to date of $65,948.04, equaling .77% of the vendor's annual administrative fee.

MEASURE	Annual Percent of Fees at Risk	Total Percent Assessed Vendor (BASED ON MISSED MEASURE)
Average Speed to Answer <30 seconds	.50%	• 0.04%: WHICH EQUALS 1 MONTHS MISSED OUT OF 12 MONTHS MEASURED • Corrective Action: Customer care was in a training ramp up period in October to meet 1/1 staffing needs and this metric was missed for October 2009. Appropriate staffing and training has since taken place to resolve this issue.
Written appeals resolved in 15 calendar days after receipt of participant's request for review in the case of pre-service claims.	0.25%	• 0.06%: WHICH EQUALS 3 MONTHS MISSED OUT OF 12 MONTHS MEASURED • Corrective Action: Each of the missed appeals were unique analyst errors. Appropriate feedback and training was given to the analyst associated with the appeals triage team. Appeals supervisory continue to monitor our triage teams. •

97% of all fully documented claims received will be completely processed within 10 calendar days after they are received.	0.75%	• 0.12%: WHICH EQUALS 2 MONTHS MISSED OUT OF 12 MONTHS MEASURED • Corrective Action: This metric was missed for October and November 2009 since our Transaction team was incorrectly managing this policy to 94% into workday versus 97% percent in 10 calendar days. The change was made with our teams and we have successfully managed to 97% in 10 calendar days the rest of the plan year.
99.3% of claims dollars submitted for payment will be accurately processed and paid.	2%	• 0.33%: WHICH EQUALS 2 MONTHS MISSED OUT OF 12 MONTHS MEASURED • Corrective Action: This metric was missed due to one claim in October 2009 where our Transaction Operations team requested information when it was not needed to process the claim. For the metric that was missed in March, there were two errors that caused the missed metric. On the first error, the processor had the incorrect other insurance allowable on the claim, which caused an overpayment. On the second error, the processor did not split the claim correctly for accurate repricing. The Transaction Operations analysts received appropriate feedback and training to prevent further issues.
97% of al claims will be process accurately. Accurate processing includes payment amount; communication to claimant or provider; data entry errors affecting current or future benefit determinations and management reports.	1%	• 0.17%: WHICH EQUALS 2 MONTHS MISSED OUT OF 12 MONTHS MEASURED • Corrective Action: This metric was missed in October 2009 due to one claim where our Transaction Operations team requested information when it was not needed to process the claim. The Transaction Operations analyst received appropriate feedback and training to prevent further issues. • The December 2009 metric was missed due to one claims where an incorrect remark code was used.

		The Transaction Operations analyst received appropriate feedback and training to prevent further issues.
Contractor will deliver its monthly reports to the ADOA within 30 calendar days from the end of the month. Reports to be provided: Total billed claims sorted by type of claim; Total number of claims; Provider discounts; Ineligible charges broken down as follows: over UCR or allowable amount, no plan benefit or plan provision, not eligible for coverage; Total allowable expenses, Deductible dollars, COB payments broken down as follows: other plan payments, total claims paid sorted by type of claim; Total members' co-insurance payments; IBNR; Demographic report (by age, gender, plan selected, tier of coverage and county); Direct pay member delinquent report; Utilization reports (including inpatient admissions per 1,000 members, inpatient days per 1,000 members, ALOS, emergency	.50%	• .04%: WHICH EQUALS 1 MONTHS MISSED OUT OF 12 MONTHS MEASURED • Corrective Action: Target was missed by one day no corrective action request as the measure was met for the rest of the year.

room visits/1,000, and outpatient surgeries/1,000); and any additional reporting as specified in the implementation plan.		
Contractor will provide a detailed provider report which identifies providers by TIN number.	No fees at Risk	• 0.%: WHICH EQUALS 1 MONTHS MISSED OUT OF 12 MONTHS MEASURED • Corrective Action: Target was missed by one day no corrective action request as the measure was met for the rest of the year.

B. **AmeriBen (Claims Administrator)** – penalties to date of $9,298.60, equaling 0.33% of the vendor's annual administrative fee.

MEASURE	Annual Percent of Fees at Risk	Total Percent Assessed Vendor (BASED ON MISSED MEASURE)
First Call Resolution >90%	0.30%	• 0. 08%: WHICH EQUALS 4 MONTHS MISSED OUT OF 12 MONTHS MEASURED • Corrective Action: AmeriBen implemented quality controls subsequently met the measure for the rest of the year.
Contractor will acknowledge within 2 working days and resolve 95% or more of all correspondence (inquiries and requests) within 30 calendar days of receipt.	0.10%	• 0.008% WHICH EQUALS 1 MONTHS MISSED OUT OF 12 MONTHS MEASURED Corrective Action: AmeriBen implemented quality controls subsequently; met the measure for the rest of the year.
Processing of a claim will be completed when it has been approved for payment, denied or pended with a request for further information. 97% of all fully documented claims received will be completely	.75%	• 0.25% WHICH EQUALS 4 MONTHS MISSED OUT OF 12 MONTHS MEASURED • Corrective Action: AmeriBen implemented five action items: Insure claims are properly segregated into unique files for priority electronic registration. Daily inventory of ADOA file receipts into the adjudication system.

processed within 10 calendar days after they are received.		Allocate additional resource to pre-adjudication queues where claims are routed for manual intervention. Review use of internal routing specifically: Precertification confirmations Provider credentialing confirmations

C. Cigna (Claims Administrator) – penalties to date of $5,806.05, equaling .49% of the vendor's annual administrative fee and .37% of the nurse line administrative fee.

MEASURE	Annual Percent of Fees at Risk	Total Percent Assessed Vendor (BASED ON MISSED MEASURE)
Average Speed to Answer <30 seconds	.50%	• .08%: WHICH EQUALS 2 MONTHS MISSED OUT OF 12 MONTHS MEASURED Corrective Action: New "OneView" tracking system introduced to AZ market, learning curve issues slowed ASA during transition. CIGNA introduced 24/7 customer service access and staffing level needs were underestimated at during roll out. All Reps now acclimated to OneView and staffing issue shortfalls corrected.
Written appeals resolved in 45 calendar days after receipt of participant's request for review in the case of post-service claims.	.33%	• .028%: WHICH EQUALS 1 MONTH MISSED OUT OF 12 MONTHS MEASURED Corrective Action: This target was missed due to additional information not being submitted to consider the appeal by the provider.
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.	.75%	• .18%: WHICH EQUALS 3 MONTHS MISSED OUT OF 12 MONTHS MEASURED • Corrective Action: Based on audit results Cigna will be implementing several system enhancements in 2011. In addition a specialized team has been created to process specific claim types.

97% of al claims will be process accurately. Accurate processing includes payment amount; communication to claimant or provider; data entry errors affecting current or future benefit determinations and management reports.	.50%	• .208%: WHICH EQUALS 5 MONTHS MISSED OUT OF 12 MONTHS MEASURED • Corrective Action: Based on audit results Cigna will be implementing several system enhancements in 2011. In addition a specialized team has been created to process specific claim types.
Nurse line- Average Speed to Answer 45 seconds or less	2%	• .16%: WHICH EQUALS 1 MONTHS MISSED OUT OF 12 MONTHS MEASURED • Corrective Action: Higher than expected call volume across country. HIL monitors for increased call volume and adjusts staffing appropriately
Nurse line- Abandonment Rate <5%	2.5%	• .20%: WHICH EQUALS 1 MONTHS MISSED OUT OF 12 MONTHS MEASURED • Corrective Action: Abandonment rate is a component of total calls received. 1 - 2 abandoned calls is normal for this account, but because call volume is low (37 for Sept) the abandonment rate shows higher. ASA for that month was 26 seconds indicating no issues with hold times.

D. Aetna (Claims Administrator) – penalties to date of $7,307.31, equaling.50% of the vendor's annual administrative fee.

MEASURE	Annual Percent of Fees at Risk	Total Percent Assessed Vendor (BASED ON MISSED MEASURE)
Contractor will resolve 95% or more of all "normal" correspondence within 15 calendar days of receipt. Normal correspondence is	1%	• .08%: WHICH EQUALS 1 MONTHS MISSED OUT OF 12 MONTHS MEASURED • Corrective Action: The correspondence TAT was missed due to one of the five items received was not resolved until the 17th day. The delay was a result of

defined as: plan descriptive materials requests; and premium and/or coverage verification.		needing additional time to confirm that a member was eligible for a review under the plan. This was an isolated issue that did not require additional corrective action.
98% of all fully documented claims received will be processed within 30 calendar days	.50%	• .04%: WHICH EQUALS 1 MONTHS MISSED OUT OF 12 MONTHS MEASURED • July 2010 TAT was missed due to a claim rework project based upon a plan clarification. This was an isolated issue that did not require additional corrective action.
92% of all fully documented claims received will be completely processed within 12 calendar days after they are received.	.50%	• .04%: WHICH EQUALS 4 MONTHS MISSED OUT OF 12 MONTHS MEASURED • Corrective Action: As result of missing the November/December TAT Aetna set up a custom process, including a designated team of claims processors, to process all ADOA claims. Aetna also incorporated additional reporting metrics to better monitor performance results. March and July 2010 TAT were missed due to large claim rework projects based upon a plan clarification and updated provider rates. These were isolated issues that did not require additional corrective action.
98.2% of claims dollars submitted for payment will be accurately processed and paid.	1%	• .25%: WHICH EQUALS 3 MONTHS MISSED OUT OF 12 MONTHS MEASURED • Corrective Action: The Target was missed due to the mis-interpretation of pricing instructions. There were a total of four individual processors involved. Analysis of all errors are performed by the Quality Analyst. One-on-one educational sessions occur with each individual processor involved. A follow up discussion with the Claim Supervisor also occurs to assure the processor understands their error. All errors identified in

		the auditing process are educational opportunities that are discussed and addressed during our monthly meetings with the designated ADOA Claim Processing Team.
96% of al claims will be process accurately. Accurate processing includes payment amount; communication to claimant or provider; data entry errors affecting current or future benefit determinations and management reports.	1%	• .17% WHICH EQUALS 2 MONTHS MISSED OUT OF 12 MONTHS MEASURED • Corrective Action: Total claim accuracy was missed due coding and procedural errors. There were a total of two individual processors involved. Analysis of all errors are performed by the Quality Analyst. One-on-one educational sessions occur with each individual processor involved. A follow up discussion with the Claim Supervisor also occurs to assure the processor understands their error. All errors identified in the auditing process are educational opportunities that are discussed and addressed during our monthly meetings with the designated ADOA Claim Processing Team.
Nurse line- Average Speed to Answer 45 seconds or less	No fees at Risk	• 0% WHICH EQUALS 2 MONTHS MISSED OUT OF 12 MONTHS MEASURED • Corrective Action: Aetna constantly evaluates performance results and adjusts staffing, resources and workflows to ensure a high quality service experience - this includes additional employee training, auditing and investment in technology.
Nurse line- Abandonment Rate <5%	No fees at Risk	• 0% WHICH EQUALS 2 MONTHS MISSED OUT OF 12 MONTHS MEASURED • Corrective Action: Aetna constantly evaluates performance results and adjusts staffing, resources and workflows to ensure a high quality service experience - this includes additional employee

		training, auditing and investment in technology.

E. MedImpact (Pharmacy Management) - penalties to date of $6,250.00, equaling of the .30% vendor's annual fee at risk.

MEASURE	Annual Fees at Risk (Max $2,090,000.00)	Total Percent Assessed Vendor (BASED ON MISSED MEASURE)
Total mail service prescriptions with available generics shall be dispensed with a generic product. 97% of potential	$25,000	• $6,250.00: WHICH EQUALS 1 QUARTERS MISSED OUT OF 4 QUARTERS MEASURED • Corrective Action: The first quarter PG was missed regarding Generic Substitution/Utilization but moving forward has not been missed. The plan design for ADOA is set up so as to best promote generic utilization which is why overall, for the year in aggregate, we have met this PG.

F. Avesis (Vision) - penalties to date of $14,500.00, equaling 1% of the vendor's annual fee at risk.

MEASURE	Annual Percent of Fees at Risk	Total Percent Assessed Vendor (BASED ON MISSED MEASURE)
95% of claims will be processed within two working days	$12,000	• $2,000: WHICH EQUALS 2 MONTHS MISSED OUT OF 12 MONTHS MEASURED • Corrective Action: The target was missed due to eligibility loading issues. The eligibility issues where resolved by Avesis subsequently; met the measure for the rest of the year.
90% of all calls requesting a member services representative will be answered in 30 seconds or less.	$30,000	• $12,500: WHICH EQUALS 5 MONTHS MISSED OUT OF 12 MONTHS MEASURED • Corrective Action: Avesis hired additional staff to support the call volume.

G. ASI (Flexible Spending) - penalties to date of $324.95, equaling .25% of the vendor's annual fee at risk.

MEASURE	Annual Percent of Fees at Risk	Total Percent Assessed Vendor (BASED ON MISSED MEASURE)
Timeliness of claims processing (turnaround time) as 90% of clean claims processed (pay or deny) within 10 calendar days of receipt of claim. Clean claims are defined as requiring no intervention to process. For enrollment greater than 10,000 this measure	1%	• 0.25%: WHICH EQUALS 1 QUARTER MISSED OUT OF 4 QUARTERS MEASURED • Corrective Action: The 3rd Quarter target was missed due to high claim volume in April 2010. In April, 72,846 claims were processed. We have added additional personnel to accommodate for the claims fluctuation so hopefully we can avoid the same situation next plan year.

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 71 out of 72 targets), Appeals (met 44 out of 48 targets), Open Enrollment, Implementation, Claims Adjudication (met 53 out of 60 targets), Administration, Account Management Meeting, Reports (met 28 out of 29 targets, Network Management (met 22 out of 24 targets), Medical Management, Case Management, Disease Management, Nurse Line
AmeriBen	15% Total Administration Fee	Customer Service (met 80 out of 84 targets), Appeals, Open Enrollment, Implementation, Claims Adjudication (met 55 out of 60 targets), Administration, Account Management Meeting, Reports, Finance Accounting, & Network Management
Cigna	26% Total Administration Fee 27% Medical Management Fee	Customer Service (met 82 out of 84 targets), Appeals (met 47 out of 48 targets), Open Enrollment, Implementation, Claims Adjudication (met 66 out of 72 targets), Account Management Meeting, Administration, Reports, Finance Accounting, Network Management (met 22 out of 24 targets),

		Medical Management, Case Management, Disease Management, & Nurse Line (met 22 out of 24 targets).
Aetna	23% Total Administration Fee 20% Medical Management Fee	Customer Service, Appeals, Open Enrollment, Implementation, Claims Adjudication (met 67 out of 72 targets), Administration, Account Management Meeting, Reports, & Network Management, Medical Management HIPPA Compliance, Case Management, & Nurse Line (met 32 out of 36 targets)
American Health Holding	Total Administration Fee 7.8% Case Management Fee 7.5% Disease Management Fee 5% Nurse line Fee 5%	Implementation, Utilization Management, Case Management, Disease Management, Reporting, Systems, Nurse & Other Call Center Activity.
MedImpact		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 targets).
Delta Dental	5% Total Administration Fee	Implementation, Reporting, Network Management, Claims Administration, Appeals, Quality of Service and Responsiveness to Members
TDA	3% Total Administration Fee	Implementation, Reporting, Network Management, Appeals, Quality of Service and Responsiveness to Members
Hartford	10% Total Administration Fee	Conversion/Implementation/Annual Open Enrollment, Report Timeliness, Quality of Service and Responsiveness to Members, Appeals/Grievance, Claims Administration
Avesis	$309,000.00 Total Fees at Risk	Implementation, Reporting, Networking, Claims (met 34 of 36 targets), Appeals, & Call Center (met 31 of 36 targets).
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 2009-2010 plan year, 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

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.

Table A: 3015 FUND PLAN YEAR 10/1/2009 - 9/30/2010

BEGINNING CASH PER AFIS					**$ 58,542,766.10**
REVENUE					**$ 753,305,139.91**
EXPENDITURES					**$ 660,261,467.96**
VENDOR	ADMIN FEES	PERF PENALTIES			
AZ FOUNDATION	$ 5,460.00				
BEECH STREET	$ 1,464.66				
HMA	$ 33,486.22	$ -			
HARRINGTON	$ 954,466.28	$ 1,715.63			
AHH UR/UM	$ 1,030,152.75	$ -			
AETNA	$ 1,235,431.58	$ -			
CIGNA	$ 2,880,173.64	$ -			
UHC	$ 12,428,020.70	$ 85,792.00			
AMERIBEN	$ 2,760,650.99	$ -			
WHI	$ 96,528.30	$ -			
MEDIMPACT	$ 1,064,676.97	$ -			
OTHER FEES**	$ 178,845.62				
ATTORNEY GENERAL	$ 741.69				
NET ADMIN FEES^	**$ 22,670,099.40**	**$ 87,507.63**		**$ 22,582,591.77**	
	MEDICAL CLAIMS	RECOVERIES*			
HARRINGTON	$ 31,081,661.77	$ 2,509,356.90			
AETNA	$ 15,003,486.28	$ -			
CIGNA	$ 27,886,871.41	$ -			
UHC	$ 329,370,391.91	$ 76,013.70			
AMERIBEN	$ 67,923,081.02	$ 201,125.41			
WHI	$ 1,248,951.62	$ 7,049,984.23			
MEDIMPACT	$ 104,823,774.05	$ 3,047,271.86			
RDS SUBSIDY		$ 1,249,718.22			
OTHER WELLNESS	$ 553,948.00				
NET MEDICAL CLAIMS	**$ 577,892,166.06**	**$ 14,133,470.32**		**$ 563,758,695.74**	
	STOP LOSS PREM	CLAIM REIMB			
SYMETRA	$ 3,396,801.60	$ 7,519,971.48		**$ (4,123,169.88)**	
SELF INSURED EXPENDITURES				***$ 582,218,117.63***	
	FULL SVC PREM				
BCBS	$ 30,664,726.00				
PACIFICARE	$ 2,260,433.67				
TOTAL FS INS PREMS^	$ 32,925,159.67	$ -		**$ 32,925,159.67**	
	DENTAL PREM	PERF PENALTIES			
DELTA	$37,692,017.18	$ 23,394.25			
TDA	$3,603,382.95	$ -			
NET DENTAL PREM	$ 41,295,400.13	$ 23,394.25		**$ 41,272,005.88**	
HITF APPROP EXP	$ 3,846,184.78			**$ 3,846,184.78**	
TOTAL EXPENDITURES	**$ 682,025,811.64**				
TOTAL RECOVERIES*		**$ 21,764,343.68**			
NET EXPENDITURES				**$ 660,261,467.96**	
ENDING CASH BALANCE PER AFIS					**$ 151,586,438.05**

*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.

PLAN YEAR 10/1/2009 - 9/30/2010

BEGINNING CASH PER AFIS				**$**	**4,133,542.11**
REVENUE				**$**	**37,333,824.91**
	VENDOR	INSURANCE	AMOUNT		
	STANDARD	BASIC LIFE	$ 1,538.14		
		SUPP LIFE	$ 2,438.26		
		DEP LIFE	$ 463.03		
		STD	$ 2,926.98		
		LTD	$ 4,961.26		
	TOTAL STANDARD		$ 12,327.67		
	HARTFORD	BASIC LIFE	$ 2,353,727.67		
		SUPP LIFE	$ 11,569,011.51		
		DEP LIFE	$ 2,635,373.39		
		STD	$ 7,538,133.36		
		LTD	$ 2,744,220.40		
	TOTAL HARTFORD		$ 26,840,466.33		
	AVESIS	VISION	$ 4,657,317.95		
	ASI	AMRA	$ 4,426,995.32		
		DCRA	$ 1,396,727.82		
	TOTAL FLEX SPENDING		$ 5,823,723.14		
	PAYROLL CLEARING		$ (10.18)		
TOTAL REVENUE			$ 37,333,824.91		
EXPENDITURES				**$**	**36,769,807.15**
	VENDOR	INSURANCE	AMOUNT		
	STANDARD	BASIC LIFE	$ 202,411.77		
		SUPP LIFE	$ 804,342.26		
		DEP LIFE	$ 123,582.34		
		STD	$ 762,942.85		
		LTD	$ 352,720.54		
	TOTAL STANDARD		$ 2,245,999.76		
	HARTFORD	BASIC LIFE	$ 1,276,155.96		
		SUPP LIFE	$ 10,710,483.34		
		DEP LIFE	$ 2,437,622.10		
		STD	$ 6,977,592.13		
		LTD	$ 2,528,281.64		
	TOTAL HARTFORD		$ 23,930,135.17		
	AVESIS	VISION	$ 4,728,106.40		
	ASI	AMRA	$ 4,372,168.62		
		DCRA	$ 1,359,497.29		
		ADMIN FEES	$ 129,699.91		
	TOTAL FLEX SPENDING		$ 5,861,365.82		
	GAO AFIS COST		$ 4,200.00		
TOTAL EXPENDITURES			$ 36,769,807.15		
ENDING CASH BALANCE PER AFIS				**$**	**4,697,559.87**

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

Telephone: 602-542-5008
Fax: 602-542-4744