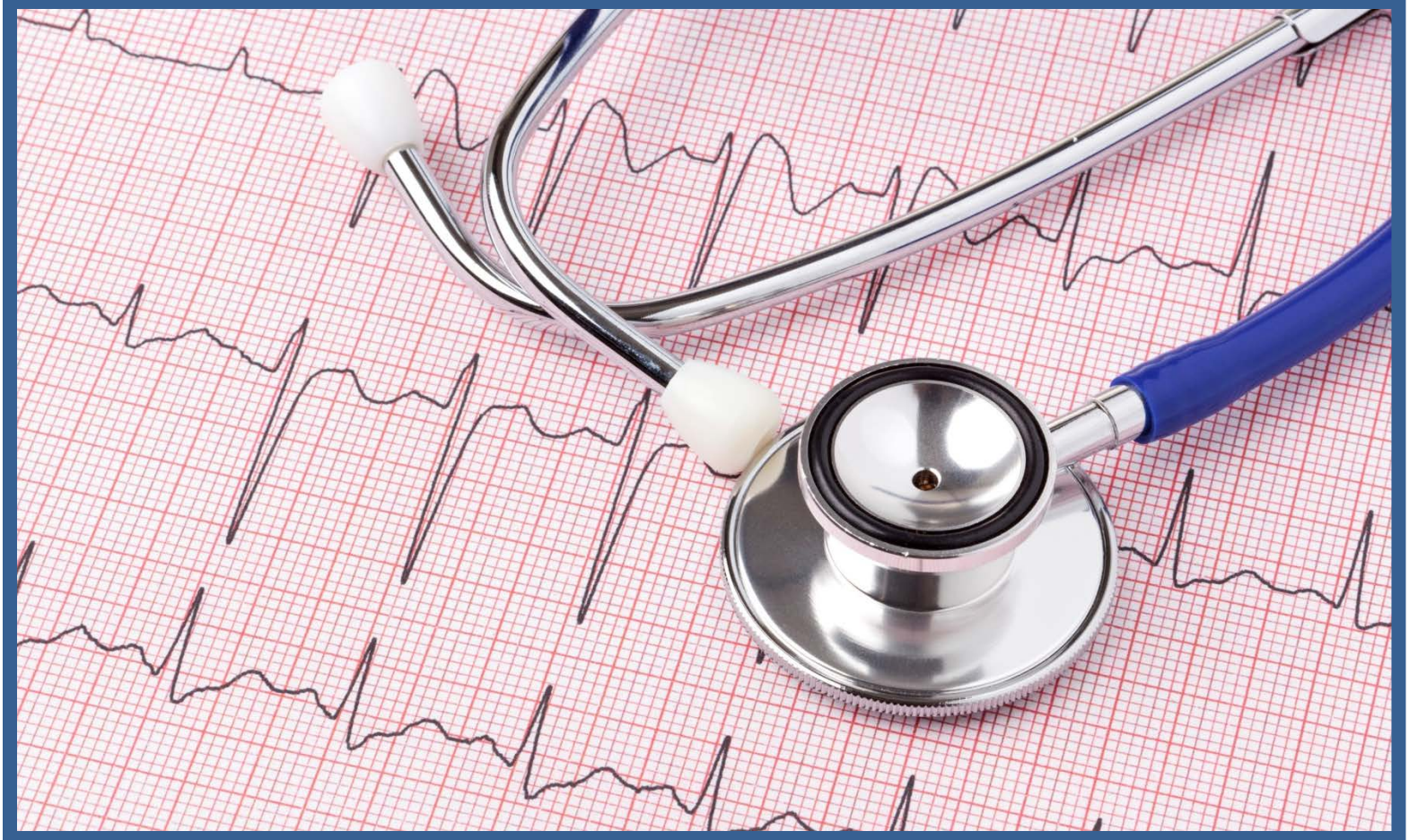
ADOA-HRD
Human Resources

Benefit Options
Choice Value Health

2013
Health Insurance Trust Fund
Annual Report



Arizona Department of Administration
Human Resources Division – Benefit Services

Janice K. Brewer
Governor

Brian C. McNeil
Director

FOREWORD

Benefit Options is the program name for the benefits offered to State of Arizona ("State") employees and retirees by the Arizona Department of Administration ("ADOA"). This report provides a broad overview of the Benefit Options program, and meets the requirements of A.R.S. §38-652 (G) and A.R.S. §38-658 (B).

The data shown is presented for the period January 1, 2013 through December 31, 2013. The active and retiree plans were concurrent for this period.

For this report, ADOA internally developed a consistent statistical model based on generally accepted actuarial principles and standards, including *Milliman Health Cost Guidelines Commercial Rating Structures, July 1, 2012*.

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

Arizona Department of Administration
Human Resources Division
100 N. 15th Avenue, Suite 261
Phoenix, Arizona 85007

Telephone: 602-542-5482

Table of Contents

Figures and Tables

Report Background

This document reports the financial status of the Employee Health Insurance Trust Fund pursuant to A.R.S. §38-652 (G), which reads:

> 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, Human Resources Division, Benefit Services operations. The ERE/Benefits Administration Fund, or Fund 3035, is primarily a "pass through" fund for other benefits including vision, life, and disability insurance, and flexible spending accounts.

The benefits offered through the program fall into one of two types — self-funded or fully-insured. For 2013, the health benefit plan and the dental PPO plan were self-funded, whereas the dental HMO plan, vision plan, life, and disability insurance plans were fully-insured.

The State's self-funded medical plan began on October 1, 2004, and consists of both integrated and nonintegrated options for the medical plan with a carved-out pharmacy plan. The integrated option combines the functions of claims review and payment, network access, and medical management, including utilization management, case management and disease management. The non-integrated option is similar, except the medical management function is carved out to a separate contracted vendor.

Plan Year (PY) 2013 was the first year of the self-funded dental PPO plan.

Schedules of premiums received and accounted for in Fund 3015, distribution by enrollment, incurred and paid medical/drug claims, and expenses related to the medical and dental plans are included within this Annual Report. Also included is a summary of premiums collected and paid for life insurance, disability insurance, vision insurance, and flexible spending accounts for Fund 3035.

All data provided herein is for PY 2013 (January 1, 2013 – December 31, 2013).

Executive Summary

During PY 2013, ADOA offered a comprehensive insurance package through Benefit Options to over 128,000 members consisting of active state and university employees, retirees, and their qualified dependents. The benefits offered in the package include medical, pharmaceutical, dental, flexible spending, vision, wellness, life, and disability insurance.

Based on the 2013 contribution strategy, the sum of health and dental premiums collected was $810 million with total plan expenses of $804 million, resulting in a net operational gain of $6 million.

Health Plan

- The average plan cost to insure each member was $5,302
  - Average active member cost was $5,033
  - Average retiree cost was $8,773
- The medical claims expense was $505 million of total health plan costs for 2013
  - The leading diagnosis category by cost was the musculoskeletal system
    - Just over 13% of the total medical claims cost
  - Claims showed members are seeking care from physicians or specialists for the majority of their medical needs, indicating appropriate care
    - 170 emergency room visits per 1,000 members
    - 221 urgent care visits per 1,000 members
    - 4,515 physician visits per 1,000 members
- The pharmacy claims expense was $118 million of total health plan cost for 2013
  - The leading therapeutic drug class by cost was diabetes
    - 11% of the total pharmacy claims cost
  - 1.4 million prescriptions were filled during PY 2013
    - Retirees filled an average of 31 prescriptions per year
    - Active members averaged 10 per year

Wellness Program

- Administered over 12,600 flu vaccines through 635 worksite or public events
- Administered over 6,400 screenings through 150 worksite events
  - 590 referrals to physicians for various health issues

Performance Measures

Financial guarantees are in place to manage the performance of the contracted vendors. Most vendors met the majority or all of the agreed-upon performance measures. However, penalties in excess of $301,000 were collected in 2013 from a few vendors failing to meet agreed upon PY 2012 performance targets in areas such as customer service, claims processing, and disease management clinical improvements.

Review

The PY 2013 ratio of expenses to premiums of 99% indicates that the ADOA effectively controlled the rise in health care costs through quality benefit design, administrative oversight, strategic planning, auditing, and effective contract management. Detailed evidence of ADOA's accomplishments can be reviewed herein.

Health Insurance Trust Fund Summary

Table 1 is a cash statement of receipts received and expenses paid during 2013 for PY 2013 and prior plan years.

ADOA Health Plan is the self-funded medical program and includes Aetna, Blue Cross Blue Shield of Arizona administered by AmeriBen, Cigna, and UnitedHealthcare networks. State and university employees and retirees choose coverage from one of the self-funded networks. BCBS (NAU) is a fully-insured option available only to NAU employees and NAU retirees.

The Medicare Part D Retiree Drug Subsidy is available to employers who provide a qualified pharmacy plan to Medicare-eligible retirees.

The Early Retiree Reinsurance Program was instituted by the Affordable Care Act as an incentive for employers to continue health coverage for early retirees. The 2013 expense is reimbursement to the federal government for an overpayment of subsidies received in a prior year.

Health Insurance Trust Fund Summary	
	PY 2013
Prior Balance December 31, 2012	$276,902,422.88
Revenues	
ADOA Health Plan	735,881,822.01
BCBS (NAU)	33,699,732.27
ADOA Dental Plan	36,900,448.89
PrePaid Dental Plan	3,501,446.15
Other Revenue	163,733.63
Total Revenues	$810,147,182.95
Expenditures	
Administrative Fees	26,524,977.54
Medical Claims	504,773,882.95
Drug Claims	119,048,078.11
Dental Claims	33,437,510.58
Medicare Part D Retiree Drug Subsidy	(1,982,399.22)
Early Retiree Reinsurance Program	4,559.23
BCBS (NAU) Premiums	32,340,627.85
Dental Premiums	6,700,748.82
Appropriated Expenses	4,403,539.75
Fund Transfers Out^	73,496,000.00
Federal Participation Reimbursement	5,104,143.00
Total Expenditures	$803,851,668.61
Fund Balance December 31, 2013	$283,197,937.22
Reserves	
IBNR Liability (Medical & Dental)	104,400,000.00
Contingency Reserve (Medical & Dental)	104,400,000.00
Total Reserves	$208,800,000.00
Unrestricted Balance December 31,2013	$ 74,397,937.22

Table 1: Health Insurance Trust Fund Summary

^Interfund transfers from HITF to other State operating funds. Future transfers include $53.9 million pursuant to Laws 2014, Chapter 18, Sec. 139 (HB2703 2014-2015; general appropriations) for fiscal year 2015.

Reserves are monies set aside for the purpose of paying claims that have been incurred but not reported (IBNR) and for a contingency reserve to cover any insufficiencies that may develop, such as actual medical trend exceeding assumed medical trend in rate setting, shifts in plan membership, unexpected catastrophic claims, and changes in provider reimbursement rates that may occur in a given plan year.

Medical Plan Enrollment

The ADOA Benefit Options group medical plan is available to the following:

- 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; and
- State employees or university staff eligible for COBRA benefits.

The three types of medical plans offered to eligible participants are the Exclusive Provider Organization (EPO), the Preferred Provider Organization (PPO), and the Health Savings Account Option (HSAO).

The EPO Plan
If a member chooses the EPO plan, services must be obtained from a network provider. Out-of-network services are only covered in emergency situations. Under the EPO plan, the employee pays the monthly premium and any required copay at the time of service. Members selecting the EPO plan choose from four networks: Aetna, Blue Cross Blue Shield of Arizona administered by AmeriBen*, Cigna, or UnitedHealthcare.

The PPO Plan
If a member chooses the PPO plan, services can be provided in-network or out-of-network, but there are higher costs for out-of-network services. Additionally, there is an in-network and out-of-network deductible that must be met. Under the PPO plan, the employee will pay the monthly premium and any required copay or coinsurance (percent of the cost) at the time of service. Members selecting the PPO plan choose from Aetna, Blue Cross Blue Shield of Arizona administered by AmeriBen*, or UnitedHealthcare.

The HSAO Plan
The HSAO plan is a high deductible health plan only available to active employees through the Aetna network. If an employee enrolls in the HSAO, the employee is eligible to open a Health Savings Account (HSA) which is a special type of account that allows tax-free contributions, earnings, and healthcare-related withdrawals. If the employee opens the Aetna associated qualifying HSA, the State makes a bi-weekly deposit to the account.

When enrolled in the HSAO plan, members can use in-network and out-of-network providers. Members pay the copay and/or coinsurance after the deductible is met, except for qualified preventative services that are covered without a copay or coinsurance.

**Blue Cross Blue Shield of Arizona Network administered by AmeriBen. Blue Cross Blue Shield of Arizona, an independent licensee of the Blue Cross Blue Shield Association, provides Network access only and does not provide administrative or claims payment services and does not assume any financial risk or obligation with respect to claims. AmeriBen has assumed all liability for claims payment. No network access is available from Blue Cross Blue Shield plans outside of Arizona.*

Table 2 shows how enrollment was distributed by plan and network between active, retired, university, and COBRA members.

Average Monthly Medical Enrollment by Plan & Network					
		2013		2012	
Network	Plan Type	Subscribers	Members	Subscribers	Members
AETNA					
Active	EPO	1,595	3,639	1,451	3,306
Retiree	EPO	247	327	260	344
University	EPO	1,639	3,000	1,392	2,573
COBRA	EPO	21	25	13	19
Active	PPO	96	176	89	161
Retiree	PPO	41	50	46	54
University	PPO	182	328	140	235
COBRA	PPO	0	0	0	0
Active	HSAO	250	487	196	369
Retiree	HSAO	-	-	-	-
University	HSAO	317	566	242	423
COBRA	HSAO	1	1	1	1
AmeriBen*					
Active	EPO	6,513	16,122	6,112	15,138
Retiree	EPO	1,125	1,488	1,105	1,451
University	EPO	2,185	4,626	1,889	3,998
COBRA	EPO	35	41	23	33
Active	PPO	310	570	267	476
Retiree	PPO	103	122	126	153
University	PPO	300	539	267	479
COBRA	PPO	4	7	3	5
CIGNA					
Active	EPO	3,009	7,228	2,929	6,964
Retiree	EPO	589	764	605	774
University	EPO	1,160	2,361	1,101	2,256
COBRA	EPO	14	17	6	8
UnitedHealthcare					
Active	EPO	20,557	49,366	21,148	50,452
Retiree	EPO	4,771	6,109	4,718	6,084
University	EPO	10,847	24,508	11,034	24,798
COBRA	EPO	114	145	104	141
Active	PPO	516	943	509	932
Retiree	PPO	108	136	113	144
University	PPO	602	1,153	592	1,134
COBRA	PPO	4	4	6	6
Blue Cross Blue Shield**					
NAU only	PPO	2,877	5,311	2,770	4,304
Total		60,131	130,156	59,258	127,213

Table 2: Average Medical Enrollment by Plan & Network

**AmeriBen administering the Blue Cross Blue Shield of Arizona Network for the self-funded Benefit Options program. **Blue Cross Blue Shield fully insured plan only available to NAU employees and NAU retirees.*

Medical Premiums

Table 3 lists the medical premium by plan and coverage tier per pay period for active members.

Active Medical Premiums by Pay Period (26 pay periods)*					
Plan	**Tier**	**Employee Premium**	**State Premium**	**Total Premium**	**State HSA Contribution**
EPO	Employee only	$18.46	$253.85	$272.31	-
	Employee + adult	$54.92	$522.92	$577.84	-
	Employee + child	$46.62	$497.54	$544.16	-
	Family	$102.00	$648.46	$750.46	-
PPO	Employee only	$71.54	$342.00	$413.54	-
	Employee + adult	$161.54	$695.08	$856.62	-
	Employee + child	$152.77	$667.85	$820.62	-
	Family	$224.31	$890.31	$1,114.62	-
HSAO	Employee only	$12.00	$232.15	$244.15	$27.70
	Employee + adult	$47.08	$466.15	$513.23	$55.39
	Employee + child	$37.38	$450.92	$488.30	$55.39
	Family	$89.08	$583.85	$672.93	$55.39

Table 3: Active Medical Premiums by Pay Period
**University of Arizona has 24 pay period deductions.*

Table 4 lists the monthly medical premium by plan and coverage tier for both retirees not enrolled in Medicare and for those retirees who are enrolled in Medicare, or have at least one family member enrolled in Medicare.

Monthly Retiree Medical Premiums				
	Without Medicare		**With Medicare**	
Plan	**Tier**	**Premium**	**Tier**	**Premium**
EPO	Retiree only	$593	Retiree only	$442
	Retiree +1	$1,387	Retiree +1 (Both Medicare)	$878
			Retiree +1 (One Medicare)	$1,024
	Family	$1,869	Family (Two Medicare)	$1,166
PPO	Retiree only	$943	Retiree only	$789
	Retiree +1	$2,219	Retiree +1 (Both Medicare)	$1,576
			Retiree +1 (One Medicare)	$1,740
	Family	$3,074	Family (Two Medicare)	$1,980

Table 4: Monthly Retiree Medical Premiums

Medical Premium vs. Plan Cost

The 2013 contribution strategy for the self-insured medical plan resulted in employees paying 11% of the average monthly total premium, while the State paid the remaining 89%.

The figure below shows how the average monthly premium compared to the average monthly plan cost for active and retired members.

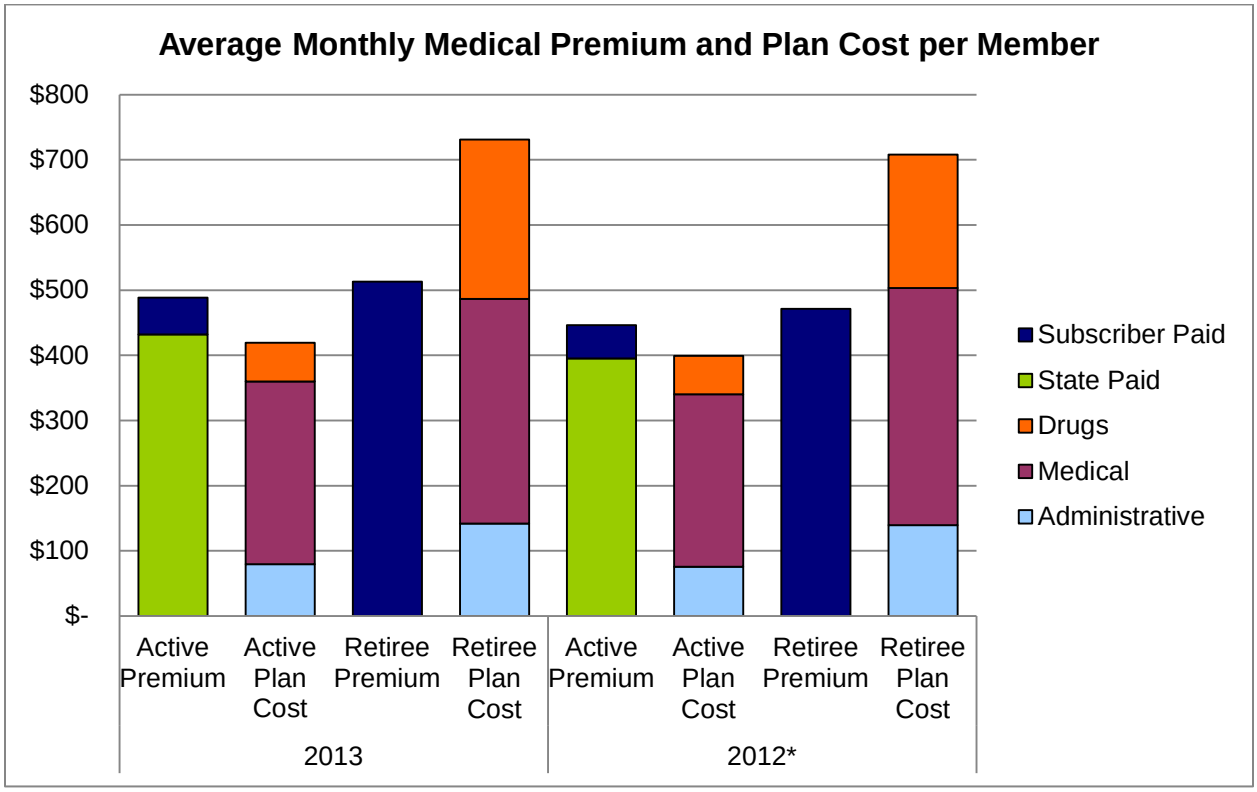


Figure 1: Average Monthly Premium & Plan Cost per Member
**2012 Premiums are net of the legislatively mandated Premium Holiday*

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 premiums lower and active premiums higher than what their experiences would otherwise dictate.

Expenses for Self-Funded Medical Plans

The tables below show the distribution of claims and expenses incurred in PY 2013, and the average annual cost to insure each type of subscriber/member.

Self-funded Medical Expenses by Active, Retiree, and Plan						
Expenses	**Overall**	**Active**	**Retiree**	**EPO**	**PPO**	**HSAO**
Medical Claims	427,775,592	390,439,405	37,336,187	409,515,551	16,991,818	1,268,222
Drug Claims	117,820,657	88,642,885	29,177,772	110,508,634	7,065,358	246,666
Medicare Part D Subsidy	(1,982,399)		(1,982,399)	(1,895,671)	(86,728)	
ERRP Reimbursement	4,559	4,161	398	4,365	181	14
Rebates & Recoveries	(7,771,566)	(6,824,130)	(947,436)	(7,407,314)	(342,675)	(21,578)
Administration Fees	25,116,368	22,100,300	3,016,068	23,499,888	978,247	638,232
Appropriated Expenses	4,178,481	3,668,741	509,741	3,971,678	165,332	41,471
Total Expenses	565,141,692	498,031,362	67,110,330	538,197,131	24,771,534	2,173,027
IBNR Liability	96,800,000	84,999,055	11,800,945	92,262,990	4,268,238	268,772
Total	$661,941,692	$583,030,417	$78,911,275	$630,460,120	$29,039,772	$2,441,799
Enrollment in self-funded plans						
Subscribers	57,255	50,270	6,985	54,421	2,265	568
Members	124,845	115,850	8,995	119,765	4,026	1,053
Annual cost						
Per subscriber	$ 11,561	$ 11,598	$ 11,298	$ 11,585	$ 12,819	$ 4,297
Per member	$ 5,302	$ 5,033	$ 8,773	$ 5,264	$ 7,213	$ 2,318

Table 5: Self-funded Expenses by Active, Retiree, & Plan

Self-funded Medical Expenses by Plan for Active & Retiree						
Expenses (in dollars)	**Overall**	**Active EPO**	**Active PPO**	**Active HSAO**	**Retiree EPO**	**Retiree PPO**
Medical Claims	427,775,592	373,578,827	15,592,356	1,268,222	35,936,724	1,399,463
Drug Claims	117,820,657	82,607,359	5,788,861	246,666	27,901,275	1,276,497
Medicare Part D Subsidy	(1,982,399)				(1,895,671)	(86,728)
ERRP Reimbursement	4,559	3,982	166	14	383	15
Rebates & Recoveries	(7,771,566)	(6,497,994)	(304,558)	(21,578)	(909,319)	(38,117)
Administration Fees	25,116,368	20,592,602	869,465	638,232	2,907,286	108,782
Appropriated Expenses	4,178,481	3,480,322	146,947	41,471	491,356	18,385
Total Expenses	565,141,692	473,765,098	22,093,237	2,173,027	64,432,033	2,678,297
IBNR Liability	96,800,000	80,936,815	3,793,468	268,772	11,326,174	474,770
Total	**$661,941,692**	**$554,701,913**	**$25,886,705**	**$ 2,441,799**	**$75,758,207**	**$3,153,067**
Enrollment in self-funded plans						
Subscribers	57,255	47,688	2,014	568	6,733	252
Members	124,845	111,078	3,719	1,053	8,687	307
Annual cost						
Per subscriber	$ 11,561	$ 11,632	$ 12,857	$ 4,297	$ 11,252	$ 12,516
Per member	$ 5,302	$ 4,994	$ 6,961	$ 2,318	$ 8,721	$ 10,265

Table 6: Self-funded Expenses by Plan for Actives & Retirees

Medical Expenses Associated with Medical Diagnoses

Table 7 shows how medical expenses were distributed among different diagnoses. More dollars were spent treating conditions related to the musculoskeletal system than any other diagnosis.

Medical Expenses by Diagnosis for Actives & Retirees						
	2013			2012		
	All members	Actives	Retirees	All members	Actives	Retirees
Diagnosis	% of Total	% of Total	% of Total	% of Total	% of Total	% of Total
Musculoskeletal System and Connective Tissue	13.28%	13.10%	15.10%	12.08%	12.07%	12.17%
Supplementary Classification of Factors Influencing Health Status and Contact With Health Service	11.03%	11.19%	9.39%	10.04%	10.20%	8.57%
Neoplasms	9.96%	9.46%	15.10%	9.86%	9.20%	15.97%
Symptoms, Signs, and Ill-Defined Conditions	9.47%	9.57%	8.36%	9.38%	9.64%	6.96%
Injury and Poisoning	8.78%	8.95%	7.09%	7.52%	7.20%	10.51%
Circulatory System	6.85%	6.61%	9.29%	8.72%	9.00%	6.12%
Digestive System	6.80%	6.85%	6.27%	5.99%	5.83%	7.42%
Genitourinary System	6.11%	6.10%	6.15%	7.06%	6.58%	11.46%
Nervous System and Sense Organs	5.83%	5.52%	9.06%	6.93%	7.16%	4.83%
Respiratory System	4.85%	4.97%	3.64%	5.08%	5.09%	4.97%
Pregnancy, Childbirth, and The Puerperium	4.50%	4.93%	0.02%	4.30%	4.76%	0.07%
Endocrine, Nutritional and Metabolic Diseases, and Immunity Disorders	3.99%	3.89%	5.07%	4.21%	4.12%	5.09%
Mental Disorders	2.73%	2.87%	1.23%	2.73%	2.86%	1.50%
Infectious and Parasitic Diseases	2.07%	2.09%	1.84%	2.27%	2.30%	1.98%
Skin and Subcutaneous Tissue	1.44%	1.43%	1.55%	1.52%	1.54%	1.34%
Blood and Blood-Forming Organs	0.88%	0.89%	0.75%	0.87%	0.88%	0.76%
Congenital Anomalies	0.86%	0.94%	0.07%	1.04%	1.12%	0.28%
Certain Conditions Originating in the Perinatal Period	0.59%	0.65%	0.00%	0.41%	0.45%	0.00%
Supplementary Classification of External Causes of Injury and Poisoning	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Total	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%

Table 7: Medical Expenses by Diagnosis for Actives & Retirees

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.

Hospital Care

Inpatient hospital care represents a significant portion of total medical expenses: 35% for active members and 32% for retired members. The figures below show a comparison of hospital admissions and the average length of stay for active and retired members and EPO, PPO, and HSAO members.

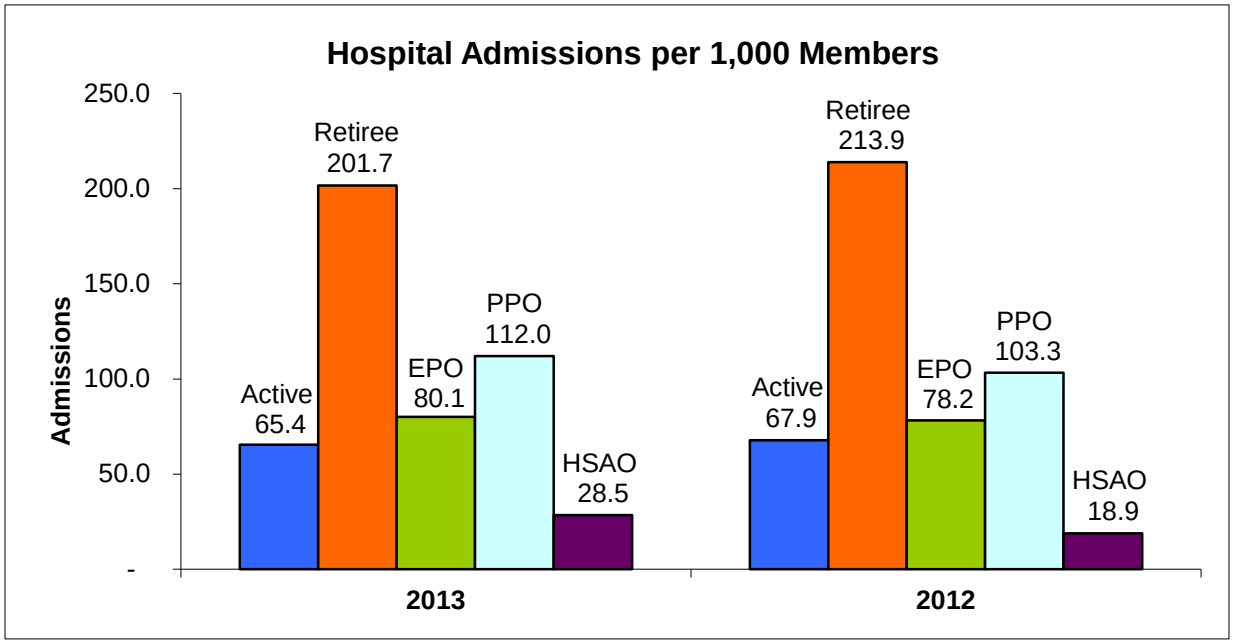


Figure 2: Hospital Admissions per 1,000 Members

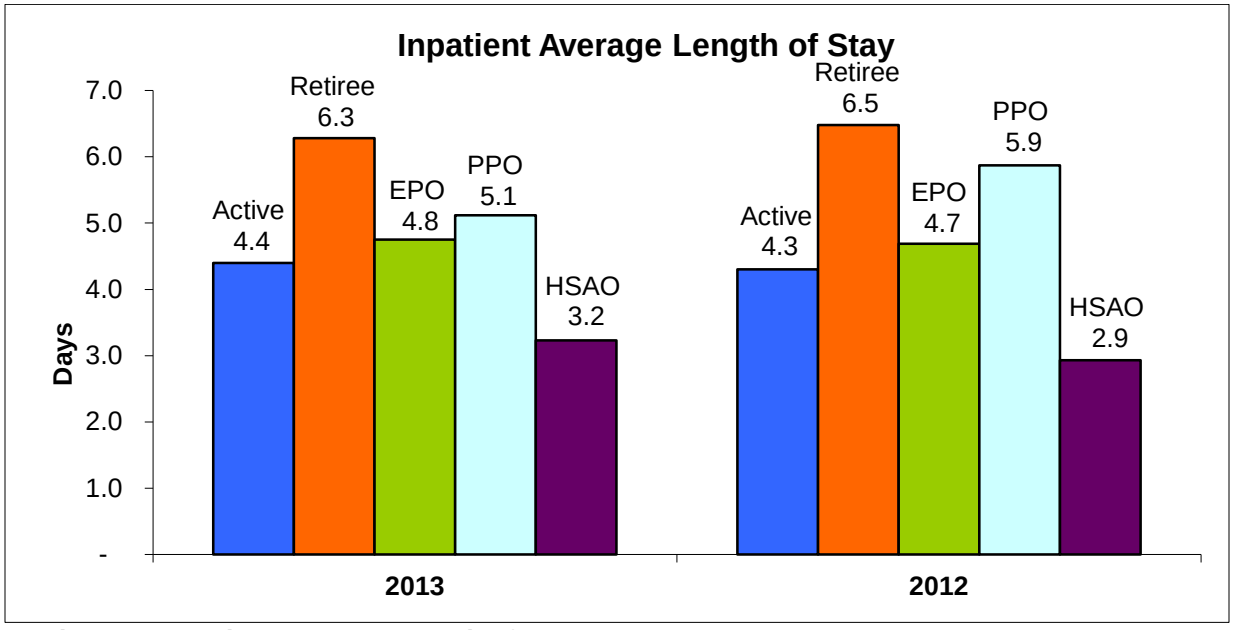


Figure 3: Inpatient Average Length of Stay

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 number of hospital days and average cost per admission. As a group, retirees spent 4.4 times as many days in the hospital as active members. While the plan pays less for Medicare enrolled retiree admissions than for active admissions, the total cost of retiree admissions is 2 times higher than the cost of active admissions when all sources of insurance are considered.

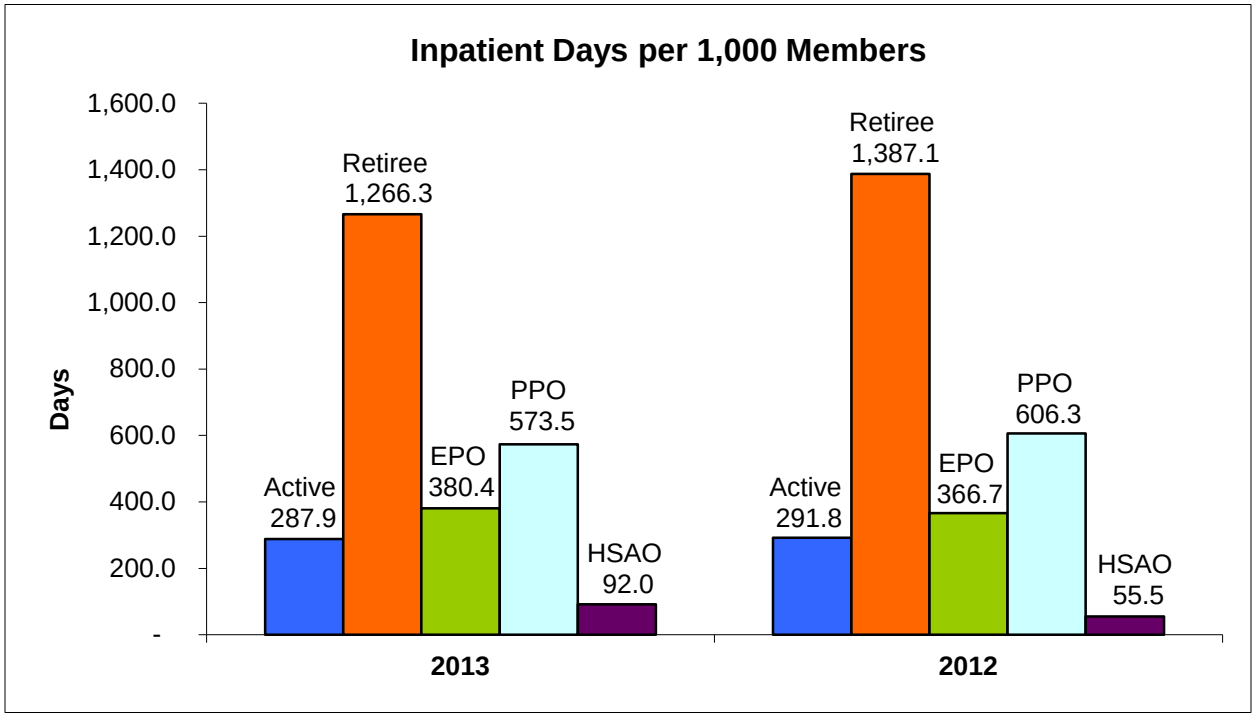


Figure 4: Inpatient Days per 1,000 Members

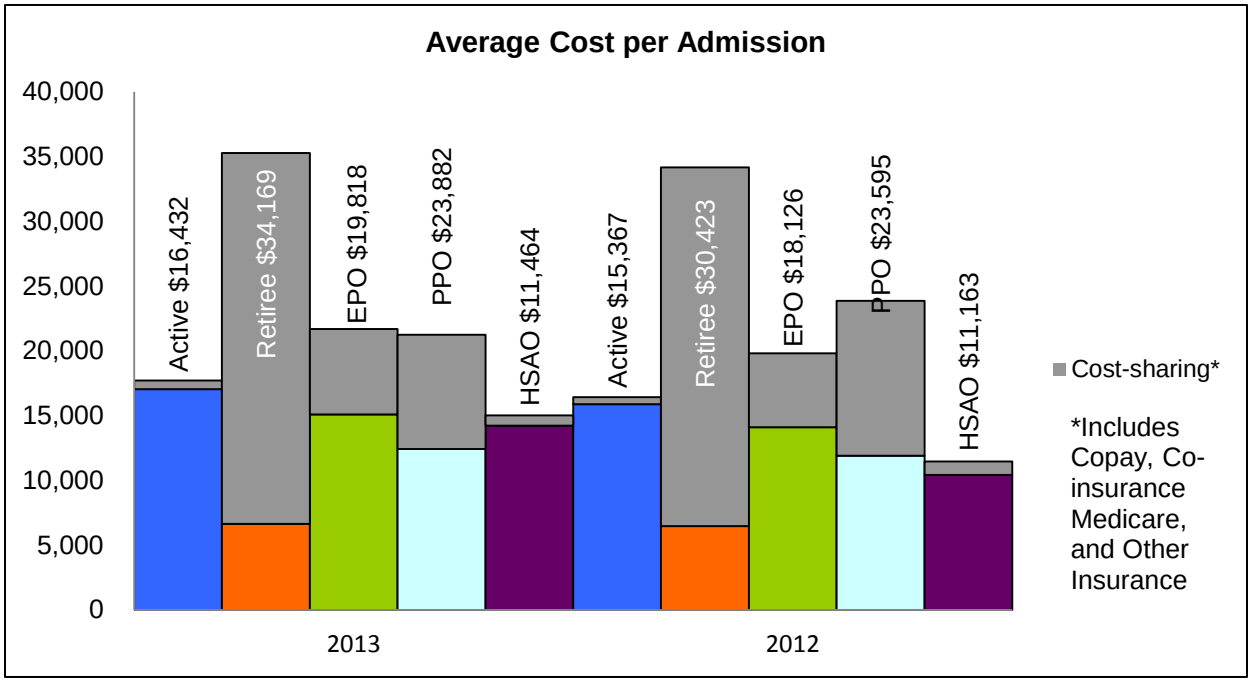


Figure 5: Average Cost per Admission

Emergency Room Visits

During PY 2013, there were approximately 170 emergency room visits per 1,000 members of the self-funded plan. The average plan cost per emergency room visit was $1,320. This cost is indicative of proper utilization of emergency room visits. These figures include facility claims and professional fees.

Urgent Care Visits

During PY 2013, there were approximately 221 urgent care visits per 1,000 members of the self-funded plan. The average plan cost per urgent care visit was $91.

Physician Visits

During PY 2013, there were approximately 4,515 physician visits per 1,000 members (or each member of the self-funded plan visited a physician approximately 4 times). The average plan cost per office visit cost was $89.

Figures 6 and 7 show how total active and retiree medical expenses were distributed by type of care. Emergency room care for active employees was 4.8% of medical expenses, compared to 1.97% of medical expenses for retired members.

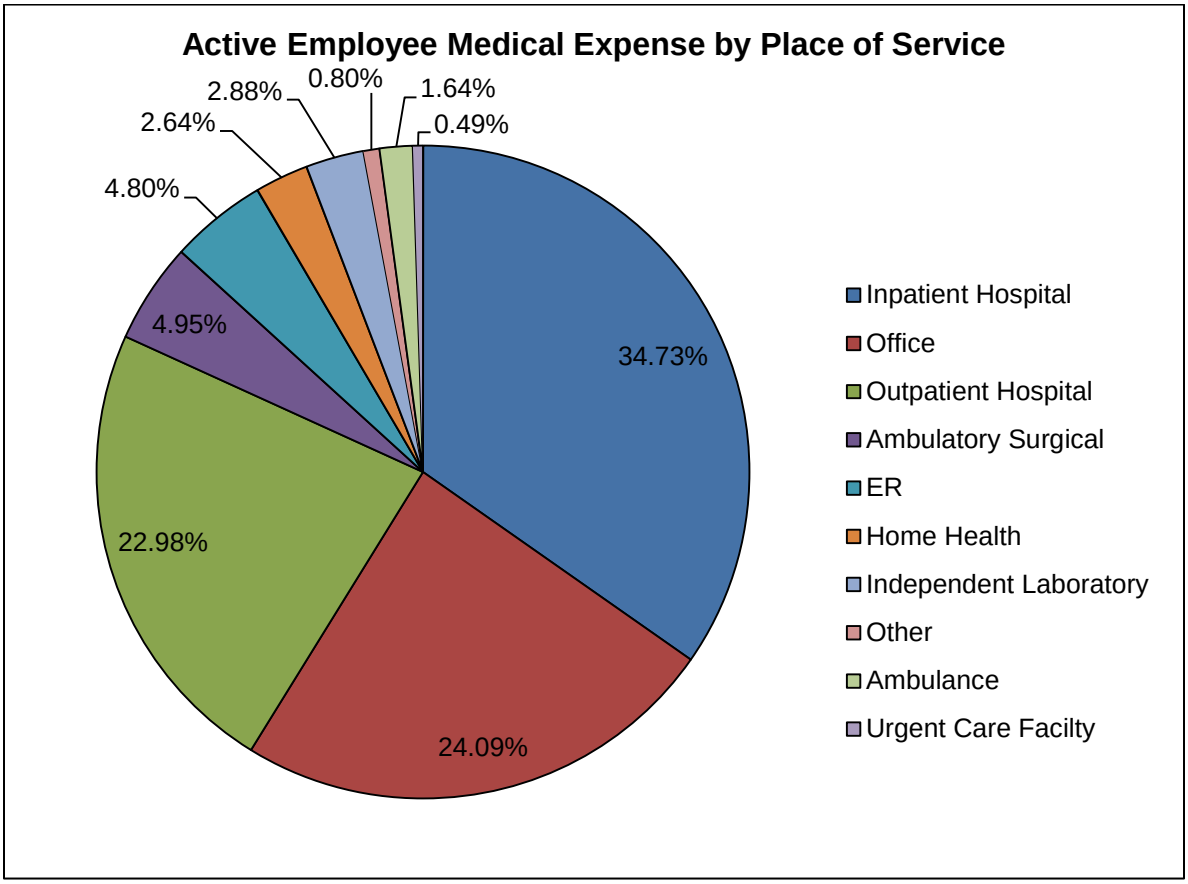


Figure 6: Active Medical Expense by Place of Service

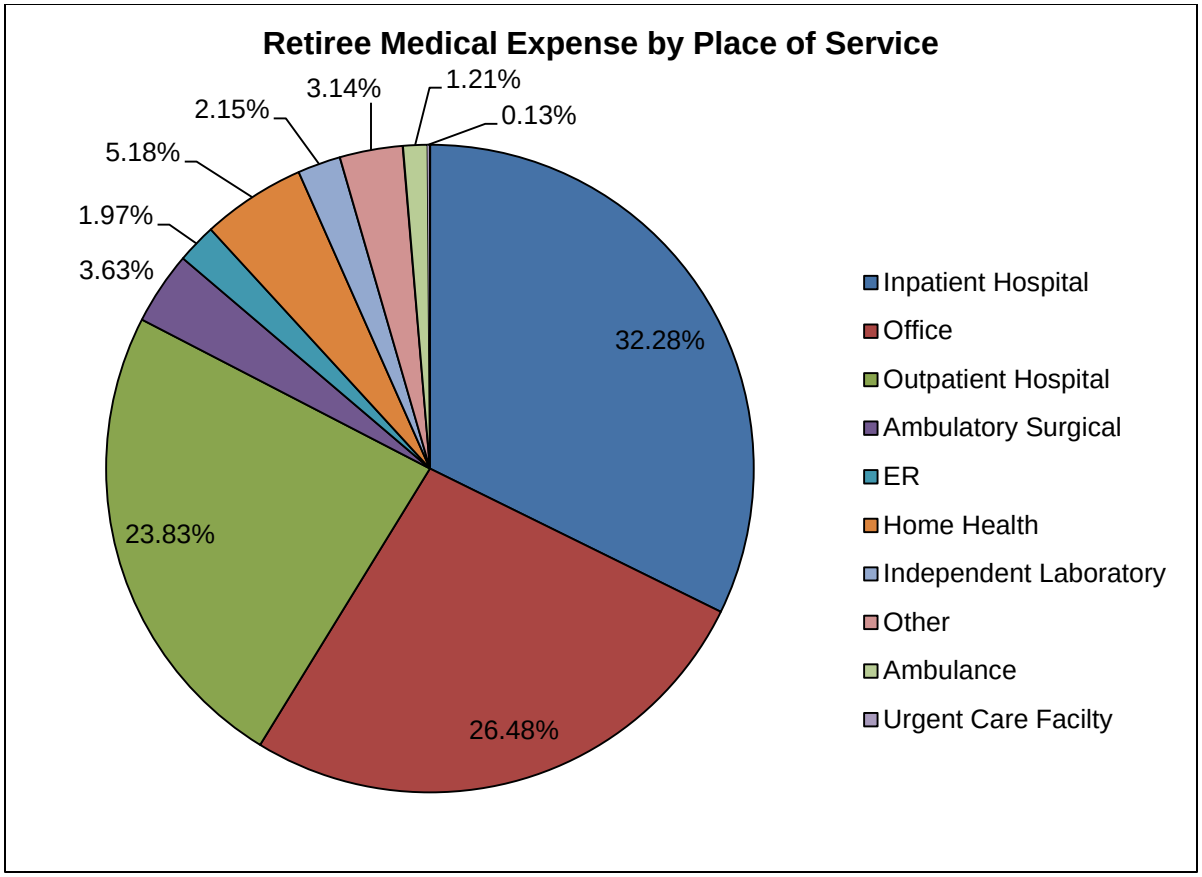


Figure 7: Retiree Medical Expense by Place of Service

Annual Prescription Use

Figure 8 compares the average number of prescriptions filled by active and retired members for PY 2012 and PY 2013.

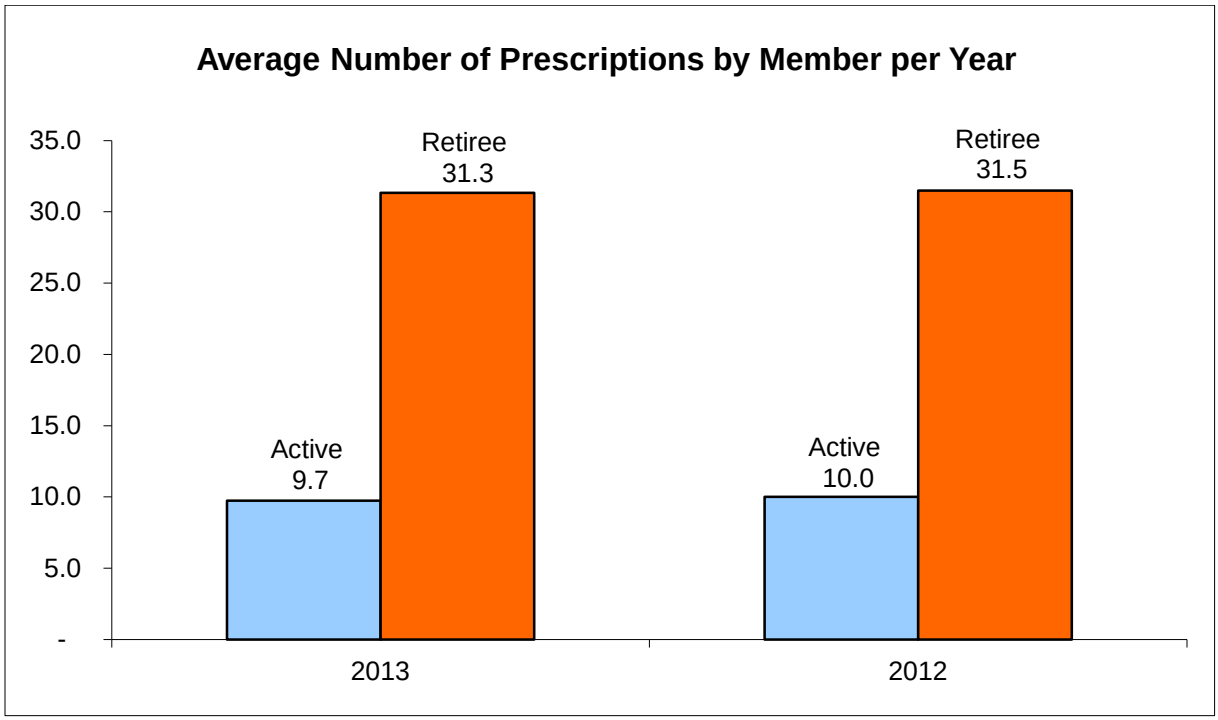


Figure 8: Average Number of Prescriptions per Year

Figure 9 compares pharmacy expense per utilizer by age for PY 2012 and PY 2013.

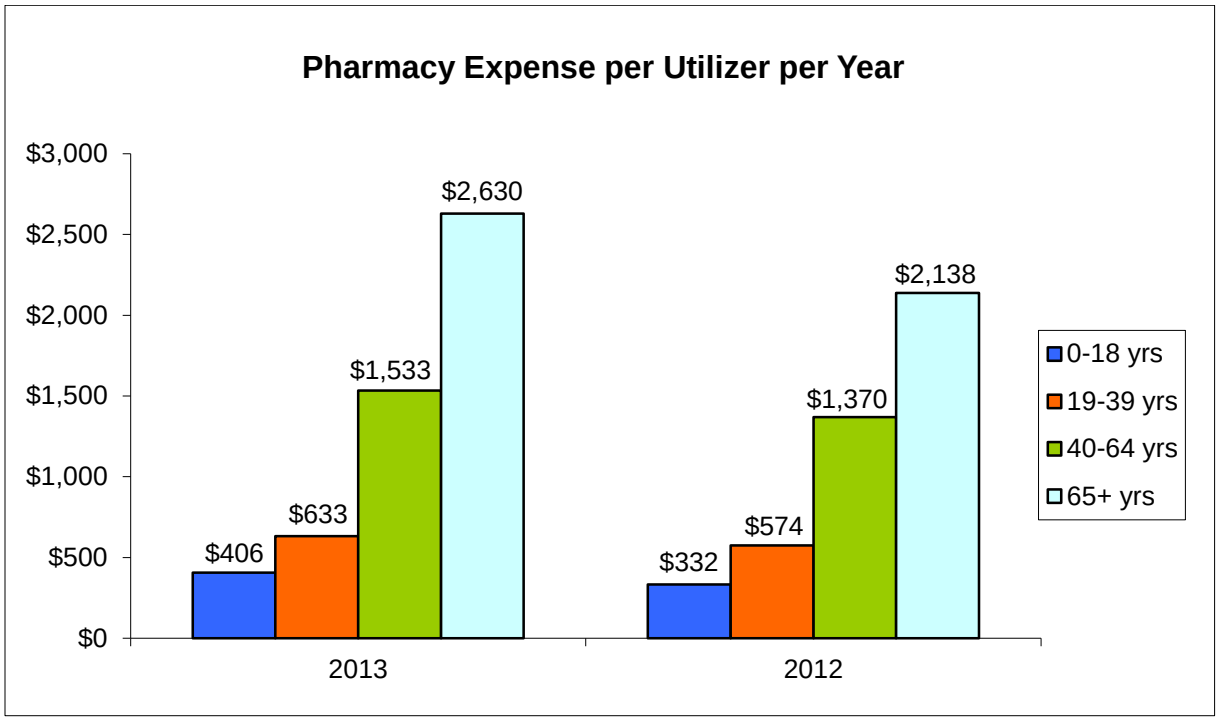


Figure 9: Pharmacy Expense per Utilizer per Year

Generic and Brand-Name Prescription Use

Table 8 shows how total pharmacy expenses were distributed among generic, preferred, and non-preferred types of drugs.

Total Prescriptions by Tier				
	2013		2012	
	Prescriptions	Percent	Prescriptions	Percent
Tier 1 Generic ($10 copay)	1,121,620	79.5%	1,074,935	75.5%
Tier 2-Preferred ($20 copay)	224,623	15.9%	284,675	20.0%
Tier 3-Non-Preferred ($40 copay)	64,087	4.5%	63,688	4.5%
Total	1,410,330	100.0%	1,423,298	100.0%

Table 8: Total Prescriptions by Tier

Prescription Use by Therapeutic Class

Table 9 shows the 10 most utilized classes of drugs according to total expense. More dollars were spent on diabetes than any other therapeutic class.

Pharmacy Top Therapeutic Classes by Total Plan Paid				
	2013		2012	
Therapeutic class	Plan Paid	Percent	Plan Paid	Percent
Diabetes	13,843,844	10.90%	12,099,557	10.00%
Inflammatory Disease	10,110,767	7.96%	8,197,472	6.78%
Behavioral Health - Other	9,322,174	7.34%	8,897,548	7.40%
Cardiovascular Disease - Lipid	6,878,345	5.42%	9,416,313	7.78%
Asthma	6,701,347	5.28%	7,677,516	6.35%
Neoplastic Disease	6,209,999	4.89%		
Pain Management - Analgesics	6,047,926	4.76%	5,710,999	4.72%
Neurological Disease - Miscellaneous	6,013,200	4.74%	5,456,252	4.51%
Infectious Disease - Viral	5,579,962	4.39%	6,476,226	5.35%
Cardiovascular Disease - Hypertension	5,489,872	4.32%	5,412,245	4.47%
Behavioral Health - Antidepressants			6,236,733	5.16%
Total	$ 76,197,436	60.01%	$ 75,580,861	62.52%

Table 9: Pharmacy Top Therapeutic Classes by Plan Paid

Prescription Use by Type of Drug

Table 10 shows the 10 most utilized drugs according to total expense. Humira is the leading prescription by cost for PY 2013.

Top Ten Drugs by Total Plan Paid					
2013			2012		
Drug Name	**Plan Paid**	**Percent**	**Drug Name**	**Plan Paid**	**Percent**
Humira	4,344,534	3.42%	Humira	3,276,990	2.71%
Cymbalta	2,977,875	2.35%	Crestor	3,067,585	2.54%
Enbrel	2,540,418	2.00%	Cymbalta	2,626,269	2.17%
Copaxone	2,282,720	1.80%	Enbrel	2,415,040	2.00%
Crestor	2,079,421	1.64%	Copaxone	2,316,883	1.92%
Abilify	1,876,169	1.48%	Carbaglu	1,821,311	1.51%
Lantus Solostar	1,629,963	1.28%	Singulair	1,740,462	1.44%
Oxycontin	1,596,691	1.26%	Atorvastatin Calcium	1,695,500	1.40%
Androgel	1,550,551	1.22%	Oxycontin	1,646,261	1.36%
Revlimid	1,418,124	1.12%	Abilify	1,565,730	1.29%
Total	$ 22,296,466	17.56%	Total	$ 22,172,031	18.33%

Table 10: Top Ten Drugs by Total Plan Paid

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.

Dental Plan Enrollment

ADOA Benefit Options offers two different types of dental plans: a fully-insured dental health maintenance organization (DHMO) plan provided by Total Dental Administrators and a self-funded dental preferred provider organization (DPPO) plan administered by Delta Dental.

DHMO Plan – Total Dental Administrators (TDA)
Key components of DHMO plan include:

- Seeing 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;
- $1,500 per person lifetime for orthodontia; and
- No claim forms (except for emergency services).

DPPO Plan – Delta Dental
Key components of the self-funded DPPO plan include:

- Members 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; and
- Benefits may be based on reasonable and customary charges.

Table 11 shows how active employee and retiree dental enrollments were distributed among plans.

Average Monthly Dental Enrollment by Plan					
		2013		2012	
Network	Plan Type	Subscribers	Members	Subscribers	Members
Delta Dental					
Active	DPPO	21,159	48,943	20,656	47,094
Retiree	DPPO	11,215	17,386	11,146	17,050
University	DPPO	13,405	27,514	12,947	26,510
COBRA	DPPO	179	241	161	230
Total Dental Administrators					
Active	DHMO	9,708	23,740	10,565	25,861
Retiree	DHMO	2,104	3,203	1,137	2,274
University	DHMO	5,122	11,063	6,074	12,148
COBRA	DHMO	68	99	66	111
Total		62,959	132,188	62,751	131,278

Table 11: Average Dental Enrollment by Plan

Dental Premiums

Table 12 shows the active employee dental premiums per pay period.

Active Dental Premiums per Pay Period (26 pay periods)*				
Plan	**Tier**	**Employee Premium**	**State Premium**	**Total Premium**
DPPO	Employee only	$14.30	$2.29	$16.59
	Employee + adult	$30.33	$4.58	$34.91
	Employee + child	$23.34	$4.58	$27.92
	Family	$48.26	$6.32	$54.58
DHMO	Employee only	$1.86	$2.29	$4.15
	Employee + adult	$3.72	$4.58	$8.30
	Employee + child	$3.50	$4.58	$8.08
	Family	$6.12	$6.32	$12.44

Table 12: Active Dental Premiums

Table 13 shows the retiree monthly dental premiums.

Retiree Monthly Dental Premiums		
Plan	**Tier**	**Premium**
DPPO	Employee only	$35.94
	Employee + adult	$75.63
	Employee + child	$60.48
	Family	$118.26
DHMO	Employee only	$8.99
	Employee + adult	$17.98
	Employee + child	$17.51
	Family	$26.97

Table 13: Retiree Dental Premiums

Dental Premium vs. Plan Cost

The 2013 contribution strategy for the dental plans resulted in employees paying 85% of the average monthly total premium, and the State paying the remaining 15%.

Figure 10, on page 22, shows how the average monthly premiums compared to the average monthly cost for active and retired members.

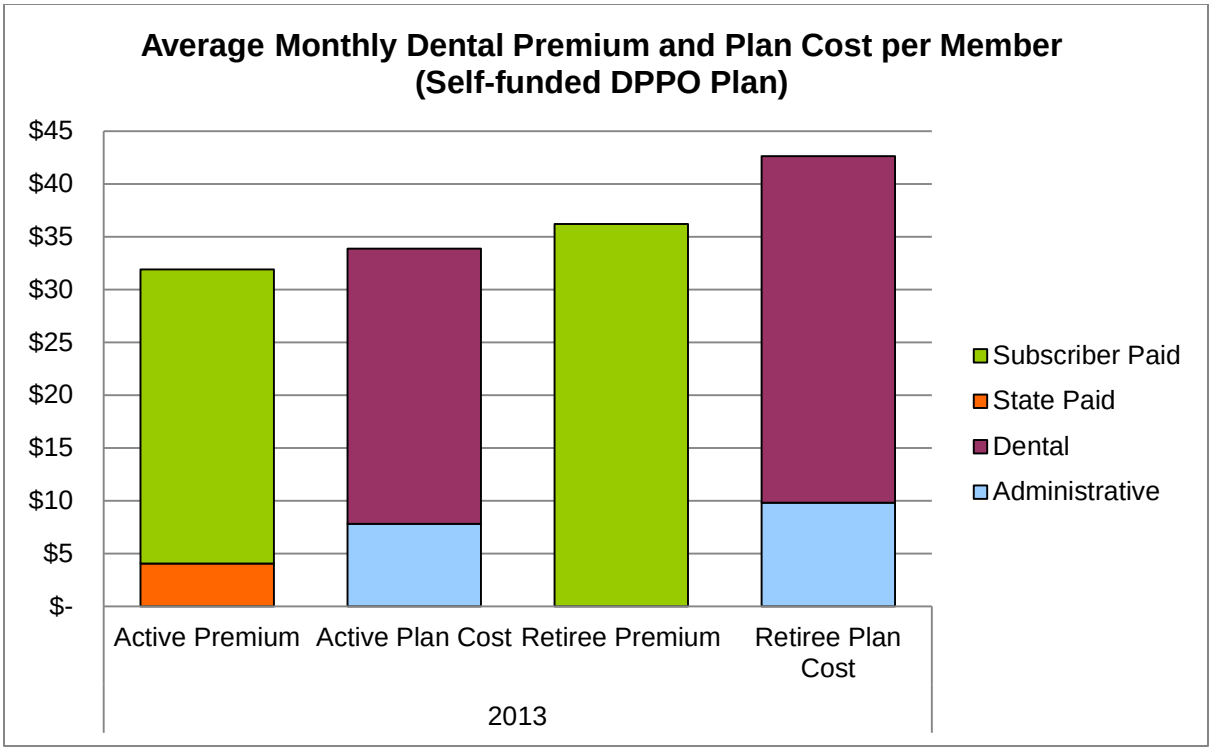


Figure 10: Average Dental Premiums & Expenses per Member

Expenses for Self-funded Dental Plan

The table below shows the distribution of dental claims and expenses incurred in PY 2013, and the average annual cost to insure each type of subscriber/member.

Self-funded Dental Expenses by Active, Retiree			
Expenses	**Overall**	**Active**	**Retiree**
Dental Claims	$30,847,795	24,002,179	6,845,616
Rebates & Recoveries	$ -		
Administration Fees	$ 1,408,610	1,096,017	312,593
Appropriated Expenses	$ 225,058	175,114	49,944
Total Expenses	$32,481,463	25,273,310	7,208,153
IBNR Liability	$ 7,600,000	5,913,439	1,686,561
Total	$40,081,463	$31,186,749	$8,894,714
Enrollment in self-funded plans			
Subscribers	45,958	34,743	11,215
Members	94,084	76,698	17,386
Annual cost			
Per subscriber	$ 872	$ 898	$ 793
Per member	$ 426	$ 407	$ 512

Table 14: Self-funded Dental Expenses by Active & Retiree

Wellness

ADOA Benefit Options Wellness provides services to State employees, retirees, and covered dependents as part of the benefits package. Members have access to preventive health screenings, health management and health education courses, annual flu vaccines, online stress management seminars, and Employee Assistance Program (EAP) benefits.

Table 15 shows the total utilization of the health screening benefit during PY 2013 and the number of at-risk employees referred for follow-up care.

PY 2013 Screenings			
	Events	**Participant*** **	**Referrals**
Mini Health Screening*	61	2,287	406
Osteoporosis Screening**		879	13
Prostate Specific Antigen (PSA)**		157	8
Facial Skin Analysis**		1,523	57
Mobile Onsite Mammography	59	1,158	37
Prostate Onsite Projects	30	432	69
Total	150	6,436	590

Table 15: PY 2013 Wellness Screenings

** The basic Mini Health Screening includes; full lipid panel, fasting blood glucose, blood pressure, BMI, and body composition.*

*** Optional tests offered as a package with the basic Mini Health Screening.*

**** Participants are not unique.*

Table 16 shows the total utilization of the 2013 Annual Flu Vaccine Program held October through December. Wellness provided a total of 12,624 vaccines to employees and dependents who met eligibility requirements. Members had access to the flu vaccine at a total of 635 locations, both at the worksite and at publicly held clinics. This is almost double the amount of total flu vaccine locations that were available in 2012. A total of 95.9% of members who received a flu vaccine did so at a worksite location, and 10,497 flu shot recipients held active employee status.

PY 2013 Flu Vaccines		
	Locations	**Participants**
State Agency Worksite	127	9,198
University Worksite	13	157
Combined Worksite (Wesley Bolin)	4	1,481
Open Enrollment Clinics	5	517
Public Clinics	486	1,271
Total	635	12,624

Table 16: PY 2013 Flu Vaccines

Table 17, on page 24, shows the utilization of the Employee Assistance Program (EAP) and support services offered to agencies covered under the Arizona Department of Administration. Total utilization for 2013 reached over 32%, showing sustained high usage especially when compared to the 17.5% national standard for government entities. ADOA covered agencies continue to show utilization higher than our EAP

vendor's Book of Business, and has seen a consistent increase in the past 5 years from 19% in 2009 to 32% in 2013.

PY 2013 EAP Utilization			
	Eligible Population	**Users**	**Utilization Rate**
Live Telephonic Access		2,040	8.8%
EAP Counseling		1,550	6.7%
FamilySource		115	0.5%
FinancialConnect		73	0.3%
LegalConnect		302	1.3%
On-line Access		4,829	20.8%
EAP Counseling		754	3.2%
FamilySource		1,099	4.7%
FinancialConnect		432	1.9%
GlobalConnect		9	0.0%
Health & Wellness		682	2.9%
LegalConnect		1,853	8.0%
Critical Incident Stress Debriefing		285	1.2%
Trainings		364	1.6%
Overall Utilization	23,232	7,518	32.4%

Table 17: PY 2013 Employee Assistance Program Utilization

In addition to health screenings, vaccines, and EAP services, the PY 2013 Wellness strategic plan provided employees access to online mindfulness and stress reduction opportunities through a first-year pilot with eMindful, Inc. The purpose of the pilot was to gain feedback from members regarding the online platform and program details in order to better serve them with this new type of wellness programming. Overall feedback of eMindful and its programming was positive and this contract continues in 2014. Table 18 shows the class series held during PY 2013 and total participation.

PY 2013 Health Management Courses		
	Classes	**Participants**
On-Line Courses: Mindfulness at Work (12 weeks)	12	231
Total	12	231

Table 18: PY 2013 Health Management Courses

The Wellness strategic plan continues to progress as scheduled. Wellness achievements for PY 2013 included, most notably, an increased EAP utilization, implementation of the eMindful contract and web-based wellness programming for all State employees, initiation of a new onsite health education class contract to address various health needs of employee groups, and increased offerings of flu clinics to eligible recipients throughout the State, making this benefit even more accessible to employees in rural areas.

Life, Disability, Vision Insurance, and Flexible Spending Accounts Premiums

Fund 3035, ERE/Benefits Administration, is used to pay insurance premiums and administer State employee benefit plans other than health and dental. Vision, supplemental, dependent, and short-term disability insurance, and flexible spending are funded solely by employee premiums. Basic life and non-ASRS long-term disability insurance are funded solely by employer premiums. Fund 3035 is primarily a pass-through fund with collections funding the insurance vendor premium payments.

ERE/Benefits Administration Fund Summary				
				PY 2013
Prior Balance December 31, 2012				**$ 3,410,911.15**
Revenues				**$ 35,250,346.13**
Insurance Product	**Amount**			
Basic Life	1,381,847.17			
Supplemental Life	11,130,981.56			
Dependent Life	2,592,684.67			
Short Term Disability	7,557,615.25			
Long Term Disability	2,901,440.81			
Total Life & Disability	25,564,569.46			
Vision	5,005,426.20			
Health Care FSA	3,480,700.95			
Dependent Care FSA	1,199,649.52			
Total Flex Spending	4,680,350.47			
Total Revenues	35,250,346.13			
Expenditures				**$ 34,929,454.47**
Insurance Product	**Amount**	**Penalties**		
Basic Life	1,375,724.57			
Supplemental Life	11,119,803.75			
Dependent Life	2,580,492.42			
Short Term Disability	7,506,770.15			
Long Term Disability	2,890,080.26			
Total Life & Disability*	25,472,871.15	-		
Vision*	4,976,653.03	(2,500.00)		
Health Care FSA	3,245,229.85			
Dependent Care FSA	1,117,163.98			
Administrative Fees*	118,422.00	(485.54)		
Total Flex Spending	4,480,815.83	(485.54)		
GAO AFIS Cost	2,100.00			
Total Expenditures	34,932,440.01	(2,985.54)	34,929,454.47	
Ending Balance December 31, 2013				**$ 3,731,802.81**

Table 19: ERE/Benefits Administration Fund Summary

**Vendor administrative fees and fully insured premiums are paid 55 days in arrears per contract.*

Vendor Performance Standards

Pursuant to A.R.S. § 38-658(B), “On or before October 1 of each year, the Director of the Department of Administration shall report to the Joint Legislative Budget Committee 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 and other contracts for the Benefit Options program are a number of ADOA-negotiated performance measures with specific financial guarantees tied to vendor performance of the contracted services. If a vendor fails to meet any of the measures within the specified performance range, the vendor is required to submit a Corrective Action Plan detailing why the measure was missed and any actions taken to address the issue and improve performance to meet the standard of the measure. A percentage of the vendor’s annual payment, or previously agreed upon amount, is then withheld by ADOA as a performance penalty per the terms of the vendor contract. This percentage is allocated among the more critical measures of the contract.

The following is a report of the agreed-upon performance standards both met and missed by contracted vendors during PY 2013. In each case, performance penalties for measures missed are assessed per the terms of the individual vendor contract.

Aetna		
Successfully Met Performance Measures		
Fees At Risk		**Performance Measure**
23.00% of Total Administrative Fee		Customer Service - 63 of 72 targets Claims Adjudication - 52 of 60 targets Appeals, Open Enrollment, Administration, Reporting, Medicare Administration & Survey – all 98 targets
16.50% Medical Management Fee		Disease Management - 16 of 20 targets, pending results on 1 target Medical Management – all 6 targets
3.50% Case Management Fee		Case Management – 1 target
Performance Measures Not Met		
Percent of Fees at Risk	**Total Percent Assessed Based on Reporting Frequency**	**Performance Measure**
1.00%	Missed 3 months of 12 months measured = 0.25%	Customer Service: average speed to answer call <30 seconds.
1.00%	Missed 5 months of 12 months measured = 0.42%	Customer Service: first call resolution 90% or greater.
1.00%	Missed 1 month of 12 months measured = 0.08%	Customer Service: 97% telephone call quality.
0.50%	Missed 1 month of 12 months measured = 0.04%	Claims Adjudication: 98% of all fully documented claims received will be processed within 30 calendar days
1.00%	Missed 4 months of 12 months measured = 0.33%	Claims Adjudication: 98.2% of claims dollars submitted for payment will be accurately processed and paid.
1.00%	Missed 3 months of 12 months measured = 0.25%	Claims Adjudication: 96% of all claims will be processed accurately.
0.75%	Missed 2 of 2 semi-annual measurements = .75%	Disease Management: clinical improvements for each program will be agreed to and monitored; CAD/PAD members have had their cholesterol monitored in the past 12 months, up to a 75% target.
0.75%	Missed 2 of 2 semi-annual measurements = .75%	Disease Management: clinical improvements for each program will be agreed to and monitored; Post myocardial infarction (MI) Post-MI members using beta blockers in the past 12 months up to a 75% target.

Vendor Performance Measures 1: Aetna

Cigna		
Successfully Met Performance Measures		
Fees At Risk		**Performance Measure**
15.20% of Total Administrative Fee		Customer Service - 70 of 72 targets Appeals – 33 of 36 targets Reporting – 28 of 29 targets Claims Adjudication - 47 of 48 targets, pending results on 1 target Open Enrollment, Administration & Survey - all 38 targets
7.00% Medical Management Fee		Medical Management – all 16 targets
8.00% Case Management Fee		Case Management – all 12 targets
7.00% Disease Management Fee		Disease Management – all 24 targets
5.00% Nurse Line Fee		Nurse Line – 10 of 12 targets
Performance Measures Not Met		
Percent of Fees at Risk	**Total Percent Assessed Based on Reporting Frequency**	**Performance Measure**
0.25%	Missed 2 months of 12 months measured = 0.04%	Customer Service: contractor will respond to 95% or more of all routine customer service telephone inquiries within 5 calendar days.
0.33%	Missed 1 month of 12 months measured = 0.03%	Appeals: 100% of written appeals resolved in 15 calendar days after receipt of participant's request for review in the case of pre-service claims.
0.33%	Missed 2 months of 12 months measured = 0.05%	Appeals: 100% of written appeals resolved in 45 calendar days after receipt of participant's request for review in the case of post-service claims.
0.25%	Missed 1 month of 12 months measured = 0.03%	Reporting: contractor will deliver its monthly reports to the ADOA within 30 calendar days from the end of the month.
0.50%	Missed 1 month of 12 months measured = 0.04%	Claims Adjudication: 97% of all 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.
2.50%	Missed 2 quarters of 4 quarters = 1.25%	Nurse Line: abandonment rate <5%.

Vendor Performance Measures 2: Cigna

UnitedHealthcare		
Successfully Met Performance Measures		
Fees At Risk		**Performance Measure**
18.55% of Total Administrative Fee		Claims Adjudication - 59 of 60 targets Customer Service, Appeals, Reporting, Open Enrollment, Administration & Survey - all 164 targets
6.50% Medical Management Fee		Medical Management – all 13 targets
8.50% Case Management Fee		Case Management – all 16 targets
5.00% Disease Management Fee		Disease Management – all 22 targets
5.00% Nurse Line Fee		Nurse Line - all 12 targets
Performance Measures Not Met		
Percent of Fees at Risk	**Total Percent Assessed Based on Reporting Frequency**	**Performance Measure**
2.00%	Missed 1 month of 12 months measured = 0.17%	Claims Adjudication: 99.3% of claims dollars submitted for payment will be accurately processed and paid.

Vendor Performance Measures 3: UnitedHealthcare

AmeriBen		
Successfully Met Performance Measures		
Fees At Risk		**Performance Measure**
15.00% of Total Administrative Fee		Customer Service – 71 of 72 targets Administration – 27 of 28 targets Claims Adjudication – 59 of 60 targets Appeals, Open Enrollment, Reporting, Survey & Medicare Administration – all 68 targets
Performance Measures Not Met		
Percent of Fees at Risk	**Total Percent Assessed Based on Reporting Frequency**	**Performance Measure**
0.10%	Missed 1 month out of 12 months measured = 0.01%	Customer Service: contractor will acknowledge all correspondence (inquiries and requests) within 2 working days and resolve 95% or more within 30 calendar days of receipt.
0.50%	Missed 1 month out of 12 months measured = 0.04%	Administration: contractor will mail appropriate plan descriptive material to participants within 2 calendar days of receiving a request.
0.75%	Missed 1 month out of 12 months measured = 0.06%	Claims Adjudication: 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 processed within 10 calendar days after they are received.

Vendor Performance Measures 4: AmeriBen

American Health Holding		
Successfully Met Performance Measures		
Fees At Risk		**Performance Measure**
21.00% of Total Administrative Fee		Reporting – 24 of 25 targets Implementation, Systems & Survey - all 19 targets
5.00% of Disease Management Fee		Disease Management – all 16 targets
10.00% of Case Management Fee		Case Management – all 16 targets
10.00% of Preadmission Certification Fee		Utilization Management – 2 targets
5.00% of Nurse Line Fee		Nurse Line - all 12 targets
Performance Measures Not Met		
Percent of Fees at Risk	**Total Percent Assessed Based on Reporting Frequency**	**Performance Measure**
1.00%	Missed 1 month of 12 months measured = 0.08%	Reporting: contractor will submit monthly reports within 15 calendar days following the end of the reported month.

Vendor Performance Measures 5: American Health Holding

MedImpact		
Successfully Met Performance Measures		
Fees At Risk		**Performance Measure**
Fixed Amounts Totaling $1,500,000		Network Management, Eligibility, Claims/Paper, Claims/Mail Order, Customer Service, Survey, Account Management, Implementation, Reporting & Generic Substitution/Utilization - all 112 targets
Performance Measures Not Met		
Fees At Risk	**Total Amount Assessed Based on Reporting Frequency**	**Performance Measure**
		No measures missed

Vendor Performance Measures 6: MedImpact

Delta Dental		
Successfully Met Performance Measures		
Fees At Risk		**Performance Measure**
28.92% of Total Administrative Fee		Account Management, Administration, Appeals, Claims Adjudication, Customer Service, Open Enrollment, Network Management, Reporting & Satisfaction – all 258 targets
Fixed Amounts Totaling $50,000		Implementation – all 4 targets
Performance Measures Not Met		
Percent of Fees At Risk	**Total Amount Assessed Based on Reporting Frequency**	**Performance Measure**
		No measures missed.

Vendor Performance Measures 7: Delta Dental

Total Dental Administrators		
Successfully Met Performance Measures		
Fees At Risk		**Performance Measure**
15.50% of Total Premiums Paid		Customer Service – 46 of 48 targets Account Management, Administration, Appeals, Implementation, Open Enrollment, Network Management & Reporting – all 87 targets
Performance Measures Not Met		
Percent of Fees At Risk	**Total Amount Assessed Based on Reporting Frequency**	**Performance Measure**
0.25%	Missed 2 months of 12 months measured = 0.04%	Customer Service: average speed to answer call <=30 seconds.
2.00%	Missed 1 of 1 annual measure = 2.00%	Satisfaction: no less than 80% overall member satisfaction on annual survey.

Vendor Performance Measures 8: Total Dental Administrators

ComPsych		
Successfully Met Performance Measures		
Fees At Risk		**Performance Measure**
17.00% of Total Administrative Fee		Customer Service – 19 of 20 targets Reporting, Program Administration & Survey – all 18 targets
Performance Measures Not Met		
Percent of Fees at Risk	**Total Percent Assessed Based on Reporting Frequency**	**Performance Measure**
3.00%	Missed 1 quarter of 4 quarters measured = 0.75%	Customer Service: member call abandonment Rate <3%

Vendor Performance Measures 9: ComPsych

Avesis		
Successfully Met Performance Measures		
Fees At Risk		**Performance Measure**
Fixed Amounts Totaling $84,333.32		Call Center - met 34 of 36 targets Implementation, Reporting, Network Management, Claims Administration, Appeals & Survey - all 79 targets
Performance Measures Not Met		
Fees At Risk	**Total Amount Assessed Based on Reporting Frequency**	**Performance Measure**
$2,500	Missed 2 month out of 12 months measured = $416.67	Call Center: 90% of all calls requesting a member services representative will be answered in 30 seconds or less.

Vendor Performance Measures 10: Avesis

Application Software Inc. (ASI)		
Successfully Met Performance Measures		
Fees At Risk		**Performance Measure**
33.10% of Total Administrative Fees		Administration – 6 of 8 targets Claims Adjudication – met 15 of 16 targets Customer Service, Reporting & Implementation – all 25 targets
Performance Measures Not Met		
Percent of Fees at Risk	**Total Percent Assessed Based on Reporting Frequency**	**Performance Measure**
2.50%	Missed 2 quarters of 4 quarters measured = 1.25%	Administration: contractor will distribute materials to participants within 5 calendar days.
2.50%	Missed 1 quarter of 4 quarters measured = 0.75%	Claims Adjudication: 100% of claims will be processed within five working days.

Vendor Performance Measures 11: Application Software Inc.

The Hartford		
Successfully Met Performance Measures		
Fees At Risk		**Performance Measure**
7.28% of Total Premiums Paid		Financial Payment – 11 of 12 targets Report Timeliness – 15 of 17 targets Implementation, Survey, Quality of Service, Appeals & Claimant Notification – all 75 targets
1.25% of Total STD Premiums Paid		Short Term Disability Processing – all 36 targets
0.50% of Total LTD Premiums Paid		Long Term Disability Processing – all 2 targets
1.00% of Total Life Premiums Paid		Life Claims Processing – all 13 targets
Performance Measures Not Met		
Percent of Fees at Risk	**Total Percent Assessed Based on Reporting Frequency**	**Performance Measure**
0.25%	Missed 1 month out of 12 months measured = 0.02%	Financial Payment: maintain accuracy of 98% (defined as the total paid dollars) reviewed minus the sum of the errors identified divided by the total paid claim dollars audited, expressed as a percentage.
0.17%	Missed 2 months out of 12 months measured = 0.03%	Report Timeliness: contractor will submit monthly reports within 30 calendar days after the close of month.

Vendor Performance Measures 12: The Hartford

Audit Services

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

During PY 2013, 33 audit projects were completed to ensure the Benefit Options vendors provided contracted services appropriately. The audit schedule for PY 2013 was developed using a combination of contract elements and risk analysis. The 33 audit projects resulted in 23 recommendations, 17 of which were fully implemented by the end of the year, and resulted in $143,574.17 of identified recoverable overpayments.

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.

Table 20 is a summary of the functional areas in which audits were completed and the corresponding audit methodology.

Audit Services Summary	
Functional Area	**Audit Methodology**
Vendor operating transactions	Statement on Standards for Attestation Engagements No. 16 Audits ("SSAE 16") Evaluation of external audit results
Vendor execution of benefit design and contract elements	Plan Implementations Plan Allowances/Exclusions ("A&E") Plan Authorizations Claims adjudication compliance Inquiries (i.e., research, plan coverage design, etc.)
ADOA accuracy of shared data	Dependent Eligibility Audit (DEA)
Audit program improvement initiatives	Performance Guarantees Quality management standards Vendor Report Card Administrative functions and program-specific improvements

Table 20: Audit Services Summary

Vendor Operating Transactions

All Benefit Options contracted vendors that pay claims are required to provide a copy of an SSAE 16, which is an independently assessed operational annual audit. SSAE 16 audits evaluate the internal control of the vendor's systems utilized to adjudicate claims and identify deficiencies. Audit Services reviewed the SSAE 16 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. In addition, audits performed by external or third party vendors were evaluated and considered for the development of the audit schedule when there is significant impact on the Benefit Options program and contract compliance (i.e. large medical and/or pharmacy claims audit).

Vendor Execution of Benefit Design and Contract Elements

Plan implementation audits are completed annually for new, deleted, or revised plan design elements. Implementation audits are designed to measure compliance with new and/or revised plan elements as they are executed at the start of a new plan year. Plan elements may include revisions to language in the plan document, vendor system edits (claim adjudication), plan allowances/limitations, internal controls, etc. Audit results for 2013 indicated that, in some cases, claims for compression garments, wigs/hair pieces, and amino acid based formulas were not adjudicated properly. Additionally, some thresholds were not applied to hearing aids and durable medical equipment. Estimated recoverable overpayments of $13,318.79 were identified.

Plan allowance/exception (A&E) audits are designed to evaluate whether the contracted vendors' systems were set up correctly in compliance with Benefit Options' plan design. A&E audit findings for PY 2013 indicated that plan limitations and restrictions were processed accurately and members received the benefits allowed to them as defined in the plan description with the exception of two coverage elements. Chiropractic allowance and excluded biofeedback treatment were erroneously adjudicated. Impact reports identified recoverable overpayments of $2,347.20.

Plan authorization reviews are conducted to ensure contracted vendors implement operational changes, language revisions, and claim payment exceptions in an accurate and timely manner. A plan authorization is an agreement between ADOA and the contracted vendor to revise a process or operating standard and may be initiated by either party. Results for 2013 indicated that plan authorizations were correctly implemented and no corrective action was required.

Claims adjudication compliance audits are performed to evaluate the contracted vendors' adherence to regulatory guidelines, current operating standards, contractual elements, vendor performance, and/or plan authorization documents. During PY 2013, an end-stage renal disease (ESRD) audit was conducted to follow up the initial evaluation completed in 2012 of the medical vendors' accuracy of primary and secondary payer status. The follow up audit identified $127,908.18 of recoverable overpayments.

ADOA Accuracy of Shared Data

Dependent eligibility audits are performed annually on the Benefit Options program membership. The eligibility audits provide assurance that dependent eligibility is monitored effectively and the risk of claims paid on behalf of ineligible dependents minimized. The results of the 2013 eligibility audit indicated 2 ineligible individuals enrolled in the plan and who were receiving benefits erroneously due to system limitations. Additionally, 2 different dependents received benefits due to unreported or untimely filing of qualified life events. Finally, 6 dependents who received benefits were removed from the plan because the subscribers did not provide documentation supporting their dependent statuses.

Appendix

Table A: Special Employee Health Fund Cash Statement

					PY 2013
Prior Balance December 31, 2012				$	276,902,422.88
Revenues				$	810,147,182.95
Source	Premiums	Reductions			
ADOA Health Plan (EE)	134,147,242.76				
ADOA Health Plan (ER)	601,734,579.25				
BCBS NAU Plan (EE)	6,634,740.19				
BCBS NAU Plan (ER)	27,064,992.08				
ADOA Dental Plan (EE)	31,665,258.39				
ADOA Dental Plan (ER)	5,235,190.50				
PrePaid Dental Plan (EE)	1,771,282.67				
PrePaid Dental Plan (ER)	1,730,163.48				
Other Revenue	163,733.63				
Net Revenue	810,147,182.95	0.00	810,147,182.95		
Expenditures				$	803,851,668.61
Vendor	Admin Fees	Penalties			
AHH Medical Management	1,177,437.76	0.00			
Aetna	2,659,200.61	(18,258.58)			
Cigna	2,382,069.35	(17,496.10)			
UnitedHealthcare	13,434,992.10	(49,737.50)			
AmeriBen	4,022,709.93	(3,406.03)			
MedImpact	1,066,661.50	(200,000.00)			
Delta Dental	1,408,609.62	0.00			
Other Fees**	659,400.59				
AG Collection Fees	2,794.29				
Net Administrative Fees***	26,813,875.75	(288,898.21)	26,524,977.54		
	Claims	Recoveries*			
Harrington	0.00	(84,560.50)			
Aetna	30,013,939.89	0.00			
Cigna	42,885,856.15	(376.58)			
UnitedHealthcare	328,079,667.02	(41,573.08)			
AmeriBen	103,979,651.94	(707,891.39)			
Other Wellness	649,169.50				
MedImpact	125,985,242.94	(6,937,164.83)			
Delta Dental	33,437,510.58	0.00			
Medicare Part D Retiree Drug Subsidy		(1,982,399.22)			
Early Retiree Reinsurance Program		4,559.23			
Net Claims	665,031,038.02	(9,749,406.37)	655,281,631.65		
Self-Insured Expenditures			*681,806,609.19*		
	Premiums	Penalties			
BCBS (NAU Only)	32,340,627.85				
Delta Dental	3,186,760.40				
Total Dental Administrators	3,523,302.50	(9,314.08)			
*Fully Insured Expenditures****	*39,050,690.75*	*(9,314.08)*	*39,041,376.67*		
HITF Operating	4,403,539.75		4,403,539.75		
Fund Transfers Out^	73,496,000.00		73,496,000.00		
Federal Participation Reimbursement	5,104,143.00		5,104,143.00		
NET EXPENDITURES	813,899,287.27	(10,047,618.66)	803,851,668.61		
Fund Balance December 31, 2013				$	283,197,937.22
IBNR Liability (Medical & Dental)				$	104,400,000.00
Contingency Reserve (Medical & Dental)				$	104,400,000.00
Unrestricted Cash Balance As Of December 31, 2013				$	74,397,937.22

**Recoveries include prescription drug rebates, overpayment recoveries (including stop payments and voids), subrogation recoveries, etc. **Other Fees include HSA Administration, surcharges by other states (MA, MI, NYHCR), and legal fees. ***Vendor administrative fees and fully insured premiums are paid 55 days in arrears per contract. ^Interfund transfers from HITF to other State operating funds. Future transfers include $53.9 million pursuant to Laws 2014, Chapter 18, Sec. 139 (HB2703 2014-2015; general appropriations) for fiscal year 2015.*

Glossary of Terms

Active member(s) – An employee and their eligible dependents, as defined in the Arizona Administrative Code, who are 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, MI 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 by an insured member 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 that a member pays during the plan year, before the health plan starts to make payments for covered medical services.

Dependent – An unmarried child or a spouse of the employee who meets the conditions established by the relevant plan description.

DHMO/Pre-Paid Dental – A dental plan that offers members dental services with no annual maximums or claim forms, and services based on a discounted rate. Total Dental is the current prepaid dental vendor.

DPPO – A dental plan, with an in-network and out-of-network coinsurance structure, that allows members to visit any dentist. There is an annual deductible, and maximum annual benefit of $2,000 per member per year for dental services. The current administrator for the DPPO plan is Delta Dental.

Disease management – A comprehensive, ongoing, and coordinated approach to achieving desired outcomes for a population of patients. These outcomes include improving members' clinical conditions and qualities 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 – The process for a member to request a review of a health plan decision regarding a claimant's qualifications for, or entitlement to, benefits under a plan.

Employee – As defined in the Arizona Administrative Code who works for the State of Arizona or a State university.

Exclusive Provider Organization (EPO) – A health plan designed with an exclusive provider organization or network. Enrollees are limited to access in-network providers and are subject to co-pays. 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 and put 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 brand-name drugs. The most cost-effective brand-name drugs are placed in the "preferred" category and all other brand-name drugs are placed in the "non-preferred" category.

Fully-insured – An insurance model wherein a commercial insurer collects premiums, pays claims for services, and takes the risk of revenue to expense. Benefit Options may collect the premiums for transfer to the commercial insurer.

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 – A health plan operation administered by one entity. Such 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 must 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 to members. Contract terms include agreed upon fee arrangements for services and performance standards.

Non-integrated – A health plan with operations administered 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 – Defined as the period of January 1 through December 31 of a given year.

Preferred Provider Organization (PPO) – A health plan designed with a preferred provider organization or network. Enrollees have access to in-network and out-of-network providers, and are subject to co-pays, or co-insurance, and annual deductibles. Out-of-network providers require greater copays.

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

Retiree – A former State of Arizona employee, State university employee, officer, or elected official who is retired under a State-sponsored retirement plan. For reporting purposes, this term encompasses both actual retirees and their dependents.

Self-funded – An 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 – A dependent legally married to an employee or a retiree, as defined by the Arizona Revised Statutes.

Stop-loss – A form of insurance for self-insured employers that limits the amount that the employer, as primary insurer, will pay for medical expenses.

Subscriber – An 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 claims, compiling and producing management reports, and providing customer service.

Utilization management – The evaluation of appropriateness and efficiency of health care services procedures and facilities according to established criteria or guidelines and under the provisions of an applicable health benefits plan.

Utilization review – A process whereby an insurer evaluates the appropriateness, necessity, and cost of services provided.

Utilizer – A member who receives a specific service.

Arizona Department of Administration
Human Resources Division
100 N. 15th Avenue, Suite 261
Phoenix, Arizona 85007

Telephone: 602-542-5482