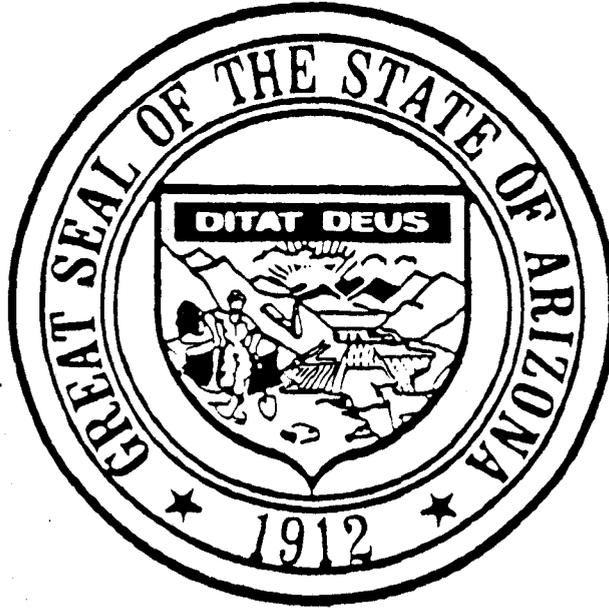


*Mark Bogart
Minority Research*

**LEGISLATIVE OVERSIGHT
HEALTH INSURANCE BENEFITS
REVIEW COMMITTEE**



FINAL REPORT

December 1993

TABLE OF CONTENTS

Final Report	Page 1
Background	page 1
Composition	page 1
Proceedings	page 3
Recommendations	page 6
Attachments	A through N
Statutory Authority	Attachment A
Meeting Notice/Minutes of 10/28/93 meeting	Attachment B
Meeting Notice/Minutes of 11/30/93 meeting	Attachment C
Excerpts from Auditor General's Performance Audit of DOA Personnel Division	Attachment D
Overview of State of Arizona Health Insurance Benefits	Attachment E
Claims Audit of Interflex	Attachment F
Intergroup's Response to Claims Audit	Attachment G
Correspondence from AAUP	Attachment H
DOA's Response to AAUP	Attachment I
Intergroup's Response to AAUP	Attachment J
DOA Materials Comparing Urban and Rural State Employee Health Insurance	Attachment K
Description/Historical Overview of Retiree Health Insurance Program	Attachment L
DOA Materials Concerning Retiree Health Insurance Coverage	Attachment M
Letter Requesting Attorney General's Opinion Regarding Reblending Issue	Attachment N

**LEGISLATIVE OVERSIGHT
HEALTH INSURANCE BENEFITS
REVIEW COMMITTEE**

FINAL REPORT

Background

Laws 1993, Chapter 176 established the Legislative Oversight Health Insurance Benefits Review Committee to consider issues concerning state employee health insurance coverage, including issues relating to the size of the risk pool and the type of coverage provided to active and retired state employees.

In addition to the Committee's prescribed on-going statutory duties, the Committee was charged with reporting the legislature on the following issues before December 31, 1993:

1. the feasibility of grouping former state employees or former elected officials or their dependents with officers and employees of this state and its departments and agencies or the dependents of these employees as necessary to obtain health and accident coverage at favorable rates;
2. any discrepancies between insurance plans offered in rural and urban counties and methods to minimize or eliminate such discrepancies;
3. methods to allow former employees who terminated insurance coverage provided by the Department of Administration between August 1, 1992 and December 31, 1992 to re-enroll for the same or similar coverage in one of the insurance programs provided by DOA; and
4. the feasibility of allowing any AHCCCS provider to respond to any request for proposals or for bids initiated by DOA to procure health and accident coverage for full-time officers and employees of the State and its departments and agencies.

Composition

The Committee consists of the following 12 members:

House

Speaker (or designee) Rep. Brenda Burns

Minority Party Leader (or designee) Rep. Eden
Three members appointed by the Speaker,
each from different legislative districts
and no more than two from the same political
party, as follows:

One member from a legislative district
whose boundaries lie wholly within a
county with a population of at least
500,000 persons Rep. Conner*

One member from a legislative district
whose boundaries lie wholly or partially
within a county with less than 500,000
persons Rep. Ortega

One member from a legislative district
whose boundaries include a state
university Rep. Edens

(*Rep. Conner replaced Rep. Hershberger)

Senate

President (or designee) Senator Brewer

Minority Party Leader (or designee) Sen. Hardt

Three members appointed by the President,
each from different legislative districts
and no more than two from the same political
party, as follows:

One member from a legislative district
whose boundaries lie wholly within a
county with a population of at least
500,000 persons Sen. Soltero

One member from a legislative district
whose boundaries lie wholly or partially
within a county with less than 500,000
persons Sen. Springer

One member from a legislative district
whose boundaries include a state
university Sen. Hermon

One member appointed by the Board of Regents Prof. Williams

One member appointed by the Supreme Court Connie Butchee

Proceedings

The Committee held two public hearings for the purpose of considering the issues to be reported on before December 31, 1993, as follows:

October 28, 1993

The Committee's first public hearing focused primarily on the performance of Intergroup. One of the impetuses for legislation creating the Legislative Oversight Health Insurance Benefits Review Committee were complaints concerning the performance of Intergroup's Interflex program. Many state employees had selected coverage under Interflex with the impression it was an indemnity plan. They were dismayed to learn it is actually a hybrid plan with both managed care and traditional fee for service features. Additionally, legislators received numerous complaints about the quality of care received under the Intergroup/Interflex and about the discrepancies between coverage offered to state employees residing in metropolitan areas versus those residing in rural areas. Another common complaint was the issue of increasing health care costs.

Sandra Spellman, Senior Manager with Ernst and Young, presented a historical overview of health care trends for the Committee, noting that managed health care was the trend across the nation. Following Ms. Spellman's presentation, J. Elliott Hibbs, Director of the Department of Administration presented an overview of health insurance benefits offered to state employees. Mr. Hibbs noted that at the time he became director of DOA, the State was faced with three problems concerning health care coverage for state employees: 1) there was a lack of incentive for competitive bids; 2) employees were not required to make cost conscious decisions about their health coverage; and 3) there was not sufficient managed care options in rural communities. Mr. Hibbs went on to recount how these three problems affected decisions made at the time contracts were let for the current plan year and to discuss the coverage options available to state employees.

Mr. Hibbs acknowledged that there were indeed problems with Intergroup's Interflex program and that DOA was going to impose sanctions on Intergroup for failing to meet certain performance standards prescribed in their contract with the State. He explained that when setting the penalty amount, DOA had taken into consideration that there were mitigating circumstances surrounding Interflex's failure to meet certain performance standards. Mr. Hibbs also informed the Committee that DOA was going to submit a RFP for indemnity coverage for employees in Maricopa and Pima counties.

The Committee heard next from Gary Petersen, Consulting Actuary with the Wyatt Company, who summarized the Claims Audit of Interflex in which it was found Interflex had failed to meet certain performance standards specified in its contract with the State and which Mr. Hibbs had referenced in his remarks about imposing sanctions on Intergroup.

Rick Barrett, President and CEO of Intergroup Health Care Corporation, responded to the Claims Audit and to complaints rendered against Intergroup and the Interflex program, noting the following: 1) only 3% of state employees were in fact enrolled under the Interflex program; 2) the Interflex plan had in fact failed to meet the prescribed criteria, some of it through no fault of their own; 3) Intergroup will strive to make improvements where needed; and 4) Intergroup remains committed to providing the best health care at a reasonable cost.

The Committee heard next from Ruth Kolb Smith, Chairman of the Arizona Conference of the American Association of University Professors (AAUP) Benefits Committee. Mrs. Smith and other members of AAUP had a number of complaints and recommendations for improving the health care benefits offered state employees.

The major areas of complaint and resulting recommendations expressed by AAUP and other persons who testified on their own behalf were the following:

- 1) they requested a true indemnity plan be offered to all state employees and that the costs for this more expensive coverage be subsidized by the State and/or employees;
- 2) they wanted Intergroup to meet certain performance standards and to be sanctioned for not having done so previously;
- 3) they wanted quality of care standards prescribed in any contract for state employee health insurance;
- 4) they wanted state employees represented on all groups having input into decisions involving health insurance coverage for state employees; and
- 5) they requested better information be made available to state employees concerning their health insurance coverage.

[Refer to Attachment B for minutes of the October 28, 1993 meeting]

November 30, 1993

During the Committee's second public hearing, the Committee adopted recommendations based on testimony received at the October 28, 1993 meeting and

proceeded to receive testimony concerning other issues the Committee was charged with reporting on before December 31, 1993.

Bill Bell, Assistant Director of DOA's Personnel Division, gave an overview comparing health insurance benefits available to state employees in rural and urban counties. The Committee was charged with looking at this issue primarily because legislators had received complaints from state employees residing in both rural and metropolitan areas that their health insurance options were not the same nor even comparable. The Committee discussed how contracts are let (ie. on a statewide versus regional basis) and the merits and drawbacks of each approach.

The Committee next considered issues affecting health care coverage offered through DOA to retired state employees. This became an issue for consideration by the Legislature during the 1993 session and as a study item for this Committee as a result of a change in policy on the part of DOA concerning retirees whereby DOA decided to "unblend" retirees from the active pool for the purpose of procuring health insurance. DOA based its decision on the following: 1) statutory interpretation; 2) an informal Attorney General's opinion; 3) cost containment considerations; and 4) maintaining parity with other state retirees. [Note: Unlike other state retirees who received health insurance coverage under the program administered by ASRS, retirees receiving coverage through DOA were having their health care costs subsidized twice: a) their state retirement system was paying the prescribed subsidy amount; and b) state active employees were reportedly paying approximately \$4.6 M more in premiums to offset retirees' higher health insurance costs.] This change in policy resulted in substantially higher health insurance costs for state retirees receiving coverage and an outpouring of negative publicity with the call for legislative intervention.

Staff provided a description and historical overview of the Retiree Health Insurance Benefit Program established by the Legislature in 1988 to assist state retirees with their health insurance costs. [Refer to Attachment L] The Committee also heard from DOA and the Arizona State Retirement System (ASRS) concerning their coverage of state retirees. Based on testimony received, the Committee recommended "reblending" retirees with the active pool for the purpose of procuring health insurance coverage for state employees and further recommended that any retirees who were previously covered under DOA when the decision was made to separate retirees as a distinct group and who transferred to other coverage (either through the State or a private carrier) should be permitted to re-enroll under coverage administered by DOA. The Committee requested a formal opinion from the Attorney General's Office concerning the retiree reblending issue.

The Committee recommended deferring the final issue it was charged with looking at concerning AHCCCS and state employee health insurance until a later time.

[Refer to Attachment C for minutes of the November 30, 1993 meeting.]

Recommendations

The Committee made the following recommendations:

Recommendations based on October 28, 1993 meeting:

Re: Indemnity Coverage

1. DOA should offer an indemnity plan to all state employees.
2. State and/or employee subsidization of a more costly indemnity plan should remain an issue for further discussion by the Committee.

Re: RFP Process

1. Specific guidelines concerning quality of care should be included in any RFP concerning state employee health insurance coverage.
2. The Committee should be allowed to have input into determining the contents of an RFP for state employee health insurance coverage.
3. Public notification should be given of pre-bid conferences held to discuss state employee health insurance contracts.

Re: Contracts

1. DOA shall provide penalties for noncompliance of contract provisions/standards within the time periods specified in the contract.
2. Specific performance standards concerning quality of care should be included as part of the contract.
3. DOA shall provide quarterly reports on the performance of contracted insurers to the Committee for review.

Re: Information

1. DOA should provide better, more accurate information to state employees

about their coverage through the DOA health newsletter, seminars and other means.

2. State employees should be represented on all groups having input into any decisions regarding state employee health insurance coverage.

Re: Other Recommendations

1. DOA should examine the feasibility of expanding the two-tiered approach to coverage.
2. DOA should look into the feasibility of allowing larger quantity purchases of prescription medication by insurance subscribers.

Recommendations based on November 30, 1993 meeting

Re: Rural and Urban Coverage

1. DOA should solicit bids for state employee health insurance coverage on a statewide basis.

Re: Retiree Coverage

1. Retirees covered through DOA should be reblended with the active state employee pool.
2. A formal opinion from the Attorney General should be requested concerning the reblending issue.
3. Retirees who were previously enrolled under health insurance coverage offered through DOA at the time the decision was made to separate retirees as a distinct group and who transferred to other coverage (either through the State or a private carrier) should be permitted to re-enroll under coverage administered by DOA.

Re: AHCCCS Coverage

1. Discussion of this issue should be deferred to a later time.

Staff was asked to prepare legislation accordingly to implement the Committee's recommendations.

ATTACHMENT A
Statutory Authority

LEGISLATIVE OVERSIGHT HEALTH INSURANCE
BENEFITS REVIEW COMMITTEE

(A.R.S. 38-655)

(Authorized by Laws 1993, Chapter 176)

Laws 1993, Chapter 176:

Sec. 4. Title 38, chapter 4, article 4, Arizona Revised Statutes, is amended by adding section 38-655, to read:

38-655. Legislative oversight health insurance benefits review committee

A. The legislative oversight health insurance benefits review committee is established consisting of the following members:

1. The speaker of the house of representatives, or his designee.

2. The president of the senate, or his designee.

3. The leader of the minority party of the house of representatives, or his designee.

4. The leader of the minority party of the senate, or his designee.

5. Three members of the house of representatives who are appointed by the speaker of the house of representatives, no more than one of whom shall be from the same legislative district and no more than two of whom shall be members of the same political party. One member shall represent a legislative district whose boundaries lie wholly within a county with a population of five hundred thousand or more persons, one member shall represent a legislative district whose boundaries lie wholly or partially within a county with less than five hundred thousand persons and one member shall represent a legislative district whose boundaries include a state university.

6. Three members of the senate who are appointed by the president of the senate, no more than one of whom shall be from the same legislative district and no more than two of whom shall be members of the same political party. One member shall represent a legislative district whose boundaries lie wholly within a county with a population of five hundred thousand or more persons, one member shall represent a legislative district whose boundaries lie wholly or partially within a county with less than five hundred thousand persons and one member shall represent a legislative district whose boundaries include a state university.

7. One member appointed by the board of regents.

8. One member appointed by the arizona supreme court.

B. The speaker of the house of representatives and the president of the senate shall serve as cochairmen of the committee.

C. The committee shall meet at least once a year and may hold meetings at such times determined to be necessary by either cochairman or the cochairmen of the committee for the purpose of

considering issues concerning state employee medical and dental insurance coverage, including issues relating to the size of the risk pool and the type of coverage provided to state employees.

D. The director of the department of administration shall inform the committee of any changes being considered by the department with respect to a request for proposals for state employee medical and dental insurance coverage, including decisions affecting the size of the risk pool and the type of coverage provided to state employees.

E. The director of the department of administration shall brief the committee in executive session about the contract that the department intends to award for state employee medical and dental insurance coverage. Information provided in executive session shall remain confidential until the contract award is made in compliance with title 41, chapter 23.

F. Members of the committee appointed pursuant to subsection a, paragraphs 7 and 8 of this section, shall serve two year terms.

G. Members of the committee are not eligible to receive compensation for their services but are eligible to receive reimbursement for their expenses under chapter 4, article 2 of this title.

The Committee Terminates: Ongoing.

Sec. 5. Legislative oversight health insurance benefits review committee; additional duties; recommendations

A. In addition to the duties specified pursuant to section 38-655, Arizona Revised Statutes, as added by this act, the legislative oversight health insurance benefits review committee shall:

① Study and make recommendations to the legislature on the feasibility of grouping former state employees or former elected officials or their dependents with officers and employees of this state and its departments and agencies or the dependents of these employees as necessary to obtain health and accident coverage at favorable rates.

② Identify discrepancies between insurance plans offered in rural and urban counties and recommend to the legislature methods to minimize or eliminate such discrepancies.

③ Identify and recommend to the legislature methods to allow former employees who terminated insurance coverage provided by the department of administration between August 1, 1992 and December 31, 1992 to reenroll for the same or similar coverage in one of the insurance programs provided by the department of administration.

④ Study and make recommendations to the legislature on the feasibility of allowing any Arizona health care cost containment system provider to respond to any request for proposals or for bids initiated by the department of administration to procure health and accident coverage for full-time officers and employees of the state and its departments and agencies.

B. Recommendations made pursuant to subsection A of this section shall be submitted to the legislature on or before December 31, 1993. --

Section 5 of this act is repealed from and after January 1, 1994.

House Members Appointed April 1993.

Members:

1. (R) B. Burns Speaker, or designee, Cochair
2. (R) Brewer President, or designee, Cochair
3. (D) Eden House Minority Leader, or designee
4. (D) Hardt Senate Minority Leader, or designee

Three members of the house of representatives who are appointed by the speaker of the house of representatives, no more than one of whom shall be from the same legislative district and no more than two of whom shall be members of the same political party. One member shall represent a legislative district whose boundaries lie wholly within a county with a population of five hundred thousand or more persons, one member shall represent a legislative district whose boundaries lie wholly or partially within a county with less than five hundred thousand persons and one member shall represent a legislative district whose boundaries include a state university.

5. (R) Edens Representative
6. (R) Conner Representative
7. (D) Ortega Representative

Three members of the senate who are appointed by the president of the senate, no more than one of whom shall be from the same legislative district and no more than two of whom shall be members of the same political party. One member shall represent a legislative district whose boundaries lie wholly within a county with a population of five hundred thousand or more persons, one member shall represent a legislative district whose boundaries lie wholly or partially within a county with less than five hundred thousand persons and one member shall represent a legislative district whose boundaries include a state university.

8. (R) Springer Senator
9. (R) Hermon Senator
10. (D) Soltero Senator

11. Prof. Frank Williams Member appointed by the Board of Regents
12. Connie Butchee Member appointed by the Arizona Supreme Court

STAFF: Hardy

ATTACHMENT B

Notice/Minutes of 10/28/93 Meeting

ARIZONA STATE LEGISLATURE
INTERIM MEETING NOTICE

Open to the Public

LEGISLATIVE OVERSIGHT HEALTH INSURANCE BENEFITS REVIEW COMMITTEE

DATE: Thursday, October 28, 1993
TIME: 10:30 a.m.
PLACE: House Hearing Room 3
SUBJECT: Review of State Employee Health Insurance Benefits

AGENDA

1. Call to order
2. Discussion of committee's purpose and scope of first meeting
3. Presentation - Historical overview of health care trends
4. Presentation by DOA - Overview of state employee health insurance benefits
5. Presentation by the Wyatt Company, - Summary of the Claims Audit of Interflex
6. Presentation by Intergroup
7. Presentation by the American Association of University Professors, AZ Conference, Benefits Committee
8. Public Testimony
9. If time permits - Presentation by the Department of Administration comparing health insurance benefits offered state employees in rural and urban counties
10. Schedule next meeting
11. Adjourn

Senator Jan Brewer
Cochairman

Representative Brenda Burns
Cochairman

MEMBERS:

Senator Hardt	Representative Eden
Senator Hermon	Representative Edens
Senator Springer	Representative Conner
Senator Soltero	Representative Ortega
Connie Butchee, Supreme Court appointee	
Professor Frank Williams, Board of Regents appointee	

10/21/93

NOV 05 1993

ARIZONA STATE LEGISLATURE
Forty-first Legislature - First Regular Session

LEGISLATIVE OVERSIGHT HEALTH INSURANCE
BENEFITS REVIEW COMMITTEE

Minutes of Meeting
Thursday, October 28, 1993
House Hearing Room 3 - 10:30 a.m.

(Tape 1, Side A)

The meeting was called to order at 10:35 a.m. by Cochairman B. Burns and roll call was taken.

Members Present

Connie Butchee, Supreme Court Appointee
Representative Conner
Representative Edens
Senator Hardt
Senator Hermon
Representative Ortega
Senator Soltero
Senator Springer
Professor Frank Williams, Board of Regents Appointee
Representative B. Burns, Cochair

Members Absent

Representative Eden
Senator Brewer, Cochair (Excused)

Speakers Present

Sandy Spellman, Senior Manager, Ernst & Young
J. Elliott Hibbs, Director, Arizona Department of Administration (DOA)
Gary L. Petersen, Senior Consulting Actuary, The Wyatt Company
Rick Barrett, CEO, Intergroup Healthcare Corporation
Ruth Kolb Smith, Chair of the Benefits Committee, Arizona Conference of the American Association of University Professors, Tucson
Dr. John Sullivan, President and Medical Director, University Physicians, University Medical Center, Tucson
David Mendoza, Legislative Director, American Federation of State, County and Municipal Employees (AFSCME)
Jacqueline Sharkey, Vice Chair of the Benefits Committee, Arizona Conference of the American Association of University Professors (AAUP), Tucson
Susan Gallinger, Director, Department of Insurance (DOI), (submitted written note)

LEGISLATIVE OVERSIGHT HEALTH INSURANCE
BENEFITS REVIEW COMMITTEE
10/28/93

Norma Greer, Researcher, Benefits Committee, Arizona Conference of the American Association of University Professors (AAUP), Tucson
Dr. Carol Bernstein, President, American Association of University Professors (AAUP), Tucson
Anne Schutte, Faculty Associate, Arizona State University (ASU), Tempe, representing herself
Dr. Harvey A. Smith, Professor, Arizona State University (ASU), Tempe, representing himself
Dr. Mel Firestone, Associate Professor, Arizona State University (ASU), Tempe, representing himself
Robert E. McConnell, Tucson, representing himself
Jane Baez, Motor Vehicle Customer Service, Flagstaff, representing herself
Ruth Stokes, Tucson, representing herself
Vernette Fitzpatrick, Tucson, representing herself
Art Weese, Flagstaff, representing himself
Dr. Robert J. Letson, University of Arizona Retirees Association Legislative Committee, Tucson
Louise Muir, representing herself
Tedde Scharf, Associate Director, Disabled Resources, Arizona State University (ASU), Tempe
Jim Hemauer, Senior Program Coordinator, Arizona State University (ASU), Tempe
Sherry Santee, Physical Therapist, Tucson, representing herself
Carol Long, representing herself
Mary E. Green, Professor Emerita, Arizona State University (ASU), Tempe, representing herself
Dr. David W. Smith, Chair, Legislative Committee, University of Arizona, Tucson
Roger Carter, representing himself
Carole Dow, representing herself
Eli Kaminsky, Professor Emeritus of Political Science, Arizona State University (ASU), Tempe, representing himself
Christy Bison, Tempe, representing herself
Marianne Alcorn (submitted copy of remarks in lieu of testifying)

Guest List (Attachment 1)

PRESENTATIONS

Mrs. Burns stated that she anticipates this Committee in the future to meet on an annual basis, just prior to the signing of the contract for health insurance for State employees. She said that in the meantime, however, in order for the Committee to have a better understanding of what has transpired and future options available in health care coverage for State employees, today's meeting will include an overview of the changes being made in health care, a presentation by the Department of Administration (DOA) citing what health insurance is available to State employees, and public testimony from State employees about their concerns with Intergroup and Interflex.

Sandy Spellman, Senior Manager, Ernst & Young, with the aid of slides, presented a historical perspective and trends in managed care. She noted that in the 1930's Blue Cross and Blue Shield Plans were among the first to use the concept of insurance for health care. The national HMO (Health Maintenance Organization) Act of 1973 offered federal monies for development and operation of HMO's and

required employers to offer an HMO option to their employees. In 1982, Arizona became the first state in the nation to pass enabling legislation to provide managed care, which is the AHCCCS program (Arizona Health Care Cost Containment System). From that date until present, Arizona has seen an incredible increase in interest and penetration of managed care in the State, which is also indicative of what is happening around the country, and most of President Clinton's health care proposals include a managed care provision.

Ms. Spellman explained that in a managed care plan, health care providers assume the financial risk for offering health care services to their patients. If expenses exceed revenues, the managed care plan is at risk for the loss, which may be shared with the physicians and hospitals included in the arrangement. In an indemnity plan, the insurance company takes the sole financial risk. Ms. Spellman pointed out that the managed care plan increases provider incentive to control costs and offer health maintenance and preventative care for the patient. She added that most managed care plans use a primary physician for contact of care and said that statistics show that physician contacts in an HMO environment, per capita, rank more than 77 percent below those contacts in an indemnity plan. While the indemnity plan was once the most popular of the two (indemnity and managed care), by 1988 the number of people choosing an indemnity plan had decreased by 50 percent.

Ms. Spellman opined that the trend across the nation is toward managed health care. She said that there are many common elements among the various plans being considered by Congress. Among the most common is the managed care element. At this point, a managed care plan is the preferred option in President Clinton's plan. She said, too, that the trend in Arizona closely parallels national data, with the penetration of managed care ranking in the commercial sector from 30 percent to 60 percent, depending on what is included. She also noted that 100 percent of Medicaid patients enjoy managed care health insurance. Ms. Spellman stated that most of the national proposals, and President Clinton's in particular, provide for an in-plan and out-of-plan rate.

Mrs. Burns raised a concern that managed care plans lack incentives for good patient care. Ms. Spellman conceded that while this historically has been a concern shared by many, the cost containment element does require looking at the resource consumption side of the issue, and said that studies indicate that sometimes the over-abundance of medical services can be just as much a concern as a lack of service. She agreed, however, that patient care is of primary importance.

J. Elliott Hibbs, Director, Arizona Department of Administration (DOA), stated that DOA is very sensitive to the importance of the health benefits program, for both employees and the taxpayers of the State. He said that Bill Bell, Assistant Director, in charge of the Personnel Division; Mary Ann Knight, in charge of the Benefits/Insurance Unit; and Stuart Goodman, Legislative Liaison, are available to assist employees with any problems they have with their insurance coverage.

Mr. Hibbs said that in March 1992, when he assumed leadership of DOA, he found that the State had rapidly growing employee health insurance expenses, with a potential \$44 million increase in costs to be paid either by the State or its employees. There were three problems to be addressed at that time: 1) a lack

of incentive for competitive bids; 2) employees were not required to make cost conscious decisions about their health coverage; and 3) while there were some indications that there was some managed care in rural communities, that actually was not true. The result was a potential \$44 million increase at a time when the State was trying to balance the budget with limited revenues. He said that with some programs being cut and employees not receiving a pay increase, it was felt that employees would not be able to withstand a substantial increase in health care costs. Therefore, the State's health care contract was put out for bid. This provided competition among the various providers. The result of the new contract is that DOA has begun to manage rural health care costs more effectively than ever before and employees have now become responsible consumers of health care. By shifting to lower-cost programs, instead of an increase of \$44 million, employee health care premiums have become stabilized.

Mr. Hibbs explained that because the August 1 renewal date with an open-enrollment period held in June and July is inconvenient for many employees, the start date for the policy period has been changed to October 1 of each year, giving employees a better opportunity for making informed decisions. He added that in virtually every county in the State there is now an opportunity to enroll in an HMO plan. He noted, however, that the Flagstaff area is the only area in the State without an HMO opportunity.

Mr. Hibbs stated that through complaints received throughout the past year, DOA learned that coverage of durable medical equipment was omitted from the new contract with Intergroup. Intergroup has now restored that coverage and made it retroactive to the beginning of the plan. Mr. Hibbs reported that among other improvements to the plan under consideration is an expansion of the tiered system beyond the current two tiers for individual and family coverage. There are multi-tiered systems that can provide for individuals, two people (state employee and spouse), three people (state employee, spouse and child), etc. Also, DOA would like to invite bids on an indemnity program. Currently, there is no indemnity option for employees since Interflex is not a true indemnity program. Mr. Hibbs said that although providers were invited to bid on an indemnity program in the last bid process, no one did, so no contract was awarded for this option. He added that although DOA believes this option will be very high cost, the Department would like to be able to offer this plan to State employees. He assured the Committee that DOA will give serious consideration to any other options that may be recommended to improve the quality of the State health benefits program.

Mr. Hibbs commented on concerns that have been raised about the performance of the Interflex program. He noted that only 3 percent (1,388) of State employees are enrolled in this program. Mr. Hibbs cited the standards that must be adhered to by Interflex or risk assessment of penalties. Payment of claims must be paid within fourteen days, with a 95 percent accuracy rate on technical matters and 99 percent accuracy on dollar amounts of reimbursements. Mr. Hibbs said that for a period of time Interflex was not meeting these standards. According to an audit conducted by The Wyatt Company, Interflex was in violation of all of these standards for part or all of the plan year. However, DOA determined that there were mitigating circumstances that should be taken into consideration before penalties were assessed. There were some communication problems and problems in transferring employee information to the new program. There also

was the issue of coverage for durable medical equipment that had to be resolved and claims for those items that had to be reexamined. All of these things contributed to difficulties in getting the new program operational. DOA determined that it would be appropriate to assess penalties if the plan did not measure up to standards in the last six months of the year. The Wyatt Company audit revealed that during that last six months, two standards were not met for the full six months and three standards were not met for four of the six months. Mr. Hibbs said that DOA has informed Intergroup that penalties have been assessed for the violations in the Interflex plan. He added that DOA will continue to monitor Interflex and take whatever appropriate action is necessary to ensure that the standards in their contract are being adhered to.

Mr. Edens stated that he has gotten stacks of letters about the service being provided by Interflex. He admonished Mr. Hibbs that discussions involving the problems with Interflex have been going on since last December and said that he is concerned that it has taken until October 1993 for DOA to apply sanctions on Interflex for its violations of contract standards. He submitted that in order to represent both employees and the State in the best possible manner, it is important that DOA ensure that providers are in compliance with contract standards and DOA's reaction to contract violations be better than one year. He stressed that when the bid goes out for the new indemnity plan, providers must be advised that adherence to contract standards is expected or the provider will be penalized.

Mr. Hibbs responded that this is the first time that DOA has ever issued a penalty against a provider. He pointed out that DOA has met with Intergroup and discussed the problems that have occurred. He opined that Intergroup is concerned about the performance of the Interflex plan and has worked hard the past year to address the problems.

Mr. Edens reiterated that the State needs to set a pattern of enforcing contracts.

Mr. Ortega asked if the State has a basic benefits package that goes out to bid. Mr. Hibbs answered that while some specific levels of coverage are required, in order to give potential bidders an opportunity to submit innovative approaches, he thinks it is better to allow flexibility and invite bids on a variety of packages rather than restrict bidding to just one package.

Mr. Ortega asked Mr. Hibbs, in his role as Director of DOA, if he feels it is his role to implement public policy or determine public policy. Mr. Hibbs replied that he thinks he only has the ability to determine public policy in the areas the Legislature has given him the right to do so.

Senator Hardt protested Mr. Hibbs' statement that there are HMO plans in every county. Mr. Hibbs answered that according to the information DOA has, there is an HMO plan available in every county.

Senator Hardt said that he is concerned about why there aren't more bidders on the health benefits package. Mr. Hibbs said that while he doesn't know the reason in every case, in 1992, when the current contract went out to bid, it was at the same time that AHCCCS was gathering bids for their program. Many

companies were working on bidding the AHCCCS contract, so perhaps if the timing had been different, there may have been more bidders on the employee benefits package.

Senator Hardt asked Mr. Hibbs if any consideration has been given to allowing AHCCCS to bid on the employee benefits package. Mr. Hibbs responded that AHCCCS was given an opportunity to bid on the package in 1992. He said that while DOA is not suggesting moving State employees into AHCCCS, there may be an advantage in using the same type of insurance companies that provide their insurance coverage and in utilizing the expertise of AHCCCS people in negotiating contracts.

Mrs. Burns asked if the sanctions that have been applied to Interflex were for the full amount allowable under the contract. Mr. Hibbs answered affirmatively, saying that the penalty assessed to Interflex for the last six-month period was in the full amount allowable of \$51,839 under the terms of the contract.

Mrs. Burns asked Mr. Hibbs when the penalty payment is due. Mr. Hibbs replied that a letter was sent to Interflex notifying them that the penalty payment is due by November 15, 1993.

Mrs. Burns said that she, too, has gotten stacks of letters with heart-wrenching stories about the quality of care being provided by Interflex. She added that many people want the opportunity to have an indemnity plan, and said that she is pleased such a plan will be offered in the future. She also stated that a tiered system was suggested in some of the letters.

(Tape 1, Side B)

Mr. Conner raised the question of how employees are notified about the changes and programs available in the benefits package. Mr. Hibbs replied that DOA issued a newsletter containing information about the benefits that are available to State employees. He said that meetings were also held throughout the State and an Employees' Advisory Committee assists employees with questions about their insurance coverage.

Mr. Edens asked Mr. Hibbs for the amount of the annual premium paid to Intergroup. Mr. Hibbs said that while he doesn't have that information at this time, he will provide the amount to the Committee later.

Mr. Edens inquired as to how the Committee will keep abreast of problems and assess quality control for providers in the future. Mr. Hibbs replied that the Committee only has to ask and DOA will provide whatever information is requested. He noted, however, that the benefits package contract clearly states what penalties will be assessed and how; it is not something that can be assessed at will.

Mr. Edens submitted that there should be some type of regular reporting so that the Committee can know what the providers are doing. Mr. Hibbs said that if that is what the Committee would like, he would be happy to provide that information. He added that within six months another audit of Interflex will be conducted and

DOA will continue to monitor them. If it is found that Interflex is not complying with contract standards, appropriate action will be taken.

Mrs. Burns suggested she and Mr. Edens work with Mr. Hibbs to determine what data would be appropriate to be included in the report DOA will provide the Committee.

Mrs. Burns noted that most of the penalties being assessed on Interflex are in regard to how quickly claims are being processed. She said that she is more concerned with the quality-of-care issue. She added that some of the concerns expressed in the letters she has received relate to procedures that weren't approved. She submitted that there should be some quality control on this kind of issue. Mr. Hibbs noted that there have been some occasions when employees have sat down with Intergroup and worked out their problems to the mutual satisfaction of the provider and employee.

Gary L. Peterson, Senior Consulting Actuary, The Wyatt Company, stated that of the four health-care claims audits The Wyatt Company has performed over the past four years, one was on Intergroup. He noted that Intergroup was very cooperative with the auditors and agreed with the results of the audit. He explained that the audit involved 300 claims in the Interflex program. These claims were evaluated for turn-around time and whether they were processed properly, and also correctness of diagnosis and date of service. Mr. Peterson said that of these 300 claims, 23 errors were identified (7.7 percent) in the area of diagnosis and date of service, while the State's performance standard is 95 percent. In the area of errors in payments, 34 errors (11.3 percent) were identified, averaging \$24 each, while the performance standard is 95 percent. At \$24 each for 34 errors, the net payment error was \$818, out of a total payout of \$24,638 (3.3 percent), while the performance standard is 100 percent. The performance standard for turn-around time in payment of claims is fourteen days. Of the 300 claims audited, 100 were paid in fifteen days or more.

Rick Barrett, CEO, Intergroup Healthcare Corporation, distributed a copy of his remarks (Attachment 2), relating to the history of Intergroup's relationship with the State. He noted that Intergroup first received the award to service State employees in 1984. He said that 5,000 employees joined the plan that year. By 1988 that figure rose to 21,000, in 1989 it grew again to 29,000, and in July, 1992, 33,500 State employees had chosen Intergroup's HMO, even though they were offered other choices, including the subsidized indemnity plan. At this time, the State's ability to support the subsidy to the indemnity plan became unbearable, the reason being, affordability.

Mr. Barrett refuted the accusations against Intergroup of poor service and bad doctors, saying that he doesn't think such accusations have much basis in fact. He submitted that in 1992, the State made a courageous decision to move toward a true managed competition model. By August of 1992, Intergroup's membership had grown from 33,500 to 43,650. He said that he doesn't think this would have been possible if the allegations being hurled at Intergroup were true. He noted that Intergroup, the HMO plan, takes care of the largest portion of State employees, with Interflex, the source of so many difficulties, having a membership of only 3 percent of State employees.

Mr. Barrett addressed the subject of profitability, saying that in 1988 and 1989, the combined losses for HMOs in the State exceeded \$100 million; however, Intergroup managed its business prudently enough to remain financially stable. He submitted that today, that remains the same, with a financial performance that is prudent, not excessive. Mr. Barrett added that Intergroup's medical loss ratio (the percent of premium dollars that go directly to health care expense) is 82.1 percent. The norm for the group of large, publicly traded, managed care companies is 79.3 percent. Intergroup's net income is at 5.1 per cent, compared to the group at 5.5 per cent. Mr. Barrett emphasized that a company such as Intergroup must make profits to build its reserves in order to expand its services, which is what Intergroup is doing. He noted that in the past 18 months, Intergroup has committed \$27 million to medical group facility expansion and equipment improvements to increase capacity and service throughout the State. Mr. Barrett contended that Intergroup's profits are not exorbitant, but are ethical and go to serve the needs of all Arizonans, with over \$1 million being donated last year to worthy causes around the State.

Mrs. Burns said that she thinks a company should work toward 100 percent satisfaction of its clients, rather than expressing satisfaction that a majority are pleased. She related that the House staff contacted 81 State employees that have used the Intergroup plan. She noted that 51 of those contacted were happy with Intergroup; of the 30 who were unhappy, there were varying levels of discontent. She said that the interesting thing about the differences in these individuals is that the ones who were happy rarely used the system and those who used the system a lot were the ones most likely to be unhappy.

Mr. Barrett responded that Intergroup's goal is always to have 100 percent satisfaction from its members, but said that surveys indicate that there is a direct correlation between those who are most satisfied and those who use the system most frequently. He said that he would be happy to make the results of those surveys available to the Committee. He added that satisfaction has moved upward in the last six months. He noted, too, that Intergroup has spent a great deal of money in the past few years in identifying problems and improving service and satisfaction. He submitted that in comparing Intergroup nationally in terms of service and quality of care, Intergroup is dramatically above the national average, being 25th out of 600 in a recent study of HMOs. Mr. Barrett said that he thinks Interflex has been tremendously improved and is now meeting the State's standards. He opined that there is a profound truth that the last people into a managed care system are those people who absolutely don't want to be there, and as hard as Intergroup may try, there are always going to be some of those people who it will be impossible to satisfy. Mr. Barrett stated that the overall satisfaction with Intergroup, the HMO, in FY 93 in Phoenix is 91 percent, and in Tucson it is the same, overall, at 91 percent.

Mrs. Burns told Mr. Barrett that her only concern is that he is saying that the problems employees are having is because they want an indemnity plan.

Mr. Edens commented that there is only a certain length of time before the frustration level reaches the highest point, and said that he thinks a year's time is an adequate length of time for making improvements, and now they must be made.

Mr. Barrett responded that Intergroup fully recognizes the problems that have occurred and continues to devote all efforts of the company to customer satisfaction. He said that he is just as distressed, or more so, than Mr. Edens with the results of the Interflex survey.

Ruth Kolb Smith, Chair of the Benefits Committee, Arizona Conference of the American Association of University Professors, Tucson, stated that she is appearing before this Committee because State employees and their families are suffering severely as a result of the current State health care contracts. Ms. Smith also said that she is attending this meeting today to ask for new health insurance contracts for employees of the State and said that the present contract, bid in a hasty and irregular manner, is based on a callous or ignorant philosophy, is not providing adequate and satisfactory care, and is in violation of State law ARS §38-651. She added that Intergroup is in violation of every quantitative standard prescribed in the contract and said that it is not in the State's interest to continue a contract which was arrived at on an impromptu basis with a nonperforming contractor for more than a year.

Ms. Smith stated that the current contract incorporates a "no subsidization" policy suggested by an Intergroup lobbyist in a letter to Mr. Hibbs. She submitted that while this policy appears fair, analysis exposes it. She said that it would indeed be fair if all employees were the same; however, statistically, HMOs are chosen by younger and healthier people, while the disabled and others with serious health problems cannot withstand delay and denials of tests, treatment and referrals commonly practiced by HMOs to minimize costs. The patients tend to choose an indemnity plan, if they can afford it, so that they can get specialized care.

(Tape 2, Side A)

Ms. Smith submitted that Intergroup has been in chronic violation of meeting State contract standards, but said that promises from Intergroup that it will improve must be treated skeptically, due to their long history of broken promises. She stressed that the current health benefits contract is not working, with too many lives being affected adversely and the consequences of denying treatment to State employees being evident, and said that the State needs to rebid the contract - but it needs to be done right this time! She stated that the last time the contract was bid, it was done in haste, but said that if the State starts now, it can be done properly this time.

Ms. Smith charged that Intergroup has demonstrated that it is incapable of paying bills promptly and accurately, incapable of keeping records, incapable of answering mail, and apparently incapable of receiving mail from the U.S. Post Office and distributing it to the proper place in its organization. She further charged that delay and denial of appropriate medical treatment is causing suffering to State employees, and noted that the cost to the State in time lost from work, in employee frustration, and pain and suffering is enormous. Ms. Smith said that she has received hundreds of letters of complaint reflecting a lack of medical treatment and said that physicians are receiving bonuses for not making referrals. She stressed the need for performance standards for HMOs to be incorporated into the health benefits contract and a physician advocate to help protect people from abuse by the HMOs in pursuit of the bottom line.

Ms. Smith emphasized the need for adequate health care for all State employees and said that it should not require droves of letters and newspaper headlines to get that care. She submitted that DOA is concerned with the welfare of Intergroup and is not concerned with the welfare of State employees. Ms. Smith contended that State employees have nowhere else to turn but to the Legislature and said that she is pleading for a new contract to provide the adequate and satisfactory health coverage that is needed. (Copy of full text of testimony - Attachment 3.)

Mrs. Burns stated that she, too, is an unhappy Intergroup patient and said that there is only one reason she is still with the plan - so that she can know what other State employees are experiencing. She chastised Ms. Smith, however, for distributing a paper (Attachment 4) implying that Mrs. Burns is working with the American Association of University Professors and supporting their efforts in getting the State's health benefits contract rebid. She said that she would like the record to reflect that she was not a part of this movement and urged Ms. Smith to be more careful in the future about giving the impression that someone has a part in something that they do not.

Mr. Edens asked Ms. Smith for her suggestions for preventing problems in the future. Ms. Smith said that there needs to be representation from the universities and the needs of the disabled and elderly must be met.

PUBLIC TESTIMONY

Dr. John Sullivan, President and Medical Director, University Physicians, University Medical Center, Tucson, stated he is responsible for quality assurance, peer review and ensuring that patients get the quality of care they deserve, and personally responds to each complaint. He noted that 1,000 University Medical Center patients have been enrolled in the Intergroup health plan, and said that of that number, he has only had two complaints this year.

David Mendoza, Legislative Director, American Federation of State, County and Municipal Employees (AFSCME), submitted that health care reform is the key issue today, and said that the bottom line is that the current law allows DOA to negotiate a health plan for State employees on a regional basis versus Statewide basis, leading to a disparity of benefits and costs. He pointed out that employees in urban areas were not given the option of an indemnity plan and there is still not a viable HMO plan in Flagstaff after a year. He said that while DOA has worked diligently to fix the accessibility and affordability of health care for State employees, in view of the current problems, he supports an oversight of any health plan negotiated by DOA in the future. He suggested that this Committee support legislation which will reblend retirees with active employees and move toward comparable benefits and costs being available to all employees throughout the State. Mr. Mendoza stressed that the provision of health care benefits and the decision to provide certain levels of benefits are policy decisions that should be made by the Legislature.

Mr. Edens asked Mr. Mendoza if his group is doing any type of surveys regarding satisfaction levels of State employees. Mr. Mendoza answered affirmatively, saying that AFSCME has started tracking the complaints they have received, as

well as conducting their own survey on employee satisfaction. He said that most of the problems cited in the complaints AFSCME has received have come from retirees, especially in the rural areas.

Jacqueline Sharkey, Vice Chair of the Benefits Committee, Arizona Conference of the American Association of University Professors, Tucson, recommended that the health benefits contract be rebid and an indemnity plan be offered for employees. She further recommended that future contracts incorporate more specific standards regarding quality of care and that State employees be represented on all committees reviewing health care contracts, especially employees from elected groups. Ms. Sharkey suggested that there should be a specified method provided for obtaining feedback from health care providers and some standardization of the data received. She added that there should be a way for employees to get more comprehensive information about the health care plans offered and contracts should be enforced for noncompliance. She questioned why Intergroup was allowed a six-month leeway in spite of the provisions in the contract requiring the provider to be reliable and experienced. She noted that Intergroup has used the excuse of not having experience with this program, which is contradictory to the terms of the contract. She pointed out that Intergroup went through an investigation a few years ago and was found to be out of compliance in reliability and experience in a previous plan, causing a delay of the Consent Order from the Department of Insurance. She questioned why this wasn't brought out during the evaluation portion of the bidding process. (Copy of rebuttal from Susan Gallinger, Director, Department of Insurance - Attachment 5.)

Norma Greer, Researcher, Benefits Committee, Arizona Conference of the American Association of University Professors, Tucson, said that when she enrolled in the State's health care plan she believed that Interflex was an indemnity plan. She cited an experience of being refused a prescription for Seldane by her physician and being told to go to Mexico to get medication. She stated that she would like to have quality standards included in future health care contracts and would also like to have contracts set up so as not to favor one insurance company over another.

Dr. Carol Bernstein, President, American Association of University Professors, Tucson, said that she thinks it is a very good idea to have elected people on committees that are reviewing health care plans and suggested that people who teach how to evaluate insurance policies could be utilized.

Anne Schutte, Faculty Associate, Arizona State University, Tempe, representing herself, shared her personal health problems. She said that she takes eleven different medications daily at a cost of \$350 per month. She stated that in 1992 she enrolled in Interflex but because of the high premiums and noncovered claims, she found this to be a costly program. She reported that she spent \$4,000 last year in out-of-pocket expenses. She suggested that she is the type of person the State didn't consider last year when the new insurance program was selected. (Copy of full text of remarks - Attachment 6.)

Dr. Harvey A. Smith, Professor, Arizona State University, Tempe, representing himself, submitted documentation of cost efficiency and cost analysis of the Intergroup and Interflex health plans (Attachment 7).

Dr. Mel Firestone, Associate Professor, Arizona State University, Tempe, representing himself, voiced his concern that the cost of the employees' insurance premium has drastically gone up, but employees have not gotten a salary increase.

Robert E. McConnell, Tucson, representing himself, stated that as a long-time State employee and a recent retiree, he has been ambushed and astonished by an unbelievable increase in the cost of health insurance, which has been coupled with a frustrating decline in the quality and quantity of health care for his wife and himself. He noted that his health care premium has increased 212 percent, totaling \$270 per month, in a little over a year. (Copy of full text of remarks - Attachment 8.)

(Tape 2, Side B)

Jane Baez, Motor Vehicle Customer Service, Flagstaff, representing herself, stated that she has been involved in government work for almost 20 years, choosing to stay in a low-paying job because of the benefits and security it offers. She noted that she takes home \$1,000 per month, which is the only support her family has. She said that she needs an HMO badly, which Flagstaff does not have. Ms. Baez described the medical bills that have resulted from her husband being struck by a snow plow and her son being hit by a bicycle and said that these bills have accumulated to the point of her being sued for nonpayment. She related that not one woman in the office where she works has had a pap smear or mammogram since the current insurance coverage went into effect because they can't afford it. Ms. Baez also stated that she has missed four times as much work this year as she has ever missed because she cannot afford to go to the doctor and she is not given time off to come to Phoenix to see an HMO doctor. She commented that she had written a letter to Mary Ann Knight, but had never received an answer. She then wrote a letter to Ms. Knight's supervisor, but never got an answer to that letter either.

Ruth Stokes, Tucson, representing herself, stressed the need for the State to offer a true indemnity plan to its employees and suggested that drugs should be permitted to be bought in larger quantities for cost savings. (Copy of full text of remarks - Attachment 9.)

Vernette Fitzpatrick, Tucson, representing herself, described her circumstances of being a widow with three sons, her mother being in a nursing home, and having an incurable disease herself. She said that her take-home pay is \$1,100 per month. She explained that she works for this low salary in exchange for the benefits provided by the State. She expressed the need to have an indemnity plan because of her particular medical problems.

Art Weese, Flagstaff, representing himself, testified that State employees in Northern Arizona are concerned about the lack of an HMO plan in their area. He noted that the shortest distance to see an HMO doctor is 200 miles round trip. He also noted that employees in the Flagstaff area were told their premiums were high because they lived in a high-stress area of the State. Mr. Weese reported that some people are working while sick because they can't afford to go to the doctor.

Dr. Robert J. Letson, University of Arizona Retirees Association Legislative Committee, Tucson, expressed concerns about availability of benefits to retirees. He said that his insurance premium has increased from \$69 to \$170 per month and suggested that a capitation program will save retirees money.

Louise Muir, representing herself, stated that she is a twenty-six-year State employee who has Lupus. She said that because of the treatment program she has worked out with her physician, she is rarely sick or absent from work. She expressed concern about jeopardizing that program by transferring to an HMO doctor and stressed the need for an indemnity plan. She said that when she called DOA about her problems with Interflex, she was referred to Ms. Stewart, who is actually an employee of Intergroup, and said that she feels this is a conflict of interest.

Tedde Scharf, Associate Director, Disabled Resources, Arizona State University, Tempe, said that she has worked in higher education for twenty years. She submitted that the drastic changes in insurance coverage for State employees has affected the quality of care and trust level of those employees.

Jim Hemauer, Senior Program Coordinator, Arizona State University, Tempe, said that he is very happy to learn of the enhancements that were done to the insurance plans this last year but said that he doesn't think this should mislead anyone into thinking that they are as good as what has been presented. He noted that many items are no longer covered that were covered by the previous insurance provider. He also stressed the need for an indemnity plan and said that he would like to have the option of staying with the physician he has had for the past 23 years.

Sherry Santee, Physical Therapist, Tucson, representing herself, reported that Interflex was misrepresented as an indemnity plan to her when she enrolled in the State's insurance program. She said that she would like to hear an admission from Intergroup that Interflex was misrepresented, and that they be held accountable for this misrepresentation. She added that she supports including an indemnity plan in the benefits package.

Carol Long, representing herself, described her problems with Intergroup. She said that in 1990, she was diagnosed with bilateral hip dysplasia. Due to this condition, her legs are not properly positioned in the hip socket. She said that with this problem, she has considerable excruciating pain when walking or at rest, and her activity has become severely restricted. She was treated with a variety of non-steroidal anti-inflammatory drugs and referred to a local orthopedic surgeon by her primary care physician. The orthopedic surgeon's recommendation to her was to "tough it out," doing hip exercises at home and treating the pain with drugs, until she is 65, when she can get a total hip replacement. Ms. Long said that in May 1993, at her own expense, she sought an independent analysis of her condition outside of the Intergroup network. Dr. Hatstrup of the Mayo Clinic Scottsdale recommended a surgical procedure to reconstruct the hip rather than replacing it. Dr. Hatstrup stated that he and his colleagues were unaware of anyone in Arizona remotely qualified to do this procedure but that the benefit of this procedure would be pain relief and normal mobility. This information was transmitted to her primary care physician in the form of a consultative letter. His response was to again refer her to the

orthopedic surgeon, who in turn referred her to another doctor identified as a "local expert" in the field of hip reconstruction; however, the referral to the "expert" was denied by the Medical Review Committee of Intergroup.

Ms. Long submitted that Intergroup's "bottom line" seems to be adversely influencing the care of the patient. She noted that she has few options available to her at this point: 1) become crippled until she reaches a suitable age when surgeons will perform a total hip replacement, or 2) personally bear the extreme financial burden for the reconstructive procedure that will correct her medical problem. Ms. Long opined that this is not how the system is supposed to work, but is how the Intergroup system works. (Copy of full text of remarks - Attachment 10.)

Mary E. Green, Professor Emerita, Arizona State University, Tempe, representing herself, said that she would not have taken early retirement if she had known what was in store for her in the way of insurance coverage. She pointed out that her insurance premium rose 26 percent with the new coverage and was told that Interflex is an indemnity program. Ms. Green alleged that a letter dated October 25, 1993 and signed by Rick Barrett, President and CEO of Intergroup, sent to all Interflex members is replete with inaccuracies and the convenient use of the passive voice to avoid responsibility. She opined that Interflex most certainly does not ensure "access to the highest quality healthcare available in the State of Arizona," but quite the contrary. (Copy of handout - Attachment 11.)

Dr. David W. Smith, Chair, Legislative Committee, University of Arizona, Tucson, maintained that in the U.S., the health care industry is HMO driven because the majority of people are not chronically ill and the costs for their care are less. He said that his experience has been that the chronically ill person seeks an indemnity plan.

(Tape 3, Side A)

Dr. Smith contended that the chronically ill people and those who are not chronically ill cannot be serviced by the same type of medical plan. He stressed the need to have an indemnity option in the State health plan and some kind of advocacy group to ensure that the patient gets appropriate health care.

Roger Carter, representing himself, stated that he spent \$3,741 out of pocket in 1991 and \$5,994 in 1992 on medical care for his ill wife. He questioned why other states can have a good Blue Cross/Blue Shield plan for their employees and Arizona can't.

Carole Dow, representing herself, said that she thinks it should be clear to everyone that employees should be offered a choice of what type of insurance they want to have, whether it be an HMO, indemnity, or whatever.

Eli Kaminsky, Professor Emeritus of Political Science, Arizona State University, Tempe, representing himself, testified that the right to choose a physician is a sacred right that should be preserved.

Christy Bison, Tempe, representing herself, said that her major complaint with Intergroup is that nurses are making diagnoses rather than scheduling an

appointment with a doctor. She said that in a recent call, her doctor made a diagnosis and prescribed medicine over the phone without having examined her. She said, too, that her doctor advised her that she doesn't need a mammogram until she is 50 years of age, even though she was experiencing breast problems at the time.

Marianne Alcorn submitted a copy of her remarks but did not testify before the Committee (Attachment 12).

Mrs. Burns announced that the next Committee Meeting will be held on November 18, 1993 early in the morning.

The meeting adjourned at 2:42 p.m.


Carolyn Richter, Committee Secretary

(Attachments and tapes on file in the Office of the Chief Clerk.)

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11/4/93

ATTACHMENT C

Notice/Minutes of 11/30/93 Meeting

ARIZONA STATE LEGISLATURE
INTERIM MEETING NOTICE

Open to the Public

LEGISLATIVE OVERSIGHT HEALTH INSURANCE BENEFITS REVIEW COMMITTEE

DATE: Tuesday, November 30, 1993
TIME: 1:00 p.m.
PLACE: ~~House Hearing Room 2~~ House Hearing Room 3
SUBJECT: Review of State Employee Health Insurance Benefits

AGENDA

1. Opening Remarks
2. Committee recommendations based on October 28 meeting
3. Comparison of Health Insurance Benefits Available to State Employees in Rural and Urban Counties
 - a. Overview by the Department of Administration (DOA)
 - b. Public testimony
4. State Retiree Health Insurance Coverage
 - a. Staff overview of legislative enactments concerning the retiree health insurance program
 - b. DOA overview of policies regarding retired state employee health insurance coverage
 - c. Presentation by the Arizona State Retirement System (ASRS) on the retiree health insurance program administered by ASRS
 - d. Public testimony
5. AHCCCS and State Employee Health Insurance
 - a. Presentation by Representative Schweikert
 - b. Public testimony
6. Committee recommendations
7. Adjourn

Senator Carol Springer
Acting Cochair

Representative Brenda Burns
Cochair

MEMBERS:

Senator Brewer, Cochair	Representative Eden
Senator Hardt	Representative Edens
Senator Hermon	Representative Conner
Senator Soltero	Representative Ortega
Connie Butchee, Supreme Court appointee	
Professor Frank Williams, Board of Regents appointee	

10/17/93
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Lisa Hardy

ARIZONA STATE LEGISLATURE
Forty-first Legislature - First Regular Session
Interim Committee Meeting

LEGISLATIVE OVERSIGHT HEALTH INSURANCE BENEFITS REVIEW COMMITTEE

Minutes of Meeting
Tuesday, November 30, 1993
House Hearing Room 3 - 1:00 p.m.

(Tape 1, Side A)

The meeting was called to order at 1:10 p.m. by Cochairman B. Burns and attendance was noted.

Members Present

Connie Butchee
Mr. Conner
Ms. Eden
Mr. Edens
Senator Hardt

Senator Hermon
Senator Soltero
Prof. Frank Williams
Senator Springer, Cochairman
Mrs. B. Burns, Cochairman

Members Absent

Senator Brewer (excused)
Mr. Ortega

Speakers Present

Sue Dunaway, Senate Research Analyst
Bill Bell, Assistant Director, Personnel Department, Arizona Department of Administration (ADOA)
MaryAnn Knight, Benefits Manager, Arizona Department of Administration (ADOA)
Lisa Hardy, House Research Analyst
Tom Finnerty, Legislative Liaison, Arizona State Retirement System (ASRS)
Donna Buelow, Manager, Retiree Health Insurance Unit, Arizona State Retirement System (ASRS)
David Mendoza, Legislative Director, AFSCME Council 97
Norma Greer, representing herself, Tucson
Anne Schutte, representing herself, Tempe
Richard Murra, representing himself, Chandler
Harvey A. Smith, representing himself, Tempe
Jim Witner, President, University of Arizona Retirees Association
Dr. Robert Letson, representing himself, Tucson
Dr. David Smith, representing himself, Tucson
John Brand, representing Arizona State Retired Employees Association
Bill Cook, representing himself, Glendale

LEGISLATIVE OVERSIGHT HEALTH
INSURANCE BENEFITS REVIEW COMM.
NOVEMBER 30, 1993

DISCUSSION OF RECOMMENDATIONS

Sue Dunaway, Senate Research Analyst, related the Committee recommendations based on the October 28 meeting (Attachment 1) for discussion by the Members.

Recommendation #1

Ms. Dunaway noted that Elliott Hibbs, Director, Arizona Department of Administration (ADOA), stated at the last meeting that they are presently in the process of compiling a Request for Proposal (RFP) for an indemnity plan.

Cochairman Springer suggested that the Committee recommend that the state offer an indemnity program that is not subsidized; the state portion should only be the same as with other coverages. She added that if the state employee chooses the indemnity program he/she should pay the difference.

Mr. Edens stated that he received the RFP for an indemnity plan today. He said he has not had a chance to look at it but opined that it would be better to review the rate of subsidization after making sure the RFP is proper.

Senator Hermon spoke against state employees subsidizing the indemnity program for other employees.

Chairman B. Burns clarified that the Committee recommends that there be an indemnity option for employees which is not cost prohibitive and takes into account the cautions pointed out by Cochairman Springer, Senator Hermon and Mr. Edens.

Recommendation #2

Ms. Eden suggested that DOA, in preparation for the bid, should ask for representation from AFSCME, the universities, and a variety of people.

Bill Bell, Assistant Director, Personnel Department, Arizona Department of Administration (ADOA), explained that ADOA has prepared the RFP for an indemnity plan as mentioned in the last meeting. He said they will have a pre-bid conference meeting which will be open to the public in which they can talk to the carriers; they will also invite comment from interested parties. He said this will be done before the RFP is finalized before going to bid. They plan to have this meeting sometime next week; the State Procurement Office will be notifying the public shortly. He added that their intent, because there is great interest in an indemnity plan, is to obtain as much input as possible from those who are interested. Since they have a very short time frame, they believe this might be the best route to go.

He clarified for Ms. Eden that ADOA has existing contracts for HMO carriers throughout the state; they are in the second year of those five-year contracts so they will not be bid at this time.

Cochairman B. Burns suggested that a change be made in Item #2c: Delete the word "Require" and insert "Recommend."

The Members agreed to adopt Recommendation #2 incorporating the above suggestions.

Recommendation #3

Ms. Dunaway said it is up to the Committee whether or not to add a specific time frame for Item #3a. She pointed out that Interflex was out of compliance for nearly the entire plan year although they were only penalized during the last six months.

Regarding Item #3c, she noted that DOA and Mr. Edens were to meet on this issue but due to miscommunication they were not able to meet before the meeting, so they will meet after the meeting to develop a form for reporting the contract performance of the carriers to the Committee.

Senator Hermon indicated that the language in this recommendation is not strong enough. She suggested that in Items #3a and #3c, the word "should" be changed to "will" or "shall."

Cochairman B. Burns pointed out that Recommendations #2 and #3 contain specific bullet points regarding the quality of care which have been lacking in RFP's and contract awards. She noted that she is glad to see that.

Mr. Edens suggested that this Committee meet on at least a quarterly basis so that ADOA can present the required information, allowing the Committee to provide administrative oversight.

Chairman B. Burns replied that statute requires that the Committee meet annually, and the Committee can meet quarterly if the Members wish to. She said another alternative is that after receiving the reports, it can be determined if there is a need to meet on a quarterly basis rather than annually.

The Members agreed that Item #3c should require that the reports from ADOA be submitted to the Committee on a quarterly basis.

Cochairman B. Burns suggested in Item #3a "in a timely manner" should be changed to "in keeping with the time provided in the contract."

Mr. Conner stated that in Item #3c, if the Committee is going to be an ongoing oversight committee, a recommendation should be made that Wyatt and Company has to review any problems and the Committee would make a recommendation from their findings.

The Members agreed with the suggested changes in Recommendation #3.

RECOMMENDATION #4

Cochairman B. Burns asked if Item #4a refers specifically to ADOA or the providers.

Ms. Dunaway said the brunt of this request stems from the people who testified at the last meeting; they indicated that when they spoke to different carriers

they received different stories. This requires that ADOA will be the primary disseminator of information.

The Members agreed to adopt Recommendation #4.

RECOMMENDATION #5

Senator Hermon said she is one of the people who brought up Item #5b, and although it is minutia, it is a major annoyance to have to get an annual prescription filled every month.

Cochairman B. Burns expressed a concern that Item #5a may be detrimental to families. None of the other Members shared her concern.

The Members agreed to adopt Recommendation #5.

PRESENTATIONS

Cochairman B. Burns noted that DOA's testimony will focus on comparison of health insurance benefits available to state employees in rural and urban counties and state retiree health insurance coverage.

Bill Bell, Assistant Director, Personnel Department, Arizona Department of Administration (ADOA), noted that there is a national health care crisis resulting in a 37 percent increase in costs nationally over the last three years. He said he is proud that the premium costs to state employees have risen only 7 percent during that same period of time.

He recognized that there are some state employees who are still unhappy with the plans available to them but emphasized that only some of the employees are still unhappy. He opined that most employees are satisfied with the health care coverage administered by the state; however, they will be conducting a survey of state employees again in early 1994.

(Tape 1, Side B)

He noted that the State offers quality health care plans in all areas (Attachments 2 and 3). He stated that coverages under Health Maintenance Organizations (HMOs) vary by carrier but there are some commonalities, whether provided in the rural or urban areas, such as prescriptions for \$3 to \$5, no hospitalization charges, preventative coverage, durable medical goods coverage, minimum co-pay for doctor's office visits from zero to \$10, unlimited coverage for most conditions and catastrophic coverage.

Mr. Bell explained that all state employees have access to HMO's except in the Flagstaff area but added that they have just arranged for Coconino County employees to have access to any HMO in the state for routine, plannable situations while maintaining their indemnity. He said this is not an ideal option but it meets some of the employees' needs for now. Announcement of this option will be mailed to eligible employees next week with meetings scheduled for December 13 in Flagstaff. The effective start date will be January 1, 1994. He expressed hope that this move will encourage local providers to offer the HMO option to employees in the Flagstaff area in the near future.

He said, historically, Blue Cross/Blue Shield had bid and was awarded an indemnity program; however, ADOA wanted to offer employees in the rural areas a choice of health care plans. Therefore, ADOA and Blue Cross/Blue Shield formed a partnership of commitment with Blue Cross/Blue Shield dedicated to expanding their HMO network. As a result of this partnership, they have been able to enrich the benefits for Blue Cross/Blue Shield participants without increasing costs. He said to date ADOA has increased the number of HMO provider hospitals (Attachment 4) and they have more than doubled the number of physicians who are HMO providers in the rural areas (Attachment 5). This expansion has allowed many state employees to have continuity of care when their physicians under previous coverages became Blue Cross/Blue Shield HMO providers.

He related the changes made so that the rural HMO is more comparable (Attachments 6 and 7). In addition, the deductible period was extended to 21 months, from January 1, 1992 to October 1, 1993 when deductibles were converted from calendar year to a plan year.

Senator Hardt requested a copy of Mr. Bell's testimony. Mr. Bell agreed to provide him with a copy.

Mr. Bell related to the Committee that for retirees ADOA provides policies often based on statute covering choice of plans, level of benefits, premium costs, and separation of groups. He said A.R.S. 38-651.01 and personnel rules currently allow a retiree to remain in his/her current ADOA-administered plan or opt into the Arizona State Retirement System's (ASRS) administered plan. Retirees who choose to move into the ASRS plan may not rejoin the ADOA-administered program. If it were possible to opt back and forth, the plan would have a fluctuating pool of participants, and therefore, would be difficult to bid and very difficult to administer.

He said that retirees receive the same level of benefits as active employees. Retirees pay the total premium cost for their health care insurance, unlike active employees who pay a portion of the total. However, retirees receive a subsidy from the ASRS. In addition, those retirees who are Medicare-eligible have significantly lower premiums due to Medicare coordination of benefits.

He mentioned that in the process of bidding the new health care program, ADOA became aware of A.R.S. 36-651.01 which prohibited combining active and retiree groups. Based on advice from the Attorney General's Office, information from their carriers and recommendations from consultants, they decided to bid the retirees plan as a separate demographic group. He acknowledged that many retirees experienced premium increases as a result of unblending; however, there were a number who experienced decreased premiums (Attachments 8 and 9). He said they have been and will continue to work with the carriers to find ways to enhance coverages under these plans for retirees. He expressed the Department's continued support of increased subsidies for retiree premiums.

Mr. Bell presented a program enhancement announced by ADOA last week called the Senior Care Program. It reduces health insurance premiums for retirees who are Medicare-eligible by allowing them to assign their Medicare benefits to the CIGNA staff or Intergroup HMO's. Retirees may reduce their premiums by as much as \$1,000 to \$4,200 per year at no increased cost to the state. He said meetings

to introduce this enhancement will be held in December, 1993 and January, 1994 with coverage effective February 1, 1994. He added that Blue Cross/Blue Shield is developing a similar plan which he anticipates will be available in the spring of 1994.

In addition, Mr. Bell said ADOA has developed new communication tools for both active and retired employees. He said newsletters will provide tips on wellness and utilizing health care plans; they hope this will increase the retirees' understanding and ability to maximize their benefits. They have established a Benefits Advisory Task Force that will include retirees as members. The Task Force will be meeting later this week to provide input to ADOA.

He noted that there has been some discussion relating to reblending the retirees and active employee group. He said ADOA is committed to fully supporting and working with the Committee to reach an equitable solution to this and other health insurance concerns. He pointed out issues that should be considered before such a recommendation is made:

1. Premium rates for active employees would increase; this increased cost would have to be borne by either the employee or the state.
2. Premium rates for those retirees who are currently paying less than active employees would increase.
3. Consideration might be given to allowing retirees who opted out of the ADOA-administered plan to return to the ADOA plan. If this should occur, it would be difficult to bid and administer plans with fluctuating participant pools. This may cause significant increases in administrative costs.

Mr. Bell clarified for Mr. Edens that RFP's are drafted in his office, then they are submitted to the Procurement Office where they are refined. He said enforcement of the provisions of the RFP fall jointly to the Personnel Division and the State Procurement Office within ADOA.

Mr. Edens emphatically stated that the reason this Committee is meeting is because one carrier is not complying with their RFP and something needs to be done about it. Mr. Bell replied that he agrees that this needs to be addressed. He related to Mr. Edens that they have assessed penalties to Intergroup and will be meeting with them to make sure they are in compliance with the RFP and that they will stay in compliance. He noted that the other carriers are in compliance.

Cochairman Springer asked if reblending of the retirees with active state employees would require a statutory change. Mr. Bell answered that he has been advised by the Attorney General's Office that a statutory change would be necessary.

Cochairman Springer asked the reason why all state employees and/or retirees do not have the same health programs available.

Mr. Bell stated that he was not on the Committee but he believes the RFP's were put out asking for a variety of combinations; one was for a bid on a statewide

program. Some of the carriers did bid a statewide program but the Committee believed the cost was prohibitive.

Cochairman Springer asked if ADOA has considered breaking the state up into quarters or some other kind of situation in an effort to try to make available to the rural areas those plans which are available in the urban areas. Mr. Bell replied that they are considering a variety of options including her suggestion; they understand that this is a major problem for many of the retirees and they hope to resolve it.

Cochairman Springer asked if a rural employee or retiree opts to pick up a plan from an urban area, i.e., could they choose to be a member of one of the plans available in the Metropolitan area if they want to drive to Phoenix or wherever to take advantage of that. Mr. Bell replied that this can be done as long as that plan is offered in the area. He referred to the option which will be available in Flagstaff.

Cochairman Springer asked if ADOA would object to changing the statute to allow retirees who opted out of the system an opportunity to come back in. Mr. Bell replied that he is not sure they would object, however, there are some conditions which would need to be considered. He clarified that those over 65 are paying lower premiums now so he doesn't know if they should be given this option.

Cochairman Springer noted that the separation of retirees from the active employees was sprung on the retirees without notice, and under the circumstances, they should be offered the opportunity to opt back into the system without a big hassle. Mr. Bell agreed with her statement. He said they have approximately 3,000 retirees in the ADOA-administered program but he doesn't know how many retirees opted out.

Cochairman B. Burns asked if the rate to active employees decreased as a result of the unblending. Mr. Bell said it did. He elaborated that if reblending occurs, there will be an additional cost; that cost will be picked up either by the employee or it can be picked up by the state.

Cochairman B. Burns disagreed with Mr. Bell's statement that the state has continued to offer quality health care at an affordable cost. Regarding his comment that the increase to the state employee premium has increased only 7 percent over the last three years, she opined that the same level of care has not been maintained mostly due to the spiraling cost of health care.

MaryAnn Knight, Benefits Manager, Arizona Department of Administration (ADOA), explained that ADOA is currently offering the ability to choose an HMO outside of Flagstaff to be effective January 1, 1994. The participant will maintain the indemnity coverage in Flagstaff but will have the option to travel to Maricopa County or anywhere else and utilize HMO benefits. She agreed that this is not an ideal situation but they are hoping that the economic impact will motivate providers to opt into the HMO system.

Cochairman Springer assumed the Chair.

Ms. Eden expressed reservation about a viable indemnity program. Mr. Bell said state employees want an indemnity program and they are trying to do that. He said they do not expect a groundswell of carriers to bid on the plan but he believes they will have sufficient bids to make a reasonable decision.

Ms. Butchee noted that she conducted a survey of several states, their indemnity plans, HMO's and how costs are passed on to the employee. She related the information to the Committee pointing out that the State of Massachusetts offers 14 HMO's and a State Hancock indemnity plan while Washington, D.C. offers four HMO's and a Blue Cross/Blue Shield indemnity plan (Attachment 10). She asked if the HMO's and PPO's were included in the bid for an indemnity plan, would the cost be lower for state employees.

Mr. Bell replied that it probably would be more advantageous to bid as a package but reiterated his earlier remarks that they currently have existing five-year contracts with the present carriers, and he believes the rates have been very favorable. With respect to the RFP for an indemnity plan, they are responding to what they have heard from employees and this Committee.

Cochairman Springer asked if the current five-year contracts have an annual renewal clause. Mr. Bell replied that they do, and they can eliminate the carriers on any given year.

Cochairman Springer asked if when ADOA initially requested bids for these programs, they specified coverage and price. Mr. Bell replied that they did specify coverage and price but they also requested that they be flexible and submit other programs.

Cochairman B. Burns resumed the Chair.

Lisa Hardy, House Research Analyst, referred to a handout (Attachment 11) which shows how the retiree health insurance benefit program works, the four state retirement systems and types of employees included under each program. She presented a historical recap of the program.

She clarified for Cochairman Springer that a policy change was made within ADOA to separate the retirees from the active employees during the 1992 enrollment period based on an informal opinion from the Attorney General's Office and the statutory language cited by Mr. Bell previously. The practiced policy prior to this enrollment period was to blend the retirees with the active employees.

(Tape 2, Side A)

Cochairman Springer said it is her understanding that there were no bidders for the rural areas for retirees so ADOA had to solicit a carrier for that coverage. Mr. Bell answered that Blue Cross/Blue Shield bid for this coverage; ADOA did not have to solicit bids for the retirees. He recalled that CIGNA, Blue Cross/Blue Shield and Intergoup bid on this coverage.

Tom Finnerty, Legislative Liaison, Arizona State Retirement System (ASRS), thanked Ms. Hardy for presenting the history of the program. He stressed the fact that one of the reasons ASRS took over the administration of the health insurance program is that they have over 200 employers, each with their own

health insurance program with varying degrees of when coverage is terminated; part of the intent is that ASRS not steal anybody from the coverage they are already receiving. Basically, the law states that ASRS can only provide coverage when employees are no longer eligible to receive coverage from their plan employer, i.e., those who are uninsurable go to ASRS and they have to provide that insurance. He said this leaves ASRS in a vulnerable position because it is very hard to attract insurers who provide competent bids. He said FHP has been the only one that has come through each time.

Donna Buelow, Manager, Retiree Health Insurance Unit, Arizona State Retirement System (ASRS), noted that the retiree group insurance program through the ADOA Procurement Office issued a RFP for health insurance coverage in 1990 to be effective January 1, 1991. Proposals were received and reviewed by the Procurement Committee which consisted of ASRS staff and others in the benefit community. National Dental Health was chosen for a prepaid dental plan and FHP for an indemnity dental plan. The proposal from FHP was accepted for HMO and indemnity medical coverage. The terms of the contract were for one year with four renewable options, each for a one-year period. She said included in the contracts was a pricing schedule which indicates maximum increases allowable for each renewal period.

She said procurement procedures necessitate that staff indicate annually whether a renewal will be accepted or if the contract should be placed out to competitive bidding. ASRS staff has historically presented the renewable proposals to the ASRS Governing Board and their appointed subcommittees for their approvals or rejections. The renewal proposals presented by the carriers for 1992, 1993 and 1994 have been accepted by the Board and approved by the ADOA Procurement Office.

She went over their current plans:

1. A prepaid dental plan which offers preventive services and no out-of-pocket costs for the member through participating offices. Benefits are also available through an alternate reimbursement program if a provider is not available within a geographic distance from the member's residence. Premiums range from \$6.12 per month for a single member within Arizona to \$15.58 for a family residing in one of the other states in which this plan is offered. Current enrollment figures indicate that approximately 8,700 retirees and 3,300 dependents are enrolled in this plan; the majority (97 percent) reside in Arizona.
2. Indemnity dental plan offered by FHP. The benefits are based on the type of service provided. By accessing a preferred provider network of dentists, benefits are paid at higher percentages. This plan includes annual deductibles and maximum benefit amounts. There are currently approximately 3000 members and their dependents enrolled in this plan.
3. The FHP HMO medical plan office services, through contracted providers, in approved zip code areas of Arizona in Maricopa, Pima and Pinal Counties. Members enrolled in Medicare as well as those who are not are eligible to enroll in this plan. The plan for those enrolled in Medicare is the Golden Health Care Plan. Benefits are

similar for both plans and include a \$5 copayment for office visits, \$3 copayment for prescription drugs and a \$200 per year allowance for hearing aids. The premiums for the HMO plans are based on Medicare eligibility of both the member and his/her dependents. Current enrollment data indicates that there are approximately 2,600 members who are not eligible for Medicare. Those enrolled in the Golden Health Care Plan total approximately 4,600.

She noted that expansion has been a priority for this plan. Beginning in 1994 retirees living in areas of California, Nevada and New Mexico will be able to access the HMO's available within those areas. Expansion within the State of Arizona is somewhat more difficult as it is imperative that any expansion be coupled with a Medicare risk contract. While negotiation is not yet complete, there are some areas within Arizona in which they may see a completion within the calendar year of 1994.

4. The indemnity medical program offered by FHP includes coverage for those not Medicare-enrolled and those enrolled in Medicare in the form of a Medicare supplement plan. The Medicare supplement plan includes benefits such as prescription drugs for either a \$5 or \$10 copayment depending on whether a generic or brand name drug is received. There is an annual maximum on this benefit of \$1,600. FHP pays the Medicare deductible of \$100 per year for medical care. The plan also pays 20 percent of Medicare allowable charges. There are currently 11,000 individuals enrolled in the Medicare supplement plan. Sixty percent of those reside in Metropolitan areas of Arizona.

For those not enrolled in Medicare, the indemnity plan has a deductible of \$250 for an individual and \$500 for family coverage. Benefits are paid based on the usage and availability of PPO networks that have been established. Realizing that this type of plan is expensive both in terms of premium and out-of-pocket expenses, ASRS has worked with the carriers and benefits consultants to offer some relief.

To this end, two features have been included in this plan. The availability of the PPO network offers the possibility of eliminating the deductible and coinsurance for office visits in lieu of a \$10 copayment. When PPO providers are accessed for other services, the insured is reimbursed at a higher rate than a non-network provider would be. Effective January 1, 1994, each insured in rural Arizona residing in a PPO-service area can call a toll free number and obtain assistance in receiving a physician referral. If a PPO provider is not available within a reasonable geographic distance, a non-PPO provider will be recommended. By obtaining this referral, the insured has the claim paid at the higher PPO rate regardless of whether the physician is a contracted PPO physician. This is called the Personal Care Network and they currently have approximately 2,100 individuals insured in this plan; 1,300 of those live out of state or in the rural areas of Arizona.

She offered two of the many items they are looking forward to in the upcoming years in this program: 1) Creation of a position to serve as an ombudsman or retiree advocate for the purpose of medical care for the enrolled members. This would be over and above the activities carried out by the representatives who presently work at the system. 2) It has been suggested that a post-RFP process be undertaken prior to the next bidding to ascertain and determine how to encourage competition among the carriers for the upcoming years.

Mr. Conner asked about providing insurance for those who take early retirement. Mr. Finnerty replied that the people who retire prior to age 65 are probably in the highest risk group in the country. Traditionally, when ASRS goes out for bid on programs, they receive more than just FHP bidding on the contracts but they are usually only willing to take those on the Medicare level; they don't bid for any coverage below 65. He explained to Mr. Conner that under ASRS their contract insurer is the FHP company, PPO (Preferred Provider Organization) is a program provided by many insurers within their indemnity coverage. Usually it is a 90-10 reimbursement (the insurer will pay 90 percent, the individual pays 10 percent). If a PPO provider is not used, the reimbursement drops down to 70-30.

Mr. Finnerty explained to Mr. Conner that when retirees become 65 or disabled, under social security, after two years they become Medicare-eligible. Then the subsidy drops from \$95 per month to \$65 per month recognizing the fact that the primary insurance from age 65 on is Medicare; ASRS only provides the supplement. Before age 65, the insurance provided by ASRS is primary.

David Mendoza, Legislative Director, AFSCME Council 97, submitted a Fact Sheet and related legislation (Attachments 12 and 13). He referred to a Report by the Auditor General on the Personnel Division of ADOA (Attachment 14) which identifies many of the concerns of AFSCME and the Committee. He pointed out the recommendations made by the Auditor General on page 30 of the report noting that he believes they are a step in the right direction but they do not go far enough. He opined that ADOA should be required to negotiate health plans which provide comparable benefits at comparable costs to all state employees regardless of their residence and A.R.S. 38-561 should be amended to provide for that process. He urged the Committee to do that.

He referred to a Fact Sheet concerning the reblending issue (Attachment 15) and submitted a position statement, for the record, in support of legislation to require blending of retirees with active employees (Attachment 16).

PUBLIC TESTIMONY

Norma Greer, representing herself, Tucson, said she spent the last year researching the hurriedly bid health care contract of 1992 and the resulting health care options. She submitted that the entire premise for the 1992 bid for the state employee's health insurance is flawed and the entire contract needs to be rebid; not only the indemnity program. The unblending of retirees, rural employees and people choosing indemnity-type insurance has sabotaged the intended stated goals of saving the state money. It has not only cost the state more money but has cost the state in angry current and former employees.

Cochairman Springer assumed the Chair.

Ms. Greer endorsed the FHP indemnity plan presently in effect with the City of Tucson (Attachment 17). She stated that what Interflex offers the State of Arizona is a PPO which is very restrictive and requires that a single person pay \$804 more per year (compared to the City of Tucson) for single coverage with a \$400 deductible and Interflex pays 80-20 of "covered" expenses. She contended that the contract that Intergroup has written in their Interflex program is riddled with exceptions, misleading verbiage, and doubletalk.

She explained that Pima County offers their employees Intergroup HMO; their Benefits Manager related to her that the larger the pool, the cheaper the insurance. They have wonderful rates with Intergroup HMO because they have 3,000 people insured by Intergroup (Attachment 18). The State of Arizona has 12,000 people who are insured by Intergroup HMO and they are paying \$610 more per year in Maricopa County and \$508 more per year in Pima County. She indicated that this doesn't make sense. Not only does the state have three times the number of employees but those employees have been unpooled from the high risk groups and high cost employees.

She proposed that the Committee very carefully review the RFP for an indemnity program. She suggested that the Committee be required to choose an evaluation committee and make sure they know what they are doing. She remarked that fines ought to be imposed on Interflex for the full year they were not in compliance with the RFP.

She pointed out that the 1992 contract with Intergroup contains proposed renewal rates which clearly don't match the 35 percent required by the RFP for cost containment. She said they are making a lot of money and the State is losing a lot of money. She concluded by commenting that somebody needs to carefully look into what is going on.

Mr. Edens asked if it would be possible to have staff review the Pima County policies to determine if they are the same or better. Ms. Hardy agreed to do that.

Anne Schutte, representing herself, Tempe, testified that the state must pay more if necessary so individuals needing an indemnity plan can afford an indemnity plan. There should be performance standards for all plans; insurance must be affordable and accessible to everyone. She submitted that all contracts should be rebid at this time. She suggested elimination of the no subsidization philosophy because it violates the nature and purpose of insurance. Employees do not have the same medical needs; the disabled, seriously ill and the elderly suffer physically and already shoulder high medical expenses. They feel further victimized by high premiums, high copays and insurance loopholes. The insurance pool should include all state employees thereby making insurance affordable and truly available to everyone. The cost should be shared by everyone, including the young and healthy.

She asked under the pressure to contain health care costs, what protection will consumers have to ensure that their accountable health plan will not refuse to provide or pay for covered services on the grounds that the treatment is not medically necessary. Employees should be represented on all boards, panels,

committees or other bodies concerned with health care options. These representatives should be chosen from groups whose members are elected by the employees and are not appointed.

She stated that the HMO's need supervision; the disabled, seriously ill, and elderly are faced with many problems when they are confronted only with HMO options. She questioned the sense of offering new contracts to companies with a poor performance history. She expressed a need to properly inform employees as to the detail regarding plans so they can make informed decisions. Employees should have the option to opt out of their insurance plan into another if the services provided by the plan are not satisfactory following grievance procedures.

Cochairman B. Burns resumed the Chair.

Richard Murra, representing himself, Chandler, addressed the Committee and read from a prepared statement (Attachment 19).

Harvey A. Smith, representing himself, Tempe, indicated the Attorney General's opinion concerning unblending of the retirees from the active employees was solicited in August, 1992 after the contracts were concluded. He opined that to state that the opinion was the basis for the unblending is somewhat misleading. He advised the Committee that bidding for an indemnity program alone is not viable. He said he talked to several large insurance companies such as Aetna and their representatives said they do not believe their actuaries will allow them to bid on such a program. He expressed his preference of a \$2,000 or \$3,000 deductible with the state paying most of the cost of the premium, allowing the employees to go to their own physician.

Jim Witner, President, University of Arizona (UA) Retirees Association, Tucson, noted that he represents 775 members. He related the following points:

1. The Association supports the goal of affordable health care insurance for all active and retired state employees.
2. Retirees should continue to be eligible to retain their membership in the ADOA's sponsored health programs upon their retirement.
3. Retirees should be retained in the same health insurance pool as active employees particularly in the case of retirees not yet Medicare-eligible. The current subsidy which is taken from ASRS funds at no cost to the state and accounted to retirees with ten or more years of service should be increased \$25 per month in each category in 1994-1995 to assist retirees and their dependents in their efforts to meet the increased cost of health insurance within approved programs. Retirees with five to nine years of service should receive a reduced percentage of this increase according to the previously established formula.
4. The State of Arizona should provide a pure indemnity health insurance option for the active and retired employees who prefer such a plan; they should be made aware that it may be costly.

5. The State of Arizona must provide appropriate oversight to insure that timely and competent health care is provided to active and retired employees in either an HMO or an indemnity plan.

Dr. Robert Letson, representing himself, Tucson, stated that it has been six years since the Legislature adopted the provision to establish retiree benefits under ASRS with the aim of allowing people to continue their coverage with their employers. That has not been a problem with the State but this is not the case with many of the school districts.

(Tape 2, Side B)

He said ADOA was notified of this concern before the bill was passed. After the bill was passed, at the last minute, they took bids but the bids were written in such a way that only one company could make a bid. Those who were unable to stay under those provisions only had one choice which was FHP, and while they have a pretty good program, the continuity of their care was broken. In 1992 when the unblending occurred, Dr. Letson said his premium increased \$60 per month which comes to a total of \$720 annually. He said he called ADOA about this but they have never gotten back to him on that. He submitted that neither the Attorney General's opinion nor statutory legislation required the unblending of retirees from active employees. He opined that someone needs to watch what goes on in ADOA.

Dr. David Smith, representing himself, Tucson, testified that he is beginning to wonder if he made a mistake by joining an HMO because what is being implied is that you get better health care in an indemnity program rather than an HMO. He requested that the Committee search for some data showing the difference between an HMO in terms of quality of care and the indemnity system in this country. He indicated that the majority of state employees, active and retired, are in HMO's; if they are not a high-quality provider, the Committee must do something to alleviate the fears that arise in the minds of those people that they are not receiving first-class medical attention.

He addressed the statement that the larger the pool of participants, the better the rates will be. He suggested that the entire group of people be formed into one pool and bid to multiple carriers. He claimed that people who gravitate to indemnity plans are by and large chronically ill and applauded the State of Arizona for employing chronically ill people. He said they do deserve a better break with respect to health care, but if the HMO is a quality deliverer of care, their needs are better served in a huge pool in an HMO with this Committee and other committees giving oversight. If, on the other hand, the HMO is not a first-class health care delivery system, it is the Committee's responsibility to provide an alternate plan.

John Brand, representing Arizona State Retired Employees Association, expressed his support of Dr. Smith's testimony. He added that the main reason people in his organization are opting for HMO's is because they cannot afford indemnity plans. He requested a break in premiums for retirees.

Bill Cook, representing himself, Glendale, stated that he was in the FHP HMO program and he "fired" them but he still has the dental plan. He said he continues to maintain the indemnity plan that he had which was a MediGap policy.

He doesn't have to send in a claim to them; they pay automatically. He requested that the statutes be amended to provide an automatic trigger that would increase health insurance coverage whenever it reaches a certain point, and to provide coverage for early retirees.

Cochairman B. Burns noted that Mr. Schweikert is not available to make a presentation concerning AHCCCS and state employee health insurance.

Mr. Mendoza stated that his organization would support the concept of AHCCCS for state employees if the following items take place before implementation:

1. The transition should begin with a well-defined pilot program.
2. The program should be optional and not forced upon employees.
3. There should be no reduction in the benefit level employees currently receive.

Cochairman B. Burns said this issue will not be addressed since there is no one here to advocate for that.

DISCUSSION AND RECOMMENDATION OF ISSUES BROUGHT UP AT THIS MEETING

Ms. Hardy summarized the issues brought up during this meeting for discussion by the Members.

1. Discrepancies between coverage offered to employees in rural versus urban areas, i.e. should the state be allowed to bid on a regional county or some other basis for state employee health insurance or should it be required to bid on a statewide basis.

Discussion followed among the Members and Mr. Bell.

Cochairman Springer moved, seconded by Mr. Edens, that the Committee recommend that all bids for state employee health insurance be on a statewide basis. The motion carried.

2. Reblending of retirees with active employees, keeping them in a separate pool or transferring them to the system operated by ASRS.

Mr. Bell contended that the Attorney General's opinion was not sought after the bids; they had a representative from the Attorney General's Office on the committee while going through negotiations. He said after the bids, he was asked by one of the Senators to produce the opinion so he had the representative on the committee from the Attorney General's Office place it in writing.

Mr. Edens remarked that the issue of legality of reblending should be clarified.

Senator Hermon moved, seconded by Mr. Conner, that the Committee recommend reblending of the retirees, that a formal opinion be requested from the Attorney General's Office, and if it is necessary, a bill be drafted to change the statutes. The motion carried.

3. Consideration of allowing the retirees who dropped out of the state system and moved to ASRS, to re-enroll in ADOA on a one-time window-type basis.

Mr. Finnerty stressed the fact that this might have impacts on their program if there is a mass removal. He suggested that this be narrowed so that only those with a most recent change be allowed to go back.

Discussion followed on the time frame. The Members agreed that after the meeting this can be finalized.

Mr. Edens moved, seconded by Cochairman Springer, that the retirees who were previously under ADOA coverage and who transferred either to ASRS or private coverage from (date to be determined) be allowed to re-enroll in ADOA health insurance, and legislation be prepared to accommodate re-enrollment. The motion carried.

4. AHCCCS proposal

(Tape 3, Side A)

Cochairman Springer moved, seconded by Mr. Conner, that the AHCCCS proposal be tabled. The motion carried.

Professor Williams brought up the problem of spouses of active employees who are not eligible for insurance if the employee dies before retirement.

Cochairman B. Burns said this is an item the Committee could make recommendations on but stated that they should become more informed on the issue before doing so. She added that the Government Operations Committee would be the appropriate Committee for this subject. Professor Williams agreed to forward information to that Committee.

5. Additional recommendations from the audience, i.e. should all plans be bid on instead of just an indemnity plan.

Mr. Bell noted that beginning in January ADOA will be in the process of obtaining new rates for the coming year for the present contracts. He submitted that eliminating the existing contracts could place a strain on the Department as well as the health insurance companies. He said he did not interpret the Committee's recommendation for a statewide bid to start right now.

Discussion followed between Mr. Edens and Mr. Bell concerning Intergroup.

Cochairman B. Burns commented that this Committee can meet at any time at the request of any Member who has a concern which needs to be addressed. She added that she and Cochairman Springer will send a letter to the Attorney General regarding the reblending issue, and hopefully, will get a bill drafted to change the statutes. She said a bill regarding the time frame for re-enrollment in ADOA for retirees will also be drafted. She noted that the Members will be receiving a draft list of the Committee recommendations and asked to be apprised of any concerns the Members might have. She stated that quarterly reports should be forthcoming.

Mr. Edens noted that each Member has been given a copy of the RFP on the indemnity policy (Attachment 20).

Cochairman B. Burns encouraged the Members to review the RFP and to let the Chairs know if they notice anything that has not been addressed.

Without objection, the meeting adjourned at 5:13 p.m.


Linda Taylor, Committee Secretary

(Attachments and tapes are on file in the Office of the Chief Clerk.)

ATTACHMENT D

**Excerpts from Auditor General's
Performance Audit of
DOA's Personnel Division**



PERFORMANCE AUDIT

DEPARTMENT OF ADMINISTRATION

Personnel Division

Report to the Arizona Legislature

By the Auditor General

October 1993

93-6

SUMMARY

The Office of the Auditor General has conducted a performance audit and Sunset Review of the Department of Administration, Personnel Division, pursuant to a December 13, 1991, resolution of the Joint Legislative Oversight Committee. The audit was conducted as part of the Sunset Review set forth in Arizona Revised Statutes (A.R.S.) §§41-2951 through 41-2957, and is the first of six audits scheduled on the Department.

In order to meet the needs of its users, Arizona must significantly revise the manner in which personnel services are provided. Our audit work found that in the most important service areas -- hiring, classification, compensation, and benefits -- Arizona's current personnel system does not respond to its user's needs. The Federal Government and many other state and local governments are examining or discarding personnel systems that rely on extensive rules and restrictions in favor of systems offering the flexibility and responsiveness needed to provide efficient, effective service.

The State Needs To Redesign Its Outmoded Hiring System (see pages 5 through 12)

Currently, Arizona's hiring system can deter the best candidates from entering State service. The hiring lists provided by Personnel often contain unqualified or unavailable candidates. Some hiring supervisors stated that it was often difficult to find even one qualified, available applicant on lists submitted to them. In addition, the Division requires agencies to follow policies that are often counterproductive to effective hiring. For example, we identified one case where a supervisor was required to offer an interview to a candidate who did not speak English for a position that involved working with the public.

A comprehensive reform effort is needed to change Arizona's hiring system to allow agencies increased flexibility and service. Such reform will require revision of rules and statutes that restrict agencies' hiring options. In addition, more immediate changes in the Division's operating practices are also needed, including the use of supplemental applications, increased participation of agency supervisors in candidate evaluations, and recruiting at colleges and job fairs.

DOA Needs To Address Fundamental Problems With The State's Classification System (see pages 13 through 17)

Arizona's classification system is not being properly maintained or managed. While positions should be reviewed periodically to ensure that job duties, qualifications, and compensation are still appropriate, in the last 5 years, the Personnel Division has conducted reviews of only 22 percent of the 1,500 classifications in State government.

According to DOA officials, regular classification reviews were discontinued because there was not enough funding to implement salary upgrades which often result from such reviews. However, failure to maintain the system hampers the State's recruitment efforts, and results in inappropriate employee compensation. While DOA is considering significant changes to the classification system, their efforts may be premature, particularly until an assessment of needed changes is developed and funding issues are addressed.

DOA Should Improve Efforts To Inform Decision Makers On Salary Issues (see pages 19 through 23)

Although State employees are an essential resource of State government, employee salaries have not remained competitive. While State salaries were only 7 percent behind the market in 1988, lack of salary increases has now widened the gap to over 22 percent. As a result, State agencies have difficulty attracting and retaining high-quality employees. While DOA is responsible for presenting salary recommendations to the Legislature, it has based these recommendations on available funding rather than presenting the results of its analysis to policymakers and allowing them to determine the course of action. As the State's expert on compensation, DOA needs to provide the Governor and Legislature with timely, objective, and comprehensive reports detailing various alternatives.

DOA Needs To More Proactively Manage Its Employee Health Benefits Program (see pages 25 through 30)

The Personnel Division needs to more proactively manage State employee health care insurance benefits. In 1992, in an effort to meet the Governor's demand that there be no increases in State funding for employee health care insurance, the Division made several controversial decisions. These decisions resulted in increased costs and/or reduced services for a number of current State employees and retirees alike. Further, the decisions were made with little input from the Legislature or State employees. To prevent similar problems from occurring in the future, the Personnel Division needs to ensure the State's health care needs are defined in conjunction with the Legislature and State employees; that usage is monitored; and that its Request for Proposals is specific. Further, whenever a new contract is awarded, DOA needs to ensure that employees are adequately notified, and that the carrier's performance is monitored.

DOA Should Implement Mechanisms To Curb Escalating Health Care Benefit Costs (see pages 31 through 36)

With State employee health benefits costing \$168 million annually, and continuing to rise, DOA needs to adopt measures to curb these costs. DOA should consider implementing cost containment measures (such as comprehensive wellness programs and eligibility audits) that are utilized in other states and private industry. In addition, it should monitor State health care expenditures to target costly areas needing additional efforts.

FINDING IV

DOA NEEDS TO MORE PROACTIVELY MANAGE ITS EMPLOYEE HEALTH CARE BENEFITS PROGRAM

The Department of Administration's Personnel Division needs to more proactively manage State employee health insurance benefits. In early 1992, in an effort to prevent significant premium increases to the State, the Division made several controversial decisions. These decisions, however, increased costs and/or reduced services to both State employees and retirees. To prevent similar problems from occurring in the future, the Personnel Division needs to ensure that State employees' health care needs are defined in conjunction with the Legislature and State employees, that usage is monitored, and that its Request for Proposals is specific. Further, whenever a new contract award is made, DOA needs to ensure that employees are adequately notified, and that carrier performance is monitored.

Decisions Made To Contain Costs Result In Controversy

In an effort to thwart an increase in health care costs, DOA made several controversial decisions. These decisions resulted in reduced services and increased out-of-pocket costs for a number of State employees and retirees. Due to considerable pressure from many sources, the Division has made some changes to specifically address these problems; however, their cause has not been addressed.

Decisions made to avoid cost increases - In 1992, the Personnel Division received a proposed premium increase of over 26 percent from its health insurance carriers. The Division projected that the premium increases would cost the State an additional \$44 million per year. However, the Governor mandated that there be no increase in State funding for employee health insurance. After weeks of negotiations with the insurance carriers, the Division determined that they had reached an impasse.

In an effort to prevent an increase in State health insurance premiums, the Division made several controversial decisions. First, the Division decided to place the health insurance contracts out to bid, rather than continue the current contracts, although there was very little time to complete the bidding process. In addition, the Division changed the way bids were requested to separate the more expensive groups, retirees and rural employees, from the general risk pool (to discontinue subsidizing of these groups by urban State employees). The Division also allowed the carriers to define the coverage they would provide, rather than the Division explicitly indicating the State's needs. Finally, the Division selected a cost-sharing strategy whereby the State

contributes an equal amount toward premium costs for each employee located in a given geographic region, rather than contributing more toward the more expensive plans. While these decisions did result in savings to the State, employees and retirees suffered the following consequences:

- Because the counties were bid individually, insurance plans offered different coverage for rural and urban employees. While HMO coverage had been previously available in most counties, in many rural counties HMO coverage was either eliminated or altered such that it was no longer a viable option. Many State employees in rural communities found that while HMO coverage was available, their community either lacked providers and/or a participating hospital. Further, urban employees were no longer offered an indemnity plan.
- Retirees, rural employees, and those urban employees enrolled in non-HMO plans were faced with huge out-of-pocket increases. Some retirees saw premium increases of over 50 percent (from \$485 to \$757 per month for family coverage). Further, some rural State employees were offered only indemnity coverage and were faced with paying up to \$1,250 per person or \$2,500 per family in out-of-pocket expenditures.
- Some employee populations were left without coverage for their medical conditions, although they had coverage under past plans. For example, a prior plan had covered durable medical equipment and diabetic supplies, and the new plan limited coverage for some of these items. In other instances, medical conditions were covered, but at a much greater cost. For example, hospice and home care which had previously been available through the indemnity program at 80/20 and no limits was limited to 70/30 coverage, with a \$7,500 maximum.
- Employees in rural areas of the State reported that they were unable to find providers. In some instances, the employees found that providers listed in the directory were not accepting new patients.
- Because new carriers were added and these new carriers had a short lead time to begin providing service, employees received inadequate service from the carriers at the beginning of the plan year. Claim payments were delayed for over two months by one carrier, and some employees did not receive plan information or identification cards from two carriers for several months.

Division took action to reduce burden on employees - After receiving pressure from employee groups, legislators, the media, and an employee petition drive, the Division made some changes to the medical plans to address employees' concerns over coverage and cost. The Division added coverage for conditions that had been omitted under the new plans and decreased deductibles and out-of-pocket costs for employees living in the rural areas. The Division also encouraged the development of HMOs in some of the rural areas to provide plans with lower employee costs. Although these

actions reduced some of the employees' financial burdens, they do not address the problems' causes.

Number Of Actions Needed To Avert Future Problems

DOA needs to take a number of steps to prevent similar problems from occurring in the future. DOA needs to work with legislators and employees to define the State's health care needs and goals. Further, DOA needs to monitor health care utilization to prevent "surprise" increases. Finally, when DOA does go to bid, it needs to ensure that its Request for Proposal (RFP) is as specific as possible.

Division must define the health care program with input from concerned parties -
Because key policy questions regarding the State's health care program remain controversial, decisions need to be made regarding what coverages should be provided. For example:

- What types of health care plans should be offered (i.e. HMOs, Indemnity, PPOs)?
- Should coverages and costs vary between urban and rural employees?
- Who should be covered (i.e. retirees and current employees)?
- What level of coverage should be provided?
- How should costs be allocated between the State and its employees (i.e. equal contribution for each employee versus greater subsidizing of the more expensive plans)?
- Should the current contracts be renewed or rebid?

In defining State health care program needs and goals, DOA needs to work in conjunction with the Legislature. In procuring the health insurance programs in 1992, the Division excluded legislators from its decision making process. Not only did the exclusion result in less-than-desirable coverage for employees and retirees, it eliminated the Legislature's ability to take action to avert the problem. For example, during a legislative meeting, a legislator indicated that had the Legislature been aware of the increasing cost of the former health care plans, it may have elected to continue those plans by funding the premium increase, instead of offering an employee raise.

Further, legislators noted that the decision to separate retirees from the rating pool drastically impacted their policy to offer early retirement packages to employees.¹

Further, because decisions so strongly impact employees, efforts should be made to ensure that employee interests are considered and to identify potential problems. Other states, as well as other Arizona employers we contacted, indicated that they use employee focus groups, surveys, and committees when planning benefits programs.

Division does not monitor claims experiences - As described previously, the Division was surprised by the large increases proposed for renewing their contracts in 1992 and this was due, in part, to a lack of utilization data. Utilization data is critical in allowing the Division to know how much carriers are expending for claims, and whether premium increases may be warranted during contract negotiations. Although the State's provider contracts require monthly, quarterly, and annual utilization reports, the Division has not ensured that all carriers have submitted these reports on a consistent basis. In addition, when information is received, it is often untimely, incomplete, and unreliable.

Our panel of benefits managers indicated that employers must push the carriers into providing data on how health care dollars are being spent. Without obtaining this information, the Division cannot monitor and evaluate the services carriers are providing or determine what medical services the State is paying for.

RFP needs to be specific - Contrary to its 1989 RFP, DOA's 1992 RFP was vague with regard to the State's desired health coverage. According to DOA officials, the RFP was intentionally left open so that the Department could identify the most cost-efficient carriers in each area of the State. However, by not dictating what coverages it desired, the State was left to choose from the various plans offered and varying benefit levels. Thus, when the contracts were awarded, employees in various geographic regions had varying plans and different benefit levels.

In the future, DOA should prepare a detailed request for bids specifying the coverage desired for State employees. The RFP should detail the plan design and specify deductibles and co-insurance levels. If the Division needs to explore alternative plans, this can still be done in the RFP. The State of Kansas, for example, included several questions for the carriers about options they were considering, after they had presented the specific plan design. The RFP also allowed carriers to bid an alternate plan in addition to those that were specified.

1. After being excluded in 1992 decisions, the Legislature enacted legislation in 1993 establishing the Legislative Oversight Health Insurance Benefits Review Committee. The Committee has been charged with reviewing some of the more controversial problems stemming from DOA's 1992 decisions, including whether retirees should be regrouped with State employees, whether there are ways to minimize the differences in coverages between rural and urban employees, and whether employees who terminated coverage in the last six months of 1992 should be allowed to reenroll.

Additional Actions Needed Once An Award Is Made

When DOA awards new contracts, it needs to ensure that employees have sufficient information regarding coverage options on which to base their selection decisions. Further, DOA needs to monitor carriers to ensure they are meeting contract requirements.

Communication regarding coverage options is important - During the open enrollment period in 1992 in which the new benefit plans were introduced, employees received incomplete information regarding them. Although the State was adding new carriers and eliminating coverages with others, employees could not determine from materials provided what medical conditions would be covered. For example, employees enrolled in one plan were not informed for several months that allergy shots were not covered on an out-of-network basis. Further, although the State held meetings for employees to learn about the new plans, carrier representatives were not present and the Division representatives providing the information lacked specifics.

Other states use a variety of methods to distribute benefit information. For example, Nevada produces a video presentation of the benefits plans to use at open enrollment meetings and for new employee orientation. Ohio and Utah arrange a health benefits fair at open enrollment where carrier representatives are on hand to answer questions for employees.

Once employees select health plan options, DOA needs to ensure that they promptly receive information regarding how and where to obtain medical services. In 1992, employees enrolled in some programs did not receive users manuals until two months after the date coverage began. Complaints were received that employees were confused about where to go for treatment. This was especially problematic for those enrollees who experienced medical emergencies.

Division needs to monitor carrier performance - The Division should monitor the carrier's performance to ensure employees are receiving adequate service. The Division has set several performance standards for the carriers in the contract. For example, carriers are required to pay 90 percent of claims within 14 calendar days of receipt, achieve a payment processing accuracy rate of 95 percent, and have a 75 percent satisfaction rate. The contract also allows monetary penalties for failure to meet these standards on a quarterly basis.

Although empowered by the contract to monitor performance, the Division has failed to do so adequately. Without this monitoring, the State does not know if the carriers are meeting the contract terms. Further, the State may not be collecting the penalties to which it is likely entitled. For example, one carrier delayed some claims payments well beyond the 14-day standard for the first quarter of the plan year, however the Division did not determine the extent of the delays, and thus does not know if the State is entitled to a 5 percent reduction in the carrier's retention fees for the quarter.

RECOMMENDATIONS

1. In making major policy decisions, the Division should include employees and the Legislature in the decision making process to help define goals for the health insurance plans.
2. The Division should establish the design of the health insurance plans prior to beginning the procurement process, and include the specifics of the plan design in the RFP.
3. The Division should improve communications with employees on the benefits programs.
4. The Division must work to obtain utilization information from the carriers and use this information to project potential carrier premium increases and determine their validity.
5. The Division must monitor the health insurance program and evaluate the insurance carriers for achievement of performance standards, assessing the contractual penalties for nonperformance.

FINDING V

THE DIVISION SHOULD IMPLEMENT MECHANISMS TO CURB ESCALATING HEALTH CARE BENEFIT COSTS

Soaring health insurance costs have forced governments and private companies across the nation to seek control over further increases. Arizona's cost to provide its employees' health benefits has risen to \$168 million, with additional increases on the horizon. While the Personnel Division has taken some steps to curb costs, it should consider implementing additional cost containment measures utilized in other states and private industry. In addition, it should monitor health care expenditures to target costly areas.

Health Benefit Costs Rapidly Rising At The National And State Levels

Nationally, the cost of health care is increasing at a rapid rate. Currently, the medical inflation rate is outpacing the Consumer Price Index and insurers are predicting that the cost for the typical medical plan will increase 20 to 25 percent per year. In fact, studies predict that by the year 2000, employers will need to spend over \$20,000 per employee each year to provide traditional health insurance plans¹. Benefits literature attributes the increasing costs to medical inflation, technological changes, and use of costly medical treatments.

In line with national trends, Arizona has also experienced dramatic increases in its health insurance costs, with future increases predicted. Between fiscal year 1989-90 and 1991-92, the State's contribution toward employee benefits rose almost 35 percent (from \$101 million to \$135 million). Over this same period, the average premium cost paid by Arizona per employee rose from approximately \$2,400 to \$3,000 (25 percent increase). For fiscal year 1993-94, the program will experience a cost increase of 5.9 percent overall, with one plan increasing by over 15 percent. One Arizona carrier projects health care cost increases to be about 14 percent per year. Even if cost increases were kept to 10 percent annually, the State would be expending over \$200 million within 5 years.

1. Higgins, A.E. "Yes, Companies Can Cut Health Costs," Fortune Magazine, July 1, 1991, p. 52.
Rimler, G.W. "Managed Care: the Solution or the Problem?" Benefits Review, May-June 1992, p. 34.

The Division Should Consider Aggressive Cost Containment Measures

Although increases in health care insurance are likely to continue, the Personnel Division should consider implementing measures taken by other states and private companies to lessen the extent of the increases. The Division has made some efforts to curb its costs, yet additional efforts should be considered. "Carve out" programs could be instituted to reduce the cost of mental health and drug programs. In addition, implementing a wellness program and conducting eligibility audits could lessen utilization of health insurance.

A variety of sources were utilized to identify commonly used cost containment measures. We conducted an extensive literature search of over 100 current benefits articles. In addition, we surveyed seven other states regarding their programs.¹ Further, we interviewed human resources and benefits professionals representing several major Arizona employers and held a panel discussion with a group of these professionals.²

From this research, we discovered a variety of cost containment measures currently in place within other organizations. While the Personnel Division is already utilizing some measures, such as the use of less costly managed health care plans (i.e. HMOs versus indemnity plans), we identified other measures which DOA should consider implementing to curb cost increases. These measures are presented as follows.

"Carve out" of mental health and prescription drug programs - Under Arizona's current health benefit plans, all health care services are provided by the plan providers. However, a number of Arizona employers and other State officials we interviewed indicated that they have revised their plans to essentially "carve out" some of their more costly services, including mental health and prescription drug programs. These programs are then separately contracted and managed.

Managed mental health/substance abuse programs could be an effective mechanism to manage both costs and the care provided. Two of the larger Arizona employers we interviewed indicated that they had implemented this type of program and had positive feedback from employees; both felt that employees were receiving better care than had been previously provided. Several other states, including New York and Ohio, had also implemented managed mental health/substance abuse programs.

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1. We selected the states in our survey based on geographic location (Utah, Nevada, and Colorado), a similar covered employee population to Arizona (Ohio and Kansas), and recognition in the literature for having successful cost containment programs (New York and Illinois).
 2. Our panel consisted of human resource and benefits professionals from Salt River Project, Arizona Public Service, McDonnell Douglas, Honeywell, and the City of Phoenix.

Managed prescription drug programs are another means of providing better cost control. Prescription drugs generally account for about 15 percent of an employer's expenditure for health care, and the cost of drugs is rising at over 20 percent annually. Some employers separately manage prescription drug programs and encourage the use of less costly prescription drugs through techniques such as generic substitution, differing copayments for brand name and generic drugs, use of a mail-order service, and use of a formulary (a predetermined set of cost-effective drugs).

Comprehensive wellness program - Studies indicate that wellness programs can be an effective means of reducing utilization of medical plans through developing a healthier workforce. Wellness programs typically include employee health screenings to determine areas of health risk, educational programs aimed at educating employees in health risk areas identified in health screenings, and follow-up screenings and counseling to measure progress toward wellness goals. Further, some wellness programs provide incentives to employees to encourage them to participate.

Although it is difficult to measure the dollars saved by wellness programs, there are some compelling reasons for implementing them. Lifestyle-related illnesses are costly; in fact, lifestyle-related costs are estimated to account for 55 percent of all health care costs. One study indicated that employees who smoke or drink excessively, or who are overweight, cost employers up to \$900 per employee in excess costs per year. Employers with comprehensive programs have experienced lower health care costs and reaped additional savings from reduced absenteeism and turnover.

The Legislature, recognizing the value of wellness programs, passed legislation in 1990 requiring DOA to implement such a program. Further, funding for wellness programs is available through the Special Employee Health Insurance Trust Fund.¹ In spite of the legislation and funding, the Personnel Division has developed a very limited program consisting of a library of material for employees to use, distribution of a wellness/benefits newsletter, and offering of wellness classes. In fact, for fiscal year 1992-93 the Division budgeted over \$380,000 for wellness programs; however, as of May 31, 1993, they have spent less than \$34,000 for wellness activities.

Implementation of measures to eliminate ineligible dependents - Another means of decreasing utilization of health insurance is by eliminating coverage for ineligible dependents. Although enrolling ineligible dependents on insurance plans is a common form of employee fraud, the Personnel Division does not have adequate mechanisms in place to prevent or detect such occurrences. Prior to enrolling dependents, the Division should require proof of eligibility. Currently, the Division limits its screening efforts to a review of the enrollment application for inconsistencies (such as children with last names different from the employee's). Some other employers require

1. The Special Employee Health Insurance Trust Fund was established by A.R.S. §38-654 for use in administering the State employee health insurance monies. These monies are collected from employer and employee premium contributions and can be expended for health insurance premiums, claims costs, administration, and plan improvements. As of May 31, 1993, the Fund had a balance of over \$1 million available for wellness programs.

employees enrolling dependents to provide supporting documentation, such as a marriage license or a birth certificate.

In addition, the Division should consider conducting eligibility audits to identify ineligible dependents who are already enrolled. The City of Chicago, for example, conducted a year-long investigation which resulted in letters being sent to 1,988 employees questioning the eligibility of their 3,228 dependents (the City had 130,000 employees, dependents, and retirees). The investigative report showed that there was gross abuse of the City's health care benefits, including the carrying of ex-employees who were no longer paying, and employees enrolling ineligible grandchildren and college-age children.

Finally, the Division should develop a policy which includes penalties to deter employees from enrolling ineligible dependents. Currently, Arizona has no such penalty. The Division should establish a policy on handling employees who commit enrollment fraud, and communicate it so that it is well known. Two of our panel members indicated that it is their companies' policy that enrollment fraud is grounds for termination. In addition, one of our panel members indicated that during open enrollment, employees are given an "amnesty period" whereby they are provided with clear notice as to which dependents are eligible, and then given the opportunity to drop those who are not.

Personnel Division Needs To Monitor Costs To Effectively Target Its Cost Containment Efforts

For the Division to implement effective cost containment measures, it needs to obtain comprehensive and accurate expenditure data from the carriers. Expenditure information is critical for determining actions needed as well as monitoring the impact of actions taken.

Necessary information lacking - While the Personnel Division receives expenditure reports from its three carriers, the data does not allow the Division to adequately analyze cost containment options. We reviewed the expenditure report submitted by one of the carriers for the period of August 1 through October 31, 1992, and found that the carrier listed a majority of claims paid as "unknown," and thus did not indicate the types of services rendered. Without this information, the Division is limited in its ability to determine what cost containment actions are warranted.

Part of the Division's problem in obtaining reliable data may stem from its failure to require such information. The Division's contracts clearly indicate that it is entitled to expenditure information from the carriers. While it has received information, it has, to our knowledge, not attempted to force the carriers to submit complete and reliable information. Further, we saw no evidence that the Division attempts to use the information to routinely perform any analyses of its expenditures.

Cost containment efforts should be targeted and measured - Lack of comprehensive expenditure information limits the Division's ability to identify needed cost containment measures. Expenditure information is critical to determining areas with high expenditures, or problematic areas needing attention. This information should be used in designing the State's wellness program and in modifying the design of the health care plan. Other employers have used cost information to target their efforts to control costs; for example:

- One of our panel members commented that in reviewing trends in his company's utilization data, he found that prescription drug expenditures were high, which then triggered a decision to address this area through a carve-out from their existing plans.
- Another panel participant noted that reviewing the top ten expenses for his company's health insurance program impacts what is offered through the company's wellness program. For example, if premature babies are a top expense, then prenatal care may be added to the wellness program.
- A university in New York established a committee to identify potential cost containment areas. The committee analyzed the employee population's health care cost demographics and trends, and conducted a specific utilization analysis of the health plans. As a result of its analysis, numerous changes were made. For example, the indemnity plan was revised to make it easier and less expensive for patients to seek mental health care on an outpatient basis. Further, the university offered an incentive program (cash payments of \$300 to \$500 per year) to encourage employees to use their spouses' health benefits rather than the university's plans. In addition, the wellness program was revised to offer programs designed to address problems found during their health screenings.

Comprehensive expenditure information is also necessary to evaluate the effectiveness of cost containment measures that are taken and to identify areas where further efforts are needed. The Division needs to have information available on the utilization expenditures of the health plans both before and after implementing cost containment measures to allow evaluation of their impact. For example, a New York university evaluation committee began with techniques that it later realized had limited value, such as adjusting premiums to shift more costs to employees. By studying the impact of its changes, the committee was able to evaluate its actions, and then make additional changes to modify its efforts.

RECOMMENDATIONS

1. The Division should consider implementing cost containment techniques used by other employers, including carving out of the mental health or prescription drug programs, developing a comprehensive wellness program, and conducting eligibility audits.
2. The Division should obtain adequate expenditure data on the health plans in order to target and measure the effectiveness of cost containment efforts.
3. The Division should develop a policy regarding enrollment fraud, and make the policy widely known to employees to deter its occurrence.

Finding V: The Division should implement mechanisms to curb escalating health care benefit costs.

Recommendation 1: The Division should consider implementing cost containment techniques used by other employers, including carving out of mental health or prescription drug programs, developing a comprehensive wellness program and conducting eligibility audits.

Response: The State has and will continue to implement cost containment techniques. It must be considered, however, that many of those employers cited have done less to control costs to date than the State has accomplished as an ongoing practice. Therefore, many of these programs would be less useful for the State than they are for employers who have implemented them. For example, the prescription programs currently in place offer as great a savings as would a stand-alone plan. This is accomplished through the discounts negotiated by the carriers, the use of generic drugs and formularies within the plans. Generally, carved-out mental health plans offer a more comprehensive level of benefits than are available under current state plans. A study performed by the Wyatt Company determined that the start up costs for implementation of a carved-out mental health plan for the state would negate any potential savings. Additionally, the State's wellness program is in the process of being further developed. Following the development of a policy regarding eligibility enrollment fraud, eligibility audits will be conducted.

Recommendation 2: The Division should obtain adequate expenditure data on the health plans in order to target and measure the effectiveness of cost containment efforts.

Response: The Division continuously has utilized expenditure data to target cost containment efforts and validate renewal requests. For example, in response to an analysis of the number of low birth weight babies and associated complications, the Division has developed a comprehensive prenatal care/education program in conjunction with the State's carriers. Efforts are ongoing to improve the quality of the data received from the carriers.

Recommendation 3: The Division should develop a policy regarding enrollment fraud and make the policy widely known to employees to deter its occurrence.

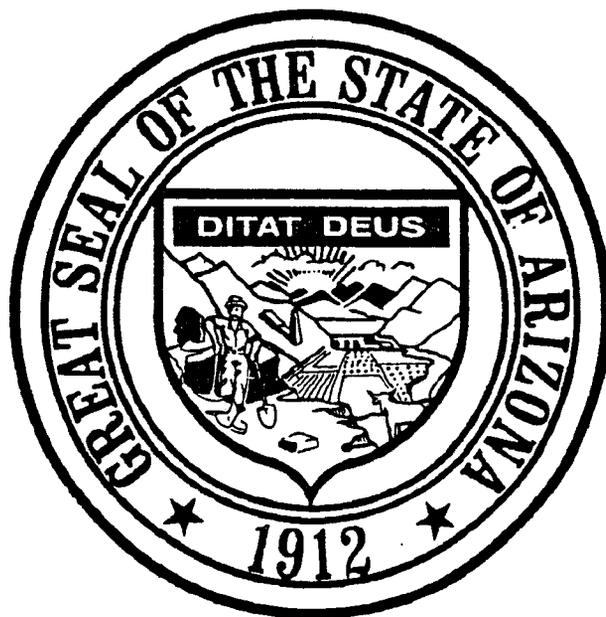
Response: The Division agrees and is developing such a policy.

ATTACHMENT E

**Overview of State of Arizona
Health Insurance Benefits**

ARIZONA DEPARTMENT OF ADMINISTRATION
HEALTH INSURANCE BENEFITS OVERVIEW

FISCAL YEAR 1993-1994



AUGUST 1993

TABLE OF CONTENTS

Table of Contents	1
Employee Contribution Schedule	1
Medical Benefits Comparison	
Maricopa and Pima Counties	3
Geographic Locations Other Than Cochise, Maricopa, Pima, and Pinal Counties	8
Cochise and Pinal Counties	11
Dental Benefits Comparison	15

**Employee Portion of Monthly Insurance Premium
10/1/93 Through 9/30/94**

County of Residence	Carrier	Single/Month	Family/Month
<i>Medical Carriers:</i>			
Maricopa County	CIGNA Staff HMO	\$ 5.00	\$ 75.00
	CIGNA IPA HMO	\$ 53.36	\$195.08
	Intergroup HMO	\$ 9.54	\$ 77.96
	Interflex	\$ 65.82	\$223.22
Pima County	CIGNA HMO	\$ 5.00	\$ 75.00
	Intergroup HMO	\$ 14.60	\$ 86.54
	Interflex	\$ 70.76	\$228.30
Cochise & Pinal Counties	BCBSAZ HMO	\$ 5.00	\$ 75.00
	BCBSAZ PPO	\$ 5.00	\$ 75.00
All Other Counties	BCBSAZ HMO	\$ 5.00	\$ 75.00
	BCBSAZ Indemnity	\$ 5.00	\$ 75.00
Outside Arizona	BCBSAZ Indemnity	\$ 5.00	\$ 75.00
<i>Dental Carriers:</i>			
All Counties	Associated Health Plans	\$ 2.50	\$ 10.36
	Delta Dental	\$ 4.92	\$ 23.26
<i>Vision:</i> All Counties	Vision Service Plan	\$ 7.96	\$ 18.32

MEDICAL BENEFITS COMPARISON

MARICOPA AND PIMA COUNTIES

Medical Benefits Comparison Chart
for Maricopa and Pima Counties
 Benefits in Effect October 1, 1993



Benefits <small>All benefits are subject to plan limitations and exclusions.</small>	Interflex Option		Intergroup HMO Option	CIGNA Options IPA & Staff HMO
	In Network	Out-of-Network		
Inpatient Mental Health	Covered Expenses paid at 90%. **Maximum 30 days/calendar year.	Covered Expenses paid at 70% after deductible. **Maximum 30 days/calendar year. <i>Precertification required.</i>	No charge. Maximum 30 days/12 consecutive months. Limited to short-term crisis intervention.	No charge. Limited to 30 days/plan year.
	** Limited to short-term crisis intervention. In- and out-of-network benefits combined.			
Outpatient Mental Health	\$25 copayment/visit. **Maximum 20 visits/calendar year.	**Covered Expenses paid at 50% after deductible up to \$1,000/calendar year/individual. <i>Precertification required.</i>	\$15 copayment/individual visit. \$7.50 copayment/group visit. Maximum 20 visits/12 consecutive months. Limited to short-term crisis intervention.	\$20 copayment/visit. Limited to 20 visits/plan year. \$5 copayment/group therapy.
	** Limited to short-term crisis intervention. In- and out-of-network benefits combined.			
Inpatient Substance Abuse	Covered Expenses paid at 90%. **Lifetime maximum 2 treatment programs/person for treatment of drug & alcohol abuse. <i>Substance abuse program must be completed or out-of-network benefits apply.</i>	Covered Expenses paid at 70% after deductible. **Limited to 30 days/calendar year. <i>Precertification required.</i>	Same benefit for in- and out- patient. No charge. Lifetime maximum 2 treatment programs/person for treatment of drug and alcohol abuse. <i>Must complete program to receive benefits.</i>	No charge. Detoxification only.
	** Substance Abuse in- and out-of-network benefits combined.			

If there is a discrepancy between this information and the official documents, the documents will always govern.

Medical Benefits Comparison Chart

for Maricopa and Pima Counties

Benefits in Effect October 1, 1993



Benefits <small>All benefits are subject to plan limitations and exclusions.</small>	Interflex Option		Intergroup HMO Option	CIGNA Options IPA & Staff HMO
	In Network	Out-of-Network		
Outpatient Substance Abuse	<p>Covered Expenses paid at 100%. **Lifetime maximum 2 treatment programs/person for treatment of drug & alcohol abuse. <i>Substance abuse program must be completed or out-of-network benefits apply.</i></p> <p>** <i>Substance Abuse in- and out-of-network benefits combined.</i></p>	<p>Covered Expenses paid at 50% after deductible. **\$1,000/calendar year/person. <i>Precertification required.</i></p>	<p>Same benefit for in- and out- patient. No charge. Lifetime maximum 2 treatment programs/person for treatment of drug and alcohol abuse. <i>Must complete program to receive benefits.</i></p>	<p>\$5 copayment/visit. Limited to 60 visits/plan year.</p>
Durable Medical Equipment (DME) Purchase & Repair	<p>Covered Expenses paid at 100%. Repair and replacement covered.</p>	<p>Covered Expenses paid at 70% after deductible. Repair and replacement <i>not</i> covered.</p>	<p>No charge. Covered Expenses for repair and replacement paid at 100%.</p>	<p>\$200 deductible/member/plan year. Limited to max of \$5,000/member/plan year. Maintenance/repair/replacement due to normal use.</p>
Hearing Aids <i>Must be medically necessary.</i>	<p>Covered Expenses paid up to \$750/ear/year.</p>	<p><i>Not covered</i></p>	<p>Covered Expenses paid up to \$750/ear/year.</p>	<p>\$200 deductible/member/plan year. Limited to \$1,000 max/member/plan yr. Ded/max combined with external prosthetic appliances.</p>
Diabetic Supplies	<p>\$8 copayment/packaged unit.</p>	<p>\$50 prescription deductible, then 70% coinsurance.</p>	<p>\$5 copayment/packaged unit</p>	<p>\$3 copayment/prescription/refill (30 day supply.) Limited to home glucose monitoring device, glucose test strips and lancets--<i>available only at CIGNA Staff Model pharmacies.</i></p>
Allergy Shots	<p>\$10 copayment/visit</p>	<p><i>Not covered</i></p>	<p>No charge</p>	<p>No charge-nurse \$5 copay-doctor</p>
Chiropractors <small>[Maintenance rehab/service not covered.]</small>	<p>\$10 copayment/visit. <i>Referral by PCP required.</i></p>	<p>Covered Expenses paid at 70% after deductible.</p>	<p><i>Not covered</i></p>	<p><i>Not covered</i></p>

If there is a discrepancy between this information and the official documents, the documents will always govern.

MEDICAL BENEFITS COMPARISON

GEOGRAPHIC LOCATIONS OTHER THAN
COCHISE, MARICOPA, PIMA, AND PINAL COUNTIES

Medical Benefits Comparison Chart

For All Geographic Locations Other Than Cochise, Maricopa, Pima and Pinal Counties

Benefits in Effect October 1, 1993



Benefits All benefits are subject to plan limitations and exclusions.	Blue Cross Blue Shield of Arizona	
	Indemnity Option	HMO Option <i>May Not Be Available in All Locations. Call 1-800-232-2345, extension 4828 for network information.</i>
Annual Deductible (Plan Year)	\$150/person \$300/family	None
Coinsurance THE PLAN PAYS	Covered Expenses paid at 80% for first \$3,000 after deductible/plan year, then 100% for the rest of the plan year. (If you use a "preferred provider", coinsurance will be based on discounted fees.)	Coinsurance does not apply to this option.
* Out-of-Pocket Maximum Including Deductibles (Plan Year) [WHAT YOU PAY]	\$750/person \$1,500/family	Limited to stated copayments. Stated copayments.
Lifetime Maximum Benefits	\$1 million including \$25,000 lifetime maximum for mental health and substance abuse benefits.	Unlimited except \$25,000 lifetime maximum for mental health and substance abuse benefits.
Pre-existing Conditions	Not covered until in the plan for 11 months.	Not covered until in the plan 11 months.
Preventive Care	<ul style="list-style-type: none"> • Well-child care through age 5 • Prenatal care - Covered Expenses paid at 80%, deductible waived • Well-woman care - Covered Expenses paid at 80% after deductible 	\$10 copayment/visit for: Well-baby care Well-woman care Physical exams Immunizations
Doctor's Office Visit	Covered Expenses paid at 80% after deductible	\$10 copayment/visit
Prescription Drugs	\$5 copayment/prescription or refill through PERFORM network (34 day supply)	\$5 copayment/prescription/refill through PERFORM network (34 day supply)
<i>Inpatient</i> Hospital (facility charges)	Covered Expenses paid at 80% after deductible Requires precertification.	Covered at 100% Requires precertification.
<i>Outpatient</i> Hospital	Covered Expenses paid at 80% after deductible	Covered Expenses paid at 100% Requires precertification.
Emergency Treatment Facility	Covered Expenses paid at 80% after deductible	\$50 copayment Waived if admitted to HMO hospital.
Outpatient Accident Benefit	Plan pays \$300/person/accident before you pay any deductible or coinsurance.	
Ambulance (Medical Emergency Only)	Covered Expenses paid at 80% after deductible (Medical Emergency Only)	No charge (Medical Emergency Only)
<i>Outpatient</i> Rehabilitation (eg. Physical Therapy)	Covered Expenses paid at 80% after deductible	Covered at 100%. 40 visit limit/plan year.
Skilled Nursing Facility (must be medically necessary.)	Covered Expenses paid at 80% after deductible Requires precertification.	Covered Expenses paid at 100% up to 90 days/plan year Requires precertification.

Using providers who do not have participating agreements with BCBSAZ may result in out-of-pocket expenses in excess of those stated.

Medical Benefits Comparison Chart

For All Geographic Locations Other Than Cochise, Maricopa, Pima and Pinal Counties
Benefits in Effect October 1, 1993



Benefits All benefits are subject to plan limitations and exclusions.	Blue Cross Blue Shield of Arizona	
	Indemnity Option	HMO Option <i>May Not Be Available in All Locations. Call 1-800-232-2345, extension 4828 for network information.</i>
Home Health Care <i>Must be medically necessary.</i>	Covered Expenses paid at 80% after deductible (Part-time and intermittent) Requires precertification.	No charge (Part-time and intermittent) Requires precertification.
Hospice Care <i>Must be medically necessary.</i>	Subject to case management	No charge. Requires precertification.
Inpatient Mental Health and Substance Abuse (This benefit's out-of-pocket expenses are not included in out-of-pocket maximum.)	Covered Expenses paid at 80% after deductible up to \$10,000 maximum benefit in any 12-month period. \$25,000 lifetime maximum benefit.	Biodyne determines necessity. Covered Expenses paid at 100% up to \$10,000 maximum benefit in any 12-month period. \$25,000 lifetime max benefit.
Outpatient Mental Health and Substance Abuse (This benefit's out-of-pocket expenses are not included in out-of-pocket maximum.)	<ul style="list-style-type: none"> Covered Expenses paid at 80% after deductible up to \$1,000 maximum benefit/person/calendar year. Biodyne Centers - \$5 copayment/visit for first 10 visits/plan year; out-of-pocket maximum of \$50/person and \$100/family. Additional visits covered at 100%. 	Biodyne Centers only \$5 copayment/visit for first 10 visits per plan year; out-of-pocket maximum of \$50/person and \$100/family. Additional visits covered at 100%.
Durable Medical Equipment (DME)	Covered Expenses paid at 80% after deductible Purchase and Repair Requires Precertification.	Covered Expenses paid at 100% Purchase and Repair Requires Precertification.
Hearing Aids	Covered Expenses paid at 100% up to \$750 maximum benefit/ear/plan year	Covered Expenses paid at 100% up to \$750 maximum benefit/ear/plan year
Diabetic Supplies	Insulin and syringes covered through PERFORM prescription program. Other items covered as DME. See DME above.	Insulin and syringes covered through PERFORM prescription program. Other items covered as DME. See above.
Allergy Shots	Covered Expenses paid at 80% after deductible	\$10 copayment
Chiropractors	Covered Expenses paid at 80% after deductible	Not Covered

IMPORTANT INFORMATION REGARDING PRECERTIFICATION

The following items require precertification.

Failure to precertify may result in the reduction or elimination of payments for such benefits.
(If you are enrolled in the HMO, your PCP must precertify services for you.)

- Hospital Inpatient Admission (precertification waived for emergency and maternity admissions)
- Magnetic Resonance Imaging (MRI)
- Durable Medical Equipment (DME)
- Home Health Care
- Skilled Nursing Facility
- Inpatient Active Rehabilitation
- Home IV Therapy
- Outpatient Surgery (HMO Only)
- Referrals to Specialists (HMO Only)

If there is a discrepancy between this information and the official documents, the documents will always govern.

MEDICAL BENEFITS COMPARISON

COCHISE AND PINAL COUNTIES

Medical Benefits Comparison Chart
for Cochise and Pinal Counties
Benefits in Effect October 1, 1993



Benefits All benefits are subject to plan limitations and exclusions.	Blue Cross Blue Shield of Arizona		
	Preferred Care PPO Option		HMO Option
	PPO	Non - PPO	
Annual Deductible (Plan Year)	\$150/person \$300/family	\$300/person \$600/family	None
Coinsurance THE PLAN PAYS	Covered Expenses paid at 80% for first \$3,000 after deductible/plan year, then 100% for rest of year.	Covered expenses paid at 70% for first \$10,000/plan year, then 100% for rest of year.	Coinsurance does not apply to this option.
** Out-of-Pocket Maximum Including deductibles (Plan Year) [WHAT YOU PAY]	\$ 750/person \$1,500/family	\$3,300/person \$6,600/family	Stated copayments.
Lifetime Maximum Benefits	\$1 million including \$25,000 lifetime maximum for mental health and substance abuse benefits	\$1 million including \$25,000 lifetime maximum for mental health and substance abuse benefits	Unlimited except \$25,000 lifetime maximum for mental health and substance abuse benefits.
Pre-existing Conditions	Not covered until in the plan 11 months.	Not covered until in the plan 11 months.	Not covered until in the plan 11 months.
Preventive Care	<ul style="list-style-type: none"> • Well-child care through age 5 • Prenatal care-Covered Expenses paid at 80%, deductible waived • Well-woman care-Covered Expenses paid at 80% after deductible 	<ul style="list-style-type: none"> • Well-child and Well-woman care <i>not</i> covered • Prenatal care-Covered Expenses paid at 70%, deductible waived 	\$10 copayment/visit for: Well-baby care Well-woman care Physical exams Immunizations
Doctor's Office Visit	Covered Expenses paid at 80% after deductible	Covered Expenses paid at 70% after deductible	\$10 copayment/visit
Prescription Drugs	\$5 copayment/prescription or refill through PERFORM network (34 day supply)	\$5 copayment/prescription or refill through PERFORM network (34 day supply)	\$5 copayment/prescription or refill through PERFORM network (34 day supply)
<i>Inpatient</i> Hospital (facility charges)	Covered Expenses paid at 80% after deductible Requires precertification.	Covered Expenses paid at 70% after deductible Requires precertification.	Covered at 100% Requires precertification.
<i>Outpatient</i> Hospital	Covered Expenses paid at 80% after deductible	Covered Expenses paid at 70% after deductible	Covered Expenses paid at 100% Requires precertification.

** Using providers who do not have participating agreements with BCBSAZ may result in out-of-pocket expenses in excess of those stated. Using both PPO and Non-PPO providers will subject the member to both the PPO and non-PPO maximums. HMO participants must always use the HMO AZ network of providers or no benefits are available.

Medical Benefits Comparison Chart
for Cochise and Pinal Counties
Benefits in Effect October 1, 1993



Benefits All benefits are subject to plan limitations and exclusions.	Blue Cross Blue Shield of Arizona		
	Preferred Care PPO Option		HMO Option
	PPO	Non - PPO	
Emergency Treatment Facility	\$50 deductible/visit (waived if admitted) then Covered Expenses paid at 80% after annual deductible	\$50 deductible/visit (waived if admitted) then Covered Expenses paid at 70% after annual deductible	\$50 copayment. Waived if admitted to HMO hospital.
Ambulance (Medical Emergency Only)	Covered Expenses paid at 80%; deductible waived. (Medical Emergency Only)	Covered Expenses paid at 80%; deductible waived. (Medical Emergency Only)	No charge (Medical Emergency Only)
Urgent Care Facility	Covered Expenses paid at 80% after deductible	Covered Expenses paid at 70% after deductible	\$10 copayment/visit
Outpatient Rehabilitation (eg. Physical Therapy)	Covered Expenses paid at 80% after deductible	Covered Expenses paid at 70% after deductible	Covered at 100%. 40 visit limit/plan year
Skilled Nursing Facility <i>Must be medically necessary.</i>	Covered Expenses paid at 80% after deductible Requires precertification.	Covered Expenses paid at 70% after deductible Requires precertification.	Covered Expenses paid at 100% to 90 days/plan year Requires precertification.
Home Health Care <i>Must be medically necessary.</i>	Covered Expenses paid at 80% after deductible (Part-time and intermittent) Requires precertification.	Covered Expenses paid at 70% after deductible (Part-time and intermittent) Requires precertification.	No charge (Part-time and intermittent) Requires precertification.
Hospice Care <i>Must be medically necessary.</i>	Subject to case management	Subject to case management	No charge Requires precertification.
Inpatient Mental Health and Substance Abuse (This benefit's out-of-pocket expenses are not included in the out-of-pocket maximum.)	Covered Expenses paid at 80% after deductible up to \$10,000 maximum benefit in any 12-month period. \$25,000 lifetime maximum benefit.	Covered Expenses paid at 70% after deductible up to \$10,000 maximum benefit in any 12-month period. \$25,000 lifetime maximum benefit.	Biodyne determines necessity. Covered Expenses paid at 100% up to \$10,000 maximum benefit in any 12-month period. \$25,000 lifetime maximum benefit.
Outpatient Mental Health and Substance Abuse (This benefit's out-of-pocket expenses are not included in the out-of-pocket maximum.)	<ul style="list-style-type: none"> Covered Expenses paid at 80% after deductible up to \$1,000 maximum benefit/person/calendar year. Biodyne Centers only - \$5 copayment/visit for first 10 visits/plan year to out-of-pocket maximum of \$50/person; \$100/family. Additional visits covered at 100%. 	<ul style="list-style-type: none"> Covered Expenses paid at 70% after deductible up to \$1,000 maximum benefit/person/calendar year. 	Biodyne Centers only \$5 copayment/visit for first 10 visits/plan year; out-of-pocket maximum of \$50/person and \$100 per family. Additional visits covered at 100%.

If there is a discrepancy between this information and the official documents, the documents will always govern.

Medical Benefits Comparison Chart
for Cochise and Pinal Counties
Benefits in Effect October 1, 1993



Benefits All benefits are subject to plan limitations and exclusions.	Blue Cross Blue Shield of Arizona		
	Preferred Care PPO Option		HMO Option
	PPO	Non - PPO	
Durable Medical Equipment (DME) Purchase & Repair	Covered Expenses paid at 80% after deductible. Requires precertification.	Covered Expenses paid at 70% after deductible. Requires precertification.	Covered Expenses paid at 100%. Requires precertification.
Hearing Aids	Covered Expenses paid at 100% up to \$750 maximum benefit/ear/plan year		Covered Expenses paid at 100% up to \$750 maximum benefit/ear/plan year
Diabetic Supplies	Insulin and syringes covered through PERFORM prescription drug program. Other items covered as Durable Medical Equipment (DME). See DME above.		Insulin and syringes covered through PERFORM prescription program. Other items covered as Durable Medical Equipment (DME). See DME above.
Allergy Shots	Covered Expenses paid at 80% after deductible	Covered Expenses paid at 70% after deductible	\$10 copayment
Chiropractors	Covered Expenses paid at 80% after deductible	Covered Expenses paid at 70% after deductible	<i>Not Covered</i>

IMPORTANT INFORMATION REGARDING PRECERTIFICATION

The following items require precertification.

Failure to precertify may result in the reduction or elimination of payments for such benefits.
(If you are enrolled in the HMO, your PCP must precertify services for you.)

- Hospital Inpatient Admission (precertification waived for emergency and maternity admissions)
- Magnetic Resonance Imaging (MRI)
- Durable Medical Equipment (DME)
- Home Health Care
- Skilled Nursing Facility
- Inpatient Active Rehabilitation
- Home IV Therapy
- Outpatient Surgery (HMO Only)
- Referrals to Specialists (HMO Only)

If there is a discrepancy between this information and the official documents, the documents will always govern.

DENTAL BENEFITS COMPARISON

ALL COUNTIES

Dental Benefits Comparison Chart

All Counties

Benefits in Effect October 1, 1993



• Benefits	Associated Health Plans	Delta Dental Plan
Deductibles (Calendar Year - 1/1 to 12/31)	No deductibles	\$ 50/person \$150/family Applies to basic restorative & major restorative only
	YOUR COPAYMENTS <i>All benefits are subject to plan limitations and exclusions.</i>	PLAN PAYS <i>All benefits are subject to plan limitations and exclusions.</i>
Preventive Care Oral Exam Prophylaxis (Cleaning) Fluoride X-rays - 2 films - 4 or more films	No charge (By general dentist) No charge (One/6 months) No charge No charge (By general dentist) No charge (By general dentist)	Cleanings limited to 2/calendar year 100% of allowed amount (No deductible)
Basic Restorative Sealants Fillings Extractions Periodontal Oral Surgery	\$9.00/tooth No charge (amalgam fillings) No charge (routine extractions) \$0 - \$315* \$0 - \$100 each	After deductible, 80% of allowed amount. " " " "
Major Restorative Crowns Dentures Fixed Bridgework Crown/Bridge Repair Inlays	\$165 - \$185* \$260 - \$280* \$185/unit* Lab fee \$110 - \$155*	After deductible, 50% of allowed amount. " " " Inlays not covered.
Orthodontia Under Age 19 Age 19 and Up	<i>Standard 24-month treatment plan</i> \$1,985 - \$2,410* \$2,185 - \$2,610*	50% (No deductible)
Maximum Benefits Preventive, Basic & Major Combined Periodontal Lifetime Maximum (applies toward calendar year max) Orthodontia Lifetime Maximum	Unlimited Unlimited Unlimited	\$1,000/calendar year \$1,000 \$1,500

* Indicates area of increased copayments.

If there is a discrepancy between this information and the official documents, the documents will always govern.

ATTACHMENT F

Claims Audit of Interflex

**Claims Audit
of Interflex
Tucson, Arizona**



**State
of Arizona**

Prepared by:

**The Wyatt Company
100 W. Clarendon, Suite 800
Phoenix, AZ 85013**

(602) 279-3600

September 1993

Table of Contents

	<i>Page</i>
I. Scope of Audit	1
II. Executive Summary	2
III. Procedural/System Issues & Recommendations	7
A. Systems	7
B. Quality Control	7
C. Data Coding/Reporting	8
D. Workflow	8
IV. Exhibits	9
A. Payment Errors	10
B. Procedural Errors	12
C. Turnaround Time	13
V. Sampling Methodology	14
VI. Glossary	15
VII. Appendix	16

I. Scope of Audit

The Wyatt Company was retained by the State of Arizona to provide an assessment of the payment accuracy, procedural accuracy, and the timeliness of the Point-of-Service claims processing under the Interflex program. The Intergroup HMO claims were not included as part of the statistical audit since this program is community rated and employees are not responsible for payment of providers except for copays and excluded services. However, a small sample of 54 HMO claims was briefly reviewed while we were on site at the request of the State.

The following statistical categories were measured for the Point-of-Service plan based upon a randomly selected claims sample:

- ◆ Procedural error rate
- ◆ Payment error rate
- ◆ Dollar error rate
- ◆ Turnaround time

All errors, as reported by The Wyatt Company, were reviewed and verified by the internal staff of the Tucson, Arizona claims office.

The undersigned Wyatt Company consultant was responsible for the management of the audit and is available to answer questions regarding the results contained in this report.



Gary L. Petersen

II. Executive Summary

The Wyatt Company conducted an on-site audit of Interflex at Intergroup's Tucson, Arizona claims office. In general, accuracy and turnaround time performance is lower than desired. Observations and recommendations which go beyond the statistical outcome of the audit are contained in Section III. A summary of the overall statistical results is contained in this section.

One procedural and two payment errors were found in our review of 54 Intergroup HMO claims reviewed. These errors are not reported in the statistical summary below since the HMO sample is too small to produce a reasonably tight confidence interval. All errors reported in the statistical summaries below are from Point-of-Service (Interflex) claims. Actual sample error rates for those categories reported in the audit fall outside both the desired State Performance Standard and the Industry Standard we have reported for comparison purposes. Although the tail of the 95% confidence interval does fall within the standards for Procedural and Net Dollar errors, it does not do so for the number of claims with no errors, payment errors, or for turnaround time.

A comparison to our fifteen most recent audits of major carriers contained on page 5 shows the Interflex program's performance results to be less favorable than all of those audits with the exception of the procedural error category where they are still 2.5% (7.7% - 5.2%) higher than the average of the comparison group.

The results also fall significantly below the performance standards negotiated in the State's contract. We have included a comparison to State performance standards on page 6.

In summary, it is our belief that there is substantial room for improvement in the Interflex program's medical claim processing and that Intergroup should be requested to pursue such improvements.

STATISTICAL SUMMARY

The following pages present the key quantitative findings of our audit of 300 randomly selected Interflex claims. All statistics were developed using a 95% confidence level. A glossary of terms is included in Section VI.

SAMPLE ERROR RATES

Claim Type: Point-of-Service (Interflex)

Error Type: All Errors are Verified

INCIDENCE OF ERROR

	<u>Number</u>	<u>Percent</u>	<u>95% Confidence Interval</u>	<u>State Performance Standard</u>	<u>Industry Standard</u>
A. No Errors	243	81.0%	76.6% to 85.4%	N/A	>93%
B. Procedural Errors	23	7.7%	4.7% to 10.7%	<5%	<5%
C. Payment Errors	<u>34</u>	<u>11.3%</u>	7.7% to 14.9%	<5%	<5%
D. Total Sample * (A+B+C)	300	100.0%			

DOLLAR ACCURACY

	<u>Number</u>	<u>Amount</u>	<u>95% Confidence Interval</u>	<u>State Performance Standard</u>	<u>Industry Standard</u>
A. Overpayments	19	\$933.05			
B. Underpayments	5	\$114.96			
C. Zero Dollar Payment Errors	10	\$0.00			
D. Absolute Mispayments (A+B+C)	34	\$1,048.01			
E. Net Payment Errors (A-B)		\$818.09			
F. Adjusted Total Payment of Sample (Adjusted for net errors)		\$24,638.12			
G. Gross Dollar Error Percentage (D/F)		4.3%	1.1% to 7.4%	N/A	<1.0 to 1.5%
H. Net Dollar Error Percentage (E/F)		3.3%	0.4% to 6.2%	<1.0%	<0.5 to 1.0%

TURNAROUND TIME

Claim Type:		Point-of-Service, Non-Contracted Provider and Member Reimbursement Claims		
Measurement:		From date received to date processed		
<u>Calendar Days</u>	<u>Number</u>	<u>Percent</u>	<u>95% Confidence Interval</u>	
14 days or less	6	6.2%	1.4% to 11.1%	
15 days or more	90	93.8%	88.9% to 98.6%	
Total	96	100.0%		

Claim Type:		Point-of-Service, Non-Contracted Provider and Member Reimbursement Claims		
Measurement:		From date received to date paid		
<u>Calendar Days</u>	<u>Number*</u>	<u>Percent</u>	<u>95% Confidence Interval</u>	<u>State Performance Standard</u>
14 days or less	0	0.0%	0.0% to 6.4%	> 90%
15 days or more	45	100.0%	93.6% to 100.0%	< 10%
Total	45	100.0%		
<p>* Only reflects data received on dates paid. However, complete data would not cause the result to be better than Turnaround Time listed at the top of the page based on date processed.</p>				

COMPARISON TO OTHER ADMINISTRATORS

Performance Indicator	Interflex	Other Wyatt Audits ⁽¹⁾		
		Average	Best	Worst
Incidence of Error				
No Errors	81.0%	89.5%	95.0%	83.4%
Procedural Errors	7.7%	5.2%	2.7%	10.5%
Payment Errors	11.3%	5.4%	1.2%	9.9%
Dollar Accuracy				
Gross Dollar Error Rate	4.3%	2.2%	0.5%	9.5%
Net Dollar Error Rate	3.3%	-0.1%	0.0%	2.9%
Turnaround Time				
Processed (or Adjudicated) within 14 Calendar Days	4.7% ⁽²⁾	76.7%	97.7%	24.6%
Average TAT	43	10	4	21

⁽¹⁾ Fifteen most recent full scope audit results of major carriers. Vendors included are: Aetna, Blue Cross Blue Shield of Arizona, CIGNA, Equicor, Mediplan, Metropolitan, Prudential, The TPA of AZ and CO, and Travelers.

⁽²⁾ Reflects all Interflex claims for comparison purposes. See Appendix for detail.

COMPARISON TO STATE PERFORMANCE STANDARDS

Although State performance standards were drafted generically and technically apply to both the HMO and Point-of-Service plans in some areas, the focus of the State's audit was the Interflex Point-of-Service plan.

Claims Turnaround Time

The State Standards are based on 14 calendar days and apply only to non-contracted providers and member reimbursements under Interflex. Our sample found 0.0% of claims paid in 14 calendar days with a 95% confidence interval of 0.0% to 6.4%. Since payment of 90% of claims in 14 days was not achieved, a 5% reduction in retention (18.5%) should be available as a rate credit, i.e. 0.925% of premium.

Average Dollar Accuracy Rate

The intent of this measure is most closely represented by our Net Dollar Error Rate of 3.3%. Since this error rate is greater than the 1% allowed in the State's Standard, a 5% reduction in retention should be available as a rate credit, i.e. 0.925% of premium.

Payment Error Rate

Our sample found a payment error rate of 11.3% which is in excess of the State Standard of 5%. A 5% reduction in retention should be available as a rate credit, i.e. 0.925% of premium.

Procedural Accuracy Ratio

Our sample found a procedural error rate of 7.7% which is in excess of the State Standard of 5%. A 5% reduction in retention should be available as a rate credit, i.e., 0.925%.

Utilization Reports

We did not audit this requirement.

Satisfaction Rates

We did not audit this requirement as part of the claims audit but will be doing so as part of our Performance Management Report to be delivered at a later time.

Conclusion

It appears the State may request up to a 3.7% rate credit on Interflex members based on the criteria audited.

III. Procedural/System Issues & Recommendations

The internal audit staff was very cooperative in completing the audit. The State benefit program, particularly the managed care portions, is extremely complex to administer and has been assigned to a dedicated claim unit. The Interflex program has attempted to set up their system to facilitate and support the achievement of high quality processing within a very challenging environment. However, there are several areas where improvement may be possible. While the purpose of our audit was not to evaluate the workflow processes or recommend alternative procedures, we believe the following issues merit special mention.

A. SYSTEMS

Observation:

The claim system is automated. However, some functions, e.g. calculating benefit maximums for Physical Therapy, Mental Illness, Routine Physicals, or checking for duplicate payments, are performed manually. Other functions occur only upon participant appeal. For example, if an authorization does not get entered into the system before the claim is paid, the system does not pick this up and the claim will remain paid in error until a participant complaint results in a review of the case.

Comment:

The claim system appears to have been designed for HMO claims and is not state-of-the-art for purposes of handling Point-of-Service claims.

B. QUALITY CONTROL

Observation:

Appropriate separation of duties and procedures for fraud control are in evidence.

Observation:

The internal audit function is active and routinely performs State specific audits for processing accuracy of non-contracted provider claims (not turnaround time). State specific audits are performed on Interflex claims only. The internal error definitions are consistent with those used by Wyatt for purposes of this report. However, there does appear to be the potential for a significant lag between payment and audit timing.

Observation:

All claims over \$10,000 must be sent to the audit department for review before release. In addition, the audit department manually reviews all claims for duplicates by date.

C. DATA CODING/REPORTING

Observation:

The paid date recorded on the system is the date the check is cut and not the day the check is mailed. Thus, internal reports on turnaround time are understated.

D. WORKFLOW

Observation:

The claim flow through the office results in an unusually high number of stops for entry of a limited set of the complete data. This appears to be somewhat inefficient and may be driving up turnaround time.

RECOMMENDATION

The Interflex program should consider reengineering, if necessary with the help of an experienced claims administration consultant, the paper flow and data entry/processing procedures in order to eliminate bottlenecks in claim processing.

Observation:

Checks are cut only once per week, presumably at the request of the State.

RECOMMENDATION

The State should consider requesting checks to be cut more frequently, e.g. 2 x per week like Mesa Public Schools.

STATE OF ARIZONA
INTERFLEX
PAYMENT ERRORS

<u>Sample No.</u>	<u>TCN</u>	<u>Amount Paid</u>	<u>Dollar Error</u>	<u>Comments</u>
45	0112219281703	\$50.39	(\$43.00)	Denied eligible expense. Allowed ineligible expense.
52	0112249281912	\$76.72	\$76.72	Allowed ineligible expense.
54	0101289381005	\$0.00	\$0.00	Denied eligible expense. Deductible undercredited.
55	0102019381636	\$106.27	\$29.97	Allowed ineligible expense. Incorrect diagnosis code.
82	0101049380308	\$157.50	\$157.50	Participant exceeded short term rehabilitation maximum.
108	0103019380401	\$75.00	\$75.00	Duplicate payment.
122	0111129281719	\$0.00	\$0.00	Overcredited deductible.
134	0102269380410	\$14.00	\$10.00	Copayment not taken.
137	0111129280611	\$0.00	\$0.00	Undercredited deductible.
154	0111259284203	\$23.05	\$10.00	Copayment not taken.
157	0102159382628	\$14.00	\$10.00	Copayment not taken.
170	0102049380616	\$14.00	\$10.00	Copayment not taken.
173	0102099383302	\$5.00	(\$15.00)	Took too much deductible.
178	0101159380618	\$0.00	(\$30.30)	Medicare COB error.
197	0102239380406	\$10.45	\$10.00	Copayment not taken.
198	0102239380019	\$11.00	\$10.00	Copayment not taken.
237	0112019280709	\$241.50	\$241.50	Payment should be \$0 due to COB.
239	0112309280120	\$12.00	\$10.00	Copayment not taken.
252	0101059381141	\$0.00	\$0.00	Overcredited deductible.
260	0102019381612	\$297.00	(\$24.75)	Calculated payment incorrectly.
264	0112299282219	\$93.05	\$30.55	Allowed ineligible expense.
267	0111249283901	\$27.80	(\$1.91)	Coinsurance taken in lieu of copayment.

STATE OF ARIZONA
INTERFLEX
PAYMENT ERRORS (CONT'D)

<u>Sample No.</u>	<u>TCN</u>	<u>Amount Paid</u>	<u>Dollar Error</u>	<u>Comments</u>
269	0111039282312	\$96.80	\$17.16	Error on adjustment. Incorrect procedure entered.
271	0112319282935	\$0.00	\$0.00	Overcredited deductible. Applied ineligible expense to deductible.
275	0112109285918	\$34.25	\$17.08	Services reimbursed under incorrect fee schedule.
277	0112159280801	\$5,351.97	\$77.97	Services reimbursed at incorrect coinsurance level. Out-of-pocket maximum not satisfied.
283	0102179381902	\$168.47	\$73.75	Medicare COB error.
287	0102189380811	\$39.20	\$0.00	Ineligible expense applied to deductible. (Short-term rehabilitation benefit maximum reached.)
289	0112249281504	\$0.00	\$55.85	Medicare COB error.
332	0101119380648	\$0.00	\$0.00	Medicare COB error - deductible overcredited.
334	0101209380841	\$0.00	\$0.00	Medicare COB error - incorrectly denied charges which should be applied to deductible.
335	0101049380342	\$0.00	\$0.00	Applied ineligible expense to deductible.
338	0101159383210		\$10.00	Copayment not applied.
343	0101089380004	\$0.00	\$0.00	Medicare COB error - undercredited deductible.

STATE OF ARIZONA
INTERFLEX
PROCEDURAL ERRORS

<u>Sample No.</u>	<u>TCN</u>	<u>Comments</u>
33	0102269380103	Incorrect date of service.
36	0103059380602	No diagnosis code.
42	0101079380313	Incorrect date of service and diagnosis.
56	0102059380038	Incorrect date of service.
67	0111179282309	Claim linked to incorrect authorization.
69	0101049380243	Incorrect date of service.
102	0102229381306	Incorrect diagnosis code.
112	0103199380004	Batch date and claim number do not match.
126	0102179381217	Batch date and claim number do not match.
162	0103049380005	Entered date received incorrectly.
183	0102049380448	Incorrect date of service.
187	0102159382614	Incorrect date of service.
191	0112309280310	Batch date and claim number do not match.
193	0101129383705	Incorrect procedure code.
205	0102049380443	Claim paid under incorrect family member.
212	0102179381201	Incorrect date and place of service.
222	0101199380108	Incorrect date received entered on system.
254	0101059381234	Incorrect diagnosis code.
257	0101289380818	Missed line of charges.
259	0111199284004	Deductible carryover information not updated.
296	0103029381014	COB field should indicate Medicare.
326	0112249281903	Incorrect denial remark
353	0101079383418	Incorrect denial remark.

TURNAROUND TIME

Claim Type: Point-of-Service, Non-Contracted Provider and Member Reimbursement Claims	
Measurement: From date received to date processed	
<u>Calendar Days</u>	<u>% Completed</u>
7 days or less	1.0%
14 days or less	6.3%
21 days or less	16.7%
28 days or less	34.4%
35 days or less	58.3%
42 days or less	69.8%
49 days or less	76.0%
Average: 40 days	

Claim Type: Point-of-Service, Non-Contracted Provider and Member Reimbursement Claims	
Measurement: From date received to date paid	
<u>Calendar Days</u>	<u>% Completed</u>
7 days or less	0.0%
14 days or less	0.0%
21 days or less	2.2%
28 days or less	11.1%
35 days or less	35.6%
42 days or less	57.8%
49 days or less	68.9%
Average: 51 days	

V. Sampling Methodology

Claims paid from February through March 1993 were used as the data base for sample selection. These claims included claims processed from November 1992 through March 1993 and services rendered between August 1992 and March 1993. The data was stratified into Interflex and Intergroup HMO categories. We chose 300 Interflex medical claims and 54 Intergroup HMO claims. The Wyatt Company generated random numbers to select the claims.

We requested documentation on the claim for each individual selected. If a claim selected was subsequently adjusted, Wyatt followed the course of events to the ultimate satisfaction of the submitted claim.

Of the 354 claims selected, we were able to completely review all of the claims during our on-site visit. All statistical measures are reported using a 95% confidence interval. Statistical results are only presented for the Interflex plan as this is the only portion of the sample large enough in order to estimate a reasonable confidence interval.

Errors identified during the course of the audit were verified by the internal audit staff.

VI. Glossary

95% Confidence Interval	The 95% confidence interval surrounding the sample error rate or turnaround time. A 95% confidence interval indicates that if additional samples of similar size were taken, the stated intervals would include the actual performance for the entire claim population 95% of the time.
COB	Coordination of Benefits is the process of integrating one employer's benefit payments with that of another employer in order to preclude more than 100% reimbursement of claims.
Gross Dollar Error Rate	The absolute value of overpayments and underpayments added together and divided by the adjusted total payment (corrected for net errors).
Industry Standard	Industry standards are based on The Wyatt Company survey (Fall of 1988) of major insurers' internal performance standards.
Net Dollar Error Rate	The excess of overpayments over underpayments divided by the adjusted total payment (corrected for net errors).
Payment Error Rate	The number of claims with payment errors divided by the total number of claims reviewed.
Procedural Error Rate	The number of coding and/or procedural errors which do not result in a payment error divided by the total number of claims reviewed.
Turnaround Time	The number of calendar days between receipt of claims and the date processed or paid, as appropriate.

TURNAROUND TIME

Claim Type:		Point-of-Service, All Claims	
Measurement:		From date received to date processed	
<u>Calendar Days</u>	<u>Number</u>	<u>Percent</u>	<u>95% Confidence Interval</u>
14 days or less	14	4.7%	2.3% to 7.1%
15 days or more	<u>286</u>	<u>95.3%</u>	92.9% to 97.7%
Total	300	100.0%	

Claim Type:		Point-of-Service, All Claims		
Measurement:		From date received to date paid		
<u>Calendar Days</u>	<u>Number*</u>	<u>Percent</u>	<u>95% Confidence Interval</u>	<u>Industry Standard**</u>
14 days or less	1	0.5%	0.0% to 1.3%	85-95%
15 days or more	<u>219</u>	<u>99.5%</u>	98.7% to 100.0%	5-15%
Total	220	100.0%		
<p>* Only reflects data received on dates paid. However, complete data would not cause the result to be better than Turnaround Time listed at the top of the page based on date processed.</p> <p>** Industry standard based on 10 working days.</p>				

TURNAROUND TIME

Claim Type:	Point-of-Service, All Claims
Measurement:	From date received to date processed
<u>Calendar Days</u>	<u>% Completed</u>
7 days or less	1.0%
14 days or less	4.7%
21 days or less	11.7%
28 days or less	23.3%
35 days or less	54.0%
42 days or less	69.0%
49 days or less	75.0%
Average: 43 days	

Claim Type:	Point-of-Service, All Claims
Measurement:	From date received to date paid
<u>Calendar Days</u>	<u>% Completed</u>
7 days or less	0.0%
14 days or less	0.5%
21 days or less	2.7%
28 days or less	7.3%
35 days or less	20.5%
42 days or less	53.6%
49 days or less	67.3%
Average: 54 days	

STATE OF ARIZONA
INTERGROUP HMO
PAYMENT ERRORS

<u>Sample No.</u>	<u>TCN</u>	<u>Amount Paid</u>	<u>Dollar Error</u>	<u>Comments</u>
312	0102229304916	\$1,780.00	(\$4,240.00)	Incorrect procedure code.
323	0101059304929	\$0.00	(\$77.48)	Incorrectly denied as a duplicate.

STATE OF ARIZONA
INTERGROUP HMO
PROCEDURAL ERRORS

<u>Sample No.</u>	<u>TCN</u>	<u>Comments</u>
1	0101199303212	Incorrect date received.

ATTACHMENT G

Intergroup's Response to Claims Audit

STATE OF ARIZONA - INTERFLEX

Intergroup Healthcare Corporation's

Response to the Wyatt Audit

Dated September 1993

October 22, 1993

Table of Contents

<u>Section Title</u>	<u>Page</u>
IGHC Response Summary	1
I. SCOPE OF AUDIT	3
II. EXECUTIVE SUMMARY	3
Statistical Summary	4
1. External Encumbrances	4
○ Carryover Information	4
○ Delayed Interflex Certificate of Coverage and "How to Use Interflex" Booklet	5
○ Open Enrollment	6
2. Internal Encumbrances	6
○ Pend Inventory Management	6
○ Non-Contracted Provider Batching	7
○ Staffing for New Plan Design	7
3. Operational Improvements	7
○ Claims Process Re-engineering	8
○ Improved Internal Audits	8
○ Internal Audit Findings	9
4. Claims Turnaround Improvement	9
○ Reporting of Improvement	9
○ Clean Versus Non-Clean Claims	10
○ Paid Versus Mailed Date	11
Comparison to Other Administrators	12
1. Start-Up/Take-Over Plans	12
2. Plan Complexity	13
3. Turnaround Time	13

<u>Section Title</u>	<u>Page</u>
Comparison to State Performance Standards	14
1. Percentage Penalties	14
2. Retention	14
3. Maximum Penalty	15
4. IGHC's Position on Penalties	15
III. PROCEDURAL/SYSTEM ISSUES & RECOMMENDATIONS	16
A. Systems	16
B. Quality Control	16
C. Date Coding/Reporting	17
D. Workflow	17
Wyatt Recommendation: Re-engineering	17
Wyatt Recommendation: Cut Checks 2 Times per Week	17
IV. EXHIBITS	17
V. SAMPLING METHODOLOGY	18
VI. GLOSSARY	18
VII. APPENDIX	18
Attachment A: Dates and Events Leading to Final Approval and Mailing of Interflex Certificate of Coverage and "How to Use Interflex" Booklet	
Attachment B: Proposed Rates	
Attachment C: Robert Stephenson Letter	
Attachment D: Wyatt State Audit - Claims Errors Analysis	

The Wyatt audit focused on the Interflex plan which accounts for six percent of the State of Arizona membership at Intergroup Healthcare Corporation (IGHC) and three percent of total State employees. The State Interflex plan was:

- Designed as an option for State employees by the State of Arizona and its insurance consultants.
- Designed to respond to the State's need to save money and create equity of benefit plan design and State financial contributions between managed care and indemnity plans.
- Designed to achieve a balanced benefit design that incorporated the strongest elements of managed care and indemnity approaches.
- Designed with a benefit structure unlike any other IGHC health plan.

IGHC Response Summary

The remainder of the document contains IGHC's response to The Wyatt Company audit dated September 1993. A summary of this response is provided below:

- IGHC agrees with the claims accuracy findings presented.
- Claims accuracy and turnaround problems were contributed to by IGHC, the State and the State's consultant.
- IGHC's internal operations problems have been resolved as evidenced by internal claims audits and claims turnaround reports delivered to the State.
- IGHC's re-engineering efforts, which began in January 1993, will continue to result in improved operations.
- The comparison of the State's Interflex Wyatt audit results with other administrators does not appear to be appropriate.
- The potential penalties calculated by Wyatt are inconsistent with those agreed to in the contract between IGHC and the State which was developed by Wyatt.

STATE OF ARIZONA - INTERFLEX

IGHC's Response to Wyatt Audit

October 22, 1993

Page 2

- IGHC and the State should work together to clarify and enhance the contracted performance standards, for example:
 - Clarify claims turnaround time to consider "clean" versus "non-clean" claims issues.
 - Include quality of care standards such as immunization rates and low birth weight rates and C-Section rates.
- Wyatt should audit all State of Arizona carriers' performance according to clear, consistent and comparable standards.
- As part of any decision to assess penalties, the information included in this response should be considered.

IGHC's responses are discussed in detail in the following pages. For ease of comparison, the response follows the same format used in the Wyatt audit.

I. SCOPE OF AUDIT

No comments on this section.

II. EXECUTIVE SUMMARY

The introductory comments in the Executive Summary of the Wyatt audit will be addressed as part of the responses to the more specific sections in the Wyatt audit that follow.

The Executive Summary portion of the Wyatt audit includes the following sections:

- Statistical Summary
 - . Sample Error Rates
 - . Turnaround Time
- Comparison to Other Administrators
- Comparison to State Performance Standards

Each Section listed above is responded to on the pages that follow.

STATISTICAL SUMMARY

The Statistical Summary Section of the Wyatt audit also includes the Sample Error Rates and Turnaround Time tables. These sections indicate that Interflex did not meet the State of Arizona performance standards. IGHC's audit staff found similar results when conducting internal audits of the State Interflex plan when auditing the same period.

To understand what caused the error rates and turnaround time problems presented in the Wyatt audit, a detailed discussion of external encumbrances, internal encumbrances, operational improvements and claims turnaround improvement reporting is necessary.

1. EXTERNAL ENCUMBRANCES

The external encumbrances that IGHC experienced during the first several months of the State Interflex plan implementation resulted in claims processing errors and delays in claims payment. These external encumbrances were beyond IGHC's control.

○ Carryover Information

There were several problems with the carryover information received from the previous carrier. These problems caused many late payments, claims errors and subsequent adjustments.

The tape from the previous carrier was received in August 1992. Due to the format of the tape, the data could not easily be read by IGHC's system. It was not until mid-October 1992 that the data was deciphered.

Once deciphered, IGHC began using the data. Then, however, several other problems were identified:

- . Critical information was missing for some members.
- . Some information was incorrect regarding deductible amounts, out-of-pocket maximums and lifetime maximums.

Claims information was not included for the month of July 1992, the month before the State Interflex plan went into affect. After deciphering the data, the IGHC claims staff had to call the previous carrier to request information regarding services delivered in July for about 90 percent of all State Interflex claims.

All of these items contributed to claims errors, impacted claims payment timeliness and caused member complaints.

○ **Delayed Interflex Certificate of Coverage and "How to Use Interflex" Booklet**

The finalized and approved Interflex Certificate of Coverage was not received by IGHC from the State until October 1992. In addition, IGHC did not receive final approval on the "How to Use Interflex" booklet from the State until the end of October 1992. Therefore, the mailings of this information to the State Interflex members was not completed until November 9, 1992.

A summary of the specific dates and events leading to the final approval of the Interflex Certificate of Coverage and the "How to Use Interflex" booklet is included as Attachment A.

During the period from August 1992 to November 1992, several problems might have been avoided had Interflex members had the detailed information provided in the Interflex Certificate of Coverage and the "How to Use Interflex" booklet. For example:

· If a member did not know a particular medical procedure required pre-certification and subsequently submitted a claim without pre-certification, the examiner would pay the claim at the reduced rate.

· Although the information was generally discussed in the State's open enrollment materials, State Interflex members might not have known they were required to select a primary care physician (PCP).

PCP information is required to appropriately determine if a claim is in- or out-of-network and whether or not an authorization is required. Without PCP information, several manual follow-up steps to determine the proper claims payment are required. This slows claims processing and/or creates a need to later adjust the claim.

STATE OF ARIZONA - INTERFLEX

IGHC's Response to Wyatt Audit

October 22, 1993

Page 6

The Interflex Certificate of Coverage is used by the claims examiners to pay claims. The delay in receiving the approved Interflex Certificate of Coverage affected the State Interflex Claims Team's ability to pay claims in a timely and accurate manner. Once the finalized Interflex Certificate of Coverage was received by IGHC, several manual adjustments had to be made to the claims that had already been paid.

○ Open Enrollment

IGHC was not permitted to hold open enrollment meetings to more fully explain the State Interflex plan. State employee questions and concerns could not be addressed by IGHC. Also, IGHC did not have the opportunity to hear the employees' issues. Although this was also the case for all State insurance carriers, the complexities of the new State Interflex plan required comprehensive explanation.

Other than a brief IGHC marketing piece, the only information the State employees had at open enrollment was that which was prepared by the State and the State's insurance consultants. Although IGHC was allowed to review the State's materials, the material did not provide sufficient detail to fully explain the complexities of the State Interflex plan to the members. The State's insurance carriers were not permitted to provide any additional written materials.

2. INTERNAL ENCUMBRANCES

IGHC's internal claims processing problems caused some of the claims errors and delays in claims payment. These internal encumbrances are controlled by IGHC and are IGHC's responsibility.

○ Pend Inventory Management

Lack of a comprehensive pended claims inventory management process caused older claims not to receive appropriate priority processing.

○ **Non-Contracted Provider Batching**

Batch Control area was erroneously batching some non-contracted provider claims with contracted provider claims.

Since contracted provider claims must be paid within an average of 45 days versus the 14-day requirement, some non-contracted and member reimbursement claims were not processed as priority. IGHC pays contracted providers according to its provider contract. The contract states that claims must be paid within 30 days after the end of the month in which the claims were received by IGHC.

The State and its insurance consultant agreed that the 14-day rule **should not** apply to contracted providers. Contracted providers account for 85 to 90 percent of the claims received by IGHC for the State Interflex plan.

○ **Staffing for New Plan Design**

Although the appropriate number of staff were placed on the State Interflex Claims Team, the team required extensive training on the new benefit plan design. Developing a fully-trained team for the State Interflex plan was especially difficult due to the items listed in the External Encumbrances Section of this document.

3. **OPERATIONAL IMPROVEMENTS**

Several operational improvements have been made which directly affect the State Interflex plan. These improvements began in January 1993 and continue to be implemented. Internal reporting and audit results confirm that these changes are resulting in greatly improved accuracy and turnaround time. These improvements are discussed below.

○ **Claims Process Re-engineering**

In January 1993, IGHC began massive re-engineering of its operations areas beginning with the claims process. Many of the improvements implemented for the State Interflex Claims Team were used as the basis for re-engineering the entire claims process at IGHC. Two major improvements to the claims process are listed below:

- . Multiple claims handling processes were collapsed into two steps, reducing the number of times a claim is handled.
- . A comprehensive inventory management process and associated reports were implemented in May 1993.

The results of the re-engineering are already being realized as evidenced by internal audits and claims lag reporting which will be discussed later in this document. Re-engineering remains a top priority and resulting changes will continue to be implemented.

○ **Improved Internal Audits**

The internal audit program was increased for the State Interflex plan in January 1993. The audits have remained current and reflect continued improvement since the time the Wyatt audit was conducted.

○ **Internal Audit Findings**

As previously mentioned, the Wyatt audit results are similar to IGHC's internal audit results performed for the same period. Internal audits of paid claims for periods following the Wyatt audit show substantial improvement.

	2nd Qtr '93	July '93	August '93
Total Claims Reviewed	300	300	200
Adjusted Total Payment	\$58,705.41	\$67,596.04	\$31,766.10
Procedural Accuracy	93.00%	95.67%	96.50%
Net Dollar Accuracy	96.24%	97.96%	99.94%
Payment Accuracy	87.67%	91.00%	95.50%

August 1993 results indicate that IGHC has met all three contracted performance standards for claims payment accuracy.

4. **CLAIMS TURNAROUND IMPROVEMENT**

Since June 7, 1993, 90 percent of "clean" claims have been paid within 14 days. The reporting of this performance to the State is discussed in this Section. Also discussed in this Section are two issues that repeatedly surface and affect the interpretation of actual claims turnaround times and the State's performance standard.

○ **Reporting of Improvement**

Several items that affected late claims payment have already been addressed. This Section includes a detailed discussion of how IGHC communicated its claims turnaround improvement to the State commencing in May 1993.

On May 20, 1993, a letter was sent to Lanette Landreth, the State of Arizona Benefits Plan Manager at the time, which included the following Interflex Claims Lag Reports:

- August 1, 1992 through December 31, 1992
- January 1, 1993 through March 31, 1993
- April 26, 1993 through May 2, 1993
- May 3, 1993 through May 9, 1993

The letter stated that any analysis provided after May 27 would be adjusted to reflect "clean" claims only. (The definition of "clean" versus "non-clean" claims is provided in the following Section.)

The letter further stated that the June 7, 1993 Claims Lag Report would reflect that 90 percent of non-contracted "clean" claims would be paid within 14 days. The June 7 report did, in fact, reflect that IGHC fulfilled this commitment.

IGHC continues to supply the State with the weekly Claims Lag Reports and the accompanying analysis. These reports continue to show that 90 percent of non-contracted "clean" claims are paid within 14 days.

○ Clean Versus Non-Clean Claims

The current State performance standard for claims turnaround does not allow for "non-clean" claims to be excluded from the calculation of the turnaround statistic.

"Non-clean" claims are defined as those which require additional information from either the member or the provider to complete processing. Many carriers deny these claims rather than pend them and subsequently attempt to obtain the missing information. This definition is based on the Arizona Department of Insurance definition of claims turnaround requirements.

It is IGHC's policy to pend the claim and attempt to obtain the missing information. When the information is obtained from either the member or the provider, the claim is either paid or denied. Obtaining this missing information may take several days or weeks. This procedure is intended to be of service to both the member and the provider.

"Non-clean" claims are included in the turnaround times calculated in the Wyatt audit. The weekly Claims Lag Reports and accompanying analysis which have been forwarded to the State since June 1993 identify any "non-clean" claims which were paid outside the 14-day turnaround requirement, but do not include them in the calculation of the claims turnaround time for that week. This weekly reporting to the State clearly shows how the claims turnaround time for the week is calculated.

The "clean" versus "non-clean" claims issue and its relationship to the State's performance standards should be addressed in the future. Two possible resolutions to this issue are:

- . IGHC could change its internal processes to immediately deny "non-clean" claims.
- . The State and IGHC could revise the performance standard to exclude "non-clean" claims.

The State and IGHC should work together to clarify the claims turnaround standard to consider the "clean" versus "non-clean" claims issues.

○ **Paid Versus Mailed Date**

The Wyatt audit Glossary defines the Turnaround Time as **"the number of days between receipt of claims and the date processed or paid, as appropriate."** Although this is the same definition used by IGHC to calculate turnaround time, there has been discussion that IGHC's Claims Lag Reports are invalid because they do not use the date the check was mailed.

If no errors or discrepancies are found when the checks and the Explanation of Benefits and Explanation of Payments are printed, they are mailed within two days from the date the check was printed, i.e., the paid date. Although it occurs very infrequently, if a discrepancy is found, an additional one or two days may be required before the check is mailed.

COMPARISON TO OTHER ADMINISTRATORS

Wyatt's comparison of the State Interflex plan with 15 of their recent audits does not appear to be appropriate. There are three major reasons this appears inappropriate. Each of these is discussed below.

1. START-UP/TAKE-OVER PLANS

The "fifteen most recent audits of major carriers" referred to in the Wyatt audit were not all start-up benefit plans or take-over plans such as the State's Interflex plan. Although IGHC's Point-of-Service product had been in place for other employers, the State Interflex plan consisted of a new benefit design and was a take-over from a previous carrier. This resulted in exactly the same problems frequently encountered during plan start-ups and take-overs.

As part of being a take-over plan, IGHC was required to transfer the carryover information from the previous insurance carrier. The difficulties that resulted are explained in the Section entitled "Carryover Information" on Page 4 of this document.

Transition of care was also required during the take-over period which means that IGHC provided continuity of care to the members transferring from another carrier. This type of coordination requires many manual steps to ensure that benefits are applied properly and the claims paid accordingly. An example of transition of care is provided below:

If a member from another State insurance carrier in the last half of her pregnancy selected Interflex for her new health plan, IGHC would encourage her to continue with her current physician during the remainder of her pregnancy and delivery. IGHC would pay for the care at the in-network level, even if her physician was not one of IGHC's in-network doctors.

As part of being a start-up benefit plan, IGHC was required to hire and train claims examiners in the new benefit structure designed by the State and Wyatt. During a hiring and training period, operational difficulties are expected.

2. **PLAN COMPLEXITY**

The fifteen plans included POSs, PPOs and several indemnity plans. In order to produce a valid comparison, the plans in the comparison group need to be of similar complexity. For example, traditional indemnity plans are significantly less difficult to administer as compared to plans that offer in- and out-of-network options, providers and benefits, such as Interflex.

3. **TURNAROUND TIME**

If all claims, "clean" and "non-clean," are included, IGHC's claims payment is negatively affected by its policy to pend "non-clean" claims. For a valid comparison of claims turnaround times, it is critical that the carriers handle "non-clean" claims in the same manner.

It is likely that many of the fifteen audits used for comparison deny "non-clean" claims instead of pending them as IGHC does.

In order for a comparison of this type to be valid, the comparison group would have to be very similar in all areas affecting the payment of claims.

COMPARISON TO STATE PERFORMANCE STANDARDS

The Wyatt audit interpretation of the penalties associated with the performance standards do not appear to be appropriate. The reasons are discussed below.

1. Percentage Penalties

Section 17.5 of the bid outlines three areas of performance standards and penalties for not meeting them as follows:

- | | |
|--------|---|
| 17.5.1 | Payment of 90% of all claims within 14 calendar days of receipt |
| 17.5.2 | Payment and procedural accuracy rate of 95% or more |
| 17.5.3 | Average dollar accuracy rate of 99% or more |

IGHC understood the maximum penalty associated with each of the above to be 5% of retention, to a maximum of 15% of retention. The Wyatt audit takes the position that standard 17.5.2 is equivalent to two penalties. Thus, the audit indicates that a maximum penalty would be 20% of retention. Three staff members of IGHC had discussions with the consultant on this issue and it was confirmed that 15% of retention, one for each section, was the maximum.

2. Retention

For the standards outlined above, Wyatt has referred to IGHC's retention as being 18.5%. IGHC disagrees with this figure for the following reasons:

- On the rate sheets submitted by IGHC in the bid which became the contract, the format was typed to reflect various components of retention. There was a clear break in the sheet separating retention from premium tax and profit (see Attachment B).
- On May 26, 1992, a response was sent to Robert Stephenson of the State Purchasing Office. Under the cost section for IGHC/Bay Colony, Question #3, 1.2, "IGHC's retention fees of 12.5% are guaranteed" was stated (see Attachment C).

- IGHC believes the intent of the contract is that penalties should not be assessed on premium tax and margin percentages.
- Three staff members of IGHC specifically discussed this issue with a Wyatt representative and it was confirmed that 12.5% was the retention.

3. Maximum Penalty

The Wyatt audit calculates the maximum penalty to be 20% (4 penalties) times 18.5% retention which equals 3.7% of the Interflex premium. Based on items 1 and 2 above, IGHC calculates the maximum penalty to be 15% (3 penalties) times 12.5% retention which equals 1.87% of the Interflex premium.

4. IGHC's Position on Penalties

IGHC's position on any penalties assessed to IGHC is summarized below:

- All events and parties which contributed to the claims payment performance should be considered when evaluating IGHC's performance.
- Several good faith changes to the contract were implemented by IGHC to benefit State employees at no cost to the State.
- IGHC and the State should more clearly define the performance standards in the contract before any future evaluation of IGHC's performance is conducted.

III. PROCEDURAL/SYSTEM ISSUES & RECOMMENDATIONS

Below are responses related to the Procedural/System Issues and Recommendations included in the Wyatt audit.

A. SYSTEMS

The benefit calculations for physical therapy, mental illness, routine physicals and duplicate claims verification continue to be manual processes. In order to ensure accuracy, additional systems and benefits training have been given to the examiners. As is evidenced by IGHC's internal audit results, this has significantly reduced error rates.

IGHC continues to work with the claims software vendor to improve the duplicate claims verification program. The enhanced program is expected to substantially reduce the manual processes.

Several upgrades to the claims software will be included in the next release of the software scheduled for November 1993. Among the upgrades will be the automation of the mental illness benefit calculation.

The Wyatt audit states that IGHC's claims system appears to have been designed for HMO claims. The fact is that IGHC's claims system has very strong HMO/managed care capabilities which is what saves money for employers and members.

The Wyatt audit also states that IGHC's claims system is not state-of-the-art for purposes of handling Point-of-Service claims. IGHC's claims system does, in fact, support Point-of-Service plans as well as a variety of other plans. The claims system continues to be enhanced as requirements arise for new benefit plan designs.

B. QUALITY CONTROL

The Wyatt audit appears to indicate that internal audits are not conducted on turnaround time. This is not true. IGHC reviews the Claims Lag Report each week for claims that were paid within the previous week. Any claim that is outside the 14-day turnaround

requirement is analyzed to determine the cause of the delay. The results of the analysis along with key claims turnaround statistics are reported to the State each week.

The Wyatt audit includes a comment that there "does appear to be the potential for significant lag between payment and audit timing." This is not true. Audits for the State Interflex plan have been current since January 1993.

C. DATE CODING/REPORTING

(See Section entitled "Paid Versus Mailed Date" on Page 11 of this document.)

D. WORKFLOW

The two recommendations included in the Wyatt audit are discussed below.

WYATT RECOMMENDATION: RE-ENGINEERING

(See Section entitled "Claims Process Re-Engineering" on Page 8 of this document.)

WYATT RECOMMENDATION: CUT CHECKS 2 TIMES PER WEEK

IGHC has been cutting State Interflex checks at least twice per week for several months. Checks were cut daily during the May 1993 catch-up period. Once IGHC was meeting the claims turnaround standard, the number of times State Interflex checks were cut was returned to twice per week.

IV. EXHIBITS

An analysis of each claim included in the Wyatt audit that contained an error has been completed (see Attachment D). This analysis groups the claims by error type and explains why the error occurred and what has been done to ensure that the error does not occur in the future.

The Turnaround Time exhibit was addressed in previous sections of this response.

V. SAMPLING METHODOLOGY

No comments on this Section.

VI. GLOSSARY

(See Section entitled "Paid Versus Mailed Date" on Page 11 of this document.)

VII. APPENDIX

See Section entitled "Claims Turnaround Improvement" on Page 9 of this document.

Although the Appendix includes information from the 54 HMO claims audited, the information provided is not sufficient to comment on. It appears that the HMO claims are not part of the formal Wyatt audit.

Attachment A

Dates and Events Leading to Final Approval and

Mailing of Interflex Certificate of Coverage and

"How to Use Interflex" Booklet

- 6/24/92** IGHC attended meeting with State, Wyatt and all carriers. At that meeting, the State informed carriers of request for customized Certificates of Coverage.
- 7/30/92** The draft Interflex Certificate of Coverage was delivered to the State with the State's required changes.
- 8/19/92** A meeting was held with the State, Wyatt and IGHC to discuss the draft Interflex Certificate of Coverage. The State and Wyatt were not satisfied with the content and language in the Interflex Certificate of Coverage. The result of the meeting was that Wyatt was to send IGHC specific language on eligibility and effective dates. Also, a new document, "How to Use Interflex" was to be created.
- 8/20/92** IGHC began re-writing the Interflex Certificate of Coverage to meet the State's requirements.
- 9/2/92** IGHC received information from Wyatt regarding the specific language to be used for certain areas of the Interflex Certificate of Coverage. Several areas were still pending.
- 9/17/92** IGHC still waiting for language from Wyatt. A conference call was placed and approval was given for IGHC to use their own language in the pended areas.
- 9/24/92** Final Interflex Certificate of Coverage was sent to the State and Wyatt for approval.
- 10/13/92** IGHC received approval on the Interflex Certificate of Coverage but the State and Wyatt did not want to send the Interflex Certificate of Coverage to members without the "How to Use Interflex" booklets.
- 10/28/92** IGHC received approval on the "How to Use Interflex" booklets.
- 11/9/92** All mailings to Interflex members were completed.

Attachment B

EXHIBIT VI

Proposed Rates

These rates stand if IGHC is awarded both Pima and Maricopa Counties.

Option: Alternative Plan 2 - \$0 copay HMO (V2A) alongside POS (F2RD)

Region: Maricopa County

A. Full Coverage	Rate ^{(1)***}		Additional For Staffing	Additional For Expanded Wellness	Additional For COBRA Administration
	HMO	POS			
Active: Employee	<u>148.75</u>	<u>184.70</u>	<u>.44</u>	<u>.50</u>	<u>2%</u>
Active: Family	<u>377.90</u>	<u>471.10</u>	<u>.44</u>	<u>.50</u>	<u>2%</u>
Retiree: Pre 65 Adult	<u>148.75</u>	<u>184.70</u>	_____	_____	_____
Retiree: Post 65 Adult	<u>126.65</u>	<u>126.65</u>	_____	_____	_____

(All retirees and dependents referenced over age 65 must have Medicare Parts A & B.)

B. The rate components below should reflect all expenses used to determine the employee rate. Please also identify additional expenses, if any, which would apply to future renewal rates (i.e., retention accounting margin).

	\$ Amount of Above Employee Rate		% of Above Employee Rate ⁽²⁾		% of Family Rate - if Different than Employee
	HMO	POS	HMO	POS	
Retention:					
Claims Administration)					
Utilization Review)					
Network Access Fees)			combined 8.5%	combined 12.5%	
Other Op Expenses*)					
Pooling Charge)					
Risk Charge)					
Premium Tax	<u>2%</u>	<u>2%</u>			
Cont. Reserve/Profit	<u>4%</u>	<u>4%</u>			
Commissions	<u>0</u>	<u>0</u>			
Other:					
<u>Enrollment & Communication</u>	<u>\$1.00/ee/month</u>				
(per addendum)					
Capitation Expense:			<u>HMO</u>	<u>POS</u>	
PCP/Gatekeeper			<u>Gatekeeper</u>	<u>n/a</u>	
Laboratory			<u>capitation represents</u>	<u>_____</u>	
Substance Abuse			<u>approximately 40-45%</u>	<u>n/a</u>	
and/or M/N			<u>of the rate</u>	<u>_____</u>	
Prescription Drug					

100
INTERGROUP
HEALTHCARE
CORPORATION

May 26, 1992

Lama

Robert F. Stephenson
Administrator, Professional Services Unit
State Purchasing Office
State of Arizona
1688 W. Adams, Room 220
Phoenix, AZ 85007-2687

Re: RFP A2-0093

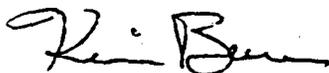
Dear Mr. Stephenson:

Thank you for providing Intergroup Healthcare Corporation with the opportunity to meet with you and the members of the evaluation committee on Friday, May 22nd.

Enclosed is our response to the follow-up requested follow-up questions.

If I may offer further assistance, please call me at 381-7877.

Sincerely,



Kevin Buron,
Marketing Director, Northern Region

2800 NORTH
44TH STREET
SUITE 500
PHOENIX, ARIZONA
85008-1502

(602) 224-5528
1-800-388-3909
FAX: (602) 381-7878

INTERGROUP/BAY COLONY

COST

1. Explain rationale for increasing base HMO rates when written in conjunction with POS plan.

The base HMO rates are increased when written in conjunction with the POS plan because of adverse selection factors.

2. The committee cannot guarantee the level of State contributions toward medical premiums as this is set by legislature. The DOA's philosophical position on this issue for recommendation purposes was outlined in the RFP, i.e., it is not desired that inefficient plans be subsidized by efficient plans. Do any statements in your response to the RFP in any way reduce the State's flexibility with regard to the establishment of employee contribution levels?

IGHC's statement regarding the level of contributions paid by the State is not a prerequisite to offering the plan, rather a statement regarding our philosophy as to what is in the State's best interest.

3. Since point of service renewals are partially experience rated, will you provide answers to questions 1.2 and 1.3 of Part 1 of the Questionnaire so that the State may assess the reasonableness of your renewal methodology?

1.2 IGHC's retention fees of 12.5% are guaranteed.

1.3 IGHC will provide reports updating the estimated incurred but unpaid claims liability. The estimates will be based solely on the State's specific utilization if the enrollment is determined to be credible (1000 lives). Otherwise it will be estimated using standard actuarial lag factors.

4. Please expand upon and clarify your approach to partial experience rating as outlined in question 1.6 of Part 1.

The State account will be considered 100% credible at the 1000 life level. If this enrollment level is not reached in the POS plan, standard actuarial credibility tables will be combined with the State's experience.

WYATT STATE AUDIT - CLAIMS ERRORS ANALYSIS

CLAIM NUMBER/ SAMPLE NUMBER	PROCEDURAL OR FINANCIAL	ERROR	WHY THE ERROR OCCURRED	WHAT HAS BEEN DONE TO CORRECT IT
02019381612/260 01049380243/69 02059380038/56 11179282309/67 02229381306/102 02049380448/183 02159382614/187 02179381201/212 11039282312/269 01059381234/254 01289380818/257 02269380103/33 01079380313/42	F P P P P P P P F P P P P	Incorrect data originally entered (i.e., Date of Service and Diagnosis) caused the procedural errors Incorrect data originally entered (i.e., Number of Time Units and Service Codes) caused inaccurate allowed amounts which resulted in financial errors	Data Entry Team had entered incorrect data and the examiner had not corrected the errors	Combined Entry function with Examining, in mid-August 1993, to reduce Data Entry errors
12299282219/264 02019381636/55 12319282935/271 12249281912/52 01049380342/335 01059381141/252	F F F F F F	Allowed a non-covered service instead of denying	The Examiners paid claims which are not a covered benefit and claims with services disallowed by the surgical ground rule coding guidelines	Benefit plan training was conducted in July 1993 to review the State's certificate exclusions. Individual one on one instruction was given, to each Examiner, to review the surgical ground rule coding guidelines.
01159380618/178 01119380648/332 01209380841/334 01089380004/343 12019280709/237 02179381902/283 12249281504/289 03029381014/296	F P P P F F F P	Coordination of Benefits processing error	Lack of understanding unique processing guidelines for claims with COB caused error	The Claim Manager gave one on one instruction, to each Examiner, on COB processing procedures. A State Team Training session was conducted in April 1993 on COB processing.

Attachment D

WYATT STATE AUDIT - CLAIMS ERRORS ANALYSIS

CLAIM NUMBER/ SAMPLE NUMBER	PROCEDURAL OR FINANCIAL	ERROR	WHY THE ERROR OCCURRED	WHAT HAS BEEN DONE TO CORRECT IT
12249281903/326 11129280611/137 01079383418/353	P P P	Incorrect reason code used for denial	The Examiner used the wrong reason codes which resulted in an inaccurate denial message on the explanation of benefit form	Additional training regarding reason codes was held with the examiners to ensure accuracy
02099383302/173 11129281719/122	F F	Incorrect calculation of deductible for member	Calculation of deductible was a manual process for the examiners causing the errors	System upgrade was completed, in April 1993, resulting in automated calculation of calendar year deductible
11199284004/259	F	Excessive deductible applied	Claim was paid by report; Examiner did not have all of the original documentation to review	Additional Research Specialist have been added to the State Team to pull required documentation needed for claim payment
12109285918/275	F	Paid as Urgent Care resulting in an overpayment	Provider specialty was identified inaccurately	Examiners were trained on provider coding
12159280801/277	F	Incorrect calculation of Out Of Pocket	A separate claim was adjusted after this claim had been processed causing the incorrect calculation	Provided training emphasizing importance of Out Of Pocket calculations and reviewing the claim history to determine if additional claim adjustments are necessary

WYATT STATE AUDIT - CLAIMS ERRORS ANALYSIS

CLAIM NUMBER/ SAMPLE NUMBER	PROCEDURAL OR FINANCIAL	ERROR	WHY THE ERROR OCCURRED	WHAT HAS BEEN DONE TO CORRECT IT
02049380616/170 02269380410/134 11259284203/154 02159382628/157 02239380019/198 12309280120/239 02239380406/197 01159383210/338	F F F F F F F F	Co-pay should have been applied to claim	Inaccurate processing information received in claims area	Procedure clarified and examiners instructed to apply co-pay
11249283901/267	F	Should have paid claim in-network	Examiner interpreted the claim as a self referral by member	Examiners were trained in PCP verification on system
02179381217/126 03199380004/112 12309280310/191 03049380005/162 01199380108/222	P P P P P	Incorrect Batch date (i.e., did not match received date)	Batch Control Entry Error	The Batch Control area has been re-engineered to ensure these errors do not continue
03019380401/108	F	Duplicate payment	Examiner did not review claims history to check for previous payment	Examiners instructed to review members' histories
02189380851/287 01049380308/82	F F	Payment exceeded benefit maximum allowed	Examiner did not review claims for benefit maximum	Additional training on tracking rehabilitation benefit maximums

WYATT STATE AUDIT - CLAIMS ERRORS ANALYSIS

CLAIM NUMBER/ SAMPLE NUMBER	PROCEDURAL OR FINANCIAL	ERROR	WHY THE ERROR OCCURRED	WHAT HAS BEEN DONE TO CORRECT IT
02049380443/205	P	Claim processed under wrong family member	Data Entry Error	Combined entry function with examining to reduce Data Entry errors
12219281703/45 01289381005/54	F F	Denied covered services	Examiner denied claim because of additional routine diagnosis on claim	Additional training to recognize covered diagnoses
03059380602/36 01129383705/193	P P	Diagnosis and procedure codes required clarification	Examiner did not document phone calls to provider on the system	Importance of documentation was stressed to the examiners

ATTACHMENT H

**Selected Correspondence from AAUP
Concerning DOA and Intergroup**

American Association of University Professors, AZ Conference
Benefits Committee

September 22, 1993

Chair:
Ruth Kolb Smith
18 E Concorda Drive
Tempe, AZ 85282
Voice: 968-6813
FAX: 968-7780

To: *Senator Joe Brewer*

Legislative Oversight Committee for Health Insurance

Vice-Chair:
Jacqueline Sharkey
Journalism Dept., UA
Voice: 885-9333
FAX: 296-0758

From: Ruth Kolb Smith, Chair
Jacqueline Sharkey, Vice-Chair
Norma Greer, research staff

Members:
UA
Alberta Charney
621-2291
Theodore Downing
323-8766
Norma Greer
297-1495

Re: Anonymous letters received by our committee concerning DOA and Intergroup.

Staff Rep.:
Carl K. Irwin
6266850

Following publication of an article in the Phoenix Gazette on 9/8/93 we received several anonymous letters which purported to be from state employees knowledgeable about the health insurance programs. These letters say the reasons given by DOA for going to bid on state employee health care contracts in 1992 are misleading. They allege that the emergency bidding process cost the state and its employees millions of dollars while reducing benefits and that it resulted in greatly increased profits for Intergroup.

ASU
Anne Schutte
Art 1505
968-3626
Mel Firestone
965-5807
Harvey A. Smith
Mathematics 1804
968-6813
Phyllis Tambs
965-5778

Although anonymous letters must always be treated cautiously, these writers make good cases for remaining anonymous and not even having their agencies named. They cite fear of losing their jobs and other potential unpleasant consequences. They assert that two employees have been placed on administrative leave and their jobs threatened "because they told of wrongdoing." One writer requests that the letter not even be shown to anyone, presumably for fear it could be traced, but asks us to communicate the information to legislators.

Staff Rep.:
Marcie Katler
968-3021

The letters, which appear to be by different writers from different agencies, support one another on major details. Moreover, much of what they allege is known to those of us who have been researching these matters and has previously been documented or has been verified through telephone conversations with DOA and insurance company personnel.

NAU
Joseph Lingerfelt
523-3481

In the attached document we have undertaken to consolidate, commingle and paraphrase the letters in a fashion that we hope will not jeopardize the writers. In the interest of accuracy we have allowed some ambiguities and repetitions which occur in the original letters to stand rather than editing and clarifying them. While the writers agree and repeat one another on the majority of items, not every point is in every letter. To help preserve their anonymity we refer to "the writers" in all cases, even if a particular item is contained in only one letter. Where we can verify or support particular assertions from our research or personal knowledge, we have added comments (indented) and supplied sources.

State Agencies Rep.:
Louise Muir
433-7440

Ex-Officio
President, AAUP
AZ Conference,
Carol Bernstein,
Voice: 626-6069
FAX: 795-0073

We very much appreciate the efforts legislators have made on behalf of state employees regarding health care options during the last session. We all want our health insurance dollars spent wisely to provide maximum benefit to the employees and control the cost to the state. We support any efforts your committee can make to further that goal.

Encl.

1. Major Issues Raised by Anonymous Letters about State Employee Health Care Benefits
2. Documentation
 - A. Report by G. E. Harris et al. 9/24/92, Smith Barney, Harris Upham & Co.
 - B. p.7 from Stock Prospectus of Intergroup Healthcare Corporation, 7/10/91.
 - C. p. 1 of Memorandum, 8/27/92, from William Bell to Scot Pitcairn, JLBC analyst.
 - D. Associated Press article, dateline Phoenix, printed 7/22/92.
 - E. Letter from J. Elliott Hibbs to Margaret E. McConnell, dated 3/20/92, changed to 3/24/92
 - F. Letter (undated, but received 7/20/92) to state employees from J. Elliott Hibbs
 - G. JLBC Staff Memorandum, 8/26/92, from Scot Pitcairn to Rep. Susan Gerard (3 pp.)
 - H. Memorandum, 3/3/92, from Robert E. Stephenson, Jr. to Margaret E. McConnell (3 pp.)
 - I. p. 2 of F above, from J. Elliott Hibbs to state employees
 - J. Chart of comparative health care costs

Major Issues Raised by Anonymous Letters about State Employee Health Care Benefits

1. The writers allege that the health insurance program for state employees has been "ruined" and that the legislature and the employees have been "misled" regarding the program and its costs.

We have copious letters from employees complaining about the quality and cost of the new programs. Many employees have complained that they were misled about coverage. Misleading information from Intergroup and DOA employees has been very thoroughly documented. We will supply examples on request.

2. The writers allege "that Intergroup bought a shell insurance company just so it could bid and offer a combined HMO and indemnity plan to the state in 1992." The writers state that Intergroup had no experience running an indemnity plan and find it amazing that they were awarded the contract by DOA despite this inexperience.

Intergroup's reason for offering a POS plan [Interflex] is stated by stock market analysts to be "penetration of the indemnity market" (attachment A, #8.) The analysts also note the importance of high penetration of the state government employee market (attachment A, #1.)

The "shell insurance company" referred to is presumably Bay Colony. The stock prospectus of Intergroup Healthcare Corporation says, on p. 7 (attachment B), "Bay Colony became operational in July 1991. The Company [Intergroup Healthcare Corporation] has a limited operating history with regard to these additional products, and there is no assurance that the company will be successful in marketing them or in managing the additional risk Bay Colony will assume as an insurer." Intergroup personnel have confirmed to us by telephone that Interflex was a very small program prior to August 1992. The Interflex program was known in the industry to be very troubled in its first year of operation and an individual was hired by Intergroup specifically to work on these problems. William Bell (attachment C) says that the criteria upon which offerors were evaluated was stated in the RFP as follows: Experience, Expertise, Reliability 45%, Cost 35% and Method of Approach 20%. These criteria are hard to reconcile with award of the contract for the inexperienced Interflex program, which had had serious problems.

The primary example of successful experience adduced by Intergroup in support of their proposal was managing the POS program for Honeywell. Although Honeywell self-insures, the POS program has been managed since July 1991 by the Intercare subdivision of Intergroup, as is Interflex. We talked by telephone with Sophia Mullins in Benefits at Honeywell (602) 436-1857. She said that no one from the State of Arizona had ever contacted her about the performance of Intercare, that she has been there for the entire time, and she would

have been the person to whom such an inquiry would be directed. She said that at no time would she have given a positive description of their performance. The problems with Intercare which she described exactly paralleled those which have been experienced by state employees.

3. The writers allege that DOA paid Intergroup a 13-16% increase on its HMO program AFTER BIDDING and that DOA did not attempt to negotiate it down. The authors allege that PRIOR TO GOING TO BID Intergroup offered to renew for an 8.5% increase. They say that any extra benefits offered for the extra price were very slight. They allege that Intergroup profited by an unnecessarily large increase in rates and by the greatly increased number of employees who joined Interflex and Intergroup after the state dropped the Connecticut General indemnity plan and CIGNA Flexcare POS plan. They allege that Intergroup earned millions more because DOA awarded them much higher rates than necessary and also gave them much additional business. The authors repeatedly warn that legislators should not confuse the Intergroup HMO with the Intergroup Interflex program. [The Interflex contract is with Bay Colony, a subsidiary of Intergroup distinct from the HMO.] The writers allege that Intergroup was inexperienced with Interflex and that the DOA awarded them the business despite this.

The Associated Press, 7/22/92 (attachment D), says, "Hibbs told lawmakers yesterday that the state was late when it bid for the insurance plans and didn't have time for negotiations to lower premiums." Mr. Hibbs authorized emergency procurement procedures which effectively limited competition (attachment E.) Also see comments above on Interflex lack of experience.

4. The writers say that DOA's repeated citation of \$44 million in increased costs to the state as a rationale for going to bid on the contracts is improper because there were other, much less expensive alternatives that would have been less disruptive. The writers allege that prior to going to bid, Intergroup offered to renew its contract for an increase of 8.5%, but received a 13-16% increase after their bid was accepted.

The \$44 million reflects the initial "asking price" prior to negotiations. (For an example of the DOA use of this figure see attachment F.) After some negotiation, shortly before going to bid, DOA said that "additional health insurance costs could rise to \$12 million" (attachment G). Since the legislature had authorized an increase of \$4 million and the DOA did eventually pass on at least \$7-8 million in increases to the employees, the rationale for breaking off negotiations and going to bid on a competition-limiting emergency basis appears weak. By using the authorized state funds and passing the rest on to employees, agreement could have been reached.

The \$44 million figure apparently includes a 29% increase initially requested by CIGNA (attachment G.) CIGNA executive Peggy Beaver has verified to us by telephone that before DOA went to bid CIGNA had reduced its demands to a 13% overall increase with little change in benefits. (The CIGNA non-HMO programs could be expected to include more of the seriously ill and disabled than the Intergroup HMO.)

We have not verified the 8.5% figure with Intergroup, but it is cited independently by different writers.

5. The writers say that the state did not get a bargain by going to bid but that there were, in fact, many millions in extra costs which were passed on to the employees. The writers suggest that this can be confirmed by requesting a TOTAL COST [all amounts paid from all sources] for the period August 1, 1991 to July 31, 1992 and a TOTAL COST for August 1, 1992 to July 31, 1993. The authors insist that, to see the increase, this information should not be broken down by employees' or states' cost or fund sources but should be TOTAL COST only. The writers say that this information is currently and readily available in the Personnel Division of DOA, but suggest DOA may attempt to avoid or delay disclosure.
6. The writers allege that DOA's implication to the legislature that costs for health insurance did not go up for the coming year is untrue. The writers allege that the state will pay an additional \$7 million more in costs this year [1993-1994] and that employees will pay millions more in increased contributions. The writers say that that the fiscal-year costs "look OK" because the new rates don't go into effect until October 1, 1993 instead of at the beginning of the fiscal year. They allege that the new rates from October 1, 1993 until September 30, 1994 will show a big increase for both the state and the employees.
7. The writers reiterate that the 1992 contracts were no bargain and note that they increased costs dramatically for Phoenix and Tucson employees.

In a memorandum (attachment H) dated 3/3/92, addressed to Margaret E. McConnell, the State Procurement Administrator, Robert E. Stephenson, Jr. (Administrator, Professional Services Unit) questions whether the bidding process will not artificially drive up the rates. He asks whether all options and alternatives were considered prior to deciding on a new RFP. He asks what type of formal negotiations were accomplished with the contractors and why the State Procurement Office was not party to the formal negotiations.

8. The writers say that because of a questionable rationale, the state is now paying much more for rural employees (as much as \$1,195 family and \$526 single). They state that rural employees now have the choice between an indemnity and an HMO, which is denied to Phoenix and Tucson employees. They allege that the state has cut rural employees' expenses and increased their benefits by reducing deductibles and out of pocket expenses. They allege that it would now cost the state about \$20 million to equalize its contribution strategy in all counties and that this cannot be recommended by DOA because it would show that they did not get a bargain in 1992 when they went out to bid on an "emergency" procurement basis. The writers say that, contrary to what has been told to the legislature, costs have not been contained.

The disparity between rural and urban counties is widely known. Analysis indicates the total cost of the CIGNA "best and final offer" would have been lower than the package accepted, but it required an exclusive contract. According to a statement (attachment I) by Mr. Hibbs that was circulated to employees, this bid was rejected because "The State would not have been allowed to offer Intergroup to our employees." Intergroup's "lower rates" cited as an additional reason by Mr. Hibbs in that memo are problematic. The differences between CIGNA and Intergroup in total premiums for the HMOs were a few dollars per month, with CIGNA a bit lower for individual coverage and Intergroup a bit lower for family coverage. For 1993-94 the Intergroup HMO premiums are markedly higher than CIGNA HMO premiums for all categories and locations.

9. The writers allege that the DOA has made a point of saying that to blend the retirees with active employees constitutes an illegal subsidy, yet allows NAU to continue blending their retirees. The writers assert that if it is illegal to blend retirees for the rest of the state it is also illegal to blend retirees at NAU.

The Associated Press, 7/22/92 (Attachment D), reports, "Personnel Director Bill Bell said the state decided to single out retirees ... because it was trying to keep costs down." In the same article, J. Elliott Hibbs reportedly "said that he wasn't sure how the retirees got moved into a separate group."

10. The writers allege that premiums were scheduled to rise on the dental insurance and that a hearing regarding this, scheduled for February 24, 1993 on Senate Bill 1213, was subsequently canceled. The writers allege that the DOA was reluctant to be questioned by the legislators and avoided the hearing by raising the employee's share of premiums and cutting the state's contribution. The writers allege that no questions were ever raised about how this was done and that none of the legislators knew or wondered why the state was paying less for dental insurance.

See cost sheet (attachment J), which was included with one of the anonymous letters.

A

1. A specific example of a large account (comprising more than 15% of the company's total enrollment) that recently renewed its contract for the eighth consecutive year with IG is THE STATE EMPLOYEES ACCOUNT. As the largest employer in the market, the state gov employs more than 50,000 people, of which 28% are already enrolled in IG. Besides the SUBSTANTIAL PREMIUMS that are involved, IG's high penetration of state gov and school district employees is especially important because it encourages greater support from government for the company and for managed care in general.
2. One of the most important additions to IG's product line has been its point-of-service plan. Given the market's PREFERENCE for POS PLANS, which ALLOW for a GREATER CHOICE of providers, membership growth is expected to be strong. Despite premiums per member/per month being higher for POS plans, they are less profitable because they attract less healthy individuals who want a greater selection. IG offers it because it appeals to employers who wish a wider variety of health plans.
3. Medicare pays IG a little more than \$300 per member/per month to receive the same benefits they would from the government. This amount represents roughly a 7% increase over 1991's rate, and the projected increase for 1993 is approx 12%. Such favorable rate increases could be indicative of strong support Medicare risk program and margins on these contracts are likely to remain high until COMPETITION intensifies.
4. IG recently was AWARDED ONLY commercial Medicaid risk contract covering Phoenix and Tucson by AHCCCS. Once the product is launched, the company will immediately begin to cover 17,000 lives that it ACQUIRED FROM UNIVERSITY PHYSICIANS, INC. (UPI). The initial cost of the acquisition, at less than \$30 per member, was relatively insignificant, although IG has agreed to pay an additional \$41 per member if the plan meets certain performance criteria.
5. The state government had put a freeze on further enrollment in UPI's plan because it was not awarded an ongoing contract. Therefore, to avoid the freeze, the medial group opted to sell its members to INTERGROUP, but it HAS CONTRACTED with the company to remain on of the chief medical groups providing care to the recipients. IG has considerably reduced its underwriting risk by capitating roughly 955 of the primary physician and specialist costs. Although the capitation rates are approximately 20% higher than those for commercial members, the MEDICAID RATE per member is roughly 40% HIGHER than the company's commercial rates. Additionally, Medicaid limits the hospital cost per member/per patient day; thus, the company is only partly at risk for these costs. Also Intergroup is guaranteed a 4% TAX MARGIN.

6. IG's commercial Medicaid plan will be the only one of its kind, offered in Arizona until another commercial HMO enters the Medicaid market, growth prospects of the new plan appear promising. We believe that membership in this plan should increase sharply in 1992-93 reaching 25,000-30,000 members by 1994. We expect the company receive STRONG support from the STATE government, which could mean HIGH MEDICAID RATE INCREASES for IG in the first couple of years.

7. We believe IG will continue annual growth of 8-10% in lives covered, while charging ABOVE AVERAGE, due to the QUALITY and DISTINCTION of its existing provider network.

8. IG has offered POS plans because these are an important tool in facilitating the penetration of the INDEMNITY market; many individuals who are uncomfortable with the idea of being restricted to a provider network, will initially opt for a POS plan instead of an HMO.

9. Management's aim is to establish a sufficiently broad product line so it can gain competitive advantage in bidding large contracts "from, SAY, the ARIZONA STATE GOVERNMENT, by offering ONE-STOP SHOPPING.

10. Thomas-Davis Medical Clinic currently has 65% ownership. Accordingly, this medical group presently occupies five of Intergroup's nine board seats, giving rise to concerns regarding CONFLICTING INTERESTS between TDMS and equity investors.

11. Investing heavily in provider relationships NOT ONLY CREATES BARRIERS TO ENTRY (into the Arizona HMO market) but also ensures high quality. ABOUT 90% of the physicians in IG's network are EITHER BOARD-CERTIFIED or BOARD ELIGIBLE, and all of them have been trained in the U.S.

12. IG has a sophisticated cost control system that shares almost all of the underwriting risk its providers. The strategy is predicated on forming partnerships with the providers so they become as interested in containing costs as the HMO. As a result, almost 90% of the HMO's underwriting risk is passed on to the provider either through risk-sharing or capitation agreements. The company has retained the risk for one major component of health care costs - PRESCRIPTION COSTS and it has used in-house formularies since 1982. IG has devised a set of prescription guidelines, referred to as a "FORMULARY LOCK-IN" which went INTO EFFECT IN 1992. 100% of primary physician and specialist costs are capitated, there is a risk pool for estimated hospital costs, if the actual cost turn out to be lower then IG and the physician group SPLIT additional funds in the pool.

Control Relationships

After completion of this offering, the current stockholder of the Company, TDMC, will own approximately 67% (64% if the Underwriters' over-allotment option is exercised in full) of the outstanding Common Stock of the Company. As a result, TDMC will be in a position to exercise control over the Company. Accordingly, TDMC will be able to determine the outcome of all matters required to be submitted to stockholders for approval, including the election of the Board of Directors, the consummation of a merger, and other major corporate transactions that, under applicable law, require stockholder approval. Five of the nine current members of the Company's Board of Directors are stockholders or employees of TDMC. TDMC is also the Company's largest physician group provider, providing service for approximately 53% of the Company's enrollees, and Intergroup represents approximately 70% of TDMC's net revenues. The relationship with TDMC creates the potential for conflicts of interest in negotiating, interpreting, and implementing contracts between TDMC and the Company. See "Principal Stockholders" and "Certain Transactions."

Expansion of Provider Network and Facilities

In order to develop the additional provider capacity necessary to support its future growth, the Company's business strategy calls for the investment of significant capital resources to construct and equip new or expanded facilities that will be leased to certain physician groups participating in or joining the Intergroup network. While the Company believes that the proceeds from this offering together with internally generated funds should be sufficient for these projects through year-end 1992, the Company may seek additional equity or debt financing to fund these projects. There can be no assurance that such additional financing will be available to the Company on acceptable terms. Lack of sufficient capital to support expansion of the Company's provider network could inhibit its future growth. In addition, unanticipated construction delays or other problems in the build-out of these projects could adversely impact the Company's operating results and future growth. See "Use of Proceeds" and "Business - Business Strategy."

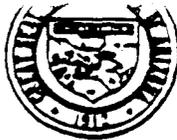
Expansion of the Company's provider network is also dependent on the ability of TDMC and other participating physician groups to recruit qualified physicians who are compatible with its group practice, managed care delivery system. There can be no assurance that these physician groups will be successful in their recruitment efforts.

New Health Care Related Products

To date, the vast majority of the Company's business has been conducted through its HMO, Intergroup. In January 1991 the Company commenced offering TPA services for self-funded employer groups and others through its InterCare subsidiary and has begun offering multi-option plans including PPO, point of service, and indemnity insurance options through its subsidiary, Bay Colony. Bay Colony became operational in July 1991. The Company has a limited operating history with regard to these additional products, and there is no assurance that the Company will be successful in marketing them or in managing the additional risk Bay Colony will assume as an insurer. See "Business - Products and Services."

Management Information Systems

Computer systems and skilled data processing personnel are critical components of the operations of any managed care company and are becoming a more significant competitive factor. The Company has recently installed a new computer system to provide more detailed information concerning the utilization of hospital services and more efficient claims processing. During the conversion, the Company experienced some delays and inaccuracies in processing claims. Although the Company believes it has corrected substantially all of these problems, there can be no assurance that it will not encounter such problems in the future or that such problems will not have an adverse effect on the Company's operations. See "Business - Management Information Systems."



C

ARIZONA DEPARTMENT OF ADMINISTRATION
PERSONNEL DIVISION
1831 WEST JEFFERSON • PHOENIX, ARIZONA 85007



MEMORANDUM

TO: Scot Pitcairn, Fiscal Analyst
Joint Legislative Budget Committee

FROM: William Bell *William Bell*
Assistant Director for Personnel

SUBJECT: Health Insurance Bidding Process

DATE: 8/27/92

The following is provided in response to your recent memo. I hope it is helpful information for you to use

- This letter maintains that, despite the Administration's concerns over the state absorbing additional costs for health insurance, cost was set as a relatively low priority in the scoring of the health insurance bids. Please explain how the various factors were prioritized in the bid review process, and how cost was factored into the scoring.*

When the Department of Administration seeks an organization to provide employee insurance or other related benefits, it is of paramount importance that such organizations have the ability to properly service this state and its employees in the best possible manner. Chief among the criteria for any health insurance company is their experience, expertise and reliability. For purposes of the recent RFP, this criteria was weighted 10 points higher than the cost factors. To have selected cost as the major factor would not have assured the state of a quality vendor.

The criteria upon which offerors were evaluated was stated in the RFP as follows:

Experience, Expertise, Reliability	45%
Cost	35%
Method of Approach	20%

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JUL 22 1992
Insurance
change to hit
retirees hard

The Associated Press

PHOENIX — New health-insurance plans for state employees and retirees go into effect next month, and for some, that means their monthly premium will double.

Retirees younger than 65 in the state's 13 rural counties will be hit hardest, seeing their premiums for family coverage increase about \$400. In some counties, the bill would be as high as \$757.

"Seven hundred dollars is well over 50 percent of what a retired senior DPS officer would retire at," said Barbara Phinzy, a secretary at the Department of Public Safety's district office in Coconino County.

Personnel Director Bill Bell said the state decided to single out retirees and create region-based rates because it was trying to keep health-insurance costs down.

"The state system, up to this point, has functioned on the basis of blended rates, which means certain programs were subsidized by other programs," he said. "We wanted all the programs to stand on their own, and, subsequently, the retirement program was bid separately."

J. Elliott Hibbs, director of the Department of Administration, which administers the health-insurance plans, said he wasn't sure how the retirees got moved into a separate group.

Hibbs told lawmakers yesterday that the state was late when it bid for the insurance plans and didn't have time for negotiations to lower premiums.

Rep. John Wettaw, R-Flagstaff, said it was unclear what lawmakers needed to do to remedy the situation.

"We've got to try," Wettaw said. Senate Majority Leader Alan Stephens, D-Casa Grande, said that lawmakers are discussing a subsidy that would compensate those employees in rural areas.

He said, as a last resort, the Legislature might have to go into special session to craft laws to retain the incentive offered by the state's early-retirement program.

State workers in Maricopa and Pima counties also are upset because the state is forcing them to choose a health-maintenance organization over one that allows them to choose their own doctors.

The monthly cost of the plan that lets workers pick their doctors will increase to \$100 to \$175 for family coverage, while the HMO will remain at \$75. JUL 22 1992



FIFE SYMINGTON
Governor

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J. Elliott Hibbs
Director

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ARIZONA DEPARTMENT OF ADMINISTRATION

OFFICE OF THE DIRECTOR

1700 WEST WASHINGTON - ROOM 801
PHOENIX, ARIZONA 85007

(602) 542-1500

24

March 20, 1992

Margaret E. McConnell
State Procurement Administrator
State Procurement Office
1688 West Adams, Room 220
Phoenix, Arizona 85007

Re: Request for Emergency Procurement

Dear Ms. McConnell:

We have reviewed your letter dated March 18, 1992 requesting authorization for an emergency procurement to shorten the vendors' list for the upcoming procurement of employee health benefits.

Based on that request, we have determined that competition under A.R.S. §§ 41-2533 and 41-2534 is impractical and that an emergency exists according to A.R.S. § 41-2537. Thus, we approve the limited vendors' list for the services as described in your March 18 letter. The State Procurement Office shall conduct the procurement with as much competition as is practicable under the circumstances and determine before entering into a contract that the contract price is reasonable.

Sincerely,

J. Elliott Hibbs
Director

JEH:ag

cc: William Bell
Robert E. Stephenson, Jr.

ATTACHMENT I

DOA's Response to AAUP



MIKE SYMINGTON
Governor

J. ELLIOTT HIBBS
Director

ARIZONA DEPARTMENT OF ADMINISTRATION

OFFICE OF THE DIRECTOR
1700 WEST WASHINGTON • ROOM 801
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(602) 542-1500

Hand Delivered

October 15, 1993

The Honorable Brenda Burns
Arizona House of Representatives
1700 West Washington
Phoenix, Arizona 85007

Dear Representative Burns:

I am in receipt of the September 22, 1993, correspondence from the The American Association of University Professors, Arizona Conference, Benefits Committee (AAUP), which raises numerous allegations regarding the state employee health insurance program.

The AAUP correspondence is an anthology of issues divided into ten (10) separate sections written by a combination of AAUP and anonymous sources. I am providing, for your review, the Department of Administration's (the Department) response to these allegations. The allegations will be addressed in the order presented.

1. Allegation: *The AAUP anthology alleges that employees have been misled regarding the health insurance program and its costs; and that the Department has "ruined" the health insurance program (AAUP Section 1).*

The Department's philosophy for health benefits is one of managed competition. The ultimate goal of the 1992 bid was to continue to provide state employees with comprehensive and affordable health coverage. In terms of affordability, employees in every county are eligible to receive health coverage for \$5.00 for single coverage and \$75.00 for family coverage (the base plan). The base plan represents the health benefits option which has the most competitive rates and the lowest cost. While the Department recognizes that the employee premium contributions for certain plans are greater than the base plan, the employee premium for the base plan has remained unchanged. The premium costs for the non-base plans reflect the higher costs of the non-base plans.

Prior to the 1992 bid process, the State was experiencing a \$44 million rate renewal premium increase. The \$44 million premium increase could not have been absorbed by the State or its employees.

According to the Personnel Services Division, Arizona Department of Administration the original renewal request from CIGNA and Intergroup represented renewal premium increases of 33.7% and 12.7%, respectively. The Department was able to negotiate the CIGNA annual renewal rate increase without any changes to benefits to an unacceptable 29% renewal rate (the CIGNA negotiated rate).

While several alternative rates were discussed during the renewal process, all rates below the CIGNA negotiated rate reduced benefits and significantly increased employee out-of-pocket expenses. In addition, renewal rates below Intergroup's 12.7% increase also were accomplished by reducing benefits and significantly increasing co-payments.

(DOA Responses #5 and #11 address the renewal rate alternatives offered by Intergroup and CIGNA prior to the 1992 re-bid process.)

It is important to recognize that, according to the Personnel Services Division, enrolled urban state employees who remained with the health maintenance organization option, which included the CIGNA Staff HMO and Intergroup HMO, were not significantly impacted, if at all, by the 1992 re-bid, as their plans remained virtually unchanged in costs and benefits provided.

2. Allegation: *The AAUP anthology alleges that the Intergroup Healthcare Corporation purchased a "shell insurance company" for the sole purpose of bidding for a combined HMO and indemnity plan in 1992 (AAUP Section 2).*

In an effort to fully address this allegation, the Department requested a response from the Arizona Department of Insurance. The Department of Insurance's response is re-printed in its entirety:

"Many insurers and/or HCSOs (HMOs) wishing to underwrite lines of insurance other than those for which they already have a license do so by acquiring an already existing insurer. Acquisition has advantages that forming a new insurer does not. It takes less time to acquire an existing insurer than to form and obtain licenses in various states for a new insurer. Also, A.M. Best, Moody's and other rating agencies give consideration to licensed insurers with a proven track record, etc.

Bay Colony Life Insurance Company of Arizona is licensed to underwrite life and disability (health) insurance in Arizona and was first licensed on August 25, 1971. It was purchased from a wholly owned subsidiary of Massachusetts Mutual Life Insurance Company (a \$31 billion dollar life insurer domiciled in Massachusetts). It was inactive at the time of acquisition and had been apparently for quite some time. Professional Management Group of Arizona, Inc. (the then-current Parent of Intergroup Prepaid Health Plan of Arizona, Inc.) was acquired pursuant to public hearings held on November 7, 1990 at the Arizona Department of Insurance (ADOI) and concluded on November 19, 1990. ADOI granted final approval on December 7, 1990.

As of December 31, 1992, Bay Colony reported admitted assets of \$3,536,443, statutory net worth of \$1,378,337 and was active, reporting written premiums of \$4,698,629 (all in the State of Arizona and all accident and health). Statutory 1992 net gain from operations was \$45,170 (before Federal income taxes). The 1992 financial statement was audited

by Ernst & Young who also reported statutory net worth of \$1,378,000 and the reserves were certified by Tillinghast."

According to the response from the Arizona Department of Insurance, the acquisition of Bay Colony Life Insurance was concluded in 1990 -- which is at least a year before the Department even determined to go out and re-bid the contract in 1992.

3. Allegation: *The AAUP anthology attempts to establish a correlation between the evaluation criteria and the reconcilability of the contract award to Intergroup (AAUP Section 2).*

Historically, the evaluation committee members chosen by the State Procurement Office for any procurement proposal process allows the evaluators the opportunity to establish the evaluation criterion as well as, the weight factors to be assigned to that criterion.

The evaluation criteria was weighted in relative importance pursuant to state statute (A.R.S. § 41-2534(E)). The evaluation committee determined that Experience, Expertise, Reliability was equal to 45%, Cost was equal to 35%, and Method of Approach was 20%. The percentages given represent the weighted average for each of the criteria to be evaluated.

According to the evaluation committee, members felt that the experience of the company, their track record in the related health field environment, the key personnel associated with the organization along with their proven educational credentials was essential. Another major factor was the financial stability of the company. Additionally, since the majority of health containment companies offer either an indemnity or health maintenance organization, the methodology of the how they would satisfy the requirement of the State's health issues should have been, and was, the least important criteria. Therefore, the committee voted to have cost as the second most important criterion.

Although the Arizona Procurement Code does not require that the criterion be weighted, it has been proved in past issues that such a methodology is sound and provides excellent results in the total evaluation process.

The evaluation committee developed a "score card" for the purposes of rating the offerors. All of the evaluation committee's "score cards" rated, with a maximum score of 100, Intergroup and CIGNA as the best offerors for Maricopa and Pima Counties. The average score for Intergroup and CIGNA in Maricopa County was 94 and 91.4, respectively. The average score for Intergroup and CIGNA in Pima County was 94.8 and 91.4, respectively (DOA Attachment A).

4. Allegation: *The AAUP anthology alleges (by inference) that the Department did not do reference checks on behalf of Intergroup; and had such a reference check been conducted, the State would not have received a positive response regarding Intergroup (AAUP Section 2).*

With respect to reference checks by the evaluation committee, the AAUP anthology cites that the Department failed to contact Honeywell for a reference check regarding Inter-

group's performance with that company. The AAUP anthology bases this allegation on the supposition that the only appropriate individual that the Department could have contacted was Ms. Sophia Mullins, Honeywell's Benefits Manager.

However, according to Ms. Mullins, she was not the Benefits Manager during the 1992 re-bid process. In fact, according to Ms. Mullins, the Benefits Manager position during the Department's 1992 re-bid process was held by Mr. Randy Jacobs.

According to the State Procurement Office's official record, the evaluation committee had, in deed, contacted Mr. Jacobs during the 1992 re-bid process. The record clearly exhibits that Mr. Jacobs noted the existing operational deficiencies of Intergroup's Point of Service Plan, however, he also clearly stated that the plan would be recommendable in the future. While Mr. Jacobs noted difficulties, he did not recommend aversion or avoidance. In addition, Mr. Jacobs did positively recommend the Intergroup HMO product (DOA Attachment B).

The AAUP anthology allegation that the Department failed to seek a reference verification is without merit.

5. Allegation: *The AAUP anthology alleges that Intergroup offered to renew the then-existing contract at 8.5% and the Department elected to re-bid the contract for 13%; and that the extra benefits offered in the larger percentage increase were slight (AAUP Sections 3 and 4).*

It is inappropriate to compare the 8.5% rate increase to the 13% rate increase offered by Intergroup.

More specifically, a review of a comparison of benefits produced by The Wyatt Company clearly illustrates that the 8.5% renewal rate increase significantly increased employee out-of-pocket expenses. In essence, co-payments for most HMO services were significantly increased. A complete comparison of the then-current and the then-proposed benefits are provided, for your review, in DOA Attachment C.

Under the new contract, which represented a 13% increase from the previous contract, the Intergroup HMO maintained the same level of benefits from FY 1991-92.

6. Allegation: *The AAUP anthology alleges that Intergroup experienced an increase in enrollment under the 1992-93 contract; and that "Intergroup earned millions more because DOA awarded them much higher rates than necessary and also gave them much more additional business" (AAUP Section 3).*

A review of the 1992 open enrollment data clearly shows that the membership of Intergroup increased as a result of the managed competition between CIGNA and Intergroup. The Personnel Services Division attributes the increase in membership to the different and competitive rates and benefits offered by each individual plan. Fluctuations in plan membership, due to competition among plans, are an inherent and positive result under a managed competition scenario.

The Department is aware that the Intergroup Healthcare Corporation is experiencing increased profitability. As the Department believes it is inappropriate to address Intergroup's profitability, a previous response from the Intergroup Health Corporation is provided for your review (DOA Attachment D).

The open enrollment process is a voluntary process provided to employees to give the opportunity to make adjustments to their health insurance needs. According to the Personnel Services Division, the Department does not assign employees to any particular health plan. Each employee selects their own health insurance based on a personal decision making process. The suggestion that the Department has given Intergroup additional business has no merit.

7. Allegation: *The AAUP anthology discusses that the Department used emergency procedures to limit competition during the 1992 re-bid process (AAUP Section 3).*

The Personnel Services Division and the State Procurement Office requested, and were granted, emergency authority under A.R.S. § 41-2537 solely to waive the requirements of Arizona Administrative Code R2-7-326(E) which mandates that all vendors on the State's registered vendor be notified of a contracting opportunity in their area. The emergency authority was requested in this instance, because of the time sensitivity issue and the fact that the vendors' list includes firms that do not provide the type of insurance that was being sought.

The State Procurement Office has the authority under A.R.S. § 41-2537 to determine when a competitive process, either in whole or in part, is impractical and it may request from the Director of the Department, subsequent to its finding of impracticability, an emergency procurement waiver pursuant to A.R.S. § 41-2537.

Nevertheless, while the authority was granted, it is important to recognize that it was not used. In essence, the request for that waiver was made prior to the realization that enough time existed to notify all vendors of the competition for the health insurance contract.

Subsequently, the State Procurement Office sent a solicitation notice letter to all registered vendors on the State's Registered Vendor List who had registered for health insurance related services. According to the State Procurement Office, it transmitted 127 solicitation notices for the 1992 re-bid process (DOA Attachment E).

In addition, at the same time the solicitation notices were being sent, the State Procurement Office sent 27 actual solicitation packets to vendors who were identified as the most likely to bid on the health insurance contract. Finally, the State Procurement Office advertised the solicitation pursuant to A.R.S. § 41-2534(C) (DOA Attachment F).

8. Allegation: *The AAUP anthology alleges that the Department did not have to re-bid the health insurance contract in 1992 as there were less much less expensive alternatives available (AAUP Section 4).*

The AAUP allegation that less expensive plans were available in 1992 is true. In fact, the

then-existing plans offered, during the renewal negotiations, to provide such plans. However, the alternative plans were accomplished by increasing employee out-of-pocket expenses and deductibles; and reducing medical benefits.

The AAUP allegation presupposes that the so-called less expensive alternatives were comparable to the then-existing health insurance program; when, in fact, they were not .

(DOA Responses #5 and #11 address the renewal rate alternatives offered by Intergroup and CIGNA prior to the 1992 re-bid process.)

9. Allegation: *The AAUP anthology alleges that the Arizona Legislature had authorized an increase of \$4 million for health insurance for FY 1992-93 , prior to the 1992 re-bid process (AAUP Section 4).*

A review of the budget recommendations from the Joint Legislative Budget Committee (JLBC) and the Governor's Office of Strategic Planning and Budgeting (OSPB) for FY 1992-93 exhibit that the Arizona Legislature did not authorize a \$4 million increase in the health insurance appropriation prior to the 1992 re-bid process. While the JLBC budget recommendation did, indeed, include an additional \$4 million targeted for health insurance, the OSPB budget recommendation had no increase allocated for health insurance (DOA Attachment G).

The JLBC and OSPB budget recommendations provide excellent guidance for the budget process. However, to treat the initial budget recommendation as a legislative authorization is an erroneous interpretation of the initial JLBC and OSPB budget recommendations. It is well-documented that the initial budget recommendations undergo numerous adjustments during the appropriation process and seldom are appropriated as initially recommended. The FY 1992-93 appropriation process was not unique in this regard.

10. Allegation: *The AAUP anthology alleges that the Department passed on at least \$7 to \$8 million in increases to employees. The AAUP anthology questions the Department's rationale for breaking off negotiations when the Department appeared to attempt to avoid an increase of \$12 million in health insurance premiums (AAUP Section 4).*

A review of the Health Insurance Trust Fund's Statement of Revenues, Expenditures And Changes in Fund Balance, which is prepared by the General Accounting Office, Financial Services Division, Arizona Department of Administration, exhibits that employee contributions increased by \$4, 881,784, for FY 1992-93 (DOA Attachment H).

The Department maintains that the increased employee contributions are a result of employees selecting non-base plans. Had all employees selected the base plan, employee contributions would have remained equal to that of the prior year.

The Department decided to re-bid the health insurance contract after it was determined that the renewal process had created three options: 1) The Department could accept a large increase to maintain the then-current level of benefits; 2) The Department could accept the

lower CIGNA and Intergroup renewal rate options with their accompanying reduction in benefits and increased employee out-of-pocket expenses; and 3) The Department could re-bid the contract and introduce a managed competition philosophy in an effort to control costs for the State and employees.

The Department stands behind its decision to introduce managed competition to the state employee health insurance program. Through managed competition, the State was able to continue to offer an affordable and comprehensive base plan to all employees in all counties.

(DOA Responses #13, #18, and #19 address the control of costs as a result of managed competition.)

11. Allegation: *The AAUP anthology alleges that according to Ms. Peggy Beaver, CIGNA had reduced its renewal rate increase to 13% with "little change in benefits" (AAUP Section 4).*

According to CIGNA officials, there were three "final" rate renewal options available. Each renewal option contained a principal assumption: a) the 16.4% option assumed no change in participation; b) the 13.8% option assumed elimination of the retiree plan; and c) the 12.9% option assumed the elimination of the retiree and indemnity plans.

Again, according to CIGNA officials, the 13% renewal option cited in the AAUP anthology is actually the 13.8% option (b). While the 13.8% option did maintain Flexcare and indemnity plans, the proposal was accomplished by significantly reducing benefits.

More specifically, regardless of the option, all three options required that out-of-pocket expenses incurred by employees be increased for the indemnity, in-network, and out-of-network options, when applicable. Such increases in out-of-pocket expenses include, but were not limited to, deductibles, coinsurance percentages, and co-payments for most HMO services. A complete comparison of the then-current and the then-proposed benefits are provided, for your review, in DOA Attachment I.

The AAUP allegation that there were was little change in benefits with CIGNA's renewal rate(s) is erroneous and is not supported by the record.

12. Allegation: *The AAUP anthology alleges that the total cost, which AAUP defines as all amounts paid from all sources, will show that the Department passed on "many millions in extra costs" to state employees (AAUP Section 5).*

A review of the total expenditures made with respect to the Health Insurance Trust Fund have determined the following:

FY 1991-92 Total Expenditures	\$173,938,535
FY 1992-93 Total Expenditures	\$173,596,839

Furthermore, total expenditures are defined as the total cost of the health and accident program, dental program, and administrative costs. The total expenditures of the Health In-

insurance Trust Fund have decreased under the Department's managed competition philosophy (DOA Attachment H).

In the interest of full disclosure, however, the AAUP anthology has asked for the wrong information. More specifically, the more appropriate inquiry is a review of the Employee and Employer Insurance Contributions, rather than the "total cost" (DOA Attachment H).

FY 1991-92 Employee Contributions	\$32,425,465
FY 1992-93 Employee Contributions	\$37,307,249
FY 1991-92 Employer Contributions	\$135,873,010
FY 1992-93 Employer Contributions	\$141,488,379

As stated earlier, the Department advocates a philosophy of managed competition for health benefits. Employees in every county are eligible to receive health coverage for \$5.00 for single coverage and \$75.00 for family coverage, otherwise known as the base plan. The Department agrees that employees who select non-base plans do pay higher premiums which reflect the higher costs of such non-base plans.

13. Allegation: *The AAUP anthology alleges that the State will pay an additional \$7 million more in health costs for FY 1993-94. AAUP further alleges that employees will "pay millions more in increased contributions" (AAUP Section 6).*

A review of the Appropriations Report for FY 1992-93, published by JLBC, exhibits that the total appropriation for health insurance was \$100,147,500 (DOA Attachment J). Conversely, the Appropriation Report for FY 1993-94 exhibits that the total appropriation for health insurance is \$90,713,700 (DOA Attachment K).

Subsequently, according to the appropriated amounts for the FY 1992-93 and FY 1993-94, as exhibited in the respective Appropriation Reports, health insurance costs for FY 1993-94 were reduced by \$9,423,800, as compared to FY 1992-93.

Of this decrease, \$5 million is primarily attributable to the decoupling of university tuition fees. This decoupling transferred a portion of the university's budgets, including Employee Related Expenses (ERE) to a non-appropriated status. Other possible causes for the decrease include a shift of participants from more expensive indemnity coverage to the base plan, a possible decline in participation, and technical adjustments due to a change in calculating premiums payable from a statewide participation percentage to an agency-based participation percentage.

The Department disagrees with the context of the allegation that employees "will pay millions more in increased contributions." As stated above, the base plan has remained unchanged in FY 1993-94. As in FY 1992-93, employees in every county have the option to receive health coverage for \$5.00 for single coverage and \$75.00 for family coverage (DOA Attachment L).

Again, the Department recognizes that employees who select non-base plans will experience an increase in premiums for FY 1993-94 compared to their FY 1992-93 premi-

ums. However, the premiums represent the higher costs associated with the non-base plans (DOA Attachment L).

14. Allegation: *The AAUP anthology alleges that an internal memorandum questioned whether the bidding process will not artificially drive up rates and whether all options and alternatives had been considered prior to the decision to re-bid (AAUP Section 7).*

The AAUP anthology cites a March 3, 1992, State Procurement Office internal memorandum between Mr. Bob Stephenson, Administrator, Professional Services Unit, and Ms. Maggie McConnell, State Procurement Administrator. The internal memorandum was prepared at the request of Ms. McConnell to assist in the preparation of a meeting with the Personnel Division on March 5, 1992, to discuss competing the health insurance benefits contract. It was a working paper setting forth procurement, not programmatic, concerns about re-bidding.

The concerns raised in the internal memorandum were not based on any in-depth factual information about the negotiations that had taken place and that had reached an impasse between the current health benefits vendors and the Personnel Division. Mr. Stephenson and Ms. McConnell were unaware of the extent to which there was a problem in the negotiations for the annual renewal because neither Mr. Stephenson nor Ms. McConnell had been a party to them. Therefore, the internal memorandum being questioned by AAUP was prepared without knowing anything about the problem and the need to re-bid.

After the meeting on March 5, 1992, with the Personnel Division, Mr. Stephenson and Ms. McConnell fully supported the decision to re-bid the health benefits contract. The concerns raised in Mr. Stephenson's memorandum were addressed and satisfied at the meeting, and there was overwhelming evidence presented for the need to go back out and compete.

15. Allegation: *The AAUP anthology alleges that the State is paying more for rural employees than (by inference) urban employees. AAUP further alleges that the Department has cut rural employee expenses and increased their benefits by reducing deductibles and out of pocket expenses (AAUP Section 8).*

The AAUP allegation compares the most expensive rural plan to the least expensive urban plan. Subsequently, in this scenario, the State does indeed pay more for rural employee health care. Specifically, as AAUP alleges, \$526 per year for single coverage and \$1,195 per year for family coverage. (It is important to note that the AAUP allegation does not discuss whether the cost differentials were based on a per month or per year basis. For the record, the cost differential cited by AAUP is based on an annual basis.)

However, while the Department acknowledges that the AAUP scenario cited above is correct, the opposite is also true. That is, if the most expensive urban plan is compared to the least expensive rural plan (the inverse of the AAUP scenario), the State is paying more for urban employees. More specifically, the differential in this scenario is equal to \$869.52 per year for single coverage and \$2,304.96 per year for family coverage.

It has been demonstrated that there are differences in the cost of health care delivery between geographical areas. The State has historically paid more for rural employee health care than urban employees, due to demographics, lack of competition, and lack of the availability of health services in rural Arizona. However, in the past, the difference was camouflaged due to the blending of rates regardless of geographical area.

16. Allegation: *The AAUP anthology alleges that rural employees have the choice between an indemnity plan and a health maintenance organization which employees in Maricopa and Pima Counties do not enjoy (AAUP Section 8).*

The Department fully acknowledges that rural employees have the opportunity to select either an HMO or indemnity plan. Conversely, urban employees have the opportunity to select from three forms of managed care which consists of the traditional staff model, individual physicians association (IPA), Group HMO model, and a point of service model.

A comparison of the point of service (Interflex) and the indemnity (Blue Cross/Blue Shield) plans, illustrates that both plans have rules and limitations.

Under the Interflex plan, in order to receive the maximum benefits, a patient must go to their primary care physician (PCP). After the consultation with the PCP, the patient has the option of going to an in-network specialist with a referral or an out-of-network specialist without a referral. If an in-network specialist is selected, the patient is only responsible for traditional HMO fees. Conversely, if an out-of-network specialist is selected, the patient is responsible for deductibles and co-insurance.

The Interflex plan has a third option available. A patient may select to avoid the PCP and go straight to an out-of-network physician. In this scenario, the benefits are greatly reduced from the two scenarios listed above and may contain services which are not covered or have limitations.

Under the Blue Cross/Blue Shield plan, in order to receive the maximum benefits, a patient must go to a participating provider. Like the Interflex plan, an individual may select a non-participating provider. However, the patient selecting a non-participating provider is responsible for 20% of the "prevailing charges" plus any amount above the Blue Cross/Blue Shield determined "prevailing charge."

While the above comparison recognizes the fundamental and philosophical differences between the point of service and indemnity concepts, the comparison attempts to illustrate that in both scenarios, rules and limitations exist and must be followed to achieve the maximum level of benefits.

It is important to note, however, that the rural health care contract was designed as an indemnity plan due to the limited availability of health care opportunities in rural counties. As health maintenance organization networks began to be established, rural employees received the ability to select from either an HMO or indemnity plan.

17. Allegation: *The AAUP anthology alleges that the Department believes it will cost the State \$20 million to equalize its contribution strategy in all counties; and that the Department will not recommend such action as it would show that the Department's 1992 re-bid process was not successful (AAUP Section 8).*

The Department has not considered, contemplated, or calculated such an equalization contribution strategy.

18. Allegation: *The AAUP anthology alleges that the Department has not contained costs (AAUP Section 8).*

From the State's perspective, as discussed above, the total expenditures made on behalf of employee health insurance was reduced by \$341,696 in FY 1992-93, as compared to FY 1991-92.

In terms of future costs, again, as discussed above, according to the appropriated amounts for the FY 1992-93 and FY 1993-94, as exhibited in the respective Appropriation Reports, health insurance costs for FY 1993-94 were reduced by \$9,423,800, as compared to FY 1992-93.

With respect to employee premiums, the Department continues to provide the base plan at \$5.00 for single coverage and \$75.00 for family coverage. The cost of the base plan to employees has not changed from FY 1992-93 to FY 1993-94.

19. Allegation: *The AAUP anthology alleges that the total cost of the CIGNA best and final offer would have been lower than the package finally accepted. AAUP further alleges that the Department rejected the CIGNA proposal because it required an exclusive contract (AAUP Section 8).*

As previously discussed, CIGNA provided three renewal rate options with different assumptions. Each renewal rate option contained a principal assumption: a) the 16.4% option assumed no change in participation; b) the 13.8% option assumed elimination of the retiree plan; and c) the 12.9% option assumed the elimination of the retiree and indemnity plans.

While all three renewal rate options had unique assumptions, each alternative was built by identical reductions in medical benefits and increasing employee out-of-pocket expenses.

The Department stands firmly behind its decision to resist, when practical, offering exclusive contracts for employee health insurance. The managed competition embraced by the Department is providing stability in health insurance premiums for the State and employees alike. Again, as discussed above, according to the appropriated amounts for the FY 1992-93 and FY 1993-94, as exhibited in the respective Appropriation Reports, health insurance costs for FY 1993-94 were reduced by \$9,423,800, as compared to FY 1992-93(DOA Attachments J and K).

In addition, under the CIGNA exclusive contract, the State would not have been allowed to offer Intergroup. The Department had concerns regarding the ability of whether one insurer could meet the demands of 36,000 employees and their families in Maricopa and Pima Counties. Ironically, during the inaugural year of the program (FY 1992-93), Intergroup rates for employees were lower than rates offered by CIGNA. As the program begins its second year (FY 1993-94), the competition for employees has produced a reduction in CIGNA rates. Subsequently, employees still maintain the opportunity to receive the base plan for the same rates they incurred in FY 1992-93.

20. Allegation: *The AAUP anthology alleges that the FY 1993-94 Intergroup HMO premiums are markedly higher than CIGNA HMO premiums for all categories and locations (AAUP Section 8).*

A review of the published employee premiums clearly shows that premiums for Intergroup HMO are higher than CIGNA HMO for all categories and locations.

<u>Maricopa County</u>	<u>Single</u>	<u>Family</u>
CIGNA Staff HMO	\$5.00	\$75.00
Intergroup HMO	\$9.54	\$77.96
 <u>Pima County</u>		
CIGNA HMO	\$5.00	\$75.00
Intergroup HMO	\$14.60	\$86.54

However, the AAUP anthology fails to mention the differences in medical benefits between CIGNA HMO and Intergroup HMO. More specifically, CIGNA HMO has \$5.00 co-payments for preventative care, doctor office visits, outpatient hospital, outpatient rehabilitation, and use of an urgent care facility. Conversely, the Intergroup HMO does not charge any co-payment for the aforementioned medical benefits (DOA Attachment M).

21. Allegation: *The AAUP anthology alleges that the Department's position not to blend retirees with active employees is based on the constitutional question of providing an illegal gift. The allegation is made that if such is the case, then why are NAU retirees not separated from NAU active employees (AAUP Section 9).*

The Department requested guidance from the Arizona Attorney General regarding the appropriateness of procuring group health insurance for active and retired public employees. Upon the advice of legal counsel, the 1992 re-bid process un-blended active and retired public employees (DOA Attachment N).

The Department's discussion on the blending of active and retired public employees did not focus on employees participating in the Northern Arizona University health plan. The Northern Arizona University health plan is a different plan with different statutory authority (A.R.S. § 38-651). The Northern Arizona University health plan, established in 1974

The Honorable Brenda Burns
October 15, 1993
Page Thirteen

(Laws 1974, Chapter 56 § 1) is experience rated and pays dividends on unused claim reserves. Historically, the Arizona Legislature has afforded the Northern Arizona University health plan a different status. Legal counsel did not address the Northern Arizona University health plan in its comments to the Personnel Services Division.

22. Allegation: *The AAUP anthology alleges SB 1213 (First Regular Session, 1993) was introduced to increase dental premiums. AAUP further alleges that the legislative hearing on SB 1213 was canceled by the Department to avoid questions by legislators (AAUP Section 10).*

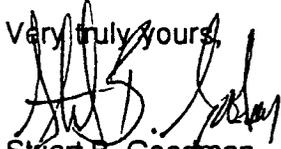
SB 1213 was introduced by Senator Carol Springer at the request of the Department. SB 1213 was intended to be the "annual rate bill" that the Department typically introduces in case it is determined that the State's contribution to employee health insurance is to be increased.

SB 1213, as introduced, amended A.R.S. 38-651, to extend a surviving spouse's health insurance benefits from six months to thirty-six months and to set the amount to be paid by the surviving spouse at 102% of the group rate. This change was consistent with federal law. In addition, the bill provided, as discussed above, blank spaces for the amount of public funds to be extended on employee health insurance if a change was necessary (DOA Attachment O).

The Department determined that no increase in the State's contribution was needed. Therefore, no bill was needed and, subsequently, the Department requested that the bill be held.

Representative Burns, this concludes the Department's response to the AAUP allegations of September 22, 1993. I trust this response has answered many questions as well as created new ones. As always, if you have any questions or concerns, please do not hesitate to contact me.

Very truly yours,


Stuart B. Goodman
Legislative Liaison

Attachments

cc: Ms. Lisa Hardy, Legislative Research Analyst
Ms. Cindy Kappler, Policy Advisor

Evaluation Report



STATE OF ARIZONA
DEPARTMENT OF ADMINISTRATION
STATE PURCHASING OFFICE

EVALUATION CRITERIA
FOR
RFP NO. A2-0093

	MAXIMUM POINTS	BIDDERS						
		HUMANA	PARTNERS	INTERGROUP	CIGNA	F H P	BLUE CROSS/BLUE SHIELD	
1. EXPERTISE/EXPERIENCE/RELIABILITY	45	35	35	45	45	40	45	
2. COST	35	35	34	33	33	32	26	
3. METHOD OF APPROACH	20	10	10	20	20	18	18	
4.								
5.								
6.								
7.								
8.								
TOTAL POINTS	100	80	79	98	98	90	89	

I hereby attest that the points awarded to each bidder listed above were scored in accordance with the established evaluation criteria and represent my best judgment of the bidders' proposals. As indicated by the highest total score, my selection of the proposal which offers the most advantageous service to the State of Arizona is:

CIGNA & INTERGROUP

[Signature]

Signature

6/5/92

Date

DPS

Division

LT

Title

223-2038

Telephone

DPS-DIST 11

Department

Evaluation Report



STATE OF ARIZONA
DEPARTMENT OF ADMINISTRATION
STATE PURCHASING OFFICE

EVALUATION CRITERIA
FOR
RFP NO. A2-0093

	MAXIMUM POINTS	BIDDERS								
		HUMANA	PARTNERS	INTERGROUP	CIGNA	F H P	BLUE CROSS/BLUE SHIELD			
1. EXPERTISE/EXPERIENCE/RELIABILITY	45	20	10	42	43	35	44			
2. COST	35	35	34	33	33	32	26			
3. METHOD OF APPROACH	20	5	5	17	15	10	18			
4.										
5.										
6.										
7.										
8.										
TOTAL POINTS	100	60	49	92	91	77	88			

I hereby attest that the points awarded to each bidder listed above were scored in accordance with the established evaluation criteria and represent my best judgment of the bidders' proposals. As indicated by the highest total score, my selection of the proposal which offers the most advantageous service to the State of Arizona is:

Intergroup HMO, Intergroup P.O.S., CIGNA HMO, Humana & IPA

Scott Luchessa _____ 6/5/92 _____ *Personnel*
Signature Date Division

Benefits Manager _____ 542-4788 _____ *DOA*
Title Telephone Department

Evaluation Report



STATE OF ARIZONA
DEPARTMENT OF ADMINISTRATION
STATE PURCHASING OFFICE

EVALUATION CRITERIA
FOR
RFP NO. A2-0093

	MAXIMUM POINTS	BIDDERS						
		HUMANA	PARTNERS	INTERGROUP	CIGNA	F I I P	BLUE CROSS/BLUE SHIELD	
1. EXPERTISE/EXPERIENCE/RELIABILITY	45	30	35	45	45	40	45	
2. COST	35	35	34	33	33	32	26	
3. METHOD OF APPROACH	20	16	15	19	19	18	15	
4.								
5.								
6.								
7.								
8.								
TOTAL POINTS	100	81	84	97	97	90	86	

I hereby attest that the points awarded to each bidder listed above were scored in accordance with the established evaluation criteria and represent my best judgment of the bidders' proposals. As indicated by the highest total score, my selection of the proposal which offers the most advantageous service to the State of Arizona is:

CIGNA Stand-alone HMO; Intergroup HMO w/ P.O.S.

Sandra Lewis
Signature

6-5-92
Date

Division

Executive Asst.
Title

255-4034
Telephone

ADOI
Department

Evaluation Report



STATE OF ARIZONA
DEPARTMENT OF ADMINISTRATION
STATE PURCHASING OFFICE

EVALUATION CRITERIA
FOR
RFP NO. A2-0093

	MAXIMUM POINTS	BIDDERS						
		HUMANA	PARTNERS	INTERGROUP	CIGNA	F H P	BLUE CROSS/BLUE SHIELD	
1. EXPERTISE/EXPERIENCE/RELIABILITY	45	27	27	41	36	32	38	
2. COST	35	35	34	33	33	32	26	
3. METHOD OF APPROACH	20	12	12	20	14	14	16	
4.								
5.								
6.								
7.								
8.								
TOTAL POINTS	100	74	73	94	83	78	80	

I hereby attest that the points awarded to each bidder listed above were scored in accordance with the established evaluation criteria and represent my best judgment of the bidders' proposals. As indicated by the highest total score, my selection of the proposal which offers the most advantageous service to the State of Arizona is:

INTERGROUP HMO and POS, CIGNA STAFF and IPA HMO

Signature

Date

Division

Title

Telephone

Department

Evaluation Report



STATE OF ARIZONA
DEPARTMENT OF ADMINISTRATION
STATE PURCHASING OFFICE

EVALUATION CRITERIA
FOR
RFP NO. A2-0093

	MAXIMUM POINTS	BIDDERS				
		PARTNERS	INTERGROUP	CIGNA	F H P	BLUE CROSS/BLUE SHIELD
1 EXPERTISE/EXPERIENCE/RELIABILITY	45	38	49	49	35	40
2 COST	35	35	34	33	30	29
3 METHOD OF APPROACH	20	18	20	20	15	18
4.						
5.						
6.						
7.						
8.						
TOTAL POINTS	100	91	99	98	80	87

I hereby attest that the points awarded to each bidder listed above were scored in accordance with the established evaluation criteria and represent my best judgment of the bidders' proposals. As indicated by the highest total score, my selection of the proposal which offers the most advantageous service to the State of Arizona is:

Cigna, Intergroup

D. Rubin Signature 6/5/92 Date DPS Division

LT Title 223-2038 Telephone DPS Dist 11 Department

Evaluation Report



STATE OF ARIZONA
DEPARTMENT OF ADMINISTRATION
STATE PURCHASING OFFICE

EVALUATION CRITERIA
FOR
RFP NO. A2-0093

	MAXIMUM POINTS	BIDDERS					
		PARTNERS	INTERGROUP	CIGNA	F H P	BLUE C ROSS/BLUE SHIELD	
1 EXPERTISE/EXPERIENCE/RELIABILITY	45	42	45	45	38	42	
2 COST	35	35	34	33	30	29	
3 METHOD OF APPROACH	20	16	18	19	16	16	
4.							
5.							
6.							
7.							
8.							
TOTAL POINTS	100	93	97	97	84	87	

I hereby attest that the points awarded to each bidder listed above were scored in accordance with the established evaluation criteria and represent my best judgment of the bidders' proposals. As indicated by the highest total score, my selection of the proposal which offers the most advantageous service to the State of Arizona is:

CIGNA Stand-alone HMO; Intergroup HMO w/ POS

Sanara Lewis
Signature

6-5-92
Date

Division

Executive Asst.
Title

255-4034
Telephone

ADOI
Department

Evaluation Report



STATE OF ARIZONA
DEPARTMENT OF ADMINISTRATION
STATE PURCHASING OFFICE

EVALUATION CRITERIA
FOR
RFP NO. A2-0093

	MAXIMUM POINTS	BIDDERS									
		PARTNERS	INTERGROUP	CIGNA	FHP	BLUE CROSS/BLUE SHIELD					
1 EXPERTISE/EXPERIENCE/RELIABILITY	45	20	40	40	20	40					
2 COST	35	35	34	33	30	29					
3 METHOD OF APPROACH	20	13	16	15	12	18					
4.											
5.											
6.											
7.											
8.											
TOTAL POINTS	100	68	90	88	62	87					

I hereby attest that the points awarded to each bidder listed above were scored in accordance with the established evaluation criteria and represent my best judgment of the bidders' proposals. As indicated by the highest total score, my selection of the proposal which offers the most advantageous service to the State of Arizona is:

Based on Best and Final offers Intergroup's HMO V2A and POS F2RD and CIGNA plan 3

Gary J Peterson
Signature

6/5/92
Date

Division _____

Consulting Actuary
Title

(602) 279-3600
Telephone

The Wyatt Company
Department

Evaluation Report



STATE OF ARIZONA
DEPARTMENT OF ADMINISTRATION
STATE PURCHASING OFFICE

EVALUATION CRITERIA
FOR
RFP NO. A2-0093

	MAXIMUM POINTS	BIDDERS					
		PARTNERS	INTERGROUP	CIGNA	F H P	BLUE CROSS/BLUE SHIELD	
1 EXPERTISE/EXPERIENCE/RELIABILITY	45	27	41	36	32	32	
2 COST	35	35	34	33	30	29	
3 METHOD OF APPROACH	20	12	20	14	16	16	
4.							
5.							
6.							
7.							
8.							
TOTAL POINTS	100	74	95	83	78	77	

I hereby attest that the points awarded to each bidder listed above were scored in accordance with the established evaluation criteria and represent my best judgment of the bidders' proposals. As indicated by the highest total score, my selection of the proposal which offers the most advantageous service to the State of Arizona is:

InterGroup HMO and POS, CIGNA STOPP and IPA HMO

[Signature]

Signature

Date

Division

Title

Telephone

Department

OFFEROR: Intergroup HealthCare Corporation

RFP NO: A2-0093

REFERENCE VERIFICATION

REFERENCE

- COMPANY: Honeywell
- CONTACT PERSON: Randy Jacobs, Benefits Manager
- PHONE NUMBER: (602) 436-2344

QUESTIONS

- * How many employees are served within your company? Is the service on a local, regional, statewide, or nationwide basis?
 - 3,000 employees - Phx area
- * How long (lead/time) does it take for an individual to see a doctor? Day, several days, week, etc.
 - depends on situation - usually a couple of days to a week - urgent care available immediately
 - take into account critical nature
- * Does the contractor respond to issues in a timely fashion? Are they prompt in dealing with individual complaints?
 - pretty good in this area
- * How would you rate the "Quality of Care/Level of Care" received from the contractor, as relates to the individual employee(s) assessment?
 - competent providers
 - learning to be a better Fee for Service provider
 - established as an HMO
- * Do you consider the contractor's rates that are currently being charged to your company reasonable? What type of increase have you seen from the contractor during the past three (3) years?
 - yes, rates are reasonable
 - just started 2nd year, not much of an increase this year
- * Have you experienced an unusual turnover rate among Doctors and Hospitals that are subcontractors to your contractor during the past year?
 - doctors in Thomas Davis system are owners
 - happened to be weak in the geographic area they are located - they are getting better

- * Have prompt payments been made to subcontractors by contractor? What type of feedback have you received from the subs in this area?
 - presume they have, not an issue
- * Have you surveyed your employees as to their choice of provider(s) and plan(s) that are currently available in the industry?
 - sort-of - during open enrollment there was an increase in the number of employees enrolling
- * Have you found instances where invoices or billings reflected charges for services that were not actually performed?
 - minor situations - resolved easily
- * Fees for Services, usual and customary, geographic area? Individual pays difference. What percentage is encountered?
 - typically not a problem - people are concentrated
- * What type of program (i.e., HMO, Indemnity, IPA, Staff Model, PPO, etc.) is the contractor providing to your company?
 - developed their own Fee for Service plan (self-insured)
 - Intergroup helped them develop it
- * Overall satisfaction with their performance/professional expertise.
 - pretty good, with exclusion of using as a TPA
 - weak network in north end or maybe any other area where they would have to contract with other doctors
- * Repeat business/recommendations to others
 - would recommend as HMO; that's where their strength is
 - in future will be able to recommend as Fee for Service/TPA - there is now area for improvement
- * Additional comments on Company

STATE OF ARIZONA
 1992/93 PROPOSED MEDICAL BENEFITS
 IN-NETWORK/HMO
 FLEXCARE IN-NETWORK & INTERGROUP HMO

	CURRENT	PROPOSED
Inpatient Hospital Services, including physicians, surgeons & facility charges	\$0 copay	\$100 copay per admission
Outpatient Surgery	FlexCare: \$5 copay Intergroup: \$0 copay	\$50 copay
Preventive Care	FlexCare: \$5 copay Intergroup: \$0 copay	\$10 copay
Office Visits, Primary Care Physician	FlexCare: \$5 copay Intergroup: \$0 copay	\$10 copay
Urgent Care (Non-ER)	FlexCare: \$10 copay Intergroup: \$0 copay	\$10 copay
Specialist	FlexCare: \$5 copay Intergroup: \$0 copay	\$10 copay
Inpatient Mental Health	\$0 copay, 30 days ⁽¹⁾	Same as current program
Inpatient Substance Abuse	\$0 copay, Detox only ⁽²⁾	Same as current program
Outpatient Mental Health	FlexCare: \$20 copay, 20 visits Intergroup: \$15 copay, 20 visits ⁽¹⁾	Same as current program
Outpatient Substance Abuse	FlexCare: \$5 copay Intergroup: \$0 copay ⁽²⁾	Same as current program
Prescription	FlexCare: \$3 copay Intergroup: \$5 copay	\$10 copay
Emergency Room (Waived if admitted)	\$25 copay	\$50 copay

⁽¹⁾ Intergroup mental health coverage is limited to short term crisis intervention only.

⁽²⁾ Intergroup substance abuse coverage is limited to 2 detoxifications lifetime.

INTERGROUP
HEALTHCARE
CORPORATION

June 27, 1993

First of all, we know that what we perceive as good news about Intergroup's financial performance may raise questions about individual operating areas of the company. However, we believe that Intergroup's strong financial performance benefits all of our customers. We see it as evidence that the company is working smart, managing its resources well, being a good steward of the resources entrusted to it, and planning to be able to serve customers for many years to come.

It's true that most people are paying more for health care than in the past. Because of budget constraints and other pressures, many employers, including the State, have found it necessary to ask employees to share in the cost of health care coverage. However, without a health care company like Intergroup working to help manage health care costs, the price each of us pays for coverage would be significantly more. For example, costs for indemnity plans (traditional fee-for-service health care coverage) increased an average of 25% last year. That compares to an increase of 7% from HMO's. Managed health care companies are working hard to help control costs.

According to the article you referenced, Intergroup's 1992 financial results were due in part to the company negotiating favorable rates with pharmaceutical companies. Through smart negotiations with suppliers, hospitals and physicians, Intergroup manages health care costs which benefits employers and members, you and I.

Intergroup is a financially cautious and conservative company. We conduct our business to build long-term relationships so we can continue to serve our customers for years to come. That's not true of all HMOs. For example, many HMOs operating in Arizona in the late 1980s suffered financial losses resulting from poor financial management and planning. Intergroup was one of the few that maintained its financial strength. That stability and performance is reassuring for employers who contract with Intergroup and for members of our health plans.

2800 NORTH
44TH STREET
SUITE 500
PHOENIX, ARIZONA
85008-1502

(602) 224-5528
1-800-308-3909
FAX: (602) 381-7878

In addition, Intergroup invests resources in people and technology to meet its customers' managed care needs now and the future. Profits are invested back into the company -- Intergroup does not pay a dividend to its shareholders. Instead, profits are used to assist the company, and the medical groups Intergroup contracts with, to expand their services and care for more patients.

Like a cautious company, we plan for the possibility of difficult times. For example, if there was a tremendous increase in the need for health care services (a severe flu season, for example) our financial reserves would enable us to meet that need.

I hope this addresses your questions. Please call me if you would like to discuss this further. If you have concerns specifically about care of services you have received from Intergroup, I encourage you to call. I would be happy to work with you to resolve your concerns.

Again, thank you for taking the time to write and giving us an opportunity to address your questions.

Sincerely,


Mark D. Fabiano
Member Services Manager



FIFE SYMINGTON
GOVERNOR

J. ELLIOTT HIBBS
DIRECTOR

ARIZONA DEPARTMENT OF ADMINISTRATION
STATE PROCUREMENT OFFICE

1688 West Adams, Room 220, Phoenix, Arizona 85007
(602) 542-5511

NOTICE OF INTENT TO ISSUE A REQUEST FOR PROPOSAL

REQUEST FOR PROPOSAL NO.: A2-0093

SERVICE: State of Arizona Employee Health Benefits Program

SOLICITATION DUE DATE & TIME: May 1, 1992, 3:00 P.M. MST

Dear Vendor:

*MAILED 3-31-92
Jm
PD
M*

You are registered with the State Procurement Office for the service listed above. This letter is your official notification that the State intends to issue a Request for Proposal for the acquisition of the subject service.

THIS IS THE ONLY NOTICE YOU WILL RECEIVE

If you wish to submit an offer, you must request a Request for Proposal document. A copy of the document will be provided only to those vendors explicitly requesting one. You may fax or telephone your request to the State Procurement Office at:

FAX No. (602) 542-5508

Telephone (602) 542-5526 Ext. 75

If you choose to fax your request to this office, please utilize this notice. Please print the requested information on the lines below, sign and return to the fax number stated.

If you choose to telephone your request to this office, please be prepared to identify the subject Request for Proposal document by name and number, as well as provide your company's name and mailing address.

Please take note of the official due date and time, for it is the responsibility of the potential offeror to request a Request for Proposal in sufficient time to prepare and submit a proposal in accordance with the official due date and time.

COMPANY NAME: _____

CONTACT PERSON: _____

STREET ADDRESS: _____

CITY, STATE, ZIP CODE: _____

TELEPHONE NO.: _____

VENDOR NO.: _____

INTENT
LETTER

A2-0093

STATE OF ARIZONA EMPLOYEE HEALTH BENEFITS PROGRAM

✓ Associated Health Plans
Bruce Buchanan
2412 E. Campbell, STE. 200
Phoenix, AZ 85016

ADDRESS CHANGE

✓ #14874

✓ #24748

✓ #22911

✓ #22917

✓ #24771

✓ Arizona Physicians Inc.
4041 N. Central Avenue
Phoenix, AZ 85012

✓ Avesis, Inc.
Thomas Cifrodella
4201 N. 24th St.
Phoenix, Az 85016

✓ AFLAC
Sylvia McCallister
1932 Wynnton Road
Columbus, GA 3199

✓ Colonial Life & Accident Insurance Comp.
Monica Loving
1200 Colonial Life Bouelevard
Columbia, SC 29202

✓ Dental Benefit Providers
Theresa Dowdall
7200 Wisconsin Ave., Ste. 800
Bethesda, MD 20814

✓ # 18461
US Dental Plan of Arizona
Doris Amdur
1702 E. Highland Ave., #110
Phoenix, AZ 85016-4665

✓ Safeguard Health Plans, Inc.
Wayne K. Butts
505 N. Euclid St.
Anaheim, CA 92803-3210

✓ Primatica Financial SVCS
Steve Belcher
209 E. Baseline, Ste. 206
Tempe, AZ 85283

a20093 cont.

Medstat Systems
Shelby Solomon
777 East Eisenhower Parkway
Ann Arbor, Michigan 48108

✓ Benesys
1775 St. James Place, Ste. 200
Houston, Texas 77056

PROGRAM ID: P003BG00
REPORT ID : P003BG00.0
BUYER : 14 ROBERT STEPHENSON

ARIZONA STATE MASTER VENDOR

DATE: 03/06/92
PAGE: 001
BID : XX-XXXX

A2-0093

VENDOR	FEIN	SSN	NAME & ADDRESS
107	86-0452161	000-00-0000	H & M BUILDING COMPANY P.O. BOX 1311 PHOENIX, AZ 85001
10150	86-0467691	000-00-0000	SUN BELT EMPLOYERS ASSN INC SUITE 260 3200 NORTH HAYDEN ROAD SCOTTSDALE, AZ 85251
10202	86-0105953	000-00-0000	SEDGWICK JAMES OF ARIZONA SUITE #200 1414 W BROADWAY RD TEMPE AZ 85282
10358	86-0129041	000-00-0000	STUCKEY INSURANCE & ASSOCIATED P.O. BOX 7020 531 E. BETHANY HOME RD PHOENIX, AZ 85011-7020
10504	86-0188405	000-00-0000	HARRIS/SHCOLNIK & ASSOC INC 4808 N. CENTRAL AVE PHOENIX, AZ 85012
10563	36-3238867	000-00-0000	ROLLINS BURDICK HUNTER OF AZ SUITE 1100 100 W. CLARENDON PHOENIX, AZ 85013
10835	86-0267532	000-00-0000	APEX DATA/BABOCK INSURANCE 6464 E. GRANT ROAD TUCSON, AZ 85715
11831	86-6050329	000-00-0000	M & D AGENCIES INC 7804 N. 27TH AVE PHOENIX, AZ 85051
11942	00-0000000	526-02-8259	DABBS, STEVE ASSOC. P.O. BOX 25770 TEMPE, AZ 85282
12207	53-0181291	000-00-0000	WYATT COMPANY, THE SUITE 800 100 W CLARENDON PHOENIX, AZ 85028
12494	95-2143064	000-00-0000	F H P 1604 S. EDWARD TEMPE, AZ 85281
12579	43-0126719	000-00-0000	RISK ANALYSIS & MGMT CORP SUITE 100 700 ST. LOUIS UNION STA. ST. LOUIS, MO 63103

INTENT
LETTER

F4/3

PROGRAM ID: P003BG00
REPORT ID : P003BG00.01
BUYER : 14 ROBERT STEPHENSON

ARIZONA STATE MASTER VENDOR

DATE: 03/06/92
PAGE: 002
BID : XX-XXXX

VENDOR	FEIN	SSN	NAME & ADDRESS
0653	86-0506149	000-00-0000	LOCKWOOD, ANN INSURANCE AGENCY PO BOX 26660 PHOENIX, AZ 85068
12726	00-0000000	431-48-5310	GODWIN, MILTON C INSURANCE DBA: MUTUAL OF NY INS CO 2013 11TH ST LAKE CHARLES LA 70601
12929	00-0000000	527-25-8316	BRIMHALL, M KIRK-FINANCIAL P.O. BOX 750 SNOWFLAKE, AZ 85937
13117	86-0037567	000-00-0000	TUCSON MEDICAL CENTER MARKET DEVELOPMENT & SVC P O BOX 42195 TUCSON AZ 85733
13164	86-0425844	000-00-0000	HEALTH DIMENSIONS OF ARIZONA SUITE 180 9201 N. 25TH AVENUE PHOENIX, AZ 85021
13199	86-0529198	000-00-0000	PARTNERS HEALTH PLAN/ARIZONA SUITE 300 5210 E WILLIAMS CIRCLE TUCSON AZ 85711
13228	86-0096778	000-00-0000	SAMARITAN HEALTH SERVICES MATERIALS MANAGEMENT P O BOX 25489 PHOENIX AZ 85002-5489
13472	86-0533978	000-00-0000	A 1 MEDICAL EQUIPMENT CO 151 S MORRIS MESA, AZ 85202
13584	91-0789292	000-00-0000	GREAT REPUBLIC LIFE INSURANCE 226 2ND AVENUE WEST SEATTLE, WA 98119
13720	33-0056039	549-92-4564	LOGANS MARKETING SUITE 324 636 BROADWAY SAN DIEGO, CA 92101
13767	86-0428820	000-00-0000	ASSOCIATED HEALTH PLANS 4625 E FT LOWELL RD P.O. BOX 32590 TUCSON, AZ 85751
14107	86-0490754	000-00-0000	AMOS LOVITT DOWNEY & TOUCHE P.O. BOX 32702 7202 E. ROSEWOOD TUCSON, AZ 85751-2705

F 4/6

T 4/1

PROGRAM ID: P0038G00
REPORT ID : P0038G00.0
BUYER : 14 ROBERT STEPHENSON

ONA STATE MASTER VENDOR BT

DATE: 03/06/92
PAGE: 003
BIB : XX-XXXX

VENDOR	FEIN	SSN	NAME & ADDRESS
166	58-0663085	000-00-0000	AMERICAN LIFE ASSURANCE CO 1932 WYNNTON RD COLUMBUS, GA 31999
14350	22-1211670	000-00-0000	PRUDENTIAL INSURANCE COMPANY SUITE 3090 2049 CENTURY PARK EAST LOS ANGELES, CA 90067
14373	13-2545662	000-00-0000	FRONTIER PLANNING CORP OF AMER SUITE 906 211 EAST 43RD STREET NEW YORK, NY 10017
14377	00-0000000	248-74-3570	COLONIAL LIFE & ACCIDENT - PHN BLOG E 7220 N 16TH STREET PHOENIX, AZ 85020
14395	13-5651567	000-00-0000	BARCO ASSOCIATES INC SUITE 1000 2 PARK AVENUE NEW YORK, NY 10016
14456	86-0538651	000-00-0000	NATIONAL DENTAL HEALTH INSURAN SUITE 165 1600 WEST BRADWAY TEMPE, AZ 85282
14490	57-0144607	031-26-5020	COLONIAL LIFE & ACCIDENT - SC P.O. BOX 1365 COLUMBIA, SC 29202
14667	13-3365372	000-00-0000	EQUICOR-EQUITABLE HCA CORP SUITE 380 5353 N. 16TH ST.T PHOENIX, AZ 85016
14874	86-0328922	000-00-0000	EMPLOYERS DENTAL SERVICES INC <i>4747 W 7th St Ste 410</i> 7202 EAST ROSEWOOD TUESON, AZ 85710
14979	86-0565955	000-00-0000	SOUTHWEST RISK SERVICES INC STE 223 11801 N TATUM BLVD PHOENIX AZ 85028
15110	44-0308260	000-00-0000	KANSAS CITY LIFE INSURANCE CO SUITE 280 6373 E. TANQUE VERDE TUCSON, AZ 85715
15606	86-0440025	000-00-0000	SAFEGUARD HEALTH PLANS INC SUITE 301 2207 EAST CAMELBACK ROAD PHOENIX, ARIZONA 85016

T4-2

T4/3

PROGRAM ID: P0038G00
REPORT ID : P0038G00.0
BUYER : 14 ROBERT STEPHENSON

ARIZONA STATE MASTER VENDOR

DATE: 03/06/92
PAGE: 004
BID : XX-XXXX

VENDOR	FEIN	SSN	NAME & ADDRESS
820	58-0663085	000-00-0000	AFLAC SUITE 1 1350 EAST MCKELLIPS MESA ARIZONA 85203
15835	86-0435982	000-00-0000	MINICO INC, GENERAL INS AGENCY SUITE 200 2531 W DUNLAP AVE PHOENIX, AZ 85021
16127	95-2043126	000-00-0000	COMPUTER SCIENCES CORPORATION 15245 SHADY GROVE ROAD ROCKVILLE MD 20850
16135	86-0498245	000-00-0000	SUN LAND ADJUSTING COMPANY P O BOX 30452 TUCSON, AZ 85751
16149	13-2747054	000-00-0000	GAB BUSINESS SERVICES INC 9 CAMPUS DRIVE PARSIPPANY NJ 07054
16702	39-1258067	000-00-0000	NATIONAL INS SVCS OF WI INC 250 SOUTH EXECUTIVE DRIVE BROOKFIELD WI 53005
17135	41-0451140	000-00-0000	NORTHWESTERN NATIONAL LIFE SUITE 330 4742 N 24TH ST PHOENIX, AZ 85016
17311	86-0490754	000-00-0000	ALD & T - MT STATES ADJ AGENCY P O BOX 32702 TUCSON AZ 85751-2702
17595	06-0843808	000-00-0000	AETNA LIFE & CASUALTY SUITE 580 100 W. CLARENDON AVE. PHOENIX, AZ 85013
17629	86-0390844	000-00-0000	NORTH AMERICAN PHARMACEUTICAL SUITE 380 4201 N. 24TH STREET PHOENIX, AZ 85016
17637	86-0507074	000-00-0000	METLIFE HEALTHCARE NETWORK AZ SUITE 300 1314 NORTH 3RD STREET PHOENIX, AZ 85004
17799	74-1915841	000-00-0000	AMERICAN FOUNDERS LIFE INS CO 2720 EAST CAMELBACK RD P.O. BOX 52121 PHOENIX, AZ 85072-2121

F 4/7

PROGRAM ID: P003BG00
REPORT ID : P003BG00.C
BUYER : 14 ROBERT STEPHENSON

HUMANA STATE MASTER VENDO

BT

DATE: 03/06/92
PAGE: 005
BID : XX-XXXX

VENDOR	FEIN	SSN	NAME & ADDRESS
18104	86-0544353	000-00-0000	PRINCIPAL HEALTH CARE OF AZ SUITE 180 9201 NORTH 25TH AVENUE PHOENIX, AZ 85021
18106	62-0331200	000-00-0000	PROVIDENT LIFE & ACCIDENT SUITE 440 1 EAST CAMELBACK ROAD PHOENIX, AZ 85012
18201	86-0466046	000-00-0000	PATIENTS' CHOICE INC SUITE #100 7776 POINTE PARKWAY WEST PHOENIX, AZ 85044
18473	86-0572798	000-00-0000	HEALTH HORIZONS INC SUITE A-114 5055 EAST BROADWAY BLVD TUCSON, AZ 85732-3206
18517	58-0663085	000-00-0000	AMERICAN FAMILY LIFE ASSUR(GA) 1932 WYNNTON ROAD COLUMBUS, GA 31999
18561	00-0000000	527-58-8418	ACTION HEALTH CARE INC SUITE C-278 301 E. BETHANY HOME RD. PHOENIX, AZ 85012
18891	76-0196493	000-00-0000	CARONIA CORPORATION SUITE 400 9800 CENTRE PARKWAY HOUSTON, TX 77036
19211	43-0535350	000-00-0000	HUMANA INSURANCE COMPANY SUITE 208 2231 E. CAMELBACK ROAD PHOENIX, AZ 85016
19231	61-1013183	000-00-0000	HUMANA HEALTH PLAN INC SUITE 208 2231 E. CAMELBACK ROAD PHOENIX, AZ 85016
19393	00-0000000	298-32-7933	S L P CORPORATION 4830 E. WATER ST. TUCSON, AZ 85712
19592	86-0353084	000-00-0000	GROUP PLANS INC SUITE 101 729 E. HATCHER PHOENIX, AZ 85020
19702	37-1057804	000-00-0000	MANAGEMENT SERVICES INC SUITE #208 2 E. MAIN STREET DANVILLE, IL 61832

F 4-2

PROGRAM ID: P0038G00
REPORT ID : P0038G00.0
BUYER : 14 ROBERT STEPHENSON

ONA STATE MASTER VEND.

BT

DATE: 03/06/92
PAGE: 006
BID : XX-XXXX

VENDOR	FEIN	SSN	NAME & ADDRESS
20022	86-0586500	000-00-0000	AMERIWEST INSURANCE AGENCY INC SUITE 200 4167 N. SCOTTSDALE RD. SCOTTSDALE, AZ 85251
20264	33-0141815	000-00-0000	ADVANCED RISK MGMT TECH INC SUITE 100 25251 PASEO DE ALICIA LAGUANA HILLS, CA 92653
20512	13-3437435	000-00-0000	HIGGINS, A FOSTER & CO INC SUITE 500 1800 K. STREET, N.W. WASHINGTON, D.C. 20006
20738	00-0000000	062-62-2268	GREENBERG, RANDY L CAMPBELL OFFICE PLAZA 3509 N. CAMPBELL, STE.151 TUCSON, AZ 85719
20959	00-0000000	439-86-3358	BLACKSTOCK, TRUETT & ASSOC 7209 W. CANAL SHREVEPORT, LA 71108
21094	00-0000000	296-12-9395	EXECUTIVE RISK RESEARCH P.O. BOX 10014 PHOENIX, AZ 85064
21162	00-0000000	000-00-0000	RED LION'S LA POSADA RESORT 4949 E LINCOLN DRIVE SCOTTSDALE, AZ 85253
21303	86-0412811	000-00-0000	TEMPORARY TECHS OF AZ INC SUITE #201 3260 N HAYDEN ROAD SCOTTSDALE AZ 85251
21542	00-0000000	344-52-3780	FEBDA INTERNATIONAL ENTERPRISE 2159 W. DEVONSHIRE MESA, AZ 85201
21646	86-0227388	000-00-0000	ANDERSON-REEVE & ASSOCIATES GAINNEY RANCH FINANCIAL CT 7373 E DOUBLETREE RNCH RD SCOTTSDALE, AZ 85258
21718	86-0633978	298-32-7933	5 L P CORPORATION 4830 E WATER STREET TUCSON AZ 85712
21785	00-0000000	358-50-7520	COPPERSTATE CLAIM & ADJUSTMENT P.O. BOX 9035 SCOTTSDALE, AZ 85252-9035

F 2/3

PROGRAM ID: P0038G00
REPORT ID : P0038G00.0
BUYER : 14 ROBERT STEPHENSON

ONA STATE MASTER VENDOR

BT

DATE: 03/06/92
PAGE: 007
BID : XX-XXXX

VENDOR	FEIN	SSN	NAME & ADDRESS
21869	86-0143852	000-00-0000	ALEXANDER & ALEXANDER PLAZA TOWER, EIGHTH FLOOR 2800 N. 44TH STREET PHOENIX, AZ 85008
21902	00-0000000	170-42-6353	CUNNINGHAM & ASSOCIATES SUITE H-1 10255 N. 32ND STREET PHOENIX, AZ 85028
21977	13-3031281	000-00-0000	ADJUSTCO INC P.O. BOX 7089-91109 PASADENA, CA 91105
22006	86-0484580	000-00-0000	DRACHMAN-LEED INSURANCE INC SUITE 104 2096 N. KOLB ROAD TUCSON, AZ 85715
22231	86-0461140	000-00-0000	H M A INC P.O. BOX 276 COTTONWOOD, AZ 86326
22316	00-0000000	294-64-4921	FELDMAN AGENCY (THE) SUITE 300 6263 N. SCOTTSDALE ROAD SCOTTSDALE, AZ 85250
22380	00-0000000	526-70-6756	SOUTHWEST SEMINARS # 100 13416 N. 32ND STREET PHOENIX, AZ 85032
22381	86-0432904	000-00-0000	R P RYAN & ASSOCIATES # 100 13416 N. 32ND STREET PHOENIX, AZ 85032
22386	13-3089709	000-00-0000	H C M CLAIM MANAGEMENT CORP-NJ 225 BRAE BLVD PARK RIDGE NJ 07656
22422	86-0334392	000-00-0000	CIGNA EMPLOYEE BENEFITS DIV SUITE 200 6245 N. 24TH PARKWAY PHOENIX, AZ 85016
22430	95-2829463	000-00-0000	F H P LIFE INSURANCE CO WEST TOWER, 3RD FLOOR 10540 TALBERT AVENUE FOUNTAIN VLY, CA 92708-0840
22455	86-0558332	000-00-0000	TRAVELERS PLAN ADMIN OF AZ SUITE 265 11024 N. 28TH DRIVE PHOENIX, AZ 85029

F 4/2

F 4/2-2

F 4/3

PROGRAM ID: P0038G00
REPORT ID : P0038G00.0
BUYER : 14 ROBERT STEPHENSON

ARIZONA STATE MASTER VENDOR

DATE: 03/06/92
PAGE: 008
BID : XX-XXXX

VENDOR	FEIN	SSN	NAME & ADDRESS
22464	36-3097810	000-00-0000	INTERGROUP OF ARIZONA SUITE 500 2800 N 44TH STREET PHOENIX, AZ 85008-1502
22471	23-2613530	000-00-0000	HAY/HUGGINS COMPANY INC SUITE 1000 1500 K STREET NW WASHINGTON, DC 20005
22504	86-0257206	000-00-0000	EYE SERVICE PLAN/M D OPTICAL 2919 N 2ND STREET PHOENIX, AZ 85012
22898	52-1327971	000-00-0000	DENTAL BENEFIT PROVIDERS INC STE 800 7200 WISCONSIN AVE BETHESDA MD 20814
22911	86-0375764	301-52-9510	DUNN, GARY INSURANCE STE 319 #15 4810 N BLACK CANYON ^{1344 N. 32ND ST} PHOENIX AZ ^{PHOENIX AZ} 85017 85032
22917	59-1657263	000-00-0000	FRINGE BENEFITS MANAGEMENT CO ^{1720 S. Godson St. P.O. Box 1878} 2424 ALLEN RD TALLAHASSEE FL ³²³⁰² 32312 - 1878
22933	00-0000000	273-58-3504	MASS MUTUAL STE 206 2160 N FOURTH ST FLAGSTAFF AZ 86004
23027	93-0242990	000-00-0000	STANDARD INSURANCE COMPANY POINTE CORR CNT STE 217 7600 N 15 ST PHOENIX AZ 85020
23109	74-2341105	000-00-0000	ERISA ADMINISTRATIVE SERVICES BLDG 4 12325 HYMEADOW DR AUSTIN TX 78750
23138	86-0484144	000-00-0000	FINANCIAL INDEPENDENCE CORP-AZ P O BOX 12805 TUCSON AZ 85732-2805
23213	56-0359860	000-00-0000	JEFFERSON PILOT LIFE INS CO DEPARTMENT 4240 P O BOX 20727 GREENSBORO, NC 27420
23238	59-0676017	000-00-0000	AMERICAN BANKERS INS GRP(PHX) HUMANA HEALTH CARE PLANS 2231 E CAMELBACK, STE 208 PHOENIX, AZ 85032

Hertz
550 N. Brand Blvd
Ste 200

Glendale, CA
91203

David H. Zlogar

#23963 didn't
request
change

1720093 address

PROGRAM ID: P0038G00
REPORT ID : P0038G00.0
BUYER : 14 ROBERT STEPHENSON

ONA STATE MASTER VENDOR

DATE: 03/06/92
PAGE: 009
BID : XX-XXXX

VENDOR	FEIN	SSN	NAME & ADDRESS	
23239	59-0676017	000-00-0000	AMERICAN BANKERS LIFE CO (FL) EMPLOYEE BENEFITS MARKING 11222 QUAIL ROOST DR MIAMI, FL 33157	
23306	86-0489277	000-00-0000	C S A MARKETING RESOURCES INC SUITE 101 4415 S WENDLER DR TEMPE, AZ 85282	F 4/2
23612	86-0217845	000-00-0000	WOLF, ANDREW L BUSINESS MEN ASSURANCE CO P O BOX 1030 FLAGSTAFF AZ 86002	
23635	95-2504490	000-00-0000	AMERICAN BENEFIT PLAN ADMINIST STE 8155 1430 E MISSOURI AVE PHOENIX AZ 85014-2452	T 4/3
23963	13-3089709	000-00-0000	H C M CLAIM MANAGEMENT CORP-CA P O BOX 29051 GLENDALE CA 91209-9051	T 4/7 <i>4/2/92 second copy sent to this address and</i>
24013	00-0000000	526-04-1449	DWENS GROUP (THE) 4826 W. HATCHER ROAD GLENDALE, AZ 85302	T 4.2
24062	84-0423453	000-00-0000	WESTERN FARM BUREAU LIFE INS 10253 N SCOTTSDALE RD SCOTTSDALE AZ 85253-1493	F 4-2
24078	01-0278678	000-00-0000	U N U M LIFE OF AMERICA STE 260 2198 E CAMELBACK PHOENIX AZ 85016	
24589	13-3410971	000-00-0000	EMPLOYEE BENEFIT SERVICES INC 26TH FLOOR 555 MADISON AVENUE NEW YORK NY 10022	F 46
24602	86-0443874	000-00-0000	BAKER RISK SERVICES SUITE #401 2345 E THOMAS ROAD PHOENIX AZ 85016	F 4/2
24718	36-3105904	000-00-0000	TOPLIS AND HARDING INC SUITE #730 222 S RIVERSIDE PLAZA CHICAGO IL 60606	
24740	23-0990450	232-80-0484	PROVIDENT MUTUAL SUITE #105 3333 E CAMELSACK ROAD PHOENIX AZ 85018	

PROGRAM ID: P0038G00 ARIZONA STATE MASTER VENDC ST
 REPORT ID : P0038G00.C
 BUYER : 14 ROBERT STEPHENSON

DATE: 03/06/92
 PAGE: 010
 BID : XX-XXXX

VENDOR	FEIN	SSN	NAME & ADDRESS
24748	00-0000000	526-68-8561	MAS GROUP (THE) 690 LAKE MARY ROAD <i>170 W. Dole St. 2A</i> FLAGSTAFF AZ 86001 <i>F 4/7</i>
24771	86-0665106	000-00-0000	U H C INC SUITE #220 <i>#1 in 3</i> Theresa C Williams 1951 W CAMELBACK ROAD 1212 W. Camelback PHOENIX AZ 85015 85013
24828	86-0680507	000-00-0000	S R T CORPORATION SUITE #220 426 N 44TH STREET PHOENIX AZ 85008
24942	74-2017248	000-00-0000	BENESYS SUITE #200 1775 ST JAMES PLACE HOUSTON TX 77056 <i>T 4/13</i>
25534	00-0000000	546-44-8331	BAKER, ROBERT S 15427 NORTH 2ND AVENUE PHOENIX AZ 85023 <i>F 4/6</i>
25850	86-0554195	000-00-0000	BENMAR GROUP INC (THE) SUITE 211 4300 NORTH MILLER ROAD SCOTTSDALE AZ 85251 <i>F 4/2</i>
25931	86-0477690	000-00-0000	JOHN HANCOCK - TUCSON SUITE 180 950 N FINANCIAL CENTER DR TUCSON AZ 85710 <i>F 4/3</i>
25961	86-0344191	000-00-0000	INSURERS ADMINISTRATIVE CORP SUITE 300 10210 NORTH 25TH AVENUE PHOENIX AZ 85021 <i>F 4/2</i>

NO. OF VENDORS: 116

Kevin Buron
Insurance Group of Arizona
2800 N 44th St, Ste 500
Phoenix, AZ 85008

Thom Lewis
Principal Financial Group
2231 E Camelback Rd, Ste 301
Phoenix, AZ 85016

*Sent
Solicitation
Amendment
4-20-92
Red EY*

Mark Besh
IGNA Employee Benefits Div
6245 N 24th Parkway, Ste 200
Phoenix, AZ 85016

Breanda Rangel
National Dental Health
1600 W Broadway, Ste 165
Phoenix, AZ 85282

Tony J Rangel
Standard Insurance Co
7600 N 15th St, #217
Phoenix, AZ 85020

John Pignotti
Provident Life & Accident
11801 N Tatum Blvd, Ste 123
Phoenix, AZ 85028

James M Saplis
Ameritas Group Office
4545 E Sheal Blvd, Ste 208
Phoenix, AZ 85028

Michael Mullins
The Travelers Insurance Co
Metrocenter Bus Park-1
10000 N 31st Ave
Phoenix, AZ 84038

Ed Judd
Delta Dental Plan of AZ
15648 N 35th Ave
Phoenix, AZ 85023

Barry Tobin
Great West Life
2425 E Camelback Rd, Ste 500
Phoenix, AZ 85016

David C Quitno
Blue Cross Blue Shield of AZ
2444 W Las Palmaritas Dr
Phoenix, AZ 85021

AFLAC
Suite 1
1350 East McKellips
Mesa, AZ 85203

A2-0093
AFLAC
Sylvia S. McCallister
1932 Wynnton Road
Columbus, GA 31999

Godwin, Milton C Insurance
DBA Mutual of NY Ins Co
2013 11th St
Lake Charles, LA 70601

A2-0093
Arizona Physicians Inc.
4041 N. Central Avenue
Phoenix, AZ 85012

A2-0093 Doris Amdur
US Dental Plan of Arizona
1702 E. Highland Ave., #110
Phoenix, AZ 85016-4665

Alvin J Bieniek
Northwestern National Life Ins
2390 E Camelback Rd, Ste 320
Phoenix, AZ 85016

Diane H Welle
Metropolitan Life Insurance Co
432 N 44th St, Ste 420
Phoenix, AZ 85008

Jean Petrecca
AETNA Life Insurance Co
7878 N 16th St, Ste 210
Phoenix, AZ 85020

Robert Berra
Pacific Mutual
Bldg 3, Ste 1380
2400 E Arizona Biltmore Circle
Phoenix, AZ 85016

Sharon Coates
The Prudential Insurance Co
3003 N Central Ave, #1400
Phoenix, AZ 85012

Hattie Blanco
FHP, Inc
410 N 44th St
Phoenix, AZ 85008

Tom White
Samaritan Health Services
5300 N Central Ave, Ste 220
Phoenix, AZ 85012

Michael Finnerty
United of Omaha
Suite 1920
10 Universal City Plaza
Universal City, CA 91608

Glen Padula
Humana Health Care Plans
2231 E Camelback Rd, Ste 208
Phoenix, AZ 85016

John DeLong
John Hancock Mutual Life Ins co
10 Universal City Plaza
Universal City, CA 91608

Bobby Davids
Planned Administrators, Inc
7499 Park Lane road, Ste 168
Columbia, SC 28260

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Meritas Group Office
545 E Sheal Blvd, Ste 208
Phoenix, AZ 85028

David C Quitno
Blue Cross Blue Shield of AZ
144 W Las Palmaritas Dr
Phoenix, AZ 85021

Michael Mullins
The Travelers Insurance Co
Metrocenter Bus Park-1
0000 N 31st Ave.
Phoenix, AZ 84038

David Judd
Delta Dental Plan of AZ
5648 N 35th Ave
Phoenix, AZ 85023

Marilyn Tobin
Great West Life
125 E Camelback Rd, Ste 500
Phoenix, AZ 85016

Tom Lewis
Principal Financial Group
231 E Camelback Rd, Ste 301
Phoenix, AZ 85016

Reanda Rangel
National Dental Health
600 W Broadway, Ste 165
Phoenix, AZ 85282

John Pignotti
Provident Life & Accident
1801 N Tatum Blvd, Ste 123
Phoenix, AZ 85028

Alvin J Bieniek
Northwestern National Life Ins
2390 E Camelback Rd, Ste 320
Phoenix, AZ 85016

Diane H Welle
Metropolitan Life Insurance Co
432 N 44th St, Ste 420
Phoenix, AZ 85008

Jean Petrecca
AETNA Life Insurance Co
7878 N 16th St, Ste 210
Phoenix, AZ 85020

Sharon Coates
The Prudential Insurance Co
3003 N Central Ave, #1400
Phoenix, AZ 85012

Tom White
Samaritan Health Services
5300 N Central Ave, Ste 220
Phoenix, AZ 85012

Hattie Blanco
FHP, Inc
410 N 44th St
Phoenix, AZ 85008

Robert Berra
Pacific Mutual
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Phoenix, AZ 85016

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Phoenix, AZ 85020

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Phoenix, AZ 85016



P.O. BOX 1547 • MESA, ARIZONA 85211

P. O. Number: 017144

Invoice Number: 591250

AFFIDAVIT OF PUBLICATION

STATE OF ARIZONA
County of Maricopa

I, CONNIE RICHMOND, Legal Clerk,
acknowledge that the attached hereto was
published in a newspaper of general circulation at
Mesa, Arizona, County of Maricopa on the
following dates:

4-7-92, 18 1992

M, T, C

M—Mesa T—Tempe C—Chandler G-GILBERT

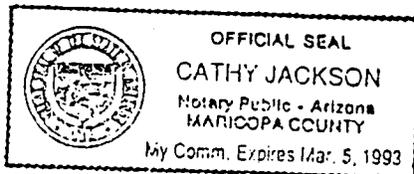
Connie Richmond

LEGAL CLERK

Subscribed and sworn to before me this
date: 18-APR-92

Cathy Jackson

NOTARY PUBLIC



REQUEST FOR PROPOSALS
The Arizona State Procurement
Office, 1688 West Adams, Room
#220, Phoenix, Arizona 85007,
will accept sealed Proposals for
the services indicated below. A
copy of the Request For Proposal
is available upon request. (602)
542-5511.

RFP No. A2-0093; A Pre-Propo-
sal Conference will be con-
ducted on April 14, 1992, 9:00
A.M., at the Arizona Industrial
Commission Building, Main Con-
ference Room, 1st Floor, 800 W.
Washington, Phoenix, AZ;

Proposal Due: May 1, 1992,
3:00 P.M.

Description: EMPLOYEE
HEALTH BENEFITS PROGRAM/DE-
PARTMENT OF ADMINISTRA-
TION, STATE PERSONNEL OFFICE
Any/all proposals may be
rejected.

Pub April 8 & 16, 1992
TMGC-922230

STATE
PERSONNEL
OFFICE
APR 10 6 52 AM '92

ANNUAL BUDGET

FY 1993

**SUMMARY OF RECOMMENDATIONS
AND
ECONOMIC AND REVENUE FORECAST**

Prepared By

JOINT LEGISLATIVE BUDGET COMMITTEE

SENATOR JAIME GUTIERREZ
Chairman 1992

THEODORE A. FERRIS
Director

REPRESENTATIVE JOHN WETTAW
Chairman 1991

RICHARD STAVNEAK
Deputy Director

*1716 West Adams Street
Phoenix, Arizona 85007
(602) 542-5491*

JLBC

OVERVIEW OF THE JLBC STAFF RECOMMENDED GENERAL FUND BUDGET FOR FISCAL YEAR 1993

Because Statutory Mandates are More Fully Funded, the JLBC Staff Budget is \$98.5 Million Higher Than Governor's and 5.8% Above FY 1992

Because of differences in our revenue forecasts, our assumed gains from the AHCCCS disproportionate share plan and the Governor's proposed income tax cut, the JLBC Staff budget incorporates some \$104.5 million more revenue than the Governor. As shown in the balance sheet below, the additional revenues are primarily allocated to agency operating budgets (an additional \$83.3 million), state employee pay (an additional \$7 million), the first required payment to the Budget Stabilization Fund (\$5.4 million), and a higher ending balance or contingency (an additional \$6.1 million).

The greater level of operating budgets generally reflects higher funding of statutory mandates in several large agencies. In terms of individual agency operating budgets the major differences of JLBC Staff over the Governor are: K-12, +\$35.7 million (with \$21.8m for a 1% inflation adjustment); AHCCCS, +\$49.7 million (we do not concur with the Governor's \$80 million MN/MI cut); Community Colleges, +\$14 million (we do not recommend eliminating capital aid of \$10.3m). For the "non-Big 10" agencies taken as a group, the JLBC Staff recommendation is \$2.1 million below FY 1992 and \$9.7 million below the Executive recommendation. The JLBC Staff recommendation would leave some 34 of 74 agencies with smaller General Fund budgets in FY 1993 than they had in FY 1992. Furthermore, the JLBC Staff recommendation for 38 agencies (over half) is lower than the Governor's.

FY 1993 GENERAL FUND BALANCE SHEET

	EXEC REC	JLBC REC	\$ DIFF
REVENUES:			
-Balance Forward	\$5,000,000	\$5,000,000	\$0
-Base Revenues	3,606,789,800	3,637,650,000	30,860,200
-Medical Deduct on Income Tax	(1,438,000)	(1,438,000)	0
-AHCCCS Disproportionate Share Holding Fund	31,886,300	31,886,300	0
-AHCCCS Disproportionate Share for FY 93	50,000,000	56,000,000	6,000,000
-DOR Centrally-Assessed Property Auditors	0	2,755,000	2,755,000
-Extend Prop & Casualty Ins Premium Tax Credit	0	4,900,000	4,900,000
-Governor's Proposed Income Tax Cut	(60,000,000)	0	60,000,000
Subtotal-Revenues	\$3,632,238,100	\$3,736,753,300	\$104,515,200
EXPENDITURES:			
-Prior Session Appropriations	\$4,879,700	\$4,879,700	\$0
-Operating Budgets	3,593,659,500	3,676,989,300	83,329,800
-State Employee Pay Increase	18,000,000	25,000,000	7,000,000
-Permanent Fund Earnings Proposal	0	(4,000,000)	(4,000,000)
-Capital Outlay	5,000,000	4,381,000	(619,000)
-Incr. Risk Mgmt. Charges	0	5,100,000	5,100,000
-Incr. Health Insurance	0	4,000,000	4,000,000
-Admia. Adj. & Emery.	21,000,000	21,000,000	0
-Reversions	(35,000,000)	(36,800,000)	(1,800,000)
-Pay-Is to Budget Stabilization Fund	0	5,400,000	5,400,000
Subtotal-Expenditures	\$3,607,539,200	\$3,705,950,000	\$98,410,800
RECOMMENDED SURPLUS (Contingency)	\$24,698,900	\$30,803,300	\$6,104,400

STATE OF ARIZONA
 HEALTH INSURANCE TRUST FUND
 STATEMENT OF REVENUES, EXPENDITURES
 AND CHANGES IN FUND BALANCE
 FOR FISCAL YEAR ENDED JUNE 30, 1992

REVENUES:

Employee Insurance Contributions	\$	32,425,465
Employer Insurance contributions		135,873,010
Prior Year Reversion		(1,852,792)
		166,445,683
Total Revenues		166,445,683

EXPENDITURES:

Health and Accident	163,095,233
Dental	10,061,402
Administraton	781,900
	173,938,535

Total Expenditures 173,938,535

Revenue Over Expenditures (7,492,852)

Fund Balance, July 1, 1991 14,918,464

Fund Balance, June 30, 1992 \$ 7,425,612

The Notes to the Financial Statements are an integral part of this statement.

STATE OF ARIZONA
 HEALTH INSURANCE TRUST FUND
 STATEMENT OF REVENUES, EXPENDITURES
 AND CHANGES IN FUND BALANCE
 FOR FISCAL YEAR ENDED JUNE 30, 1993

REVENUES:

Employee Insurance Contributions	\$	37,307,249
Employer Insurance contributions		141,488,379
Prior Year Reversion		<u>(368,000)</u>
Total Revenues		<u><u>178,427,628</u></u>

EXPENDITURES:

Health and Accident		160,634,023
Dental		11,973,137
Administraton		<u>989,679</u>
Total Expenditures		173,596,839
Revenue Over Expenditures		4,830,789
Fund Balance, July 1, 1992		<u>7,425,611</u>
Fund Balance, June 30, 1993	\$	<u><u>12,256,400</u></u>

The Notes to the Financial Statements are an integral part of this statement.

**STATE OF ARIZONA
1992/93 PROPOSED MEDICAL BENEFITS
IN-NETWORK/HMO**

	<u>CURRENT</u>	<u>PROPOSED</u>	<u>ANNUAL CLAIM SAVINGS</u>
Inpatient Hospital Services, including physicians, surgeons & facility charges	\$0 copay	\$100 copay per day, \$1000 maximum copay	\$1,826,070 (1.8%)
Outpatient Surgery	\$5 copay	\$50 copay	\$299,475 (.3%)
Preventive Care	\$5 copay	\$10 copay	*
Office Visits, Primary Care Physician	\$5 copay	\$10 copay	*
Urgent Care (Non-ER)	\$10 copay	\$20 copay	\$58,434 (.06%)
Specialist	\$5 copay	\$10 copay	*
Inpatient Mental Health	\$0 copay, 30 days	Same as current program	---
Inpatient Substance Abuse	\$0 copay, Detox only	Same as current program	---
Outpatient Mental Health	\$20 copay, 20 visits	Same as current program	----
Outpatient Substance Abuse	\$5 copay	Same as current program	---
Prescription	\$3 copay	\$10 copay	\$2,790,235 (2.7%)
Emergency Room (Waived if admitted)	\$25	\$50 copay	\$306,780 (.3%)

* Combined impact of \$1,373,205 (1.3%)

January 7, 1992

**STATE OF ARIZONA
1992/93 PROPOSED MEDICAL BENEFITS
OUT-OF-NETWORK**

	<u>CURRENT</u>	<u>PROPOSED</u>	<u>ANNUAL CLAIMS SAVINGS</u>
Deductible (applicable to all services except pre-natal care)	\$300 per person \$900 per family	\$600 per person \$1,800 per family	**
Coinsurance	70%	60%	**
Maximum out-of-pocket expense including deductible	\$3,000 per person \$6,000 per family	\$5,000 per person \$10,000 per family	**
Inpatient Hospital	\$100 per admission	\$100 per day deductible (\$1,000 max.) subject to 60% coinsurance (deductible not applicable to O-O-P max.)	\$412,516 (.4%)
Inpatient Mental Health	70%, 30 days calendar year max, \$20,000 lifetime max.	As any other expense, subject to 30 days max. per year, \$20,000 lifetime max.	**
Inpatient Substance Abuse	70%, 30 days calendar year max., 60 days lifetime max.	As any other expense subject to 30 days max. per year, 60 days lifetime max.	**
Outpatient Mental Health	50%, \$1,000 max per year	As any other expense, subject to \$1,000 max. per year.	**
Outpatient Substance Abuse	50%, \$1,000 max. per year	As any other expense, subject to \$1,000 max. per year.	**
Prescription Drug	70%	As any other expense	**
Reasonable & Customary		Expand to Medical, X-ray & Lab	\$103,129 (.1%)
Deductible Carryover		Eliminate	**

* Combined Impact of \$1,237,548 (1.2%)

Note: Packaging the proposed deductible, coinsurance and out-of-pocket maximums would provide the maximum amount in claim savings (see combined impact). However, if one of those proposed benefit changes is elected singly (non-packaged) the claim savings for that specific benefit as described above would be: Deductible \$309,387 (.3%), Coinsurance \$412,516 (.4%), and Out-of-Pocket Maximum \$309,387 (.3%).

**STATE OF ARIZONA
1992/93 PROPOSED MEDICAL BENEFITS
INDEMNITY**

	<u>CURRENT</u>	<u>PROPOSED</u>	<u>ANNUAL CLAIM SAVINGS</u>
Deductible (applicable to all services except pre-natal care)	\$200 per person \$400 per family	\$500 per person \$1,500 per family	***
Coinsurance	80%	70%	***
Maximum out-of-pocket expense including deductible	\$1,000 per person \$3,000 per family	\$3,000 per person \$6,000 per family	***
Inpatient Hospital	\$100 per admission	\$100 per day deductible (\$1,000 max.) subject to 70% coinsurance (deductible not applicable to O-O-P max.)	\$1,654,889 (4.6%)
Inpatient Mental Health	80%, 30 days calendar year max, \$20,000 lifetime max.	As any other expense, subject to 30 days max. per year, \$20,000 lifetime max.	***
Inpatient Substance Abuse	80%, 30 days calendar year max., 60 days lifetime max.	As any other expense subject to 30 days max. per year, 60 days lifetime max.	***
Outpatient Mental Health	80%, \$1,000 max. per year	As any other expense subject to \$1,000 max. per year	***
Outpatient Substance Abuse	80%, \$1,000 max. per year	As any other expense, subject to \$1,000 max. per year	***
Prescription Drug	80%	As any other expense	***
Reasonable & Customary		Expand to Medical, X-ray & Lab	\$365,090 (1.0%)
Deductible Carryover		Eliminate	***

*** Combined impact of \$5,001,728 (13.7%)

Note: Packaging the proposed deductible, coinsurance and out-of-pocket maximums would provide the maximum amount in claim savings (see combined impact). However, if one of those proposed benefit changes is elected singly (non-packaged) the claim savings for that specific benefit as described above would be: Deductible \$1,131,778 (3.1%), Coinsurance \$1,204,796 (3.3%), and Out-of-Pocket Maximum \$ 1,825,448 (5.0%).

**STATE OF ARIZONA
PROJECTIONS FOR PROPOSED BENEFIT PLAN**

A. Assuming No Change in Participation

	<u>MANAGED CARE</u>	<u>INDEMNITY</u>	<u>DENTAL</u>	<u>TOTAL</u>
Expected Claims	\$103,129,001	\$36,508,962	\$8,741,803	\$148,379,766
Plan Change Adj.	- 8,407,392	- 7,061,707	0	- 15,469,099
Revised Claims	\$94,721,609	\$29,447,255	\$8,741,803	\$132,910,667
Breakeven Loss Ratio	89.3%	89.3%	89.3%	89.3%
Premium Needed	\$106,071,231	\$32,975,649	\$9,789,253	\$148,836,133
Current Premium	\$94,491,192	\$23,063,928	\$9,235,080	\$126,790,200
Rate Increase	+12.3%	+43.0%	+6.0%	+17.4%

Adjusted Package Increase: $(1.174 + 1.301 \times 1.290) - 1 = +16.4\%$

B. Assuming Elimination of the Retiree Plan

	<u>MANAGED CARE</u>	<u>INDEMNITY</u>	<u>DENTAL</u>	<u>TOTAL</u>
Expected Claims	\$97,633,185	\$31,153,815	\$8,741,803	\$137,528,803
Plan Change Adj.	- 7,959,356	- 6,025,893	0	- 13,985,249
Revised Claims	\$89,673,829	\$25,127,922	\$8,741,803	\$123,543,554
Breakeven Loss Ratio	88.9%	88.9%	88.9%	88.9%
Premium Needed	\$100,870,449	\$28,265,379	\$9,833,299	\$138,969,127
Current Premium	\$91,027,476	\$20,774,112	\$9,235,080	\$121,036,668
Rate Increase	+10.8%	+36.1%	+6.5%	+14.8%

Adjusted Package Increase: $(1.148 + 1.301 \times 1.290) - 1 = +13.8\%$

January 7, 1992

**STATE OF ARIZONA
PROJECTIONS FOR PROPOSED BENEFIT PLAN
(Continued)**

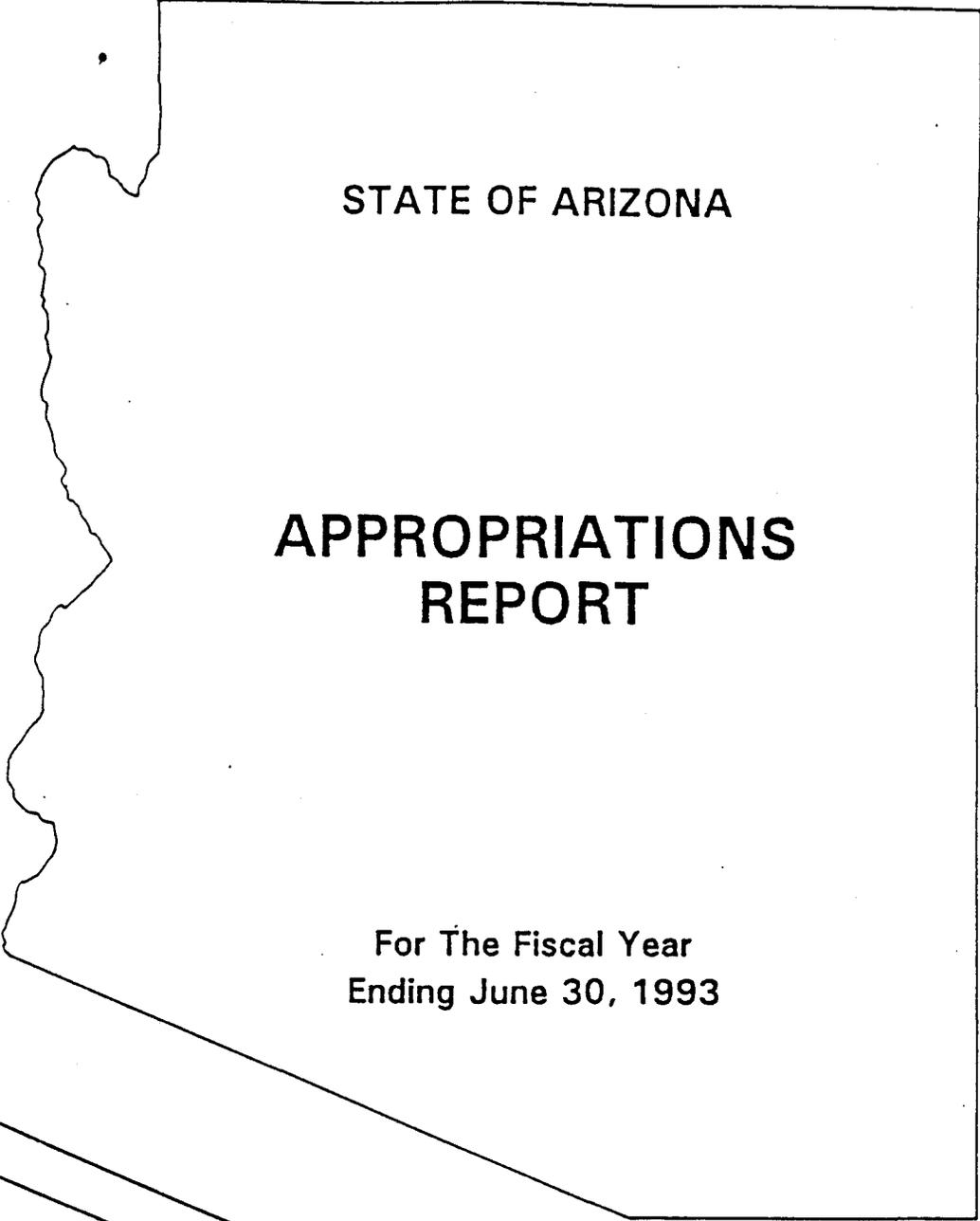
C. Assuming Elimination of the Retiree and Indemnity Plans

	<u>MANAGED CARE</u>	<u>DENTAL</u>	<u>TOTAL</u>
Expected Claims	\$121,727,075	\$8,741,803	\$130,468,878
Plan Change Adj.	<u>- 9,923,564</u>	<u>- 0</u>	<u>- 9,923,564</u>
Revised Claims	\$111,803,511	\$8,741,803	\$120,545,314
Breakeven Loss Ratio	88.9%	88.9%	88.9%
Premium Needed	\$125,763,229	\$9,833,299	\$135,596,528
Current Premium*	\$109,794,172	\$9,235,080	\$119,029,252
Rate Increase	+14.5%	+6.5%	+13.9%

Adjusted Package Increase: $(1.139 + 1.301 \times 1.290) - 1 = +12.9\%$

* Current premium was calculated based on the current Managed Care rates.

January 7, 1992

An outline map of the state of Arizona is positioned on the left side of the page, partially overlapping the main title area. The map shows the state's irregular border, including the Colorado River to the west and the Mexican border to the south and east.

STATE OF ARIZONA

**APPROPRIATIONS
REPORT**

For The Fiscal Year
Ending June 30, 1993

**JOINT
LEGISLATIVE
BUDGET
COMMITTEE**

GENERAL FUND
APPROVED SALARY AND OTHER ADJUSTMENTS
FISCAL YEAR 1993

	SALARY ADJUSTMENTS			INSURANCE AMOUNTS		
	Personal Services	Employee Related Expenditures	Total Change	Medical Insurance	Dental Insurance	Total Insurance
GENERAL GOVERNMENT						
Administration, Department of						
Central Operations	\$34,600	\$4,300	\$38,900	\$377,400	\$19,300	\$396,700
AFIS II*	500	100	600	5,700	300	6,000
Finance	11,300	1,400	12,700	123,300	6,300	129,600
SLLAG*	1,500	200	1,700	15,600	800	16,400
GAAP*	4,200	500	4,700	46,500	2,400	48,900
Cost Recovery/Cash Management*	700	100	800	9,500	500	10,000
General Services	47,400	7,900	55,300	526,000	26,900	552,900
Total - Dept of Administration	\$100,200	\$14,500	\$114,700	\$1,104,000	\$56,500	\$1,160,500
Attorney General						
Administration	11,100	1,300	12,400	119,300	6,100	125,400
Civil	32,500	3,800	36,300	345,400	17,500	362,900
Tax Section - Property Tax Appeals*	700	100	800	8,700	400	9,100
Human Services	7,600	900	8,500	79,400	4,100	83,500
Criminal	33,600	4,200	37,800	361,600	18,500	380,100
Special & Hazardous Waste*	700	100	800	9,400	500	9,900
Total - Attorney General	\$86,200	\$10,400	\$96,600	\$923,800	\$47,100	\$970,900
Commerce, Department of						
Motion Picture Office*	11,500	1,400	12,900	124,800	6,300	131,100
	1,200	100	1,300	13,600	700	14,300
Total - Dept of Commerce	\$12,700	\$1,500	\$14,200	\$138,400	\$7,000	\$145,400
Courts						
Court of Appeals						
Division I	20,400	2,500	22,900	254,100	12,900	267,000
Division II	7,400	900	8,300	88,700	4,600	93,300
Commission on Judicial Conduct	500	100	600	5,200	300	5,500
Superior Court	0	0	0	245,900	11,900	257,800
Probation State Aid*	11,500	1,500	13,000	2,600	100	2,700
Probation Enhancement*	98,900	13,200	112,100	15,600	800	16,400
Adult Intensive Probation*	72,700	9,700	82,400	20,800	1,100	21,900
Juvenile Intensive Probation*	23,400	3,100	26,500	18,200	900	19,100
Juvenile Probation Services*	20,700	2,800	23,500	31,100	1,600	32,700
Community Punishment*	10,800	1,400	12,200	7,800	400	8,200
Child Support Enforcement*	500	100	600	5,200	300	5,500
Supreme Court	27,500	3,600	31,100	314,800	16,000	330,800
Law Library*	2,200	300	2,500	23,400	1,200	24,600
Foster Care Review Board	7,100	900	8,000	75,700	3,900	79,600
Total - Courts	\$303,600	\$40,100	\$343,700	\$1,109,100	\$56,000	\$1,165,100
Governor						
Office of the Governor	12,900	1,700	14,600	137,500	7,100	144,600
Project SLIM*	2,700	300	3,000	29,400	1,500	30,900
Total - Governor	\$15,600	\$2,000	\$17,600	\$166,900	\$8,600	\$175,500
Office of Affirmative Action						
	1,200	100	1,300	13,400	700	14,100
Office of Strategic Planning and Budgeting						
GRRC*	5,400	600	6,000	58,200	3,000	61,200
	300	0	300	2,000	100	2,100
Total - OSPB	\$5,700	\$600	\$6,300	\$60,200	\$3,100	\$63,300
Law Enforcement Merit System Council						
	300	0	300	1,800	200	2,000
Legislature						
Auditor General	36,500	4,300	40,800	378,900	19,500	398,400
House of Representatives	31,900	4,100	36,000	535,300	27,500	562,800
Joint Legislative Budget Committee	7,900	900	8,800	80,500	4,200	84,700
Legislative Council	8,500	1,000	9,500	96,300	5,000	101,300
Senate	30,700	3,900	34,600	419,100	21,600	440,700
Library, Archives & Public Records, Department of	25,900	3,200	29,100	278,700	14,400	293,100
Talking Book*	700	100	800	7,800	400	8,200
Total - Legislature	\$142,100	\$17,500	\$159,600	\$1,796,600	\$92,600	\$1,889,200
Personnel Board						
	700	100	800	8,000	400	8,400
Revenue, Department of						
Director's Office	2,000	200	2,200	20,800	1,000	21,800

	SALARY ADJUSTMENTS			INSURANCE AMOUNTS		
	Personal Services	Employee Related Expenditures	Total Change	Medical Insurance	Dental Insurance	Total Insurance
Administrative Services	\$17,400	\$2,200	\$19,600	\$181,900	\$9,400	\$191,300
Property Valuation	18,800	2,500	21,300	236,200	12,100	248,300
Fiscal Services	20,100	2,500	22,600	213,900	10,900	224,800
Special Support	8,100	1,000	9,100	83,500	4,300	87,800
Tax Enforcement	139,300	17,600	156,900	1,552,200	80,100	1,632,300
Taxpayer Support	30,500	3,900	34,400	314,400	16,300	330,700
Data Management	59,100	7,200	66,300	656,400	33,700	690,100
Total - Dept of Revenue	\$295,300	\$37,100	\$332,400	\$3,259,300	\$167,800	\$3,427,100
Secretary of State	7,600	1,000	8,600	83,500	4,300	87,800
Proposition 200*	1,200	100	1,300	12,900	700	13,600
Total - Secretary of State	\$8,800	\$1,100	\$9,900	\$96,400	\$5,000	\$101,400
Tax Appeals, Board of	2,400	200	2,600	24,600	1,300	25,900
Tourism, Office of	4,200	500	4,700	49,300	2,500	51,800
Treasurer	7,200	900	8,100	85,700	4,400	90,100
TOTAL - GENERAL GOVERNMENT	\$986,200	\$126,600	\$1,112,800	\$8,837,500	\$453,200	\$9,290,700
HEALTH AND WELFARE						
AHCCCS						
Administration	114,200	14,200	128,400	1,202,100	61,800	1,263,900
Indian Advisory Council*	500	100	600	6,300	300	6,600
DES-AHCCCS	116,900	15,000	131,900	1,122,100	57,600	1,179,700
DES DDSA*	500	100	600	5,100	300	5,400
DES PASARR*	500	100	600	3,100	200	3,300
DES Program to Maximize Federal Funding*	4,000	500	4,500	36,300	1,900	38,200
DHS-AHCCCS	3,000	400	3,400	32,600	1,700	34,300
DHS PASARR*	100	0	100	2,200	100	2,300
Total - AHCCCS	\$239,700	\$30,400	\$270,100	\$2,409,800	\$123,900	\$2,533,700
Economic Security, Department of						
Administration	68,700	9,000	77,700	882,500	45,300	927,800
Medics*	2,100	300	2,400	18,600	1,000	19,600
Developmental Disabilities	120,500	18,000	138,500	1,266,400	65,000	1,331,400
Long Term Care	83,900	12,500	96,400	879,400	45,200	924,600
Family Support	188,900	24,300	213,200	1,980,800	102,100	2,082,900
Social Services	150,200	21,400	171,600	1,908,200	97,800	2,006,000
Video Taping*	700	100	800	7,800	400	8,200
LTC Ombudsman*	100	0	100	1,000	100	1,100
Child Support Enforcement	21,500	2,800	24,300	224,300	11,500	235,800
Employment and Rehabilitation Services	25,700	3,400	29,100	273,000	13,900	286,900
Navajo Employment*	2,000	300	2,300	22,500	1,200	23,700
Total - Dept of Economic Security	\$664,300	\$92,100	\$756,400	\$7,464,500	\$383,500	\$7,848,000
Environmental Quality, Department of						
Special Waste*	62,900	8,200	71,100	591,000	30,100	621,100
Aquifer Protection Permits*	3,500	500	4,000	34,600	1,800	36,400
Total - Dept of Environmental Quality	\$68,400	\$9,000	\$77,400	\$658,600	\$33,600	\$692,200
Health Services, Department of						
Office of the Director	48,800	6,600	55,400	523,500	27,100	550,600
EMS/Health Care Facilities	28,600	4,100	32,700	430,400	22,000	452,400
Disease Prevention	16,200	2,300	18,500	170,400	8,700	179,100
Health Effect-West	1,000	100	1,100	9,500	500	10,000
Chronic Disease Surveillance	1,500	200	1,700	14,500	700	15,200
Family Health	21,000	2,900	23,900	197,800	10,200	208,000
Behavioral Health	273,900	43,800	317,700	2,902,500	148,800	3,051,300
Transitional Living Unit	3,500	600	4,100	44,600	2,300	46,900
Laboratory Services	14,700	2,400	17,100	154,400	7,900	162,300
Total - Dept of Health Services	\$409,200	\$63,000	\$472,200	\$4,447,600	\$228,200	\$4,675,800
Hearing Impaired, Council for the	1,200	100	1,300	13,000	700	13,700
Indian Affairs, Commission on	1,000	100	1,100	9,100	500	9,600
Pioneer's Home	26,200	4,100	30,300	275,900	14,200	290,100
Veterans' Service Commission	5,200	700	5,900	53,300	2,700	56,000
TOTAL - HEALTH AND WELFARE	\$1,415,200	\$199,500	\$1,614,700	\$15,331,800	\$787,300	\$16,119,100
INSPECTION AND REGULATION						
Agricultural Employment Relations Board	0	0	0	9,500	500	10,000
Agriculture, Department of						

	SALARY ADJUSTMENTS			INSURANCE AMOUNTS		
	Personal Services	Employee Related Expenditures	Total Change	Medical Insurance	Dental Insurance	Total Insurance
Director's Office	\$10,000	\$1,200	\$11,200	\$105,100	\$5,400	\$110,500
Animal Services	21,400	3,100	24,500	252,400	13,100	265,500
Plant Industries	21,800	3,000	24,800	335,800	17,400	353,200
Chemical/Environmental	2,500	300	2,800	25,200	1,300	26,500
Total - Dept of Agriculture	\$55,700	\$7,600	\$63,300	\$718,500	\$37,200	\$755,700
Banking Department	12,100	1,500	13,600	130,600	6,700	137,300
Receiverships*	1,200	100	1,300	10,100	500	10,600
Total - Banking Department	\$13,300	\$1,600	\$14,900	\$140,700	\$7,200	\$147,900
Building & Fire Safety, Department of	17,200	2,300	19,500	201,600	10,300	211,900
Contractors, Registrar of	25,000	3,200	28,200	263,300	13,600	276,900
Corporation Commission						
Administration	7,500	1,000	8,500	91,300	4,700	96,000
Corporations	9,000	1,100	10,100	98,600	5,100	103,700
Securities	9,900	1,200	11,100	103,700	5,400	109,100
Railroad Safety	2,000	300	2,300	20,800	1,100	21,900
Total - Corporation Commission	\$28,400	\$3,600	\$32,000	\$314,400	\$16,300	\$330,700
Insurance, Department of	20,800	2,600	23,400	222,800	11,500	234,300
Liquor Licenses & Control, Department of	13,200	1,700	14,900	140,700	7,200	147,900
Mine Inspector	2,400	300	2,700	27,200	1,400	28,600
Racing, Department of						
Commercial Racing	12,100	1,600	13,700	127,800	6,600	134,400
Radiation Regulatory Agency						
Evaluation and Compliance	5,000	700	5,700	54,900	2,800	57,700
Real Estate Department	17,700	2,400	20,100	186,700	9,700	196,400
Weights and Measures, Department of	11,800	1,600	13,400	129,200	6,700	135,900
Boxing Commission	300	0	300	3,300	200	3,500
TOTAL - INSPECTION AND REGULATION	\$222,900	\$29,200	\$252,100	\$2,540,600	\$131,200	\$2,671,800
EDUCATION						
Arts, Commission on the	2,900	400	3,300	29,400	1,500	30,900
Community Colleges	2,700	300	3,000	29,000	1,500	30,500
Deaf and Blind, School for the						
Phoenix Day School	30,400	4,000	34,400	320,200	16,400	336,600
ADTEC	11,700	1,400	13,100	150,000	7,800	157,800
Tucson Campus	78,500	10,000	88,500	796,800	41,000	837,800
Total - School for the Deaf and Blind	\$120,600	\$15,400	\$136,000	\$1,267,000	\$65,200	\$1,332,200
Education, Department of						
State Board	600	100	700	6,500	300	6,800
General Services Administration	37,300	4,900	42,200	388,000	20,000	408,000
Assistance to Schools						
Special Education Audit*	1,200	200	1,400	13,000	700	13,700
SLIAG Administration*	100	0	100	1,300	100	1,400
SLIAG Out*	100	0	100	600	0	600
Vocational Education*	6,500	900	7,400	68,800	3,500	72,300
Academic Decathlon*	300	0	300	2,600	100	2,700
Adult Education*	1,400	200	1,600	14,900	800	15,700
Teacher Evaluation*	1,200	200	1,400	13,000	700	13,700
Chemical Abuse*	1,600	200	1,800	17,100	900	18,000
Dropout Prevention*	400	100	500	3,900	200	4,100
Full-Day Kindergarten*	400	100	500	4,800	200	5,000
Gifted Support*	500	100	600	5,200	300	5,500
K-3 Support*	800	100	900	8,600	400	9,000
Preschool Pilot Program*	400	100	500	4,800	200	5,000
SLIAG Adult Education*	300	0	300	3,400	200	3,600
Vocational Education Support	2,500	300	2,800	26,000	1,300	27,300
Total - Department of Education	\$55,600	\$7,500	\$63,100	\$582,500	\$29,900	\$612,400
Historical Society, Arizona	12,000	1,500	13,500	128,500	6,600	135,100
Historical Society, Prescott	3,900	500	4,400	40,100	2,100	42,200
Universities/Board of Regents						
Board of Regents	7,000	800	7,800	72,300	3,700	76,000
ASU-Main Campus	1,172,100	153,700	1,325,800	9,955,200	573,700	10,528,900
ASU-West Campus	131,900	17,100	149,000	1,296,800	81,800	1,378,600
Northern Arizona University	484,700	65,600	550,300	5,871,900	444,800	6,316,700
University of Arizona	1,098,900	139,300	1,238,200	8,364,200	499,700	8,863,900

	SALARY ADJUSTMENTS			INSURANCE AMOUNTS		
	Personal Services	Employee Related Expenditures	Total Change	Medical Insurance	Dental Insurance	Total Insurance
Agriculture	\$196,700	\$24,900	\$221,600	\$1,499,300	\$89,600	\$1,588,900
U of A College of Medicine	153,300	19,200	172,500	971,400	60,200	1,031,600
Total - Universities/Regents	\$3,244,600	\$420,600	\$3,665,200	\$28,031,100	\$1,753,500	\$29,784,600
TOTAL - EDUCATION	\$3,442,300	\$446,200	\$3,888,500	\$30,107,600	\$1,860,300	\$31,967,900
PROTECTION AND SAFETY						
Corrections, Department of						
Adult Institutions	1,218,300	211,000	1,429,300	13,040,300	672,700	13,713,000
Human Resources	127,200	19,700	146,900	1,339,100	68,000	1,407,100
Administration	47,100	6,500	53,600	500,900	25,600	526,500
Community Corrections	37,000	6,100	43,100	424,400	21,800	446,200
Total - Dept of Corrections	\$1,429,600	\$243,300	\$1,672,900	\$15,304,700	\$788,100	\$16,092,800
Emergency and Military Affairs, Department of						
Military Affairs	11,500	1,800	13,300	124,500	6,400	130,900
Emergency Services	3,700	500	4,200	39,200	2,000	41,200
Total - Dept of Emergency & Military Affairs	\$15,200	\$2,300	\$17,500	\$163,700	\$8,400	\$172,100
Pardons and Paroles, Board of						
	10,600	1,400	12,000	110,500	5,600	116,100
Public Safety, Department of						
Criminal Investigation Bureau	61,600	6,500	68,100	647,400	32,800	680,200
Administration Bureau	51,300	5,800	57,100	538,500	27,400	565,900
Criminal Justice Support Bureau	31,400	3,500	34,900	344,400	20,400	364,800
Telecommunications Bureau	45,400	5,400	50,800	357,900	18,600	376,500
Total - Dept of Public Safety	\$189,700	\$21,200	\$210,900	\$1,888,200	\$99,200	\$1,987,400
Youth Treatment & Rehabilitation, Department of						
Administration	17,700	2,500	20,200	285,500	14,800	300,300
Task Force	500	100	600	10,200	500	10,700
Community Care	21,900	3,500	25,400	274,600	14,000	288,600
Secure Care	104,600	17,600	122,200	1,001,100	51,200	1,052,300
Total - Dept of Youth Treatment & Rehab	\$144,700	\$23,700	\$168,400	\$1,571,400	\$80,500	\$1,651,900
TOTAL - PROTECTION AND SAFETY	\$1,789,800	\$291,900	\$2,081,700	\$19,038,500	\$981,800	\$20,020,300
TRANSPORTATION						
Transportation, Department of						
Public Transit Division	500	100	600	4,800	200	5,000
NATURAL RESOURCES						
Environment, Commission on the						
Geological Survey	3,600	500	4,100	37,800	2,000	39,800
Land Department						
Water Litigation*	500	100	600	3,900	200	4,100
Water Rights*	300	0	300	2,000	100	2,100
Total - Land Department	\$40,300	\$5,100	\$45,400	\$425,100	\$21,900	\$447,000
Mines and Mineral Resources, Department of						
State Parks Board	1,700	200	1,900	17,600	900	18,500
Administrative and Support Services						
Arizona Conservation Corps*	1,000	100	1,100	16,200	800	17,000
Total - State Parks Board	\$25,700	\$3,700	\$29,400	\$254,200	\$13,100	\$267,300
Water Resources, Department of						
Administration	10,700	1,300	12,000	115,000	6,000	121,000
Engineering	22,600	3,000	25,600	242,800	12,500	255,300
Water Management	19,400	2,600	22,000	209,800	10,800	220,600
Total - Dept of Water Resources	\$52,700	\$6,900	\$59,600	\$567,600	\$29,300	\$596,900
TOTAL - NATURAL RESOURCES	\$124,700	\$16,500	\$141,200	\$1,316,900	\$68,000	\$1,384,900
ADJUSTMENTS - SUBTOTAL	\$7,981,600	\$1,110,000	\$9,091,600	\$77,177,700	\$4,282,000	\$81,459,700
Unallocated Salary Adjustments	8,400	0	8,400	0	0	0
Section 103 Health Insurance Adjustments	0	0	0	808,000	0	808,000
TOTAL ADJUSTMENTS	\$7,990,000	\$1,110,000	\$9,100,000	\$77,985,700	\$4,282,000	\$82,267,700

* Denotes special line item.

** Represents 2% inequity salary adjustment for FY 1993.

**OTHER FUNDS
APPROVED SALARY AND OTHER ADJUSTMENTS
FISCAL YEAR 1993**

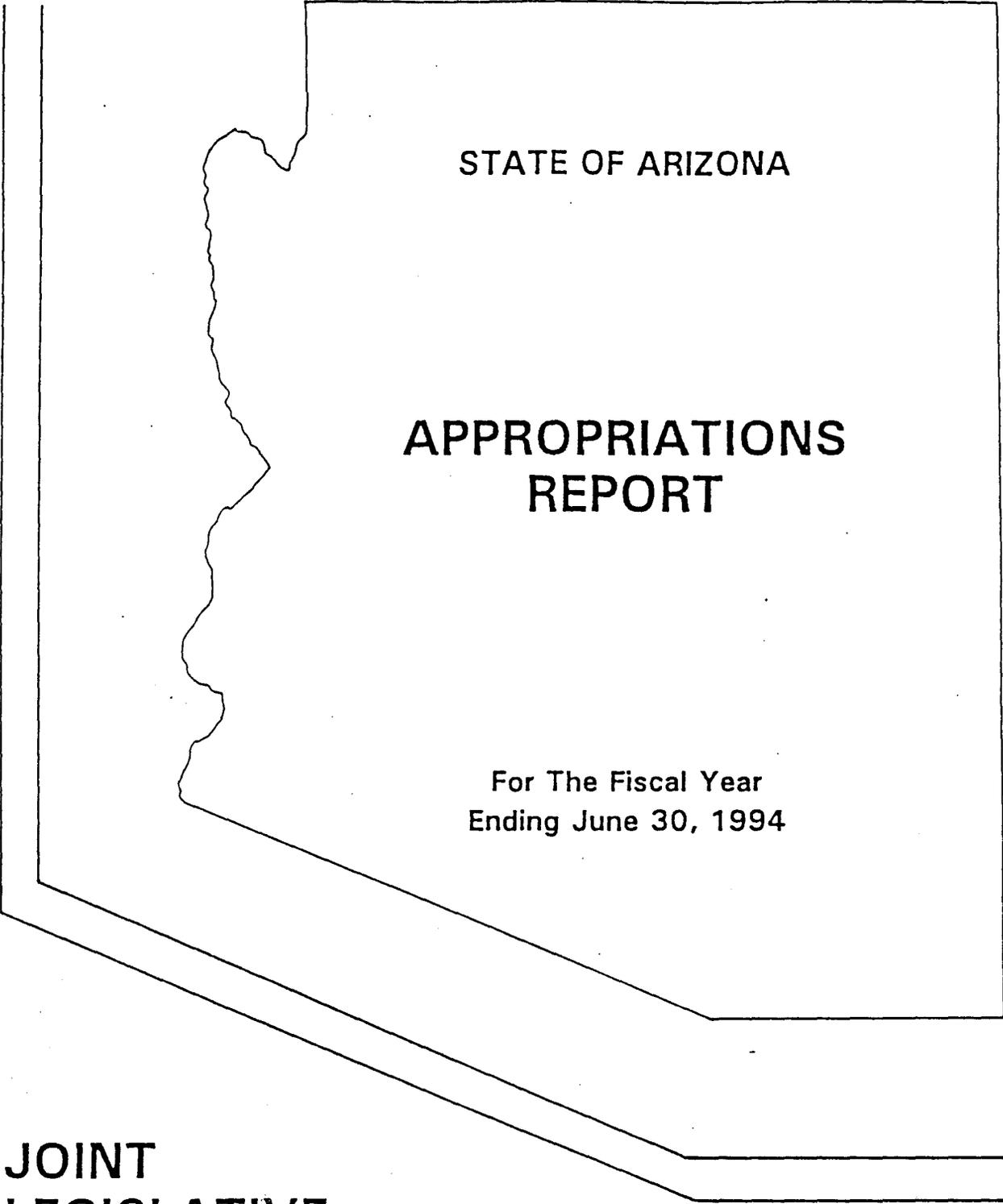
	SALARY ADJUSTMENTS			INSURANCE AMOUNTS		
	Personal Services	Employee Related Expenditures	Total Change	Medical Insurance	Dental Insurance	Total Insurance
GENERAL GOVERNMENT						
Administration, Department of						
Risk Management	\$13,700	\$1,700	\$15,400	\$150,100	\$7,700	\$157,800
Workers' Compensation	1,000	100	1,100	10,400	500	10,900
Personnel	28,800	3,600	32,400	299,600	15,200	314,800
Facilities Management	3,100	400	3,500	41,300	2,100	43,400
Total - Dept of Administration	\$46,600	\$5,800	\$52,400	\$501,400	\$25,500	\$526,900
Attorney General						
Civil						
Collection Enforcement*	2,500	300	2,800	34,200	1,700	35,900
Criminal						
Victims' Rights Implementation*	500	100	600	3,900	200	4,100
Total - Attorney General	\$3,000	\$400	\$3,400	\$38,100	\$1,900	\$40,000
Coliseum and Exposition Center	21,400	3,100	24,500	203,000	10,200	213,200
Commerce, Department of	2,900	400	3,300	32,900	1,700	34,600
Indian Economic Development*	300	0	300	2,100	100	2,200
Oil Overcharge*	500	100	600	7,000	400	7,400
Total - Dept of Commerce	\$3,700	\$500	\$4,200	\$42,000	\$2,200	\$44,200
Office of the Governor						
Project SLIM	1,500	200	1,700	14,700	800	15,500
Superior Court						
Court Appointed Special Advocate*	4,000	500	4,500	13,000	700	13,700
Lottery	32,300	4,100	36,400	340,000	17,400	357,400
Retirement System	21,500	2,700	24,200	225,800	11,700	237,500
TOTAL - GENERAL GOVERNMENT	\$134,000	\$17,300	\$151,300	\$1,378,000	\$70,400	\$1,448,400
HEALTH AND WELFARE						
Economic Security, Department of						
Public Assistance Collection Fund*	1,600	200	1,800	16,600	800	17,400
Children Protective Services Training*	1,700	200	1,900	18,100	900	19,000
Total - Dept of Economic Security	\$3,300	\$400	\$3,700	\$34,700	\$1,700	\$36,400
Environmental Quality, Department of						
Pollution Prevention*	3,700	500	4,200	40,500	2,100	42,600
Aquifer Protection Permits*	5,500	700	6,200	45,300	2,300	47,600
Air Permits Administration*	1,000	100	1,100	11,700	600	12,300
Air Quality*	700	100	800	7,900	400	8,300
Used Oil*	500	100	600	4,100	200	4,300
Total - Dept of Environmental Quality	\$11,400	\$1,500	\$12,900	\$109,500	\$5,600	\$115,100
Health Services, Department of						
EMS*	8,400	1,200	9,600	88,100	4,600	92,700
Veterans' Service Commission						
Veterans Conservatorship	3,500	500	4,000	36,400	1,900	38,300
TOTAL - HEALTH AND WELFARE	\$26,600	\$3,600	\$30,200	\$268,700	\$13,800	\$282,500
INSPECTION AND REGULATION						
Agriculture, Department of						
Animal Services						
Egg Inspections*	1,600	200	1,800	17,000	900	17,900
Aquaculture*	100	0	100	1,000	100	1,100
Plant Industries						
Standardization*	5,500	700	6,200	56,300	2,900	59,200
Chemical/Environmental	2,700	400	3,100	37,000	2,000	39,000
Agriculture Worker Safety*	2,500	300	2,800	5,600	300	5,900
Total - Dept of Agriculture	\$12,400	\$1,600	\$14,000	\$116,900	\$6,200	\$123,100
Corporation Commission						
Arts Trust Fund*	300	0	300	2,500	100	2,600
Utilities	21,000	2,700	23,700	227,000	11,700	238,700
Legal	4,100	500	4,600	42,800	2,200	45,000
Total - Corporation Commission	\$25,400	\$3,200	\$28,600	\$272,300	\$14,000	\$286,300

	SALARY ADJUSTMENTS			INSURANCE AMOUNTS		
	Personal Services	Employee Related Expenditures	Total Change	Medical Insurance	Dental Insurance	Total Insurance
Industrial Commission						
Administration	\$10,700	\$1,300	\$12,000	\$114,500	\$5,900	\$120,400
Claims	20,700	2,600	23,300	217,100	11,200	228,300
Administrative Law Judge	13,400	1,800	15,200	144,500	7,400	151,900
Labor	3,500	500	4,000	36,000	1,900	37,900
Special Fund	3,700	500	4,200	38,800	2,000	40,800
OSHA	9,000	1,200	10,200	90,700	4,700	95,400
Legal	3,700	500	4,200	38,900	2,000	40,900
Total - Industrial Commission	\$64,700	\$8,400	\$73,100	\$680,500	\$35,100	\$715,600
Racing, Department of						
County Fair Racing	1,600	200	1,800	16,900	900	17,800
Radiation Regulatory Agency						
MRTBE	500	100	600	5,200	300	5,500
Residential Utility Consumer Office	3,000	400	3,400	31,200	1,600	32,800
Weights and Measures, Department of						
Air Quality	2,000	300	2,300	19,500	1,000	20,500
Used Oil	2,500	300	2,800	21,300	1,100	22,400
Total - Dept of Weights and Measures	\$4,500	\$600	\$5,100	\$40,800	\$2,100	\$42,900
Accountancy, Board of	2,200	300	2,500	23,400	1,200	24,600
Appraisal, Board of	1,000	100	1,100	11,600	600	12,200
Barber Examiners Board	1,000	100	1,100	7,700	400	8,100
Behavioral Health Examiners, Board of	1,000	100	1,100	11,100	600	11,700
Chiropractic Examiners Board	1,000	100	1,100	10,000	500	10,500
Cosmetology, Board of	3,900	500	4,400	40,200	2,100	42,300
Dental Examiners Board	2,200	300	2,500	23,700	1,200	24,900
Funeral Directors and Embalmers Board	700	100	800	7,800	400	8,200
State Boards Office Contribution	100	0	100	700	100	800
Total - Funeral Directors Board	\$800	\$100	\$900	\$8,500	\$500	\$9,000
Homeopathic Medical Examiners Board	100	0	100	0	0	0
State Boards Office Contribution	100	0	100	700	0	700
Total - Homeopathic Board	\$200	\$0	\$200	\$700	\$0	\$700
Medical Examiners, Board of	10,100	1,200	11,300	104,600	5,400	110,000
Naturopathic Physician Examiners Board	100	0	100	0	0	0
State Boards Office Contribution	100	0	100	700	0	700
Total - Naturopathic Board	\$200	\$0	\$200	\$700	\$0	\$700
Nursing Board	5,000	600	5,600	56,200	2,900	59,100
NARP*	400	100	500	4,000	200	4,200
Total - Nursing Board	\$5,400	\$700	\$6,100	\$60,200	\$3,100	\$63,300
Nursing Care Institution Administrators Board	200	0	200	1,800	100	1,900
State Boards Office Contribution	100	0	100	700	0	700
Total - Nursing Care Administrators Board	\$300	\$0	\$300	\$2,500	\$100	\$2,600
Occupational Therapy Examiners, Board of	300	0	300	3,300	200	3,500
Dispensing Opticians, Board of	200	0	200	2,500	100	2,600
State Boards Office Contribution	100	0	100	700	0	700
Total - Dispensing Opticians Board	\$300	\$0	\$300	\$3,200	\$100	\$3,300
Optometry, Board of	400	0	400	4,800	200	5,000
State Boards Office Contribution	100	0	100	700	0	700
Total - Optometry Board	\$500	\$0	\$500	\$5,500	\$200	\$5,700
Osteopathic Examiners Board	1,200	100	1,300	12,800	700	13,500
Pharmacy Board	2,700	300	3,000	28,300	1,500	29,800
Physical Therapy Examiners Board	300	0	300	2,800	100	2,900
State Boards Office Contribution	100	0	100	700	0	700
Total - Physical Therapy Board	\$400	\$0	\$400	\$3,500	\$100	\$3,600
Podiatry Examiners Board	300	0	300	2,600	100	2,700
State Boards Office Contribution	100	0	100	700	0	700
Total - Podiatry Board	\$400	\$0	\$400	\$3,300	\$100	\$3,400
Private Postsecondary Education, Board of	700	100	800	7,800	400	8,200
Psychologist Examiners Board	500	100	600	7,400	400	7,800
State Boards Office Contribution	100	0	100	2,200	200	2,400
Total - Psychologist Board	\$600	\$100	\$700	\$9,600	\$600	\$10,200
Respiratory Care Examiners, Board of	500	100	600	5,500	300	5,800
Structural Pest Control Commission	5,800	700	6,500	61,000	3,100	64,100
Technical Registration, Board of	3,700	500	4,200	38,400	2,000	40,400
Veterinary Medical Examining Board	700	100	800	7,300	400	7,700

	SALARY ADJUSTMENTS			INSURANCE AMOUNTS		
	Personal Services	Employee Related Expenditures	Total Change	Medical Insurance	Dental Insurance	Total Insurance
State Boards Office Contribution	\$100	\$0	\$100	\$700	\$100	\$800
Total - Veterinary Board	\$800	\$100	\$900	\$8,000	\$500	\$8,500
TOTAL - INSPECTION AND REGULATION	\$159,300	\$20,000	\$179,300	\$1,658,900	\$85,700	\$1,744,600
PROTECTION AND SAFETY						
Corrections, Department of						
Adult Institutions	95,100	16,500	111,600	998,900	51,500	1,050,400
Criminal Justice Commission	1,500	200	1,700	15,600	800	16,400
Public Safety, Department of						
Highway Patrol Bureau	176,300	18,600	194,900	1,853,000	94,900	1,947,900
Criminal Justice Support Bureau	6,900	800	7,700	54,400	3,200	57,600
Telecommunications Bureau	2,900	300	3,200	10,300	500	10,800
Flagstaff Dispatch*	6,400	800	7,200	60,000	3,100	63,100
Phoenix Dispatch*	8,600	1,000	9,600	73,700	3,800	77,500
Tucson Dispatch*	5,900	700	6,600	49,700	2,600	52,300
Total - Dept of Public Safety	\$207,000	\$22,200	\$229,200	\$2,101,100	\$108,100	\$2,209,200
Youth Treatment and Rehabilitation, Department of						
Education	13,700	2,100	15,800	177,000	9,100	186,100
TOTAL - PROTECTION AND SAFETY	\$317,300	\$41,000	\$358,300	\$3,292,600	\$169,500	\$3,462,100
TRANSPORTATION						
Transportation, Department of						
Director's Staff	1,500	200	1,700	16,100	800	16,900
Transportation Planning Division	24,300	3,000	27,300	251,400	13,000	264,400
Administrative Services Division	78,500	9,900	88,400	840,700	43,200	883,900
Special Support Group	20,600	2,500	23,100	217,800	11,300	229,100
Motor Vehicle Division	204,100	26,000	230,100	2,210,500	113,900	2,324,400
Medical Advisory Board*	500	100	600	7,100	400	7,500
Mandatory Insurance*	6,200	800	7,000	47,300	2,400	49,700
Highways Division	233,500	31,700	265,200	2,471,300	128,400	2,599,700
Highway Maintenance*	230,800	37,100	267,900	2,426,000	123,800	2,549,800
Aeronautics Division	8,100	1,100	9,200	83,300	4,300	87,600
Public Transit Division	300	0	300	3,800	200	4,000
TOTAL - TRANSPORTATION	\$808,400	\$112,400	\$920,800	\$8,575,300	\$441,700	\$9,017,000
NATURAL RESOURCES						
Game and Fish Department						
Administrative and Field Services	58,900	13,100	72,000	620,100	32,000	652,100
Watercraft Licensing	6,500	900	7,400	68,100	3,500	71,600
Game, Non-game, Fish, Endangered Species	1,000	100	1,100	10,100	500	10,600
Total - Game and Fish Department	\$66,400	\$14,100	\$80,500	\$698,300	\$36,000	\$734,300
State Parks Board						
Administrative and Support Services	18,100	2,600	20,700	162,500	8,400	170,900
TOTAL - NATURAL RESOURCES	\$84,500	\$16,700	\$101,200	\$860,800	\$44,400	\$905,200
ADJUSTMENTS - SUBTOTAL	\$1,530,100	\$211,000	\$1,741,100	\$16,034,300	\$825,500	\$16,859,800
Unallocated Salary Adjustments	158,900	0	158,900	0	0	0
Section 103 Health Insurance Adjustments	0	0	0	1,020,000	0	1,020,000 **
TOTAL ADJUSTMENTS	\$1,689,000	\$211,000	\$1,900,000	\$17,054,300	\$825,500	\$17,879,800

* Denotes special line item.

** Represents appropriation from the State Highway Fund.

The image features a large, hollow outline of the state of Arizona, which serves as a background for the title text. The outline is composed of two parallel lines, with the irregular, jagged western border being the most prominent feature.

STATE OF ARIZONA

**APPROPRIATIONS
REPORT**

For The Fiscal Year
Ending June 30, 1994

**JOINT
LEGISLATIVE
BUDGET
COMMITTEE**

GENERAL FUND
HEALTH INSURANCE
RETIREMENT REDUCTION, AND
RISK MANAGEMENT ADJUSTMENTS
FISCAL YEAR 1994 1/

	Health & Dental Amounts	Section 103 Retirement Reduction	Section 104 Risk Management	Total Section 103 & 104 Adjustments
GENERAL GOVERNMENT				
Administration, Department of				
Central Operations	\$374,000	(\$17,800)	\$0	(\$17,800)
AFIS II*	0	0	0	0
GRCC*	5,300	(300)	0	(300)
Finance	109,700	(4,800)	0	(4,800)
SLIAG*	15,800	(600)	0	(600)
GAAP*	44,800	(1,700)	0	(1,700)
Cost Recovery/Cash Management*	7,900	(400)	0	(400)
General Services	504,000	(16,400)	0	(16,400)
Chapter 124	2,600	0	0	0
Total - Dept of Administration	\$1,064,100	(\$42,000)	\$0	(\$42,000)
Affirmative Action, Governor's Office of				
Attorney General	9,100	(700)	(300)	(1,000)
Administration	151,800	(8,500)	6,200	(2,300)
Civil	285,500	(21,100)	55,200	34,100
Human Services	74,700	(4,100)	6,100	2,000
Criminal	328,200	(20,000)	55,200	35,200
Total - Attorney General	\$840,200	(\$53,700)	\$122,700	\$69,000
Commerce, Department of				
Motion Picture Office*	142,300	(8,100)	3,500	(4,600)
	12,000	(900)	0	(900)
Total - Dept of Commerce	\$154,300	(\$9,000)	\$3,500	(\$5,500)
Courts				
Court of Appeals				
Division I	246,300	(10,600)	(200)	(10,800)
Division II	90,800	(4,800)	(1,400)	(6,200)
Commission on Judicial Conduct				
	4,400	(400)	0	(400)
Superior Court				
	245,600	0	66,700	66,700
Probation State Aid*	2,000	(5,900)	0	(5,900)
Probation Enhancement*	11,800	(43,600)	0	(43,600)
Adult Intensive Probation*	15,800	(33,300)	0	(33,300)
Juvenile Intensive Probation*	13,800	(12,900)	0	(12,900)
Juvenile Probation Services*	23,700	(11,900)	0	(11,900)
Community Punishment*	5,900	(5,200)	0	(5,200)
Child Support Enforcement*	3,900	(200)	0	(200)
Supreme Court				
	256,600	(15,100)	137,400	122,300
Judicial Performance Review*	6,700	(500)	0	(500)
Law Library*	20,000	(800)	0	(800)
Foster Care Review Board	63,700	(3,600)	0	(3,600)
Total - Courts	\$1,011,000	(\$148,800)	\$202,500	\$53,700
Governor, Office of the				
Office of the Governor	123,800	(10,100)	47,300	37,200
Office for Excellence*	39,000	(3,600)	0	(3,600)
Total - Governor	\$162,800	(\$13,700)	\$47,300	\$33,600
Gov's Ofc of Strategic Planning and Budgeting				
	59,900	(4,100)	100	(4,000)
Law Enforcement Merit System Council				
	1,800	(100)	200	100
Legislature				
Auditor General	354,700	(23,300)	90,500	67,200
House of Representatives	422,900	(16,800)	900	(15,900)
Joint Legislative Budget Committee	94,800	(5,800)	(1,200)	(7,000)
Chapter 258	6,000	0	0	0
Legislative Council	87,500	(5,800)	(8,100)	(13,900)

	Health & Dental Amounts	Section 103 Retirement Reduction	Section 104 Risk Management	Total Section 103 & 104 Adjustments
Senate	\$346,900	(\$14,300)	(\$2,300)	(\$16,600)
Lib, Archives & Public Rec, Department of	236,700	(10,700)	(5,000)	(15,700)
Total - Legislature	\$1,549,500	(\$76,700)	\$74,800	(\$1,900)
Personnel Board	5,500	(300)	1,300	1,000
Revenue, Department of				
Director's Office	\$19,800	(\$1,800)	\$0	(\$1,800)
Administrative Services	256,800	(10,600)	(27,400)	(38,000)
Property Valuation	187,000	(9,900)	0	(9,900)
Fiscal Services	0	0	0	0
Special Support	115,000	(6,300)	0	(6,300)
Tax Enforcement	1,385,800	(58,900)	0	(58,900)
Taxpayer Support	365,800	(13,100)	0	(13,100)
Data Management	584,100	(24,100)	0	(24,100)
Total - Dept of Revenue	\$2,914,300	(\$124,700)	(\$27,400)	(\$152,100)
Secretary of State	76,200	(2,800)	(5,500)	(8,300)
Elections Expenses*	0	(100)	0	(100)
Proposition 200*	11,300	(600)	0	(600)
Total - Secretary of State	\$87,500	(\$3,500)	(\$5,500)	(\$9,000)
Tax Appeals, Board of	30,600	(1,300)	(400)	(1,700)
Tourism, Office of	42,400	(2,500)	(1,300)	(3,800)
Treasurer	92,400	(4,500)	(1,700)	(6,200)
Uniform State Laws, Commission on	0	0	400	400
TOTAL - GENERAL GOVERNMENT	\$8,025,400	(\$485,600)	\$416,200	(\$69,400)
HEALTH AND WELFARE				
Arizona Health Care Cost Containment System				
Administration	1,199,400	(48,900)	599,700	550,800
Indian Advisory Council*	5,400	(200)	0	(200)
DES-AHCCCS	1,293,400	(43,500)	0	(43,500)
DES DDSA*	3,200	(300)	0	(300)
DES PASARR*	1,900	(100)	0	(100)
DES Program to Maximize Federal Funding*	42,800	(1,400)	0	(1,400)
MEDICS	22,700	(1,000)	0	(1,000)
DHS-AHCCCS	32,100	(1,200)	0	(1,200)
DHS PASARR*	1,900	(100)	0	(100)
Total - AHCCCS	\$2,602,800	(\$96,700)	\$599,700	\$503,000
Economic Security, Department of				
Administration	677,300	(37,600)	554,100	516,500
Developmental Disabilities	1,197,200	(46,900)	0	(46,900)
Long Term Care	566,500	(22,100)	0	(22,100)
Benefits & Medical Eligibility	1,953,100	(72,800)	0	(72,800)
Aging & Community Services	178,000	(9,800)	0	(9,800)
Children & Family Services	1,337,400	(70,100)	0	(70,100)
Video Taping*	7,800	(400)	0	(400)
LTC Ombudsman*	1,300	(100)	0	(100)
Child Support Enforcement	224,800	(7,500)	0	(7,500)
Employment and Rehabilitation Services	250,800	(10,500)	0	(10,500)
Total - Dept of Economic Security	\$6,394,200	(\$277,800)	\$554,100	\$276,300
Environmental Quality, Department of	518,100	(27,400)	87,700	60,300
Aquifer Protection Permits*	20,400	(1,200)	4,600	3,400
Total - Dept of Environmental Quality	\$538,500	(\$28,600)	\$92,300	\$63,700
Health Services, Department of				
Office of the Director	458,400	(23,100)	(725,300)	(748,400)
EMS/Health Care Facilities	272,100	(12,600)	0	(12,600)
Disease Prevention	161,600	(8,100)	0	(8,100)
Family Health	200,000	(10,200)	0	(10,200)
Behavioral Health	2,607,000	(113,300)	0	(113,300)
Laboratory Services	140,100	(6,800)	0	(6,800)
Total - Dept of Health Services	\$3,839,200	(\$174,100)	(\$725,300)	(\$899,400)

	Health & Dental Amounts	Section 103 Retirement Reduction	Section 104 Risk Management	Total Section 103 & 104 Adjustments
Hearing Impaired, Council for the	\$17,800	(\$600)	\$1,000	\$400
Indian Affairs, Commission on	12,300	(500)	200	(300)
Pioneer's Home	174,200	(5,400)	0	(5,400)
Veterans' Service Commission				0
Veterans' Affairs	58,800	(2,200)	2,300	100
TOTAL - HEALTH AND WELFARE	\$13,637,800	(\$585,900)	\$524,300	(\$61,600)
INSPECTION AND REGULATION				
Agricultural Employment Relations Board - Ch. 139	2,500	0	0	0
Agriculture, Department of				
Administration	71,200	(3,200)	30,300	27,100
Animal Services	252,900	(9,500)	104,200	94,700
Plant Industries	260,200	(9,500)	103,100	93,600
Chemical/Environmental	32,200	(1,100)	13,900	12,800
Agriculture Worker Safety*	8,800	(400)	4,300	3,900
Agriculture Lab	41,000	(1,600)	16,800	15,200
Total - Dept of Agriculture	\$666,300	(\$25,300)	\$272,600	\$247,300
Banking Department	127,400	(6,500)	(10,400)	(16,900)
Receiverships*	13,100	(600)	0	(600)
Total - Banking Department	\$140,500	(\$7,100)	(\$10,400)	(\$17,500)
Building & Fire Safety, Department of	210,400	(8,200)	(1,900)	(10,100)
Contractors, Registrar of	264,800	(11,300)	36,800	25,500
Corporation Commission				
Administration	71,700	(3,700)	(28,500)	(32,200)
Corporations	101,300	(3,400)	0	(3,400)
Securities	96,400	(5,900)	0	(5,900)
Railroad Safety	20,000	(1,100)	0	(1,100)
Total - Corporation Commission	\$289,400	(\$14,100)	(\$28,500)	(\$42,600)
Insurance, Department of	203,300	(9,400)	104,100	94,700
Liquor Licenses & Control, Department of	136,300	(5,200)	(6,000)	(11,200)
Mine Inspector	28,600	(1,300)	(67,500)	(68,800)
Racing, Department of				
Commercial Racing	148,800	(6,100)	(72,300)	(78,400)
Radiation Regulatory Agency				
Evaluation and Compliance	56,100	(2,800)	(1,900)	(4,700)
Real Estate Department	170,400	(7,700)	43,600	35,900
Weights and Measures, Department of	108,600	(4,400)	40,100	35,700
Boxing Commission	4,400	(200)	0	(200)
TOTAL - INSPECTION AND REG	\$2,430,400	(\$103,100)	\$308,700	\$205,600
EDUCATION				
Arts, Commission on the	24,600	(1,400)	(8,300)	(9,700)
Community Colleges	28,400	(2,100)	2,400	300
Deaf and Blind, School for the				
Phoenix Day School	169,200	(8,600)	0	(8,600)
ADTEC	95,400	(3,700)	0	(3,700)
Tucson Campus	584,100	(28,700)	137,200	108,500
Total - School for the Deaf and Blind	\$848,700	(\$41,000)	\$137,200	\$96,200
Education, Department of				
State Board	5,000	(200)	0	(200)
General Services Administration	366,000	(19,000)	228,000	209,000
Special Education Audit*	12,600	(700)	0	(700)
Assistance to Schools				
Basic State Aid	0	(6,510,000)	0	(6,510,000)
Additional State Aid	0	(210,100)	0	(210,100)
SLIAG Adult Education*	3,300	(100)	0	(100)
Vocational Education*	25,200	(1,200)	0	(1,200)
Academic Decathlon*	2,500	(100)	0	(100)
Adult Education*	14,400	(800)	0	(800)

	Health & Dental Amounts	Section 103 Retirement Reduction	Section 104 Risk Management	Total Section 103 & 104 Adjustments
Teacher Evaluation*	\$12,600	(\$700)	\$0	(\$700)
Chemical Abuse*	16,600	(900)	0	(900)
Dropout Prevention*	3,800	(100)	0	(100)
Full-Day Kindergarten*	4,500	(200)	0	(200)
Gifted Support*	5,000	(200)	0	(200)
K-3 Support*	8,300	(500)	0	(500)
Preschool Pilot Program*	4,500	(200)	0	(200)
Vocational Education Support	65,500	0	0	0
Total - Department of Education	\$549,800	(\$6,745,000)	\$228,000	(\$6,517,000)
Historical Society, Arizona	106,400	(5,500)	(26,000)	(31,500)
Historical Society, Prescott	66,500	(1,600)	(800)	(2,400)
Universities/Board of Regents				
Board of Regents	81,500	(5,200)	102,500	97,300
ASU-Main Campus	8,553,100	(247,900)	244,900	(3,000)
ASU-West Campus	1,174,700	(36,100)	0	(36,100)
Northern Arizona University	3,580,800	(97,800)	(86,400)	(184,200)
Yuma*	58,900	(1,600)	0	(1,600)
University of Arizona	8,220,600	(333,800)	151,300	(182,500)
Agriculture	1,646,300	(66,100)	0	(66,100)
U of A College of Medicine	1,430,600	(54,700)	242,700	188,000
Total - Universities/Regents	\$24,746,500	(\$843,200)	\$655,000	(\$188,200)
TOTAL - EDUCATION	\$26,370,900	(\$7,639,800)	\$987,500	(\$6,652,300)
<u>PROTECTION AND SAFETY</u>				
Corrections, Department of				
Adult Institutions	15,566,000	(47,800)	0	(47,800)
Human Resources	1,596,100	(42,300)	0	(42,300)
Administration	523,300	(16,600)	4,565,400	4,548,800
Community Corrections	419,200	(4,100)	0	(4,100)
Total - Dept of Corrections	\$18,104,600	(\$110,800)	\$4,565,400	\$4,454,600
Emergency and Military Affairs, Department of				
Military Affairs	127,300	(5,000)	155,400	150,400
Emergency Services	40,600	(1,900)	42,400	40,500
Total - Dept of Emergency & Military Affairs	\$167,900	(\$6,900)	\$197,800	\$190,900
Pardons and Paroles, Board of				
	93,700	(5,000)	(120,600)	(125,600)
Public Safety, Department of				
Criminal Investigation Bureau	268,400	(16,200)	0	(16,200)
Support Bureau (Administration)	804,200	(56,600)	(1,051,500)	(1,108,100)
Total - Dept of Public Safety	\$1,072,600	(\$72,800)	(\$1,051,500)	(\$1,124,300)
Youth Treatment & Rehabilitation, Department of				
Administration	175,900	(7,800)	23,900	16,100
Community Care	210,900	(2,300)	28,100	25,800
Secure Care	1,177,000	(8,100)	179,300	171,200
Total - Dept of Youth Treatment & Rehab	\$1,563,800	(\$18,200)	\$231,300	\$213,100
TOTAL - PROTECTION AND SAFETY	\$21,002,600	(\$213,700)	\$3,822,400	\$3,608,700
<u>TRANSPORTATION</u>				
Transportation, Department of				
Public Transit Division	5,800	(200)	100	(100)
<u>NATURAL RESOURCES</u>				
Environment, Commission on the	3,600	(200)	200	0
Geological Survey	40,300	(1,700)	(2,100)	(3,800)
Land Department	375,000	(19,900)	1,025,800	1,005,900
Streambed Ownership*	2,500	(200)	0	(200)
Water Litigation*	2,500	(100)	0	(100)
Total - Land Department	\$380,000	(\$20,200)	\$1,025,800	\$1,005,600
Mines and Mineral Resources, Department of	16,100	(1,000)	(1,800)	(2,800)
State Parks Board	251,200	(10,800)	36,200	25,400

	Health & Dental Amounts	Section 103 Retirement Reduction	Section 104 Risk Management	Total Section 103 & 104 Adjustments
Arizona Conservation Corps*	8,400	(500)	0	(500)
Total - State Parks Board	\$259,600	(\$11,300)	\$36,200	\$24,900
Water Resources, Department of				
Administration	106,500	(6,500)	226,700	220,200
Engineering	224,000	(13,200)	0	(13,200)
Water Management	183,200	(9,500)	0	(9,500)
Total - Dept of Water Resources	\$513,700	(\$29,200)	\$226,700	\$197,500
TOTAL - NATURAL RESOURCES	\$1,213,300	(\$63,600)	\$1,285,000	\$1,221,400
ADJUSTMENTS - SUBTOTAL	\$72,686,200	(\$9,091,900)	\$7,344,200	(\$1,747,700)
Unallocated Amounts			97,400	97,400
TOTAL ADJUSTMENTS	\$72,686,200	(\$9,091,900)	\$7,441,600	(\$1,650,300)

* Denotes special line item.

1/ This table identifies the dollar amounts appropriated in the FY 1994 General Appropriation Act for the state share of employee health insurance. The Act also requires the JLBC Staff to compute the reduction associated with a 3.14% employee contribution rate to the State Retirement Fund (Section 103) and to determine the dollar amounts for additional risk management premiums (Section 104).

**OTHER FUNDS
HEALTH INSURANCE
AFIS II CHARGES,
RETIREMENT REDUCTION, AND
RISK MANAGEMENT ADJUSTMENTS
FISCAL YEAR 1994 1/**

	Health & Dental Amounts	Section 102 AFIS Charges	Section 103 Retirement Reduction	Section 104 Risk Management	Total Sec 102 - 104 Adjustments
GENERAL GOVERNMENT					
Administration, Department of					
Risk Management	\$145,500	\$13,500	(\$7,000)	\$4,100	\$10,600
Data Management	458,100	4,200	(23,000)	6,600	(12,200)
Workers' Compensation	39,500	500	(1,500)	200	(800)
Personnel	308,700	2,900	(16,000)	5,500	(7,600)
Facilities Management	33,000	3,100	(2,200)	1,700	2,600
Total - Dept of Administration	\$984,800	\$24,200	(\$49,700)	\$18,100	(\$7,400)
Attorney General					
Civil					
Collection Enforcement*	25,900	1,700	(1,300)	0	400
Criminal					
Victims' Rights Implementation*	2,600	0	(200)	0	(200)
Total - Attorney General	\$28,500	\$1,700	(\$1,500)	\$0	\$200
Coliseum and Exposition Center					
	171,700	0	0	0	0
Commerce, Department of					
Indian Economic Development*	31,300	2,200	(1,800)	1,600	2,000
Oil Overcharge*	2,400	0	(100)	0	(100)
Total - Dept of Commerce	4,800	0	(300)	0	(300)
Total - Dept of Commerce	\$38,500	\$2,200	(\$2,200)	\$1,600	\$1,600
Superior Court					
Court Appointed Special Advocate*	9,900	0	(1,900)	0	(1,900)
Lottery					
	337,300	4,100	(15,600)	19,000	7,500
Retirement System					
	213,900	0	(9,800)	900	(8,900)
TOTAL - GENERAL GOVERNMENT	\$1,784,600	\$32,200	(\$80,700)	\$39,600	(\$8,900)
HEALTH AND WELFARE					
Economic Security, Department of					
Public Assistance Collection Fund*	16,700	0	(600)	0	(600)
Children Protective Services Training*	18,200	200	(1,000)	0	(800)
Total - Dept of Economic Security	\$34,900	\$200	(\$1,600)	\$0	(\$1,400)
Environmental Quality, Department of					
Pollution Prevention*	36,000	5,200	(1,900)	7,400	10,700
Aquifer Protection Permits*	56,100	7,300	(2,700)	10,500	15,100
Special Waste*	7,700	1,300	(500)	1,900	2,700
Air Permits Administration*	137,000	0	0	0	0
Air Quality*	7,700	1,100	(400)	1,600	2,300
Used Oil*	5,100	600	(200)	900	1,300
Total - Dept of Environmental Quality	\$249,600	\$15,500	(\$5,700)	\$22,300	\$32,100
Health Services, Department of					
EMS*	62,600	0	(3,100)	(17,200)	(20,300)
Pioneer's Home					
	131,600	0	(4,100)	0	(4,100)
Veterans' Service Commission					
Veterans Conservatorship	38,100	0	(1,200)	2,700	1,500
TOTAL - HEALTH AND WELFARE	\$516,800	\$15,700	(\$15,700)	\$7,800	\$7,800

	Health & Dental Amounts	Section 102 AFIS Charges	Section 103 Retirement Reduction	Section 104 Risk Management	Total Sec 102 - 104 Adjustments
INSPECTION AND REGULATION					
Agriculture, Department of					
Animal Services					
Egg Control*	\$19,300	\$0	(\$700)	\$9,400	\$8,700
Aquaculture*	1,200	0	0	700	700
Plant Industries					
Citrus/Fruits/Vegetables*	64,500	0	(2,100)	30,900	28,800
Chemical/Environmental					
Commercial Feed*	9,700	0	(400)	4,700	4,300
Pesticide*	12,600	0	(500)	5,000	4,500
Fertilizer Maintenance*	10,000	0	(400)	4,600	4,200
Total - Dept of Agriculture	\$117,300	\$0	(\$4,100)	\$55,300	\$51,200
Corporation Commission					
Arts Trust Fund Administration*	2,500	0	(100)	0	(100)
Utilities	214,900	3,600	(12,100)	(62,900)	(71,400)
Legal	41,200	0	(3,000)	0	(3,000)
Total - Corporation Commission	\$258,600	\$3,600	(\$15,200)	(\$62,900)	(\$74,500)
Industrial Commission					
Administration	98,100	19,000	(4,600)	22,200	36,600
Claims	193,000	0	(6,600)	0	(6,600)
Administrative Law Judge	125,500	0	(8,600)	0	(8,600)
Labor	33,000	0	(1,300)	0	(1,300)
Special Fund	35,400	0	(1,400)	0	(1,400)
OSHA	88,700	0	(4,900)	0	(4,900)
Legal	35,400	0	(1,900)	0	(1,900)
Total - Industrial Commission	\$609,100	\$19,000	(\$29,300)	\$22,200	\$11,900
Racing, Department of					
County Fair Racing	19,900	0	(700)	(10,200)	(10,900)
State Gaming Agency	42,800	0	(1,500)	0	(1,500)
Total - Dept of Racing	\$62,700	\$0	(\$2,200)	(\$10,200)	(\$12,400)
Radiation Regulatory Agency					
MRTBE	5,800	0	(200)	(100)	(300)
Residential Utility Consumer Office	31,400	0	(2,000)	(1,400)	(3,400)
Weights and Measures, Department of					
Air Quality	34,000	0	(1,400)	7,400	6,000
Used Oil	27,000	0	(800)	3,800	3,000
Total - Dept of Weights and Measures	\$61,000	\$0	(\$2,200)	\$11,200	\$9,000
Accountancy, Board of					
Appraisal, Board of	27,800	0	(900)	(1,700)	(2,600)
Barber Examiners Board	11,000	0	(500)	300	(200)
Behavioral Health Examiners, Board of	6,000	0	(400)	(800)	(1,200)
Chiropractic Examiners Board	17,200	0	(600)	400	(200)
Cosmetology, Board of	9,900	0	(500)	(500)	(1,000)
Dental Examiners Board	37,300	0	(1,400)	(2,000)	(3,400)
Funeral Directors and Embalmers Board	14,600	0	(1,100)	(1,100)	(2,200)
State Boards Office Contribution	8,500	0	(400)	600	200
Total - Funeral Directors Board	600	0	0	0	0
Total - Funeral Directors Board	\$9,100	\$0	(\$400)	\$600	\$200
Homeopathic Medical Examiners Board					
State Boards Office Contribution	200	0	0	400	400
Total - Homeopathic Board	500	0	0	0	0
Total - Homeopathic Board	\$700	\$0	\$0	\$400	\$400
Medical Examiners, Board of					
Naturopathic Physician Examiners Board	102,600	2,900	(5,300)	(11,100)	(13,500)
State Boards Office Contribution	0	0	(100)	2,400	2,300
Total - Naturopathic Board	500	0	0	0	0
Total - Naturopathic Board	\$500	\$0	(\$100)	\$2,400	\$2,300
Nursing Board					
Nursing Care Institution Administrators Board	47,900	0	(2,700)	6,200	3,500
State Boards Office Contribution	2,900	0	(100)	200	100
Total - Nursing Board	500	0	0	0	0

	Health & Dental Amounts	Section 102 AFIS Charges	Section 103 Retirement Reduction	Section 104 Risk Management	Total Sec 102 - 104 Adjustments
Total - Nursing Care Administrators Bd	\$3,400	\$0	(\$100)	\$200	\$100
Occupational Therapy Examiners, Board of	7,500	0	(200)	400	200
Dispensing Opticians, Board of	1,500	0	(100)	0	(100)
State Boards Office Contribution	500	0	0	0	0
Total - Dispensing Opticians Board	\$2,000	\$0	(\$100)	\$0	(\$100)
Optometry, Board of	1,800	0	(200)	(100)	(300)
State Boards Office Contribution	500	0	0	0	0
Total - Optometry Board	\$2,300	\$0	(\$200)	(\$100)	(\$300)
Osteopathic Examiners Board	16,000	0	(700)	(1,700)	(2,400)
Pharmacy Board	35,200	0	(1,800)	(2,200)	(4,000)
Physical Therapy Examiners Board	1,800	0	(100)	200	100
State Boards Office Contribution	500	0	0	0	0
Total - Physical Therapy Board	\$2,300	\$0	(\$100)	\$200	\$100
Podiatry Examiners Board	1,800	0	(100)	400	300
State Boards Office Contribution	500	0	0	0	0
Total - Podiatry Board	\$2,300	\$0	(\$100)	\$400	\$300
Private Postsecondary Education, Board of	7,900	0	(300)	600	300
Psychologist Examiners Board	7,300	0	(300)	(100)	(400)
State Boards Office Contribution	600	0	0	0	0
Total - Psychologist Board	\$7,900	\$0	(\$300)	(\$100)	(\$400)
Respiratory Care Examiners, Board of	4,200	0	(300)	400	100
Structural Pest Control Commission	63,800	0	(2,600)	2,400	(200)
Technical Registration, Board of	39,400	0	(1,400)	(6,100)	(7,500)
Veterinary Medical Examining Board	10,100	0	(300)	(200)	(500)
State Boards Office Contribution	600	0	0	0	0
Total - Veterinary Board	\$10,700	\$0	(\$300)	(\$200)	(\$500)
TOTAL - INSPECTION AND REG	\$1,635,400	\$25,500	(\$77,600)	\$1,400	(\$50,700)
EDUCATION					
Deaf and Blind, School for the					
Phoenix Day School	134,300	0	0	0	0
ADTEC	54,700	0	0	0	0
Tucson Campus	172,500	0	0	0	0
Total - School for the Deaf and Blind	\$361,500	\$0	\$0	\$0	\$0
TOTAL - EDUCATION	\$361,500	\$0	\$0	\$0	\$0
PROTECTION AND SAFETY					
Corrections, Department of					
Adult Institutions	0	5,800	0	0	5,800
Criminal Justice Commission	13,100	0	(900)	(100)	(1,000)
Public Safety, Department of					
Criminal Investigations Bureau	626,200	0	0	0	0
Highway Patrol Bureau	2,122,700	0	(6,700)	0	(6,700)
Support Bureau (Administration)	804,200	35,600	0	245,800	281,400
Total - Dept of Public Safety	\$3,553,100	\$35,600	(\$6,700)	\$245,800	\$274,700
Youth Treatment and Rehabilitation, Department of					
Education	141,500	0	(3,800)	0	(3,800)
TOTAL - PROTECTION AND SAFETY	\$3,707,700	\$41,400	(\$11,400)	\$245,700	\$275,700
TRANSPORTATION					
Transportation, Department of					
Director's Staff	17,500	0	(1,600)	0	(1,600)
Transportation Planning Division	284,000	0	(13,600)	0	(13,600)
Administrative Services Division	1,003,200	258,500	(44,800)	2,958,800	3,172,500
Special Support Group	155,000	0	(9,200)	0	(9,200)
Motor Vehicle Division	2,091,000	0	(71,900)	0	(71,900)
Dealer Enforcement	14,600	0	(400)	1,500	1,100

	Health & Dental Amounts	Section 102 AFIS Charges	Section 103 Retirement Reduction	Section 104 Risk Management	Total Sec 102 - 104 Adjustments
Air Quality	\$8,700	\$0	(\$100)	\$900	\$800
Medical Advisory Board*	5,800	0	(300)	100	(200)
Mandatory Insurance*	33,500	0	(1,400)	3,400	2,000
Highways Division	2,673,000	0	(130,000)	0	(130,000)
Highway Maintenance*	2,700,400	0	(89,800)	0	(89,800)
Aeronautics Division	95,300	3,600	(3,500)	6,900	7,000
Public Transit Division	2,900	0	(100)	300	200
TOTAL - TRANSPORTATION	\$9,084,900	\$262,100	(\$366,700)	\$2,971,900	\$2,867,300
<u>NATURAL RESOURCES</u>					
Game and Fish Department					
Administrative and Field Services	681,400	84,800	(15,400)	200	69,600
Watercraft Licensing	74,100	2,400	(2,100)	0	300
Game, Non-game, Fish, Endangered Species	11,500	800	(500)	0	300
Total - Game and Fish Department	\$767,000	\$88,000	(\$18,000)	\$200	\$70,200
State Parks Board	169,600	10,100	(7,000)	22,300	25,400
TOTAL - NATURAL RESOURCES	\$936,600	\$98,100	(\$25,000)	\$22,500	\$95,600
ADJUSTMENTS - SUBTOTAL	\$18,027,500	\$475,000	(\$577,100)	\$3,288,900	\$3,186,800
Unallocated Amounts		287,600		476,700	764,300
TOTAL ADJUSTMENTS	\$18,027,500	\$762,600	(\$577,100)	\$3,765,600	\$3,951,100

*denotes special line item.

1/ This table identifies the dollar amounts appropriated in the FY 1994 General Appropriation Act for the state share of employee health insurance. The Act also requires the JLBC Staff to determine the dollar amounts for additional statewide accounting system payments (Section 102), compute the appropriation reduction associated with a 3.14% employee contribution rate to the State Retirement Fund (Section 103), and determine the dollar amounts for additional risk management premiums (Section 104).

Employee Portion of Monthly Insurance Premium
10/1/93 Through 9/30/94

County of Residence	Carrier	Single/Month	Family/Month
<i>Medical Carriers:</i>			
Maricopa County	CIGNA Staff HMO	\$ 5.00	\$ 75.00
	CIGNA IPA HMO	\$ 53.36	\$ 195.08
	Intergroup HMO	\$ 9.54	\$ 77.96
	Interflex	\$ 65.82	\$ 223.22
Pima County	CIGNA HMO	\$ 5.00	\$ 75.00
	Intergroup HMO	\$ 14.60	\$ 86.54
	Interflex	\$ 70.76	\$ 228.30
Cochise & Pinal Counties	BCBSAZ HMO	\$ 5.00	\$ 75.00
	BCBSAZ PPO	\$ 5.00	\$ 75.00
All Other Counties	BCBSAZ HMO	\$ 5.00	\$ 75.00
	BCBSAZ Indemnity	\$ 5.00	\$ 75.00
Outside Arizona	BCBSAZ Indemnity	\$ 5.00	\$ 75.00
<i>Dental Carriers:</i>			
All Counties	Associated Health Plans	\$ 2.50	\$ 10.36
	Delta Dental	\$ 4.92	\$ 23.26
Vision: All Counties	Vision Service Plan	\$ 7.96	\$ 18.32

Medical Benefits Comparison Chart
for Maricopa and Pima Counties
 Benefits in Effect October 1, 1993



Benefits <small>All benefits are subject to plan limitations and exclusions.</small>	Interflex Option		Intergroup HMO Option	CIGNA Options IPA & Staff HMO
	In Network	Out-of-Network		
Annual Deductible (Calendar Year)	None	\$400/person \$800/family	None	None
Coinsurance THE PLAN PAYS	Covered Expenses for inpatient hospital paid at 90% for the first \$7,500/calendar year, then 100% for rest of calendar year.	Covered Expenses paid at 70% for the first \$7,500/calendar year after deductible, then 100% for rest of calendar year.	Coinsurance does not apply to this option.	Coinsurance does not apply to this option.
Out-of-Pocket Maximum Including Deductibles (Calendar Yr) [WHAT YOU PAY]	Limited to stated copayments and coinsurance +	\$2,650/person + \$5,300/family +	Limited to stated copayments	Limited to stated copayments
Lifetime Maximum Benefits	\$1 million including \$25,000 lifetime maximum for mental health and substance abuse benefits	\$1 million including \$25,000 lifetime maximum for mental health and substance abuse benefits	No dollar maximums	No maximum
Pre-existing Conditions	Not covered until 3 months treatment free or 12 continuous months of coverage.	Not covered until 3 months treatment free or 12 continuous months of coverage.	None	No limitation
Preventive Care (i.e., routine physicals, gynecological exams, well-baby care and immunizations)	\$10 copayment/visit	Not covered	No charge	\$5 copayment/visit
Doctor's Office Visit	\$10 copayment/visit	Covered Expenses paid at 70% after deductible	No charge	\$5 copayment/visit
Prescription Drugs	\$8/prescription or refill (31 day supply)	\$50 separate deductible, then 70% coinsurance (31 day supply)	\$5/prescription or refill (31 day supply)	\$3 copayment/prescription or refill (30 day supply)
Inpatient Hospital (Including Doctor & Facility Charges)	Covered Expenses paid at 90% the first \$7500, then 100%.	Covered Expenses paid at 70% after deductible. <i>Precertification required.</i>	No charge	No charge

- + The following Interflex expenses do not apply to the out-of-pocket maximum:
- Penalties for failure to obtain or follow precertification rules
 - Use of emergency room for non-emergency
 - Mental Health or Substance Abuse expenses
 - Expenses incurred for Outpatient Prescription Drugs

Medical Benefits Comparison Chart
for Maricopa and Pima Counties
Benefits in Effect October 1, 1993



Benefits <small>All benefits are subject to plan limitations and exclusions.</small>	Interflex Option		Intergroup HMO Option	CIGNA Options IPA & Staff HMO
	In Network	Out-of-Network		
<i>Outpatient Hospital</i>	Covered Expenses paid at 100%	Covered Expenses paid at 70% after deductible. <i>Precertification required.</i>	No charge	\$5 copayment for surgery.
Emergency Room <i>(Must Be Medical Emergency)</i>	\$50 copayment. If admitted, copayment waived and inpatient coinsurance applies.	\$50 copayment. If admitted, copayment waived and coinsurance applies.	• In-area: \$25 copayment. Waived if admitted. • Out-of-area: No charge.	\$25 copayment. Waived if admitted.
Ambulance <i>(Medical Emergency Only)</i>	Covered Expenses paid at 100% <small>(Medical Emergency Only)</small>	Covered Expenses paid at 100% <small>(Medical Emergency Only)</small>	No charge <small>(Medical Emergency Only)</small>	No charge <small>(Medical Emergency Only)</small>
Urgent Care Facility	\$10 copayment/visit	Covered Expenses paid at 70% after deductible	No charge. \$25 copayment in service area but not Intergroup authorized facility.	\$10 copayment/visit
<i>Outpatient Rehabilitation</i> (eg. Physical Therapy) <small>[Maintenance rehabilitation/service not covered.]</small>	\$10 copayment/visit. Limited to 30 visits/calendar year/illness/injury.	Covered Expenses paid at 70% after deductible. Limited to 30 visits/calendar year/illness/injury. <i>Must be precertified.</i>	No charge for short-term therapy only. Limited to 60 consecutive days/illness/injury.	\$5 copayment/visit for short-term therapy only. Limited to 60 consecutive days/condition.
	* <i>Combined in- and out-of-network benefit. Short-term therapy only.</i>			
Skilled Nursing Facility <i>Must be medically necessary.</i>	Covered Expenses paid at 100%	Covered Expenses paid at 70% after deductible. <i>Precertification required.</i>	No charge	No charge. Limited to 60 days/plan year.
Home Health Care <i>Must be medically necessary.</i>	Covered Expenses paid at 100% for up to 24 hour skilled care.	Covered Expenses paid at 70% after deductible. Part-time intermittent care. <i>Precertification required.</i>	No charge for up to 24 hour skilled care.	No charge for up to 24 hour skilled care.
Hospice Care <i>Must be medically necessary.</i>	Covered Expenses paid at 100%	Covered Expenses paid at 70% after deductible. <i>Precertification required.</i>	No charge	No charge

If there is a discrepancy between this information and the official documents, the documents will always govern.

Medical Benefits Comparison Chart
for Maricopa and Pima Counties
 Benefits In Effect October 1, 1993



Benefits <small>All benefits are subject to plan limitations and exclusions.</small>	Interflex Option In Network Out-of-Network		Intergroup HMO Option	CIGNA Options IPA & Staff HMO
Inpatient Mental Health	Covered Expenses paid at 90%. **Maximum 30 days/calendar year.	Covered Expenses paid at 70% after deductible. **Maximum 30 days/calendar year. <i>Precertification required.</i>	No charge. Maximum 30 days/12 consecutive months. Limited to short-term crisis intervention.	No charge. Limited to 30 days/plan year.
Outpatient Mental Health	\$25 copayment/visit. **Maximum 20 visits/calendar year.	**Covered Expenses paid at 50% after deductible up to \$1,000/calendar year/individual. <i>Precertification required.</i>	\$15 copayment/individual visit. \$7.50 copayment/group visit. Maximum 20 visits/12 consecutive months. Limited to short-term crisis intervention.	\$20 copayment/visit. Limited to 20 visits/plan year. \$5 copayment/group therapy.
Inpatient Substance Abuse	Covered Expenses paid at 90%. **Lifetime maximum 2 treatment programs/person for treatment of drug & alcohol abuse. <i>Substance abuse program must be completed or out-of-network benefits apply.</i>	Covered Expenses paid at 70% after deductible. **Limited to 30 days/calendar year. <i>Precertification required.</i>	Same benefit for in- and out- patient. No charge. Lifetime maximum 2 treatment programs/person for treatment of drug and alcohol abuse. <i>Must complete program to receive benefits.</i>	No charge. Detoxification only.

If there is a discrepancy between this information and the official documents, the documents will always govern.

Medical Benefits Comparison Chart

for Maricopa and Pima Counties

Benefits in Effect October 1, 1993



Benefits <small>All benefits are subject to plan limitations and exclusions.</small>	Interflex Option		Intergroup HMO Option	CIGNA Options IPA & Staff HMO
	In Network	Out-of-Network		
Outpatient Substance Abuse	<p>Covered Expenses paid at 100%. **Lifetime maximum 2 treatment programs/person for treatment of drug & alcohol abuse. <i>Substance abuse program must be completed or out-of-network benefits apply.</i></p> <p>** <i>Substance Abuse in- and out-of-network benefits combined.</i></p>	<p>Covered Expenses paid at 50% after deductible. **\$1,000/calendar year/person. <i>Precertification required.</i></p>	<p>Same benefit for in- and out-patient. No charge. Lifetime maximum 2 treatment programs/person for treatment of drug and alcohol abuse. <i>Must complete program to receive benefits.</i></p>	<p>\$5 copayment/visit. Limited to 60 visits/plan year.</p>
Durable Medical Equipment (DME) Purchase & Repair	<p>Covered Expenses paid at 100%. Repair and replacement covered.</p>	<p>Covered Expenses paid at 70% after deductible. Repair and replacement <i>not</i> covered.</p>	<p>No charge. Covered Expenses for repair and replacement paid at 100%.</p>	<p>\$200 deductible/member/plan year. Limited to max of \$5,000/member/plan year. Maintenance/repair/replacement due to normal use.</p>
Hearing Aids <i>Must be medically necessary.</i>	<p>Covered Expenses paid up to \$750/ear/year.</p>	<p><i>Not covered</i></p>	<p>Covered Expenses paid up to \$750/ear/year.</p>	<p>\$200 deductible/member/plan year. Limited to \$1,000 max/member/plan yr. Ded/max combined with external prosthetic appliances.</p>
Diabetic Supplies	<p>\$8 copayment/packaged unit.</p>	<p>\$50 prescription deductible, then 70% coinsurance.</p>	<p>\$5 copayment/packaged unit</p>	<p>\$3 copayment/prescription/refill (30 day supply.) Limited to home glucose monitoring device, glucose test strips and lancets--<i>available only at CIGNA Staff Model pharmacies.</i></p>
Allergy Shots	<p>\$10 copayment/visit</p>	<p><i>Not covered</i></p>	<p>No charge</p>	<p>No charge-nurse \$5 copay-doctor</p>
Chiropractors <small>[Maintenance rehab/service not covered.]</small>	<p>\$10 copayment/visit. <i>Referral by PCP required.</i></p>	<p>Covered Expenses paid at 70% after deductible.</p>	<p><i>Not covered</i></p>	<p><i>Not covered</i></p>

If there is a discrepancy between this information and the official documents, the documents will always govern.



STATE OF ARIZONA

OFFICE OF THE ATTORNEY GENERAL

GRANT WOODS
ATTORNEY GENERAL

1275 WEST WASHINGTON, PHOENIX 85007

MAIN PHONE: 542-5025
TELECCPIER: 542-4085

August 5, 1992

William Bell
Assistant Director, Personnel Division
Arizona Department of Administration
1831 West Jefferson Street
Phoenix, Arizona 85007

Re: Procurement of Group Health Insurance Coverage For Active
And Retired State Employees

Dear Mr. Bell:

Pursuant to your request, this letter is to confirm verbal advice previously given to you, regarding two issues relating to the procurement of group health insurance coverage for active and retired State employees.

First, you have asked whether it is proper for the Department of Administration to require an employee upon retirement to make a one-time election to maintain coverage under the Department's group health insurance. A review of the statute governing the Department's provision of health insurance to retired employees, A.R.S. Sec. 38-651.01, discloses that such an election is required.

A.R.S. Sec. 38-651.01(A) provides:

The department of administration shall, by rule, adopt standards to establish group health and accident coverage for former employees who worked for the state of Arizona and who opt upon retirement to enroll or continue enrollment in the group health and accident coverage for active employees. . . [Emphasis added.]

The statute clearly provides that an employee must "opt upon retirement" to maintain coverage in the Department's group health insurance. The statute does not contain any language authorizing a retired employee to later change this election.

Further, it should be noted that the version of A.R.S. Sec. 38-651.01 in effect prior to a 1990 amendment did not contain any language requiring an employee to make a choice of insurance coverage upon retirement. The later addition of language requiring an employee to "opt upon retirement" is strong evidence

William Bell
August 5, 1992
Page 2.

of a specific legislative intent that such a choice be made. (A copy of the previous version of A.R.S. Sec. 38-651.01 is enclosed for your reference.)

Your second question is whether the Department should require that potential providers of group health insurance coverage bid separate premiums for active employee coverage and retired employee coverage. It is my view that, in order to carry out the mandates of A.R.S. Sec. 38-651.01, separate premiums should be obtained.

A.R.S. Sec. 38-651.01(I) provides:

No public funds shall be expended to pay all or any part of the premium of such insurance pursuant to this section. . . [Emphasis added.]

It would appear that this mandate could only be met if separate premiums are bid. Insurance premiums are in large part dependant upon the anticipated amount of claims; it is therefore possible that the premium for retired employees would be different than that for active employees. Requesting a single premium encompassing both groups could result in an averaging, or "blending," of potentially different rates for each group, with one group in effect subsidizing the other. Because public funds pay a portion of the premium for active employees pursuant to A.R.S. Sec. 38-651, in an instance where the premium for retired employees is higher than that of active employees, "blending" both into a single premium could violate A.R.S. Sec. 38-651.01(I). Requiring separate premium amounts for active and retired employees carries an assurance that no part of the retired employee premium is paid with public funds.

As you know, this advice is furnished only for internal agency guidance, and does not constitute a formal Opinion of the Attorney General. Should you deem it advisable, this office would be happy to consider a request for a formal Opinion.

Sincerely,


GRAHAM ALEX TURNER
Assistant Attorney General
Unit Chief, Procurement Law Section

CC:
James M. Howard
Chief Counsel, Civil Division

GAT/ms



STATE OF ARIZONA

OFFICE OF THE ATTORNEY GENERAL

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1275 WEST WASHINGTON, PHOENIX 85007

MAIN PHONE : 542-5025
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February 25, 1993

William Bell
Assistant Director, Personnel Division
Arizona Department of Administration
1831 West Jefferson Street
Phoenix, Arizona 85007

Re: Procurement of Group Health Insurance For Active And
Retired Public Employees

Dear Mr. Bell:

Pursuant to your request, this is to supplement the matters discussed in my August 5, 1993 letter to you, regarding the procurement of group health insurance coverage for active and retired public employees. A copy of my previous letter is attached for your reference. Specifically, you have inquired whether the Legislature has the ability to statutorily provide for the "blending" of active and retired employee health insurance premiums.

A.R.S. § 38-651.01(I) currently provides that no public funds may be expended to pay "all or any part of the premium" of any insurance provided to a retired employee. As stated in my previous letter, it was my view that this mandate could only be met if separate premiums were bid. As insurance premiums are in large part dependant upon the anticipated amount of claims, averaging or "blending" the premiums of the active employee group with the retired employee group could result in one group subsidizing the other. Since public funds pay a portion of the premium for active employees pursuant to A.R.S. § 38-651, in an instance where the premium for retired employees is higher than that of active

employees, blending both into a single premium could violate A.R.S. § 38-651.01(I). Indeed, I have been informed by Wyatt & Company, the State's health insurance consultant, that last year the blending of premiums resulted in an estimated \$4,600,000 subsidy of the retired employee group by the active employee group.

The Legislature could mandate the blending of the active and retired employee insurance premiums. It is possible, however, that such a statute would raise the issue of constitutionality. Article 9, Section 7 of the Arizona Constitution prohibits the State from making "any donation or grant, by subsidy or otherwise, to any individual." Under this provision, public funds may be expended only for purposes benefiting the public at large, and cannot be used to foster or promote purely private or personal interests of any individual. Wistuber v. Paradise Valley Unified School Dist., 141 Ariz. 346 (1984); Town of Gila Bend v. Walled Lake Door Co., 107 Ariz. 545 (1971). The State may part with its funds only by agreement and for valuable consideration. Yeazell v. Copins, 98 Ariz. 109 (1965). The question would be whether there is a sufficient public benefit to be derived from subsidizing health insurance for retired state employees.

The provision of active employee benefits, such as subsidized health insurance, annual and sick leave, and contributions to a retirement plan, is viewed as part of the State's contract with the employee. It is part of the "salary package" paid to the employee in consideration for his services. It is my understanding that an employee's promised compensation has never included insurance after retirement subsidized by the State's General Fund. Consequently, the argument can be made that as retired employees have already been fully compensated for their services, an insurance subsidy could constitute a gift of public funds.

On the other hand, it can be argued that a benefit to the public at large results from adequate health care insurance for retired government workers. Without such coverage some retired government workers would have to rely on direct government sources (welfare) for health care costs. This might be more expensive than insurance costs. It could also be said that failure to provide adequate insurance might make it more difficult to retain government workers until retirement age.

I hope the foregoing has been of assistance to you. Please feel free to contact me should you wish to discuss this matter further. As you know, this advice is furnished only for internal

agency guidance and is subject to attorney-client privilege; this does not constitute a formal Opinion of the Attorney General. Should you deem it advisable, this office would be happy to consider a request for a formal Opinion.

Sincerely,


GRAHAM A. TURNER
Unit Chief, Procurement and
Contract Law
Administrative Law Section

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1 CENT OF THE group rates by paying the premiums. No public funds shall be
 2 expended to pay all or any part of the premium of health insurance
 3 continued in force by the surviving spouse. The department of
 4 administration by rule shall adopt standards for and designate qualifying
 5 plans which may include plans of indemnity health insurance, hospital and
 6 medical service plans, closed panel medical and dental plans and health
 7 maintenance organizations, and for eligibility of officers and employees
 8 to participate in such plans. Any indemnity health insurance or hospital
 9 and medical service plan designated as a qualifying plan by the department
 10 of administration must be open for enrollment to all permanent full-time
 11 state employees, except that any plan established prior to June 6, 1977
 12 may be continued as a separate plan. Any closed panel medical or dental
 13 plan or health maintenance organization designated as the qualifying plan
 14 by the department of administration must be open for enrollment to all
 15 permanent full-time state employees residing within the geographic area or
 16 area to be served by the plan or organization. Officers and employees may
 17 select coverage under the available options.

18 B. The department of administration may expend public funds
 19 appropriated for such purpose to procure health and accident coverage for
 20 the dependents of full-time officers and employees of the state and its
 21 departments and agencies. The department of administration by rule shall
 22 adopt standards for and designate qualifying plans which may include plans
 23 of indemnity health insurance, hospital and medical service plans, closed
 24 panel medical and dental plans and health maintenance organizations, and
 25 for eligibility of the dependents of officers and employees to participate
 26 in such plans. Any indemnity health insurance or hospital and medical
 27 service plan designated as a qualifying plan by the department of
 28 administration must be open for enrollment to all permanent full-time
 29 state employees, except that any plan established prior to June 6, 1977
 30 may be continued as a separate plan. Any closed panel medical or dental
 31 plan or health maintenance organization designated as a qualifying plan by
 32 the department of administration must be open for enrollment to all
 33 permanent full-time state employees residing within the geographic area or
 34 area to be served by the plan or organization. Officers and employees may
 35 select coverage under the available options.

36 C. The department of administration shall designate the Arizona
 37 health care cost containment system established by title 36, chapter 29 as
 38 a qualifying plan for the provision of health and accident coverage to
 39 state officers and employees and their dependents. The Arizona health
 40 care cost containment system shall not be the exclusive qualifying plan
 41 for health and accident coverage for state officers and employees either
 42 on a statewide or regional basis.

43 D. Except as provided in section 38-652, public funds expended
 44 pursuant to this section shall not exceed:

45 1. ~~One hundred sixty dollars fifty eight cents~~ _____
 46 monthly per officer or employee who receives individual coverage.

ATTACHMENT J

Intergroup's Response to AAUP

DRAFT

ARIZONA DEPARTMENT OF ADMINISTRATION

Allegation 1:

The AAUP anthology alleges that employees have been misled regarding the health insurance program and its costs; and that the Department has "ruined" the health insurance program.

Response:

Prior to the 1992 bid process, the State was experiencing a \$44 million rate renewal premium increase. While several alternative rates were discussed during the renewal process, all rates below the CIGNA and Intergroup negotiated rate reduced benefits and increased employee's out-of-the-pocket expenses.

Allegation 2:

The AAUP anthology alleges that the Intergroup Healthcare Corporation purchased a "shell insurance company" for the sole purpose of bidding for a combined HMO and indemnity plan in 1992.

Response:

Bay Colony Life Insurance Company of Arizona has been licensed to underwrite life and disability insurance in Arizona since 1971. The acquisition was concluded in 1990, a year before the Department even determined to go out and re-bid the contract in 1992.

Allegation 3:

The AAUP anthology attempts to establish a correlation between the evaluation criteria and the reconcilability of the contract award to Intergroup.

Response:

The evaluation committee members chosen by The State Procurement Office establish the evaluation criteria and the weight factors. They determined experience, expertise, reliability was equal 45%, cost 35%, and method of approach 20%. Intergroup's report card = 94.8%; CIGNA's = 91.4%.

Allegation 4:

The AAUP anthology alleges that the Department did not do reference checks on behalf of Intergroup; and had such a reference check been conducted, the State would not have received a positive response regarding Intergroup.

Response:

Allegation is based on incorrect information regarding Honeywell's Benefits Manager during that time. Mr. Jacob's, Honeywell's Benefits Manager, was contacted and noted operational deficiencies of POS, did not recommend aversion or avoidance and did recommend Intergroup's HMO product.

Allegation 5:

The anthology alleges that Intergroup offered to renew the then-existing contract at 8.5% and the Department elected to re-bid the contract for 13%; and that the extra benefits offered in the larger percentage were slight.

Response:

A review of a comparison of benefits by The Wyatt Company clearly illustrates that the 8.5% renewal rate significantly increase out-of-pocket expenses.

Allegation 6:

The AAUP anthology alleges that Intergroup experienced an increase in enrollment under the 1992-93 contract; and that Intergroup earned millions more because DOA awarded them much higher rates than necessary and also gave them much more additional business.

Response:

The Personnel Services Division attributes the increase in membership to the different and competitive rates and benefits offered by each individual plan.

Allegation 7:

The AAUP anthology discusses that the Department used emergency procedures to limit competition during

the 1992 rebid process.

Response:

The Personnel Services Division and the State Procurement Office requested to waive the requirements to notify all vendors on the State's vendor list because of time sensitivity and the fact that many of the firms do not provide the type of insurance that was being sought.

Allegation 8:

The AAUP anthology alleges that the Department did not have to re-bid the health insurance contract in 1992 as there were much less expensive alternatives.

Response:

Less expensive plans were available in 1992 but with reduced benefits, higher copayments and deductibles and out-of-the-pocket expenses.

Allegation 9:

The AAUP anthology alleges that the Arizona Legislature had authorized an increase of \$4 million for health insurance for FY 1992-93, prior to the 1992 re-bid process.

Response:

The Joint Legislative Budget Committee (JLBC) budget recommendation did include an additional \$4 million targeted for health insurance but the Governor's Office of Strategic Planning and Budgeting (OSPB) budget recommendations had no increase allocated for health insurance. Recommendations are not the same as legislative authority.

Allegation 10:

The AAUP anthology alleges that the Department passed on at least \$7 to \$8 million in increases to employees. The AAUP anthology questions the Department's rationale for breaking off negotiations when the Department appeared to attempt to avoid an increase of \$12 million in health insurance premiums.

Response:

The Department maintains that the increased employee contributions are a result of employees selecting non-based plans. Had all employees selected the base plan, employee contributions would have remained equal to that of the prior year.

Allegation 11:

The AAUP anthology alleges that according to Ms. Peggy Beaver, CIGNA had reduced its renewal rate increase to 13% with "little change in benefits".

Response:

The 13% (actually 13.8%) rate renewal option assumed elimination of the retiree plan. While the option did maintain Flexcare and indemnity plans, the proposal was accomplished by significantly reducing benefits.

Allegation 12:

The AAUP anthology alleges that the total cost, which AAUP defines as all amounts paid from all sources, will show that the Department passed on "many millions in extra costs" to state employees.

Response:

More appropriate inquiry is Employer and Employer Insurance Contribution because total costs include health and accident, dental and administrative costs.

FY 1991-92 Employee Contributions.....	\$32,425,465
FY 1992-93 Employee Contributions.....	\$37,307,249
FY 1991-92 Employer Contributions.....	\$135,873,010
FY 1992-93 Employer Contributions.....	\$141,488,379

Allegation 13:

The AAUP alleges that the state will pay an additional \$7 million more in health costs for FY 1993-94. AAUP further alleges that employees will "pay millions more in increased contributions"

Response:

According to the appropriated amounts for the FY 1992-93 and FY 1993-94, as exhibited in the respective Appropriation Reports, health insurance cost for FY 1993-94 were reduced by \$9,423,800, as compared to FY 1992-93. Reductions attributed to decoupling of university tuition fees, shift from indemnity to base plans and technical adjustments in calculating premiums payable.

Allegation 14:

The AAUP anthology alleges that an internal memorandum questioned whether the bidding process will not artificially drive rates and whether all options and alternatives had been considered prior to the decision to re-bid.

Response:

The internal memorandum was a working paper setting forth procurement, not programmatic concerns about re-bidding. It was prepared without any knowledge of the problems in the negotiations for the annual renewal and the need for re-bid.

Allegation 15:

The AAUP anthology alleges that the State is paying more for rural employees than urban employees. AAUP further alleges that the Department has cut rural employees expenses and increased their benefits by reducing deductibles and out-of-pocket expenses.

Response:

The allegation compares the most expensive rural plan to the least expensive urban plan. In this scenario it is true. However, the opposite is also true (if the most expensive urban plan is compared to the least expensive rural plan).

Allegation 16:

The AAUP anthology alleges that rural employees have the choice between an indemnity plan and a HMO which employees in Maricopa and Pima Counties do not enjoy.

Response:

The Department fully acknowledges that rural employees have the opportunity to select either an HMO or indemnity. Conversely, urban employees have the opportunity to select from three forms of managed care. A comparison of the POS (Interflex) and the indemnity (BC/BS) plans, illustrates that both plans have rules and regulations.

Allegation 17:

The AAUP anthology alleges that the Department believes it will cost the State \$20 million to equalize its contribution strategy in all counties; and that the Department will not recommend such action as it would show that the Department's 1992 re-bid process was not successful.

Response:

The Department has not considered, contemplated or calculated such an equalization contribution strategy.

Allegation 18:

The AAUP anthology alleges that the Department has not contained costs

Response:

From the State's perspective the total expenditures made on behalf of employees health insurance was reduced by \$341,696 in FY 1992-93, as compared to FY 199-93

Allegation 19:

The AAUP anthology alleges that the total cost of the CIGNA best and final offer would have been lower than the package finally accepted. AAUP further alleges that the Department rejected the CIGNA proposal because it required an exclusive contract.

Response:

Although CIGNA provided 3 renewal options each alternative was built by identical reductions in benefits and increasing out-of-pocket expenses. The Department stands firmly behind its decision to resist, when practical, offering exclusive contracts for employee health insurance.

Allegation 20:

The AAUP anthology alleges that the FY 1993-94 Intergroup HMO premiums are markedly higher than CIGNA HMO premiums for all categories and locations.

Response:

That is true. However, the Intergroup's benefit is richer. No co-payment for preventive care, Dr. visits, outpatient hospital, outpatient rehab., and urgent care as compared with CIGNA's \$5 co-pay.

Allegation 21:

The AAUP anthology alleges that the Department's position not to blend retirees with active employees is based on the constitutional question of providing an illegal gift. The allegation is made that if such is the case, than why are NAU retirees not separated from NAU active employees

Response:

Upon the advise of the Arizona Attorney General the 1992 re-bid process un-blended active and retired public employees. The Arizona Legislature has afforded the NAU Health Plan a different status.

Allegation 22:

The AAUP anthology alleges SB 1213 was introduced to increase dental premiums. AAUP further alleges that the legislative hearing on SB 1213 was canceled by the Department to avoid questions by legislators.

Response:

SB 1213 was intended to be the "annual rate bill" that the Department typically introduces in case it is determined that the State's contribution to employee health insurance is to be increased. The Department determined that no increase in the State's contribution was needed. Therefore, no bill was needed and subsequently the Department requested that the bill be held.

ATTACHMENT K

**DOA Materials Comparing
Urban and Rural
State Employee Health Insurance**

State of Arizona
Department of Administration
Personnel Services
Employee Benefits



Comparison of Medical and Dental Benefits

Benefits and Premiums in Effect

October 1, 1993 Through September 30, 1994

This information is intended solely as a guide to help you make important enrollment decisions.

The benefits described are highlights of the State of Arizona's benefit program provided through the Department of Administration.

This is a brief summary of the State's official plan documents and contracts that govern the plans. If there is a discrepancy between this information and the official documents, the official documents will always govern.

The State of Arizona reserves the right to change or terminate any of its plans, in whole or in part, at any time.

Participation in any of the State's benefit plans should not be considered a contract of employment.

Table of Contents

Employee Portion of Monthly Insurance Premium	2
Medical Benefits Comparison Charts	3 - 11
Maricopa & Pima Counties	3 - 6
Cochise & Pinal Counties	7 - 9
All Geographic Locations Other Than Cochise, Maricopa, Pima & Pinal Counties	10 - 11
Dental Benefits Comparison Chart [All Counties]	12

**Employee Portion of Monthly Insurance Premium
10/1/93 Through 9/30/94**

County of Residence	Carrier	Single/Month	Family/Month
<i>Medical Carriers:</i>			
Maricopa County	CIGNA Staff HMO	\$ 5.00	\$ 75.00
	CIGNA IPA HMO	\$ 53.36	\$195.08
	Intergroup HMO	\$ 9.54	\$ 77.96
	Interflex	\$ 65.82	\$223.22
Pima County	CIGNA HMO	\$ 5.00	\$ 75.00
	Intergroup HMO	\$ 14.60	\$ 86.54
	Interflex	\$ 70.76	\$228.30
Cochise & Pinal Counties	BCBSAZ HMO	\$ 5.00	\$ 75.00
	BCBSAZ PPO	\$ 5.00	\$ 75.00
All Other Counties	BCBSAZ HMO	\$ 5.00	\$ 75.00
	BCBSAZ Indemnity	\$ 5.00	\$ 75.00
Outside Arizona	BCBSAZ Indemnity	\$ 5.00	\$ 75.00
<i>Dental Carriers:</i>			
All Counties	Associated Health Plans	\$ 2.50	\$ 10.36
	Delta Dental	\$ 4.92	\$ 23.26

Medical Benefits Comparison Chart
for Maricopa and Pima Counties
Benefits in Effect October 1, 1993



Benefits <small>All benefits are subject to plan limitations and exclusions.</small>	Interflex Option		Intergroup HMO Option	CIGNA Options IPA & Staff HMO
	In Network	Out-of-Network		
Annual Deductible (Calendar Year)	None	\$400/person \$800/family	None	None
Coinsurance THE PLAN PAYS	Covered Expenses <i>for inpatient hospital</i> paid at 90% for the first \$7,500/calendar year, then 100% for rest of calendar year.	Covered Expenses paid at 70% for the first \$7,500/calendar year after deductible, then 100% for rest of calendar year.	Coinsurance does not apply to this option.	Coinsurance does not apply to this option.
Out-of-Pocket Maximum Including Deductibles (Calendar Yr) [WHAT YOU PAY]	Limited to stated copayments and coinsurance +	\$2,650/person + \$5,300/family +	Limited to stated copayments	Limited to stated copayments
Lifetime Maximum Benefits	\$1 million including \$25,000 lifetime maximum for mental health and substance abuse benefits	\$1 million including \$25,000 lifetime maximum for mental health and substance abuse benefits	No dollar maximums	No maximum
Pre-existing Conditions	Not covered until 3 months treatment free or 12 continuous months of coverage.	Not covered until 3 months treatment free or 12 continuous months of coverage.	None	No limitation
Preventive Care (i.e., routine physicals, gynecological exams, well-baby care and immunizations)	\$10 copayment/visit	Not covered	No charge	\$5 copayment/visit
Doctor's Office Visit	\$10 copayment/visit	Covered Expenses paid at 70% after deductible	No charge	\$5 copayment/visit
Prescription Drugs	\$8/prescription or refill (31 day supply)	\$50 separate deductible, then 70% coinsurance (31 day supply)	\$5/prescription or refill (31 day supply)	\$3 copayment/prescription or refill (30 day supply)
Inpatient Hospital (Including Doctor & Facility Charges)	Covered Expenses paid at 90% the first \$7500, then 100%.	Covered Expenses paid at 70% after deductible. <i>Precertification required.</i>	No charge	No charge

- + The following Interflex expenses do not apply to the out-of-pocket maximum:
- Penalties for failure to obtain or follow precertification rules
 - Use of emergency room for non-emergency
 - Mental Health or Substance Abuse expenses
 - Expenses incurred for Outpatient Prescription Drugs

Medical Benefits Comparison Chart
for Maricopa and Pima Counties
 Benefits in Effect October 1, 1993



Benefits <small>All benefits are subject to plan limitations and exclusions.</small>	Interflex Option		Intergroup HMO Option	CIGNA Options IPA & Staff HMO
	In Network	Out-of-Network		
Outpatient Hospital	Covered Expenses paid at 100%	Covered Expenses paid at 70% after deductible. <i>Precertification required.</i>	No charge	\$5 copayment for surgery.
Emergency Room <i>(Must Be Medical Emergency)</i>	\$50 copayment. If admitted, copayment waived and inpatient coinsurance applies.	\$50 copayment. If admitted, copayment waived and coinsurance applies.	●In-area: \$25 copayment. Waived if admitted. ●Out-of-area: No charge.	\$25 copayment. Waived if admitted.
Ambulance <i>(Medical Emergency Only)</i>	Covered Expenses paid at 100% <small>(Medical Emergency Only)</small>	Covered Expenses paid at 100% <small>(Medical Emergency Only)</small>	No charge <small>(Medical Emergency Only)</small>	No charge <small>(Medical Emergency Only)</small>
Urgent Care Facility	\$10 copayment/visit	Covered Expenses paid at 70% after deductible	No charge. \$25 copayment in service area but not Intergroup authorized facility.	\$10 copayment/visit
Outpatient Rehabilitation <small>(eg. Physical Therapy)</small> <small>[Maintenance rehabilitation/service not covered.]</small>	\$10 copayment/visit. Limited to 30 visits/calendar year/illness/injury. <i>* Combined in- and out-of-network benefit. Short-term therapy only.</i>	Covered Expenses paid at 70% after deductible. Limited to 30 visits/calendar year/illness/injury. <i>Must be precertified.</i>	No charge for short-term therapy only. Limited to 60 consecutive days/illness/injury.	\$5 copayment/visit for short-term therapy only. Limited to 60 consecutive days/condition.
Skilled Nursing Facility <i>Must be medically necessary.</i>	Covered Expenses paid at 100%	Covered Expenses paid at 70% after deductible. <i>Precertification required.</i>	No charge	No charge. Limited to 60 days/plan year.
Home Health Care <i>Must be medically necessary.</i>	Covered Expenses paid at 100% for up to 24 hour skilled care.	Covered Expenses paid at 70% after deductible. Part-time intermittent care. <i>Precertification required.</i>	No charge for up to 24 hour skilled care.	No charge for up to 24 hour skilled care.
Hospice Care <i>Must be medically necessary.</i>	Covered Expenses paid at 100%	Covered Expenses paid at 70% after deductible. <i>Precertification required.</i>	No charge	No charge

If there is a discrepancy between this information and the official documents, the documents will always govern.

Medical Benefits Comparison Chart
for Maricopa and Pima Counties
 Benefits in Effect October 1, 1993



Benefits <small>All benefits are subject to plan limitations and exclusions.</small>	Interflex Option In Network Out-of-Network		Intergroup HMO Option	CIGNA Options IPA & Staff HMO
Inpatient Mental Health	Covered Expenses paid at 90%. **Maximum 30 days/calendar year.	Covered Expenses paid at 70% after deductible. **Maximum 30 days/calendar year. <i>Precertification required.</i>	No charge. Maximum 30 days/12 consecutive months. Limited to short-term crisis intervention.	No charge. Limited to 30 days/plan year.
Outpatient Mental Health	\$25 copayment/visit. **Maximum 20 visits/calendar year.	**Covered Expenses paid at 50% after deductible up to \$1,000/calendar year/individual. <i>Precertification required.</i>	\$15 copayment/individual visit. \$7.50 copayment/group visit. Maximum 20 visits/12 consecutive months. Limited to short-term crisis intervention.	\$20 copayment/visit. Limited to 20 visits/plan year. \$5 copayment/group therapy.
Inpatient Substance Abuse	Covered Expenses paid at 90%. **Lifetime maximum 2 treatment programs/person for treatment of drug & alcohol abuse. <i>Substance abuse program must be completed or out-of-network benefits apply.</i>	Covered Expenses paid at 70% after deductible. **Limited to 30 days/calendar year. <i>Precertification required.</i>	Same benefit for in- and out- patient. No charge. Lifetime maximum 2 treatment programs/person for treatment of drug and alcohol abuse. <i>Must complete program to receive benefits.</i>	No charge. Detoxification only.

If there is a discrepancy between this information and the official documents, the documents will always govern.

Medical Benefits Comparison Chart
for Maricopa and Pima Counties
Benefits in Effect October 1, 1993



Benefits <small>All benefits are subject to plan limitations and exclusions.</small>	Interflex Option		Intergroup HMO Option	CIGNA Options IPA & Staff HMO
	In Network	Out-of-Network		
Outpatient Substance Abuse	Covered Expenses paid at 100%. **Lifetime maximum 2 treatment programs/person for treatment of drug & alcohol abuse. <i>Substance abuse program must be completed or out-of-network benefits apply.</i> ** Substance Abuse in- and out-of-network benefits combined.	Covered Expenses paid at 50% after deductible. **\$1,000/calendar year/person. <i>Precertification required.</i>	Same benefit for in- and out- patient. No charge. Lifetime maximum 2 treatment programs/person for treatment of drug and alcohol abuse. <i>Must complete program to receive benefits.</i>	\$5 copayment/visit. Limited to 60 visits/plan year.
Durable Medical Equipment (DME) Purchase & Repair	Covered Expenses paid at 100%. Repair and replacement covered.	Covered Expenses paid at 70% after deductible. Repair and replacement <i>not</i> covered.	No charge. Covered Expenses for repair and replacement paid at 100%.	\$200 deductible/member/plan year. Limited to max of \$5,000/member/plan year. Maintenance/repair/replacement due to normal use.
Hearing Aids <i>Must be medically necessary.</i>	Covered Expenses paid up to \$750/ear/year.	<i>Not covered</i>	Covered Expenses paid up to \$750/ear/year.	\$200 deductible/member/plan year. Limited to \$1,000 max/member/plan yr. Ded/max combined with external prosthetic appliances.
Diabetic Supplies	\$8 copayment/packaged unit.	\$50 prescription deductible, then 70% coinsurance.	\$5 copayment/packaged unit	\$3 copayment/prescription/refill (30 day supply.) Limited to home glucose monitoring device, glucose test strips and lancets-- <i>available only at CIGNA Staff Model pharmacies.</i>
Allergy Shots	\$10 copayment/visit	Not covered	No charge	No charge-nurse \$5 copay-doctor
Chiropractors <small>(Maintenance rehab/service not covered.)</small>	\$10 copayment/visit. <i>Referral by PCP required.</i>	Covered Expenses paid at 70% after deductible.	Not covered	Not covered

If there is a discrepancy between this information and the official documents, the documents will always govern.

Medical Benefits Comparison Chart
for Cochise and Pinal Counties
Benefits in Effect October 1, 1993



Benefits All benefits are subject to plan limitations and exclusions.	Blue Cross Blue Shield of Arizona		
	Preferred Care PPO Option		HMO Option
	PPO	Non - PPO	
Annual Deductible (Plan Year)	\$150/person \$300/family	\$300/person \$600/family	None
Coinsurance THE PLAN PAYS	Covered Expenses paid at 80% for first \$3,000 after deductible/plan year, then 100% for rest of year.	Covered expenses paid at 70% for first \$10,000/plan year, then 100% for rest of year.	Coinsurance does not apply to this option.
** Out-of-Pocket Maximum Including deductibles (Plan Year) [WHAT YOU PAY]	\$ 750/person \$1,500/family	\$3,300/person \$6,600/family	Stated copayments.
Lifetime Maximum Benefits	\$1 million including \$25,000 lifetime maximum for mental health and substance abuse benefits	\$1 million including \$25,000 lifetime maximum for mental health and substance abuse benefits	Unlimited except \$25,000 lifetime maximum for mental health and substance abuse benefits.
Pre-existing Conditions	Not covered until in the plan 11 months.	Not covered until in the plan 11 months.	Not covered until in the plan 11 months.
Preventive Care	<ul style="list-style-type: none"> • Well-child care through age 5 • Prenatal care-Covered Expenses paid at 80%, deductible waived • Well-woman care- Covered Expenses paid at 80% after deductible 	<ul style="list-style-type: none"> • Well-child and Well- woman care <i>not</i> covered • Prenatal care- Covered Expenses paid at 70%, deductible waived 	\$10 copayment/visit for: Well-baby care Well-woman care Physical exams Immunizations
Doctor's Office Visit	Covered Expenses paid at 80% after deductible	Covered Expenses paid at 70% after deductible	\$10 copayment/visit
Prescription Drugs	\$5 copayment/prescription or refill through PERFORM network (34 day supply)	\$5 copayment/prescription or refill through PERFORM network (34 day supply)	\$5 copayment/prescription or refill through PERFORM network (34 day supply)
<i>Inpatient</i> Hospital (facility charges)	Covered Expenses paid at 80% after deductible Requires precertification.	Covered Expenses paid at 70% after deductible Requires precertification.	Covered at 100% Requires precertification.
<i>Outpatient</i> Hospital	Covered Expenses paid at 80% after deductible	Covered Expenses paid at 70% after deductible	Covered Expenses paid at 100% Requires precertification.

** Using providers who do not have participating agreements with BCBSAZ may result in out-of-pocket expenses in excess of those stated. Using both PPO and Non-PPO providers will subject the member to both the PPO and non-PPO maximums. HMO participants must always use the HMO AZ network of providers or no benefits are available.

Medical Benefits Comparison Chart
for Cochise and Pinal Counties
 Benefits in Effect October 1, 1993



Benefits All benefits are subject to plan limitations and exclusions.	Blue Cross Blue Shield of Arizona		
	Preferred Care PPO Option		HMO Option
	PPO	Non - PPO	
Emergency Treatment Facility	\$50 deductible/visit <i>(waived if admitted)</i> then Covered Expenses paid at 80% after annual deductible	\$50 deductible/visit <i>(waived if admitted)</i> then Covered Expenses paid at 70% after annual deductible	\$50 copayment. Waived if admitted to HMO hospital.
Ambulance <i>(Medical Emergency Only)</i>	Covered Expenses paid at 80%; deductible waived. <i>(Medical Emergency Only)</i>	Covered Expenses paid at 80%; deductible waived. <i>(Medical Emergency Only)</i>	No charge <i>(Medical Emergency Only)</i>
Urgent Care Facility	Covered Expenses paid at 80% after deductible	Covered Expenses paid at 70% after deductible	\$10 copayment/visit
Outpatient Rehabilitation (eg. Physical Therapy)	Covered Expenses paid at 80% after deductible	Covered Expenses paid at 70% after deductible	Covered at 100%. 40 visit limit/plan year
Skilled Nursing Facility <i>Must be medically necessary.</i>	Covered Expenses paid at 80% after deductible Requires precertification.	Covered Expenses paid at 70% after deductible Requires precertification.	Covered Expenses paid at 100% to 90 days/plan year Requires precertification.
Home Health Care <i>Must be medically necessary.</i>	Covered Expenses paid at 80% after deductible (Part-time and intermittent) Requires precertification.	Covered Expenses paid at 70% after deductible (Part-time and intermittent) Requires precertification.	No charge (Part-time and intermittent) Requires precertification.
Hospice Care <i>Must be medically necessary.</i>	Subject to case management	Subject to case management	No charge Requires precertification.
Inpatient Mental Health and Substance Abuse (This benefit's out-of-pocket expenses are not included in the out-of-pocket maximum.)	Covered Expenses paid at 80% after deductible up to \$10,000 maximum benefit in any 12-month period. \$25,000 lifetime maximum benefit.	Covered Expenses paid at 70% after deductible up to \$10,000 maximum benefit in any 12-month period. \$25,000 lifetime maximum benefit.	Bodyne determines necessity. Covered Expenses paid at 100% up to \$10,000 maximum benefit in any 12-month period. \$25,000 lifetime maximum benefit.
Outpatient Mental Health and Substance Abuse (This benefit's out-of-pocket expenses are not included in the out-of-pocket maximum.)	<ul style="list-style-type: none"> Covered Expenses paid at 80% after deductible up to \$1,000 maximum benefit/person/calendar year. Bodyne Centers only - \$5 copayment/visit for first 10 visits/plan year to out-of-pocket maximum of \$50/person; \$100/family. Additional visits covered at 100%. 	<ul style="list-style-type: none"> Covered Expenses paid at 70% after deductible up to \$1,000 maximum benefit/person/calendar year. 	Bodyne Centers only \$5 copayment/visit for first 10 visits/plan year; out-of-pocket maximum of \$50/person and \$100 per family. Additional visits covered at 100%.

If there is a discrepancy between this information and the official documents, the documents will always govern.

Medical Benefits Comparison Chart
for Cochise and Pinal Counties
 Benefits in Effect October 1, 1993



Benefits All benefits are subject to plan limitations and exclusions.	Blue Cross Blue Shield of Arizona		
	Preferred Care PPO Option		HMO Option
	PPO	Non - PPO	
Durable Medical Equipment (DME) Purchase & Repair	Covered Expenses paid at 80% after deductible. Requires precertification.	Covered Expenses paid at 70% after deductible. Requires precertification.	Covered Expenses paid at 100%. Requires precertification.
Hearing Aids	Covered Expenses paid at 100% up to \$750 maximum benefit/ear/plan year		Covered Expenses paid at 100% up to \$750 maximum benefit/ear/plan year
Diabetic Supplies	Insulin and syringes covered through PERFORM prescription drug program. Other items covered as Durable Medical Equipment (DME). See DME above.		Insulin and syringes covered through PERFORM prescription program. Other items covered as Durable Medical Equipment (DME). See DME above.
Allergy Shots	Covered Expenses paid at 80% after deductible	Covered Expenses paid at 70% after deductible	\$10 copayment
Chiropractors	Covered Expenses paid at 80% after deductible	Covered Expenses paid at 70% after deductible	<i>Not Covered</i>

IMPORTANT INFORMATION REGARDING PRECERTIFICATION

The following items require precertification.

Failure to precertify may result in the reduction or elimination of payments for such benefits.
 (If you are enrolled in the HMO, your PCP must precertify services for you.)

- Hospital Inpatient Admission (precertification waived for emergency and maternity admissions)
- Magnetic Resonance Imaging (MRI)
- Durable Medical Equipment (DME)
- Home Health Care
- Skilled Nursing Facility
- Inpatient Active Rehabilitation
- Home IV Therapy
- Outpatient Surgery (HMO Only)
- Referrals to Specialists (HMO Only)

If there is a discrepancy between this information and the official documents, the documents will always govern.

Medical Benefits Comparison Chart

For All Geographic Locations Other Than Cochise, Maricopa, Pima and Pinal Counties

Benefits in Effect October 1, 1993



Benefits All benefits are subject to plan limitations and exclusions.	Blue Cross Blue Shield of Arizona	
	Indemnity Option	HMO Option <i>May Not Be Available in All Locations. Call 1-800-232-2345, extension 4828 for network information.</i>
Annual Deductible (Plan Year)	\$150/person \$300/family	None
Coinsurance THE PLAN PAYS	Covered Expenses paid at 80% for first \$3,000 after deductible/plan year, then 100% for the rest of the plan year. (If you use a "preferred provider", coinsurance will be based on discounted fees.)	Coinsurance does not apply to this option.
* Out-of-Pocket Maximum Including Deductibles (Plan Year) [WHAT YOU PAY]	\$750/person \$1,500/family	Limited to stated copayments. Stated copayments.
Lifetime Maximum Benefits	\$1 million including \$25,000 lifetime maximum for mental health and substance abuse benefits.	Unlimited except \$25,000 lifetime maximum for mental health and substance abuse benefits.
Pre-existing Conditions	Not covered until in the plan for 11 months.	Not covered until in the plan 11 months.
Preventive Care	<ul style="list-style-type: none"> • Well-child care through age 5 • Prenatal care - Covered Expenses paid at 80%, deductible waived • Well-woman care - Covered Expenses paid at 80% after deductible 	\$10 copayment/visit for: Well-baby care Well-woman care Physical exams Immunizations
Doctor's Office Visit	Covered Expenses paid at 80% after deductible	\$10 copayment/visit
Prescription Drugs	\$5 copayment/prescription or refill through PERFORM network (34 day supply)	\$5 copayment/prescription/refill through PERFORM network (34 day supply)
<i>Inpatient</i> Hospital (facility charges)	Covered Expenses paid at 80% after deductible Requires precertification.	Covered at 100% Requires precertification.
<i>Outpatient</i> Hospital	Covered Expenses paid at 80% after deductible	Covered Expenses paid at 100% Requires precertification.
Emergency Treatment Facility	Covered Expenses paid at 80% after deductible	\$50 copayment Waived if admitted to HMO hospital.
Outpatient Accident Benefit	Plan pays \$300/person/accident before you pay any deductible or coinsurance.	
Ambulance (Medical Emergency Only)	Covered Expenses paid at 80% after deductible (Medical Emergency Only)	No charge (Medical Emergency Only)
<i>Outpatient</i> Rehabilitation (eg. Physical Therapy)	Covered Expenses paid at 80% after deductible	Covered at 100%. 40 visit limit/plan year.
Skilled Nursing Facility <i>Must be medically necessary.</i>	Covered Expenses paid at 80% after deductible Requires precertification.	Covered Expenses paid at 100% up to 90 days/plan year Requires precertification.

* Using providers who do not have participating agreements with BCBSAZ may result in out-of-pocket expenses in excess of those stated.

Medical Benefits Comparison Chart
For All Geographic Locations Other Than Cochise, Maricopa, Pima and Pinal Counties
 Benefits in Effect October 1, 1993



Benefits All benefits are subject to plan limitations and exclusions.	Blue Cross Blue Shield of Arizona	
	Indemnity Option	HMO Option <i>May Not Be Available in All Locations. Call 1-800-232-2345, extension 4828 for network information.</i>
Home Health Care <i>Must be medically necessary.</i>	Covered Expenses paid at 80% after deductible (Part-time and intermittent) Requires precertification.	No charge (Part-time and intermittent) Requires precertification.
Hospice Care <i>Must be medically necessary.</i>	Subject to case management	No charge. Requires precertification.
Inpatient Mental Health and Substance Abuse (This benefit's out-of-pocket expenses are not included in out-of-pocket maximum.)	Covered Expenses paid at 80% after deductible up to \$10,000 maximum benefit in any 12-month period. \$25,000 lifetime maximum benefit.	Biodyne determines necessity. Covered Expenses paid at 100% up to \$10,000 maximum benefit in any 12-month period. \$25,000 lifetime max benefit.
Outpatient Mental Health and Substance Abuse (This benefit's out-of-pocket expenses are not included in out-of-pocket maximum.)	Covered Expenses paid at 80% after deductible up to \$1,000 maximum benefit/person/calendar year. • Biodyne Centers - \$5 copayment/visit for first 10 visits/plan year; out-of-pocket maximum of \$50/person and \$100/family. Additional visits covered at 100%.	Biodyne Centers only \$5 copayment/visit for first 10 visits per plan year; out-of-pocket maximum of \$50/person and \$100/family. Additional visits covered at 100%.
Durable Medical Equipment (DME)	Covered Expenses paid at 80% after deductible Purchase and Repair Requires Precertification.	Covered Expenses paid at 100% Purchase and Repair Requires Precertification.
Hearing Aids	Covered Expenses paid at 100% up to \$750 maximum benefit/ear/plan year	Covered Expenses paid at 100% up to \$750 maximum benefit/ear/plan year
Diabetic Supplies	Insulin and syringes covered through PERFORM prescription program. Other items covered as DME. See DME above.	Insulin and syringes covered through PERFORM prescription program. Other items covered as DME. See above.
Allergy Shots	Covered Expenses paid at 80% after deductible	\$10 copayment
Chiropractors	Covered Expenses paid at 80% after deductible	<i>Not Covered</i>

IMPORTANT INFORMATION REGARDING PRECERTIFICATION

The following items require precertification.

Failure to precertify may result in the reduction or elimination of payments for such benefits.
 (If you are enrolled in the HMO, your PCP must precertify services for you.)

- Hospital Inpatient Admission (precertification waived for emergency and maternity admissions)
- Magnetic Resonance Imaging (MRI)
- Durable Medical Equipment (DME)
- Home Health Care
- Skilled Nursing Facility
- Inpatient Active Rehabilitation
- Home IV Therapy
- Outpatient Surgery (HMO Only)
- Referrals to Specialists (HMO Only)

If there is a discrepancy between this information and the official documents, the documents will always govern.

Dental Benefits Comparison Chart

All Counties

Benefits in Effect October 1, 1993



Benefits	Associated Health Plans	Delta Dental Plan
Deductibles (Calendar Year - 1/1 to 12/31)	No deductibles	\$ 50/person \$150/family Applies to basic restorative & major restorative only
Preventive Care Oral Exam Prophylaxis (Cleaning) Fluoride X-rays - 2 films - 4 or more films	YOUR COPAYMENTS <i>All benefits are subject to plan limitations and exclusions.</i>	PLAN PAYS <i>All benefits are subject to plan limitations and exclusions.</i>
	No charge (By general dentist) No charge (One/6 months) No charge No charge (By general dentist) No charge (By general dentist)	Cleanings limited to 2/calendar year 100% of allowed amount (No deductible)
Basic Restorative Sealants Fillings Extractions Periodontal Oral Surgery	\$9.00/tooth No charge (amalgam fillings) No charge (routine extractions) \$0 - \$315 \$0 - \$100 each	After deductible, 80% of allowed amount. " " " "
Major Restorative Crowns Dentures Fixed Bridgework Crown/Bridge Repair Inlays	\$165 - \$185 \$260 - \$280 \$185/unit Lab fee \$110 - \$155	After deductible, 50% of allowed amount. " " " Inlays not covered.
Orthodontia Under Age 19 Age 19 and Up	<i>Standard 24-month treatment plan</i> \$1,985 - \$2,410 \$2,185 - \$2,610	50% (No deductible)
Maximum Benefits Preventive, Basic & Major Combined Periodontal Lifetime Maximum (applies toward calendar year max) Orthodontia Lifetime Maximum	Unlimited Unlimited Unlimited	\$1,000/calendar year \$1,000 \$1,500

*If there is a discrepancy between this information and the
official documents, the documents will always govern.*



Medical Benefits Comparison Chart
Blue Cross Blue Shield of Arizona Indemnity Plan
 1992/93 Benefits and 1993/94 Benefits



Benefits All benefits subject to plan limitations & exclusions.	Effective October 1, 1993	August 1, 1992 to September 30, 1993
Outpatient Rehabilitation (eg. Physical Therapy)	Covered Expenses paid at 80% after deductible.	Covered Expenses paid at 80% after deductible.
Skilled Nursing Facility <i>Must be medically necessary.</i>	Covered Expenses paid at 80% after deductible. Requires precertification.	Covered Expenses paid at 80% after deductible. Requires precertification.
Home Health Care <i>Must be medically necessary.</i>	Covered Expenses paid at 80% after deductible. (part-time and intermittent) Requires precertification.	Covered Expenses paid at 80% after deductible. (part-time and intermittent) Requires precertification.
Hospice Care <i>Must be medically necessary.</i>	Subject to case management.	Subject to case management.
Inpatient Mental Health and Substance Abuse <small>(This benefit's out-of-pocket expenses are not included in out-of-pocket maximum.)</small>	Covered Expenses paid at 80% after deductible up to \$10,000 maximum benefit in any 12-month period. \$25,000 lifetime maximum benefit.	Covered Expenses paid at 80% after deductible up to \$10,000 maximum benefit in any 12-month period. \$25,000 lifetime maximum benefit.
Outpatient Mental Health and Substance Abuse <small>(This benefit's out-of-pocket expenses are not included in out-of-pocket maximum.)</small>	<ul style="list-style-type: none"> • Covered Expenses paid at 80% after deductible up to \$1,000 maximum benefit/person/calendar year. • Biodyne Centers - \$5 copayment/visit for first 10 visits/plan year; out-of-pocket maximum of \$50/person and \$100/family. Additional visits covered at 100%. 	<ul style="list-style-type: none"> • Covered Expenses paid at 80% after deductible up to \$1,000 maximum benefit/person/calendar year. • Biodyne Centers - \$5 copayment/visit for first 10 visits/plan year; out-of-pocket maximum of \$50/person and \$100/family. Additional visits covered at 100%.
Durable Medical Equipment (DME)	Covered Expenses paid at 80% after deductible. Purchase and Repair Requires Precertification.	Covered Expenses paid at 80% after deductible. Purchase and Repair Requires Precertification.
Hearing Aids	Covered Expenses paid at 100% up to \$750 maximum benefit/ear/plan year.	Not covered.
Diabetic Supplies	Insulin and syringes covered through PERFORM prescription program. Other items covered as DME. See DME above.	Insulin and syringes covered through PERFORM prescription program. Other items/DME. See DME above.
Allergy Shots	Covered Expenses paid at 80% after deductible.	Covered Expenses paid at 80% after deductible.
Chiropractors	Covered Expenses paid at 80% after deductible.	Covered Expenses paid at 80% after deductible.

Important precertification information.

Failure to precertify the following items may result in reduction or elimination of payments for such benefits.

- Hospital Inpatient Admission (precertification waived for emergency and maternity admissions)
- Magnetic Resonance Imaging (MRI)
- Durable Medical Equipment (DME)
- Home Health Care
- Skilled Nursing Facility
- Inpatient Active Rehabilitation
- Home IV Therapy

Medical Benefits Comparison Chart

Blue Cross Blue Shield of Arizona Indemnity Plan

1992/93 Benefits and 1993/94 Benefits



Benefits All benefits subject to plan limitations & exclusions.	Effective October 1, 1993	August 1, 1992 to September 30, 1993
Annual Deductible (Plan Year)	\$150/person \$300/family	\$250/person \$500/family
Coinsurance THE PLAN PAYS	Covered Expenses paid at 80% for first \$3,000 after deductible/plan year, then 100% for the rest of the plan year. (If you use a "preferred provider", coinsurance will be based on discounted fees.)	Covered Expenses paid at 80% for first \$5,000 after deductible/plan year, then 100% for the rest of the plan year. (If you use a "preferred provider", coinsurance will be based on discounted fees.)
* Out-of-Pocket Maximum Including Deductibles (Plan Yr) [WHAT YOU PAY]	\$750/person \$1,500/family	\$1,250/person \$2,500/family
Lifetime Maximum Benefits	\$1 million including \$25,000 lifetime maximum for mental health and substance abuse benefits.	\$1 million including \$25,000 lifetime maximum for mental health and substance abuse benefits.
Pre-existing Conditions	Not covered until in the plan for 11 months.	Not covered until in the plan for 11 months.
Preventive Care	<ul style="list-style-type: none"> • Well-child care through age 5. • Prenatal care - Covered Expenses paid at 80%, deductible waived. • Well-woman care - Covered Expenses paid at 80% after deductible. 	<ul style="list-style-type: none"> • Well-child care through age 5. • Prenatal care - Covered Expenses paid at 80%, deductible waived. • Well-woman care - Covered Expenses paid at 80% after deductible.
Doctor's Office Visit	Covered Expenses paid at 80% after deductible.	Covered Expenses paid at 80% after deductible.
Prescription Drugs	\$5 copayment/prescription or refill through PERFORM network. (34 day supply)	\$50 deductible then \$5 copayment/prescription or refill. (34 day supply) - \$100 family deductible maximum.
Inpatient Hospital	Covered Expenses paid at 80% after deductible. Requires precertification.	Covered Expenses paid at 80% after deductible. Requires precertification.
Outpatient Hospital	Covered Expenses paid at 80% after deductible.	Covered Expenses paid at 80% after deductible.
Emergency Treatment Facility	Covered Expenses paid at 80% after deductible.	Covered Expenses paid at 80% after deductible.
Outpatient Accident Benefit	Plan pays \$300/person/accident before you pay any deductible or coinsurance.	Plan pays \$300/person/accident before you pay any deductible or coinsurance.
Ambulance <i>(Medical Emergency Only)</i>	Covered Expenses paid at 80% after deductible. <i>(Medical Emergency Only)</i>	Covered Expenses paid at 80% after deductible. <i>(Medical Emergency Only)</i>

Using providers who do not have participating agreements with BCBSAZ may result in **out-of-pocket expenses** in excess of those stated. Prescription and other stated copayments do not apply to out-of-pocket maximum.

STATE OF ARIZONA -- ACTIVE EMPLOYEES

HEALTH INSURANCE ENROLLMENT BY PLAN AND COUNTY
OCTOBER, 1993

MEDICAL	COCHISE	COCONINO	MARICOPA	NAU*	PIMA	PINAL	RURAL	TOTAL	MEDICAL
SINGLE									SINGLE
INTERGROUP HMO	###	###	5,253	###	3,015	###	###	8,268	INTERGROUP HMO
INTERFLEX	###	###	410	###	162	###	###	572	INTERFLEX
CIGNA HMO	###	###	5,654	###	1,792	###	###	7,446	CIGNA HMO
CIGNA IPA HMO	###	###	1,798	###	###	###	###	1,798	CIGNA IPA HMO
BCBS PPO	27	###	###	###	###	47	###	74	BCBS PPO
BCBS HMO	289	41	###	###	###	603	775	1,708	BCBS HMO
BCBS INDEMNITY	###	243	###	570	###	###	447	1,260	BCBS INDEMNITY
TOTAL SINGLE	316	284	13,115	570	4,969	650	1,222	21,126	TOTAL SINGLE
FAMILY									FAMILY
INTERGROUP HMO	###	###	5,821	###	3,658	###	###	9,479	INTERGROUP HMO
INTERFLEX	###	###	235	###	128	###	###	363	INTERFLEX
CIGNA HMO	###	###	5,071	###	1,947	###	###	7,018	CIGNA HMO
CIGNA IPA HMO	###	###	1,244	###	###	###	###	1,244	CIGNA IPA HMO
BCBS PPO	30	###	###	###	###	58	###	88	BCBS PPO
BCBS HMO	589	94	###	###	###	988	1,535	3,206	BCBS HMO
BCBS INDEMNITY	###	361	###	1,337	###	###	610	2,308	BCBS INDEMNITY
TOTAL FAMILY	619	455	12,371	1,337	5,733	1,046	2,145	23,706	TOTAL FAMILY
MEDICAL GRAND TOTAL	935	739	25,486	1,907	10,702	1,696	3,367	44,832	MEDICAL GRAND TOTAL
								=====	
									DENTAL
							SINGLE	10,359	DELTA INDEMNITY
							SINGLE	11,893	AHP
								22,252	TOTAL SINGLE
							FAMILY	11,819	DELTA INDEMNITY
							FAMILY	11,890	AHP
								23,709	TOTAL FAMILY
								45,961	DENTAL GRAND TOTAL
								=====	

STATE OF ARIZONA

RETIREES
 MEDICAL/DENTAL ACTUAL ENROLLMENTS BY COUNTY AND PLAN
 OCTOBER, 1993

MEDICAL	SINGLE UNDER 65	SINGLE OVER 65	FAMILY UNDER 65	RET+SP OVER 65	FAMILY <65>	TOTAL
	=====	=====	=====	=====	=====	=====
MARICOPA COUNTY						
Intergroup HMO	166	109	96	40	56	467
Interflex	65	55	21	25	10	176
CIGNA Staff HMO	143	146	110	54	57	510
CIGNA IPA HMO	103	116	49	33	33	334
PIMA COUNTY						
Intergroup HMO	179	189	108	124	62	662
Interflex	17	26	11	16	10	80
CIGNA HMO	56	63	42	55	37	253
COCHISE COUNTY						
BCBS PPO	2	3	3	2	0	10
BCBS HMO	6	3	12	5	3	29
COCONINO COUNTY						
BCBS HMO	0	0	0	0	1	1
BCBS Indemnity	4	3	3	6	2	18
COCONINO CO-NAU						
BCBS Indemnity	45	30	51	35	46	207
PINAL COUNTY						
BCBS PPO	3	5	0	3	2	13
BCBS HMO	4	17	1	5	6	33
ALL OTHER COUNTIES						
BCBS HMO	22	23	3	12	9	69
BCBS Indemnity	29	70	12	32	22	165
	=====	=====	=====	=====	=====	=====
TOTAL MEDICAL	844	858	522	447	356	3027

RETIREES
MEDICAL/DENTAL ACTUAL ENROLLMENTS BY COUNTY AND PLAN
OCTOBER, 1993

DENTAL	SINGLE	FAMILY	TOTAL
DELTA	957	550	1507
AIIP	427	458	885
TOTAL DENTAL	1384	1008	2392

BENEFIT IMPROVEMENTS TO BCBSAZ PLANS
(ALL SAVINGS ARE ANNUAL AMOUNTS)

EFFECTIVE OCTOBER 1, 1993

ALL PLANS (HMO, PPO, INDEMNITY)

- o Remove \$50.00 deductible from prescription drug benefit.

Savings to Employee: \$ 50.00 Individual
\$100.00 Family

- o Add \$750.00 per ear hearing aid benefit.

Possible Savings to Employee and each family member:

\$750.00 to \$1,500.00

HMO PLAN

- o Removed co-payment from hospital confinement benefit and pay at 100%.

Possible Savings to Employee: \$1,000.00
Possible Savings to Family: \$2,000.00

INDEMNITY PLAN

- o Reduce deductible to \$150.00 per individual and \$300.00 per family.

- o Reduce co-payment base from first \$5,000.00 to first \$3,000.00.

Possible Savings in total out-of-pocket expenses to employee and family:

\$500.00 per employee/\$1,000 per family

PPO PLAN

- o Reduce PPO and Non-PPO deductibles by \$100 per employee and \$200 per family.

- o Reduce co-payment base from first \$5,000 to first \$3,000.

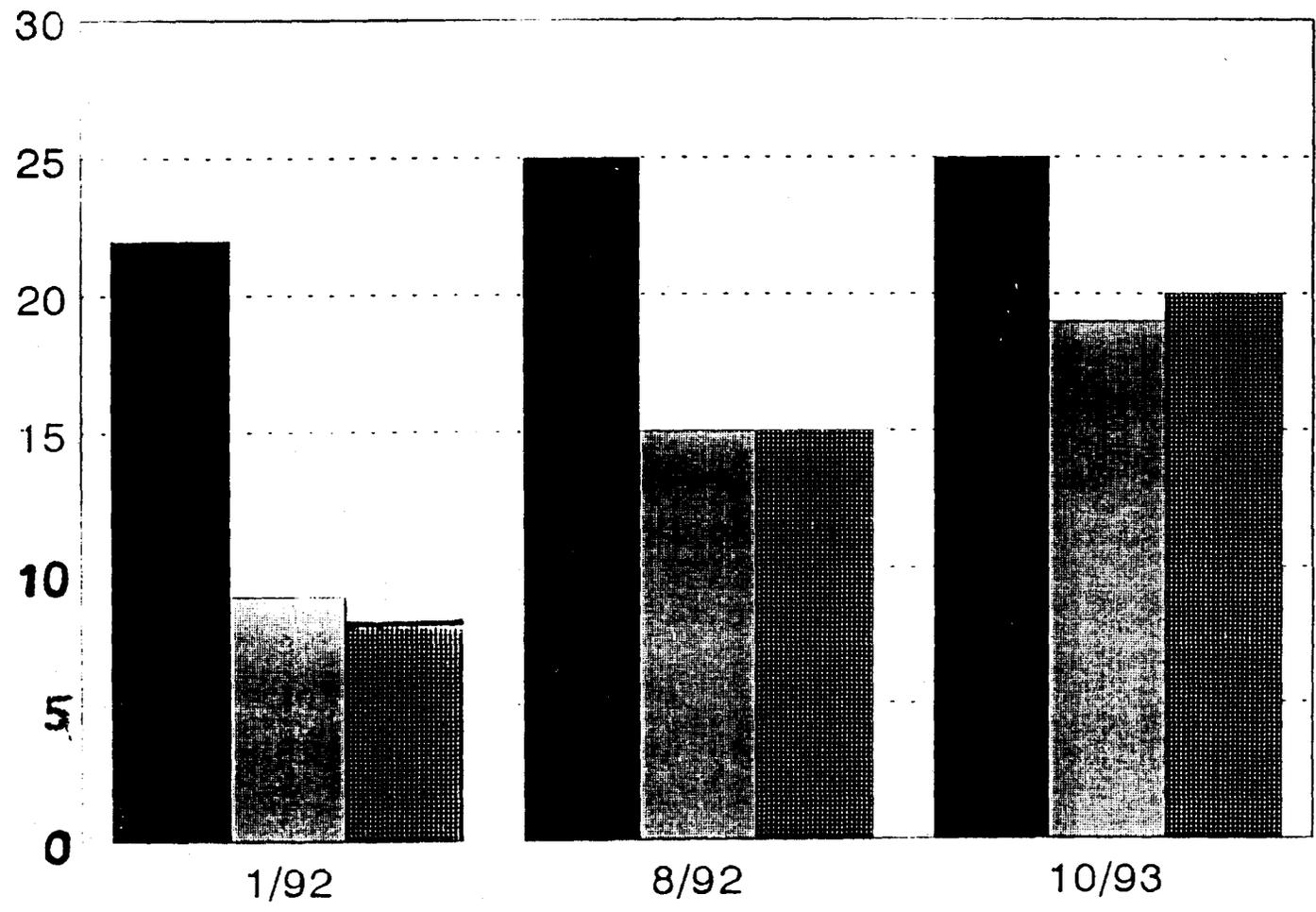
Possible PPO savings in total out-of-pocket expenses to employee and family:

\$500.00 per employee/\$1,000 per family

Number of Contracted Hospitals

Blue Cross Blue Shield of Arizona

[Servicing State Employees In 13 Counties]



*29 total statewide
20 now HMO w/ State*

Plan Type

- Indemnity
- PPO
- HMO

Blue Cross Blue Shield of Arizona Hospitals

Counties	Total Number of Hospitals ¹	Indemnity ²			PPO ³			HMO ⁴		
		1/92	8/92	10/93	1/92	8/92	10/93	1/92	8/92	10/93
Apache	2	1	2	2	1	1	1	1	1	1
Cochise	6	5	5	5	3	5	5	3	5	5
Coconino	3	2	2	2	1	1	1	1	1	1
Gila	2	2	2	2	1	1	1	1	1	1
Graham	1	1	1	1	1	1	1	0	1	1
Greenlee	0	0	0	0	0	0	0	0	0	0
La Paz	1	1	1	1	0	0	1	0	0	1
Mohave	4	3	4	4	2	2	3	2	2	3
Navajo	2	2	2	2	0	2	2	0	2	2
Pinal	3	2	2	2	0	2	2	0	2	2
Santa Cruz	1	1	1	1	0	0	1	0	0	1
Yavapai	2	1	2	2	0	0	1	0	0	1
Yuma	2	1	1	1	0	0	0	0	0	⁶ 1
Totals	29	22	25	25	9	15	19	8	15	20

¹ Total number of licensed hospitals with full facilities.

² Not offered to State employees who reside in Pinal or Cochise counties.

³ Offered only to State employees who reside in Pinal and Cochise counties.

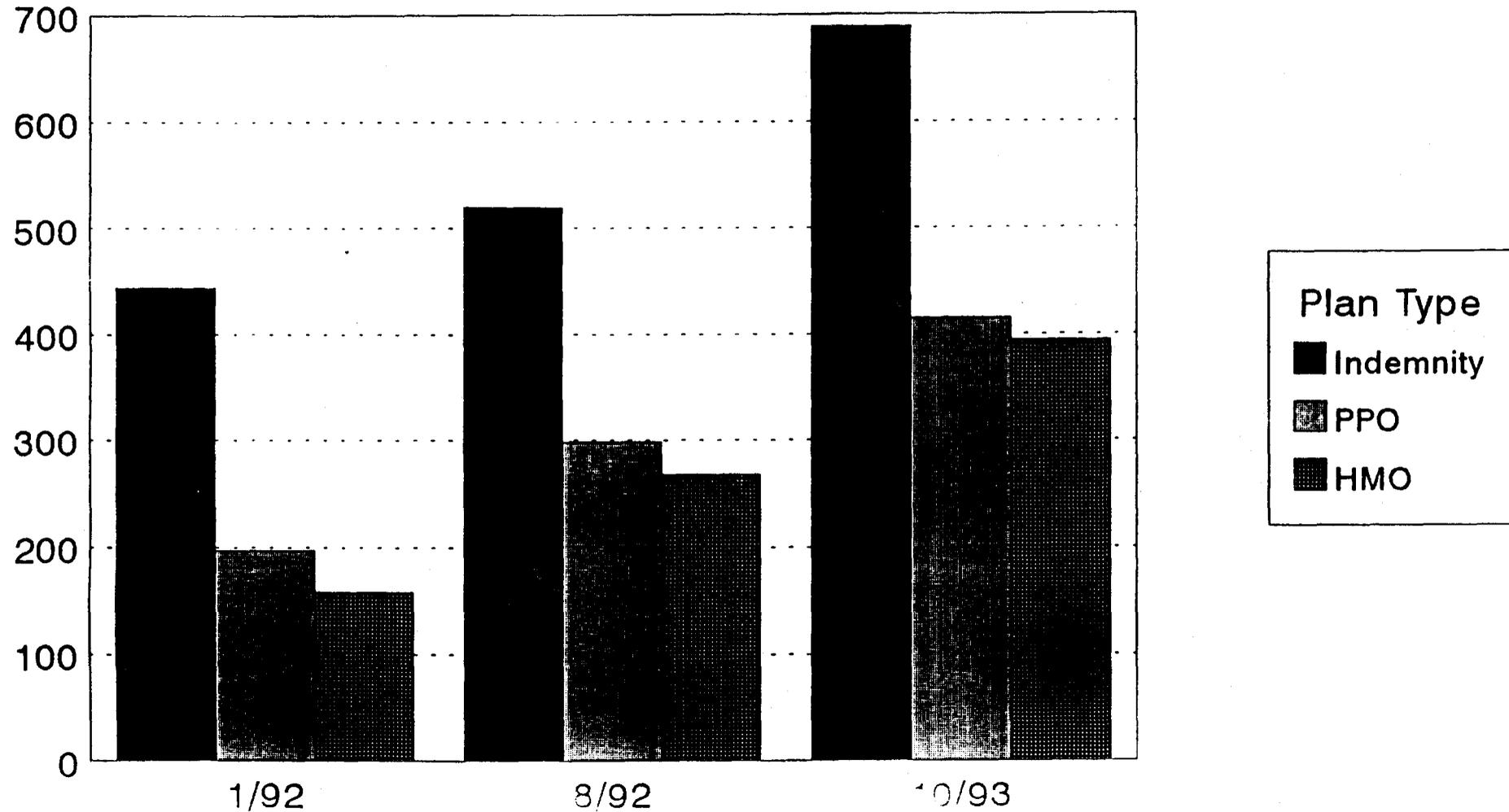
⁴ Offered to State employees in all or parts of all counties covered by the Blue Cross Blue Shield contract.

⁶ Yuma Medical Center is an HMO hospital to State employees only.

Number of Contracted Physicians

Blue Cross Blue Shield of Arizona

[In 13 Counties Servicing State Employees]



Blue Cross Blue Shield of Arizona Physicians

Counties	Total ¹ Number of Drs	Indemnity ²			PPO ³			HMO ⁴		
		1/92	8/92	10/93	1/92	8/92	10/93	1/92	8/92	10/93
Apache	17	5	5	9	4	4	8	0	4	8
Cochise	104	72	79	101	58	71	86	55	69	84
Coconino	168	65	81	112	10	18	25	2	14	20
Gila	53	38	38	49	15	22	32	15	22	32
Graham	29	13	14	28	5	11	18	4	11	18
Greenlee	5	4	4	4	4	4	4	4	4	4
La Paz	11	7	7	8	3	5	7	3	5	7
Mohave	115	46	62	78	17	40	53	9	28	52
Navajo	49	25	37	40	7	22	31	4	22	31
Pinal	100	57	67	86	37	48	64	32	45	61
Santa Cruz	31	24	26	27	23	25	23	18	23	21
Yavapai	132	32	39	71	4	10	32	2	6	32
Yuma	142	56	61	76	10	18	32	10	15	24
Totals	956	444	520	689	197	298	415	158	268	394

1. Total number of doctors (MDs + DOs) by county as of 11/5/93 as obtained from the State Medical Licensing Board.
The BCBS figures include approximately 7% duplication. (The physicians are listed by specialty; therefore, a physician with two specialties would be counted twice.)
2. Not offered to State employees who reside in Pinal or Cochise counties.
3. Offered only to State employees who reside in Pinal and Cochise counties.
4. Offered to State employees in all or parts of all counties covered by Blue Cross Blue Shield contract.

RETIREES
 MEDICAL/DENTAL ACTUAL ENROLLMENTS BY COUNTY AND PLAN
 OCTOBER, 1993

MEDICAL	SINGLE		SINGLE		FAMILY		RET+SP		FAMILY		TOTAL
	UNDER 65	PREMIUM	OVER 65	PREMIUM	UNDER 65	PREMIUM	OVER 65	PREMIUM	<65>	PREMIUM	
MARICOPA COUNTY											
Intergroup HMO	166	\$159.06	109	\$135.70	96	\$405.70	40	\$271.40	56	\$382.34	467
Interflex	65	\$215.32	55	\$135.70	21	\$550.96	25	\$271.40	10	\$471.34	176
CIGNA Staff HMO	143	\$208.34	146	\$177.00	110	\$456.58	54	\$352.10	57	\$425.24	510
CIGNA IPA HMO	103	\$270.76	116	\$229.96	49	\$590.72	33	\$458.02	33	\$549.92	334
PIMA COUNTY											
Intergroup HMO	179	\$150.60	189	\$135.70	108	\$375.78	124	\$271.40	62	\$360.88	662
Interflex	17	\$206.76	26	\$135.70	11	\$517.52	16	\$271.40	10	\$446.46	80
CIGNA HMO	56	\$188.20	63	\$159.92	42	\$411.42	55	\$317.94	37	\$383.14	253
COCHISE COUNTY											
BCBS PPO	2	\$296.36	3	\$83.98	3	\$592.70	2	\$167.94	0	\$380.32	10
BCBS HMO	6	\$296.36	3	\$83.98	12	\$592.70	5	\$167.94	3	\$380.32	29
COCONINO COUNTY											
BCBS HMO	0	\$328.22	0	\$83.98	0	\$656.46	0	\$167.94	1	\$412.20	1
BCBS Indemnity	4	\$328.22	3	\$83.98	3	\$656.46	6	\$167.94	2	\$412.20	18
COCONINO CO-NAU											
BCBS Indemnity	45	\$159.08	30	\$111.22	51	\$408.70	35	\$222.50	46	\$361.48	207
PINAL COUNTY											
BCBS PPO	3	\$328.22	5	\$83.98	0	\$656.46	3	\$167.94	2	\$412.20	13
BCBS HMO	4	\$328.22	17	\$83.98	1	\$656.46	5	\$167.94	6	\$412.20	33
ALL OTHER COUNTIES											
BCBS HMO	22	\$328.22	23	\$83.98	3	\$656.46	12	\$167.94	9	\$412.20	69
BCBS Indemnity	29	\$328.22	70	\$83.98	12	\$656.46	32	\$167.94	22	\$412.20	165
TOTAL MEDICAL	844		858		522		447		356		3027

NOTE: TOTAL PREMIUMS AS OF 10/1/93 BEFORE SUBSIDY

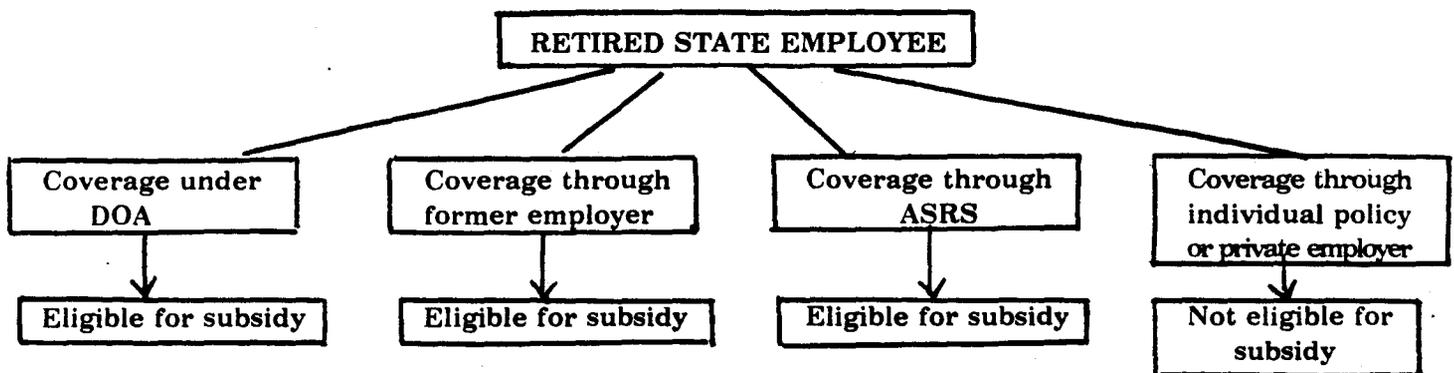
ATTACHMENT L

**Description/Historical Overview
of Retiree Health Insurance Coverage**

RETIREE HEALTH INSURANCE BENEFIT PROGRAM

Description:

The Retiree Health Insurance Premium Benefit Program is designed to assist retired and disabled members of ASRS, PSPRS, CORP and EORP with their health insurance premium costs. To be eligible for the subsidy amount, members must participate in the coverage authorized by ARS 38-651.01 and administered by DOA, be covered by their former employer's group health insurance or enroll in the retiree health insurance plan administered by ASRS on behalf of all four state retirement systems. (Currently, ASRS has contracted with FHP for coverage.) (Note: In 1992 the legislature authorized retirees under PSPRS who re-employ with an employer who participates in PSPRS to have their retiree health insurance premium subsidy amount applied towards their health insurance costs as an active employee.) The subsidy amount is applied to the member's health insurance costs and the member is responsible for any remaining balance.



Subsidy Amounts and Requirements:

ASRS: Arizona State Retirement System

- Premedicare eligible: \$95 individual coverage/\$80 dependent coverage
- Medicare eligible: \$65 individual coverage/\$50 dependent coverage
- 10 year service requirement for full subsidy
- Subsidy amounts prorated for members with 5-10 years service

CORP: Corrections Officer Retirement Plan

- Premedicare eligible: \$95 individual coverage/\$80 dependent coverage
- Medicare eligible: \$65 individual coverage/\$50 dependent coverage

PSPRS: Public Safety Personnel Retirement System

- \$60 individual coverage/\$25 dependent coverage

EORP: Elected Officials Retirement Plan

- \$60 individual coverage/\$25 dependent coverage
- 10 year service requirement for full subsidy
- Subsidy amounts prorated for members with 5-10 years service

MEMBERSHIP IN STATE RETIREMENT PLANS

ASRS - Arizona State Retirement System

Membership includes employees of:

- 1) the State (who do not participate in other state retirement plans)
(Note: State employees represent less than 1/3 of the ASRS employee members, about 27%)
- 2) political subdivisions, including: 214 school districts, 55 municipalities (Phoenix and Tucson are not participating employers), 14 counties (La Paz is not a participating employer), 12 special districts, 10 community college districts, and 3 state universities

PSPRS - Public Safety Personnel Retirement System

Membership includes:

- 1) municipal police officers
- 2) municipal fire fighters
- 3) paid full-time fire fighters employed directly by a fire district organized pursuant to ARS 48-803 with 5 or more full-time fire fighters, but not including fire fighters employed by a fire district pursuant to a contract with a corporation
- 4) State highway patrol officers
- 5) State fire fighters
- 6) county sheriffs and deputies
- 7) fish and game warden
- 8) fire fighters and police officers of a nonprofit corporation operating a public airport pursuant to ARS 2-311 and 2-312
- 9) police officers appointed by the Arizona board of regents
- 10) police officers appointed by a community college district governing board
- 11) state attorney general investigators who are certified peace officers
- 12) county attorney investigators who are certified peace officers
- 13) police officers who are employed by an Indian reservation police agency and are ALEOAC certified
- 14) fire fighters who are employed by an Indian reservation fire fighting agency.

(Note: State employees represent approx. 11% of PSPRS employees)

CORP - Corrections Officer Retirement Plan

Membership includes:

- 1) DOC Correctional Service Officers, State Correctional Program Officers and certain other designated positions within DOC
- 2) DYTR Youth Corrections Officers, Youth Program Officers and certain other designated positions within DYTR
- 3) county detention officers or nonuniformed employees of a sheriff's department whose primary duties require direct inmate contact
- 4) city/town detention officers

EORP - Elected Officials' Retirement Plan

Membership includes:

- 1) State elected officials
- 2) County elected officials
- 3) Elected officials of (15) incorporated cities and towns that have elected to participate in EORP
- 4) Judges of the Arizona supreme court, court of appeals, and superior court
- 5) Full-time superior court commissioners
- 6) Administrator of EORP's fund manager (EORP, CORP and PSPRS all have the same administrator for each system's fund manager)

RETIREE HEALTH INSURANCE BENEFIT PROGRAM

Historical Recap:

1988 - HB 2143 (Chapter 307) and SB 1235 (Chapter 277) were passed in lieu of an ad hoc COLA for ASRS retirees. Together, these bills established the Retiree Health Insurance Benefit Program for ASRS retirees and their dependents. The subsidy amounts were established as follows:
1) premedicare eligible: **\$95 individual coverage/\$80 dependent coverage;**
2) medicare eligible: **\$65 individual coverage/\$50 dependent coverage.** To be eligible for the subsidy payments, the retiree had to have at least 10 years of credited service and participate in coverage offered specifically for retirees through the State or other coverage provided by a participating employer of ASRS.

Additionally, SB 1159 (Chapter 331) was passed authorizing PSPRS's fund manager to pay \$35 per month toward health insurance coverage for PSPRS retirees. To be eligible for the subsidy amount, retirees had to participate in the coverage offered specifically for retirees through the State or other coverage provided by a participating employer of PSPRS.

1989 - SB 1129 (Chapter 310) amended and expanded the Retiree Health Insurance Benefit Program as follows:

ASRS: a) coverage was extended to surviving dependents

PSPRS: a) subsidy amount was increased from \$35 to \$60 per month
b) **a \$25 subsidy was added for dependent coverage**

SB 1129 also established a study committee to evaluate various issues affecting ASRS, including the retiree health insurance program. The Legislature had received numerous complaints about the program from retirees concerning: 1) program administration; 2) the 10 year service requirement; and 3) having to join the coverage offered by the State (if they were not enrolled under their former employer's group coverage).

Regarding issues #1 and #2: The study committee directed DOA and ASRS to determine among themselves how best to administer the program and recommended prorating the subsidy amounts to retirees with less than 10 but at least 5 years of credited service.

Regarding issue #3: Prior to creation of the study committee, the Legislature had received numerous requests to allow retirees to choose their own coverage yet still be eligible for the subsidy; that is, provide all retirees with a prescribed dollar amount/voucher to be applied towards the coverage of their choice. This discussion came up during drafting and deliberations on HB 2143/SB 1235 in 1988. At that time, it was determined to be in the State's best interest to require retirees to use the carrier selected by the State, or by their former employer, for the following reasons: 1) direct cash payments to retirees would be considered taxable income whereas paying the subsidy to a third party is a non-taxable event; 2) cost containment - deliberate "pooling" of retirees for the purpose of lower group rates; 3) maintain parity with active employees - actives don't get to "shop around" for the coverage of their choice; 4) accountability - difficult to ensure that a direct cash payment would in fact be used for health care costs; and 5) it was felt at the time the program would be easier to administer.

The study committee did not make any recommendations regarding the issue of retirees having to join the coverage offered by the State (if they were not enrolled in coverage through their former employer), primarily because: 1) the arguments against doing so were still valid; and 2) it was the general consensus of both persons making formal presentations to the committee and of retirees that the program was, after a problematic first year, in fact working well. (The committee received testimony about why so many problems arose during the first year. It was incorrectly assumed that the health insurance carriers covering active state employees would also willingly cover state retirees. This was not the case and DOA had to go out to bid at the last minute, thus causing a lot of misinformation and confusion. After better information was disseminated, concerns over retirees having to change insurance carriers in general, and about FHP in particular, had been mitigated.)

1990 -

HB 2192 (Chapter 235) prorated the health insurance subsidy amounts for individual and dependent coverage to ASRS retirees with between 5 and 10 years of credited service. Those with less than 5 years of credited service do not qualify for the subsidy.

Additionally, HB 2192 transferred administration of the retiree health insurance program from DOA to ASRS and provided for ASRS administration of the health insurance program for PSPRS as well. In time, ASRS would also administer the program for CORP, EORP and the other optional retirement programs authorized pursuant to law.

HB 2209 (Chapter 236) extended the retiree health insurance benefit program to members of EORP. Subsidy amounts were the same as those prescribed for PSPRS (\$60 and \$25 for dependent coverage). Retirees had to have at least 10 years of credited service to receive the full subsidy, but received a prorated amount for between 5 and 10 years of credited service. The retiree had to participate in the State's health insurance plan for retirees or other coverage provided by a participating employer under EORP.

HB 2669 (Chapter 272) extended the retiree health insurance benefit program to members of CORP. Subsidy amounts were prescribed the same as for those under ASRS (\$95 or \$65/\$80 or \$50) and the retiree had to participate in the State's health insurance plan for retirees or other coverage provided by a participating employer under CORP. Because CORP members have to have at least 10 years of credited service to retire, there was no 10 year service requirement prescribed, nor was the subsidy amounts prorated for less than 10 years of credited service.

1991 - No legislation was passed affecting the retiree health insurance benefit program.

1992 - HB 2117 (Chapter 228) contained a provision allowing PSPRS retirees who reemploy with the State or a participating employer under PSPRS to have their retiree health insurance subsidy amount applied toward their health insurance costs as an active employee.

Numerous bills were introduced to increase the prescribed subsidy amounts under the various retirement systems in response to increasing health care costs. None were passed.

During the interim, the legislature became aware of a change in policy on the part of DOA concerning retirees whereby DOA decided to "unblend" retirees from the active pool for the purpose of procuring health insurance. DOA based its decision on the following: 1) statutory interpretation; 2) an informal Attorney General's opinion; 3) cost containment considerations; and 4) maintaining parity with other state retirees. [Note: Unlike other state retirees who received health insurance coverage under the program administered by ASRS, retirees receiving coverage through DOA were having their health care costs subsidized twice: a) their state retirement system was paying the prescribed subsidy amount; and b) state active employees were reportedly paying approximately \$4.6 M more in premiums to offset retirees' higher health

insurance costs.] This change in policy resulted in substantially higher health insurance costs for state retirees receiving coverage and an outpouring of negative publicity with the call for legislative intervention.

1993 - Numerous proposals to increase the prescribed subsidy amounts were introduced, but were not passed by the Legislature.

SB 1277 (Chapter 176) created the Legislative Oversight Health Insurance Benefits Review Committee. Although the Committee is statutory and on-going, it was charged with studying and reporting on several issues before December 31, 1993, including the issue of "reblending" retirees with the active pool for the purpose of lowering retirees' health insurance costs. With respect to this issue, the Committee recommended "reblending" retirees with the active pool for the purpose of procuring health insurance coverage for state employees.

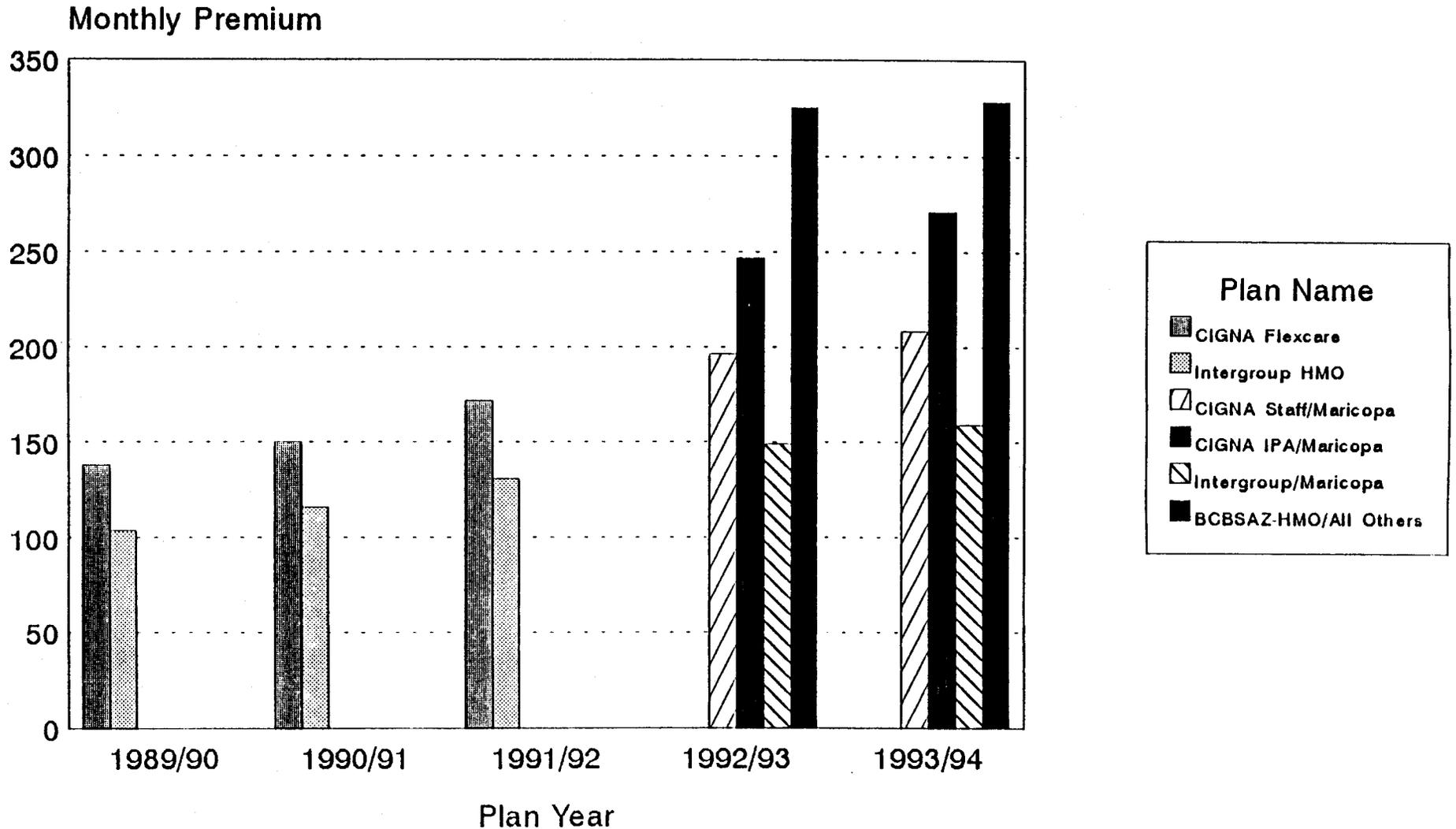
ATTACHMENT M

**DOA Materials Concerning Retiree
Health Insurance Coverage**

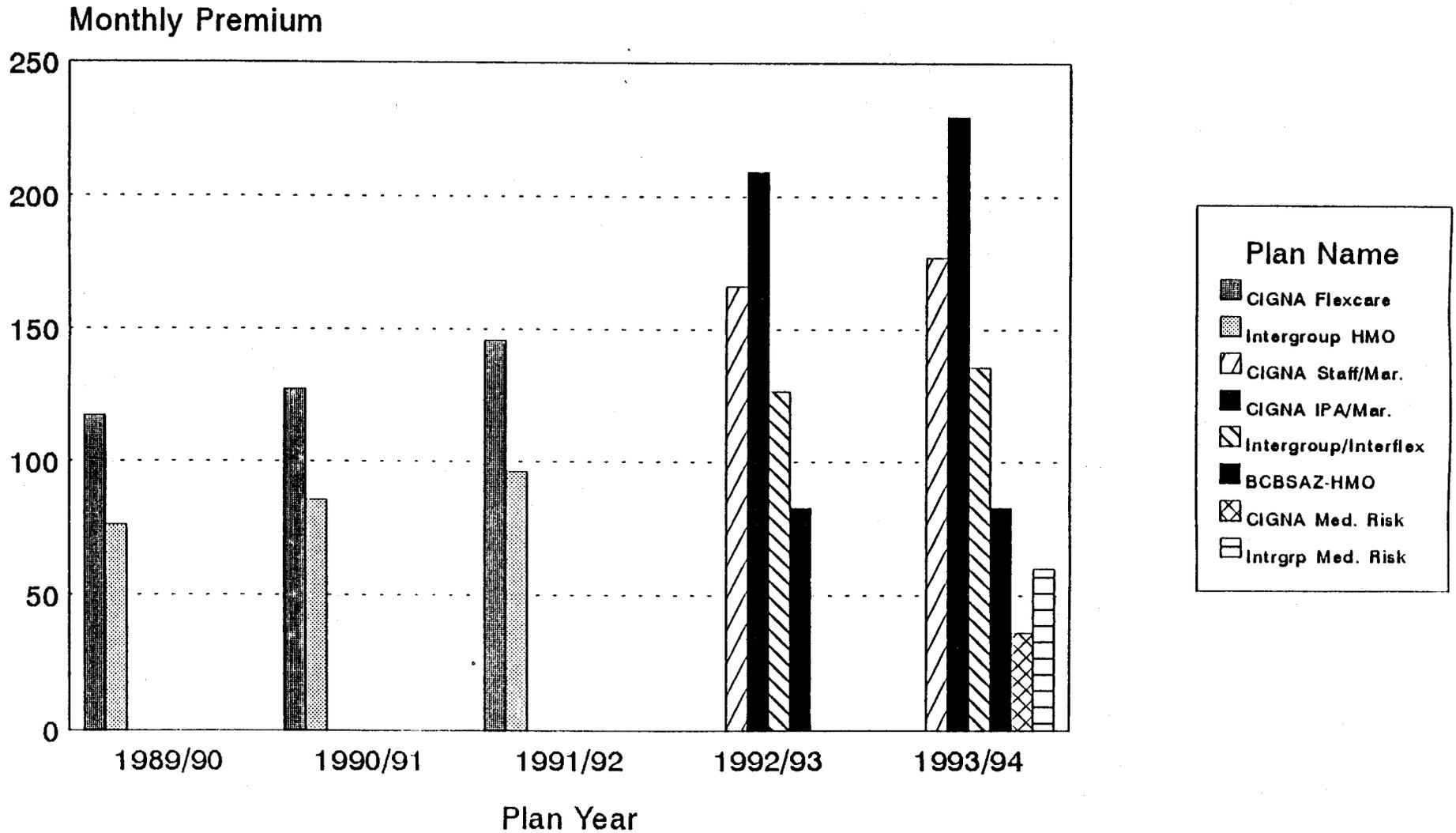
Retiree Only - Under 65

Health Insurance Cost Before Subsidy

HMO/POS



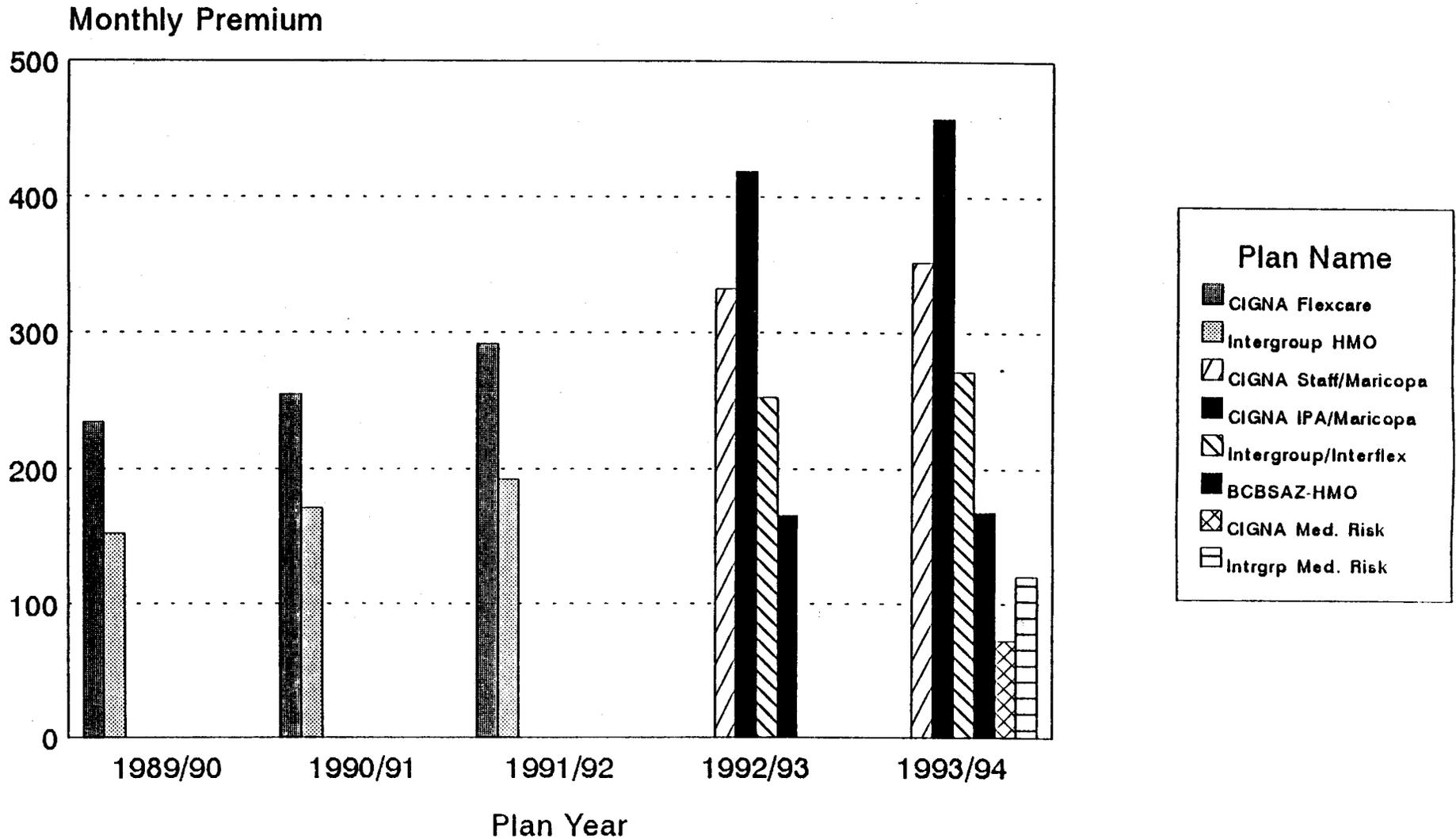
Retiree 65+ / Medicare Eligible Health Insurance Cost Before Subsidy HMO/POS



Retiree & Spouse - Over 65

Health Insurance Cost Before Subsidy

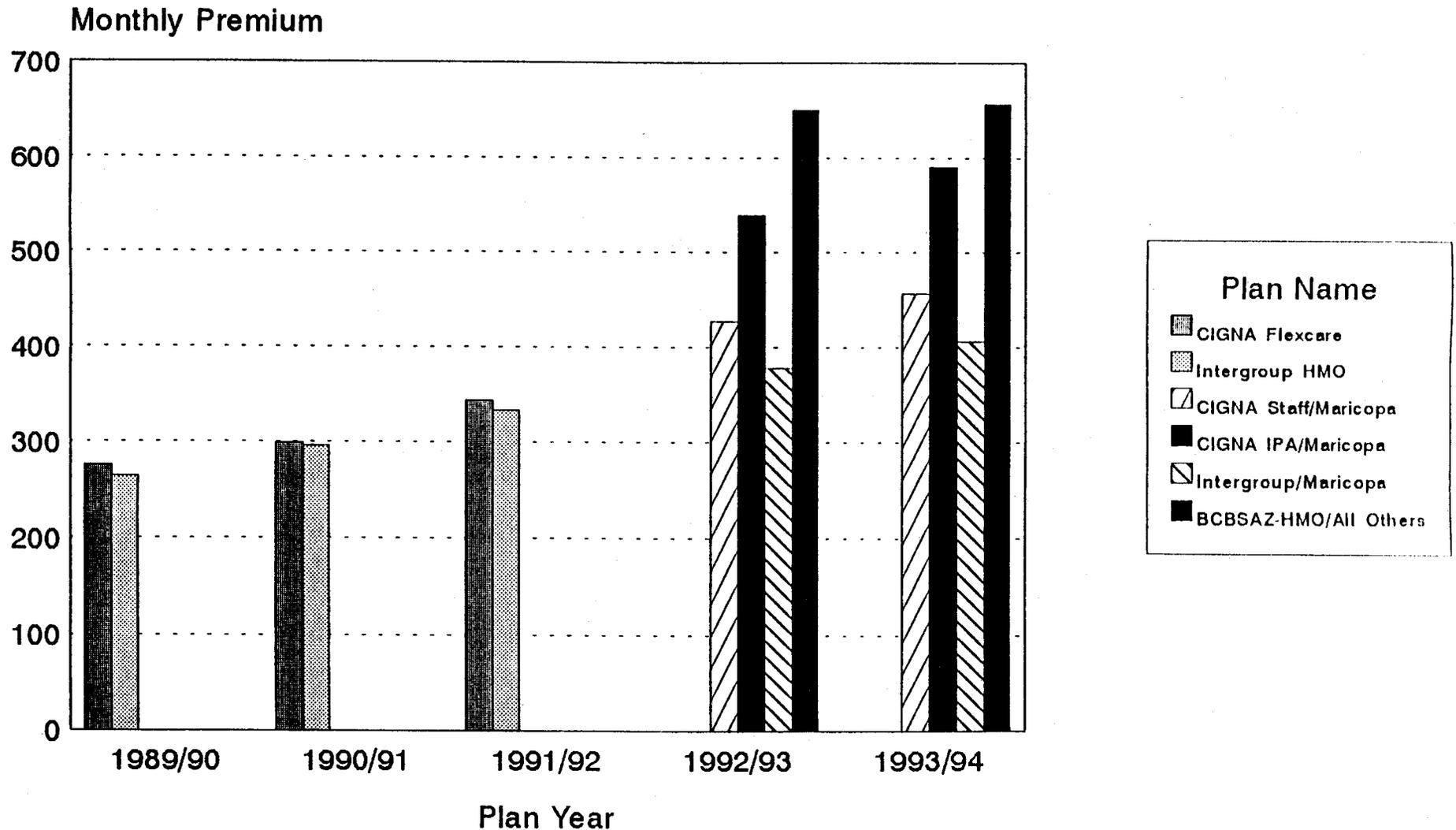
HMO/POS



Retiree & Dependents - Under 65

Health Insurance Cost Before Subsidy

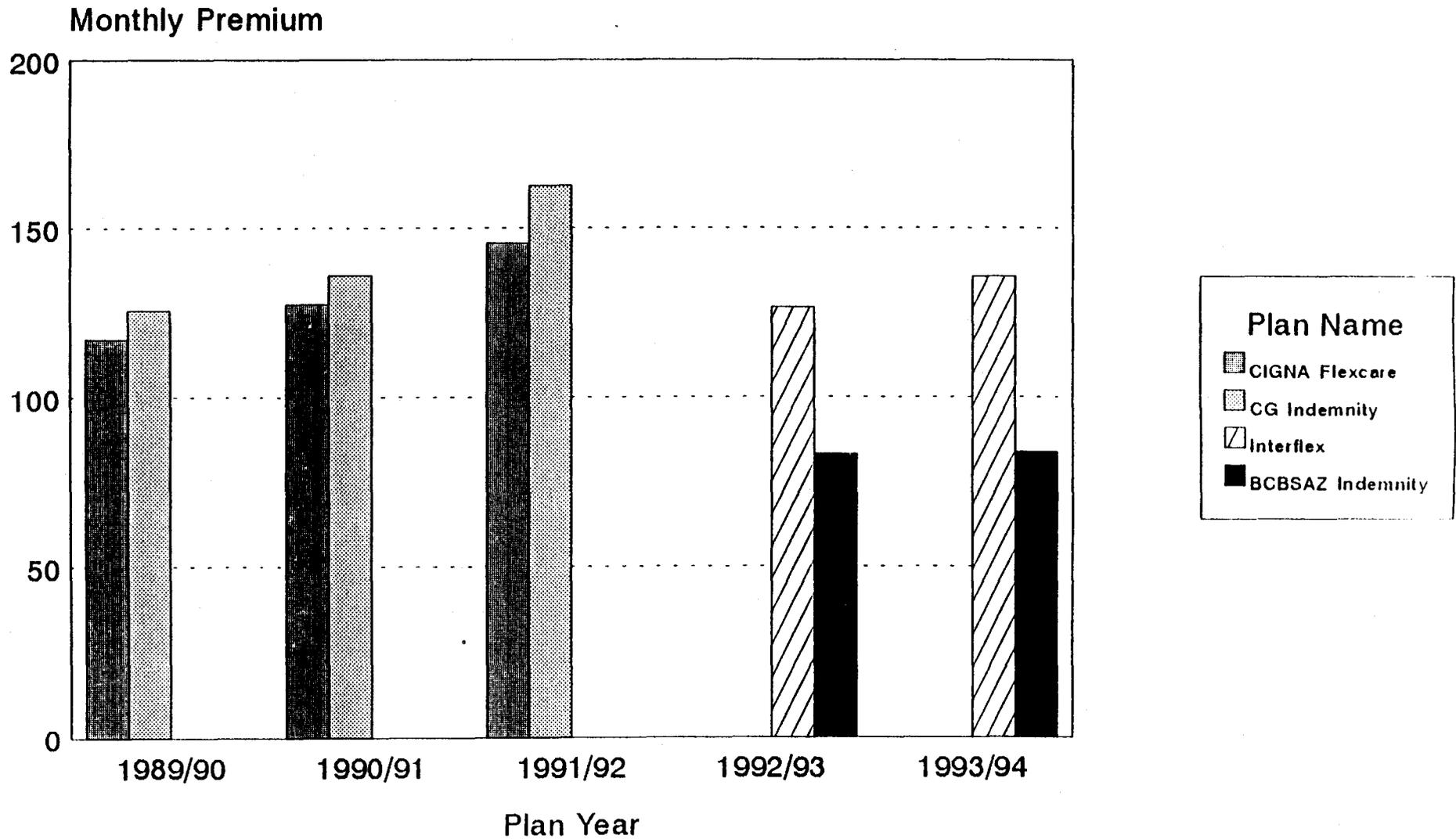
HMO/POS



Retiree Only - Over 65

Health Insurance Cost Before Subsidy

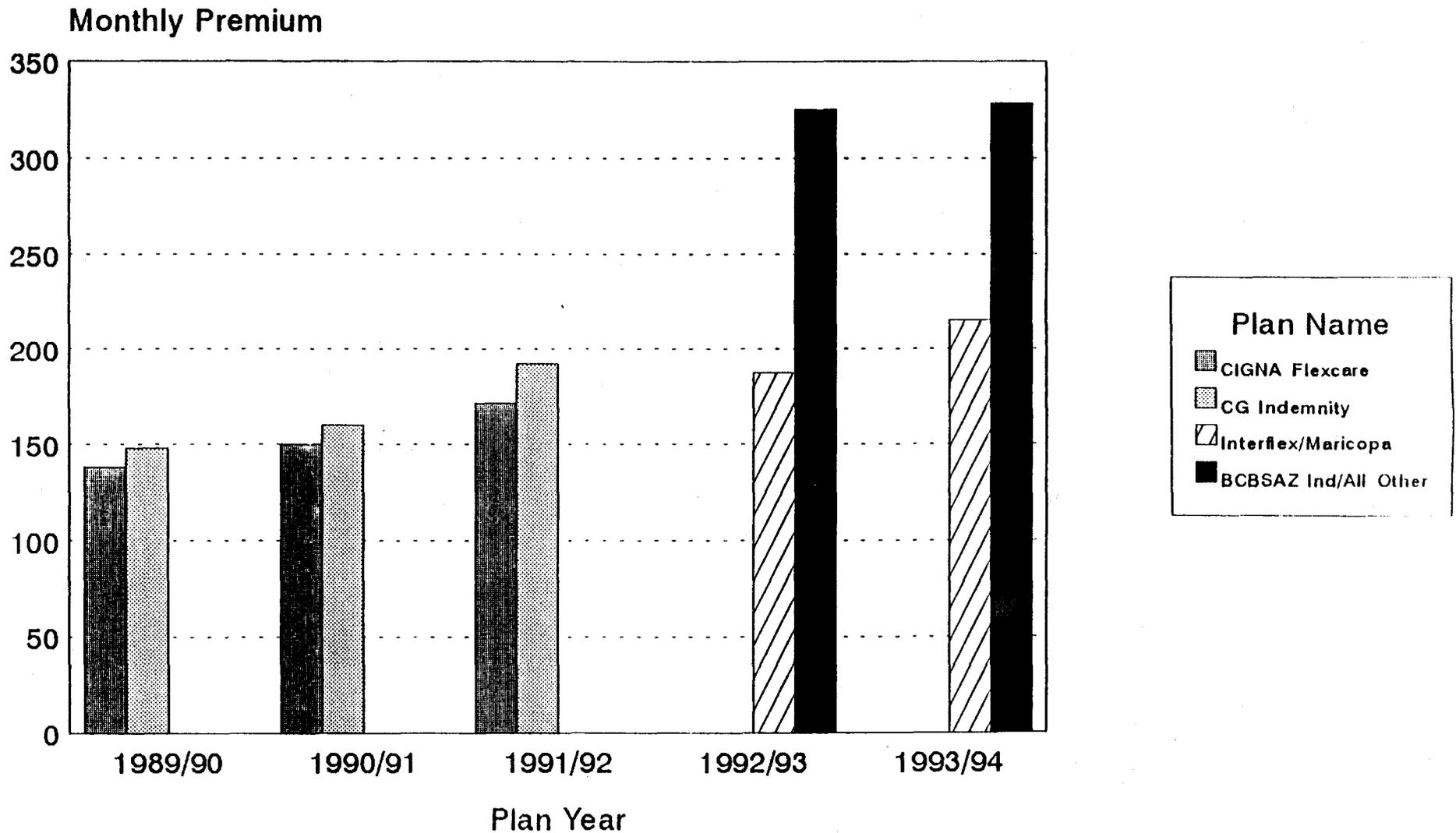
Indemnity/P.O.S.



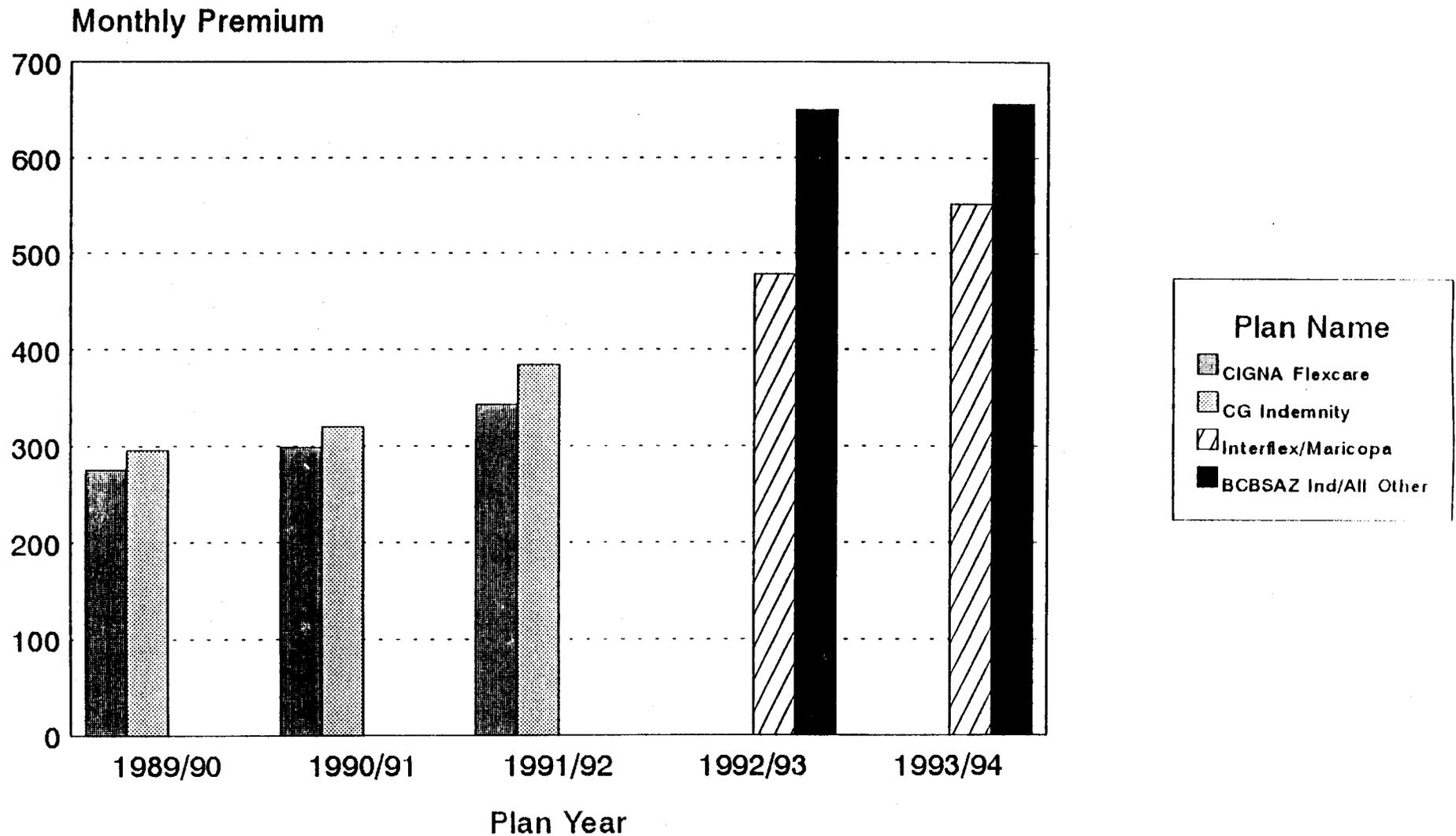
Retiree Only - Under 65

Health Insurance Cost Before Subsidy

Indemnity/P.O.S.



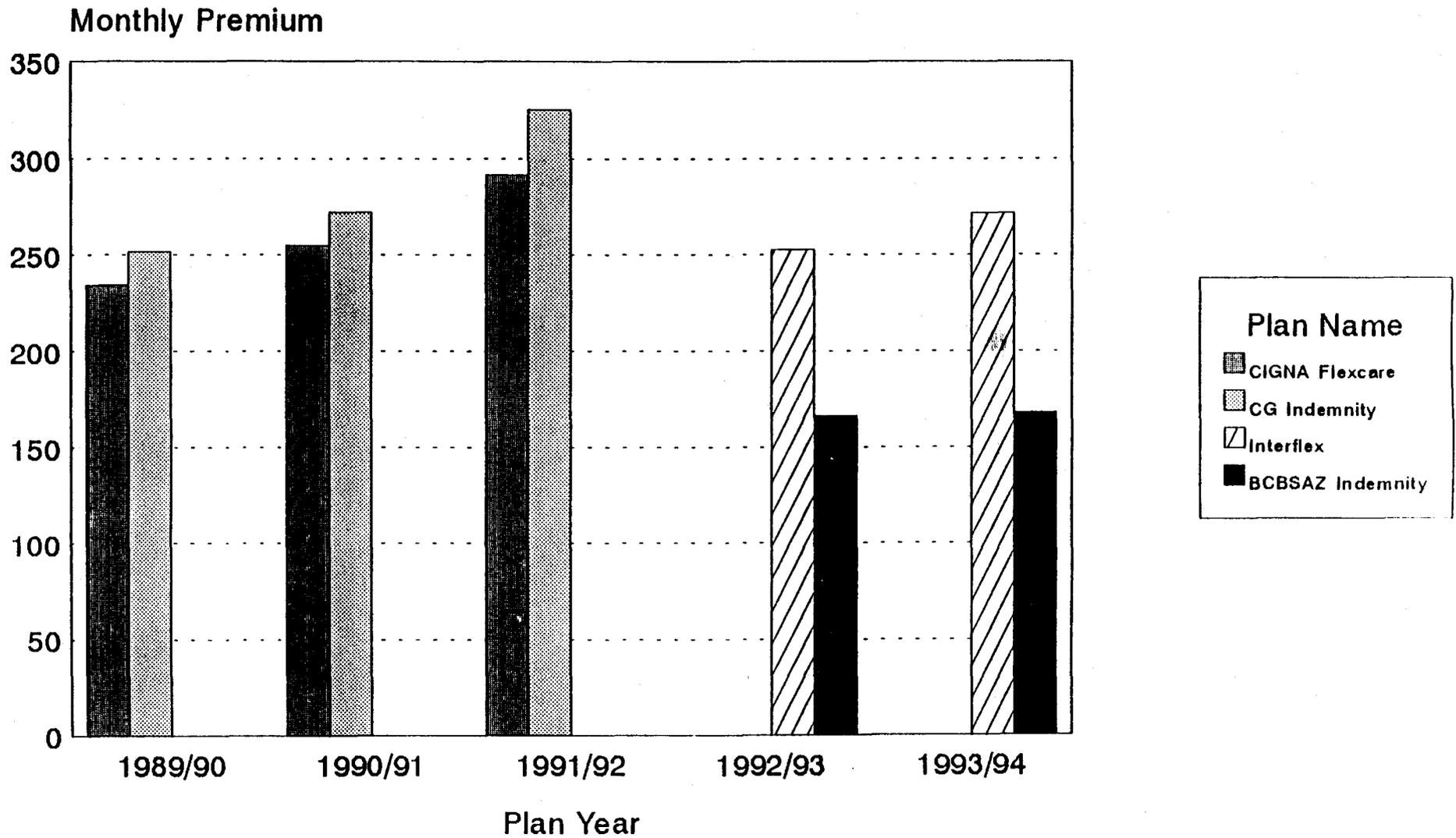
Retiree & Dependents - Under 65 Health Insurance Cost Before Subsidy Indemnity/P.O.S.



Retiree & Spouse - Over 65

Health Insurance Cost Before Subsidy

Indemnity/P.O.S.



**MARICOPA COUNTY
EFFECTIVE 10-1-93
(EXCEPT FHP IS EFFECTIVE 1-1-94)**

	RETIREE ONLY HAS MEDICARE	RETIREE + SPOUSE BOTH HAVE MEDICARE	RETIREE + SPOUSE ONE HAS MEDICARE	RETIREE OR SPOUSE HAS MEDICARE + DEPENDENTS
MEDICARE SUPPLEMENT				
INTERGROUP HMO	\$135.70	\$271.40	\$294.76	\$382.34
INTERFLEX	\$135.70	\$271.40	\$351.02	\$471.34
CIGNA STAFF HMO	\$177.00	\$352.10	\$383.44	\$425.24
CIGNA IPA HMO	\$229.96	\$458.02	\$498.82	\$549.92
ASRS - FHP INDEMNITY	\$138.04	\$277.48	\$516.78	\$516.78
SENIOR CARE PLAN				
INTERGROUP HMO	\$ 60.00	\$120.00	\$219.06	\$306.64
CIGNA STAFF HMO	\$ 36.00	\$ 72.00	\$284.24	\$408.36
ASRS - FHP GOLDEN HMO	\$ 65.00	\$130.00	\$344.64	\$344.64

**PIMA COUNTY
EFFECTIVE 10-1-93
(EXCEPT FHP IS EFFECTIVE 1-1-94)**

	RETIREE ONLY HAS MEDICARE	RETIREE + SPOUSE BOTH HAVE MEDICARE	RETIREE + SPOUSE ONE HAS MEDICARE	RETIREE OR SPOUSE HAS MEDICARE + DEPENDENTS
MEDICARE SUPPLEMENT				
INTERGROUP HMO	\$135.70	\$271.40	\$286.30	\$360.88
INTERFLEX	\$135.70	\$271.40	\$342.46	\$446.46
CIGNA STAFF HMO	\$159.92	\$317.94	\$346.22	\$383.14
ASRS - FHP INDEMNITY	\$138.04	\$277.48	\$516.78	\$516.78
SENIOR CARE PLAN				
INTERGROUP HMO	\$ 60.00	\$120.00	\$210.60	\$285.18
CIGNA STAFF HMO	NOT AVAILABLE UNTIL AFTER 2-1-94.			
ASRS - FHP GOLDEN HMO	\$ 65.00	\$130.00	\$344.64	\$344.64

**RURAL COUNTIES
EFFECTIVE 10-1-93
(EXCEPT FHP IS EFFECTIVE 1-1-94)**

	RETIREE ONLY HAS MEDICARE	RETIREE + SPOUSE BOTH HAVE MEDICARE	RETIREE + SPOUSE ONE HAS MEDICARE	RETIREE OR SPOUSE HAS MEDICARE + DEPENDENTS
MEDICARE SUPPLEMENT				
BC/BS HMO/PPO-COCHISE	\$ 83.98	\$167.94	\$380.32	\$380.32
BCBS HMO/PPO/INDEMNITY	\$ 83.98	\$167.94	\$412.20	\$412.20
ASRS - FHP INDEMNITY	\$120.04	\$241.29	\$449.37	\$449.37
SENIOR CARE PLAN				
BCBS	NOT AVAILABLE UNTIL AFTER 2/1/94.			
ASRS - FHP GOLDEN HMO	NO NETWORKS AVAILABLE.			

ATTACHMENT N

**Letter Requesting Attorney General's
Opinion Regarding Reblending Issue**

MAJORITY LEADER

BRENDA BURNS
1700 WEST WASHINGTON
PHOENIX, ARIZONA 85007
CAPITOL PHONE: (602) 542-3255
HOME PHONE: (602) 872-1297

DISTRICT 17



COMMITTEES:
ECONOMIC DEVELOPMENT,
INTERNATIONAL TRADE & TOURISM
WAYS & MEANS
LEGISLATIVE COUNCIL
JOINT COMMITTEE ON CAPITAL
REVIEW
JOINT LEGISLATIVE BUDGET
COMMITTEE
JOINT LEGISLATIVE TAX
COMMITTEE

Arizona House of Representatives
Phoenix, Arizona 85007

December 7, 1993

Mr. Grant Woods, Attorney General
1275 W. Washington
Phoenix, AZ 85007

Dear Attorney General Woods:

Pursuant to Laws 1993, Chapter 176, the Legislative Oversight Health Insurance Benefits Review Committee is charged with considering issues concerning state employee medical and dental insurance coverage, including issues relating to the size of the risk pool and the type of coverage provided to state employees. In addition, the Committee is to examine and report on specific issues, one of which is the feasibility of grouping former state employees with current state employees for purposes of obtaining health and accident insurance coverage at favorable rates.

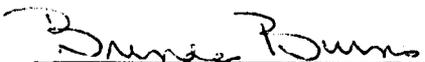
The Committee has conducted two meetings, October 28 and November 30, 1993, and has recommended that the former employees and their dependents be rebled with the active employees and their dependents for insurance coverage purposes.

The Department of Administration (DOA) indicated that your office worked with the Department, providing verbal advice regarding the separation of the two employee pools during the 1992 carrier selection process. Assistant Attorney General Graham A. Turner furnished two letters detailing the advice given to the Department (copies attached), indicating they did not constitute a formal opinion.

The Legislative Oversight Health Insurance Benefits Review Committee requests the Attorney General's office to prepare a formal opinion addressing the following questions:

1. Does A.R.S. Sec. 38-651.01 require the Department of Administration to solicit separate premiums for active employee coverage and retired employee coverage from potential group health insurance providers?
2. If legislation is passed mandating the rebleding of the two groups, would the issue of Constitutionality be raised, specifically as it relates to Article 9, Section 7?

The Committee appreciates your assistance in this matter. Please address your response to our offices.


Representative Brenda Burns,
Co-Chair


Senator Carol Springer,
Acting Co-Chair

Attachment



STATE OF ARIZONA

OFFICE OF THE ATTORNEY GENERAL

GRANT WOODS
ATTORNEY GENERAL

1275 WEST WASHINGTON, PHOENIX 85007

MAIN PHONE: 542-5025
TELECOPIER: 542-4085

August 5, 1992

William Bell
Assistant Director, Personnel Division
Arizona Department of Administration
1831 West Jefferson Street
Phoenix, Arizona 85007

Re: Procurement of Group Health Insurance Coverage For Active
And Retired State Employees

Dear Mr. Bell:

Pursuant to your request, this letter is to confirm verbal advice previously given to you, regarding two issues relating to the procurement of group health insurance coverage for active and retired State employees.

First, you have asked whether it is proper for the Department of Administration to require an employee upon retirement to make a one-time election to maintain coverage under the Department's group health insurance. A review of the statute governing the Department's provision of health insurance to retired employees, A.R.S. Sec. 38-651.01, discloses that such an election is required.

A.R.S. Sec. 38-651.01(A) provides:

The department of administration shall, by rule, adopt standards to establish group health and accident coverage for former employees who worked for the state of Arizona and who opt upon retirement to enroll or continue enrollment in the group health and accident coverage for active employees. . . [Emphasis added.]

The statute clearly provides that an employee must "opt upon retirement" to maintain coverage in the Department's group health insurance. The statute does not contain any language authorizing a retired employee to later change this election.

Further, it should be noted that the version of A.R.S. Sec. 38-651.01 in effect prior to a 1990 amendment did not contain any language requiring an employee to make a choice of insurance coverage upon retirement. The later addition of language requiring an employee to "opt upon retirement" is strong evidence

William Bell
August 5, 1992
Page 2.

of a specific legislative intent that such a choice be made. (A copy of the previous version of A.R.S. Sec. 38-651.01 is enclosed for your referenca.)

Your second question is whether the Department should require that potential providers of group health insurance coverage bid separate premiums for active employee coverage and retired employee coverage. It is my view that, in order to carry out the mandates of A.R.S. Sec. 38-651.01, separate premiums should be obtained.

A.R.S. Sec. 38-651.01(I) provides:

No public funds shall be expended to pay all or any part of the premium of such insurance pursuant to this section. . . [Emphasis added.]

It would appear that this mandate could only be met if separate premiums are bid. Insurance premiums are in large part dependant upon the anticipated amount of claims; it is therefore possible that the premium for retired employees would be different than that for active employees. Requesting a single premium encompassing both groups could result in an averaging, or "blending," of potentially different rates for each group, with one group in effect subsidizing the other. Because public funds pay a portion of the premium for active employees pursuant to A.R.S. Sec. 38-651, in an instance where the premium for retired employees is higher than that of active employees, "blending" both into a single premium could violate A.R.S. Sec. 38-651.01(I). Requiring separate premium amounts for active and retired employees carries an assurance that no part of the retired employee premium is paid with public funds.

As you know, this advice is furnished only for internal agency guidance, and does not constitute a formal Opinion of the Attorney General. Should you deem it advisable, this office would be happy to consider a request for a formal Opinion.

Sincerely,


GRAHAM ALEX TURNER
Assistant Attorney General
Unit Chief, Procurement Law Section

CC:
James M. Howard
Chief Counsel, Civil Division

GAT/ms



STATE OF ARIZONA

OFFICE OF THE ATTORNEY GENERAL

1275 WEST WASHINGTON, PHOENIX 85007

GRANT WOODS
ATTORNEY GENERAL

MAIN PHONE : 542-5025
TELECOPIER : 542-4085

February 25, 1993

William Bell
Assistant Director, Personnel Division
Arizona Department of Administration
1831 West Jefferson Street
Phoenix, Arizona 85007

Re: Procurement of Group Health Insurance For Active And
Retired Public Employees

Dear Mr. Bell:

Pursuant to your request, this is to supplement the matters discussed in my August 5, 1993 letter to you, regarding the procurement of group health insurance coverage for active and retired public employees. A copy of my previous letter is attached for your reference. Specifically, you have inquired whether the Legislature has the ability to statutorily provide for the "blending" of active and retired employee health insurance premiums.

A.R.S. § 38-651.01(I) currently provides that no public funds may be expended to pay "all or any part of the premium" of any insurance provided to a retired employee. As stated in my previous letter, it was my view that this mandate could only be met if separate premiums were bid. As insurance premiums are in large part dependant upon the anticipated amount of claims, averaging or "blending" the premiums of the active employee group with the retired employee group could result in one group subsidizing the other. Since public funds pay a portion of the premium for active employees pursuant to A.R.S. § 38-651, in an instance where the premium for retired employees is higher than that of active

employees, blending both into a single premium could violate A.R.S. § 38-651.01(I). Indeed, I have been informed by Wyatt & Company, the State's health insurance consultant, that last year the blending of premiums resulted in an estimated \$4,600,000 subsidy of the retired employee group by the active employee group.

The Legislature could mandate the blending of the active and retired employee insurance premiums. It is possible, however, that such a statute would raise the issue of constitutionality. Article 9, Section 7 of the Arizona Constitution prohibits the State from making "any donation or grant, by subsidy or otherwise, to any individual." Under this provision, public funds may be expended only for purposes benefiting the public at large, and cannot be used to foster or promote purely private or personal interests of any individual. Wistuber v. Paradise Valley Unified School Dist., 141 Ariz. 346 (1984); Town of Gila Bend v. Walled Lake Door Co., 107 Ariz. 545 (1971). The State may part with its funds only by agreement and for valuable consideration. Yeazell v. Coons, 98 Ariz. 109 (1965). The question would be whether there is a sufficient public benefit to be derived from subsidizing health insurance for retired state employees.

The provision of active employee benefits, such as subsidized health insurance, annual and sick leave, and contributions to a retirement plan, is viewed as part of the State's contract with the employee. It is part of the "salary package" paid to the employee in consideration for his services. It is my understanding that an employee's promised compensation has never included insurance after retirement subsidized by the State's General Fund. Consequently, the argument can be made that as retired employees have already been fully compensated for their services, an insurance subsidy could constitute a gift of public funds.

On the other hand, it can be argued that a benefit to the public at large results from adequate health care insurance for retired government workers. Without such coverage some retired government workers would have to rely on direct government sources (welfare) for health care costs. This might be more expensive than insurance costs. It could also be said that failure to provide adequate insurance might make it more difficult to retain government workers until retirement age.

I hope the foregoing has been of assistance to you. Please feel free to contact me should you wish to discuss this matter further. As you know, this advice is furnished only for internal

agency guidance and is subject to attorney-client privilege; this does not constitute a formal Opinion of the Attorney General. Should you deem it advisable, this office would be happy to consider a request for a formal Opinion.

Sincerely,


GRAHAM A. TURNER
Unit Chief, Procurement and
Contract Law
Administrative Law Section

GAT/ict

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