EXHIBIT 29

Message

From: Scott Bender [Scott.Bender@azdoa.gov]
on behalf of Scott Bender <Scott.Bender@azdoa.gov> [Scott.Bender@azdoa.gov]
Sent: 6/8/2016 7:08:11 PM
To: Marie Isaacson [Marie.Isaacson@azdoa.gov]
Subject: FW: Final Rule on Nondiscrimination in Health Programs and Activities

From: Emmons, Erica 654 [mailto:Erica.Emmons@Cigna.com]
Sent: Wednesday, May 18, 2016 9:56 AM
To: Amanda Accatino <Amanda.Accatino@azdoa.gov>; Elizabeth Schafer <Elizabeth.Schafer@azdoa.gov>; Kelly Sharritts <Kelly.Sharritts@azdoa.gov>; Michael Meisner <Michael.Meisner@azdoa.gov>; Rose Bernal <Rose.Bernal@azdoa.gov>; Scott Bender <Scott.Bender@azdoa.gov>; Yvette Medina <Yvette.Medina@azdoa.gov>
Cc: Maddalena, Diana M 646 <Diana.Maddalena@Cigna.com>
Subject: Final Rule on Nondiscrimination in Health Programs and Activities

Cigna.

INFORMED ON REFORM

KEEPING YOU UP-TO-DATE ON THE PPACA

Health Care Reform Alert

May 17, 2016

Final Rule on Nondiscrimination in Health Programs and Activities

On May 13, the Department of Health and Human Services (HHS), and specifically the Office of Civil Rights (OCR), issued a final rule on nondiscrimination in health programs and activities under Section 1557 of the Affordable Care Act (ACA). This section of the ACA serves protected classes of individuals whose health coverage may not be denied, cancelled, limited or refused on the basis of race, color, national origin, sex, age, or disability. The final rule clarifies existing nondiscrimination requirements, and sets new implementation standards for Section 1557.

This rule is effective July 18, 2016. However, health plans that require changes in benefits design are required to comply on the first day of the plan or policy year beginning on or after January 1, 2017.

The broad application of this final rule will affect the federal and state Marketplaces, all health care providers and health insurance issuers and employers that receive federal

financial assistance. Financial assistance from HHS includes Medicare Part A, student health plans, advanced premium tax credits and many other programs.

The final rule is broad in scope. Any entity that is subject to the nondiscrimination requirements must also ensure that its own employer-sponsored plans are compliant.

Key provisions and clarifications in the final rules include:

- **Expanded protection for transgender individuals**

Insurers and group health plans cannot limit accessibility to health services typically or exclusively available to one gender. In other words, certain services cannot be denied or limited due to an individual's sex assigned at birth, gender identity, or recorded gender. With that, plans are not required to cover any specific item or service.

- **Required language assistance**

Insurers, employers and other entities sponsoring group health plans must provide nondiscrimination notices and "taglines" to their employees and the general public that explain how individuals can obtain language services. These notices must be provided in at least the top 15 non-English languages spoken in a given state, and must be made available on physical premises, on the web and in significant documents, such as a Summary of Benefits and Coverage (SBC).

Sample tagline provided in regulations: ATTENTION: If you speak [insert language], language assistance services, free of charge, are available to you. Call 1-xxx-xxx-xxxx (TTY: 1-xxx-xxx-xxxx).

- **Communication assistance for individuals with disabilities**

Notices must also be readily available for individuals and the general public that confirm how individuals with disabilities can receive auxiliary aids and communication services without charge and in a timely manner. These services include qualified interpreters and information in alternate formats, to ensure equal participation opportunity.

- **Application to administrative services only (ASO) self-insured employer plans** Complaints that involve self-insured plans will be reviewed on a case-by-case basis to determine liability for discriminatory activity between the employer, insurer and/or third party administrators. Third party administrators of self-insured plans will generally be liable only for their own discriminatory actions, such as discriminatory denial of claim. This is in contrast to insured plans, where insurers are liable for any discriminatory benefit design. As a result, benefits design changes in both types of plans may be appropriate to ensure compliance with the final rule.

Expatriate Plans

The final regulations confirm that Section 1557 of the ACA and the final rule do not apply to expatriate health plans, expatriate health insurance issuers, or employer plan sponsors of expatriate plans, as defined in the Expatriate Health Coverage Clarification Act (EHCCA).

Reference Materials

HHS has established a web page with links to their press release, fact sheets, sample notices and FAQs.

We encourage you to bookmark Cigna's health care reform website, www.InformedonReform.com, where we continuously update information as it becomes available.

Together, all the way.®

This document is for general informational purposes only. While we have attempted to provide current, accurate and clearly expressed information, this information is provided "as is" and Cigna makes no representations or warranties regarding its accuracy or completeness. The information provided should not be construed as legal or tax advice or as a recommendation of any kind. External users should seek professional advice from their own attorneys and tax and benefit plan advisers with respect to their individual circumstances and needs.

Erica Emmons | Strategic Account Executive | Government and Education | Cigna | 5310 East High Street, Suite 200 | Phoenix, AZ 85054 | Direct: 480.426.6761 | Mobile: 480.622.0899 | erica.emmons@cigna.com

EXHIBIT 30 LODGED UNDER SEAL

EXHIBIT 31

Message

From: Leslie Feldman [Leslie.Feldman@azdoa.gov]
on behalf of Leslie Feldman <Leslie.Feldman@azdoa.gov> [Leslie.Feldman@azdoa.gov]
Sent: 10/14/2016 10:13:51 AM
To: Yvette Medina [Yvette.Medina@azdoa.gov]
Subject: Medical Director's
Attachments: Med Dir Mtg Minutes 10.13.16_draft.docx

Please see attached.

Leslie Feldman, PHR
Plan Administrator
ADOA – Benefit Services Division | State of Arizona
100 North 15th Avenue, Suite 260, Phoenix AZ 85007
p: 602.542.4320 | f: 602.542.4048 | leslie.feldman@azdoa.gov

Arizona Department of Administration

Benefit Services Division

Medical Directors Meeting

ADOA First Floor Conference Room

September 29, 2016

1:30 pm - 3:30 pm

MINUTES

Invitees:	**State of Arizona** Marie Isaacson Scott Bender Yvette Medina Michael Meisner Monika Luksikova-Hickcox Rose Bernal Kayla Stivason Amanda Accatino Nickie Schultz Leslie Feldman	**Aetna** Dr. Jim Krominga Ray Eveleth	**BCBSAZ** Dr. James Napoli Ken Muth Sharon Tucker	**CIGNA** Dr. Rudolph Cane Wilson Rodgers Erica Emmons	**UHC** Dr. Thomas Biuso Heather Gallegos Stephanie Martin
	MedImpact Erin Russell	**Delta Dental** Dr. John Mehlem Ann Coupland	**TDA** Dr. Ock Peterson Jeff Wilkinson		

I. Meeting Review

A. Agenda

II. Discussion Items

A. 2018 Plan Design Considerations

1. Medical Recommendations

(1) Item #1: Adult immunizations; All plans recommending to remove grandfathered status to include free preventive care and preventive immunizations

(2) Item #10: Urgent Care Center; UHC proposed an increase in urgent care copayment, which would put their copayment in line with the other plans who are already at the $50-$75 range.

(3) Item #17: Hospital Admission; UHC recommending an increase from $150 to $250 to make the plan competitive among the other plans and avoid Cadillac tax; all other plans recommend a $250 copay

(4) Item #28: Mental/Nervous, and Substance Abuse Inpatient services; All plans recommending a $250 copay to create parity with the medical outpatient benefit.

(5) Item #30: Contraceptive appliances; UHC proposes removing the copayment for preventive services to be in line with HCR

(6) Item #39: Organ and Tissue Transplant; UHC recommends for PPO plan to remove coverage out of network to ensure members utilize Centers of Excellence for Organ Transplants. If out-of-network benefit will not be removed, consider limiting the benefit to a dollar amount, which is allowable under HCR. Most benchmark plans do not allow out-of-network coverage.

PRE-CERTIFICATION/PRIOR AUTHORIZATION

(7) Item #9: Non-emergency ambulance transportation; UHC suggests removing requirement for pre-cert for non-emergency ground transportation. This is common amongst book of business. Potential for the plan to be charged additional days for inpatient hospital care. The risk inherent is that if a member needs a pre-cert for ground transportation, they could be waiting at the hospital longer than necessary for the pre-cert to be approved. Cigna and Aetna require a pre-cert. It is rare that an ambulance will be called spontaneously as it is typically part of care. There is no pre-cert between participating medical facilities.

(8) Item #13: Infusion/IV Therapy in an Outpatient setting; UHC recommends removing the reference to specific drug names and require pre-cert/prior-auth for infusion/IV therapy for drugs required by TPA. Treatment would not be limited to the clarified list and would

Redacted

Redacted

Redacted

C. Transgender Benefits, ruling on requirements

1. What vendors are doing for their fully insured products

(1) Cigna – for fully insured plans, complying with law and adding the benefit; if ASO plans receive federal funding, they must comply. Most of the clients are taking steps to not have to add the benefit.

(2) BCBS – exclusion for cosmetic services; coverage area is psychotherapy, reassignment surgery, and medication. Generally the recommendation is conservative because of concern for litigation (but it's more of a legal issue rather than a benefit issue)

(3) Aetna – has had some customers who have had the benefit for a couple of years; most of the surgeons who perform reassignment surgery tend not to contract with health plans at present. There may be more to come as definitions are more clearly defined and the benefit becomes more common.

(4) UHC – benefit is being added for 1/1/17 for fully insured plans. One of their plans in book of business had to add the plan on an off cycle to prevent EEOC complaints and adopted UHC standard language (examples provided in a separate document)

2. Costs

(1) Cigna – cost is fairly minimal, less than 1/10th of a percentage, unless you have known people who are asking about the benefit, in which case add $35,000 per person.

(2) BCBS - Actuarially had a .3% impact including medication.

(3) Aetna – it is not unusual to see costs over $50,000 for the surgery alone

(4) UHC - $.09/pmpm and $.01/pmpm prescriptions cost

3. Recommendations

(1) Cosmetic procedures are not part of the typical covered procedures (i.e. chest, facial..etc). The cost is mostly associated with hormone therapy, reassignment surgery, and post-op therapy.

(2) BCBS – had several groups that wanted to voluntarily add the benefit before litigation. Previously had dollar limits, but the recommendation is not to have a maximum.

(3) Aetna – Currently it is a very costly procedure since there are few providers who contract with insurance

(4) UHC – Review with legal counsel as to requirements of offering the benefit

Redacted

Redacted

EXHIBIT 32

UNITED STATES DISTRICT COURT

DISTRICT OF ARIZONA

RUSSELL B. TOOMEY, Plaintiff, vs. STATE OF ARIZONA; ARIZONA BOARD OF REGENTS, d/b/a UNIVERSITY OF ARIZONA, a governmental body of the State of Arizona; et al., Defendants.	4:19-CV-00035

VIDEOTAPED DEPOSITION OF CHRISTINA CORIERI

(Via Zoom Videoconference)
July 13, 2022
8:30 a.m.
Phoenix, Arizona

Glennie Reporting Services, LLC
1555 East Orangewood Avenue
Phoenix, Arizona 85020
602.266.6535
www.glennie-reporting.com

Prepared by:
Robin L. B. Osterode
CSR, RPR
CA CSR No. 7750
AZ CR No. 50695

Q. For example, was the cost of including gender reassignment surgery discussed at that meeting?

A. I do not recall it being discussed at that meeting.

Q. Did you discuss the cost of gender reassignment surgery with anyone at any time during the time you have been at the Office of the Governor?

MS. LAMM: Object to the form of the question.

THE WITNESS: I -- I don't recall specific discussions about the cost.

BY MR. ECKSTEIN:

Q. Did anyone -- anyone ever tell you that gender reassignment surgery was not going to be covered by the State of Arizona, by the Arizona Department of Administration healthcare plan because of its cost?

A. I know that cost is something that we look at for everything. Especially in the context of adding cost to the State Health Insurance Trust Fund or to State employees. So our position, in general at that time, was that the State was in a very bad economic situation. In 2015, we had something like a billion dollar deficit and had to cut across the board in agencies. The State health insurance plan was in trouble and had to be bailed out. We still had to put dollars into the health insurance trust fund because it's under water, our State

employees had not had a raise since 2008, and every time we add anything to the plan or do anything that would change their cost structure, we hear from employees. So our position, in general, is that we don't add things that we are not required to add to the plan that would affect the trust fund cost or the cost to employees. Again, because of the impact it would have on a fund that is not -- that is not in good financial shape or the impact on employees, many of whom don't make a lot of money and had not had a raise for many, many years.

Q. Did the State employees get a raise this year?

A. They received a raise on January 1st, 2022 -- I'm sorry, not January 1st, July 1st, 2022. That was the first raise since, I believe, 2007. Yeah.

Q. Is -- did the State end the fiscal year, June 30 -- it was really -- yeah, June 30, 2021, with a surplus?

A. June -- last fiscal year, I believe we did, but I don't know how much.

Q. You never heard the figure 4 million -- 4 billion -- $5 billion, you didn't hear that?

A. I'm sorry, that's for this fiscal year, 2022, you asked 2021.

Q. Okay. And what -- so what is it with respect to this fiscal year? I'm sorry, yes, I did get my -- I

A. No.
Q. What do you disagree with?
MS. LAMM: Object to the form of the question.
THE WITNESS: Well, some of it I don't even know what she's referring to. I don't know what the mass resistance is. I don't know what the Alfred Kinsey occultic faux science is. I don't even know what she's talking about.
BY MR. ECKSTEIN:
Q. Okay. You've never heard of Alfred Kinsey?
A. I think I have vaguely heard of him as a university professor. I've never read anything --
Q. I guess --
A. I'm sorry?
Q. I guess that's the difference -- the difference in our generations. You've never heard of the Kinsey Reports --
A. I never --
Q. -- in the 1940s?
All right. That's fine.
I want to ask you, do you agree that gender reassignment surgery was not welcome in the governor's office?
MS. LAMM: Object to the form of the question.
THE WITNESS: We -- we have never had a

conversation about this, so I have no objection to decisions that -- that people make.

BY MR. ECKSTEIN:

Q. Okay. And so you don't know whether it was welcome or not welcome. Correct?

A. We don't have a position on this.

Q. Or -- no position at all?

A. No, this is an individual decision.

Q. All right. When you're saying individual decision, what do you mean by that?

A. I mean it's a decision for somebody to make for themselves. I -- I do not have a position on feelings on whether or not somebody, you know, gets it or not. It just doesn't --

Q. But if a person is employed by the State of Arizona, say by the University of Arizona and wants to have gender reassignment surgery, that person could not have it at any time during the time you've been employed by that office. Correct?

MS. COHAN: Form.

MS. LAMM: Object to the form of the question.

THE WITNESS: That's not true.

BY MR. ECKSTEIN:

Q. Oh, tell me why it's not true.

A. Because you can always get it if you are

A. No, but I know the cost of surgeries simply varies, and I've seen, you know, every year we have bills in the legislature to add specific benefits to the AHCCCS program, and each one of those carries with it a cost. The costs vary depending on what that particular benefit is.

Q. But, again, you -- that's with respect to other types of coverage, you, as you sit here today, have no knowledge one way or the other about the cost of adding gender reassignment surgery to the ADOA plan?

A. I do not know specifically on that, but I have never seen a benefit added to any plan that didn't involve costs.

Q. But you don't know whether that cost was a dollar or some other number in this context?

A. I don't know what that is for that individual one. I do know that the health insurance trust fund was deeply under water and had to be bailed out at that time, so any costs would make a bad situation in the State employee health trust fund worse, and that every dollar that we add to employees' costs made it difficult for employees who, again, had not had a raise in many years, and many are not high-paid employees.

Q. Well, let me ask you, in -- in -- when you had any of these meetings in 2000- -- in the fall of 2016,

SIGNATURE PAGE

I, CHRISTINA CORIERI, a deponent exercising my right to read and sign my deposition taken on July 13, 2022, place my signature hereon and make the following changes on this _____day of_____, 2022.

(IF THERE ARE NO CHANGES, WRITE "NONE.")

_____

CHRISTINA CORIERI

PAGE	LINE	READS	CHANGE TO	REASON
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STATE OF ARIZONA)
COUNTY OF MARICOPA)

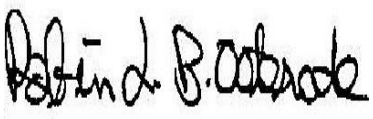
BE IT KNOWN that the foregoing proceedings were taken before me; that the witness before testifying was duly sworn by me to testify to the whole truth; that the foregoing pages are a full, true, and accurate record of the proceedings all done to the best of my skill and ability; that the proceedings were taken down by me in shorthand and thereafter reduced to print under my direction.

[X] Review and signature was requested.

[ ] Review and signature was waived.

[ ] Review and signature not required.

I FURTHER CERTIFY that I have complied with the ethical obligations set forth in the ACJA 7-206(F)(3) and ACJA 7-206(J)(1)(g)(1) and (2). Dated at Phoenix, Arizona, this 23rd day of July, 2022.



ROBIN L. B. OSTERODE, RPR
CA CSR No. 7750
AZ CR No. 50695

* * * * *

I CERTIFY that Glennie Reporting Services, LLC, has complied with the ethical obligations set forth in ACJA 7-206(J)(1)(g)(1) through (6).

GLENNIE REPORTING SERVICES, LLC
Registered Reporting Firm
Arizona RRF No. R1035

EXHIBIT 33

FY 2016 BASELINE SUMMARY

Overview

The FY 2016 Baseline provides an estimate of the state's General Fund balances. The revenue projections reflect a consensus economic forecast while the spending estimates represent active funding formula requirements and other obligations. The Baseline does not represent a budget proposal, but an estimate of available resources after statutory requirements.

A.R.S. § 35-125 requires that the General Appropriation Act annually delineate the revenue and expenditure projections for 3 years. The budget, however, would only provide actual appropriations for FY 2016.

In terms of the budget outlook:

- Total FY 2016 General Fund revenue is projected to be $8.77 billion. Revenues would be $(440) million less than in FY 2015. While the 4-sector consensus base revenues are forecast to grow by $300 million, or 3.3%, the decline in the balance forward, annualization of prior year tax law changes and the loss of one-time fund transfers offset those gains.
- In comparison, FY 2016 spending is projected to be $9.45 billion. This amount reflects $90 million, or 1.0%, growth in expenditures, which is limited to current funding formulas. K-12 growth of $181 million is offset by declines in one-time information technology, capital, Department of Child Safety spending, and technical adjustments for administrative adjustments and revertments.
- The projected FY 2016 ending balance shortfall is $(678) million prior to any resolution of the K-12 inflation litigation and assuming that the FY 2015 shortfall is solved with one-time measures. The shortfall would increase slightly to $(690) million in FY 2017, then decline to $(581) million in FY 2018.
- The litigation regarding unfunded K-12 inflation could significantly affect the projected shortfall. The additional cost per year to "reset" the Basic State Aid weight at the level sought by the plaintiffs is $337 million in FY 2016, with similar costs in subsequent years. If the state were ultimately required to reset the rate at that level, the FY 2016 shortfall would increase to $(1.02) billion. These figures do not include the impact of back payments for years without the additional inflation payments. The plaintiffs seeking back payments have suggested the state pay an additional $1.26 billion total over a 5-year period.
- The projected FY 2015 ending balance shortfall is now projected to be $(148) million, primarily the result of a decrease in forecasted FY 2015 revenues. This figure does not include additional obligations that might be required pursuant to resolution of the K-12 inflation litigation.
- These cash balance estimates do not include $464 million in the state's Rainy Day reserve (Budget Stabilization Fund).

The Path from a Healthy Surplus to a Large Shortfall

At the end of FY 2013, the state had a balance of $895 million. The following factors lead to the projected FY 2016 shortfall of $(678) million (or $(1.02) billion with the K-12 litigation):

- The state had a $300 million to $400 million underlying structural shortfall in the past several years as ongoing spending exceeded ongoing revenue. These budgets were balanced with one-time monies such as the temporary 1-cent sales tax.
- When the $900 million 1-cent sales tax ended in FY 2013, the FY 2014 budget replaced it with a nearly equivalent carry forward. By the end of FY 2015, however, the carry forward will have been eliminated.
- Lower-than-expected revenue growth.
- Phase-in of tax law changes enacted in 2011 and 2012.
- K-12 inflation litigation.

The current shortfall is not unexpected. The FY 2015 budget was enacted last spring with project shortfalls of $(237) million in FY 2016 and $(489) million in FY 2017.

FY 2015

The FY 2015 ending balance is currently projected to be a shortfall of $(148) million, a decrease of $(278) million from the original budget estimate of a $130 million balance. Total revenues, including the beginning balance, are forecast to be $9.21 billion compared to spending of $9.36 billion. The $(278) million adjustment has 3 components:

- A decrease of $(175) million in ongoing revenues under the updated January consensus forecast, the result of lower-than-budgeted FY 2014 revenues and a decrease in the FY 2015 growth rate from 5.3% to 4.3%.
- Decreased balance forward from FY 2014. The original budget assumed an ending balance of $596 million for FY 2014. The actual balance carried forward into FY 2015 was $577 million, a decrease of $(18) million.
- An increase of $85 million in FY 2015 expenditures, including $36 million for an expected decrease in unspent FY 2015 appropriations, $29 million for higher-than-expected administrative adjustments (expenditures for FY 2014 bills received in FY 2015), and $17 million to reflect the actual timing of capital expenditures delayed from FY 2014. These increases are partially offset by $(7) million of net ex-appropriations.

FY 2016 Baseline Revenues

While base revenues are forecast to grow in FY 2016, the growth is insufficient to fully offset the loss of carry-forward balances and declines in other sources of revenues. Overall FY 2016 collections would decline to $8.77 billion, or $(440) million below the revised FY 2015 estimate for the following reasons:

- Based on JLBC's 4-sector consensus, FY 2016 base revenues are projected to grow by $300 million, or 3.3%. Base revenues reflect the underlying growth in the economy and exclude one-time adjustments, urban revenue sharing and new tax law changes.
- The primary reason for the decline in overall FY 2016 revenues is a $(577) million loss in the balance forward as the FY 2014 carry forward is fully expended in FY 2015.
- The state set-aside for urban revenue sharing formula distributions would decline slightly from $609 million to $606 million, thereby increasing state revenue by $3 million.
- Previously enacted legislative changes would reduce state revenue by $(112) million, primarily from the continued phase-in of a corporate income tax rate reduction from 6.968% to 4.9%, the phase-in of a change in how multi-state corporations are permitted to treat sales in calculating tax liability ("corporate sales factor"), and a reduction of long term capital gain taxation.
- Discontinuing fund transfers would reduce revenue by $(54) million.

The 4-sector estimate was developed using a consensus forecasting process. This consensus equally weights the results of 4 forecasts:

- The Finance Advisory Committee (FAC), an independent 13-member group of public and private sector economists;
- The University of Arizona Economic and Business Research (EBR) Center's econometric forecasting baseline model;
- The EBR's conservative forecast model; and
- The JLBC Staff forecast.

The FY 2016 growth rate of 3.3% reflects sluggish growth. There are a number of reasons for the slow growth, including:

- Slowdown in housing permits and a decline in construction jobs, which is particularly noticeable amidst growth in the construction sector nationally
- Federal defense contract reductions
- Lingering effects of the "housing bubble" that led to the 2007-2009 recession.

(See the General Fund Revenue section for more information.)

FY 2016 Baseline Spending

Based on statutory funding formulas and other obligations, FY 2016 Baseline spending is projected to be $9.45 billion, a $90 million, or a 1.0%, increase above FY 2015 prior to any potential spending associated with the K-12 inflation litigation. The major adjustments are:

- Department of Education spending would increase by $181 million due to a 1.4% increase in student enrollment, base support level inflation increase of 1.6%, an increase in the state share of homeowner K-12 property taxes, and an offset from new construction property taxes. Since charter school and special education pupils are a larger proportion of student growth (and are more expensive per student), the Baseline includes a higher cost per pupil.
- AHCCCS and Department of Health Services Medicaid spending would increase by $7 million, reflecting modest caseload growth and a 3% capitation rate increase offset by an increase in the federal matching rate. Costs of Medicaid expansion authorized in the FY 2014 budget are primarily offset by the hospital assessment.
- The Department of Economic Security (DES) budget would also increase by $22 million for Developmental Disabilities Medicaid growth.
- Department of Corrections spending would increase $8 million to annualize the costs of opening 500 medium-security private beds and 500 maximum-security state-operated beds in the middle of FY 2015. The Baseline excludes funding to address the recent prison health litigation settlement.
- One-time spending for capital, information technology and establishing the Department of Child Safety would not be repeated in FY 2016, reducing spending by $(86) million.

The $9.45 billion spending level would support a Full-Time Equivalent (FTE) Position ceiling of 50,733 state employees.

Forecast Risks

As an estimate of state revenues and spending obligations, there are both positive and negative risks to the JLBC Baseline estimates. Because small percent changes in growth assumptions can have a substantial impact – over 3 years, a 1% change in base revenue growth could change available revenues by $575 million through FY 2018 – these risks could significantly change the final results of these budgets.

The potential gains to the forecast include:

- Improving national economic recovery: The national economy has been improving since the second quarter of 2014. Stronger economic growth, better job prospects, and an increase in consumer confidence could translate into increased net migration to the state, which would also result in more demand for housing and an overall boost to the Arizona economy and related revenue growth.
- The "windfall" from the sharp reduction in gasoline prices: If gas prices remain at the current level for the next 12 months, it could free up an estimated $2 billion for Arizona households. While consumers are likely to save part of this windfall, they will also spend of a portion of their gains. Considering the volatility of energy prices, however, any related windfall in state revenues from such a shift in consumer spending should be regarded as one-time.

The potential losses to the forecast include:

- Uncertainty of international events: As Arizona's economy has become increasingly tied to the international economy, so has the potential for economic disruptions from global events. Adverse weather events, terrorist actions, and a sluggish worldwide economic situation could dampen the economic recovery nationally and in Arizona.
- Litigation expenses: Beyond the K-12 inflation litigation, the state faces other resolved and potential litigation impacts that have not been incorporated into the Baseline. These impacts include the following:
    - Prison health care settlement (a potential $26 million impact).
    - Higher state employer contribution rates related to retirement litigation (a potential $2 million or $21 million impact, depending on whether higher rates are phased-in).
    - Hospital assessment litigation (a potential minimum impact of $64 million): If the hospital assessment was eliminated, the state would at least have the cost of backfilling the assessment used to fund the mandatory Proposition 204 parents program. The cost would be substantially higher if childless adults were retained on the program.

JLBC Staff Suggested Budget Reforms and Process Improvements

Based on its review of agency requests in preparing this Baseline, the JLBC Staff has developed several suggestions to improve legislative oversight and transparency of government spending, including:

Align Ongoing Revenues and Spending Over Several Years: While the state can operate with a structural shortfall in the short term if it has one-time balances, the current structural shortfall does not significantly shrink in subsequent years. As a result, a fiscal policy goal should be to bring permanent revenues and expenditures into alignment.
Develop Multi-Year Targets and Formalize in General Appropriation Act: The Legislature may not be able to eliminate the structural shortfall in a single year. As a result, the JLBC Staff recommends that the General Appropriation Act include a multi-year plan for resolving budget shortfalls with specific out-year targets.

Dedicate One-Time Revenues for One-Time Spending: The Legislature may want to consider whether to deposit one-time revenues into a new special initiatives fund for one-time purposes. One-time revenues would include higher-than-expected General Fund balances and unusually large income tax collections from capital gains. The latter would require developing a reporting mechanism for "excess" capital gain tax growth so as to permit the deposit of these monies into the one-time special initiatives fund.

While the tax base for most General Fund revenue categories is fairly stable over time, other revenue sources are inherently volatile. For example, it is not unusual for capital gains and corporate income tax to grow at double-digit rates in one year only to be followed by double-digit rate declines in the next year. Such large swings in revenue collections make the budgeting process more difficult. One-time revenue windfalls can also come from non-recurring events such as the recent decline in gas prices. Since energy prices can rise and fall in a short span of time, any revenue windfall associated with such shift in spending patterns is likely to be short-lived.

Voters in California recently approved a ballot measure ("Proposition 2") that requires the state to deposit any "excess" revenue from capital gains taxes into its Rainy Day Fund. In addition, the state would deposit 1.5% of its General Fund revenue into the fund. Half of the fund will remain in reserve while the other half will be used to buy down state debts, including unfunded retirement and operating loans.

Better Tax Reporting: Estimating General Fund revenues is made more difficult by not having current information of tax credit usage. The Baseline includes statutory provisions requiring more timely fiscal year tax credit reporting by the Department of Revenue and insurance premium tax reporting by the Department of Insurance.

Annual Retirement Report: The current budget structure does not give a full picture of retirement expenditures by system, agency, and fund source. The JLBC Staff recommends a new statutory report separately delineating the state's retirement expenses. The JLBC Staff begins this initiative by incorporating a new section, the Consolidated Retirement Report, in the *FY 2016 Baseline Book* which provides this information.

Review of Acute and Behavioral Health Services Integration: AHCCCS and the Department of Health Services have begun to implement smaller scale integration projects. The JLBC Staff suggests that the Legislature evaluate accountability measures as it considers further consolidation of the acute and behavioral health services systems.

In addition to these items which affect overall budget or multiple agencies, the Baseline also includes these agency-specific suggestions:

- Contracted Health Care Rates (Arizona Department of Corrections): The Baseline includes a provision requiring increases in ADC contracted health per diem rates to be reviewed by JLBC, similar to the current process used in the Medicaid program. In the past year, ADC raised contracted health per diem, which may have a budget impact.
- Divisional of Developmental Disabilities (DDD) Budget Transparency (Department of Economic Security): The Baseline separately delineates DDD administrative expenditures to help provide a total budget picture of DDD services. These administrative expenditures had previously been displayed in DES' overall administrative costs.
- 1% Property Tax Cap Subsidy (Arizona Department of Education): The Baseline delineates the state subsidy to local districts which exceed the 1% property tax cap; these costs are currently incorporated into a larger line item. The Arizona Constitution prohibits homeowners from paying more than 1% of their assessed value in primary property taxes from all sources. The Constitution does not specify the solution if a local jurisdiction exceeds 1%, but the state has effectively paid the difference. The projected FY 2016 cost to the state is $28 million.
- Proposition 301 0.6% Sales Tax Planning (Arizona Department of Education): The Proposition 301 sales tax expires after FY 2021. The JLBC Staff recommends that the Legislature begin a planning process to accommodate this expiration.
- Intergovernmental Agreement Funding Transparency (Department of Health Services): The Baseline includes a provision to divide DHS' Intergovernmental Agreements/Interagency Service Agreements Fund into 4 separate funds to ensure that monies are not inappropriately comingled.

- Probation and Automation Transparency (Judiciary): The Baseline shifts funding within the Judiciary's budget in order to better align expenditures with appropriations and bring transparency to how much money the Judiciary transfers to counties for probation activities and how much money the Judiciary spends on other activities.
- Local K-12 Bonding Report (School Facilities Board): The Baseline includes a provision requiring SFB to report annually on capital bond approvals by school districts to provide a better understanding of bond issuances and school construction occurring outside of state funding.
- University Tuition Collections: Tuition collections are split between appropriated and non-appropriated amounts. To increase transparency, the JLBC Staff recommends that tuition collections either be fully appropriated or fully non-appropriated.
- Displaying Rio Nuevo Expenditures (Revenues): The Baseline shifts the display of Rio Nuevo expenditures from being an offset to General Fund revenue to being an operating budget expenditure, increasing transparency and conforming its display with that of the Phoenix Civic Center payment.

Further details on the issues raised here can be found in the relevant agency narrative.

Debt

In FY 2016, the state's projected level of lease-purchase and bonding obligations is $7.5 billion. This amount includes:

- $3.2 billion, state and university office buildings
- $1.7 billion, state highway construction projects
- $1.1 billion, school district projects
- $1.2 billion, state operating debt from FY 2011
- $260 million, Phoenix Convention Center

The associated annual debt service payment is $913 million.

Of the $7.5 billion in total obligations, the General Fund share is $2.8 billion. The General Fund annual debt service is projected to be $365 million in FY 2016.

As a remnant of the Great Recession, the state pays $1.2 billion of current year obligations in the next year (the "rollover"). The $7.5 billion estimate of total obligations also does not include any unfunded retirement liability.

With both major credit rating agencies, Arizona has the fourth highest rating out of 10 possible levels (Standard & Poor's: AA- and Moody's: Aa3). In comparison to other states, Arizona is tied for fourth worst, with only New Jersey, California and Illinois having a lower rating from both firms. Along with an overall rating, credit agencies also provide an outlook in terms of the future direction of rating changes. Both major agencies have a positive outlook for Arizona; while the rating is positive, that outlook was released a year ago.

Other Funds

Besides the General Fund, the state has dedicated special revenue funds. Only a portion of these monies is subject to legislative appropriation. The Baseline includes a FY 2016 Other Fund appropriated spending level of $3.5 billion, or (0.8)% below FY 2015.

The level of FY 2016 non-appropriated state funds is expected to be $8.0 billion, while non-appropriated Federal Funds are forecast to be $12.3 billion. When all appropriated and non-appropriated fund sources are combined, total FY 2016 state spending would be $33.2 billion.

EXHIBIT 34

Douglas A. Ducey
Governor

Gilbert Davidson
Chief of Operations
and Interim
Director

ARIZONA DEPARTMENT OF ADMINISTRATION
OFFICE OF THE DIRECTOR
100 NORTH FIFTEENTH AVENUE SUITE 401
PHOENIX, ARIZONA 85007
(602) 542-1500

June 29, 2018

The Honorable Douglas A. Ducey, Governor, State of Arizona
The Honorable Steven B. Yarbrough, President, Arizona State Senate
The Honorable Javan D. Mesnard, Speaker, House of Representatives
1700 West Washington Street
Phoenix, AZ 85007

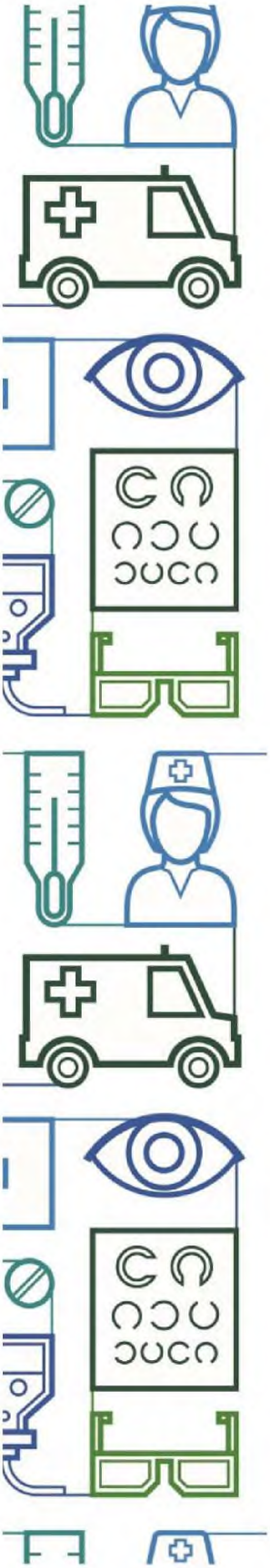
Dear Governor Ducey, President Yarbrough, and Speaker Mesnard:

Pursuant to A.R.S. § 38-652 (G) and A.R.S. § 38-658 (B), we are pleased to present the *2017 Annual Report for the Health Insurance Trust Fund*, including a report on the performance standards for the health and dental plans.

Sincerely,

Gilbert Davidson
Chief of Operations and Interim Director

cc: Richard Stavneak, Director, Joint Legislative Budget Committee
Rebecca Perrera, Staff, Joint Legislative Budget Committee
Matthew Gress, Director, Office of Strategic Planning and Budgeting
Jacob Wingate, Budget Analyst, Office of Strategic Planning and Budgeting
Derik Leavitt, Assistant Director, ADOA Budget and Resource Planning
Holly Henley, State Librarian and Director, Arizona Department of Library and Archives
Paul Shannon, Interim Assistant Director, ADOA Benefit Services Division



ARIZONA
DEPARTMENT OF ADMINISTRATION
BENEFITS

Health Insurance Trust Fund

2017 Annual Report

Douglas A. Ducey
Governor

Gilbert Davidson
Chief Operating Officer
and Interim Director

FOREWORD

The Arizona Department of Administration ("ADOA") offers health, dental, life, and disability insurance as well as medical and dependent care flexible spending accounts to the State of Arizona ("State") Active employees, COBRA members and Retirees. These combined group of benefits offered is referred to as Benefit Options. This report provides a broad overview of the Benefit Options program, and meets the requirements of the A.R.S. §38-652 (G) and A.R.S. §38-658 (B).

The data shown is presented for the period January 1, 2017 through December 31, 2017. The Active and Retiree plans were concurrent for this period.

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

Arizona Department of Administration
Benefit Services Division
100 N. 15th Ave, Suite 260
Phoenix, AZ 85007

Telephone: 602-542-5008

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Report Background

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

"The department of administration shall annually report the financial status of the trust account to officers and employees who have paid premiums under one of the insurance plans from which monies were received for deposit in the trust account since the inception of the health and accident coverage program or since submission of the last such report, whichever is later."

The Annual Report also reports the performance standards for the health plans pursuant to A.R.S. §38-658 (B), which reads:

"On or before October 1 of each year, the director of the department of administration shall report to the joint legislative budget committee on the performance standards of health plans, including indemnity health insurance, hospital and medical service plans, dental plans and health maintenance organizations."

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

The benefits offered are either self-insured or fully-insured. For year 2017, the medical and dental PPO plans were self-insured, whereas the dental HMO, vision, life and disability insurance plans were fully-insured.

The State's medical plan became self-insured on October 1, 2004. The current set of contract runs from July 15, 2014 through December 31, 2018. The State contracts with the medical and pharmacy vendors to provide network access and related discounts, claim adjudication and payment, and medical management including utilization management, case management and disease management. The State is responsible for the full cost of all claims and programs offered by the vendors.

The State's self-insured dental PPO began on January 1, 2013.

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

All data provided herein is for Plan Year ("PY") 2017 running January 1, 2017 through December 31, 2017.

Please note statistics will vary from previous annual reports due to the late receipt of program data following the completion of the previous annual report. Further, the Benefit Services Division has moved to using a new data-mining platform called MedInsight to extract the data, which further explains some of the variances in reported statistics. In no case does the variation represent a substantive change in trend.

Executive Summary

During PY 2017, ADOA offered a comprehensive insurance package through Benefit Options to approximately 136,000 members consisting of Active state and University employees, COBRA members, Retirees and their qualified dependents. This figure excludes the 5,500 of members that are served through the BCBC NAU fully-insured program. The benefits offered in the package include medical, pharmaceutical, dental, flexible spending, vision, wellness, an employee assistance program (EAP), life and disability insurance.

During PY 2017, the sum of health and dental premiums collected was $852.8M with total plan expenses, including transfers, of $981.2M. Reported expenses include claims incurred in 2017 and prior plan years paid in PY 2017 as well as transfers out to other State funds (Figure 1).

Figures referred below apply to 2017 incurred claims only, regardless of paid dates.

Health Plan

- The average annual plan expense, including claims, administrative costs and fees, per member was $6,513.
- Average Active member expense was $6,340; average Retiree member expense was $9,060.
- The PY 2017 medical claims expenses totaled $622.6M, excluding IBNR liability (Figures 6 & 7). This differs from the $630M number in Figure 1 which represents medical claims expenses paid during PY 2017 regardless of incurred dates. This figure also includes any other related expenditure related transactions, including adjustments and corrections.
- The leading diagnosis group by cost is the musculoskeletal system and connective tissue category at 13% of total medical spend.
- Claims indicate that members are seeking appropriate level of care by seeking the majority of care from physicians or specialists.
- 3,954 physician visits per 1,000 members (slightly higher than prior year).
- 211 urgent care visits per 1,000 members (slightly lower than prior year).
- 227 emergency room visits per 1,000 members (slightly higher than prior year).
- The PY 2017 pharmacy claims expense was $181.9M. This differs from the $163.4M number in Figure 1 which represents pharmacy claims expenses paid during PY 2017 regardless of incurred dates. This figure also includes any other related expenditure related transactions, including adjustments and corrections.
- The leading therapeutic drug class by cost was antidiabetics at 14% of total pharmaceutical spend.

- Over 1.4 million prescriptions were filled in PY 2017.
- Active employees filled an average of 9 prescriptions per year while Retirees filled an average of 28.

Wellness Program

- Administered over 14,692 flu vaccines through 413 worksite or public events.
- Administered over 10,545 screenings (this represents 33.9% increase over PY 2016) through 211 statewide worksite events resulting in 678 referrals to physicians for various health issues. This represents a 31.4% increase in referrals over the prior year.
- Incentives covering 2,884 employees participating in the HIP programs in PY 2017 were paid out during spring of calendar year 2018 and amount to 577K.

Performance Measures

Financial guarantees are in place to manage the performance of the contracted vendors. Most vendors met the majority or all of the agreed-upon performance measures. However, estimated penalties of approximately $334K will be collected in calendar year 2018 from vendors failing to meet agreed upon PY 2017 performance targets in customer service, claims processing, appeals, reporting, survey, and network management. During calendar year 2017, $294K of performance penalties were collected related to the PY 2016 performance period. Those collections occurred during calendar year 2016 and 2017.

Health Insurance Trust Fund Review & Summary

Total PY 2017 expenses, including 2017 and prior PY claims, were covered by revenues collected during 2017 and the unrestricted reserve from prior years.

The Health Insurance Trust Fund Summary (Figure 1) is a cash statement of receipts received and expenses paid during PY 2017 that relate to PY 2017 as well as prior plan years.

ADOA Health Plan is the self- insured medical program and includes Aetna Life Insurance Company (Aetna), Blue Cross Blue Shield of Arizona (BCBS), Cigna Health and Life Insurance Company (Cigna), and United HealthCare Services, Inc. (UHC) networks. State and University Active employees and Retirees choose coverage from one of the self-insured networks. NAU Active, COBRA and retiree members have an option to choose between BCBS ADOA self-insured medical plan and the BCBS NAU plan, which is a fully insured plan.

Effective January 1, 2014, all Medicare eligible participants covered under the State of Arizona Benefit Services Division health plans were transitioned from the Medicare Part D Drug Subsidy program to a Medicare Employer Group Prescription Drug Plan (EGWP). The EGWP program is a prescription drug plan that combines a standard Medicare Part D plan with additional prescription drug coverage provided by the Benefit Services Division health plan. The EGWP program achieved savings of $13.6M in PY 2017. Pharmacy benefits management for all members services are provided by MedImpact Healthcare Systems Inc. The pharmacy offers a three-tier formulary for a 31-day supply of medication, with $10 copay for generic drugs, $20 copay for preferred brands and $40 copay for non-preferred brands.

ADOA Dental Plan services were provided by two vendors during PY 2017: Delta Dental Plan of Arizona (Delta Dental) and Total Dental Administrators (TDA), Inc. Starting January 1, 2018, TDA was succeeded by Cigna Health and Life Insurance Company (Cigna Dental).

Benefit Services Division holds reserves for paying claims that have been incurred but not reported (IBNR) and for a contingency to cover any insufficiencies that may develop, such as actual medical trend exceeding projected medical trend, unplanned shifts in plan membership, unexpected catastrophic claims, and changes in provider reimbursement rates that may occur during each plan year. At the end of PY 2017, ADOA was short $19.2M (unrestricted balance) of the desired total reserve amount of $170.5M.

Special Employee Health Trust Fund Summary	
Plan Year 2017	
Beginning Fund Balance January 01, 2017	**$279,616,289**
Revenues	
ADOA Benefit Options	$763,768,902
BCBS (NAU)	42,470,237
ADOA Dental Plan	43,177,252
PrePaid Dental Plan	3,839,112
Other Revenue	(454,862)
Total Revenues	**$852,800,641**
Expenditures	
Administrative Fees	$31,791,068
Medical Claims	630,896,054
Drug Claims	163,443,848
Dental Claims	38,420,493
Medicare Part D Retiree Drug Subsidy	(13,624,879)
BCBS (NAU) Premiums	42,508,253
Fully Insured Dental Premiums	3,597,298
Appropriated Expenses	5,206,357
Administrative/Cash Adjustments	24,005
Fund Transfers Out ^	78,904,000
Total Expenditures and Transfers	**$981,166,498**
Ending Fund Balance December 31, 2017	**$151,250,433**
Reserves	
IBNR Liability (Medical & Dental)	$85,241,000
Contigency Reserve (Medical & Dental)	85,241,000
Total Reserves	**$170,482,000**
Unrestricted Balance December 31,2017	**($19,231,567)**

^ Fund transfers from HITF to other State funds.

Figure 1: Health Insurance Trust Fund Summary

Medical Plan Enrollment

Benefit Services Division offers medical coverage to the following employees and their dependents:

- Eligible state employees and university staff, officers, and elected officials
- State Retirees receiving pension benefits through any of the State retirement systems
- State employees or university staff accepted for long-term disability benefits
- State employees or university staff eligible for COBRA benefits

The three types of medical plans offered to eligible participants are the Exclusive Provider Organization (EPO), the Preferred Provider Organization (PPO) and the High Deductible Health Plan (HDHP) with Health Savings Account (HSA).

The EPO Plan
Within the EPO plan, services must be obtained from an in-network provider; out-of-network services are only covered in emergencies. The employee pays the monthly premium and any required copay at the time of service. Employees who select the EPO plan may choose from four networks: Aetna, BCBS, Cigna or UHC.

The PPO Plan
Within the PPO plan, services may be obtained from an in- or out-of-network provider. There are separate in- and out-of-network deductibles that must be met before copays or coinsurance (percent of the cost) are allowed. The employee pays the monthly premium and at the time of service pays 100% of the allowed amount of service until the deductible is met. After the deductible is met, the employee pays copays if the provider is in-network and coinsurance if the provider is out-of-network until the out of pocket maximum (OOP) is met. Once the OOP is met the plan pays 100% of services for the remaining plan year, with a few exceptions, e.g. pharmacy copays. Employees who select the PPO plan may choose from three networks: Aetna, BCBS or UHC. Employees at NAU also have the option of participating in their fully insured BCBS NAU plan.

The HDHP with HSA Plan
Within the HDHP, services may be obtained from both in and out-of-network providers. Separate in- and out-of-network deductibles must be met before coinsurance is allowed. The employee pays the monthly premium and at the time of service pays 100% of the allowed amount of service (except for qualified preventative services that are covered 100% by the plan) until the deductibles are met. After the deductibles are met, the employee pays coinsurance up to the out of pocket maximum at which time the plan pays 100% of any additional costs for the year.

Employees who enroll in the HDHP and are under the age of 65 are eligible to open a HSA. This account allows employees to make pre-tax contributions into the account and withdraw the monies to pay for qualified medical expenses. When the employee opens the HSA with the State HDHP, the State also contributes bi-weekly to the account. Employee contribution to the HSA is

not mandatory. The HDHP is only available to Active employees and only under the Aetna network.

The figure below shows enrollment distribution by plan and network between Active, Retired, University, and COBRA members. The subscriber references the employee and the member references the employee plus dependents.

Average Monthly Medical Enrollment by Plan & Network					
		2017		2016	
Network	Plan Type	Subscribers	Members	Subscribers	Members
Active	EPO	2,017	4,471	2,001	4,464
Retiree	EPO	251	331	252	329
University	EPO	2,155	4,244	2,170	4,189
COBRA	EPO	13	23	18	29
Active	PPO	278	548	240	454
Retiree	PPO	27	31	26	30
University	PPO	354	739	307	609
COBRA	PPO	3	6	3	5
Active	HDHP	578	1,268	502	1,063
Retiree	HDHP	-	-	0	0
University	HDHP	783	1,570	660	1,284
COBRA	HDHP	14	22	7	11
Total AETNA		**6,473**	**13,253**	**6,185**	**12,467**
Active	EPO	7,791	19,351	7,489	18,623
Retiree	EPO	1,237	1,688	1,197	1,635
University	EPO	3,736	7,889	3,317	7,014
COBRA	EPO	56	97	46	67
Active	PPO	1,167	2,727	863	1,907
Retiree	PPO	67	85	65	82
University	PPO	915	1,985	678	1,407
COBRA	PPO	22	47	12	21
Total Blue Cross Blue Shield AZ		**14,991**	**33,869**	**13,667**	**30,756**
Active	EPO	2,959	7,342	3,083	7,574
Retiree	EPO	605	798	595	776
University	EPO	1,389	3,004	1,364	2,959
COBRA	EPO	19	28	21	30
Total CIGNA		**4,972**	**11,172**	**5,062**	**11,339**
Active	EPO	17,659	43,252	18,541	45,156
Retiree	EPO	4,989	6,532	4,930	6,424
University	EPO	9,975	22,930	10,210	23,419
COBRA	EPO	99	156	88	138
Active	PPO	1,179	2,672	979	2,131
Retiree	PPO	93	114	94	114
University	PPO	984	2,130	849	1,846
COBRA	PPO	17	24	16	24
Total UnitedHealthcare		**34,995**	**77,810**	**35,707**	**79,252**
NAU only*	PPO	2,958	5,466	3,035	5,594
Total Blue Cross Blue Shield NAU		**2,958**	**5,466**	**3,035**	**5,594**
Total		**64,389**	**141,570**	**63,656**	**139,408**

* NAU and COBRA dependent count is an estimaed number based on 1 count of dependent for Emp + 1 coverage option and 2 count of dependents for Emp + Family coverage option

Figure 2: Average Monthly Enrollment by Plan & Network

Medical Premiums

The tables below show the medical premium by plan and coverage tier per pay period for Active employees and Retirees. Retirees have two different tier structures: 1) those who are not enrolled in Medicare and have no dependents enrolled in Medicare and 2) those who either are enrolled in Medicare themselves or have a dependent who is enrolled in Medicare.

During the First Regular Session of the Fifty-third Legislature, a one-time infusion of $25M of General Fund was appropriated for Active employer contribution rate in fiscal year (FY) 2018. This resulted in a 12.62% increase to the state (employer) premium. The rates for the first and second halves of PY 2017 are represented below. This increase did not apply to Retiree medical premiums.

Active rates effective 01/01/2017 through 06/30/2017:

Active Medical Premiums per Pay Period (26 pay periods)*					
Plan	**Tier**	**Employee Premium**	**State Premium**	**Total Premium**	**State HSA Contribution**
EPO	Employee only	$18.46	$253.85	$272.31	-
	Employee + adult	$54.92	$521.54	$576.46	-
	Employee + child	$46.62	$338.77	$385.39	-
	Family	$102.00	$571.38	$673.38	-
PPO	Employee only	$47.08	$258.00	$305.08	-
	Employee + adult	$99.23	$545.54	$644.77	-
	Employee + child	$66.46	$365.08	$431.54	-
	Family	$115.85	$636.46	$752.31	-
HDHP	Employee only	$9.23	$171.69	$180.92	$27.69
	Employee + adult	$27.69	$355.85	$383.54	$55.38
	Employee + child	$23.54	$232.62	$256.16	$55.38
	Family	$51.23	$396.46	$447.69	$55.38

* University of Arizona has 24 pay period deductions

Figure 3: Active Medical Premiums per Pay Period (26 pay periods) for 01/01/2017 through 06/30/2017

Active rates effective 07/01/2017 through 12/31/2017:

Active Medical Premiums per Pay Period (26 pay periods)*					
Plan	Tier	Employee Premium	State Premium	Total Premium	State HSA Contribution
EPO	Employee only	$18.46	$285.88	$304.34	-
	Employee + adult	$54.92	$587.38	$642.30	-
	Employee + child	$46.62	$381.54	$428.16	-
	Family	$102.00	$643.54	$745.54	-
PPO	Employee only	$47.08	$290.58	$337.66	-
	Employee + adult	$99.23	$614.42	$713.65	-
	Employee + child	$66.46	$411.15	$477.61	-
	Family	$115.85	$716.81	$832.66	-
HDHP	Employee only	$9.23	$193.38	$202.61	$27.69
	Employee + adult	$27.69	$400.77	$428.46	$55.38
	Employee + child	$23.54	$262.00	$285.54	$55.38
	Family	$51.23	$446.46	$497.69	$55.38

* University of Arizona has 24 pay period deductions

Figure 4: Active Medical Premiums per Pay Period (26 pay periods) for 07/01/2017 through 12/31/2018

Retiree rates effective 01/01/2017 through 12/31/2017:

Monthly Retiree Medical Premiums				
	Without Medicare		With Medicare	
Plan	Tier	Premium	Tier	Premium
EPO	Retiree only	$593	Retiree only	$442
	Retiree +1	$1,387	Retiree +1 (Both Medicare)	$878
			Retiree +1 (One Medicare)	$1,024
	Family	$1,869	Family (Two Medicare)	$1,166
PPO	Retiree only	$825	Retiree only	$789
	Retiree +1	$2,009	Retiree +1 (Both Medicare)	$1,576
			Retiree +1 (One Medicare)	$1,740
	Family	$2,197	Family (Two Medicare)	$1,980

Figure 5: Monthly Retiree Medical Premiums

Medical Premium vs. Plan Cost

The PY 2017 contribution strategy for the self-insured medical plan resulted in employees paying 12% of the average monthly premium while the state paid the remaining 88%. This ratio remains mostly unchanged from PY 2016. The overall premium revenue collected in PY 2017 was not sufficient to cover expenses in PY 2017 and the fund was not structurally balanced. However, the fund had sufficient carry-over balance from prior years to cover all expenses in the fund in PY 2017.

The one-time FY 2018 infusion of 12.62%, effective in July 2017, generated an additional $38.2M of revenue to the HITF in PY 2017 (or an estimated $76.4M annually total by end of June 2018). While this additional revenue improved the cash balance of the fund, it did not address the underlying structural shortfall for PY 2017. As mentioned previously, at the end of PY 2017, ADOA was short $19.2M (unrestricted balance) of the desired total reserve amount of $170.5M. Thus, additional premium and other plan changes were necessary for PY 2018.

The figure below shows how the average monthly premium compared to the average monthly plan cost for Active employees and Retirees and their dependents (Active and Retiree members). Pursuant to A.R.S. §38.651.01 (B), Retiree and Active medical expenses shall be grouped together to "obtain health and accident coverage at favorable rates." This requirement results in lower Retiree premiums and higher Active premiums than what their experiences would otherwise dictate.

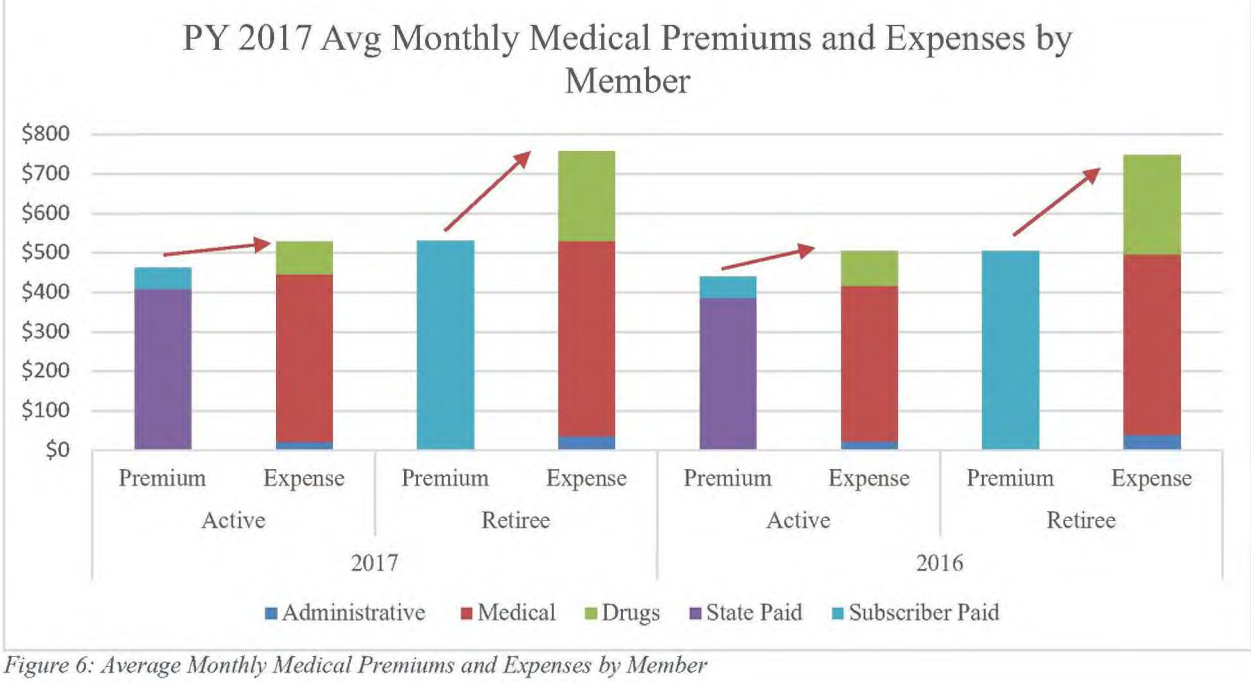


Figure 6: Average Monthly Medical Premiums and Expenses by Member

Expenses for Self-Insured Medical Plans

The figures below show the distribution of claims and expenses incurred in PY 2017 and the average annual cost to insure each type of subscriber/member.

2017 Incurred and Paid Self-funded Medical Expenses by Active, Retiree, and Plan						
Expenses	**Overall**	**Active**	**Retiree**	**EPO**	**PPO**	**HDHP**
Medical Claims	$622,581,341	$572,094,325	$50,487,016	$563,069,622	$53,736,996	$5,774,723
Drug Claims	$181,887,931	$138,167,631	$43,720,300	$164,944,282	$15,963,783	$892,337
Medicare Part D Subsidy	($13,624,879)	$0	($13,624,879)	($12,422,585)	($1,202,294)	$0
Rebates & Recoveries	($19,138,604)	($14,538,268)	($4,600,335)	($17,355,760)	($1,679,740)	($103,103)
Administration Fees	$30,023,274	$26,474,337	$3,548,937	$26,828,187	$2,492,898	$702,189
Operating Expenses & Adj.	$4,983,338	$4,393,670	$589,668	$4,457,594	$414,203	$111,541
Total Expenses	$806,712,401	$726,591,695	$80,120,707	$729,521,340	$69,725,846	$7,377,687
IBNR Liability	$82,189,000	$75,524,044	$6,664,956	$74,332,663	$7,093,997	$762,340
Total	$888,901,401	$802,115,738	$86,785,663	$803,854,003	$76,819,843	$8,140,027
Enrollment in self-funded plans						
Subscribers	61,431	54,162	7,269	54,950	5,106	1,375
Members	136,104	126,525	9,579	122,136	11,108	2,860
Annual cost						
Per subscriber	$14,470	$14,810	$11,939	$14,629	$15,045	$5,920
Per member	$6,531	$6,340	$9,060	$6,582	$6,916	$2,846

Figure 7: 2017 Incurred and Paid Self-funded Medical Expenses by Active, Retire, and Plan

2017 Incurred and Paid Self-funded Medical Expenses by Plan for Active & Retiree						
		Active	**Active**	**Active**	**Retiree**	**Retiree**
Expenses (in dollars)	**Overall**	**EPO**	**PPO**	**HDHP**	**EPO**	**PPO**
Medical Claims	$622,581,341	$513,871,466	$52,448,136	$5,774,723	$49,198,156	$1,288,860
Drug Claims	$181,887,931	$121,275,438	$15,788,203	$1,103,990	$42,367,421	$1,352,879
Medicare Part D Subsidy	($13,624,879)	$0	$0	$0	($12,422,585)	($1,202,294)
Rebates & Recoveries	($19,138,604)	($12,760,839)	($1,661,266)	($116,164)	($4,457,983)	($142,353)
Administration Fees	$30,023,274	$23,370,549	$2,401,599	$702,189	$3,457,638	$91,299
Operating Expenses & Adj.	$4,983,338	$3,883,095	$399,034	$111,541	$574,498	$15,170
Total Expenses	$806,712,401	$649,639,710	$69,375,706	$7,576,279	$78,717,146	$1,403,561
IBNR Liability	$82,189,000	$67,837,854	$6,923,850	$762,340	$6,494,810	$170,147
Total	$888,901,401	$717,477,563	$76,299,556	$8,338,619	$85,211,956	$1,573,707
Enrollment in self-funded plans						
Subscribers	61,431	47,868	4,919	1,375	7,082	187
Members	136,104	112,787	10,878	2,860	9,349	230
Annual cost						
Per subscriber	$14,470	$14,989	$15,511	$6,064	$12,032	$8,416
Per member	$6,531	$6,361	$7,014	$2,916	$9,115	$6,842

Figure 8: 2017 Incurred and Paid Self-funded Medical Expenses by Plan for Active, Retiree

Medical Expenses Associated with Medical Diagnoses

The tables below show the trend in cost by diagnosis for Actives and Retirees. For Actives, the first ten categories make up approximately 70.0% ($455.1M) of the total PY 2017 medical spend. The top ten medical categories total spent for Actives have increased by 5% ($21.7M) over PY 2016. Musculoskeletal System/Connective Tissue diagnosis group has experienced the largest percentage growth for the Active population in PY 2017 over PY 2016 with 10.6% increase with a total growth in spent of $7.1M. The Respiratory System treatment group has experienced the largest percentage drop from PY 2016 to PY 2017 of 6.8% in the top ten categories.

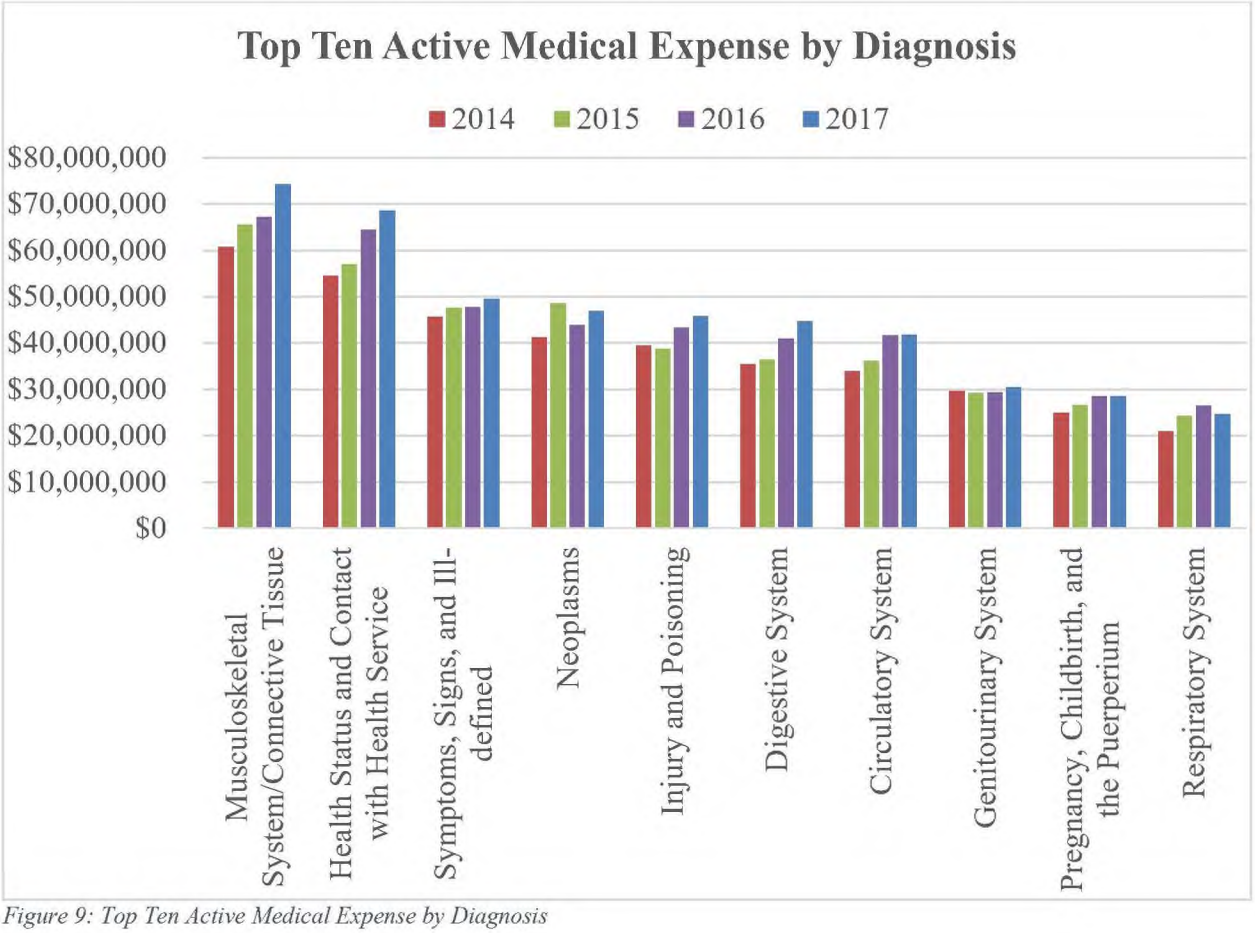


Figure 9: Top Ten Active Medical Expense by Diagnosis

For Retirees, spending on the top ten categories has increased in PY 2017 over PY 2016 by 3.8% ($1.5M). The top ten categories make up approximately 73% ($41.7M) of the total PY 2017 Retiree medical spend. The Musculoskeletal System/Connective Tissue treatment group continues as the largest spend category for both the Active and Retiree populations. The highest percentage growth for the Retiree population was observed in the Circulatory diagnosis group with a 29.6% increase in expenditures PY 2017 over PY 2016. The largest spent increase of $1.3M PY 2017 over PY 2016 was experienced in the Health Status and Contact with Health Service category.

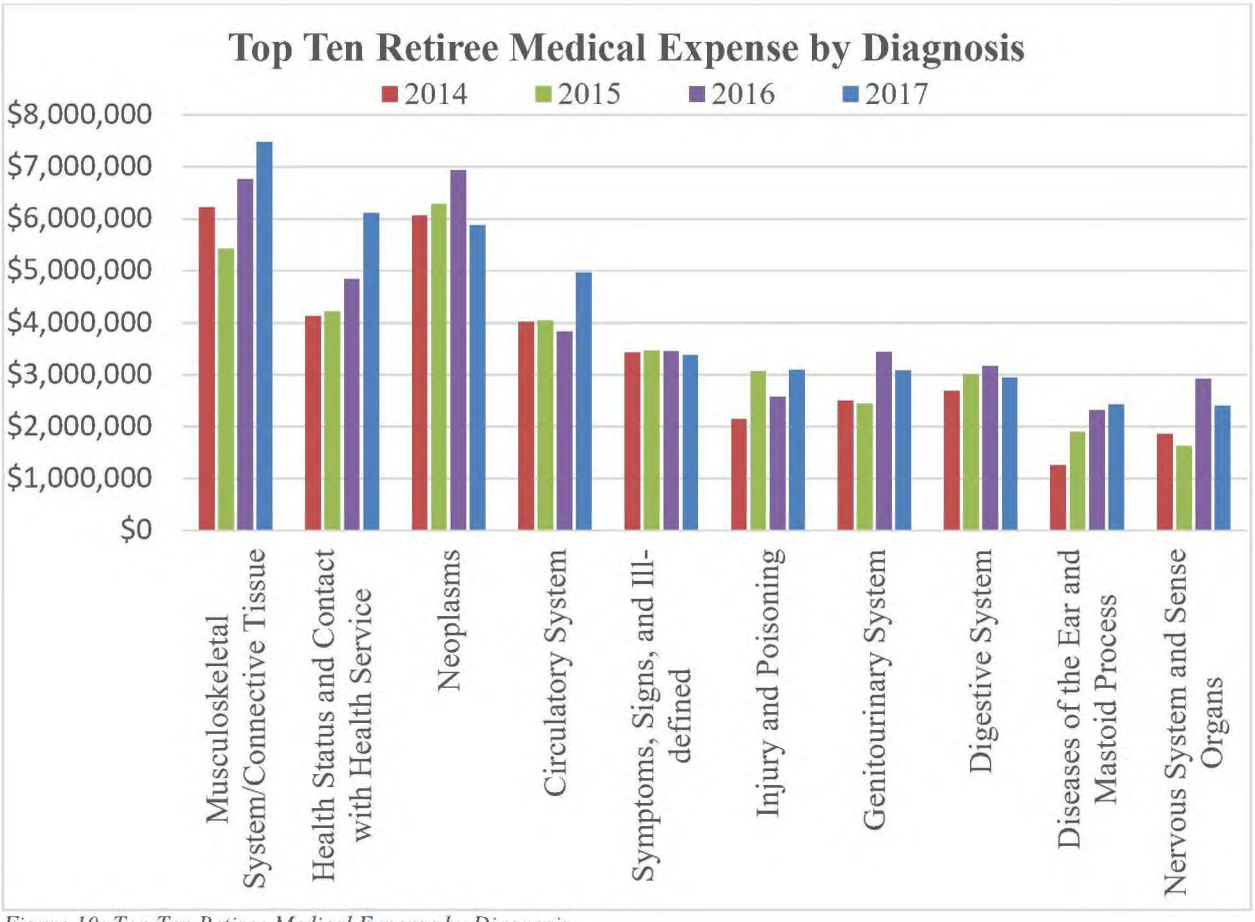


Figure 10: Top Ten Retiree Medical Expense by Diagnosis

Inpatient Hospital Care

Inpatient hospital care represents a significant portion of total medical expenses. Inpatient hospital care includes the cost of hospitalizations, skilled nursing facilities and hospice. The tables below show the Hospital Admissions per 1,000 members and average length of stay. Retirees are admitted more often and longer than Active employees which is in line with their higher overall costs. When comparing plans, PPO members are admitted more often than EPO members, which are admitted more often than HDHP members are. This is all in line with the average costs of these members in each plan. The length of stay is similar between the EPO and PPO while the Active employees in the HDHP tend to have a shorter length of stay.

The number of hospital admissions is holding steady; however, the length of stay has seen a slight increase. The number of hospital admissions for Retirees has decreased slightly which is a positive development. There was a very minimal increase in admissions for the Active population. Please note

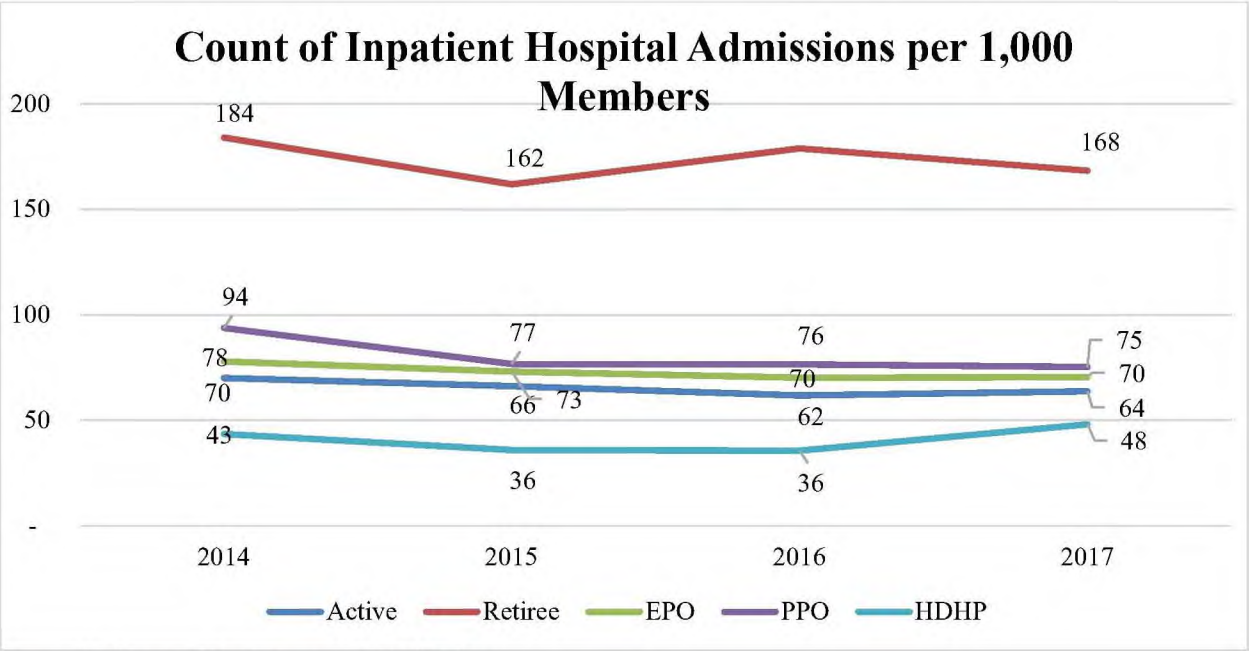


Figure 11: Hospital Admissions per 1,000 Members

The average inpatient length of stay for Active and Retiree populations has decreased slightly PY 2017 over PY 2016 and now closely matches PY 2015, which is an encouraging sign. It remains to be seen if this trend will hold in PY 2018.

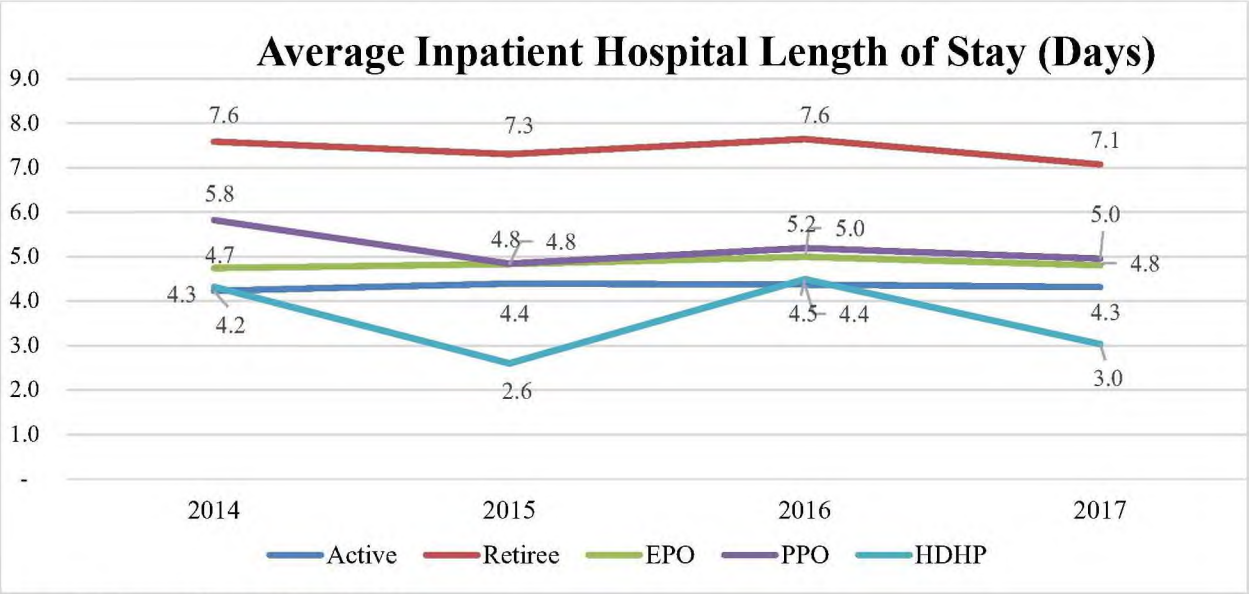
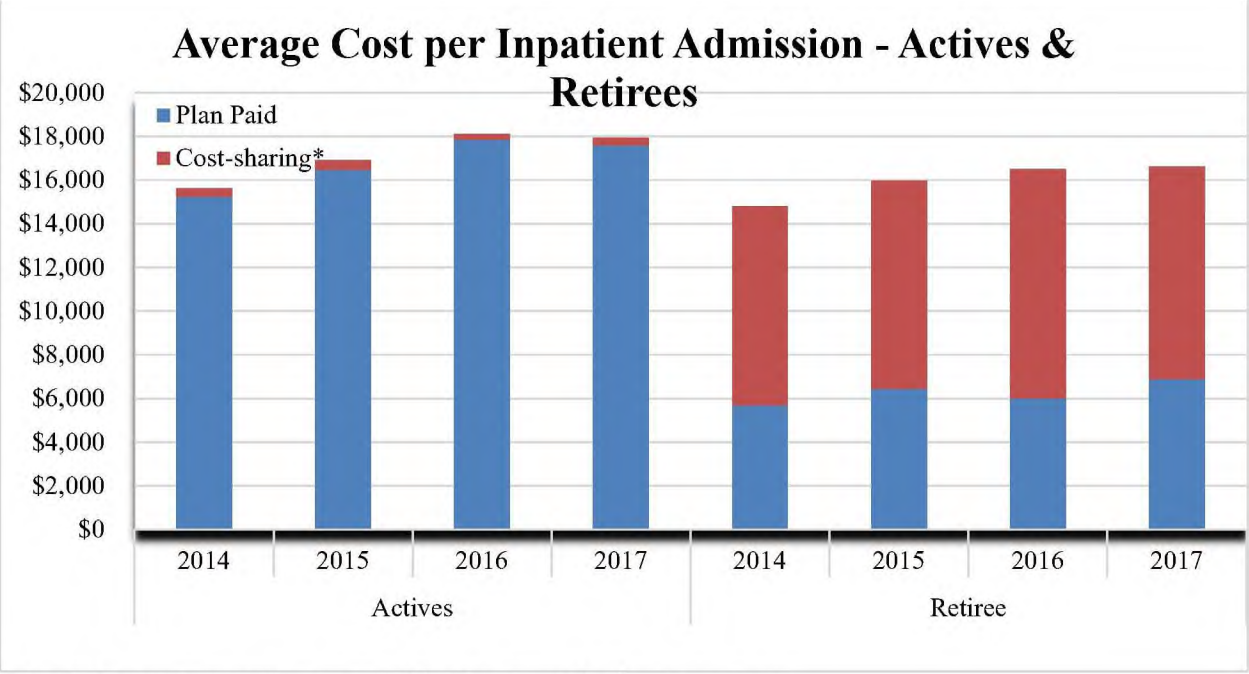


Figure 12: Average Inpatient Length of Stay

There is greater cost sharing with the Retirees because approximately two-thirds of Retirees have Medicare paying as primary for their claims. Overall, the Plan paid approximately 98% ($139.1M of $141.8M total) of Active inpatient costs and 41.4% ($10.9M of $26.3M total) of Retiree inpatient costs during PY 2017. This cost sharing experience has been about the same

over the last four years for Active members averaging 98%. For Retirees, the cost share experience over the last four years ranged between 36.3% in PY 2016 and 41.4% in PY 2017. The chart also indicates that Retirees cost, on average per admission, slightly less than Actives. The cost per admission does include the cost of skilled nursing facilities, which Retirees use more frequently than Actives. This drives the cost per admission down since skilled nurse facility care is less expensive than traditional hospital stays. Yet Retirees more often than not require additional medical care following hospital admission, resulting in more frequent visits and therefore they cost more on a per member per month basis.



* Includes copay, coinsurance, Medicare, and other insurance

Figure 13: Average Cost per Inpatient Admission - Actives & Retirees

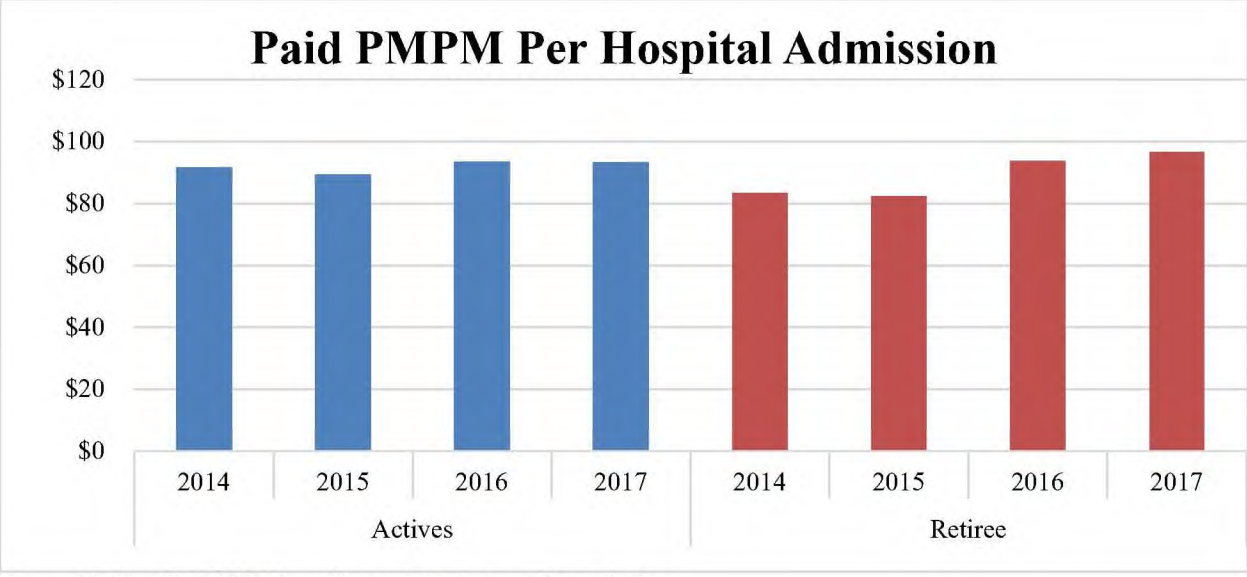
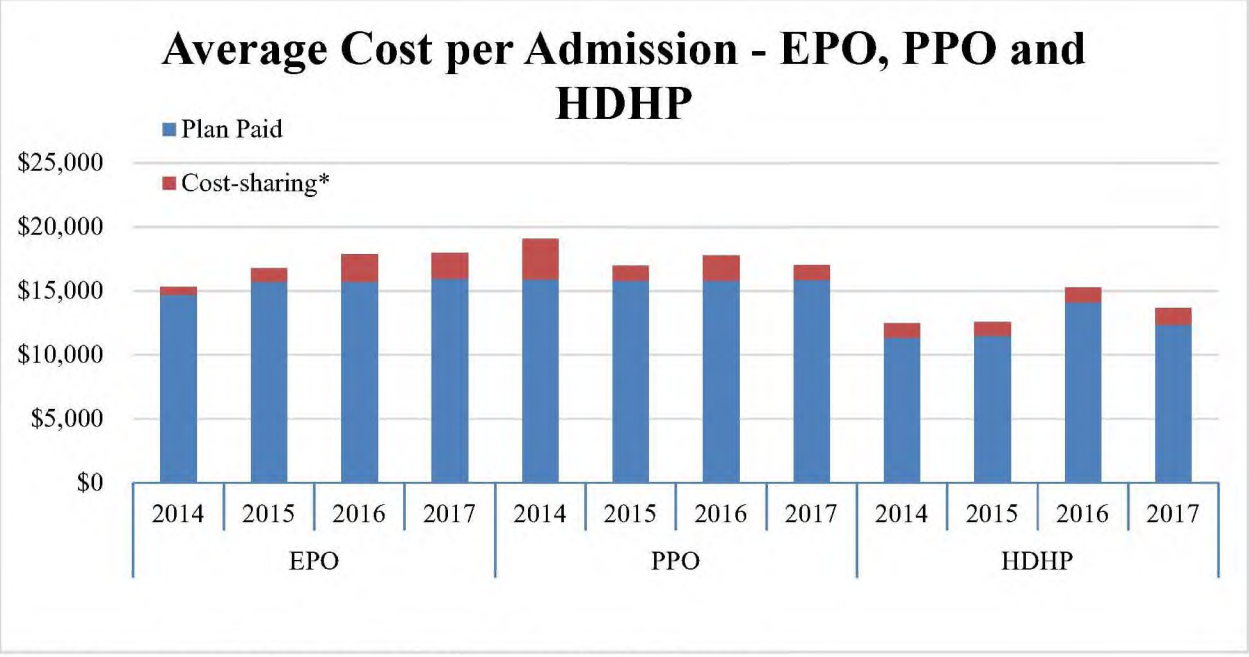


Figure 14: Plan Paid PMPM per Hospital Admission - Active & Retiree

Referencing the total cost share per admission by plan chart below, greater average cost per admission costs were realized in the EPO and PPO plan than in the HDHP plan. This is partly due to Retirees not being eligible for the HDHP. During PY 2017, the Plan paid approximately 89% ($137.9M of $155.1M total) of EPO, 93% ($10.3M of $11.1M total) of PPO and 90% ($1.4M of $1.6M total) of HDHP inpatient costs during PY 2017.



* Includes copay, coinsurance, Medicare, and other insurance

Figure 15: Average Cost per Admission – EPO, PPO and HDHP

Place of Service

The figures below show the total cost by place of service for Active and Retirees over the past four years. Increasing medical costs consistent with the industry trend as well as a slight increase in both Active and Retiree membership are the main causes of the increase in costs for most service settings.

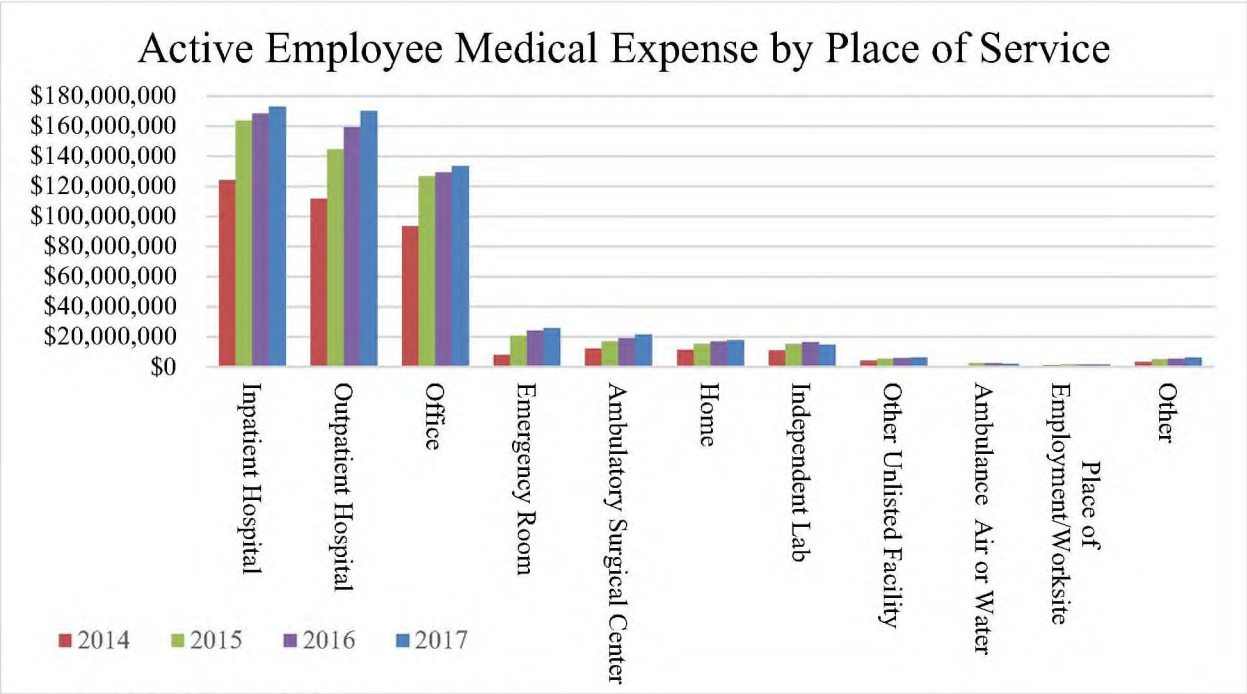


Figure 16: Medical Expense by Place of Service – Actives

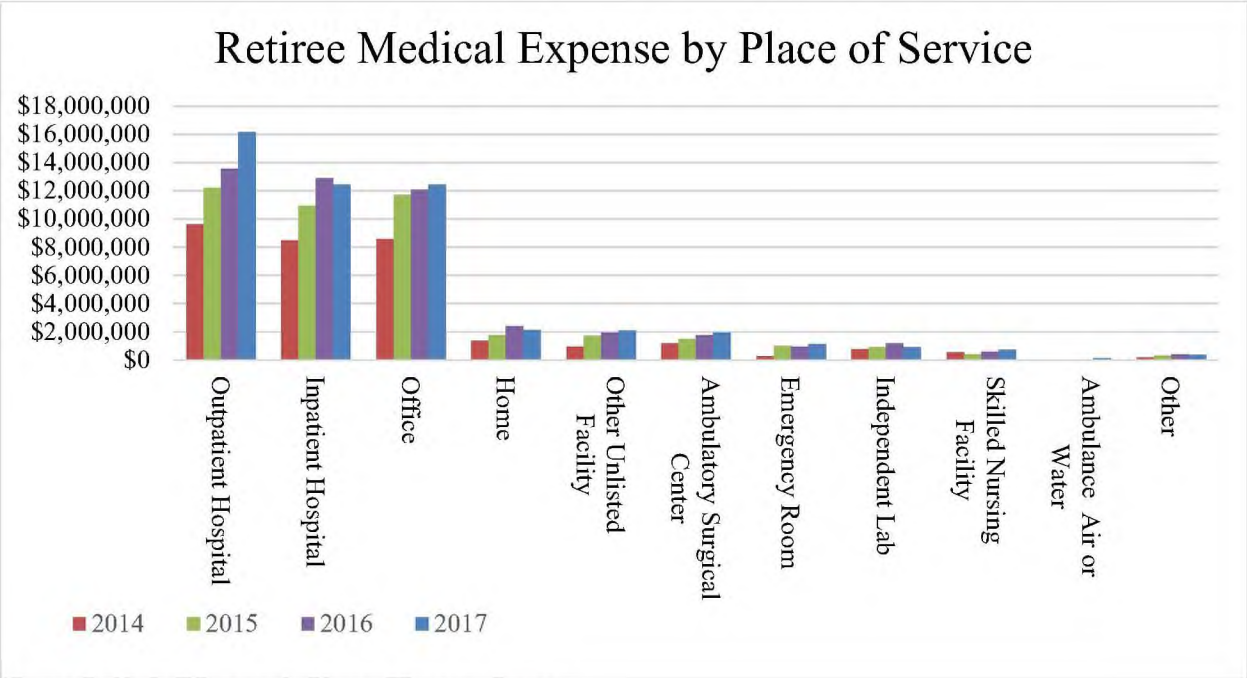


Figure 17: Medical Expense by Place of Service – Retirees

Emergency
During PY 2017, there were approximately 223 emergency room visits per 1,000 members of the self-funded plan. That is a slight decrease over the PY 2016 number of member visits per 1,000, which was 227, a positive sign. The average plan cost per visit was $1,291 (inclusive of both facility and professional costs), slightly higher than in previous three years where the average plan paid per member visits ranged between $1,146 and $1,227 in costs.

Urgent Care Visits
During PY 2017, there were approximately 214 urgent care visits per 1,000 members of the self-funded plan. The average plan costs per urgent care visit was $70 in PY 2017 and the costs have held steady around $70 per visit for the past four years. However, the utilization of urgent care has been steadily increasing since PY 2014 when the urgent care visit figure was 180 per 1,000.

Physician Visits
During PY 2017, there were approximately 3,933 physician visits per 1,000 members of the self-funded plan (or each member of the plan visited a physician's office approximately four times a year on average). Utilization is slightly lower than in the prior three years ranging from 3,951 in PY 2014 to 3,954 in PY 2016. This is not a favorable movement. With routine preventative visits being covered at no cost in PY 2018, we are hoping to see the number of physician visits to go back up. The average plan costs per office visit in PY 2017 was $73. Costs have increased over the last three years from $65 in PY 2014 to $73 in PY 2017.

Annual Prescription Use
The table below show the average number of prescriptions filled by Active and Retiree members, including those that did not utilize the pharmacy benefit at all during the year. This shows a slight positive downward trend for the Retiree population; meaning as new people are coming on the plan, they are utilizing the pharmacy benefit at a lower rate than those already on the plan. The average number of prescriptions per Retiree member per year over the last four years was 29.5 while the PY 2017 figure came out to 28.3. The Active population's utilization has been steady between PY 2014 and PY 2017 at an average of 9.3 filled prescriptions per year. In fact, it has slightly decreased in PY 2017 to 9 filled prescriptions per year. As expected, the cost of average prescription refill goes up by age.

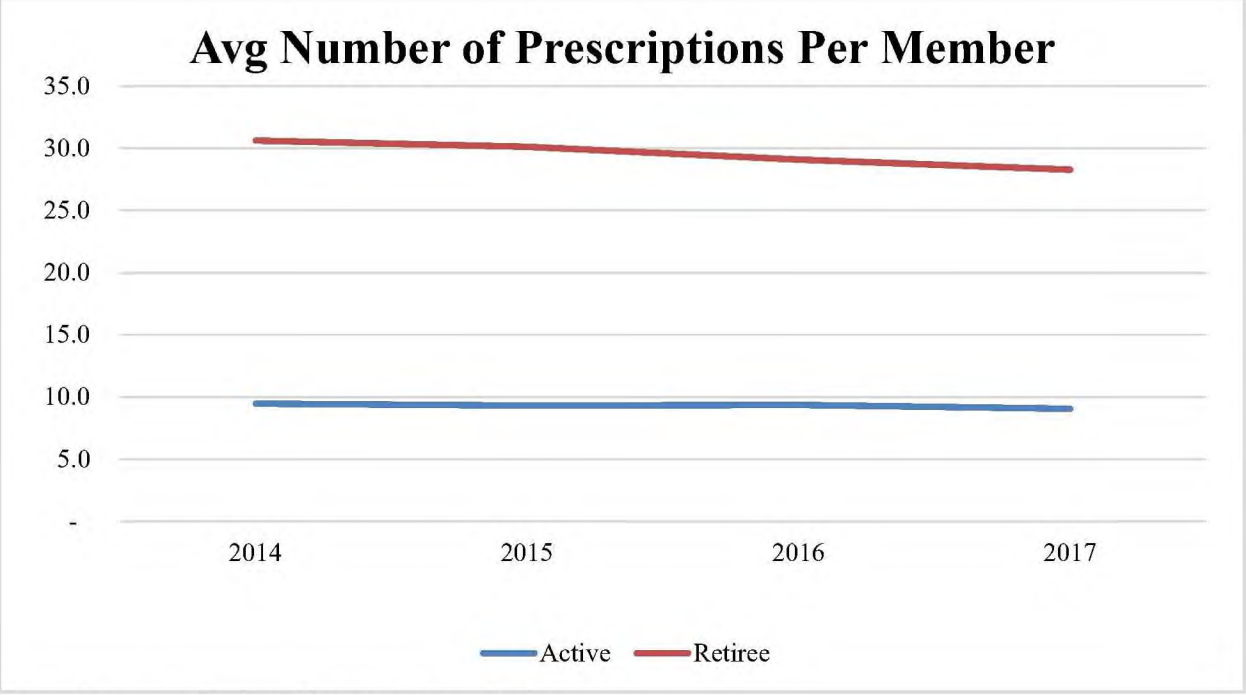


Figure 18: Average Number of Prescriptions per Member

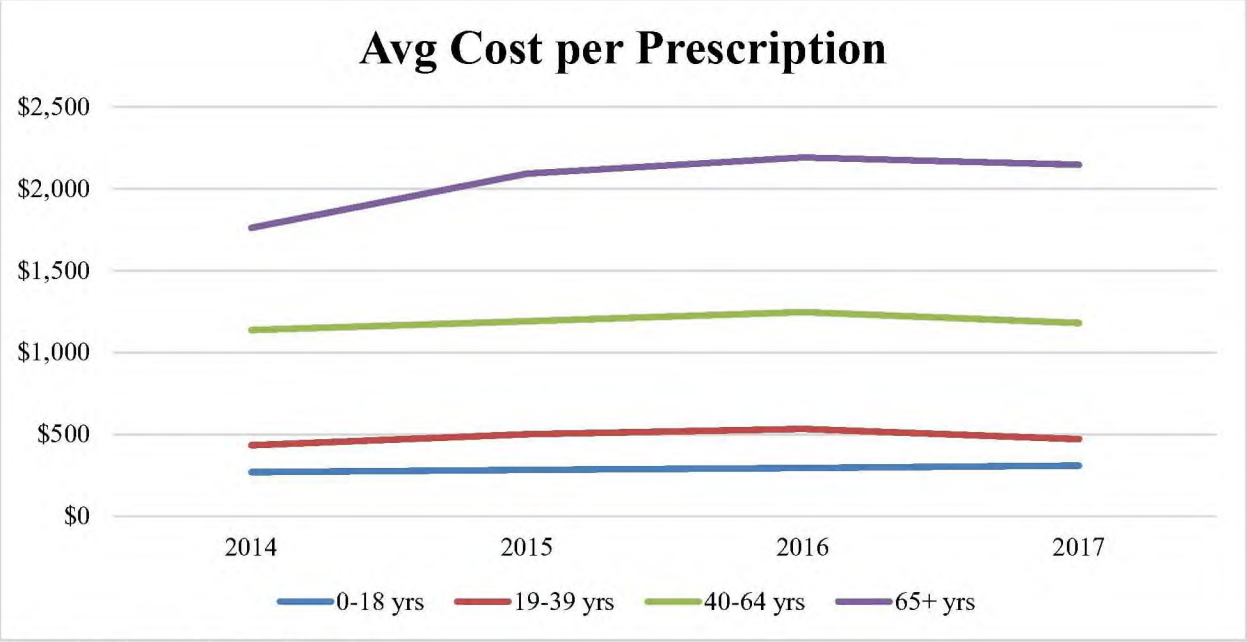


Figure 19: Average Cost per Prescription

When examining the utilization of the pharmacy benefit, it shows those utilizing the pharmacy benefit are overall maintaining or even decreasing the number of prescriptions filled but the cost per utilizing member is steadily increasing. This indicates an increasing overall cost in the pharmacy benefit.

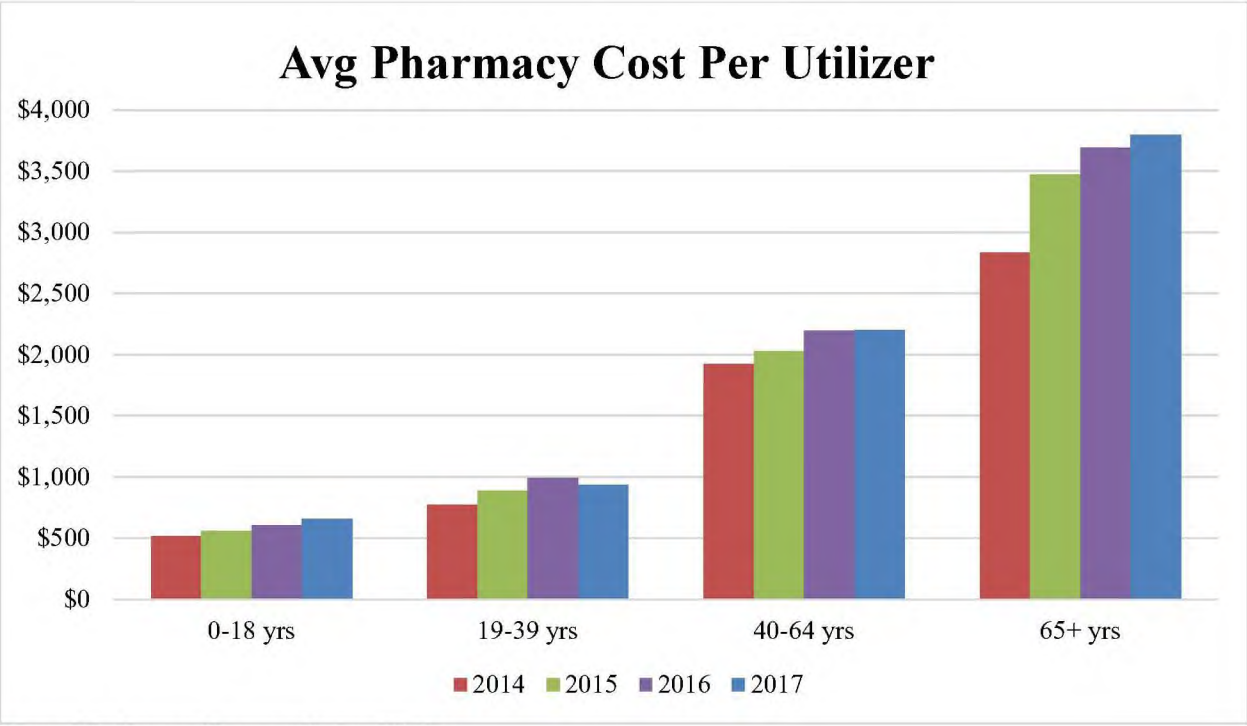


Figure 20: Average Pharmacy Cost per Utilizer

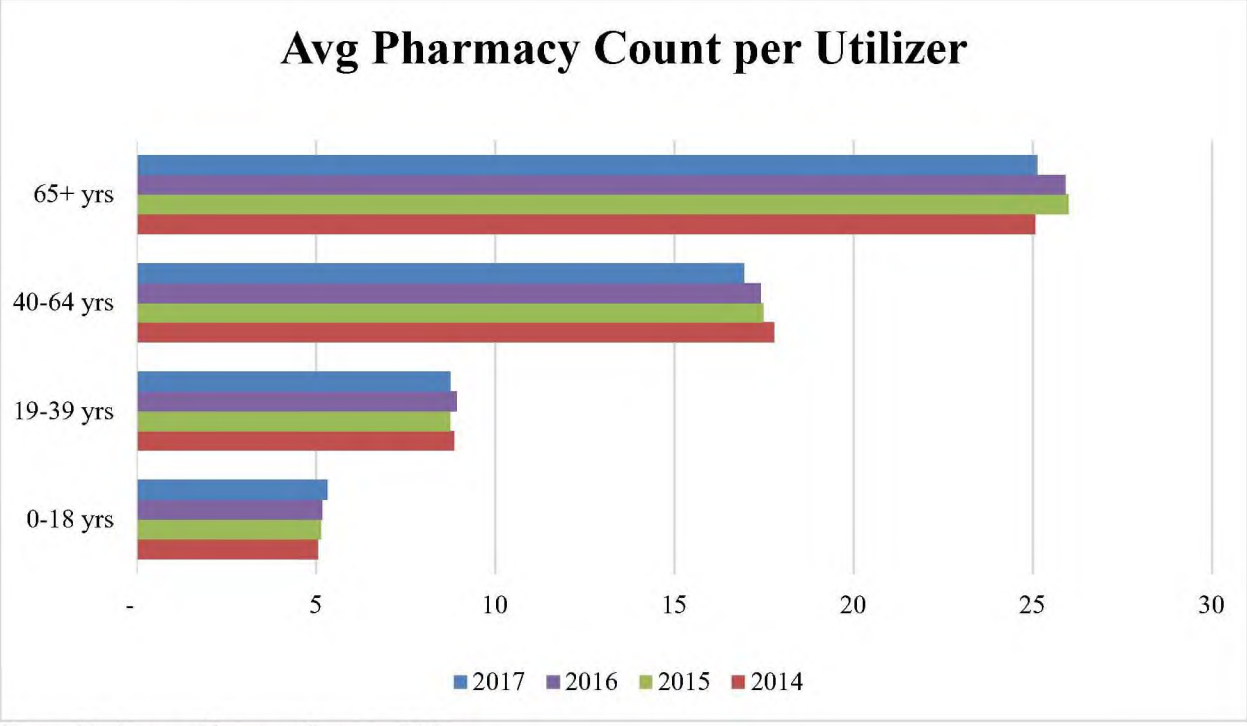


Figure 21: Average Pharmacy Count per Utilizer

Generic and Brand-name Prescription Utilization

The table below shows a positive trend in the utilization of the lower cost drugs. Generic drugs tend to have the lower overall cost to the plan, preferred have a higher cost to the plan and non-preferred tend to have the highest cost to the plan. The trend shown below indicates a slight

increase in the utilization of the generic drugs with a slight decrease in preferred and non-preferred drugs and that generic drugs make up an increasing count of total drugs (just over 84% in PY 2017). This is a positive development.

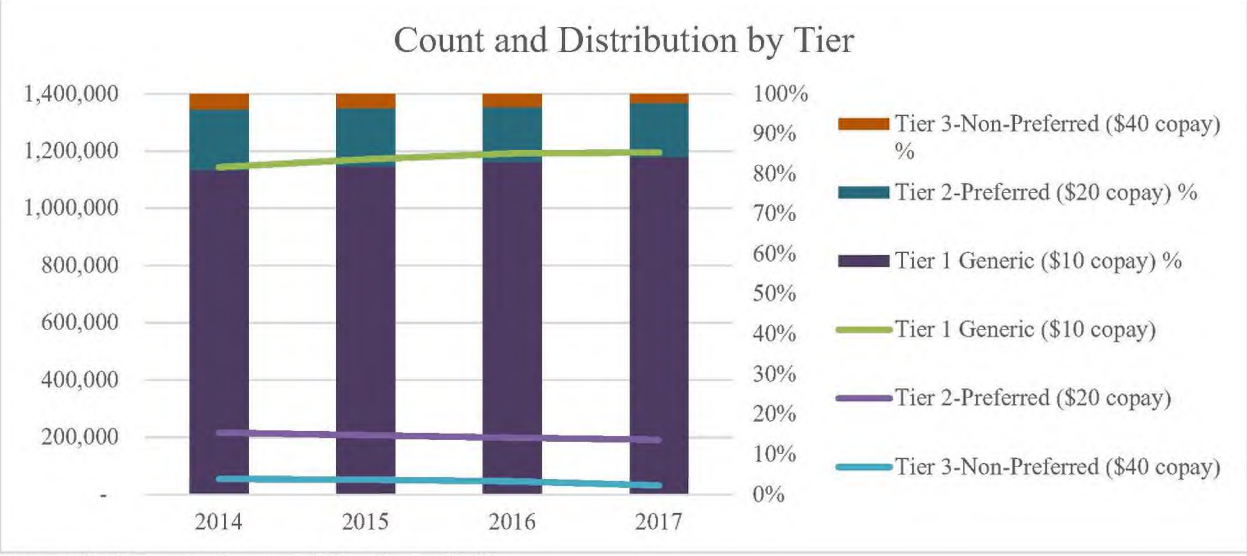


Figure 22: Pharmacy Count and Distribution by Tier

Prescription Use by Therapeutic Class

The following graph shows spend by therapeutic class by year. In seven out of the top ten classes, expenses have increased. However, the PY 2017 medical trend remained flat, and thus the overall pharmacy spent only increased marginally due to slightly higher membership. The top ten classes make up approximately 63.8% ($116.1M) of the total spend ($181.9M) in PY 2017 which is slightly up from 59.7% in PY 2016. Diabetes and inflammatory disease appear to be the highest cost drivers. Even though the top ten therapeutic classes have seen an increase, the remaining classes have seen a decrease, which explains the nearly flat total pharmacy spent.

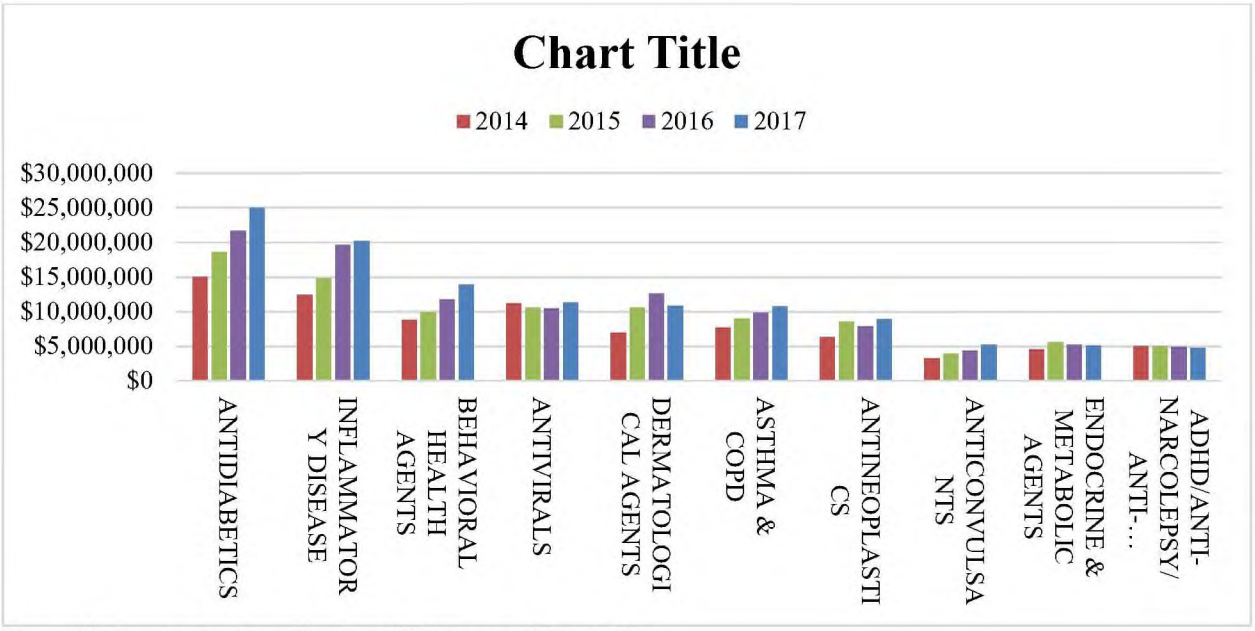


Figure 23: Prescription Spend by Top 10 Therapeutic Class by Year

Prescription Use by Type of Drug

The graph below shows spend for top ten drug by year. In almost all of the top ten drugs, expenses have increased. The top ten drugs make up approximately 15.4% ($28M) of the total $181.8M drug spend in PY 2016, which is slightly up from the prior year of 14.8%. The top two drugs in 2016 are Humira Pen and Enbrel (both are drugs used to treat inflammation). The top three drugs make up more than half ($14.7M) of the spend for the top ten drugs ($28M).

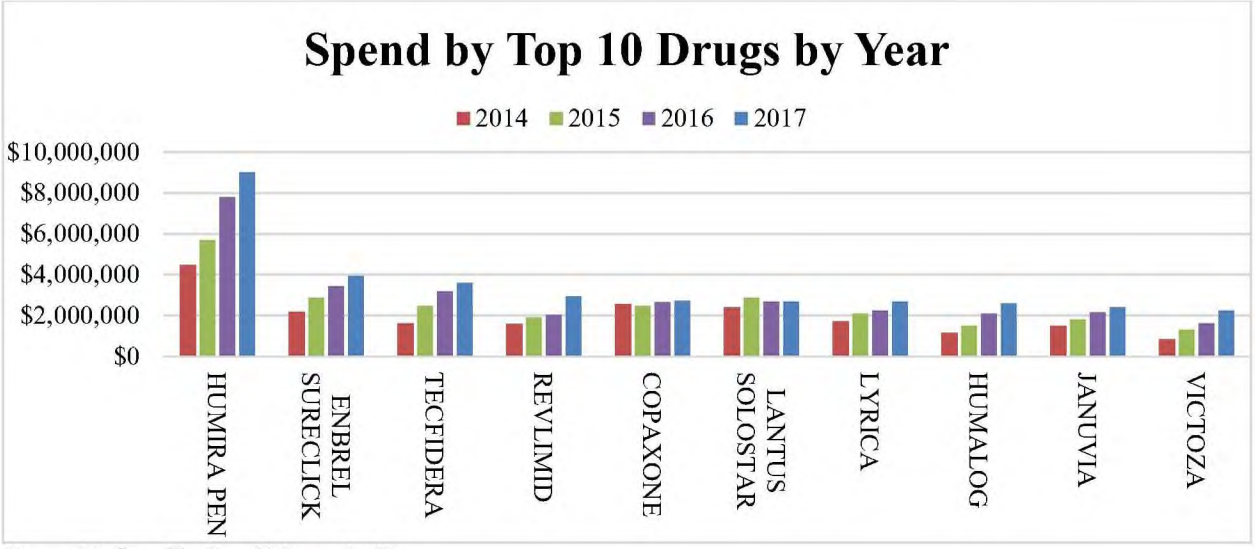


Figure 24: Spend by Top 10 Drugs by Year

Dental Plan Enrollment

In PY 2017, Benefit Services Division offered two different types of dental plans: a fully-insured Dental Health Maintenance Organization (DHMO) plan administered by Total Dental Administrators (TDA) and a self-insured Dental Preferred Provider Organization (DPPO) plan administered by Delta Dental. In PY 2018, the fully-insured DHMO vendor became Cigna Dental.

DHMO Plan
Within the DHMO plan, services must be obtained from a participating dental provider (PDP). There are no annual deductibles or out of pocket maximums. The plan coverage maximums include a $200 maximum reimbursement for non-PDP emergency services, $50 for emergency services less member cost share for the service and a $1,500 per person lifetime maximum for orthodontia.

DPPO Plan
Within the DPPO plan, services may be obtained from any dentist and deductibles and out of pocket maximums apply. Benefits may be based on reasonable and customary charges. The plan coverage maximums include a $2,000 maximum per person per year and a $1,500 per person lifetime maximum for orthodontia. Delta Dental administers this plan. The figure below shows how enrollment was distributed by plan and network between Active, Retired, University, and COBRA members. The subscriber references the employee and the member references the employee plus dependents.

Average Monthly Dental Enrollment by Plan					
		2017		2016	
Network	Plan Type	Subscribers	Members	Subscribers	Members
Active	DPPO	22,224	52,866	22,220	52,403
Retiree	DPPO	15,009	23,768	14,183	22,457
University	DPPO	15,465	33,420	16,646	33,292
COBRA	DPPO	205	308	206	296
Total Delta Dental		**52,903**	**110,361**	**53,255**	**108,448**
Active	DHMO	9,686	22,658	9,820	23,169
Retiree	DHMO	2,485	3,797	2,388	3,661
University	DHMO	6,216	12,976	6,060	12,717
COBRA	DHMO	69	121	71	104
Total Dental Administrators		**18,456**	**39,552**	**18,339**	**39,652**
Total		**71,359**	**149,913**	**71,594**	**148,099**

Figure 25: Average Monthly Dental Enrollment by Plan

Dental Premiums

The below tables show the dental premiums by plan and coverage tier per pay period for Active employees and Retirees.

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

*University of Arizona has 24 pay period deductions

Figure 26: Active Dental Premiums per Pay Period (26 pay periods)

Retiree Monthly Dental Premiums		
Plan	**Tier**	**Premium**
DPPO (Delta Dental)	Employee only	$35.94
	Employee + adult	$75.63
	Employee + child	$60.48
	Family	$118.26
DHMO (TDA)	Employee only	$8.99
	Employee + adult	$17.99
	Employee + child	$17.51
	Family	$26.97

Figure 27: Retiree Monthly Dental Premiums

Dental Premium vs. Plan Cost

There were no changes to the PY 2017 contribution strategy for the self-insured dental plan. The Active employees are paying 89% of the average monthly premium while the state paid the remaining 11%. The figure below shows how the average monthly premium compared to the average monthly plan cost for Active employees and Retirees and their dependents (Active and Retiree members).

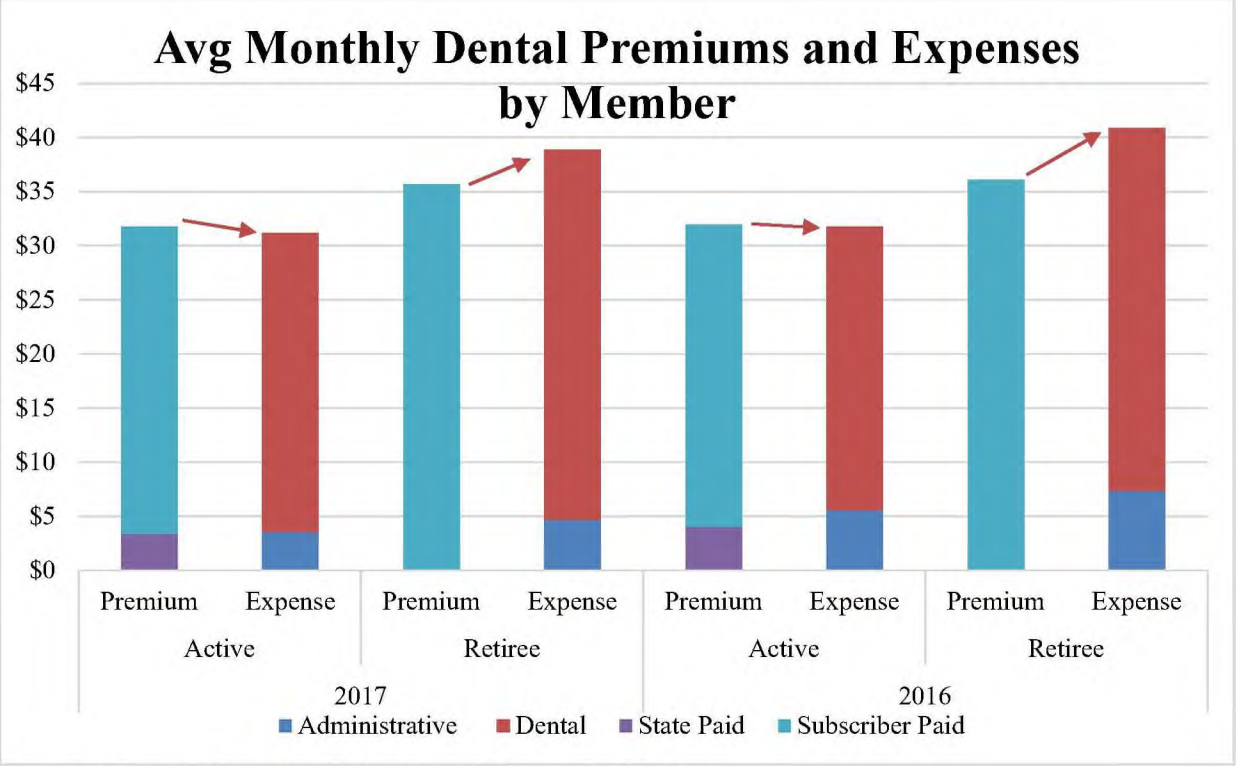


Figure 28: Average Monthly Dental Premiums and Expenses by Member

Expenses for Self-Insured Dental Plan

The figure below show the distribution of claims and expenses incurred in PY 2017 and the average annual cost to insure each type of subscriber/member.

2017 Self-Insured Dental Expenses by Active, Retiree			
Expenses	**Overall**	**Active**	**Retiree**
Dental Claims	38,388,398	$28,652,448	$9,735,951
Rebates & Recoveries	$0	$0	$0
Administration Fees	$1,767,794	$1,266,251	$501,543
Operating Expenses & Adj.	$247,024	$176,941	$70,083
Total Expenses	$40,403,217	$30,095,640	$10,307,577
IBNR Liability	$3,052,000	$2,277,961	$774,039
Total	$43,455,217	$32,373,601	$11,081,616
Enrollment in self-funded plans			
Subscribers	52,902	37,893	15,009
Members	110,361	86,593	23,768
Annual cost			
Per subscriber	$821	$854	$738
Per member	$394	$374	$466

Figure 29: Self-Insured Dental Expenses by Active and Retiree

Wellness

Benefits Services Division provides wellness programs and services to Active State employees. Members have access to preventive health screenings, health management and health education webinars and courses, annual flu vaccines, online lifestyle management programs, onsite seminars, activity challenges and Employee Assistance Program (EAP) benefits.

The Health Impact Program (HIP) offers an incentive based employee wellness program for benefits eligible State of Arizona employees. For PY 2017, the program ran between January and December of 2017. The program launched a new portal to allow employees to engage in preventive services and healthy activities throughout the full year. The mission of the HIP is to promote prevention for early detection and defense against chronic disease thereby encouraging employees to engage in health management programs to reduce risks, change behaviors that lead to healthy outcomes, and to foster greater total health and well-being.

Employees who successfully completed the program by engaging in a variety of wellness activities while accumulating and logging progress towards an end goal of 500 points, were eligible to receive up to a $200 incentive payout which was paid out in the spring of 2018.

Engagement & Incentives

The PY 2017 chart below shows that of the 57,000 eligible members, there were 1,277 new employees in 2017 in addition to the 10,395 employees enrolled in 2016, totaling 11,672 or 20% of the eligible population. Of those that enrolled in the HIP program, 6,872 completed the online Health Assessment, which translates to a 59% completion rate. This represents an increase over PY 2016.

The number of enrolled participants that actively logged points was 8,839 (or 76%). Out of the 4,124 participants logging 500 points, 2,884 were validated and earned the $200 incentive for an estimated payout of $577k (25% of total enrolled). This represents an increase from 20% of those earning the reward in PY 2016. Of total eligible employees, 5% earned the incentive.

By providing the Health Impact Program (HIP) and incentive component, the year over year participation metrics showed an increase in employee engagement and in overall active participation in preventive services, screening referrals, health assessment completion, and educational/behavior change and challenge activities.

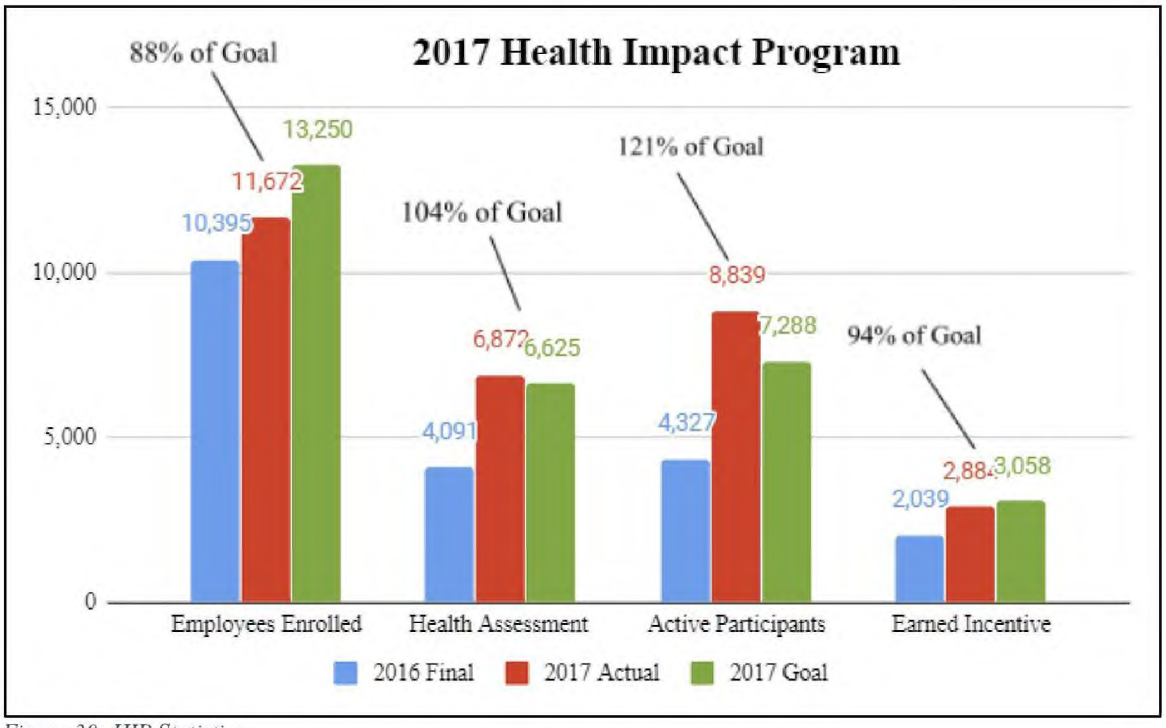


Figure 30: HIP Statistics

Screening Utilization

The table below shows the total utilization of core health screening benefits during the PY 2017 and the number of at-risk employees referred to follow-up care.

PY 2017 Screenings			
	Events	**Participant**	**Referrals**
Mini Health Screening*	95	4,440	
Osteoporosis Screening**		2,002	396
Prostate Specific Antigen (PSA)**		692	23
Hemoglobin A1C **		1,782	183
Mobile Onsite Mammography	64	1,137	27
Prostate Onsite Projects	52	492	49
Total	**211**	**10,545**	**678**

*The basis Mini Health Screening includes: fill lipid panel, fasting blood glucose, blood pressure, BMI and body composition measurements.

** Additional tests offered as a package with the basic Mini Health Screening for those meeting specific age requirements.

Figure 31: Health Screenings

The table below shows the total utilization for the PY 2017 State Wellness Annual Flu Vaccine Program held September 1, 2017 through December 31, 2017. A total of 14,692 vaccines were administered to Active and Retiree members. Members had access to the flu vaccine at 413 locations throughout the state. Ninety four percent of members who received a flu vaccine did so

at a worksite or open enrollment clinic. To contrast, 8,573 members and their dependents received flu vaccines through the medical plan in PY 2017.

PY 2017 Flu Vaccines		
	Locations	**Participants**
State Agency Worksite	193	7,279
University Worksite	41	5,196
Combined Worksite (Wesley Bolin)	3	620
Open Enrollment Clinics	9	779
Public Clinics	167	818
Total	**413**	**14,692**

Figure 32: Flu Vaccines

The plan costs of the PY 2017 State Wellness Annual Flu Vaccine Program totaled $370K, which comes out to an average of $25 per participant. As per Passport Health USA (see link below), each year 5 to 20 percent of the U.S. population gets the flu. Adults 18-64 years of age accounted for almost 60% of reported flu hospitalizations. The result is lost employee productivity, an increase in absenteeism, and costly medical bills. Per the Passport Health USA portal calculator, the estimated medical savings are $1.4M. Taking into account the cost of administering this program of $370K, the estimated net cost avoidance is $1M or an ROI of 3:1 (https://www.passporthealthusa.com/employer-solutions/flu-roi-calculator/). This calculation does not include the cost of absenteeism.

Employee Assistance Program

The table below shows the utilization for the Employee Assistance Program (EAP) and support services offered to agencies covered under the Benefits Services Division. Total utilization for PY 2017 reached 37.2%, an increase from 31% over PY 2016, showing sustained high usage especially when compared to the 24% national standard for government entities. Benefit Services Division covered agencies continue to show utilization higher than Compsych's Book of Business. The PY 2017 contract increased the number of visits from 6 - 12 per issue, per person/year. It also increased the hours available for employee training, events and Critical Incident Support Management from 117 to 230 respectively.

PY 2017 EAP Utilization			
	Eligible Population	**Users**	**Utilization Rate**
Live Telephonic Access		**2,912**	
EAP		2,247	
FamilySource		129	
FinancialConnect		98	
LegalConnect		438	
Online Access		**9,633**	
EAP		2,408	
FamilySource		2,572	
FinancialConnect		819	
GlobalConnect		8	
Health & Wellness		1,042	
LegalConnect		2,784	
Critical Incident Stress Debriefing		**310**	
Trainings		**961**	
Overall Utilization	**37,148**	**13,816**	**37.2%**

Figure 33: EAP Utilization

In addition to health screenings, vaccines, and EAP services, the strategic plan for PY 2017 continued to provide employees with increased access to online mindfulness and stress reduction by enhancing the options for participation in the sessions through eMindful, Inc.

PY 2017 Online Courses through eMindful, Inc.		
	Classes	**Participants**
Mindfulness at Work 1-hr Webinars	**24**	**2,937**

Figure 34: Online Webinar Participation

Life, Disability, Vision Insurance and Flexible Spending Accounts

Fund 3035, ERE/Benefits Administration, is used to pay fully insured premiums and administer State employees benefit plans other than health and dental. These include basis, supplemental, and dependent life insurance, short-term and non-ASRS long-term disability insurance, vision insurance, and medical and dependent care flexible spending accounts. Basic life and non-ASRS long term disability insurance is funded solely by State agency premiums (employer premiums) while all others are funded solely be employee premiums. Fund 3035 is primarily a pass-through fund with collections funding the premiums payments. The table below is a cash statement of receipts received and expenses paid during PY 2017 for 2017 incurred revenues and expenditures as well as for prior plan years. In PY 2017, the life & disability insurance services were provided by Hartford Life and Accident Insurance Company, while vision benefits were offered through Avesis Third Party Administrators, Inc. (Avesis) and dependent and flexible spending account services through Application Software, Inc. (ASIFlex).

ERE/Benefits Administration Fund Summary				
				Plan Year 2017
Beginning Fund Balance January 01, 2017				**$4,286,420**
Revenues				
Insurance Product	**Amount**			
Basic Life	$1,127,343			
Supplemental Life	10,320,081			
Dependent Life	2,714,305			
Short Term Disability	4,329,884			
Long Term Disability	3,505,543			
Total Life & Disability			**$21,997,157**	
Vision			**5,389,677**	
Health Care FSA	$3,395,091			
Dependent Care FSA	1,390,616			
Total Flex Spending			**$4,785,707**	
Total Revenues				**$32,172,540**
Expenditures				
Insurance Product	**Amount**	**Penalties**		
Basic Life	$1,126,485	(3,089)		
Supplemental Life	10,316,315	(29,466)		
Dependent Life	2,713,487	(8,030)		
Short Term Disability	4,539,051	(13,168)		
Long Term Disability	3,495,226	(7,997)		
Total Life & Disability*			**$22,128,815**	
Vision*	5,371,950		**$5,371,950**	
Health Care FSA	3,246,703	(2,655)		
Dependent Care FSA	1,446,960	(1,138)		
Administrative Fees*	79,164.00			
Total Flex Spending			**$4,769,034**	
Total Expenditures	**$32,335,342**	**(65,543)**		**$32,269,799**
Ending Fund Balance December 31, 2017				**$4,189,161**

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

Figure 35: ERE/Benefits Administration Fund 3035 Summary

Vendor Performance Standards

Pursuant to A.R.S. § 38-658(B), "On or before October 1 of each year, the Director of the Department of Administration shall report to the Joint Legislative Budget Committee on the performance standards for health plans, including indemnity health insurance, hospital and medical service plans, dental plans, and health maintenance organizations."

Among the terms of the self-insured health insurance contracts and other contracts the Benefit Services Division administers are several ADOA negotiated performance measures with specific financial guarantees tied to vendor performance of the contracted services. If a vendor fails to meet any of the measures within the specified performance range, the vendor is required to submit a Corrective Action Plan detailing why the measure was missed and any actions taken to address the issue and improve performance to meet the standard of the measure. A percentage of the vendor's annual payment, or previously agreed upon amount, is then withheld by ADOA as a performance penalty per the terms of the vendor contract. This percentage is allocated among the more critical measures of the contract.

The following is a report of the agreed-upon performance standards both met and missed by contracted vendors during PY 2017. In each case, performance penalties for measures missed are assessed per the terms of the individual vendor contract. As some performance metrics are yet to be finalized, the estimated performance penalty paid to Benefit Services Division related to PY 2017 will be approximately $325,600.

Aetna

Performance Measures	
Performance Measure	Fees At Risk
Total Performance Measures = 194 Targets successfully met = 175 Targets missed resulting in penalties = 6 Targets Pending = 13	Approximately $9,721

Performance Measures Not Met		
Performance Measure	Fees At Risk	Total % Assessed
Account Management – At least 98% of enrollments processed within 2 business days of receipt of the file load	1% of Total Administrative Fee	Missed 1 of 12 months measured = 0.08%
Appeals – At least 95% of urgent pre-service appeals are resolved within 15 calendar days of receipt; post-service appeals resolved within 30 days.	1.50% of Total Administrative Fee	Missed 1 of 12 months measured = 0.125%
Claims – Processing Turnaround Time: At least 98% of all fully-documented claims will be processed within 30 calendar days of receipt	1.00% of Total Administrative Fee	Missed 1 of 12 months measured = 0.08%
HSA Administration – Quality Member Phone Services: Call abandonment rate is ≤	3.00% of HSA Fees	Missed 1 of 12 months measured = 0.25%

Performance Measures Not Met		
Performance Measure	Fees At Risk	Total % Assessed
3%; average speed to answer for all phone calls is 30 seconds or less		
Claims – Processing Accuracy: At least 98% of claims will be processed accurately	1.00% of Total Administrative Fee	Missed 1 of 12 months measured = 0.08%
HSA Administration – Member Satisfaction: At least 90% satisfaction rate on the annual member satisfaction survey conducted by ADOA.	3.00% of HSA Fees	Missed 1 of 1 annual measurement = 3.00%

Cigna

Performance Measures	
Performance Measure	Fees At Risk
Total Performance Measures = 200 Targets successfully met = 183 Targets missed resulting in penalties = 11 Targets Pending = 6	Approximately $12,155

Performance Measures Not Met		
Performance Measure	Fees At Risk	Total % Assessed
Appeals - Accurate and timely response to member request for review; urgent appeals resolved within three (3) business days of request, pre-service resolved within 15 calendar days of request and post-service resolved within 30 calendar days of request	0.75% of Total Administrative Fee	Missed 6 of 12 months measured = 0.375%
Customer Service Nurse Line - Cigna will provide Nurse Line phone service to members with no more than 3% abandonment rate, an average speed to answer of 30 seconds or less, and 90% of all calls must be appropriately triaged	0.66% of Total Administrative Fee	Missed 1 of 12 months measured = 0.05%
Customer Service – Member Satisfaction Survey: At least 90% satisfaction rate on the annual member satisfaction survey conducted by ADOA	0.67% of Total Administrative Fee	Missed 1 of 1 annual measurement = .67%
Claims – Processing Accuracy: At least 99% of claims will be processed accurately	1.34% of Total Administrative Fee	Missed 3 of 12 months measured = 0.335%

UnitedHealthcare

Performance Measures	
Performance Measure	Fees At Risk
Total Performance Measures = 200 Targets successfully met = 192 Targets missed resulting in penalties = 3 Targets Pending = 5	Approximately $30,675

Performance Measures Not Met		
Performance Measure	Fees At Risk	Total % Assessed
Claims – Overall Accuracy Rate: At least 99% of all claims will be processed accurately	.50% of Total Administrative Fee	Missed 2 of 12 months measured = 0.08%
Case Management and Disease Management – Member Satisfaction Survey: At least 90% satisfaction rate on the annual Member Satisfaction Survey conducted by ADOA	1.00% of CM/DM Administrative Fee	Missed 1 of 1 annual measurement = 1.00%

Blue Cross Blue Shield (BCBS) of Arizona

Performance Measures	
Performance Measure	Fees At Risk
Total Performance Measures = 200 Targets successfully met = 192 Targets missed resulting in penalties = 2 Targets Pending = 6	Approximately $8,221

Performance Measures Not Met		
Performance Measure	Fees At Risk	Total % Assessed
Claims – Processing accuracy: At least 99% of all claims will be processed accurately	1.00% of Total Administrative Fee	Missed 1 of 12 measured = 0.08%
Case Management and Disease Management – Member Satisfaction Survey: At least 90% satisfaction rate on the annual Member Satisfaction Survey conducted by ADOA	1.00% of CM/DM Administrative Fee	Missed 1 of 1 annual measurement = 1.00%

MedImpact

Performance Measures	
Performance Measure	Fees At Risk
Total Performance Measures = 109 Targets successfully met = 106 Targets Pending = 1	Approximately $74,000

Performance Measures Not Met		
Performance Measure	Fees At Risk	Total % Assessed
Customer Service – Member Satisfaction Survey: At least 90% satisfaction rate on the annual member satisfaction survey conducted by ADOA	$70,000 annual amount at risk	Missed 1 of 1 annual measurement = $70,000
EGWP – Enrollment Request Acknowledgement: Acknowledgement provided within 10 calendar days of receipt of a completed enrollment	$16,000 annual amount at risk, $4,000 quarterly	Missed 1 of 4 quarterly measurements = $4,000

Delta Dental

Performance Measures	
Performance Measure	Fees At Risk
Total Performance Measures = 262 Targets successfully met = 260 Targets missed resulting in penalties = 2	Approximately $3,691

Performance Measures Not Met		
Performance Measure	Fees At Risk	Total % Assessed
Customer Service – Abandonment Rate: Abandonment rate no more than 2%	.75% of Total Administrative Fee	Missed 1 of 12 measured = 0.06%
Customer Service – Average time to answer: average time to answer calls requesting member services representative will be answered in no more than 30 seconds	1.75% of Total Administrative Fee	Missed 1 of 12 measured = 0.145%

Total Dental Administrators (TDA)

Performance Measures	
Performance Measure	Fees At Risk
Total Performance Measures = 136 Targets successfully met = 135 Targets missed resulting in penalties = 1	Approximately $68,779

Performance Measures Not Met		
Performance Measure	Fees At Risk	Total % Assessed
Customer Service – Member Satisfaction Survey: At least 80% satisfaction rate on the annual member satisfaction survey conducted by ADOA	2.00% of Total Administrative Fee	Missed 1 of 1 annual measurement = 2.00%

Compsych

Performance Measures	
Performance Measure	Fees At Risk
Total Performance Measures = 39 Targets successfully met = 38 Targets missed resulting in penalties = 0	No penalties

Performance Measures Not Met		
Performance Measure	Fees At Risk	Total % Assessed
N/A	N/A	N/A

Avesis

Performance Measures	
Performance Measure	Fees At Risk
Total Performance Measures = 182 Targets successfully met = 181 Targets missed resulting in penalties = 1	Approximately $53,847

Performance Measures Not Met		
Performance Measure	Fees At Risk	Total % Assessed
Account Management – Satisfaction Survey: Average of 90% of management staff satisfied with account management staff	1.00% of Premiums	Missed 1 of 1 annual measurement = 1.00%

Application Software, Inc. (ASI)

Performance Measures	
Performance Measure	Fees At Risk
Total Performance Measures = 49 Targets successfully met = 49	No penalties

Performance Measures Not Met		
Performance Measure	Fees At Risk	Total % Assessed
N/A	N/A	N/A

The Hartford

Performance Measures	
Performance Measure	Fees At Risk
Total Performance Measures = 141 Targets successfully met = 138 Targets missed resulting in penalties = 2 Targets pending = 1	Approximately $64,158

Performance Measures Not Met		
Performance Measure	Fees At Risk	Total % Assessed
STD Claims – Fully Documented Claim	.50% of Total	Missed 1 of 12 measured =

Performance Measures Not Met		
Performance Measure	Fees At Risk	Total % Assessed
Turnaround Time: At least 95% of all fully documented STD claims processed within 5 calendar days of receipt	Premiums	0.04%
Customer Service – Member Satisfaction Survey: At least 85% satisfaction rate on the annual member satisfaction survey conducted by ADOA	.25% of Total Premiums	Missed 1 of 1 annual measurement = 2.00%

Audit Services

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

The audit schedule for the 2017 plan year was developed using a combination of contract elements and risk analysis to ensure the health plan vendors appropriately provided contracted services. One completed audit project for the 2017 plan year identified no exceptions, dollars for recovery, or recommendations to be implemented. Three audit projects began during the 2017 plan year and were not completed until 2018 due to their complexity, in addition to an unscheduled project that included user acceptance testing of a newly implemented claims data warehouse tool.

The reporting year of implementation of any given plan year recommendations and health plan recoveries for completed audits will vary based on the completion date of all corrective action plan directives. In many cases, directives may still be in progress and may roll over to a new plan year.

Individual audit objectives were developed with the consideration of dollar value, complexity of operations, changes in personnel or operations, loss exposure, and previous audit results. Audits and other projects were completed, but were not limited to the following functional areas:

Functional Area	**Audit Methodology**
Vendor operating transactions	Statement on Standards for Attestation Engagements No. 16 Audits (SSAE 16)
Audit program improvement initiatives	Administrative functions and program-specific improvements

Vendor Operating Transactions

All health plan contracted vendors that pay claims are required to provide a copy of a SSAE 16, which is an independently assessed operational annual or semi-annual audit. SSAE 16 audits evaluate the internal controls of the vendor's systems utilized to process claims and identify deficiencies. Audit Services reviewed the SSAE 16 reports provided by each of the vendor's

external auditors. There were no instances of significant operating failure noted and no corrective action was required. In addition, audits performed by external or third party vendors are evaluated and considered for the development of the audit schedule when there is significant impact the on the health plan and contract compliance (i.e. large medical and/or pharmacy claims audit).

Audit Program Improvement Initiatives

In addition to the regularly scheduled audits, reviews, and evaluations listed above, Audit Services assisted in performing user acceptance testing of a newly implemented claims data warehouse tool. Claims paid on behalf of the health plan members are loaded into the MedInsight warehouse tool. The tool allows for the ease and accuracy of extraction of claims data based on various data fields to accommodate audit objectives and scope, among other functionalities that the tool provides.

Audit Services continues to strive towards improvement and efficiency; the focus during the 2017 plan year was to streamline administrative functions to improve audit program initiatives.

External Audits

In addition to audits concluded by the Benefit Services Division's Audit Services Unit, BSD also contracts with external consulting forms to perform external audits of the self-insured medical, pharmacy and dental vendors.

Towards the end of 2016 and concluding in the second half of 2017, the self-insured medical, pharmacy and dental vendors were audited. Mercer Health & Benefits LLC conducted the plan audits of all four medical vendors while Conduent HR Consulting conducted the MedImpact pharmacy and Delta Dental PPO plan audits. The audits covered PY 2014 and PY 2015, and evaluated a sample selected using a combined financial stratified attribute sampling. This approach provided a sample of claims that was representative of actual claim payment patterns over the audit period.

The audits focused on financial accuracy, payment incidence accuracy, claim processing accuracy, and turnaround time. The audit results were mostly satisfactory, with some vendor results falling short of the ADOA performance guarantees and generally accepted industry standards. The total dollars paid in error in the statistical samples amounted to the following:

- Aetna: $9,697
- BCBS: $15,475
- Cigna: $10,771
- UHC: $8,351
- MedImpact: $10,414
- Delta Dental: $0

Any incorrectly processed and paid claims were reprocessed within timely processing timeliness, or the plan was reimbursed for plan overpayments. Several instances of error because plan clarifications or intent were resolved and the plan documents were updated to reflect the plan intent.

Appendix

Special Employee Health Fund Cash Statement

Special Employee Health Fund Cash Statement

Plan Year 2017				
Beginning Fund Balance January 01, 2017				**$279,616,289**
Revenues				
Source	**Premiums**			
ADOA Health Plan (EE)	$132,748,373			
ADOA Health Plan (ER)	631,020,529			
BCBS NAU Plan (EE)	8,583,683			
BCBS NAU Plan (ER)	33,886,554			
ADOA Dental Plan (EE)	29,485,646			
ADOA Dental Plan (ER)	13,691,606			
PrePaid Dental Plan (EE)	1,715,780			
PrePaid Dental Plan (ER)	2,123,332			
Other Revenue	(454,862)			
Net Revenue	**$852,800,641**			**$852,800,641**
Expenditures				
Vendor	**Admin Fees**	**Penalties**		
Aetna	3,067,024	(11,025)		
Blue Cross Blue Sheild AZ	6,557,365	(72,264)		
Cigna	1,821,319	(10,468)		
UnitedHealthcare	12,903,528	(36,008)		
MedImpact	1,808,339	(25,000)		
HSA Funding (EE and ER)	608,865	-		
Delta Dental	1,767,794	-		
HIP Payout	1,902	-		
ACA Related Taxes/Fees	3,400,366	-		
AG Collection Fees	9,331	-		
Net Administrative Fees*	31,945,833	(154,764)	31,791,068	
	Claims	**Recoveries****		
Aetna	46,757,510	-		
AmeriBen	-	(138,601)		
Blue Cross Blue Shield AZ	150,034,291	(1,548,343)		
Cigna	55,384,517	(1,623)		
UnitedHealthcare	380,167,647	(511,471)		
MedImpact	180,382,413	(16,938,565)		
Medicare Part D Retiree Drug Subsidy	-	(13,624,879)		
Delta Dental	38,420,493	-		
Other Wellness	752,129	-		
Net Claims	851,898,999	(32,763,482)	819,135,516	
Self-Insured Expenditures	**883,844,831**	**(32,918,247)**	**$850,926,584**	
	Premiums	**Penalties**		
BCBS (NAU Only)	42,508,253	-		
Total Dental Administrators	3,670,713	(73,414)		
Fully Insured Expenditures	**46,178,965**	**(73,414)**	**46,105,551**	
HITF Operating	$5,206,357	-		
Fund Transfers Out***	78,904,000	-		
Administrative/Cash Adjustments	24,005	-		
Operating Expenes and Transfers	**$84,134,362**	**$0**	**$84,134,362**	
Net Expenditures and Transfers	**$1,014,158,159**	**($32,991,661)**		**$981,166,498**
Ending Fund Balance December 31, 2017				**$151,250,433**
IBNR Liability (Medical & Dental)				$85,241,000
Contingency Reserve (Medical & Dental)				$85,241,000
Unrestricted Cash Balance As Of December 31, 2017				**($19,231,567)**

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

** Recoveries include Medicare Part D Retiree Drug Subsidy reimbursement, prescription drug rebates, overpayment recoveries (including stop payments and voids) and subrogation recoveries.

*** Fund transfers from HITF to other State funds.

Figure 36: Special Employee Health Fund Cash Statement

Glossary of Terms

Active member(s) – An employee and their eligible dependents, as defined in the Arizona Administrative Code, who are enrolled in one of the health plan options offered by the State. (Also referred to as "Actives".)

Administrative fees – Fees paid to third-party vendors for plan administration, network rental, transplant network access fees, shared savings for negotiated discounted rates with other providers, COBRA administration, direct pay billing, additional reporting billing, State fees (MA, MI and NY), and bank reconciliation fees.

Case management – A collaborative process that facilitates recommended treatment plans to ensure that appropriate medical care is provided to disabled, ill, or injured individuals.

Claim – A provider's demand upon the payer for payment for medical services or products.

Claim appeal – A request by an insured member for a review of the denial of coverage for a specific medical procedure contemplated or performed.

COBRA, Consolidated Omnibus Budget Reconciliation Act of 1985 – A federal law that requires an employer to allow eligible employees, Retirees, and their dependents to continue their health coverage after they have terminated their employment or are no longer eligible for the health plan - COBRA enrollees must pay the total premium, in addition to an administrative fee of 2%.

Contribution strategy – A premium structure that includes both the employer's financial contribution and the employee's financial contribution towards the total plan cost.

Copayment – A form of medical cost-sharing in the health plan that requires the member to pay a fixed dollar amount for a medical service or prescription.

Deductible – A fixed dollar amount that a member pays during the plan year, before the health plan starts to make payments for covered medical services.

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

DHMO/Pre-Paid Dental – A dental plan that offers members dental services with no annual maximums or claim forms, and services based on a discounted rate. Total Dental was the PY 2017 prepaid dental vendor.

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

Disease management – A comprehensive, ongoing, and coordinated approach to achieving desired outcomes for a population of patients. These outcomes include improving members' clinical conditions and qualities of life as well as reducing unnecessary healthcare costs. These objectives require rigorous, protocol-based, clinical management in conjunction with intensive patient education, coaching, and monitoring.

Eligibility appeal – The process for a member to request a review of a health plan decision regarding a claimant's qualifications for, or entitlement to, benefits under a plan.

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

Employee Group Waiver Program (EGWP) – An employer group Medicare Prescription D drug plan.

Exclusive Provider Organization (EPO) – A health plan designed with an exclusive provider organization or network. Enrollees are limited to access in-network providers and are subject to co-pays. Any exceptions require prior authorization.

Flexible spending account (FSA) – An account that can be set up through the State's Benefit Options program, an FSA allows an employee to set aside a portion of his/her earnings to pay for qualified medical and dependent care expenses. Money deducted from an employee's pay and put into an FSA is not subject to payroll taxes.

Formulary – A list of preferred medications covered by the health plan. The list contains generic and brand-name drugs. The most cost-effective brand-name drugs are placed in the "preferred" category and all other brand-name drugs are placed in the "non-preferred" category.

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

High Deductible Health Plan (HDHP) – A health plan designed with an open access provider organization or network. Enrollees have access to in-network and out-of-network providers, and are subject to coinsurance and higher annual deductibles than traditional plans. Out-of-network providers require greater coinsurance.

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

Inpatient Admissions per 1,000 Members – the number of hospital admissions for every 1,000 members. And admission can be more than one day

Integrated – A health plan operation administered by one entity. Such operations include claims processing and payment, a network of medical providers, utilization management, case management, and disease management services.

Medicare – The federal health insurance program provided to those who are age 65 and older, or those with disabilities, who are eligible for Social Security benefits. Medicare has four parts: Part A, which covers hospitalization; Part B, which covers physicians and medical providers; Part C, which expands the availability of managed care arrangements for Medicare recipients; and Part D, which provides a prescription drug benefit. Retirees signing up for ADOA insurance must enroll in Parts A and B, but not C or D.

Member – A health plan participant. This individual can be an employee, Retiree, spouse, or dependent.

Network – An organization that contracts with providers (hospitals, physicians, and other healthcare professionals) to provide health care services to members. Contract terms include agreed upon fee arrangements for services and performance standards.

Non-integrated – A health plan with operations administered by multiple entities. These operations include claims processing and payments, a network of medical providers, and disease management services.

Payer – The entity responsible for paying a claim.

Pharmacy Benefit Manager (PBM) – An organization that provides a pharmacy network, processes and pays for all pharmacy claims, and negotiates discounts on medicines directly from the pharmaceutical manufacturers. These discounts are passed to the employer/payer in the form of rebates and reduced costs in the formulary.

Plan Year (PY) – Defined as the period of January 1 through December 31 of a given year.

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

Premium – The agreed-upon fees paid for medical insurance coverage. Both the employer and the health plan member pay premiums.

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

Self-funded – An insurance program wherein Benefit Options collects premiums, pays claims, and assumes the risk of revenues to expenses.

Self-insured – A plan that is funded by the employer who is financially responsible for all medical claims and administrative expenses.

Spouse – A dependent legally married to an employee or a Retiree, as defined by the Arizona Revised Statutes.

Subscriber – An employee, officer, elected official, or Retiree who is eligible and enrolls in the health plan.

Third party administrator – An organization that handles all administrative functions of a health plan including: processing and paying claims, compiling and producing management reports, and providing customer service.

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

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

Utilizer – A member who receives a specific service.

EXHIBIT 35

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**Admitted Pro hac vice*

Attorneys for Plaintiff Russell B. Toomey

UNITED STATES DISTRICT COURT

DISTRICT OF ARIZONA

Russell B. Toomey,

Plaintiff,

v.

State of Arizona; Arizona Board of Regents, d/b/a University of Arizona, a governmental body of the State of Arizona; **Ron Shoopman**, in his official capacity as chair of the Arizona Board of Regents; **Larry Penley**, in his official capacity as Member of the Arizona Board of Regents; **Ram Krishna**, in his official capacity as Secretary of the Arizona Board of Regents; **Bill Ridenour**, in his official capacity as Treasurer of the Arizona Board of Regents; **Lyndel Manson**, in her official capacity as Member of the Arizona Board of Regents; **Karrin Taylor Robson**, in her official capacity as Member of the Arizona Board of Regents; **Jay Heiler**, in his official capacity as Member of the Arizona Board of Regents; **Fred Duval**, in his official capacity as Member of the Arizona Board of Regents; **Andy Tobin**, in his official capacity as Director of the Arizona Department of Administration; **Paul Shannon**, in his official capacity as Acting Assistant Director of the Benefits Services Division of the Arizona Department of Administration,

Defendants.

4:19-cv-00035-TUC-RM (LAB)

PLAINTIFF'S SUPPLEMENTAL RESPONSES AND OBJECTIONS TO STATE DEFENDANTS' FIRST SET OF INTERROGATORIES

Pursuant to Rules 26 and 33 of the Federal Rules of Civil Procedure and the Local Rules of Civil Procedure for the District of Arizona, Plaintiff Russell B. Toomey hereby provides these supplemental responses and objections to the First Set of Interrogatories from State Defendants, dated May 21, 2021, as follows:

PRELIMINARY STATEMENT

Plaintiff responds without prejudice to amend and/or supplement his responses. Plaintiff is presently engaged in investigating the facts relating to this case, and has not completed his preparation for trial. All of the answers contained herein are based only upon such information and documents which currently are available and specifically known to the Plaintiff and disclose only those facts which currently occur to the Plaintiff. It is anticipated that further independent investigation, discovery, legal research and analysis may supply additional facts, add meaning to the known facts, and establish substantial additions to, changes in, and variations from the responses set forth herein.

The following discovery responses are given without prejudice to the Plaintiff's right to introduce evidence of any subsequently discovered fact or facts which the Plaintiff may later recall. Plaintiff accordingly reserves the right to change any and all answers herein as additional facts are ascertained, analyses are made, legal research is completed, and/or contentions are made. These answers and objections contained herein are made in good faith to supply as much factual information as possible and as such in no way be to the prejudice of the Plaintiff in relation to further discovery, research and analysis.

Counsel's signature below is for purpose of making the legal objections raised in the response and for no other purpose. Any accompanying verification signed by Plaintiff is for the purpose of the remainder of the question.

GENERAL OBJECTIONS & RESERVATIONS

1. Plaintiff objects to the Interrogatory to the extent that it calls for information not properly requested through interrogatories, or seek to impose obligations beyond the

scope permitted by the Federal Rules of Civil Procedure, the Local Rules of the District of Arizona, any orders of this Court, or any stipulations or agreements of the Parties.

2. Plaintiff objects to the Interrogatory to the extent that it seeks information protected from disclosure by privileges and other protections, including, without limitation, the attorney-client privilege, the attorney work-product doctrine, and/or any other constitutional, statutory, common law, or regulatory protection, immunity, or proscription from disclosure. The fact that Plaintiff does not specifically object to an individual Interrogatory on the ground that it seeks such privileged or protected information shall not be deemed a waiver of the protection afforded by the attorney-client privilege, the attorney work-product doctrine, or any other applicable privilege or protection.

3. Plaintiff objects to this Interrogatory to the extent that it is vague, ambiguous, overbroad, not relevant to any party's claims or defenses, not proportional to the needs of the case, or unduly burdensome.

4. Plaintiff objects to this Interrogatory as overbroad and unduly burdensome to the extent that it purports to require the equivalent of a narrative account of Plaintiff's case or require Plaintiff to provide more than the material or principal facts that support his claim.

5. Nothing in this written response constitutes, or is intended to constitute, an admission or representation by Plaintiff of any fact or contention in this litigation, including an admission or representation by Plaintiff that any information requested by this Interrogatory ever existed or currently exists. Nor shall anything in this written response limit proof allowed to be admitted by Plaintiff at trial. See Notes of Advisory Committee on F.R.C.P. 33 ("The general rule governing the use of answers to interrogatories is that under ordinary circumstances they do not limit proof.").

6. Plaintiff objects to this Interrogatory to the extent that they seek sensitive and/or confidential information impinging upon Plaintiff's or others' privacy interests.

Such information will be provided, if they are discoverable, only under the terms of the Protective Order filed in this case. *See* Doc. 165.

7. Plaintiff's response is made without waiving or intending to waive (a) the right to object on any ground to the use of these responses, or their subject matter, in any subsequent proceeding or the trial of this or any other actions, (b) the right to object to a demand for further responses to this or any other discovery or related to the subject matter of the interrogatories, and (c) the right at any time to revise correct, add to, or clarify any or all of this response.

8. Plaintiff has not completed his discovery of the facts concerning this case, including facts in Defendants' possession. Plaintiff reserves the right to withdraw, amend, and/or supplement these responses upon further discovery.

9. Nothing in any of Plaintiff's responses shall be deemed an admission, concession, or waiver by Plaintiff of the validity of any defense asserted by Defendants in this action.

10. Plaintiff responds to this Interrogatory subject to and without waiving any of the General Objections and Reservations, which are hereby expressly incorporated by reference into the response below. Plaintiff's reference to any of these General Objections individually in the Response does not waive any other General Objections that may be applicable.

RESPONSE

INTERROGATORY NO. 1:

Describe in detail any facts supporting that the Exclusion was created and/or maintained for a discriminatory purpose, and identify all documents and witnesses who support that the Exclusion was created and/or maintained for a discriminatory purpose.

RESPONSE:

Plaintiff objects to this interrogatory as a premature contention interrogatory. *See* Fed. R. Civ. P. 33(a)(2); *Core Optical Techs. V. Infinera Corp.*, No. SACV 17-0548,

2018 WL 2684693, at *2 (C.D. Cal. Mar. 7, 2018) ("It is generally the case that contention interrogatories need not be answered until discovery is substantially complete.") Information regarding Defendants' purpose lies exclusively within Defendants' control. Evidence of Defendants' purpose will be developed through discovery and deposition of Defendants' current and former agents and employees, which has only just begun. Defendants are also currently withholding highly relevant documents and communications about their motivations through improper assertions of the "deliberative process privilege."

In addition to any documents or testimony developed through discovery, Plaintiffs may also provide Defendants' discriminatory purpose through the factors outlined in *Village of Arlington Heights v. Metropolitan Housing Development Corp.*, 429 U.S. 252, 266 (1977), and by demonstrating that the Defendants' asserted justification for their policies are pretextual.

SUPPLEMENTAL RESPONSE:

Without waiving the foregoing objections, Plaintiff provides the following interim response based on discovery that has occurred through June 1, 2021. Plaintiff continues to object to the interrogatory to the extent that it could be interpreted to "require a party to provide the equivalent of a narrative account of its case, including every evidentiary fact, details of testimony of supporting witnesses, and the contents of supporting documents." *Valcor Eng'g Corp. v. Parker Hannifin Corp.*, No. 816-CV-00909-JVS-KESx, 2017 WL 10440700, at *3 (C.D. Cal. Aug. 28, 2017).

For purposes of Title VII and the Equal Protection Clause, discriminatory purpose includes any form of intentional unequal treatment. Circumstantial evidence of discriminatory purpose may be shown through (a) the disparate impact of a policy on a particular group, (b) the historical background of the decision, (c) the departure from usual procedures "particularly if the factors usually considered important by the decisionmaker strongly favor a decision contrary to the one reached," and (d)

contemporary statements by members of the decisionmaking body, minutes of its meetings, or reports. *Vill. of Arlington Heights v. Metro. Hous. Dev. Corp.*, 429 U.S. 252, 266–68 (1977). Discriminatory purpose can also be shown by demonstrating that an asserted purpose is pretextual.

Plaintiff relies on the deposition testimony of current and former employees of the ADOA, which is still ongoing, and documents produced (and still to be produced) throughout the course of discovery. Plaintiff also relies on reports submitted by Joan Barrett and Loren Schechter. The following is neither exhaustive nor final and may be supplemented as justice so requires. Plaintiff expects to show that:

a) The decisionmakers understood that the Exclusion of coverage for "gender reassignment surgery" affected transgender people and only transgender people. Indeed, the deposition exhibits reflect that ADOA employees referred to the coverage excluded as "transgender benefits."

b) ADOA current and former employees have claimed to not know why coverage for gender dysphoria was originally excluded from the State's self-funded healthcare plan (the "Plan"), but have nevertheless maintained the gender reassignment Exclusion despite repeated entreaties from ABOR to remove the Exclusion and despite recommendations from insurance companies to lift the Exclusion.

c) In its decision to maintain the Exclusion, ADOA departed from the typical procedures that it follows when deciding to cover other medical treatments. In particular, ADOA has removed other exclusions or limitations from the Plan when informed by insurance companies that the treatment at issue is medically necessary, ADOA has removed other exclusions or limitations without conducting a cost analysis, and ADOA has removed other exclusions without involving the Governor's office.

d) The ADOA applied a strict test when analyzing whether to cover benefits on behalf of transgender people (currently excluded under the Exclusion), which was

different from its approach to coverage for other benefits. Specifically, the ADOA set out to cover no more than what ADOA allegedly understood to be required by law, despite its coverage for several other procedures not required by law, and despite evidence of the minimal cost and medical necessity of the excluded benefits, and a trend amongst insurance companies to cover the excluded benefits after changes to healthcare law in 2016, and support for the benefit from members and ABOR.

e) The ADOA plan covers the same procedures, such as hysterectomies, for cis women when medically necessary, but excludes medically necessary hysterectomies for transgender people specifically if they are suffering from gender dysphoria.

f) Based on the cost analysis performed by ADOA in 2015-16, ADOA understood at the time of decision-making that the economic impact of lifting the Exclusion would be trivial and would not normally be a basis for excluding medically necessary treatment.

g) The cost analysis performed by Mr. Meisner in 2019 as a result of this lawsuit departed so dramatically from professional actuarial standards that it can only be explained as a desire to generate the highest possible cost prediction.

Additional evidence of discriminatory intent is evidenced by: (i) Christina Corieri's April 2013 tweet; (ii) ADOA's reaction to Kelly Sharritts's research on cost, as reflected in produced documents and witness testimony; and (iii) Michael Meisner's bias towards not covering transgender benefits, as reflected in deposition testimony, Joan Barrett's expert report, and produced documents.

Dated: June 2, 2021

Respectfully submitted,

ACLU FOUNDATION OF ARIZONA

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Attorneys for Plaintiff Russell B. Toomey

VERIFICATION

I, Russell B. Toomey, am the Plaintiff in the above-captioned matter. I am familiar with the contents of the foregoing **PLAINTIFF RUSSELL B. TOOMEY'S SUPPLEMENTAL RESPONSES AND OBJECTIONS TO STATE DEFENDANTS' FIRST SET OF INTERROGATORIES.** The information supplied therein is based on my own personal knowledge and/or has been supplied by my attorneys or other agents and is therefore provided as required by law. The information contained in the foregoing document is true, except as to the matters which were provided by my attorneys or other agents, and, as those matters, I am informed and believe that they are true.

I declare under penalty of perjury under the laws of the State of Arizona and the United State that the foregoing is true and correct.

Executed on June 2, 2021 at Tucson, Arizona.

Russell B Toomey

_____

Russell B. Toomey

CERTIFICATE OF SERVICE

I, Christine K. Wee, hereby certify that on June 2, 2021, I emailed the attached document to:

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