PERFORMANCE AUDIT REPORT
OF THE
COST OF HEALTH INSURANCE
FOR STATE OF NEBRASKA EMPLOYEES

JULY 1, 2009 THROUGH JUNE 30, 2011

Issued on May 14, 2012

*The **Nebraska Auditor of Public Accounts Office** was created by the first territorial Legislature in 1855. The Auditor was the general accountant and revenue officer of the territory. The duties have expanded and evolved over the decades as modern accounting theory has been implemented. The office of the Auditor of Public Accounts is one of six offices making up the executive branch of Nebraska State Government. Mike Foley was elected November 2006 and re-elected November 2010 as the Nebraska Auditor of Public Accounts. He was sworn into office on January 4, 2007, as Nebraska's 24th State Auditor.*

The mission of the Nebraska Auditor of Public Accounts' office is to provide independent, accurate, and timely audits, reviews, or investigations of the financial operations of Nebraska State and local governments.

We will provide this information, as required by statute, to all policymakers and taxpayers through written reports and our Internet based Budget and Audit databases.

We will maintain a professionally prepared staff, utilizing up to date technology, and following current Government Auditing Standards.

Audit Staff Working On This Performance Audit
Mary Avery, Assoc. CFE, Special Audits and Finance Manager
Cindy Janssen, Audit Manager
Lance Lambdin, JD, CFE, Legal Counsel
Philip Olsen, CPA, CISA, Senior Auditor-In-Charge
Craig Kubicek, CPA, CFE, Auditor-In-Charge
Jennifer Cromwell, CFE, Investigation Examiner
Joan Arnold, Auditor II

Copies of the Auditor of Public Accounts' reports are free. You may request them by contacting us at:

Nebraska Auditor of Public Accounts
State Capitol, Suite 2303
P.O. Box 98917
Lincoln, Nebraska, 68509
Phone: 402-471-2111

Additionally, our reports can be found in electronic format at:
http://www.auditors.nebraska.gov

COST OF HEALTH INSURANCE
FOR STATE OF NEBRASKA EMPLOYEES

TABLE OF CONTENTS

	Page
Introductory Section	
Insurance Programs' Costs	1
Audit Objective, Scope, and Methodology	2 - 3
Background Section	
Performance Audit Background	4 - 5
Nebraska Health Insurance Programs Background	5 - 8
Summary of Results	9 - 10
Lack of Cooperation	11 - 18
Performance Audit Section	
Premium Rate Analysis	19 - 25
Performance Factors Examined	
Plan Designs	26 - 33
Administrative Expenses	33 - 44
Stop Loss Insurance	44 - 47
Program Monitoring and Control	47 - 50
Level of Fund Balances	51 - 59
Other Factors Examined	59 - 63
Overall Conclusion	64
Exit Conference	65
Legislative Performance Audit Committee Response	
Exhibits and Attachments	
Exhibit A – Performance Audit Timeline	
Exhibit B – Annual Cost Comparison Between Nebraska Government Entities	
Exhibit C – Plan Design Comparison Between States	
Exhibit D – Program Cost Comparison Between States	
Exhibit E – Plan Design Comparison Between Local Municipalities	
Exhibit F – Program Cost Comparison Between Local Municipalities	
Exhibit G – State of Nebraska's Various Plan Designs	
Exhibit H – University of Nebraska's Various Plan Designs	
Attachment A – NCSL Data - State Premium Comparison of Family Coverage	
Attachment B – APA Request for Performance Audit	

COST OF HEALTH INSURANCE
FOR STATE OF NEBRASKA EMPLOYEES

TABLE OF CONTENTS
(Continued)

Exhibits and Attachments (Continued)

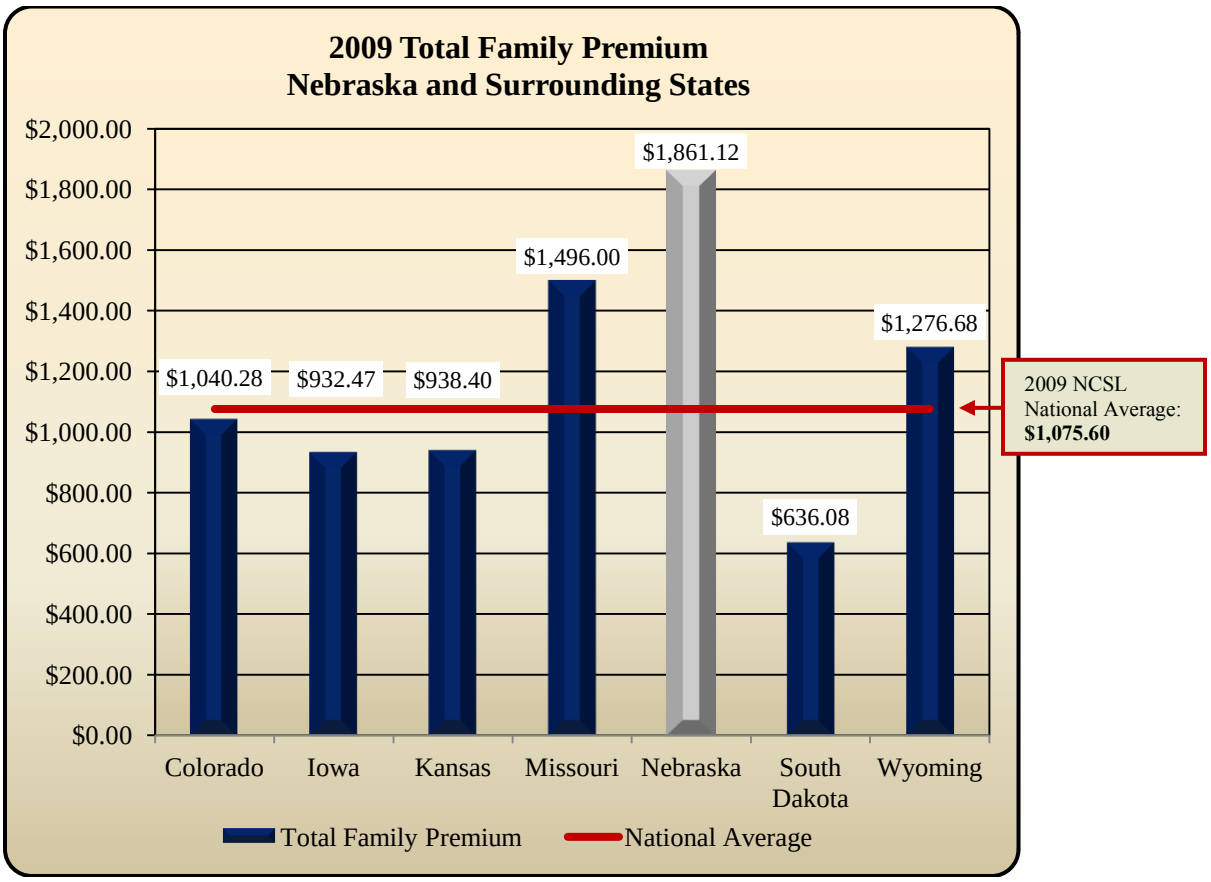
Attachment C – Legislative Performance Audit Committee Approval of Request for APA Performance Audit
Attachment D – Letter From DAS Director to Senator Harms Dated August 16, 2010
Attachment E – Letter from DAS, University, NSCS, and State Patrol to Legislative Performance Audit Committee Dated December 3, 2010
Attachment F – Letter from DAS, University, and NSCS Dated January 11, 2011
Attachment G – Email from DAS Financial Administrator Dated March 10, 2011
Attachment H – The Kaiser Family Foundation and Health Research & Educational Trust, Employer Health Benefits 2011 Annual Survey

INTRODUCTORY SECTION

Insurance Programs' Costs

According to health insurance data compiled in 2009 by the National Conference of State Legislatures (NCSL), the State of Nebraska had the ***highest*** monthly premiums in the nation for family health insurance coverage.

A comparison to neighboring Midwest states indicated that Nebraska's premiums are ***double*** the cost of the premiums of Kansas and Iowa, and are nearly ***triple*** the cost that South Dakota pays for their State employee health benefits. The monthly premiums in the following table are from NCSL, showing the average 2009 State employee health benefit premium for family coverage along with the rates for Nebraska and neighboring states.



See **Attachment A** for the NCSL results from 2009.

As a result of this information, the Auditor of Public Accounts (APA) requested and received permission from the Legislative Performance Audit Committee to conduct a performance audit of the cost of health insurance for State of Nebraska employees.

INTRODUCTORY SECTION
(Continued)

Audit Objective, Scope, and Methodology

The objective of the performance audit was to provide a comparison of costs of various government health insurance programs and member information for July 1, 2009, through June 30, 2011.

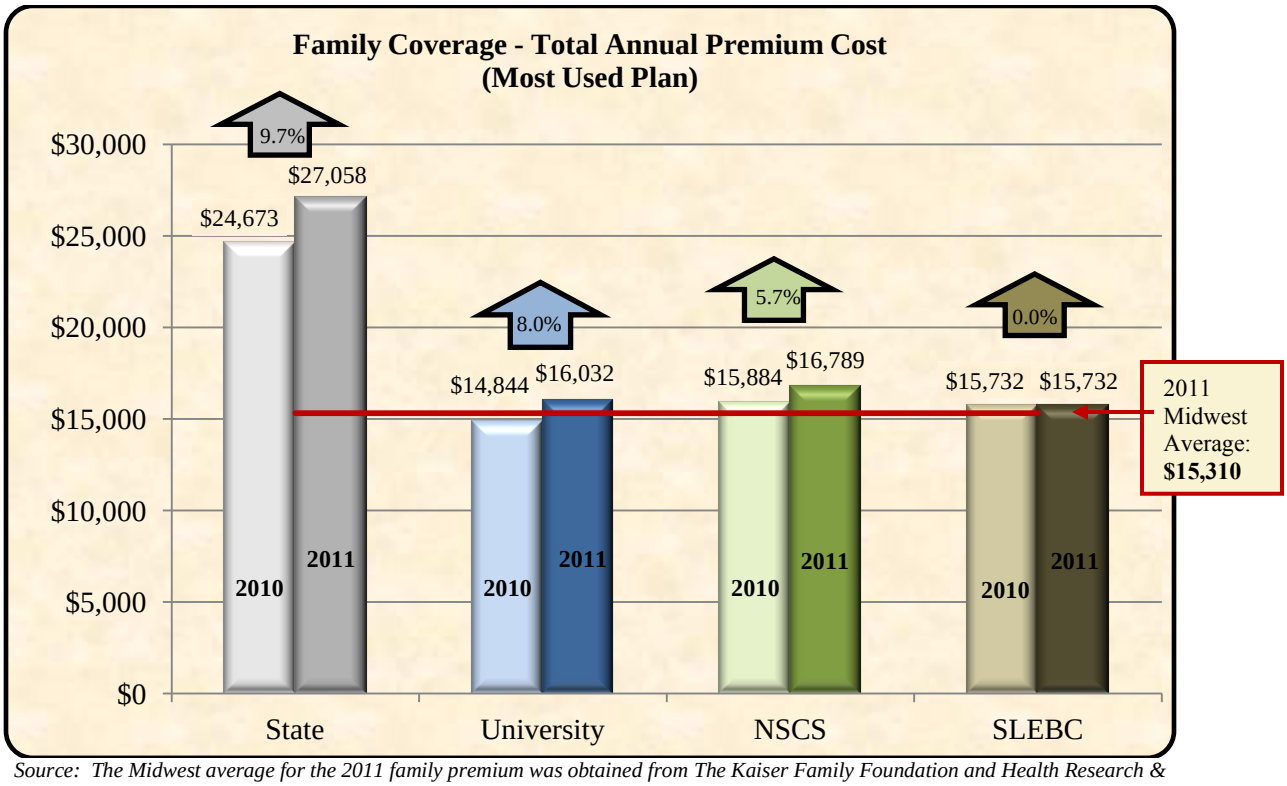
The audit scope is intended to provide a broad view, comparison, and analysis of Nebraska employees' health insurance programs, including plan designs, administrative fees, service usage, stop loss insurance usage, and any other comparisons deemed necessary by the APA.

The performance audit was conducted in accordance with the standards applicable to performance audits contained in *Government Auditing Standards* issued by the Comptroller General of the United States.

State of Nebraska employees are covered under one of four programs:

- The Nebraska State Insurance Program, covering State employees
- The University of Nebraska Health Insurance Program
- The Nebraska State College System (NSCS) Health Insurance Program
- The State Law Enforcement Bargaining Council (SLEBC) Health and Dental Program, covering members of the law enforcement bargaining unit.

Those four programs were primarily used in our comparisons throughout this report. Even among the four programs, the Nebraska State Insurance Program had the highest premium costs.



Source: The Midwest average for the 2011 family premium was obtained from The Kaiser Family Foundation and Health Research & Educational Trust, Employer Health Benefits 2011 Annual Survey (Kaiser Survey), Exhibit 1.3.

INTRODUCTORY SECTION
(Continued)

Three of the four programs, with the exception of the NSCS program, were self-insured programs, in which the employer assumes responsibility for health care costs of its covered employees and their eligible dependents. In a fully-insured program, the employer is not responsible for claims that exceed total premiums, as the insurance company assumes the risk.

Benefits of the self-insured programs include the ability to control costs, the ability to control the plan designs and available benefits, and the ability to retain any excess premium funds remaining after claims have been paid. However, self-insured programs require significant oversight and monitoring procedures to ensure adequate funds are available to cover costs, to safeguard assets, and to provide affordable premiums.

The audit was conducted by gathering and reviewing background information such as contracts, plan design information, various reports and statistical information, and from interviews with government officials regarding claims processing, plan design, setting premium rates and other administrative processes. The APA also obtained limited claims data for the various Nebraska programs.

Government Auditing Standards (July 2007 Revision), Chapter 8.11 states:

> *"Auditors should describe the scope of the work performed and any limitations, including issues that would be relevant to likely users, so that they could reasonably interpret the findings, conclusions, and recommendations in the report without being misled. Auditors should also report any significant constraints imposed on the audit approach by information limitations or scope impairments, including denials of access to certain records or individuals."*

Significant restraints were imposed on the audit including denials of requested information, redaction of information, and excessive delays of access to certain records. These issues will be addressed in the Lack of Cooperation section of this report.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

BACKGROUND SECTION

Performance Audit Background

The origins of this performance audit can be traced to a citizen's inquiry of the APA regarding the cost of providing health insurance to State employees under the Nebraska State Insurance Program. The APA's research revealed that the total monthly premium cost of family coverage for Nebraska State employees was ***the most expensive in the nation***, according to data compiled in 2009 by the NCSL. Each state's premiums can be seen in **Attachment A**.

The State and its employees paid approximately $180 million in premiums for health insurance coverage under the State's program during fiscal year 2009. Startled by this information, as well as determined to inquire into the cause of such seemingly expensive premiums, the APA conceived of carrying out a performance audit to examine the reasonableness of the State's program costs and requested permission to pursue such audit on April 1, 2010. See **Attachment B**.

Neb. Rev. Stat. § 84-322 (Reissue 2008), gives the APA the authority to conduct performance audits only upon receiving authorization from the Legislative Performance Audit Committee. Such authorization was approved by the Committee on April 9, 2010. See **Attachment C**.

The APA planned to complete the performance audit in time to present the Legislature with a finished audit report prior to the commencement of the 2011 legislative session. Doing so, it was hoped, might assist the senators in addressing budgetary concerns relating specifically to State employee health care expenditures. However, due to a lack of cooperation by more than one entity, the issuance of this report has been significantly delayed. (See the Lack of Cooperation section later in this report for detailed information.)

Comparative data was needed to meet the objectives of this performance audit. The APA chose to primarily examine the cost and quality of health care coverage offered under the State's program, with programs offered by the University of Nebraska (University), the NSCS, and SLEBC.

Neb. Rev. Stat. § 84-1610 (Reissue 2008) prohibits a State agency from furnishing "its employees any program of life or health insurance supplementary to that provided under" the State's program. However, Neb. Rev. Stat. § 84-1601(1) (Reissue 2008) excludes employees of both the University and NSCS from participating in the State's program, as follows:

> *"There is hereby established a program of group life and health insurance for all permanent employees of this state who work one-half or more of the regularly scheduled hours during each pay period, excluding employees of the University of Nebraska, the state colleges, and the community colleges. Such program shall be known as the Nebraska State Insurance Program and shall replace any current program of such insurance in effect in any agency and funded in whole or in part by state contributions."*

BACKGROUND SECTION
(Continued)

Though excluded from the State's program, both the University and the NSCS are authorized, under Neb. Rev. Stat. § 85-106(6) (Reissue 2008) and Neb. Rev. Stat. § 85-304(7) (Reissue 2008), respectively, to establish health care programs for their own employees. Likewise, in an informal opinion issued in 1996, the Attorney General counseled that, notwithstanding the prohibition in § 84-1601(1), SLEBC is entitled by law to operate a health insurance program exclusively for the State law enforcement personnel who comprise its membership. Thus, these three unique Nebraska employee health insurance programs not only exist legally but also are uniquely situated, for purposes of this performance audit, to provide comparative data for examining both the cost and quality of coverage offered under the State's program.

Nebraska Health Insurance Programs Background

The APA has issued separate reports on each of the four insurance programs: The Department of Administrative Services (DAS) - Nebraska State Insurance Program, the University of Nebraska Insurance Program, the SLEBC Employee Health and Dental Funds, and the Nebraska State College System Health Insurance Premiums. More detailed background information on those programs can be found in the respective attestation reports available on the APA's website at http://www.auditors.nebraska.gov.

The following lists the type of program for each of the entities:

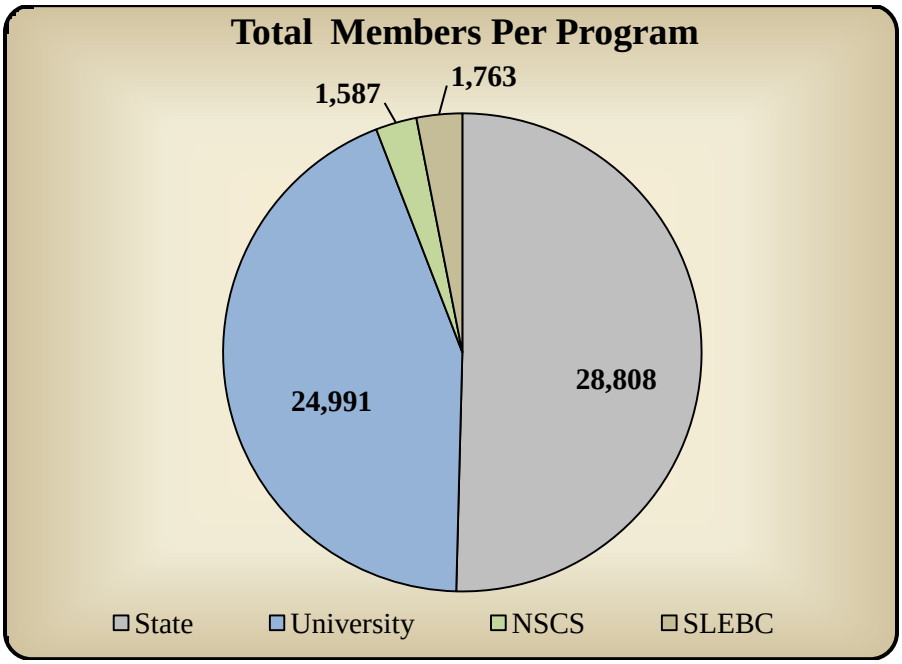
Entity	Type
State	Self-insured
University	Self-insured
NSCS	Fully-insured
SLEBC	Self-insured

Membership

The membership requirements for three of the Nebraska programs were similar in that they required active employees to work approximately half of a full-time work schedule, at a minimum, in order to receive benefits. SLEBC's program, however, required active employees to be full time to be eligible for benefits. Qualifying dependents in all programs included spouses, unmarried children up to age 19 (step, adopted, etc. included), and children who are full-time students up to age 24. Under 29 CFR § 2590.715-2714 (June 17, 2010), which implements the Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the Health Care and Education Reconciliation Act of 2010 (Public Law 111-152), jointly referred to as PPACA, all plan years beginning on or after September 23, 2010, must expand coverage to include children up to the age of 26.

BACKGROUND SECTION
(Continued)

The following chart shows the number of total members in each program as of June 2010 (July 2010 for SLEBC):



A detailed breakdown of the membership as of June 2010 (July 2010 for SLEBC) is as follows:

	State		University		NSCS		SLEBC	
Employees	13,649	48%	10,302	41%	706	44%	466	26%
Dependents	14,786	51%	12,114	48%	840	53%	1,262	72%
Retirees & COBRA **(2)**	363	1%	965	4%	19	1%	35	2%
Non-Employees	5	0%	698	3%	12	1%	0	0%
Non-Employee Dependents	5	0%	912	4%	10	1%	0	0%
Total Members	**28,808**		**24,991**		**1,587**		**1,763**	
As of Date **(1)**	6/24/2010		6/27/2010		6/30/2010		7/30/2010	

(1) *These membership numbers are as of a point in time, not for the entire year.*
(2) *NSCS only includes retirees.*

Plan Design
Each program covers eligible employees, retirees, COBRA participants, and their eligible dependents. The State and University programs offer more than one plan option to its employees, while the NSCS and SLEBC offer only one plan to its active employees.

BACKGROUND SECTION
(Continued)

A summary of the services covered under the most used health plan for 2010, were as follows:

Plan Design Comparison (1)		**State**	**University**	**NSCS**	**SLEBC**
Plan Year Ending 2010		Jul 1 - Jun 30	Jan 1 - Dec 31	Sept 1 - Aug 31	Jan 1 - Dec 31
Medical Provider		BCBS of Nebraska	BCBS of Nebraska	BCBS of Nebraska	Meritain
Medical Plan Type		Self-Insured	Self-Insured	Fully-Insured	Self-Insured
Most Used Medical Plan (In-Network)		BlueChoice	Basic Option	$350 Deductible PPO	PPO
Plan/Lifetime Maximum	Individual	Unlimited	$3 million	$5 million	$3 million
Annual Deductible (2)	Individual	$200	$400	$350	$400
	Family	$400	$800	$700	$800
Out-of-Pocket Maximum	Individual	$1,500	$1,500	$2,000	$1,400
	Family	$3,000	$3,000	$4,000	$2,800
Copay/ Coinsurance (3)	Office Visit	$20 Copay	Plan pays 70%	$35 Copay	$20 Copay
	Annual exam	$20 Copay for annual exam Plan pays 80% for most screenings	Plan pays 100% ($250 max)	Plan pays 80% for annual exam Plan pays 100% for most screenings	$20 Copay ($400 max)
	Well baby exam	$20 Copay	Plan pays 100% ($500 max)	Plan pays 80% for immunizations Plan pays 100% for other well baby services	$20 Copay
	Urgent care	$25 Copay	Plan pays 70%	Not available	Not available
	Hospital ER	$50 Copay (waived if admitted)	Plan pays 70%	Plan pays 80%	$40 Copay Plan pays 90% after copay
	Inpatient hospital	Plan pays 80%	Plan pays 70%	Plan pays 80%	Plan pays 90%
	Outpatient surgical center	$50 Copay	Plan pays 70%	Plan pays 80%	Plan pays 90%
	Inpatient mental health	Plan pays 80% (30 day max)	Plan pays 70%	Plan pays 80% (30 day max)	Plan pays 90%
	Outpatient mental health	$20 Copay (60 visit max)	Plan pays 70%	Plan pays 75% or $30 Copay for therapy (60 visit max)	Plan pays 90%

(1) This table includes only the in-network descriptions for the most used plan at each entity. The member copayment and the plan coinsurance are shown in this table.

(2) The deductibles are per benefit year. The plan year noted above is the same as the benefit year for all of the entities, except for NSCS, whose benefit year is January 1 to December 31.

(3) The deductible is generally waived for all copayment amounts and must be met prior to plan coinsurance benefits beginning, unless the coinsurance is noted as "Plan pays 100%" which would be prior to the deductible.

BACKGROUND SECTION
(Continued)

Financial Schedule Comparison

The following financial information, which covers all plans for fiscal year ended June 30, 2010, has been included as background information only. Separate financial attestation examinations were conducted on each program and can be found on the APA website.

	State	University	NSCS	SLEBC
Beginning Fund Balances – July 2009	**$ 20,179,482**	**$ 78,614,554**	**$ -**	**$ 2,633,096**
Revenues				
Employee and Employer Premium Contributions **(1)**	$179,625,790	$ 105,597,590	$ 7,314,454	$ 5,913,261
COBRA and Retiree Contributions	$ 2,889,333	$ 8,018,260	$ 202,311	$ 227,918
General Fund or Cash Fund Support **(3)**	$ -	$ 3,311,782	$ -	$ -
Pharmaceutical Rebates	$ 4,144,425	$ -	$ -	$ -
Investment Income	$ 1,152,063	$ 6,662,632	$ -	$ 221,147
Stop Loss Reimbursements **(2)**	$ -	$ -	$ -	$ 690,799
Miscellaneous	$ 169,566	$ 10,288	$ -	$ 34,933
Total Revenues	**$187,981,177**	**$ 123,600,552**	**$ 7,516,765**	**$ 7,088,058**
Expenses				
Claims Paid:				
Medical	$121,940,889	$ 82,882,211	$ -	$ 4,960,009
Pharmaceutical	$ 30,533,939	$ 22,372,544	$ -	$ 611,784
Total Claims Paid	***$152,474,828***	***$ 105,254,755***	***$7,516,765***	***$ 5,571,793***
Administrative Fees:				
Medical	$ 5,635,750	$ 3,972,824	$ -	$ 187,316
Pharmaceutical **(4)**	$ 1,108,285	$ -	$ -	$ -
Total Administrative Fees	***$ 6,744,035***	***$ 3,972,824***	***$ -***	***$ 187,316***
Stop Loss Insurance	$ 1,970,412	$ -	$ -	$ 501,310
Wellness Program **(7)**	$ 1,267,338	$ -	$ -	$ -
Actuarial/Consulting Services	$ 387,397	$ 9,462	$ -	$ -
Payroll Expense **(5)**	$ 334,244	$ 164,000	$ -	$ -
Miscellaneous	$ 519,455	$ 217,563	$ -	$ 346,030
Total Expenses	**$163,697,709**	**$ 109,618,604**	**$ 7,516,765**	**$ 6,606,449**
Transfers Into Funds **(6)**	$ 95,834	$ -	$ -	$ -
Transfers Out of Funds	$ -		$ -	$ -
Change in Fund Balances	**$ 24,379,302**	**$ 13,981,948**	**$ -**	**$ 481,609**
Ending Fund Balances – June 2010	**$ 44,558,784**	**$ 92,596,502**	**$ -**	**$ 3,114,705**

(1) Employee and employer premium contributions also include non-employee premium contributions such as the Credit Union employees for the State and the ancillary groups for the University.

(2) The State did not record Stop Loss Reimbursements separately in the accounting system, so they could not be recorded separately in this comparative schedule.

(3) During fiscal year 2010, the University transferred $3,311,782 in general and cash funds to its health insurance trust to cover the anticipated increase in the employer contribution.

(4) The University's pharmaceutical administrative fees are part of the claims paid and are not invoiced or recorded separately. Likewise, SLEBC's pharmacy administrative fees also have not been recorded separately from the medical administrative fees.

(5) The University transferred $164,000 from its health insurance trust to be used for payroll and other administrative expenses during fiscal year 2010. This was classified as an expense.

(6) In the State program, the net transfers in included unused flexible spending money remaining from the end of fiscal year 2009.

(7) The University participates in the Blue Partners – Disease Management program, which is a member support service for those with diabetes, heart disease, asthma, and chronic obstructive pulmonary disease. Monthly, the University is billed for this service. For May 2010, the amount paid was $45,198. The University did not separately record these services as an administrative cost, but included the costs in the claims paid. Therefore, the APA was unable to determine a cost of the wellness portion of the University's program.

SUMMARY OF RESULTS

The goal of this performance audit was to explain the large variance between the State's health insurance premiums compared to those of other Nebraska governmental entities, such as the University of Nebraska, the Nebraska State College System, and the State Law Enforcement Bargaining Council. Several factors can influence health insurance premium costs including:

- Benefits offered to employees through plan designs
- Levels of program reserves and fund balances
- Administrative costs of the program
- The age of the members enrolled
- Use of services provided to members
- Negotiation and oversight of contracts
- Ineligible members

The APA has isolated several factors that have led to higher premium costs for employees in the Nebraska State Insurance Program:

Plan Designs: The State plan option used by the majority of State employees is also the option with the highest premiums. The State relies on the use of copayments for most services, including office visits, well baby exams, annual exams, urgent care, and hospital emergency room services. The University requires deductibles to be met for most services before a coinsurance amount is utilized. Therefore, the University paid only 82% of its claims costs for 2010, while the State paid 89% of its claims costs for 2010. Significant savings to the State's program could be realized if the State followed the University's plan design concepts, using deductibles and coinsurance rather than copayments.

Administrative Expenses: Administrative expenses contribute to the cost of the premiums because premiums should be set to cover not only claims costs, but also the administrative costs of the programs. The largest administrative expense is the administrative services fees charged to the programs by the third party administrator. During fiscal year 2010, BCBSNE charged the State $31.50 per member per month, but only charged the University $27.11 during calendar year 2010 per member per month for medical services.

The State's wellness program is also significantly more expensive than the University and SLEBC wellness programs. Based on estimated University amounts, the State paid more than double the amount paid by the University on wellness program services.

The State also pays a significantly higher amount of actuarial and consulting fees than the other entities, $28 per member in fiscal year 2010, compared to $1 per member for the University.

Payroll expenses and other miscellaneous expenses paid by the State are significantly higher than the University.

SUMMARY OF RESULTS
(Continued)

Stop Loss Insurance: Since 2007, when the State implemented the use of stop loss insurance, the State has paid more for the expense of the insurance than the benefits received from the insurance. From the information available, the State has incurred $5,431,961 in stop loss insurance expenses and has only received $1,093,527 in reimbursements for individuals who have exceeded the stop loss limits. It is clear in this analysis that the cost of stop loss insurance greatly outweighed its benefits.

Program Monitoring and Control: Each program had a significant lack of controls and monitoring of its self-insured health insurance program. For instance, during fiscal year 2010, the State paid $678,882 in claims for individuals who were not eligible for coverage. This amount included claims payments for ancillary groups or non-employees, who by statute are not eligible for participation. Additionally, for the State and University, only one individual has the final authority on decisions such as plan designs, premium amounts, etc.

***Level of Fund Balances*:** The State's health insurance fund balances have increased over ten times the level of the fiscal year 2007 fund balances, from $6,216,213 in June 2007 to $64,865,128 in June 2011. The only way the fund balances can increase at this rate is for the State to consistently set its premiums at a level that exceeds both claims and any other administrative expenses of the program. Even if no other changes to the State's program were made, health insurance premiums could be reduced due to the amount of fund balances on hand.

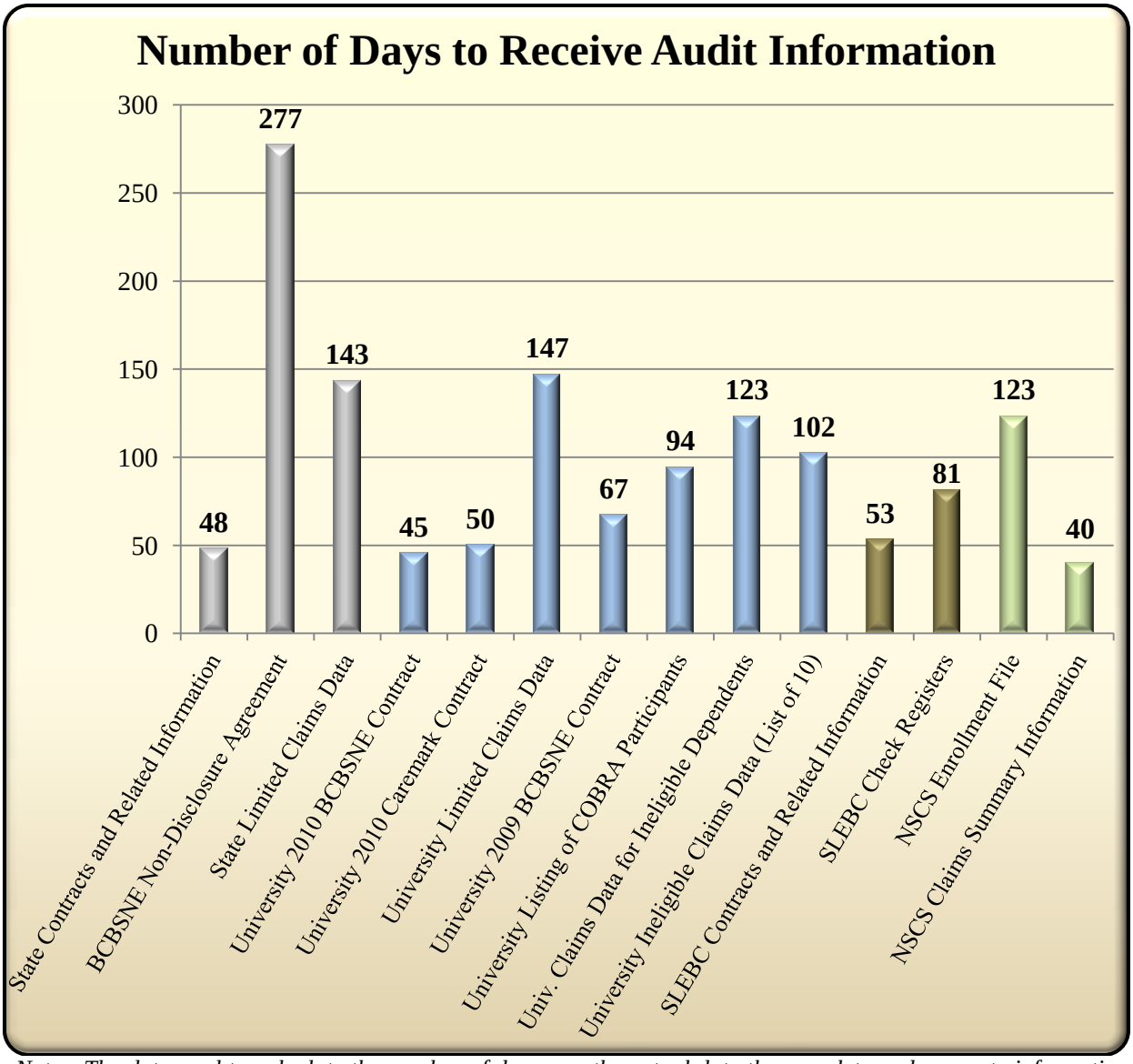
We recommend the Legislature use these issues to continue its analysis of health insurance costs for State employees. The Legislature should consider whether changes in the administration of the health insurance programs are necessary, so that each program provides health insurance coverage at reasonable prices.

More detail on each of these issues is explained in the Performance Audit section later in this report.

LACK OF COOPERATION

From the outset, this performance audit was hampered by the unwillingness of all of the parties involved to provide the documentation needed to assess the distressing concerns of both Nebraska taxpayers and the State legislature. This persistent lack of cooperation is responsible for delaying, ***by more than a year***, the completion of each of the respective financial audits as well as the release of this performance report.

The following chart shows some of the more significant delays encountered by the APA during the course of the audit:



Note: The date used to calculate the number of days was the actual date the complete and accurate information was obtained, which may not necessarily be the date of first response. In many cases, the information initially received was not complete and/or accurate.

LACK OF COOPERATION
(Continued)

Many years ago, the APA was authorized by State statute to undertake both financial and performance audits; however, current Nebraska law restricts the APA to only financial auditing. An exception is provided under Neb. Rev. Stat. § 84-322 (Reissue 2008), which states:

> *"The Auditor of Public Accounts, when expressly authorized by a majority vote of the members of the Legislative Performance Audit Committee, may conduct performance audits of state executive branch offices, state agencies, state bureaus, state boards, state commissions, the state library, societies and associations supported by the state, state institutions, state colleges, and the University of Nebraska. The auditor shall issue the performance audit report to the Governor, the appropriate standing committee of the Legislature, and the Legislative Performance Audit Committee."*

In a letter dated April 13, 2010, Senator John Harms, Chairman of the Legislative Performance Audit Committee, informed the APA that the Committee had approved the APA's request to conduct a performance audit. See **Attachment C** for the Committee's letter. Having obtained the statutorily mandated authorization, the APA began the necessary preparation for the audit work.

Neb. Rev. Stat. § 84-304(9) (Reissue 2008) directs the APA to "conduct all audits and examinations in a timely manner and in accordance with the standards for audits of governmental organizations, programs, activities, and functions published by the Comptroller General of the United States[.]" Those standards are set out in the *Government Auditing Standards* and promulgated by the United States Government Accountability Office. *Government Auditing Standards* (July 2007 Revision), Chapter 8.11 states:

> *"Auditors should also report any significant constraints imposed on the audit approach by information limitations or scope impairments, including denials of access to certain records or individuals."*

Unfortunately, the APA's original plan to have an audit report completed prior to the commencement of the 2011 legislative session was frustrated due to an ongoing lack of cooperation. While each of these entities displayed their own unique unwillingness to cooperate, the most troublesome delays primarily came from DAS and the University. In violation of Neb. Rev. Stat. § 84-305 (Reissue 2008), which grants the APA "access to all records of any public entity," both entities refused to provide the APA with documentation needed to carry out the audit work. Additionally, despite the clear language provided in § 84-322, as noted above, the authority of the APA to pursue an independent performance audit was challenged.

In an effort to circumvent such obstruction, the APA decided to divide the audit work into separate examinations – a financial attestation focused on each of the Nebraska health insurance programs, and the performance audit to provide a comparison of costs of the programs and member information for July 1, 2009, through June 30, 2011. By doing so, the APA hoped to overcome the stalling tactics employed by both DAS and the University and gain access to records needed to complete the audit; however, this seemed to only bring about more delays.

LACK OF COOPERATION
(Continued)

See **Exhibit A** for a complete timeline of events from the initial complaint received by the APA to the actual receipt of the necessary audit data. Included below is a brief summary of the highlights from that timeline. It is important to note that the instances of non-cooperation from the entities did not end with the receipt of this audit data. See the respective financial attestation reports for the entities for additional details of the subsequent lack of cooperation experienced by the APA.

Date	Description
4/13/2010	The APA received a letter from the Legislative Performance Audit Committee indicating that on April 9, 2010, the Committee had granted approval for the APA to conduct the performance audit. See **Attachment C**.
5/4/2010	The original entrance conference held with staff from DAS.
5/14/2010	The APA notified the University of the performance audit in an email to the Senior Associate to the President.
6/2/2010	The APA first requested State claims data for July 2009 through May 2010 from BCBSNE.
6/23/2010	The APA first requested University and NSCS claims data for July 2009 through June 2010 from BCBSNE. Also expanded request for State claims data through June 2010 instead of May 2010 to cover full fiscal year.
7/13/2010	Original BCBSNE Confidentiality and Non-Disclosure Agreement signed by the APA.
8/16/2010	DAS Director sent a letter to the Legislative Performance Audit Committee citing numerous issues he had with the authorization of the APA to conduct the performance audit. See **Attachment D**.
11/23/2010	Due to the numerous delays in getting the necessary audit data, the APA held a second entrance conference with DAS, the University, and NSCS requesting data be provided no later than December 17, 2010. SLEBC did not send a representative to this meeting.
12/3/2010	Top officials from DAS, the University, NSCS, and the State Patrol all sent a letter to the Legislative Performance Audit Committee again citing numerous issues with the audit. See **Attachment E**.
12/23/2010	Legislative Performance Audit Committee responded to the December 3, 2010 letter attempting to clarify any issues noted and encouraging cooperation with the APA.
12/30/2010	The APA sent an email to all parties involved noting that the deadline requested to receive the audit data had passed and nothing had been received.
1/11/2011	In response to the December 30, 2010 email, the APA received a letter from DAS, the University, and NSCS again noting additional issues considered unresolved. See **Attachment F**.
2/14/2011	The APA met with the Governor, the Attorney General, the Speaker of the Legislature, the Legislative Performance Audit Committee Chair, and other senators to discuss the claims information requested by the APA. In spite of the APA's unwavering opinion that it has express authority under Federal and State laws to obtain all of the detailed health insurance claims, an agreement was reached, in order to expedite the audit process, for the APA to receive a more limited set of audit data in which names and birthdates would be removed. One data set would be provided for the performance audit, and a second, differing set of data would be provided for the financial audit. At this meeting DAS agreed to provide the data by March 11, 2011.
3/10/2011	The DAS Financial Administrator emailed the APA and indicated that DAS was waiting for final direction from the Governor before they could provide the audit data. See **Attachment G**.
3/24/2011	Auditor Foley received a letter from the Governor indicating he was pleased the APA had agreed to receive more limited audit data and that DAS was planning on providing the data.
4/15/2011	Final audit data was received from BCBSNE for DAS.
4/19/2011	Final audit data received from the University.

LACK OF COOPERATION
(Continued)

The harmful impact of the delay of this audit cannot be overstated. The intentional procrastination has caused some of the data contained herein, as well as in the financial attestation reports, to be outdated – due to the fact that additional, untested data that accrued during the intervening year could not be included. Furthermore, that delay has nullified the initial goal agreed upon by both the APA and the Legislative Performance Audit Committee in undertaking this audit – namely, producing an audit report in time to be presented to the Legislature prior to the 2011 legislative session. Doing so, it was hoped, would assist the senators in addressing budgetary concerns relating specifically to employee health care expenditures. Unfortunately, the stalling tactics of each of the agencies rendered such a goal untenable.

On multiple occasions, the agencies cited issues they had with the performance audit in an attempt to indefinitely postpone the process. There were three primary issues brought up throughout the year-long quest to obtain audit data. The first was getting all parties involved to agree on the terms of the confidentiality and non-disclosure agreements. The term negotiations began in June 2010 and were thought to have been finalized in July 2010, until the issue was brought up again in March 2011 when the APA was asked to sign a revised agreement.

The second issue commonly used to deny the APA access to data was DAS' insistence that the APA pay for the expense of compiling the requested data. The APA declined to pay for such information, noting that such a requirement would essentially permit any public entity to thwart an audit simply by charging unreasonable fees for needed documents. Even so, the APA attempted to obtain a formal opinion from the Attorney General (AG) on this issue in a letter dated August 12, 2010. Furthermore, the Legislative Performance Audit Committee agreed with the APA's position on this issue and sent a follow-up letter to the AG on November 15, 2010, requesting an expedited response and noting that the Committee intended to introduce a bill in the next legislative session to clarify the issue. On January 3, 2011, the AG declined to provide a response on the issue.

The final and most-hindering issue was the claim that providing the APA with the requested records would constitute a violation of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Though unable or unwilling to specify which provisions of the act risked violation, all of the agencies involved maintained spuriously that the APA's request would jeopardize the privacy of their employees' protected health information. The APA was able to point to specific exceptions in HIPAA permitting State auditors to access otherwise protected employee health information. Specifically, 42 U.S.C. § 1320d-7(c) (2006) of HIPAA states:

> *"Nothing in this part shall limit the ability of a State to require a health plan to report, or to provide access to, information for management audits, financial audits, program monitoring and evaluation, facility licensure or certification, or individual licensure or certification."*

LACK OF COOPERATION
(Continued)

The applicability of the above audit exceptions within HIPAA to the APA's request was verified by a representative from the Office of Inspector General, U.S. Department of Health and Human Services via email on September 7, 2010, and again with the Kansas City Regional Inspector General for Audit Services via conference call on November 18, 2010. Additionally, the APA again requested a formal opinion on the issue from the AG on September 20, 2010. The APA followed up on that request by extending a formal invitation on November 10, 2010, for the AG to participate in the above-mentioned conference call. On January 3, 2011, the AG declined to provide a response on this issue as well.

In January 2011, the APA developed plans to include a finding in the State of Nebraska Statewide Single Audit for fiscal year ended June 30, 2010, pertaining to the failure of the State to provide requested health insurance claims information. On February 4, 2011, the APA met with the DAS Director regarding the requested records. After that meeting, APA staff and DAS staff began discussions as to the possibility of limiting the data by excluding identifying information.

On February 14, 2011, the APA met with the Governor, the Attorney General, and other State officers to discuss the continuing impasse over the requested audit documentation. The meeting accomplished little other than to accentuate the positions of the various parties involved: the APA insisting upon the legal authority of his office to access the requested documents; the Governor continuing to refuse to authorize DAS to release those requested records; and the Attorney General declining to provide any legal direction in the matter.

On March 1, 2011, a representative from BCBSNE requested the APA to sign a revised nondisclosure agreement. The APA responded that the original nondisclosure agreement was sufficient, as the APA was now willing to accept less information than previously requested. While continuing to pursue the newly agreed-upon information request, the APA received the following email from DAS on March 10, 2011:

> Mary, to follow up on your note, we are waiting for final direction from the Governor to provide the data. Roger
>
> **Best Regards;**
> **Roger Wilson**
> **Administrator of Central Services**
> *301 Centennial Mall South, PO Box 94953, Lincoln, NE 68509-4953*
> *Phone 402.471.1638*
> *www.das.state.ne.us*
>
> NEBRASKA AS AdministrativeServices Central Services

LACK OF COOPERATION
(Continued)

Finally, on March 28, 2011, DAS provided the APA with a "limited data set" of information. However, the last piece of information, which would allow the APA to connect the ESI and BCBSNE claims for purposes of reviewing stop loss information, was not made available until April 15, 2011.

The refusal of these agencies to abide by both State and Federal law by providing the APA with access to requested audit records severely impeded not only the APA's ability to audit the financial data of Nebraska's health insurance programs but also the State's accountability and transparency in its handling of many millions of taxpayer dollars.

> Based on the approved request to conduct a performance audit and the lack of cooperation our office experienced throughout the audit, we encourage the Legislature to mandate each entity fully comply with all current and future audits. It is impossible for the APA and their staff to complete an extensive and relevant audit without the collaboration of all parties involved. Whether it would be through future legislation or other means necessary, it is essential for the APA to get timely access to all relevant records without missing or redacted information.

DAS and University Response: The respondents strongly disagree with this comment which is flawed in a number of respects:

- *It fails to acknowledge the reason for many of the delays was the Auditor's refusal to sign standard non-disclosure agreements. The respondents have a fiduciary duty and legal obligations to employees, faculty, staff and third party administrators to protect confidential personal health information.*
- *It fails to note that after receiving signed non-disclosure and confidentiality agreements from the APA all information requested was provided in a reasonable time frame.*

The respondents would like to explore alternative approaches with the Legislature that would accomplish the mutual goals of creating more accountability and transparency into these important programs.

APA Response: The original non-disclosure agreement with Blue Cross and Blue Shield was signed by the APA very early in the process, on July 13, 2010, and specifically included both DAS and the University of Nebraska. (See copy of the agreement below.) Subsequent to that initial, signed agreement, additional non-disclosure agreements and memorandums of understandings were requested and appropriately signed by the APA.

Additionally, the APA was able to provide specific exceptions in HIPAA permitting State auditors to access otherwise protected employee health information. Neither DAS nor the University ever provided citations to federal laws supporting their position.

LACK OF COOPERATION
(Continued)

CONFIDENTIALITY AND NONDISCLOSURE AGREEMENT

This Confidentiality and Nondisclosure Agreement (Agreement), is made and entered into this 13th day of July, 2010, by and between **BLUE CROSS AND BLUE SHIELD OF NEBRASKA**, a Nebraska company with principal offices at 7261 Mercy Road, Omaha, Nebraska (BCBSNE) and **NEBRASKA AUDITOR OF PUBLIC ACCOUNTS** (AUDITOR).

Pursuant to this Agreement, BCBSNE and AUDITOR may provide each other with certain Confidential Information for the purpose of auditing the benefit and/or health insurance programs for the State of Nebraska, the University of Nebraska, and the Educators Health Alliance. This Agreement also pertains to any Confidential Information either party may possess which is obtained from the State of Nebraska, University of Nebraska or Educators Health Alliance regarding their benefit and/or health insurance programs. Accordingly, the parties agree as follows:

I. Confidential Information

The term "Confidential Information" shall mean, regardless of whether in written or oral form, all proprietary information pertaining to BCBSNE's or AUDITOR's business, including but not limited to: a) business plans; b) trade secrets and patent information; c) actuarial analysis; and d) pricing, discount, and provider reimbursement rate information.

For the purposes of this Agreement, "Confidential Information" shall not include, and the obligations herein shall not apply to, information that: a) is obtained from EnterpriseOne and/or the State of Nebraska's accounting system; b) is now or subsequently becomes generally available to the public; c) either party can demonstrate was rightfully in its possession prior to disclosure; d) is independently developed by either party without the use of any Confidential Information; e) either party rightfully obtains from a third party; f) is released or approved for release by BCBSNE or AUDITOR without restriction; or g) is inherently disclosed in the use, lease, sale, or other distribution of any present or future product or service produced by, for, or under authorization of BCBSNE or AUDITOR or in publicly available supporting documentation for any such product or service.

II. Protection of Confidential Information

Both parties agree to maintain the confidentiality of Confidential Information during and after the term of this Agreement.

III. Use and Disclosure of Confidential Information

Both parties may use Confidential Information only for the purpose described above. Other than for purposes of an external quality control review pursuant to Neb. Rev. Stat. § 84-311 (Reissue 2008), such information may not be included in any database or material for subsequent use in connection with other parties. Both parties may disclose Confidential Information to employees, contractors, directors and officers only on a need-to-know basis and at no time may the AUDITOR disclose information to any representative of a hospital, physician, or other health care provider that is responsible for or works on negotiating reimbursement discounts with BCBSNE or other health care payers or insurers. In all cases in which a party shall permit a person other than an employee of that party to have access to or use or disclose confidential information, such party, as a condition precedent thereto, shall obtain a confidentiality agreement in writing from such person to the effect contained herein.

In addition, both parties may use or disclose Confidential Information if and to the extent: a) required by any request or order of any government authority; b) otherwise required by law; or c) necessary to establish rights under this Agreement; provided that, in each case each party will first notify the other party of such requirement, permit the other party to contest such requirement if reasonably appropriate, and cooperate with the other party in limiting the scope of the proposed use or disclosure.

1

LACK OF COOPERATION
(Continued)

IV. Return of Confidential Information

Upon termination of this Agreement or upon request, both parties shall promptly return all documents and other tangible materials representing Confidential Information. However, it is understood that, pursuant to the directives set out in Section 4.19 et seq. of *Government Auditing Standards* (July 2007 Revision), promulgated by the United States Government Accountability Office, the AUDITOR must prepare and maintain working papers containing sufficient documentation to support all audit findings. Documents and other tangible materials comprising any part of audit working papers prepared by the AUDITOR shall be exempt from the requirements of this section. Nevertheless, such items shall be subject to the non-disclosure provisions of Neb. Rev. Stat. § 84-311 (Reissue 2008).

V. Remedies

It is agreed that the unauthorized use or disclosure of any Confidential Information by either could cause severe and irreparable damage. In the event of such unauthorized disclosure, the non-breaching party is entitled to obtain from any court of competent jurisdiction preliminary and/or permanent injunctive relief, as well as any other form of relief permitted by applicable law. The disclosing party shall notify the non-breaching party immediately upon discovery of any loss or compromise of Confidential Information.

VI. Entire Agreement

This Agreement constitutes the entire agreement between the parties and may not be amended except in a writing executed by both parties. This Agreement shall be governed by the laws of the State of Nebraska.

VII. Relationship of the Parties

BCBSNE and AUDITOR are independent entities and nothing in this Agreement shall be interpreted to create any type of partnership, joint venture, or other similar business relationship.

VIII. Term and Termination

This Agreement shall commence as of the date set forth above and shall remain in force until terminated in writing by either party.

AUDITOR

BY: Mary Avery (Signature) DATE: 7/13/10

NAME: Mary Avery (Print Name)

TITLE: Special Audits and Finance Manager

BLUE CROSS AND BLUE SHIELD OF NEBRASKA

BY: _____ (Signature) DATE: _____

NAME: _____ (Print Name)

TITLE: _____

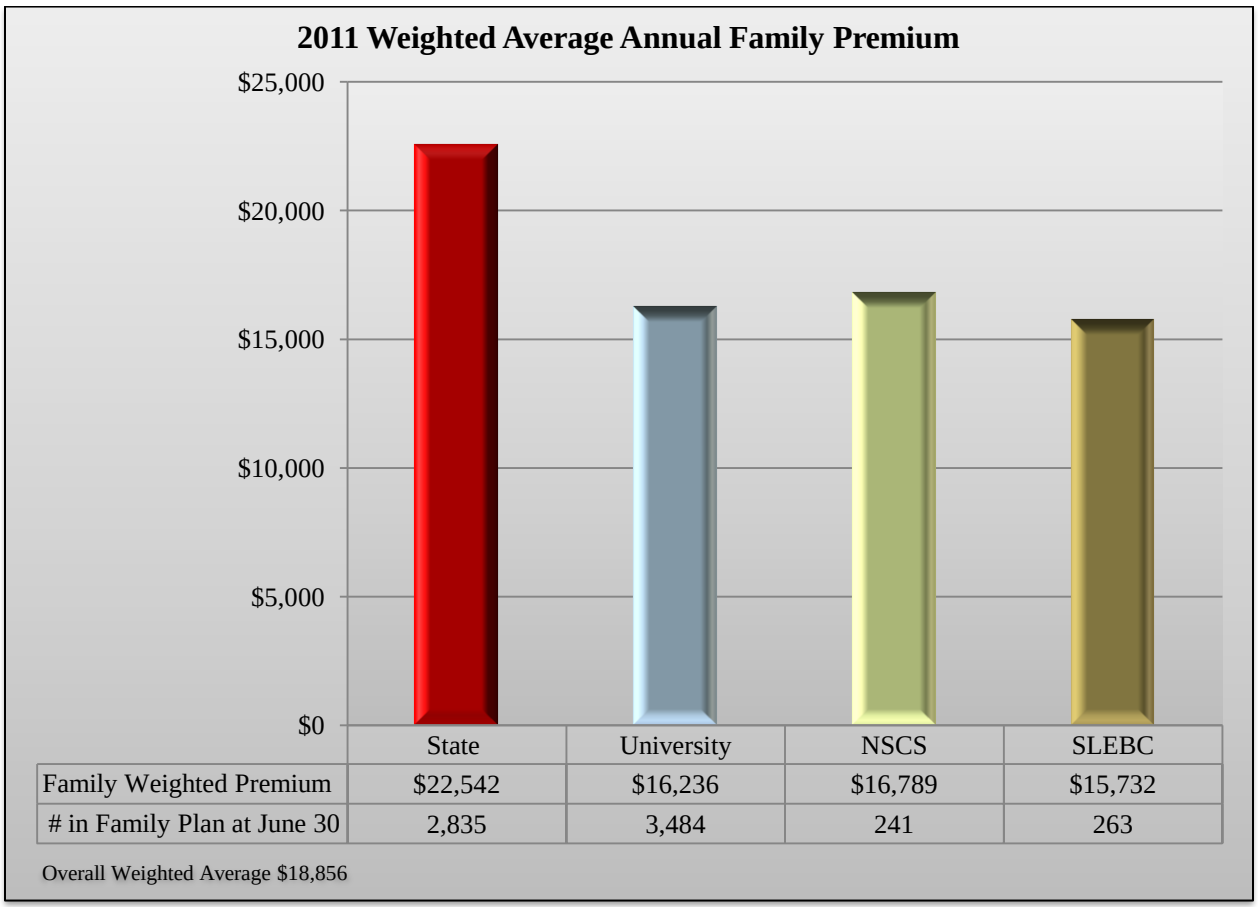
2

PERFORMANCE AUDIT SECTION

Premium Rate Analysis

The primary objective of this performance audit was to identify factors that contribute to the State of Nebraska's high premiums. As noted previously, the 2009 NCSL health insurance data comparison showed the highest State premiums in the nation were being paid by the State of Nebraska. Again, see **Attachment A** for the full comparison.

Generally, the APA used data for the most-used plan for each entity for comparison purposes in this report. However, to more accurately portray the overall premium cost for each program, the APA also calculated the weighted average premiums for all plans at each entity. The chart below shows the 2011 Weighted Average Annual Family Premium for each program:



	State	University	NSCS	SLEBC
Family Weighted Premium	$22,542	$16,236	$16,789	$15,732
# in Family Plan at June 30	2,835	3,484	241	263

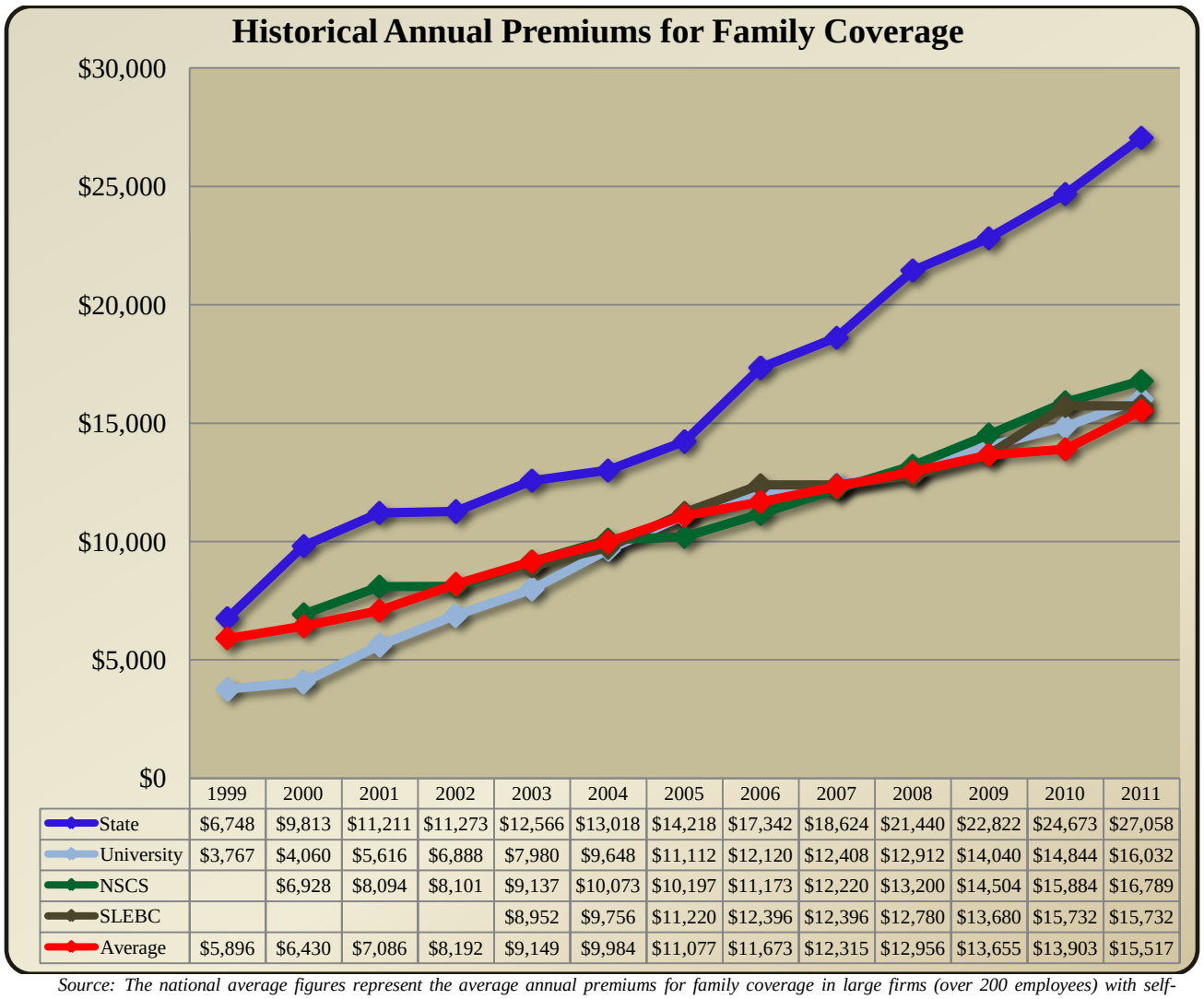
Overall Weighted Average $18,856

PERFORMANCE AUDIT SECTION
(Continued)

The following chart represents the 2011 Weighted Average Annual Single (Employee Only) Premium for each Program:

A separate comparison by the APA of the State's premiums to the other health insurance programs in Nebraska revealed that the State's program has had high premium rates for many years. The national average data, accumulated by the Kaiser Family Foundation in 2011, was added to the chart below. This illustrates not only that Nebraska has had historically above-average premium rates, but also that the gap between Nebraska's rates and the national average has only increased more significantly with each passing year.

PERFORMANCE AUDIT SECTION
(Continued)



	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011
State	$6,748	$9,813	$11,211	$11,273	$12,566	$13,018	$14,218	$17,342	$18,624	$21,440	$22,822	$24,673	$27,058
University	$3,767	$4,060	$5,616	$6,888	$7,980	$9,648	$11,112	$12,120	$12,408	$12,912	$14,040	$14,844	$16,032
NSCS		$6,928	$8,094	$8,101	$9,137	$10,073	$10,197	$11,173	$12,220	$13,200	$14,504	$15,884	$16,789
SLEBC					$8,952	$9,756	$11,220	$12,396	$12,396	$12,780	$13,680	$15,732	$15,732
Average	$5,896	$6,430	$7,086	$8,192	$9,149	$9,984	$11,077	$11,673	$12,315	$12,956	$13,655	$13,903	$15,517

Source: The national average figures represent the average annual premiums for family coverage in large firms (over 200 employees) with self-insured plans according to the Kaiser Survey, Exhibit 1.14.

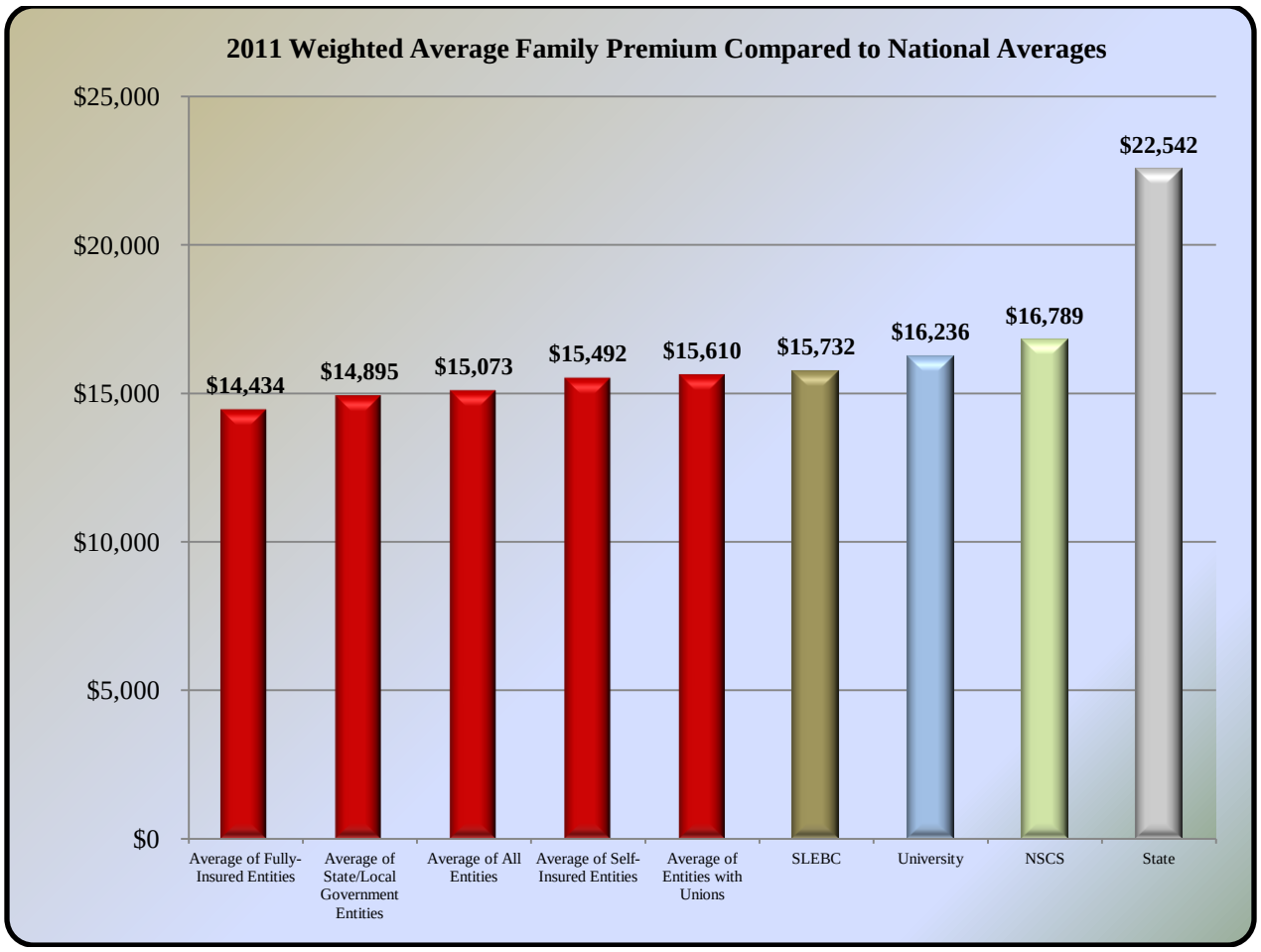
Note: The University transferred general and cash funds in fiscal years 2000 and 2006 through 2011 to help cover the cost of increased premiums for its employees. See page 56 for more information on these transfers. The graph above only reflects these general and cash fund transfers from 2009 forward.

According to its website at http://www.kff.org/about/index2.cfm, the Kaiser Family Foundation is a leader in health policy analysis, health journalism and communication, and is dedicated to filling the need for trusted, independent information on the major issues facing our nation and its people. They serve as a non-partisan source of facts, information, and analysis for policymakers, the media, the health care community, and the public.

Annually, the Kaiser Family Foundation and the Health Research and Educational Trust conduct a survey of employers to provide a detailed look at trends in employer-sponsored health coverage, including premiums, employee contributions, cost-sharing provisions, and other relevant information. The Kaiser Family Foundation and Health Research & Educational Trust, Employer Health Benefits 2011 Annual Survey (Kaiser Survey) can be found at http://ehbs.kff.org. The APA has used certain information in that report for comparison purposes in this performance audit.

PERFORMANCE AUDIT SECTION
(Continued)

The Kaiser Survey included national averages based on a variety of categories – all of which the State program far-exceeded. The State's 2011 weighted average annual family premiums were compared to national averages accumulated by Kaiser as indicated below:

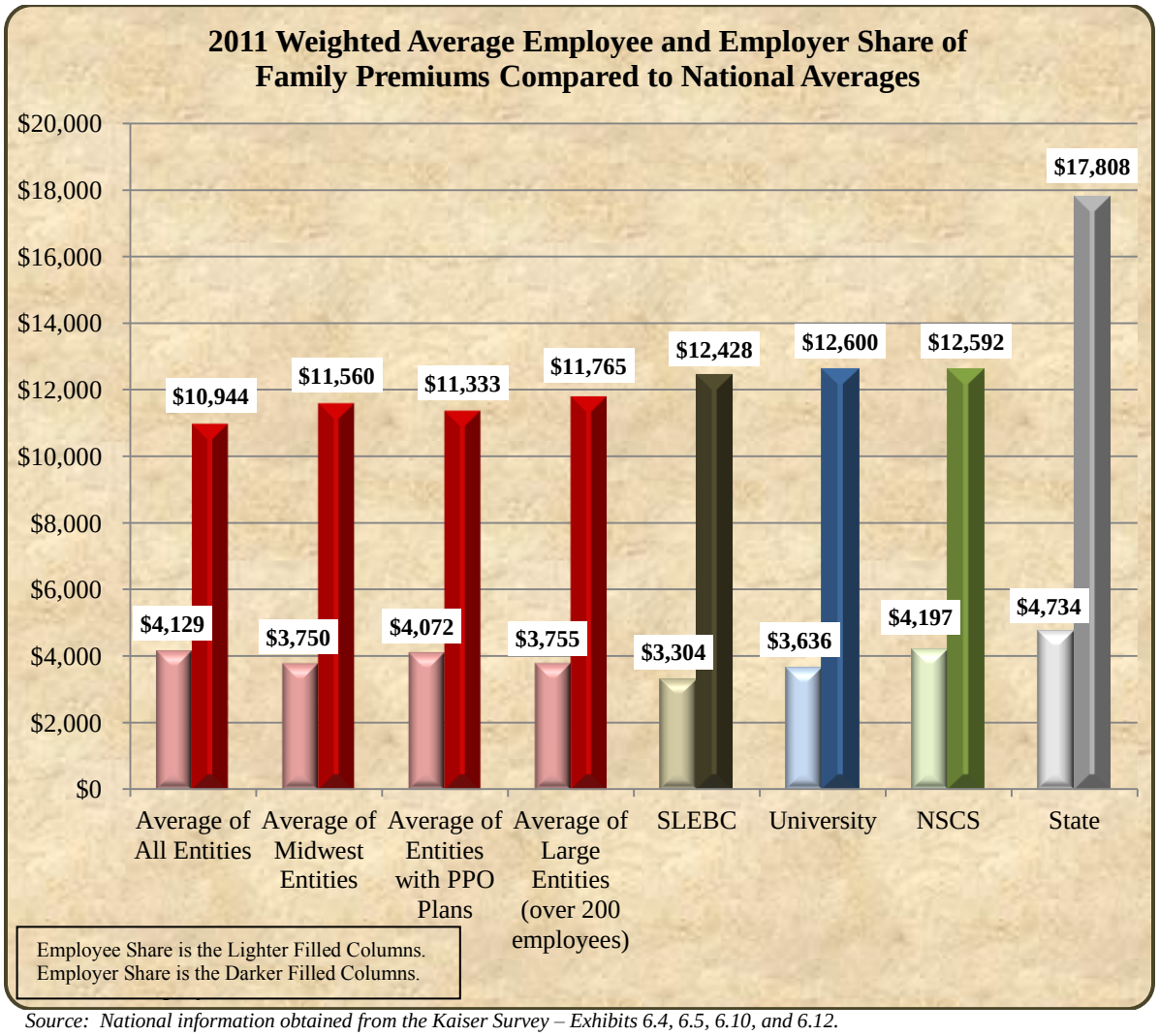


Source: National information obtained from the Kaiser Survey, Exhibits 1.4 and 1.6.

In fact, the Kaiser Survey noted that ***only 5% of entities nationwide*** had family premiums over $22,000. See **Attachment H** for the distribution of family premiums according to the survey.

PERFORMANCE AUDIT SECTION
(Continued)

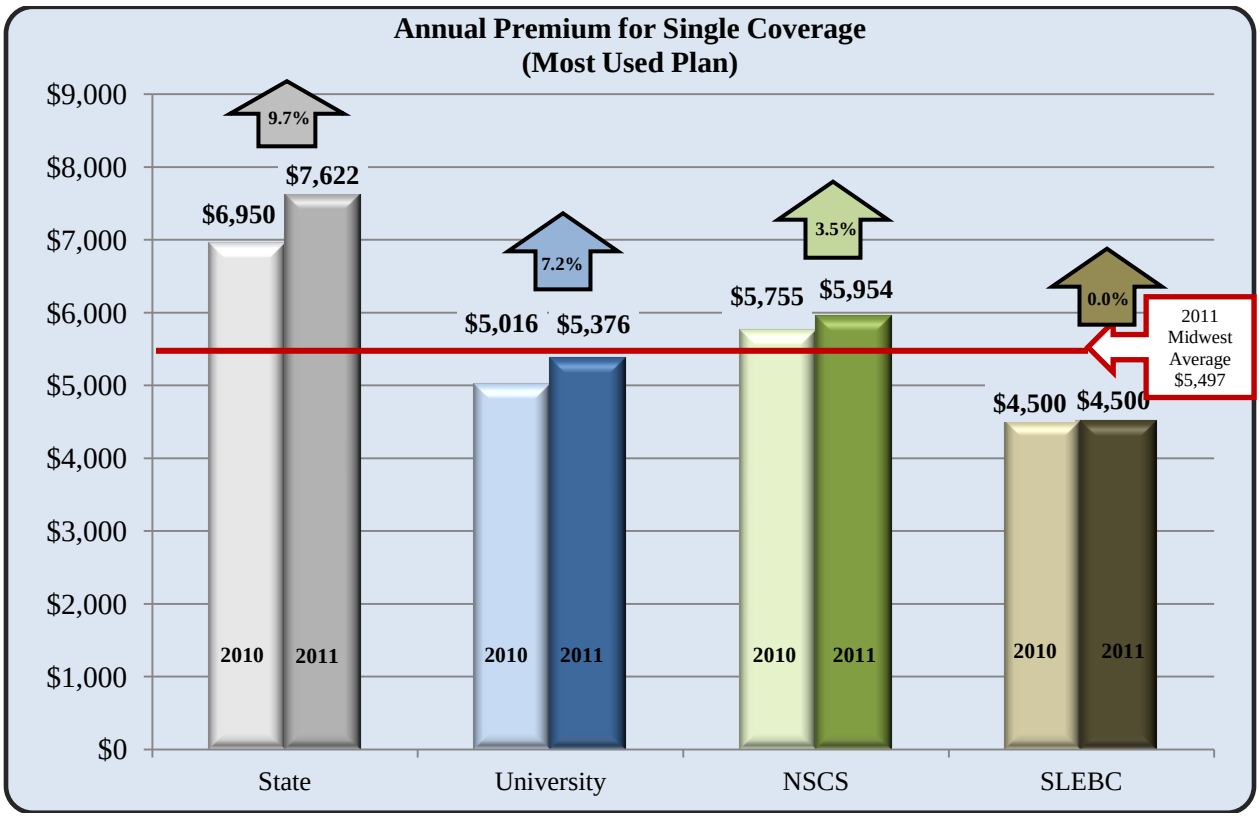
The employee and employer share of the weighted average annual family premiums for 2011 are included below:



Source: National information obtained from the Kaiser Survey – Exhibits 6.4, 6.5, 6.10, and 6.12.

The annual premiums for the employee only (single) coverage had similar results as the family coverage noted previously in this report. The following chart illustrates the total annual premiums for employee only coverage among the four Nebraska plans for plan years 2010 and 2011, and the 2011 national average for single coverage according to the Kaiser Survey.

PERFORMANCE AUDIT SECTION
(Continued)



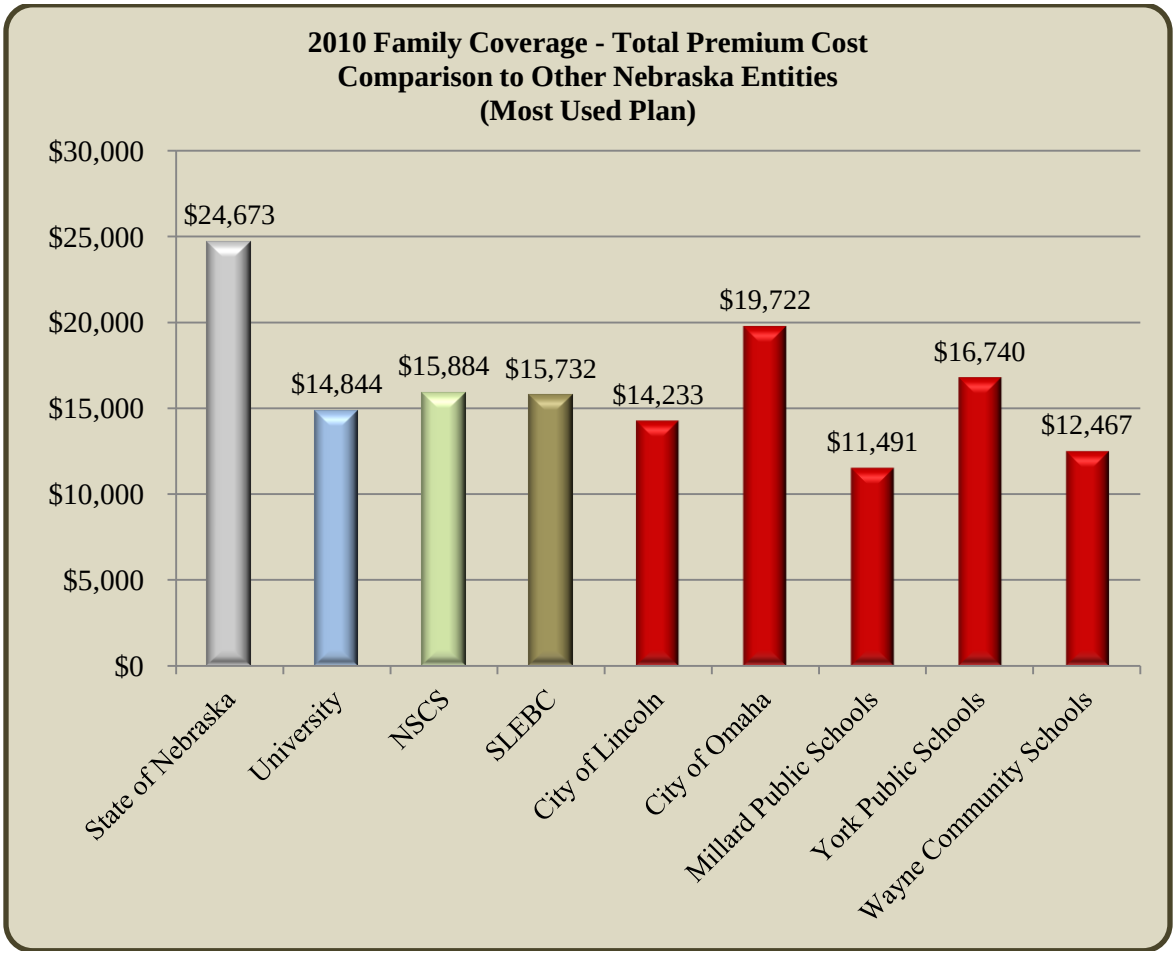
Note: The Midwest Average for the 2011 annual premium for single coverage was obtained from the Kaiser Survey, Exhibit 1.3.

Clearly, the State of Nebraska's premiums are well above average, but this information also illustrates that the State approved the highest increase in the single coverage premium from 2010 to 2011. As noted throughout this report, the APA has used the plan with the largest number of participating employees for comparison purposes. **Exhibit B** provides the costs for all of the coverage options for the four Nebraska plans.

The APA performed additional analysis of Nebraska's premiums in comparison to other states for each entity's 2010 plan year. **Exhibits C** & **D** provide detailed information regarding these other states' plans for 2010.

PERFORMANCE AUDIT SECTION
(Continued)

The APA also performed an analysis of Nebraska's premium costs compared to other local entities in Nebraska. The chart below illustrates the 2010 family premium costs for each entity. **Exhibit E** & **F** provides additional details regarding the employee and employer share of the cost of these plans as well as the various plan designs.



This analysis was insightful because not only did it illustrate Nebraska's high premiums; it also revealed a variety of premium structuring options that many other government entities utilize. Some of these alternative methods included additional premium categories based on age or number of dependents, premium incentives for wellness programs, premium increases for tobacco users, and different percentages of the premium paid by the agency for single versus family coverage.

In the following section, the APA discusses possible factors which could help explain Nebraska's exorbitant premium rates.

Performance Factors Examined

Plan Designs

Plan design refers to the benefits provided by different health insurance options. Throughout this report, the APA has included the most-used State or University plan for comparison purposes. However, the State offers four different options to its employees and the University offers three different options under their respective health insurance programs. The different State options can be seen in **Exhibit G**, while the University's options are shown in **Exhibit H**.

Plan design includes the following variables:

Deductible – A fixed dollar amount during a benefit period that an insured individual pays before his or her health insurance program begins to make payments for covered medical services. Health insurance programs may include both individual and family deductibles.

Copayment – A form of medical cost sharing in a health insurance plan that requires an insured individual to pay a fixed dollar amount when a medical service is received. The health insurance program is then responsible for the remainder of the cost of the service.

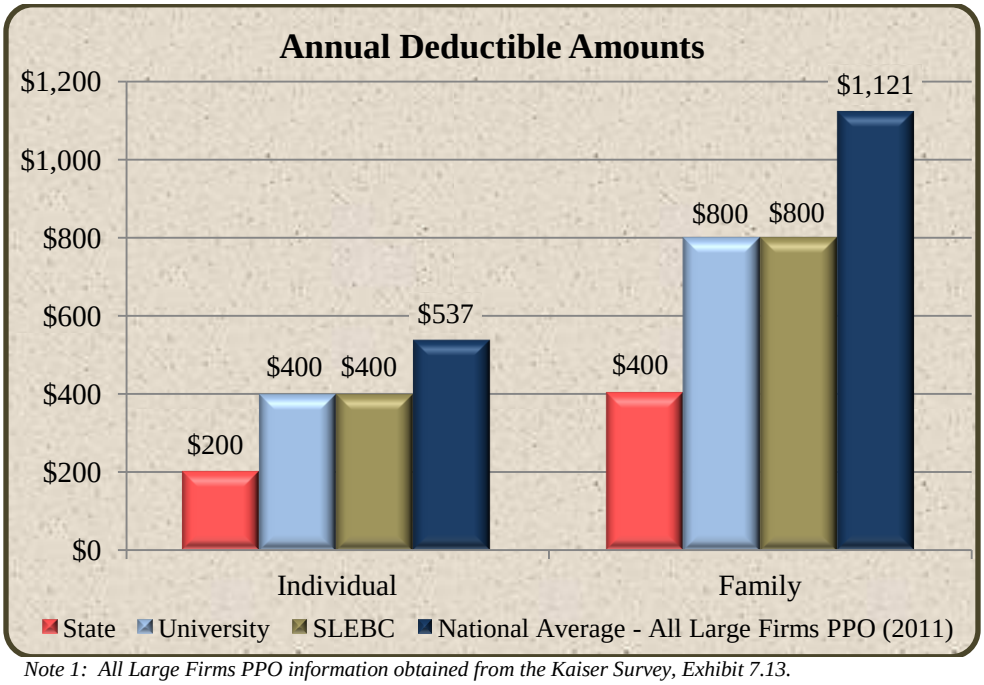
Coinsurance – A form of medical cost sharing in a health insurance program that requires an insured individual to pay a stated percentage of medical expenses after the deductible amount, if any, has been paid. Once any deductibles and coinsurance amounts have been paid, the health insurance program is responsible for the remainder of the cost of the services.

Maximum Out of Pocket Expense – The maximum dollar amount a member of a health insurance program is required to pay during a year. Until this maximum is met, the health insurance program and the covered individual shares in the cost of covered expenses. After the maximum is reached, the health insurance plan pays all of the covered expenses, often up to a lifetime maximum.

These factors play a significant role in the amount needed to cover the claims costs in the form of premiums and will be reviewed in more detail below.

A low deductible amount means the health insurance program begins making payments for services sooner than a health insurance program with a higher deductible amount, resulting in higher costs to those health insurance programs. The health insurance option used by the majority of State employees had the lowest deductible amounts of the three self-insured programs for 2010, but all three Nebraska plans included below had deductible amounts below the national average for large firms with PPO plans, as follows:

PERFORMANCE AUDIT SECTION
(Continued)



Note 1: All Large Firms PPO information obtained from the Kaiser Survey, Exhibit 7.13.
Note 2: As of July 1, 2011, the State's annual deductibles increased to $500 and $1,000 for its most-used plan. As of January 1, 2011, the University's annual deductibles increased from $450 and $900 for its most used plan. SLEBC would not provide current information.

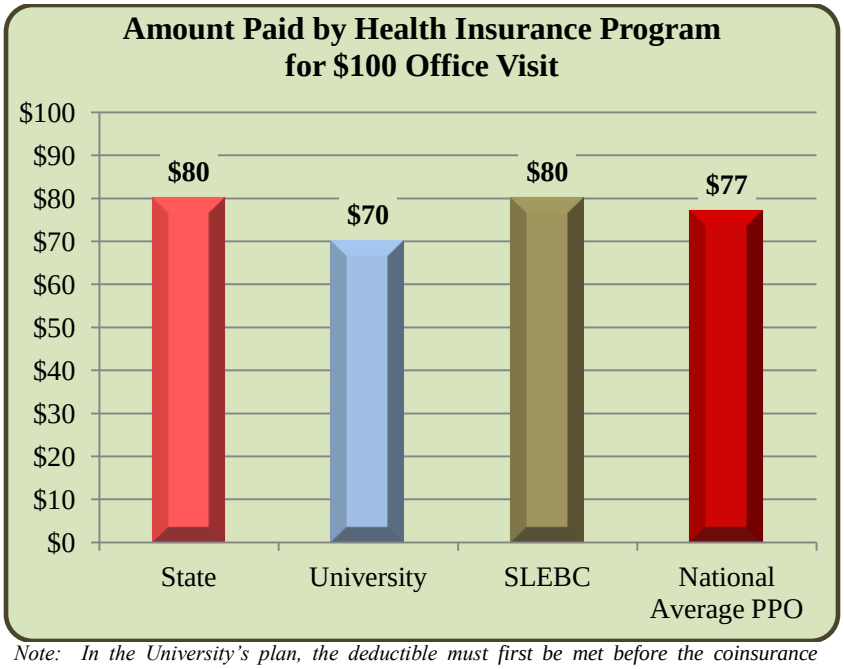
Copayments and coinsurance amounts also significantly affect the premium costs for health insurance programs. For example, the University has a slightly different plan design for the payment of an office visit, than the State and SLEBC:

Service	State	University	SLEBC	National Average PPO
Office Visit	$20 Copay	Coinsurance: Member pays 30% Program pays 70% (after deductible is met)	$20 Copay	$23 Copay

Note 1: The national average was obtained from the Kaiser Survey, Exhibit 7.23, PPO Average Copay for Primary Care Office Visit.
Note 2: As of July 1, 2011, the State's copay for office visits was $25 for the most used plan. Two of the State's plans still had a $20 copay for office visits. The University's plans remain unchanged and SLEBC would not provide current information.

PERFORMANCE AUDIT SECTION
(Continued)

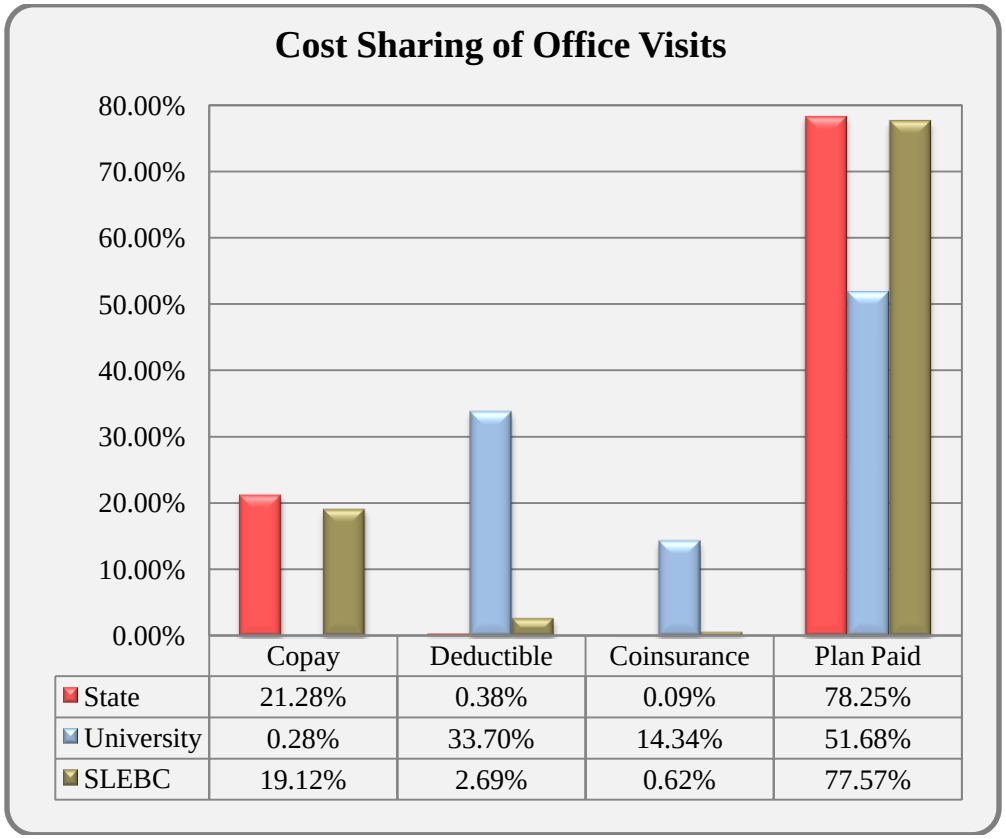
This design results in different amounts paid by each health insurance program. Assuming an office visit costs $100, and any applicable deductibles have been met, each plan pays the following amounts:



Note: In the University's plan, the deductible must first be met before the coinsurance provision begins, so in the example above, the $70 is only paid by the plan, if the deductible has been met by the member.

The effect of these differences on each program can be seen below. In order to compare the various programs, the APA obtained claims detail from the State, University, and SLEBC. The APA requested claims data for the Nebraska State College System, but due to its fully-insured nature, was unable to obtain the data. The APA identified all claims for office visits for new and existing patients based on Current Procedural Terminology (CPT) codes included in the information provided to the APA for fiscal year 2010.

PERFORMANCE AUDIT SECTION
(Continued)



	Copay	Deductible	Coinsurance	Plan Paid
State	21.28%	0.38%	0.09%	78.25%
University	0.28%	33.70%	14.34%	51.68%
SLEBC	19.12%	2.69%	0.62%	77.57%

From the graph above, it is clear that the University's plan design allows its health insurance program to pay a lower overall portion of the cost of office visits. These lower costs are one reason the University is able to provide lower premiums than the State.

A similar comparison was made for outpatient mental health services. The APA identified claims with a CPT code for outpatient psychotherapy services, outpatient psychiatric services, and the initial diagnostic exam. The plan design for these services is as follows:

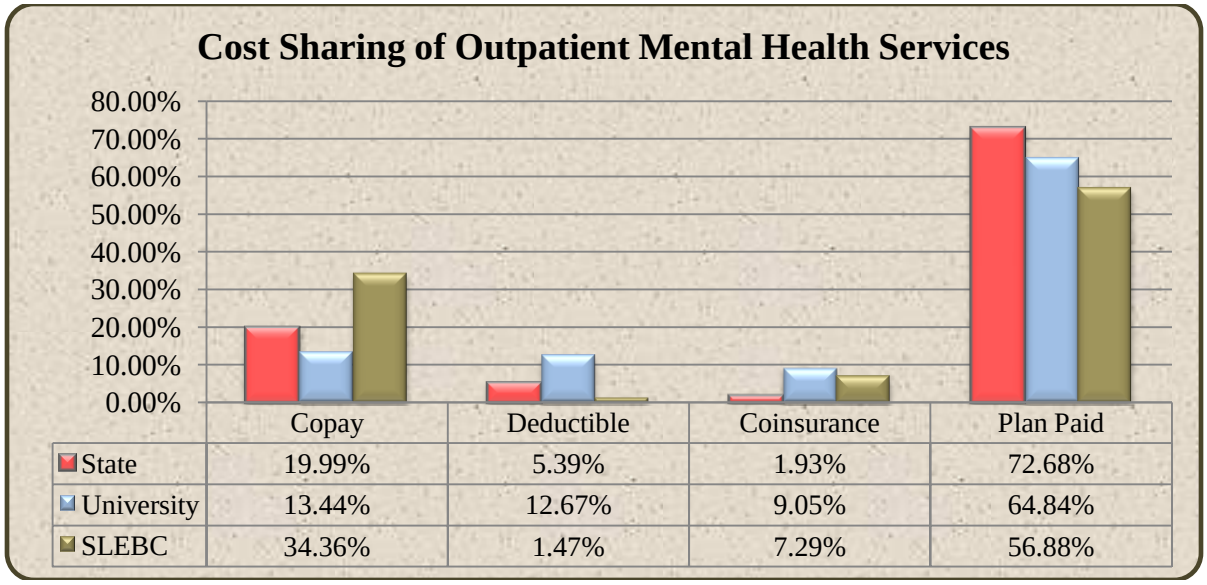
Service	State	University	SLEBC
Outpatient Mental Health Services	$20 Copay	2009: $30 Copay 2010: Coinsurance – Member pays 30% Program pays 70%	Coinsurance: Member pays 10% Program pays 90%

Note 1: As of July 1, 2010, the State's plan pays for these services using coinsurance rather than copayment. The most used plan had a 20% coinsurance after the deductible.

Note 2: For SLEBC, the APA used the outpatient hospital benefit from the plan document and summary of plan description for the coinsurance amount. SLEBC's summary of plan description also included as a hospital a facility operating legally as a psychiatric hospital or a residential treatment facility for mental health. SLEBC would not provide current information.

PERFORMANCE AUDIT SECTION
(Continued)

As a result of these differing plan designs for 2010, the State paid the highest percentage of outpatient mental health services at 72.68%, while SLEBC paid only 56.88% as can be seen in the table below.



	Copay	Deductible	Coinsurance	Plan Paid
State	19.99%	5.39%	1.93%	72.68%
University	13.44%	12.67%	9.05%	64.84%
SLEBC	34.36%	1.47%	7.29%	56.88%

Note: The SLEBC plan had a significant amount of costs paid by copayments from members. The only copayments included in SLEBC's plan document and summary plan description were for office visits and emergency room services. It appears the initial diagnostic exam for these outpatient mental health services could be considered office visits, but the APA was unable to verify this.

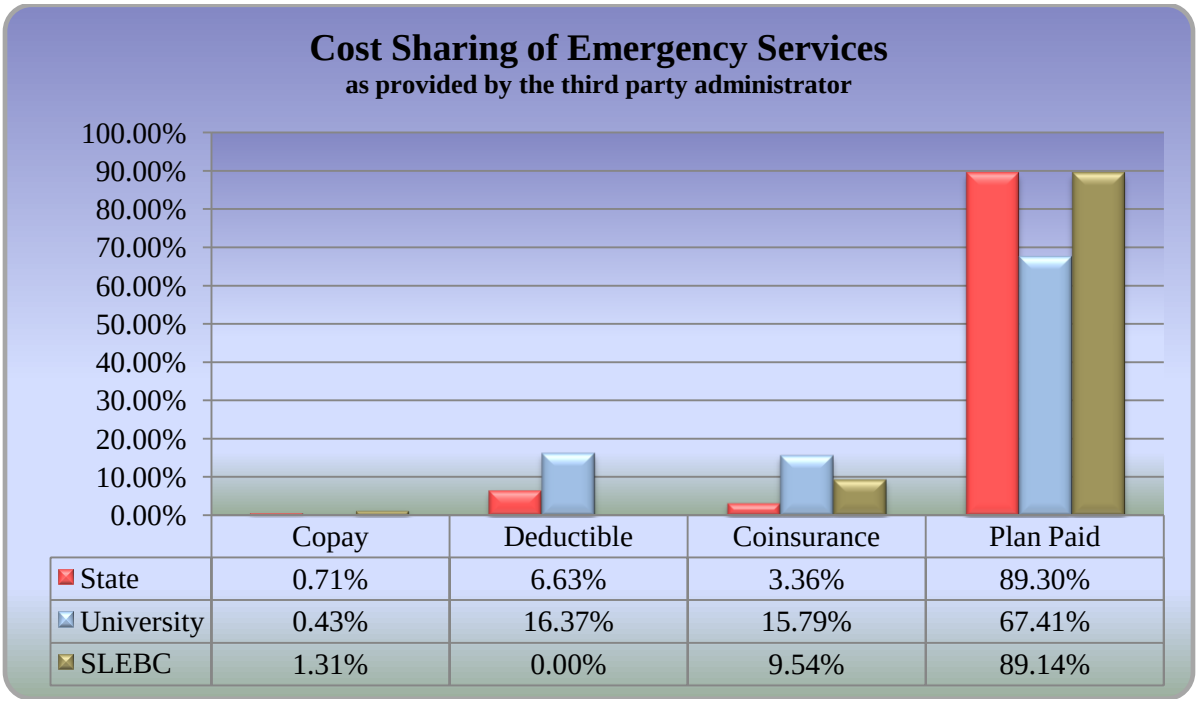
Finally, the APA compared plan designs for emergency services. The APA identified claims with a CPT code for emergency services which varied from minor to high severity. During 2010, the plan designs were as follows:

Service	State	University	SLEBC
Emergency Services	$50 Copay	Coinsurance: Member pays 30% Program pays 70%	$40 Copay; Plus Coinsurance: Member pays 10% Program pays 90%

Note: The State changed its plan design for the most used plan effective July 1, 2011, so that the State employees pay a $100 copay for emergency room services in all four plan options. SLEBC would not provide current information.

Again, the University's plan design caused a higher percentage of claims to be paid by participants. The State and SLEBC plans paid 89% of the allowable charges, while the University plan paid 67%.

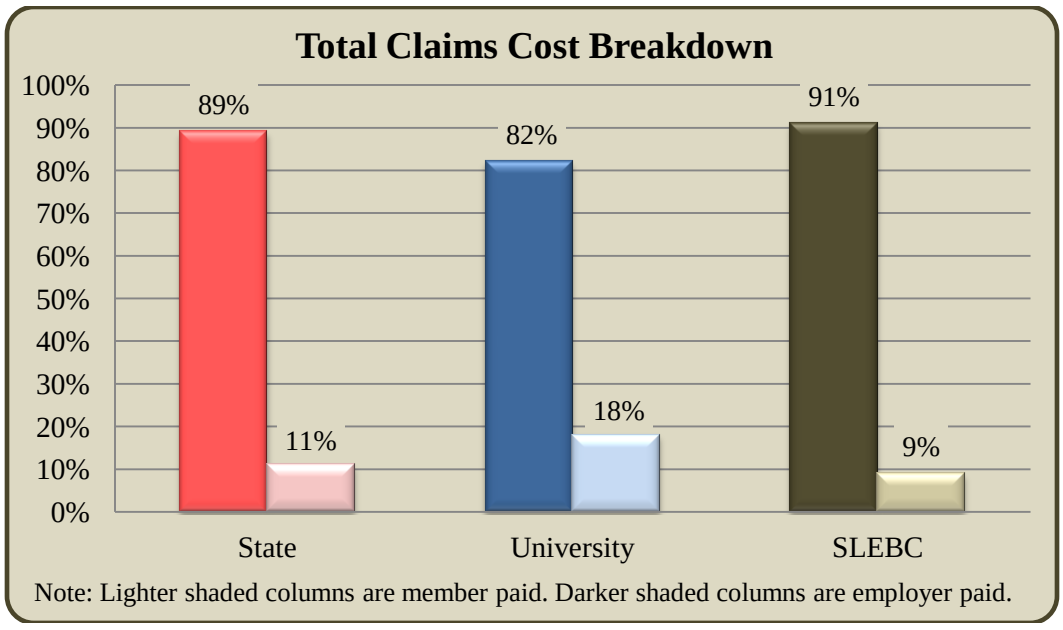
PERFORMANCE AUDIT SECTION
(Continued)



	Copay	Deductible	Coinsurance	Plan Paid
State	0.71%	6.63%	3.36%	89.30%
University	0.43%	16.37%	15.79%	67.41%
SLEBC	1.31%	0.00%	9.54%	89.14%

Note: Copayments are waived in the following instances: for the State, if admitted within 24 hours with the same diagnosis; for SLEBC, if admitted and Medical Management is notified within 48 hours of the admission.

The following charts summarize the overall effect of the plan designs on each entity for fiscal year 2010. The larger number represents the share paid by the Program, the smaller number is the share paid by the member.



As indicated, the University paid the lowest percentage of the total claims cost compared to the other two programs.

If the State's plan design mirrored the University's and the State paid 82% of the total claims cost, the State's program would have paid an estimated $9 million less than what was actually paid in fiscal year 2010. These savings could be used to lower premiums.

A good internal control plan and sound business practice requires policies and procedures be established to ensure the development of the health plan design is both beneficial to participants and cost effective to the government entity. Currently, the State does not make changes uniformly across its plan options.

We recommend the State review its plan designs and consider the use of coinsurance over the use of copayments, as coinsurance tends to lower the program costs for the employers. The State still relies heavily on the use of copayments in its health insurance plans, while the University primarily uses deductibles and coinsurance. The State should examine the fiscal impact of various deductible, copayment, and coinsurance scenarios. Both of these recommendations would allow the State to lower it premiums. Additionally, as seen above, the University's structure results in lower costs to its program.

We also recommend the Legislature require the State to annually examine its health insurance program plan designs to determine if the current employee cost sharing levels are appropriate and to analyze the effect of any changes on premium costs. The State's analysis should be available and should include:

- Documentation to support any analysis performed on proposed plan design changes and the effect of those changes on the cost sharing of claims. If proposed plan design changes differ among the State's four plan options, documentation should exist explaining why the plan design changes differ.
- After plan design changes have been implemented, the State should provide documentation on the annual analysis of all actual plan design changes and the effect on the cost sharing of claims.
- An annual analysis of the percentage of total claims paid by the program and the employee.
- A more detailed annual analysis of the total claims paid by the program or by the employee through copayments, coinsurance, deductibles, or other methods.

We also recommend the Legislature review the current administration of the health insurance programs and determine whether changes are needed in the administration of the program, such as the formation of a committee of professionals to help guide the entities in their administration of the self-insured health insurance program.

DAS and the University's Response: There are several key points regarding plan design that are misleading, not appropriately highlighted or were incorrectly omitted in the report.

- *The APA fails to mention the significant changes State has made and will continue to make in plan design to the health plans offered. There is no mention in the report that in 2007 a twelve million dollar line of credit was established because the program was barely able to fund claim payments. Due in part to plan design changes over the last few years, the line of credit was never used and the program now has a reserve.*
- *The State has increased copays and where deemed appropriate is moving more to a coinsurance approach as demonstrated by previous plan design changes.*
- *In consultation with the State's actuary, health insurance provider, pharmacy benefit manager and wellness provider, the State regularly reviews the State's health plan.*

APA Response: In spite of the changes to the State's plan highlighted by DAS in the above response, the State's program still had higher weighted average annual premiums than the other State and local entities reviewed. This leads the APA to the conclusion that further monitoring and controls are necessary.

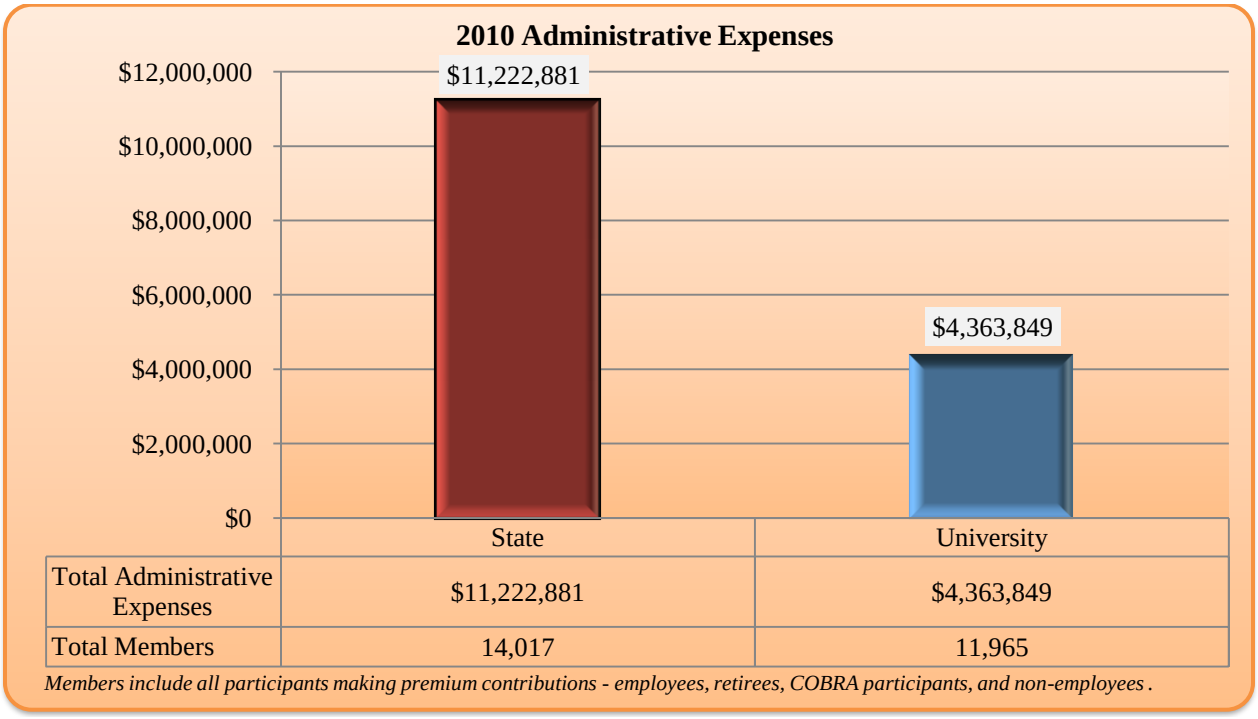
Administrative Expenses

As previously mentioned, in a self-insured program, the premiums collected from the employer and participants must cover the cost of the claims incurred, fund a reserve, and fund an appropriate fund balance. However, the premiums must also cover a number of other non-claim expenses incurred in the administration of the self-insured program. In a self-insured program, the employer often utilizes the services of a third party to process claims. The cost of these services is considered an administrative expense of the program. Other administrative expenses include costs of wellness programs, payroll expenses, actuarial/consultant expenses, and others.

Monitoring these administrative expenses becomes a critical responsibility of those charged with managing a self-insured insurance program, because the higher the administrative costs rise, the higher the participants' premiums must increase to cover those growing costs.

The following chart represents the amount of administrative expenses incurred by the State and the University during fiscal year 2010:

PERFORMANCE AUDIT SECTION
(Continued)



	State	University
Total Administrative Expenses	$11,222,881	$4,363,849
Total Members	14,017	11,965

Members include all participants making premium contributions - employees, retirees, COBRA participants, and non-employees .

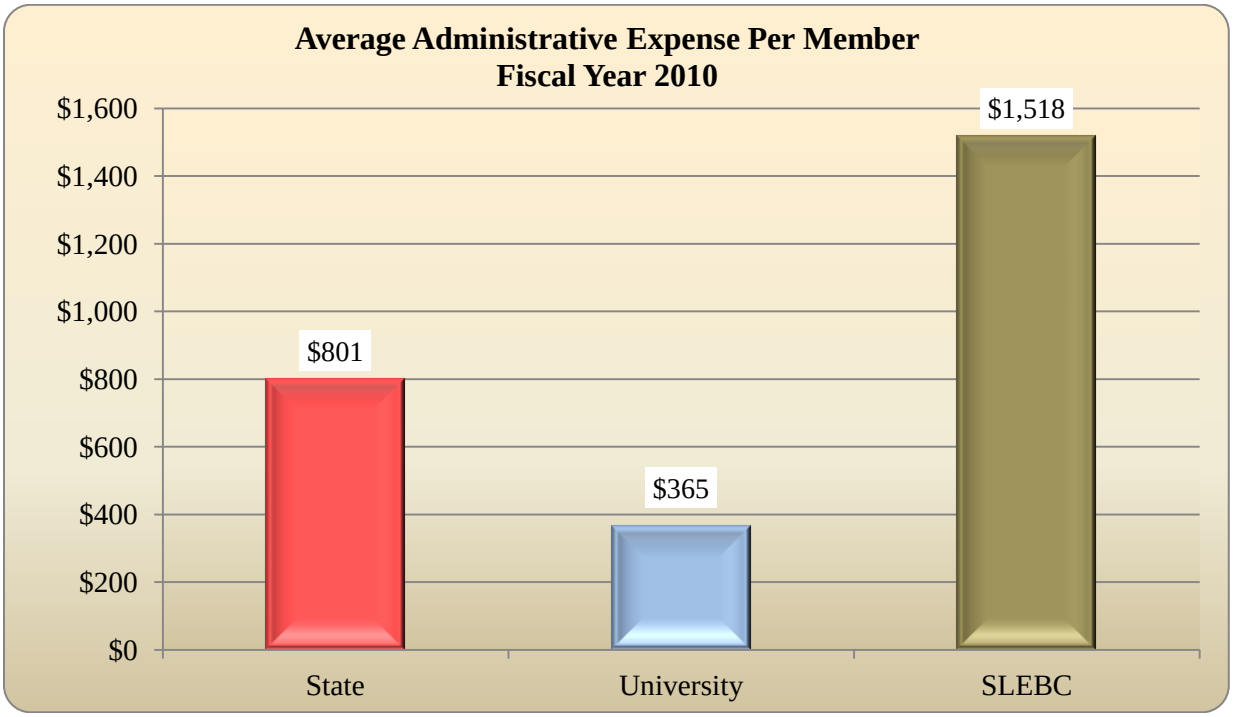
The following charts illustrate the average administrative expenses per member for each self-insured program during fiscal year 2010:

	State	University	SLEBC
Total Members	14,017	11,965	501
Total Expenses	$163,697,709	$109,618,604	$ 6,332,190
Total Claims Paid	$152,474,828	$105,254,755	$ 5,571,793
Total Administrative Expenses	$ 11,222,881	$ 4,363,849	$ 760,397
Stop Loss Insurance	$ 1,970,412	$ -	$ 501,310
Administrative Expenses Without Stop Loss Insurance	$ 9,252,469	$ 4,363,849	$ 259,087
Average Administrative Cost Per Member Including Stop Loss Insurance	$ 801	$ 365	$ 1,518
Average Administrative Cost Per Member without Stop Loss Insurance	$ 660	$ 365	$ 517

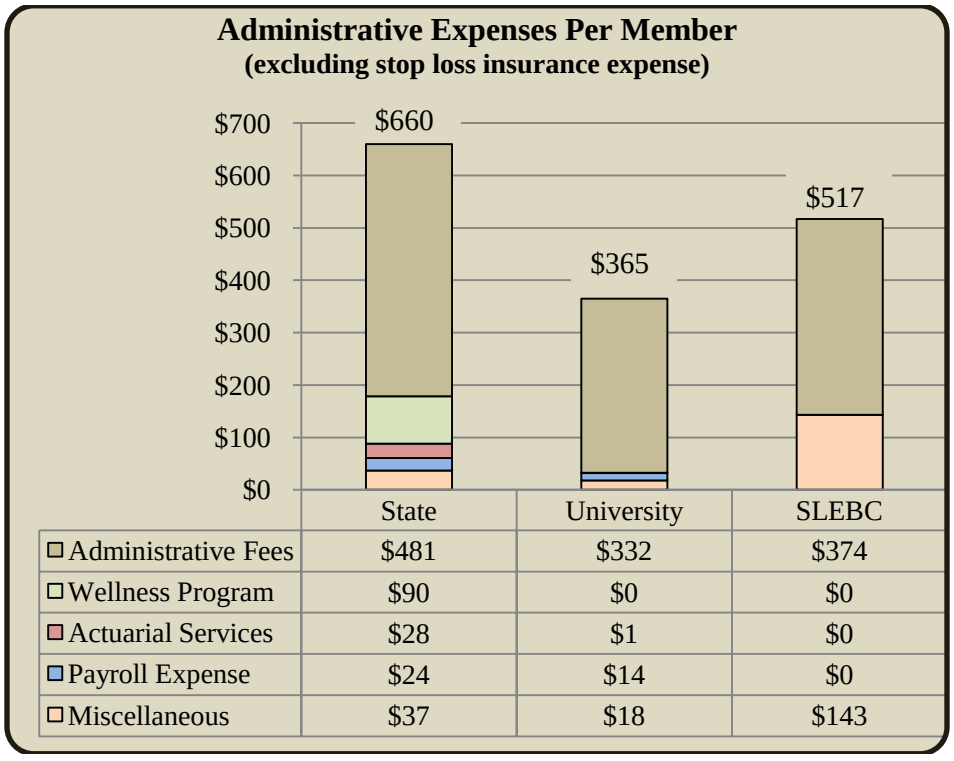
Note 1: The total administrative expenses were determined by taking the total expenses less the claims paid. For SLEBC, the APA excluded $274,259 in premium payments made to vendors for other types of insurance, such as long-term disability, vision, etc.

Note 2: Members include all participants making premium contributions - employees, retirees, COBRA participants, and non-employees (excludes dependents for each of these categories).

PERFORMANCE AUDIT SECTION
(Continued)



Since stop loss insurance is analyzed separately, below, the APA removed stop loss insurance from the following chart, which shows all other administrative expenses for fiscal year 2010:

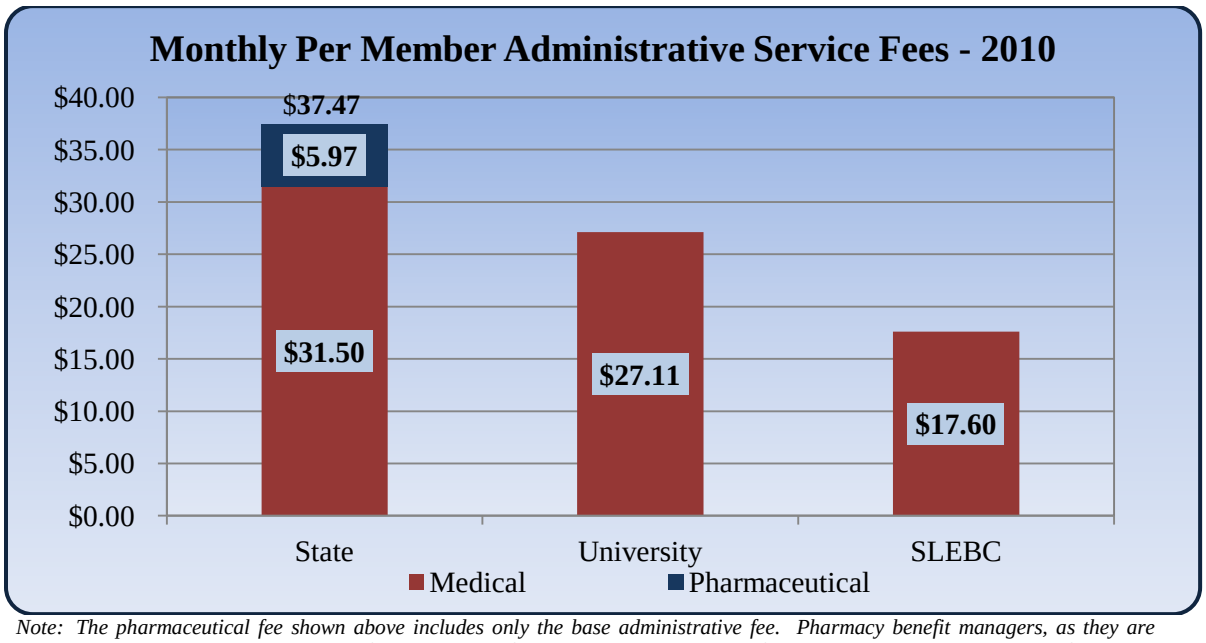


	State	University	SLEBC
Administrative Fees	$481	$332	$374
Wellness Program	$90	$0	$0
Actuarial Services	$28	$1	$0
Payroll Expense	$24	$14	$0
Miscellaneous	$37	$18	$143

PERFORMANCE AUDIT SECTION
(Continued)

As shown above, excluding Stop Loss Insurance costs, the State program had the highest amount of administrative fees. The administrative service fees, wellness program fees, actuarial/ consulting services and miscellaneous expenses will be reviewed in more detail below.

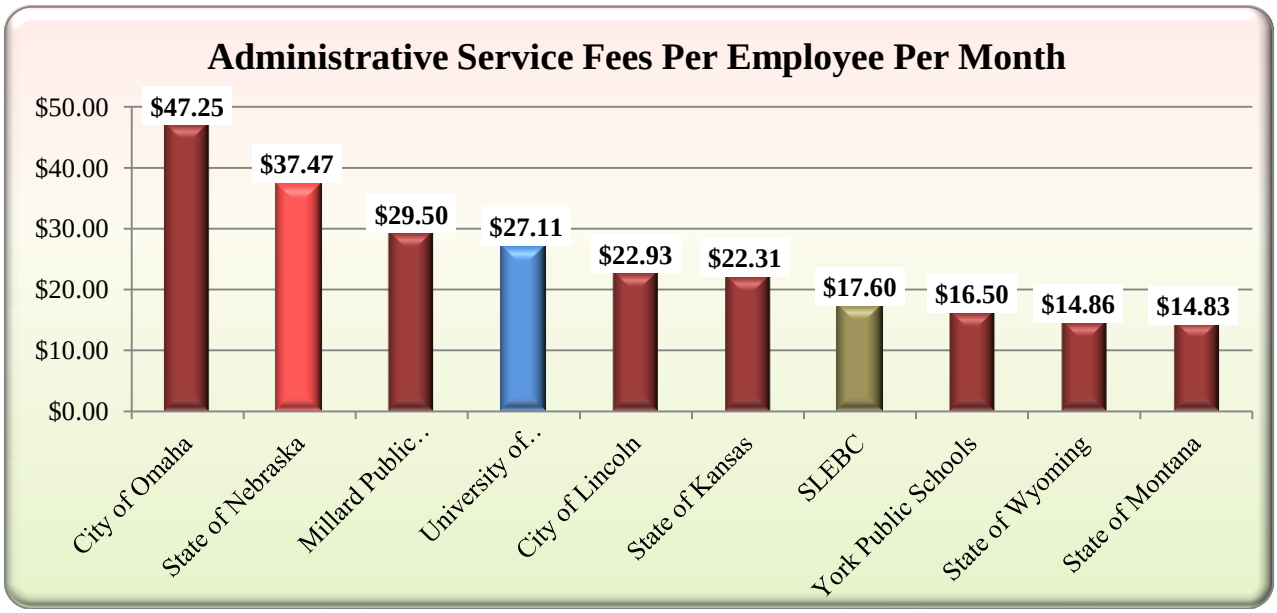
Administrative Service Fees
The largest of the non-claim expenses for self-insured programs is most commonly the fees charged by a third party administrator (TPA) for receiving and processing claims, as well as providing customer support services. Third party administrators generally charge a per member per month (PEPM) administrative fee, which is typically set in a contractual agreement between the employer and the TPA. The following chart illustrates the administrative service fees on a per member basis among the three self-insured Nebraska programs for fiscal year ended June 30, 2010.



Note: The pharmaceutical fee shown above includes only the base administrative fee. Pharmacy benefit managers, as they are known, also charge drug pricing fees, dispensing fees, and other agreed-upon fees. The University did not pay a flat PEPM administrative fee for their prescription drug program; rather Caremark either kept the rebates earned or reduced the discounts on drug costs.

Despite engaging in a competitive bidding process to secure its vendor, it does not appear the State secured a competitive rate from its medical third party administrator. A comparison of the third party administrative fees with other states and local governments for 2010, further illustrates this concern.

PERFORMANCE AUDIT SECTION
(Continued)



Note: The PEPM administrative fees for other states and local municipalities were obtained from staff with those entities and were not verified to contracts in all cases. The administrative fees were for the most used plan, if applicable (except for Montana as the administrative fee for the most used plan was not available, so the next most used plan fee is shown).

The State should consider whether its administrative service fees paid to BCBSNE are competitive with the University and other entities served by the third party administrator.

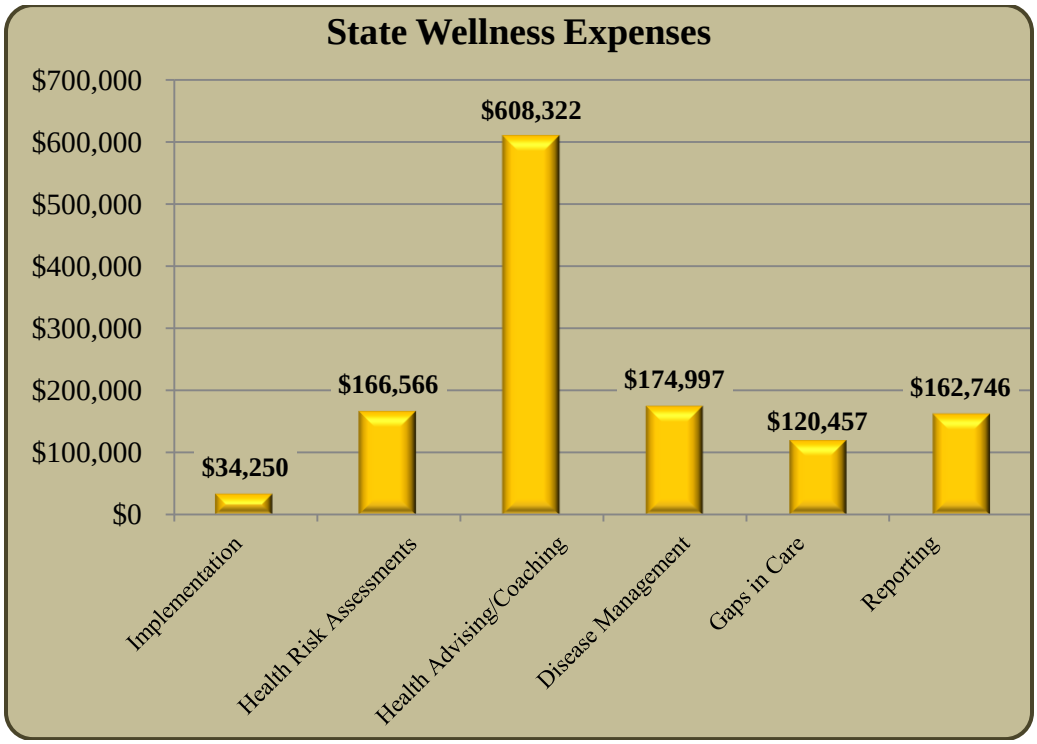
Wellness Programs

The recent implementation of the State's wellness program has significantly increased the program's administrative expenses. On a number of occasions, State officials have indicated that the wellness program is working to reduce health issues of those enrolled and have documented new cases of high blood pressure, high cholesterol, diabetes, etc.

(Continued on Next Page)

PERFORMANCE AUDIT SECTION
(Continued)

However, State officials have not performed a cost-benefit analysis of the wellness program to ensure that the significant costs of the program are beneficial. The State's wellness program features a significant number of additional services which drastically increased the overall cost to the State. During fiscal year 2010, the State paid $1,267,338 to Health Fitness Corporation for its wellness program, as follows:



Note: Per review of the State's contract with Health Fitness Corporation, the Disease Management fees noted above were set to increase each year after fiscal year 2010, while all other fees begin increasing after fiscal year 2012.

A brief description of the expenses included above is as follows:

Contract Description	Services Provided
Implementation	One-time implementation fee.
Health Risk Assessments	Online services including assessments, education, activity tracking and health coaching; fee of $0.56 per person per month (PPPM).
Health Advising/Coaching	Health action programs including walk this way ($28.00 per person), feel like a million ($14.70 per person), and empowered coaching ($165.00 per person).
Disease Management	Nurture individuals relating to diabetes, chronic obstructive pulmonary disease, asthma, depression, and heart failure. Fees range from $24.00 to $39.00 PPPM.
Gaps in Care	Preventative and chronic communication reminders; fee of $0.65 and $0.52 per employee per month.
Reporting	Onsite program manager pay of $125,000 per year, ongoing integration, and database customizations of $150.00 per hour.

The University participates in the BluePartners – Disease Management program, which is a member support service for those with diabetes, heart disease, asthma, and chronic obstructive pulmonary disease. The University's program was described on the UNL Human Resources website, at http://hr.unl.edu/benefits/insurance/medical.shtml, as follows: "The BluePartners program offers personalized attention from a team of health care professionals, custom-designed to fit individual needs, lifestyles and doctors' instructions. BluePartners strives to educate and empower program participants by providing a wide variety of support: personal phone contact with a registered nurse, educational materials and Internet tools. Health care professionals can answer questions about specified chronic conditions, as well as consult with you and your doctor regarding treatment plans." The program was available to members with any of the specific conditions mentioned at no cost to the member.

Monthly, the University was billed for this service. For May 2010, the amount paid was $45,198, which equals an estimated $540,000 per year. The monthly cost per member paid by the University ranged from $9 to $41 and varied based on the condition of each member. The University did not separately record those services as an administrative cost, but included the costs in the claims paid. Therefore, the APA was unable to determine an actual cost of the wellness portion of the University's program.

SLEBC members may participate in Guided2Health, a wellness program that provided health assessments, coaching, educational material, and health screenings. In fiscal year 2010, SLEBC paid $28,986 to Guided2Health.

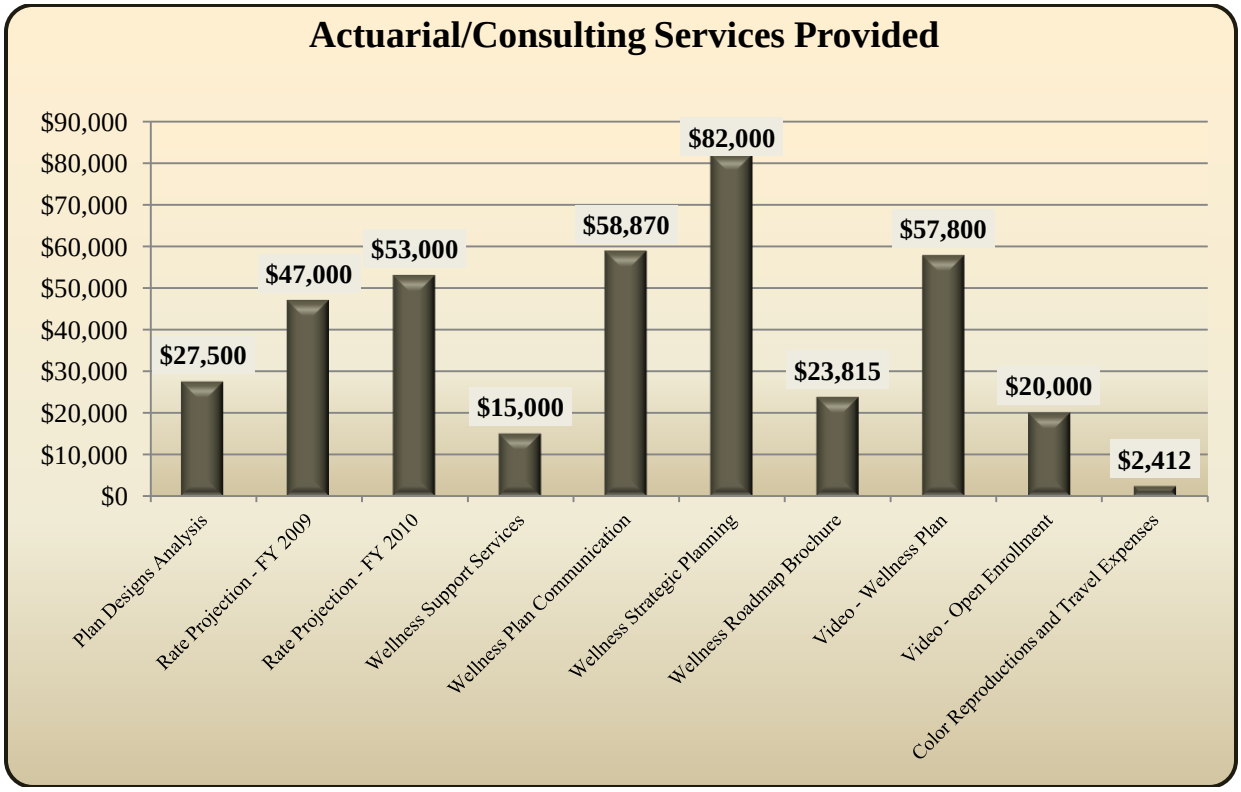
Actuarial/Consulting Expenses

Actuarial consulting is yet another area in which the State is paying significantly higher expenses. While both the State and University have a relatively similar number of participants, the two entities paid dramatically different amounts for actuarial services during fiscal year 2010. The State paid $387,397, while the University only paid $9,462. SLEBC incurred no expenses for actuarial services.

(Continued on Next Page)

PERFORMANCE AUDIT SECTION
(Continued)

The following chart illustrates the amounts paid during fiscal year 2010:



Note: The majority of these expenses ($237,485) were related to the State's Wellness Program.

(Continued on Next Page)

PERFORMANCE AUDIT SECTION
(Continued)

The following table provides a brief description of the services provided to the State during fiscal year 2010:

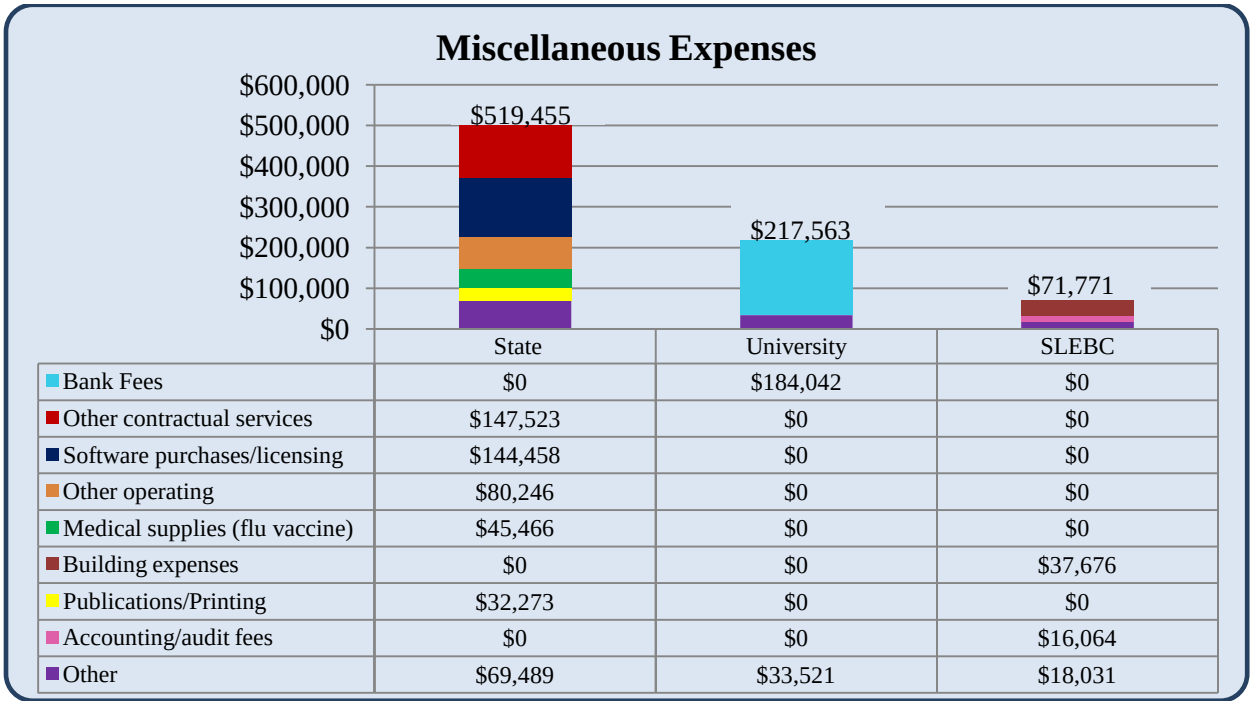
Contract Description	Description of Services
Plan Designs Analysis	Analysis of plans currently offered including detailed assessments of current benefit plan options. Development of recommendations for changes and presentation of those recommendations to any State entities as necessary.
Rate Projection – FY 2009	Projection of rates for new plans and current plans effective July 1, 2009, including analyzing the impact of benefit changes with the new Wellness plan and migration among the plans. Determination of the reserve balance that should be maintained as of June 30, 2009.
Rate Projection - FY 2010	Projection of rates incorporating plan changes effective July 1, 2010 including analyzing the impact of benefit changes and migration among the plans, as well as the determination of the reserve balance that should be maintained as of June 30, 2010.
Wellness Support Services	Support implementation and management of Wellness program including assistance with vendor management, periodic reviews of available reports (such as participation, utilization, administration, as well as functional, clinical, and satisfaction outcomes), and development of recommendations regarding program offerings.
Wellness Plan Communication	Includes three separate elements. 1) Development of an enrollment kit which includes revising and/or updating enrollment guides, enrollment instructions, and Q&A's ($32,070). 2) Development of a four-page pre-enrollment newsletter which announces the upcoming open enrollment, introduces the Wellness plan, and highlights what employees need to do ($16,800). 3) Planning and project management meetings and communication for open enrollment and Wellness program services ($10,000).
Wellness Strategic Planning	Consulting services provided by Aon for the creation, review, and award of the Wellness contract to Health Fitness Corporation.
Wellness Roadmap Brochure	Development of a brochure that serves as a high level roadmap and reinforces the State's challenges, objectives, and next steps in an easy-to-digest and visual way. Includes two versions - one for those who have completed requirements and one for those who have not. Costs include drafting and finalizing brochures, peer review/proofing, process mapping, graphic design, and project management.
Video - Wellness Plan	Creation of informative video on new Wellness program option including shooting footage to cover new plan and to provide confidence in the program.
Video - Open Enrollment	Creation of informative video on upcoming FY 2010 open enrollment including shooting footage to cover program changes.
Color Reproductions and Travel Expenses	Color reproductions for above videos and travel expenses at cost.

The actuarial services that would be comparable to the University's actuary payments include the Rate Projection services. The only exception being that the University did not get an analysis of the impact of benefit changes and migration among plans, and the reserve calculation included only IBNR, not CFR (as discussed in the Fund Balance section below). The State paid $47,000 for this service for plan year 2009 and $53,000 for plan year 2010 (both years' charges were paid in fiscal year 2010); while, the University paid less than $10,000.

Miscellaneous Expenses

The following explains in greater detail the miscellaneous expenses for each entity during fiscal year 2010. The State had the highest dollar amount of miscellaneous expenses. The University's miscellaneous expenses were primarily comprised of bank fees for their separate bank account. SLEBC's miscellaneous expenses were related to the building purchased with health insurance funds.

PERFORMANCE AUDIT SECTION
(Continued)



	State	University	SLEBC
Bank Fees	$0	$184,042	$0
Other contractual services	$147,523	$0	$0
Software purchases/licensing	$144,458	$0	$0
Other operating	$80,246	$0	$0
Medical supplies (flu vaccine)	$45,466	$0	$0
Building expenses	$0	$0	$37,676
Publications/Printing	$32,273	$0	$0
Accounting/audit fees	$0	$0	$16,064
Other	$69,489	$33,521	$18,031

Note 1: Other contractual services for the State included $146,666 paid to ASI Flex for their monthly administrative fee.
Note 2: Software purchasing for the State included $137,000 for a training tool to function with the open enrollment system. (The training tool was purchased in fiscal year 2008; DAS was reimbursing other funds for it in 2010.)
Note 3: Other operating expenses for the State included $79,817 paid to other DAS divisions for services.
Note 4: The APA excluded $274,259 from SLEBC's expenses for other types of insurance such as long-term disability, vision, etc.

Good internal control includes procedures to ensure the cost effectiveness and necessity of non-claim expenses. When non-claim expenses exceed those expenses in other programs, there is a greater risk the program is obtaining services that may not be necessary, which in turn drives up the premiums to cover the additional costs.

We recommend the Legislature require the State to determine whether the administrative services are cost effective and necessary. The following are some suggested procedures to accomplish this goal:

- Document the reasons why other programs receive more competitive administrative service rates from BCBSNE and attempt to negotiate more competitive PEPM fees.
- Perform a cost-benefit analysis of the State's wellness program and establish policies and procedures to monitor and track the program's effectiveness. The program's effectiveness may be measured by whether there is a reduction in health care costs, a reduction in disability and worker's compensation costs, a reduction in sick leave used, a reduction in safety incidents,

and increased productivity. Wellness program tracking would include evaluating employee participation, conducting satisfaction surveys among participants, and tracking the health risk status of participants (i.e., are there fewer employees in high or moderate-risk categories compared to when the program began). The State should evaluate whether the higher cost programs are truly cost beneficial to the State. The State could easily continue the health risk assessments and disease management programs, while eliminating some or all of the higher priced health advising and coaching services.

- Review the services provided by the actuarial consulting firm to determine if all the services are entirely necessary for the State, as it appears the University is administering their self-insured program using fewer actuarial services and paying a fraction of the cost.

An alternate recommendation to counter the State's high administrative expenses would be for the State to solicit and maintain bids for both a self-insured program or a fully-insured program to determine which type of insurance plan would provide the greatest benefits at the lowest cost to its employees.

DAS and the University's Response: The Auditors' comment fails to accurately describe or demonstrate a complete understanding of the State's extensive efforts to develop and implement a comprehensive wellness program for State employees.

- *The APA fails to report that the State used a competitive bidding process to secure the vendor and according to law selected the lowest, most responsible bidder. The APA should refer to the bids received for RFP 2395Z1.*
- *The APA fails to report the State does meet regularly with the State's wellness service provider, HealthFitness, to discuss the program's effectiveness and conducts an annual review of the program's performance with key executives from HealthFitness, including their chief medical officer.*
- *The APA failed to report the State does measure the wellness program's results by evaluating key data.*
- *The APA draws comparisons between the University's wellness program and the State's wellness program without accurately reporting the significant differences and the components of each program.*
- *The APA's reports that all the actuarial consulting expenses may not be necessary but fails to report the full explanation or reason for incurring these costs. During the year reviewed, the State was implementing a comprehensive wellness program and a new Wellness PPO Health Plan. It would hold true that with such major changes, the State's administrative expenses would be higher.*

APA Response: The APA understands the efforts made by the State to implement the wellness program and is simply recommending appropriate documentation be available to support whether the financial benefits of the wellness program exceed the costs associated with it.

Stop Loss Insurance

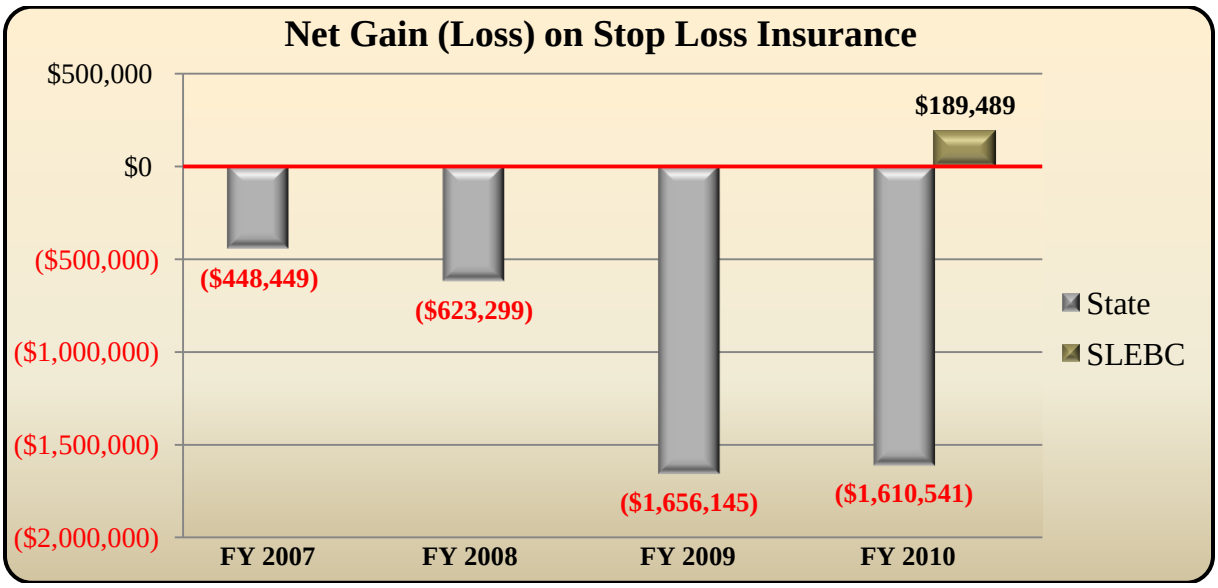
Stop loss insurance is a form of reinsurance for self-insured employers which limits the maximum amount the employer must pay for either each participant's health care costs per plan year or an aggregate total cost per plan year. When claims at the individual or aggregate level exceed the level set in the policy, the stop loss insurance is activated and reimburses the employer for any claims incurred individually or in aggregate after the limit has been reached.

According to the Kaiser Survey, self-insured plans in small firms up to 199 workers are more likely to have stop-loss protection than larger firms because the larger the population covered, the more predictable the amount of claims paid will be. In fact, according to the annual survey, 72% of small firms and 57% of large firms are in plans with stop-loss insurance. (See Exhibit 10.9 of the Kaiser Survey).

Large firms usually also have a higher fund balance to absorb unexpected high-dollar claims. As noted in the Reserves and Fund Balance Section of this report, all three self-insured programs have a high fund balance which could potentially cover those types of claims.

The State and SLEBC both utilized stop loss insurance, while the University did not. Neither the State nor SLEBC had adequate monitoring of its stop loss insurance program. Stop loss insurance can be a factor in the premium costs, as premiums must be increased to cover the insurance costs. Larger programs with a healthy fund balance can generally bear more risk than smaller programs, and may choose to forgo stop loss insurance. The following chart shows the historic net cost of the stop loss insurance for the State, as well as the SLEBC net stop loss gain for 2010:

PERFORMANCE AUDIT SECTION
(Continued)



Note 1: Because the State did not separately record its stop loss reimbursements, these are only the reimbursements the APA could identify and may not be all inclusive. Additionally, for fiscal year 2011, the stop loss expense incurred by the State was $2,310,235. The APA did not have sufficient information to determine the stop loss reimbursements for the year.

Note 2: Historical financial information, including stop loss revenues and expenses, for SLEBC was not available to the APA, so only fiscal year 2010 information was shown for that plan.

As noted above, during fiscal year 2010, SLEBC actually received more in stop loss reimbursements than it paid out in premiums – a net gain of $189,489. SLEBC is a much smaller program than the State or University, so its claims may fluctuate more than the larger programs. SLEBC's stop loss program includes both specific and aggregate limits, as follows:

Specific Deductible	$ 85,000
Monthly Premium Per Covered Member	$ 76.78
Aggregate Deductible	$ 6,636,450
Monthly Premium Per Covered Member	$ 3.58
Total Monthly Premium Per Member	$ 80.36

The State purchased stop loss insurance coverage even though they are a large employer with a significant fund balance. In fact, the nearly $65 million fund balance at June 30, 2011, was enough to cover more than 5 months of claims expenses based on past claims experience. In addition, DAS did not perform an analysis to determine whether stop loss insurance has been cost beneficial to the State. Based on the information available, it does not appear stop loss insurance has been cost beneficial to the State since it was purchased beginning in January 2007.

The State's specific stop loss insurance for fiscal year 2010 covered all employee claims in excess of $500,000. According to the Kaiser Survey, as mentioned previously, the average per employee claims cost at which stop loss insurance pays benefits is $208,280 for all large firms. (See Exhibit 10.10 of the Kaiser Survey).

PERFORMANCE AUDIT SECTION
(Continued)

Each State participant's medical and prescription claims expense is broken down below to show the number of State participants with high claims in fiscal year 2010.

Dollar Level of Claims Per Individual	Number of Individuals
Less than $50,000	29,640
$50,001 - $100,000	322
$100,001 - $150,000	83
$150,001 - $200,000	31
$200,001 - $250,000	21
$250,001 - $300,000	7
$300,001 - $350,000	1
$350,001 - $400,000	1
$400,001 - $450,000	1
$450,001 - $500,000	1
More than $500,000	2

Note: This table represents all claims processed in fiscal year 2010, regardless of when they were incurred. Stop loss insurance contracts set timeframe restrictions on when a claim can be incurred and paid to meet the deductible.

The University made the decision not to purchase stop loss insurance coverage for its program. According to its rate projection for the 2009 plan year, Milliman stated, "Based on the demographics, plan design, and the size of the group, we do not recommend aggregate stop-loss coverage for University of Nebraska."

Good internal control and sound business practices include effective analysis and monitoring to ensure services are cost beneficial and the correct amount of reimbursements are received. Without proper analysis, there is an increased risk the State could be paying for services that provide little benefit. Additionally, without proper monitoring of stop loss reimbursements, there is an increased likelihood the State and SLEBC programs may not be collecting all monies due to them.

We recommend the Legislature require the State to perform a more detailed analysis of the stop loss insurance and determine whether stop loss insurance should continue as part of the State's health insurance program, given the size of the program and its current fund balance. If stop loss insurance for the State is continued, the level at which the insurance begins to pay benefits should be evaluated so that the expense of the insurance does not continue to exceed to benefits obtained.

We also recommend the Legislature encourage both the State and SLEBC to consider the stop loss coverage when determining the appropriate fund balances to maintain and to implement adequate monitoring procedures to ensure the correct amount of reimbursements are received timely from the insurance provider.

DAS and the University's Response: The Auditor fails to report that the State and its advisers annually reviews stop loss insurance coverage. The actuarial analysis that determines premium levels for the State's health plans takes into consideration the impact of stop loss insurance on premiums. Events of prior years have very little or no bearing on what may occur in the future. Stop loss insurance protects the State health plans from unforeseen large claims. Whether or not to purchase stop loss is a business decision and is the sole discretion of DAS.

APA Response: The APA strongly recommends DAS document its review of the costs of stop loss insurance against the benefits provided, in addition to the various levels and limits of stop loss insurance available. This is particularly important in light of our analysis, in which the State has spent in excess of $4 million more than the benefits received under the current agreement and limits.

Program Monitoring and Control

Self-insured programs require significant oversight and monitoring to provide affordable plans to its members. As noted previously, all three self-insured programs have contracted with a third party administrator (TPA) to process and pay insurance claims on their behalf. However, the responsibility of collecting premiums and ensuring all individuals are eligible for coverage remains with the employer. The benefits of a self-insured program, as compared to a fully-insured program, can only be maximized when there are sufficient controls and monitoring procedures.

In each of the financial attestation reports issued by the APA for the self-insured programs, the APA noted a lack of adequate controls and monitoring. As it seems, all three self-insured programs have put too much reliance on outside parties and key plan design decisions have been made without much oversight or input from others. In the case of the University and State, one individual was primarily responsible for all decisions regarding the program.

None of the self-insured programs had sufficient procedures in place to ensure all individuals receiving benefits were eligible to receive those benefits. The APA identified ineligible claims paid within each of the three programs from July 1, 2009, through June 30, 2010, as follows:

Program	Ineligible Medical and Prescription Claims Paid
State	$ 678,882
University	$ 2,913
SLEBC	$ 74,309

Note: The APA was not provided with NSCS claims detail as they are a fully-insured program.

PERFORMANCE AUDIT SECTION
(Continued)

The University agreed to provide the detailed claims data for only 10 individuals identified by the APA.

None of the three programs had procedures to ensure the proper premium was paid for all individuals who incurred claims. The APA found the following issues related to each program:

- *Insurance premiums were paid for an incorrect amount, were not paid at all, or were not submitted timely.*
- *Terminated employees benefits did not cease timely, which allowed ineligible claims to be paid for the terminated employees and their dependents.*
- *Dependents enrolled in the program did not meet the requirements of an eligible dependent resulting in ineligible claims paid.*
- *Significant issues were noted related to the collection of COBRA and retiree premium payments, including a lack of procedures to ensure only those claims were paid in the month that a premium payment was collected.*

The APA performed limited procedures regarding the eligibility of dependents. None of the three programs had procedures in place to ensure dependents enrolled were eligible. Both the University and the State paid outside vendors to audit dependent eligibility.

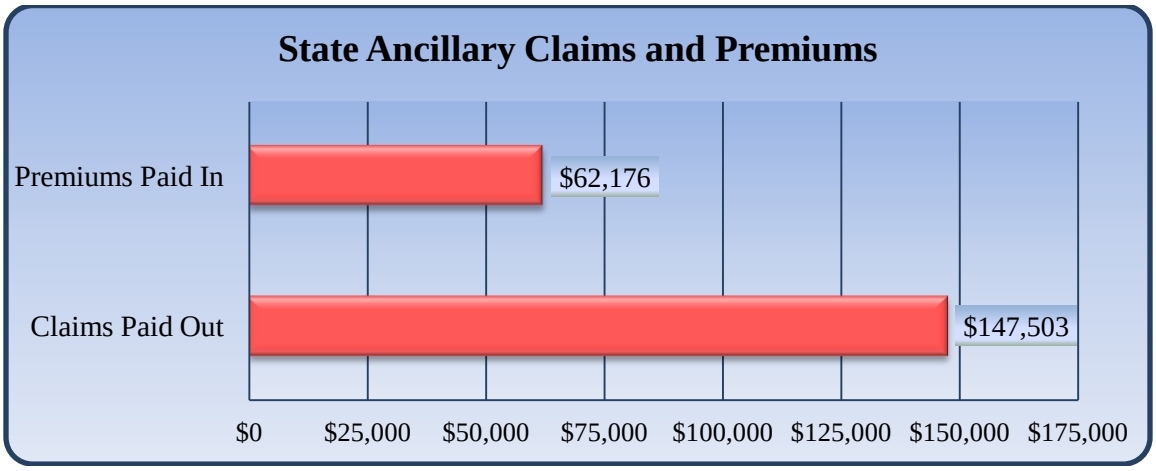
The University removed 421 dependents in March or April 2011 from its program as a result of the outside audit. These 421 dependents incurred $802,432 in claims during the period July 1, 2009, through June 30, 2010. It is likely some of the claims were ineligible during that period.

The State's review included 8,640 participants covering 17,219 dependents. There were 311 unverified dependents from 199 participants. Because the State provided the final report to the APA on March 12, 2012, we were unable to verify the number of claims incurred by these unverified dependents for this audit period.

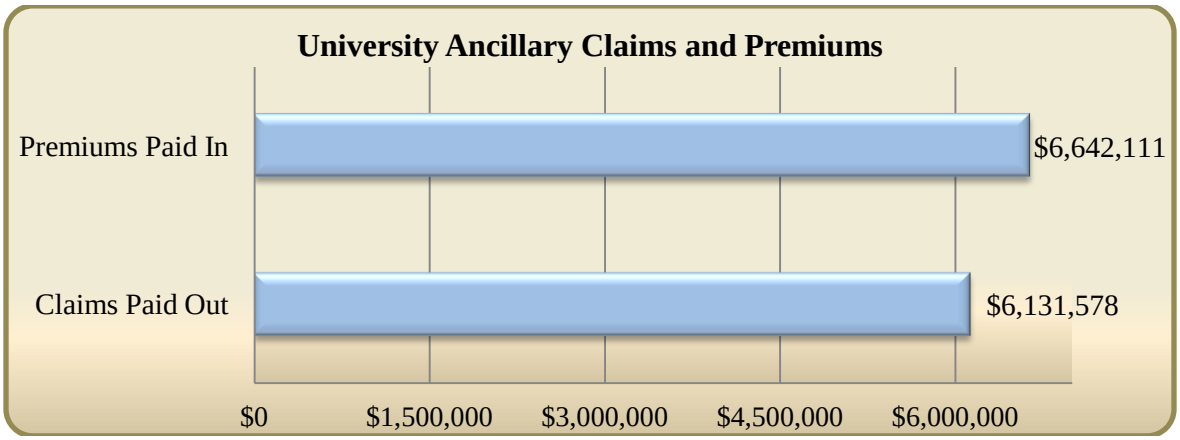
In addition to the issues noted above, the State and University allowed ancillary groups to participate in their programs. The members of these ancillary groups are **not** State or University employees. For the State, this would include certain State Credit Union employees; while the University ancillary groups, include UNMC Physicians, Foundation and Alumni Association employees, and others. The State and University only have statutory authority to allow employees to participate. The ancillary groups pay the full premium; however, if claims paid out on behalf of the ancillary groups exceed the amount of premiums paid in, State or University employees and the Nebraska taxpayers cover the cost of the excess claims.

PERFORMANCE AUDIT SECTION
(Continued)

During fiscal year 2010, the State and its employees were stuck with the burden of covering medical and prescription claims for its ancillary members, as the premiums paid were not sufficient to cover the claims paid for the ancillary members. The State and its employees should not be responsible for covering the costs of these outside groups. The activity of the State's ancillary group during fiscal year 2010 is as follows:



The University provided only a total number of claims paid by its ancillary members, without any detail. While the premiums paid by the ancillary members covered the medical and prescription claims paid for fiscal year 2010, the APA was unable to verify if the amount of claims paid was accurate. The following is the activity of the University's ancillary groups during fiscal year 2010:



The APA also learned that the State has requested its TPAs to provide even less claims information to the State. The prescription TPA, Express Scripts, complied with the request, while the medical TPA, BCBSNE, did not. If the State does not implement proper monitoring and review procedures over the claims it has paid, the Legislature should seriously consider requiring a fully-insured program for the State.

Within a self-insured program, monitoring all expenses is crucial as the members are the ones who ultimately bear the burden of covering any unnecessary inflated costs, such as ineligible claims paid.

> We recommend the Legislature require each State government entity that maintains a self-insured health insurance program to provide adequate oversight and monitoring of their programs. One consideration might be the establishment of an insurance/benefits committee made up of health insurance professionals to assist in the development of the provisions of the State's health insurance program.
>
> We also recommend each entity implement procedures to ensure individuals who incur claims that are paid by these programs have paid the health insurance premium for the month the claim was incurred. The entities should also provide on-going assurance that all dependents are eligible. If these entities do not commit to providing the oversight and monitoring required of these significant funds, the Legislature should examine whether fully-insured insurance programs are more appropriate.
>
> We also recommend DAS and the University comply with State laws which currently allow only permanent State or University employees to be in the program. This would require the removal of all ancillary group participants from the State and University's health insurance programs. We recommend adequate notification be provided to allow other coverage to be obtained without undue burden.

DAS and the University's Response: The respondents disagree with the auditors' overdramatic description of "severe lack of controls" as there are monitoring processes and controls present. It is important to note that the Auditor offers no evidence that remotely approaches a material level of problems. The comment is also misleading where it characterizes, through omission of facts, medical claims as being losses to the plan. There may be immaterial exceptions of the type noted by the Auditor from time to time in plans that have approximately 23,000 employees and 51,000 covered lives for the University and the State. The cost-benefit of adding additional staff to increase controls will be considered.

APA Response: The APA feels there is a lack of adequate controls and monitoring over the health insurance programs. Had the APA not identified errors regarding the payment of ineligible claims, neither the State nor the University had controls to identify or prevent the errors from occurring.

PERFORMANCE AUDIT SECTION
(Continued)

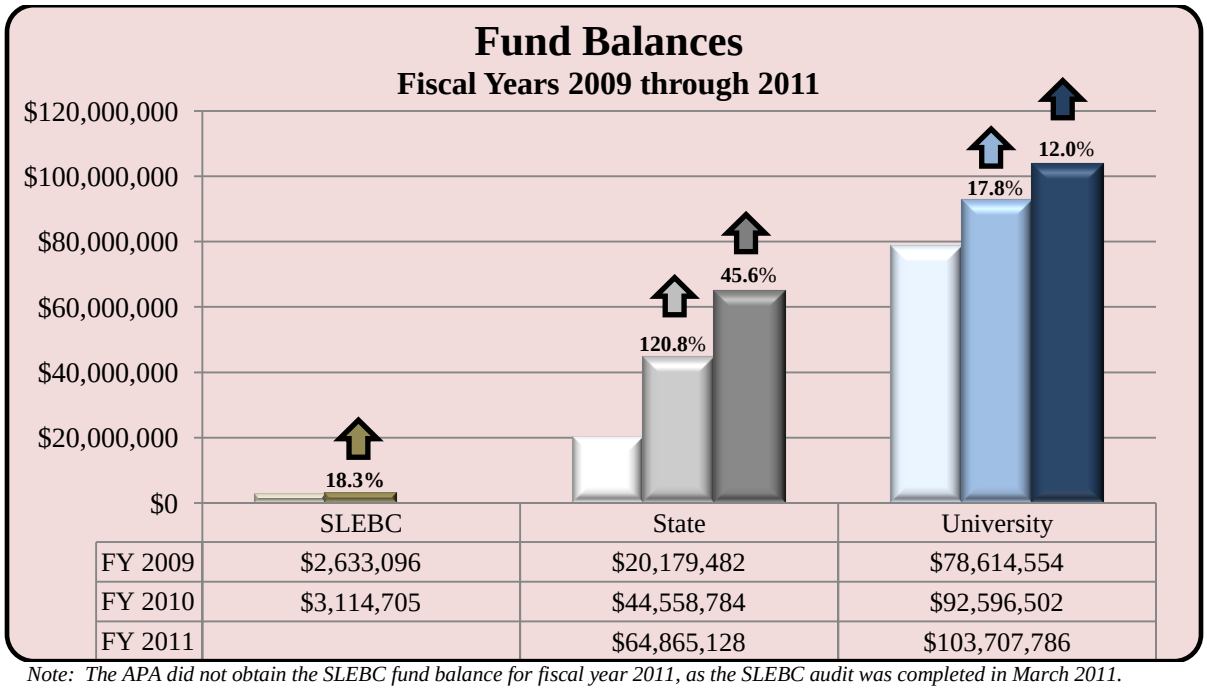
Level of Fund Balances

Each self-insured program has a fiduciary responsibility to maintain adequate reserves and fund balances to ensure all claims incurred will be appropriately paid, while at the same time maintaining affordable premiums for its participants. Reserves are maintained in order to cover future timing issues in the processing of claims, while fund balances would cover unexpected losses experienced periodically when claims exceed the contributions. In many cases, employers use the work of an actuary to determine an appropriate level of reserves and fund balances to maintain.

Reserve levels can be maintained at any level deemed appropriate by the employer's governing body and can include different types of reserves. There were two different reserve types found in the Nebraska programs:

> *Incurred But Not Reported (IBNR)* claims: All liability components incurred but not reported, claims awaiting processing, and claims incurred and processed but not yet paid. This amount is usually calculated by an actuary based on past claims paid.
>
> *Claims Fluctuation Reserve (CFR)*: An additional reserve to reduce the risk of future, potentially catastrophic events that could result in a large loss to program assets.

The program's fund balance is also a factor in the cost of premiums, as the premium should be sufficient to pay claims, administrative fees, fund the reserve, and fund an appropriate fund balance. The following were the fund balances for fiscal years 2009 through 2011, for each of the self-insured Nebraska programs:



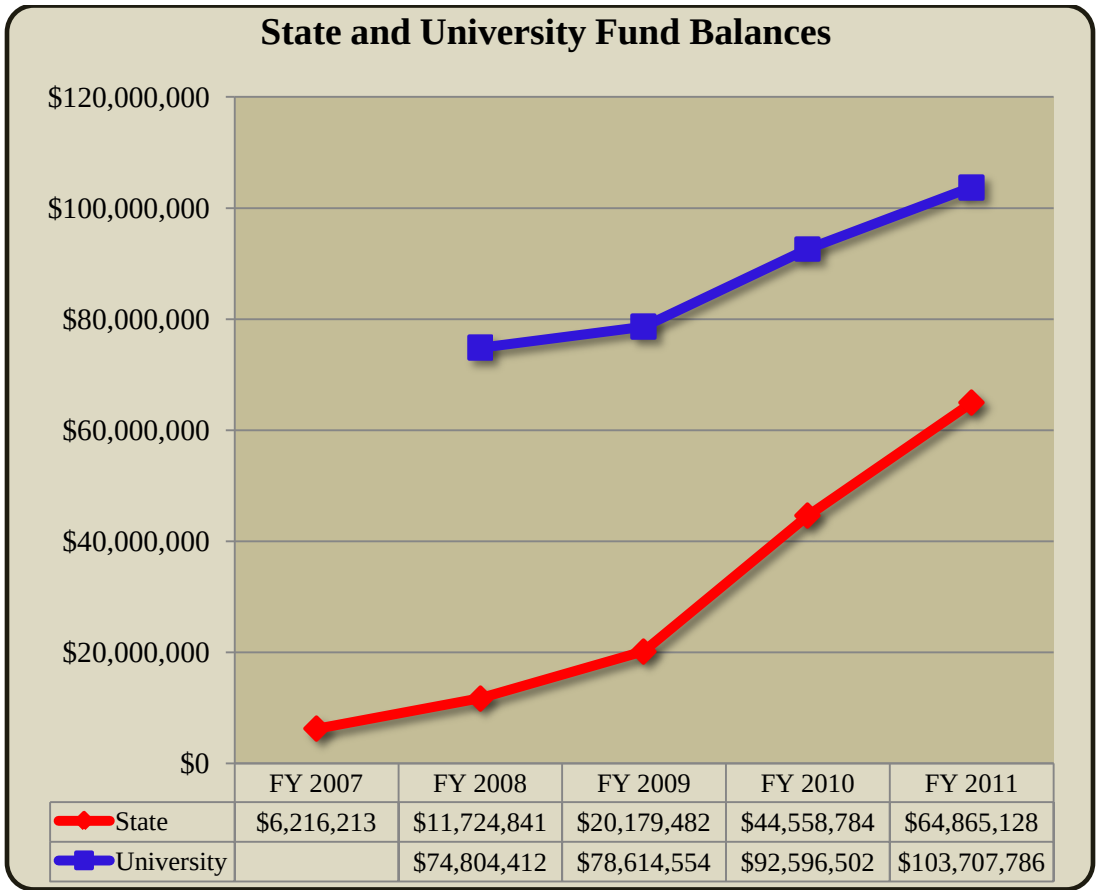
	SLEBC	State	University
FY 2009	$2,633,096	$20,179,482	$78,614,554
FY 2010	$3,114,705	$44,558,784	$92,596,502
FY 2011		$64,865,128	$103,707,786

Note: The APA did not obtain the SLEBC fund balance for fiscal year 2011, as the SLEBC audit was completed in March 2011.

PERFORMANCE AUDIT SECTION
(Continued)

Without adequate policies, increasing fund balances can be one factor explaining higher than average premiums. In the financial audits issued for both the State and the University, the APA found neither entity had policies regarding their health insurance reserves or fund balances and that both had fund balances that increased dramatically. The APA also found that the State and the University both delegate the health insurance program decision-making authority to one individual, either the DAS Director or the University's Vice President for Business and Finance.

A closer look at the State and University's fund balances reveals the substantial rate at which the balances have grown:



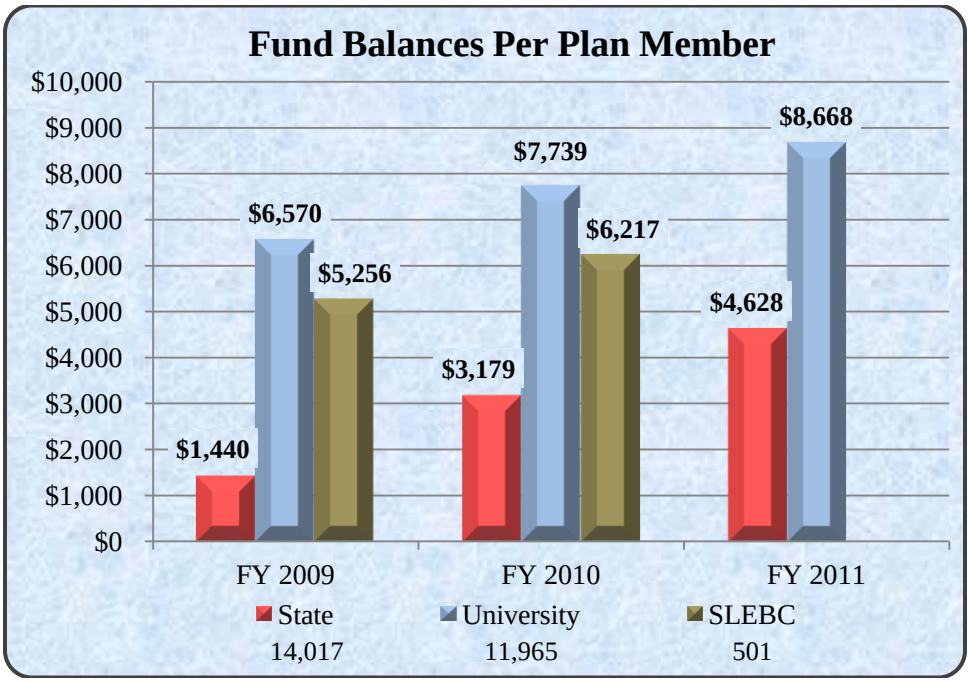
	FY 2007	FY 2008	FY 2009	FY 2010	FY 2011
State	$6,216,213	$11,724,841	$20,179,482	$44,558,784	$64,865,128
University		$74,804,412	$78,614,554	$92,596,502	$103,707,786

Two areas stand out upon review of this graph. First, the State's fund balance from 2009 to 2010 has ***more than doubled***, and continued to increase significantly in the subsequent year.

Second, the University has a fund balance of more than $100 million, which is nearly enough to cover an entire year's worth of University medical, dental, and prescription drug claims based on the history of claims paid over the past few years. This fund balance is held in a separate trust fund outside the control of the Nebraska State Treasurer and the State's accounting system.

PERFORMANCE AUDIT SECTION
(Continued)

The concern with the University's fund balance is further accentuated in the chart below, which shows the fund balances on a per member basis. This chart also includes the fund balances of the SLEBC program, which were not included in the chart above because the APA did not obtain information after SLEBC's financial attestation.



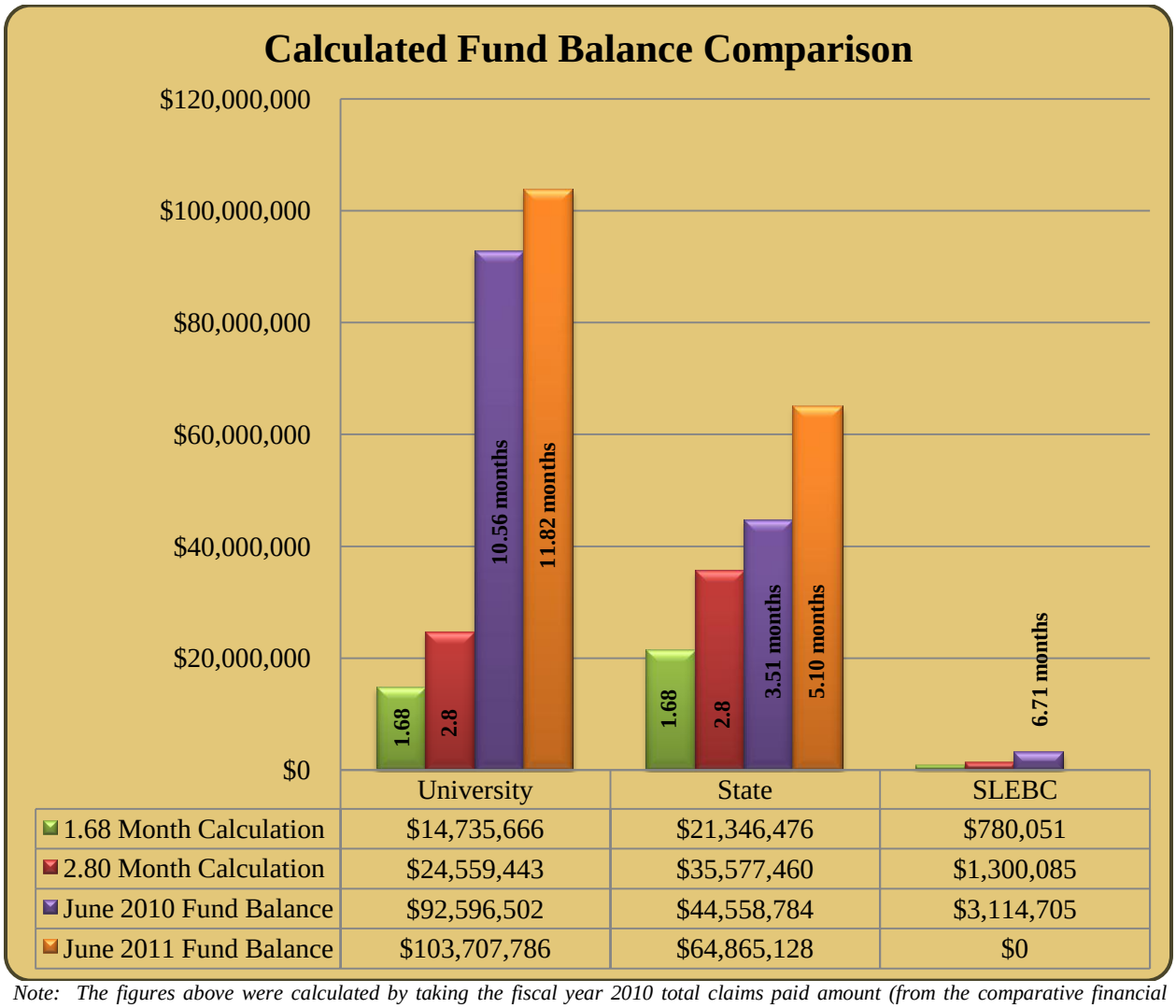
Note: The figures below the entity represent the number of members in each health insurance program at June 2010 (July 2010 for SLEBC.) Members include active employees, retirees, COBRA participants, and non-employees – the number of individuals who made premium payments. This total does ***not*** *include dependents.*

Not only did the University have an extremely high overall fund balance, its fund balance per member was the highest among the three entities. Likewise, SLEBC had a high fund balance per member, based upon its much smaller population of members, even though the overall fund balance initially appears low.

The APA found no industry standard for the appropriate fund balance to maintain for self-insured programs. However, in an actuarial study of the Utah Public Employees' Health Program released in 2011 and conducted by the State of Utah Office of Legislative Auditor General, Milliman, the same actuarial consultant used by the University, recommended a "contingency reserve" balance be maintained to cover between 1.68 and 2.8 months of claims using various confidence levels. The actuary's estimates were based on IBNR, claims fluctuation, trend fluctuation, and other risks. In Utah, the Legislative Auditor General recommended that Utah maintain a 1.68 month reserve policy.

PERFORMANCE AUDIT SECTION
(Continued)

As noted previously, the State and the University did not have a formal reserve or fund balance policy. Using the highest recommended amounts from Utah's study above, the APA determined all three health insurance programs maintain fund balances that appear to be higher than necessary.



	University	State	SLEBC
1.68 Month Calculation	$14,735,666	$21,346,476	$780,051
2.80 Month Calculation	$24,559,443	$35,577,460	$1,300,085
June 2010 Fund Balance	$92,596,502	$44,558,784	$3,114,705
June 2011 Fund Balance	$103,707,786	$64,865,128	$0

Note: The figures above were calculated by taking the fiscal year 2010 total claims paid amount (from the comparative financial schedule in the background section) divided by 12 to get an average amount of claims paid per month. This monthly average was then multiplied by 1.68 and 2.8 to get the 1.68 and 2.8 months, respectively. In order to calculate the representative number of months noted in the graph above, the APA took the fund balances divided by fiscal year 2010 total claims paid multiplied by 12 months.

The University's 2011 fund balance was over four times larger than the estimated amount considered necessary by the Utah study. SLEBC's 2010 fund balance was over two times larger, and the State's fund balance was almost two times as large as the estimated amount considered necessary by the Utah study.

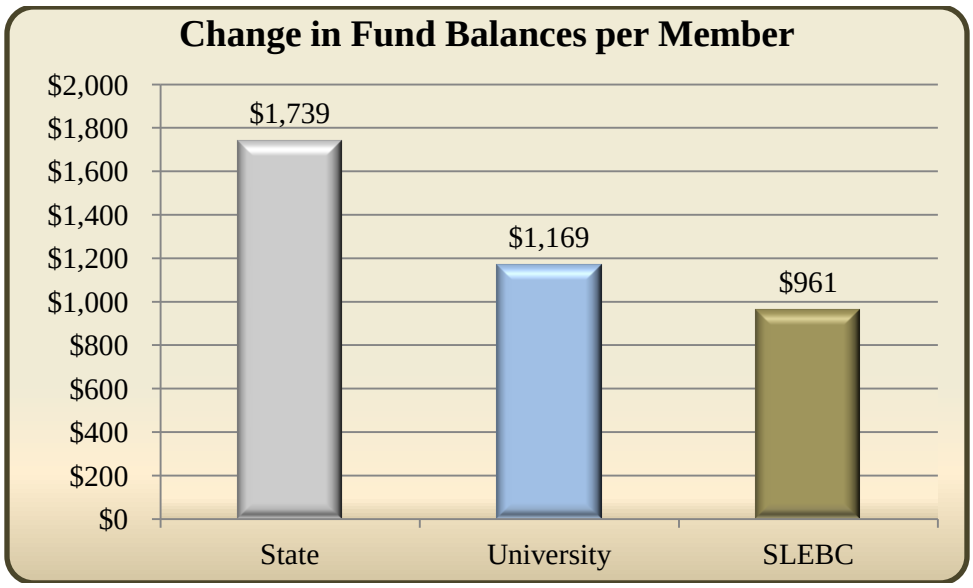
PERFORMANCE AUDIT SECTION
(Continued)

Fund balances increase when premiums collected exceed the claims and administrative expenses paid out of the programs. Since the fund balances have been increasing for the last several years, the premiums collected have exceeded the cost of claims and administrative expenses.

The following table illustrates the dollar amount per member by which the total revenues for each program exceeded the total expenses and transfers (change in fund balances) for fiscal year 2010:

	State	University	SLEBC
Change in Fund Balances	$ 24,379,302	$ 13,981,948	$ 481,609
Total Members	14,017	11,965	501
Calculated Change in Fund Balances per member	$ 1,739	$ 1,169	$ 961

Note: The change in fund balances comes directly from the financial schedule comparison presented in the background section. The total members include the employees, retirees and COBRA participants, and non-employees, but do not include their dependents.



Neb. Rev. Stat. § 84-1611 (Reissue 2008) defines the State contribution toward payment of a health insurance program. Each section of this statute states, "the state shall pay seventy-nine percent of the total cost" of the plan. The remaining 21% is paid by the member employee.

PERFORMANCE AUDIT SECTION
(Continued)

Because over 97% of the fiscal year 2010 revenues were from contributions and State employees are required to pay 21% of a set premium, it appears the State employees paid more in premium contributions than they received in health insurance benefits. Likewise, State agencies paid the other 79% in excess premium contributions for their employees, which are illustrated below:

Change in Fund Balances		**$ 24,379,302**
Employee Share	21%	$ 5,119,653
Employer (State) Share	79%	$ 19,259,649

The University, on the other hand, has discretion on the cost sharing arrangement between the University and its members. In fact, in the last three years, the University has held the employee share of the premium steady, and the University has paid a larger share of the premium amount. In addition to the premiums paid by the University and its employees, the University has also transferred General and Cash Funds into its health insurance trust fund for several years, as follows:

	FY 06	**FY 07**	**FY 08**	**FY 09**	**FY 10**	**FY 11**	**Total**
General Fund Transfers	$2,430,375	$7,476,594	$5,447,857	$3,311,782	$1,655,891	$3,311,782	$ 23,634,281
Cash Fund Transfers	$ -	$ -	$ -	$ -	$1,655,891	$ -	$ 1,655,891
Total Transfers	**$2,430,375**	**$7,476,594**	**$5,447,857**	**$3,311,782**	**$3,311,782**	**$3,311,782**	**$ 25,290,172**

The taxpayers of Nebraska paid for excessive employer contributions for the State, University and SLEBC programs.

Two of the three programs paid an actuary company to help determine reserve amounts, as follows:

- Aon Consulting, Inc. (Aon) is the State's actuary and calculated a $36 million reserve in order to be 95% confident claims would not exceed expectations for fiscal year ended June 30, 2010. This $36 million included both the IBNR and the claims fluctuation reserve.

  Aon reported to the Kansas Health Policy Authority that most other states use a 90% confidence level, which equates to a $33 million reserve for Nebraska at June 30, 2010. As noted previously, the State's June 2010 overall fund balance was $44,558,784, which is $8.5 million more than the highest amount recommended by its actuary.

  Furthermore, the State also pays for stop loss insurance which reduces the risk of claims fluctuation from large claims payments for any one individual – allowing the State to accept higher risk on its fund balance (i.e. a lower fund balance).

- Milliman calculated an IBNR reserve at $5.1 million for medical claims and $248,000 for dental claims for the University for fiscal year 2010. No other reserve information was provided by the University's actuary. With its $92,596,502 fund balance as of June 30, 2010, the University also well-exceeded the amount determined by its actuary.

University staff indicated that the 2010 premium rates calculated by the actuary were reduced in an attempt to reduce this fund balance; however, from June 30, 2010, to June 30, 2011, the overall fund balance increased over $11 million.

- While SLEBC did not hire an actuary to calculate an appropriate reserve balance, SLEBC officials were keenly aware of the overall fund balance and used part of the fund balance to construct a brand new building at a cost well over a million dollars. SLEBC's attorney at the time of the APA's financial attestation work described the use of insurance assets to build/purchase a building as a "non permitted transaction."

Without policies and procedures regarding the appropriate level of reserves and fund balances, these entities could continue to increase the fund balances by setting premium costs higher than necessary to cover the costs of the program. The current practice of increasing fund balances AND increasing premiums simply does not make sense.

We recommend the Legislature implement the following recommendations regarding each of the self-insured entities' reserves and fund balances:

- Require an independent actuary to calculate an appropriate amount of reserves and fund balances for each program to maintain each year.
- Require each entity to implement formal, written policies regarding an appropriate fund balance, with approval of its governing body.
- Require each entity to develop plans in the event fund balances are determined to be higher than necessary, such as lowering premium costs.
- Consider the need for an independent, committee of qualified health insurance professionals to annually review each program's reserves, fund balances, and premium levels.
- Finally, encourage the University to properly handle its more than $100 million fund balance by bringing the account under the control of the State Treasurer, as required.

We also recommend the Legislature consider whether the statutorily mandated premium sharing, in which the State is required to contribute 79 percent of the annual premium, is necessary. Contribution rates set in statute provide no discretion on the rates contributed by the employee and employer.

DAS and the University's Response: The Auditors' comment fails to accurately describe or demonstrate a complete understanding of the careful, deliberative, consultative process involved in setting premiums to keep a competitive, cost-effective benefit in place for employees, faculty, staff and their families. Senior leadership and actuaries are all involved in the process. Additional input is sought from appropriate sources. Another factor complicating the states' execution of its plan is bargaining agreements.

We disagree with the need for a committee to oversee the operations of these plans. As stated in the prior response, we would welcome the opportunity to create regular dialogues with the Legislature that would allow insights into planning for insurance operations.

The observation about the University's handling of its reserve balances is totally in error. The Board of Regents is fully empowered to establish trust accounts. Other parts of the comment misinterpret standard trust administration provisions, ignore program requirements and third party administrator contracts that cover withdrawals, and mistakenly states that the funds are University funds. The University is very comfortable with its position and has the backing of a nearly identical case by the Nebraska Attorney General and the advice of an independent outside counsel assuring that practices and authority around the trust funds are fully compliant with applicable law.

The APA fails to acknowledge or understand previous issues and subsequent efforts by the State regarding the reserve balance. The State has made substantial gains in reestablishing a stable reserve balance to protect the health plans. The APA refers to a study by the Utah Public Employees' Health Program released in 2011, which the performance audit report uses as a measure to judge the state's plan reserve. The APA fails to mention that the Utah study makes several references to funding reserves "at least" at a certain level. This clearly implies there is no set industry standard, the reserve balance identified is a minimum level and an organization may decide to fund a reserve at a higher level to reduce risk. Finally, the APA further fails to recognize the State's efforts in the 2008 legislative session to change the State's contribution percentage from the 79% which received no support. These APA's omissions mislead the reader to the conclusion that DAS has not tried to address this issue, which is incorrect.

APA's Response: First, the State's bargaining units control only one of the four plans offered by the State, with 16% of State employees belong to that plan, which does not have a significant effect on the overall level of fund balances included in this comment.

The APA continues to encourage the Legislature to consider a committee of professionals to help oversee these significant funds.

The University cites a "nearly identical legal opinion" in its response above. The legal opinion referenced is hardly identical – as it refers to funds held by an organization outside of State government (SLEBC) as opposed to funds of the University, which are included in the University's basic financial statements. As such, we do not agree that this outside trust fund held by the University is compliant with State laws.

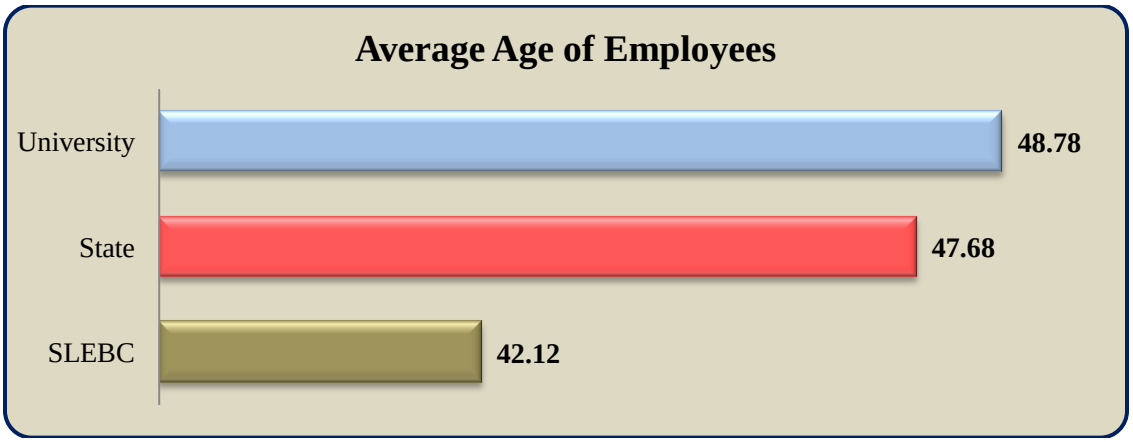
It is clear from the information shown in this comment, appropriate levels of fund balance need to be agreed upon to prevent the fund balances in both the State and University plans from further dramatic increases. This would be a prime example of an issue the independent committee of professionals could help with.

Other Factors Examined

The APA asked BCBSNE for their opinion on the differences in premiums paid by State employees and those paid by University employees. BCBSNE identified the following additional factors not previously examined by the APA in this report, which contributed to premium differences: (1) State employees were older, (2) State employees went to the doctor more often, (3) the State's program covered procedures that other programs did not, such as bariatric surgery, and (4) the effect of Union negotiations on the plan. As such, the APA more closely examined those factors to determine their validity.

Average Age

The APA calculated the average age of employees in the three self-insured programs as of June 2010:

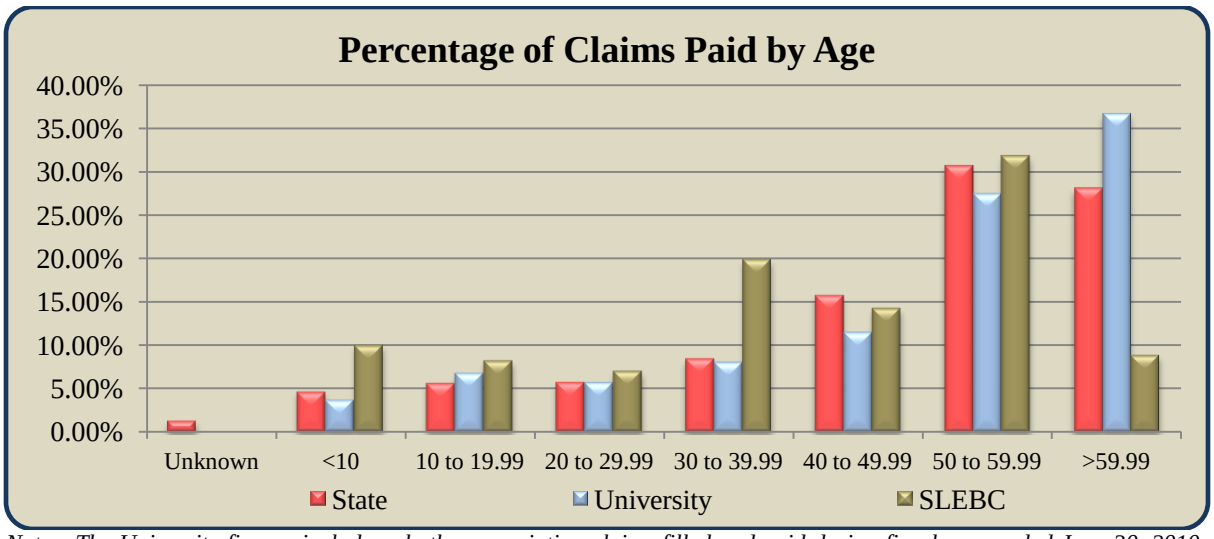


Note: Certain factors could affect the average ages. The University allows retirees over the age of 65 to continue in the University's program, unlike the State program. The University had 825 retirees at June 27, 2010 which made up about 7% of their total member population of 11,965. For SLEBC participants, an earlier retirement age for State Patrol employees appears to be a major contributor to their lower average age.

The assertion that State employees are older is not a valid reason for the premium differences. The data compiled by the APA indicates that University employees, who pay significantly lower premiums than State employees, had a higher average age than State employees.

PERFORMANCE AUDIT SECTION
(Continued)

The APA also compared the percentage of claims paid by age range for fiscal year 2010.



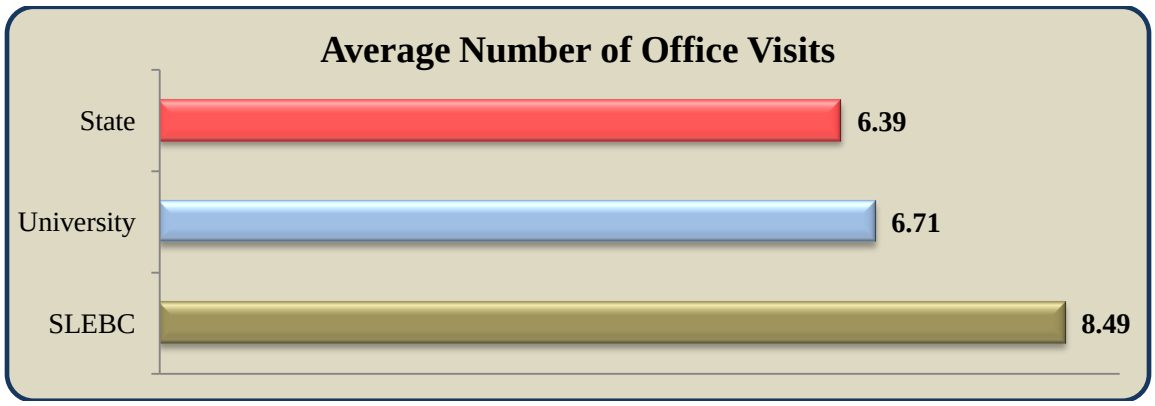
Note: The University figures include only the prescription claims filled and paid during fiscal year ended June 30, 2010. Age-specific summary information on medical claims could not be presented as the University did not provide the participants' date of birth in the BCBSNE claims file. The unknown figures for the State represent records that were redacted by DAS for June 2010 claims, after other detailed records had already been provided to the APA.

For the State and SLEBC, the highest percentage of claims paid ranged from ages 50 to 59.99; however, for the University the highest percentage of claims paid was for individuals over 60 years of age. This is due to the fact that the University allowed retirees over the age of 65 to continue in the program as a supplement to Medicare, while the State required coverage to end once the retiree reached age 65 and was Medicare eligible.

Average Office Visits

The APA reviewed the number of office visits for each programs' participants (using the procedure codes for office visits) during fiscal year 2010:

	University		State		SLEBC	
Office Visit Type	**Office Visits**	**Amount Paid**	**Office Visits**	**Amount Paid**	**Office Visits**	**Amount Paid**
New Patient, 10 min	761	$ 14,235.38	794	$ 21,309.00	59	$ 1,055.31
New, Patient, 20 min	3,742	$ 123,857.12	4,224	$ 267,452.41	260	$ 14,430.89
New Patient, 30 min	3,645	$ 200,765.28	4,010	$ 422,372.98	169	$ 15,764.00
New Patient, 45 min	1,171	$ 115,470.81	1,302	$ 238,869.09	65	$ 8,767.39
New Patient, 60 min	286	$ 34,782.77	205	$ 48,058.60	4	$ 588.65
Est. Patient, 5 min	2,613	$ 33,732.36	2,538	$ 21,194.11	135	$ 3,094.58
Est. Patient, 10 min	9,038	$ 223,878.89	13,600	$ 448,217.49	660	$ 20,801.58
Est. Patient, 15 min	39,085	$ 1,555,687.27	55,767	$ 3,772,898.58	2,373	$ 147,041.57
Est. Patient, 25 min	14,687	$ 944,154.48	18,750	$ 2,128,662.38	587	$ 58,139.28
Est. Patient, 40 min	1,468	$ 127,221.73	1,474	$ 239,399.39	25	$ 3,395.31
Total July 2009 to June 2010	**76,496**	**$ 3,373,786.09**	**102,664**	**$ 7,608,434.03**	**4,337**	**$ 273,078.56**
Total of Household	**11,399**		**16,058**		**511**	
Average Number of Office Visits	**6.71**		**6.39**		**8.49**	



Note: The average number of office visits was based on a member and their dependents, so these figures indicate the average number of times a covered household had an office visit.

State employees had fewer office visits on average than both SLEBC and University households. The number of doctor visits for State employees was not a contributing factor for the State's higher premium costs.

Bariatric Procedures

The State's health insurance program covered surgical treatment of clinically severe obesity when certain criteria were met. According to the State of Nebraska BCBSNE summary plan description, "Morbid Obesity Surgery includes, but is not limited to stomach surgery (gastroplasty), stomach stapling (gastric stapling), stomach bypass (gastric bypass) or surgery for the removal of fat from the belly (panniculectomy and abdominopasty)." Those bariatric procedures were not covered under the SLEBC and University health programs and have been attributed to the higher cost of the State's health program.

The APA examined the cost of bariatric procedures to determine if they were a major contributor to program costs. As expected, the University and SLEBC had no bariatric claims processed as their programs did not cover those procedures. The State had claims processed under several Bariatric CPT codes as follows:

CPT Description	Net Paid Amount
*Gastric Bypass for Morbid Obesity	$ 12,084
*Gastric Restrictive Procedure – Band	$ 34,147
*Biliopancreatic Diversion with Duodenal Switch	$ 9,750
Revision of an Adjustable Gastric Restrictive Device	$ 4,691
Removal of an Adjustable Gastric Restrictive Device	$ 2,847
Revision of Subcutaneous Port Component used in Gastric Restrictive Procedure	$ 440
Removal of Subcutaneous Port Component used in Gastric Restrictive Procedure	$ 534
Total	**$ 64,493**

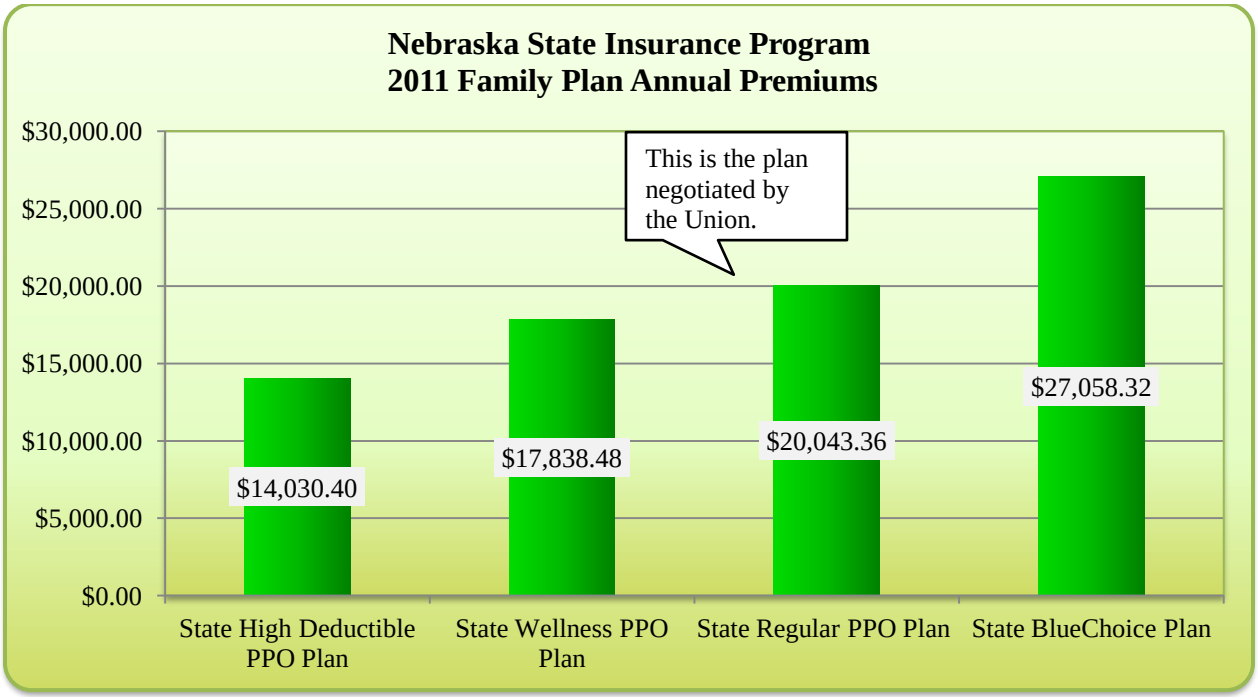
***These procedures are also considered reasonable and necessary under certain conditions for the treatment of morbid obesity under the Medicare program.*

PERFORMANCE AUDIT SECTION
(Continued)

The total amount paid by the State for bariatric-related procedures in fiscal year 2010 was $64,493. The allowance of such procedures did not appear to be a significant contributor to the premium costs paid by State employees.

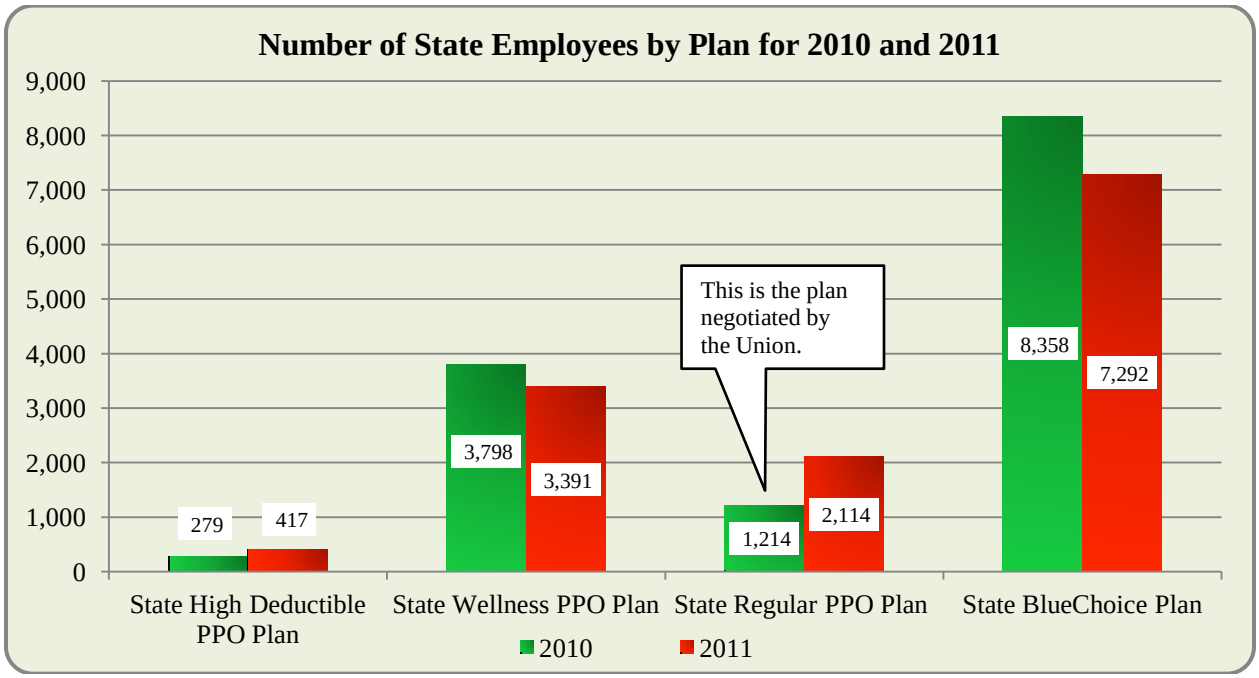
Union Plan

One of the plan options used in the Nebraska State Insurance Program is the Regular PPO Plan, which is the plan that is used in labor negotiations between the State and the Nebraska Association of Public Employees Local 61 of the American Federation of State, County and Municipal Employees (NAPE/AFSCME). The plan designs are determined through this negotiation process. Any State employee can join this plan, not just employees who belong to this labor union. The following chart illustrates the annual premiums for the family plan for 2011:



PERFORMANCE AUDIT SECTION
(Continued)

The following chart represents the number of State employees in each of the four plans for 2010 and 2011:



As the chart illustrates, employees left both the BlueChoice and Wellness Plans and moved to either the Regular PPO or the High Deductible PPO Plan.

The additional factors identified by BCBSNE as contributors to the State's higher premiums were unsubstantiated. It does not appear DAS or BCBSNE had an adequate explanation for the high State premiums. When the State does not understand what is driving up the health care costs, they are unable to identify opportunities for improvement and develop effective solutions to lower costs and premiums. Good internal control and sound business practice includes policies and procedures be in place to ensure there is a thorough understanding of health care cost drivers in a self-insured health insurance program.

> We recommend the State gain and understanding of the contributing factors for higher premiums. These factors should be reviewed annually.

DAS and the University's Response: The State is fully aware of the cost drivers associated with the State's program and does review them annually. For the APA to ask the State to compare our cost drivers to those of the University can only amount to a guess as the State is not involved in the specifics of the University's health insurance program. To take an answer to that question and infer that State is not aware of its cost drivers is misleading and false.

APA Response: The APA feels that it may be beneficial for the State to understand and review the University's program, as they are able to offer health insurance at lower costs to its employees.

Overall Conclusion

Both the NSCS's fully-insured health insurance program and the University's self-insured health insurance program offer comparable benefits with lower premiums than the State's self-insured program. We recommend the Legislature analyze this information to determine whether the State continue to maintain the self-insured health insurance program or switch to a fully-insured health insurance program.

From the information presented in this performance audit report as well as the APA's financial attestation reports issued for each entity, there is a lack of monitoring and oversight over the self-insured health insurance programs to ensure the lowest premiums are offered, the correct amount of benefits are paid, and appropriate reserves and fund balances are maintained. If these entities do not commit to providing the oversight and monitoring required of these significant funds, the Legislature should examine whether fully-insured health insurance programs would be more appropriate and cost effective.

If the State continues to maintain a self-insured health insurance program it should consider the establishment of an insurance/benefits committee made up of health insurance professionals and appropriate staffing to assist in the decision making, monitoring, and oversight of the State's health insurance program.

* * * * *

This report is intended solely for the information and use of the Nebraska Legislature, other management within the State of Nebraska, and the appropriate Federal and regulatory agencies. However, this report is a matter of public record and its distribution is not limited.

SIGNED ORIGINAL ON FILE

May 14, 2012

Mike Foley
Auditor of Public Accounts

EXIT CONFERENCE

An exit conference was held March 19, 2012, to discuss the results of our performance audit. Those in attendance were:

NAME	TITLE
Martha Carter	Legislative Auditor
Stephanie Meese	Legal Counsel; Legislative Audit Office
Carlos Castillo	DAS Director
Dacia Kruse	DAS Deputy Director
Roger Wilson	DAS Central Services Financial Administrator
David Lechner	Vice President for Business and Finance; University
Mike Justus	Assistant Vice President and Director of Internal Audit and Advisory Services; University
Keith Dietze	Director of University-wide Benefits
Carolyn Murphy	Vice Chancellor for Finance and Administration; NSCS
Becky Kohrs	Accountant; NSCS
David Sankey	Superintendent; Nebraska State Patrol
Maria Manning	SLEBC Office Manager
Gary Young	SLEBC Council

LEGISLATIVE PERFORMANCE AUDIT COMMITTEE RESPONSE

April 5, 2012

Mr. Mike Foley
Auditor of Public Accounts
State Capitol, Room 2303
Lincoln, NE 68509

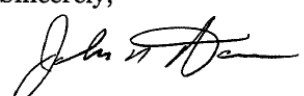
Dear Mike:

On behalf of the Legislative Performance Audit Committee I would like to thank you for your performance audit report on the cost of state employees' health insurance. We will work this interim with the appropriate subject matter committees to address the issues raised in the report. We are especially concerned that:

- The State and University have high fund balances, in excess of reasonable standards for such balances, which may contribute to higher than necessary premium costs;
  - In addition, the State purchases stop-loss insurance coverage, which has consistently cost more than it has saved and appears unnecessary given the State's substantial fund balance;
  - The University added general funds to its health insurance fund, which appears to have been unnecessary given the large balance in that fund;
- The State and the University have allowed non-employees to participate in their health insurance plans in conflict with statute;
- The State and the University have single individuals responsible for key insurance plan decisions; and
- The University holds its health insurance funds in an account outside of the state accounting system.

In addition, we are concerned with the amount of time it reportedly took the audited entities to complete some of your information requests. For example, the report indicates that in several cases it took a month and a half, or more, for the audited entities to provide complete copies of the insurance contracts, which are public documents. We believe those documents would be available to a member of the public within four days if requested under Nebraska's public records statutes.

Sincerely,



John Harms

COST OF HEALTH INSURANCE
FOR STATE OF NEBRASKA EMPLOYEES
PERFORMANCE AUDIT TIMELINE

EXHIBIT A

Date	Description
12/2/2009	Initial complaint received. Auditor Foley met with two concerned citizens regarding the State's health insurance costs. They presented the Auditor with a packet of information including the 2009 NCSL data indicating Nebraska had the highest family premiums nationwide. The citizens indicated they had provided the Governor's Policy Research Office with a copy of the information packet as well.
12/15/2009	The APA met with the DAS Director, DAS Financial Administrator, and a representative of the Governor's Policy Research Office to discuss the health insurance cost information. The DAS Financial Administrator indicated the information was misleading and they would draft a letter to the citizens explaining the misinformation.
2/10/2010	The APA followed up with the DAS Financial Administrator to see if a letter had been sent to the citizens. No letter had been sent.
3/31/2010	Auditor Foley received an additional complaint via email from a concerned citizen regarding health insurance costs throughout Nebraska.
4/1/2010	Auditor Foley sent a letter to the Legislative Performance Audit Committee requesting authorization to conduct a performance audit of the cost of health insurance coverage for State employees. See **Attachment B**.
4/13/2010	The APA received a letter from the Legislative Performance Audit Committee indicating the Committee had granted approval for the APA to conduct the performance audit on April 9, 2010. See **Attachment C**.
4/27/2010	The APA sent a letter to the DAS Director informing him of the upcoming performance audit relating to the cost of health insurance for State employees.
5/4/2010	The original entrance conference was held with staff from DAS.
5/14/2010	The APA notified the University of the performance audit in an email to the Senior Associate to the President.
6/2/2010	The APA first requested State claims data for July 2009 through May 2010 from BCBSNE.
6/3/2010 & 6/4/2010	In conjunction with other emails sent to political subdivisions, the APA emailed representatives from the University, SLEBC, and NSCS requesting specific information on each entity's health insurance program, including copies of contracts.
6/7/2010	The APA began working on a Non-Disclosure agreement with BCBSNE.
6/14/2010	After almost two weeks, the APA had yet to receive a response from the University; therefore, a follow-up email was sent to the Director of Benefits.
6/15/2010	The University Director of Benefits finally responded; however, several of the responses simply indicated that information would be provided shortly.
6/17/2010	After receiving no response to the June 4, 2010 email, the APA again email the health insurance administrator for SLEBC.
6/17/2010	The APA also followed up with the EHA representative for NSCS. He subsequently responded that a response would be provided in a day or so.
6/23/2010	The APA first requested University and NSCS claims data for July 2009 through June 2010 from BCBSNE. Also expanded request for State claims data through June 2010 instead of May 2010 to cover full fiscal year.
6/24/2010	EHA representative responded that they were attempting to send the information but it was not working so he would bring it in.
6/25/2010	Received information for NSCS from EHA representative.
6/30/2010	Original Confidentiality Agreement was signed between Express Scripts (State's Pharmacy Benefit Manager) and the APA.
6/30/2010	Having received no further correspondence from the University, the APA sent another follow-up email to the Director of Benefits.
7/1/2010	The APA received an email from the DAS Financial Administrator indicating that the APA should pay the cost of producing documents for the performance audit.
7/1/2010	The APA sent another email to the University Director of Benefits, requesting a meeting to discuss processes over the administration of the program.
7/1/2010	After receiving no response to either the June 4, 2010 or the June 17, 2010 emails, the APA emailed the health insurance administrator for SLEBC once more.
7/6/2010	The University Director of Benefits responded that the APA should check with audit staff who had worked on the University's previous financial audit for copies of the contracts.
7/8/2010	The APA emailed the University Director of Benefits, explaining that the APA did not have copies of the contracts and was still in need of them.
7/12/2010	The Senior Associate to the President called the APA to apologize for the University's failure to provide the requested contracts.

COST OF HEALTH INSURANCE
FOR STATE OF NEBRASKA EMPLOYEES
PERFORMANCE AUDIT TIMELINE

EXHIBIT A

Date	Description
7/12/2010	After receiving no response to the June 4, 2010, June 17, 2010, or July 1, 2010 emails, the APA emailed various alternate representatives from SLEBC. The APA did receive a phone call the same day from one representative indicating he would look into the lack of response.
7/13/2010	Copies of University contracts were delivered to the APA, but the documents did not include the fee schedule for the BCBSNE agreement. The Caremark contract was also heavily redacted so financial terms could not be determined. APA immediately emailed the University Director of Benefits and requested the missing or redacted information. The University responded, but did not provide the requested information. The APA requested a meeting to obtain the contracts and discuss the University's procedures regarding health insurance.
7/13/2010	Original BCBSNE Confidentiality and Non-Disclosure Agreement signed by the APA.
7/13/2010	The SLEBC President indicated a response would be provided shortly.
7/14/2010	A lawyer for SLEBC contacted the APA indicating he was working with the health insurance administrator originally contacted by the APA to get a response.
7/16/2010	The SLEBC President indicated the APA should work with an alternate representative to get a response.
7/18/2010	The BCBSNE fee schedule was received from the University's Legal Counsel.
7/20/2010	A portion of the audit data was received from Express Scripts (prescription) for DAS.
7/21/2010	The APA met with the University, but the Caremark contract was not provided.
7/22/2010	The APA emailed the University's Legal Counsel, indicating that the Caremark contract had still not been received. The APA also called Caremark in an attempt to obtain the complete contract.
7/23/2010	The University provided the non-redacted Caremark contract.
7/26/2010	The APA followed up on a telephone call (via email) with the health insurance administrator for SLEBC, asking for a date in which the information would be received.
7/27/2010	The APA received the requested information from SLEBC.
7/28/2010	The APA formally requested SLEBC claims data from Meritain.
8/12/2010	Auditor Foley sent a letter to the Attorney General requesting an opinion on whether or not the APA could be held responsible for the cost of producing documents for a performance audit.
8/16/2010	DAS Director sent a letter to the Legislative Performance Audit Committee citing numerous issues he had with the authorization of the APA to conduct the performance audit and requesting clarification of those issues. The primary issue raised was the Administrator's belief that the data needed to conduct the audit violated the Health Insurance Portability and Accountability Act (HIPAA). See **Attachment D**.
8/23/2010	The APA received the audit data from SLEBC.
9/7/2010	The APA received an email from a representative of the Office of Inspector General (OIG) for the United States Department of Health and Human Services (USDHHS) citing a section of HIPAA which allows access to protected health information for audits and program evaluation.
9/13/2010	Additional Confidentiality Statement signed by the APA and DAS.
9/20/2010	Auditor Foley sent a letter to the Attorney General requesting an opinion on whether or not the APA can have access to financial records containing protected health information under HIPAA.
11/4/2010	Auditor Foley sent a letter to the Legislative Performance Audit Committee to update them on the status of the audit. The letter indicated the APA would be conducting separate financial attestations of the health insurance plans as well as one overall performance audit. In the letter, the Auditor also requested assistance from the Committee in obtaining legal clarification of the HIPAA and audit cost issues raised. The objective, scope, and plan of the performance audit were provided to the Committee at this time as well.
11/10/2010	Auditor Foley sent a letter to the Attorney General inviting him to a telephone conference with representatives from the USDHHS OIG to discuss the applicability of HIPAA to the APA.
11/15/2010	The APA received a letter from the Legislative Performance Audit Committee approving the performance audit objective, scope, and plan and also informed the APA that they had sent a letter to the Attorney General requesting an expedited response to the question of who should pay the audit costs. The Committee also indicated that they intended to introduce a bill in the next Legislative session to clarify that neither the APA nor the Committee should be required to pay for access to audit data.
11/18/2010	Telephone conference was held with representatives from the USDHHS OIG including the Kansas City Regional Inspector General at which time the applicability HIPAA audit exceptions to the APA was confirmed. A representative from the Attorney General's office was in attendance.
11/23/2010	Due to the numerous delays in getting the necessary audit data, the APA held a second entrance conference with DAS, the University, and NSCS requesting data be provided no later than December 17, 2010. SLEBC did not send a representative to this meeting.

COST OF HEALTH INSURANCE
FOR STATE OF NEBRASKA EMPLOYEES
PERFORMANCE AUDIT TIMELINE

EXHIBIT A

Date	Description
12/3/2010	Top officials from DAS, the University, NSCS, and the State Patrol all sent a letter to the Legislative Performance Audit Committee again raising concerns about HIPAA, questioning the APA's planned audit methodology, and requesting that the Committee postpone the performance audit until the APA finished each of the financial attestations. See **Attachment E**.
12/17/2010	No claims data was received from any of the entities.
12/23/2010	Legislative Performance Audit Committee responded to the December 3, 2010 letter indicating the Committee did not believe the APA's approach was in violation of HIPAA, that the audit methodology was to be left up to the auditor's professional judgment, and a postponement of the performance would not be granted.
12/30/2010	The APA sent an email to all parties involved noting that the deadline requested to receive the audit data had passed, nothing had been received, and no response had been provided indicating when it would be received.
1/3/2011	The APA received a letter from the Attorney General indicating he declined to provide an opinion on either of the questions posed.
1/11/2011	In response to the December 30, 2010 email, the APA received a letter from DAS, the University, and NSCS again noting concerns with personal health information and additional issues considered unresolved. The letter did not indicate how the APA could resolve their issues or when the audit data could be provided. Se**e Attachment F**.
2/14/2011	The APA met with the Governor and agreed to receive a more limited set of audit data. At this meeting, DAS Administrators agreed to provide the data by March 11, 2011.
3/1/2011	DAS and BCBSNE contacted the APA and requested that the APA sign more restrictive confidentiality non-disclosure agreements.
3/7/2011 & 3/10/2011	The APA sent emails to DAS to verify that the data was still going to be provided by March 11, 2011 as previously discussed.
3/10/2011	The DAS Financial Administrator emailed the APA and noted that DAS was waiting for final direction from the Governor before they could provide the audit data. See **Attachment G**.
3/11/2011	Revised Confidentiality Non-Disclosure Agreement signed between BCBSNE and the APA.
3/24/2011	Auditor Foley received a letter from the Governor indicating he was pleased the APA had agreed to receive more limited audit data and that DAS was planning on providing the data.
3/28/2011	Additional Confidentiality Agreement signed between the APA and University.
3/28/2011	A portion of the audit data was received from BCBSNE (medical) for DAS.
4/8/2011	Audit data received from the University.
4/15/2011	Additional audit data was received from BCBSNE (medical) for DAS.
4/19/2011	Revised audit data received from the University.
5/18/2011	Additional Confidentiality Statement signed by the APA, University, and Caremark.
5/19/2011	As detailed claims data was not available for NSCS, because it is a fully-insured program, the APA requested claims summary information for NSCS from EHA.
6/28/2011	Summary audit data received from EHA for NSCS.

COST OF HEALTH INSURANCE **EXHIBIT B**
FOR STATE OF NEBRASKA EMPLOYEES
ANNUAL COST COMPARISON BETWEEN NEBRASKA GOVERNMENT ENTITIES

2010 State Annual Premiums	BlueChoice*			Wellness PPO			Regular PPO			High Deductible PPO		
	Population = 8,358			Population = 3,798			Population = 1,214			Population = 279		
	EE Share	ER Share	Total	EE Share	ER Share	Total	EE Share	ER Share	Total	EE Share	ER Share	Total
Employee	$1,460	$5,490	$6,950	$1,126	$4,236	$5,362	$1,185	$4,459	$5,644	$1,016	$3,824	$4,840
Employee + spouse	$3,874	$14,573	$18,447	$2,988	$11,243	$14,231	$3,146	$11,834	$14,980	$2,698	$10,147	$12,845
Employee + children	$2,998	$11,278	$14,276	$2,313	$8,700	$11,013	$2,435	$9,158	$11,593	$2,088	$7,853	$9,941
Family	$5,181	$19,492	$24,673	$3,997	$15,036	$19,033	$4,207	$15,828	$20,035	$3,608	$13,572	$17,180

2010 University Annual Premiums	Basic Option*			High Option			Low Option		
	Population = 7,598			Population = 1,497			Population = 1,207		
	EE Share	ER Share	Total	EE Share	ER Share	Total	EE Share	ER Share	Total
Employee	$1,608	$3,408	$5,016	$2,400	$3,408	$5,808	$960	$3,408	$4,368
Employee + spouse	$2,568	$8,124	$10,692	$4,272	$8,124	$12,396	$1,224	$8,124	$9,348
Employee + children	$2,160	$6,144	$8,304	$4,032	$6,144	$10,176	$1,104	$6,144	$7,248
Family	$3,264	$11,580	$14,844	$5,616	$11,580	$17,196	$1,392	$11,580	$12,972

2010 NSCS Annual Premiums	Low Option*		
	Population = 706		
	EE Share	ER Share	Total
Employee	$863	$4,892	$5,755
Employee + spouse	$3,021	$9,064	$12,085
Employee + children	$2,662	$7,985	$10,647
Family	$3,971	$11,913	$15,884

2010 SLEBC Annual Premiums	Low Option*		
	Population = 466		
	EE Share	ER Share	Total
Employee	$945	$3,555	$4,500
Employee + spouse	$2,331	$8,769	$11,100
Employee + children	$2,331	$8,769	$11,100
Family	$3,304	$12,428	$15,732

*This was the most used plan for entity. Populations include employees only and do not account for retiree, COBRA, or other non-employee members.

COST OF HEALTH INSURANCE
FOR STATE OF NEBRASKA EMPLOYEES
PLAN DESIGN COMPARISON BETWEEN STATES

EXHIBIT C

		Nebraska	Iowa	Kansas	South Dakota	Wyoming	North Dakota	Montana
Medical Plan Type		Self-Insured	Fully-Insured	Self-Insured	Self-Insured	Self-Insured	Fully-Insured	Self-Insured
Plan Year Ending 2010		Jul 1 - Jun 30	Jan 1 - Dec 31	Jan 1 - Dec 31	Jul 1 - Jun 30	Jan 1 - Dec 31	Jul 1 - Jun 30	Jan 1 - Dec 31
Medical Provider		BCBS of Nebraska	Wellmark BCBS	BCBS of Kansas	DAKOTACARE Health	CIGNA Healthcare/ Great-West	BCBS of North Dakota	BCBS of Montana
Most Used Medical Plan (In-Network for PPO's)		BlueChoice	BlueAccess HMO	Plan A - PPO	$300 Deductible PPO	Option 1 - $350 Deductible PPO	PPO Plan	BlueChoice
Plan/Lifetime Maximum	Individual	Unlimited	Unlimited	Unlimited	$2 million	$2 million	$2 million	$2 million
Annual Deductible	Individual	$200	None	$150	$300	$350	$400	$425
	Family	$400	None	$300	$750	$700	$1,200	$850
Out-of-Pocket Maximum	Individual	$1,500	$750	$1,200	$2,500	$2,000	$1,150	$2,000
	Family	$3,000	$1,500	$2,400	n/a	$4,000	$2,700	$4,500
Copay/ Coinsurance **(1)**	Office Visit	$20 Copay	$10 Copay	$20 Copay	$30 Copay after deductible	Plan pays 85%	$25 Copay	$15 Copay
	Annual exam **(3)**	$20 Copay or Plan pays 80% for most screenings	$10 Copay	Plan pays 100%	Plan pays 100% for most screenings	Plan pays 100% ($500 max)	$25 Copay ($200 max)	$15 Copay or Plan pays 75% for most screenings
	Hospital ER	$50 Copay (waived if admitted)	$50 Copay (waived if admitted)	$100 Copay (waived if admitted) Plan pays 80%	$200 Copay after deductible (waived if admitted)	Plan pays 85%	$50 Copay (waived if admitted) Plan pays 80%	$150 Copay (waived if admitted) Plan pays 75%
	Inpatient hospital	Plan pays 80%	Plan pays 100%	Plan pays 80%	$550 Copay after deductible	Plan pays 85%	Plan pays 80%	Plan pays 75%
	Outpatient surgical center	$50 Copay	Plan pays 100% (with preauth)	Plan pays 80%	$450 Copay after deductible Plan pays 75%	Plan pays 85%	Plan pays 80%	Plan pays 75%
	Inpatient mental health	Plan pays 80% (30 day max)	Plan pays 100%	Plan pays 80%	$550 Copay after deductible (with preauth)	Plan pays 85%	Plan pays 80% (45 day max)	Plan pays 75%
	Outpatient mental health	$20 Copay (60 visit max)	$10 Copay	Plan pays 80%	$30 Individual or $20 Group Copay after deductible (30 visit max)	Plan pays 85%	Plan pays 100% for first 5 hrs and 80% for next 25 hrs (30 hr max)	$15 Copay
Prescription Provider		Express Scripts	Wellmark BCBS	CVS Caremark	Express Scripts	CIGNA Healthcare/ Great-West	BCBS of North Dakota	MedImpact
Copay/ Coinsurance **(2)** for Retail 30 Day Supply (North Dakota is for 1-34 Day Supply)	Generic	$10 Copay	$5 Copay	Plan pays 80%	$9 Copay after deductible	$10 Copay	$5 Copay Plan pays 85%	$0 Copay (Class A)
	Preferred	$25 Copay	$15 Copay	Plan pays 65%	$25 Copay after deductible	$20 Copay	$20 Copay Plan pays 75%	$15 Copay (Class B)
	Non-Preferred	$40 Copay	Greater of: $30 Copay or 25%	Plan pays 40%	$40 Copay after deductible	$50 Copay	$25 Copay Plan pays 50%	$40 Copay (Class C)

(1) Unless otherwise noted, the deductible is waived for all copays and the coinsurance percentage applies only after the deductible has been met unless the coinsurance is stated as "Plan pays 100%" which is prior to the deductible (i.e. deductible waived).

(2) There was generally a separate deductible and out-of-pocket max for prescription coverage; however, those figures were not included.

(3) "Most screenings" generally includes preventative cancer screenings such as mammograms, pap smears, colonoscopies, and prostate screenings. For Montana, screenings also included bone density scans, EKG's, and proctoscopies; and mammograms were actually covered at 100% instead of 75%.

COST OF HEALTH INSURANCE
FOR STATE OF NEBRASKA EMPLOYEES
PLAN COST COMPARISON BETWEEN STATES

EXHIBIT D

2010 Premiums (1)		Nebraska	Iowa	Kansas (2)	South Dakota (3)	Wyoming (4)	North Dakota	Montana (5)
Medical Plan Type		Self-Insured	Fully-Insured	Self-Insured	Self-Insured	Self-Insured	Fully-Insured	Self-Insured
Plan Year Ending 2010		Jul 1 - Jun 30	Jan 1 - Dec 31	Jan 1 - Dec 31	Jul 1 - Jun 30	Jan 1 - Dec 31	Jul 1 - Jun 30	Jan 1 - Dec 31
Medical Provider		BCBS of Nebraska	Wellmark BCBS	BCBS of Kansas	DAKOTACARE Health	CIGNA Healthcare/ Great-West	BCBS of North Dakota	BCBS of Montana
Most Used Plan		BlueChoice	BlueAccess HMO	Plan A - PPO	$300 Deductible PPO	Option 1 - $350 Deductible PPO	PPO Plan	BlueChoice
Employee Monthly Premium	EE Only	$121.64	$0.00	$9.26 - $29.08	$0.00	$75.61	$0.00	$0.00
	EE/Spouse	$322.82	n/a	$179.16 - $218.76	$103.12 - $327.26	$171.40	n/a	$148.80
	EE/Children	$249.84	n/a	$144.28 - $179.92	$82.70 - $193.00	$126.31	n/a	$57.30
	Family	$431.78	$0.00	$307.42 - $362.84	$174.72 - $473.66	$198.88	$0.00	$182.90
Employer Monthly Premium	EE Only	$457.56	$442.76	$445.66 - $426.30	$521.48	$550.83	$825.66	$679.00
	EE/Spouse	$1,214.42	n/a	$728.24 - $692.22	$521.48	$1,093.60	n/a	$679.00
	EE/Children	$939.86	n/a	$672.72 - $637.68	$521.48	$838.07	n/a	$679.00
	Family	$1,624.28	$1,036.03	$962.70 - $907.66	$521.48	$1,249.32	$825.66	$679.00
Total Monthly Premium	EE Only	$579.20	$442.76	$454.92 - $455.38	$521.48	$626.44	$825.66	$660.00
	EE/Spouse	$1,537.24	n/a	$907.40 - $910.98	$624.60 - $848.74	$1,265.00	n/a	$827.80
	EE/Children	$1,189.70	n/a	$817.00 - $817.60	$604.18 - $714.48	$964.38	n/a	$736.30
	Family	$2,056.06	$1,036.03	$1,270.12 - $1,270.50	$696.20 - $995.14	$1,448.20	$825.66	$861.90

(1) Premiums shown are based on a regular full-time (1.0 FTE) active employee (for the most used plan).

(2) Kansas premium rates vary based on the employee's salary. The 3 categories are as follows: 1) Less than $28,000; 2) $28,000 to $48,000; 3) More than $48,000. The total premiums for each of these categories are essentially the same, but the employee share is lower for individuals with lower salaries resulting in the employer share being higher for those individuals and vice versa for individuals with higher salaries. Kansas also had a separate higher premium rate structure for tobacco users.

(3) South Dakota premium rates vary based on the number and age of dependents. The categories are shown below in the manner in which they were grouped for the table above. With this premium rate structure individuals with more dependents and individuals with older spouses had the highest employee share of premiums, but the employer share stayed the same regardless of coverage type. South Dakota also had a $60/month premium rate increase for tobacco users.

EE Only = EE Only
EE/Spouse = EE and Spouse (based on spouse's age*)
EE/Children = EE and 1 Child; EE and 2 Children; EE and 3+ Children
Family = EE, Spouse (based on age*), and 1 Child; EE, Spouse (based on age*), and 2+ Children
*Spouse's age categories were: <30; 30-39; 40-44; 45-49; 50-54; 55-59; and 60+

(4) Wyoming employer share of the monthly premium includes medical, dental, and life insurance as it was not possible to breakout the medical premium only. Likewise the employee share of the premium includes medical and dental as it was not possible to break out medical only (nor was it possible to include life insurance). Wyoming also had a $40 per month premium reduction available through a wellness incentive program.

(5) Montana employee and employer share of the monthly premium includes medical, dental, and basic life insurance which are the minimum requirements of the plan; therefore, it was not possible to break out these amounts separately. The employer contributes the same amount regardless of the plan selected by the employee; therefore for some plans the employer actually contributes more than the total plan cost, as with the BlueChoice plan shown above. The total monthly premium for medical only was available (without an employee/employer breakdown), which is as follows:

EE Only = $624.00
EE/Spouse = $774.00
EE/Children = $684.00
Family = $802.00

COST OF HEALTH INSURANCE **EXHIBIT E**
FOR STATE OF NEBRASKA EMPLOYEES
PLAN DESIGN COMPARISON BETWEEN LOCAL MUNICIPALITIES

		State of Nebraska	**Educators Health Alliance (4)**	**City of Lincoln**	**City of Omaha**	**Millard Public Schools**	**York Public Schools**	**Wayne Community Schools**
Medical Plan Type		Self-Insured	Fully-Insured	Self-Insured	Self-Insured	Self-Insured	Self-Insured	Fully-Insured
Plan Year Ending 2010		Jul 1 - Jun 30	Jan 1 - Dec 31	Nov 1 - Oct 31	Jan 1 - Dec 31	Sept 1 - Aug 31	Sept 1 - Aug 31	Sept 1 - Aug 31
Medical Provider		BCBS of Nebraska	BCBS of Nebraska	Coventry Healthcare of Nebraska	BCBS of Nebraska	Coventry Health and Life Insurance Co.	Regional Care Inc.	Coventry Health and Life Insurance Co.
Most Used Medical Plan (In-Network for PPO's)		BlueChoice	Option 1 - $350 Deductible PPO	POS	PPO	PPO	PPO	PPO
Plan/Lifetime Maximum	Individual	Unlimited	$5 million	Unlimited	$2 million	$5 million	$5 million	$5 million
Annual Deductible	Individual	$200	$350	$300	$400	$350	$500	$500
	Family	$400	$700	$600	$800	$700	$1,000	$1,000
Out-of-Pocket Maximum	Individual	$1,500	$2,000	$500	$600	$1,850	$1,250	$2,000
	Family	$3,000	$4,000	$1,000	$1,200	$3,700	$2,500	$4,000
Copay/ Coinsurance **(1)**	Office Visit	$20 Copay	$35 Copay	$20 Copay	Plan pays 80%	Plan pays 80%	$35 Copay	$20 Copay
	Annual exam **(3)**	$20 Copay or Plan pays 80% for most screenings	Plan pays 100% for most screenings or Plan pays 80%	$20 Copay	Plan pays 80%	Plan pays 80%	Plan pays 80%	$20 Copay or Plan pays 100% for mammograms
	Hospital ER	$50 Copay (waived if admitted)	Plan pays 80%	$150 Copay (waived if admitted)	Plan pays 80%	Plan pays 80%	Plan pays 80%	$150 Copay (waived if admitted) Plan pays 80%
	Inpatient hospital	Plan pays 80%	Plan pays 80%	$100 Copay Plan pays 90%	Plan pays 80%	Plan pays 80%	Plan pays 100% for physician and 80% for facility charges	Plan pays 80%
	Outpatient surgical center	$50 Copay	Plan pays 80%	Plan pays 90%	Plan pays 80%	Plan pays 80%	$35 Copay	Plan pays 80%
	Inpatient mental health	Plan pays 80% (30 day max)	Plan pays 80% (30 day max)	$100 Copay Plan pays 90%	Plan pays 80%	Plan pays 80%	Plan pays 80% (30 day max)	n/a
	Outpatient mental health	$20 Copay (60 visit max)	Plan pays 75% or $30 Copay for therapy (60 visit max)	$20 Copay	Plan pays 80%	Plan pays 80%	Plan pays 80% for facility charges (60 visit max)	n/a
Prescription Provider		Express Scripts	BCBS of Nebraska/ RxNebraska	Coventry Healthcare of Nebraska	Prime Theraputics	Coventry	Regional Care Inc.	Coventry Health and Life Insurance Co.
Copay/ Coinsurance **(2)** for Retail 30 Day Supply (City of Lincoln is 31 Day Supply)	Generic	$10 Copay	Plan pays 75%	$10 Copay	$5 Copay	$10 Copay	$10 Copay	n/a
	Preferred	$25 Copay	Plan pays 75%	$25 Copay	Plan pays 80%	$25 Copay	$25 Copay	n/a
	Non-Preferred	$40 Copay	Plan pays 50%	$50 Copay	Plan pays 80%	$40 Copay	n/a	n/a

(1) Unless otherwise noted, the deductible is waived for all copays and the coinsurance percentage applies only after the deductible has been met unless the coinsurance is stated as "Plan pays 100%" which is prior to the deductible (i.e. deductible waived).

(2) There was generally a separate deductible and out-of-pocket max for prescription coverage (sometimes there was also a minimum and maximum the member paid for each prescription); however, those figures were not included.

(3) "Most screenings" generally includes preventative cancer screenings such as mammograms, pap smears, colonoscopies, and prostate screenings.

(4) NSCS and all Nebraska public schools except Millard, York, and Wayne are members of the Educators Health Alliance and therefore all have the same plan design noted above.

(5) Items noted as n/a were not available to the APA.

COST OF HEALTH INSURANCE **EXHIBIT F**
FOR STATE OF NEBRASKA EMPLOYEES
PLAN COST COMPARISON BETWEEN LOCAL MUNICIPALITIES

2010 Premiums (1)		**State of Nebraska**	**EHA (4)**	**City of Lincoln (2)**	**City of Omaha (3)**	**Millard Public Schools**	**York Public Schools**	**Wayne Community Schools**
Medical Plan Type		Self-Insured	Fully-Insured	Self-Insured	Self-Insured	Self-Insured	Self-Insured	Fully-Insured
Plan Year Ending 2010		Jul 1 - Jun 30	Sept 1 - Aug 31	Nov 1 - Oct 31	Jan 1 - Dec 31	Sept 1 - Aug 31	Sept 1 - Aug 31	Sept 1 - Aug 31
Medical Provider		BCBS of Nebraska	BCBS of Nebraska	Coventry Healthcare of Nebraska	BCBS of Nebraska	Coventry	Regional Care Inc.	Coventry Health and Life Insurance Co.
Most Used Plan		BlueChoice	$350 Deductible PPO	POS	PPO	PPO	PPO	PPO
Employee Monthly Premium	EE Only	$121.64	Each member subgroup of EHA can set their own employee and employer share of the total premium rates.	$0.00 - $20.16	$35.23	$0.00	$0.00	$0.00
	EE/Spouse	$322.82		$53.74 - $197.04	$70.46	n/a	$0.00	n/a
	EE/Children	$249.84		$53.74 - $197.04	$98.61	n/a	$0.00	n/a
	Family	$431.78		$71.16 - $260.94	$98.61	$0.00	$0.00	$0.00
Employer Monthly Premium	EE Only	$457.56		$383.28 - $403.40	$551.72	$349.68	$495.00	$367.11
	EE/Spouse	$1,214.42		$698.60 - $841.90	$1,103.44	n/a	$944.00	n/a
	EE/Children	$939.86		$698.60 - $841.90	$1,544.87	n/a	$841.00	n/a
	Family	$1,624.28		$925.14 - $1,114.92	$1,544.87	$957.60	$1,395.00	$1,038.89
Total Monthly Premium	EE Only	$579.20	$479.57	$403.40	$586.95	$349.68	$495.00	$367.11
	EE/Spouse	$1,537.24	$1,007.11	$895.64	$1,173.90	n/a	$944.00	n/a
	EE/Children	$1,189.70	$887.22	$895.64	$1,643.48	n/a	$841.00	n/a
	Family	$2,056.06	$1,323.63	$1,186.08	$1,643.48	$957.60	$1,395.00	$1,038.89

(1) Premiums shown are based on a regular full-time (1.0 FTE) active employee (for the most used plan).

(2) City of Lincoln premium rates for the employee and employer portions vary based on the labor contracts which are different for police, firefighters, transit workers, administration, etc… Employees of certain labor contracts have lower premiums with the respective agency paying a higher portion and vice versa, while the total premiums remain the same for all labor contracts.

(3) City of Omaha offers EE Only, Family, and EE +1 coverage. EE +1 coverage is for the employee plus one dependent (spouse or 1 child); therefore EE +1 rates were shown as EE/Spouse and the Family rates were shown as both EE/Children and Family in the table above.

(4) Premium rates for EHA are set on a plan year from September 1 to August 31, while benefits are set on a calendar year (January 1 to December 31).

COST OF HEALTH INSURANCE
FOR STATE OF NEBRASKA EMPLOYEES
STATE OF NEBRASKA'S VARIOUS PLAN DESIGNS

EXHIBIT G

State of Nebraska Plan Year: July 1, 2009 through June 30, 2010										
Medical Provider		**BCBS of Nebraska**							
Medical Plan		**BlueChoice**		**Wellness PPO**		**Regular PPO**		**High Deductible PPO**	
		In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Plan/Lifetime Maximum	Individual	Unlimited	$2 million	$4 million	$4 million	$4 million	$4 million	$4 million	$4 million
Annual Deductible	Individual	$200	$500	$400	$600	$400	$600	$1,000	$2,000
	Family	$400	$1,000	$800	$1,200	$800	$1,200	$2,000	$4,000
Out-of-Pocket Maximum	Individual	$1,500	$3,000	$1,400	$3,400	$1,400	$3,400	$2,000	$4,000
	Family	$3,000	$5,000	$2,800	$5,200	$2,800	$5,200	$4,000	$8,000
Copay/ Coinsurance **(1)**	Office Visit	$20 Copay	Plan pays 60%	$20 Copay	Plan pays 70%	$20 Copay	Plan pays 70%	$25 Copay	Plan pays 60%
	Annual exams **(2)**	$20 Copay for annual exam Plan pays 80% for most screenings	Plan pays 60%	No Copay	Plan pays 70%	Annual exam not covered Plan pays 80% for most screenings	Annual exam not covered Plan pays 70% for most screenings	Annual exam not covered Plan pays 70% for most screenings	Annual exam not covered Plan pays 60% for most screenings
	Well baby exam	$20 Copay	Plan pays 60%	No Copay	Plan pays 70%	Not Covered	Not Covered	Not Covered	Not Covered
	Urgent care	$25 Copay	$25 Copay	$40 Copay	Plan pays 70%	Plan pays 80%	Plan pays 70%	Plan pays 70%	Plan pays 60%
	Hospital ER	$50 Copay (waived if admitted)	$50 Copay (waived if admitted)	$100 Copay (waived if admitted)	$100 Copay (waived if admitted)	$50 Copay (waived if admitted)	$50 Copay (waived if admitted)	$100 Copay (waived if admitted)	$100 Copay (waived if admitted)
	Inpatient hospital	Plan pays 80%	Plan pays 60%	Plan pays 80%	Plan pays 70%	Plan pays 80%	Plan pays 70%	Plan pays 70%	Plan pays 60%
	Outpatient surgical center	$50 Copay	Plan pays 60%	Plan pays 80%	Plan pays 70%	Plan pays 80%	Plan pays 70%	Plan pays 70%	Plan pays 60%
	Inpatient mental health	Plan pays 80% (30 day max)	Plan pays 50% (30 day max)	Plan pays 80% (60 day max)	Plan pays 60% (60 day max)	Plan pays 80% (60 day max)	Plan pays 60% (60 day max)	Plan pays 70% (60 day max)	Plan pays 60% (60 day max)
	Outpatient mental health	$20 Copay (60 visit max)	Plan pays 50% (60 visit max)	$40 Copay (60 visit max)	$50 Copay (60 visit max)	$40 Copay (60 visit max)	$50 Copay (60 visit max)	$40 Copay (60 visit max)	$50 Copay (60 visit max)
Prescription Provider		**Express Scripts**							
Retail Days Supply		30-Day Supply	180-Day Supply or Home Delivery	30-Day Supply	180-Day Supply or Home Delivery	30-Day Supply	180-Day Supply or Home Delivery	30-Day Supply	180-Day Supply or Home Delivery
Copay	Generic	$10 Copay	$35 Copay	$10 Copay	$35 Copay	$10 Copay	$35 Copay	$10 Copay	$35 Copay
	Preferred	$25 Copay	$100 Copay	$25 Copay	$100 Copay	$25 Copay	$100 Copay	$25 Copay	$100 Copay
	Non-Preferred	$40 Copay	$150 Copay	$40 Copay	$150 Copay	$40 Copay	$150 Copay	$40 Copay	$150 Copay

(1) For the purposes of this table, the deductible is waived for all copays and the coinsurance percentage applies only after the deductible has been met.
(2) "Most screenings includes preventative screenings such as mammograms, pap smears, colonoscopies, and .prostate cancer screenings.

COST OF HEALTH INSURANCE
FOR STATE OF NEBRASKA EMPLOYEES
UNIVERSITY OF NEBRASKA'S VARIOUS PLAN DESIGNS

EXHIBIT H

University of Nebraska

Plan Year: January 1, 2010 through December 31, 2010

Medical Provider		BCBS of Nebraska					
Medical Plan		High Option		Basic Option		Low Option	
		In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Plan/Lifetime Maximum	Individual	$3 million	$3 million	$3 million	$3 million	$3 million	$3 million
Annual Deductible	Individual	$300	$400	$400	$600	$1,500	$1,900
	Family	$600	$800	$800	$1,200	$3,000	$3,800
Out-of-Pocket Maximum	Individual	$1,300	$1,600	$1,500	$1,900	$2,400	$2,800
	Family	$2,600	$3,200	$3,000	$3,800	$4,800	$5,600
Coinsurance (1)	Office Visit	Plan pays 80%	Plan pays 65%	Plan pays 70%	Plan pays 55%	Plan pays 70%	Plan pays 55%
	Annual exams (2)	Plan pays 100% (deductible waived) $250 max per person	Plan pays 100% (deductible waived) $250 max per person	Plan pays 100% (deductible waived) $250 max per person	Plan pays 100% (deductible waived) $250 max per person	Plan pays 100% (deductible waived) $250 max per person	Plan pays 100% (deductible waived) $250 max per person
	Well baby exam (2)	Plan pays 100% (deductible waived) $500 max per person	Plan pays 100% (deductible waived) $500 max per person	Plan pays 100% (deductible waived) $500 max per person	Plan pays 100% (deductible waived) $500 max per person	Plan pays 100% (deductible waived) $500 max per person	Plan pays 100% (deductible waived) $500 max per person
	Hospital ER	Plan pays 80%	Plan pays 65%	Plan pays 70%	Plan pays 55%	Plan pays 70%	Plan pays 55%
	Inpatient hospital	Plan pays 80%	Plan pays 65%	Plan pays 70%	Plan pays 55%	Plan pays 70%	Plan pays 55%
	Outpatient surgical center	Plan pays 80%	Plan pays 65%	Plan pays 70%	Plan pays 55%	Plan pays 70%	Plan pays 55%
	Inpatient mental health	Plan pays 80%	Plan pays 65%	Plan pays 70%	Plan pays 55%	Plan pays 70%	Plan pays 55%
	Outpatient mental health	Plan pays 80%	Plan pays 65%	Plan pays 70%	Plan pays 55%	Plan pays 70%	Plan pays 55%
Prescription Provider		Caremark					
Copay (3)	Generic	$9 Copay	$9 Copay	$9 Copay	$9 Copay	$9 Copay	$9 Copay
	Preferred	$28 Copay	$28 Copay	$28 Copay	$28 Copay	$28 Copay	$28 Copay
	Non-Preferred	$47 Copay	$47 Copay	$47 Copay	$47 Copay	$47 Copay	$47 Copay

(1) For the purposes of this table, the coinsurance percentage applies only after the deductible has been met unless otherwise noted, such as when the plan pays 100%.
(2) Participants had the option to take a Health Risk Assessment and receive an increased maximum per person for these services.
(3) Prescription copays are for a Retail 30-Day Supply (or Mail Order).

COST OF HEALTH INSURANCE **ATTACHMENT A**
FOR STATE OF NEBRASKA EMPLOYEES
NCSL DATA - STATE PREMIUM COMPARISON OF FAMILY COVERAGE

State Employee Health Benefits - Monthly premium costs (Family coverage)

Compiled by the NCSL Health Program - Updated: August 19, 2009

Year			2006			2009		
			Family coverage			Family coverage		
State cost			$ 818.74	50 state avg		$ 880.37	(47 state avg)	
Employee			$ 193.93	as above		$ 192.01	(47 state avg)	
Ave. Total			$ 1,012.67	as above		$ 1,075.60	(48 state avg)	
	FT #	period	State	Employee	Total	State	Employee	Total
AL		10/1-9/30	$ 650.00	$ 164.00	$ 814.00	$ 775.00	$ 180.00	$ 955.00
AK	1	7/1-6/30	$ 763.00	$ 270.00	$ 1,033.00	$ 895.95	$ 0.00	$ 895.95
AZ		10/1-9/30	$ 818.52	$ 125.00	$ 943.52	$ 1,158.00	$ 150.00	$ 1,308.00
AR	2	1/1-12/31	$ 522.84	$ 346.90	$ 869.74	$ 621.99	$ 443.70	$ 1,097.48
CA		1/1-12/31	$ 807.00	$ 141.82	$ 948.82	$ 994.00	$ 233.00	$ 1,227.00
CO		7/1-6/30	$ 460.26	$ 362.46	$ 822.72	$ 782.92	$ 257.36	$ 1,040.28
CT		7/1-6/30	$ 995.38	$ 176.07	$ 1,171.45	$ 942.57	$ 97.57	$ 1,040.13
DE		7/1-6/30	$ 1,053.52	$ 57.84	$ 1,111.36	$ 1,221.10	$ 0.00	$ 1,221.10
FL		7/1-6/30	$ 715.92	$ 180.00	$ 895.92	$ 835.98	$ 64.30	$ 900.28
GA	3	1/1-12/31	$ 587.22	$ 217.16	$ 804.38	$ 875.78	$ 223.10	$ 1,098.88
HI	4	7/1-6/30	$ 487.38	$ 322.34	$ 809.72	$ 523.72	$ 284.20	$ 807.92
ID		7/1-6/30	$ 576.68	$ 80.00	$ 656.68	$ 705.08	$ 103.00	$ 808.08
IL	5	7/1-6/30	$ 1,096.52	$ 245.50	$ 1,342.02	$ 715.71	$ 127.99	$ 843.70
IN		1/1-12/31	$ 917.58	$ 291.66	$ 1,209.24	$ 961.56	$ 182.94	$ 1,239.87
IA		1/1-12/31	$ 989.75	$ 222.08	$ 1,211.83	$ 932.47	$ 0.00	$ 932.47
KS	6	7/1-6/30	$ 604.30	$ 357.08	$ 961.38	$ 586.66	$ 351.74	$ 938.40
KY	7	1/1-12/31	$ 703.37	$ 320.14	$ 1,023.51	$ 785.44	$ 376.72	$ 1,162.16
LA		7/1-6/30	$ 645.90	$ 397.18	$ 1,043.08	$ 713.36	$ 453.00	$ 1,166.36
ME		7/1-6/30	$ 1,117.44	$ 337.34	$ 1,454.78	$ 1,238.26	$ 373.84	$ 1,612.10
MD		7/1-6/30	$ 694.49	$ 151.72	$ 846.21	$ 741.93	$ 130.93	$ 872.86
MA	8	7/1-6/30	$ 1,160.14	$ 204.73	$ 1,364.87	$ 781.92	$ 195.48	$ 977.40
MI*		10/1-9/30	$ 1,187.27	$ 62.49	$ 1,249.76	1182.84*	131.42*	$ 1,314.28
MN		1/1-12/31	$ 976.84	$ 107.32	$ 1,084.16	$ 1,185.14	$ 130.20	$ 1,315.34
MS	9	7/1-6/30	$ 305.00	$ 477.00	$ 782.00	$ 343.00	$ 581.00	$ 924.00
MO	10	1/1-12/31	$ 977.00	$ 258.00	$ 1,235.00	$ 1,219.00	$ 277.00	$ 1,496.00
MT		1/1-12/31	$ 506.00	$ 187.00	$ 693.00	$ 626.00	$ 204.00	$ 830.00
NE		7/1-6/30	$ 1,141.64	$ 303.46	$ 1,445.10	$ 1,470.28	$ 390.84	$ 1,861.12
NV	11	1/1-12/31	$ 676.57	$ 114.54	$ 791.11	$ 726.75	$ 150.84	$ 877.59
NH		1/1-12/31	$ 1,886.21	$ 0.00	$ 1,886.21	$ 1,710.47	$ 30.00	$ 1,740.47
NJ	12	1/1-12/31	$ 835.77	$ 0.00	$ 835.77	Remain $	1.5% of Sal	$ 1,080.60
NM	13	7/1-6/30	$ 550.87	$ 236.09	$ 786.96	$ 806.42	$ 201.62	$ 1,008.04
NY	14	1/1-12/31	$ 830.25	$ 185.20	$ 1,015.45	$ 771.26	$ 180.78	$ 952.04
NC		7/1-6/30	$ 321.14	$ 521.32	$ 842.46	$ 346.38	$ 413.46	$ 759.84
ND	15	1/1-12/31	$ 553.94	$ 0.00	$ 553.94	$ 664.66	$ 0.00	$ 664.66
OH		7/1-6/30	$ 853.23	$ 128.50	$ 981.73	$ 762.04	$ 134.88	$ 896.92
OK		1/1-12/31	$ 1,098.18	$ 0.00	$ 1,098.18	$ 1,427.08	$ 0.00	$ 1,427.08
OR	16	1/1-12/31	$ 1,002.97	$ 0.00	$ 1,002.97	$ 1,036.36	$ 0.00	$ 1,036.36
PA		1/1-12/31	$ 595.83	$ 108.50	$ 704.33	n/a	n/a	n/a
RI		7/1-6/30	$ 1,098.01	$ 43.92	$ 1,141.93	n/a	n/a	n/a
SC		1/1-12/31	$ 529.00	$ 294.58	$ 823.58	$ 602.56	$ 294.58	$ 897.14
SD	17	7/1-6/30	$ 415.36	$ 297.68	$ 713.04	$ 481.08	$ 155.00	$ 636.08
TN		1/1-12/31	$ 885.60	$ 221.40	$ 1,107.00	$ 1,013.92	$ 182.85	$ 1,196.77
TX		9/1-8/31	$ 671.08	$ 327.60	$ 998.68	$ 637.84	$ 311.31	$ 949.15
UT		7/1-6/30	$ 882.70	$ 66.43	$ 949.13	$ 915.42	$ 48.18	$ 963.60
VT		1/1-12/31	$ 1,200.55	$ 300.15	$ 1,500.70	$ 1,123.82	$ 280.96	$ 1,404.78
VA	18	7/1-6/30	$ 889.00	$ 127.00	$ 1,016.00	$ 1,035.00	$ 147.00	$ 1,201.00
WA	19	1/1-12/31	$ 953.00	$ 49.00	$ 1,002.00	$ 561.00	$ 79.00	$ 640.00
WV	20	7/1-6/30	$ 649.00	$ 95.00	$ 744.00	$ 748.00	$ 118.00	$ 866.00
WI	21	1/1-12/31	$ 1,200.45	$ 55.00	$ 1,255.45	$ 1,189.60	$ 78.00	$ 1,267.60
WY	22	1/1-12/31	$ 897.11	$ 158.31	$ 1,055.42	$ 1,002.18	$ 274.50	$ 1,276.68

Note: Footnotes referenced in the second column above have not been included in this attachment as none were applicable to Nebraska.

ATTACHMENT B

NEBRASKA AUDITOR OF PUBLIC ACCOUNTS

Mike Foley
State Auditor

Mike.Foley@nebraska.gov
P.O. Box 98917
State Capitol, Suite 2303
Lincoln, Nebraska 68509
402-471-2111, FAX 402-471-3301
www.auditors.state.ne.us

April 1, 2010

Senator John Harms
Chair of Performance Audit Committee
P.O. Box 94604
State Capitol Building, Room #2015
Lincoln, NE 68509

RE: Authorization to Conduct Performance Audit

Dear Senator Harms:

The purpose of this letter is to seek authorization from the Legislative Performance Audit Committee, pursuant to Neb. Rev. Stat. § 84-322 (Reissue 2008), for my office to conduct a performance audit relating to the cost of health insurance coverage for State employees. For the most recent fiscal year, the combined premiums paid by the State and its employees for health insurance amounted to approximately $180 million.

Recently, I was contacted by concerned parties regarding what they allege to be unreasonably high expenditures for State employee health insurance coverage. Among the information provided to me in support of their contention was data compiled by the National Conference of State Legislatures (please see attached) showing that Nebraska pays more for such insurance coverage than almost any other state in the nation. Many millions of dollars paid annually to furnish insurance coverage for State employees, they argued, could be saved – without sacrificing either quality or quantity of services – by exercising greater selectivity in choosing providers and plans.

After considering the information presented, I directed a few of my auditors to collect some preliminary financial information about State employee insurance expenditures. The numbers that they have compiled indicate that the State may indeed be paying more – in some cases, considerably more – than any other Nebraska public entity, including the University of Nebraska, for comparable employee health insurance coverage. This information leads me to believe that a more thorough and comprehensive comparability analysis of such expenditures, as well as the services being provided, is warranted.

Carrying out the proposed task will involve detailed scrutiny of complex and intricate financial data and records. With 17 auditors who have passed the Certified Public Account's exam, 16 auditors who have passed the Certified Fraud Examiners' exam, and many decades of combined experience in carrying out financial examinations of the State and its political subdivisions, my audit staff is uniquely qualified to gather and compile the numbers needed to provide both the Legislature and the public with a complete picture of State expenditures for employee health insurance coverage.

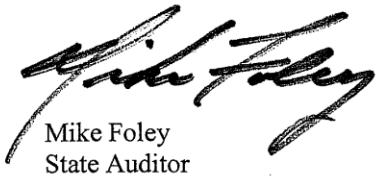
In pursuit of that aim, I would like to do more than merely report upon the raw numbers obtained – although such a revelation would, in and of itself, likely prove quite informative and revealing. Rather, I believe it to be in everyone's best interest for my office to offer a full analysis of the issue, which would entail a comprehensive comparison of employee health insurance expenditures made by various states, agencies, and public entities.

In order to allow my staff to present the most comprehensive report possible, I would appreciate the support of you and the other members of the Legislative Performance Audit Committee. Specifically, I wish to be authorized under § 84-322 to conduct a full performance audit of the State of Nebraska Health Insurance program, including expenditures, benefits, the self-insurance pool, and related activities. Because of the State's current economic predicament, time is of the essence, and it is necessary that we begin the audit as soon as possible. Thus, I would urge the Committee to act without delay in this matter.

Should you or any other members of the Committee have questions or concerns regarding the present request, I would be more than happy to visit with you and the others, either individually or collectively, at your convenience.

Thank you for your assistance and consideration.

Sincerely,



Mike Foley
State Auditor

cc: Legislative Performance Audit Committee

Enclosure

Enclosure included table shown in **Attachment A** as well as a similar table for Individual coverage.

ATTACHMENT C

LEGISLATIVE PERFORMANCE AUDIT COMMITTEE
APPROVAL OF REQUEST FOR APA PERFORMANCE AUDIT

Legislative Performance Audit Committee

Committee Members:
Senator John Harms, Chair
Senator Danielle Conrad, Vice Chair
Speaker Mike Flood
Senator Lavon Heidemann
Senator Arnie Stuthman
Senator Dennis Utter
Senator John Wightman

Legislative Audit Office
P.O. Box 94945, State Capitol
Lincoln, NE 68509-4945
402-471-2221

Office Staff:
Martha Carter, Legislative Auditor
Don Arp, Jr., Analyst
Clarence Mabin, Analyst
Dana McNeil, Analyst
Stephanie Meese, Legal Counsel
Sandy Harman, Committee Clerk

April 13, 2010

Mr. Mike Foley
Auditor of Public Accounts
State Capitol, Room 2303
Lincoln, NE 68509

Dear Mike:

On April 9, 2010, the Legislative Performance Audit Committee approved your request to conduct a performance audit, pursuant to the provisions of Neb. Rev. Stat. sec. 84-322, relating to the cost of health insurance for state employees. We look forward to hearing what you learn, and we appreciate your willingness to keep us informed as the project develops.

Additionally, we are requesting your assistance in reviewing the Department of Health and Human Services' accounting for behavioral health funds. In particular, the Committee is concerned that funds the Legislature intended to be spent on services may instead have been used for program administration. This issue is raised in the report released today titled "Community-based Behavioral Health: Funds, Efficiency, and Oversight," a copy of which is enclosed. Please contact Martha directly if you need any additional information relating to this report.

Feel free to contact me if you have questions about either of these projects.

Sincerely,

Senator John Harms
Committee Chair

Enclosure

Enclosure not applicable to this audit and therefore not included in attachment.

AdministrativeServices
Dave Heineman, Governor

Carlos Castillo, Jr.
Director

August 16, 2010

Senator John Harms
Nebraska State Legislature
District 48, Room 2015
P.O. Box 94604
Lincoln, NE 68509

Dear Senator Harms:

As you know, the Auditor of Public Accounts (APA) was recently authorized by the Legislative Performance Audit Committee to conduct a Performance Audit of the State Employee Health Plan. During the course of this audit, significant issues have surfaced that we believe need further clarification.

1. The APA has asked us to release to him the personal healthcare records for all state employees, their spouses and children for the period covering July 1, 2009, through May 31, 2010 (email dated June 2, 2010 attached). Protecting the confidentiality of individual healthcare records is of utmost concern to us. Releasing confidential personal health information without state employees' and their families' consent could have a negative effect on our employee population and bring about potential legal issues for the State. We have taken great strides to assure our employees that their healthcare information would not be unnecessarily accessed by the State. The APA's request runs completely contrary to our policy. It should also be noted, federal laws, namely HIPAA (Health Insurance Portability and Accountability Act) surrounding the release of individually identifiable health information are very stringent and any violations could subject the State and our health partners to serious violations along with legal and monetary penalties. With this in mind, is it the Performance Audit Committee's intention that this confidential healthcare information be released to the APA?

2. We request clarification as to whether or not this performance audit will be conducted pursuant to the Legislative Performance Audit Act. If not, what guidelines, standards or statutes are being applied for this performance audit?

3. From documents presented during our Entrance Conference, it appears that this performance audit covers July 1, 2009 through June 30, 2011. It is unusual that this audit would cover a period of time that has not yet occurred. Is it the Performance Audit Committee's intention to make this an ongoing audit for the next 11 months?

Administrative Services • Suite 1315, State Capitol • Lincoln, Nebraska 68509-4664 • Phone: 402-471-2331 • Fax: 402-471-4157

As you know, the State's healthcare plans cover approximately 15,000 State employees and have nearly 30,000 members. Protecting the personal healthcare information of those employees, their spouses and children is critically important to us. We hope to better understand the full scope and nature of this audit.

We look forward to continuing our work with the Legislative Performance Audit Committee and are willing to meet with you at any time to discuss this further.

Sincerely,

Carlos Castillo
Director, Administrative Services

Senator Danielle Conrad
Senator Mike Flood
Senator Lavon Heidemann
Senator Arnie Stuthman
Senator John Wightman
Senator Dennis Utter
Martha Carter, Legislative Auditor

Attachment

From: Janssen, Cindy [mailto:cindy.janssen@nebraska.gov]
Sent: Wednesday, June 02, 2010 10:16 AM
To: Hogan, Angela
Cc: Fankhauser, Paula; Wilson, Roger; Avery, Mary; Smith, Julie C; Crist, Acacia; Cromwell, Jennifer
Subject: Information request to BCBS

Angela, as discussed in our phone conversation this morning, the Auditor of Public Accounts is requesting all of the claims detail for the State of Nebraska from July 1, 2009, through May 31, 2010, in an electronic format. We have reviewed information provided by BCBS to the State and are requesting additional fields that are not included in the information already provided. Basically, what we are needing is all of the information included in an explanation of benefits form and the claim form submitted by the providers.

As discussed, in selecting a sample of claims to test, we must know the population of the claims. We need this additional information (such as procedure codes, co-pay amounts, adjustments, etc) to analyze the claims and select a proper sample of claims to test.

Below you will find a list of the fields we are requesting for each claim provided. We are requesting the information on ALL claims submitted for this time period, whether it is a zero dollar claim or a negative claim amount. If you have any questions regarding this request, please give me a call. As mentioned, we had hoped to receive this information in a week to ten days. Please advise the best way for us to obtain this information – do you need us to provide a flash drive or DVDs on which to download the information?

Thanks for your help in this request.

1. All fields on the Daily Claims Detail for State of NE including:
    a. Group (Plan)
    b. Subscriber ID
    c. Last Name
    d. First Name
    e. Claim Number
    f. Incurred Date (Date of Service)
    g. Pay to Name
    h. Provider Name
    i. Billed Charge
    j. Allowance (Not covered amount)
    k. Net Paid Amount

1. Access Amount
2. Procedure Code
3. Diagnosis Code
4. Type of Care
5. % of Benefit
6. Total Benefits
7. Type of subscriber and ID number
    a. Member
    b. Dependent
    c. COBRA
    d. Retiree
8. Billed date (Date claim received)
9. Date processed
10. Date paid to provider
11. Cleared date
12. Co-insurance amount
13. Deductible
14. Copay
15. Any other adjustments made to claim and reason codes with explanation

Cindy Janssen
Audit Manager
NE Auditor of Public Accounts
(402) 326-3047

Cindy.Janssen@nebraska.gov

COPY

December 3, 2010

Legislative Performance Audit Committee
P.O. Box 94945, State Capitol
Lincoln, NE 68509-4945

Dear Senator Harms:

We raise the following issues with the primary concern for the duty we all share to safeguard Protected Health Information (PHI). We respect the authority of the Legislative Performance Audit Committee and we do not have any desire to impede the Committee's access to information and will always fully cooperate with both the Committee and the Auditor of Public Accounts.

On November 23, 2010, the Nebraska Department of Administrative Services, the University of Nebraska, the Nebraska State College System, and the Nebraska State Patrol received a document entitled, "Updated Entrance Conference Memo" from the Auditor of Public Accounts regarding a Legislative Performance Audit of the State's Health Insurance Plan. The memo states that the objective of the audit is to "provide a comparison of costs of various government health insurance plans *and member information* (emphasis added) for fiscal year ending June 30, 2010 and the current fiscal year ending June 30, 2011." We believe plan coverage and cost comparison information could be provided for the Legislative Performance audit without triggering confidentiality concerns over PHI, however, the portion of the objective dealing with member information is problematic particularly given that the Auditor has also initiated an Attestation Examination Audit concurrent with the Legislative Performance Audit.

During the November 23 Legislative Performance Audit Entrance conference we were informed that the Auditor's Office would utilize the same staff members to perform the Legislative Performance Audit of the State's Health Insurance Plan simultaneously with the Auditor's own Attestation Examination Audit. The Auditor informed us that information collected for one audit could, and would likely, be utilized in the second audit. The documentation provided by the Auditor at the entrance conference did not provide any safeguards for access to PHI. In response to a question, the Auditor's Office agreed that it would be possible to triangulate information, thereby gaining access to PHI for state employees. This is a concern because HIPAA penalties and remedies apply to disclosures of information "in combination with other reasonably available information." One option to safeguard PHI while "conducting or arranging for medical review, legal services, and auditing functions, including fraud and abuse detection and compliance programs" (45 CFR 164.501), is to provide "Limited data set disclosures." However, the data requested in the table for the Legislative Performance Audit includes dates and membership information beyond what can be characterized as "limited data set disclosures." As a result all of the covered entities involved (upon request for an accounting under 45 CFR 164.528) will be required to include the date of the disclosure, the name and address of the entity or person who received the PHI, a brief description of the PHI disclosed and a brief statement of the purpose of the disclosure. Even disclosures of PHI made as required by law under 45 CFR 164.512(a) are subject to this accounting requirement. It is also likely that all of the Third Party Administrators will require a non-disclosure agreement that will have to be administered and agreed to ahead of any responses.

Based on the information currently at our disposal, we are left to conclude that concurrent audits, at a minimum, require additional safeguards against disclosure of PHI. As employers, we all have taken steps to utilize third party administrators to properly safeguard PHI. Assuming that all are in agreement that the Performance Audit Committee's scope statement, and audit plan answers the access question under the law, we have been advised as plan sponsors that only those few employees authorized under the various plans can furnish access to PHI and then only after taking reasonable steps for safeguarding the same. We also have concerns about two simultaneous audits from separate legislative and executive authority. In State of Nebraska ex rel. Spire v. Conway, 238 Neb. 766, 472 N.W.2d 403 (1991), the Nebraska Supreme Court held that state Senator Gerald Conway could not both serve in the Legislature and also act as an assistant professor at Wayne State College. The court indicated that such dual service violated Article II, § 1 of the Nebraska Constitution, as Senator Conway was an officer in the Legislative Branch of government, and also an employee within the Executive Branch of government through his employment at Wayne State. In the Conway opinion, the court set out the following rule which governs the application of Article II, § 1 to the activities of government officials in Nebraska: Article II prohibits one who exercises the power of one branch - that is, an officer in the broader sense of the word - from being a member - that is, either an officer or employee - of another branch. We are concerned regarding the dual service prohibition given that the Auditor, as an Executive Branch officer, would be simultaneously performing duties for the Legislative Branch of government. Even without providing PHI, we believe the concurrent audit processes and commingling the Legislative Audit Committee's work with a simultaneous Attestation Examination Audit by the Auditor raises the question of the dual service prohibition in Article II, § 1 of the Nebraska Constitution.

If the dual service prohibition does not constitute a legal barrier to proceeding with concurrent audits, we would ask the Committee to at least consider postponing the Legislative Performance Audit until after the Auditor's Attestation Examination Audit was completed in order to mitigate some of our confidentiality concerns. There also seems to be more duplication of efforts when the Auditor already has access to the SAS-70 claims reports on the related health plans for the State of Nebraska and University. The SAS-70 claims reports are paid for in the plan contracts and they are obtained from independent financial auditors. Additionally, the Auditor's Office has indicated that as part of the Legislative Performance Audit they will also conduct an eligibility review for program participants. The University of Nebraska has already undertaken a contracted external eligibility review. Since we also do not have a cost estimate or a clear scope and plan for the Auditors review, we are not in the best position to defend additional expenditures for another review of the same area. By postponing the Legislative Performance Audit, the University of Nebraska, through an independent contractor will have completed an external insurance eligibility audit by April of 2011. Therefore, the Committee could be provided assurance from an independent third party regarding the valid eligibility and participation for individuals allowed in the University's insurance program, without creating additional administrative time and expense for a duplicate verification through the Auditor's Office. In a similar way, the SAS-70 reports could be used to identify specific areas of concern to avoid duplication of efforts in the Auditor's Attestation Examination Audit. In this current economic environment, all involved would appreciate the Legislative Performance Audit Committee's sensitivity to alleviating such burdens and avoiding duplication of effort whenever possible.

The Auditor has directed us to request claims data from our respective insurance providers at no cost to the APA no later than December 17, 2010. Our current provider agreements allow only for a limited number of hours to comply with this type of request from our third party administrators, and we do not have any funds identified to pay for additional charges to meet these claims data requests. The

sophistication of these plan agreements already has provided and paid for independent reviews and reports such as the SAS-70 which we believe are a more cost effective starting point for the review.

Given the overlapping audits from both the Legislative Audit Committee and the Auditor, in addition to existing and paid for independent reports in this area, along with previously engaged independent reviews that will be reported next spring, we would all benefit from a more strategic review of the next steps and believe a conversation would be the most productive way to address these concerns and respond to the Committee. Part of the confusion is caused because of the simultaneous audits and that no specific objectives were provided for the Auditor's Attestation Examination Audit. In your letter to Carlos Castillo dated November 15, 2010, you stated that the Legislative Performance Audit Committee adopted a scope statement and audit plan for the Legislative Performance Audit on November 12, 2010. Our respectful suggestion, specifically for comparing "member information" and addressing concerns about PHI with our third party administrators, would be to receive a copy of the scope statement and plan adopted by the Legislative Performance Audit Committee.

We await your response before proceeding further to request claims data. Thank you in advance for your time and consideration.

Sincerely,

Carlos Castillo, Director
Department of Administrative Services
State Of Nebraska

David Lechner,
Vice President for Business and Finance
University of Nebraska

Carolyn Murphy,
Vice-Chancellor for Finance and Administration
Nebraska State College System

Bryan Tuma, Superintendent
Nebraska State Patrol

cc: Martha Carter, Legislative Auditor
Mike Foley, Auditor of Public Accounts

January 11, 2011

Mary Avery
Nebraska Auditor of Public Accounts
State Capitol, Suite 2303
Lincoln, NE 68509-8917

Dear Mary,

We believe that due to the performance and financial audits being conducted concurrently, it is likely that personal health information will be identified. Additionally, we believe there remain unresolved issues regarding both of these audits as presented in the recent letter from the Attorney General Bruning to Auditor Foley.

Sincerely;

Carlos Castillo, Director
Department of Administrative Services
State of Nebraska

David Lechner,
Vice President for Business and Finance
University of Nebraska

Carolyn Murphy,
Vice Chancellor for Finance and Administration
Nebraska State College System

cc: Martha Carter, Legislative Auditor
Mike Foley, Auditor of Public Accounts

COST OF HEALTH INSURANCE
FOR STATE OF NEBRASKA EMPLOYEES
EMAIL FROM DAS FINANCIAL ADMINISTRATOR
DATED MARCH 10, 2011

ATTACHMENT G

From: Wilson, Roger
Sent: Thursday, March 10, 2011 5:19 PM
To: Avery, Mary
Cc: Janssen, Cindy; Foley, Mike; Fankhauser, Paula; Anderson, Shannon
Subject: RE: Insurance Data

Mary, to follow up on your note, we are waiting for final direction from the Governor to provide the data. Roger

Best Regards;
Roger Wilson
Administrator of Central Services
301 Centennial Mall South, PO Box 94953, Lincoln, NE 68509-4953
Phone 402.471.1638
www.das.state.ne.us

NEBRASKA
Administrative Services
Central Services

From: Avery, Mary
Sent: Thursday, March 10, 2011 11:15 AM
To: Wilson, Roger
Cc: Janssen, Cindy; Foley, Mike
Subject: Insurance Data

Just following up again, since we haven't seen a test file yet and tomorrow is the 11th.

Any word on when we'll get the data files?

THANKS

Mary Avery
Special Audits and Finance Manager
Auditor of Public Accounts
Room 2303, State Capitol
Lincoln, NE 68509
Phone 402-471-3686
Cell Phone 402-326-3039
mary.avery@nebraska.gov

From: Avery, Mary
Sent: Monday, March 07, 2011 4:22 PM
To: Wilson, Roger
Cc: Foley, Mike; Janssen, Cindy
Subject: Insurance Data

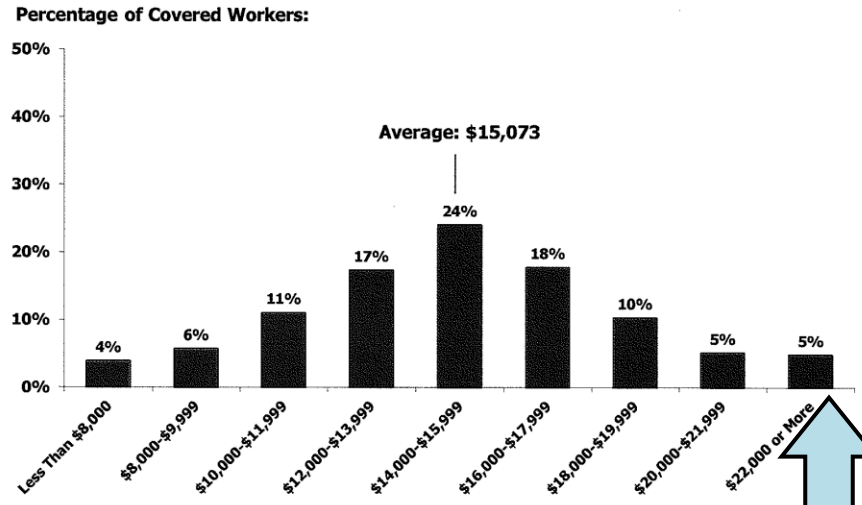
Roger, Any word on the files, both BC/BS and Pharmacy ones?

Are we still shooting for this week? Will we get a test sample?

1

ATTACHMENT H

Exhibit 1.10
Distribution of Annual Premiums for Covered Workers with Family Coverage, 2011



Source: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2011.

Nebraska's 2011 Weighted Average Annual Family premium was $22,542 and would fall into this category.