For Immediate Release
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State Auditor Releases Financial and Performance Audit Reports on State Employee Health Insurance Costs

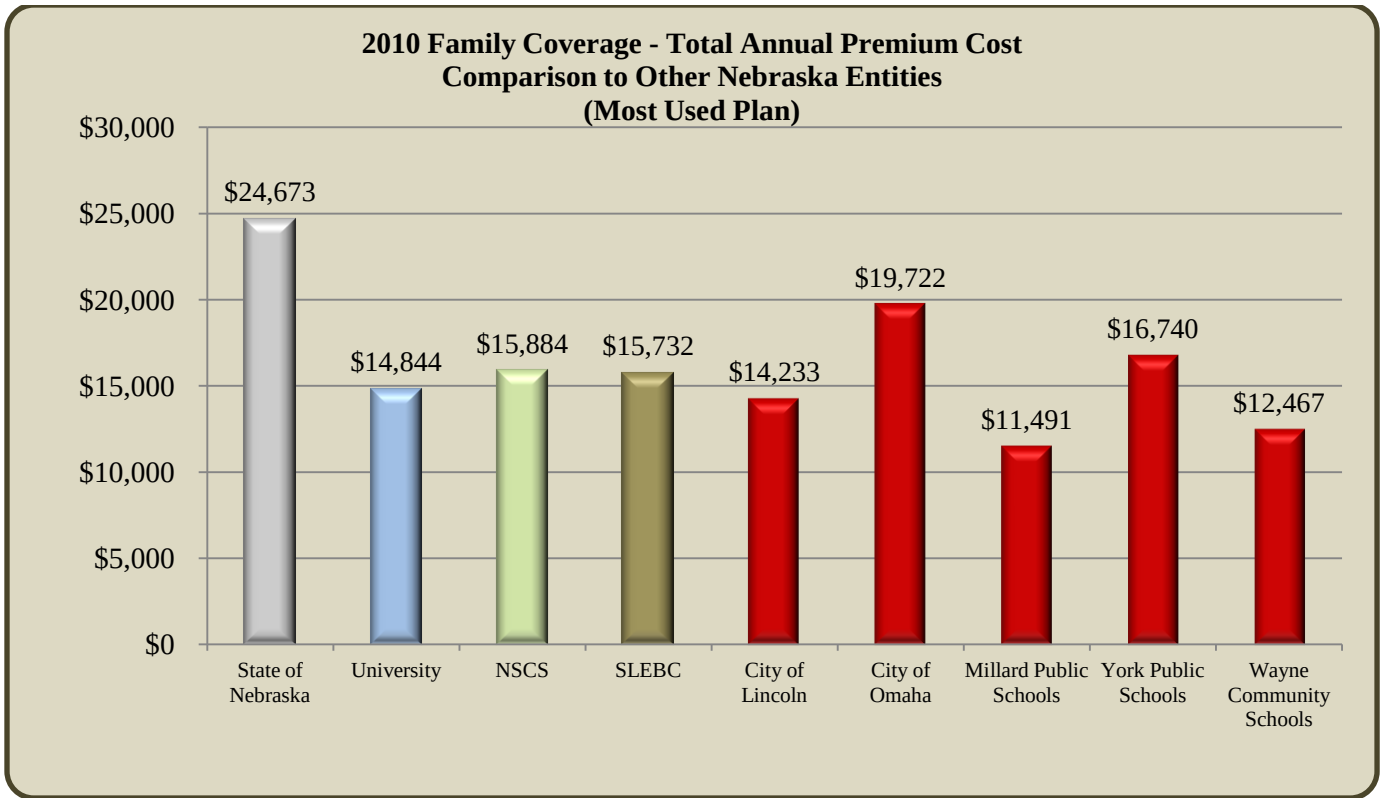
State Auditor Mike Foley announced today the release of his office's long-awaited financial and performance audit reports on state employee health insurance costs. Together, the financial attestation report of the Department of Administrative Services (DAS) – Nebraska State Insurance Program (Program) and its counterpart Performance Audit of the Cost of Health Insurance For State of Nebraska Employees not only illustrate the degree to which the price of Program premiums have far exceeded those of other state employee insurance plans, both in Nebraska and elsewhere, but also indicate the likely reasons for such exorbitant costs.

To serve as a basis of comparison for the performance audit, the Auditor of Public Accounts (APA) carried out financial audits of both the Program and similar state employee health insurance plans operated by the University of Nebraska, the Nebraska State College System, and the State Law Enforcement Bargaining Council. The first of those financial audits, which was completed in early 2011, revealed that the State Law Enforcement Bargaining Council used employee premium payments to purchase a $1.2 million office building equipped with expensive large-screen televisions, an elaborate sound system, and ornate art work and office furniture. Subsequently, the other health insurance financial attestations were released on March 8, 2012, for Nebraska State Colleges; March 29, 2012, for the University of Nebraska; and today for the Program.

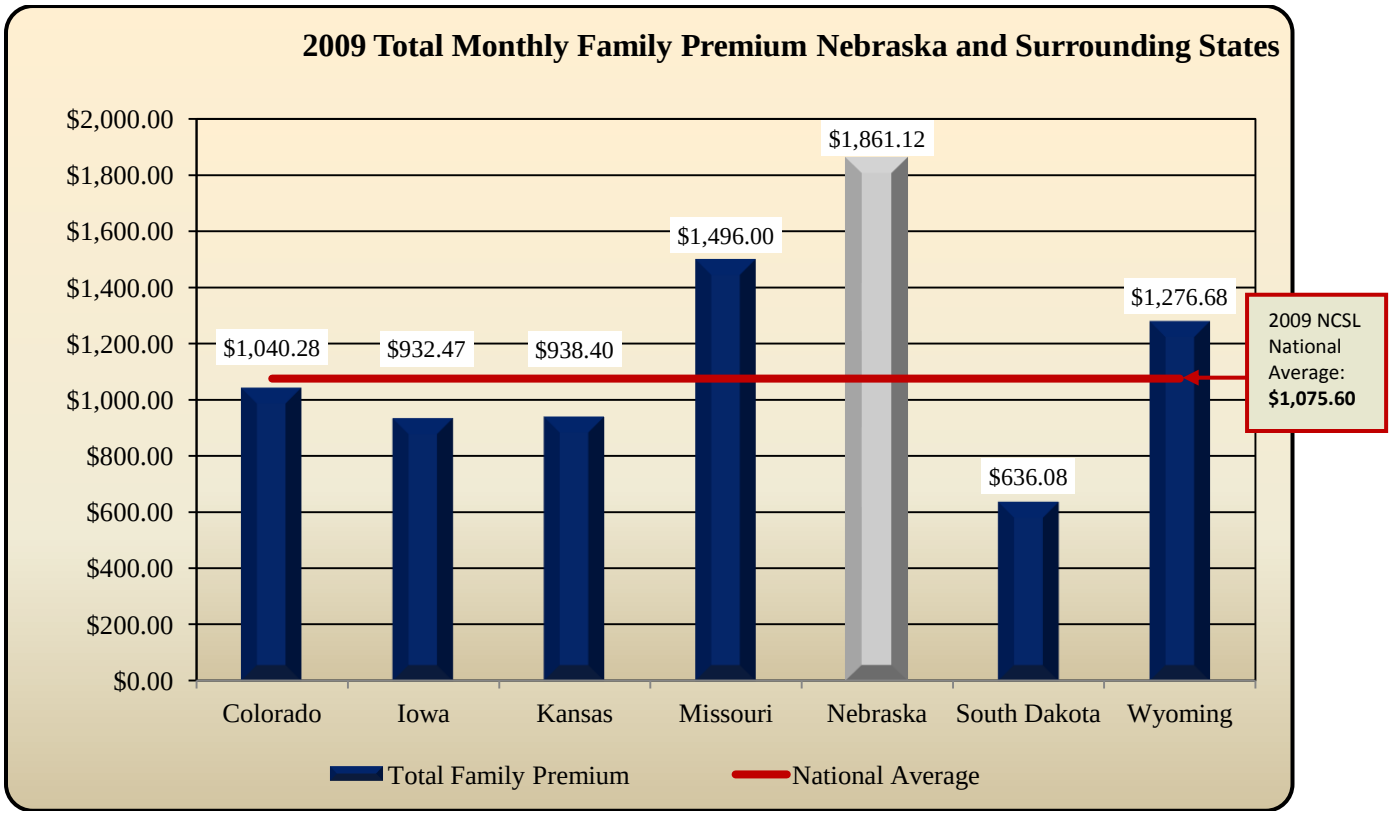
Started in 1974, the Program, which is administered by DAS, now provides health insurance coverage to some 29,000 State employees and their dependents. The State pays, with public funds, 79% of the total employee premium costs, generally referred to as the employer portion of the premium. Because the Program is self-insured, the actual claims of all covered health care expenses are paid directly from the premium funds paid by the employee and employer shares – making the present report findings important to all Nebraska taxpayers.

Program Premium Costs

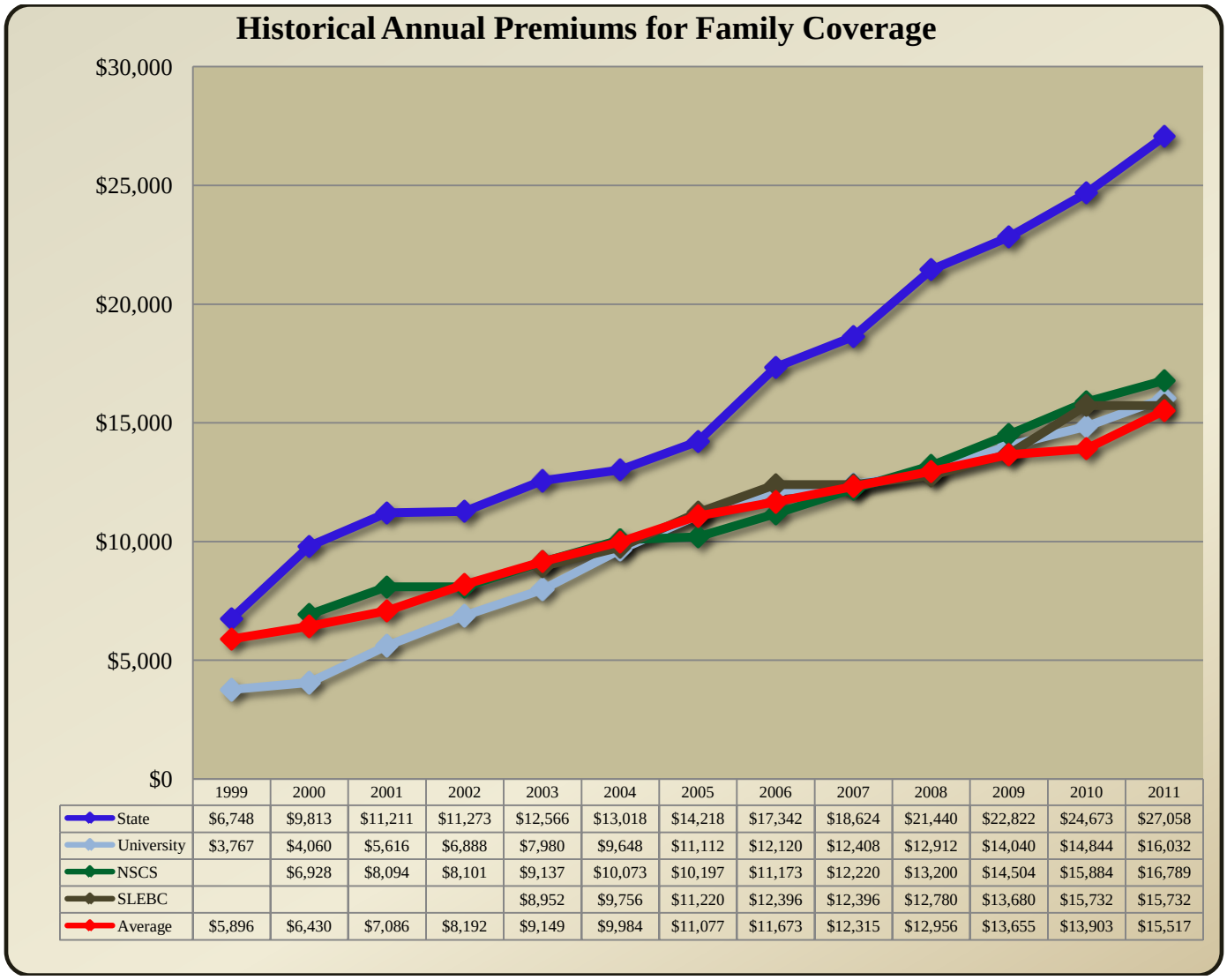
The audit reports reveal the extent to which insurance premium costs under the Program are dramatically higher than those of plans sponsored by various other Nebraska institutions, including those tested for audit purposes. This is reflected in a comparison of 2010 annual premium costs, as set out in the graph below:



No less disturbing is the degree to which, according to a 2009 study of the National Conference of State Legislatures, monthly Program costs exceed those of all other state employee insurance plans nationwide.



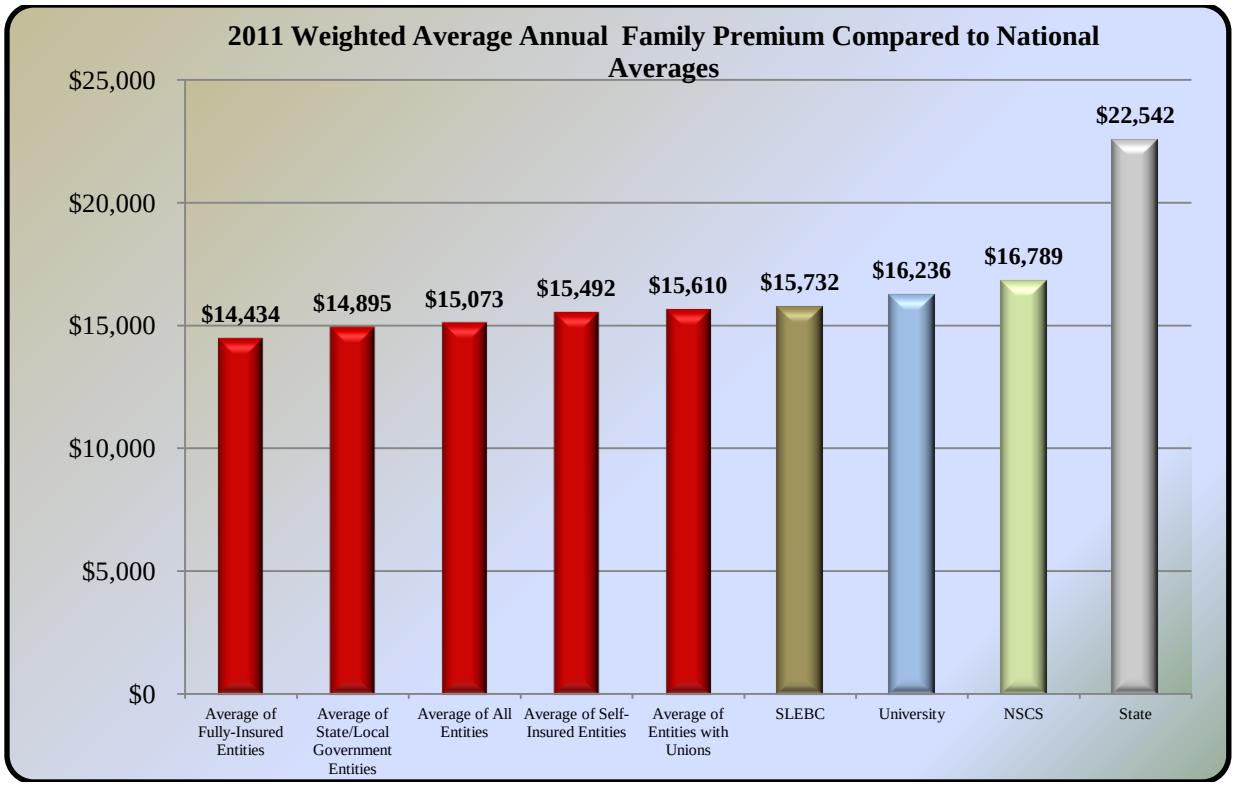
As revealed in the chart below, moreover, the gap between Nebraska's premium rates and all of those other rates, both within and outside of this state, has increased with each passing year.



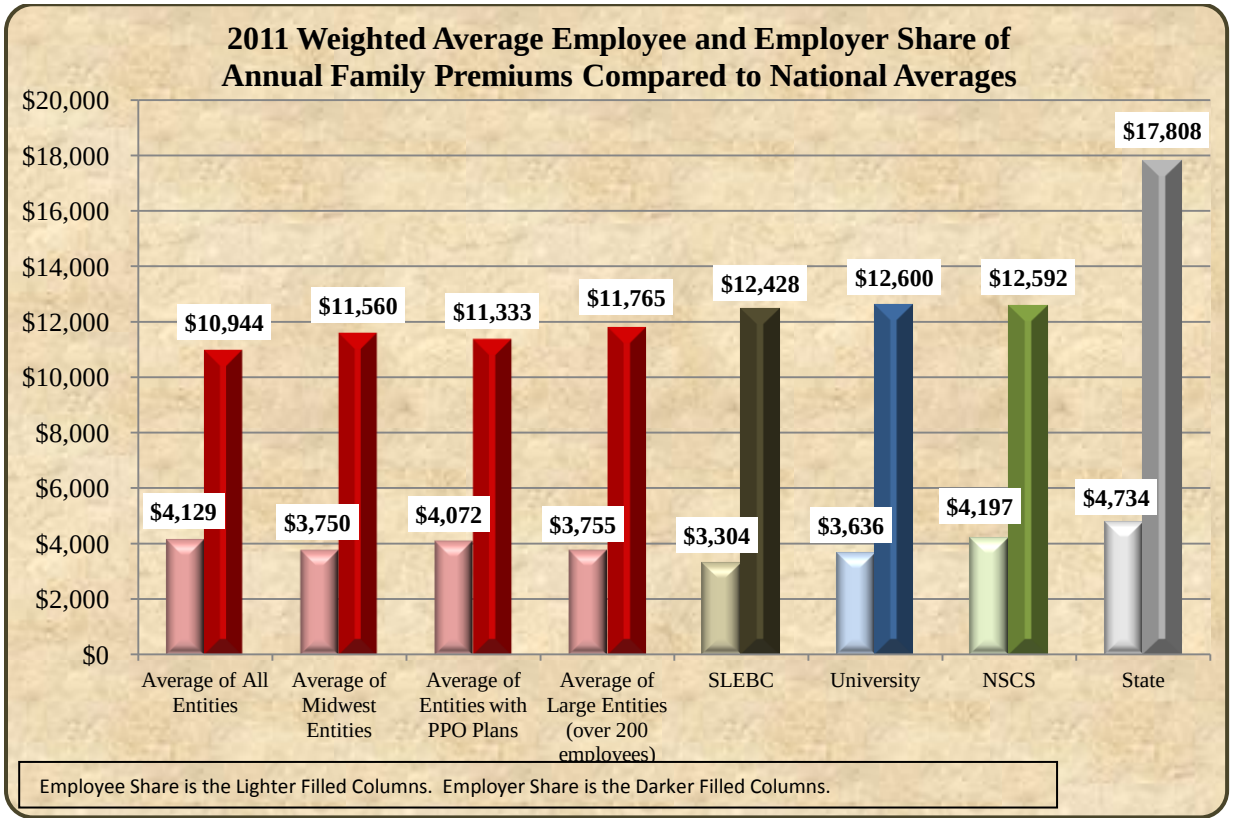
	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011
State	$6,748	$9,813	$11,211	$11,273	$12,566	$13,018	$14,218	$17,342	$18,624	$21,440	$22,822	$24,673	$27,058
University	$3,767	$4,060	$5,616	$6,888	$7,980	$9,648	$11,112	$12,120	$12,408	$12,912	$14,040	$14,844	$16,032
NSCS		$6,928	$8,094	$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

As a result of this upward trend, by 2011, the annual cost of insurance under the Program was $27,058 per employee – almost $12,000 more than the national average. The graphs above were prepared using the most used plan by each entity.

As can be seen below, using the weighted average of all family plans for each entity, the State still has the most expensive premiums. Using the weighted average of all State family plan costs and number of employees enrolled in the plans, the $22,542 spent annually for premiums under the Program is exorbitant.



As mentioned already, the State pays 79% of total premium cost, while the employee pays the remaining 21% of the total premium cost under the Program. The following chart illustrates how poorly both shares of the premiums compare to corresponding premium amounts paid for state employee plans nationally.



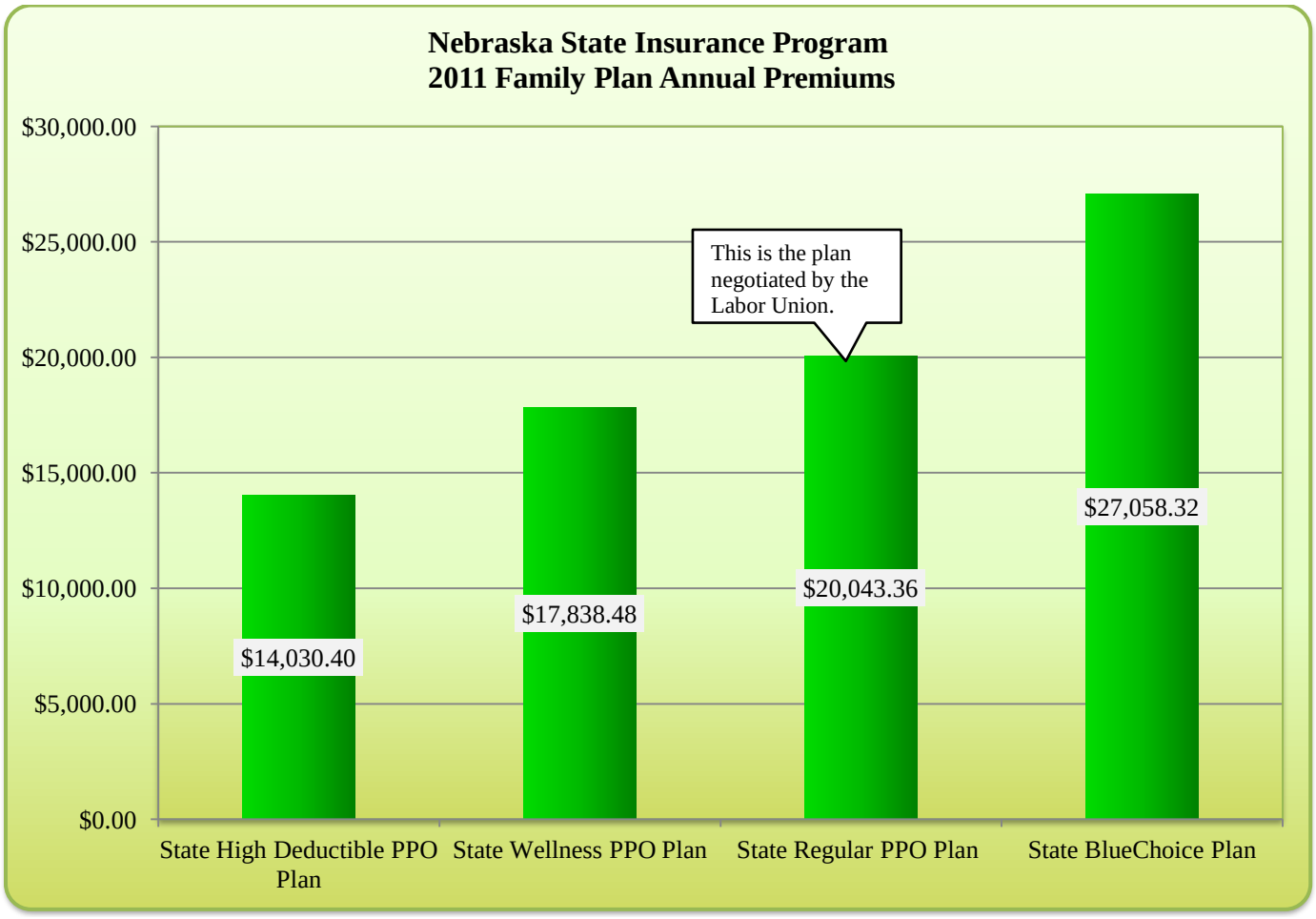
Reasons for Excessive Program Costs

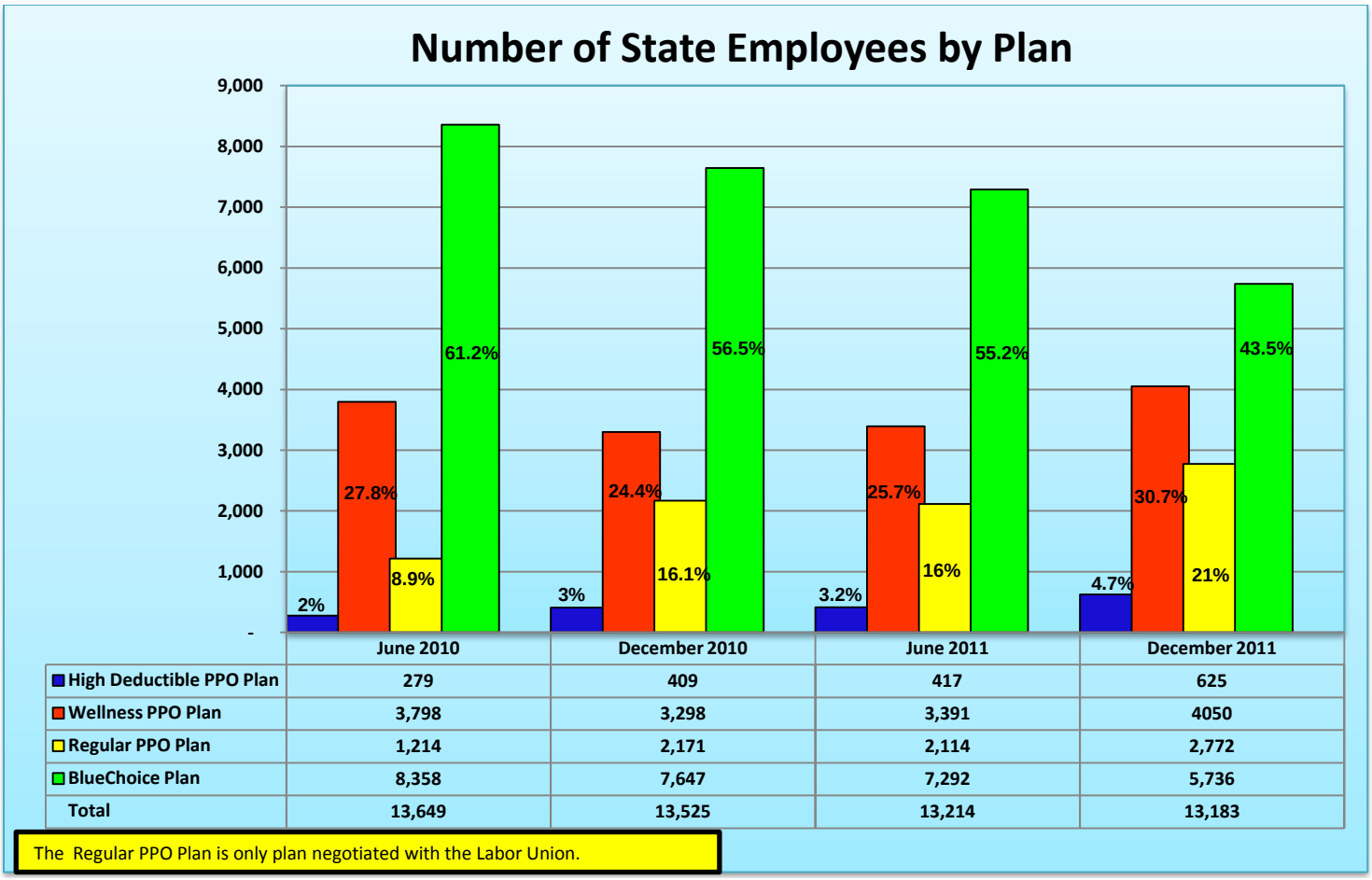
The audit reports provide detailed analyses of the causes for the curiously high costs of the Program. The complexity of the Program, involving many thousands of individual accounts with annual medical claims in excess of $150 million, requires strategic management practices. Those practices were found to be deficient in five key areas:

1) Inefficient Plan Design
2) Excessive Administrative Expenses
3) Unnecessary Stop Loss Insurance Coverage
4) Poor Program Monitoring and Control
5) Lack of Strategic Planning in Setting the Reserve Balances

1. Plan Design

The plan option used by the majority of Program participants is the option with the highest premiums.

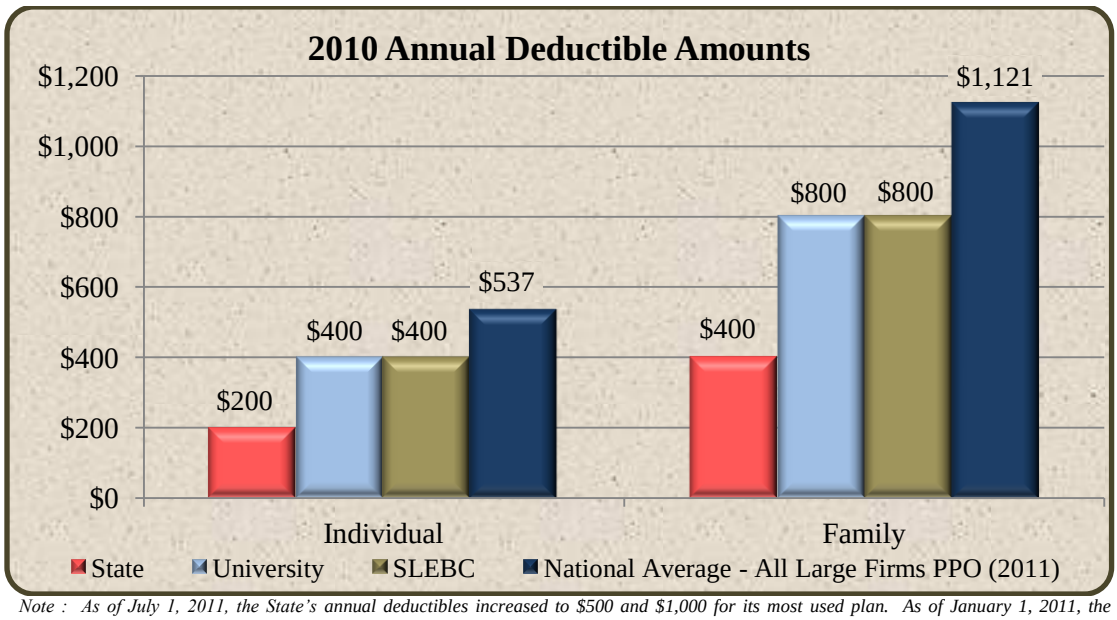




	June 2010	December 2010	June 2011	December 2011
High Deductible PPO Plan	279	409	417	625
Wellness PPO Plan	3,798	3,298	3,391	4050
Regular PPO Plan	1,214	2,171	2,114	2,772
BlueChoice Plan	8,358	7,647	7,292	5,736
Total	13,649	13,525	13,214	13,183

The Regular PPO Plan is only plan negotiated with the Labor Union.

All of the State's plans rely primarily upon the use of copayments for most services, including office visits, well baby exams, annual exams, urgent care, and hospital emergency room services. The University, on the other hand, requires higher deductibles to be met for most services before a coinsurance amount is utilized. The chart below provides a comparison of the deductible amounts charged by each entity's most used plan.



Note : 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.

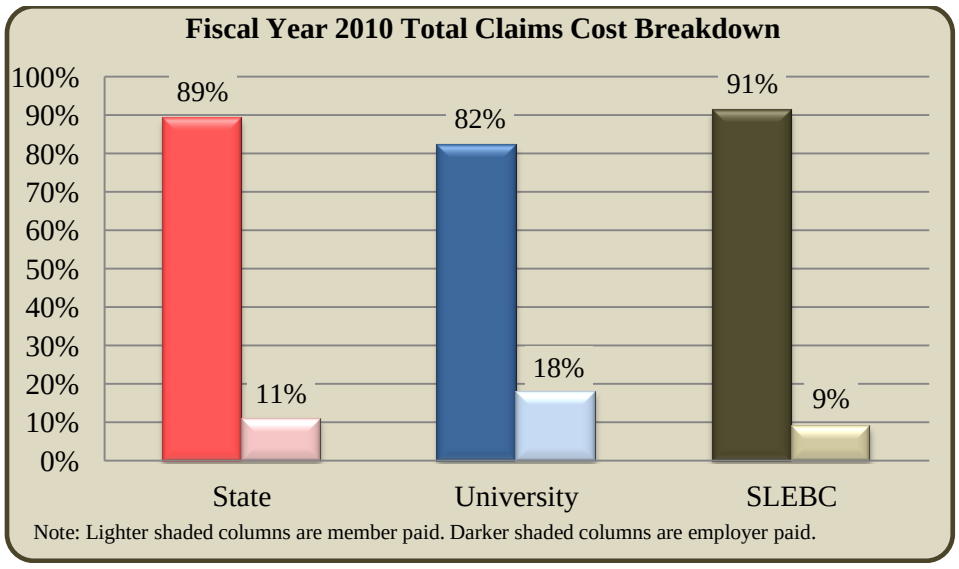
The deductible amounts charged by all three of Nebraska's different insurance plans for State employees were considerably smaller than the national average. However, the Program's charges are, by far, the smallest deductible of all.

Additionally, the various plans require different copayment and coinsurance amounts, as seen below for 2010, using an office visit as an example.

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: 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.

Due to these plan design differences, the University paid only 82% of its total claims costs for 2010, while the State paid 89% of its total claims costs for that same year.

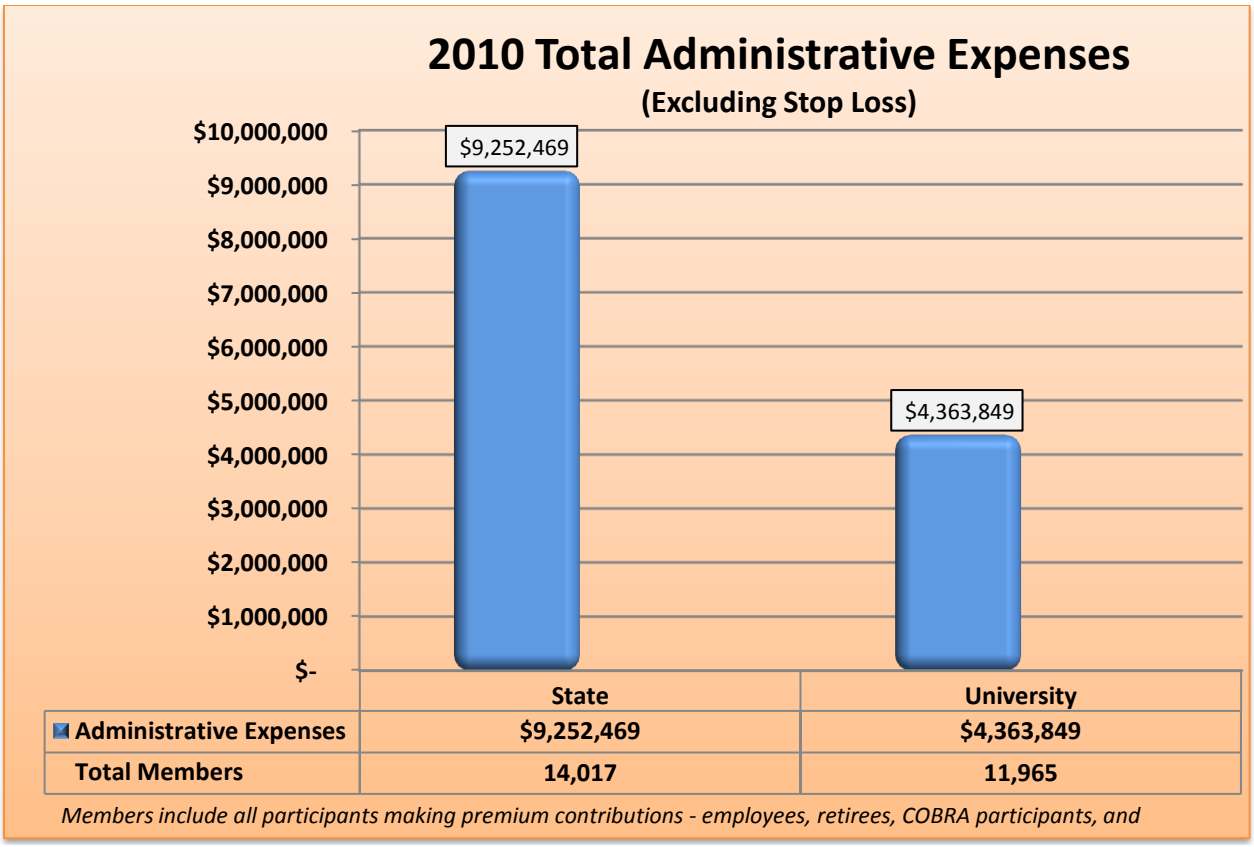


If, like the University plan, the Program paid only 82% of the total claims cost, as opposed to the current 89%, the State would have paid an estimated $9 million less than what was actually paid in fiscal year 2010.

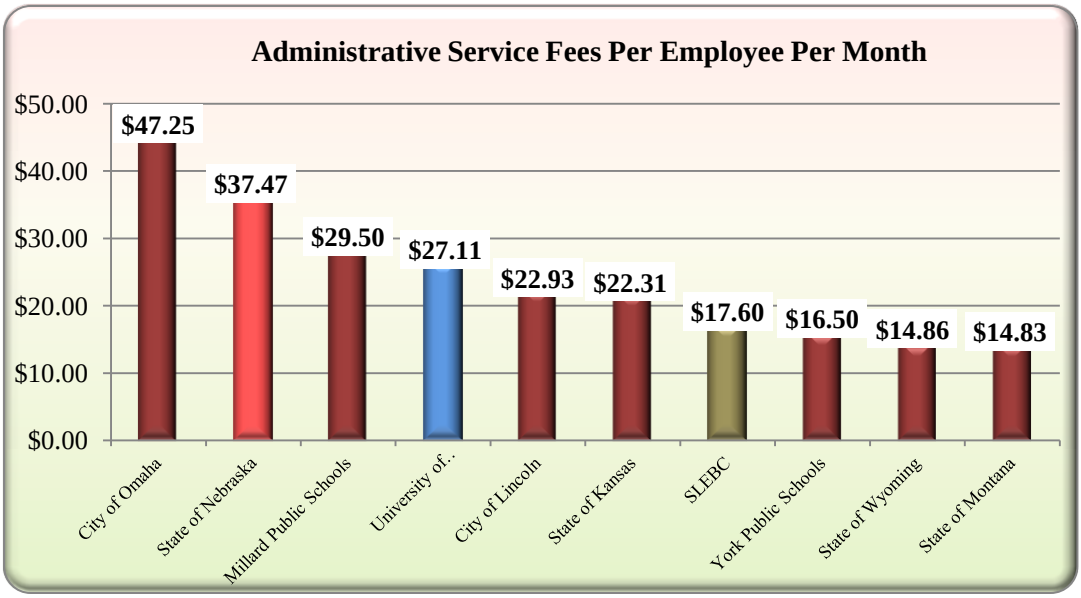
2. Administrative Expenses

In addition to paying the cost of claims incurred, premiums collected for a self-insured plan, such as the Program, must also cover administrative expenses. The greatest of those Program expenses is the cost of the third-party administrative services provided by BlueCross BlueShield of Nebraska (BCBSNE).

The charts below reveal that, when stop loss insurance expenses are not included, the administrative costs of the Program have far exceeded those of the other self-insured State employee plans in Nebraska. Per member, in 2010, the Program paid almost twice as much as expended by the University for administrative services.



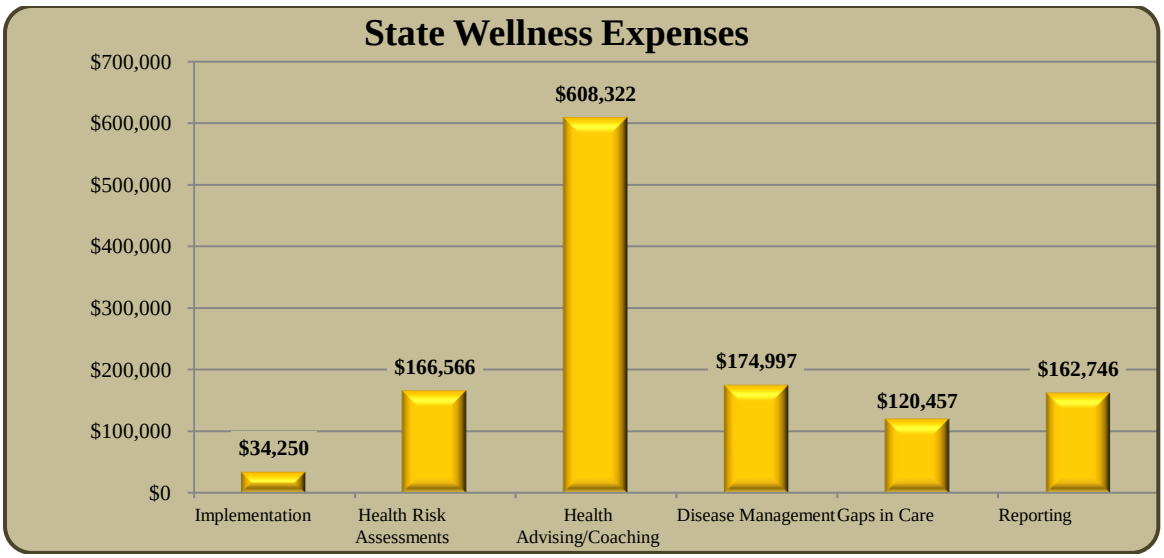
The overall administrative costs are largely the result of the "per member/employee per month" (PEPM) administrative fee negotiated with the third party administrator. In 2010, the PEPM costs for the Program were considerably more expensive than those paid by the other Nebraska plans. More revealing yet is the following chart, which illustrates that the PEPM fee paid for the Program is also more expensive than that charged for employee insurance plans provided by a variety of larger political subdivisions in Nebraska, as well as by other states. Especially noteworthy is the fact that both Wyoming and Montana pay a PEPM fee less than half that agreed to for the Program.



Despite engaging in a competitive bidding process to secure its vendor, the State does not appear to have secured a competitive PEPM rate from its medical third party administrator, which contributes to the excess of overall costs.

Wellness Program

The Program has recently implemented a "wellness program" aimed at combating serious health concerns, such as high blood pressure, high cholesterol, diabetes, etc. The wellness program includes a variety of services – all of which, as shown in the chart below, are provided at considerable expense.



Needless to say, the costs associated with the wellness program have significantly increased the Program's overall administrative expenses. For 2010 alone, the wellness program added an additional $1,267,338 to the Program's budget. Nevertheless, DAS has not performed a cost-benefit analysis to ensure that the added expense of the wellness program is proving worthwhile.

Actuarial / Consulting Expenses

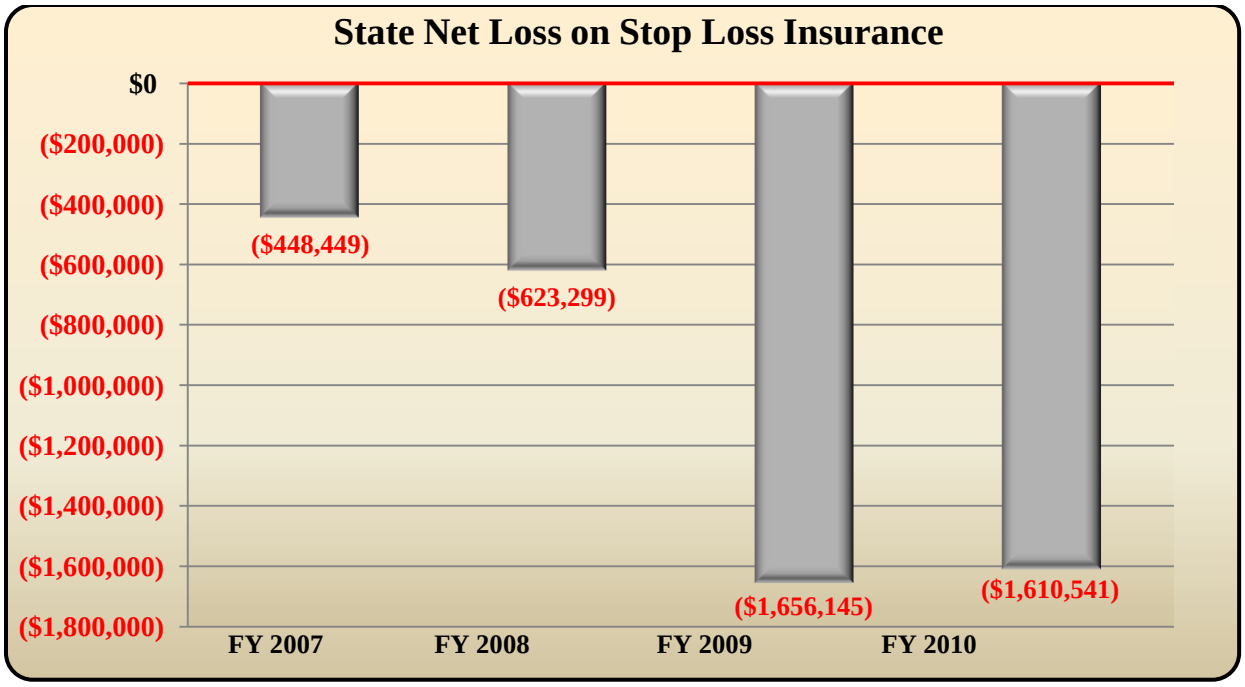
In 2010, the Program paid $387,397 for actuarial services – more than 40 times as much as the $9,462 that the University expended to obtain similar actuarial services for its own comparably-sized employee insurance plan.

DAS's only explanation for the enormity of the Program's actuarial/consulting costs was the implementation of the wellness plan.

3. Stop Loss Insurance Costs

The Program has obtained stop loss insurance to reduce the risk posed by significant claims payments for any one individual. Due to the size of the Program's reserve fund, however, the necessity of such insurance is questionable. In fact, the nearly $65 million reserve at June 30, 2011, was enough to cover more than 5 months of claims expenses, based on past claim experience.

More importantly, because the expense of such supplementary coverage has far outweighed any return realized from it, the purchase of the stop loss insurance has resulted in a series of annual net losses for the Program, ranging from $448,449 in 2007 to $1,610,541 in 2010.



As the chart reveals, between 2007 and 2010, the aggregate cost of purchasing stop loss insurance was nearly $4.5 million more than the total reimbursement received from that supplementary coverage during the same period of time. Despite the loss of millions of dollars as calculated by the APA, DAS has not performed an analysis to determine whether stop loss insurance has been cost beneficial to the State.

4. Program Monitoring and Control

Because the Program is self-insured, and State funds are used to pay both claims expenses and administrative costs not covered by the employee share of annual premiums, significant oversight and monitoring is required on the part of DAS to ensure the propriety of all expenditures. The audit work revealed, however, that a lack of such oversight and monitoring has resulted in a number of costly errors to the Program.

The APA noted a total of $1,177,050 in questionable or unallowable claims between July 1, 2009, and June 30, 2010.

Description	Amount
Ineligible/No Premiums Paid at Time of Claims, etc.	$ 492,725
Unsupported/Undocumented Claims Paid	$ 431,594
Duplicate Claims Paid	$ 66,573
Ancillary Member Claims Paid	$ 147,503
Ineligible Participant Claims Paid	$ 38,655
Total Questionable/Unallowable Claims Paid	**$ 1,177,050**

Ineligible / Unsupportable Claims

To start, improper monitoring by DAS was responsible, in fiscal year 2010 alone, for the payment of $492,725 in ineligible medical and prescription claims. The majority of these claims were for members who had not paid premiums in the month the claim occurred. For example, terminated employees were filling and receiving prescriptions after their termination date.

Additionally, there were $431,594 in unsupportable claims and $66,573 in claims that were paid more than once.

In September 2011, some 17 months after the APA audit began, DAS had contracted with Aon Consulting, Inc., (Aon) to conduct a dependent eligibility audit costing $149,558. The Dependent Verification Final Results Summary, dated February 28, 2012, revealed 164 unverified dependents. The summary showed a first year savings of $574,587, based on the employer cost of the dependents (164 active dependents) per month ($367.96) less the audit cost. However, the audit did not report the cost of ineligible claims paid for all of the unverified dependents.

The testing performed by the APA and Aon represent two different types of eligibility audits. The APA tested to determine if premiums were paid in the month claims were incurred, while the Aon audit tested for legitimate/qualified dependents, such as the age of children and legal documentation of spouses.

Ancillary Group Participation

Program participants are required by law to be State employees who work a minimum of 20 hours per week. Nevertheless, DAS and the 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 included certain Nebraska State Employees Credit Union staff; the University ancillary groups include UNMC Physicians, Foundation and Alumni Association employees, and others.

As illustrated by the chart below, in 2010 alone, the State paid $147,502.51 in claims for five Credit Union employees, while premiums collected from these five employees amounted to only $62,175.84.

	Coverage Type	Annual Premium	Medical Claims	Prescription Claims	Total Claims Paid
Credit Union Employee 1	Employee + Children	$ 11,592.96	$ 63,881.65	$ 13,598.01	$ 77,479.66
Credit Union Employee 2	Employee	$ 5,644.08	$ 39,063.14	$ 1,969.10	$ 41,032.24
Credit Union Employee 3	Employee + Spouse	$ 14,979.60	$ 13,879.29	$ 4,036.52	$ 17,915.81
Credit Union Employee 4	Employee + Spouse	$ 14,979.60	$ 5,872.14	$ 5,038.19	$ 10,910.33
Credit Union Employee 5	Employee + Spouse	$ 14,979.60	$ 120.53	$ 43.94	$ 164.47
Totals		$ 62,175.84	$ 122,816.75	$ 24,685.76	$ 147,502.51

Because the Program is self-insured, and claims are paid with State funds, paying the claims of ineligible participants constitutes a misuse of taxpayer dollars, as the premiums collected for the non-state employees tested did not cover the claim costs incurred by them.

Ineligible Participant

In a particularly egregious example of ineffective oversight, DAS has permitted an inactive state employee, who has not worked for the State in the past 17 years, to continue receiving health insurance coverage through the Program.

Monthly premiums for the 17 years in which the inactive employee has continued to receive insurance coverage through the Program have exceeded $80,000, with the State paying 79% of the premiums and the former employee paying 21%. Additionally, according to the chart below, in 2010 alone, the State paid $32,217 in claims over and above the amount of any premiums received for the inactive employee.

Description	FY 2010 Amount
Premiums Contributed to Self-insured Plan	
Employee-Paid Share of Premium	$ 1,460
State-Paid Share of Premium	$ 5,491
Total Premium	$ 6,951
Claims and Expenses Paid from Self-insured Plan	
Medical Claims Paid	$ 34,411
Prescription Claims Paid	$ 4,244
Subtotal Claims Paid	$ 38,655
Administrative and Stop Loss Fees	$ 513
Total Claims and Expenses	$ 39,168
Excess of Claims and Expenses over Premiums	$ 32,217

Despite having been approved by a physician to return to work with certain restrictions in 1995, the inactive employee has made no effort to return to the agency. Rather, though claiming to be too incapacitated to perform any former duties, the employee has managed to enjoy extensive domestic and international travel. By the employee's own account, as of 2003, those excursions included no fewer than 8 ocean cruises and 58 airplane trips, as well as trips to 10 foreign countries, during the preceding four and-a-half years. Throughout this time, the State has never stopped paying, with taxpayer dollars, for that individual's health insurance and other benefits.

Aside from its underlying illegality, permitting the inactive employee to continue receiving benefits through the Program has resulted in a blatant and intentional misuse of taxpayer dollars.

Contract Amendments

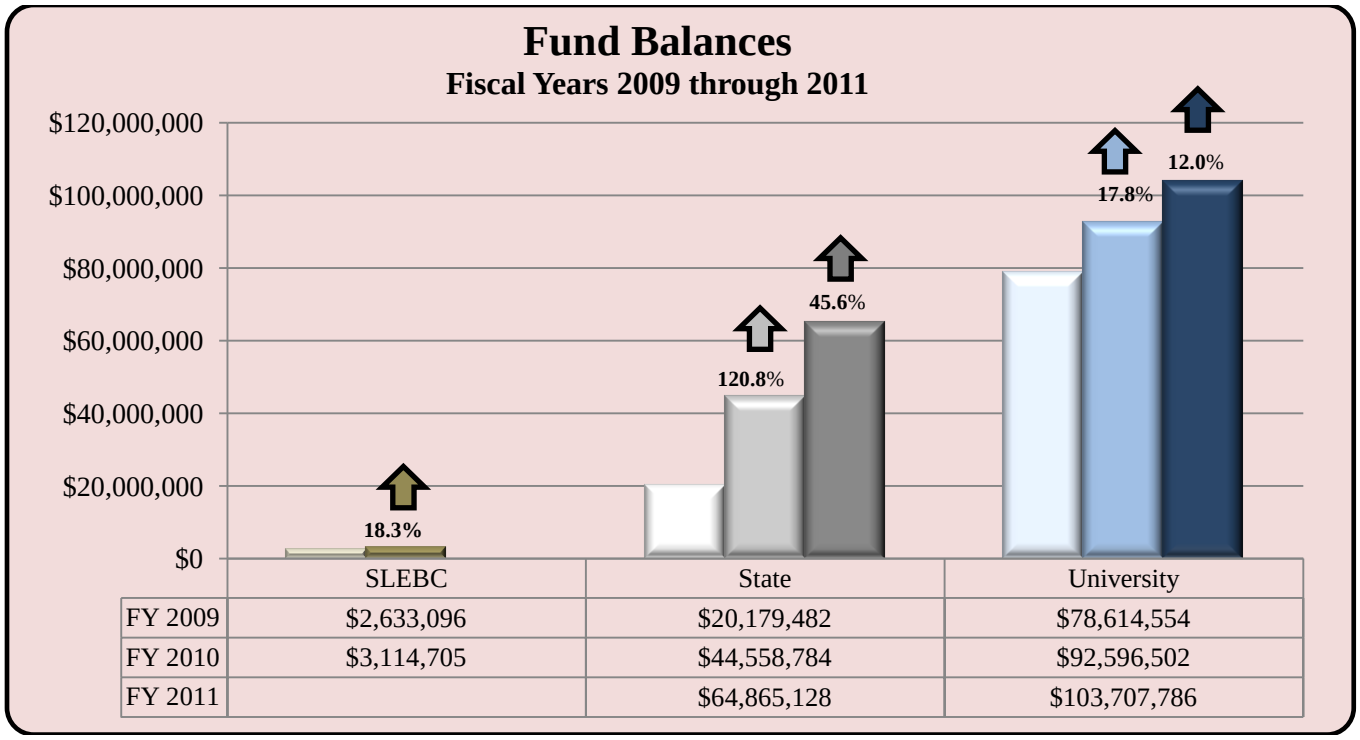
Several provider contracts entered into by DAS for the administration of the Program have been amended and/or extended a number of times without any sort of formal process or review to ensure that such revisions are cost efficient and the best use of taxpayer funds. Moreover, not all contract information was available in either the State accounting system or on the DAS website.

A 2007 contract entered into with Aon Consulting, Inc., for $247,707.75 offers an example of the primary concerns noted regarding the ad hoc amendment of provider contracts. Between 2007 and 2011, that contract was amended 13 separate times. These amendments entailed both the addition of specific duties and an increase of the State's expenditures by $1,135,561.85 – more than five times the cost of the original agreement. Such significant changes resulted in what was essentially a new contract, bearing little resemblance to the original. Because these additional services and expenditures were agreed upon without the benefit of any sort of formal bidding process, DAS has no way of knowing whether it would have been more economical to contract with other providers.

5. Reserve Fund Amounts

Typical of most self-insured insurance plans, the Program maintains a reserve fund to cover unexpected losses experienced when claims exceed premium contributions. Equaling almost $65 million, the Program's reserve fund has increased over 10 times the level of the fiscal year 2007 reserves – from $6,216,213 in June 2007 to $64,865,128 in June 2011.

The following chart illustrates the explosive growth of the Program's reserve fund compared to the reserve funds utilized by the University of Nebraska and SLEBC for their own self-funded insurance plans.



	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

Neither DAS nor the University has a formal policy for determining the appropriate amount to be maintained in their respective reserve funds. Likewise, there appears to be no industry standard for the ideal reserve fund balance. Based upon actuarial analysis performed during a 2011 study of the Utah Public Employees' Health Program, however, the Utah Office of Legislative Auditor General recommended that a reserve balance be maintained to cover between 1.68 and 2.8 months of claims.

The ten-fold increase in the Program's reserve fund balance over the past years has been due to an excess of premiums collected over the actual costs of claims and administrative expenses.

Decreasing the amount of the reserve fund balance would permit the Program to charge lower premiums, helping to bring costs more in line with those of other state employee insurance plans, both here in Nebraska and throughout the nation.

6. Transfer of General, Cash, and Reserve Funds

The reserve funds maintained by DAS are held, as directed by statute, in the State Employees Insurance Fund. At the end of fiscal year 2010, DAS transferred nearly $20 million out of that fund and into the Health History Fund – a separate fund lacking statutory basis and directive. At the time of that transfer, the Health History Fund was comprised of excess premium contributions to claims paid during the 18-month period from January 2008 through June 2009. In November 2011, DAS transferred another $25.8 million out of the State Employees Insurance Fund and into the Health History Fund.

By transferring a total $45.8 million in reserve funds out of the State Employees Insurance Fund, DAS tacitly acknowledged the excessiveness of its reserve amounts. No less important, such a transfer gives rise to a risk that funds moved to the Health History Fund, which is of a decidedly indeterminate nature, could be expended for purposes unrelated to health insurance claims and costs.

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 transfer of funds indicated that the taxpayers of Nebraska paid for excessive employer contributions for the State and University programs.

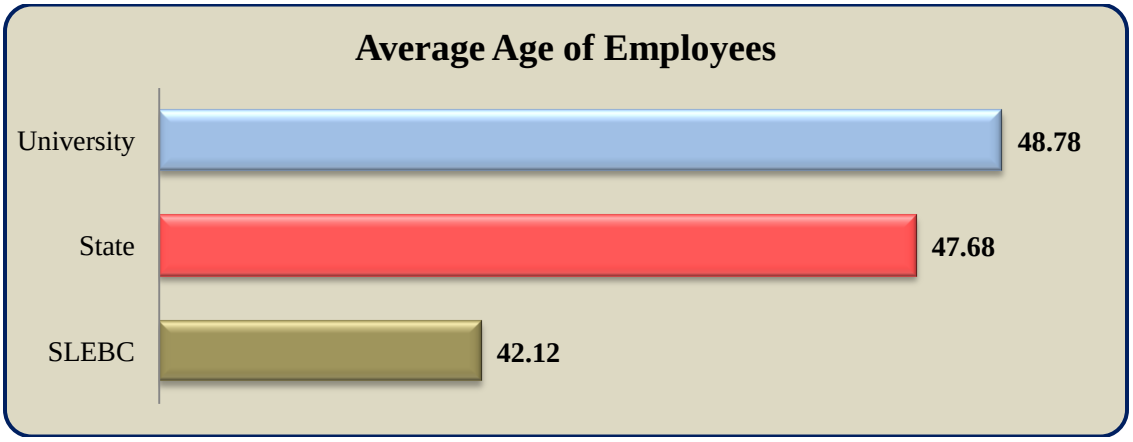
7. Factors Examined

Upon beginning the performance audit, the APA asked why Program premiums were higher. The following reasons were identified:

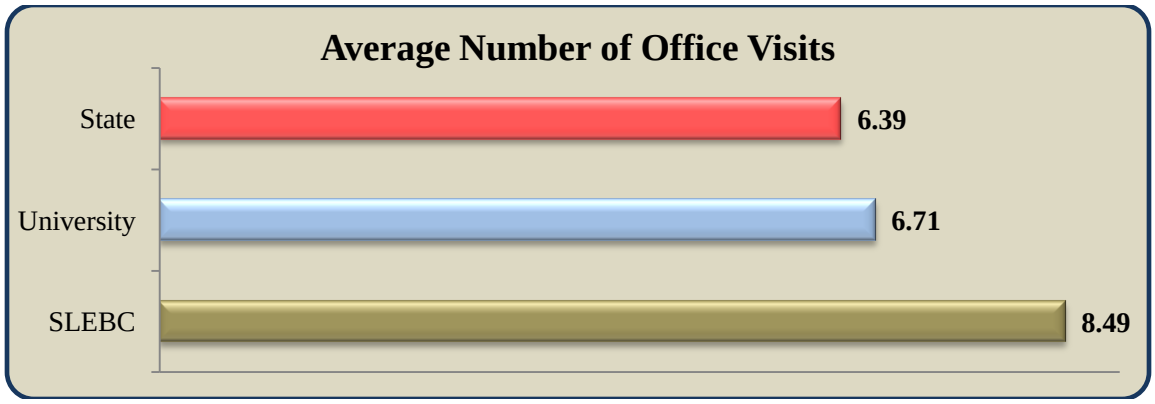
(1) State employees were older.
(2) State employees went to the doctor more often.
(3) The State's program covered procedures that other programs did not, such as bariatric surgery.
(4) One of the State's plans is negotiated with the Labor Union.

The APA calculated results follow:

As of June 2010, the State actually has a lower average age than the University.



During fiscal year 2010, 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.



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 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.

Finally, as noted in the charts under Plan Design above, the negotiated plan is not the most used plan and also is not the most expensive plan. As the chart illustrates, from 2010 to 2011, employees left both the BlueChoice and Wellness Plans and moved to either the Regular PPO or the High Deductible PPO Plan.

Summary

Given the nature of the audit findings discussed briefly herein, along with other findings of significance in both the financial and performance audit reports, it is apparent that the Program lacks the type of thorough and careful management required of a self-insured insurance plan – especially, one in which taxpayer dollars are at stake. "Unlike a fully insured plan, the Program is responsible for both paying its own claims and all attendant operational expenses," explained Foley. "It seems evident," Foley continued, "that DAS has not exercised the level of administrative care required to ensure that taxpayer dollars are not wasted, and the State is getting the most for its money in providing a self-insured employee health insurance plan."

By choosing to implement a self-insured Program, DAS necessarily assumes the responsibility of managing it effectively, even when utilizing the services of a third party administrator. DAS has failed to implement and maintain the financial reporting and operational controls required to ensure the Program's financial integrity

Although both reports call for stricter administrative control over the Program, the performance audit report concludes by urging the Legislature to consider, in light of the findings presented, whether the Program should continue as a self-insured plan or become fully insured. The report advocates also for the creation of an insurance/benefits committee, comprised of health insurance professionals and appropriate staffing, to assist in the decision making, monitoring, and oversight of the Program.

All of the health insurance audit reports are available in their entirety on the APA's web site at http://www.auditors.state.ne.us/.