ATTESTATION REPORT
OF THE
UNIVERSITY OF NEBRASKA
HEALTH INSURANCE PROGRAM

JULY 1, 2009 THROUGH JUNE 30, 2010

Issued on March 29, 2012

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UNIVERSITY OF NEBRASKA HEALTH INSURANCE PROGRAM

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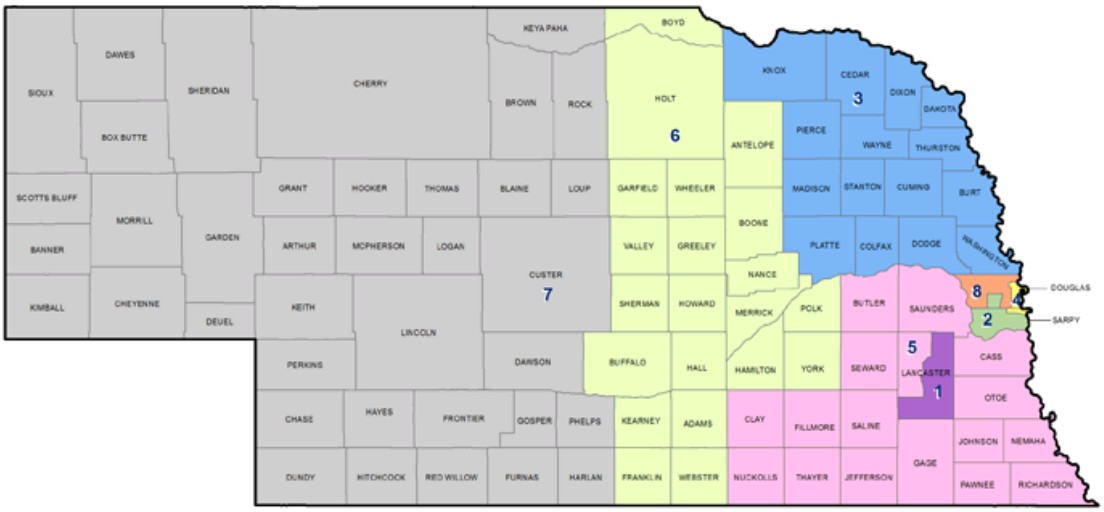
UNIVERSITY OF NEBRASKA HEALTH INSURANCE PROGRAM

BACKGROUND

Program History

Founded in 1869, the University of Nebraska system (University) is the public university system for the State of Nebraska. The University began with one campus in Lincoln – the University of Nebraska-Lincoln (UNL) but, over a century, added four more campuses: the University of Nebraska Medical Center (UNMC), located in Omaha, which joined in 1902; the University of Nebraska at Omaha (UNO), which joined in 1968; the University of Nebraska at Kearney (UNK), which joined in 1991; and the Nebraska College of Technical Agriculture, located in Curtis, which was established in 1965.

Pursuant to both Article VII, Section 10, of the Nebraska Constitution and Neb. Rev. Stat. § 85-103 (Reissue 2008), the University operates under the direction of the Board of Regents (Regents). Section 85-103 requires there to be eight Regents, all of whom are elected from the geographical regions specified in Neb. Rev. Stat. § 32-510 (Reissue 2008). Below is the present district map for the Regents:



As of January 27, 2012, the eight Regents are as follows:

Office	Name
District 1	Timothy Clare (Vice Chairman)
District 2	Howard Hawks
District 3	Chuck Hassebrook
District 4	Bob Whitehouse
District 5	Jim McClurg (Chairman)
District 6	Kent Schroeder
District 7	Bob Phares
District 8	Randolph Ferlic

BACKGROUND
(Continued)

In addition to the eight voting members listed above, the Regents also include four non-voting student members, one from each campus, and a corporation secretary responsible for managing all records, including agendas, minutes, notices, policies and bylaws.

The powers of the Regents are set out in Neb. Rev. Stat. § 85-106 (Reissue 2008). Specifically, § 85-106(6) authorizes the Regents "[t]o equalize and provide for uniform benefits for all present and future employees, including group life insurance, group hospital-medical insurance, group long-term disability income insurance, and retirement benefits[.]"

The University is specifically excluded from joining the Nebraska State Insurance Program by Neb. Rev. Stat. § 84-1601(1) (Reissue 2008), which states, "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 University of Nebraska Health Insurance Program (Program) is provided for under the University's NUFlex program, which includes medical, prescription, dental, and vision insurance, among others. The Auditor of Public Accounts (APA) reviewed only the medical and prescription coverages.

The Program offers four types of coverage options: 1) single membership, which provides coverage for the employee alone; 2) subscriber-spouse membership, which provides coverage for the employee and spouse; 3) single parent membership, which provides coverage for the employee and eligible dependent children; and 4) family membership, which provides coverage for the employee, spouse, and eligible dependent children.

The eligibility requirements for faculty and staff can be found in the on-line version of the University's "Medical Insurance Benefits Overview" at http://www.nebraska.edu/docs/benefits/benefits_medical.pdf. The January 1, 2010, version of that document stated, "Faculty and Staff are eligible for group medical insurance coverage if they are employed in a 'Regular' position with an FTE [full-time equivalent] of .5 or greater or employed in a 'Temporary' position for more than 6 months with an FTE of .5 or greater."

That same document defined eligible dependents as follows:

Spouse

- Husband or wife, as recognized under the laws of the State of Nebraska.
- Common-law spouse if the common-law marriage was contracted in a jurisdiction recognizing common-law marriage.

Child

- Natural-born or legally adopted child who has not reached the limiting age of 19.
- Stepchild who has not reached the limiting age of 19.
- Child for whom the employee has legal guardianship and who has not reached the limiting age of 19.

BACKGROUND
(Continued)

- Child with a mental or physical disability who has attained the limiting age of 19 may continue coverage beyond age 19 if proof of disability is provided within 31 days of attaining age 19.

Student (ages 19 through 23)

- Unmarried, dependent child who has not reached the limiting age of 24 and is a full-time student.
- Dependent child who is a student also must receive over half of their financial support from the employee.

According to Board of Regents Policy (RP) 3.2.3 (amended October 19, 2001), participation in the Program is also open to "persons representing groups or organizations ancillary to the University[.]" Though stating that "[n]o University of Nebraska contribution to any such person's premium cost will be made," the policy extends employee health insurance coverage to the following individuals:

> *"[M]embers and former members of the Board of Regents, and full-time employees of the University of Nebraska-Lincoln Alumni Association, the University of Nebraska at Kearney Alumni Association, the University of Nebraska at Omaha Alumni Association, the University of Nebraska Medical Center Alumni Association, the University of Nebraska Medical Center Hospital Association, the University of Nebraska Foundation, Nebraska Specific Pathogen Free Swine Accrediting Agency, Nebraska Crop Improvement Association, Nebraska Pork Producers Association, the UNL Federal Credit Union, the UNMC Credit Union, the Nebraska 4-H Development Foundation, Lab Interlink, Ximer[e]x, Inc, UNeMed Corporation, University Medical Associates, and Museum of Nebraska Art, Inc."*

The University of Nebraska also provides medical, dental, and University health center pharmacy coverage for graduate students. According to the Office of Graduate Studies website at http://www.unl.edu/gradstudies/current/health-faq.shtml, graduate assistants will contribute about 21% of the total annual cost, leaving 79% for the University's share of the premiums. The coverage is provided by Aetna Student Health. As the graduate student insurance plan is separate from the Program, the APA did not include this plan within our testing.

The Program is self-insured, which means that the employer – in this case, the University – assumes the major cost of health insurance for participants. The University, through its Trust Fund, pays the majority of the claims incurred by plan participants through the collection of premiums from its employees, as well as from other public funds, such as the University's share of the premium. Premiums are set to cover the claims incurred by participants and to help fund a reserve.

BACKGROUND
(Continued)

Program Administration

The Board of Regents Bylaws, Section 6.4 (amended December 10, 1994) states, in relevant part:

> *"The Board may authorize the President, or administrative officers and professional staff employees designated by the President, to approve and execute certain contracts without Board approval. The exact types of contracts that the President or his or her designees may approve and execute shall be determined by written policy of the Board."*

RP 6.3.1 (amended December 2, 2010) grants the President authority to approve and execute contracts pursuant to Section 6.4 of the Bylaws noted above. Specifically, RP 6.3.1(4)(a) allows the President to approve and execute the following type of contract:

> *"Any contract for the procurement of services or non-capital goods used in the regular course of business in operation of the University."*

Section 5 of RP 6.3.1 authorizes the President to delegate the approval and execution of contracts as follows:

> *"The President may from time to time delegate all or any part of his or her authority to approve and execute contracts, as specified above in Section 4 of this policy, to such other administrative officers and professional staff employees of the University as the President shall determine will provide for the most efficient conduct of the University business affairs. Any such delegation of authority shall be made in writing, signed by the President, and a copy of each written delegation shall be maintained on file as a matter of public record in the office of the Corporation Secretary. Such delegations shall be reported to the Audit Committee of the Board of Regents at their first meeting of each calendar year."*

The President has delegated his authority to approve and execute certain contracts to the Vice President for Business and Finance, whose office has broad responsibilities in the areas of university-wide accounting and finance, budget and planning, internal audit, endowments and investments, facilities planning and management, human resources and benefits, administrative computing, and risk management. As such, the Vice President for Business and Finance is responsible for approving and executing the medical and prescription agreements. Although the administration of the Program is handled centrally, each of the four campuses has a separate benefits office. These offices handle the day-to-day benefits of each campus, including collecting ancillary, COBRA, or retiree payments. Key employees of the Program include:

Name	**Title**
David Lechner	*Vice President for Business and Finance*
Keith Dietze	*Director of University-wide Benefits*
Greg Clayton	*UNL Benefits Manager*
Esther Scarpello	*UNO Benefits Manager*
Joanne Watkins	*UNMC Benefits Specialist*
Linda Clark	*UNK Benefits Manager*

BACKGROUND
(Continued)

The University has also set up a fringe benefit committee, which is made up of representatives from each of the campuses. The committee discusses what benefits to include or exclude; however, it lacks decision-making authority and is not involved with setting the premium amounts.

University's Group Health Trust Fund

The University does not record the daily health insurance financial transactions through its own accounting system or deposit the funds in the State's bank accounts. A separate trust fund is used to record the financial activity of the Program, including premium contributions and claims paid. This separate fund is referred to throughout this report as the University's health insurance trust fund or trust fund.

Many years ago, the University gave authority for Blue Cross Blue Shield of Nebraska (BCBSNE) and CaremarkPCS Health, L.L.C. (Caremark) to withdraw payments directly from the trust fund, without express University approval for each transaction. BCBSNE and Caremark draw on this trust fund every few days to pay for medical and prescription claims incurred. None of these individual transactions are recorded in the University's accounting system; rather, an entry is made once per year to record the annual activity of this trust fund. The following is a brief history of the University's balance for this separate trust fund:

	FY 2009	FY 2010	FY 2011
Beginning Fund Balance	$ 74,804,412	$ 78,614,554	$ 92,596,502
Change	$ 3,810,142	$ 13,981,948	$ 11,111,284
Ending Fund Balance	$ 78,614,554	$ 92,596,502	$ 103,707,786

Contracts

The University is ultimately responsible for the approval of premiums and any plan design changes; however, several contracts are utilized for the administration of the Program. These contracts are negotiated by the Director and signed by the Vice President for Business and Finance. The following is a summary of the significant contracts and/or agreements entered into by the University as well as the amounts paid with health insurance funds during fiscal year 2010 for the contracted services:

Contract Vendor	Contract Description	Amount (1)
BCBSNE	Provides complete administrative and support services for medical claims. BCBSNE acts as the third party administrator, receiving and processing medical claims for a fee; however, claims are paid by the University's Trust Fund. For calendar year 2010, the University was charged $27.11 per employee per month for this service. According to the Vice President for Business and Finance, bid proposals were last requested in 1996, for the contract period beginning January 1, 1997.	$ 3,972,824

BACKGROUND
(Continued)

Contract Vendor	Contract Description	Amount (1)
Employers Health Purchasing Corporation of Ohio (EHPCO)	EHPCO is a national coalition of employers seeking to cut costs of pharmacy and other services by leveraging their collective size and resources. The University has been a member of EHPCO since January 1, 2008. EHPCO provides the bidding of prescription-related contracts and also provides audits of the pharmacy provider (Caremark) related to pricing, rebates, and performance guarantees. The University agreement with EHPCO is part of the Prescription Benefit Services Agreement between Caremark and EHPCO. For contract and administrative services, the agreement requires Caremark to pay EHPCO an annual fee of up to $75,000, in addition to a monthly fee of the greater of $0.45 per claim or $0.90 per mail claim and $0.25 per retail claim, effective January 1, 2010, through December 31, 2010.	$ 12,000
Caremark	Caremark acts as the third party administrator, receiving and processing pharmaceutical claims; however, claims are paid by the University's Trust Fund. The Prescription Benefit Services Agreement is between Caremark and EHPCO, where Caremark provides complete administrative and support services for pharmaceutical claims. The University is not involved in the bidding process. From January 2008 to December 2009, Caremark received its fee for providing these services in the form of manufacturers' drug rebates. In the pricing option selected by the University, Caremark retained 100% of the drug rebates received from manufacturers. No administrative fee was charged to the University. As of January 1, 2010, the University changed the pricing option under the Caremark agreement so that the University receives 95% of the drug rebates, while Caremark retained 5%. Because the University selected this pricing option, the discounts on the drug costs were reduced. Again, under this option, no administrative fee was charged to the University. Under either option, it is impossible for the APA or the University to know the dollar amount Caremark actually charged for administering the pharmaceutical services.	N/A
Milliman	Provides professional consulting and actuarial services, including detailed analysis of costs and contributions. These services have been provided for ten years; however, there is no formal contract between the two parties.	$ 9,462
Chapman Kelly (2)	The University contracted with Chapman Kelly to perform a dependent verification audit to determine if dependents enrolled in the Program were eligible for coverage. The contract was signed June 13, 2010.	$ 0

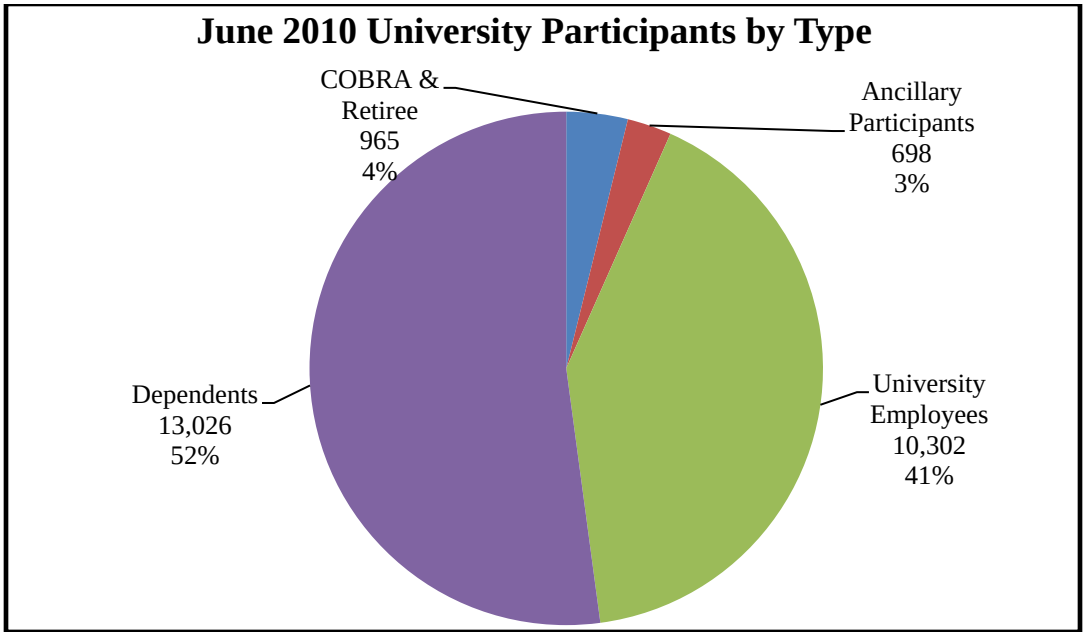
(1) Amounts paid do not include claims paid by the University's Trust Fund. The purpose is to show the cost charged for these services.
(2) All payments to Chapman Kelly were made after the fiscal year ended June 30, 2010. The University agreed to pay $91,100 for up to 13,300 dependents and $6.45 per dependent in excess of 13,300 for these services.

Stop loss insurance is a form of reinsurance for self-insured employers that helps limit the amount paid for each participant's health care costs. The University has made the decision not to purchase separate stop loss coverage for its participants. 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."

Claims Information

The Program covers employees, retirees, COBRA participants, ancillary members, and dependents. An enrollment file dated June 27, 2010, was provided to the APA and indicated the total number of participants in the Program was 24,991, as illustrated in the chart below.

BACKGROUND
(Continued)



Source: The APA obtained the employees and dependents figures from the enrollment file run by the University on June 27, 2010. This enrollment file is run weekly and is used to provide BCBSNE and Caremark a listing of eligible participants at a given point in time, not throughout the entire fiscal year. The COBRA and retiree and ancillary participant figures were obtained from other listings provided by the University.

The APA initially requested the complete detailed claims files from the University as part of a performance audit authorized by the Legislative Performance Audit Committee (Committee). The APA agreed to accept more limited claims data in order to expedite completion of the performance audit of the State's health insurance plans. See Comment Number 1 for more details regarding the delays and lack of cooperation by the University. Finally, on April 8, 2011, the APA received this limited claims data from the University.

Unfortunately, the limited nature of the information received prevented the APA from presenting University data comparable to that provided in the State and SLEBC financial audits. For instance, the detailed medical claims data received did not contain dates of birth for Program participants. Additionally, the information given to the APA lacked the names of each participant. Because the names were excluded, the APA requested a unique identifier that would be the same on both the medical and prescription claims data in order to combine and report on the total claims per participant. However, the University failed to provide the same unique number to identify employees on both the medical and prescription claim files. Therefore, the APA is unable to present the combined medical and prescription claim numbers and amounts filed by age range, the top 10 participants by total claims paid, and a summary of the claims by dollar range, including the number of households with a claim processed for the Program.

BACKGROUND
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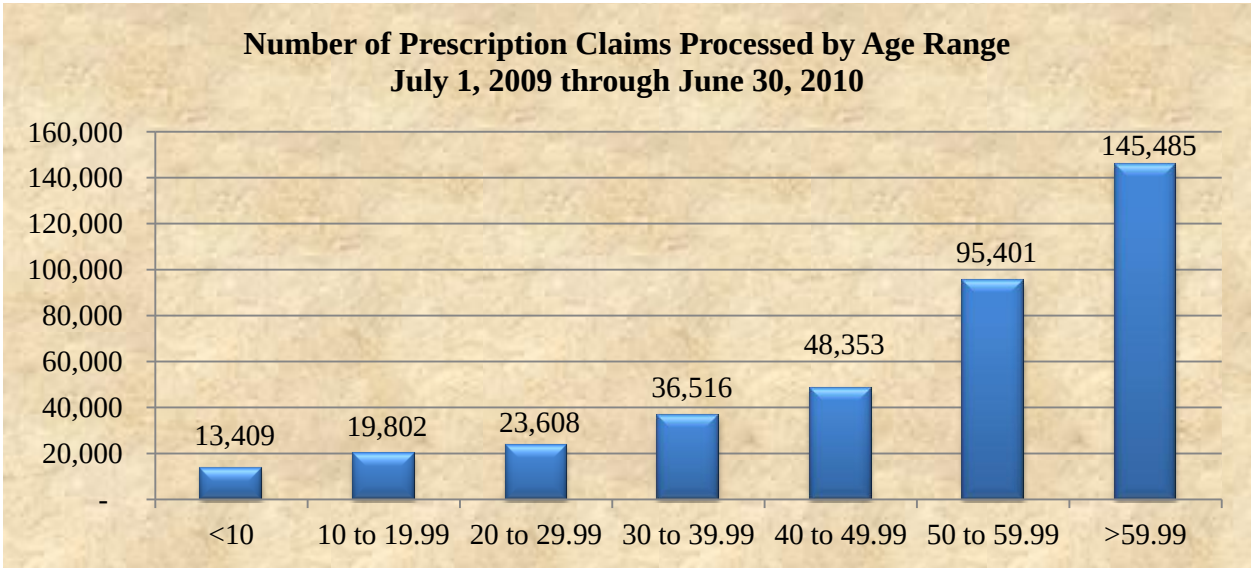
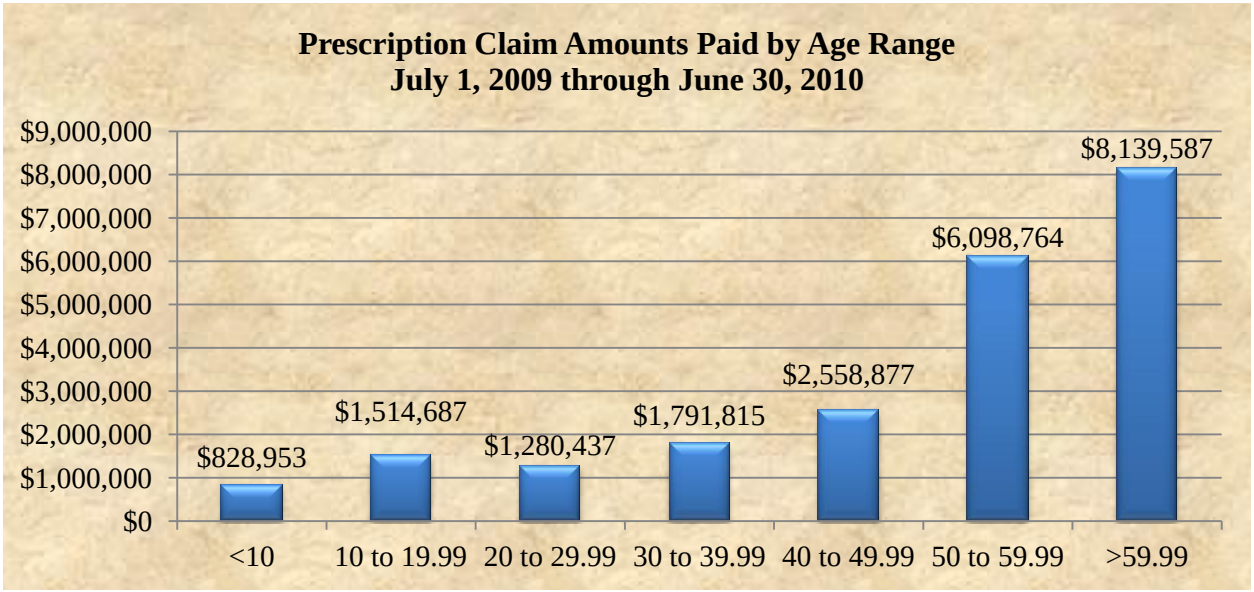
The prescription data provided by the University included the dates of birth of the Program participants, so the APA is able to present the number and amount of claims processed per age. Again, this is only for the prescription data, not medical claims.



Based on the enrollment files obtained from the University, and other information provided by the University, the APA determined the average age of the members in the Program (excluding dependents) is 48.78 years.



BACKGROUND
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The largest amount of prescription claims paid is for individuals over 59.99 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.

According to claims data that was provided to the APA, the total amount of medical and prescription claims paid by the University for the fiscal year was $98,178,156.

Claim Type	Amount
Medical	$ 75,965,035
Prescription	$ 22,213,121
Total	$ 98,178,156

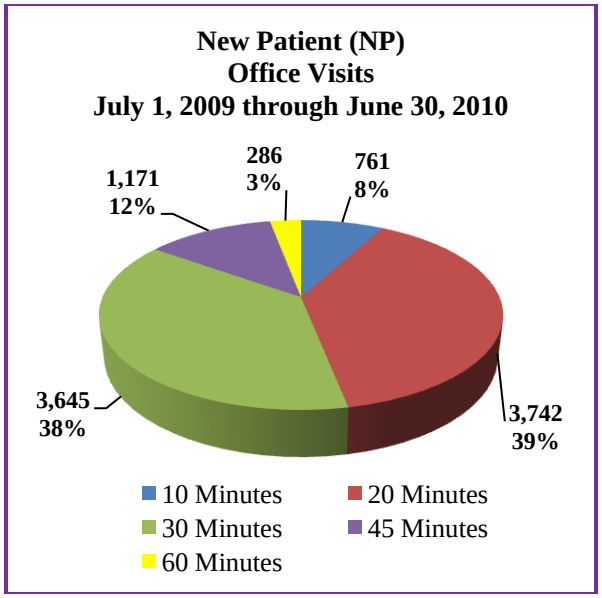
Note: The total amount of claims paid noted above does not agree to the claims paid per the Schedule of Revenues, Expenditures, and Changes in Fund Balance, as it does not include $6,404,303 in dental claims paid and other additional optional services totaling $672,296. The optional services were not broken out separately from the medical and prescription claims paid in the University's trust statements.

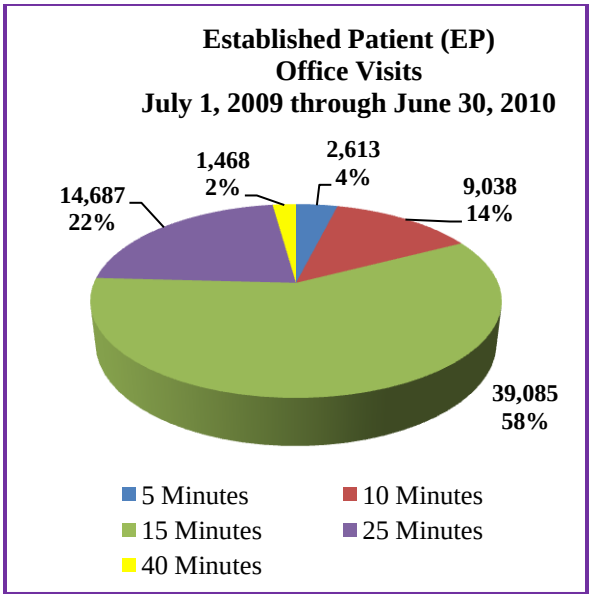
From the June 27, 2010, enrollment files, the APA calculated that there were 11,399 participating households in the Program, resulting in an estimated average claim cost of $8,612.87 per household.

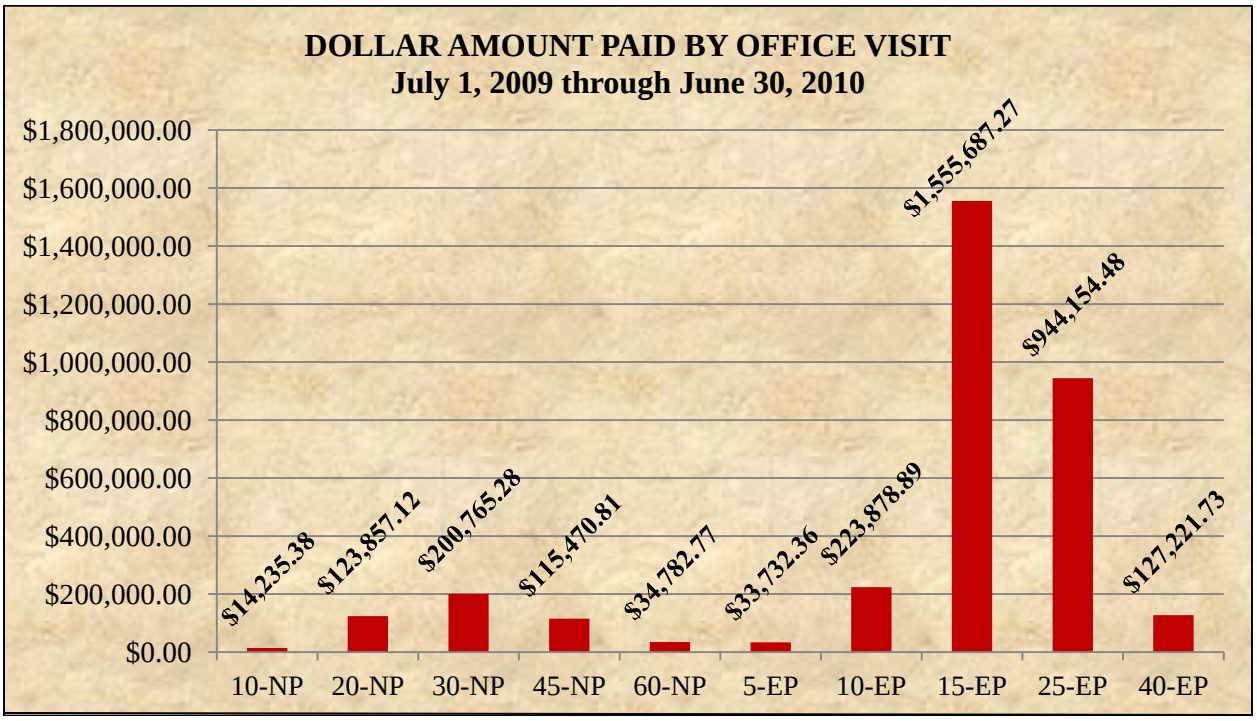
The 11,399 contributing households also averaged 6.71 office visits per year, for an average cost to the Program of $295.97 per visit. The following tables and graphs offer the details of doctor office visits for the period July 1, 2009, through June 30, 2010. The minutes refer to the amount of face-to-face time the physician spent with the patient and/or family. Included are the numbers of visits as well as the total amounts paid for each type of visit.

Office Visit Description	New or Established	Office Visits	Amount Paid
10 Minutes	New Patient (NP)	761	$ 14,235.38
20 Minutes	New Patient	3,742	$ 123,857.12
30 Minutes	New Patient	3,645	$ 200,765.28
45 Minutes	New Patient	1,171	$ 115,470.81
60 Minutes	New Patient	286	$ 34,782.77
5 Minutes	Established Patient (EP)	2,613	$ 33,732.36
10 Minutes	Established Patient	9,038	$ 223,878.89
15 Minutes	Established Patient	39,085	$ 1,555,687.27
25 Minutes	Established Patient	14,687	$ 944,154.48
40 Minutes	Established Patient	1,468	$ 127,221.73
Total July 1, 2009 through June 30, 2010		**76,496**	**$ 3,373,786.09**

BACKGROUND
(Continued)







Premium and Plan Information

As mentioned previously, because the Program is self insured, the University is charged with setting the premiums and ensuring those premiums are adequate to cover claims and other administrative expenses. The University has used Milliman to provide a calculation of the total premium rates based on the plan designs and past claims data. However, at its discretion, the University chose to charge a lower total premium than the level recommended by Milliman for the 2010 plan year. See Comment Number 3 for further information on this process.

BACKGROUND
(Continued)

Milliman also calculates an amount needed to pay claims that have been incurred but not yet reported, claims awaiting processing, and claims incurred and processed but not yet paid. From Milliman's August 2009 calculations for the 2010 plan year, $5.1 million was reported as the required amount for these medical reserves. As noted previously, the University had in excess of $92 million available as of June 30, 2010.

The University offers three different plans within its Program – the Low Option Plan, Basic Option Plan, and High Option Plan. Each plan has a different set of coverage levels and services provided. The following is a summary of the services covered under these different plans for calendar year 2010:

		Low Option Plan		Basic Option Plan		High Option Plan	
Blue Cross Blue Shield of Nebraska							
		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	
Annual Deductible	Individual	$1,500	$1,900	$400	$600	$300	$400
	Family	$3,000	$3,800	$800	$1,200	$600	$800
Out-of-Pocket Maximum	Individual	$2,400	$2,800	$1,500	$1,900	$1,300	$1,600
	Family	$4,800	$5,600	$3,000	$3,800	$2,600	$3,200
Office visit	Coinsurance	Deductible, then 70%	Deductible, then 55%	Deductible, then 70%	Deductible, then 55%	Deductible, then 80%	Deductible, then 65%
Annual exam	Coinsurance	No deductible. Program pays 100%, not to exceed $250 per covered person per calendar year.		No deductible. Program pays 100%, not to exceed $250 per covered person per calendar year.		No deductible. Program pays 100%, not to exceed $250 per covered person per calendar year.	
Well baby exam	Coinsurance	No deductible. Program pays 100%, not to exceed $500 per covered person per calendar year.		No deductible. Program pays 100%, not to exceed $500 per covered person per calendar year.		No deductible. Program pays 100%, not to exceed $500 per covered person per calendar year.	
Hospital ER	Coinsurance	Deductible, then 70%	Deductible, then 55%	Deductible, then 70%	Deductible, then 55%	Deductible, then 80%	Deductible, then 65%
Inpatient hospital	Coinsurance	Deductible, then 70%	Deductible, then 55%	Deductible, then 70%	Deductible, then 55%	Deductible, then 80%	Deductible, then 65%
Outpatient surgical center	Coinsurance	Deductible, then 70%	Deductible, then 55%	Deductible, then 70%	Deductible, then 55%	Deductible, then 80%	Deductible, then 65%
Inpatient mental health	Coinsurance	Deductible, then 70%	Deductible, then 55%	Deductible, then 70%	Deductible, then 55%	Deductible, then 80%	Deductible, then 65%
Outpatient mental health	Coinsurance	Deductible, then 70%	Deductible, then 55%	Deductible, then 70%	Deductible, then 55%	Deductible, then 80%	Deductible, then 65%
Caremark							
Prescription Drug Copay (For retail or mail order – up to 30-day supply)	Generic	$9 copay		$9 copay		$9 copay	
	Preferred (Formulary)	$28 copay		$28 copay		$28 copay	
	Non-Preferred (Non-Formulary)	$47 copay		$47 copay		$47 copay	

BACKGROUND
(Continued)

Unlike the Nebraska State Insurance Program, which by law requires the State to pay 79% of the total premium, the University is not required by law to contribute a certain percentage of the premium. Effective January 1, 2010, through December 31, 2010, the ***monthly*** premiums for the three health insurance plans were as follows:

Plan	Coverage Type	Total Premium	University Share	Employee Share	Percent of Premium Paid by University
Low Option Plan	Employee	$ 364	$ 284	$ 80	**78%**
	Employee + spouse	$ 779	$ 677	$ 102	**87%**
	Employee + children	$ 604	$ 512	$ 92	**85%**
	Family	$ 1,081	$ 965	$ 116	**89%**
Basic Option Plan	Employee	$ 418	$ 284	$ 134	**68%**
	Employee + spouse	$ 891	$ 677	$ 214	**76%**
	Employee + children	$ 692	$ 512	$ 180	**74%**
	Family	$ 1,237	$ 965	$ 272	**78%**
High Option Plan	Employee	$ 484	$ 284	$ 200	**59%**
	Employee + spouse	$ 1,033	$ 677	$ 356	**66%**
	Employee + children	$ 848	$ 512	$ 336	**60%**
	Family	$ 1,433	$ 965	$ 468	**67%**

Note 1: Employee + spouse is also referred to as 2-Party, while Employee + children is referred to as 4-Party.

Note 2: Comment Number 3 includes more information regarding the University's process to set premiums.

As part of the University's benefit package under NUFlex, each full-time employee receives a portion of the University's benefit contribution in the form of NUCredits. Each month, the University provides its employees $63 to spend on any of his or her benefit choices. Therefore, the employee share of the total premium, as noted in the table above, could be further reduced by the NUCredits. For example, after factoring in the NUCredits, an employee with the low option plan might only pay $17 per month for coverage. If an employee declines all benefits, he or she will receive the NUCredits as taxable cash.

The premiums listed above are not applicable to part-time employees, retirees, COBRA participants, ancillary employees, or dual spouse employees. Each of these groups have separate premium rates.

Dual spouse employees refer to spouses who are both employed by the University. These employees each pay a discounted premium, while the University contributes its full share of the premium for each employee. Therefore, the University actually contributes more to the Program when both spouses work for the University. The following is an example of a regular employee with High Option – Family coverage, as compared to two spouses working for the University with the same coverage:

BACKGROUND
(Continued)

Family - High Option Plan				
	Regular Employee Premium	Dual Spouse Premium		
Share of Premium		Spouse 1	Spouse 2	Total
Employee Share	$ 468	$ 63	$ 63	$ 126
University Share	$ 965	$ 965	$ 965	$ 1,930
Total Premium	**$ 1,433**	**$ 1,028**	**$ 1,028**	**$ 2,056**

The University's budget is set by fiscal year – July through June – while the health insurance program is on a calendar basis – January through December. In an effort to spread the calendar year 2010 program costs over the July 2009 through June 2010 fiscal year, the University contributed an additional 8%, or $2,589,404, to the health insurance trust fund from July through December 2009, until the actual rate increase took effect on January 1, 2010.

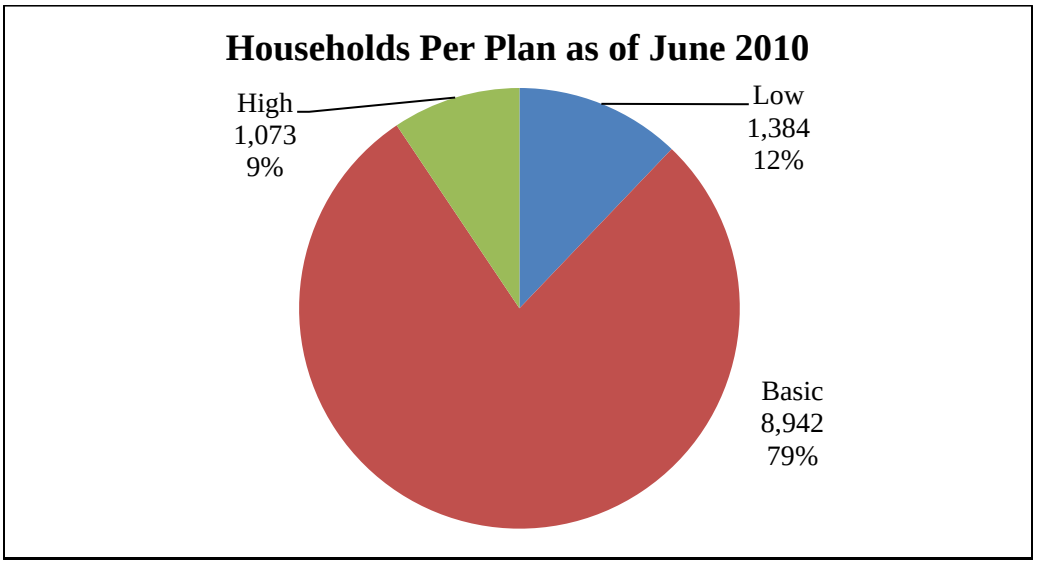
In setting the premiums for calendar year 2010, the University chose not to increase the employee share of the premium, but increased the employer share of the premium by an average of 7.96%, as indicated below. Because there was no employee increase in premiums, the overall premiums increased on average by only 5.74%.

Type of Coverage	Low Option								
	Employee			Employer			Total		
	CY2009	CY2010	Increase	CY2009	CY2010	Increase	CY2009	CY2010	Increase
Single	$960	$960	0.00%	$3,120	$3,408	9.23%	$4,080	$4,368	7.06%
2 Party	$1,224	$1,224	0.00%	$7,584	$8,124	7.12%	$8,808	$9,348	6.13%
4 Party	$1,104	$1,104	0.00%	$5,688	$6,144	8.02%	$6,792	$7,248	6.71%
Family	$1,392	$1,392	0.00%	$10,776	$11,580	7.46%	$12,168	$12,972	6.61%
Type of Coverage	**Basic Option**								
	Employee			Employer			Total		
	CY2009	CY2010	Increase	CY2009	CY2010	Increase	CY2009	CY2010	Increase
Single	$1,608	$1,608	0.00%	$3,120	$3,408	9.23%	$4,728	$5,016	6.09%
2 Party	$2,568	$2,568	0.00%	$7,584	$8,124	7.12%	$10,152	$10,692	5.32%
4 Party	$2,160	$2,160	0.00%	$5,688	$6,144	8.02%	$7,848	$8,304	5.81%
Family	$3,264	$3,264	0.00%	$10,776	$11,580	7.46%	$14,040	$14,844	5.73%
Type of Coverage	**High Option**								
	Employee			Employer			Total		
	CY2009	CY2010	Increase	CY2009	CY2010	Increase	CY2009	CY2010	Increase
Single	$2,400	$2,400	0.00%	$3,120	$3,408	9.23%	$5,520	$5,808	5.22%
2 Party	$4,272	$4,272	0.00%	$7,584	$8,124	7.12%	$11,856	$12,396	4.55%
4 Party	$4,032	$4,032	0.00%	$5,688	$6,144	8.02%	$9,720	$10,176	4.69%
Family	$5,616	$5,616	0.00%	$10,776	$11,580	7.46%	$16,392	$17,196	4.90%
Average Increase			**0.00%**			**7.96%**			**5.74%**

*Note: The amounts shown above are **annual** plan costs.*

BACKGROUND
(Continued)

The following is a breakdown of employees by plan:



Note: This chart differs from the chart on page 7 because it indicates the number of households in each Plan. It includes the 10,302 employees, the 698 ancillary participants, and the 965 COBRA and retiree participants. It does not include the dependents or 566 dual spouse participants.

The University, as the employer, withholds the employee share of the premiums from the employee's pay. Then an accounting entry moves these premiums to the University's imprest holding fund. US Bank is then instructed to transfer the premiums from the imprest holding fund to the separate health insurance trust fund at Wells Fargo Bank.

The ancillary groups either send in a check or make an Automated Clearing House (ACH) payment to the Benefits Office at each campus and those funds are also deposited into the health insurance trust fund at Wells Fargo Bank. Retiree and COBRA participants, as well as employees on a leave of absence, are handled in a similar manner, although they are required to pay only by check.

EXIT CONFERENCE

An exit conference was held February 21, 2012, with the University to discuss the results of our examination. Those in attendance for the University were:

NAME	TITLE
David Lechner	Vice President for Business and Finance
Michael Justus	Assistant Vice President and Director of Internal Audit and Advisory Services
Keith Lauber	Director of University-wide Accounting
Keith Dietze	Director of University-wide Benefits

SUMMARY OF COMMENTS

During our examination of the University of Nebraska Health Insurance Program, we noted certain deficiencies in internal control and other operational matters that are presented here.

These comments and recommendations are intended to improve the internal control over financial reporting or result in operational efficiencies in the areas as follows:

1. Lack of Cooperation

2. Group Health Trust Fund

3. Administration of Reserves, Fund Balance, and Premiums

4. Ancillary Members

5. Eligibility Issues

6. Lack of Monitoring and Controls

7. Dependent Eligibility Audit

8. Payroll Vendor Payments

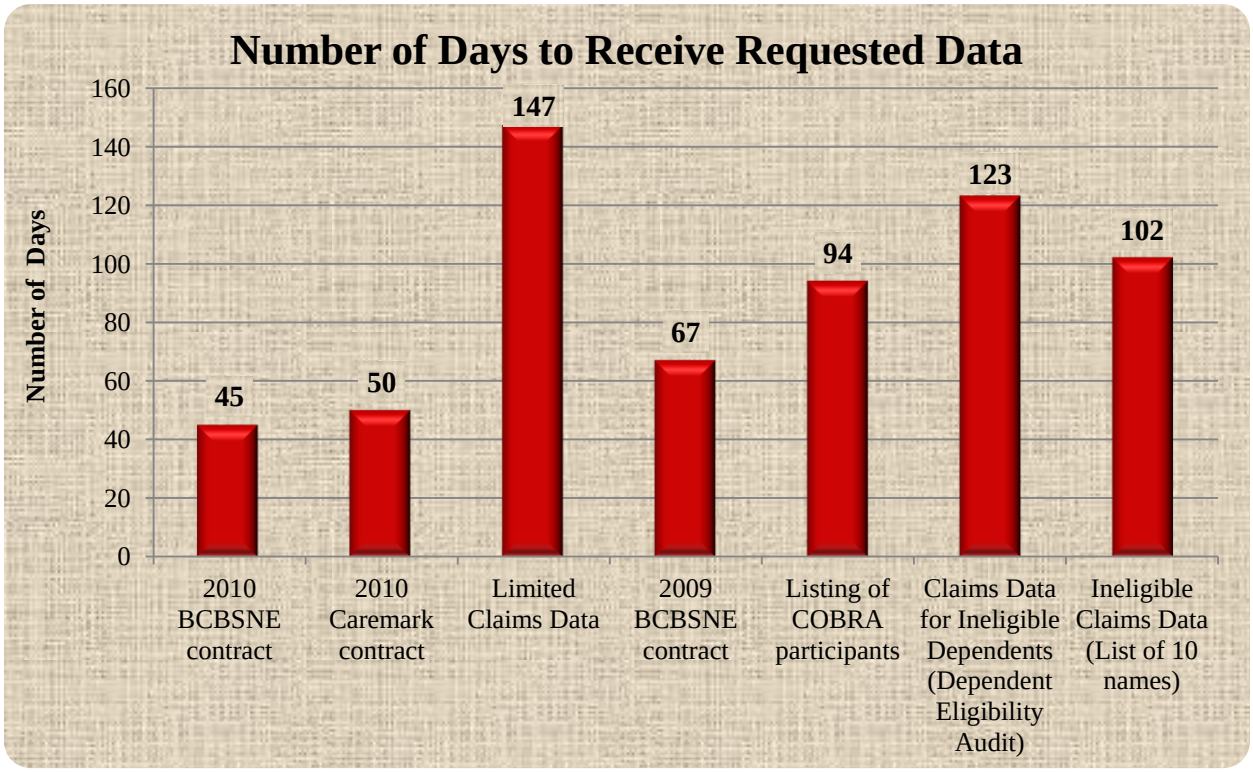
More detailed information on the above items is provided hereafter. It should be noted that this report is critical in nature as it contains only our comments and recommendations on the areas noted for improvement and does not include our observations on any accounting strengths of the University of Nebraska Health Insurance Program.

Draft copies of this report were furnished to the University to provide them an opportunity to review the report and to respond to the comments and recommendations included in this report. All formal responses received have been incorporated into this report. Responses have been objectively evaluated and recognized, as appropriate, in the report. Responses that indicate corrective action has been taken were not verified at this time, but will be verified in the next examination.

COMMENTS AND RECOMMENDATIONS

1. Lack of Cooperation

The University has displayed a marked reluctance to cooperate with this audit by refusing to provide the APA with requested information in a timely manner. Throughout the audit process, the APA asked for essential information from designated University staff – only to have the responses significantly delayed. The following chart illustrates a few of the significant delays encountered throughout the audit and was presented and discussed with the Board of Regents Audit Committee on December 7, 2011:



Note: The date of completion for purposes of this chart is the date complete and accurate information was obtained and may not be the same as the first response date from the University.

As noted in the Background Section of this report, the Program is self-insured, meaning that the majority of employee medical and prescription claims are paid by the University's Trust Fund through the collection of premiums. During fiscal year 2010, the University's Trust Fund paid more than $100 million dollars in medical and prescription claims.

With Legislative approval, the APA initially began a performance audit of the State's various health insurance programs in April 2010. From the outset of the audit, the APA has emphasized the necessity of determining whether those funds were used to pay claims solely for the benefit of qualified participants and their eligible dependents. The only way to make such a determination is by testing and comparing the actual claims data with the University records.

COMMENTS AND RECOMMENDATIONS
(Continued)

1. Lack of Cooperation (Continued)

Due to the University's persistent refusal to cooperate, this audit was delayed for more than a year. In fact, in an effort to obtain the data more efficiently, the APA began this simultaneous financial audit.

The harmful impact of the intentional obstruction by the University and the resulting delay cannot be overstated. Aside from undermining the usefulness of the data once received, such procrastination effectively frustrated the initial goal agreed upon by both the APA and the Legislative Performance Audit Committee – namely, producing an audit report in time to be presented to the Legislature prior to the 2011 legislative session. Unfortunately, the stalling tactics of the University rendered such a goal untenable.

The refusal to provide requested documents for the audit also constitutes an open and deliberate violation of State law. Neb. Rev. Stat. § 84-305 (Reissue 2008) provides:

> *"The Auditor of Public Accounts shall have access to all records of any public entity, in whatever form or mode the records may be, unless the auditor's access to the records is specifically prohibited or limited by federal or state law."*

The records withheld by the University included University health care claims payment data maintained by BCBSNE, which is not shielded from the APA by either Federal or State law, as explained above.

University representatives made clear from the beginning their opposition to the audit as planned. The following timeline covers the first few months of the initial performance audit:

Date	Description of Events
5/4/2010	The APA held an entrance conference for the initial performance audit with representatives from the Department of Administrative Services (DAS).
5/14/2010	The APA emailed the Senior Associate to the President of the University to inform her of the performance audit and to obtain an individual to contact with questions. The APA was told to contact the Director of University-wide Benefits (Director).
6/3/2010	In conjunction with other emails sent to various political subdivisions, the APA emailed the Director, requesting specific information on the University's health insurance program, including copies of contracts.
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.
6/15/2010	The Director finally responded. See **Attachment A**. Several of the responses indicated that information would be provided shortly.
6/30/2010	Having received no further correspondence from the University, the APA sent another follow-up email to the Director.
7/1/2010	The APA sent another email to the Director, requesting a meeting to discuss processes over the administration of the Program.

1. Lack of Cooperation (Continued)

Date	Description of Events
7/6/2010	The Director responded that the APA should check with audit staff who had worked on the University's previous financial audit.
7/8/2010	The APA emailed the Director, 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.
7/13/2010	The APA signed a non-disclosure agreement with BCBSNE.
7/13/2010	Copies of 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. See **Attachment B** for an example of the redacted pages. The APA immediately emailed the Director and requested the missing or redacted information.
7/13/2010	The APA sent a separate email to the Director with some questions for clarification and again requested copies of the missing information.
7/13/2010	The Director responded with the email shown in **Attachment C**, which did not provide the requested information.
7/13/2010	The APA sent an email to the Director, requesting a meeting to obtain the contracts and discuss the premium process.
7/15/2010	A meeting between the APA and the University was scheduled for July 21st.
7/18/2010	The BCBSNE fee schedule was received from the University's Legal Counsel.
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.
7/22/2010	The APA emailed a list of pending issues from the July 21st meeting.
7/22/2010	The APA called Caremark in an attempt to obtain the full contract.
7/23/2010	The University provided the non-redacted Caremark contract, 50 days after it was initially requested.

The lack of cooperation that manifested at the beginning of the performance audit in 2010 continued unabated throughout the remainder of the audit work. In many instances, the supporting documentation and responses by staff in the University's Central Administration were incorrect, redacted, incomplete, or *not* provided in a timely fashion.

During the summer of 2010, the APA signed a non-disclosure agreement with BCBSNE in order to obtain the requested claims data. The APA also had discussions with the University and Caremark officials regarding a confidentiality agreement, which was ultimately signed in March 2011. However, interference and further delays by both State officials and the University hampered our efforts to obtain that data.

COMMENTS AND RECOMMENDATIONS
(Continued)

1. Lack of Cooperation (Continued)

Date	Description of Events
11/16/2010	Due to the overall lack of cooperation during the performance audit, the APA felt the requested information might be more easily obtained through a financial audit. Thus all parties, including the University, were notified of the APA's intention to conduct separate financial audits of the health insurance programs.
11/23/2010	The APA held an entrance conference for a financial attestation of each of the health insurance programs and followed up that conference with an email, requesting the detailed claims data by December 17, 2010.
12/3/2010	The University, among other entities, sent a letter to the Legislative Performance Audit Committee, complaining about the financial attestation, as well as requesting that the performance audit be postponed. See **Attachment D**.
12/17/2010	No claims were received from the University.
12/23/2010	Legislative Performance Audit Committee responded to the December 3, 2010, letter, stating that a postponement of the performance audit would not be granted.
12/30/2010	The APA sent an email to the Vice President for Business and Finance and one Regent, pointing out that the claims files were to have been received by December 17, 2010; however, the APA had received neither the requested files nor any indication of when those files would be provided.
1/11/2011	The APA received a letter from the Vice President for Business and Finance and other State officials noting additional concerns with personal health information, as well as other supposedly unresolved issues.
4/8/2011	The APA received limited claims files from the University.
4/19/2011	The APA received a revised claims file from the University.
10/7/2011	The APA requested full claims details for individuals identified as ineligible in testing.
11/16/2011	Conference call between the APA and the University. The University did not want to provide claims detail for 100 or more employees identified as ineligible. The APA agreed to narrow the list to 10 ineligible individuals for claims detail testing.
11/18/2011	The University did not provide the claims detail, as agreed. Rather, the University provided only the total amount of the ineligible claims without the detailed records.
11/21/2011	The APA emailed the University, indicating the information provided was not the information that was requested and discussed.
12/7/2011	The APA met with the Board of Regents audit committee to discuss the lack of cooperation and information provided by the University. As a result, a pending issues audit log was created.
12/12/2011	The APA sent the University three pending issues for completion of the audits: detailed claims for 10 ineligible individuals, claims for the 421 dependents removed as a result of the dependent eligibility audit, and one other pending question.
12/22/2011	The University sent a response to the last pending question from above and a partial response to the 10 ineligible individuals' detailed claims.
12/27/2011	The APA responded to the University that they still had not provided all of the data requested for the 10 ineligible individuals.
12/27/2011	The Vice President for Business and Finance asked the APA to explain what documentation would resolve the issue. The APA explained we needed the detailed claims records, whether the claim had a positive amount paid, negative amount paid, or no amount paid.
1/2/2012	The Vice President for Business and Finance asked for further clarification on what was needed.
1/3/2012	The APA provided specific, detailed examples for the remaining 10 ineligible individuals.

COMMENTS AND RECOMMENDATIONS
(Continued)

1. Lack of Cooperation (Continued)

Date	Description of Events
1/5/2012	The APA emailed the University and indicated that since we still hadn't received all of the pending information from the 12/7/2011 Board of Regents audit committee meeting, we would like to again meet with the audit committee at its January meeting. The University again expressed its confusion as to what was required. The APA again explained all of the information that was pending, and indicated if it was not received, we would again appear before the audit committee.
1/5/2012	The University provided additional information for the remaining list of 10 ineligible members.
1/6/2012	The APA informed the University that four of the individuals still were not complete. The University provided information on one of the four individuals.
1/13/2012	The University provided information for two of the remaining three individuals on the list of 10 ineligible individuals.
1/16/2012	The University provided the total amount of claims paid for the 421 dependents removed as a result of the dependent eligibility audit.
1/17/2012	The final individual from the list of 10 was provided by the Univeristy.

Note: As noted in the background, the claims files received did not include the full detail of each claim. The University would not provide the APA with the full set of claims data.

The following are additional examples of the University's failure to provide complete and accurate information to the APA during the course of the audit:

- The APA also requested copies of the 2009 administrative services agreement between the University and BCBSNE to compare the fees charged each year. This agreement was requested on July 11, 2011. A redacted version of the agreement was provided by the University on August 4, 2011. See **Attachment E**. The APA requested an unredacted version of the agreement on September 9, 2011, and received a copy on September 16, 2011.

- The APA requested contact names to discuss control processes in place at each campus. The Director provided contact names, but required responses be sent to him for review and editing before he forwarded the information to the APA. The APA obtained the original responses from the University campus contacts and found that the Director had indeed altered the contents of some of those responses before sending them to the APA. Additionally, the APA had to request the original responses from the University of Nebraska – Lincoln (UNL) repeatedly before they were finally released.

- The APA requested a file of all University COBRA participants for fiscal year 2010, which was provided on August 4, 2011. However, the APA noted at least 21 COBRA participants who were not included on that file. The APA discussed this issue with the Director on September 14, 2011, requesting that an updated COBRA file be provided.

1. Lack of Cooperation (Continued)

On October 13, 2011, almost a month after asking the Director for an updated file and three months after the initial request for the COBRA data, the University finally acquiesced. At that point, testing had already been completed, but the APA did compare the updated listing received on October 13th to the original listing provided on August 4th and found 97 individuals included on the updated listing who had not been included on the original listing, as noted below:

Date Received	Number of COBRA Participants
August 4, 2011	155
October 13, 2011	252
Missing Individuals	**97**

All of the 21 individuals whom the APA identified as missing from the original file received were included in the subsequent file. The APA also noted one individual on the updated COBRA listing who did not pay premiums during the period tested and should not have been included in the listing. There were similar errors on the retiree listing provided by the University, as all individuals who paid retiree premiums were not included.

Additionally, the University could not provide a listing of UNL ancillary group members who paid premiums during fiscal year 2010. According to the UNL Benefits Office, the electronic file containing this information is reused each month to create the billing for the next month. Therefore, UNL received $1,981,899 in ancillary premiums but did not maintain documentation to indicate which individuals paid those premiums.

- The APA received several versions of the payment spreadsheets from the UNL Benefits Manager for an employee on a leave of absence (LOA) without pay. After reviewing the original payment spreadsheet, the APA determined the December 2009 premium was not paid by this employee. The UNL Benefits Office provided a revised payment spreadsheet that indicated the payment was made, but the coverage dates had been incorrectly entered. After several inquiries about the change, it was determined the December 2009 payment was not made and the original coverage dates were correct. See **Exhibit A** for LOA Payment Revisions.

- At the start of the audit, the University requested that all questions be provided via email. It was very difficult to set up a face-to-face meeting with University personnel. Even when simple questions were posed over the telephone, the Director requested the questions be put in an email. In addition to being inefficient, the process insisted upon by the University further delayed the audit work, as shown in the table below:

COMMENTS AND RECOMMENDATIONS
(Continued)

1. Lack of Cooperation (Continued)

Date	Description of Events
9/14/2011	The APA emailed the Director and requested a complete listing of COBRA participants because the first list provided by the University was not accurate. The APA also inquired about COBRA premiums.
9/15/2011	The APA emailed the Director and requested the total amount of claims paid for all individuals removed during the University's own Dependent Eligibility Audit.
9/15/2011	The APA emailed the Director regarding certain reconciliation and health insurance procedure questions.
9/16/2011	*The APA received a response from the Director that did not answer all outstanding questions.*
9/21/2011	The APA emailed the Director regarding premiums paid when two spouses both work for the University.
9/29/2011	The APA emailed the Director regarding the outstanding questions that had not been answered in his September 16, 2011, response.
9/30/2011	The APA emailed the Director, requesting an explanation for the variances between the premium prices established by the University and the premium prices included in the University's "price tags."
9/30/2011	The APA emailed the Director regarding Caremark performance guarantees, Milliman letters, and support for certain expense payments.
10/6/2011	The APA emailed the Director to request a listing of UNL ancillary premium payments for fiscal year 2010 because the UNL Benefits Office did not keep that documentation.
10/7/2011	The APA emailed the Director to request detailed claims payments for individuals who appeared to be ineligible. The APA also requested assistance in identifying the employees associated with a list of unknown dependents.
10/13/2011	*The APA received an email response from the Director that again did not completely answer the questions asked. The Director's email also discussed the Dependent Eligibility Audit request made by the APA, but it did not provide the requested information. This response from the Director was received shortly after the APA emailed a member of the Board of Regents to inquire about the lack of response to outstanding audit questions.*

The University's reluctance to cooperate with the audit by refusing to provide the APA with requested information in a timely manner not only constituted a clear and ongoing violation of § 84-305 but also severely impeded the APA's ability to carry out an effective and relevant audit of the Program.

> We recommend the Board of Regents insist University management take immediate corrective action regarding the lack of cooperation that occurred throughout this audit and develop procedures to ensure future compliance with § 84-305 by providing prompt and accurate responses to the APA's requests for audit information.

COMMENTS AND RECOMMENDATIONS
(Continued)

1. Lack of Cooperation (Continued)

University's Response: The University strongly disagrees with this comment which is flawed in a number of respects:

- *It fails to include details demonstrating that the reason for many of the delays was the Auditor's refusal to sign standard non-disclosure agreements. The University has a fiduciary duty and legal obligations to faculty, staff and third party administrators to protect confidential and proprietary information.*
- *It fails to note that after receiving signed non-disclosure and confidentiality agreements from the APA in March and May of 2011 all information requested by the APA was provided in a reasonable time frame.*

It fails to note that similar concerns about releasing protected health information to the Auditor were voiced by the Governor, the Department of Administrative Services, Blue Cross Blue Shield and CVS/Caremark. The University was not the only party concerned about surrounding personal health information with strong safeguards as to its use.

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 the University of Nebraska. (See copy of the agreement below.) However, subsequent to that signed agreement additional non-disclosure agreements and memorandums of understandings were requested as noted above. The concerns of other parties are addressed in our other health insurance reports.

(Continued on Next Page)

COMMENTS AND RECOMMENDATIONS
(Continued)

1. 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

COMMENTS AND RECOMMENDATIONS
(Continued)

1. Lack of Cooperation (Concluded)

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

2. Group Health Trust Fund

Many years ago, the University established a Group Health Trust Fund (Trust Fund) at the National Bank of Commerce Trust and Savings Association (NBC) in Lincoln, Nebraska. The purpose of the Trust Fund is, according to the preamble to the Trust Agreement, to "provide for the investment and administration of contributions made pursuant to the Program . . ." NBC was appointed Trustee of the Trust Fund – a responsibility later assumed by Wells Fargo as the result of a banking merger in 2000. As of June 30, 2010, the Trust Fund had a balance of $92,596,502.

Under Section 1.1 of the Trustee Agreement, the Trustee is directed to "manage, invest and reinvest the Trust Fund, collect the income thereof and add the same to the principal of the Trust Fund, and shall make payments therefrom, all as hereinafter provided." The investment powers of the Trustee are limited, however, by Section 2.1 of the Trust Agreement, which makes any investment decisions subject "to instructions from time to time from agents of the University as to what portion of the Trust Fund must be maintained in cash or cash-equivalent obligations."

The Trust Agreement makes clear that the University exercises ultimate authority over the Trust Fund. For instance, Trust Fund disbursements are to be made at the direction of the University. Section 3.2 of the Trust Agreement states:

> *"The Trustee shall make such payments from the Trust Fund at such time or times and to such person or persons, including the University, a paying agent or agents designated by the University or any of them, as the University shall direct in writing . . . Any written direction of the University shall constitute a certification that the payment so directed is one which the University is authorized to direct, and the Trustee need make no investigation."*

Additionally, Section 6.2 of the Trust Agreement directs:

> *"The University shall have complete control and authority to determine the existence, non-existence, nature and amount of the rights and interests of all persons in or to the Trust Fund or under the Program, and the Trustee shall have no power, authority or duty in respect of such matters or to question, or to examine into, any determination made or direction given by the University to the Trustee."*

Under Sections 7.2 and 8.1 of the Trust Agreement, respectively, the University retains the power both to "remove the Trustee at any time" and to "terminate [the Trust] at any time . . ." Moreover, Section 8.2 of the Trust Agreement provides for the distribution of the Trust's corpus upon termination, as follows:

> *"If this trust is terminated, the Trustee upon written direction of the University shall liquidate the Trust Fund to the extent required for distribution, and, after its final account has been settled as provided in Article VI, shall distribute the net balance thereof to such person or persons, at such time or times and in such proportions and manner as may be directed by the University . . ."*

COMMENTS AND RECOMMENDATIONS
(Continued)

2. Group Health Trust Fund (Continued)

The University's Trust authorizes BCBSNE and Caremark to withdraw – with little, if any, oversight – funds directly from the Trust Fund for the payment of claims. In fact, under that broad grant of authority, these third parties withdraw funds directly from the Trust Fund without either prior or subsequent University approval for each transaction.

From July 1, 2009, through June 30, 2010, the following activity was recorded in the Trust Fund:

Group Health Trust Fund	
Beginning Fund Balance	$ 78,614,554
Total Revenues	$ 123,600,552
Total Expenditures (Transfers) **(1)**	$ 109,618,604
Ending Fund Balance	$ 92,596,502

(1) The University paid $184,042 in administrative fees for the Trust Fund, which is included in the total expenditures noted above.

By June 30, 2011, the Trust Fund balance had grown to $103,707,786.

Under Nebraska law, the State Treasurer serves as the custodian of University funds. Neb. Rev. Stat. § 85-128 (Reissue 2008) states:

> *"The State Treasurer shall be the custodian of all the funds of the university. Disbursements from the funds named in sections 85-124 to 85-127 shall be made in accordance with the provisions of law relating to the disbursement of university funds in the hands of the State Treasurer as provided by law."*

Neb. Rev. Stat. § 85-129 (Reissue 2008) adds:

> *"The State Treasurer shall be the treasurer of the state university and the custodian of all funds donated to the university or to the Agricultural Research Division by the United States, including the Morrill, Hatch, and Adams funds, all other donations, gifts, and bequests, income from land and productive funds, fees paid by students, and all funds for the use of the university derived from any source, except (1) funds created by taxation and paid into the state treasury as taxes and (2) the University Trust Fund which shall be held and managed in the manner provided by section 85-123.01."*

Neb. Rev. Stat. § 85-131 (Reissue 2008) provides also:

> *"Disbursements from the university funds shall be made by the State Treasurer upon warrants drawn by the Director of Administrative Services who shall issue warrants upon certificates issued as authorized by the Board of Regents."*

COMMENTS AND RECOMMENDATIONS
(Continued)

2. Group Health Trust Fund (Continued)

In addition to serving as the treasurer of the University, as well as the custodian of that agency's funds, the State Treasurer exercises sole authority when it comes to establishing banking relationships on behalf of the State. Neb. Rev. Stat. § 77-2301(1) (Reissue 2009) provides:

> *"The State Treasurer shall deposit, and at all times keep on deposit for safekeeping, in the state or national banks, or some of them doing business in this state and of approved standing and responsibility, the amount of money in his or her hands belonging to the several current funds in the state treasury."*

Similarly, Neb. Rev. Stat. § 77-2309 (Reissue 2009) says:

> *"It is made the duty of the State Treasurer to use all reasonable and proper means to secure to the state the best terms for the depositing of the money belonging to the state, consistent with the safekeeping and prompt payment of the funds of the state when demanded."*

The Attorney General has opined, in Op. Att'y Gen. No. 98006 (Jan. 21, 1998), that the University may not maintain a separate bank account outside of the control of the State Treasurer, explaining:

> *"Since Art. VII, § 10 of the Nebraska Constitution [which provides that '[t]he general government of the University of Nebraska shall, under the direction of the Legislature, be vested in a board of not less than six nor more than eight regents to be designated the Board of Regents of the University of Nebraska . . .'] must be read together with Art. IV, § 1 [which designates the State's executive officers], and since the core functions of the State Treasurer seem to include those matters enumerated above, we believe that the general government of the University vested in the Board of Regents under the Nebraska Constitution may only be exercised in such a way as to preserve the Treasurer's general authority over the custody of state funds and the supervision of the State's relationships with state and national banks."*

In reaching that conclusion, the Attorney General emphasized the authority of the State Treasurer to establish banking relationships for the State:

> *"We are unaware, generally, of any other statutes [§ 77-2301 and § 77-2309] which specifically give other state officials or state agencies the authority to deposit the state's funds in a bank. As a result, to the extent that 'establishing a banking relationship' in your question is synonymous with depositing funds in the state treasury in a bank, we believe that your office is the only agency with such authority."* Id.

2. Group Health Trust Fund (Continued)

Additionally, regarding the State Treasurer's role as custodian of University funds, the Attorney General opined:

> *"When those various statutes [§ 85-128 and § 85-129] are read in their entirety and together, as they must be, it appears to us that the State Treasurer is the custodian of all funds of the University and of all funds donated to the University except those funds created by taxation and those funds in the University Trust Fund. We believe that authority to act as custodian necessarily implies that the funds in question will be receipted into the State Treasury. Consequently, for those funds for which you [the State Treasurer] are the custodian, we believe that they should be receipted into the State Treasury even if they involve non-tax sources."* Id.

Based upon both the statutes and the Attorney General's opinion noted above, the APA questions the authority of the University, statutory or otherwise, to establish the Trust Fund outside of the custody and control of the State Treasurer.

In communications with the APA regarding this issue, the University has defended its right to maintain the Trust Fund. According to the University, the Trust Fund is not a bank account; therefore, no "bank relationship" has been established for purposes of § 77-2301 and § 77-2309. Furthermore, the University points to the fact that, under both the Nebraska Uniform Trust Code and the common law, a trustee holds legal title to property conveyed to a trust. The University points also to its inherent constitutional authority to manage its own integral affairs, as recognized by the Nebraska Supreme Court in *Board of Regents of University of Nebraska v. Exon,* 199 Neb. 146, 256 N.W.2d 330 (1977).

Though not dismissing them altogether, the APA remains largely unconvinced by the University's arguments. To start, contracting with a bank to hold and manage funds belonging to the University – even if those funds are to be held in trust for a particular purpose – appears to be a banking relationship of sorts. This is especially true given the authority that the University has retained over the Trust Fund, as pointed out in the above excerpts from the Trust Agreement.

At the very least, the creation of the Trust Fund seems an intrusion upon the State Treasurer's duties under § 77-2301 and § 77-2309. In this particular instance, moreover, the Trust Fund could be viewed as effectively operating to deny the State Treasurer's ability to exercise his duties under § 85-128 and § 85-129, respectively, as "the custodian of all the funds of the university" and the "treasurer of the state university and the custodian of" its various funds.

Additionally, if the Trustee now enjoys legal title to the Trust Fund's corpus, the question that must be asked is under what authority the University transferred custody of such funds without the State Treasurer's express prior approval. Having done so might well be considered a fundamental abrogation of the State Treasurer's duties as the custodian of University funds under both § 85-128 and § 85-129. It is worth mentioning, moreover, that the Trust Fund amounts are included in the University's annual financial statements, which would appear to conflict with the Trustee's legal title to the trust corpus.

2. Group Health Trust Fund (Continued)

As for the relevance of the University's inherent constitutional authority to govern its own affairs, the Attorney General has cautioned, in Op. Att'y Gen. No. 24 (Feb. 13, 1981), against "giving an overly broad construction to the case of Board of Regents v. Exon . . ." More specifically, in the previously referenced Op. Att'y Gen. No. 98006 (Jan. 21, 1998), the Attorney General observed, "First of all, while *Exon* provides that the 'general government' of the University must remain vested in the Board of Regents, it does not state that all statutes which pertain to state government have no application to the University." Id. That opinion continued:

> *"Despite what Board of Regents v. Exon says, the Board of Regents is probably not totally insulated from the impact of general laws passed by the Legislature. When the Legislature attempts to specifically direct or control actions of the Board, the legislation is suspect. But we do not believe the court intended to say that the Board could ignore laws of general application. [The Board of Regents] . . . is not, after all, a separate, independent sovereignty."* Id. (quoting Op. Att'y Gen. No. 117 (May 16, 1979))

The opinion then concluded:

> *"As a result, it seems to us that statutes which pertain generally to state agencies and which do not purport to direct the Board of Regents as to matters which are central to the University's educational function or its 'government,' can have application to the University, even under Exon. To some extent, examples of such statutes include those described in University Police Officers Union, International Brotherhood of Police Officers, Local 567 v. University of Nebraska, 203 Neb. 4, 277 N.W.2d 529 (1979) in which the Court stated that the University is subject to actions before the Court of Industrial Relations, to the Nebraska Workmen's Compensation Law and the Nebraska Employment Securities Law . . ."* Id.

Finally, as noted already, Op. Att'y Gen. No. 98006 (Jan. 21, 1998) declared that only the State Treasurer alone has the authority to establish banking relationships on behalf of the State. In reaching that conclusion, the Attorney addressed the interplay between the inherent constitutional authority of the University, as addressed in the *Board of Regents v. Exon* case, and that of the State Treasurer:

> *"Since Art. VII, § 10 [which provides that '[t]he general government of the University of Nebraska shall, under the direction of the Legislature, be vested in a board of not less than six nor more than eight regents to be designated the Board of Regents of the University of Nebraska . . .'] of the Nebraska Constitution must be read together with Art. IV, § 1 [which designates the State's executive officers], and since the core functions of the State Treasurer seem to include those matters enumerated above, we believe that the general government of the University vested in the Board of Regents under the Nebraska Constitution may only be exercised in such a way as to preserve the Treasurer's general authority over the custody of state funds and the supervision of the State's relationships with state and national banks."* Id.

2. Group Health Trust Fund (Concluded)

In addition to these concerns, it should be noted also that Neb. Rev. Stat. § 85-122 (Supp. 2011) designates 18 separate funds that are to be used to hold University money. That same statute provides, in relevant part, "Any money in the funds designated in this section available for investment shall be invested by the state investment officer pursuant to the Nebraska Capital Expansion Act . . ." By establishing a separate Trust Fund, with the bank as the Trustee responsible for holding and managing Program funds, the University may also have run afoul of § 85-122 by interfering with the duties of the State Investment Officer.

In light of all the above, the APA must express serious reservations regarding the University's establishment of the Trust Fund, outside of the custody and oversight of the State Treasurer, to hold and manage Program funds. To resolve this present uncertainty, the University should consult with the State Treasurer – perhaps, even seeking jointly, if needed, a formal opinion from the Attorney General as to the legality of the Trust Fund's existence.

> We recommend that the University consult with the State Treasurer to resolve this issue. We recommend also that the University join with the State Treasurer in seeking, if needed, a formal opinion from the Attorney General as to the legality of the Trust Fund's existence.

University's Response: This observation 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.

APA Response: The APA remains unpersuaded by the University's response. To start, the informal Attorney General's opinion referenced therein, Op. Att'y Gen. No. I-12002 (Feb. 1, 2012), has no bearing upon the present issue. Furthermore, the University has refused to provide the APA with any details regarding the advice obtained from outside counsel – thereby precluding an objective evaluation of that legal analysis' credibility. The University has failed also, either during the audit exit conference or in this response, to offer any specific legal reasoning for its position. As a result, the APA has been provided with no basis whatsoever for questioning, much less altering in any way, its own conclusion. Nevertheless, as communicated already to the University, the APA is willing to assist in seeking a formal legal opinion from the Attorney General regarding the proper disposition of the trust funds in question.

COMMENTS AND RECOMMENDATIONS
(Continued)

3. Administration of Reserves, Fund Balance, and Premiums

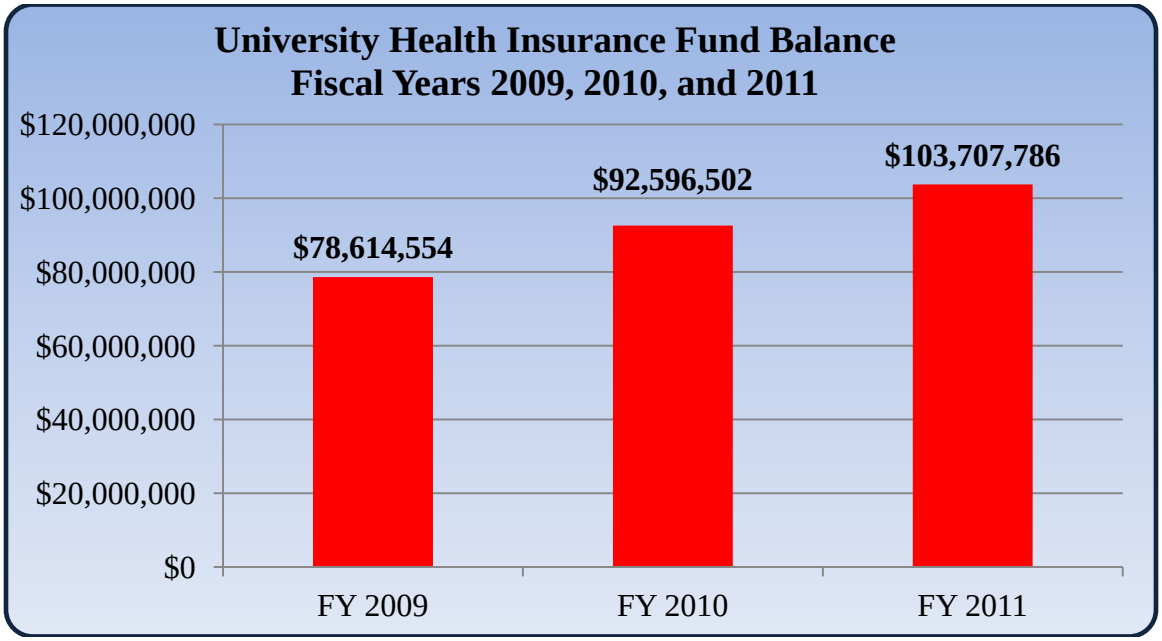
The University has no formal policies for establishing the level of reserves and fund balance to maintain, the amount to charge for premiums, or the approval of these amounts.

Reserves and Fund Balance
The University hired Milliman, an independent actuarial and consulting firm, to help set premiums and calculate a reserve amount for incurred but not reported (IBNR) claims. This IBNR reserve amount represents all liability components incurred but not reported to BCBSNE, claims awaiting processing, and claims incurred and processed but not yet paid.

In its "University of Nebraska Projection for the 2009 Plan Year" report, Milliman stated:

> *"As part of the University of Nebraska's fiduciary responsibility to the plan, it is important to maintain an adequate level of reserves, especially in light of the continual increase in the size and variability of claims, changes in enrollment, and plan design changes. In addition to the calculation provided in this letter, we recommend that you continue to monitor the reserve levels going forward to ensure financial stability and viability."*

The University does not have a formal policy for determining the amount to be maintained as reserves or as an overall fund balance. Milliman calculated the IBNR to be slightly over $5 million for both calendar years 2009 and 2010. See **Attachments F and G**. However, the fund balance in the University's health insurance trust fund grew by more than $10 million in each of the last two fiscal years, becoming almost enough to cover an entire year's worth of claims and expenses, which for fiscal year 2010 totaled just under $110 million.



3. Administration of Reserves, Fund Balance, and Premiums (Continued)

Without a formal University policy for determining the appropriate level of reserves and fund balance, there is an increased risk University funds will be used to augment the balance in the health insurance trust fund.

Premiums
The University sets new premium rates for the Program annually, using information from Milliman as the basis for determining the rates. However, the University offered no documentation to support that the Vice President of Business and Finance, the President, or any other University official ever formally approved the new premium rates.

Milliman provides the University with an annual evaluation of its optimum premium renewal rates for each plan and coverage option. That evaluation is based upon enrollment details, claims data, and expense information provided by BCBSNE and the University. The suggested rates for active members in 2010 are shown in **Attachment H**, and include an overall 9.5% increase from the 2009 rates. It does not appear the existing balance of the health insurance trust fund is considered in the calculation of the premium, as the fund balance is not listed by Milliman in its assumptions and methodology shown in **Attachment G**.

Despite having paid Milliman to determine the premiums necessary to cover future anticipated expenses, the University used the suggested premium rates only as a guide in setting its final premiums for calendar year 2010.

The following table compares the 2010 premium rates calculated by Milliman to the final premiums adopted by University staff.

Plan	Coverage Type	Total Monthly Premium Calculated by Milliman	Final Total Monthly Premium for CY 2010	Variance: Monthly University Buy-Down
Low Option Plan	Employee	$ 378.50	**$ 364.00**	$ 14.50
	Employee + spouse	$ 812.23	**$ 779.00**	$ 33.23
	Employee + children	$ 630.32	**$ 604.00**	$ 26.32
	Family	$ 1,128.02	**$ 1,081.00**	$ 47.02
Basic Option Plan	Employee	$ 441.05	**$ 418.00**	$ 23.05
	Employee + spouse	$ 946.45	**$ 891.00**	$ 55.45
	Employee + children	$ 734.47	**$ 692.00**	$ 42.47
	Family	$ 1,314.41	**$ 1,237.00**	$ 77.41
High Option Plan	Employee	$ 491.30	**$ 484.00**	$ 7.30
	Employee + spouse	$ 1,054.30	**$ 1,033.00**	$ 21.30
	Employee + children	$ 818.17	**$ 848.00**	$ (29.83)
	Family	$ 1,464.19	**$ 1,433.00**	$ 31.19

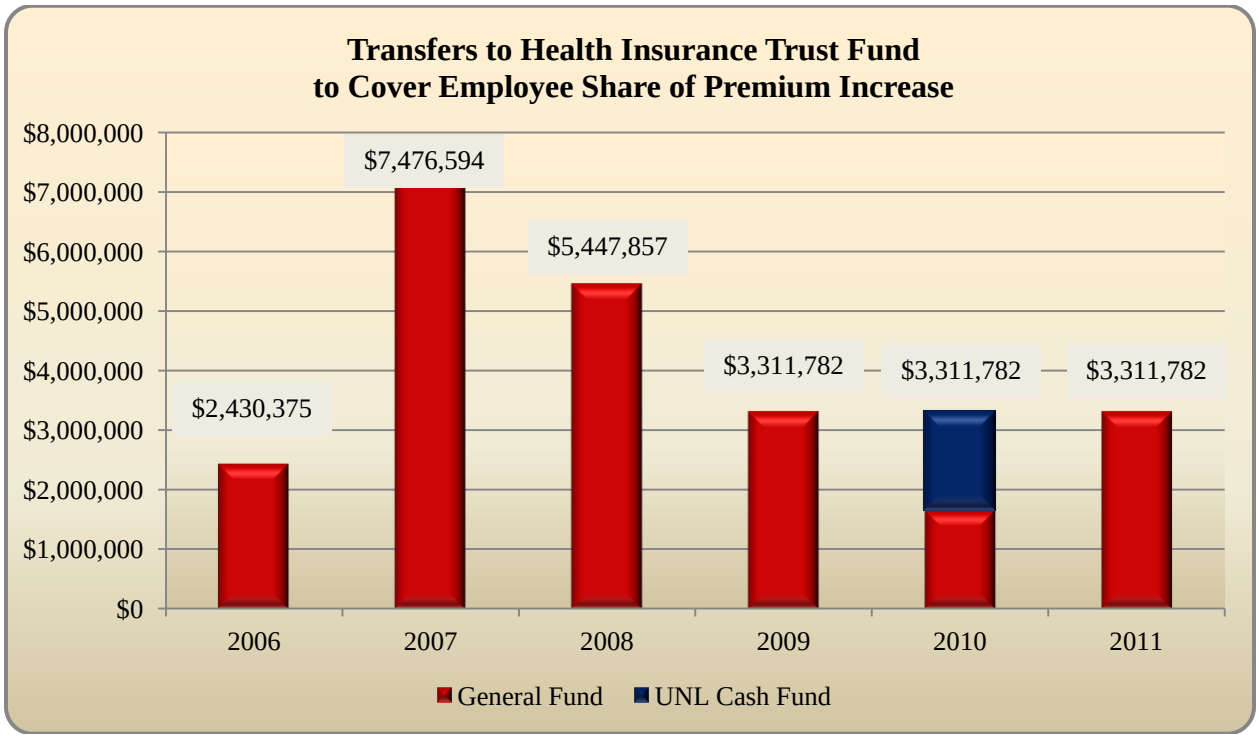
COMMENTS AND RECOMMENDATIONS
(Continued)

3. Administration of Reserves, Fund Balance, and Premiums (Continued)

The difference between the Milliman rates and the final rates charged by the University represents a "buy-down" for active employees in 2010, in which the University attempted to decrease its fund balance by charging a lower premium amount than calculated by its actuary. This attempt is reflected in the "Monthly University Buy-Down" column in the table above. The premiums for all plan options, except the High Option Plan for employee and children, were reduced; however, the University did not provide documentation to support the method used to calculate the buy down.

University employees have also benefited from another action that prevented larger increases in premium rates. For several years, the University has used general fund monies to cover the increases in the cost of premiums for its employees. As a result, the employee share of the premium for University employees has not been increased since 2009.

The University transferred $3,311,782 into its separate health insurance trust fund during fiscal year 2010, half of which came from the general fund and half from the UNL cash fund. A review of the University's accounting records revealed that similar transfers to the health insurance trust fund have occurred for several years. From 2006 through 2009 and for 2011, all funds transferred to the health insurance trust fund came from the general fund.



3. Administration of Reserves, Fund Balance, and Premiums (Continued)

Because of the transfer of general and cash fund monies to the trust fund, the employees' share of the health insurance premium for University employees did not increase between 2009 and 2011, as seen below:

Plan	Coverage Type	Employee Share of Premium				
		2009	2010	2011	$ Change between 2009-2011	% Change between 2009-2011
Low Option Plan	Employee	$ 80	$ 80	$ 80	$ 0	0%
	Employee + spouse	$ 102	$ 102	$ 102	$ 0	0%
	Employee + children	$ 92	$ 92	$ 92	$ 0	0%
	Family	$ 116	$ 116	$ 116	$ 0	0%
Basic Option Plan	Employee	$ 134	$ 134	$ 134	$ 0	0%
	Employee + spouse	$ 214	$ 214	$ 214	$ 0	0%
	Employee + children	$ 180	$ 180	$ 180	$ 0	0%
	Family	$ 272	$ 272	$ 272	$ 0	0%
High Option Plan	Employee	$ 200	$ 200	$ 200	$ 0	0%
	Employee + spouse	$ 356	$ 356	$ 356	$ 0	0%
	Employee + children	$ 336	$ 336	$ 336	$ 0	0%
	Family	$ 468	$ 468	$ 468	$ 0	0%

The University's actions in transferring general and cash funds to the trust fund while simultaneously depleting the health insurance trust fund through the University's "buy-down" appear contradictory. On one hand, the University seeks to stabilize the cost of health insurance premiums by using the trust fund balance to cover some of the increase in that cost, which would then decrease the overall balance of the trust fund. On the other hand, the University transferred some $3 million in State funding into the trust fund, effectively increasing the balance of that fund. Regardless of intentions, the University neither properly documented nor formally approved the premium rates for the Program.

Without formal policies and procedures for establishing and approving premiums, there is an increased risk the University is not setting premium rates appropriately and correctly for all participants. A good internal control plan requires adequate documentation of decisions regarding both plan design and premium rates, as well as the approval of those decisions.

COBRA and Ancillary Premiums

Non-employee participants receiving benefits, such as COBRA and ancillary members, should pay the full cost of the premium recommended by Milliman. Otherwise, fund balances, premiums from employees and employers, and general or cash fund transfers will be used to cover the recommended cost of premiums for these COBRA and ancillary members.

The APA found that COBRA and ancillary participants were not charged the full premium cost. The following chart compares the 2010 Milliman calculated rates to the rates the University charged to ancillary members.

COMMENTS AND RECOMMENDATIONS
(Continued)

3. Administration of Reserves, Fund Balance, and Premiums (Continued)

Coverage Type	Milliman Calculated Rate	Ancillary Rate	Difference
Low Option Plan			
Employee Only	$ 378.50	$ 380.00	$ (1.50)
Employee + Spouse	$ 812.23	$ 814.00	$ (1.77)
Employee + Children	$ 630.32	$ 632.00	$ (1.68)
Employee + Family	$ 1,128.02	$ 1,128.00	$0.02
Basic Option Plan			
Employee Only	$ 441.05	$ 442.00	$ (0.95)
Employee + Spouse	$ 946.45	$ 918.00	$ 28.45
Employee + Children	$ 734.47	$ 714.00	$ 20.47
Employee + Family	$ 1,314.41	$ 1,274.00	$ 40.41
High Option Plan			
Employee Only	$ 491.30	$ 492.00	$ (0.70)
Employee + Spouse	$ 1,054.30	$ 1,024.00	$ 30.30
Employee + Children	$ 818.17	$ 810.00	$ 8.17
Employee + Family	$ 1,464.19	$ 1,422.00	$ 42.19

Note 1: The rows highlighted in yellow are the coverage types for which the University did not charge enough to cover the cost of the plan, as determined by Milliman.
Note 2: The COBRA rates charged for fiscal year 2010 were the same as the ancillary rates multiplied by 102%. Therefore, COBRA rates also did not cover the cost of the insurance for the same coverage type, as noted above for the ancillary employees.

When non-employee participants are not charged the full premium amounts, as determined necessary by the actuary to cover the costs of the Program, the resulting shortfall must be offset by either raising the premiums of the University and its employees or increased reliance upon general and cash fund transfers into the trust fund.

We recommend:

- The University establish a formal policy for determining the appropriate level of reserves and fund balance to maintain.
- The University implement a formal procedure for the annual determination and approval of health insurance premium amounts. Such procedure should include documentation to indicate the actuary has considered the balance of the University's health insurance trust fund, which is necessary in order to obtain premiums based on the balance maintained in that fund. Documentation could include having the actuary address the consideration of the fund balance in the assumptions and methodologies section of the actuarial report. These procedures should also provide for documenting and explaining any rates that differ from those determined appropriate by the actuary.

COMMENTS AND RECOMMENDATIONS
(Continued)

3. Administration of Reserves, Fund Balance, and Premiums (Concluded)

- The University ensure all non-employee groups are charged the full cost of health insurance determined by the actuary to cover the true cost of the insurance.

University's Response: The comment fails to accurately describe the careful, deliberative, consultative process involved in setting premiums to keep a competitive, cost-effective benefit in place for University faculty and staff and their families. In addition to University senior leadership, Blue Cross Blue Shield, CVS/Caremark and the actuaries at Milliman are all involved in the process. Additional input is sought from the University-wide Benefits Committee and with regard to health care trends and coordination, Legislative and Executive branch personnel at the State.

The comment is in error on several other points:

- *The use of terms such as public fund and general funds as used in this comment can mislead readers as to sources of funding for the plan. As a reminder, the University does not receive a line item appropriation from the State of Nebraska. Money put into the health plan trust to defray employee premium increases since 2007 was identified through existing budget reallocations and other sources. Additionally, state-aided budget only accounts for about 60% of trust activity.*
- *Employees were not charged a portion of increased premiums because of a conscious decision by University senior leadership to cover increased costs through employer contributions. This was intentional in a year when there were small or no salary increases because of budgetary challenges. The report suggests this was done inadvertently.*
- *The suggestion that the University should make available to the actuary trust balances is not accurate as the actuary is fully aware of trust balances.*

APA Response: Our recommendation very simply indicates that the University should adopt a formal policy regarding the appropriate levels of reserves and fund balances. Additionally, the University needs to improve its documentation to support its fund balance levels and its determination of premiums to charge employees, as well as the approval of each.

4. Ancillary Members

As noted in the Background Section of this report, ancillary employees have been permitted to participate in the Program for more than 36 years. On December 6, 1973, the Regents first approved a policy extending the University's group insurance benefits to persons within ancillary groups or organizations.

4. Ancillary Members (Continued)

RP 3.2.3 (amended October 19, 2001) reads, in part:

> *"The following designated persons representing groups or organizations ancillary to the University are eligible for participation in the University Group Insurance Plan. No University of Nebraska contribution to any such person's premium cost will be made, and each ancillary group or organization or its individual members will arrange for payment of premiums with the appropriate University benefits manager."*

Based upon information provided by the University, the APA estimates that approximately 698 ancillary employees were enrolled in the University's health insurance program as of June 2010. The total amount of premiums paid by those ancillary members during the fiscal year ended June 30, 2010, according to the University's Trust statements, is shown below:

Ancillary Group	Premiums Received
UNMC Physicians	$ 4,633,770
University of Nebraska Foundation	$ 1,488,936
UNL Federal Credit Union	$ 244,034
UNL Alumni Association	$ 116,194
Nebraska Champions Club Catering **(1)**	$ 11,484
Nebraska Champions Club Gameday **(1)**	$ 6,236
Nebraska Champions Club **(1)**	$ 2,766
Nebraska Champions Club Marketing **(1)**	$ 2,263
Nebraska Crop Improvement Association	$ 56,628
Nebraska Pork Producers Association	$ 36,960
UNeMed and Ximerex	$ 26,442
Nebraska 4-H Development Foundation	$ 15,454
Nebraska Specific Pathogen Free Swine Accrediting Agency	$ 944
Total Ancillary Premiums Received	**$ 6,642,111**

(1) The Nebraska Champions Club is a part of the UNL Alumni Association ancillary group.

Despite having allowed these ancillary members to participate in the Program for a number of years, the Regents lack the statutory authority to do so. Neb. Rev. Stat. § 85-106 (Reissue 2008) sets out the general powers and duties of the Regents. Specifically, subsection (6) of that statute permits the Regents:

> *"To equalize and provide for uniform benefits for all present and future employees, including group life insurance, group hospital-medical insurance, group long-term disability income insurance, and retirement benefits[.]"* (Emphasis added)

On November 27, 2001, the Nebraska Attorney General responded to an inquiry from then Director of the Department of Administrative Services (DAS), Lori McClurg. That inquiry asked whether non-State employees should be permitted to participate in the Nebraska State

4. Ancillary Members (Continued)

Insurance Program. Though relating specifically to DAS, the Attorney General's response is instructive regarding the issue of whether the University should extend health benefits to employees of ancillary groups or organizations.

The Attorney General concluded that the Director of DAS lacks the statutory authority to permit non-State employees to participate in the Nebraska State Insurance Program, which was created exclusively for the benefit of State employees. In arriving at that conclusion, the Attorney General pointed out that the applicable statutory provisions limit participation in the State's health insurance program to State employees alone. As the Attorney General noted, Neb. Rev. Stat. § 84-1601(1) (Reissue 2008) provides, in part:

> *"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 . . ."*

Similarly, the Attorney General added, Neb. Rev. Stat. § 84-1604 (Reissue 2008) reiterates that participation in the Nebraska State Insurance Program is limited to permanent and temporary State employees.

Based upon those statutory provisions, the Attorney General opined that the Director of DAS may not "allow non-state employees to expand their coverages and participate in all the insurance options offered to state employees..." In the same way, § 85-106(6) directs the Regents to provide "uniform benefits for all present and future employees." Applying the Attorney General's analysis, there is nothing in § 85-106 that specifically authorizes the Regents to extend health insurance benefits to non-University employees. Thus, for the same reason that the Attorney General took the unequivocal position that the Director of DAS lacks authority to allow non-employees to participate in the State's health insurance program, it is also reasonable to conclude that the Regents lack authority to extend University health insurance to anyone but an employee of that institution.

It should be noted that the Nebraska Supreme Court has recognized, in *Board of Regents of University of Nebraska v. Exon*, 199 Neb. 146, 256 N.W.2d 330 (1977) ("*Regents v. Exon*"), the authority of the Board of Regents to manage University affairs largely free from legislative interference.

Be that as it may, the Court emphasized that, under Article VII, section 10, of the Nebraska Constitution, "the Legislature may set forth the powers and duties of the Regents." Id. at 149, 256 N.W.2d at 333. The Court warned, however:

> *"Thus, although the Legislature may add to or subtract from the powers and duties of the Regents, the general government of the University must remain vested in the Board of Regents and powers or duties that should remain in the Regents cannot be delegated to other officers or agencies."* Id.

4. Ancillary Members (Continued)

The Court explained further:

> *"In prescribing the powers and duties of the Regents a legislative act must not be so detailed and specific in nature as to eliminate all discretion and authority on the part of the Regents as to how a duty shall be performed."* Id.

By authorizing the Regents, under § 85-106(6), to provide benefits, including health insurance, for "all present and future employees" of the University, the Legislature exercised its constitutional authority to prescribe a particular power or duty to the Regents – but doing so without intruding upon the Regent's prerogative as to how best to carry out that responsibility. The Regent's, on the other hand, have exceeded the authority granted to them under § 85-106(6) by extending University health insurance to individuals other than employees.

Due to having such a difficult time obtaining information from the University, especially information related to detailed claims data, the APA requested only the total amount of claims paid for its ancillary employees and dependents of ancillary groups or organizations. The University indicated these employees and their dependents had incurred $6,131,578 in medical and prescription claims during fiscal year 2010. However, as the APA never received access to the unredacted detailed claims data, the accuracy and completeness of that amount could not be verified.

In addition to the underlying question of whether employees of groups and organizations ancillary to the University should be permitted to participate in the Program, the APA noted another concern arising from the extension of University health coverage to such individuals. These ancillary groups were billed in the middle of the month of coverage, and payment was received/processed at the end of the month of coverage. For the UNMC ancillary employees Unemed and Ximerex, the payments were transferred to the University's health insurance trust fund at the end of the subsequent month. Additionally, Ximerex and UNMC Physicians, two affiliates of the University of Nebraska Medical Center, did not pay their premium timely for July 2009 and January 2010, respectively.

Allowing non-University employees to participate in the Program not only raises concerns regarding an apparent lack of statutory authority for such activity but also creates an increased risk that premiums paid by the non-employees will prove insufficient to cover the costs of all claims incurred by those participants. As a result, premiums paid by the University and its employees might be necessary to supplement the ancillary employee costs. Furthermore, it appears that the University lacked adequate procedures to ensure that premiums were received and processed timely.

> We recommend the Board of Regents deny employees of ancillary groups or organizations the opportunity to re-enroll in the plan during the next open enrollment. For equitable reasons, we

4. Ancillary Members (Concluded)

recommend also that the Board of Regents provide such employees with sufficient advance notice of this change in policy, thereby facilitating their efforts to secure alternative health insurance coverage.

University's Response: The Board of Regents enjoys certain powers that include, in our opinion, the ability to include members in its health plan. The ancillary groups included in the plan are specifically named in Board-approved policy. Management will discuss this issue with the Board.

The report should be amended to show that as of the date of the report, the University of Nebraska Foundation and Alumni Associations have left the Plan.

APA Response: The APA believes the statutes are clear regarding individuals eligible for participation in the health insurance program and that these ancillary members should be removed from the program. The APA has not performed follow-up procedures after the audit period to verify whether any ancillary members have been removed from program participation.

5. Eligibility Issues

The University lacked procedures for monitoring the eligibility of Program participants by ensuring that premiums were accurately paid for all members who incurred claims and by ensuring the coverage of former employees was properly terminated.

The APA tested the eligibility of medical (BCBSNE) and prescription (Caremark) claims paid for a sample of active employees, terminated employees, COBRA participants, and retirees. The University did not provide the requested detailed claims data for all ineligible members identified during our testing. Therefore, the following list of ineligible claims is not complete due to the University's refusal to provide the requested data for all members identified. A partial listing of ineligible claims for July 1, 2009, through June 30, 2010, follows:

Description of Testing	# of Participants with Ineligible Claims Identified by APA	# of Detailed Claims Data Provided by University	Medical (BCBSNE) Claims Paid	Prescription (Caremark) Claims Paid	Total Claims Paid
Active Employees	19	2	$ 0	$ 0	$ 0
Terminated Employees	24	5	$ 467	$ 1,276	$ 1,743
COBRA Participants	13	1	$ 1,162	$ 8	$ 1,170
Retirees	7	0	None provided	None provided	None provided
Totals	**63**	**8**	**$ 1,629**	**$ 1,284**	**$ 2,913**

Note: The University agreed to provide detailed claims data for only 10 individuals identified by the APA. Only eight are shown above because one of the ten did not have claims and one of the ineligible individuals later paid the full premium, so the APA decided not to pursue the data any further.

5. Eligibility Issues (Continued)

It is imperative to take these figures in context with the limited information provided by the University. The APA feels these figures would be significantly higher had the University provided all of the requested information.

APA Testing Procedures

As noted in the Background Section of this report, the University did not provide the APA with the full, detailed medical and prescription claims files. In order to proceed with this examination, as well as with the simultaneous performance audit of the Program, the APA requested a less extensive data file for both medical and prescription claims. That data file would include the names of the participants, dates of birth, types of subscribers (employee, spouse, or child), the months and years of service (claims), and the aggregate total claims paid for each day. Though not providing the detailed claims data needed to carry out a thorough, comprehensive, and time efficient eligibility analysis, as intended at the outset of this examination, the APA decided this alternative file, along with the University's cooperation in providing the detailed claims data upon notification of ineligible participants, would suffice for limited eligibility testing of those receiving services under the Program.

The APA also requested and received a file that included the July 1, 2009, through June 30, 2010, group health insurance payroll deductions for University employees. For those participants whose health insurance premiums were not paid through the University's payroll process, including COBRA, retiree, and ancillary members, the APA requested the detailed premium payment information. Detailed information was received from all campuses except UNL, who did not maintain the detailed premium payment information. See Comment Number 1 for a more extensive discussion of the problems encountered by the APA in obtaining this information from the University.

The APA compared the payroll deduction files to the claims files to ensure that every participant who incurred a claim paid a premium for the month in which that claim was incurred. Based upon the results of that testing, the APA compiled a list of all ineligible participants for whom appropriate premiums had not been paid.

On October 7, 2011, the APA sent this listing of ineligible individuals to the University in order to obtain the total amount of ineligible claims paid. Additional ineligible individuals were also provided to the University on October 14th, 20th, and 21st. Due to the University's persistent unwillingness to provide the requested data, the APA reluctantly agreed to obtain the detailed claims data for a small sample of 10 of the 63 ineligible members identified.

Active Employees

The University's "Medical Insurance Benefits Overview" states:

> *"Faculty and staff are eligible for group medical insurance coverage if they are employed in a 'Regular' position with an FTE [Full-Time Equivalent] of .5 or greater or employed in a 'Temporary' position for more than 6 months with an FTE of .5 or greater."*

5. Eligibility Issues (Continued)

Included in the APA's list of ineligible individuals were those who had changed job positions in less than six months or had their FTE reduced below .5, either of which should have resulted in a loss of benefits. Despite having ceased paying the health insurance premium, moreover, those individuals still had claims incurred.

The APA also found instances in which the employee was on an extended leave of absence (LOA), which is allowable per the University's "Medical Insurance Benefits Overview" as follows:

> *"Employees may continue medical coverage while on an approved leave of absence for up to two years."*

A LOA employee is responsible for paying directly to the University the full premium amount due each month, including both the employee and the employer share. Multiple instances were noted in which premiums were not received timely, if at all, for these LOA individuals.

The following table reflects the 19 active employees identified by the APA as ineligible between July 1, 2009, and June 30, 2010:

Status	Time Period Ineligible	Ineligible Medical Claims	Ineligible Prescription Claims	Reason Ineligible
Dependent	January 2010 to June 2010	$0	$0	Coverage ended 12/31/2009. No premiums were paid after December 2009. Claims were incurred between January 2010 and April 2010.
Employee	January 2010 to June 2010	$0	$0	Coverage ended 12/31/2009. No premiums paid after December 2009. Claims were incurred between January 2010 and March 2010.
Dependent	January 2010 to June 2010	Not Provided	Not Provided	Coverage ended 12/31/2009. No premiums paid after December 2009. Claims were incurred in March 2010.
Employee	January 2010 to June 2010	Not Provided	Not Provided	Coverage should have ended 1/31/2010, but January 2010 premium not paid. No premiums paid after December 2009. Claims were incurred in January 2010.
Employee	July 2009 to June 2010	Not Provided	Not Provided	Coverage should have ended 9/30/2008, but the accounting system was not updated correctly. As a result, coverage continued until 9/30/2009. No premiums paid during FY 2010. Claims were incurred in July, August, September, October, and December 2009 and January and April 2010.
Employee	January 2010 to June 2010	Not Provided	Not Provided	Coverage should have ended 1/31/2010, but only half of January premium was paid. No additional premiums paid after January 2010. Claims were incurred in February 2010.
Employee	July 2009 to June 2010	Not Provided	Not Provided	Coverage should have ended 7/31/2009, but July 2009 premium was not paid. No premiums paid after June 2009. Claims were incurred in July 2009.

5. Eligibility Issues (Continued)

Status	Time Period Ineligible	Ineligible Medical Claims	Ineligible Prescription Claims	Reason Ineligible
Dependent	July 2009 to June 2010	Not Provided	Not Provided	Coverage should have ended 7/31/2009, but July 2009 premium was not paid. No premiums paid after June 2009. Claims were incurred in October 2009.
Dependent	January 2010 to June 2010	Not Provided	Not Provided	Coverage should have ended 1/31/2010, but only half of January premium was paid. No additional premiums paid after January 2010. Claims were incurred in January and April 2010.
Employee	January 2010 to June 2010	Not Provided	Not Provided	Coverage should have ended 1/31/2010, but only half of January premium was paid. No additional premiums paid after January 2010. Claims were incurred in January and June 2010.
Dependent	June 2010	Not Provided	Not Provided	Coverage ended 5/31/2010. No premiums paid after May 2010. Claims were incurred in June 2010.
Employee	July 2009 to June 2010	Not Provided	Not Provided	Coverage should have ended 7/31/2009, but July 2009 premium was not paid. Claims were incurred in July 2009.
Employee	January 2010	Not Provided	Not Provided	Coverage should have ended 1/31/2010, but January 2010 premium was not paid. COBRA coverage began in February 2010. Claims were incurred in January 2010.
Employee	September 2009 to October 2009	Not Provided	Not Provided	Employee on LOA from September 2009 to June 2010. Premiums for September and October 2009 were not paid timely. Claims were incurred in October 2009.
Dependent	September 2009 to October 2009	Not Provided	Not Provided	Employee on LOA from September 2009 to June 2010. Premiums for September and October 2009 were not paid timely. Claims were incurred in September 2009.
Dependent	September 2009 to October 2009	Not Provided	Not Provided	Employee on LOA from September 2009 to June 2010. Premiums for September and October 2009 were not paid timely. Claims were incurred in October 2009.
Employee	April 2010	Not Provided	Not Provided	Employee on LOA in March and April 2010. Premium for April 2010 not paid timely. Claims were incurred in April 2010.
Dependent	April 2010	Not Provided	Not Provided	Employee on LOA in March and April 2010. Premium for April 2010 not paid timely. Claims were incurred in April 2010.
Employee	July 2009 to June 2010	Not Provided	Not Provided	Employee did not pay premiums in FY 2010. Claims were incurred in October 2009.
Total (19 individuals)		**$0**	**$0**	

Note: For the individuals with $0 in the claims column, this means there were claim details, but the claims were not paid by the Program. The individuals with "Not Provided" represent individuals who incurred claims during months in which the premium was not paid, and therefore, determined by the APA to be ineligible. These individuals were not included in the sample of 10 the University was willing to provide.

The APA also found one active employee on a LOA who overpaid the health insurance premium from January 2010 to June 2010. The employee had premiums withheld from his pay and also paid the premiums by check during this time period. The total overpayment was $1,284. In October 2011, upon notification of the overpayment by the APA, UNL Benefits staff sent a letter to the member informing him of the error and indicating that a refund would be sent.

5. Eligibility Issues (Continued)

Terminated Employees
The University's "Medical Insurance Benefits Overview" states:

> *"Coverage terminates on the last day of the month following the date of termination or date the employee is no longer eligible for coverage. If the date of termination or employee's coverage ineligibility is the last day of the month, coverage will terminate immediately."*

The APA identified a number of Program participants for whom coverage did not cease on the last day of the month following their termination date. In some instances, the campus staff did not update the termination date in the accounting system in a timely manner, which allowed ineligible claims to be paid. In other instances, it appeared the termination dates were updated in a timely manner; however, for unknown reasons, the individuals continued to incur claims after the month of termination.

Still in other situations, the health insurance premium was withheld from the employees' final vacation payout, in error, which resulted in the continuation of coverage. Later, the erroneous premium was refunded to the employee; however, by that time, claims had already been incurred.

Between July 1, 2009, and June 30, 2010, the following 24 individuals incurred claims after their termination.

Status	Time Period Ineligible	Ineligible Medical Claims	Ineligible Prescription Claims	Reason Ineligible
Dependent	August 2009 to June 2010	Not Provided	Not Provided	Employee terminated 7/11/2009. No premiums paid after July 2009. Claims were incurred in September and December 2009 and March 2010.
Employee	July 2009 to June 2010	$0	$0	Employee terminated 2/11/2009. No premiums paid in FY 2010. Claims were incurred in September 2009.
Dependent	July 2009 to June 2010	Not Provided	Not Provided	Employee terminated 2/11/2009. No premiums paid in FY 2010. Claims were incurred in August, October, and November 2009.
Employee	April 2010 to June 2010	Not Provided	Not Provided	Employee terminated 3/23/2010. No premiums paid after March 2010. Claims were incurred between April and June 2010.
Dependent	April 2010 to June 2010	Not Provided	Not Provided	Employee terminated 3/23/2010. No premiums paid after March 2010. Claims were incurred in April 2010.
Dependent	April 2010 to June 2010	Not Provided	Not Provided	Employee terminated 3/23/2010. No premiums paid after March 2010. Claims were incurred in April and May 2010.
Dependent	August 2009 to June 2010	Not Provided	Not Provided	Employee terminated 7/31/2009. Accounting system not updated until 8/28/2009. No premiums paid after July 2009. Claims were incurred in August and September 2009.

COMMENTS AND RECOMMENDATIONS
(Continued)

5. Eligibility Issues (Continued)

Status	Time Period Ineligible	Ineligible Medical Claims	Ineligible Prescription Claims	Reason Ineligible
Employee	July 2009 to June 2010	Not Provided	Not Provided	Employee terminated 6/23/2009. Accounting system was not updated until 7/31/2009. No premiums paid in FY 2010. Claims were incurred in July 2009.
Dependent	July 2009 to June 2010	Not Provided	Not Provided	Employee terminated 6/23/2009. Accounting system was not updated until 7/31/2009. No premiums paid in FY 2010. Claims incurred in July 2009.
Dependent	July 2009 to June 2010	Not Provided	Not Provided	Employee terminated 6/23/2009. Accounting system was not updated until 7/31/2009. No premiums paid in FY 2010. Claims incurred in July 2009.
Employee	March 2010 to June 2010	Not Provided	Not Provided	Employee terminated 3/1/2010. Accounting system was not updated until 3/25/2010. No premiums paid after February 2010. Claims incurred in March and April 2010.
Dependent	September 2009 to June 2010	Not Provided	Not Provided	Employee terminated 9/1/2009. No premiums paid after August 2009. Claims were incurred in December 2009 and January 2010.
Dependent	May 2010 to June 2010	Not Provided	Not Provided	Employee terminated 4/17/2010. No premiums paid after April 2010. Claims were incurred in May 2010.
Employee	August 2009 to June 2010	$467	$119	Employee terminated 8/18/2009; however August 2009 premium was not paid. No premiums paid after July 2009. Claims were incurred in August 2009.
Dependent	August 2009 to June 2010	Not Provided	Not Provided	Employee terminated 8/18/2009; however August 2009 premium was not paid. No premiums paid after July 2009. Claims were incurred in August 2009.
Employee	August 2009 to June 2010	Not Provided	Not Provided	Employee terminated 8/14/2009; however August 2009 premium was not paid. No premiums paid after July 2009. Claims were incurred in August 2009.
Employee	March 2010 to June 2010	No medical claims	$588	Employee terminated 2/28/2010. No premiums paid after February 2010. Claims were incurred between April and June 2010.
Dependent	March 2010 to June 2010	No medical claims	$367	Employee terminated 2/28/2010. No premiums paid after February 2010. Claims were incurred between March and June 2010.
Dependent	March 2010 to June 2010	Not Provided	Not Provided	Employee terminated 2/28/2010. No premiums paid after February 2010. Claims were incurred in March and May 2010.
Employee	February 2010 to June 2010	$0	$202	Coverage ended 1/31/2010. February 2010 premium paid but refunded in March. No additional premiums paid after January 2010. Claims were incurred in February and March 2010.

5. Eligibility Issues (Continued)

Status	Time Period Ineligible	Ineligible Medical Claims	Ineligible Prescription Claims	Reason Ineligible
Dependent	July 2009 to June 2010	Not Provided	Not Provided	Coverage ended 6/30/2009. July 2009 premium paid but refunded in September. No additional premiums paid in FY 2010. Claims were incurred in July 2009.
Dependent	September 2009 to June 2010	Not Provided	Not Provided	Coverage ended 8/31/2009. September 2009 premium paid but refunded in October. No additional premiums paid after August 2009. Claims were incurred in September 2009.
Dependent	July 2009 to June 2010	Not Provided	Not Provided	Coverage ended 6/30/2009. July 2009 premium paid but refunded in August. No additional premiums paid in FY 2010. Claims were incurred in July and August 2009.
Employee	July 2009 to June 2010	Not Provided	Not Provided	Employee on LOA from July 2009 to September 2009. July 2009 premium paid but refunded in December. No additional premiums paid in FY 2010. Claims were incurred between July and September 2009.
Total (24 individuals)		**$467**	**$1,276**	

Note: For the individuals with $0 in the claims column, this means there were claim details, but the claims were not paid by the Program. The individuals with "Not Provided" represent individuals who incurred claims during months in which the premium was not paid, and therefore, determined by the APA to be ineligible. These individuals were not included in the sample of 10 the University was willing to provide.

COBRA Participants

According to University staff, COBRA premium payments are due the last day of the month. This unwritten policy appears to be due, at least in part, to Federal regulations that require a minimum 30 day grace period for COBRA payments. (See http://www.dol.gov/ebsa/faqs/faq-consumer-cobra.html.)

This practice allows the COBRA participant to incur claims during an entire month before the premium payment is due. The APA identified several COBRA participants who incurred claims during a month in which the COBRA premium was not properly paid.

Status	Time Period Ineligible	Ineligible Medical Claims	Ineligible Prescription Claims	Reason Ineligible
Employee	July 2009 to June 2010	Not Provided	Not Provided	COBRA coverage ended 2/28/2009. No premiums paid in FY 2010. Claims were incurred between July and September 2009.
Employee	April 2010 to June 2010	Not Provided	Not Provided	COBRA coverage began 3/1/2010, but only March 2010 COBRA premium paid. No premiums paid after March 2010. Claims were incurred in April 2010.
Dependent	April 2010 to June 2010	Not Provided	Not Provided	COBRA coverage began 3/1/2010, but only March 2010 COBRA premium paid. No premiums paid after March 2010. Claims were incurred in April 2010.

5. Eligibility Issues (Continued)

Status	Time Period Ineligible	Ineligible Medical Claims	Ineligible Prescription Claims	Reason Ineligible
Employee	January 2010 to June 2010	Not Provided	Not Provided	COBRA coverage ended 12/31/2009. No premiums paid after December 2009. Claims were incurred in January and February 2010.
Dependent	January 2010 to June 2010	Not Provided	Not Provided	COBRA coverage ended 12/31/2009. No premiums paid after December 2009. Claims were incurred in February 2010.
Dependent	January 2010 to June 2010	Not Provided	Not Provided	COBRA coverage ended 12/31/2009; however the accounting system was not updated until 2/9/2010. No premiums paid after December 2009. Claims were incurred in January and March 2010.
Employee	October 2009 to June 2010	Not Provided	Not Provided	COBRA coverage ended 9/30/2009. No premiums paid after September 2009. Claims were incurred in October 2010.
Employee	April 2010 to June 2010	Not Provided	Not Provided	COBRA coverage ended 3/31/2010. No premiums paid after March 2010. Claims were incurred in April 2010.
Dependent	April 2010 to June 2010	$1,162	$8	COBRA coverage ended 3/31/2010. No premiums paid after March 2010. Claims were incurred in April 2010.
Employee	November 2009 to January 2010	Not Provided	Not Provided	Full premium amount was not paid from November 2009 to January 2010. Claims were incurred in January 2010.
Employee	April 2010	Not Provided	Not Provided	COBRA premium payment for April 2010 not paid timely. Claims were incurred in April 2010.
Employee	June 2010	Not Provided	Not Provided	COBRA coverage ended 5/31/2010. No premiums paid after May 2010. Claims were incurred in June 2010.
Employee	June 2010	Not Provided	Not Provided	COBRA coverage ended 5/31/2010. No premiums paid after May 2010. Claims were incurred in June 2010.
Ineligible (13 individuals)		**$1,162**	**$8**	

Note: The individuals with "Not Provided" represent individuals who incurred claims during months in which the premium was not paid, and therefore, determined by the APA to be ineligible. These individuals were not included in the sample of 10 the University was willing to provide.

Because of the amount of time allowed to pay the premium, the University should implement additional procedures for managing COBRA health insurance coverage. At a minimum, those procedures should include reviewing the paid claims on a periodic basis and requiring participants to reimburse the University for claims that were paid during months in which premiums were not received.

The APA also identified the following issues related to the testing of COBRA participants:

- A third party failed to pay a portion of the monthly premium timely for two COBRA participants.

5. Eligibility Issues (Continued)

1) In the first instance, the third party failed to pay its portion of the February 2010 premium until March 12, 2010.
2) In the second instance, UNL originally provided documentation that indicated the April 2010 portion of the premium owed by the third party was not paid at all. Later, however, UNL provided revised documentation that indicated the premium was paid. Despite new information in the revised documentation, the APA was unable to verify whether the April 2010 premium was actually paid.

- University staff failed to update the coverage end dates in the accounting system timely for two COBRA participants. These participants' coverage should have ended on November 30, 2009, and January 31, 2010; however, the accounting system was not changed to reflect the end dates until January 13, 2010, and March 11, 2010, respectively. Although no claims were paid, there was a risk claims could have been paid during this period.
- UNMC did not process the June 2010 premium payment timely for three COBRA participants.

Retiree Participants
Generally, retiree participants in the Program pay their premiums electronically. The University lacked procedures for properly terminating health insurance coverage if the electronic payment failed. The APA found several instances in which electronic payments did, in fact, fail – due primarily to insufficient funds or a stop payment. Nevertheless, claims were still incurred during the month. In other examples, the accounting system was not updated in a timely manner.

Status	Time Period Ineligible	Ineligible Medical Claims	Ineligible Prescription Claims	Reason Ineligible
Dependent	July 2009 to June 2010	Not Provided	Not Provided	Retiree coverage ended 1/31/2009. No premiums paid in FY 2010. Claims were incurred in April and May 2010.
Employee	December 2009 to June 2010	Not Provided	Not Provided	Coverage should have ended 11/30/2009. Electronic payment for December 2009 premium failed – no additional payments made. Claims were incurred between December 2009 and March 2010.
Employee	August 2009 to June 2010	Not Provided	Not Provided	Coverage should have ended 7/31/2009; however the accounting system was not updated until 8/17/2009. Electronic payment for August 2009 premium failed – no additional payments made. Claims were incurred in August 2009.
Dependent	August 2009 to June 2010	Not Provided	Not Provided	Coverage should have ended 7/31/2009; however accounting system was not updated until 8/17/2009. Electronic payment for August 2009 premium failed – no additional payments made. Claims were incurred in August 2009.

COMMENTS AND RECOMMENDATIONS
(Continued)

5. Eligibility Issues (Continued)

Status	Time Period Ineligible	Ineligible Medical Claims	Ineligible Prescription Claims	Reason Ineligible
Employee	December 2009 to June 2010	Not Provided	Not Provided	Electronic payment for December 2009 premium failed and was not made up. Electronic payment for January 2010 premium also failed and was not made up until February 2010. Coverage ended 1/31/2010. Claims were incurred between December 2009 and February 2010.
Employee	December 2009	Not Provided	Not Provided	Electronic payment for December 2009 premium failed and was not made up until June 2010. Claims were incurred in December 2009.
Dependent	December 2009	Not Provided	Not Provided	Electronic payment for December 2009 premium failed and was not made up until June 2010. Claims were incurred in December 2009.
Total (7 individuals)		None Provided	None Provided	

Note: The individuals with "Not Provided" represent individuals who incurred claims during months in which the premium was not paid, and therefore, determined by the APA to be ineligible. These individuals were not included in the sample of 10 the University was willing to provide.

The APA also identified the following issues related to the testing of retiree participants:

- One retiree died in January 2010. Because UNL did not properly terminate coverage in the accounting system, that individual remained on the enrollment files through June 2010. No fraudulent claims were incurred for this retiree during this ineligible period after his date of death, but he is included in the comment to indicate UNL did not have controls to properly terminate benefits.
- UNK Benefits staff failed to stop an electronic payment for one retiree. On August 5, 2009, this retiree requested UNK cancel coverage effective at the end of the month; however, the electronic premium for September was not cancelled, which required UNK to process a refund of that premium payment. No claims were incurred for this retiree during September 2009.
- Two retirees failed to notify the University of their spouses' death in a timely manner. The University processed refunds for the retirees of $1,768 and $1,960, respectively, which was the difference in the premium costs between retiree and spouse coverage and retiree only coverage. The University's "Medical Insurance Benefits Overview" requires changes in coverage to be made within 31 days of the permitted election change event. Neither employee notified the University of the spouse's death for more than 100 days from the dates of death. Because the notification was not made timely, the coverage was not changed timely and the refunds of the premiums should not have been made.

A self-insured program should include control procedures to ensure all individuals receiving benefits are eligible and have paid the correct premium amounts on time, as well as procedures to end insurance benefits in a timely manner for individuals who are no longer eligible or who have terminated. When these procedures are not in place, the risk that claims will be paid for ineligible members is significantly increased.

COMMENTS AND RECOMMENDATIONS
(Continued)

5. Eligibility Issues (Continued)

We recommend the University:

- Compare the health insurance premium payments of active employees, COBRA participants, and retirees to the claims paid to ensure premiums are paid for all members who incur claims.
- Ensure termination and coverage end dates are updated in the accounting system in a timely manner.
- Review terminated employees to ensure that benefits do not continue after the month of termination.
- Ensure premium refunds are not made for months in which claims were incurred and paid.
- Strengthen controls over employees on LOA, retirees, and COBRA participants to ensure payments are properly received, for the correct amounts, and made timely.

University's Response: The comment states that when persons leave the employ of the University, there have been instances in which these former employees incur health care costs before providers are notified that those persons are no longer eligible (sometimes referred to as "cutoff errors"). This situation is being re-examined by management.

Several points are made in error or omitted that should be corrected or included:

- *The Auditor fails to disclose that any medical or dental costs incurred by an ineligible person are reversed and billed back to that health care provider. The Plan does not ultimately bear these costs. Full disclosure would correct this omission.*
- *The Auditor fails to state that the selection of 10 participants for testing was mutually agreed upon. The voluminous "not provided" in the tables seems to suggest that the University did not honor this agreement. The University had agreed with the Auditor that "cutoff errors" exist. In an effort to save the time of APA staff, University staff, and that of Blue Cross Blue Shield and CVS/Caremark, it was suggested (and ultimately agreed) to have APA staff do a sample of 10 persons versus doing the same test 100 times to prove the same point.*
- *Because of the mutual agreement referred to in the point above, the "not provided" should be deleted from the tables as it is not reflective of the facts*

APA Response: Ineligible claims are only reversed when they are detected. Without proper monitoring of whether premiums are paid for all participants who incur claims, ineligible claims will continue to be incurred and remain undetected, such as the ones identified in this comment. The third party administrator relies on information provided by the University, such as benefit eligibility beginning and ending dates. If that information is not updated accurately or timely in the University's accounting system, the third party administrator will not be able to detect the ineligible claims, or as a result, reverse the claims.

5. Eligibility Issues (Concluded)

In an effort to finally complete the audit, the APA did compromise with the University and agreed to receive detailed claims information for only 10 individuals. The other individuals are still included in this comment because they represent potential ineligible claims, as original information provided to the APA indicated claims were incurred in months in which a premium was not paid.

6. Lack of Monitoring and Controls

Because the Program is self insured, it is essential that the University adequately monitor its activity. The APA found that the University failed to monitor the Program adequately, as follows:

Ineligible Claims and Dependent Oversight
As previously noted in Comment Number 5, ineligible claims were paid between July 1, 2009, and June 30, 2010. These claims were paid for individuals who did not properly pay premiums or were not properly removed from the accounting system after they became ineligible for coverage.

Additionally, the University failed to ensure all dependents were eligible for Program coverage. During our audit period, the University did not require documentation, such as marriage or birth certificates, divorce decrees, court orders, or college transcripts to verify the eligibility of dependents. After our performance audit was initiated in April 2010, the University entered into a contract for a Dependent Eligibility Audit. The results of that audit, which are included in Comment Number 7, highlight the risk that ineligible dependents were covered under the Program during our audit period.

Enrollment File
Each week, the University runs an enrollment file from the accounting system, which is provided to the third party administrators, BCBSNE and Caremark. This file identifies all covered participants; however, the University did not properly maintain its enrollment files. The only file maintained during fiscal year 2010 was the final June 27, 2010, enrollment file.

The APA found 13 individuals who, despite having a June 2010 payroll deduction, were not included on the June 27, 2010, enrollment file. These individuals had terminated prior to June 1, 2010, but had their final paychecks issued in June. The University incorrectly withheld the health insurance premium from these final paychecks. Five of the incorrect health insurance deductions were correctly refunded. Of the remaining eight, four were partially refunded while the other four were not refunded at all.

6. Lack of Monitoring and Controls (Continued)

	Month of Deduction – Full or Partial Premium	Amount Refunded	Amount Due to Former Employee
Employee 1	May 2010 – Full Premium	Half in June 2010	$ 67.00
Employee 2	June 2010 – Half Premium	None	$ 90.00
Employee 3	June 2010 – Half Premium	None	$ 40.00
Employee 4	June 2010 – Full Premium	Half in July 2010	$ 40.00
Employee 5	June 2010 – Half Premium	None	$ 67.00
Employee 6	June 2010 – Half Premium	None	$ 67.00
Employee 7	June 2010 – Full Premium	Half in July 2010	$ 40.00
Employee 8	June 2010 – Full Premium	Half in July 2010	$ 40.00
Total			**$ 451.00**

The APA also found the following issues related to the University's June enrollment file:

- Thirteen individuals were included on the June enrollment file, but they did not pay the June premium. According to the accounting system, twelve of these individuals' coverage terminated in May 2010, and one individual's coverage terminated in February 2010.
- One individual who made a June premium payment was not included on the June enrollment file.
- Four individuals were included on the enrollment file, but they were neither enrolled in a health insurance plan nor were paying for health insurance coverage.

COBRA Deposits
UNL COBRA premium payments could not be traced to the University's separate health insurance trust fund for the two months tested by the APA. COBRA participants pay their premiums directly to the University. Those premiums are deposited into a campus account prior to being transferred to the University's separate health insurance trust fund. The APA could not trace the premium amounts collected in December 2009 and April 2010 to the amounts transferred to the health trust fund.

Month	Premiums Collected per Deposit Reports	Premiums Transferred to University Health Trust Fund	Difference
December 2009	$ 18,268	$ 17,768	$ 500
April 2010	$ 25,613	$ 24,980	$ 633

The amounts collected, as noted above, include certain payments that are not deposited into the trust fund, such as a 2% COBRA administration fee, or COBRA vision premiums. UNL lacked procedures to ensure the amounts collected were properly deposited and could not provide the

6. Lack of Monitoring and Controls (Continued)

documentation necessary to reconcile the premiums collected to the amounts transferred to the trust fund. According to the UNL Benefits Manager, the premiums collected could not be reconciled to the amounts transferred due to possible refunds or changes that may have been made but could not be located.

Pharmaceutical Rebates
As described in the Background Section of this report, the prescription coverage for the University is part of an agreement between Caremark and EHPCO. As of January 1, 2010, the University selected a pricing option that included pharmaceutical rebates, which are rebates from pharmaceutical companies based on the use of certain drugs. Although the contract between Caremark and EHPCO allows for an audit of rebate amounts, the University never exercised its audit rights under that provision and lacked its own procedures to ensure the rebates received were complete and accurate.

The University received the following rebates from EHPCO for 2010:

Time Period	Date Check Received by the University	Amount
1st Quarter 2010	6/30/2010	$ 390,284.35
2nd Quarter 2010	9/30/2010	$ 399,751.50

See **Attachments I** and **J** for 1st and 2nd Quarter 2010 Rebate letters.

Performance Guarantees
The contract between EHPCO and Caremark contains performance guarantees, which require Caremark to maintain its performance at certain levels. Failure to meet such standards may result in financial penalties against Caremark. Such penalties are allocated among each organization participating in the EHPCO coalition for their share of any underperformance.

The University acknowledged they lacked procedures to ensure that Caremark met the performance guarantees, claiming that compliance with the contractual performance standards was difficult to monitor.

The following payments for Caremark's failure to meet the contractual performance guarantees were received by the University for calendar years 2009 and 2010. This portion represents Caremark's Generic Effective Rate (GER) reconciliation, which is the average discount realized in the dispensing of generic drugs.

Time Period	Date Check Received by the University	Total EHPCO Recovery Amount	University's share of Under-performance
Calendar Year 2009	5/5/2010	$ 306,717.37	**$ 520.29**
Calendar Year 2010	6/8/2011	$ 622,618.54	**$ 63,369.08**

6. Lack of Monitoring and Controls (Continued)

On June 8, 2011, the University also received $105,724 for its drug savings review clinical program performance, bringing the total performance guarantees received for calendar year 2010 to $169,093.08.

See **Attachments K** and **L** for calendar years 2009 and 2010 Performance Guarantees.

The table above indicates that Caremark's compliance with performance guarantees fluctuates a great deal, increasing the need for effective monitoring procedures by the University.

BCBSNE and Caremark Invoices
The University lacked procedures to ensure that its monthly payments to Caremark and BCBSNE were accurate, as indicated below:

- The University did not reconcile either the medical or prescription invoices to the detailed claims data to ensure the amounts billed were accurate and supported by adequate documentation. The APA could not reconcile the May 2010 medical invoice to the detailed claims data provided. The APA determined the detailed claims data contained $5,524 more claims than the amounts included on the invoice. Having not reconciled the data, the University was unable to explain the difference.
- Because the University reviewed invoices for reasonableness only, support was not obtained for the Caremark fees billed each month. The additional fees on the May 2010 invoice totaled $32,994 and included a drug savings review fee, an enhanced gaps in care fee, and a pre-authorization fee for therapy protocols. The drug savings review fee was billed for each claim, and the enhanced gaps in care fee was billed per employee per month. The APA could not verify whether the fees charged were accurate because the amounts billed did not agree to either the monthly prescriptions filled or the number of employees enrolled that month. There was also no documentation provided to support the number of pre-authorized therapy protocols.
- The APA also noted similar issues regarding the BCBSNE monthly invoices. The University participates in the Blue Partners-Disease Management program, which identifies members with diabetes, heart disease, asthma, and chronic obstructive pulmonary disease. The amount charged for the Blue Partners program for the month of May 2010 was $45,198. Because the rates for the Blue Partners program were not included in the contract between BCBSNE and the University, the APA requested documentation to support whether BCBSNE and the University had agreed to the fees. However, the University was only able to provide an internal BCBSNE email noting the rates charged.

Campus Segregation of Duties
The APA reviewed each campus' procedures for collecting and depositing insurance premium payments made by retirees, COBRA individuals, and ancillary organizations and noted the following:

COMMENTS AND RECOMMENDATIONS
(Continued)

6. Lack of Monitoring and Controls (Continued)

- All four campuses (UNL, UNMC, UNK, and UNO) lacked an adequate segregation of duties to ensure all premium payments received were deposited. The Benefits Office at both UNL and UNMC each had one individual who could record premium payment information, update the participant's benefit information in the accounting system, take collections to the cashier, reconcile collections to the accounting records, prepare and approve refunds, prepare the billing documents of ancillary organizations, and review ACH payments for completeness. The Benefits Office at both UNK and UNO each had two individuals who shared this responsibility. At neither campus was there an independent, documented review to ensure all premium payments collected were deposited.
- At the time of the audit, the Benefits Office at neither UNO nor UNK was restrictively endorsing checks immediately upon receipt; instead, the checks were endorsed when taken to the Cashier.

Without adequate monitoring and controls over the self-insured Program, there is an increased risk claims could be paid for ineligible participants, which could lead to higher premiums required to fund the Program.

We recommend the University implement the following changes to safeguard assets and provide affordable premiums:

- Ensure all Program participants have properly paid a premium and all dependents are eligible.
- Review employees' final paychecks to ensure insurance premiums are not incorrectly withheld.
- Maintain copies of all enrollment files and ensure information provided therein is complete and accurate.
- Establish procedures to reconcile COBRA receipts to amounts transferred to the University's separate health insurance trust fund.
- Implement procedures to ensure pharmaceutical rebate and performance guarantees amounts received are complete and accurate.
- Ensure monthly amounts paid to vendors are accurate.
- Implement a proper segregation of duties at each campus, including an independent review and comparison of premium amounts received to those deposited.

University's Response: The University disagrees with the term "Lack" in the title of the comment as there are monitoring processes and controls present. There may be immaterial exceptions of the type noted by the Auditor from time to time in a plan that has approximately 10,000 members and 23,000 covered lives. The cost-benefit of adding additional staff to increase controls will be considered.

6. Lack of Monitoring and Controls (Concluded)

APA Response: The APA does not feel the monitoring and controls currently in place at the University provide much value in the areas discussed in this comment; therefore, our use of the term "lack of" seems appropriate. The APA also disagrees with the University's use of the concept of "immaterial" when discussing the types of errors or exceptions found in this audit.

7. Dependent Eligibility Audit

Prior to this audit, the University began discussions with Chapman Kelly (HMS Employee Solutions) for a dependent eligibility audit of the Program's medical and dental insurance plans. EHPCO completed the request for proposals for the audit services and awarded the contract, which was signed in June 2010 between the University and Chapman Kelly. The dependent eligibility audit was completed when a final report was presented to the University in June 2011.

The APA requested a copy of the final independent audit report in a meeting with University staff on August 4, 2011 – a request not complied with at that time. A subsequent email message, indicating the urgency of the initial request for a copy of the final report, was sent to the Vice President for Business and Finance on August 9, 2011, and was also forwarded to the Senior Associate to the President. On August 12, 2011, having received no response from the University, the APA made a public records request, pursuant to Neb. Rev. Stat. § 84-712.01 (Reissue 2008), for a copy of the final report. The University responded to the public records request on August 18, 2011, with additional information provided on August 25, 2011.

The unwillingness to provide the APA with a copy of a highly relevant audit report prepared by a third party is but one of many examples of the University's lack of cooperation with this audit. See Comment Number 1 for further information.

Chapman Kelly's audit objectives were to:

- Conduct a thorough review of enrolled dependents.
- Verify that dependents were eligible for benefits in accordance with applicable Program rules and communicate the consequences of ineligibility.
- Remove ineligible dependents from coverage.
- Educate employees on the definition of an eligible dependent.
- Reduce overall healthcare costs.

Chapman Kelly's audit services included the following four phases:

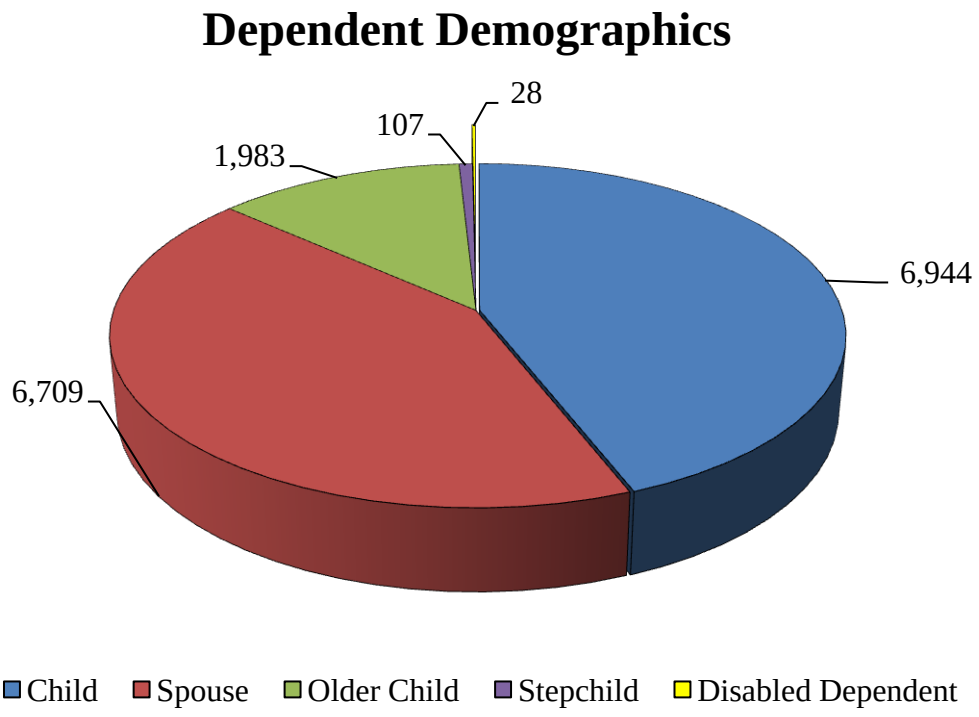
1. *Planning phase* – included defining the project timeline, the verification documents, and the enrollment data file.
2. *Amnesty phase* – allowed employees an amnesty period for removal of ineligible dependents with no penalty or consequence to the employee.

7. Dependent Eligibility Audit (Continued)

3. *Verification phase* – included a detailed review of enrolled dependents and confirmed eligibility with the employees. This phase required each employee to submit documents verifying his or her dependent's relationship, residency, dependency, and child custody status. Multiple explanatory letters were sent to the employees. A final letter was sent to those who had not responded, detailing the consequences of noncooperation.
4. *Grace period phase* – allowed non-responders a grace period for filing the required information prior to receiving the final notice of adverse action. At this time, dependents of any employee who did not meet the University's eligibility guidelines, failed to provide sufficient documentation for dependency, or did not respond to auditor inquiries, were removed from coverage.

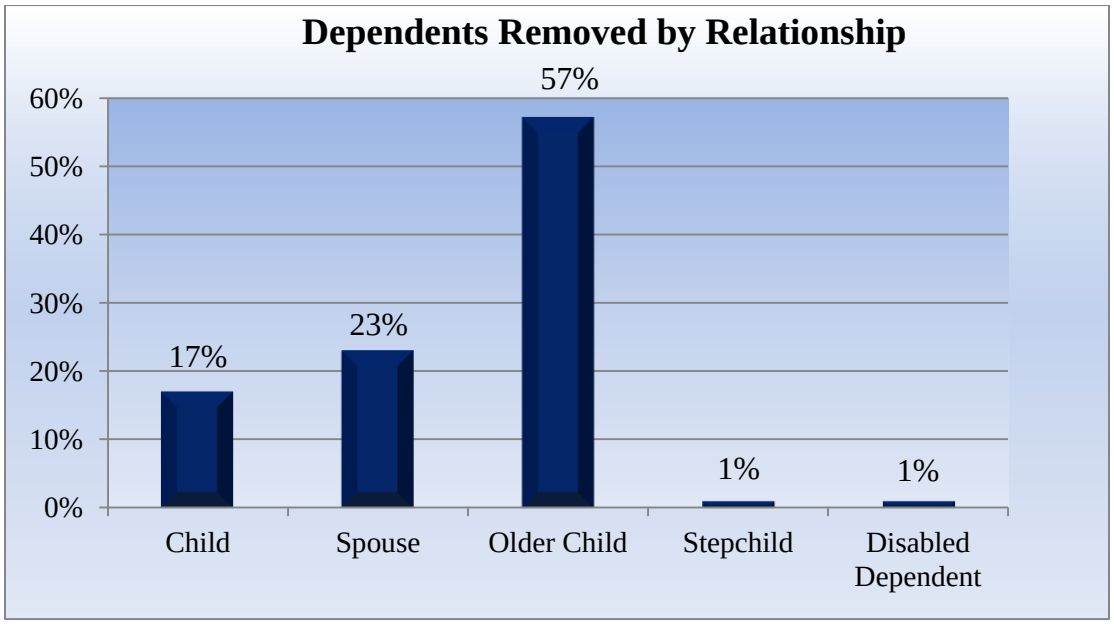
Chapman Kelly's final report contained the following information:

Demographics
The data provided by the University included 15,771 dependents to be verified, from 7,601 employees. The following graph shows the demographics of these 15,771 dependents.

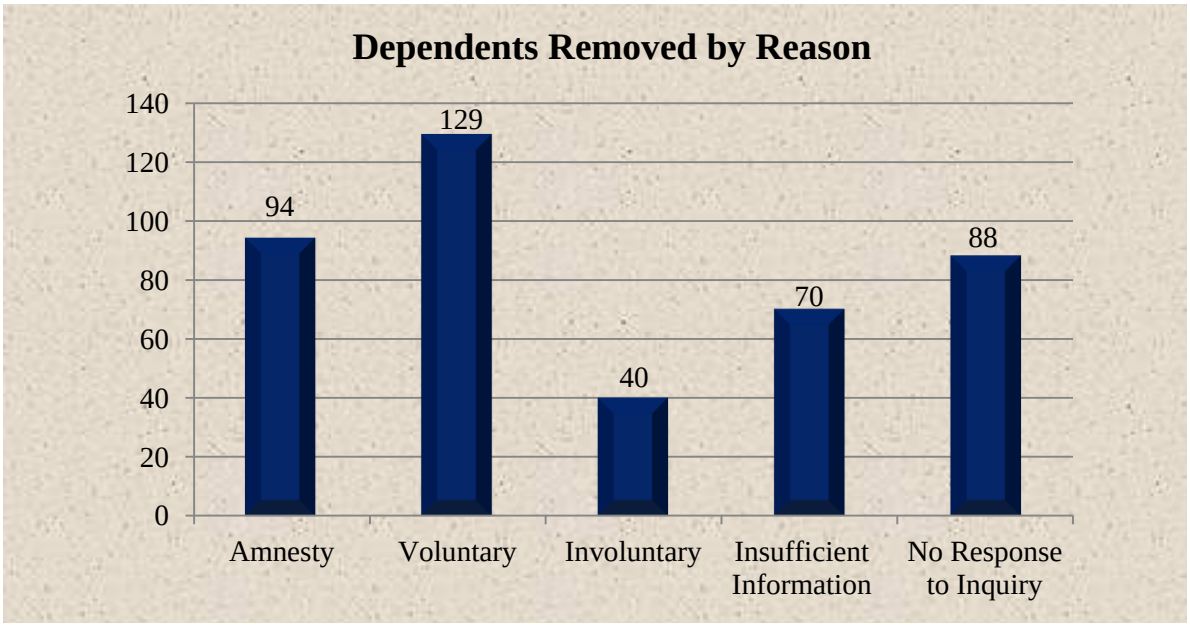


7. Dependent Eligibility Audit (Continued)

Ineligible Dependents
A total of 421 dependents, or 2.7% of all dependents, were removed from coverage because they did not meet the University's eligibility guidelines or did not provide appropriate documentation to verify eligibility, as determined by Chapman Kelly. The following graph shows the terminations by relationship to the employee.



The following graph indicates the number of terminations by type of termination.



7. Dependent Eligibility Audit (Continued)

These 421 dependents were determined to be ineligible as reported by Chapman Kelly in June 2011. The APA was not able to verify the results of the audit, as the information obtained by Chapman Kelly to determine eligibility was not available. Attachment A, Section 9 of the services agreement between the University and Chapman Kelly indicated that "Inbound mail is stored securely for one year. At the end of one year, Client shall have the option to either have the documents returned to Client or destroyed and Client supplied with a Certification of Destruction." It appears the information should have been available to the University.

Because the APA felt many of these individuals could have been ineligible during our audit period – July 2009 through June 2010, the APA requested the University provide the amount of claims paid on behalf of these 421 individuals during that timeframe. The University provided the following claims information for the 421 ineligible dependents between July 2009 and June 2010:

Claim Type	Amount
Medical	$ 647,777
Pharmacy	$ 154,655
Total	**$ 802,432**

The amounts used in this table are unaudited, as the APA had no way to determine if the amounts provided by the University were complete or accurate.

Recommendations
The report contained the following recommendations to the University:

1. The University should consider adding a working spouse provision to help control costs.
2. The University should continue to verify all newly enrolled dependents.
3. The University should establish an annual verification of spousal relationships, older children who are eligible for their own coverage, and stepchildren.

Theoretical Savings
The eligibility audit identified a theoretical savings of $1,052,500, resulting from the removal of ineligible participants from the Program. The cost of the audit was $107,038. An estimated $2,500 per dependent was used to calculate the savings. However, given that 72 of the 421 ineligible dependents participated in the dental plan alone, the calculation of this cost savings appears somewhat excessive. The average claim amount per individual in the dental plan (individuals with claims) was $312 in fiscal year 2010, considerably less than the $2,500 per dependent used in the audit. In addition, some of the identified dependents were not removed from the Program, as noted below.

Good internal control includes procedures to ensure only eligible dependents participate in the University's self-insured health insurance program.

7. Dependent Eligibility Audit (Concluded)

We recommend the University implement procedures to ensure only eligible dependents are included in its health insurance program.

University's Response: The material in this comment is repeated from an eligibility audit performed by an outside firm specializing in eligibility audits done at the request of the University. Accordingly, suggesting that the University needs to implement procedures regarding eligibility resulting from the eligibility audit fails to acknowledge this best practice adopted by management to ensure only valid persons are included. The comment also fails to mention that documentation of the type used to determine eligibility for the eligibility audit has been required of new employees since early 2011. The University and its consortium partner began discussions about eligibility audits in 2009, long before the 2010 commencement of procedures by the Auditor.

APA Response: The APA has not verified the new procedures implemented as a result of the eligibility audit.

8. Payroll Vendor Payments

Since 2003, the State has utilized EnterpriseOne accounting software to record all of its official financial records in one centralized system. However, for more than a decade, the University has relied upon its own separate software named Systems, Applications, and Products in Data Processing (SAP), which is then interfaced with EnterpriseOne, for accounting purposes.

Payroll vendor payments are set up differently in SAP than in EnterpriseOne. Payments made to vendors through the State's payroll process are recorded as vendor payments in EnterpriseOne. However, instead of generating vendor payments through SAP or EnterpriseOne during the payroll process, the University sends payroll payment instructions directly to the State's bank, authorizing the automatic deposit of payments to the vendors' banks. As a result, a vendor payment entry is not created in either accounting system; rather, a mere journal entry is made to record such payments. Because the University's accounting system does not record vendor payments to health insurance vendors, such as BCBSNE, the total amounts paid to these vendors cannot be determined or identified.

The University paid the following amounts through the payroll process for fiscal year 2010 and fiscal year 2011:

Description of Payment	FY 2010	FY 2011
Payment for Health and Dental Insurance (1)	$ 98,924,365	$ 106,096,005
TIAA/CREF (Retirement)	$ 72,243,794	$ 72,849,608
All Other Payments	$ 69,423,132	$ 72,427,665
Total	**$ 240,591,291**	**$ 251,373,278**

(1) Because its employee health insurance program is self-insured, the University's health insurance payments go to its own separate trust fund.

8. Payroll Vendor Payments (Concluded)

Sound accounting procedures include complete and accurate reporting of all payments to vendors to allow users of the State's accounting system to review and report on all vendor payments. According to Neb. Rev. Stat. § 81-1110.01 (Reissue 2008), the purpose of the accounting division of DAS is:

> *"[T]o prescribe, coordinate, and administer a centralized, uniform state accounting and payroll system and personnel information system, to establish and enforce accounting policies and procedures for all state agencies, boards, and commissions, to monitor and enforce state expenditure limitations established by approved state appropriations and budget allotments, and to administer the federal Social Security Act for the state and the state's political subdivisions."*

When vendor payments are not identified properly in the University's accounting system or, alternatively, do not originate from the State's accounting system, as would appear appropriate under § 81-1110.01, it is difficult for users of the system to ascertain the total amount paid to all vendors.

> We recommend the University work with DAS to develop a process that allows vendor payments to be accurately recorded in the State's accounting system.

University's Response: The University is weighing the cost-benefit of adopting this practice. Our foremost goal is to appropriately handle payroll and related employee deductions. The current practice using a State imprest account in conjunction with DAS works very well and has been very accurate in getting employees' retirement, health care and other withholdings to the proper authorities and parties on a timely basis.

Overall Conclusion

The issues addressed herein pertain to specific deficiencies in internal control over financial reporting and other operational matters relating to the Program. Left uncorrected, those issues risk having – both individually and collectively – a substantial impact upon the Program's well being.

The issues noted are especially problematic for a self-insured insurance plan, such as the Program. By choosing to implement a self-insured Program, the University necessarily assumes the responsibility of managing it effectively. Even when utilizing the services of a third party administrator, the University remains ultimately responsible for ensuring the proper management of the Program. As the various comments contained herein make clear, the University has failed to implement and maintain the financial reporting and operational controls required to ensure the Program's financial integrity.

The APA strongly encourages the University to implement, as soon as practicable, all of the recommendations provided herein.

NEBRASKA AUDITOR OF PUBLIC ACCOUNTS

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UNIVERSITY OF NEBRASKA HEALTH INSURANCE PROGRAM

INDEPENDENT ACCOUNTANT'S REPORT

We have examined the accompanying Schedule of Revenues, Expenditures, and Changes in Fund Balance (Schedule) of the University of Nebraska Health Insurance Program as of and for the period July 1, 2009, through June 30, 2010. The University's management is responsible for the Schedule. Our responsibility is to express an opinion based on our examination.

Our examination was conducted in accordance with attestation standards established by the American Institute of Certified Public Accountants, and the standards applicable to attestation engagements contained in *Government Auditing Standards* issued by the Comptroller General of the United States and, accordingly, included examining, on a test basis, evidence supporting the amounts and disclosures in the Schedule and performing such other procedures as we considered necessary in the circumstances. We believe that our examination provides a reasonable basis for our opinion.

In our opinion, the Schedule referred to above presents, in all material respects, the Revenues, Expenditures, and Changes in Fund Balance of the University of Nebraska Health Insurance Program for the period July 1, 2009, through June 30, 2010, based on the accounting system and procedures prescribed by the University of Nebraska as described in Note 1.

In accordance with *Government Auditing Standards*, we are required to report findings of deficiencies in internal control, violations of provisions of contracts or grant agreements, and abuse that are material to the Schedule and any fraud and illegal acts that are more than inconsequential that come to our attention during our examination. We are also required to obtain the views of management on those matters. We performed our examination to express an opinion on whether the Schedule is presented in accordance with the criteria described above and not for the purpose of expressing an opinion on the internal control over the Schedule or on compliance and other matters; accordingly, we express no such opinions. Our examination disclosed no findings that are required to be reported under *Government Auditing Standards.*

This report is intended solely for the information and use of management, the Board of Regents, others within the University, 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

March 28, 2012

Mike Foley
Auditor of Public Accounts

UNIVERSITY OF NEBRASKA HEALTH INSURANCE PROGRAM

SCHEDULE OF REVENUES, EXPENDITURES, AND CHANGES IN FUND BALANCE
For the period July 1, 2009 through June 30, 2010

Beginning Fund Balance	**$ 78,614,554**
Revenues	
Premium Contributions	98,955,479
COBRA, Retiree and Other Premium Contributions	8,018,260
Ancillary Premium Contributions	6,642,111
General Fund or Cash Fund Support	3,311,782
Total Premium Contributions	116,927,632
Unrealized Gain on Investments	6,319,332
Investment Income	343,300
Miscellaneous	10,288
Total Revenues	**123,600,552**
Expenditures	
Claims Paid	
BCBSNE (Medical)	82,882,211
Caremark (Pharmacy)	22,372,544
Total Claims Paid	105,254,755
Administrative Fees	
BCBSNE (Third party administrator)	3,972,824
Bank Fees for Trust	184,042
University Administrative Expenses	164,000
Miscellaneous	33,521
Actuarial Services	9,462
Total Expenditures	**109,618,604**
Change in Fund Balance	13,981,948
Ending Fund Balance	**$ 92,596,502**

NOTES TO FINANCIAL SCHEDULE
For the period July 1, 2009 through June 30, 2010

1. Criteria

A. Reporting Entity

The University of Nebraska Health Insurance Program is a self-insured plan administered by the University and established by Neb. Rev. Stat. § 85-106(6) (Reissue 2008).

The accounting policies of the University of Nebraska Health Insurance Program are on the basis of accounting prescribed by the University of Nebraska.

The University currently utilizes SAP to maintain the general ledger and all detailed accounting records within its accounting system. However, the University has made the decision to not record all health insurance financial transactions into SAP, but instead utilizes a separate trust fund to track the Programs regular activity. An accounting entry is made at the end of each year to record the annual activity into the University's accounting system. The information used to prepare the Schedule of Revenues, Expenditures, and Changes in Fund Balance was obtained directly from the separate trust fund statements maintained by the University.

The following account classifications were used in the Schedule:

Premium Contributions – Included both the employee and University share of premiums, as well as premiums from employees on a leave of absence. This amount also included the dental premiums.

COBRA, Retiree, and Other Premium Contributions – Included premiums paid by COBRA participants and retirees, as well as any refunds issued to retirees.

Ancillary Premiums – Total premium amounts contributed by employees of ancillary organizations.

General Fund or Cash Fund Support – General and Cash funds transferred to the trust fund to maintain stable premium rates for employees.

Unrealized Gain on Investments – Gains on investments in the University's Trust fund. These amounts were included to reconcile to the market value of the University's Trust fund with Wells Fargo.

Claims Paid – The amount recorded for BCBSNE also included dental claims paid. The amount recorded for Caremark included the University's pharmaceutical administrative fee, as they were not recorded separately by the University.

NOTES TO FINANCIAL SCHEDULE
(Continued)

1. Criteria (Concluded)

B. Basis of Accounting

The University is established and governed by the laws of the State of Nebraska. As such, the University is exempt from State and Federal income taxes. The Schedule includes all funds of the University of Nebraska Health Insurance Program.

2. Subsequent Events

A. Calendar Year 2011 Rates

The following table identifies the calendar year 2011 total premium rates.

Plan	Coverage Type	2011 Total Premium
Low Option Plan	Employee	$ 4,632
	Employee + spouse	$ 9,936
	Employee + children	$ 7,704
	Family	$ 13,800
Basic Option Plan	Employee	$ 5,376
	Employee + spouse	$ 11,544
	Employee + children	$ 8,952
	Family	$ 16,032
High Option Plan	Employee	$ 5,976
	Employee + spouse	$ 12,816
	Employee + children	$ 10,560
	Family	$ 17,784

B. Dependent Eligibility Audit

In June 2011, the University received a report on the results of its dependent eligibility audit conducted by Chapman Kelly (HMS Employee Solutions). For more information on the audit, see Comment Number 7.

SUPPLEMENTARY INFORMATION

Our examination was conducted for the purpose of forming an opinion on the Schedule of Revenues, Expenditures, and Changes in Fund Balance. Supplementary Information is presented for purposes of additional analysis. Such information has not been subjected to the procedures applied in the examination of the Schedule and, accordingly, we express no opinion on it.

UNIVERSITY OF NEBRASKA HEALTH INSURANCE PROGRAM **EXHIBIT A**

LEAVE OF ABSENCE PAYMENT REVISIONS

ORIGINAL			FIRST REVISION (1)			SECOND REVISION (2)			THIRD REVISION (3)		
Month Paid	**Month Covered**	**Amount Paid***	**Month Paid**	**Month Covered**	**Amount Paid***	**Month Paid**	**Month Covered**	**Amount Paid***	**Month Paid**	**Month Covered**	**Amount Paid***
Sept 2009	Sept 2009	$ 394	Not provided on First Revision			Sept 2009	Sept 2009	$ 394	Sept 2009	Sept 2009	$ 394
Sept 2009	Oct 2009	$ 394	Not provided on First Revision			Oct 2009	Oct 2009	$ 394	Oct 2009	Oct 2009	$ 394
Oct 2009	Nov 2009	$ 394	Not provided on First Revision			Nov 2009	Nov 2009	$ 394	Oct 2009	Nov 2009	$ 394
Jan 2010	Jan 2010	$ 402	Jan 2010	Dec 2009	$ 402	Jan 2010	Dec 2009	$ 394	Jan 2010	Jan 2010	$ 402
Feb 2010	Feb 2010	$ 402	Feb 2010	Jan 2010	$ 402	Feb 2010	Jan 2010	$ 402	Feb 2010	Feb 2010	$ 402
Mar 2010	Mar 2010	$ 402	Mar 2010	Feb 2010	$ 402	Mar 2010	Feb 2010	$ 402	Mar 2010	Mar 2010	$ 402
Mar 2010	Apr 2010	$ 402	Mar 2010	Mar 2010	$ 402	Mar 2010	Mar 2010	$ 402	Mar 2010	Apr 2010	$ 402
May 2010	May 2010	$ 402	May 2010	Apr 2010	$ 402	May 2010	Apr 2010	$ 402	May 2010	May 2010	$ 402

* The amount paid column refers only to the medical premium amount paid. The medical premium rate was $394 for calendar year 2009 and $402 for calendar year 2010.

(1) The coverage months were changed on the first revision (received October 14, 2011) in order to show that the December 2009 premium was paid. After receiving this revision, the APA questioned why the 2010 premium rate was paid for December 2009 coverage.

(2) The premium amount paid for December 2009 was changed on the second revision (received October 18, 2011). UNL Benefits staff indicated that the individual would be getting a refund of the overpayment for this month. After receiving this revision, the APA questioned why several of the premiums were not paid timely as they appeared to have been paid in the following month.

(3) The coverage months and amounts paid were changed back to match the original on the third and final revision (received October 19, 2011). The premiums were now paid timely; however, the December 2009 premium was not paid - as the APA had noted with the original spreadsheet.

UNIVERSITY'S JUNE 15, 2010, RESPONSE

University of Nebraska
Response to Nebraska Auditor of Public Accounts Questions
June 15, 2010

1) Plan year – Is your health insurance program by calendar year, fiscal year (July 1-June 30) or some other time frame?

   Calendar year (January 1 – December 31)

2) Structure of the program (fully insured or self insured)

   Self Insured or Administrative Services Only (ASO)

3) What health and prescription plan(s) are offered for the current fiscal year and the next fiscal year? Please include name of carrier/administrator and type of plan -- for example, BCBS PPO plan by year.

   The Low, Basic, and High medical options are administered by Blue Cross Blue Shield of Nebraska. The dental insurance plan is also administered by Blue Cross Blue Shield of Nebraska.

   The Prescription Drug Plan is administered by CVS Caremark.

   ***Administration of the vision care insurance plan is separate from the medical, prescription drug, and dental plan.**

4) Number of plan participants (including dependents and retirees) broken down by tier (single, family, etc) in each plan indicated from question #3 as of December 31, 2009 and May 31, 2010.

   Period ending December 31, 2009

	Employee	Employee & Spouse	Employee & Child	Employee & Family
Low	**730**	**209**	**81**	**321**
Basic	**3,614**	**2,145**	**709**	**2,386**
High	**286**	**386**	**11**	**399**

   Period ending May 31, 2010

	Employee	Employee & Spouse	Employee & Child	Employee & Family
Low	**770**	**216**	**90**	**322**
Basic	**3,600**	**2,173**	**734**	**2,451**
High	**265**	**389**	**16**	**410**

A summary of the enrollment for both periods above will be provided to you shortly. Dependent enrollment information is not readily available.

5) Please provide any demographics information you might have regarding your health insurance program and identify the time period this information covers. For example,
   a. Average age of your organization.
   b. Average age plan participants (including dependents and retirees) in each plan
   c. Average age plan participants (including dependents and retirees) in each plan broken down by tier.
   d. Any other demographics that your organization uses in determining any aspect of your health insurance plan (plan selection, premiums, co-pays)

Information is not readily available.

6) Who is your plan administrator – do you administer the plan or a third party? If third party, how much are they paid?

Medical and Dental Plan Administrator - Blue Cross Blue Shield of Nebraska

The related administrative fees are provided separately in Attachment 1 to the BC/BS agreement, and the University has not inquired with BC/BS whether it would assert any proprietary interests in the fee information in Attachment 1. Should the Auditor determine that disclosing the information in Attachment 1 is required in any distributed report, table or findings, the University respectfully requests the opportunity to notify BC/BS.

Prescription Drug Plan Administrator - CVS Caremark

The related administrative fees are provided separately in the CVS Caremark agreement, and the University has not inquired with CVS Caremark whether it would assert any proprietary interests in the fee information. Should the Auditor determine that disclosing the information is required in any distributed report, table or findings, the University respectfully requests the opportunity to notify CVS Caremark.

7) Actual plan documents (i.e. certificates of coverage) describing the details of each plan, including:
   a. Employee eligibility
   b. Dependent eligibility
   c. Premiums/contributions (employee and employer share of cost)
   d. Tier structure (single, family, etc.)
   e. Coinsurance/copayments/deductibles
   f. Out-of-pocket and lifetime maximums
   g. Coverage offered for various medical services
   h. Any other plan documents that might be useful

The Blue Cross Blue Shield Certificate of Coverage, CVS Caremark Prescription Drug Summary, NUFlex Booklet, benefits web page summary and Health Insurance premium matrix will be provided to you shortly.

8) What is the employee verse employer share percentage? How is this established? Is it changeable or restricted each year? If so, how is it restricted?

The Employer/Employee percentage is tracked but we do not use percentages as a restriction. Current percentages include Employer 84% and Employee 16%.

9) Copies of the contracts between your entity and its health insurance carriers/administrators. Please include contracts for administrative fees, stop loss provisions, prescription drug programs, and wellness programs.

The Blue Cross Blue Shield Administrative Services Agreement, Master Group Application for Claims Administration Services (ASA), Preferred Provider Organization Master Group Benefit Contract For The Universtiy of Nebraska Group Health Plan and CVS Caremark contract will be provided to you shortly.

10) If your agency/entity allows other groups to participate in your health insurance program, please provide the following information:

- What outside groups are allowed to join your program (for example, State plans allowing schools districts to join)? If so, is there a cost to join (per member or flat rate cost)?

  Ancillary organizations include employees of the University of Nebraska Foundation, University of Nebraska Alumni Association, Nebraska SPF Swine Accrediting Agency, Nebraska Crop Improvement Association, Nebraska Pork Producers Association, members of the Board of Regents, University of Nebraska Federal Credit Union, 4-H Youth Development Foundation, UNMC Physicians Group, UneMed, and Ximerex.

  Premium costs are passed on to each Ancillary group. Participating Ancillary employees are charged the full cost of the insurance coverage (though we do not determine the Employee or Employer pricing).

- Do you have limits on the number of people who are required to join the program for each group?

  No

- Are administrative fees passed on to these participant groups?

  Yes

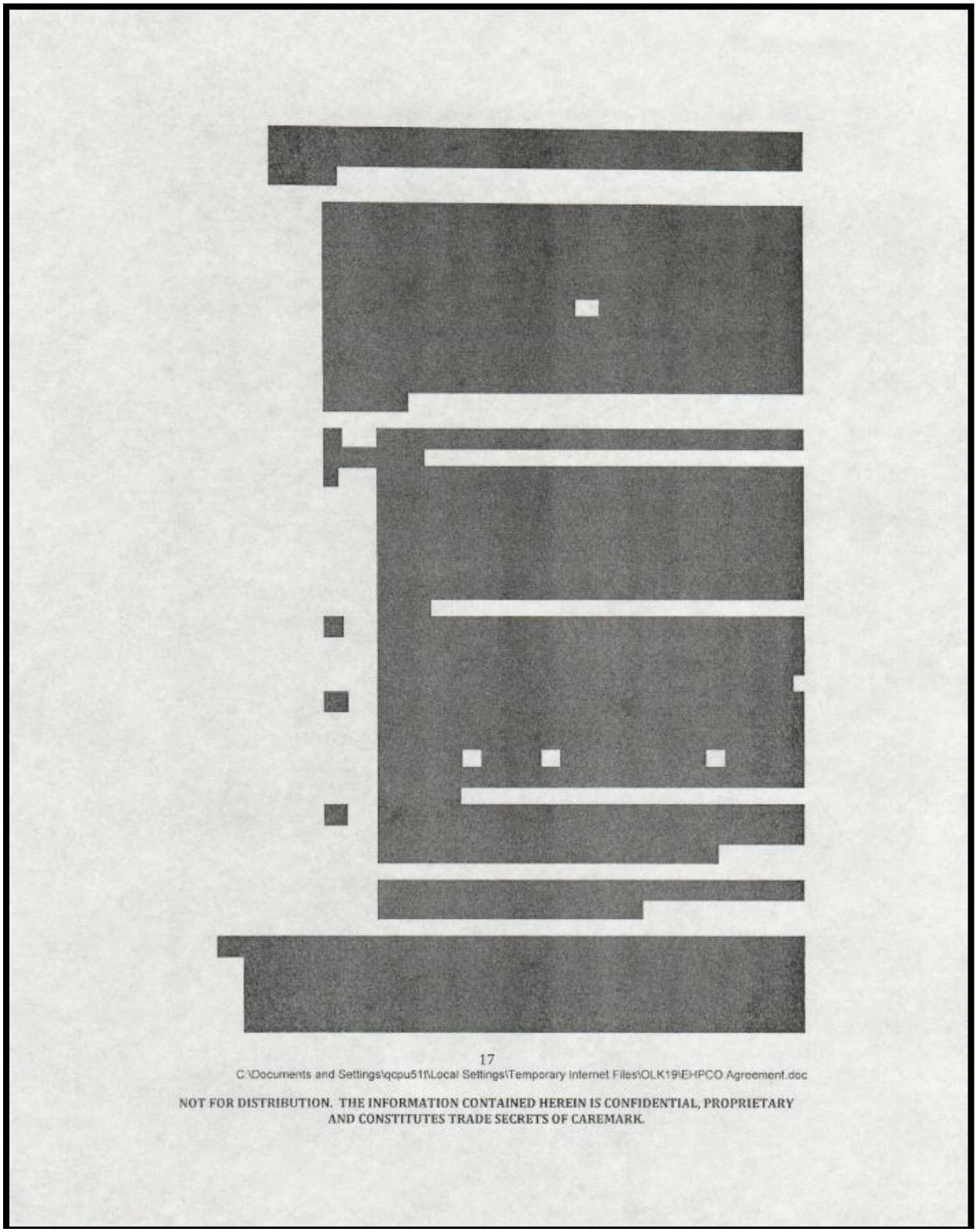
- What is the premium structure for outside participant groups? Are all entities within the program paying the same rates?

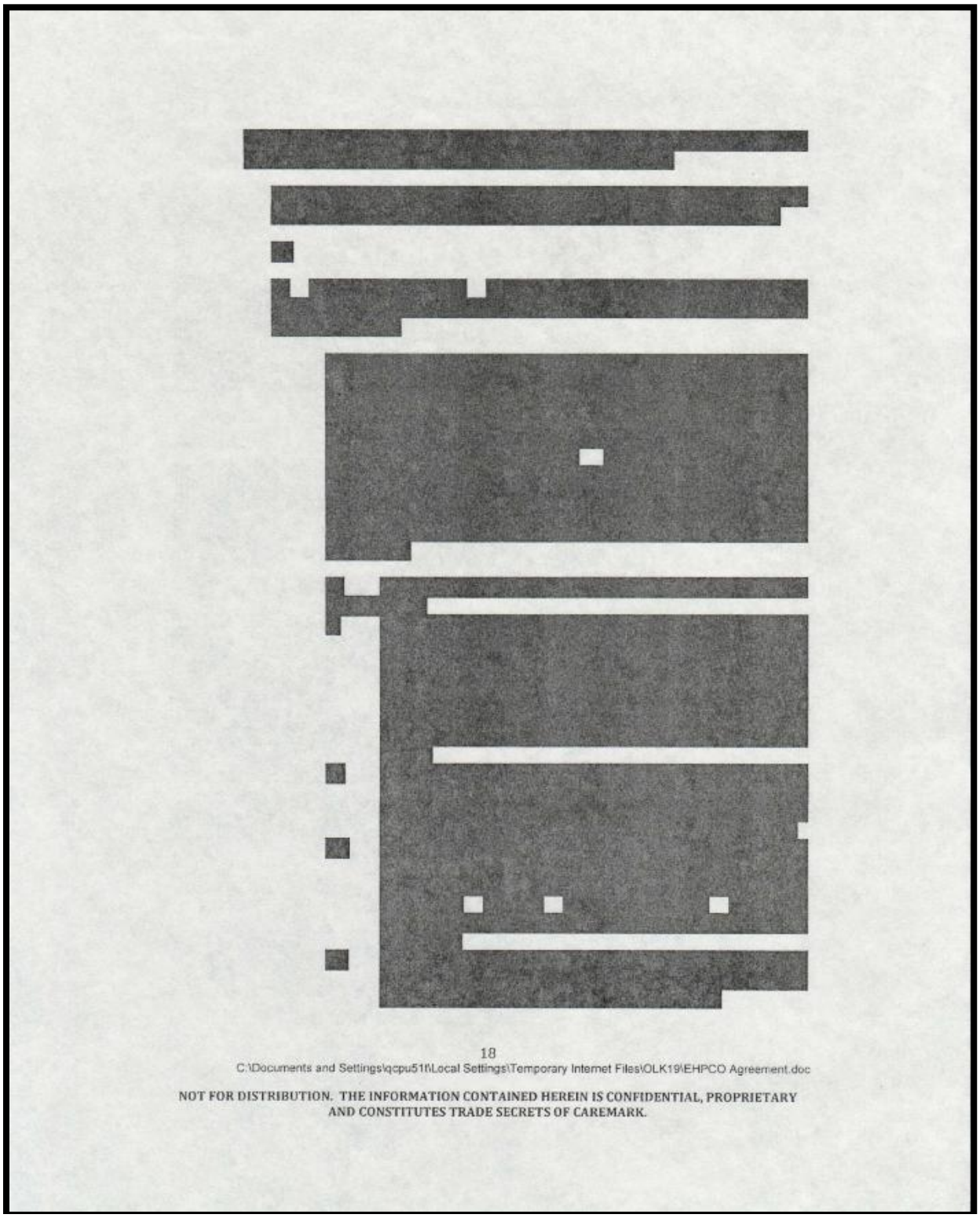
  The full cost of each medical insurance coverage option is passed on to the Ancillary employee enrolled in the plan.

  Yes

- Are there restrictions on joining or leaving the program?

  No





Janssen, Cindy

From: Keith Dietze [kdietze@nebraska.edu]
Sent: Tuesday, July 13, 2010 2:23 PM
To: Janssen, Cindy
Cc: Smith, Julie C; Avery, Mary; Foley, Mike
Subject: RE: University of Nebraska Health Plan Documents

Yes, we belong to the EHPCO group. The EHPCO agreement is included in the CVS Caremark contract. Thanks

Keith Dietze
Director of Universitywide Benefits
University of Nebraska
Phone: (402) 472-7162
Fax: (402) 472-2038
Email: kdietze@nebraska.edu

Response does not provide the documents as requested in the previous email.

From: "Janssen, Cindy" <cindy.janssen@nebraska.gov>
To: "Dietze, Keith" <kdietze@nebraska.edu>
Cc: "Foley, Mike" <mike.foley@nebraska.gov>, "Avery, Mary" <mary.avery@nebraska.gov>, "Smith, Julie C" <julie.c.smith@nebraska.gov>
Date: 07/13/2010 09:32 AM
Subject: RE: University of Nebraska Health Plan Documents

Keith, another question on the CVS Caremark contract you provided. It appears this contract is between CVS Caremark and the Employers Health Purchasing Corporation of Ohio (EHPCO) on behalf of EHPCO's participating groups. It is my understanding that the University of Nebraska is a participating group of EHPCO. Is this correct?

Is there an agreement between the University and EHPCO? As part of the contract you provided, it appears each participating group is required to execute an addendum shown in Exhibit I, but the Exhibit I you provided is blank (as is the agreement between CVS Caremark and EHPCO). Could you provide the signed documents that constitute the actual agreement between CVS Caremark and the University?

I would appreciate a copy of these documents today without sections or text being "blacked out".

Thanks. Cindy Janssen

-----Original Message-----
From: Janssen, Cindy
Sent: Tuesday, July 13, 2010 9:07 AM
To: Dietze, Keith
Cc: Foley, Mike; Avery, Mary; Smith, Julie C
Subject: RE: University of Nebraska Health Plan Documents

Keith, we received the most of the information requested this morning; however, as noted in your cover letter, you did not provide the BCBS and CVS Caremark administrative fees. As these contracts are public documents, we request you provide those to our office immediately. It has been over a month since our initial request for this information.

If it would be easier to scan the documents and email them to me, that would be fine.

Thanks.

Cindy Janssen

-----Original Message-----
From: Keith Dietze [mailto:kdietze@nebraska.edu]
Sent: Monday, July 12, 2010 3:00 PM
To: Janssen, Cindy; Smith, Julie C
Subject: University of Nebraska Health Plan Documents

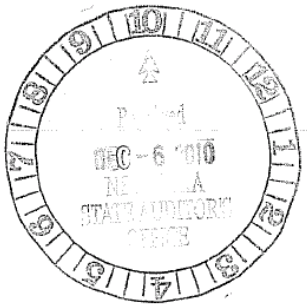
Within the next hour, a courier will be delivering a package to your attention which includes the group health plan information that you previously requested. Please call me if you have any questions. Thanks

Keith Dietze
Director of Universitywide Benefits
University of Nebraska
Phone: (402) 472-7162
Fax: (402) 472-2038
Email: kdietze@nebraska.edu

2

DECEMBER 3, 2010, LETTER TO
LEGISLATIVE PERFORMANCE AUDIT COMMITTEE

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

ATTACHMENT 1

ADMINISTRATIVE SERVICES AGREEMENT
SUMMARY

Group: Board of Regents of the University of Nebraska

Contract Term: January 1, 2009 through December 31, 2009

Group No.: 04446

Master Group Contract Number and revision date: Health: 96-041 1/06
Dental: 96-011 4/94

X Plan Assets. N/A General Assets.

A. **Administrative Service Fee:**

1.

2.

3.

4.

5.

Information on fees was not provided.

B. **BlueCard Fees:**

The BlueCard Fees below will be adjusted for claims if the effective membership of THE GROUP on January 1, 2009 verifies that THE GROUP has less than 10,000 subscribers. The January 1 effective membership determines the Access Fee percentage and the AEA fees until January 1 of the following year.

1.

2.

3.

LEG170-09 Rev. 10-01-08 (AF-UNIVNE09) - 12 -

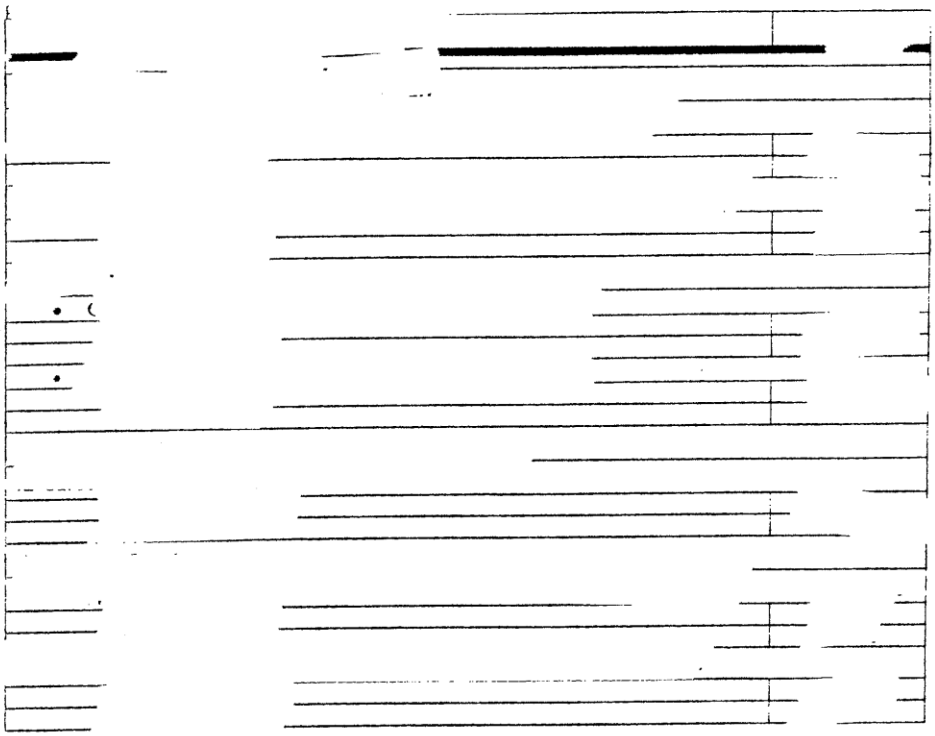
ATTACHMENT 6

Board of Regents of the University of Nebraska
"THE GROUP"

January 1, 2009
Effective Date

STANDARD PERFORMANCE GUARANTEES

BlueCross BlueShield of Nebraska is willing to enter into a performance-driven contract with THE GROUP for the contract period January 1, 2009 through December 31, 2009. Each guarantee level will place a portion of the annual administrative fees at risk. THE GROUP will have the opportunity to reduce their administrative



Financial information on performance guarantees was also redacted.

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Milliman

1120 South 101st Street
Suite 400
Omaha, NE 68124
USA

Tel +1 402 393 9400
Fax +1 402 384 5776

milliman.com

August 22, 2008

Mr. Keith Dietze
Director of University-Wide Benefits
University of Nebraska
217 Varner Hall
3835 Holdrege Street
Lincoln, NE 68553-0742

Re: University of Nebraska Renewal Projection for the 2009 Plan Year and IBNR Reserves Calculation

Dear Mr. Dietze:

At your request, Milliman, Inc. (Milliman) has completed a projection of University of Nebraska's 2008 renewals and performed a calculation of the incurred but not reported (IBNR) reserve of the medical and dental plans. This letter includes the executive summary, detailed analysis, methodology, reliance, and limitations of our findings.

Executive Summary

University of Nebraska currently offers its eligible employees various medical, dental, life, disability, and other types of coverage. You engaged Milliman to perform our calculation of expected claims cost for self-insured medical and dental benefits for the 2009 plan year assuming their current plan design structure, comment on the current trend and performed a calculation of the IBNR reserves for the self insured medical and dental plans. Our major findings are summarized below:

- **We estimate that self-insured annual claims and expenses for the 2009 plan year will be approximately**
  - **$89.2 million for the Active employees' medical and prescription drugs based on current enrollment levels of 9,889 employees and a projected premium of $751 per employee per month (PEPM);**
  - **$9.0 million for the Retiree medical and prescription drugs based on current enrollment levels of 998 employees and a projected premium of $750 per employee per month (PEPM);**

Milliman

August 22, 2008

- $6.63 million for Active and Retiree dental based on current enrollment levels of 11,451 employees and a projected premium of $48 PEPM;

- Note that these figures also depend on current plan designs, claims experience that was available to us, and proposed vendor fees. If enrollment levels, plan designs, vendor, or locations should change dramatically, this number should be updated with the new information.
- Based on our calculations, University of Nebraska should be holding approximately $5.26 million in medical IBNR reserves. This represents 7.9% of total annual paid medical claims. Please note that this does not include prescription drugs.
- Based on our calculations, University of Nebraska should be holding approximately $238,000 in dental IBNR reserves. This represents 4.2% of total annual paid dental claims.

2

MILLIMAN PROJECTION AND RESERVES
FOR 2010 PLAN YEAR

Milliman

1120 South 101st Street
Suite 400
Omaha, NE 68124
USA

Tel +1 402 393 9400
Fax +1 402 384 5776

milliman.com

August 27, 2009

Mr. Keith Dietze
Director of University-Wide Benefits
University of Nebraska
217 Varner Hall
3835 Holdrege Street
Lincoln, NE 68553-0742

Re: University of Nebraska 2010 Renewal Evaluation and IBNR Reserves Calculation

Dear Mr. Dietze:

At your request, Milliman, Inc. (Milliman) has completed an evaluation of the University of Nebraska's 2010 renewals and performed a calculation of the incurred but not reported (IBNR) reserve of the medical and dental plans. This letter includes the executive summary, detailed analysis, methodology, reliance, and limitations of our findings.

Executive Summary

The University of Nebraska currently offers its eligible employees medical and dental coverage. The table below outlines BCBS-NE's CY 2010 administrative fees for the medical and dental plans:

	BCBS-NE Proposal	BCBS-NE Current	Percent Increase
BCBS-NE Medical ASO (PEPM) (admin only)	$27.11	$25.82	5.0%
Stop-Loss			
Individual	n/a	n/a	n/a
Aggregate	n/a	n/a	n/a
BCBS-NE Dental (PEPM) (admin only)	$2.72	$2.72	0.0%

Note: We will use the "BCBS-NE Proposal" fees in our projection of budgets for the upcoming plan year.

Milliman

August 27, 2009

- We estimate that self-insured annual claims and expenses for the 2010 plan year will be approximately
  - $103.2 million for the Active employee's medical and prescription drugs based on current enrollment levels of 10,230 employees and a projected premium of $841.06 per employee per month (PEPM). This is based on expected claims cost and projected expenses.
  - $7.6 million for the Retiree medical and prescription drugs based on current enrollment levels of 895 retirees and a projected premium of $706.37 per employee per month (PEPM). This is based on expected claims cost and projected expenses.
  - $7.0 million for Active and Retiree dental based on current enrollment levels of 11,679 employees and a projected premium of $50.21 PEPM. This is based on expected claims cost and projected expenses.
- Note that these figures also depend on current plan designs, claims experience that was available to us, and proposed expenses. If enrollment levels, plan designs, vendors, or locations should change dramatically, this number should be updated with the new information.
- Based on our calculations, the University of Nebraska should be holding approximately $5.1 million in medical IBNR reserves. This represents 6.8% of total annual paid medical claims.
- Based on our calculations, the University of Nebraska should be holding approximately $248,000 in dental IBNR reserves. This represents 4.0% of total annual paid dental claims.

2

Milliman

August 27, 2009

payments in the coming year. Since dental claims were provided separately, we used the same method to calculate those reserves shown in Attachment #18.

Assumptions and Methodology

The steps we used to arrive at the results are outlined below:

1. We collected enrollment information from BCBS-NE and the University of Nebraska. We assumed that those employees electing coverage would continue to elect that same coverage and that employees waiving coverage would continue to waive coverage.
2. Claims and expense information was also provided by BCBS-NE and the University of Nebraska.
3. Our expected claims range encompasses the current plan designs offered to employees. Should plan designs change, the Benefit Plan Design Factor should be updated accordingly.
4. We calculated trends using a regression analysis but did not blend those results with national averages.
5. Using claims experience and assumed trend factors, we calculated a projected claims costs on a per employee per month basis.
6. Using plan pricing levels, tier pricing levels, and enrollment assumptions, we calculated premium equivalency rates by plan and coverage tier.
7. The claims data was complete and accurate. We received claims data in a paid-and-incurred triangle format from BCBS-NE from June 2006 thru June 2009.
8. We assume that claims will continue to be incurred at the same rate as those incurred in the data that we received.

MILLIMAN 2010 RATE PROJECTION

Attachment #6

Milliman

Calendar Year 2010 Medical Plans - Premium Equivalencies (Active)

~ University of Nebraska ~

Assumptions

	Projected Enrollment	Milliman HCG Value[1]	Plan Pricing Level[2] Current	Plan Pricing Level[2] Proposed
Low	11.4%	80.5%	73.6%	77.0%
Basic	79.3%	94.8%	84.8%	89.8%
High	9.3%	100.0%	100.0%	100.0%

Tier Pricing Level[3]	EE Only	EE+Spouse	EE+Child(ren)	EE+Family
Projected Enrollment	38.9%	23.6%	7.8%	29.7%
Milliman HCG	1.000	2.146	1.665	2.980
Current	1.000	2.172	1.710	3.008
Proposed	1.000	2.146	1.665	2.980

1. Milliman HCG values are based on actual values of plan designs as determined by *Health Cost Guidelines, v.2008*

2. Current plan pricing levels are based on current premium distributions across plans. Proposed tier pricing levels are based on an average of the Milliman relativities and the current relativities in place.

3. Current tier pricing levels are based on current premium distributions across plans. Proposed tier pricing levels are based on recommended premium distributions across plans

Premium Equivalency Calculations

	Monthly Premium EE Only	Monthly Premium EE+Spouse	Monthly Premium EE+Child(ren)	Monthly Premium EE+Family	Enrollment EE Only	Enrollment EE+Spouse	Enrollment EE+Child(ren)	Enrollment EE+Family	Total Annual Cost
	CY 2009**				CY 2009				CY 2009
Low	$343.52	$750.00	$575.84	$1,038.32	621	169	72	304	$8,366,228
Basic	$397.52	$862.00	$663.84	$1,194.32	3,168	1,889	714	2,346	$73,962,214
High	$463.52	$1,004.00	$819.84	$1,390.32	189	356	10	392	$11,978,797
Total									**$94,307,240**
	CY 2010 Proposed				CY 2010 Estimated				CY 2010 Estimated
Low	$378.50	$812.23	$630.32	$1,128.02	621	169	72	304	$9,127,405
Basic	$441.05	$946.45	$734.47	$1,314.41	3,168	1,889	714	2,346	$81,517,129
High	$491.30	$1,054.30	$818.17	$1,464.19	189	356	10	392	$12,603,992
Total									**$103,248,526**
	Variance				Variance				Variance
Low	$34.98	$62.23	$54.48	$89.70	0	0	0	0	$761,176
Basic	$43.53	$84.45	$70.63	$120.09	0	0	0	0	$7,554,915
High	$27.78	$50.30	($1.67)	$73.87	0	0	0	0	$625,195
Total									**$8,941,286**
	Percent Change				Percent Change				Percent Change
Low	10.2%	8.3%	9.5%	8.6%	0.0%	0.0%	0.0%	0.0%	9.1%
Basic	10.9%	9.8%	10.6%	10.1%	0.0%	0.0%	0.0%	0.0%	10.2%
High	6.0%	5.0%	(0.2%)	5.3%	0.0%	0.0%	0.0%	0.0%	5.2%
Total									**9.5%**

** Derived from 2009 budgeted rates assuming an 8% increase as of July 2009 to the Employer contribution.

Prepared on:
8/27/2009

Milliman, Inc.

smn
2009 University of Nebraska Pricing.xlsx

EMPLOYERS HEALTH™
www.ehpco.com

June 30, 2010

Mr. Keith Dietze
University of Nebraska
3835 Holdrege St Rm 217
Lincoln, NE 68583-0742

Dear Keith:

Enclosed is a check for $ 390,284.35, which represents University of Nebraska's 1st Quarter 2010 CVS Caremark rebates.

The University of Nebraska's rebates were calculated as follows:

Plans that qualify for 3-tier rebates					
3,181	Mail Order Rx	x	$19.35	=	$ 61,552.35
64,763	Retail Rx	x	$ 4.00	=	$ 259,052.00
6,713	Retail 90 Rx	x	$ 10.00	=	$ 67,130.00
255	Specialty Rx	x	$ 10.00	=	$ 2,550.00
			Total 3-Tier Rebate	=	$ 390,284.35

Thank you for your participation in our prescription drug program! Please feel free to contact me with any questions regarding your rebate check.

Sincerely,

David Uldricks
Director, Strategic Initiatives and Assistant General Counsel

Enclosure

Northeast Ohio
4143 Fulton Drive NW - Canton, Ohio 44718
phone 330-305-6565 *fax* 330-305-9055

Central Ohio
5400 Frantz Road, Suite 180 - Dublin, OH 43016
phone 614-336-2883 *fax* 614-336-3042

SECOND QUARTER 2010 CAREMARK REBATE

EMPLOYERS HEALTH™
www.ehpco.com

September 30, 2010

Mr. Keith Dietze
University of Nebraska
3835 Holdrege St Rm 217
Lincoln, NE 68583-0742

Dear Keith:

Enclosed is a check for $ 399,751.50, which represents University of Nebraska's 2nd Quarter 2010 CVS Caremark rebates.

The University of Nebraska's rebates were calculated as follows:

Plans that qualify for 3-tier rebates					
3,490	Mail Order Rx	x	$19.35	=	$ 67,531.50
64,855	Retail Rx	x	$ 4.00	=	$ 259,420.00
7,027	Retail 90 Rx	x	$ 10.00	=	$ 70,270.00
253	Specialty Rx	x	$ 10.00	=	$ 2,530.00
			Total 3-Tier Rebate	=	$ 399,751.50

Thank you for your participation in our prescription drug program! Please feel free to contact me with any questions regarding your rebate check.

Sincerely,

David Uldricks
Director, Strategic Initiatives and Assistant General Counsel

Enclosure

Northeast Ohio
phone [illegible] *fax* [illegible]

Central Ohio
phone [illegible] *fax* [illegible]

EMPLOYERS HEALTH
www.ehpco.com

May 5, 2010

Mr. Keith Dietze
University of Nebraska
3835 Holdrege St Rm 217
Lincoln, NE 68583-0742

Dear Keith:

Part of the value your organization receives as a member of Employers Health is ongoing plan management performed on your behalf. In particular, EHPCO works with CVS Caremark to ensure that your plan is performing as it should, through financial and performance guarantee true-ups. Below are results of the latest analysis, and enclosed you will find a check in the amount of $ 520.29, which represents your organization's share of any underperformance.

GENERIC EFFECTIVE RATE
Recently, we completed a review of CVS Caremark's Generic Effective Rate (GER) guarantee reconciliation for the period January 2009 through December 2009. During this true-period, CVS Caremark did not meet the GER for some of our members, resulting in a recovery of $306,717.37.

What exactly is GER? GER is the average discount realized on the dispensing of claims for generic drugs. It is calculated by subtracting the discounted cost of dispensed generic drugs from the un-discounted cost of dispensed generic drugs, and dividing that result by the un-discounted cost of dispensed generic drugs. Due to a number of factors, the discount realized on generic drugs varies widely. Because of this great variation, the GER guarantee EHPCO negotiated with CVS Caremark is the most effective way to ensure competitive discounts on overall generic drug utilization.

At the end of each true up period, CVS Caremark calculates the GER realized for each EHPCO member. According to the EHPCO Agreement with CVS Caremark, if CVS Caremark has over-performed on the GER guarantee, the plan sponsor retains any over-performance. If Caremark has under-performed on the GER guarantee, CVS Caremark sends EHPCO a check for the difference which EHPCO, in turn, disburses to its members.

Below is a summary of how your organization performed during the latest true up period.

True Up Period: January 2009 through December 2009						
Retail			Mail			
GER Guarantee	Actual GER	Performance Difference	GER Guarantee	Actual GER	Performance Difference	Total Refund
61.0%	61.5%	$ 68,305.29	65.0%	64.8%	$- 520.29	$ 520.29

Northeast Ohio
6[illegible] Canton, Ohio 6[illegible]
phone [illegible] *fax* [illegible]

Central Ohio
5[illegible] Dublin, OH [illegible]
phone [illegible] *fax* [illegible]

EMPLOYERS HEALTH™
www.ehpco.com

2009 PERFORMANCE GUARANTEES

Enclosed you will find your organization's 2009 Performance Guarantee report. Performance Guarantees are standards established by EHPCO as part of its RFP. Any failure to meet those standards results in a financial penalty as outlined in the master agreement.

Please let me know if you have any questions or would like additional information!

Sincerely,

David Uldricks
Director, Strategic Initiatives and Assistant General Counsel

Enclosures

Northeast Ohio
4143 Tuscarawas Street West - Canton, Ohio 44718
phone 330-493-0595 *fax* 330-493-0643

Central Ohio
4900 Parkway Road, Suite 180 - Dublin, OH 43016
phone 614-766-2683 *fax* 614-766-2687

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www.ehpco.com

June 8, 2011

Mr. Keith Dietze
University of Nebraska
3835 Holdrege St Rm 217
Lincoln, NE 68583-0742

Dear Keith:

Part of the value your organization receives as a member of Employers Health is ongoing plan management performed on your behalf. In particular, EHPCO works with CVS Caremark to ensure that your plan is performing as it should, through financial and performance guarantee true-ups. Below are results of the latest analysis, and enclosed you will find a check in the amount of $ 169,093.08, which represents your organization's share of any underperformance.

GENERIC EFFECTIVE RATE
Recently, we completed a review of CVS Caremark's Generic Effective Rate (GER) guarantee reconciliation for the period January 2010 through December 2010. During this true-up period, CVS Caremark did not meet the GER for some of our members, resulting in a recovery of $622,618.54.

What exactly is GER? GER is the average discount realized on the dispensing of claims for generic drugs. It is calculated by subtracting the discounted cost of dispensed generic drugs from the un-discounted cost of dispensed generic drugs, and dividing that result by the un-discounted cost of dispensed generic drugs. Due to a number of factors, the discount realized on generic drugs varies widely. Because of this great variation, the GER guarantee EHPCO negotiated with CVS Caremark is the most effective way to ensure competitive discounts on overall generic drug utilization.

At the end of each true up period, CVS Caremark calculates the GER realized for each EHPCO member. According to the EHPCO Agreement with CVS Caremark, if CVS Caremark has over-performed on the GER guarantee, the plan sponsor retains any over-performance. If Caremark has under-performed on the GER guarantee, CVS Caremark sends EHPCO a check for the difference which EHPCO, in turn, disburses to its members.

Below is a summary of how your organization performed during the latest true up period.

True Up Period: January 2010 through December 2010						
Retail			**Mail**			
GER Guarantee	Actual GER	Performance Difference	GER Guarantee	Actual GER	Performance Difference	Total Refund
66.0%	65.6%	$-57,939.41	70.0%	69.8%	$ - 5,429.67	$ 63,369.08

2010 Drug Savings Review Clinical Program

Please find below a summary of your organization's 2010 Drug Savings Review Clinical Program performance. The ROI guarantee for this program is 200% based on fees paid. Any over performance is retained by the plan sponsor. For plans that under perform, CVS Caremark sends EHPCO a check for the difference which EHPCO, in turn, disburses to its members.

Below is a summary of how your organization performed under this program in 2010.

January 2010 through December 2010						
Fee per Rx	Total Rx	Total Fees Paid	ROI Guarantee 200%	Total Savings Achieved	Over* or Under Performance	Total Refund
$1.10	305,119	$335,631	$671,262	$565,538	$ - 105,724	$105,724

*Over performance is retained by each plan sponsor.

Please let me know if you have any questions or would like additional information!

Sincerely,

Darcy Fiocca

Darcy Fiocca
Senior Director, Member Services

Enclosures