



## NEBRASKA AUDITOR OF PUBLIC ACCOUNTS

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April 15, 2026

Sean Davis, State Personnel Director  
Nebraska Department of Administrative Services  
1526 K Street  
Lincoln, NE 68508

Dear Mr. Davis:

As you know, the Nebraska Auditor of Public Accounts (APA) has been involved in various conversations with your office regarding the Nebraska State Insurance Program (Program) administered by the Nebraska Department of Administrative Services (Department). As a result, the APA began limited preliminary planning work to determine if a full financial audit or attestation of the Program would be warranted. Pursuant thereto, the APA obtained financial records and other relevant documentation from the Department. Based on the outcome of this preliminary planning work, including an analysis of the information obtained, the APA has determined that a separate financial audit or attestation is unnecessary at this time.

Nevertheless, during the preliminary planning work, the APA noted certain issues that merit corrective action.

### **Background Information**

The Program is governed by Neb. Rev. Stat. §§ 84-1601 to 84-1617 (Reissue 2024) and became operative on January 1, 1974, as provided under § 84-1615. Prior to that time, no general program of health insurance applied uniformly to all permanent State employees. Instead, individual State agencies established separate group insurance programs for their respective workers. Although the Program includes both life and health insurance, § 84-1604 requires the two coverages to “be totally independent of one another and the loss experience and the rates for the two coverages . . . [to] be maintained separate and apart from one another.”

The Program is currently self-insured, meaning that the employer – in this case, the State of Nebraska – assumes the major cost of health insurance for its employees. The State of Nebraska pays most of the claims incurred by the Program’s participants through the collection of premiums from its employees and from other public funds comprising the employer’s share of the premium. Premiums are set to cover the claims incurred by participants, to fund a reserve, and to maintain a fund balance.

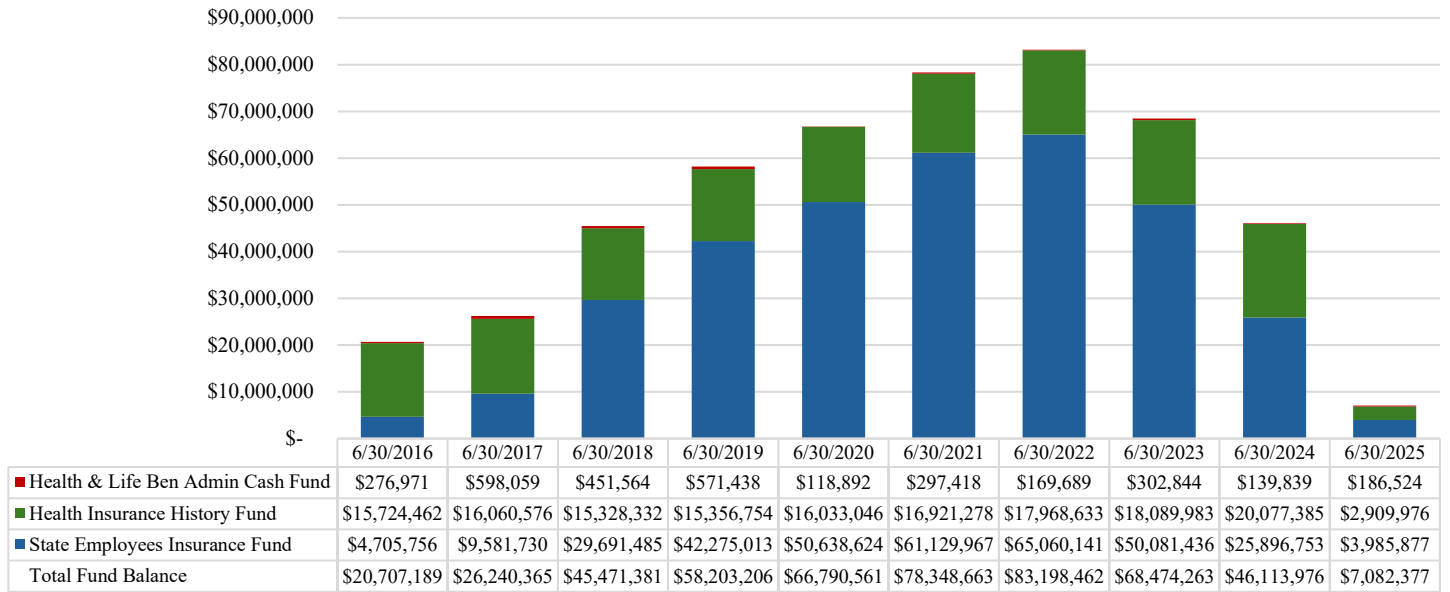
Two separate funds have been created to manage Program money. Neb. Rev. Stat. § 84-1613 establishes the State Employees Insurance Fund, which receives “[a]ll funds appropriated to pay the state’s share of the cost of the coverages” and “all payroll deductions” used to pay for the Program. Premium payments to the administrator(s) of the insurance contract(s) under § 84-1603 are also paid from that fund. At the same time, the Health and Life Benefit Administration Cash Fund, created under § 84-1616, consists of “payments made by individuals eligible for program benefits, transfers from the State Employees Insurance Fund for administrative and operation expenses as authorized by the Legislature, and interest earnings as authorized by the Legislature.” The fund is used “to administer the provisions of the federal Public Health Service Act and for the administration of the section 125 plan.” Though not expressly authorized by statute to do so, the Department also maintains the Health History Fund. That fund is used to transfer money to the Health and Life Benefit Administration Cash Fund to be used for the administrative costs of the Program. These three funds are included in the financial schedule within this report.

The following table shows the financial information of the Program for the fiscal year ended June 30, 2025:

	<b>State Employees Insurance Fund</b>	<b>Health Insurance History Fund</b>	<b>Health &amp; Life Benefits Administration Cash Fund</b>	<b>Totals</b>
<b>REVENUES:</b>				
Premium Contributions	\$ 225,546,689	\$ -	\$ -	\$ 225,546,689
COBRA and Retiree Contributions	1,794,953	-	10,624	1,805,577
Investment Interest	589,765	649,476	21,327	1,260,568
<b>TOTAL REVENUES</b>	<b>227,931,407</b>	<b>649,476</b>	<b>31,951</b>	<b>228,612,834</b>
<b>EXPENDITURES:</b>				
Personal Services	-	-	493,546	493,546
Claims Paid	293,048,215	-	-	293,048,215
Pharmaceutical Rebates	(32,218,241)	-	-	(32,218,241)
Administrative Fees	5,693,790	-	196,368	5,890,158
Actuarial Services	-	-	349,038	349,038
Miscellaneous Operating	61,350	-	158,998	220,348
Travel	-	-	1,335	1,335
<b>TOTAL EXPENDITURES</b>	<b>266,585,114</b>	<b>-</b>	<b>1,199,285</b>	<b>267,784,399</b>
Excess (Deficiency) of Revenues Over (Under) Expenditures	(38,653,707)	649,476	(1,167,334)	(39,171,565)
<b>OTHER FINANCING SOURCES (USES):</b>				
Sales of Assets	-	-	46	46
Operating Transfers In	19,000,000	1,183,115	1,213,973	21,397,088
Operating Transfers Out	(2,257,168)	(19,000,000)	-	(21,257,168)
<b>TOTAL OTHER FINANCING SOURCES (USES)</b>	<b>16,742,832</b>	<b>(17,816,885)</b>	<b>1,214,019</b>	<b>139,966</b>
Net Change in Fund Balances	(21,910,875)	(17,167,409)	46,685	(39,031,599)
FUND BALANCES, July 1, 2024	25,896,753	20,077,385	139,839	46,113,977
FUND BALANCES, June 30, 2025	<u>\$ 3,985,878</u>	<u>\$ 2,909,976</u>	<u>\$ 186,524</u>	<u>\$ 7,082,378</u>
<b>FUND BALANCES CONSIST OF:</b>				
General Cash	\$ 6,545,862	\$ 3,001,282	\$ 297,387	\$ 9,844,531
Due to Vendors	(2,559,985)	-	(110,863)	(2,670,848)
Due to Fund	-	(91,306)	-	(91,306)
<b>TOTAL FUND BALANCES</b>	<u>\$ 3,985,877</u>	<u>\$ 2,909,976</u>	<u>\$ 186,524</u>	<u>\$ 7,082,377</u>

As noted above, the fund balances on June 30, 2025, totaled slightly over \$7 million, which is the lowest fund balance in at least the last 10 years. The chart below shows the total fund balances for each of the three funds that make up the total Program fund balance over the last 10 fiscal years:

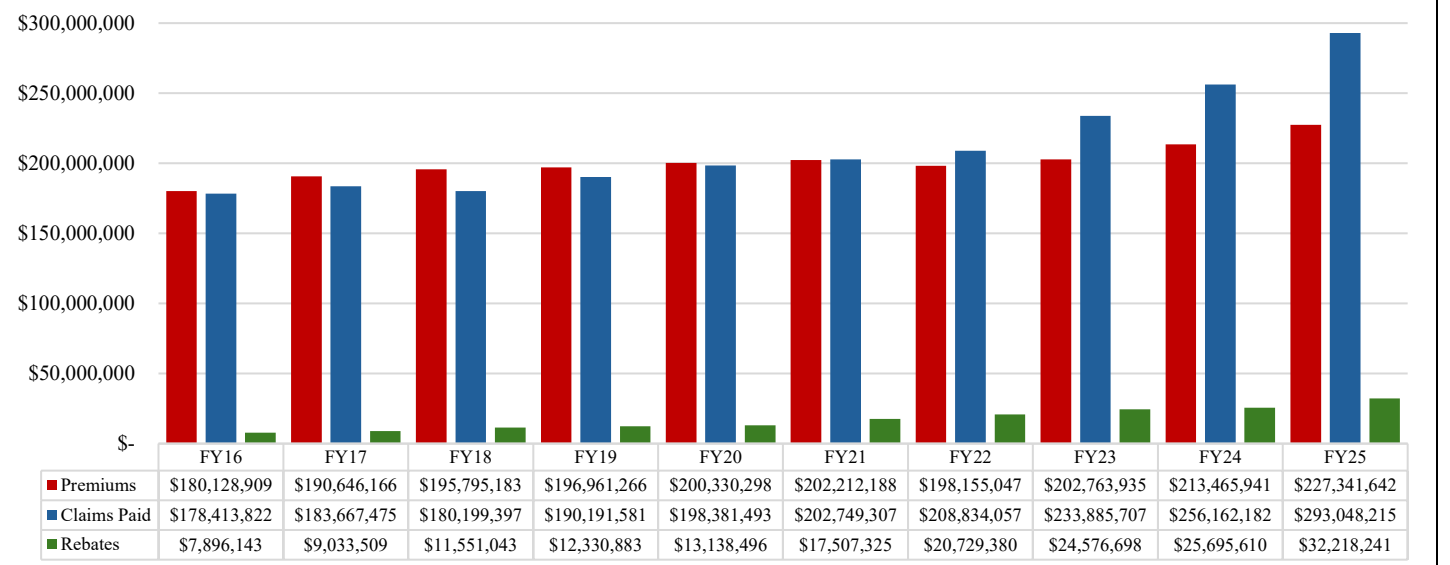
### Total Health Insurance Fund Balances Previous 10 Fiscal Years



In May 2012, the APA issued an attestation report of the Nebraska State Insurance Program for the fiscal year ended June 30, 2010. In that report, the APA included a table showing the fund balances from fiscal year 2006, which was \$8,123,063, to fiscal year 2010 when the total of the fund balances was \$44,558,784. During that attestation, the APA recommended that formal policies be implemented to support decisions regarding premium setting, benefit plan designs, reserves, and fund balances. As shown in the chart above, the fund balances grew to a high of over \$83 million for the fiscal year ended June 30, 2022, before plummeting to slightly over \$7 million at fiscal year end June 30, 2025.

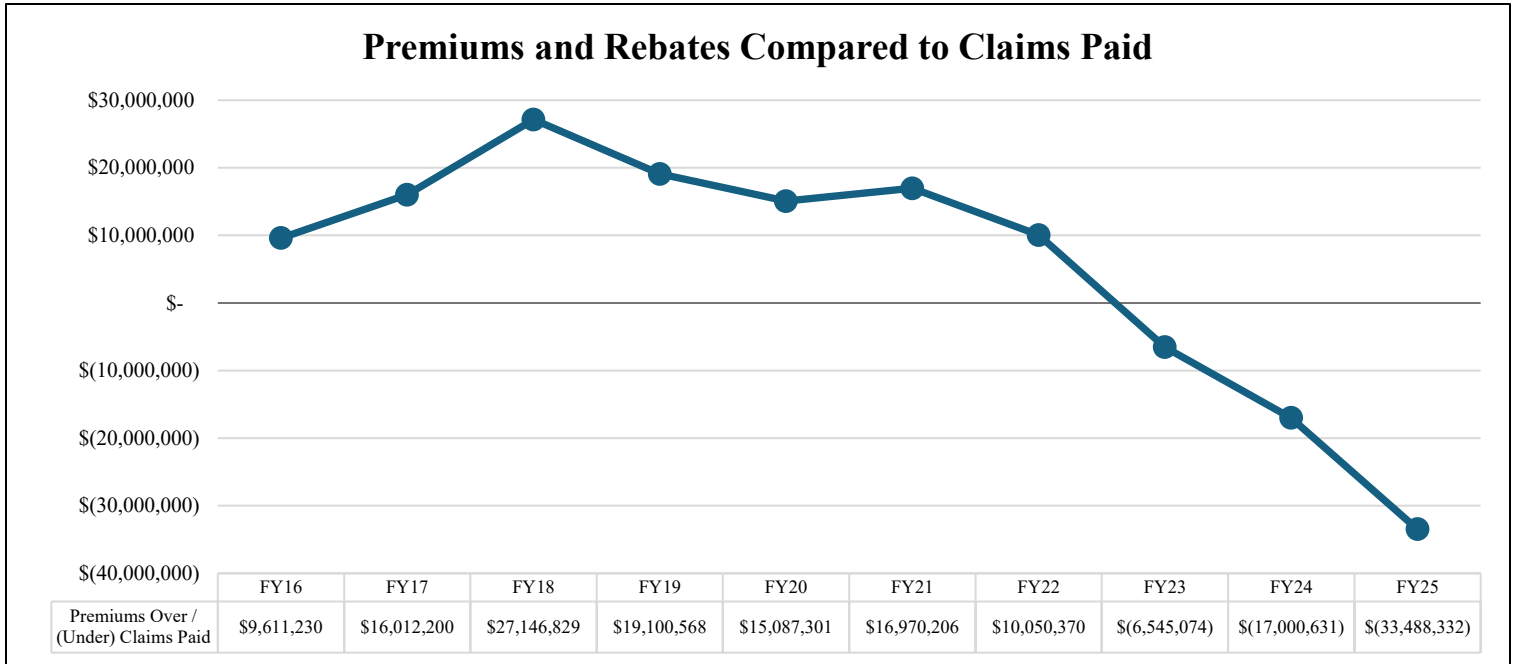
The biggest contributors to the changes in fund balances are the premiums contributed by employees and the State, the rebates received, and the claims paid. The graph below compares the premiums, rebates, and claims paid for last 10 fiscal years:

### 10 Year Comparison of Premiums and Rebates and Claims Paid



From fiscal years 2016 to 2020, the premiums exceeded the claims paid each year. From fiscal year 2016 until fiscal year 2022, the average annual increase in the claims paid was 2.69%. However, in fiscal year 2023, the Program experienced a 12% increase in claims paid, followed by a 9.52% increase for fiscal year 2024, and a 14.40% increase in fiscal year 2025.

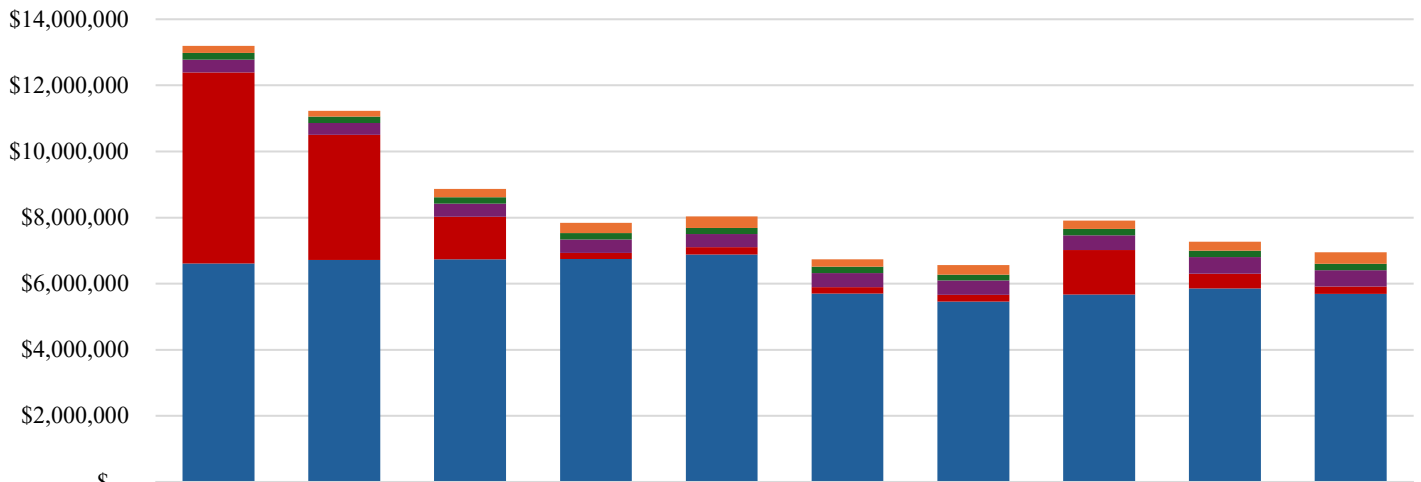
The graph below shows the net difference between the premium contributions, rebates received, and claims paid from the above table for the last 10 years.



The average amount of monthly claims paid was under \$18 million per month from fiscal year 2016 until fiscal year 2022. The average monthly claims paid jumped to almost \$19.5 million in fiscal year 2023, then \$21.3 million in fiscal year 2024, and \$24.4 million in fiscal year 2025. For the first eight months of fiscal year 2026, the average claims paid per month increased to nearly \$26.5 million – with a whopping \$30.7 million in claims paid in December 2025.

While not as significant as the claims paid, the Program also incurs various administrative fees in managing the Program. The table below details the fees and expenses charged to the Program for the last 10 years.

## 10 Years of Fees and Expenses



	FY16	FY17	FY18	FY19	FY20	FY21	FY22	FY23	FY24	FY25
Actuarial Fees	\$218,875	\$166,417	\$251,500	\$318,000	\$349,000	\$227,000	\$284,000	\$251,000	\$274,000	\$349,038
ASI Admin Fees	\$203,214	\$197,615	\$190,610	\$188,247	\$182,622	\$191,797	\$180,768	\$186,267	\$192,110	\$196,368
Personnel Costs	\$377,955	\$353,688	\$399,026	\$407,956	\$399,695	\$420,964	\$432,332	\$446,004	\$500,169	\$493,546
Other	\$5,788,554	\$3,791,248	\$1,281,099	\$179,324	\$219,945	\$199,996	\$205,618	\$1,354,483	\$448,912	\$221,683
UHC Admin Fees	\$6,607,233	\$6,716,226	\$6,741,074	\$6,750,527	\$6,883,505	\$5,698,893	\$5,456,123	\$5,667,122	\$5,853,958	\$5,693,790

**Note:** The Application Software Inc. (ASI Flex) Admin Fees in the table above generally refer to the vendor selected to administer the flexible spending account and the COBRA and retiree benefits services. The UHC admin fees generally refer to the vendor or vendors selected to provide administrative support services for the healthcare benefit plans.

During fiscal years 2016 to 2018, the Department entered into significant contracts that charged fees to the Program, including with Health Fitness Corporation for health education-type expenses. Payments to Health Fitness Corporation alone exceeded \$3.8 million in fiscal year 2016. There was also over \$1 million in payments to the Department of Health and Human Services. The State also had stop-loss insurance at that time, which appeared to cost approximately \$659,000. Those same expenses declined through fiscal year 2018. Since 2019, the expenses and fees have ranged from \$6 million to slightly over \$8 million.

Interestingly, one of the fees included in the chart above, the “ASI Admin Fees,” is related to a contract the Department has with Application Software Inc, DBA ASI Flex, to provide administrative services for the State’s Flexible Spending Account Program and the retiree and COBRA benefits. According to the State’s Request for Proposal, the costs are \$.95 per eligible employee per month. Approximately \$196,000 was paid to ASI Flex during fiscal year 2025. Per the APA’s review of the contract with ASI Flex, the term “eligible employee” was not defined. Approximately 17,000 employees were included on the list of eligible employees provided to ASI Flex by the Department, while the APA noted during testing that only 281 individuals were enrolled in the Early Retirement or COBRA plans in January 2025, and 3,725 were enrolled in the Medical or Dependent Care Flexible Spending Accounts (FSA) as of June 2025.

UnitedHealthcare (UHC) has provided services under an Administrative Services Agreement since July 2012. After a Request for Proposal (RFP) process in 2019, UHC was awarded another contract beginning in March 2020. In May 2023, the contract was renewed for a one-year period, expiring on June 30, 2024. A second renewal for an additional one-year period, expiring June 2025, was agreed upon in June 2024. Finally, in May 2025, the third renewal was executed through fiscal year 2026.

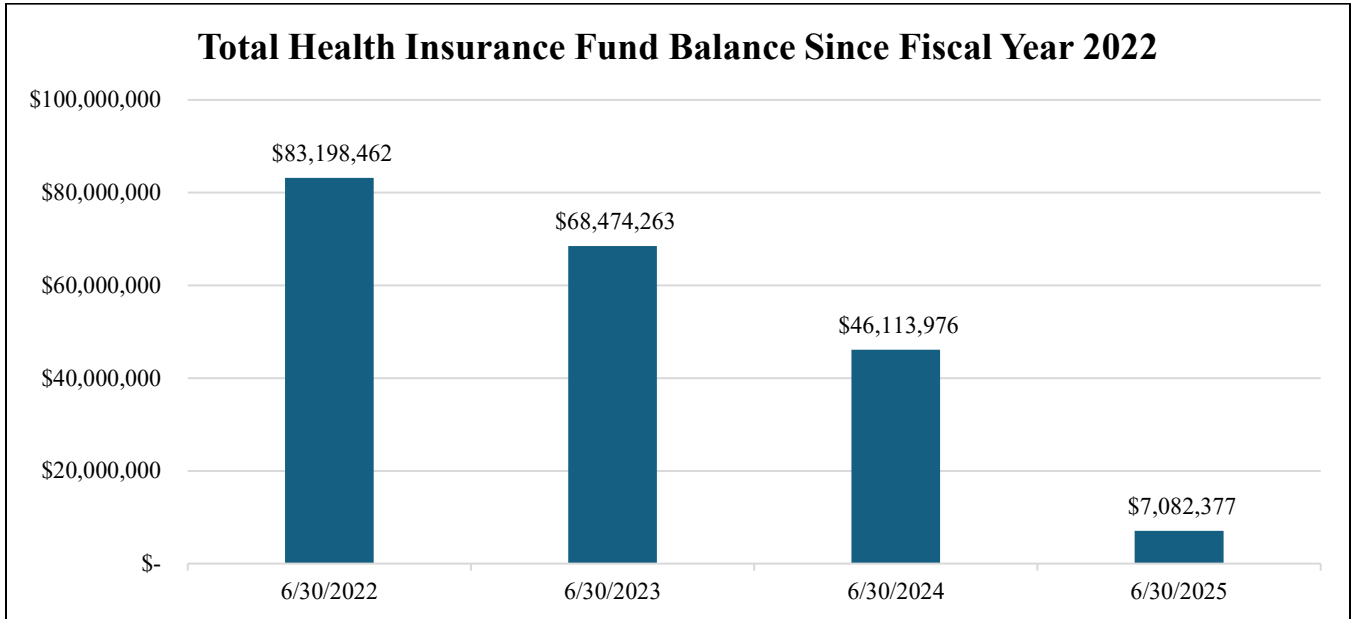
In June 2025 the Department issued another RFP soliciting a bidder to provide Administrative Support Services for the State’s medical benefit plans. The bid opening date was July 17, 2025. On October 10, 2025, the Department issued an Intent to Award the contract for Administrative Support Services to Blue Cross Blue Shield of Nebraska.

The following comments and recommendations, which have been discussed with the appropriate members of the Department and its management, are intended to improve internal control or result in other operating efficiencies.

## Comments and Recommendations

### 1. Declining Fund Balances

As noted in the “Background Information” section herein, the Program’s fund balance has been decreasing significantly since fiscal year 2022, with the largest drop occurring between fiscal years 2024 and 2025. The following table illustrates this progressive annual decline:



It is important to understand the different plans offered in the Program, which currently include the Regular Health Plan, the WellNebraska Plan, and the Consumer Focused Health Plan. The table below shows the differences in each of the plans, with the red font indicating changes from the prior fiscal year:

Description	Fiscal Year			
	25-26	24-25	23-24	22-23
<b>Regular Plan</b>				
Projected Enrollment	3,551	2,645	2,676	2,721
Single Plan Premium (EE/ER)	\$196.50/\$876.30	\$181.96/\$684.50	\$174.96/\$658.18	\$168.22/\$632.86
Employee & Spouse Premium (EE/ER)	\$520.74/\$2,322.17	\$482.18/\$1,813.90	\$463.62/\$1,744.14	\$445.80/\$1,677.04
Employee & Children Premium (EE/ER)	\$402.84/\$1,796.42	\$373.00/\$1,403.24	\$358.66/\$1,349.26	\$344.86/\$1,297.36
Family Premium (EE/ER)	\$697.62/\$3,110.84	\$645.94/\$2,429.96	\$621.08/\$2,336.50	\$597.20/\$2,246.62
<b>Plan Design</b>				
Deductible	\$1,400/\$2,600	\$1,400/\$2,600	\$1,400/\$2,600	\$1,400/\$2,600
Coinsurance (EE)	20%	20%	20%	20%
Med Out of Pocket Max	\$4,000/\$8000	\$4,000/\$8000	\$4,000/\$8000	\$4,000/\$8000
PCP/SCP	\$35/\$45	\$35/\$45	\$35/\$45	\$45/\$55
Rx Tier 1/2/3	\$5/\$40/\$60	\$5/\$40/\$60	\$5/\$40/\$60	\$5/\$40/\$60
Rx Out of Pocket Max	\$2,250/\$4,500	\$2,250/\$4,500	\$2,250/\$4,500	\$2,250/\$4,500
<b>WellNebraska</b>				
Projected Enrollment	8,248	9,150	8,799	8,622
Single Plan Premium (EE/ER)	\$167.22/\$745.66	\$150.64/\$566.72	\$144.84/\$544.92	\$139.28/\$523.96
Employee & Spouse Premium (EE/ER)	\$443.12/\$1,976.03	\$399.20/\$1,501.82	\$383.86/\$1,444.04	\$369.10/\$1,388.50
Employee & Children Premium (EE/ER)	\$342.80/\$1,528.62	\$308.82/\$1,161.78	\$296.94/\$1,117.10	\$285.52/\$1,074.12
Family Premium (EE/ER)	\$593.62/\$2,647.10	\$534.78/\$2,011.84	\$514.22/\$1,934.44	\$494.44/\$1,860.04
<b>Plan Design</b>				
Deductible	\$800/\$1,600	\$800/\$1,600	\$800/\$1,600	\$800/\$1,600
Coinsurance (EE)	20%	20%	20%	20%
Med Out of Pocket Max	\$2,700/\$5,400	\$2,700/\$5,400	\$2,700/\$5,400	\$2,700/\$5,400
PCP/SCP	\$25/\$40	\$25/\$40	\$25/\$40	\$35/\$50
Rx Tier 1/2/3	\$5/\$30/\$50	\$5/\$30/\$50	\$5/\$30/\$50	\$5/\$30/\$50
Rx Out of Pocket Max	\$2,000/\$4,000	\$2,000/\$4,000	\$2,000/\$4,000	\$2,000/\$4,000

Description	Fiscal Year			
	25-26	24-25	23-24	22-23
<b>Consumer Focused</b>				
Projected Enrollment	1,738	1,734	1,446	1,401
Single Plan Premium (EE/ER)	\$111.14/\$495.58	\$102.90/\$387.12	\$98.94/\$372.22	\$95.14/\$357.90
Employee & Spouse Premium (EE/ER)	\$294.50/\$1,313.29	\$272.68/\$1,025.86	\$262.20/\$986.38	\$252.12/\$948.44
Employee & Children Premium (EE/ER)	\$227.82/\$1,015.96	\$210.96/\$793.60	\$202.84/\$763.08	\$195.04/\$733.72
Family Premium (EE/ER)	\$394.52/\$1,759.33	\$365.30/\$1,374.26	\$351.24/\$1,321.40	\$337.74/\$1,270.58
<b>Plan Design</b>				
Deductible	\$3,300/\$5,200	\$3,200/\$5,200	\$3,000/\$5,200	\$2,800/\$5,200
Coinsurance (EE)	20%	20%	20%	20%
Med Out of Pocket Max	\$4,300/\$8,200	\$4,100/\$8,200	\$4,100/\$8,200	\$4,100/\$8,200
PCP/SCP	20% after deductible	20% after deductible	20% after deductible	20% after deductible
Rx Tier 1/2/3	20% after deductible	20% after deductible	20% after deductible	20% after deductible
Rx Out of Pocket Max	Combined	Combined	Combined	Combined

The Department contracted with an actuary to provide a variety of services, including an annual plan cost analysis and annual calculation of the employer and employee contributions for each health plan and calculating an annual Claims Fluctuation Reserve level at the end of the plan year. The claim fluctuation reserve is an actuarially determined balance that is calculated to ensure the balances in the funds are sufficient to pay the costs of any unusual or high-volume claims that might arise during the year.

In its January 2024 analysis of the projected premiums for fiscal year 2024-2025, at the request of the Department, the actuary calculated a 4% increase in premiums that was part of a prior year projection. The following email from the Department shows the request to include the 4% increase in its current projections:

**From:** Osentowski, Christy <[Christy.Osentowski@nebraska.gov](mailto:Christy.Osentowski@nebraska.gov)>  
**Sent:** Wednesday, January 3, 2024 1:02 PM  
**To:** Klein, Patrick J. <[pklein@segalco.com](mailto:pklein@segalco.com)>; Ronsini, Olga <[oronsini@segalco.com](mailto:oronsini@segalco.com)>  
**Subject:** RE: Segal Projections

**CAUTION: External Sender**

I believe 4% is already approved for 24-25, however it might not hurt to show that projection for the upcoming plan year.

The image below shows the actuary's projections with the 4% increase which would create a shortfall of \$11,655,705 from the State's targeted fund balance of \$44,526,692:

Projection	Plan Year 2024-2025				
	All Plan Designs				
Projected Medical Claims					\$188,924,908
\$500 FSA/HSA Contr & Wellness					
Projected Rx Claims					\$78,147,338
Rx Rebates					(\$31,392,495)
Admin Fees (includes ACA)					\$6,418,814
<b>Total Cost</b>					\$242,098,565
EE Contributions					\$46,480,774
ER Contributions					\$174,856,246
<b>Total Contributions</b>					\$221,337,020
Interest					\$777,375
<b>Total Revenue</b>					\$222,114,394
<b>Gain/(Loss)</b>					(\$19,984,171)
<b>Cash Balance EOY</b>					\$32,870,388
<b>Cash Balance Target</b>					\$44,526,692
<b>Surplus/(Deficit)</b>					(\$11,655,705)
<b>Monthly Premium Rates</b>					
Plan Design	Plan Year 2024-2025				
	WellNebraska (NonWellness Track) / Regular Plan	WellNebraska (Wellness Track)	Consumer Focused	Select DPC Plan <sup>1</sup>	Standard DPC Plan <sup>1</sup>
<b>Premium</b>					
EE Only	\$866.45	\$717.36	\$490.01	\$349.70	\$302.16
EE+Spouse	\$2,296.07	\$1,901.02	\$1,298.53	\$991.80	\$865.80
EE+Children	\$1,776.22	\$1,470.59	\$1,004.54	\$753.42	\$655.93
Family	\$3,075.88	\$2,548.61	\$1,739.56	\$1,260.52	\$1,091.70
<b>Proposed Increase:</b>	<b>4.0%</b>	<b>4.0%</b>	<b>4.0%</b>	<b>4.0%</b>	<b>4.0%</b>

The following email from the actuary accompanied the projection included in the image above. In it, the actuary explains his concerns about the fund balance and the need to increase the premium rates:

Please see the multi-year fund projections under the various scenarios requested. As we've discussed, this is a much more challenging year than we've had in the past. The fund has accumulated a sizable loss position as you'll see on the gain/loss row on the exhibits. This loss is a result of low or even flat funding increases and plan design enhancements over the past few years, which were aimed at decreasing the surplus in the fund balance and saving the plan's members money. In response to the current financial position, we have also included two recommended scenarios that target mitigating that loss position since the requested scenarios fall short. One recommended scenario assumes the 4% is locked in for 24-25, while the other allows for a higher increase for the upcoming year. The future increases on both are intentionally staggered to help smooth out the gain/loss over time.

For reference, I included the final projection from last year after the plan enhancements and 4% was agreed upon. Notice the large losses that increase with each plan year. The losses are a bit larger this year compared to last year due to unfavorable emerging claims experience, but the story is still the same. There needs to be an increase to the rates that exceed historical amounts to help re-align the revenue and the expenses.

The APA also obtained the actuarial analysis for the fiscal year 2025-2026 premiums. In December 2024, the actuary provided an analysis of the premiums using data through October 2024 and plan changes provided by the Department. One scenario for changes included an 11% premium increase for the Wellness Plan and an 8% increase for both the Regular and the Consumer Focused plans. The projections in that scenario showed a \$42 million deficit for the fund at the end of the fiscal year, leaving a projected fund balance of almost \$5.9 million. The image below shows the actuary's analysis with those premium increases:

Projection		Plan Year 2025-2026		
Plan Design		All Plan Designs		
Projected Medical Claims				\$208,288,893
Projected Rx Claims				\$86,438,670
Rx Rebates				(\$36,330,493)
Admin Fees (Includes ACA)				\$5,734,844
<b>Total Cost</b>				\$264,131,915
EE Contributions				\$52,679,399
ER Contributions				\$198,174,865
<b>Total Contributions</b>				\$250,854,260
Interest				\$257,431
<b>Total Revenue</b>				\$251,111,691
<b>Gain/(Loss)</b>				(\$13,020,224)
Cash Balance EOY				\$5,892,570
Cash Balance Target				\$48,619,680
<b>Surplus/(Deficit)</b>				(\$42,727,110)
Monthly Premium Rates		Plan Year 2025-2026		
Plan Design	WellNebraska (NonWellness Track) / Regular Plan	WellNebraska (Wellness Track)	Consumer Focused	
Premium				
EE Only	\$935.77	\$796.27		\$529.21
EE+Spouse	\$2,479.75	\$2,110.13		\$1,402.41
EE+Children	\$1,918.32	\$1,632.35		\$1,084.91
Family	\$3,321.95	\$2,826.74		\$1,878.72
<b>Proposed Increase:</b>	<b>8.0%</b>	<b>11.0%</b>		<b>8.0%</b>

In a December 5, 2024, email to the Department, the actuary expressed the following reservations about these premium increases:

The first scenario we ran was what we've been calling "6A", which has an 11% increase on Wellness / 8% on all other plans. We've included the plan design changes as well. With data through June, we projected the Fund Balance around \$24M at the end of PY 2025, after including data through October, this amount falls to just below \$19 million. Plan changes will produce annual savings of approximately \$2.7M starting in PY 2026, but their impact is offset by the cumulative higher medical claims and enrollment growth. You'll see that the Fund Balance declines to dangerously low levels in PY 2026-2029.

That same email ended with the following warning from the actuary:

Big picture, we don't advise a single-digit increase for FY25-26 and it may be worth considering increases higher than the 11%/8% scenario, given incorporation of the latest data and how thin the sensitivity to future medical trend. Unless of course, a contingency plan exists where money can be injected into the fund from an outside source.

The Program continued to experience significant increases in the claims paid during the last half of fiscal year 2025, which would not have been considered in the actuary's analysis for the new premiums for fiscal year 2026. The following table shows the monthly claims paid for fiscal year 2025:

Month	Claims Paid
July 2024	\$ 24,806,045
August 2024	\$ 20,198,401
September 2024	\$ 20,820,515
October 2024	\$ 23,568,167
November 2024	\$ 22,888,241
December 2024	\$ 24,917,905
January 2025	\$ 23,202,374
February 2025	\$ 24,479,228
March 2025	\$ 25,192,269
April 2025	\$ 29,805,909
May 2025	\$ 27,502,019
June 2025	\$ 25,667,142
<b>Total</b>	<b>\$ 293,048,215</b>

Due to the declining fund balance in the last half of fiscal year 2025, the Department made several transfers from the Health Insurance History Fund to the State Employees Insurance Fund to cover the cost of the claims paid the prior day:

Date	Transfers Out
April 9, 2025	\$ 5,000,000
May 7, 2025	\$ 6,000,000
May 21, 2025	\$ 4,000,000
June 5, 2025	\$ 4,000,000
<b>Total</b>	<b>\$ 19,000,000</b>

As pointed out already, the fund balances on June 30, 2025, were just over \$7 million. At that time, it had also become clear that the premiums originally set for fiscal year 2026 – only a few short months prior – would be insufficient to pay claims for the fiscal year.

Therefore, the Department took an extreme measure and required the State agencies to incur larger premium increases than had been established previously for fiscal year 2026. This would spare the employees from increases in the premiums promised to them during the State's open enrollment process, which was completed in May 2025. In a June 13, 2025, message, therefore, the Department required State agencies to increase the employer share of health insurance premiums. See **Attachment A** hereto.

The following table shows the changes to the fiscal year 2026 premiums. The "Initial Premium" column represents the Department's original 8% or 11% increase from the fiscal year 2025 premiums. The "Revised Premium" column relates to the additional amount required to be covered by the State agencies after the original premiums were set.

Premium Split	Initial Premium		Revised Premium	
	FY 2026	%	FY 2026	%
<b>Wellness</b>				
Single Coverage	\$ 167.22	21.0%	\$ 167.22	18.3%
State Share Single Coverage	\$ 629.06	79.0%	\$ 745.66	81.7%
<b>Total</b>	<b>\$ 796.28</b>		<b>\$ 912.88</b>	<b>14.6%</b>
Employee & Spouse Coverage	\$ 443.12	21.0%	\$ 443.12	18.3%
State Share Employee & Spouse Coverage	\$ 1,667.02	79.0%	\$ 1,976.03	81.7%
<b>Total</b>	<b>\$ 2,110.14</b>		<b>\$ 2,419.15</b>	<b>14.6%</b>
Employee & Children Coverage	\$ 342.80	21.0%	\$ 342.80	18.3%
State Share Employee & Children Coverage	\$ 1,289.58	79.0%	\$ 1,528.62	81.7%
<b>Total</b>	<b>\$ 1,632.38</b>		<b>\$ 1,871.42</b>	<b>14.6%</b>
Family Coverage	\$ 593.62	21.0%	\$ 593.62	18.3%
State Share Family Coverage	\$ 2,233.14	79.0%	\$ 2,647.10	81.7%
<b>Total</b>	<b>\$ 2,826.76</b>		<b>\$ 3,240.72</b>	<b>14.6%</b>
<b>Regular</b>				
Single Coverage	\$ 196.50	21.0%	\$ 196.50	18.3%
State Share Single Coverage	\$ 739.28	79.0%	\$ 876.30	81.7%
<b>Total</b>	<b>\$ 935.78</b>		<b>\$ 1,072.80</b>	<b>14.6%</b>
Employee & Spouse Coverage	\$ 520.74	21.0%	\$ 520.74	18.3%
State Share Employee & Spouse Coverage	\$ 1,959.04	79.0%	\$ 2,322.17	81.7%
<b>Total</b>	<b>\$ 2,479.78</b>		<b>\$ 2,842.91</b>	<b>14.6%</b>
Employee & Children Coverage	\$ 402.84	21.0%	\$ 402.84	18.3%
State Share Employee & Children Coverage	\$ 1,515.50	79.0%	\$ 1,796.42	81.7%
<b>Total</b>	<b>\$ 1,918.34</b>		<b>\$ 2,199.26</b>	<b>14.6%</b>
Family Coverage	\$ 697.62	21.0%	\$ 697.62	18.3%
State Share Family Coverage	\$ 2,624.36	79.0%	\$ 3,110.84	81.7%
<b>Total</b>	<b>\$ 3,321.98</b>		<b>\$ 3,808.46</b>	<b>14.6%</b>
<b>Consumer Focused</b>				
Single Coverage	\$ 111.14	21.0%	\$ 111.14	18.3%
State Share Single Coverage	\$ 418.08	79.0%	\$ 495.58	81.7%
<b>Total</b>	<b>\$ 529.22</b>		<b>\$ 606.72</b>	<b>14.6%</b>
Employee & Spouse Coverage	\$ 294.50	21.0%	\$ 294.50	18.3%
State Share Employee & Spouse Coverage	\$ 1,107.92	79.0%	\$ 1,313.29	81.7%
<b>Total</b>	<b>\$ 1,402.42</b>		<b>\$ 1,607.79</b>	<b>14.6%</b>
Employee & Children Coverage	\$ 227.82	21.0%	\$ 227.82	18.3%
State Share Employee & Children Coverage	\$ 857.10	79.0%	\$ 1,015.96	81.7%
<b>Total</b>	<b>\$ 1,084.92</b>		<b>\$ 1,243.78</b>	<b>14.6%</b>
Family Coverage	\$ 394.52	21.0%	\$ 394.52	18.3%
State Share Family Coverage	\$ 1,484.20	79.0%	\$ 1,759.33	81.7%
<b>Total</b>	<b>\$ 1,878.72</b>		<b>\$ 2,153.85</b>	<b>14.6%</b>

The subsequent increase in the employer share of premiums, as directed by the Department, has resulted in an additional \$24.8 million in premium contributions to the Program through February 2026.

A proper system of internal control requires procedures to ensure that the Program's fund balances are maintained at levels sufficient to cover Program expenditures, per actuarial recommendation. Without such procedures, there is an increased risk of the Program being unable to cover health insurance claims incurred.

We recommend the Department implement procedures to ensure the Program's fund balance is maintained at a sufficient level, as recommended by the actuary. Such procedures might include obtaining the detailed claims data, so a more current analysis of claims data can be made. Detailed claims data would also allow the Department to identify the need for further changes to plan provisions.

*Department Response: In the last several years DAS has sought to balance the Program's funds with the operational and employment considerations of State employees. Aspects of the Program that do not deliver adequate ROI or impact are removed, as seen in the discontinuation of stop loss coverage in 2017 due to high fund balances, early termination of the Health Fitness Corporation contract in 2018, and early termination of the contract with the*

current medical and pharmacy vendors in order to bid for new contracts. The Program’s fund balance maintained healthy levels through this management with market level or below market level cost trends. The fund balance climbed even higher due to a drop in utilization and costs during the 2020 – 2022 plan years. Efforts were made by the State to return that value to State employees and agency budgets via smaller, below market premium increases and other programming. The last couple years have seen a sudden well above market cost trend in the State’s Program, driven in part by increased utilization and a string of large, catastrophic health claims and related pharmacy costs. The State will continue to work with its partners, including actuaries and the new medical and pharmacy vendors, to adjust the State’s Program to these trends in the context of the overall State budget and operations.

**2. Monitoring of Claims Paid**

One of the main factors in the Program’s rapidly decreasing fund balances was the significant increase in claims paid. During fiscal year 2025, the Department paid over \$293 million in health insurance and prescription claims under the Program – an increase of more than \$36 million from fiscal year 2024. Claims paid to UnitedHealthcare (UHC) continued to rise during the first eight months of fiscal year 2026, with over \$30 million in claims paid during December 2025 alone.

The following table shows the claims paid (excluding rebate amounts) in each of the last 10 fiscal years.

Fiscal Year	Claims Paid
2016	\$ 178,413,822
2017	\$ 183,667,475
2018	\$ 180,199,397
2019	\$ 190,191,581
2020	\$ 198,381,493
2021	\$ 202,749,307
2022	\$ 208,834,057
2023	\$ 233,885,707
2024	\$ 256,162,182
2025	\$ 293,048,215

The Department lacks the ability to perform detailed monitoring of claims paid, delegating to its contractor under an administrative services agreement for paying claims the responsibility to ensure the accuracy of those payments.

The APA has explained in greater detail below our concerns in the following areas:

- Detailed Claims Data Not Obtained
- Ineligible Individuals with Claims Paid
- Duplicate Claims

***Detailed Claims Data Not Obtained***

In our previous attestation for the fiscal year ended 2010, the APA addressed similar concerns with the Department’s lack of monitoring claims paid. Many of those same concerns have continued to the present. In fact, the Department lacks the data necessary to perform any meaningful analysis of claims paid.

During our audit of the Annual Comprehensive Financial Report (ACFR) for the fiscal year ended June 30, 2025, the APA requested a listing of all claims paid for fiscal years 2024 and 2025. The Department provided a summarized file of those claims, lacking the requested details needed for analytical purposes.

The claims data for fiscal year 2025 included 865,788 individual claims paid to 4,066 providers, totaling \$293,042,677. The table below shows the top 20 providers:

Provider Name	Count of Claims	Amount
PRESCRIPTION CLAIMS	353,294	\$ 85,328,077
BRYAN MEDICAL CENTER	18,502	\$ 28,147,734
NEBRASKA MEDICAL CENTER CORP	16,270	\$ 14,363,584
NEBRASKA METHODIST HOSPITAL IN	4,961	\$ 5,125,383
CHILDREN'S HOSPITAL & MEDICAL	1,932	\$ 5,076,074
NORTH PLATTE NEBRASKA HOSPITAL	3,873	\$ 4,228,521
SAINT ELIZABETH REGIONAL MEDIC	3,988	\$ 4,054,825
BRYAN HOSPITAL KEARNEY CORP	3,076	\$ 3,789,212
REGIONAL WEST MEDICAL CENTER C	2,904	\$ 3,357,105
FAITH REGIONAL HEALTH SERVICES	1,662	\$ 3,262,523
BEATRICE COMMUNITY HOSPITAL &	6,796	\$ 3,123,845
LINCOLN SURGERY CENTER LLC	479	\$ 3,120,723
UNMC PHYSICIANS CORP	12,344	\$ 3,079,853
GOOD SAMARITAN HOSPITAL	1,390	\$ 2,987,489
ALEGENT HEALTH CLINICS INC	15,599	\$ 2,944,516
CANCER PARTNERS OF NEBRASKA PC	6,466	\$ 2,920,379
ALEGENT HEALTH BERGAN MERCY HE	2,663	\$ 2,762,420
BRYAN PHYSICIAN NETWORK INC	15,922	\$ 2,676,003
MARY LANNING HEALTHCARE	1,930	\$ 2,418,297
METHODIST FREMONT HEALTH CORP	1,354	\$ 2,097,372
<b>Total of Top 20 Providers</b>	<b>475,405</b>	<b>\$ 184,863,935</b>
<b>Remaining Claims</b>	<b>390,383</b>	<b>\$ 108,178,742</b>
<b>Grand Total</b>	<b>865,788</b>	<b>\$ 293,042,677</b>

The table below shows the top 20 claimants:

Subscriber	Count of Claims	Amount
Subscriber #1	230	\$ 1,091,422
Subscriber #2	680	\$ 897,246
Subscriber #3	254	\$ 866,992
Subscriber #4	643	\$ 845,298
Subscriber #5	373	\$ 756,576
Subscriber #6	265	\$ 666,515
Subscriber #7	1,166	\$ 630,718
Subscriber #8	85	\$ 585,279
Subscriber #9	724	\$ 576,403
Subscriber #10	207	\$ 571,275
Subscriber #11	479	\$ 566,816
Subscriber #12	100	\$ 559,625
Subscriber #13	612	\$ 556,590
Subscriber #14	219	\$ 555,564
Subscriber #15	95	\$ 550,386
Subscriber #16	527	\$ 516,024
Subscriber #17	176	\$ 506,272
Subscriber #18	143	\$ 488,259
Subscriber #19	386	\$ 487,746
Subscriber #20	91	\$ 480,101
<b>Top 20 Totals</b>	<b>7,455</b>	<b>\$ 12,755,107</b>

Despite the enormous number of claims paid annually, as well as the significant increases in the amounts of those payments in recent years, the Department does not obtain the detailed claims data required to perform a meaningful analysis of the claims paid.

When making the daily payments to UHC, the Department relied on a Charged Claim Activity file that lacked any detailed information about the claims. Among other less relevant information, the file includes the employee and dependent name, the employee social security number, the amount paid, and the date of the service.

During the fiscal year 2025 ACFR, as explained already, the APA requested a listing of all the claims paid for fiscal years 2024 and 2025. The Department provided a summarized file of claims that did not include relevant details needed for properly analyzing those claims, including the Current Procedural Terminology (CPT) codes for identifying the services received on each claim or any details for the prescription claims, including the drugs dispensed.

In January 2026, at the beginning of our work to determine if an audit or attestation was necessary, the APA requested more detailed claims information than the information previously provided. Two days after that request, the Department responded, “UHC has indicated that they have already provided data with as much details as exists in that reporting.”

The Department’s contract with UHC grants the State unlimited access to information and data needed to “perform planning, administration, audit, and financial functions.” Addendum One of the Administrative Services Agreement, Section III (“Contractor Duties”), contains the following:

**W. OWNERSHIP OF INFORMATION AND DATA / DELIVERABLES**  
The State shall have the unlimited right to publish, duplicate, use, and disclose all information and data developed or obtained by Contractor on behalf of the State pursuant to this contract, except the State shall withhold proprietary business information of Contractor that would serve no public purpose if such information is not required to be disclosed pursuant to law. Specifically information and/or data that contains Contractor proprietary business information (e.g., reasonable & customary amounts, network discounts, reimbursement methodologies); we have proprietary business rights to that information and/or data.

All eligibility records are the sole property of the State, and shall be made available upon request to the State and its representatives. Within a reasonable time frame Contractor will make available to the State or its representatives relevant information (e.g., eligibility and claim records) reasonably necessary for the State to perform planning, administration, audit and financial functions, except as may be prohibited by law or by third-party contract, provided there are appropriate confidentiality and hold harmless agreements in place.

In response to the APA’s continued pursuit of this more detailed data, UHC hinted at a willingness to provide more information. The Department asked the APA to review an outline of the information that UHC was willing to make available. The APA requested that the information include the amounts billed or paid for coverage, CPT codes, drug names, and social security numbers of spouses and dependents. On February 23, 2026, the Department responded that UHC declined to provide the requested information and forwarded this response from UHC:

*The request for additional data is outside of our available financial report. In addition, our external audit team that assists accountant audit firms’ that conduct a financial audit, typically has an accountant audit firm selects a small # of samples, about 10-20, ( from a population file that shows the claims that would tie back to one of the customers financial banking report that they have access to in eServices) for which UHC will then provide claim information for purposes of proving positive payment (i.e. that UHC actually received a claim from the provider for that sample)- however, this financial audit process does not include customer conducting claim adjudication accuracy reviews of the claim samples selected.*

In addition to flying in the face of the express Section III contractual language quoted above, the refusal by UHC to honor the APA’s request for information virtually ensured the Department’s inability to perform any meaningful real-time analysis of the claims paid – even when those claims increased by \$36 million between fiscal year 2024 and fiscal year 2025.

The above response from UHC highlights one of our most serious concerns – namely, the vendor charged with paying the claims is also responsible for auditing and adjudicating its own processes. As explained already, the Department has generally relied on its contactors to ensure the veracity of claims paid in accordance with a plan’s provisions.

One such procedure performed by the Department included a review of individual claims larger than \$40,000 or claims with old dates of service. These procedures helped to ensure that the individuals for whom claims were paid were enrolled properly in the Program for the date of service, while UHC verified that the amounts were correct.

Some of the real-time analysis capable of being performed with more detailed claims data would include: 1) investigating whether duplicate claims have been paid; 2) analyzing the costs charged by different providers for the same services; 3) ensuring that claims paid are only for eligible individuals; and 4) determining which medical costs are causing the significant increases in overall claims costs. Such analysis could lead to broader questions about the management of the plans – for instance, whether the State should negotiate with providers for the cost of services rather than the insurance company. Because all of this data is available electronically, the APA does not believe that the analysis would prove time intensive.

A proper system of internal control requires procedures for performing an analysis of claims paid to ensure Program funds are used appropriately. Without such procedures, there is an increased risk of not only ineligible and duplicate payments significantly increasing plan costs but also the Department proving unable to prevent such improper disbursements through effective Program oversight.

We recommend the following: 1) any service provider responsible for claim payments be required contractually to provide details, as requested by the Department, sufficient to allow for a thorough analysis of those disbursements; and 2) such contractual provision be both comprehensive in scope and rigorously enforced.

*Department Response: The Department agrees that more in-depth analysis of claims is necessary to ascertain areas driving cost trends and opportunities for cost savings for the Program, and has taken steps in that direction with vendor partners. This has included adjustments to the medical and pharmacy vendor contracts to allow for greater access to data, including that for claims. The State is actively exploring options for conducting claims analysis and auditing outside of the medical and pharmacy vendors as the resources do not currently exist to conduct such an extensive audit of the thousands of claims processed under the Program annually.*

***Ineligible Individuals with Claims Paid***

The State uses Workday, a financial management software platform, for administering its human resources, payroll, and employee benefits functions. From this system, the APA obtained a listing of State employees termination dates, which were used to determine whether any claims were paid for services received after employment had ended.

In another test, the APA compared the social security numbers from the claims paid to a listing of State employees obtained from Workday to ensure the claims paid were for eligible State employees.

In the limited testing performed, the APA identified two individuals for whom claims were paid despite their ineligibility to be in the Program. The details of these findings are included in the table below:

Individual	Description	Amount Paid
Individual #1	<p>This individual was covered under the Program as the spouse of a retiree from the State. The retiree enrolled in the State’s early retiree program, which provides health insurance for retirees until the age of 65. However, the retiree passed away in October 2019. Under the Program’s rules, the spouse of the retiree should have been offered 36 months of COBRA insurance, which would have provided coverage through October 2022.</p> <p>According to the Department, the contractor responsible for the COBRA/Early Retiree administration was not informed of the retiree’s death. The spouse of the retiree continued to submit the early retirement enrollment forms by signing the deceased retiree’s name until December 2022. At that point, the spouse of the retiree was offered 36 months of COBRA insurance, from December 2022 through November 2025.</p> <p>The State paid ineligible insurance claims for over three years, totaling \$45,442.</p>	\$ 45,442

Individual	Description	Amount Paid
Individual #2	<p>This individual was employed by the State until his retirement in June 2018; however, in January 2024, he was rehired and remained an employee until June 2024, when his coverage under the Program should have terminated. However, \$13,484 in claims were paid for him between July 2024 and August 2025.</p> <p>According to the Department, when an employee reaches the age of 55, a certain field in Workday is changed to “retiree” to indicate that he or she is eligible for the early retiree program upon termination of employment. This data is included in the eligibility file sent to UHC. The field that housed this “retiree” status on the UHC side apparently locked the insurance from being automatically canceled. Therefore, when the Department remitted a file that included the employee’s termination date, the UHC system did not update the termination date in their system. This allowed the employee to remain active on the UHC side – allowing claims to process subsequent to termination of employment.</p> <p>The Department lacked controls to ensure claims were paid only for eligible individuals. Once the issue was discovered, the Department was able to recoup \$9,484 in medical claims but was unable to recover \$4,000 in prescription claims that had been paid.</p>	\$ 4,000
<b>Total</b>		<b>\$ 49,442</b>

It is important to note that these issues were identified by applying simple data analytic techniques to the limited claims information available. The APA would expect similar issues had we been provided the more detailed claims data.

The “Guide to Public Servant Wellness & Benefits Program” (2025-26) (p.38), issued by the Department, states the following, “Unlike COBRA, a dependent cannot continue coverage through the Early Retiree Insurance Program unless the public servant/retiree is also enrolled.” ([https://das.nebraska.gov/personnel/docs/NE\\_DAS\\_Personnel\\_Wellness\\_and\\_Benefits-2025\\_2026\\_Open\\_Enrollment\\_Benefits\\_Guide.pdf](https://das.nebraska.gov/personnel/docs/NE_DAS_Personnel_Wellness_and_Benefits-2025_2026_Open_Enrollment_Benefits_Guide.pdf))

A proper system of internal controls requires procedures to ensure that claims paid are only for individuals eligible under the Program. Without such procedures, there is an increased risk of claims being paid for ineligible individuals, as shown above.

We recommend the Department implement procedures to ensure claims are paid only to eligible individuals. Such procedures necessarily require a more complete review of claims payments, as compared to premiums remitted, for active, terminated, or retired individuals.

*Department Response: The Department currently works with State Agencies, Boards and Commissions to appropriately manage State employee eligibility for the Program, including removing those who should no longer be eligible for coverage. We are committed to continuing the actions begun to shore up those processes, which include active participation from our medical and COBRA/Retiree vendors. The State is actively exploring options for conducting claims analysis and auditing outside of the medical and pharmacy vendors as the resources do not currently exist to conduct such an extensive audit of the thousands of claims processed under the Program annually. The Department would note that current processes include the reprocessing of medical claims in order to recoup money spent by the Program. In this case with the referenced Individual #1, the Department became aware of the situation internally and is coordinating with Legal for next steps as the matter involves fraudulent activity.*

**APA Response: In a phone call with the APA, Department staff indicated that they were not aware of the ineligible claims paid on behalf of Individual #1 until it was brought to their attention by the APA.**

***Duplicate Claims***

Using the limited claims data provided, the APA performed an analysis to identify duplicate claims paid – searching, in effect, for multiple claims paid on behalf of the same individual, for the same service received, to the same provider, on the same date, and for the same amount. From this review, a list was compiled of \$688,435 in apparently duplicate claims paid during fiscal year 2025. The APA then selected 10 individuals from that list, and the Department sent those names and the accompanying information to UHC for further review and an explanation of any duplicate payments verified.

The table below details the claims, totaling \$67,408, for seven of the individuals reviewed. This information highlights the fact that the subsequent data provided by UHC is needed to allow the State to ascertain whether the claims paid were duplicate because the benefit type, provider, service date, and total payment were all the same for each recipient.

Ind #	Financial Benefit Type	Provider Full Name	Service Day	Charge Day	UHC Response	Total Payment
1	Surgery	WASHINGTON UNIVERSITY	7/13/2024	8/12/2024	This was a surgery involving two surgeons. In fact, a third surgeon was also involved whose claim was paid, totaling \$15,866.	\$ 16,422
	Surgery	WASHINGTON UNIVERSITY	7/13/2024	8/19/2024		\$ 16,422
2	Surgery	UNMC PHYSICIANS CORP	1/5/2025	2/24/2025	Each claim included three different procedures codes. Two of the codes had a separate modifier. However, the third code was the same for both claims. One claim was determined to be duplicate.	\$ 11,082
	Surgery	UNMC PHYSICIANS CORP	1/5/2025	3/10/2025		\$ 11,082
3	Managed Pharm. Benefit	PRESCRIPTION CLAIMS	12/11/2024	12/19/2024	The two claims were for drugs prescribed at different strengths.	\$ 3,953
	Managed Pharm. Benefit	PRESCRIPTION CLAIMS	12/11/2024	12/19/2024		\$ 3,953
4	Anesthesia	PRISMA HEALTH UNIVERSITY MEDIC	11/21/2024	12/13/2024	The procedure required dual anesthesiologists – one a medical doctor and one a nurse anesthetist.	\$ 1,105
	Anesthesia	PRISMA HEALTH UNIVERSITY MEDIC	11/21/2024	12/13/2024		\$ 1,105
5	Inpatient Hospital Misc.	UNMC PHYSICIANS CORP	2/20/2025	3/3/2025	The claim paid two different doctors for the same procedures code. The doctors appear to have different specialties. The APA noted two other claims on the same date for radiology services.	\$ 500
	Inpatient Hospital Misc.	UNMC PHYSICIANS CORP	2/20/2025	3/3/2025		\$ 500
6	Anesthesia	CHI HEALTH CLINIC ANES LLC	11/11/2024	12/17/2024	The procedure required dual anesthesiologists – one a medical doctor and one a nurse anesthetist.	\$ 411
	Anesthesia	CHI HEALTH CLINIC ANES LLC	11/11/2024	12/17/2024		\$ 411
7	Outpatient/Prof . Medical	KANSAS UNIVERSITY PHYSICIANS	2/25/2025	3/13/2025	The claim paid two different doctors for the same procedures code. The doctors appear to have different specialties. The APA noted one other claim on the same date for radiology services.	\$ 231
	Outpatient/Prof . Medical	KANSAS UNIVERSITY PHYSICIANS	2/25/2025	3/27/2025		\$ 231
<b>Total</b>						<b>\$ 67,408</b>

During our questioning, it was determined that the claims related to Individual #2 in the above table were duplicate. The initial response from UHC, as reflected in the table, explained that the procedure codes on the two claims had modifiers, making them separate services. However, only two of the three procedure codes billed had the separate modifier. We inquired further and received the following response from the Department on March 17, 2026:

I have just heard back from Erica on item #44. The processors confirmed duplicate claim that they have now reprocessed as not covered  
Top line below shows denied as not covered, duplicate. Taking back the \$11081.77 duplicate paid on line 2 (negative amount).

First Date	Last Date	Charge	Paid	Deductible	Not Covered	Provider Name	ICN	Process Date	Draft	
01/05/2025	01/05/2025	20,909.00	0.00	0.00	20,909.00	A HOFFMAN	EV97535185	03/16/2026	0127141870	Denied as duplicate
01/05/2025	01/05/2025	-20,909.00	-11,081.77	0.00	-9,827.23	A HOFFMAN	EV97535185	03/16/2026	0118791304	Adjustment
01/05/2025	01/05/2025	20,909.00	11,081.77	0.00	9,827.23	A HOFFMAN	EV97535185	03/06/2025	0118791304	Duplicate claim paid
01/05/2025	01/05/2025	0.00	0.00	0.00	0.00	A HOFFMAN	EV97535185	03/06/2025	0117557777	
01/05/2025	01/05/2025	20,909.00	11,081.77	0.00	9,827.23	A HOFFMAN	EX31084481	02/17/2025	0118392934	Original Claim

It is important to understand that these claims originally paid by UHC were processed on the same date, for the same services, by the same provider. Not until the APA questioned the claims, was one of them determined to be duplicate and was reversed on March 16, 2026.

During our review of these health insurance claims, the APA also became aware of other potentially duplicate claims paid related to one of our own employees.

On February 7, 2026, a dependent of an APA employee went to an urgent care clinic. Upon receiving the explanation of benefits, questions were raised about dual charges. First, one provider billed \$156 for urgent care services, in which the plan paid \$100.40, and the employee was charged a \$40 copay. A second provider billed \$244 as an office visit, in which the plan paid \$48.34, and the employee was charged a second \$25 copay for the same visit. This visit is recorded as Lines 1 and 2 on the table below.

Two days later, the dependent returned to the same facility for services. Again, upon receipt of the explanation of benefits, it appears the service was billed twice to the insurance company. First, one provider billed \$69 for urgent care services, in which the plan paid \$22.10, and the employee was charged a \$40 copay. A second provider billed \$127 as an office visit, in which the plan paid nothing, and the employee was charged a second \$24.87 copay for the same visit. This visit is recorded as Lines 4 and 5 on the table below.

The employee contacted both the provider and the insurance company to question the charges – especially since they appeared to be duplicative for the same services, including charging the employee two copays for the same service. When contacted by the employee, representatives for both the provider and the insurance company appeared to have difficulty understanding that these appeared to be duplicate charges for the same service. Finally, a supervisor at the insurance company agreed to investigate the claims further.

The employee received an adjusted explanation of benefits for the two services dated March 10, 2026. The adjustments are included in the table below in Lines 3 and 6.

The adjustment shown in Line 3 was labeled an adjustment and reversed the Plan Paid amount in Line 2. The adjustment shown in Line 6 simply moved the \$24.87 copay from the Claimant Paid column to the Plan Paid column. Consequently, the Plan still paid for both services on the same date.

Line	Date	Provider	Service Rendered	Provider Billed	Amount Saved	Plan Allowed	Plan Paid	Claimant Paid
1	2/7/2026	Providence Medical	Urgent Care	\$ 156.00	\$ 15.60	\$ 140.40	\$ 100.40	\$ 40.00
2	2/7/2026	M Garcia	Office Visits	\$ 244.00	\$ 170.66	\$ 73.34	\$ 48.34	\$ 25.00
3	2/7/2026	M Garcia	Adjustment				\$ (48.34)	\$ -
4	2/9/2026	Providence Medical	Urgent Care	\$ 69.00	\$ 6.90	\$ 62.10	\$ 22.10	\$ 40.00
5	2/9/2026	H Kreber	Office Visits	\$ 127.00	\$ 102.13	\$ 24.87	\$ -	\$ 24.87
6	2/9/2026	H Kreber	Office Visits				\$ 24.87	\$ -

These examples show the importance of obtaining more detailed information to identify duplicate claims of both the same and differing amounts. However, the Department relies solely on UHC to identify and correct any duplicated claims.

A proper system of internal control requires procedures to ensure the accuracy of claims paid, particularly in times of significantly increasing costs. Without such procedures, there is an increased risk for loss and misuse of Program funds.

We recommend the Department implement procedures for obtaining detailed information needed to identify duplicate claims – including not only those for the same service, on the same date, and for the same amounts but also billings for the

same service but with different costs. We also recommend the Department consider whether it is logical for the vendor charged with paying the claims to be responsible also for preventing any overpayments. Finally, the Department should obtain an understanding of the new vendor’s overpayment identification and review process and whether there needs to be an independent audit of claims on a periodic basis.

*Department Response: The State is actively exploring options for conducting claims analysis and auditing outside of the medical and pharmacy vendors as the resources do not currently exist to conduct such an extensive audit of the thousands of claims processed under the Program annually. The Department would note that the list of duplicate claims in the table on page 15, and the subsequent comments, does not account for current processes including the reprocessing of medical claims in order to recoup payments. The Department would also note that claims may be billed for the same day by the same provider and for the same amount due to different doctors or nurses, as well as negotiated rates with the medical or pharmacy provider. This is reflected in some of the notes within the referenced table.*

**3. Concerns over Rebates & Performance Guarantees Received**

As noted in the “Background Information” section herein, the State has engaged UHC to provide administrative support services for the State’s Employee Health Care Benefit Plans. That service contract between the State and UHC (signed March 6, 2020) contains provisions pertaining to rebates and performance guarantees. Specifically, the “Glossary of Terms,” which is found in Addendum 1 of that agreement, defines “rebates” as follows:

*Any discount, rebate administration fee, price concession or other direct or indirect remuneration UnitedHealthcare receives from a drug manufacturer under a rebate agreement that is contingent upon and related directly to Participant use of a prescription drug under the Plan’s pharmacy benefit or the medical benefit during the Term. Rebate does not include any discount, price concession or other direct or indirect remuneration UnitedHealthcare receives from a drug manufacturer for direct purchase of a prescription drug.*

Additionally, “performance guarantee” is defined as follows:

*Commitment of a level of performance that must be delivered and continue to be delivered up to or above certain guarantee target.*

**Rebates**

The Department received more than \$30 million in rebates from UHC during fiscal year 2025, as shown in the following table:

<b>Time Period of Rebates Received</b>	<b>Date</b>	<b>Amount</b>
Quarter Ended June 30, 2024	7/15/2024	\$ 6,147,269
Quarter Ended September 30, 2024	10/15/2024	\$ 8,028,717
Quarter Ended December 31, 2024	1/27/2025	\$ 7,961,934
Quarter Ended March 31, 2025	4/21/2025	\$ 8,462,806
<b>Total Rebates</b>		<b>\$ 30,600,727</b>

Addendum 2 of the agreement, Section 4.6 (“Medical Benefit Drug Rebate Payments”), contains the following:

*From time to time, we or a subcontractor may negotiate with drug manufacturers regarding the payment of medical benefit Rebates on applicable prescription drug products dispensed to Participants under the Plan’s medical benefit. You will receive 80% of the medical benefit Rebates we receive.*

Section 4.8 (“Pharmacy Benefit Rebates”) addresses other rebates, as follows:

*We will negotiate with drug manufacturers for the payment of Rebates. The amount of Rebates that is available depends on many factors including whether you have an incentive benefit design, arrangements with drug manufacturers, the volume of prescription drug claims and the structure of the PDL [Prescription Drug List]. We*

will pay you an amount equal to 100% of the Rebates we receive (and we may pay interest on this amount as described in this Section). You agree that all payments associated with Rebates and any related interest are not due and owing to You until We actually pay them to You pursuant to this Agreement.

The following is an excerpt from a quarterly report that UHC submitted to the Department to support the rebates obtained and the accrued interest thereon remitted to the State:

UnitedHealthcare Rebate Payment Summary Report							
Policy Number 0744240							
Payment Year - Month	Payment Type	2021 And Prior	2022 Q1	2022 Q2	2022 Q3	2022 Q4	
2024-10	Pharmacy Rebates	3,099.42	(12,015.37)	0.18	(2.51)	(1,664.14)	
	Medical Rebates	7.94	(60.64)	52.37	5,497.98	13.10	
	Interest	344.53	(1,199.36)	0.60	272.52	(127.47)	
2024-10 Total		3,451.89	(13,275.37)	53.15	5,767.99	(1,778.51)	
2023 Q1	2023 Q2	2023 Q3	2023 Q4	2024 Q1	2024 Q2	2024 Q3	Grand Total
1,845.24	(23,506.38)	(14,260.27)	32,487.44	3,797,057.86	3,862,244.52	.	7,645,285.99
14,523.09	48,889.82	134,163.88	70,045.71	23,834.99	.	.	296,968.24
589.29	218.27	1,960.66	2,925.79	50,394.71	31,083.49	.	86,463.03
16,957.62	25,601.71	121,864.27	105,458.94	3,871,287.56	3,893,328.01	.	8,028,717.26

The image below is a portion of a “Rebate Statement” received from UHC for October 2024. The total reflected in the statement agreed to the \$8,028,717.26 total shown in the quarterly report above.

Invoice Number	Policy Number	Suffix	Invoice Date	Invoice Amount	Description
074424099428401	0744240	99	2024-10-10	129,188.64	COLLECTED PHARMACY REBATES. 100.00 % REBATES, GUAR \$/CLAIM PROC FOR SCRIPTS FILLED DURING THE PERIOD ENDED 06/2024
074424099428401	0744240	99	2024-10-10	490.93	INTEREST ON REBATES FOR SCRIPTS FILLED DURING THE PERIOD ENDED 06/2024
074424099428401	0744240	99	2024-10-10	1,724,404.38	COLLECTED PHARMACY REBATES. 100.00 % REBATES, GUAR \$/CLAIM PROC FOR SCRIPTS FILLED DURING THE PERIOD ENDED 05/2024
074424099428401	0744240	99	2024-10-10	10,735.04	INTEREST ON REBATES FOR SCRIPTS FILLED DURING THE PERIOD ENDED 05/2024
074424099428401	0744240	99	2024-10-10	2,008,651.50	COLLECTED PHARMACY REBATES. 100.00 % REBATES, GUAR \$/CLAIM PROC FOR SCRIPTS FILLED DURING THE PERIOD ENDED 04/2024
074424099428401	0744240	99	2024-10-10	19,857.52	INTEREST ON REBATES FOR SCRIPTS FILLED DURING THE PERIOD ENDED 04/2024
074424099428401	0744240	99	2024-10-10	2,098,645.18	COLLECTED PHARMACY REBATES. 100.00 % REBATES, GUAR \$/CLAIM PROC FOR SCRIPTS FILLED DURING THE PERIOD ENDED 03/2024
074424099428401	0744240	99	2024-10-10	8,057.71	RX REBATES, MEDICAL BENEFIT. 80.00 % REBATES COLLECTED FOR SCRIPTS FILLED DURING THE PERIOD ENDED 03/2024
074424099428401	0744240	99	2024-10-10	28,588.50	INTEREST ON REBATES FOR SCRIPTS FILLED DURING THE PERIOD ENDED 03/2024

The two images above constitute the entirety of the support provided by UHC for the rebates received. Clearly, based on this information, the Department has virtually no way to verify whether rebate amounts remitted, much less the underlying interest calculations performed, are in accordance with the terms of the service agreement.

A proper system of internal control requires procedures to ensure that the Department obtains sufficient information to evaluate whether rebate amounts received under the UHC service agreement, as well as the underlying interest calculations performed, are correct. Without such procedures, there is an increased risk for loss of Program funds.

We recommend the Department implement procedures to ensure information provided by the administrative services provider is sufficient for the Department to ascertain whether rebates received, as well as the underlying interest calculations performed, are in accordance with the terms of the service agreement.

*Department Response: The Department agrees that more in-depth analysis of pharmacy claims is necessary to evaluate and audit rebate amounts. The State is actively exploring options for conducting claims analysis and auditing outside of the medical and pharmacy vendors as the resources do not currently exist to conduct such an extensive audit of the thousands of pharmacy claims processed under the Program annually. Information and documentation will be obtained from the pharmacy vendor in order to understand more clearly the procedure regarding pharmacy rebate calculations.*

**Performance Guarantees**

The Department received \$1,512,423 from UHC for performance guarantees during fiscal year 2025, as detailed in the following table:

Category	Amount
Performance Guarantee Payout	\$ 230,875
Discount Guarantee Payout	\$ 1,080,779
Rx Discounts, Dispensing Fee, Rebate, Specialty Payout	\$ 200,769
<b>Total</b>	<b>\$ 1,512,423</b>

Addendum 2 of the UHC service agreement, Exhibit B (“Performance Standards for Health Benefits”), contains 37 different service levels that are measured and compared to a target, including service levels related to claims processing, eligibility, network, member services, data transmittal, communications, website, reporting, satisfaction, and data and security. See **Attachment B** hereto for the full list of performance standards.

Similar to the unverified rebates from UHC, as discussed above, the Department lacked procedures for ensuring that the amounts received for performance guarantees were accurate and in accordance with the terms of the service agreement.

The three categories of performance guarantees displayed in the above table were reviewed by the APA, and our concerns therewith are set out below:

- **The Performance Guarantee Payout** of \$230,875 consisted of four of the service level standards listed in **Attachment B**. The following table shows details for service standard #12 – compliance with access standards – making up \$222,500 of that total:

#	Service Level	Measurement	Target	Frequency	Assessment	Penalty	Amount Remitted
12	Compliance with Access Standards	Contractor shall submit Geo Access reports demonstrating compliance with Provider access standards as defined in the Provider Network section of the RFP.	A minimum of 90% of plan members will have access to network providers as defined in the RFP. (Virtual Dermatologists and Endocrinologists are included for rural specialty categories as of 7,1,2023)	Measured and Assessed Quarterly	\$2,500 for each percentage below the standard.	Missed all 5 categories	\$ 222,500

Having obtained documentation to support the failure of the service standard, the APA found that the guarantee was to be measured and assessed quarterly; however, only one annual payment was made in fiscal year 2025.

The following data was obtained for the service penalty:

Area	Provider Type	Members with Access	Total Members	Actual	Goal	Difference	Penalty
Rural	Ambulatory Service Center	13,803	17,628	78.30%	90.00%	11.70%	\$ 27,500
Rural	Urgent Care	9,794	17,628	55.56%	90.00%	34.44%	\$ 85,000
Rural	Imaging	12,841	17,628	72.84%	90.00%	17.16%	\$ 42,500
Rural	Inpatient BH	14,136	17,628	80.19%	90.00%	9.81%	\$ 22,500
Rural	Allergy	12,527	17,628	71.06%	90.00%	18.94%	\$ 45,000
<b>Total</b>							<b>\$ 222,500</b>

- The Network Provider Discount Guarantee of \$1,080,779, contains guarantees for discounts in the provider network. The provision is shown in the following image from Addendum Two, Exhibit B (“Performance Standards for Health Benefits”), of the UHC service agreement:

**Effective for the periods: July 01, 2020 through June 30, 2027**

**Network Provider Discount Guarantee**

The State of Nebraska (the State) seeks the most favorable discounts from providers in the proposed provider network. It is also a requirement of the State, upon completion of each plan year, to have the selected network provide an analysis of actual discounted savings, which were realized over the course of the plan year, and use this analysis to compare the results to the expected discounts. The State shall receive fixed discounts throughout the initial contract period in addition to the optional periods. If further discounts are achieved, those discounts shall be passed on to the State. Discounts less than the fixed discounts in the initial contract shall not be allowed

Indicate the level of discounts that will be guaranteed from year to year over the contract term. For example, if inpatient facility discounts are 40% for 7/1/20 - 6/30/21 and it is guaranteed they will increase to 41% in 7/1/21 - 6/30/22, enter "40%" in the cell in the inpatient facility row under the 7/1/20 - 6/30/21 column and "41%" under the 7/1/21 - 6/30/22 column.

**D. Effective July 1, 2023, the performance standards set forth in Exhibit B of Addendum Two are amended to replace the tables for the period July 01, 2023 through June 30, 2024:**

Service Category	7/1/20-6/30/21	7/1/21-6/30/22	7/1/22-6/30/23	Optional Year 7/1/23-6/30/24	Optional Year 7/1/24-6/30/25	Optional Year 7/1/25-6/30/26	Optional Year 7/1/26-6/30/27
Guaranteed Overall Inpatient Facility Discounts	35.1%	35.8%	36.4%	40.0%	TBD	TBD	TBD
Guaranteed Overall Outpatient Facility Discounts	40.4%	40.9%	41.2%	44.9%	TBD	TBD	TBD
Guaranteed Overall Professional Discounts	44.0%	44.3%	44.6%	44.6%	TBD	TBD	TBD
Percentage of Administrative Fees at Risk for Inpatient Facility Discount Guarantees*	20.0%	20.0%	20.0%	20.0%	TBD	TBD	TBD
Percentage of Administrative Fees at Risk for Outpatient Facility Discount Guarantees*	20.0%	20.0%	20.0%	20.0%	TBD	TBD	TBD
Percentage of Administrative Fees at Risk for Professional Discount Guarantees*	20.0%	20.0%	20.0%	20.0%	TBD	TBD	TBD

The **Discount Guarantee Payout** required UHC to meet a 40% guaranteed discount on the amounts charged by providers for inpatient facility claims during fiscal year 2024. If this guarantee was not met, UHC would be required to pay back 20% of the administrative fees received from the State.

The image below shows the documentation provided by UHC to support the payment of this performance guarantee, including only a 39.5% discount from providers on inpatient facility claims during fiscal year 2024.

State of Nebraska # 744240				
July 1, 2023 to July 1, 2024				
In-Network Discount Guarantee				
Service Category	7/1/23- 6/30/24 Guaranteed	7/1/23- 6/30/24 Actual	Guarantee Met?	% Amount at risk
Guaranteed Overall Inpatient Facility	40.0%	39.5%	No	20.0%
Guaranteed Overall Outpatient Facility	44.9%	46.1%	Yes	20.0%
Guaranteed Overall Professional Discounts	44.6%	45.9%	Yes	20.0%
Additional Administrative Fees due UHC/(Customer)				\$1,080,779

This constitutes the entirety of the documentation provided to support the payment of this guarantee. The Department reviewed no underlying data to ensure the accuracy of information received.

- Finally, Addendum Two, Exhibit C (“Pharmacy Fees and Guarantees), of the UHC service agreement, guarantees certain payments related to pharmacy rates. This section is related to the \$200,769 guarantee payout shown at the top of this section. Included below is the specific provisions from the agreement:

**EXHIBIT C – PHARMACY FEES AND GUARANTEES**

The fees and guarantees as agreed to in contract 89546 O4 are for Pharmacy Services by Us. These fees and guarantees apply to pharmacy benefits effective for the period beginning July 1, 2020 through the initial period and any agreed to renewal periods (each twelve month period is a "Guarantee Period").

The pharmacy pricing and guarantees will become effective upon the effective date of this Contract.

Once agreed to by both parties, we will from time to time, upon written approval by you, replace any report or change the format of any report referenced in these guarantees. In such event, the guarantees may be modified by mutual written agreement of the parties as required to carry out the intent of the parties. We shall not be required to meet any of the guarantees provided for in this Agreement or amendments thereto to the extent our failure is due to your actions or inactions or if we fail to meet these standards due to Force Majeure as defined in Section II. O. of contract 89546 O4 or Our required compliance with any law, regulation, or governmental agency mandate.

At least 3 months prior to the end of the current guarantee Period, and provided that this Agreement remains in force, we may recommend to you in writing new guarantees, subject to your review and written approval, for the subsequent Guarantee Periods. If the new guarantees are approved by You, We will also provide you with a new Exhibit that will replace this Exhibit for that subsequent Guarantee Periods.

Pharmacy Financials						
Definition	Pharmacy rate guarantees.					
Measurement and Criteria		07/01/2020	7/1/2021	7/1/2022	7/1/2023	7/1/2024 to 6/30/27
		<b>Component Discount Guarantee</b>				
	Retail Brand, Average Wholesale Price (AWP) less	18.5%	18.6%	18.7%	18.9%	18.9%
	Retail Brand -- 90 Day Supply, AWP less	22.4%	22.6%	22.7%	22.8%	22.9%
	Retail Generic - 30 and 90 Day Supply, AWP less	84.0%	84.2%	84.2%	84.2%	84.2%
	Mail Order Brand, AWP less	24.0%	24.0%	24.0%	24.0%	24.0%
	Mail Order Generic, AWP less	85.0%	85.2%	85.2%	85.2%	85.2%
The Guaranteed Discount amount will be determined by multiplying the AWP by the guaranteed discount off AWP by each component.						

Dispensing Fee Guarantee					
Retail Brand - 30 Day	\$0.52	\$0.47	\$0.42	\$0.37	\$0.34
Retail Brand - 90 Day Supply	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Retail Generic - 30 Day	\$0.52	\$0.47	\$0.42	\$0.37	\$0.34
Retail Generic - 90 Day Supply	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Dispensing fee totals are calculated by multiplying the actual scripts for each type by the contracted rate for that script type.					
Minimum Rebate Guarantee (Advantage PDL)					
Rebate Sharing Percentage	100.0%	100.0%	100.0%	100.0%	100.0%
Basis, per script	Brand	Brand	Brand	Brand	Brand
Retail - 30 Day	\$162.00	\$172.00	\$189.00	\$195.00	\$203.00
Retail - 90 Day Supply	\$377.00	\$400.00	\$431.00	\$450.00	\$468.00
Mail Order	\$432.00	\$460.00	\$473.00	\$491.00	\$520.00
Specialty	\$2,152.00	\$2,373.00	\$2,414.00	\$2,454.00	\$2,570.00
Fees					
Pharmacy Administration Fee (PEPM)	\$1.68	\$1.68	\$1.68	\$1.69	7/1/24 \$1.71, 7/1/25 \$1.72, 7/1/26 \$1.74

This guarantee pertains to the “pharmacy rate” and the “dispensing fee” guarantees highlighted above. The documentation provided by the Department to support those amounts is shown in the image below:

UHC Pharmacy Guarantee Reconciliation						
Discount % off AWP and Dispensing Fee per RX Summary						
Client:	STATE OF NEBRASKA					
Policy Number:	0744240					
Policy Period:	7/1/2023 through			6/30/2024		
Discount Guarantee:	Component					
Specialty Guarantee:	Aggregate Specialty					
Brand	Channel	Guaranteed Rates		Actual vs. Guaranteed		
		Disc %	DF/RX	Discounts	Disp. Fee	Total
Brand	Mail order	24.0%	\$0.00	Achieved		\$0
Brand	Retail	18.9%	\$0.37	Not Achieved	Not Achieved	(\$19,582)
Brand	Retail 90	22.8%	\$0.00	Not Achieved	Not Achieved	(\$44,535)
Generic	Mail order	85.2%	\$0.00	Achieved		\$0
Generic	Retail	84.2%	\$0.37	Not Achieved	Not Achieved	(\$130,584)
Generic	Retail 90	84.2%	\$0.00	NA	Not Achieved	(\$6,068)
Specialty	Aggregate Specialty	20%	NA	Achieved	NA	
<b>Amount Due Client</b>						<b>\$200,769</b>

For each drug type (brand or generic) and channel (mail order, retail, retail 90) shown above, two guarantees are calculated – the “discount guarantee” and the “dispensing guarantee.” For the “discount guarantee,” the contract promises a certain percentage discount on the types of prescriptions obtained through various channels. The “discount guarantee” is calculated by subtracting the guaranteed discount from the average wholesale price. If the discount is not achieved, the contractor owes the State an amount per prescription included in the images above.

The “dispensing fee” relates only to the retail channel, which guarantees a certain amount for dispensing fees on each prescription filled.

The reconciliation in support of the amounts remitted to the Department shows only whether the discounts were given and a total due to the client. Failing to obtain any other documentation to verify that the correct amount was received under the terms of the service agreement, the Department relies solely on the minimal information contained in the contractor’s reconciliation.

A proper system of internal control requires procedures to ensure adequate documentation is obtained to support the accuracy and completeness of all performance guarantees received under the UHC contract. Without such procedures, there is an increased risk of the State not receiving the stipulated amounts.

We recommend the Department implement procedures to ensure adequate documentation is obtained to support the performance guarantees received, including the underlying data for those amounts and the calculations thereof.

*Department Response: The Department will be gathering additional documentation and data regarding performance guarantee metrics, and ensuring contractual provisions are met, in coordination with our partners. It should be noted that the Department currently engages the medical and pharmacy vendors in conversations regarding these materials and works with our actuaries to evaluate the data and performance metrics. While some areas of review may be measured and assessed quarterly, payments are made annually.*

**4. Other Administrative Expenses and Internal Control Issues**

For fiscal year 2025, the following administrative expenses were paid from the health insurance funds:

<b>EXPENDITURES:</b>	<b>AMOUNT</b>
Administrative Fees	\$ 5,890,158
Personal Services	\$ 493,546
Actuarial Services	\$ 349,038
Miscellaneous Operating	\$ 220,348
Travel	\$ 1,335
<b>TOTAL EXPENDITURES</b>	<b>\$ 6,954,425</b>

The APA identified the following issues related to these administrative expenses:

<b>Financial Statement Area</b>	<b>Description of Issue</b>
Personal Services	<p>The payroll expenses for the employees of the Department’s State Personnel Division – Wellness and Benefits – are charged to the health insurance program. Wellness and Benefits has five full-time employees and a director. The five full-time employees had 100% of their payroll costs charged to the Program, while the Wellness and Benefits Director and the State Personnel Director had a portion of their payroll costs charged to the program. The Department lacked documentation to support the allocation of payroll costs for the two employees.</p> <ul style="list-style-type: none"> <li>• The Department initially charged 80% of the Wellness and Benefits director’s payroll costs, totaling \$82,124, to the Program. The Department provided no documentation showing that the director spent 80% of her time on activities related to the Program. At the end of the fiscal year, the Department reduced the payroll charges to the Program to \$51,423, or 50% of the director’s pay. There was also no documentation to support this reduced amount.</li> <li>• The Department charged 10% of the State Personnel director’s payroll costs, to the Program, totaling \$11,740. The Department provided no documentation showing the State Personnel director spent 10% of his time on activities related to the Program.</li> </ul>
UHC Administrative Fees	<p>The Department paid \$5,693,790 in administrative fees during fiscal year 2025, which are charged monthly based on the number of active State employees enrolled in the Program. The Department’s procedures for monitoring these fees were inadequate. The Department compared the names on the monthly invoices from UHC to the employees listing from the HR system and randomly selected 100 employees to review. In our review of the May 2025 invoice, the APA identified 357 individuals who were included on the UHC invoice but were not on the Department’s employee listing. The Department failed to review any of these discrepancies for May 2025 because its random sample did not include any of the individuals identified by our review. The APA determined that 172 of the 357 individuals were likely early retirees or COBRA participants, who would not be on the Department’s employee listing. This left 185 individuals who were billed by UHC but were not listed as active employees, early retirees, or COBRA participants. In the APA’s review, we determined that some of the remaining individuals could be the result of the name on the UHC file not matching exactly the name on the employee listing, but the Department failed to review the remaining individuals.</p>
Actuarial Services	<p>The Department paid over \$349,000 in actuarial services under a contract with The Segal Company (Southeast) d/b/a Segal to provide consulting services. Among the several actuarial services required under the agreement, Segal was required to “[h]elp the State prepare a Value on Investment (VOI or ROI) for the State’s wellness program each year.” However, neither the actuary nor the Department seemed to be aware of this provision in the contract, and no such report was prepared.</p>

In fiscal year 2025, the Department also collected \$1,805,577 in premium contributions from its early retiree and COBRA participants through ASI Flex, which administered that portion of the Program. The APA noted the following issue:

Financial Statement Area	Description of Issue
COBRA and Retiree Contributions	ASI Flex collects the premiums for these participants and remits them to the Department. The vendor includes with its remittance a list of individuals who paid the premiums for insurance coverage. The Department lacked procedures to ensure that the list was complete and accurate. Had the Department compared the individuals on this list to the claims paid file and also compared the active employees' premiums paid to the claims file, it would have likely identified the ineligible participant #2 addressed on page 15 herein.

Finally, as shown on page 2 herein, a \$91,306 liability was recorded in the Health Insurance History Fund. We noted the following:

Financial Statement Area	Description of Issue
Due To Fund	In 2012, when UHC became the administrator of the plans, two Blue Cross Blue Shield funds were closed. The Department moved the Due to Funds from the closed funds to the Health History Fund. No other activity had been recorded in the liability account since that time. The Department should review this activity to determine the proper disposition of the funds.

A proper system of internal control requires procedures to ensure the following: 1) adequate documentation is on file to support the expenses charged to the Program; 2) adequate reviews of revenues and expenses are performed prior to payment; 3) contracts are monitored to verify compliance with all contractual provisions; and 4) liabilities accounts are reviewed to ensure the proper disposition of those funds.

Without such procedures, there is an increased risk for inappropriate expenses, insufficient premium payments, non-receipt of items paid for under the contract, and misuse of funds allocated to the Program.

We recommend the Department implement procedures to ensure that adequate supporting documentation is obtained for expenses charged to the Program, and adequate reviews of revenues and expenses are performed prior to payment. Additionally, contracts should be monitored for compliance with all provisions therein, and liability accounts should be reviewed to ensure the proper disposition of those funds.

*Department Response: The Department regularly reviews data with our vendors, including our actuaries. This includes annual reporting and review covering topics such as general VOI or ROI, including on specific aspects of plan design and programming. The Department is implementing changes to its processes, including with partners such as ASI COBRA, to more accurately identify active enrollees within the Program and verify eligible members. It should be noted that for the purposes of UHC Administrative Fees, the State is credited for active member adjustments as those occur retroactively. The Department was not consulted regarding time spent by the Wellness & Benefits Director or the State Personnel Director in managing the Program but will continue to make appropriate budget allocations and charges in accordance with proper procedures.*

\* \* \* \* \*

Our procedures are designed primarily on a test basis and, therefore, may not bring to light all weaknesses in policies or procedures that may exist. Our objective is, however, to use the knowledge gained during our work to make comments and recommendations that we hope will be useful to the Department.

Draft copies of this letter were furnished to the Department to provide its management with an opportunity to review and to respond to the comments and recommendations contained herein. Any formal response received has been incorporated into this letter. Such response has been objectively evaluated and recognized, as appropriate, in the letter. A response that indicates corrective action has been taken was not verified at this time.

This communication is intended solely for the information and use of the Department and its management. It is not intended to be, and should not be, used by anyone other than these specified parties. However, this communication is a matter of public record, and its distribution is not limited.

If you have any questions regarding the above information, please contact our office.

Audit Staff Working on this Examination:

Cindy Janssen – Audit Manager

Nick Fleming, CPA – Auditor-In-Charge

Nathan Tomjack – Auditor-In-Charge

Sincerely,



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## Health Plan Employer Premiums Memo

June 13, 2025

Department of Administrative Services – Director's Office

## From the Director's Desk

NEBRASKA  
Good Life. Great Mission.

Colleagues,

The State's medical and pharmacy plans have long been a strong point in our offerings as an employer, and the State has done all that it can in the last several years to make it as rich as possible. However, market cost trends and member claims have led the State to the point where change is necessary. A few points to outline some history:

- The fund balance grew beyond the target because of multiple below market claims trend years. The COVID lockdowns further increased the fund balance up to \$90M as of 6/30/2021.
- There was a concerted effort to reduce the fund balance through plan design enhancements, low (or no) premium increases, premium holidays, one-time wellness payments to members, etc. These strategies were effectively passing the surplus back to plan members and employer agencies
- Medical and pharmacy claims began running at or above market trends in this last biennium, accelerating and compounding the depletion of the fund
- These recognized trends were evaluated, and the decision was made to maintain low premiums for our public servants and agency budgets for that period. Unfortunately, those trends have continued and placed the plan in a position without the flexibility to meet the demands being placed upon it

Managing future costs will be key in returning the fund to a healthy state, and the State is taking steps to do so including bidding the medical and pharmacy contracts to push greater accountability with our medical and pharmacy vendor managers, evaluating plan changes and premium increases, and requiring greater involvement of members in the management of their health. The current contract has not been competitively bid in over 7 years.

The continued above market trajectory in usage and claims costs necessitate additional funding outside of the current funding rates to maintain the health of the plan as these changes are implemented. We will be collecting additional funds from agencies to assist in this endeavor. Members will not be required to pay more than what has been outlined previously. **Agencies will be contributing an additional 18.5% to premiums for a total of 81.7% of the total premium costs to support the plan.** The breakdown of this contribution by plan is outlined at the end of this document.

We appreciate your assistance in getting our plan back in good standing for our public servants. Updates will be provided routinely to keep you up to date with the fiscal health of the plan.

Health Plan Employer Premiums Memo

June 13, 2025

Regards,

Lee Will



Director, Nebraska Department of Administrative Services

State of Nebraska				
PY 2026 Rate Surcharge Levels				
With 18.5% Surcharge				
Regular				
EE	ER	Total	ER Cost Share	
\$ 196.51	\$ 876.30	\$ 1,072.81	81.7%	
\$ 520.75	\$ 2,322.17	\$ 2,842.92	81.7%	
\$ 402.85	\$ 1,796.42	\$ 2,199.26	81.7%	
\$ 697.61	\$ 3,110.84	\$ 3,808.45	81.7%	
Wellness				
EE	ER	Total	ER Cost Share	
\$ 167.22	\$ 745.66	\$ 912.88	81.7%	
\$ 443.13	\$ 1,976.03	\$ 2,419.16	81.7%	
\$ 342.79	\$ 1,528.62	\$ 1,871.41	81.7%	
\$ 593.61	\$ 2,647.10	\$ 3,240.72	81.7%	
Consumer Focus				
EE	ER	Total	ER Cost Share	
\$ 111.13	\$ 495.58	\$ 606.71	81.7%	
\$ 294.51	\$ 1,313.29	\$ 1,607.80	81.7%	
\$ 227.83	\$ 1,015.96	\$ 1,243.79	81.7%	
\$ 394.53	\$ 1,759.33	\$ 2,153.86	81.7%	

**Exhibit B – Performance Standards for Health Benefits**

Effective July 1, 2020, through June 30, 2027

**EXHIBIT B – PERFORMANCE STANDARDS FOR HEALTH BENEFITS**

Effective for the periods: July 01, 2020 through June 30, 2027.

The State of Nebraska (the State) and the Contractor agree the standards and guarantees/penalties outlined below are at risk each year for the duration of the Contract based on actual performance. The following describes the minimum performance guarantees that are included with the Contract between the State and the Contractor. The Contractor shall self-report results and the State shall utilize their decision support vendor and other partners and internal staff to validate reported baseline and results for these outcomes. Contractor agrees to the State's right to independently audit and confirm all results. **All measurements and standards are specific to the State's services, and not to be based on Contractor's performance for their book of business, or any other group that includes non-State members.**

	Service Level	Measurement	Service Level Target	Frequency of Measurement and Assessment	Assessments
1	All services outlined in the RFP shall take effect/ go live and be fully operational on the initial go live date(s) as specified in the Contract. (excluding ID cards)	Measured and reported no later than one month after the go live date. Per the RFP, the standards for measurement shall include, but not be limited to: i. Adherence to implementation timeline ii. Readiness of claims and customer service systems iii. Readiness of eligibility system iv. Completion of plan documents	100% of services outlined in the RFP will take effect and be fully operational on the go live date(s) as specified in the Contract. There shall be no systems errors. The State Wellness and Benefits team along with IT Support shall have online access to all tools no less than 30 days prior to the effective date.		\$20,000 for the first day and \$2,000 for each subsequent calendar day the deadline that the administrative services are not fully operational.

2	All services outlined in the RFP shall take effect/ go live and be fully operational on the annual go live date for each plan year. (excluding ID cards)	Measured and reported no later than one month after the go live date. Per the RFP, the standards for measurement shall include, but not be limited to: i. Adherence to annual enrollment timeline ii. Readiness of claims and customer service systems iii. Readiness of eligibility system iv. Completion of plan documents  The response level must be maintained each month.	100% of services outlined in the RFP will take effect and be fully operational on the go live date(s) as specified in the Contract. There shall be no systems errors. The State Wellness and Benefits team along with IT Support shall have online access to all tools no less than 30 days prior to the effective date.	Annually	\$10,000 for the first day and \$1,000 for each subsequent calendar day the deadline that the administrative services are not fully operational.
<b>Claims Processing</b>					
3	Claims Processing (self-funded medical plan for non-Medicare members): Turnaround Time (TAT)	TAT will be calculated using all claims received each month, including any that need review, and results will be based on aggregate statistics for the applicable period. Contractor will submit Claims Time to Process and Claims Inventory reports monthly.	95% of clean claims will be paid or denied within 12 Business days	Measured Monthly and Assessed Quarterly	\$1,250 for each percentage below the standard for all claims
4	Claims Processing (self-funded medical plan for non-Medicare members): Turnaround Time (TAT)	TAT will be calculated using all claims received each month, including any that need review, and results will be based on aggregate statistics for the applicable period. Contractor will submit Claims Time to	99% of all claims shall be paid or denied within 30 calendar days of receipt (excluding claims subject to appeal or medical review).	Measured Monthly and Assessed Quarterly	\$1,250 for each percentage below the standard for all clean claims

**Exhibit B – Performance Standards for Health Benefits**

Effective July 1, 2020, through June 30, 2027

		Process and Claims Inventory reports monthly. A clean claim is defined as original submission with all requested information.			
5	Financial accuracy of claims processed	To determine the financial accuracy rate, the total payment amount reviewed minus the absolute value of overpayments and underpayments is divided by the total amount reviewed.	99.2% or greater at the office level	Measured Quarterly and Assessed Quarterly	\$2,500 for each tenth of a percentage below the standard.
6	Mail Service Non-Financial Accuracy	Contractor will accurately and correctly dispense prescriptions at mail service pharmacies. Retail Paper Claim Processing 98% of clean claims requiring no intervention processed within an annual average of 5 business days. 99.9% of clean claims requiring no intervention processed within an annual average of 10 business days. Mail Order Average Dispensing Time 95% in an average of 2 days for clean prescription orders or prescription orders requiring no intervention. 90% in an average of 4 days for prescription orders requiring intervention - measured annually.	The mail service pharmacy shall guarantee dispensing accuracy of at least 99.995% (correct participant name, correct participant address, correct drug, correct dosage form, and correct strength)	Reported Quarterly and Assessed Annually  Book-of-business measurement	\$2,500 for each tenth of a percentage below the standard. Penalties based on annual aggregate results.

7	On-line availability of Contractor's claims adjudication and related system platforms	Downtime is any time a Contractor's system (adjudication or related system such as eligibility, etc.) is unavailable for any reason other than scheduled maintenance downtime for which the State has received prior notice in accordance with the terms of this Contract. Contractor will provide quarterly reports to the State for review.	System available at least 99.5% of the time, excluding scheduled maintenance downtime.	Measured Quarterly and Assessed Quarterly	\$2,500 for each tenth of a percentage below the standard.
8	Overall system downtime (for the State view only access)	Downtime is any time a Contractor's system (adjudication or related system such as eligibility, etc.) is unavailable for any reason other than scheduled maintenance downtime for which the State has received prior notice in accordance with the terms of this contract. Contractor will provide quarterly reports to the State for review.	The State will have access to Contractor's system (view only access to claims processing, eligibility, etc. - as stipulated in the RFP and your response) at least 99.5% of the time, except for scheduled maintenance.	Measured Quarterly and Assessed Quarterly	\$2,500 for each tenth of a percentage below the standard.
<b>Eligibility</b>					
9	Eligibility Loads (Initial and Open Enrollment)	Initial and Open Enrollment clean eligibility files will be loaded within 3 business days of receipt.	Loaded accurately, in use, and notification transmitted to the State following 3 business days of receipt.	Ongoing/per occurrence	\$5,000 for each business day that the standard is not met.
10	Eligibility updates (weekly)	Weekly clean eligibility files will be loaded in the same business day the State or its data partner transmits the data.	Loaded accurately, in use, and notification transmitted to the State in the same business day the data was transmitted.	Reported Monthly and Assessed Quarterly	\$1,000 for each business day that the standard is not met.

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11	ID Cards	99% of Members ID cards are mailed within ten (10) business days after final open enrollment eligibility is received, system loaded, and passes a quality assurance check. 99% of replacement ID cards must be mailed within three (3) business days of notification.	Mailing of open enrollment ID Cards: 99% of cards mailed within 10 business days AFTER final eligibility is received, system loaded, and passes a quality assurance check. Mailing of maintenance ID Cards: 98% of cards mailed within 10 business days after eligibility data has been received, system loaded, passed a quality assurance check, passed a system load test, and has been released to the ID card production area.	Measured Daily and Assessed Quarterly	\$5,000 for each business day that the standard is not met.
<b>Network</b>					
12	Compliance with Access Standards	Contractor shall submit Geo Access reports demonstrating compliance with Provider access standards as defined in the Provider Network section of the RFP.	A minimum of 90% of plan members will have access to network providers as defined in the RFP.	Measured and Assessed Quarterly	\$2,500 for each percentage below the standard.
13	Provider Turnover	Contractor will monitor turnover rates and provide notice to State staff and members of all Provider Turnover within 30 days of termination. Notice includes complete terminations of providers from the network as well as notice of providers ceasing to offer services at a specific location but remaining in the network and practicing at other locations	100% of Provider Turnover reported to State staff and members within 30 days of termination.	Reported Quarterly, Assessed Annually	\$2,500 for each percentage below the standard.

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14	Retail Network Access	To ensure that State members have sufficient access to a stable pharmacy network of providers, Contractor shall submit Geo Access reports demonstrating compliance with pharmacy network provider access standards as defined in the RFP.	Less than 5% of retail network pharmacies will leave the network quoted in the RFP.	Measured Quarterly and Assessed Annually	\$2,500 for each percentage below the standard.
<b>Member Service</b>					
15	Average Speed of Answer (ASA)	Average Speed to Answer of 30 seconds or less on average at team level effective. Average Speed to Answer is defined as the average time in seconds it takes a CSR to answer the Call. It is measured from the time the Call arrives to the time it is answered.	97% within 30 seconds for member calls selecting a live Member Service Representative (MSR). This excludes calls abandoned before answering.	Report and measure Monthly and Assessed Quarterly	\$1,500 for each percentage point below the threshold
16	Telephone Abandonment Rate	The response level must be maintained each month. The abandonment rate will be measured at the team level by Contractor's standard internal call reports produced by Contractor's automated phone system for all member calls. These reports shall be submitted to the State monthly for monitoring purposes and summarized in quarterly reports. Abandonment Rate is measured as the number of	Average call abandonment rate will be equal to or less than 3%.	Measured Quarterly and Assessed Quarterly	\$2,500 for each percentage point below the threshold for a month.

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		calls offered where the caller hangs up before an agent can answer the phone			
17	First Call Resolution	The response level must be maintained each month. The rate of the number of calls that are resolved with one phone call to Member Services will be measured by the Contractor's internal reports which will be submitted to the State monthly for monitoring purposes.	85% First Call Resolution defined as no call from the member within 60 days for the same claim number (ICN) at policy level.	Report Monthly and Assessed Quarterly	\$2,500 for each percentage point below the threshold for a month.
18	Written Inquiries	Contractor must maintain the service level target each month.	Administrator will resolve 95% of all written inquiries within 15 business days of receipt of inquiry.	Measured Monthly and Assessed Annually	\$2,500 for each percentage point below the threshold for a month.
19	Timeliness of resolution for grievances, complaints and appeals	The response level must be maintained each month. All grievances, complaints and appeals will be addressed and resolved in a timely manner as reported by Contractor's standard reports submitted to the State on a monthly basis for monitoring purposes.	95% of grievances, complaints and appeals will be resolved within 30 calendar days per the Department of Labor (DOL) standard.	Reported and measured Monthly and Assessed Quarterly	\$1,800 for each percentage point below the threshold for a month.

20	Mail Turnaround – Prescriptions not requiring intervention	Contractor must maintain the service level target each month.	95% of prescriptions dispensed within average of 2 business days and 100% within average of 3 business days.	Reported Monthly and Assessed Annually	\$2,500 for each percentage point below the threshold for a month.
21	Mail Turnaround – Prescriptions requiring intervention	Contractor must maintain the service level target each month.	95% of prescriptions dispensed within average of 4 business days and 100% within average of 5 business days	Reported Monthly and Assessed Annually	\$2,500 for each percentage point below the threshold for a month.
22	Paper Claims Turnaround	Contractor must maintain the service level target each month.	98% of clean claims requiring no intervention processed within an annual average of 5 business days.  99.9% of clean claims requiring no intervention processed within an annual average of 10 business days.	Measured Monthly and Assessed Annually	\$2,500 for each percentage point below the threshold for a month.
23	Dispensing Accuracy Rate	Specialty pharmacy prescriptions dispensed with the correct drug and strength.	99.99%	Reported and measured Monthly and Assessed Quarterly	\$2,500 for each percentage point below the threshold for a month.

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24	Prior Authorization (PA) Request Turnaround Time	Contractor shall submit monthly reports of PA activity to the State and results will be based on PA request and appeals meeting the turnaround standards of time each month. Standard measured quarterly.	<p><b>Initial Determinations</b> At least 98 percent of initial determinations for Urgent prior authorizations will be made within 1 business day once all information required to the process the review is received. At least 98 percent of initial determinations for Standard prior authorizations will be made within 3 business days once all information required to process the review is received.</p> <p><b>Appeals:</b> At least 95 percent of redeterminations for urgent prior authorizations will be made within 3 business days once all information required to the process the review is received. At least 95 percent of redeterminations for standard prior authorizations will be made within 15 calendar days once all information required to the process the review is received.</p>	Measured Quarterly and Assessed Annually	\$2,500 for each percentage point below the threshold for a month.
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25	Generic Fill Rate	<p>Contractor will provide the State with a generic potential fill rate guaranteed level. Upon the State's acceptance of the Contractor's proposed Generic Fill Rate, the Contractor will achieve the generic fill rate target upon the State's approval of Contractor's proposed programs. Contractor will provide annual report. Standard measured annually.</p> <p>FORMULA: The number of generic Rx's divided by ALL Rx's [generic + Multiple Source Brand (MSB) + Single Source Brand (SSB)]*</p> <p>*This guarantee excludes compounds</p>	Annually the Contractor will improve the State's generic fill rate by a rate that is mutually agreed to by Contractor and the State.	Measured Annually and Assessed Annually	\$5,000 for each percentage point below the threshold for a month.
<b>Data Transmittal</b>					
26	Transmittal of Claims and Other Data	Contractor must provide transmittal of claims and other relevant data to any third parties as identified by the State. This standard shall be reported to the State monthly and measured in concurrence with the data feed frequencies.	Contractor will provide accurate data feeds within mutually agreed to time frame(s) to be determined after assessing the needs of the State and its vendors.	Reported Monthly and Assessed Quarterly	\$5,000 for each occurrence in which an agreed upon time frame is not met.

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27	Contractor will provide access to data required to properly process claims in coordination with the HSA and any relevant benefit components.	Contractor will provide access to data required to properly process claims in coordination with the HSA and any relevant benefit components. HSA information includes the daily exchange of both medical and pharmacy related claims data from the Administrator to the HSA vendor	This standard shall be reported to the State monthly and measured daily, subject to an annual review/audit by the State, or an agent selected by the State.	Reported monthly and Assessed Quarterly	\$1,000 for each occurrence in which access to data is not provided per the mutually agreed upon time frame.
<b>Communications</b>					
28	Approval of Communications	Correspondence and information (whether written, electronic, telephonic, or in any other medium or form) developed by the Contractor and intended for Members, (e.g., open enrollment materials, network changes) must be reviewed and approved by the State prior to dissemination. This standard will be measured quarterly if any communications materials were developed during the previous quarter.	Contractor will submit correspondence and information to the State for review and approval prior to dissemination.	Measured and Assessed Quarterly	\$5,000 for each occurrence any communication is disseminated without review and prior approval.

<b>Website</b>					
29	The Contractor's website for the State members will offer online, real-time access, except for scheduled maintenance.	This standard shall be reported to the State monthly and measured monthly.	Contractor website for the State members available and fully operational 98.5% of the time, except for scheduled maintenance.	Reported and measured monthly and paid quarterly	\$3,000 for each percentage point below the threshold for a month.
<b>Reporting</b>					
30	Create and deliver Standard Management Reports for medical and pharmacy benefits reporting as described in the RFP	Contractor must provide Standard Management Reports for medical and pharmacy benefits reporting as described in the RFP by the specified timeframes.	98% of standard reports will be delivered to the State within 3 business days of the request and/or no later than 30 days following the end of the reporting period (i.e., quarterly, monthly, annually). Annual year-end reconciliation will be provided within 120 days of the end of the contract period	Measured by the specified report receivable timeframe and Assessed Annually	\$5,000 per day for each business day that the standard is not met.
31	Accuracy of Standard Medical Reports	Contractor must provide accurate Standard Medical Reports as described in the RFP.	All standard medical reports provided will be 100% accurate. 100% accurate will be based on the reporting methodology in place at the time the data was reported.	Measured by the specified report receivable timeframe and Assessed Annually	\$5,000 per day for each business day that the standard is not met.
32	Ad-hoc Reports	Contractor must provide requested ad-hoc reports by the specified timeframe.	90% of Ad-hoc reports will be delivered to State within 7 business days of the request. Ad-hoc reports are defined as reports that are not part of the vendor's standard reporting package	Measured by the specified report receivable timeframe and Assessed Annually	\$5,000 per day for each business day that the standard is not met.

**Exhibit B – Performance Standards for Health Benefits**

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33	Online Reporting Data Availability	Contractor must provide real-time access to online reporting data.	Online reporting data will be available within an annual average of fifteen (15) business days after the billing cycle that contains the last day of the month. Certain data may not be available real-time	Measured Quarterly and Assessed Annually	\$2,500 per day for each business day that the standard is not met.
<b>Satisfaction</b>					
34	Client Satisfaction	Based on the response to the question, "Overall, how satisfied are you with UnitedHealthcare?" If the response is a score of 5-10 on the 0-10 scale where 0 means very dissatisfied and 10 means very satisfied, the guarantee has been met.	90% or better satisfaction rate	Measured Annually and Assessed Annually	\$5,000 for each percentage point below the threshold
35	Member Satisfaction	State specific United Experience Survey (UES) member post service call evaluations	90% or better satisfaction rate	Measured Quarterly and Assessed Annually	\$5,000 for each percentage point below the threshold
36	Contract Drafting Cooperation	Contractor will respond to recommended contract language changes within the appropriate timeframe.	Response to recommended contract language changes within 10 business days.	Measured bi-weekly until contract is signed and fully executed	\$1,000 per day for each business day that the standard is not met.
<b>Data and Security</b>					
37	SOC1 Report (type 2)	Contractor is required to submit Service Organization Control reports, as outlined in the RFP, based upon service(s) performed on behalf of the State.	The required SOC 1 report will be delivered by the 5th business day of December by 12:00 PM CT.	Annually	\$5,000 per business day that each SOC report is late. \$10,000 for each report that is not delivered by the 10th business day of December.