

# Employees Group Insurance Department

## Comprehensive Annual Financial Report

Year Ended Dec. 31, 2015

Perpetual Motion Dance  
Oklahoma City, Oklahoma  
*Photograph courtesy of Perpetual Motion Dance*





**Office of Management and Enterprise Services  
Employees Group Insurance Department**

*Comprehensive  
Annual  
Financial  
Report*

**Year Ended  
Dec. 31, 2015**

**Prepared by EGID Finance**



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# Introductory Section



The Wizard of Oz  
Lyric Theater  
Oklahoma City, Oklahoma  
*Photo courtesy of Lyric Theater*  
*Photograph by K. O. Rinearson*





**State of Oklahoma**  
Office of Management and Enterprise Services  
Employees Group Insurance Division

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Sept. 30, 2016

**To the citizens of the State of Oklahoma:**

The comprehensive annual financial report for the Office of Management and Enterprise Services Employees Group Insurance Department (EGID) for the fiscal year ended Dec. 31, 2015, is hereby submitted. Responsibility for both the accuracy of the data and the completeness and fairness of the presentation, including all disclosures, rests with the management of EGID. To the best of our knowledge and belief, the enclosed data are accurate in all material respects and are reported in a manner designed to present fairly the financial position and results of operations of EGID. All disclosures necessary to enable the reader to gain an understanding of EGID's financial activities have been included.

The comprehensive annual financial report is presented in three sections: introductory, financial and statistical. The introductory section includes this transmittal letter, EGID's executive organizational chart and a list of principal officials. The financial section includes the independent auditors' report, Management's Discussion and Analysis (MD&A) and the basic financial statements. The statistical section includes selected financial and demographic information presented on a multiyear basis.

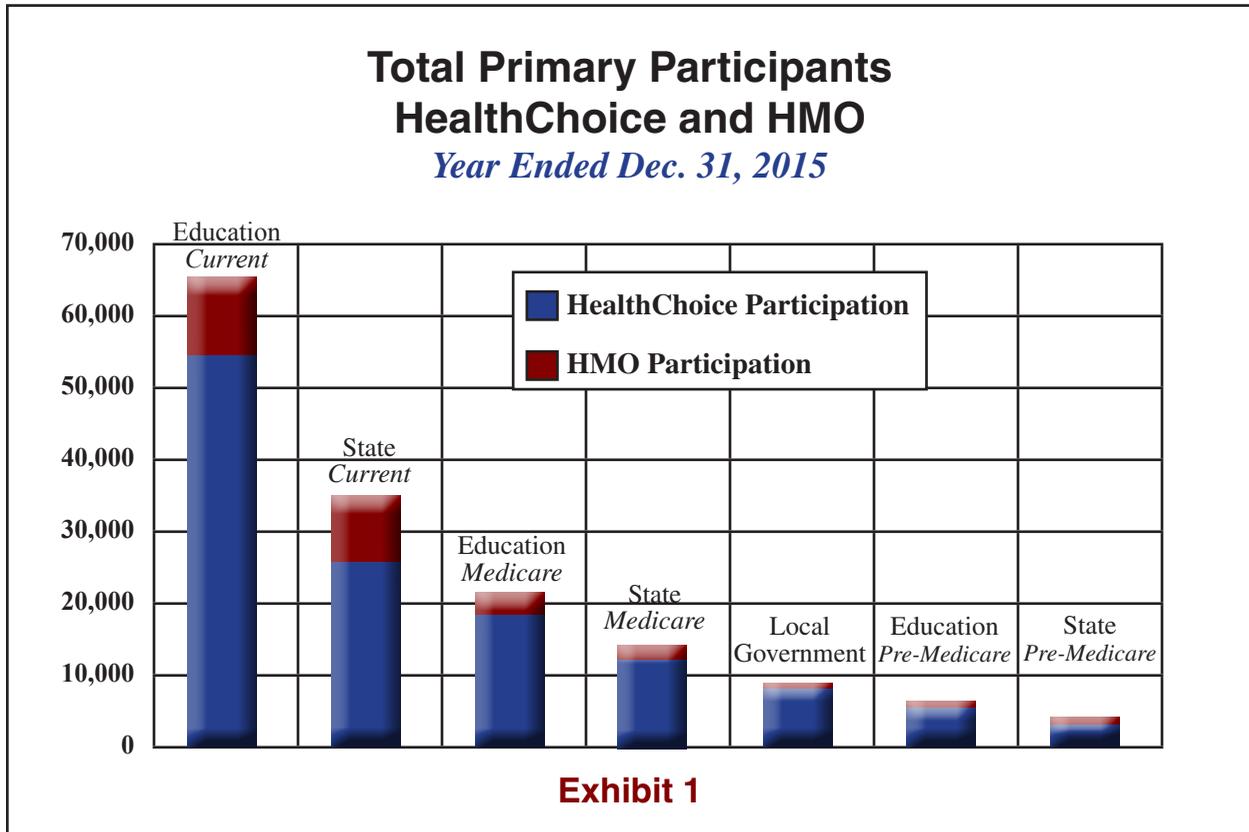
EGID is a special-purpose, government entity engaged solely in business-type activities. EGID is a legal trust which administers, manages and provides group health, dental, life and disability insurance for current and former employees of state agencies, school districts and other governmental units of the State of Oklahoma. EGID provides insurance solely to eligible current and former employees and their dependents. The Oklahoma Insurance and Benefits Board has oversight responsibility and decision-making authority to adopt policies regarding EGID financial matters.

It is EGID's mission to serve Oklahoma by providing, with the highest degree of efficiency, a wide range of quality insurance benefits that are competitively priced and uniquely designed to meet the needs of participants.

EGID provides a self-insured health, dental, life and disability program (HealthChoice) which is actuarially rated to provide premiums adequate to meet the payment of all claims, administrative expenses and any change in reserve estimates. EGID maintains reserves to provide for current claim liabilities as required. At the present time, EGID has not transferred any risk of loss through reinsurance contracts.

During the year ended Dec. 31, 2015, participants could choose between HealthChoice and four, federally qualified health maintenance organizations (HMO) during their initial enrollment. Each HMO requires participants to reside or work within a designated service area, which consists primarily of the Oklahoma City and Tulsa metropolitan areas, but have expanded to rural parts of Oklahoma as provider networks have been established. HealthChoice has no such restriction and is thus available to all eligible participants statewide and across the nation. After enrollment, members have the opportunity to change health carriers during an annual Option Period. Coverage elections can be changed during the year if the member experiences a change in family status event as defined by Internal Revenue Service Code Section 125.

The following chart illustrates total primary participation in coverage offered by HealthChoice and HMOs by type of entity as of Dec. 31, 2015.



Among the current primary members, approximately 19 percent were covered by the HMO plans at Dec. 31, 2015. For the Medicare and pre-Medicare populations, approximately 9 percent were covered by the HMO plans at Dec. 31, 2015.

Each year during the months of October and November, participants can change their coverage elections for the next year. All carrier changes and coverage elected during this period will be effective from Jan. 1 until Dec. 31 of the same year.

EGID, by statute, provides insurance coverage to all employees and dependents that meet eligibility requirements. An employee's coverage begins the first day of the month following the month of employment. The employee has 30 days after beginning employment to acquire health, dental and life insurance for his dependents. If the employee elects dependent coverage, the employee must cover all eligible dependents, unless the dependent is covered by other group

insurance. The employee also has 30 days after acquiring a new dependent to add that dependent to coverage. After this period, an employee may still add dependents during the aforementioned annual Option Period. Coverage could be delayed, however, if the dependent has been dropped in the past 12 months.

A current employee who leaves employment can add or retain certain insurance coverage depending on his status at the end of his employment. A former employee can also add or continue dependent coverage that was in effect while he was a current employee. Retired employees can continue all health, dental and life coverage. If the member has vested his retirement benefits but is not yet eligible to draw those benefits, he also retains the right to health, dental and life coverage. In the event an employee terminates employment or a dependent loses eligibility due to divorce or by exceeding age limitations, health and dental coverage can be continued if the member or his dependent meet the requirements set forth under the Consolidated Omnibus Budget Reconciliation Act (COBRA).

The following table illustrates the available coverage by participant group:

<b>Available Coverage by Participant Group</b>							
	<b>State Employees</b>	<b>Education Employees</b>	<b>Local Government Employees</b>	<b>OK Public Employees Retirement System</b>	<b>Teachers' Retirement System</b>	<b>Survivors</b>	<b>COBRA</b>
<b>Health</b>	✓	✓	✓	✓	✓	✓	✓
<b>Dental</b>	✓	✓	✓	✓	✓	✓	✓
<b>Life</b>	✓	✓	✓	✓	✓	✓	
<b>Disability</b>	✓		✓				
<b>Medicare Supplement</b>				✓	✓	✓	✓

## **ECONOMIC OUTLOOK**

The economic issues facing the state, its agencies and school districts, other participating groups, and their employees are a key consideration when EGID sets premium rates. The board and EGID administration are very aware that increases in premiums affect the already tight budgets of participating groups, as well as individual members. Alternatives to rate increases such as changes in copays or deductibles must be considered, especially when groups are facing budget cuts. EGID is faced with the daunting task of weighing the alternatives and making the difficult and sometimes unpopular decisions necessary to meet projected costs. EGID's goal is to keep premiums as low as possible and continue to provide quality and affordable health care to current and former employees of state, education and local government entities.

### **Health Care Trends**

The insurance industry monitors health care costs by establishing a percentage of cost increases known as "trend." The definition and factors affecting trend are discussed in Management's Discussion and Analysis.

According to the 2016 Segal Health Plan Cost Trend Survey, health benefit plan cost trend rates for 2016 are forecast to increase for most medical plan options and increase substantially for prescription drug coverage to double-digit rates. The survey goes on to say prescription drug price inflation is approaching double digits, more than 10 times the rate of overall consumer price index (CPI) for all goods and services. The survey states prescription drugs account for 20 to 25 percent of total health care spending for the average plan sponsor.

According to the 2016 Segal survey, projected trends for PPO plans for 2016 are:

- Medical and Prescription Drug (Current and Former < Age 65) 7.8 percent
- Medical and Prescription Drug (Former Ages 65+) 3.2 percent
- Dental (Indemnity Plans) 3.5 percent

Projected trends for 2016 for all categories above are higher than that projected for 2015.

EGID's actuaries used the following trends for setting rates for 2015:

- Medical (Current and Former < Age 65) 5.5 percent
- Medical (Former Ages 65+) 3.0 percent
- Prescription Drug 8.5 percent
- Dental 1.0 percent

The actual trends experienced by EGID for 2015 are discussed in Management's Discussion and Analysis.

According to the survey, health care cost trends continue to outpace wage increases and overall consumer price inflation for other goods and services. Efforts to bend the cost curve seem to be working to lower the utilization rates for medical treatments, but price inflation for treatment continues to be problematic. Segal is also optimistic that plan sponsors that engage in some types of cost containment strategies will continue to get high value from their medical benefit programs, while controlling plan cost increases in the future. As a result, substantial opportunities exist to avoid unnecessary costs and lower future trend rates.

## **Investment Outlook**

EGID's investment portfolio experienced a positive return in 2015 (+1.82 percent) and through Aug. 31, 2016 (+5.42 percent). The U.S. economy continues to improve with lower unemployment and rising wage growth, although the Federal Reserve has maintained interest rates near zero. Year-to-date through August, both the equity portfolio (+8.44 percent) and the fixed income portfolio (+5.93 percent) have contributed positively to overall results.

More information on how economic conditions affected EGID in 2015, as well as EGID's 2015 trend experience, is included in Management's Discussion and Analysis.

## MAJOR INITIATIVES

In an effort to secure member's confidential information and cut costs, beginning with plan year 2017, HealthChoice members can access their Explanation of Benefits (EOB) via a secure website and opt out of receiving paper EOBs. HealthChoice network providers and non-network providers will also have online access to their remittance advices via secure website or via a standard HIPAA transaction.

Beginning Jan. 1, 2016, HealthChoice introduced a new program called HealthChoice Select that will result in overall plan savings while improving members' access to quality and affordable care by designing an innovative care model for bundled payments for services. This program offers members the opportunity to have certain services performed at certain participating facilities with no out-of-pocket costs (i.e., deductibles or coinsurance). Participating facilities agree to offer certain services to members at a bundled rate. A bundled rate is a single payment for facility, physician and ancillary services associated with a particular service. Providers can choose to participate in one or more of the categories, however, providers are not required to participate in the program. Currently there are 53 facility locations providing over 800 outpatient services and over 80 inpatient services.

CVS/caremark became HealthChoice's pharmacy benefit manager (PBM) effective Jan. 1, 2016. EGID is utilizing CVS/caremark's Standard Performance Drug List with Exclusions and national pharmacy network for all claims. The contract with CVS/caremark will produce an estimated 12 percent savings in pharmacy spend through 2016 compared to the 2015 contract with Express Scripts.

As part of the transition to CVS/caremark, EGID ended the direct contract for Medicare Part D with the Centers for Medicare & Medicaid Services (CMS) and moved its HealthChoice members onto the PBM's Part D contract, commonly referred to as an Employer Group Waiver Plan (EGWP). This change was made due to the increased administrative burden CMS places on plans and due to an industry shift away from CMS direct contracts.

Beginning Jan. 1, 2016, the responsibility of transmitting eligibility and remitting premium payments for state employees to the respective health, dental and vision carriers was transitioned from the Employees Benefits Department (EBD) to EGID. This transition streamlined the current reconciliation process for all insurance premium payments, standardized exports, reporting and premium payment, and achieved overall agency consolidation efficiency in this area. Streamlining the reconciliation process also enables reports to be automated and made available to coordinators and carriers in a timely manner.

The HealthChoice FOCUS Plan was effective Jan. 1, 2016, and was offered to pre-Medicare former employees and surviving dependents who live in designated ZIP code areas. This plan offered a focused network of providers affiliated with Oklahoma Health Network's (OHN's) population health management program and extensive coordinated care initiatives. In cooperation with OHN, HealthChoice offered a plan that provides lower out-of-pocket costs, high-quality health care and a high-performing, value based network. Due to minimal participation in the FOCUS plan, it will be discontinued effective Dec. 31, 2016 and HealthChoice intends to implement a robust care coordination program through OHN for the entire pre-Medicare population effective Jan. 1, 2017.

Office of Management and Enterprise Services Employees Group Insurance Department

In an effort to reduce the risk of exposing confidential member information and to reduce printing and mailing costs, EGID implemented two significant changes to the employer group monthly billing statements. By making these changes, EGID is proactively reducing the risk of identity theft for covered individuals, employers and to EGID itself. The first change was implemented April 1, 2016. That change removed Social Security numbers from the billing statements and replaced them with Member ID codes. The second phase of this implementation began May 1, 2016, and it eliminated the physical mailing of these billing statements. Insurance coordinators were trained instead to retrieve the billing statements by logging into the secure Employer Self Service application which they have utilized for enrollment purposes for many years.

EGID upgraded its primary operations system, which includes eligibility and premium accounting functions, from the V3 Classic application to the V3 Browser version. The classic application went live in 2003 and had been very effective since that time, but had reached the end of its developmental life cycle. The intent of this upgrade was to take advantage of new functionality not available in the classic version and create a more web-friendly application. After a two-year implementation, the system successfully went live in May 2015.

Beginning in September 2014, EGID instituted a new program for managing the increasing commercial spend on compound medications. Plans across the country saw costs for compound medications increase exponentially during plan year 2013. EGID's current pharmacy benefit manager (PBM), Express Scripts (ESI), presented a robust prior authorization and exclusion compound management program, which EGID implemented on Sept. 15, 2014. During the rolling year before Sept. 15, 2014, EGID had spent \$6.75 million on compounded medications for our commercial population. For plan year 2015, EGID spent \$190,675 on compounded medications for our commercial members, a decrease of 95.6 percent. The ESI Compound Management program successfully controlled the compound spend for EGID through plan year 2015, but keeping it under control requires vigilance.

During plan year 2015, EGID saw compound spend for the Medicare population begin to rise, from \$715,683 during plan year 2014 to \$1,222,011 for plan year 2015. EGID also made the decision in 2015 to transition to a new PBM, CVS/caremark, for plan year 2016. During the transition, EGID ensured that a robust compound management program was continued for the commercial population and that a new compound management program was initiated for the Medicare population. The new program for commercial members requires prior authorization for any compounds costing more than \$300. The new compound management program for the Medicare population ensures that all ingredients of a compound are Part D covered medications and if any ingredients are not Part D medications the compound is not covered.

In 2014, HealthChoice established the tier system of reimbursement for short-term acute inpatient and mental health and substance use services that recognizes differences in facility characteristics. In 2015, HealthChoice worked to apply the same tier system for reimbursement of outpatient services for these providers. In both instances in an effort to achieve the highest results and be transparent in the process, HealthChoice collaborated with a task force of impacted network provider facilities. HealthChoice finalized the outpatient reimbursement system in the fourth quarter of 2015 to be effective for dates of service beginning June 1, 2016.

In September 2015, EGID implemented a health care decision support system. This integrated analytic database provides advanced analysis and reporting capabilities that will support the effective management of the HealthChoice insurance plans. The system enables informed and timely decision-making in areas such as plan design and modeling, early identification of trends, and measurement of program effectiveness.

EGID continues to research the possibility of joining a coalition of other Oklahoma health care organizations in an effort to improve health care quality and access to care while controlling costs. This partnership will link patients and their providers together in a communitywide health information network focused on improving the health of patients and communities, reducing inefficiency and waste, and coordinating care more effectively.

On Jan. 1, 2014, EGID began a three year pilot project to test the value proposition of a program that offers financial incentives to both the health care provider and the patient. The program engages both stakeholders for each care encounter in which the provider and patient incorporate evidence-based medicine treatment guidelines, patient health education remedies, and other proven medical interventions made available and recorded through the program in rendering and utilization of health care. The pilot ends Dec. 31, 2016.

EGID conducted a pilot program during 2013 to evaluate bariatric weight loss procedures for participants that met specific medical criteria through a certification process. Outcomes over a two-year period were monitored and studied to determine future policies regarding bariatric procedures. A final report was issued in 2016 and a limited benefit will be implemented Jan. 1, 2017.

In 2015, EGID received over \$18.5 million from the Medicare Coverage Gap Discount Program and \$19 million from the Medicare Part D Reinsurance. These additional funds offset pharmacy costs for members enrolled in a HealthChoice Medicare Supplement Part D plan. For 2016, EGID no longer holds a direct contract for Part D with CMS but became an Employer Group Waiver Plan through its Pharmacy Benefit Manager's Part D plan. EGID anticipates receiving similar funds for the Gap Discount and Reinsurance programs in 2016.

In order to streamline, standardize and improve the quality of the Network Provider contracting process and to address the needs of the provider community, delegated contracting was made available to select provider groups during 2014 and was extended to additional providers during 2015. Delegated contracting is a formal process by which EGID gives another entity the authority to perform contracting functions on behalf of its practitioners. Practitioners covered under delegated contracting agreements do not have to submit full contracting paperwork and document copies to health plans. Instead, the delegated entity submits preapproved provider profiles containing the required information for enrollment. Delegated contracting offers an industry standard method for large provider groups to contract and enroll providers without providing copious amounts of documentation.

EGID has reduced errors from provider matching for claims payment by implementing inpatient and mental health and substance use (MH/SU) tiers. The tiers were put in place in the third quarter of 2014. Multiple National Provider Identifier numbers were transitioned to the newly implemented Provider Network Management software in 2015. The recent implementation

of inpatient and MH/SU tiers has also helped to assure the reimbursement is consistent with the provider contract terms no matter the claim submission type.

The HealthChoice H.E.L.P. 4 program began in plan year 2011 as a wellness initiative for primary members ages 20 and older enrolled in the HealthChoice High, Basic and S-Account plans. The primary goals of H.E.L.P. 4 included:

- Placing attention on face-to-face interaction between the member and their primary care physician.
- Using preventive medicine in addressing health concerns.
- Promoting wellness by making members aware of health risks related to lifestyle choices.
- Supporting initiatives that work to improve the overall health of participating members.

For plan years 2011 and 2012, the following requirements had to be met to qualify for the incentive:

- Complete a preventive visit with a physician (covered at no cost to the member).
- Have a metabolic and/or lipid blood panel (covered at no cost to the member).
- Complete an online health risk assessment (HRA) and update the biometric information within the HRA.

To increase participation in 2013, the H.E.L.P. 4 initiative was streamlined. A member was no longer required to have a metabolic or lipid blood panel or complete the HRA, although both services were still free of charge and available to the member. During plan year 2011, eligible members who completed the program requirements received a \$100 incentive payment. Beginning plan year 2012, the incentive payment was increased to \$200. Since inception of the program, adult preventive office visits have increased approximately 60 percent. The program will end Dec. 31, 2016.

## **LEGISLATION**

The following are recently passed laws that affect EGID:

### **Federal**

The Patient Protection and Affordable Care Act (ACA) went into effect March 23, 2010. Recent changes that affect EGID are as follows:

- For plan years 2012-2019, the ACA requires plan sponsors, such as EGID, be subject to an annual fee to fund a federal comparative effectiveness research program (known as the PCORI fee). In 2013, the fee was \$2 per covered life and in 2015 became \$2.08 per covered life.

- Beginning in 2014, the Transitional Reinsurance Fee under ACA imposed an annual fee on group health plans, including EGID. The established rate for 2014 was \$63 per covered life, \$44 per covered life for 2015, and \$27 per covered life for 2016.
- Beginning Jan. 1, 2014, ACA imposed annual limits on the amount an enrollee in a non-grandfathered plan must pay for essential health benefits through cost sharing. The deadline was modified to Jan. 1, 2015, for plans, such as EGID, that use a separate combination of TPAs and PBMs to manage claims payments.
- The ACA requirements for automatic enrollment will not be implemented, so this is no longer a concern for EGID.
- The penalty phase of ACA's Pay or Play or Shared Employer Responsibility was delayed until 2016, covering the 2015 plan year. Pay or Play had a modest effect on HealthChoice enrollment.
- Under §6055 of the Internal Revenue Code as implemented by ACA, insurers had new reporting requirements to both participants and the IRS. EGID completed the necessary programming changes and reporting for plan year 2015.
- Under Section 2717 of ACA, plan sponsors of non-grandfathered plans must submit annual reports on features of the sponsor's health care coverage that may improve health care quality, such as disease management or wellness programs. These reports were to be provided to both the U.S. DHHS and to employees during open enrollment beginning in 2012. In the absence of guidance through 2015, no reporting has been required. In 2016, the Department of Labor published proposed regulations that would require the reporting beginning for plan year 2019 and thereafter.
- Beginning in 2020, ACA imposes a 40 percent excise tax (the "Cadillac tax") on the value of health insurance benefits that exceeds certain limits defined in regulations. Currently, only one HealthChoice plan would exceed these limits, and it will be phased out during 2017 due to its low enrollment.
- Other ongoing changes include implementation of the HIPAA 5010 transmission standards.

## Oklahoma

**House Bill 1711** (2016) permits the Health Insurance Plan to offer an alternative insurance plan to retirees under the age of 65 at a rate that is between \$100 less and up to \$100 more than the monthly premium for active employees.

**House Bill 2785** (2016) allows cities to participate in the Disability Insurance Program.

**House Bill 2963** (2016) requires the Health Insurance Plan to provide coverage for the screening, diagnosis and treatment of autism spectrum disorders.

**House Bill 3071** (2016) requires that any mandated health insurance coverage enacted after Nov. 1, 2016, apply to the Health Insurance Plan.

**House Bill 1567** (2015) permits the Health Insurance Plan to provide for the application of deductibles and copayment or coinsurance provisions that are based on contracts with providers for specific services based on levels of outcomes or cost or type of provider.

**House Bill 2190** (2014) requires health benefit plans to utilize prior authorization forms for obtaining any prior authorization for prescription drug benefits. The bill provides that a form cannot exceed three pages in length, excluding any instructions or guiding documentation and a health benefit plan may customize the content of the form specific to the prescription drug for which the prior authorization is being requested.

**House Bill 3215** (2014) changes the liability of a county jail for the medical expenses or expenses of a state inmate or person in custody from \$8,000 to \$6,000.

**House Bill 3282** (2014) provides that certain policies terminate on a certain date. The bill also repeals all sections of law pertaining to the Health Insurance High Risk Pool Act.

**House Bill 1107** (2013) permits current state employees to opt out of the health and dental basic plan options only and retain the life and disability plan benefits; and also provides that the disbursement of the flexible benefit allowance for participants on a biweekly payroll system will be credited over 24 pay periods resulting in two pay periods that do not reflect a credit.

## **FINANCIAL INFORMATION**

EGID management is responsible for establishing and maintaining an internal control structure designed to ensure that assets are protected and to provide accurate accounting data. The internal control structure is designed to provide reasonable, but not absolute, assurance that these objectives are met. The concept of reasonable assurance recognizes that the cost of a control should not exceed the benefits likely to be derived. The valuation of costs and benefits requires estimates and judgments by management.

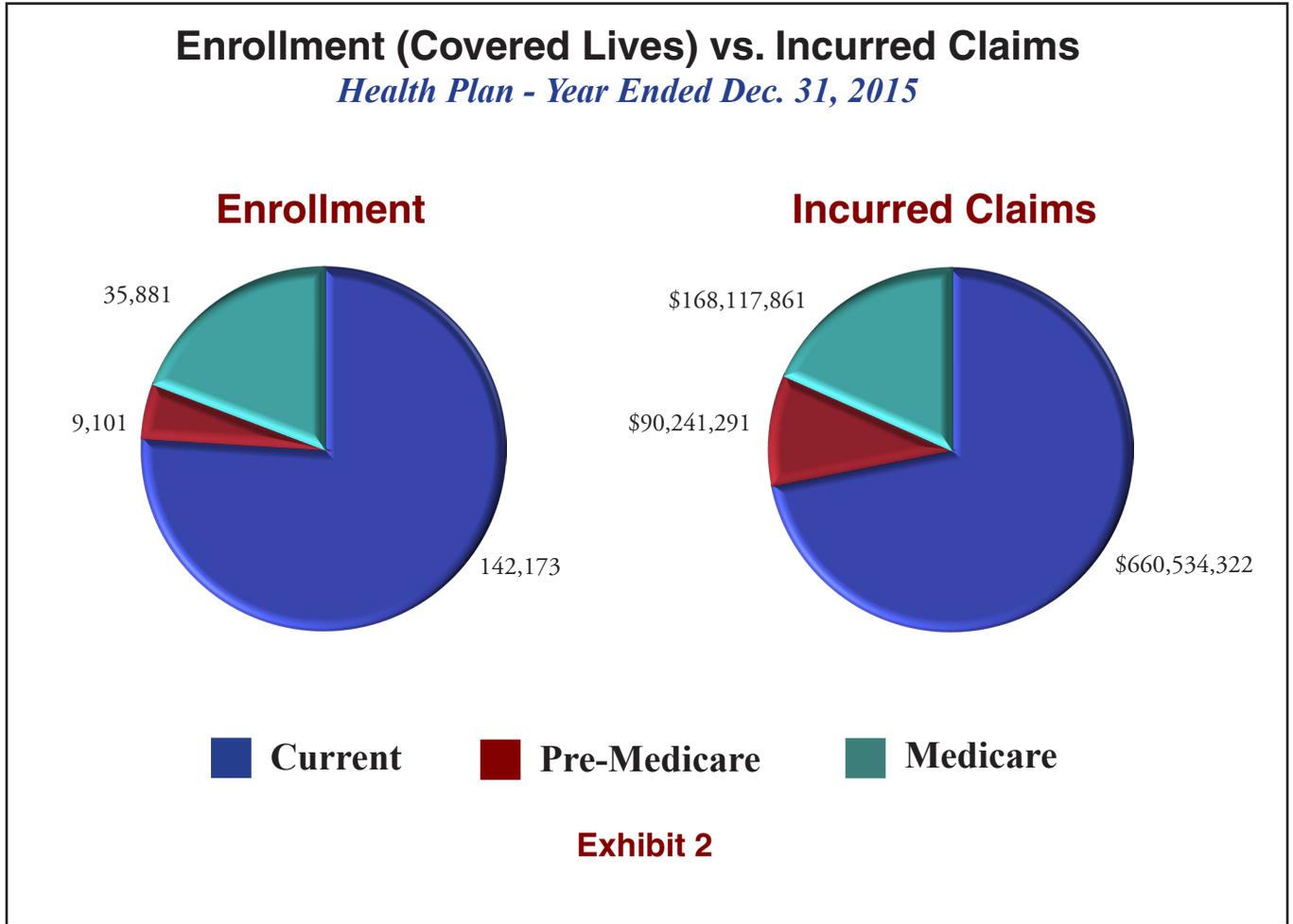
**Single Audit.** EGID does not receive federal funding and, therefore, is not required to undergo an annual single audit in conformity with the provisions of the Single Audit Amendments of 1996 and U.S. Office of Management and Budget Circular A-133, Audits of States, Local Governments, and Non-Profit Organizations.

**Budgeting Controls.** All administrative expenses are funded from premiums. Funds needed for administrative expenses are transferred to a revolving fund, which is not subject to fiscal year limitations and is under the control of EGID. EGID maintains budgetary controls to ensure compliance with provisions embodied in the annual budget. The level of budgetary control (that is, the level at which expenditures cannot exceed the budgeted amount) is established by function and activity. EGID maintains an encumbrance accounting system as its primary technique for accomplishing budgetary control.

As demonstrated by the financial statements included in this report, EGID is meeting its responsibility for sound financial management.

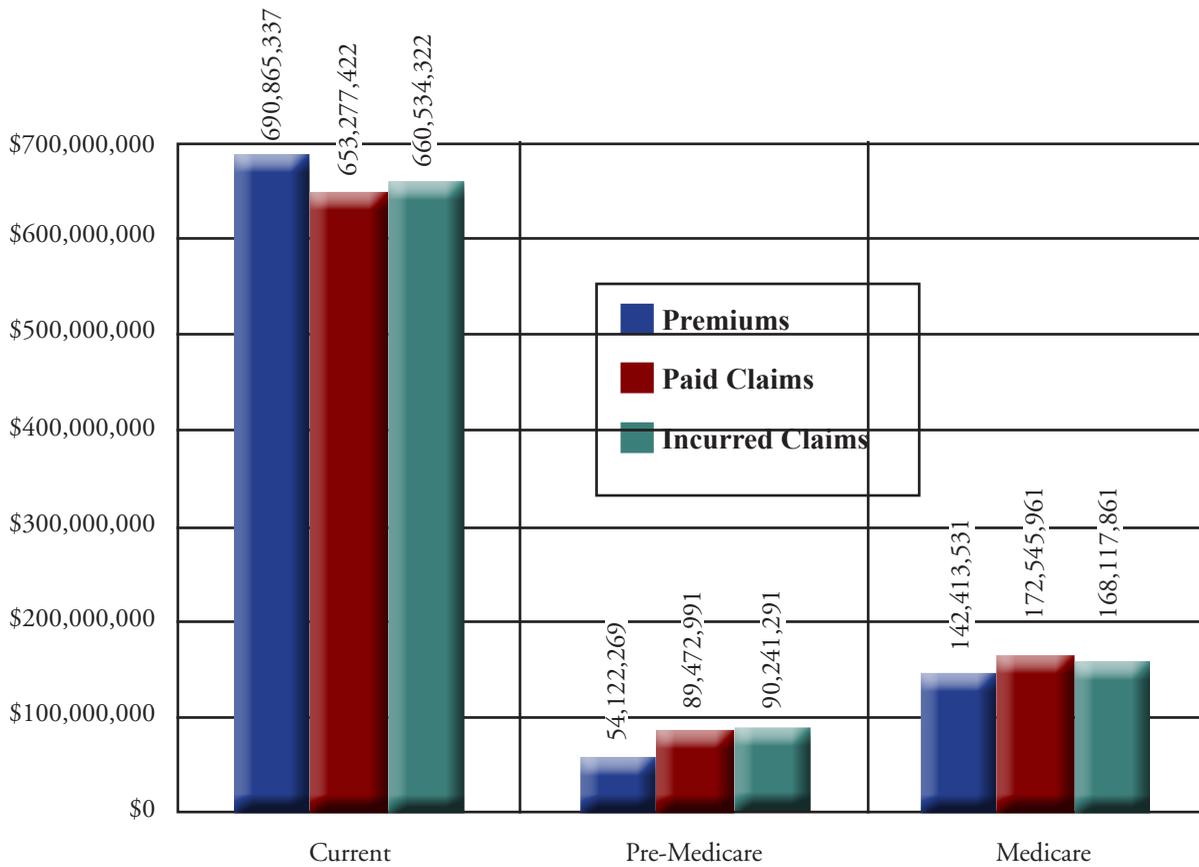
**Proprietary Operations.** EGID revenue from operations consists of health, dental, life and disability premiums remitted by each participating entity for their employees, or directly by former employees and participants under COBRA. Also included in premium revenue are premium subsidies received from the Centers for Medicare & Medicaid Services (CMS) Medicare Part D program. Another source of operating revenues is a risk adjustment fee collected from HMOs. Operational expenses are primarily paid and incurred claims.

The following charts illustrate enrollment, premiums and claims broken down between current employees and pre-Medicare and Medicare-eligible former employees.



Current employees comprise 76 percent of EGID’s primary member population and 72 percent of 2015 paid claims. Pre-Medicare former employees make up only 5 percent of EGID’s primary member population but account for 10 percent of paid claims, and Medicare-eligible former employees ages 65 and older make up 19 percent of EGID’s primary member population and 18 percent of paid claims.

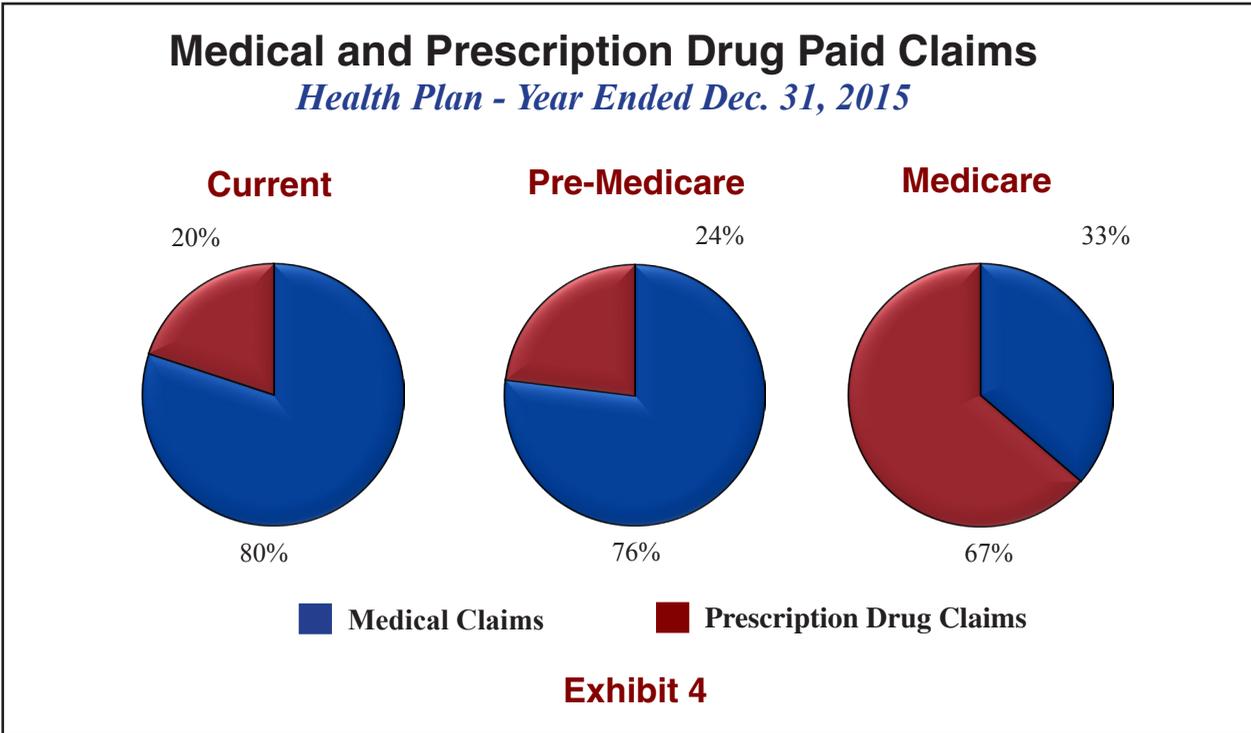
## Comparison of Premiums, Paid Claims, and Incurred Claims *Health Plan - Year Ended Dec. 31, 2015*



**Exhibit 3**

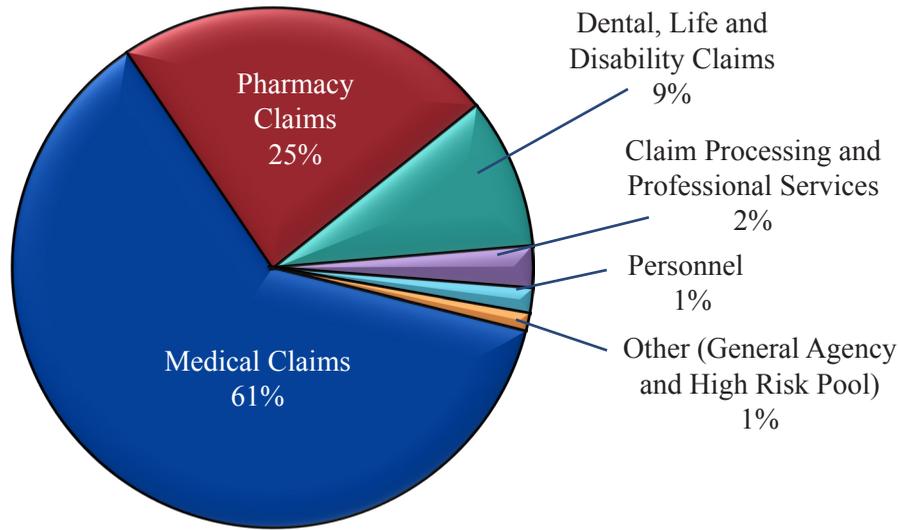
Pharmacy claims are included in total health claims. For current employees, health premiums for 2015 were \$30.3 million over incurred claims for the year, a difference of 5 percent. For pre-Medicare former employees, health premiums fell short of covering incurred claims by \$36.1 million or 40 percent, primarily because premiums for current employees and pre-Medicare former employees are priced at a fully blended rate. For Medicare-eligible former employees, health premiums were \$26.0 million over incurred claims for a difference of 15 percent.

The following exhibit illustrates medical and prescription drug claims for each participant category.



For the current employee and pre-Medicare former employee population, approximately one-fifth of total paid claims are for prescription drugs. For the Medicare-eligible former employee population, nearly two-thirds of paid claims are for prescription drugs.

**Total HealthChoice Expenses<sup>(1)</sup>**  
*Year Ended Dec. 31, 2015*



<sup>1)</sup> Chart does not include booking or amortization of premium deficiency reserve.

**Exhibit 5**

The HealthChoice expense for payment of health, pharmacy, dental, life and disability claims was 95.5 percent. Only 4.5 percent of the department’s total expenses were for administrative costs which compares favorably with industry averages.

**Cash and Investment Management.** EGID maintains minimum cash balances as required by statute to fund released warrants. All excess cash is deposited with a custodial bank, which in turn credits the EGID short-term cash money market account. In addition to the money market account, EGID has two fixed income money managers and three equity securities managers.

All invested funds are regulated by the EGID investment policy set by the Oklahoma Employees Insurance and Benefits Board (OEIBB) and monitored by EGID administration.

The policy speaks specifically to liquidity, asset quality, maturity and duration of fixed income terms, and specific asset mix by statutory fund. In addition, the policy sets benchmark expectations for each type of money manager.

A more detailed summary of EGID’s financial position and result of operations is included in Management’s Discussion and Analysis.

## OTHER INFORMATION

**Independent Audit.** The accounting firm of KPMG LLP has been retained to perform an annual audit. The independent auditors' report on the basic financial statements is included in the financial section of this report.

**Acknowledgments.** The preparation of the comprehensive annual financial report was made possible by the dedicated service of the entire staff of the finance unit. In addition, I wish to acknowledge the contribution made by Mr. Gary Beebe, Comptroller.

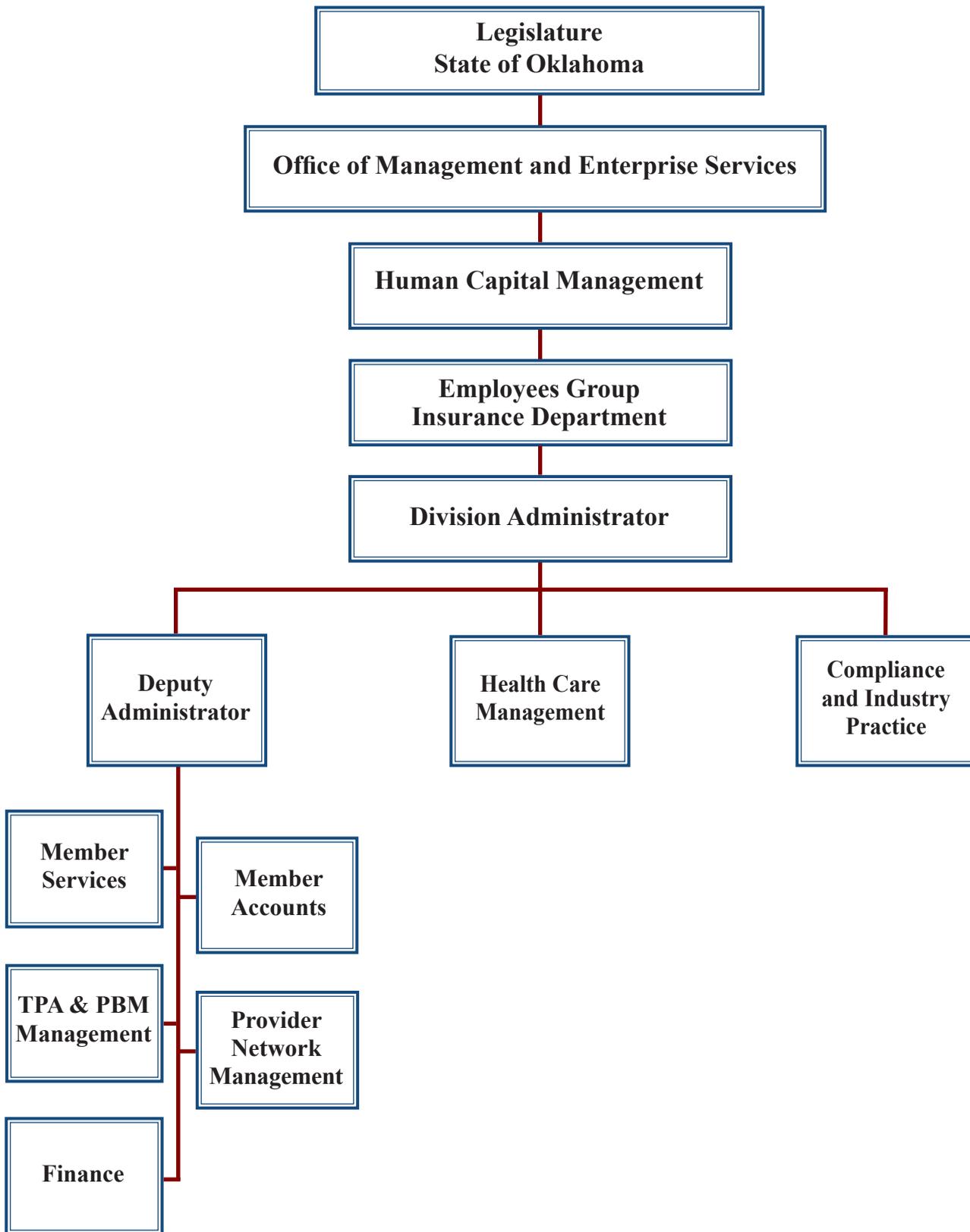
In closing, without the leadership and support of the OEIBB and senior staff of EGID, preparation of this report would not have been possible.

Respectfully submitted,



Diana O'Neal  
Deputy Administrator, Finance

# Executive Organizational Chart



**List of Principal Officials**  
**Dec. 31, 2015**

**OKLAHOMA EMPLOYEES INSURANCE AND BENEFITS BOARD**

Jimmy J. Williams, CPA, Chairman  
S. Shane Pate II, Secretary  
Commissioner John Doak/Frank Stone

Eric W. Wright, Vice Chairman  
Steven M. Montgomery  
Mike Felty

**EMPLOYEES GROUP INSURANCE DEPARTMENT**

**ADMINISTRATOR**

Frank Wilson

**DEPUTY ADMINISTRATOR**

Diana O'Neal

**DEPARTMENT DIRECTORS**

Compliance and Industry Practice  
Health Care Management  
Internal Audit  
Finance  
Provider Network Management  
Pharmacy  
Member Accounts  
Member Services

Paul King  
Frank Lawler, MD  
Joe McCoy  
Gary Beebe  
Teresa South  
Travis Tate  
Michelle Toliver  
Cassie Waters and Tom Carpenter



# Financial Section



Tulsa Opera  
The Pearl Fishers  
Tulsa, Oklahoma  
*Photograph by Shane Bevel*





**KPMG LLP**  
210 Park Avenue, Suite 2850  
Oklahoma City, OK 73102-5683

## **Independent Auditors' Report**

Members of the Board  
Oklahoma Employees Insurance and Benefits Board:

### **Report on the Financial Statements**

We have audited the accompanying financial statements of the Employees Group Insurance Department (EGID), a department of the Office of Management and Enterprise Services, as of and for the years ended December 31, 2015 and 2014, and the related notes to the financial statements, which collectively comprise the EGID's basic financial statements as listed in the table of contents.

### ***Management's Responsibility for the Financial Statements***

Management is responsible for the preparation and fair presentation of these financial statements in accordance with U.S. generally accepted accounting principles; this includes the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of financial statements that are free from material misstatement, whether due to fraud or error.

### ***Auditors' Responsibility***

Our responsibility is to express an opinion on these financial statements based on our audits. We conducted our audits in accordance with auditing standards generally accepted in the United States of America and the standards applicable to financial audits contained in *Government Auditing Standards*, issued by the Comptroller General of the United States. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditors' judgment, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

### ***Opinion***

In our opinion, the financial statements referred to above present fairly, in all material respects, the respective financial position of the Employees Group Insurance Department, as of December 31, 2015 and 2014, and the respective changes in its financial position and its cash flows for the years then ended, in accordance with U.S. generally accepted accounting principles.



***Emphasis of Matter***

As discussed in note 2 to the financial statements, in 2015, EGID adopted Governmental Accounting Standards Boards Statement No. 68, *Accounting and Financial Reporting of Pensions*, effective January 1, 2014. Our opinion is not modified with respect to this matter.

***Other Matters***

***Required Supplementary Information***

U.S. generally accepted accounting principles require that *management's discussion and analysis* on pages 21 through 26 and the schedules of EGID's proportionate share of the net pension liability and contributions on pages 57 through 59 be presented to supplement the basic financial statements. Such information, although not a part of the basic financial statements, is required by the Governmental Accounting Standards Board who considers it to be an essential part of financial reporting for placing the basic financial statements in an appropriate operational, economic, or historical context. We have applied certain limited procedures to the required supplementary information in accordance with auditing standards generally accepted in the United States of America, which consisted of inquiries of management about the methods of preparing the information and comparing the information for consistency with management's responses to our inquiries, the basic financial statements, and other knowledge we obtained during our audit of the basic financial statements. We do not express an opinion or provide any assurance on the information because the limited procedures do not provide us with sufficient evidence to express an opinion or provide any assurance.

***Other Reporting Required by Government Auditing Standards***

In accordance with *Government Auditing Standards*, we have also issued our report dated May 13, 2016 on our consideration of the EGID's internal control over financial reporting and on our tests of its compliance with certain provisions of laws, regulations, contracts, and grant agreements and other matters. The purpose of that report is to describe the scope of our testing of internal control over financial reporting and compliance and the results of that testing, and not to provide an opinion on internal control over financial reporting or on compliance. That report is an integral part of an audit performed in accordance with *Government Auditing Standards* in considering the EGID's internal control over financial reporting and compliance.

**KPMG LLP**

Oklahoma City, Oklahoma  
May 13, 2016

**EMPLOYEES GROUP INSURANCE DEPARTMENT**  
(A Department of the Office of Management and Enterprise Services)

Management's Discussion and Analysis

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**Overview of the Financial Statements**

The EGID basic financial statements are prepared on the basis of accounting principles generally accepted in the United States of America for governmental entities and insurance enterprises where applicable. The primary purpose of EGID is to provide group health, dental, life, and disability insurance for employees of state agencies, school districts, and other governmental units as set forth in Title 74 of the Oklahoma Statutes. EGID is a department of the Office of Management and Enterprise Services.

The three financial statements presented within the basic financial statements are as follows:

**Balance Sheets** – This statement presents information reflecting EGID's assets, liabilities, and fund equity. Fund equity represents the amount of total assets less total liabilities. The balance sheet is classified as to current and noncurrent assets and liabilities. For purposes of the financial statements, current assets and liabilities are those assets and liabilities with immediate liquidity or which are collectible or becoming due within twelve months of the statement date. EGID's investment balances are considered current assets, as EGID has historically experienced a high portfolio turnover rate.

**Statements of Revenue, Expenses, and Changes in Fund Equity** – This statement reflects EGID's operating revenue and expenses, as well as nonoperating revenue during the year. The major source of operating revenue is premium income and the major sources of operating expenses are health, dental, life, and disability benefits. The change in fund equity for an enterprise fund is similar to net profit or loss for a private sector insurance company.

**Statements of Cash Flows** – The statements of cash flows are presented on the direct method of reporting, which reflects cash flows from operating, capital and related financing, and investing activities. Cash collections and payments are reflected in this statement to arrive at the net increase or decrease in cash for the fiscal year.

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**Financial Highlights**

The management of the EGID offers readers of EGID's financial statements this narrative overview and analysis of the financial activities of the entity for the years ended December 31, 2015, 2014, and 2013.

	<b>December 31</b>			<b>2015 vs. 2014</b>
	<b>2015</b>	<b>2014</b>	<b>2013</b>	<b>Change Amount</b>
Cash and investments	\$ 334,006,622	411,778,392	422,638,868	(77,771,770)
Premiums receivable, net	25,933,023	33,600,779	30,127,034	(7,667,756)
Other current assets	38,186,542	36,225,345	19,496,261	1,961,197
Total current assets	398,126,187	481,604,516	472,262,163	(83,478,329)
Office equipment, net	2,697,956	1,787,003	1,353,617	910,953
Total assets	400,824,143	483,391,519	473,615,780	(82,567,376)
Deferred outflows of resources	1,645,058	572,776	—	1,072,282
Total assets and deferred outflows	\$ 402,469,201	483,964,295	473,615,780	(81,495,094)
Claims liabilities	\$ 118,001,000	114,338,000	98,073,000	3,663,000
Disability liabilities (current only)	3,004,000	3,019,103	3,119,124	(15,103)
Premium deficiency reserves	43,966,000	54,331,462	10,896,876	(10,365,462)
Other current liabilities	25,682,486	31,621,810	20,708,730	(5,939,324)
Total current liabilities	190,653,486	203,310,375	132,797,730	(12,656,889)
Total noncurrent liabilities	10,477,338	11,190,883	11,685,000	(713,545)
Total liabilities	201,130,824	214,501,258	144,482,730	(13,370,434)
Deferred inflows of resources	1,880,237	2,773,089	—	(892,852)
Invested in capital assets	2,697,956	1,787,003	1,353,617	910,953
Unrestricted fund equity	196,760,184	264,902,945	327,779,433	(68,142,761)
Total fund equity	199,458,140	266,689,948	329,133,050	(67,231,808)
Total liabilities, deferred inflows, and fund equity	\$ 402,469,201	483,964,295	473,615,780	(81,495,094)

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	Year ended December 31			2015 vs. 2014
	2015	2014	2013	Change Amount
Premium revenue	\$ 979,663,600	941,358,109	903,192,032	38,305,491
Other operating revenue	123,231	936,685	1,708,711	(813,454)
Total operating revenue	<u>979,786,831</u>	<u>942,294,794</u>	<u>904,900,743</u>	<u>37,492,037</u>
Incurred claims expense	1,015,375,127	929,382,378	873,841,859	85,992,749
Change in premium deficiency reserves	(10,365,462)	43,434,586	10,746,876	(53,800,048)
Administrative and claims processing expense	46,955,893	50,027,600	40,738,475	(3,071,707)
Total operating expenses	<u>1,051,965,558</u>	<u>1,022,844,564</u>	<u>925,327,210</u>	<u>29,120,994</u>
Operating loss	(72,178,727)	(80,549,770)	(20,426,467)	8,371,043
Net investment income	4,946,919	22,137,347	36,989,410	(17,190,428)
Change in fund equity	<u>(67,231,808)</u>	<u>(58,412,423)</u>	<u>16,562,943</u>	<u>(8,819,385)</u>
Fund equity, beginning of year	266,689,948	329,133,050	312,570,107	(62,443,102)
Cumulative effect of adopting new accounting standard (note 2(p))	—	(4,030,679)	—	4,030,679
Fund equity, beginning of year restated	<u>266,689,948</u>	<u>325,102,371</u>	<u>312,570,107</u>	<u>(58,412,423)</u>
Fund equity, end of year	<u>\$ 199,458,140</u>	<u>266,689,948</u>	<u>329,133,050</u>	<u>(67,231,808)</u>

EGID's total assets for the year ended December 31, 2015 decreased by approximately 17% from the previous year, where there was an increase of 2% in 2014. Cash and investments decreased by \$77.8 million or 18.9% during 2015 due to liquidating investments as a result of unfavorable claims experience while 2014 showed increases of \$10.9 million or 2.6%.

In 2015, EGID earned approximately \$4.9 million in interest and dividend income, experienced \$22.4 million in realized gains and \$21.6 million in unrealized losses, and paid \$711,418 in investment expenses for a net investment gain of \$4.9 million. In 2014, EGID earned approximately \$3.3 million in interest and dividend income, experienced \$9.1 million in realized gains and \$10.4 million in unrealized gains, and paid \$606,000 in investment expenses for a net investment gain of \$22.1 million. EGID's investment allocation at December 31, 2015 comprises approximately 50% fixed income securities, 31% equities, and 19% cash equivalents and comprises approximately 58% fixed income securities, 34% equities, and 8% cash equivalents at December 31, 2014.

At year-end, for December 31, 2015, premiums receivable decreased from the prior year by \$7.7 million due to an \$8.2 million employer group payment for premiums being received and posted on December 31, 2015 whereas in the prior year this payment was received after year-end. In the prior year, premiums receivable increased \$3.5 million, primarily due to an increase in premiums. The increase in other current assets during 2015 of \$2.0 million is primarily due to \$4.2 million increase in the Medicare Part D reinsurance receivable offset by a

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\$3.8 million decrease in the Medicare Part D Coverage Gap Discount Program. The increase for other current assets in 2014 of \$7.2 million is primarily due to a \$4.4 million increase in the Medicare Part D Coverage Gap Discount Program receivable, a \$1.8 million receivable for pharmacy rebates and a \$575,000 receivable from the pharmacy benefits manager for overpaid claims.

Total liabilities as of December 31, 2015 decreased \$13.4 million from December 31, 2014 primarily due to a \$10.4 million decrease in premium deficiency reserves booked at December 31, 2015 combined with a \$3.7 million increase in claim liabilities. Additionally, there was a \$5.9 million decrease in other liabilities due to a decrease of \$2.3 million in transitional reinsurance fee assessed as part of the Affordable Care Act (ACA) at year-end and a \$2.4 million decrease in the Medical Expense Liability Fund (MELF) (see note 15 for additional information regarding this fund). Total liabilities as of December 31, 2014 increased \$70.0 million from December 31, 2013 primarily due to a \$43.4 million increase in premium deficiency reserves booked at December 31, 2014 combined with a \$16.3 million increase in claim liabilities and a \$9.6 million increase in other liabilities primarily due to the transitional reinsurance fee assessed as part of the Affordable Care Act (ACA) at year-end.

A premium deficiency is required to be recognized if the sum of expected claims costs (including incurred, but not yet reported (IBNR)) and all expected claim adjustment expenses exceeds related premiums and anticipated investment income. For the health plan, a premium deficiency liability of \$40.7 million and \$53.9 million was recorded at December 31, 2015 and 2014, respectively. For the dental plan, a premium deficiency liability of \$3.3 million and \$304,000 was booked at December 31, 2015 and 2014, respectively. For the disability plan, at December 31, 2015, no premium deficiency was necessary. For 2014, a premium deficiency liability of \$111,000 was recorded.

EGID saw an overall increase in premium revenue for 2015 of approximately \$38.3 million due primarily to a 2.6% increase in premium rates and a 5.2% increase in HealthChoice health plan membership. In 2014, EGID saw an overall increase in premium revenue of approximately \$38.2 million due primarily to a 3.6% increase in rates and an increase in membership during plan year 2014. For the years ended December 31, 2015 and 2014, EGID earned approximately \$123,231 and \$937,000, respectively, in other operating income, which consisted primarily of risk adjustment fee income.

Incurred claims comprise 95.6% and 94.8% of EGID's total expenses in 2015 and 2014, respectively. Changes in premium deficiency reserves are not considered in the calculation. For the years ended December 31, 2015 and 2014, total incurred claims increased by \$86.0 million and \$55.5 million, or 9% and 6.4% over the prior year.

For the years ended December 31, 2015 and 2014, health and dental claim costs increased by approximately \$84.6 million and \$57.2 million, respectively, or 9% and 7% over the prior year due to normal claim trend projections. In 2015, life benefits expense increased from the prior year by \$1.8 million or 7% above the expense reported for 2014. During 2014, the expense for life benefits decreased by approximately \$341,000 or 1% below the prior year. Disability benefits for 2015 decreased \$401,680 or 18% from the prior year. Disability benefits for 2014 decreased \$1.3 million or 37% over the prior year. Life and Disability claims can be volatile from year to year.

Administrative expenses decreased by \$3.1 million in 2015 over 2014 primarily due to the decrease in transitional reinsurance fee and increased \$9.3 million in 2014 over the prior year primarily due to the new transitional reinsurance fee. Administrative expenses make up 4.5% of EGID's total expenses in 2015 and 4.9% in 2014.

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EGID experienced a decrease in total fund equity of approximately \$67.2 million, or 25.2%, for the year ended December 31, 2015. For 2014, there was a decrease in fund equity of approximately \$62.4 million, or 19%.

During 2015, the Health and Dental program experienced a decrease in fund equity of approximately \$66.6 million, or 33% from the prior year. The decrease is primarily due to an increase in incurred claims. For the year ended December 31, 2014, the Health and Dental program experienced a decrease in fund equity of approximately \$64.4 million, or 24% over the prior year. The decrease is primarily due to a \$54.2 premium deficiency booked at December 31, 2014.

The Life program experienced a decrease in fund equity of approximately \$2.7 million or 11% in 2015 and a decrease of \$601,000 or 2% in 2014.

The Disability program experienced an increase in fund equity of \$2.0 million or 5% in 2015 and an increase in fund equity of \$4.4 million or 12% in 2014.

**Economic Conditions**

Like many health insurance plans, EGID has experienced higher than anticipated claims costs the past couple years, resulting in a decrease in excess fund equity amounts that exceed recommended minimum levels. While excess fund equity in self-funded plans is often utilized to mitigate, to some degree, the impact of anticipated cost increases on premium rates, many factors may influence the availability of fund equity. As fund equity is essentially a function of the size of the plan, minimum required levels could be materially impacted by large increases in covered members due to the individual and employer coverage mandates required by the ACA, as well as the enrollment of large employer groups that are eligible but do not currently participate in the plan.

The insurance industry monitors healthcare costs by establishing a percentage of cost increases known as "trend." Trend is the forecast change in health plans' per capita claims cost determined by insurance carriers, managed care organizations, and third-party administrators. Many factors influence trend, including the following:

- Price inflation
- Deductibles and copayments
- Cost-shifting
- Utilization increases due to aging, product promotion, and improved diagnostic services
- The availability and use of more expensive drug therapies
- Government mandated benefits and other legislative changes
- Advances in medical technologies

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According to Aon Hewitt, EGID's consulting actuarial firm, the 2015 national healthcare trends for plans similar to the HealthChoice High plan was 2.7% for medical only, 13.4% for pharmacy only, or 5.1% combined. The national trend for Medicare supplement plans was 4.0% for medical only, 9.3% for pharmacy only, or 8.0% combined. In 2015, on average, EGID's active and pre-Medicare retiree trend was 5.4% for medical only, 6.3% for pharmacy only, or 5.6% combined. EGID's trend for the Medicare supplement plan increased to 7.0% for medical only, 17.6% for pharmacy only, or 14.5% combined. These trends are adjusted for plan design and provide contracting changes during the measurement period.

Since premium rates for the following plan year are set in August, the rate setting process applies trend factors for claims incurred through April. The medical trend applied by EGID's actuaries for calculating 2015 rates was 4.5% for active employees and pre-Medicare retirees and 2.0% for Medicare retirees. The medical trend applied by EGID's actuaries for calculating 2014 rates was 5.5% for active employees and pre-Medicare retirees and 3.0% for Medicare retirees. The prescription drug trend used for setting 2015 and 2014 rates was 7.5% and 8.5% for active employees, pre-Medicare retirees, and Medicare retirees. The dental trend used for setting 2015 and 2014 rates was 2.5% and 1.0%.

EGID's investment portfolio experienced positive returns during 2015. Performance returns for EGID's total investment portfolio was 1.8% in 2015 and 6.2% in 2014.

In the commercial health insurance industry, "medical loss ratio" (MLR) measures the percentage of each premium dollar that is spent on providing healthcare to their customers versus administrative costs. The medical loss ratio is a basic indicator of an insurer's efficiency in delivering services. The ACA establishes a minimum loss ratio of 80% for the individual and small group health insurance segments, and 85% for the large group segment. While this requirement does not apply to self-insured plans, EGID's MLR of 103.6% in 2015 and 98.3% in 2014 compares very favorably to the ACA requirements and industry standards.

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Balance Sheets

December 31, 2015 and 2014

<b>Assets</b>	<b>2015</b>	<b>2014</b>
Current assets:		
Cash and cash equivalents	\$ 90,349,079	88,321,322
Investments	243,657,543	323,457,070
Receivables:		
Interest and dividends receivable	1,143,962	733,176
Unsettled investment sales	—	9,589
Premiums, net of allowance of \$1,811,713 and \$1,041,000 at December 31, 2015 and 2014, respectively	25,933,023	33,600,779
Pharmacy rebate receivable	11,676,387	10,107,027
Other, net	25,366,193	25,375,553
Total current assets	<u>398,126,187</u>	<u>481,604,516</u>
Noncurrent assets:		
Office equipment	4,281,159	5,244,203
Less accumulated depreciation	<u>(1,583,203)</u>	<u>(3,457,200)</u>
Office equipment, net	<u>2,697,956</u>	<u>1,787,003</u>
Total assets	<u>400,824,143</u>	<u>483,391,519</u>
<b>Deferred Outflows of Resources</b>		
Pension amounts	<u>1,645,058</u>	<u>572,776</u>
Total deferred outflows of resources	<u>1,645,058</u>	<u>572,776</u>
Total assets and deferred outflows of resources	<u>\$ 402,469,201</u>	<u>483,964,295</u>
<b>Liabilities</b>		
Current liabilities:		
Health and dental reserves	\$ 112,486,000	108,063,000
Life reserves	5,515,000	6,275,000
Disability reserves	3,004,000	3,019,103
Premium deficiency reserve	43,966,000	54,331,462
Premiums due to health maintenance organizations and other insurers	8,819,181	9,117,171
Payable for investment purchases	1,392,129	506,666
Other accrued liabilities	15,471,176	21,997,973
Total current liabilities	<u>190,653,486</u>	<u>203,310,375</u>
Noncurrent liabilities:		
Disability reserves	9,125,000	10,435,897
Net pension liability	<u>1,352,338</u>	<u>754,986</u>
Total liabilities	<u>201,130,824</u>	<u>214,501,258</u>
Commitments and contingencies (note 15)		
<b>Deferred Inflows of Resources</b>		
Pension amounts	<u>1,880,237</u>	<u>2,773,089</u>
Total deferred inflows of resources	<u>1,880,237</u>	<u>2,773,089</u>
<b>Fund Equity</b>		
Invested in capital assets	2,697,956	1,787,003
Unrestricted (note 2(f))	<u>196,760,184</u>	<u>264,902,945</u>
Total fund equity	<u>199,458,140</u>	<u>266,689,948</u>
Total liabilities, deferred inflows of resources and fund equity	<u>\$ 402,469,201</u>	<u>483,964,295</u>

See accompanying notes to basic financial statements.

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Statements of Revenue, Expenses, and Changes in Fund Equity  
Years ended December 31, 2015 and 2014

	<u>2015</u>	<u>2014</u>
Operating revenue:		
Premium revenue	\$ 979,663,600	941,358,109
Other operating revenue	123,231	936,685
Total operating revenue	<u>979,786,831</u>	<u>942,294,794</u>
Operating expenses:		
Incurred claims expense	1,015,375,127	929,382,378
Change in premium deficiency reserve	(10,365,462)	43,434,586
Administrative and claim processing	46,955,893	50,027,600
Total operating expenses	<u>1,051,965,558</u>	<u>1,022,844,564</u>
Operating loss	(72,178,727)	(80,549,770)
Nonoperating revenue:		
Net investment income	4,946,919	22,137,347
Change in fund equity	<u>(67,231,808)</u>	<u>(58,412,423)</u>
Fund equity, beginning of year	266,689,948	329,133,050
Cumulative effect of adopting new accounting standard (note 2(p))	—	(4,030,679)
Fund equity, beginning of year restated	<u>266,689,948</u>	<u>325,102,371</u>
Fund equity, end of year	<u>\$ 199,458,140</u>	<u>266,689,948</u>

See accompanying notes to basic financial statements.

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Statements of Cash Flows

Years ended December 31, 2015 and 2014

	<b>2015</b>	<b>2014</b>
Cash flows from operating activities:		
Premiums collected	\$ 973,020,970	924,618,142
Premiums collected on behalf of health maintenance organizations and other insurers	119,084,766	119,904,019
Payments collected from Centers for Medicare and Medicaid Services	13,474,283	13,664,985
Risk adjustment premium collected	159,708	977,927
Benefits paid	(1,014,607,487)	(913,892,815)
Premiums paid to health maintenance organizations and other insurers	(118,546,673)	(119,943,989)
Payments to employees for services	(9,166,916)	(9,485,323)
Payments to suppliers for goods and services	(45,180,861)	(30,992,578)
Other operating cash paid	(27,097)	(17,479,777)
Net cash used in operating activities	(81,789,307)	(32,629,409)
Cash flows from capital and related financing activity:		
Acquisition of office equipment	(1,413,648)	(598,410)
Net cash used in capital and related financing activity	(1,413,648)	(598,410)
Cash flows from investing activities:		
Purchases of investments	(312,146,612)	(171,969,826)
Proceeds from sales and maturities of investments	393,593,840	189,905,179
Investment income received	3,783,484	2,733,087
Net cash provided by investing activities	85,230,712	20,668,440
Net change in cash and cash equivalents	2,027,757	(12,559,379)
Cash and cash equivalents, beginning of year	88,321,322	100,880,701
Cash and cash equivalents, end of year	\$ 90,349,079	88,321,322
Reconciliation of operating loss to net cash used in operating activities:		
Operating loss	\$ (72,178,727)	(80,549,770)
Adjustments to reconcile operating loss to net cash used in operating activities:		
Depreciation	502,695	165,024
Change in operating assets and liabilities:		
Premium receivable	7,667,756	(3,473,745)
Prepaid premiums	601,236	180,183
Net pension liability	597,352	(3,828,213)
Deferred inflows of resources	(892,852)	(20,256)
Deferred outflows of resources	(1,072,282)	2,773,089
Other receivables	(1,560,000)	(16,864,848)
Claim reserves	3,663,000	16,265,000
Disability reserves	(1,326,000)	(1,349,124)
Premium deficiency reserves	(10,365,462)	43,434,586
Premiums due to health maintenance organizations and other insurers	(297,990)	358,793
Other liabilities	(7,128,033)	10,279,872
Total adjustments	(9,610,580)	47,920,361
Net cash used in operating activities	\$ (81,789,307)	(32,629,409)

See accompanying notes to basic financial statements.

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Notes to Basic Financial Statements

December 31, 2015 and 2014

**(1) Description of EGID**

The Employees Group Insurance Department (EGID) is a nonappropriated department of the Office of Management and Enterprise Services (OMES) and is a special-purpose state and local government engaged solely in business-type activities. EGID manages a legal trust, which administers, manages, and provides group health, dental, life, and disability insurance for active employees and retirees of state agencies, school districts, and other governmental units of the State of Oklahoma (the State). EGID is self-insured and is financed through premiums collected from employers and employees. The EGID retains a legal obligation to establish a trustee relationship whereby EGID's funds are held for the ultimate benefit of those who obtain insurance from EGID. EGID provides insurance to all statutorily defined eligible employees, dependents, and retirees.

The following brief description of EGID is provided for general information purposes only. Participants should refer to Title 74 of the Oklahoma Statutes, Sections 1301 et seq. as amended, for more complete information.

In accordance with Title 74, EGID maintains three separate programs, the Health and Dental program, the Life program, and the Disability program. There is no statutory restriction that would prevent assets accumulated in one program from paying benefits due from another program.

Effective November 1, 2012, with the consolidation discussed below in (a), there was a change in the make-up of the board. There is a seven-member board, which comprises four members appointed by the governor, one member appointed by the speaker of the House of Representatives, one member appointed by the president pro tempore of the Senate, and the Oklahoma Insurance Commissioner or his designee.

**(a) General**

In 1968, EGID was formed by the State Legislature to provide group health, dental, and life benefits to participants of the Oklahoma Public Employees Retirement System (OPERS) and active employees of the State. Subsequently, other groups became eligible for participation, including persons covered under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), survivors, and certain local government employees. COBRA allows temporary continuance of insurance coverage under certain circumstances. Survivors are individuals who were covered eligible dependents of a participant in EGID at the time of the participant's death. EGID was created by the State Legislature and could be abolished by the same body.

In 1978, EGID became self-insured and uses the trade name HealthChoice. Beginning in 1985, participants were given the option of electing health coverage from certain health maintenance organizations (HMOs). Plans similar to HMOs provide dental coverage for those participants who elect to participate in them (DMOs). In 1986, the State added a self-insured disability program administered by EGID.

In 1989, participants of the Teachers' Retirement System of Oklahoma (TRS) and active employees of school districts became eligible to enroll in EGID (educational participants). House Bill No. 1731, which provided TRS participants the option to enroll in EGID, required the TRS to transfer \$39,600,000 to EGID. The educational participants receive the same health and dental coverage

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options provided to state and local governmental participants. Life coverage was made available to active educational participants beginning July 1, 1991. Disability coverage is not available to educational participants.

Effective July 1, 1993, the Oklahoma State Employee Benefit Council (EBC) began contracting with HMOs and DMOs on behalf of state employees to provide health and dental coverage for those participants who elect such coverage.

Effective January 1, 2006, EGID's self-funded plan HealthChoice became a Medicare Part D Prescription Drug Plan pursuant to the *Medicare Prescription Drug Improvement and Modernization Act of 2003*.

In 2012, pursuant to House Bill 3053 and House Bill 3079, various agencies including EGID (formerly, the Oklahoma State and Education Employees Group Insurance Board (OSEEGIB)) were consolidated as divisions within the Office of Management and Enterprise Services (formerly, the Office of State Finance). EGID's duties were transferred to the Director of OMES and the newly created Oklahoma Employees Insurance and Benefits Board (OEIBB). Only the administrative functions of EGID were consolidated. The EGID funds continue to be held in trust and managed pursuant to state law for the benefit of its members.

Effective November 1, 2013, EGID and the Employee Benefits Department (formerly, EBC) were further consolidated under the Human Capital Management Division (HCM) of OMES and EGID became a department within OMES.

**(b) Premiums and Participants**

The health, dental, life, and disability benefits for governmental participants are funded by monthly premiums paid by the State, local governmental units, OPERS, and individuals. The health, dental, and life benefits for educational participants are funded by monthly premiums paid by school districts, the TRS, and individuals. A participant may extend coverage to dependents for an additional monthly premium based on the coverage requested. Premiums for active state employees and their dependents are collected by Employee Benefits Department and remitted to EGID or other insurer elected by the employee.

Premiums remitted to EGID on behalf of active state employees and their dependents for the years ended December 31, 2015 and 2014 are reported gross of a fee retained by EBD, which is equal to 1.15% of premiums. This fee, which was approximately \$3,403,000 and \$3,206,000 for the years ended December 31, 2015 and 2014, respectively, is included in administrative expenses in the statements of revenue, expenses, and changes in fund equity. For the years ended December 31, 2015 and 2014, premiums for local government, education, and inactive participants who have elected an HMO for health coverage or DMO for dental coverage are collected by EGID and remitted to the HMO or DMO carrier net of a fee retained by EGID of 1% of premiums. This fee, which was approximately \$1,189,000 and \$1,207,000 for the years ended December 31, 2015 and 2014, respectively, is included as an offset to administrative expenses in the statements of revenue, expenses, and changes in fund equity. The premium related to HMOs, DMOs, and vision plans was approximately \$118,249,000 and \$120,303,000 for 2015 and 2014, respectively, and, as EGID only

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acts in an agency capacity, the premiums collected on behalf of HMOs, DMOs, and vision plans are not reflected in the statements of revenue, expenses, and changes in fund equity.

Pursuant to the authority granted by Oklahoma Statute, EGID has the authority to establish and change HealthChoice premium rates for the members, employers, and other contributing entities each year. An outside consultant advises EGID regarding changes in premium rates. If premium rates are changed, they generally become effective at the beginning of the next calendar year. Each HMO, DMO, and vision plan determines its own premium rates.

At the time of premium payment, the risk of loss due to incurred benefit costs is transferred from the participant to EGID. If the assets of EGID were to be exhausted, participants would not be responsible for EGID's liabilities.

At December 31, 2015, EGID's self-funded health plan HealthChoice provided health coverage to 133 state agency divisions with approximately 25,000 primary participants (not including dependents), 600 educational entities with approximately 55,000 primary participants, 308 local government entities with approximately 8,000 primary participants, and 36 other groups, which include the governmental and educational retirement systems, COBRA, and survivors, with approximately 39,000 primary participants. Approximately 60,000 dependents participated in HealthChoice as well. In addition, EGID collected and remitted premiums for approximately 24,000 primary participants and 17,000 dependents who were covered by HMOs. These counts are provided for health coverage only.

At December 31, 2014, EGID's self-funded health plan HealthChoice provided health coverage 132 state agency divisions with approximately 23,000 primary participants (not including dependents), 594 educational entities with approximately 52,000 primary participants, 305 local government entities with approximately 8,000 primary participants, and 36 other groups, which include the governmental and educational retirement systems, COBRA, and survivors, with approximately 39,000 primary participants. Approximately 55,000 dependents participated in HealthChoice as well. In addition, EGID collected and remitted premiums for approximately 27,000 primary participants and 20,000 dependents who were covered by HMOs. These counts are provided for health coverage only.

All state agencies in Oklahoma are required to offer to their active employees the coverage selections offered by EBD. All eligible education or local government entities may elect to participate in EGID. Any education entity or local government entity, which elects to withdraw from offering EGID as an insurance option may do so with 30 days written notice and must withdraw both its current and former employee participants.

**(c) Benefits**

A provider Network arrangement is available for health and dental benefits. According to this arrangement, Network providers agree to accept amounts for covered services that do not exceed the charges allowed by EGID. Therefore, the Network provider can only expect to receive payment from the participant for the charges allowed by the Network agreement.

HealthChoice offers a high, basic, High Deductible Health Plan (HDHP), and USA option health benefit plan for non-Medicare participants. A member who elects the high option plan is responsible

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for a \$30 copayment for primary care physician or \$50 copayment for specialist and no deductible for office visits and preventive care services when using Network providers. The same services when using non-Network providers are reimbursed at 50% after the member meets a \$500 calendar year deductible. For other services, Network provider and non-Network provider benefits are generally reimbursed at 80% and 50%, respectively, after the appropriate deductibles of \$500 (\$1,500 per family). HealthChoice reimburses allowed charges at 100% once the member has reached \$3,300 and \$3,800 per member out-of-pocket maximum for Network providers and non-Network providers, respectively.

The basic option plan pays 100% of the first \$500 of allowed charges for covered medical services. The member pays 100% of the next \$1,000 (\$1,500 per family) of allowed charges. The member and HealthChoice each pay 50% of the next \$4,000 of allowed charges (\$9,000 per family). HealthChoice reimburses allowed charges at 100% once the member has reached the out-of-pocket maximum of \$4,000 (\$9,000 per family).

To enroll or remain enrolled in the HealthChoice high or basic option, the member must attest that he and his covered dependents are tobacco-free by completing an attestation as part of the annual Option Period enrollment process. If the member cannot complete the tobacco-free attestation because he or his dependents are not tobacco-free, he can still qualify for the high or basic option if they can provide proof of an attempt to quit using tobacco by enrolling in the quit tobacco program available through the Oklahoma Tobacco Helpline and Alere Wellbeing and completing three coaching calls or provide a letter from his doctor indicating it is not medically advisable for him or his dependent to quit tobacco. If a member cannot complete the tobacco-free attestation or one of the reasonable alternatives described, he will automatically be enrolled in the HealthChoice High Alternative or Basic Alternative Plan and the annual deductible and out-of-pocket limit will be \$250 higher.

In addition, for both plans, when using non-Network providers, the member is responsible for the excess of billed charges over allowed charges.

The HealthChoice HDHP option is a qualified, high deductible health plan that can be used in combination with a Health Savings Account. A member who selects the high deductible plan must meet a deductible of \$1,500 (\$3,000 per family) before any benefits are paid by the plan. Additional deductibles of \$300 for each non-Network hospital confinement and \$100 for each emergency room visit apply. After deductibles are met, the member is responsible for the same copayments and coinsurance percentages as the high option plan. There is a Network out-of-pocket limit of \$3,000 per individual or \$6,000 per family, after which HealthChoice pays 100% of allowed charges for covered services from a Network provider.

A HealthChoice USA option is offered to active participants who work outside Oklahoma and Arkansas for more than 90 consecutive days and to non-Medicare retired participants who live outside those two states. These members have the same benefits as the HealthChoice high option, but they access a nation-wide provider Network.

For all HealthChoice plans, certain preventive services are covered at 100% of allowable fees when using a Network provider.

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Pharmacy benefits are the same for the high, high alternative, basic, and basic alternative plans. Medications are categorized as generic, Preferred brand name, non-Preferred brand name, Preferred Specialty, or non-Preferred Specialty. When purchasing generic medications from a Network provider, the member is responsible for up to a \$10 copay for up to a 30-day supply or up to a \$25 copay for a 31-90 day supply of medication. For up to a 30-day supply of Preferred brand name medications, the member is responsible for up to \$45. For a 31-90 day supply of Preferred brand name medications, the member is responsible for up to \$90. For up to a 30-day supply of non-Preferred brand name medications, the member is responsible for up to \$75. For a 31-90 day supply of non-Preferred brand name medications, the member is responsible for up to \$150. All Specialty medications are covered for up to a 30-day supply and only when ordered through Accredo Health. The member is responsible for a \$100 copay for Preferred Specialty medications, and \$200 for non-Preferred Specialty medications. Certain prescription medications for smoking cessation are available at a \$0 copayment. In addition, there is an annual \$2,500 individual/\$4,000 family out-of-pocket maximum, for which only generic and Preferred medications purchased at Network Pharmacies apply. There is no out-of-pocket maximum for non-Preferred medications or medications purchased at non-Network pharmacies.

For non-Network providers, the member is responsible for 50% of the cost of the medication, plus the dispensing fee for Preferred medications, and 75% of the cost of the medication, plus the dispensing fee for non-Preferred medications.

If a brand-name medication is chosen when a generic is available, the member is responsible for the difference in cost between the brand-name medication and the generic, in addition to the applicable copay. This applies to all commercial plans, as well as all Medicare with and without Part D plans.

Allowed expenses for HealthChoice dental benefits are reimbursed at a percentage ranging from 60% to 100%, based on the class of the allowed expense, when using Network providers. The same services when using a non-Network provider are reimbursed at a percentage ranging from 50% to 100%. There is a \$25 deductible (\$75 per family) when using either Network or non-Network providers. There is a calendar year maximum dental benefit of \$2,500 per covered person.

HealthChoice basic life benefits of \$20,000 are provided to active state, education, and local government employees. In addition to the basic life benefit of \$20,000, participants may elect additional coverage in increments of \$20,000 up to \$500,000. Additional dependent life coverage is also available under three separate plans. The low option plan offers dependent life coverage of \$6,000 for spouses and \$3,000 for children. The standard option plan offers dependent life coverage of \$10,000 for spouses and \$5,000 for children. The premier option offers dependent life coverage of \$20,000 for spouses and \$10,000 for children.

Retirees may elect to retain the full coverage for basic life benefits held at the time of termination of employment. Coverage thereafter may be decreased in \$5,000 increments to a minimum of \$5,000 or totally terminated. Prior to July 1, 2002, no more than \$15,000 of basic life insurance could be retained after termination of employment. The retiree may retain dependent life coverage in force on eligible dependents in \$500 increments.

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HealthChoice disability benefits are based on the length of employment, base salary limited by a maximum allowable salary, and length of disability. There is a 30-day qualifying period for short-term disability. Long-term disability becomes effective 180 days after disablement. Income from other sources is used to reduce the benefit amount. The duration of the long-term benefit is determined based upon the age of the participant at disablement and length of employment.

A high option and low option HealthChoice Medicare supplement benefit plan is available to those retired participants and their dependents who are eligible to enroll in Medicare, where Medicare is the primary payor. This coverage provides for reimbursement of Medicare-eligible expenses, which may not be fully covered by or which exceed the amount allowed by Medicare. Medicare Part A expenses are generally reimbursed at 100% of eligible Medicare expenses not reimbursed by Medicare. The Medicare Part A deductible is also fully reimbursed by HealthChoice. Medicare Part B expenses are generally reimbursed at 20% of eligible Medicare expenses not reimbursed by Medicare.

EGID has adopted Plan “G modified” for medical benefits for both the high option and low option plans in accordance with the National Association of Insurance Commissioners’ schedule of Medicare supplement plans, with the addition of a pharmacy prescription program, preventive care benefits, out-of-country benefits, and an at-home recovery benefit.

Pharmacy benefits for the HealthChoice High Option Medicare Supplement Plan are very similar to the HealthChoice High Option Plan. The High Option with Part D copay structure is the same as the copay structure for the High Option Plan, with the exception of Specialty medications. The High Option with Part D Plan does not have a non-Preferred Specialty medication copay and all Specialty medications have a \$100 copay. High Option with Part D plan members who reach total drug costs of \$2,960 receive a 50% discount toward their copay costs when purchasing covered brand-name medications. There are also a few minor differences in the formulary. The low option Medicare supplement plan is modeled after the Center for Medicare and Medicaid Services (CMS) standard Part D plan design. Once a participant reaches catastrophic coverage, EGID pays 100% of the pharmacy cost rather than 95% per CMS’ standard Part D plan design. In addition, HealthChoice Low Option with Part D members who reach total drug costs of \$2,960 receive a 55% discount on the cost of covered brand-name medications, and HealthChoice pays 35% of the cost of generic medications.

Health benefits and dental benefits are provided directly by the HMOs and DMOs for all participants who elect such coverage. For each participant who elects HMO or DMO coverage, excluding active state employees, EGID collects and pays the premiums to each HMO or DMO carrier. For each active state employee who elects HMO or DMO coverage, EBD collects and pays the premiums to each HMO or DMO carrier. The amounts paid by EGID to each HMO or DMO are in accordance with their respective contracts. Benefits are the responsibility of each HMO or DMO carrier and are subject to the provisions defined in their insurance policies. EGID has no liability for health benefits or dental benefits of participants who elect HMO or DMO coverage; therefore, activity related to HMO, DMO, and vision benefits are not reflected in the basic financial statements of EGID.

All benefits for HealthChoice are processed and paid by third-party administrators (TPAs). The fees incurred by EGID for services performed by the TPAs totaled approximately \$22,754,000 and

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\$21,754,000 for the years ended December 31, 2015 and 2014, respectively. TPA fees are included in administrative expenses in the statements of revenue, expenses, and changes in fund equity.

A summary of available coverage and eligible groups for the years ended December 31, 2015 and 2014 is as follows:

	<u>State employee</u>	<u>Education employee</u>	<u>Local government employee</u>	<u>OPERS</u>	<u>TRS</u>	<u>COBRA</u>
Health	X	X	X	X	X	X
Dental	X	X	X	X	X	X
Life	X	X	X	X	X	
Disability	X					
Medicare supplement			X	X	X	X

**(2) Summary of Significant Accounting Policies**

**(a) Basis of Accounting**

EGID's basic financial statements are prepared in accordance with U.S. generally accepted accounting principles as they apply to governmental units. The Governmental Accounting Standards Board (GASB) is the accepted standard setting body for establishing governmental accounting and financial reporting principles.

**(b) Use of Estimates**

The preparation of financial statements in conformity with U.S. generally accepted accounting principles requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the financial statements and the reported amounts of revenue and expenses during the reporting period. Management evaluates its estimates and assumptions on an ongoing basis using historical experience and other factors, including the current economic environment, which management believes to be reasonable under the circumstances. EGID adjusts such estimates and assumptions when facts and circumstances dictate. As future events and their effects cannot be determined with precision, actual results could differ significantly from these estimates. Changes in those estimates resulting from continuing changes in the economic environment will be reflected in the financial statements in future periods.

**(c) Investments and Investment Income**

Investments are stated at fair value based on quoted prices with changes in fair value included in the statements of revenue, expenses, and changes in fund equity. If quoted prices are not available from active exchanges for identical instruments, then fair values are estimated using quoted prices from less active markets, quoted prices of securities with similar characteristics, or by pricing models utilizing other significant observable inputs. Investments in external investment pools, such as commingled funds, are stated at fair value based on actual transaction values. There was no difference in the fair value and the net asset value in the pool of shares in the commingled fund at December 31, 2015 and 2014.

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EGID records investment purchases and sales based upon the trade date. Therefore, EGID records either receivables or payables for unsettled sales or purchases, respectively. Such transactions are usually settled within a few days after the trade date.

Realized gains and losses are determined on the average-cost method. The calculation of realized gains and losses is independent of the calculation of the change in net unrealized gains and losses. Realized gains and losses on investments that had been held in more than one year and sold in the current year may have been recognized as unrealized gains and losses in prior years.

Interest income is recorded on the accrual basis. Dividends are recorded on the ex-dividend date.

**(d) Office Equipment**

Office equipment is recorded at cost and depreciated on a straight-line basis over the estimated useful lives of the equipment, which range from 5 to 10 years. Purchases of equipment costing less than \$2,500 are considered to be immaterial and are expensed when purchased.

**(e) Reserves**

EGID establishes HealthChoice health and dental and life reserves based on the ultimate estimated cost of settling claims that have been reported but not settled, and of claims that have been incurred but not yet reported. HealthChoice disability reserves are also established based on the estimated ultimate cost of settling claims of participants currently receiving benefits and for disability claims incurred but not yet reported to EGID. Long-term disability reserves are carried at the present value of expected future benefits. The reserves are determined using EGID's historical benefit payment experience. These estimates are based on data available at the time of estimate and are reviewed by EGID's independent consulting actuaries. The health, dental, and life reserves and the disability reserves include liabilities for claim processing expenses associated with paying claims, which have been incurred, but not yet paid. The length of time for which costs must be estimated depends on the coverage involved.

Although reserves reflect EGID's best estimates of the incurred claims to be paid, due to the complex nature of the factors involved in the calculation, the actual results may be more or less than the estimate. The claim reserves are recomputed on a periodic basis using actuarial and statistical techniques, which consider the effects of general economic conditions, such as inflation, and other factors of past experience, such as changes in participant counts. Adjustments to claim reserves are recorded in the periods in which they are made. Claims must be filed no later than the last day of the calendar year immediately following the calendar year in which the loss is sustained unless an extenuating circumstance can be shown to exist.

Premium deficiency reserves are required to be recorded when the anticipated costs of settling claims plus policy maintenance costs for the following fiscal year are in excess of the anticipated premium receipts and investment income for the following fiscal year.

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**(f) Fund Equity**

At December 31, 2015 and 2014, EGID has no legally required minimum fund equity. However, EGID has elected to set a benchmark for minimum fund equity based upon the National Association of Insurance Commissioners (NAIC), the Managed Care Organizations Risk Based Capital Formula for the Health and Dental program, and the NAIC Life/Health Risk Based Capital Formula for the Life and Disability programs. EGID utilizes the NAIC Risk Based Capital methodology to establish the fund equity benchmark. The minimum fund equity benchmark by EGID at December 31, 2015 and 2014 is approximately \$195,393,000 and \$184,473,000, respectively.

The NAIC Risk Based Capital Formulas were selected as the basis for determining minimum fund equity primarily due to the following factors:

- Degree and nature of the risks undertaken
- Size of EGID
- Degree of conservatism inherent in the premium rates
- Degree of safety desired

The primary risks that would threaten EGID's solvency include the following:

- The risk that claims incurred will exceed premiums collected
- The risk of default or decline in value of EGID's assets
- The risk of large monetary judgments stemming from possible lawsuits against EGID

A comparison of the minimum fund equity benchmark by EGID and unrestricted fund equity at December 31, 2015 and 2014 as reported in the basic financial statements is as follows (in thousands):

	<b>2015</b>
	<b>Total</b>
	<hr/>
Minimum fund equity	\$ 195,393
Unrestricted fund equity	196,760
	<hr/>
	<b>2014</b>
	<b>Total</b>
	<hr/>
Minimum fund equity	\$ 184,473
Unrestricted fund equity	264,903

As part of the rate setting process, EGID considers total fund equity in comparison with the minimum fund equity benchmark in setting rates toward achieving the minimum fund equity benchmark. Title 74 of the Oklahoma Statutes, Section 1321C provides that EGID may adjust rates mid-year if the need

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is substantiated by an actuarial determination. Consistent with prior years, EGID does not anticipate the need for a mid-year rate adjustment for 2016.

**(g) Premiums**

Premiums are recognized in the period when the insurance coverage is provided. Premiums are due monthly from the employers or participants based on the rates adopted by EGID.

**(h) Medicare Part D Subsidies**

As a Medicare Part D Prescription Drug Plan (PDP), EGID receives a monthly payment from Medicare. The effect of these payments is to subsidize premiums for the individuals enrolled in the PDP since they pay a reduced premium rate. This amount is approximately \$13,474,000 and \$13,664,000 for the years ended December 31, 2015 and 2014, respectively, and is included in premium revenue within the statements of revenue, expenses, and changes in fund equity.

Additionally, Medicare pays EGID a catastrophic reinsurance subsidy as a cost reimbursement for 80% of the claim costs incurred by individuals in excess of the individual annual out-of-pocket maximum. A settlement is made based on actual cost experience subsequent to the end of the year. EGID accrued approximately \$18,811,000 and \$14,636,000 at December 31, 2015 and 2014, respectively, and is included in other, net in the balance sheets.

**(i) Pharmacy Rebate**

Effective January 1, 1999, under EGID's agreement with its pharmacy benefit manager, EGID receives a guaranteed rebate for each non-Medicare Part D prescription. Effective January 1, 2006, EGID also receives a specified percentage of manufacturers' rebates received by the pharmacy benefit manager related to Medicare Part D prescriptions. This amount is approximately \$15,169,000 and \$13,271,000 for the years ended December 31, 2015 and 2014, respectively, and is included as an offset to incurred claims expense within the statements of revenue, expenses, and changes in fund equity.

**(j) Risk Adjustment Premiums**

Risk adjustment premiums are received from HMOs based on factors, which are applied to premiums remitted to HMOs for all non-Medicare primary members during the plan year; the factors are intended to offset any adverse selection that may occur to EGID as a result of younger, healthier members electing HMO coverage. This amount is approximately \$74,000 and \$931,000 for the years ended December 31, 2015 and 2014, respectively, and is included in other operating revenue within the statements of revenue, expenses, and changes in fund equity.

**(k) Administrative Expenses**

Administrative expenses are primarily related to employees of EGID and professional services, including fees paid to TPAs to process and pay benefits.

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EGID does not record deferred acquisition costs since administrative expenses are primarily maintenance expenses and not acquisition expenses. EGID maintains a budget; however, it is not a legally adopted annual budget.

**(l) Transitional Reinsurance Fees**

The Affordable Care Act (ACA) was signed into law on March 23, 2010. Several significant new provisions were enacted in 2014, including the Transitional Reinsurance Program. The federal government sponsors a Transitional Reinsurance Program designed to stabilize the Individual insurance marketplace during the first three years of the new ACA Exchange initiative.

To fund this program, all Commercial health insurance companies and employers providing self-insured plans are required to pay an annual per member fee (\$44 and \$63 in 2015 and 2014, respectively), which decreases over the three-year transition period. A portion of the annual funding (17%–25%) is apportioned to the Treasury Department. The remainder is used to fund covered claims.

EGID accrues the estimated amount of the annual fees based on projected current year membership, which is submitted to the federal government in November of each year. The claim funding portion of the fee is payable in January of the following year. The Treasury portion is payable in November of the following year. The transitional reinsurance fees are accounted for as federal assessment fees in administrative and claims processing in the statements of revenue, expenses, and changes in fund equity.

EGID accrued approximately \$6,575,000 and \$8,877,000 at December 31, 2015 and 2014, respectively, for the payment of Transitional Reinsurance fees due in 2016 and is included in other accrued liabilities in the balance sheets.

**(m) Income Taxes**

EGID obtained its latest determination letter dated March 30, 2005, in which the Internal Revenue Service stated that income from the exercise of the essential governmental functions of EGID is exempt from federal income taxes under Section 115 of the Internal Revenue Code (the Code).

**(n) Operating Revenue and Expenses**

Balances classified as operating revenue and expenses are those, which comprise the EGID's principal ongoing operations. Since EGID's operations are similar to those of any other insurance company, most revenue and expenses are considered operating.

**(o) Pension**

For purposes of measuring the net pension liability, deferred outflows of resources and deferred inflows of resources related to pensions and pension expense, information about the fiduciary net position of the Oklahoma Public Employees Retirement Plan (the Plan), and additions to/deductions from the Plan's fiduciary net position have been determined on the same basis as they are reported by the Plan. For this purpose, benefit payments (including refunds of employee contributions) are

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recognized when due and payable in accordance with the benefit terms. Investments are reported at fair value.

**(p) Recently Issued Accounting Standards**

In June 2012, the GASB issued Statement No. 68, *Accounting and Financial Reporting for Pensions* (GASB 68). The objective of this statement is to improve the accounting and financial reporting by state and local governments for pensions. This Statement establishes standards for measuring and recognizing liabilities, deferred outflows of resources, deferred inflows of resources, and expense/expenditure. For defined benefit pensions, this Statement identifies the methods and assumptions that should be used to project benefit payments, discount projected benefit payments to their actuarial present value, and attribute that present value to periods of employee service. In financial statements prepared using the economic resources measurement focus and accrual basis of accounting, a cost-sharing employer that does not have a special funding situation is required to recognize a liability for its proportionate share of the net pension liability. EGID adopted GASB 68 in 2015 and presented the cumulative effect of applying GASB 68 as a restatement of beginning fund balance as of January 1, 2014. The impact of this adoption was a cumulative effect of \$4,030,679 on 2014 beginning of the year fund equity.

In May 2015, the FASB issued ASU 2015-09, *Financial Services – Insurance: Disclosures about Short-Duration Contracts*. ASU 2015-09 expands the disclosures an insurance entity would provide about its short duration contracts. The disclosure about the liability for unpaid claims and claim adjustment expenses is intended to increase the transparency of significant estimates made in the measuring of those liabilities and provide insight into an insurance entity's ability to underwrite and anticipate costs associated with claims. The amended guidance is effective for annual reporting periods beginning after December 15, 2016 and for interim reporting periods beginning after December 15, 2017. The guidance affects disclosures only and will not impact EGID's results of operations or financial position.

**(q) Prior Year Classifications**

Certain 2014 balances have been reclassified to conform to 2015 presentation.

**(3) Fair Values of Financial Instruments**

Accounting Standards Codification Topic 820, *Fair Value of Measurement*, requires EGID to disclose estimated fair values for its financial instruments. Fair value estimates are made at a point in time, based on relevant market data as well as the best information available about the financial instruments. Fair value estimates for financial instruments for which no or limited observable market data is available are based on judgments regarding current economic conditions, credit and interest rate risk, and loss experience. These estimates involve significant uncertainties and judgments and cannot be determined with precision. As a result, such calculated fair value estimates may not be realizable in a current sale or immediate settlement of the instrument. In addition, changes in the underlying assumptions used in the fair value measurement technique, including discount rate and estimates of future cash flows, could significantly affect these fair values. Fair value estimates, methods, and assumptions at December 31, 2015 and 2014 are described below

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for EGID's financial instruments. The carrying value of all EGID's financial instruments approximates fair value.

In accordance with guidance on fair value measurements and disclosures, EGID groups its financial assets and liabilities measured at fair value in three levels, based on inputs and assumptions used to determine the fair value. An asset's or liability's classification within the fair value hierarchy is based on the lowest level of significant input to its valuation. The levels are as follows:

- Level 1 inputs are quoted prices in active markets for identical securities.
- Level 2 inputs are other significant observable inputs (including quoted prices for similar securities, interest rates, prepayment speeds, credit risk, etc.).
- Level 3 inputs are significant unobservable inputs (including the EGID's own assumptions used to determine the fair value of investments).

The carrying amounts reported in the balance sheets are at fair value for investment securities. Fair values for debt securities are based on quoted market prices, where available. If quoted prices are not available from active exchanges for identical instruments, the fair values are estimated using quoted prices from less active markets, quoted prices of securities with similar characteristics, or by pricing models utilizing other significant observable inputs. The debt securities fair values are considered Level 2. The fair values for equity securities are based on quoted market prices and are considered Level 1.

The carrying values of the receivable for unsettled investment sales, premiums receivable, interest and dividends receivable, pharmacy rebate receivable, other receivables, premiums due to HMOs and other insurers, payable for investment purchases, and other accrued liabilities approximate fair value due to the short maturity of these financial instruments and the fact that they do not present undue credit concerns and are considered Level 2.

**(4) Cash and Cash Equivalents**

Cash includes amounts on deposit with the Office of State Treasurer (State Treasurer) in a pooled account, which is required by the Oklahoma Statutes to be insured or collateralized. The amount of collateral securities required to be pledged to secure public deposits is established by rules and regulations promulgated by the State Treasurer. In accordance with the State Treasurer's policies, the market value of collateral securities to be pledged by financial institutions through the State Treasurer's Office must be 110% of the carrying value of the amount on deposit, less any federal insurance coverage.

At December 31, 2015 and 2014, cash totaling \$32,799,000 and \$59,695,000, respectively, was deposited with and collateralized by the official bond of the State Treasurer of Oklahoma.

The carrying amount and bank balance of the cash equivalents totaled \$57,550,000 and \$28,626,000 at December 31, 2015 and 2014, respectively, and consists of an investment in a mutual fund composed of short-term investments with an original maturity date of three months or less, which are readily convertible into cash. The current duration of the underlying investments in the money market mutual fund is approximately 37 days.

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***Custodial Credit Risk***

Custodial credit risk for deposits is the risk that in the event of a bank failure, EGID's deposits may not be returned or EGID may not be able to recover collateral securities in the possession of an outside party. EGID's cash and cash equivalents include deposits that are insured, registered, or for which the securities are held by a custodian in EGID's name.

**(5) Investments**

EGID's investment policy is predicated on a multiple manager structure to provide the benefits of more than one manager's special skills and a diversity of investment styles. Upon recommendation of the OEIBB, external managers are appointed to assume the investment management function. The managers, within guidelines determined by EGID's Board, have full discretion to buy and sell investment assets of EGID. Authorized investments are defined in Title 36 of the Oklahoma Statutes, as amended, and EGID's investment policy, and include U.S. government obligations, state and district obligations, corporate obligations, mortgage-backed and assets-backed debt securities, and Preferred and common stock. All investments held by EGID are in compliance with statutes and the investment policy.

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As of December 31, 2015 and 2014, EGID had the following investments:

<u>Types of investments</u>	<u>2015</u>		<u>2014</u>	
	<u>Fair values</u>	<u>Duration <sup>(1)</sup></u>	<u>Fair values</u>	<u>Duration <sup>(1)</sup></u>
Debt securities:				
Commingled fund	\$ —	—	\$ 95,310,791	3.89
Asset-backed securities <sup>(2)</sup>	9,399,090	1.71	5,145,861	0.92
Agencies	12,576,987	4.78	33,396,712	3.70
Corporate	63,440,423	5.57	36,190,466	6.07
Mortgages	13,851,444	3.66	10,804,255	3.01
Collateralized mortgage obligations <sup>(2)</sup>	1,173,221	1.24	2,067,731	1.52
U.S. Treasuries	39,710,383	9.79	8,850,601	9.42
Municipals	725,102	1.32	1,336,111	11.72
USD denominated foreign government	721,134	8.44	1,709,554	7.83
Collateralized mortgage-backed securities (CMBS) <sup>(2)</sup>	8,025,628	4.25	5,894,133	3.72
Certificates of Deposit (CDs)	2,200,538	3.06	1,941,070	1.29
Total debt securities	151,823,950		202,647,285	
Equities:				
Domestic	91,833,593		120,809,785	
Total investments	\$ 243,657,543		\$ 323,457,070	

<sup>(1)</sup> Interest rate risk is estimated using effective duration (in years).

<sup>(2)</sup> These include investments highly sensitive to interest rate changes.

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**(a) Credit Risk**

The credit risk profile as listed by Moody's or Standard & Poor's for debt securities and money market mutual funds at December 31, 2015 and 2014 is as follows:

		2015					
		Aaa	Aa/A	Baa/Ba	Ccc	Not rated	Total
Debt securities:							
Asset-backed securities	\$	8,447,133	39,816	912,141	—	—	9,399,090
Agencies		12,052,312	—	524,675	—	—	12,576,987
Corporate		1,083,959	23,571,328	38,741,886	43,250	—	63,440,423
Mortgages		13,851,444	—	—	—	—	13,851,444
Collateralized mortgage obligations		853,229	128,084	191,908	—	—	1,173,221
U.S. Treasuries		39,710,383	—	—	—	—	39,710,383
Municipals		—	725,102	—	—	—	725,102
USD denominated foreign government		721,134	—	—	—	—	721,134
CMBS		7,255,603	94,530	519,167	—	156,328	8,025,628
CDs		2,200,538	—	—	—	—	2,200,538
Total debt securities		<u>\$ 86,175,735</u>	<u>24,558,860</u>	<u>40,889,777</u>	<u>43,250</u>	<u>156,328</u>	<u>151,823,950</u>
Money market mutual funds	\$	—	—	—	—	57,550,492	57,550,492

		2014					
		Aaa	Aa/A	Baa/Ba	Ccc	Not rated	Total
Debt securities:							
Commingled fund <sup>(1)</sup>	\$	—	—	—	—	95,310,791	95,310,791
Asset-backed securities		4,292,550	853,311	—	—	—	5,145,861
Agencies		33,396,712	—	—	—	—	33,396,712
Corporate		8,099,475	19,482,586	8,608,405	—	—	36,190,466
Mortgages		10,804,255	—	—	—	—	10,804,255
Collateralized mortgage obligations		1,836,541	—	—	231,190	—	2,067,731
U.S. Treasuries		8,850,601	—	—	—	—	8,850,601
Municipals		1,336,111	—	—	—	—	1,336,111
USD denominated foreign government		—	1,709,554	—	—	—	1,709,554
CMBS		5,894,133	—	—	—	—	5,894,133
CDs		—	—	—	—	1,941,070	1,941,070
Total debt securities		<u>\$ 74,510,378</u>	<u>22,045,451</u>	<u>8,608,405</u>	<u>231,190</u>	<u>97,251,861</u>	<u>202,647,285</u>
Money market mutual funds	\$	—	—	—	—	28,626,404	28,626,404

<sup>(1)</sup> There is no rating on the commingled fund; however, the average rating of the underlying investments in the commingled fund as provided by the fund manager is Aa at December 31, 2014.

Credit risk is the risk an issuer or other counterparty to an investment will not fulfill its obligations. The Board's investment policy authorizes EGID to invest in obligations of the U.S. Treasury, agencies and instrumentalities, bankers' acceptances rated AA or better, commercial paper rated A-1 or P-1 and

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A-2 or P-2, fixed income investments rated investment grade and stocks of companies with a minimum capitalization of \$50,000,000, and other investments of similar risk.

Investments in “restricted securities,” including fixed income securities, preferred stock, common stock, or any common stock acquired upon conversion thereof are prohibited. “Restricted securities” are securities, which have not been registered under the Securities Act of 1933 and are subject to restrictions on sale. Engagements in short sales, purchases on margin, or investments in commodities or transactions of a similar or speculative nature are prohibited. EGID is in compliance with its investment policy for the years ended December 31, 2015 and 2014.

**(b) Custodial Credit Risk**

Custodial credit risk for investments is the risk that, in the event of the failure of the counterparty, EGID will not be able to recover the value of its investments or collateral securities in the possession of an outside party. The current master custodian has been approved by EGID’s Board. EGID’s investments include investments that are insured or registered or for which the securities are held by a custodian in EGID’s name. They may also include investments held for the custodian by the Federal Reserve Bank or Depository Trust Corporation in EGID’s name.

**(c) Concentration of Credit Risk**

An increased risk of loss occurs as more investments are acquired from one issuer. EGID’s policy states investments in one issuer shall not exceed 2.5% of the fair value of each manager’s assets, except for obligations of the U.S. government or of any state of the U.S. The policy also restricts investments in the common stock of any U.S. corporation to no more than 5% of each manager’s assets valued at the lower of cost or market value, except where the manager’s benchmark holds more than 5% in a single issue or with prior consent of EGID’s Board.

**(d) Interest Rate Risk**

Interest rate risk is the risk changes in interest rates will adversely affect the fair value of an investment. Fixed income investments held for longer periods are subject to increased risk of adverse interest rate changes.

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**(e) Investment Income**

Net investment income for the years ended December 31, 2015 and 2014 comprises the following:

	<u>2015</u>	<u>2014</u>
Fixed income securities	\$ 4,666,868	2,962,201
Equity securities	238,820	320,099
Realized gains	22,354,552	9,089,036
Unrealized (loss) gain	(21,601,556)	10,372,607
Other investment loss	(347)	(1,070)
Less investment expenses	<u>(711,418)</u>	<u>(605,526)</u>
Net investment income	<u>\$ 4,946,919</u>	<u>22,137,347</u>

**(6) Office Equipment**

The changes in office equipment for the years ended December 31, 2015 and 2014 are as follows:

	<u>2015</u>	<u>2014</u>
Office equipment, at cost:		
Balance, beginning of year	\$ 5,244,203	4,708,483
Additions	1,413,648	598,410
Retirements	<u>(2,376,692)</u>	<u>(62,690)</u>
Balance, end of year	<u>4,281,159</u>	<u>5,244,203</u>
Accumulated depreciation:		
Balance, beginning of year	3,457,200	3,354,866
Depreciation expense	502,695	165,024
Retirements	<u>(2,376,692)</u>	<u>(62,690)</u>
Balance, end of year	<u>1,583,203</u>	<u>3,457,200</u>
Office equipment, net	<u>\$ 2,697,956</u>	<u>1,787,003</u>

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**(7) Health and Dental and Life Reserves**

The following represents changes in the Health and Dental and Life Reserves during the year ended December 31, 2015 (in thousands):

	<u>Health and Dental</u>	<u>Life</u>	<u>Total</u>
Reserves, beginning of year	\$ 108,063	6,275	114,338
Incurred claims expense provisions for insured events of the current year	986,857	27,503	1,014,360
Changes in provisions for insured events of prior years	<u>(1,518)</u>	<u>738</u>	<u>(780)</u>
	<u>985,339</u>	<u>28,241</u>	<u>1,013,580</u>
Less payments:			
Claims expense insured events of the current year	878,100	24,593	902,693
Claims expense insured events of prior years	<u>102,816</u>	<u>4,408</u>	<u>107,224</u>
	<u>980,916</u>	<u>29,001</u>	<u>1,009,917</u>
Reserves, end of year	<u>\$ 112,486</u>	<u>5,515</u>	<u>118,001</u>

As a result of changes in estimates of insured events in prior years, the provision for claims decreased by approximately \$780,000 in the year ended December 31, 2015, due primarily to favorable health and dental claims development.

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The following represents changes in the Health and Dental and Life Reserves during the year ended December 31, 2014 (in thousands):

	<b>Health and Dental</b>	<b>Life</b>	<b>Total</b>
Reserves, beginning of year	\$ 91,003	7,070	98,073
Incurred claims expense provisions for insured events of the current year	908,574	25,615	934,189
Changes in provisions for insured events of prior years	(7,795)	791	(7,004)
	900,779	26,406	927,185
Less payments:			
Claims expense insured events of the current year	804,541	22,064	826,605
Claims expense insured events of prior years	79,178	5,137	84,315
	883,719	27,201	910,920
Reserves, end of year	\$ 108,063	6,275	114,338

As a result of changes in estimates of insured events in prior years, the provision for claims decreased by approximately \$7,004,000 in the year ended December 31, 2014, due primarily to favorable development on Medicare catastrophic reinsurance subsidy of approximately \$13,393,000 less adverse development of approximately \$6,389,000 on health and dental claims development.

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**(8) Disability Reserves**

The following represents changes in the disability reserves during the years ended December 31, 2015 and 2014 (in thousands):

	<b>2015</b>	<b>2014</b>
Reserves, beginning of year	\$ 13,455	14,804
Incurred claims:		
Provisions for insured events of the current year	4,564	4,604
Changes in provisions for insured events of prior years	(2,769)	(2,407)
	1,795	2,197
Payments:		
Claims attributable to insured events of the current year	735	629
Claims attributable to insured events of prior years	2,386	2,917
	3,121	3,546
Reserves, end of year	\$ 12,129	13,455

EGID estimates current and noncurrent reserves for disability reserves based on historical claim experience.

As a result of changes in estimates of insured events in prior years, the provision for disability reserves decreased by approximately \$2,769,000 and \$2,407,000 in the years ended December 31, 2015 and 2014, respectively, due primarily to favorable claims development.

The following is a brief description of the significant assumptions used for disability reserves:

- Actual claim experience for the group, based upon claim lag studies, was used for males and females for short-term disability.
- The 2012 Group Long-term Disability Valuation Table was used.
- The discount rate was 3.5% for the years ended December 31, 2015 and 2014.

**(9) Premium Deficiency Reserve**

A premium deficiency reserve is recorded at the end of the year when the anticipated costs of settling claims plus policy maintenance costs for the following year are in excess of the anticipated premium receipts and investment income for the following year. Anticipated premium receipts are projected based on the premium rates adopted by EGID for the following plan year and current enrollment levels. Incurred claims for subsequent years are projected based on current year incurred claims, increased for anticipated inflation rates and benefit design changes. EGID does not have the intention to change the adopted premium rates after the fiscal year has begun. For 2015, a premium deficiency for the health and dental plans was booked in the amount of approximately \$40,677,000 and \$3,289,000, respectively. For 2014, a premium deficiency for the health and dental plans was booked in the amount of approximately \$53,916,000 and \$304,000, respectively.

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For the disability plan, at December 31, 2015, no premium deficiency was necessary. At December 31, 2014, a premium deficiency of approximately \$111,000 was booked.

**(10) General Information About the Pension Plan**

*Plan description.* EGID contributes to the Oklahoma Public Employees Retirement Plan, a cost-sharing multiple-employer public employee retirement system administered by the Oklahoma Public Employees Retirement System (OPERS). The Plan provides retirement, disability, and death benefits to plan members and beneficiaries. The benefit provisions are established and may be amended by the legislature of the State of Oklahoma. Title 74 of the Oklahoma Statutes, Sections 901-943, as amended, assigns the authority for management and operation of the Plan to the Board of Trustees of OPERS. OPERS issues a publicly available annual financial report that includes financial statements and required supplementary information for the Plan. That annual report may be obtained by writing to OPERS, P.O. Box 53007, Oklahoma City, Oklahoma 73152 or at [www.opers.ok.gov/](http://www.opers.ok.gov/).

*Benefits Provided.* Members qualify for full retirement benefits at their specified normal retirement age or, for any person who became a member prior to July 1, 1992, when the sum of the member's age and years of credited service equals or exceeds 80 (Rule of 80), and for any person who became a member after June 30, 1992, when the member's age and years of credited service equals or exceeds 90 (Rule of 90).

Normal retirement date is further qualified to require that all members employed on or after January 1, 1983 must have six or more years of full-time equivalent employment with a participating employer before being eligible to receive benefits. Credited service is the sum of participating and prior service. Prior service includes nonparticipating service before January 1, 1975, or the entry date of the employer and active wartime military service.

A member with a minimum of ten years of participating service may elect early retirement with reduced benefits beginning at age 55 if the participant became a member prior to November 1, 2011, or age 60 if the participant became a member on or after November 1, 2011.

Disability retirement benefits are available for members having eight years of credited service whose disability status has been certified as being within one year of the last day on the job by the Social Security Administration. Disability retirement benefits are determined in the same manner as retirement benefits, but are payable immediately without an actuarial reduction.

*Contributions.* Plan members and EGID are required to contribute at a rate set by statute. The contribution requirements of plan members and EGID are established and may be amended by the legislature of the State of Oklahoma. The contribution rate for EGID and plan members is as follows:

	<b>Employee rate</b>	<b>Employer rate</b>
January 1, 2015–December 31, 2015	3.5%	16.5%
January 1, 2014–December 31, 2014	3.5	16.5
July 1, 2013–December 31, 2013	3.5	16.5

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EGID's contributions to the Retirement Plan for the years ended December 31, 2015 and 2014 were approximately \$1,075,000 and \$1,127,000, respectively, and were equal to EGID's required contributions for the year.

***Pension Liabilities, Pension Expense, and Deferred Outflows of Resources and Deferred Inflows of Resources Related to Pensions***

At December 31, 2015 and 2014, EGID reported a liability of approximately \$1,352,000 and \$755,000, respectively, for its proportionate share of the net pension liability. The net pension liability was measured as of June 30, 2015 and 2014, and the total pension liability used to calculate the net pension liability was based on the employer contributing entity's percentage of the total employer contributions for the years ended June 30, 2015 and 2014. At June 30, 2015 and 2014, EGID's proportion was approximately 0.376 and 0.411%, respectively.

For the years ended December 31, 2015 and 2014, EGID recognized pension (benefit) expense of approximately \$(293,000) and \$51,000, respectively. At December 31, 2015, EGID reported deferred outflows of resources and deferred inflows of resources related to pensions from the following sources:

	<b>Deferred outflows of resources</b>	<b>Deferred inflows of resources</b>
Difference between expected and actual experience	\$ —	150,362
Changes of assumptions	21,039	—
Net difference between projected and actual earnings on pension plan investments	1,116,448	1,729,875
EGID contributions subsequent to the measurement date	507,571	—
	<u>\$ 1,645,058</u>	<u>1,880,237</u>

At December 31, 2014, EGID reported deferred outflows of resources and deferred inflows of resources related to pensions from the following sources:

	<b>Deferred outflows of resources</b>	<b>Deferred inflows of resources</b>
Difference between expected and actual experience	\$ —	249,956
Changes of assumptions	43,204	—
Net difference between projected and actual earnings on pension plan investments	—	2,523,133
EGID contributions subsequent to the measurement date	529,572	—
	<u>\$ 572,776</u>	<u>2,773,089</u>

\$507,571 reported as deferred outflows of resources related to pensions resulting from EGID contributions subsequent to the measurement date will be recognized as a reduction of the net pension liability in the year

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ended December 31, 2016. Other amounts reported as deferred outflows of resources and deferred inflows of resources related to pensions will be recognized in pension expense as follows:

Year ended December 31:		
2016	\$	(399,405)
2017		(323,451)
2018		(299,006)
2019		279,113

*Actuarial assumptions.* The total pension liability in the June 30, 2015 and 2014 actuarial valuation was determined using the following actuarial assumptions, applied to all periods included in the measurement:

Actuarial cost method	Entry age normal
Inflation	3
Salary increases	4.5% to 8.4%, including inflation
Investment rate of return	7.5%, net of pension plan investment expense, including inflation

Mortality rates were based on the RP-2000 Combined Active/Retired Healthy Mortality Table projected to 2010 using Scale AA (disabled members were set forward 15 years).

The actuarial assumptions used in the June 30, 2015 and 2014 valuation were based on the results of the most recent actuarial experience study, which covered the three-year period ending June 30, 2013.

The long-term expected rate of return on pension plan investments was determined using a log-normal distribution analysis in which best estimate ranges of expected future real rates of return (expected returns, net of pension plan investment expense and inflation) are developed for each major asset class. These ranges are combined to produce the long-term expected rate of return by weighing the expected future real rates of return by the target asset allocation percentage and by adding expected inflation. The target asset allocation and best estimates of geometric real rates of return for each major asset class are summarized in the following table:

Asset class	Target allocation	Long-term expected real rate of return
U.S. Large Cap Equity	38.0%	5.3%
U.S. Small Cap Equity	6.0	5.6
U.S. Fixed Income	25.0	0.7
International Stock	18.0	5.6
Emerging Market Stock	6.0	6.4
TIPS	3.5	0.7
Rate Anticipation	3.5	1.5
Total	100.0%	

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*Discount rate.* The discount rate used to measure the total pension liability was 7.50%. The projection of cash flows used to determine the discount rate assumed that contributions from plan members and the employers will be made at the current contribution rate as set out in state statute. Based on those assumptions, the pension plan's fiduciary net position was projected through 2114 to be available to make all projected future benefit payments of current plan members. Therefore, the long-term expected rate of return on pension plan investments was applied to all periods of projected benefit payments to determine the total pension liability. The discount rate determined does not use a municipal bond rate.

*Sensitivity of EGID's proportionate share of the net pension liability to changes in the discount rate.* The following presents EGID's proportionate share of the net pension liability calculated using the discount rate of 7.5%, as well as what EGID's proportionate share of the net pension liability would be if it were calculated using a discount rate that is one percentage point lower (6.5%) or one percentage point higher (8.5%) than the current rate:

	<b>2015</b>		
	<b>1% Decrease (6.5%)</b>	<b>Discount rate (7.5%)</b>	<b>1% Increase (8.5%)</b>
EGID's proportionate share of the net pension liability (asset)	\$ 5,039,156	1,352,338	(1,782,043)
	<b>2014</b>		
	<b>1% Decrease (6.5%)</b>	<b>Discount rate (7.5%)</b>	<b>1% Increase (8.5%)</b>
EGID's proportionate share of the net pension liability (asset)	\$ 4,700,361	754,986	(2,599,149)

*Pension plan fiduciary net position.* Detailed information about the Plan's fiduciary net position is available in the separately issued OPERS financial report.

**(11) Deferred Compensation Plan**

The State offers to its own employees, state agency employees, and other duly constituted authority or instrumentality employees a deferred compensation plan created in accordance with Internal Revenue Code Section 457 and Chapter 45 of Title 74, Oklahoma Statutes. The Oklahoma State Employees Deferred Compensation Plan (SoonerSave) is a voluntary plan that allows participants to defer a portion of their salary into SoonerSave. Participation allows a person to shelter the portion of their salary that they defer from current federal and state income tax. Taxes on the interest or investment gains on this money, while in SoonerSave, are also deferred. The deferred compensation is not available to employees until termination, retirement, death, or approved unforeseeable emergency.

Under SoonerSave, the untaxed deferred amounts are invested as directed by the participant among various investment options. Effective January 1, 1998, a Trust and Trust Fund covering SoonerSave assets was

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established pursuant to federal legislation enacted in 1996, requiring public employers to establish such trusts for plans meeting the requirements of Section 457 of the Internal Revenue Code. Under terms of the Trust, the corpus or income of the Trust Fund may be used only for the exclusive benefit of SoonerSave participants and their beneficiaries. Further information may be obtained from the Oklahoma State Employees Deferred Compensation Plan audited financial statements for the year ended June 30, 2015. EGID believes it has no liabilities with respect to SoonerSave.

**(12) Compensated Absences**

It is EGID's policy to accrue compensated absences for annual leave, including the related employer's share of social security and Medicare taxes, in accordance with state statute, not to exceed one of the following:

- 240 hours for employees with continuous service of less than five years
- 480 hours for employees with continuous service of five years or more

During 2015, EGID's liability for compensated absences increased by approximately \$89,000 for 83 employees, decreased by approximately \$159,000 for 64 employees, and did not change for 20 employees.

During 2014, EGID's liability for compensated absences increased by approximately \$127,000 for 85 employees, decreased by approximately \$97,000 for 60 employees, and did not change for 17 employees.

EGID's liability for compensated absences at December 31, 2015 and 2014 amounted to approximately \$748,000 and \$818,000, respectively, and is included in other accrued liabilities in the balance sheets.

**(13) Operating Leases**

EGID has agreements for one-year commitments to lease office space and equipment with options to renew for additional periods. If the leases are renewed in accordance with the options in the agreements, the future minimum rentals for operating leases as of December 31, 2015 are as follows:

2016	\$	619,222
2017		254,486
2018		123,858
		<hr/>
	\$	<u>997,566</u>

Rent expense for office space and equipment for the years ended December 31, 2015 and 2014 was approximately \$868,000 and \$652,000, respectively, and is included in administrative expenses in the statements of revenue, expenses, and changes in fund equity.

**(14) Risks and Uncertainties**

EGID invests in various investment securities. As described in note 5, investment securities are exposed to various risks such as interest rate, market, and credit risks. It is at least reasonably possible that changes in the values of investment securities will occur in the near term and such changes could materially affect the amounts reported in the balance sheets.

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Notes to Basic Financial Statements

December 31, 2015 and 2014

As described in note 2, the estimates of reserves are determined based on actuarial and statistical techniques, which considers the effects of general economic conditions, such as inflation, and other factors of past experience, such as changes in participant counts, all of which are subject to change. Due to uncertainties inherent in the estimation and assumption process, it is at least reasonably possible that changes in these estimates and assumptions in the near term would be material to the financial statements.

**(15) Commitments and Contingencies**

EGID's legal counsel has determined that the statute of limitations for claims denied or paid improperly is three years. Typically, all claims are reported within a 24-month period. Currently, EGID is not aware of any material claims that were denied or paid improperly that should be reserved for in the basic financial statements. To the extent such claims exist, EGID may be responsible for payment.

During 2003, the Oklahoma Legislature created the Medical Expense Liability Revolving Fund (the Fund), which enacted a fee to cover inmate medical costs. By law, EGID is the administrator of the Fund. Any person convicted of certain offenses is required to pay a fine of \$10, which goes into the Fund. The moneys from the Fund are used when an inmate's medical costs exceed \$6,000 up to a maximum of \$100,000. As of December 31, 2015 and 2014, the Fund has assets and liabilities of approximately \$891,000 and \$3,312,000, respectively, which are included in cash and other accrued liabilities in the balance sheets.

During 1995, the Oklahoma Legislature created the Health Insurance High Risk Pool (the Pool), which was designed to provide health insurance for certain state residents who were unable to obtain coverage through other insurers. All insurers and reinsurers providing health insurance or reinsurance in the state of Oklahoma were required to participate in the Pool. With the exception of EGID, all self-insured plans were exempted from participation. Participating insurers were assessed periodically. Participating insurers were also assessed additional amounts in the Pool experienced adverse claim development. In 2014, this law was repealed with an effective date of January 1, 2017. No assessments were made in 2015. For the year ended December 31, 2014, EGID recorded assessments totaling approximately \$2,206,000, which were included in administrative expense in the statements of revenue, expenses, and changes in fund equity.

In the normal course of operations, there are various legal actions and proceedings pending against EGID. In management's opinion, the ultimate liability, if any, resulting from these legal actions will not have a material adverse effect on EGID's financial position, results of operations, or liquidity.

**(16) Subsequent Events**

EGID has evaluated subsequent events from the balance sheet date through May 13, 2016, the date at which the financial statements were available to be issued, and determined there are no other items to disclose.

**EMPLOYEES GROUP INSURANCE DEPARTMENT**  
(A Department of the Office of Management and Enterprise Services)

Schedules of Required Supplementary Information

Schedule of the Proportionate Share of the Net Pension Liability of the  
Oklahoma Public Employees Retirement Plan

Last 10 June 30 Fiscal Years\*

	<b>2015</b>	<b>2014</b>
EGID's proportion of the net pension liability	0.37597945%	0.41129259%
EGID's proportionate share of the net pension liability	\$ 1,352,338	754,986
EGID's covered-employee payroll	6,646,436	6,968,066
EGID's proportionate share of the net pension liability as a percentage of its covered-employee payroll	20.35%	10.83%
Plan fiduciary net position as a percentage of the total pension liability	96.00	97.90

\* This schedule is required to show information for 10 years. However, only fiscal years 2015 and 2014 are presented as the information for prior years is not available.

See accompanying independent auditors' report.

**EMPLOYEES GROUP INSURANCE DEPARTMENT**  
(A Department of the Office of Management and Enterprise Services)

Schedules of Required Supplementary Information

Schedule of Contributions of the Oklahoma Public Employees Retirement Plan

Last 10 June 30 Fiscal Years\*

	<b>2015</b>	<b>2014</b>
Contractually required contribution	\$ 1,096,662	1,149,731
Contributions in relation to the contractually required contribution	(1,096,662)	(1,149,731)
Contribution deficiency (excess)	\$ —	—
EGID's covered-employee payroll	\$ 6,646,436	6,968,066
Contributions as a percentage of cover-employee payroll	16.50%	16.50%

\* This schedule is required to show information for 10 years. However, only fiscal years 2015 and 2014 are presented as the information for prior years is not available.

See accompanying independent auditors' report.

**EMPLOYEES GROUP INSURANCE DEPARTMENT**  
(A Department of the Office of Management and Enterprise Services)

Notes to Required Supplementary Information

Fiscal Years Ended June 30, 2015 and 2014

**(1) Changes of Benefit Terms**

The plan has been amended by House Bill 2630 in 2014, which states that effective November 1, 2015, OPERS shall create a defined contribution plan for most people first employed by a participating employer. Exemptions from the new defined contribution plan include hazardous duty members and district attorneys, assistant district attorneys, and employees of the district attorney's office. Each employer shall send to OPERS the difference between the required employer contribution to OPERS and the amount required to match the participating employee's contributions in the defined contribution plan.

Senate Bill 2120, also enacted in 2014, amends House Bill 2630 to further exempt from the new defined contribution plan county elected officials and employees of a county, county hospital, city or town, conservation district, circuit engineering district, and any public or private trust in which a county, city, or town participates. Senate Bill 2120 also states that employees who participate in the defined contribution system are excluded from the \$105 healthcare subsidy.

New employees specifically exempted from the defined contribution plan will participate in the existing defined benefit plan.

**(2) Changes of Assumptions**

As a result of the most recent experience study, the following assumptions were revised.

- Withdrawal rates
- Disability rates
- Retirement rates
- Salary scale assumptions
- Probability of electing a vested benefit assumption



# Statistical Section



NSU Center for the Performing Arts  
Tahlequah, Oklahoma  
*Photograph courtesy of travelok.com*



## Fund Equity Over the Last Ten Years

(Accrual basis of accounting) • (Amounts expressed in thousands)

**Table 1**

	2015	2014	2013	2012	2011	2010	2009	2008	2007 <sup>(1)</sup>	2006 <sup>(1)</sup>
<b>Health &amp; Dental Program</b>										
Minimum fund equity	\$ 170,696	\$ 159,542	\$ 150,450	\$ 145,430	\$ 140,552	\$ 133,154	\$ 138,818	\$ 125,046	\$ 120,344	\$ 116,936
Fixed assets net of accumulated depreciation	2,698	1,787	1,354	946	738	631	609	710	856	1,340
Other fund equity	(37,969)	40,667	116,365	109,182	73,320	41,533	(21,931)	(57,214)	(372)	(2,831)
Total fund equity	135,425	201,996	268,169	255,558	214,610	175,318	117,496	68,542	120,828	115,445
<b>Life Program</b>										
Minimum fund equity	14,324	14,601	14,810	14,573	14,146	11,311	10,370	10,086	10,106	9,399
Other fund equity	6,941	9,342	9,771	10,883	12,429	11,135	7,522	10,196	14,670	11,060
Total fund equity	21,265	23,943	24,581	25,456	26,575	22,446	17,892	20,282	24,776	20,459
<b>Disability Program</b>										
Minimum fund equity	10,373	10,330	10,494	9,889	9,104	5,455	5,088	4,793	5,083	4,485
Other fund equity	32,396	30,421	25,888	21,667	19,895	22,782	19,569	16,826	20,803	22,399
Total fund equity	42,769	40,751	36,382	31,556	28,999	28,237	24,657	21,619	25,886	26,884
<b>Combined Programs</b>										
Minimum fund equity	195,393	184,473	175,754	169,892	163,802	149,920	154,276	139,925	135,533	130,820
Fixed assets net of accumulated depreciation	2,698	1,787	1,354	946	738	631	609	710	856	1,340
Other fund equity	1,368	80,430	152,024	141,732	105,644	75,450	5,160	(30,192)	35,101	30,628
Total fund equity	\$ 199,459	\$ 266,690	\$ 329,132	\$ 312,570	\$ 270,184	\$ 226,001	\$ 160,045	\$ 110,443	\$ 171,490	\$ 162,788

(1) The 2007 and 2006 financial information has been adjusted to reflect the change in accounting principle and reporting presentation for comparability purposes.

# Change in Fund Equity Over the Last Ten Fiscal Years

(Accrual basis of accounting) • (Amounts expressed in thousands)

Table 2

	2015 <sup>(1)(4)</sup>	2014 <sup>(1)(4)</sup>	2013 <sup>(1)(2)(6)</sup>	2012 <sup>(1)(2)(6)</sup>	2011 <sup>(1)(2)(6)</sup>	2010 <sup>(2)</sup>	2009 <sup>(2)</sup>	2008 <sup>(1)(3)</sup>	2007 <sup>(1)(5)</sup>	2006 <sup>(1)(5)</sup>
<b>Expenses</b>										
<b>Health and Dental Program</b>										
Incurrd claims expense	\$ 985,339	\$ 900,780	843,627	795,817	744,550	749,849	792,950	765,931	731,807	700,005
Pass-through grant expense	-	-	-	-	4,233	4,988	-	-	-	-
Change in premium deficiency reserves	(10,254)	43,620	10,600	(20,275)	18,521	1,754	(11,915)	(12,712)	24,627	(9,065)
Administrative and claim processing expense	44,724	47,686	38,383	36,434	35,911	36,361	36,125	36,830	39,807	38,091
Total Health and Dental Program expense	1,019,809	992,086	892,610	811,976	803,215	792,952	817,160	790,049	796,241	729,031
<b>Life Program</b>										
Incurrd claims expense	28,241	26,406	26,746	24,759	21,934	20,632	23,774	21,005	15,278	17,305
Change in premium deficiency reserves	-	-	-	-	-	-	-	-	-	-
Administrative and claim processing expense	980	1,035	1,021	987	890	818	897	726	811	757
Total Life Program expense	29,221	27,441	27,767	25,746	22,824	21,450	24,671	21,731	16,089	18,062
<b>Disability Program</b>										
Incurrd claims expense	1,795	2,196	3,468	3,917	4,449	3,416	3,652	2,093	6,052	3,702
Change in premium deficiency reserves	(111)	(185)	147	150	-	-	-	-	-	-
Administrative and claim processing expense	1,252	1,307	1,335	1,276	1,180	1,236	1,401	1,161	604	956
Total Disability Program expense	2,936	3,318	4,950	5,343	5,629	4,652	5,053	3,254	6,656	4,658
<b>Combined Programs</b>										
Incurrd claims expense	1,015,375	929,382	873,841	824,493	770,933	773,897	820,376	789,029	753,137	721,012
Pass-through grant expense	-	-	-	-	4,233	4,988	-	-	-	-
Change in premium deficiency reserves	(10,365)	43,435	10,747	(20,125)	18,521	1,754	(11,915)	(12,712)	24,627	(9,065)
Administrative and claim processing expense	46,956	50,028	40,739	38,697	37,981	38,415	38,423	38,717	41,222	39,804
Total Combined Programs expense	\$ 1,051,966	\$ 1,022,845	925,327	843,065	831,668	819,054	846,884	815,034	818,986	751,751

# Change in Fund Equity Over the Last Ten Fiscal Years

Table 2 cont.

(Accrual basis of accounting) • (Amounts expressed in thousands)

	2015 <sup>(1)(4)</sup>	2014 <sup>(1)(4)</sup>	2013 <sup>(1)(2)(6)</sup>	2012 <sup>(1)(2)(6)</sup>	2011 <sup>(1)(2)(6)</sup>	2010 <sup>(2)</sup>	2009 <sup>(2)</sup>	2008 <sup>(1)(3)</sup>	2007 <sup>(1)(5)</sup>	2006 <sup>(1)(5)</sup>
<b>Revenue</b>										
<b>Health and Dental Program</b>										
Premiums	\$ 936,074	\$ 898,688	856,614	811,466	800,156	792,495	812,996	714,236	749,855	674,949
Pass-through grant revenue	-	-	-	-	4,233	4,988	-	-	-	-
Medicare Part D Subsidy	13,474	13,665	19,098	21,705	22,075	23,958	25,173	23,817	26,688	25,599
Pharmacy rebates	-	-	-	-	-	13,345	13,060	12,145	12,885	11,490
Risk adjustment	74	931	1,706	1,496	2,351	2,245	1,670	2,147	2,218	1,564
Other	49	6	3	54	4,829	367	-	91	30	-
Net investment income (loss)	3,567	16,561	27,800	18,203	8,863	13,376	13,215	(14,673)	9,455	10,504
Total Health and Dental Program revenue	953,238	929,851	905,221	852,924	842,507	850,774	866,114	737,763	801,131	724,106
<b>Life Program</b>										
Premiums	26,068	24,946	23,476	22,074	25,494	23,830	19,887	20,241	18,784	16,909
Net investment income (loss)	475	1,937	3,417	2,553	1,459	2,174	2,393	(3,004)	1,623	1,788
Total Life Program revenue	26,543	26,883	26,893	24,627	26,953	26,004	22,280	17,237	20,407	18,697
<b>Disability Program</b>										
Premiums	4,048	4,059	4,004	3,973	4,049	4,227	3,726	3,651	3,635	3,002
Other	-	-	-	-	-	-	-	-	3	-
Net investment income (loss)	905	3,639	5,772	3,927	2,342	4,005	4,365	(4,664)	2,512	2,781
Total Disability Program revenue	4,953	7,698	9,776	7,900	6,391	8,232	8,091	(1,013)	6,150	5,783
<b>Combined Programs</b>										
Premiums	966,190	927,693	884,094	837,513	829,699	820,552	836,609	738,128	772,274	694,860
Pass-through grant revenue	-	-	-	-	4,233	4,988	-	-	-	-
Medicare Part D subsidy	13,474	13,665	19,098	21,705	22,075	23,958	25,173	23,817	26,688	25,599
Pharmacy rebates	-	-	-	-	-	13,345	13,060	12,145	12,885	11,490
Risk adjustment	74	931	1,706	1,496	2,351	2,245	1,670	2,147	2,218	1,564
Other	49	6	3	54	4,829	367	-	91	33	-
Net investment income (loss)	4,947	22,137	36,989	24,683	12,664	19,555	19,973	(22,341)	13,590	15,073
Total Combined Programs revenue	984,734	964,432	941,890	885,451	875,851	885,010	896,485	753,987	827,688	748,586
<b>Change in fund equity</b>										
Health and Dental Program	(66,571)	(62,235)	12,611	40,948	39,292	57,822	48,954	(52,286)	4,890	(4,925)
Life Program	(2,678)	(558)	(874)	(1,119)	4,129	4,554	(2,391)	(4,494)	4,318	635
Disability Program	2,017	4,380	4,826	2,557	762	3,580	3,038	(4,267)	(506)	1,125
Total Combined Programs change in fund equity	\$ (67,232)	\$ (58,413)	16,563	42,386	44,183	65,956	49,601	(61,047)	8,702	(3,165)

(1) For 2014, 2013, 2012, 2011, 2008, 2007, and 2006, premium rates were set at a level expected to use \$28.5 million, 47.8 million, \$38.7 million, \$16.0 million, \$22.8 million, \$26.8 million and \$13.6 million in fund equity, respectively.

(2) The large increase in fund equity in 2003 and 2004, 2009, 2010, 2011 and 2012 is due to favorable claims experience.

(3) The large decrease in fund equity in 2008 is a result of unfavorable claims experience, coupled with investments losses due to a downturn in the economy.

(4) The large decrease in fund equity in 2014 is primarily a result of a \$54.2 million premium deficiency in the health and dental fund.

(5) The 2007 and 2006 financial information has been adjusted to reflect the change in accounting principle and reporting presentation for comparability purposes.

(6) Pharmacy rebates were reclassified beginning in 2011 to offset claims expense.

# Operating Revenues by Type of Entity Last Ten Years

(Accrual basis of accounting) • (Amounts expressed in thousands)

**Table 3**

	2015	2014	2013	2012	2011	2010	2009	2008	2007	2006
<b>State and Local Government Entities</b>										
Health and Dental Program	\$ 438,352	\$ 414,356	393,527	372,068	373,297	378,498	375,638	332,794	328,925	296,877
Life Program	16,517	15,900	14,992	14,269	16,583	15,773	13,597	14,111	13,217	12,096
Disability Program	4,048	4,059	4,004	3,973	4,049	4,227	3,726	3,651	3,638	3,002
Total	458,916	434,315	412,523	390,310	393,928	398,498	392,961	350,556	345,779	311,975
<b>Education Entities</b>										
Health and Dental Program	511,319	498,934	483,894	462,652	460,347	458,901	477,261	419,641	462,751	416,724
Life Program	9,551	9,046	8,484	7,805	8,912	8,057	6,290	6,130	5,567	4,813
Total	520,871	507,980	492,378	470,457	469,259	466,958	483,551	425,771	468,319	421,537
<b>All Entities</b>										
Health and Dental Program	949,671	913,290	877,421	834,720	833,643	837,399	852,899	752,435	791,676	713,601
Life Program	26,068	24,946	23,476	22,074	25,495	23,830	19,887	20,241	18,784	16,909
Disability Program	4,048	4,059	4,004	3,973	4,049	4,227	3,726	3,651	3,638	3,002
Total	\$ 979,787	\$ 942,295	904,901	860,767	863,187	865,456	876,512	776,327	814,098	733,512

# Top Ten Sources of Premium Revenue Premiums Received During the Plan Year for the Last Five Years

(Amounts expressed in thousands)

**Table 4**

2015		2012	
Group	Receipts	Group	Receipts
Employees Benefits Department	\$295,180	Employees Benefits Council	\$224,944
Teachers Retirement System	\$131,762	Teachers Retirement System	\$133,149
Oklahoma Public Employees Retirement System	\$86,347	Oklahoma Public Employees Retirement System	\$74,394
Tulsa Public Schools	\$29,933	Tulsa Public Schools	\$27,380
Oklahoma City Public Schools	\$27,554	Oklahoma City Public Schools	\$22,657
Edmond Public Schools	\$12,838	Edmond Public Schools	\$11,283
Moore Public Schools	\$12,641	Moore Public Schools	\$11,113
Putnam City Public Schools	\$12,320	Lawton Public Schools	\$10,696
Broken Arrow Public Schools	\$11,378	Putnam City Public Schools	\$10,309
Lawton Public Schools	\$10,936	Norman Public Schools	\$7,806

2014		2011	
Group	Receipts	Group	Receipts
Employees Benefits Department	\$274,928	Employees Benefits Council	\$246,072
Teachers Retirement System	\$127,575	Teachers Retirement System	\$120,508
Oklahoma Public Employees Retirement System	\$98,280	Oklahoma Public Employees Retirement System	\$78,273
Tulsa Public Schools	\$28,512	Tulsa Public Schools	\$27,964
Oklahoma City Public Schools	\$23,492	Oklahoma City Public Schools	\$22,158
Edmond Public Schools	\$12,356	Lawton Public Schools	\$11,279
Putnam City Public Schools	\$11,463	Edmond Public Schools	\$11,009
Moore Public Schools	\$10,908	Moore Public Schools	\$10,723
Lawton Public Schools	\$10,872	Putnam City Public Schools	\$9,747
Broken Arrow Public Schools	\$10,396	Norman Public Schools	\$7,884

2013	
Group	Receipts
Employees Benefits Department	\$257,853
Teachers Retirement System	\$133,175
Oklahoma Public Employees Retirement System	\$85,569
Tulsa Public Schools	\$26,752
Oklahoma City Public Schools	\$23,402
Edmond Public Schools	\$11,658
Moore Public Schools	\$11,443
Lawton Public Schools	\$10,662
Putnam City Public Schools	\$10,589
Broken Arrow Public Schools	\$8,961

# HealthChoice Medical Participation

Last Ten Years

Table 5A

Year Ended	State Entities						Local Government Entities						Education Entities					
	Current			Former			Current			Former			Current			Former		
	Employees	Dependents	Total	Employees	Dependents	Total	Employees	Dependents	Total	Employees	Dependents	Total	Employees	Dependents	Total	Employees	Dependents	Total
2015	24,982	33,907	58,889	14,626	2,814	17,440	8,290	1,871	10,161	160	26	186	54,831	18,292	24,117	3,239	187,155	
2014	23,007	30,081	53,088	14,655	2,843	17,498	7,934	1,622	9,556	154	28	182	52,227	17,047	23,841	3,280	176,719	
2013	21,503	27,471	48,974	14,660	2,867	17,527	7,646	1,726	9,372	203	38	241	49,653	16,608	23,737	3,421	169,533	
2012	20,186	25,705	45,891	14,649	2,926	17,575	7,892	1,746	9,638	185	40	225	48,028	16,251	23,384	3,498	164,490	
2011	20,285	24,959	45,244	14,793	3,029	17,822	7,772	1,770	9,542	171	33	204	46,645	16,101	23,368	3,632	162,558	
2010	21,006	25,001	46,007	14,678	3,054	17,732	7,939	1,889	9,828	129	25	154	46,503	16,419	22,992	3,610	163,245	
2009	23,702	27,373	51,075	14,622	3,117	17,739	8,751	2,206	10,957	171	49	220	53,294	19,934	24,665	4,095	181,979	
2008	24,362	26,508	50,870	14,445	3,103	17,548	9,125	2,471	11,596	126	37	163	52,180	20,798	24,055	4,067	181,277	
2007	24,349	23,567	47,916	14,357	3,056	17,413	8,979	2,409	11,388	103	32	135	56,622	22,588	24,637	4,273	184,972	
2006	26,021	23,829	49,850	14,281	3,114	17,395	8,394	2,618	11,012	87	30	117	56,758	24,661	24,279	4,315	188,387	

## HMO Participation

Year Ended	State Entities (1)						Local Government Entities						Education Entities					
	Current			Former			Current			Former			Current			Former		
	Employees	Dependents	Total	Employees	Dependents	Total	Employees	Dependents	Total	Employees	Dependents	Total	Employees	Dependents	Total	Employees	Dependents	Total
2015	9,891	12,693	22,584	1,824	328	2,152	494	239	733	8	2	10	9,735	3,293	2,187	296	40,990	
2014	11,701	15,668	27,369	1,831	351	2,182	554	296	850	6	2	8	10,663	3,794	2,233	332	47,431	
2013	12,161	16,245	28,406	1,880	387	2,267	606	329	935	8	3	11	10,737	4,105	2,255	355	49,071	
2012	13,767	17,988	31,755	2,189	448	2,637	662	379	1,041	8	2	10	11,945	4,896	2,456	382	55,122	
2011	13,739	17,974	31,713	2,116	442	2,558	598	402	1,000	7	2	9	12,259	5,203	2,394	420	55,556	
2010	14,229	17,941	32,170	1,876	421	2,297	626	374	1,000	5	3	8	12,903	5,421	2,165	387	56,351	
2009	13,742	16,716	30,458	1,702	386	2,088	799	382	1,181	12	6	18	12,348	5,373	2,122	405	53,993	
2008	13,606	16,017	29,623	1,644	374	2,018	939	420	1,359	4	3	7	11,877	5,138	2,106	434	52,562	
2007	13,408	15,337	28,745	1,560	394	1,954	927	463	1,390	7	3	10	12,697	6,551	2,077	465	53,889	
2006	11,850	12,677	24,527	1,342	354	1,696	768	400	1,168	3	2	5	11,652	6,367	1,863	427	47,705	

(1) HMO premiums for current state employees and their dependents are collected by the Employees Benefits Department and remitted to the HMO.

# HealthChoice Dental Participation

Last Ten Years

Table 5B

Year Ended	State Entities		Local Government		Education Entities		Total
	Employees	Dependents	Employees	Dependents	Employees	Dependents	
2015	34,627	30,773	6,042	2,685	62,541	31,929	168,597
2014	34,750	30,684	6,020	2,615	61,678	31,809	167,556
2013	34,484	30,169	6,007	2,777	60,877	31,687	166,001
2012	35,160	30,740	6,165	2,910	61,370	32,136	168,481
2011	35,717	30,777	6,070	2,991	61,360	32,438	169,353
2010	36,122	30,916	5,954	2,897	59,081	31,044	166,014
2009	38,587	33,105	6,756	3,425	64,890	34,459	181,222
2008	39,108	32,626	7,114	3,597	63,566	33,885	179,896
2007	39,023	30,845	6,964	3,492	62,205	33,124	175,653
2006	38,953	29,298	6,736	3,457	61,536	33,346	173,326

Year Ended	State Entities (1)		Local Government		Education Entities		Total
	Employees	Dependents	Employees	Dependents	Employees	Dependents	
2015	15,395	17,619	1,592	809	22,580	12,503	70,498
2014	14,762	16,738	1,332	634	21,040	11,817	66,323
2013	13,620	15,173	1,259	603	19,340	11,316	61,311
2012	13,147	14,539	1,113	560	17,965	10,960	58,284
2011	12,282	13,495	925	505	16,290	10,361	53,858
2010	11,593	12,470	910	528	16,501	10,303	52,305
2009	11,574	12,313	1,230	681	16,785	10,774	53,357
2008	11,061	11,493	1,181	674	15,617	10,212	50,238
2007	10,452	10,342	1,124	668	14,045	9,399	46,030
2006	10,096	9,852	950	604	12,634	8,903	43,039

**Note:** Dental participation is not tracked separately for current employees or former employees.

(1) DMO premiums for current state employees and their dependents are collected by the Employees Benefits Department and remitted to the DMO.

# Monthly Premiums by Coverage Type and Billing Categories

*Last Ten Years*

**Table 6A**

## HealthChoice High Current Employees

Year	Employee	Spouse	One Child	Two or More Children
CY 2015	\$499.42	\$676.28	\$253.56	\$391.20
CY 2014	484.87	675.82	246.17	379.81
CY 2013	463.99	681.96	235.57	363.45
CY 2012	449.48	668.10	228.20	352.08
CY 2011	449.48	682.74	228.20	352.08
CY 2010	442.80	625.88	228.32	342.44
CY 2009	409.12	587.92	199.98	343.10
CY 2008	364.24	496.61	181.44	290.22
CY 2007	364.24	554.18	189.04	298.60
CY 2006	310.46	450.22	157.10	250.40

## HealthChoice High Former Employees Under Age 65

Year	Employee	Spouse	One Child	Two or More Children
CY 2015	\$499.42	\$676.28	\$253.56	\$391.20
CY 2014	484.87	675.82	246.17	379.81
CY 2013	463.99	681.96	235.57	363.45
CY 2012	449.48	668.10	228.20	352.08
CY 2011	449.48	682.74	228.20	352.08
CY 2010	442.80	625.88	228.32	342.44
CY 2009	409.12	587.92	199.98	343.10
CY 2008	364.24	496.61	181.44	290.22
CY 2007	364.24	554.18	189.04	298.60
CY 2006	400.46	583.68	157.10	250.40

## HealthChoice High Former Employees Ages 65 and Over

Year	Employee	Spouse	One Child	Two or More Children
CY 2015	\$307.28	\$307.28	\$307.28	\$307.28
CY 2014	323.38	323.38	323.38	323.38
CY 2013	316.34	316.34	316.34	316.34
CY 2012	332.54	332.54	332.54	332.54
CY 2011	332.54	308.34	308.34	616.68
CY 2010	289.42	289.42	289.42	578.84
CY 2009	279.28	279.28	279.28	558.56
CY 2008	245.80	245.80	245.80	491.60
CY 2007	245.80	245.80	245.80	491.60
CY 2006	245.80	245.80	245.80	491.60

CY - Calendar Year

# Monthly Premiums by Coverage Type and Billing Categories

*Last Ten Years*

**Table 6B**

## HealthChoice Basic/Low

### Current Employees

Year	Employee	Spouse	One Child	Two or More Children
CY 2015	\$391.52	\$501.74	\$215.94	\$342.74
CY 2014	421.11	594.78	217.00	334.19
CY 2013	402.98	593.32	207.66	319.80
CY 2012	391.64	571.84	201.82	310.80
CY 2011	391.64	598.48	201.82	310.80
CY 2010	384.22	546.84	200.36	300.88
CY 2009	347.96	503.74	171.56	586.88
CY 2008	318.18	425.65	155.32	248.88
CY 2007	318.18	491.20	165.14	262.08
CY 2006	269.22	388.18	135.18	215.46

## HealthChoice Basic/Low

### Former Employees Under Age 65

Year	Employee	Spouse	One Child	Two or More Children
CY 2015	\$391.52	\$501.74	\$215.94	\$342.74
CY 2014	421.11	594.78	217.00	334.19
CY 2013	402.98	593.52	207.66	319.80
CY 2012	391.64	571.84	201.82	310.80
CY 2011	391.64	598.48	201.82	310.80
CY 2010	384.22	546.84	200.36	300.88
CY 2009	347.96	503.74	171.56	586.88
CY 2008	318.18	425.65	155.32	248.88
CY 2007	318.18	491.20	165.14	262.08
CY 2006	359.22	504.90	135.18	215.46

## HealthChoice Basic/Low

### Former Employees Ages 65 and Over

Year	Employee	Spouse	One Child	Two or More Children
CY 2015	\$239.90	\$239.90	\$239.90	\$239.90
CY 2014	261.84	261.84	261.84	261.84
CY 2013	255.62	255.62	255.62	255.62
CY 2012	273.02	273.02	273.02	273.02
CY 2011	251.66	251.66	251.66	503.32
CY 2010	236.10	236.10	236.10	472.20
CY 2009	222.92	222.92	222.92	445.84
CY 2008	197.32	197.32	197.32	394.64
CY 2007	197.32	197.32	197.32	394.64
CY 2006	197.32	197.32	197.32	394.64

CY - Calendar Year

# Monthly Premiums by Coverage Type and Billing Categories

*Last Ten Years*

**Table 6C**

## HealthChoice Dental

Year	Employee	Spouse	One Child	Two or More Children
<b>CY 2015</b>	\$32.00	\$32.00	\$27.40	\$68.20
<b>CY 2014</b>	31.38	31.38	26.90	66.96
<b>CY 2013</b>	31.38	31.38	26.90	66.96
<b>CY 2012</b>	30.20	30.20	25.18	65.32
<b>CY 2011</b>	29.84	29.84	24.88	64.56
<b>CY 2010</b>	30.28	30.28	25.24	65.50
<b>CY 2009</b>	28.58	28.58	23.82	61.84
<b>CY 2008</b>	26.80	26.80	22.34	57.98
<b>CY 2007</b>	26.80	26.80	26.80	57.98
<b>CY 2006</b>	26.80	26.80	22.34	57.98

## HealthChoice Basic Life

Year	Employee
<b>CY 2015</b>	\$4.00
<b>CY 2014</b>	4.00
<b>CY 2013</b>	4.00
<b>CY 2012</b>	4.00
<b>CY 2011</b>	4.56
<b>CY 2010</b>	4.56
<b>CY 2009</b>	3.50
<b>CY 2008</b>	3.90
<b>CY 2007</b>	3.90
<b>CY 2006</b>	3.90

## HealthChoice Disability

Year	Employee
<b>CY 2015</b>	\$9.10
<b>CY 2014</b>	9.10
<b>CY 2013</b>	9.10
<b>CY 2012</b>	9.10
<b>CY 2011</b>	9.10
<b>CY 2010</b>	9.10
<b>CY 2009</b>	7.62
<b>CY 2008</b>	7.54
<b>CY 2007</b>	7.54
<b>CY 2006</b>	6.28

CY - Calendar Year

## Outside Insurance Carriers - Health

(Offered in Addition to the HealthChoice Self-insured Plan)

**Table 7A**

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<u>CY 2015</u> CommunityCare GlobalHealth	<u>CY 2014</u> CommunityCare GlobalHealth	<u>CY 2013</u> CommunityCare GlobalHealth
<u>CY 2012</u> CommunityCare GlobalHealth UnitedHealthcare	<u>CY 2011</u> CommunityCare GlobalHealth PacifiCare/UnitedHealthcare	<u>CY 2010</u> Aetna CommunityCare GlobalHealth PacifiCare
<u>CY 2009</u> Aetna CommunityCare GlobalHealth PacifiCare	<u>CY 2008</u> Aetna CommunityCare GlobalHealth PacifiCare	<u>CY 2007</u> Aetna ASITricare Supplement CommunityCare GlobalHealth PacifiCare
	<u>CY 2006</u> Aetna ASITricare Supplement CommunityCare GlobalHealth PacifiCare	

CY - Calendar Year

## Outside Insurance Carriers - Dental

(Offered in Addition to the HealthChoice Self-insured Plan)

**Table 7B**

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### CY 2015

Assurant Dental  
CIGNA Dental  
Delta Dental

### CY 2014

Assurant Dental  
CIGNA Dental  
Delta Dental

### CY 2013

Assurant Dental  
CIGNA Dental  
Delta Dental

### CY 2012

Assurant Dental  
CIGNA Dental  
Delta Dental

### CY 2011

Assurant Dental  
CIGNA Dental  
Delta Dental

### CY 2010

Assurant Dental  
CIGNA Dental  
Delta Dental

### CY 2009

Assurant Dental  
CIGNA Dental  
Delta Dental

### CY 2008

Assurant Dental  
CIGNA Dental  
Delta Dental

### CY 2007

Assurant Dental  
CIGNA Dental  
Delta Dental

### CY 2006

Assurant Dental  
CIGNA Dental  
Delta Dental

CY - Calendar Year

## Outside Insurance Carriers - Vision

**Table 7C**

<u>CY 2015</u>	<u>CY 2014</u>	<u>CY 2013</u>
Humana/CompBenefits VisionCare Primary Vision Care Services Superior Vision Plan UnitedHealthcare Vision Vision Care Direct Vision Service Plan	Humana/CompBenefits VisionCare Primary Vision Care Services Superior Vision Plan UnitedHealthcare Vision Vision Care Direct Vision Service Plan	Humana/CompBenefits VisionCare Primary Vision Care Services Superior Vision Plan UnitedHealthcare Vision Vision Service Plan
<u>CY 2012</u>	<u>CY 2011</u>	<u>CY 2010</u>
Humana/CompBenefits VisionCare Primary Vision Care Services Superior Vision Plan UnitedHealthcare Vision Vision Service Plan	Humana/CompBenefits VisionCare Primary Vision Care Services Superior Vision Plan UnitedHealthcare Vision Vision Service Plan	CompBenefits VisionCare Primary Vision Care Services Spectera Vision UnitedHealthcare Vision Plan Vision Service Plan
<u>CY 2009</u>	<u>CY 2008</u>	<u>CY 2007</u>
CompBenefits VisionCare Primary Vision Care Services Spectera Vision Superior Vision Plan Vision Service Plan	CompBenefits VisionCare Primary Vision Care Services Spectera Vision Superior Vision Plan Vision Service Plan	CompBenefits VisionCare Primary Vision Care Services Spectera Vision Superior Vision Plan Vision Service Plan
<u>CY 2006</u>		
CompBenefits Primary Vision Care Services Spectera Vision Superior Vision Plan Vision Service Plan		

CY - Calendar Year





