KPMG LLP
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Independent Auditors' Report on Internal Control over Financial Reporting and on Compliance and Other Matters Based on an Audit of Financial Statements Performed in Accordance With *Government Auditing Standards*

Members of the Board
Oklahoma Employees Insurance
and Benefits Board:

We have audited, in accordance with the 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, the balance sheet, statement of revenues, expenses and changes in fund equity, and cash flow of the Employees Group Insurance Division (EGID), a division of the Office of Management and Enterprise Services, as of and for the year ended December 31, 2012, and the related notes to the financial statements, which collectively comprise the EGID's basic financial statements, and have issued our report thereon dated April 29, 2013.

Internal Control over Financial Reporting

In planning and performing our audit of the financial statements, we considered EGID's internal control over financial reporting (internal control) to determine the audit procedures that are appropriate in the circumstances for the purpose of expressing our opinion on the financial statements, but not for the purpose of expressing an opinion on the effectiveness of EGID's internal control. Accordingly, we do not express an opinion on the effectiveness of EGID's internal control.

A deficiency in internal control exists when the design or operation of a control does not allow management or employees, in the normal course of performing their assigned functions, to prevent, or detect and correct, misstatements on a timely basis. A material weakness is a deficiency, or combination of deficiencies, in internal control, such that there is a reasonable possibility that a material misstatement of the entity's financial statements will not be prevented, or detected and corrected on a timely basis. A significant deficiency is a deficiency, or a combination of deficiencies, in internal control that is less severe than a material weakness, yet important enough to merit attention by those charged with governance.

Our consideration of internal control was for the limited purpose described in the first paragraph of this section and was not designed to identify all deficiencies in internal control that might be material weaknesses or significant deficiencies. Given these limitations, during our audit we did not identify any deficiencies in internal control that we consider to be material weaknesses. However, material weaknesses may exist that have not been identified.

Compliance and Other Matters

As part of obtaining reasonable assurance about whether EGID's financial statements are free from material misstatement, we performed tests of its compliance with certain provisions of laws, regulations, contracts, and grant agreements, noncompliance with which could have a direct and material effect on the determination of financial statement amounts. However, providing an opinion on compliance with those provisions was not an objective of our audit, and accordingly, we do not express such an opinion. The results of our tests disclosed no instances of noncompliance or other matters that are required to be reported under *Government Auditing Standards*.

Purpose of this Report

The purpose of this report is solely to describe the scope of our testing of internal control and compliance and the results of that testing, and not to provide an opinion on the effectiveness of the EGID's internal control or on compliance. This report is an integral part of an audit performed in accordance with *Government Auditing Standards* in considering the EGID's internal control and compliance. Accordingly, this communication is not suitable for any other purpose.

KPMG LLP

Oklahoma City, Oklahoma
April 29, 2013

EMPLOYEES GROUP INSURANCE DIVISION

(A Division of the Office of Management and Enterprise Services)

Basic Financial Statements

December 31, 2012 and 2011

(With Independent Auditors' Report Thereon)

EMPLOYEES GROUP INSURANCE DIVISION
(A Division of the Office of Management and Enterprise Services)

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KPMG LLP
210 Park Avenue, Suite 2850
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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 Division (EGID), a division of the Office of Management and Enterprise Services, as of and for the years ended December 31, 2012 and 2011, 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 opinions 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 Division, as of December 31, 2012 and 2011, 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.

Other Matters

Required Supplementary Information

U.S. generally accepted accounting principles require that the management's discussion and analysis on pages 3 through 8 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 April 29, 2013 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
April 29, 2013

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 division 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 Revenues, Expenses, and Changes in Fund Equity – This statement reflects EGID's operating revenues and expenses, as well as nonoperating revenues 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.

EMPLOYEES GROUP INSURANCE DIVISION
(A Division of the Office of Management and Enterprise Services)

Management's Discussion and Analysis

December 31, 2012 and 2011

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, 2012, 2011, and 2010.

	December 31			2012 v. 2011 Change
	2012	2011	2010	Amount
Cash and investments	$ 405,738,428	371,392,253	306,453,926	34,346,175
Premiums receivable, net	29,612,047	35,174,018	44,250,802	(5,561,971)
Other current assets	12,303,387	14,253,763	10,085,146	(1,950,376)
Total current assets	447,653,862	420,820,034	360,789,874	26,833,828
Office equipment, net	946,350	737,889	631,066	208,461
Total assets	$ 448,600,212	421,557,923	361,420,940	27,042,289
Claims liabilities	$ 94,671,000	88,380,000	95,620,000	6,291,000
Disability liabilities (current only)	3,197,000	3,082,000	2,921,000	115,000
Premium deficiency reserves	150,000	20,275,000	1,754,000	(20,125,000)
Other current liabilities	26,224,105	23,662,407	19,068,764	2,561,698
Total current liabilities	124,242,105	135,399,407	119,363,764	(11,157,302)
Total noncurrent liabilities	11,788,000	15,974,609	16,056,061	(4,186,609)
Total liabilities	136,030,105	151,374,016	135,419,825	(15,343,911)
Invested in capital assets	946,350	737,889	631,066	208,461
Unrestricted fund equity	311,623,757	269,446,018	225,370,049	42,177,739
Total fund equity	312,570,107	270,183,907	226,001,115	42,386,200
Total liabilities and fund equity	$ 448,600,212	421,557,923	361,420,940	27,042,289

	Year ended December 31,			2012 v. 2011 Change
	2012	2011	2010	Amount
Premium revenue	$ 859,218,057	851,773,819	844,510,757	7,444,238
Pass-through grant revenue	—	4,232,609	4,988,061	(4,232,609)
Other operating revenues	1,549,090	7,180,556	2,611,972	(5,631,466)
Total operating revenues	860,767,147	863,186,984	852,110,790	(2,419,837)
Incurred claims expense	824,493,271	770,933,569	760,551,957	53,559,702
Change in premium deficiency reserves	(20,125,000)	18,521,000	1,754,000	(38,646,000)
Pass-through grant expense	—	4,232,609	4,988,061	(4,232,609)
Administrative and claims processing expense	38,697,157	37,980,672	38,415,484	716,485
Total operating expenses	843,065,428	831,667,850	805,709,502	11,397,578
Operating income	17,701,719	31,519,134	46,401,288	(13,817,415)
Net investment income	24,684,481	12,663,658	19,555,038	12,020,823
Change in fund equity	42,386,200	44,182,792	65,956,326	(1,796,592)
Fund equity, beginning of year	270,183,907	226,001,115	160,044,789	44,182,792
Fund equity, end of year	$ 312,570,107	270,183,907	226,001,115	42,386,200

EGID's total assets for the year ended December 31, 2012 increased by approximately 6.4% from the previous year, significantly less than the increase of 17% in 2011. Cash and investments increased by $34.3 million or 9.2% during 2012 due to another year of favorable claims experience, while 2011 showed increases of $64.9 million or 21%.

In 2012, EGID earned approximately $4.7 million in interest and dividend income, experienced $4.6 million in realized gains and $16.2 million in unrealized gains, and paid $795,134 in investment expenses for a net investment gain of $24.7 million. In 2011, EGID earned approximately $6.4 million in interest and dividend income, experienced $3.1 million in realized gains and $3.9 million in unrealized gains, and paid $709,000 in investment expenses for a net investment gain of $12.7 million. EGID's investment allocation at December 31, 2012 is comprised of approximately 50% fixed income securities, 35% equities, and 15% cash equivalents compared to approximately 50% fixed income securities, 32% equities, and 18% cash equivalents at December 31, 2011.

At year-end for both December 31, 2012 and 2011, premiums receivable decreased from the prior year by $5.6 million and $9.1 million, respectively, primarily due to an increase in premiums received over what was billed during the year. The decrease for other current assets in 2012 of $2.0 million is primarily due to the $1.1 million decrease in the receivable for the Medicare Part D Coverage Gap Discount Program and a nearly $700,000 decrease in the receivable for pending investment sales. In contrast, for 2011 the increase for other current assets of $4.2 million is primarily due to a $2.6 million receivable for the Medicare Part D Coverage Gap Discount Program, a $747,000 increase in a receivable for overpaid claims as well as an almost $700,000 increase in a receivable for pending investment sales.

Total liabilities as of December 31, 2012 decreased $15.3 million from December 31, 2011 due to a $20.1 decrease in premium deficiency reserves booked at December 31, 2012, and a $6.5 million increase in claim reserves booked at December 31, 2012 primarily due to an increase in incurred claims and a slower claim run-off. In contrast, total liabilities as of December 31, 2011 increased $16.0 million from the prior year primarily due to an increase in premium deficiency reserves booked at December 31, 2011. Claim reserves in 2011 including noncurrent disability reserves decreased by $7.1 million from reserves reported the prior year. This is due to the timing of claim payments being paid faster in 2011 primarily due to more electronic submission of claims.

Premium deficiency reserves are required to be recorded when the anticipated cost to settling claims plus policy maintenance costs for the following fiscal year are in excess of the anticipated premium receipts for the following fiscal year. For the health plan, no premium deficiency liability was booked at December 31, 2012, but a premium deficiency liability of $20.3 million was booked at December 31, 2011. For the disability plan, at December 31, 2012 a premium deficiency liability of $150,000 was booked, but no premium deficiency liability was necessary at December 31, 2011.

Other current liabilities increased $2.6 million at December 31, 2012 primarily due to a $1.0 million increase in the payable for administrative expenses and an increase of $1.3 million in the payable for pending investments. Other current liabilities at December 31, 2011 increased $4.6 million from the prior year primarily due to ERRP funds that will be amortized during 2013 from a noncurrent to a current liability.

EGID saw an overall increase in premium revenue for 2012 of approximately $7.4 million due primarily to a change in the membership resulting in an increase in the primary member and the two or more child rate categories with a slight decrease occurring in the spouse and one child rate category. In 2011, EGID saw an overall increase in premium revenue of approximately $7.3 million. There was an increase in premium received from members and groups for the non-Medicare population of $9.2 million and a decrease in Centers for Medicare and Medicaid Services (CMS) revenue of $1.9 million. The increase in premium received is due primarily to the increase in the premium rate for 2011. The decrease in CMS revenue is due in part to a reduced subsidy received from CMS during 2011 and also a decrease in the amount received from the annual CMS reconciliation. For the year ended December 31, 2012, EGID earned approximately $1.5 million in other operating income, which consisted primarily of risk adjustment fee income. For 2011, EGID earned approximately $7.2 million in other operating income, which consisted of $2.4 million in risk adjustment fee income and $4.8 million from the settlement of a class action lawsuit relating to pharmacy payments.

Incurred claims comprised 95.5% and 95.4% of EGID's total expenses in 2012 and 2011, respectively. Changes in premium deficiency reserves and pass-through grant expenses are not considered in the calculation. For the years ended December 31, 2012 and 2011, total incurred claims increased by $53.6 and $10.4 million, or 6.9% and 1% over the prior year.

For the year ended December 31, 2012, health and dental claim costs increased by approximately $51.3 million or 7% over the prior year due to normal claim trend projections. For the year ended December 31, 2011, health and dental claim costs increased by approximately $8.1 million or 1% over the prior year due to an increase in outpatient claims cost and one unusually large claim for one individual of which $4.5 million was paid. For 2011, the copayment was reduced from $50 to $30 for primary care physician visits. Additionally, EGID's HealthChoice plan offered a new program called Help Check which encouraged members to have a preventive visit with their primary care doctor and take advantage of certain preventive services offered by HealthChoice. In 2012, life benefits expense increased from the prior year by $2.8 million or 13% over the expense reported for 2011. During 2011, the expense for life benefits increased by approximately $1.3 million or 6% over the prior year. Disability benefits for 2012 decreased $532,000 or 12% over the prior year. Disability benefits for 2011 increased $1.0 million or 30% over the prior year.

Pass-through grant expense decreased by $4.2 million due to the Affordable Care Act (ACA) Early Retiree Reinsurance Program (ERRP) that established $5 billion to be used to subsidize the cost of coverage for retirees who are not yet Medicare eligible ended. EGID received its last disbursement amount in 2011 and no additional money will be received from this program. The pass-through grant liability of $4.2 million received in 2011 for funds received will be used to reduce premiums for the 2013 plan year. This liability will be amortized in 2013 as it is used.

Administrative expenses increased by $716,000 in 2012 over 2011, but decreased $435,000 the prior year. Administrative expenses make up 5% of EGID's total expenses in both 2012 and 2011.

EGID experienced an increase in total fund equity of approximately $42.4 million, or 16%, for the year ended December 31, 2012. For 2011, there was an increase in fund equity of approximately $44.2 million, or 20%.

During 2012, the Health and Dental program experienced an increase in fund equity of approximately $40.9 million, or 19% over the prior year. The increase is due to favorable claims experience and positive investment performance. According to EGID's consulting actuaries, this is not unique to EGID and plans nationwide have experienced favorable claims experience during 2012. We believe this is due to both the economy and the anticipated health cost trends and potential impact from new legislation that was built into the premium rates for 2012. For the year ended December 31, 2011, the Health and Dental program experienced an increase in fund equity of approximately $39.3 million, or 22% due to improvement in the investment markets and favorable claims experience.

The Life program experienced a decrease in fund equity of approximately $1.1 million or 4% in 2012 and an increase of $4.1 million or 18% in 2011.

The Disability program experienced an increase in fund equity of $2.6 million or 9% in 2012 while in 2011 the Disability program experienced an increase in fund equity of $762,000 or 3%.

Economic Conditions

The insurance industry monitors healthcare costs by establishing a percentage of cost increases known as "trend". According to the Segal Health Plan Cost Trend Survey, 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:

- 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, and
- Technological changes.

For 2012, the overall nationwide health trend for employer sponsored plans, according to Aon Hewitt, EGID's actuarial firm, was 7.5% for PPO plans with pharmacy benefits. The national trend for Medicare supplement plans was 6.5% for 2012 and 5.5% for 2011. Historically, EGID's cost trends have tracked below national averages. As a large self-funded plan, EGID's cost trends are cyclical in nature, and can vary during a given plan year. EGID's average trends were well below national averages for both 2011 and 2012. On average, medical trend was 5.5% for 2012 for active members and retirees under age 65. EGID's trend for the Medicare supplement plan averaged a slight decrease in 2012. These figures measured EGID's paid claims including adjustments for plan design and provider 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 2012 rates was 8.0% for active employees and pre-Medicare retirees and 9.0% for Medicare retirees. The prescription drug trend used for setting 2012 rates was 9.5% for active employees, pre-Medicare retirees, and Medicare retirees. The dental trend used for setting 2012 rates was 3%. The medical trend applied by EGID's actuaries for calculating 2011 rates was 8.25% for active employees and pre-Medicare retirees and 5.0% for Medicare retirees. The prescription drug trend used for setting 2011 rates was 9.5% for active employees, pre-Medicare retirees, and Medicare retirees. The dental trend used for setting 2011 rates was 3.0%.

EGID's investment portfolio experienced positive returns during 2012. Performance returns for EGID's total investment portfolio was 7.7% in 2012 and 4.4% in 2011.

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 95.8% in 2012 and 92% in 2011 compares very favorably to the ACA requirements and industry standards.

EMPLOYEES GROUP INSURANCE DIVISION
(A Division of the Office of Management and Enterprise Services)

Balance Sheets

December 31, 2012 and 2011

Assets	2012	2011
Current assets:		
Cash and cash equivalents	$ 103,770,287	99,330,698
Investments	301,968,141	272,061,555
Receivables:		
Interest and dividends receivable	612,120	672,091
Unsettled investment sales	240	663,789
Premiums, net of allowance of $429,000 and $315,000 at December 31, 2012 and 2011, respectively	29,612,047	35,174,018
Pharmacy rebate	8,801,738	8,788,249
Other, net	2,889,289	4,129,634
Total current assets	447,653,862	420,820,034
Noncurrent assets:		
Office equipment	4,348,749	4,050,770
Less accumulated depreciation	(3,402,399)	(3,312,881)
Office equipment, net	946,350	737,889
Total assets	$ 448,600,212	421,557,923
Liabilities		
Current liabilities:		
Health and dental reserves	$ 88,683,000	82,493,000
Life reserves	5,988,000	5,887,000
Disability reserves	3,197,000	3,082,000
Premium deficiency reserve	150,000	20,275,000
Premiums due to health maintenance organizations and other insurers	9,803,160	9,490,476
Payable for investment purchases	1,315,210	25,336
Other accrued liabilities	10,873,126	9,158,534
Prepaid premiums	4,232,609	4,988,061
Total current liabilities	124,242,105	135,399,407
Noncurrent liabilities:		
Disability reserves	11,788,000	11,742,000
Prepaid premiums	—	4,232,609
Total liabilities	136,030,105	151,374,016
Commitments and contingencies (note 14)		
Fund Equity		
Invested in capital assets	946,350	737,889
Unrestricted (note 2 (f))	311,623,757	269,446,018
Total fund equity	312,570,107	270,183,907
Total liabilities and fund equity	$ 448,600,212	421,557,923

See accompanying notes to basic financial statements.

EMPLOYEES GROUP INSURANCE DIVISION
(A Division of the Office of Management and Enterprise Services)

Statements of Revenues, Expenses and Changes in Fund Equity

Years ended December 31, 2012 and 2011

	2012	2011
Operating revenues:		
Premium revenue	$ 859,218,057	851,773,819
Other operating revenues	1,549,090	7,180,556
Pass-through grant revenue	—	4,232,609
Total operating revenues	860,767,147	863,186,984
Operating expenses:		
Incurred claims expense	824,493,271	770,933,569
Change in premium deficiency reserve	(20,125,000)	18,521,000
Administrative and claim processing	38,697,157	37,980,672
Pass-through grant expense	—	4,232,609
Total operating expenses	843,065,428	831,667,850
Operating income	17,701,719	31,519,134
Nonoperating revenues:		
Net investment income	24,684,481	12,663,658
Change in fund equity	42,386,200	44,182,792
Fund equity, beginning of year	270,183,907	226,001,115
Fund equity, end of year	$ 312,570,107	270,183,907

See accompanying notes to basic financial statements.

EMPLOYEES GROUP INSURANCE DIVISION
(A Division of the Office of Management and Enterprise Services)

Statements of Cash Flows

Years ended December 31, 2012 and 2011

	2012	2011
Cash flows from operating activities:		
Premiums collected	$ 837,356,298	837,602,074
Premiums collected on behalf of health maintenance organizations and other insurers	127,475,968	124,398,528
Pass-through grant revenue	—	4,232,609
Payments collected from Centers for Medicare and Medicaid Services	21,704,586	22,074,790
Risk adjustment premium collected	1,685,797	2,158,325
Benefits paid	(818,054,760)	(777,313,284)
Premiums paid to health maintenance organizations and other insurers	(126,432,202)	(123,295,329)
Payments to employees for services	(9,219,373)	(9,528,142)
Payments to suppliers for goods and services	(27,542,705)	(28,102,368)
Other operating cash received	1,103,639	1,732,811
Net cash provided by operating activities	8,077,248	53,960,014
Cash flows from capital and related financing activity:		
Acquisition of office equipment	(428,948)	(291,559)
Net cash used in capital and related financing activity	(428,948)	(291,559)
Cash flows from investing activities:		
Purchases of investments	(194,629,853)	(228,128,428)
Proceeds from sales and maturities of investments	187,490,392	180,930,174
Investment income received	3,930,750	5,423,707
Net cash used in investing activities	(3,208,711)	(41,774,547)
Net increase in cash and cash equivalents	4,439,589	11,893,908
Cash and cash equivalents, beginning of year	99,330,698	87,436,790
Cash and cash equivalents, end of year	$ 103,770,287	99,330,698
Reconciliation of operating income to net cash provided by operating activities:		
Operating income	$ 17,701,719	31,519,134
Adjustments to reconcile operating income to net cash provided by operating activities:		
Depreciation	195,893	184,736
Loss on disposal of fixed assets	24,594	—
Change in operating assets and liabilities:		
Premium receivable	5,561,971	9,076,784
Prepaid premiums	(4,988,061)	4,232,609
Other receivables	1,226,856	(3,264,135)
Claim reserves	6,291,000	(7,240,000)
Disability reserves	161,000	835,000
Premium deficiency reserves	(20,125,000)	18,521,000
Premiums due to health maintenance organizations and other insurers	312,684	(70,541)
Other liabilities	1,714,592	165,427
Total adjustments	(9,624,471)	22,440,880
Net cash provided by operating activities	$ 8,077,248	53,960,014

See accompanying notes to basic financial statements.

(1) Description of EGID

The Employees Group Insurance Division (EGID) is a non-appropriated division 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.

For the majority of 2012, there was an eight-member board comprised of two members appointed by the governor, two members appointed by the speaker of the House of Representatives, and two members appointed by the president pro tempore of the Senate, the commissioner of the Oklahoma Insurance Department, and the director of the Office of Management and Enterprise Services. The Board has a fiduciary responsibility to oversee the funds management and investment of EGID assets. Effective, November 1, 2012 with the consolidation discussed below in (a), there was a change in the make-up of the board. There is now a seven-member board which is comprised of 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. 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 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 became a Medicare Part D Prescription Drug Plan pursuant to the *Medicare Prescription Drug Improvement and Modernization Act of 2003*.

In 2011, pursuant to 62 O.S. § 34.3 various agencies including EGID (formerly the Oklahoma State and Education Employees Group Insurance Division) were consolidated as divisions within the Office of Management and Enterprise Services (formerly the Office of State Finance). The Office of Management and Enterprise Services already consisted of a Division of the Budget, Division of Central Accounting and Reporting and an Information Services Division. Pursuant to the State Government Administrative Process Consolidation and Reorganization Reform Act 62 O.S. (2012) Section 34.5, the Office of State Finance was renamed the Office of Management and Enterprise Services. On August 24, 2012, OSEEGIB's name became the Office of Management and Enterprise Services (OMES) Employees Group Insurance Division (EGID). 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.

(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 OMES Human Capital Management (HCM) Employees Benefit Division (EBD) 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, 2012 and 2011 are reported gross of a fee retained by EBD, which is equal to 1.25% of premiums. This fee, which was approximately $2,669,000 and $2,926,000 for the years ended December 31, 2012 and 2011, respectively, is included in administrative expenses in the statements of revenues, expenses and changes in fund equity. For the years ended December 31, 2012 and 2011, 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 $1,268,000 and $1,229,000 for the years ended December 31, 2012 and

2011, respectively, is included as an offset to administrative expenses in the statements of revenues, expenses and changes in fund equity. The premium related to HMOs, DMOs, and vision plans was approximately $126,745,000 and $123,225,000 for 2012 and 2011, respectively, and, as EGID only acts in an agency capacity, the premiums collected on behalf of HMOs, DMOs, and vision plans are not reflected in the statements of revenues, expenses and changes in fund equity.

Pursuant to the authority granted by Oklahoma Statute, EGID has the authority to establish and change 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 and DMO determines its own premium rates.

EGID participants are not subject to supplemental assessment in the event of a premium deficiency. 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, 2012, EGID provided health coverage to 130 state agency divisions with approximately 20,000 primary participants (not including dependents), 595 educational entities with approximately 48,000 primary participants, 300 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 38,000 primary participants. Approximately 50,000 dependents participated in EGID as well. In addition, EGID collected and remitted premiums for approximately 31,000 primary participants and 24,000 dependents who were covered by HMOs. These counts are provided for health coverage only.

At December 31, 2011, EGID provided health coverage to 134 state agency divisions with approximately 20,000 primary participants (not including dependents), 594 educational entities with approximately 47,000 primary participants, 295 local government entities with approximately 8,000 primary participants, and 35 other groups, which include the governmental and educational retirement systems, COBRA, and survivors, with approximately 38,000 primary participants. Approximately 50,000 dependents participated in EGID as well. In addition, EGID collected and remitted premiums for approximately 31,000 primary participants and 24,000 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 option and a basic option health benefit plan for non-Medicare participants. A member who elects the high option plan is responsible 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). EGID reimburses allowed charges at 100% once the member has reached $2,800 and $3,300 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 $500 ($1,000 per family) of allowed charges. The member and EGID each pay 50% of the next $10,000 of allowed charges ($20,000 per family). EGID reimburses allowed charges at 100% once the member has reached the out-of-pocket maximum of $5,500 ($11,000 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 a form 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 S-Account option is a qualified, high deductible health plan that must 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 nationwide provider Network.

Pharmacy benefits are the same for the high, high alternative, basic and basic alternative plans. Medications are categorized as either Preferred or non-Preferred. When purchasing Preferred medications from a Network provider, the member is responsible for a copayment of up to $15 for medications costing $60 or less and up to $30 for medications costing more than $60. The maximum copay doubles for non-Preferred medications. Certain prescription medications for smoking cessation are available at a $0 copayment. In addition, there is a $2,500 per person annual out-of-pocket maximum for Preferred medications. There is no out-of-pocket maximum for non-Preferred medications. For non-Network providers, the member is responsible for a copay of up to $45 for Preferred medications costing $90 or less, plus a dispensing fee. If the cost of the Preferred medication is more than $90, the member pays 50% of ingredient cost, plus dispensing fee. If the cost of the non-Preferred medication is $160 or less, the member pays a maximum copay of $120, plus a dispensing fee. If the cost of the non-Preferred medication is more than $160, the member pays 75% of ingredient cost, plus dispensing fee.

Allowed expenses for 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 $2,000 per covered person.

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, $3,000 for children, and $1,000 for children less than six months of age. The standard option plan offers dependent life coverage of $10,000 for spouses, $5,000 for children, and $1,000 for children less than six months of age. The premier option offers dependent life coverage of $20,000 for spouses, $10,000 for children, and $1,000 for children less than six months of age.

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.

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 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 EGID. Medicare Part B expenses are generally reimbursed at 20% of eligible Medicare expenses not reimbursed by Medicare.

EGID has adopted Plan "F" 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 high option Medicare supplement plan are the same as for the HealthChoice high option plan, with 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.

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 EGID are processed and paid by third-party administrators (TPAs). The fees incurred by EGID for services performed by the TPAs totaled approximately $18,622,000 and $18,700,000 for the years ended December 31, 2012 and 2011, respectively. TPA fees are included in administrative expenses in the statements of revenues, expenses, and changes in fund equity.

A summary of available coverage and eligible groups for the years ended December 31, 2012 and 2011 is as follows:

	State employee	Education employee	Local government employee	OPERS	TRS	COBRA
Health	X	X	X	X	X	X
Dental	X	X	X	X	X	X
Life	X	X	X	X	X	
Disability	X		X			
Medicare supplement				X	X	X

(Continued)

(2) Summary of Significant Accounting Policies

(a) Basis of Accounting

EGID has prepared its financial statements in accordance with U.S. generally accepted accounting principles for state and local governments. The Governmental Accounting Standards Board (GASB) establishes the U.S. generally accepted accounting principles for state and local governments. GASB requires that proprietary activities apply all applicable GASB pronouncements and Financial Accounting Standards Board (FASB) Statements and Interpretations, Accounting Principles Board Opinions, and Accounting Research Bulletins issued on or before November 30, 1989, to the extent that they do not conflict with GASB pronouncements. The entity can elect, at its option, to apply all FASB Statements and Interpretations issued after November 30, 1989, except for those that conflict with or contradict GASB pronouncements. EGID has adopted this option.

(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 revenues 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 revenues, 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, 2012 and 2011.

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 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. 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 for the following fiscal year.

(f) Fund Equity

At December 31, 2012 and 2011, 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, 2012 and 2011 is approximately $169,892,000 and $163,802,000, 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, 2012 as reported in the basic financial statements is as follows (in thousands):

	2012			
	Health and Dental Program	Life Program	Disability Program	Total
Minimum fund equity	$ 145,430	14,573	9,889	169,892
Unrestricted fund equity	254,612	25,456	31,556	311,624

A comparison of the minimum fund equity benchmark by EGID and unrestricted fund equity at December 31, 2011 as reported in the basic financial statements is as follows (in thousands):

	2011			
	Health and Dental Program	Life Program	Disability Program	Total
Minimum fund equity	$ 140,552	14,146	9,104	163,802
Unrestricted fund equity	213,872	26,575	28,999	269,446

As part of the rate setting process, EGID considers total fund equity in comparison with the minimum fund equity benchmark in setting rates towards achieving the minimum fund equity benchmark. Title 74 of the Oklahoma Statutes, Section 1321C allows that EGID may adjust rates mid-year if the need is substantiated by an actuarial determination. Consistent with prior years, EGID does not anticipate the need for a mid-year rate adjustment for 2013.

(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 Subsidy

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 $21,705,000 and $22,075,000 for the years ended December 31, 2012 and 2011, respectively, and is included in premium revenue within the statements of revenues, expenses, and changes in fund equity.

(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 $13,277,000 and $13,631,000 for the years ended December 31, 2012 and 2011, respectively, and is included as an offset to benefits expense within the statements of revenues, 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 $1,496,000 and $2,351,000 for the years ended December 31, 2012 and 2011, respectively, and is included in other operating revenue within the statements of revenues, 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.

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) 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).

(m) Operating Revenues and Expenses

Balances classified as operating revenues 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 revenues and expenses are considered operating.

(n) Pass-Through Grant Revenue and Expense

As part of the Patient Protection and Affordable Care Act, the Early Retiree Reinsurance Program (ERRP) provides reimbursement to participating employment-based plans for a portion of the costs of health benefits for early retirees and early retirees' spouses, surviving spouses, and dependents. All employment-based plans who are accepted into the Early Retiree Reinsurance Program are eligible to receive reimbursement for certain incurred claims on or after June 1, 2010, regardless of the date on which the employment-based plan was accepted into the program. The employment-based plan must be able to demonstrate that it used program funds exclusively to reduce or offset increases in plan participants' health benefit premium contributions, copayments, deductibles, coinsurance, or a combination of these costs. EGID has filed the ERRP application on behalf of the State and participating employers that are the plan sponsors. In the ERRP application, EGID indicated that the planned use of the reimbursements from the ERRP program received in calendar years 2011 and 2012 would be to lower the premiums beginning in fiscal years 2012 and 2013, respectively. EGID acting in its capacity is receiving the reimbursement funds on behalf of the plan sponsors, which represents a pass-through grant from the federal government to the State and is recognized as revenue and expense in the period received. EGID received $4,988,061 and $4,232,609 of reimbursement under the program in 2010 and 2011, respectively, and recorded a liability for prepaid premiums in the balance sheets. The prepaid premium is recognized as premium income monthly in 2012 and 2013 when the premium reductions are applied to the participant's premium. The ERRP fund has been fully disbursed. The EGID received its last disbursement in 2011 and no additional money will be received from this program.

(o) Reclassifications

Reclassifications have been made to certain amounts reported in 2011 to conform to the 2012 presentation.

(3) Fair Values of Financial Instruments

Accounting Standards Codification Topic 820, *Fair Value of Measurements*, 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, 2012 and 2011 are described below for EGID's financial instruments. The carrying value of all EGID's financial instruments approximates fair value.

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 fair values for equity securities are based on quoted market prices.

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.

(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, 2012 and 2011, cash totaling $48,548,843 and $34,048,656, 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 $55,221,444 and $65,282,042 at December 31, 2012 and 2011, 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 duration of the underlying investments in the money market mutual fund at December 31, 2012 and 2011 is approximately 52 and 50 days, respectively.

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 approval of EGID's Board, 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.

As of December 31, 2012 and 2011, EGID had the following investments:

	2012		2011	
Types of investments	**Fair values**	**Duration [1]**	**Fair values**	**Duration [1]**
Debt securities:				
Commingled fund	$ 82,164,191	3.89	$ 79,142,364	3.96
Asset-backed securities[2]	3,275,516	3.33	869,555	1.17
Agencies	20,830,304	5.61	1,758,263	9.64
Corporate	29,580,424	6.85	26,864,504	6.75
Mortgages	12,337,133	1.74	27,689,423	2.57
Collateralized mortgage obligations[2]	603,580	0.58	762,411	1.73
U.S. Treasuries	20,084,310	4.37	20,710,241	3.85
Municipals	1,070,001	16.52	1,160,628	16.67
Collateralized mortgage-backed securities (CMBS)[2]	5,397,802	2.89	5,578,471	1.71
Certificates of Deposit	1,490,381	4.05	—	
Total debt securities	176,833,642		164,535,860	
Equities:				
Domestic	125,134,499		107,525,695	
Total investments	$ 301,968,141		$ 272,061,555	

(1) Interest rate risk is estimated using effective duration (in years).

(2) These include investments highly sensitive to interest rate changes.

(a) Credit Risk

The credit risk profile as listed by Moody's or Standards & Poor's for debt securities and money market mutual funds at December 31, 2012 and 2011 is as follows:

	2012						
	Aaa	**Aa**	**A**	**Baa/Ba**	**Ccc**	**Not rated**	**Total**
Debt securities:							
Commingled fund [(1)]	$ —	—	—	—	—	82,164,191	82,164,191
Asset-backed securities	1,243,566	1,403,913	628,037	—	—	—	3,275,516
Agencies	20,608,421	221,883	—	—	—	—	20,830,304
Corporate	2,101,555	7,298,968	17,474,545	2,705,356	—	—	29,580,424
Mortgages	12,098,776	238,357	—	—	—	—	12,337,133
Collateralized mortgage obligations	168,056	—	—	57,780	377,744	—	603,580
U.S. treasuries	20,084,310	—	—	—	—	—	20,084,310
Municipals	—	1,070,001	—	—	—	—	1,070,001
CMBS	4,593,942	803,860	—	—	—	—	5,397,802
CDs	—	—	—	—	—	1,490,381	1,490,381
Total debt securities	$ 60,898,626	11,036,982	18,102,582	2,763,136	377,744	83,654,572	176,833,642
Money market mutual funds	$ —	—	—	—	—	55,221,444	55,221,444

	2011					
	Aaa	**Aa**	**A**	**Baa/Ba**	**Not rated**	**Total**
Debt securities:						
Commingled fund [(1)]	$ —	—	—	—	79,142,364	79,142,364
Asset-backed securities	869,555	—	—	—	—	869,555
Agencies	1,758,263	—	—	—	—	1,758,263
Corporate	774,044	5,637,531	16,764,798	3,688,131	—	26,864,504
Mortgages	27,689,423	—	—	—	—	27,689,423
Collateralized mortgage obligations	58,200	337,015	—	367,196	—	762,411
U.S. treasuries	20,710,241	—	—	—	—	20,710,241
Municipals	—	1,160,628	—	—	—	1,160,628
CMBS	4,873,367	556,634	148,470	—	—	5,578,471
Total debt securities	$ 56,733,093	7,691,808	16,913,268	4,055,327	79,142,364	164,535,860
Money market mutual funds	$ —	—	—	—	65,282,042	65,282,042

(1) There is no rating to the commingled fund; however, the average rating of the underlying investments in the commingled fund as provided by the fund manager is Aa at both December 31, 2012 and 2011.

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 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.

(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. No issuer represents 5% or more of EGID's total investments. 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. EGID's policy requires that the total fixed income portfolio maintain an average effective maturity of 10 years or less and for average duration to be plus or minus 1 year from the benchmark, which has been identified by management to assess the performance of each manager.

(e) Investment Income

Net investment income for the years ended December 31, 2012 and 2011 is comprised of the following:

		2012	2011
Fixed income securities	$	3,283,790	4,519,037
Equity securities		1,382,363	1,856,512
Realized gains		4,628,049	3,114,829
Unrealized gains		16,185,413	3,882,253
Other investment income		—	292
Less investment expenses		(795,134)	(709,265)
Net investment income	$	24,684,481	12,663,658

(6) Office Equipment

The changes in office equipment for the years ended December 31, 2012 and 2011 are as follows:

		2012	2011
Office equipment, at cost:			
Balance, beginning of year	$	4,050,770	4,177,236
Additions		428,948	291,559
Retirements		(130,969)	(418,025)
Balance, end of year		4,348,749	4,050,770
Accumulated depreciation:			
Balance, beginning of year		3,312,881	3,546,170
Depreciation expense		195,893	184,736
Retirements		(106,375)	(418,025)
Balance, end of year		3,402,399	3,312,881
Office equipment, net	$	946,350	737,889

(Continued)

(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, 2012 (in thousands):

		Health and Dental	Life	Total
Reserves, beginning of year	$	82,493	5,887	88,380
Incurred claims expense provisions for insured events of the current year		792,484	24,403	816,887
Changes in provisions for insured events of prior years		3,334	356	3,690
		795,818	24,759	820,577
Less payments:				
Claims expense insured events of the current year		706,501	20,481	726,982
Claims expense insured events of prior years		83,127	4,177	87,304
		789,628	24,658	814,286
Reserves, end of year	$	88,683	5,988	94,671

As a result of changes in estimates of insured events in prior years, the provision for claims increased by approximately $3,690,000 in the year ended December 31, 2012, due primarily to unfavorable claims development.

(Continued)

The following represents changes in the Health and Dental and Life Reserves during the year ended December 31, 2011 (in thousands):

		Health and Dental	Life	Total
Reserves, beginning of year	$	90,880	4,740	95,620
Incurred claims expense provisions for insured events of the current year		760,107	22,544	782,651
Changes in provisions for insured events of prior years		(15,556)	(610)	(16,166)
		744,551	21,934	766,485
Less payments:				
Claims expense insured events of the current year		680,635	17,624	698,259
Claims expense insured events of prior years		72,303	3,163	75,466
		752,938	20,787	773,725
Reserves, end of year	$	82,493	5,887	88,380

As a result of changes in estimates of insured events in prior years, the provision for claims decreased by approximately $16,166,000 in the year ended December 31, 2011, due primarily to more favorable than anticipated claims experience.

(Continued)

(8) Disability Reserves

The following represents changes in the disability reserves during the years ended December 31, 2012 and 2011 (in thousands):

		2012	2011
Reserves, beginning of year	$	14,824	13,989
Incurred claims:			
Provisions for insured events of the current year		5,693	5,011
Changes in provisions for insured events of prior years		(1,777)	(562)
		3,916	4,449
Payments:			
Claims attributable to insured events of the current year		799	632
Claims attributable to insured events of prior years		2,956	2,982
		3,755	3,614
Reserves, end of year	$	14,985	14,824

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 $1,777,000 and $562,000 in the years ended December 31, 2012 and 2011, 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 1987 Commissioner's Group Disability Table was used.
- The discount rate was 3.5% for the years ended December 31, 2012 and 2011.

(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 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. EGID determined that reserves for premium deficiency for the health plan were not necessary as of December 31, 2012. For 2011, a premium deficiency for the health plan was booked in the

(Continued)

amount of $20,275,000. For the Disability plan, at December 31, 2012 a $150,000 premium deficiency was booked and no premium deficiency reserve was necessary as of December 31, 2011.

(10) Employee Benefit Plans

For the fiscal year ended December 31, 2008, EGID implemented GASB Statement No. 50, *Pension Disclosures – an amendment of GASB Statements No. 25 and No. 27*.

GASB Statement No. 50 amends GASB Statement No. 27 to require employers participating in a cost-sharing plan to include the following in the note disclosure: the required contribution rates and the employer(s) in dollars and the percentage of that amount contributed for the current year and each of the two preceding years, and how the contractually required contribution rate is determined (for example, by statute or by contract, or on an actuarially determined basis) or that the cost-sharing plan is financed on a pay-as-you-go basis.

GASB Statement No. 50 also amends GASB Statement No. 27 to require that if a cost-sharing plan does not issue a publicly available stand-alone plan financial report prepared in accordance with the requirements of GASB Statement No. 25, as amended, and the plan is not included in the financial report of another entity, each employer in that plan should present, as required supplementary information, the schedules of funding progress and employer contributions for the plan (and notes to their schedules). Also, each employer should disclose that the information presented relates to the cost-sharing plan as a whole, of which the employer is one participating employer, and should provide information helpful for understanding the scale of the information presented relative to the employer. EGID has made all required disclosures under GASB Statement No. 50.

(a) Retirement Plan

EGID contributes to the Oklahoma Public Employees Retirement Plan (the Retirement Plan), a cost-sharing multiple-employer public employee retirement system administered by the Oklahoma Public Employees Retirement System (OPERS). The Retirement Plan provides retirement, disability, and life benefits to Retirement 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 Retirement 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 Retirement Plan. That annual report may be obtained by writing to OPERS, 5801 Broadway Extension, Suite 400, Oklahoma City, Oklahoma, 73118-7484 or by calling 800.733.9008.

Retirement Plan members, state employees and EGID are required to contribute at a rate set by statute. The contribution requirements of Retirement Plan members and EGID are established and may be amended by the legislature of the state of Oklahoma. Each member participates based on his or her gross salary earned (excluding overtime).

The contribution rate for EGID and employees for 2012, 2011, and 2010 is as follows:

	Employee rate	Employer rate
July 1, 2012 – December 31, 2012	3.5%	16.5%
July 1, 2011 – June 30, 2012	3.5	16.5
July 1, 2010 – June 30, 2011	3.5	16.5
July 1, 2009 – June 30, 2010	3.5	15.5

EGID's contributions to the Retirement Plan for the years ended December 31, 2012 and 2011, and 2010 were approximately $1,200,000, $1,222,000, and $1,192,000, respectively, and were equal to EGID's required contributions for the year. Contributions are included in administrative expenses in the statements of revenues, expenses and changes in fund equity.

(b) 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 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, 2012. EGID believes it has no liabilities with respect to SoonerSave.

(11) 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:

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

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During 2012, EGID's liability for compensated absences increased by approximately $108,000 for 84 employees, decreased by approximately $181,000 for 69 employees, and did not change for 14 employees.

During 2011, EGID's liability for compensated absences increased by approximately $125,000 for 104 employees, decreased by approximately $86,000 for 44 employees, and did not change for 13 employees.

EGID's liability for compensated absences at December 31, 2012 and 2011 amounted to approximately $864,000 and $937,000, respectively, and is included in other accrued liabilities in the balance sheets.

(12) 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, 2012 are as follows:

2013	$	607,556
2014		123,744
	$	731,300

Rent expense for office space and equipment for the years ended December 31, 2012 and 2011 was approximately $628,000 and $586,000, respectively, and is included in administrative expenses in the statements of revenues, expenses and changes in fund equity.

(13) 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.

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.

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(14) 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 monies from the Fund are used when an inmate's medical costs exceed $8,000 up to a maximum of $100,000. As of December 31, 2012 and 2011, the Fund has assets and liabilities of approximately $2,375,000 and $1,866,000, 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 are unable to obtain coverage through other insurers. All insurers and reinsurers providing health insurance or reinsurance in the state of Oklahoma are required to participate in the Pool. With the exception of EGID, all self-insured plans are exempted from participation. Participating insurers are assessed periodically. EGID has recorded assessments totaling approximately $3,467,000 and $2,378,000 during the years ended December 31, 2012 and 2011, respectively, which is included in administrative expense in the statements of revenues, expenses and changes in fund equity. Participating insurers may also be assessed additional amounts if the Pool experiences adverse claim development.

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.

(15) Subsequent Events

EGID has evaluated subsequent events from the balance sheet date through April 29, 2013, the date at which the financial statements were available to be issued, and determined there are no other items to disclose.