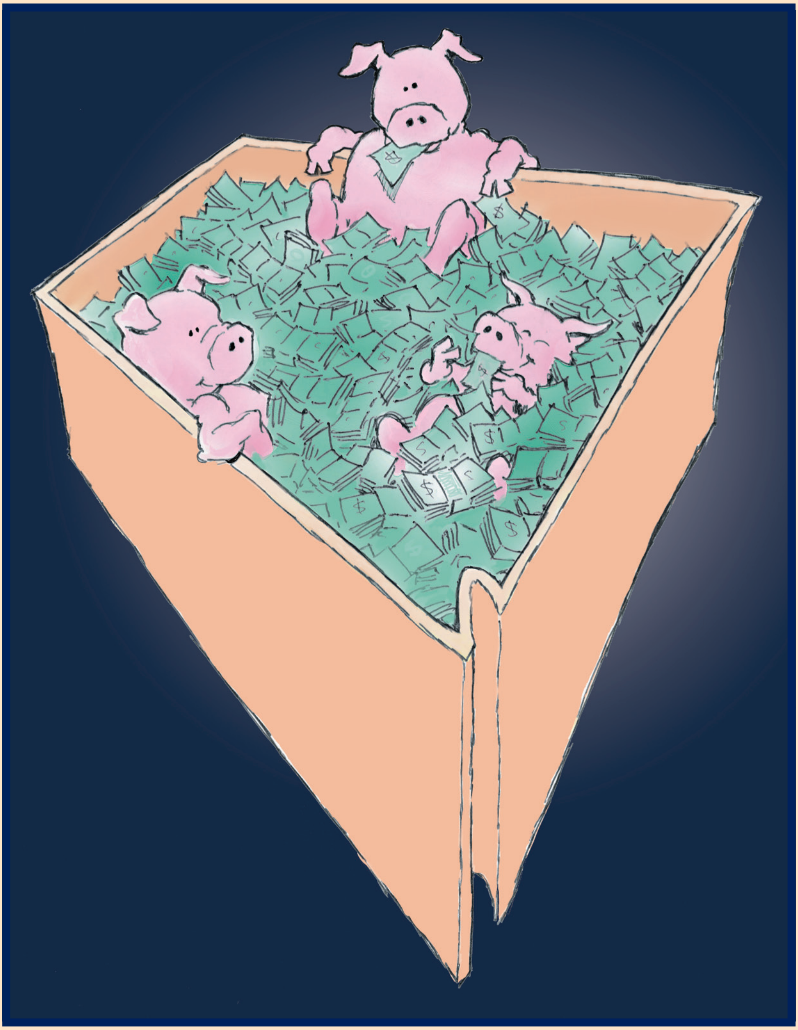
The Nevada Piglet Book 2014



by Geoffrey Lawrence & Cameron Belt

Introduction

Some politicians have the savvy and know-how to fix any problem that has ever confronted society.

Just ask them.

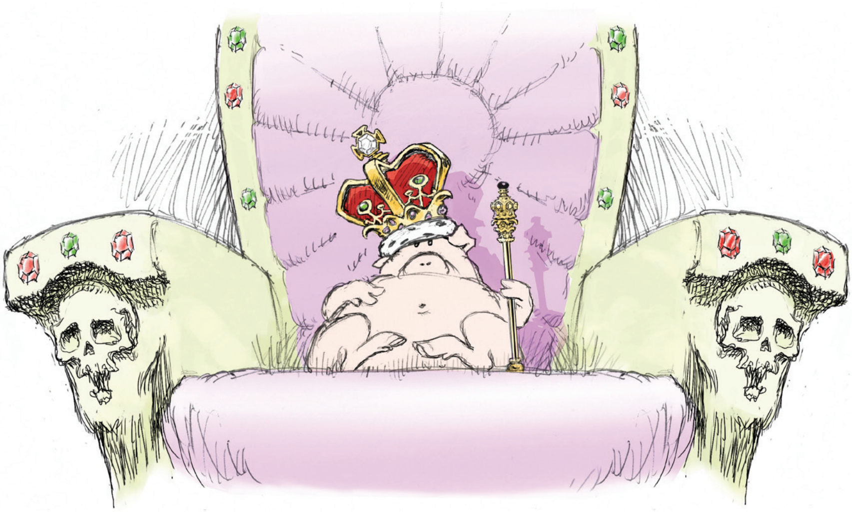
Armed with a hearty handshake, a brilliant smile and a list of pre-approved talking points, they'll nonchalantly promise citizens all the goodies that people have been trying to develop in greater quantities for centuries.

"You want quality health care?" ask the politicians, "You got it!

"You want cheap transportation? You got it!

"You want extra spending cash? You got it!"

These supposedly visionary leaders are quick to inform us that we needn't pay attention to the millions of researchers, scientists and engineers who strive day and night to develop the things that make our lives better. Nor should we pay attention to the millions of miners, factory-line workers and heavy machinery operators who produce the items for mass consumption, nor to the millions of freight workers, truck drivers and store clerks who deliver those items to the



places where they are in greatest need, nor to the millions of bankers, savers, analysts and financiers who provide the capital necessary for all of these other activities to take place.

No, every election cycle we are now implicitly told that a single politician can accomplish all the tasks necessary to deliver us the things we desire with the simple stroke of a pen. All that prevented us from living in abundance in the past, we are led to believe, was that previous politicians were too timid in issuing governmental decrees.

Presumably, their timidity resulted from some nefarious and secretive relationship with "The Man," who doesn't want us to have the things we need. Apparently "The Man" works behind the scenes to ensure that reality's unlimited abundance is destroyed before we can receive it, compelling us all to remain subject to the conditions of economic scarcity.

His identity remains unknown.

Unfortunately, we have discovered over and over that the promises of these politicians rarely pan out. Could it be that the narratives they promote are overly simplistic?

Maybe the human progress achieved by mankind in the last 1,000 years really did – and still does – rest upon the indescribably complex profusion of exchanges between billions of individuals, all across the globe, each person lending his or her own specialized knowledge and personal desires to the creation, production and delivery to each of us of the goods and services that we each individually value.

Perhaps this massive and infinitely detailed endeavor – efficiently and naturally coordinated by processes that emerge from the very nature of purposively acting individual human beings – is far superior to any diktat offered by politicians.

Perhaps.

But such an explanation is too long to fit on a politician's talking-point card. Or maybe the more basic problem is that it fails to promote the superhuman aura that politicians covertly crave.

In either case, this year's edition of *The Nevada Piglet*

Book explores the promises of key politicians to deliver citizens things of value by simple decree. In the end, these promises virtually never work out, since most politicians ignore, or never even comprehend, the vast complexity involved in the creation and delivery to market of any good or service.

How politicians play games with your life

Politicians or bureaucrats who ignore the fundamentals of how markets work and instead try to force certain outcomes purely by legal decree virtually guarantee a breakdown in society's ability to freely and efficiently coordinate resources so that individuals can procure the things they need.

Few examples underscore this point better than politicians' attempt in recent years to provide citizens with health care by decree. The federal "Affordable Care Act" and the creation of state-run exchanges through which individuals would purportedly gain access to quality, reliable health care at prices they could afford has instead delivered outrageous price increases for new, ACA-compliant health insurance policies.[1] These high-priced policies typically offer coverage inferior to policies the market previously delivered on its own – albeit while laboring under a complex, costly and restrictive regulatory environment that limited innovation and competition.[2] Worse yet, as Nevadans have seen, the political establishment completely failed to even provide a delivery mechanism through which individuals might successfully purchase these high-priced, low-quality insurance plans.

Full steam ahead

The fiasco jointly perpetrated by the State of Nevada and Xerox may soon rank among the greatest public policy catastrophes in Nevada history. State leaders spent at least $12 million on this entirely optional subsidiary project of the ACA[3] – a pseudo-marketplace to be run by a new state bureaucracy facilitating the sale of poor-quality, ACA-compliant insurance policies. It has become infamous for its pervasive failure to perform its one and only function: facilitating those very sales.

In July 2012, the Nevada state Board of Examiners,[4] at the prompting of then-Silver State Health Insurance Exchange executive director Jon Hager, awarded Xerox a $72 million contract to develop an online portal and insurance plan selection tool.[5] The agreement stipulated that, in addition to the technical development of the Health Insurance Exchange (HIX), Xerox would open a call center in Las Vegas to provide local customer assistance and support.[6] Of the total $72 million slated for this contract, $50 million came from a series of grants issued by the federal government.[7]

Leaders in most states initially took a risk-averse approach, waiting to see which options would be best for creating an ACA-compliant exchange in their states. Nevada's leaders, by contrast, jumped headlong into the rhetoric emanating from Washington that presumed politicians, in their infinite wisdom, could deliver health care more efficiently than markets. Under the leadership of Gov. Brian Sandoval, who proposed, championed and signed the bill to create one of the first state-run ACA exchanges, Nevada's political class rushed to get the state out front where it could posture as an industry leader.[8] Every state lawmaker present voted for the 2011 legislation.[9]

Nevada's political class wanted to act quickly in order to become eligible for federal grant funding for state-run exchanges. The Obama administration had committed to shelling out over $1 billion in 2010, 2011 and 2012 to assist states establishing such exchanges.[10] By acting quickly, and without pause, state leaders would position Nevada to be one of seven states awarded the Tier 2 federal grant that amounted to $50 million.[11]

Requirements of this funding stipulated that the multi-million dollar HIX site had to be fully functional by October 2013 – roughly 15 months after Xerox won the contract bid.

The HIX was intended as both a portal for individuals to compare and buy health insurance plans for themselves as well as a gateway to determine whether individuals were eligible for newly expanded medical entitlement programs such as Medicaid. All applications, eligibility and enrollment activities were to be organized and brought together through the HIX – a task that had never before been attempted in human history, but which Sandoval and other state leaders thought feasible within 15 months.

One little, two little, three little setbacks

The next year of development was full of missed deadlines, miscommunications and politicians' implausible expectations. Xerox promised deliverables that the company was incapable of creating. By August 30, 2013 – just over a month shy of the deadline – the platform was able to successfully execute only 22 test applications out of 235 prescribed scenarios. That was a successful execution rate of only 9.4 percent.

Any acclaim for even this level of "success" was tempered, however, since none of the 22 test scenarios executed actually resulted in a finalized insurance plan enrollment. The enrollments appeared to just hang in some electronic limbo.[12]

To make matters worse, the various state bureaucracies whose participation was required for the exchange to become functional were unable to provide the exchange system with the information it needed in a timely manner. The Nevada Division of Welfare and Supportive Services failed to fulfill its task of providing Medicaid and CHIP plan data to the exchange, and, as a result, plan eligibility could not be correctly identified.[13] "According to the last status report issued three days before the site launched," noted the *Las Vegas Sun*, "four of seven system components were at risk of being incomplete."[14]

When the site went live on Oct. 1, 2013, it was clear that the system remained incomplete. Nevadans, many of whom were facing cancellation of their existing health care plans because they did not conform to decrees emanating from

Washington, were unable to procure new, ACA-compliant policies from the state-run pseudo-market. The exchange's executive director reported that even he was unable to enroll through the exchange using his own, personal account.[15]

Within the first week of being open to the public, the exchange was taken offline on two separate occasions to apply software patches designed to fix the thousands of bugs that made the site unusable. Yet it remained unusable.[16]

Given the botched system, enrollment numbers fell significantly lower than officials' initial forecasts. Those estimates by state officials projected that 118,000 Nevadans would sign up for coverage between October 1, 2013 and March 2014. By April 2014, approximately 45,000 individuals had selected plans and, of those, only 32,000 had begun to pay for premiums.[17]

In a further twist, even individuals who were able to navigate the exchange, select a plan and begin paying premiums, didn't necessarily acquire coverage under an ACA-compliant health insurance policy. The political "solution" for providing Nevadans with health care had yet another curveball: Some Nevadans who signed up and paid premiums – believing they now had insurance coverage – would later learn that no insurance provider had any record of them and thus they had no coverage.

Things get human

In April, some of those Nevadans launched a class-action lawsuit on behalf of all who had gone through the enrollment process but were subsequently left without proper coverage. Both of the initial co-plaintiffs of the lawsuit, Larry Baisch and Lea Swartley, had used the exchange to select plans they believed would meet their needs. And they began making payments in November – supposedly qualifying them both for coverage beginning January 1, 2014.

Tragically, Baisch suffered a heart attack December 31 and had to undergo a triple heart bypass. The surgery and associated hospital stay yielded a bill of $407,000. Due to an uncorrected "glitch" in the exchange software, however, his insurance provider could not be identified. Baisch possesses paperwork showing he selected coverage from the MyHPNSilver1 plan, but Xerox's system ostensibly shows that Baisch instead had enrolled in a Nevada Health CO-OP plan.[18]

Similarly, Swartley learned of confusion about her coverage the day after it was supposed to have become effective. Thus, when she recently gave birth, it was without any guarantee that she had coverage.

Baisch and Swartley were both able to receive care due to the immediate emergency of their situations. Others, however, whose situations could not be so classified have been even less fortunate.

Las Vegas resident Linda Rolain tragically passed away on June 30, with complications caused by her inability to receive treatment for a brain tumor. Rolain was diagnosed with the tumor in January 2014. The condition called for immediate treatment, but it was unclear when the insurance coverage she chose from the Silver State Health Insurance Exchange took effect. Only in May, given miscommunication by Xerox, did Rolain and her husband learn that their policy had actually taken effect in March – meaning she could have begun treatment at that time. Rolain's doctor claims that if treatments had begun in March they may have helped to prolong her life.[19]

While the political class – exuberant about its self-proclaimed triumph in delivering what it calls "quality health care" to the public – will undoubtedly regard Rolain's case as merely the result of an unfortunate technical "glitch" in an otherwise visionary and forward-thinking social achievement, the loss of her life is a human testament to what happens when the political class substitutes its own hubris for the collective wisdom embodied in a true marketplace.

As of July, about 150 Nevadans are involved in the class-action lawsuit against Xerox and the Silver State Health Insurance Exchange.[20] Recent estimates by the law firm pursuing the case indicate that as many as 6,000 Nevadans may be in a similar situation and not yet know it.[21]

The buck gets passed on from here!

In May 2014, amidst burgeoning public unrest and a growing lawsuit, Nevada officials voted to cancel their contract with Xerox and to abandon plans for a state-run HIX. Looking toward 2015 and beyond, the Nevada Health Link will redirect Nevadans to the federal exchange website, HealthCare.gov. Because the existing federal site is incompatible with Nevada's failed state-run exchange, all 37,000 Nevadans who enrolled through the state exchange must go through the process again on the marginally more functional federal exchange beginning in November 2014.[22]

Aside from having the contract revoked, Xerox will not be penalized for the firm's inability to fulfill all its contractual obligations. According to exchange spokesman C. J. Bawden, exchange officials decided not to penalize Xerox, saying that the site had technically met its obligations under the law. "Because Nevadans were able to determine eligibility, select plans and pay for them on Oct. 1," Bawden says, "staff did not feel it was appropriate to charge for liquidated damages."[22] Since visitors to the site were able to see the different options and, depending on their luck, perhaps sign up for one of those options, the officials appointed to run the Silver State Health Insurance Exchange opined that Xerox had met its obligations.

Although Nevada households would face tax penalties for their inability to enroll in plans offered through the exchange – in addition to going without health coverage – the contract agreed to by exchange bureaucrats and approved by the state's governor, secretary of state and attorney general (each of them attorneys) apparently only required Xerox to make plan information visible to shoppers. A reliable mechanism for

shoppers to actually purchase the plans was not something the vendor necessarily had to provide. Thus, per terms of the contract, Xerox is still to receive $12 million for work already completed.

The politicians who presumed that their decrees would be more capable of delivering health care to citizens than markets were quick to distance themselves from Xerox and place all the blame on the vendor, as opposed to the premise upon which they had been operating.

Gov. Sandoval railed to the *Las Vegas Review-Journal*, "We hired Xerox to build this system and ensure that it works and right now it's not... I am going to hold Xerox's feet to the fire."[24]

Sen. Harry Reid, who pushed the ACA to passage as leader of the U.S. Senate decried, "There is no reason Nevada's exchange couldn't have been as successful as other state-based exchanges, like Kentucky or Connecticut, if not for Xerox."[25]

In essence, the reflexive reaction of these politicians was to claim that the exchange's failures could not have stemmed from the hubris inherent in their directives. Instead, all the blame had to fall upon a private company – Xerox, in this case. Nowhere are these leaders on record recognizing that Xerox was simply a government contractor selected by these leaders' subordinates to carry out their biddings based on the belief that Xerox was best positioned to do so.

B...b...but...but...but...

More than a year before the Silver State Health Exchange went live, Sandoval described to the media why it was so important for him to establish a state-run exchange even though the ACA gave states the option of not doing so. "I feel like I would prefer to have this state have the control over this," he explained, "We don't know if we were to not have our own exchange what the federal government would do and what it would look like and what they would charge the state." [26]

As the first Republican governor to endorse the idea of a state-run exchange, Sandoval was drawing national attention for his move. He would eventually be joined by Susana Martinez in New Mexico and Butch Otter in Idaho. The other 26 Republican governors, meanwhile, adamantly rejected the idea of a state-run exchange. Republicans have not been alone in their opposition, however. Seven states with Democratic governors refused to set up state-run exchanges, choosing instead to let the responsibility remain with the federal government. In total, only 16 states and the District of Columbia opted to create state-run exchanges.[27]

Sandoval's public rationale for implementing a state-run exchange in Nevada was that doing so would allow state policymakers greater control over how the platform functioned. In reality, however, the ACA has always been clear that this would not be the case, as any state exchange that did not meet strict adherence to all federal dictates could simply be commandeered by federal authorities. As the Centers for Medicare and Medicaid Services instructed state leaders, the ACA "authorizes [federal authorities] to ensure that States with Exchanges are substantially enforcing the Federal standards ... and to set up Exchanges in States that elect not to do so or are not substantially enforcing related provisions."[28] In other words, federal authorities could force any state-run exchange to behave exactly as the federal exchange through regulations.

Nevertheless, under this guise of "autonomy" the Sandoval administration enthusiastically pursued creation of a state-run exchange and selected Xerox to build the platform. Yet Xerox, from the beginning should have been rated a questionable choice. The firm, after all, already had a track record of failing to perform on health-care-related contracts. It was six years late and $30 million over budget in providing New Hampshire with a Medicaid payment system. The company also botched and failed to deliver a functioning Medicaid system to Alaska on time, and it appears that may be the case in Montana as well.[29] Currently Xerox is also in a federal lawsuit filed by Houston's city attorney over the company's inability

to provide accurate financial information for that city's Emergency Medical Service.[30]

It is unclear whether these past failures were brought to the attention of Nevada officials during the initial bid process. Official documents state that Xerox was chosen because the company ranked the highest on the bid criteria.[31] These included: "financial stability; demonstrated competence; experience and performance on comparable contracts; expertise and availability of key personnel; and cost."[32] Sandoval told reporters in early 2014 that Xerox had edged out the second-place bidder, Deloitte, by four points on the bid-evaluation scale.[33] However, the scoring performance and supporting materials are not available for public inspection – on the grounds that much of it is proprietary.

In the wake of the many failures of the exchange, state officials have now granted a $16.4 million contract to Deloitte to try and patch the broken exchange temporarily. Deloitte was selected using emergency provisions that obviate the legal requirement for open and competitive bidding.[34] Nevada's exchange will ultimately be merged with the federal exchange that Nevadans would have participated in anyway had state leaders not pursued a state-run exchange. State officials estimate that the transition will cost roughly $20 million.[35]

Meanwhile, thousands of Nevadans may still be lacking coverage, despite their earnest efforts to procure an ACA-compliant policy from the state's dysfunctional exchange. Nevada's foray into the political doling out of health care has entailed costs not just financial but also deeply human, as political solutions to economic problems usually do.

And now, for my next trick

After going on record numerous times expressing his dissatisfaction with the performance of Xerox, Gov. Sandoval and his colleagues on the Board of Examiners approved two new state contracts for Xerox in August 2014. The new contracts will pay Xerox a total of $7.8 million to "provide unclaimed property audits and other services to the treasurer's office."[36] We can rest easy, however, because Xerox once again scored highest on the state's bid criteria!

Too big to succeed

As enterprises grow, it becomes increasingly difficult to communicate useful information across functional areas and to coordinate the efforts of different functional departments in pursuit of a single, unified objective. Large corporations, for instance, have purchasing departments that tend to operate more-or-less independently of retail departments, human resources and other key functional areas.

Despite the challenges of coordinating activities across a large organization, private firms have a unifying incentive that encourages workers to ensure they operate cohesively with workers in other departments: the bottom line. If an enterprise is unable to deliver quality goods to market at prices customers are willing to pay, the firm will lose business, endangering all workers' jobs. The quest for profitability drives firms to ensure that critical information is shared across departments and that the various functional areas act cohesively.

Governments, however, are quite different. While governments also have many disparate functional areas, little incentive actually exists for these functional areas to operate cohesively. That's because governments receive revenues through taxes long before any services are actually provided and independently of the quality of those services.

The differences in incentive only encourages the "silo" mentality in which various functional departments act autonomously from one another, leading frequently to duplication of efforts, unproductive inter-departmental competition for resources and to poor communication of critical information.

Nevada's state bureaucracy has been plagued by each of these problems in recent years, as one might expect based on the incentive structure.

Unemployed prisoners

The 2012 Piglet Book detailed how nearly 40 percent of the workforce development funds distributed by Nevada's Department of Employment, Training and Rehabilitation (DETR) are absorbed by administrative expenses that pay the salaries of bureaucrats and well-connected contractors.[37]

That finding, made by state auditors, was later followed by another audit of DETR that clearly illustrates state agencies' collective inability or unwillingness to coordinate their efforts in order to provide value for taxpayers.

The state's unemployment insurance program, which is managed by DETR, was the subject of this subsequent audit. The program is funded primarily through a payroll tax levied against employers throughout the state. Between 2009 and 2012, however, DETR had to borrow $1.1 billion from the federal government to cover its legal obligations for replacing lost wages due to extraordinary unemployment rates during the recession.[38] The audit brought attention to the fact that DETR does not have a reliable system in place to ensure that unqualified individuals do not receive these unemployment benefits. Auditors found that inmates in the state's correctional system and dead people have been drawing these benefits for extended periods.

Auditors identified 67 different claimants who received unemployment benefits totaling $241,000 while detained in one of the state's correctional facilities during January 2012 alone.[39] While receiving food, clothing and shelter through the Department of Corrections' (DOC) budget, two clever inmates also received unemployment benefits for more than a year, collecting $26,745 apiece.

Auditors compared the rolls of unemployment beneficiaries to inmate lists available from the DOC and found that 31 recipients of state unemployment benefits during January 2012 were concurrently housed in state prisons. Together, these 31 inmates received $208,000 that month alone. Another $33,000 was disbursed to inmates at county jails that month. On average, inmates receiving unemployment benefits received $6,700 over a period of 20 weeks.[40]

Based on their findings over a very limited time period, auditors estimated "the amount of unemployment benefits that may have been paid to incarcerated individuals to be as much as $5 million over the last 3 years [2009-2011]."[41]

The inappropriate disbursement of unemployment benefits to inmates resulted from DETR's inability to work cooperatively with DOC and share mission-critical information across departments. DETR officials complained to auditors that they have no legal means of compelling DOC to provide this information and DOC has not voluntarily supplied it, but then DETR officials didn't think to ask, either. Auditors received the information they sought about inmate roles by submitting information requests to DOC, and DOC responded to two out of three requests.[42]

In fact, there was reason for DETR officials to suspect the agency was disbursing money to inmates because one inmate who was receiving benefits openly discussed his situation with a claims examiner while incarcerated, but the examiner did nothing to stop payments. The inmate informed the examiner that an acquaintance of his would be filing weekly claims on his behalf since he was in jail. The examiner continued with his job and processed the claim without an investigation.

He made a note of the event, but failed to follow through in due diligence. This inmate continued to receive benefits for 73 weeks, over half of which occurred after he informed the claims examiner that his claim was fraudulent.[43]

Dead and jobless

DETR's failure to communicate with other agencies and obtain mission-critical information extended far beyond DOC's inmate rolls. According to auditors, "The Division does not compare claimant information with records of the deceased." During the month of January 2012, "improper payments totaled $40,417 made to accounts of deceased claimants."[44]

In one instance, weekly benefit claims continued for 83 weeks until the deceased's benefits reached its limits and more than $33,000 was dispersed.[45] Similar to the inmate information issue, DETR officials failed to compare their record of beneficiaries to records of deceased individuals from the Office of Vital Records.

Finally, DETR was also found delinquent in assuring that a beneficiary was not simultaneously receiving workers' compensation benefits (disability, temporary partial disability or rehabilitative services as a result of on the job injuries).[46] State law explicitly charges DETR with the responsibility to crosscheck records of unemployment beneficiaries against workers' compensation recipients by collecting reported information from private workers' compensation insurers.[47] Despite the legal requirement, DETR has failed to even ask for this information since 1999. Auditors were unable to estimate how many inappropriate payments had been paid to workers' compensation recipients.

On the corner of Death and Easy Street

Nevada is a great place to be a corpse.

Not only can you receive benefits for losing your job – on account of being dead – you can also receive welfare payments for falling below the poverty line!

When state auditors examined the Division of Welfare and Supportive Services, they found that division, like DETR, was not cooperating with other agencies to obtain mission-critical information. The division's failure to crosscheck its automatic data system against databases from other agencies (such as the Office of Vital Statistics) resulted in welfare payments being sent to dead people.[48]

Auditors simply requested the data from the Office of Vital Statistics and found that the welfare division's database contained 189 deceased individuals. Auditors further examined 50 of those accounts and found that 27 of the 50 had continued to receive deposits into their accounts electronically after their death. In some cases, deposits were made for 10 months after the recipient had died.[49]

JP Morgan, the firm that handles electronic benefits transfers on the division's behalf, was able to recover the payments that were sent to 65 deceased individuals after determining that there had been no withdrawals from the accounts for an extended time period, but the accounts still remained active even after this one-time recovery of funds.[50]

The welfare division also allowed JP Morgan to overcharge for its vendor services. Although the rate had been lowered by a new contract agreement, the firm continued billing at an old service rate. This resulted in the Division overpaying the vendor by $77,000. Once auditors pointed out the error, the firm promptly returned the money, but the division should have paid attention to the invoice amounts. As the auditors observe, "The Division did not adequately review the invoices from the EBT vendor before paying."[51]

Too big to succeed: Part II

In the business world, managers must constantly evaluate the benefits available from a restructuring of operations and workers must remain open to change because market conditions, consumer preferences and available technologies are always changing. Successful enterprises must change with the times in order to remain profitable.

In government, however, change comes much more slowly. The ability to receive revenues before services are provided, combined with the power to raise prices (taxes) at will and force residents to continue paying, drastically limit incentives for agencies to change and adapt to new conditions.

Further, entrenched interest groups such as public-employee unions, government contractors and others form an organized resistance to change while directly influencing political decision-makers.

Pork-mobiles

A case in point is Nevada's Department of Public Safety. When auditors examined the department, they found multiple cases in which expenses could be reduced through a consolidation or restructuring of certain operations. In total, auditors highlighted more than $10.6 million in immediately available savings along with ongoing annual savings of $3.4 million.[52]

First, auditors noted that Highway Patrol dispatch centers were operating inefficiently. A single dispatch center is able to coordinate officers throughout the state and auditors noted that the Carson City dispatch center had extra capacity that allows it to frequently pick up the slack for other centers. Despite a larger budget, however, the Elko dispatch center was only able to handle six percent of Northern Nevada's workload. Auditors noted that the Department could take advantage of Carson City's greater efficiency by consolidating the two centers and expanding the staff size in Carson City by 26 percent. Such a change would reduce costs by $696,000 annually.[53]

Auditors also noted that the Department still transmits and receives arrest warrants by physically picking up these warrants from local courthouses or by receiving them through traditional mail. This system is costly and obsolete when warrant information can easily be transmitted electronically between courts and Highway Patrol. The auditors estimated that the Highway Patrol Division could save $492,000 annually, were officers to stop playing pony express and start communicating electronically with the court system.[54]

The Highway Patrol Division could realize $7.2 million in one-time savings and $1.8 million annually with greater control over its fleet size. Auditors noted the division has purchased far more vehicles than it even has officers capable of driving. The Division had purchased 593 automobiles for 396 officers. Each of these vehicles cost the Division between $38,000 and $45,000. Auditors recommended limiting automobile purchases to the total number of officers available to drive them, plus a safety increment of 5 percent, in case some vehicles required long-term repairs. This would still leave the Division with 177 excess automobiles that could be sold for $7.2 million.[55]

In addition, the Division spends between $5,000 and $12,000 annually to maintain each vehicle, excluding fuel costs. Reducing fleet inventory by 177 would reduce annual maintenance costs by $1.8 million.[56]

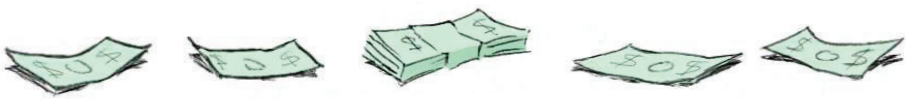
A further $426,000 in annual savings could be achieved simply by encouraging fleet repair shops to be more productive. According to auditors, "We found the lack of effective management may have contributed to low productivity and incomplete work orders and inventories at the shops," and that "shop staff could increase productivity by about 35 percent to achieve NHP goals."[57] "NHP's goal for mechanics and communications technicians," continued auditors, is for "80 percent of available hours [to be] productive. We reviewed the system records of staff from FY11 and found less than 50 percent of recorded available hours were productive."[58]

While the recommendations from auditors were straightforward, the institutional and political resistance to change inherent within the state bureaucracy was made

obvious by the response from NHP management.

Director Chris Perry responded to the auditors' recommendation to consolidate dispatch centers, saying, "A consolidation of this nature should be properly addressed and approved through the State budgetary process during the Legislative Session. Personnel impacts and political concerns... need to be assessed and addressed."[59] Perry continued by explaining that lawmakers had already approved the Division's ability to make the unnecessary expenses and, therefore, the Division wouldn't consider a consolidation until a future budget cycle.

Perry did indicate in his response to auditors that the Division would follow through on their recommendation to reduce fleet size. However, more than a year later, the fleet size stood at 554 vehicles. Although auditors recommended a reduction of 177 vehicles, NHP only reduced the fleet by 39 vehicles after telling auditors they would comply with the recommendations. When asked if the Division was saving the kind of money envisioned by auditors, Department of Public Safety Director James Wright responded in July 2014, "I don't have the calculator to say that."[60]



It is unclear whether the Department has since been able to procure a calculator.

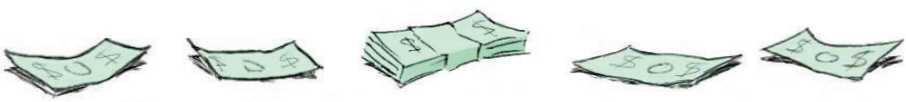
Too big to succeed: Part III

As organizations grow and start to employ more and more people, the safeguarding of assets becomes increasingly difficult. Money and other valuables begin to pass through more hands, and it is often difficult to track the behavior of all workers to ensure they do not misappropriate organizational assets and that all revenues are appropriately collected and reported. For this reason, auditors often refer to the strength of an organization's system of "internal controls." These are mechanisms for ensuring that assets are not lost or stolen, and include provisions such as limiting employees' access to inventory or requiring the approval of management for purchasing decisions.

Private companies must pay careful attention to the strength of internal controls, because widespread theft of firm assets or failure to collect and record all revenues can upset the balance sheet and erode profitability. This can result in a reduced ability to borrow funds and an erosion of stock prices. In the government sector, however, weak internal controls are often the norm and accountability may well be nonexistent. This allows employees to frequently misappropriate assets for personal gain – even as taxpayers foot the bill for weakened balance sheets.

Hemorrhaging $$, no fiscal tourniquet in sight

Perhaps no entity has displayed so blatant a breakdown in internal controls as Clark County's major public hospital, University Medical Center (UMC). UMC has operated at astounding losses in recent years. Between 2011 and 2012, the hospital sustained losses of $113 million – an amount that would have been larger if state lawmakers had not



allowed for retroactive collections from the Medicaid Upper Limit program.[61]

Clark County compensates the hospital for losses with transfers out of the county's general fund. In other words, county taxpayers are forced to cover the losses due to any mismanagement at UMC. In 2014, the county will subsidize the hospital to the tune of $70 million. In addition, UMC has taken out $45 million in emergency loans this year to address a cash shortage that would otherwise have left the hospital unable to service its debts.[62]

A significant share of UMC losses may be attributable to a total breakdown of internal controls. Repeated audits have revealed that UMC has no mechanism in place to ensure that customers pay their hospital bills and that cash receipts are safeguarded. In fact, with an alarming regularity, UMC does not even ask customers to pay their bills, while administrators expect any loss to simply be made up by county taxpayers.

Auditors revealed in 2012 that UMC does not require patients presenting for non-emergency procedures to make payment arrangements prior to treatment. While the hospital must treat patients in emergency situations regardless of ability to pay, proper accounting rules stipulate that the hospital should try to arrange payment with patients in non-emergency situations prior to treatment. As auditors noted, "Once a self-pay patient receives [his] procedure, the patient no longer has incentive to be complicit in obtaining assistance or making payments. Also, once the patient is not held responsible for paying for services rendered, they return to UMC for additional 'free services' without expectation of payment."[63]

In fact, UMC administrators routinely allowed patients with outstanding bills to repeatedly return for non-emergency treatments without ever trying to arrange for payment. In one case, a patient received more than 150 treatments over a two-year period while accumulating $146,000 in charges without ever making a payment or attempting to find financial assistance.[64]

Auditors identified 10,003 self-pay patients who had a combined outstanding balance of $2.7 million for outpatient visits in select divisions of the hospital. Auditors tested 179 of those accounts and found that, in addition to the $807,363 owed by these patients for procedures in the hospital divisions under examination by auditors, these 179 patients also had $9.8 million in outstanding balances due to care received through other hospital divisions.[65]

In addition to UMC's failure to make payment arrangements prior to treatment, auditors cited the hospital for not maintaining a discharge desk in the emergency room so the hospital could at least ask patients to pay their bills prior to leaving. Auditors noted that in just the first half of 2011, 7,095 self-pay patients had gone through the emergency room accumulating charges of $19.3 million, but the hospital only collected $17,011 on these accounts.[66]

Finally, the hospital pharmacy regularly handed out prescriptions without even trying to arrange payment. During 2011, auditors identified 8,324 self-pay patients who obtained prescriptions from the pharmacy, but only 2 percent of these patients made any form of payment. Nearly half of these prescriptions were immediately written off as losses by the hospital without ever even sending a bill to patients. As auditors noted, "All self-pay prescriptions should be paid for at time of pick-up, especially the ones under $30."[67]

Auditors revisited these issues in late 2013 and found that hospital administrators had implemented almost none of the auditors' recommendations. Despite being chastised in the original audit, UMC still does not attempt to make payment arrangements prior to treatment for self-pay patients. The collection rate for medical procedures during the follow-up audit was only 2.01 percent. In addition, the collection rate at the pharmacy had actually declined from 2 percent to zero percent. In light of the first audit, the few patients who had paid for prescriptions apparently learned that they needn't do that anymore.[68]

As a public hospital, UMC also receives many patients who are not self-pay, but who instead qualify for Medicaid or other forms of public assistance. Even for these patients, however, hospital management has not been diligent in recovering the costs of care from the appropriate public financing agencies. All UMC needs to do to recover costs from public health financing programs is to correctly fill out the paperwork and submit it in a timely manner. However, auditors found in late 2013 that UMC fails to complete this task far too often. Administrators do not update patients' medical records with sufficient information to support findings of medical necessity for major surgeries, such as joint replacement,[69] spinal fusions,[70] and medical device implant procedures.[71] As a result of failing to maintain adequate records, these surgeries go uncompensated.

In cases where patients had coverage under Medicare, auditors found that UMC did not always complete the appropriate forms or submit payment requests to Medicare as they should. Auditors noted that UMC's laxity in completing the paperwork subjects the hospital to penalties of between $5,500 to $11,000 per claim submitted to Medicare under the federal False Claims Act.[72]

Auditors continued to investigate UMC operations into 2014 and found that UMC doesn't even appropriately bill other departments within Clark County government! The hospital provides physicals and drug screens for employees of the county fire department, police department, aviation department and others and should seek payment for these services from the respective departments. However, auditors found that UMC has not kept their contracts with these agencies up to date and has not sought collection of the amounts due.[73]

Auditors have also noted that employees have far too much access to cash drawers and that UMC's cash handling policies don't adequately protect against employee theft. In the words of auditors, "The existing cash handling policies and procedures for UMC are outdated, [which] causes control weaknesses ... that could result in theft that is not identified or attributable to a specific person."[74] Auditors found that employees were sharing managers' keys and had unsupervised access to cash drawers, drawers were not closed and counted at the end of shifts, and that cash drawers sometimes sit in employee break rooms without camera surveillance.[75]

One for me...another for me...one more for me...

Unfortunately, UMC is not the only government agency where a breakdown of internal controls has produced a weaker balance sheet. Over the past two years, auditors have found weak controls enabling employee theft at multiple public agencies across Nevada.

At the Las Vegas parks department, for instance, auditors found that one employee was able to steal at least $2,770 in cash by opening safes where the money was held prior to deposit at the bank. Auditors noted that while the department's written policies provide adequate controls, those policies aren't being followed. For instance, safe combinations are not changed periodically or when personnel who've had access to the safes separate from employment. Employees were also able to circumvent controls over the daily cash amounts by deleting cash balance reports from the safe log sheet.[76]

Parks department employees have also been able to pad their retirement benefits, say auditors, due to lax supervision regarding overtime and callback hours. From 2011 to 2012, one worker was able to increase his take home pay by $102,000 above his annual base salary of $71,000, due to misclassification of overtime and callback hours. On average, the employee worked 42 additional hours of callback per pay period. Management allowed this time to be classified as callback incorrectly, when it should have been classified as normal overtime.[77]

The difference is significant because, although both forms of overtime pay time-and-a-half, callback pay is included in an employee's calculation of retirement benefits whereas normal overtime is not. Auditors found that department administrators did not follow city procedures in approving the employee's use of callback pay and that the hours worked did not satisfy the conditions for receiving callback pay. As a result, the employee's pay level from which retirement benefits will be calculated has been overstated by $92,000 and the city will be responsible for making increased payments to the employee for decades to come.[78]

The Traffic Division at the Las Vegas Justice Court has suffered from some breakdown in cash controls recently, too. The Traffic Division collects fines assessed on motorists for driving citations and during 2013 alone collected $37.5 million in total receipts. In early 2014, auditors revealed that some employees had improperly obtained the authority to enter the division's computer system and void the fines owed by motorists. Based on their jobs, that authority was not warranted. At least one employee began exploiting this authorization to void out amounts owed after having received cash payments from motorists. This would erase the amount owed from the system while the employee pocketed the cash.

Said the auditors:

> We … found 151 transactions where a user … accepted a cash payment, voided the cash transaction by close of business, and then adjusted down the balance owed to the Court by the amount voided. In these instances, the voids did not appear warranted or legitimate. We believe it is likely the cash in these

> cases was stolen by the employee... We found that the suspected theft of cash occurred from February 2012 to December 2013. Total cash unaccounted for is $91,502.[79]

Auditors further noted that it was the court's lack of effective controls that enabled the employee's theft. "We found that the Traffic Division does not, as a policy, routinely review adjustments to funds owed to the Court," said auditors. "Without a formal review process in place, unauthorized or unwarranted adjustments to balances owed to the Court may go undetected."[80]

These cases demonstrate exactly the kinds of breakdown in internal controls that cannot be tolerated by profit-seeking organizations, but which are symptomatic of government enterprises where all losses are backstopped by taxpayers.

The Insiders' Club

For many politicians, a primary virtue of getting elected to public office is the ability to purchase personal indulgences using public funds. Nevada's politicians have been no less brazen about this in recent years than politicians anywhere in the nation.

Now you'll pay our greens fees!

In 2004, the Henderson City Council voted to acquire the Wildhorse Golf Course through a land swap deal with businesses operated by Billy Walters and the Greenspun family. As seen in the Nevada Piglet Book 2012, Walters has made millions through lucrative land deals agreed to by naïve elected officials across Southern Nevada.[81]

The council chose to swap $40.2 million of residential land to obtain the course that had been purchased by Walters earlier that year for only $9.35 million.[82]

Some officials were skeptical of the deal, saying that the appraisals of the land were suspect. The council pushed forward regardless – eager to not miss out on what one member of the panel described as the "prime golfing months" that fall.[83] Certain council members were shockingly candid, however, about the fact that they saw the deal as beneficial in a personal capacity, if not an official capacity. Then-councilman Jack Clark, for instance, openly stated, “I haven’t played golf in four years mostly because I can’t afford $150 per round.”[84] While Clark aimed to get city taxpayers to subsidize his golfing habits, he did acknowledge that the deal would cause the city to lose money, saying “[t]here will probably be a subsidy in the first few years and then it would break even.”[85]

Unfortunately, even Clark’s less-than-rosy assessment has proven to be overly optimistic. The golf course has always operated at a loss, and the city has been forced to advance more than $1.3 million over the years to keep the course operational. Auditors have recommended that “the continued subsidy of WGC operations be evaluated in light of the City’s strategic and balanced budget goals.”[86] In other words, auditors believed that subsidizing a golf course might not be the highest priority for a city faced with declining revenues.

Worse, the city has made little effort to collect on debts owed by golf course operators. At the time of acquisition, the city agreed to give the course an advance of $417,000 to provide working capital with the stipulation that the advance would later be returned to the city’s general fund. That advance remains outstanding and will likely never be paid, which means the city should write down its assets. Auditors have also noted that the contract agreement between course operators and city officials was never reviewed by the city attorney’s office, as it should have been.[87]

In addition, the course has never repaid a $750,000 loan made by the city at the time of acquisition to finance construction of a new, reclaimed water line added to resurface greens. City officials hand-delivered a bill for the loan to golf course management two years later, but auditors note that “the invoice was not submitted to the City of Henderson’s Finance Department’s Accounts Receivable Division for invoicing and collection.”[88] Therefore, city finance professionals had no record of the outstanding balance and could not follow up for payment. These loans are now likely to remain unpaid due to a six-year statute of limitations to collect on a contractual liability.

No estimate is available on how much Clark has saved in greens fees due to the city's acquisition of the course.

Colorful personalities on the school board

The Nevada Piglet Book 2010 detailed a contract negotiated by the Clark County School Board in which board members paid a consultant $86,000 to describe board members' personality types in colors of blue, green, red or yellow. That consultant, Dale Erquiaga, would later become a senior advisor to Gov. Brian Sandoval and is now Nevada Superintendent of Public Instruction. At the time, CCSD officials said it would end the controversial contract.

CCSD officials have since doubled down on the infamous contract, however, by hiring one of Erquiaga's old colleagues, Erik Kieser, to once again perform the dubious color-coded personality profiles at a price of more than $80,000. In total, the district has paid the two consultants about $350,000 over the past six years to perform this service.[89]

Clark County Association of School Administrators Executive Director Stephen Augspurger says the service is "the kind of stuff you do at a cocktail party. It's fun. It's an icebreaker. But, at the end of the day, is it something we should be spending money on in the Clark County School District when we have other pressing needs in schools, which aren't funded?"[90]

William Follette, a professor of clinical psychology at the University of Nevada has criticized the consultancy firm through which Erquiaga and Kieser contracted with CCSD, Emergenetics. "I couldn't find a single refereed article saying what Emergenetics does compared to anything," he says. "I think the school district was sold a bill of goods." Follette noted that he has been unable to establish contact with anyone listed on the firm's website, raising a serious question of illegitimacy. He also said that none of the firms' leaders have ever published anything in the field of psychology.[91]

Even more alarming, district officials chose to procure the color-coded personality profiling at an unnecessarily high price. According to the contract between CCSD and Emergenetics, the district could have paid a one-time fee of $2,999 to send an employee to Denver to become certified in the Emergenetics approach. Then, that employee could have performed the assessments – assuming they actually have some value – at little cost to the district. Instead, CCSD officials chose to use the contract to enrich insiders like Erquiaga – now a state official with substantial influence over the state appropriations that CCSD receives.

But the Emergenetics contract has been far from the only example of waste at CCSD, even while district officials continue pleading poverty before state officials and taxpayers alike.

In late 2012, as district officials were campaigning for a ballot initiative to raise property taxes to finance the district's alleged needs for buildings and supplies, reporters caught district personnel throwing their existing supplies into dumpsters. Apparently, CCSD officials needed to create the appearance of need in order to justify calls for the tax increase. Reporters caught district personnel on camera filling dumpsters with shrink-wrapped tables, chairs, desks, bookcases and other items.[92]

The reporters had been tipped to the dumping by a former employee, who said, "I started working in the purchasing department in 2009, and I immediately noticed a lot of waste going on." The employee blew the whistle on the waste after she saw three dumpsters full of furniture. She was subsequently demoted and transferred. Similarly, a retired CCSD teacher had told reporters, "They would tell us they didn't have money for crayons, they didn't have money for paper, but they were making these huge purchases of new furniture that we didn't think they needed to make because the stuff we had was perfectly fine."[93]

Conclusion

In *The Wisdom of Crowds: Why the Many are Smarter than the Few and How Collective Wisdom Shapes Business, Economics, Societies and Nations*, James Surowiecki – financial columnist for *The New Yorker* – filled a 300-page book with instances of how large groups of people are regularly smarter than the elite few. No matter the individual brilliance of the experts, large groups turn out to be better at solving problems, fostering innovation, coming to wise decisions and even predicting the future.

Exploring this seemingly counterintuitive reality, Surowiecki identifies the factors that – when met – make market-based decisions so superior to those of politicians, bureaucrats and other governmental experts.

"Wise crowds," he demonstrates, exist when four conditions are met:

- Diversity of opinion (each person should have some private information, even if it's just an eccentric interpretation of the known facts),
- Independence (people's opinions are not determined by the opinions of those around them),
- Decentralization (people are able to specialize and draw on local knowledge), and
- Aggregation (some mechanism exists for turning private judgments into a collective decision).

"If a group satisfies those conditions," he writes, "its judgment is likely to be accurate."

> At heart, the [reason why] rests on a mathematical truism. If you ask a large enough group of diverse, independent people to make a prediction or estimate a probability, and then average

> those estimates, the errors each of them makes in coming up with an answer will cancel themselves out. Each person's guess, you might say, has two components: information and error. Subtract the error, and you're left with the information.

Surowiecki does not simplistically assert that all groups produce good judgments. "For the group to be smart," he notes, "there has to be at least some information in the 'information' part of the 'information minus error' equation."

What this year's edition of the Piglet Book has highlighted are just a few of the many follies Nevada politicians have recently perpetrated by elevating their own rhetorical agility above the collective wisdom operating in true marketplaces. Many other stories could have made their way into this booklet. NPRI's cutting room floor is littered with them.

When politicians promise to deliver goods or services purely by legal decree they reveal, on a personal level, a profound lack of practical understanding. Unfortunately, our governments are increasingly populated by such individuals.

Because of the key ways in which governments differ from for-profit entities, the operating incentives are usually inferior and accountability is inherently weak. So, as governments grow, the public is increasingly plagued by these differences.

Here in Nevada, we see governments unable to:

- share mission-critical information across functional departments,
- restructure operations to change with the times, or to
- effectively implement systems of internal controls.

By their nature, governments are plagued by inefficiency, duplication of efforts, wasteful spending and employee theft. And because of the widespread ignorance concerning the superiority of markets, Nevada governments are becoming too big to succeed.

This year's edition of *The Piglet Book* makes clear that government must be restricted to a size and scope that protects the rule of law and allows free individuals to supply the needs of society through the profound intelligences that operate within the marketplace. Any other approach will, inevitably, merely yield more stories of waste and tragic outcomes – such as the ones detailed above.

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About the Authors

Geoffrey Lawrence is director of research at the Nevada Policy Research Institute. His commentaries run frequently in the *Las Vegas Review-Journal* and *Nevada Business Magazine* and have appeared in *Forbes, The Washington Examiner* and *New Hampshire Union-Leader,* among many others. Geoffrey's numerous studies and other works have drawn praise from The Tax Foundation, Americans for Tax Reform and the editorial pages of the *Las Vegas Review-Journal* and the *Las Vegas Sun*.

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