University of Nebraska
SENIOR VICE PRESIDENT AND CFO

November 30, 2015

Senator Heath Mello
Chair, Appropriations Committee
PO Box 94604, State Capitol
Lincoln, NE 68509

Dear Senator Mello:

LB 620, enacted during the 2013 legislative session, requires the University of Nebraska to present, on or before December 1 of each year, its plan regarding the management of the university's health care insurance programs and its health care trust fund to the Appropriations Committee of the Legislature.

Enclosed is the University's report for the year ended December 31, 2014. The report provides an overview of the University's health plan, chronicles financial activity for the year, and offers insights into the plan's trends.

The University of Nebraska is proud of the prudent management of its health plan, which has positioned us to provide competitive, affordable benefits to our employees – our greatest asset – and their families. These are challenging times for health care, but we are committed to offering quality health benefits that meet the needs of our employees and help us retain and attract additional talent for Nebraska.

If you should have any further questions about the University's plan, please do not hesitate to contact me.

Sincerely,

David E. Lechner
Senior Vice President and CFO

cc: Kathy Tenopir, Legislative Fiscal Office

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University of Nebraska
Health Insurance Plan Annual Report

Year Ended December 31, 2014

Executive Summary

The University of Nebraska's health insurance plan enjoyed good operating results during calendar 2014 as indicated by several measures. Most importantly, the Board of Regents and management were able to provide employees with a benefit that is highly valued by employees and prospective employees alike. In one survey, 73 percent of workers said that the insurance provided by their employer was a "very important" factor in their decision to take or keep a job[i].

In 2014, the University's health plan costs increased $4.6 million or 4 percent when compared to the prior year and was primarily attributable to increased medical and pharmacy costs, as well as the new transitional reinsurance program fee associated with the Affordable Care Act that totaled approximately $1.3 million in 2014. Despite the cost increases, premiums offered to active employees did not change for 2014, reflecting the seventh time out of the last nine years that the University has not had to raise premiums for active employees.

University management, in concert with Board members, and similar to what the State of Nebraska had done in prior years, offered a premium holiday to employees. The holiday was part of an overall strategy to draw down trust reserves while staying true to the purpose for which the trust was established. Legislative leadership was also apprised of this strategy in advance.

The University of Nebraska is proud to provide a competitive, cost-effective health insurance plan to its employees and their families. We believe the University's plan is well managed, provides competitive benefits, and is favorably positioned to serve employees' future health needs despite the increasingly uncertain challenges facing the health care industry.

University of Nebraska Strategic Objective:
Recruit and retain exceptional faculty and staff

Contents

Plan Overview

The University of Nebraska offers a preferred provider (PPO) "self-insured" health plan providing medical, dental, and pharmacy coverage to its employees. Most employers the size of the University are self-insured for medical coverage as it gives them more control over plan design. In addition, any 'profits', typically built into insurance company prices, are retained by the plan and its participants.

The University utilizes the expertise of the following outside vendors to assist in the administration of the plan:

Entity	Description of Service Provided
BlueCross BlueShield of Nebraska	Third party administrator for medical and dental claims
CVS Caremark	Third party administrator for pharmacy claims
Wells Fargo	Trustee bank
Milliman	Independent actuaries – provide projections used to set premiums

The plan, which operates on a calendar year basis, collects premiums through payroll deductions from eligible, participating employees and combines them with University premium contributions. The Plan deposits these funds into a trust account held by a trustee bank, Wells Fargo. Under state law, the Board of Regents is fully empowered to establish trust accounts, as they ensure the funds are protected and, in this case, can only be spent for health care purposes.

When covered employees and their dependents incur medical expenses, health providers (hospitals, doctors, pharmacies) send their bills to either (a) BlueCross BlueShield of Nebraska (BCBSNE) for medical and dental claims or (b) CVS Caremark (CVS) for pharmacy claims. BCBSNE and CVS, as third-party administrators, assure that the submitted claims are valid using coverage criterions, limits, deductibles and co-pays as set by the University. When BCBSNE and CVS pay claims, they are reimbursed by Wells Fargo, the trustee bank, for the claims cost plus an administrative fee.

Premiums charged to both the employer (University) and employees are designed to cover the plan's projected claim costs plus administrative expenses. Any potential changes in premiums, which become effective on January 1, are established by University management each fall after analyzing Milliman's actuarial expense projections, which are based on a combination of University internal experience along with Milliman's book of business experience. University management reviews the plan's projected premiums and anticipated expenses with the President and Chancellors before finalizing employee premiums for the upcoming year.

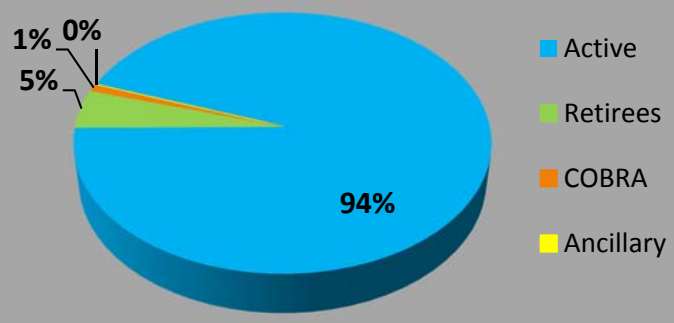
Members of the Board of Regents are kept apprised of the plan's performance through updates provided to the Business Affairs Committee.

Enrollment and Demographics

The University's health plan had 11,100 participants as of December 31, 2014, about 300 fewer than the prior calendar year. When including dependents, the plan served approximately 26,000 covered lives.

Active employees, by far the largest membership group in the plan, were the only group that increased in 2014. Participant groups comprised of ancillary employees, retirees, and Cobra electees all declined in 2014.

University retirees are allowed to belong to the plan but must pay the entirety of their premium, which is computed separately by plan actuaries from that of active employees. The number of retirees in the plan decreased 8 percent, a percentage comparable to 2013. This is attributed to a number of favorably priced "gap" polices available in the marketplace (when combined with a base of Medicare coverage) that are financially more attractive than the premium offered by the University.



University of Nebraska
Number of Health Plan Participants

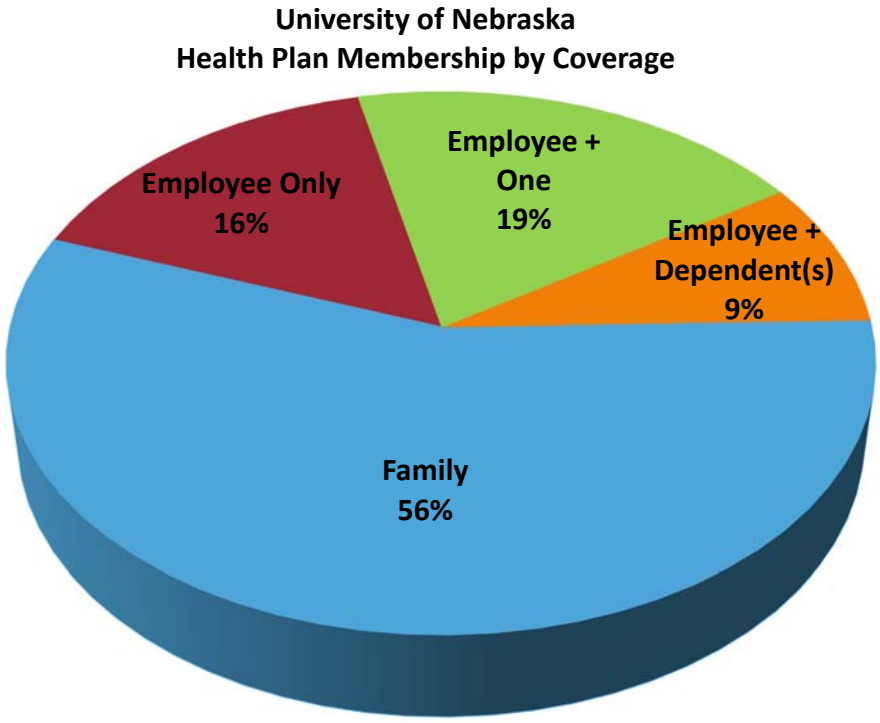
	Dec 2014	Dec 2013	Change Number	Change Percent
Active Employees	10,469	10,196	273	3%
Retirees	530	573	(43)	(8)
Ancillary Members	3	518	(515)	(99)
Cobra	98	132	(34)	(26)
Total	11,100	11,419	(319)	(3)%

University ancillary members, who are specifically approved for membership by the Board of Regents, also pay the entirety of their premiums without any University contributions. As of January 1, 2014, the University of Nebraska Medical Center Physicians left the plan after obtaining stand-alone coverage, leaving only the National Strategic Research Institute as the sole remaining ancillary member.

Demographically, plan participants are about 52 percent female and 48 percent male. Average age for all members was 36 years which remained stable from 2013.

In terms of covered lives, the average number of members for 2014 remained relatively stable. Enrollment decreased slightly in all coverages except family coverage. Net, these changes resulted in about 350 fewer covered lives in 2014.

	Average 2014		Average 2013		% Change	
	Members	% of Total	Members	% of Total	Members	%
Employee Only	4,124	16%	4,341	17%	(217)	(5)%
Employee + One	5,024	19	5,202	20	(178)	(3)
Employee + Dependent(s)	2,254	9	2,392	9	(138)	(6)
Family	14,498	56	14,310	54	188	1
Totals	25,900	100%	26,245	100%	(345)	(1)%



The plan offers three levels of coverage: low, basic, and high, with each (respectively) offering increasing levels of coverage. The high plan has much lower deductibles and co-insurance compared to the low plan. Enrollments in each of the levels has stayed fairly stable on a historical basis, with about 75 percent of members choosing the basic plan, 15 percent the low plan, and 10 percent the high plan.

The University of Nebraska's health plan covers almost 26,000 lives (employees plus their dependents)

Financial Performance

The University health plan's financial results for the years ended December 31, 2014 and 2013 are shown below (cash basis in thousands). A more detailed description of the plan's income, expenses and calendar year activities is provided in the following sections.

Plan expenses exceeded plan revenues in 2014, resulting in a $6.8 million shortfall that was absorbed by the plan's fund balance. This shortfall is attributable to several factors:

- As previously mentioned, the University offered a premium holiday to employees in December of 2014.
- Total premiums and income fell by 2 percent in 2014, primarily as a result of the drop in retiree, ancillary and cobra premiums that is attributed to the aforementioned 3 percent decline in total plan participants from 2013.
- Despite the decline in participants, medical claims expense in 2014 increased 2 percent from 2013. This growth was driven primarily by an increase in high cost claims (claims individually exceeding $100,000). Five of the top 15 high cost claimants are no longer enrolled in the plan. Excluding high cost claims, medical claims expense actually fell approximately 1 percent from 2013.
- Pharmacy claims expense in 2014 increased 8 percent from 2013. This growth was driven primarily by an approximate 16 percent increase in specialty drug costs.
- TPA and other expenses in 2014 increased 13 percent from 2013, entirely due to the new transitional reinsurance program fee associated with the Affordable Care Act, which totaled approximately $1.3 million. This annual fee was established on a 3-year sliding scale and is expected to decline approximately 30 percent in 2015.

University of Nebraska Health Plan
Schedule of Income, Expenses, and Net Activity
Cash Basis (thousands)

	Actual 2014	Actual 2013	Year-over-Year Change Dollars	Year-over-Year Change Percent
Employer Premiums	$ 97,414	$ 94,191	$ 3,223	3%
Employee Premiums	17,233	16,739	494	3
Retiree, Ancillary, Cobra Premiums	5,628	12,274	(6,646)	(54)
Trust Investment Income	2,843	2,763	80	3
Other Income	2,036	1,637	399	24
Total Premiums and Income	125,154	127,604	(2,450)	(2)
Medical Claims	91,024	88,956	2,068	2
Pharmacy Claims	27,432	25,358	2,074	8
Dental Claims	7,300	7,560	(260)	(3)
TPA and Other Expenses	6,217	5,509	708	13
Total Claims and Expenses	131,973	127,383	4,590	4%
Net Activity	$ (6,819)	$ 221	$ (7,040)	

Note, the University implemented a one month premium holiday for both the employer and employees in Dec 2014 and Dec 2013.

Income

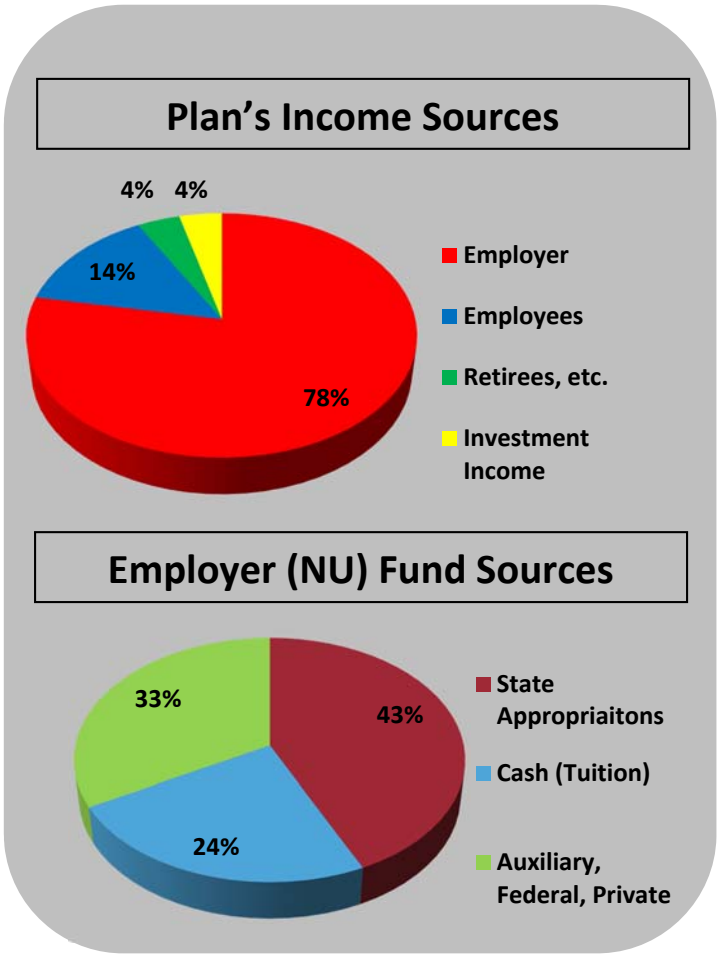
The University's health plan is funded from a variety of sources, although employer premiums account for the bulk (78 percent) of the plan's income. Employer premiums are funded primarily from state appropriations (43 percent), cash funds such as tuition (24 percent), and other self-supporting business-type activities (auxiliaries) and federal grants and contracts (33 percent).

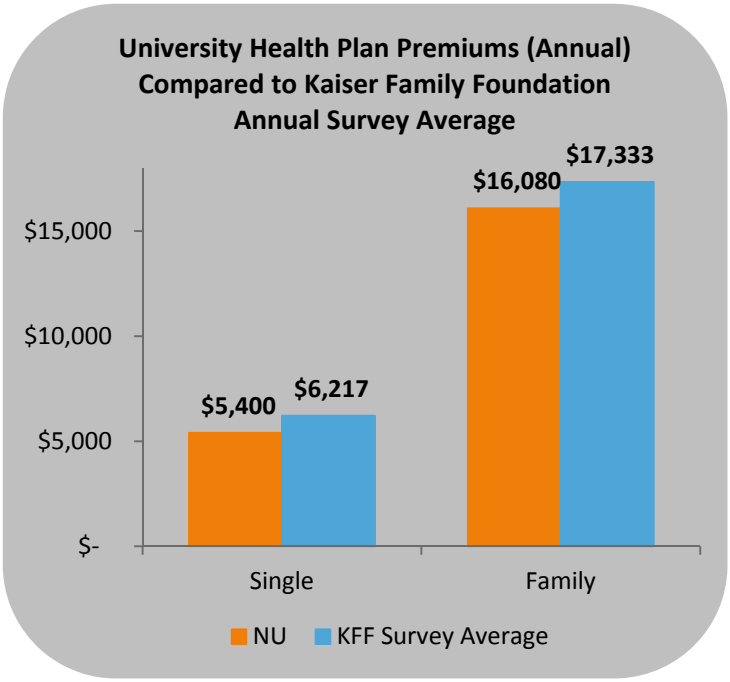
The plan's remaining income comes from employees (14 percent), retirees, ancillaries and Cobra electees (4 percent) and investment income (4 percent).

For the year ended December 31, 2014, the plan's income from employer and employee premiums increased by 3 percent. This was primarily the result of a 3 percent increase in active employees. The decreased income from retirees, ancillaries and Cobra electees was driven by the University of Nebraska Medical Center Physicians ancillary organization no longer participating in the University's health plan effective January 1, 2014.

Trust investment income gained 3 percent for the year ended December 31, 2014. The plan will continue to see low earnings into the future on its fixed income portfolio because of artificially low interest rate strategies being employed by the Federal government in its efforts to stimulate economic recovery. In spite of the lower returns, trust cash earnings saved the University and employees almost $3 million in premiums again this year.

The University offers a very competitive premium pricing structure. Premiums (employer plus employee) under the University's plan are lower than the average as reported in the 2014 Kaiser Family Foundation Annual Survey[ii] by approximately 13 percent on single and 7 percent for family coverage.





Expenses

Medical Expenses

The plan's medical claims increased by 2 percent for the calendar year. Medical claims in 2014 and 2013, arrayed by amount of claims per covered lives, were as follows:

University of Nebraska
2014 Claims Distribution (Claims in Thousands)

Total Claims/Member	Covered Lives	Percent of Lives	Amount	Percent of Claims $$
Less than $200	6,756	27%	$ 78	< 1%
$200 - $999	8,835	36	4,236	5
$1,000 to $4,999	6,057	25	13,921	15
$5,000 to $9,999	1,270	5	9,134	10
$10,000 to $29,999	1,324	5	21,768	24
$30,000 to $49,999	261	1	9,874	11
$50,000 and above	284	1	31,544	35
	24,787	100%	$ 90,555	100%

Note: only persons presenting claims are included in this analysis. An estimated 1,100 persons had no claims. Claims are per BCBS.

University of Nebraska
2013 Claims Distribution (Claims in Thousands)

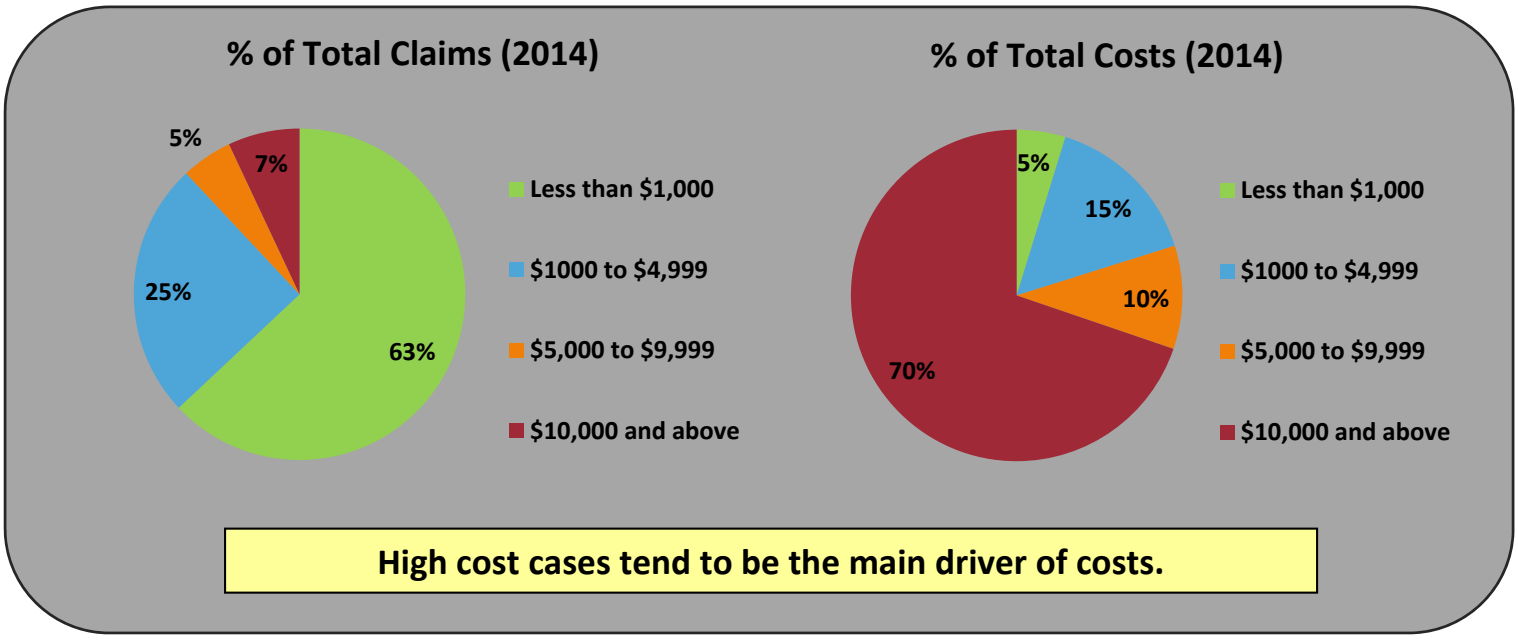
Total Claims/Member	Covered Lives	Percent of Lives	Amount	Percent of Claims $$
Less than $200	6,284	25%	$ 400	< 1%
$200 - $999	9,053	37	4,335	5
$1,000 to $4,999	6,302	26	14,382	16
$5,000 to $9,999	1,290	5	9,282	11
$10,000 to $29,999	1,306	5	21,596	24
$30,000 to $49,999	263	1	10,130	12
$50,000 and above	302	1	28,647	32
	24,800	100%	$ 88,772	100%

Note: only persons presenting claims are included in this analysis. An estimated 1,650 persons had no claims. Claims are per BCBS.

Note that the table above shows medical claims paid by Blue Cross Blue Shield of Nebraska (BCBSNE) during the reporting period and therefore may not be consistent with amounts paid by the trustee.

As is typical in health plans, high cost cases tend to be the main driver of costs. As can be seen in the table above and the charts below, in 2014 (with parentheticals showing 2013 figures):

- The top 2 percent of the covered lives accounted for 46 percent (44 percent) of medical costs.
- The top 7 percent of the covered lives accounted for 70 percent (68 percent) of medical costs.
- 63 percent (62 percent) of the covered lives had total claims of less than $1,000.

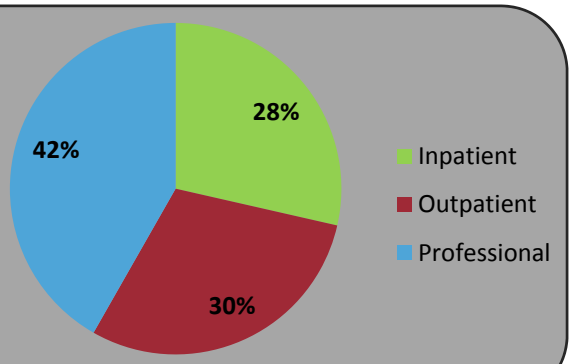


Medical costs are comprised of inpatient, outpatient and professional services. Inpatient services represent the costs that come with a hospital/facility stay. Outpatient costs are comprised of procedures that do not require a hospital stay, such as ambulatory surgery, emergency room visits, radiology and dialysis. Professional costs encompass all the services provided by physicians and other clinicians, ancillary services and medical services/supplies.

Net payments by service type as reported by BCBS in 2014 and 2013 were:

University of Nebraska
2014 Net Payments by Type (millions)

	2014	2013	Change Dollars	Change Percent
Inpatient	$ 26	$ 24	$ 2	9%
Outpatient	27	27	(0)	(1)
Professional	38	38	0	0
	$ 91	$ 89	$ 2	2%



Inpatient

Inpatient costs rose 9 percent, to $26 million in 2014 when compared to 2013. The average price paid per admission increased from $11,275 to $14,769, an increase of 31 percent. However, this increase was negated in part by an approximate 15 percent decrease in number of admissions/1000.

These major diagnostic categories combined for approximately 58 percent of total inpatient spend in 2014:

- Diseases and disorders of the musculoskeletal system/connective tissue
- Pregnancy and childbirth
- Diseases and disorders of the digestive system
- Diseases and disorders of the circulatory system

The top 10 diagnostic categories combined to account for approximately 86 percent of total expenses.

Outpatient

Outpatient costs were flat year-over-year, accounting for $27 million of expenses in each year. The cost of a typical in-network outpatient service increased from $619 to $695 in 2014, a 12 percent increase. However, the increase was offset by an approximate 8 percent decrease in number of visits/1000.

Most of the costs in the outpatient classification are comprised of ambulatory surgery and radiology. Ambulatory surgery, representing about 45 percent of all outpatient costs, rose about 9 percent in 2014 on a per member basis. Radiology, the second largest component, comprises about 24 percent of outpatient costs and was down about 1 percent on a per member basis.

Professional Costs

Professional costs were also flat year-over-year, accounting for $38 million of expenses each year. Participant visits to physicians, clinicians, and others were up approximately 1 percent year-over-year on a per member basis. The average cost increased from $151 to $160. Costs are divided evenly between primary care and specialty visits, with office visits accounting for about 59 percent of the total paid expenses.

Medical Benchmarking/Statistics

There are several medical benchmarks and statistics worth noting that allow us to compare the plan's current year results to those seen in the industry or provide trend considerations:

- The average age of the University's plan member is 36 compared to the Blue Cross Blue Shield of Nebraska's (BCBSNE) book of business average of 34.
- The average age of the University's employee participant is 48 compared to the Blue Cross Blue Shield of Nebraska's (BCBSNE) book of business average of 45.
- Utilization in all categories (inpatient, outpatient and professional) was approximately 2-10 percent higher than the BCBSNE benchmark. The financial impact of this was offset by prices per service, which were approximately 17 percent below the BCBSNE benchmark for inpatient and outpatient services.
- The average cost for claimants with total paid claims of $30,000 or greater was about $75,000, with musculoskeletal and connective tissue, neoplasms, and circulatory accounting for almost 44 percent of the approximate $41 million of costs for this group.
- Preventative care services were utilized by almost 65 percent of members, up from about 63 percent in the prior year. Almost 8 percent of paid claims went to these services in both 2014 and 2013.
- Number of persons with at least one chronic disease is about 11 percent lower than the benchmark (U of N at approximately 18 percent versus about 20 percent for the benchmark)
- Hypertension is far and away the most prevalent chronic condition, followed by hyperlipidemia and diabetes.

Pharmacy Expenses

Pharmacy claims are handled through a third party administrator, CVS Caremark. The University also belongs to the Employers Health consortium, a buying coalition that offers additional rebates and discounts to the plan based on combined purchasing power. Rebates and discounts received in 2014, which are reported as Other Income, totaled approximately $1.7 million.

In 2014, pharmacy costs were up 8 percent to $27.4 million. Approximately 9,300 members utilized the plan's pharmacy program each month. The average annual net claim per participant totaled almost $2,950.

The increase in pharmacy costs is primarily attributable to specialty prescription costs, which were 32 percent of total pharmacy costs in 2014 compared to 31 percent in 2013. Specialty prescription costs increased almost 16 percent, driven in part by price inflation and in part by drug mix.

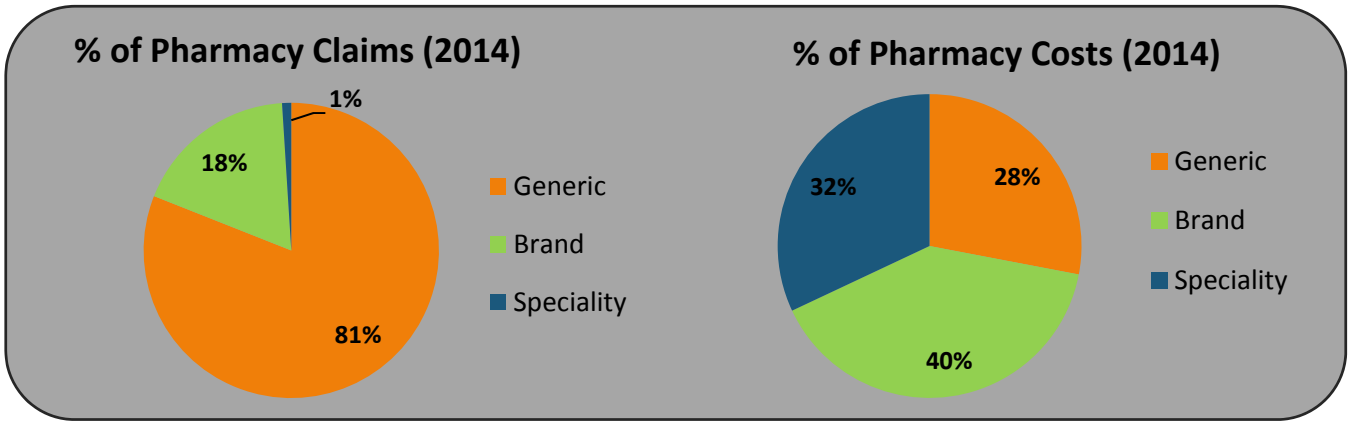
Pharmacy expenditures by category of drugs were as follows for the past two years.

University of Nebraska
Pharmacy Spend/Number of Claims
(Claims Net Cost in thousands)

	Claims Net Cost		Claims Cost as Percent of Total		Total Claims		Percent of Total Claims		Cost Per Claim	
	2014	2013	2014	2013	2014	2013	2014	2013	2014	2013
Generic	$ 7,567	$ 7,383	28%	30%	223,738	233,183	81%	80%	$ 34	$ 32
Brand	10,825	9,831	40	39	50,553	56,072	18	19	214	175
Specialty	8,907	7,700	32	31	1,826	1,990	1	1	4,878	3,869
	$ 27,299	$ 24,914			276,117	291,245				

Note that the table above shows pharmacy claims paid by CVS Caremark during the reporting period and therefore may not be consistent with amounts paid by the trustee.

The importance of generic drugs in controlling costs can be gleaned from the foregoing table and the charts below. While generics represent 81 percent of total prescriptions, they only account for 28 percent of pharmacy costs.



The generic dispensing rate increased from almost 81 percent in 2013 to almost 82 percent in 2014. The University of Nebraska's success in adoption of generics is underscored by the fact that its 2014 generic dispensing rate equals or exceeds that of its university peers in 7 of 10 top therapeutic classes. Generic use for anticonvulsants, antidepressants, antihypertensives and ulcer drugs exceeded 85 percent. The difference in prices is dramatic: for new generic launches in 2015 alone, the University's projected savings was approximately $700,000.

Conversely, specialty drugs are 1 percent of the plan's prescriptions, but account for 32 percent of the costs. 6 out of the top 10 prescription drugs used by members were specialty drugs. Primary among the specialty classes are multiple sclerosis, rheumatoid arthritis, oncology, hemophilia and hepatitis C. There are 281 users of specialty drugs, accounting for over $31,000 of cost per user per year.

Reserves and Fund Balances

Reserves are amounts needed to be held in the health trust at Wells Fargo in order to pay health benefit claims that have been incurred, but have not yet been presented to the health trust and its trustee for payment. This is commonly referred to as "incurred but not reported" or IBNR.

Fund balances are the cumulative amounts of cash left over after expenses are paid and sufficient IBNR has been set aside.

Reserves and fund balances are the cornerstone of financial flexibility. Much like a savings account, they are one-time resources that provide the health plan with options for responding to unexpected issues and a buffer against shocks and other forms of risk.

University management has targeted holding, at a minimum, health plan fund balances equal to at least six months of plan expenses plus IBNR. Six months represents the time difference between the start of the Plan's calendar year (January 1) and the University's fiscal year (July 1), which are the two points in time where management has an opportunity to make premium pricing changes if required. In addition, six months of fund balances provides some flexibility given the State's two year biennial appropriation funding cycle.

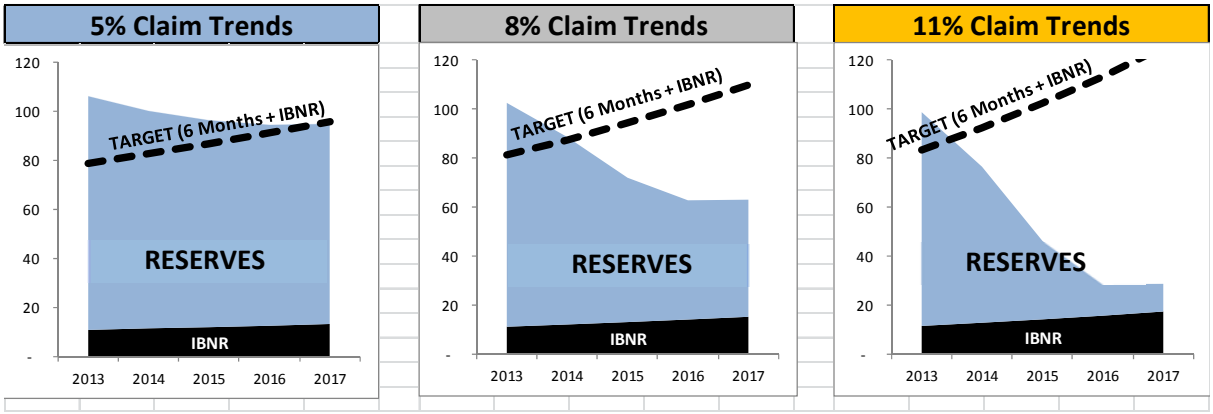
Minimum Fund Balance Target:

Six months of plan expenses

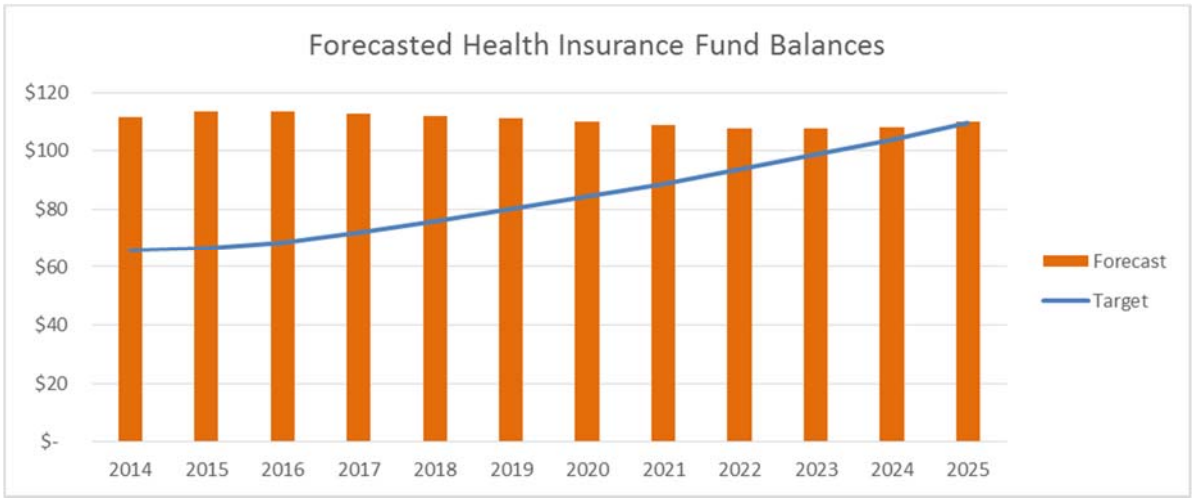
Through a combination of proper pricing, aggressive management of deductibles and co-pays, prudent planning regarding potential cost increases, and favorable claims experience resulting from staying on the forefront of health care trends, the University has accumulated (over several years) fund balances that could be utilized for one-time health related purposes. As of December 31, 2014, the University's health plan had a trust fund balance of approximately $114 million, with a net balance of over $104 million after subtracting IBNR. This represents a fund balance equal to about 9 months of plan expenses.

Suggestions have been made that the University should consider lowering premiums to move a portion of the fund balance into the plan's operations. This recommendation is ill-advised given the one-time nature of fund balances and the recurring nature of claims expenses, and creates the potential of a "fiscal cliff" as demonstrated in the charts on the following page. In times of austerity, it is not prudent to knowingly expose the University's budget and employees to these risks.

University of Nebraska Health Plan Reserve Sensitivity Scenarios



In addition, the fund balance saves money by allowing the University to avoid the need for stop-loss insurance. Should the plan have a year with a large number of high-dollar claims, the plan can absorb those losses without having to buy high-cost stop-loss insurance or seek state deficit appropriations. Our current projections would suggest that through continued careful plan management and an average 5-6 percent increase in annual premium rates, the plan will naturally grow, through claim growth, into our six month target by 2025.



Conclusions and Looking Ahead

Despite a decline in the number of participants, the University's health plan costs increased in 2014, with such increases ultimately being absorbed by the plan's fund balance. However, it is important to note that such increases would have been fully offset by premium income, with a resulting increase to the plan's fund balance, had the University not offered a premium holiday to employees. There were several factors that contributed to the upward trend in costs:

- Increased cost of medical claims, which were driven upward by an increase in costs attributable to high cost cases.
- Increased cost of pharmacy claims, which were driven upward by an increase in costs associated with specialty drugs.
- New transitional reinsurance program fee associated with the Affordable Care Act.

Going forward, University management must continue to focus on chronic disease management, including case management and lifestyle behaviors. We also must continue to promote preventive services to our members given the aging of our workforce.

In terms of pharmacy, the biggest challenge going forward is to control the use of specialty drugs. Potential future pharmacy opportunities include:

- Getting a handle on specialty drugs to assure the drugs match the diagnosis.
- Movement of pharmacy costs out of medical and into the pharmacy pipeline to assure consistent treatment for members.
- Increasing generic pharmacy by mail and creating incentives to do so. While incentivizing is currently contrary to state law, the financial impact of generics when used versus name brands is profound, thus further discussions about the current statute may be warranted.
- Continued focus on step therapies. Under this concept, high-priced drugs are not available without having tried generics first.

The impact of the Affordable Care Act continues to unfold. Because of the requirements to make health care available to all persons working more than 30 hours, a bronze plan was introduced for graduate assistants, adjunct faculty, and full-time temporary employees in calendar 2015 which could cost the University more than $1 million dollars annually. Additionally, while the overall plan continues to be "grandfathered", it will be increasingly difficult to maintain that status. Should that status be lost, the University would be required to expand its offerings to meet federal dictates in the areas of required coverage, definitions around medical necessity, and the combining of medical and pharmacy deductibles and co-pays.

Looking ahead to 2015, on a last-twelve-month basis through July of 2015, plan activity is relatively comparable to 2014. Medical claims are up about 2 percent, pharmacy claims are up about 10 percent, and dental claims are up about 3 percent. Overall claims and expenses are up approximately 5 percent, compared to about a 2 percent increase in total premiums and income.

The University of Nebraska is proud of its prudent management of its health plan, which has positioned us to provide competitive, affordable benefits to our employees – our greatest asset – and their families. These are challenging times for health care, but we are committed to offering quality health benefits that meet the needs of our employees and help us attract and retain additional talent for Nebraska.

Endnotes and References

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[i] Duchon L, Schoen C, Simantov E, Davis K, An C. Listening to Workers: Finding from the Commonwealth Fund 1999 National Survey of Workers" Health Insurance. New York. The Commonwealth Fund; 2000.

[ii] Kaiser Family Foundation 2014 Employer Benefits Survey, http://kff.org/health-costs/report/2014-employer-health-benefits/