State of Nebraska

Health Insurance Plan Annual Report

Presented to the

Legislature's Appropriations Committee

November 2018

For the Plan Year

July 1, 2017 to June 30, 2018

Prepared by

State of Nebraska

Department of Administrative Services

NEBRASKA

DEPT. OF ADMINISTRATIVE SERVICES

Introduction

The Nebraska Department of Administrative Services (DAS) submits this annual report pursuant to Neb. Rev. Stat. §50-502. The agency, in conjunction with its third-party administrators, assures the State's health plans and all other benefits programs comply with state and federal guidelines; provides assistance to state agencies and employees regarding wellness and benefit issues; manages third party administrators and actuarial consultants; provides financial management to the health plan; and continuously researches health care and benefit program trends to assure the State continues to offer a competitive employment package to State employees.

Providing employees health insurance is one of the largest costs of doing business in the modern economy. This is no exception for the State of Nebraska. Prudent financial management of the program is a critical responsibility of DAS.

In order to manage costs and ensure the program is on solid financial footing, significant plan design changes have been implemented over the last several years including but not limited to: increasing deductibles, adjusting copays and coinsurance, and increasing maximum out-of-pocket expenses for employees.

Like many businesses, in 2009, the State of Nebraska began focusing on employee wellness as a means to contain health care costs and improve the health of employees and their spouses. The State created a Wellness Health Plan (was called WellNebraska), becoming one of the first states to launch an integrated plan for health coverage tied to wellness program participation. The WellNebraska health plan, in conjunction with its wellness program, called wellNEssoptions, was a unique value-based package which emphasizes smart use of health care along with individually-tailored wellness programs.

DAS will continue to evaluate programs and take steps to control costs and offer competitive health and pharmacy benefits – win-win prospect for agencies, employees, and taxpayers across the state. A glossary of commonly used health plan terms used throughout this report has been added at the end of this document.

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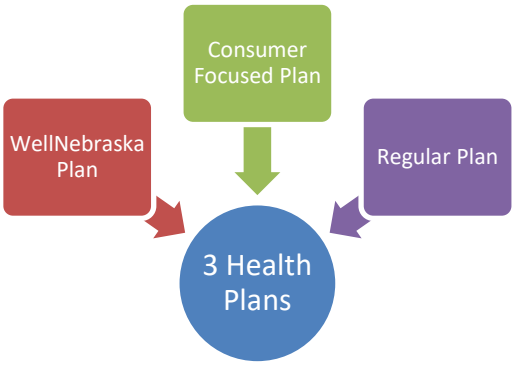
Health Plan Overview

The State of Nebraska's health insurance program consisted of three self-insured health plans in 2017-2018, the WellNebraska/Wellness Plan, Regular Plan, and Consumer Focused Plan. The Regular Plan is the base PPO, negotiated by the union. The WellNebraska Plan gives employees incentives for staying healthy by participating in the Wellness program. The Consumer-Focused Health Plan (CFHP) provides an option for employees to take advantage of a Health Savings Account (HSA) to set aside pre-tax funds for future health care expenses.



Each plan included medical and pharmacy coverage for in-network and out-of-network providers, as well as wellness benefits. The plan year ran from July 1, 2017 through June 30, 2018 with open enrollment held May 8, 2017 through May 22, 2017. All employees were encouraged to review the pre-populated elections in the WorkDay system to verify what they currently were enrolled in and/or to make any necessary changes.

There are no prerequisites or requirements for employees to participate in the Consumer Focused Plan or Regular Plan. In previous years, to enroll in the WellNebraska/Wellness Health Plan, employees and spouses were required to complete specific program criteria in the wellNEssoptions program, including (1) Completing an annual biometric health screening; (2) Completing the annual online health assessment; and (3) Enrolling and completing a Wellness program. Because of the EEOC regulations, a new WellNebraska Health Plan was created. All employees are eligible to enroll in this new plan, however those who have completed the activities listed above for the wellNEssoptions criteria listed above will benefit from reduced premiums and lower out-of-pocket costs for certain benefits. The WellNebraska health plan without incentives is identical to the Regular health plan. Throughout this report, the Wellness health plan refers to participants under the WellNebraska health plan who met the incentive requirements. The Regular health plan encompasses those that chose the Regular health plan and the WellNebraska health plan members who did not meet the incentive requirements.

When covered employees and dependents incurred medical claims, health providers (hospitals, doctors, etc.) sent claims to the State's third-party administrators. For the 2017-2018 plan year, UnitedHealthcare (UHC) was the third-party administrator for health care claims, and its subsidiary, OptumRx, was the third-party administrator for pharmacy claims. UHC and OptumRx assured submitted claims were adjudicated correctly under the provisions outlined in the plan documents set forth by the State. UHC and OptumRx then paid the providers, and once payment cleared the bank, the State reimbursed UHC or OptumRx for the claims through the State Employee Insurance Fund.

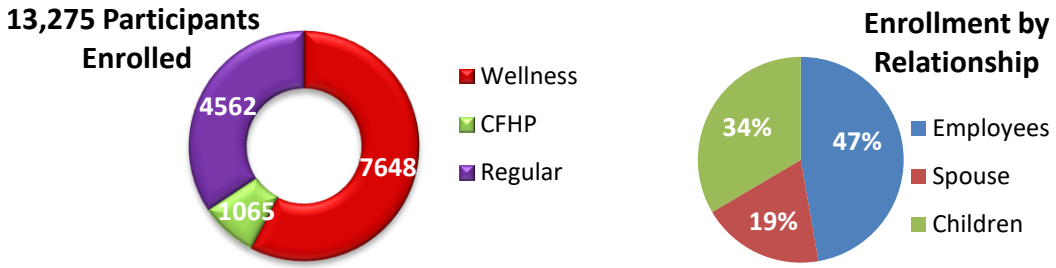
What does Self-Insured mean?

The State assumes the financial risk for providing health care benefits to its employees and contracts with United Healthcare (UHC) to process the claims. Instead of paying fixed premiums to UHC, which may be inflated to include profit margins and taxes, the State collects contributions from employees and State agencies itself and deposits them in a State trust fund, using the premiums to pay health care claims for plan participants after copays and deductibles.

Enrollment & Eligibility

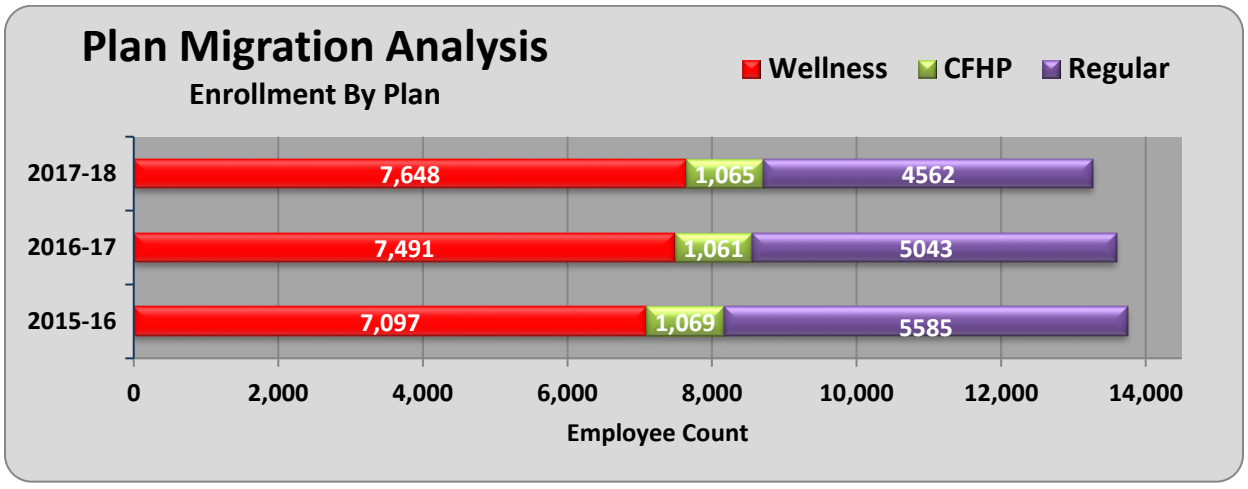
Neb. Rev. Stats. §84-1601 and §84-1604 allow for permanent full-time and part-time employees who work a minimum of 20 hours per week to participate in the State health plans. These employees are eligible for coverage on the first of the month following 30 days of employment. In addition, Neb. Rev. Stats. §84-1601 and §84-1604 also allow temporary employees working a minimum of 20 hours per week and hired into an assignment that is six months or longer eligibility for coverage in the State health plans after the standard waiting period. State retirees can continue coverage in a State health insurance plan until they are Medicare-eligible, which is age 65, as allowed in State of Nebraska Classified System Personnel Rules and Regulations, Chapter 17.014; and the NAPE/AFSCME (NAPE) and State of Nebraska Labor Contract, Article 13.2.

The plan averaged 13,275 employees enrolled in the 2018 plan year, which included approximately 241 retirees and 97 COBRA participants. The total number of covered lives was 28,183 which decreased 2.3% from the 2016-2017 plan year. Ongoing dependent verification audits were conducted for all new dependents added to the health plan to ensure only eligible employees used State benefits.



Approximately 55.7% of employees were female and 44.3% were male. The average age of employees enrolled was 47.0, the same as last year's average.

Total enrollment in the State Health Insurance Plan over the past year has decreased 2%. The Wellness plan had 58% of the employees enrolled during the 2017-2018 plan year. The popularity of the plan has increased every year. Most of the migrating members came from the Regular plan.



Plan Management & Fund Management

DAS assures the State's health plans and all other benefits programs comply with state and federal guidelines and provides financial management to the health plan. DAS consults with experts in health plan management including Segal, UHC, and attorneys to constantly monitor changes in health plan management and assure our plan and documentation is in compliance.

Regulatory Mandates

- State Statutes
- Department of Insurance
- ACA
- IRS
- COBRA
- HIPAA
- Medicare
- Employment Laws -FMLA, USERRA, ADA, Title VII, GINA

Health Plan Documents

- Summary Plan Document (SPD)
- Summary of Benefits & Coverage (SBC)
- Section 125 Plan Document
- Business Associate Agreements
- Benefits Administration Manual for State HR Partners
- Wellness & Benefits Options Guide
- Wellness & Benefits Website

Neb. Rev. Stat. §84-1613 established the State Employees Insurance Fund #68960 to pay medical and pharmacy claims, administrative fees and wellness program fees. This fund was administered by DAS and reserve targets were adjusted annually using cost projections from the State's actuary and health care consulting firm. For the 2017-2018 plan year the actuary and health care consultant was Segal.

Reserves are imperative to successful management of a self-insured health plan with about 28,000 covered lives. The Health Insurance History Fund #68922 is a subsidiary fund of the State Employees Insurance Fund #68960 and contained the Claims Fluctuation Reserve (CFR). Health Insurance History Fund #68922 is designed to pay for the costs of coverage of unusual or high volume claims that may occur. Health Insurance History Fund #68922 also contains the amount to finance the operation of Program 606, Wellness and Benefits Administration, as approved by and stated in the biennium budget bill. The amount required for Program 606 operation was transferred by the State Treasurer from Fund Health Insurance History Fund #68922 to Health and Life Benefit Administration Fund #28010, established in Neb. Rev. Stat. §84-1616.

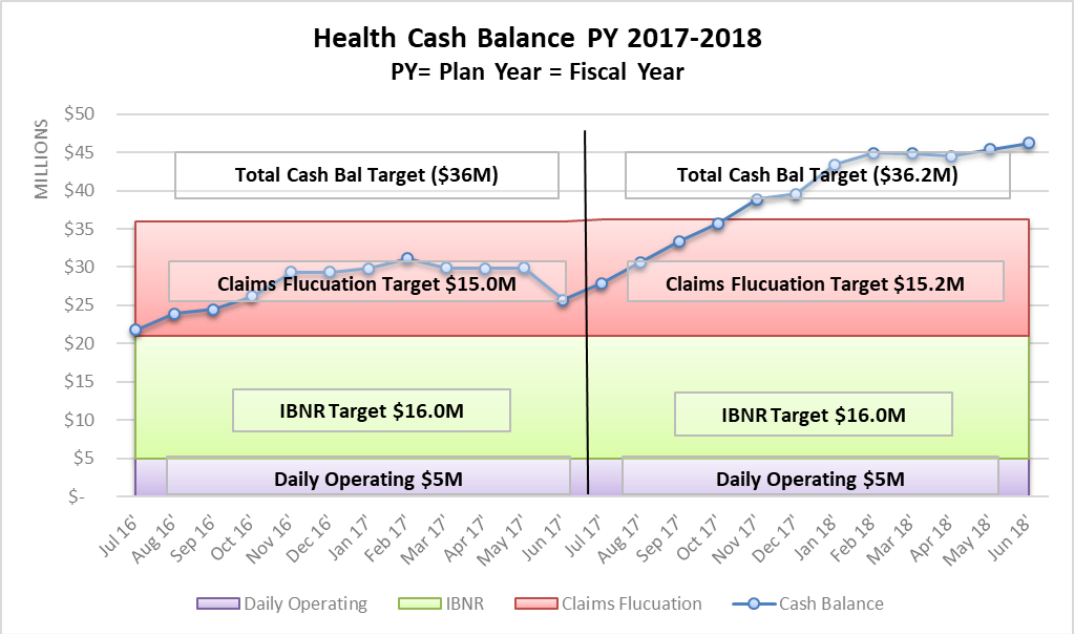
During the 2017-2018 plan year, a payment was made for the Patient-Centered Outcomes Research Institute (PCORI) fee as prescribed by the Affordable Care Act (ACA). This fee will be paid every July. In July 2017 the State paid $51,700 for PCORI and in July 2018 the fee increased to $53,200.

Self-insured health plans can purchase Stop Loss insurance to limit the amount a plan pays each year for each participant. In 2012-2013 the State of Nebraska purchased a Specific Stop Loss insurance policy through UHC with a $1 million deductible. However, based on the price of coverage, the infrequency of million dollar claimants decreased frequency of high cost claimants who exceed $100,000, the size of the insured population, and the reserves fund help by the State, the State decided to discontinue Stop Loss insurance for the 2017-2018 plan year.

Segal in conjunction with DAS prepared an Incurred But Not Paid (IBNP) Analysis Report, Premium Rate Analysis Report, and Claims Fluctuation Reserve (CFR) Analysis Report for the State. These reports were reviewed at meetings conducted between the Wellness and Benefits Administrator, Personnel Director, Director of DAS, Budget Division, and the Governor to establish plan contribution funding, effective plan designs, and set targets for the plan year.

For plan year 2017-2018, Segal recommended a CFR of at least $15.2 million and IBNP of $16.0 million. In accordance, the State established a targeted balance of $15.2 million in Health Insurance History Fund for the CFR. A targeted balance of $21 million in the State Employees Insurance Fund #68960 was established to include the Daily Operating Target of $5 million to cover daily expenses and IBNP of $16.0 million to cover claims run out from the prior plan year. The Cash Balance Target, as recommended by Segal, was at $36.2 million, equal to the summation of the two funds.

A summary of financial activities in State Employees Insurance Fund #68960 for the plan years ending June 30, 2017 and June 30, 2018 are shown on the following page.



State of Nebraska Health Insurance Fund Summary of State Employees Insurance Fund #68960 Activity Comparison of Plan Years Ending June 30, 2017 and 2018				
	Plan Year 2017-2018	Plan Year 2016-2017	Change	
Contributions			**Dollars**	**Percent**
Contributions	$207,346,227	$199,679,675	$7,666,552	4%
Investment Income	$432,648	$228,327	$204,321	89%
Total Contributions	$207,778,875	$199,908,002	$7,870,873	4%
Distributions				
Medical Claims & IBNP	$136,960,313	$139,858,456	-$2,898,143	-2%
Pharmacy Claims	$43,239,084	$43,809,018	-$569,934	-1%
Wellness-Health Fitness	$1,043,063	$2,193,397	-$1,150,334	-52%
Administration Fees	$6,882,448	$8,211,395	-$1,328,947	-16%
Total Distributions	$188,124,908	$194,072,266	-$5,947,358	-3%
Net Difference	**$19,653,967**	**$5,835,736**		

State of Nebraska Health Insurance Funds As of June 30, 2018				
	6/30/2018	6/30/2017	$ Change	% Change
State Employees Insurance Fund #68960	$30,770,463	$9,581,730	$21,188,733	221%
Health Insurance History Fund #68922	$15,419,638	$16,151,882	-$732,244	-5%
Total Reserves	**$46,190,101**	**$25,733,612**	**$20,456,489**	**79%**

Health Plan Contributions

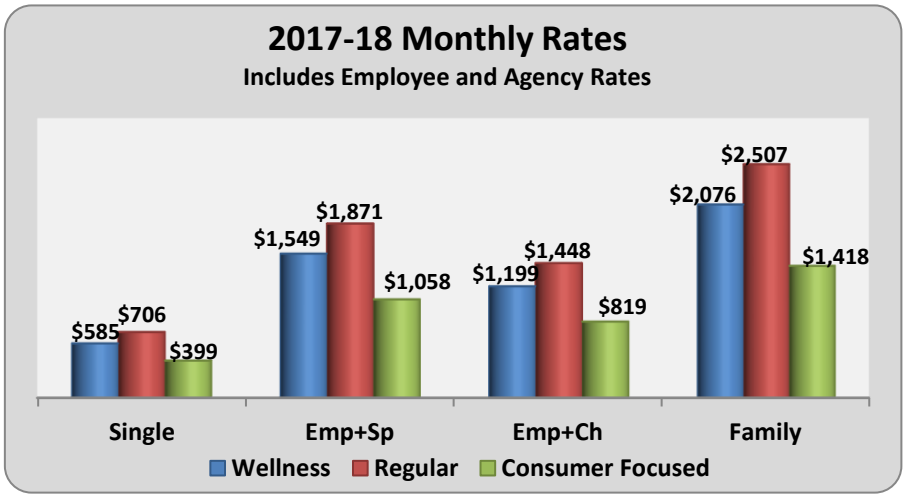
The State Employees Insurance Fund #68960 is funded by health plan contributions from participants and the State. Contributions are collected from employees through payroll deductions and combined with State contributions.

In accordance with Neb. Rev. Stat. §84-1611, the State pays 79% of monthly rates and active, full-time employees pay 21%. Neb. Rev. Stat. §84-1604 requires part-time employees (20-29 hours a week) receive only a proportion of the State contribution. Part-time employees pay 21% of the monthly rate plus a pro-rated amount of the State's share. Retirees pay 100% of the monthly rate and COBRA participants pay 100% of the monthly rate plus a 2% COBRA administration fee.

Health plan contributions are reviewed each year. In November 2017, Segal provided the Wellness and Benefits Administrator with a Preliminary Premium Rate Analysis Report. The Wellness and Benefits Administrator, Personnel Director, and Director of DAS reviewed the report along with the State Budget Division and Governor. Contributions and plan design changes were approved in February 2018 and communicated to employees in April 2018, prior to Open Enrollment, and implemented on July 1, 2018.

Contributions to the plan increased from $200 million to $208 million in the 2017-18 fiscal year.

Monthly rates for all State health plans are determined by actual claims history, projected enrollment, and projected health plan costs. Each health plan is adjusted individually for plan design and plan usage, which can result in different rate changes by plan. In addition, the Regular plan is negotiated as part of the Nebraska Association of Public Employees (NAPE) labor contract.



2017-18 Rate Increases

Wellness – 5.8%

Consumer Focused – 5.8%

Regular – 6.5%

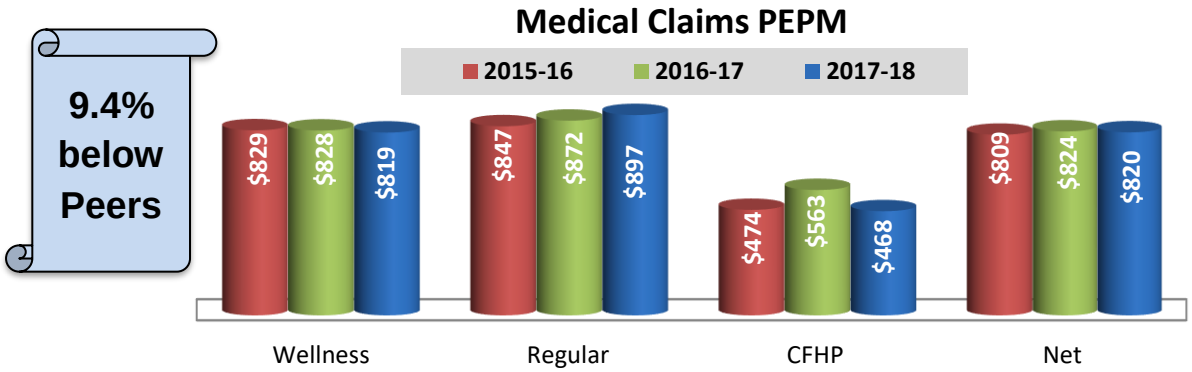
Medical Claims Review

Medical claims were administered by UHC and include costs associated with hospital stays, outpatient services, emergency care, behavior health care, physician office visits and preventive health care, among other services.

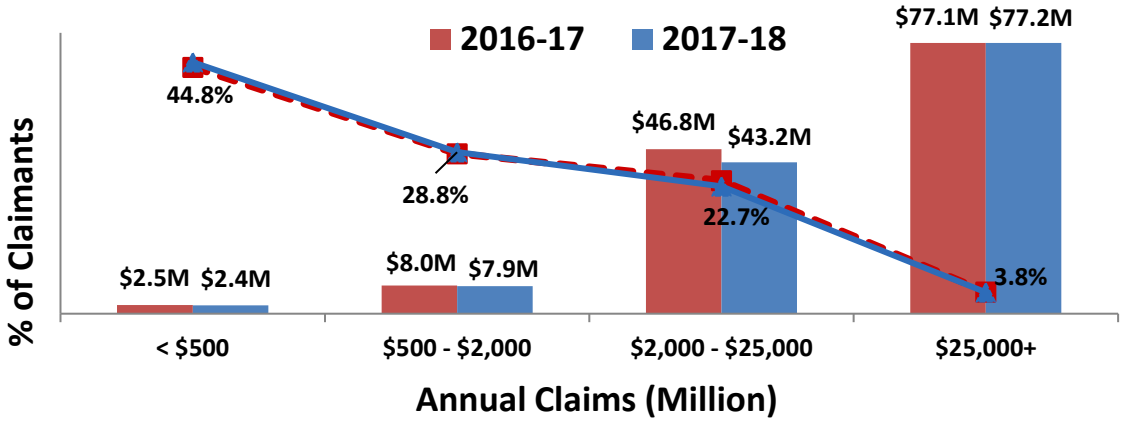
The State Employees Insurance Fund #68960 has paid $137 million in reported medical claims in fiscal year 2017-18, which reflected a 2% decrease from the prior year. Factors attributed to this change include a 2.3% decrease in employee and member count and a 5.2% decrease of non-catastrophic claimant claims PEPM.

Consistent with 2016-2017, treatment for musculoskeletal conditions, neoplasms (cancer), and circulatory (heart disease) were the top cost driver of medical claims. Combined, these three diagnoses drove 36% of total medical claims paid per employee per month (PEPM).

The 2018 Net Incurred PEPM of $820 reflects a 0.5% decrease from the previous year and was 9.4% below our peer group according to UHC.



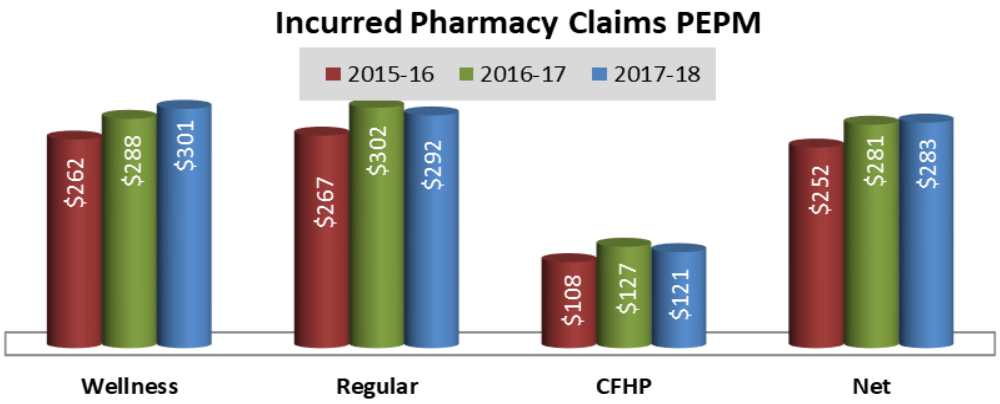
Consistent with other group health plans, a small percentage of participants incurred a high proportion of total medical claims paid. Of the $131 million spent thru July of 2018 for 2017-2018 incurred medical claims, the plan paid $77.2 million for 3.8% of the total plan participation of 28,183. The total incurred amount (PEPM) for claimants with claims over $100,000 increased by 13.4% from the previous year but decreased by 6.2% for claimants with incurred claims between 25,000 and 100,000.



Pharmacy Claims Review

Pharmacy claims were administered by OptumRx, an affiliate of UHC. The plan paid about $43.2 million for prescription claims in 2017-2018, a 1% decrease from the previous year. The use of specialty drugs is a growing trend that continues to be monitored by the State. There was an approximate $2 million (11%) increase in specialty drug payments from the previous plan year. This was negated by an almost equivalent $2 million decrease in non-specialty drug payments.

Roughly 23,900 participants utilized pharmacy benefits in the health plan, filling about 362,000 prescriptions. The average cost per prescription of $133.54 for the state was a slight increase from $132.29 paid the prior year. On average, each member filled 12.8 prescriptions annually. This is lower than last year's average of 13.8.



For the regular and wellness plans, members pay a copay for each prescription and the remainder of the cost is paid by the plan. For the CDHP plan, members pay a coinsurance payment after the deductible.

UHC's plan breaks drugs in to three tiers by cost. Tier 1 includes mostly generic plus some low-cost brand-name drugs. Encouraging participants to choose generic prescriptions, primarily in Tier 1, reduces costs for both the employee and the plan.

	2017-18	2016-17	% Change
Annual Scripts per Member	12.8	13.8	-7.2%
Average Cost	$133.54	$132.29	0.9%
Plan Cost Share	93.5%	92.5%	1%
Employee Cost Share	6.5%	7.5%	-1%
Generic Utilization	85.3%	84.6%	0.7%

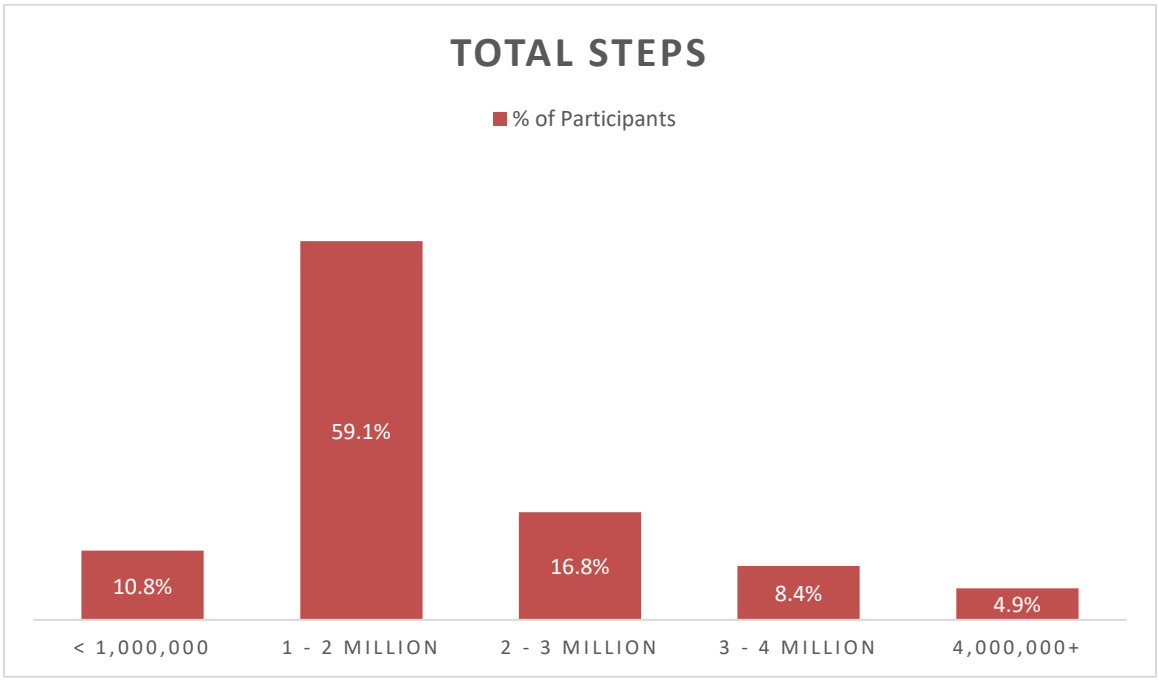
Wellness Program – HealthFitness™

2017-2018 marked the tenth year of the State's wellness program, wellNEssoptions. Program fees were paid through the State Employees Insurance Fund #68960 and cost approximately $1.0 million for the plan year ending June 30, 2018. The HealthFitness™ contract was terminated in April 2018 and wellness and disease management shifted to UHC. Thus, the annual cost of the program decreased 52%.

Employees and spouses who complete a biometric screening, health risk assessment, and criteria for their chosen wellness program are eligible to receive the benefits of the Wellness Health Plan, which offers lower out-of-pocket costs for medical and pharmacy services. For 2017-2018, about 58% qualified and enrolled in the Wellness Health Plan, compared to 54% the previous year.

Health assessment participation for wellNEssoptions saw a slight increase compared to 2017. About 12,500 people completed the health assessment in 2018, a 7.8% increase over the previous year.

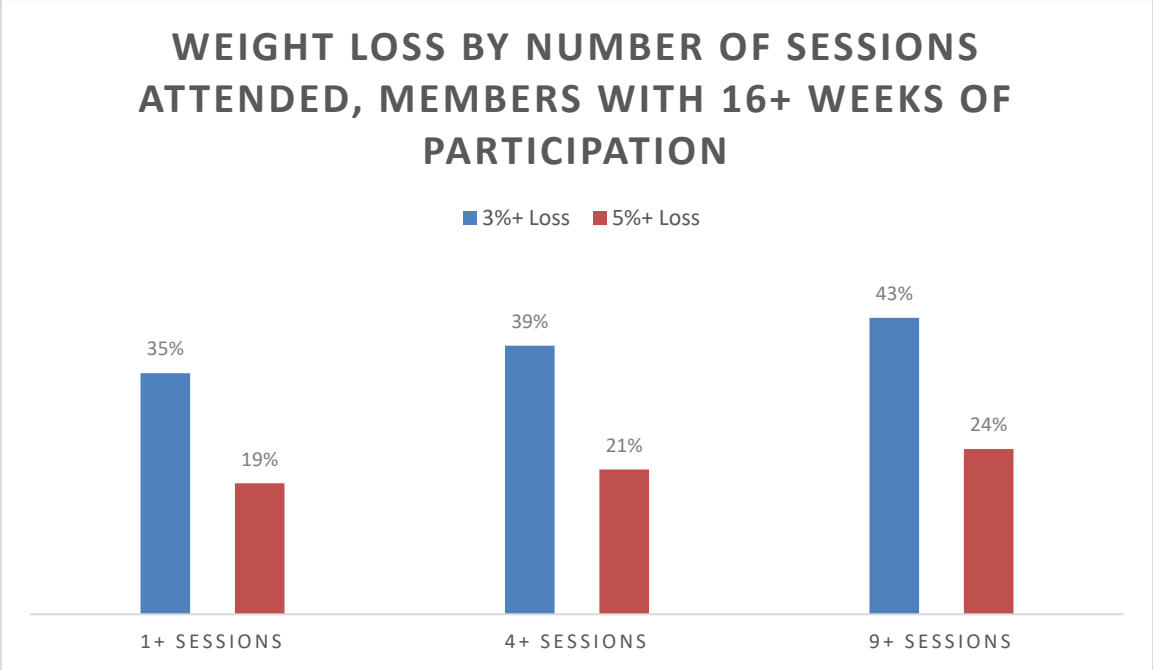
Of the 7,031 members who logged steps with wellNEssoptions throughout the plan year, 6,272 achieved the wellness goal of walking at least one million steps. Below is a graph of results broken down by step cohorts:



Wellness Program - UHC

Real Appeal is a weight loss wellness program provided by UHC that was added as of 4/1/18. With 3 months of data, the State saw 864 members enrolled in the program, with 87% of enrollees deemed at risk of diabetes, cardiovascular disease, or other weight-related health conditions.

Overall, the program scored a 4.72 out of 5 satisfaction rating in a survey of 662 participants.



Snapshot of 2017-2018 Health Program Outcomes

Financial

- Net PEPM for medical decreased 0.5%.
- Excluding catastrophic claims, medical PEPM is trending -5.2%.
- Catastrophic claims increased by 13.4% PEPM
- Net PEPM for pharmacy increased 0.9%
- Medical PEPM was 9.4% below peer group.
- Pharmacy PEPM at least 20% above peer group.
- Network discount rate was 38.6% and saved $93 million.
- 189 participants drive 29% of medical and exceed $100,000 in claims.
- Average cost for catastrophic claimants was $200,050.
- 2 participants exceeded $1 million in claims.

Clinical

- Demographic factor/risk is 7.5% higher than peer.
- Member medical utilization for benefits was 96.3%.
- Emergency room visits are 24.3% lower than UHC Peer group and utilization decreased by 6.1% from last year.
- Inpatient utilization decreased 15.2% but the amount paid per admission increased by 11.6%
- Outpatient surgeries decreased 4.3%.
- The amount of PCP and Specialists visits both decreased by 9.3%
- Muskuloskeletal issues, cancer, and diabetes still drive medical costs.
- 11% of members had a primary diagnosis of diabetes.
- Claimants with COPD decreased 19.6% from the previous year.
- Generic medication dispense rate was 85.3%

Looking Ahead

The State continues to focus on providing employees with a quality health insurance program integrated with a focus on wellness and disease prevention.

Segal Consulting provided the State with actuarial cost projections for the 2018-19 plan year. Costs were impacted by plan design changes, underlying health care trend, fixed fee contracts, and demographic changes. Plan design changes were bargained for the Regular Plan with NAPE for the 2017-18 and 2018-19 plan years through negotiations. Premiums were set based on expected costs and multi-year strategy to align the fund balance with the target reserve.

	2018-2019 Contribution Increases
WellNebraska (wellness track)	**3.3%**
Regular Health Plan	**3.3%**
Consumer Focused Health Plan	**3.3%**

The Affordable Care Act continues to impact the State's health plan costs and administrative requirements for compliance. Beginning July 1, 2015, the State was required to offer health insurance at full-time rates for employees working 30 hours or more on average. The State determines eligibility for employees working more than 30 hours a week through a 12-month look-back measurement.

In early 2016, the State was required to issue financial reports to the IRS and to employees eligible and enrolled on the State's health insurance coverage during 2015.

Finally, the State continues to monitor the impact of the excise tax exposure that will affect health plans and other tax advantaged benefits beginning in 2022.

The State is continually monitoring health care trends in the industry and partnering with groups such as Segal, UHC and others to seek out, analyze and provide the best features and options for employees and taxpayers. Cutting-edge practices, particularly in the area of specialty drug management and utilization will continue to be a challenge for the State. New initiatives to reverse the increasing trend of diabetic health plan members also will be a priority.

In addition to a competitive health and wellness program, DAS also works to ensure that employees and their families are able to participate in other group benefits including dental, vision, employee assistance program, flexible spending accounts, life and long term disability. A quality benefit package is offered that designed to attract and retain a best in class State of Nebraska workforce.

Glossary

ACA (Affordable Care Act) – Health care legislation signed in to law March 23, 2010. The law includes new health plan provisions rolled out over multiple years.

Brand Name Drug - A drug that has a trade name and is protected by a patent (It can be produced and sold only by the company holding the patent).

CFR (Claims Fluctuation Reserve) - An amount of money set aside (reserved) to pay for an unusually high volume of claims or unexpected number of claims.

Chronic Conditions - A diagnosis of diabetes mellitus, migraine, hypertension, hypertensive heart disease, heart failure, chronic bronchitis, asthma, etc.

Claimant - A unique participant for whom a claim was submitted for payment.

COBRA (Consolidated Omnibus Budget Reconciliation Act) - An option for a worker to continue group health benefits for a limited time following the termination of those benefits due to job loss, reduction in work hours, etc.

Employee - The primary subscriber of the health benefits. Employee includes active employees, retirees, and COBRA participants.

Generic Drug - Drug which contains the same active ingredients as brand-name medications but often cost less. Once the patent of a brand-name medication ends, the FDA can approve a generic version with the same active ingredients.

HealthFitness™ - Administrator of the State's wellness program, wellNEssoptions.

High Cost Claimant - A claimant whose total net payments for a given time period are equal to or in excess of $100,000.

HIPAA (Health Insurance Portability and Accountability Act of 1996) – Law designed to help people keep health insurance and provide privacy standards to protect healthcare information.

IBNP (Incurred But Not Paid) - Estimate of health plan claims incurred for a time period for which payments have not been processed.

Glossary (continued)

IBNP Analysis Report – Report prepared by actuarial consultants for the State which provides an estimate of medical and pharmacy claims incurred as of the last day of the plan year but not yet processed for payment.

NAPE/AFSCME – Nebraska Association of Public Employees, Local 61, of the American Federation of State, County and Municipal Employees. The labor union who represents several groups of employees who work at the State of Nebraska.

Net Paid - The total amount paid by the plan, after the application of discounts and after any member responsibility and coordination of benefits.

Network Discount Percent - Amount of reduction from billed amount that the third party administrator has negotiated with the provider.

Network Utilization - Eligible charges incurred using in-network providers.

OptumRx – Pharmacy benefit manager affiliated with UHC and administrator of the State's pharmacy benefit plan.

Norm - Based on a peer group average and not adjusted for characteristics of covered population.

Outpatient – Medicare care or treatment that does not require an overnight stay in a hospital or medical facility. It may be provided in a medical office, hospital or outpatient surgery center.

Participant - A person eligible for plan benefits. A participant may be an employee, covered spouse or other legal dependent.

PCORI (Patient-Centered Outcomes Research Institute) Fee – The Affordable Care Act imposed fee on issuers of specified health insurance policies and plan sponsors of applicable self-insured health plans to help fund the Patient-Centered Outcomes Research Institute. The fee is reported annually on Form 720 and is based on average number of lives covered under the policy or plan.

Peer Group - A group of city, state, and county public employers selected by UHC.

PEPM (Per Employee Per Month) - The average revenues, expense, or utilization of services for one employee for one month.

PMPM (Per Member Per Month) - The average revenues, expense or utilization of services for one participant for one month.

PPACA (Patient Protected and Affordable Care Act) – Health care legislation signed in to law March 23, 2010. The law includes new health plan provisions rolled out over multiple years.

Glossary (continued)

Premium Rate Analysis Report – Report used to project contribution rates for the upcoming plan year(s) based on claims experience and participant data.

Preventive Visits - Professional office visits considered precautionary.

Real Appeal – Health management program administered by UnitedHealthcare (UHC) focused on weight loss.

Segal - An independent, nationally recognized actuary and employee benefits consulting firm responsible for Nebraska's actuarial reports and calculations starting in 2016.

UnitedHealthcare (UHC) – Administrator of the State's health insurance program.

wellNEssoptions - The State of Nebraska's wellness program, administered by HealthFitness™.