University of Nebraska
Health Insurance Plan Annual Report

Year Ended December 31, 2016

Executive Summary

This report is designed to meet a reporting mandate established by the Nebraska Legislature requiring an annual report be filed detailing operating activity of the University of Nebraska's health plan operations each year. This report covers the University's plan year January 1 through December 31 of 2016.

The University of Nebraska's strategic objective is to recruit and retain exceptional faculty and staff. One of the most highly valued benefits are medical, dental and pharmacy coverage. In one national 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].

This report documents that the University of Nebraska's health insurance plan continues its track record of providing this benefit at a reasonable cost with operating results reflective of national trends. Success in any health plan rests largely with members taking control of their health through adopting healthy life-styles, taking advantage of preventive screenings, regular visits with health professionals, and adherence to drug and other prescribed therapies.

Overall, the plan lost $42 million in calendar 2016. This can be attributed to two factors:

1. The plan granted a "premium holiday" in April through June of 2016. The monetary impact of this action was income to the plan was approximately $33 million less than it would have been had the holiday not been adopted.

   The holiday was a by-product of discussions between legislative leadership and university management to draw down reserve levels. The premium income that would have been contributed to the plan from state-aided budget was then allowed to be redirected to other strategic purposes or, in the case of revolving operations, decrease pressures on prices to students, faculty and others for housing, unions, parking and other self-funded operations.

2. The second factor creating the operating loss is the continued price increases in medical and pharmacy services. On the medical side, inpatient and outpatient costs saw double digit price increases. Pharmacy costs continue to spiral upward, particularly in the specialty drug area. These high cost drugs used to treat complex situations are 43% of cost while comprising only 1% of the total prescriptions. The impact of the medical and pharmacy increases account for an $18 million dollar increase in plan cost for 2016 – roughly $1,500 per participant.

The university will continue to strive to maintain this valuable benefit, but the challenge in doing so is significant. With decreases in state funding and the desire to provide affordable access, the funding for benefits will bear much scrutiny over the 2018 calendar year. Consultants have been engaged to examine the plans to provide a competitive benefit while holding the line on costs for both employees and the University.

In summary, 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

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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 parties 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 employer (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.

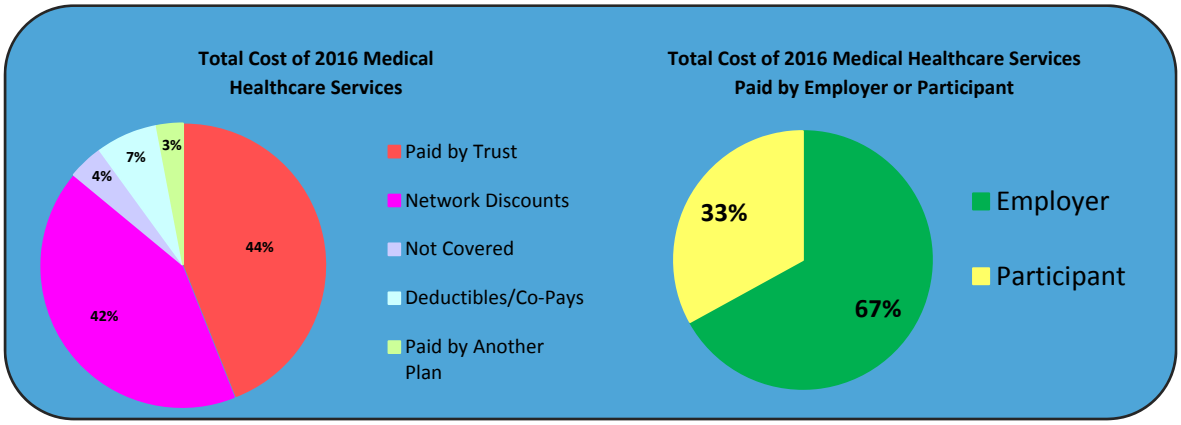
Premiums charged to both the employer and employees are designed to cover the plan's projected claim costs plus administrative expenses. Any potential changes in premiums, which become effective on January 1, are established by University management each fall after analyzing Milliman's actuarial expense 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.

For the years ended December 31, 2016 and 2015, 78 percent of premium income was contributed by the employer and 22 percent of premium income was contributed by the employee. University employees selecting basic coverage pay between 20 percent and 29 percent of the total medical premium depending upon the coverage selected. While the University offers a variety of coverage options, a majority of the employees are enrolled in basic coverage for a

"family" or "employee+one", both of which have close to a 79/21 percent employer/employee contribution ratio, as noted in the table below:

	2016 Monthly Premiums - Basic Coverage		
	Employee	Employer	Total
Family	$ 270	$ 1,091	$ 1,361
Employee+One	$ 212	$ 777	$ 989
Employee+Dependent(s)	$ 178	$ 580	$ 758
Employee Only	$ 132	$ 324	$ 456

It is also worthwhile mentioning that the healthcare costs paid by the health trust are but a portion of the total cost of healthcare services provided under the University's plan. A substantial portion of the cost of healthcare services is paid for by another plan (for example, Medicare), paid for by the participant through deductibles and co-pays, discounted through network agreements, or simply not covered, as demonstrated in the graphs below:



The pie chart above shows that the aforementioned 79/21 percent employer/employee contribution ratio is not reflective of the total expense borne by each party. In fact, the pie chart depicts that when counting deductibles and co-pays, participants pay roughly 33 percent of the total cost. It is likely that the total cost of healthcare services paid by the participant is even greater than 33 percent, as a portion of healthcare services "not covered" or "paid by another plan" were possibly costs ultimately borne by the participant.

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

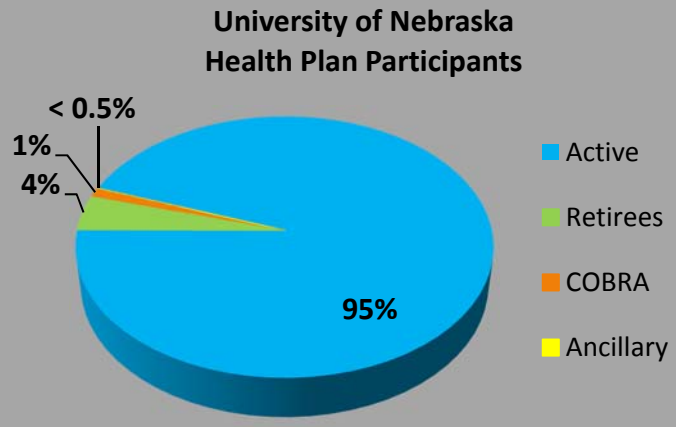
Enrollment and Demographics

The University's health plan had almost 11,600 participants as of December 31, 2016, about 300 more than the prior calendar year. When including dependents, the plan served approximately 27,000 covered lives.

Active employees, by far the largest membership group in the plan increased in 2016. Participant groups comprised of Cobra electees and retirees declined slightly in 2016.

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 2015. 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 ancillary members, who are specifically approved for membership by the Board of Regents, also pay the entirety of their premiums without any University contributions. Presently, the National Strategic Research Institute is the primary ancillary member.



University of Nebraska
Number of Health Plan Participants

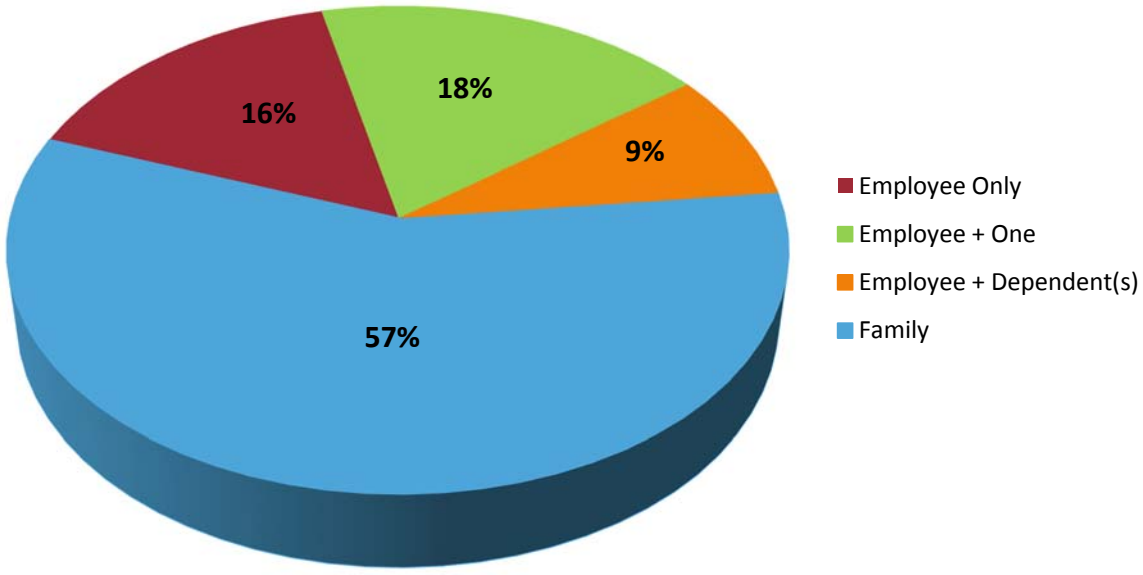
	Dec 2016	Dec 2015	Change Number	Change Percent
Active Employees	11,008	10,651	357	3%
Retirees	454	493	(39)	(8)
Ancillary Members	6	3	3	100
Cobra	113	121	(8)	(7)
Total	11,581	11,268	313	3%

Demographically, covered lives were about 51 percent female and 49 percent male. Average age for all covered lives was 35 years which remained stable from 2015.

In terms of covered lives, the average number of members for 2016 also increased from 2015 by approximately 3 percent, with all four coverage categories noting increases. This resulted in 904 additional covered lives in 2016.

	Average 2016		Average 2015		% Change	
	Members	% of Total	Members	% of Total	Members	%
Employee Only	4,283	16%	4,176	16%	107	3%
Employee + One	4,959	18	4,895	19	64	1
Employee + Dependent(s)	2,305	9	2,222	9	83	4
Family	15,482	57	14,832	56	650	4
Totals	27,029	100%	26,125	100%	904	3%

University of Nebraska
Health Plan Membership by Coverage



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 but higher premiums 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 approximately 27,000 lives (employees plus their dependents)

Financial Performance

The University health plan's financial results for the years ended December 31, 2016 and 2015 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 income fell short of plan expenses in 2016, resulting in a $44.2 million decrease in net activity as compared to 2015. This excess of expense over income was due in part to the timing of premium holidays, which were not offered in 2015 but were offered April – June of 2016, and in part to increased claims expense driven primarily by pharmacy and medical claims.

Plan income would have been approximately $33 million higher if a premium holiday had not been offered in April-June of 2016.

Expenses increased in 2016 due to the following factors:

- Medical claims expense in 2016 increased 14 percent from 2015. This growth was driven by an increase in utilization and cost of all three service categories – inpatient, outpatient and professional services.
- Pharmacy claims expense in 2016 increased 17 percent from 2015. This growth was driven primarily by a 31 percent increase in specialty drug costs. Specialty drugs are costly medications prescribed for the treatment of complex, chronic conditions such as rheumatoid arthritis, multiple sclerosis, cancer and hemophilia.

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

	Actual 2016	Actual 2015	Year-over-Year Change Dollars	Year-over-Year Change Percent
Employer Premiums	$ 77,569	$ 99,927	$ (22,358)	(22)%
Employee Premiums	21,275	27,410	(6,135)	(22)
Retiree, Ancillary, Cobra Premiums	5,839	5,539	300	5
Trust Investment Income	3,135	2,729	406	15
Pharmacy Rebates/Discounts	5,604	3,636	1,968	54
Total Premiums and Income	113,422	139,241	(25,819)	(19)
Medical Claims	106,713	93,437	13,276	14
Pharmacy Claims	35,020	29,988	5,032	17
Dental Claims	7,944	7,789	155	2
TPA, ACA, and Other Expenses	5,752	5,843	(91)	(2)
Total Claims and Expenses	155,429	137,057	18,372	13%
Net Activity	$ (42,007)	$ 2,184	$ (44,191)	

Note, the University implemented a three-month premium holiday for both the employer and employees in April - June 2016.

Income

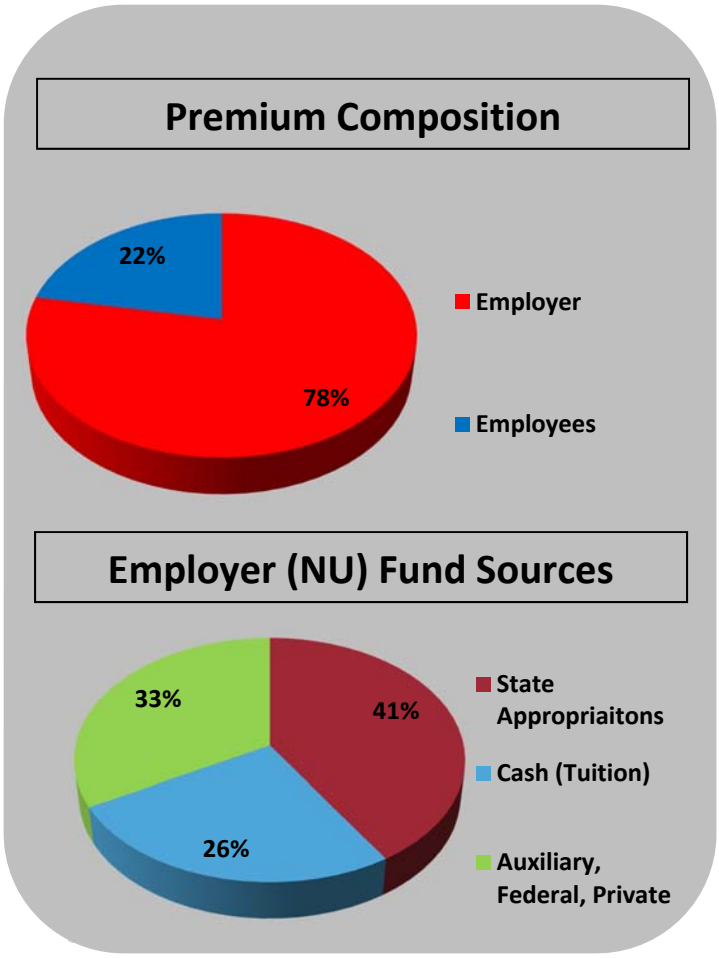
The University's health plan is funded from a variety of sources, although employer and employee premiums account for the bulk (87 percent) of the plan's income. Employer premiums are funded primarily from state appropriations (41 percent), cash funds such as tuition (26 percent), and other self-supporting business-type activities (auxiliaries) and federal grants and contracts (33 percent).

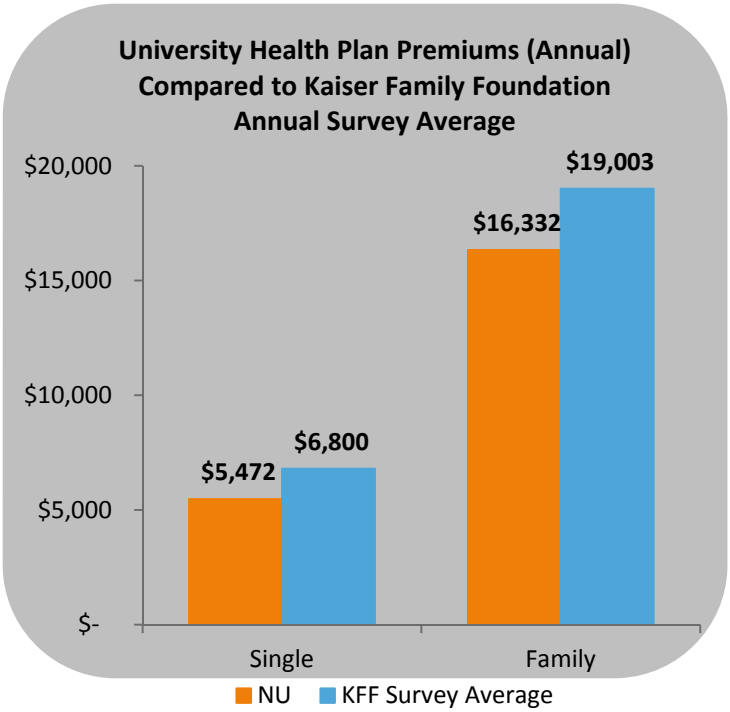
The plan's remaining income comes from retirees, ancillaries, and Cobra electees (5 percent), and investment income and pharmacy rebates/discounts (8 percent).

For the year ended December 31, 2016, the plan's income from employer and employee premiums decreased by 22 percent. This was the result of premium holidays being offered in 2016.

Trust investment income increased 15 percent for the year ended December 31, 2016. 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 approximately $3 million in premiums again this year.

As pharmacy claims continue to climb, so do pharmacy rebates/discounts, which increased from $3.6 million in 2015 to $5.6 million in 2016. The rebates/discounts are a result of the University's membership in the Employers Health consortium, a buying coalition that offers additional rebates and discounts to the plan based on combined purchasing power.





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 Kaiser Family Foundation and HRET Employer Health Benefits 2016 Annual Survey[ii] by approximately 20 percent on single and 14 percent for family coverage.

Expenses

Medical Expenses

The plan's medical claims increased by 14 percent for the calendar year. Medical claims in 2016 and 2015, arrayed by amount of claims per covered lives, were as follows:

University of Nebraska
2016 Claims Distribution (Claims in Thousands)

Total Claims/Member	Covered Lives	Percent of Lives	Amount	Percent of Claims $$
$5,000 or less	22,397	86%	$ 20,152	19%
$5,001 to $10,000	1,403	5	9,972	9
$10,001 to $25,000	1,461	6	22,266	21
$25,001 to $50,000	444	2	15,300	14
$50,001 to $100,000	214	1	14,854	14
$100,001 to $250,000	86	0	12,620	12
$250,001 and above	26	0	11,150	11
	26,031	100%	$ 106,314	100%

Note: only persons presenting claims are included in this analysis. Claims are per BCBS.

University of Nebraska
2015 Claims Distribution (Claims in Thousands)

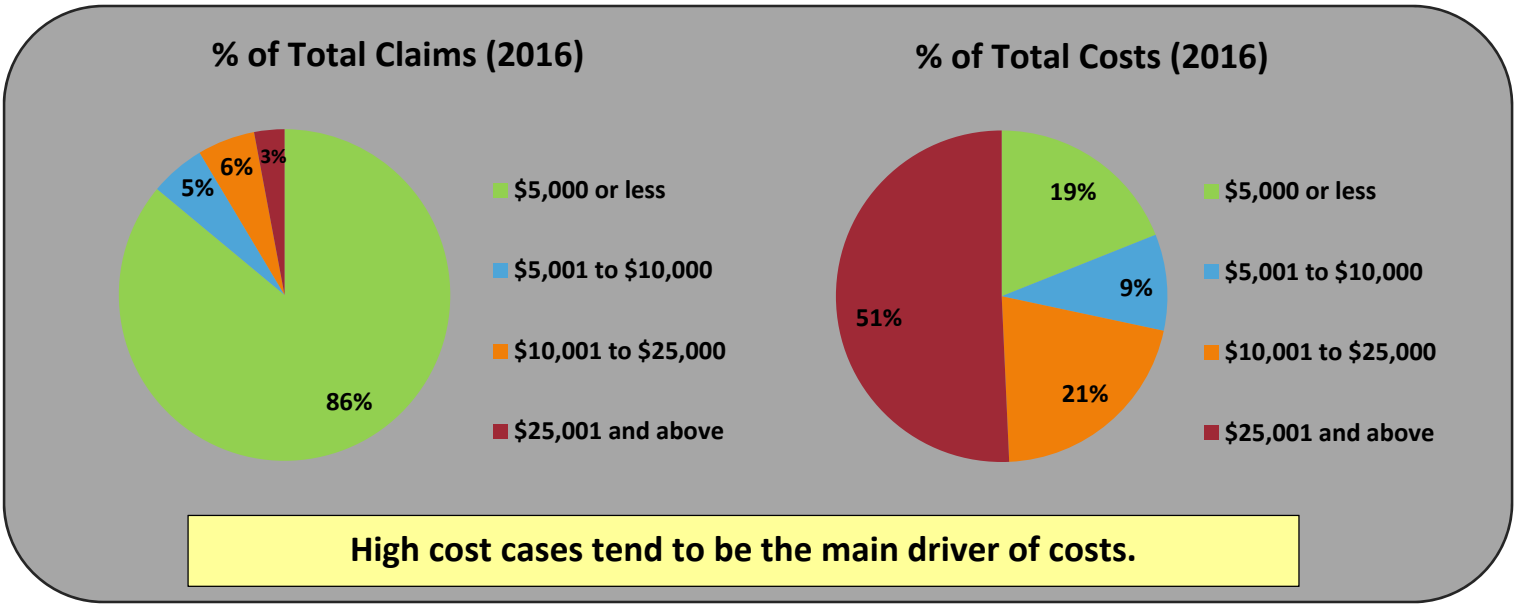
Total Claims/Member	Covered Lives	Percent of Lives	Amount	Percent of Claims $$
$5,000 or less	21,728	87%	$ 19,138	21%
$5,001 to $10,000	1,339	5	9,662	10
$10,001 to $25,000	1,271	5	19,376	21
$25,001 to $50,000	403	2	14,018	15
$50,001 to $100,000	194	1	13,567	15
$100,001 to $250,000	79	0	11,256	12
$250,001 and above	16	0	6,040	6
	25,030	100%	$ 93,057	100%

Note: only persons presenting claims are included in this analysis. 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 2016 (with parentheticals showing 2015 figures):

- The top 3 percent of the covered lives accounted for 51 percent (48 percent) of medical costs.
- Total claims greater than $10,000 accounted for 72 percent (69 percent) of medical costs.
- Of the $13.3 million increase in medical costs, $7.8 million was attributable to claims greater than $50,000.
- 86 percent (87 percent) of the covered lives had total claims of $5,000 or less.

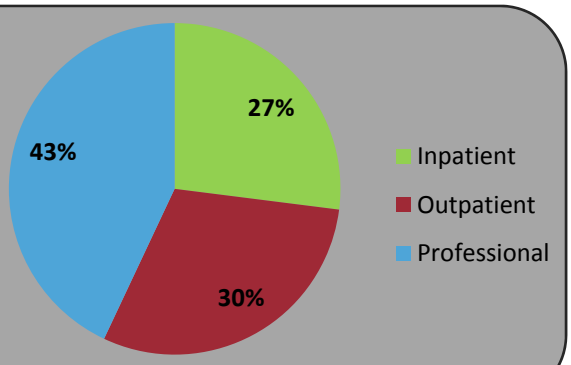


Medical costs are comprised of inpatient, outpatient and professional services. Inpatient services represent the costs that come with a hospital/facility stay. Outpatient costs are comprised of procedures that do not require a hospital stay, such as ambulatory surgery, emergency room visits, radiology 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 2016 and 2015 were:

University of Nebraska
Net Payments by Type (millions)

	2016	2015	Change Dollars	Change Percent
Inpatient	$ 28	$ 24	$ 4	18%
Outpatient	32	28	4	14
Professional	46	41	5	12
	$ 106	$ 93	$ 13	14%



Inpatient

Inpatient costs rose 18 percent, to $28 million in 2016 when compared to 2015. The average price paid per admission increased about 16 percent, while the number of admissions increased over 2 percent. The increase in inpatient costs was driven by surgical and medical procedures, which comprised over 75% of all inpatient costs.

Outpatient

Outpatient costs rose 14 percent, to $32 million in 2016 when compared to 2015. The cost of a typical outpatient service per member per month was up almost 11 percent, while membership increased about 3 percent. The increase in outpatient costs was driven primarily by services such as dialysis, chemotherapy, radiation, and others.

Professional Costs

Professional costs rose 12 percent, to $46 million in 2016 when compared to $41 million in 2015. Participant visits increased almost 8 percent, while the amount paid per visit increased over 3 percent. Service types comprising the majority of professional costs include evaluation & management, surgical, medical services & supplies, and medical.

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 covered lives under the University's plan is 35 compared to the Blue Cross Blue Shield of Nebraska (BCBSNE) benchmark of 33.
- The average age of the University's employee participant is 49 compared to the BCBSNE benchmark of 43.
- The highest cost diagnostic category was neoplasms (abnormal growth of tissue), which increased almost 20 percent and comprised over 13 percent of total paid claims.

- In regards to claims exceeding $50,000, the leading diagnostic categories and the percentage of payments for such claims were neoplasms (28 percent), musculoskeletal (10 percent), circulatory (10 percent), injury/poisoning (9 percent), and genitourinary (7 percent).
- Utilization in all categories (inpatient, outpatient and professional) was higher than the BCBSNE benchmark.
- The percentage of the plan's membership that is considered "at risk" (high or very high risk of significant claim experience) is comparable between years at approximately 20 percent.
- Number of persons with at least one chronic disease is comparable in 2016 and 2015 at 17 percent.
- The top five prevalent chronic conditions, all of which are below the BCBSNE norm, include behavioral health, musculoskeletal, hypertension, hyperlipidemia and diabetes.
- While emergency room visits/1000 are down about 2 percent, frequent emergency room visitors increased almost 11 percent.
- Preventative office visits were utilized by 64 percent of members, compared to the BCBSNE norm of 55 percent. All three primary cancer screenings (pap test, mammogram, and colorectal screening) were 2 percent to 6 percent above the BCBSNE norm.

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 2016 totaled approximately $5.6 million.

In 2016, pharmacy costs were up 17 percent to $35.0 million. Approximately 9,400 members utilized the plan's pharmacy program each month. The average annual net claim per participant totaled over $3,700.

The increase in pharmacy costs is primarily attributable to specialty prescription costs, which were 43 percent of total pharmacy costs in 2016 compared to 37 percent in 2015. Specialty prescription costs increased about 31 percent, driven mainly by price inflation, coupled with smaller increases in drug mix and utilization.

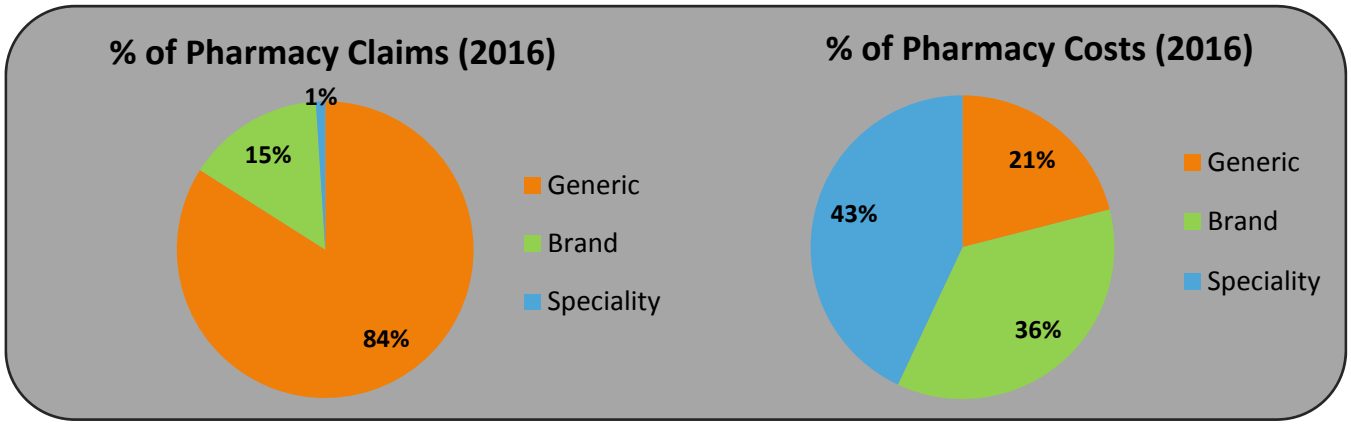
Pharmacy expenditures by category of drugs were as follows for the past two years:

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	
	2016	2015	2016	2015	2016	2015	2016	2015	2016	2015
Generic	$ 7,308	$ 7,340	21%	25%	228,866	227,639	84%	82%	$ 32	$ 32
Brand	12,669	11,400	36	38	41,996	46,787	15	17	302	244
Specialty	14,911	11,048	43	37	2,370	3,071	1	1	6,292	3,597
	$ 34,888	$ 29,788			273,232	277,497				

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 84 percent of total prescriptions, they only account for 21 percent of pharmacy costs.



The generic dispensing rate increased from 82 percent in 2015 to 84 percent in 2016. The University of Nebraska's success in adoption of generics is underscored by the fact that its generic use of therapeutic drugs for analgesics – anti-inflammatory, endocrine & metabolic agents, antineoplastics, and dermatologicals exceeded 80 percent. The difference in prices is dramatic: for new generic launches in 2017 alone, the University's projected savings for 2017 was approximately $300,000.

Conversely, specialty drugs are 1 percent of the plan's prescriptions, but account for 43 percent of the costs. 7 out of the top 10 prescription drugs used were specialty drugs. Primary among the specialty classes are multiple sclerosis, rheumatoid arthritis, oncology, hemophilia, seizure disorders, and hereditary angioedema. There are 331 users of specialty drugs, accounting for over $44,000 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. An incurred but not reported ("IBNR") reserve represents claims that have been incurred, but have not yet been presented to the health trust and its trustee for payment. A claims fluctuation reserve ("CFR") represents the financial impact if the University were to encounter an unusually high volume of claims or unexpected number of claims that exceeded the claims estimate utilized to establish premium rates for the plan. Each of these reserves is based upon the results of an annual actuarial study performed by Milliman.

Fund balances are the cumulative amounts of cash left over after expenses are paid and sufficient reserves have 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.

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, 2016, the University's health plan had a trust fund balance of approximately $75 million, with a net balance of about $53 million after subtracting estimated reserves. This represents a fund balance equal to about 4 months of plan expenses.

Conclusions and Looking Ahead

The University's trust fund balance decreased in 2016 from approximately $118 million to approximately $75 million. Over half of this decline was strategic in nature - upon the consent of legislative leadership, University management, in concert with Board members, chose to offer University employees premium holidays in April, May and June of 2016 to effectively lower the trust fund balance, resulting in total income declining 19 percent. Additionally, overall claims and expenses went up approximately 13 percent. Medical claims went up 14 percent, pharmacy claims went up 17 percent, and dental claims went up 2 percent. There were a couple factors that contributed to the upward trend in healthcare costs:

- The increased cost of medical claims were driven upward by an increase in utilization and cost of inpatient, outpatient and professional services, particularly pertaining to claims in excess of $50,000.
- The increased cost of pharmacy claims were driven upward by an increase in costs associated with specialty and brand drugs.

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.

At the present time, the future of the Affordable Care Act ("ACA") is uncertain. Presently the overall plan continues to be "grandfathered" in regards to the ACA, but 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.

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 and HRET Employer Health Benefits 2016 Annual Survey, http://files.kff.org/attachment/report-employer-health-benefits-2016-annual-survey