University of Nebraska

VICE PRESIDENT AND CFO

November 27, 2018

Senator John Stinner
Chair, Appropriations Committee
PO Box 94604, State Capitol
Lincoln, NE 68509

Dear Senator Stinner:

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, 2017. 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,

Chris J. Kabourek

Christopher J. Kabourek
Vice President/CFO

cc: Kathy Tenopir, Legislative Fiscal Office

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University of Nebraska
Health Insurance Plan Annual Report

Year Ended December 31, 2017

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 2017.

The University of Nebraska's strategic objective is to recruit and retain exceptional faculty and staff. One of the most highly valued benefits is 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 gained approximately $6 million in calendar 2017, as compared to an approximately $42 million loss in 2016. This approximately $48 million swing can be attributed to three significant factors:

1. The plan granted a "premium holiday" in April through June of 2016. The monetary impact of this action was a reduction in income to the plan in 2016 of approximately $33 million.

   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. For the first time since 2009 for active employees, the University increased premium rates in 2017. The approximate 10 percent increase in both employer and employee premium rates was implemented in response to the continued upward trend in healthcare costs, which were up 14 percent in 2016, and contributed approximately $13 million in additional income for 2017.

3. The final factor was stable claims experience in 2017, with a slight increase in pharmacy and dental claim expenses being offset by a slight decrease in medical claim expenses.

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 competitive access, the University hired consultants in 2017 to examine the plan with a goal of continuing 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
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 the Trustee, 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, for the claims cost plus an administrative fee.

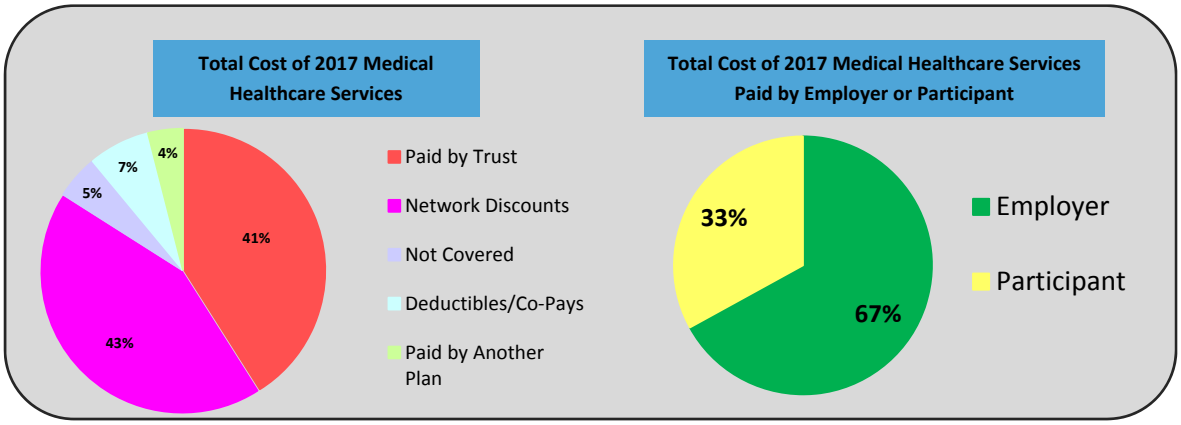
Premiums charged to both the employer and employees are designed to cover the plan's projected claim costs plus administrative expenses. Any potential changes in premiums, which become effective on January 1, are established by University management each fall after analyzing Milliman's actuarial expense 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 year ended December 31, 2017, 79 percent of premium income was contributed by the employer and 21 percent of premium income was contributed by the employee, as compared to the year ended December 31, 2016, where 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:

	2017 Monthly Premiums - Basic Coverage		
	Employee	Employer	Total
Family	$ 297	$ 1,200	$ 1,497
Employee+One	$ 233	$ 855	$ 1,088
Employee+Dependent(s)	$ 196	$ 638	$ 834
Employee Only	$ 146	$ 356	$ 502

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 borne by either the employer or participant. 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.

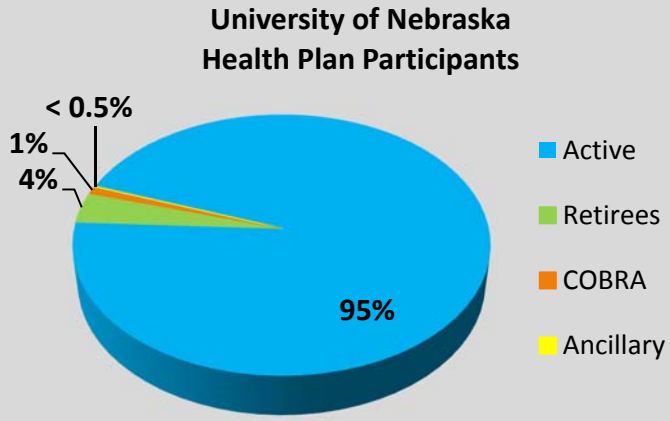
Enrollment and Demographics

The University's health plan had over 11,600 participants as of December 31, 2017, about 60 more than the prior calendar year-end. When including dependents, the plan served approximately 27,700 covered lives.

Active employees, by far the largest membership group in the plan increased, in 2017. Participant groups comprised of Cobra electees and retirees declined slightly in 2017.

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 4 percent, as compared to 8 percent in 2016. 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

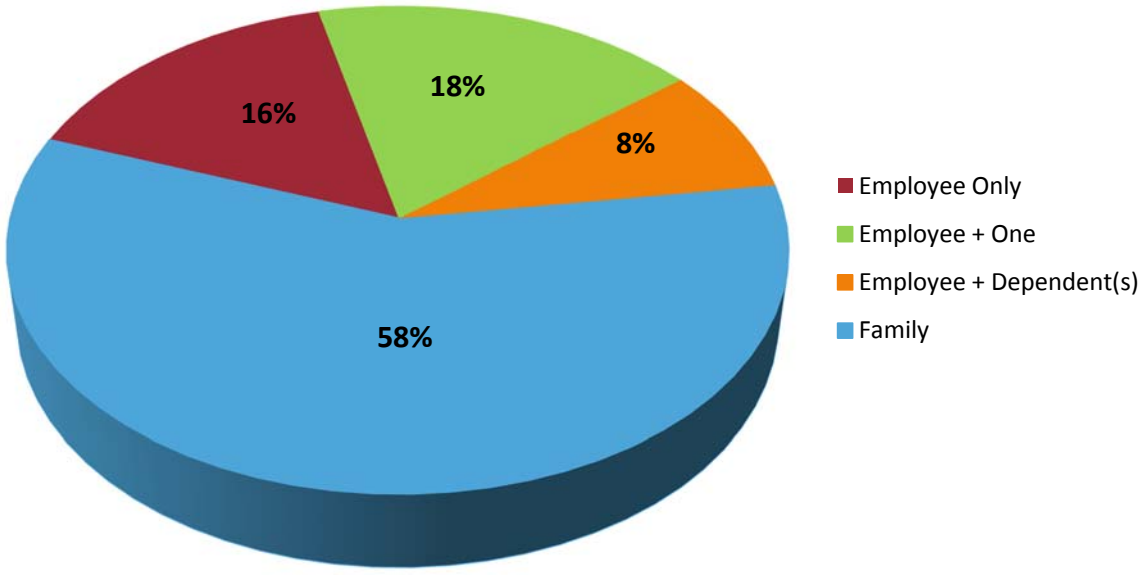
	Dec 2017	Dec 2016	Change Number	Change Percent
Active Employees	11,087	11,008	79	1%
Retirees	437	454	(17)	(4)
Ancillary Members	9	6	3	50
Cobra	109	113	(4)	(4)
Total	11,642	11,581	61	1%

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 2016.

In terms of covered lives, the average number of members for 2017 increased from 2016 by approximately 3 percent, with all four coverage categories noting increases. This resulted in almost 700 additional covered lives in 2017.

	Average 2017		Average 2016		% Change	
	Members	% of Total	Members	% of Total	Members	%
Employee Only	4,350	16%	4,283	16%	67	2%
Employee + One	5,004	18	4,959	18	45	1
Employee + Dependent(s)	2,343	8	2,305	9	38	2
Family	16,021	58	15,482	57	539	3
Totals	27,718	100%	27,029	100%	689	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 participants choosing the basic plan, 15 percent the low plan, and 10 percent the high plan.

The University of Nebraska's health plan covers approximately 27,700 lives (employees and their family members)

Financial Performance

The University health plan's financial results for the years ended December 31, 2017 and 2016 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 exceeded plan expenses in 2017, resulting in a $48.2 million increase in net activity as compared to 2016. This increase in net activity between years was due in part to the timing of premium holidays, which were not offered in 2017 but were offered April – June of 2016, and in part to an approximate 10 percent increase in employer and employee premium rates in 2017.

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

The approximate 10 percent increase in premium rates in 2017, the first increase to active employee rates since 2009, was implemented in response to the continued upward trend in healthcare costs, which were up 14 percent in 2016, and in accordance with annual actuarial projections. This increase contributed approximately $13 million in additional income for 2017.

After increasing 13 percent in 2016 due to a 14 percent increase in claims expenses, total plan expenses stabilized in 2017 at $155.4 million.

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

	Actual 2017	Actual 2016	Year-over-Year Change Dollars	Year-over-Year Change Percent
Employer Premiums	$ 115,243	$ 77,569	$ 37,674	49%
Employee Premiums	31,396	21,275	10,121	48
Retiree, Ancillary, Cobra Premiums	5,647	5,839	(192)	(3)
Trust Investment Income	1,670	3,135	(1,465)	(47)
Pharmacy Rebates/Discounts	7,647	5,604	2,043	36
Total Premiums and Income	161,603	113,422	48,181	42
Medical Claims	103,889	106,713	(2,824)	(3)
Pharmacy Claims	37,716	35,020	2,696	8
Dental Claims	8,195	7,944	251	3
TPA, ACA, and Other Expenses	5,633	5,752	(119)	(2)
Total Claims and Expenses	155,433	155,429	4	0%
Net Activity	$ 6,170	$ (42,007)	$ 48,177	

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

Income

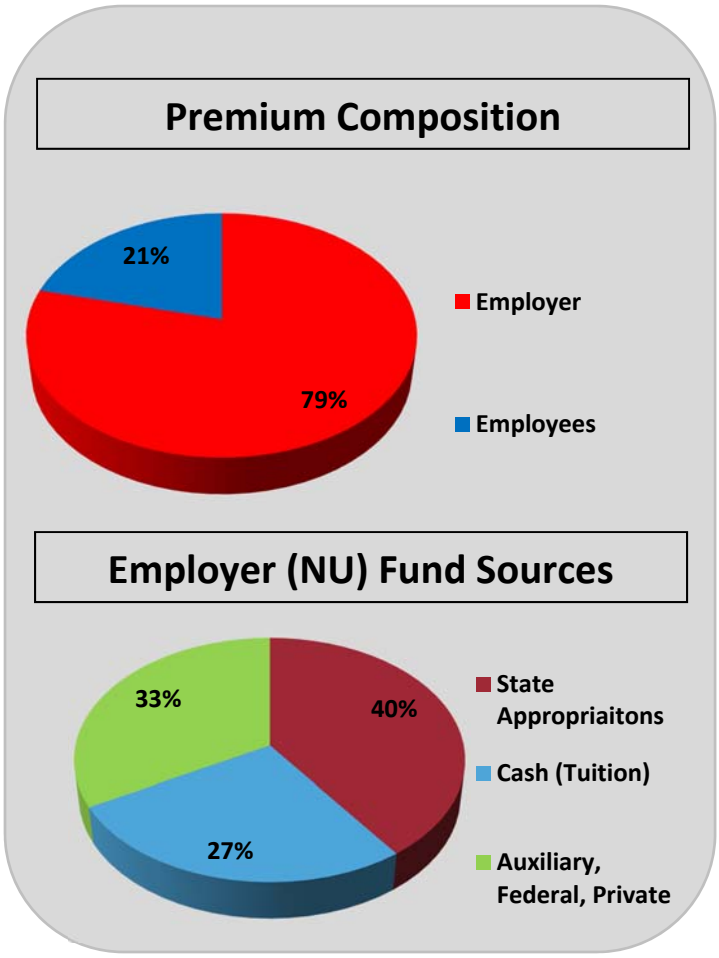
The University's health plan is funded from a variety of sources, although employer and employee premiums account for the bulk (91 percent) of the plan's income. Employer premiums are funded primarily from state appropriations (40 percent), cash funds such as tuition (27 percent), and other self-supporting business-type activities (auxiliaries) and federal grants and contracts (33 percent).

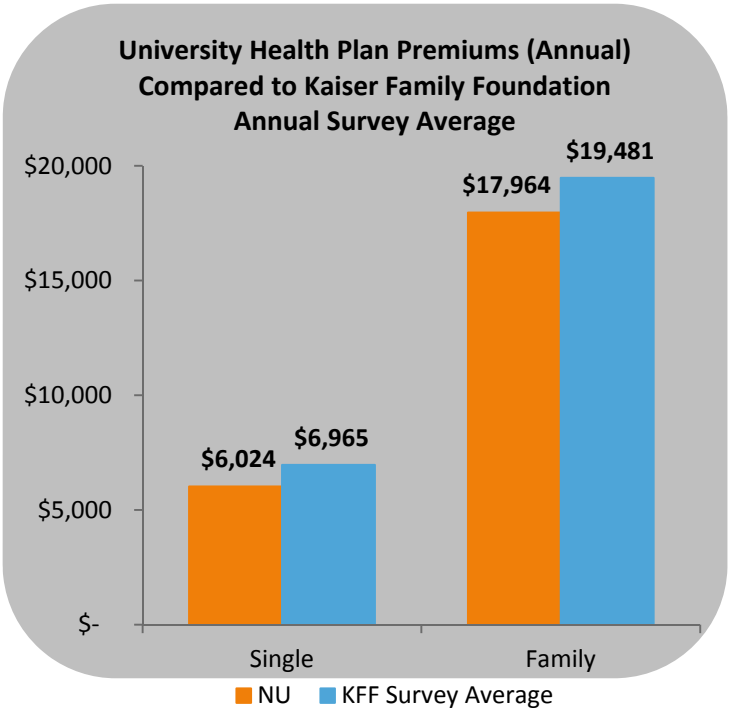
The plan's remaining income comes from retirees, ancillaries, and Cobra electees (3 percent), and investment income and pharmacy rebates/discounts (6 percent).

For the year ended December 31, 2017, the plan's income from employer and employee premiums increased by 48 percent. This was primarily the result of premium holidays being offered in 2016, along with an approximately 10 percent increase in premium rates in 2017.

As pharmacy claims continue to climb, so do pharmacy rebates/discounts, which increased from $5.6 million in 2016 to $7.6 million in 2017. 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 2017 Annual Survey[ii] by approximately 14 percent on single and 8 percent for family coverage.





Expenses

Medical Expenses

The plan's medical claims decreased by 3 percent for the calendar year. Medical claims in 2017 and 2016, arrayed by amount of claims per covered lives, were as follows:

University of Nebraska
2017 Claims Distribution (Claims in Thousands)

Total Claims/Member	Covered Lives	Percent of Lives	Amount	Percent of Claims $$
$5,000 or less	23,407	86%	$ 20,623	20%
$5,001 to $10,000	1,524	6	10,791	10
$10,001 to $25,000	1,385	5	21,348	21
$25,001 to $50,000	473	2	16,354	16
$50,001 to $100,000	216	1	14,804	14
$100,001 to $250,000	88	0	12,887	13
$250,001 and above	18	0	6,256	6
	27,111	100%	$ 103,063	100%

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

University of Nebraska
2016 Claims Distribution (Claims in Thousands)

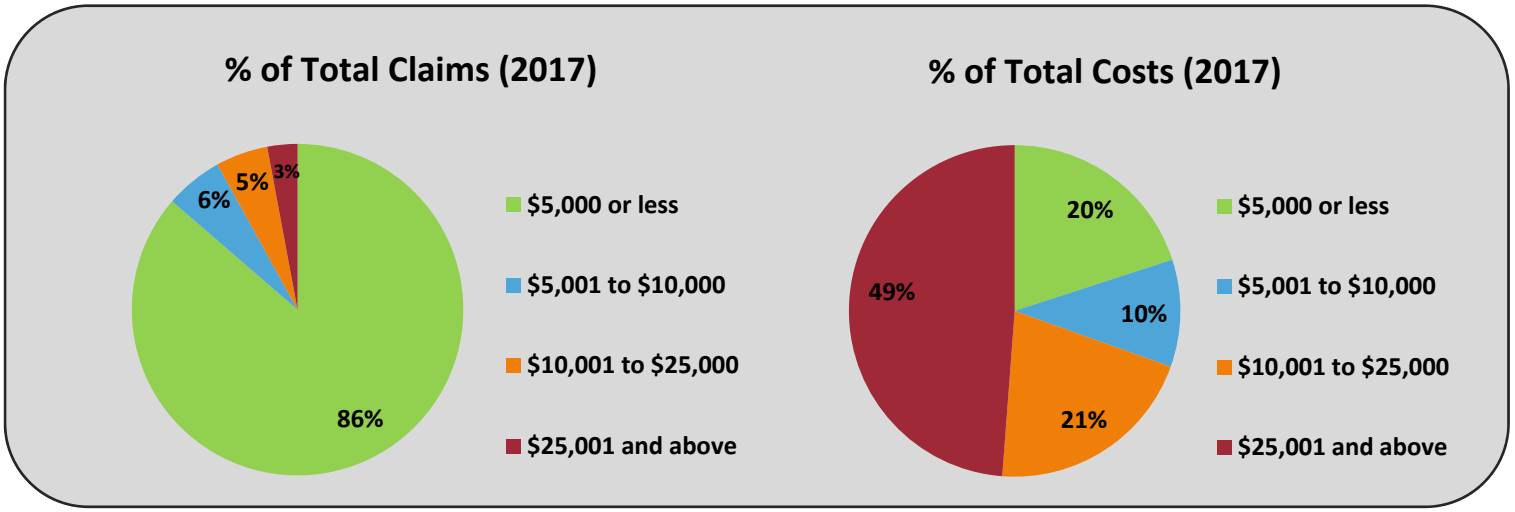
Total Claims/Member	Covered Lives	Percent of Lives	Amount	Percent of Claims $$
$5,000 or less	22,397	86%	$ 20,152	19%
$5,001 to $10,000	1,403	5	9,972	9
$10,001 to $25,000	1,461	6	22,266	21
$25,001 to $50,000	444	2	15,300	14
$50,001 to $100,000	214	1	14,854	14
$100,001 to $250,000	86	0	12,620	12
$250,001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

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 2017 (with parentheticals showing 2016 figures):

- The top 3 percent of the covered lives accounted for 49 percent (51 percent) of medical costs.
- Total claims greater than $10,000 accounted for 70 percent (72 percent) of medical costs.
- Claims greater than $250,000 were the primary driver of the approximately $3 million decrease in medical costs in 2017.
- 86 percent (86 percent) of the covered lives had total claims of $5,000 or less.



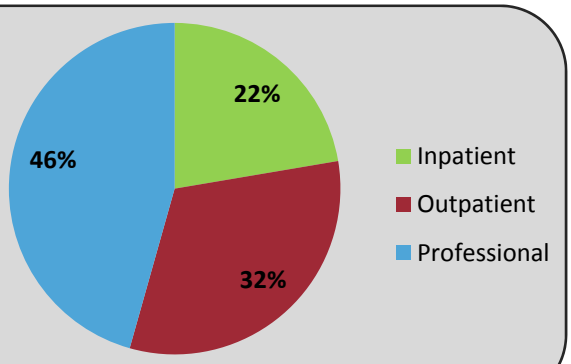
High cost cases tend to be the main driver of costs.

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 2017 and 2016 were:

University of Nebraska
Net Payments by Type (millions)

	2017	2016	Change Dollars	Change Percent
Inpatient	$ 23	$ 28	$ (5)	(18)%
Outpatient	33	32	1	3
Professional	47	46	1	2
	$ 103	$ 106	$ (3)	(3)%



Inpatient

Inpatient costs decreased 18 percent, to $23 million in 2017 when compared to 2016. The average price paid per admission decreased about 11 percent, while the number of admissions decreased about 8 percent. The decrease in inpatient costs was driven by surgical and medical procedures, which comprised over 75% of all inpatient costs.

Outpatient

Outpatient costs rose 3 percent, to $33 million in 2017 when compared to 2016. The cost of a typical outpatient service per member per month was relatively unchanged, while membership increased about 3 percent. The increase in outpatient costs was driven primarily by medical specialties services.

Professional Costs

Professional costs rose 2 percent, to $47 million in 2017 when compared to $46 million in 2016. Participant visits increased almost 9 percent, while the amount paid per visit decreased about 6 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 was 35 compared to the Blue Cross Blue Shield of Nebraska (BCBSNE) benchmark of 33.
- The average age of the University's employee participant was 48 compared to the BCBSNE benchmark of 43.

- In regards to claims exceeding $100,000, the leading diagnostic categories and the percentage of payments for such claims were neoplasms (38 percent), circulatory (11 percent), digestive system (9 percent), musculoskeletal (8 percent), and injury/poisoning (4 percent).
- Utilization in all categories (inpatient, outpatient and professional) was higher than the BCBSNE benchmark.
- The percentage of the plan's membership that was considered "at risk" (high or very high risk of significant claim experience) was down from 20 percent in 2016 to 17 percent in 2017.
- Number of persons with at least one chronic disease was up from 17 percent in 2016 to 25 percent in 2017.
- The top five prevalent chronic conditions, all of which were above the BCBSNE norm, included behavioral health, musculoskeletal, hypertension, hyperlipidemia and diabetes.
- Emergency room visits were up 7 percent, while the amount paid per emergency room visit was up 12 percent. The primary driver of emergency room visits was injury/poisoning.
- Preventative office visits were utilized by 62 percent of members, compared to the BCBSNE norm of 47 percent. All three primary cancer screenings (pap test, mammogram, and colorectal screening) were 3 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 2017 totaled approximately $7.6 million.

In 2017, pharmacy costs were up 8 percent to $37.7 million. Approximately 9,600 members utilized the plan's pharmacy program each month. The average annual net claim per participant totaled over $3,900.

The increase in pharmacy costs is primarily attributable to specialty prescription costs, which were 46 percent of total pharmacy costs in 2017 compared to 43 percent in 2016. Specialty prescription costs increased about 17 percent, driven mainly by increases due to utilization and price inflation, offset by a small decrease due to drug mix.

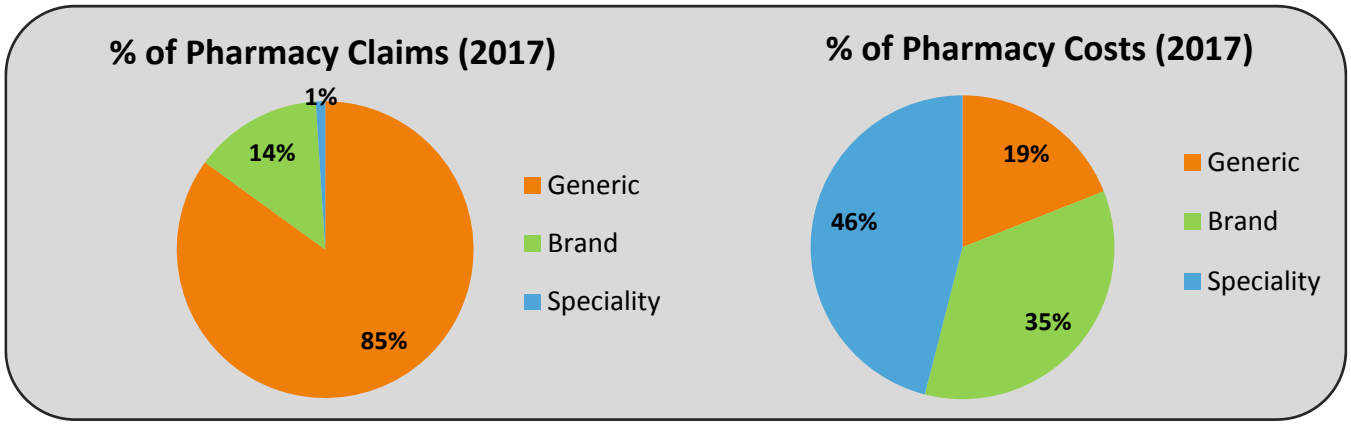
Pharmacy expenditures by category of drugs were as follows for the past two years:

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	
	2017	2016	2017	2016	2017	2016	2017	2016	2017	2016
Generic	$ 6,931	$ 7,308	19%	21%	233,108	228,866	85%	84%	$ 30	$ 32
Brand	13,163	12,669	35	36	38,592	41,996	14	15	341	302
Specialty	17,395	14,911	46	43	3,711	2,370	1	1	4,687	6,292
	$ 37,489	$ 34,888			275,411	273,232				

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 represented 85 percent of total prescriptions, they only accounted for 19 percent of pharmacy costs.



The generic dispensing rate increased from 84 percent in 2016 to 85 percent in 2017. 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, antineoplastics, dermatologicals, and antivirals exceeded 80 percent in 2017. The difference in prices is dramatic: for new generic launches in 2018 alone, the University's projected savings for 2018 was approximately $200,000.

Conversely, specialty drugs are 1 percent of the plan's prescriptions, but account for 46 percent of the costs. 8 out of the top 10 prescription drugs used in 2017 were specialty drugs. Primary among the specialty classes are multiple sclerosis, rheumatoid arthritis, oncology, hemophilia, and cystic fibrosis. There were 388 users of specialty drugs in 2017, accounting for approximately $45,000 of net 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, 2017, the University's health plan had a trust fund balance of approximately $81 million, with a net balance of about $60 million after subtracting estimated reserves. This represents a fund balance equal to about 5 months of plan expenses.

Conclusions and Looking Ahead

The University's trust fund balance increased in 2017 from approximately $75 million to approximately $81 million. An increase in 2017 premium income, driven primarily by the lack of premium holidays and an approximately 10 percent increase in premiums rates, were more than sufficient to cover relatively stable claims experience, resulting in the approximately $6 million increase in the trust fund balance.

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, as well as promote the use of urgent care facilities or telehealth to reduce increases associated with emergency room visits.

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.

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.

In its continuing efforts to provide University employees with a quality yet affordable healthcare program and in response to budget constraints resulting from recent reductions in state appropriations, the University hired consultants in 2017 to examine the plan with a goal of continuing to provide a competitive benefit while holding the line on costs for both employees and the University.

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 2017 Annual Survey, https://www.kff.org/health-costs/report/2017-employer-health-benefits-survey