Nebraska Department of Administrative Services

Health Insurance Plan Annual Report

Presented to the Legislature's Appropriations Committee

For the Plan Year July 1, 2019 to June 30, 2020

November 23, 2020

Table of Contents

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 teammates regarding wellness and benefit issues; manages third party administrators and actuarial consultants; provides financial management to the health plan; and continuously researches healthcare and benefit program trends to assure the State continues to offer a competitive benefit package to its teammates.

Providing health insurance is a key component of the State's investment in its workforce. The investment through State contributions totaled over $168 million. This, along with compensation and retirement benefits illustrate how the State prioritizes their teammate's wellbeing. Health insurance is one of the largest costs of doing business in the modern economy. Thus, prudent financial management of the program is a critical responsibility of DAS. Strong management allows the State to offer the most comprehensive benefits possible.

Like many businesses, in 2020, the State of Nebraska was affected by the emergence of the COVID-19 global pandemic. In response to this challenge, DAS implemented a number of plan changes, such as waiving member cost sharing for COVID-related virtual and telehealth visits, and non COVID-related virtual and telehealth visits with an in-network provider which encouraged plan participants to stay home and practice social distancing without jeopardizing their ability to receive timely diagnosis and treatments.

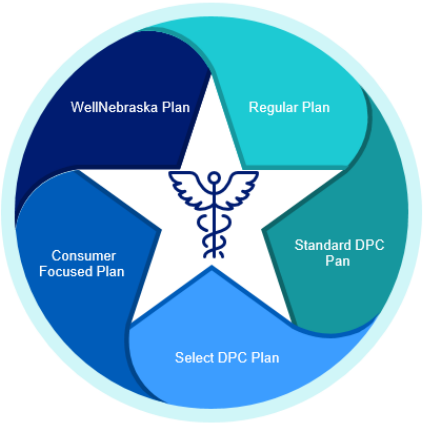
Over the past few years, the Governor's administration has worked to make the State a family-friendly employer; specifically a premier workplace for moms. To achieve this goal, enhancements to the State's maternity benefits went into effect July 1, 2020. The changes are aimed at reducing childbirth-related medical expenses for State teammates.

In 2018, the legislature mandated a pilot program for a Direct Primary Care (DPC) benefit offering. As a result, the State introduced two new plans focused on accessible and low-cost primary care services. These plans have both a direct primary care component as well as a catastrophic plan design for services outside of primary care.

DAS will continue to evaluate such programs and take steps to control costs and offer competitive health and prescription drug benefits—a win-win prospect for agencies, teammates, and taxpayers across the State.

Health Plan Overview

The State of Nebraska's health insurance program consisted of five self-insured health plans in 2019 – 2020, the Regular Plan, the WellNebraska/Wellness Plan, the Consumer-Focused Health Plan, and two Direct Primary Care (DPC) plans. Each plan included medical and prescription drug coverage for in-network and out-of-network providers, as well as wellness benefits



The Regular Plan is the base PPO. The WellNebraska Plan gives teammates incentives for meeting wellness-related requirements. The Consumer-Focused Health Plan (CFHP) provides an option for teammates to take advantage of a Health Savings Account (HSA) to set aside pre-tax funds for future health care expenses. The two new DPC plans were offered for the first time in the 2019 -2020 plan year as a part of State-mandated pilot program. DPC is membership-based healthcare and is provided by Strada Healthcare. The DPC aspects of the plan are offered in conjunction with two high deductible plans (Standard Plan or Select Plan) and are administered by UnitedHealthcare (UHC). These plans provide preventive and direct primary care services at no additional charge beyond the monthly membership fee. Services outside of the preventive and primary care spectrum are subject to the high deductible component of the plans. DPC members also have access to discounted cash prices for additional medical services such as lab work, imaging, physical therapy, and chiropractic care. DPC plans do not meet the IRS requirements for HSA accounts, therefore, their members are not eligible to make contributions to an HSA account.

There are no prerequisites or requirements for teammates to participate in the Regular Plan, Consumer-Focused or DPC plans. To enroll in the WellNebraska/Wellness Plan, teammates and spouses were required to complete and submit a health survey. All teammates are eligible to enroll in this plan, however those who have completed the health survey 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 plan refers to participants under the WellNebraska health plan who met the incentive requirements. The Regular health plan encompasses those that chose the Regular Plan while the WellNebraska health plan covers those members who did not meet the incentive requirements.

The plan year ran from July 1, 2019 through June 30, 2020 with open enrollment held May 5, 2020 through May 19, 2020. All teammates were encouraged to review the pre-populated elections in the WorkDay system to verify what plans they currently were enrolled in and/or to make any necessary changes.

Medical Third-Party Administrator and PBM Procurement

The State provides benefits through a self-funded arrangement in which the State assumes the financial risk for providing health care benefits to its teammates and contracts with the third-party administrator (TPA) to process the claims. Instead of paying fully-insured, fixed premiums to an insurance company, which may be inflated to include profit margins and taxes, the State collects contributions from teammates and State agencies and deposits them in a State trust fund, using the premiums to pay health care claims for plan participants after member copays and deductibles are applied.

When covered teammates and dependents incur medical and prescription drug claims, health providers (hospitals, doctors, pharmacies, etc.) send those claims to the State's TPAs. The medical and pharmacy benefit management (PBM) administrators ensure that submitted claims are adjudicated correctly under the provisions outlined in the plan documents set forth by the State and pay the providers. Once payment clears the bank, the State reimburses the administrators for the claims through the State Employee Insurance Fund.

For the 2019 – 2020 plan year, UHC was the TPA for medical claims, and its subsidiary, OptumRx, was the TPA/PBM for pharmacy claims. UHC's contract with the State was set to expire at the end of 2020 plan year, therefore in June 2019, a request for proposal (RFP) was issued by the State to solicit competitive bids for TPAs and PBMs to provide medical and prescription drug benefits. Four vendors responded with proposals: Aetna, BCBS, UHC, and Medica. After meeting with their legal team, Medica (the Bidder) did not provide the required repriced claim files as instructed, the cost proposal did not meet the requirements therefore could not be evaluated.

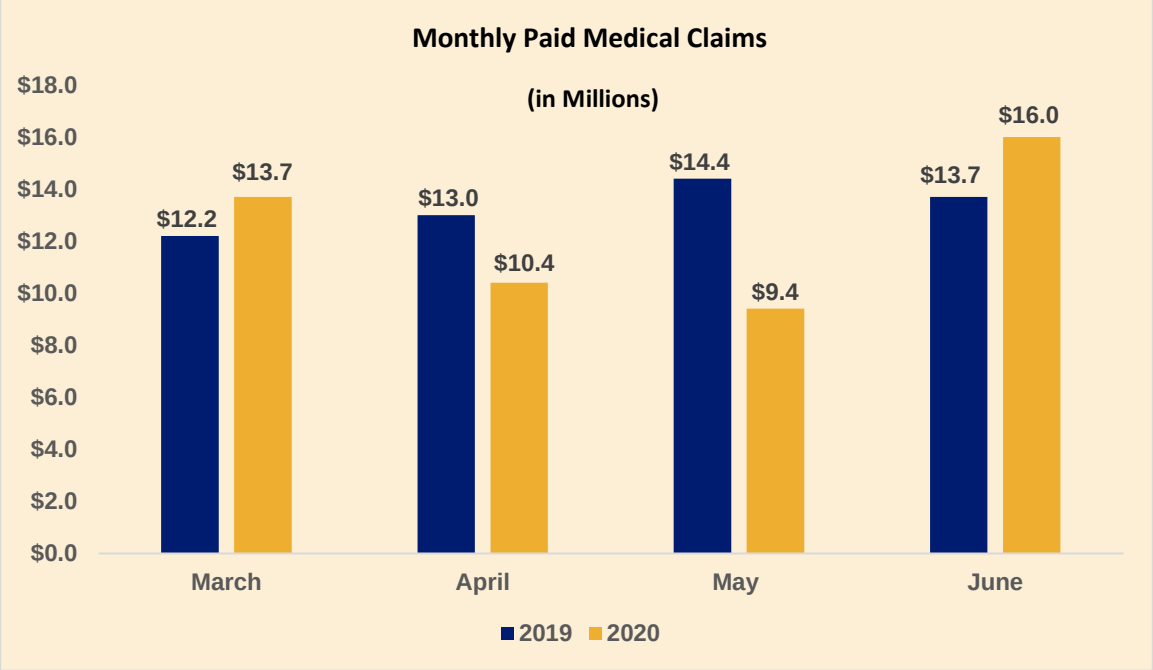
A team of State-appointed evaluators carefully reviewed and evaluated the remaining proposals based on a number of factors such as guaranteed network discounts, geographical availability of in-network providers, quality and cost of administrative services, as well as many others. As a result of this evaluation, UHC and its subsidiary, OptumRx were identified as the most competitive vendor and retained their positions as TPA/PBM for the State's medical and prescription drug claims, respectively. The new contract between DAS and UHC will remain in force until June 30, 2023. The contract also includes the option to renew for four (4) additional one (1) year periods upon mutual agreement of the Parties. The State reserves the right to extend the period of the contract beyond the termination date when mutually agreeable to the Parties. Over the period of three years, the new contract is expected to produce savings of approximately $2 Million in administrative fees, and $10.5 Million in prescription drug expenses.

COVID-19

The end of 2019-2020 plan year was marked by the emergence of the novel coronavirus and the disease caused by it, COVID-19. In order to encourage plan participants to seek timely diagnosis and treatment, and to help them practice social distancing, DAS made following changes to its plans:

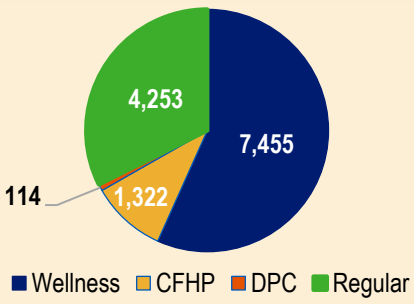
- Eliminated cost sharing for COVID-19 Testing and Testing-Related Visits
- Eliminated cost sharing for covered health care services related to a COVID-19 treatment
- Eliminated cost sharing for Telehealth visits received from a designated virtual network provider and related to diagnosis or treatment of COVID-19
- Eliminated cost sharing for Telehealth visits with in-network medical providers through live audio/videoconferencing or audio-only (telephonic) technology for visits that are not related to COVID-19. This included physical, occupational and speech therapy, as well as behavioral health
- Allowed plan participant to re-fill their prescriptions in advance of their normal re-fill schedule

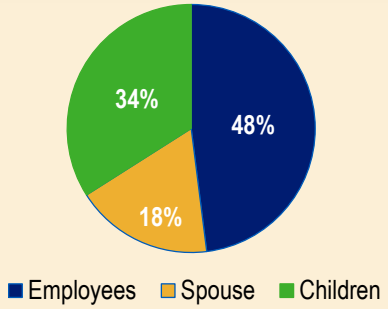
As of September 30, 2020, 2,852 individuals, or approximately 10% of plan participants were tested for COVID-19, with 277 of them receiving a confirmed COVID-19 diagnosis. The total cost of tests and treatment for the COVID-19 related services amounted to $1.4 Million. These expenses were offset by savings due to the decline in utilization of non-COVID related, non-emergency services, a trend that started to appear in April, 2020 and continues into the plan year 2020-2021 as members practice social distancing and elect to delay in person medical services and treatment.



Enrollment and Eligibility

Neb. Rev. Stats. §84-1601 and §84-1604 allow for permanent full-time and part-time teammates who work a minimum of 20 hours per week to participate in the State health plans. These teammates 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 teammates 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.

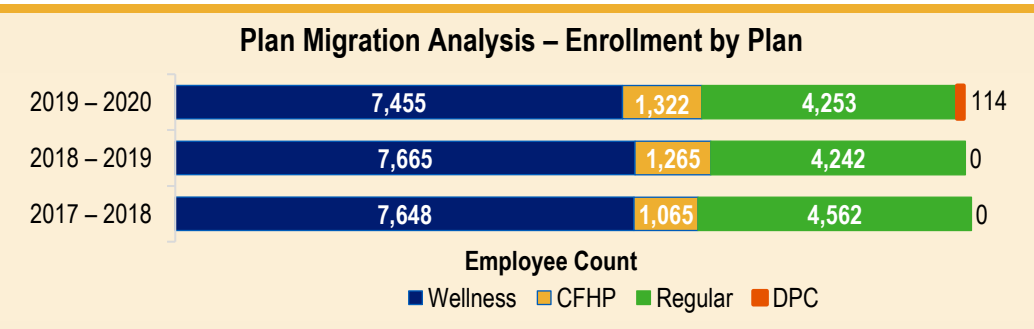




The plan averaged 13,143 teammates enrolled in the 2020 plan year, which included approximately 235 retirees and 68 COBRA participants. The total number of covered lives was 27,529, which decreased 0.6% from the 2018 – 2019 plan year. Ongoing dependent verification audits were conducted for all new dependents added to the health plan to ensure only eligible teammates used State benefits.

Approximately 56.0% of teammates were female and 44.0% were male. The average age of teammates enrolled was 46.4, down from last year's average of 46.7.

Total enrollment in the State Health Insurance Plan over the past year has decreased 0.2%. The Consumer-Focused Health plan had 10% of the population enrolled during the 2019 – 2020 plan year, compared to 8% in the prior year. The popularity of the Consumer-Focused plan has been steadily increasing. Most of the migrating members moved from the Wellness plan. The enrollment in the new DPC plans were low, making it difficult to evaluate their effectiveness.



Plan Management and 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, the State's actuary and healthcare consulting firm, UHC, and attorneys to constantly monitor changes in health plan management and assure the plan and all required 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, and administrative fees. This fund is administered by DAS and reserve targets are adjusted annually using cost projections from Segal for the 2019 – 2020 plan year.

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.

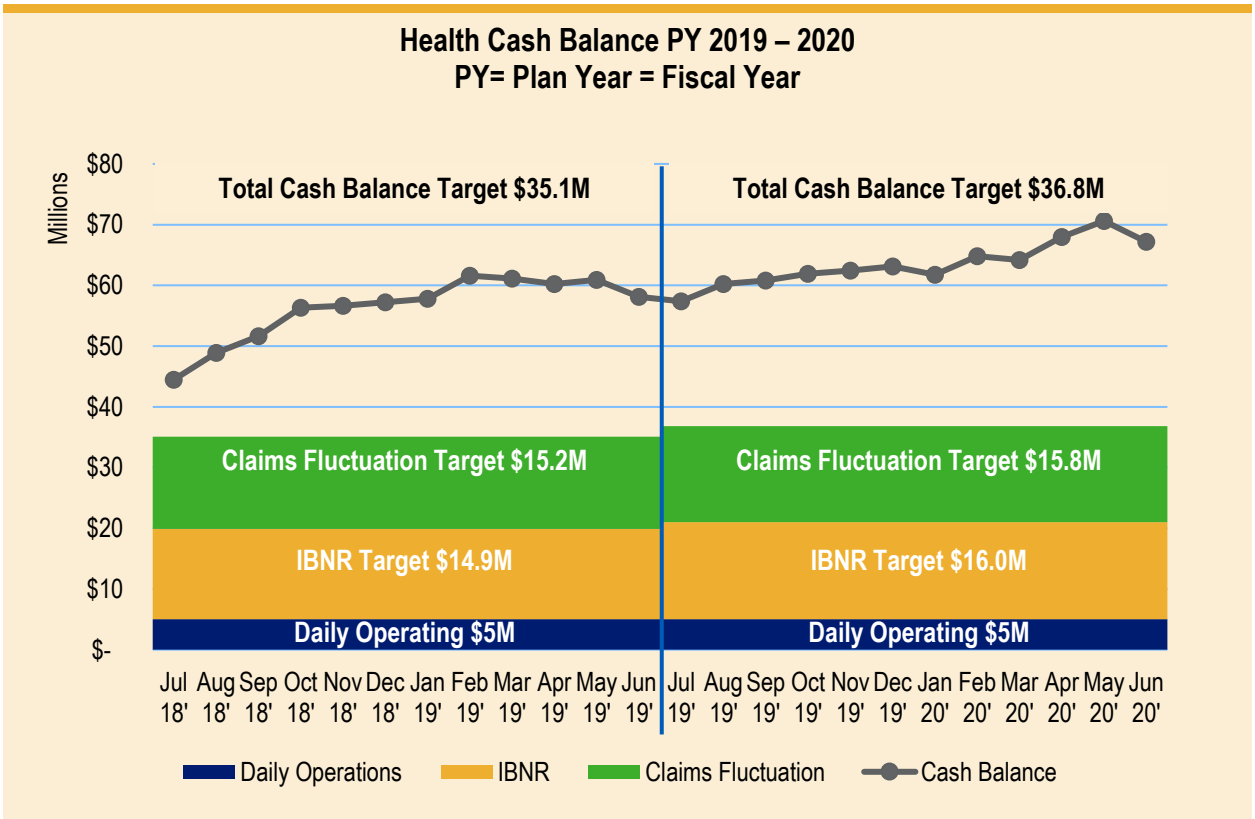
During the 2019 – 2020 plan year, a payment was made for the Patient-Centered Outcomes Research Institute (PCORI) fee as prescribed by the Affordable Care Act (ACA). The institute is a government-sponsored organization charged with funding comparative effectiveness research that assists consumers, clinicians, purchasers, and policy makers to make informed decisions intended to improve healthcare at both the individual and population levels. This fee is paid every July. In July 2019 and in July 2020 the State paid $55,000, each year, for the PCORI fee.

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 2019 – 2020, Segal recommended a CFR of at least $15.8 Million and IBNP of $16.0 Million. In accordance, the State established a targeted balance of $15.8 Million in Health Insurance History Fund for the CFR. A targeted balance of $21.0 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 $36.8 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, 2019 and June 30, 2020, respectively, 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, 2019 and 2020

	Plan Year			
	2019 – 2020	**2018 – 2019**	**$ Change**	**% Change**
Contributions				
Contributions	$213,468,794	$209,292,148	$4,176,646	2%
Investment Income	$1,003,926	$941,637	$62,289	7%
Total Contributions	**$214,472,720**	**$210,233,785**	**$4,238,935**	**2%**
Distributions				
Medical Claims & IBNP	$151,588,282	$144,322,330	$7,265,952	5%
Pharmacy Claims	$46,793,211	$45,869,251	$923,960	2%
Administration Fees	$6,938,464	$6,803,692	$134,772	2%
Total Distributions	**$205,319,957**	**$196,995,273**	**$8,324,684**	**4%**
Net Difference	**$9,152,763**	**$13,238,512**		

State of Nebraska Health Insurance Funds
as of June 30, 2020

	6/30/2020	**6/30/2019**	**$ Change**	**% Change**
State Employees Insurance Fund #68960	$51,065,317	$42,647,908	$8,417,410	20%
Health Insurance History Fund #68922	$16,124,352	$15,448,061	$676,292	4%
Total Reserves	**$67,189,669**	**$58,095,968**	**$9,903,701**	**16%**

Health Plan Contributions

The State Employees Insurance Fund #68960 is funded by health plan contributions from participants and the State. Contributions are collected from teammates 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 teammates pay 21%. Neb. Rev. Stat. §84-1604 requires part-time teammates (20-29 hours a week) receive only a proportion of the State contribution. Part-time teammates 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.

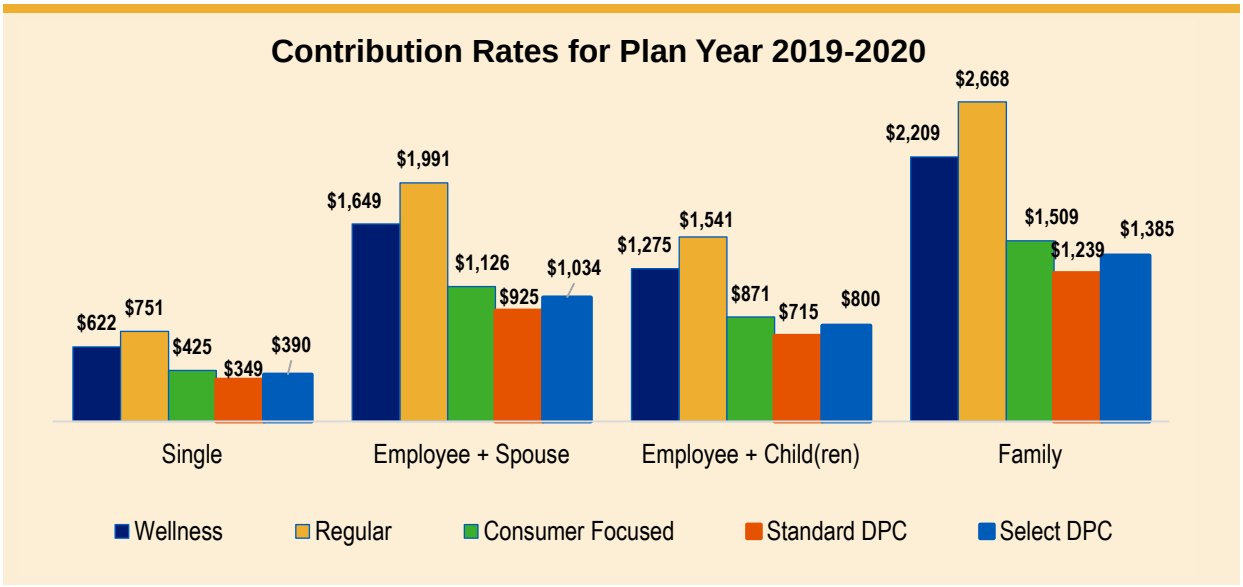
Health plan contributions are reviewed each year. In November 2018, Segal provided the State's Wellness and Benefits Administrator with a Preliminary Premium Rate Analysis Report. The Wellness and Benefits Administrator, Personnel Director, and Director of DAS reviewed the report along with the State Budget Division and Governor. Contributions and plan design changes were approved in February 2019 and communicated to teammates in April 2019, prior to Open Enrollment. The changes were implemented on July 1, 2019.

2019 – 2020 Rate Increases

- Wellness: 3.0%
- Consumer-Focused: 3.0%
- Regular: 3.0%

Contributions to the plan increased from $210 Million to $214 Million in the 2019 – 2020 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 analyzed individually for plan design and plan usage, which can result in different rate changes by plan if substantial. Otherwise, the rate changes are uniform, which help reduce year-to-year rate fluctuation and maintaining plan relativities.



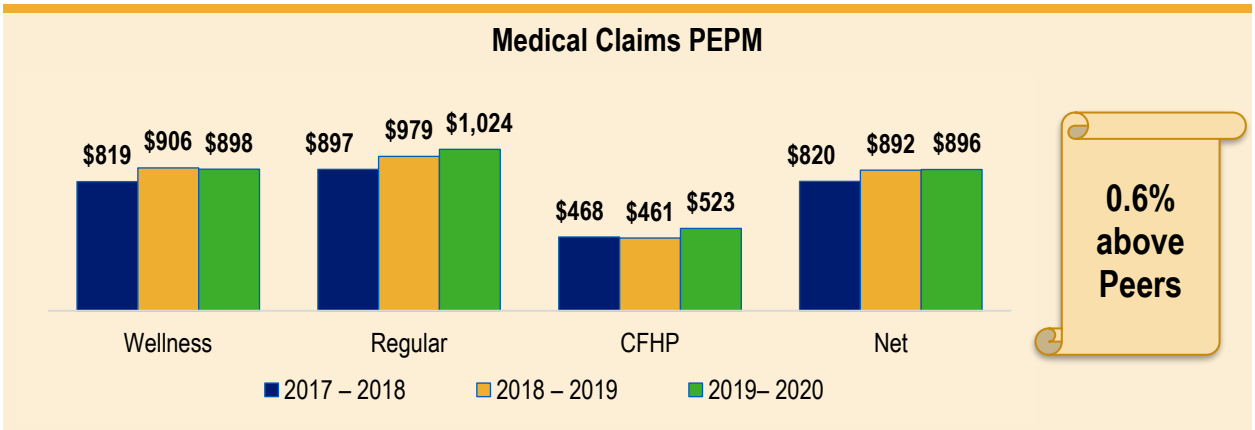
Medical Claims Review

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 $152 Million in reported medical claims in fiscal year 2019 – 2020, which reflected a 5.0% increase from the prior year. This increase is inflated by delays in processing run-out claims from 2018-2019 plan year. Claims fell below projected amounts leading to the growth of the cash balance. Most of this gain can be attributed to the pandemic.

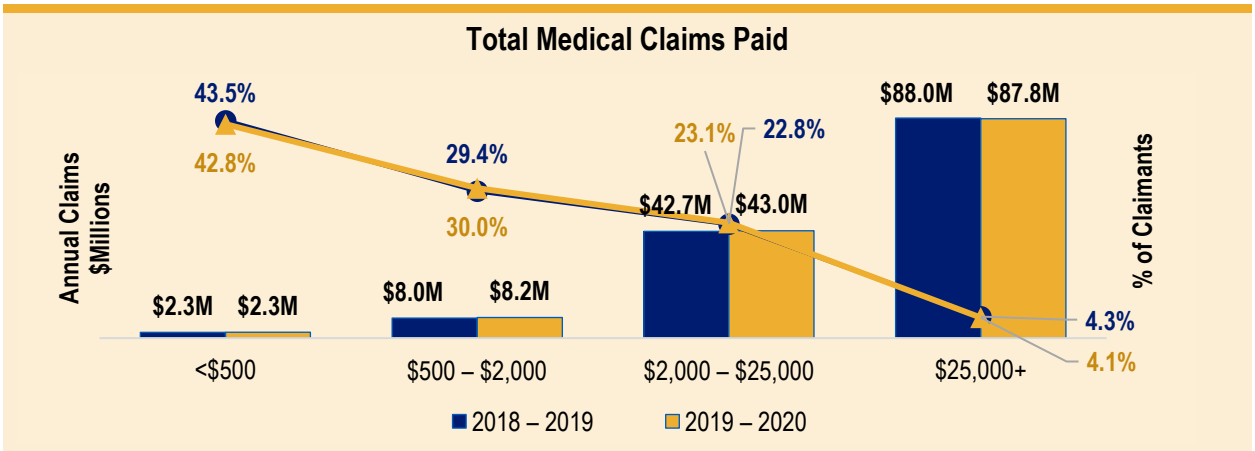
Consistent with 2018 – 2019, treatment for neoplasms (cancer), musculoskeletal conditions, and circulatory (heart disease) were the top cost drivers of medical claims. Combined, these three diagnoses drove 36% of total medical claims paid per employee per month (PEPM).

The 2019 – 2020 Net paid PEPM of $896 reflects a 0.4% increase from the previous year and was 0.6% above our peer group according to UHC.



For the purposes of this graph, DPC plans are combined with CFHP

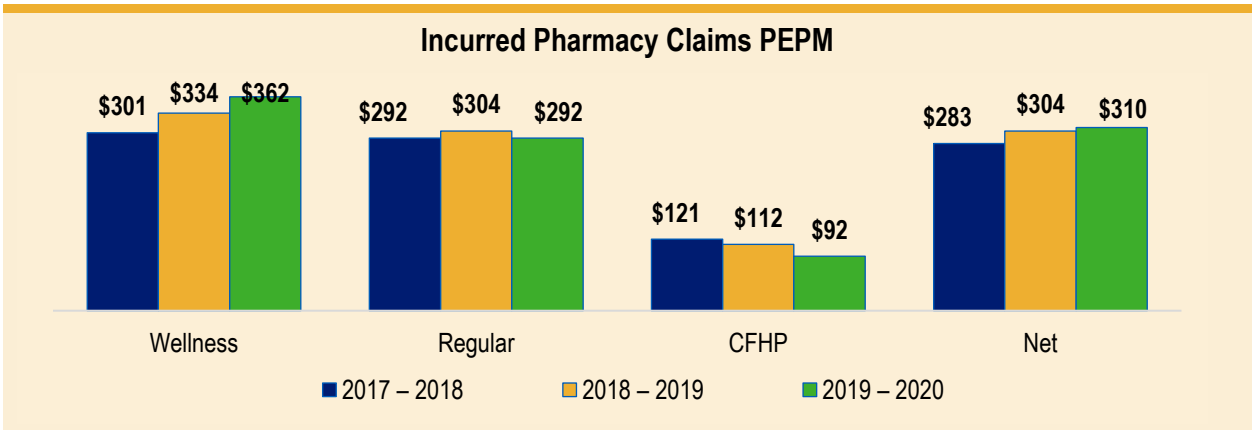
Consistent with other group health plans, a small percentage of participants incurred a high proportion of total medical claims paid. Of the $141 Million paid through July of 2020 for 2019-2020 incurred medical claims, the plan paid $87.8 million for 4.1% of the total plan participation of 27,529. The total incurred amount (PEPM) for claimants with claims over $100,000 increased by 7.7% from the previous year and decreased by 7.8% 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 $46.8 Million for prescription claims in 2019 – 2020, a 2.0% increase 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 $1.0 Million (5%) increase in specialty drug payments from the previous plan year. Again, the claims experience fell below expected trends leading to the growth of the cash balance.

Roughly 22,700 participants utilized pharmacy benefits in the health plan, filling about 339,600 prescriptions. The average cost per prescription of $143.77 for the State was a 2.6% increase from $140.18 paid the prior year. On average, each member filled 12.3 prescriptions annually. This is lower than last year's average of 12.4.



For the purposes of this graph, DPC plans are combined with CFHP

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 generics 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.

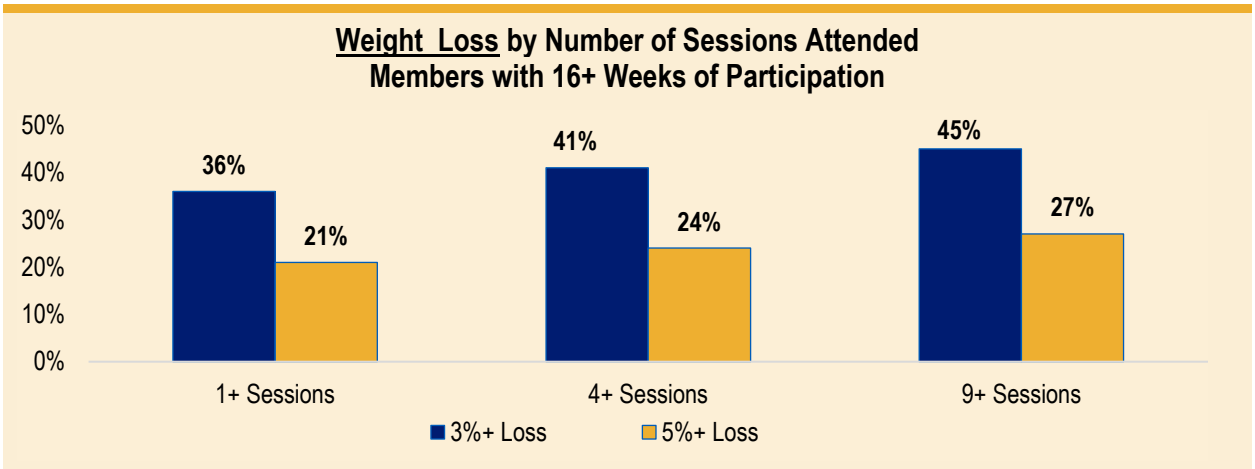
	2019 – 2020	2018 – 2019	% Change
Annual Scripts per Member	12.3	12.4	-0.8%
Average Cost per Member	$147.80	$144.49	2.3%
Plan Cost Share	92.0%	91.8%	0.2%
Employee Cost Share	8.0%	8.2%	-2.4%
Generic Utilization	85.3%	85.6%	-0.4%

Wellness Program

Real Appeal®

Real Appeal is a weight loss wellness program provided by UHC that was added as of April 1, 2018. During the plan year 2019 – 2020 the State saw 2,549 members enrolled in the program, with 87% of enrollees deemed at risk of diabetes, cardiovascular disease, or other weight-related health conditions.

According to the Real Appeal report with data through June 30, 2020, the program scored a 4.76 out of 5 satisfaction rating in a survey of 15,632 participants. The graph below shows the percentage of Real Appeal program participants who lost over 3% and 5% of their body weight respectively while being engaged with the program.



NOTE: This is in reference to the Real Appeal Programming/Participation.

Snapshot of 2019-2020 Health Program Outcomes

Financial	• Net PEPM for medical increased 0.4%. • Cost of COVID-19 testing and treatment amounted to $1.4 Million • Excluding catastrophic claims, medical PEPM is trending -3.0% due to decrease in utilization of non-emergency services. • Catastrophic claims increased by 7.7% PEPM • Net PEPM for pharmacy increased 1.9% • Medical PEPM was 0.6% above peer group. • Network discount rate was 40.9% and saved $113.1 Million. • 219 participants drive 33.8% of medical and exceed $100,000 in claims. • Average cost for catastrophic claimants was $217,742. • 5 participants exceeded $1 Million in claims.
Clinical	• Demographic factor/risk is 1.5% lower than peer. • Network utilization for medical benefits was 97.8%. • Approximately 10% of enrolled members were tested for COVID-19, 277 of them were diagnosed with the disease. • Emergency room visits are 20.8% lower than UHC Peer group and utilization decreased by 0.8% from last year. • Inpatient utilization decreased 3.6% and the amount paid per admission increased by 8.1%. • Outpatient surgeries decreased 8.2%, but cost per surgery increased 2.7% • The amount of PMPY PCP visits decreased by 5.0% and Specialists visits decreased by 3.3% • Musculoskeletal issues, cancer, and circulatory system diseases still drive medical costs. • 10% of members had a primary diagnosis of diabetes. • Generic medication dispensing rate was 85.3%

Looking Ahead

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

Segal provided the State with actuarial cost projections for the 2020 – 2021 plan year. Costs were impacted by underlying healthcare trend, fixed fee contracts, and demographic changes. Premiums were set based on expected costs and multi-year strategy to align the fund balance with the target reserve.

2020 – 2021 Contribution Increases	
WellNebraska (wellness track)	2.5%
Regular Health Plan	2.5%
Consumer-Focused Health Plan	2.5%
Select DPC Plan	2.5%
Standard DPC Plan	2.5%

Starting July 1, 2020, the State began to offer enhanced maternity benefits to the participants enrolled into the Wellness plan. Under this benefit, all medically necessary outpatient maternity related services will be covered at 100%, in-network inpatient medically necessary hospital charges that are maternity related, including inpatient well baby nursery, will have a $500 copay and then be paid at 100% of eligible charges.

The State will continue to offer DPC plans while monitoring their claim experience and effectiveness in controlling the costs of healthcare. In September 2021, a report describing the results of this pilot program will be provided to the State legislators.

Since the excise tax was repealed in December 2019, there is no longer a need to consider its potential future impact.

The State is continually monitoring healthcare trends in the industry and partnering with groups such as Segal, UHC, Strada and others to seek out, analyze and provide the best features and options for teammates and taxpayers. Cutting-edge practices, particularly in the area of specialty drug management and utilization will continue to be a primary focus 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 teammates and their families are able to participate in other group benefits including dental, vision, employee assistance program, flexible spending accounts, life, short-term, and long-term disability. A quality benefit package is offered that is designed to attract and retain a best in class State of Nebraska workforce.

Glossary

ACA (Affordable Care Act): Healthcare 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. The State of Nebraska refers to their employees as "teammates."

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.

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.

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 a teammate, 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): Healthcare legislation signed in to law March 23, 2010. The law includes new health plan provisions rolled out over multiple years.

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.