University of Nebraska

UNK N O

November 24, 2020

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, 2019. 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

Chris J. Kabourek
Vice President/CFO

cc: Phil Hovis & Suzanne Houlden, Legislative Fiscal Office

Office of the Vice President for Business and Finance | CFO
Varner Hall | 3835 Holdrege Street | Lincoln, NE 68583-0742 | 402.472.2191 | nebraska.edu

University of Nebraska
Health Insurance Plan Annual Report

Year Ended December 31, 2019

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 2019.

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 lifestyles, taking advantage of preventive screenings, having regular visits with health professionals, and adhering to drug and other prescribed therapies.

Overall, total claims and expenses exceeded total premiums and income by approximately $12 million in calendar 2019, as compared to approximately $7 million in 2018. Although medical claims declined by 8 percent in 2019, this was more than offset by an average 2 percent decrease in medical premium rates and a one-month "premium holiday" granted to active employees in December of 2019. The "premium holiday" reduced 2019 premium income by approximately $12.8 million. The holiday was a by-product of discussions between legislative leadership and university management to draw down reserve levels. This allowed the premium income that would have been contributed to the plan from state-aided budget to be redirected to other strategic purposes and, in the case of revolving operations, alleviated the need to increase prices to students, faculty and others for housing, unions, parking and other self-funded operations.

We speculate that some of the decreased medical claims experience in 2019 may have been as a result of the University's announcement in May 2018 that the third-party administrators for our medical and dental insurance claims would be changing on January 1, 2019 (as discussed in further detail below). We think that this announcement, after over 20 years with the same third-party

administrators for our medical and dental insurance claims, may have caused some concerns for our plan members regarding future coverages, resulting in plan members incurring increased services in 2018 before the transition on January 1, 2019. Our benefits consultant advised us that it is not uncommon to see a significant increase in claims experience prior to a third-party administrator change.

The third-party administrator change was one of the results of a comprehensive review of the plan as the University developed strategies to manage budget challenges in 2017. This examination resulted in several significant changes to the plan in 2019, including a new third-party administrator for medical insurance claims (UMR, a UnitedHealthcare Company), a new third-party administrator for dental insurance claims (Ameritas), the addition of a qualified high deductible health plan option, the addition of a preferred provider tier for members who use a Nebraska Medicine provider, and an approximately 2 percent decrease in medical premium rates.

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 healthcare industry.

University of Nebraska Strategic Objective:

Recruit and retain exceptional faculty and staff

Contents

Plan Overview

The University of Nebraska offers a preferred provider (PPO) "self-insured" health plan providing medical, dental, and pharmacy coverage to its employees and their families. 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 currently utilizes the expertise of the following outside parties to assist in the administration of the plan (prior to 2019, BlueCross BlueShield of Nebraska was the third-party administrator for medical and dental claims):

Entity	Description of Service Provided
UMR	Third-party administrator for medical claims
CVS Caremark	Third-party administrator for pharmacy claims
Ameritas	Third-party administrator for dental 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 healthcare purposes.

When covered employees and their dependents incur healthcare expenses, health providers (hospitals, doctors, pharmacies) send their bills to either (a) UMR, a UnitedHealthcare Company (UMR) for medical claims, (b) CVS Caremark (CVS) for pharmacy claims, or (c) Ameritas for dental claims. UMR, CVS, and Ameritas, 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 UMR, CVS, and Ameritas pay claims, they are reimbursed by Wells Fargo, the trustee, for the claims cost plus an administrative fee.

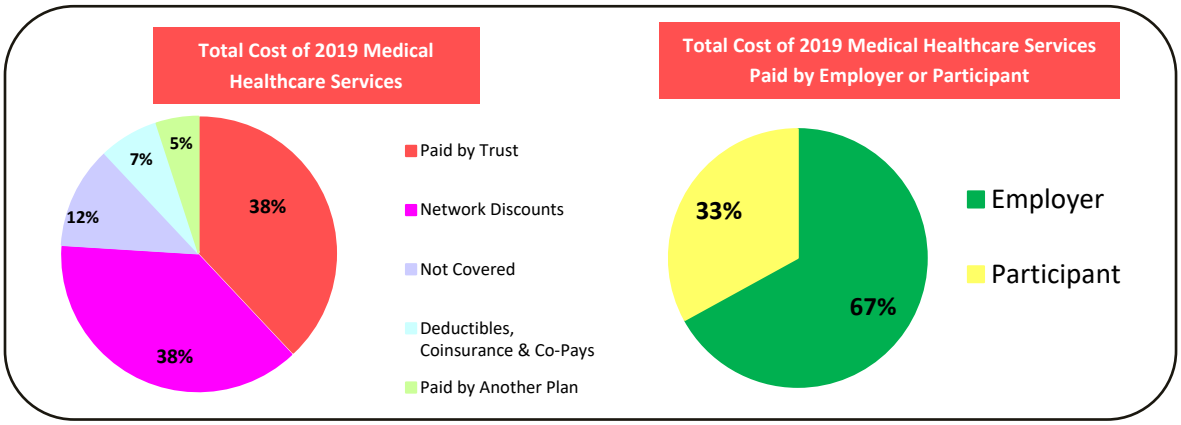
Premiums charged to both the employer and employees are designed to cover the plan's projected claim costs plus administrative expenses. Any potential changes in premiums, which become effective on January 1, are established by University management each fall after analyzing Milliman's actuarial expense 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 years ended December 31, 2019 and 2018, 79 percent of premium income was contributed by the employer and 21 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 medical 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:

	2019 Monthly Premiums - Basic Medical Coverage		
	Employee	Employer	Total
Family	$ 307	$ 1,243	$ 1,550
Employee+One	$ 241	$ 886	$ 1,127
Employee+Dependent(s)	$ 203	$ 661	$ 864
Employee Only	$ 152	$ 368	$ 520

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, coinsurance & co-pays, discounted through network agreements, or simply not covered, as demonstrated in the graphs below for medical healthcare services:



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, coinsurance 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 medical healthcare services paid by the participant is even greater than 33 percent, as a portion of medical 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 & Finance Committee.

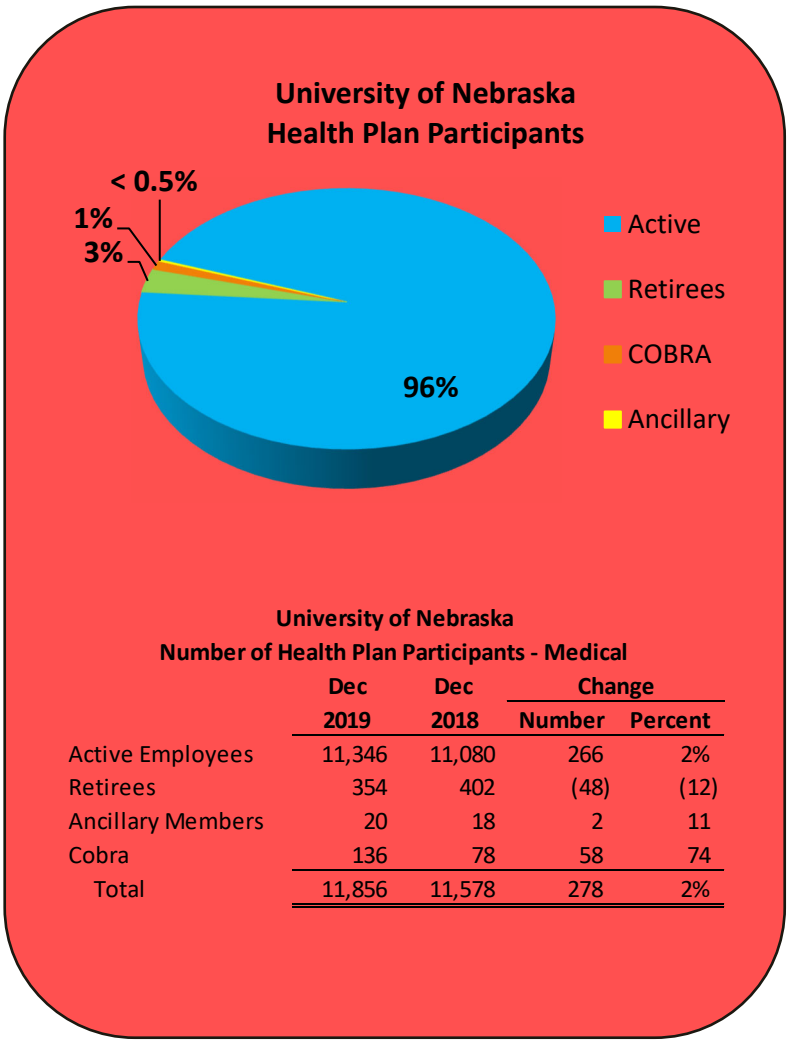
Enrollment and Demographics

The University's health plan had over 11,800 medical participants as of December 31, 2019, 278 more than the prior calendar year-end. When including family members, the plan had average annual medical membership of approximately 28,000 covered lives.

The number of individuals in each participant group was relatively unchanged for 2019, with the 2 percent increase being driven by an increase in active employees.

University retirees can 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 12 percent, as compared to 8 percent in 2018. This is attributed to 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.



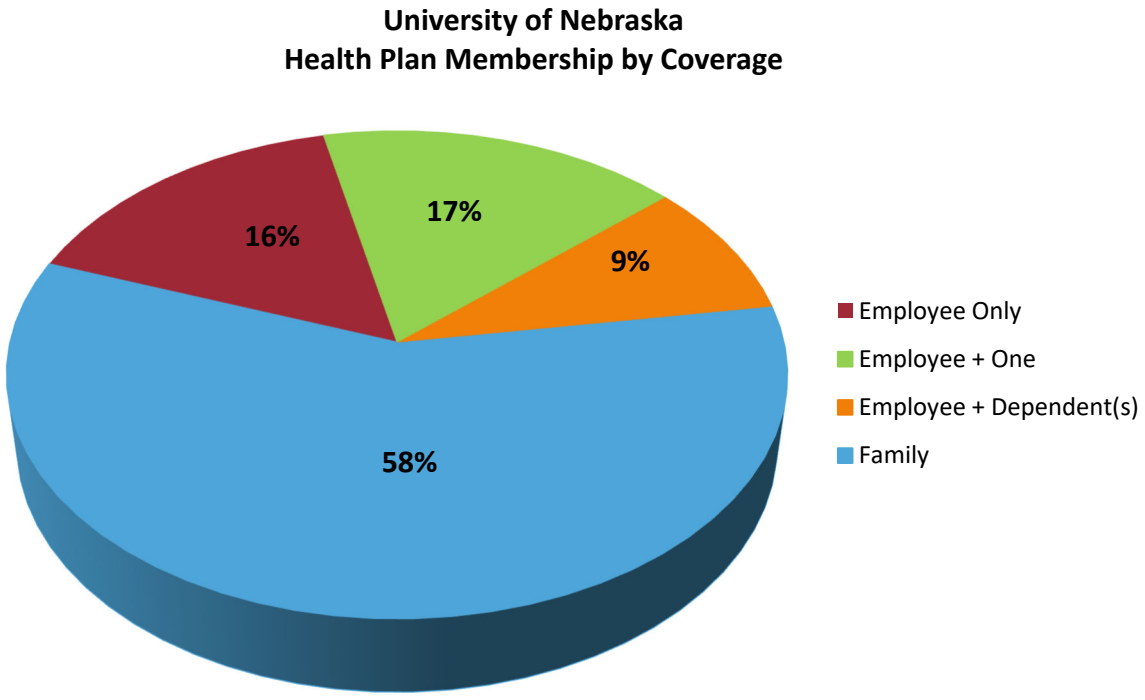
University of Nebraska
Number of Health Plan Participants - Medical

	Dec 2019	Dec 2018	Change Number	Change Percent
Active Employees	11,346	11,080	266	2%
Retirees	354	402	(48)	(12)
Ancillary Members	20	18	2	11
Cobra	136	78	58	74
Total	11,856	11,578	278	2%

Demographically, covered lives were about 51 percent female and 49 percent male. Average age for all covered lives was 34 years, as compared to 35 years in 2018.

In terms of covered lives, the average number of members for 2019 increased from 2018, with a small decrease in the "employee+one" category being offset by small increases in the other three categories.

	Covered Lives for Medical Benefits					
	Average - 2019		Average - 2018		% Change	
	Members	% of Total	Members	% of Total	Members	%
Employee Only	4,356	16%	4,293	15%	63	1%
Employee + One	4,770	17	4,940	18	(170)	(3)
Employee + Dependent(s)	2,477	9	2,370	9	107	5
Family	16,444	58	16,075	58	369	2
Totals	28,047	100%	27,678	100%	369	1%



The plan originally offered three levels of medical coverage: low, basic, and high, with each (respectively) offering increasing levels of coverage. The high plan has much lower deductibles and coinsurance but higher premiums compared to the low plan. In 2019, a fourth level was added – the qualified high deductible plan, which has much higher deductibles but lower coinsurance than the other levels, and a premium that is comparable to the low plan. Enrollments in each of the original three levels shifted just slightly in 2019 with the addition of the qualified high deductible plan, with about 72 percent of participants choosing the basic plan, 15 percent the low plan, 11 percent the high plan, and 2 percent the qualified high deductible plan.

The University of Nebraska's health plan had average annual medical membership of approximately 28,000 covered lives (employees and their family members)

Financial Performance

The University health plan's financial results for the years ended December 31, 2019 and 2018 are shown below (cash basis in thousands). A more detailed description of the plan's income, expenses and calendar year activities is provided in the following sections.

Plan expenses exceeded plan income in 2019, resulting in a $4.6 million decrease in net activity as compared to 2018. This decrease in net activity between years was driven by an average 2 percent decrease in medical premium rates and a one-month "premium holiday" granted to active employees in December of 2019, which more than offset an 8 percent decline in medical claims in 2019.

After back-to-back increases in medical premium rates in 2017 and 2018, the first increases for active employees since 2009, the University was able to decrease medical premium rates in 2019 due to the anticipated savings from the aforementioned changes made to the plan in 2019. Additionally, positive plan performance for the year resulted in a "premium holiday" in December of 2019 for active employees.

The decrease in claims and expenses is primarily attributable to a decrease in medical claims. As mentioned earlier, we speculate that this decrease may in part be the result of the University's announcement in May 2018 that the third-party administrators for our medical and dental insurance claims would be changing on January 1, 2019. We think that this announcement, after over 20 years with the same third-party administrators for our medical and dental insurance claims, may have caused some concerns for our plan members regarding future coverages, resulting in plan members incurring increased services in 2018 before the transition on January 1, 2019. Furthermore, we believe the decrease is also partly attributable to savings realized from the plan changes that were made in 2019.

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

	Actual 2019	Actual 2018	Year-over-Year Change Dollars	Year-over-Year Change Percent
Employer Premiums	$ 111,383	$ 122,097	$ (10,714)	(9)%
Employee Premiums	29,650	32,656	(3,006)	(9)
Retiree, Ancillary, Cobra Premiums	5,286	5,723	(437)	(8)
Trust Investment Income	2,049	1,962	87	4
Pharmacy Rebates/Discounts	9,091	8,208	883	11
Total Premiums and Income	157,459	170,646	(13,187)	(8)
Medical Claims	111,584	120,664	(9,080)	(8)
Pharmacy Claims	43,986	43,042	944	2
Dental Claims	8,347	8,483	(136)	(2)
TPA, ACA, and Other Expenses	5,302	5,588	(286)	(5)
Total Claims and Expenses	169,219	177,777	(8,558)	(5)%
Net Activity	$ (11,760)	$ (7,131)	$ (4,629)	

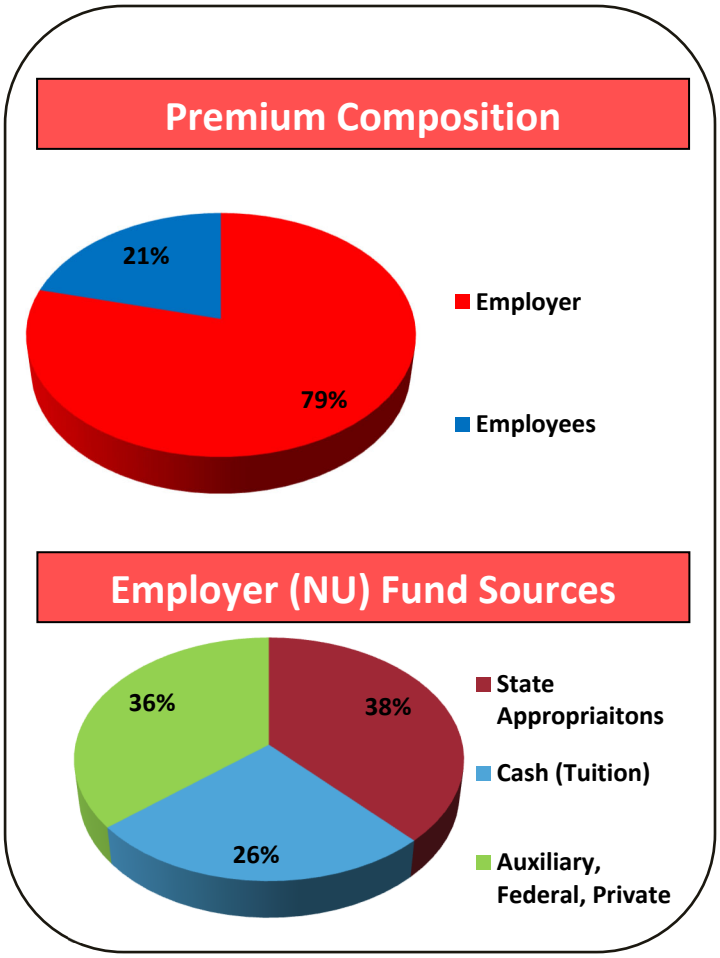
Income

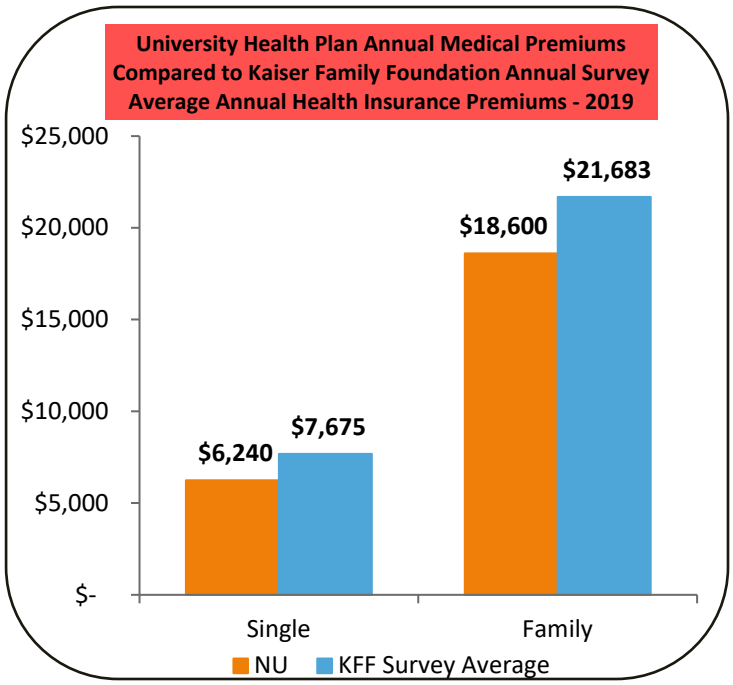
The University's health plan is funded from a variety of sources, although employer and employee premiums account for the bulk (90 percent) of the plan's income. Employer premiums are funded primarily from state appropriations (38 percent), cash funds such as tuition (26 percent), and other self-supporting business-type activities (auxiliaries) and federal grants and contracts (36 percent).

The plan's remaining income comes from retirees, ancillaries, and Cobra electees (3 percent), and investment income and pharmacy rebates/discounts (7 percent).

For the year ended December 31, 2019, the plan's income from employer and employee premiums decreased by about 9 percent. This was primarily the result of an approximately 2 percent decrease in medical premium rates in 2019 and the granting of a "premium holiday" in December of 2019 for active employees.

As pharmacy claims continue to climb, so do pharmacy rebates/discounts, which increased from $8.2 million in 2018 to $9.1 million in 2019. Note that the increase in 2019 would have been more dramatic, excepting that approximately $2 million in rebates received in 2019 were utilized to support benefit administration in the University's state-aided budget rather than deposited in the health trust. 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. Medical premiums (employer plus employee) under the University's basic coverage plan are lower than the average annual health insurance premiums as reported in the

Kaiser Family Foundation Employer Health Benefits 2019 Annual Survey[ii] by approximately 19 percent for single and 14 percent for family coverage.

Expenses

Medical Expenses

The plan's medical claims decreased by over 7 percent for the calendar year. Medical claims in 2019 and 2018, arrayed by amount of medical claims per covered lives, were as follows:

University of Nebraska
2019 Medical Claims Distribution (Claims in Thousands)

Total Claims/Member	Covered Lives	Percent of Lives	Amount	Percent of Claims $$
Less than $5,000	22,457	87%	$ 23,508	21%
$5,000 to $9,999	1,442	5	11,478	10
$10,000 to $24,999	1,293	5	22,120	20
$25,000 to $49,999	426	2	17,275	16
$50,000 to $99,999	189	1	13,874	12
$100,000 to $199,999	86	0	13,093	12
$200,000 and above	30	0	10,194	9
	25,923	100%	$ 111,542	100%

Note: only persons presenting claims are included in this analysis. Claim amounts are per UMR & BCBS and covered lives are per UMR.

University of Nebraska
2018 Medical Claims Distribution (Claims in Thousands)

Total Claims/Member	Covered Lives	Percent of Lives	Amount	Percent of Claims $$
$5,000 or less	23,991	85%	$ 22,082	19%
$5,001 to $10,000	1,581	6	11,060	9
$10,001 to $25,000	1,559	6	24,250	20
$25,001 to $50,000	526	2	18,368	15
$50,001 to $100,000	199	1	13,612	11
$100,001 to $250,000	109	0	16,187	14
$250,001 and above	35	0	14,700	12
	28,000	100%	$ 120,259	100%

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

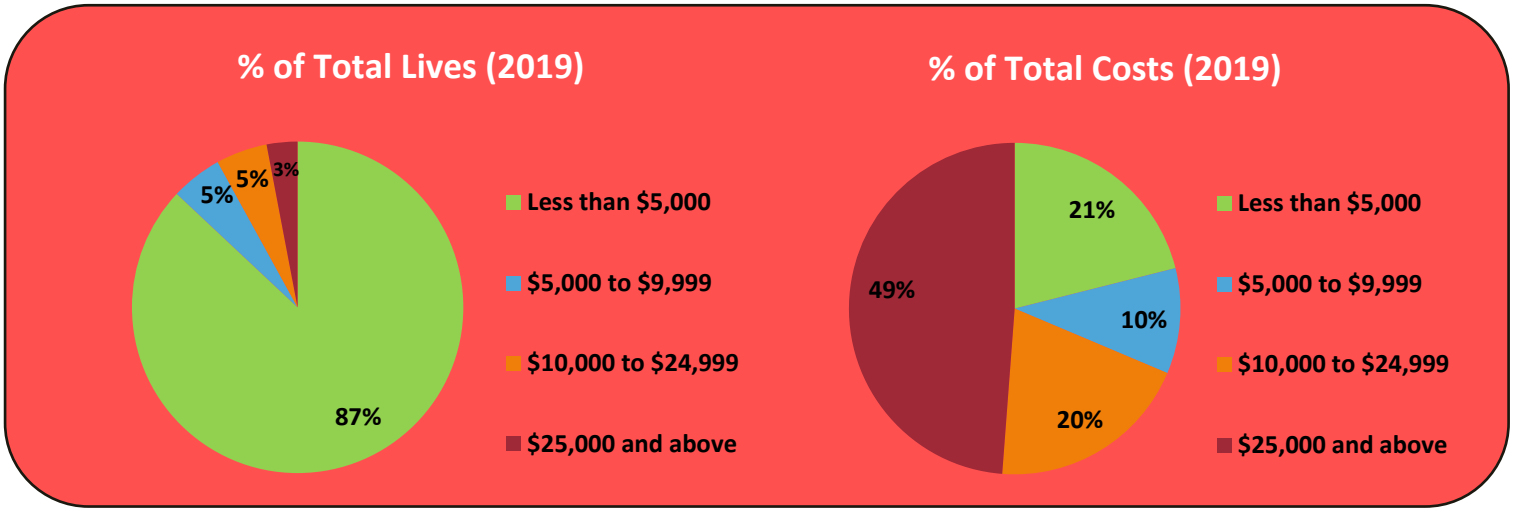
Note that the table above shows medical claims paid by UMR, a UnitedHealthcare Company (UMR) and BlueCross BlueShield of Nebraska (BCBS) during the reporting period and therefore may not be consistent with amounts paid by the trustee.

Also note that the 2019 payment bands (UMR) differ slightly from the 2018 payment bands (BCBS). Approximately 10 percent of the 2019 medical claim payments originated from BCBS – while BCBS was able to classify such payments in bands relatively consistent with UMR, the payment bands for the two administrators were simply combined rather than any attempt made to match claimants first before determining payment bands. As indicated in the table above, 2019 covered lives are based solely on UMR data.

Costs associated with high cost claimants tend to be the main driver of costs.

As is typical in health plans, costs associated with high cost claimants tend to be the main driver of costs. As can be seen in the table above and the charts below, in 2019 (with parentheticals showing 2018 figures):

- The top 3 percent of the covered lives accounted for 49 percent (52 percent) of medical costs.
- Covered lives with total claims greater than about $10,000 accounted for 69 percent (72 percent) of medical costs.
- Covered lives with total claims greater than about $100,000 were the primary driver of the approximately $9 million decrease in medical costs in 2019.
- 87 percent (85 percent) of the covered lives had total medical claims of about $5,000 or less.

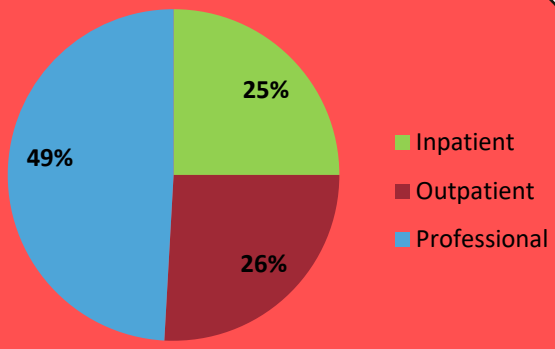


Medical costs are comprised of inpatient, outpatient and professional services (UMR classifies medical costs as inpatient, outpatient, physician, and ancillary services – for comparative purposes with 2018 data, physician and ancillary services have been combined in the professional services classification). 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 UMR and BCBS in 2019 and 2018 were:

University of Nebraska
Net Medical Payments by Type (millions)

	2019	2018	Change Dollars	Change Percent
Inpatient	$ 28	$ 32	$ (4)	(13)%
Outpatient	29	37	(8)	(22)
Professional	55	51	4	8
	$ 112	$ 120	$ (8)	(7)%



Inpatient

Inpatient costs decreased 13 percent, to $28 million in 2019 when compared to 2018. Costs per member per month were approximately 22% less than the UMR Norm (which comprises UMR active groups consisting of approximately 3,000 groups and 4.3 million members).

Outpatient

Outpatient costs declined 22 percent, to $29 million in 2019 when compared to 2018. Costs per member per month were approximately 18% less than the UMR Norm.

Professional Costs

Professional costs rose 8 percent, to $55 million in 2019 when compared to $51 million in 2018. Costs per member per month were approximately 6% less than the UMR Norm.

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 34, which is consistent with the UMR Norm.
- The average age of the University's employee participant was 47 compared to the UMR Norm of 45.

- The percentage of covered lives age 65+ under the University's plan was 6.5% compared to the UMR Norm of 3.8%.
- The top 10 major diagnostic categories included musculoskeletal, wellness/preventative, circulatory, digestive, nervous system, neoplasms, skin, pregnancy, ear/nose/mouth/throat, and respiratory.
- Admissions per 1,000 members of 48.0 compares favorably to the UMR Norm of 50.1.
- Office visits per 1,000 members of 3,226 compares favorably to the UMR Norm of 3,298.
- Outpatient surgery visits per 1,000 members of 149 compares favorably to the UMR Norm of 164.
- 20.0 percent of emergency room visits resulted in a non-emergency diagnosis compared to the UMR Norm of 20.6 percent. The top non-emergency diagnosis was acute upper respiratory infection. Emergency room visits per 1,000 members of 126 was well below the UMR Norm of 208.
- Number of members with at least one disease management condition (including asthma, coronary artery disease (CAD), chronic obstructive pulmonary disease (COPD), diabetes, heart failure, and hypertension) was 21% compared to UMR Norm of 22%.
- Preventative screening rates for mammograms and cholesterol were above the UMR Norm, while preventative screening rates for cervical and colorectal cancer were below the UMR 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 deposited in the health trust in 2019 totaled approximately $9.1 million.

In 2019, pharmacy costs were up 2 percent to about $44 million. Approximately 9,750 members utilized the plan's pharmacy program each month. The average annual net pharmacy cost per utilizing member totaled almost $4,500.

The increase in pharmacy costs is primarily attributable to specialty prescription costs, which were 52 percent of total pharmacy costs in 2019 compared to 51 percent in 2018. Specialty prescription costs increased about 5 percent, driven mainly by an increase in utilization and drug mix, as well as an increase in the average number of members. The increase in specialty prescription costs was down dramatically from 2018, which saw specialty prescription costs increase about 25%, helping to explain the slowdown in pharmacy expense growth in 2019.

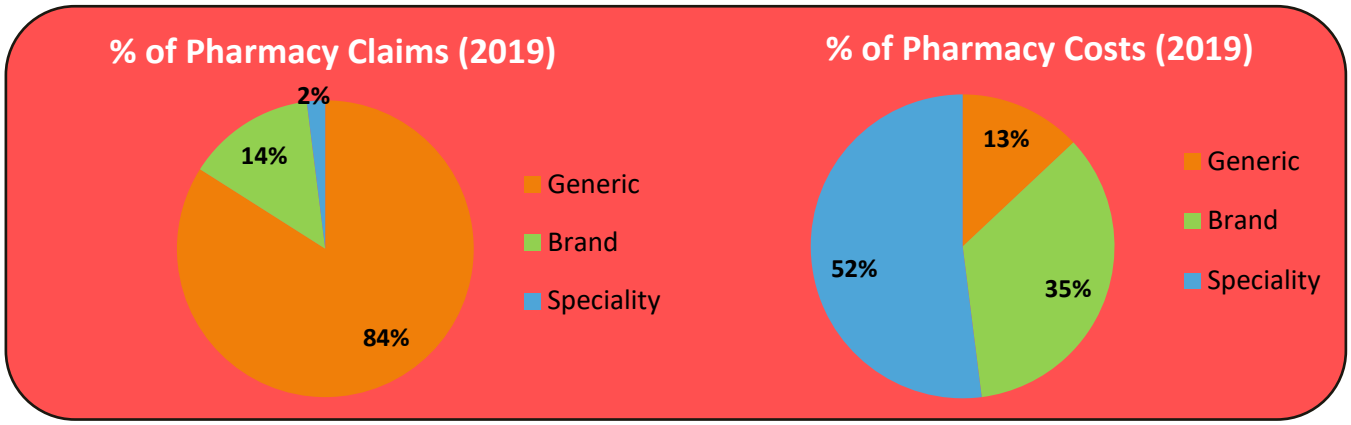
Pharmacy expenditures by category of drugs were as follows for the past two years:

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	
	2019	2018	2019	2018	2019	2018	2019	2018	2019	2018
Generic	$ 5,793	$ 6,530	13%	15%	230,613	230,472	84%	84%	$ 25	$ 28
Brand	15,000	14,400	35	34	37,777	39,211	14	14	397	367
Specialty	22,808	21,782	52	51	4,425	4,105	2	2	5,154	5,306
	$ 43,601	$ 42,712			272,815	273,788				

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 84 percent of total prescriptions, they only accounted for 13 percent of pharmacy costs in 2019.



The generic dispensing rate remained strong in 2019 at 84 percent, consistent with 2018. 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, and dermatologicals exceeded 80 percent in 2019. The difference in prices is dramatic: for new generic launches in 2020 and 2019, the University's projected savings was approximately $50,000 and $700,000, respectively.

Conversely, specialty drugs are 2 percent of the plan's prescriptions, but account for 52 percent of the costs in 2019. 8 out of the top 10 prescription drugs used in 2019 were specialty drugs. Primary among the specialty classes are multiple sclerosis, rheumatoid arthritis, oncology, hemophilia, cystic fibrosis, psoriasis, and growth failure. There were 501 users of specialty drugs in 2019, accounting for approximately $46,000 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 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 actuarial studies performed by Milliman.

Net 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 healthcare trends, the University has accumulated (over several years) fund balances that could be utilized for one-time health related purposes. As of December 31, 2019, the University's health plan had a trust fund balance of approximately $62 million, with a net balance of about $42 million after subtracting estimated reserves. This represents a fund balance equal to about 3 months of plan expenses.

As previously mentioned, the plan selected a new third-party administrator for medical insurance claims (UMR, a United Healthcare company) starting January 1, 2019. In December of 2018 and in conjunction with the transition from BlueCross BlueShield of Nebraska to UMR, the plan's trustee transferred $4 million to a separate UMR account to be utilized by UMR to pay medical claims beginning in 2019. UMR bills the plan weekly for medical claims paid so as to replenish this separate account back to $4 million. The $62 million trust fund balance on December 31, 2019 includes the $4 million held in the separate UMR account.

Conclusions and Looking Ahead

The University's trust fund balance decreased in 2019 from approximately $77 million to approximately $62 million. An average 2 percent decrease in medical premium rates, a one-month "premium holiday" granted to active employees in December of 2019, and claims payment timing differences resulted in the approximately $15 million decrease 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.

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 plan continues to be "grandfathered" in regard to the ACA.

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 healthcare, 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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