Nebraska Department of Administrative Services

Health Insurance Plan Annual Report

Presented to the Legislature's Appropriations Committee

For the Plan Year July 1, 2020 to June 30, 2021

November 29, 2021

Table of Contents

Introduction

Dear Nebraskans,

The Nebraska Department of Administrative Services (DAS) is proud to administer the State of Nebraska's health insurance program (Health Fund) and present the Health Insurance Plan Annual Report. This report describes the health insurance benefits provided to State teammates and outlines the Health Fund's financial performance during plan year 2020-2021.

Providing health insurance is a key component of the State's investment in our workforce. The investment in the Health Fund for the plan year 2020–2021 through State contributions totaled over $158 million and made up 14% of the $1.2 trillion total benefits portfolio that includes compensation and retirement benefits. The Health Fund provides medical and prescription drug benefits to approximately 13,200 teammates and their family members, covering 27,620 lives overall.

Over the last several years, DAS has had three key strategic objectives:

- Align benefits with compensation and teammate engagement as part of a total rewards portfolio;
- Efficiently manage the Health Fund to provide the best value for teammates and taxpayers;
- And give value back to the teammates by holding costs low and adding new benefits.

During plan year 2020-2021, we took a few significant steps to achieve these goals:

- Despite steady growth of medical expenses all over the country, DAS has kept benefits intact (no recent increases to deductibles or copays) and held annual contribution and funding increases below healthcare cost trends, while simultaneously seeing growth in reserves.
- In our effort to make the State a premier employer for families, we enhanced the State's maternity benefits to help reduce childbirth-related medical expenses for State teammates enrolled in the Wellness plan. During the first year of the program, the number of babies born on the State's plan increased by 12%, while NICU admissions have declined by 28%.
- Benefits related to the response to the COVID-19 pandemic were extended for another plan year allowing plan participants to seek timely diagnosis and accessible treatment.

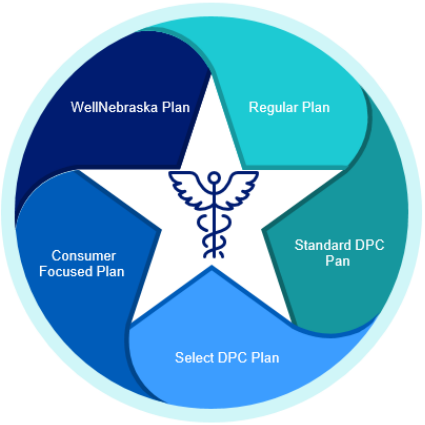
Overall, the State of Nebraska is proudly administering a high performing Health Fund that is providing better benefits, at a lower cost, and supporting our teammates and their families.

Jason Jackson
Director, Nebraska Department of Administrative Services, Chief HR Officer, Office of Governor Pete Ricketts

Kevin Workman,
State Personnel Director

Health Plan Overview

The State of Nebraska's health insurance program consisted of five self-insured health plans in
2020 – 2021, the Regular Plan, the WellNebraska 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 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 plan options (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 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 are 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 have met the incentive requirements. The Regular health plan encompasses those that chose the Regular Plan as well as members of the WellNebraska health plan who did not meet the incentive requirements.

The plan year ran from July 1, 2020 through June 30, 2021 with open enrollment held May 4, 2021 through May 18, 2021. 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

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 a 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) administrator ensures that submitted claims are adjudicated correctly under the provisions outlined in the plan documents set forth by the State and pays the providers. Once payment clears the bank, the State reimburses the administrators for the claims through the State Employee Insurance Fund.

For the 2020 – 2021 plan year, UHC was the TPA for medical claims, and its subsidiary, OptumRx, was the TPA/PBM for pharmacy claims. The contract between DAS and UHC will remain in force until June 30, 2023. The contract also includes the option to renew for four additional one-year periods upon mutual agreement of the Parties.

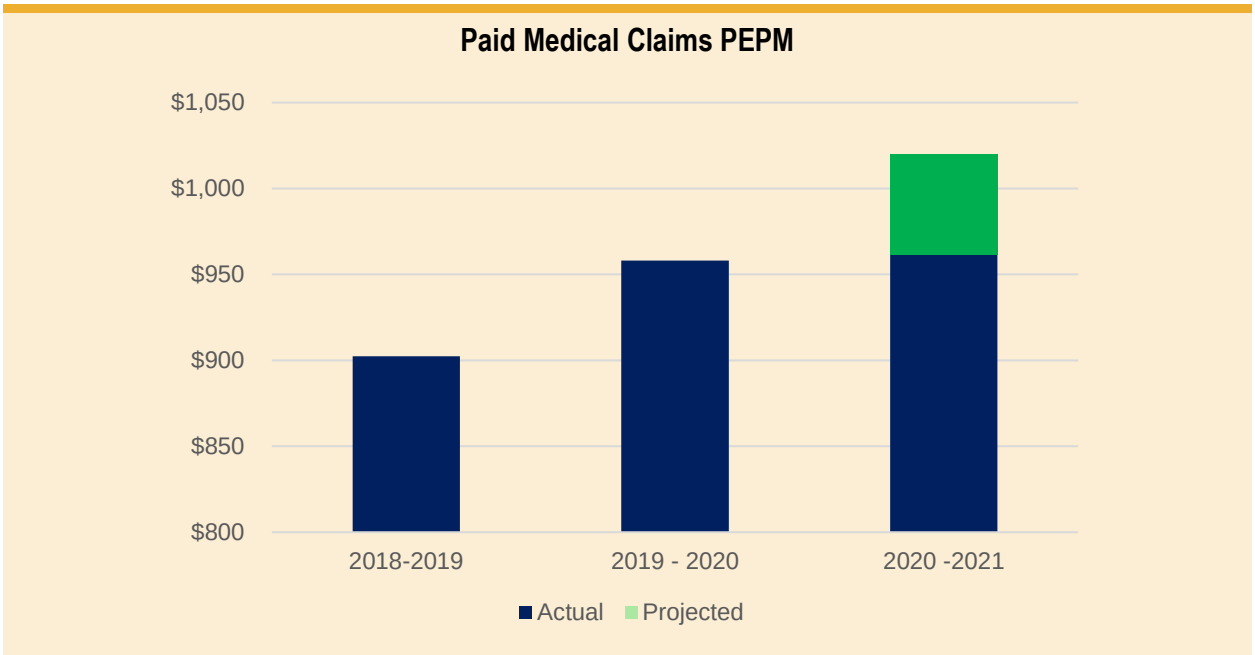
COVID-19

The previous plan year was marked by the emergence of the novel coronavirus and the disease caused by it, COVID-19. In response to this challenge, 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 including vaccinations
- 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 were not related to COVID-19. This included physical, occupational and speech therapy, as well as behavioral health
- Allowed teammates to re-fill their prescriptions in advance of their normal re-fill schedule

In order to continue to encourage plan participants to seek timely diagnosis and treatment, and to help them practice social distancing, DAS has made the decision to keep all of these changes in force for plan year 2020-2021.

As members continued to practice social distancing and elect to delay medical services and treatments, the State's medical expenses for plan year 2020-2021 remained below projected levels, as outlined in the chart below.



Maternity Benefit

On July 1, 2020 the State offered enhanced maternity benefits to the participants enrolled in the Wellness plan. This program is an important part of upholding the Governor's commitment to make the State a premier workplace for moms.

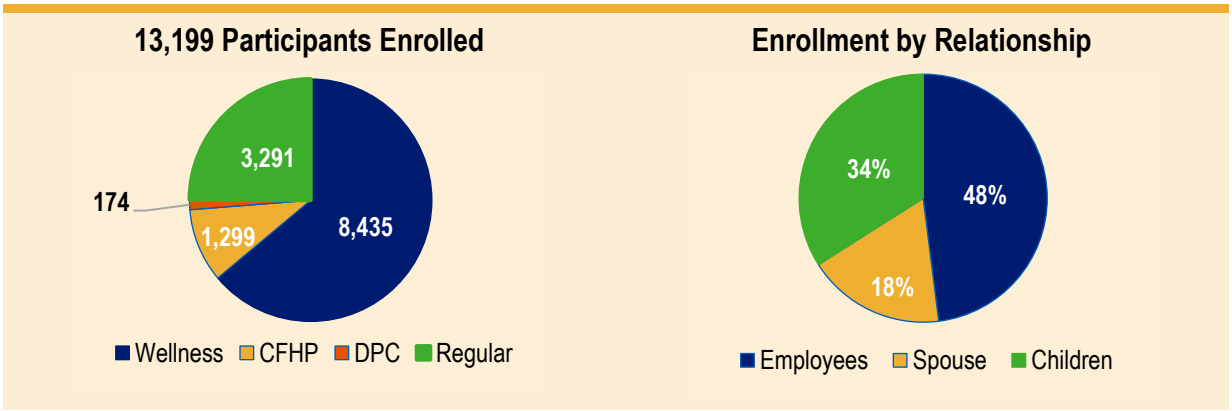
Under the new benefit, all medically necessary outpatient maternity related services are covered at 100%, in-network inpatient medically necessary hospital charges that are maternity related, including inpatient well baby nursery, have a $500 copay and then are paid at 100% of eligible charges. The changes were primarily aimed at reducing childbirth-related medical expenses for State teammates. The secondary goal was to encourage plan participants to seek timely care, which reduces the rate of pregnancy complications, leads to healthier babies, and lowers expenses for the State.

During the first year of the program, 329 babies were born to plan participants, which is a 12% increase from the previous year. While the percentage of C-section deliveries grew from 28.9% to 33.7%, NICU admissions declined by 28%. At the same time, average length of stay (ALOS) in the NICU decreased from 12.8 to 7.7 days, which is 40% lower than the norm. Net PEPM cost of normal pregnancy and delivery amounted to $3.99, 12.1% lower than the norm of $4.54.

	Plan Year 2020 – 2021	Plan Year 2019 – 2020	Variance from Norm
Number of Deliveries	329.0	294.0	11.9%
Delivery Days per 1,000	27.6	25.2	9.5%
Deliveries ALOS	2.3	2.4	-4.2%
NICU Admissions	21.0	29.0	-27.6%
NICU ALOS	7.7	12.8	-39.8%

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.

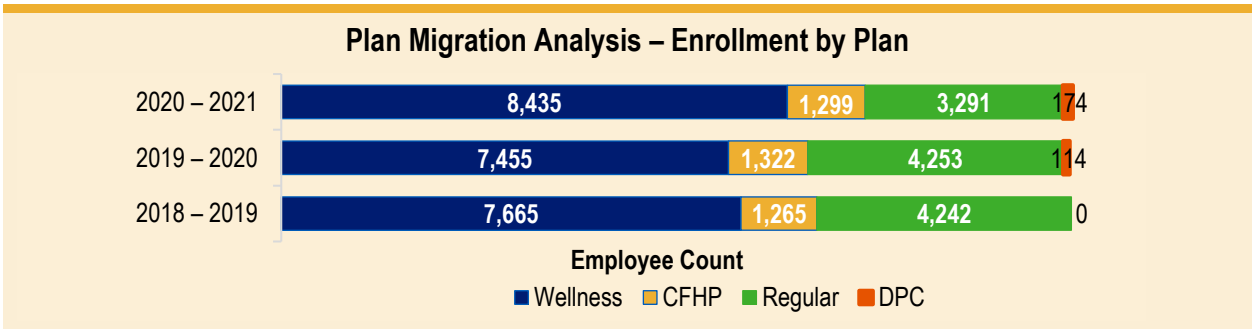


Per the charts above, the plan averaged 13,199 teammates enrolled in the 2021 plan year, which included approximately 217 retirees and 167 COBRA participants. The total number of covered lives, including spouses and dependents, was 27,620, which increased 0.3% from the 2019 – 2020 plan year. Ongoing dependent verification audits were conducted for all new dependents added to the health plan to ensure only eligible teammates and their dependents used State benefits.

Approximately 55.7% of teammates were female and 44.3% were male. The average age of teammates enrolled was 46.3, down from last year's average of 46.4.

Total enrollment in the State Health Insurance Plan over the past year has increased 0.4%. The Wellness Plan saw a sizeable increase of 13% from the prior plan year. Most of the migrating members came from the Regular plan. Enrollment in the Consumer-Focused Health plan did not change significantly compared to the past year. During the 2020 – 2021 plan year, it served approximately 10% of the population enrolled.

The enrollment in the new DPC plans remained low, making it difficult to evaluate their effectiveness. Plan migration and enrollment by plan for the last three plan years are shown in the graph below.



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 have been adjusted annually using cost projections from Segal for the 2020 – 2021 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 contains the Claims Fluctuation Reserve (CFR). The 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.

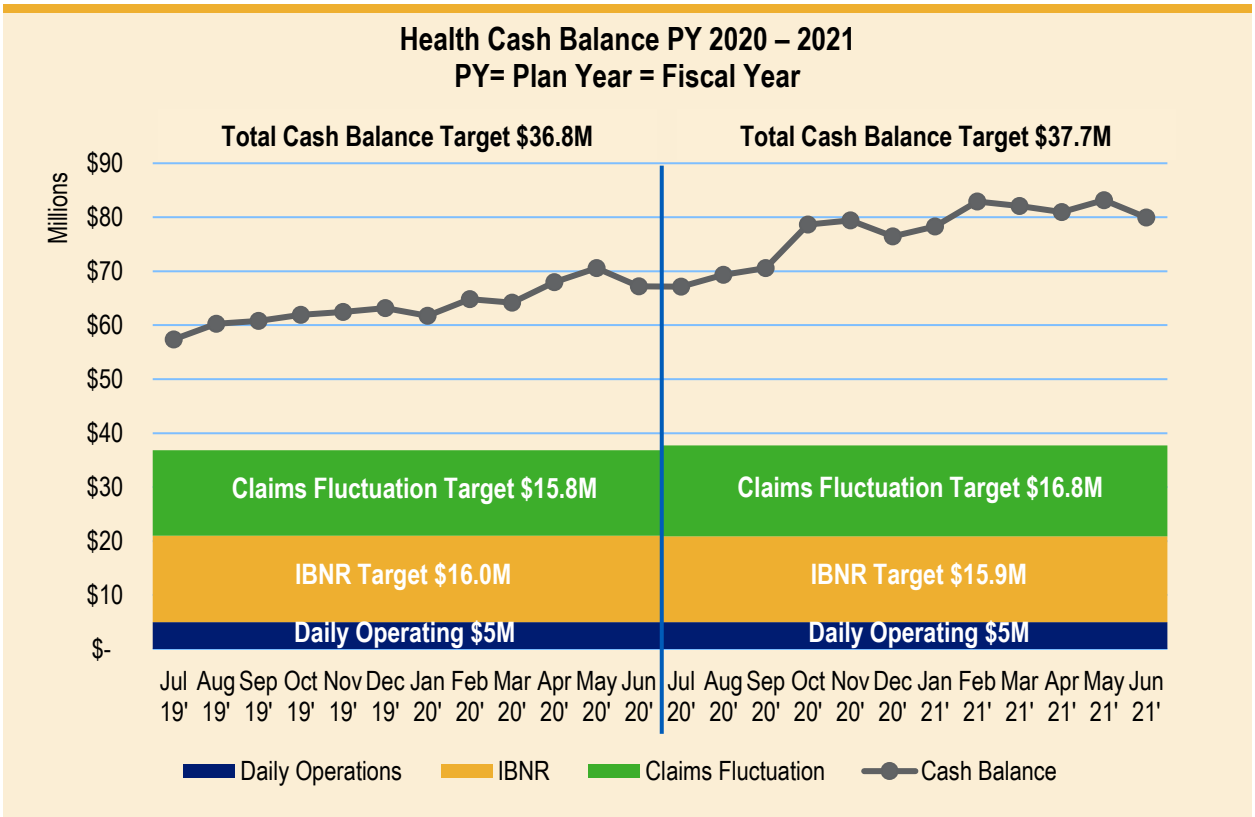
During the 2020 – 2021 plan year, a payment was made for the Patient-Centered Outcomes Research Institute (PCORI) fee as prescribed by the Affordable Care Act (ACA). This institute is a government-sponsored organization charged with funding comparative effectiveness research that assists consumers, clinicians, 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 2021 the State paid $57,000 for the PCORI fee for plan year ending June 30, 2020.

Segal, in conjunction with DAS, prepared an Incurred But Not Paid (IBNP) Analysis Report, a Premium Rate Analysis Report, and a 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 2020 – 2021, Segal recommended a CFR of at least $16.8 Million and IBNP of $15.9 Million. In accordance with Segal's recommendation, the State established a targeted balance of $16.8 Million in Health Insurance History Fund for the CFR. A targeted balance of $20.9 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 $15.9 Million to cover claims run out from the prior plan year. The Cash Balance Target, as recommended by Segal, was at $37.7 Million, equal to the summation of the two funds.

The Cash Balance Target and actual monthly cash balance for plan years 2019 - 2020 and 2020 - 2021 are shown in the table below:



A summary of financial activities in State Employees Insurance Fund #68960 for the plan years ending June 30, 2020 and June 30, 2021, respectively, are shown on the next page.

State of Nebraska Health Insurance Fund
Summary of State Employees Insurance Fund #68960 Activity
Comparison of Plan Years Ending June 30, 2020 and 2021

	Plan Year			
	2020 – 2021	**2019 – 2020**	**$ Change**	**% Change**
Revenue				
Contributions	$202,212,188	$200,330,298	$1,881,890	1%
Pharmacy Rebates	$17,507,325	$13,138,496	$4,368,829	33%
Investment Income	$897,867	$1,003,926	$(106,059)	-11%
Total Contributions	**$220,617,380**	**$214,472,720**	**$6,144,660**	**3%**
Distributions				
Medical Claims & IBNP	$152,678,239	$151,588,282	$1,089,957	1%
Pharmacy Claims	$50,071,068	$46,793,211	$3,277,857	7%
Administration Fees	$5,754,212	$6,938,464	$(1,184,252)	-17%
Total Distributions	**$208,503,519**	**$205,319,957**	**$3,183,562**	**2%**
Net Difference	**$12,113,861**	**$9,152,763**		

State of Nebraska Health Insurance Funds
as of June 30, 2021 and 2020

	6/30/2021	**6/30/2020**	**$ Change**	**% Change**
State Employees Insurance Fund #68960	$62,920,336	$51,065,317	$11,855,018	23%
Health Insurance History Fund #68922	$17,012,584	$16,124,352	$888,232	6%
Total Reserves	**$79,932,920**	**$67,189,669**	**$12,743,251**	**19%**

The increase in fund balance of $12.7 million during plan year 2020 - 2021 was driven by combination of lower administrative expenses and medical cost trend running below market level.

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.

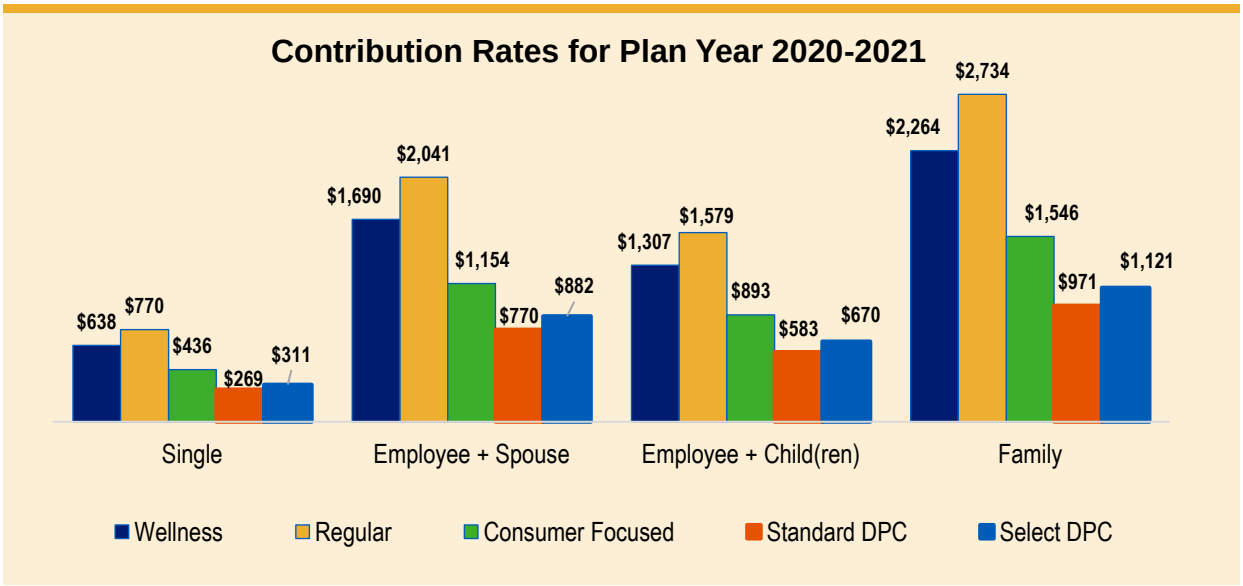
Health plan contributions are reviewed each year. In November 2019, Segal provided the State's Wellness and Benefits Administrator with a Preliminary Premium Rate Analysis Report. The Wellness and Benefits Administrator, Personnel Director, and Director of DAS reviewed the report along with the State Budget Division and Governor. Contributions and plan design changes were approved in February 2020 and communicated to teammates in April 2020, prior to Open Enrollment. The changes were implemented on July 1, 2020.

2020 – 2021 Rate Increases

- Wellness: 2.5%
- Consumer-Focused: 2.5%
- Regular: 2.5%

Contributions to the plan increased from $200 Million to $202 Million in the 2020 – 2021 fiscal year. The increase in aggregated contributions lagged behind the rate increase due to substantial migration from Regular plan to Wellness.

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

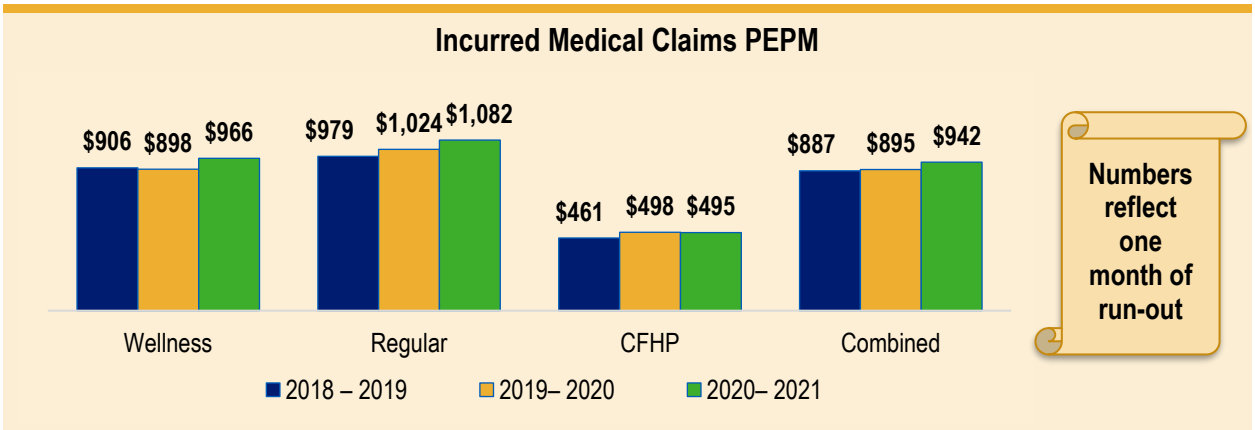
Medical claims were administered by UHC and include costs associated with hospital stays, outpatient services, emergency care, behavioral health care, physician office visits and preventive health care, among other services.

The State Employees Insurance Fund #68960 has paid $153 Million in reported medical claims in fiscal year 2020 – 2021, which reflected a 0.7% increase from the prior year. The increase is 5.8% lower than expected cost trend of 6.5%. The claims experience came in below expected levels, as a result of reduced utilization from the COVID-19 pandemic, particularly during April –June of 2020. This resulted in substantially lower run-in claims (IBNP) for the 2020 – 2021 plan year as compared to the previous plan year. The table below shows paid medical claims for plan years 2019 - 2020 and 2020 - 2021 split between incurred during the same year and IBNP:

State of Nebraska Paid Medical Claims for Plan Years 2019 - 2020 and 2020 - 2021

	2020 – 2021	2019 - 2020	$ Change	% Change
Incurred and Paid During the Plan Year	$137,916,111	$130,176,763	$7,739,348	5.9%
IBNP	$14,678,239	$21,411,519	-$6,649,391	-31.1%
Total	**$152,678,239**	**$151,588,282**	**1,089,957**	**0.7%**

Net paid PEPMs for claims incurred during the last three plan years and paid through July of the following year are shown in the table below:



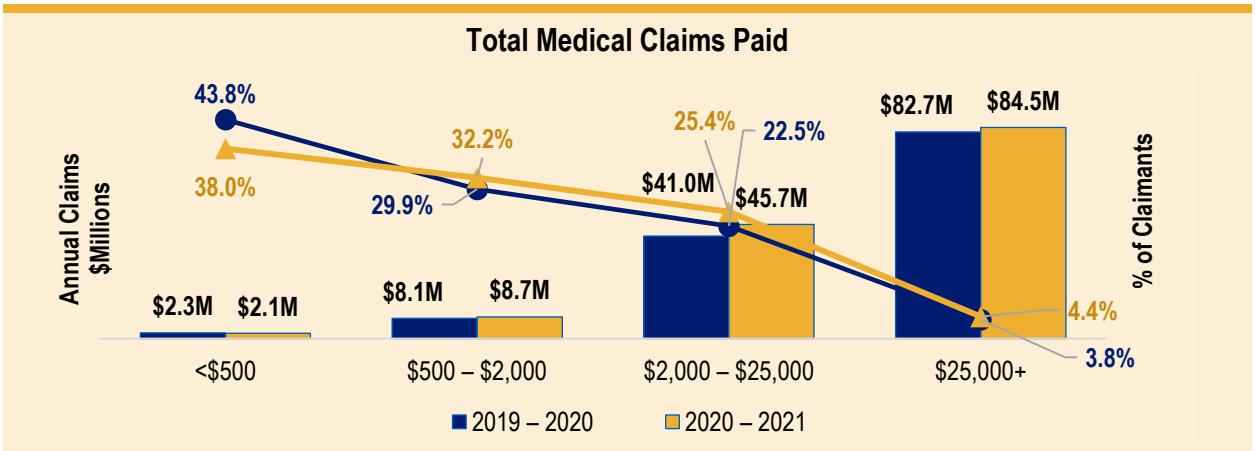
For the purposes of this graph, DPC plans are combined with CFHP.

The PEPM of $942 for claims incurred after July 1, 2020 is 4.9% higher than the PEPM cost from the same time period for plan year 2019 - 2020. The rate of increase indicates that claim volume began to recover during the plan year, but has not yet returned to pre-pandemic levels.

Consistent with 2019 – 2020, treatment for neoplasms (cancer), musculoskeletal conditions, circulatory (heart disease) were the top cost drivers of medical claims. Combined, these three diagnoses drove 36% of total medical claims paid PEPM.

Consistent with other group health plans, a small percentage of participants incurred a high proportion of the total medical claims paid. Of the $141 million paid through June of 2021 for the 2020-2021 plan year's incurred medical claims, 4.4% of the plan's total population were responsible for driving over half of those claims dollars ($84.5 million)

The total amount (PEPM) for claimants with claims over $100,000 decreased by 7.0% from the previous year, and decreased by 1.3% for claimants with incurred claims between 25,000 and 100,000.



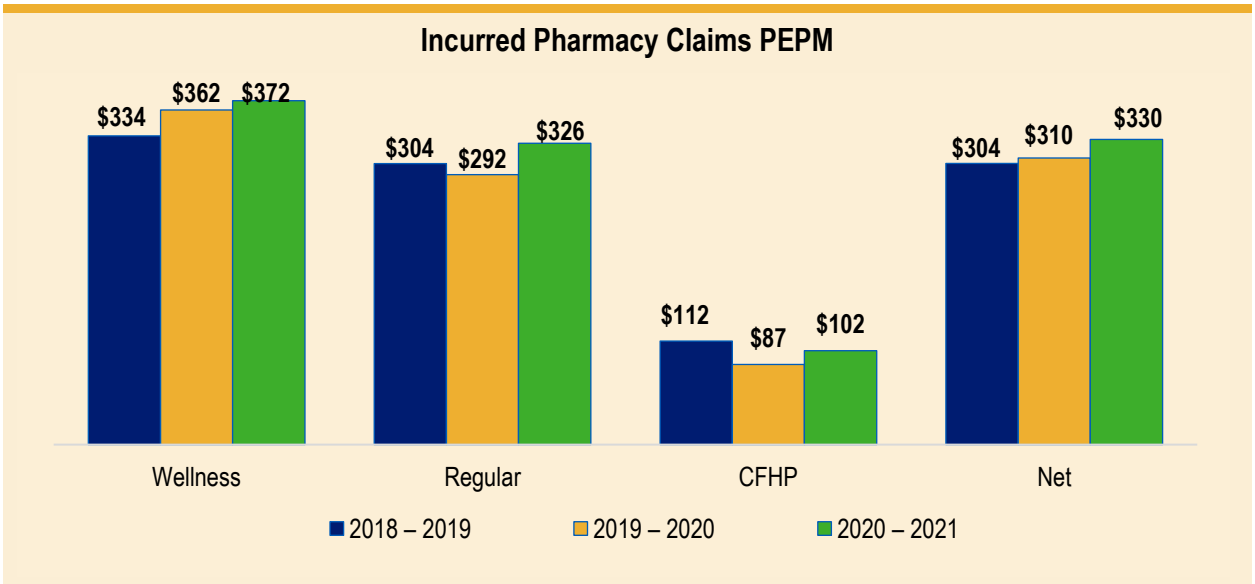
Pharmacy Claims Review

Pharmacy claims were administered by OptumRx, an affiliate of UHC. The plan paid about $50.0 Million for prescription drug claims in 2020 – 2021, a 7.0% increase from the previous year. This increase is in close range of the projected cost trend of 7.5%. Unlike the pattern of decreased utilization seen for medical services as a result of COVID-19, the utilization pattern for pharmacy trends remained relatively unchanged as a result of the pandemic.

The use of specialty drugs is a growing cost trend that continues to be monitored by the State. There was an approximate $1.1 Million (5.4%) increase in specialty drug payments from the previous plan year.

Roughly 23,000 participants utilized pharmacy benefits in the health plan, filling about 338,800 prescriptions. The average cost per prescription of $154.33 for the State was a 7.3% increase from $143.77 paid the prior year. On average, each member filled 12.27 prescriptions annually. This is similar to last year's average of 12.34 prescriptions filled annually.

The chart below illustrates the incurred pharmacy claims PEPM by plan.



PEPM figures shown above include one month of run-out.
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.

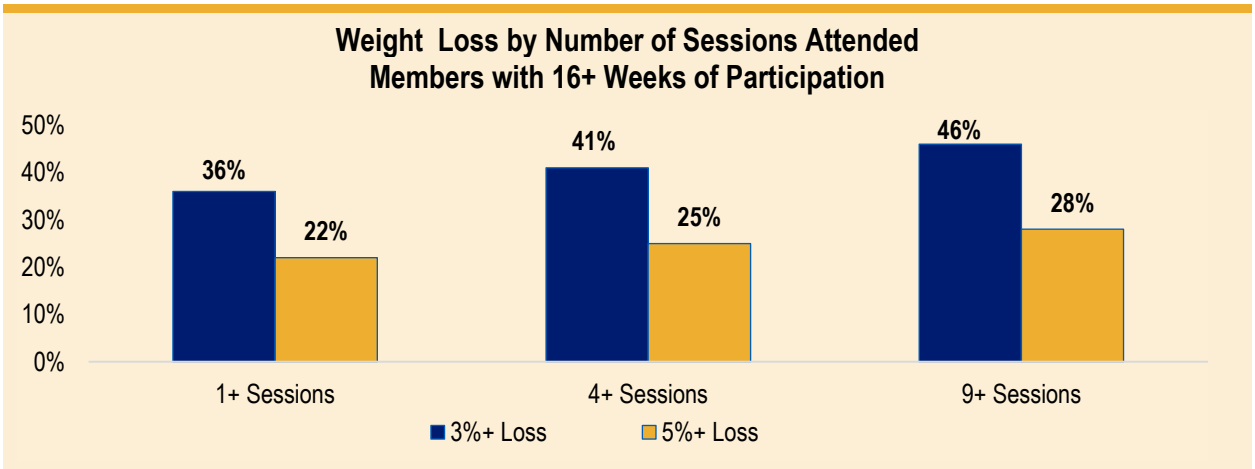
UHC's plan breaks out their prescription drugs in to three cost tiers. Tier 1 includes mostly generics plus some low-cost brand-name drugs, with copays limited to $5. Higher cost brand-name drugs are placed in Tiers 2 and 3 with higher copays. Encouraging participants to choose generic prescriptions, primarily in Tier 1, reduces costs for both the employee and the plan.

	2020 – 2021	2019 – 2020	% Change
Annual Scripts per Member	12.27	12.34	-0.6%
Average Cost per Member	$157.77	$147.80	6.7%
Plan Cost Share	93.4%	92.0%	1.6%
Employee Cost Share	6.6%	8.0%	-17.8%
Generic Utilization	82.2%	85.3%	-3.5%

Wellness Program

Real Appeal is a weight loss wellness program provided by UHC that was added as of April 1, 2018. During the plan year 2020 – 2021 the State saw 3,148 members enrolled in the program, with 87% of enrollees deemed at risk of diabetes, cardiovascular disease, or other weight-related health conditions. Approximately 43% of participants have lost weight after 16 weeks on the program with average reported weight loss amounting to 2.7% of body weight.

According to the Real Appeal report with data through August 31, 2021, the program scored a 4.76 out of 5 satisfaction rating in a national survey of 16,934 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. This level of detail was not available specifically for the State's Real Appeal Program results.



Snapshot of 2020-2021 Health Program Outcomes

Financial	• Net PEPM for medical increased 4.9%. • Excluding catastrophic claims, medical PEPM is trending 11.5% due to an increase in outpatient surgeries. • Changes in costs for Outpatient Facility contributed 4.7% to medical trend. • Plan cost share was to 82.4% compared 80.8% in the prior year • Catastrophic claims decreased by 8.3% PEPM • Net PEPM for pharmacy increased 6.7% • Medical PEPM was 12.4% above peer group. • Network discount rate was 42.1% and saved $116.4 Million. • There were 221 participants with claims in excess of $100,000. Combined these claims represented 29.2% of medical costs. • Average cost for catastrophic claimants was $204,241. • 2 participants exceeded $1 Million in claims.
Clinical	• Demographic factor/risk is 2.1% lower than peer. • Members age 40 and older represent 44.3% of the population and account for 68.1% of claim costs. • Emergency room visits are 16.5% lower than UHC Peer group and utilization decreased by 1.5% from last year. • Inpatient utilization decreased 9.3% but the amount paid per admission increased by 0.4%. • Outpatient surgeries increased 12.0%, and cost per surgery increased 8.2% • The amount of PMPY PCP visits decreased by 5.4% and Specialists visits decreased by 1.7% • Cancer is a primary driver of medical costs. • 11% of members had a primary diagnosis of diabetes. • Generic medication dispensing rate was 82.2% • Specialty medications represented 41.6% of pharmacy costs

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 2021– 2022 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.

2021 – 2022 Contribution Increases	
WellNebraska (wellness track)	4.0%
Regular Health Plan	4.0%
Consumer-Focused Health Plan	4.0%
Select DPC Plan	4.0%
Standard DPC Plan	4.0%

While the plan will continue to provide 100% coverage for all preventive services including COVID-19 vaccines, other COVID -19 related plan changes will be gradually rolled back. Cost sharing for telehealth visits returned at the beginning of plan year 2021-2022. Testing for COVID-2019 will be covered for teammates for the duration of the COVID-19 public health emergency, which was extended until January 21, 2021.

In recent years, the Fund Balance has been growing beyond projected levels due to both medical and pharmacy trends running below market for three out of the last five plan years. In order to mitigate this issue, premium rate increases were set below expected cost trends since plan year 2018. Expenses were on track to exceed revenue during plan year 2021, but a decrease in utilization of non-emergency medical services related to COVID-19 has changed their trajectory. As the State recovers from the pandemic, claim volume is expected to increase, and to start driving the Fund Balance down. To help accelerate this process, DAS will be implementing a one month premium holiday for teammates in December 2021.

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 for 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.