Nebraska Department of Administrative Services

Health Insurance Plan Annual Report

Presented to the Legislature's Appropriations Committee

For the Plan Year July 1, 2021 to June 30, 2022

November 28, 2022

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Introduction

Dear Nebraskans,

This annual report is submitted to the legislature by the Nebraska Department of Administrative Services (DAS) pursuant to Neb. Rev. Stat. §50-502. Its main goal is to describe benefits provided by the Health Fund to the State's teammates during plan year 2021 - 2022, and to outline the Fund's financial performance during the same time period.

Providing health insurance is a key component of the State's investment in its workforce. The investment in the Health Fund for the plan year 2021 – 2022 through State contributions totaled over $157.6 million and made up 14% of $1.2 trillion total rewards portfolio that includes compensation and retirement benefits. The Health Fund provides medical and prescription drug benefits to approximately 12,700 eligible teammates and their family members, covering 26,700 lives overall.

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

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

During plan year 2021 - 2022, there were significant steps taken to achieve these goals:

- Despite steady growth of medical expenses all over the country, DAS has been able to keep its benefits intact (no recent increases to deductibles or copays) and allow for annual contribution and funding changes that fall below the rate of health care cost trends.
- DAS provided a premium holiday for the State's teammates, suspending all employee contributions for health coverage during the month of December 2021.
- In our effort to make the State a premier employer for families, we continue to provide the State's enhanced maternity benefits to help reduce childbirth-related medical expenses for State teammates enrolled in the Wellness Plan. Three hundred babies were born on the plan during the last plan year.

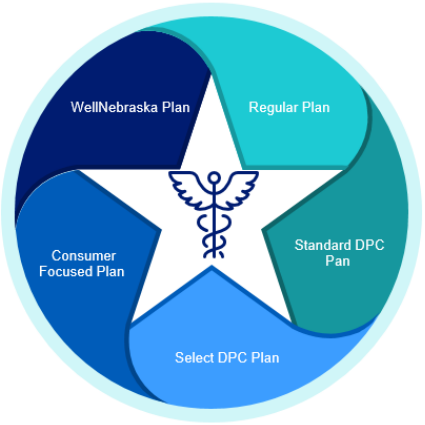
Overall, the State of Nebraska can be proud that we are administering a high performing health care benefit program that is providing excellent benefits at a low cost and supporting our teammates and their families at their moments of greatest needs.

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 2021 – 2022, the Regular Plan, the WellNebraska Plan, the Consumer-Focused Health Plan (CFHP), 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 (Preferred Provider Organization). The WellNebraska Plan provides teammates with incentives for meeting wellness-related requirements. The 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 a 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, 2021 through June 30, 2022 with open enrollment held May 3, 2022 through May 17, 2022. All teammates were encouraged to review the pre-populated elections and select coverages/amounts for certain benefits (i.e., HSA contributions) 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 TPA. 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 2021 – 2022 plan year, UHC served as 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.

Premium Holiday

In recent years, the Fund Balance has sat comfortably above the target reserves due to successful cost containment of medical and pharmacy claims. The pandemic caused a material decrease in utilization, which resulted in additional fund surpluses.

The Fund Balance was also increased by taking advantage of federal relief. In March 2020, the CARES Act was enacted and provided $150 billion in direct, flexible funding to state, local and tribal governments, known as the Coronavirus Relief Fund (CRF). The State of Nebraska received a payment of $7.5 million from CRF as a reimbursement for the expenditures incurred due to the public health emergency related to COVID-19 during the period between March 1, 2020, and December 31, 2021.

The State made a strategic decision to use the excess Fund Balance by putting money back into their employee's pockets. Specifically, DAS implemented a one-month premium holiday for teammates in December 2021. State agencies continued to make contributions as scheduled. As a result of implementing a premium holiday, the State's teammates saved approximately $3.5 million during plan year 2021-2022, reducing Fund Balance by the same amount.

Maternity Benefit

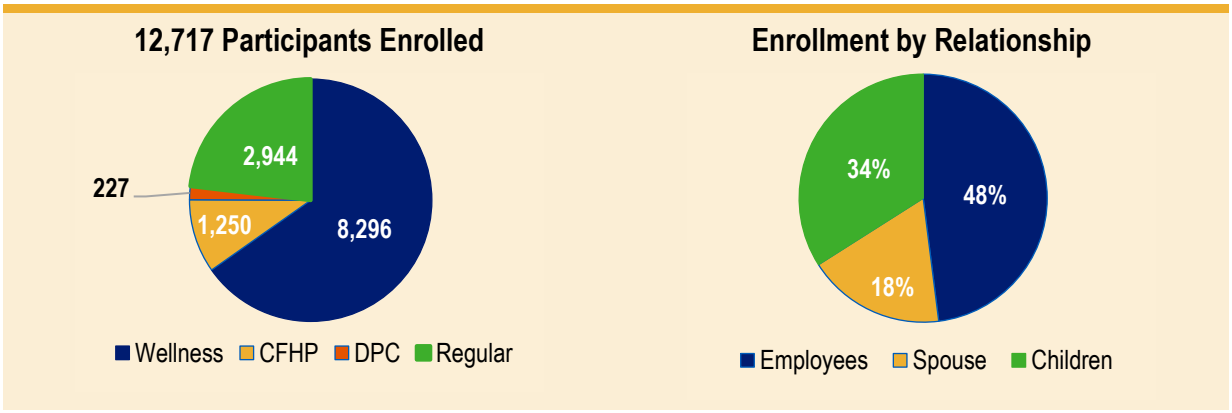
On July 1, 2020, the State offered enhanced maternity benefits to the participants enrolled in the Wellness plan. This program is an important part of upholding the Governor's commitment to make the State a premier workplace for parents and families.

Under the current 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 benefit 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 this plan year (the second year of the program), 300 babies were born to plan participants. While the percentage of C-section deliveries decreased from 33.7% to 26.0%, NICU admissions increased by 35%. At the same time, average length of stay (ALOS) in the NICU increased from 7.7 to 11.2 days, which is still lower than the norm of 15.4 days. Maternity related claims made up 5.8% of medical plan spend.

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's health plans. Such 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's health plans after the standard waiting period. State retirees can continue coverage in a State health insurance plan until they are Medicare-eligible, at age 65, as allowed in the 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 12,717 teammates enrolled in the 2022 plan year, which included approximately 230 retirees and 47 COBRA participants. The number of COBRA participants was significantly larger in the previous plan year due to COBRA premium assistance provided by the American Rescue Plan Act (ARPA) to participants whose period of coverage began between April 1, 2021, and September 30, 2021.

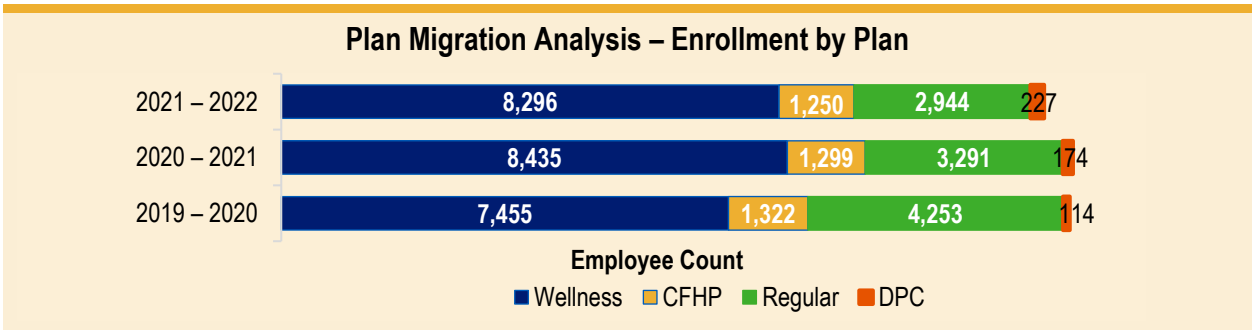
The total number of covered lives in the Health Fund, including spouses and dependents, was 26,657, which decreased 3.5% from the 2020 – 2021 plan year. Ongoing dependent verification audits were conducted for all new dependents added to ensure only eligible teammates and their dependents used State benefits.

Approximately 55.6% of teammates were female and 44.4% were male. The average age of teammates enrolled was 46.3, up slightly from last year's average of 46.2.

While enrollment in traditional health plans declined, DPC plans saw a small increase in their membership. The Regular Health Plan experienced a decrease of approximately 10% of its population compared to the previous plan year. The Wellness and Consumer-Focused Health Plans saw 2% and 4% declines for enrollment respectively

Despite slight growth during plan year 2021-2022, 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, the State's TPA/PBM, and their attorneys to constantly monitor changes in health plan management and assure the plan and all required documentation is in compliance.

Regulatory Mandates	Health Plan Documents
• State Statutes • Department of Insurance • ACA • IRS • COBRA • HIPAA • Medicare • Employment Laws -FMLA, USERRA, ADA, Title VII, GINA	• 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 most recent plan years.

Reserves are imperative to the successful management of a self-insured health plan with about 27,000 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 the Health Insurance History Fund #68922 to the Health and Life Benefit Administration Fund #28010, established in Neb. Rev. Stat. §84-1616.

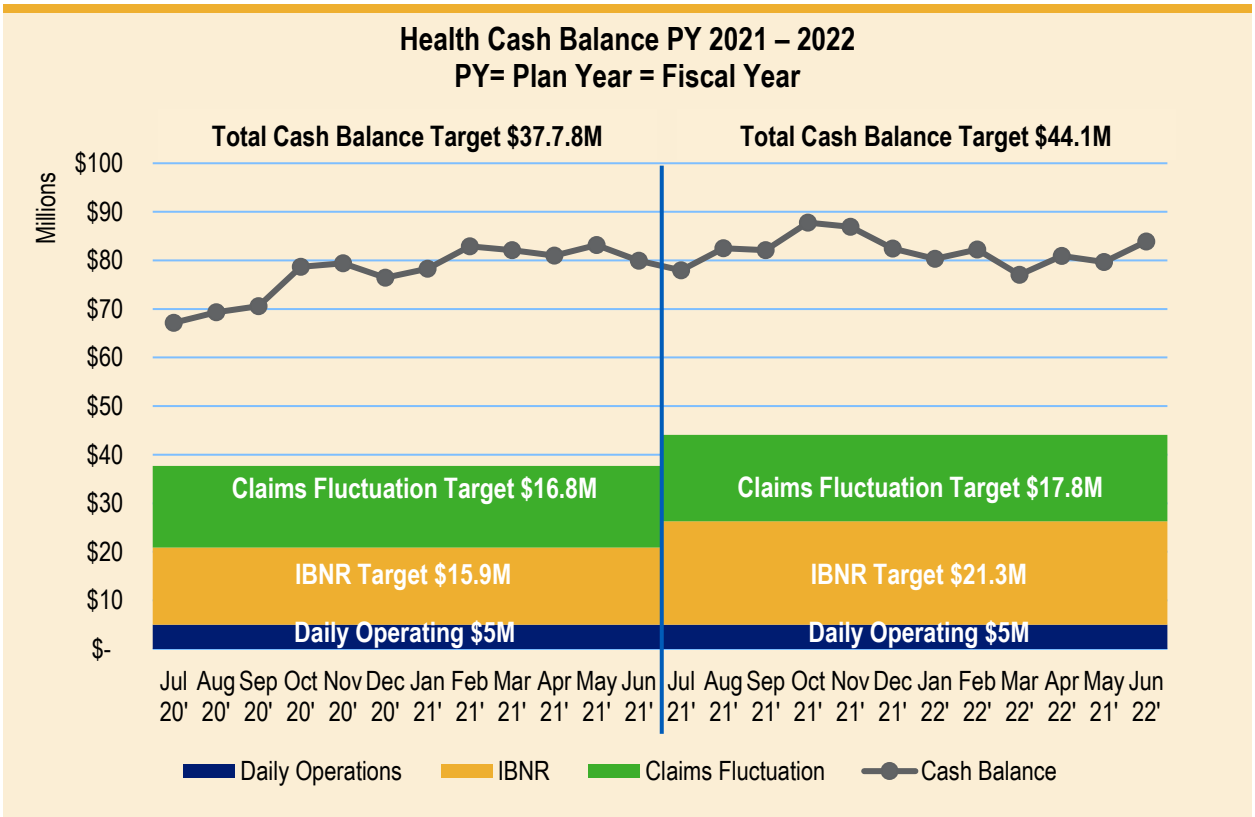
During the 2021 – 2022 plan year, a payment was made for the Patient-Centered Outcomes Research Institute (PCORI) fee as prescribed by the Affordable Care Act (ACA). This institute is a government-sponsored organization charged with funding comparative effectiveness research that assists consumers, clinicians, 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 2022, the State paid $59,500 for the PCORI fee for the plan year ending June 30, 2021.

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, maintain effective plan designs, and set targets for the plan year.

For plan year 2021 – 2022, Segal recommended a CFR of at least $17.8 Million and IBNP of $21.3 Million. In accordance with Segal's recommendation, the State established a targeted balance of $17.8 Million in the Health Insurance History Fund for the CFR. A targeted balance of $26.3 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 $21.3 Million to cover claims run out from the prior plan year. The Cash Balance Target, as recommended by Segal, was at $44.1 Million, equal to the summation of the two funds.

The Cash Balance Target and actual monthly cash balance for plan years 2020 - 2021 and 2021 – 2022 are shown in the table below:



A summary of financial activities in State Employees Insurance Fund #68960 for the plan years ending June 30, 2021, and June 30, 2022, respectively, are shown on the next page.
The premium holiday was a main driver in the decline of the Fund Balance between November 2021 and December 2021. The increase in Fund Balance between May 2021 and June 2021 is due to receipt of federal subsidy.

The increases in IBNR and CFR between plan years 2020-2021 and 2021-2022 are driven by an increased claim volume after a recovery from COVID-19 pandemic.

State of Nebraska Health Insurance Fund
Summary of State Employees Insurance Fund #68960 Activity
Comparison of Plan Years Ending June 30, 2021 and 2022

	Plan Year			
	2021 – 2022	**2020 – 2021**	**$ Change**	**% Change**
Revenue				
Contributions	$198,155,047	$202,212,188	$(4,057,141)	-2%
Pharmacy Rebates	$20,381,169	$17,507,325	$2,873,844	16%
CARES Act Subsidy	$7,459,307	$0	$7,459,307	N/A
Investment Income	$929,034	$897,867	$31,167	3%
Total Revenue	**$226,924,557**	**$220,617,380**	**$6,307,177**	**3%**
Distributions				
Medical Claims & IBNP	$163,994,400	$152,678,239	$11,316,161	7%
Pharmacy Claims	$51,950,753	$50,071,068	$1,879,685	4%
Administration Fees	$5,513,090	$5,754,212	$(241,122)	-4%
Total Distributions	**$221,458,243**	**$208,503,519**	**$12,954,724**	**6%**
Net Difference	**$5,466,314**	**$12,113,861**		

State of Nebraska Health Insurance Funds
as of June 30, 2022 and 2021

	6/30/2022	**6/30/2021**	**$ Change**	**% Change**
State Employees Insurance Fund #68960	$65,801,682	$62,920,336	$2,881,346	5%
Health Insurance History Fund #68922	$18,059,939	$17,012,584	$1,047,355	6%
Total Reserve Fund Balance	**$83,861,621**	**$79,932,920**	**$3,928,701**	**5%**

Health Plan Premiums & 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.

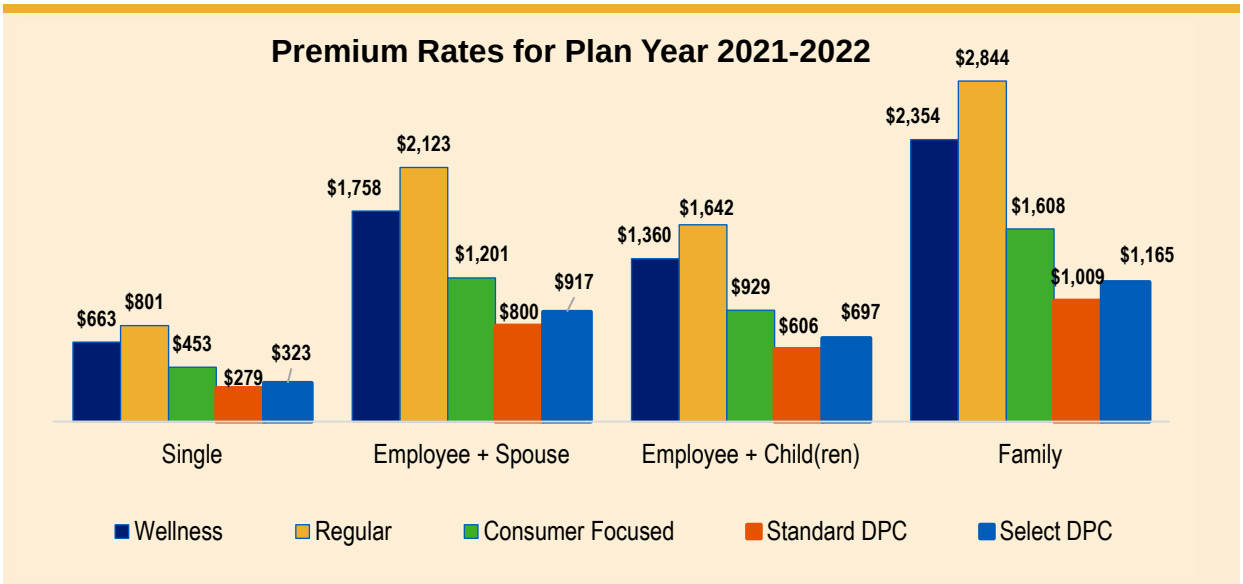
In accordance with Neb. Rev. Stat. §84-1611, the State pays 79% of monthly rates and active, full-time teammates pay 21%. Neb. Rev. Stat. §84-1604 requires part-time teammates (20-29 hours a week) receive only a proportion of the State contribution. Part-time teammates pay 21% of the monthly rate plus 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 2020, 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 2021 and communicated to teammates in April 2021, prior to Open Enrollment. The changes were implemented on July 1, 2021.

2021 – 2022 Rate Increases

- Wellness: 4.0%
- Consumer-Focused: 4.0%
- Regular: 4.0%

Monthly premium 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 helps to reduce year-to-year rate fluctuation and maintain plan relativities. For plan year 2021-2022 rates were increased by 4% for all plans.

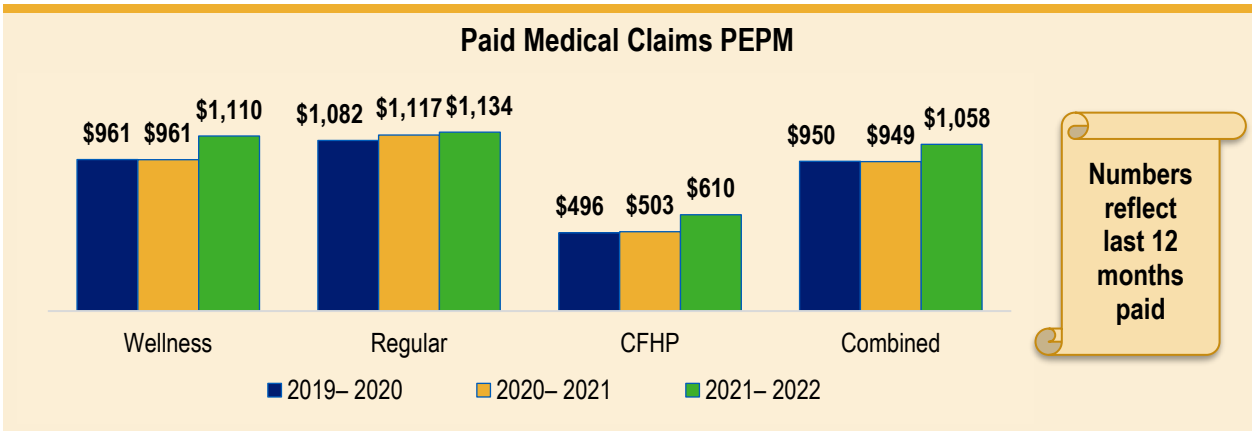


Medical Claims Review

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 $164 Million in reported medical claims in fiscal year 2021 – 2022, which reflected a 7.4% increase from the prior year. The increase was higher than expected cost trend of 6.5% driven by a rebound in utilization of non-emergency services after the pandemic. On a PEPM basis the increase in medical spending was compounded by a decline in enrollment.

The illustration below captures the net paid PEPMs for claims paid during the last three plan years:



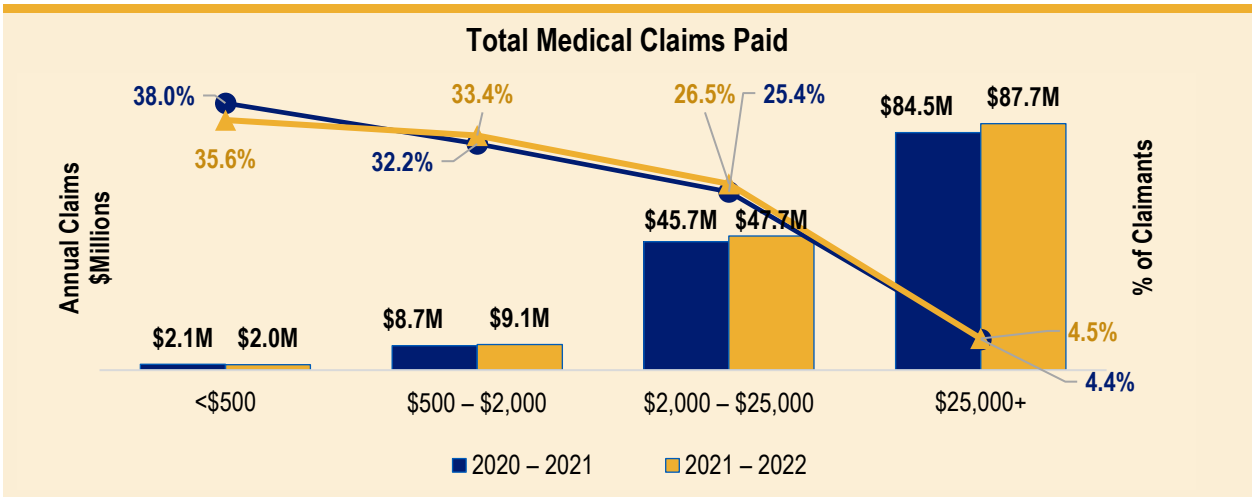
For the purposes of this graph, DPC plans are combined with CFHP.

The combined PEPM of $1,058 for medical claims paid between July 1, 2021 and June 30, 2022 is 11.5% higher than the PEPM cost from the same time period for plan year 2020 - 2021. The rate of increase indicates that claim volume has returned to pre-pandemic levels.

Consistent with 2020 – 2021, treatment for musculoskeletal conditions, circulatory (heart disease) and neoplasms (cancer), were the top cost drivers of medical claims. Combined, these three diagnoses drove 32% 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 $146 million paid through June of 2022 for the 2021-2022 plan year's incurred medical claims, 4.5% of the plan's total population was responsible for driving over half of those claims dollars ($87.7 million).

The total amount (PEPM) for claimants with claims over $100,000 increased by 5.7% from the previous year and increased by 0.4% for claimants with incurred claims between $25,000 and $100,000.



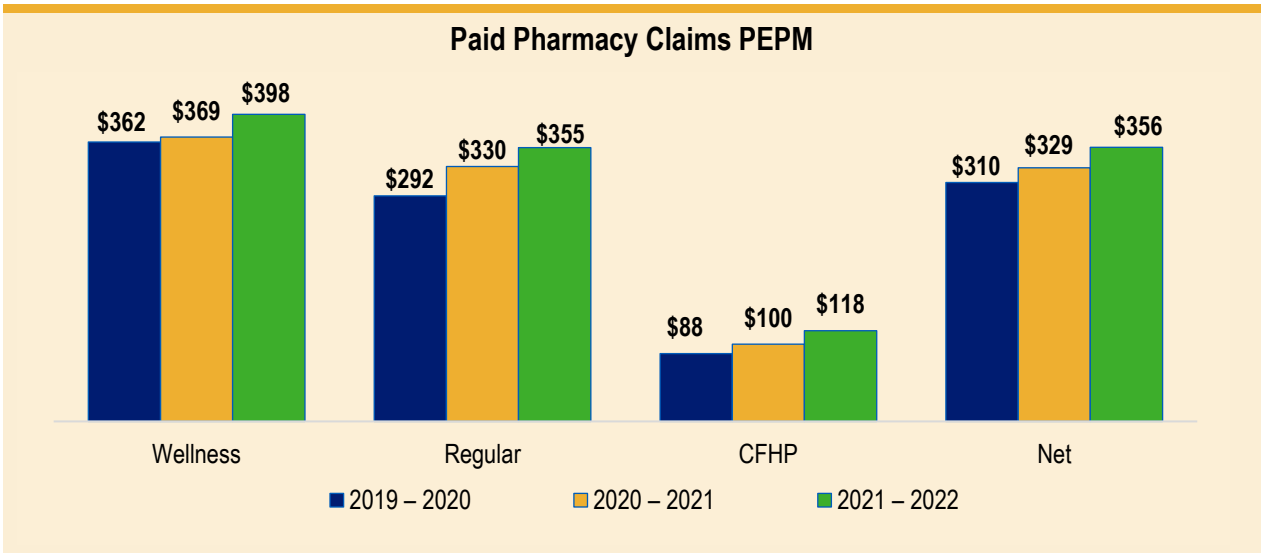
Pharmacy Claims Review

Pharmacy claims were administered by OptumRx, an affiliate of UHC. The plan paid about $52.0 Million of prescription drug claims in 2021 – 2022, a 3.8% increase from the previous year. This increase is below the projected cost trend of 7.5%, however, an increase on an aggregate paid basis was suppressed by a decrease in enrollment of approximately 3.5%. On a PEPM basis the increase in cost was 8.0% which is slightly above projected trend.

Prescription drug rebates received by the plan amounted to $20.4 million, an increase of 16% compared to the prior plan year.

The use of specialty drugs is a growing cost trend that continues to be monitored by the State. During plan year 2021-2022 specialty drugs were responsible for 40.8% of overall pharmacy spend. Compared to the previous plan year specialty drug payments increased by approximately $0.4 Million, or 1.8%.

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



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

Roughly 24,000 participants utilized pharmacy benefits in the health plan, filling about 345,100 prescriptions. The average cost per prescription of $157.42 for the State was a 2.0% increase from the $154.33 paid in the prior year. On average, each member filled 12.95 prescriptions annually. This is an 5.5% increase from last year's average of 12.27 prescriptions filled annually. The average cost per member to the State was $169.86, a 7.7% increase from $157.77 last year.

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 and the remainder of the cost is paid by the plan. The State's prescription drug plan breaks out its prescription drugs in to three cost tiers.

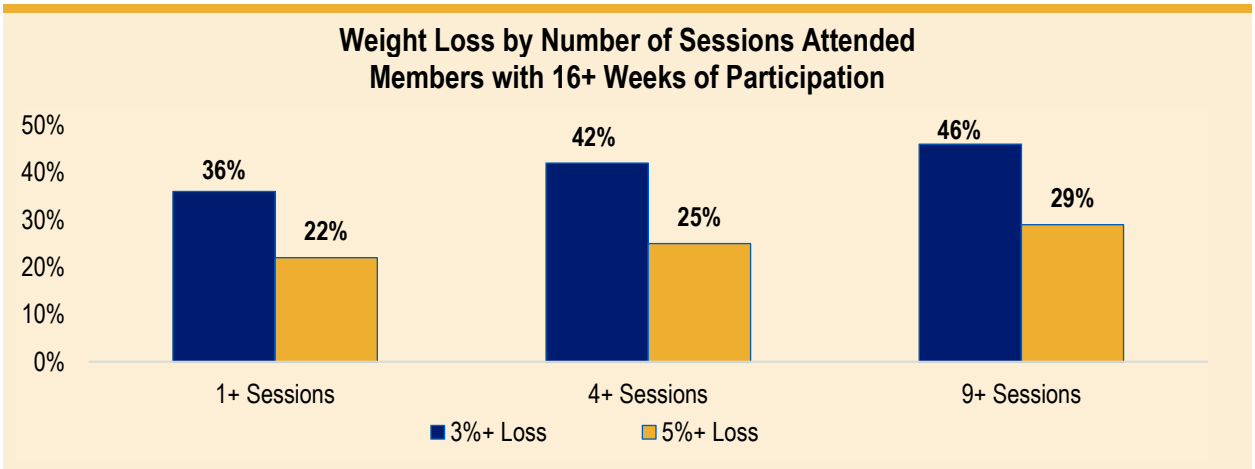
Tier 1 includes mostly generics plus some low-cost brand-name drugs, with copays limited to $5 for the Wellness and Regular plans. Higher cost brand-name drugs are placed in Tiers 2 and 3 with higher copays. Encouraging participants to choose generic prescriptions, primarily in Tier 1, reduces costs for both the employee and the plan.

	2021 – 2022	2020 – 2021	% Change
Annual Scripts per Member	12.95	12.27	5.5%
Average Cost per Member	$169.86	$157.77	7.7%
Plan Cost Share	93.6%	93.4%	0.3%
Employee Cost Share	6.4%	6.6%	-3.8%
Generic Utilization	82.1%	82.2%	-0.2%

Wellness Program

Real Appeal is a weight loss wellness program provided by UHC that was added as of April 1, 2018. Since the beginning of the program the State saw 3,530 members enrolled in the program, with 87% of enrollees deemed at risk of diabetes, cardiovascular disease, or other weight-related health conditions. Approximately 42% of participants have lost weight after 16 weeks on the program with average reported weight loss amounting to 2.7% of body weight per person.

According to the Real Appeal report with data through August 31, 2022, the program scored a 4.75 out of 5 satisfaction rating in a national survey of 19,228 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 2021-2022 Health Program Outcomes

Financial	• Net PEPM for medical increased 7.7%. • Excluding catastrophic claims, medical PEPM is trending 7.1% due to an increase in outpatient surgeries and emergency room visits. • Changes in costs for Inpatient and Outpatient Facility were the main driver of medical trend. • Plan cost share was 81.4% compared to 82.4% in the prior year • Catastrophic claims increased by 9.2% PEPM. • Medical PEPM was 7.1% above peer group. • The network discount rate was 42.1% and saved $122.8 Million. • Net PEPM for pharmacy increased 7.8% • There were 212 participants with claims in excess of $100,000. Combined these claims represented 29.9% of medical costs. • Average cost for catastrophic claimants was $204,767. • 4 participants exceeded $1 Million in claims.
Clinical	• Demographic factor/risk is 4.5% lower than peer group. • Members age 40 and older represent 44.5% of the population and account for 65.7% of claim costs. • Emergency room visits are 18.1% lower than UHC Peer group and utilization increased by 12.8% from last year. • Inpatient utilization increased 1.9% and the amount paid per admission increased by 9.9%. • Outpatient surgeries increased 4.5% and cost per surgery increased 2.6% • The amount of PMPY PCP visits increased by 7.6% and Specialists visits decreased by 4.1% • Musculoskeletal problems are a primary driver of medical costs. • 11% of members had a primary diagnosis of diabetes. • The generic medication dispensing rate was 82.1% • Specialty medications represented 40.8% 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 2022– 2023 plan year. Given continuing growth of the Fund Balance, and favorable claim experience in recent years, the decision has been made not to pass premium increases for plan year 2022-2023, and to keep teammates and State Agencies contributions at the level of 2021-2022 plan year.

2022 – 2023 Contribution Increases	
WellNebraska (wellness track)	0.0%
Regular Health Plan	0.0%
Consumer-Focused Health Plan	0.0%
Select DPC Plan	0.0%
Standard DPC Plan	0.0%

In addition to the decision not to increase health plan contributions for the teammates, the State will make a one-time contribution of $500 to an HSA/FSA account of every teammate enrolled in one of the State's medical plans.

To uphold its commitment to help the state employees reach their wellness goals and to maintain a healthier lifestyle, DAS implemented a one-time Wellness Reimbursement program that will allow the State to reimburse teammates for wellness-related expenses such as gym membership or home exercise equipment up to $250 during plan year 2022-2023.

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).

CARES (The Coronavirus Aid, Relief, and Economic Security Act): Legislation signed into law on March 27, 2020, provided direct economic assistance for American workers, families, small businesses, and industries.

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: Per the CDC, chronic conditions are defined broadly as conditions that last 1 year or more and require ongoing medical attention or limit activities of daily living or both. Examples of such conditions include but are not limited to 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 costs 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: Medical 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's 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.