

Dave Heineman, Governor

November 26, 2014

Senator Heath Mello  
Appropriations Committee, Chairperson  
PO Box 94604  
State Capital Building  
Lincoln, NE 68509

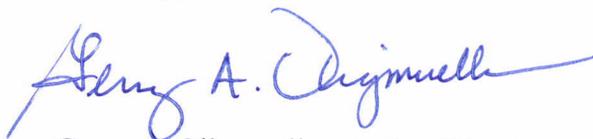
Dear Chairman Mello:

Nebraska Department of Administrative Services is pleased to submit the State of Nebraska Health Insurance Plan Annual Report for the plan year July 1, 2013 to June 30, 2014. This submission is pursuant to Nebraska Revised Statute 50-502.

This report provides an overview of the financial management, participation, and outcomes for the State's most recent health plan year. It also includes a brief summary of changes made for the current health plan year (July 1, 2014 to June 30, 2015) and a glossary of health insurance terminology used throughout the report.

We appreciate the committee's interest in the State's health insurance program and look forward to answering any of the committee's questions concerning this report at a future date and time.

Sincerely,



Gerry A. Oligmueller, Acting Director  
Department of Administrative Services

cc: Members of the Appropriations Committee

# **State of Nebraska Health Insurance Plan Annual Report**

**Presented to the  
Legislature's Appropriations Committee  
November 2014**

**For the Plan Year  
July 1, 2013 to June 30, 2014**

**Prepared by  
State of Nebraska  
Department of Administrative Services**



## Introduction

The Nebraska Department of Administrative Services (DAS) submits this annual report pursuant to Nebraska Revised Statute 50-502. The agency assures the State's health plans and all other benefits programs comply with state and federal guidelines; provides assistance to state agencies and employees regarding wellness and benefit issues; manages third party administrators and actuarial consultants; provides financial management to the health plan; and continuously researches health care and benefit program trends to assure the State continues to offer a competitive employment package to State employees.



Providing employees health insurance is one of the largest costs of doing business in the modern economy. This is no exception for the State of Nebraska.

In order to manage costs and ensure the program is on solid financial footing, significant plan design changes have been implemented over the last several years including but not limited to: increasing deductibles, adjusting copays and coinsurance, and increasing maximum out-of-pocket expenses for employees.



And like many businesses, in 2009, the State of Nebraska began focusing on employee wellness as a means to contain health care costs and improve the health of employees and their spouses. The State created a Wellness health plan, becoming one of the first states to launch an integrated plan for health coverage tied to wellness program participation. The Wellness health plan, in conjunction with its wellness program, called **wellNEssoptions**, is a unique value-based package which emphasizes smart use of health care along with individually tailored wellness programs.

The State of Nebraska has set a standard for others in the public sector to follow. Since its implementation, the State of Nebraska has earned several prestigious national awards, including:

- ❖ 2010 and 2012 Gold Well Workplace by the Wellness Council of America
- ❖ 2011 Innovations Award from The Council of State Governments
- ❖ 2012 C. Everett Koop National Health Award

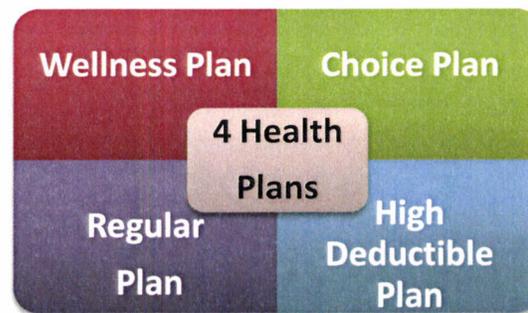
DAS will continue to evaluate programs and take steps to control costs, which benefits agencies, employees, and taxpayers across the state. A glossary of commonly used health plan terms used throughout this report has been added at the end of this document.

# Report Contents

Health Plan Overview -----	4
Enrollment & Eligibility -----	5
Plan Management & Fund Management -----	6
Health Plan Contributions-----	9
Medical Claims Review-----	10
Pharmacy Claims Review -----	11
Wellness Program -----	12
Snapshot of 2013-2014 Health Program Outcomes -----	14
Looking Ahead-----	15
Glossary -----	16

## **Health Plan Overview**

For 2013-2014, the State of Nebraska's health insurance program consisted of four (4) self-insured health plans that included the Wellness Plan, Regular Plan, Choice Plan and High Deductible Plan.



Each plan included medical and pharmacy coverage for in-network and out-of-network providers, as well as wellness benefits. The plan year ran from July 1, 2013 through June 30, 2014 with open enrollment running from May 14, 2013 – May 28, 2013. The State ran an active open enrollment, thus, all employees were required to enroll or re-enroll in health insurance during Open Enrollment.

Coverage was offered to eligible State of Nebraska employees and COBRA participants. (Please see Enrollment and Eligibility on page 5 for additional enrollment information.) There were no prerequisites or requirements for employees to participate in the Choice Plan, Regular Plan or High Deductible Plan. To enroll in the Wellness Health Plan, employees and spouses were required to complete the following three (3) steps during the annual wellness cycle. New employees were able to participate in the Wellness Health Plan (with the completion of an online health assessment) until they go through Open Enrollment and then must complete these steps:

- STEP 1 – Enroll in and complete a wellness program
- STEP 2 – Complete biometric screening
- STEP 3 – Complete the Insight Health Assessment (online)

When covered employees and their dependents incurred medical claims, health providers (hospitals, doctors, etc.) sent claims to the State's third party administrators. For the 2013-2014 plan year, United Healthcare (UHC) was the third party administrator for health care claims and its subsidiary, OptumRx, was the third party administrator for pharmacy claims. UHC and OptumRx assured that submitted claims were adjudicated correctly under the provisions outlined in the plan documents set forth by the State of Nebraska. UHC and OptumRx then paid the providers, and once payment cleared the bank, the State reimbursed UHC or OptumRx for the claims through the State Employee Insurance Fund.

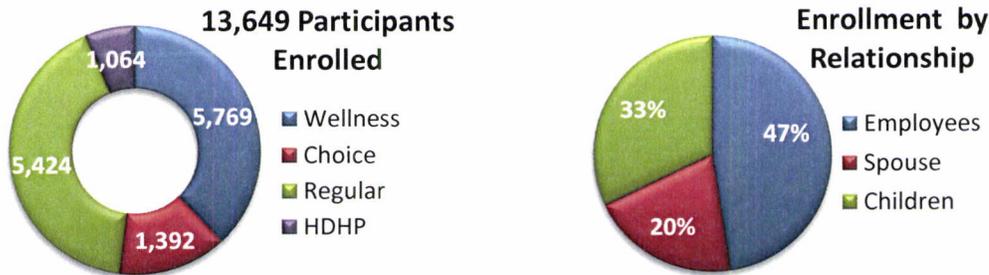
### **What does Self-Insured mean?**

The State assumes the financial risk for providing health care benefits to its employees and contracts with United Healthcare (UHC) to process the claims. Instead of paying fixed premiums to UHC, which are inflated to include profit margins and taxes, the State collects contributions from employees and State agencies which are deposited in to a trust fund and used to pay for health care claims for plan participants after copays and deductibles.

**Enrollment & Eligibility**

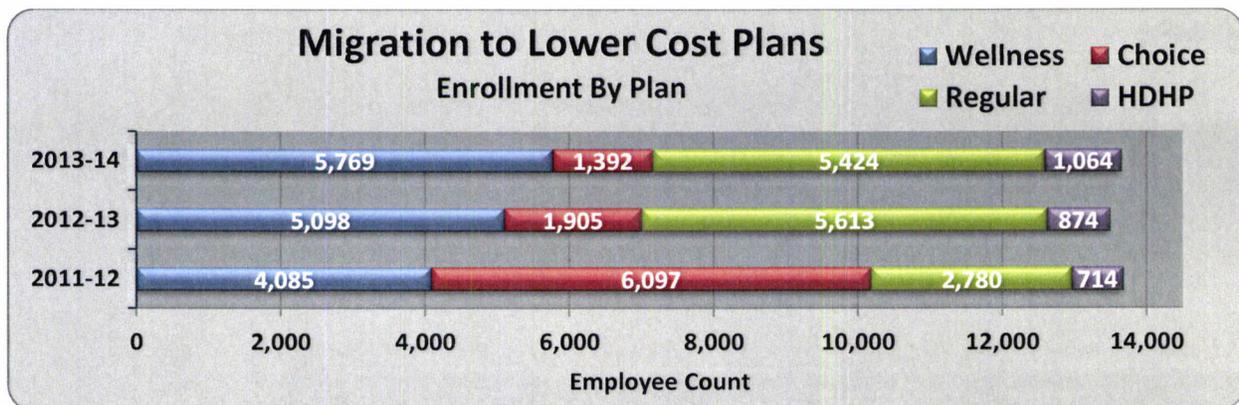
State statute 84-1601 and statute 84-1604 allows for permanent full-time and part-time employees who work a minimum of 20 hours per week to participate in the State health plans. These employees are eligible for coverage the first of the month following 30 days of employment. In addition, state statute 84-1601 and statute 84-1604 also allows temporary employees working a minimum of 20 hours per week and hired into an assignment that is 6 months or longer to also be eligible for coverage in the State health plans after the regular waiting period. State of Nebraska 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 Personnel Rules and Regulations, Chapter 17.014; and the NAPE/AFSCME (NAPE) and State of Nebraska Labor Contract, Article 13.2.

As of June 30, 2014, the plan had 13,649 employees enrolled, which included about 330 retirees and 50 COBRA participants. The total number of covered lives was 28,765 which increased 1.4% from 2012-2013 plan year. Dependent verification audits were conducted for all new dependents added to the health plan.



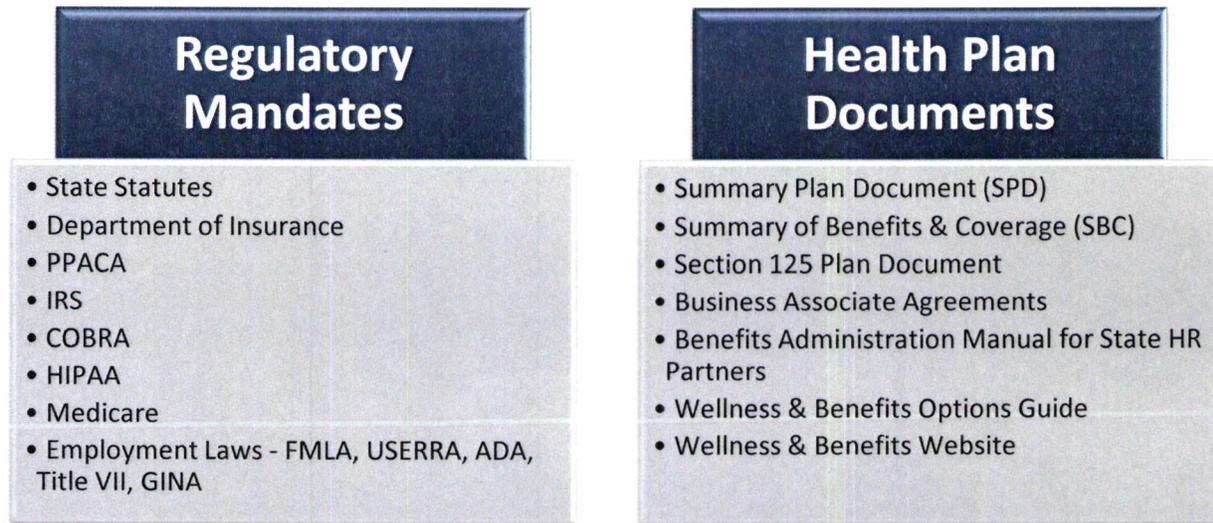
Approximately 56% of participants were female and 44% were male. The average age of employees enrolled in the plan was 47.6, slightly lower than prior year’s average of 47.9.

Total enrollment in the State Health Insurance Plan over the past three years has fluctuated less than 1%; however, individual plan enrollments have changed significantly. More employees have migrated from the Choice plan to the Regular, Wellness or High Deductible plan. Enrollment in lower cost plans like Wellness, Regular, and High Deductible, saves money for the employee and the State.



## **Plan Management & 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 AON Hewitt, UHC, and attorneys to constantly monitor changes in health plan management and assure our plan and documentation is in compliance.



State statute 84-1613 established the State Employees Insurance Fund #68960 to pay medical and pharmacy claims, administrative fees and wellness program fees. This fund was administered by DAS and reserve targets were adjusted annually using cost projections from the State's actuary and health care consulting firm. For the 2013-2014 plan year the actuary and health care consultant was Aon Hewitt.

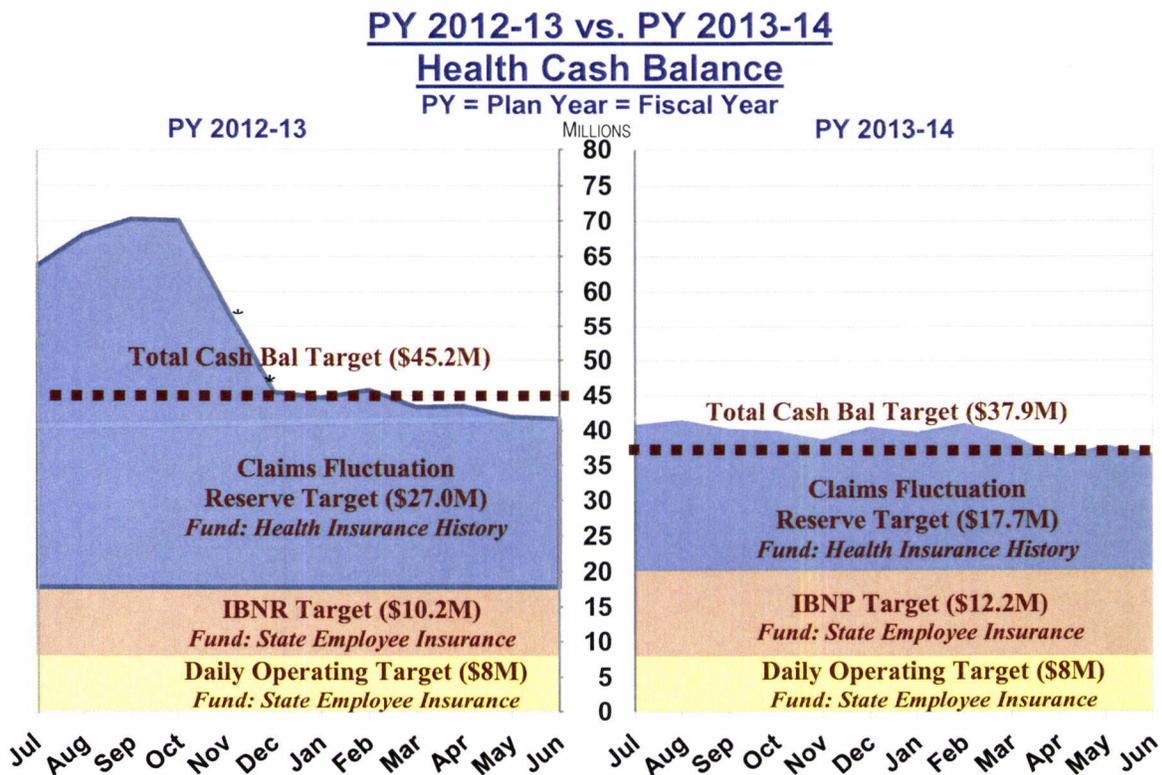
Reserves are imperative to successful management of a self-insured health plan for over 28,000 covered lives. The Health Insurance History Fund #68922 is a subsidiary fund of the State Employees Insurance Fund #68960 and contained the Claims Fluctuation Reserve (CFR). Health Insurance History Fund #68922 is designed to pay for the costs of coverage of unusual or high volume claims that may occur. Health Insurance History Fund #68922 also contains the amount to finance the operation of Program 606, Wellness and Benefits Administration, as approved by and stated in the biennium budget bill. The amount required for Program 606 operation was transferred by the State Treasurer from Fund Health Insurance History Fund #68922 to Health and Life Benefit Administration Fund #28010, established in state statute 84-1616.

Self-insured health plans can purchase Stop Loss insurance to limit the amount a plan pays each year for each participant. In 2012-2013 the State of Nebraska purchased a Specific Stop Loss insurance policy through UHC with a \$1 million deductible. Thus, the State's health fund is only responsible for the first \$1 million of claims paid for an individual participant for the plan year.

During renewal for 2013-2014 the State analyzed whether or not to continue purchasing Stop Loss Insurance. The State looked at claims for the State and industry health care. The plan had seen a higher frequency of claims above \$100,000 as compared to UHC book of business and decided to continue Stop Loss insurance for 2013-2014 plan year.

In 2013-2014 one participant exceeded \$1 million in claims and three additional participants exceeded \$500,000. All four participants were being treated for cancer.

Aon Hewitt in conjunction with DAS prepared an Incurred But Not Paid (IBNP) Analysis Report, Premium Rate Analysis Report, and Claims Fluctuation Reserve (CFR) Analysis Report for the State. These reports were reviewed at meetings conducted between the Wellness and Benefits Administrator, Personnel Director, Director of DAS, Budget Division, and the Governor to establish plan contribution funding, effective plan designs, and set targets for the plan year.



For 2013-2014, the Cash Balance Target was reduced from \$45.2 million to \$37.9 million as recommended by AON Hewitt. A \$7.3 million was used as a premium subsidy to reduce the contributions for employee and State agencies.

For plan year 2013-2014, Aon Hewitt recommended a CFR of at least \$17.7 million and IBNP of \$12.2 million. In accordance, the State established a CFR targeted balance of \$17.7 million in Health Insurance History Fund and a targeted balance of \$20.2 million in the State Employees Insurance Fund #68960

which included a Daily Operating Target of \$8 million to cover daily expenses and IBNP of \$12.2 million to cover claims run out from the prior plan year.

A summary of activities in State Employees Insurance Fund #68960 for the plan years ending June 30, 2013 and June 30, 2014 are shown below.

<b>State of Nebraska Health Insurance Fund</b>				
<b>Summary of State Employees Insurance Fund #68960 Activity</b>				
<b>Comparison of Plan Years Ending June 30, 2013 and 2014</b>				
	<b>Plan Year 2013-2014</b>	<b>Plan Year 2012-2013</b>	<b>Change</b>	
			<b>Dollars</b>	<b>Percent</b>
<b>Contributions</b>				
Contributions	\$160,848,652	*\$131,889,940	\$29,958,712	22%
Investment Income	\$330,562	\$430,843	-\$100,281	-23%
<b>Total Contributions</b>	<b>\$161,179,214</b>	<b>\$132,320,783</b>	<b>\$28,858,431</b>	<b>22%</b>
<b>Distributions</b>				
Medical Claims & IBNR	\$124,130,373	\$113,681,448	\$10,448,925	9%
Pharmacy Claims	\$33,098,022	\$28,762,371	\$4,335,651	15%
Wellness-Health Fitness	\$2,042,507	\$2,978,609	-\$936,102	-31%
Administration Fees	**\$6,912,538	\$8,488,762	-\$1,572,224	-19%
<b>Total Distributions</b>	<b>\$166,183,440</b>	<b>\$153,911,190</b>	<b>-\$26,211,321</b>	<b>8%</b>
<b>Net Difference</b>	<b>-\$5,004,226</b>	<b>-\$21,159,564</b>		

\*2012-2013 Contributions understated due to Nov & Dec 2012 contribution abatement.

\*\*2013-2014 Administration Fees reduction due to performance guarantees.

<b>State of Nebraska Health Insurance Funds</b>				
<b>As of June 30, 2014</b>				
	<b>6/30/2014</b>	<b>6/30/2013</b>	<b>\$ Change</b>	<b>% Change</b>
State Employees Insurance Fund #68960	\$17,793,411	\$12,242,015	\$5,551,396	45%
Health Insurance History Fund #68922	\$18,922,188	\$29,845,726	-\$10,923,538	-37%
<b>Total Reserves</b>	<b>\$36,715,599</b>	<b>\$42,087,741</b>	<b>-\$5,372,142</b>	<b>-13%</b>

\*2013-2014 contributions included a \$7.3 million subsidy from reserves.

**Health Plan Contributions**

The State Employees Insurance Fund #68960 is funded by health plan contributions from participants and the State. Contributions are collected from employees through payroll deductions and combined with State contributions.

In accordance with state statute 84-1611, the State pays 79% of monthly rates and active, full-time employees pay 21%. Statute 84-1604 requires part-time employees (21-39 hours a week) receive only a proportion of the State contribution. Part-time employees 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% administration fee.

Health plan contributions are reviewed each year. During the third quarter of the previous plan year (January -March 2013), Aon Hewitt provided the 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. Changes to contributions and plan design were communicated to employees prior to and during Open Enrollment and implemented on July 1, 2013.

Contributions to the plan increased from \$132 million to \$161 million. About \$3 million of the difference was an increase in contributions through higher monthly rates and increased enrollment. The remaining difference of \$26 million reflected 2012 Contribution Abatement which understated 2012-2013 contributions. During the Abatement no contributions were collected from employees or State agencies during November and December of 2012 which helped reduce reserved cash balance of the State Employee Insurance Fund.

Monthly rates for all State health plans are determined by actual claims history, projected enrollment, and projected health plan costs. Each health plan is rated individually which can result in different rate changes by plan. In addition, the Regular plan is negotiated as part of the Nebraska Association of Public Employees (NAPE) labor contract. The 2013-2014 rates for the Regular plan were a provision of the NAPE labor contract. The projected cost increases in the Regular health plan was pulled from the reserves in the State Health Insurance Fund as part of the \$7.3 million premium subsidy.

**2013-14 Rate Increases**

- Wellness – 2%**
- Choice – 5%**
- HDHP – 3.6%**
- Regular – 0%\***

\*Per NAPE labor contract provisions



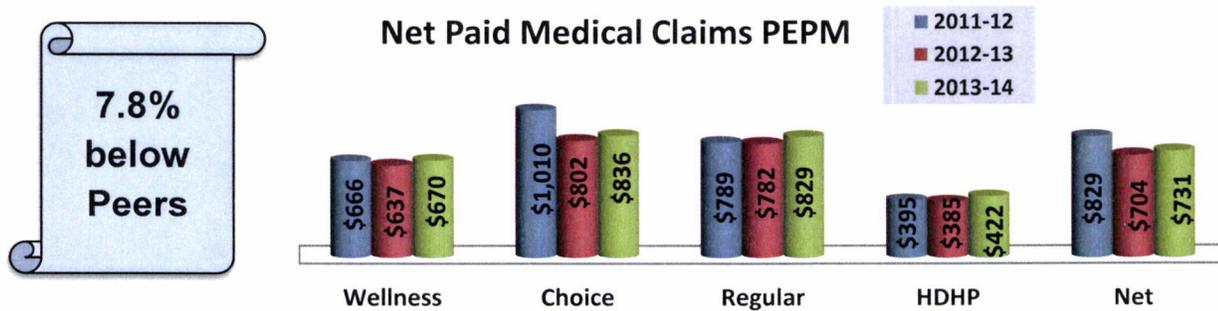
## Medical Claims Review

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

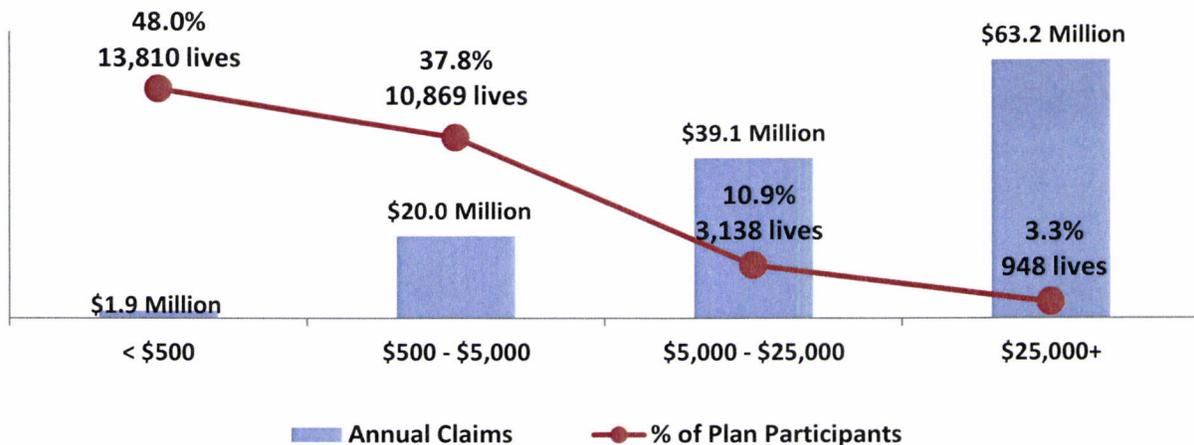
The State Employees Insurance Fund #68960 paid approximately \$124 million of medical claims during plan year 2013-2014, which reflected a 9% increase from the prior year. Factors attributed to this increase include a 12.3% increase in claimants exceeding \$100,000 of medical claims (High Cost Claimants), increase in participants, and increased number of participants utilizing medical benefits.

Consistent with 2012-2013, treatment for neoplasms (cancer), circulatory (heart disease), and musculoskeletal conditions were the top cost driver of medical claims. Combined, these three diagnosis drive 35% of total medical claims paid per employee per month (PEPM).

The Net Paid PEPM of \$731 reflects a 3.8% increase from the previous year but 7.8% below our peer group and 9.5% below industry according to UHC. Despite an increase, the Net PEPM remains below 2011-2012 cost per employee.



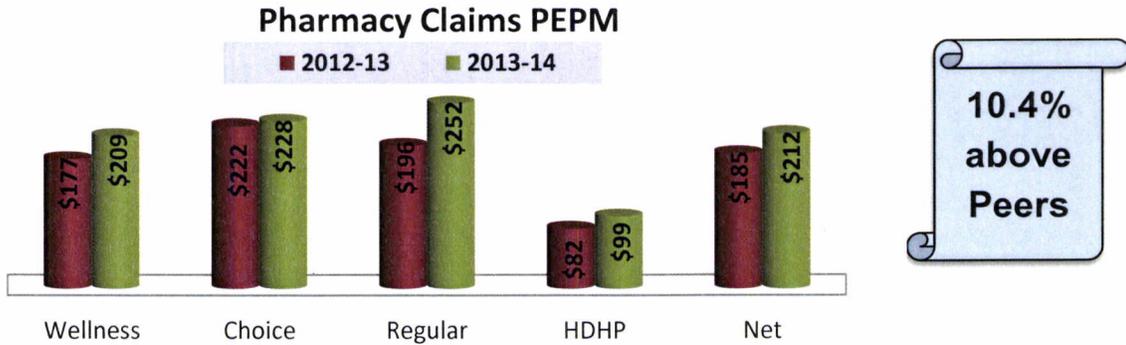
Consistent with other group health plans, a small percentage of participants incurred a high proportion of total medical claims paid. Of the \$124 million spent on medical claims, the plan paid nearly \$63.2 million for 3.3% (948 lives) of the total plan participation of 28,765. In contrast, the plan paid \$1.9 million for 35.1% (10,091 lives) plan participants.



**Pharmacy Claims Review**

Pharmacy claims were administered by OptumRx, an affiliate of UHC. The plan paid about \$33 million for prescription claims in 2013-2014, a 15% increase from the previous year. The cost paid by the plan per employee was 10.4% higher than the peer group due to higher utilization, according to UHC.

Over 24,000 participants utilized pharmacy benefits in the health plan, filling about 420,000 prescriptions. The average cost per prescription of \$83 increased from \$77 paid the prior year. On average, each participant filled 14.6 prescriptions annually compared to industry average of 11.7.

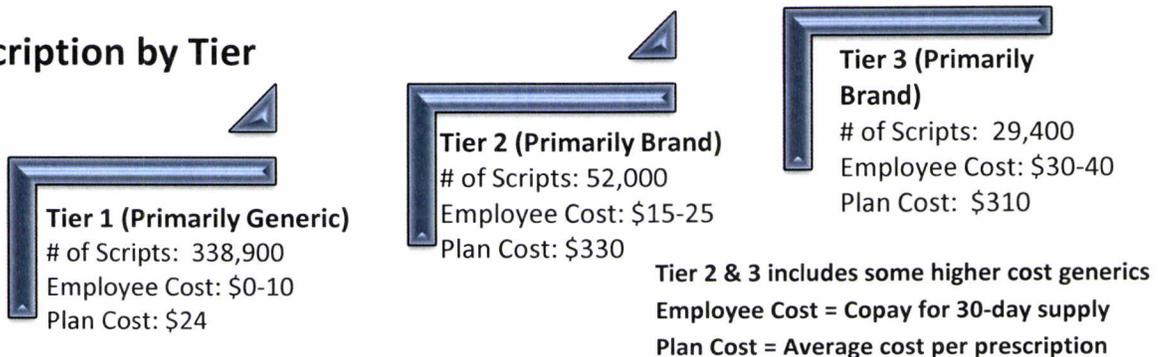


	2013-14	2012-13	% Change	Peer
Annual Scripts per Participant	14.6	13.7	6.3%	11.7
Avg. Cost per Rx	\$82	\$77	7.4%	\$91
Avg. Cost per Specialty Rx	\$2,658	\$2,420	9.8%	
Avg. Cost per Retail Rx (30 days)	\$50	\$46	8.9%	
Avg. Cost per Mail Order (180 days)	\$366	\$312	17.1%	
Generic Utilization	81.2%	79.0%	2.2%	
Member Cost Share	12.1%	13.8%	-12.3%	15.3%

Members pay a copay for each prescription and the remainder of the cost is paid by the plan. The cost per prescription paid by the plan increased 7.4% on average.

UHC’s plan breaks drugs in to 3 tiers by cost. Tier 1 includes mostly generic plus some low-cost brand name drugs. Encouraging participants to choose generic prescriptions, primarily in Tier 1, reduces costs for both the employee and the plan as shown below.

**Prescription by Tier**



**Wellness Program - wellNEssoptions**



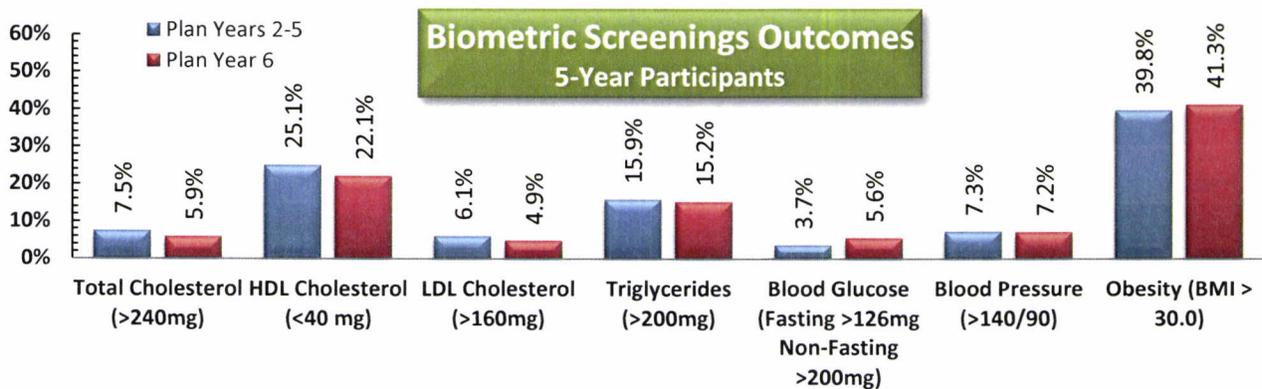
The State’s wellness program was administered by *HealthFitness™*, which provided the State with two dedicated, onsite Wellness employees.

Wellness program fees were paid through the State Employees Insurance Fund #68960 and cost about \$2.0 million for the plan year ending June 30, 2014. The fees in the report do not include some expenses incurred in 2013-2014 which will appear in the 2014-15 financials due to timing of billing. These costs, shared by the State and employees enrolled in the State health plans, provided a comprehensive wellness program that yielded positive health and economic benefits now and likely will in the future. A return on investment analysis performed for the period of April 1, 2011, to March 31, 2013, showed a \$1.30 return for every dollar spent towards wellness.

- Wellness Programs**
- Interactive Health Platform
  - Biometric Screenings
  - Health Risk Assessment
  - EMPOWERED Coaching
  - Personalized Lifestyle Program
  - Walk This Way
  - Cardio Log
  - Preventive Reminders
  - Chronic Care Reminders
  - Online Resources

Employees and spouses who complete each of (1) Biometric Screening, (2) Health Risk Assessment, and (3) their choice of a wellness program are eligible to elect the Wellness Health Plan which offers lower out of pocket costs for medical and pharmacy health care.

Over 10,700 employees and spouses participated in **wellNEssoptions** health screenings and health risk assessments offered during April through May 2014. This reflects a 29% increase from prior year. Employees and spouses who participated in wellness for the past five years saw their number of health risks reduce in five out of seven biometric risks.



**Positive Results** 78.6% of participants who had 0 risks in Plan Years 2–5 also had 0 risks in Plan Year 6. 75.7% of participants had 1 or less risk.

According to the Gallup Healthways Well-Being Index, obesity increased 1.0% in one year. State’s obesity increased 1.5% in a 5-year time span (39.8% to 41.3%).



State of Nebraska honors employees who share personal stories about how **wellNEssoptions** has influenced their personal health. Following is one of several testimonials the Wellness and Benefits team has received from State employees.



Barbara Whitehead has been employed with the State since 2004 with the Department of Administrative Services - OCIO. She was honored at the Governor's Wellness Awards luncheon by Governor Heineman as a Wellness Advocate and shared her story about her commitment to a healthier lifestyle.

### Barbara's story:

*In May of 2009, I learned that my son was about to deploy as an Army Reservist. I knew that I had to do something to manage my stress better. My daughter-in-law invited me to join a weight loss center with her. Standing only 5 foot 3 inches tall, I tipped their scale on the initial visit at 201 pounds.*

*After a week on their nutrition plan, I began adding activity. The base of my fitness program was walking. I walked 30 minutes a day for 30 consecutive days, breaking it up into 10 minute segments when needed. I had read a book by a cardiac surgeon who said that's what he wanted his patients to do before surgery. I figured if it was good enough for them, it was good enough for me. It was a good thing I did, because later that year, I needed surgery to correct a misbehaving parathyroid that was resulting in bone loss. I had surgery days before my son left for pre-mobilization training. I said good bye to him at the airport with bandages on my neck. Several months would pass before I would see him again.*

*At the end of this training, his unit transitioned to Fort Hood, Texas, arriving the night of November 4, 2009. The next day he gave up his seat in the Soldier Readiness Center to another soldier and went to lunch. While he was on his way back to the building, things began to go horribly wrong inside that room. The soldier to whom he had given up his seat was one of 32 wounded; 13 lost their lives that day. My son had many emotions to deal with in the aftermath of those events. So did his mother.*

*In the course of processing those feelings, it was clear that one cannot go back and undo horrible things that happen. But I could live my life from there on in such a way as to honor those who lost theirs that day, or had theirs forever altered. Midway through the next year, someone decided that a Run to Remember would be a good way to honor the fallen. The distance was based on the lives lost, 13.1 miles, which is a half marathon. At that point I had lost the weight, but I did not believe I could up my game to a half marathon in the months before the run. Instead, I committed to a 5K (3.1 miles) on the anniversary of the tragedy.*

*I trained for that 5K with a Couch to 5K training plan I found online. I was unable to go run it in Fort Hood, but by the time the anniversary rolled around, my son was home from Iraq. He agreed to "run to remember" with me, right here on the MoPac trail outside Lincoln. We ran our 5K together and released gold star-shaped balloons with the names of the fallen on them.*

*This, however, was not enough for me. I have gone on to finish a half marathon 7 times. At each starting line, I invoke the name or names of someone who cannot do it. My motto is: "I run BECAUSE I can; I run FOR those who cannot."*

*Life is good. It is better when I'm fit. It is at its best when my journey touches those of kindred spirits and we can encourage one another. The culture of a healthier lifestyle that has been encouraged here at the State of Nebraska is one way we have of finding those kindred spirits, and helping one another along the path to living life to the fullest: creatively, consciously, and consistently making better choices to support our health and well-being.*

## Snapshot of 2013-2014 Health Program Outcomes

### Financial

- Medical PEPM was 7.8% below peer group.
- Pharmacy PEPM was 10.4% above peer group.
- Net PEPM for medical is trending 3.8%.
- For 2 consecutive years, Emergency Room utilization was 31% lower than Peer Group.
- Inpatient hospital admissions and emergency room visits decreased.
- Muskeletal, cancer, and diabetes drive 39% of medical costs.
- Network discount rate was 36.6% and saved \$77.1 million.
- 148 participants exceeded \$100,000 in claims.
- 1 participant exceed \$1 million in claims.

### Clinical

- Emergency room visits decrease 5%; 31.9% lower than UHC Peer group.
- Inpatient utilization decreased 3.5%; Outpatient increased 0.3%.
- Top three diagnosis was diabetes, hypertension, and back pain.
- Top primary conditions by Net Paid -diabetes, cancer, coronary artery disease.
- 50% of high cost claimants have cancer - breast, colon, multiple myeloma had the most cost and claimants.
- 9% of total membership are considered a high health risk.
- 33% more members qualified for clinical programs.
- 68% of osteoarthritis claimants are employees.
- Diabetics cost 194% more than non-diabetics.

### Engagement

- Wellness Health Plan participation increased 12%.
- Over 4,400 employees received a flu shot at a State onsite clinic.
- Over 10,000 participants participated in **wellNEssoptions** programs.
- Participants in the Wellness Health Plan option had higher utilization of wellness visits and cancer screenings.
- Walk This Way® participants showed a 12.2% reduction in high risk for HDL cholesterol.
- Over 160,000 cardio log activities submitted.
- Participants walked over 7 billion steps. - 3,839 participants walked 1 million steps or more.
- Wellnes & Benefits traveled statewide hosting education meetings and help desks about health plans and wellness.

## Looking Ahead

The State continues to focus on providing employees with a quality health insurance program integrated with wellness. The State discontinued the Choice Health Plan on June 30, 2014. Beginning July 1, 2014, the State began offering a Consumer Focused Health plan with the option to contribute to a Health Savings Account. The State made no contributions to the Health Savings Account.

Aon Hewitt provided the State with actuarial cost projections. Costs were impacted by new PPACA plan design requirements and fees, health care trend of 4.5-6.5%, and prior year premium subsidies pulled from State Health Insurance Funds. Plan design changes were limited on the Regular plan due to NAPE contract provisions. Plan increases for year 2014-2015 ranged 9.4 – 10.9% and included an additional subsidy of \$5.2 million. Although rate increases were higher than previous years, the average five-year rate increase remained below 4% for all plans.

	2014-2015 Contribution Increases	Average 5- year Rate Increase
Wellness	9.4 - 9.7%	0.6%
Regular	10.6 - 10.9%	3.3%
High Deductible	9.5 - 9.8%	-3.3%
Consumer Focused	NEW	

For 2014-2015, HealthFitness continues to administer **wellNEssoptions** and offer programs designed to help employees manage the risk of the top health conditions experienced by 2013-2014 claims. The following changes were implemented beginning April 1, 2014:

- ✓ New wellness website and **wellNEssoptions** logo.
- ✓ All new Wellness Health Plan participants must complete health assessment within 30 days after enrollment.
- ✓ Increased the number of steps to 900,000 in Walk This Way program.
- ✓ Increased Cardio Log to 60 workouts to qualify for Wellness Health Program.
- ✓ EMPOWERED Coaching participants complete 8 goals to qualify for Wellness Health Plan.

The State is continually monitoring health care trends in the industry and partnering with groups such as Aon Hewitt, UHC and others to seek out, analyze and provide the best features and options for employees and taxpayers. The State is researching alternative cost management solutions including value based network agreements. A high focus is placed on complying with new PPACA requirements including the PCORI (Patient-Center Outcomes Research Institute) fee and transitional reinsurance program fees, plan design, affordable coverage, minimum essential coverage to full-time employees, and new IRS reporting requirements for both employees and IRS.

The State also recognizes the total health of our workforce extends beyond physical well-being to also include other personal and economic needs. In addition to a competitive health and wellness program, DAS also works to ensure that employees and their families are able to participate in other group benefits including dental, vision, employee assistance program, flexible spending accounts, life and long term disability. We offer a quality benefit package designed to attract and retain a best in class State of Nebraska workforce.

## Glossary

**Aon Hewitt** – An independent, nationally recognized actuary and health care consulting firm.

**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.

**Claims Fluctuation Reserve Report** – Report illustrating the appropriate level for various claim fluctuation reserves developed through simulation modeling of expected claims.

**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.

**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.

**HealthFitness™** - Administrator of the State's wellness program, **wellNEssoptions**.

**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.

**IBNR Analysis Report** – Report prepared by Aon Hewitt 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.

## **Glossary (continued)**

**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 an employee, covered spouse or other legal dependent.

**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)** – Health care 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.

**United Healthcare (UHC)** – Administrator of the State’s health insurance program.

**wellNEssoptions** - The State of Nebraska’s wellness program, administered by HealthFitness™.