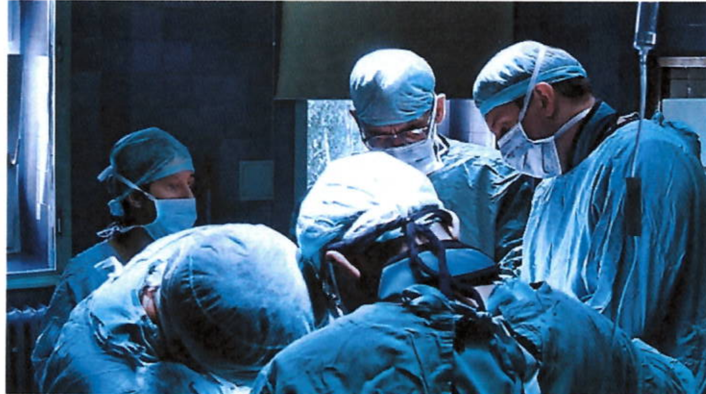
University of Nebraska
Health Insurance Plan Annual Report

Year Ended December 31, 2018

Executive Summary

This report is designed to meet a reporting mandate established by the Nebraska Legislature requiring an annual report be filed detailing operating activity of the University of Nebraska's health plan operations each year. This report covers the University's plan year January 1 through December 31 of 2018.

The University of Nebraska's strategic objective is to recruit and retain exceptional faculty and staff. One of the most highly valued benefits is medical, dental and pharmacy coverage. In one national survey, 73 percent of workers said that the insurance provided by their employer was a "very important" factor in their decision to take or keep a job[i].



This report documents that the University of Nebraska's health insurance plan continues its track record of providing this benefit at a reasonable cost with operating results reflective of national trends. Success in any health plan rests largely with members taking control of their health through adopting healthy lifestyles, taking advantage of preventive screenings, having regular visits with health professionals, and adhering to drug and other prescribed therapies.

Overall, the plan balance declined approximately $7 million in calendar 2018, as compared to an approximately $6 million increase in 2017. This approximately $13 million swing, despite an approximate 6 percent increase in 2018 premium revenues, can be attributed to higher claims during 2018. Whereas claims experience was relatively stable in 2017, the plan experienced double digit increases in both medical and pharmacy claims in 2018, triggered primarily by an increase in the costs associated with high cost claimants and specialty prescription costs.

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

the transition on January 1, 2019. Our benefits consultant advised us that it is not uncommon to see a 15 to 20 percent increase in claims experience prior to a third-party administrator change.

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

In summary, the University of Nebraska is proud to provide a competitive, cost-effective health insurance plan to its employees and their families. We believe the University's plan is well managed, provides competitive benefits, and is favorably positioned to serve employees' future health needs despite the increasingly uncertain challenges facing the healthcare industry.

University of Nebraska Strategic Objective:
Recruit and retain exceptional faculty and staff

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Plan Overview

The University of Nebraska offers a preferred provider (PPO) "self-insured" health plan providing medical, dental, and pharmacy coverage to its employees and their families. Most employers the size of the University are self-insured for medical coverage as it gives them more control over plan design. In addition, any 'profits', typically built into insurance company prices, are retained by the plan and its participants.

Up through 2018, the University utilized the expertise of the following outside parties to assist in the administration of the plan:

Entity	Description of Service Provided
BlueCross BlueShield of Nebraska	Third-party administrator for medical and dental claims
CVS Caremark	Third-party administrator for pharmacy claims
Wells Fargo	Trustee
Milliman	Independent actuaries – provide projections used to set premiums

The plan, which operates on a calendar year basis, collects premiums through payroll deductions from eligible, participating employees and combines them with employer (University) premium contributions. The plan deposits these funds into a trust account held by the Trustee, Wells Fargo. Under state law, the Board of Regents is fully empowered to establish trust accounts, as they ensure the funds are protected and, in this case, can only be spent for healthcare purposes.

When covered employees and their dependents incur healthcare expenses, health providers (hospitals, doctors, pharmacies) send their bills to either (a) BlueCross BlueShield of Nebraska (BCBSNE) for medical and dental claims or (b) CVS Caremark (CVS) for pharmacy claims. BCBSNE and CVS, as third-party administrators, assure that the submitted claims are valid using coverage criterions, limits, deductibles and copays as set by the University. When BCBSNE and CVS pay claims, they are reimbursed by Wells Fargo, the Trustee, for the claims cost plus an administrative fee.

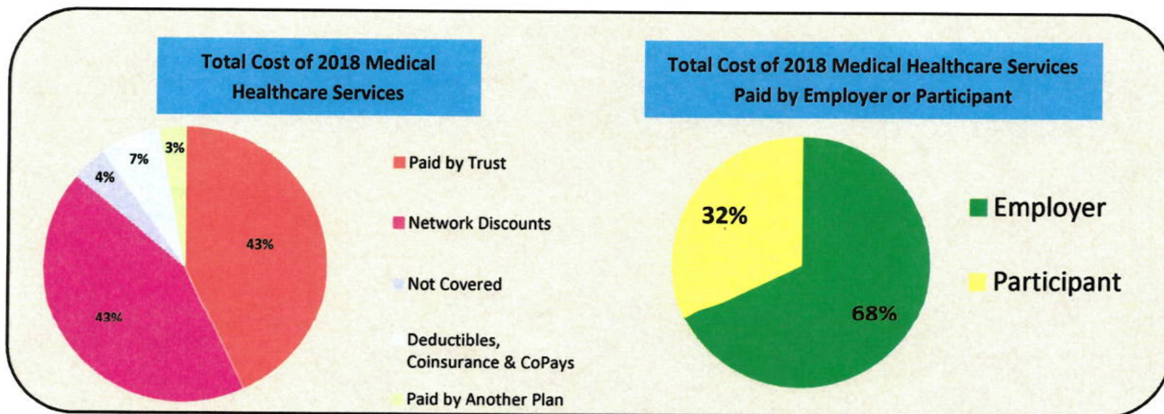
Premiums charged to both the employer and employees are designed to cover the plan's projected claim costs plus administrative expenses. Any potential changes in premiums, which become effective on January 1, are established by University management each fall after analyzing Milliman's actuarial expense projections, which are based on a combination of University internal experience along with Milliman's book of business experience. University management reviews the plan's projected premiums and anticipated expenses with the President and Chancellors before finalizing employee premiums for the upcoming year.

For the years ended December 31, 2018 and 2017, 79 percent of premium income was contributed by the employer and 21 percent of premium income was contributed by the employee. University employees selecting basic coverage pay between 20 percent and 29 percent of the total medical premium depending upon the coverage selected. While the University offers

a variety of coverage options, a majority of the employees are enrolled in basic medical coverage for a "family" or "employee+one", both of which have close to a 79/21 percent employer/employee contribution ratio, as noted in the table below:

	2018 Monthly Premiums - Basic Medical Coverage		
	Employee	Employer	Total
Family	$ 314	$ 1,268	$ 1,582
Employee+One	$ 246	$ 904	$ 1,150
Employee+Dependent(s)	$ 208	$ 674	$ 882
Employee Only	$ 155	$ 376	$ 531

It is also worthwhile mentioning that the healthcare costs paid by the health trust are but a portion of the total cost of healthcare services provided under the University's plan. A substantial portion of the cost of healthcare services is paid for by another plan (for example, Medicare), paid for by the participant through deductibles, coinsurance & copays, discounted through network agreements, or simply not covered, as demonstrated in the graphs below for medical healthcare services:

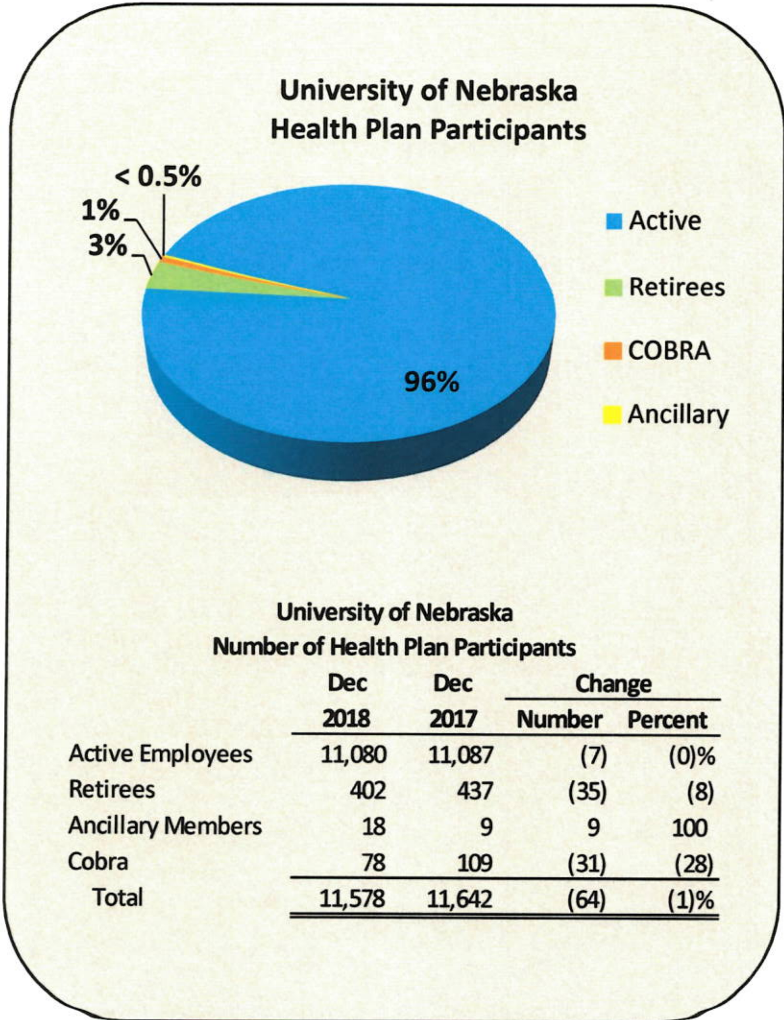


The pie chart above shows that the aforementioned 79/21 percent employer/employee contribution ratio is not reflective of the total expense borne by each party. In fact, the pie chart depicts that when counting deductibles, coinsurance and copays, participants pay roughly 32 percent of the total cost borne by either the employer or participant. It is likely that the total cost of medical healthcare services paid by the participant is even greater than 32 percent, as a portion of medical healthcare services "not covered" or "paid by another plan" were possibly costs ultimately borne by the participant.

Members of the Board of Regents are kept apprised of the plan's performance through updates provided to the Business Affairs Committee.

Enrollment and Demographics

The University's health plan had almost 11,600 medical participants as of December 31, 2018, 64 less than the prior calendar year-end. When including family members, the plan had average annual medical membership of approximately 27,700 covered lives.



University of Nebraska
Number of Health Plan Participants

	Dec 2018	Dec 2017	Change Number	Change Percent
Active Employees	11,080	11,087	(7)	(0)%
Retirees	402	437	(35)	(8)
Ancillary Members	18	9	9	100
Cobra	78	109	(31)	(28)
Total	11,578	11,642	(64)	(1)%

The number of individuals in each participant group were relatively unchanged for 2018, with a slight increase in ancillary members being more than offset by slight decreases in active employees, retirees, and Cobra electees.

University retirees are allowed to belong to the plan but must pay the entirety of their premium, which is computed separately by plan actuaries from that of active employees. The number of retirees in the plan decreased 8 percent, as compared to 4 percent in 2017. This is attributed to a number of favorably priced "gap" polices available in the marketplace (when combined with a base of Medicare coverage) that are financially more attractive than the premium offered by the University.

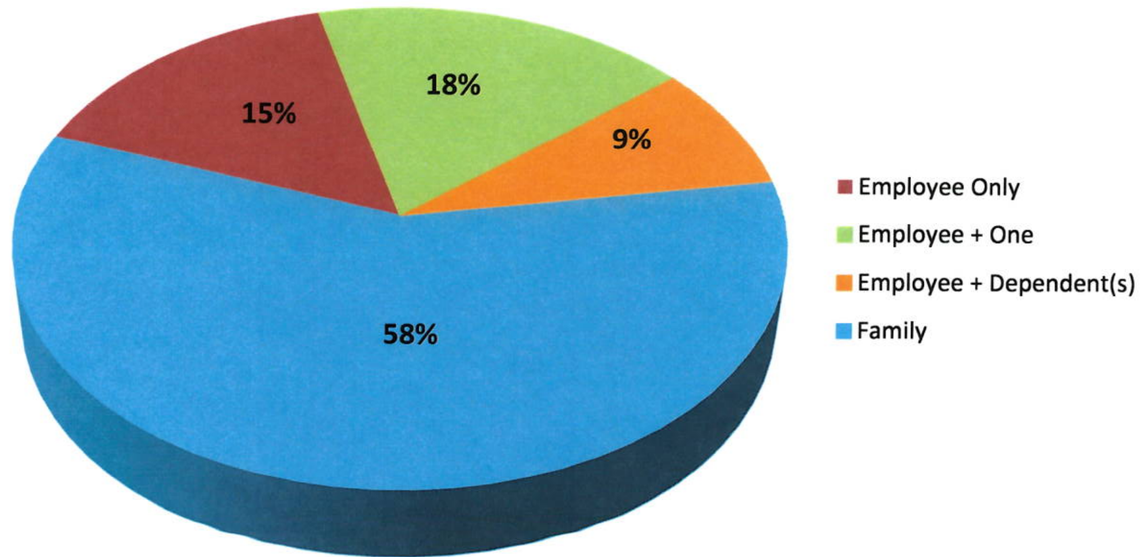
University ancillary members, who are specifically approved for membership by the Board of Regents, also pay the entirety of their premiums without any University contributions. Presently, the National Strategic Research Institute is the primary ancillary member.

Demographically, covered lives were about 51 percent female and 49 percent male. Average age for all covered lives was 35 years which remained stable from 2017.

In terms of covered lives, the average number of members for 2018 decreased ever so slightly from 2017, with slight decreases in the "employee only" and "employee+one" categories offsetting slight increases in the other two categories.

	Average 2018		Average 2017		% Change	
	Members	% of Total	Members	% of Total	Members	%
Employee Only	4,293	15%	4,350	16%	(57)	(1)%
Employee + One	4,940	18	5,004	18	(64)	(1)
Employee + Dependent(s)	2,370	9	2,343	8	27	1
Family	16,075	58	16,021	58	54	0
Totals	27,678	100%	27,718	100%	(40)	(0)%

University of Nebraska
Health Plan Membership by Coverage



The plan offers three levels of medical coverage: low, basic, and high, with each (respectively) offering increasing levels of coverage. The high plan has much lower deductibles and coinsurance but higher premiums compared to the low plan. Enrollments in each of the levels has stayed fairly stable on a historical basis, with about 75 percent of participants choosing the basic plan, 15 percent the low plan, and 10 percent the high plan.

The University of Nebraska's health plan had average annual medical membership of approximately 27,700 covered lives (employees and their family members)

Financial Performance

The University health plan's financial results for the years ended December 31, 2018 and 2017 are shown below (cash basis in thousands). A more detailed description of the plan's income, expenses and calendar year activities is provided in the following sections.

Plan expenses exceeded plan income in 2018, resulting in a $13.3 million decrease in net activity as compared to 2017. This decrease in net activity between years was driven by double digit increases in medical and pharmacy claims in 2018, which more than offset an approximate 6 percent increase in premium revenues in 2018.

An approximate 6 percent increase in medical premium rates in 2018, only the second increase to active employee rates since 2009, was implemented in response to the anticipated continued upward trend in healthcare costs and in accordance with annual actuarial projections. This increase contributed approximately $8 million in additional income for 2018.

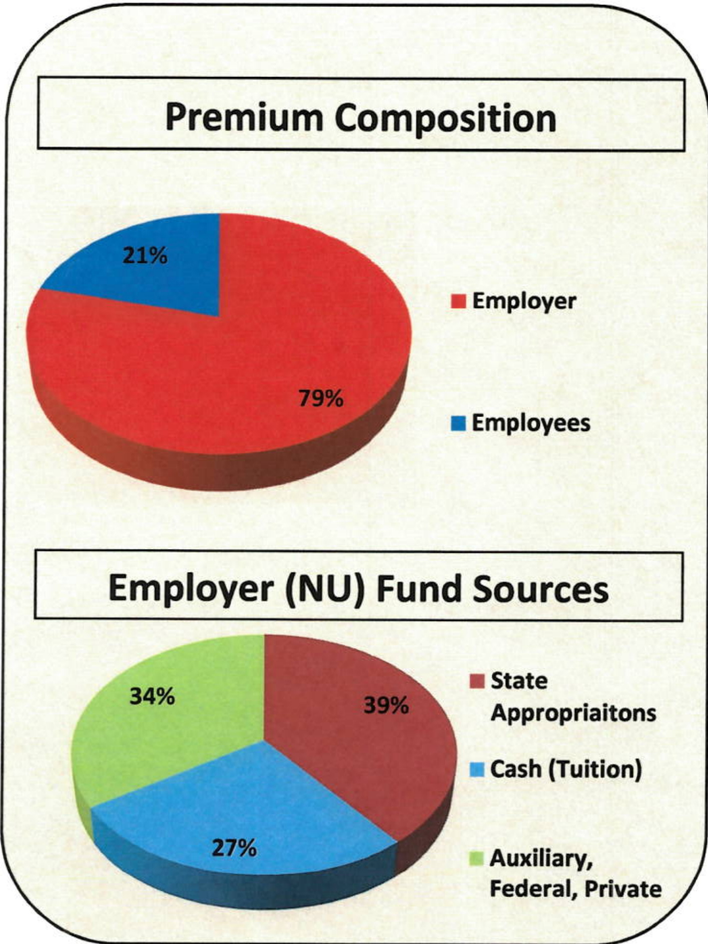
After stable claims experience in 2017, the plan experienced double digit increases in medical and pharmacy claims in 2018, driven primarily by an increase in the costs associated with high cost claimants and specialty prescription costs.

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

	Actual	Actual	Year-over-Year Change	
	2018	2017	Dollars	Percent
Employer Premiums	$ 122,097	$ 115,243	$ 6,854	6%
Employee Premiums	32,656	31,396	1,260	4
Retiree, Ancillary, Cobra Premiums	5,723	5,647	76	1
Trust Investment Income	1,962	1,670	292	17
Pharmacy Rebates/Discounts	8,208	7,647	561	7
Total Premiums and Income	170,646	161,603	9,043	6
Medical Claims	120,664	103,889	16,775	16
Pharmacy Claims	43,042	37,716	5,326	14
Dental Claims	8,483	8,195	288	4
TPA, ACA, and Other Expenses	5,588	5,633	(45)	(1)
Total Claims and Expenses	177,777	155,433	22,344	14%
Net Activity	$ (7,131)	$ 6,170	$ (13,301)	

Income

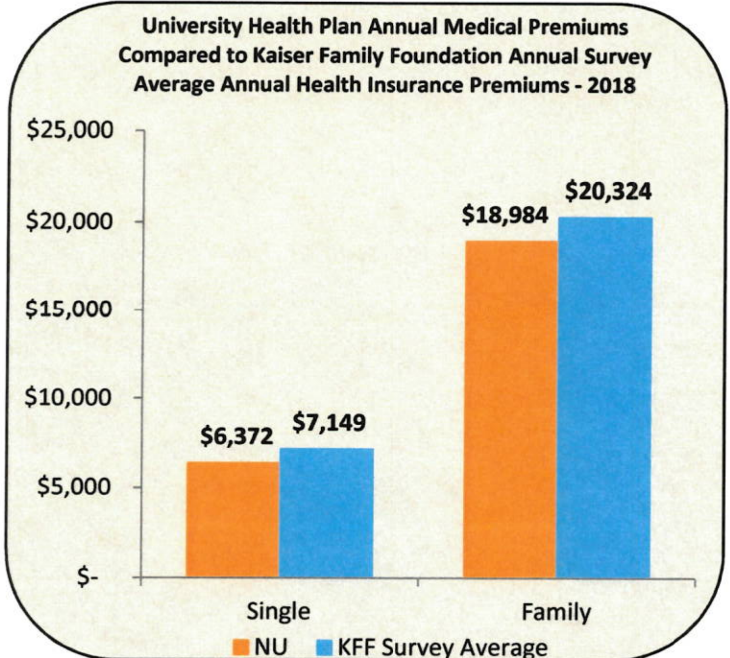
The University's health plan is funded from a variety of sources, although employer and employee premiums account for the bulk (91 percent) of the plan's income. Employer premiums are funded primarily from state appropriations (39 percent), cash funds such as tuition (27 percent), and other self-supporting business-type activities (auxiliaries) and federal grants and contracts (34 percent).



The plan's remaining income comes from retirees, ancillaries, and Cobra electees (3 percent), and investment income and pharmacy rebates/discounts (6 percent).

For the year ended December 31, 2018, the plan's income from employer and employee premiums increased by about 6 percent. This was primarily the result of an approximately 6 percent increase in medical premium rates in 2018.

As pharmacy claims continue to climb, so do pharmacy rebates/discounts, which increased from $7.6 million in 2017 to $8.2 million in 2018. The rebates/discounts are a result of the University's membership in the Employers Health consortium, a buying coalition that offers additional rebates and discounts to the plan based on combined purchasing power.



The University offers a very competitive premium pricing structure. Medical premiums (employer plus employee) under the University's basic coverage plan are lower than the average annual health insurance premiums as reported in the Kaiser Family Foundation Employer Health Benefits 2018 Annual Survey[ii] by approximately 11 percent for single and 7 percent for family coverage.

Expenses

Medical Expenses

The plan's medical claims increased by over 16 percent for the calendar year. Medical claims in 2018 and 2017, arrayed by amount of medical claims per covered lives, were as follows:

University of Nebraska
2018 Claims Distribution (Claims in Thousands)

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

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

University of Nebraska
2017 Claims Distribution (Claims in Thousands)

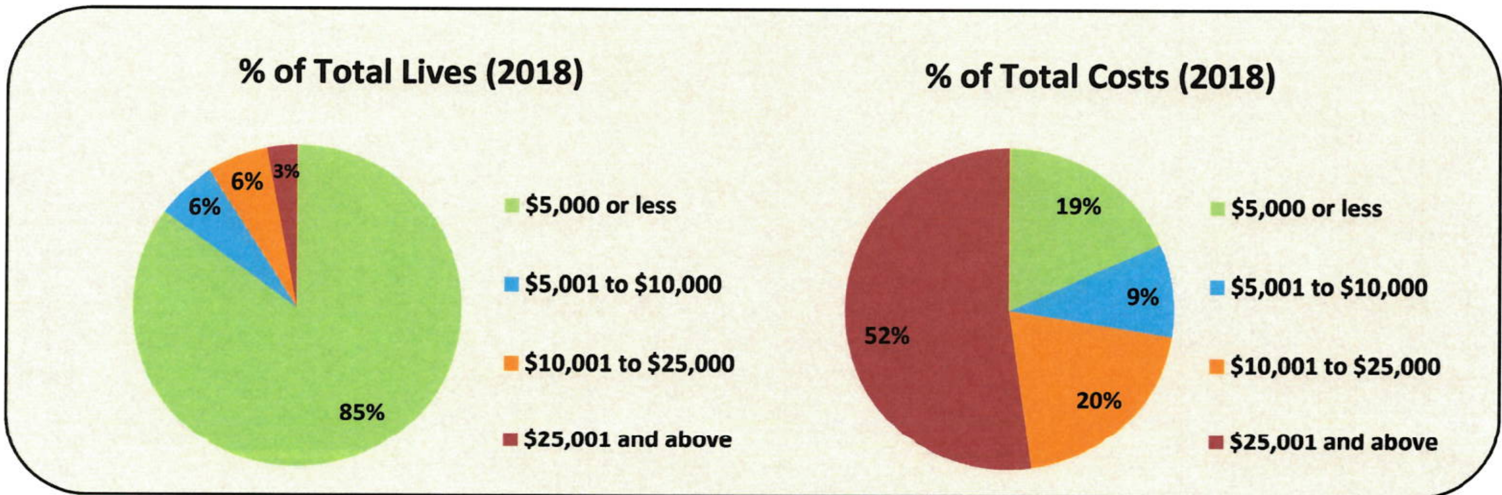
Total Claims/Member	Covered Lives	Percent of Lives	Amount	Percent of Claims $$
$5,000 or less	23,407	86%	$ 20,623	20%
$5,001 to $10,000	1,524	6	10,791	10
$10,001 to $25,000	1,385	5	21,348	21
$25,001 to $50,000	473	2	16,354	16
$50,001 to $100,000	216	1	14,804	14
$100,001 to $250,000	88	0	12,887	13
$250,001 and above	18	0	6,256	6
	27,111	100%	$ 103,063	100%

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

Note that the table above shows medical claims paid by Blue Cross Blue Shield of Nebraska (BCBSNE) during the reporting period and therefore may not be consistent with amounts paid by the trustee.

As is typical in health plans, costs associated with high cost claimants tend to be the main driver of costs. As can be seen in the table above and the charts below, in 2018 (with parentheticals showing 2017 figures):

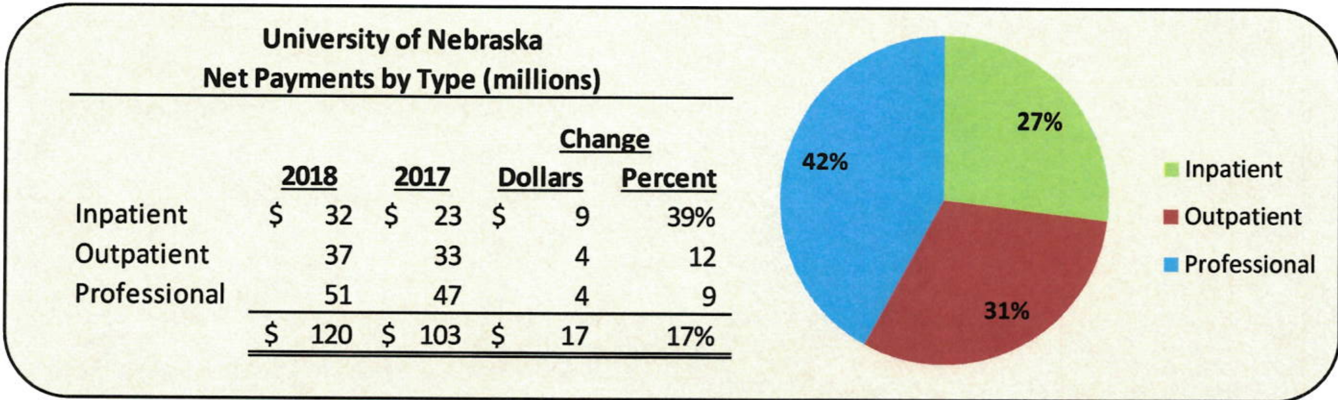
- The top 3 percent of the covered lives accounted for 52 percent (49 percent) of medical costs.
- Covered lives with total claims greater than $10,000 accounted for 72 percent (70 percent) of medical costs.
- Covered lives with total claims greater than $100,000 were the primary driver of the approximately $17 million increase in medical costs in 2018.
- 85 percent (86 percent) of the covered lives had total medical claims of $5,000 or less.



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

Medical costs are comprised of inpatient, outpatient and professional services. Inpatient services represent the costs that come with a hospital/facility stay. Outpatient costs are comprised of procedures that do not require a hospital stay, such as ambulatory surgery, emergency room visits, radiology and dialysis. Professional costs encompass all the services provided by physicians and other clinicians, ancillary services and medical services/supplies.

Net payments by service type as reported by BCBS in 2018 and 2017 were:



University of Nebraska
Net Payments by Type (millions)

			Change	
	2018	**2017**	**Dollars**	**Percent**
Inpatient	$ 32	$ 23	$ 9	39%
Outpatient	37	33	4	12
Professional	51	47	4	9
	$ 120	$ 103	$ 17	17%

Inpatient

Inpatient costs increased 39 percent, to $32 million in 2018 when compared to 2017. The average price paid per admission increased about 30 percent, while the number of admissions increased about 8 percent. The increase in inpatient costs was driven by surgical and medical procedures, which comprised over 75 percent of all inpatient costs.

Outpatient

Outpatient costs rose 12 percent, to $37 million in 2018 when compared to 2017. The cost of a typical outpatient service per member per month was up about 10 percent. While surgical procedures were up slightly, the increase in outpatient costs was driven in large part by other services.

Professional Costs

Professional costs rose 9 percent, to $51 million in 2018 when compared to $47 million in 2017. Member visits increased over 19 percent, while the amount paid per visit decreased about 8 percent. Service types comprising the majority of professional costs include evaluation & management, surgical, medical services & supplies, and medical.

Medical Benchmarking/Statistics

There are several medical benchmarks and statistics worth noting that allow us to compare the plan's current year results to those seen in the industry or provide trend considerations:

- The average age of covered lives under the University's plan was 35 compared to the Blue Cross Blue Shield of Nebraska (BCBSNE) benchmark of 33.
- The average age of the University's employee participant was 47 compared to the BCBSNE benchmark of 44.
- In regard to covered lives with total medical claims exceeding $100,000, the leading diagnostic categories and the percentage of payments for such claims were neoplasms (26 percent), injury and poisoning (10 percent), genitourinary system (8 percent), circulatory system (8 percent), digestive system (7 percent), respiratory system (6 percent), nervous system (6 percent), and mental illness (6 percent).
- Utilization in all categories (inpatient, outpatient and professional) was higher than the BCBSNE benchmark.
- The percentage of the plan's membership that was considered "at risk" (high or very high risk of significant medical claim experience) was up from 17 percent in 2017 to 19 percent in 2018.
- Number of members with at least one chronic disease remained steady at about 25 percent.
- Five of the most prevalent chronic conditions included diabetes, hyperlipidemia, obesity, hypertension, and asthma.
- All three primary cancer screenings (pap test, mammogram, and colorectal screening) were 3 percent to 8 percent above the BCBSNE benchmark.

Pharmacy Expenses

Pharmacy claims are handled through a third-party administrator, CVS Caremark. The University also belongs to the Employers Health consortium, a buying coalition that offers additional rebates and discounts to the plan based on combined purchasing power. Rebates and discounts received in 2018 totaled approximately $8.2 million.

In 2018, pharmacy costs were up 14 percent to about $43 million. Approximately 9,600 members utilized the plan's pharmacy program each month. The average annual net pharmacy cost per utilizing member totaled over $4,400.

The increase in pharmacy costs is primarily attributable to specialty prescription costs, which were 51 percent of total pharmacy costs in 2018 compared to 46 percent in 2017. Specialty prescription costs increased about 25 percent, driven mainly by an increase in utilization, as well as increases due to price inflation and drug mix.

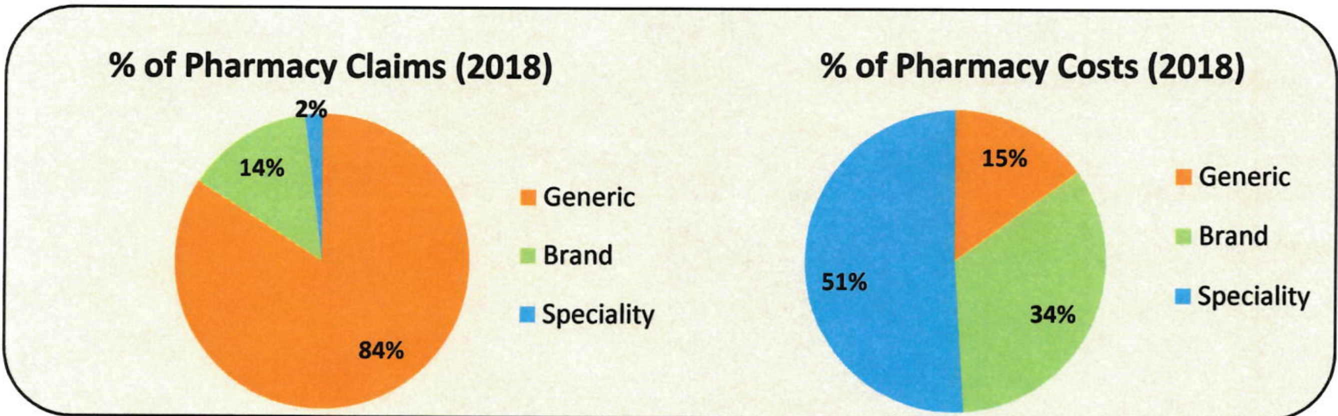
Pharmacy expenditures by category of drugs were as follows for the past two years:

University of Nebraska
Pharmacy Spend/Number of Claims
(Claims Net Cost in thousands)

	Claims Net Cost		Claims Cost as Percent of Total		Total Claims		Percent of Total Claims		Cost Per Claim	
	2018	2017	2018	2017	2018	2017	2018	2017	2018	2017
Generic	$ 6,530	$ 6,931	15%	19%	230,472	233,108	84%	85%	$ 28	$ 30
Brand	14,400	13,163	34	35	39,211	38,592	14	14	367	341
Specialty	21,782	17,395	51	46	4,105	3,711	2	1	5,306	4,687
	$ 42,712	$ 37,489			273,788	275,411				

Note that the table above shows pharmacy claims paid by CVS Caremark during the reporting period and therefore may not be consistent with amounts paid by the trustee.

The importance of generic drugs in controlling costs can be gleaned from the foregoing table and the charts below. While generics represented 84 percent of total prescriptions, they only accounted for 15 percent of pharmacy costs in 2018.



The generic dispensing rate remained strong in 2018 at 84 percent, down slightly from 85 percent in 2017. The University of Nebraska's success in adoption of generics is underscored by the fact that its generic use of therapeutic drugs for analgesics – anti-inflammatory, antineoplastics, dermatologicals, antivirals, and endocrine & metabolic agents exceeded 80 percent in 2018. The difference in prices is dramatic: for new generic launches in 2019 alone, the University's projected savings for 2019 was approximately $700,000.

Conversely, specialty drugs are 2 percent of the plan's prescriptions, but account for 51 percent of the costs in 2018. 6 out of the top 10 prescription drugs used in 2018 were specialty drugs. Primary among the specialty classes are multiple sclerosis, rheumatoid arthritis, oncology, hemophilia, cystic fibrosis, psoriasis, and growth failure. There were 429 users of specialty drugs in 2018, accounting for approximately $51,000 of net cost per user per year.

Reserves and Fund Balances

Reserves are amounts needed to be held in the health trust at Wells Fargo in order to pay health benefit claims. An incurred but not reported ("IBNR") reserve represents claims that have been incurred but have not yet been presented to the health trust and its trustee for payment. A claims fluctuation reserve ("CFR") represents the financial impact if the University were to encounter an unusually high volume of claims or unexpected number of claims that exceeded the claims estimate utilized to establish premium rates for the plan. Each of these reserves is based upon the results of annual actuarial studies performed by Milliman.

Net fund balances are the cumulative amounts of cash left over after expenses are paid and sufficient reserves have been set aside.

Reserves and fund balances are the cornerstone of financial flexibility. Much like a savings account, they are <u>one-time</u> resources that provide the health plan with options for responding to unexpected issues and a buffer against shocks and other forms of risk.

Through a combination of proper pricing, aggressive management of deductibles and copays, prudent planning regarding potential cost increases, and favorable claims experience resulting from staying on the forefront of healthcare trends, the University has accumulated (over several years) fund balances that could be utilized for one-time health related purposes. As of December 31, 2018, the University's health plan had a trust fund balance of approximately $77 million, with a net balance of about $52 million after subtracting estimated reserves. This represents a fund balance equal to about 3.5 months of plan expenses.

As previously mentioned, the plan selected a new third-party administrator for medical insurance claims (UMR, a United Healthcare company) starting January 1, 2019. In December of 2018 and in conjunction with the transition from BlueCross BlueShield of Nebraska to UMR, the plan's trustee transferred $4 million to a separate UMR account to be utilized by UMR to pay medical claims beginning in 2019. UMR bills the plan weekly for medical claims paid so as to replenish this separate account back to $4 million. The $77 million trust fund balance at December 31, 2018 includes the $4 million held in the separate UMR account.

Conclusions and Looking Ahead

The University's trust fund balance decreased in 2018 from approximately $81 million to approximately $77 million. Double digit increases in medical and pharmacy claims more than offset an approximate 6 percent increase in medical premium rates, resulting in the approximately $4 million decrease in the trust fund balance.

Going forward, University management must continue to focus on chronic disease management, including case management and lifestyle behaviors. We also must continue to promote preventive services to our members, given the aging of our workforce, as well as promote the use of urgent care facilities or telehealth.

In terms of pharmacy, the biggest challenge going forward is to control the use of specialty drugs. Potential future pharmacy opportunities include:

- Getting a handle on specialty drugs to assure the drugs match the diagnosis.
- Movement of pharmacy costs out of medical and into the pharmacy pipeline to assure consistent treatment for members.
- Increasing generic pharmacy by mail and creating incentives to do so. While incentivizing is currently contrary to state law, the financial impact of generics when used versus name brands is profound, thus further discussions about the current statute may be warranted.
- Continued focus on step therapies. Under this concept, high-priced drugs are not available without having tried generics first.

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

In 2018 we conducted a competitive Request for Proposals (RFP) for third-party administrators for our medical, dental, and pharmacy insurance claims. Our goal throughout the RFP process was to make certain we had a benefits plan that is both competitive and cost-effective for our employees and their families. In June 2018, and effective January 1, 2019, the University's Board of Regents approved changing the third-party administrator for medical insurance claims from BlueCross BlueShield of Nebraska to UMR (a United Healthcare company) and the third-party administrator for dental insurance claims from BlueCross BlueShield of Nebraska to Ameritas. CVS Caremark will continue as the third-party administrator for pharmacy insurance claims.

We anticipate the dollar savings from these changes will be significant. At the time of the RFP we projected over $10 million in savings, and our year to date experience in 2019 is in line with these projections. The savings from this transition was applied to employee premiums and the University's 2018-19 budget shortfall.

The University of Nebraska is proud of its prudent management of its health plan, which has positioned us to provide competitive, affordable benefits to our employees – our greatest asset – and their families. These are challenging times for healthcare, but we are committed to offering quality health benefits that meet the needs of our employees and help us attract and retain additional talent for Nebraska.

Endnotes and References

[i] Duchon L, Schoen C, Simantov E, Davis K, An C. Listening to Workers: Finding from the Commonwealth Fund 1999 National Survey of Workers" Health Insurance. New York. The Commonwealth Fund; 2000.

[ii] The Kaiser Family Foundation Employer Health Benefits 2018 Annual Survey, https://www.kff.org/health-costs/report/2018-employer-health-benefits-survey