Nebraska Department of Administrative Services

# Health Insurance Plan Annual Report

## Presented to the Legislature's Appropriations Committee

For the Plan Year July 1, 2024 to June 30, 2025

October 31, 2025

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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 public servants during plan year 2024 - 2025, 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 2024 – 2025 through State contributions totaled over $178.2 million and made up 12% of $1.5 billion total rewards portfolio that includes compensation and retirement benefits. The Health Fund provides medical and prescription drug benefits to approximately 13,640 eligible public servants and their family members, covering 28,300 lives overall.

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

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

During plan year 2024 - 2025, there were significant steps taken to achieve these goals:

- 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 public servants enrolled in the Wellness plan.
- Over the past year DAS chose to prioritize giving value to the public servants by keeping contribution rate increases below market level and maintain benefit levels.

The State of Nebraska can be proud that we are administering a high performing health care benefit program that is providing excellent benefits and supporting our public servants and their families at their moments of greatest needs.

Lee Will
Director, Nebraska Department of Administrative Services,
Chief Operations Officer

Sean Davis,
State Personnel Director

## Plan Design

The State of Nebraska's health insurance program in 2024 – 2025 consisted of three self-insured health plans, the Regular Plan, the WellNebraska Plan, and the Consumer-Focused Health Plan (CFHP). Each plan included medical and prescription drug coverage for in-network and out-of-network providers, as well as wellness benefits.

**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 may be inflated to include profit margins and taxes, the State collects contributions from employees and State agencies itself and deposits them in a State trust fund, using the premiums to pay health care claims for plan participants after copays and deductibles.

There are no prerequisites or requirements for public servants to participate in the Regular Plan or CFHP. To enroll in the WellNebraska/Wellness Plan for the 2024-2025 plan year, public servants and spouses were required to complete and submit an annual health survey. All public servants are eligible to enroll in this plan, however, those who have completed the health survey will benefit from incentives such as 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 CFHP provides an option for public servants to take advantage of a Health Savings Account (HSA) to set aside pre-tax funds for future health care expenses.

The plan year ran from July 1, 2024 through June 30, 2025 with open enrollment held May 7, 2024 through May 21, 2024. All public servants 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.

## Plan Design Changes

Effective July 1, 2024 the State has implemented the following changes to the design of health plans:

Two Direct Primary Care plans offered during plan years 2020-2024 were eliminated effective July 1, 2025. These plans had limited enrollment.

The deductible for CFHP increased from $3,000 to $3,200 in order to comply with minimum deductible requirement for HSA qualified plans. There was no corresponding increase to out of pocket maximum, or family deductible.

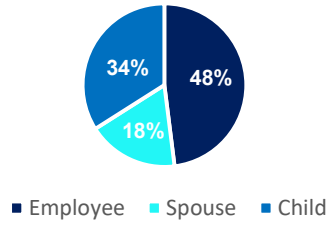
The summary of plan designs is shown in the table below:

| | Regular | Wellness | Consumer Focused |
|---|---|---|---|
| **Medical Benefits** | | | |
| Deductible *(Individual / Family)* | $1,400 / $2,600 | $800 / $1,600 | $3,200 / $5,200 |
| Coinsurance (EE) | 20% | 20% | 20% |
| PCP / Specialist | $35 / $40 | $25 / $40 | Deductible & Coinsurance |
| Maternity | Deductible & Coinsurance | $0 | Deductible & Coinsurance |
| OOP Maximum *(Individual / Family)* | $4,000 / $8,000 | $2,700 / $5,400 | $4,100 / $8,200 |
| **Prescription Drug Benefits** | | | |
| Tier 1 | $5 | $5 | 20% after Deductible |
| Tier 2 | $40 | $30 | |
| Tier 3 | $60 | $50 | |
| OOP Maximum | $2,250 / $4,500 | $2,000 / $4,000 | Combined with Medical |

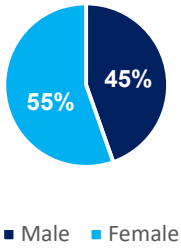
## Enrollment and Eligibility

Neb. Rev. Stats. §84-1601 and §84-1604 allow for permanent full-time and part-time public servants who work a minimum of 20 hours per week to participate in the State's health plans. Such public servants 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 public servants 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 16.010; and the NAPE/AFSCME (NAPE) and State of Nebraska Labor Contract, Article 13.2.

**Enrollment by Relationship**




**Enrollment by Gender**




Per the charts above, the plan averaged 13,638 public servants enrolled in the 2025 plan year, which included approximately 129 retirees and 38 COBRA participants.

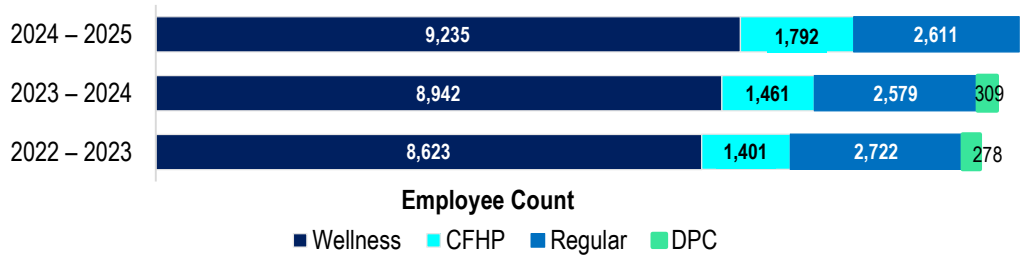
The total number of covered lives in the Health Fund, including spouses and dependents, was 28,266, which increased 2.5% from the 2023 – 2024 plan year.

Approximately 55.4% of public servants were female and 44.6% were male. The average age of members enrolled was 34.8, down slightly from last year's average of 35.1.

During plan year 2024-2025 Regular Plan, Wellness, and CFHP, all saw increases in their respective membership. The CFHP had the biggest increase in membership, percentage wise, with an increase of 23%. The Wellness and Regular plans had enrollment increases of 3% and 1% respectively.

Plan migration and enrollment by plan for the last three plan years are shown in the graph below:

**Plan Migration Analysis – Enrollment by Plan**



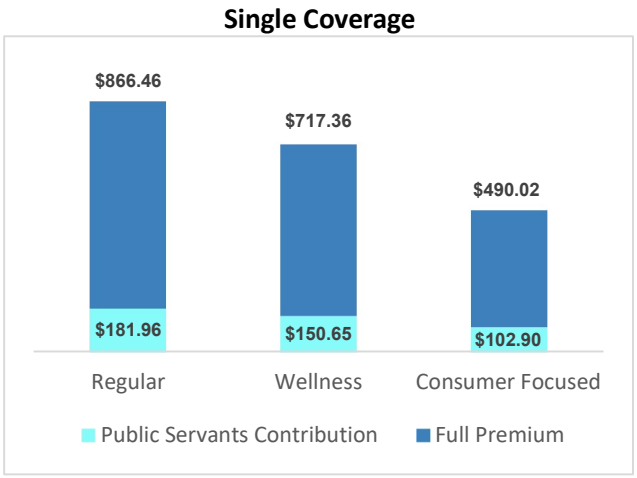
## Plan Premiums and Contributions

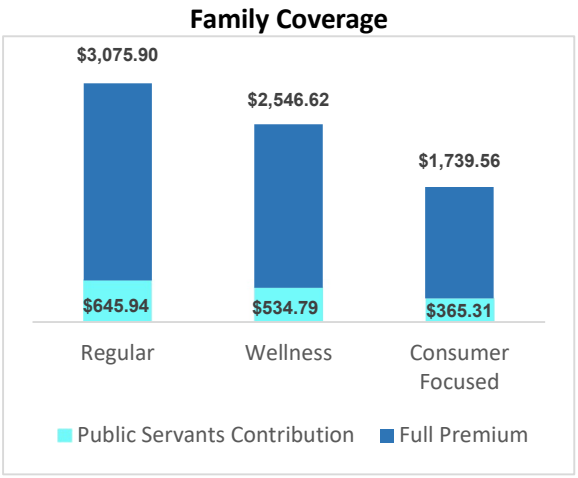
The State Employees Insurance Fund #68960 is funded by health plan contributions from participants and the State. Contributions are collected from public servants through payroll deductions and combined with State contributions.

In accordance with Neb. Rev. Stat. §84-1611, the State pays 79% of monthly rates and active, full-time public servants pay 21%. Neb. Rev. Stat. §84-1604 requires part-time public servants (20-29 hours a week) receive only a proportion of the State contribution. Part-time public servants 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. Monthly premium rates for all State health plans are determined by reviewing actual claims history, projected enrollment, and projected health plan costs. Each health plan is analyzed individually for plan design and plan usage. However, the rate changes are uniform, which helps to reduce year-to-year rate fluctuation and maintain plan relativities. A uniform rate increase of 4% was adopted for plan year 2024 - 2025. The increase is set below market level that ran closer to 8%.

In November 2023, 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. Contribution rates were approved in February 2024 and communicated to public servants in April 2024, prior to Open Enrollment.

**Premium Rates for Single and Family Coverage for Plan Year 2024 – 2025**



## Plan Management and Fund Management

DAS assures the State's health plans and all other benefit 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 Third Party Administrator (TPA) as well as PBM (Pharmacy Benefit Manager), 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<br>• Department of Insurance<br>• ACA<br>• IRS<br>• COBRA<br>• HIPAA<br>• Medicare<br>• Employment Laws - FMLA, USERRA, ADA, Title VII, GINA<br>• No Surprises Act<br>• Transparency in Coverage | • Summary Plan Document (SPD)<br>• Summary of Benefits & Coverage (SBC)<br>• Section 125 Plan Document<br>• Business Associate Agreements<br>• Benefits Administration Manual for State HR Partners<br>• Wellness & Benefits Options Guide<br>• 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 28,300 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 2024 – 2025 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 2025, the State paid $71,913 for the PCORI fee for the plan year ending June 30, 2024.

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 help determine reserve levels.

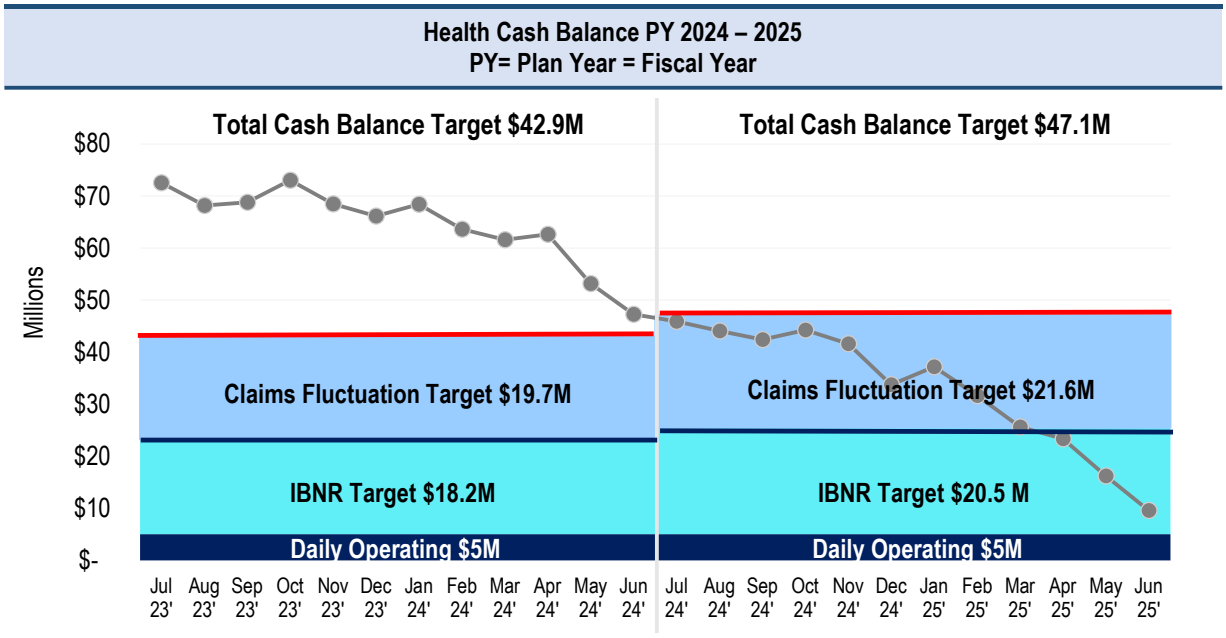
The Total Cash Balance Target includes three different pieces:

- Claims Fluctuation Reserve calculated by Segal based on a 90% confidence interval.
- Incurred But Not Paid Reserve set at 7% of actual claims.
- Daily Operating Target of $5 Million.

The Fund Balance grew well above Cash Balance Target between plan years 2018-2019 and 2022-2023 due to favorable experience, slowed down demand for elective services during the pandemic and reimbursements received from the Coronavirus Relief Fund. In order to bring the Fund Balance closer to the Target, DAS implemented plan design improvements, premium holidays, special programs and kept contribution rate increases well below market level. During the second half of plan year 2023-2024, the impact of these enhancements has been exacerbated by an influx of catastrophic claims and high pharmacy trends.

At the beginning of plan year 2024-2025, the Fund Balance came close to the Target that was set at $47.1 million and continued to decline at a fast pace driven by increased utilization and growing costs of medical care and prescription drugs. Rate increases adopted for plan year 2024-2025 were insufficient in realigning revenue with emerging expenses. This drove the Fund Balance to a dangerously low level by the end of the year.

The Cash Balance Target and actual monthly cash balance for plan years 2023 - 2024 and 2024 – 2025 are shown in the table below:



A summary of financial activities in State Employees Insurance Fund #68960 for the plan years ending June 30, 2024, and June 30, 2025, respectively, are shown below.

**State of Nebraska Health Insurance Fund**
**Summary of State Employees Insurance Fund #68960 Activity**
**Comparison of Plan Years Ending June 30, 2024 and 2025**

| | Plan Year | | | |
|---|---|---|---|---|
| | **2024 – 2025** | **2023 – 2024** | **$ Change** | **% Change** |
| **Revenue** | | | | |
| Contributions | $227,341,641 | $213,465,941 | $13,875,700 | 7% |
| Pharmacy Rebates | $32,218,241 | $31,441,067 | $777,174 | 2% |
| Investment Income | $589,765 | $1,220,637 | $(630,872) | -52% |
| **Total Revenue** | **$260,149,647** | **$246,127,645** | **$14,022,002** | **6%** |
| **Distributions** | | | | |
| Medical Claims & IBNP | $210,310,300 | $190,766,637 | $19,543,663 | 10% |
| Pharmacy Claims | $82,737,913 | $69,719,877 | $13,018,036 | 19% |
| Administration Fees | $5,759,640 | $5,914,117 | $(154,477) | -3% |
| Flex/HSA $500 Cont | $(4,500) | $1,386,643 | $(1,391,143) | -100% |
| Wellness Reimbursement | $0 | $243,579 | $(243,579) | -100% |
| **Total Distributions** | **$298,803,353** | **$268,030,853** | **$30,772,500** | **11%** |
| **Fund Net Increase/(Decrease)** | **$(38,653,706)** | **$(21,903,208)** | | |

**State of Nebraska Health Insurance Funds**
**as of June 30, 2025 and 2024**

| | **6/30/2025** | **6/30/2024** | **$ Change** | **% Change** |
|---|---|---|---|---|
| State Employees Insurance Fund #68960 | $6,545,682 | $27,062,166 | $(20,516,304) | -76% |
| Health Insurance History Fund #68922 | $3,001,282 | $20,168,691 | $(17,167,408) | -85% |
| **Total Reserve Fund Balance** | **$9,547,145** | **$47,230,857** | **$(37,683,712)** | **-80%** |

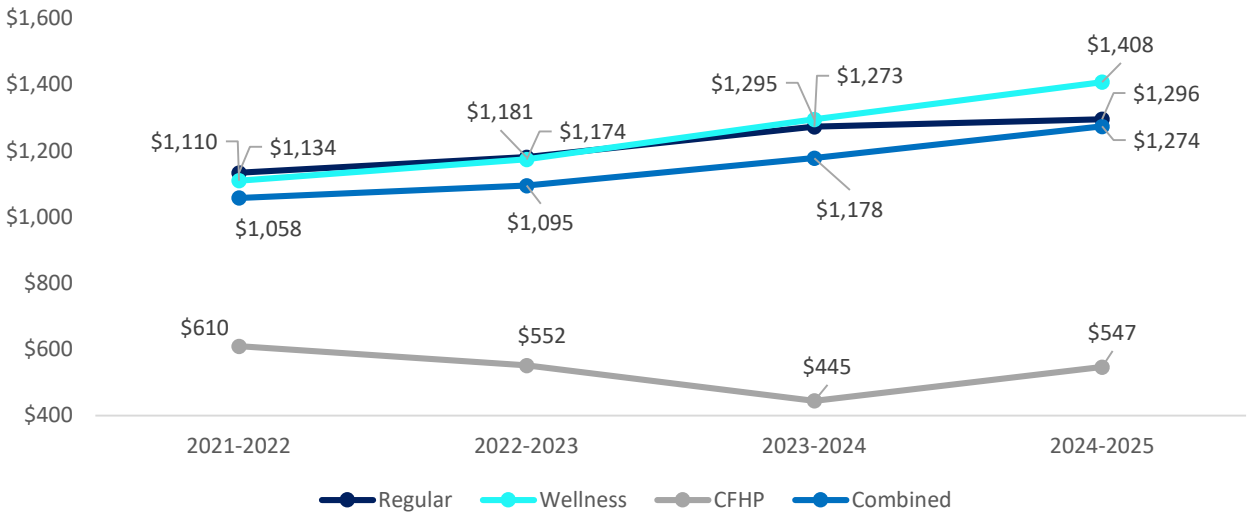
## Medical Claims Review

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 has paid $210 Million in reported medical claims in fiscal year 2024 – 2025. This amount includes $190 Million for claims that were incurred and paid during plan year 2024-2025, as well as $20 Million for claims that were incurred during plan year 2023-2024 but paid in the following year.

Total amount of medical claims grew by approximately 10.2% from the prior year driven by an increase in enrollment of 2.5% and a surging cost of care. The illustration below captures the net paid Per Employee Per Month (PEPM) for claims paid during the last four plan years:

**Paid Medical Claims PEPM**




The Wellness Plan has the highest per capita cost due to its rich plan design. Keeping cost sharing provisions level while costs grow means that the State Fund covers a larger and larger percentage of overall expenses every year.

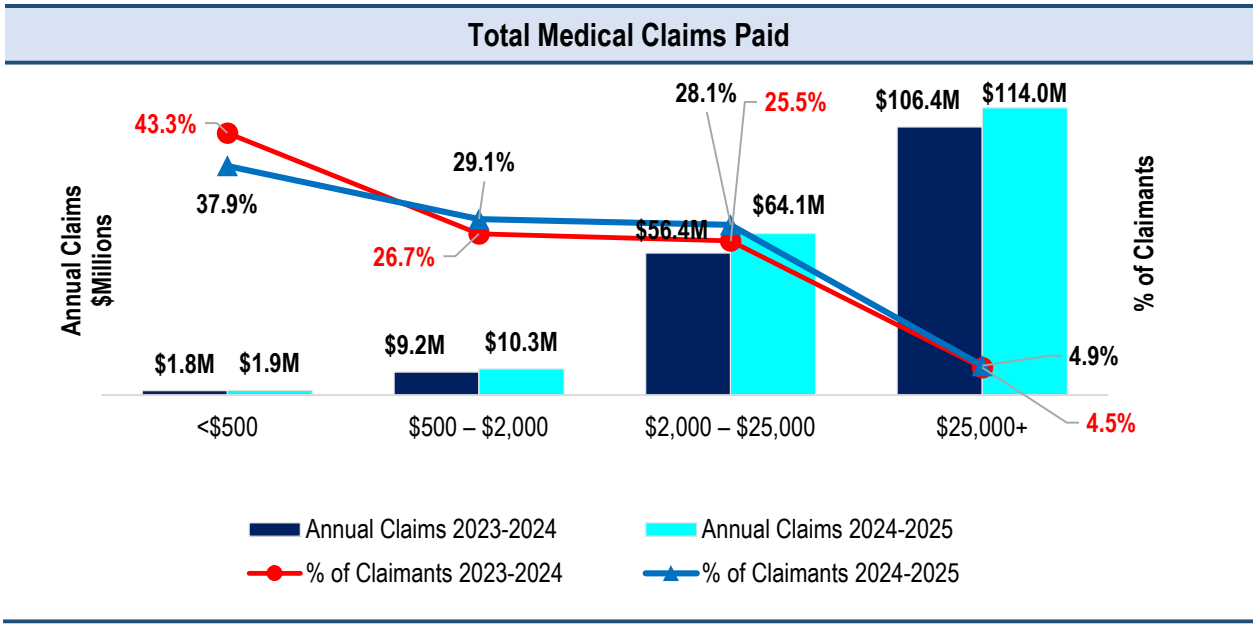
On the other hand, the Consumer Focused Health Plan has the lowest per capita cost due to higher member cost-sharing and lower risk profile of the plan population.

On a paid basis, the combined PEPM of $1,274 for medical claims paid for all three plans between July 1, 2024 and June 30, 2025 is 8.1% higher than the PEPM cost from the same time period for plan year 2023 - 2024. On the incurred basis, year-to-year PEPM increase amounted to 6.7% according to UHC's report.

Consistent with 2023 – 2024, treatment for musculoskeletal conditions, circulatory systems, and neoplasms (cancer) were the top cost drivers of medical claims. Combined, these three diagnoses drove 30% of total medical claims.

A small percentage of participants incurred a high proportion of the total medical claims paid. As illustrated by the graph below, 4.9% of the plan's total population was responsible for $114.0 million in claims, which is more than a half of total amount paid in the 2024-2025 plan year.

Medical cost inflation continues to push expenses from lower to higher brackets. As services became more expensive, the plan population with claims between $0 and $500 declined from 43.3% in the prior year to 37.9% in 2024-2025. Conversely, the percentage of claimants with claims in $500 - $2,000 and $2,000 - $25,000 brackets grew by 2.4% and 2.6%, respectively.




Note that this analysis only includes claims that were incurred and paid during plan year 2024-2025 and amounted to approximately $190 million.

## Pharmacy Claims Review

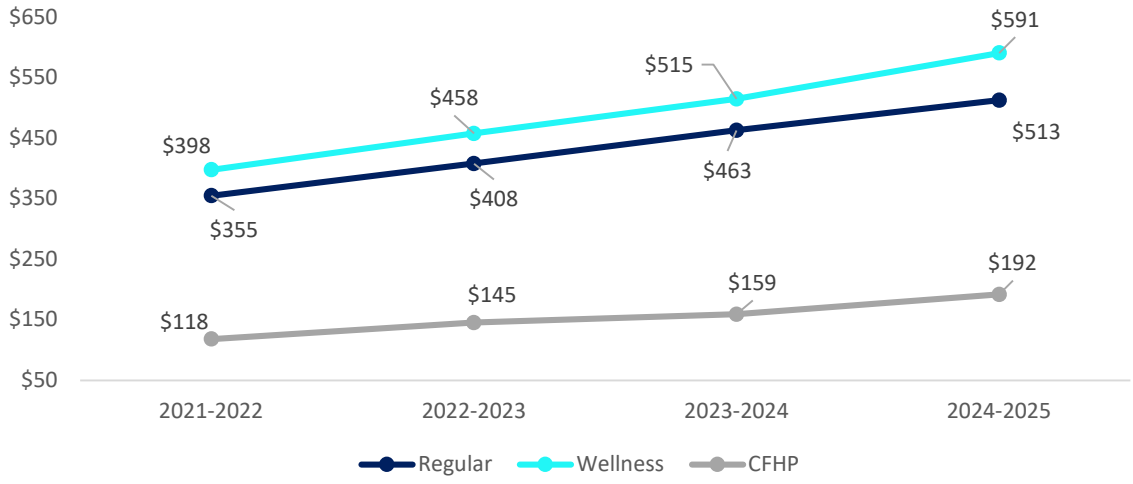
Pharmacy claims were administered by OptumRx, an affiliate of UHC, and the plan's Pharmacy Benefit Manager (PBM). The plan paid about $82.7 Million of prescription drug claims in 2024 – 2025, an 18.7% increase from the previous year. This increase is above the projected cost trend of 10.0%. Due to a slight increase in enrollment, the overall increase on the aggregate PEPM for Pharmacy is around 14.7% on a paid basis and 16.1% when calculated on an incurred basis.

**What are specialty drugs?**
Specialty drugs are high-cost prescription medications that are used to treat complex, chronic, or rare health conditions. They are often biologics, which are drugs derived from living cells, and can be injectable, infused, or oral.

The use of specialty drugs is a growing cost trend that continues to put pressure on the State's finances. During plan year 2024-2025 specialty drugs were responsible for 46.2% of overall pharmacy spend. Their overall cost amounted to $39.9 Million, that is $7.9 Million or 24.8% higher than the previous plan year.

The chart below illustrates the paid PEPM pharmacy claims by plan. The combined graph of PEPM costs of all three plans is very similar to the graph of Regular plan costs.

**Paid Pharmacy Claims PEPM**




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

Roughly 24,500 participants utilized pharmacy benefits in the health plan, filling about 369,400 prescriptions. The average cost per prescription of $234.19 for the State was a 13.1% increase from the $207.07 paid in the prior year. On average, each member filled 13.07 prescriptions annually. This is a 2.7% increase from last year's average of 12.73 prescriptions filled annually. The average prescription drug cost per member to the State was $255.10, a 16.2% increase from $219.59 last year.

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 public servants and the plan.

| | 2024 – 2025 | 2023 – 2024 | % Change |
|---|---|---|---|
| Annual Scripts per Member | 13.07 | 12.73 | 2.7% |
| Generic Utilization | 84.3% | 83.9% | 0.5% |
| Average Cost per Member | $255.10 | $219.59 | 16.2% |
| Specialty Cost per Member | $117.79 | $96.68 | 21.8% |
| Non-Specialty Cost per Member | $137.31 | $122.91 | 11.7% |
| Employee Cost Share | 4.6% | 4.9% | -5.8% |

## Catastrophic Cases

A catastrophic case is defined as a situation when claims incurred by a single member during the course of the year exceed a certain threshold. The State of Nebraska historically considered $75,000 a catastrophic threshold.

Due to their large size, catastrophic cases have significant impact on the claim experience.

The table below shows number and amount of claims that exceeded catastrophic threshold of $75,000 for plan years 2022-2023 through 2024-2025.

| | 2024 – 2025 | 2023 – 2024 | 2022 – 2023 |
|---|---|---|---|
| Number of Claimants over $75K | 761 | 655 | 594 |
| Total Amount of Claims over $75K | $116,858,128 | $104,863,174 | $91,469,016 |
| Average Claim Size | $153,559 | $160,096 | $153,988 |

Both quantity and size of catastrophic claims increased in plan year 2024, putting additional pressure on the State's finances.

The number of claims continued to climb in plan year 2025, although the average claim size shrank. During plan year 2024 -2025, total claim volume in catastrophic category increased by 11.4% compared to plan year 2023-2024.

Medical cost inflation is a big driver of catastrophic case count, as it pushes more claimants over the threshold by increasing the cost of each service they use. Therefore, it makes sense to increase the catastrophic threshold every few years to make sure only true catastrophic cases are included in the analysis.

If medical trends accumulated over the last ten years were accounted for, the catastrophic threshold of $75,000 in 2015 would be equivalent to $150,000 today. The following table represents the catastrophic case experience during the last three plan years under the $150,000 threshold:

| | 2024 – 2025 | 2023 – 2024 | 2022 – 2023 |
|---|---|---|---|
| Number of Claimants over $150K | 235 | 220 | 181 |
| Total Amount of Claims over $150K | $63,037,015 | $60,804,369 | $49,854,199 |
| Average Claim Size | $268,243 | $276,383 | $ 275,438 |

The number of catastrophic cases increased by 22% in plan year 2023-2024 with a corresponding increase in total claim volume. Plan year 2024-2025 saw only a small increase of 15 new cases, which is equivalent to 7%, with average claim size declining by 3%, and total amount paid only growing by 4%.

# Special Programs

## Maternity

On July 1, 2020, the State offered enhanced maternity benefits to the participants enrolled in the Wellness plan.

Initially all medically necessary outpatient maternity related services were covered at 100%. In-network inpatient medically necessary hospital charges that are maternity related, including inpatient well baby nursery, had a $500 copay and then were paid at 100% of eligible charges. The benefit was primarily aimed at reducing childbirth-related medical expenses for State public servants. 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.

At the beginning of plan year 2023 – 2024 the decision was made to further improve the program by eliminating the $500 copay, and making all maternity-related care free to Wellness plan participants.

During this plan year (the fifth year of the program), 333 babies were born to plan participants.

## Tri-Care Stipend

A Tri-Care Stipend was offered by the State at the first-time during plan year 2023-2024 Open Enrollment Period.

The program allows public servants who are eligible for Tri-Care benefits through prior military service to elect receiving a stipend that would cover their Tri-Care premium in lieu of the State's health benefits. Electing this option completely eliminates healthcare-related expenses for eligible public servants.

During plan year 2024 - 2025 (the second year of the program), 73 public servants elected to receive the Tri-Care stipend.

## Real Appeal

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 4,988 members enrolled in the program, with 87% of enrollees deemed at risk of diabetes, cardiovascular disease, or other weight-related health conditions. Approximately 36.3% of participants have lost weight after 16 weeks on the program with average reported weight loss amounting to 2.1% of body weight per person.

According to the Real Appeal report with data through June 30, 2025, the program scored a 4.77 out of 5 satisfaction rating in a national survey of 23,628 participants.

## Looking Ahead

Despite difficult financial circumstances, the State continues to focus on providing public servants with a quality health insurance program integrated with a focus on wellness and disease prevention.

| 2025 – 2026 Contribution Increases | |
|---|---|
| WellNebraska (wellness track) | 11.0% |
| Regular Health Plan | 8.0% |
| Consumer-Focused Health Plan | 8.0% |

Segal provided the State with actuarial cost projections for the 2025– 2026 plan year. Costs were impacted by underlying healthcare trends, fixed fee contracts, and demographic changes. Given the condition of the Fund, the State chose to align rate increases with market trends for the 2025-2026 plan year. The Wellness Plan got the highest rate increase due to a large gap between its expenses and revenue.

In addition, State added a surcharge of 18.5% to the employer portion of the premium in 2025-2026. This was necessary to bolster revenue enough to keep the fund solvent.

In an effort to stay competitive with best in class market terms, the State conducted a procurement for a new medical plan administrator as well as a pharmacy benefit manager. New contracts are expected to go into effect on July 1, 2026.

No plan design changes were implemented for plan year 2024-2025 except for an increase in the deductible for CFHP from $3,200 to $3,300. The increase was necessary to comply with the minimum deductible requirement for HSA qualified plans. There was no corresponding increase to the out-of-pocket maximum, or family deductible. However, future changes to plan design are likely to be in order to bring the Fund back to a sound financial position.

The State is continually reaching out to UHC, Segal and others to identify, analyze and provide the best features and options for public servants 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 public servants 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.