Attachment C

State of Nebraska

Health Insurance Plan

Annual Report

Presented to the

Legislature's Appropriations Committee

November 2015

For the Plan Year

July 1, 2014 to June 30, 2015

Prepared by

State of Nebraska

Department of Administrative Services

NEBRASKA
AdministrativeServices

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.

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.

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Health Plan Overview

For 2014-2015, the State of Nebraska's health insurance program consisted of four (4) self-insured health plans that included the Wellness Plan, Regular Plan, Consumer Focused Plan and High Deductible Plan. The Consumer-Focused Health Plan was added to provide an option for employees to take advantage of Health Savings Accounts to set aside pre-tax funds for future health care expenses.

The Choice Health Plan was no longer offered after June 30, 2014. The State also notified employees the High Deduction Health Plan would be discontinued on June 30, 2015.

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, 2014 through June 30, 2015 with open enrollment running from May 13, 2014 – May 27, 2014. 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. There were no prerequisites or requirements for employees to participate in the Consumer Focused Plan, Regular Plan or High Deductible Plan. To enroll in the Wellness Health Plan, employees and spouses were required to completed specific programs in the wellNEssoptions program, the requirements include (1) Complete an annual biometric health screening; (2) Complete the annual online health assessment; and (3) Enroll and complete a Wellness Program.

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 2014-2015 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.

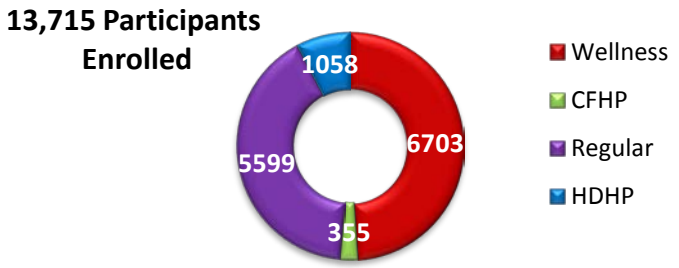
What does Self-Insured mean?

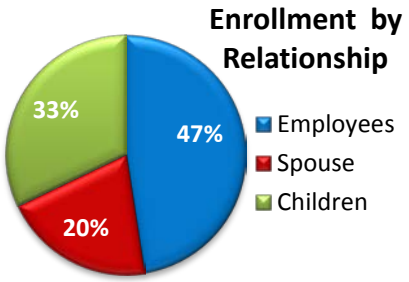
The State assumes the financial risk for providing health care benefits to its employees and contracts with United Healthcare (UHC) to process the claims. Instead of paying fixed premiums to UHC, which are inflated to include profit margins and taxes, the State collects contributions from employees and 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 standard 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.

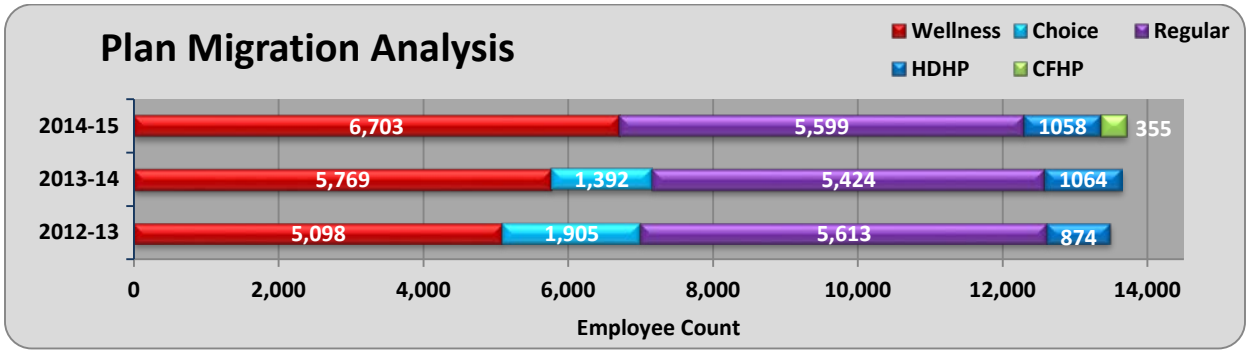
As of June 30, 2015, the plan had 13,715 employees enrolled, which included about 277 retirees and 62 COBRA participants. The total number of covered lives was 28,897 which increased .5% from 2013-2014 plan year. Ongoing dependent verification audits were conducted for all new dependents added to the health plan.





Approximately 56% of employees were female and 44% were male. The average age of employees enrolled in the plan was 47.4, slightly lower than prior year's average of 47.6.

Total enrollment in the State Health Insurance Plan over the past two years has increased 1.7%, potentially due to the impact from the ACA requirement that everyone have healthcare. Individual plan enrollments have changed significantly. Since the Choice plan was eliminated, employees have migrated to the Regular, Wellness or High Deductible plan. The Wellness plan had 49% of the employees enrolled in a health plan during the 2014-2015 plan year, which reflects the importance of the wellness program.



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.

Regulatory Mandates

- State Statutes
- Department of Insurance
- PPACA
- IRS
- COBRA
- HIPAA
- Medicare
- Employment Laws - FMLA, USERRA, ADA, Title VII, GINA

Health Plan Documents

- Summary Plan Document (SPD)
- Summary of Benefits & Coverage (SBC)
- Section 125 Plan Document
- Business Associate Agreements
- Benefits Administration Manual for State HR Partners
- Wellness & Benefits Options Guide
- Wellness & Benefits Website

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 2014-2015 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.

During the 2014-2015 plan, the first payment of the Transitional Reinsurance Fee, required under the PPACA, was made. For the calendar year 2014, the fee was $63 per participant, or approximately $1.5M. The first installment of $1.25M was paid in January, 2015. The second installment will be paid in November, 2015. For the calendar year 2015, the fee will be reduced to $44 per participant.

Another new fee required under PPACA is the PCORI (Patient-Centered Outcomes Research Institute) fee. This fee will be paid every July. In July 2014 the State paid $23,500 for PCORI and in July 2015 the fee increased to $47,300.

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.

Each year during renewal, the State analyzes whether or not to continue purchasing Stop Loss Insurance. The State looked at claims for the State and industry health care. Based on the growing frequency of high cost claimants who exceed $100,000 and health care cost trends, the State decided to continue Stop Loss insurance for 2014-2015 plan year.

In 2014-2015 one participant exceeded $2 million in claims and eight additional participants exceeded $500,000. This illustrates the continuing trend of high cost claimants. In 2013-2014, only four claimants exceeded $500,000 in claims. The State recovered $1,642,000 in stop loss insurance payments and paid $653,000 in stop loss premiums.

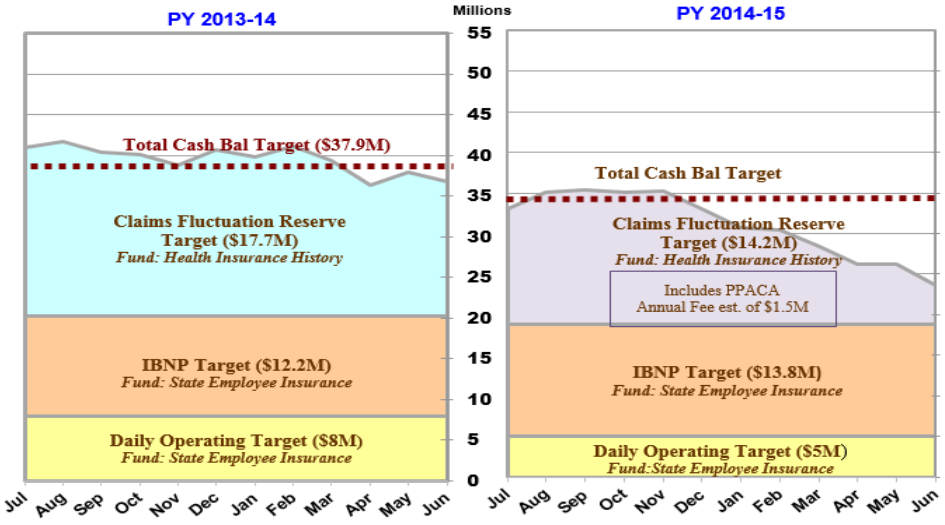
During 2014-15, DAS conducted three audits of the State's 2013-14 health plan. DAS contracted with AON Hewitt to conduct a medical claims audit. DAS contracted with Myers & Stauffer to complete a pharmacy claims audit which also included rebates, customer service, and appeals. Myers & Stauffer also completed a UHC customer service audit. DAS has shared outcomes and recommendations from these audits with our vendors to assure accuracy of claims processing and an improved customer service for our participants.

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 plan year 2014-2015, Aon Hewitt recommended a CFR of at least $14.2 million and IBNP of $13.8 million. In accordance, the State established a CFR targeted balance of $14.2 million in Health Insurance History Fund and a targeted balance of $18.8 million in the State Employees Insurance Fund #68960 which included a Daily Operating Target of $5 million to cover daily expenses and IBNP of $13.8 million to cover claims run out from the prior plan year. The Cash Balance Target was reduced from $37.9 million to $34.5 million as recommended by AON Hewitt.

A summary of financial activities in State Employees Insurance Fund #68960 for the plan years ending June 30, 2014 and June 30, 2015 are shown on the following page.

PY 2013-14 vs. PY 2014-15
Health Cash Balance*
PY = Plan Year = Fiscal Year



State of Nebraska Health Insurance Fund Summary of State Employees Insurance Fund #68960 Activity Comparison of Plan Years Ending June 30, 2014 and 2015				
	Plan Year 2014-2015	Plan Year 2013-2014	Change	
Contributions			Dollars	Percent
Contributions	$167,392,946	$160,848,652	$6,544,294	4%
Investment Income	$331,073	$330,572	$501	0%
Total Contributions	$167,724,019	$161,179,214	$6,544,795	4%
Distributions				
Medical Claims & IBNR	$131,211,499	$124,130,373	$7,081,126	5%
Pharmacy Claims	$37,971,608	$33,098,022	$4,873,586	13%
Wellness-Health Fitness	*$2,885,150	$2,042,507	$842,643	29%
Administration Fees	$8,390,622	**$6,912,538	$1,478,084	18%
Total Distributions	$180,458,879	$166,183,440	$14,275,439	8%
Net Difference	**-$12,734,859**	**-$5,004,227**		

***2014-2015 Wellness-Health Fitness fees included carry over from prior year.**

****2013-2014 Administration Fee were lower due to performance guarantees.**

State of Nebraska Health Insurance Funds As of June 30, 2015				
	6/30/2015	6/30/2014	$ Change	% Change
State Employees Insurance Fund #68960	$9,675,057	$17,793,411	-$8,118,354	-46%
Health Insurance History Fund #68922	$14,499,927	$18,922,188	-$4,422,261	-23%
Total Reserves	**$24,174,984**	**$36,715,599**	**-$12,540,615**	**-34%**

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

2014-15 contributions included a $5.2 million subsidy from reserves.

Health Plan Contributions

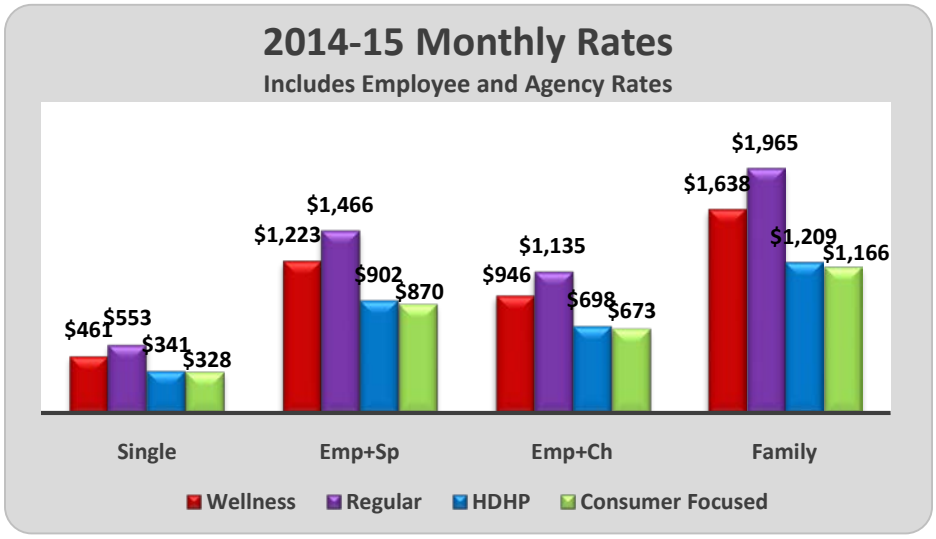
The State Employees Insurance Fund #68960 is funded by health plan contributions from participants and the State. Contributions are collected from employees through payroll deductions and combined with State contributions.

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. In December 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. Contributions and plan design changes were approved in February 2014 and communicated to employees in April 2014, prior to Open Enrollment, and implemented on July 1, 2015.

Contributions to the plan increased from $161 million to $168 million.

Monthly rates for all State health plans are determined by actual claims history, projected enrollment, and projected health plan costs. Each health plan is adjusted individually for plan design and experience 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 projected cost increases for 2014-2015 were offset by a $5.2 million premium subsidy.



2014-15 Rate Increases

Wellness – 9.6%

HDHP – 9.7%

Regular – 10.8%

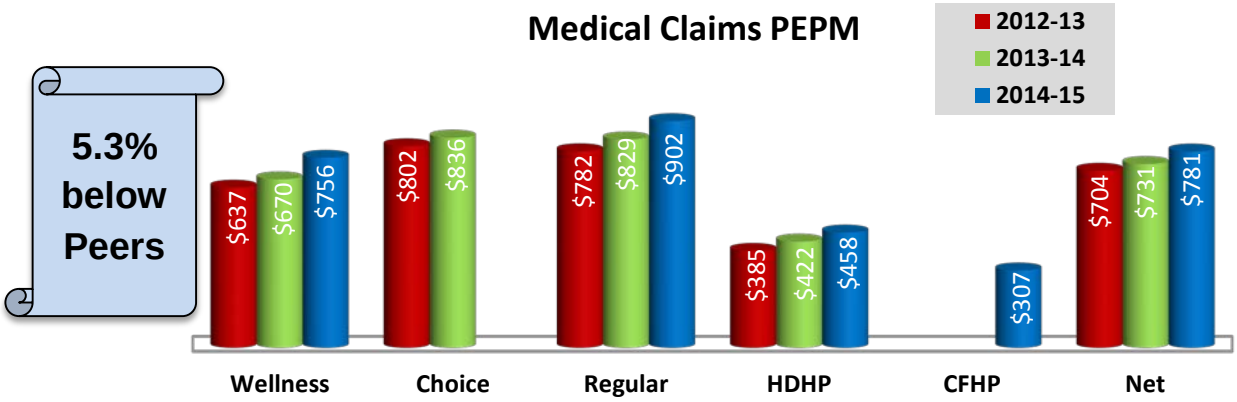
Medical Claims Review

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.

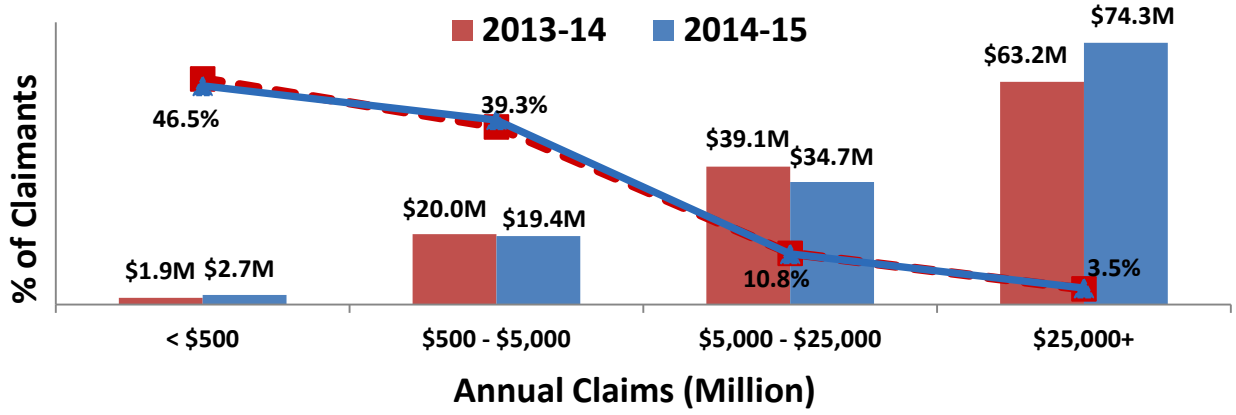
The State Employees Insurance Fund #68960 paid approximately $131 million of medical claims during plan year 2014-2015, which reflected a 5% increase from the prior year. Factors attributed to this increase include a 13.5% increase in claimants exceeding $100,000 of medical claims (High Cost Claimants), increase in participants, and increased number of participants utilizing medical benefits.

Consistent with 2013-2014, treatment for musculoskeletal conditions, neoplasms (cancer), and circulatory (heart disease) were the top cost driver of medical claims. Combined, these three diagnosis drive 36% of total medical claims paid per employee per month (PEPM).

The Net Paid PEPM of $781 reflects a 6.8% increase from the previous year but was 5.3% below our peer group according to UHC. Despite an increase, the Net PEPM remains below 2011-2012 cost per employee.



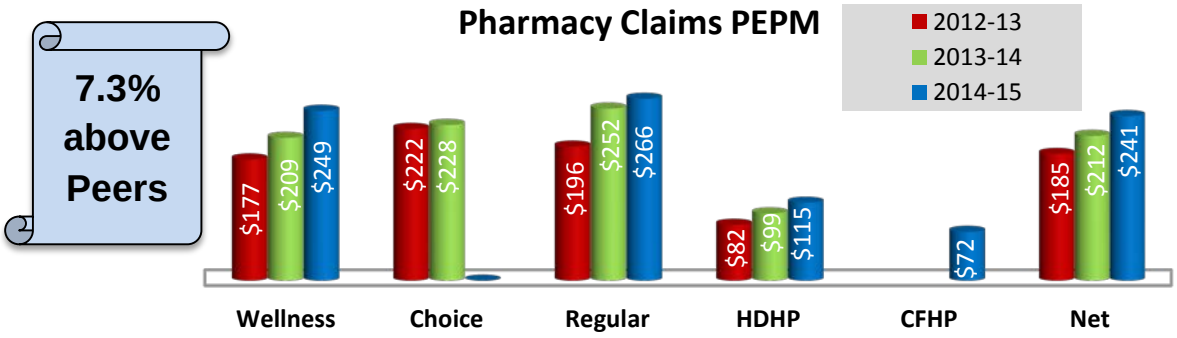
Consistent with other group health plans, a small percentage of participants incurred a high proportion of total medical claims paid. Of the $131 million spent on medical claims, the plan paid nearly $74.3 million for 3.5% (998 lives) of the total plan participation of 28,897. Compared to prior year, the percentage of claimants remained consistent for each claims group, however, the plan saw a $11.1 million increase in claims paid for those who incurred claims of $25,000 or more.



Pharmacy Claims Review

Pharmacy claims were administered by OptumRx, an affiliate of UHC. The plan paid about $38M for prescription claims in 2014-2015, a 13% increase from the previous year. The cost paid by the plan per employee was 7.3% higher than the peer group due to higher utilization of specialty drugs, according to UHC.

Roughly 24,700 participants utilized pharmacy benefits in the health plan, filling about 433,000 prescriptions. The average cost per prescription of $91 increased from $82 paid the prior year. On average, each participant filled 15.0 prescriptions annually compared to peer group of 10.6.



Members pay a copay for each prescription and the remainder of the cost is paid by the plan.

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.

	2014-15	2013-14	% Change	Peer
Annual Scripts per Participant	15.0	14.6	3.1%	10.6
Average Cost	$126.25	$113.44	11.3%	$116.07
Plan Cost Share	89.9%	87.9%	2.0	87.8%
Employee Cost Share	10.1%	12.2%	-2.1	15.2%
Generic Utilization	82.8%	81.2%	1.6	

Wellness Program - wellNEssoptions

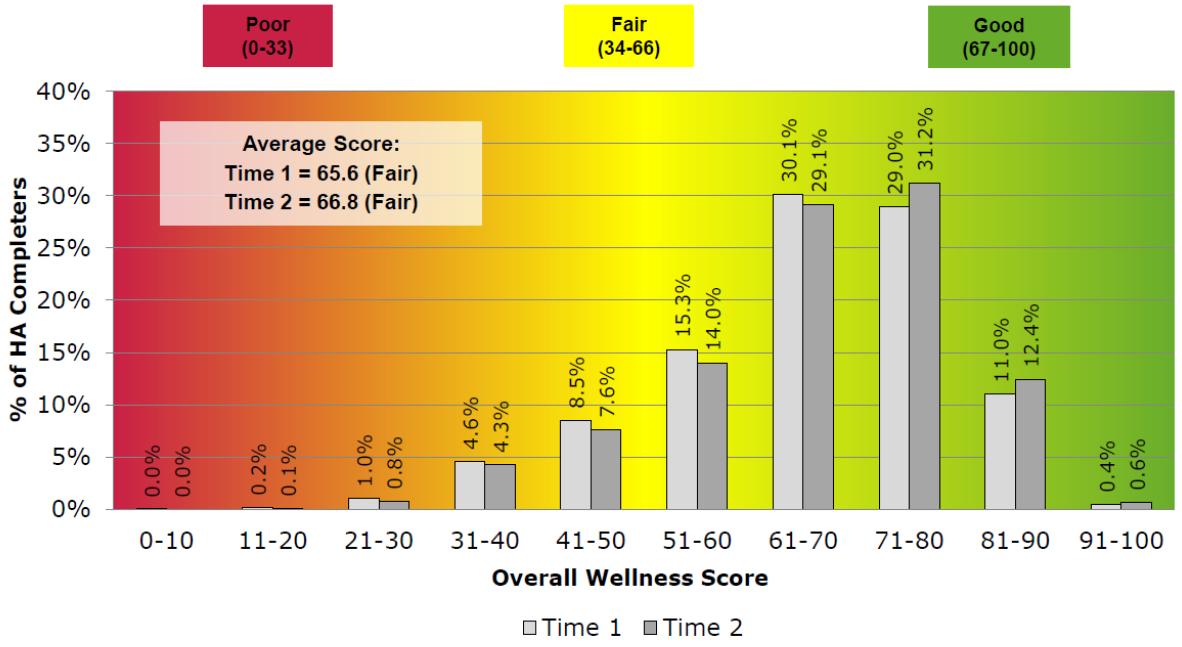
The State's wellness program was administered by *HealthFitness™,* which provided the State with two dedicated, onsite Wellness employees. Wellness program fees were paid through the State Employees Insurance Fund #68960 and cost about $2.9 million for the plan year ending June 30, 2015. The fees in the report include some expenses incurred in 2013-2014 but paid in 2014-15 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.

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. For 2014-2015, about 49% of health plan participants qualified and enrolled in the Wellness Health Plan.

Participation in the health screenings and health risk assessments offered during April through May 2015 through **wellNEssoptions** remained consistent with prior year. About 10,700 employees and spouses participated in these event. Employees and spouses who completed a health assessment in 2014 and 2015 saw their overall health score improve 1.8%.



State of Nebraska recognizes individuals and agencies who participate in the **wellNEssoptions** program throughout the year.

Wellness Incentive

Employees and spouses who complete the incentive requirements receive an incentive to elect the Wellness Health Plan for the upcoming year. Over 6,400 employees met the incentive requirements in 2014-2015 and were eligible to elect the wellness health plan on July 1, 2015.

Walk This Way Recognition

In April 2015 Governor Pete Ricketts honored participants in the **wellNEssoptions** Walk This Way® program in the Capitol. Participants in the program averaged over 1.9 million steps during the program year.

Wellness Award Luncheon

On September 11, 2015, over 100 employees joined Governor Ricketts at the Wellness Award Luncheon to honor our 140 Wellness Champions, Wall of Fame recipients, and Agency Directors for their help with promoting and supporting a culture of wellness. This year the following individuals and agencies were recognized for going above and beyond in promoting and establishing a healthy lifestyle.

Wellness Champion Awards

Douglas Barry, Department of Environmental Quality
Kris Bourke, Department of Administrative Services

Agency Wellness Culture Awards

Department of Education
Department of Roads
Nebraska State Treasurer's Office

Snapshot of 2014-2015 Health Program Outcomes

Financial

- Net PEPM for medical increased 6.8%.
- Excluding catastrophic claims, medical PEPM is trending 1.9%.
- Net PEPM for pharmacy increased 13.6%
- Medical PEPM was 5.3% below peer group.
- Pharmacy PEPM was 7.3% above peer group.
- Back and joint replacement surgery account for 8% medical spend.
- Network discount rate was 39% and saved $91 million.
- 168 participants drive 26% of total spend and exceed $100,000 in claims.
- 1 participant exceeded $2 million in claims.

Clinical

- Age/gender risk is 10.4% higher than peer.
- Emergency room visits are 35.0% lower than UHC Peer group.
- Inpatient utilization decreased 2.0%; Outpatient decreased 0.5%.
- Top three diagnosis was diabetes, hypertension, and back pain.
- Muskeletal, cancer, and diabetes drive 36% of medical costs.
- Increased prevalence since 2012-2013 of Chronic Obstructive Pulmonary Disease (COPD), diabetes, and pregnancy.
- Claimants with COPD increased 21% over the last two years.
- 9.2% of members have primary diagnosis of diabetes.

Engagement

- 53.5% of eligible employees and spouses participate in wellness.
- Wellness Health Plan participation increased 16%.
- Over 4,000 employees received a flu shot at a State onsite clinic.
- Over 11,900 participants participated in **wellNEssoptions** programs.
- 95% of high cost claimants engaged in clinical program with UHC.
- Overall wellness score increased 1.8% for for 2-year participants.
- Healthy eating and physical activity are top coaching goals.
- 5,793 participants enrolled in wellNEssoptions coaching programs.
- Wellness & 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 High Deductible Health Plan on June 30, 2015. The strategy of the plan designs is to offer three distinct options: a wellness and non-wellness PPO plan and a qualified high deductible plan with lower premiums. This strategy is designed to leverage the value of wellness and the value of a tax advantaged consumer-focused health plan.

Aon Hewitt provided the State with actuarial cost projections. Costs were impacted by new PPACA plan design requirements and fees, health care trend of 5 to 7%, and eliminating premium subsidies which reduced premium increases in previous years but also reduced reserves in the State Health Insurance Funds. Plan design changes were bargained for the Regular plan with NAPE for the 2015-16 and 2016-17 plan years through negotiations.

	2015-2016 Contribution Increases
Wellness Health Plan	**11.0%**
Regular Health Plan	**11.0%**
Consumer Focused Health Plan	**6.5%**

The Accountable Care Act continues to impact the State's health plan cost and administrative requirements for compliance. Beginning July 1, 2015, the State is required to offer health insurance at full-time rates for employees working 30 hours or more on average. The State determines eligibility for employees working more than 30 hours a week through a 12-month look-back measurement.

Also, in January 2016, the State will be required to report to the IRS and to employees eligible and enrolled on the State's health insurance coverage during 2015.

Finally, the State continues to monitor the impact of the excise tax exposure that will affect the health plans and other tax advantaged benefits beginning in 2018.

HealthFitness continues to administer **wellNEssoptions** for 2015-16. The following changes were implemented beginning April 1, 2015:

- ✓ Added a nutrition program called Colorful Choices.
- ✓ Coaching participants must complete 10 or more 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.

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™.