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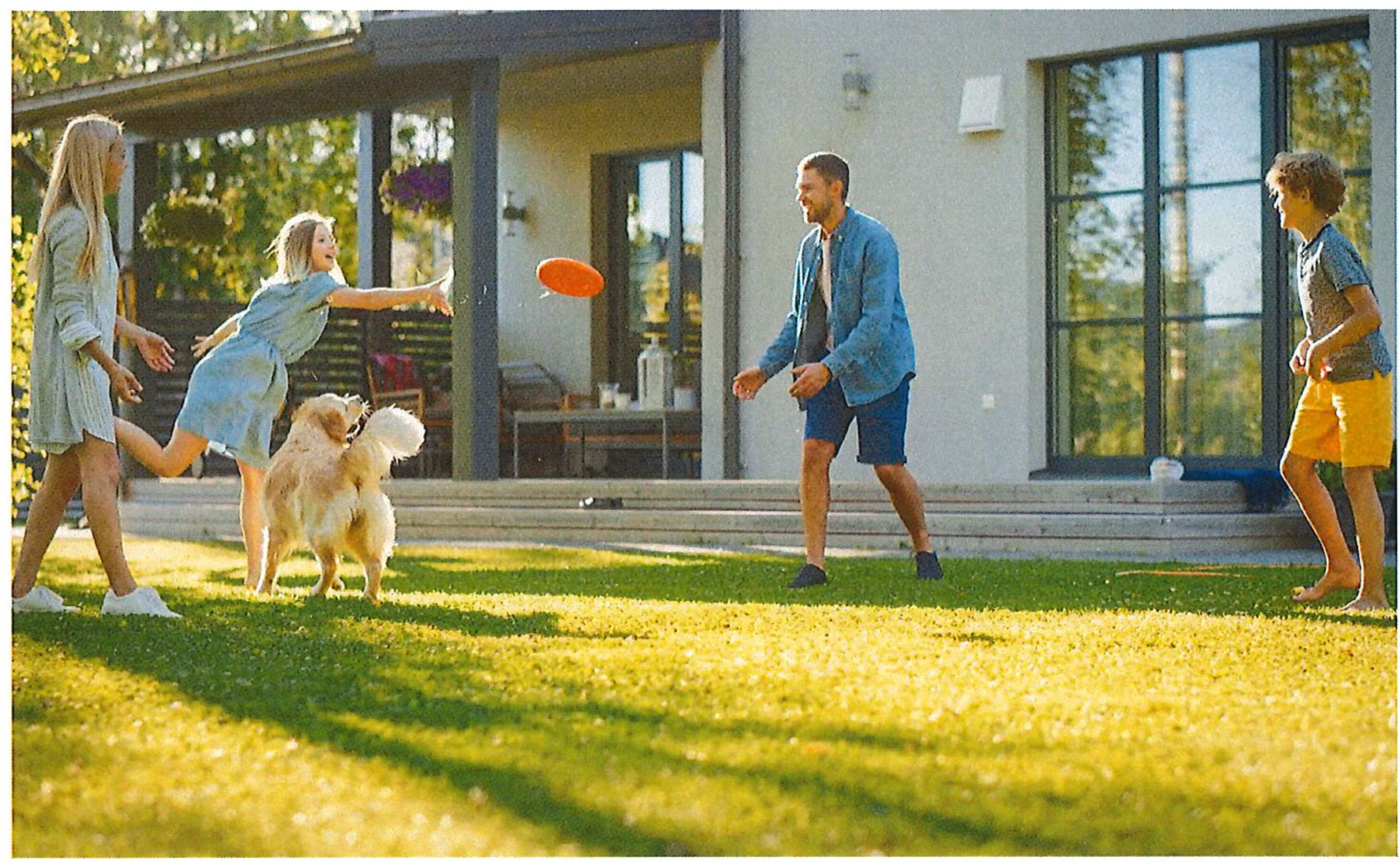

Nebraska Department of Administrative Services

Health Insurance Plan Annual Report

Presented to the Legislature's Appropriations Committee

For the Plan Year July 1, 2023 to June 30, 2024

November 19, 2024

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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 2023 - 2024, 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 2023 – 2024 through State contributions totaled over $167.2 million and made up 12% of $1.4 billion total rewards portfolio that includes compensation and retirement benefits. The Health Fund provides medical and prescription drug benefits to approximately 13,300 eligible public servants and their family members, covering 27,600 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.
- Efficiently manage the State's Health Fund to provide the best value for public servants and taxpayers.
- Give value back to the public servants by holding costs low and adding new benefits.

During plan year 2023 - 2024, there were significant steps taken to achieve these goals:

- DAS implemented benefit improvements while keeping contribution rate increases below market level. This is rare in a market where most plan sponsors are reducing benefit values and increasing contributions to keep up with medical and pharmacy inflation. As a result, the plan spent down the reserve surplus it had amassed over time. Contribution rates are likely to grow at a faster pace to close the gap between revenue and plan expenses.
- 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. This year the program was further improved by eliminating the $500 copay to make having a baby free for public servants enrolled in the Wellness plan.

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

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

Sean Davis,
State Personnel Director

Plan Design

The State of Nebraska's health insurance program in 2023 – 2024 consisted of five self-insured health plans, the Regular Plan, the WellNebraska Plan, the Consumer-Focused Health Plan (CFHP), and two Direct Primary Care (DPC) plans. Each plan included medical and prescription drug coverage for in-network and out-of-network providers, as well as wellness benefits.

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, CFHP or DPC plans. To enroll in the WellNebraska/Wellness Plan for the 2023-2024 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 two DPC plans were offered for the first time in the 2019-2020 plan year as a part of a State-mandated pilot program. DPC is membership-based healthcare and is provided by Strada Healthcare. The DPC aspects of the plan are offered in conjunction with two high deductible plan options (Standard Plan or Select Plan) and are administered by UnitedHealthcare (UHC). These plans provide preventive and direct primary care services at no additional charge beyond the monthly membership fee. Services outside of the preventive and primary care spectrum are subject to the high deductible component of the plans. DPC plans do not meet the IRS requirements for HSA accounts, therefore, their members are not eligible to make contributions to an HSA account.

Plan Design Changes

Effective July 1, 2023 the State has implemented several changes to the design of health plans in order to make medical care more affordable for public servants. These plan design changes include the following:

- Decrease of $10 for all medical copays in Wellness and Regular plans
- Elimination of $500 copay for the maternity services in Wellness plan.
- Expansion of UHC's Preventive Drug List for all plans.
- Physical, speech and occupational therapy limits increased by 10 sessions for all plans.

The deductible for CFHP increased from $2,800 to $3,000 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	DPC Select	DPC Standard
Medical Benefits					
Deductible *(Individual / Family)*	$1,400 / $2,600	$800 / $1,600	$3,000 / $5,200	$3,500 / $7,000	$5,000 / $10,000
Coinsurance (EE)	20%	20%	20%	20%	30%
PCP / Specialist	$35 / $40	$25 / $40	Deductible & Coinsurance	Covered by Strada/ Deductible & Coinsurance	
Maternity	Deductible & Coinsurance	$0	Deductible & Coinsurance	Deductible & Coinsurance	
OOP Maximum *(Individual / Family)*	$4,000 / $8,000	$2,700 / $5,400	$4,100 / $8,200	$5,000 / $10,000	$7,000 / $14,000
Prescription Drug Benefits					
Tier 1	$5	$5	20% after Deductible	20% after Deductible	30% after Deductible
Tier 2	$40	$30			
Tier 3	$60	$50			
OOP Maximum	$2,250 / $4,500	$2,000 / $4,000	Combined with Medical		

How Nebraska's Plans Compare to Neighboring States

In order to ensure that benefits provided to public servants of the State of Nebraska are competitive and cost effective, it is important to regularly benchmark them to the programs provided by the other State plan sponsors. Below we provide an analysis where benefits offered by State of Nebraska are compared to those offered by neighboring states.

The following State health plans were compared to State of Nebraska's Plans:

- Colorado
- Iowa
- Kansas
- Missouri
- North Dakota
- South Dakota
- Wyoming

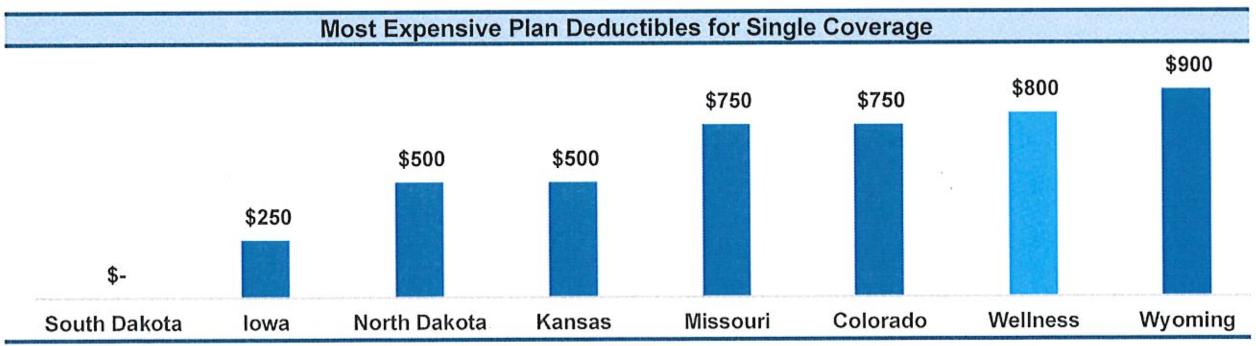
State programs offer different plan combinations with varying cost sharing parameters and costs to participants. To make the analysis valid, we compared Nebraska's richest plan (Wellness Health Plan) to the richest plans from other states, and Nebraska's least expensive plan (Consumer Focused Health Plan) to the least expensive plans from other states. DPC plans were excluded since their unconventional design cannot be adequately compared to traditional health plans.

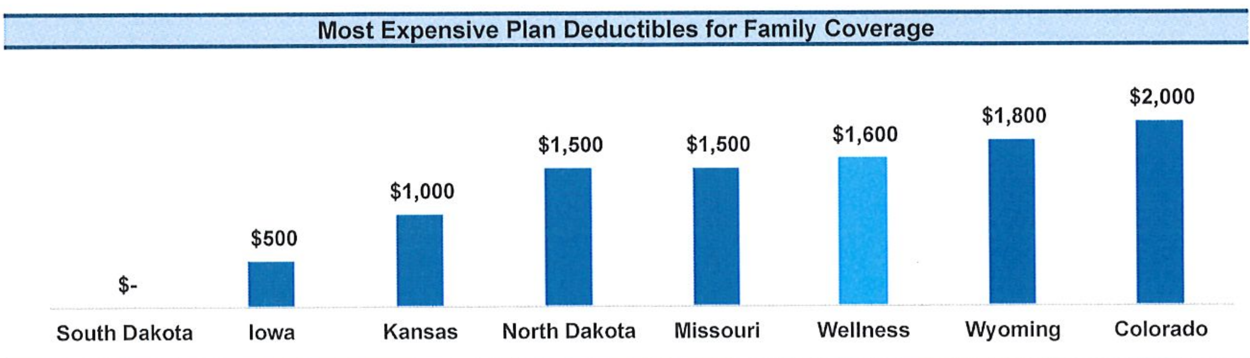
Data used in the analysis below was obtained through Segal's State Health Benefits Survey Tool.

Cost Sharing Parameters

Deductible and Out of Pocket (OOP) Maximum are two of the most important cost-sharing provisions of a traditional health plan.

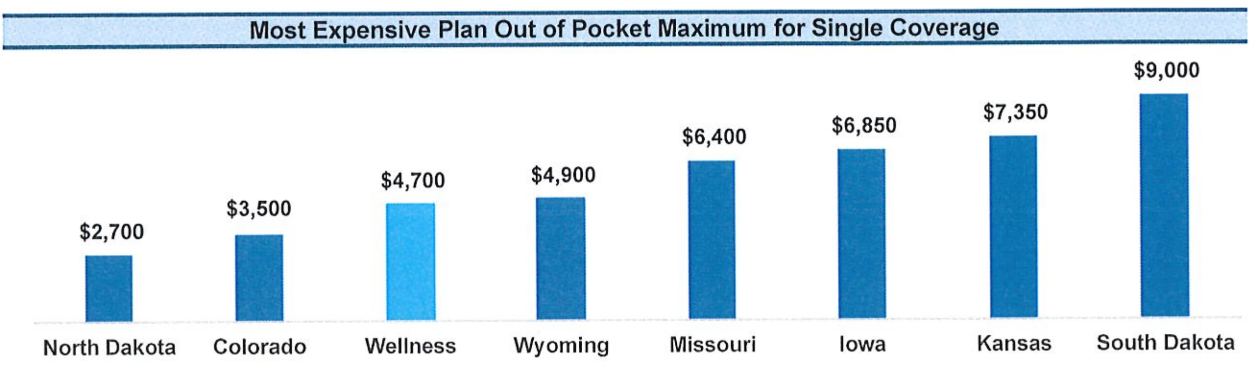
The first two graphs show how single and family coverage deductible for Wellness plan compare to the deductibles of the most expensive plans from the other states.

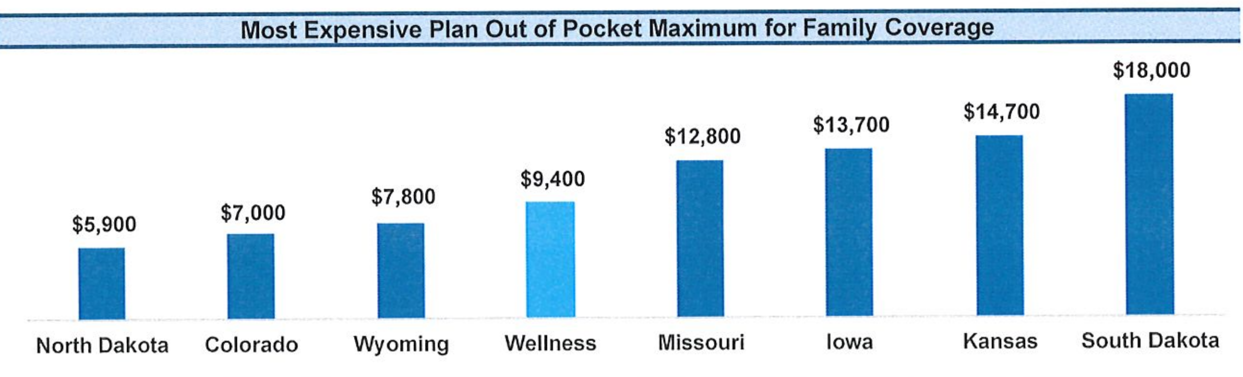




When compared to the richest plans from the other states, the Wellness plan deductible overall is in line with similar plans from other state programs.

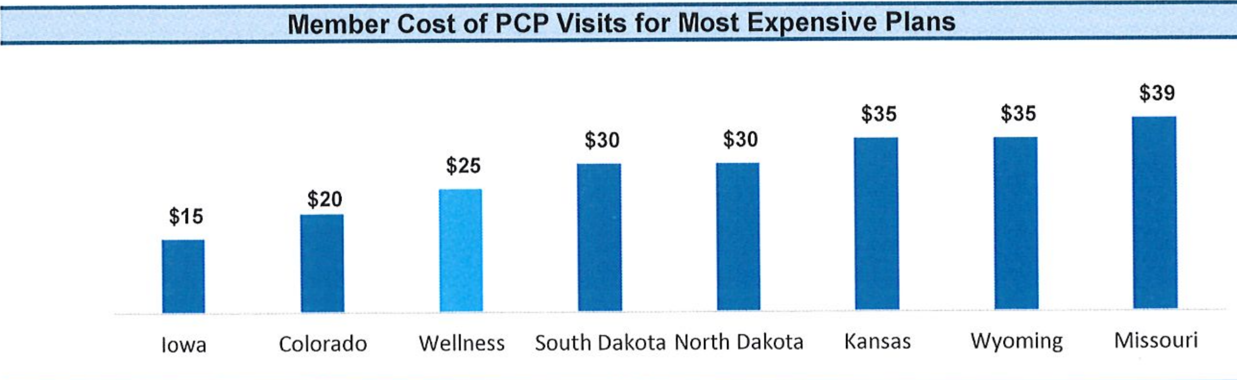
The following two graphs illustrates the comparison of single and family coverage OOP Maximums for Wellness plan to OOP Maximums of the most expensive plans from other states.





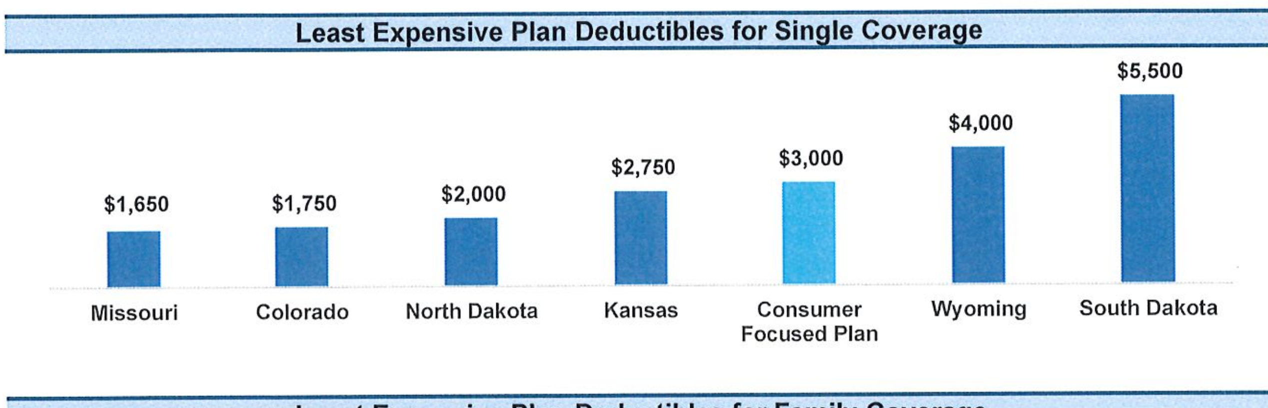
As shown on the graphs, OOP Maximum of the Wellness plan is similar to OOP Maximums of the most expensive plans from other states in this group.

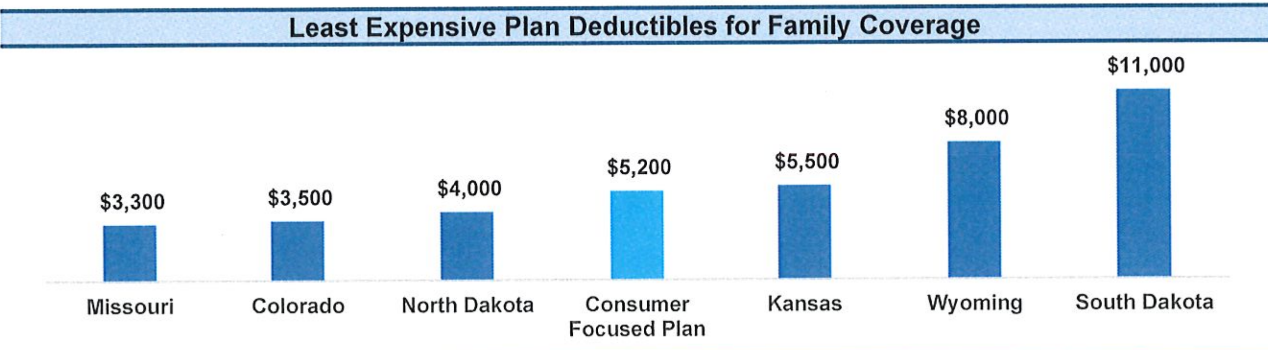
The graph below compares cost of PCP visit for Wellness plan members against those for the members of the most expensive plans from other states. Wellness plan copay for PCP visits is the third lowest in the peer-group.



The following set of graphs illustrates comparison of Consumer Focused plan parameters against the least expensive plans offered by other states.

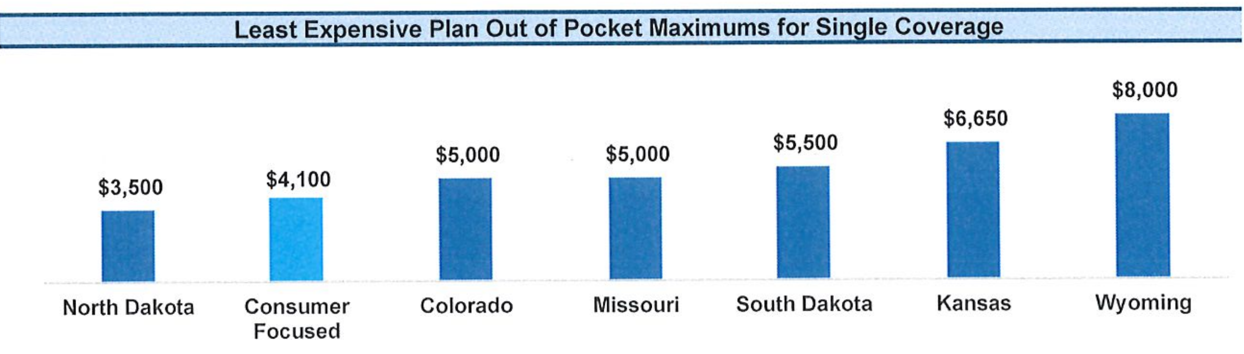
The first two graphs show how single and family coverage deductible for Consumer Focused plan compare to the deductibles for least expensive plans from other states.

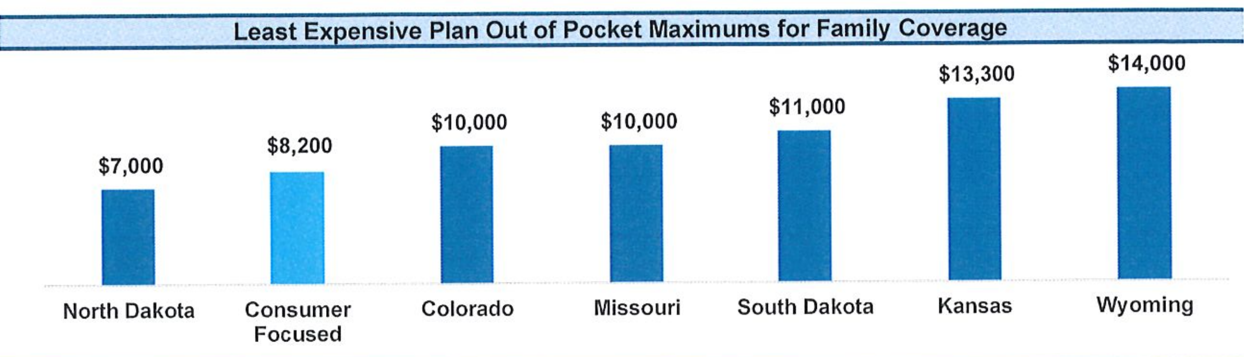




Consumer Focused plans deductibles for both single and family coverage are on par with the deductibles from similar plans provided by other states.

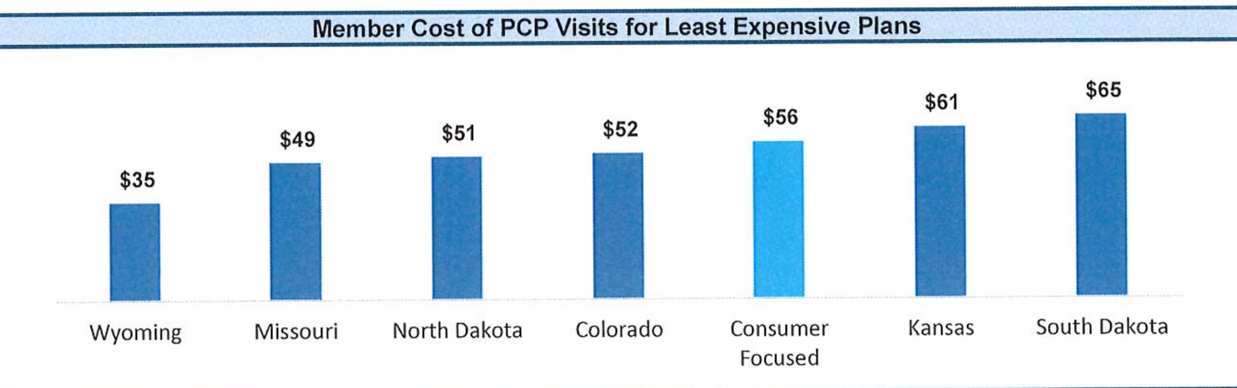
The following two graphs compare single and family coverage OOP Maximums of the Consumer Focused plan to OOP Maximums for least expensive plans from other states.





OOP Maximums for Consumer Focused plans are on the lower end of the spectrum in their peer group.

The last graph in this section compares cost of PCP visit for Consumer Focused plans member against the amounts paid by members of the least expensive plans from other states. On average Consumer Focused plan member pays $56 for a PCP visit, this is similar to the least expensive plans from peer-states.



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.

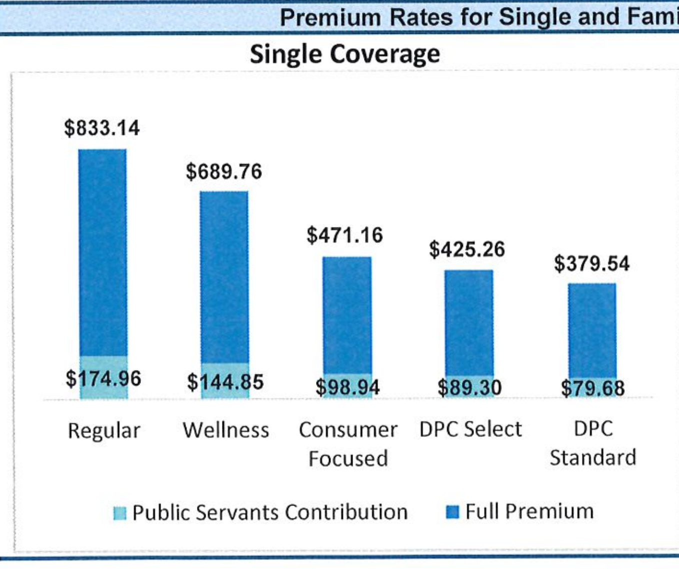
In accordance with Neb. Rev. Stat. §84-1611, the State pays 79% of monthly rates and active, full-time public servants pay 21%. Neb. Rev. Stat. §84-1604 requires part-time public servants (20-29 hours a week) receive only a proportion of the State contribution. Part-time public servants pay 21% of the 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. For plan year 2023 - 2024 uniform rate increase of 4% was adopted.

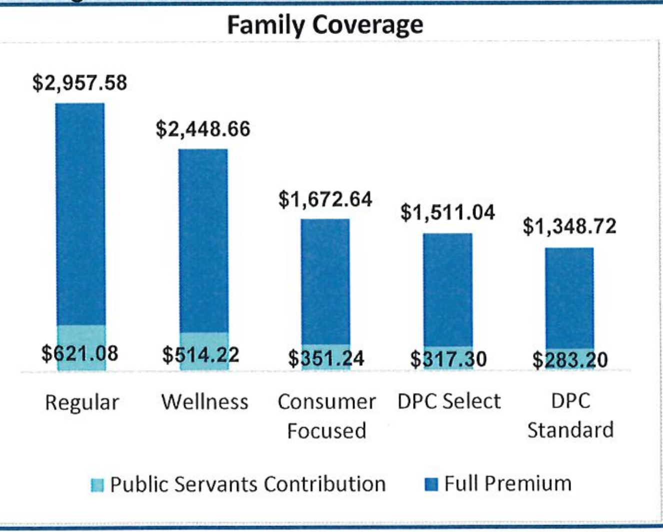
In November 2022, Segal provided the State's Wellness and Benefits Administrator with a Preliminary Premium Rate Analysis Report. The Wellness and Benefits Administrator, Personnel Director, and Director of DAS reviewed the report along with the State Budget Division and Governor. Contribution rates were approved in February 2023 and communicated to public servants in April 2023, prior to Open Enrollment.

Premium Rates for Single and Family Coverage for Plan Year 2023 – 2024

Single Coverage

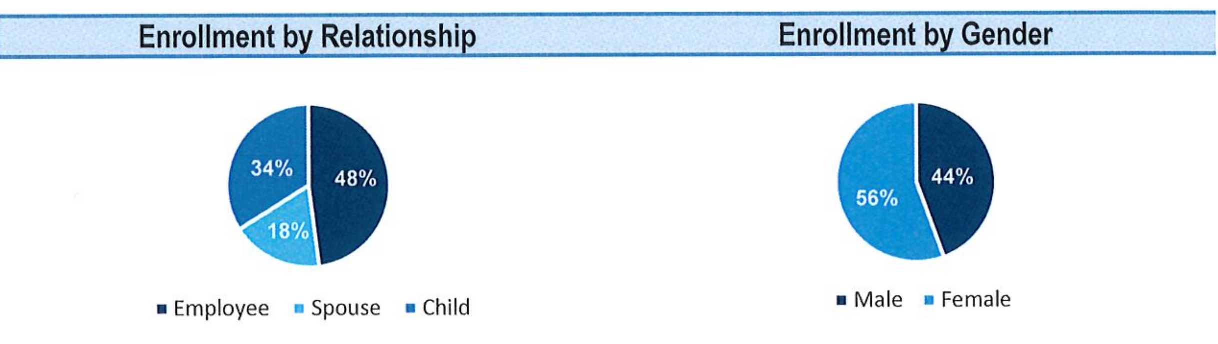


Family Coverage



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 17.014; and the NAPE/AFSCME (NAPE) and State of Nebraska Labor Contract, Article 13.2.



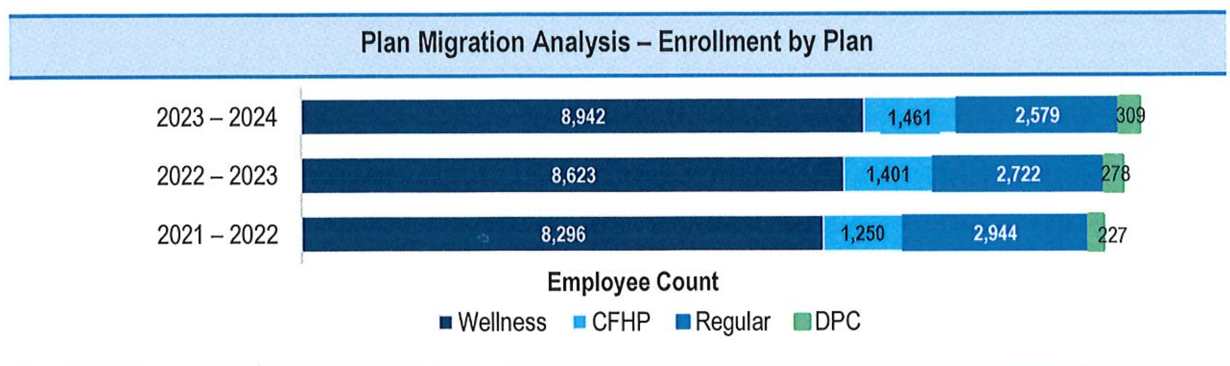
Per the charts above, the plan averaged 13,293 public servants enrolled in the 2024 plan year, which included approximately 263 retirees and 25 COBRA participants.

The total number of covered lives in the Health Fund, including spouses and dependents, was 27,580, which increased 1.9% from the 2022 – 2023 plan year.

Approximately 55.6% of public servants were female and 44.4% were male. The average age of members enrolled was 35.1, down slightly from last year's average of 35.2.

While enrollment in the Regular Plan declined, Wellness, CFHP, and DPC plans saw increases in their respective membership. The Regular Health Plan experienced a decrease of approximately 5% of its population compared to the previous plan year. The Wellness, CFHP, and DPC plans saw 4%,4%, and 11% increases for enrollment respectively.

Despite slight growth during plan years 2022-2023 and 2023-2024, enrollment in the new DPC plans remained low, making it difficult to evaluate their effectiveness. Plan migration and enrollment by plan for the last three plan years are shown in the graph below:



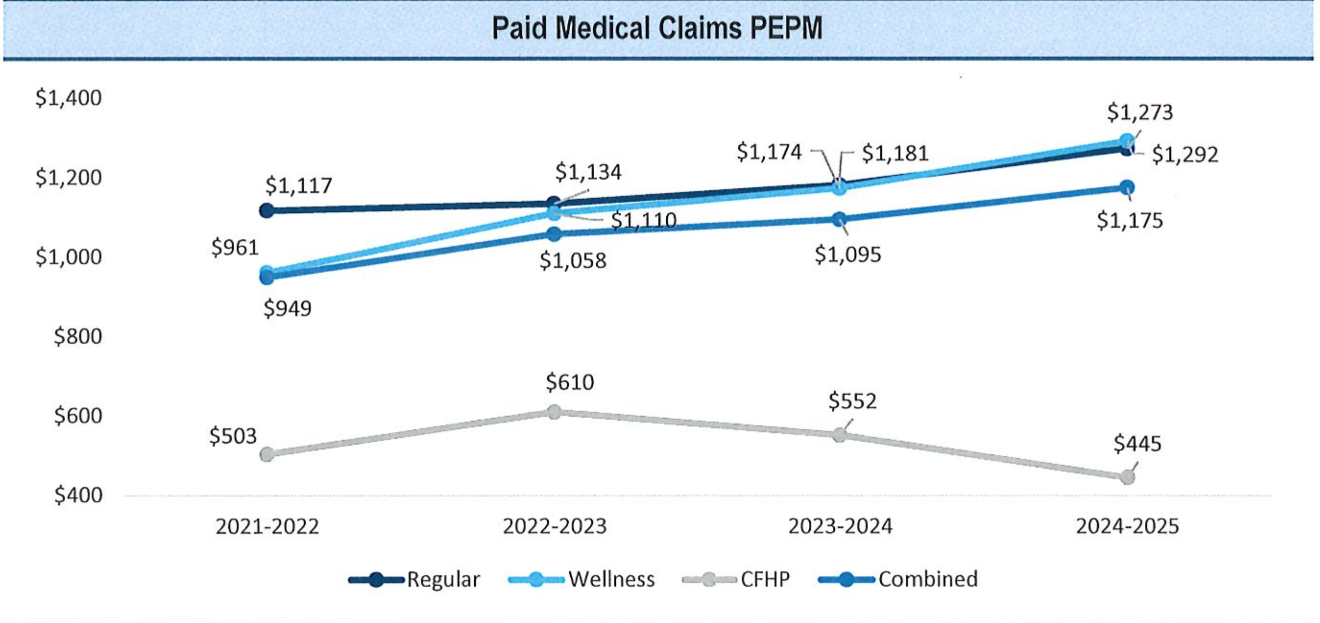
Medical Claims Review

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 $191 Million in reported medical claims in fiscal year 2023 – 2024. This amount includes $174 Million for claims that were incurred and paid during plan year 2023-2024, as well as $17 Million for claims that were incurred during plan year 2022-2023 but paid in the following year.

Total amount of medical claims grew by approximately 10.5% from the prior year driven by increase in enrollment of 1.9% and a surging number of catastrophic claims.

The illustration below captures the net paid Per Employee Per Month (PEPM) for claims paid during the last four plan years:



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

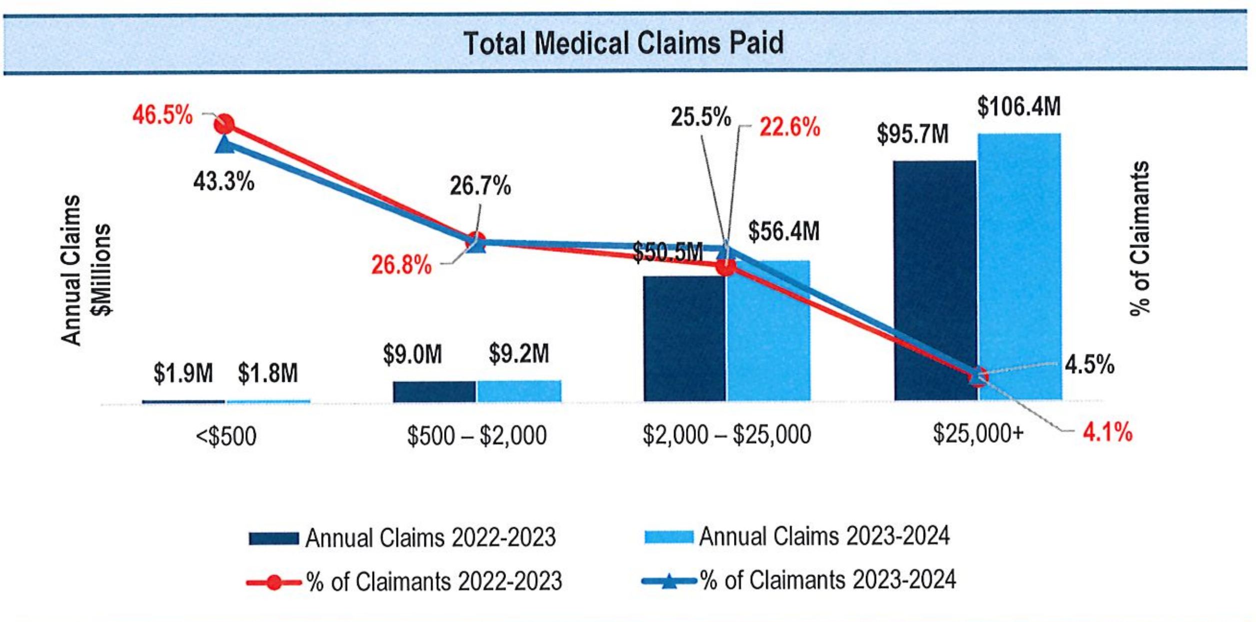
On a paid basis, the combined PEPM of $1,175 for medical claims paid for all three plans between July 1, 2023 and June 30, 2024 is 7.3% higher than the PEPM cost from the same time period for plan year 2022 - 2023. On the incurred basis, year to year PEPM increase amounted to 8.1% according to UHC's report.

Consumer Focused Health Plan has lower cost due to higher member cost-sharing and lower risk profile of the plan population.

Consistent with 2022 – 2023, treatment for musculoskeletal conditions and neoplasms (cancer) were the top cost drivers of medical claims. Combined, these two diagnoses drove 24% of total medical claims paid PEPM.

The total allowed amount (PEPM) for claimants with claims over $100,000 increased by 11.4% from the previous year and increased by 7.0% for claimants with incurred claims between $25,000 and $100,000.

A small percentage of participants incurred a high proportion of the total medical claims paid. As illustrated by the graph below, 4.5% of the plan's total population was responsible for $106.4 million in claims, which is more than a half of total amount paid through June of 2024 for the 2023-2024 plan year. On the other hand, majority of plan participants incurred low claims, or did not have claims at all. 43.3% of plan's population had annual claims between $0 and $500. In aggregate, these low claims amounted to $1.8 million or 1.0% of total paid amount.



Note that this analysis only includes claims that were incurred and paid during plan year 2023-2024 and amounted to approximately $174 million.

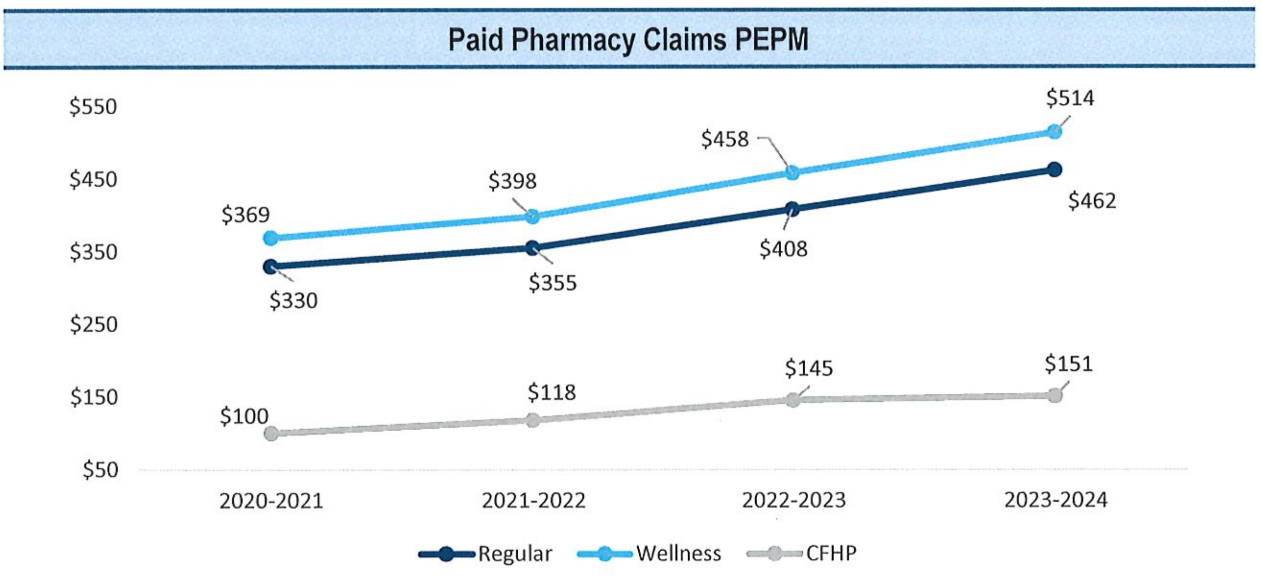
Pharmacy Claims Review

Pharmacy claims were administered by OptumRx, an affiliate of UHC, and the plan's Pharmacy Benefit Manager (PBM). The plan paid about $69.7 Million of prescription drug claims in 2023 – 2024, a 13.9% 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 12.0% on a paid basis and 11.0% 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 be monitored by the State. During plan year 2023-2024 specialty drugs were responsible for 44.0% of overall pharmacy spend. Compared to the previous plan year specialty drug payments increased by approximately $3.7 Million, or 13.0%.

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



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

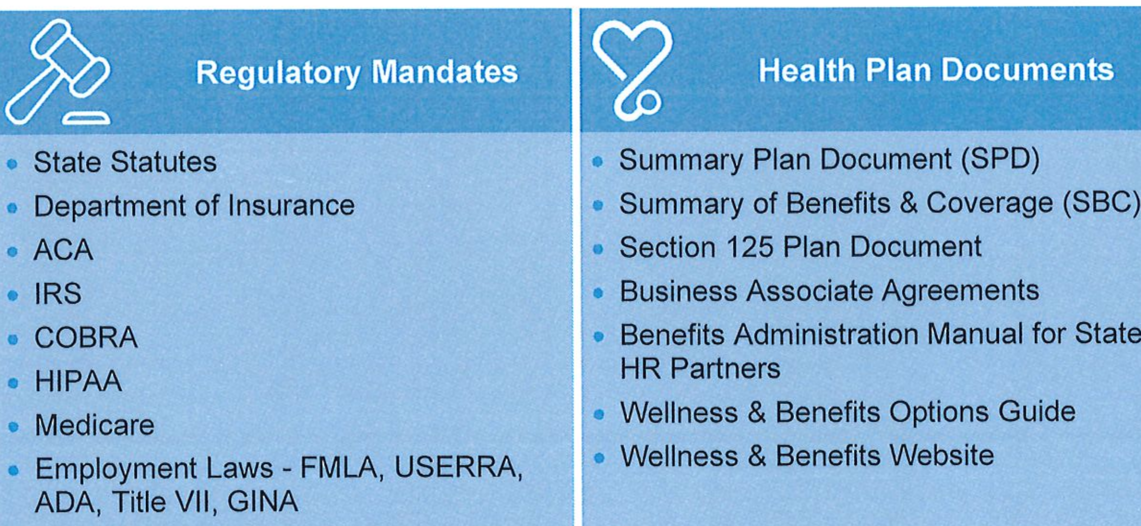
Roughly 24,000 participants utilized pharmacy benefits in the health plan, filling about 351,000 prescriptions. The average cost per prescription of $207.07 for the State was a 11.6% increase from the $185.57 paid in the prior year. On average, each member filled 12.73 prescriptions annually. This is a 0.2% decrease from last year's average of 12.76 prescriptions filled annually. The average prescription drug cost per member to the State was $219.59, a 11.3% increase from $197.25 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.

	2023 – 2024	2022 – 2023	% Change
Annual Scripts per Member	12.73	12.76	-0.2%
Generic Utilization	83.9%	83.3%	0.7%
Average Cost per Member	$219.59	$197.25	11.3%
Specialty Cost per Member	$96.68	$87.18	10.9%
Non-Specialty Cost per Member	$122.91	$110.08	11.7%
Employee Cost Share	4.9%	5.5%	-11.9%

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, and their attorneys to constantly monitor changes in health plan management and assure the plan and all required documentation is in compliance.



Neb. Rev. Stat. §84-1613 established the State Employees Insurance Fund #68960 to pay medical and pharmacy claims, and administrative fees. This Fund is administered by DAS and reserve targets are adjusted annually using cost projections from Segal for the most recent plan years.

Reserves are imperative to the successful management of a self-insured health plan with about 27,600 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 2023 – 2024 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 2024, the State paid $65,850 for the PCORI fee for the plan year ending June 30, 2023.

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.

What are CFR and IBNP reserves?

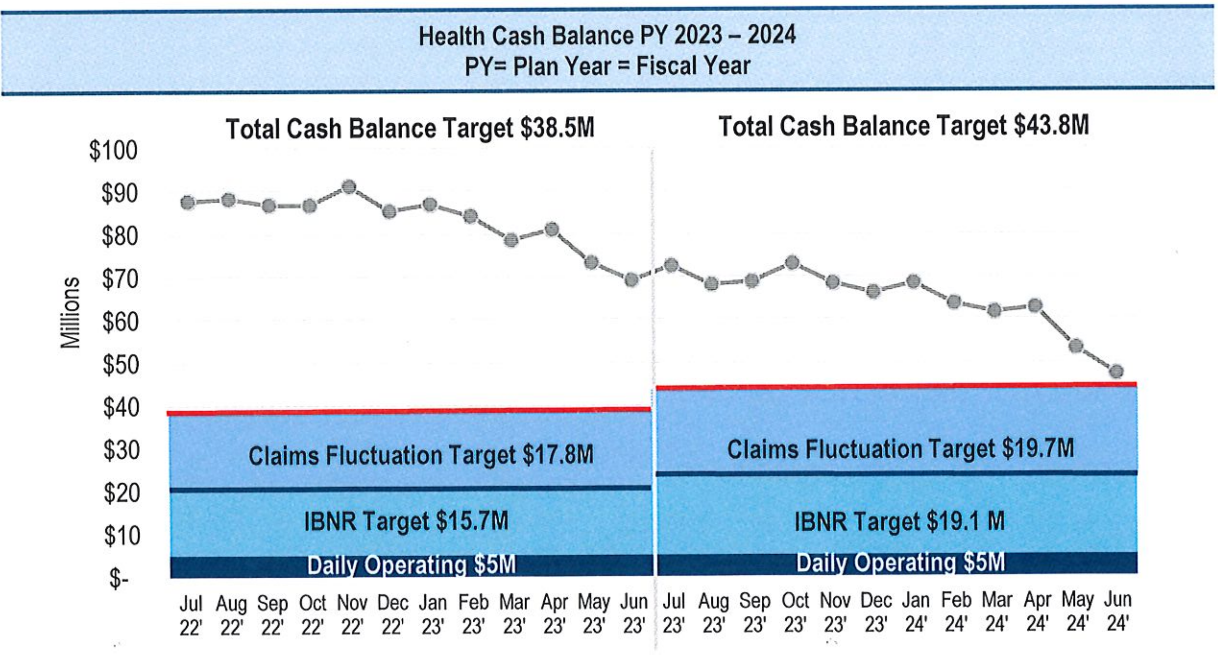
CFR (Claims Fluctuation Reserve) is an amount of money set aside (reserved) to pay for an unusually high volume of claims or unexpected number of claims.

IBNP (Incurred But Not Paid) reserve is an estimated amount of medical and pharmacy claims incurred as of the last day of the plan year but not yet processed for payment.

The Total Cash Balance Target for PY 2023-2024 is $43.8M. This Cash Balance Target includes three different pieces:

- Claims Fluctuation Reserve of $19.7M calculated by Segal based on a 90% confidence interval.
- Incurred But Not Paid Reserve of $19.1M set at 7% of actual claims.
- Daily Operating Target of $5 Million.

The Cash Balance Target and actual monthly cash balance for plan years 2022 - 2023 and 2023 – 2024 are shown in the table below:



A summary of financial activities in State Employees Insurance Fund #68960 for the plan years ending June 30, 2023, and June 30, 2024, 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, 2023 and 2024

	Plan Year			
	2023 – 2024	**2022 – 2023**	**$ Change**	**% Change**
Revenue				
Contributions	$213,465,941	$202,763,934	$10,702,007	5%
Pharmacy Rebates	$31,441,067	$24,535,592	$6,905,475	28%
Investment Income	$1,220,637	$1,400,368	$(179,731)	-13%
CARES Act Subsidy	$0	$41,106	$(41,106)	-100%
Total Revenue	**$246,127,645**	**$228,741,000**	**$17,386,645**	**8%**
Distributions				
Medical Claims & IBNP	$190,766,637	$172,665,084	$18,101,553	10%
Pharmacy Claims	$69,719,877	$61,220,624	$8,499,253	14%
Administration Fees	$5,914,117	$5,726,594	$187,523	3%
Flex/HSA $500 Cont	$1,386,643	$2,800,877	$(1,414,234)	-50%
Wellness Reimbursement	$243,579	$553,086	$(309,507)	-56%
Total Distributions	**$268,030,853**	**$242,966,265**	**$25,064,588**	**10%**
Net Difference	**$(21,903,208)**	**$(14,225,264)**		

State of Nebraska Health Insurance Funds
as of June 30, 2024 and 2023

	6/30/2024	**6/30/2023**	**$ Change**	**% Change**
State Employees Insurance Fund #68960	$27,062,166	$50,984,395	$(23,922,229)	-47%
Health Insurance History Fund #68922	$20,168,691	$18,181,289	$1,987,402	11%
Total Reserve Fund Balance	**$47,230,857**	**$69,165,685**	**$(21,934,828)**	**-32%**

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 $500 copay, and making all maternity-related care free to Wellness plan participants.

During this plan year (the fourth year of the program), 332 babies were born to plan participants. The percentage of C-section deliveries was 34.3%, 0.6% below the UHC benchmark. Lastly, the average cost of vaginal birth and C-Section were 1.2% and 9.9% below the norm respectively.

Tri-Care Stipend

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 State's health benefits. Electing this option completely eliminates healthcare-related expenses for eligible public servants.

During plan year 2023 - 2024 (the first year of the program), 58 public servants elected to receive Tri-Care stipend.

Real Appeal

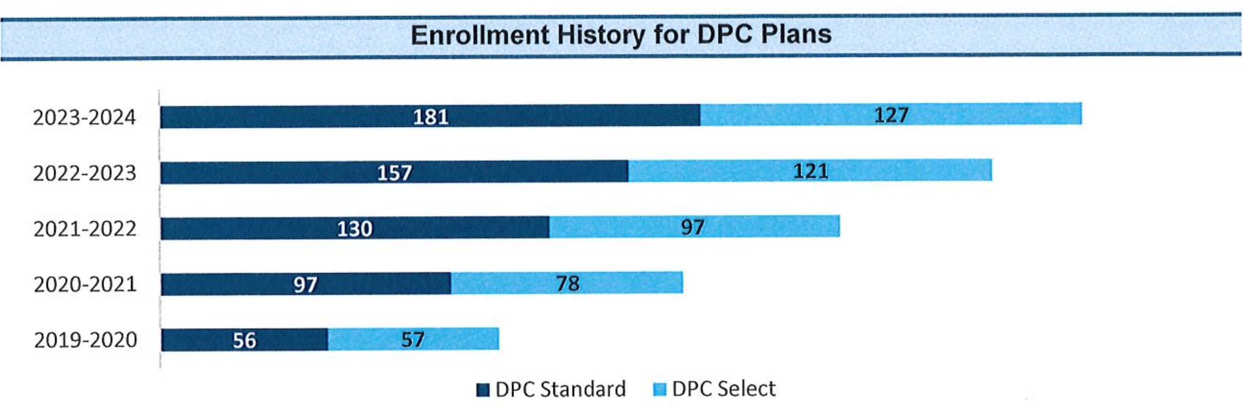
Real Appeal is a weight loss wellness program provided by UHC that was added as of April 1, 2018. Since the beginning of the program the State saw 4,512 members enrolled in the program, with 87% of enrollees deemed at risk of diabetes, cardiovascular disease, or other weight-related health conditions. Approximately 38.0% of participants have lost weight after 16 weeks on the program with average reported weight loss amounting to 2.3% of body weight per person.

According to the Real Appeal report with data through June 30, 2024, the program scored a 4.76 out of 5 satisfaction rating in a national survey of 21,908 participants.

Direct Primary Care Plans

Two direct primary care (DPC) plans were implemented by DAS in the beginning of 2019-2020 plan year as a part of State-mandated pilot program. DPC plans were offered through Strada Healthcare and

provide preventive and primary care services at no additional charge beyond the monthly membership fee. Strada also provided an access to cash pricing for some other medical services such as laboratory testing, imaging, and physical therapy. Services outside of the preventive and primary care spectrum are subject to high deductible plans administered by UHC. During Open Enrollment for 2019 – 2020 plan year, 113 members chose DPC plans. Enrollment continued to grow throughout the years, but remained very low compared to the traditional plans.



The DPC value proposition is that face-to-face and virtual PCP visits are covered by monthly membership fee which could mean lower healthcare costs for State and public servants by making primary care more affordable. However, the utilization of primary care was insufficient compared to the monthly fees charged by Strada in the table shown. Specifically, the per encounter charge for DPC plan members in FY 2023 amounted to approximately $900 when factoring in the fees and the utilization. For comparison, average cost of PCP visit for traditional plans during the same time was only $81.

In addition, members who chose to enroll in DPC plans trended to be younger and healthier than their peers in the traditional plans, leading to lower utilization of all medical services including PCP visits. While overall Per Member Per Month (PMPM) costs of DPC members were low compared to the other plans, this aligned with the risk profile of the population and the cost sharing requirement in the UHC portion of the plan design.

Monthly Strada Fees	
Employee only	$89
Employee & Spouse	$178
Employee & Children	$150
Employee & Family	$299

DAS made the decision to end pilot program and to terminate both DPC plans effective July 1, 2024 for some of the reasons above.

Looking Ahead

The State continues to focus on providing public servants with a quality health insurance program integrated with a focus on wellness and disease prevention.

Segal provided the State with actuarial cost projections for the 2024– 2025 plan year. Costs were impacted by underlying healthcare trend, fixed fee contracts, and demographic changes. The State chose to hold premium rate increases well below expected cost trends for 2024-2025 plan year.

2024 – 2025 Contribution Increases	
WellNebraska (wellness track)	4.0%
Regular Health Plan	4.0%
Consumer-Focused Health Plan	4.0%

The surplus in the fund balance has been spent down over the past several years through favorable rate increases, plan design enhancements, premium holidays, and special programs. In the absence of the surplus, increases will likely be higher than those realized historically.

The deductible for CFHP increased from $3,000 to $3,200 effective July 1, 2024 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.

As mentioned above, DAS decided to terminate both DPC plans effective July 1, 2024.

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.