University of Nebraska System

November 26, 2025

Senator Robert Clements
Chair, Appropriations Committee
PO Box 94604, State Capitol, Room 1004
Lincoln, NE 68509

Dear Senator Clements,

LB 620, enacted during the 2013 legislative session, requires the University of Nebraska to present, on or before December 1 of each year, its plan regarding the management of the University's health care insurance programs and its health care trust fund to the Appropriations Committee of the Legislature.

Enclosed is the University's report for the year ended December 31, 2024. The report provides an overview of the University's health plan, chronicles financial activity for the year, and offers insights into the plan's trends.

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

If you should have any further questions about the University's plan, please do not hesitate to contact me.

Sincerely,

Anne Barnes

Anne Barnes, M.B.A.
Senior Vice President and Chief Financial Officer

cc: Suzanne Houlden, Legislative Fiscal Office

Office of Business and Finance
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University of Nebraska
Health Insurance Plan Annual Report

Year Ended December 31, 2024

Executive Summary

This report is designed to meet a reporting mandate established by the Nebraska Legislature requiring an annual report be filed detailing operating activity of the University of Nebraska's health plan operations each year. This report covers the University's plan year January 1 through December 31 of 2024.

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

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

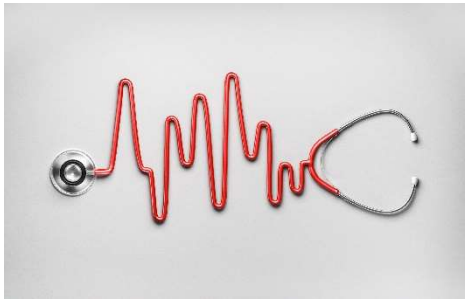
After volatile results in 2023, driven by high-cost claims and possibly an acceleration of elective visits/procedures before the change in medical, pharmacy and dental third-party administrators on January 1, 2024 (UMR was replaced by BlueCross BlueShield Nebraska ("BCBS") as the third-party administrator for medical claims, CVS Caremark was replaced by EmpiRx Health ("EmpiRx") as the third-party administrator for pharmacy claims, and Ameritas was replaced by BlueCross BlueShield Nebraska as the third-party administrator for dental claims), 2024 saw plan expenses continue to outpace plan income, but at a slower pace than 2023.

Overall, total premiums and income fell short of total claims and expenses by approximately $13 million in calendar 2024, compared to approximately $18 million in calendar 2023.

Premiums and income increased by about 5 percent in 2024, driven primarily by an average 12.5 percent increase in medical premium rates, which was largely offset by a 39 percent decline in pharmacy rebates & discounts driven by the change in third-party administrators for pharmacy claims.

A modest 3 percent increase in claims and expenses was driven primarily by a 6 percent increase in medical claims and 54 percent increase in administrative fees, partially offset by an 8 percent decrease in pharmacy claims. The increase in administrative fees and decrease in pharmacy claims were again largely attributable to the change in third-party administrators.

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



University of Nebraska Strategic Objective:

Recruit and retain exceptional faculty and staff

Contents

Plan Overview

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

The University utilized the expertise of the following outside parties to assist in the administration of the plan in 2024:

Entity	Description of Service Provided
BCBS	Third-party administrator for medical claims
EmpiRx	Third-party administrator for pharmacy claims
BCBS	Third-party administrator for dental claims
Principal Financial	Trustee
Milliman	Independent actuaries – provide projections used to set premiums

As mentioned earlier, beginning January 1, 2024, certain outside party relationships changed. BlueCross BlueShield Nebraska replaced UMR as the third-party administrator for medical claims, EmpiRx Health replaced CVS Caremark as the third-party administrator for pharmacy claims, and BlueCross BlueShield Nebraska replaced Ameritas as the third-party administrator for dental claims.

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

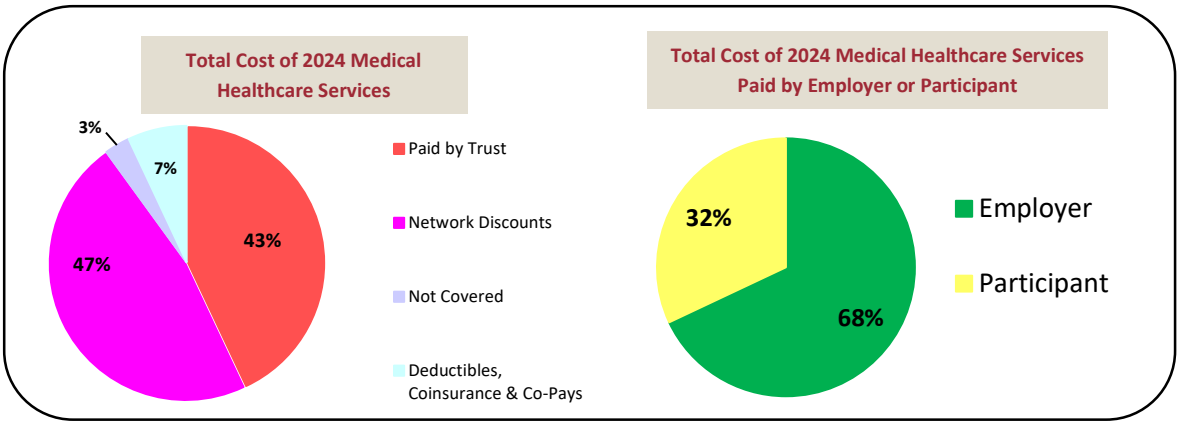
When covered employees and their dependents incur healthcare expenses, health providers (hospitals, doctors, pharmacies) send their bills to either (a) BlueCross BlueShield Nebraska for medical claims, (b) EmpiRx Health for pharmacy claims, or (c) BlueCross BlueShield Nebraska for dental claims. BCBS and EmpiRx, as third-party administrators, assure that the submitted claims are valid using coverage criterions, limits, deductibles, and co-pays as set by the University. When BCBS and EmpiRx pay claims, they are reimbursed by Principal Financial Group, the trustee, for the claims cost plus an administrative fee.

Premiums charged to both the employer and employees are designed to cover the plan's projected claim costs plus administrative expenses. Employees electing medical benefits are assessed a premium intended to cover medical and pharmacy costs, while employees electing dental benefits are assessed a separate premium intended to cover dental costs. Any potential changes in premiums, which become effective on January 1, are established by University

management each fall after analyzing Milliman's actuarial expense projections, which are based on a combination of University internal experience along with Milliman's book of business experience. University management reviews the plan's projected premiums and anticipated expenses with the President and Chancellors before finalizing employee premiums for the upcoming year.

For the years ended December 31, 2024 and 2023, approximately 80 percent of premium income was contributed by the employer and 20 percent of premium income was contributed by the employee. University employees selecting basic coverage pay between 20 percent and 29 percent of the total medical premium depending upon the coverage selected. While the University offers a variety of coverage options, a majority of the employees are enrolled in basic medical coverage for a "family" or "employee+one", both of which have close to a 79/21 percent employer/employee contribution ratio.

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



The preceding pie chart shows the 79/21 percent employer/employee premium contribution ratio is not reflective of the total expenses borne by each party. In fact, when counting deductibles, coinsurance and co-pays, participants pay roughly one-third of the total cost. It is likely the total cost of medical healthcare services paid by the participant is even greater, as a portion of medical healthcare services "not covered" or "paid by another plan" were possibly costs ultimately borne by the participant.

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

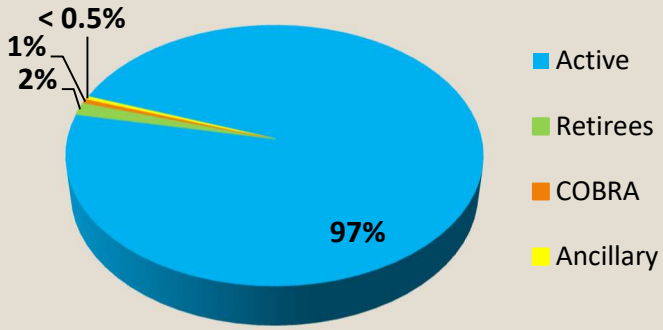
Enrollment and Demographics

The University's health plan had 11,718 medical participants as of December 31, 2024, 16 less than the prior calendar year-end. When including family members, the plan had an average annual medical membership of approximately 28,000 covered lives.

The number of individuals in each participant group was relatively unchanged for 2024.

University retirees can belong to the plan but must pay the entirety of their premium, which is computed separately by plan actuaries from that of active employees. The number of retirees in the plan continues to drop, decreasing 12 percent in 2024. This is attributed to favorably priced "gap" policies available in the marketplace that when combined with a base of Medicare coverage are financially more attractive than the plan offered by the University.

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



University of Nebraska
Number of Health Plan Participants - Medical

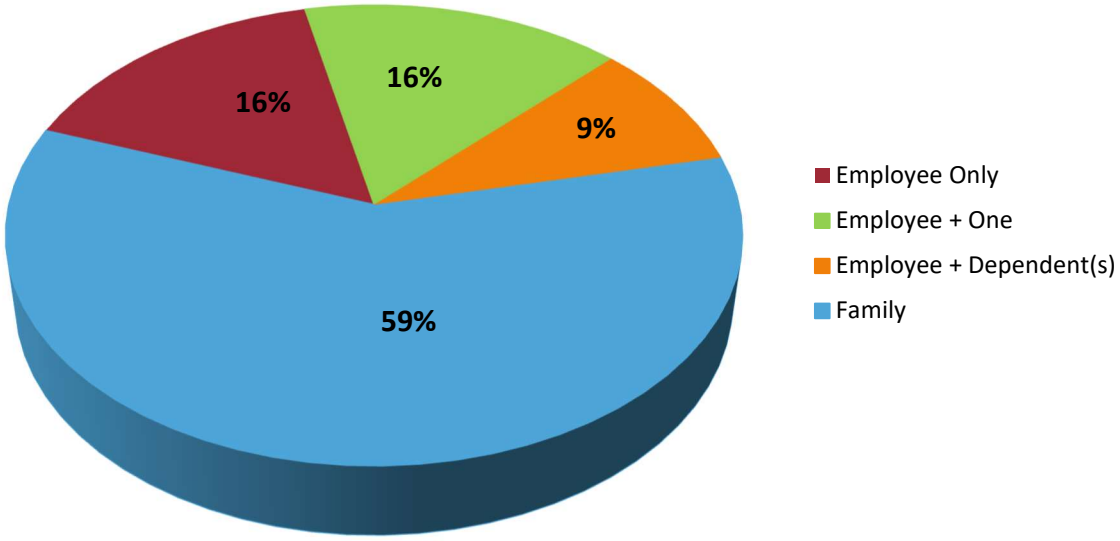
	Dec 2024	Dec 2023	Change Number	Change Percent
Active Employees	11,431	11,429	2	0%
Retirees	188	213	(25)	(12)
Ancillary Members	37	33	4	12
Cobra	62	59	3	5
Total	11,718	11,734	(16)	(0)%

Demographically, covered lives for medical benefits were about 50 percent female and 50 percent male. Average age for all covered lives for medical benefits was 34 years.

In terms of covered lives for medical benefits, the average number of members for 2024 decreased from 2023, with slight increases in the "employee only" and "employee + dependent(s)" categories being more than offset by small decreases in the other two categories.

	Covered Lives for Medical Benefits					
	Average - 2024		Average - 2023		% Change	
	Members	% of Total	Members	% of Total	Members	%
Employee Only	4,611	16%	4,560	16%	51	1%
Employee + One	4,337	16	4,388	16	(51)	(1)
Employee + Dependent(s)	2,492	9	2,490	9	2	0
Family	16,487	59	16,681	59	(194)	(1)
Totals	27,927	100%	28,119	100%	(192)	(1)%

University of Nebraska
Health Plan Medical Benefit Membership by Category



The plan originally offered three levels of medical coverage: low, basic, and high, with each (respectively) offering increasing levels of coverage. The high plan has much lower deductibles and coinsurance but higher premiums compared to the low plan. In 2019, a fourth level was added – the qualified high deductible plan, which has much higher deductibles but lower coinsurance than the other levels and a premium that is comparable to the low plan. Enrollments shifted ever-so-slightly in 2024 through participant growth in the low and qualified high deductible plans, with about 64 percent of participants choosing the basic plan, 16 percent the low plan, 11 percent the high plan, and 9 percent the qualified high deductible plan.

The University of Nebraska's health plan had average annual medical membership of approximately 28,000 covered lives (employees and their family members)

Financial Performance

The University health plan's financial results for the years ended December 31, 2024 and 2023 are shown below (cash basis in thousands). A more detailed description of the plan's income, expenses and calendar year activities is provided in the following sections.

Plan income again fell short of plan expenses in 2024, though less than in 2023, resulting in a $4.7 million increase in net activity as compared to 2023. This increase in net activity between years was driven by a 5 percent increase in total premiums and income, which more than offset a 3 percent increase in total claims and expenses.

The reason for the increase in plan income in 2024 is attributable to the average 12.5 percent increase in medical premium rates, which marked the seventh time in the past eight years that the medical premium rate has increased after several years which saw no increase in the medical premium rates.

The increase in plan expenses is primarily attributable to a 6 percent increase in medical claims and a 41 percent increase in TPA, ACA, and other expenses. These increases were offset by an 8 percent decrease in pharmacy claims.

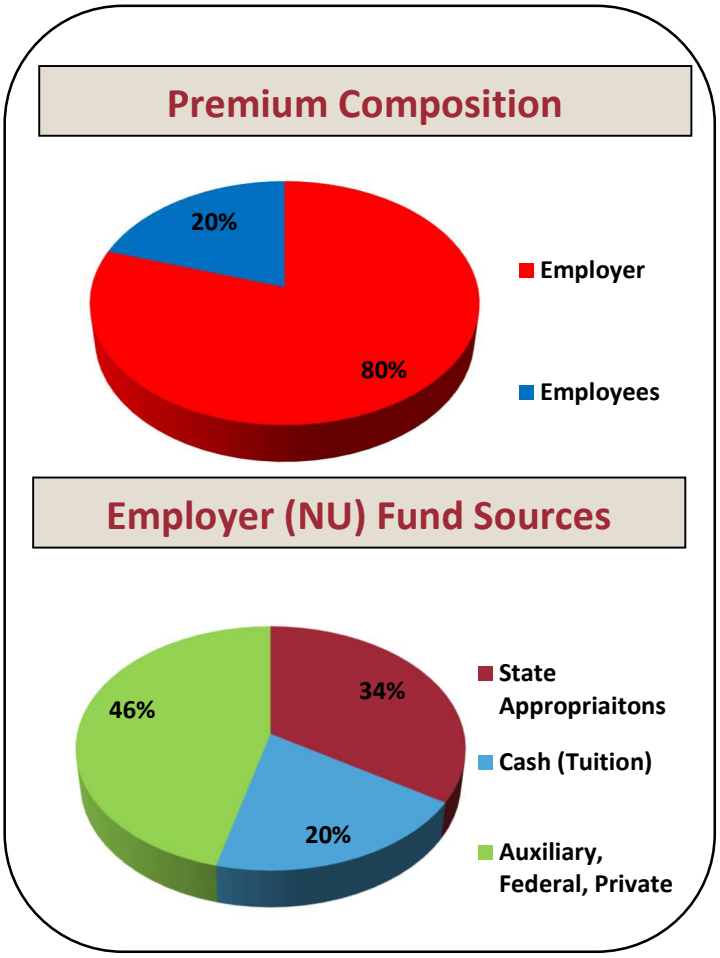
University of Nebraska Health Plan
Schedule of Income, Expenses, and Net Activity
Cash Basis (thousands)

	Actual 2024	Actual 2023	Year-over-Year Change Dollars	Year-over-Year Change Percent
Employer Premiums	$ 166,433	$ 149,343	$ 17,090	11%
Employee Premiums	41,841	38,389	3,452	9
Retiree, Ancillary, Cobra Premiums	5,075	5,166	(91)	(2)
Trust Investment Income	(106)	822	(928)	(113)
Pharmacy Rebates & Discounts/Misc	12,156	20,497	(8,341)	(41)
Total Premiums and Income	225,399	214,217	11,182	5
Medical Claims	160,164	150,659	9,505	6
Pharmacy Claims	61,222	66,375	(5,153)	(8)
Dental Claims	9,591	9,590	1	0
TPA, ACA, and Other Expenses	7,252	5,140	2,112	41
Total Claims and Expenses	238,229	231,764	6,465	3%
Net Activity	$ (12,830)	$ (17,547)	$ 4,717	

Income

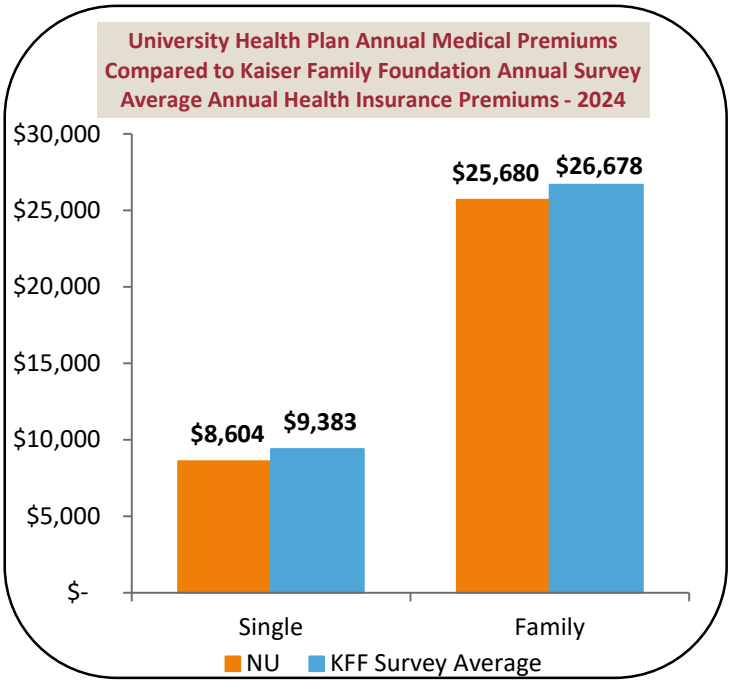
The University's health plan is funded from a variety of sources, although employer and employee premiums account for the bulk (93 percent) of the plan's income. Employer premiums are funded primarily from state appropriations (34 percent); cash funds such as tuition (20 percent); and self-supporting business-type activities (auxiliaries), federal grants and contracts, & other sources (46 percent).

The plan's remaining income comes from retirees, ancillaries, and Cobra electees (2 percent), and investment income, pharmacy rebates & discounts and miscellaneous income (5 percent).



For the year ended December 31, 2024, the plan's income from employer and employee premiums increased by about 11 percent. This was primarily the result of an average 12.5 percent increase in medical premium rates in 2024. Additionally, dental premium rates increased by an average of just under 4 percent in 2024 (only the third increase since 2014). Finally, these premium increases were offset by about a half-percent decrease in average annual medical participants in 2024.

The 2024 change in the third-party administrator for pharmacy claims had significant impacts on both pharmacy rebates/discounts and pharmacy claims. EmpiRx drug prices are lower than the previous third-party administrator, but in turn EmpiRx also distributes fewer rebates/discounts. Additionally, EmpiRx quarterly rebates/discounts are typically received about five months after the end of the calendar quarter, whereas quarterly rebates/discounts from the previous third-party administrator were typically received about three months after the end of the calendar quarter. As a result, factoring in the 2024 third quarter rebates of $3.0 million not received until 2025, pharmacy rebates/discounts were down $4.8 million, while pharmacy claims were down $5.2 million.



The University continues to offer a competitive premium pricing structure. Annual medical premiums (employer plus employee) under the University's basic coverage plan are lower than the average annual health insurance premiums as reported in the Kaiser Family Foundation Employer Health Benefits 2024 Annual Survey[ii] by approximately 8 percent for single and 4 percent for family coverage.

Expenses

Medical Expenses

The plan's medical claims increased by approximately 6 percent for the calendar year. Medical claims in 2024 and 2023, arrayed by amount of medical claims per covered lives, were as follows:

University of Nebraska
2024 Medical Claims Distribution (Claims in Thousands)

Total Claims/Member	Covered Lives	Percent of Lives	Amount	Percent of Claims $$
Less than $5,000	21,132	81%	$ 29,247	18%
$5,000 to $9,999	2,065	8	15,957	10
$10,000 to $24,999	1,743	7	30,479	19
$25,000 to $49,999	692	3	26,131	16
$50,000 to $99,999	299	1	23,346	15
$100,000 to $199,999	105	0	17,412	11
$200,000 and above	43	0	17,407	11
	26,079	100%	$ 159,979	100%

Note: only persons presenting claims are included in this analysis. Claim amounts are per BCBS & UMR, and covered lives are per BCBS (to avoid duplication of covered lives).

University of Nebraska
2023 Medical Claims Distribution (Claims in Thousands)

Total Claims/Member	Covered Lives	Percent of Lives	Amount	Percent of Claims $$
Less than $5,000	22,909	83%	$ 23,908	16%
$5,000 to $9,999	2,038	7	14,148	9
$10,000 to $24,999	1,775	6	27,979	19
$25,000 to $49,999	614	2	21,180	14
$50,000 to $99,999	274	1	18,941	13
$100,000 to $199,999	132	1	18,281	12
$200,000 and above	59	0	25,479	17
	27,801	100%	$ 149,916	100%

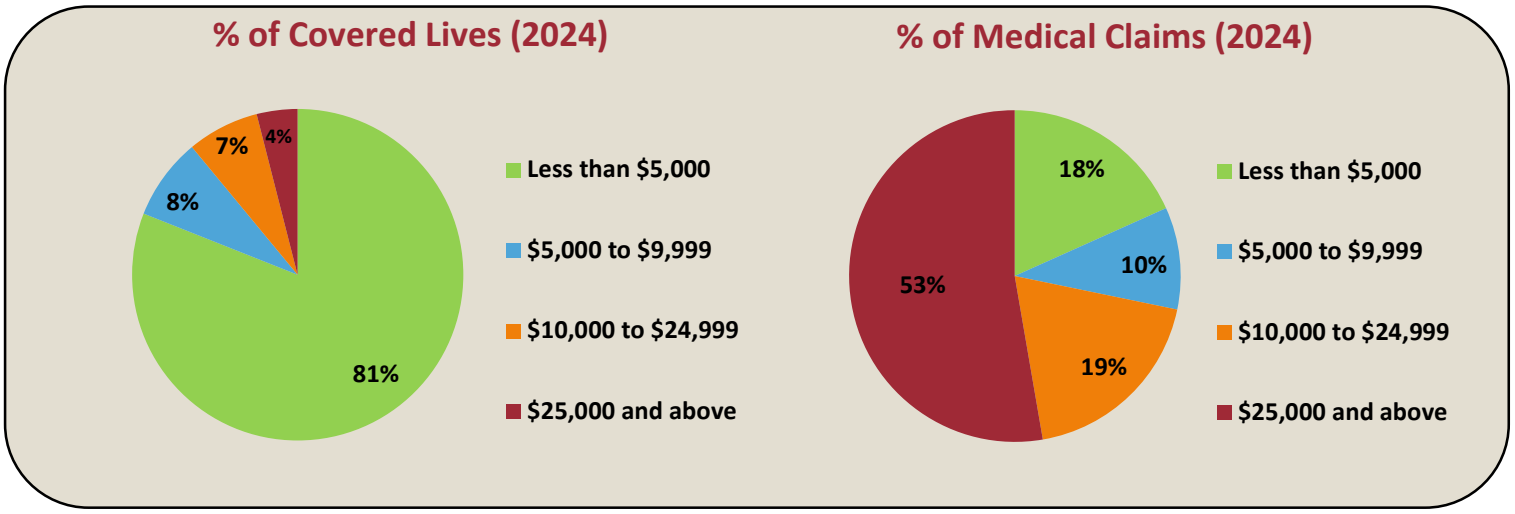
Note: only persons presenting claims are included in this analysis. Claim amounts and covered lives are per UMR.

Note that the table above shows medical claims paid by the third-party administrator during the reporting period and therefore may not be consistent with amounts paid by the trustee.

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

As is typical in health plans, costs associated with high-cost claimants tend to be the main driver of costs. As can be seen in the table on the previous page and the charts below, in 2024 (with parentheticals showing 2023 figures):

- The top 4 percent of the covered lives accounted for 53 percent (56 percent) of medical claims.
- Covered lives with medical claims of $10,000 and above accounted for 72 percent (75 percent) of medical claims.
- Covered lives with medical claims of less than $25,000 were the primary driver of the approximately $10 million increase in medical claims in 2024.
- 81 percent (83 percent) of the covered lives had medical claims of less than $5,000.
- Covered lives with medical claims of less than $5,000 accounted for just 18 percent (16 percent) of medical claims.

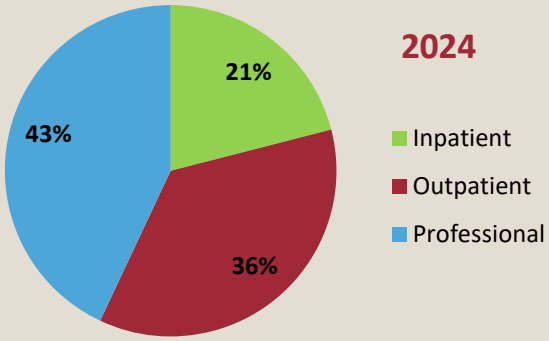


Medical costs are comprised of inpatient, outpatient, and professional services (physician and ancillary). Inpatient services represent the costs that come with a hospital/facility stay. Outpatient services are comprised of procedures that do not require a hospital stay, such as ambulatory surgery, emergency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

Net payments by service type as reported by the third-party administrator were:

University of Nebraska
Net Medical Payments by Type (millions)

	2024	2023	Change Dollars	Change Percent
Inpatient	$ 33	$ 39	$ (6)	(15)%
Outpatient	58	39	19	49
Professional	69	72	(3)	(4)
	$ 160	$ 150	$ 10	7%



Inpatient

Inpatient costs decreased 15 percent, to $33 million in 2024 compared to $39 million in 2023. Costs per member per month were approximately 3 percent less than the BCBS Book of Business for 2024 (which comprises approximately 3,100 groups and 0.4 million members).

Outpatient

Outpatient costs increased 49 percent, to $58 million in 2024 compared to $39 million in 2023. Costs per member per month were approximately 6 percent higher than the BCBS Book of Business for 2024.

Professional Costs

Professional costs decreased 4 percent, to $69 million in 2024 compared to $72 million in 2023. Costs per member per month were approximately 16 percent higher than the BCBS Book of Business for 2024.

Medical Benchmarking/Statistics

There are several medical benchmarks and statistics worth noting that allow us to compare the plan's current year results to those seen in the industry or provide trend considerations, though do note that such comparisons could be skewed a bit given this is "year 1" with BCBS and most benchmarks/statistics do not include the claim run-off from UMR:

- The average age of covered lives under the University's plan was 34, which is slightly higher than the BCBS Book of Business of 33.

- The average age of the University's employee participant was 43 compared to 46 in 2023.
- The percentage of covered lives age 65+ under the University's plan was 6 percent compared to the BCBS Book of Business of 3 percent.
- The top 10 major diagnostic categories included wellness/preventative, musculoskeletal, mental, neoplasms, circulatory, digestive, pregnancy/childbirth, abnormalities, genitourinary, and injury/poisoning.
- Admissions per 1,000 members were 45.4, well below the BCBS Book of Business of 56.7. Additionally, the average length of stay in 2024 was 5.5 days, again below the BCBS Book of Business of 6.0 days.
- Outpatient visits per 1,000 members were 1,779, well above the BCBS Book of Business of 1,593.
- Professional visits per 1,000 members were 11,772, slightly below the BCBS Book of Business of 11,860.

Pharmacy Expenses

Pharmacy claims are handled through a third-party administrator, who offers rebates and discounts to the plan based on combined purchasing power. In 2024, EmpiRx was named the third-party administrator for pharmacy claims. As was mentioned in greater detail earlier, adjusted pharmacy rebates/discounts were down just under $5 million in 2024, as EmpiRx's pricing philosophy is to offer lower drug prices and distribute fewer rebates/discounts. Correlating to this decrease in pharmacy rebates/discounts and as discussed below, pharmacy claims were down just over $5 million in 2024. All things considered, pharmacy results were relatively stable in 2024.

In 2024, pharmacy costs were down about 8 percent to around $61 million. Approximately 9,000 members utilized the plan's pharmacy program each month. The average annual net pharmacy cost per utilizing member totaled about $6,700.

The decrease in pharmacy costs was attributable to brand-name prescription costs, which were 30 percent of total pharmacy costs in 2024 compared to 36 percent in 2023. Brand-name prescription costs decreased about 24 percent, from $24.1 million in 2023 to $18.3 million in 2024.

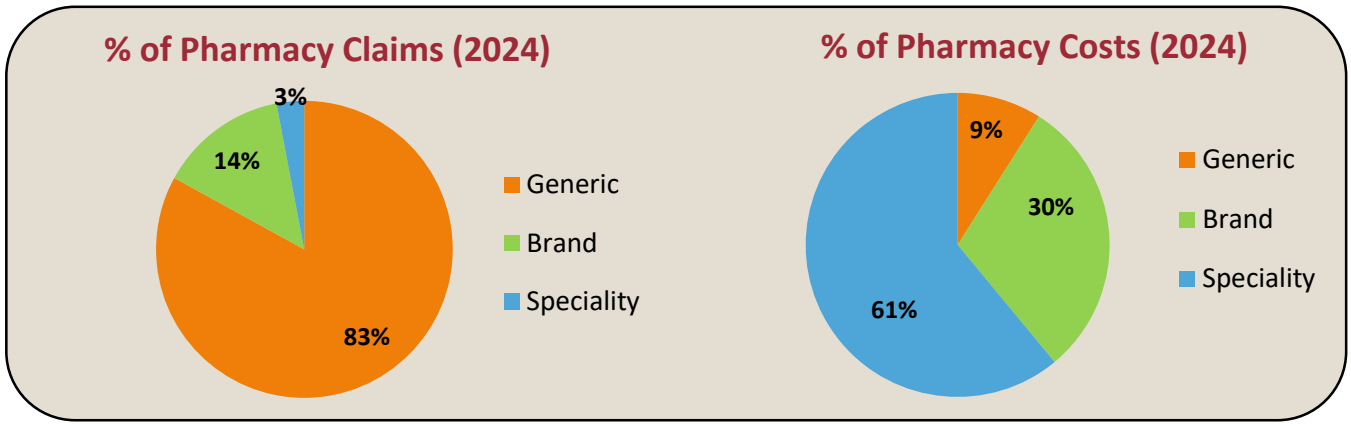
Pharmacy expenditures by category of drugs were as follows for the past two years:

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

	Claims Net Cost		Claims Cost as Percent of Total		Total Claims		Percent of Total Claims		Cost Per Claim	
	2024	2023	2024	2023	2024	2023	2024	2023	2024	2023
Generic	$ 5,503	$ 5,175	9%	8%	212,861	220,984	83%	81%	$ 26	$ 23
Brand	18,340	24,102	30	36	34,437	47,940	14	17	533	503
Specialty	37,172	36,807	61	56	7,445	5,473	3	2	4,993	6,725
	$ 61,015	$ 66,084			254,743	274,397				

Note that the table above shows pharmacy claims paid by the third-party administrator during the reporting period and therefore may not be consistent with amounts paid by the trustee.

The importance of generic drugs in controlling costs can be gleaned from the foregoing table and the charts below. While generics represented 83 percent of total prescriptions, they only accounted for 9 percent of pharmacy costs in 2024.



The generic dispensing rate remained strong in 2024 at 83 percent, up from 81 percent in 2023. Pricing drove the increase in pharmacy costs associated with generic drugs, as a 4 percent decrease in the number of generic drug claims was more than offset by a 6 percent increase in the net cost of generic drug claims.

Conversely, specialty drugs are 3 percent of the plan's prescriptions, but account for 61 percent of the costs in 2024. 8 out of the top 10 prescription drugs used in 2024 were specialty drugs. Primary among the specialty classes are oncology, psoriasis, crohn's disease, rheumatoid arthritis, cystic fibrosis, hereditary angioedema, hemophilia, psoriatic arthritis, multiple sclerosis, atopic dermatitis, and asthma. While the net cost of specialty drug claims increased 1 percent, the total

number of specialty drug claims actually increased 36 percent, equating to a 26 percent decline in average cost per specialty drug prescription.

Utilization drove the decrease in pharmacy costs associated with brand-name drugs, as a 28 percent decline in the number of brand-name drug claims resulted in a 24 percent decline in the net cost of brand-name drug claims.

Reserves and Fund Balances

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

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

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

Through a combination of proper pricing, aggressive management of deductibles and co-pays, prudent planning regarding potential cost increases, and favorable claims experience resulting from staying on the forefront of healthcare trends, the University has accumulated (over several years) fund balances that could be utilized for one-time health related purposes. However, over the past couple of years, claims and expenses have significantly outpaced premiums and income, dramatically eating into these accumulated fund balances, which sat at $60.3 million at December 31, 2022. The University is combatting the adverse trend in health care expenses by competitively bidding third-party administration of medical, pharmacy, and dental claims; continuing to increase annual premiums; and implementing increases in certain plan design costs (deductibles, out-of-pocket maximums, copays) in 2026, something that was last done in 2011.

As of December 31, 2024, the University's health plan had a trust fund balance of $25.2 million, with a net balance of $5.3 million after subtracting estimated IBNR reserves. This remaining net balance represents approximately 2.5% of annual medical/pharmacy claims and would be available to offset any unusually high volume of claims or unexpected number of claims that exceeded the claims estimate utilized to establish premium rates, which has historically been reserved at 5 percent of annual medical/pharmacy claims.

As previously mentioned, the trust fund balance at December 31, 2024 is distorted a bit due to the change in pharmacy third-party administrators in 2024. The new third-party administrator typically distributes quarterly rebates/discounts about five months after the end of the calendar

quarter, whereas quarterly rebates/discounts from the previous third-party administrator were typically distributed about three months after the end of the calendar quarter. Hence, the third quarter rebate, which has historically been received by calendar year-end, was not received until after December 31, 2024. This rebate totaled $3.0 million and is not reflected in the $25.2 million trust fund balance at December 31, 2024.

In December of 2018 and in conjunction with the transition from BlueCross BlueShield of Nebraska to UMR, the plan's trustee transferred $4 million to a separate UMR account to be utilized by UMR to pay medical claims beginning in 2019. With the transition back to BCBS in 2024, UMR began to incrementally return the $4 million as run-off claims tailed off, returning $2 million in July of 2024. The remaining $2 million, which is included in the $25.2 million trust fund balance at December 31, 2024, was returned in March of 2025.

Conclusions and Looking Ahead

The University's trust fund balance decreased in 2024 from $41.1 million to $25.2 million. As noted earlier in this report, we believe that claims payment timing differences are a primary contributing factor for the difference between the $15.9 million decrease in the trust fund balance and the $12.8 million net activity negative balance reflected in the Financial Performance section of this report for 2024.

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

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

- Getting a handle on specialty drugs to assure the drugs match the diagnosis.
- Movement of pharmacy costs out of medical and into the pharmacy pipeline to assure consistent treatment for members.
- Continued focus on step therapies. Under this concept, high-priced drugs are not available without having tried generics first.

Presently, the plan continues to be "grandfathered" in regard to the Affordable Care Act.

Trends in the national health insurance market, such as inflation, rising pharmacy costs, and higher reimbursement rates for providers will continue to impact the plan. In the last two years alone, the trust fund balance has declined significantly, in large part due to these trends. Management will continue to be proactive in managing the plan and addressing such trends, including increasing premiums and making changes to plan design, when deemed necessary.

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

Endnotes and References

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

[ii] The Kaiser Family Foundation Employer Health Benefits 2024 Annual Survey, https://www.kff.org/health-costs/report/2024-employer-health-benefits-survey