Report of the

Task Force to Explore

Health Insurance Opportunities

Submitted to the Governor and Nebraska Legislature pursuant to LB 1217 (2000)

December 14, 2000

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SUMMARY

The cost of providing health care benefits to public employees has increased significantly. In January 2000, Senator Curt Bromm introduced LB 1416 in the Nebraska Unicameral. This bill was later amended into LB 1217. This bill created the Task Force to Explore Health Insurance Opportunities in order to examine the various means by which publicly funded employers provide health care benefits to their employees. The Task Force was charged with the task of developing possible alternatives and opportunities to providing health insurance to employees and to identify the advantages and disadvantages to each alternative.

Self-insured pooling of various publicly funded employer plans may result in some savings and moderate the premium increases of smaller employers. However, pooling must be a long-term commitment to function properly. Pooling will be more successful if it is mandatory. If it is voluntary employer plans that pay lower premium rates than the pool rate will probably not join the pool. This may result in only plans with higher claims experience joining the pool. Illinois has a self-insured pool for political subdivisions. Some political subdivisions pay a lower premium through the Illinois plan because of this group purchasing. The Illinois plan is successful in Illinois but would be difficult to duplicate in Nebraska.

Group purchasing of health insurance by several separate employers provides possible reduction of premium for smaller plans. However, there must be a long-term commitment for this to be effective or employer plans with favorable claims experience that are able to pay a lower premium rate will leave the larger group. Also, whether or not group purchasing is feasible, depends on whether an insurance company will issue a health insurance policy or HMO contract to a group of separate employer entities. This may be difficult to accomplish.

The cost of providing health benefits to public employees may be affected by changing the benefit structure. Three benefit targets that provide the most significant opportunity to reduce the cost and stabilize utilization are pharmaceuticals, increasing individual and family deductibles, and increasing the annual threshold for maximum out-of-pocket expense.

Requiring publicly funded employer health benefit plans to provide a standard package of health care benefits to their employees may reduce premium costs. Such standardization of benefits may also provide a consistent benefit to all public employees and may result in more predictability in funding. However, standardizing benefits could result in reducing the benefit package for some employees. Further, health benefits may be subject to collective bargaining and may have previously been traded for salary dollars which makes it more difficult to require standardization during the current bargaining period.

Nebraska statutes that mandate coverage for specific illnesses or mandate coverage for certain medical procedures increase the premium cost of health insurance for employee benefit plans. However, these mandates do not adversely impact publicly funded employer plans since most other employers appear to provide such coverage and Nebraska has fewer health benefit mandates than other states. The managed care statutes should be examined for requirements that are not necessary or that provide minimal benefit to insureds, yet increase the cost of providing insurance coverage.

Introduction

In the past few years the cost of providing health care benefits to public employees has increased significantly. All employers have experienced increases in the cost of providing health insurance. The causes are various and include factors such as the increased cost of prescription drugs, more informed and active patients, direct marketing by drug manufacturers, and benefit structures that do not provide enough incentive to employees to use lower cost quality benefits.

In January 2000 Senator Curt Bromm introduced LB 1416 in the Nebraska Unicameral. This bill created a task force to examine the various means by which publicly funded employers provide health care benefits to their employees. LB 1416 was later amended into LB 1217. The task force created by LB 1217 is called the Task Force to Explore Health Insurance Opportunities. It is composed of twenty members who were appointed by the Governor. The Nebraska Department of Insurance provided staff support to the Task Force. The Department of Health and Human Services provided a facilitator for many of the meetings of the Task Force.

LB 1217 states that the Legislature found that: (a) the state and political subdivisions are challenged with limited resources for all services; (b) costs to provide health insurance to employees have risen sharply, particularly during the last year; and (c) a need exists to explore all opportunities for government to seek efficiencies in providing quality, affordable health insurance to its employees.

The Task Force to Explore Health Insurance Opportunities was charged with the task of developing possible alternatives and opportunities to providing health insurance to employees and to identify the advantages and disadvantages to each alternative. LB 1217 requires the Task Force to issue a final report containing these findings to the Governor and each member of the Legislature by December 15, 2000.

The Task Force to Explore Health Insurance Opportunities held seven meetings. Initially the task force prepared an analysis of the various health benefit plans of publicly funded employers. This analysis compared the basic benefits and costs of each plan. The Task Force thoroughly discussed several different alternatives for providing health care benefits including fully-insured employer plans, self-funded employer plans, group purchasing by several employer groups, pooling of self-funded plans, state statutory mandates, prescription drug costs, and the Illinois political subdivision plan. The Task Force also developed criteria to evaluate the various alternatives. The criteria are composed of significant factors that should be considered when developing and changing an employee benefit plan. There was considerable discussion of the different alternatives during the meetings of the task force. This final report describes alternatives to providing health insurance to employees of publicly funded entities and the advantages and disadvantages of each alternative.

Advantages and Disadvantages of Self-Insured Pooling

Self-insured pooling is an agreement among a group of homogenous entities to jointly fund each other's risks. Members pay premiums to the pool, which in turn pays losses and handles administrative functions in a manner similar to an insurance company. Self-insured pooling is a mechanism through which many small to medium sized insureds may join together to pool their loss exposures. The pool members agree to fund a set amount of any one loss and purchase reinsurance above that amount to guard against catastrophic claims. The pool may also agree to an aggregate limit and purchase reinsurance above that amount to guard against the expense of total claims exceeding the preset aggregate limit. Premiums and loss limits are annual amounts and each year stands on its own.

Advantages of self-insured pooling

- The risk of loss is spread among all members of the pool.
- Possible reduction in administrative costs.
- Possible reduction in reinsurance costs.
- Since premiums are most volatile at the primary level, pooling provides the possibility of stability of year to year costs.
- Investment income can be realized from investing money retained for reserves.
- Pool members have control of the benefit plan and can tailor coverage to the needs of the members.
- Pool members share in the gains from good claims experience.
- Pool members may screen applicants to exclude entities with high risk or experience.
- Pools are an alternate method of providing coverage.

Disadvantages of self-insured pooling

- Pools can not be entered and exited at will. Pooling is a long-term commitment.
- Pool members share in the losses from poor claims experience.
- A management team must be developed and adequately funded.
- To be successful, pools must have a strong financial base. Hence, there must be adequate premium and contribution levels.
- To be successful, pools must be properly structured and follow a well laid out business plan.
- Not all entities may qualify for admittance to the pool.
- The benefit plan is a compromise and individual entities may lose flexibility in the design of the benefit plan.
- Someone must take the time and energy to spearhead the establishment of a pool.

To be successful, a self-insured pool should consist of the same types of risks and be as homogenous of a unit as possible. Mixing entities with different opinions regarding coverages, premium savings, loss control practices, claims services, investment beliefs, deductibles and loyalty commitments will often lead to failure. Oversight by the Department of Insurance of a health insurance pool subject to volatility with immediate and high cost claims is important for both the entities involved as well as the individual participants covered by the pool.

Advantages and Disadvantages of Group-Purchasing

Group purchasing is an agreement among a group of homogenous entities to combine together to purchase fully insured coverage. The group would agree upon the benefit package or packages to be offered. The combination of several entities increases the number of lives to be covered by the benefit packages. The group would then place coverage with existing insurance companies.

Advantages of group-purchasing

- The combination increases the size of the plan for placement with insurance companies
- Possible reduction in costs due to the increase in size of the group.
- Group members have control of the benefit plan and can tailor coverage to the needs of the group.
- Group members share in the lower costs from good claims experience.
- Since coverage is through an indemnity plan, there is no obligation beyond the premiums paid in the case of bad experience for the group.
- Group members may screen applicants to exclude entities with high risk or experience.
- Group purchasing is an alternate method of obtaining coverage.

Disadvantages of group-purchasing

- Group members can not enter and exit at will. Group purchasing is a long-term commitment.
- Group members share in the increased costs from poor claims experience.
- A management team must be developed and adequately funded.
- To be successful, group purchasing must be properly structured and follow a well laid out business plan.
- Not all entities may qualify for admittance to the group.
- The benefit plan is a compromise and individual entities may lose flexibility in the design of the benefit plan.
- Someone must take the time and energy to spearhead the establishment of a group-purchasing plan.

To be successful, a group-purchasing plan should consist of the same types of risks and be as homogenous of a unit as possible. Mixing entities with different opinions regarding coverages, premium savings, deductibles and loyalty commitments will often lead to failure. The establishment of a voluntary group-purchasing plan increases the possibility of only entities with poor experience joining. In the current health insurance environment, it may be very difficult to find a carrier willing to write coverage for group purchasing by local government entities in the state of Nebraska.

Advantages and Disadvantages of the Illinois Plan

The Illinois Local Government Health Plan (LGHP) started July 1, 1990. The LGHP was created to provide a comprehensive program of quality and affordable health care coverage for local governments. LGHP is a self-insured pool, funded solely by the participants of the program. There are no profits or commissions involved with the program. The LGHP is a self-insured pool separate from the Illinois State Employees Group Insurance Program. The LGHP plan does benefit from its relationship to the much larger state plan in the areas of administrative efficiencies and provider discounts. The Illinois Department of Central Management Services administers the LGHP plan.

The State Employees Group Insurance Program is a pool of 400,000 employees, dependents, and retirees. The LGHP plan includes 29,000. There are approximately 630 entities in the LGHP. The majority of groups are less than 50 participants. At least 85% of an entity's full-time employees must participate. Part-time employees who work between 50% and 90% of the entity's normal work period may participate. Elected officials who receive a salary may participate regardless of the number of hours worked. The entity decides if retirees are to be covered. Groups eligible for the LGHP plan include:

- Counties
- Municipalities
- Villages
- School districts
- Community colleges
- Libraries
- Sanitary districts
- Domestic violence shelters
- Park districts
- Rehabilitation centers

The LGHP plan includes dental and vision coverage. Subject to availability in a given area, the LGHP plan offers three different medical options:

- Quality Care Health Plan PPO
- Health Maintenance Organization (HMO)
- Point-of-Service Plan (POS)

To meet the demographic needs of a changing workforce, LGHP offers three levels of premium rates, including:

- Single coverage
- Member plus one dependent
- Family coverage

The LGHP plan carries a stop loss of $ 150,000 for any one claim up to a maximum of $ 3,000,000. It does not appear that the plan has an aggregate limit. The actuaries have set rates, to this point, that have prevented a problem regarding the aggregate limit. The LGHP plan has the right to hold payments to facilitate cash flow. For the past year, the plan has had to hold payments up to three weeks in order to manage cash flow.

The LGHP has ten tiers of rates (AAA, AA, A+, A, B+, B, C+, C, D+ and D). The spread in rates for single coverage from AAA to D is currently $ 242 per month with the difference between tiers of approximately $ 30 per month. Entities apply by providing the:

- Number of employees/elected officials and retirees/survivors
- Number of dependents for the above
- Sex
- Age
- Zip code

The actuaries for the plan, using the entity's demographics, employee and dependent participation in the health plan and geographic location, assign the entity to a tier. Enrollment requires a two-year contract. If the entity cancels within the contract period, it is ineligible to re-enroll for five years. Entities may move up or down one tier each year based on the entity's claim experience. Each entity receives its own claims experience report. New rates are developed at the beginning of each fiscal year based on a combination of:

- Actual claims
- Experience
- Employer demographics
- Projected health care costs increases
- Administrative expenses

For the current fiscal year, rates increased approximately:

- 19% if you stayed in your tier
- 10% if you moved up a tier
- 28% if you moved down a tier

Advantages of the Illinois LGHP Plan

- No single entity has to shoulder the rate increases that can occur if a member has catastrophic losses
- Small entities have access to coverage options and rates usually reserved for larger organizations
- There are three different medical plan options
- No group is too small to participate
- Eligibility includes elected officials and retirees
- There are no cancellations due to a entity's claims history

Disadvantages of the Illinois LGHP Plan

- Because LGHP benefits mirror those of the State Employees, benefits are subject to change without an entity's approval
- 85% of an entity's employees must enroll in the plan, and that percentage must be maintained
- Enrollment requires a two-year contract. If entity cancels in contract period, it is ineligible to re-enroll for five years
- If a local hospital withdraws from the PPO network, benefits can be affected.
- Because any eligible entity can enroll, the plan does experience some adverse selection since entities that can obtain a lower rate do not enroll.

There are several aspects to the Illinois LGHP plan that would be difficult to duplicate in Nebraska. The size (in excess of 400,000) of the group involved provides more bargaining power with provider and provider net works. The number of providers and provider networks available in Illinois also provides the possibility of more competition in negotiations. The size of the Illinois group provides economies of scale for administration that would not exist in Nebraska.

Benefit Structure Alternatives And Benefit Standardization

This work group was charged to seek alternative ways to reduce or stabilize health coverage premium costs. In addition, the group was asked to examine if such a program could be employed as a standard policy for all Nebraska public Employees. Publicly funded entities should encourage their employees to use the flexible spending program, which will result in cost savings for both the employer and the employees.

Based on consultation from the Blue Cross and Blue Shield of Nebraska chief actuary, the Subcommittee focused on three benefit targets that have the most significant opportunity to reduce monthly premium costs and stabilize utilization. The three targets are:

- Pharmaceuticals
- Increase individual and family deductibles
- Increase the annual threshold for maximum out-of-pocket expenses

<u>Benefit Structure Alternatives</u>

The following benefit structure is considered by the Subcommittee as an example of a base level program that would reduce premium costs. Future healthcare cost inflation could require increases in the deductibles to adjust for such inflation.

- Annual deductible amounts:
  - $ 500.00 individual
  - $1,000.00 family

- Maximum annual out-of-pocket expense:
  - $2,000.00 individual
  - $4,000.00 family
- 80%/20% (coinsurance) for benefits received within the PPO network statewide for:
  - Inpatient care*
  - Outpatient care*
  - Pharmacy*

  *Note: Each of these benefits would be monitored and measured against the selected stop loss annually. One could achieve the same approximate savings on pharmacy through a drug card with a $15/$35 component, and no stop loss.

- $50.00 fixed deductible per emergency room visit unless the patient is admitted
- Mental health – same as physical medicine for inpatient
  - Fixed copay of $50.00 for outpatient per visit
- Out of PPO network copay 70%/30% for all above benefits
- DME (durable medical equipment) valued at greater than $500.00 per visit would be payable after deductible at 80%/20% in-network and 70%/30% out-of-network.

  *Note: This benefit structure, in the current environment, is subject to both federal and Nebraska benefit mandates. It is also conditioned by the current and emerging directives of the federal Health Insurance Portability and Accountability Act (HIPAA).

Using current 2000 premium rates applicable to State of Nebraska employees, the following premium reductions, by category, could be achieved:

Deductible to $500.00/$1,000.00	4.0%
Coinsurance to 80%/70%	2.5%
Out of Pocket to $2,000 individual	2.5%
RX Subject to Deductible and Coinsurance	5.0%
Removal of Fertility Endorsement	2.0%
Removal of Routine Care Endorsement	1.7%
Cumulative Total	17.7%*

*This potential reduction in the premium cost benefits both the employer and health plan member because it reduces the overall premium cost. However, health plan members will be negatively impacted because they will likely experience higher out-of-pocket expenses. The reduction in premium cost is primarily generated by shifting more expense to the health plan member. Some cost savings may be experienced if these changes which are intended to modify utilization result in fewer claims.

Benefit Standardization

Such a program may be applicable as a public employee model.

Advantages

- Reduction of premium costs
- Perceived fairness to public employees through standardization
- Modification of employee behavior resulting in more prudent use of medical service
- Predictability in funding
- Open access to health care providers

Disadvantages

- Probable benefit reduction for public employees
- Conflicts with public employee collective bargaining statutes
- May disrupt compensation systems in which salary dollars were traded for benefit enhancements
- Agreement on the specific details of the care plan may be difficult to achieve
- Some premium savings result from shifting costs from the employer over to the employees

Nebraska Statutes

This section provides an analysis of Nebraska statutes that may affect the various alternatives presented by the Task Force to Explore Health Insurance Opportunities. Also attached is a listing of significant health insurance statutes that were reviewed.

Health insurance mandates

There are several state statutes that require insurance policies and HMO contracts to provide coverage for specific illnesses or mandate that certain medical procedures be covered. However, Nebraska has fewer statutes that mandate coverage than most other states.

These various mandates add some additional cost to insurance policies that increases the premium the policyholder must pay. These state statutes also contain provisions that limit the cost to provide the mandated coverage. Therefore, even though the cost to provide all of the mandated benefits does add some cost to insurance policies these control measures minimize the impact.

Further, most of these mandated benefits are routinely provided by almost all employer health benefit plans. Consequently, it would be difficult to exclude them from a group employer plan because these benefits appear to be standard in most group employer plans. Excluding them from publicly funded employer plans could make public employers less attractive to prospective employees.

A few of these mandates are required by federal law (Health Insurance Portability and Accountability Act of 1996) such as the requirement to cover costs of re-constructive surgery for mastectomies. Since all employer plans must comply with these laws it seems reasonable that political subdivisions should be subject to the same mandates. Non-Federal governmental plans may elect to be exempt with respect to the portion of the plan not provided through health insurance.

There are also a few statutes that require equal access to payment under the insurance policy to certain medical providers. In general these statutes do not appear to add significant costs to insurance policies. Neb. Rev. Stat. §44-513.02 requires insurers to impose the same copayment for prescription drugs that are less than one hundred eighty days, regardless of whether they are obtained through a local pharmacy or through mail order. However, a different copayment may be imposed on prescriptions of one hundred and eighty days or more. As an example, if a $10 copayment is applied to each 30-day supply, a ninety-day supply of a drug will cost $30 regardless of whether it is obtained through mail order or a local pharmacy. However, a one hundred eighty-day prescription could cost $60 at a local pharmacy, but be subject to only a $40 copayment if obtained through mail order for the same supply. It is feasible that there could be some cost savings if health insurance plans were able to impose different copayments for all mail order prescription drugs in an effort to encourage the use of mail order prescriptions. Copay structure and discount differential will have a significant impact on the level of savings that could be generated.

Advantages of mandates

Uniformity with other fully-insured and most self-funded plans
Attract and retain employees
Cost increase is not as high as other states with more mandates

Disadvantages of mandates

Increases cost to employer and employees

Self-funded versus fully-insured

Under current Nebraska law political subdivisions may self-fund their employee health benefit plans. These plans are not subject to health insurance mandates since there is no commercial insurance arrangement. Consequently, state statutes that mandate health benefits would not be a consideration under this funding mechanism.

Pooling

An alternative discussed in this report is pooling. This includes political subdivisions: (a) that pool their assets to pay claims on a self-funded basis; or (b) that keep separate insured plans and jointly purchase coverage or reinsurance. The health insurance mandates do not affect the ability to pool on either basis. However, the Intergovernmental Risk Management Act, does not specifically authorize a pool to purchase health insurance and would have to be amended. Also, the Political Subdivisions Self-funding Benefits Act, prohibits pooling by political subdivisions so this statute would have to be amended. If the legislature considers amending state law to allow self-funded political subdivisions to pool to purchase health insurance or to provide health benefits the legislature should consider whether additional amendments are necessary. The legislature should review the appropriate level of excess insurance, adequate financial reserves for political subdivisions, and oversight by the Department of Insurance.

Managed Care Laws

The Nebraska insurance code contains several statutes that apply only to managed care insurance policies. Most political subdivisions are covered by some type of managed care policy, such as a health maintenance organization (HMO) or preferred provider organization contract (PPO). Political subdivisions that self-fund are not subject to these requirements. These managed care laws were enacted in 1998 and impose standards that should be reviewed to determine if they are still necessary. There could be some cost savings to employer plans if requirements that are no longer necessary but add cost are eliminated from these statutes.

Relevant Statutes

1. Health insurance mandates –

   (a) Neb. Rev. Stat. §44-788. Insurance policies that pay for prescription drugs approved by FDA for treatment of cancer or AIDS cannot exclude coverage for combination of FDA approved drugs if it is a recognized treatment.

   (b) Neb. Rev. Stat. §44-789. Insurers and HMOs must provide coverage for treatment of bones or joints of face, neck or head (TMJ). Requires minimum benefit of $2,500.

   (c) Neb. Rev. Stat. §44-790. Insurers must provide coverage for (1) diabetes equipment, supplies, medication, and (2) diabetes education up to maximum benefit of $500.

   (d) Neb. Rev. Stat. §44-791 through 44-795. If an insurance policy provides coverage for mental health conditions the policy may not establish any term, rate or condition that places a greater financial burden for access to treatment for a "serious mental illness" than for treatment of a physical health condition.

   (e) Neb. Rev. Stat. §44-710.19 Newborn children must be covered for the first 31 days after birth.

   (f) Neb. Rev. Stat. §44-784. Insurance policies must pay for the complete set of childhood immunizations to six years of age.

   (g) Neb. Rev. Stat. §44-785. Insurance policies must pay for mammography screening for women beginning at age thirty-five. The statute sets forth the frequency of screening. Deductibles and copayments may apply.

   (h) LB 930. Requires coverage for the cost of re-constructive surgery following a mastectomy.

   (i) Insurance policies must provide coverage for not less than a 48 or a 96 hour hospital stay following delivery of a newborn child, depending on type of delivery, as required by HIPAA.

2. Equal Access.

   (a) Neb. Rev. Stat. §44-513.02. Insurance contracts cannot require insureds to obtain their prescription drugs through mail-order. However, if mail-order drugs are provided as an option, the fee or copayment imposed on mail-order and non mail-order drugs may not be different. Prescriptions of one hundred eighty days or more may impose a different fee or copay.

(b) Neb. Rev. Stat. §44-513. Insurers that pay for the cost of a service under an insurance contract if the service is provided by a physician must also pay certain medical providers that are not physicians to provide the service if that medical provider is also licensed to provide the service.

(c) Neb. Rev. Stat. §44-786. Insurers and HMOs must allow insureds to select an obstetrician/gynecologist as a primary care physician.

3. Managed Care

(a) Neb. Rev. Stat. §44- 7001 et seq., Health Care Professional Credentialing Verification. Requires insurers and HMOs offering managed care plans to establish a program to verify that medical providers contracted with the PPO or HMO meet certain minimum standards of professional qualification.

(b) Neb. Rev. Stat. §44-7101 et seq., Managed Care Plan Network Adequacy. Requires that insurers and HMOs meet standards regarding their provider network and maintain an access plan.

(c) Neb. Rev. Stat. §44-7201 et seq., Quality Assessment and Improvement. Establishes criteria for insurers and HMOs to assess and improve their delivery of health care services.

(d) Neb. Rev. Stat. §44-7301 et seq., Health Carrier Grievance Procedure. Requires insurers and HMOs to maintain a grievance procedure and establishes standards for first, second, standard and expedited review.

(e) Neb. Rev. Stat. §44-6825 et seq., Managed Care Emergency Services. Establishes standard for coverage for emergency services by insurers and HMOs.

4. Pooling

(a) Neb. Rev. Stat. §44-4301 et seq., Intergovernmental Risk Management. Does not include authority to self-fund health coverage (44-4304).

(b) Neb. Rev. Stat. §13-1601 et seq., “Political subdivisions self-funding benefits Act”. Prohibits pooling to self-fund health benefits (13-1617)

5. State Employee Plan

(a) Neb. Rev. Stat. §84-1601 et seq., Nebraska State Insurance Program

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COMPARISON OF NEBRASKA PUBLIC FUNDED EMPLOYEE HEALTH CARE PLANS

	Plans Offered	Number Insured	Funding	Contract Cycle	Administrator
University of Nebraska	Medical PPO with several difference options, and several HMOs.	6,801 Participants	Minimum Premium Reserves held by employer; Annual claims aggregate stop-loss equal to 120% of projected claims	Calendar year basis	Blue Cross/Blue Shield
State of Nebraska Employees	HMO, POS, and two levels of a PPO	13,870 Employees are covered by health insurance; 8,824 are enrolled in the Blue Cross Blue Shield High Option PPO	Fully insured through BC/BS	Calendar year basis; rates guaranteed for two-year period.	
Educators Health Alliance (Neb. State college system, community colleges, school administrators)	3 PPO options, HMO option	29,118 (est.)	Self funded.	Fiscal year: September 1-August 31	Blue Cross/Blue Shield
Natural Resources Districts	PPO	310 Participants	Self funded; Reserve Fund is held by the Nebraska Assoc. of Resources Districts	Fiscal year: July 1 – June 30	Claims Admin: Mid-American Benefits

COMPARISON OF HEALTH PLAN DESIGNS

	Deductible	Copay	Stop Loss	Lifetime Max.	Pharmacy
University of Nebraska	$225 Individual $450 Family	Member pays 25%	$1,100 individual $2,220 family	$2,000,000	Generic copay = $5.00 for a 30 day supply; Preferred Brand Name (formulary) copay = $13 for a 30 day supply; Non-preferred Brand Name (non-formulary) copay = $20 for a 30 day supply.

	Deductible	Copay	Stop Loss	Lifetime Max.	Pharmacy
State of Nebraska Employees	$200 Individual/ $400 Family	Member pays 15%	$1,000 Individual/ $2,000 Family	$2,000,000	Included with the medical plan, Deductible does not apply Generic copay: $10 for 30 day supply; Brand Name copay: $15 for a 30 day supply; Mail Order: $10.00 copay for a 180 day supply; *Plan does not use Formulary*
Educators Health Alliance	Either $0, $100, or $250, HMO – high or low option plan	With the $100 deductible plan copay is 20% in network, and 30% for out of network.	In Network: $1,100 Individual $2,200 Family Out of Network: $2,200 Individual $4,400 Family	$5,000,000	*Deductible does not apply* For In Network: Generic copay: $10 Brand Name copay: $25; Generic Mail Order copay: $40; Brand Mail Order copay: $100; For Out-of-Network: Same copays less 24% Reimbursement

	Deductible	Copay	Stop Loss	Lifetime Max.	Pharmacy
Natural Resources Districts (there are 23 different districts)	$200 Individual/ $400 Family	Member Pays: In Network: 20% of $5,000, then 100% Out of Network: 30% of $5,000, then 100%	Single: In Network: $1,200 Out of Net.: $1,700 Family: In Network: $1,400 Out of Net: $1,900	$2,000,000	Retail (30 days): Brand w/o Generic Available: $20; Brand w/ Generic Available: $20 plus member pays difference b/t the brand and the generic drug price; Generic: $10; Mail Order: 90 days: Brand w/o Generic Available: $20; Brand w/ Generic Available: $20 plus member pays difference b/t the brand and the generic drug price; Generic: $10.

COMPARISON OF MONTHLY AND TOTAL PREMIUMS

	Monthly Premium			Total Premium		
	Employee	**Employer**	**Total**	**Employee**	**Employer**	**Total**
University of Nebraska	Single $3.00 Two/four party $35.12 Family $40.32	Single $154.32 Two/four party $244.34 Family $298.02	Single $157.32 Two/four party $279.46 Family $338.34	1999 Employee $1,208,326 2000 (estimate) Employee $2,041,416	1999 Employer $18,537,454 2000 (estimate) Employer $21,935,992	$4,211,775.36 1999 Total Members: 6,262 Ave Cost: $3,153 2000 (estimate) Total Members: 6,801 Ave Cost: $3,526
State of Nebraska Employees	Single Coverage $ 48.37 Two Party $120.93 Four Party $120.93 Family $171.73	Single Coverage $181.98 Two Party $454.94 Four Party $454.94 Family $646.02	Single Coverage $230.35 Two Party $575.87 Four Party $575.87 Family $817.75	1999 Employee $ 6,635,304 2000 Employee $12,099,432	1999 Employer $33,467,571 2000 Employer $45,517,512	

	Monthly Premium			Total Premium		
	Employee	**Employer**	**Total**	**Employee**	**Employer**	**Total**
Educators Health Alliance (all rates as of 9-1-00)		Family: 100% - 18% of employers, 75-99% - 58%, less than 75% - 24% Single: 100% - 36% 75-99% - 58% less 75% - 7%	For $100 Deductible: Single Health $217.11 Family Health $588.29 For $250 Deductible: Single Health $207.49 Family Health $561.17 For High Option HMO: Individual $262.60 Family $740.40			
Natural Resources Districts (there are 23 different districts)		Family Coverage : 11 districts pay 0%, 7 other districts range from 50% to 80%, 3 pay 100%, 1- pays $250 Single Coverage : 18 districts pay 100%, 1 pays 98%, 1 pays 80%, 1 pays 70%, 1 pays $250.	Premiums Effective 7/1/2000: Employee: $260.32 Employee + Children: $421.94 Employee + Spouse: $475.79 Family: $691.29			Total 2000 (est.): $1,066,125 Average Cost: $3,439.11/person Total 2001 (est.): $1,332,656 Average Cost: $4,298/person

COMPARISON OF HEALTH PLAN DESIGNS

	Vision	Dental	Routine Care	Mental Health	Reproductive
University of Nebraska			100% not to exceed $150 in a calendar year	Mental & Nervous Inpatient: Deductible and 25% coinsurance apply, up to a 60 day max per calendar year (for all other conditions). Deductible and 25% coinsurance apply; 100% after stop-loss is reached (for serious conditions). Outpatient: 100% after $25.00 copay per visit Chemical & Dependency Inpatient: Deduct. and 25% coinsurance apply, up to a 30 day maximum per calendar year. $100,000 lifetime maximum for chemical dependency services Outpatient: 100% after $25.00 copay per visit	Fertility testing and related services are not covered, contraceptives are not covered, and male enhancements are not covered

	Vision	Dental	Routine Care	Mental Health	Reproductive
State of Nebraska			The state PPO plan offers a $250 per year per family benefit for routine care	<u>Inpatient</u> Deductible and 15% coinsurance apply 60 day maximum per calendar year $2,000,000 limit for serious mental illness <u>Outpatient</u> $50.00 copay per therapy visit $2,000,000 limit for serious mental illness $20,000 limit for drug abuse and alcoholism	Fertility testing and related services are covered, Contraceptives are covered. Both are subject to the same copay, deductible and coinsurance as all other covered services. Male enhancements are not covered.
Educators Health Alliance	Not covered	Dental plan available		<u>Inpatient</u> In Network: 20% 30 days per year Out-of-Network: 50% 30 days per year <u>Outpatient</u> In Network: $25 Copay 60 visits per year; Out-of-Network: $50 Copay 60 visits per year; $20,000 per person maximum benefit for alcoholism and drug abuse services.	Artificial insemination, fertility testing, erectile dysfunction, and reversal of voluntary sterilization are not covered

	Vision	Dental	Routine Care	Mental Health	Reproductive
Natural Resources Districts	Benefit: $200 per insured annual vision reimbursement; Cost: $5/mo for employee, and $10/mo for employee + family	Dental coverage is provided separately from the medical plan, and is not a PPO.	In Network: after $15 copay, covered at 100% up to $250 per calendar year, per insured. Out of Network: deductible is waived and paid at 80% up to $250 per calendar year, per insured.	Inpatient care: (limited to 30 days per calendar year): Deductible + Co-payment; Outpatient Care: (limited to 52 visits/year): Deductible + 50% of first $80.00 per visit. Lifetime Max: $25,000 Benefits identical for In or Non-Network.	Birth Control pills are covered. Viagra is covered if there is a medical need. Fertility treatments are not covered.

PUBLIC FUNDED HEALTH CARE PLANS

	State of Nebraska Employee Benefit Plan	Educators Health Alliance
Plans Offered	HMO, POS, and two levels of a PPO	3 PPO options.
Number Insured	13,970 employees are covered by health insurance; 8,824 are enrolled in the Blue Cross Blue Shield High Option PPO	27,500 estimated participants
Funding	Fully insured through BC/BS	Self-funded
Contract Cycle	Calendar year basis; rates guaranteed for two-year period.	Fiscal year: September 1 to August 31.
Plan Design:		
Deductible	$200 Individual/ $400 Family	Either $0, $100, or $250
Copay	Member pays 15%	With the $100 deductible plan copay is 20% in network, and 30% for out-of-network.
Stop Loss	$1,000 Individual/ $2,000 Family	In Network: $1,100 Individual $2,200 Family Out of Network: $2,200 Individual $4,400 Family
Lifetime Max.	$2,000,000	$5,000,0000
Routine Care	The state PPO plan offers a $250 per year per family benefit for routine care	
Pharmacy	Included with the medical plan Deductible does not apply Generic copay: $10 for 30 day supply Brand Name copay: $15 for a 30 day supply	Deductible does not apply For In Network: Generic copay: $10 Brand Name copay: $25

	Mail Order: $10 copay for a 180 day supply Plan does not use Formulary	Generic Mail Order copay: $40 Brand Mail Order copay: $100 <u>For Out-of-Network</u>: Same copays less 24% Reimbursement
Mental Health Drug and Alcohol	<u>Inpatient</u> Deductible and 15% coinsurance apply 60 day maximum per calendar year $2,000,000 limit for serious mental illness <u>Outpatient</u> $50.00 copay per therapy visit $2,000,000 limit for serious mental illness $20,000 limit for drug abuse and alcoholism	<u>Inpatient</u> In Network: 20% 30 days per year Out-of-Network: 50% 30 days per year <u>Outpatient</u> In Network: $25 Copay 60 visits per year Out-of-Network: $50 Copay 60 visits per year $20,000 per person maximum benefit for alcoholism and drug abuse services.
Well-Child Care	Covered as part of the $250 per family per year routine care	
Reproductive	Fertility testing and related services are covered, Contraceptives are covered. Both are subject to the same copay, deductible and coinsurance as all other covered services. Male enhancements are not covered.	Artificial insemination, fertility testing, erectile dysfunction, and reversal of voluntary sterilization are not covered.
Monthly Premium		
Employee	Single Coverage $ 48.37 Two Party $120.93 Four Party $120.93 Family $171.73	
Employer	Single Coverage $181.98 Two Party $454.94 Four Party $454.94 Family $646.02	
Total	Single Coverage $230.35 Two Party $575.87 Four Party $575.87 Family $817.75	<u>For $100 Deductible</u>: Single Health $217.11 Family Health $588.29

			For $250 Deductible: Single Health $207.49 Family Health $561.17 For High Option HMO: Individual $262.60 Family $740.40
Total Premium			
Employee	1999 Employee 2000 Employee	$ 6,635,304 $12,099,432	
Employer	1999 Employer 2000 Employer	$33,467,571 $45,517,512	
Total			

University of Nebraska Medical Insurance Benefits	
Plans Offered	Medical PPO with several difference options, and several HMOs.
Number Insured	6,801 members
Funding	Minimum Premium Reserves held by employer; Annual claims aggregate stop-loss equal to 120% of projected claims
Contract Cycle	One year contract on a calendar year basis
Plan Design:	
Deductible	$225 Individual $450 Family
Copay	Member pays 25%
Stop Loss	$1,100 Individual $2,220 Family
Lifetime Max.	$2,000,000
Routine Care	100% not to exceed $150 in a calendar year
Pharmacy	Generic copay = $5.00 for a 30 day supply Preferred Brand Name (formulary) copay = $13 for a 30 day supply Non-preferred Brand Name (non-formulary) copay = $20 for a 30 day supply *Administered by Caremark*
Mental Health Drug and Alcohol	<u>Mental & Nervous</u> Inpatient: Deductible and 25% coinsurance apply, up to a 60 day maximum per calendar year (for all other conditions). Deductible and 25% coinsurance apply; 100% after stop-loss is reached (for serious conditions).

	Outpatient: 100% after $25.00 copay per visit <u>Chemical & Dependency</u> Inpatient: Deductible and 25% coinsurance apply, up to a 30 day maximum per calendar year. $100,000 lifetime maximum for chemical dependency services Outpatient: 100% after $25.00 copay per visit
Well-Child Care	Covered as part of the $150 annual routine care coverage
Reproductive	Fertility testing and related services are not covered, contraceptives are not covered, and male enhancements are not covered.
Other	
Monthly Premium	
Employee	Single $3.00 Two/four party $35.12 Family Coverage $40.32
Employer	Single $154.32 Two/four party $244.34 Family Coverage $298.02
Total	Single $157.32 Two/four party $279.46 Family Coverage $338.34
Total Premium	
Employee	1999 Employee $1,208,326 2000 (estimate) Employee $2,041,416
Employer	1999 Employer $18,537,454 2000 (estimate) Employer $21,935,992

Total	1999 Total Members: 6,262 Ave Cost: $3,153 2000 (estimate) Total Members: 6,801 Ave Cost: $3,526

	Natural Resources Districts	**Nebraska Association of County Officials**
Plans Offered	PPO	PPO, (Blue*Classic* and Blue*Preferred*), HMO (Blueprime)
Number Insured	310 Participants	
Funding	Self insured; Reserve Fund is held by the Nebraska Association of Resources Districts	
Contract Cycle	Fiscal year basis (July 1 – June 30)	July 1, 2000 through June 30, 2001
Plan Design:		*Plan design is for PPO*
Deductible	$200 Individual/ $400 Family	3 Levels: $100 $250 $500
Copay	Dr.'s Office Visit: $15 copay In Network: 80% of $5,000, then 100% Out of Network: 70% of $5,000, then 100%	Blue*Classic*: 20% Blue*Preferred*: 20% PPO, 30% Non-PPO
Stop Loss	Single: In Network: $1,200 Out of Network: $1,700 Family: In Network: $1,400 Out of Net: $1,900	$2,000 single membership; $4,000 family/ employee-spouse/employee-children memberships
Lifetime Max.	$2,000,000	

Routine Care	In Network: after $15 copay, covered at 100% up to $250 per calendar year, per insured. Out of Network: deductible is waived and paid at 80% up to $250 per calendar year, per insured.	
Pharmacy	Retail: 30 days Brand w/o Generic Available: $20 Brand w/ Generic Available: $20 plus member pays difference b/t the brand and the generic drug price. Generic: $10 Mail Order: 90 days Brand w/o Generic Available: $20 Brand w/ Generic Available: $20 plus member pays difference b/t the brand and the generic drug price. Generic: $10	Blue*Classic*: $20/generic, $30/brand name up to a calendar year copay maximum of $2,000/ single and $4,000 family. Blue*Preferred*: $20/generic, $25/brand name up to a calendar year copay maximum of $2,000/ single and $4,000 family.
Mental Health Drug and Alcohol	Inpatient care (limited to 30 days per calendar year): Deductible + Co-payment Outpatient Care (limited to 52 visits/year): Deductible + 50% of first $80.00 per visit. Lifetime Maximum: $25,000 *Benefits identical for In or Non-Network.*	Blue*Classic*: Inpatient: Participating Providers: 20%, Non-Participating Providers: 60%. Outpatient: $50 Blue *Preferred*: 20% copay, $50 office visit
Well-Child Care	In PPO network: Post natal check-ups and shots are covered w/ $15 copay per visit. Out of network: Post natal check-ups and shots are covered at 70% after deductible is met.	Blueprime: $10 copay
Reproductive	Birth Control pills are covered. Viagra is covered if there is a medical need. Fertility treatments are not covered.	
Other	Dental and vision coverage is available separate from plan.	

Monthly Premium		
Employee	*Employee/Employer cost share dependent upon individual regional NRD Boards.*	
Employer		
Total	Employee: $260.32 Employee + Children: $421.94 Employee + Spouse: $475.79 Family: $691.29	Blue*Classic:* $250 deductible: $335 – Employee only, $677 – Employee + spouse/child, $775 – Family Blue *Preferred*: $250 deductible: $278 – Employee only, $562 – Employee + spouse/child, $642 - Family
Total Premium		
Employee		
Employer		
Total	Total Premium FY 2000: $1,066,125 Estimated Total Premium FY 2001: $1,332,656	

	First Class Cities (fifteen cities surveyed)	Second Class Cities (nineteen cities surveyed)
Plans Offered	PPO	PPO
Number Insured	Less than 50 – 4 50-100 – 3 101-200 – 5 201-300 – 2 Over 400 – 1	Less than 50 – 15 50-100 – 1 3 NA
Funding	2 Cities are fully insured 12 are partially Self-funded 1 is totally self-funded	13 Cities are fully insured 2 are partially Self-funded (funds $5,000 per individual, other funds $50,000 per individual before it goes to reinsurance) 1 is totally self-funded 3 NA
Contract Cycle	All one year	15 – one year 1 – more than one year 3 – NA
Plan Design:		
Deductible	Single $0 – 1 $100 - $349 – 12 $350 - $499 – 1 $500 and above – 1 Family $0 - $299 – 1 $300 - $499 – 2 $500 - $999 – 9 $1000 - $2499 – 1 NA – 2	Single $0 – 2 $100 - $349 – 7 $350 - $499 – 1 $500 - $999 – 4 $1000 and above – 1 NA – 4 Family $0 - $299 – 1 $300 - $499 – 2 $500 - $999 – 9 $1000 - $2499 – 1 NA – 2
Copay	90/10 – 6 80/20 – 8 NA – 1	-0- – 90/10 – 7 80/20 – 9

		75/25 – 1 50/50 – 2 NA – 3
Stop Loss	Indiv $500 - $999 – 7 $1000 - $1999 – 4 $2000 - $2999 –1 $5000 or more – 1 NA – 2	Indiv $0 - $499 – 2 $500 - $499 – 6 $1000 - $1999 – 2 $2000 - $2999 – 2 $5000 or more – 3 NA – 4 Family $0 - $499 – 2 $1000 - $1999 – 7 $2000 - $2999 – 2 $5000 or more – 4 NA – 4
Lifetime Max.	$1,000,000: Nine Cities $2,000,000: Five Cities NA: One City	$1,000,000: Five Cities $2,000,000: Six Cities over $2,000,000: Five Cities NA: Three Cities
Routine Care	Nine cover, 5 don't, and 1 unknown	10 Cities cover, 6 cities don't cover, and 3 are NA.
Pharmacy	8 have prescription cards, 6 don't, and 1 NA. Of those with cards: Generic Co-Pay: $5.00-$9.99 – 1 $10-$19.99 – 7 Six plans pay a differential between generic and brand.	15 have prescription cards, 1 doesn't, and 3 NA. Of those with cards: Generic Co-Pay: $5.00-$9.99 – 1 $10-$19.99 – 5 $20-$29.99 – 2 Nine plans pay a differential between generic and brand.
Mental Health Drug and Alcohol	14 Cities cover mental health/substance abuse, 1 is NA.	14 Cities cover mental health/substance abuse, 5 are NA.
Well-Child Care	11 Cities cover, 3 cities don't cover, and 1 is unknown.	9 Cities cover, 6 cities don't cover, and 4 are NA.
Reproductive	2 Cover, 10 don't, 3 are NA	3 Cities cover, 8 cities don't cover, and 8 are NA
Other	3 plans include dental at no additional charge	1 plan includes dental at no additional charge; 2 plans include vision at no additional cost.
Monthly Premium		

Employee	Single $0 - 11 $10 - $19.99 - 1 $20 - $39.99 - 2 $300 and above - 1 Family $0 - $49 - 8 $50 - $99 - 4 $100 - $200 - 3	Family $0 - $199 - 2 $200 - $399- 1 $400 - $599 - 6 $600 and above - 7 NA - 3
Employer	Single $0 – $149 - 5 $150 - $199 - 3 $200 - $299 - 6 $300 and above - 1 Family $200 - $299 - 1 $300 - $399 - 6 $400 - $499 - 2 $500 and above - 6	Single $0 – 199 - 8 $200 - $399 - 6 $400 - $599 - 0 $600 and above - 2 NA - 3
Total	Percentage Paid by City: 75% - 99% – 6 100% – 4 NA – 5	Percentage Paid by City: 50% - 75% – 3 75% - 99% – 2 100% – 7 NA – 7

Updated 8/01/00 AP

Criteria for Recommendations of LB 1217 Task Force

Cost of providing benefits

Cost sharing between employer and employee, i.e. employer/employee contribution

Recruitment and retaining employees

Assist smaller plans in obtaining more affordable coverage

Uniform employee health benefits among publicly funded plans

Reduce cost increases

Plan benefits with incentives to control utilization of benefits, i.e. copayments, coinsurance

Fair package of benefits to employees

Impact on employees

Plan does not conflict with state and federal laws and existing bargaining agreements

Voluntary or mandatory participation of political subdivisions

Price stability

Prudent use of taxpayers funds

Text of Legislative Bill 1217

(1) The Legislature finds that:

(a) The state and political subdivisions are challenged with limited resources for all services;

(b) Costs to provide health insurance to employees have risen sharply, particularly during the last year; and

(c) A need exists to explore all opportunities for government to seek efficiencies in providing quality, affordable health insurance to its employees.

(2) The Task Force to Explore Health Insurance Opportunities is created. The Governor shall appoint twenty members to the task force by June 1, 2000. The task force shall examine the various means by which the state, the University of Nebraska, state colleges, community colleges, and other political subdivisions provide health insurance to their employees. The task force shall develop possible alternatives and opportunities to providing health insurance to employees and identify the advantages and disadvantages to each alternative provided. The task force shall complete its work and issue a final report to the Governor and each member of the Legislature outlining its findings and recommendations for the providing of health insurance to employees by December 15, 2000.

(3) The Department of Insurance shall provide staff support to the task force.

(4) Members of the task force shall be reimbursed for their actual and necessary expenses as provided in sections 81-1174 to 81-1177.