2024 State Employee Health Benefits Study

How Does Your State's Coverage Compare?

Segal

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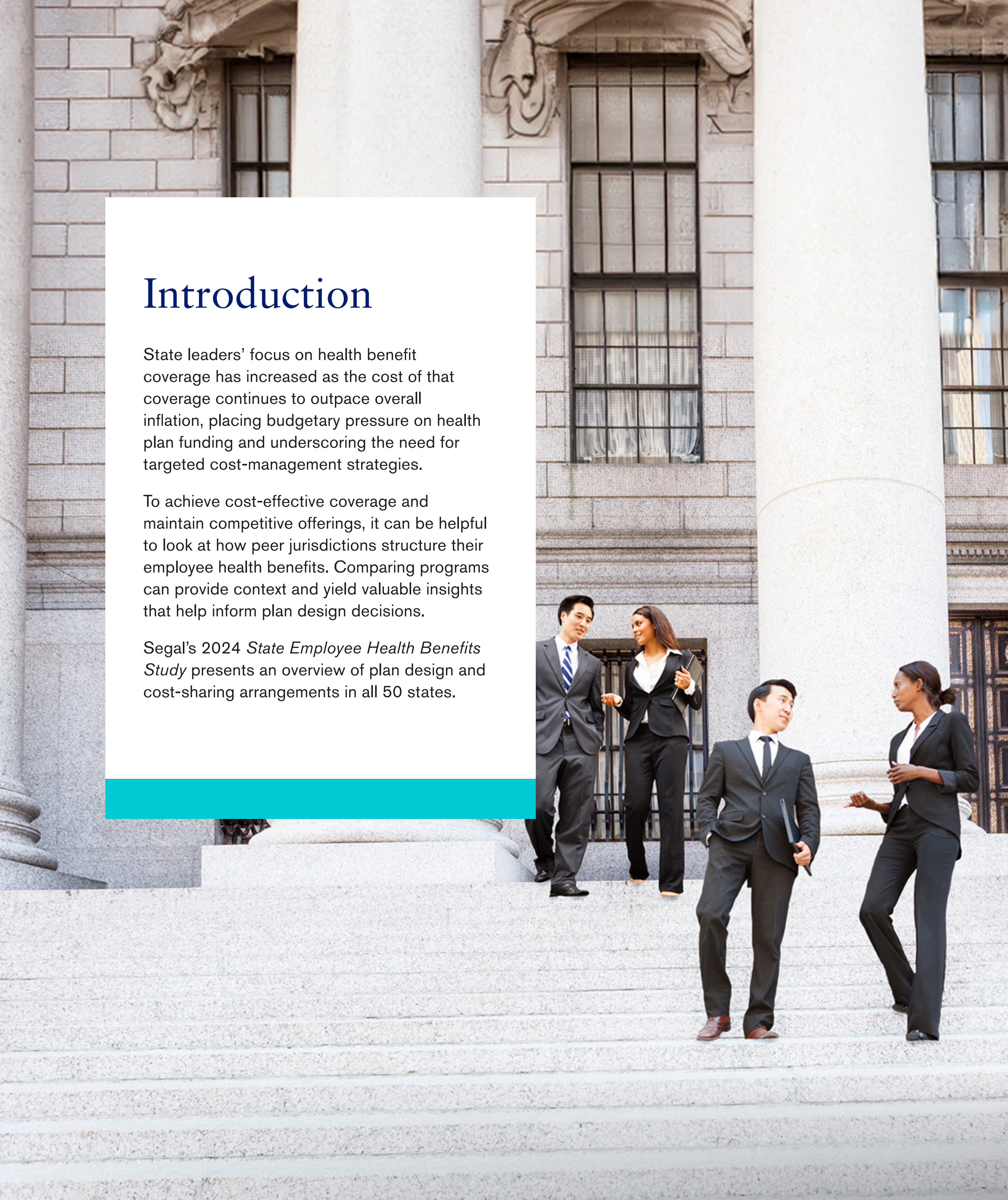


Introduction

State leaders' focus on health benefit coverage has increased as the cost of that coverage continues to outpace overall inflation, placing budgetary pressure on health plan funding and underscoring the need for targeted cost-management strategies.

To achieve cost-effective coverage and maintain competitive offerings, it can be helpful to look at how peer jurisdictions structure their employee health benefits. Comparing programs can provide context and yield valuable insights that help inform plan design decisions.

Segal's 2024 *State Employee Health Benefits Study* presents an overview of plan design and cost-sharing arrangements in all 50 states.

About the Study

Segal's 2024 *State Employee Health Benefits Study* is based on a review conducted in the fourth quarter of 2023 and January 2024 of health benefit information on the websites of all 50 states. It covers medical and prescription drug plan design and benefit cost-sharing arrangements offered to full-time active employees for 2023–2024 for the:

- Least expensive plan option
- Most expensive plan option

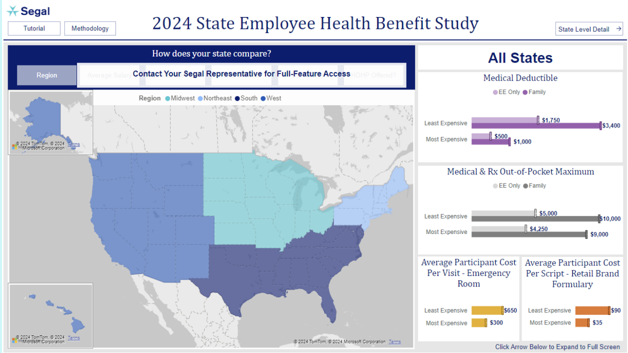
The study methodology is described on page 15.

Our interactive online tool can be accessed for comparisons of your state benefits to national and regional peers.

The Study Data Is Available Through Our New Interactive Online Tool

We've created a custom interactive online tool that allows you to compare your state benefits to aggregate data for all states or by region. You can also choose to benchmark your benefits to your peers, by region or specific states.

The adjacent image shows the tool's homepage.



Anyone may access the tool free of charge to make comparisons, such as learning how your least or most expensive plan compares to other state plans in your region or how it compares nationally for the following plan features:

Medical Deductible

Out-of-Pocket Limit

ER Visit Copay

Retail Brand Formulary Copay

Views of these two plan option comparisons are in the sample for all states.

Much more study data about state employee health benefit plans is available to those who request full access, including plan features like these:

- How does my average salary compare to other states?
- How do my contribution ratios compare to other plans for single and family coverage?
- For my least expensive plan, what's the variance from the national benchmark for my plan's annual deductible?
- For my most expensive plan, how do my out-of-pocket levels compare to other states and nationally?
- How much variance is there in participant primary care provider cost per visit relative to specific states in my region?
- How does the average cost per visit for ER copayments compare to specific states in my region and nationally?
- What is the variation from benchmarks for the average participant cost per visit for urgent care for my most expensive plan?
- What is the average participant cost per script for retail formulary brand drugs nationally?

To request access to the full tool, contact your Segal consultant or get in touch with Melanie Clark, National Public Sector Health Practice Leader.

Key Findings

The key findings from the 2024 study are:

- Almost all states (47) give their employees a choice of medical plans.
- Health insurance as a percentage of salary ranges by region and plan type, with employees in the West contributing 0.47 percent of their salary towards coverage for the least expensive plan and employees in the Midwest paying 3.21 percent of their salary for the most expensive plan.
- While deductible levels for high-deductible health plans (HDHP) are much higher than for PPO plan options, including POS plans, by design, the variance of out-of-pocket (OOP) maximums between these plan types is not as significant.
- States are using plan design to manage prescription drug costs by influencing utilization towards more efficient delivery channels and more cost-effective medications.

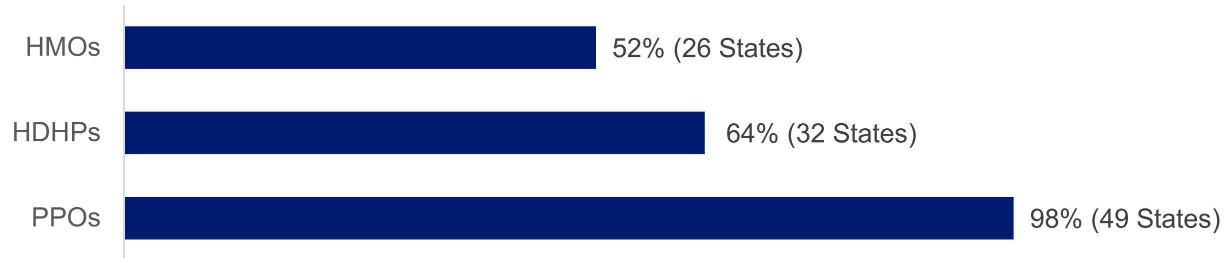
Most States Offer a Choice of Medical Plan Types

Almost all states (88 percent) offer more than one medical plan type, providing choice of coverage.

PPOs continue to be offered by every state studied, except Minnesota, which offers an EPO.

Offerings of HDHPs have increased since the last time Segal studied these benefits five years ago.

Almost All States Offer PPOs; Many Also Offer HDHPs and HMOs*



* For simplicity, this study uses "HMOs" to also represents EPOs, which have a similar plan design.

Source: Segal, 2024

Regional differences in offerings

There are noteworthy differences in medical offerings by region, especially for HDHPs. HDHPs are still not offered by most states in the Northeast. New Jersey and Rhode Island are the exceptions.

The Midwest is the only region in which not all states offer a PPO.

A majority of states in the Northeast and West offer HMOs.

Regional Differences in Medical Plan Offerings Are Most Pronounced for HDHPs

	Northeast # States	Northeast % States	South # States	South % States	Midwest # States	Midwest % States	West # States	West % States
PPOs	9	100%	16	100%	11	92%	13	100%
HDHPs	2	22%	12	75%	11	92%	7	54%
HMOs	6	67%	8	50%	5	42%	7	54%

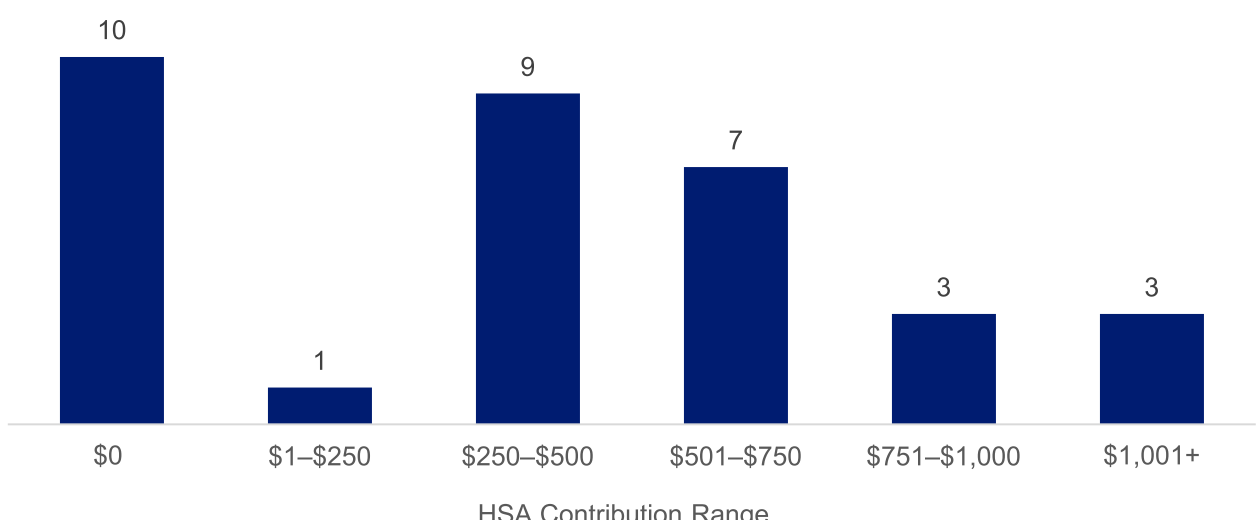
Notes: This study's regional breakdown follows the regions used by the U.S. Census Bureau: Northeast = CT, MA, ME, NH, NJ, NY, PA, RI and VT; South = AL, AR, DE, FL, GA, KY, LA, MD, MS, NC, OK, SC, TN, TX, VA and WV; Midwest = IL, IN, IA, KS, MI, MN, MO, ND, NE, OH, SD, WI; and West = AK, AZ, CA, CO, HI, ID, MT, NM, NV, OR, UT, WA, and WY. The total for each region exceeds the number of states in the region because many states offer more than one plan type.

Source: Segal, 2024

Health Savings Accounts (HSAs)

Of the 32 states that offer HDHPs, 23 states contribute to an HSA. For single employees in those states, the median employer contribution is $600 annually, with contribution amounts ranging from $250 to $1,825.

There's Wide Variation in State Contributions Towards Employee-Only HSA Accounts



Source: Segal, 2024

Observations

By offering a choice of medical plan types, states are stratifying employees' interest in choice. According to MetLife's 21st Annual U.S. Employee Benefit Trends Study 2023, 70 percent of employees are interested in customizable benefits in line with their personal needs.

As HDHPs coupled with HSAs or Health Reimbursement Accounts (HRAs) continue to grow in popularity, a greater investment in participant consumer education programs might be required. States that do not offer HDHPs may want to reconsider that plan design's tax advantages.

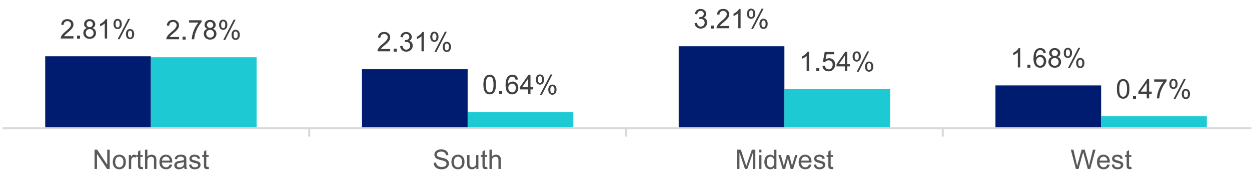
Interested in More Data About Health Plan Types?

Check out our new interactive online tool that allows you to compare your state benefits to aggregate data for all states or by region.

Contribution Ratios Vary by Plan Type and Region

For most state health plans, premium levels vary by plan type as well as coverage tier. However, seven state plans also vary contributions based on an employee's salary level so that coverage is more affordable for lower-wage earners.

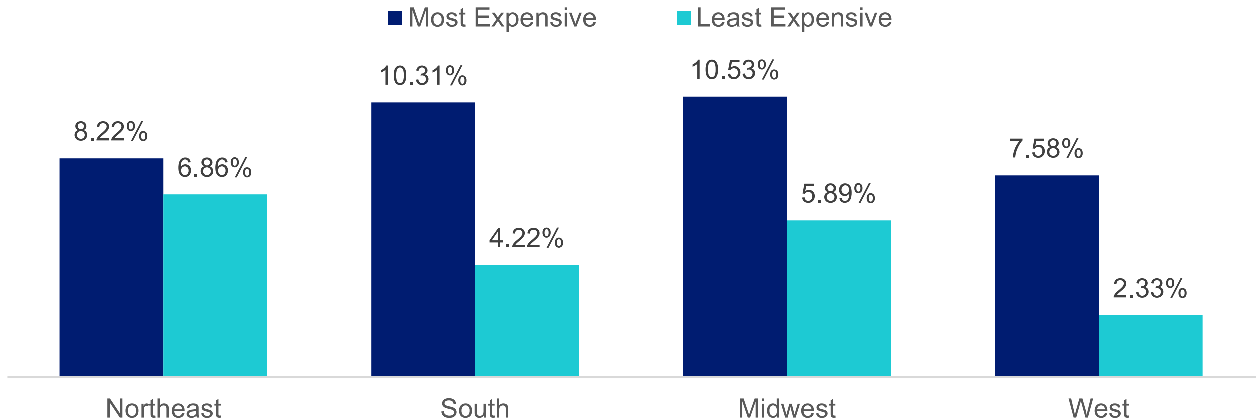
Variation in the Median Employee-Only Contribution as a Percentage of Median State Salary* Is Least Significant in the Northeast



* Salary only reflects employees and, consequently, does not account for dual-income households.

Source: Segal, 2024

Variation in the Median Family Contribution as a Percentage of Median State Salary* Is Most Significant in the South



* Salary reflects employees only and does not account for dual income households.

Source: Segal, 2024

Observations

Under the Patient Protection and Affordable Care Act (ACA), large employer health insurance coverage must consider affordability (e.g., if employee's contribution for self-only coverage for the lowest cost plan does not exceed 8.39 percent in 2024 of the employee's household income for the taxable year). Salary-based models can help health plans comply with that ACA requirement.

As noted in the *2024 Segal Health Plan Cost Trend Survey*, medical plan costs are increasing, with outpatient pharmacy benefit cost trends approaching almost 10 percent. Although most state plan sponsors pay a significant portion of health benefit costs, increases to health insurance premiums can negatively impact wage growth.

Putting the numbers into context, consider that the average annual cost of an employer-sponsored health insurance premium for family coverage was $23,968 in 2023, according to the Kaiser Family Foundation. An annual increase of 8 percent in healthcare costs translates to approximately $1,900 in additional healthcare spending. This compares to the average wage increase of 4 percent on a median salary of $60,000, or $2,400 in wage growth. Under this scenario, an 8 percent annual increase in health trend could consume almost 80 percent of a plan sponsor's budget towards wage increases.

State plan sponsors that proactively manage their benefits program, drawing on claims data analytics to make informed decisions on effective cost-management strategies, can better manage trend increases, so they can offer competitive benefits.

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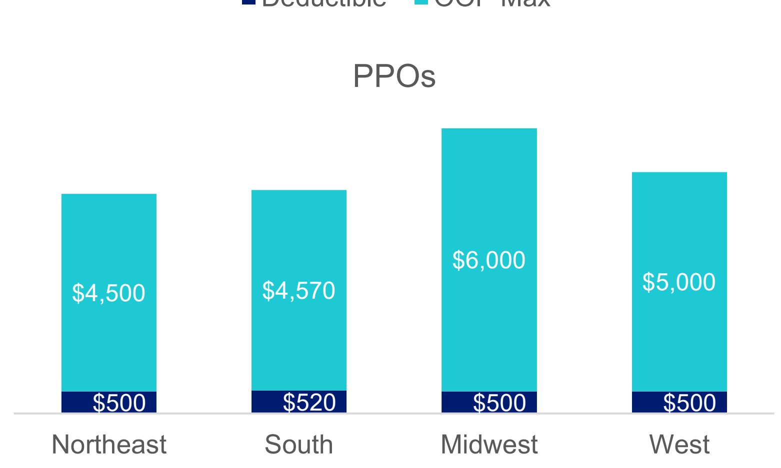
Significant Difference in PPO and HDHP Deductibles

Among states, deductibles for employee-only coverage differ significantly by plan type. While deductibles levels for HDHPs are much higher than PPOs, the variance of OOP maximums between these plan types is not as significant, which is partially due to maximum allowable OOP limits required by the ACA.

Median In-Network Employee-Only Out-of-Pocket Maximums* Are Highest in the Midwest for PPOs and Highest in the South for HDHPS; Deductibles Are Consistent Across Regions for PPOs and Are Highest in the Northeast for HDHPs



* Includes both medical and prescription drug coverages.

Source: Segal, 2024

Observations

As health plan cost trends continue to increase, many state plan sponsors have looked at ways to avoid greater shifting of costs to their employees through higher deductibles and OOP maximums. This includes use of network strategies that promote value-based care through tiered networks or that direct participants to providers that cost less and/or deliver higher-quality care through the use of custom or narrow networks. The strategy has also included offering additional virtual care programs, such as virtual mental health counseling and virtual physical therapy programs, that are not subject to plan deductibles.

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Most States Have a Fixed Copayment Design for Medical Cost Sharing

Regardless of deductible levels, most states have plan designs where participants pay a portion of primary care physician (PCP) office visit costs, urgent care visits and emergency room (ER) visits. The majority of state plan sponsors have a fixed copayment for these services, although some, including most HDHPs, require coinsurance.

Median Participant Cost Per Visit* by Plan Type and Setting Shows States Are Using Cost Sharing to Encourage Participants to Seek More Cost-Effective Care

	PCP	Urgent Care	ER
PPOs	$25	$50	$324
HDHPs	$52	$96	$727
Total	**$30**	**$70**	**$515**

* Average cost per visit takes into account deductible, copayment/coinsurance and OOP maximum.

Source: Segal, 2024

Observations

Plan design is an effective way to help to control healthcare cost trend increases. There can be dramatic cost differences in price per visit by setting. Copayments to steer patients seeking care to more cost-effective settings, when appropriate, can achieve significant savings to a plan. Plans should be designed so that participant cost sharing is aligned to drive the right utilization and minimize visits to higher cost settings when inappropriate. For example, plan participants seeking care for non-emergent issues should be incentivized to use lower cost settings such as urgent care, office-based care or telehealth instead of the emergency room. As ambulatory surgical centers continue to expand, plan sponsors are also implementing benefit design differentials to encourage lower-cost sites of service, supporting further reductions in hospital inpatient utilization.

A key driver of price increase is consolidation activity, including mergers occurring between physician groups, vertical consolidation (e.g., mergers with hospitals) and private equity acquisition of physician practices. In vertical consolidation, hospitals that own private practices tend to charge facility fees in addition to professional reimbursement, leading to higher outpatient prices. Site-neutral payment reform has been proposed under Medicare to equalize payments across different sites of service for the same outpatient services (such as hospital outpatient departments, ambulatory services and office visits). While this legislation would only apply to Medicare, typically, the commercial market is also impacted by what's implemented in Medicare. Expansion of site-neutral payment would help protect patients from inappropriate billing practices and ultimately help improve access to high-quality, affordable care. State plan sponsors may wish to track site-neutral payment reform and use it as a tool to negotiate on behalf of their plans.

Interested in More Data About Health Plan Types?

Check out our new interactive online tool that allows you to compare your state benefits to aggregate data for all states or by region.

Prescription Drug Cost Sharing Is Designed to Encourage Behavior

As fixed-dollar prescription drug copayments erode in value over time, some state plans have adopted coinsurance with minimum/maximum amounts to protect plan values and improve participant utilization patterns. For the most expensive plans offered by states, five states charge coinsurance for generic drugs, with 10 percent being the most common amount. The remainder charge a fixed copayment. For more expensive brand drugs, 10 states charge coinsurance, with 20 percent being the most common charge.

State plan design strategies include offering lower cost sharing for generic drug therapies and higher cost sharing for more costly brand drugs, where interchangeable or lower-cost alternative therapies exist. These plan designs drive increases in generic drug dispensing rates that maximize savings for both the plan and the patient, as well as create greater incentives for patients and their prescribers to find the best-value formulary drug therapies for their conditions.

Median Participant Cost Share* Per Prescription (30-Day Supply) by Plan Type and Drug Type Shows How Cost Sharing Incentivizes Use of Generics and Discourages Use of Specialty Drugs

	Retail Generic	Retail, Brand Formulary	Specialty
PPOs	$10	$35	$72
HDHPs	$17	$111	$236
Total	**$10**	**$40**	**$100**

* The average participant cost share per prescription above incorporates any applicable deductibles, fixed copayments, coinsurance, and OOP maximums for which patients are responsible.

Source: Segal, 2024

For the least expensive plans offered, 23 states charge coinsurance for generic drugs, with 20 percent being the most common amount. For brand drugs, 26 states charge coinsurance, with 20 percent being the most common charge.

Observations

Delivering cost-effective prescription drug coverage to plan participants is increasingly challenging because there are numerous cost drivers and complexities. Plan sponsors should consider each of the following:

- Plan design
- PBM formulary offerings and contracting provisions
- PBM contracts, which may need to be restructured to require transparency and include low net-cost risk targets
- Clinical controls

Best-practice, effective prescription drug plan designs address these questions:

- What is the appropriate balance of coverage for prescription drug benefits?
- How much should participants pay for their medications?
- What incentives should be used to reduce waste and excessive utilization?
- Does the plan cover high-cost, “me-too” brand drugs that are just re-packaged over-the-counter products, combination medication or multisource brand drugs for which generic equivalents are available?
- Are the costs to participants resulting in underuse of needed drug therapies that stave off complications of disease and high-cost hospital events, or worse?
- Are the plan’s prior authorization rules optimizing patient outcomes by ensuring appropriate medications are received, while reducing waste, unnecessary drugs and costs?

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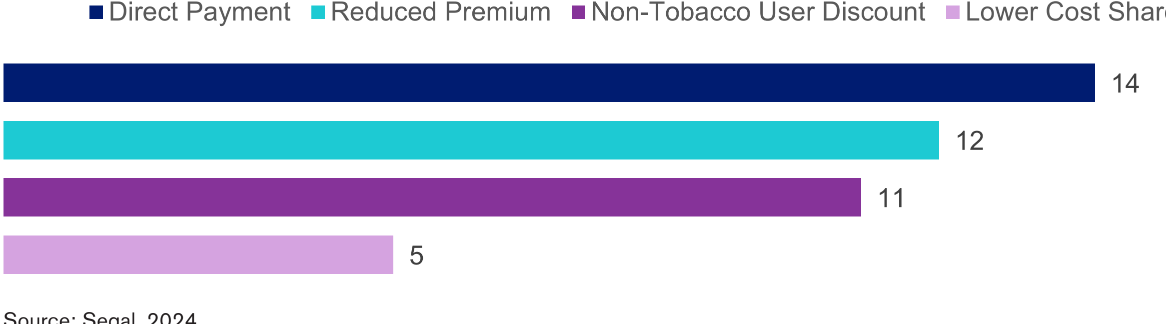
Wellness Incentives Are Designed to Encourage Healthy Behaviors

For a number of state plan sponsors, employee contributions and/or cost-sharing requirements can decrease if participants take advantage of wellness incentives. Incentives include completion of health risk assessment, biometric screening, participating in health promotion programs and attesting to non-tobacco use. Some programs provide gift cards as opposed to contribution differentials for wellness activities.

The Most Common Method of Wellness Incentive is a Direct Financial Payment, Followed by Lower Participant Premium, Discounts for Non-Tobacco Users and Lower Cost Sharing



Source: Segal, 2024

Observations

When assessing the effectiveness of wellness programs, plans sponsors should focus on the value of the investment, rather than the return on investment. The value goes beyond lowering healthcare costs. It encompasses the programs' long-term effectiveness.

Over time, a well-designed wellness program that's tailored to participants' needs will have a positive impact in many areas. Potential benefits include:

- Reducing modifiable health-risk factors to slow the onset and progression of chronic disease
- Improving employee job satisfaction and productivity
- Reducing demand for healthcare services, which helps control both short-term and long-term costs
- Keeping healthy participants healthy, improving productivity and potentially reduce disability costs
- Promoting positive behavior changes that help participants achieve a healthy lifestyle

For more information about well-designed wellness programs, see our May 2023 insight, "A Five Step Strategic Approach to Wellness Program Success."

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Study Methodology

Segal based the 2024 *State Employee Health Benefits Study* on a review of the websites for all 50 states in the fourth quarter of 2023 and January 2024. We captured information on medical and prescription drug plan design and benefit cost-sharing arrangements offered to full-time, active employees at the time the information was gathered for the least and most expensive plans. The least expensive and most expensive plan options are defined by the magnitude of employee contribution rates for employee-only coverage.

For regional comparisons, states were divided into four geographic regions: Northeast, South, Midwest and West. High-level benchmarks are available by region in our tool free of charge (see "About the Study"). State-level benefit details can also be compared for variations to the national median.

Average salary

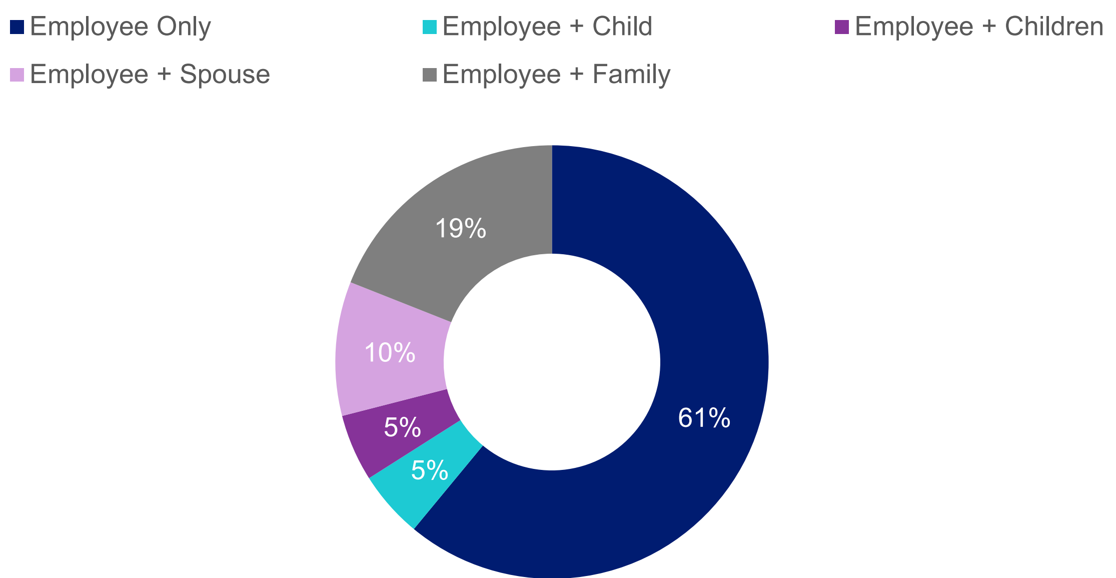
Average state employee salary based on the most recent data available from the Bureau of Labor Statistics (BLS) is shown in the interactive tool online for each respective state. Salary reflects employees only and does not account for dual-income households.

Annual contributions and contribution ratios

The study shows annual contribution rates for employee-only and family coverages for the least expensive and most expensive plan options.

To derive the average contribution ratio, we used the total annual composite contribution divided by the average salary for each applicable state, based on the most recent data available data from BLS. Salary reflects employees only and does not account for dual-income households.

The total annual composite contributions were derived assuming the following distribution for each coverage level:



The study does not include wellness incentives and their impact on any contribution calculations. However, if contribution rates are higher for tobacco users, the lower rate for non-tobacco users is taken into account.

Medical deductibles

Deductible benchmarks shown are for in-network coverage only for employee-only and family coverage. Plans may have separate deductibles for medical and prescription drug benefits, or the deductibles may be integrated, meaning both medical and prescription drug costs accumulate towards the same deductible.

OOP maximums

OOP maximum benchmarks shown are for in-network coverage only and include all deductibles, copayments and coinsurance for which participants are responsible. Plans may have separate OOP maximums for medical and prescription drug benefits or the OOP maximums may be integrated. A few plans do not have an OOP maximum for prescription drug benefits, which is only permitted if a plan is considered grandfathered under the ACA. The OOP maximums are shown by type (e.g., integrated plans are benchmarked together, plans that have separate medical and prescription drug coverage are benchmarked separately).

Average participant cost per visit

Since not all plans have a fixed dollar copayment per visit, we converted all cost sharing to an average participant cost dollar amount per visit using a rating model tool. For example, one plan sponsor may require a participant to pay a coinsurance of 20 percent after meeting an annual deductible amount of $250 for an office visit, whereas another plan sponsor may have a benefit design that only requires a flat copayment amount of $20 for the same service. We factored in the effect of coinsurance, deductible and copayment to better reflect the actual dollar cost the participants is responsible to pay for each service type in each benefit arrangement. We performed an average participant cost per visit calculation for in-network ER, primary care physician and urgent care visits.

Prescription drug benefits

The study captures copayment and coinsurance plan design for retail 30-day supply and specialty drug coverage, but not mail-order plan design. Average participant cost per prescription factors in the effect of deductibles, copayments, coinsurance and OOP maximums to reflect the actual dollar cost for the participant.

Plans in the study

The interactive online tool includes a list of every plan in the study.

You can access the tool from the link in the box below.

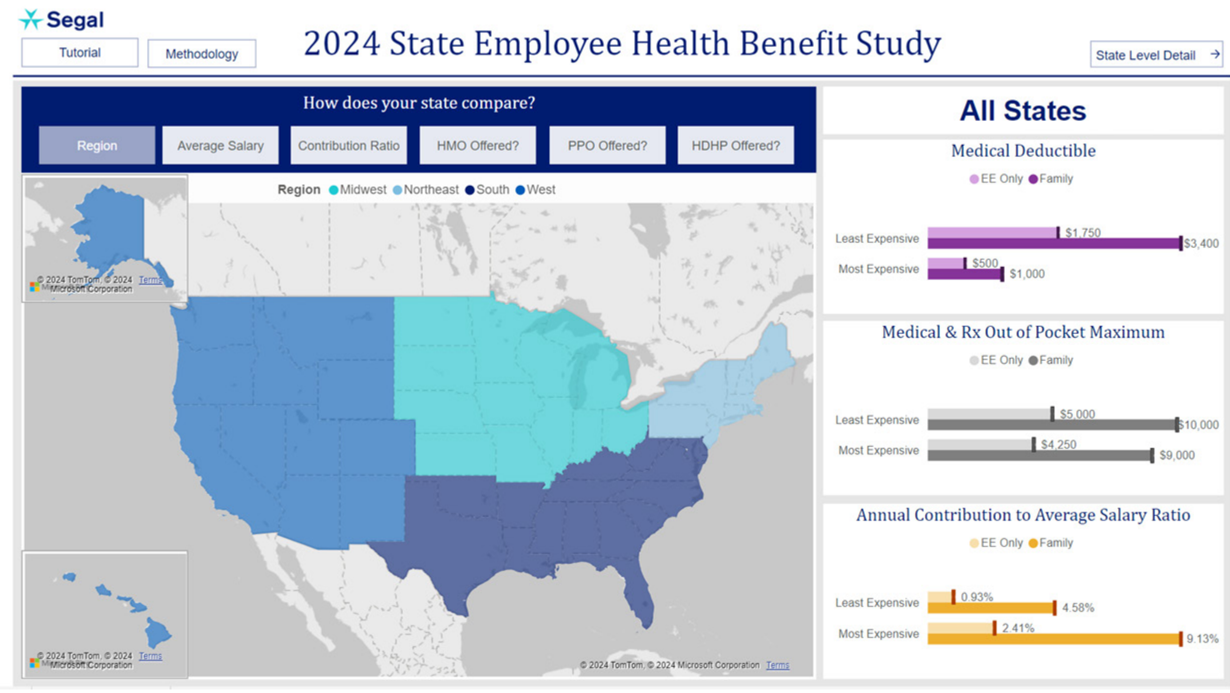
Interested in More Data About Health Plan Types?

Check out our new interactive online tool that allows you to compare your state benefits to aggregate data for all states or by region.

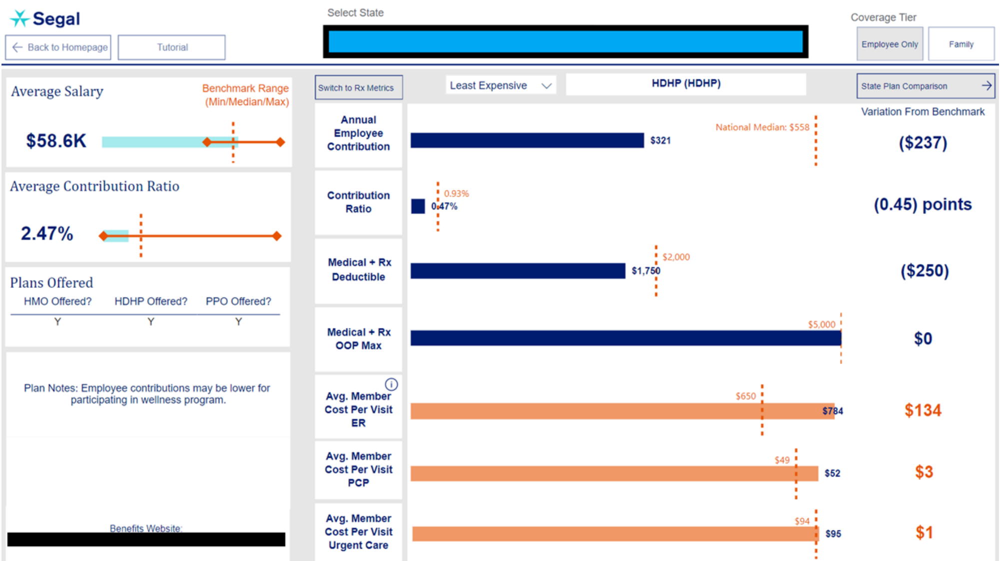
Sample Comparisons from Our Online Study Tool

Included below are sample screen shots of the full access version of the online study tool. Through the interactive map, state plan sponsors can select a state or region to see how their plan(s) compare. Using the buttons at the top of the screen, an interactive map allows for comparison of metrics as follows:

- **Region.** How does your least expensive plan or most expensive plan compare to other state plans in your region for the following plan features: medical deductible, OOP maximum and contribution ratio? Comparisons can also be made nationally or at the state level for employee-only and family coverage.
- **Average salary.** You can click on a state to see how its average salary compares to other states. The shading in this map ranges from light blue (lower salary) to dark blue (higher salary).
- **Contribution ratio.** You can click on a state to see how its contribution ratios compare to other state plans on a composite basis. The colors in this map range from shades of green for states with lower contribution rations to shades of orange for those with higher contribution ratios.
- **HMO offered?** This map shows HMO prevalence, including specific states that offer HMOs vs. those that do not.
- **PPO offered?** This map shows PPO prevalence, including specific states that offer PPOs vs. those that do not.
- **HDHP offered?** This map shows HDHP prevalence, including specific states that offer HDHPs vs. those that do not. For state plan sponsors that contribute to HSA accounts, 2023 contribution amounts are shown.



A drill-down of state plan comparison of cost-sharing features to national benchmarks is available for medical and Rx coverage for the most expensive and least expensive plan options by coverage tier. Below is a sample of metrics for medical coverage:



State plan sponsors can also benchmark to specific states to compare medical and Rx cost-sharing features.

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Questions? Interested in More Detail? Contact Us.

If you have questions about the 2024 *State Employee Health Benefits Study*, contact your Segal consultant or Melanie Clark. You can find her contact information on the next page.

Melanie can also assist if you're interested in accessing the additional study data on the plan features discussed in this report, which is available in the online tool mentioned on the previous page. That tool includes medical and prescription drug cost sharing that you can use to benchmark your plan against another plan or regional data.

For a more detailed study of benchmarking of your plan's wellness design, actuarial values, custom regional cohorts or other plan data, please contact your Segal consultant or Melanie Clark.

Strategic consulting services for public sector health plans

Segal's strategic health consulting services for state and local government employers and health plan sponsors include:

- Plan design and analysis
- Cost and utilization modeling
- Financial modeling
- Data mining and analysis
- Benchmarking

For information about these services and how Segal can help your jurisdiction, contact your Segal consultant or one of our subject matter experts on public sector health plans:

Melanie C. Clark
Vice President, Consulting Actuary and
National Public Sector Health Practice Leader
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Melanie has more than 20 years of benefits consulting experience, primarily in the public sector. Melanie provides consulting to and is the signing actuary for numerous retiree health actuarial valuations, including several state systems and city clients. Her areas of subject matter expertise include Medicare Part D plans, retiree health and VEBAs, as well as assistance with the development of internal training programs on these topics. She is the lead consultant for one of Segal's largest public sector clients.

Bob Mitchell
Senior Vice President and Benefits Consultant
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Bob has more than 20 years of experience consulting to public sector clients. He advises them on all aspects of the design, financing, compliance and communications of employee and retiree health and welfare benefits. Bob's clients include counties and unified school districts on the West Coast.

Kirsten Schatten
Senior Vice President and Consulting Actuary
kschatten@segalco.com

Kirsten has more than 25 years of actuarial and consulting experience working with public sector plans and employers. She consults to more than a dozen state health plans and three state Medicaid agencies on complex issues. Kirsten is known for innovative benefit designs, pricing strategies, quality-of-care initiatives and consumer and wellness initiatives. She has extensive experience in the analysis and implementation of retiree medical and prescription drug strategies.

Andrew D. Sherman
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Andrew has more than 30 years of experience as a benefits consultant working with plan sponsors throughout the U.S. on a wide range of employee benefit issues and opportunities including plan design, benefit strategies, funding and plan management. He consults to large public sector employee benefit plans as well as city and state health plans. His expertise includes total health management, prescription drug benefit plan design, cost analysis and benefit program implementation.

To receive study reports and other Segal insights as soon as they are available online, join our email list.

Segal's Health Benefits Consulting Services

Today's benefits environment demands a comprehensive approach to formulating health plan design strategies that leverage innovative approaches as well as the power of data analysis, modeling and benchmarking.

Our professionals can help your organization plan, design and strategize by providing:

Plan design and analysis — Are you providing high-quality, cost-effective healthcare to your plan participants? Segal's health professionals can help plan sponsors with the design and redesign of health benefit plans, including medical, dental, prescription drug, vision, behavioral health, short- and long-term disability, life, accidental death and dismemberment and flexible benefits.

Strategies for improving workforce wellness and well-being — To improve participants' and their families' physical health, are you offering wellness programs that focus on fitness, nutrition and weight management? Are you offering benefits, which may include voluntary benefits, designed to promote well-being? Such offerings include stress management, caregiver benefits, paid leave and student debt relief as well as other financial advice. Do health benefits address the unique needs of a diverse workforce and workers living in underserved communities?

Cost and utilization modeling — Has your plan modeled plan sponsor expenses or calculated the out-of-pocket cost of plan changes to participants? Segal's consultants and actuaries can help you evaluate the financial impact of plan design modifications, predict future utilization patterns and estimate changes in claims costs.

Financial monitoring — Does your plan have the proper budgeting tools in place to ensure long-term financial stability? Segal can assist in reviewing or developing your plan's reserve policy and analyzing the impact of proposed plan design changes on future expenses.

Service provider and insurer competitive bidding — When was the last time you put your plan out for a competitive bid? Segal brings industry-leading expertise and innovative contracting to secure highly competitive pricing and service terms for our clients.

Data mining and analysis — Are you getting the information you need to make important plan design decisions? Segal can provide data-mining services through our proprietary warehouse, SHAPE — such as exploring emerging population health-risk factors that impact utilization and uncovering potential fraud and abusive provider practices — to help you better manage future healthcare expenses.

Benchmarking — Have you compared your policies and initiatives to what other plan sponsors are offering? Segal provides benchmark assessments that provide a unique and invaluable understanding of how benefit programs compare to others.

Our communications consultants work closely with our health consultants to develop communications campaigns that capture the attention of participants and their families to support desired behaviors.

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