Segal Consulting

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Practical Research on Public Sector Benefits

Summer 2017

Choice and Incremental Increases in Cost Sharing Characterize Health Benefits for State Employees

Compare Your Jurisdiction's Coverage

State leaders are always interested in how peer jurisdictions structure their employee health benefits. Health benefits have become more important as the cost of that coverage outpaces overall inflation, placing budget pressure on health plan funding and underscoring the need for ongoing cost-management efforts. Examining what other states offer can be helpful when making difficult decisions about potential changes in coverage, such as the number and types of plans offered and how to share costs with employees. Since the mid-1970s, Segal Consulting has gathered data about health benefits for state employees and prepared a summary of plans offered as a resource for government leaders.

Segal's 2017 *State Employee Health Benefits Study* presents an overview of plan designs and cost-sharing arrangements. The key findings are:

- Most states provide their employees with a range of choices in medical plan types as well as multiple premium tiers.
- Employees' premium contributions remain fairly consistent as a percentage of total costs, yet on a dollar basis those contributions are increasing as the cost of coverage rises.
- Employees' out-of-pocket costs are also increasing as states increase deductibles, copayments and out-of-pocket limits. The annual out-of-pocket maximum for non-grandfathered plans under the Affordable Care Act has provided a new standard of comparison for many employers, including states.
- States continue to use plan design to manage prescription drug costs by influencing utilization towards more efficient delivery channels and more cost-effective medications.

When comparing their plans with the study data, states and other jurisdictions may also want to examine overall plan value, as discussed on pages 19 and 20.

About the Survey

The study includes data from every state and the District of Columbia. For simplicity, it refers to all of the jurisdictions as states. It covers the following medical plan types offered to full-time employees for 2017:

- Preferred provider organizations (PPOs)/ point-of-service (POS) plans,
- High-deductible health plans (HDHPs)/consumer-driven health plans CDHPs),
- Health maintenance organizations (HMOs)/ exclusive provider organization (EPOs), and
- Indemnity plans.

The study, which also examines prescription drug coverage, reports findings.

The methodology is described on page 21.

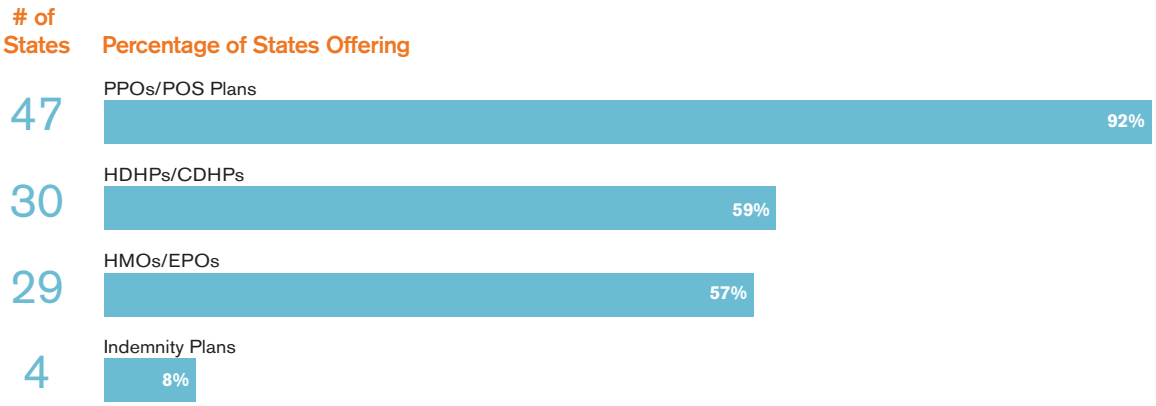
Most States Offer a Choice of Plan Types

PPOs/POS plans continue to be the dominant type of plan — offered by most jurisdictions studied. The exceptions are Georgia, Minnesota, Nevada and the District of Columbia.

HDHPs/CDHPs, which have also become more prevalent since 2003, when Health Savings Accounts (HSAs) were first authorized under the Medicare Prescription Drug, Improvement, and Modernization Act, now edge out HMOs/EPOs as an offering (by one state).

Very few states offer indemnity plans, which were ubiquitous just before the new millennium. The four states that still offer indemnity plans are Idaho, Iowa, Massachusetts and Vermont.

Almost all states offer PPOs/POS plans; many also offer HDHPs/CDHPs and HMOs/EPOs.



Source: Segal Consulting, 2017

Segal Observations By offering more than one plan type, states are addressing individuals' interest in having a choice of coverage. For example, the 2015 Health and Voluntary Workplace Benefits Survey conducted by the Employee Benefit Research Institute and Greenwald & Associates found that 80 percent of workers said a choice of health plan is either extremely important (41 percent) or very important (39 percent) to them.[1] Since a sharp rise in HDHP/CDHP offerings five plus years ago, the mix of plan choices has remained relatively stable.

[1] Paul Fronstin, Ph.D., and Ruth Helman, "Views on Employment-based Health Benefits: Findings from the 2015 Health and Voluntary Workplace Benefit Survey," (Employee Benefit Research Institute Notes, Vol. 37:3, March 2016): 1.

> As HDHPs/CDHPs coupled with HSAs and HRAs continue to grow in popularity, they become less affordable for some segments of the workforce. ... To meet that challenge, a greater investment in participant health consumer educational programs might be required.

Some Regional Differences in Offerings

There are some notable differences in medical plan offerings by region. HDHPs/CDHPs are most prevalent in the South and the Midwest. They are a relatively uncommon offering in the Northeast, where states are more likely to offer PPOs/POS plans and HMOs/EPOs.

Regional differences are most pronounced for HDHPs/CDHPs.

	Northeast		South		Midwest		West	
	Number of States	Percent of States	Number of States	Percent of States	Number of States	Percent of States	Number of States	Percent of States
PPO/POS Plan	9	100%	15	88%	11	92%	12	92%
HDHP/CDHP	2	22%	13	76%	8	67%	7	54%
HMO/EPO	6	67%	10	59%	5	42%	8	62%
Indemnity Plan	2	22%	0	0%	1	8%	1	8%

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, DC, 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 and 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. The data from this table formatted as graphs is available upon request.

Source: Segal Consulting, 2017

Segal Observations States continue to implement new HDHP/CDHP options. As HDHPs/CDHPs coupled with HSAs and HRAs continue to grow in popularity, they become less affordable for some segments of the workforce. In order to meet that challenge, a greater investment in participant health consumer educational programs might be required.

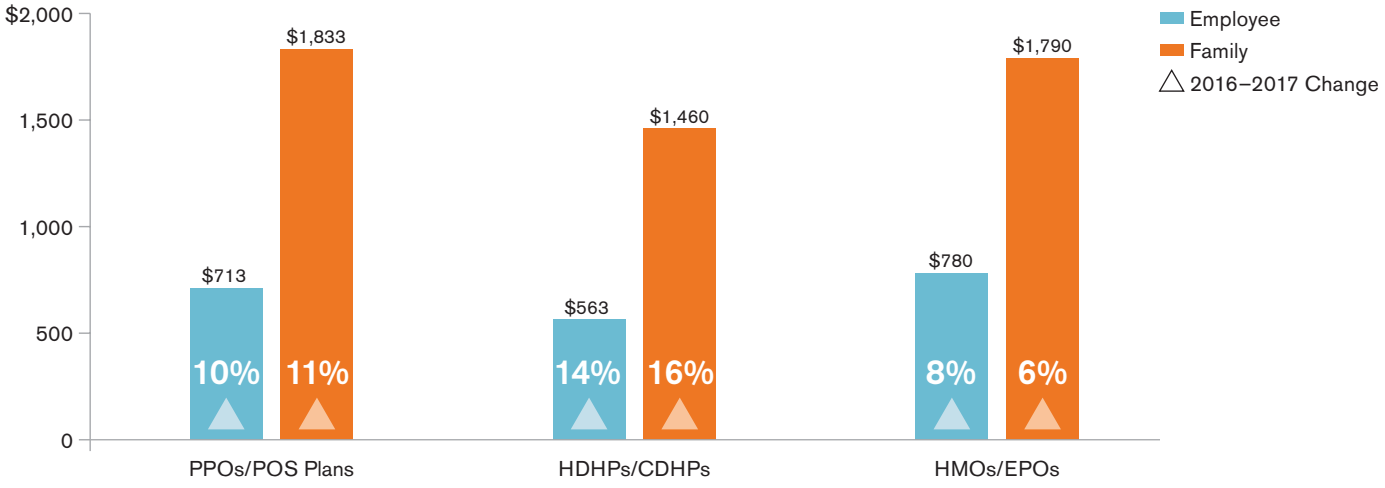
Those states that do not yet offer an HDHP/CDHP may find that their ability to recruit employees from the private sector hampered. That plan type is common in the private sector. The 2016 Employer Health Benefits Survey conducted by the Kaiser Family Foundation the Health Research & Educational Trust found that 17 percent of covered workers are enrolled in an HDHP. Enrollment in HDHPs grew 8 percentage points over the last two years while PPO enrollment fell 10 percentage points. Most respondents to the survey (93 percent) are in the private sector.

> The average *annual* premium for family PPO/POS plan coverage of nearly $22,000 in 2017 accounts for approximately 29 percent of projected median household income for families.

Total Cost of Coverage and Rate of Increase Differ by Plan Type

On average, total premiums (including both the state share and employee contributions) for employee-only are highest for HMOs/EPOs, but that plan type experienced the lowest increases for that coverage category from 2016 to 2017.

In both PPOs/POS plans and HDHPs/CDHPs, average total monthly premiums for family coverage (orange bars below) are more than double premiums for employee-only coverage (blue bars below) — and rose by double digits between 2016 and 2017 (indicated by the triangles in the bars).



Source: Segal Consulting, 2017

Segal Observations The double-digit premium increases are higher than trend projections. Segal's 2017 *Health Plan Cost Trend Survey*, which is based on information provided by managed care organizations, health insurers, pharmacy benefit managers and third-party administrators, found medical cost trends were projected to be 7.6 percent for open-access PPOs/POS plans, 7.7 percent for HDHPs, and 6.7 percent for HMOs. (Of course, trend is a forecast of increases in allowed claims cost. Changes in an individual plan sponsor's costs can be significantly different.) With the overall Consumer Price Index (CPI-U) for all goods and services running at approximately 2 percent annually, these medical plan cost trends are straining the expense side of ledger beyond sustainability. Increasing revenue streams to keep pace with current medical inflation rates is improbable for most jurisdictions. Here is another way to view this cost crisis: the average *annual* premium for family PPO/POS plan coverage of nearly $22,000 in 2017 accounts for approximately 29 percent of projected median household income for families.[2]

[2] According to the U.S. Census Bureau, median U.S. household income for families was $72,165 in 2015. Assuming annual wage increases of 2.5 percent, median family income in 2017 is $75,818. Bernadette D. Proctor, Jessica L. Semega, and Melissa A. Kollar, "Income and Poverty in the United States: 2015," (Washington, D.C., U.S. Census Bureau, September 2016): 5.

Total costs and premiums continue to increase despite ongoing efforts to mitigate and manage trend, such as plan design reductions and member incentives to promote healthy and efficient choices. Comparing states' premium increases to those shown in the Kaiser Family Foundation and the Health Research & Educational Trust's Employer Health Benefits Survey shows that states' premium increases are also higher than what large private sector employers experienced recently, as noted in the following table.

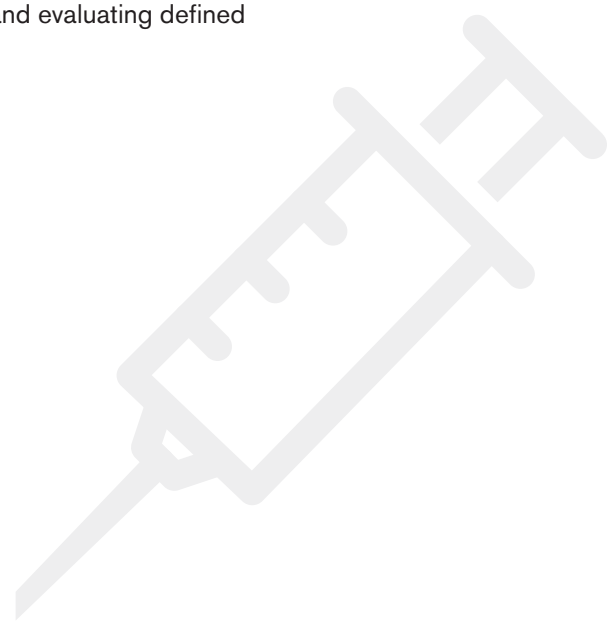
Comparative Data on Premium Increases (2015–2016)

	PPOs	POS Plans	HDHPs with Savings Option	HMOs
Single Coverage	14%	3%	2%	4%
Family Coverage	3%	9%	–7%	13%

Source: Kaiser Family Foundation and the Health Research & Educational Trust's 2015 Employer Health Benefits Survey and 2016 Employer Health Benefits Survey. Most respondents to this annual survey are in the private sector.

One possible explanation is the demographics of state plans, which have relatively older employee populations. Nearly half (49.7 percent) of state employees were between the ages of 45 and 64 in 2013, the most recent government data available, which compares to 42 percent of full-time private sector workers.[3] Public sector employees also tend to have higher health risks than private sector employees.[4] Higher annual cost trends for HDHPs/CDHPs than other plan coverage options may be the result of changing health status of enrollment over time, and not any inefficiencies in these plan types. In our experience, the initial enrollees of HDHPs/CDHPs tend to have healthier risk profiles. As enrollment in these plans grows, the employees that select this option over time will more closely match the health-status risk of the overall participant population. As a result, the annual cost trend rates may be higher until this risk fully transitions to an average level.

Given their older demographics, states should evaluate their Medicare arrangements, including reviewing the advantages and disadvantages of continuing to apply for a retiree drug subsidy rather than contracting with a Medicare Part D employer group waiver plan, determining if Medicare Advantage plans for retirees age 65 and older are the right solution and evaluating defined contribution private Exchange options.



[3] Gerald Mayer, "Selected Characteristics of Private and Public Sector Workers," Congressional Research Service, (March 21, 2014): 1.

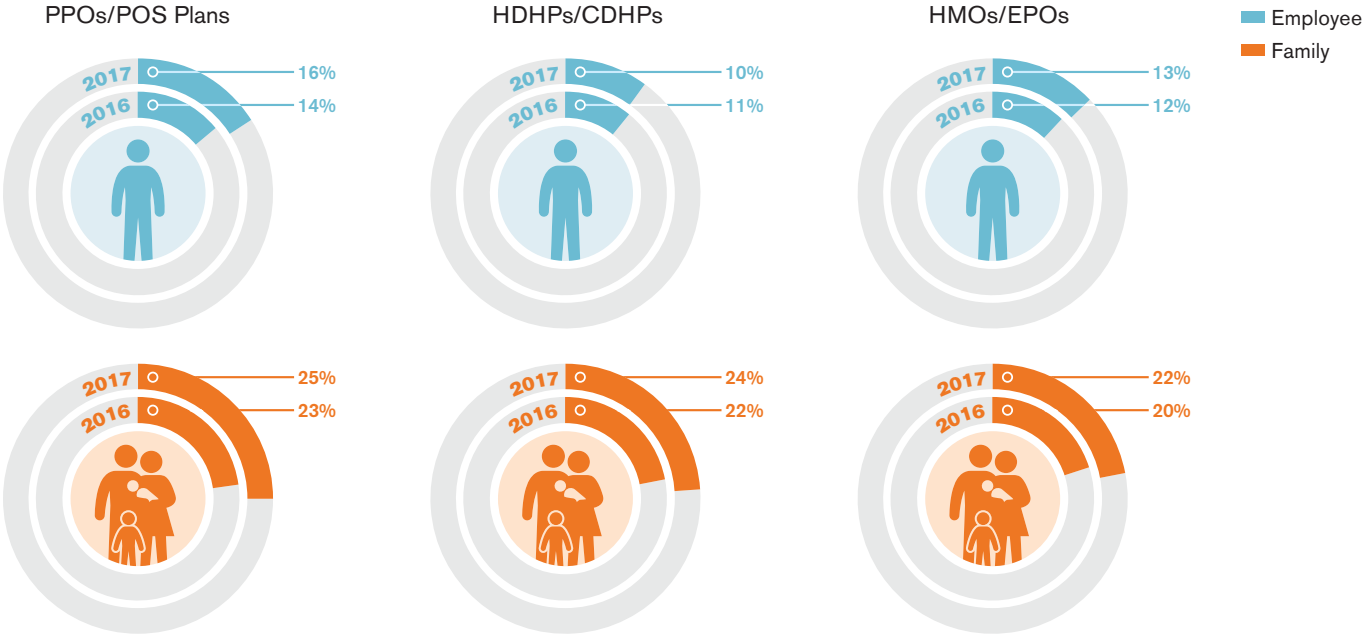
[4] Truven Health Analytics, *Government Employees Cost 20 Percent More to Insure Than the Private Workforce*, https://truvenhealth.com/media-room/press-releases/detail/prid/111/government-employees-cost-20-percent-more-to-insure-than-the-private-workforce (accessed June 16, 2017).

Incremental Increases in Cost Sharing

How states share the cost of the medical premium for employee-only and family coverage varies modestly by plan type. Regardless of plan type, on average, states pay a large majority of the cost of coverage (84 percent or more for employee-only coverage and at least 75 percent for family coverage).

In 2017, employees in HDHPs/CDHPs pay 6 percentage points less of the total share of the cost of employee-only coverage than do employees in PPOs/POS plans. That is a slightly wider gap between those plan types than existed in 2016 for employee-only coverage. Employees in all plans are paying a greater percentage of the cost of family coverage in 2017 than they did last year.

For all plan types, the average cost sharing for employee-only coverage changed by no more than 2 percentage points between 2016 and 2017. Similarly, the average cost sharing for family coverage increased over that period by 2 percentage points for all plan types.



Source: Segal Consulting, 2017

Segal Observations The one-percentage-point decline in cost sharing for employee-only coverage in HDHPs/CDHPs is likely attributable to the fact that more states offer that plan type this year and are likely offering a lower "introductory" rate than more established plans offer. The cost-sharing findings demonstrate that, on average, state employees contribute less toward the cost of coverage than employees at other employers. For example, the table below shows employee cost-sharing percentages for firms with 200 or more workers by plan and coverage type.

Comparative Data on Cost Sharing (2016)

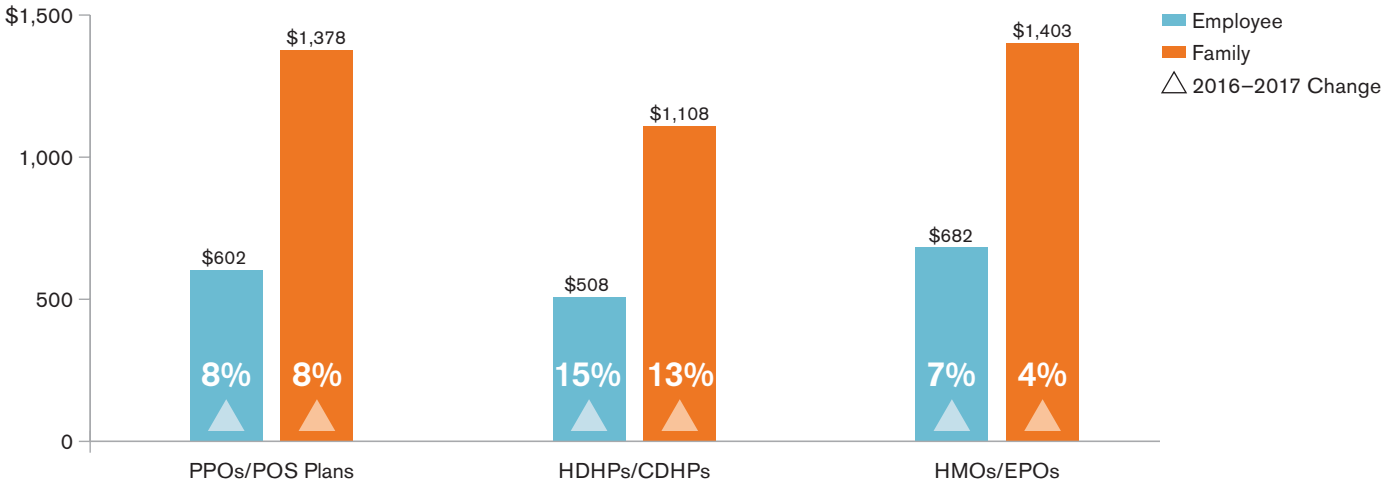
	PPOs	POS Plans	HDHPs with Savings Option	HMOs
Single Coverage	19%	18%	18%	17%
Family Coverage	27%	29%	24%	24%

Source: Kaiser Family Foundation and the Health Research & Educational Trust's 2016 Employer Health Benefits Survey

Increases in State Share of the Premium Cost and Employee Contributions Vary Widely by Plan Type

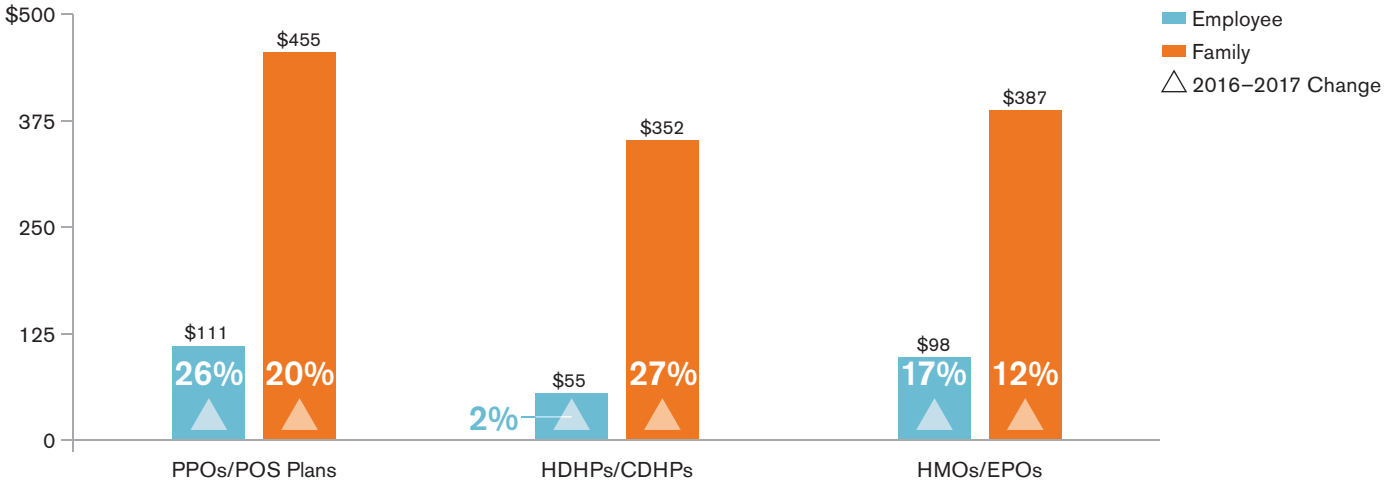
The state share of the premium cost is lowest for HDHPs/CDHPs, but the premium payments have increased most for that plan type since 2016 — by almost double the increase for PPOs/POS plans and HMOs/EPOs. Employee premium contributions are also lowest for HDHPs/CDHPs. The increase for that plan type was low for employee-only coverage and high for family coverage.

Average monthly state share of the premium cost for HDHPs/CDHPs increased by double digits between 2016 and 2017 for both employee-only coverage (blue bars) and family coverage (orange bars).



Source: Segal Consulting, 2017

Average monthly employee contributions to premiums is highest for PPOs/POS plans and increased the most for that plan type between 2016 and 2017 for both employee-only coverage (blue bars) and family coverage (orange bars).



Source: Segal Consulting, 2017

Segal Observations States are more likely to share premium increases with employees in HMOs/EPOs and PPOs/POS plans. They continue to maintain attractive cost sharing for single-only coverage in HDHPs/CDHPs. States should periodically review employee contributions to ensure they are aligned

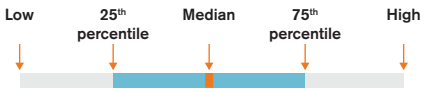
with the plan sponsor's goals. For example, if a plan sponsor wants to target a certain percentage of employee contributions (*e.g.*, family coverage will set at 25 percent of the lowest-cost plan) than contributions for family HMO/EPO family coverage noted in the above graph would need to be adjusted to be better aligned with that target.

States with multiple plan offerings need to weigh the usefulness of offering a wide array of plan choices against the administrative costs and communications complexities that accompany a lengthy lineup of plans. Fewer choices are easier to manage and may be less confusing for employees. Segal recommends a periodic review of the number and types of plans offered to ensure that a state's plan lineup remains optimal.

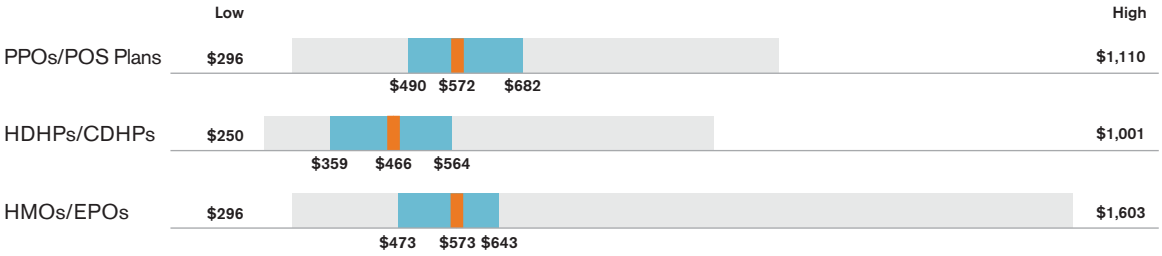
Range of State Payments and Employee Contributions

Median monthly state payments for employee-only coverage are lowest for HDHPs/CDHPs and are almost identical for PPOs/POS plans and HMOs/EPOs. Similarly, median monthly state payments for employee-only coverage are lowest for HDHPs/CDHPs and are only $5 apart for PPOs/POS plans and HMOs/EPOs.

When reviewing these graphs, and all other graphs in this report that show ranges, it is important to keep in mind that the lowest and highest amounts may be associated with just one plan. The following key is for all graphs that show ranges:

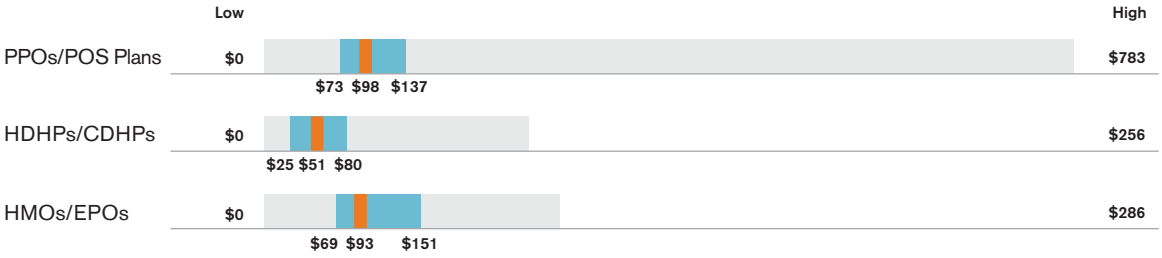


Most monthly state payments for employee-only coverage fall within a range of about $200 between the 25th and 75th percentiles for all plan types.



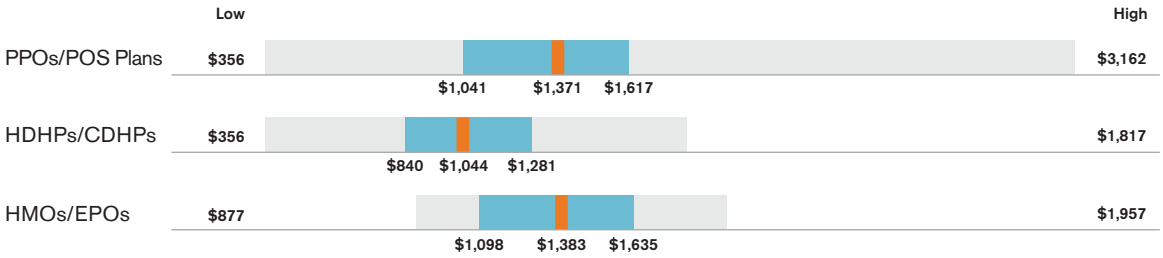
Source: Segal Consulting, 2017

Monthly employee contributions for employee-only coverage fall within a wider range between the 25th and 75th percentiles for PPOs/POS plans and HMOs/EPOs than for HDHPs/CDHPs.



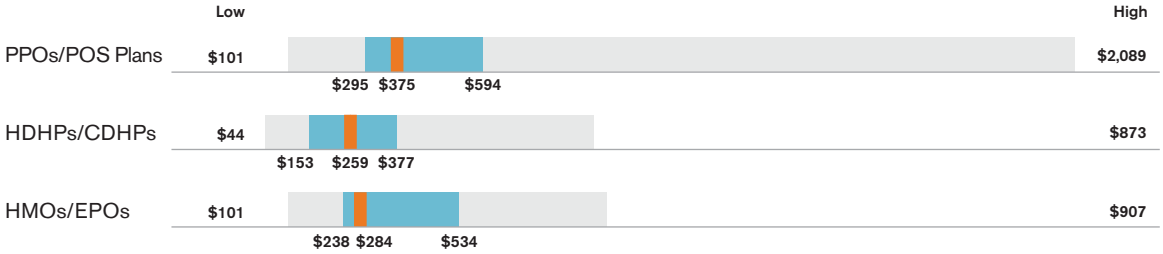
Source: Segal Consulting, 2017

Monthly state payments for family coverage fall within a range of more than $500 between the 25th and 75th percentiles for PPOs/POS plans and HMOs/EPOs and a much narrower range of $200 for HDHPs/CDHPs.



Source: Segal Consulting, 2017

Median monthly employee contributions for family coverage are more than three times higher than for employee-only coverage and fall within a wider range between the 25th and 75th percentiles.



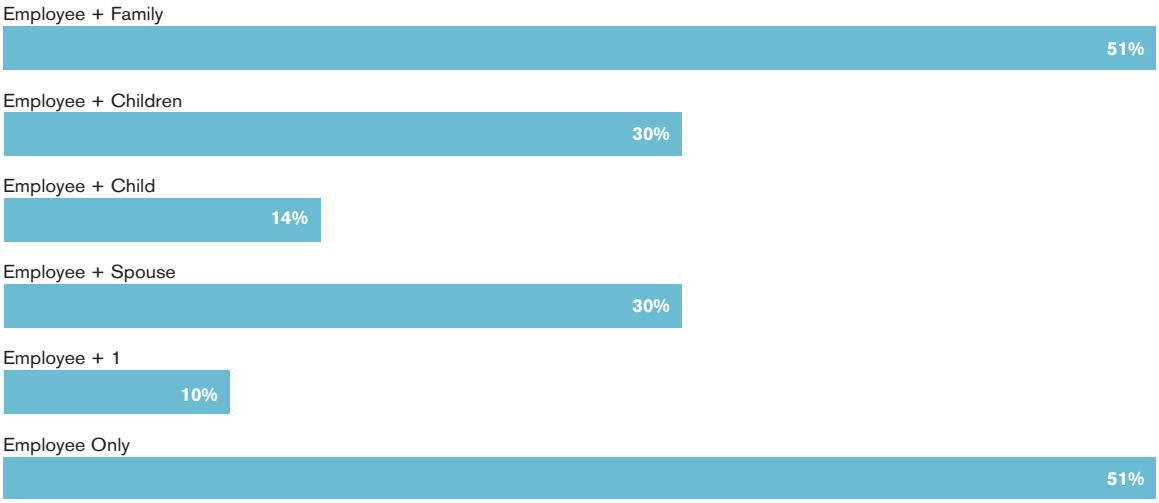
Source: Segal Consulting, 2017

Segal Observations States continue to offer employees plan choices with a wide range of price points. For some employees in some states, affording PPO/POS plan coverage is becoming increasingly more challenging while employees in HMO/EPO and HDHP/CDHP options likely find those plans more affordable, particularly when covering their families. Additionally, cost differentials may reflect adverse selection among medical plan offerings.

Multiple Coverage Tiers Offered

Although this report focuses on employee-only and family coverage, which all states offer, it is important to note that many plans offered by states continue to provide premiums for different family sizes. States use a range of different premium and contribution structures to align with the variation in family composition within their membership. For example, states with many single-parent families in their plans may consider a tier structure with Employee+Child (coverage for only one child) or Employee+Children (coverage for two or more children) options.

At least half of states offer coverage tiers for employee+spouse and employee+children.

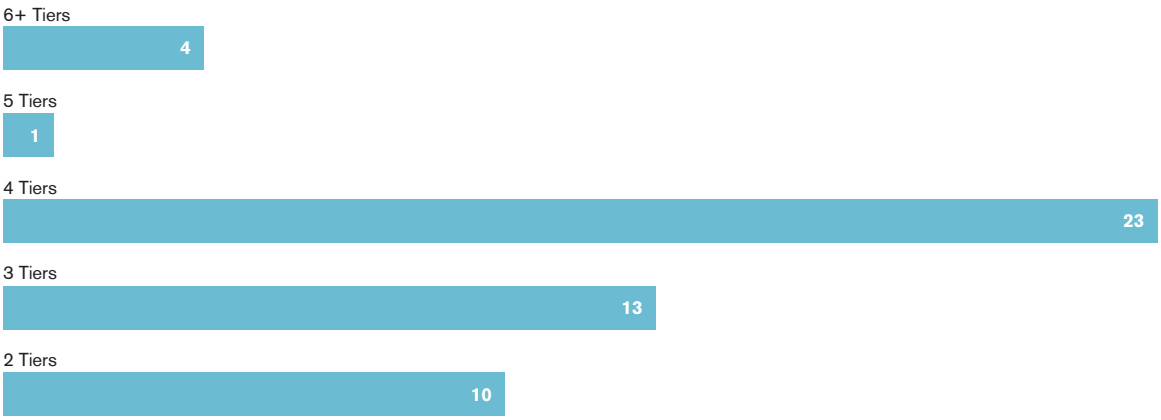


Notes: The total exceeds 100 percent because all states offer more than one tier. Employee +1 can refer to either an employee plus a spouse or an employee plus a child.

Source: Segal Consulting, 2017

The large majority of states (90 percent) offer four or fewer coverage tiers. Five states have at least five tiers.

Three- and four-tier structures are most prevalent.



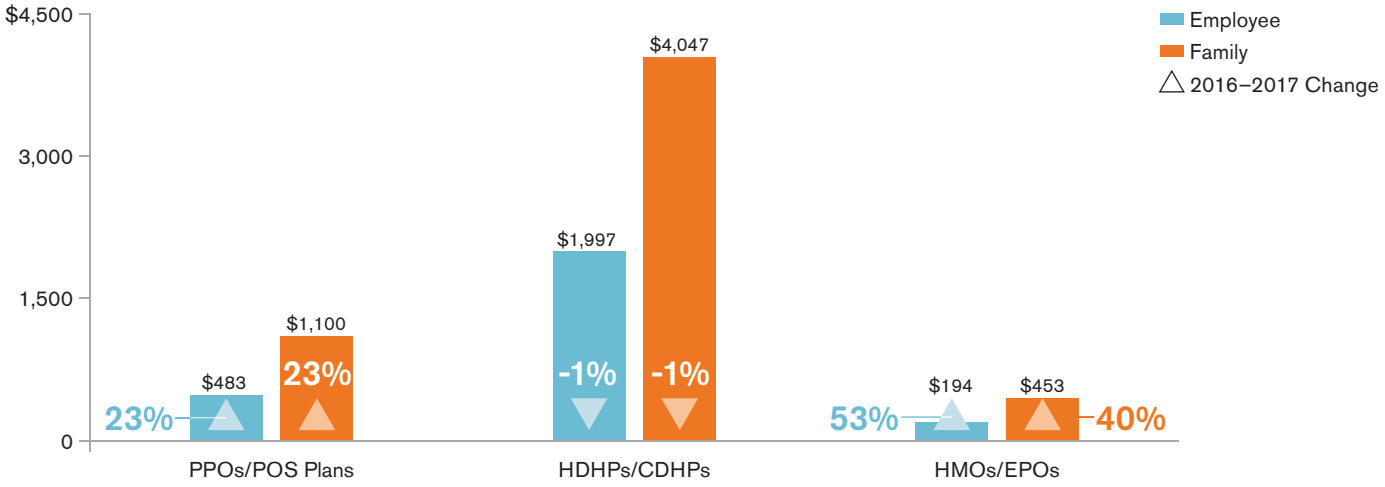
Source: Segal Consulting, 2017

Segal Observations States with five or more coverage tiers may want to consider reducing the numbers of tiers offered. Fewer tiers are easier to manage and may be less confusing for employees. Segal recommends a periodic review of enrollment levels and premium differentials across the tier structure to ensure the options offered remain aligned with a jurisdiction's demographics.

Dramatic Difference in Deductibles

Average deductibles for employee-only coverage differ dramatically by plan type. In this study, the amounts shown are the sum of medical deductibles and prescription drug deductibles for plans that have separate deductibles for prescription drugs.

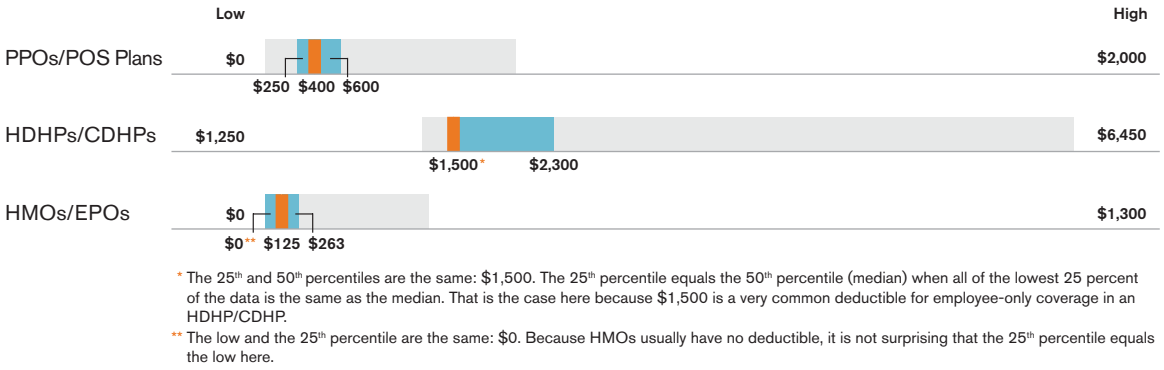
Average deductibles are highest — by design — for HDHPs/CDHPs, but the greatest increase is for HMOs/EPOs for both employee-only coverage (blue bars) and family coverage (orange bars).



Source: Segal Consulting, 2017

The range of deductibles for both employee-only and family coverage is greatest for HDHPs/CDHPs.

There is a wide range of deductibles for employee-only coverage.

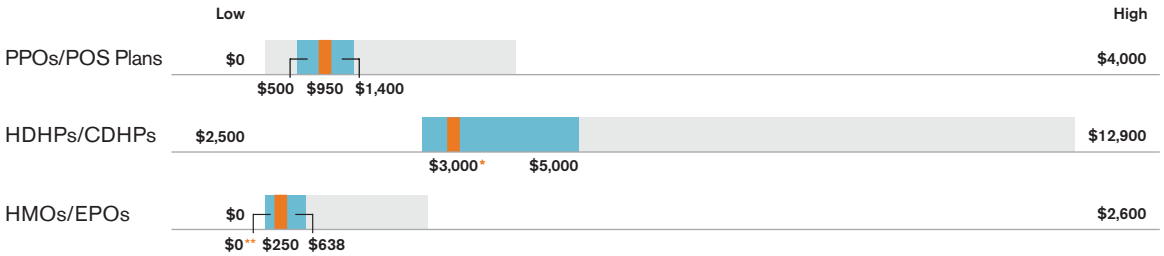


* The 25th and 50th percentiles are the same: $1,500. The 25th percentile equals the 50th percentile (median) when all of the lowest 25 percent of the data is the same as the median. That is the case here because $1,500 is a very common deductible for employee-only coverage in an HDHP/CDHP.

** The low and the 25th percentile are the same: $0. Because HMOs usually have no deductible, it is not surprising that the 25th percentile equals the low here.

Source: Segal Consulting, 2017

The range of deductibles for family coverage is wider.



* The 25th and 50th percentiles are the same: $3,000, a very common deductible for family coverage in an HDHP/CDHP.

** The low and the 25th percentile are the same: $0

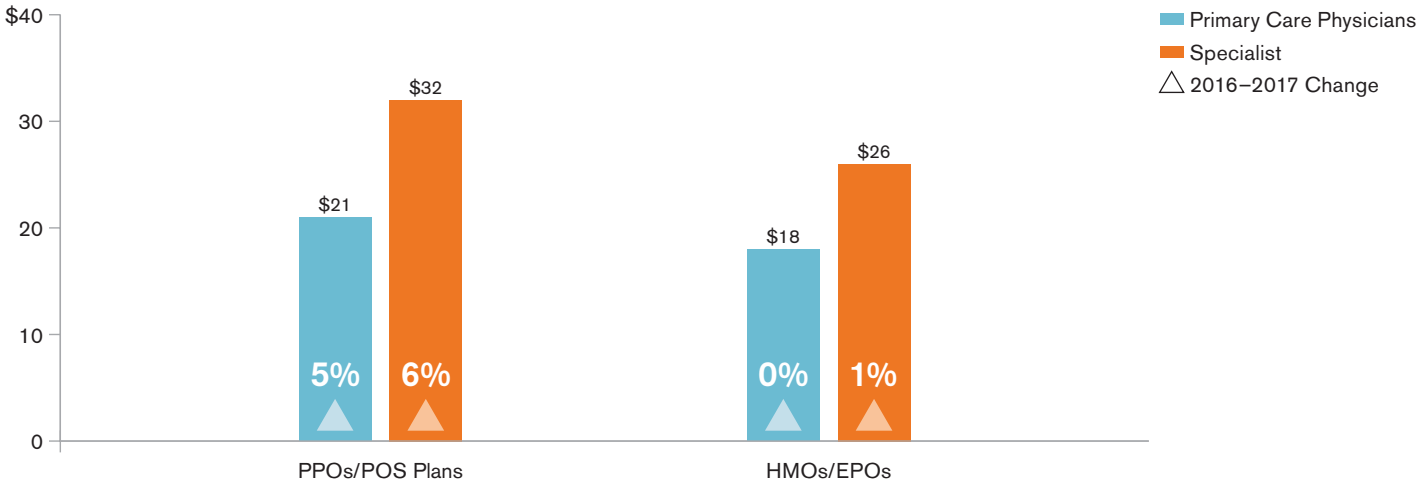
Source: Segal Consulting, 2017

Segal Observations PPO/POS plan deductibles continue to increase, which is necessary to keep pace with trend. However, the increase from 2016 to 2017 shown in the vertical bar graph on page 11 exceeds expected trend, resulting in some cost shifting to employees. HMOs/EPOs have historically been zero deductible plans, but states are increasingly introducing deductibles into their HMO/EPO options, leading to a rapid increase in the average. The one-percentage-point decline in average deductibles in HDHPs/CDHPs is likely attributable to the fact that more states offer that plan type this year than in 2016. The general trend of higher plan cost sharing in the form of copayments and deductibles is the preferred method of cost sharing, as employee premium contributions directly reduce take-home pay for all employees.

Small Increases in Copayments for Office Visits, which Fall in a Narrow Range

Segal also examined how plans share the cost of participants' visits to doctors' offices. Results for PPOs/POS plans and HMOs/EPOs that use fixed copayments as the primary method of cost sharing for those services are illustrated below. Copayment data is not shown for HDHPs/CDHPs because very few plans of that type have copayments.

Average copayments for specialist office visits are about 50 percent higher than for visits to primary care physicians. Copayment increases are modest for PPOs/POS plans, negligible for HMOs/EPOs.



Source: Segal Consulting, 2017

We also examined copayment data for plans that have different copayments for primary care physician and specialist office visits. We found the differences is in the specialist copayment.

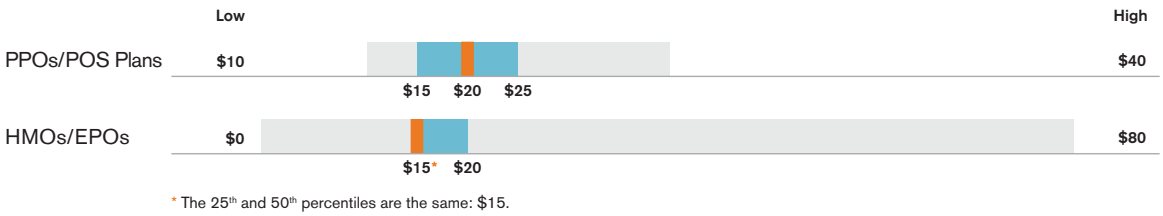
Plans with different copayments by type of visit tend to set copayments at the same rate as plans with no copayment differential, but charge more for specialist visits.

	Different Copayments		Same Copayments	
	HMOs/EPOs	PPOs/POS Plans	HMOs/EPOs	PPOs/POS Plans
Primary Care Physicians	$18	$22	$18	$19
Specialists	$31	$36	$18	$19

Source: Segal Consulting, 2017

As illustrated in the two graphs below, most copayments for primary care physician office visits fall within a narrow $10 range for PPOs/POS plans and a narrower $5 range for HMOs/EPOs. The ranges between the 25th and 75th percentiles are at last twice as large for specialist office visits: $20 for PPOs/POS plans and $15 for HMOs/EPOs.

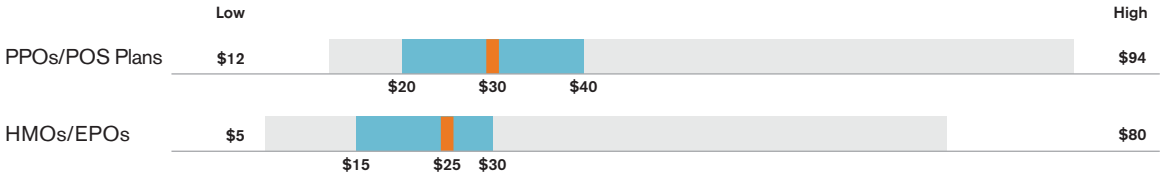
Most copayments for primary care physician office visits are at or close to the median.



* The 25th and 50th percentiles are the same: $15.

Source: Segal Consulting, 2017

Most copayments for specialist office visits fall into a $20 range for PPOs/POS plans and a $15 range for HMOs/EPOs.



Source: Segal Consulting, 2017

Segal Observations Office visit copayments continue to increase, which is necessary to keep pace with trend. Overall, increases are close to trend from 2016 to 2017, and in the case of HMOs/EPOs, below trend. Copayments for PPOs/POS plans continue to be higher than in HMOs/EPOs, reflecting the traditional trade-off of choice versus cost sharing.

Plan sponsors tend to set office visit copayments lower for primary care physicians than for specialists to encourage participants to seek care from less expensive providers. However, we found states' copayments for these services are, on average, only a few dollars apart. Using national average costs per visits for primary care physician office visits vs. specialist visits, the effective coinsurance for primary care physician office visits under the PPO/POS plan is 19 percent vs. 16 percent for specialist visits. These national average costs for primary care physician office visits (of $110) and specialist visits (of $200) were determined from Segal's database of 2 million covered lives. Costs may differ by region.

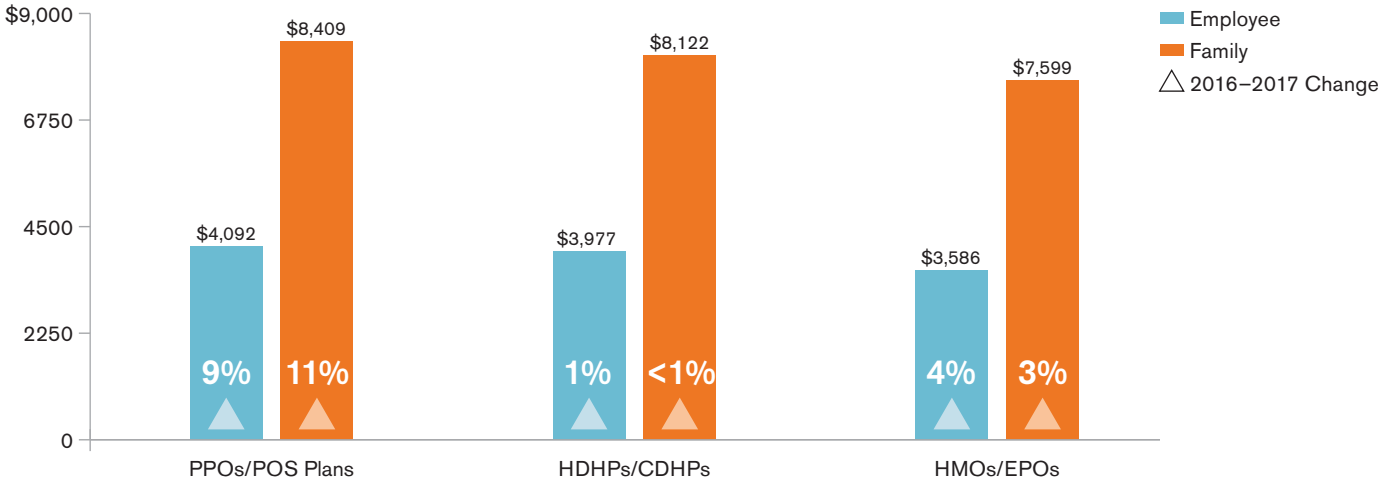
Plan sponsors use copayments because they are easy to explain and participants can budget for a fixed-dollar expense. Yet plans with fixed- dollar employee copayments erode in value, adding to the plan sponsor cost trends. Moving away from fixed per-use copayments for some treatments may help alleviate some of the cost-sharing erosion.

Some state PPOs/POS plans and HMOs/EPOs have returned to coinsurance designs rather than copayments to share the cost of office visits with participants. Plans with coinsurance also keep pace with trend automatically, whereas plans with copayments or other fixed-dollar provisions need to be updated more frequently to avoid "trend leveraging" (plan costs increasing at a higher rate than overall costs due to the plan's fixed-dollar provisions).

Annual Out-of-Pocket Maximums Increasing; Most Are Not at the Affordable Care Act Limits

The annual out-of-pocket maximums we captured in this study are for in-network services. They are the sum of medical and prescription drug maximums.

Average annual out-of-pocket maximums are highest for PPOs/POS plans and increased most for that plan type for both employee-only coverage (blue bars) and family coverage (orange bars).



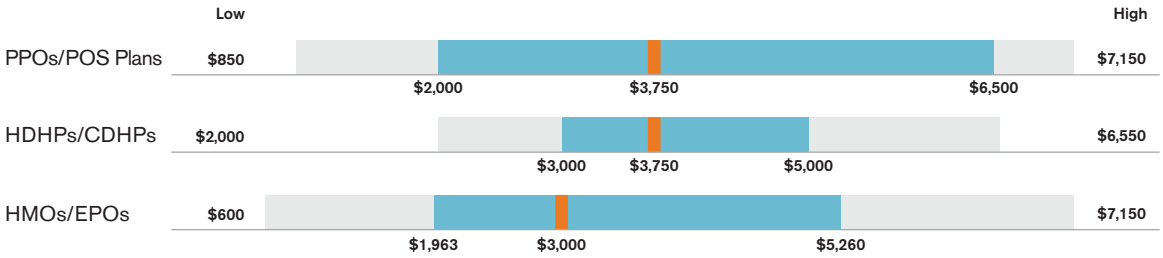
Note that the Affordable Care Act's maximum for individual coverage offered by non-grandfathered plans was $6,850 for 2016 and is $7,150 for 2017. The maximum for family coverage was $13,700 for 2016 and is $14,300 for 2017.

Source: Segal Consulting, 2017

> Most plans' limits are below the Affordable Care Act's maximums for non-grandfathered plans.

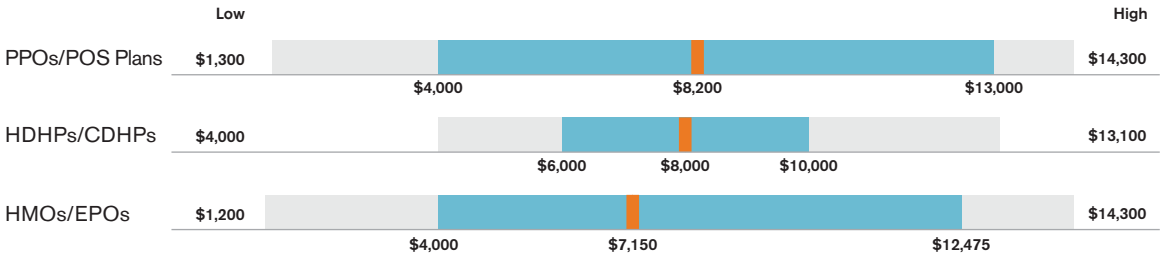
States use a wide range of out-of-pocket maximums to limit employee costs, with the highest limits generally found in PPOs/POS plans.

The range of annual out-of-pocket maximums for employee-only coverage is narrowest between the 25th and 75th percentiles for HDHPs/CDHPs.



Source: Segal Consulting, 2017

The range of annual out-of-pocket maximums for family coverage is also narrowest between the 25th and 75th percentiles for HDHPs/CDHPs.



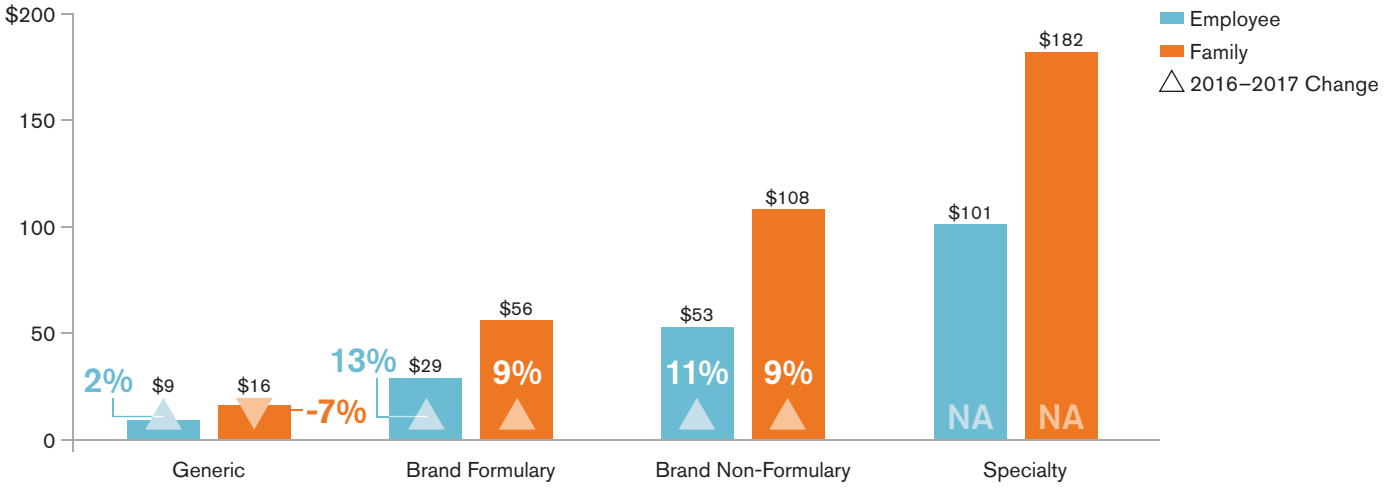
Source: Segal Consulting, 2017

Segal Observations Although states are increasing their plans' annual out-of-pocket maximums, most plans' limits are below the Affordable Care Act's maximums for non-grandfathered plans. The maximum for individual coverage is $7,150 for 2017 (up from $6,850 for 2016) and the maximum for family coverage is $14,300 for 2017 (up from $13,700 for 2016). Fifteen percent of state PPO/POS plans and 4 percent of HMOs/EPOs are at the Affordable Care Act's maximum for individual coverage. No HDHPs/CDHPs are at that limit.

Prescription Copayments Designed to Encourage Behavior

For non-specialty drugs, copayments for a 90-day mail-order prescription are typically two to three times that for a 30-day retail prescription. Plans tend to keep the mail-order copayment to an amount that is no greater than three times retail in order to encourage mail-order use; a philosophy we confirmed in this study.

On average, mail-order copayments for non-specialty drugs are two times retail copayments; mail-order copayments for specialty drugs are about one and one-half times retail copayments; and average mail-order copayments declined.

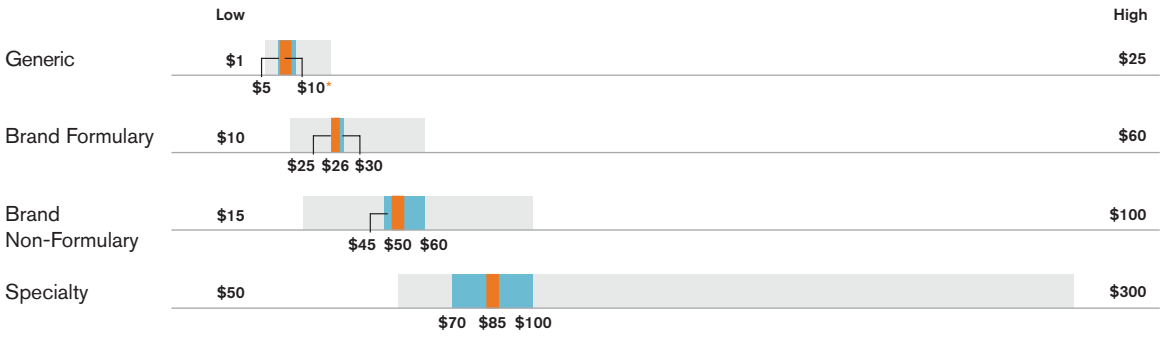


Specialty drug data for 2016 was not collected.

Source: Segal Consulting, 2017

Most plans continue to use plan design to influence employees to use more cost-efficient drugs and less expensive delivery channels. This typically takes the form of low(er) generic copayments and high(er) copayments for non-formulary brand drugs.

The range of copayments for retail prescriptions is narrowest for generic drugs and greatest for specialty drugs.



* The 50th and 75th percentiles are the same.

Source: Segal Consulting, 2017

Segal Observations Our findings are consistent with other research. For example, the Kaiser Family Foundation and the Health Research & Educational Trust's 2016 Employer Health Benefits Survey reported that among firms whose largest health plan has at least three cost-sharing tiers for prescription drugs, the average copayments are $11 for first-tier drugs, $33 second-tier drugs, $57 third-tier drugs and $102 for fourth-tier drugs. We also found that the average copayment for specialty drugs is $89.

Low copayments for generic drugs encourage use of those less expensive drugs. By setting copayments for non-formulary brand-name drugs at about two times the copayments for formulary brand-name drugs plans aim to steer utilization towards more efficiently priced drugs. High copayments for specialty drugs are intended to stem the rapidly increasing cost of those drugs. Specialty drug trend was projected to be 18.7 percent for 2017, according to our 2017 *Health Plan Cost Trend Survey*.

A few plans have rather high generic copayments, even at levels that exceed the full cost of many generic medications, resulting in participants paying 100 percent of the cost of many generics. While these costs may still be lower than the brand drug copayments, it would be advisable to remain mindful of the impact and benefits of utilization steerage.

Mail-order pharmacies, which offer more efficient pricing than retail pharmacies, are a good alternative for most maintenance medications. Copayments for mail order continue to be about two times that for retail for three times the day supply (90 days at mail vs. 30 days at retail) to encourage more mail-order utilization.

State plans continue to follow the industry practice in establishing a separate tier for specialty medications with higher copayments, with copayment differentials for mail order also being about two times that for retail.

Some state plans use coinsurance rather than copayments for prescriptions. More plans use coinsurance for specialty drugs than for generic drugs. According to the Pharmacy Benefit Management Institute 2017 *Trends in Specialty Drug Benefits Report*, coinsurance has become the primary cost-sharing design for pharmacy benefits (used by 51 percent of employers surveyed) compared to copayments (used by 43 percent of the surveyed employers). Plans with coinsurance also keep pace with trend automatically, whereas plans with copayments or other fixed-dollar provisions need to be updated more frequently to avoid "trend leveraging."

Sharing the cost of prescription drugs with participants is only one of a wide range of tactics for managing the rapidly rising cost to the plan sponsor of that coverage. Others include contracting directly with pharmacies, utilizing narrow formularies, implementing or expanding clinical management programs (step therapy, prior-authorization and pre-certification protocols), carving out specialty medication programs, and employing aggressive contracting tactics, such as market-check provisions and trend guarantees.

Benchmarking Your Offerings to Help Set Strategy — But Don't Stop There

It is often useful and informative to review specific benefit components, such as deductibles, copayments and out-of-pocket limits, in light of what peer jurisdictions are offering. A state may also be interested in how large private sector employers within the state (their competitors for talent) structure those plan features. While a variety of data is available in the industry, the best approach is to perform a custom survey and target the specific employers that are the most relevant. While it is not necessary to perform this review annually, it is advisable to review the competitiveness of your program every three to five years.

Overall plan value is important to employees, often more so than any single individual component. However, plan value can be difficult to assess when focusing on individual benefit components. To assess value, Segal benchmarks plans' actuarial value. The actuarial value is the overall share of cost covered by the plan across all services for the average participant, not accounting for any employee premium share. For example, in a plan with a 90 percent actuarial value, the participant will be responsible for only 10 percent of overall costs. The case study on the next page gives a brief overview of some results of our benchmarking of the actuarial value of a state client's health benefits.

Data analytics and predictive modeling can be used to help understand true drivers of costs and uncover substantial savings. High-performing plan sponsors often use data-driven techniques to continuously assess the investments needed for more efficient and effective care without simply shifting costs to participants.

A concerted effort to explore what health care conditions drive the most cost, what providers and treatments produce the best value and what levers and incentives help change an individual's behavior to drive healthier lifestyles can reduce long-term claim cost trends. This will allow plan sponsors to maintain control over providing high-value medical benefits that are well received by current and future participants. Understanding the underlying health risk and related drivers and developing targeted strategies can improve plan efficiencies and costs and enable plan sponsors to preserve overall plan value.

Although for this study we did not report on retiree coverage, states should also review that coverage periodically and evaluate their strategy for managing the cost of that coverage. The Governmental Accounting Standards Board's accounting changes for public sector retiree health insurance and other postemployment benefits (OPEB) makes that vigilance important. A 2016 *Public Sector Retiree Health Survey* conducted by Segal, the State and Local Government Benefits Association and the Public Sector HealthCare Roundtable found relatively few jurisdictions had taken action to mitigate the impact of the OPEB accounting changes.

> "Data analytics and predictive modeling can be used to help understand true drivers of costs and uncover substantial savings."

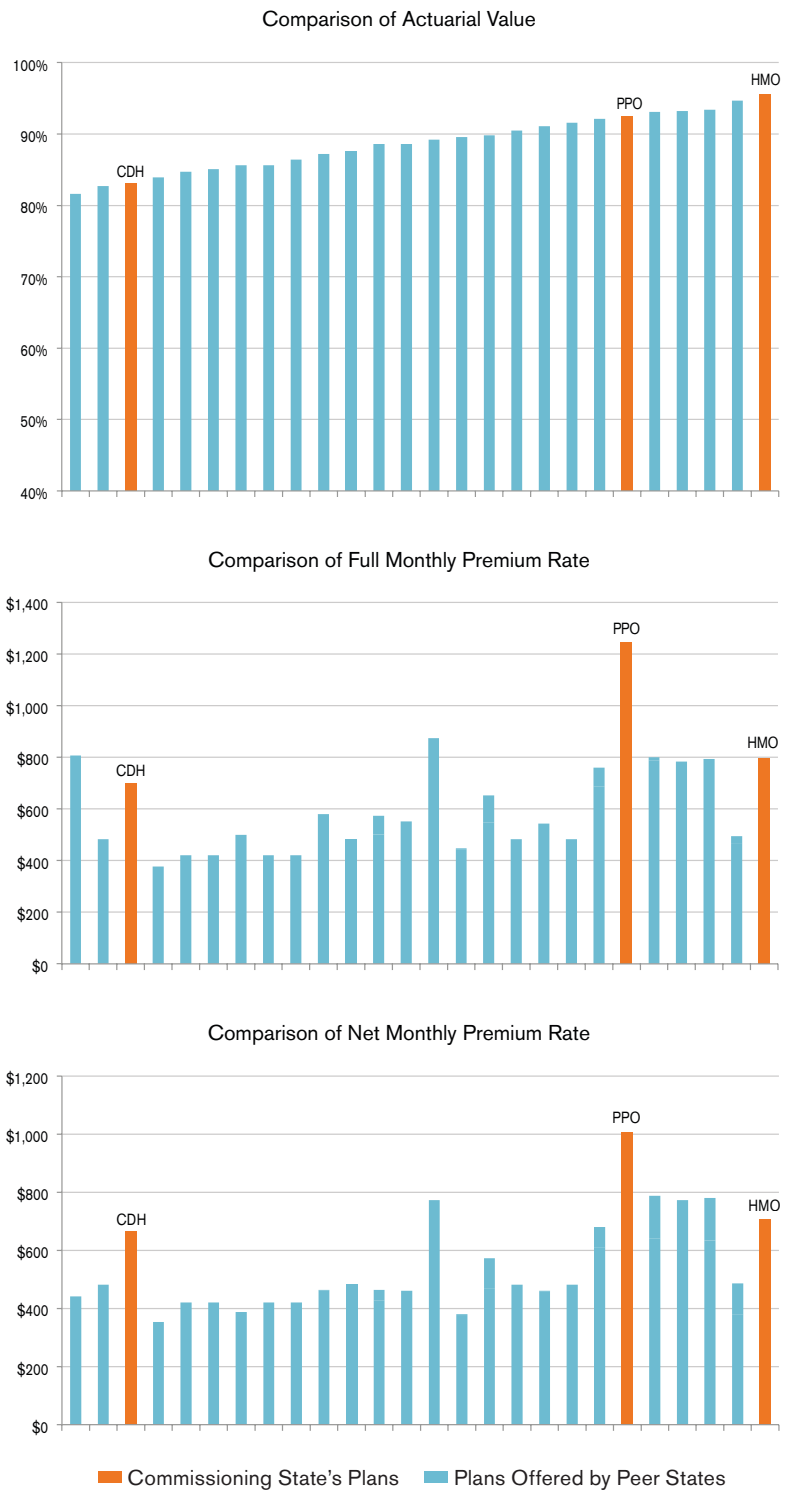
Benchmarking Actuarial Value Can Reveal Opportunities for Improvement

Since the Affordable Care Act introduced the concept of actuarial value as a way to categorize health plans available to individuals through the state Exchanges and the federal Marketplace as "platinum," "gold," "silver" and "bronze," sponsors of group plans have been interested in that measurement. Recently, Segal benchmarked the actuarial value of one state's health plans against plans offered by five other states in the region. As shown in the top graph, which lists the plans studied in order of ascending actuarial value, all three plans of the state that commissioned the study (represented by orange bars) offer very generous benefits. In fact, the state's richest plan, an HMO with an actuarial value of 93 percent, is at the top end for the chosen group of peer states. The state's other two plan options provide lower-cost options.

We also reviewed the total costs associated with each plan type (*i.e.*, the full premium rate). That analysis was very revealing. We found that some lower-cost options provide richer benefits than the higher-cost options. The second graph shows the results in the same order as in the first graph (low to high actuarial value) for employee-only coverage. The results varied somewhat for family coverage.

The third graph shows the net costs to the states for each plan after taking into account participant cost sharing. The plans are shown in the same order as the other two graphs. Net costs to states do not necessarily follow actuarial value.

This benchmarking study suggested this state's plans might not be as efficiently managed as the peer states' plans. A subsequent, detailed review of the state's cost-management and wellness programs indicated there were significant opportunities for improvement in both pricing and cost management.



Methodology

Segal based the 2017 *State Employee Health Benefits* Study on a review of the websites for all 50 states and the District of Columbia in the fourth quarter of 2016. We captured information for medical, prescription drug, vision and dental coverage, as well as wellness and tobacco-cessation programs offered to full-time employees as of January 1, 2017, including plans with July 1, 2016 effective dates.

This report focuses on information about medical and prescription drug coverage. The study covers 105 PPOs/POS plans, 83 HDHPs/CDHPs, 149 HMOs/EPOs and five indemnity plans. Data about some features was not available for all plans, so not all graphs represent all plan of each type.

To calculate averages, we used population data from the U.S. Census Bureau to weight each plan's data for employee-only and family coverage tiers.

Questions? Interested in More Data? Contact Us.

If you have questions about the 2017 *Study of State Employee Health Benefits*, contact your Segal consultant or Richard Ward, FSA, MAAA, FCA.

Additional study data on the plan features discussed in this report is available on request.

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