

Oklahoma State Regents for Higher Education

Employee Health Benefits Across the Oklahoma State System of Higher Education

A System Overview: Plan Structures, Cost Trends, Current Practices, and Opportunities for Shared Strategy

OSRHE Division of Budget and Finance

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1. Executive Summary

Employee health benefits are among the largest and fastest-growing costs facing Oklahoma's public colleges and universities. Salaries and benefits account for roughly seventy percent of institutional spending, and within benefits, health coverage has been rising at eight to twelve percent a year for well over a decade. At the 2026 tuition hearings, institution after institution named health benefit costs as a principal driver of the increases they were seeking.

This overview describes how the seventeen institutions of the state system outside OU, OSU, and their constituent campuses provide employee health benefits today: the plan structures they use, what they spend, the renewals they face for 2027, the contribution and plan-design choices they are making, the cost-management programs already in place, and the support they say would help.

Principal findings

1. **Cost pressure is universal and accelerating.** Nearly every institution describes its recent trend as "significant increases," and every institution with a 2027 renewal faces double digits. OKHEEI consortium members face an increase of roughly 12.2–12.4%. HealthChoice institutions, which enjoyed a flat 2026, now face a 2027 increase of roughly 16–19% depending on plan. OCCC, on its own self-funded plan, faces a 36% renewal.
2. **The system operates through three distinct plan structures** with very different levers: the OKHEEI self-funded trust (nine institutions, the largest pool), the state EGID/HealthChoice program (six institutions, including Tulsa Community College's multi-carrier offering), and standalone self-funded plans at UCO and OCCC.
3. **The fully employer-paid employee benefit is reaching its limit.** Many smaller institutions still pay 100% of employee-only coverage, and several say this is no longer sustainable. SEOSU is moving to a defined-contribution model for 2027; Redlands is re-basing its employer contribution to a lower-cost plan. Dependent coverage is the pressure valve, and dependent affordability is a top concern across the system.
4. **Pharmacy is the most-cited cost driver and the most actionable target.** Institutions consistently name pharmacy among their top concerns, several are being told it is the primary reason for their increases, and a review of pharmacy benefit management is among the most requested forms of support.
5. **What institutions are asking for.** Cost-management strategies, benchmarking against peer institutions, and pharmacy/PBM review are the most requested forms of support. Institutions are broadly open to follow-up conversations.

Scale

Taken together, these seventeen institutions employ more than 4,500 benefits-eligible faculty and staff and cover several hundred retirees. Annual health-benefit spending systemwide likely exceeds \$100 million. At the trend institutions are now experiencing, that spending grows by tens of millions of dollars every year — which is the scale of the opportunity in front of the system.

2. The System at a Glance

The table below summarizes institutions by plan structure. Enrollment, cost, and renewal figures are as reported by each institution; a dash indicates a figure not provided in completed surveys.

Institution	Eligible	Enrolled	Retirees	Annual cost	Most recent renewal
OKHEEI consortium — self-funded trust administered by BCBSOK					
Northeastern State University	~800	~760	334	~\$9.4M	15.7%*
Southwestern Oklahoma State University	500	450	35	\$5.6M	12.2%
Southeastern Oklahoma State University	480	475	30	\$4.9M	12.4%
Northwestern Oklahoma State University	233	222	9	\$2.7M	9.4%
Northern Oklahoma College	215	213	53	\$2.6M	12.4%
Redlands Community College	103	101	25	\$1.2M	12.4%
East Central University	—	—	—	—	—
Seminole State College	—	—	14	—	—
Murray State College	—	—	8	—	—
EGID / HealthChoice — state employee group insurance program					
Tulsa Community College	—	—	—	~\$9.9M	0–9.5% by carrier (2026)
Carl Albert State College	185	175	—	~\$1.4M	~4% (2024–26)
Eastern Oklahoma State College	128	126	12	\$1.3M	15.8%
Western Oklahoma State College	87	67	31	—	15.8–19.5% by plan
University of Science and Arts of Oklahoma	—	—	—	—	—
Rose State College	—	—	17	—	—
Standalone self-funded plans					
University of Central Oklahoma	~1,300	—	—	—	—
Oklahoma City Community College	500	488	~200	\$6.7M	36%

*NSU's most recent increase, partly offset by a plan redesign the university credits with more than \$1.2M in premium savings. Cost figures include retiree cost where institutions reported it separately.

3. Three Plan Structures

3.1 The OKHEEI consortium

Nine institutions — NSU, SWOSU, SEOSU, NWOSU, East Central, Northern Oklahoma, Redlands, Seminole State, and Murray State — provide coverage through the Oklahoma Higher Education Employee Insurance group. OKHEEI is a self-funded trust: institutions pay premiums into the trust, claims are paid from it by the plan administrator, and each institution independently sets its own contribution strategy. Blue Cross Blue Shield of Oklahoma administers medical coverage, with Prime Therapeutics as pharmacy benefit manager (changing to BCBS for 2027), Delta Dental, VSP, The Standard (moving to Mutual of Omaha at some campuses), and Empyrean/HRPRO for benefits administration. The group offers medical Plans A through D, which are PPO variants with differing deductibles, out-of-pocket maximums, and networks, and Plan F, a high-deductible HSA-eligible plan. Gallagher serves as the group's consultant and broker, and the member institutions collectively decide which programs, procedures, and payment options are available.

3.2 EGID / HealthChoice

Six institutions participate in the state's Employees Group Insurance Division program: Tulsa Community College, Carl Albert, Eastern Oklahoma State, Western Oklahoma State, USAO, and Rose State. Most buy HealthChoice High, Basic, and HDHP plans at state-set rates; Tulsa Community College additionally offers three HMO carriers — BCBS BlueLincs, CommunityCare, and GlobalHealth — alongside HealthChoice. These are, apart from TCC, the smallest institutions in the system and the ones with the least flexibility: they cannot negotiate plan design or rates, and they have the fewest add-on cost-mitigation programs, relying on the wellness and telehealth features built into the state plan and, at Western, the HealthChoice Select program.

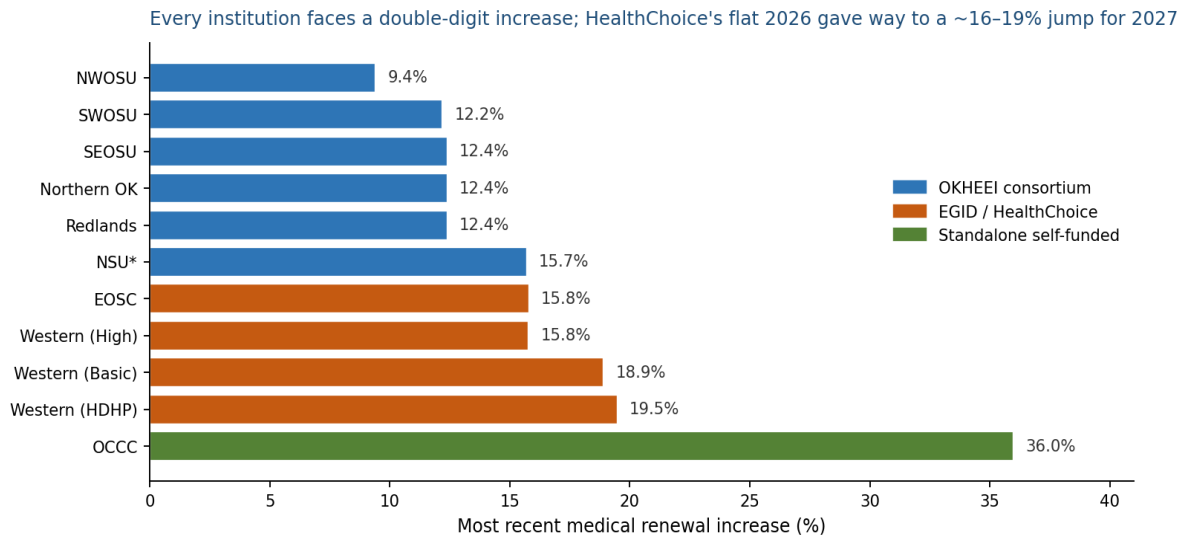
Their historical advantage has been price. HealthChoice per-employee cost runs roughly \$8,000 to \$9,800 a year, below the OKHEEI range, and Carl Albert's experience from 2024 through 2026 was a modest four percent. That advantage narrowed sharply for 2027: after the state held 2026 premiums flat, HealthChoice rates rise 15.8% (High), 18.9% (Basic), and 19.5% (HDHP). Because rates are set by the state, these institutions have no renewal lever; their strategies are limited to plan mix, contribution design, and whatever can be layered alongside the state plan. ***Carl Albert's use of monthly stipends — \$125 on the Basic plan and \$150 to the HSA on the HDHP — to steer employees toward lower-cost plans is a notable contribution-design practice within these constraints.***

3.3 Standalone self-funded plans

Two institutions administer their own self-funded plans. UCO, with roughly 1,300 benefits-eligible employees, has self-funded since 2019; for 2026 it moved to BCBSOK, consolidated its menu to a \$1,250-copay plan, a \$3,000 plan, and an HSA option, and retained ZERO and Primary Health Partners direct primary care. OCCC, with about 500 eligible employees, self-funds through BCBSOK on a July–June plan year, offering a \$3,400-deductible HSA plan with a \$1,000 employer HSA contribution and a \$500-deductible PPO. OCCC faces the largest renewal in the system for 2027 — 36% — and has the most distinctive pharmacy program among the smaller institutions, OCCCRx, an international mail-order prescription program, alongside TimelyCare telehealth and a wellness committee.

4. Cost and Renewal Trends

4.1 Renewal pressure for 2027



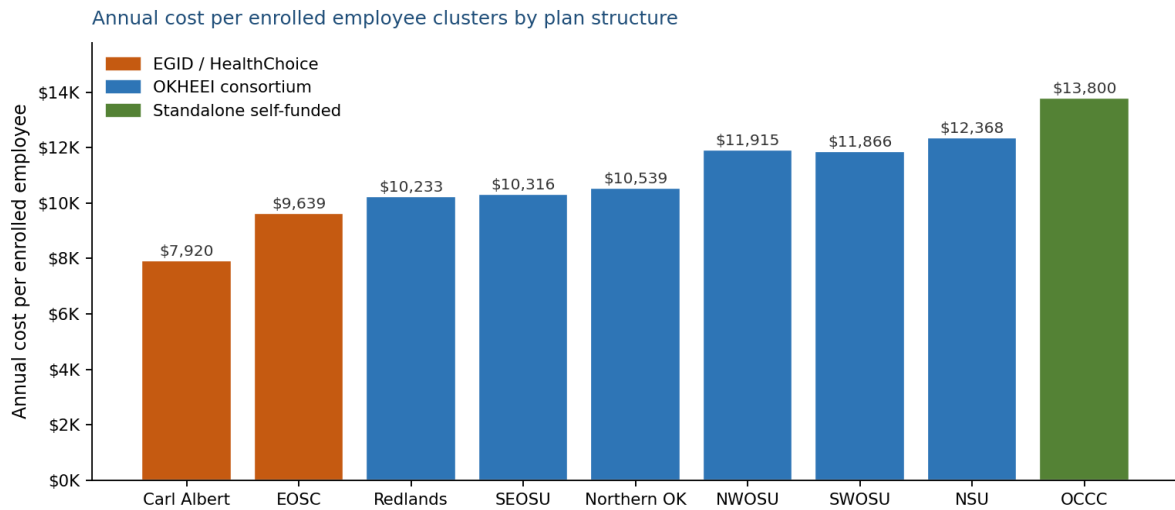
*NSU's most recent increase (15.7%) was partly offset by a plan redesign the university credits with more than \$1.2M in premium savings. Carl Albert's 2024–26 experience was –4%.

Figure 1. Most recent medical renewal increase by institution.

The OKHEEI group renewal for 2027 was reported almost identically by SEOSU, Northern Oklahoma, and Redlands (12.4%) and SWOSU (12.2%), consistent with a single pooled trust. NWOSU's 9.4% is the lowest in the group and likely reflects a different plan mix or contribution base. NSU's most recent increase was 15.7%, which it partly offset through a plan redesign it credits with more than \$1.2 million in premium savings.

HealthChoice: The state held 2026 premiums flat, and Tulsa Community College's 2026 experience ranged from a 1.3% decrease (CommunityCare) to a 9.5% increase (BlueLincs) with HealthChoice itself at zero. The 2027 HealthChoice rates then jumped roughly 16 to 19 percent depending on plan.

4.2 Cost levels and per-employee benchmarks



Derived from each institution's reported annual cost and medical enrollment. Bases vary somewhat across institutions (employer-only vs. total).

Figure 2. Annual cost per enrolled employee, derived from each institution's reported cost and enrollment.

Two points bear on how these figures should be read. Lower per-employee cost does not mean better value: HealthChoice plan richness, networks, and out-of-state coverage differ from OKHEEI's, and HealthChoice coverage is limited for participants who may seek care outside of Oklahoma. And institutions report cost on somewhat different bases — employer-only in some cases, total in others. ***A standard annual reporting template covering employer cost, employee cost, cost per employee per month, covered lives, and renewal by line of coverage would turn this snapshot into a durable system benchmark; Redlands' detailed accounting is a good model for it.***

5. Employer Contribution Strategy

A number of institutions still pay 100% of employee-only coverage. Employees typically bear the full cost of dependent coverage. This design concentrates the renewal shock on the institution's budget for employee coverage and on employees' paychecks for dependents — which is why dependent coverage cost is a leading concern across the system and why Redlands and SEOSU both describe dependent premiums as the sharpest pain.

Several institutions are changing their contribution strategy for 2027, and their decisions are instructive case studies for the rest of the system:

- **SEOSU is moving to defined contribution.** In the university's words: "We are moving to defined contribution to both help with cost — not fully covering such a high plan — and with the hopes of lowering claim costs and giving employees more options, such as taking lower-cost plans and using savings to pay for dependent coverage."
- **Redlands is re-basing its employer contribution.** Rather than absorb the 12.4% increase on Plan B, the college will pay 100% of Plan C instead, preserving a fully employer-paid option at a lower benefit level. No Redlands employee is currently enrolled in the high-deductible plan.
- **Carl Albert and OCCC use incentives to steer plan choice.** Carl Albert pays monthly stipends of \$125 on the Basic plan and \$150 to the HSA on the HDHP; OCCC contributes \$1,000 a year to employee health savings accounts.

Contribution and plan-design strategy are likely focus areas for an advisory to work with institutions systemwide.

6. Pharmacy

Pharmacy surfaces more than any other specific cost driver. SEOSU, NWOSU, Northern Oklahoma, NSU, and OCCC all name pharmacy among their top concerns, and Redlands reports that "we are being told the reason for such high increases are due to pharmacy." ***A review of pharmacy benefit management is among the most requested forms of support, sought by NWOSU, NSU, Redlands, SWOSU, and OCCC. For OKHEEI members, this is a request to examine a vendor relationship they do not individually control.***

Several developments make pharmacy the natural first target for shared work:

- **OKHEEI is changing its pharmacy vendor for 2027,** from Prime Therapeutics to BCBS. A vendor transition is the moment when contract terms, rebate arrangements, and pricing benchmarks are most open to scrutiny.
- **OSRHE has a claims-level pharmacy analysis in development.** Working with the Attorney General's PBM Compliance and Enforcement Unit, which has recovered \$46 million for state health plans, and the OU College of Pharmacy, which has administered the state Medicaid pharmacy benefit for three decades, ***OSRHE is working to develop a pathway for any institution to engage a confidential, de-identified benchmarking of pharmacy claims (OKHEEI already participating).***

7. Cost-Management Programs in Place

The system has more cost-mitigation activity in place than is generally recognized. OKHEEI institutions uniformly offer ZERO Health (bundled surgical care and generic pharmacy at no cost to the employee), BCBS wellness and disease-management programs, and telehealth. Redlands' inventory is the most complete: VIDA for weight management, Cylinder Health for digestive health, Hinge Health for musculoskeletal care, Livongo for diabetes and blood pressure, BCBS virtual visits, the Well onTarget assessment (a \$250 deductible credit), and an employee assistance program through The Standard. NWOSU additionally reports medical cost transparency and provider-quality navigation, and NSU uses the ZERO card for the same purpose. Redlands reports ZERO Health is highly used by its employees for maintenance prescriptions, lab work, and surgeries.

HealthChoice institutions report far less: the wellness and telehealth features built into the state plan and, at Western, the HealthChoice Select program. None reports navigation, centers of excellence, pharmacy management, or direct primary care. These are also the institutions facing the largest 2027 increases. Among the standalone plans, OCCC has assembled a creative set — OCCC Rx, TimelyCare, HSA funding, a wellness committee — and UCO retains ZERO, MDLive telehealth, and Primary Health Partners direct primary care.

Provider-quality navigation of the kind OU delivers through Garner Health appears at only a few institutions, and direct or near-site primary care appears only at UCO (according to available survey information). ***Extending navigation and high-value-care programs across all institutions — particularly to the HealthChoice institutions, where they would need to sit alongside rather than inside the state plan — is a concrete opportunity.***

9. Institutional Priorities and Needs

9.1 What institutions are most concerned about

Concern	Institutions citing it
Overall cost increases	SEOSU, Western, Eastern, NWOSU, Northern Oklahoma, NSU, SWOSU, OCCC
Employee affordability	Western, Eastern, NWOSU, Northern Oklahoma, NSU, SWOSU, OCCC
Dependent coverage cost	SEOSU, Western, Eastern, NWOSU, Northern Oklahoma, NSU, OCCC
Pharmacy costs	SEOSU, NWOSU, Northern Oklahoma, NSU, OCCC, Redlands
High-cost claims	SEOSU, NWOSU, Northern Oklahoma, NSU, OCCC
Limited internal staffing or expertise; vendor support; compliance	NSU

9.2 What institutions have asked for

Support requested	Institutions
Cost-management strategies	NWOSU, Northern Oklahoma, Eastern, Western, Redlands, NSU, OCCC
Benchmarking against similar institutions	NWOSU, Northern Oklahoma, Eastern, Redlands, SWOSU, OCCC
Pharmacy / PBM review	NWOSU, NSU, Redlands, SWOSU, OCCC
Education on alternative funding models	NWOSU, Northern Oklahoma, SWOSU, OCCC

Support requested	Institutions
General plan design review	NWOSU, NSU, OCCC
Renewal strategy	NWOSU, Redlands, OCCC
Employee contribution strategy; vendor/consultant evaluation	NWOSU, OCCC
Open to a follow-up conversation	SEOSU, Eastern, NWOSU, Northern Oklahoma, NSU, SWOSU, OCCC (Western: depending on topic)

The two most common requests — cost-management strategies and benchmarking.

10. Opportunities for Shared Strategy

10.1 Pharmacy and PBM — the highest-leverage near-term target

Demand is explicit, the analytical partners are already engaged, and a few institutions already have a directly relevant playbook.

10.2 A standard cost benchmark and reporting template

Benchmarking is the second-most requested form of support, and the system currently lacks a consistent basis for it. A simple annual template — employer cost, employee cost, cost per employee per month, covered lives, and renewal by line of coverage — would turn this overview into a durable benchmark.

10.3 Contribution-strategy and plan-design advisory

Institutions are making consequential contribution decisions now without access to the modeling. A short advisory engagement or a shared decision guide on defined-contribution design, plan-steerage incentives, dependent-tier pricing, and affordability trade-offs would meet a live need.

10.4 Extending navigation and high-value-care programs — especially to HealthChoice institutions

The HealthChoice institutions face the largest 2027 increases and have the fewest add-on programs, yet cannot change the state plan itself. The question is what can be layered alongside it: navigation and provider-quality tools of the kind OU uses, centers-of-excellence access, or telehealth and direct-primary-care arrangements. OU's experience with Garner Health and Zero Health is directly applicable.

10.5 Consortium leverage on ancillary lines and services

SEOSU and Northern Oklahoma each changed life and disability vendors for 2027 savings — a signal that ancillary lines are being shopped one institution at a time. Stop-loss coverage for the standalone self-funded plans, navigation and telehealth vendors, and benefits-administration platforms are all candidates for system-wide pricing, connecting to OSRHE's broader consortium-purchasing work through OHEPC.